



**Office of Vermont Health Access
Pharmacy Benefit Management Program**

**VERMONT
PREFERRED DRUG LIST
and
DRUGS REQUIRING PRIOR
AUTHORIZATION**

Clinical Criteria Manual

January 5, 2009

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.

I. THERAPEUTIC CLASS CRITERIA

Acne Medications:

[Oral](#)..... 5
[Topical-Anti-infectives](#)..... 7
[Topical-Retinoids](#)..... 9
[Topical-Rosacea](#)..... 10

Alzheimer’s Medications:

[Cholinesterase Inhib/NMDA Receptor Antagonists](#) . 11

Analgesics:

[Cox-2 Inhibitors and NSAIDs](#)..... 12
[Local Anesthetics: Transdermal Patch](#)..... 14
[Narcotics-Short Acting](#)..... 15
[Narcotics-Long Acting](#)..... 17
[Long Acting Narcotics - P. A. Request Form](#)..... 19
[Methadone 40mg disp. Tab. P.A. Request Form](#)..... 20

Anemia Medications..... 21

Ankylosing Spondylitis-Injectables..... 22

[Ankylosing Spondylitis – P. A. Request Form](#)..... 23

Anti-anxiety: Anxiolytics..... 24

Anticoagulants..... 25

Anticonvulsants..... 26

Anti-depressants:

[Miscellaneous...](#)..... 28
[SNRIs](#)..... 29
[SSRIs](#)..... 31
[Tricyclics & MAOIs](#)..... 33

Anti-diabetics:

[Insulin-Injectable](#)..... 35
[Oral](#)..... 36
[Peptide Hormones](#)..... 38

Anti-emetics:

[5-HT₃ Antagonists](#)..... 39
[NK1 Antagonists](#)..... 41
[Other](#)..... 42

Anti-hyperkinesia and Anti-Narcolepsy:

[Short/Intermediate-Acting MPH](#)..... 43
[Long-Acting MPH](#)..... 43
[Short/Intermediate-Acting Amphetamines](#)..... 43
[Long-Acting Amphetamines](#)..... 43
[Non-Stimulant Products](#)..... 44
[Xyrem](#)..... 44

Anti-hypertensives:

[ACE Inhibitors & ACEI Combinations](#)..... 46
[ARBs & ARB Combinations](#)..... 47
[Beta-Blockers](#)..... 49
[Calcium Channel Blockers](#)..... 51
[Renin Inhibitors](#)..... 53

Anti-infectives:

[Antibiotics: Cephalosporins -1st, 2nd and 3rd Gen.](#)..... 54
[Antibiotics: Ketolides](#)..... 56

[Antibiotics: Macrolides](#)..... 57
[Antibiotics: Oxazolidinones](#)..... 58
[Antibiotics: Penicillins \(Oral\)](#)..... 59
[Antibiotics: Quinolones](#)..... 60
[Anti-fungal: Allylamines](#)..... 61
[Anti-fungal: Azoles](#)..... 63
[Anti-fungal: Topical: Onychomycosis](#)..... 65
[Antivirals: Herpes \(Oral\)](#)..... 66
[Influenza Medications](#)..... 67
[Influenza Vaccines](#)..... 69
[Miscellaneous](#)..... 71
[Topical Antibiotics](#)..... 72
Anti-migraine: Triptans..... 73
Anti-Obesity..... 75
[Anti-Obesity - P. A. Request Form](#)..... 77
Anti-psychotics:
[Atypicals & Combinations](#)..... 78
[Typicals](#)..... 80
Botulinum Toxins..... 81
BPH:
[Alpha Blockers](#)..... 82
[Androgen Hormone Inhibitors](#)..... 83
Cardiac Glycosides..... 84
Chemical Dependency..... 85
[Buprenorphine - P. A. Request Form](#)..... 87
[Vivitrol - P. A. Request Form](#)..... 88
Compounded Products..... 89
Constipation: Chronic or IBS-C..... 90
Contraceptives: Vaginal Ring..... 91
Coronary Vasodilators/Antianginals:
[Oral and Topical](#)..... 92
Cough and Cold Preparations..... 94
Dermatological Agents:
[Genital Wart Therapy](#)..... 95
[Scabicides and Pediculicides](#)..... 96
Desmopressin: Intranasal..... 97
Diabetic Testing Supplies..... 98
Gastrointestinals:
[Crohn’s Disease-Injectables](#)..... 99
[Crohn’s Disease-Injectables P. A. Request Form](#).... 100
[H2-blockers](#)..... 101
[Inflammatory Bowel Agents \(Oral/Rectal\)](#)..... 102
[Proton Pump Inhibitors](#)..... 103
[Ulcerative Colitis-Injectables](#)..... 105
[Ulcerative Colitis-Injectables P.A. Request Form](#)..... 106
Glucocorticoids: Topical..... 107
Growth Stimulating Agents..... 109
[Growth Stimulating Agents - P.A./Order Form](#)..... 111
Hemophilia Factors:
[Specialty Pharmacy Order Form](#)..... 112

