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

Effective July 1, 2015

PA Forms: available online at https://www.colorado.gov/hcpf/provider-forms

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

Brand Name Required = BNR
Prior Authorization = PA

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
ALZHEIMER'S AGENTS *Effective 4/1/2015*	**No PA Required (*Must meet eligibility criteria)** donepezil tab donepezil ODT galantamine galantamine ER NAMENDA IR	**PA Required** ARICEPT (donepezil) ARICEPT 23mg (donepezil) ARICEPT ODT (donepezil) EXELON (rivastigmine) (cap, soln. and patch) NAMENDA XR (memantine) NAMZARIC (memantine/donepezil) RAZADYNE (galantamine) RAZADYNE ER (galantamine)	***eligibility criteria for Preferred Agents –** All preferred products will be approved without PA if the member has a diagnosis of dementia which can be verified by SMART PA. Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) Members currently stabilized on a non-preferred product can receive approval to continue on that agent for one year if medically necessary and if there is a diagnosis of dementia.
ANTICOAGULANTS- ORAL *Effective 10/1/2014*	**No PA Required(*Must meet eligibility criteria)** warfarin *XARELTO (rivaroxaban) (2nd line)	**PA Required** COUMADIN (warfarin) ELIQUIS (apixaban)	**ELIQUIS®** will be approved if: • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) **OR** • The member is need of prophylaxis for DVT following knee or hip replacement surgery **OR** • The member has a diagnosis of non-valvular atrial fibrillation **AND**

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		PRADAXA (dabigatran)
		
		SAVAYSA (edoxaban)
			• The member does not have a mechanical prosthetic heart valve **AND**
			• The member does not have an active pathological bleed **AND**
			• The member has failed warfarin or is not a candidate for warfarin as defined as meeting one of the following criteria:
			  o The member has a labile INR for reasons other than noncompliance (e.g, member has an INR outside of 2-3 > 60% of the time for a period of two months) **OR**
			  o The member has significant difficulty with complying with monitoring **OR**
			  o The member is on dialysis
			  o The member has an allergy or intolerance to warfarin **AND**
			• The member has failed a one month trial of Xarelto®. (Failure is defined as : lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)
			
			PRADAXA® will be approved if:
			• The member is not on dialysis **AND**
			• The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) **OR**
			• The member has a diagnosis of non-valvular atrial fibrillation **AND**
			• The member does not have a mechanical prosthetic heart valve **AND**
			• The member does not have an active pathological bleed **AND**
			• The member has failed warfarin or is not a candidate for warfarin as defined as meeting one of the following criteria:
			  o The member has a labile INR for reasons other than noncompliance (e.g, member has an INR outside of 2-3 > 60% of the time for a period of two months) **OR**
			  o The member has significant difficulty with complying with monitoring **OR**
			  o The member has an allergy or intolerance to warfarin **AND**
			• The member has failed a one month trial of Xarelto®. (Failure is defined as : lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)

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			***XARELTO®** will be approved if all the following criteria have been met:
			• The member is not on dialysis **AND**
			• The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) **OR**
			• The member is in need of a prophylaxis of DVT following knee or hip replacement surgery **OR**
			• The member has a diagnosis of non-valvular atrial fibrillation **AND**
			• The member does not have a mechanical prosthetic heart valve **AND**
			• The member does not have an active pathological bleed **AND**
			• The member has failed warfarin or is not a candidate for warfarin as defined as meeting one of the following criteria:
			  o Labile INR for reasons other than noncompliance (e.g, member has an INR outside of 2-3 > 60% of the time for a period of two months) **OR**
			  o The member has significant difficulty with complying with monitoring **OR**
			  o The member has an allergy or intolerance to warfarin
			
			SAVAYSA® will be reviewed for medical necessity after use of both preferred products. Failure is defined as : lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction
			
			Grandfathering:
			Beginning 10/1/2013, members currently stabilized on a non-preferred agent can receive approval to continue on that agent for one year if medically necessary

ANTI-EMETICS *Effective 1/1/2015*	**No PA Required** ondansetron tablets ondansetron ODT tab ondansetron oral solution (members under 5 years only)	**PA Required** ALOXI (palonosetron) AKYNZEO (netupitant/palensetron) ANZEMET (dolasetron) DICLEGIS (doxylamine/pyridoxine)	Non-preferred products will be approved for members who have failed treatment with brand or generic ondansetron within the last year. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Ondansetron suspension will be approved for members < 5 years and those members ≥ 5 years of age with a feeding tube. Emend will be approved upon verification that the member is undergoing moderately emetogenic or highly emetogenic chemotherapy as part of a

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		EMEND (apepritant) KYTRIL (granisetron) SANCUSO (granisetron) ZOFRAN (ondansetron) tabs ZOFRAN (ondansetron) suspension ZOFRAN ODT (ondansetron) ZUPLENZ (ondansetron)	regimen with a corticosteroid and a 5HT3 antagonist. **Verification may be provided from the prescriber or the pharmacy.** Emend will be approved for prophylaxis of postoperative nausea and vomiting (one 40mg capsule will be approved). **Verification may be provided from the prescriber or the pharmacy.** Approval for DICLEGIS will be granted if the member has nausea and vomiting associated with pregnancy **AND** The member has failed a trial of doxylamine 10-12.5mg **OR** The member has failed a trial of oral ondansetron 4mg every 8 hours for five days **OR** The member has an intolerance or contraindication to ondansetron
ANTI-DEPRESSANTS **Newer Generation Antidepressants** *Effective 1/1/2015*	**No PA Required** bupropion IR, SR, XL citalopram escitalopram fluoxetine mirtazipine paroxetine sertraline venlafaxine IR tabs venlafaxine XR capsules	**PA Required** APLENZIN ER (bupropion ER) BRINTELLIX (vortioxetine) CYMBALTA (duloxetine) duloxetine FETZIMA (levomilnacipran) fluvoxamine (generic Luvox) KHEDEZLA (desvenlafaxine base) LEXAPRO (escitalopram) LUVOX CR (fluvoxamine CR) Nefazodone (generic Serzone) OLEPTRO ER (trazodone ER) PRISTIQ (desvenlafaxine succinate)	Non-preferred products will be approved for members who have failed treatment with three Preferred Products with exceptions for Cymbalta (see below). (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **Grandfathering:** Members currently stabilized on a Non-preferred newer generation antidepressant can receive approval to continue on that agent for one year if medically necessary. **Verification may be provided from the prescriber or the pharmacy.** Cymbalta or duloxetine: Members will NOT need to fail on three Preferred Products if the diagnosis is Diabetic Peripheral Neuropathic Pain. Cymbalta will also be approved for patients with chronic musculoskeletal pain (e.g. osteoarthritis or chronic lower back pain) who have failed a one month consecutive trial of three non-narcotic analgesic agents (e.g. acetaminophen, NSAID, tramadol) at maximally tolerated doses.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		PEXEVA (paroxetine) paroxetine CR PAXIL CR (paroxetine controlled release) PROZAC Weekly (fluoxetine) VIIBRYD (vilazodone)	
ANTI-HERPETIC AGENTS *Effective 1/1/2015*	**No PA Required** acyclovir tablet, capsule, suspension (generic)	**PA Required** FAMVIR (famciclovir) famcyclovir SITAVIG (acyclovir) VALTREX (valacyclovir) valacyclovir VALCYTE (valgancyclovir) ZOVIRAX (acyclovir)	Non-preferred products will be approved for members who have failed an adequate trial with acyclovir (dose and duration) as deemed by approved compendium (see below) (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)

Indication	Adult	Pediatric
Genital herpes simplex: Inital	400 mg orally 3 times daily for 7 to 10 days or 200 mg orally 5 times daily (guideline dosing) for 10 days.	12 years or older, 1000 to 1200 mg/day orally in 3 to 5 divided doses for 7 to 10 days.
Genital herpes simplex: episodic	400 mg orally 3 times daily for 5 days or 800 mg orally twice daily for 5 days or 800 mg orally 3 times daily for 2 days (guideline dosing); or 200 mg orally every 4 hours, 5 times daily for 5 days; initiate at earliest sign or symptom of recurrence.	12 years or older, 1000 to 1200 mg/day orally in 3 divided doses for 3 to 5 days
Genital herpes simplex: Suppressive	400 mg orally twice daily for up to 12 months; alternative dosing, 200 mg orally 3 to 5 times daily.	12 years or older, 800 to 1200 mg/day orally in 2 divided doses for up to 12 months

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			An adequate trial of acyclovir for Genital Herpes Simplex (Suppressive) will be one month.		
			Genital Herpes Simplex with HIV infection: Initial or Recurrent	400 mg ORALLY 3 times daily for 5 to 14 days	< 45 kg: 20 mg/kg (MAX, 800 mg) ORALLY 4 times daily for 7 to 10 days or until no new lesions appear for 48 hours. Adolescents: 400 mg ORALLY twice daily for 5 to 14 days.
			Genital Herpes Simplex with HIV infection: Chronic suppression	400 mg orally twice daily	
			Herpes labialis	400 mg orally 3 times daily for 5 to 10 days	
			Herpes zoster, Shingles	800 mg orally every 4 hours 5 times a day for 7 to 10 days	
			Herpes Zoster, Shingles with HIV infection	800 mg orally 5 times daily for 7 to 10 days	
			Varicella	800 mg orally 4 times a day for 5 days	2 years or older: 20 mg/kg ORALLY 4 times a day for 5 days; over 40 kg, 800 mg ORALLY 4 times a day for 5 days

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			Varicella with HIV infection — 20 mg/kg (MAX, 800 mg) ORALLY 5 times daily for 5 to 7 days — 20 mg/kg (MAX, 800 mg) ORALLY 4 times daily for 7 to 10 days or until no new esions appear for 48 hours.
ANTI-HISTAMINES **Newer Generation Antihistamines** *Effective 7/1/2015*	**No PA Required** cetirizine (generic OTC Zyrtec) 5mg and 10mg tab, chew tab, syrup loratadine (generic OTC Claritin) 10mg tab and syrup	**PA Required** ALAVERT (loratadine) ALLEGRA (fexofenadine) CLARINEX (desloratadine) CLARITIN (loratadine) fexofenadine (generic Allegra) levocetirizine loratadine ODT XYZAL (levocetirizine) ZYRTEC (cetirizine) Brand	Non-preferred antihistamines and antihistamine/decongestant combinations will be approved for members who have failed treatment with two preferred products in the last 6 months 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.)
Antihistamine/Decongestant Combinations *Effective 7/1/2015*	**No PA Required**	**PA Required** ALLEGRA-D (fexofenadine./PSE) CLARINEX-D (desloratadineD) CLARITIN-D (loratadine-D) loratadine-D SEMPREX-D (acrivastine-D) ZYRTEC-D (cetirizine-D)	

