Office of Vermont Health Access
Pharmacy Benefit Management Program

VERMONT
PREFERRED DRUG LIST
and
DRUGS REQUIRING PRIOR AUTHORIZATION

Clinical Criteria Manual

July 1, 2008

Preferred Drug List and Drugs Requiring Prior Authorization

> The Commissioner for Office of Vermont Health Access shall establish a pharmacy best practices and cost control program designed to reduce the cost of providing prescription drugs, while maintaining high quality in prescription drug therapies. The program shall include:
>
> > "A preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic alternatives"
>
> From Act 127 passed in 2002

The following pages contain:

1. The therapeutic classes of drugs subject to the Preferred Drug List, the drugs within those categories and the criteria required for Prior Authorization (P.A.) of non-preferred drugs in those categories.
2. The therapeutic classes of drugs which have Clinical Criteria for Prior Authorization may or may not be subject to a preferred agent.
3. Within both of these categories there may be drugs or even drug classes that are subject to Quantity Limit Parameters.

Therapeutic class criteria are listed alphabetically. Within each category the Preferred Drugs are noted in the left-hand columns. Representative non-preferred agents have been included and are listed in the right-hand columns. Any drug not listed as preferred in any of the included categories requires Prior Authorization.

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Acne Drugs: Oral

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Brand name minocycline products:

- The patient has had a documented side effect, allergy, or treatment failure with generic minocycline. If a product has an AB rated generic, the trial must be the generic formulation.

Brand name doxycycline products (see below for Oracea®, Adoxa® and doxycycline monohydrate Pak):

- The patient has had a documented side effect, allergy, or treatment failure with generic doxycycline. If a product has an AB rated generic, the trial must be the generic formulation.

Oracea®:

- The patient has a diagnosis of Rosacea.

AND

- The patient has had a documented side effect, allergy, or treatment failure with doxycycline, minocycline, and tetracycline.

Adoxa® and doxycycline monohydrate Pak:

- The prescriber provides clinically compelling rationale for the specialty packaging.

Brand name erythromcyin products:

- The patient has had a documented side effect, allergy, or treatment failure with generic erythromycin. If a product has an AB rated generic, the trial must be the generic formulation.

Brand name tetracycline products:

- The patient has had a documented side effect, allergy, or treatment failure with generic tetracycline. If a product has an AB rated generic, the trial must be the generic formulation.

Accutane®:

- The patient has had a documented side effect, allergy, or treatment failure with generic isotretinoin (Sotret®, Claravis®, and Amnesteem®).

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Acne Drugs: Oral

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
DOXYCYCLINE† 20mg, 50mg, 75mg, 100mg tab, cap	Adoxa® (doxycycline monohydrate) 50 mg, 75 mg, 100 mg, 150mg tab Adoxa Pak® (doxycycline monohydrate) 1/75 mg, 1/100 mg, 1/150 mg, 2/100 mg Doryx®* (doxycycline hyclate) 75 mg, 100 mg tab doxycycline monohydrate pak (compare to Adoxa Pak®) 1/75 mg, 1/100 mg, 1/150 mg, 2/100 mg Monodox®* (doxycycline monohydrate) 50 mg, 100 mg cap Oracea® (doxycycline monohydrate) 40 mg cap Periostat®* (doxycycline hyclate) 20 mg Vibramycin®* (doxycycline hyclate) 50 mg, 100 mg cap Vibramycin® (doxycycline hyclate) suspension Vibratab®* (doxycycline hyclate) 100 mg tab All other brands
ERY-TAB® (erythromycin base, delayed release) ERYTHROCIN† (erythromycin stearate) ERYTHROMYCIN BASE† ERYTHROMYCIN ESTOLATE† ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S.®, Eryped®) ERYTHROMYCIN STEARATE†	E.E.S.®* (erythromycin ethylsuccinate) Eryc®* (erythromycin base, delayed release) Eryped® (erythromycin ethylsuccinate) PCE Dispertab® (erythromycin base) All other brands
MINOCYCLINE† 50 mg, 75 mg, 100 mg	Minocin®* (minocycline) 50 mg, 75 mg, 100 mg cap Dynacin®* (minocycline) 50 mg, 75 mg, 100 mg cap/tab Solodyn® (minocycline) 45 mg, 90 mg, 135 mg tabs All other brands
TETRACYCLINE† 250 mg, 500 mg cap SUMYCIN† 250 mg, 500 mg cap	Sumycin® (tetracycline) 250 mg, 500 mg tab Sumycin® (tetracycline) 125 mg/5ml syrup All other brands
ISOTRETINOIN† 10 mg, 20 mg, 40 mg cap (SOTRET, CLARAVIS, AMNESTEEM)	Accutane®* (isotretinoin) 10 mg, 20 mg, 40 mg cap All other brands

Acne Drugs: Topical-Anti-infectives

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Brand name single ingredient and combination products:

- The patient has had a documented side effect, allergy, or treatment failure with generic benzoyl peroxide, clindamycin, erythromycin, erythromycin/benzoyl peroxide, sodium sulfacetamide, sodium sulfacetamide/sulfur, and other topical anti-infective acne medications as applicable.

Azelex®

- The diagnosis or indication is acne or rosacea.

AND

- The patient has had a documented side effect, allergy, or treatment failure with two generic topical anti-infective agents (benzoyl peroxide, clindamycin, erythromycin, erythromycin/benzoyl peroxide, sodium sulfacetamide, sodium sulfacetamide/sulfur etc).

LIMITATIONS:

Kits with non-drug products are not covered.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Acne Drugs: Topical Anti-Infectives

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
BENZOYL PEROXIDE PRODUCTS	
BENZOYL PEROXIDE 2.5%, 5%, 10% *G, L, W*; 10% *C*; 3%, 5%, 6%, 8%, 9%, 10% *L*; 3%, 6%, 9% *P* †	Benzac AC® 2.5%, 5%, 10% *G, W* Benzashave® 5%, 10% *C* Brevoxyl® 4%, 8% W; 4%G; 4%, 8% *L* Clinac BPO® 7% *G* Desquam-E/X® 2.5%, 5%, 10% G; 5%, 10% *W* Inova 4% *P* Panoxyl/AQ 2.5%, 5%, 10% *G*; 5%, 10% *B* Triaz® 3%, 6%, 9% *G*; 3%, 6%, 9% *P* Zaclir®4%, 8% *L* All other brands
CLINDAMYCIN PRODUCTS	
CLINDAMYCIN 1% *S, G, L, P* †	Cleocin-T®* (clindamycin 2% *G*) Evoclin® (clindamycin 2% *F*) Clindagel® (clindamycin 1% *G*) All other brands
ERYTHROMYCIN PRODUCTS	
ERYTHROMYCIN 2% *S, G, P* †	Akne-Mycin® (erythromycin 2% *O*) Erygel®* (erythromycin 2% *G*) All other brands
SODIUM SULFACETAMIDE PRODUCTS	
SODIUM SULFACETAMIDE 10% *L* †	Klaron®* (sodium sulfacetamide 10% *L*) All other brands
COMBINATION PRODUCTS	
ERYTHROMYCIN / BENZOYL PEROXIDE†	Benzaclin®, DUAC® (clindamycin/benzoyl peroxide) Benzamycin®* (erythromycin/benzoyl peroxide) Sulfoxyl (erythromycin/benzoyl peroxide) Z-Clinz® (clindamycin/benzoyl peroxide kit) All other brands
SODIUM SULFACETAMIDE / SULFUR *L* † SODIUM SULFACETAMIDE / SULFUR *W* †	Avar® (sodium sulfacetamide/sulfur *G*) Plexion® (sulfacetamide/sulfur *S*) Rosac®* (sulfacetamide/sulfur *W*) Rosula®* (sulfacetamide/sulfur *W*) Sulfacet-R®* (sodium sulfacetamide/sulfur *L*) All other brands
OTHER	
	Azelex® (azelaic acid 20% *C*) All other brands any topical anti-infective acne medication

C=cream, E=emulsion, F=foam, G=gel, L=lotion, O=ointment, P=pads, S=solution, W=wash, B=bar

Acne Drugs: Topical - Retinoids

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Brand name tretinoin products:

- The diagnosis or indication is acne vulgaris, actinic keratosis, or rosacea.

  AND
- The patient has had a documented side effect, allergy, or treatment failure with a generic topical tretinoin product. If a product has an AB rated generic, the trial must be the generic formulation.

Differin (adapalene):

- The diagnosis or indication is acne vulgaris, actinic keratosis, or rosacea.

  AND
- The patient has had a documented side effect, allergy, or treatment failure with a generic topical tretinoin product.

Tretinoin (age <10 or >34):

- The diagnosis or indication is acne vulgaris, actinic keratosis, or rosacea.

LIMITATIONS:

Coverage of topical retinoid products will not be approved for cosmetic use (wrinkles, age spots, etc.).

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Acne Drugs: Topical - Retinoids

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
TRETINOIN† *(specific criteria required for ages <10 or >34)* 0.025%, 0.05%, 0.1% *C*; 0.01%, 0.025% *G* TAZORAC® (tazarotene) 0.05%, 0.1% *C, G*	All brand tretinoin products (Atralin® 0.05% *G*, Avita®*, Retin-A®*, Retin-A Micro® 0.1%, 0.04%, Tretin-X® etc.) Differin® (adapalene) 0.1% *C, G; 0.3% G* Avage® (tazarotene) ♣ Renova® (tretinoin) ♣ Solage® (tretinoin/mequinol) ♣ Tri-Luma® (tretinoin/hydroquinone/fluocinolone) ♣ *♣ Not indicated for acne. Coverage of topical retinoid products will not be approved for cosmetic use (wrinkles, age spots, etc.).*

C=cream, G=gel

Acne Drugs: Topical - Rosacea

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Brand name metronidazole products and Finacea:

- The diagnosis or indication is acne or rosacea.

AND

- The patient has had a documented side effect, allergy or treatment failure with a generic topical metronidazole product. If a product has an AB rated generic, the trial must be the generic formulation.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Acne Drugs: Topical – Rosacea

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
METRONIDAZOLE† 0.75% *C, G, L*	All brand metronidazole products (MetroCream®* 0.75% *C*, Metrogel®* 0.75% *G*, Metrogel® 1% *G*, MetroLotion®* 0.75% *L*, Noritate® 1% *C*, Rozex® 0.75% *G* etc.) Finacea® (azelaic acid) 15% *G*

C=cream, G=gel, L=lotion

Alzheimer's: Cholinesterase Inhibitors/NMDA Receptor Antagonists

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Cognex Capsule, Razadyne Tablet, Razadyne ER Capsule:

- The diagnosis or indication for the requested medication is Alzheimer's disease.

AND

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient had a documented side effect, allergy or treatment failure to Aricept and Exelon.

Razadyne Oral Solution:

- The diagnosis or indication for the requested medication is Alzheimer's disease.

AND

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient had a documented side effect, allergy or treatment failure to Exelon Oral Solution.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Alzheimer's: Cholinesterase Inhibitors/NMDA Receptor Antagonists

Length of Authorization: 1 year

Key: § Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS (No PA Required)	PA REQUIRED
CHOLINESTERASE INHIBITORS	
ARICEPT® (donepezil) Tablet *(QL = 1 tablet/day)*	Cognex® (tacrine) Capsule §
EXELON® (rivastigmine) Capsule *(QL = 2 capsules/day)*	Razadyne® (galantamine) Tablet §
	Razadyne ER® (galantamine) Capsule §
ARICEPT® ODT (donepezil) *(QL = 1 tablet/day)*	
EXELON® (rivastigmine) Oral Solution	Razadyne® (galantamine) Oral Solution §
EXELON® (rivastigmine transdermal) Patch *(QL = 1 patch/day)*	
NMDA RECEPTOR ANTAGONIST	
NAMENDA® (memantine) Tablet	
NAMENDA® (memantine) Oral Solution	

Analgesics: COX IIs and NSAIDs

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

PA required NSAIDs (see specific criteria for Celebrex, ketorolac oral, and Flector):

- The patient has had a documented side effect, allergy, or treatment failure to two or more preferred generic NSAIDS.

Celebrex: (Prior-authorization is not required for patients who are 60 years of age or older.)

- The patient does not have a history of a sulfonamide allergy.

AND

- The patient has had a documented side effect, allergy, or treatment failure to two or more preferred generic NSAIDS.

OR

- The patient has a contraindication to medications not requiring prior approval, including:
  - History of GI bleed
  - Patient is currently taking an anticoagulant (warfarin or heparin)
  - Patient is currently taking an oral corticosteroid
  - Patient is currently taking methotrexate

Ketorolac oral:

- The patient does not have an increased risk for renal insufficiency or GI bleed.

AND

- The patient has had a documented side effect, allergy, or treatment failure to two or more preferred generic NSAIDS.

AND

- The quantity requested does not exceed 20 doses for a 5 day supply every 30 days.

Flector Patch:

- The patient has a documented medical necessity for a transdermal formulation (ex. dysphagia, inability to take oral medications).

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Consider selectivity for cyclooxygenase-2 of the available nonsteroidal anti-inflammatory agents.
In order of most to least selective for COX-2: (preferred agents bold)

Diclofenac (Voltaren®) > Mefenamic acid (Ponstel®) > Meloxicam (Mobic®) > **Celecoxib** (Celebrex®) = **Etodolac** (Lodine®) > **Nambumetone** (Relafen®) > **Piroxicam** (Feldene®) > Ketorolac (Toradol®) > **Ibuprofen** (Motrin®, Advil®) > **Indomethacin** (Indocin®) > **Naproxen** (Naprosyn®, Aleve®) > **Oxaprozin** (Daypro®) > **Aspirin** > **Tolmetin** (Tolectin®) > **Fenoprofen** (Nalfon®) > **Ketoprofen** (Orudis®) > **Flurbiprofen** (Ansaid®)[1]

Analgesics: COX IIs AND NSAIDs

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

NSAIDs

PREFERRED DRUGS (No PA Required)	PA REQUIRED
ORAL	
DICLOFENAC POTASSIUM† (compare to Cataflam®)	Anaprox®*
DICLOFENAC SODIUM† (compare to Voltaren®)	Anaprox DS®*
DIFLUNISAL† (compare to Dolobid®)	Ansaid®*
ETODOLAC†	Arthrotec®
FENOPROFEN† (compare to Nalfon®)	Cataflam®*
FLURBIPROFEN† (compare to Ansaid®)	Clinoril®*
IBUPROFEN† (compare to Motrin®)	Daypro®*
INDOMETHACIN† (compare to Indocin®)	Dolobid®*
KETOPROFEN†	EC-Naprosyn®*
KETOPROFEN ER†	Feldene®*
MECLOFENAMATE SODIUM† (compare to Meclomen®)	Indocin®*
MELOXICAM† (compare to Mobic®)	Indocin SR®*
NABUMETONE†	ketorolac† *(QL = 20 doses post PA approval)*
NAPROXEN† (compare to Naprosyn®)	mefanamic acid† (compare to Ponstel®)
NAPROXEN SODIUM† (compare to Anaprox®, Naprelan®)	Mobic®*
OXAPROZIN† (compare to Daypro®)	Motrin®*
PIROXICAM† (compare to Feldene®)	Nalfon®*
SULINDAC† (compare to Clinoril®)	Naprelan®*
TOLMETIN SODIUM†	Naprosyn®*
	Ponstel®
	Voltaren®*
	Voltaren XR®*
INJECTABLE	
KETOROLAC † Injection *(QL = 1 dose per fill)*	
TOPICAL/TRANSDERMAL	
	Flector® (diclofenac) Patch *(QL = 2 patches/day)*

COX II Inhibitors

PREFERRED DRUGS (No PA Required)	PA REQUIRED
CELEBREX® (age ≥ 60 yrs) (Quantity limit all strengths = 2 capsules/day)	CELEBREX® (age < 60 yrs) (Quantity limit all strengths = 2 capsules/day)

[1] Feldman, McMahon in Ann Intern Med. 2000:132:134-143, Do Cyclooxygenase-2 Inhibitors Provide Benefits Similar to Those of Traditional Nonsteroidal Anti-Inflammatory Drugs, with Less Gastrointestinal Toxicity?

Analgesics: Local Anesthetics: Transdermal Patch

LENGTH OF AUTHORIZATION: 6 months

CRITERIA FOR APPROVAL:

LIDODERM®

- The diagnosis or indication is neuropathic pain/post-herpetic neuralgia.

  AND
- The patient has had a documented side effect, allergy, treatment failure or contraindication to TWO drugs in the tricyclic antidepressant (TCA) class and/or anticonvulsant class

  AND
- The patient has had a documented side effect, allergy, treatment failure or contraindication to Lyrica

  OR
- The patient has a medical necessity for a transdermal formulation (ex. dysphagia, inability to take oral medications)

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Analgesics: Local Anesthetics: Transdermal Patch *Length of Authorization: 6 months*	
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
	Lidoderm® Patch (lidocaine 5 %) *Quantity Limit = 3 patches/day*

Analgesics: Short Acting Narcotics

LENGTH OF AUTHORIZATION: initial approval 3 months, subsequent approval up to 6 months

CRITERIA FOR APPROVAL:

Butorphanol Nasal Spray

- The member has had a documented side effect, allergy, treatment failure, or contraindication to codeine, hydrocodone, morphine, and oxycodone (all 4 generic entities) as single or combination products.

OR

- The member is unable to use tablet or liquid formulations.

AND

- The quantity requested does not exceed 2 bottles/month.

Actiq®, fentanyl transmucosal, Fentora®

- Indication of cancer breakthrough pain (**no** approval for acute pain or postoperative pain)

AND

- Documentation that the patient is opioid tolerant (morphine ≥ 60 mg/day, transdermal fentanyl 50 mcg/hr, or an equianalgesic dose of another opioid for ≥ 1 week)

AND

- The member is on a long-acting opioid formulation

AND

- The member has had a documented treatment failure with or intolerance to 2 of the following 3 immediate –release breakthrough pain treatment options: morphine, hydromorphone or oxycodone.

OR

- The member is unable to use tablet or liquid formulations.

AND

- If the request is for brand name Actiq®, the member has a documented side effect, allergy, or treatment failure with generic fentanyl transmucosal.

Other Short-acting Narcotics

- The member has had a documented side effect, allergy, or treatment failure to at least two medications not requiring prior approval. (If a product has an AB rated generic, one trial must be the generic.)

LIMITATIONS:

Acetaminophen containing products: Daily doses that result in > 4 grams of acetaminophen/day will reject for Prior Authorization..

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on the **General Prior Authorization Request Form.**

Analgesics: Short Acting Narcotics

Length of Authorization: initial approval 3 months, subsequent approval up to 6 months

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (NO PA REQUIRED)	PA REQUIRED
ACETAMINOPHEN W/CODEINE† (compare to Tylenol w/codeine®)	Acetaminophen w/codeine: *all branded products*
ACETAMINOPHEN W/HYDROCODONE† (compare to Vicodin®, Lorcet®, Maxidone®, Norco®, Zydone®) *(QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)*	Acetaminophen w/hydrocodone: *all branded products (QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)*
ACETAMINOPHEN W/OXYCODONE† (compare to Percocet®) *(QL 10/650 = 6 tablets/day)*	Acetaminophen w/oxycodone: *all branded products (QL 10/650 = 6 tablets/day)*
ACETAMINOPHEN W/PROPOXYPHENE† (compare to Darvocet-N®) *(QL 100/650 = 6 tablets/day)*	Actiq® (fentanyl citrate transmucosal)
ASPIRIN W/CODEINE†	Anexsia®*
ASPIRIN W/OXYCODONE† (compare to Percodan®)	Bancap HC®
BUTALBITAL COMPOUND W/ CODEINE† (compare to Fiorinal® w/codeine)	Butorphanol Nasal Spray† (Qty Limit = 2 bottles/month)
CODEINE SULFATE†	Capital® w/codeine*
DIHYDROCODEINE COMPOUND† (compare to Synalgos-DC®)	Combunox®* (oxycodone w/ ibuprofen)
FIORTAL W/ CODEINE #3® (butalbital w/ codeine)	Darvocet-N®* *(QL 100/650 = 6 tablets/day)*
HYDROCODONE† (plain, w/acetaminophen or w/ibuprofen)	Darvon Compound®*
HYDROMORPHONE† (compare to Dilaudid®)	Darvon®*/ Darvon-N®*
MEPERIDINE† (compare to Demerol®) (Maximum 30 tabs or 5 day supply)	Dazidox®* (oxycodone)
MORPHINE SULFATE†	Demerol*
MORPHINE SULFATE SOLN† (compare to Roxanol®)	Dilaudid®*
OXYCODONE† (plain, w/acetaminophen or w/ibuprofen)	Endocet® (oxycodone w/ acetaminophen)
PENTAZOCINE† (compare to Talwin®)	Endodan® (oxycodone w/ aspirin)
PROPOXYPHENE† (compare to Darvon®)	fentanyl citrate transmucosal† (compare to Actiq®)
PROPOXYPHENE COMPOUND† (compare to Darvon Compound®)	Fentora® (fentanyl citrate buccal tablets)
PROPOXYPHENE N W/ ACETAMINOPHEN†	Fioricet® w/codeine*
ROXICET® (oxycodone w/ acetaminophen)	Liquicet® (hydrocodone w/ acetaminophen)
ROXICODONE INTENSOL® (oxycodone)	Lorcet®* (also HD, PLUS)
ROXICODONE® (oxycodone HCL)	Lortab®*
TRAMADOL† (compare to Ultram®)	Magnacet®
TRAMADOL/APAP† (compare to Ultracet®)	Maxidone®*
	Meperidine (Qty > 30 tabs or 5 day supply)
	Nalbuphine
	Norco®*
	Nubain®*
	Numorphan®
	Opana®
	Oxyfast®*
	OxyIR®*
	Panlor DC®
	Pentazocine and Naloxone
	Percocet®*
	Percodan®*
Note: Acetaminophen containing products: (Preferred and PA Required)	Propoxyphene: *all branded products**
Maximum daily dose acetaminophen = 4 grams	Roxanol®*
	Synalgos DC®*
	Talacen®*
	Talwin®* and branded combinations/ Talwin NX®*
	Trezix®
	Tylenol® #3*,#4*
	Tylox®*
	Ultracet®
	Ultram®*/Ultram ER®
	Vicodin®*
	Vicoprofen®*
	Wygesic®*
	Xodol®
	Zydone®*

Analgesics: Long Acting Narcotics

LENGTH OF AUTHORIZATION: initial approval 3 months, subsequent approval up to 6 months

PHARMACOLOGY/INDICATION:

Long acting narcotics are potent medications. They are indicated for the management of moderate to severe pain in adults when a continuous, around-the-clock analgesic is needed for an extended period of time.

CLINICAL CONSIDERATIONS:

- Long acting narcotic dosage forms are intended for use in opioid tolerant patients only. These tablet/capsule/topical medication strengths may cause fatal respiratory depression when administered to patients not previously exposed to opioids.
- Long acting narcotics should be prescribed for patients with a diagnosis or condition that requires a continuous, around-the-clock analgesic.
- Long acting narcotics are NOT intended for use as a 'prn' analgesic.
- Long acting narcotics are NOT indicated for pain in the immediate post-operative period (the first 12-24 hours following surgery) or if the pain is mild, or not expected to persist for an extended period of time.
- Long acting narcotics are not intended to be used in a dosage frequency other than FDA approved regimens.
- Patients should not be using other extended release narcotics prescribed by another physician.

CRITERIA FOR APPROVAL:

Methadone 40mg DispersibleTablets:

Due to reports of death and life-threatening adverse events such as respiratory depression and cardiac arrhythmias in patients receiving methadone, the FDA has issued an alert for healthcare providers. The FDA made the following recommendations (for more details, go to www.fda.gov/cder/drug/InfoSheets/HCP/methadoneHCP.pdf):

- Avoid prescribing methadone 40 mg dispersible tablets for pain; it is only FDA-approved for detoxification and maintenance treatment of narcotic addiction.
- Patients should be titrated to analgesic effect slowly even in patients who are opioid-tolerant, since methadone's elimination half-life (8-59 hours) is longer than its duration of analgesic action (4-8 hours) and cross-tolerance between methadone and other opioids is incomplete.
- This dosing scheme was derived as a guide to convert chronic pain patients to methadone from morphine. See the methadone label (Dolophine) for more details (http://www.fda.gov/cder/foi/label/2006/006134s028lbl.pdf).

Total Daily Baseline Oral Morphine Dose	Estimated Daily Oral Methadone Requirement Percent of Total Daily Morphine Dose*
< 100 mg	20% to 30%
100 to 300 mg	10% to 20%
300 to 600 mg	8% to 12%
600 to 1000 mg	5% to 10%
> 1000 mg	< 5%

*Methadone dosing should not be based solely on this table. Dosing should always be individualized to account for the patient's general medical condition, concomitant medication, and anticipated breakthrough medication use.

Prior-Authorization will be required for methadone 40mg dispersible tablets for patients who have no previous methadone claims history (past 60 days). For approval, the patient must have a diagnosis or condition that requires a continuous, around-the-clock analgesic and the prescriber must submit a completed and signed "Methadone 40mg Dispersible Tablets" Prior Authorization form.

Other Non-preferred medications:

- The patient has a diagnosis or condition that requires a continuous, around-the-clock analgesic.

AND

- The patient has had a documented side effect, allergy, or treatment failure to at least one medication not requiring prior approval. (If a product has an AB rated generic, the trial must be the generic.). Additionally, for approval of an oral non-preferred medication, the patient must have had a documented side effect, allergy, or treatment failure to morphine sulfate ER.

.Fentanyl Patch 12.5 mcg/hr will be approved for patients who are titrating from one strength to another and the available strengths of fentanyl patch are not appropriate. Fentanyl Patch 12.5 mcg/hr is not indicated for initial dosing. For approval of Duragesic-12®, the patient must have had a documented side effect, allergy, or treatment failure to Fentanyl Patch 12.5 mcg/hr.

DOCUMENTATION:

- ✓ For methadone 40mg dispersible tablets, please complete and submit the **Methadone 40mg Dispersible Tablets Prior Authorization Request Form**. For requests for other Long Acting Narcotics, please complete and submit the **Long Acting Narcotics Prior Authorization Request Form**.

Analgesics: Long Acting Narcotics

Length of Authorization: initial approval 3 months, subsequent approval up to 6 months

Key: † Generic product, *Indicates generic equivalent is available without a PA
§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS (NO PA REQUIRED)	PA REQUIRED
TRANSDERMAL	Duragesic-12® 12.5 mcg/hr *(QL=15 patches/30 days)*
FENTANYL PATCH† (compare to Duragesic®) 25 mcg/hr, 50 mcg/hr, (*QL=15 patches/30 days)*	Duragesic®* 25 mcg/hr, 50 mcg/hr, *(QL=15 patches/30 days)*
FENTANYL PATCH† (compare to Duragesic®) 75 mcg/hr, 100 mcg/hr, (*QL=30 patches/30 days)*	Duragesic®* 75 mcg/hr, 100 mcg/hr *(QL= 30 patches/30 days)*
	Fentanyl Patch† (compare to Duragesic®) 12.5 mcg/hr *(QL=15 patches/30 days)*
ORAL	
METHADONE† (compare to Dolophine®) 5 mg, 10 mg	Avinza® (morphine sulfate XR) *(QL= 30 capsules/strength/30 days)*
MORPHINE SULFATE ER† (compare to MS Contin®, Oramorph SR®) (*QL=90 tablets/strength/30 days)*	Dolophine®* (methadone)
	Kadian® (morphine sulfate XR*)* *(QL= 60 capsules/strength/30 days)*
	Methadone 40 mg Dispersible Tablets §
	MS Contin®* (morphine sulfate ER) (*QL=90 tablets/strength/30 days)*
	Opana ER® (oxymorphone ER) *(QL=60 tablets/strength/30 days)*
	Oramorph SR®* (morphine sulfate ER) *(QL=90 tablets/strength/30 days)*
	Oxycodone ER† *(QL=90 tablets/strength/30 days)*
	OxyContin® (Oxycodone ER) *(QL= 90 tablets/strength/30 days)*

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ LONG ACTING NARCOTICS~

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of long acting narcotics. These limits and criteria are based on concerns about safety and the potential for abuse and diversion. In order for beneficiaries to receive coverage for this drug, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Contact Person at Office:_____

Drug Requested:

Please indicate: □ Brand Name or □ Generic Equivalent

Dose /Frequency and Length of Therapy:

Diagnosis or Indication for Use:

Has the member previously tried any of the following preferred medications?

Check all that apply:	***Response, check all that apply:***
□ Fentanyl Patches	□ side-effect □ non-response □ allergy
□ Methadone	□ side-effect □ non-response □ allergy
□ Morphine ER	□ side-effect □ non-response □ allergy

Is this an initial request or a subsequent request? □ Initial □ Subsequent

Prescriber comments:

Prescriber Signature:_____**Date of this request:**_____

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ METHADONE 40 MG DISPERSIBLE TABLETS ~

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of methadone 40mg dispersible tablets. These limits and criteria are based on concerns about safety and the potential for abuse and diversion. In order for beneficiaries to receive coverage for this drug, it will be necessary for the prescriber to complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Contact Person at Office:_____

Dose/Frequency and Length of Therapy: _____

Diagnosis or Indication for Use: _____

Due to reports of death and life-threatening adverse events such as respiratory depression and cardiac arrhythmias in patients receiving methadone, the FDA has issued an alert for healthcare providers. The FDA made the following recommendations (for more details, go to www.fda.gov/cder/drug/InfoSheets/HCP/methadoneHCP.pdf):

- Avoid prescribing methadone 40 mg dispersible tablets for pain; it is only FDA-approved for detoxification and maintenance treatment of narcotic addiction. (Please note: methadone 5mg and 10mg tablets do not require prior-authorization.)
- Patients should be titrated to analgesic effect slowly even in patients who are opioid-tolerant, since methadone's elimination half-life (8-59 hours) is longer than its duration of analgesic action (4-8 hours) and cross-tolerance between methadone and other opioids is incomplete.
- This dosing scheme was derived as a guide to convert chronic pain patients to methadone from morphine. See the methadone label (Dolophine) for more details.

Total Daily Baseline Oral Morphine Dose	Estimated Daily Oral Methadone Requirement Percent of Total Daily Morphine Dose*
< 100 mg	20% to 30%
100 to 300 mg	10% to 20%
300 to 600 mg	8% to 12%
600 to 1000 mg	5% to 10%
> 1000 mg	< 5%

*Methadone dosing should not be based solely on this table. Dosing should always be individualized to account for the patient's general medical condition, concomitant medication, and anticipated breakthrough medication use.

Please select one of the following:

☐ I have read the FDA recommendations and want to continue with the methadone prescription as written.
Prescriber comments:

☐ I will be changing the methadone dose or drug selection to: _____
Prescriber comments:

Prescriber Signature: _____ **Date of this request:** _____

Anemia Medications: Hematopoietic/Erythropoietic Agents

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

- The diagnosis or indication for the requested medication is anemia.

AND

- The patient has had a documented side effect, allergy, or treatment failure to both Aranesp® and Procrit®.

DOCUMENTATION:

✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Anemia: Hematopoietic/Erythropoietic Agents

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
ARANESP® (darbepoetin alfa) PROCRIT® (epoetin alpha)	Epogen® (epoetin alpha)

Ankylosing Spondylitis Medications: Injectables

LENGTH OF AUTHORIZATION: Initial PA of 3 months, and 12 months thereafter if medication is well tolerated. Re-evaluate every 12 months.

CRITERIA FOR APPROVAL:

Humira®

Patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on Humira®

OR

Patient has a confirmed diagnosis of AS, and conventional NSAID treatment and DMARD* therapy (e.g. methotrexate therapy) resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried.

Notes: Approval should be granted in cases where patients have been treated with infliximab, but have lost response to therapy.

Enbrel®

Patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on Enbrel®

OR

Diagnosis is AS, and conventional NSAID treatment and DMARD* therapy (e.g. methotrexate therapy) resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried.

Remicade®

Patient has a diagnosis of ankylosing spondylitis (SA) and has already been stabilized on Remicade®

OR

Diagnosis is AS, and conventional NSAID treatment and DMARD* therapy (e.g. methotrexate therapy) resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried.

AND

The prescriber must provide a clinically valid reason why either Humira® or Enbrel® cannot be used.

* Patients with a documented diagnosis of active axial involvement should have a trial of NSAID therapy, but a trial with DMARD is not required. If no active axial skeletal involvement, then an NSAID trial and a DMARD trial are required (unless otherwise contraindicated) prior to receiving Humira®, Enbrel®, or Remicade®.

