
Ohio Health Plans Fee-For-Service

Pharmacy Benefit Management Program

Preferred Drug List



Effective October 1, 2011

Ohio Department of Job and Family Services

Revised September 15, 2011

Table of Contents

Drug Category	Page
Analgasic Agents: COX-2 Inhibitors	1
Analgasic Agents: NSAID-PPI Combination	3
Analgasic Agents: Gout	4
Analgasic Agents: Opioids	5
Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents	9
Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations	10
Blood Formation, Coagulation, and Thrombosis Agents: Platelet Aggregation Inhibitors	11
Cardiovascular Agents: Hypertension & Heart Failure	12
Cardiovascular Agents: Lipotropics	17
Central Nervous System (CNS) Agents: Alzheimer's Agents	19
Central Nervous System (CNS) Agents: Anti-Migraine Agents	20
Central Nervous System (CNS) Agents: Antidepressants	22
Central Nervous System (CNS) Agents: Antipsychotics, Second Generation, Oral	24
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	26
Central Nervous System (CNS) Agents: Fibromyalgia Agents	27
Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction	29
Central Nervous System (CNS) Agents: Multiple Sclerosis Agents	30
Central Nervous System (CNS) Agents: Parkinson's Agents	31
Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate	32
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	33
Central Nervous System (CNS) Agents: Smoking Deterrents	34
Endocrine Agents: Diabetes Adjunctive Therapy	35
Endocrine Agents: Diabetes – Insulin	36
Endocrine Agents: Diabetes – Oral Hypoglycemics	37
Endocrine Agents: Estrogenic Agents	39
Endocrine Agents: Growth Hormones	41
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers	42
Gastrointestinal Agents: Anti-Emetics	43
Gastrointestinal Agents: Chronic Constipation Agents	44
Gastrointestinal Agents: H. Pylori Packages	45
Gastrointestinal Agents: Pancreatic Enzymes	46
Gastrointestinal Agents: Proton Pump Inhibitors	47
Gastrointestinal Agents: Ulcerative Colitis Agents	48
Genitourinary Agents: Benign Prostatic Hyperplasia	49
Genitourinary Agents: Electrolyte Depletter Agents	50
Genitourinary Agents: Urinary Antispasmodics	51
Infectious Disease Agents: Antibiotics – Cephalosporins	52
Infectious Disease Agents: Antibiotics – Macrolides	54
Infectious Disease Agents: Antibiotics – Quinolones	55
Infectious Disease Agents: Antifungals for Onychomycosis & Systemic Infections	56
Infectious Disease Agents: Antivirals – Hepatitis C Agents	57
Infectious Disease Agents: Antivirals – Herpes	58
Injectable Antirheumatic Agents	59
Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments	60
Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers	62
Ophthalmic Agents: Glaucoma Agents	63
Ophthalmic Agents: NSAIDs	65
Otic Agents: Antibacterial and Antibacterial/Steroid Combinations	66
Respiratory Agents: Antihistamines – Second Generation	67
Respiratory Agents: Beta-Adrenergic Agonists – Inhaled, Short Acting	68
Respiratory Agents: Beta-Adrenergic Agonists – Inhaled, Long Acting	69
Respiratory Agents: COPD Anticholinergic Agents	71
Respiratory Agents: Glucocorticoid Agents – Inhaled	72

Respiratory Agents: Leukotriene Receptor Modifiers and Inhibitors	73
Respiratory Agents: Nasal Preparations.....	74
Topical Agents: Acne Preparations.....	75
Topical Agents: Anti-Fungals	78
Topical Agents: Anti-Parasitics.....	79
Topical Agents: Immunomodulators.....	80
Topical Agents: Pleuromutilin Derivatives.....	81
Topical Agents: Post-Herpetic Neuralgia.....	82

Analgesic Agents: COX-2 Inhibitors

LENGTH OF AUTHORIZATIONS: 1 year, except as specified in items (2) and (3)

INDICATIONS AND DOSING:

- Osteoarthritis – 200mg daily or 100mg BID
- Rheumatoid arthritis in adults – 100mg to 200mg BID
- Ankylosing spondylitis – 200mg daily or 100mg BID; if no response after 6 weeks, can try 400mg daily
- Acute pain in adults – 400mg initially, additional 200mg dose if needed on first day; 200mg BID as needed on subsequent days
- Primary dysmenorrhea – 400mg initially, additional 200mg dose if needed on first day; 200mg BID as needed on subsequent days
- Familial adenomatous polyposis (FAP) – 400mg BID with food (indication removed from FDA-approved labeling 2/4/11)

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval. Acceptable contraindications include:
 - Concurrent or history of a GI event (perforation, ulcer, bleed)
 - Other risks for treatment with non-selective NSAIDs:
 - Coagulation disorders (i.e. hemophilia, chronic liver disease), erosive esophagitis
 - Documented NSAID-induced ulcer
 - Peptic ulcer disease (PUD)
 - Patient on anticoagulants (warfarin or heparin)
 - Patient on oral corticosteroids
 - Patient on methotrexate
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

ADDITIONAL INFORMATION

1. The requested medication may be approved if both of the following are true:
 - If there have been therapeutic failures to no less than a one-month trial of at least two non-COX 2 NSAID medications not requiring prior approval.
 - If there is a specific indication for medication requiring prior approval, for which medications not requiring prior approval are not indicated, then document details and refer to RPh (i.e. Celebrex[®] utilization in the treatment of various cancer treatment protocols).
2. COX-2 medications may be approved for patients who are undergoing surgical or other medical procedures that may predispose them to potential bleeding complications. Authorization will be for a 2-month time period.
3. A patient who is being treated for H. pylori may be given authorization for a COX-2 medication for a 30-day period.

CRITICAL INFORMATION TO CONSIDER

1. If the patient is 60 years of age or older, Celebrex[®] does not require prior approval.
2. If the patient is allergic to one NSAID or aspirin, the patient may be allergic to other NSAIDS.
3. If allergic to sulfonamides, a patient is not to receive prior approval for Celebrex[®].

CRITERIA FOR SYSTEMATIC PRIOR AUTHORIZATION

1. Patient age equal to or over 60 years; or
2. Patient has claims history of warfarin, heparin, or heparin-related agents in past 120 days; or
3. Patient has claims history of oral corticosteroid in past 120 days; or
4. Patient has claims history of methotrexate in past 120 days; or
5. Patient has claims history of aspirin in past 120 days; or
6. If there have been therapeutic failures to no less than a one-month trial of at least two non-COX 2 NSAID medications not requiring prior approval.

ANALGESIC AGENTS: COX-2 INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CELEBREX [®] (celecoxib) (no PA required for age 60 or older)	CELEBREX [®] (celecoxib) (PA required for under age 60)

Analgesic Agents: NSAID-PPI Combination

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to an NSAID not requiring prior approval?

Acceptable reasons include:

- Contraindication to or drug-to-drug interaction with medications not requiring prior approval. Acceptable contraindications include:
 - Concurrent or history of a GI event (perforation, ulcer, bleed)
 - Other risks for treatment with NSAIDs:
 - Coagulation disorders (i.e. hemophilia, chronic liver disease), erosive esophagitis
 - Documented NSAID-induced ulcer
 - Peptic ulcer disease (PUD)
 - Patient on anticoagulants (warfarin or heparin)
 - Patient on oral corticosteroids
 - Patient on methotrexate
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

ADDITIONAL INFORMATION

1. The requested medication may be approved if there have been therapeutic failures to no less than a one-month trial of at least two NSAID medications not requiring prior approval.

CRITICAL INFORMATION TO CONSIDER

If the patient is allergic to one NSAID or aspirin, the patient may be allergic to other NSAIDS.

CRITERIA FOR SYSTEMATIC PRIOR AUTHORIZATION

- Patient has claims history of warfarin, heparin, or heparin-related agents in past 120 days; or
- Patient has claims history of oral corticosteroid in past 120 days; or
- Patient has claims history of methotrexate in past 120 days; or
- Patient has claims history of aspirin in past 120 days; or
- If there have been therapeutic failures to no less than a one-month trial of at least two NSAID medications not requiring prior approval.

ANALGESIC AGENTS: COX-2 INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	VIMOVO [®] (naproxen/esomeprazole)

Analgesic Agents: Gout

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to an agent not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- Agents to reduce hyperuricemia will be approved after adequate trial of allopurinol, or intolerance/contraindication to allopurinol.
- Analgesic agents will be approved if any one of the following is true:
 - Diagnosis of Familial Mediterranean Fever (FMF) (6 month approval); OR
 - Trial of one of the following:
 - NSAID (i.e., indomethacin, naproxen, ibuprofen, sulindac, ketoprofen)
 - Oral corticosteroid

ANALGESIC AGENTS: GOUT – Agents to Reduce Hyperuricemia

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ALLOPURINOL (generic of Zyloprim®) PROBENECID (generic for Benemid) PROBENECID-COLCHICINE	ULORIC® (febuxostat)

ANALGESIC AGENTS: GOUT – Analgesic Agents

NO PA REQUIRED “PREFERRED”	PA REQUIRED
	COLCRYS®* (colchicine)

- * Colcris® (colchicine) quantity limit 6 tabs/claim for acute gout, 60 tabs/month for chronic gout after trial on xanthine oxidase inhibitor, 120 tabs/month for FMF

Analgesic Agents: Opioids

LENGTH OF AUTHORIZATIONS: 6 months

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to at least two unrelated medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there have been inadequate clinical responses to no less than one-week trials of at least two unrelated medications not requiring prior approval, then may approve the requested medication.
3. Patient must have failed the generic product (if covered by the state) before brand is authorized, in addition to the above.

ADDITIONAL CRITERIA FOR TRANSMUCOSAL FENTANYL:

- Diagnosis of cancer pain; and
- Prescription is from oncologist or pain specialist; and
- Concurrently taking a long-acting opioid at therapeutic dose (any of the following for ≥ 1 week without adequate pain relief):
 - ≥ 60 mg oral morphine/day, or
 - ≥ 25 mcg/hr transdermal fentanyl, or
 - ≥ 30 mg oral oxycodone/day, or
 - ≥ 8 mg oral hydromorphone/ day, or
 - ≥ 25 mg oral oxymorphone/ day, or
 - Equianalgesic dose of another opioid; and
- Dose is ≤ 4 units per day

Document clinically compelling information

ANALGESIC AGENTS: OPIOIDS – Long-Acting Oral

NO PA REQUIRED "PREFERRED"	PA REQUIRED
Extended Release Morphine Products	
MORPHINE SULFATE ER (generic of MS Contin [®]) ORAMORPH SR [®] (morphine)	AVINZA [®] (morphine) EMBEDA [®] (morphine/naltrexone) KADIAN [®] (morphine)
Extended Release Oxycodone Products	
	OXYCODONE ER (generic of Oxycontin [®]) OXYCONTIN [®] (oxycodone)
Extended Release Tramadol Products	
	TRAMADOL ER (generic of Ultram ER [®]) RYZOLT ER [®] (tramadol)
Extended Release Oxymorphone Products	
	OPANA ER [®] (oxymorphone)
Extended Release Hydromorphone Products	
	EXALGO [®] (hydromorphone)

ANALGESIC AGENTS: OPIOIDS – Long-Acting Transdermal

NO PA REQUIRED “PREFERRED”	PA REQUIRED
DURAGESIC [®] PATCH (fentanyl) FENTANYL PATCH (generic of Duragesic [®])	BUTRANS [®] PATCH (buprenorphine)

ANALGESIC AGENTS: OPIOIDS – Immediate-Release Single Entity

NO PA REQUIRED “PREFERRED”	PA REQUIRED
Codeine Products	
CODEINE SULFATE TABLETS	
Hydromorphone Products	
HYDROMORPHONE HCL TABLETS (generic of Dilaudid [®])	
Levorphanol Products	
	LEVORPHANOL TABLETS (generic of Levo-Dromoran)
Meperidine Products	
MEPERIDINE TABLETS (generic of Demerol [®])	
Methadone Products	
METHADONE TABLETS (generic of Dolophine [®])	
Morphine Products	
MORPHINE SULFATE: IMMEDIATE-RELEASE TABLETS (generic of MSIR [®])	
Oxycodone Products	
ROXICODONE [®] (OXYCODONE): IMMEDIATE-RELEASE TABLETS (generic of M-OXY [®]) OXYCODONE HCL TABLETS OXYCODONE HCL: IMMEDIATE-RELEASE CAPSULES (generic of OxyIR [®])	
Oxymorphone Products	
	OXYMORPHONE HCL tablets (generic of Opana [®])

ANALGESIC AGENTS: OPIOIDS – Immediate-Release Combination

NO PA REQUIRED “PREFERRED”	PA REQUIRED
Codeine Combinations	
ACETAMINOPHEN w/CODEINE TABLETS (generic of Tylenol #2 [®] , Tylenol #3 [®] , Tylenol #4 [®])	COCET [®] (acetaminophen-codeine) COCET PLUS [®] (acetaminophen-codeine)
Dihydrocodeine Combinations	
	DIHYDROCODEINE/ACETAMINOPHEN/CAFFEINE (generic of Zerlor [®]) TREZIX [®] (acetaminophen/caffeine/dihydrocodeine)
Hydrocodone Combinations	
HYDROCODONE/ACETAMINOPHEN tablets all strengths (generic of Anexsia, Lorcet, Lortab, Maxidone, Norco, Vicodin)	HYDROCODONE/ IBUPROFEN (generic of Vicoprofen [®]) IBUDONE [®] (hydrocodone/ibuprofen) MARGESIC H [®] (hydrocodone/acetaminophen) REPREXAIN [®] (hydrocodone/ibuprofen) XODOL [®] (hydrocodone/acetaminophen) ZYDONE [®] (hydrocodone/acetaminophen)