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ANTI-HYPERTENSIVES **Angiotensin Receptor Blockers (ARBs)** *Effective 7/1/2015*	**No PA Required** BENICAR (olmesartan) DIOVAN **BNR** (valsartan) irbesartan losartan	**PA Required** ATACAND (candesartan) AVAPRO (irbesartan) brand COZAAR (losartan) EDARBI (azilsartan) MICARDIS (telmisartan) TEVETEN (eprosartan) Valsartan	Non-preferred ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products will be approved for members who have failed treatment with three preferred products in the last 12 months (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.). Renin inhibitors and combinations will not approved in patients with diabetes. Receiving an ACE-inhibitor, ACE-inhibitor combination, ARB, or ARB-combination in combination with a renin inhibitor is contraindicated. **Grandfathering:** Members currently stabilized on brand name Avapro or Avalide can receive approval to continue on that agent for one year if medically necessary. **Verification may be provided from the prescriber or the pharmacy.**
ARB Combinations *Effective 7/1/2015*	**No PA Required** BENICAR-HCT BNR (olmesartan/HCTZ) DIOVAN-HCT **BNR** (valsartan/HCTZ) losartan/HCTZ	**PA Required** ATACAND-HCT (candesartan/HCTZ) candesartan/HCTZ AVALIDE (irbesartan/HCTZ) AZOR(amlodipine/olmesartan) EDARBYCLOR (azilsartan/chlorthalidone) EXFORGE (amlodipine/valsartan) amlodipine/valsartan EXFORGE HCT (amlodipine/valsartan/hctz) Amlodipine/valsartan/hctz	

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		HYZAAR HCT (losartan/hctz) irbesartan/HCTZ MICARDIS-HCT (telmisartan/HCTZ) telmisartan/HCTZ TEVETEN-HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/hctz) TWYNSTA (telmisartan/amlodipine) VALTURNA (aliskiren/valsartan) valsartan/HCTZ	
Renin Inhibitors & Renin Inhibitor Combinations *Effective 7/1/2015*	**No PA Required**	**PA Required** AMTURNIDE (aliskirin/amlodipine/HCTZ) TEKAMLO (aliskiren/amlodipine) TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ) VALTURNA (aliskiren/valsartan)	
ANTI-PLATELETS *Effective 1/1/2015*	**No PA Required** AGGRENOX (ASA/dipyridamole) clopidogrel	**PA Required** BRILINTA (tigacrelor) PLAVIX (clopidogrel)	EFFIENT 10mg should only be considered for patients < 75 years of age and patients weighing ≥ 60 kg without a known diagnosis of TIA or ischemic stroke. BRILINTA will be approved for patients who have a contraindication to Effient (e.g., body weight < 60kg, age ≥ 75 years OR who have had a

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	EFFIENT (prasugrel) Ticlopidine	TICLID (ticlopidine) ZONTIVITY (vorapaxar)	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 be approved for patients with a diagnosis of myocardial infarction or peripheral artery disease without a history of stroke, transient ischemic attack, intracranial bleeding, or active pathological bleeding. Patients must also be taking aspirin and/or clopidogrel concomitantly.
ATYPICAL ANTI-PSYCHOTICS (oral) *Effective 4/1/2015*	**No PA Required**** ABILIFY (aripiprazole) ABILIFY ODT (aripiprazole) clozapine CLOZARIL (clozapine) GEODON (Ziprasidone) LATUDA (lurasidone) olanzapine risperidone risperidone ODT RISPERDAL (risperidone) RISPERDAL ODT (risperidone)	**PA Required** FANAPT (iloperidone) FAZACLO (clozapine) INVEGA (paliperidone) SAPHRIS (asenapine) SEROQUEL XR (quetiapine) ZYPREXA ZYDIS (olanzapine) *** for injectable Atypical Antipsychotics please see Appendix P for criteria**	**IR quetiapine when given at sub therapeutic doses may be restricted for therapy exceeding 30 days. Low-dose quetiapine (<150mg/day) is only FDA approved as part of a drug titration schedule to aid patients in getting to the target quetiapine dose. PA will be required for quetiapine < 150mg per day for longer than 30 days, except for utilization (when appropriate) in members age 65 years or older.* Non-preferred products will only be approved for their FDA approved indications and age limits and only if the member has failed on three preferred products in the last 5 years. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). See Table 1. **Age Limits: All products including preferred products will require a PA for members younger than the FDA approved age for the agent. Members younger than the FDA approved age for the agent who are currently stabilized on an atypical antipsychotic will be eligible for grandfathering. See Table 3. **New Atypical Antipsychotic prescriptions for members under 5 years of age will be reviewed on an individual basis by a clinical health care professional at the Department. PA approval will be based upon medical necessity, evidence to support therapy, proposed monitoring and additional risk/benefit information supplied by the prescriber. Members under 5 years will be reviewed annually for appropriateness of therapy and proper monitoring.**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	quetiapine* SEROQUEL IR* (quetiapine) ziprasidone ZYPREXA (olanzapine)		Grandfathering: Members currently stabilized on a non-preferred atypical antipsychotic can receive approval to continue on that agent for two years even if the member does not meet the age, dosing or FDA approved indication requirements. **Verification may be provided from the prescriber or the pharmacy.** Quantity Limits: All products including preferred products will have quantity limits. In order to receive approval for off-label dosing, the member must have an FDA approved indication and must have tried and failed on the FDA approved dosing regimen. See Table 2. Fazaclo will be approved for the treatment of schizophrenia if the member is 18 years of age or older and has tried and failed treatment with three preferred products (one of which must be generic clozapine) in the last 5 years. Invega will be approved for the treatment of schizophrenia or schizoaffective disorder if the member is 18 years of age or older (12 years or older for schizophrenia) and has tried and failed treatment with / has had adherence issues with three preferred products in the last 5 years. A maximum of one tablet per day will be approved. Seroquel XR will be approved if the member is 18 years of age or older, has tried and failed treatment with three preferred products in the last five years and is being treated for one of the FDA approved indications. See Table 1. If a member has been stabilized on quetiapine for at least 30 days with a positive response but is unable to tolerate the side effects, Seroquel XR may be approved without failure of two additional agents. Zyprexa Zydis will be approved for the treatment of schizophrenia or bipolar 1 disorder if the member is 13 years of age or older and has tried and failed treatment with three preferred products (one of which must be an olanzapine tablet) in the last 5 years. For members that are stabilized on Zyprexa tablets with a documented need for occasional supplementation to treat acute symptoms, up to 5 tablets per month will be allowed without three product failures.

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			Table 1: Approved Indications Drug: Fanapt® Indication: • Acute treatment of schizophrenia in adults Drug: Fazaclo® Indication: • Treatment-resistant schizophrenia • Reducing the risk of recurrent suicidal behavior in patients with schizophrenia or schizoaffective disorder Drug: Invega® Indication: • Schizophrenia • Schizoaffective disorder Drug: Saphris® Indication: • Acute and maintenance of schizophrenia • Bipolar mania, monotherapy • Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex Drug: Seroquel XR® Indication: • Treatment of schizophrenia • Acute treatment of manic or mixed episodes associated with bipolar I disorder, as monotherapy or as an adjunct to lithium or divalproex • Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex • Adjunctive treatment of major depressive disorder (MDD) Table 2: Quantity Limits **Brand Name / Generic Name / Quantity Limits** **Abilify / aripiprazole / Maximum one tablet per day** **clozapine / Maximum dosage of 900mg per day** **Fazaclo / clozapine / Maximum dosage of 900mg per day** **Fanapt / iloperidone / Maximum two tablets per day** **Invega / paliperidone / Maximum one tablet per day** **Latuda / lurasidone / Maximum one tablet per day**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)

	olanzapine	**Maximum one tablet per day (see Zyprexa Zydis criteria for Zydis information)**
	quetiapine	**Maximum three tablets per day**
	risperidone	**Maximum two tablets per day except 4mg tablets will be approved for up to 4 tablets per day**
Saphris	**asenapine**	**Maximum two tablets per day**
Seroquel XR	**quetiapine XR**	**Maximum one tablet per day (for 300mg & 400mg tablets max 2 tablets per day)**
	ziprasidone	**Maximum two tablets per day**

Table 3: FDA Approved Dosing by Age

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 Gilles de la Torette's syndrom	6-17 years 10-17 years 13-17 years 13-17years 6-17 years	15mg/day 30mgday 30mg/day 30mg/day 20mg/day
Clozapine (Fazaclo®, Clozaril®)	NOT APPROVED		
Iloperidone (Fanapt®)			
Lurasidone (Latuda®)			
Olanzapine (Zyprexa®)	Schizophrenia Bipolar Disorder/Mixed Mania	13-17 years 13-17 years	10mg/day 10mg/day
Olanzapine (Zyprexa Zydis®)			

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<table><tr><td>Paliperidone (Invega ER®)</td><td>Schizophrenia</td><td>12-17 years</td><td>12mg/day</td></tr><tr><td>Risperidone (Risperdal®)</td><td>Autism/Psychomotor Agitation Bipolar Disorder/Mixed Mania Schizophrenia</td><td>5-16 years 10-17 years 13-17 years</td><td>3mg/day 6mg/day 6mg/day</td></tr><tr><td>Quetiapine Fumarate (Seroquel®)</td><td>Schizophrenia Bipolar Disorder/Mixed Mania</td><td>13-17 years 10-17 years</td><td>800 mg/day 800 mg/day</td></tr><tr><td>Quetiapine Fumarate (Seroquel XR®)</td><td colspan="3">NOT APPROVED</td></tr><tr><td>Ziprasidone (Geodon®)</td><td colspan="3">NOT APPROVED</td></tr></table>
BISPHOSPHONATES (oral) *Effective 10/1/2014*	**No PA Required** alendronate (generic) 5mg, 10mg, 35mg, 70mg tablets	**PA Required** ACTONEL (risedronate) ACTONEL w/Calcium (risedronate w/calcium) ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate) FOSAMAX (alendronate) FOSAMAX plus D (alendronate w/D) Etidronate SKELID (tiludronate)	Non-preferred products will be approved for members who have failed treatment with at least one strength of alendronate. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) PA will be approved for etidronate in members with heterotopic ossification without treatment failure. For members who have a low risk of fracture, prior authorization will be required for members exceeding 5 years of either a preferred or non-preferred bisphosphonate. Low risk will be defined as having an osteopenic bone mineral density (most recent T-score between -1 and -2.5) **AND** has a FRAX score corresponding to low risk.
DIABETES MANAGEMENT CLASSES **Amylin**	**No PA Required**	**PA Required** SYMLIN (pramlintide)	Symlin® will only be approved after a member has failed a three month trial of two of the following: metformin, a sulfonylurea, or any of the preferred products (Tradjenta or Byetta). Failure is defined as: lack of