DOCUMENTATION:

- ✓ Document clinical information on an **Ankylosing Spondylitis Injectable Prior Authorization Request Form**.

Ankylosing Spondylitis: Injectables

Length of authorization: Initial PA of 3 months; 12 months thereafter

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET
ENBREL® (etanercept) HUMIRA® (adalimumab)	Remicade® (infliximab)

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ ANKYLOSING SPONDYLITIS INJECTABLE MEDICATIONS ~

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of Ankylosing Spondylitis Injectable medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Ankylosing Spondylitis Injectable medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address: _____

Contact Person at Office: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis: _____

Will this medication be billed via the: □ pharmacy benefit or □ medical benefit (J-code or other code)?

Pharmacy (if known)**:**_____ Phone:_____ &/or FAX:_____

Please select one of the following 'preferred' drug therapies from the VT Medicaid Preferred Drug List:

☐ **Enbrel**_____Strength & Frequency:_____Length of therapy:_____

☐ **Humira**_____Strength & Frequency:_____Length of therapy:_____

For any other injectable Ankylosing Spondylitis treatment, please explain medical necessity for non-preferred product:

Drug:_____ Strength & Frequency:_____ Length of therapy:_____

Medical justification: _____

_____

List previous medications tried and failed for this condition:

Name of medication	Reason for failure	Date(s) attempted

Prescriber comments:

Prescriber Signature:_____ **Date of this request:**_____

Anti-Anxiety: Anxiolytics

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):

- The patient has a documented side effect, allergy, or treatment failure to at least two preferred medications. (If a product has an AB rated generic, one trial must be the generic formulation.)

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

MANAGEMENT OF MENTAL HEALTH DRUGS: See page 118 for a description of the management of mental health drugs.

Anti-Anxiety: General

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
ALPRAZOLAM† (compare to Xanax®)	Ativan®*
ALPRAZOLAM XR† (compare to Xanax® XR)	Buspar®*
BUSPIRONE† (compare to Buspar®)	Klonopin®*
CHLORDIAZEPOXIDE† (compare to Librium®)	Klonopin Wafers®*
CLONAZEPAM† (compare to Klonopin®)	Librium®*
CLONAZEPAM ODT† (compare to Klonopin Wafers®)	Niravam® (alprazolam ODT)
CLORAZEPATE† (compare to Tranxene®)	Serax®*
DIAZEPAM† (compare to Valium®)	Tranxene®* (all brand forms)
LORAZEPAM† (compare to Ativan®)	Valium®*
MEPROBAMATE†	Xanax®*
OXAZEPAM† (compare to Serax®)	Xanax XR®*

Anticoagulants

LENGTH OF AUTHORIZATION: 6 months

CRITERIA FOR APPROVAL:

Coumadin®

- The patient has been started and stabilized on the requested medication.

OR

- The patient has had a documented side effect, allergy or treatment failure to generic warfarin.

Innohep®

- The diagnosis is treatment of acute, symptomatic deep vein thrombosis (DVT) with or without pulmonary embolism, administered in conjunction with warfarin sodium.

AND

- The patient does not have a bleeding disorder or documented heparin-induced thrombocytopenia (HIT).

AND

- The prescriber must provide a clinically valid reason why one of Lovenox®, Fragmin® or Arixtra® cannot be used.

OR

- The patient has been started and stabilized on the requested medication in conjunction with warfarin.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Request Form Prior Authorization**

Anticoagulants

Length of Authorization: 6 months

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
ORAL WARFARIN † (compare to Coumadin®)	Coumadin®* (warfarin)
UNFRACTIONATED HEPARIN HEPARIN †	
LOW MOLECULAR WEIGHT HEPARINS FRAGMIN® (dalteparin) LOVENOX® (enoxaparin) *(QL = 2 syringes/day calculated in ml volume)*	Innohep® (tinzaparin)
SELECTIVE FACTOR XA INHIBITOR ARIXTRA® (fondaparinux)	

LENGTH OF AUTHORIZATION: lifetime for seizure disorders*♠; duration of need for mental health indications*♠; 1 year for other indications

CRITERIA FOR APPROVAL:

Depakene®, Klonopin®, Klonopin Wafers®, Mysoline®, Neurontin®, Tegretol®, Zarontin®, Zonegran®

- The patient has been started and stabilized on the requested medication.

OR

- The patient has had a documented side effect, allergy, or treatment failure to the generic equivalent of the requested medication.

Gabarone®

- The patient has been started and stabilized on the requested medication.

OR

- The patient has had a documented side effect, allergy, or treatment failure to generic gabapentin.

Lamotrigine chew tabs, Oxcarbazepine tablets

- The patient has been started and stabilized on the requested medication.

OR

- The patient has had a documented side effect, allergy, or treatment failure to the brand name product.

Lyrica®

- The patient has a diagnosis of epilepsy.

OR

The patient has had a documented side effect, allergy, or treatment failure to TWO drugs in the tricyclic antidepressant (TCA) class and/or anticonvulsant class, if medication is being used for neuropathic pain.

OR

- The patient has had a documented side effect, allergy, or treatment failure to TWO drugs from the following: gabapentin, tricyclic antidepressant, SSRI antidepressant, novel antidepressant or cyclobenzaprine, if medication is being used for fibromyalgia

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

After a 4-month lapse in use of a non-preferred agent for a mental health indication, or if there is a change in therapy, a look-back through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.

MANAGEMENT OF MENTAL HEALTH DRUGS (Anticonvulsants Used as Mood Stabilizers): See page 118 for a description of the management of mental health drugs.

Anticonvulsants

Length of Authorization: lifetime for seizure disorders♠; duration of need for mental health indications*♠; 1 year for other indications*

Key: † Generic product, *Indicates generic equivalent is available without a PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS (No PA Required)	PA REQUIRED
CARBAMAZEPINE† (compare to Tegretol®)	Depakene®* (valproic acid)
CARBATROL® (carbamazepine)	Gabarone®* (gabapentin)
CELONTIN® (methsuxamide)	Klonopin®*
CLONAZEPAM† (compare to Klonopin®)	Klonopin Wafers®*
CLONAZEPAM ODT† (compare to Klonopin Wafers®)	lamotrigine† chew tabs (compare to Lamictal® chew tabs)
DEPAKOTE® (divalproex sodium)	Lyrica® (pregabalin) § *(Quantity Limit = 3 capsules/day)*
DEPAKOTE ER® (divalproex sodium)	Mysoline®* (primidone)
DIASTAT® (diazepam rectal gel)	Neurontin®* (gabapentin)
DILANTIN® (phenytoin)	oxcarbazepine† (compare to Trileptal®)
EPITOL† (carbamazepine)	Tegretol®* (carbamazepine)
ETHOSUXAMIDE† (compare to Zarontin®)	Zarontin®* (ethosuxamide)
FELBATOL® (felbamate)	Zonegran®* (zonisamide)
GABAPENTIN† (compare to Neurontin®)	
GABITRIL® (tiagabine)	
KEPPRA® (levetiracetam)	
LAMICTAL® tabs (lamotrigine tabs)	
LAMICTAL® chew tabs (lamotrigine chew tabs)	
NEURONTIN® oral solution (gabapentin)	
PEGANONE® (ethotoin)	
PHENYTEK® (phenytoin)	
PHENYTOIN† (compare to Dilantin®)	
PRIMIDONE† (compare to Mysoline®)	
TEGRETOL XR® (carbamazepine)	
TOPAMAX® (topiramate)	
TRILEPTAL® (oxcarbazepine)	
VALPROIC ACID† (compare to Depakene®)	
ZONISIMIDE† (compare to Zonegran®)	

* For brand name products with generic equivalents, length of authorization is 1 year.

♠ For generic product when brand name product preferred, length of authorization is 1 year.

Anti-Depressants: Novel

LENGTH OF AUTHORIZATION: Duration of need for mental health indications*♠; 1 year for other indications

CRITERIA FOR APPROVAL:

Remeron, Remeron SolTab, Wellbutrin, Wellbutrin SR, Desyrel, Effexor:

- The patient has had a documented side effect, allergy, or inadequate response to the generic formulation of the requested medication.

Budeprion XR, Bupropion XL:

- The patient has had a documented side effect, allergy, or inadequate response to Wellbutrin XL.

Venlafaxine, Effexor XR:

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient has had a documented side effect, allergy, or inadequate response to at least 2 different antidepressants from the SSRI and/or Novel Antidepressant categories.

Cymbalta:

Depression:

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient has had a documented side effect, allergy, or inadequate response to at least 2 different antidepressants from the SSRI and/or Novel Antidepressant categories.

Neuropathic pain:

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient has had a documented side effect, allergy, or inadequate response to gabapentin or a tricyclic antidepressant.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

After a 4-month lapse in use of a non-preferred agent for a mental health indication, or if there is a change in therapy, a look-back through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.

MANAGEMENT OF MENTAL HEALTH DRUGS: See page 118 for a description of the management of mental health drugs.

Anti-Depressants: Novel

Length of Authorization: Duration of need for mental health indications♠; 1 year for other indications*

Key: † Generic product, *Indicates generic equivalent is available without a PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS (No PA Required)	PA REQUIRED
BUDEPRION® /BUPROPION SR† (compare to Wellbutrin SR®) *suggested max dose = 400 mg/day* BUPROPION† (compare to Wellbutrin®) MAPROTILINE† (compare to Ludiomil®) MIRTAZAPINE† (compare to Remeron®) *suggested max dose = 90 mg/day* MIRTAZAPINE RDT† (compare to Remeron Sol-Tab®) *suggested max dose = 90 mg/day* NEFAZADONE† (compare to Serzone®) *suggested max dose = 750 mg/day* TRAZODONE HCL† (compare to Desyrel®) *suggested max dose = 750 mg/day* WELLBUTRIN XL®	Budeprion XR/bupropion XL† (compare to Wellbutrin XL®) Cymbalta® Desyrel®* *suggested max dose = 750 mg/day* Effexor® Effexor XR® § *suggested max dose = 450 mg/day, Quantity limit = 1 cap/day (37.5 mg & 75 mg)* Remeron®* *suggested max dose = 90 mg/day* Remeron Sol Tab®* *suggested max dose = 90 mg/day* venlafaxine IR †§ Wellbutrin®* Wellbutrin SR®* *suggested max dose = 400 mg/day*

* For brand name products with generic equivalents, length of authorization is 1 year.

♠ For generic product when brand name product preferred, length of authorization is 1 year.

Anti-Depressants: SSRIs

LENGTH OF AUTHORIZATION: Duration of need for mental health indications*; 1 year for other indications

CRITERIA FOR APPROVAL

Celexa, Luvox, Paxil, Prozac, Zoloft:

- The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. (One trial must be the generic formulation of the requested medication.)

Pexeva, Paroxetine CR, Paxil CR:

- The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. (One trial must be generic paroxetine.)

Paroxetine suspension:

- The patient has a requirement for an oral liquid dosage form.

  AND
- The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs.

Sarafem, Selfemra:

- The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. (One trial must be generic fluoxetine.)

Lexapro:

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

  OR
- The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs.

Prozac Weekly:

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

  OR
- The patient failed and is not a candidate for daily fluoxetine.

  AND
- The prescriber provides clinically compelling rationale for once-weekly dosing.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

After a 4-month lapse in use of a non-preferred agent for a mental health indication, or if there is a change in therapy, a look-back through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.

MANAGEMENT OF MENTAL HEALTH DRUGS: See page 118 for a description of the management of mental health drugs..

Anti-Depressants: SSRI

Length of Authorization: Duration of need for mental health indications; 1 year for other indications*

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
CITALOPRAM† (compare to Celexa®) *suggested max dose = 75 mg/day* FLUOXETINE† (compare to Prozac®) *suggested max dose = 100 mg/day* FLUVOXAMINE† (compare to Luvox®) *suggested max dose = 300 mg/day* PAROXETINE tablet† (compare to Paxil®) *suggested max dose = 75 mg/day* SERTRALINE† (compare to Zoloft®) *suggested max dose = 250 mg/day, Quantity limit = 1.5 tabs/day (25 mg & 50 mg tabs)*	Celexa®* *suggested max dose = 75 mg/day* Lexapro® *suggested max dose = 25 mg/day, Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)* Luvox®* *suggested max dose = 300 mg/day* paroxetine suspension† (compare to Paxil® susp) *suggested max dose = 75 mg/day* Paroxetine CR† (compare to Paxil CR®) *suggested max dose = 75 mg/day* Paxil®* *suggested max dose = 75 mg/day* Paxil CR® *suggested max dose = 75 mg/day* Pexeva® *suggested max dose = 75 mg/day* Prozac®* *suggested max dose = 100 mg/day* Prozac Weekly® *suggested max weekly dose = 540 mg* Sarafem® *suggested max dose = 100 mg/day* Selfemra® Zoloft®* *suggested max dose = 250 mg/day, Quantity limit = 1.5 tabs/day (25 mg & 50 mg tabs)*

* For brand name products with generic equivalents, length of authorization is 1 year.

Anti-Depressants: Tricyclics & MAOIs

LENGTH OF AUTHORIZATION: Duration of need for mental health indications*; 1 year for other indications

CRITERIA FOR APPROVAL:

Tricyclics (TCAs):

- The patient has had a documented side effect, allergy, or treatment failure to 2 or more TCAs not requiring prior-authorization. If a product has an AB rated generic, one trial must be the generic formulation.

MAOIs:

Marplan®

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient has had a documented side effect, allergy, or treatment failure to Nardil ®and tranylcypromine.

Parnate®

- The patient has had a documented side effect, allergy, or treatment failure to Nardil ®and tranylcypromine.

EMSAM®

- The patient has had a documented side effect, allergy, or treatment failure with at least 3 antidepressants from 2 of the major antidepressant classes (SSRIs, Novel Antidepressants, Tricyclic Antidepressants).

OR

- The patient is unable to tolerate oral medications.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

After a 4-month lapse in use of a non-preferred agent for a mental health indication, or if there is a change in therapy, a look-back through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.

MANAGEMENT OF MENTAL HEALTH DRUGS: See page 118 for a description of the management of mental health drugs..

Anti-Depressants: Tricyclics & MAOIs

Length of Authorization: Duration of need for mental health indications; 1 year for other indications*

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
TRICYCLICS	
AMITRIPTYLINE† (compare to Elavil®) *suggested max dose = 375 mg/day* AMITRIPTYLINE/CHLORDIAZ.† (compare to Limbitrol®) AMITRIPTYLINE/PERPHEN†.(compare to Etrafon®, Triavil®) AMOXAPINE† (compare to Asendin®) CLOMIPRAMINE† (compare to Anafranil®) DESIPRAMINE† (compare to Norpramin®) DOXEPIN† (compare to Sinequan®) IMIPRAMINE† (compare to Tofranil®) *suggested max dose = 250 mg/day* NORTRIPTYLINE† (compare to Aventyl®, Pamelor®) TOFRANIL PM® (imipramine pamoate) TRIMIPRAMINE (compare to Surmontil®) VIVACTIL® (protriptyline)	Anafranil®* Aventyl®* Limbitrol®* Limbitrol DS® Norpramin®* Pamelor®* Sinequan®* Surmontil®* Tofranil®*
MAOIs	
NARDIL® (phenylzine) *suggested max dose = 110 mg/day* TRANYLCYPROMINE (compare to Parnate®) *suggested max dose = 120 mg/day*	EMSAM® (selegiline) *(QL = 1 patch/day)* Marplan® (isocarboxazid) Parnate®*

* For brand name products with generic equivalents, length of authorization is 1 year.

Anti-Diabetics: Insulin

LENGTH OF AUTHORIZATION: lifetime

CRITERIA FOR APPROVAL:

INJECTABLE

Apidra® or Humalog®

- The patient has had a documented side effect, allergy, or treatment failure to Novolog®

Humulin/ReliOn R®, Humulin/ReliOn N® or Humulin/ReliOn 70/30®

- The patient has had a documented side effect, allergy, or treatment failure to the corresponding Novolin® product

INHALED

- The diagnosis or indication for the requested medication is uncontrolled type I or type II diabetes.
  AND
- The patient will be using Exubera® as an adjunct to long-acting insulin or oral hypoglycemic combination therapy. AND
- The patient has a contraindication to subcutaneous injections (latex allergy, dermatologic condition, needle phobia, etc.) AND
- The patient does not have any of the following contraindications: poorly-controlled asthma, chronic obstructive pulmonary disease or a history of smoking within the past 6 months.
  AND
- The patient is > 18 years old.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Insulins	*Length of Authorization: lifetime*
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
RAPID-ACTING INJECTABLE	
NOVOLOG® (Aspart)	Apidra® (insulin glulisine) Humalog® (insulin lispro)
SHORT-ACTING INJECTABLE	
NOVOLIN R® (Regular)	Humulin R® (Regular) ReliOn R® (Regular)
INTERMEDIATE-ACTING INJECTABLE	
NOVOLIN N® (NPH)	Humulin N® (NPH) ReliOn N® (NPH)
LONG-ACTING ANALOGS INJECTABLE	
LANTUS® (insulin glargine) LEVEMIR® (insulin detemir)	
MIXED INSULINS INJECTABLE	
HUMULIN MIX 50/50® (NPH/Regular) NOVOLIN 70/30® (NPH/Regular) NOVOLOG MIX 70/30® (Protamine/Aspart) HUMALOG MIX 75/25® (Protamine/Lispro) HUMALOG MIX 50/50® (Protamine/Lispro)	Humulin 70/30® (NPH/Regular) ReliOn 70/30® (NPH/Regular)
INHALED	
	Exubera® (insulin human [rDNA] Inhalation Powder)

Anti-Diabetics: Oral

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

ALPHA GLUCOSIDASE INHIBITORS

- For approval of Precose®, the patient must have a documented intolerance to generic acarbose.

BIGUANIDES AND COMBINATIONS

Fortamet, glucophage XR, Glumetza

- The patient has had a documented side effect, allergy or treatment failure with metformin XR.

Glucophage, Glucovance, Metaglip

- The patient has had a documented side effect, allergy or treatment failure with at least one preferred biguanide or biguanide combination product. (If a product has an AB rated generic, the trial must be the generic.)

MEGLITINIDES

Prandin

- The patient has been started and stabilized on the requested medication.

OR

- The patient has had a documented side effect, allergy or treatment failure with at Starlix.

SECOND GENERATION SULFONYLUREAS

- The patient has had a documented side effect, allergy or treatment failure with glimepiride, and glipizide/glipizide ER, and glyburide/glyburide micronized.

THIAZOLIDINEDIONES AND COMBINATIONS

- The patient has been started and stabilized on the requested medication.

OR

- The patient has had a documented side effect, allergy, contraindication or treatment failure with metformin.

DIPEPTIDYL PEPTIDASE (DPP-4) INHIBITORS

Januvia

- The patient has had a documented side effect, allergy, contraindication or treatment failure with metformin.

Janumet

- The patient has had an inadequate response with Januvia or metformin monotherapy.

OR

- The patient has been started and stabilized on Januvia and metformin combination therapy.

WELCHOL®

- See Lipotropics: Bile Acid Sequestrants

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Anti-Diabetics: Oral

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA
§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS (No PA Required)	PA REQUIRED
ALPHA GLUCOSIDASE INHIBITORS	
ACARBOSE† (compare to Precose®) GLYSET® (miglitol)	PRECOSE®* (acarbose)
BIGUANIDES AND COMBINATIONS	
SINGLE AGENT METFORMIN† (compare to Glucophage®) METFORMIN XR† (compare to Glucophage XR®) RIOMET® (metformin oral solution)	Fortamet® (metformin extended-release) Glucophage®* (metformin) Glucophage XR®* (metformin extended-release) Glumetza® (metformin extended-release)
COMBINATION GLIPIZIDE/METFORMIN†(compare to Metaglip®) GLYBURIDE/METFORMIN† (compare to Glucovance®)	Glucovance®* (glyburide/metformin) Metaglip®*(glipizide/metformin)
MEGLITINIDES	
STARLIX® (nateglinide)	Prandin® (replaglinide)
SULFONYLUREAS SECOND GENERATION	
GLIMEPIRIDE† (compare to Amaryl®) GLIPIZIDE† (compare to Glucotrol®) GLIPIZIDE ER† (compare to Glucotrol XL®) GLYBURIDE† (compare to Diabeta®, Micronase®) GLYBURIDE MICRONIZED† (compare to Glynase® PresTab®)	Amaryl®* (glimepiride) Diabeta®* (glyburide) Glucotrol®* (glipizide) Glucotrol XL®* (glipizide extended-release) Glynase® PresTab®* (glyburide micronized) Micronase®* (glyburide)
THIAZOLIDINEDIONES AND COMBINATIONS (after clinical criteria are met)	
SINGLE AGENT ACTOS® (pioglitazone) § AVANDIA® (rosiglitazone) § **COMBINATION** ACTOPLUS MET® (pioglitazone/metformin) § AVANDAMET® (rosiglitazone/metformin) § AVANDARYL® (rosiglitazone/glimeperide) § DUETACT® (pioglitazone/glimepiride) § *(Quantity Limit = 1 tablet/day)*	
DIPEPTIDYL PEPTIDASE (DPP-4) INHIBITORS AND COMBINATIONS (after clinical criteria are met)	
SINGLE AGENT JANUVIA® (sitagliptin)§ *(Quantity limit=1 tab/day)* **COMBINATION** JANUMET® (sitagliptin/metformin)§ *(Quantity limit=2 tabs/day)*	

Note: Please refer to "Lipotropics: Bile Acid Sequestrants" for Welchol®.

Anti-Diabetics: Peptide Hormones

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

BYETTA

- The patient has a diagnosis of diabetes mellitus.
  AND
- The patient is at least 18 years of age.
  AND
- The patient has had a documented side effect, allergy, or treatment failure to at least two oral anti-diabetic agents (one medication from two different classes).
  AND
- The quantity requested does not exceed 1 pen/month.

SYMLIN

- The patient has a diagnosis of diabetes mellitus.
  AND
- The patient is at least 18 years of age.
  AND
- The patient is on insulin.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Anti-Diabetics: Peptide Hormones

Length of Authorization: 1 year

Key: § Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	PA REQUIRED
BYETTA® (exenatide) § *(Quantity Limit=1 pen/30 days)*	Symlin® (pramlintide) (No quantity limit applies)

Anti-Emetics: 5-HT_3 Receptor Antagonists

LENGTH OF AUTHORIZATION: 6 months for Chemotherapy/Radiotherapy and 1 time Post-Op

CRITERIA FOR APPROVAL (non-preferred agents):

Aloxi®, Anzemet®, Granisetron, Kytril®

- The patient has had a documented side effect, allergy, or treatment failure to generic ondansetron. Additionally, after above trial, for approval of Kytril® injection, oral solution or tablets, generic granisetron injection, oral solution or tablets must have been tried.

Zofran®

- The patient must have a documented side effect, allergy, or treatment failure to the corresponding generic ondansetron product (tablets, orally disintegrating tablets (ODT), oral solution or injection).

Ondansetron oral solution

- The patient is unable to use ondansetron ODT or ondansetron tablets.

Ondansetron 24 mg

- The prescriber provides rationale why generic ondansetron 8 mg tablets cannot be used to achieve the desired dose.

CRITERIA FOR APPROVAL (quantity limit):

Ondansetron 4 mg and 8 mg

- For nausea and vomiting associated with chemotherapy, 3 tablets for each day of chemotherapy and 3 tablets for each day on days 2-4 after chemotherapy may be approved.

- For hyperemesis gravadarum, the patient must have a documented side effect, allergy, or treatment failure to at least one other anti-emetic. Three tablets per day of 4 mg or 8 mg may be approved for 3 months.

Anzemet®

- For nausea and vomiting associated with chemotherapy, 1 tablet for each day of chemotherapy and 1 tablet for each day on days 2-4 after chemotherapy may be approved.

Kytril®

- For nausea and vomiting associated with chemotherapy, 2 tablets for each day of chemotherapy and 2 tablets for each day on days 2-4 after chemotherapy may be approved.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent, to exceed quantity limits of a preferred agent, or for a diagnosis outside of FDA approval on a **General Prior Authorization Request Form**.

Anti-Emetics: 5-HT_3 Receptor Antagonists

Length of Authorization: 6 months for Chemotherapy/Radiotherapy, 1 time Post-Op

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
Ondansetron Tablet and Orally Disintegrating Tablet† (compare to Zofran®) 4 mg, 8 mg *Quantity Limit = 12 tablets/month (4 mg), 6 tablets/month (8 mg)* Ondansetron Injection† (compare to Zofran®)	Aloxi® (palonosetron) *Quantity Limit = 2 vials/month* Anzemet® (dolasetron) *Quantity Limit = 4 tablets/month (50 mg), 2 tablets/month (100 mg)* Granisetron† (compare to Kytril®) *Quantity Limit = 6 tablets/month* Granisetron† (compare to Kytril®) Injectable Granisetron† (compare to Kytril®) Oral Solution Kytril® (granisetron) *Quantity Limit = 6 tablets/month* Kytril® Injectable (granisetron) Ondansetron Solution† (compare to Zofran®) Ondansetron† 24 mg tablet (previously Zofran®) *Quantity Limit = 1 tablet/month* Zofran®* (ondansetron) Tablet and Orally Disintegrating Tablet *Quantity Limit = 12 tablets/month (4 mg), 6 tablets/month (8 mg)* Zofran®* (ondansetron) Injection Zofran® (ondansetron) Solution

Anti-Emetics: NK1 Antagonists

LENGTH OF AUTHORIZATION: up to 1 year

CRITERIA FOR APPROVAL WHEN QUANTITY LIMIT IS EXCEEDED:

EMEND® (aprepitant) 80 mg, 125 mg, Tri-Fold pack

- The medication will be prescribed by an oncology practitioner.

AND

- The patient requires prevention of nausea and vomiting associated with moderate to highly emetogenic cancer chemotherapy.

AND

- The requested quantity does not exceed one 125 mg and two 80 mg capsules OR one Tri-Fold Pack per course of chemotherapy. Patients with multiple courses of chemotherapy per month will be approved quantities sufficient for the number of courses of chemotherapy.

EMEND® (aprepitant) 40 mg

- The patient requires prevention of postoperative nausea and vomiting.

AND

- The requested quantity does not exceed one 40 mg capsule per surgery or course of anesthesia. Patients with multiple surgeries or courses of anesthesia in a 30 day period will be approved quantities sufficient for the number of surgeries or courses of anesthesia.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the need to exceed the established quantity limits on the **General Prior Authorization Request Form.**

Anti-Emetics: NK1 Antagonists	*Length of Authorization: up to 1 year*
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
EMEND® (aprepitant) 40 mg (Qty Limit =1 cap/30 days) ♣ EMEND® (aprepitant) 80 mg (Qty Limit = 2 caps/30 days) ♣ EMEND® (apreptiant) 125 mg (Qty Limit = 1 cap/30 days) ♣ EMEND® (aprepitant) Tri-fold Pack (Qty Limit = 1 pack/30 days) ♣ *To be prescribed by oncology practitioners ONLY*	

Anti-Emetics: Other

LENGTH OF AUTHORIZATION: 3 months

PHARMACOLOGY:

Marinol® is a schedule III cannabinoid agent containing the same active ingredient, tetrahydrocannabinol, as marijuana. While its exact mechanism of action is unknown, it is speculated to inhibit medullary activity as well as suppress prostaglandin and endorphan synthesis. Cesamet® is a schedule II synthetic cannabinoid that acts by activating the endocannabinoid receptors, CB1 and CB2, which are involved in nausea/vomiting regulation. Both Marinol® and Cesamet® are FDA-approved for use in chemotherapy associated nausea and vomiting refractory to conventional antiemetics. In addition, Marinol® is indicated for patients with AIDS-related anorexia or wasting syndrome.

CRITERIA FOR APPROVAL:

Marinol

- The patient has a diagnosis of chemotherapy-induced nausea/vomiting.

  AND
- The patient has had a documented side effect, allergy, or treatment failure to **at least 2** antiemetic agents, of which, one must be a **preferred** 5HT3 receptor antagonist.

  OR
- The patient has a diagnosis of AIDS associated anorexia.

  AND
- The patient has had an inadequate response, adverse reaction, or contraindication to megestrol acetate.

Cesamet

- The patient has a diagnosis of chemotherapy-induced nausea/vomiting.

  AND
- The patient has had a documented side effect, allergy, or treatment failure to **at least 2** antiemetic agents, of which, one must be a **preferred** 5HT3 receptor antagonist.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Anti-Emetics: Other

*Length of Authorization: Initial approval **3 months,** subsequent approval up to **6 months***

PREFERRED DRUGS (No PA Required)	PA REQUIRED
	Marinol® (dronabinol) (Quantity Limit = 30 days supply for AIDS anorexia or quantity required for one chemotherapy treatment course) Cesamet® (nabilone) (Quantity Limit = quantity required for one chemotherapy treatment course)

Anti-Hyperkinesis and Anti-Narcolepsy/Cataplexy

LENGTH OF AUTHORIZATION: Duration of need for mental health indications*; 1 year for other indications

CRITERIA FOR APPROVAL:

Dexmethylphenidate, Focalin®, Ritalin® and Ritalin SR®

- Metadate ER®, Methylin®, Methylin® ER, methylphenidate, and methylphenidate SR are available without prior-authorization.
- For approval of Ritalin®, Focalin®,, and dexmethylphenidate, the patient must have a diagnosis of ADHD or narcolepsy and have had a documented side-effect, allergy, or treatment failure on Methylin® or methylphenidate. In addition, for approval of brand name Focalin®, the patient must have had a documented side effect, allergy, or treatment failure with dexmethylphenidate.
- For approval of Ritalin SR®, the patient must have a diagnosis of ADHD or narcolepsy and have had a documented side-effect, allergy, or treatment failure Methylin® ER or methylphenidate SR.

Metadate CD® and Ritalin LA®

- Focalin XR® and Concerta® are available without prior-authorization.
- For approval of Metadate CD® and Ritalin LA®, the patient must have a diagnosis of ADHD or narcolepsy and have had a documented side-effect, allergy, or treatment failure on Focalin XR® or Concerta®.

Adderall® and Dexedrine® (CR)

- Amphetamine salt combo, dextroamphetamine, dextroamphetamine CR, and Dextrostat are available without prior-authorization.
- For approval of Adderall® or Dexedrine® CR), the patient must have a diagnosis of ADHD or narcolepsy and have had a documented side-effect, allergy, or treatment failure on amphetamine salt combo, dextroamphetamine, dextroamphetamine CR, or dextrostat.

Desoxyn®

- Given the high abuse potential of Desoxyn®, the patient must have a diagnosis of ADHD or narcolepsy and have failed all preferred treatment alternatives.

CNS stimulants for beneficiaries age < 3

- The prescriber must provide a clinically valid reason for the use of the requested medication in a patient < 3 years of age.

Provigil®

Narcolepsy, Excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome (adjunct to standard treatment), fatigue associated with multiple sclerosis, fatigue associated with the treatment of depression or schizophrenia:

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient has had a documented side-effect, allergy or treatment failure to a CNS stimulant or has a contraindication for use of these agents (e.g. substance abuse history).

ADHD age >12:

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient has a documented treatment failure, due to lack of efficacy, to *two* long-acting CNS stimulants or the patient has had a documented side effect, allergy, or direct contraindication (e.g. comorbid tics, moderate-to-severe anxiety, substance abuse) to *one* long-acting CNS stimulant.

AND

- The patient has had a documented side-effect, allergy, or treatment failure to Strattera®.

Provigil® **will not be approved** for sleepiness associated with shift work sleep disorder, idiopathic hypersomnolence, excessive daytime sleepiness, fatigue associated with use of narcotic analgesics, or **for ADHD in children age ≤12.**

Strattera®

- The patient has a diagnosis of ADHD.

AND

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient has a documented treatment failure, due to lack of efficacy, to *two* long-acting CNS stimulants (Metadate CD®, Ritalin LA®, Focalin XR®, Adderal XR®, Concerta® and Vyvanse®)

OR

- The patient has had a documented side effect, allergy, or direct contraindication (e.g. comorbid tics, moderate-to-severe anxiety) to *one* long-acting CNS stimulant (Metadate CD®, Ritalin LA®, Focalin XR®, Adderal XR®, Concerta® and Vyvanse®)
-

Xyrem®

- The patient has a diagnosis of narcolepsy/cataplexy.

AND

- The patient has been started and stabilized on the medication.