Continued on next page

Hepatitis C Medications	113
Hepatitis C Medications - P.A./Order Form	114
Immunomodulators: Topical	115
Lipotropics:	
Bile Acid Sequestrants	116
Fibric Acid Derivatives	117
Niacin	118
Statins	119
Miscellaneous/Combinations	120
Management of Mental Health Medications	121
Miscellaneous	
Arcalyst® (CAPS Injectable)	122
Elaprase® (Hunter’s Syndrome Injectable)	123
Soliris® (Paroxysmal Nocturnal Hemoglobinuria Injectable)	124
Somatuline® (Acromegaly Injectable)	125
Mood Stabilizers	126
Multiple Sclerosis Injectables	127
Self Injectables Specialty Pharmacy Order Form	128
Nutritionals, enteral	129
Nutritionals, enteral - P.A. Request Form	130
Ophthalmics:	
Antihistamines	132
Glaucoma Agents/Miotics	133
Mast Cell Stabilizers	135
NSAIDs	136
Quinolone Anti-infectives	137
Ossification Enhancers	138
Bisphosphonate Injectable – P.A. Request form	140
Otic: Anti-infectives	141
Parkinson’s Medications	142
Phosphodiesterase-5 Inhibitors	144
Platelet Inhibitors	145
Psoriasis Injectables	146
Psoriasis Injectable Medications– P.A. Request form	149
Psoriasis Non-biologics	150
Pulmonary:	
Anticholinergics, Inhaled	151
Antihistamines: Intranasal	152
Antihistamines-1st Generation	153
Antihistamines-2nd Generation	154
Persistent Asthma: Xolair®	156
Xolair® - P.A. Request Form	157
Beta-Adrenergic Agents	158
Inhaled Glucocorticoids	160
Nasal Glucocorticoids	161
Systemic Glucocorticoids	162
Leukotriene Modifiers	163
RSV Prevention: Synagis®	164
Synagis® - P. A./Order Form	165
Renal Disease: Phosphate Binders	166

Rheumatoid, Juvenile and Psoriatic Arthritis Medications	167
Rheumatoid, Juvenile and Psoriatic Arthritis – P.A. Request Form	169
Saliva Stimulants	170
Sedative/Hypnotics:	
Benzodiazepine	171
Non-Benzodiazepine, Non-Barbiturate	172
Skeletal Muscle Relaxants: Oral	
Musculoskeletal Agents	173
Antispasticity Agents	173
Smoking Cessation Therapies	175
Testosterone: Topical	176
Urinary Antispasmodics	177
Vaginal: Anti-infectives	179
Vitamins: Prenatal Vitamins	180

