COLORADO
Department of Health Care Policy & Financing

Health First COLORADO
Colorado's Medicaid Program

Colorado Department of Health Care Policy and Financing
Preferred Drug List (PDL)
Effective October 1, 2019

PA Forms: Available online at https://www.colorado.gov/hcpf/pharmacy-resources
PA Requests: Colorado Pharmacy Call Center Phone Number: 800-424-5725 | Colorado Pharmacy Call Center Fax Number: 800-424-5881
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.

Initiation of pharmaceutical product subject to Prior Authorization:
Please note that starting the requested drug, including a non-preferred drug, prior to a PA request being reviewed and approved, through either inpatient use, by using office "samples", or by any other means, does not necessitate Medicaid approval of the PA request.

Health First Colorado, at 25.5-5-501, requires the generic of a brand name drug be prescribed if the generic is therapeutically equivalent to the brand name drug. Exceptions to this rule are: 1) If the brand name drug is more cost effective than the generic as determined by the Department, 2) If the patient has been stabilized on a brand name drug and the prescriber believes that transition to a generic would disrupt care, and 3) If the drug is being used for treatment of mental illness, cancer, epilepsy, or human immunodeficient virus and acquired immune deficiency syndrome.

Brand Name Required = BNR, Prior Authorization = PA, AutoPA = authorization can be automated at the point of sale transaction if criteria is met
Preferred drug list applies only to prescription (RX) products, unless specified

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred products will be approved for one year unless otherwise stated.)
I. Analgesics		
Therapeutic Drug Class: **NON-OPIOID ANALGESIA AGENTS -Oral** - *Effective 7/1/2019*		
No PA Required *Brand/generic changes effective 10/01/19* Duloxetine 20mg, 30mg, 60mg Gabapentin capsule, tablet, solution	**PA Required** CYMBALTA (duloxetine) Duloxetine 40mg GRALISE (gabapentin) IRENKA (duloxetine)	Non-preferred oral non-opioid analgesic agents may be approved if member meets all of the following criteria: • Member has trialed and failed duloxetine (20mg, 30mg, or 60mg) AND has trialed and failed gabapentin OR Lyrica (Failure is defined as lack of efficacy with 8 week trial, allergy, intolerable side effects, or significant drug-drug interaction) AND Duloxetine (20mg, 30mg, or 60mg) will be approved for members with a diagnosis of fibromyalgia, neuropathic pain, or chronic musculoskeletal pain (e.g. osteoarthritis or chronic

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Pregabalin capsules	LYRICA capsules, solution, CR tablets (pregabalin) NEURONTIN (all forms) Pregabalin solution SAVELLA (milnacipran)	lower back pain) through automated verification (AutoPA) upon claim submission of the corresponding ICD-10 diagnosis code related to indicated use of the medication Prior authorization will be required for Lyrica dosages > 600mg per day (maximum of 3 capsules daily) and gabapentin dosages > 3600mg per day.
Therapeutic Drug Class: **NON-OPIOID ANALGESIA AGENTS -Topical -** *Effective 7/1/2019*		
No PA Required Lidocaine Patch	**PA Required** DERMACINRX PHN Pak LIDODERM Patch (lidocaine) ZTLIDO Patch (lidocaine)	Non-preferred topical products require a trial/failure with an adequate 8-week trial of gabapentin AND Lyrica AND duloxetine AND lidocaine patch. Failure is defined as lack of efficacy with an 8 week trial, allergy, intolerable side effects, or significant drug-drug interaction. Prior authorization will be required for Lidocaine Patch quantities exceeding 90 patches per 30 days (maximum of 3 patches daily).
Therapeutic Drug Class: **NON-STEROIDAL ANTI-INFLAMMATORIES (NSAIDS)- Oral** - *Effective 1/1/2019*		
No PA Required Celecoxib Diclofenac sodium EC tablets, DR/ER tablets Ibuprofen suspension, tablets (RX) Indomethacin capsule, ER capsule Ketorolac tablet** Meloxicam tablet Nabumetone Naproxen EC, DR/ER, suspension, and tablets (RX)	**PA Required** ARTHROTEC (diclofenac sodium/ misoprostol) CELEBREX (celecoxib) DAYPRO (oxaprozin) Diclofenac potassium Diclofenac sodium/misoprostol Diflunisal DUEXIS (ibuprofen/famotidine) Etodolac capsule, IR and ER tablet	Non-preferred oral agents will be approved for members who have trialed and failed four preferred agents. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) **Duexis** (ibuprofen/famotidine) or **Vimovo** (naproxen/esomeprazole) will be approved if the member meets the following criteria: • Trial and failure of all preferred NSAIDs at maximally tolerated doses **AND** • Trial and failure of three preferred proton pump inhibitors in combination with NSAID within the last 6 months **AND** • Have a documented history of gastrointestinal bleeding (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) **Ketorolac tablets quantity limit: 5 days of therapy for every 30 days Tablets:20 tablets for 30 days

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Sulindac	FELDENE (piroxicam) Fenoprofen capsule and tablet Flurbiprofen Ibuprofen capsules (RX) INDOCIN (indomethacin) suspension Ketoprofen IR, ER Meclofenamate capsule Mefenamic acid Meloxicam suspension MOBIC (meloxicam) tablet NALFON (fenoprofen) capsule NAPRELAN (naproxen sodium CR) Oxaprozin Piroxicam QMIIZ (meloxicam) ODT TIVORBEX (indomethacin) Tolmetin tablet, capsule VIMOVO (naproxen/esomeprazole) VIVLODEX (meloxicam)	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	ZIPSOR (diclofenac potassium) ZORVOLEX (diclofenac)	
Therapeutic Drug Class: **NON-STEROIDAL ANTI-INFLAMMATORIES (NSAIDS)- Non-Oral** - *Effective 1/1/2019*		
No PA Required *Brand/generic changes effective 10/18/19* FLECTOR 1.3% PATCH BNR (diclofenac) VOLTAREN (diclofenac) 1% gel Diclofenac sodium 1% (generic Voltaren) gel	**PA Required** Diclofenac 1.3% topical patch (generic Flector) Diclofenac 1.5% topical solution PENNSAID (diclofenac solution) 2% Pump, 2% Solution Packet SPRIX (ketorolac) nasal spray XYRLIX (diclofenac) Kit	Non-preferred topical agents will be approved for members who have trialed and failed Voltaren gel and Flector patch. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) **Sprix** (ketorolac nasal spray) will be approved if the member meets the following criteria: • Unable to tolerate, swallow or absorb oral NSAIDs **OR** • Trial and failure of three preferred oral or topical NSAID agents (failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) • Quantity limit: 5-single day nasal spray bottles per 30 days Solaraze 3% Gel (diclofenac sodium) approval criteria can be found on the Appendix P

Opioid Utilization Policy (long-acting and short-acting opioids):

It is highly encouraged that the healthcare team utilize the Prescription Drug Monitoring Program (PDMP) to aid in ensuring safe and efficacious therapy for members using controlled substances.

Total Morphine Milligram Equivalent Policy Effective 10/1/17:

- The maximum allowable morphine milligram equivalent (MME) is 200 MME. Prescriptions for short-acting (SA) and long-acting (LA) opioids are cumulatively included in this calculation. The prescription that exceeds the cumulative MME limit of 200 MME for a member will require prior authorization and may require a provider to provider telephone consultation with the pain management physician (free of charge and provided by Health First Colorado).
- Prior authorization will be granted to allow for tapering
- Prior authorization for 1 year will be granted for diagnosis of sickle cell anemia
- Prior authorization for 1 year will be granted for admission to or diagnosis of hospice or end of life care
- Prior authorization for 1 year will be granted for pain associated with cancer
- Only one LA opioid agent (including different strengths) and one SA opioid agent (including different strengths) will be allowed concomitantly

MME calculation is conducted using conversion factors from the following website: http://agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm

Only one long-acting oral opioid agent (including different strengths) and one short-acting opioid agent (including different strengths) will be considered for a prior authorization.

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

Medicaid provides guidance on the treatment of pain, including tapering, on our webpage under the heading Pain Management Resources and Opioid Use at: https://www.colorado.gov/pacific/hcpf/pain-management-resources-and-opioid-use

Opioid Naïve Policy Effective 8/1/17 (*Update effective 11/27/19 in Italics)*:
Members who have not filled a prescription for an opioid within the past 180 days will be identified as "opioid treatment naïve" and have the following limitations placed on the initial prescription(s):

- The prescription is limited to short-acting opioid agents *or Butrans (buprenorphine) 5mcg patch*. *Use of other* long-acting opioid agents will require prior authorization approval for members identified as opioid treatment naïve.
- The days supply of the first, second, and third prescription for an opioid will be limited to 7 days, the quantity will be limited to 8 dosage forms per day (tablets, capsules), maximum #56 tablets/capsules for a 7 day supply
- The fourth prescription for an opioid will require prior authorization, filling further opioid prescriptions may require a clinical pharmacist review or provider to provider telephone consultation with a pain management physician (free of charge and provided by Health First Colorado).
- If a member has had an opioid prescription filled within the past 180 days, then this policy would not apply to that member and other opioid policies would apply as applicable.

Dental Prescriptions Opioid Policy Effective 11/15/18 (implemented in the claims system 01/07/19):
Members who receive an opioid prescribed by a dental provider will be subject to day supply limits and quantity per day limits for short acting opioids.

- The prescription is limited to short-acting opioid agents only. Use of long-acting opioid agents and short acting fentanyl agents will require prior authorization approval for members' prescriptions written by a dental provider.
- The days supply of the first, second, and third prescription for an opioid will be limited to 4 days, the quantity will be limited to 6 dosage forms per day (tablets, capsules), maximum #24 tablets/capsules for a 4 day supply
- The fourth prescription for an opioid will require prior authorization. A prior authorization for the fourth fill may be approved for up to a 7 day supply and the quantity will be limited to 8 dosage forms per day (#56 tablets/capsules) for members with any of the following diagnoses/undergoing any of the following procedures:
    - Traumatic oro-facial tissue injury with major mandibular/maxillary surgical procedures
    - Severe cellulitis of facial planes
    - Severely impacted teeth with facial space infection necessitating surgical management
- Other potential exemptions that exceed the first 3 fill limits (day supply and quantity) may be evaluated with a provider to provider telephone consult with a pain management specialist (free of charge and provided by Health First Colorado)

If a member has had an opioid prescription prescribed by a non-dental provider, then this policy would not apply to that member and other opioid policies would apply as applicable. Dental prescriptions do not impact the opioid treatment naïve policy, but the prescriptions will be counted towards the Morphine Milligram Equivalent (MME) daily dose.

Opioid and Benzodiazepine Combination Effective 9/15/19:
Prior authorization will be required for members receiving long-term therapy with an opioid medication who are newly started on a benzodiazepine medication OR for members receiving long-term therapy with a benzodiazepine medication who are newly started on an opioid medication. Prior authorization may be approved if meeting the following:

- The member discontinued or is no longer taking either the opioid or benzodiazepine medication and will not be using these in combination **OR**

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

- The member will not be taking the prescribed opioid and benzodiazepine medications at the same time based on prescribed dosing interval (such as prn administration) for the regimen AND the prescriber attests that the member has received appropriate counseling* regarding the risks associated with combining opioid and benzodiazepine medications including increased risk for sedation, respiratory depression, overdose, and overdose-related death and counseling regarding the FDA Boxed Warning for combining these medications **OR**
- The prescriber has evaluated the regimen and attests that it is appropriate for the member to continue use of the concomitant opioid and benzodiazepine medication regimen as prescribed AND the prescriber attests that the member has received appropriate counseling* regarding the risks associated with combining opioid and benzodiazepine medications including increased risk for sedation, respiratory depression, overdose, and overdose-related death and counseling regarding the FDA Boxed Warning for combining these medications **OR**
- Prior authorization may be approved for members receiving palliative or hospice care **OR**
- For benzodiazepine prior authorizations, approval may be granted if the benzodiazepine is being prescribed for seizure disorder or convulsions.

**If counseling has not been provided, the prescriber attests that a reasonable effort will be made to contact the member or the member's pharmacy to ensure that counseling is provided.*

Opioid and Quetiapine Combination Effective 9/15/19:
Pharmacy claims for members receiving opioid and quetiapine medications in combination will require entry of point-of-sale DUR service codes (Reason for Service, Professional Service, Result of Service) for override of drug-drug interaction (DD) related to risk of increased sedation from concomitant use of this drug combination.

Therapeutic Drug Class: **OPIOIDS, Short Acting** -*Effective 7/1/2019*

No PA Required* (if criteria is met)	PA Required	
Hydrocodone/apap tablet Hydrocodone/apap solution Hydrocodone/ibuprofen Hydromorphone tablet Morphine IR tablet Morphine soln Oxycodone tablet Oxycodone Soln Oxycodone/apap tablet	Acetaminophen / codeine elixir, tablets** Butalbital / caffeine / acetaminophen w/ codeine** Butalbital compound w/ codeine** Butorphanol tartrate (nasal) Carisoprodol compound / codeine** Codeine (all forms)** DILAUDID liquid DVORAH (acetaminophen / caffeine / dihydrocodeine)	*__Tramadol and tramadol-containing products__ will require prior authorization approval to verify that the following criteria are met: • Member is ≥ 12 years of age AND • If member is less than 18 years of age, tramadol is NOT being prescribed for post-surgical pain following tonsil or adenoid procedure AND • If member is between 12 and 18 years of age, member is not obese (BMI greater than 30kg/m2), does not have obstructive sleep apnea or severe lung disease AND • Non-preferred tramadol products will require trial/failure of generic tramadol tablet AND generic tramadol/APAP tablet. Failure is defined as allergy‡, lack of efficacy, intolerable side effects, or significant drug-drug interaction. **Rybix® ODT (tramadol hydrochloride)** will be approved without trial/failure of three preferred agents for members who meet the tramadol products criteria above AND who are unable to swallow oral tablets or absorb oral medications. **__Codeine and codeine-containing products__ will receive prior authorization approval for members meeting the following criteria: • Member is ≥ 12 years of age AND

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

Tramadol*
 	
Tramadol/apap tablet*
	Fiorinal/codeine**
	
	Fioricet / codeine**
	
	Hydromorphone liquid
	
	IBUDONE (hydrocodone/ibuprofen)
	
	LORTAB (hydrocodone/apap)
	
	Levorphanol
	
	Meperidine solution, tablet
	
	Morphine concentrated solution
	
	NORCO (hydrocodone/apap)
	
	NUCYNTA*** (tapentadol)
	
	OPANA (oxymorphone)
	
	OXAYDO (oxycodone)
	
	Oxycodone / aspirin
	
	Oxycodone / acetaminophen solution
	
	Oxycodone / ibuprofen
	
	Oxycodone capsule, syringe, conc solution
	
	Oxymorphone
	
	Pentazocine / naloxone
	
	PERCOCET (oxycodone/apap)
		• If member is less than 18 years of age, codeine is NOT being prescribed for post-surgical pain following tonsil or adenoid procedure AND
		• If member is between 12 and 18 years of age, member is not obese (BMI greater than 30kg/m2), does not have obstructive sleep apnea or severe lung disease
		• Member is not pregnant or breastfeeding AND
		• Renal function is not impaired (GFR > 50 ml/min) AND
		• Member is not receiving strong inhibitors of CYP3A4 (e.g, erythmromycin, clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole [≥200mg daily], voriconazole, delavirdine, and milk thistle) AND
		• Member meets one of the following:
		  o Member has trialed codeine or codeine-containing products in the past no history of allergy or adverse drug reaction to codeine
		  o Member has not trialed codeine or codeine-containing products in the past and the prescriber acknowledges reading the following statement: "Approximately 1-2% of the population metabolizes codeine in a manner that exposes them to a much higher potential for toxicity. Another notable proportion of the population may not clinically respond to codeine. We ask that you please have close follow-up with members newly starting codeine and codeine-containing products to monitor for safety and efficacy."
		
		<u>Maximum Doses:</u>
		*Tramadol maximum dose is 400mg/day
		**Codeine maximum dose is 360mg/day
		
		*****Nucynta® IR (tapentadol)** may be approved for members who meet the following criteria:
		• Member has history of trial/failure of 7-days utilization of preferred product(s)in the last 21 days OR
		• If member does not meet the above criteria, prior authorization approval for Nucynta IR will require trial and failure of three preferred agents. Failure is defined as lack of efficacy, intolerable side effects, significant drug-drug interaction, allergy‡, or significant adverse drug reaction.
		• Nucynta IR will have a maximum daily quantity of 6 tablets (180 tabs per 30 days).
		
		Prior authorization for all other non-preferred short-acting opioid products will be approved if the member has trialed/failed three preferred products. Failure is defined as allergy‡, or significant adverse drug reaction.
		
		‡Allergy: hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, and angioedema

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Roxicodone tablet TYLENOL w/codeine ULTRACET* (tramadol/apap) ULTRAM* (tramadol) ZAMICET (hydrocodone/apap)	Quantity Limits: Short-acting opioids will be limited to a total of 120 tablets per 30 days (4/day) per member for members who are not included in the opioid treatment naive policy. Exceptions will be made for members with a diagnosis of a terminal illness (hospice or palliative care) or sickle cell anemia. For members who are receiving more than 120 tablets currently and who do not have a qualifying exemption diagnosis, a 6-month prior authorization can be granted via the prior authorization process for providers to taper members. Please note that if more than one agent is used, the combined total utilization may not exceed 120 units in 30 days. There may be allowed certain exceptions to this limit for acute situations (for example: post-operative surgery, fractures, shingles, car accident). Butorphanol intranasal maximum quantity is 10ml per 30 days (four 2.5ml 10mg/ml package units per 30 days).
Therapeutic Drug Class: **FENTANYL PREPARATIONS (buccal, intranasal, transmucosal, sublingual)** -*Effective 7/1/2019*		
	PA Required Abstral (fentanyl citrate) Actiq (fentanyl citrate) Fentanyl citrate Fentora (fentanyl citrate) Lazanda (fentanyl citrate) Subsys (fentanyl citrate)	Fentanyl buccal, intranasal, transmucosal, and sublingual products: Prior authorization approval will be granted for members experiencing breakthrough cancer pain and those that have already received and are tolerant to opioid drugs for the cancer pain AND are currently being treated with a long-acting opioid drug. The prior authorization may be granted for up to 4 doses per day. For patients in hospice or palliative care, prior authorization will be automatically granted regardless of the number of doses prescribed. Ionsys transdermal system requires administration in the hospital setting and is not covered under the pharmacy benefit
Therapeutic Drug Class: **OPIOIDS, Long Acting** -*Effective 7/1/2019*		
No PA Required BUTRANS (buprenorphine) patch BNR EMBEDA (morphine/naltrexone) Fentanyl patches 12mcg, 25mcg, 50mcg, 75mcg, 100mcg	**PA Required** *NUCYNTA ER (tapentadol ER) BELBUCA (buprenorphine) buccal film Buprenorphine patch	*__Nucynta ER__ will be approved for members who have trialed and failed‡ treatment with TWO preferred agents in the last 6 months. Non-Preferred Agents: All non-preferred abuse-deterrent formulations (OxyContin®, Xtampza® ER, Hysingla® ER, etc) will require trial and failure‡ of three preferred agents, one trial must be with Embeda® (morphine sulfate/naltrexone) within the past year.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Morphine ER (generic MS Contin) Tramadol ER (generic Ultram ER)	CONZIP (tramadol ER) DOLOPHINE (methadone) DURAGESIC (fentanyl) patch EXALGO (hydromorphone ER) Fentanyl patches 37mcg, 62mcg, 87mcg Hydromorphone ER HYSINGLA (hydrocodone ER) KADIAN (morphine ER capsules) brand and generic Methadone (all forms) MS CONTIN (morphine ER) MORPHABOND (morphine ER) OXYCONTIN (oxycodone ER) Tramadol ER (generic Ryzolt/ Conzip) VANTRELA ER (hydrocodone bitartrate) XARTEMIS XR (oxycodone/acetaminophen) XTAMPZA ER (oxycodone ER) ZOHYDRO ER (hydrocodone ER)	All other non-preferred agents may be approved for members who have trialed and failed‡ three preferred products within the past year. ‡Failure is defined as lack of efficacy with 14 day trial due to allergy (hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, and angioedema), intolerable side effects, or significant drug-drug interaction. <u>Methadone Continuation:</u> Members who have been receiving methadone for pain indications do not have to meet non-preferred criteria. All new starts for methadone will require prior authorization under the non-preferred criteria listed above. *If a prescriber would like to discuss strategies for tapering off methadone or transitioning to other pain management therapies for a Health First Colorado member, consultation with the Health First Colorado pain management physician is available free of charge by contacting the pharmacy call center helpdesk and requesting an opioid prescriber consult.* <u>Reauthorization:</u> Reauthorization for a non-preferred agent may be approved if the following criteria are met: • Provider attests to continued benefit outweighing risk of opioid medication use AND • Member met original prior authorization criteria for this drug class at time of original authorization <u>Quantity/Dosing Limits:</u> • **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. • **Fentanyl patches** will require a PA for doses of more than 15 patches/30 days (taking one strength) or 30 patches for 30 days (taking two strengths). For fentanyl patch strengths of 37mcg/hr, 62mcg/hr, and 87mcg/hr. Member must trial and fail two preferred strengths of separate patches summing desired dose (i.e. 12mcg/hr + 50mcg/hr =62mcg/hr)

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

II. Anti-Infectives

Therapeutic Drug Class: **ANTI-HERPETIC AGENTS- Oral** -*Effective 1/1/2019*

No PA Required	PA Required	
Acyclovir tablet, capsule Acyclovir suspension (members under 5 years only)	Famciclovir SITAVIG (acyclovir) VALTREX (valacyclovir) Valacyclovir ZOVIRAX (acyclovir)	Non-preferred products will be approved for members who have failed an adequate trial with acyclovir (diagnosis, dose and duration) as deemed by approved compendium (see table below) (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) For members with a diagnosis of Bell's palsy, valacyclovir 1000 mg three times daily will be approved for 7 days if member presents with severe facial palsy. Acyclovir suspension will be approved for members with a feeding tube.