OR

- The patient has a documented side effect, allergy, treatment failure, or contraindication to a preferred CNS stimulant or tricyclic antidepressants (e.g., protriptyline, clomipramine).

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

After a 4-month lapse in use of a non-preferred agent for a mental health indication, or if there is a change in therapy, a look-back through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.

MANAGEMENT OF MENTAL HEALTH DRUGS: See page 118 for a description of the management of mental health drugs.

Anti-Hyperkinesis and Anti-Narcolepsy/Cataplexy

Length of Authorization: Duration of need for mental health indications; 1 year for other indications*

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
AMPHETAMINE-LIKE STIMULANTS	
Short/Intermediate-Acting Methylphenidate Preps	
METADATE ER® (compare to Ritalin® SR) METHYLIN® (compare to Ritalin®) METHYLIN® ER (compare to Ritalin® SR) METHYLPHENIDATE † (compare to Ritalin®) METHYLPHENIDATE SR † (compare to Ritalin® SR)	Dexmethylphenidate † (compare to Focalin®) Focalin® Ritalin®* Ritalin SR®*
Long-Acting Methylphenidate Preps	
FOCALIN XR® (dexmethylphenidate IR/ER, 50:50%) CONCERTA® (methylphenidate IR/ER, 22:78%) DAYTRANA® (methylphenidate patch) (*QL = 1 patch/day)*	Metadate CD® (methylphenidate, IR/ER, 30:70%) Ritalin LA® (methylphenidate, IR/ER, 50:50%)
Short/Intermediate-Acting Amphetamine Preps	
AMPHETAMINE salt combo† (compare to Adderall®) DEXTROAMPHETAMINE † DEXTROAMPHETAMINE CR† (compare to Dexedrine®CR) DEXTROSTAT †	Adderall®* Desoxyn® (methamphetamine) Dexedrine®* (CR)
Long-Acting Amphetamine Preps	
ADDERALL XR® (dextroamphetamine IR/ER, 50:50%) VYVANSE® (lisdexamfetamine) *(QL = 1 capsule/day)*	***CNS stimulants*** *(all forms short- & long-acting): PA for beneficiaries < 3 yrs*
NON-STIMULANTS	
	Provigil® (modafinil) **(not approvable for ADHD in children age ≤12).** Strattera® (atomoxetine) *max dose = 100 mg/day* Xyrem® (sodium oxybate)

* For brand name products with generic equivalents, length of authorization is 1 year.

Anti-Hypertensives: ACE Inhibitors and ACEI Combinations

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

ACE Inhibitors:

- The patient has had a documented side effect, allergy, or treatment failure to a preferred generic ACEI. If a medication has an AB rated generic, the trial must be the generic formulation. For products where both the brand and generic are non-preferred, there must also be a trial of the generic before approval of the brand (except for Altace® where brand will be preferred over generic).

ACE Inhibitor/Hydrochlorothiazide combinations:

- The patient has had a documented side effect, allergy, or treatment failure with a preferred generic ACEI/Hydrochlorothiazide combination. If a medication has an AB rated generic, the trial must be the generic formulation. For products where both the brand and generic are non-preferred, there must also be a trial of the generic before approval of the brand.

ACE Inhibitor/Calcium Channel Blocker combination:

- The patient has had a documented side effect, allergy, or treatment failure with a preferred ACEI/Calcium Channel Blocker combination. . If a medication has an AB rated generic, the trial must be the generic formulation.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

ACE Inhibitors and ACEI Combinations

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA Required
ACE INHIBITORS: BENAZEPRIL† (compare to Lotensin®) CAPTOPRIL† (compare to Capoten®) ENALAPRIL† (compare to Vasotec®) FOSINOPRIL† (compare to Monopril®) LISINOPRIL† (compare to Zestril®, Prinivil®) MOEXIPRIL† (compare to Univasc®) QUINAPRIL† (compare to Accupril®)	Accupril®* (quinapril) Aceon® (perindopril) Altace® (ramipril) Capoten®* (captopril) Lotensin®* (benazepril) Mavik® (trandolapril) Monopril®* (fosinopril) Prinivil®* (lisinopril) ramipril† (compare to Altace®) trandolapril† (compare to Mavik®) Univasc®* (moexipril) Vasotec®* (enalapril) Zestril®* (lisinopril)
ACE INHIBITOR/HYDROCHLOROTHIAZIDE: BENAZEPRIL/HCTZ† (compare to Lotensin HCT®) CAPTOPRIL/HCTZ† (compare to Capozide®) ENALAPRIL/HCTZ† (compare to Vaseretic®) FOSINOPRIL/HCTZ† (compare to Monopril HCT®) LISINOPRIL/HCTZ† (compare to Zestoretic®, Prinzide®) QUINAPRIL/HCTZ† (compare to Accuretic®)	Accuretic®* (quinapril/HCTZ) Capozide®* (captopril/HCTZ) Lotensin HCT®* (benazepril/HCTZ) moexipril/hydrochlorothiazide† Monopril HCT®* (fosinopril/HCTZ) Prinzide®* (lisinopril/HCTZ) Uniretic® (moexipril/HCTZ) Vaseretic®* (enalapril/HCTZ) Zestoretic®* (lisinopril/HCTZ)
ACE INHIBITOR/CALCIUM CHANNEL BLOCKER: benazepril/amlodipine† (compare to Lotrel®)	Lexxel® (enalapril/felodipine) Lotrel®* (benazepril/amlodipine) Tarka® (trandolapril/verapamil)

Anti-Hypertensives: Angiotensin Receptor Blockers (ARBs) and ARB Combinations

LENGTH OF AUTHORIZATION: lifetime

CRITERIA FOR APPROVAL:

Avapro, Benicar, Cozaar, Diovan, Micardis, Avalide, Benicar HCT, Diovan HCT, Hyzaar, Micardis HCT, Exforge

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination.

Atacand, Teveten

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient has had a documented side effect, allergy, or treatment failure with a preferred Angiotensin Receptor Blocker (ARB) or ARB combination.

Atacand HCT, Teveten HCT

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient has had a documented side effect, allergy, or treatment failure with a preferred ARB/Hydrochlorothiazide combination.

Azor

- The patient has had a documented side effect, allergy, or treatment failure to Exforge® or to amlodipine and valsartan as separate entities

AND

- The patient is unable to use Benicar and amlodipine as separate entities.

AND

- The quantity requested does not exceed 30 tablets per month (QL = 1 tablet/day).

DOCUMENTATION:

✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

ARBs and ARB Combinations

Length of Authorization: lifetime

Key: § Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET
ANGIOTENSIN RECEPTOR BLOCKERS:	
AVAPRO® (irbesartan) § BENICAR® (olmesartan) § COZAAR® (losartan) § DIOVAN® (valsartan) § MICARDIS® (telmisartan) §	Atacand® (candesartan) § Teveten® (eprosartan) §
ANGIOTENSIN RECEPTOR BLOCKER/HYDROCHLOROTHIAZIDE:	
AVALIDE® (irbesartan/hydrochlorothiazide) § BENICAR HCT® (olmesartan/hydrochlorothiazide) § DIOVAN HCT® (valsartan/hydrochlorothiazide) § HYZAAR® (losartan/hydrochlorothiazide) § MICARDIS HCT® (telmisartan/hydrochlorothiazide) §	Atacand HCT®(candesartan/hydrochlorothiazide)§ Teveten HCT® (eprosartan/hydrochlorothiazide) §
ANGIOTENSIN RECEPTOR BLOCKER/CALCIUM CHANNEL BLOCKER:	
EXFORGE® (valsartan/amlodipine) § *(QL = 1 tab/day)*	Azor®(olmesartan/amlodipine) *(QL = 1 tablet/day)*

Anti-Hypertensives: Beta-Blockers

LENGTH OF AUTHORIZATION: 5 years

CRITERIA FOR APPROVAL

Non-preferred drugs (except Coreg CR®):

- The patient has had a documented side effect, allergy, or treatment failure to at least one preferred drug. (If a medication has an AB rated generic, the trial must be the generic formulation.)

Coreg CR®:

Indication: Heart Failure

- The patient has been started and stabilized on Coreg CR®. (Note: Samples are not considered adequate justification for stabilization.)

OR

- The patient has had a documented side effect, allergy, or treatment failure to metoprolol SR or bisoprolol.

AND

- The patient has been unable to be compliant with or tolerate twice daily dosing of carvedilol IR.

Indication: Hypertension

- The patient has been started and stabilized on Coreg CR®. (Note: Samples are not considered adequate justification for stabilization.)

OR

- The patient has had a documented side effect, allergy, or treatment failure to 3(three) preferred anti-hypertensive beta-blockers.

DOCUMENTATION:

✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Beta-Blockers

Length of Authorization: 5 years

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
SINGLE AGENT	Betapace®*
ACEBUTOLOL† (compare to Sectral®)	Betapace AF®*
ATENOLOL† (compare to Tenormin®)	Cartrol® (carteolol)
BETAXOLOL† (compare to Kerlone®)	Coreg® (carvedilol)
BISOPROLOL FUMARATE† (compare to Zebeta®)	Coreg CR® *(QL = 1 tablet/day)*
CARVEDILOL† (compare to Coreg®)	Corgard®*
LABETALOL† (compare to Trandate®)	Inderal®* (all products)
METOPROLOL† (compare to Lopressor®)	Inderal LA®
METOPROLOL XL† (compare to Toprol XL®)	InnoPran XL®
NADOLOL† (compare to Corgard®)	Kerlone®*
PINDOLOL†	Levatol® (penbutalol)
PROPRANOLOL† (compare to Inderal®)	Lopressor®* (all products)
SOTALOL† (compare to Betapace®, BetapaceAF®)	propranolol ER† (compare to Inderal LA®)
TIMOLOL† (compare to Blocadren®)	Sectral®*
	Tenormin®*
	Timolide®
	Toprol XL®* (metoprolol succinate)
	Trandate®* (all products)
	Zebeta®*
BETA-BLOCKER/DIURETIC COMBINATION	
ATENOLOL/CHLORTHALIDONE† (compare to Tenoretic®)	Corzide®
BISOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Ziac®)	Inderide®*
METOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Lopressor HCT®)	Lopressor HCT®*
PROPRANOLOL/HYDROCHLOROTHIAZIDE† (compare to Inderide®)	Nadolol/bendroflumethiazide† (compare to Corzide®)
	Tenoretic®*
	Ziac®*

Anti-Hypertensives: Calcium Channel Blockers

LENGTH OF AUTHORIZATION: 5 years

CRITERIA FOR APPROVAL (except for Azor®, Caduet® and Exforge®):

- The patient has had a documented side effect, allergy, or treatment failure to at least one preferred drug. (If a medication has an AB rated generic, the trial must be the generic formulation.)

Azor

- The patient has had a documented side effect, allergy, or treatment failure to Exforge® or to amlodipine and valsartan as separate entities

AND

- The patient is unable to use Benicar and amlodipine as separate entities.

AND

- The quantity requested does not exceed 30 tablets per month (QL = 1 tablet/day).

Caduet®

- The prescriber must provide a clinically valid reason for the use of the requested medication.

Exforge®

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient has had a documented side effect, allergy, or treatment failure to an angiotensin converting enzyme inhibitor (ACEI), an ACEI combination or any other angiotensin receptor blocker (ARB) or ARB combination.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Calcium Channel Blockers

Length of Authorization: 5 years

Key: † Generic product, *Indicates generic equivalent is available without a PA, § Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS (No PA Required)	PA REQUIRED
SINGLE AGENT	Adalat® CC*
AMLODIPINE † (compare to Norvasc®)	Calan®*
CARTIA® XT (diltiazem HCL)	Calan® SR*
DILTIA® XT (diltiazem HCL)	Cardene®*
DILTIAZEM† (compare to Cardizem®)	Cardene® SR (no AB rated generic)
DILTIAZEM ER† (compare to Cardizem® SR)	Cardizem®*
DILTIAZEM CD† (compare to Cardizem®CD)	Cardizem® CD*
DILTIAZEM XR† (compare to Dilacor®XR)	Cardizem® LA (no AB rated generic)
FELODIPINE† (compare to Plendil®)	Covera-HS® (no AB rated generic)
NICARDIPINE† (compare to Cardene®)	Dilacor® XR*
NIFEDIAC® CC (compare to Adalat® CC)	Dynacirc® CR (no AB rated generic)
NIFEDICAL XL† (compare to Procardia® XL)	Isoptin® SR*
NIFEDIPINE IR† (compare to Procardia®)	isradipine†
NIFEDIPINE ER† (compare to Procardia® XL)	Nimotop®* (nimodipine)
NIMODIPINE † (compare to Nimotop®)	Norvasc®* (amlodipine)
TAZTIA® XT (compare to Tiazac®)	Plendil®*
VERAPAMIL† (compare to Calan®)	Procardia®*
VERAPAMIL CR† (compare to Calan SR®, Isoptin® SR)	Procardia XL®*
VERAPAMIL SR† 120 mg, 180 mg 240 mg and 360 mg (compare to Verelan®)	Sular® (nisoldipine)
	Tiazac®*
	verapamil SR† 100 mg, 200 mg, 300mg (compare to Verelan PM®)
	Verelan®*
	Verelan® PM
CALCIUM CHANNEL BLOCKER/OTHER COMBINATION **(preferred after clinical criteria are met)**	
EXFORGE® (valsartan/amlodipine) § *(QL = 1 tab/day)*	Azor® (olmesartan/amlodipine) *(QL = 1 tablet/day)*
	Caduet® (amlodipine/atorvastatin)

Anti-hypertensives: Renin Inhibitors

LENGTH OF AUTHORIZATION: lifetime

CRITERIA FOR APPROVAL:

Tekturna®:

- The patient has a diagnosis of hypertension.

AND

- The patient has had a documented side effect, allergy, or treatment failure with an Angiotensin Receptor Blocker (ARB). *Note:* Approval of an ARB requires a documented side effect, allergy, or treatment failure with an Angiotensin Converting Enzyme (ACE) inhibitor.

AND

- The request is for a quantity not exceeding one tablet per day.

Tekturna HCT®:

- The patient has a diagnosis of hypertension.

AND

- The patient has had a documented side effect, allergy, or treatment failure with an Angiotensin Receptor Blocker (ARB). *Note:* Approval of an ARB requires a documented side effect, allergy, or treatment failure with an Angiotensin Converting Enzyme (ACE) inhibitor.

OR

- The patient has had a documented treatment failure with Tekturna® alone.

AND

- The request is for a quantity not exceeding one tablet per day.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the use of this medication on a **General Prior Authorization Request Form**.

Anti-hypertensives: Renin Inhibitors

Length of Authorization: lifetime

Key: § Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED DRUGS AFTER CLINICAL CRITERIA ARE MET
Single Agent Tekturna® (aliskiren) § *(Qty Limit = 1 tablet/day)* **Combination** Tekturna HCT® (aliskiren/hydrochlorothiazide) § *(Qty Limit = 1 tablet/day)*	

Anti-Infectives: Cephalosporins

LENGTH OF AUTHORIZATION: for the date of service, only: no refills

CRITERIA FOR APPROVAL:

Duricef®, Keflex®:

- The patient has had a documented side effect, allergy, or treatment failure to generic cefadroxil and cephalexin.

Lorabid® capule/suspension:

- The patient is completing a course of therapy which was initiated in the hospital.

OR

- The patient has had a documented side effect, allergy, or treatment failure to at least two of the following medications: cefaclor/ER, cefprozil, and cefuroxime (for the capsule) or the patient has had a documented side effect, allergy, or treatment failure to at least two of the following medications: cefaclor suspension, cefprozil suspension and Ceftin® suspension (for the suspension).

Ceftin® tablets, Cefzil® tablets:

- The patient has had a documented side effect, allergy, or treatment failure to at least two of the following medications: cefaclor/ER, cefprozil, and cefuroxime. If a product has an AB rated generic, one trial must be the generic formulation.

Cefuroxime suspension, Cefzil® suspension:

- The patient has had a documented side effect, allergy, or treatment failure to at least two of the following medications: cefaclor suspension, cefprozil suspension and Ceftin® suspension. If a product has an AB rated equivalent that is preferred, one trial must be the preferred formulation.

Spectracef® tablet, Cedax® Capsule:

- The patient is completing a course of therapy which was initiated in the hospital.

OR

- The patient has had a documented side effect, allergy, or treatment failure to both cefpodoxime and Omnicef®.

Cefdinir capsule or suspension:

- The patient has had a documented side effect or treatment failure to brand Omnicef®.

Cefpodoxime suspension, Cedax®suspension:

- The patient is completing a course of therapy which was initiated in the hospital.

OR

- The patient has had a documented side effect or treatment failure to both, brand Omnicef® and Suprax® suspension.

Vantin® suspension:

- The patient is completing a course of therapy which was initiated in the hospital and the patient is unable to use generic cefpodoxime.

OR

- The patient has had a documented side effect or treatment failure to brand Omnicef® or Suprax®suspension AND cefpodoxime suspension.

Vantin® tablets:

- The patient is completing a course of therapy which was initiated in the hospital and the patient is unable to use generic cefpodoxime.

OR

- The patient has had a documented side effect or treatment failure to both brand Omnicef® and cefpodoxime. If a product has an AB rated generic, one trial must be the generic formulation.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Anti-Infectives: Cephalosporins *Length of Authorization: Date of service only. No refills.*

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
1st GENERATION:	
CEFADROXIL† (compare to Duricef®) CEPHALEXIN† (compare to Keflex®) IV drugs are not managed at this time.	Duricef®* Keflex®*
2nd GENERATION:	
TABLETS CEFACLOR CAPSULE† CEFACLOR ER TABLET† CEFPROZIL TABLETS† (compare to Cefzil®) CEFUROXIME TABLETS† (compare to Ceftin®) SUSPENSION CEFACLOR SUSPENSION† CEFPROZIL SUSPENSION† (compare to Cefzil®) CEFTIN® suspension IV drugs are not managed at this time.	Ceftin® tablets* Cefzil® tablets* Lorabid® (loracarbef) capsule Cefuroxime† suspension (compare to Ceftin®) Cefzil® suspension* Lorabid® (loracarbef) suspension
3rd GENERATION:	
CAPSULES/TABLETS CEFPODOXIME PROXETIL TABS† (compare to Vantin®) OMNICEF® CAPSULE (cefdinir) SUSPENSION OMNICEF® SUSPENSION (cefdinir) SUPRAX® SUSPENSION (cefixime) IV drugs are not managed at this time.	Cedax® capsule (ceftibuten) Cefdinir capsule† Spectracef® tablet (cefditoren) Vantin® tablet* (cefpodoxime) Cedax® Suspension (ceftibuten) Cefdinir suspension† Cefpodoxime proxetil suspension† (compare to Vantin®) Vantin® suspension (cefpodoxime)

Anti-Infectives: Ketolides

LENGTH OF AUTHORIZATION: Date of service only, no refills

CRITERIA FOR APPROVAL:

- The member is continuing a course of therapy initiated while an inpatient at a hospital.

OR

- The diagnosis or indication for the requested medication is community-acquired pneumonia.

AND

- The member is at least 18 years of age at the time of the request.

AND

- The member has no contraindication or a history of hypersensitivity or serious adverse event, from any macrolide antibiotic.

AND

- Infection is due to documented *Streptococcus pneumoniae* (including multi-drug resistant [MDRSP*] *s.pneumoniae*), *Haemophilus influenzae*, *Moraxella catarrhalis*, *Chlamydophila pneumoniae*, or *Mycoplasma pneumoniae.*

AND

- The member does not have any of the following medical conditions: myasthenia gravis, hepatitis or underlying liver dysfunction, history of arrhythmias (e.g. QTc prolongation, or antiarrhythmic therapy), uncorrected hypokalemia or hypomagnasemia, clinically significant bradycardia, a history of therapy with Class IA (e.g. quinidine or procainamide) or Class III (e.g. dofetilide) antiarrhythmic medications.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the use of a non-preferred agent on the **General Prior Authorization Request Form**.

*MDRSP includes penicillin-resistant *S. pneumoniae* isolates (PRSP) that are resistant to ≥ 2 of the following antibiotics: penicillin, 2nd generation cephalosporins, macrolides, tetracyclines, and trimethoprim/sulfamethoxazole.

Anti-Infectives: Ketolides	*Length of Authorization: Date of Service Only; no refills*
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
n/a	Ketek® (telithromycin)

Anti-Infectives: Macrolides

LENGTH OF AUTHORIZATION: For the date of service only: no refills.

CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):

- The patient has a documented side-effect, allergy, or treatment failure to at least two of the preferred medications. (If a product has an AB rated generic, one trial must be the generic.)

OR

- The patient is completing a course of therapy with the requested medication that was initiated in the hospital.

CRITERIA FOR APPROVAL OF AZITHROMYCIN FOR > 5 DAY SUPPLY:

- The patient has a diagnosis of Lyme Disease AND has had a documented side effect, allergy, or treatment failure to doxycycline, amoxicillin, or a 2nd generation cephalosporin.

OR

- The patient has a diagnosis of Cystic Fibrosis. (length of authorization up to 6 months)

OR

- The patient has a diagnosis of HIV/immunocompromised status and azithromycin is being used for MAC or Toxoplasmosis treatment or prevention.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting provision of a non-preferred agent or more than the stated quantity limits on a **General Prior Authorization Request Form**.

Anti-Infectives: Macrolides

Length of Authorization: Date of service only. No refills.

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
AZITHROMYCIN† tabs (≤ 5 day supply) (compare to Zithromax®) AZITHROMYCIN† liquid (≤ 5 day supply) (compare to Zithromax®) CLARITHROMYCIN† (compare to Biaxin®) ERY-TAB® (erythromycin base, delayed release) ERYTHROCIN† (erythromycin stearate) ERYTHROMYCIN BASE† ERYTHROMYCIN ESTOLATE† ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S.®, Eryped®) ERYTHROMYCIN STEARATE† ERYTHROMYCIN W/SULFISOXAZOLE† (compare to Pediazole®) IV drugs are not managed at this time.	azithromycin† tablets and liquid (if > 5 day supply) Biaxin®* Biaxin XL® Dynabac® (dirithromycin) E.E.S.®* (erythromycin ethylsuccinate) Eryc®* (erythromycin base, delayed release) Eryped® (erythromycin ethylsuccinate) PCE Dispertab® (erythromycin base) Pediazole®* (erythromycin-sulfisoxazole) Zithromax®* tablets and liquid Zmax® Suspension (azithromycin extended release for oral suspension)

Anti-Infectives: Oxazolidinones

LENGTH OF AUTHORIZATION: 28 days

CRITERIA FOR APPROVAL:

- The patient has been started on intravenous or oral linezolid in the hospital and will be finishing the course of therapy in an outpatient setting **AND** the quantity requested does not exceed 56 tablets per 28 days.

OR

- The patient has a documented blood, tissue, sputum, or urine culture that is positive for Vancomycin-Resistant Enterococcus (VRE) species or Methicillin-Resistant Staphylococcus species **AND** the quantity requested does not exceed 56 tablets per 28 days.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent and quantities exceeding the established limit on a **General Prior Authorization Request Form**.

Anti-Infectives: Oxazolidinones	*Length of authorization: 28 days*
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
IV form of this medication not managed at this time	Zyvox® (linezolid) *QL = 56 tablets per 28 days*

Anti-infectives: Penicillins (Oral)

LENGTH OF AUTHORIZATION: For the date of service only; no refills

CRITERIA FOR APPROVAL:

Augmentin and Augmentin ES:

- The patient has had a documented side effect, allergy, or treatment failure to the generic formulation of the requested medication.

OR

- The patient is < 12 weeks of age and requires the 125 mg/5 mL strength of Augmentin.

Augmentin XR:

- The prescriber must provide a clinically valid reason for the use of the requested medication.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Anti-Infectives: Penicillins (oral) *Length of Authorization: Date of service only. No refills.*

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
AMOXICILLIN† (compare to Amoxil®, Trimox®, DisperMox®) AMOXICILLIN/CLAVULANATE† (compare to Augmentin®) AMPICILLIN† (compare to Principen®) DICLOXACILLIN† PENICILLIN VK† (compare to Veetids®)	Augmentin®*♣ Augmentin ES®* Augmentin XR® ♣ PA will be granted for 125 mg/5 mL strength for patients < 12 weeks of age

Anti-Infectives: Quinolones

LENGTH OF AUTHORIZATION: for the date of service, no refills

CRITERIA FOR APPROVAL:

Noroxin®:

- The patient is completing a course of therapy with the requested medication that was initiated in the hospital.

OR

- The patient has had a documented side effect, allergy, or treatment failure to ciprofloxacin immediate-release tablets/solution or ofloxacin.

Cipro®, Cipro XR®, ciprofloxacin ER, ProQuin XR®:

- The patient has had a documented side effect, allergy, or treatment failure to generic ciprofloxacin immediate-release tablets or oral solution.

Avelox®, Factive®:

- The patient is completing a course of therapy with the requested medication that was initiated in the hospital.

OR

- The patient has had a documented side effect, allergy, or treatment failure to Levaquin.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred quinolone on a **General Prior Authorization Request Form**.

Anti-Infectives: Quinolones

Length of Authorization: Date of service only. No refills.

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
CIPROFLOXACIN† (compare to Cipro®) CIPRO® OS (ciprofloxacin oral solution) LEVAQUIN® (levofloxacin) OFLOXACIN†	Avelox ® (moxifloxacin HCL) Avelox® ABC PACK (moxifloxacin HCL) Cipro®* Cipro® XR ciprofloxacin ER† Factive® (gemifloxacin) Noroxin® (norfloxacin) ProQuin XR® (ciprofloxacin extended-release)
IV drugs are not managed this time	

LENGTH OF AUTHORIZATION: Up to 3 months

Onychomycosis (terbinafine):
Fingernails: 2 tablets (500mg) per day for 1 week/month for 2 months (pulse) or 1 tablet (250mg) per day for 6 weeks
Toenails: 2 tablets (500mg) per day for 1 week per month for 3 months (pulse) or 1 tablet (250mg) per day for 12 weeks

Other indications: 3 months

CRITERIA FOR APPROVAL (TERBINAFINE):

- The patient has a diagnosis of a fingernail/toenail onychomycosis infection (confirmed with a positive KOH stain, PAS stain, or fungal culture or physician clinical judgment).

AND

- The patient meets at least 1 of the following criteria:
  - Pain to affected area that limits normal activity
  - Diabetes Mellitus
  - Patient is immunocompromised
  - Patient has diagnosis of systemic dermatosis
  - Patient has significant vascular compromise

AND

- The quantity requested does not exceed 30 tablets per month for a maximum of 3 months.

OR

- The patient has a diagnosis of a *Tinea capitis* infection (confirmed with a positive KOH stain, PAS stain, or fungal culture).

AND

- The quantity requested does not exceed 30 tablets per month for a maximum of 1 month.

OR

- The patient has a diagnosis of a *Tinea pedis*, *Tinea cruris*, or *Tinea corporis* infection (confirmed with a positive KOH stain, PAS stain, or fungal culture).

AND

- The patient has a documented side-effect, allergy, or treatment failure to at least **THREE** different topical antifungal medications (one of the trials **must** have included a topical terbinafine product).

AND

- The quantity requested does not exceed 30 tablets per month for a maximum of 1 month.

- For approval of Lamisil®, the patient must have a documented intolerance to generic terbinafine.

LIMITATIONS:
Coverage of Onychomycosis agents will **NOT be approved solely for cosmetic purposes.**

DOCUMENTATION:

- ✓ Document clinically compelling information supporting provision of the non-preferred agent or more than the stated quantity limits on a **General Prior Authorization Request Form**.

Anti-Infectives: Antifungals: Allylamines

Length of Authorization: Up to 3 months

Key: † Generic product

PREFERRED DRUGS (No PA Required)	PA REQUIRED
	terbinafine† (compare to Lamisil®) tablets *(QL: 30 tab/month post PA approval)* Lamisil® tablets (terbinafine) *(QL: 30 tab/month post PA approval)*

LENGTH OF AUTHORIZATION: Up to 3 months

Onychomycosis (Sporanox/itraconazole):
Fingernails: 2 capsules (200mg) twice daily for 1 week per month for 2 months (pulse) or
2 capsules (200mg) per day for 6 weeks
Toenails: 2 capsules (200mg) twice daily for 1 week per month for 3 months (pulse) or
2 capsules (200mg) per day for 12 weeks

Other medications/indications: 3 months

CRITERIA FOR APPROVAL (ITRACONAZOLE/ SPORANOX®):

- The patient has a diagnosis of invasive aspergillosis, blastomycosis, or histoplasmosis

OR

- The patient has a diagnosis of a fingernail/toenail onychomycosis infection (confirmed with a positive KOH stain, PAS stain, fungal culture or physician clinical judgment) **AND** has a documented side-effect, allergy, contraindication, or treatment failure to oral terbinafine **AND** meets at least 1 of the following criteria:
  - Pain to affected area that limits normal activity
  - Diabetes Mellitus
  - Patient is immunocompromised
  - Patient has diagnosis of systemic dermatosis
  - Patient has significant vascular compromise

OR

- The patient is completing a course of therapy with the requested medication that was initiated in the hospital.

OR

- The patient has a documented side-effect, allergy, or treatment failure to at least **ONE** of the preferred medications.

- For approval of Sporanox®, the patient must have a documented intolerance to generic itraconazole.

LIMITATIONS:
Coverage of Onychomycosis agents will **NOT be approved solely for cosmetic purposes.**

CRITERIA FOR APPROVAL OF VFEND:

- VFend is being used for the treatment of invasive aspergillosis.

OR

- The patient is completing a course of therapy with the requested medication that was initiated in the hospital.

OR

- The patient has a documented side-effect, allergy, or treatment failure to **ONE** of the preferred medications **AND** itraconazole.

CRITERIA FOR APPROVAL OF NOXAFIL:

- The patient has a diagnosis of HIV/immunocompromised status (neutropenia secondary to chemotherapy, hematopoietic stem cell transplant recipients) **AND** Noxafil is being used for the prevention of invasive *Aspergillus*/*Candida* infections.

OR

- The patient is completing a course of therapy with the requested medication that was initiated in the hospital.

OR

- The patient has a documented side-effect, allergy, or treatment failure to **ONE** of the preferred medications **AND** itraconazole **AND** the patient is being treated for oropharyngeal candidiasis.

CRITERIA FOR APPROVAL OF NIZORAL®/DIFLUCAN® (BRANDS):

- For approval of Nizoral® brand name product, the patient must have a documented intolerance to generic ketoconazole.

- For approval of Diflucan® brand name product, the patient must have a documented intolerance to generic fluconazole.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting provision of a non-preferred agent on a **General Prior Authorization Request Form**.

Anti-Infectives: Antifungals: Azoles

Length of Authorization: Up to 3 months (see above)

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
FLUCONAZOLE† (compare to Diflucan®) KETOCONAZOLE† (compare to Nizoral®) IV drugs are not managed at this time.	itraconazole† (compare to Sporanox®) Sporanox® (itraconazole) VFend® (voriconazole) Diflucan®* (fluconazole) Nizoral®* (ketoconazole) Noxafil® (posaconazole)

Anti-Infectives: Antifungals: Topical: Onychomycosis

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL (CICLOPIROX/PENLAC SOLUTION):

- The patient has a diagnosis of a fingernail/toenail onychomycosis infection (confirmed with a positive KOH stain, PAS stain, or fungal culture or physician clinical judgment).

AND

- The patient meets at least 1 of the following criteria:
  - Pain to affected area that limits normal activity
  - Diabetes Mellitus
  - Patient is immunocompromised
  - Patient has diagnosis of systemic dermatosis
  - Patient has significant vascular compromise

- For approval of Penlac®, the patient must have a documented intolerance to generic ciclopirox.

LIMITATIONS:
Coverage of Onychomycosis agents will **NOT be approved solely for cosmetic purposes.**

DOCUMENTATION:

- ✓ Document clinically compelling information supporting provision of the non-preferred agent on a **General Prior Authorization Request Form**.