II. PRIOR AUTHORIZATION REQUEST & SPECIALTY PHARMACY ORDER FORMS

Ankylosing Spondylitis	182
Anti-Obesity	183
Bisphosphonate Injectable	184
Buprenorphine	185
Crohn’s Disease-Injectable	186
General	187
General SPECIALTY	188
Growth Stimulating Agents	189
Hemophilia Factors	190
Hepatitis C	191
Long-Acting Narcotics	192
Methadone 40 mg dispersible tablets	193
Multiple Sclerosis Self Injectables	194
Nutritionals	195
Psoriasis Injectable Medications	197
Rheumatoid, Juvenile and Psoriatic Arthritis	198
Synagis®	199
Ulcerative Colitis-Injectable	200
Vivitrol®	201
Xolair®	202

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 erythromycin 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, 25mg/5ml tab, cap, susp	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) 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	All 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 products:

- The patient has had a documented side effect, allergy, or treatment failure with generic benzoyl peroxide, clindamycin, erythromycin, and sodium sulfacetamide. (If a product has an AB rated generic, one trial must be the generic.)

Brand name combination products:

- The patient has had a documented side effect, allergy, or treatment failure with generic erythromycin/benzoyl peroxide and sodium sulfacetamide/sulfur. (If a product has an AB rated generic, one trial must be the generic.)
AND
- The patient has had a documented side effect or treatment failure on combination therapy with the separate generic ingredients of the requested combination product, if 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
<u>BENZOYL PEROXIDE PRODUCTS</u>	
BENZOYL PEROXIDE 2.5%, 5%, 10% <i>G, L, W</i> ; 10% <i>C</i> ; 3%, 5%, 6%, 8%, 9%, 10% <i>L</i> ; 3%, 6%, 9% <i>P</i> †	Benzac AC [®] 2.5%, 5%, 10% <i>G, W</i> Benzashave [®] 5%, 10% <i>C</i> Brevoxyl [®] 4%, 8% <i>W</i> ; 4% <i>G</i> ; 4%, 8% <i>L</i> Clinac BPO [®] 7% <i>G</i> Desquam-E/X [®] 2.5%, 5%, 10% <i>G</i> ; 5%, 10% <i>W</i> Inova 4% <i>P</i> Panoxyl/AQ 2.5%, 5%, 10% <i>G</i> ; 5%, 10% <i>B</i> Triaz [®] 3%, 6%, 9% <i>G</i> ; 3%, 6%, 9% <i>P</i> Zaclir [®] 4%, 8% <i>L</i> All other brands
<u>CLINDAMYCIN PRODUCTS</u>	
CLINDAMYCIN 1% <i>S, G, L, P</i> †	Cleocin-T ^{®*} (clindamycin 2% <i>G</i>) Evoclin [®] (clindamycin 2% <i>F</i>) Clindagel [®] (clindamycin 1% <i>G</i>) All other brands
<u>ERYTHROMYCIN PRODUCTS</u>	
ERYTHROMYCIN 2% <i>S, G, P</i> †	Akne-Mycin [®] (erythromycin 2% <i>O</i>) Erygel ^{®*} (erythromycin 2% <i>G</i>) All other brands
<u>SODIUM SULFACETAMIDE PRODUCTS</u>	
SODIUM SULFACETAMIDE 10% <i>L</i> †	Klaron ^{®*} (sodium sulfacetamide 10% <i>L</i>) All other brands
<u>COMBINATION PRODUCTS</u>	
ERYTHROMYCIN / BENZOYL PEROXIDE † SODIUM SULFACETAMIDE / SULFUR <i>L</i> † SODIUM SULFACETAMIDE / SULFUR <i>W</i> †	Benzaclin [®] (clindamycin/benzoyl peroxide) DUAC [®] (clindamycin/benzoyl peroxide) gel, kit Benzamycin ^{®*} (erythromycin/benzoyl peroxide) Sulfoxyl (erythromycin/benzoyl peroxide) Z-Clinz [®] (clindamycin/benzoyl peroxide kit) All other brands Avar [®] (sodium sulfacetamide/sulfur <i>G</i>) Plexion [®] (sulfacetamide/sulfur <i>S</i>) Rosac ^{®*} (sulfacetamide/sulfur <i>W</i>) Rosula ^{®*} (sulfacetamide/sulfur <i>W</i>) Sulfacet-R ^{®*} (sodium sulfacetamide/sulfur <i>L</i>) All other brands
<u>OTHER</u>	
	Azelex [®] (azelaic acid 20% <i>C</i>) Aczone [®] (dapsone 5% <i>G</i>) 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		<i>Length of Authorization: 1 year</i>
Key: † Generic product, *Indicates generic equivalent is available without a PA		
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
<p>TRETINOIN† (<i>specific criteria required for ages <10 or >34</i>) 0.025%, 0.05%, 0.1% C; 0.01%, 0.025% G</p> <p>TAZORAC® (tazarotene) 0.05%, 0.1% C, G</p>	<p>All brand tretinoin products (Atralin® 0.05% G, Avita®*, Retin-A®*, Retin-A Micro® 0.1%, 0.04%, Tretin-X® etc.)</p> <p>Differin® (adapalene) 0.1% C, G; 0.3% G</p> <p>Avage® (tazarotene) ♣ Renova® (tretinoin) ♣ Solage® (tretinoin/mequinol) ♣ Tri-Luma® (tretinoin/hydroquinone/fluocinolone) ♣</p> <p>♣ <i>Not indicated for acne. Coverage of topical retinoid products will not be approved for cosmetic use (wrinkles, age spots, etc.).</i></p>	