Oxycodone Combinations	
OXYCODONE W/ ACETAMINOPHEN TABLETS all strengths (generic of Percocet®) OXYCODONE W/ ACETAMINOPHEN CAPSULES (generic of Tylox®) OXYCODONE W/ ASPIRIN TABLETS 4.5mg/325mg (generic of Percodan®) ROXICET® 5mg/325mg (oxycodone/acetaminophen)	Magnacet® (oxycodone/acetaminophen) OXYCODONE W/ IBUPROFEN (generic of Combunox®) PRIMLEV® (oxycodone/acetaminophen) ROXICET® 5mg/500mg (oxycodone/acetaminophen)
Pentazocine Combinations	
<i>Not advocated for use</i>	PENTAZOCINE and NALOXONE (generic of Talwin NX®) PENTAZOCINE HCL and ACETAMINOPHEN (generic of Talacen®)

ANALGESIC AGENTS: CENTRAL, WITH OPIOID ACTIVITY

NO PA REQUIRED "PREFERRED"	PA REQUIRED
TRAMADOL (generic of Ultram®)	NUCYNTA® (tapentadol) RYBIX® ODT (tramadol) TRAMADOL/ACETAMINOPHEN (generic of Ultracet®)

ANALGESIC AGENTS: OPIOIDS – Liquids and Oral Syrup Immediate-Release (Single Entity)

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DILAUDID-5® 1mg/ml liquid (hydromorphone) MEPERIDINE HCL SYRUP: 50 mg/5ml (generic of Demerol Oral Syrup®) METHADONE HCL SOLN 5mg/5ml, 10mg/5ml METHADONE HCL ORAL CONCENTRATE and METHADONE INTENSOL® 10mg/ml MORPHINE SULFATE SOLN: 10 mg/5ml, 20mg/5ml, 20mg/ml (generic of MSIR Soln® and Roxanol Soln®) ROXICODONE® (Oxycodone oral solution) 5mg/5ml (generic of Oxydose®) ROXICODONE INTENSOL® (Oxycodone oral solution concentrate: 20 mg/ml) (generic of Oxyfast®)	

ANALGESIC AGENTS: OPIOIDS – Liquids and Oral Syrup Immediate-Release (Combination)

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACETAMINOPHEN w/CODEINE ORAL SOLN 120mg-12mg/5ml (generic of Tylenol w/Codeine Elixir®) HYDROCODONE BITARTRATE w/ ACETAMINOPHEN ELIXIR 2.5mg-167mg/5ml (generic of Lortab Elixir®) ROXICET ORAL SOLN® (5mg Oxycodone-325mg APAP/5ml)	CAPITAL w/CODEINE® ORAL SUSP 12mg codeine-120mg APAP/5ml HYCET® (hydrocodone/acetaminophen) HYDROCODONE/ACETAMINOPHEN ORAL SOLUTION 10mg-325mg/15ml (generic of Zamicet®) ZOLVIT® ORAL SOLUTION 10mg hydrocodone-300mg acetaminophen/15ml

ANALGESIC AGENTS: OPIOIDS – Nasal Inhalers

NO PA REQUIRED “PREFERRED”	PA REQUIRED
BUTORPHANOL TARTRATE NS (generic of Stadol NS [®])	

ANALGESIC AGENTS: OPIOIDS – Transmucosal System *

NO PA REQUIRED “PREFERRED”	PA REQUIRED
	ABSTRAL [®] (fentanyl) FENTANYL CITRATE (generic of Actiq [®]) FENTORA [®] (fentanyl) ONSOLIS [®] (fentanyl)

* Note: Clinical criteria must be met for transmucosal systems

Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents

LENGTH OF AUTHORIZATIONS: Dependent on diagnosis

All products in this class require clinical prior authorization:

Approval of epoetin alfa or darbepoetin:

Diagnosis	Hemoglobin Level	Approval Length
Anemia due to chronic renal failure, patient on dialysis	<=11	12 months
Anemia due to chronic renal failure, patient not on dialysis	<=11	12 months
Chemotherapy-induced anemia	<=10	3 months
Anemia in myelodysplastic syndrome	<=11	6 months

Approval of epoetin alfa only (not darbepoetin):

Diagnosis	Hemoglobin Level	Approval Length
Autologous blood donation, patient will require blood transfusions	>10, <=13	1 month
Anemia of prematurity, age <=6 months	N/A	6 weeks
Anemia associated with chronic inflammatory disorders (e.g., rheumatoid arthritis)	<=11	6 months
Anemia associated with ribavirin combination therapy in hepatitis C-infected patient	<=11	6 months
Anemia in zidovudine-treated HIV-infected patients	<=11	6 months

PDL criteria:

- Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to all medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
- Has the patient failed therapeutic trials of two weeks with medications not requiring prior approval? If so, document and approve the requested medication.

Document clinically compelling information

BLOOD AGENTS: HEMATOPOIETIC AGENTS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ARANESP® (darbepoetin alfa) SYRINGE OR VIAL PROCRIT® (epoetin alfa)	EPOGEN® (epoetin alfa)

Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations

LENGTH OF AUTHORIZATIONS: Varies based on criteria below

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to all medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Has the patient failed therapeutic trials of two weeks with medications not requiring prior approval? If so, document and approve the requested medication.

Document clinically compelling information

DURATION OF THERAPY LIMIT: 35 days

Guidelines from the American College of Chest Physicians limit duration of therapy in the outpatient setting for most indications to less than five weeks. Patients should be transitioned to oral warfarin as soon as possible.

1. Is there any reason the patient cannot be changed to oral warfarin? Acceptable reasons include:
 - patients with cancer (approved up to 6 months),
 - pregnant women (approved up to 40 weeks), or
 - patients unable to take warfarin (approved up to 6 months).

BLOOD AGENTS: HEPARIN-RELATED PREPARATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ARIXTRA [®] (fondaparinux)	ENOXAPARIN (generic of Lovenox [®])
FRAGMIN [®] SYRINGE (dalteparin)	
FRAGMIN [®] VIAL (dalteparin)	
INNOHEP [®] (tinzaparin)	
LOVENOX [®] AMPULE (enoxaparin)	
LOVENOX [®] PREFILLED SYRINGE (enoxaparin)	
LOVENOX [®] VIAL (enoxaparin)	

Blood Formation, Coagulation, and Thrombosis Agents: Platelet Aggregation Inhibitors

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to all medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Has the patient failed therapeutic trials of two weeks with medications not requiring prior approval? If so, document and approve the requested medication.

Document clinically compelling information

BLOOD AGENTS: PLATELET AGGREGATION INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AGGRENOL [®] (aspirin/dipyridamole) CILOSTAZOL (generic of Pletal [®]) DIPYRIDAMOLE (generic of Persantine [®]) EFFIENT [®] (prasugrel) PLAVIX [®] (clopidogrel) TICLOPIDINE (generic of Ticlid [®])	

Cardiovascular Agents: Hypertension & Heart Failure

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if both of the following are true:
 - If there has been a therapeutic failure to no less than a one-month trial of at least one medication within the same class not requiring prior approval
 - The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated

Document clinically compelling information

ADDITIONAL INFORMATION TO AID IN FINAL DECISION

- If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then may approve the requested medication. This medication should be reviewed for need at each request for reauthorization.

CARDIOVASCULAR AGENTS: ACE INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BENAZEPRIL (generic of Lotensin [®]) CAPTOPRIL (generic of Capoten [®]) ENALAPRIL (generic of Vasotec [®]) FOSINOPRIL (generic of Monopril [®]) LISINOPRIL (generic of Zestril [®] , Prinivil [®]) MOEXIPRIL (generic of Univasc [®]) PERINDOPRIL ERBUMINE (generic of Aceon [®]) QUINAPRIL (generic of Accupril [®]) RAMIPRIL (generic of Altace [®]) TRANDOLAPRIL (generic of Mavik [®])	ALTACE [®] (ramipril) tablets

CARDIOVASCULAR AGENTS: ACE INHIBITORS/CCB Combination

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LOTREL [®] (Amlodipine/Benazepril) TARKA [®] (Verapamil/Trandolapril)	AMLODIPINE/BENAZEPRIL (generic of Lotrel [®]) TRANDOLAPRIL/VERAPAMIL (generic of Tarka [®])

CARDIOVASCULAR AGENTS: ACE INHIBITORS/DIURETIC Combination

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BENZAEPRILOL/HCTZ (generic of Lotensin HCT [®]) CAPTOPRIL/HCTZ (generic of Capozide [®]) ENALAPRIL/HCTZ (generic of Vasertic [®]) FOSINOPRIL/HCTZ (generic of Monopril HCT [®]) LISINOPRIL/HCTZ (generic of Zestoretic [®] , Prinzipide [®]) MOEXIPRIL/HCTZ (generic of Uniretic [®]) QUINAPRIL/HCTZ (generic of Accuretic [®])	

CARDIOVASCULAR AGENTS: ALPHA-BETA BLOCKERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CARVEDILOL (generic of Coreg [®]) LABETALOL (generic of Trandate [®])	COREG CR [™] (carvedilol)

CARDIOVASCULAR AGENTS: ANGIOTENSIN II RECEPTOR ANTAGONISTS *

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
AVAPRO [®] (irbesartan) BENICAR [®] (olmesartan) DIOVAN [®] (valsartan) LOSARTAN (generic of Cozaar [®]) MICARDIS [®] (telmisartan)	ATACAND [®] (candesartan) EDARBI [®] (azilsartan) TEVETEN [®] (eprosartan)

* Note: Step therapy required for Angiotensin Receptor Antagonists – patient must have a claim for an ACE Inhibitor or combination within the last 120 days.

CARDIOVASCULAR AGENTS: ANGIOTENSIN II RECEPTOR ANTAGONISTS/DIURETIC Combination *

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
AVALIDE [®] (irbesartan/hctz) BENICAR HCT [®] (olmesartan/hctz) DIOVAN HCT [®] (valsartan/hctz) LOSARTAN-HCTZ (generic of Hyzaar [®]) MICARDIS HCT [®] (telmisartan/hctz)	ATACAND HCT [®] (candesartan/hctz) TEVETEN HCT [®] (eprosartan/hctz)

* Note: Step therapy required for Angiotensin Receptor Antagonists – patient must have a claim for an ACE Inhibitor or combination within the last 120 days.

CARDIOVASCULAR AGENTS: ANGIOTENSIN II RECEPTOR ANTAGONISTS/CALCIUM CHANNEL BLOCKER Combination *

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
AZOR [®] (Amlodipine/Olmesartan) EXFORGE [®] (Amlodipine/Valsartan)	TWYNSTA [®] (Amlodipine/Telmisartan)

* Note: Step therapy required for Angiotensin Receptor Antagonists – patient must have a claim for an ACE Inhibitor or combination within the last 120 days.

CARDIOVASCULAR AGENTS: ANGIOTENSIN II RECEPTOR ANTAGONISTS/CALCIUM CHANNEL BLOCKER/DIURETIC Combination *

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
EXFORGE HCT [®] (amlodipine/valsartan/hctz) TRIBENZOR [®] (olmesartan/amlodipine/hctz)	

* Note: Step therapy required for Angiotensin Receptor Antagonists – patient must have a claim for an ACE Inhibitor or combination within the last 120 days.

CARDIOVASCULAR AGENTS: BETA-BLOCKERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACEBUTOLOL (generic of Sectral [®]) ATENOLOL (generic of Tenormin [®]) BETAXOLOL (generic of Kerlone [®]) BISOPROLOL FUMARATE (generic of Zebeta [®]) METOPROLOL SUCCINATE (generic of Toprol XL [®]) METOPROLOL TARTRATE (generic of Lopressor [®]) NADOLOL (generic of Corgard [®]) PINDOLOL (generic of Visken [®]) PROPRANOLOL (generic of Inderal [®]) PROPRANOLOL ER (generic of Inderal LA [®]) SOTALOL (generic of Betapace [®]) SOTALOL AF (generic of Betapace AF [®]) TIMOLOL (generic of Blocadren [®])	BYSTOLIC [®] (nebivolol) INNOPRAN XL [®] (propranolol) LEVATOL [®] (penbutolol)

CARDIOVASCULAR AGENTS: BETA-BLOCKERS/DIURETIC COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ATENOLOL/CHLORTHALIDONE (generic of Tenoretic [®]) BISOPROLOL/HCTZ (generic of Ziac [®]) METOPROLOL/HCTZ (generic of Lopressor HCT [®]) NADOLOL/BENDROFLUMETHIAZIDE (generic of Corzide [®]) PROPRANOLOL/HCTZ (generic of Inderide [®])	

CALCIUM CHANNEL BLOCKERS

There are two main classes of Calcium Channel Blockers (each with different actions on the peripheral vasculature and cardiac tissue):

1. Dihydropyridine Calcium Channel Blockers (DHPCCB)
2. Non-Dihydropyridine Calcium Channel Blockers (NDHPCCB)

CARDIOVASCULAR AGENTS: CALCIUM CHANNEL BLOCKERS-DIHYDROPYRIDINE (DHPCCB)

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AMLODIPINE (generic of Norvasc [®]) FELODIPINE (generic of Plendil [®]) NICARDIPINE (generic of Cardene [®]) NIFEDIPINE ER (generic of Procardia XL [®] , Adalat CC [®]) NIFEDIPINE IMMEDIATE RELEASE (generic of Procardia [®])	CARDENE SR [®] (nicardipine) DYNACIRC CR [®] (isradipine) ISRADIPINE (generic of Dynacirc [®]) NIMODIPINE (generic of Nimotop [®]) NISOLDIPINE (generic of Sular [®]) SULAR [®] (nisoldipine)

Nimodipine (Nimotop®) CRITERIA to APPROVE

- Nimotop®: Indicated for the improvement of neurological outcome by reducing the incidence and severity of ischemic deficits in patients with subarachnoid hemorrhage from ruptured intracranial berry aneurysms regardless of the post-ictus neurological condition (Hunt and Hess grades I-V). This agent is usually dosed every 4 hours for 21 days; therapy should begin within 96 hours after the subarachnoid hemorrhage.