Acyclovir Dosing Table

Indication	Adult	Pediatric
Genital herpes simplex: initial	400 mg orally 3 times daily for 7 to 10 days or 200 mg orally 5 times daily (guideline dosing) for 10 days.	12 years or older, 1000 to 1200 mg/day orally in 3 to 5 divided doses for 7 to 10 days.
Genital herpes simplex: episodic	400 mg orally 3 times daily for 5 days or 800 mg orally twice daily for 5 days or 800 mg orally 3 times daily for 2 days (guideline dosing); or 200 mg orally every 4 hours, 5 times daily for 5 days; initiate at earliest sign or symptom of recurrence.	12 years or older, 1000 to 1200 mg/day orally in 3 divided doses for 3 to 5 days
Genital herpes simplex: Suppressive An adequate trial of acyclovir for Genital Herpes Simplex (Suppressive) will be one month.	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
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 OR Topically 5 times daily or every 2 hours while awake for 4 days	12 years of age or older, topically 5 times daily or every 2 hours while awake for 4 days
Herpes zoster, Shingles	800 mg orally every 4 hours 5 times a day for 7 to 10 days	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
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
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 lesions appear for 48 hours.

Therapeutic Drug Class: **ANTI-HERPETIC AGENTS- Topical -***Effective 1/1/2019*		
No PA Required	**PA Required**	**Generic Acyclovir ointment/cream** will be approved for members who have failed an adequate trial with Zovirax ointment/cream (diagnosis, dose and duration) as deemed by approved compendium. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **Xerese** (acyclovir/hydrocortisone) prior authorization will be approved for members that meet the following criteria: • Documented diagnosis of recurrent herpes labialis AND • Member is immunocompetent AND • Member has failed treatment of at least 10 days with acyclovir (Failure will be defined as significant drug-drug interaction, lack of efficacy, contraindication to or intolerable side effects) AND • Member has failed treatment of at least one day with famciclovir 1500 mg OR valacyclovir 2 GM twice daily (Failure is defined as significant drug-drug interaction, lack of efficacy, contraindication to or intolerable side effects)
DENAVIR (penciclovir) ZOVIRAX (acyclovir) CREAM **BNR** ZOVIRAX (acyclovir) OINT**BNR**	Acyclovir cream Acyclovir ointment XERESE (acyclovir/hydrocortisone)	

Therapeutic Drug Class: **TETRACYCLINES-** *Effective 7/1/2019*		
No PA Required	**PA Required**	Prior authorization for non-preferred tetracycline agents will be approved if member has trialed/failed a preferred doxycycline agent AND preferred minocycline capsule. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction Prior authorization for liquid oral tetracycline formulations will be approved if member has difficulty swallowing and cannot take solid oral dosage forms.
Doxycycline hyclate capsules Doxycycline hyclate tablets Doxycycline monohydrate 50mg, 100mg, capsule Doxycycline monohydrate tablets	Demeclocycline DORYX (doxycycline) Doxycycline hyclate tablet DR Doxycycline monohydrate 40mg, 75mg, 150mg, capsule	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Minocycline capsules	Doxycycline monohydrate Suspension Minocycline ER Minocycline tablets MINOLIRA (minocycline) MORGIDOX (doxycycline) NUZYRA (Omadacycline) SOLODYN (minocycline) Tetracycline VIBRAMYCIN (doxycycline) XIMINO (minocycline)	
Therapeutic Drug Class: **FLUOROQUINOLONES (Oral)** -*Effective 1/1/2019*		
No PA Required *Brand Generic changes effective 05/01/19* CIPRO oral suspension (<5 years old)[BNR] Ciprofloxacin oral suspension (<5 years old) Ciprofloxacin tablet Levofloxacin tablet	**PA Required** AVELOX (moxifloxacin) BAXDELA (delafloxacin) CIPRO (ciprofloxacin) tablet CIPRO XR (ciprofloxacin) Ciprofloxacin oral suspension (>5 years old), ER tablet LEVAQUIN (levofloxacin) Levofloxacin oral solution	Non-preferred products will be approved for members who have failed an adequate trial (7 days) 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.)

<table>
<tr><th>Preferred Agents</th><th>Non-preferred Agents</th><th>Prior Authorization Criteria
(All Non-Preferred Products will be approved for one year unless otherwise stated.)</th></tr>
<tr><td></td><td>Moxifloxacin

Ofloxacin</td><td></td></tr>
<tr><td colspan="3">Therapeutic Drug Class: HEPATITIS C VIRUS TREATMENTS -Effective 1/1/2019</td></tr>
<tr><td colspan="3">Direct Acting Antivirals (DAAs)</td></tr>
<tr><td colspan="2">PA Required for all agents in this class</td><td rowspan="2"></td></tr>
<tr><td>EPCLUSA[BNR]
(sofosbuvir/velpatasvir)

HARVONI[BNR]
(sofosbuvir/ledipasvir)

MAVYRET
(glecaprevir/pibrentasvir)

*Prescriber criteria changes effective 08/01/19</td><td>Sofosbuvir/ledipasvir

Sofosbuvir/velpatasvir

SOVALDI (sofosbuvir)

VOSEVI
(sofosbuvir/velpatasvir/voxilaprevir)

ZEPATIER (elbasvir/grazoprevir)</td></tr>
<tr><td colspan="3">
<table>
<tr><th colspan="2">Preferred Hepatitis C Virus Treatment Regimens</th></tr>
<tr><td>Harvoni
(ledipasvir/sofosbuvir)</td><td>Harvoni will be approved for members >11 years old or >34 kg with chronic HCV infection; GT 1, 4-6; who are NC, have CC, or in combination with ribavirin in adults with DC; and meet the below applicable criteria</td></tr>
<tr><td>Mavyret
(glecapravir/pibrentasvir)</td><td>Mavyret will be approved for members 12 years and older or weighing at least 45 kg with chronic HCV infection, GT 1-6 who are NC or have CC (Child-Pugh A), and meet the below applicable criteria</td></tr>
<tr><td>Epclusa
(sofosbuvir/velpatasvir)</td><td>Epclusa will be approved for adult members with chronic HCV infection, GT 1-6, who are NC, have CC, or in combination with ribavirin in DC; and meet the below applicable criteria</td></tr>
</table>
(GT-Genotype, NC-Non-Cirrhotic, CC-Compensated Cirrhosis, DC-Decompensated Cirrhosis)

All preferred agents will be granted prior authorization if the following criteria are met:
• Physician attests to provide SVR12 and SVR24; AND
• Member must have received, or be in the process of receiving, full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity; AND
• Members must have genotyping results within 1 year before anticipated therapy start date; AND
• If member is abusing/misusing alcohol or controlled substances, member must be receiving or be enrolled in counseling or a substance use treatment program for at least 1 month prior to starting treatment; AND
• Agent must be prescribed by an infectious disease specialist, gastroenterologist, or hepatologist OR prescribed by any primary care provider in consultation with an infectious disease specialist, gastroenterologist or hepatologist; OR *for treatment naïve members without cirrhosis, prescribed by any primary care who has completed the hepatitis C (HCV) ECHO series (four, 1-hour trainings); AND
• Physician attests to the member’s readiness for adherence; AND
</td></tr>
</table>

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		○ Prescribers may utilize assessment tools to evaluate readiness of the patient for treatment, some examples are available at: http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs or Psychosocial Readiness Evaluation and Preparation for Hepatitis C Treatment (PREP-C) is available at: https://prepc.org/ • Physician attests to member having Chronic HCV infection (Presence of HCV RNA viral load for ≥ 6 months to confirm infection is not acute or evidence that the infection has spontaneously resolved) **AND** • The provider must provide the following laboratory tests within 12 weeks of initiating therapy: ○ Complete Blood Count (CBC) ○ International Normal Ratio (INR) ○ Hepatic Function Panel (i.e. albumin, total and direct bilirubin, alanine aminotransferase (ALT), aspartate aminotransferase (AST), and alkaline phosphatase levels) ○ Calculated glomerular filtration rate (GFR) ○ If cirrhosis is present, calculation of the Child-Turcotte-Pugh (CTP) Score ○ Transplant status as applicable (pre-, post-, N/A) **For ribavirin-containing regimens only:** • Member is not a pregnant female or a male with a pregnant female partner. Initial pregnancy test must be performed not more than 30 days prior to beginning therapy; **AND** • Women of childbearing potential and their male partners must attest that they will use two forms of effective (non-hormonal) contraception during treatment • Ribavirin ineligibility criteria: • Pregnant women and men whose female partners are pregnant • Known hypersensitivity to ribavirin • Autoimmune hepatitis • Hemoglobinopathies • Creatinine Clearance < 50mL/min • Co-administered with didanosine **Non-Preferred Agents:** All non-preferred agents or treatment regimens will be granted prior authorization if the criteria for preferred agents above is satisfied **PLUS** documentation is provided indicating an acceptable rationale for not prescribing a preferred treatment regimen. (Acceptable rationale may include: patient-specific medical contraindications to a preferred treatment, member has initiated treatment on a non-preferred drug and needs to complete therapy)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		Re-treatment: All requests for HCV re-treatment for members who have failed therapy with a DAA will be reviewed on a case-by-case basis. Additional information will be requested for retreatment requests including, but not limited to: • Previous regimen medications and dates treated • Genotype of previous HCV infection • Any information regarding adherence to previously trialed regimen(s) and current chronic medications • Adverse effects experienced from previous treatment regimen • Concomitant therapies during previous treatment regimen **For regimens ≥ 12 weeks in duration:** • Physician attests that if the week 4 HCV RNA is detectable (>25 copies) while on 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 which supports continuation of therapy; **AND** • All approvals will initially be for an 8-week time period, with further approvals dependent on the submission of HCV RNA levels at treatment times of 4 weeks, 12 weeks, and 20 weeks as applicable to justify continuing drug therapy; **AND** • 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. Please allow ample time for reauthorization after HCV RNA levels are submitted. **Grandfathering:** Members currently receiving treatment with a non-preferred agent will receive approval to finish their treatment regimen, provided required documentation is sent via normal PAR process. Hepatitis C Treatment requests must be submitted via the Hepatitis C specific PAR form which can be accessed on the Pharmacy Resources page at: https://www.colorado.gov/hcpf/pharmacy-resources
Ribavirin Products		
No PA Required Ribavirin capsule	**PA Required** MODERIBA (ribavirin)	Non-preferred ribavirin products require prior authorizations which will be evaluated on a case-by-case basis.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Ribavirin tablet	REBETOL (ribavirin) solution RIBASPHERE (ribavirin) Ribavirin solution	Members currently receiving non-preferred ribavirin product will receive approval to continue that product for the duration of their HCV treatment regimen.
III. Cardiovascular		
Therapeutic Drug Class: **ANGIOTENSIN MODIFIERS** -*Effective 7/1/2019*		
Angiotensin-converting enzyme inhibitors (ACE Inh)		
No PA Required Benazepril tablet Enalapril tablet Fosinopril tablet Lisinopril tablet Quinapril tablet Ramipril tablet	**PA Required** Captopril EPANED powder/solution* (enalapril) QBRELIS solution (lisinopril) Moexipril Perindopril Trandolapril	Non-preferred ACE inhibitors, ACE inhibitor combinations, ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products will be approved for members who have trialed and failed treatment with three preferred products in the last 12 months (Failure is defined as lack of efficacy with a 4 week trial, allergy, intolerable side effects, or significant drug-drug interaction). ***Epaned® (enalapril)** powder and solution will be approved without trial/failure of three preferred agents for members under the age of 5 years who cannot swallow a whole or crushed tablet.
ACE Inh Combinations		
No PA Required Enalapril HCTZ Lisinopril HCTZ	**PA Required** Benazepril HCTZ Captopril HCTZ Fosinopril HCTZ Moexipril HCTZ Quinapril HCTZ	Non-preferred ACE inhibitors, ACE inhibitor combinations, ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products will be approved for members who have trialed and failed treatment with three preferred products in the last 12 months (Failure is defined as lack of efficacy with a 4 week trial, allergy, intolerable side effects, or significant drug-drug interaction).

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	ZESTORETIC (lisinopril HCTZ)	
Angiotensin II receptor blockers (ARBs)		
No PA Required BENICAR (olmesartan) Irbesartan Losartan Olmesartan Telmisartan Valsartan	**PA Required** ATACAND (candesartan) AVAPRO (irbesartan) Candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) Eprosartan MICARDIS (telmisartan) TEVETEN (eprosartan)	Non-preferred ACE inhibitors, ACE inhibitor combinations, ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products will be approved for members who have trialed and failed treatment with three preferred products in the last 12 months (Failure is defined as lack of efficacy with a 4 week trial, allergy, intolerable side effects, or significant drug-drug interaction).
ARB Combinations		
No PA Required Irbesartan/HCTZ Losartan/HCTZ Olmesartan/HCTZ Valsartan/HCTZ	**PA Required** Amlodipine/olmesartan Amlodipine/olmesartan/HCTZ Amlodipine/valsartan Amlodipine/valsartan/HCTZ ATACAND HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ)	Non-preferred ACE inhibitors, ACE inhibitor combinations, ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products will be approved for members who have trialed and failed treatment with three preferred products in the last 12 months (Failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction).

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	AVALIDE (irbesartan/HCTZ) AZOR (amlodipine/olmesartan) BENICAR HCT (olmesartan/HCTZ) BYVALSON (nebivolol/valsartan) Candesartan/HCTZ DIOVAN HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) Eprosartan/HCTZ EXFORGE (amlodipine/valsartan) EXFORGE HCT (amlodipine/valsartan/HCTZ) HYZAAR HCT (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ) Telmisartan/HCTZ Telmisartan/amlodipine Telmisartan/HCTZ TRIBENZOR (amlodipine/olmesartan/HCTZ) TWYNSTA (telmisartan/amlodipine)	

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

Renin Inhibitors & Renin Inhibitor Combinations		
	PA Required Aliskiren TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ)	Non-preferred 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 be approved in patients with diabetes. Renin inhibitors are contraindicated when used in combination with an ACE-inhibitor, ACE-inhibitor combination, ARB, or ARB-combination.
Therapeutic Drug Class: **BILE SALTS** -*Effective 4/1/2019*		
No PA Required Ursodiol capsule Ursodiol tablet	**PA Required** ACTIGALL (ursodiol) capsule CHENODAL (chenodiol) tablet CHOLBAM (cholic acid) capsule OCALIVA (obeticholic acid) tablet URSO (ursodiol) tablet URSO FORTE (ursodiol) tablet	Non-preferred bile salts agents with a preferred product with same strength, dosage form, and active ingredient will be approved with adequate trial and/or failure of the preferred product with the same ingredient (such as preferred ursodiol tablet and Urso tablet). (Failure is defined as: lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions). **Chenodal** (chenodiol) and **Actigall** (ursodiol) will be approved for members who meet the following criteria: • Member ≥ 18 years of age AND • Members has tried and failed a 12-month trial of ursodiol. **Cholbam** (cholic acid) capsules may be approved for members who meet the following criteria: • Bile acid synthesis disorders: o Member must be greater than 3 weeks old in age AND o Member has a diagnosis for bile acid synthesis disorder due to single enzyme defect (Single Enzyme-Defect Disorders: Defective sterol nucleus synthesis, 3β-hydroxy-Δ-c27-steroid oxidoreductase deficiency, AKR1D1 deficiency, CYP7A1 deficiency, Defective side-chain synthesis, CYP27A1 deficiency (cerebrotendinous xanthomatosis), 2-methylacyl-CoA racemase deficiency (AMACR), 25-hydroxylation pathway (Smith–Lemli-Opitz). • Peroxisomal disorder including Zellweger spectrum disorders: o Member must be greater than 3 weeks old in age AND o Member has diagnosis of peroxisomal disorders (PDs) including Zellweger spectrum disorders AND o Member has manifestations of liver disease, steatorrhea or complications from decreased fat-soluble vitamin absorption. **Ocaliva** (obeticholic acid) and **Urso** (ursodiol) will be approved for members who meet the following criteria:

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		• Member is ≥18 years of age AND • Ocaliva® or Urso® is prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant provider AND • Member has the diagnosis of Primary Biliary Cholangitis as evidenced by two of the following at the time of diagnosis: o Evidence of cholestasis with an alkaline phosphatase elevation of at least 1.5 times the upper limit of normal o Presence of antimitochondrial antibody: a titer of 1:40 or higher o Histologic evidence of nonsuppurative destruction cholangitis and destruction of interlobular bile ducts AND • Member has failed treatment with ursodiol for at least 1 year with an inadequate response OR • Member has intolerable side effects, drug-drug interaction, or allergy to ursodiol.
Therapeutic Drug Class: **PULMONARY ARTERIAL HYPERTENSION THERAPIES** -*Effective 1/1/2019*		
Phosphodiesterase Inhibitors		
***Must meet eligibility criteria** *Brand Generic changes effective 08/01/19* *Sildenafil **(**generic Revatio) 20 mg tablet *Tadalafil 20mg *Alyq (tadalafil) 20mg	**PA Required** ADCIRCA (tadalafil) REVATIO (sildenafil) 20mg tablet, suspension Sildenafil (generic Revatio) oral suspension	***Eligibility Criteria for all agents in the class** Approval will be granted for a diagnosis of pulmonary hypertension. **Revatio tablet** will be approved for members who have failed treatment with sildenafil AND Adcirca. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **Revatio suspension** will approved for members who are unable to take/swallow tablets **Grandfathering:** Members who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication.
Endothelin Antagonists		
***Must meet eligibility criteria** *LETAIRIS (ambrisentan) [BNR] *TRACLEER 62.5mg, 125mg (bosentan) tablet [BNR]	**PA Required** Ambrisentan Bosentan 62.5mg, 125mg tablet OPSUMIT (macitentan)	***Eligibility Criteria for all agents in the class** Approval will be granted for a diagnosis of pulmonary hypertension. **Opsumit** (macitentan) and TRACLEER **(bosentan) 32mg tablet** will be approved for members who have failed treatment with Letairis AND Tracleer 62.5mg, 125mg (bosentan) tablet (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.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	TRACLEER (bosentan) 32mg tablet for suspension	
Prostanoids		
***Must meet eligibility criteria** *Epoprostenol *ORENITRAM (treprostinil) *VENTAVIS (iloprost)	**PA Required** FLOLAN (epoprostenol) REMODULIN (treprostinil) Treprostinil (generic Remodulin) TYVASO (treprostinil) VELETRI (epoprostenol) UPTRAVI (selexipag)	***Eligibility Criteria for all agents in the class** Approval will be granted for a diagnosis of pulmonary hypertension. 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) **Grandfathering:** Members who have been previously stabilized on a non-preferred product can receive approval to continue on the medication.
Guanylate Cyclase (sGC) Stimulator		
	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

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		• Patient has a diagnosis of pulmonary hypertension and has failed treatment with a preferred product for pulmonary hypertension. (Failure is defined as a lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions).
Therapeutic Drug Class: **LIPOTROPICS** -*Effective 4/1/2019*		
No PA Required Colesevelam tablet Colestipol tablet Cholestyramine packet, light packet Ezetimibe Fenofibrate tablet Gemfibrozil Niacin ER tablet *Omega-3 ethyl esters cap (generic Lovaza)	**PA Required** ANTARA (fenofibrate) Colesevelam packet COLESTID (colestipol) tablet, granules Colestipol granules Fenofibrate capsule Fenofibric acid DR capsule Fenofibric acid tablet LOPID (gemfibrozil) LOVAZA* (omega-3 ethyl esters) PREVALITE (cholestyramine/aspartame) packet QUESTRAN (cholestyramine/sugar) packet NIASPAN ER (niacin ER) TRIGLIDE (fenofibrate) TRILIPIX (fenofibric acid) VASCEPA* (icosapent ethyl)	Non-preferred bile acid sequestrates will be approved if the member has failed treatment with 2 preferred products in the last 12 months. (Failure is defined as: lack of efficacy with 4 week trial, allergy, intolerable side effects or significant drug-drug interactions). Non-preferred fibrates will be approved if the member has failed treatment with generic gemfibrozil or generic fenofibrate and niacin ER in the last 12 months. (Failure is defined as: lack of efficacy with 4 week trial of each drug, allergy, intolerable side effects or significant drug-drug interactions). Non-preferred lipotropic agents with a preferred product with same strength, dosage form, and active ingredient will be approved with adequate trial and/or failure of the preferred product with the same ingredient (such as preferred ezetimibe and Zetia) and 2 additional agents. (Failure is defined as: lack of efficacy with 4 week trial, allergy, intolerable side effects or significant drug-drug interactions). ***Omega-3 ethyl esters** (generic Lovaza) will be approved for members who have a baseline triglyceride level ≥ 500 mg/dL ***Vascepa** (icosapent ethyl) and **Lovaza** (omega-3 fatty acids) will be approved for members who meet the following criteria: • Member has a baseline triglyceride level ≥ 500 mg/dl And • Member has failed an adequate trial of omega-3 Ethyl Esters and an adequate trial of gemfibrozil or fenofibrate (Failure is defined as: lack of efficacy with 4 week trial, allergy, intolerable side effects or significant drug-drug interactions).

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	WELCHOL (colesevalam) tablet, packet ZETIA (ezetimibe)	
Therapeutic Drug Class: **STATINS** -*Effective 4/1/2019*		
No PA Required Atorvastatin Lovastatin Pravastatin Rosuvastatin Simvastatin*	**PA Required** ALTOPREV (lovastatin ER) CRESTOR (rosuvastatin) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) LIPITOR (atorvastatin) LIVALO (pitavastatin) 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 not be approved for members < 18 years of age. Caduet, fluvastatin and lovastatin will not be approved for clients < 10 years of age. *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: **STATIN COMBINATIONS** -*Effective 4/1/2019*		
	PA Required amlodipine /atorvastatin CADUET (amlodipine/atorvastatin) ezetimibe/simvastatin* VYTORIN* (ezetimibe/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, and Vytorin will not be approved for members < 18 years of age. Caduet, fluvastatin and lovastatin will not be approved for clients < 10 years of age. Livalo will not be approved for clients < 6 years of age *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"

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		for updated guidance on contraindications, dose limits and relative LDL lowering doses of alternatives.