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Effective 10/1/2014			efficacy (e.g., hemoglobin A1C ≥ 7%), allergy, intolerable side effects, or a significant drug-drug interaction. **For all products**, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing. PA will be approved for Symlin products for members with Diabetes Mellitus Type 1 without failed treatment. (Failure is defined as: lack of efficacy (e.g., hemoglobin A1C ≥ 7%), allergy, intolerable side effects, or significant drug-drug interaction.)
Biguanides *Effective 10/1/2014*	metformin generic 500mg, 850mg, and 1000mg tablets metformin generic extended-release 500mg tablets (generic Glucophage XR)	FORTAMET (metformin) GLUCOPHAGE (brand) (metformin) GLUCOPHAGE XR (brand) (metformin XR) GLUMETZA ER (metformin) metformin ER 750mg metformin extended-release 500 and 1000mg (generic Fortamet) RIOMET 500mg/5ml (metformin)	Non-preferred products will be approved for members who have failed treatment with two Preferred Products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Liquid metformin will be approved for members who meet one of the following: ➢ under the age of 12 ➢ with a feeding tube who have difficulty swallowing
DPP-4 Inhibitor *Effective 10/1/2014*	*TRADJENTA (linagliptin)	JANUVIA (sitagliptin) NESINA (alogliptin) ONGLYZA (saxagliptin)	*Approval for preferred products require a three month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy. **For all products**, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing. Non preferred DPP-4 inhibitors will be approved after a member has failed a three month trial of metformin and Tradjenta®. Failure is defined as lack of efficacy (e.g., hemoglobin A1C ≥ 7%), allergy, intolerable side effects, or a significant drug-drug interaction.)
GLP-1 Agonist *Effective 10/1/2014*	*BYETTA (exenatide)	BYDUREON (exenatide)	*Approval for preferred products require a three month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy.

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		TANZEUM (albiglutide) TRULICITY (dalaglutide) VICTOZA (liraglutide)	**For all products**, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing. Non preferred GLP-1 agonists will be approved after a member has failed a three month trial of metformin and Byetta®. Failure is defined as lack of efficacy (e.g., hemoglobin A1C ≥ 7%), allergy, intolerable side effects, or a significant drug-drug interaction. Grandfathering: Members currently stabilized on Victoza® can receive approval to continue on that agent for one year.
Hypoglycemic Combinations *Effective 10/1/2014*	**No PA Required**	**PA Required** ACTOPLUS MET (pioglitazone/metformin) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glimepiride) DUETACT (glipizide/metformin) GLUCOVANCE (brand) (glyburide/metformin) glyburide/metformin GLYXAMBI (empagliflozin/linagliptin) INVOKAMET (canagliflozin/metformin) JANUMET (sitagliptin/metformin) JENTADUETO (linagliptin/metformin)	Non-preferred products will be approved for members who have been stable on the two individual ingredients for 3 months and have an adherence issue.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		JUVISYNC (sitagliptin/simvastatin) KAZANO (alogliptin/metformin) KOMBIGLYZE (saxaglipin/metformin) METAGLIP (glipizide/metformin) OSENI (alogliptin/pioglitazone) PRANDIMET (repaglinide/metformin) XIGDUO XR (dapagliflozen/metformin)	
Meglitinides *Effective 10/1/2014*	**No PA Required**	**PA Required** PRANDIN (repaglinide) STARLIX (nateglinide)	Non-preferred products will be approved for members who have failed treatment with one Sulfonylurea (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
SGLT-2 Inhibitor *Effective 10/1/2014*	**No PA Required**	FARXIGA (dapagliflozin) INVOKANA (canaglifozin) JARDIANCE (empagliflozin)	The SGLT-2 inhibitors will only be approved after a member has failed a three month trial of two of the following: metformin, a sulfonylurea, or any of the preferred products (Byetta or Tradjenta). Failure is defined as: lack of efficacy (e.g., hemoglobin A1C ≥ 7%), allergy, intolerable side effects, or a significant drug-drug interaction. The SGLT-2 inhibitors will not be approved for members requiring dialysis or those who are pregnant, or have type 1 diabetes, end stage renal disease or severe renal impairment (defined as a creatinine clearance < 45ml/min). **For all products**, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing.
Thiazolidinediones *Effective 10/1/2014*	**No PA Required** pioglitazone	**PA Required** ACTOS (pioglitazone)	*Note: Agents in this class may be associated with increased cardiovascular risks. Risk/benefit analysis should be considered before initiating therapy. Prior authorizations for rosiglitazone will be manually

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		AVANDIA (rosiglitazone)	reviewed by the Department based upon reported risk mitigation, medical justification and contraindication to pioglitazone.
ERYTHROPOIESIS STIMULATING AGENTS *Effective 10/1/2014*	***Must meet eligibility criteria** PROCRIT (epoetin alfa)	**PA Required** ARANESP (darbepoetin alfa) EPOGEN (epoetin alfa) MIRCERA (methoxy peg-epoetin beta)	***Eligibility Criteria for all agents in the class** Members must meet all criteria in one of the following four areas: ➢ A diagnosis of cancer, currently receiving chemotherapy, with chemotherapy-induced anemia, and hemoglobin of 10g/dL or lower. ➢ A diagnosis of chronic renal failure, and hemoglobin below 10g/dL ➢ A diagnosis of hepatitis C, currently taking Ribavirin and failed response to a reduction of Ribavirin dose, and hemoglobin less than 10g/dL (or less than 11g/dL if symptomatic). ➢ A diagnosis of HIV, currently taking Zidovudine, hemoglobin less than 10g/dL, and serum erythropoietin level of 500mUnits/mL or less. Hemoglobin results must be from the last 30 days. Medication must be administered in the member's home or long-term care facility. **Non-preferred products:** ➢ Same as above; **and** ➢ Failed treatment with Procrit. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) **Note: The FDA has announced a risk evaluation mitigation strategy for the use of Erythropoeisis Stimulating Agents (ESAs) in patients with cancer, who are currently receiving chemotherapy, and who are experiencing chemotherapy induced anemia. Patients must receive a medication guide outlining the risks and benefits of treatment, and patient consent must be obtained before therapy. Prescribers are required to enroll and register in the ESA APPRISE Oncology program and complete training prior to prescribing ESAs to patients with cancer. For non-cancer indications, the distribution of a medication guide to the patient is the only requirement currently.**
FIBROMYALGIA AGENTS *Effective 7/1/2015*	**No PA Required** LYRICA (pregabalin)	**PA Required** CYMBALTA (duloxetine)	Non-preferred agents will be approved for fibromyalgia if member has failed an adequate trial (8 weeks) of both Lyrica and duloxetine OR the member has contraindication to Lyrica and duloxetine

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	duloxetine	SAVELLA (milnacipran)	GENERIC DULOXETINE will be approved if the member has diagnosis for fibromyalgia. For members with no epilepsy diagnosis in the last two years (as confirmed by SMART PA), PA will be required for LYRICA prescriptions requiring more than 3 capsules per day or for prescriptions requiring doses greater than 600mg per day.
FLUOROQUINOLONE (oral) *Effective 1/1/2015*	**No PA Required** Ciprofloxacin tablet CIPRO oral suspension (<5 years old) Levofloxacin tablet	**PA Required** AVELOX (moxifloxacin) CIPRO TABLET (ciprofloxacin) LEVAQUIN TABLET (levofloxacin) NOROXIN (norfloxacin) Ofloxacin	Non-preferred products will be approved for members 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 members < 5 years of age without PA For members ≥ 5 years of age, CIPRO suspension will only be approved for those members who cannot swallow a whole or crushed tablet Levofloxacin solution will be approved for members who require administration via feeding tube **OR** who have failed an adequate trial (7 days) of ciprofloxacin suspension. (Failure is defined as: lack of efficacy, presence of feeding tube, allergy, intolerable side effects, or significant drug-drug interaction.)
GROWTH HORMONES *Effective 4/1/2015*	**No PA Required** GENOTROPIN	**PA Required** HUMATROPE NORDITROPIN NUTROPIN OMNITROPE SAIZEN SEROSTIM TEV-TROPIN	Non-preferred Growth Hormones will be approved if **both** of the following criteria are met: ▪ Member failed treatment with Genotropin within the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) ▪ Member has a qualifying diagnosis: ➢ Prader-Willi ➢ Chronic renal insufficiency/failure ➢ Turner's Syndrome ➢ Hypopituitarism: as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma ➢ Wasting associated with AIDS or cachexia ➢ Noonan Syndrome