CARDIOVASCULAR AGENTS: CALCIUM CHANNEL BLOCKERS- NON-DIHYDROPYRIDINE (NDHPCCB)

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DILTIAZEM (generic of Cardizem®) DILTIAZEM ER (generic of Cardizem CD® q24h, Tiazac®) DILTIAZEM SR (generic of Cardizem SR® q12h) VERAPAMIL (Generic of Calan®) VERAPAMIL SR/ER (Generic of Calan SR®, Isoptin SR®, Verelan®)	COVERA HS® (verapamil) DILTIAZEM 24H ER tablet (generic of Cardizem LA®) VERAPAMIL ER PM (generic of Verelan PM®)

CARDIOVASCULAR AGENTS: DIRECT RENIN INHIBITORS*

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
TEKTURNA® (aliskiren)	

* Note: Step therapy required for direct renin inhibitors – patient must have a claim for an alternative anti-hypertensive agent within the last 120 days.

CARDIOVASCULAR AGENTS: DIRECT RENIN INHIBITOR/DIURETIC COMBINATION*

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
TEKTURNA HCT® (aliskiren/HCTZ)	

* Note: Step therapy required for direct renin inhibitors – patient must have a claim for an alternative anti-hypertensive agent within the last 120 days.

CARDIOVASCULAR AGENTS: DIRECT RENIN INHIBITOR/ANGIOTENSIN RECEPTOR BLOCKER COMBINATION*

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
VALTURNA® (Aliskiren/Valsartan)	

* Note: Step therapy required for direct renin inhibitors – patient must have a claim for an alternative anti-hypertensive agent within the last 120 days.

CARDIOVASCULAR AGENTS: DIRECT RENIN INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATION*

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
TEKAMLO® (Aliskiren/Amlodipine)	

* Note: Step therapy required for direct renin inhibitors – patient must have a claim for an alternative anti-hypertensive agent within the last 120 days.

CARDIOVASCULAR AGENTS: DIRECT RENIN INHIBITOR/CALCIUM CHANNEL BLOCKER/DIURETIC COMBINATION*

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
AMTURNIDE [®] (Aliskiren/Amlodipine/HCTZ)	

* Note: Step therapy required for direct renin inhibitors – patient must have a claim for an alternative anti-hypertensive agent within the last 120 days.

CARDIOVASCULAR AGENTS: SYMPATHOLYTIC ANTIHYPERTENSIVES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CATAPRES-TTS [®] patches (clonidine)	CLONIDINE patches (generic of Catapres-TTS [®] patches)
CLONIDINE tablets (generic of Catapres [®])	CLORPRES [®] (clonidine/clorthalidone)
GUANFACINE (generic of Tenex [®])	NEXICLON XR [®] (clonidine)
METHYLDOPA	RESERPINE
METHYLDOPA-HCTZ	

CARDIOVASCULAR AGENTS: LIPOTROPICS - STATINS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LIPITOR [®] (atorvastatin) LOVASTATIN (generic of Mevacor [®]) PRAVASTATIN (generic of Pravachol [®]) SIMVASTATIN (generic of Zocor [®])	ALTOPREV [®] (lovastatin) CRESTOR [®] (rosuvastatin) LESCOL [®] (fluvastatin) LESCOL XL [®] (fluvastatin) LIVALO [®] (pitavastatin)

CARDIOVASCULAR AGENTS: LIPOTROPICS – STATIN/NIACIN COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
SIMCOR [®] (Simvastatin/Niacin)	ADVICOR [®] (Lovastatin/Niacin)

CARDIOVASCULAR AGENTS: LIPOTROPICS - FIBRIC ACID DERIVATIVES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ANTARA [®] (fenofibrate) GEMFIBROZIL (generic of Lopid [®]) TRICOR [®] (fenofibrate) TRILIPIX [®] (fenofibrate)	FENOFIBRATE FENOFIBRIC ACID (generic of Fibricor [®]) FENOGLIDE [®] LIPOFEN [®] (fenofibrate) LOFIBRA [®] (fenofibrate) TRIGLIDE [®] (fenofibrate)

CARDIOVASCULAR AGENTS: LIPOTROPICS - NICOTINIC ACID DERIVATIVES

NO PA REQUIRED PREFERRED"	PA REQUIRED
NIACIN NIASPAN [®] (niacin)	

CARDIOVASCULAR AGENTS: LIPOTROPICS - OMEGA-3 POLYUNSATURATED FATTY ACIDS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
OTC FISH OIL 340-1000, 360-1200, 435-880, 500-1000	LOVAZA [®] (omega 3 fatty acids)

CARDIOVASCULAR AGENTS: LIPOTROPICS - SELECTIVE CHOLESTEROL ABSORPTION INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ZETIA [®] (ezetimibe)	

CARDIOVASCULAR AGENTS: LIPOTROPICS – STATIN / SELECTIVE CHOLESTEROL ABSORPTION INHIBITOR COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
VYTORIN [®] (Simvastatin/Ezetimibe)	

CARDIOVASCULAR AGENTS: LIPOTROPIC/HYPERTENSION COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	CADUET [®] (Amlodipine/Atorvastatin)

Central Nervous System (CNS) Agents: Alzheimer's Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval

2. The requested medication may be approved if the following is true:
 - If there has been a therapeutic failure to no less than a one-month trial of at least one medication within the same class not requiring prior approval

Document clinically compelling information

CNS AGENTS: ALZHEIMER'S AGENTS

NO PA REQUIRED PREFERRED"	PA REQUIRED
ARICEPT® (donepezil)	DONEPEZIL (generic of Aricept®)
ARICEPT® ODT (donepezil)	EXELON® 2mg/ml solution (rivastigmine)
COGNEX® (tacrine)	GALANTAMINE 4mg/ml solution (generic of Razadyne™)
EXELON® (rivastigmine)	RIVASTIGMINE (generic of Exelon®)
EXELON® patch (rivastigmine)	
GALANTAMINE (generic of Razadyne™)	
GALANTAMINE ER (generic of Razadyne™ ER)	
NAMENDA® (memantine)	
NAMENDA® 10mg/5ml solution (memantine)	
RAZADYNE™ 4mg/ml solution (galantamine)	

Central Nervous System (CNS) Agents: Anti-Migraine Agents

LENGTH OF AUTHORIZATIONS: 6 months

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to at least two medications not requiring prior approval
 - Contraindication to all medications not requiring prior approval
 - History of unacceptable/toxic side effects to at least two medications not requiring prior approval
2. Has the patient failed therapeutic trials of two weeks with two medications not requiring prior approval? If so, document and approve the requested medication.

Document clinically compelling information

CLINICAL CONSIDERATIONS:

Prior Authorization will not be given for prophylactic therapy of migraine headache unless the patient has exhausted or has contraindications to all other “controller” migraine medications (i.e., beta-blockers, neuroleptics, calcium channel blockers, etc.)

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. In addition to utilizing a preferred agent when applicable, the number of tablets/doses allowed per month is restricted based on the manufacturer’s package insert.
2. Prior authorization should not be given to patients with a history of ischemic heart disease.

CNS AGENTS: ANTI-MIGRAINE AGENTS – SEROTONIN 5-HT1 RECEPTOR AGONISTS – “Fast” Onset

NO PA REQUIRED PREFERRED”	PA REQUIRED
IMITREX [®] INJECTION (sumatriptan)	AXERT [®] (almotriptan)
IMITREX [®] NASAL SPRAY (sumatriptan)	RELPAK [®] (eletriptan)
MAXALT [®] (rizatriptan)	SUMATRIPTAN INJECTION (generic of Imitrex [®])
MAXALT-MLT [®] (rizatriptan)	SUMATRIPTAN NASAL SPRAY (generic of Imitrex [®])
SUMATRIPTAN TABLETS (generic of Imitrex [®])	SUMAVEL DOSEPRO [®] (sumatriptan)
	ZOMIG [®] (zolmitriptan)
	ZOMIG ZMT [®] (zolmitriptan)
	ZOMIG [®] NASAL SPRAY (zolmitriptan)

CNS AGENTS: ANTI-MIGRAINE AGENTS – SEROTONIN 5-HT1 RECEPTOR AGONISTS - “Slow” Onset

NO PA REQUIRED “PREFERRED”	PA REQUIRED
NARATRIPTAN (generic of Amerge [®])	FROVA [®] (frovatriptan)

**CNS AGENTS: ANTI-MIGRAINE AGENTS – SEROTONIN 5-HT1 RECEPTOR
AGONIST/NSAID COMBINATION**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
	TREXIMET [®] (Sumatriptan/Naproxen)

Central Nervous System (CNS) Agents: Antidepressants

GRANDFATHERING:

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug through the automated PA system. Patients who have taken the drug in the previous 120 days, but do not have claims history (new to Medicaid, samples, etc.), will be approved for PA after prescriber contact.

PSYCHIATRIST EXEMPTION:

Physicians who are registered with Ohio Health Plans as having a specialty in psychiatry are exempt from prior authorization of any non-preferred antidepressant in the standard tablet/capsule dosage forms. Other dosage forms may still require prior authorization by a psychiatrist. The exemption will be processed by the claims system when the pharmacy has submitted the prescriber on the claim using the individual identifier for the psychiatrist.

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- For orally disintegrating tablet dosage forms, the patient is unable or unwilling to swallow the standard tablet/capsule dosage form.

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if the following are true:

- If there has been a therapeutic failure to no less than a one-month trial of at least two medications not requiring prior approval.
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.
- If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then may approve the requested medication (e.g., Cymbalta[®] may be authorized for diabetic peripheral neuropathic pain or fibromyalgia). This medication should be reviewed for need at each request for reauthorization.

ANTIDEPRESSANTS: SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CITALOPRAM solution (generic of Celexa®) CITALOPRAM tablets (generic of Celexa®) FLUOXETINE HCL 10mg, 20mg (generic of Prozac®) FLUOXETINE HCL solution (generic of Prozac®) FLUVOXAMINE MALEATE (generic of Luvox®) LEXAPRO® solution (escitalopram) LEXAPRO® tablet (escitalopram) PAROXETINE HCL (generic of Paxil®) PAROXETINE HCL solution (generic of Paxil®) SERTRALINE (generic of Zoloft®) SERTRALINE oral concentrate (generic of Zoloft®)	FLUOXETINE ER (generic of Prozac Weekly®) FLUOXETINE HCL 40mg (generic of Prozac®) LUVOX CR® (fluvoxamine) PAROXETINE ER (generic of Paxil CR®) PEXEVA® (paroxetine mesylate) SELFEMRA (generic of Sarafem®)

*Patients on current regimens will be grandfathered.

ANTIDEPRESSANTS: SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CYMBALTA® (duloxetine) VENLAFAXINE (generic of Effexor®) VENLAFAXINE ER capsule (generic of Effexor XR®)	PRISTIQ® (desvenlafaxine) VENLAFAXINE ER tablet

*Patients on current regimens will be grandfathered.

ANTIDEPRESSANTS: NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIBITORS (NDRI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BUPROPION HCL (generic of Wellbutrin®) BUPROPION SR (generic of Wellbutrin SR®) BUPROPION XL (generic of Wellbutrin XL®)	APLENZIN™ (bupropion)

*Patients on current regimens will be grandfathered.

ANTIDEPRESSANTS: ALPHA-2 RECEPTOR ANTAGONISTS*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
MIRTAZAPINE (generic of Remeron®) MIRTAZAPINE rapid dissolve (generic of Remeron® Sol-Tab)	

*Patients on current regimens will be grandfathered.

ANTIDEPRESSANTS: MONOAMINE OXIDASE INHIBITORS (MAOI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	EMSAM® patches (selegiline) MARPLAN® (isocarboxazid) NARDIL® (phenelzine) TRANLYCYPROMINE (generic of Parnate®)

*Patients on current regimens will be grandfathered.

ANTIDEPRESSANTS: SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
NEFAZODONE TRAZODONE	OLEPTRO ER® (trazodone)

*Patients on current regimens will be grandfathered.

Central Nervous System (CNS) Agents: Antipsychotics, Second Generation, Oral

GRANDFATHERING:

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug through the automated PA system. Patients who have taken the drug in the previous 120 days, but do not have claims history (new to Medicaid, samples, etc.), will be approved for PA after prescriber contact.

PSYCHIATRIST EXEMPTION:

Physicians who are registered with Ohio Health Plans as having a specialty in psychiatry are exempt from prior authorization of any non-preferred second generation antipsychotic in the standard tablet/capsule dosage forms. Other dosage forms may still require prior authorization by a psychiatrist. The exemption will be processed by the claims system when the pharmacy has submitted the prescriber on the claim using the individual identifier for the psychiatrist.

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- For orally disintegrating tablet dosage forms, the patient is unable or unwilling to swallow the standard tablet/capsule dosage form.

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a fourteen-day trial of at least one medication not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

ANTIPSYCHOTICS, SECOND GENERATION *

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ABILIFY [®] (aripiprazole)	ABILIFY DISCMELT [®] (aripiprazole)
ABILIFY [®] solution (aripiprazole)	CLOZAPINE (generic of Clozaril [®])
GEODON [®] (ziprasidone)	CLOZARIL [®] (clozapine)
RISPERIDONE solution (generic of Risperdal [®])	FANAPT [®] (iloperidone)
RISPERIDONE tablet (generic of Risperdal [®])	FAZACLO [®] (clozapine)
RISPERIDONE M-TAB (generic of Risperdal M-tab [®])	INVEGA [®] (paliperidone)
SAPHRIS [®] (asenapine)	LATUDA [®] (lurasidone)
SEROQUEL [®] (quetiapine)	ZYPREXA [®] (olanzapine)
SEROQUEL XR [®] (quetiapine)	ZYPREXA ZYDIS [®] (olanzapine)

*Patients on current regimens will be grandfathered.