IV. Central Nervous System

Therapeutic Drug Class: **ANTI-CONVULSANTS -Oral-***Effective 10/1/2019*

No PA Required (age and dosing limits may apply*)	PA Required ***Non-preferred brand name medications do not require a prior authorization when the equivalent generic is preferred and "dispense as written" is indicated on the prescription.***	Prior Authorization for members currently stabilized (in outpatient or acute care settings) on any non-preferred medication will be approved. <u>Non-Preferred Products Newly Started for Treating Seizure Disorder or Convulsions:</u> • Non-preferred medications newly started for members with a diagnosis of seizure disorder/convulsions may be approved if meeting the following criteria: o The medication is being prescribed by a neurologist **OR** o The medication is being prescribed in conjunction with prescriber consultation by a neurologist and meets the following: ▪ The prescription meets minimum age and maximum dose limits listed in Table 1 AND ▪ For medications indicated for use as adjunctive therapy, the medication is being used in conjunction with another anticonvulsant medication **AND** o The prescription meets additional criteria listed for any of the following: **Sympazan** (clobazam) film: o Member has history of trial and failure‡ of clobazam tablet or solution OR o Provider attests that member cannot take clobazam tablet or solution **Epidiolex** (cannabidiol): o Member has diagnosis of Lennox-Gastaut syndrome (LGS) or Dravet Syndrome **Briviact** (brivaracetam): o Member has history of trial and failure‡ of any levetiracetam-containing product. **Aptiom** (eslicarbazepine): o Member has history of trial and failure‡ of any carbamazepine-containing product. **Diacomit** (stiripentol): o Member is concomitantly taking clobazam AND o Member has diagnosis of seizures associated with Dravet syndrome
Carbamazepine IR tablet, ER tablet, chewable, ER capsule Clobazam tablet Clonazepam tablet, ODT Divalproex capsule, IR tablet, ER tablet DILANTIN[BNR] (phenytoin) 30 mg capsules Ethosuximide capsule, solution FELBATOL[BNR] (felbamate) tablet, suspension Lamotrigine tablet, chewable/disperse tabs Levetiracetam IR, ER tablet, solution Oxcarbazepine tablet, suspension Phenobarbital elixir, soln, tab PHENYTEK[BNR] (phenytoin ER)	APTIOM (eslicarbazepine) BANZEL (rufinamide) BRIVIACT (brivaracetam) CARBATROL ER (carbamazepine) Carbamazepine suspension CELONTIN (methsuximide) DEPAKENE (valproic acid) DEPAKOTE (divalproex) DILANTIN (phenytoin ER) suspension, infatab, 100 mg capsules EPIDIOLEX (cannabidiol) Felbamate tablet, suspension	

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

Phenytoin suspension, chewable, ER capsule

Primidone tablet

TEGRETOL [BNR] (carbamazepine) suspension

Topiramate tablet, sprinkle cap

Valproic acid capsule, solution

Zonisamide capsule

FYCOMPA (perampanel)

EQUETRO (carbamazepine)

GABITRIL (tiagabine)

KEPPRA (levetiracetam) IR tablet, XR tablet, solution

KLONOPIN (clonazepam)

LAMICTAL (lamotrigine)

Lamotrigine ODT, ER tablet

MYSOLINE (primidone)

ONFI (clobazam)

OXTELLAR XR (oxcarbazepine) tablet

PEGANONE (ethotoin)

QUDEXY XR capsule

SPRITAM tablet

TEGRETOL (carbamazepine) IR tablet, XR tablet, capsule, chewable

Tiagabine tablet

TOPAMAX tablet, sprinkle cap

Topiramate ER capsule

TROKENDI XR capsule

Non-Preferred Products Newly Started for Non-Seizure Disorder Diagnoses:

- Non-preferred medications newly started for non-seizure disorder diagnoses may be approved if meeting the following criteria:
  - Member has history of trial and failure[‡] of two preferred agents AND
  - The prescription meets minimum age and maximum dose limits listed in Table 1

[‡]Failure is defined as lack of efficacy, allergy, intolerable side effects, significant drug-drug interaction, or documented contraindication to therapy, or inability to take preferred formulation. Members identified as HLA-B*15:02 positive, carbamazepine and oxcarbazepine should be avoided per Clinical Pharmacogenetics Implementation Consortium Guideline. This may be considered a trial for prior authorization approvals of a non-preferred agent.

Table 1: Non-preferred Anticonvulsant Product Table

	Minimum Age*	Maximum Dose*
Mysoline (primidone)		2000 mg per day
Dilantin (phenytoin ER)		1000 mg per loading day 600 mg maintenance dose
Peganone (ethotoin)		3000 mg per day
Celontin (methsuximide)		Not listed
Zarontin (ethosuximide)		Not listed
Klonopin (clonazepam)		
Onfi (clobazam) tablet, suspension	1 year	40 mg per day
Diacomit (stiripentol)	2 years	50mg/kg/day
Aptiom (eslicarbazepine)	4 years	1600 mg per day
Carbatrol (carbamazepine ER)		1600 mg per day
Epitol (carbamazepine)		1600 mg per day
Equetro (carbamazepine ER)		1600 mg per day
Oxtellar XR (oxcarbazepine ER)		Not listed
Tegretol (carbamazepine) all except suspension		Not listed
Tegretol XR (carbamazepine ER)		Not listed
Trileptal (oxcarbazepine)		Not listed
Depakene (valproic acid)	10 years	
Depakote (divalproex DR)	10 years	
Depakote ER (divalproex ER)	10 years	
Depakote Sprinkle (divalproex DR)	10 years	
Lamictal (lamotrigine)	2 years	400 mg per day

<table>
<tr><th>Preferred Agents</th><th>Non-preferred Agents</th><th>Prior Authorization Criteria
(All Non-Preferred Products will be approved for one year unless otherwise stated.)</th></tr>
<tr><td></td><td>TRILEPTAL tablet, suspension

SABRIL (vigabatrin) powder packet and tablet

Vigadrone powder packet

Vigabatrin tablet

VIMPAT tablet, solution, start kit

ZARONTIN capsule, solution</td><td>
<table>
<tr><td>Lamictal ODT (lamotrigine)</td><td>2 years</td><td>400 mg per day</td></tr>
<tr><td>Lamictal XR (lamotrigine ER)</td><td>13 years</td><td>600 mg per day</td></tr>
<tr><td>Qudexy XR (topiramate ER)</td><td>2 years</td><td>400 mg per day</td></tr>
<tr><td>Topamax (topiramate)</td><td></td><td>400 mg per day</td></tr>
<tr><td>Trokendi XR (topiramate ER)</td><td>6 years</td><td>400 mg per day</td></tr>
<tr><td>Briviact (brivaracetam)</td><td>4 years</td><td>200 mg per day</td></tr>
<tr><td>Gabitril (tiagabine)</td><td>12 years</td><td>64 mg per day</td></tr>
<tr><td>tiagabine</td><td>12 years</td><td>64 mg per day</td></tr>
<tr><td>Vimpat (lacosamide)</td><td>4 years</td><td>400 mg per day</td></tr>
<tr><td>Banzel (rufinamide)</td><td>1 year</td><td>3200 mg per day</td></tr>
<tr><td>Felbamate</td><td>18 years</td><td></td></tr>
<tr><td>Fycompa (perampanel)</td><td>4 years</td><td>12 mg per day</td></tr>
<tr><td>Sabril (vigabatrin)</td><td>1 month</td><td>3000 mg per day</td></tr>
<tr><td>Spritam (levetiracetam)</td><td>4 years</td><td>3000 mg per day</td></tr>
<tr><td>Vigabatrin</td><td>1 month</td><td>3000 mg per day</td></tr>
<tr><td>Zonegran (zonisamide)</td><td>16 years</td><td>600 mg per day</td></tr>
<tr><td>Keppra (levetiracetam)</td><td>4 years</td><td>3000 mg per day</td></tr>
<tr><td>Keppra XR (levetiracetam ER)</td><td>12 years</td><td>3000 mg per day</td></tr>
<tr><td>Epidiolex (cannabidiol)</td><td>2 years</td><td>20 mg/kg/day</td></tr>
<tr><td colspan="3">** Limits based on data from FDA package insert. Approval for age/dosing that falls outside of the indicated range may be evaluated on a case-by-case basis</td></tr>
</table>
</td></tr>
<tr><td colspan="3">Therapeutic Drug Class: NEWER GENERATION ANTI-DEPRESSANTS -Effective 1/1/2019</td></tr>
<tr><td>No PA Required

Bupropion IR, SR, XL

Citalopram tablet, solution

Escitalopram tablet

Fluoxetine capsules, solution

Fluvoxamine tablet (generic Luvox)

Mirtazapine</td><td>PA Required

Non-preferred brand name medications do not require a prior authorization when the equivalent generic is preferred and “dispense as written” is indicated on the prescription.

APLENZIN ER (bupropion ER)

CYMBALTA (duloxetine)</td><td>Prior authorization for Fetzima, Trintellix, or Viibryd will be approved for members who have failed four preferred newer generation anti-depressant products. (Failure is defined as: lack of efficacy after 8 week trial, allergy, intolerable side effects, or significant drug-drug interaction)

All non-preferred products not listed above will be approved for members who have failed adequate trial (8 weeks) of three preferred newer generation anti-depressant products. If three preferred newer generation anti-depressant products are not available for indication being treated, approval of prior authorization for non-preferred products will require adequate trial of all preferred products FDA approved for that indication. (Failure is defined as: lack of efficacy (8 week trial), allergy, intolerable side effects, or significant drug-drug interaction)</td></tr>
</table>

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Paroxetine Sertraline Trazodone Venlafaxine IR tabs Venlafaxine ER capsules	CELEXA (citalopram) Desvenlafaxine ER Desvenlafaxine fumarate ER Duloxetine EFFEXOR IR EFFEXOR XR Escitalopram solution FETZIMA (levomilnacipran) Fluoxetine tablets, fluoxetine DR capsules Fluvoxamine ER capsule FORFIVO XL (bupropion ER) IRENKA (duloxetine) KHEDEZLA (desvenlafaxine base) LEXAPRO (escitalopram) LUVOX CR (fluvoxamine CR) Nefazodone (generic Serzone) PRISTIQ (desvenlafaxine succinate) PEXEVA (paroxetine) Paroxetine CR	**Citalopram** doses higher than 40mg/day for ≤60 years of age and 20mg for >60 years of age will require prior authorization. Please see the FDA guidance at: https://www.fda.gov/drugs/drugsafety/ucm297391.htm for important safety information. **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.**

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	PAXIL CR (paroxetine CR) PROZAC Weekly (fluoxetine) REMERON (mirtazapine) SARAFEM (fluoxetine) TRINTELLIX (vortioxetine) Venlafaxine ER tablets VIIBRYD (vilazodone) WELLBUTRIN IR, SR, XL (bupropion) ZOLOFT (sertraline)	
Therapeutic Drug Class: **MONOAMINE OXIDASE INHIBITORS (MAOis)** -*Effective 1/1/2019*		
	PA Required EMSAM (selegiline) patch MARPLAN (isocarboxazid) NARDIL (phenelzine) PARNATE (tranylcypromine) Phenelzine Tranylcypromine	Non-preferred products will be approved for members who have failed adequate trial (8 weeks) with three preferred anti-depressant products. If three preferred anti-depressant products are not available for indication being treated, approval of prior authorization for non-preferred products will require adequate trial of all preferred anti-depressant products FDA approved for that indication. (Failure is defined as: lack of efficacy after 8 week trial, allergy, intolerable side effects, or significant drug-drug interaction) **Grandfathering:** Members currently stabilized on a Non-preferred MAOi 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.**
Therapeutic Drug Class: **TRICYCLIC ANTI-DEPRESSANTS (TCAs)** -*Effective 1/1/2019*		
No PA Required Amitriptyline	**PA Required** ***Non-preferred brand name medications do not require a prior***	Non-preferred products will be approved for members who have failed adequate trial (8 weeks) with three preferred tricyclic products. If three preferred products are not available for indication being treated, approval of prior authorization for non-preferred products will require adequate trial

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Doxepin 10mg, 25mg, 50mg, 75mg, 100mg, 150mg capsule Doxepin solution Imipramine HCl Nortriptyline capsule, solution	***authorization when the equivalent generic is preferred and "dispense as written" is indicated on the prescription.*** Amoxapine ANAFRANIL (clomipramine) Clomipramine Desipramine Imipramine pamoate PAMELOR capsule (nortriptyline) Protriptyline Maprotiline NORPRAMIN (Desipramine) SURMONTIL (Trimipramine) Trimipramine TOFRANIL (imipramine HCl)	of all tricyclic preferred products FDA approved for that indication. (Failure is defined as: lack of efficacy after 8 week trial, allergy, intolerable side effects, or significant drug-drug interaction) **Grandfathering:** Members currently stabilized on a Non-preferred TCA 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.** Silenor (doxepin 3mg, 6mg) approval criteria can be found on the Appendix P
Therapeutic Drug Class: **ANTI-PARKINSON'S AGENTS** -*Effective 4/1/2019*		
Dopa Decarboxylase inhibitors and combinations		
No PA Required Carbidopa/Levodopa IR, ER	**PA Required** Carbidopa tablet Carbidopa/Levodopa ODT DUOPA (carbidopa/levodopa) Suspension	**Non-preferred dopa-decarboxylase inhibitors** and combinations will be approved with adequate trial and/or failure of carbidopa-levodopa IR and ER formulations. (Failure is defined as: lack of efficacy with 4 week trial, allergy, intolerable side effects or significant drug-drug interactions). **Carbidopa** single agent products will be approved for members with diagnosis of Parkinson's disease as add-on therapy to carbidopa-levodopa.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	INBRUJA (levodopa) RYTARY ER (carbidopa/levodopa) SINEMET (carbidopa/levodopa) IR, ER STALEVO (carbidopa/levodopa/entacapone)	Non-preferred medications that <u>are not</u> prescribed for Parkinson's Disease or an indication related to Parkinson's Disease may receive approval without meeting trial and failure step criteria outlined in this section. Members with history of trial and failure of a non-preferred Parkinson's Disease agent that is the brand/generic equivalent of a preferred product (same strength, dosage form and active ingredient) may be considered as having met a trial and failure of the equivalent preferred. <u>Grandfathering</u>: Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product.
MAO-B inhibitors		
No PA Required Selegiline capsule	**PA Required** AZILECT (Rasagiline) tablet Rasagiline mesylate tablet Selegiline tablet XADAGO (safinamide) tablet ZELAPAR (selegiline) ODT	**Non-preferred MAO-B inhibitors** will be approved with adequate trial and/or failure of selegiline capsule. (Failure is defined as: lack of efficacy with 4 week trial, allergy, intolerable side effects or significant drug-drug interactions). Non-preferred medications that <u>are not</u> prescribed for Parkinson's Disease or an indication related to Parkinson's Disease may receive approval without meeting trial and failure step criteria outlined in this section. Members with history of trial and failure of a non-preferred Parkinson's Disease agent that is the brand/generic equivalent of a preferred product (same strength, dosage form and active ingredient) may be considered as having met a trial and failure of the equivalent preferred. <u>Grandfathering</u>: Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product.
Dopamine Agonists		
No PA Required Pramipexole IR Ropinirole IR	**PA Required** Bromocriptine capsule, tablet CYCLOSET (bromocriptine) tablets MIRAPEX (pramipexole) IR, ER tablet NEUPRO (rotigotine) patch	**Non-preferred dopamine agonists** will be approved with adequate trial and/or failure of ropinirole IR and pramipexole IR. (Failure is defined as: lack of efficacy with 4 week trial, allergy, intolerable side effects or significant drug-drug interactions). Non-preferred medications that <u>are not</u> prescribed for Parkinson's Disease or an indication related to Parkinson's Disease may receive approval without meeting trial and failure step criteria outlined in this section. Members with history of trial and failure of a non-preferred Parkinson's Disease agent that is the brand/generic equivalent of a preferred product (same strength, dosage form and active ingredient) may be considered as having met a trial and failure of the equivalent preferred.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	PARLODEL (bromocriptine) Pramipexole ER tablet REQUIP (ropinirole) tablet, XR tablet	Grandfathering: Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product.
Other Parkinson's agents		
No PA Required Amantadine cap, syrup Benztropine Trihexyphenidyl tab, elixir	**PA Required** COMTAN (entacapone) tablet Entacapone tablet GOCOVRI (amantadine) OSMOLEX ER tab (amantadine) TASMAR (tolcapone) Tolcapone tablet	**Other non-preferred agents** that are prescribed for Parkinson's Disease will be approved with adequate trial and/or failure of 2 preferred agents. (Failure is defined as: lack of efficacy with 4 week trial, allergy, intolerable side effects or significant drug-drug interactions). Non-preferred medications that are not prescribed for Parkinson's Disease or an indication related to Parkinson's Disease may receive approval without meeting trial and failure step criteria outlined in this section. Members with history of trial and failure of a non-preferred Parkinson's Disease agent that is the brand/generic equivalent of a preferred product (same strength, dosage form and active ingredient) may be considered as having met a trial and failure of the equivalent preferred. Grandfathering: Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product.
Therapeutic Drug Class: **ATYPICAL ANTI-PSYCHOTICS -Oral** -*Effective 4/1/2019*		
No PA Required* Aripiprazole tablet, oral solution, ODT Clozapine tablet, ODT LATUDA (lurasidone) 2nd line** Olanzapine tablet, ODT Quetiapine IR tablet*** Quetiapine ER tablet	**PA Required** ***Non-preferred brand name medications do not require a prior authorization when the equivalent generic is preferred and "dispense as written" is indicated on the prescription.*** ABILIFY tablet, oral soln, ODT, MyCite CLOZARIL (clozapine)	Non-preferred products will only be approved for their FDA approved indications (Table 1) and age limits (Table 3) AND only if the member has adequate trial and/or failed on three preferred products in the last 5 years (failure defined as lack of efficacy with 6 week trial, allergy, intolerable side effects, significant drug-drug interactions, or known interacting genetic polymorphism that prevents safe preferred product dosing). Non-preferred atypical antipsychotic agents with a preferred product with same strength, dosage form, and active ingredient will be approved with adequate trial and/or failure of the preferred product (such as preferred clozapine ODT and Fazaclo) and 2 other preferred products. (failure defined as lack of efficacy with 6 week trial, allergy, intolerable side effects, significant drug-drug interactions or known interacting genetic polymorphism that prevents safe preferred product dosing).

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Risperidone tablet, oral soln, ODT Ziprasidone **For injectable Atypical Antipsychotics please see Appendix P for criteria**	GEODON (ziprasidone) FANAPT (iloperidone) FAZACLO (clozapine ODT) Iloperidone INVEGA (paliperidone) olanzapine/fluoxetine NUPLAZID (pimavanserin) Paliperidone REXULTI (brexpiprazole) RISPERDAL (risperidone) tablet, M-tab (ODT), oral solution SAPHRIS (asenapine) SEROQUEL IR (quetiapine IR)*** SEROQUEL XR (quetiapine ER)*** SYMBYAX (olanzapine/fluoxetine) VERSACLOZ (clozapine suspension) VRAYLAR (cariprazine) ZYPREXA (olanzapine) ZYPREXA ZYDIS (olanzapine ODT)	*Age Limits: All products including preferred products will require a PA for members younger than the FDA approved age for the agent (Table 3). Members younger than the FDA approved age for the agent who are currently stabilized on an atypical antipsychotic will be eligible for grandfathering. **New Atypical Antipsychotic prescriptions for members under 5 years of age may require a provider-provider telephone consult with a child and adolescent psychiatrist (provided at no cost to provider or member).** ****Latuda** will be approved for the treatment of schizophrenia or bipolar depression if the member has tried and failed treatment with one preferred product (qualifying diagnosis verified by AutoPA). *****Quetiapine IR** when given at sub therapeutic doses may be restricted for therapy. 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 except for utilization (when appropriate) in members 65 years or older. PA will be approved for members 10-17 years of age with approved diagnosis (Table 3) stabilized on <150mg quetiapine IR per day. **Nuplazid** will be approved for the treatment of hallucinations and delusions associated with Parkinson disease psychosis and tried and failed either quetiapine or clozapine (Failure will be defined as intolerable side effects, drug-drug interaction, or lack of efficacy). **Abilify MyCite** tabs will be approved with adequate trial and/or failure of 5 preferred agents within the past year, one trial must include aripiprazole tablet. (failure defined as lack of efficacy with 6 week trial on maximally tolerated dose, allergy, intolerable side effects, significant drug-drug interactions) The member must meet all of the following additional criteria: • Documentation of adherence measures recommended by provider and being followed by member (such as medication organizer or digital medication reminders) AND • Adequate trial and/or failure of 3 long-acting injectable formulations of atypical antipsychotics within the past 2 years, one of which must contain aripiprazole. (failure defined as lack of efficacy with 8 week trial, allergy, intolerable side effects, significant drug-drug interactions) AND • Abilify MyCite is being used with a MyCite patch and member is using a compatible mobile application. AND • Medication adherence information is being shared with their provider via a web portal or dashboard Quantity Limits: Quantity limits will be applied to all products (Table 2). 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.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		Grandfathering: Members currently stabilized on a non-preferred atypical antipsychotic or Latuda can receive approval to continue therapy with that agent for one year.