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		<i>Length of Authorization: 1 year</i>
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, Galantamine Tablet, Galantamine ER 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.
- AND**
- If the product has an AB rated generic, the patient has a documented intolerance to the generic.

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	
<i>Length of Authorization: 1 year</i>	
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
<u>CHOLINESTERASE INHIBITORS</u>	
ARICEPT [®] (donepezil) Tablet <i>(QL = 1 tablet/day)</i>	Cognex [®] (tacrine) Capsule § galantamine† tablet (compare to Razadyne [®])
EXELON [®] (rivastigmine) Capsule <i>(QL = 2 capsules/day)</i>	galantamine ER† capsule (compare to Razadyne ER [®]) Razadyne [®] (galantamine) Tablet § Razadyne ER [®] (galantamine) Capsule §
ARICEPT [®] ODT (donepezil) <i>(QL = 1 tablet/day)</i>	
EXELON [®] (rivastigmine) Oral Solution	Razadyne [®] (galantamine) Oral Solution §
EXELON [®] (rivastigmine transdermal) Patch <i>(QL = 1 patch/day)</i>	
<u>NMDA RECEPTOR ANTAGONIST</u>	
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, Voltaren Gel:

- The patient has a documented medical necessity for a topical/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[®]) > **Nabumetone** (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

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: COX II 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† tabs (compare to Mobic®)	Indocin SR®*
NABUMETONE†	ketorolac† (<i>QL = 20 doses post PA approval</i>)
NAPROXEN† (compare to Naprosyn®)	meloxicam† susp (compare to Mobic®)
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 (<i>QL = 1 dose per fill</i>)	
TOPICAL/TRANSDERMAL	
	Flector® (diclofenac) Patch (<i>QL = 2 patches/day</i>)
	Voltaren® (diclofenac) Gel
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)

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 <i>Length of Authorization: 6 months</i>	
PREFERRED DRUGS (No PA Required)	PA REQUIRED
	Lidoderm® Patch (lidocaine 5 %) <i>Quantity Limit = 3 patches/day</i>