ANTIPSYCHOTICS, SECOND GENERATION and SSRI COMBINATION *

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	SYMBYAX [®] (fluoxetine/olanzapine)

*Patients on current regimens will be grandfathered.

Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to at least two medications not requiring prior approval
 - Contraindication to all medications not requiring prior approval
 - History of unacceptable/toxic side effects to at least two medications not requiring prior approval
2. Has the patient failed therapeutic trials of two weeks with two medications not requiring prior approval? If so, document and approve the requested medication.

Document clinically compelling information

CNS AGENTS: ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS – Short Acting

NO PA REQUIRED “PREFERRED”	PA REQUIRED
AMPHETAMINE SALTS (generic of Adderall [®]) DEXTROAMPHETAMINE (generic of Dexedrine [®])* DEXTROSTAT [®] * (dextroamphetamine) FOCALIN [®] (dexmethylphenidate) METHYLIN [®] tablets (methylphenidate) METHYLIN [®] solution (methylphenidate) METHYLPHENIDATE solution (generic of Methylin [®]) METHYLPHENIDATE tablets (generic of Ritalin [®])	DEXMETHYLPHENIDATE (generic of Focalin [®]) METHAMPHETAMINE (generic of Desoxyn [®])* METHYLIN [®] chewable tablets PROCENTRA [®] solution* (dextroamphetamine)

* Dextroamphetamine/methamphetamine products require clinical PA for age 18 and over

CNS AGENTS: ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS – Long Acting

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ADDERALL XR [®] (amphetamine/dextroamphetamine) CONCERTA [®] (methylphenidate) DEXTROAMPHETAMINE SA (generic of Dexedrine [®] spansule) * FOCALIN [®] XR (dexmethylphenidate) INTUNIV [®] (guanfacine) KAPVAY [®] (clonidine) METADATE [®] CD (methylphenidate) METADATE [®] ER (methylphenidate) METHYLIN [®] ER (methylphenidate) METHYLPHENIDATE ER (generic of Ritalin SR [®]) STRATTERA [®] (atomoxetine) VYVANSE [™] (lisdexamfetamine)	DAYTRANA [®] (methylphenidate) DEXTROAMPHETAMINE-AMPHETAMINE (generic of Adderall XR [®]) RITALIN [®] LA (methylphenidate)

* Dextroamphetamine/methamphetamine products require clinical PA for age 18 and over

Central Nervous System (CNS) Agents: Fibromyalgia Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to at least two medications not requiring prior approval
 - Contraindication to all medications not requiring prior approval
 - History of unacceptable/toxic side effects to at least two medications not requiring prior approval
2. Has the patient failed therapeutic trials of four weeks with two medications not requiring prior approval? If so, document and approve the requested medication.

Document clinically compelling information

ADDITIONAL INFORMATION

- If non-preferred, medication will be approved after trial of agents from no less than 3 of the following drug classes in the past 90 days (guidelines suggest use of multiple agents concurrently to manage the signs of fibromyalgia):
 - Tricyclic antidepressants
 - SSRIs
 - SNRIs
 - Short- and/or long-acting opioids
 - Skeletal muscle relaxants
 - Tramadol
 - Trazodone
 - Gabapentin
- If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then may approve the requested medication.
- If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then may approve the requested medication.
 - If non-preferred, duloxetine may be authorized for the following:
 - Diabetic peripheral neuropathic pain
 - Major Depressive Disorder (if duloxetine is a preferred antidepressant)
 - Generalized Anxiety Disorder (if duloxetine is a preferred antidepressant)
 - If non-preferred, pregabalin may be authorized for the following:
 - Diabetic peripheral neuropathic pain
 - Post-herpetic neuralgia
 - Seizure disorder

This medication should be reviewed for need at each request for reauthorization.

CNS AGENTS: FIBROMYALGIA AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CYMBALTA [®] (duloxetine) LYRICA [®] (pregabalin) SAVELLA [®] (milnacipran)	

Central Nervous System (CNS) Agents: Multiple Sclerosis Agents

DISEASE MODIFYING AGENTS

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a one-month trial on at least one medication not requiring prior approval.

Document clinically compelling information

CNS AGENTS: MULTIPLE SCLEROSIS DISEASE MODIFYING AGENTS *

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AVONEX [®] (interferon beta 1a) BETASERON [®] (interferon beta 1b) COPAXONE [®] (glatiramer) GILENYA [®] (fingolimod) REBIF [®] syringe (interferon beta 1a) REBIF [®] titration pack (interferon beta 1a)	EXTAVIA [®] (interferon beta 1b)

*Patients on current regimens will be grandfathered.

POTASSIUM CHANNEL BLOCKERS

LENGTH OF AUTHORIZATIONS: Initial authorization 90 days,
subsequent authorizations 1 year

1. Clinical criteria for initial authorization:
 - Diagnosis of multiple sclerosis; and
 - Prescription written by physician specializing in neurology
2. Criteria for subsequent authorizations
 - Improvement in function

Document clinically compelling information

CNS AGENTS: MULTIPLE SCLEROSIS POTASSIUM CHANNEL BLOCKERS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
AMPYRA [®] (dalfampridine)	

Central Nervous System (CNS) Agents: Parkinson's Agents

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a one-month trial of at least one medication not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

CNS AGENTS: PARKINSON'S AGENTS – COMT Inhibitor

NO PA REQUIRED "PREFERRED"	PA REQUIRED
COMTAN [®] (entacapone)	TASMAR [®] (tolcapone)

CNS AGENTS: PARKINSON'S AGENTS – Dopamine Receptor Agonists, Non-Ergot, Injectable

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	APOKYN [®] (apomorphine)

CNS AGENTS: PARKINSON'S AGENTS – Dopamine Receptor Agonists, Non-Ergot, Oral

NO PA REQUIRED "PREFERRED"	PA REQUIRED
PRAMIPEXOLE (generic of Mirapex [®])	MIRAPEX ER [®] (pramipexole)
ROPINIROLE (generic of Requip [®])	REQUIP XL [®] (ropinirole)

CNS AGENTS: PARKINSON'S AGENTS – Dopaminergic Agents, Oral

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CARBIDOPA/LEVODOPA (generic of Sinemet [®])	AZILECT [®] (rasagiline)
CARBIDOPA/LEVODOPA CR (generic of Sinemet [®] CR)	CARBIDOPA/LEVODOPA DISPERSIBLE TABLETS (generic of Parcopa [®])
SELEGILINE (generic of Eldepryl [®])	STALEVO [®] (Carbidopa/Levodopa/Entacapone)
	ZELAPAR [®] ODT (selegiline)

Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate

LENGTH OF AUTHORIZATIONS: 6 months

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there has been a therapeutic failure to no less than a 10-day trial of at least one medication not requiring prior approval, then may approve the requested medication.
3. If the prescriber indicates the patient has a history of addiction, then may approve a requested non-controlled medication.

Document clinically compelling information

CNS AGENTS: SEDATIVE-HYPNOTICS, NON-BARBITURATE

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ESTAZOLAM (generic of Prosom [®])	DORAL [®] (quazepam)
FLURAZEPAM (generic of Dalmane [®])	EDLUAR [®] SL (zolpidem)
TEMAZEPAM 15mg, 30mg (generic of Restoril [®])	LUNESTA [®] (eszopiclone)
ZALEPLON (generic of Sonata [®])	ROZEREM [®] (ramelteon)
ZOLPIDEM (generic of Ambien [®])	SILENOR [®] (doxepin)
	TEMAZEPAM 7.5mg, 22.5mg (generic of Restoril [®])
	ZOLPIDEM ER (generic of Abmien [®] CR)
	ZOLPIMIST [®] (zolpidem)

Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there has been a therapeutic failure to an agent not requiring prior approval, then may approve the requested medication.

Document clinically compelling information

CNS AGENTS: SKELETAL MUSCLE RELAXANTS - ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BACLOFEN (generic of Lioresal [®]) CHLORZOXAZONE (generic of Parafon Forte [®]) CYCLOBENZAPRINE (generic of Flexeril [®]) DANTROLENE (generic of Dantrium [®]) METHOCARBAMOL (generic of Robaxin [®]) TIZANIDINE tablets (generic of Zanaflex [®])	CYCLOBENZAPRINE ER (generic of Amrix [®]) CARISOPRODOL (generic of Soma [®]) * CARISOPRODOL COMPOUND (generic of Soma Compound [®]) * CARISOPRODOL COMPOUND W/CODEINE (generic of Soma Compound w/Codeine [®]) * FEXMID [®] (cyclobenzaprine) METAXOLONE (generic of Skelaxin [®]) ORPHENADRINE (generic of Norflex [®]) ORPHENADRINE COMPOUND (generic of Norgesic [®]) ORPHENADRINE COMPOUND FORTE (generic of Norgesic Forte [®]) SOMA [®] * (carisoprodol) ZANAFLEX [®] capsules (tizanidine)

* Note: Clinical criteria must be met for Soma[®]/Carisoprodol products– approvable only if no other muscle relaxant or agent to treat fibromyalgia, or any musculoskeletal condition, would serve the clinical needs of the patient.

Central Nervous System (CNS) Agents: Smoking Deterrents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there has been a therapeutic failure to an agent not requiring prior approval, then may approve the requested medication.

Document clinically compelling information

CNS AGENTS: SMOKING DETERRENTS – NICOTINE REPLACEMENT

NO PA REQUIRED “PREFERRED”	PA REQUIRED
COMMIT™ lozenge (nicotine) NICODERM®CQ patch (nicotine) NICORETTE® gum (nicotine) NICOTINE gum (generic of Nicorette®) NICOTINE lozenge (generic of Commit™) NICOTINE patch (generics) NICOTROL® inhaler (nicotine) NICOTROL® nasal spray(nicotine) THRIVE® nicotine gum	

CNS AGENTS: SMOKING DETERRENTS – NON-NICOTINE PRODUCTS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
BUPROPION (generic of Zyban®) CHANTIX®(varenicline)	

Endocrine Agents: Diabetes Adjunctive Therapy

LENGTH OF AUTHORIZATIONS: 1 year

All drugs in this class require step therapy: Patient must have a claim for an oral hypoglycemic or insulin in the previous 120 days.

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
 - Condition is difficult to control (i.e. prone to ketoacidosis, hypoglycemia)

2. The requested medication may be approved if there has been a therapeutic failure to at least one medication within the same class not requiring prior authorization.

Document clinically compelling information

ENDOCRINE AGENTS: DIABETES – AMYLIN ANALOGS

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
SYMLIN [®] (pramlintide)	

ENDOCRINE AGENTS: DIABETES – INCRETIN MIMETICS

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
BYETTA [™] (exenatide) VICTOZA [®] (liraglutide)	

Endocrine Agents: Diabetes – Insulin

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
 - Condition is difficult to control (i.e. prone to ketoacidosis, hypoglycemia)
2. The requested medication may be approved if there has been a therapeutic failure to at least one medication within the same class not requiring prior authorization.

Document clinically compelling information

ENDOCRINE AGENTS: DIABETES - INSULINS - Rapid and Short Acting*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
HUMALOG [®] (insulin lispro) HUMULIN R [®] (insulin regular human) HUMULIN R 500-U [®] (insulin regular human) NOVOLIN R [®] (insulin regular human) NOVOLOG [®] (insulin aspart) RELION R [®] (insulin regular human)	APIDRA [®] (insulin glulisine)

* Patients on current insulin regimens will be grandfathered.

ENDOCRINE AGENTS: DIABETES - INSULINS - Intermediate Acting*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
HUMALOG MIX 50/50, 75/25 [®] (insulin lispro protamine/insulin lispro) HUMULIN 50/50 [®] (insulin NPH/regular) HUMULIN 70/30 [®] (insulin NPH/regular) HUMULIN N [®] (insulin NPH) NOVOLIN 70/30 [®] (insulin NPH/regular) NOVOLIN N [®] (insulin NPH) NOVOLOG MIX 70/30 [®] (insulin aspart protamine/insulin aspart) RELION 70/30 [®] RELION N [®] (insulin NPH)	

* Patients on current insulin regimens will be grandfathered.

ENDOCRINE AGENTS: DIABETES - INSULINS - Long Acting*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LANTUS [®] (insulin glargine)	LEVEMIR [®] (insulin detemir)

* Patients on current insulin regimens will be grandfathered.

Endocrine Agents: Diabetes – Oral Hypoglycemics

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication within the same class not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to at least two trials of thirty days each with medications not requiring prior approval.

Document clinically compelling information

ENDOCRINE AGENTS: DIABETES – ORAL HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ACARBOSE (generic of Precose [®]) GLYSET [®] (miglitol)	

ENDOCRINE AGENTS: DIABETES – ORAL HYPOGLYCEMICS, BIGUANIDES

NO PA REQUIRED “PREFERRED”	PA REQUIRED
METFORMIN (generic of Glucophage [®]) METFORMIN ER (generic of Glucophage XR [®])	FORTAMET [®] (metformin) GLUMETZA [™] (metformin) RIOMET [®] 500mg/5ml (Metformin)

ENDOCRINE AGENTS: DIABETES – ORAL HYPOGLYCEMICS, BIGUANIDES COMBINATION

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ACTOPLUS MET [®] (pioglitazone/metformin) GLIPIZIDE/METFORMIN (generic of Metaglip [®]) GLYBURIDE/METFORMIN (generic of Glucovance [®])	ACTOPLUS MET XR [®] (pioglitazone/metformin) AVANDAMET [®] (rosiglitazone/metformin) PRANDIMET [®] (repaglinide/metformin)

ENDOCRINE AGENTS: DIABETES – DIPEPTIDYL PEPTIDASE-4 INHIBITOR *

STEP THERAPY REQUIRED “PREFERRED”	PA REQUIRED
JANUVIA [®] (sitagliptin) ONGLYZA [®] (saxagliptin) TRADJENTA [™] (linagliptin)	

* Note: Step therapy required for DPP-4 Inhibitors – patient must have a claim for an alternate oral hypoglycemic or insulin within the last 120 days.