Table 1: Approved Indications

Drug	Indication
Fanapt® (iloperidone)	• Acute treatment of schizophrenia in adults
Fazaclo®, Versacloz® (clozapine)	• Treatment-resistant schizophrenia • Reducing the risk of recurrent suicidal behavior in patients with schizophrenia or schizoaffective disorder
Nuplazid® (pimavanserin)	• hallucinations and delusions associated with Parkinson's disease psychosis
Invega® (paliperidone)	• Schizophrenia • Schizoaffective disorder
Rexulti® (brexpiprazole)	• Adjunctive therapy to antidepressants for the treatment of major depressive disorder • Schizophrenia
Saphris® (asenapine)	• Acute and maintenance of schizophrenia • Bipolar mania, monotherapy • Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex
Seroquel XR® (quetiapine)	• 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)
Vraylar® (cariprazine)	• Schizophrenia • Bipolar (acute treatment)

Table 2: Quantity Limits

Brand Name	Generic Name	Quantity Limits
Abilify	Aripiprazole	Maximum one tablet per day
Clozaril	Clozapine	Maximum dosage of 900mg per day
Fazaclo	Clozapine	Maximum dosage of 900mg per day
Fanapt	Iloperidone	Maximum two tablets per day
Geodon	Ziprasidone	Maximum two capsules per day
Invega	Paliperidone	Maximum one capsule per day

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

Latuda	Lurasidone	Maximum one tablet per day (If dosing 160mg for schizophrenia, then max of two tablets per day)
Risperdal	Risperidone	Maximum dosage of 12mg/day
Rexulti	Brexpiprazole	Maximum of 3mg/day for MDD adjunctive therapy, Maximum of 4mg/day for schizophrenia
Saphris	Asenapine	Maximum two tablets per day
Seroquel	Quetiapine	Maximum three tablets per day
Seroquel XR	Quetiapine XR	Maximum one tablet per day (for 300mg & 400mg tablets max 2 tablets per day)
Vraylar	Cariprazine	Maximum dosage of 6mg/day
Zyprexa	Olanzapine	Maximum one tablet per day
Zyprexa Zydis	Olanzapine ODT	Maximum one tablet per day

Table 3: FDA Approved Pediatric Dosing by Age

Drug	FDA Approved Indication	FDA Approved Age	Max FDA App'd Dose
Asenapine (Saphris®)	APPROVED FOR ADULTS ONLY		
Aripiprazole (Abilify®)	Autism/Psychomotor Agitation Bipolar Disorder/Mixed Mania Schizophrenia Gilles de la Tourette's syndrome	6-17 years 10-17 years 13-17 years 6-17 years	15mg/day 30mgday 30mg/day 20mg/day
Cariprazine (Vraylar®)	APPROVED FOR ADULTS ONLY		
Clozapine (Fazaclo®, Clozaril®)			
Iloperidone (Fanapt®)			
Lurasidone (Latuda®)	Schizophrenia Bipolar Depression	13-17 years 10-17 years	80mg/day 80mg/day
Olanzapine (Zyprexa®)	Schizophrenia	13-17 years	10mg/day
Olanzapine (Zyprexa Zydis®)	Bipolar Disorder/Mixed Mania	13-17 years	10mg/day
Paliperidone (Invega ER®)	Schizophrenia	12-17 years	12mg/day
Risperidone (Risperdal®)	Autism/Psychomotor Agitation Bipolar Disorder/Mixed Mania Schizophrenia	5-16 years 10-17 years	3mg/day 6mg/day

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

		13-17 years	6mg/day
Quetiapine Fumarate (Seroquel®)	Schizophrenia Bipolar Disorder/Mixed Mania	13-17 years 10-17 years	800 mg/day 600 mg/day
Quetiapine Fumarate (Seroquel XR®)	APPROVED FOR ADULTS ONLY		
Ziprasidone (Geodon®)	APPROVED FOR ADULTS ONLY		

Therapeutic Drug Class: **CALCITONIN GENE – RELATED PEPTIDE INHIBITORS (CGRPis)** -*Effective 4/1/2019*

PA Required for all agents		
EMGALITY (galcanezumab)	AIMOVIG (erenumab) AJOVY (fremanezumab)	**Emgality** (galcanezumab) may be approved for members meeting CGRP inhibitor prior authorization approval criteria below. Non-preferred medications may be approved if the member meets the CGRP inhibitor prior authorization approval criteria below AND the member has history of adequate trial and failure of Emgality therapy (failure is defined as lack of efficacy with 4 week trial, allergy, intolerable side effects, or significant drug-drug interaction). <u>CGRP Inhibitor Prior Authorization Approval Criteria (must meet all of the following):</u> • Member is 18 years of age or older AND • Member is in need of prevention of episodic or chronic migraine AND • Member has diagnosis of migraine with or without aura AND • Member has tried and failed 2 oral preventative pharmacological agents listed as Level A per American Headache Society/American Academy of Neurology (i.e. divalproex, topiramate, metoprolol, propranolol). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction AND • Headache count: If prescribed for episodic migraine member has history of 4-14 migraine days per month OR if prescribed for chronic migraine member has history of 15 or more headache days per month where 8 or more were migraine days for three or more months AND • Member is not prescribed this medication for medication overuse headache AND • Member does not have history of MI, stroke, TIA, unstable angina, coronary artery bypass surgery, or other revascularization procedures within previous 12 months AND • Initial authorization will be limited to the following: o For episodic migraine: Initial authorization will be for 6 months. Continuation (12 month authorization) will require documentation of clinically significant improvement after 4 months use (and documentation of number of migraine days per month)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		○ For chronic migraine: Initial authorization will be for 4 months. Continuation (12 month authorization) will require documentation of clinically significant improvement after 3 months use (and documentation of number of migraine days per month) Grandfathering: Members taking a non-preferred agent meeting who have shown clinically significant improvement for 4 months with diagnosis of episodic migraine or 3 months with diagnosis of chronic migraine will be allowed to continue the non-preferred agent. Members taking a non-preferred agent who have not shown clinically significant improvement for 4 months with diagnosis of episodic migraine or 3 months with diagnosis of chronic migraine will be allowed to transition to a preferred CGRP agent without meeting the "headache count" criteria listed above. Maximum Dosing: Aimovig® (erenumab): 140mg monthly Ajovy® (fremanezumab): 225mg monthly or 675mg every three months Emgality® (galcanezumab): 240mg once as first loading dose then 120mg monthly
Therapeutic Drug Class: **NEUROCOGNITIVE DISORDER AGENTS** -*Effective 4/1/2019*		
***Must meet eligibility criteria** *Donepezil 5mg, 10mg tablet *Donepezil ODT *EXELON (rivastigmine) patch BNR *Memantine tablets	**PA Required** ARICEPT (donepezil) tablets (all strengths), ODT Donepezil 23mg tablet EXELON (rivastigmine) cap, soln. Galantamine tablet, soln Galantamine ER capsule Memantine ER capsule, solution MESTINON (pyridostigmine) tab, syrup NAMENDA IR, XR (memantine)	***Eligibility criteria for Preferred Agents –** All preferred products will be approved without PA if the member has a diagnosis of neurocognitive disorder 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) Non-preferred neurocognitive disorder agents with a preferred product with same strength, dosage form, and active ingredient will be approved with adequate trial and/or failure of the preferred product with the same ingredient (such as memantine and Namenda). (Failure is defined as: lack of efficacy with 4 week trial, 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 neurocognitive disorder.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	NAMZARIC (memantine/donepezil) RAZADYNE (galantamine) tab, oral soln RAZADYNE ER (galantamine) cap Rivastigmine patch	
Therapeutic Drug Class: **SEDATIVE HYPNOTICS** -*Effective 4/1/2019*		
Non-Benzodiazepines		
No PA Required* (unless age, dose, or duplication criteria apply) Eszopiclone Zaleplon Zolpidem IR tablet	**PA Required** AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant) EDLUAR (zolpidem) sublingual INTERMEZZO (zolpidem) sublingual LUNESTA (eszopiclone) ROZEREM (ramelteon) SONATA (zaleplon) Zolpidem ER tablet, sublingual ZOLPIMIST (zolpidem) soln	Non-preferred non-benzodiazepine sedative hypnotics will be approved for members who have failed treatment with two preferred non-benzodiazepine agents in the last 12 months (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). Children: Prior authorization will be required for all agents for children < 18 years of age Duplications: Only one agent in the sedative hypnotic drug class will be approved at a time (e.g. concomitant use of agents in the same sedative hypnotic class or differing classes will not be approved) All sedative hypnotics will require PA for member's ≥65 years of age exceeding 90 days of therapy. **Belsomra** (suvorexant) will be approved for adult 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 John's Wort) of CYP3A4 **AND** • Member does not have a diagnosis of narcolepsy **Rozerem** (ramelteon) will be approved for adult members with a history/concern of substance abuse or for documented concern of diversion within the household without failed treatment on a preferred agent

<table>
<tr><th>Preferred Agents</th><th>Non-preferred Agents</th><th>Prior Authorization Criteria
(All Non-Preferred Products will be approved for one year unless otherwise stated.)</th></tr>
<tr><td></td><td></td><td>Prior authorization will be required if member exceeds FDA recommended dose listed in the table below.</td></tr>
<tr><td colspan="3">Benzodiazepines</td></tr>
<tr><td>No PA Required* (unless age, dose, or duplication criteria apply)

Temazepam 15mg, 30mg

Triazolam</td><td>PA Required

Estazolam

Flurazepam

Halcion

RESTORIL (all strengths)

Temazepam 7.5mg, 22.5mg</td><td>Temazepam 7.5mg and 22.5 mg will be approved if the member has trialed and failed temazepam 15mg or 30mg AND one other preferred product (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction).
Non-preferred benzodiazepine sedative hypnotics will be approved for members who have failed treatment with two preferred benzodiazepine agents in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction).

<u>Children:</u> Prior authorization will be required for all sedative hypnotic agents when prescribed for children < 18 years of age

<u>Duplications:</u> Only one agent in the sedative hypnotic drug class will be approved at a time (e.g. concomitant use of agents in the same sedative hypnotic class or differing classes will not be approved)

All sedative hypnotics will require PA for member’s ≥65 years of age exceeding 90 days of therapy.

<u>Grandfathering:</u> Members currently stabilized on a non-preferred benzodiazepine medication will receive authorization to continue that medication.

Prior authorization will be required if member exceeds FDA recommended dose listed in the table below.</td></tr>
<tr><td colspan="3">
<table>
<tr><th>Brand</th><th>Generic</th><th>FDA Maximum Dose</th></tr>
<tr><td colspan="3">Non-Benzodiazepines</td></tr>
<tr><td>Ambien CR</td><td>Zolpidem CR</td><td>12.5 mg/day</td></tr>
<tr><td>Ambien IR</td><td>Zolpidem IR</td><td>10 mg/day</td></tr>
<tr><td>Belsomra</td><td>Suvorexant</td><td>20 mg/day</td></tr>
<tr><td>Edluar</td><td>Zolpidem sublingual</td><td>Men: 10 mg/day
Women: 5 mg/day</td></tr>
<tr><td>Intermezzo</td><td>Zolpidem sublingual</td><td>Men: 3.5mg/day
Women:1.75 mg/day</td></tr>
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Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

Lunesta	Eszopiclone	3 mg/day
Sonata	Zaleplon	20 mg/day
Rozerem	Ramelteon	8 mg/day
Zolpimist	Zolpidem spray	Men: 10 mg (2 sprays)/day Women: 5 mg (1 spray)/day
Benzodiazepines		
Halcion	Triazolam	0.5 mg/day
Restoril	Temazepam	30 mg/day
-	Estazolam	2 mg/day
-	Flurazepam	30 mg/day
-	Quazepam	15 mg/day

Therapeutic Drug Class: **SKELETAL MUSCLE RELAXANTS** -*Effective 7/1/2019*

No PA Required (if under 65 years of age)*	PA Required	
Baclofen (generic Lioresal) Cyclobenzaprine (generic Flexeril) 5mg and 10mg tablet Methocarbamol Tizanidine (generic Zanaflex) 2mg and 4mg tablet	AMRIX ER (cyclobenzaprine ER) Carisoprodol Chlorzoxazone Cyclobenzaprine 7.5mg tabs DANTRIUM (dantrolene) *Dantrolene FEXMID (cyclobenzaprine) LORZONE (chlorzoxazone) METAXALL (metaxolone) Metaxolone Orphenadrine	All agents in this class will require a PA for members 65 years of age and older. The maximum allowable approval will be for a 7-day supply. Non-preferred skeletal muscle relaxants will be approved for members who have trialed and failed‡ three preferred agents. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, contraindication to, 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 three preferred products within the last 6 months. ***Dantrolene** will be approved for members 5-17 years of age who have trialed and failed‡ one preferred agent and meet the following criteria: • Documentation of age-appropriate liver function tests AND • One of following diagnoses: Multiple Sclerosis, Cerebral Palsy, stroke, upper motor neuron disorder, or spinal cord injury • Dantrolene will be approved for the period of one year • If a member is stabilized on dantrolene at <18 years of age, they may continue to receive approval after turning 18 years of age • (Failure is defined as: lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	PARAFON FORTE (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) Tizanidine 2, 4, 6mg caps ZANAFLEX (tizanidine)	‡Failure is defined as: lack of efficacy with 14 day trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.
Therapeutic Drug Class: **STIMULANTS AND RELATED AGENTS** -*Effective 10/1/2019*		
***No PA Required (if age, max daily dose, and diagnosis met)** *Brand/generic changes effective 11/01/19* Armodafinil (generic Nuvigil) Atomoxetine (generic Strattera) Mixed-amphetamine salts (generic Adderall IR) Mixed-Amphetamine salts ER (generic Adderall XR) CONCERTA (Methylphenidate ER) tablet[BNR] Dexmethylphenidate IR (generic Focalin) FOCALIN XR [*BNR*] (dexmethylphenidate ER)	**PA Required** ADDERALL IR (mixed-amphetamine salts) ADDERALL XR (mixed amphetamine salts ER) ADHANSIA XR (methylphenidate ER) capsule ADZENYS ER, XR ODT (amphetamine) APTENSIO XR (methylphenidate XR) Clonidine ER tablet COTEMPLA XR ODT (methylphenidate ER) D-amphetamine spansule	*Preferred medications may be approved through AutoPA for indications listed in Table 1 (preferred medications may also receive approval for off-label use for fatigue associated with multiple sclerosis). Prior authorization for non-preferred medications used for indications listed in Table 1 may be approved for members meeting the following criteria (For Sunosi (solriamfetol), refer to criteria listed below): • Member has documented failure with three preferred products in the last 24 months if age ≥6 years or documented failure with one preferred product in the last 24 months if age 3 –5 years (Failure is defined as: lack of efficacy with a four week trial, allergy, intolerable side effects, or significant drug-drug interaction). Trial and failure of preferred agents will not be required for members meeting the following: • For Daytrana, Methylin solution, Quillichew, Quillivant XR and Dyanavel XR, one preferred trial must include Vyvanse chewable tablet, Focalin XR, Vyvanse capsules or mixed amphetamine salts ER (generic Adderall XR) and member must have a documented difficulty swallowing that are unable to utilize alternative dosing with preferred tablet and capsule formulations. ****Max Dose:** Prior authorization may be approved for doses that are higher than the listed maximum dose (Table 2) if member meets all of the following criteria: • Member is taking medication for indicated use listed in table 1 **AND** • Member has 30 day trial or failure of three different preferred or non-preferred agents at maximum doses listed in table 2 **AND**

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Guanfacine ER Methylphenidate IR (generic Ritalin IR) Modafinil (generic Provigil) VYVANSE (lisdexamfetamine) capsules, chewables	DAYTRANA (methylphenidate transdermal) DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) DEXTROSTAT (dextroamphetamine) Dexmethylphenidate (generic Focalin XR) DYANAVEL XR solution (amphetamine) EVEKEO (amphetamine) FOCALIN IR (dexmethylphenidate) INTUNIV (guanfacine ER) JORNAY PM (methylphenidate) KAPVAY (clonidine ER) METADATE ER (methylphenidate ER) Methylphenidate ER (generic Concerta) Methylphenidate ER 72mg (generic Relexxii) Methylphenidate ER (generic Metadate CD, ER, Ritalin LA)	• Documentation of member's symptom response to maximum doses of three other agents is provided **AND** • Member is not taking a sedative hypnotic medication (from sedative hypnotic PDL class, i.e. temazepam, triazolam, zolpidem) **Sunosi** (solriamfetol) prior authorization will be approved if member meets the following criteria: • Member is 18 years of age or older AND • Member has diagnosis of either narcolepsy or obstructive sleep apnea (OSA) and is experiencing excessive daytime sleepiness AND • Member does not have end stage renal disease AND • If Sunosi is being prescribed for OSA, member has 1 month trial of CPAP AND • Member has trial and failure of modafinil AND armodafinil AND one other agent in stimulant PDL class (Failure is defined as: lack of efficacy with 4 week trial, allergy, intolerable side effects, or significant drug-drug interaction.)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	METHYLIN SUSPENSION (methylphenidate) MYDAYIS ER (dextroamphetamine/amphetamine) NUVIGIL (armodafinil) PROCENTRA (dextroamphetamine liquid) PROVIGIL (modafinil) QUILLICHEW (methylphenidate) QUILLIVANT XR suspension (methylphenidate) RELEXXII (methylphenidate ER) RITALIN IR (methylphenidate) RITALIN LA (methylphenidate ER (LA)) STRATTERA (atomoxetine) SUNOSI (solriamfetol) ZENZEDI (dextroamphetamine)	

Table 1: Indication and Age

- Approval for medically accepted indications not listed in Table 1 may be given with prior authorization review and may require submission of peer-reviewed literature or medical compendia showing safety and efficacy of the medication used for the prescribed indication. Medications may also receive approval for off-label use for fatigue associated with multiple sclerosis if meeting all other criteria for approval.
- Prior authorization will be required for doses that are higher than the FDA approved maximum doses.**
- **Bolded Drug names are Preferred**

Drug	Indications

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

Stimulants – Immediate Release	
amphetamine sulfate (Evekeo™)	ADHD (Age ≥ 3 years), Narcolepsy (Age ≥ 6 years)
armodafinil (Nuvigil®)	Excessive sleepiness associated with narcolepsy, OSA, and SWD for age ≥ 18 years
dexmethylphenidate IR (Focalin®)	ADHD (Age ≥ 6 years)
dextroamphetamine IR (Zenzedi™)	ADHD (Age 3 to ≤ 16 years), Narcolepsy (Age ≥ 6 years)
dextroamphetamine solution (ProCentra™)	ADHD (Age 3 to ≤ 16 years), Narcolepsy (Age ≥ 6 years)
methamphetamine (Desoxyn®)	ADHD (Age ≥ 6 years)
methylphenidate IR (Ritalin®)	ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years), OSA
methylphenidate IR (Methylin®)	ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years)
methylphenidate XR ODT (Contempla® XR ODT)	ADHD (Age ≥ 6 years)
mixed amphetamine salts IR (Adderall®)	ADHD (Age ≥ 3 years), Narcolepsy (Age ≥ 6 years)
modafinil (Provigil®**)**	Excessive sleepiness associated with narcolepsy, OSA, and SWD (Age ≥18 years)
Solriamfetol (Sunosi®)	Excessive sleepiness associated with narcolepsy, OSA (Age ≥18)
Stimulants – Extended-Release	
amphetamine ER (Adzenys® XR-ODT and Adzenys® ER suspension)	ADHD (Age ≥ 6 years)
amphetamine ER (Dyanavel™ XR)	ADHD (Age ≥ 6 years)
Mixed-Amphetamine salts ER (generic Adderall XR)	ADHD (Age ≥ 6 years)
dexmethylphenidate ER (**Focalin XR®**)	ADHD (Age ≥ 6 years)
dextroamphetamine ER (Dexedrine®)	ADHD (Age 3 to ≤ 16 years), Narcolepsy (Age ≥ 6 years)
dextroamphetamine ER/amphetamine ER (Mydayis ER®)	ADHD (Age ≥ 13 years)
lisdexamfetamine dimesylate (**Vyvanse® capsule** and **Vyvanse® chewable**)	ADHD (Age ≥ 6 years), Moderate to severe binge eating disorder in adults (Age ≥ 18 years)
methylphenidate ER OROS (**Concerta**®)	ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years), OSA
methylphenidate SR (Metadate ER®)	ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years)
methylphenidate ER† (Metadate CD®)	ADHD (Age ≥ 6 years)
methylphenidate ER (QuilliChew™ ER)	ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years)
methylphenidate ER (Quillivant XR®)	ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years)
methylphenidate ER (Ritalin LA®)	ADHD (Age ≥ 6 years)
methylphenidate ER (Aptensio XR®)	ADHD (Age ≥ 6 years)
methylphenidate XR ODT (Contempla® XR ODT)	ADHD (Age ≥ 6 years)

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

Methylphenidate ER (Jornay PM ®)	ADHD (Age ≥ 6 years)
Non-Stimulants	
atomoxetine (Strattera®)	ADHD (Age ≥ 6 years)
clonidine ER (Kapvay™)	ADHD (Age ≥ 6 years), Treatment of ADHD as adjunct to stimulants
guanfacine ER (Intuniv™)	ADHD (Age ≥ 6 years), Treatment of ADHD as adjunct to stimulants

Table 2: Max Daily Dose

Drug	Maximum Daily Dose
ADDERALL ®	60 mg/day
ADDERALL XR®	60mg/day
ADZENYS XR-ODT® | ADZENYS ER-SUSPENSION®	18.8 mg/day (age 6-12) | 12.5 mg/day (age >13)
AMPHETAMINE SALTS	40 mg/day
CONCERTA®	54 mg/day or 72 mg/day >age 13
COTEMPLA XR-ODT®	51.8mg/day
DESOXYN ®	25mg/day
DEXEDRINE ®	40mg/day
DEXTROSTAT ®	40mg/day
DYANAVEL XR ®	20mg/day
FOCALIN ®	20 mg/day
FOCALIN XR ®	40 mg/day
JORNAY PM ®	100mg/day
METHYLPHNIDATE ER	60 mg/day
MYDAYIS ER®	25 mg/day (age 13-17) | 50 mg/day (age ≥ 18)
INTUNIV ER®	4 mg/day
RITALIN® IR	60 mg/day
RITALIN SR®	60 mg/day
RITALIN LA ®	60 mg/day
STRATTERA®	100 mg/day
VYVANSE CAPS AND CHEWABLE ®	70 mg/day
D-AMPHETAMINE ER	40 mg/day
DAYTRANA ®	30 mg/day
EVEKEO ®	40 mg/day
KAPVAY ER®	0.1 mg/day
METHYLIN ER ®	60 mg/day

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

METHYLIN	60 mg/day
METHYLIN SUSPENSION®	60 mg/day
METADATE CD ®	60mg/day
METADATE ER ®	60mg/day
METHYLPHENIDATE	60 mg/day
PROVIGIL ®	400 mg/day
NUVIGIL ®	250 mg/day
QUILLIVANT ®	60 mg/day
SUNOSI ®	150 mg/day
ZENZEDI ®	40 mg/day

Therapeutic Drug Class: **TRIPTANS AND OTHER MIGRAINE TREATMENTS (Oral)**-*Effective 1/1/2019*