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 \geq 60 mg/day, transdermal fentanyl 50 mcg/hr, or an equianalgesic dose of another opioid for \geq 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
<p>ACETAMINOPHEN W/CODEINE† (compare to Tylenol w/codeine®)</p> <p>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)</p> <p>ACETAMINOPHEN W/OXYCODONE† (compare to Percocet®) (QL 10/650 = 6 tablets/day)</p> <p>ACETAMINOPHEN W/PROPOXYPHENE† (compare to Darvocet-N®) (QL 100/650 = 6 tablets/day)</p> <p>ASPIRIN W/CODEINE†</p> <p>ASPIRIN W/OXYCODONE† (compare to Percodan®)</p> <p>BUTALBITAL COMPOUND W/ CODEINE† (compare to Fiorinal® w/codeine)</p> <p>CODEINE SULFATE†</p> <p>DIHYDROCODEINE COMPOUND† (compare to Synalgos-DC®)</p> <p>FIORTAL W/ CODEINE #3® (butalbital w/ codeine)</p> <p>HYDROCODONE† (plain, w/acetaminophen or w/ibuprofen)</p> <p>HYDROMORPHONE† (compare to Dilaudid®)</p> <p>MEPERIDINE† (compare to Demerol®) (Maximum 30 tabs or 5 day supply)</p> <p>MORPHINE SULFATE†</p> <p>MORPHINE SULFATE SOLN† (compare to Roxanol®)</p> <p>OXYCODONE† (plain, w/acetaminophen or w/ibuprofen)</p> <p>PENTAZOCINE† (compare to Talwin®)</p> <p>PROPOXYPHENE† (compare to Darvon®)</p> <p>PROPOXYPHENE COMPOUND† (compare to Darvon Compound®)</p> <p>PROPOXYPHENE N W/ ACETAMINOPHEN†</p> <p>ROXICET® (oxycodone w/ acetaminophen)</p> <p>ROXICODONE INTENSOL® (oxycodone)</p> <p>ROXICODONE® (oxycodone HCL)</p> <p>TRAMADOL† (compare to Ultram®)</p> <p>TRAMADOL/APAP† (compare to Ultracet®)</p>	<p>Acetaminophen w/codeine: <i>all branded products</i></p> <p>Acetaminophen w/hydrocodone: <i>all branded products</i> (QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)</p> <p>Acetaminophen w/oxycodone: <i>all branded products</i> (QL 10/650 = 6 tablets/day)</p> <p>Actiq® (fentanyl citrate transmucosal)</p> <p>Anexsia®*</p> <p>Bancap HC®</p> <p>Butorphanol Nasal Spray† (Qty Limit = 2 bottles/month)</p> <p>Capital® w/codeine*</p> <p>Combunox®* (oxycodone w/ ibuprofen)</p> <p>Darvocet-N®* (QL 100/650 = 6 tablets/day)</p> <p>Darvon Compound®*</p> <p>Darvon®*/ Darvon-N®*</p> <p>Dazidox®* (oxycodone)</p> <p>Demerol®*</p> <p>Dilaudid®*</p> <p>Endocet® (oxycodone w/ acetaminophen)</p> <p>Endodan® (oxycodone w/ aspirin)</p> <p>fentanyl citrate transmucosal† (compare to Actiq®)</p> <p>Fentora® (fentanyl citrate buccal tablets)</p> <p>Fioricet® w/codeine*</p> <p>Ibudone®*</p> <p>Liquicet® (hydrocodone w/ acetaminophen)</p> <p>Lorcet®* (also HD, PLUS)</p> <p>Lortab®*</p> <p>Magnacet®</p> <p>Maxidone®*</p> <p>Meperidine (Qty > 30 tabs or 5 day supply)</p> <p>Nalbuphine</p> <p>Norco®*</p> <p>Nubain®*</p> <p>Numorphan®</p> <p>Opana®</p> <p>Oxyfast®*</p> <p>OxyIR®*</p> <p>Panlor DC®</p> <p>Pentazocine and Naloxone</p> <p>Percocet®*</p> <p>Percodan®*</p> <p>Propoxyphene: <i>all branded products</i>*</p> <p>Reprexain®*</p> <p>Roxanol®*</p> <p>Synalgos DC®*</p> <p>Talacen®*</p> <p>Talwin®* and branded combinations/ Talwin NX®*</p> <p>Trezix®</p> <p>Tylenol® #3*,#4*</p> <p>Tylox®*</p> <p>Ultracet®</p> <p>Ultram®*/Ultram ER®</p> <p>Vicodin®*</p> <p>Vicoprofen®*</p> <p>Wygesic®*</p> <p>Xodol®</p> <p>Zydone®*</p>
<p>Note: Acetaminophen containing products: (Preferred and PA Required)</p> <p>Maximum daily dose acetaminophen = 4 grams</p>	