ENDOCRINE AGENTS: DIABETES – DIPEPTIDYL PEPTIDASE-4 INHIBITOR COMBINATIONS *

STEP THERAPY REQUIRED “PREFERRED”	PA REQUIRED
JANUMET [™] (sitagliptin/metformin) KOMBIGLYZE XR [®] (saxagliptin/metformin)	

* Note: Step therapy required for DPP-4 Inhibitors – patient must have a claim for an alternate oral hypoglycemic or insulin within the last 120 days.

ENDOCRINE AGENTS: DIABETES – ORAL HYPOGLYCEMICS, MEGLITINIDES

NO PA REQUIRED “PREFERRED”	PA REQUIRED
STARLIX [®] (nateglinide)	NATEGLINIDE (generic of Starlix [®]) PRANDIN [®] (repaglinide)

**ENDOCRINE AGENTS: DIABETES – ORAL HYPOGLYCEMICS, SULFONYLUREAS
SECOND GENERATION**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
GLIMEPIRIDE (generic of Amaryl [®]) GLIPIZIDE (generic of Glucotrol [®]) GLIPIZIDE ER (generic of Glucotrol XL [®]) GLYBURIDE (generic of Diabeta [®] , Micronase [®]) GLYBURIDE MICRONIZED (generic of GlynasePressTabs [®])	

**ENDOCRINE AGENTS: DIABETES – ORAL HYPOGLYCEMICS,
THIAZOLIDINEDIONES**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ACTOS [®] (pioglitazone)	AVANDIA [®] (rosiglitazone)

**ENDOCRINE AGENTS: DIABETES – ORAL HYPOGLYCEMICS,
THIAZOLIDINEDIONES / SULFONYLUREAS COMBINATION**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
DUETACT [®] (glimepiride/pioglitazone)	AVANDARYL [®] (glimepiride/rosiglitazone)

Endocrine Agents: Estrogenic Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval

2. The requested medication may be approved if there has been a therapeutic failure to at least two trials of thirty days each with medications not requiring prior approval

Document clinically compelling information

ENDOCRINE AGENTS: ESTROGENS – ORAL ESTROGENS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CENESTIN [®] (synthetic conjugated estrogens) ENJUVIA [®] (synthetic conjugated estrogens) ESTRADIOL (generic of Estrace [®]) ESTROPIPATE MENEST [®] (esterified estrogens) PREMARIN [®] (conjugated estrogens)	FEMTRACE [®] (estradiol)

ENDOCRINE AGENTS: ESTROGENS – ORAL ESTROGEN/PROGESTERONE COMBINATIONS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ETHINYL ESTRADIOL/NORETHINDRONE ACETATE (generic of FemHRT [®]) FEMHRT [®] (norethindrone/ethinylestradiol) PREMPHASE [®] (medroxyprogesterone/estrogens conjugated) PREMPRO [®] (medroxyprogesterone/estrogens conjugated)	ANGELIQ [®] (drospirenone/estradiol) ESTRADIOL/NORETHINDRONE ACETATE tablets (generic of Activella [®]) PREFEST [®] (estradiol/norgestimate)

ENDOCRINE AGENTS: ESTROGENS – TRANSDERMAL ESTROGENS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ALORA [®] patch (estradiol) ESTRADIOL patch (generic of Climara [®])	DIVIGEL [®] transdermal gel (estradiol) ELESTRIN [®] transdermal gel (estradiol) ESTRADERM [®] patch (estradiol) ESTRASORB [®] transdermal emulsion (estradiol) EVAMIST [®] transdermal solution (estradiol) MENOSTAR [®] patch (estradiol) VIVELLE-DOT [®] patch (estradiol)

**ENDOCRINE AGENTS: ESTROGENS – TRANSDERMAL
ESTROGEN/PROGESTERONE COMBINATIONS**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
COMBIPATCH [®] (estradiol/norethindrone)	CLIMARA PRO [®] (estradiol/levonorgestrel oral)

ENDOCRINE AGENTS: ESTROGENS – VAGINAL ESTROGENS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ESTRING [®] vaginal ring (estradiol)	ESTRACE [®] vaginal cream (estradiol)
PREMARIN [®] vaginal cream (estrogens conjugated)	FEMRING [®] vaginal ring (estradiol)
	VAGIFEM [®] vaginal tablet (estradiol)

Endocrine Agents: Growth Hormones

LENGTH OF AUTHORIZATIONS: 1 year

All products in this class require clinical prior authorization:

- Diagnosis of one of the following:
 - Classic Growth Hormone Deficiency
 - Growth Failure Due to Chronic Renal Insufficiency
 - Growth Hormone Deficiency Due to Somatropin Deficiency
 - Congenital Absence of Pituitary
 - Pituitary Gland Removal
 - Growth Hormone Deficiency Due to Radiation Therapy
 - Small for Gestational Age
 - Prader-Willi Syndrome
 - Turner's Syndrome
 - Krause-Kivlin Syndrome
 - AIDS Wasting
 - Short Bowel Syndrome

PDL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval?
Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a three-month trial of at least one medication not requiring prior approval

GROWTH HORMONES

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
GENOTROPIN [®] CARTRIDGE (somatropin)	HUMATROPE [®] CARTRIDGE (somatropin)
GENOTROPIN [®] MINIQUICK (somatropin)	HUMATROPE [®] VIAL (somatropin)
NORDITROPIN [®] CARTRIDGE (somatropin)	NUTROPIN AQ [®] NUSPIN (somatropin)
NORDITROPIN [®] FLEXPLO (somatropin)	NUTROPIN AQ [®] PEN CARTRIDGE (somatropin)
NORDITROPIN [®] NORDIFLEX (somatropin)	NUTROPIN AQ [®] VIAL (somatropin)
NORDITROPIN [®] VIAL (somatropin)	NUTROPIN [®] VIAL (somatropin)
OMNITROPE [®] CARTRIDGE (somatropin)	SAIZEN [®] CARTRIDGE (somatropin)
OMNITROPE [®] VIAL (somatropin)	SAIZEN [®] VIAL (somatropin)
TEV-TROPIN [®] VIAL (somatropin)	SEROSTIM [®] VIAL (somatropin)
	ZORBTIVE [®] VIAL (somatropin)

Endocrine Agents: Osteoporosis – Bone Ossification Enhancers

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. There are two (2) classes of drugs in this category of Ossification Enhancers
 - a. Bisphosphonates
 - b. Calcitonin-Salmon

Document clinically compelling information

CRITICAL INFORMATION

- Patients should only be on ONE (1) of the above therapeutic classes (bisphosphonates, calcitonin-salmon).

ENDOCRINE AGENTS: OSTEOPOROSIS - BONE OSSIFICATION ENHANCERS - ORAL BISPHOSPHONATES

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ALENDRONATE (generic of Fosamax [®])	ACTONEL [®] (risedronate) ATELVIA [®] (risedronate) BONIVA [®] (ibandronate) ETIDRONATE (generic of Didronel [®]) FOSAMAX [®] ORAL SOLN 70mg/75ml (alendronate) FOSAMAX PLUS D [™] (alendronate/cholecalciferol) SKELID [®] (tiludronate)

ENDOCRINE AGENTS: OSTEOPOROSIS - BONE OSSIFICATION ENHANCERS - CALCITONIN-SALMON

NO PA REQUIRED “PREFERRED”	PA REQUIRED
FORTICAL [®] (calcitonin salmon) MIACALCIN [®] (calcitonin salmon)	CALCITONIN-SALMON (generic of Miacalcin [®])

Gastrointestinal Agents: Anti-Emetics

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

GASTROINTESTINAL AGENTS: ANTI-EMETIC AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
EMEND [®] (aprepitant)	ANZEMET [®] (dolasetron)
EMEND [®] TRIFOLD (aprepitant)	GRANISETRON solution (generic of Kytril [®])
ONDANSETRON ODT (generic of Zofran [®])	GRANISETRON tablet (generic of Kytril [®])
ONDANSETRON oral solution (generic of Zofran [®])	SANCUSO [®] patch (granisetron)
ONDANSETRON tablets (generic of Zofran [®])	ZUPLENZ [®] soluble film (ondansetron)

Gastrointestinal Agents: Chronic Constipation Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a one-week trial of at least one medication not requiring prior approval.

Document clinically compelling information

GASTROINTESTINAL AGENTS: CHRONIC CONSTIPATION AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AMITIZA® (lubiprostone)	

Gastrointestinal Agents: H. Pylori Packages

LENGTH OF AUTHORIZATIONS: 1 course of treatment

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
- Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

Also consider whether components are appropriate vs. package

GASTROINTESTINAL AGENTS: H. PYLORI PACKAGES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
HELIDAC [®] (metronidazole/tetracycline/bismuth subsalicylate)	PREVPAC [®] (lansoprazole/amoxicillin/clarithromycin) PYLERA [®] (metronidazole/tetracycline/bismuth subsalicylate)

Gastrointestinal Agents: Pancreatic Enzymes

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval?
Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a one-month trial of at least [number to be discussed by P&T Committee if any non-preferred drugs are added] medications not requiring prior approval

GASTROINTESTINAL AGENTS: PANCREATIC ENZYMES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CREON [®] (pancrelipase) PANCREAZE [®] (pancrelipase) PANCRELIPASE 5000 ZENPEP [®] (pancrelipase)	

Gastrointestinal Agents: Proton Pump Inhibitors

LENGTH OF AUTHORIZATIONS: 6 months, except as listed under clinical criteria

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there has been a therapeutic failure to no less than a one-month trial of at least one medication in the same class not requiring prior approval, then may approve the requested medication.
3. If a medication requiring prior approval was initiated in the hospital for the treatment of a condition such as a GI bleed, may approve the requested medication.

ADDITIONAL INFORMATION

- No PA needed for preferred PPI at once-daily dosing
- No PA needed for preferred PPI at any dose for age under 21
- Must have therapeutic failure on preferred agent before PA of non-preferred

CLINICAL CRITERIA FOR PPI DOSES GREATER THAN ONCE DAILY

1. For diagnosis of H. Pylori, BID dosing may be authorized for 1 month
2. For diagnosis of COPD, Dyspepsia, Gastritis, Gastroparesis, Symptomatic Uncomplicated Barrett's Esophagus, Carcinoma of GI tract, Crest Syndrome, Esophageal Varices, Scleroderma, Systemic Mastocytosis, Zollinger Ellison Syndrome:
 - Length of authorization: 1 year
 - Criteria for approval: Must have failed QD dosing

Document clinically compelling information

GASTROINTESTINAL AGENTS: PPIs

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LANSOPRAZOLE capsules (generic of Prevacid®)	ACIPHEX® (rabeprazole)
LANSOPRAZOLE ODT (generic of Prevacid SoluTab®) (No PA required for age 6 or under)	DEXILANT® (dexlansoprazole)
OMEPRAZOLE capsules (generic of Prilosec®)	LANSOPRAZOLE ODT (generic of Prevacid SoluTab®) (PA required for age over 6)
OMEPRAZOLE tablets (generic of Prilosec OTC®)	NEXIUM® capsules (esomeprazole)
PANTOPRAZOLE (generic of Protonix®)	NEXIUM® packets (esomeprazole)
PREVACID 24 HOUR® (OTC) (lansoprazole)	OMEPRAZOLE/SOCIUM BICARBONATE
PRILOSEC OTC® tablets (omeprazole)	PRILOSEC® suspension (omeprazole)
ZEGERID OTC® (omeprazole/sodium bicarbonate)	PROTONIX® suspension

Gastrointestinal Agents: Ulcerative Colitis Agents

LENGTH OF AUTHORIZATIONS: 6 months

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval

2. The requested medication may be approved if there has been a therapeutic failure to at least two trials of thirty days each with medications not requiring prior approval

ADDITIONAL INFORMATION

1. Ulcerative Colitis Agents are available in both oral (IR, ER) and rectal (enema, suppository) formulations. Patients with mild or moderate disease may be treated with either topical or oral agents.
2. The efficacy among the different 5-ASA derivatives appears to be comparable.

GASTROINTESTINAL AGENTS: ULCERATIVE COLITIS AGENTS - ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
APRISO [®] (mesalamine) ASACOL [®] (mesalamine) ASACOL HD [®] (mesalamine) BALSALAZIDE DISODIUM (generic of Colazal [®]) LIALDA [®] (mesalamine) SULFASALAZINE (generic of Azulfidine [®]) SULFASALAZINE EC (generic of Azulfidine Entab [®])	DIPENTUM [®] (olsalazine) PENTASA [®] (mesalamine)

GASTROINTESTINAL AGENTS: ULCERATIVE COLITIS AGENTS - RECTAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CANASA [®] suppositories (mesalamine) MESALAMINE enema (generic of Rowasa [®] and SRowasa [®])	MESALAMINE enema kit (generic for Rowasa [®] kit)

Genitourinary Agents: Benign Prostatic Hyperplasia

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindications to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Patient must have a therapeutic failure to no less than a one-month trial on at least one medication not requiring prior approval.