No PA Required (monthly quantity limits may apply)	PA Required	
Sumatriptan tablets Naratriptan tablets RELPAX BNR (eletriptan) Rizatriptan tablets, MLT tablets	AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) IMITREX (sumatriptan) tablets MAXALT MLT tablets (rizatriptan) Maxalt tablets (rizatriptan) Sumatriptan/Naproxen TREXIMET (sumatriptan/ naproxen) Zolmitriptan tablet, ODT ZOMIG (zolmitriptan) ZMT and tablet	Non-preferred oral products will be approved for members who have trialed and failed three preferred oral products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) **Quantity Limits:** • Amerge, Frova, Imitrex, Treximet and Zomig: Max 9 tabs / 30 days • Axert and Relpax: Max 6 tabs / 30 days • Maxalt: Max 12 tabs / 30 days

Therapeutic Drug Class: **TRIPTANS AND OTHER MIGRAINE TREATMENTS (Non-Oral)**-*Effective 1/1/2019*

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
No PA Required (monthly quantity limits may apply) Sumatriptan vial ZOMIG (zolmitriptan) nasal spray	**PA Required** IMITREX (sumatriptan) nasal spray and injection ONZETRA nasal powder (sumatriptan) SUMAVEL DOSEPRO (sumatriptan) Sumatriptan injection kit and nasal spray) ZEMBRACE SYMTOUCH injection (sumatriptan)	Non-preferred non-oral products will be approved for members who have trailed and failed two preferred non-oral products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions, documented inability to tolerate dosage form) **Quantity Limits:** Imitrex injection: Max 4 injectors / 30 days Zomig nasal spray and Imitrex Nasal Spray: Max 6 inhalers / 30 days.
V. Dermatological		
Therapeutic Drug Class: **ACNE – Topical** -*Effective 7/1/2019*		
No PA Required (if age and diagnosis criteria is met*) *Brand/generic changes effective 10/15/19* *Adapalene gel *Adapalene/benzoyl peroxide (generic Epiduo) *Clindamycin phosphate med swab *Clindamycin phosphate solution *Clindamycin/benzoyl peroxide gel jar (generic Benzaclin)	**PA Required** ACANYA gel, pump ACZONE gel, pump Adapalene cream, gel pump, soln ALTRENO (tretinoin) ATRALIN (tretinoin) AVAR (all products) AVITA (tretinoin) cream, gel AZELEX (azelaic acid)	Authorization for all acne agents prescribed solely for cosmetic purposes will not be approved. Preferred topical acne agents prescribed for members > 25 years of age will require prior authorization and will be approved following prescriber verification that the medication is not being utilized for cosmetic purposes AND prescriber verification that the indicated use is for acne vulgaris, psoriasis, cystic acne, disorders of keratinization, neoplasms, or comedonal acne. These medications are only eligible for prior authorization approval for the aforementioned diagnoses. Preferred topical acne agents prescribed for members ≤ 25 years of age will only be approved for members with a diagnosis of acne vulgaris, psoriasis, cystic acne, disorders of keratinization, neoplasms, or comedonal acne. Diagnosis will be verified through automated verification (AutoPA) of the appropriate corresponding ICD-10 diagnosis code related to the indicated use of the medication. Preferred topical clindamycin and erythromycin products prescribed for members ≤ 25 may also be approved for a diagnosis of folliculitis, hidradenitis suppurativa, or perioral dermatitis (erythromycin only). Approval of preferred topical clindamycin and erythromycin products for

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
*DIFFERIN gel pump (adapalene) BNR *Erythromycin soln *RETIN-A cream BNR *Sodium sulfacetamide/sulfur cleanser, wash *Sulfacetamide suspension Tretinoin gel	BENZAC (benzoyl peroxide) BENZACLIN (all products) Benzoyl peroxide gel, kit, lotion, med pad, microspheres, towelette Benzoyl peroxide / sulfur CLINDACIN PAC Kit Clindamycin phosphate gel, lotion, foam Clindamycin/benzoyl peroxide (generic Duac) Clindamycin/benzoyl peroxide w/ pump (generic Benzaclin) Clindamycin/tretinoin Dapsone gel DIFFERIN (adapalene) cream, gel, lotion EPIDUO (all products) Erythromycin gel, med swab Erythromycin / Benzoyl peroxide ONEXTON (clindamycin/benzyoyl peroxide) OVACE (all products) RETIN-A gel	other medically accepted indications for members ≤ 25 may be considered following clinical prior authorization review by a call center pharmacist. Non-preferred topical products will be approved for members meeting all of the following criteria: • Member has trialed/failed three preferred topical products with different mechanisms (i.e. tretinoin, antibiotic). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction AND • Prescriber verification that the medication is being prescribed for one of the following diagnoses: acne vulgaris, psoriasis, cystic acne, disorders of keratinization, neoplasms, or comedonal acne.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	RETIN-A Micro (all products) Sulfacetamide cleanser Sulfacetamide sodium/ sulfur cream, lotion, cleanser kit TAZORAC cream, gel Tazarotene cream Tretinoin cream (generic Retin-A, Avita) Tretinoin microspheres (all products)	
Therapeutic Drug Class: **ACNE – ISOTRETINOIN** -*Effective 7/1/2019*		
PA Required for all agents		All preferred and non-preferred oral isotretinoin agents will require prior authorization and will be approved for severe, recalcitrant nodulocystic acne for adults and children ≥ 12 years of age and has been unresponsive to conventional therapy AND Non-preferred oral isotretinoin agents will be approved if member has trialed/failed two preferred agents. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.
AMNESTEEM capsule CLARAVIS capsule	ABSORICA capsule isotretinoin capsule MYORISAN capsule ZENATANE capsule	
Therapeutic Drug Class: ANTI-PSORIATICS (Oral) -*Effective 1/1/2019*		
No PA Required	**PA Required**	Prior authorization for non-preferred oral agents will be approved with failure of two preferred agents, one of which must be a preferred oral agent. (Failure is defined as: lack of efficacy of a 4 week trial, allergy, intolerable side effects or significant drug-drug interaction.)
Acitretin (generic Soriatane) capsule -*authorized generic only -Prasco labs*	Acitretin capsule -*all other manufacturers* Soriatane (acitretin) Oxsoralen-Ultra (methoxsalen)	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Methoxsalen Rapid	
Therapeutic Drug Class: **ANTI-PSORIATICS (Topical)** -*Effective 1/1/2019*		
No PA Required Calcipotriene cream Calcipotriene soln Taclonex scalp BNR (calcipotriene/betamethasone) Taclonex ointment BNR (calcipotriene/betamethasone)	**PA Required** Calcipotriene ointment Calcipotriene/betamethasone ointment Calcitriol ointment Calcitrene (calcipotriene) Dovonex (calcipotriene) cream Enstilar (calcipotriene/betamethasone) Sorilux (calcipotriene) Vectical (calcitriol) cream	Prior authorization for non-preferred topical agents will be approved with failure of two preferred topical agents. If non-preferred topical agent being requesting is a combination product, trial of two preferred agents must include a preferred combination agent. (Failure is defined as: lack of efficacy of a 4 week trial, allergy, intolerable side effects or significant drug-drug interaction.) Preferred and non-preferred products that contain a corticosteroid ingredient (such as betamethasone) will be limited to 4 weeks of therapy. Continued use will require one week of steroid-free time in between treatment periods. Members with >30% of their body surface area affected may not use Enstilar foam or Taclonex ointment products as safety and efficacy have not been established.
Therapeutic Drug Class: **ROSACEA AGENTS (Topical)** -*Effective 7/1/2019*		
No PA Required *Brand/generic changes effective 10/15/19* Azelaic acid gel Metronidazole cream, gel, lotion	**PA Required** Azelaic acid gel FINACEA (azelaic acid) foam, gel METROCREAM (metronidazole) METROGEL (metronidazole) METROLOTION (metronidazole) MIRVASO (brimonidine)	Prior authorization for non-preferred products in this class may be approved if member meets the following criteria: • Member has a diagnosis of persistent (non-transient) facial erythema with inflammatory papules and pustules due to rosacea AND • Prescriber attests that medication is not being used solely for cosmetic purposes AND • Member has tried and failed two preferred agents of different mechanisms of action (Failure is defined as lack of efficacy with 4 week trial, allergy, intolerable side effects) *Oracea® (doxycycline monohydrate DR) may be approved if the member meets all of the following criteria:

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	ORACEA (doxycycline)* NORITATE (metronidazole) RHOFADE (oxymetazoline) ROSADAN Kit (metronidazole) SOOLANTRA (ivermectin)	• Member has taken generic doxycycline for a minimum of three months and failed therapy in the last 6 months. Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions AND • Member has history of an adequate trial/failure (8 weeks) of 2 other preferred agents (oral or topical). Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions AND • Member is ≥ 18 years of age and has been diagnosed with rosacea with inflammatory lesions
Therapeutic Drug Class: **TOPICAL STEROIDS** – *Effective 4/1/2019*		
Low potency		
No PA Required Hydrocortisone (Rx) cream, ointment, lotion Derma-Smoothe oil BNR (fluocinolone acetonide 0.01%) Desonide 0.05% cream	**PA Required** Aclometasone dipropionate cream, ointment Ala-cort cream Aqua glycolic HC kit (hydrocortisone) Capex (fluocinolone acetonide) shampoo Cortifoam 10% aerosol (hydrocortisone acetate) Desonide ointment, lotion, foam Dermasorb (hydrocortisone) HC 2% kit Fluocinolone acetonide 0.01% body oil, 0.01% scalp oil Fluocinolone acetonide 0.01% cream, 0.01% solution	Non-preferred Low Potency topical corticosteroids will require adequate trial of 2 preferred agents of the same potency. (Failure is defined as: lack of efficacy with 4 week trial, allergy, intolerable side effects or significant drug-drug interactions)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Hydrocortisone enema Nucort (hydrocortisone acetate) Proctocort (hydrocortisone acetate) cream Procto-pak cream (hydrocortisone) Synalar (fluocinolone) 0.01% solution Texacort (hydrocortisone) solution	
Medium potency		
No PA Required Betamethasone dipropionate 0.05% cream, 0.05% lotion Betamethasone valerate 0.1% cream, 0.1% ointment Fluticasone propionate 0.05% cream, 0.05% ointment Mometasone furoate 0.1% cream, 0.1% ointment, 0.1% solution Triamcinolone acetonide 0.025% cream, 0.1% cream, 0.025% ointment, 0.1% ointment, 0.025% lotion, 0.1% lotion	**PA Required** Betamethasone valerate 0.1% lotion, 0.12% foam Clocortolone cream, cream pump Cultivate cream (fluticasone propionate) Dermatop ointment (prednicarbate) Elocon cream, ointment (mometasone furoate) Fluocinonide-E cream 0.05% Flurandrenolide cream, ointment, lotion Fluocinolone acetonide 0.025% cream, 0.025% ointment	Non-preferred Medium Potency topical corticosteroids will require adequate trial of 2 preferred agents of the same potency. (Failure is defined as: lack of efficacy with 4 week trial, allergy, intolerable side effects or significant drug-drug interactions).

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Fluticasone propionate 0.05% lotion Hydrocortisone butyrate 0.1% lotion, 0.1% solution, 0.1% ointment Lipocream 0.1% (hydrocortisone butyrate) Hydrocortisone valerate 0.2% cream, 0.2% ointment Kenalog (triamcinolone) spray Locoid cream (hydrocortisone) Luxiq foam (betamethasone valerate) Prednicarbate ointment Sernivo spray (betamethasone dipropionate) Synalar (fluocinolone acetonide) 0.025% cream Triamcinolone 0.1% paste, 0.147 mg/gm spray Xilapak kit (fluocinolone acetonide)	
High potency		
No PA Required (unless exceeds duration of therapy*) *Betamethasone dipropionate propylene glycol (aug) 0.05% cream *Fluocinonide 0.05% gel, 0.05% solution	**PA Required** Amcinonide cream Apexicon (diflorasone) cream Betamethasone dipropionate 0.05% ointment	Non-preferred High Potency topical corticosteroids will require adequate trial of 2 preferred agents of the same potency. (Failure is defined as: lack of efficacy with 4 week trial, allergy, intolerable side effects or significant drug-drug interactions). *All High Potency topical corticosteroids will require prior authorization beyond 4 weeks of therapy. The provider will be encouraged to transition to a moderate or low potency topical steroid after this time has elapsed.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
*Triamcinolone acetonide 0.5% cream, 0.5% ointment	Dermacinrx silapak (triamcinolone) Dermawerx sds pak (triamcinolone) Desoximetasone cream, ointment Fluocinonide 0.05% cream, 0.05% ointment Halog 0.1% cream, 0.1% ointment (halcinonide) Topicort cream, ointment (desoximetasone)	
Very high potency		
No PA Required (unless exceeds duration of therapy*) *Betamethasone dipropionate propylene glycol (aug) 0.05% ointment *Clobetasol propionate 0.05% cream, 0.05% gel, 0.05% ointment, 0.05% solution	**PA Required** Bryhali lotion (halobetasol) Betamethasone dipropionate propylene glycol (aug) 0.05% gel, 0.05% lotion Clobetasol emollient 0.05% cream Clobetasol propionate 0.05% lotion, 0.05% foam, spray, shampoo Clobex (clobetasol) 0.05% lotion, 0.05% spray, 0.05% shampoo Clodan (clobetasol) 0.05% shampoo Desoximetasone spray Diprolene ointment (betamethasone dipropionate propylene glycol (aug))	Non-preferred Very High Potency topical corticosteroids will require adequate trial and/or failure of clobetasol propionate in the same formulation as the non-preferred product being requested if possible. If formulation of non-preferred product is not available in preferred clobetasol propionate, then trial of any preferred clobetasol propionate is required. (Failure is defined as: lack of efficacy with 2 week trial, allergy, intolerable side effects or significant drug-drug interactions). *All Very High Potency topical corticosteroids will require prior authorization beyond 2 weeks of therapy. If clobetasol propionate shampoo is being used to treat plaque psoriasis, then prior authorization will be required beyond 4 weeks of therapy. The provider will be encouraged to transition to a moderate or low potency topical steroid after this time has elapsed.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Fluocinonide 0.1% cream Halobetasol cream, ointment, foam Lexette foam (halobetasol) Olux foam (clobetasol) Temovate (clobetasol) cream Topicort 0.25% spray (desoximetasone) Ultravate lotion, ream, ointment (halobetasol) Ultravate-X (halobetasol/lactic acid) cream, ointment Vanos cream (fluocinonide 0.1%)	
VI. Endocrine		
Therapeutic Drug Class: **ANDROGENIC AGENTS -***Effective 7/1/2019*		
***Must meet criteria** *Testosterone 1.62% packet (generic Androgel) *ANDRODERM (testosterone) patch *Testosterone gel pump (generic Axiron) *Testosterone gel (generic Fortesta) *Testosterone gel (generic Testim)	**PA Required** ANDROGEL 1.62% (testosterone gel) pump ANDROGEL 1% (testosterone gel) ANDROID (methyltestosterone) capsule DELATESTRYL (testosterone enanthate) IM injection	<u>Hypogonadotropic or Primary Hypogonadism (may be secondary to Klinefelter Syndrome</u>): Preferred androgenic drugs will be approved for members meeting the following: 1. Male patient > 16 years of age AND 2. Has a documented diagnosis of hypogonadotropic or primary hypogonadism (Patients with other diagnoses will require a manual review) AND 3. Has two documented low serum testosterone levels below the lower limit of normal range for testing laboratory prior to initiation of therapy AND 4. Does not have a diagnosis of breast or prostate cancer AND 5. Does not have a palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL AND 6. Has normal liver function tests prior to initiation of therapy <u>Gender Transition/Affirming Hormone Therapy:</u> Preferred androgenic drugs will be approved for members meeting the following:

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
*Testosterone gel, packet, pump (generic Vogelxo) *Testosterone cypionate IM injection ***Injectable testosterone cypionate is a pharmacy benefit when self-administered. Administration in an office setting is a medical benefit.***	DEPO TESTOSTERONE (testosterone cypionate) IM injection FORTESTA (testosterone) gel METHITEST (methyltestosterone) tablet Methyltestosterone capsule NATESTO (testosterone) topical nasal gel STRIANT (testosterone) buccal TESTIM (testosterone gel) Testone CIK (testosterone cypionate) IM injection TESTRED (methyltestosterone) capsule Testosterone enanthate IM injection Testosterone gel 1.62% 1.25 gram/ actuation pump VOGELXO (testosterone) gel XYOSTED (testosterone enanthate) SC injection	1. Female sex assigned at birth> 16 years of age* AND 2. Is undergoing female to male transition AND 3. Has a negative pregnancy test prior to initiation AND 4. Has normal liver function tests prior to initiation of therapy *Testosterone 1.62% packet (generic Androgel®) is a preferred agent for gender transition/affirmation and is non-preferred for all other indications. Non-preferred topical androgenic agents may be approved for patients meeting the above criteria with trial and failed‡ therapy with two preferred topical androgen formulations. Non-preferred injectable androgenic agents may be approved for patients meeting the above criteria with trial and failed‡ therapy with a preferred injectable androgenic drug. Prior authorization for oral androgen agents (tablet, capsule, buccal) may be approved if member has trialed and failed‡ therapy with a preferred topical agent AND testosterone cypionate injection. ‡Failure is defined as lack of efficacy with 8 week trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction. For all agents and diagnoses, members < 16 years of age will require a manual prior authorization review by a pharmacist. Reauthorization Criteria (for Hypogonadism diagnoses): Members may continue to receive preferred agents without requirement of updated low serum testosterone laboratory testing that meet the following criteria: • Male patient > 16 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 AND • Has normal liver function tests prior to initiation of therapy
Therapeutic Drug Class: **BONE RESORPTION SUPPRESSION AND RELATED AGENTS -***Effective 10/1/2019*		
Bisphosphonates		

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
No PA Required Alendronate (generic) 5mg, 10mg, 35mg, 70mg tablets Ibandronate tablet	**PA Required** ACTONEL (risedronate) ACTONEL w/Calcium (risedronate w/calcium) Alendronate 40mg tab Alendronate oral solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate) FOSAMAX (alendronate) FOSAMAX plus D (alendronate w/D) Etidronate	Non-preferred bisphosphonates may be approved for members who have failed treatment with one preferred product at treatment dose. (Failure is defined as: lack of efficacy with a 12 month trial, allergy, intolerable side effects, or significant drug-drug interaction.) Prior authorization for alendronate 70mg/75ml solution will be approved if member cannot swallow solid oral dosage forms or has a feeding tube. Prior authorization may be approved for **etidronate** in members with heterotopic ossification without treatment failure of a preferred agent. • 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** no history of vertebral facture.
Non-Bisphosphonates		
	PA Required Calcitonin salmon (nasal) EVISTA (raloxifene) FORTEO (teriparatide) Raloxifene TYMLOS (abaloparatide)	**Calcitonin salmon (nasal)** will be approved if the member meets the following criteria: • Member has a diagnosis of post-menopausal osteoporosis (BMD T-scores of –2.5 or less) **AND** • Has trial and failure of preferred bisphosphonate for one year (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **OR** • Member cannot swallow solid oral dosage forms or has a feeding tube. Quantity limit of one spray per day **Raloxifene** will be approved if the member meets the following criteria: • Diagnosis of postmenopausal osteoporosis (BMD T-scores of –2.5 or less) AND • Has trial and failure of preferred bisphosphonate for one year (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		Maximum Dose of raloxifene is 60mg oral daily **Forteo (teriparatide)** will be approved if the member meets the following criteria: • Member has one of the following diagnoses: • Osteoporosis, (BMD T-scores of –2.5 or less) primary or hypogonadal in men • Osteoporosis due to corticosteroid use • Postmenopausal osteoporosis AND • Has trial and failure of preferred bisphosphonate for one year (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) • Prior authorization will be given for one year and total exposure of parathyroid hormone analogs (Forteo and Tymlos) shall not exceed two years Maximum dose of Forteo is 20mcg subcutaneous daily **Tymlos (abaloparatide)** will be approved if the member meets the following criteria: • Member has a diagnosis of postmenopausal osteoporosis (BMD T-scores of –2.5 or less) AND • Has trial and failure of preferred bisphosphonate for one year (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) AND • Prior authorization will be given for one year and total exposure of parathyroid hormone analogs (Forteo and Tymlos) shall not exceed two years. Maximum dose of Tymlos is 80 mcg injection daily **Prolia (denosumab)** is a physician administered drug and prior authorization criteria may be found on the Appendix P.
Therapeutic Drug Class: **CONTRACEPTIVE - ORAL** *Effective 10/1/2019*			
No PA Required		**PA Required**	
<u>Monophasic 28:</u> Altavera 28 0.15-30 Alyacen 28 1-35 Apri 28 0.15-30 Aubra EQ-28 0.1-20 Aviane 28 0.1-20 Balziva 28 0.4-35 Chateal 28 0.15-30 Chateal EQ 28 0.15-30 Cryselle 28 0.3-30	Levonor-Eth Estrad 28 0.1-20 Levonor-Eth Estrad 28 0.15-30 Levora 28 0.15-30 Lillow 28 0.15-30 Low-Ogestrel 28 0.3-30 Lutera 28 0.1-20 Marlissa 28 0.15-30 Mili 28 0.25-35 Mono-Linyah 28 0.25-35 Mononessa 28 0.25-35	All other rebateable products are non-preferred	Non-preferred oral contraceptive products will be approved if member fails one-month trial with four preferred agents OR if preferred products with medically necessary ingredients and/or doses are unavailable. (Failure is defined as: allergy, intolerable side effects, or significant drug-drug interaction) Initial fills may be dispensed for three-month supply to establish tolerance (i.e. lack of adverse