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 Dispersible Tablets:

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/2006/006134s0281bl.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. For approval of fentanyl patch, the patient must have a documented intolerance to Duragesic). 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.

Duragesic-12 will be approved for patients who are titrating from one strength to another and the available strengths of Duragesic are not appropriate. Duragesic-12 is not indicated for initial dosing. For approval of Fentanyl 12.5 mcg/hr, the patient must have had a documented intolerance to Duragesic-12.

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	
<i>Length of Authorization: initial approval 3 months, subsequent approval up to 6 months</i>	
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
<u>TRANSDERMAL</u>	Duragesic-12 [®] 12.5 mcg/hr (<i>QL=15 patches/30 days</i>)
DURAGESIC [®] 25 mcg/hr, 50 mcg/hr, (<i>QL=15 patches/30 days</i>)	Fentanyl Patch† (compare to Duragesic [®]) 12.5 mcg/hr (<i>QL=15 patches/30 days</i>)
DURAGESIC [®] 75 mcg/hr, 100 mcg/hr (<i>QL= 30 patches/30 days</i>)	Fentanyl Patch† (compare to Duragesic [®]) 25 mcg/hr, 50 mcg/hr, (<i>QL=15 patches/30 days</i>)
	Fentanyl Patch† (compare to Duragesic [®]) 75 mcg/hr, 100 mcg/hr, (<i>QL=30 patches/30 days</i>)
<u>ORAL</u>	Avinza [®] (morphine sulfate XR) (<i>QL= 30 capsules/strength/30 days</i>)
METHADONE† (compare to Dolophine [®]) 5 mg, 10 mg	Dolophine ^{®*} (methadone)
MORPHINE SULFATE ER† (compare to MS Contin [®] , Oramorph SR [®]) (<i>QL=90 tablets/strength/30 days</i>)	Kadian [®] (morphine sulfate XR) (<i>QL= 60 capsules/strength/30 days</i>)
	Methadone 40 mg Dispersible Tablets §
	MS Contin ^{®*} (morphine sulfate ER) (<i>QL=90 tablets/strength/30 days</i>)
	Opana ER [®] (oxymorphone ER) (<i>QL=60 tablets/strength/30 days</i>)
	Oramorph SR ^{®*} (morphine sulfate ER) (<i>QL=90 tablets/strength/30 days</i>)
	Oxycodone ER† (<i>QL=90 tablets/strength/30 days</i>)
	OxyContin [®] (Oxycodone ER) (<i>QL= 90 tablets/strength/30 days</i>)

~ 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?

<i>Check all that apply:</i>	<i>Response, check all that apply:</i>
<input type="checkbox"/> Fentanyl Patches	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> Methadone	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> Morphine ER	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy

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

Prescriber comments:

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

~ **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 <i>Length of Authorization: 1 year</i>	
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	
<i>Length of authorization: Initial PA of 3 months; 12 months thereafter</i>	
PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET
ENBREL® (etanercept) HUMIRA® (adalimumab)	Remicade® (infliximab)

~ **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 Benzodiazepines:

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

Buspar® and Vistaril®:

- The patient has a documented intolerance to 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 121 for a description of the management of mental health drugs.