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		ZORBTIVE	Grandfathering: If the member has a diagnosis for short bowel syndrome OR cachexia associated with AIDS, member will be grandfathered and receive approval for a non-preferred agent due to medical necessity based on FDA approved indications.
HEPATITIS C VIRUS TREATMENTS *Effective 10/1/2014* *Updated 4/1/15*	**No PA Required**	**PA Required** HARVONI (sofosbuvir/ledipasvir) INCIVEK (Telaprevir) OLYSIO (Simeprevir) SOVALDI (Sofosbuvir) VICTRELIS (boceprevir) VIEKIRA PAK (ombitasvir/paritaprevir/ritonavir/ dasabuvir)	All hepatitis C virus treatments will be approved on a case by case basis. Requests for **Incivek®** will be approved if the following criteria are met: 1. A documented diagnosis of Hepatitis C Genotype 1 with no HIV co-infection AND concurrent therapy with ribavirin and pegylated interferon. 2. The patient is eighteen (18) years or older. 3. The patient's previous treatment history and weight are presented at the time of initial request. 4. Member must be 6 months free of: alcohol and Schedule I controlled substances (including marijuana); and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate alcohol/drug screens. Member must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Routine alcohol/drug screens must be conducted monthly for clients that have a history (within the past 2 years) of alcohol/drug abuse. 5. The patient's Child-Pugh score is <6 (compensated cirrhotic liver disease). 6. The patient is not receiving strong CYP3A4 inducer (e.g., rifampin, rifabutin, phenytoin) or drug dependent on CYP3A4 clearance (e.g., alfuzosin, cisparide, dihydroergotamine, ergonovine, ergotamine, lovastastin, sildenafil, tadalafil, simvastatin, triazolam). 7. The patient has not previously tried/failed therapy with a hepatitis C protease inhibitor (e.g. Victrelis® or Olysio ®). 8. The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication). 9. Incivek® is prescribed in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist. 10. 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.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			Requests for **Olysio®** will be approved if the following criteria are met: 1. A documented diagnosis of Hepatitis C Genotype 1 with no HIV co-infection AND concurrent therapy with ribavirin and pegylated interferon unless in combination with a polymerase inhibitor. 2. The patient is eighteen (18) years or older. 3. The patient's previous treatment history and weight are presented at the time of initial request. 4. Member must be 6 months free of: alcohol and Schedule I controlled substances (including marijuana); and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate alcohol/drug screens. Member must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Routine alcohol/drug screens must be conducted monthly for clients that have a history (within the past 2 years) of alcohol/drug abuse. 5. The patient's Child-Pugh score is <6 (compensated cirrhotic liver disease). 6. The patient is not receiving moderate to strong inhibitors (e.g, erythmromycin, 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. 7. The patient has not previously tried/failed therapy with a hepatitis C protease inhibitor (e.g. Incivek® or Victrelis®). 8. The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication). 9. 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. 10. Olysio ® is prescribed in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist. 11. A sensitive RT-PCR assay HCV-RNA test with a lower limit of quantification of ≤25 IU/ml and a limit of detection of

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			approximately 10 to 15 IU/ml is required to be submitted before the start of therapy. 12. For patients with HCV genotype 1a, evidence should be provided that the patient does not have NS3 Q80K polymorphism prior to starting therapy. Requests for **Victrelis®** will be approved if the following criteria are met: 1. A documented diagnosis of Hepatitis C Genotype 1 with no HIV co-infection AND concurrent therapy with ribavirin and pegylated interferon. 2. The patient will be on a treatment regimen of ribavirin and pegylated interferon for four (4) weeks prior to initiation of Victrelis. 3. The patient is eighteen (18) years or older. 4. The patient is not receiving strong CYP3A4 inducer (e.g., rifampin, rifabutin, phenytoin). 5. Member must be 6 months free of: alcohol and Schedule I controlled substances (including marijuana); and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate alcohol/drug screens. Member must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Routine alcohol/drug screens must be conducted monthly for clients that have a history (within the past 2 years) of alcohol/drug abuse. 6. The patient's previous treatment history and weight are presented at the time of initial request 7. The patient's Child-Pugh score is <6 (compensated cirrhotic liver disease). 8. The patient has not previously tried/failed therapy with a hepatitis C protease inhibitor (e.g. Incivek® or Olysio®). 9. The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication). 10. Victrelis® is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist. 11. 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.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			Harvoni® Interim Criteria Will be approved on a case by case basis Will be evaluated based on the following interim criteria: 1. Physician attests that the member's health will be significantly impacted if treatment is delayed until October 2015 **AND** 2. Physician attests to the member's readiness for adherence **AND** 3. Must have chronic Hepatitis C (HCV) genotype 1a or 1b **AND** 4. Member is 18 years of age and older **AND** 5. Member does not have hepatitis B or human immunodeficiency virus (HIV) **AND** 6. 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 **AND** 7. Harvoni is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist **AND** 8. Meets one of the following categories based on liver biopsy or other accepted test: • Members with serious extra-hepatic manifestations of HCV such as leukocytoclasic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease; • Members with compensated cirrhosis defined by Child-Turcotte Pugh (CTP) class A; or CTP B and on transplant list with projected time to transplant < 1 year; • Transplant members with fibrosing cholestatic HCV or recipient who have cirrhosis from recurrent HCV and have been approved for re-transplantation; • Member is listed on the transplant list with a projected time to transplant of < 1 year; or • Member has a Metavir fibrosis score of 3-4, or equivalent using a widely recognized test **AND**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			9. Members may be treatment naïve or treatment experienced, except with a direct-acting antiviral (DAA) **AND** 10. The member does not have severe renal impairment (eGFR<30 ml/min/1.73m^2), end state renal disease, on hemodialysis **AND** 11. Member must be 6 months free of: alcohol; and Schedule I controlled substance (including marijuana), and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse 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 members that have a history (within the past 2 years) of drug or alcohol abuse **AND** 12. Member is not taking H_2 receptor antagonist with dose exceeding the equivalent of famotidine 40 mg twice daily, proton pump inhibitor with a dose exceeding the equivalent of omeprazole 20 mg, carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, tenofovir, tipranavir, simeprevir, St. John's wort, rosuvastatin **AND** 13. Member must have a baseline HCV RNA level within 30 days of anticipated start date **AND** 14. All approvals will initially be for an 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** 15. If the week 4 HCV RNA is detectable (≥25 copies) while on Harvoni therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has increased (i.e., >1 log10 IU/ml from nadir), all treatment will be discontinued unless documentation is provided to support continuation of therapy **AND** 16. Must be in accordance to approved regimens and duration (see Table 1) **AND** 17. **Must** be adherent to treatment regimen (see discontinuation criteria) **AND**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			18. Must have received or planning to receive full courses of both Hepatitis A and Hepatitis B vaccinations. **Note*:*** Once treated, the Department will only cover a once per lifetime treatment with any DAA. **Discontinuation Criteria:** • Members receiving a Sofosbuvir-based regimen should have HCV RNA levels assessed at weeks 4, 6 (if applicable), and 12 (if applicable); if the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued. • The department will prospectively evaluate medication adherence based on prescription fills. If a member documents non-adherence to filling their Harvoni prescription (e.g. within 7 days), all treatment will be discontinued. • Members with a history of drug or alcohol abuse/misuse within the last 2 years must provide random monthly drug and alcohol screens to continue receiving treatment for HCV. **Quantity and Refill Limits:** • Quantity Limit: one ledipasvir 90 mg/sofosbuvir 400 mg tablet per day (28 tablets/28days) • Length of authorization: Based on HCV subtype • Refills: Should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill. **Table 1. Recommended Regimens and Treatment Duration for Harvoni** **HCV Genotype and Comorbidities** | **Treatment** | **Duration**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)

Treatment naïve with or without compensated cirrhosis	Harvoni	12 weeks
Treatment-experienced without compensated cirrhosis	Harvoni	12 weeks
Treatment-experienced with compensated cirrhosis	Harvoni	24 weeks

Requests for **Sovaldi®** will be prior authorized if the following criteria are met:

1. Member must have chronic Hepatitis C (HCV) genotype 1, 2, 3 (on transplant list only) or 4 **AND**
2. Member is 18 years of age and older **AND**
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 **AND**
4. Sofosbuvir is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist **AND**
5. Member meets one of the following categories based on liver biopsy, symptoms or other accepted test:
   - Member with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease;
   - Members with compensated cirrhosis defined by Child-Turcotte Pugh (CTP) class A; or CTP B and on transplant list with projected time to transplant < 1 year;
   - Member is listed on the liver transplant list with a projected time to transplant of < 1 year (genotype: 1 naïve, 1 experienced, 2, 3, and 4);
   - Member has hepatocellular carcinoma meeting Milan criteria; or
   - Member has a fibrosis score equivalent to METAVIR 3-4 **AND**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			6. For members with Genotype 1, must be Hepatitis C treatment naïve **AND** 7. Member does not have severe renal impairment (eGFR<30 ml/min/1.73m2) or end stage renal disease requiring hemodialysis **AND** 8. Member must be 6 months free of: alcohol and Schedule I controlled substances (including marijuana); and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate alcohol/drug screens. Member must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Routine alcohol/drug screens must be conducted monthly for clients that have a history (within the past 2 years) of alcohol/drug abuse **AND** 9. Member must have a baseline HCV RNA level within 30 days of anticipated start date **AND** 10. If member is receiving concomitant treatment with a hepatitis protease inhibitor (e.g. simeprevir) this will be reviewed based on medical necessity **AND** 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 justify continuing drug therapy (see discontinuation criteria) **AND** 12. If the week 4 HCV RNA is detectable while on sofobuvir therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e. >1 log10 IU/ml from nadir) all treatment will be discontinued unless documentation is provided to support continuation of therapy **AND** 13. Must be in accordance to approved regimens and duration (see Table 1) **AND** 14. Must be adherent to treatment regimen (see discontinuation criteria) **AND** 15. Must be Sofosbuvir naïve. **Note:** Once treated, the Department will only cover a once per lifetime treatment with Sofosbuvir. **Discontinuation Criteria:**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			• Members receiving a Sofosbuvir based regimen should have HCV RNA levels assessed at weeks, 4, 6 (if applicable), and 12 (if applicable); if the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued. • The department will prospectively evaluate medication adherence based on prescription fills. If a member is non-adherent in filling their Sofosbuvir prescription (e.g. not filled within 7 days of the end of the previous fill), all treatment will be discontinued. **Table 1. Recommended Regimens and Treatment Duration for Sofosbuvir** **HCV Genotype** / **Treatment** / **Duration** Genotype 1: interferon eligible / Sofosbuvir + peginterferon alfa + ribavirin / 12 weeks Genotype 1: interferon ineligible / Sofosbuvir + ribavirin / 24 weeks Genotype 2: / Sofosbuvir + ribavirin / 12 weeks Genotype 3: on transplant list / Sofosbuvir + ribavirin / 24 weeks Genotype 4: interferon eligible / Sofosbuvir + peginterferon alfa + ribavirin / 12 weeks Genotype 4: interferon ineligible / Sofosbuvir + ribavirin / 24 weeks Post-transplant members follow the same treatment regimen as described above. **Quantity and Refill Limits:** • Quantity Limit: one 400mg tablet per day (28 tablets/28days) • Length of authorization: Based on HCV subtype