Anti-Infectives: Antifungals: Topical: Onychomycosis

Length of Authorization: 1 year

Key: † Generic product

PREFERRED DRUGS (No PA Required)	PA REQUIRED
	ciclopirox† 8 % solution (compare to Penlac® Nail Lacquer) *(QL=1 bottle (6.6 ml)/90 days)* Penlac® Nail Lacquer (ciclopirox 8 % solution) *(QL=1 bottle (6.6 ml)/90 days)*

Anti-Infectives: Herpes: Oral

LENGTH OF AUTHORIZATION: for duration of prescription, up to 6 months

CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):

- The patient has a documented side effect, allergy, or treatment failure (at least one course of ten or more days) with acyclovir **AND** Valtrex.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Anti-Infectives: Herpes

Length of Authorization: up to 6 months

Key: † Generic product, *Indicates generic equivalent is available without a PA
§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS (No PA Required)	PA REQUIRED
ACYCLOVIR† (compare to Zovirax®) VALTREX® (valacyclovir)	Famvir® (famciclovir) § famciclovir (compare to Famvir®) Zovirax®* (acyclovir) §

On the basis of antiviral testing results conducted at CDC and in Canada indicating high levels of resistance, CDC and ACIP recommend that neither amantadine nor rimantadine be used for the treatment or chemoprophylaxis of influenza A in the United States until susceptibility to these antiviral medications has been re-established among circulating influenza A viruses. Oseltamivir or zanamivir can be prescribed if antiviral treatment of influenza is indicated. Oseltamivir is approved for treatment of persons aged ≥1 year, and zanamivir is approved for treatment of persons aged ≥7 years. Oseltamivir and zanamivir can be used for chemoprophylaxis of influenza; oseltamivir is licensed for use in persons aged ≥1 year, and zanamivir is licensed for use in persons aged ≥5 years. (http://www.cdc.gov/flu/professionals/treatment/)

LENGTH OF AUTHORIZATION: for duration of the prescription, up to 6 weeks

CRITERIA FOR APPROVAL (Tamiflu, Relenza):

Tamiflu and Relenza will NOT require prior-authorization during the Flu season (November 1 through March 31) when prescribed within the following quantity limits:

Tamiflu (oseltamivir): 75 mg or 45 mg: 10 capsules per 30 days
30 mg: 20 capsules per 30 days
Suspension: 75 ml per 30 days
Relenza (zanamivir): 20 blisters per 30 days

For requests exceeding the quantity limits, the following criteria must be met:

Treatment:
Requests will be reviewed on a case-by-case basis

Chemoprophylaxis:
The patient must have one of the following risk factors:

1. 65 years of age or older, or child 12-23 months of age
2. Healthcare worker or caretaker of high risk patient who has not or cannot receive the flu vaccine
3. Chronic cardiovascular or pulmonary disease (*e.g.,* asthma, COPD)
4. Chronic endocrine or metabolic disorders (*e.g*., diabetes)
5. Chronic renal failure
6. Immunosuppression (*e.g.,* secondary to corticosteroid therapy, immunosuppressive therapy or chemotherapy)
7. HIV/AIDS
8. Second or third trimester of pregnancy
9. Hemoglobinopathy (*e.g.,* sickle cell anemia, thalassemia)
10. Nursing home or long-term care facility resident
11. Child receiving long-term aspirin therapy who is not a candidate for the flu vaccine

AND

The patient must be part of at least one of the following high risk influenza situations:

1. Has not been vaccinated due to
   a. allergy or intolerance to the influenza vaccine (*e.g*., history of Guillain-Barre syndrome)
   b. insufficient vaccine supply (*e.g*., vaccine unavailability)
   c. Other: _____
2. Insufficient time to develop immunity between vaccination and likely exposure (*i.e.,* 2 weeks for adults; 6 weeks for children < 9 years of age (4 weeks after the first dose and an additional 2 weeks after the second dose)
3. The presence of an active outbreak of influenza among institutionalized residents
4. Circulating influenza viruses are different than the strains used to develop the vaccine

AND

The patient must be ≥ 1 year of age (for Tamiflu request) or ≥ 5 years of age (for Relenza request)

Tamiflu: 75 mg /appropriate pediatric dose once a day for 10 days (up to 6 weeks)
Relenza: 2 inhalations once daily for 10 days (up to 28 days)

Please note, in the event of an influenza outbreak, all requests will be evaluated on a case-by-case basis in accordance with recommendations from the Department of Public Health and/or the Centers for Disease Control.

	Recommended Dosing Regimen
Treatment	Tamiflu: 75 mg/appropriate pediatric dose twice a day for 5 days Relenza: 2 inhalations twice a day for 5 days
Prophylaxis	Tamiflu: 75 mg/appropriate pediatric dose once a day for 10 days (up to 6 weeks) Relenza: 2 inhalations once daily for 10 days (up to 28 days)

CRITERIA FOR APPROVAL (amantadine, rimantadine):

Requests for amantadine and rimantadine will be evaluated on a case by case basis as susceptibility is determined.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Anti-Infectives: Influenza Medications

Length of Authorization: up to 6 weeks

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required During Flu Season November 1st through March 31st)	PA REQUIRED
RELENZA® (QL= 20 blisters/30 days) TAMIFLU® (QL = 10 caps/30 days (45 mg & 75 mg caps), 20 caps/30 days (30 mg caps), 75 ml/30 days (suspension))	amantadine† (PA required for ≤ 10 day supply) Flumadine® (rimantadine) rimantadine† Symmetrel® (amantadine) Note: amantadine and rimantadine are not CDC recommended for use in influenza

Anti-Infectives: Influenza Vaccines

LENGTH OF AUTHORIZATION:

1 dose for children and adults aged 2-49 years, including children aged 2-8 years who have been previously vaccinated with influenza vaccine.

2 doses total, given at least one month apart, for children age 2-8 years who have not been previously vaccinated with influenza vaccine.

INDICATION:

Influenza nasal vaccine (live attenuated) is FDA approved for influenza prevention in healthy people 2 - 49 years of age who are not pregnant. It is different from the standard influenza vaccines, which contain inactivated viruses and are administered intramuscularly. Theoretically, viruses from the live vaccine may be transmitted to other people. The Advisory Committee on Immunization Practices (ACIP) publishes guidelines specifying groups of people who will benefit most from influenza vaccination, such as those with chronic medical conditions, nursing home residents, and pregnant women. However, the intranasal formulation is contraindicated in many patients that would benefit from influenza vaccination, due to the fact it is a live vaccine. Results of one large study in children 15-85 months of age showed the nasal influenza vaccine reduced the chance of influenza illness by 92 % compared with placebo.. In a study among adults, the participants were not specifically tested for influenza. However, the study found 19% fewer severe febrile respiratory tract illnesses, 24% fewer respiratory tract illnesses with fever, 23-27% fewer days of illness, 13-28% fewer lost work days, 15-41% fewer health care provider visits, and 43-47% less use of antibiotics compared with placebo.

CRITERIA FOR APPROVAL:

- Flumist is being requested for influenza prophylaxis during flu season,

AND

- The patient is between the ages of 2 and 49 years old,

AND

- Prescriber provides documentation of a contraindication to an intramuscular injection (e.g., currently on warfarin; history of thrombocytopenia) or other compelling information to support the use of this dosage form.

EXCLUDED FROM APPROVAL:

- Hypersensitivity (severe allergy) to any FluMist® component including eggs and egg products.
- Children and adolescents aged 2 – 17 years receiving aspirin therapy (increased risk of Reye's Syndrome).
- History of Guillain-Barre Syndrome.
- People with a medical condition that places them at high risk for complications from influenza, including those with chronic heart or lung disease, such as asthma or reactive airways disease; people with medical conditions such as diabetes or kidney failure; or people with illnesses that weaken the immune system, or who take medications that can weaken the immune system.
- Children <5 years old with a history of recurrent wheezing
- Pregnant women

Requests will be evaluated on a case-by-case basis, in the event of vaccine shortage and/or the issuing of prioritization orders from the Department of Public Health and Centers for Disease Control.

Age Group	Vaccination Status	Dosage Schedule
Children age 2 –8 years	Not previously vaccinated with influenza vaccine	2 doses (0.2 mL* each at least one month apart)
Children age 2 – 8 years	Previously vaccinated with influenza vaccine	1 dose (0.2 mL*) per season
Children & Adults age 9-49	Not Applicable	1 dose (0.2 mL*) per season

* administered as 0.1 mL per nostril

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the use of Flumist® on the **General Prior Authorization Request Form**.

Anti-Infectives: Influenza Vaccines

Length of Authorization: up to 6 weeks

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
AFLURIA® Injection FLUARIX® Injection FLUZONE® Injection FLUVIRIN® Injection	FluMist® Nasal

Anti-Infectives: Miscellaneous

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

- The diagnosis or indication is for the treatment of malaria. (Use for leg cramps not permitted.)

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the use of a non-preferred agent on the **General Prior Authorization Request Form**.

Miscellaneous

Length of Authorization: 1 year

PREFERRED DRUGS (No PA Required)	PA REQUIRED
	Qualaquin® (quinine sulfate)

Anti-Infectives: Topical Antibiotics

LENGTH OF AUTHORIZATION: for the date of service, no refills

CRITERIA FOR APPROVAL:

Altabax®:

- The patient is being treated for impetigo.

AND

- The patient has had a documented side effect, allergy, or treatment failure with mupirocin or Bactroban® Ointment

AND

- MRSA (methicillin resistant staph aureus) has been ruled out by culture

Bactroban®Cream:

- The patient has had a documented side effect, allergy, or treatment failure with mupirocin or Bactroban® Ointment

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the use of a non-preferred agent on the **General Prior Authorization Request Form**

Topical Antibiotics *Length of Authorization: for date of service, no refills*

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
BACITRACIN† GENTAMICIN† BACITRACIN-POLYMIXIN† NEOMYCIN-BACITRACIN-POLYMIXIN† CORTISPORIN BACTROBAN® OINTMENT MUPIROCIN OINTMENT† (compare to Bactroban®)	Altabax® (retapamulin) *QL = 1 tube* Bactroban® Cream

Anti-Migraine: Triptans

LENGTH OF AUTHORIZATION: 6 months

CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):

- The patient has had a documented side-effect, allergy or treatment failure to Axert®, Maxalt®, and Imitrex®.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting provision of a non-preferred agent or more than the stated quantity limits on a **General Prior Authorization Request Form**.

Anti-Migraine: Triptans

Length of Authorization: 6 months

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
Axert® (almotriptan) *Quantity Limit = 6 tablets/month* Imitrex® (sumatriptan) *Quantity Limit = 18 tablets/month (25 mg), 9 tablets/month (50 mg, 100 mg), 4 injections/month (6 mg injection), 12 units/month (5 mg nasal spray), 6 units/month (20 mg nasal spray)* Maxalt® (rizatriptan) tablet or Maxalt-MLT® (rizatriptan ODT) *Quantity Limit = 12 tablets/month*	Amerge® (naratriptan) *Quantity Limit = 9 tablets/month* Frova® (frovatriptan) *Quantity Limit = 9 tablets/month* Relpax® (eletriptan) *Quantity Limit = 12 tablets/month* Zomig® (zolmitriptan) *Quantity Limit = 12 tablets/month (2.5 mg tablets or orally disintegrating tablets), 6 tablets/month (5 mg tablets or orally disintegrating tablets), 12 units/month (5 mg nasal spray)*

Anti-Obesity Agents

LENGTH OF AUTHORIZATION: Initial approval: 3 months
Continuation of Therapy: 3 months (Xenical/Alli and Meridia only)

CRITERIA FOR APPROVAL:

INITIAL REQUEST:

- The patient is > 12 years old for Xenical/Alli, all others age > 16 years

AND

- The patient's Body Mass Index (BMI) is:
  1) $\geq 30 kg/m^2$ **OR**
  2) $\geq 27 kg/m^2$ with comorbid condition of Hypertension, Obstructive Sleep Apnea, Type 2 Diabetes Mellitus, Dyslipidemia, or Coronary Heart Disease (history of MI, angina, coronary artery procedures)

AND

- The patient has failed to lose weight after 6 months on a weight loss regimen of low calorie diet, increased physical activity, and nutritional counseling.

AND

- The medication will be used as part of a total treatment plan including a calorie and fat restricted diet and exercise regimen.

AND

- Requested agent is not to be used in combination with another anti-obesity agent

AND

- If the request is for Xenical, the patient has had a 3 month trial of Alli and has not achieved at least a 5 pound weight loss.

AND

- The patient does not have any contraindications to use:

Alli, Xenical:	Malabsorption syndrome, cholestasis, pregnant or lactating, hyperoxaluria, calcium oxalate nephrolithiasis
Meridia:	Concomitant MAOI use, concomitant use of centrally acting appetite suppressants, poorly or uncontrolled HTN, pregnant or lactating, severe renal or hepatic dysfunction, hx of CAD, CHF, arrhythmias, stroke, bulimia or anorexia nervosa
Diethylpropion, Benzphetamine, Phendimetrazine, Phentermine:	Advanced arteriosclerosis, agitated states, concomitant use of MAOI, concomitant use of other CNS stimulants, glaucoma, hx of drug abuse, hypersensitivity or idiosyncratic reaction to sympathomimetic amines, moderate to severe HTN, hyperthyroidism, pregnant, symptomatic cardiovascular disease

CONTINUATION OF THERAPY (Xenical/Alli and Meridia only, other agents FDA approved only for short tem use)

- Xenical/Alli or Meridia may be approved if weight loss of 5 or more pounds during 3 months of therapy is documented.

DOCUMENTATION:

- ✓ Document clinically compelling information on an **Anti-Obesity Prior Authorization Request Form**.

Anti-Obesity Agents

Length of Authorization: 3 months

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS	PA REQUIRED
	Alli® (orlistat OTC) *(QL = 3 capsules/day)* benzphetamine† (all forms brand and generic) diethylpropion† (all forms brand & generic) Meridia® (sibutramine) phentermine† (all forms brand & generic) phendimetrazine† (all forms brand & genereic) Xenical® (orlistat)

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ ANTI-OBESITY MEDICATIONS~

Prior Authorization Request Form

Effective November 01, 2001, Vermont Medicaid established coverage limits and criteria for prior authorization of non-amphetamine based diet medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Anti-Obesity drug prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____ Fax#:_____

Address: _____

_____

Contact Person at Office: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Drug Requested:_____ **Strength & Frequency:**_____ **Length of therapy:**_____

1. **Current Body Mass Index (BMI):**_____**Height:**_____**Weight:** _____ **Waist Circumference:**_____
2. **Does the patient have any of the following conditions? (Please check all that apply.)**

   ☐ **Hypertension** ☐ **Obstructive Sleep Apnea** ☐ **Diabetes** ☐ **Dyslipidemia** ☐ **Coronary Heart Disease**
3. **Has the member been participating in a weight loss treatment plan (nutritional counseling, an exercise regimen, and a calorie and fat restricted diet) for the past 6 months?** □ **YES** □ **NO**
   If YES, Please provide a description of the program, dates, and results: _____
   _____
   _____
4. **Will this medication be used in addition to a weight loss treatment plan (nutritional counseling, an exercise regimen and a calorie and fat restricted diet)?** □ **YES** □ **NO**
   Please explain: _____
   _____
5. **Does the patient have any contraindications for use of this medication? (Please see table below.)**
   □ **YES** □ **NO** **If YES, please explain:** _____

Alli, Xenical:	**Malabsorption syndrome, cholestasis, pregnant or lactating, hyperoxaluria, calcium oxalate nephrolithiasis**
Meridia:	**Concomitant MAOI use, concomitant use of centrally acting appetite suppressants, poorly or uncontrolled HTN, pregnant or lactating, severe renal or hepatic dysfunction, hx of CAD, CHF, arrhythmias, stroke, bulimia or anorexia nervosa**
Diethylpropion, Benzphetamine, Phendimetrazine, Phentermine:	**Advanced arteriosclerosis, agitated states, concomitant use of MAOI, concomitant use of other CNS stimulants, glaucoma, hx of drug abuse, hypersensitivity or idiosyncratic reaction to sympathomimetic amines, moderate to severe HTN, hyperthyroidism, pregnant, symptomatic cardiovascular disease**

Prescriber Signature:_____ Date of this request:_____

Antipsychotics: Atypical and Combination

LENGTH OF AUTHORIZATION: Duration of need *

CRITERIA FOR APPROVAL:

NON-PREFERRED TABLETS: (except Seroquel XR®)

- The patient has been started and stabilized on the requested medication.

  OR
- The patient has had a documented side effect, allergy or treatment failure with at least two preferred products. (If a product has an AB rated generic, one trial must be the generic.)

Seroquel XR®:

- The patient has been started and stabilized on the requested medication.

  OR
- The patient has not been able to be adherent to a twice daily dosing schedule of Seroquel® immediate release resulting in a significant clinical impact

NON-PREFERRED ORAL SOLUTIONS:

- The patient has been started and stabilized on the requested medication.

  OR
- The patient has had a documented side effect, allergy or treatment failure with at least one preferred product.

NON-PREFERRED SHORT-ACTING INJECTABLE PRODUCTS:

- Medical necessity for a specialty dosage form has been provided.

  AND
- The patient has had a documented side effect, allergy, or treatment failure with Geodon IM.

LONG-ACTING INJECTIONS:

- Medical necessity for a specialty dosage form has been provided (swallowing disorder, non-compliance with oral medications, etc.)

ORALLY DISINTEGRATING TABLETS:

- Medical necessity for a specialty dosage form has been provided.

COMBINATION PRODUCTS:

- The patient has been started and stabilized on the requested medication.

  OR
- The patient has had a documented side effect, allergy or treatment failure with two preferred products (Geodon, Risperdal, and Seroquel).

  OR
- The prescriber provides a clinically valid reason for the use of the requested medication.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

After a 4-month lapse in use of a non-preferred agent, or if there is a change in therapy, a look-back through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.

MANAGEMENT OF MENTAL HEALTH DRUGS: See page 118 for a description of the management of mental health drugs.

Antipsychotics: Atypical and Combination

*Length of authorization: Duration of Need**

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
TABLETS	
CLOZAPINE† (compare to Clozaril®) *Suggested max dose=1125 mg/day* GEODON® (ziprasidone) *suggested max dose=200 mg/day* RISPERDAL® (risperidone) *suggested max dose=10 mg/day* SEROQUEL® (quetiapine) *suggested max dose=1000 mg/day*	Abilify® (aripiprazole) *suggested max dose = 40 mg/day, Quantity limit = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)* Clozaril®* *suggested max dose = 1125 mg/day* Invega® (paliperidone) *Quantity limit = 1 tab/day (3mg, 9mg), 2 tabs/day (6mg)* Seroquel XR® (quetiapine) *Quantity Limit = 1 tab/day (200 mg tablet strength only)* Zyprexa® (olanzapine) *suggested max dose = 50 mg/day, Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs)*
ORAL SOLUTIONS	
RISPERDAL® (risperidone) oral solution *suggested max dose=10 mg/day*	Abilify® (aripiprazole) oral solution *suggested max dose = 40 mg/day*
SHORT-ACTING INJECTABLE PRODUCTS	
GEODON® IM (ziprasidone intramuscular injection)	Abilify® IM (aripiprazole intramuscular injection) Zyprexa® IM (olanzapine intramuscular injection)
LONG-ACTING INJECTABLE PRODUCTS	
	Risperdal® Consta (risperdone microspheres)
ORALLY DISINTEGRATING TABLETS	
	Abilify Discmelt (aripiprazole) *suggested max dose = 40 mg/day, Quantity limit = 1.5 tabs/day (10 mg & 15 mg tabs)* Fazaclo® (clozapine orally disintegrating tablets) *suggested max dose = 1125 mg/day* Risperdal® M-Tab (risperidone orally disintegrating tablets) *suggested max dose = 10 mg/day* Zyprexa Zydis® (olanzapine orally disintegrating tablets) *suggested max dose = 50 mg/day, Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)*
COMBINATION PRODUCTS	
	Symbyax® (olanzapine/fluoxetine)

* For brand name products with generic equivalents, length of authorization is 1 year.

Antipsychotics: Typical

LENGTH OF AUTHORIZATION: Duration of need for mental health indications*

CRITERIA FOR APPROVAL:

- The patient has had a documented side effect, allergy or treatment failure with at least two preferred products. (If a product has an AB rated generic, one trial must be the generic.)

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

After a 4-month lapse in use of a non-preferred agent for a mental health indication, or if there is a change in therapy, a look-back through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.

MANAGEMENT OF MENTAL HEALTH DRUGS: See page 118 for a description of the management of mental health drugs.

Antipsychotics: Typical *Length of authorization: Duration of need for mental health indication*s*

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
CHLORPROMAZINE† (compare to Thorazine®)	Haldol®*
FLUPHENAZINE† (compare to Prolixin®)	Loxitane®*
HALOPERIDOL† (compare to Haldol®)	Mellaril®*
LOXAPINE† (compare to Loxitane®)	Navane®*
MOBAN® (molindone)	Prolixin®*
PERPHENAZINE† (compare to Trilafon®)	Thorazine®*
THIORIDAZINE† (compare to Mellaril®)	Trilafon®*
THIOTHIXENE† (compare to Navane®)	
TRIFLUOPERAZINE† (compare to Stelazine®)	

* For brand name products with generic equivalents, length of authorization is 1 year.

Botulinum Toxins

LENGTH OF AUTHORIZATION: initial approval 3 months, subsequent approval up to 12 months

CRITERIA FOR APPROVAL:

- The patient has an approvable diagnosis, which may include but is not limited to:
  - Strabismus and blepharospasm associated with dystonia, including essential blepharospasm, VII cranial nerve disorders/hemifacial spasm – **(type A)**
  - Focal dystonias, including cervical dystonia, spasmodic dysphonia, oromandibular dystonia – **(type A and B)**
  - Limb spasticity (e.g., due to cerebral palsy, multiple sclerosis, or other demyelinating CNS diseases) – **(type A)**
  - Focal spasticity (e.g., due to hemorrhagic stroke, anoxia, traumatic brain injury) – **(type A)**
  - Axillary Hyperhidrosis (if member has failed an adequate trial of topical therapy) – **(type A)**

AND

- The patient is >12 years of age if for blepharospasm or strabismus, >16 years of age for cervical dystonia, and >18 years of age for hyperhidrosis.

LIMITATIONS:
Coverage of botulinum toxins will not be approved for cosmetic use (e.g., glabellar lines, vertical glabellar eyebrow furrows, facial rhytides, horizontal neck rhytides, etc.).

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the request of the agent on a **General Prior Authorization Request Form**.

Botulinum Toxins

Length of Authorization: initial approval 3 months, subsequent approval up to 12 months

PREFERRED DRUGS (No PA Required)	PA REQUIRED
	Botox® (Botulinum Type A) Botox® Cosmetic (Botulinum Type A) Myobloc® (Botulinum Type B)

BPH: Alpha Blockers

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

- **Cardura®, Cardura XL®, Hytrin®:** The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

- **Cardura®, Cardura XL®:** The patient has had a documented side effect, allergy or treatment failure with two preferred drugs, one of which must be generic doxazosin.

- **Hytrin®:** The patient has had a documented side effect, allergy or treatment failure with two preferred drugs, one of which must be generic terazosin.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Alpha Blockers

Length of authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
DOXAZOSIN† (compare to Cardura®)	Cardura®*
FLOMAX® (tamsulosin)	Cardura XL®
TERAZOSIN† (compare to Hytrin®)	Hytrin®*
UROXATRAL® (alfuzosin)	

BPH: Androgen Hormone Inhibitors

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

For males age < 45:

- The patient has a diagnosis of BPH (benign prostatic hypertrophy)

LIMITATIONS:
Coverage of androgen hormone inhibitors will not be approved for cosmetic use (male-pattern baldness/alopecia or hirsutism)

Androgen Hormone Inhibitors

PREFERRED DRUGS (No PA Required)	PA REQUIRED
AVODART® (dutasteride) *(QL = 1 capsule/day)* FINASTERIDE† (compare to Proscar®) *(QL = 1 tablet/day)* PROSCAR® (finasteride) *(QL = 1 tablet/day)*	Avodart® (dutasteride) females; males age < 45 (*QL = 1 capsule/day)* finasteride† (compare to Proscar®) females; males age < 45 *(QL = 1 tablet/day)* Proscar® (finasteride) females; males age < 45 *(QL = 1 tablet/day)*

Cardiac Glycosides

LENGTH OF AUTHORIZATION: not applicable

CRITERIA FOR APPROVAL: not applicable

Cardiac Glycosides

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
DIGITEK® (digoxin) DIGOXIN† LANOXICAPS® (digoxin) LANOXIN® (digoxin)	

Chemical Dependency: Alcohol and Opiate Dependency

LENGTH OF AUTHORIZATION: Vivitrol - 6 months, no renewal

All others - 1 year

CRITERIA FOR APPROVAL:

Alcohol/Opiate Dependency: Revia

- The patient has had a documented side effect, allergy, or inadequate response to generic oral naltrexone.

Alcohol Dependency: Vivitrol

- Diagnosis of alcohol dependency (will not be approved for opiate dependency)

  AND
- An inadequate response, adverse reaction, or contraindication to 2 out of 3 oral formulations used for alcohol dependence including: oral naltrexone, acamprosate, and disulfiram OR a compelling clinical reason for use (e.g. multiple hospital admissions for alcohol detoxification)

  AND
- Patient should be opiate free for > 7 – 10 days prior to initiation of Vivitrol

  AND
- Available only through the Pharmacy Benefit (J-Code 2315 blocked from Medical Benefit) from a pharmacy provider that will deliver directly to the physician's office (Medicare Part B to be billed first if applicable)

  AND
- Quantity Limit of 1 injection (380 mg) per 30 days

Opiate Dependency: Suboxone, Subutex

- Diagnosis of opiate dependence confirmed (will not be approved for alleviation of pain).

  AND
- Prescriber has an DATA 2000 waiver ID number ("X-DEA license") in order to prescribe

  AND
- If Subutex is being requested,
  - Patient is either pregnant (duration of PA will be one 1 month post anticipated delivery date)

    OR
  - Patient has a documented allergic reaction to naloxone supported by medical record documentation.

Smoking Cessation Products: See "Smoking Cessation Therapies"

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the use of Vivitrol® or Suboxone®/Subutrex® on the **Vivitrol® or Buprenorphine Prior Authorization Request Forms**.
- ✓ Document clinically compelling information supporting the choice of Revia® on a **General Prior Authorization Request Form**.

Chemical Dependency

Length of authorization: Vivitrol 6 months, no renewal; all others 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
Alcohol Dependency ANTABUSE® (disulfiram) CAMPRAL® (acamprosate) NALTREXONE oral † (compare to Revia®)	Revia®* (naltrexone oral) Vivitrol® (naltrexone for extended-release injectable suspension) *(QL = 1 injection (380 mg) per 30 days)*
Opiate Dependency NALTREXONE oral † (compare to Revia®) Note: Methadone for opiate dependency may only be prescribed through a Methadone Maintenance Clinic	Revia®* (naltrexone oral) Suboxone® (buprenorphine/nalaxone) Subutex® (buprenorphine)

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~BUPRENORPHINE ~

Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of buprenorphine (Suboxone®, Subutex®). These criteria are based on concerns about safety and the potential for abuse and diversion. For beneficiaries to receive coverage for Suboxone® or Subutex®, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis:_____

Contact Person at Office: _____

Pharmacy (if known)**:**_____ Phone:_____ &/or FAX:_____

QUALIFICATIONS

MD/DO	Prescribers must have a DATA 2000 waiver ID ('X' DEA license) in order to prescribe.
Patients	Patients must have a diagnosis of opiate dependence confirmed.

PROCESS

► Answer the following questions:

Is buprenorphine being prescribed for opiate dependency?	□ Yes □ No
Does the prescriber signing this form have a DATA 2000 waiver ID number ("X-DEA license")?	□ Yes □ No
Request is for the following medication:	□ Suboxone® (buprenorphine/naloxone) □ Subutex® (buprenorphine)
Anticipated maintenance dose/frequency: Dose:_____ Frequency:_____	
If this request is for Subutex®, please answer the following questions: Is the member pregnant?	□ Yes □ No
If yes, anticipated date of delivery: _____ Does the member have a documented allergic reaction to naloxone? If yes, please provide medical records documenting the allergic reaction.	□ Yes □ No
Additional clinical information to support PA request:	

Prescriber Signature: _____ **Date of request:** _____

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~VIVITROL~

Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of Vivitrol (naltrexone for IM extended release suspension). These criteria are based on concerns about safety. In order for beneficiaries to receive coverage for Vivitrol, it will be necessary for the prescriber to complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via Fax: 1-866-767-2649

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____Sex:_____

Diagnosis:_____

Contact Person at Office: _____

Administering physician:

Name: _____ Address: _____

Pharmacy (required)**:**_____ Phone:_____ &/or FAX:_____

QUALIFICATIONS

MDs	Prescribers must secure direct delivery of Vivitrol from the pharmacy to the physician's office. Pharmacies may not dispense Vivitrol directly to the patient. Vivitrol **may not** be billed through the Medical Benefit as a J-Code J2315.
Patients	Patients must have a diagnosis of alcohol dependency. Patients must also have had an inadequate response, adverse reaction, or contraindication to 2 out of 3 oral formulations including: oral naltrexone, acamprosate, and disulfiram OR a compelling clinical reason for Vivitrol use. Patients should be opiate free for > 7 -10 days prior to initiation of Vivitrol.

PROCESS

► Please answer the following questions:

Does the patient have a diagnosis of alcohol dependency?	□ Yes □ No
Has the patient tried any of the following? Please document below. oral naltrexone: □ side-effect □ non-response □ allergy acamprosate: □ side-effect □ non-response □ allergy disulfiram: □ side-effect □ non-response □ allergy	□ Yes □ No
Has patient had a recent hospital admission for alcohol detoxification?	□ Yes □ No If yes, date: ____/_____/____
Has the patient been opiate free for > 7 – 10 days	□ Yes □ No
Comments and additional patient history:	

Prescriber Signature: _____ **Date of request:** _____

Compounded Products

Review Guidelines for Appropriateness of Compounded Products

Compounding of medication may be allowed:

- For making a strength of a medication when specific doses are not commercially available and a significantly different dosage form is clinically needed.
- For preparation of a medication that has been withdrawn from the marketplace due to economic concerns, NOT safety.
- For those patients that cannot swallow or have trouble swallowing and require a different dosage form than is currently available.
- For those patients who have sensitivity to dyes, preservatives, or fillers in commercial products and require allergy-free medications.
- For children who require liquid medications.

A compound drug will only be covered if it is

- Considered medically necessary according to specified criteria as detailed below **and**
- Commercially available alternative agents have been previously tried with therapeutic failure or patient intolerance.

Medically necessary criteria for a compound drug

- All ingredients are FDA approved for medical use in the United States (for example, domperidone has not been approved by the FDA for any indication in the United States).
- It is not a copy of a commercially available FDA approved product.
- It is not a substitution for an available FDA approved product (for example, there are multiple commercially available hormonal products for use in menopause. Bioidentical individualized hormonal products will not be covered).
- One or more prescription ingredients is included in the compound; a compound whose primary active ingredient is OTC will only be covered if that particular OTC is covered under the beneficiary's program
- Safety and effectiveness of use for the prescribed indication is supported by FDA approval or adequate medical and scientific evidence or medical literature.

Constipation: Chronic or IBS-C

LENGTH OF AUTHORIZATION: 3 months

CRITERIA FOR APPROVAL:

AMITIZA®

- The patient has a diagnosis of chronic idiopathic constipation (CIC) (24 mcg capsules)

  OR
- The patient is a woman and has a diagnosis of irritable bowel syndrome with constipation (IBS-C) (8 mcg capsules)

  AND
- The patient has had documented treatment failure to lifestyle and dietary modification (increased fiber and fluid intake and increased physical activity).

  AND
- The patient has had documented side effect, allergy or treatment failure to a 1 week trial each of at least 2 preferred laxatives (see below).

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Constipation: Chronic or IBS-C *Length of Authorization: 3 months* **Key: † Generic product**	
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
Bulk-Producing Laxatives PSYLLIUM† **Osmotic Laxatives** LACTULOSE† POLYETHYLENE GLYCOL 3350 (PEG)† (compare to Miralax®)	Amitiza® (lubiprostone) *(Qty limit = 2 caps/day)*

Contraceptives: Vaginal Ring

LENGTH OF AUTHORIZATION: not applicable

CRITERIA FOR APPROVAL: not applicable

Vaginal Ring	
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
NUVARING® (etonogestrel/ethinyl estradiol vaginal ring)	

Coronary Vasodilators/Antianginals: Oral and Topical

LENGTH OF AUTHORIZATION: 3 years

CRITERIA FOR APPROVAL:

Dilatrate-SR®, Imdur®:

- The patient has had a side effect, allergy, or treatment failure to at least two of the following medications: isosorbide dinitrate ER tablet, isosorbide mononitrate ER tablet, nitroglycerin ER capsule or Nitro-time®. If a product has an AB rated generic, one trial must be the generic formulation.