Anti-Anxiety: Anxiolytics		<i>Length of Authorization: 1 year</i>
Key: † Generic product, *Indicates generic equivalent is available without a PA		
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
<u>Benzodiazepine</u>		
ALPRAZOLAM† (compare to Xanax®)	Ativan®* (lorazepam)	
ALPRAZOLAM ER†, ALPRAZOLAM XR® (compare to Xanax XR®)	Klonopin®* (clonazepam)	
CHLORDIAZEPOXIDE† (compare to Librium®)	Klonopin Wafers®* (clonazepam ODT)	
CLONAZEPAM† (compare to Klonopin®)	Librium®* (chlordiazepoxide)	
CLONAZEPAM ODT† (compare to Klonopin Wafers®)	Niravam® (alprazolam ODT)	
CLORAZEPATE† tabs (compare to Tranxene T®)	Serax®* (oxazepam)	
DIAZEPAM† (compare to Valium®)	Tranxene T®* (clorazepate tablets)	
LORAZEPAM† (compare to Ativan®)	Tranxene-SD® (clorazepate SR 24 hr tab)	
OXAZEPAM† (compare to Serax®)	Valium®* (diazepam)	
	Xanax®* (alprazolam)	
	Xanax XR®* (alprazolam XR)	
<u>Non-Benzodiazepine</u>		
BUSPIRONE† (compare to Buspar®)	Buspar®* (buspirone)	
HYDROXYZINE HYDROCHLORIDE† (previously Atarax®)	Vistaril®* (hydroxyzine pamoate)	
HYDROXYZINE PAMOATE† (compare to Vistaril®)		
MEPROBAMATE† (previously Miltown®)		

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		<i>Length of Authorization: 6 months</i>
Key: † Generic product, *Indicates generic equivalent is available without a PA		
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
<u>ORAL</u> WARFARIN † (compare to Coumadin®)	Coumadin®* (warfarin)	
<u>UNFRACTIONATED HEPARIN</u> HEPARIN †		
<u>LOW MOLECULAR WEIGHT HEPARINS</u> FRAGMIN® (dalteparin) LOVENOX® (enoxaparin) (QL = 2 syringes/day calculated in ml volume)	Innohep® (tinzaparin)	
<u>SELECTIVE FACTOR XA INHIBITOR</u> ARIXTRA® (fondaparinux)		

Anticonvulsants

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.

Divalproex sodium, Lamotrigine tabs or chew tabs, Levetiracetam tablets, 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, SNRI antidepressant, miscellaneous antidepressant or cyclobenzaprine, if medication is being used for fibromyalgia. (this indication not processed via automated step therapy)

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 121 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)	divalproex sodium † (compare to Depakote [®])
CELONTIN [®] (methsuxamide)	Gabarone ^{®*} (gabapentin)
CLONAZEPAM† (compare to Klonopin [®])	Klonopin ^{®*}
CLONAZEPAM ODT† (compare to Klonopin Wafers [®])	Klonopin Wafers ^{®*}
DEPAKOTE [®] (divalproex sodium)	lamotrigine† chew tabs (compare to Lamictal [®] chew tabs)
DEPAKOTE ER [®] (divalproex sodium)	lamotrigine† tabs (compare to Lamictal [®] tabs)
DIASTAT [®] (diazepam rectal gel)	levetiracetam† tabs (compare to Keppra [®] tabs)
DILANTIN [®] (phenytoin)	Lyrica [®] (pregabalin) § (<i>Quantity Limit = 3 capsules/day</i>)
EPITOL† (carbamazepine)	Mysoline ^{®*} (primidone)
ETHOSUXAMIDE† (compare to Zarontin [®])	Neurontin ^{®*} (gabapentin)
FELBATOL [®] (felbamate)	oxcarbazepine† (compare to Trileptal [®])
GABAPENTIN† (compare to Neurontin [®])	Tegretol ^{®*} (carbamazepine)
GABITRIL [®] (tiagabine)	Zarontin ^{®*} (ethosuxamide)
KEPPRA [®] (levetiracetam)	Zonegran ^{®*} (zonisamide)
LAMICTAL [®] tabs (lamotrigine tabs)	
LAMICTAL [®] chew tabs (lamotrigine chew tabs)	
NEURONTIN [®] oral solution (gabapentin)	
PEGANONE [®] (ethoin)	
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: Miscellaneous