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			• Refills: Should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill. **Interferon Alpha Ineligible defined:** • Platelet count <75,000mm3 • Decompensated liver cirrhosis (CTP Class B or C or CTP score ≥ 7) • Documented history of depression or mood disorder, which are not stable on current drug regimen • Autoimmune hepatitis and another autoimmune disorder • Inability to complete a prior treatment course due to a documented interferon-related adverse event. **Viekira Pak (Ombitasvir, Paritaprevir, Ritonavir, and Dasabuvir) - Interim Criteria** Will be approved on a case by case basis until final criteria are effective Will be evaluated based on the following interim criteria: 1. Physician attests that the member's health will be significantly impacted if treatment is delayed until October 2015 **AND** 2. Physician attests to the member's readiness for adherence **AND** 3. Must have chronic Hepatitis C (HCV) genotype 1a or 1b **AND** 4. Member is 18 years of age and older **AND** 5. 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 **AND** 6. Viekira Pak is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist **AND** 7. Meets one of the following categories based on liver biopsy or other accepted test: • Members with serious extra-hepatic manifestations of HCV such as leukocytoclasic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease;

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			• Members with compensated cirrhosis defined by Child-Turcotte Pugh (CTP) class A; or CTP B and on transplant list with projected time to transplant < 1 year; • Transplant members with fibrosing cholestatic HCV or recipient who have cirrhosis from recurrent HCV and have been approved for re-transplantation; • Member is listed on the transplant list with a projected time to transplant of < 1 year; or • Member has a Metavir fibrosis score of 3-4, or equivalent using a widely recognized test **AND** 8. Members may be treatment naïve or treatment experienced, except with a direct-acting antiviral (DAA) **AND** 9. Members may be HIV positive **AND** 10. The member does not have severe hepatic impairment, decompensated liver disease, end-stage renal disease requiring hemodialysis, or will be taking strong CYP3A4 and CYP2C8 inducers, estradiol-containing agents, including contraceptives, or strong CYP2C8 inhibitor medications concurrently **AND** 11. Member is not taking alfuzosin, carbamazepine, phenytoin, phenobarbital, gemfobrozil, rifampin, ergoamine, dihydroergotamine, ergonovine, methylergonovine, ethinyl estradiol-containing agents (such as combined oral contraceptives), St. John's Wort, lovastatin, simvastatin, pimozide, efavirenz, sildenafil dosed for treatment of pulmonary arterial hypertension, triazolam, oral midazolam **AND** 12. Member is taking less than or equal to: 200 mg of ketoconazole, 300 mg of atazanavir (without ritonavir) in the morning, 10 mg of rosuvastatin, 40 mg of pravastatin, 40 mg of omeprazole, or adjusted tacrolimus 0.5 mg every 7 days **AND** 13. Member must be 6 months free of: alcohol; and Schedule I controlled substance (including marijuana); and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate drug screens and counseled about the importance of refraining from drug and/or alcohol abuse. Routine

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			substance/alcohol/opioid screens must be conducted monthly for members that have a history (within the past 2 years) of drug or alcohol abuse **AND** 14. Member must have baseline HCV RNA and ALT levels within 30 days of anticipated start date **AND** 15. 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** 16. If the week 4 HCV RNA is detectable while on Viekira Pak therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has increased (i.e., >1 log10 IU/ml from nadir) all treatment will be discontinued unless documentation is provided to support continuation of therapy **AND** 17. Must be in accordance to approved regimens and duration (see Table 1) **AND** 18. Must be adherent to treatment regimen **AND** prescriber to consider enrolling member in the proCeed program (by phone: 1-844-2proCeed or online at: https://www.viekira.com/proceed-program) to re-enforce adherence **AND** 19. Must have received or planning to receive full courses of both Hepatitis A and Hepatitis B vaccinations. **Note:** Once treated, the Department will only cover a once per lifetime treatment with any DAA. **Discontinuation Criteria:** • Members receiving a Viekira Pak-based regimen should have HCV RNA levels assessed at weeks, 4, 6 (if applicable), and 12 (if applicable). If the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued. • Members receiving a Viekira Pak-based regimen should have ALT levels at baseline, 4 weeks, and again as clinically

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			necessary. Members may need to discontinue if ALT levels remain over 10 times ULN, and will need to discontinue if ALT elevation is accompanied with signs or symptoms of liver inflammation, increased conjugated bilirubin, alkaline phosphatase, or INR. • The department will prospectively evaluate medication adherence based on prescription fills. If a member documents non-adherence to filling their Viekira Pak prescription (e.g. within 7 days), all treatment will be discontinued. • Members with a history of drug or alcohol abuse/misuse within the last 2 years must provide random monthly drug and alcohol screens to continue receiving treatment for HCV. **Quantity and Refill Limits:** • Quantity Limit: two ombitasvir/paritaprevir/ritonavir 12.5/75/50 mg tablets once daily and one dasabuvir 250 mg tablet twice daily (112 tablets/28days) • Length of authorization: Based on HCV subtype • Refills: Should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill. **Table 1. Recommended Regimens and Treatment Duration for Viekira Pak**

HCV Genotype and Comorbidities (Mono-infected and HCV/HIV-1 Co-infected)	Treatment	Duration
Members with genotype 1a, without compensated cirrhosis	Viekira Pak + ribavirin	12 weeks
Members with genotype 1a, with compensated cirrhosis	Viekira Pak + ribavirin	24 weeks
Members with genotype 1b, without compensated cirrhosis	Viekira Pak	12 weeks

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			Members with genotype 1b, with compensated cirrhosis: Viekira Pak + ribavirin — 12 weeks Post-transplant members: Viekira Pak + ribavirin — 24 weeks
Insulin *Effective 4/1/2015* **Rapid Acting**	**No Prior Authorization Required** NOVOLOG vial and pen	**Prior Authorization Required** AFREZZA APIDRA all forms HUMALOG vial and pen	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects) AFREZZA (human insulin) will be approved for members with the following criteria: • Member is 18 years or older AND • Member has intolerable side effects or severe allergic reactions to Novolog AND • Member must not have chronic lung disease such as asthma and COPD AND • If member is a type 1 diabetic, must use in conjunction with long-acting insulin AND • Member must not be a smoker
Short Acting	HUMULIN R vial and pen	NOVOLIN R all forms	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)
Intermediate Acting	HUMULIN N vial and pen	NOVOLIN N all forms	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)
Long Acting	LEVEMIR vial and pen	LANTUS all forms TOUJEO all forms	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)
Mixtures	HUMULIN 70/30 vial and pen NOVOLIN 70/30 vial HUMALOG MIX 50/50 vial and pen HUMALOG MIX 75/25 vial and pen	None	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	NOVOLOG MIX 70/30 vial and pen		
INTRANASAL CORTICOSTEROIDS *Effective 4/1/2015*	**No Prior Authorization Required** fluticasone (generic FLONASE) NASONEX	**Prior Authorization Required** BECONASE AQ (beclomethasone diproprionate) FLONASE (fluticasone) NASAREL (flunisolide) NASACORT AQ (triamcinolone) OMNARIS (ciclesonide) QNASL (beclomethasone diproprionate) RHINOCORT AQ (budesonide) Triamcinolone acetonide VERAMYST (fluticasone furoate) ZETONNA (ciclesonide)	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
LEUKOTRIENE MODIFIERS *Effective 4/1/2015*	**No Prior Authorization Required** Montelukast (generic SINGULAIR)	**Prior Authorization Required** ACCOLATE (zafirlukast) SINGULAIR (montelukast) ZYFLO (zileuton)	Non-preferred Leukotrienes will be approved if **both** of the following criteria are met: ▪ Client failed treatment with montelukast in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) ▪ Client has a diagnosis of Asthma
MULTIPLE SCLEROSIS AGENTS *Effective 4/1/2015*	**No Prior Authorization Required** AVONEX (interferon beta 1a)	**Prior Authorization Required** AUBAGIO (teriflunomide) AMPYRA (dalfampridine)	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). **Copaxone® 40mg** will be approved for members who have a severe intolerable injection site reactions (e.g, pain requiring local

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)

	BETASERON (interferon beta 1b)
	
	*GILENYA (fingolimid) (2nd line)
	
	REBIF (interferon beta 1a)
	
	COPAXONE 20MG INJECTION (glatiramer)
		COPAXONE 40MG INJECTION (glatiramer)
		
		EXTAVIA (interferon beta 1b)
		
		PLEGRIDY (peg-interferon beta 1a)
		
		TECFIDERA (dimethyl fumarate)
			anesthetic, oozing, lipoatrophy, swelling, or ulceration) to Copaxone 20mg.
			
			Ampyra – Up to a 90 day supply of Ampyra will be approved if all of the following criteria are met:
			• Client has a diagnosis of MS;
			• Client is ambulatory and has established a baseline which is defined as ambulating between 8-45 seconds Timed 25-foot Walk (T25FW) assessment;
			• Client has no history of seizure disorder;
			• Client has no history of moderate to severe renal dysfunction (CrCl > 50 ml/min);
			• Prescriber is a neurologist;
			• The prescribed dose does not exceed 10 mg twice daily.
			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.
			
			AUBAGIO will be approved if the client has met all the following criteria:
			• In members **without** a contraindication to GILENYA, member has failed COPAXONE or a preferred interferon product **AND** GILENYA. [Failure will be defined as intolerable side effects (3 month trial), drug-drug interaction, or lack of efficacy (6 month trial)]
			OR
			• In members **with** a contraindication to GILENYA, has failed COPAXONE or a preferred interferon product. Failure will be defined as intolerable side effects (3 month trial), drug-drug interaction, or lack of efficacy (6 month trial). Lack of efficacy will be defined as one of the following:
			  • On MRI: presence of any new spinal lesions, cerebellar or brain stem lesions, or change in brain atrophy.
			  • On clinical exam, signs and symptoms consistent with functional limitations that last one month or longer.
			