Ismo®, Isordil®, Monoket®:

- The patient has had a side effect, allergy, or treatment failure to at least two of the following medications: isosorbide dinitrate tablet or isosorbide mononitrate tablet. If a product has an AB rated generic, one trial must be the generic formulation.

Nitro-Dur®:

- The patient has had a side effect, allergy, or treatment failure to Nitrek® or generic nitroglycerin transdermal patches.

Bidil®:

- The prescriber provides a clinically valid reason why the patient cannot use isosorbide dinitrate and hydralazine as separate agents.

Ranexa®:

- The patient has had a diagnosis/indication of chronic angina.

AND

- The patient has had a documented side effect, allergy, or treatment failure with at least one medication from two of the following clases: beta-blockers, maintenance nitrates, or calcium channel blockers.

AND

- The patient does not have any of the following conditions:
  - Hepatic insufficiency
  - History of or increased risk of QT prolongation
  - Concurrent use of medications which may interact with Ranexa®:
    - Drugs that may prolong QT interval (amiodarone, erythromycin, quinidine, sotalol)
    - CYP450 3A4 inhibitors (diltiazem, verapamil, ketoconazole, protease inhibitors, grapefruit juice, macrolide antibiotics)
    - Note: doses of digoxin or drugs metabolized by CYP450 2D6 (TCAs, some antipsychotics) may need to be adjusted if used with Ranexa®.

AND

- The dose requested does not exceed 3 tablets/day (500 mg) or 2 tablets/day (1000 mg).

DOCUMENTATION:

✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Coronary Vasodilators/Antianginals:

Length of Authorization: 3 years

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
ORAL	
ISOSORBIDE DINITRATE† tab (compare to Isordil®) ISOSORBIDE DINITRATE† SL tablet ISOSORBIDE DINITRATE† ER tablet ISOSORBIDE MONONITRATE† tab (compare to, Ismo®, Monoket®) ISOSORBIDE MONONITRATE† ER tab (compare to Imdur®) NITROGLYCERIN† SL tablet NITROGLYCERIN† ER capsule NITROLINGUAL PUMP SPRAY® NITROGARD® BUCCAL NITROQUICK® (nitroglycerin SL tablet) NITROSTAT® (nitroglycerin SL tablet) NITRO-TIME® (nitroglycerin ER capsule)	Dilatrate-SR® (isosorbide dinitrate SR cap) Imdur®* (isosorbide mononitrate ER tablet) Ismo®* (isosorbide mononitrate tablet) Isordil®* (isosorbide dinitrate tab) Monoket®* (isosorbide mononitrate tablet) BiDil® (isosorbide dinitrate/hydralazine) Ranexa® (ranolazine) *(QL = 3 tablets/day (500 mg), 2 tablets/day (1000 mg))*
TOPICAL	
NITREK® (nitroglycerin transdermal patch) NITRO-BID® (nitroglycerin ointment) NITROGLYCERIN TRANSDERMAL PATCHES† (compare to Nitro-Dur®)	Nitro-Dur®* (nitroglycerin transdermal patch)

Cough and Cold Preparations

LENGTH OF AUTHORIZATION: date of service only, no refills

CRITERIA FOR APPROVAL:

Tussionex®

- The patient has had a documented side effect, allergy, or treatment failure to two of the following generically available cough and cold products: hydrocodone/homatropine (compare to Hycodan®), hydrocodone/guaifenesin (compare to Hycotuss®), promethazine/codeine (previously Phenergan® with Codeine), hydrocodone/chlorpheniramine/pseudoephedrine (compare to Hydron PSC®) or hydrocodone/pyrilamine/phenylephrine.

AND

- The patient is 6 years old of age or greater.

AND

- The quantity requested does not exceed 60 ml.

All Other Brands

- The prescriber must provide a clinically valid reason for the use of the requested medication including reasons why any of the generically available preparations would not be a suitable alternative.

DOCUMENTATION:

✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Cough and Cold Preparations *Length of Authorization: date of service only, no refills*

Key: † Generic product

PREFERRED DRUGS (No PA Required)	PA REQUIRED
All generics MUCINEX® (guaifenesin) PA required for Age < 2 years old for all products (brand and generic)	Tussionex® (hydrocodone/chlorpheniramine) *(QL = 60 ml)* All other brands Age < 2 years old for all products (brand and generic)

Dermatological Agents: Genital Wart Therapy

LENGTH OF AUTHORIZATION: 1 month

CRITERIA FOR APPROVAL:

Condylox® gel:

- The patient has had a documented side effect, allergy, or treatment failure with Aldara®.

Condylox®* solution:

- The patient has had a documented intolerance to generic podofilox solution.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Dermatological Agents: Genital Wart Therapy *Length of Authorization: 1 month* **Key: † Generic product, *Indicates generic equivalent is available without a PA**	
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
ALDARA® (imiqumod)	
PODOFILOX SOLUTION† (compare to Condylox®)	Condylox® Gel (podofilox gel) Condylox®* solution (podofilox solution)

Dermatological Agents: Scabicides and Pediculicides

LENGTH OF AUTHORIZATION: date of service only, no refills

CRITERIA FOR APPROVAL:

- The patient has had a documented side effect or allergy to permethrin or treatment failure with two treatments of permethrin.
- For approval of Elimite® Cream, the patient must have a documented intolerance to generic permethrin cream.

DOCUMENTATION:

✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Dermatological Agents: Scabicides and Pediculicides *Length of Authorization: date of service only, no refills*

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
EURAX® (crotamiton) *C, L* NIX® (permethrin) *CR, G, Sp* PERMETHRIN† (compare to Elimite®) *C* PERMETHRIN† *L* PIPERONYL BUTOXIDE AND PYRETHRINS† *G, S, Sh* RID® (piperonyl butoxide and pyrethrins) *G, Sh, Sp* All other brand and generic Scabicides and Pediculicides	Elimite®* (permethrin 5 %) *C* Lindane† *L, Sh* Ovide® (malathion) *L*

C=cream, CR=crème rinse, G=gel, L=lotion, S=solution, Sh=shampoo, Sp=spray

Desmopressin: Intranasal

LENGTH OF AUTHORIZATION: 2 years

CRITERIA FOR APPROVAL:

- The diagnosis or indication for the requested medication is (1) Diabetes Insipidus, (2) hemophilia type A, or (3) Von Willebrand disease

LIMITATIONS:
Desmopressin intranasal formulations will not be approved for the treatment of primary nocturnal enuresis (PNE) due to safety risks of hyponatremia. Oral tablets may be prescribed for this indication.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Desmopressin: Intranasal	*Length of Authorization: 2 years*
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
	DDAVP® (desmopressin) Nasal Solution or Spray 0.01% Desmopressin † Nasal Solution or Spray 0.01 % (compare to DDAVP®) Minirin † (desmopressin) Nasal Spray 0.01% Stimate® (desmopressin) Nasal Solution 1.5 mg/ml

Diabetic Testing Supplies

LENGTH OF AUTHORIZATION: 5 years

CRITERIA FOR APPROVAL:

- The prescriber demonstrates that the patient has a medical necessity for clinically significant features that are not available on any of the preferred meters/test strips.

DOCUMENTATION:

✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Diabetic Testing Supplies	*Length of Authorization:5 years*
PREFERRED PRODUCTS (No PA Required)	**PA REQUIRED**
DIABETIC MONITORS/METERS	
FREESTYLE LITE® SYSTEM KIT FREESTYLE FLASH® SYSTEM KIT FREESTYLE FREEDOM® SYSTEM KIT FREESTYLE FREEDOM LITE® SYSTEM KIT ONE TOUCH® ULTRA 2 KIT ONE TOUCH® ULTRA MINI KIT ONE TOUCH® ULTRA SMART KIT PRECISION XTRA® METER	Accucheck® Ascensia® Assure® Exactech® Prodigy® All other brands and store brands
DIABETIC TEST STRIPS	
FREESTYLE®* FREESTYLE LITE®* ONE TOUCH® BASIC* ONE TOUCH® SURESTEP* ONE TOUCH® FAST TAKE* ONE TOUCH® UL®TRA* PRECISION XTRA®* PRECISION XTRA® BETA KETONE (10 count)	Accucheck® Ascensia® Assure® Exactech® Prodigy® All other brands and store brands

* 50 and 100 count package sizes

Gastrointestinals: Crohn's Disease Medications: Injectables

LENGTH OF AUTHORIZATION: Initial PA of 3 months, and 12 months thereafter if medication is well tolerated. Re-evaluate every 12 months.

CRITERIA FOR APPROVAL:

Humira®, Remicade®:

Patient has a diagnosis of Crohn's disease and has already been stabilized on the medication.

OR

Diagnosis is moderate to severe Crohn's disease and at least 2 of the following drug classes resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure (i.e. resistant or intolerant to steroids or immunosuppressants): aminosalicylates, antibiotics, corticosteroids, and immunomodulators such as azathioprine, 6-mercaptopurine, or methotrexate.

Note: Humira® has been shown to be effective in patients who have been treated with infliximab but have lost response to therapy.

Tysabri®:

Patient has a diagnosis of Crohn's disease and has already been stabilized on Tysabri®.

OR

Diagnosis is moderate to severe Crohn's disease and at least 2 of the following drug classes resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure (i.e. resistant or intolerant to steroids or immunosuppressants): aminosalicylates, antibiotics, corticosteroids, and immunomodulators such as azathioprine, 6-mercaptopurine, or methotrexate.

AND

The patient has a documented side effect, allergy, treatment failure, or contraindication to BOTH, Remicade® and Humira®,

DOCUMENTATION:

- ✓ Document clinical information on a **Crohn's Disease Injectable Prior Authorization Request Form**.

Crohn's Disease: Injectables

Length of authorization: Initial PA of 3 months; 12 months thereafter

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET
HUMIRA® (adalimumab) REMICADE® (infliximab)	Tysabri® (natalizumab)

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ CROHN'S DISEASE INJECTABLE MEDICATIONS ~

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of injectable Crohn's disease medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Injectable Crohn's disease medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Specialty: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis: _____

Contact Person at Office: _____

Will this medication be billed via the: □ pharmacy benefit or □ medical benefit (J-code or other code)?

Pharmacy (if known)**:**_____ Phone:_____ &/or FAX:_____

Please select the following 'preferred' drug therapy from the VT Medicaid Preferred Drug List:

☐ **Humira**_____ Strength & Frequency:_____ Length of therapy:_____

☐ **Remicade**_____ Strength & Frequency:_____ Length of therapy:_____

For any other injectable Crohn's disease treatment, please explain medical necessity for non-preferred product:

Drug:_____ Strength & Frequency:_____ Length of therapy:_____

Medical justification: _____

_____

List previous therapies tried and failed for this condition:

Therapy	Reason for discontinuation	Dates Utilized

Prescriber comments:

Prescriber Signature:_____ **Date of this request:**_____

Gastrointestinals: Histamine-2 Receptor Antagonists

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Axid®capsule, nizatidine capsule, Pepcid® tablet, ranitidine capsule, Tagamet® tablet, Zantac®tablets:

- The patient has had a documented side effect, allergy, or treatment failure to at least one preferred medication. If a medication has an AB rated generic, the trial must be the generic formulation. For approval of ranitidine capsules, the patient must have had a trial of ranitidine tablets.

Axid® Oral Solution, Pepcid® Oral Suspension, ranitidine syrup:

- The patient has had a documented side effect, allergy, or treatment failure to Zantac® syrup or cimetidine oral solution. If a medication has an AB rated generic, the trial must be the generic formulation.

Zantac® Effervescent:

- The patient has had a documented side effect, allergy, or treatment failure to Zantac® syrup.

Gastrointestinals: Histamine Antagonists

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA
§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS (No PA Required)	PA REQUIRED
CIMETIDINE† (compare to Tagamet®) tablet FAMOTIDINE† (compare to Pepcid®) tablet RANITIDINE† (compare to Zantac®) tablet	Axid® (nizatidine) capsule § nizatidine† (compare to Axid®) capsule § Pepcid®* (famotidine) tablet§ ranitidine† capsule § Tagamet®* tablet § Zantac®* tablet §
SYRUP & SPECIAL DOSAGE FORMS CIMETIDINE † ORAL SOLUTION ZANTAC® (ranitidine) SYRUP	Axid® (nizatidine) Oral Solution § Pepcid® Oral Suspension § ranitidine† syrup§ Zantac Effervescent® §

Gastrointestinals: Inflammatory Bowel Agents (Oral and Rectal Products)

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Azulfidine®*, Colazal®*, Rowasa®*:

- The patient has had a documented side effect, allergy, or treatment failure with the generic equivalent of the requested medication.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Gastrointestinals: Inflammatory Bowel Agents (Oral and Rectal Products)

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
Mesalamine Products	
ASACOL® (mesalamine tablet delayed-release)	Rowasa®* (mesalamine enema)
CANASA® (mesalamine suppository)	
LIALDA® (mesalamine tablet extended-release)	
MESALAMINE ENEMA† (compare to Rowasa®)	
PENTASA® (mesalamine cap CR)	
Other	
BALSALAZIDE† (compare to Colazal®)	Azulfidine®* (sulfasalazine)
DIPENTUM® (olsalazine)	Colazal®* (balsalazide)
SULFASALAZINE† (compare to Azulfidine®)	

Gastrointestinals: Proton Pump Inhibitors

LENGTH OF AUTHORIZATION: up to 1 year

CRITERIA FOR APPROVAL (non-preferred medications):

- The member has had a documented side effect, allergy, or treatment failure to Prilosec OTC, Protonix AND Prevacid.

CRITERIA FOR APPROVAL (twice daily dosing):

- Gastroesophageal Reflux Disease (GERD) – If member has had an adequate trial (e.g. 8 weeks) of standard once daily dosing for GERD, twice daily dosing may be approved.
- Zollinger-Ellison (ZE) syndrome – Up to triple dose PPI may be approved.
- Hypersecretory conditions (endocrine adenomas or systemic mastocytosis) – Double dose PPI may be approved.
- Erosive Esophagitis, Esophageal stricture, Barrett's esophagitis (complicated GERD) – Double dose PPI may be approved.
- Treatment of ulcers caused by H. Pylori – Double dose PPI may be approved for up to 2 weeks.
- Laryngopharyngeal reflux – Double dose PPI may be approved.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Gastrointestinals: PPIs

Length of Authorization: 1 year

Key: † Generic product

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS (No PA Required)	PA REQUIRED, any dose
PREVACID® (lansoprazole) capsules *(Quantity limit=1 cap/day)* PREVACID® (lansoprazole) packets *(Quantity limit=1 packet/day)* PRILOSEC OTC® 20mg (omeprazole magnesium) tablets *(No Quantity limit applies)* PROTONIX® (pantoprazole) tablets *(Quantity limit=1 tab/day)* PREVPAC® (lansoprazole w/ H.pylori anti-bacterials) *(No Quantity limit applies)*	Aciphex® (rabeprazole) tablets § *(Quantity limit=1 tab/day)* Nexium® (esomeprazole) capsules § *(Quantity limit=1 cap/day)* Nexium® (esomeprazole) powder for suspension § *(Quantity limit=1 packet/day)* omeprazole †♣ generic RX capsules § *(Quantity limit=1 cap/day)* omeprazole †♣ generic OTC tablets § *(Quantity limit=1 tab/day)* pantoprazole † generic tablets *(Quantity limit=1 tab/day)* Prevacid Solutabs®♠ *(Quantity limit=1 tab/day)* Prilosec® (*brand*) capsules § *(Quantity limit=1 cap/day)* Zegerid®♣ (omeprazole) powder for suspension § *(Quantity limit=1 packet/day)* Zegerid® (omeprazole) capsules § *(Quantity limit=1 cap/day)* ♣No PA required for patients < 16 years ♠ No PA required for patients < 12 years

Gastrointestinals: Ulcerative Colitis Medications: Injectables

LENGTH OF AUTHORIZATION: Initial PA of 3 months, and 12 months thereafter if medication is well tolerated. Re-evaluate every 12 months.

CRITERIA FOR APPROVAL:

Remicade®

Patient has a diagnosis of Ulcerative Colitis and has already been stabilized on Remicade®.

OR

The patient has a diagnosis of Ulcerative Colitis and has had a documented side effect, allergy, or treatment failure with at least 2 of the following 3 agents: aminosalicylates (e.g. sulfasalazine, mesalamine, etc.), corticosteroids, or immunomodulators (e.g. azathioprine, 6-mercaptopurine, cyclosporine, etc.).

DOCUMENTATION:

- ✓ Document clinical information on an **Ulcerative Colitis Injectable Prior Authorization Request Form**.

Ulcerative Colitis: Injectables

Length of authorization: Initial PA of 3 months; 12 months thereafter

PREFERRED AGENTS (No PA Required)	PA REQUIRED
	Remicade® (infliximab)

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ ULCERATIVE COLITIS INJECTABLE MEDICATIONS ~

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of Ulcerative Colitis Injectable medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Ulcerative Colitis Injectable medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Contact Person at Office: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis: _____

Will this medication be billed via the: □ pharmacy benefit or □ medical benefit (J-code or other code)?

Pharmacy (if known)**:**_____ Phone:_____ &/or FAX:_____

☐ **Remicade**_____Strength & Frequency:_____Length of therapy:_____

For any other injectable Ulcerative Colitis treatment, please explain medical necessity for the specific product:

Drug:_____ Strength & Frequency:_____ Length of therapy:_____

Medical justification: _____

_____

List previous medications tried and failed for this condition:

Name of medication	Reason for failure	Date(s) attempted

Prescriber comments:

Prescriber Signature:_____ **Date of this request:**_____

Glucocorticoids: Topical

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

CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS):

- The patient has a documented side effect, allergy, or treatment failure to at least two different preferred agents of *similar* potency. (If a product has an AB rated generic, one trial must be the generic.)

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Glucocorticoids: Topical

Length of Authorization: up to 6 months

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
LOW POTENCY ALCLOMETASONE† (compare to Aclovate®) DESONIDE† (compare to Tridesilon®) FLUOCINOLONE 0.01%† (compare to Synalar®) HYDROCORTISONE ACETATE† (all generics)	Aclovate®* Cortaid®* Desonate® gel (desonide) DesOwen®* Hytone®* Synalar® 0.01%* (all products) Tridesilon®* Verdeso® (desonide foam) All other brands
MEDIUM POTENTCY BETAMETHASONE DIPROPIONATE† (compare to Alphatrex®*) BETAMETHASONE VALERATE† (compare to Beta-Val®*) DESOXIMETASONE 0.05%† (compare to Topicort®) FLUOCINOLONE 0.025%† (compare to Synalar®) FLUTICASONE TOPICAL† (compare to Cutivate®) HYDROCORTISONE BUTYRATE† (compare to Locoid®) HYDROCORTISONE VALERATE† (compare to Westcort®) MOMETASONE FUROATE† (compare to Elocon®) TRIAMCINOLONE ACETONIDE† (compare to Aristocort®)	Alphatrex®* Aristocort®* (all products) Beta-Val®* Cloderm® (clocortolone) Cordran® (all products) Cutivate®* Dermatop® Elocon®* (all products) Kenalog® (all products) Locoid® Luxiq® prednicarbate† (compare to Dermatop®) Pandel® Synalar® 0.025%* (all products) Topicort® 0.05%* (all products) Westcort®* (all products) All other brands
HIGH POTENTCY AMCINONIDE† (compare to Cyclocort®) AUGMENTED BETHAMETHASONE CREAM† (compare to Diprolene® AF) DESOXIMETASONE 0.25%† (compare to Topicort®) DIFLORASONE DIACETATE† (compare to Apexicon®, Maxiflor®, Psorcon-E®) FLUOCINOLONE 0.2%† (compare to Synalar®) FLUOCINONIDE† (compare to Lidex®)	Apexicon® Cyclocort®* Diprolene® AF* (all products) Halog® (all products) Lidex®* (all products) Maxiflor®* Synalar® 0.2%* (all products) Topicort® 0.25%* (all products) Vanos® All other brands
VERY HIGH POTENTCY AUGMENTED BETHAMETHASONE OINT.† (compare to Diprolene®) CLOBETASOL PROPIONATE† (compare to Temovate®) CLOBETASOL PROPIONATE† FOAM (compare to Olux®) DIFLORASONE DIACETATE/EMOLL† (compare to Pscorcon®) HALOBETASOL PROPRIONATE† (compare to Ultravate®	Clobex® Cormax® Diprolene®* (all products) Embeline E®* Olux®/Olux E® Psorcon-E®* Temovate®* (all products) Ultravate®* (all products) All other brands

Growth Stimulating Agents

GROWTH HORMONE

►See next page for growth hormone products.

LENGTH OF AUTHORIZATION: Up to 1 year

CRITERIA FOR APPROVAL:

PEDIATRIC:
1) The patient must have one of the following indications for growth hormone:

- Turner syndrome confirmed by genetic testing.
- Prader-Willi Syndrome confirmed by genetic testing.
- Growth deficiency due to chronic renal failure.
- Patient who is Small for Gestational Age (SGA) due to Intrauterine Growth Retardation (IUGR)and catch up growth not achieved by age 2 (Birth weight less than 2500g at gestational age of <37 weeks or a birth weight or length below the 3rd percentile for gestational age).

OR

- Pediatric Growth Hormone Deficiency confirmed by results of two provocative growth hormone stimulation tests (insulin, arginine, levodopa, propranolol, clonidine, or glucagon) showing results (peak level) <10ng/ml.

2) The requested medication must be prescribed by a pediatric endocrinologist (or pediatric nephrologist if prescribed for growth deficiency due to chronic renal failure).

3) Confirmation of non-closure of epiphyseal plates (x-ray determining bone age) must be provided for females > age 12 and males > age 14.

4) Initial requests can be approved for 6 months. Subsequent requests can be approved for up to 1 year with documentation of positive response to treatment with growth hormone.

ADULT:
The patient must have one of the following indications for growth hormone:

- Panhypopituitarism due to surgical or radiological eradication of the pituitary.

OR

- Adult Growth Hormone Deficiency confirmed by one growth hormone stimulation test (insulin, arginine, levodopa, propranolol, clonidine, or glucagon) showing results (peak level) <5ng/ml. Growth hormone deficient children must be retested after completion of growth.

GENOTROPIN®, HUMATROPE®, SAIZEN®, SEROSTIM® ,TEV-TROPIN®

- The patient has a documented side effect, allergy, or treatment failure to Norditropin and Nutropin®.

Requests can be approved for 1 year.

ZORBTIVE FOR SHORT BOWEL SYNDROME:
The patient must have:

- A diagnosis of short bowel syndrome
- Concomitant use of specialized nutritional support (specialty TPN)
- Prescription by gastroenterologist (specialist)

Request can be approved for 4 weeks.

LIMITATIONS:
Coverage of Growth Hormone products will not be approved for patients who have Idiopathic Short Stature.

INCRELEX

INDICATION: Long-term treatment of growth failure in children with severe primary insulin-like growth factor-1 deficiency (Primary IGFD)

LENGTH OF AUTHORIZATION: 6 months

CRITERIA FOR APPROVAL:

- Member has growth hormone gene deletion AND neutralizing antibodies to growth hormone, OR primary insulin-like growth factor (IGF-1) deficiency (IGFD), defined by the following:
  - Height standard deviation score < -3 AND
  - Basal IGF-1 standard deviation score < -3 AND
  - Normal or elevated growth hormone level
- Member is ≥ 2 years old (safety and efficacy has not been established in patients younger than 2), AND
- Member has open epiphysis, AND
- Member is under the care of an endocrinologist or other specialist trained to diagnose and treat growth disorders.

DOCUMENTATION:

- ✓ Document information for the indication of the use of these medications on a **Growth Stimulating Agents Prior Authorization Request Form**.

Growth Stimulating Agents	*Length of Authorization: up to1 year*
PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	**NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**
NORDITROPIN®	Genotropin®
NUTROPIN®	Humatrope®
NUTROPIN® AQ	Saizen®
	Serostim®
OMNITROPE®	Tev-Tropin®
INCRELEX® (mecasermin)	
	Zorbtive® (with special criteria)

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ GROWTH STIMULATING AGENTS ~

Prior Authorization Request Form

Effective February, 2002, Vermont Medicaid established coverage limits and criteria for prior authorization of Growth Stimulating Agents medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Growth Stimulating Agents medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing Physician:

Name:_____

Phone #:_____

Fax #:_____

Specialty: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Patient Diagnosis: _____

Contact Person at Office: _____

Address: _____

Please select one of the following 'preferred' drug therapies from the VT Medicaid Preferred Drug List:

- ☐ **Norditropin** Dose & Frequency:_____
- ☐ **Nutropin/Nutropin AQ** Dose & Frequency: _____
- ☐ **Omnitrope** Dose & Frequency:_____

For any other growth hormone product, please explain medical necessity for 'non-preferred' product:

Drug: _____

Medical justification: _____

_____

Growth Hormone Stimulation Test # 1	**Test:**	**result:**
Growth Hormone Stimulation Test # 2	**Test:**	**result:**
Patient's Height:		
Patient's Bone Age:		
Patient's Chronological Age:		
Growth Velocity:		
IGF-1 results:		

Other information/ Prescriber comments:

Prescriber Signature:_____ **Date of this request:**_____

Hepatitis C Medications

LENGTH OF AUTHORIZATION: 6 months

CRITERIA FOR APPROVAL:

- The diagnosis or indication for the requested medication is Hepatitis.
- The prescriber is, or has consulted with a gastroenterologist, or infectious disease specialist.
- For non-preferred agents, the prescriber must provide a clinically valid reason that preferred medications cannot be used.

DOCUMENTATION:

✓ Document information for the indication of the use of these medications on a **Hepatitis C Medications Prior Authorization Request Form**.

Hepatitis C Medications

Length of Authorization:6 months

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET
RIBAVIRIN	
RIBAVIRIN†	Copegus® Ribasphere® Rebetol®
INTERFERON	
PEGASYS® (peg-interferon alpha-2a) (*QL = 4 vials/28 days)* PEGASYS CONVENIENCE PACK® (peg-interferon alfa-2a) (*QL = 1 kit/28 days)*	Peg-Intron® (peg-interferon alpha-2b) Infergen® (interferon alphacon-1)
COMBINATION	
	Rebetron® (Rebetol/Intron-A)

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ HEPATITIS C MEDICATIONS ~

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of Hepatitis C medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Hepatitis C medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #: _____

Address: _____

Specialty:_____

Contact Person at Office:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis:_____

Genotype:_____

If requesting prescriber is not a Hepatologist, Gastroenterologist or ID Specialist, has one of these specialties been consulted on this case?: □ **Yes** □ **No**

Specialist name: _____ Specialist Type:_____

Preferred Drug(s) Requested:

□ Pegasys

□ Pegasys convenience Pack

□ Ribavirin

For any other Non-Preferred Drug(s) Requested:

□ Other_____

If other, please explain medical necessity for non-preferred agent:

_____

_____

_____

_____

Strength, Route & Frequency:_____

Length of therapy:_____

Prescriber comments:

Prescriber Signature:_____ **Date of this request:**_____

Immunomodulators: Topical

At the September 2006 meeting of the DUR Board, the class of topical immunomodulators was reviewed for efficacy and safety. Included in this review was the January 20, 2006, U.S. Food and Drug Administration (FDA) updated labeling and March 17, 2005 FDA Public Health Advisory regarding Elidel® Cream (pimecrolimus) and Protopic® Ointment (tacrolimus). The labeling changes include a BOXED WARNING about the possible risk of cancer and a medication guide that is to be distributed with each prescription to ensure that the parents of patients using these medications are aware of this concern. Although a causal link has not been established, rare reports of cancer (e.g. skin and lymphoma) have been reported in patients who had been receiving these products. The FDA has advised that Protopic® and Elidel® be used only as labeled. The new labeling clarifies that these drugs are recommended for use as *second-line* treatments for the short-term and non-continuous chronic treatment of mild to moderate (Elidel® Cream) or moderate to severe (Protopic® Ointment) atopic dermatitis. The FDA also advises clinicians to avoid use in children less than 2 years of age.

LENGTH OF AUTHORIZATION: up to 1 year

CRITERIA FOR APPROVAL:

Age < 2 years (requests will be approved for up to 6 months):

- The patient has a diagnosis of atopic dermatitis. AND
- The patient has had a documented side effect, allergy, or treatment failure with at least one topical corticosteroid within the last 6 months. AND
- The quantity requested does not exceed 30 grams/fill and 90 grams/6 months.

Age > 2 years (requests will be approved for up to 1 year):

- The patient has a diagnosis of atopic dermatitis. AND
- The patient has had a documented side effect, allergy, or treatment failure with at least one topical corticosteroid within the last 6 months. AND
- The quantity requested does not exceed 30 grams/fill and 90 grams/6 months.

Immunomodulators: Topical *Length of Authorization: up to 1 year*

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

NO PA REQUIRED *(For age > 2 after prerequisite trial of one topical corticosteroid)*	PA REQUIRED
ELIDEL® Cream (pimecrolimus) § *(Quantity Limit = 30 grams/fill and 90 grams/6 months)* **PROTOPIC® Ointment (tacrolimus)** § *(Quantity Limit = 30 grams/fill and 90 grams/6 months)* Note: Protopic ointment concentration limited to 0.03% for age < 16 years old.	**Elidel® Cream (pimecrolimus)** age < 2 years *(Quantity Limit = 30 grams/fill and 90 grams/6 months)* **Protopic® Ointment (tacrolimus)** age < 2 years *(Quantity Limit = 30 grams/fill and 90 grams/6 months)* Note: Protopic ointment concentration limited to 0.03% for age < 16 years old.

Lipotropics: Bile Acid Sequestrants

LENGTH OF AUTHORIZATION: lifetime

CRITERIA FOR APPROVAL:

Questran®*

- The patient has had a documented intolerance to cholestyramine powder.

Questran Light®*

- The patient has had a documented intolerance to cholestyramine light powder.

Colestid®*

- The patient has had a documented intolerance to colestipol tablets or granules.

Welchol®

- If being prescribed for lipid reduction, the patient has had a documented side effect, allergy, or treatment failure to cholestyramine and colestipol.

OR

- If being prescribed for additional improved glycemic control, the patient must have been unable to obtain a satisfactory hemoglobin A1C reduction with metformin and one other oral anti-diabetic agent.

DOCUMENTATION:

✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Lipotropics: Bile Acid Sequestrants *Length of Authorization: lifetime* **Key: † Generic product, *Indicates generic equivalent is available without a PA**	
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
CHOLESTYRAMINE† powder (compare to Questran®) CHOLESTYRAMINE LIGHT† powder (compare to Questran Light®) PREVALITE† powder (cholestyramine light)	Questran®* powder (cholestyramine) Questran Light®* powder (cholestyramine light)
COLESTIPOL† tablets, granules (compare to Colestid®)	Colestid®* tablets, granules (colestipol) Welchol® (colesevelam)

Lipotropics: Fibric Acid Derivatives

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Lopid®*

- The patient has had a documented side effect, allergy, or treatment failure to gemfibrozil.

Tricor®

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient is taking a statin concurrently.

OR

- The patient has had a documented side effect, allergy, or treatment failure to gemfibrozil.

Antara®, fenofibrate, fenofribrate micronized, Lipofen®, Lofibra® and Triglide®

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient is taking a statin concurrently and has had a documented side effect, allergy, or treatment failure with Tricor.

OR

- The patient has had a documented side effect, allergy, or treatment failure to gemfibrozil and Tricor.

(Note regarding fibrates: For patients receiving statin therapy, fenofibrate appears less likely to increase statin levels and thus may represent a safer choice than gemfibrozil for coadministration in this group of patients - *Am J Med* 2004;116:408-416)

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Lipotropics: Fibric Acid Derivatives

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA
§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS (No PA Required)	PA REQUIRED
GEMFIBROZIL† (compare to Lopid®) ♦TRICOR® (fenofibrate) § ♦ *PA required if patient not on concurrent statin*	Antara® (fenofibrate micronized) § fenofibrate† § fenofibrate micronized† § Lipofen® (fenofibrate) § Lofibra® (fenofibrate micronized) Capsules § Lofibra® (fenofibrate) Tablets § Lopid®* (gemfibrozil) § Triglide® (fenofibrate) §

Lipotropics: Niacin

LENGTH OF AUTHORIZATION: not applicable

CRITERIA FOR APPROVAL: not applicable

Lipotropics: Niacin

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
NIACIN† NIASPAN® (niacin) NIASPAN® ER (niacin)	

Lipotropics: Statins

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

HIGH POTENCY STATINS

Crestor®

- The patient has had a documented side effect, allergy, or treatment failure to generic simvastatin.