Document clinically compelling information

GENITOURINARY AGENTS: BENIGN PROSTATIC HYPERPLASIA AGENTS – ALPHA-1 ADRENERGIC BLOCKERS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
DOXAZOSIN (generic of Cardura [®])	CARDURA [®] XL (doxazosin)
PRAZOSIN (generic of Minipress [®])	RAPAFLO [®] (silodosin)
TAMSULOSIN (generic of Flomax [®])	UROXATRAL [®] (alfuzosin)
TERAZOSIN (generic of Hytrin [®])	

GENITOURINARY AGENTS: BENIGN PROSTATIC HYPERPLASIA AGENTS – 5-ALPHA REDUCTASE INHIBITORS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
FINASTERIDE (generic of Proscar [®])	AVODART [®] (dutasteride)

GENITOURINARY AGENTS: BENIGN PROSTATIC HYPERPLASIA AGENTS – COMBINATION 5-ALPHA REDUCTASE INHIBITOR/ALPHA-1 ADRENERGIC BLOCKER

NO PA REQUIRED “PREFERRED”	PA REQUIRED
	JALYN [®] (dutasteride/tamsulosin)

Genitourinary Agents: Electrolyte Depletter Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a one-week trial of at least one medication not requiring prior approval.

Document clinically compelling information

CLINICAL INFORMATION

Calcium acetate products may lead to hypercalcemia. This agent is recommended in patients with normal serum calcium levels.

GENITOURINARY AGENTS: ELECTROLYTE DEPLETERS FOR HYPERPHOSPHATEMIA

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CALCIUM ACETATE (generic of PhosLo [®] gelcap)	RENVELA [®] (sevelamer)
CALCIUM CARBONATE	
CALPHRON [®] (calcium acetate)	
ELIPHOS [®] (calcium acetate)	
FOSRENOL [®] (lanthanum carbonate)	
MAGNEBIND [®] (calcium carbonate/magnesium carbonate/folic acid)	
PHOSLO [®] (calcium acetate)	
RENAGEL [®] (sevelamer)	

Genitourinary Agents: Urinary Antispasmodics

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindications to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Patient must have a therapeutic failure to no less than a one-month trial on at least one medication not requiring prior approval.

Document clinically compelling information

GENITOURINARY AGENTS: URINARY ANTISPASMODICS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
FLAVOXATE	DETROL [®] (tolterodine)
OXYBUTYNIN ER (generic of Ditropan [®] XL)	DETROL [®] LA (tolterodine)
OXYBUTYNIN syrup (generic of Ditropan [®])	ENABLEX [®] (darifenacin)
OXYBUTYNIN tablets (generic of Ditropan [®])	GELNIQUE [®] (oxybutynin)
SANCTURA [®] (trospium)	OXYTROL [®] patch (oxybutynin,)
SANCTURA XR [®] (trospium)	TOVIAZ [®] (fesoterodine)
VESICARE [®] (solifenacin)	TROSPIUM (generic of Sanctura [®])

Infectious Disease Agents: Antibiotics – Cephalosporins

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication. Document details.
 - Note diagnosis and any culture and sensitivity reports
3. If there have been therapeutic failures to no less than a three-day trial of at least one medication not requiring prior approval, then may approve the requested medication.

Document clinically compelling information

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

INFECTIOUS DISEASE AGENTS: CEPHALOSPORINS, FIRST GENERATION – Capsules and Tablets

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CEFADROXIL (generic of Duricef®) CEPHALEXIN (generic of Keflex®)	KEFLEX 750mg capsule (cephalexin)

INFECTIOUS DISEASE AGENTS: CEPHALOSPORINS, FIRST GENERATION – Suspensions and Liquids

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CEFADROXIL suspension (generic of Duricef®) CEPHALEXIN suspension (generic of Keflex® Suspension)	

INFECTIOUS DISEASE AGENTS: CEPHALOSPORINS, SECOND GENERATION – Capsules and Tablets

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CEFACLOR (generic of Ceclor®) CEFACLOR ER (generic of Ceclor CD®) CEFPROZIL (generic of Cefzil®) CEFUROXIME (generic of Cefitin®)	

**INFECTIOUS DISEASE AGENTS: CEPHALOSPORINS, SECOND GENERATION –
Suspensions and Liquids**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CEFACLOR suspension (generic of Ceclor [®]) CEFTIN [®] suspension (no PA required for age 12 or under) (cefuroxime) CEFUROXIME suspension (generic of Cefdin [®]) (no PA required for age 12 or under) CEFPROZIL suspension (generic of Cefzil [®]) (no PA required for age 12 or under)	CEFTIN [®] suspension (PA required for age over 12) (cefuroxime) CEFUROXIME suspension (generic of Cefdin [®]) (PA required for age over 12) CEFPROZIL suspension (generic of Cefzil [®]) (PA required for age over 12)

**INFECTIOUS DISEASE AGENTS: CEPHALOSPORINS, THIRD GENERATION –
Capsules and Tablets**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CEFDINIR (generic of Omnicef [®])	CEDAX [®] (ceftibuten) CEFDITOREN PIVOXIL (generic of Spectracef [®]) CEFPODOXIME (generic of Vantin [®]) SUPRAX [®] (cefixime)

**INFECTIOUS DISEASE AGENTS: CEPHALOSPORINS, THIRD GENERATION –
Suspensions and Liquids**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CEFDINIR suspension (generic of Omnicef [®])	CEDAX [®] suspension (ceftibuten) SUPRAX [®] suspension (cefixime) CEFPODOXIME suspension (generic of Vantin [®])

Infectious Disease Agents: Antibiotics – Macrolides

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication. Document details.
 - Note diagnosis and any culture and sensitivity reports
3. If there has been a therapeutic failure to no less than a three-day trial of at least one medication not requiring prior approval, then may approve the requested medication.

Document clinically compelling information

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

INFECTIOUS DISEASE AGENTS: MACROLIDES - ORAL

NO PA REQUIRED “PREFERRED”	PA REQUIRED
AZITHROMYCIN tablets and suspension (generic of Zithromax [®])	PCE [®] (erythromycin base) ZMAX [™] (Azithromycin ER) for oral suspension
CLARITHROMYCIN ER (generic of Biaxin XL [®])	
CLARITHROMYCIN tablets and suspension (generic of Biaxin [®])	
ERYPED [®] (erythromycin ethylsuccinate)	
ERY-TAB [®] (erythromycin base)	
ERYTHROCIN STEARATE [®] (erythromycin stearate)	
ERYTHROMYCIN BASE	
ERYTHROMYCIN ETHYLSUCCINATE	
ERYTHROMYCIN W/SULFISOXAZOLE	

Infectious Disease Agents: Antibiotics – Quinolones

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication.
 - Note diagnosis and any culture and sensitivity reports
3. If there has been a therapeutic failure to at least a three-day trial of at least one medication not requiring prior approval, then may approve the requested medication.

Document clinically compelling information

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.
2. If the prescriber expresses concern over safety issues of a preferred agent (e.g., cardiotoxicity associated with Avelox[®]), a non-preferred agent may be approved.

INFECTIOUS DISEASE AGENTS: QUINOLONES, SECOND GENERATION - ORAL

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CIPROFLOXACIN (generic of Cipro [®]) CIPRO [®] suspension (no PA required for age 12 or under) (ciprofloxacin) OFLOXACIN (generic of Floxin [®])	CIPRO [®] suspension (PA required for age over 12) (ciprofloxacin) CIPROFLOXACIN ER (generic of Cipro [®] XR) NOROXIN [®] (norfloxacin) PROQUIN [®] XR (ciprofloxacin)

INFECTIOUS DISEASE AGENTS: QUINOLONES, THIRD GENERATION - ORAL

NO PA REQUIRED “PREFERRED”	PA REQUIRED
AVELOX [®] (moxifloxacin) AVELOX ABC PACK [®] (moxifloxacin)	LEVAQUIN [®] (levofloxacin)

INFECTIOUS DISEASE AGENTS: QUINOLONES, FOURTH GENERATION - ORAL

NO PA REQUIRED “PREFERRED”	PA REQUIRED
	FACTIVE [®] (gemifloxacin)

Infectious Disease Agents: Antifungals for Onychomycosis & Systemic Infections

LENGTH OF AUTHORIZATIONS: For the duration of the prescription (up to 6 months)

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval:
 - Drug interactions (inhibition of CYP450 system)
 - Ketoconazole > Itraconazole > Voriconazole > Fluconazole
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the patient has a serious illness that causes them to be immunocompromised [i.e. AIDS, cancer, organ (solid or non-solid) transplant] then may approve the requested medication.

Document clinically compelling information

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring prior approval, then may approve the requested medication.
2. If the request is for a diagnosis other than fungal infection, please refer the case to a pharmacist. An off label use may be approvable for a medication such as Nizoral[®] for advanced prostate cancer or for Cushing's Syndrome when standard treatments have failed.

INFECTIOUS DISEASE AGENTS: AGENTS FOR ONYCHOMYCOSIS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CICLOPIROX solution (generic of Penlac [®])	CICLOPIROX kit (generic of CNL [®] Nail lacquer kit)
GRIFULVIN [®] V tablets (griseofulvin, microsize)	ITRACONAZOLE (generic of Sporanox [®])
GRISEOFULVIN suspension (generic of Grifulvin [®] V)	LAMISIL Granules (terbinafine)
GRIS-PEG [®] (griseofulvin, ultramicrosize)	SPORANOX [®] 100mg/10ml oral solution
TERBINAFINE (generic of Lamisil [®])	(itraconazole)

INFECTIOUS DISEASE AGENTS: AGENTS FOR SYSTEMIC INFECTIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
FLUCONAZOLE (generic of Diflucan [®])	ITRACONAZOLE CAPSULES (generic of Sporanox [®])
FLUCONAZOLE suspension (generic of Diflucan [®])	NOXAFIL [®] (posaconazole)
KETOCONAZOLE (generic of Nizoral [®])	SPORANOX [®] 100mg/10ml oral solution
	(itraconazole)

Infectious Disease Agents: Antivirals – Hepatitis C Agents

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to a medication within the same class which does not require prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

- Pegylated Interferons have a Black Box Warning which indicates that a patient should be monitored closely with periodic clinical and laboratory evaluations.
- Ribavirins are contraindicated in women who are pregnant and in their male partner(s). At least two reliable forms of contraception must be used during therapy.

Document clinically compelling information

INFECTIOUS DISEASE AGENTS: HEPATITIS C - PEGYLATED INTERFERONS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
PEGASYS [®] (peginterferon alfa 2a) PEGASYS CONVENIENCE PACK [®] (peginterferon alfa 2a) PEG-INTRON [®] (peginterferon alfa 2b) PEG-INTRON REDIPEN [®] (peginterferon alfa 2b)	

HEPATITIS C - RIBAVIRINS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
RIBASPHERE [®] (ribavirin) RIBAVIRIN (generic of Rebetol [®])	COPEGUS [®] (ribavirin) REBETOL [®] (ribavirin) RIBAPAK [®] (ribavirin)

Infectious Disease Agents: Antivirals – Herpes

LENGTH OF AUTHORIZATIONS: For the duration of the prescription (up to 6 months)

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

INFECTIOUS DISEASE AGENTS: ANTIVIRALS - HERPES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACYCLOVIR (generic of Zovirax®) ACYCLOVIR suspension (generic of Zovirax®) VALTREX® (valacyclovir)	FAMCICLOVIR (generic of Famvir®) VALACYCLOVIR (generic of Valtrex®)

Injectable Antirheumatic Agents

LENGTH OF AUTHORIZATIONS: 1 year

All products in this class require clinical prior authorization:

- No current infection; and
- Prior non-biologic therapy appropriate for diagnosis; and
- Diagnosis of one of the following:
 - Rheumatoid Arthritis
 - Psoriatic Arthritis
 - Polyarticular Juvenile Idiopathic Arthritis
 - Crohn's Disease
 - Ankylosing Spondylitis
 - Psoriasis

PDL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a three-month trial of at least two medications not requiring prior approval

ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
CIMZIA [®] syringe (certolizumab pegol)	SIMPONI [™] pen (golimumab) SIMPONI [™] syringe (golimumab)
ENBREL [®] kit (etanercept)	
ENBREL SURECLIK [®] syringe (etanercept)	
ENBREL [®] syringe (etanercept)	
HUMIRA [®] pen (adalimumab)	
HUMIRA [®] starter packs (adalimumab)	
HUMIRA [®] syringe (adalimumab)	

ANTI-INFLAMMATORY INTERLEUKIN-1 RECEPTOR ANTAGONIST

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
KINERET [®] syringe (anakinra)	

Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills for acute infection. Refills for up to 14 days may be authorized for patients undergoing surgery.