			AND

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			• Has a diagnosis of a relapsing form of MS AND • Is being prescribed by a neurologist AND • Has no active infections AND • If a female patient of child bearing age, has a negative pregnancy test at baseline and is using a form of highly effective contraceptive AND • Had transaminase and bilirubin levels with ALT<2 times the upper limit of normal within the 6 months prior to initiating therapy AND • Had a complete blood count with differential within the six months prior to initiating therapy AND • Has a documented baseline blood pressure AND • Has been evaluated for active or latent tuberculosis infections by documented test results (purified protein derivative test) or blood test. **TECFIDERA** will be approved if the client has met all the following criteria: • In members without a contraindication to GILENYA, member has failed COPAXONE or a preferred interferon product and GILENYA. Failure will be defined as intolerable side effects (3 month trial), drug-drug interaction, or lack of efficacy (6 month trial) OR • In members with a contraindication to GILENYA, has failed COPAXONE or a preferred interferon product. Failure will be defined as intolerable side effects (3 month trial), drug-drug interaction, or lack of efficacy (6 month trial). Lack of efficacy will be defined as one of the following: • One of the following on MRI: presence of any new spinal lesions, cerebellar or brain stem lesions, or change in brain atrophy • On clinical exam, signs and symptoms consistent with functional limitations that last one month or longer. AND

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)

			• Has a diagnosis of a relapsing form of MS AND
			• Is being prescribed by a neurologist AND
			• Has no active infections AND
			• Had a complete blood count with differential within the six months prior to initiating therapy.
			
			***GILENYA** will be approved if the client has met all the following criteria:
			• Has failed COPAXONE or a preferred interferon product. Failure will be defined as intolerable side effects (3 month trial), drug-drug interaction, or lack of efficacy (6 month trial). Lack of efficacy will be defined Lack of efficacy will be defined one of the following:
			  • One of the following on MRI: presence of any new spinal lesions, cerebellar or brain stem lesions, or change in brain atrophy
			  • On clinical exam, signs and symptoms consistent with functional limitations that last one month or longer.
			
			AND
			
			• Has a diagnosis of a relapsing form of MS AND
			• Is being prescribed by a neurologist AND
			• Does not have a recent history of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or New York Heat Association Class III-IV heart failure within six months of initiating therapy
			
			AND
			
			• Does not have a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome unless patient has a pacemaker
			
			AND

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			• Has a baseline QTc interval <500 ms prior to starting therapy AND • Is not receiving treatment with a Class Ia or Class III anti-arrhythmic medication AND • Has no active infections AND • Had an ophthalmologic evaluation (ocular coherence test) prior to starting therapy within 3-4 months after starting therapy AND • Had a baseline complete blood count with differential and liver function tests. Grandfathering: Members currently stabilized on GILENYA, TECFIDERA, and AUBAGIO can receive approval to continue on that agent.
OPHTHALMIC ALLERGY *Effective 4/1/2015*	**No Prior Authorization Required** Cromolyn PATANOL (olopatadine) PATADAY (olopatadine)	**Prior Authorization Required** ALAMAST (pemirolast) ALAWAY (ketotifen) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) BEPREVE (bepotastine) ELESTAT (epinastine) EMADINE (emedastine) LASACRAFT (alcaftadine) OPTICROM (sodium cromoglicate) OPTIVAR (azelastine) ZADITOR (ketotifen)	Non-preferred Ophthalmic Allergy medications will be approved if the client has failed treatment with two preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)
OPIOIDS **Long Acting – Oral Opioids**	**FIRST LINE** **(No PA Required)**	**PA Required** AVINZA (morphine ER)	Non-preferred, long-acting oral opioids will be approved for members who have failed treatment with two preferred agents in the last six

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
Effective 7/1/2015	fentanyl patches methadone (generic Dolophine) morphine ER (generic MS Contin) tramadol ER	*BUTRANS (buprenorphine) DOLOPHINE (methadone) DURAGESIC (fentanyl patch) EMBEDA (morphine/naltrexone) HYSINGLA (hydrocodone ER) KADIAN (morphine ER) MS CONTIN (morphine ER) NUCYNTA ER (tapentadol ER) OPANA ER (oxymorphone ER) ORAMORPH SR (morphine ER) OXYCONTIN (oxycodone ER) TARGINIQ ER (oxycodone ER) XARTEMIS XR (oxycodone/acetaminophen) ZOHYDRO ER (hydrocodone ER)	months. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Fentanyl patches (Duragesic) will require a PA for doses of more than 1 patch/2 days. *Butrans patches will be approved for members who have failed treatment with ONE preferred agent in the last 6 months. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Zohydro ER and Hysingla® ER will be approved for members who have failed treatment with two preferred products, AND at least one other long acting opiate in the past year. Oxycontin®, Opana ER®, Nucynta ER®, and Zohydro ER® will only be approved for twice daily dosing. Hysingla ER® will only be approved for once 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.
OVERACTIVE BLADDER AGENTS *Effective 10/1/14*	**No Prior Authorization Required** oxybutynin tablets (generic)	**Prior Authorization Required** DETROL (tolterodine) DETROL LA (tolterodine ER)	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.)
	oxybutynin ER tablets (generic) TOVIAZ (fesoterodine ER)	DITROPAN (brand) DITROPAN XL (brand) ENABLEX (darifenacin) Flavoxate GELNIQUE (oxbutynin gel) OXYTROL (oxybutynin patch) SANCTURA (trospium) SANCTURA XL (trospium ER) Tolterodine VESICARE (solifenacin) MYRBETRIQ (mirabegron)	
PANCREATIC ENZYMES *Effective 1/1/2015*	**No PA Required** CREON (pancrelipase) ZENPEP (pancrelipase)	**PA Required** PANCREAZE (pancrelipase) PANCRELIPASE (pancrelipase) PERTZYE (pancrelipase) ULTRESA (pancrelipase) VIOKACE (pancreatin)	Non-preferred products will be approved for members who have failed an adequate trial (4 weeks) with at least two preferred products. (Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction.) Grandfathering: Members currently stabilized on a Non-preferred pancreatic enzyme can receive approval to continue on that agent for one year if medically necessary.
PROTON PUMP INHIBITORS *Effective 1/1/2015*	***Must meet eligibility criteria** lansoprazole 15mg OTC (currently available as PREVACID 24HR)	**PA Required** ACIPHEX tab, sprinkles (rabeprazole) DEXILANT (dexlansoprazole)	*PA will be required for therapy beyond 60 days of treatment per year for all agents. For members treated for GERD, once 60 days of therapy per year has been exceeded, members must fail an adequate trial of a histamine 2 receptor antagonist before PPI therapy can be reconsidered. An adequate trial is defined as 8 weeks of histamine 2 receptor antagonist.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	NEXIUM (esomeprazole) capsules and packets omeprazole generic capsules pantoprazole tablets PREVACID solutab BNR (lansoprazole) (for members under 2)	KAPIDEX (dexlansoprazole) Esomeprazole (generic Nexium) Esomeprazole strontium lansoprazole capsules NEXIUM 24 hour PREVACID (lansoprazole) capsules & suspension PRILOSEC OTC (omeprazole) PROTONIX (pantoprazole) tablets and suspension rabeprazole (generic Aciphex) ZEGERID (omeprazole/Na bicarbonate)	Long-term therapy will be approved for members with Barrett's Esophagus, Erosive Esophagitis, GI Bleed, Hypersecretory Conditions (Zollinger Ellison), Recurrent Aspiration Syndrome, chronic NSAID or prednisonetherapy, Spinal Cord Injury members with an acid reflux diagnosis, or children (< 18 years of age) with Cystic Fibrosis, on mechanical ventilation or who have a feeding tube. In addition, members with continuing, symptomatic GERD or recurrent peptic ulcer disease who have documented failure on step-down therapy to an H2-receptor antagonist will be approved for up to one year of daily PPI therapy. Non-preferred proton pump inhibitors will be approved if all of the following criteria are met: ➢ Member failed treatment with two Preferred Products within the last 24 months, ➢ Member has a qualifying diagnosis, and ➢ Member has been diagnosed by an appropriate diagnostic method. **The Qualifying Diagnoses are:** Barrett's Esophagus, Duodenal Ulcer, Erosive Esophagitis, Gastric Ulcer, GERD, GI Bleed, H. pylori, Hypersecretory Conditions (Zollinger-Ellison), NSAID-Induced Ulcer, Pediatric Esophagitis, Recurrent Aspiration Syndrome or Ulcerative GERD **The Appropriate Diagnostic Methods are:** GI Specialist, Endoscopy, X-Ray, Biopsy, Blood test, or Breath test **Quantity Limits:** Non-preferred agents will be limited to once daily dosing except for the following diagnoses: Barrett's Esophagus, GI Bleed, H. pylori, Hypersecretory Conditions, or Spinal Cord Injury patients with any acid reflux diagnosis. **Age Limits:** Aciphex, Protonix, and Zegerid will not be approved for members less than 18 years of age. Prevacid Solutab will be approved for members less than 2 years old and ≥ 2 years with a feeding tube.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
H. Pylori Treatments	NONE	HELIDAC (tetracycline/tripotassium dicitrateobismuthate/metronidazole) OMECLAMOX-PAK (amoxicillin/omeprazole/clarithromycin) PREVPAC (amoxicillin/lansoprazole/clarithromycin) amoxicillin/lansoprazole/clarithromycin PYLERA (bismuth subcitrate/metronidazole/tetracycline)	H. Pylori treatments should be used as individual products unless one of the individual products is not commercially available then a PA for the combination product will be given.
PULMONARY ARTERIAL HYPERTENSION THERAPIES **Phosphodiesterase Inhibitors** *Effective 1/1/2015*	***Must meet eligibility criteria** Sildenafil **(**generic Revatio)	**PA Required** ADCIRCA (tadalafil) REVATIO (sildenafil)	***Eligibility Criteria for all agents in the class** Approval will be granted for a diagnosis of pulmonary hypertension. Grandfathering: Members currently stabilized on Adcirca can receive approval to continue on that agent for one year if medically necessary.
Endothelin Antagonists *Effective 1/1/2015*	**No PA Required** LETAIRIS (ambrisentan)	**PA Required** OPSUMIT (macitentan) TRACLEER (bosentan)	Non-preferred products will be approved for members who have failed treatment with Letairis or for members requiring a dose preparation not available with a preferred product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **Grandfathering:** Members who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication for one year if medically necessary.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
Prostanoids *Effective 1/1/2015*	**No PA Required** epoprostenol (generic)	**PA Required** FLOLAN (brand) (epoprostenol) ORENITRAM (treprostinil) REMODULIN (treprostinil) TYVASO (treprostinil) VELETRI (epoprostenol) VENTAVIS (iloprost)	Non-preferred products will be approved for members who have failed treatment with a Preferred Product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, contraindication to IV therapy or significant drug-drug interaction)