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)	
Cyclafem 28 1-35 Dasetta 28 1-35 Drosperinone-Eth Estradiol 28 3-30 Elinest 28 0.3-30 Enskyce 28 0.15-30 Estarylla 28 0.25-35 Ethynodiol-Eth Estra 28 1-35 Ethynodiol-Eth Estra 28 1-50 Falmina 28 0.1-20 Femynor 28 0.25-35 Isibloom 28 0.15-30 Juleber 28 0.15-30 Kelnor 28 1-35 Kurvelo 28 0.15-30 Larissia 28 0.1-20 Lessina 28 0.1-20	Norg-Ethin Estra 28 0.25-35 Nortrel 28 0.5-35 Nortrel 28 1-35 Ocella 28 3-30 Philith 28 0.4-35 Pirmella 28 1-35 Portia 28 0.15-30 Previfem 28 0.25-35 Reclipsen 28 0.15-30 Sprintec 28 0.25-35 Sronyx 28 0.1-20 Syeda 28 3-30 Vienva 28 0.1-20 Vyfemla 28 0.4-35		effects). After established tolerance on the same agent for 3 months, a 12 month supply (365 days) may be dispensed (as one fill).
No PA Required **<u>Monophasic 21:</u>** Larin 21 1-20 Larin 21 1.5-30 Norethind-Eth Estrad 21 1-20 Nortrel 21 1-35 **<u>Triphasic:</u>** Alyacen 7-7-7 28 Cyclafem 7-7-7 28 Dasetta 7-7-7 28 Enpresse 28 Levonest 28 Levonor-Eth Estrad Triphasic 28 Pirmella 7-7-7 Tri-Estarylla 28 Tri-Femynor 28 Tri-Linyah 28 Tri-Lo Estarylla 28 Tri-Lo Marzia 28 Tri-Lo Sprintec 28 Trinessa 28	**No PA Required** **<u>Biphasic:</u>** Azurette 28 Bekyree 28 Desogest-Eth Estra 28 Kariva 28 Lo Loestrin FE 28 1-10 Mircette 28 Viorele 28 **<u>Extended Cycle:</u>** Amethia 91 0.03 – 0.15 – 0.01 Ashlyna 91 0.15-10-30 Introvale 91 0.15-30 Jolessa 91 0.15-30 Levonorgest-Eth Estrad 0.09-20 Levonorgest-Eth Estrad 91 0.1-10-20 Levonorgest-Eth Estrad 91 0.15-0.03 Levonorgest-Eth Estrad 91 0.15-0.03-0.01 Levonorgest-Eth Estrad 91 0.15-20-25-30 Quasense 91 0.15-30 Setlakin 91 0.15-30		

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Tri-Sprintec 28 Tri-Vylibra Lo 28 **Norethindrone Only:** Camila 28 0.35 Deblitane 28 0.35 Errin 28 0.35 Heather 28 0.35 Jencycla 28 0.35 Jolivette 28 0.35 Norethindrone 28 0.35 Norlyda 28 0.35 Sharobel 28 0.35	**Continuous Cycle:** Aurovela FE 1-20 Blisovi FE 1-20 Blisovi FE 1.5-30 Jasmiel 3-20 Junel FE 1-20 Junel FE 24 1-20 Junel FE 1.5-30 Larin FE 1-20 Larin FE 24 1-20 Larin FE 1.5-30 Loryna 3-20 Minastrin FE 24 1-20 Nikki 3-20 Noreth-Eth Estrad-FE 24 1-20 Noreth-Eth Estrad-FE 1-20 Tarina FE 24 1-20 Tarina FE 1-20 Tarina FE 1-20 EQ		
Therapeutic Drug Class: **DIABETES MANAGEMENT CLASSES**		
INSULIN Rapid Acting -*Effective 4/1/2019*		
No PA Required NOVOLOG vial/ pen	**PA Required** AFREZZA APIDRA all forms FIASP all forms HUMALOG vial/ pen/ kwikpen HUMALOG Junior kwikpen Insulin lispro	Non-preferred products will be approved if the member has failed treatment with one of the preferred products (Failure is defined as: allergy [hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, and angioedema] 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
INSULIN Short Acting -*Effective 4/1/2019*		
HUMULIN R vial (OTC)	NOVOLIN R all forms (vial OTC)	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)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
HUMULIN R concentrated vial (U-500)	HUMULIN R kwikpen	
INSULIN Intermediate Acting *Effective 4/1/2019*		
HUMULIN N vial (OTC)	HUMULIN N kwikpen 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)
INSULIN Long Acting *Effective 4/1/2019*		
LEVEMIR vial/ pen (detemir) LANTUS (glargine) vial/pen	BASAGLAR (glargine) all forms TOUJEO (glargine) all forms TRESIBA (degludec) all forms	Non-preferred products will be approved if the member has failed treatment with Levemir and Lantus (Failure is defined as: allergy or intolerable side effects)
INSULIN Mixtures *Effective 4/1/2019*		
HUMULIN 70/30 vial (OTC) HUMALOG MIX 50/50 vial HUMALOG MIX 75/25 vial NOVOLOG MIX 70/30 vial/ pen	HUMALOG MIX 75/25 pen HUMALOG MIX 50/50 pen HUMULIN 70/30 kwikpen (OTC) NOVOLIN 70/30 vial (OTC)	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)
Amylin *Effective 10/1/2019*		
	PA Required SYMLIN (pramlintide)	**Symlin**® will only be approved after a member has failed a three month trial of metformin and a DPP4-inhibitor or a GLP-1 analogue. Failure is defined as: lack of efficacy (e.g., hemoglobin A1C ≥ 7%) OR the member cannot tolerate metformin, DPP4-inhibitor and GLP-1 analogue due to allergy, intolerable side effects, or a significant drug-drug interaction. PA will be approved for Symlin products for members with Diabetes Mellitus Type 1 without failed treatment **For all products**, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing.
Biguanides *Effective 10/1/2019*		
No PA Required Metformin 500mg, 850mg, 1000mg tablets	**PA Required** FORTAMET (metformin) GLUCOPHAGE (brand) (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.)

<table>
<tr><th>Preferred Agents</th><th>Non-preferred Agents</th><th>Prior Authorization Criteria
(All Non-Preferred Products will be approved for one year unless otherwise stated.)</th></tr>
<tr><td>Metformin ER 500mg tablets
(generic Glucophage XR)</td><td>GLUCOPHAGE XR (brand)
(metformin XR)

GLUMETZA ER (metformin)

Metformin ER 750mg

Metformin ER 500 and 1000mg
(generic Fortamet, generic Glumetza)

RIOMET 500mg/5ml (metformin)</td><td>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</td></tr>
<tr><td colspan="3">DPP-4 Inhibitors Effective 10/1/2019</td></tr>
<tr><td>*Must meet eligibility criteria

*Januvia (sitagliptin)

*Tradjenta (linagliptin)</td><td>PA Required

Alogliptin

Nesina (alogliptin)

Onglyza (saxagliptin)</td><td>*Approval for preferred products require a three month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy.

Non-preferred DPP-4 inhibitors will be approved after a member has failed a three month trial of metformin AND a three month trial of two preferred products. Failure is defined as lack of efficacy (e.g., hemoglobin A1C ≥ 7%), allergy, intolerable side effects, or a significant drug-drug interaction.

For all products, prior authorization will be required for dosing above the FDA approved maximum dosing listed in the following table:

<table>
<tr><th>DPP4</th><th>FDA Approved Max Dose (mg/day)</th></tr>
<tr><td>Alogliptin (generic Nesina)</td><td>25 mg/day</td></tr>
<tr><td>Januvia (sitagliptan)</td><td>100 mg/day</td></tr>
<tr><td>Nesina (alogliptan)</td><td>25 mg/day</td></tr>
<tr><td>Onglyza (saxagliptan)</td><td>5 mg/day</td></tr>
<tr><td>Tradjenta (linagliptan)</td><td>5 mg/day</td></tr>
</table>
</td></tr>
</table>

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

DPP-4 Inhibitors – Combination with Metformin *Effective 10/1/2019*		
***Must Meet eligibility criteria**	**PA Required**	
*JANUMET (sitagliptin/metformin) *JANUMET XR (sitagliptin/metformin)	Alogliptin/metformin JENTADUETO (linagliptin/metformin) JENTADUETO XR (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE (saxagliptin/metformin)	*Approval for preferred combination agent products require a three month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy. Non-preferred combination products will be approved for members who have been stable on the two individual ingredients of the requested combination for three months AND have had adequate three-month trial and failure of a preferred combination agent. Failure is defined as lack of efficacy (e.g., hemoglobin A1C ≥ 7%), allergy, intolerable side effects, or a significant drug-drug interaction.
GLP-1 Analogues *Effective 10/1/2019*		
***Must meet eligibility criteria**	**PA Required**	*Approval for preferred products requires a three month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy. Non-preferred products may be approved following trial and failure of a three month trial of metformin AND a three month trial of two preferred products. Failure is defined as lack of efficacy (e.g., hemoglobin A1C ≥ 7%), allergy, intolerable side effects, or a significant drug-drug interaction. <u>Maximum Dose:</u> Prior authorization is required for all products exceeding maximum dose listed in product package labeling.
*BYETTA (exenatide) *BYDUREON (exenatide ER) *VICTOZA (liraglutide)	ADLYXIN (lixisenatide) BYDUREON BCISE (exenatide ER) OZEMPIC (semaglutide) TRULICITY (dulaglutide)	

Maximum Dose	
Adlyxin (lixisenatide)	20mcg per day
Bydureon (exenatide)	2mg weekly
Bydureon BCISE (exenatide)	2mg weekly
Byetta (exenatide)	20mcg per day
Ozempic (semaglutide)	1mg weekly
Trulicity (dulaglutide)	1.5mg weekly
Victoza (liaglutide)	1.8mg per day

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Other Hypoglycemic Combinations *Effective 10/1/2019*		
	PA Required Alogliptin/pioglitazone AVANDARYL (rosiglitazone/glimepiride) DUETACT (pioglitazone/glimepiride) Pioglitazone/glimepiride Glipizide/metformin GLUCOVANCE (glyburide/metformin) Glyburide/metformin GLYXAMBI (empagliflozin/linagliptin) METAGLIP (glipizide/metformin) OSENI (alogliptin/pioglitazone) Qtern (dapagliflozin/saxagliptin) Soliqua (glargine 100 U and lixisenatide 33 mcg) Steglujan (ertugliflozin/sitagliptin) Xultophy (degludec 100 U and liraglutide 3.6 mg)	Non-preferred products may be approved for members who have been stable on each of the individual ingredients in the requested combination for 3 months (including cases where the ingredients are taken as two separate 3 month trials or when taken in combination for at least 3 months).
Meglitinides *Effective 10/1/2019*		

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	PA Required Nateglinide PRANDIN (repaglinide) 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 (e.g., hemoglobin A1C ≥ 7%), allergy, intolerable side effects, or significant drug-drug interaction.)
Meglitinides Combination with Metformin *Effective 10/1/2019*		
	PA Required PRANDIMET (repaglinide/metformin) Repaglinide/metformin	Non-preferred products will be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months.
SGLT-2 Inhibitors *Effective 10/1/2019*		
***Must meet eligibility criteria** *FARXIGA (dapagliflozin) *INVOKANA (canagliflozin) *JARDIANCE (empagliflozin)	**PA Required** STEGLATRO (ertugliflozin)	*Approval for preferred products requires a three month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy. Non-preferred products may receive approval following trial and failure with a three month trial of metformin AND a three month trial of two preferred products. Failure is defined as lack of efficacy with three month trial (e.g., hemoglobin A1C ≥ 7%) allergy, intolerable side effects, or a significant drug-drug interaction <u>Maximum Dose:</u> Prior authorization is required for all products exceeding maximum dose listed in product package labeling.
SGLT-2 Inhibitors Combination with Metformin *Effective 10/1/2019*		
	PA Required INVOKAMET (canagliflozin/metformin)	Non-preferred products will be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	SEGLUROMET (ertugliflozin/metformin) SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozin/metformin)	
Thiazolidinediones (TZDs) *Effective 10/1/2019*		
No PA Required Pioglitazone	**PA Required** ACTOS (pioglitazone) AVANDIA (rosiglitazone)	Non-preferred TZDs will be approved after a member has failed a three month trial of metformin and failed a three month trial of a preferred product. Failure is defined as lack of efficacy (e.g., hemoglobin A1C $\geq$ 7%), OR the member cannot tolerate pioglitazone and metformin due to allergy, intolerable side effects, or a significant drug-drug interaction.
Thiazolidinediones Combination with Metformin *Effective 10/1/2019*		
	PA Required ACTOPLUS MET (pioglitazone/metformin) ACTOPLUS MET XR (pioglitazone/metformin) AVANDAMET (rosiglitazone/metformin) Pioglitazone/metformin	Non-preferred products will be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months.
Therapeutic Drug Class: **GROWTH HORMONES -***Effective 4/1/2019*		
No PA Required **(if diagnosis and dose met)** GENOTROPIN NORDITROPIN	**PA Required** HUMATROPE NUTROPIN AQ	All preferred products will be approved if the member has one of the qualifying diagnoses listed below (diagnosis may be verified through AutoPA) AND if prescription does not exceed limitations for maximum dosing (Table 1). Non-preferred Growth Hormones may be approved if the following criteria are met:

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	OMNITROPE SAIZEN SEROSTIM ZOMACTON ZORBTIVE	• Member failed treatment with one preferred growth hormone product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) • Member has a qualifying diagnosis: o Prader-Willi o Chronic renal insufficiency/failure requiring transplantation (defined as Creatinine Clearance < 30mL/min) o Turner's Syndrome o Hypopituitarism: as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma verified by one of the following: ▪ Has failed at least one GH stimulation test (peak GH level < 10 ng/mL) ▪ Has at least one documented low IGF-1 level (below normal range for patient's age – refer to range on submitted lab document) ▪ Has deficiencies in ≥ 3 pituitary axes (i.e. TSH, LH, FSH, ACTH, ADH) o Cachexia associated with AIDS o Noonan Syndrome o Short bowel syndrome • Prescription does not exceed limitations for maximum dosing (Table 1) based on prescriber submission/verification of patient weight from most recent clinical documentation

Table 1: Growth Hormone Product Maximum Dosing*

Medication	Pediatric Max Dosing (age < 18 years)	Adult Max Dosing (age ≥ 18 years)
Genotropin	0.33 mg/kg/week	0.08 mg/kg/week
Humatrope	0.375 mg/kg/week	0.112 mg/kg/week
Norditropin Flexpro	0.47 mg/kg/week	0.175 mg/kg/week for age ≤36 years and 0.0875 mg/kg/week for age >35 years
Nutropin AQ Nuspin	0.357 mg/kg/week	0.08 mg/kg/week
Omnitrope	0.33 mg/kg/week	0.07 mg/kg/week
Saizen	0.18 mg/kg/week	0.08 mg/kg/week
Serostim	Not Indicated	42 mg/week for cachexia with HIV only (in combination with antiretroviral therapy)
Zomacton	0.375 mg/kg/week	0.0875 mg/kg/week
Zorbtive	Not Indicated	8 mg/28 days for short bowel syndrome only

*Based on FDA labeled indications and dosing

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

VII. Gastrointestinal

Therapeutic Drug Class: **ANTI-EMETICS** -*Effective 1/1/2019*

No PA Required	PA Required	
EMEND (aprepitant) capsule BNR Ondansetron tablets Ondansetron ODT tab Ondansetron oral solution (members under 5 years only) Transderm Scop (scopolamine) BNR	AKYNZEO (netupitant/palonosetron) ANZEMET (dolasetron) Aprepitant capsule, dose/tripack Bonjesta (doxylamine/pyridoxine) DICLEGIS (doxylamine/pyridoxine) Doxylamine 25mg (OTC) Dronabinol EMEND (aprepitant) powder for suspension, dose/tri pack KYTRIL (granisetron) MARINOL (dronabinol) Pyridoxine 50mg or 100mg (OTC) SANCUSO (granisetron) Scopolamine patch VARUBI (rolapitant) ZOFRAN (ondansetron) tabs ZOFRAN (ondansetron) solution ZOFRAN ODT (ondansetron)	Non-preferred products will be approved for members who have trialed and failed treatment with two preferred products of different mechanisms of action within the last year. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Prior authorization will be approved for Emend tripack or Emend powder pack for members who have trialed and failed three preferred products including Emend capsule. (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. **Diclegis** or **Bonjesta** will be approved for 3 months for members who meet the following criteria: • Has nausea and vomiting associated with pregnancy **AND** • Has failed 7-day trial of OTC formulation of pyridoxine (Vitamin B6) at maximally tolerated dose of up to 200mg daily **AND** • Has failed 7-day combination trial of OTC formulations of doxylamine and pyridoxine (Vitamin B6) at maximum daily doses of doxylamine 40mg and pyridoxine 40mg **AND** • Has failed 7 day trial of alternate antihistamine (diphenhydramine, dimenhydrinate, meclizine) **OR** • Has failed 7 day trial of dopamine antagonist (metoclopramide, prochlorperazine, promethazine) **OR** • Has failed 7-day trial of serotonin antagonist (ondansetron, granisetron) (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) **Pyridoxine** and **doxylamine** will be approved for members who have a diagnosis of nausea and vomiting of pregnancy (NVP). Approval will be given for 3 months. Prior authorization for dronabinol will be approved via AutoPA for members with documented HIV diagnosis.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	ZUPLENZ (ondansetron)	
Therapeutic Drug Class: **GI MOTILITY, CHRONIC -***Effective 10/1/2019*		
PA Required for all agents in this class		All GI Motility Agents will only be approved for FDA labeled indications and up to FDA approved maximum doses (listed below): Preferred agents will be approved if the member meets the following criteria: • Has diagnosis of Irritable Bowel Syndrome – Constipation (IBS-C), Chronic Idiopathic Constipation (CIC), or Opioid Induced Constipation (OIC) in patients with opioids prescribed for noncancer pain **AND** • Member does not have a diagnosis of GI obstruction **AND** • For indication of OIC, member opioid use must exceed 4 weeks of treatment • For indications of CIC, OIC, IBS-C; member must have documentation of adequate trial of two or more over-the-counter motility agents (for example; polyethylene glycol, docusate, bisocodyl) (Failure is defined as a lack of efficacy for a 7 day trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions) o If the member cannot take oral medications, then the member must fail a 7-day trial with a nonphosphate enema (docusate or bisocodyl enema) • For indication of IBS-D; must have documentation of adequate trial with loperamide **AND** dicyclomine **OR** hyoscamine (Failure is defined as a lack of efficacy for a 7 day trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions) Non-preferred agents may be approved if the member meets the following criteria: • Member meets all listed criteria for preferred agents **AND** • Member has trialed and failed two preferred agents o If indication OIC caused by methadone, then non-preferred agent may be approved after trial of Movantik (Failure is defined as a lack of efficacy for a 7 day trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions) **AND** o Member meets additional criteria for the agents listed below **Viberzi**® (eluxadoline) will be approved for members who meet the following criteria: • Has diagnosis of Irritable Bowel Syndrome – Diarrhea (IBS-D) AND • Member has a gallbladder AND
AMITIZA (lubiprostone) LINZESS (linaclotide) MOVANTIK (naloxegol)	Alosetron LOTRONEX (Alosetron) RELISTOR (Methylnaltrexone bromide) tablet and syringe SYMPROIC (Naldemedine) TRULANCE (plecanatide) VIBERZI (eluxadoline)	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		• Member does not have severe hepatic impairment (Child-Pugh C), history of severe constipation, known mechanical gastrointestinal obstruction, biliary duct obstruction, history of pancreatitis or structural disease of the pancreas AND • Member does not drink more than 3 alcoholic drinks per day AND **Lotronex**® (alesotron) and Alesotron will be approved for members who meet the following criteria: • Member is a female with Irritable Bowel Syndrome – Diarrhea (IBS-D) with symptoms lasting 6 months or longer AND • Member does not have severe hepatic impairment (Child-Pugh C), history of severe constipation or ischemic colitis, hypercoagulable state, Crohn's disease or ulcerative colitis, or known mechanical gastrointestinal obstruction

Medication	FDA approved indication	FDA Max Dose
Amitiza (lubiprostone)	IBS-C (females only), CIC, OIC (not caused by methadone)	48mcg/day
Linzess (linaclotide)	IBS-C, CIC	290mcg/day
Movantik (naloxegol)	OIC	25mg/day
Viberzi (eluxadoline)	IBS-D	200mg/day
Alosetron	OIC	2mg/day (females only)
Relistor syringe (methylnaltrexone)	OIC	12mg SQ/day
Relistor oral (methylnaltrexone)	OIC	450mg/day
Lotronex (alosetron)	IBS-D (females only)	2mg/day (females only)
Symproic (Naldemedine)	OIC	0.2mg/day
Trulance (plecanatide)	CIC, IBS-C	3mg/day

CIC – chronic idiopathic constipation, OIC – opioid induced constipation, IBS – irritable bowel syndrome, D – diarrhea predominant, C – constipation predominant

Therapeutic Drug Class: **PANCREATIC ENZYMES -***Effective 1/1/2019*		
No PA Required	**PA Required**	
CREON (pancrelipase) ZENPEP (pancrelipase)	PANCREAZE (pancrelipase) PANCRELIPASE (pancrelipase) PERTZYE (pancrelipase)	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.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	ULTRESA (pancrelipase) VIOKACE (pancrelipase)	
Therapeutic Drug Class: **PROTON PUMP INHIBITORS** -*Effective 1/1/2019*		
No PA Required Esomeprazole capsules (generic Nexium) RX NEXIUM (esomeprazole) packets **BNR** Omeprazole generic capsules Pantoprazole tablets PREVACID solutab **BNR** (lansoprazole) (for members under 2)	**PA Required** ACIPHEX tab, sprinkles (rabeprazole) DEXILANT (dexlansoprazole) KAPIDEX (dexlansoprazole) Esomeprazole strontium and OTC Lansoprazole capsules Lansoprazole 15mg OTC (currently available as PREVACID 24HR) NEXIUM capsules (RX) NEXIUM 24 hour (OTC) Omeprazole/Na bicarbonate omeprazole 20mg tabs (OTC) PREVACID (lansoprazole) capsules & suspension PRILOSEC OTC (omeprazole) PROTONIX (pantoprazole) tablets and suspension	For members treating GERD symptoms that are controlled on PPI therapy, it is recommended that the dose of the PPI be re-evaluated or step-down with an H2 blocker (such as famotidine or ranitidine) be trialed in order to reduce long-term PPI use. Prior authorization for non-preferred proton pump inhibitors may be approved if all of the following criteria are met: • Member has a qualifying diagnosis (below) **AND** • Member has trailed and failed therapy with three preferred agents within the last 24 months. (Failure is defined as: lack of efficacy following 4 week trial, allergy, intolerable side effects, or significant drug-drug interaction) **AND** • Member has been diagnosed using one of the following diagnostic methods: o Diagnosis made by GI specialist o Endoscopy o X-ray o Biopsy o Blood test o Breath Test **Qualifying Diagnoses:** Barrett's esophagus, duodenal ulcer, erosive esophagitis, gastric ulcer, GERD, GI Bleed, H. pylori infection, hypersecretory conditions (Zollinger-Ellison), NSAID-induced ulcer, pediatric esophagitis, requiring mechanical ventilation, requiring a feeding tube **Quantity Limits:** All agents will be limited to once daily dosing except when used for the following diagnoses: Barrett's esophagus, GI Bleed, H. pylori, hypersecretory conditions (Zollinger-Ellison), or Spinal Cord Injury patients with associated acid reflux. **Adult members with GERD** on once daily, high-dose PPI therapy who continue to experience symptoms may receive initial prior authorization approval for a 4-week trial of twice daily, high-dose PPI therapy. Continuation of the twice daily dosing regimen for GERD beyond 4 weeks will require additional prior authorization approval verifying adequate member response