Lipitor®

- The patient has had a documented side effect, allergy, or treatment failure to BOTH generic simvastatin and Crestor®

Zocor®

- The patient has had a documented side effect, allergy, or treatment failure to BOTH generic simvastatin and Crestor®.

OTHER STATINS
Altoprev®, Lescol®, Lescol® XL, Mevacor®, Pravachol®

- The patient has had a documented side effect, allergy, or treatment failure to BOTH generic lovastatin and pravastatin.

DOCUMENTATION:

✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Lipotropics: Statins

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA
§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS (No PA Required)	PA REQUIRED
HIGH POTENCY STATINS	
SIMVASTATIN† (compare to Zocor®) *(QL = 1 tablet/day)* CRESTOR® (rosuvastatin calcium) § **AFTER GENERIC SIMVASTATIN TRIAL** *(QL = 1 tablet/day)*	Lipitor® (atorvastatin) *(QL = 1 tablet/day)* Zocor®* (simvastatin) *(QL = 1 tablet/day)*
OTHER STATINS	
LOVASTATIN† (compare to Mevacor®) *(QL = 1 tab/day (10 & 20 mg), 2 tab/day (40 mg))* PRAVASTATIN† (compare to Pravachol®)) *(QL = 1 tablet/day (10 & 20 mg), 2 tab/day (40 mg))*	Altoprev® (aka: Altocor®) (lovastatin) *(Ql = 1 tablet/day)* Lescol® (fluvastatin) *(QL = 1 tablet/day)* Lescol® XL (fluvastatin XL) *(QL = 1 tablet/day)* Mevacor®* (lovastatin)) *(QL = 1 tab/day (10 & 20 mg), 2 tabs/day (40 mg))* Pravachol®* (pravastatin) *(QL = 1 tab/day (10 & 20 mg), 2 tabs/day (40 mg))* Pravastatin † 80 mg Tablet (use 40 mg tablets)

Note: Please refer to "Lipotropics: Miscelaneous/Combinations" for statin combinations and Lovaza®.

Lipotropics: Miscellaneous/Combinations

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Lovaza®

- The patient has triglyceride levels > 500 mg/dL

AND

- The patient has a documented contraindication, side effect, allergy, or treatment failure to a fibric acid derivative and niacin.

(Note regarding fibrates: For patients receiving statin therapy, fenofibrate appears less likely to increase statin levels and thus may represent a safer choice than gemfibrozil for coadministration in this group of patients - *Am J Med* 2004;116:408-416)

Caduet®

- The prescriber must provide a clinically valid reason for the use of the requested medication.

Vytorin®

- The patient has had an inadequate response to BOTH generic simvastatin and Crestor®.

Zetia®

- The patient has a documented side effect, allergy or contraindication (eg. drug interaction) to a statin.

OR

- The patient has a diagnosis of homozygous sitosterolemia.

OR

- The patient has had an inadequate response to BOTH generic simvastatin and Crestor®.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Lipotropics: Miscelaneous/Combination

Length of Authorization: 1 year

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS (No PA Required)	PA REQUIRED
MISCELLANEOUS	
	Lovaza® (omega-3-acid ethyl esters)
CHOLESTEROL ABSORPTION INHIBITORS/COMBINATIONS	
ZETIA® (ezetimibe) § **(AFTER CLINICAL CRITERIA ARE MET)** *(Qty Limit = 1 tablet/day)*	Vytorin® (ezetimibe/simvastatin) *(QL = 1 tablet/day)*
OTHER STATIN COMBINATIONS	
ADVICOR® (lovastatin/niacin) *(Qty Limit = 1 tablet/day)* SIMCOR® (simvastatin/extended release niacin) *(Qty Limit = 1 tablet/day)* ±	Caduet® (atorvastatin/amlodipine) *(Qty Limit = 1 tablet/day)*

± Recommended to be used only when goal is not met in patients previously having experience with any niacin derivative or statin.

Management of Mental Health Medications

1. Patients on certain existing non-preferred mental health drugs as of 01/01/06 were "grandparented" and their mental health drug use was not subject to the Preferred Drug List (PDL).

   Patients of any age who were using:

   - **antipsychotics,**
   - **antidepressants,**
   - **mood stabilizers,**
   - **and/or CNS Stimulants/ADD/ADHD drugs**

   were grandfathered so as not to risk destabilization. Changes in therapy or lapses in therapy of greater than 4 (four) months resulted in the application of the PDL.

   Use of sedative hypnotics and/or anxiolytics by patients using antipsychotics, antidepressants, mood stabilizers, and/or CNS Stimulants/ADD/ADHD drugs was also grandfathered until such time as there was a change or lapse in the sedative hypnotic/anxiolytic treatment of greater than 4(four) months. If patients end all antipsychotics, antidepressants, mood stabilizers, or CNS Stimulants/ADD/ADHD drug treatment but continue sedative hypnotic or anxiolytic treatment, non-preferred sedative hypnotic or anxiolytic drugs will not be subject to PA for one year from the end of the antipsychotics, antidepressants, mood stabilizers, or CNS Stimulants/ADD/ADHD drug treatment unless there is a change or lapse in the sedative hypnotic/anxiolytic treatment of greater than 4(four) months. In either case, if there is a change or lapse in sedative hypnotic/anxiolytic therapy of greater than 4(four) months, the PDL will apply.

2. The PDL applies to new patients, patients who are prescribed a change in therapy, and patients who have had a lapse in therapy of greater than 4 (four months).

   The PDL represents a clinically effective array of mental health products that are cost effective. The classes include:

   - **SSRI Antidepressants**
   - **Tricyclic and MAOI Antidepressants**
   - **Novel Antidepressants**
   - **Atypical Antipsychotics**
   - **Typical Antipsychotics**
   - **Mood Stabilizers (including some anticonvulsants)**
   - **CNS Stimulants/ADD/ADHD Drugs (Antihyperkinesis medications)**
   - **Sedative Hypnotics**
   - **Anxiolytics**

3. The PDL includes suggested maximum dose levels.

   With some exceptions, prior authorization will be required if FDA maximum recommended daily dose levels are exceeded by 25%. These maximum daily dose limits were not applied to current patients on 01/01/06. As part of drug utilization review (DUR) activities, prescribers may be contacted by mail where patients are prescribed quantities outside these levels.

4. The prescribing of brands when generic equivalents are available will require prior authorization.

   Patients on current therapies (brand where generic equivalent available) were allowed to continue these drugs without prior authorization until October 2, 2006. Prescribers were contacted by mail and provided with lists to assist them in identifying patients who might readily transition to a preferred generic and those who would require a PA. New patients and patients who are prescribed a change in therapy require a PA for the use of a branded drug when a generic equivalent is available. A prior authorization granted for a brand name medication when a generic equivalent exists will expire after one year after which a new PA must be obtained for continuation of the brand.

Miscellaneous: Elaprase® (Hunter's Syndrome Injectable)

LENGTH OF AUTHORIZATION: 1 year

CLINICAL CONSIDERATIONS:

How supplied: 6 mg glass vials (one vial per package)
Dose: 0.5 mg/kg every week

CRITERIA FOR APPROVAL:

- The diagnosis or indication for the requested medication is Hunter's Syndrome.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

This drug must be billed through the OVHA POS prescription processing system using NDC values.
J code (J1743) will NOT be accepted.

ELAPRASE®	*Length of Authorization: 1 year*
NO PA REQUIRED	**PA REQUIRED**
	Elaprase® (idursulfase) *(QL = calculated weekly dose)*

Miscellaneous: Soliris® (Paroxysmal Nocturnal Hemoglobinuria Injectable)

LENGTH OF AUTHORIZATION: initial approval 3 months, subsequent approval 1 year

CLINICAL CONSIDERATIONS:

How supplied: 10 mg/mL (30 mL)
Dose: 600 mg IVF every 7 days x 4 weeks, followed by 900 mg IVF 7 days later and 900 mg IVF every 14 days thereafter

CRITERIA FOR APPROVAL:

- The patient has a diagnosis of paroxysmal nocturnal hemoglobinuria.

AND

- The patient receives at least one red blood cell transfusion per month or 12 transfusions per year

AND

- Hemoglobin level is < 9g/dl (in patients with symptoms), or < 7g/dl (in patients without symptoms)

AND

- The patient has received the meningococcal vaccine

AND

- The request is for a quantity limit of 20 vials (of 300 mg/30 mL) total with initial approval duration of 3 months and a quantity limit of 6 vials per month with recertification approvals.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

This drug must be billed through the OVHA POS prescription processing system using NDC values.
J codes (J1300) will NOT be accepted.

SOLIRIS®

Length of Authorization: initial approval 3months, subsequent approval 1 year

NO PA REQUIRED	PA REQUIRED
	Soliris® (eculizumab) *(Quantity Limit = 20 vials total/3 months initially; 6 vials/month subsequently)*

Miscellaneous: Somatuline® (Acromegaly Injectable)

LENGTH OF AUTHORIZATION: 1 year

CLINICAL CONSIDERATIONS:

How supplied: 60, 90 or 120 mg pre-filled syringes
Dose: initial dose is 90 mg deep subcutaneous every 4 weeks x 3 months, then dose adjusted to between 60 mg and 120 mg every 4 weeks based on lab values and symptoms

CRITERIA FOR APPROVAL:

- The diagnosis or indication for the requested medication is Acromegaly.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

This drug must be billed through the OVHA POS prescription processing system using NDC values.
J code or other code will NOT be accepted for processing through medical benefit.

SOMATULINE®	*Length of Authorization: 1 year*
NO PA REQUIRED	**PA REQUIRED**
	Somatuline® Depot Injection (lanreotide) *(QL = 0.2 ml/28 days (60 mg syringe), 0.3 ml/28 days (90 mg syringe) and 0.5 ml/28 days (120 mg syringe))*

Mood Stabilizers (See also Anticonvulsants)

LENGTH OF AUTHORIZATION: Duration of Need*

CRITERIA FOR APPROVAL:

Eskalith CR®, Lithobid®:

- The patient has had a documented side effect, allergy, or treatment failure with the generic equivalent of the requested medication.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

After a 4-month lapse in use of a non-preferred agent, or if there is a change in therapy, a look-back through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.

MANAGEMENT OF MENTAL HEALTH DRUGS: See page 118 for a description of the management of mental health drugs.

Mood Stabilizers

*Length of authorization: Duration of Need**

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
EQUETRO® (carbamazepine SR) LITHIUM CARBONATE† (compare to Eskalith®) LITHIUM CARBONATE SR† (compare to Eskalith CR®, Lithobid ®) LITHIUM CITRATE SYRUP†	Eskalith CR®* (lithium carbonate SR) Lithobid ®* (lithium carbonate SR)

* For brand name products with generic equivalents, length of authorization is 1 year.

Multiple Sclerosis: Injectables

LENGTH OF AUTHORIZATION: Initial PA of 3 months, and 12 months thereafter if medication is well tolerated. Re-evaluate every 12 months.

CRITERIA FOR APPROVAL:

Tysabri®

Patient has a diagnosis of relapsing multiple sclerosis and has already been stabilized on Tysabri®.

OR

Diagnosis is relapsing multiple sclerosis and the patient has a documented side effect, allergy, treatment failure, or contraindication to at least two preferred drugs.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Multiple Sclerosis: Injectables

Length of authorization: Initial PA of 3 months; 12 months thereafter

PREFERRED DRUGS (No PA Required)	PA REQUIRED
Interferons AVONEX® (interferon beta-1a) BETASERON® (interferon beta-1b) REBIF® (interferon beta-1a) **Other** COPAXONE® (glatiramer) *(QL = 1 kit/30 days)*	Tysabri® (natalizumab)

Nutritionals: Enteral (Oral)

LENGTH OF AUTHORIZATION: 6 months

CRITERIA FOR APPROVAL:

Caloric and/or protein intake is not obtainable through regular liquefied or pureed foods.
AND
Requested nutritional supplement will be taken by mouth (not administered via tube feeding)
AND
Patient has experienced unplanned weight loss or is extremely low weight (see further definitions below)
OR
Patient has demonstrated nutritional deficiency identified by low serum protein levels (albumin or pre-albumin levels to be provided).

UNPLANNED WEIGHT LOSS/LOW WEIGHT

Adult:
- involuntary loss of $\geq$ 10 % of body weight within 6 months
- involuntary loss of $\geq$ 5% of body weight within 1 month
- loss of $\geq$ 2% of body weight within one week
- BMI of $\leq$ 18.5 kg/m^2

Elderly: ($\geq$ 65):
- involuntary loss of $\geq$ 10 % of body weight within 6 months
- involuntary loss of $\geq$ 5 % of body weight within 3 months
- loss of $\geq$ 2 % of body weight within one month

Children:
- < 70 % of expected weight-for-height
- < 85 % of expected height-for-age
- mid-upper arm circumference/head circumference ratio < 0.25

DOCUMENTATION:
- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **Nutritionals Prior Authorization Request Form**.

Nutritionals: Enteral (Oral)	*Length of authorization: 6 months*
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
	All Note: Nutritional supplements administered via tube feeds are provided through the Medical Benefit. Please see guidelines at http://ovha.vermont.gov/forproviders/copy_of_GOC13.pdf

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~NUTRITIONALS ~

ORAL NUTRITION TAKEN BY MOUTH

Prior Authorization Request Form

Effective February 2002, Vermont Medicaid established coverage limits and criteria for prior authorization of Nutritional supplements. These limits and criteria are based on concerns about safety and appropriate use. In order for beneficiaries to receive coverage for nutritionals, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Contact Person at Office: _____

Diagnosis: _____

Baseline: Date: ___/___/____ Height: _____ Weight: _____ BMI: _____

Current: Date: ___/___/____ Height: _____ Weight: _____ BMI: _____

Children: Mid-Upper Arm Circumference: _____ Head Circumference: _____

Laboratory Values: Date: ___/___/____ Albumin: _____ Pre-Albumin:_____

Answer the following questions:

Caloric/protein intake is <u>not</u> obtainable through regular liquefied or pureed foods.	☐ Agree ☐ Disagree
Requested nutritional supplement will be taken by <u>mouth</u> (not administered via tube feeding)	☐ Yes ☐ No
Oral nutritional supplement is being requested due to:	☐ Unplanned weight loss (see complete definition by age in clinical criteria manual) ☐ Low serum protein levels (nutritional deficiency as defined by albumin or pre-albumin levels)
Underlying cause of unplanned weight loss or low serum protein levels: **Circle or describe specifics:** ▪ Increased metabolic need resulting from severe trauma (i.e.: burns, infection, major bone fractures)	☐ Yes ☐ No
▪ Malabsorption syndrome (as related to cystic fibrosis, renal disease, short gut syndrome, Crohn's disease and other unspecified disorders of the gut)	☐ Yes ☐ No
▪ Nutritional wasting due to chronic disease (i.e.: cancer, AIDS, conditions resulting in dysphagia, pulmonary insufficiency, renal disease)	☐ Yes ☐ No

▪ Other: Explain: _____ _____	☐ Yes ☐ No
Additional clinical information to support PA request:	

Requested Supplement: _____

Strength & Frequency: _____

Anticipated duration of supplementation: _____

Prescriber Signature: _____**Date of this request**: _____

Ophthalmics: Antihistamines

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Elestat®, Pataday®/Patanol®

- The patient has had a documented side effect, allergy, or treatment failure to ketotifen.

Emadine®, Optivar®,Zaditor® RX

- The patient has had a documented side effect, allergy, or treatment failure to BOTH Elestat® and Pataday® or Patanol®.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Ophthalmics: Antihistamines

Length of Authorization: 1 year

Key: † Generic product.

PREFERRED DRUGS (No PA Required)	PA REQUIRED
KETOTIFEN 0.025 % (eg. Alaway®, Zaditor® OTC, others) *(QL = 1 bottle/month)*	
After trial of ketotifen 0.025 %	
ELESTAT® (epinastine) *(QL = 1 bottle/month)* PATADAY (olopatadine 0.2%)/PATANOL® (olopatadine 0.1%) *(QL = 1 bottle/month)*	Emadine® (emedastine) *(QL = 2 bottles/month)* Optivar® (azelastine) *(QL = 1 bottle/month)* Zaditor® RX (ketotifen 0.025 %) *(QL = 1 bottle/month)*

Ophthalmics: Glaucoma Agents / Miotics

LENGTH OF AUTHORIZATION: lifetime

CRITERIA FOR APPROVAL:

ALPHA 2 ADRENERGIC AGENTS

- The patient has had a documented side effect, allergy or treatment failure with at least one preferred ophthalmic alpha 2 adrenergic agent.

BETA BLOCKERS

- The patient has had a documented side effect, allergy or treatment failure with at least one preferred ophthalmic beta blocker.

PROSTAGLANDIN INHIBITORS (Lumigan, Travatan, and Travatan Z)

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient has had a documented side effect, allergy or treatment failure with a preferred ophthalmic alpha 2 adrenergic agent, beta blocker, or carbonic anhydrous inhibitor.

PROSTAGLANDIN INHIBITORS (Xalatan)

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient has had a documented side effect, allergy or treatment failure with a preferred ophthalmic alpha 2 adrenergic agent, beta blocker, or carbonic anhydrous inhibitor.

AND

- The patient has had a documented side effect, allergy or treatment failure with Lumigan and Travatan/Travatan Z.

CARBONIC ANHYDROUS INHIBITORS

- The patient has had a documented side effect, allergy or treatment failure with a preferred carbonic anhydrous inhibitor.

MISCELLANEOUS

- The patient has had a documented side effect, allergy or treatment failure with a preferred miscellaneous ophthalmic agent.

DOCUMENTATION:

✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Glaucoma Agents / Miotics

Length of Authorization: lifetime

Key: † Generic product, *Indicates generic equivalent is available without a PA
§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS (No PA Required)	PA REQUIRED
ALPHA 2 ADRENERGIC	
Single Agent ALPHAGAN P® (brimonidine tartrate) BRIMONIDINE TARTRATE† (compare to Alphagan®) **Combination** COMBIGAN® (brimonidine tartrate/timolol maleate)	Iopidine® (no PA required for patients ≤ 10 years of age)
BETA BLOCKERS	
BETAXOLOL HCL† (compare to Betoptic®) BETOPTIC S® (betaxolol suspension) CARTEOLOL HCL† (compare to Ocupress®) LEVOBUNOLOL HCL† (compare to AKBeta®, Betagan®) METIPRANOLOL† (compare to Optipranolol®) TIMOLOL MALEATE† (compare to Istalol®, Timoptic®)	Betagan®* Betimol® Istalol®* Optipranolol®* Timoptic®* Timoptic XE®*
PROSTAGLANDIN INHIBITORS	
NOTE: COVERAGE OF A 'PREFERRED' PI AGENT IS CONTINGENT UPON A 1ST-LINE TRIAL OF ANY OTHER PREFERRED BETA-BLOCKER, A-2 ADRENDERGIC OR CAI AGENT. COVERGE OF A 'NON-PREFERRED' PI AGENT IS CONTINGENT UPON A SIMILAR FIRST-LINE TRIAL AS WELL AS A FAILED TRIAL OF BOTH LUMIGAN AND TRAVATAN/TRAVATAN Z.	
LUMIGAN® (bimatoprost) § TRAVATAN®/TRAVATAN Z® (travoprost) §	Xalatan®
CARBONIC ANHYDROUS INHIBITORS	
Single Agent TRUSOPT®(dorzolamide) **Combination** COSOPT®(dorzolamide w/timolol)	Azopt®
MISCELLANEOUS	
DIPIVEFRIN HCL† (compare to AKPro®, Propine®) EPINEPHRINE† (compare to Epifrin®, Glaucon®*) ISOPTO® CARBACHOL (carbachol) ISOPTO® CARPINE (pilocarpine) PILOCARPINE HCL† (compare to Pilocar®) PILOPINE® (pilocarpine) PHOSPHOLINE IODIDE® (echothiophate)	Miochol-E® Miostat® Pilocar®* Propine®*

Ophthalmics: Mast Cell Stabilizers

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

- The patient has had a documented side effect, allergy, or treatment failure with both Alamast and generic cromolyn sodium.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Ophthalmics: Mast Cell Stabilizers

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
ALAMAST® (pemirolast potassium) CROMOLYN SODIUM † (compare to Crolom®, Opticrom®)	Alocril® (nedocromil sodium) Alomide® (iodoxamide) Crolom®*

Ophthalmic: Non-Steroidal Anti-inflammatory Drugs (NSAIDS)

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Diclofenac, Nevanac®, Xibrom®, Voltaren®

- The patient has had a documented side effect, allergy, or treatment failure to Acular®. In addition, for approval of diclofenac, the patient must have also had a trial of Voltaren®.

Ocufen®

- The patient has had a documented side effect, allergy, or treatment failure to flurbiprofen ophthalmic solution.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Opthalmic: NSAIDs

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
ACULAR® (ketorolac 0.5% ophthalmic sol.) ACULAR LS ® (ketorolac 0.4% ophthalmic sol.) ACULAR® PF (ketorolac 0.5% ophthalmic sol.) FLURBIPROFEN 0.03% ophthalmic sol. †	Diclofenac† 0.1% ophthalmic sol (compare to Voltaren®) Nevanac® ophthalmic susp. (nepafenac 0.1%) Xibrom® ophthalmic sol. (bromfenac 0.09%) Ocufen®* ophthalmic sol. (flurbiprofen 0.03%) Voltaren® (diclofenac 0.1% ophthalmic sol.)

Ophthalmics: Quinolone Anti-infectives

LENGTH OF AUTHORIZATION: duration of therapy requested

CRITERIA FOR APPROVAL:

- The patient has had a documented side effect, allergy or treatment failure with ciprofloxacin or ofloxacin.

OR

- The request is for Vigamox or Zymar as part of a regimen to prevent postoperative infection in patients receiving any ophthalmologic surgery.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Ophthalmics: Quinolone Anti-Infectives

Length of Authorization: for date of service, no refills

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
CIPROFLOXACIN HCL† (compare to Ciloxan®) OFLOXACIN† (compare to Ocuflox®)	Ciloxan®* Iquix® (levofloxacin 1.5 %) (preservative free) Ocuflox®* Quixin® (levofloxacin 0.5 %) Vigamox® (moxifloxacin) (preservative free) Zymar® (gatifloxacin)

Ossification Enhancing Agents

LENGTH OF AUTHORIZATION: lifetime

CRITERIA FOR APPROVAL:

Actonel®, Actonel® w/calcium:

- The patient has had a documented side effect, allergy, or treatment failure (to at least a six-month trial) of Boniva® or Fosamax®.

Alendronate:

- The patient has had a documented intolerance to brand Fosamax®.

Didronel®, Etidronate, Skelid®:

- The patient has had a documented side effect, allergy, or treatment failure (to at least a six-month trial) of Boniva® or Fosamax®.

Fortical®:

- The patient has been started and stabilized on Fortical®.

OR

- The patient has had a documented side effect, allergy, or treatment failure to Miacalcin®.

Forteo®:

- The patient has a dignosis/indication of postmenopausal osteoporosis in females or primary or hypogonadal osteoporosis in males.

AND

- The patient has had a documented side effect, allergy, or treatment failure to bisphosphonates. Treatment failure is defined as documented continued bone loss after two or more years despite treatment with bisphosphonate.

AND

- The prescriber has verified that the patient has been counseled about osteosarcoma risk.

AND

- The quantity requested does not exceed 1 pen (3 mL) per 28 days.

Boniva®Injection:

- The patient has a diagnosis/indication of postmenopausal osteoporosis**.**

AND

- The patient has had a documented side effect or treatment failure to a preferred bisphosphonate. Treatment failure is defined as documented continued bone loss after two or more years despite treatment with an oral bisphosphonate.

AND

- The quantity requested does not exceed four (4) 3 mg doses per year.

Reclast® Injection:

- The patient has a diagnosis/indication of Paget's disease of bone.

OR

- The patient has a diagnosis/indication of postmenopausal osteoporosis**.**

AND

- The patient has had a documented side effect or treatment failure to a preferred bisphosphonate. Treatment failure is defined as documented continued bone loss after two or more years despite treatment with an oral bisphosphonate.

AND

- The quantity requested does not exceed a single 5 mg dose per year.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of Boniva IV or Reclast on a **Bisphosphonate Injectable – Boniva and Reclast Prior Authorization Request Form**.

- ✓ Document clinically compelling information supporting the choice of other non-preferred agents on a **General Prior Authorization Request Form**

Ossification Enhancing Agents

Length of Authorization: lifetime

Key: † Generic product,

PREFERRED DRUGS (No PA Required)	PA REQUIRED
ORAL BISPHOSPHONATE BONIVA® (ibandronate) *(Quantity Limit = 150 mg tablet/1 tablet per 28 days, 2.5 mg tablet – no QL)* FOSAMAX® (alendronate) FOSAMAX PLUS D® (alendronate/vitamin D) INJECTABLE BISPHOSPHONATE	Actonel® (risedronate) Actonel® w/calcium (risedronate/calcium) Alendronate† (compare to Fosamax®) Didronel® (etidronate) Etidronate† (compare to Didronel®) Skelid® (tiludronate) Boniva Injection (ibandronate) *(QL=3 mg/3 months (four doses)/year)* Reclast® Injection (zoledronic acid) *(QL=5 mg (one dose)/year)*
MIACALCIN® (calcitonin)	Fortical® (calcitonin)
	Forteo® (teriparatide) *(Quantity Limit = 1 pen (3 ml)/28 days*

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ BISPHOSPHONATE INJECTABLE – BONIVA AND RECLAST ~

Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of Boniva IV and Reclast. For beneficiaries to receive coverage for these agents, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis:_____

Contact Person at Office: _____

Will this medication be billed through the: ☐ **pharmacy benefit** or ☐ **medical benefit** (J-code or other code)? **(Please check one)**

Pharmacy (if known):_____ Phone:_____ &/or FAX:_____

Drug requested: ☐ Boniva IV ☐ Reclast **Dose & frequency:** _____

Diagnosis/indication:

☐ Treatment of postmenopausal osteoporosis

☐ Paget's Disease

☐ Other (Please Explain) _____

Has the member previously tried the following preferred medications? (Please check all that apply)

Drug:	***Response:***
☐ Boniva Oral	☐ side-effect ☐ treatment failure* dates of use: _____
☐ Fosamax Oral	☐ side-effect ☐ treatment failure* dates of use: _____

*Treatment failure is defined as documented continued bone loss after two or more years despite treatment with the bisphosphonate.

Prescriber comments:

_____

_____

_____

_____

Prescriber Signature:_____ **Date of this request:** _____

Otic: Anti-Infectives

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Cipro-HC®, Coly-Mycin S®, Cortisporin TC®

- The patient has had a documented side effect, allergy, or treatment failure to neomycin/polymyxin B sulfate/hydrocortisone and one other preferred product.

Cortisporin® Otic, Pediotic®:

- The patient has had a documented side effect, allergy, or treatment failure to the generic product.

Ofloxacin 0.3 % Otic Soln:

- The patient has had a documented side effect, allergy, or treatment failure to brand Floxin®.

DOCUMENTATION:

✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Otic: Anti-Infectives

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
CIPRODEX® (ciprofloxacin 0.3%/dexamethasone 0.1%; otic susp.)	Cipro-HC® (ciprofloxacin 0.2%/hydrocortisone 1%; otic susp.)
FLOXIN® (ofloxacin 0.3% otic soln.)	Ofloxacin† 0.3% Otic Soln
	Coly-Mycin S®/Cortisporin TC® (neomycin/colistin/thonzium/hydrocortisone)
NEOMYCIN/POLYMYXIN B SULFATE/HYDROCORTISONE†	Cortisporin otic®/Pediotic®* (neomycin/polymyxin B sulfate /hydrocortisone) otic solution/suspension

Parkinson's Medications

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Sinemet®, Sinemet® CR, Parlodel®, Eldepryl®, Symmetrel®

- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.)

OR

- The patient has had a documented side effect, allergy, or treatment failure with the generic product.

Neupro®

- The diagnosis or indication is Parkinson's disease.

AND

- The prescriber provides medical necessity for the transdermal formulation (eg. swallowing disorder, difficulty taking oral medications or difficulty with compliance of multiple daily doses of an oral dopamine agonist)

AND

- The dose requested does not exceed 1 patch/day.

Ropinirole

- The patient has had a documented intolerance wuth the brand product (Requip®)

Azilect®

- The diagnosis or indication is Parkinson's disease.

AND

- The patient has had a documented side effect, allergy, or treatment failure with selegiline.

AND

- The dose requested does not exceed 1 mg/day

Zelapar®

- The diagnosis or indication is Parkinson's disease.

AND

- The patient is on current therapy with levodopa/carbidopa.

AND

- Medical necessity for disintegrating tablet administration is provided (i.e. inability to swallow tablets or drug interaction with oral selegiline).

AND

- The dose requested does not exceed 2.5 mg/day.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Parkinson's Medications

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
DOPAMINE PRECURSOR CARBIDOPA/LEVODOPA† (compare to Sinemet®) CARBIDOPA/LEVODOPA† ER (compare to Sinemet® CR) PARCOPA® (carbidopa/levodopa ODT)	Sinemet®* Sinemet CR®*
DOPAMINE AGONISTS (ORAL) BROMOCRIPTINE† (compare to Parlodel®) MIRAPEX® (pramipexole) REQUIP® (ropinirole) **DOPAMINE AGONISTS (TOPICAL)**	Parlodel®* (bromocriptine) Ropinirole† (compare to Requip®) Neupro® Patch (rotigotine transdermal) *(QL = 1 patch/day)*
COMT INHIBITORS TASMAR® (tolcapone) COMTAN® (entacapone)	
MAO-B INHIBITORS SELEGILINE† (compare to Eldepryl®)	Eldepryl®* (selegiline) Azilect® (rasagiline) *(QL = 1 mg/day)* Zelapar® (selegiline ODT) *(QL = 2.5 mg/day)*
OTHER AMANTADINE† (compare to Symmetrel®) STALEVO® (carbidopa/levodopa/entacapone)	Symmetrel®* (amantadine)

ODT = orally disintegrating tablets

Phosphodiesterase-5 (PDE-5) Inhibitor Medications

Effective 7/1/06, phosphodiesterase-5 (PDE-5) inhibitors are no longer a covered benefit for all Vermont Pharmacy Programs for the treatment of erectile dysfunction. This change is resultant from changes set into effect on January 1, 2006 and as detailed in Section 1903(i)(21)(K) of the Social Security Act (the Act), precluding Medicaid Federal Funding for outpatient drugs used for the treatment of sexual or erectile dysfunction. Sildenafil will remain available for coverage via prior authorization for the treatment of Pulmonary Arterial Hypertension.

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Revatio® (sildenafil citrate) 20mg:

- Clinical diagnosis of pulmonary hypertension

  AND
- No concomitant use of organic nitrate-containing products

Viagra® (sildenafil citrate) 25mg, 50mg, and 100mg:

- Clinical diagnosis of pulmonary hypertension

  AND
- No concomitant use of organic nitrate-containing products

  AND
- Inadequate response to Revatio (sildenafil) 20 mg or currently maintained on a sildenafil dose of 25 mg TID or higher

DOCUMENTATION:

- ✓ Document clinical information supporting the choice of agent on a **General Prior Authorization Request Form**.

Phosphodiesterase Inhibitors	*Length of Authorization: 1 year*
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
	Revatio® (sildenafil citrate) *(Quantity Limit = 3 tabs/day)* Viagra® (sildenafil citrate) *(Quantity Limit = 3 tabs/day)*

Platelet Inhibitors

LENGTH OF AUTHORIZATION: 3 years

CRITERIA FOR APPROVAL:

Persantine®, Pletal®, Ticlid®:

- The patient has had a documented side effect, allergy, or treatment failure to the generic formulation of the medication.