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
Guanylate Cyclase (sGC) Stimulator *Effective 1/1/2015*	**No PA Required**	**PA Required** ADEMPAS (riociguat)	**Adempas** will be approved for patients who meet the following criteria: ○ Patient is not a pregnant female and is able to receive monthly pregnancy tests while taking Adempas and one month after stopping therapy. AND ○ Women of childbearing potential and their male partners must use one of the following contraceptive methods during treatment and one month after stopping treatment (e.g, IUD, contraceptive implants, tubal sterilization, a hormone method with a barrier method, two barrier methods, vasectomy with a hormone method, or vasectomy with a barrier method). AND ○ Patient is not receiving dialysis or has severe renal failure (e.g, Crcl < 15 ml/min). AND ○ Patient does not have severe liver impairment (e.g, Child Pugh C). AND ○ Prescriber must be enrolled with the Adempas REMS Program. AND ○ Female patients, regardless of reproductive potential, must be enrolled in the Adempas REMS program prior to starting therapy. AND ○ Patient has a diagnosis of persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4) after surgical treatment or has inoperable CTEPH OR ○ Patient has a diagnosis of pulmonary hypertension and has failed treatment with a preferred product for pulmonary hypertension. (Failure is defined as a lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions).
RESPIRATORY INHALANTS **Inhaled Anticholinergics & Anticholinergic Combinations** *Effective 7/1/2015*	**No PA Required** **<u>Solutions</u>** albuterol/ipratropium (generic Duoneb) ipratropium (generic Atrovent) **<u>Short-Acting Inhalers</u>** ATROVENT HFA (ipratropium)	**PA Required** **<u>Solutions</u>** ATROVENT (ipratropium) solution DUONEB (albuterol/ipratropium) **<u>Short-Acting Inhalers</u>** **<u>Long-Acting Inhalers</u>** TUDORZA Pressair (aclidinium)	Non-preferred anticholinergic inhalants and anticholinergic combination inhalants will require a brand-name PA stating medical necessity. ATROVENT® solution and DUONEB ® will require a brand-name prior authorization stating medical necessity. Non-preferred anticholinergic agents will be approved for members with a diagnosis of COPD including chronic bronchitis and/or emphysema who have failed treatment with Spiriva Handihaler® (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction or who have a contraindication to Spiriva Handihaler.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	COMBIVENT RESPIMAT (albuterol/ipratropium) **Long-Acting Inhalers** SPIRIVA Handihaler (tiotropium)	INCRUSE ELLIPTA (umeclindinium) ANORO ELLIPTA (umeclininium/vilanterol) SPIRIVA RESPIMAT (tiotropium)	Non-preferred combination anticholinergic agents will be approved for members with a diagnosis of COPD including chronic bronchitis and/or emphysema AND has failed treatment with Combivent Respimat® (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction), OR who have a contraindication to Combivent Respimat®.
RESPIRATORY INHALANTS **Inhaled Beta2 Agonists (short acting)** *Effective 7/1/2015*	**No PA Required** **Solutions** albuterol (generic) solution **Inhalers** PROAIR (albuterol) HFA inhaler	**PA Required** **Solutions** ACCUNEB (albuterol) solution AIRET (albuterol) solution ALUPENT (metaproterenol) PROVENTIL (albuterol) soln. VENTOLIN (albuterol) solution XOPENEX (levalbuterol) soln. **Inhalers** ALUPENT (metaproterenol) Inhaler MAXAIR (pirbuterol) autohaler PROAIR Respiclick PROVENTIL (albuterol) HFA inhaler VENTOLIN (albuterol) HFA inhaler XOPENEX (levalbuterol) Inhaler	Non-preferred, short acting beta2 agonists will be approved for members who have failed treatment with one preferred agent. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). **Proair HFA, Proventil HFA, Ventolin HFA**: Quantity limits: 2 inhalers / 30 days (will go into effect late 2015)

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
RESPIRATORY INHALANTS **Inhaled Beta2 Agonists (long acting)** *Effective 7/1/2015*	**No PA Required**	**PA Required** **Solutions** BROVANA (Arformoterol) soln. solution PERFOROMIST (formoterol) solution **Inhalers** ARCAPTA (indacaterol) neohaler FORADIL (formoterol) inhaler SEREVENT (salmeterol) inhaler STRIVERDI RESPIMAT (olodaterol)	Long acting beta-2 agonists will be approved for members with moderate to severe asthma who are currently using an inhaled corticosteroid and require add-on therapy, or for members with moderate to very severe COPD.
RESPIRATORY INHALANTS **Inhaled Corticosteroids** *Effective 7/1/2015*	**No PA Required** **Solutions** budesonide nebules 0.25mg and 0.5mg PULMICORT (budesonide) nebules 1mg **Inhalers** ASMANEX twist (mometasone) FLOVENT (fluticasone) diskus FLOVENT (fluticasone) HFA QVAR (beclomethasone)	**PA Required** **Solutions** PULMICORT (budesonide) nebules 0.25mg and 0.5mg **Inhalers** AEROBID (flunisolide) inhaler AEROSPAN HFA ALVESCO (ciclesonide) ARNUITY ELLIPTA (fluticasone furoate) ASMANEX HFA (mometasone furoate) inhaler AZMACORT (triamcinolone) inhaler PULMICORT (budesonide) flexhaler	Non-preferred inhaled corticosteroids will be approved in members with asthma who have failed an adequate trial of two preferred agents. An adequate trial is defined as at least 6 weeks. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions.) Pulmicort Flexhaler will only be approved without failure on preferred products for female members with asthma who have a new diagnosis of pregnancy. Budesonide nebulizer solution will only be approved for a maximal dose of 2mg/day.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
RESPIRATORY INHALANTS **Inhaled Corticosteroid Combinations** *Effective 7/1/2015*	**No PA Required** ADVAIR Diskus (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA 13gram canister (mometasone/formoterol)	**PA Required** BREO Ellipta (vilanterol/fluticasone furoate) DULERA 8.8 gram canister (mometasone/formoterol) SYMBICORT (budesonide/formoterol)	Non-preferred inhaled corticosteroid combination inhalants will be approved for members meeting the following criteria: ➢ Member has a qualifying diagnosis of asthma or COPD; and ➢ Members 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. ➢ Members with a diagnosis of COPD will only have to fail one preferred agent due to lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction.
SEDATIVE- HYPNOTICS (non-benzodiazepine) *Effective 4/1/2015*	**No PA Required* (unless duplication criteria apply)** eszopiclone zaleplon zolpidem	**PA Required** AMBIEN (zolpidem) BELSOMRA (suvorexant) AMBIEN CR (zolpidem) EDLUAR (zolpidem) INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon) SONATA (zaleplon) ZOLPIMIST (zolpidem)	Non-preferred sedative hypnotics will be approved for members who have failed treatment with two preferred agents in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) BELSOMRA (suvorexant) will be approved for members that meet the following criteria: • Members who have failed treatment with two preferred agents in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **AND** • Member is not receiving strong inhibitors (e.g, erythmromycin, 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 **AND** • Member does not have a diagnosis for narcolepsy Sedative hypnotics will require PA for member's ≥65 years of age exceeding 90 days of therapy. Rozerem will be approved for members with a history/concern of substance abuse or for documented concern of diversion within the household without failed treatment on a preferred agent