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Rabeprazole (generic Aciphex) ZEGERID (omeprazole/Na bicarbonate) (RX and OTC)	to the dosing regimen and approval may be placed for one year. If a member with symptomatic GERD does not respond to twice daily, high-dose PPI therapy, this should be considered a treatment failure. **Pediatric members (< 18 years of age)** on once daily dosing of a PPI who continue to experience symptoms may receive one-year prior authorization approval for twice daily PPI therapy. **Age Limits:** **Nexium 24H** and **Zegerid** will not be approved for members less than 18 years of age. **Prevacid Solutab** will be approved for members < 2 years of age OR for members ≥ 2 years of age with a feeding tube.
Therapeutic Drug Class: **H. Pylori Treatments** -*Effective 1/1/2019*		
	PA Required 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.
Therapeutic Drug Class: **ULCERATIVE COLITIS AGENTS- ORAL** -*Effective 1/1/2019*		
No PA Required Apriso ER (mesalamine) capsule Lialda (mesalamine DR) [BNR] Pentasa (mesalamine) capsule	**PA Required** Asacol HD (mesalamine) Azulfidine tablet, DR (sulfasalazine) Balsalazide disodium	Prior authorization for non-preferred oral formulations will require trial and failure of two preferred oral products with different active ingredients AND a preferred rectal product. If inflammation is not within reach of topical therapy, trial of preferred rectal product is not required. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Sulfasalazine IR and DR	Budesonide DR Colazal (balsalazide disodium) Delzicol (mesalamine) Dipentum (olsalazine sodium) Giazo (balsalazide disodium) mesalamine (generic Lialda) mesalamine (generic Asacol HD) Uceris (budesonide) tablet	Uceris or generic budesonide: If the above criteria is met, Uceris tablet prior authorization will be approved for 8 weeks. Further prior authorization may be approved if 7 days of steroid-free time has elapsed and member continues to meet the above criteria.
Therapeutic Drug Class: **ULCERATIVE COLITIS AGENTS- RECTAL** -*Effective 1/1/2019*		
No PA Required *Brand Generic changes effective 08/01/19* Mesalamine suppository (generic Canasa)	**PA Required** Canasa (mesalamine) suppository Mesalamine rectal and rectal kit Sfrowasa (mesalamine) Rowasa (mesalamine w/cleansing wipes) Uceris (budesonide) foam	Prior authorization for non-preferred rectal formulations will require trial and failure of one preferred rectal formulation and one preferred oral formulation (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Uceris: If the above criteria is met, Uceris foam prior authorization will be approved for 6 weeks. Further prior authorization may be approved if 7 days of steroid-free time has elapsed and member continues to meet the above criteria.
VIII. Hematological		
Therapeutic Drug Class: **ANTI-COAGULANTS- ORAL** -*Effective 10/1/2019*		
No PA Required Warfarin PRADAXA (dabigatran)	**PA Required** BEVYXXA (betrixaban) COUMADIN (warfarin)	**Bevyxxa** (betrixaban) may be approved if all the following criteria have been met: • The member has trialed and failed therapy with two preferred agents. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **AND** • Member is not on dialysis **AND**

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
XARELTO (rivaroxaban) 10 mg, 15 mg, 20 mg tablet XARELTO (rivaroxaban) dose pack	ELIQUIS (apixaban) SAVAYSA (edoxaban) XARELTO (rivaroxaban) 2.5 mg tablet	• The member is need of prophylaxis for DVT following hospitalization for an acute medical illness who are at risk for thromboembolic events due to limited mobility **AND** • The member does not have a mechanical prosthetic heart valve **Eliquis** (apixaban) may be approved if the following criteria have been met: • The member is on dialysis **OR** • The member has failed therapy with two preferred agents. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. If the member is on dialysis, trial and failure of preferred agents is not required **AND** • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) **OR** • The member is in need of prophylaxis for 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 **Savaysa** (edoxaban) may be approved if all the following criteria have been met: • The member has failed therapy with two preferred agents. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **AND** • Member is not on dialysis **AND** • Member does not have CrCl > 95 mL/min **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 **Xarelto 2.5mg** (rivaroxaban) may be approved for members meeting all of the following criteria: • Xarelto 2.5mg is being prescribed to reduce major CV events in members diagnosis of chronic coronary artery disease (CAD) or peripheral artery disease **AND** • Xarelto 2.5mg is being taken twice daily and in combination with aspirin 75-100mg daily **AND** • Member must not be receiving dual antiplatelet therapy, other non-aspirin antiplatelet, or other oral anticoagulant **AND** • Member must not have had an ischemic, non-lacunar stroke within the past month **AND** • Member must not have had a hemorrhagic or lacunar stroke at any time Continuation of Care: Members with current prior authorization approval on file for a non-preferred oral anticoagulant medication may continue to receive approval for that medication.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Therapeutic Drug Class: **ANTI-COAGULANTS- PARENTERAL** -*Effective 10/1/2019*		
No PA Required Enoxaparin syringe Lovenox 300mg/3ml vial BNR	**PA Required** Arixtra (fondaparinux) syringe Enoxaparin 300mg/3ml vial (generic Lovenox) Fondaparinux (generic Arixtra) Fragmin (dalteparin) vial and syringe Lovenox syringe	Non-preferred parenteral anticoagulants will be approved if member has trial and failure of one preferred agent. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction **ARIXTRA**® (fondiparinux) will be approved if the following criteria have been met: • Member is 18 years of age or older **AND** • Member has a CrCl > 30 ml/min **AND** • Member weighs > 50 kg **AND** • Member has a documented history of heparin induced-thrombocytopenia **OR** • Member has a contraindication to enoxaparin Grandfathering: Members currently stabilized on fondaparinux (Arixtra) and dalteparin (Fragmin) may receive prior authorization approval to continue on that medication.
Therapeutic Drug Class: **ANTI-PLATELETS** -*Effective 1/1/2019*		
No PA Required AGGRENOX (ASA/dipyridamole) BNR BRILINTA (tigacrelor) Cilostazol Clopidogrel Prasugrel	**PA Required** ASA/dipyridamole DURLAZA (aspirin ER) EFFIENT (prasugrel) PLAVIX (clopidogrel) PLETAL (cilostazol) TICLID (ticlopidine) ZONTIVITY (vorapaxar)	Patients taking **BRILINTA** must also 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. Non-preferred products without criteria will be reviewed on a case by case basis.
Therapeutic Drug Class: **COLONY STIMULATING FACTORS** -*Effective 10/1/2019*		
PA Required for all agents in this class		Prior authorization may be approved if meeting the following criteria: • Medication is being used for one of the following indications: o Cancer patient receiving myelosuppressive chemotherapy –to reduce incidence of infection (febrile neutropenia) (Either the post nadir ANC is less than 10,000
NEUPOGEN (filgrastim) vial, syringe	FULPHILA (pegfilgrastim-jmdb)	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) syringe NIVESYM (filgrastim-aafi) UDENYCA (pegfilgrastim-cbqv) ZARXIO (filgrastim-sndz)	cells/mm3 or the risk of neutropenia for the member is calculated to be greater than 20%) o Acute Myeloid Leukemia (AML) patients receiving chemotherapy o Bone Marrow Transplant (BMT) o Peripheral Blood Progenitor Cell Collection and Therapy o Hematopoietic Syndrome of Acute Radiation Syndrome o Severe Chronic Neutropenia (Evidence of neutropenia Infection exists or ANC is below 750 cells/mm3) **AND** • All non-preferred agents will require a documented failure of Neupogen vial or syringe for approval (Failure is defined as a lack of efficacy with a 3 month trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions) **AND** • For long-acting formulations (such as Fulphila and Neulasta), the member has trialed and failed a three month trial of Udenyca. Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions)
Therapeutic Drug Class: **ERYTHROPOIESIS STIMULATING AGENTS** *Effective 10/1/2019*		
PA Required for all agents in this class*		*Prior Authorization is required for all products and may be approved if meeting the following: • Medication is being administered in the member's home or in a long-term care facility **AND** • Members meets one of the following: o A diagnosis of cancer, currently receiving chemotherapy, with chemotherapy-induced anemia, and hemoglobin† of 10g/dL or lower **OR** o A diagnosis of chronic renal failure, and hemoglobin† below 10g/dL **OR** o 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). **OR** o A diagnosis of HIV, currently taking Zidovudine, hemoglobin† less than 10g/dL, and serum erythropoietin level of 500mUnits/mL or less **OR** o Member is undergoing elective, noncardiac, nonvascular surgery and medication is given to reduce receipt of allogenic red blood cell transfusions, hemoglobin† is greater than 10g/dL, but less than or equal to 13g/dL and high risk for perioperative blood loss. Member is not willing or unable to donate autologous blood pre-operatively. **AND** • For any non-preferred product, member has trialed and failed treatment with one preferred product. Failure is defined as lack of efficacy with a 6 week trial, allergy, intolerable side effects, or significant drug-drug interaction.
RETACRIT (epoetin alfa-epbx)	ARANESP (darbepoetin alfa) EPOGEN (epoetin alfa) MIRCERA (methoxy peg-epoetin beta) PROCRIT (epoetin alfa)	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		†Hemoglobin results must be from the last 30 days.
IX. Immunological		
Therapeutic Drug Class: **Newer Generation Antihistamines** -*Effective 7/1/2019*		
No PA Required Cetirizine (generic OTC Zyrtec) 5mg and 10mg tab Cetirizine (RX) syrup Levocetirizine (OTC) tablet Loratadine (generic OTC Claritin) 10mg tab and syrup	**PA Required** ALAVERT (loratadine) ALLEGRA (fexofenadine) Cetirizine (OTC) chewable tablet, syrup CLARINEX (desloratadine) CLARITIN (loratadine) Desloratadine Fexofenadine Levocetirizine (RX) tablets, solution Loratadine ODT XYZAL (levocetirizine) ZYRTEC (cetirizine)	Non-preferred single agent antihistamine products may be approved for members who have failed treatment with two preferred products in the last 6 months. For members with respiratory allergies, an additional trial of an intranasal corticosteroid will be required in the last 6 months. Failure is defined as lack of efficacy with a 14 day trial, allergy, intolerable side effects, or significant drug-drug interaction.
Antihistamine/Decongestant Combinations		
	PA Required ALLEGRA-D (fexofenadine/PSE) Cetirizine-D (OTC)	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. For members with respiratory allergies, an additional trial of an intranasal corticosteroid will be required in the last 6 months.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	CLARINEX-D (desloratadine-D) CLARITIN-D (loratadine-D) (OTC) Fexofenadine/PSE (OTC) Loratadine-D (OTC) SEMPREX-D (acrivastine-D) ZYRTEC-D (cetirizine-D) (OTC)	Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.
Therapeutic Drug Class: **INTRANASAL RHINITIS AGENTS** -*Effective 4/1/2019*		
No PA Required Azelastine 137 mcg Budesonide (OTC) Ipratropium Fluticasone (generic FLONASE) Rx only Triamcinolone acetonide (generic Nasacort) (OTC)	**PA Required** Astepro (azelastine) 0.15% Azelastine 0.15% BECONASE AQ (beclomethasone dipropionate) CHILD NASACORT (triamcinolone) DYMISTA (azelastine/ fluticasone propionate) Flunisolide Mometasone NASACORT AQ (triamcinolone) NASONEX (mometasone) Olopatadine OMNARIS (ciclesonide)	Non-preferred intranasal rhinitis agents will be approved if the member has failed treatment with 3 preferred products (Failure is defined as: lack of efficacy with a 2 week trial, allergy, intolerable side effects or significant drug-drug interactions). Non-preferred combination agents will be approved if member has trial of each individual agent and 1 additional agent. (Failure is defined as: lack of efficacy with 2 week trial, allergy, intolerable side effects or significant drug-drug interactions). Non-preferred intranasal rhinitis agents with a preferred product with same strength, dosage form, and active ingredient will be approved with adequate trial and/or failure of the preferred product (and 2 additional agents. (Failure is defined as: lack of efficacy with 2 week trial, allergy, intolerable side effects or significant drug-drug interactions).

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Patanase (olopatadine) QNASL (beclomethasone dipropionate) RHINOCORT AQ (budesonide) Ticanase (fluticasone propionate + saline nasal spray) Xhance (fluticasone propionate) ZETONNA (ciclesonide)	
Therapeutic Drug Class: **LEUKOTRIENE MODIFIERS -***Effective 4/1/2019*		
No PA Required Montelukast (tab, chewable)	**PA Required** ACCOLATE (zafirlukast) SINGULAIR (montelukast) (tab, chewable tab, granules) Montelukast granules ZAFIRLUKAST ZYFLO (zileuton) ZYFLO CR (zileuton)	Non-preferred Leukotrienes will be approved if **both** of the following criteria are met: • Member 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) • Member has a diagnosis of Asthma **Montelukast granules** will be approved if a member has tried and failed montelukast chewable tablets AND has difficulty swallowing.
Therapeutic Drug Class: **MULTIPLE SCLEROSIS AGENTS -***Effective 4/1/2019*		
Disease Modifying Therapies		
No PA Required (unless indicated*) AVONEX (interferon beta 1a)	**PA Required** COPAXONE 40MG (glatiramer)	Non-preferred **Interferon** products may be approved if the member 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 and glatiramer 40mg** may be approved for members who have severe

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) COPAXONE 20MG INJECTION *BNR (glatiramer) *GILENYA (fingolimod) (30 count bottle) (2nd line) * TECFIDERA (dimethyl fumarate) (2nd line) * AUBAGIO (teriflunomide) (2nd line)	EXTAVIA (interferon beta 1b) GLATOPA (glatiramer 20mg) Glatiramer 20mg, 40mg GILENYA (fingolimod) (7 count box) PLEGRIDY (peg-interferon beta 1a) REBIF (interferon beta 1a)	intolerable injection site reactions (e.g, pain requiring local anesthetic, oozing, lipoatrophy, swelling, or ulceration) to Copaxone 20mg. Approval Criteria for 2nd Line Preferred Agents: **Gilenya, Tecfidera**, and **Aubagio** may be approved for members that meet the following criteria: ● Documented diagnosis of multiple sclerosis made by neurologist in the last 3 years OR member has history of diagnosis made by a neurologist > 3 years ago but is naïve to all medications indicated for the treatment of relapsing forms of multiple sclerosis AND ● Documentation provided by prescribing neurologist, or is prescribed in conjunction with a neurologist, for marked functional decline as demonstrated by *two* of the following: MRI, EDSS scale OR medical chart notes that specify increased burden of disease AND ● Provider attests to shared decision making with respect to risks versus benefits of medical treatment AND ● Safety criteria for prescribed agent are met (Table 1) ● Appropriate safety criteria are met below:

Table 1: Safety Criteria for Aubagio, Gilenya, and Tecfidera

Tecfidera	● Has no active infections AND ● Had a complete blood count with differential within the six months prior to initiating therapy
Aubagio	● 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 (e.g. long acting reversible contraception) 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 infection by documented test results (purified protein derivative test) or blood test.
Gilenya	● Has no active infections AND ● Does not have a recent history of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, OR New York Heart Association Class III-IV heart failure within six months

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		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 • 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 • Had an ophthalmologic evaluation (ocular coherence test) prior to starting therapy and within 3-4 months follow-up after starting therapy AND • Had baseline complete blood count with differential and liver function tests For members meeting NOT meeting criteria above, **Gilenya, Tecfidera, or Aubagio** may be approved for members that meet the following criteria: • Member has failed COPAXONE or a preferred interferon product. [Failure will be defined as intolerable side effects drug-drug interaction, or lack of efficacy] • 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 or is prescribed in conjunction with a neurologist AND • Safety criteria for prescribed agent are met (Table 1) Grandfathering: Members currently stabilized on GILENYA, TECFIDERA, AUBAGIO, or a non-preferred interferon therapy may receive approval to continue on that agent.
Symptom Management Therapies		
	PA Required AMPYRA (dalfampridine) Dalfampridine	**Ampyra** (dalfampridine) prior authorization for a 3 month supply may be approved if all of the following criteria are met: • Member has a diagnosis of MS; Member is ambulatory and has established a baseline which is defined as ambulating between 8-45 seconds Timed 25-foot Walk (T25FW) assessment OR has established a baseline activities of daily living (ADL); • Member has no history of seizure disorder; • Member has no history of moderate to severe renal dysfunction (CrCl > 50 ml/min);

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		• Prescriber is a neurologist or is prescribed in conjunction with a neurologist; • The prescribed dose does not exceed 10 mg twice daily. Extended coverage of Ampyra (dalfampridine) for up to one year may be approved if documentation shows improvement in ambulation (measured by T25FW assessment) or improvement in ADLs after three months of therapy.
Therapeutic Drug Class: **OPHTHALMIC, ALLERGY** -*Effective 4/1/2019*		
No PA Required Cromolyn 4% Ketotifen (generic Zaditor) OTC LASTACAFT (alcaftadine) Olopatadine 0.1% PAZEO (olopatadine 0.7%)	**PA Required** ALAWAY (ketotifen) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) Azelastine BEPREVE (bepotastine) ELESTAT (epinastine) EMADINE (emedastine) epinastine Olopatadine 0.2% PATADAY (olopatadine 0.2%) PATANOL (olopatadine 0.1%) ZADITOR (ketotifen 0.025%) OTC	Non-preferred Ophthalmic Allergy medications will be approved if the member 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) Non-preferred ophthalmic allergy agents with a preferred product with same strength, dosage form, and active ingredient will be approved with adequate trial and/or failure of the preferred product (such as preferred olopatadine 0.1% and non-preferred Patanol) and 1 additional agent. (Failure is defined as: lack of efficacy with 4 week trial, allergy, intolerable side effects or significant drug-drug interactions).
Therapeutic Drug Class: **OPHTHALMIC, IMMUNOMODULATORS** -*Effective 10/1/2019*		
No PA Required RESTASIS (cyclosporine 0.05%)	**PA Required** Cequa (cyclosporine 0.09%) solution	Non-preferred products may be approved for members meeting all of the following criteria: • Member is 18 years and older **AND**

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	RESTASIS MULTIDOSE (cyclosporine 0.05%) XIIDRA (lifitegrast)	• Member has a diagnosis of chronic dry eye **AND** • Member has failed a three month trial of one preferred product (Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions) **AND** • Prescriber is an ophthalmologist, optometrist or rheumatologist Maximum Quantity: 60 single use containers for 30 days 5.5 mL/20 days for Restasis Multi-Dose
Therapeutic Drug Class: **TARGETED IMMUNE MODULATORS -***Effective 1/1/2019*		
First Line No PA Required **Second line agents must meet eligibility criteria*** First Line: ENBREL (etanercept) HUMIRA (adalimumab) Second Line: *COSENTYX (secukinumab) (second line) *XELJANZ IR (tofacitinib)	**PA Required** ACTEMRA (tocilizumab) ARCALYST (rilonacept) CIMZIA (certolizumab) ILARIS (canakinumab) KEVZARA (sarilumab) KINERET (anakinra) OLUMIANT (baricitinib) ORENCIA (abatacept) Subcutaneous OTEZLA (apremilast) SILIQ (brodalumab) SIMPONI (golimumab) STELARA (ustekinumab) TALTZ (ixekizumab)	First Line Preferred Agents: **Humira** and **Enbrel** do not require prior authorization Second Line Preferred Agents*: **Cosentyx** may receive prior authorization approval for FDA-labeled indications following trial and failure of Humira (Failure is defined as: lack of efficacy of a three-month trial, allergy, intolerable side effects or significant drug-drug interaction). If the prescribed indication is not included on Humira package labeling then trial and failure is not required. **Xeljanz IR** may receive prior authorization approval for FDA-labeled indications following trial and failure of Humira (Failure is defined as: lack of efficacy of a three-month trial, allergy, intolerable side effects or significant drug-drug interaction). If the prescribed indication is not included on Humira package labeling then trial and failure is not required. Xeljanz IR will 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. **Non-Preferred Tumor Necrosis Factor (TNF) Inhibitors (Cimzia, Simponi)** may receive prior authorization approval for FDA-labeled indications following trial and failure ALL preferred agents (Enbrel, Humira, Cosentyx, and Xeljanz IR) that are FDA-labeled for use for the same prescribed indication (Failure is defined as: lack of efficacy of a three-month trial, allergy, intolerable side effects or significant drug-drug interaction). **Non-Preferred Targeted Immune Modulators with Interleukin (IL) Activity (Actemra, Arcalyst, Kineret, Stelara, Taltz, Ilaris, Kevzara, Siliq, Tremfya)** may receive prior authorization approval for FDA-labeled indications following trial and failure ALL preferred agents (Enbrel, Humira, Cosentyx, and Xeljanz IR) that are FDA-labeled for use for the same prescribed indication (Failure is defined as: lack of efficacy of a three-month trial, allergy, intolerable side effects or significant drug-drug interaction).