Aggrenox®:

- The prescriber provides a clinically valid reason why the patient cannot use dipyridamole and aspirin as separate agents.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Platelet Inhibitors

Length of Authorization: 3 years

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
AGGREGATION INHIBITORS	
CILOSTAZOL† (compare to Pletal®)	Pletal®*
CLOPIDOGREL† (compare to Plavix®)	Ticlid®*
PLAVIX® (clopidogrel bisulfate)	
TICLOPIDINE† (compare to Ticlid®)	
OTHER	
ASPIRIN†	Aggrenox® (dipyridamole/ASA)
DIPYRIDAMOLE† (compare to Persantine®)	Persantine®*

Psoriasis Medications: Injectables

LENGTH OF AUTHORIZATION: Initial PA of 3 months, and 12 months thereafter upon recertification

CRITERIA FOR APPROVAL:

Enbrel®

The prescription must be written by a dermatologist

AND

The patient has a documented diagnosis of moderate to severe plaque psoriasis and has already been stabilized on Enbrel®

OR

The prescription must be written by a dermatologist

AND

The patient has a documented diagnosis of moderate to severe plaque psoriasis affecting > 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 different categories of therapy [i.e. at least 2 topical agents and at least 1 oral systemic agent, (unless otherwise contraindicated)] from the following categories:

Topical agents: emollients, keratolytics, corticosteroids, calcipotriene, tazarotene, etc.
Systemic agents: methotrexate, sulfasalazine, azathioprine, cyclosporine, tacrolimus, mycophenylate mofetil, etc.
Phototherapy: ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA, narrow band ultraviolet B (NUVA), etc.

Humira®

The prescription must be written by a dermatologist

AND

The patient has a documented diagnosis of moderate to severe plaque psoriasis and has already been stabilized on Humira®

OR

The prescription must be written by a dermatologist

AND

The patient has a documented diagnosis of moderate to severe plaque psoriasis affecting > 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 different categories of therapy [i.e. at least 2 topical agents and at least 1 oral systemic agent, (unless otherwise contraindicated)] from the following categories:

Topical agents: emollients, keratolytics, corticosteroids, calcipotriene, tazarotene, etc.
Systemic agents: methotrexate, sulfasalazine, azathioprine, cyclosporine, tacrolimus, mycophenylate mofetil, etc.
Phototherapy: ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA, narrow band ultraviolet B (NUVA), etc.

Raptiva®

The prescription must be written by a dermatologist

AND

The patient has a documented diagnosis of moderate to severe plaque psoriasis and has already been stabilized on Raptiva®

OR

The prescription must be written by a dermatologist

AND

The patient has a documented diagnosis of moderate to severe plaque psoriasis affecting > 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 different

categories of therapy [i.e. at least 2 topical agents and at least 1 oral systemic agent, (unless otherwise contraindicated)] from the following categories:

Topical agents: emollients, keratolytics, corticosteroids, calcipotriene, tazarotene, etc.
Systemic agents: methotrexate, sulfasalazine, azathioprine, cyclosporine, tacrolimus, mycophenylate mofetil, etc.
Phototherapy: ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA, narrow band ultraviolet B (NUVA), etc.

Amevive®

The prescription must be written by a dermatologist

AND

The patient has a documented diagnosis of moderate to severe plaque psoriasis and has already been stabilized on Amevive®

OR

The prescription must be written by a dermatologist

AND

The patient has a documented diagnosis of moderate to severe plaque psoriasis affecting > 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 different categories of therapy [i.e. at least 2 topical agents and at least 1 oral systemic agent, (unless otherwise contraindicated)] from the following categories:

Topical agents: emollients, keratolytics, corticosteroids, calcipotriene, tazarotene, etc.
Systemic agents: methotrexate, sulfasalazine, azathioprine, cyclosporine, tacrolimus, mycophenylate mofetil, etc.
Phototherapy: ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA, narrow band ultraviolet B (NUVA), etc.

AND

The prescriber must provide a clinically valid reason why either Enbrel®, Humira® or Raptiva® cannot be used.

Remicade®

The prescription must be written by a dermatologist

AND

The patient has a documented diagnosis of moderate to severe plaque psoriasis and has already been stabilized on Remicade®

OR

The prescription must be written by a dermatologist

AND

The patient has a documented diagnosis of moderate to severe plaque psoriasis affecting > 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 different categories of therapy [i.e. at least 2 topical agents and at least 1 oral systemic agent, (unless otherwise contraindicated)] from the following categories:

Topical agents: emollients, keratolytics, corticosteroids, calcipotriene, tazarotene, etc.
Systemic agents: methotrexate, sulfasalazine, azathioprine, cyclosporine, tacrolimus, mycophenylate mofetil, etc.
Phototherapy: ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA, narrow band ultraviolet B (NUVA), etc.

AND

The prescriber must provide a clinically valid reason why either Enbrel®, Humira® or Raptiva® cannot be used.

DOCUMENTATION:

- ✓ Document clinical information on a **Psoriasis Medications Injectable Prior Authorization Request Form**.

Psoriasis Medications: Injectables *Length of authorization: Initial PA of 3 months; 12 months thereafter*	
PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	**NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**
ENBREL® (etanercept) HUMIRA® (adalimumab) RAPTIVA® (efalizumab)	Amevive® (alefacept) Remicade® (infliximab)

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ PSORIASIS INJECTABLE MEDICATIONS ~

Prior Authorization Request Form

Effective June, 2004, Vermont Medicaid established coverage limits and criteria for prior authorization of injectable psoriasis medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Injectable Psoriasis medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address: _____

Specialty: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis: _____

Contact Person at Office: _____

Will this medication be billed via the: □ pharmacy benefit or □ medical benefit (J-code or other code)?

Pharmacy (if known)**:**_____ Phone:_____ &/or FAX:_____

Please select one of the following 'preferred' drug therapies from the VT Medicaid Preferred Drug List:

- ☐ **Enbrel**_____ Strength & Frequency:_____ Length of therapy:_____
- ☐ **Humira**_____ Strength & Frequency:_____ Length of therapy:_____
- ☐ **Raptiva**_____ Strength & Frequency:_____ Length of therapy:_____

For any other injectable psoriasis treatment, please explain medical necessity for non-preferred product:

Drug:_____ Strength & Frequency:_____ Length of therapy:_____

Medical justification:_____

_____

List previous therapies (topical, phototherapy, oral) tried and failed for this condition:

Therapy	Reason for discontinuation	Dates Utilized

Prescriber comments:

Prescriber Signature:_____ **Date of this request:**_____

Psoriasis: Non-Biologics

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Taclonex Ointment or Scalp Suspension

- The patient has had an inadequate response to a 24 month trial of a betamethasone dipropionate product and Dovonex, simultaneously, with significant non-adherence issues.

AND

- The patient has had a documented side effect, allergy, or treatment failure with Tazorac 0.05% or 0.1% cream or gel.

  Note: If approved, initial fill of Taclonex® will be limited to 60 grams.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Psoriasis: Non-Biologics *Length of Authorization: 1 year* **Key: † Generic product, *Indicates generic equivalent is available without a PA**	
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
ORAL	
CYCLOSPORINE† (all brand and generic) METHOTREXATE† (all brand and generic) OXSORALEN-ULTRA® (methoxsalen) SORIATANE CK® (acitretin)	
TOPICAL	
DOVONEX® (calcipotriene cream/ointment/solution) PSORIATEC®, DRITHO-SCALP® (anthralin cream) TAZORAC® (tazarotene cream, gel)	Taclonex® (calcipotriene/betamethasone ointment/scalp suspension) *(QL for initial fill = 60 grams)*

Pulmonary: Anticholinergics

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Ipratropium/albuterol Nebulizer

- The patient has had a documented side effect, allergy, or treatment failure with Duoneb®.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Anticholinergics *Length of Authorization: 1 year* **Key: † Generic product**	
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
METERED DOSE INHALER (SINGLE AGENT) ATROVENT HFA® (ipratropium) SPIRIVA® (tiotropium) **NEBULIZER (SINGLE AGENT)** IPRATROPIUM SOLN FOR INHALATION **METERED DOSE INHALER (COMBINATION)** COMBIVENT® (ipratropium/albuterol) **NEBULIZER (COMBINATION)** DUONEB® (ipratropium/albuterol)	Ipratropium/albuterol† (compare to Duoneb®)

Pulmonary: Antihistamines: Intranasal

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

ASTELIN

- The diagnosis or indication for the requested medication is allergic rhinitis.

AND

- The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC), cetirizine OTC or a preferred nasal glucococorticoid.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Pulmonary: Antihistamines: Intranasal	*Length of Authorization: 1 year*
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
	Astelin® (azelastine) Nasal Spray *Quantity Limit = 1 bottle (30 ml)/25 days*

Pulmonary: Antihistamines: 1st Generation

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

- The prescriber must provide a clinically valid reason for the use of the requested medication including reasons why any of the generically available products would not be a suitable alternative.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Antihistamines: 1st Generation

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
All generic antihistamines	All brand antihistamines (example: Benadryl®)
All generic antihistamine/decongestant combinations	All brand antihistamine/decongestant combinations (example: Deconamine SR®, Rynatan®, Ryna-12®)

Pulmonary: Antihistamines: 2nd Generation

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

FEXOFENADINE

- The diagnosis or indication for the requested medication is allergic rhinitis or chronic idiopathic urticaria.

AND

- The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) AND cetirizine (OTC).

ALLEGRA TABLETS, CLARINEX TABLETS, CLARITIN TABLETS, XYZAL TABLETS, ZYRTEC RX/OTC TABLETS

- The diagnosis or indication for the requested medication is allergic rhinitis or chronic idiopathic urticaria.

AND

- The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) AND cetirizine (OTC).

AND

- The patient has had a documented side effect, allergy, or treatment failure to fexofenadine.

ALLEGRA ODT, CERTIRIZINE CHEWABLE TABLETS, CLARINEX REDITABS, CLARITIN REDITABS, ZYRTEC CHEWABLE TABLETS

- The diagnosis or indication for the requested medication is allergic rhinitis or chronic idiopathic urticaria.

AND

- The patient has had a documented side effect, allergy, or treatment failure to loratadine (OTC) chewable/dissolvable tablets.

ALLEGRA SUSPENSION, CLARINEX SYRUP, CLARITIN SYRUP, XYZAL SYRUP, ZYRTEC RX SYRUP

- The diagnosis or indication for the requested medication is allergic rhinitis or chronic idiopathic urticaria.

AND

- The patient has had a documented side effect, allergy, or treatment failure to loratadine syrup AND Zyrtec OTC syrup.

ALLEGRA-D, CETIRIZINE D, CLARINEX-D, CLARITIN-D, ZYRTEC-D

- The diagnosis or indication for the requested medication is allergic rhinitis.

AND

- The patient has had a documented side effect, allergy, or treatment failure to loratadine-D (OTC).

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Antihistamines: 2nd Generation

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA
§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS (No PA Required)	PA REQUIRED
LORATADINE † (OTC) (compare to Claritin®) CETIRIZINE† OTC (compare to Zyrtec®) FEXOFENADINE † (after loratadine OTC and cetirizine OTC trials)	Allegra® (fexofenadine) Clarinex® (desloratadine) Claritin®* (loratadine) Xyzal® (levocetirizine) Zyrtec RX/OTC®* (cetirizine)
LORATADINE-D † (OTC)	Allegra-D® (12 HR & 24 HR) § Cetirizine-D SR Clarinex-D® (12 HR & 24 HR) § Claritin-D®*§ Zyrtec-D® §
LORATADINE † (OTC) syrup CETIRIZINE † (OTC) syrup ZYRTEC OTC SYRUP®	Allegra® suspension Clarinex Syrup® Claritin Syrup®* Xyzal® (levocetirizine) Syrup Zyrtec RX Syrup®
LORATADINE † (OTC) chewable tablets	Allegra ODT®§ Certirizine † Chewable Tablets Clarinex Reditabs®§ Claritin Reditabs®*§ Zyrtec Chewable Tablets® §

Pulmonary: Persistent Asthma: Xolair®

LENGTH OF AUTHORIZATION: ***3 months***, subsequent renewals will be granted upon primary care physician verification of marked clinical improvement.
Yearly pulmonologist/allergist/immunologist consult required.

PHARMACOLOGY:

Omalizumab is a recombinant humanized monoclonal antibody directed against immunoglobulin E (IgE). It inhibits the binding of IgE to the high affinity IgE receptor (FcεRI) on the surface of mast cells and basophils. The reduction in surface bound IgE on FcεRI bearing cells limits the degree of release of mediators of the allergic response. Treatment with Omalizumab also reduces the number of FcεRI receptors on basophils in the atopic patient.

MEDICATION:

Xolair®	omalizumab	A lyophilized, sterile powder in a single-use, 5-cc vial that is designed to deliver 150 mg of Xolair® upon reconstitution with 1.4 ml SWFI, USP.

INDICATION:

Omalizumab is indicated for adults and adolescents (12 years of age and older) with moderate to severe persistent asthma who have a positive skin test or *in vitro* reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids.

CRITERIA FOR APPROVAL:

- Patient must have a diagnosis of moderate to severe persistent asthma and be 12 years of age or older. In addition the patient must meet ALL of the following conditions. Patient has:
- Tried and failed an inhaled oral corticosteroid *or* has a contraindication to an inhaled corticosteroid.
- Tried and failed an oral second generation antihistamine *or* has a contraindication to an oral second generation antihistamine.
- Tried and failed a leukotriene receptor antagonist *or* has a contraindication to a leukotriene receptor antagonist.
- Tried and failed a long acting beta-agonist *or* has a contraindication to a long acting beta-agonist.
- A pulmonologist/allergist/immunologist consult.
- Tested positive to at least one perennial aeroallergen by a skin test (i.e.: RAST, CAP, intracutaneous test).
- An IgE level ≥ 30 and ≤ 700 IU/ml.

EXCLUDED FROM APPROVAL:

- Peanut allergy

This drug must be billed through the OVHA POS prescription processing system using NDC values.
J codes will NOT be accepted.

DOCUMENTATION:

- ✓ Document clinically information on the **Xolair Prior Authorization Request Form**.

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ XOLAIR ~

Prior Authorization Request Form

Effective October 2003, Vermont Medicaid established coverage limits and criteria for prior authorization of Xolair. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Xolair prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing Physician:

Name:_____

Phone #:_____

Fax #:_____

Address: _____ ___

Specialty: _____

Contact Person at Office: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Patient Diagnosis: _____

Will this medication be billed through the:□ pharmacy benefit or □ medical benefit (J-code or other code)?

If requesting prescriber is not a pulmonologist, allergist, or immunologist, has one of these specialties been consulted on this case? □Yes □No

Specialist name: _____ **Specialist Type**: _____

Pharmacy (if known):_____ Phone:_____ &/or FAX:_____

List all previous therapies (inhaled corticosteroid, second generation antihistamine, leukotriene receptor antagonist, long-acting beta-agonist) tried and failed for this condition:

Therapy	Reason for discontinuation	Dates Utilized

Has the member tested positive to at least one perennial aeroallergen by a skin test (i.e. RAST, CAP, intracutaneous test)? Y / N
Please explain: _____

Is the member's IgE level ≥ 30 and ≤ 700 IU/ml? Y / N

Please provide IgE level: _____

Prescriber Signature:_____ **Date of this request:**_____

Pulmonary: Beta-Adrenergic Agents

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Metered Dose Inhalers (Short-Acting)
Effective 11/1/06, Xopenex HFA will be the only short-acting beta-adrenergic (SABA) MDI that does not require prior-authorization. Patients who are currently receiving treatment with a non-preferred short-acting beta-adrenergic MDI will be grandfathered and will not be required to submit for prior-authorization.

For prior-authorization of a non-preferred short-acting beta-adrenergic MDI, the patient must:

- Be started and stabilized on the requested medication.
  OR
- Have a documented side effect, allergy, or treatment failure to Xopenex®.

Metered Dose Inhalers (Long-Acting)
Effective 11/1/06, prior-authorization will be required for long-acting beta-adrenergic (LABA) MDIs for patients who have not been on a controller medication in the past 6 months or who do not have a diagnosis of COPD.

For prior-authorization of a long-acting beta-adrenergic MDI, the patient must have:

- A diagnosis of COPD
  OR
- A diagnosis of asthma and prescribed a controller medication.

albuterol sulfate solution 0.63 mg/ml and 1.25mg/ml

- The patient must have had a documented side effect, allergy, or treatment failure to Accuneb®.

Xopenex® nebulizer solution (age >12 years)

- The patient must have been started and stabilized on the requested medication.
  OR
- The patient must have had a documented side effect, allergy, or treatment failure to Accuneb® , generic albuterol nebulizer solution 0.83 mg/ml. or metaproterenol neb solution.

Brovana® or Perforomist® Nebulizer Solution

- The patient must have a diagnosis of COPD**.**
  AND
- The patient must be unable to use a non-nebulized long-acting bronchodilator or anticholinergic (Foradil®, Serevent® or Spiriva®) due to a physical limitation

Brethine® tablets

- The patient must have had a documented side effect, allergy, or treatment failure to generic terbutaline tablets.

Vospire ER® tablets

- The patient must have had a documented side effect, allergy, or treatment failure to generic albuterol ER tablets.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Beta-Adrenergic Agents

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
METERED-DOSE INHALERS (SHORT-ACTING)	
XOPENEX® HFA (levalbuterol)	♣albuterol MDI † Alupent® (metaproterenol) Maxair® Autohaler (pirbuterol) ♣Proair® HFA (albuterol) ♣Proventil® HFA (albuterol) ♣Ventolin® HFA (albuterol) ♣*coverage grandfathered for current users*
METERED-DOSE INHALERS (LONG-ACTING)	
SEREVENT® DISKUS (salmeterol) (*after criteria for LABA are met)* FORADIL® (formoterol) (*after criteria for LABA are met)*	
NEBULIZER SOLUTIONS (SHORT-ACTING)	
ACCUNEB® (albuterol sulfate solution 0.63 mg/ml and 1.25mg/ml) ALBUTEROL 0.83 mg/ml neb solution † METAPROTERENOL neb solution † XOPENEX® neb solution (levalbuterol) (age ≤ 12 years)	albuterol sulfate solution † 0.63 mg/ml and 1.25mg/ml (compare to Accuneb®) Xopenex® neb solution (levalbuterol) (age >12 years)
NEBULIZER SOLUTIONS (LONG-ACTING)	
	Brovana® (arformoterol) *QL = 2 vial/day* Perforomist® (formoterol) *QL = 2 vial/day*
TABLETS/SYRUP (SHORT-ACTING)	
TERBUTALINE tablets † (compare to Brethine®) ALBUTEROL tablets/syrup † METAPROTERENOL tablets/syrup †	Brethine®* (terbutaline)
TABLETS (LONG-ACTING)	
ALBUTEROL ER tablets †	Vospire ER®* (albuterol)

Pulmonary: Inhaled Glucocorticoids

LENGTH OF AUTHORIZATION: 5 years

CRITERIA FOR APPROVAL:

Metered-dose inhalers (single agent):

- The patient has been started and stablized on the medication.

OR

- The patient has had a documented side effect, allergy, or treatment failure to at least two preferred agents.

Pulmicort Respules® (age > 12 yrs):

- The patient has been started and stablized on the medication.

OR

- The patient requires a nebulizer formulation.

DOCUMENTATION:

✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Inhaled Gluococorticoids/Combinations

Length of Authorization: 5 years

Key: § Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS (No PA Required)	PA REQUIRED
METERED-DOSE INHALERS (SINGLE AGENT)	
ASMANEX® 220 mcg/inh (mometasone furoate) *(QL =0.72 gm (3 inhalers)/90 days))* ASMANEX® 110 mcg/inh (mometasone furoate) *(QL =0.405 gm (3 inhalers)/90 days))* AZMACORT® (triamcinolone acetonide) FLOVENT DISKUS® (fluticasone propionate) FLOVENT HFA® (fluticasone propionate) *(QL = 36 gm (3 inhalers)/90 days)* PULMICORT FLEXHALER® (budesonide)	Aerobid® (flunisolide) § Aerobid M® (flunisolide/menthol) § QVAR® (beclomethasone)
METERED-DOSE INHALERS (COMBINATION PRODUCT)	
ADVAIR® DISKUS (fluticasone/salmeterol) ADVAIR® HFA (fluticasone/salmeterol) SYMBICORT® (budesonide/formoterol) *(QL = 30.6 gm (3 inhalers)/90 days)*	
NEBULIZER SOLUTIONS	
PULMICORT RESPULES® (budesonide) (age ≤ 12 yrs)	Pulmicort Respules® (age > 12 yrs)

Pulmonary: Nasal Glucocorticoids

LENGTH OF AUTHORIZATION: 5 years

CRITERIA FOR APPROVAL:

Beconase AQ®, Flonase®, Flunisolide 29 mcg/spray, Nasarel®, Rhinocort Aqua®, Veramyst®:

- The patient has had a documented side effect, allergy, or treatment failure to at least two preferred nasal glucocorticoids. If a product has an AB rated generic, one trial must be the generic formulation.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Nasal Glucocorticoids

Length of Authorization: 5 years

Key: † Generic product

PREFERRED DRUGS (No PA Required)	PA REQUIRED
FLUTICASONE Propionate† (compare to Flonase®) FLUNISOLIDE † 25mcg/spray (previously Nasalide®) NASACORT AQ® (triamcinolone) NASONEX® (mometasone)	Beconase AQ® Flonase®* (fluticasone propionate) flunisolide† 29mcg/spray (compare to Nasarel®) Nasarel® Rhinocort Aqua® Veramyst® (fluticasone furoate)

Pulmonary: Systemic Oral Glucocorticoids

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL (NON-PREFERRED):

- The patient has been started and stabilized on the requested medication.

OR

- The patient has a documented side effect, allergy, or treatment failure to at least two preferred medications. If a product has an AB rated generic, one trial must be the generic formulation.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Systemic Glucocorticoids

Length of authorizations: 1 year

Key : † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
CORTISONE ACETATE†	Celestone®
DEXAMETHASONE†	Cortef®*
HYDROCORTISONE† (compare to Cortef®)	Medrol®*
METHYLPREDNISOLONE† (compare to Medrol®)	Millipred® (prednisolone) oral solution
ORAPRED® oral solution/ODT (prednisolone sod phosphate) (age < 12 yrs)	Orapred® oral solution* (age ≥ 12 yrs)
PREDNISOLONE† tablets/liquid (compare to Pediapred®, Prelone®)	Orapred® ODT (age ≥ 12 yrs)
PREDNISONE†	Pediapred®*
	Prelone®*

Pulmonary: Leukotriene Modifiers

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

- The patient has had a documented side effect, allergy, or treatment failure to Accolate and Singulair.

DOCUMENTATION:

✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Leukotriene Modifiers

Length of Authorization: 1 year

Key: § Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

PREFERRED DRUGS (No PA Required)	PA REQUIRED
ACCOLATE® (zafirlukast) SINGULAIR® (montelukast sodium)	Zyflo® (zileuton) § Zyflo CR® (zileuton SR) §

Pulmonary: Synagis®

LENGTH OF AUTHORIZATION: Only one dose (based on recipient weight) will be approved per thirty-day period. Dose is given once monthly between November 1st and April 30th (up to 6 doses).

INDICATION:

Palivizumab is indicated for the prevention of RSV lower respiratory tract disease in selected infants and children with chronic lung disease of prematurity (CLD [formerly called bronchopulmonary dysplasia]) or with a history of preterm birth (< 35 weeks' gestation) or with congenital heart disease.

CRITERIA FOR APPROVAL:

- Infants born at 28 weeks of gestation or earlier (i.e., ≤ 28 weeks, 6 days) and under twelve months of age at the start of the RSV season.

- Infants born at 29-32 weeks (i.e., between 29 weeks, 0 days and 32 weeks, 0 days) of gestation and under 6 months of age at the start of the RSV season.

- Infants born at 32-35 weeks (i.e., between 32 weeks, 1 day and 35 weeks, 0 days) of gestation and under 6 months of age at the start of RSV season (November 1) who has two of the following risk factors:
  - Child Care Attendance
  - School-aged Siblings
  - Congenital abnormalities of the airways
  - Severe neuromuscular disease
  - Exposure to environmental air pollutants (e.g. exposure to wood burning heaters which are the primary source of heat for the family or passive household exposure to tobacco smoke)

- Children under 24 months of age with chronic lung disease of prematurity (bronchopulmonary dysplasia) who have received medical therapy (supplemental oxygen, bronchodilator, diuretic or corticosteroid therapy) within 6 months prior to the start of RSV season.

- Children under 24 months of age with hemodynamically significant cyanotic and acyanotic congenital heart disease:
  - Receiving medication to control congestive heart failure
  - With moderate to severe pulmonary hypertension
  - With cyanotic heart disease

EXCLUDED FROM APPROVAL:

- Infants and children with hemodynamically insignificant heart disease.
- Infants with lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure.
- Infants with mild cardiomyopathy who are not receiving medical therapy.
- Established RSV disease.

This drug must be billed through the OVHA POS prescription processing system using NDC values.
J codes will NOT be accepted.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the use of Synagis on the **Synagis® Prior Authorization Request Form**.

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ SYNAGIS® (PALIVIZUMAB) ~

Prior Authorization Request Form

Effective February 10, 2004, Vermont Medicaid established coverage limits and criteria for prior authorization of Synagis®. These limits and criteria are based on concerns about safety and appropriate use. In order for beneficiaries to receive coverage for this drug, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address:_____

Contact Person at Office:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis:_____

Pharmacy (if known)**:**_____ Phone:_____ &/or FAX:_____

Gestational age: _____weeks_____days **Current Weight:** _____kg **Dose:** 15mg/kg=_____mg

(**Note:** Dose is given once monthly between November 1st and April 30th (up to 6 doses) Billed as vials, **no J codes**.)

Clinical Criteria: Please check which condition(s) apply
□ Infants born at 28 weeks of gestation or earlier (i.e., ≤ 28 weeks, 6 days) and under twelve months of age at the start of the RSV season.
□ Infants born at 29-32 weeks (i.e., between 29 weeks, 0 days and 32 weeks, 0 days) of gestation and under 6 months of age at the start of the RSV season.
□ Infants born at 32-35 weeks (i.e., between 32 weeks, 1 day and 35 weeks, 0 days) of gestation and under 6 months of age at the start of RSV season (November 1) who have **two** of the following risk factors: □ Child Care Attendance □ Congenital abnormalities of the airways □ School-aged Siblings □ Severe neuromuscular disease □ Exposure to environmental air pollutants (e.g. exposure to wood burning heaters which are the primary source of heat for the family or passive household exposure to tobacco smoke)
□ Children under 24 months of age with chronic lung disease of prematurity (bronchopulmonary dysplasia) who have received medical therapy (supplemental oxygen, bronchodilator, diuretic or corticosteroid therapy) within 6 months prior to the start of the RSV season. □ Treatment: _____ □ Dates of use:_____
□ Children under 24 months of age with hemodynamically significant cyanotic or acyanotic heart disease. □ Currently receiving medication to control heart failure □ Having moderate to severe pulmonary hypertension □ Having cyanotic heart disease
□ Other: _____

Comments:

Prescriber Signature:_____ **Date of this request:** _____

Renal Disease: Phosphate Binders

LENGTH OF AUTHORIZATION: not applicable

CRITERIA FOR APPROVAL: not applicable

Phosphate Binders

Length of Authorization: not applicable

PREFERRED DRUGS (No PA Required)	PA REQUIRED
FOSRENOL® (lanthanum carbonate) PHOS LO® (calcium acetate) RENAGEL® (sevelamer)	

Rheumatoid, Juvenile & Psoriatic Arthritis Medications: Injectables

LENGTH OF AUTHORIZATION: Initial PA of 3 months, and 12 months thereafter if medication is well tolerated. Re-evaluate every 12 months.

CRITERIA FOR APPROVAL:

Humira®

Patient has a diagnosis of rheumatoid arthritis (RA), juvenile idiopathic arthritis or psoriatic arthritis and has already been stabilized on Humira®

OR

Diagnosis is RA, juvenile idiopathic arthritis or psoriatic arthritis, and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried prior to approving Humira®.

Note: Approval should be granted in cases where patients have been treated with infliximab, but have lost response to therapy.

Enbrel®

Patient has a diagnosis of RA, juvenile RA (JRA), or psoriatic arthritis and has already been stabilized on Enbrel®

OR

Diagnosis is RA, JRA, or psoriatic arthritis, and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried prior to approving Enbrel®.

Remicade®

Patient has a diagnosis of RA or psoriatic arthritis and has already been stabilized on Remicade®

OR

Diagnosis is RA or psoriatic arthritis, and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried prior to approving Remicade®.

AND

The prescriber must provide a clinically valid reason why either Humira® or Enbrel® cannot be used.

Kineret®

Patient has a diagnosis of RA and has already been stabilized on Kineret®

OR

Diagnosis is RA or psoriatic arthritis, and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried prior to approving Kineret®.

Note: Kineret® may be used as monotherapy or concomitantly with DMARDs, other than TNF antagonists. Kineret® should not be administered concomitantly with any TNF antagonists (i.e. Enbrel®, Humira®, or Remicade®).

AND

The prescriber must provide a clinically valid reason why either Humira® or Enbrel® cannot be used.

Orencia®

Patient has a diagnosis of RA and has already been stabilized on Orencia®

OR

Diagnosis is RA and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried prior to approving Orencia®. **Note:** Orencia® may be used as monotherapy or concomitantly with DMARDs, other than TNF antagonists. Orencia® should not be administered concomitantly with TNF antagonists (i.e. Enbrel®, Humira®, or Remicade®) and is not recommended for use with Kineret®.

AND

The prescriber must provide a clinically valid reason why either Humira® or Enbrel® cannot be used.

DOCUMENTATION:

- ✓ Document clinical information on a **Rheumatoid and Psoriatic Arthritis Injectable Prior Authorization Request Form**.

Rheumatoid, Juvenile and Psoriatic Arthritis: Injectables

Length of authorization: Initial PA of 3 months; 12 months thereafter

PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET
ENBREL® (etanercept) HUMIRA® (adalimumab)	Kineret® (anakinra) Orencia® (abatacept) Remicade® (infliximab)

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ RHEUMATOID, JUVENILE AND PSORIATIC ARTHRITIS INJECTABLE MEDICATIONS ~

Prior Authorization Request Form

Effective February, 2002, Vermont Medicaid established coverage limits and criteria for prior authorization of rheumatoid arthritis medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Rheumatoid, Juvenile & Psoriatic Arthritis Injectable medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address: _____

Contact Person at Office: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis:_____

Will this medication be billed through the: □ pharmacy benefit or □ medical benefit (J-code or other code) ?

Pharmacy (if known)**:**_____ Phone:_____ &/or FAX:_____

Please select one of the following 'preferred' drug therapies from the VT Medicaid Preferred Drug List:

☐ **Enbrel**_____Strength & Frequency:_____Length of therapy:_____

☐ **Humira**_____Strength & Frequency:_____Length of therapy:_____

For any other injectable Rheumatoid or Psoriatic Arthritis treatment, please explain medical necessity for non-preferred product:

Drug:_____ Strength & Frequency:_____ Length of therapy:_____

Medical justification: _____

List previous medications tried and failed for this condition:

Name of medication	Reason for failure	Date(s) attempted

Prescriber comments:

Prescriber signature: _____**Date of this request:**_____

Saliva Stimulants

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

SALAGEN®

- The patient has had a documented side effect, allergy, or treatment failure to generic pilocarpine.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Saliva Stimulants *Length of Authorization: 1 year* **Key: † Generic product, *Indicates generic equivalent is available without a PA**	
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
PILOCARPINE† (compare to Salagen®) EVOXAC® (cevimeline)	Salagen®* (pilocarpine)

Sedative Hypnotics: Benzodiazepine

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

The patient has had a documented side effect, allergy, or treatment failure with two medications not requiring prior-authorization. If a product has an AB rated generic, one trial must be the generic.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

MANAGEMENT OF MENTAL HEALTH DRUGS: See page 118 for a description of the management of mental health drugs.

Sedative Hypnotics: Benzodiazepine

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
ESTAZOLAM† (compare to Prosom®) FLURAZEPAM† (compare to Dalmane®) TEMAZEPAM† (compare to Restoril®)	Dalmane®* (flurazepam) Doral® (quazepam) Halcion® (triazolam) Prosom®* (estazolam) Restoril®* (temazepam) triazolam † (compare to Halcion®)

Sedative Hypnotics: Non-benzodiazepine

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Ambien®, Ambien CR®, Sonata®, Zaleplon: The patient has had a documented side effect, allergy or treatment failure to zolpidem and Lunesta®.

Rozerem®: The patient has had a documented side effect, allergy, or treatment failure to zolpidem and Lunesta®.

OR

There is a question of substance abuse with the patient or family of the patient.

Note: If approved, initial fill of Rozerem® will be limited to a 14 day supply.

Somnote®: The patient has had a documented side effect, allergy, or treatment failure with two medications not requiring prior-authorization from the sedative hypnotic:benzodiazepine and/or sedative hypnotic:non-benzodiazepine classes.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

MANAGEMENT OF MENTAL HEALTH DRUGS: See page 118 for a description of the management of mental health drugs.