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			Children: PAs will be approved for members 18 years of age and older. ***Duplications:** Only one agent in this drug class will be approved at a time. Approval will not be granted for members currently taking a long-acting benzodiazepine such as clonazepam or temazepam.
SKELETAL MUSCLE RELAXANTS *Effective 7/1/2015*	**No PA Required For Members under 75 years of age*** baclofen (generic Lioresal) cyclobenzaprine (generic Flexeril) 5mg and 10mg tabs tizanidine (generic Zanaflex) 2mg and 4mg tab	**PA Required** AMRIX ER (cyclobenzaprine ER) carisoprodol chlorzoxazone cyclobenzaprine 7.5mg tabs DANTRIUM (dantrolene) dantrolene FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) metaxolone methocarbamol NORFLEX (orphenadrine) orphenadrine PARAFLEX (chlorzoxazone) PARAFON FORTE (chlorzoxazone) REMULAR (chlozoxone) ROBAXIN (methocarbamol)	All agents in this class will require a PA for members over 65 years of age. Approval will only be given if the member has had at least a 7 day trial with an opiate or has a diagnosis of spasticity. The maximum allowable approval will be for a 7 days' supply. Non-preferred skeletal muscle relaxants will be approved for members who have documented lack of efficacy with two preferred agents in the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions.) Authorization for any carisoprodol product will be given for a maximum 3 week one time authorization for members with acute, painful musculoskeletal conditions who have failed treatment with two preferred products. Tapering: Due to potential withdrawal symptoms, tapering is recommended when discontinuing high doses of carisoprodol. A one month approval will be granted for members tapering off of carisoprodol. *A PA will only be granted for any carisoprodol product for short-term use or tapering.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		SKELAXIN (metaxalone) SOMA (carisoprodal) tizanidine 2, 4, 6mg caps ZANAFLEX (tizanadine) VANADOM (carisoprodal)	
STATINS *Effective 4/1/2015*	**No PA Required** atorvastatin CRESTOR (rosuvastatin) pravastatin simvastatin*	**PA Required** ALTOPREV (lovastatin ER) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) LIPITOR (atorvastatin) LIVALO (pitavastatin) lovastatin (generic Mevacor) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR* (simvastatin)	Non-preferred Statin/Statin combinations will be approved if the member has failed treatment with two preferred products in the last 24 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) **Children:** Altoprev, Advicor, Livalo and Vytorin will be approved for members 18 years of age and older. Caduet, fluvastatin and lovastatin will be approved for members 10 years of age and older. *Simvastatin 80mg dose products will only be covered for members who have been stable for more than 12 months at that dose. Providers should consider alternate preferred statins in members who have not met cholesterol goals on simvastatin at doses up to 40mg per day. Please refer to the FDA communication titled, "FDA Drug Safety Communication: New restrictions, contraindications and dose limitations for Zocor (simvastatin) to reduce the risk of muscle injury" for updated guidance on contraindications, dose limits and relative LDL lowering doses of alternatives.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
STATIN COMBINATIONS *Effective 4/1/2015*		ADVICOR (niacin ER / lovastatin) CADUET (amlodipine /atorvastatin) LIPTRUZET (ezetimibe/ atorvastatin) SIMCOR (niacin/simvastatin) VYTORIN* (ezetimibe/simvastatin.)	
STIMULANTS and other ADHD agents *Effective 10/1/2014*	**No PA Required (as long as age, daily dose and diagnosis limitations are met)** ADDERALL IR (mixed-amphetamine salts) ADDERALL XR *BNR* (mixed amphetamine salts ER) FOCALIN IR *BNR* (brand name dexmethylphenidate) FOCALIN XR *BNR* (dexmethylphenidate ER) INTUNIV (guanfacine ER) Methylphenidate IR (generic Ritaltin IR)	**PA Required** APTENSIO XR (methylphenidate XR) CONCERTA (methylphenidate ER) DAYTRANA (methylphenidate transdermal) DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) DEXTROSTAT (dextroamphetamine) Dexmethylphenidate (generic Focalin IR) dexmethylphenidate (generic Focalin XR) EVEKEO (amphetamine)	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 members who have documented failure with two Preferred products in the last 12 months (age six years or older) or documented failure with one Preferred products in the last 12 months if ages 3 – 5 years (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). However, certain exceptions exist for Daytrana, Intuniv, Methylin solution, Quillivant XR, Nuvigil and Provigil. Please see the criteria below. **In addition:**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	Methylphenidate SR or LA (generic Ritalin SR) methylphenidate ER (generic Concerta) mixed-amphetamine salts (generic Adderall IR) RITALIN IR (methylphenidate) RITALIN SR or LA (methylphenidate SR or LA) STRATTERA (atomoxetine) *BNR* VYVANSE (lisdexamfetamine)	KAPVAY (clonidine ER) METADATE CD (methylphenidate ER) METADATE ER (methylphenidate ER) METHYLIN SUSPENSION (methylphenidate) Methylphenidate (generic RITALIN) mixed amphetamine salts (generic for Adderall) mixed-amphetamine salts ER (generic for Adderall XR) modafanil (generic PROVIGIL) NUVIGIL (armodafinil) PROCENTRA (dextroamphetamine liquid) PROVIGIL (modafinil) QUILLIVANT XR (methylphenidate) ZENZEDI (dextroamphetamine)	Non-preferred agents will only be approved for FDA and official compendium indications. ▪ 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 a maximum of 400mg per day will be approved. ▪ Nuvigil will be approved for obstructive sleep apnea/hypopnea syndrome, narcolepsy and shift work sleep disorder. Beneficiaries with ADD/ADHD must fail a 4 week trial of a Preferred Stimulant before the use of Nuvigil® will be approved. Only one tablet per day will be approved. ▪ All other Non-preferred products will be approved for members with a diagnosis of ADD, ADHD, Narcolepsy, Multiple Sclerosis related fatigue, traumatic brain injury or severe autism. ▪ **Daytrana, Methylin solution and Quillivant XR**: Members with documented difficulty swallowing that are unable to utilize alternative dosing with FOCALIN XR, VYVANSE or ADDERALL XR can receive approval without failure on preferred products. Provider must document contraindications. **And** Non-preferred agents will only be approved for FDA approved age limitations. ▪ Provigil will be approved for members 16 years of age and older. ▪ Nuvigil will be approved for members 17 years of age and older. ▪ Adderall IR, Dexedrine and Dextrostat will be approved for members 3 years of age and older. ▪ All other medications in this class will be approved for members 6 years of age and older. Below are the FDA recommended maximum daily doses: **Drug** — **Maximum Daily Dose** ADDERALL ® — 40 mg

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			ADDERALL XR® 40 mg AMPHETAMINE SALTS 40 mg CONCERTA ER ® 54 mg or 72 mg ≥ age 13 D-AMPHETAMINE ER 40 mg DAYTRANA ® 30 mg DESOXYN ® 25 mg DEXEDRINE ® 40 mg DEXTROSTAT ® 40 mg FOCALIN ® 20 mg FOCALIN XR ® 40 mg INTUNIV ER® 4 mg KAPVAY ER ® 0.1 mg METADATE CD ® 60 mg METADATE ER ® 60 mg METHYLIN 60 mg METHYLIN SUSPENSION® 60 mg METHYLPHENIDATE 60 mg METHYLPHENIDATE ER 60 mg METHYLPHENIDATE SR 60 mg NUVIGIL ® 250 mg PROVIGIL ® 400 mg QUILLIVANT XR ® 60 mg RITALIN LA ® 60 mg STRATTERA ® The lesser of: 1.4mg/kg or 100 mg VYVANSE ® 70 mg
TARGETED IMMUNE MODULATORS *Effective 1/1/2015*	**No PA Required** ENBREL (etanercept) HUMIRA (adalimumab)	**PA Required** ACTEMRA (tocilizumab) CIMZIA (certolizumab) COSENTYX (secukinumab) KINERET (anakinra)	**Actemra** (SQ) will be approved for treatment of RA in members who have had treatment failure with at least one conventional DMARD (e.g, methotrexate, leflmonide, and sulfasalazine), Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects or significant drug-drug interaction.) **Cimzia** (all dosage forms) • will be approved for treatment of Crohn's disease in members who have had treatment failure with Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction.)

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		ORENCIA (abatacept) Subcutaneous OTEZLA (apremilast) PURIXAN (mercaptopurine) SIMPONI (golimumab) STELARA (ustekinumab) ENTYVIO (vedolizumab) injection XELJANZ (tofacitinib) ***for information on IV infused Targeted Immune Modulators for Rheumatoid Arthritis please see Appendix P**	• will be approved for treatment of RA in members who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) • will be approved for treatment of Ankylosing Spondylitis or Psoriatic Arthritis in members who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Kineret** will be approved for treatment of RA in members who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction). **Kineret** will be approved without PA for members with documented neonatal-onset multisystem inflammatory disease (NOMID). **Orencia** will be approved for the treatment of RA in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction). **Orencia** will be approved for the treatment juvenile idiopathic arthritis who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction). **Simponi** will be approved (in combination with methotrexate) for treatment of RA in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction). **Simponi** will be approved with or without methotrexate for the treatment of Ankylosing Spondylitis or Psoriatic Arthritis in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects or significant drug-drug interaction).

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			Simponi will be approved for treatment of ulcerative colitis in members who have tried and failed Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction). **Stelara** will be approved with or without methotrexate for the treatment of Psoriatic Arthritis in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Stelara** will be approved for moderate to severe plaque psoriasis in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Xeljanz** will be approved for the treatment of RA in members who have had treatment failure with methotrexate, Humira, and Enbrel (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Xeljanz** will be not be approved for combination therapy with a biologic disease modifying agent. Quantity Limits: 2 tablets per day or 60 tablets for a 30 day supply
TESTOSTERONE PRODUCTS *Effective 7/1/2015*	**No PA required (must meet criteria)** ANDROGEL 1.62% (testosterone topical) ANDRODERM (testosterone patch) DEPO TESTOSTERONE (testosterone cypionate injection) Testosterone Cypionate	**PA Required** ANDROGEL 1% AXIRON FORTESTA gel NATESTO STRIANT TESTIM gel Testosterone Enanthate	Preferred androgenic drugs will be approved for members meeting the following: *Hypogonadotropic or Primary Hypogonadism* • Male patient ≥18 years of age • Has a documented diagnosis of hypogonadotropic or primary hypogonadism (Patients with other diagnoses will require a manual review by a state pharmacist) AND • Has two documented low serum testosterone levels below the lower limit of normal range for testing laboratory prior to initiation of therapy AND • Does not have a diagnosis of breast or prostate cancer AND • Does not have a palpable prostate nodule or prostate-specific antigen (PSA) >4ng/ml AND • Has normal liver function tests prior to initiation of therapy

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		VOGELXO	*Gender Transition* • Biologically born female patient ≥ 18 years of age* AND • Is undergoing female to male transition AND • Has a negative pregnancy test prior to initiation AND • Has normal liver function test prior to initiation of therapy *For members <18 years of age, a manual review will be required. 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.) **Grandfathering:** Members may be grandfathered on preferred agents without requirement of updated low serum testosterone laboratory testing that meet the following criteria: • Male patient ≥ 18 years of age AND • Has at least one past documented low serum testosterone levels below the lower limit of normal range for testing laboratory prior to initiation of therapy AND • Has documented diagnosis of hypogonadotropic or primary hypogonadism AND • Does not have a diagnosis of breast or prostate cancer AND • Does not have a palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL
TOPICAL IMMUNOMODULATORS *Effective 7/1/2015*	**No PA Required (must meet criteria)** ELIDEL (pimecrolimus)*	**PA Required** PROTOPIC (tacrolimus) Tacroliumus (generic Protopic)	*Elidel will only be approved after a member 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 PA. Protopic will only be approved for a member who had an adequate trial (e.g. one month or longer) of a topical steroid and Elidel and failed treatment. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). This will be a one-time PA. PA is required for children < 2 years of age.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			PA will be required for members warranting ≥ 6 weeks of therapy with either Elidel or Protopic.
TRIPTANS *Effective 1/1/2015*	**No PA Required (monthly quantity limits may apply)** IMITREX BNR (ondansetron) nasal spray and injection naratriptan tablets RELPAX BNR (eletriptan) rizatriptan MLT tablets sumatriptan tablets	**PA Required** AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) IMITREX (ondansetron) tablets MAXALT MLT tablets (rizatriptan) Maxalt tablets (rizatriptan) SUMAVEL DOSEPRO (sumtriptan) TREXIMET (sumatriptan and naproxen) sumatriptan nasal spray and injection ZOMIG (zolmitriptan)	Non-preferred products will be approved for members who have failed treatment with two Preferred Products within the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) **Quantity Limits:** Amerge, Frova, Imitrex, Treximet and Zomig: Max 9 tabs / 30 days. Axert and Relpax: Max 6 tabs / 30 days. Imitrex injection: Max 4 injectors / 30 days Maxalt: Max 12 tabs / 30 days. Zomig nasal spray and Imitrex Nasal Spray: Max 6 inhalers / 30 days.