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication.
 - Note diagnosis and any culture and sensitivity reports

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a three-day trial of at least two medications not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

Document clinically compelling information

OPHTHALMIC AGENTS: ANTIBACTERIAL - QUINOLONES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CILOXAN [®] ointment (ciprofloxacin)	BESIVANCE [®] drops (besifloxacin)
CIPROFLOXACIN drops (generic of Ciloxan [®])	IQUIX [®] drops (levofloxacin)
MOXEZA [®] drops (moxifloxacin)	LEVOFLOXACIN drops (generic of Quixin [®])
OFLOXACIN drops (generic of Ocuflax [®])	ZYMAR [®] drops (gatifloxacin)
VIGAMOX [®] drops (moxifloxacin)	ZYMAXID [®] drops (gatifloxacin)

OPHTHALMIC AGENTS: ANTIBACTERIAL – NON-QUINOLONE

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BACITRACIN ointment	AZASITE [®] drops (azithromycin)
BACITRACIN-POLYMYXIN ointment	
ERYTHROMYCIN ointment	
GENTAMICIN drops	
GENTAMICIN ointment	
NEOMYCIN/POLYMYXIN/BACITRACIN ointment	
NEOMYCIN/POLYMYXIN/GRAMICIDIN drops (generic of Neosporin [®])	
POLYMYXIN/TRIMETHOPRIM drops (generic of Polytrim [®])	
TOBRAMYCIN drops (generic of Tobrex [®])	
TOBREX [®] ointment (tobramycin)	

OPHTHALMIC AGENTS: ANTIBACTERIAL – STEROID COMBINATIONS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
BLEPHAMIDE [®] drops (prednisolone/sulfacetamide)	TOBRADEX ST [®] (dexamethasone/tobramycin)
BLEPHAMIDE [®] ointment (prednisolone/sulfacetamide)	TOBRAMYCIN/DEXAMETHASONE drops (generic
NEOMYCIN/POLYMYXIN/BACITRACIN/HYDROC	of TobraDex [®])
ORTISONE ointment	
NEOMYCIN/POLYMYXIN/DEXAMETHASONE	
drops (generic of Maxitrol [®])	
NEOMYCIN/POLYMYXIN/DEXAMETHASONE	
ointment (generic of Maxitrol [®])	
NEOMYCIN/POLYMYXIN/HYDROCORTISONE	
drops (generic of Cortisporin [®])	
POLY-PRED [®] drops	
PRED-G [®] drops (prednisolone/gentamicin)	
PRED-G [®] ointment (prednisolone/gentamicin)	
TOBRADEX [®] drops (dexamethasone/tobramycin)	
TOBRADEX [®] ointment (dexamethasone/tobramycin)	
ZYLET [®] drops (tobramycin/loteprednol)	

Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindications to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Patient must have a therapeutic failure to at least one of the preferred agents.

Document clinically compelling information

OPHTHALMIC AGENTS: ANTIHISTAMINES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	ALAMAST [®] (pemirolast) ALOCRIL [®] (nedocromil) ALOMIDE [®] (lodoxamide)

OPHTHALMIC AGENTS: ANTIHISTAMINE/MAST CELL STABILIZERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ALAWAY [®] (ketotifen) BEPREVE [®] (bepotastine) KETOTIFEN (generic of Alaway [®] , Zaditor [®]) OPTIVAR [®] (azelastine) PATADAY [™] (olopatadine) PATANOL [®] (olopatadine) ZADITOR [®] OTC (ketotifen)	AZELASTINE (generic of Optivar [®]) EPINASTINE (generic of Elestat [®]) EMADINE [®] (emedastine) LASTACAFT [®] (alcaftadine)

Ophthalmic Agents: Glaucoma Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindications to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a one-month trial of at least one medication within the same class not requiring prior approval.

Document clinically compelling information

OPHTHALMIC AGENTS: GLAUCOMA AGENTS – BETA BLOCKERS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
BETAXOLOL BETIMOL [®] (timolol) CARTEOLOL LEVOBUNOLOL (generic of Betagan [®]) METIPRANOLOL (generic of Optipranolol [®]) TIMOLOL gel solution (generic of Timoptic-XE [®]) TIMOLOL solution (generic of Timoptic [®])	BETOPTIC [®] S (betaxolol) ISTALOL [™] (timolol)

OPHTHALMIC AGENTS: GLAUCOMA AGENTS – PROSTAGLANDIN INHIBITORS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
LATANAPROST (generic of Xalatan [®])	LUMIGAN [™] (bimatoprost) TRAVATAN [®] Z (travoprost)

OPHTHALMIC AGENTS: GLAUCOMA AGENTS – ALPHA ADRENERGIC AGONISTS/SYMPATHOMIMETICS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ALPHAGAN [®] P (brimonidine) BRIMONIDINE	APRACLONIDINE (generic of Iopidine [®])

OPHTHALMIC AGENTS: GLAUCOMA AGENTS – CARBONIC ANHYDRASE INHIBITORS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
AZOPT [®] (brinzolamide) TRUSOPT [®] (dorzolamide)	DORZOLAMIDE (generic of Trusopt [®])

OPHTHALMIC AGENTS: GLAUCOMA AGENTS – COMBINATION BETA BLOCKER AND ALPHA ADRENERGIC AGONIST

NO PA REQUIRED “PREFERRED”	PA REQUIRED
COMBIGAN [®] (Brimonidine/Timolol)	

**OPHTHALMIC AGENTS: GLAUCOMA AGENTS – COMBINATION BETA
BLOCKER AND CARBONIC ANHYDRASE INHIBITORS**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
COSOPT [®] (Dorzolamide/Timolol)	DORZOLAMIDE/TIMOLOL (generic of Cosopt [®])

Ophthalmic Agents: NSAIDs

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills for acute use. Refills for up to 14 days may be authorized for patients undergoing surgery.

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a three-day trial of at least one medication not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

OPHTHALMIC NSAIDs

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BROMDAY [®] (bromfenac)	ACUVAIL [®] (ketorolac)
DICLOFENAC (generic of Voltaren [®])	BROMFENAC (generic of Xibrom [®])
FLURBIPROFEN (generic of Ocufen [®])	NEVANAC [®] (nepafenac)
KETOROLAC (generic of Acular [®] , Acular LS [®])	

Otic Agents: Antibacterial and Antibacterial/Steroid Combinations

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills for acute infection.

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication.
 - Note diagnosis and any culture and sensitivity reports

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a one-week trial of at least one medication not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

Document clinically compelling information

OTIC AGENTS: ANTIBACTERIAL – STERIOD COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CIPRODEX [®] suspension (ciprofloxacin with dexamethasone)	CIPRO HC [®] suspension (ciprofloxacin with hydrocortisone)
NEOMYCIN-POLYMYXIN B WITH HYDROCORTISONE solution (generic of Cortisporin [®] solution)	COLY-MYCIN-S [®] suspension (neomycin and colistin with hydrocortisone)
NEOMYCIN-POLYMYXIN B WITH HYDROCORTISONE suspension (generic of Cortisporin [®] suspension)	CORTISPORIN-TC [®] suspension (neomycin and colistin with hydrocortisone)
	PEDIOTIC [®] suspension (neomycin and polymyxin B with hydrocortisone)

OTIC AGENTS: ANTIBACTERIAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
OFLOXACIN drops (generic of Floxin Otic [®])	CETRAXAL [®] solution (ciprofloxacin)
	FLOXIN [®] singles (ofloxacin)

Respiratory Agents: Antihistamines – Second Generation

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there have been therapeutic failures after courses of treatment (e.g., one month for allergic rhinitis) with medication not requiring prior approval, then may approve the requested medication.

ADDITIONAL INFORMATION

- Fexofenadine is indicated for patients 6 years of age and older
- Loratadine is indicated for patients 2 years of age and older
- Clarinex[®] and cetirizine are indicated for patients 6 months of age and older

Document clinically compelling information

RESPIRATORY AGENTS: ANTIHISTAMINES: SECOND GENERATION

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CETIRIZINE chewable (generic of Zyrtec [®]) (no PA required for age 6 or under)	ALAVERT [®] rapid dissolve (loratadine)
CETIRIZINE syrup (generic of Zyrtec [®]) (no PA required for age 6 or under)	ALAVERT [®] tablets (loratadine)
CETIRIZINE tablets (generic of Zyrtec [®])	ALLEGRA [®] ODT (fexofenadrine)
LORATADINE rapid dissolve (generic of Claritin [®] Reditabs)	ALLEGRA [®] suspension (fexofenadrine)
LORATADINE syrup (generic of Claritin [®] Syrup)	CETIRIZINE chewable (generic of Zyrtec [®]) (PA required for over age 6)
LORATADINE tablets (generic of Claritin [®])	CETIRIZINE syrup (generic of Zyrtec [®]) (PA required for over age 6)
	CLARINEX REDI-TABS [®] (desloratadine)
	CLARINEX [®] tablets (desloratadine)
	CLARINEX [®] syrup (desloratadine)
	CLARITIN REDITABS [®] 5mg (loratadine)
	CLARITIN [®] chewable (loratadine)
	FEXOFENADINE (generic of Allegra [®])
	LEVOCETIRIZINE (generic of Xyzal [®])
	XYZAL solution (levocetirizine)

RESPIRATORY AGENTS: ANTIHISTAMINE/DECONGESTANT COMBO: SECOND GENERATION

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CETIRIZINE/PSEUDOEPHEDRINE (generic of Zyrtec- D [®])	ALAVERT D-12HR [®] (loratadine/pseudoephedrine)
LORATADINE-D (generic of Claritin-D [®])	ALLEGRA-D 24 HOUR [®] (fexofenadrine/pseudoephedrine)
	CLARINEX-D 12, 24 HOUR [®] (desloratadine/pseudoephedrine)
	FEXOFENADINE/PSEUDOEPHEDRINE (generic of Allegra-D 12 Hour [®])

Respiratory Agents: Beta-Adrenergic Agonists – Inhaled, Short Acting

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a two-week trial of at least one medication not requiring prior approval within the same class and formulation. (i.e., nebulizers for nebulizers).

Document clinically compelling information

RESPIRATORY AGENTS: BETA-ADRENERGIC, SHORT-ACTING Metered Dose Inhalers or Other Devices

NO PA REQUIRED “PREFERRED”	PA REQUIRED
PROAIR [®] HFA (albuterol) PROVENTIL HFA [®] (albuterol) VENTOLIN HFA [®] (albuterol)	MAXAIR AUTOHALER [®] (pirbuterol) XOPENEX HFA [®] (levalbuterol)

RESPIRATORY AGENTS: BETA-ADRENERGIC, SHORT-ACTING NEBULIZERS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ACCUNEB [®] (Albuterol – pediatric dosing of premixed nebs) (no PA required for ages 12 and under) ALBUTEROL 0.42mg/ml, 0.63mg/ml (generic of Accuneb [®]) (no PA required for ages 12 and under) ALBUTEROL (generic of Proventil [®] , Ventolin [®]) 0.083% Premixed nebulizers, 0.5% Concentrated Solution)	ACCUNEB [®] (Albuterol – pediatric dosing of premixed nebs) (PA required for over age 12) ALBUTEROL 0.42mg/ml, 0.63mg/ml (generic of Accuneb [®]) (PA required for over age 12) LEVALBUTEROL (generic of Xopenex [®]) XOPENEX [®] (levalbuterol)

Respiratory Agents: Beta-Adrenergic Agonists – Inhaled, Long Acting

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a two-week trial of at least one medication not requiring prior approval within the same class and formulation. (i.e., nebulizers for nebulizers).

Document clinically compelling information

Step therapy required for all long-acting beta agonists and combinations:

Criteria	Approval Length
>= 3 claims for LABA (formoterol or salmeterol alone or in combination with steroid) in previous 6 months	6 months
>= 1 claim for anticholinergic (ipratropium, tiotropium, ipratropium/albuterol) in previous 6 months	12 months
>= 3 claims for inhaled corticosteroid (beclomethasone, budesonide, flunisolide, fluticasone, mometasone, triamcinolone) in previous 12 months	6 months
>= 3 claims for leukotriene modifier (montelukast, zafirlukast, zileuton) in previous 12 months	6 months
>= 3 claims for theophylline in previous 12 months	6 months
>= 3 claims for oral corticosteroid in previous 4 months	6 months
Diagnosis is COPD or exercise-induced bronchospasm	12 months
Diagnosis is moderate persistent or severe persistent asthma, or partly controlled or uncontrolled asthma (see classification below)	6 months
Patient scored <= 19 on Asthma Control Test™	6 months

RESPIRATORY AGENTS: BETA-ADRENERGIC, LONG-ACTING INHALERS

STEP THERAPY REQUIRED “PREFERRED”	PA REQUIRED
FORADIL® (formoterol)	SEREVENT DISKUS® (salmeterol)

RESPIRATORY AGENTS: BETA-ADRENERGIC, LONG-ACTING NEBULIZER SOLUTION

STEP THERAPY REQUIRED “PREFERRED”	PA REQUIRED
	BROVANA™ (arformoterol) PERFOROMIST® (formoterol)

RESPIRATORY AGENTS: BETA-ADRENERGIC COMBINATIONS

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
ADVAIR DISKUS [®] and HFA (Salmeterol/Fluticasone) DULERA [®] (Formoterol/Mometasone) SYMBICORT [®] (Formoterol/Budesonide)	

Respiratory Agents: COPD Anticholinergic Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a two-week trial of at least one medication not requiring prior approval.

Document clinically compelling information

RESPIRATORY AGENTS: COPD ANTICHOLINERGICS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ATROVENT HFA [®] (ipratropium) COMBIVENT MDI [®] (ipratropium/albuterol) IPRATROPIUM nebulizer solution IPRATROPIUM/ALBUTEROL nebulizer solution (generic of Duoneb [®]) SPIRIVA [®] (tiotropium)	

Respiratory Agents: Glucocorticoid Agents – Inhaled

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
 - Patient’s condition is clinically unstable--patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days--changing to a medication not requiring prior approval might cause deterioration of the patient’s condition.
2. If there have been therapeutic failures to no less than one-month trials of at least two medications not requiring prior approval, then may approve the requested medication.

Document clinically compelling information

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. If a medication requiring prior approval was initiated in the hospital, may approve the requested medication. Document details.
2. If the patient is a child under 13 years old or a patient with a significant disability, and unable to use an inhaler which does not require prior approval, or is non-compliant on an inhaler not requiring prior approval because of taste, dry mouth, infection; then may approve the requested medication. Document details.

RESPIRATORY AGENTS: GLUCOCORTICOIDS – Inhaled

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ASMANEX [®] (mometasone) FLOVENT DISKUS [®] and HFA (fluticasone) QVAR [®] (beclomethasone)	ALVESCO [®] (ciclesonide) PULMICORT FLEXHALER [®] (budesonide)

RESPIRATORY AGENTS: GLUCOCORTICOIDS – Nebulizers *

NO PA REQUIRED “PREFERRED”	PA REQUIRED
PULMICORT [®] nebulizer solution (no PA required for age 8 or under) (budesonide)	BUDESONIDE nebulizer solution (generic of Pulmicort [®]) PULMICORT [®] nebulizer solution (PA required for over age 8) (budesonide)

*Patients on current regimens will be grandfathered.