Sedative Hypnotics: Non-benzodiazepine *Length of Authorization: 1 year*

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
CHLORAL HYDRATE † syrup, suppository LUNESTA® (eszopiclone) *(Quantity Limit = 1 tab/day)* ZOLPIDEM † (compare to Ambien®) *(Quantity Limit = 1 tab/day)*	Ambien®* (zolpidem) *(Quantity Limit = 1 tab/day)* Ambien CR® (zolpidem) *(Quantity Limit = 1 tab/day)* Rozerem® (ramelteon) *(Quantity Limit = 1 tab/day)* Somnote® (chloral hydrate capsule) Sonata® (zaleplon) Zaleplon †

Skeletal Muscle Relaxants

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

MUSCULOSKELETAL AGENTS:
Brand Name skeletal muscle relaxants with no generic available (Skelaxin):

- The patient has had a documented side effect, allergy or treatment failure with two different musculoskeletal agents from this class that do not require prior-authorization.

Amrix

- The prescriber must provide a clinically valid reason why generic cyclobenzaprine cannot be used.

Brand skeletal muscle relaxants with generics available (Parafon Forte DSC, Flexeril, Robaxin, Robaxisol, Norflex, Norgesic Forte):

- The patient has had a documented side effect, allergy or treatment failure with two different musculoskeletal agents from this class that do not require prior-authorization. (One trial must be the AB rated generic).

carisoprodol, carisoprodol/ASA, carisoprodol/ASA//codeine, Soma, Soma Compound, Soma Compound w/codeine:

- The patient has had a documented side effect, allergy or treatment failure with two different musculoskeletal agents from this class that do not require prior-authorization.

ANTISPASTICITY AGENTS:
Lioresal, Dantrium, Zanaflex:

- The patient must have a documented side effect, allergy, or treatment failure with the AB rated generic product.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Skeletal Muscle Relaxants

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
Musculoskeletal Agents	
CHLORZOXAZONE† (compare to Parafon Forte DSC®) CYCLOBENZAPRINE† (compare to Flexeril®) METHOCARBAMOL† (compare to Robaxin®) METHOCARBAMOL, ASA† (compare to Robaxisal®) ORPHENADRINE CITRATE† (compare to Norflex®) ORPHENADRINE, ASA, CAFFEINE† (compare to Norgesic®, Norgesic Forte®) *ASA = aspirin*	Amrix®(cyclobenzaprine extended-release) carisoprodol† (compare to Soma®) carisoprodol, ASA† (compare to Soma Compound®) carisoprodol, ASA, codeine† (compare to Soma Compound with Codeine®) Fexmid® (cyclobenzaprine) Flexeril®* Norgesic®* Norgesic Forte®* Parafon Forte DSC®* Robaxin®* Robaxisal®* Skelaxin® Soma® Soma Compound® Soma Compound with Codeine®
Antispasticity Agents	
BACLOFEN† (compare to Lioresal®) DANTROLENE† (compare to Dantrium®) TIZANIDINE† (compare to Zanaflex®)	Dantrium®* Lioresal®* Zanaflex®*

Effective 11/1/06: All carisoprodol products (brand and generic) move to "PA REQUIRED"

Smoking Cessation Therapies

LENGTH OF AUTHORIZATION: up to 16 weeks (2 x 8 weeks) for nicotine replacement OR up to 24 weeks (2 x 12 weeks) for oral therapy (per rolling 365 days)

CRITERIA FOR APPROVAL:

nicotine patch OTC/Rx, Nicotine System Kit

- The patient has had a documented side effect or allergy to Nicoderm CQ patch.

nicotine gum

- The patient has had a documented side effect or allergy to Nicorette gum.

Nicotrol Nasal Spray

- The prescriber must provide a clinically valid reason for the use of the requested medication.

Zyban

- The patient has had a documented side effect or allergy to bupropion SR.

Smoking Cessation Counseling is encouraged with the use of smoking cessation therapies

Vermont QUIT LINE (available free to all patients) 1-877-YES-QUIT (937-7848)

GETQUIT™ Support Plan available free to all Chantix® patients 1-877-CHANTIX (242-6849)

DOCUMENTATION:

- Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Smoking Cessation Therapies

Length of Authorization: see table

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
NICOTINE REPLACEMENT (Maximum duration is 16 weeks (2 x 8 weeks)/365 days)♠	
NICODERM CQ PATCH® NICORETTE GUM® COMMIT LOZENGE® NICOTINE LOZENGE† NICOTROL INHALER®	nicotine patch OTC† nicotine patch RX† (compare to Habitrol®) Nicotine System Kit® nicotine gum† Nicotrol Nasal Spray®
ORAL THERAPY	
BUPROPION SR† CHANTIX® (varenicline) (Limited to 18 years and older, quantity Limit = 2 tabs/day, maximum duration 24 weeks (2 x 12 weeks)/365 days)♠	Zyban®* (bupropion SR) (maximum duration 24 weeks (2 x 12 weeks)/365 days)♠

♠ For approval of therapy beyond the established maximum duration, the prescriber must provide evidence that the patient is engaged in a smoking cessation counseling program.

Urinary Antispasmodics

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL: (for patients >21 and <65 years of age):

Please note: Patients <21 years of age are exempt from all Urinary Antispasmodics PA requirements (Exception: An adequate trial of oxybutynin/oxybutynin XL will be required before approval of Ditropan/Ditropan XL will be granted for all patients) and patients ≥ 65 years of age are exempt from the short acting oxybutynin trial requirement.

Ditropan, flavoxate, Urispas, oxybutynin XL, Enablex, Sanctura, Sanctura XR, Vesicare

- The patient has had a documented side effect, allergy, or treatment failure with oxybutynin.

Detrol, Detrol LA, Ditropan XL

- The patient has had a documented side effect, allergy, or treatment failure with oxybutynin.

  AND
- The patient has had a documented side effect, allergy, or treatment failure with 2 preferred long-acting agents. If a medication has an AB rated generic, one trial must be the generic formulation.

Oxytrol

- The patient has a medical necessity for a transdermal formulation (ex. dysphagia, inability to take oral medications).

DOCUMENTATION:

- ✓ Document clinically information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Urinary Antispasmodics

Length of Authorization: 1 year

Key : † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
SHORT-ACTING AGENTS	
OXYBUTYNIN† (compare to Ditropan®)	Ditropan®* (oxybutynin) Flavoxate † (compare to Urispas®) Urispas® (flavoxate)
LONG-ACTING AGENTS (after clinical criteria are met)	
Twice Daily ***(Qty Limit = 2 per day)*** SANCTURA® (trospium)	Detrol® (tolterodine)
Once Daily ***(Qty Limit = 1 per day)*** ENABLEX® (darifenacin) OXYBUTYNIN XL† (compare to Ditropan® XL) SANCTURA XR® (trospium) VESICARE® (solifenacin)	Detrol LA® (tolterodine) Ditropan XL® (oxybutynin XL)
Transdermal	Oxytrol® (oxybutynin transdermal) *(Qty limit = 8 patches/28 days)*
Note: ♦*Patients under the age of 65 must fail an adequate trial of generic oxybutynin before approval will be granted for either oxybutynin XL, Vesicare®, Sanctura® , Sanctura XR® or Enablex®.* ♦ *A therapeutic failure on at least two preferred long acting products is required before a PA will be approved on any non-preferred long acting medication.* ♦*Recipients < 21 years of age are exempt from all PA Requirements.(Exception: An adequate trial of oxybutynin/oxybutynin XL will be required before approval of Ditropan®/ Ditropan® XL will be granted)*	

Vaginal Anti-Infectives

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Cleocin®, Clindesse®:

- The patient has had a documented side effect, allergy, or treatment failure to generic clindamycin vaginal (clindamycin vaginal or Clindamax).

Metrogel Vaginal®:

- The patient has had a documented side effect, allergy, or treatment failure to generic metronidazole vaginal gel 0.75 % or Vandazole.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Vaginal Anti-Infectives

Length of Authorization: 1 year

Key: † Generic product, *Indicates generic equivalent is available without a PA

PREFERRED DRUGS (No PA Required)	PA REQUIRED
CLINDAMYCIN	
CLINDAMYCIN VAGINAL† (clindamycin vaginal cream 2%) CLINDAMAX† (clindamycin vaginal cream 2%)	Cleocin®* (clindamycin vaginal cream 2%) Clindesse® (clindamycin vaginal cream 2%) Cleocin® Vaginal Ovules (clindamycin vaginal suppositories)
METRONIDAZOLE	
METRONIDAZOLE VAGINAL GEL 0.75%† VANDAZOLE† (metronidazole vaginal 0.75%)	Metrogel Vaginal®* (metronidazole vaginal gel 0.75%)

Vitamins: Prenatal Multivitamins

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

All Brands

- The prescriber must provide a clinically valid reason for the use of the requested medication including reasons why any of the generically available preparations would not be a suitable alternative.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.

Prenatal Multivitamins	*Length of Authorization: 1 year*
PREFERRED DRUGS (No PA Required)	**PA REQUIRED**
All generics	All brands

II. PRIOR AUTHORIZATION REQUEST FORMS

► **Ankylosing Spondylitis Injectable** Prior Authorization Request Form

► **Anti-Obesity** Prior Authorization Request Form

► **Bisphosphonate Injectable** Prior Authorization Request Form

► **Buprenorphine** Prior Authorization Request Form

► **Crohn's Disease Injectable** Prior Authorization Request Form

► **General** Prior Authorization Request Form

► **Growth Stimulating Agents** Prior Authorization Request Form

► **Hepatitis C** Prior Authorization Request Form

► **Long Acting Narcotics** Prior Authorization Request Form

► **Methadone 40mg dispersible tablets** Prior Authorization Request Form

► **Nutritionals** Prior Authorization Request Form

► **Psoriasis Injectable Medications** Prior Authorization Request Form

► **Rheumatoid, Juvenile & Psoriatic Arthritis Injectable** Prior Authorization Request Form

► **Synagis®** Prior Authorization Request Form

► **Ulcerative Colitis Injectable Prior** Authorization Request Form

► **Vivitrol®** Prior Authorization Request Form

► **Xolair®** Prior Authorization Request Form

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ ANKYLOSING SPONDYLITIS INJECTABLE MEDICATIONS ~

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of Ankylosing Spondylitis Injectable medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Ankylosing Spondylitis Injectable medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address: _____

Contact Person at Office: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis: _____

Will this medication be billed through the: □ pharmacy benefit or □ medical benefit (J-code or other code) ?

Pharmacy (if known)**:**_____ Phone:_____ &/or FAX:_____

Please select one of the following 'preferred' drug therapies from the VT Medicaid Preferred Drug List:

☐ **Enbrel**_____Strength & Frequency:_____Length of therapy:_____

☐ **Humira**_____Strength & Frequency:_____Length of therapy:_____

For any other injectable Ankylosing Spondylitis treatment, please explain medical necessity for non-preferred product:

Drug:_____ Strength & Frequency:_____ Length of therapy:_____

Medical justification: _____

_____

List previous medications tried and failed for this condition:

Name of medication	Reason for failure	Date(s) attempted

Prescriber comments:

Prescriber Signature:_____ **Date of this request:**_____

VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ ANTI-OBESITY MEDICATIONS~

Prior Authorization Request Form

Effective November 01, 2001, Vermont Medicaid established coverage limits and criteria for prior authorization of non-amphetamine based diet medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Anti-Obesity drug prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____ Fax#:_____

Address: _____

_____

Contact Person at Office: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Drug Requested:_____ **Strength & Frequency:**_____ **Length of therapy:**_____

1. Current Body Mass Index (BMI):_____**Height:**_____**Weight:** _____ **Waist Circumference:**_____

2. Does the patient have any of the following conditions? (Please check all that apply.)

☐ **Hypertension** ☐ **Obstructive Sleep Apnea** ☐ **Diabetes** ☐ **Dyslipidemia** ☐ **Coronary Heart Disease**

3. Has the member been participating in a weight loss treatment plan (nutritional counseling, an exercise regimen, and a calorie and fat restricted diet) for the past 6 months? □ **YES** □ **NO**
If YES, Please provide a description of the program, dates, and results: _____

_____

_____

4. Will this medication be used in addition to a weight loss treatment plan (nutritional counseling, an exercise regimen and a calorie and fat restricted diet)? □ **YES** □ **NO**
Please explain: _____

_____

6. Does the patient have any contraindications for use of this medication? (Please see table below.)

□ **YES** □ **NO** **If YES, please explain:** _____

Alli, Xenical:	**Malabsorption syndrome, cholestasis, pregnant or lactating, hyperoxaluria, calcium oxalate nephrolithiasis**
Meridia:	**Concomitant MAOI use, concomitant use of centrally acting appetite suppressants, poorly or uncontrolled HTN, pregnant or lactating, severe renal or hepatic dysfunction, hx of CAD, CHF, arrhythmias, stroke, bulimia or anorexia nervosa**
Diethylpropion, Benzphetamine, Phendimetrazine, Phentermine:	**Advanced arteriosclerosis, agitated states, concomitant use of MAOI, concomitant use of other CNS stimulants, glaucoma, hx of drug abuse, hypersensitivity or idiosyncratic reaction to sympathomimetic amines, moderate to severe HTN, hyperthyroidism, pregnant, symptomatic cardiovascular disease**

Prescriber Signature:_____ Date of this request:_____

VERMONT

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Williston, Vermont 05495

Agency of Human Services

~ BISPHOSPHONATE INJECTABLE – BONIVA AND RECLAST ~

Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of Boniva IV and Reclast. For beneficiaries to receive coverage for these agents, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis:_____

Contact Person at Office: _____

Will this medication be billed through the: ☐ **pharmacy benefit** or ☐ **medical benefit** (J-code or other code)? **(Please check one)**

Pharmacy (if known):_____ Phone:_____ &/or FAX:_____

Drug requested: ☐ Boniva IV ☐ Reclast **Dose & frequency:** _____

Diagnosis/indication:

☐ Treatment of postmenopausal osteoporosis

☐ Paget's Disease

☐ Other (Please Explain) _____

Has the member previously tried the following preferred medications? (Please check all that apply)

Drug:	***Response:***
☐ Boniva Oral	☐ side-effect ☐ treatment failure* dates of use: _____
☐ Fosamax Oral	☐ side-effect ☐ treatment failure* dates of use: _____

*Treatment failure is defined as documented continued bone loss after two or more years despite treatment with the bisphosphonate.

Prescriber comments:

_____

_____

_____

_____

Prescriber Signature:_____ **Date of this request:** _____

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Agency of Human Services

~BUPRENORPHINE ~

Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of buprenorphine (Suboxone®, Subutex®). These criteria are based on concerns about safety and the potential for abuse and diversion. For beneficiaries to receive coverage for Suboxone® or Subutex®, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis:_____

Contact Person at Office: _____

Pharmacy (if known)**:**_____ Phone:_____ &/or FAX:_____

QUALIFICATIONS

MD/DO	Prescribers must have a DATA 2000 waiver ID ('X' DEA license) in order to prescribe.
Patients	Patients must have a diagnosis of opiate dependence confirmed.

PROCESS

► Answer the following questions:

Is buprenorphine being prescribed for opiate dependency?	□ Yes □ No
Does the prescriber signing this form have a DATA 2000 waiver ID number ("X-DEA license")?	□ Yes □ No
Request is for the following medication:	□ Suboxone® (buprenorphine/naloxone) □ Subutex® (buprenorphine)
Anticipated maintenance dose/frequency: Dose:_____ Frequency:_____	
If this request is for Subutex®, please answer the following questions: Is the member pregnant? If yes, anticipated date of delivery: _____	□ Yes □ No
Does the member have a documented allergic reaction to naloxone? If yes, please provide medical records documenting the allergic reaction.	□ Yes □ No
Additional clinical information to support PA request:	

Prescriber Signature: _____ **Date of request:** _____

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~ CROHN'S DISEASE INJECTABLE MEDICATIONS ~

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of injectable Crohn's disease medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Injectable Crohn's disease medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Specialty: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis: _____

Contact Person at Office: _____

Will this medication be billed via the: □ pharmacy benefit or □ medical benefit (J-code or other code)?

Pharmacy (if known)**:**_____ Phone:_____ &/or FAX:_____

Please select the following 'preferred' drug therapy from the VT Medicaid Preferred Drug List:

☐ **Humira**_____ Strength & Frequency:_____ Length of therapy:_____

☐ **Remicade**_____ Strength & Frequency:_____ Length of therapy:_____

For any other injectable Crohn's disease treatment, please explain medical necessity for non-preferred product:

Drug:_____ Strength & Frequency:_____ Length of therapy:_____

Medical justification: _____

_____

List previous therapies tried and failed for this condition:

Therapy	Reason for discontinuation	Dates Utilized

Prescriber comments:

Prescriber Signature:_____ **Date of this request:**_____

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Agency of Human Services

~ GENERAL ~

Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address:_____

Contact Person at Office:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ **Sex:**_____

Will this medication be billed through the: □ pharmacy benefit or □ medical benefit (J-code or other code) ?

Pharmacy **(if known):**_____ **Phone:**_____ **&/or FAX:**_____

1. **Drug Requested:**_____ **Strength, Route & Frequency:**_____ **Length of therapy:**_____
   □ **Brand Name** □ **Generic Equivalent**

2. **Patient's diagnosis for use of this medication:**_____

3. **Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this medication:** _____
   Was patient seen by any other provider for this condition? YES / NO What specialty? _____

4. **Please list preferred medications previously tried and failed for this condition:**

Name of medication	Reason for failure	Date

5. **Please list pertinent laboratory test(s) or procedure(s) if applicable:**

Procedure	Findings	Date

6. **Other Information/ comments:**

Prescriber Signature:_____ **Date of this request:**_____

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~ GROWTH STIMULATING AGENTS ~

Prior Authorization Request Form

Effective February, 2002, Vermont Medicaid established coverage limits and criteria for prior authorization of Growth Stimulating Agents medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Growth Stimulating Agents medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing Physician:

Name:_____

Phone #:_____

Fax #:_____

Specialty: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Patient Diagnosis: _____

Contact Person at Office: _____

Address: _____

Please select one of the following 'preferred' drug therapies from the VT Medicaid Preferred Drug List:

- ☐ **Norditropin** Dose & Frequency:_____
- ☐ **Nutropin/Nutropin AQ** Dose & Frequency: _____
- ☐ **Omnitrope** Dose & Frequency:_____

For any other growth hormone product, please explain medical necessity for 'non-preferred' product:

Drug: _____

Medical justification: _____

_____

Growth Hormone Stimulation Test # 1	**Test:**	**result:**
Growth Hormone Stimulation Test # 2	**Test:**	**result:**
Patient's Height:		
Patient's Bone Age:		
Patient's Chronological Age:		
Growth Velocity:		
IGF-1 results:		

Other information/ Prescriber comments:

Prescriber Signature:_____ **Date of this request:**_____

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~ HEPATITIS C MEDICATIONS ~

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of Hepatitis C medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Hepatitis C medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #: _____

Address: _____

Specialty:_____

Contact Person at Office:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis:_____

Genotype:_____

If requesting prescriber is not a Hepatologist, Gastroenterologist or ID Specialist, has one of these specialties been consulted on this case? □ **Yes** □ **No**

Specialist name: _____ Specialist Type:_____

Preferred Drug(s) Requested:

□ Pegasys

□ Pegasys convenience Pack

□ Ribavirin

For any other Non-Preferred Drug(s) Requested:

□ Other_____

If other, please explain medical necessity for non-preferred agent:

_____

_____

_____

_____

Strength, Route & Frequency:_____

Length of therapy:_____

Prescriber comments:

Prescriber Signature:_____ **Date of this request:**_____

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~ LONG ACTING NARCOTICS~

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of long acting narcotics. These limits and criteria are based on concerns about safety and the potential for abuse and diversion. In order for beneficiaries to receive coverage for this drug, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Contact Person at Office:_____

Drug Requested:

Please indicate: Brand Name □ or Generic Equivalent □

Dose /Frequency and Length of Therapy:

Diagnosis or Indication for Use::

Has the member previously tried any of the following preferred medications?

Check all that apply:	***Response, check all that apply:***
□ Fentanyl Patches	□ side-effect □ non-response □ allergy
□ Methadone	□ side-effect □ non-response □ allergy
□ Morphine ER	□ side-effect □ non-response □ allergy

Is this an initial request or a subsequent request? □ Initial □ Subsequent

Prescriber comments:

Prescriber Signature:_____ **Date of this request:**_____

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~ METHADONE 40 MG DISPERSIBLE TABLETS ~

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of methadone 40mg dispersible tablets. These limits and criteria are based on concerns about safety and the potential for abuse and diversion. In order for beneficiaries to receive coverage for this drug, it will be necessary for the prescriber to complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Contact Person at Office:_____

Dose/Frequency and Length of Therapy: _____

Diagnosis or Indication for Use: _____

Due to reports of death and life-threatening adverse events such as respiratory depression and cardiac arrhythmias in patients receiving methadone, the FDA has issued an alert for healthcare providers. The FDA made the following recommendations (for more details, go to www.fda.gov/cder/drug/InfoSheets/HCP/methadoneHCP.pdf):

- Avoid prescribing methadone 40 mg dispersible tablets for pain; it is only FDA-approved for detoxification and maintenance treatment of narcotic addiction. (Please note: methadone 5mg and 10mg tablets do not require prior-authorization.)
- Patients should be titrated to analgesic effect slowly even in patients who are opioid-tolerant, since methadone's elimination half-life (8-59 hours) is longer than its duration of analgesic action (4-8 hours) and cross-tolerance between methadone and other opioids is incomplete.
- This dosing scheme was derived as a guide to convert chronic pain patients to methadone from morphine. See the methadone label (Dolophine) for more details.

Total Daily Baseline Oral Morphine Dose	Estimated Daily Oral Methadone Requirement Percent of Total Daily Morphine Dose*
< 100 mg	20% to 30%
100 to 300 mg	10% to 20%
300 to 600 mg	8% to 12%
600 to 1000 mg	5% to 10%
> 1000 mg	< 5%

*Methadone dosing should not be based solely on this table. Dosing should always be individualized to account for the patient's general medical condition, concomitant medication, and anticipated breakthrough medication use.

Please select one of the following:

☐ I have read the FDA recommendations and want to continue with the methadone prescription as written.
Prescriber comments:

☐ I will be changing the methadone dose or drug selection to: _____
Prescriber comments:

Prescriber Signature: _____ **Date of this request:** _____

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~NUTRITIONALS ~

ORAL NUTRITION TAKEN BY MOUTH

Prior Authorization Request Form

Effective February 2002, Vermont Medicaid established coverage limits and criteria for prior authorization of Nutritional supplements. These limits and criteria are based on concerns about safety and appropriate use. In order for beneficiaries to receive coverage for nutritionals, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Contact Person at Office:_____

Diagnosis: _____

Baseline:Date:___/___/____ Height: _____ Weight: _____ BMI: _____

Current: Date: ___/___/____ Height: _____ Weight: _____ BMI: _____

Children: Mid-Upper Arm Circumference: _____ Head Circumference: _____

Laboratory Values: Date: ___/___/____ Albumin: _____ Pre-Albumin:_____

Answer the following questions:

Caloric/protein intake is <u>not</u> obtainable through regular liquefied or pureed foods.	☐ Agree ☐ Disagree
Requested nutritional supplement will be taken by <u>mouth</u> (not administered via tube feeding)	☐ Yes ☐ No
Oral nutritional supplement is being requested due to:	☐ Unplanned weight loss (see complete definition by age in clinical criteria manual) ☐ Low serum protein levels (nutritional deficiency as defined by albumin or pre-albumin levels)
Underlying cause of unplanned weight loss or low serum protein levels: **Circle or describe specifics:** ▪ Increased metabolic need resulting from severe trauma (i.e.: burns, infection, major bone fractures)	☐ Yes ☐ No
▪ Malabsorption syndrome (as related to cystic fibrosis, renal disease, short gut syndrome, Crohn's disease and other unspecified disorders of the gut)	☐ Yes ☐ No
▪ Nutritional wasting due to chronic disease (i.e.: cancer, AIDS, conditions resulting in dysphagia, pulmonary insufficiency, renal disease)	☐ Yes ☐ No

▪ Other: Explain: _____ _____	☐ Yes ☐ No
Additional clinical information to support PA request:	

Requested Supplement: _____

Strength & Frequency: _____

Anticipated duration of supplementation: _____

Prescriber Signature: _____**Date of this request**: _____

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~ PSORIASIS INJECTABLE MEDICATIONS ~

Prior Authorization Request Form

Effective June, 2004, Vermont Medicaid established coverage limits and criteria for prior authorization of injectable psoriasis medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Injectable Psoriasis medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address: _____

Specialty: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis: _____

Contact Person at Office: _____

Will this medication be billed via the: □ pharmacy benefit or □ medical benefit (J-code or other code)?

Pharmacy (if known)**:**_____ Phone:_____ &/or FAX:_____

Please select one of the following 'preferred' drug therapies from the VT Medicaid Preferred Drug List:

- ☐ **Enbrel**_____ Strength & Frequency:_____ Length of therapy:_____
- ☐ **Humira**_____ Strength & Frequency:_____ Length of therapy:_____
- ☐ **Raptiva**_____ Strength & Frequency:_____ Length of therapy:_____

For any other injectable psoriasis treatment, please explain medical necessity for non-preferred product:

Drug:_____ Strength & Frequency:_____ Length of therapy:_____

Medical justification:_____

_____

List previous therapies (topical, phototherapy, oral) tried and failed for this condition:

Therapy	Reason for discontinuation	Dates Utilized

Prescriber comments:

Prescriber Signature:_____ **Date of this request:**_____

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~ RHEUMATOID, JUVENILE AND PSORIATIC ARTHRITIS INJECTABLE MEDICATIONS ~

Prior Authorization Request Form

Effective February, 2002, Vermont Medicaid established coverage limits and criteria for prior authorization of rheumatoid arthritis medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Rheumatoid, Juvenile & Psoriatic Arthritis Injectable medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address: _____

Contact Person at Office: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis:_____

Will this medication be billed through the: □ pharmacy benefit or □ medical benefit (J-code or other code) ?

Pharmacy (if known)**:**_____ Phone:_____ &/or FAX:_____

Please select one of the following 'preferred' drug therapies from the VT Medicaid Preferred Drug List:

☐ **Enbrel**_____Strength & Frequency:_____Length of therapy:_____

☐ **Humira**_____Strength & Frequency:_____Length of therapy:_____

For any other injectable Rheumatoid or Psoriatic Arthritis treatment, please explain medical necessity for non-preferred product:

Drug:_____ Strength & Frequency:_____ Length of therapy:_____

Medical justification: _____

List previous medications tried and failed for this condition:

Name of medication	Reason for failure	Date(s) attempted

Prescriber comments:

Prescriber signature: _____**Date of this request:**_____

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~ SYNAGIS® (PALIVIZUMAB) ~

Prior Authorization Request Form

Effective February 10, 2004, Vermont Medicaid established coverage limits and criteria for prior authorization of Synagis®. These limits and criteria are based on concerns about safety and appropriate use. In order for beneficiaries to receive coverage for this drug, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address:_____

Contact Person at Office:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis:_____

Pharmacy (if known)**:**_____ Phone:_____ &/or FAX:_____

Gestational age: _____weeks_____days **Current Weight:** _____kg **Dose:** 15mg/kg=_____mg

(**Note:** Dose is given once monthly between November 1st and April 30th (up to 6 doses) Billed as vials, **no J codes**.)

Clinical Criteria: Please check which condition(s) apply
□ Infants born at 28 weeks of gestation or earlier (i.e., ≤ 28 weeks, 6 days) and under twelve months of age at the start of the RSV season.
□ Infants born at 29-32 weeks (i.e., between 29 weeks, 0 days and 32 weeks, 0 days) of gestation and under 6 months of age at the start of the RSV season.
□ Infants born at 32-35 weeks (i.e., between 32 weeks, 1 day and 35 weeks, 0 days) of gestation and under 6 months of age at the start of RSV season (November 1) who have **two** of the following risk factors: □ Child Care Attendance □ Congenital abnormalities of the airways □ School-aged Siblings □ Severe neuromuscular disease □ Exposure to environmental air pollutants (e.g. exposure to wood burning heaters which are the primary source of heat for the family or passive household exposure to tobacco smoke)
□ Children under 24 months of age with chronic lung disease of prematurity (bronchopulmonary dysplasia) who have received medical therapy (supplemental oxygen, bronchodilator, diuretic or corticosteroid therapy) within 6 months prior to the start of the RSV season. □ Treatment: _____ □ Dates of use:_____
□ Children under 24 months of age with hemodynamically significant cyanotic or acyanotic heart disease. □ Currently receiving medication to control heart failure □ Having moderate to severe pulmonary hypertension □ Having cyanotic heart disease
□ Other: _____

Comments:

Prescriber Signature:_____ Date of this request: _____

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Agency of Human Services

~ ULCERATIVE COLITIS INJECTABLE MEDICATIONS ~

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of Ulcerative Colitis Injectable medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Ulcerative Colitis Injectable medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Contact Person at Office: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis: _____

Will this medication be billed through the: □ pharmacy benefit or □ medical benefit (J-code or other code) ?

Pharmacy (if known)**:**_____ Phone:_____ &/or FAX:_____

☐ **Remicade**_____Strength & Frequency:_____Length of therapy:_____

For any other injectable Ulcerative Colitis treatment, please explain medical necessity for the specific product:

Drug:_____ Strength & Frequency:_____ Length of therapy:_____

Medical justification: _____

_____

List previous medications tried and failed for this condition:

Name of medication	Reason for failure	Date(s) attempted

Prescriber comments:

Prescriber Signature:_____ **Date of this request:**_____

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~VIVITROL~

Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of Vivitrol (naltrexone for IM extended release suspension). These criteria are based on concerns about safety. In order for beneficiaries to receive coverage for Vivitrol, it will be necessary for the prescriber to complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via Fax: 1-866-767-2649

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____Sex:_____

Diagnosis:_____

Contact Person at Office: _____

Administering physician:

Name: _____ Address: _____

Pharmacy (required)**:**_____ Phone:_____ &/or FAX:_____

QUALIFICATIONS

MDs	Prescribers must secure direct delivery of Vivitrol from the pharmacy to the physician's office. Pharmacies may not dispense Vivitrol directly to the patient. Vivitrol **may not** be billed through the Medical Benefit as a J-Code J2315.
Patients	Patients must have a diagnosis of alcohol dependency. Patients must also have had an inadequate response, adverse reaction, or contraindication to 2 out of 3 oral formulations including: oral naltrexone, acamprosate, and disulfiram OR a compelling clinical reason for Vivitrol use. Patients should be opiate free for > 7 -10 days prior to initiation of Vivitrol.

PROCESS

► Please answer the following questions:

Does the patient have a diagnosis of alcohol dependency?	□ Yes □ No
Has the patient tried any of the following? Please document below. oral naltrexone: □ side-effect □ non-response □ allergy acamprosate: □ side-effect □ non-response □ allergy disulfiram: □ side-effect □ non-response □ allergy	□ Yes □ No
Has patient had a recent hospital admission for alcohol detoxification?	□ Yes □ No If yes, date: ____/_____/____
Has the patient been opiate free for > 7 – 10 days	□ Yes □ No
Comments and additional patient history:	

Prescriber Signature: _____ **Date of request:** _____

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Agency of Human Services

~ XOLAIR ~

Prior Authorization Request Form

Effective October 2003, Vermont Medicaid established coverage limits and criteria for prior authorization of Xolair. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Xolair prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing Physician:

Name:_____

Phone #:_____

Fax #:_____

Address: _____ ___

Specialty: _____

Contact Person at Office: _____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Patient Diagnosis: _____

Will this medication be billed through the: □ pharmacy benefit or □ medical benefit (J-code or other code) ?

If requesting prescriber is not a pulmonologist, allergist, or immunologist, has one of these specialties been consulted on this case? □Yes □No

Specialist name: _____ **Specialist Type**: _____

Pharmacy (if known):_____ Phone:_____ &/or FAX:_____

List all previous therapies (inhaled corticosteroid, second generation antihistamine, leukotriene receptor antagonist, long-acting beta-agonist) tried and failed for this condition:

Therapy	Reason for discontinuation	Dates Utilized

Has the member tested positive to at least one perennial aeroallergen by a skin test (i.e. RAST, CAP, intracutaneous test)? Y / N
Please explain: _____

Is the member's IgE level ≥ 30 and ≤ 700 IU/ml? Y / N

Please provide IgE level: _____

Prescriber Signature:_____ **Date of this request:**_____