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	TREMFYA (guselkumab) XELJANZ XR (tofacitinib) ***for information on IV infused Targeted Immune Modulators please see Appendix P**	**Kineret** may also receive prior authorization approval for use for familial mediterranean fever if meeting above criteria **Stelara** loading dose administration prior to approval of Stelara maintenance therapy using the above criteria should be avoided and will not result in an automatic approval of Stelara maintenance therapy. **Taltz** prior authorization approval will be given for an initial 12 weeks and authorization approval for continuation will be provided based on clinical response. **Non-Preferred Janus Kinase (JAK) Inhibitors (Olumiant, Xeljanz XR)** may receive prior authorization approval for FDA-labeled indications following trial and failure ALL preferred agents (Enbrel, Humira, Cosentyx, and Xeljanz IR) that are FDA-labeled for use for the same prescribed indication (Failure is defined as: lack of efficacy of a three-month trial, allergy, intolerable side effects or significant drug-drug interaction). **Xeljanz XR** prior authorization approval will require verification of the clinically relevant reason for use of the Xeljanz XR formulation versus the Xeljanz IR formulation in addition to meeting criteria above **Non-Preferred Agents with Other Mechanisms of Action (Orencia, Otezla)** may receive prior authorization approval for FDA-labeled indications following trial and failure ALL preferred agents (Enbrel, Humira, Cosentyx, and Xeljanz IR) that are FDA-labeled for use for the same prescribed indication (Failure is defined as: lack of efficacy of a three-month trial, allergy, intolerable side effects or significant drug-drug interaction) *The Department would like to remind providers that many products have patient support programs that assist patients in drug administration, education, and emotional support for our member's diseases.*
Therapeutic Drug Class: **TOPICAL IMMUNOMODULATORS** – *Effective 7/1/2019*		
***Must meet criteria** ELIDEL (pimecrolimus) [BNR] Pimecrolimus cream - *authorized generic only -Oceanside Pharm*	**PA Required** Pimecrolimus cream - *All other manufacturers* PROTOPIC (tacrolimus)	Manual prior authorization review for preferred and non-preferred agents will be required for members exceeding ≥ 6 weeks of continuous therapy. Preferred topical immunomodulator products may be approved following adequate trial and failure‡ of a prescription topical corticosteroid (verified in claims history).

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Tacrolimus (generic Protopic)	Non-preferred topical immunomodulator products may be approved following adequate trial and failure‡ of one prescription topical corticosteroid AND one preferred agent. ‡Failure is defined as a lack of efficacy with one month trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions. For members under 18 years of age, must be prescribed by or in conjunction with a dermatologist or allergist/immunologist.
X. Miscellaneous		
Therapeutic Drug Class: **EPINEPHRINE PRODUCTS -***Effective 1/1/2019*		
No PA Required Epinephrine auto-injector (generic Epipen)	**PA Required** EPIPEN ADRENACLICK Epinephrine auto-injector (generic Adrenaclick) Symjepi	Non-preferred products will be approved if the member has failed treatment with one of the preferred products (Failure is defined as: allergy or intolerable side effects) Quantity limit: 4 auto injectors per year unless used / damaged / lost
Therapeutic Drug Class: **OPHTHALMIC, GLAUCOMA -***Effective 4/1/2019*		
No PA Required Alphagan P 0.1% (brimonidine) Azopt (brinzolamide) Brimonidine 0.2% Combigan (brimonidine/timolol) Dorzolamide Dorzolamide/Timolol	**PA Required** Alphagan P 0.15% (brimonidine) Apraclonindine Betagan (levobunolol) Betaxolol Betopic (betaxolol) Bimatoprost	Non-preferred agents will be approved with adequate trial and/or failure of 3 preferred products. One trial must be a preferred product with the same mechanism of action (for example prostaglandin analogues, Alpha2-adrenergic agonists, beta-blocking agents, carbonic anhydrase inhibitors, etc) as the non-preferred product being requested. (Failure is defined as: lack of efficacy with 4 week trial, allergy, intolerable side effects or significant drug-drug interactions). Non-preferred combination products may be approved following adequate trial and/or failure of a preferred combination product AND an adequate trial of individual products in combination product being requested (if available) to establish tolerance. (Failure is defined as: lack of efficacy with 4 week trial, allergy, intolerable side effects or significant drug-drug interactions). Non-preferred ophthalmic glaucoma agents with a preferred product with the same strength, dosage form, and active ingredient will be approved with adequate trial and/or failure of the

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Latanoprost Lumigan [BNR] (bimatoprost) Timolol Travatan Z (travoprost)	carteolol dorzolamide/timolol PF echothiopate iodide iopidine (apraclonidine) Istalol (timolol) latanoprost PF levobunolol pilocarpine Rhopressa (netarsudil) Simbrinza (brinzolamide/brimonidine) Timolol/brimonidine/dorzolamide/latanoprost PF Timolol/latanoprost Timolol gel solution Timoptic -xe Trusopt (dorzolamide) Vyzulta (latanoprostene) Xalatan (latanoprost) Xelpros (latanoprost) Zioptan (tafluprost PF)	preferred product (such as preferred timolol and Timoptic) and 2 additional agents. (Failure is defined as: lack of efficacy with 4 week trial, allergy, intolerable side effects or significant drug-drug interactions). Preservative free products may be approved with provider documentation of adverse effect to preservative-containing product.

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

Therapeutic Drug Class: **NEWER HEREDITARY ANGIOEDEMA PRODUCTS** -*Effective 10/1/2019*		
PA Required for all agents in this class		**Medications Indicated for Routine Prophylaxis:** Members are restricted to coverage of one medication for routine prophylaxis at one time. Prior authorization approval will be for one year. **Haegarda** may be approved for members meeting the following criteria: o Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, CI-INH level) **AND** o Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND o Member meets at least one of the following: ▪ Haegarda® is being used for short-term prophylaxis to undergo a surgical procedure or major dental work **OR** ▪ Haegarda® is being used for long-term prophylaxis and member meets one of the following: o History of ≥1 attacks per month resulting in documented ED admission or hospitalization **OR** o History of laryngeal attacks **OR** o History of ≥2 attacks per month involving the face, throat, or abdomen **AND** o Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications **AND** o Member has received hepatitis A and hepatitis B vaccination **AND** o Provider attests to performing annual testing or screening (as appropriate) for HBV, HCV, and HIV Max Dose: 60 IU/kg Minimum Age: 10 years **Cinryze** and **Takhzyro** may be approved for members meeting the following criteria: o Member has history of trial and failure of Haegarda®. Failure is defined as lack of efficacy allergy, intolerable side effects, or a significant drug-drug interaction **AND** o Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, CI-INH level) **AND**
Prophylaxis: HAEGARDA (C1 esterase inhibitor) 2,000 unit and 3,000 unit vial *Treatment:* BERINERT (C1 esterase inhibitor) 500 Unit kit FIRAZYR[BNR] (icatibant acetate) 30mg/3 mL syringe	*Prophylaxis:* CINRYZE (C1 esterase inhibitor) 500 unit kit TAKHZYRO (lanadelumab) 300 mg/ mL vial *Treatment:* Icatibant 30 mg/3 mL syringe RUCONEST (C1 esterase inhibitor, recomb) 2,100 unit vial	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		○ Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND ○ Member meets at least one of the following: ▪ Cinryze® is being used for <u>short-term prophylaxis</u> to undergo a surgical procedure or major dental work **OR** ▪ Cinryze® is being used for <u>long-term prophylaxis</u> and member meets one of the following: ○ History of ≥1 attacks per month resulting in documented ED admission or hospitalization **OR** ○ History of laryngeal attacks **OR** ○ History of ≥2 attacks per month involving the face, throat, or abdomen **AND** ○ Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications **AND** ○ Member has received hepatitis A and hepatitis B vaccination **AND** ○ Provider attests to performing annual testing or screening (as appropriate) for HBV, HCV, and HIV. Minimum age: Cinryze: 6 years Takhzyro: 12 years Max dose: Cinryze: 100 Units/kg Takhzyro: 300mg every 2 weeks **Medications Indicated for Treatment of Acute Attacks:** Members are restricted to coverage of one medication for <u>treatment of acute attacks</u> at one time. Prior authorization approval will be for one year. **Firazyr** may be approved for members meeting the following criteria: ○ Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, CI-INH level) **AND** ○ Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND ○ Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications Minimum age: 18 years

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		Maximum dose: 30mg **Berinert** may be approved for members meeting the following criteria: o Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, CI-INH level) **AND** o Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND o Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications **AND** o Member has received hepatitis A and hepatitis B vaccination **AND** o Provider attests to performing annual testing or screening (as appropriate) for HBV, HCV, and HIV Minimum age: 6 years Max dose: 20 IU/kg **Ruconest** may be approved for members meeting the following criteria: o Member has a history of trial and failure of Firazyr® OR Berinert®. Failure is defined as lack of efficacy, allergy, intolerable side effects, or a significant drug-drug interaction **AND** o Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, CI-INH level) **AND** o Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND o Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications **AND** o Member has received hepatitis A and hepatitis B vaccination **AND** o Provider attests to performing annual testing or screening (as appropriate) for HBV, HCV, and HIV. Minimum age: 13 years Max dose: 4200 Units/dose
Therapeutic Drug Class: **PHOSPHATE BINDERS -***Effective 7/1/19*		
No PA Required	**PA Required** AURYXIA (ferric citrate)	*Sevelamer carbonate tablet may be approved as a preferred agent for children and adolescents 6-17 years of age. For adults ≥ 18 years of age, sevelamer carbonate tablet may be approved if member meets criteria for non-preferred products listed below.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Generic changes effective 10/15/19 Calcium acetate capsule FOSRENOL[BNR] (lanthanum carbonate) chewable tablet PHOSLYRA (calcium acetate) RENAGEL[BNR] (Sevelamer hcl) Sevelamer carbonate tablet (6-17 years old)* Sevelamer HCL *authorized generic - WINTHROP US only -*	Calcium acetate tablet (generic Calphron) FOSRENOL (lanthanum carbonate) powder pack Lanthanum carbonate chewable tablet, powder pack RENVELA (sevelamer carbonate) Sevelamer carbonate powder pack Sevelamer hcl tablet -*all other manufacturers* VELPHORO (sucoferric oxide)	Prior authorization for non-preferred products in this class may be approved if member meets all of the following criteria: • Member has diagnosis of end stage renal disease AND • Member has elevated serum phosphorus [> 4.5 mg/dL or > 1.46 mmol/L] AND • Provider attests to member avoidance of high phosphate containing foods from diet AND • Member has trialed and failed‡ two preferred agents. One trial must be from the same pharmacologic class as the non-preferred agent being requested, if applicable (for example; member is requesting Phoslo® must have trial with Phoslyra® or generic calcium acetate). **Auryxia®** (ferric citrate) may be approved if the member meets all of the following criteria: • Member is diagnosed with end-stage renal disease, receiving dialysis, and has elevated serum phosphate (> 4.5 mg/dL or > 1.46 mmol/L). AND • Provider attests to counseling member regarding avoiding high phosphate containing foods from diet AND • Member has trialed and failed‡ three preferred agents with different mechanisms of action prescribed for hyperphosphatemia in end stage renal disease OR • Member is diagnosed with chronic kidney disease with iron deficiency anemia and is not receiving dialysis AND • Member has tried and failed‡ at least two different iron supplement product formulations (OTC or RX) ‡Failure is defined as lack of efficacy with 6 week trial, allergy, intolerable side effects, or significant drug-drug interaction. *Note: Medications administered in a dialysis unit or clinic are billed through the Health First Colorado medical benefit.*

Therapeutic Drug Class: **PRENATAL VITAMINS / MINERALS** -*Effective 10/1/2019*

PA Required (must meet eligibility criteria)	PA Required	
CITRANATAL 90 DHA combo pack CITRANATAL ASSURE combo pack CITRANATAL B-CALM	All other rebateable prescription products are non-preferred	*Preferred and non-preferred prenatal vitamin products are a benefit for members from 11-60 years of age who are pregnant, lactating, or trying to get pregnant.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
CITRANATAL DHA pack CITRANATAL HARMONY capsule CITRANATAL RX tablet COMPLETE NATAL DHA CONCEPT DHA capsule CONCEPT OB capsule M-NATAL PLUS NESTABS tablets PNV OB+DHA COMBO PACK PNV PNV-FERROUS FUMARATE-DOCU-FA tablet PRENAISSANCE PLUS capsule PRENATAL LOW IRON tablet PRENATAL VITAMIN PLUS LOW IRON PREPLUS tablet TRINATAL RX 1 TRUST NATAL DHA VIRT-ADVANCE TABLET VIRT-VITE GT TABLET VOL-PLUS tablet		Prior authorization for non-preferred agents will be approved if member fails 7-day trial with four preferred agents. (Failure is defined as: allergy, intolerable side effects, or significant drug-drug interaction)

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

XI. Renal/Genitourinary

Therapeutic Drug Class: **OVERACTIVE BLADDER AGENTS** -*Effective 10/1/19*

No PA Required	PA Required	
GELNIQUE (oxybutynin) gel, pump Oxybutynin IR, ER tablets, syrup Oxybutynin ER tablets TOVIAZ (fesoterodine ER)	Darifenacin ER tablet DETROL (tolterodine) DETROL LA (tolterodine ER) DITROPAN (brand) DITROPAN XL (brand) ENABLEX (darifenacin) Flavoxate MYRBETRIQ (mirabegron) OXYTROL (oxybutynin patch) SANCTURA (trospium) SANCTURA XL (trospium ER) Solifenacin tablet Tolterodine Trospium ER capsule, tablet VESICARE (solifenacin)	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. Members with hepatic failure can receive approval for trospium (Sanctura) or trospium extended-release (Sanctura XR) products without a trial on a Preferred product.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Therapeutic Drug Class: **ANTI-HYPERURICEMICS** -*Effective 1/1/19*		
No PA Required Allopurinol Probenecid Colchicine capsule Probenecid/Colchicine	**PA Required** Colchicine tablet Colcrys (colchicine) tablet Duzallo (lesinurad/allopurinol) Mitigare (colchicine) capsule Uloric (febuxostat) Zurampic (lesinurad) Zyloprim (allopurinol)	Prior authorization for non-preferred xanthine oxidase inhibitors will be approved after trial and failure of allopurinol. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. (Allopurinol and febuxostat are xanthine oxidase inhibitors.) If member has tested positive for the HLA-B*58:01 allele, it is not recommended that they trial allopurinol. A positive result on this genetic test will count as a failure of allopurinol. Prior authorization for all other (non-xanthine oxidase inhibitors) non-preferred agents will be approved after trial and failure of two preferred products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Prior authorization for colchicine tablets will be approved for members requiring treatment of gout flares. Colchicine quantity limits: • Chronic hyperuricemia/gout prophylaxis: 60 tablets per 30 days • Familial Mediterranean Fever: 120 tablets per 30 days
Therapeutic Drug Class: **BENIGN PROSTATIC HYPERPLASIA (BPH)** -*Effective 7/1/19*		
No PA Required Alfuzosin Doxazosin Dutasteride Finasteride Tamsulosin Terazosin	**PA Required** AVODART (dutasteride) CARDURA (doxazosin) CARDURA XL (doxazosin ER) *CIALIS (tadalafil) 2.5 mg, 5 mg only *Brand and generic* FLOMAX (tamsulosin) JALYN (dutasteride/tamsulosin) *Brand and generic* PROSCAR (finasteride)	Prior authorization for non-preferred products in this class may be approved if member meets all of the following criteria: • Member has tried and failed‡ three preferred agents AND • For combinations agents, member has tried and failed‡ each of the individual agents within the combination agent and one other preferred agent. ‡Failure is defined as lack of efficacy with 8 week trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction. ***Cialis** will be approved for members with a documented diagnosis of BPH who have failed a trial of finasteride (at least 3 months in duration) AND either a trial of a nonselective alpha blocker (therapeutic dose for at least two months) OR a trial of tamsulosin (therapeutic dose for at least one month). Documentation of BPH diagnosis will require BOTH of the following: • AUA Prostate Symptom Score ≥ 8 AND • Results of a digital rectal exam.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	RAPAFLO (silodosin) *Brand and generic*	Cialis will not be approved for any patient continuing alpha-blocker therapy as this combination is contraindicated in this population. Doses exceeding 5mg per day of Cialis will not be approved.
XII. RESPIRATORY		
Therapeutic Drug Class: **RESPIRATORY INHALANTS -***Effective 7/1/2019*		
Inhaled Anticholinergics		
No PA Required **Solutions** Ipratropium (generic Atrovent) solution **Short-Acting Inhalers** ATROVENT HFA (ipratropium) **Long-Acting Inhalers** SPIRIVA Handihaler (tiotropium)	**PA Required** **Solutions** ATROVENT (ipratropium) solution LONHALA Magnair (glycopyrrolate) solution YUPELRI (revefenacin) solution **Short-Acting Inhalers** **Long-Acting Inhalers** INCRUSE ELLIPTA (umeclidinium) SEEBRI Neohaler (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) TUDORZA Pressair (aclidinium)	Non-preferred single agent anticholinergic agents will be approved for members with a diagnosis of COPD including chronic bronchitis and/or emphysema who have trialed and failed‡ treatment with two preferred agents, one of which must be Spiriva Handihaler. **Spiriva Respimat®** will be approved for members with a diagnosis of asthma who have trialed and failed‡ treatment with three preferred inhaled corticosteroids, at least two of the trials must be preferred combination inhaled corticosteroid products. Members with a diagnosis of COPD must meet non-preferred criteria for single agent inhaled anticholinergics listed above for approval of Spiriva Respimat®. **Lonhala Magnair®** will receive prior authorization approval for members ≥ 18 years of age with a diagnosis of COPD including chronic bronchitis and emphysema who have trialed and failed‡ treatment with two preferred anticholinergic agents. ‡Failure is defined as lack of efficacy with 6 week trial, allergy, intolerable side effects, or significant drug-drug interaction.
Inhaled Anticholinergic Combinations		
No PA Required **Solutions** Albuterol/ipratropium solution **Short-Acting Inhalers**	**PA Required** **Solutions** **Short-Acting Inhalers**	Non-preferred combination anticholinergic agents will be approved for members with a diagnosis of COPD including chronic bronchitis and/or emphysema who have trialed and failed‡ treatment with two preferred respiratory agents, one of which must be Spiriva Handihaler®. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.

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** ANORO ELLIPTA (umeclidinium/vilanterol) BEVESPI AEROSPHERE (glycopyrrolate/formoterol fumarate) STIOLTO Respimat (tiotropium/olodaterol) UTIBRON Neohaler (glycopyrrolate/indacaterol)	‡Failure is defined as lack of efficacy with 6 week trial, allergy, intolerable side effects, or significant drug-drug interaction.
Inhaled Beta2 Agonists (short acting)		
No PA Required **Solutions** Albuterol (generic) solution **Inhalers** PROAIR (albuterol) HFA [BNR]	**PA Required** **Solutions** PROVENTIL (albuterol) solution XOPENEX (levalbuterol) solution **Inhalers** **Albuterol HFA** Levalbuterol HFA PROAIR Respiclick (albuterol) 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
Inhaled Beta2 Agonists (long acting)		

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
***Must meet eligibility criteria** **Solutions** **Inhalers** *SEREVENT DISKUS (salmeterol) inhaler	**PA Required** **Solutions** BROVANA (arformoterol) solution PERFOROMIST (formoterol) solution **Inhalers** ARCAPTA Neohaler (indacaterol) FORADIL (formoterol) STRIVERDI Respimat (olodaterol)	**SEREVENT** ® will be approved for members with moderate to very severe COPD. Non-preferred agents will be approved for members with moderate to severe COPD, AND members must have failed a trial of **Serevent®**. (Failure is defined as lack of efficacy with a 6 week trial, allergy, intolerable side effects, or significant drug-drug interaction. **For treatment of members with diagnosis of asthma needing add-on therapy, please refer to preferred agents in combination Long-Acting Beta Agonist/Inhaled Corticosteroid. SEREVENT will not be approved for treatment of asthma in members needing add-on therapy due to safety risks associated with monotherapy.
Inhaled Corticosteroids		
No PA Required **Solutions** Budesonide nebules 0.25mg 0.5mg, 1mg **Inhalers** ASMANEX Twisthaler (mometasone) FLOVENT Diskus(fluticasone) FLOVENT HFA (fluticasone)	**PA Required** **Solutions** PULMICORT (budesonide) nebules 0.25mg 0.5mg, 1mg **Inhalers** AEROSPAN HFA (flunisolide) inhaler ALVESCO (ciclesonide) inhaler ARMONAIR Respiclick (fluticasone) ARNUITY Ellipta (fluticasone furoate) ASMANEX HFA (mometasone furoate) inhaler PULMICORT Flexhaler(budesonide)	**Pulmicort** (Budesonide) **nebulizer** solution will only be approved for a maximal dose of 2mg/day. **Pulmicort Flexhaler** will only be approved for female members with asthma who have a new diagnosis of pregnancy. 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 with a 6 week trial, allergy, contraindication to, intolerable side effects, or significant drug-drug interactions.)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	QVAR Redihaler (beclomethasone)	
Inhaled Corticosteroid Combinations		
No PA Required *Brand/generic changes effective 11/01/19* ADVAIR Diskus[BNR] (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/ formoterol) SYMBICORT (budesonide/formoterol) inhaler	**PA Required** AIRDUO Respiclick (fluticasone/salmeterol) BREO Ellipta (vilanterol/fluticasone furoate) Fluticasone/salmeterol (generic Airduo) Fluticasone/salmeterol diskus (generic Advair) TRELEGY Ellipta (Fluticasone Furoate/Umeclidinium/Vilanterol) WIXELA Inhub (fluticasone/salmeterol)	Non-preferred inhaled corticosteroid combinations will be approved for members meeting both of the following criteria: • Member has a qualifying diagnosis of asthma or severe COPD; AND • Member has failed two preferred agents (Failure is defined as lack of efficacy with a 6 week trial, allergy, intolerable side effects, significant drug-drug interactions, or dexterity/coordination limitations (per provider notes) that significantly impact appropriate use of a specific dosage form.) **Trelegy Ellipta®** prior authorization will be approved if the member has trialed/failed three preferred inhaled corticosteroid combination products AND Spiriva Handihaler®. Failure is defined as lack of efficacy with a 6 week trial, allergy, intolerable side effects, significant drug-drug interactions, or dexterity/coordination limitations (per provider notes) that significantly impact appropriate use of a specific dosage form.