Respiratory Agents: Leukotriene Receptor Modifiers and Inhibitors

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there has been a therapeutic failure to the agent not requiring prior approval, then may approve the requested medication.

Document clinically compelling information

RESPIRATORY AGENTS: LEUKOTRIENE RECEPTOR ANTAGONISTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACCOLATE® (zafirlukast)	ZYFLO® (zileuton)
SINGULAIR® CHEWABLE TABLETS (montelukast)	ZYFLO CR® (zileuton)
SINGULAIR® ORAL GRANULES (montelukast)	
SINGULAIR® TABLETS (montelukast)	
ZAFIRLUKAST (generic of Accolate®)	

Respiratory Agents: Nasal Preparations

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there have been therapeutic failures to no less than one-month trials of at least two medications not requiring prior approval, then may approve the requested medication.

Document clinically compelling information

RESPIRATORY AGENTS: NASAL PREPARATIONS - GLUCOCORTICOIDS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
FLUNISOLIDE FLUTICASONONE (generic of Flonase®) NASACORT® AQ (triamcinolone)	BECONASE® AQ (beclomethasone) NASONEX® (mometasone) OMNARIS® (ciclesonide) RHINOCORT AQUA® (budesonide) VERAMYST™ (fluticasone furoate)

RESPIRATORY AGENTS: NASAL PREPARATIONS - ANTIHISTAMINES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ASTELIN® (azelastine) ASTEPRO® (azelastine) PATANASE® (olopatadine)	AZELASTINE (generic of Astelin®)

RESPIRATORY AGENTS: NASAL PREPARATIONS - ANTICHOLINERGICS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
IPRATROPIUM (generic of Atrovent®)	

Topical Agents: Acne Preparations

LENGTH OF AUTHORIZATIONS: 1 year

CLINICAL CRITERIA:

All topical retinoids require prior authorization for patients over age 23:

- Patient diagnosis psoriasis – may approve tazarotene (Tazorac[®])
- Patient diagnosis acne vulgaris – may approve retinoid if the patient has a history of at least 30 days of therapy with alternative therapy (benzoyl peroxide, sodium sulfacetamide or antibiotic) in the previous 90 days
- Patient diagnosis skin cancer – may approve retinoid

PDL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a one-month trial of at least one medication in the same class not requiring prior approval

TOPICAL AGENTS: ACNE PREPARATIONS – ANTIBIOTIC PRODUCTS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CLINDAMYCIN gel (generic of Cleocin T [®] , Clindamax [®]) CLINDAMYCIN lotion (generic of Cleocin T [®] , Clindamax [®]) CLINDAMYCIN solution (generic of Cleocin T [®]) ERYTHROMYCIN gel ERYTHROMYCIN solution (generic of A/T/S [®] , Akne-Mycin [®])	AKNE-MYCIN [®] ointment (erythromycin) CLINDAGEL [®] (clindamycin) CLINDAMYCIN foam (generic of Evoclin [®]) CLINDAMYCIN pledgets (generic of Cleocin T [®]) ERY PADS [®] (erythromycin)

TOPICAL AGENTS: ACNE PREPARATIONS – OTHER PRODUCTS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
	ACZONE [®] gel (dapsone) AZELEX [®] cream (azelaic acid) FINACEA [®] gel (azelaic acid) FINACEA PLUS [®] kit (azelaic acid)

TOPICAL AGENTS: ACNE PREPARATIONS – BENZOYL PEROXIDE AND COMBINATION PRODUCTS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
BENZACLIN [®] gel (benzoyl peroxide and clindamycin)	ACANYA [®] (Clindamycin-Benzoyl Peroxide)
BENZOYL PEROXIDE cleanser (generic of Oscion [®] , Triaz [®])	BENZACLIN CAREKIT [®] (clindamycin/benzoyl peroxide)
BENZOYL PEROXIDE gel (generic of Benzac AC [®] , Benzagel [®] , Brevoxyl [®] , Desquam-X [®])	BENZAMYCINPAK [®] gel (benzoyl peroxide and erythromycin)
BENZOYL PEROXIDE lotion (generic of Zaclir [®])	BENZASHAVE [®] cream
BENZOYL PEROXIDE wash (generic of Benzac AC [®] , Benzac W [®] , Brevoxyl [®] , Desquam-X [®] , Pacnex [®])	BENZEFOAM [®]
ERYTHROMYCIN-BENZOYL PEROXIDE gel (generic of Benzamycin [®])	BENZOYL PEROXIDE Complete Pack (generic of Brevoxyl Complete Pack [®])
PANOXYL [®] 10% foam (benzoyl peroxide)	BENZOYL PEROXIDE MICROSPHERES cream, wash (generic of Neobenz Micro [®])
ZODERM [®] cream	BENZOYL PEROXIDE foaming cloths (generic of Triaz [®])
	BENZOYL PEROXIDE pads (generic of Oscion [®] , Triaz [®])
	BENZOYL PEROXIDE-ALOE VERA gel (generic of Benziq [®] gel)
	BENZOYL PEROXIDE-ALOE VERA wash (generic of Benziq [®] wash)
	BENZOYL PEROXIDE-SULFUR gel (generic of Nuox [®] gel)
	BENZOYL PEROXIDE-UREA cleanser (generic of Zoderm [®])
	BENZOYL PEROXIDE-UREA cream (generic of Zoderm [®])
	BENZOYL PEROXIDE-UREA gel (generic of Zoderm [®])
	BENZOYL PEROXIDE-UREA pads (generic of Zoderm [®] redi-pads)
	BENZOYL PEROXIDE-UREA wash (generic of Zoderm [®] hydrating wash)
	CLINDAMYCIN-BENZOYL PEROXIDE gel (generic of Benzacilin [®])
	DUAC CS [®] kit (benzoyl peroxide and clindamycin)
	DUAC [®] gel (benzoyl peroxide and clindamycin)
	INOVA EASY PAD [®]
	PACNEX HP [®]
	PACNEX LP [®]

TOPICAL AGENTS: ACNE PREPARATIONS – RETINOID AND COMBINATION PRODUCTS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
RETIN-A MICRO [®] gel (tretinoin)	ADAPALENE cream, gel (generic of Differin [®])
RETIN-A [®] cream (tretinoin)	ATRALIN [®] gel (tretinoin)
RETIN-A [®] gel (tretinoin)	DIFFERIN [®] gel (adapalene)
TAZORAC [®] cream (tazarotene)	DIFFERIN [®] lotion (adapalene)
TAZORAC [®] gel (tazarotene)	EPIDUO [®] gel (adapalene/benzoyl peroxide)
	TRETINOIN cream (generic of Retin-A [®])
	TRETINOIN gel (generic of Retin-A [®])
	VELTIN [®] gel (clindamycin/tretinoin)
	ZIANA [®] gel (clindamycin/tretinoin)

TOPICAL AGENTS: ACNE PREPARATIONS – SODIUM SULFACETAMIDE AND COMBINATION PRODUCTS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
<p>KLARON[®] lotion (sulfacetamide) SODIUM SULFACETAMIDE-SULFUR lotion (generic of Novacet[®], Sulfacet-R[®]) SODIUM SULFACETAMIDE-SULFUR suspension (generic of Plexion[®] TS) SODIUM SULFACETAMIDE-SULFUR wash (generic of Avar[®] cleanser, Clenia[®] foaming wash, Plexion[®] cleanser, Rosac[®] wash)</p>	<p>AVAR[®] gel (sodium sulfacetamide-sulfur) CLARIFOAM EF[®] emollient foam OVACE PLUS[®] cream (sodium sulfacetamide) OVACE PLUS[®] wash (sodium sulfacetamide) OVACE[®] foam (sodium sulfacetamide) ROSULA[®] foam (sodium sulfacetamide/sulfur) SODIUM SULFACETAMIDE cream (generic of Ovace[®]) SODIUM SULFACETAMIDE gel (generic of Ovace[®]) SODIUM SULFACETAMIDE lotion (generic of Klaron[®]) SODIUM SULFACETAMIDE wash (generic of Ovace[®]) SODIUM SULFACETAMIDE-SULFUR cleanser kit SODIUM SULFACETAMIDE-SULFUR cream (generic of Avar-E[®]) SODIUM SULFACETAMIDE-SULFUR pads (generic of Plexion[®] cleansing cloths) SODIUM SULFACETAMIDE-SULFUR-AVOBENZONE cream (generic of Rosac[®] cream) SODIUM SULFACETAMIDE-SULFUR-UREA cleanser (generic of Rosula[®] cleanser) SODIUM SULFACETAMIDE-SULFUR-UREA gel (generic of Rosula[®] aqueous gel) SODIUM SULFACETAMIDE-SULFUR-UREA wash (generic of Rosula[®] clarifying wash) SODIUM SULFACETAMIDE-SULFUR-UREA WITH SUNSCREEN kit (generic of Rosula[®] CLK) SODIUM SULFACETAMIDE-SULFUR-WITCH HAZEL cream (generic of Plexion[®] SCT cream) SODIUM SULFACETAMIDE-UREA pads (generic of Rosula[®] NS medicated pads) SUMAXIN TS[®]</p>

Topical Agents: Anti-Fungals

LENGTH OF AUTHORIZATIONS: Duration of the prescription (up to 6 months)

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to at least two medications not requiring prior approval
 - Contraindication to all medications not requiring prior approval
 - History of unacceptable/toxic side effects to at least two medications not requiring prior approval
2. Is the infection caused or presumed to be caused by an organism resistant to medications not requiring prior approval? If so, document (including diagnosis and location) and approve the requested drug.
3. Has the patient failed therapeutic trials of two weeks with two medications not requiring prior approval? If so, document and approve the requested medication.

Document clinically compelling information

TOPICAL AGENTS: ANTI-FUNGALS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CICLOPIROX cream, topical suspension, shampoo (generic of Loprox [®]) CLOTRIMAZOLE (generic of Lotrimin [®]) CLOTRIMAZOLE/BETAMETHASONE (generic of Lotrisone [®]) ECONAZOLE (generic of Spectazole [®]) KETOCONAZOLE Cream & Shampoo (generic of Kuric [®] , Nizoral [®]) LOPROX [®] gel (ciclopirox) MICONAZOLE NYSTATIN NYSTATIN W/TRIAMCINOLONE TERBINAFINE (generic of Lamisil [®]) TOLNAFTATE (generic of Tinactin [®])	CICLOPIROX gel (generic of Loprox [®]) ERTACZO [®] (sertaconazole) EXELDERM [®] (sulconazole) EXTINA [®] foam (ketoconazole) MENTAX [®] (butenafine) NAFTIN [®] (naftifine) OXISTAT [®] (oxiconazole) PEDI-DRI [®] powder (nystatin) PEDIADERM AF [®] cream (nystatin) VUSION [®] ointment (miconazole/zinc) XOLEGEL [™] (ketoconazole)

Topical Agents: Anti-Parasitics

LENGTH OF AUTHORIZATIONS: 2 weeks

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a one-month trial of at least one medication not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

ANTI-PARASITICS, TREATMENT OF SCABIES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
PERMETHRIN cream (generic of Elimate [®])	EURAX [®] cream, lotion (crotamiton) LINDANE lotion

ANTI-PARASITICS, TREATMENT OF LICE

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LICE kit [piperonyl butoxide-pyrethrins shampoo, comb, permethrin home spray] (generic of Rid [®] complete kit) NATROBA [®] (spinosad) OVIDE [®] lotion (malathion) PERMETHRIN lotion (generic of Nix [®] cream rinse) PIPERONYL BUTOXIDE-PYRETHRINS lotion PIPERONYL BUTOXIDE-PYRETHRINS shampoo (generic of Rid [®] shampoo)	LINDANE shampoo MALATHION lotion (generic of Ovide [®]) ULESFIA [®] lotion (benzyl alcohol)

Topical Agents: Immunomodulators

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there has been a therapeutic failure to an agent not requiring prior approval, then may approve the requested medication.

Document clinically compelling information

CLINICAL INFORMATION

- Indicated for short-term and intermittent long-term treatment of atopic dermatitis if:
 - Alternative, conventional therapies (such as topical corticosteroids) are deemed inadvisable because of potential risks, or
 - There has been inadequate response or intolerance to alternative, conventional therapies (such as topical corticosteroids)
- Elidel[®] and Protopic[®] 0.03% are indicated in patients 2 years old or older. Protopic[®] 0.1% is indicated in adults only

TOPICAL IMMUNOMODULATORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ELIDEL [®] * (pimecrolimus) PROTOPIC [®] * (tacrolimus)	

* Elidel[®] & Protopic[®] have age restriction of 2 years or older

Topical Agents: Pleuromutilin Derivatives

LENGTH OF AUTHORIZATIONS: for the date of service only. Approval should be for 5g or 10g tube size; 15g or 30g tube may only be approved for large areas of infection (>100cm²).

Is there any reason the patient cannot be changed to a medication not requiring prior approval?
Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Note: alternative therapy may be oral or topical antibiotic therapy

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a [length of trial to be discussed] trial of at least [number of medications to be discussed] medications not requiring prior approval

PLEUROMUTILIN DERIVATIVES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	ALTABAX [®] (retapamulin)

Topical Agents: Post-Herpetic Neuralgia

LENGTH OF AUTHORIZATIONS: 3 months

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a one-month trial of at least two oral medications used for post-herpetic neuralgia.

POST-HERPETIC NEURALGIA, TOPICAL AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	LIDODERM® (lidocaine)