LENGTH OF AUTHORIZATION:

Duration of need for mental health indications*[▲]; 1 year for other indications

CRITERIA FOR APPROVAL:

Remeron, Remeron SolTab, Wellbutrin, Wellbutrin SR:

- The patient has had a documented intolerance to the generic formulation of the requested medication.

Budeprion XR, Bupropion XL:

- The patient has had a documented intolerance to brand name Wellbutrin XL.

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 121 for a description of the management of mental health drugs.

Anti-Depressants: Miscellaneous <i>Length of Authorization: Duration of need for mental health indications*[▲]; 1 year for other indications</i>	
Key: † Generic product, *Indicates generic equivalent is available without a PA	
PREFERRED DRUGS (No PA Required)	PA REQUIRED
BUDEPRION [®] SR/BUPROPION SR† (compare to Wellbutrin SR [®]) <i>FDA maximum recommended dose = 400 mg/day</i> BUPROPION† (compare to Wellbutrin [®]) <i>FDA maximum recommended dose = 450 mg/day</i> MAPROTILINE† (previously Ludiomil [®]) <i>FDA maximum recommended dose = 225 mg/day</i> MIRTAZAPINE† (compare to Remeron [®]) <i>FDA maximum recommended dose = 45 mg/day</i> MIRTAZAPINE RDT† (compare to Remeron Sol-Tab [®]) <i>FDA maximum recommended dose = 45 mg/day</i> NEFAZADONE† (previously Serzone [®]) <i>FDA maximum recommended dose = 600 mg/day</i> TRAZODONE HCL† (previously Desyre [®]) <i>FDA maximum recommended dose = 600 mg/day</i> WELLBUTRIN XL [®] (bupropion XL) <i>FDA maximum recommended dose = 450 mg/day</i>	Budeprion XR/bupropion XL† (compare to Wellbutrin XL [®]) <i>FDA maximum recommended dose = 450 mg/day</i> Remeron [®] * (mirtazapine) <i>FDA maximum recommended dose = 45 mg/day</i> Remeron Sol Tab [®] * (mirtazapine RDT) <i>FDA maximum recommended dose = 45 mg/day</i> Wellbutrin [®] * (bupropion) <i>FDA maximum recommended dose = 450 mg/day</i> Wellbutrin SR [®] * (bupropion SR) <i>FDA maximum recommended dose = 400mg/day</i>

* 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: SNRIs

LENGTH OF AUTHORIZATION:

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

CRITERIA FOR APPROVAL:

Effexor:

- The patient has had a documented intolerance to generic venlafaxine.

Pristiq, Venlafaxine, Venlafaxine ER, 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, SNRI and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred).

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, SNRI and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred).

Neuropathic pain:

- 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. (this indication not processed via automated step therapy).

Fibromyalgia:

- The patient has had a documented side effect, allergy, or treatment failure to TWO drugs from the following: gabapentin, tricyclic antidepressant, SSRI antidepressant, SNRI antidepressant, miscellaneous antidepressant or cyclobenzaprine. (this indication not processed via automated step therapy)

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 121 for a description of the management of mental health drugs.

Anti-Depressants: SNRI *Length of Authorization: Duration of need for mental health indications*;
1 year for other indications*

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
	<p>Cymbalta[®] § (duloxetine) <i>FDA maximum recommended dose = 60 mg/day</i></p> <p>Effexor[®] (venlafaxine IR) <i>FDA maximum recommended dose = 225 mg/day</i></p> <p>Effexor XR[®] § (venlafaxine XR) <i>FDA maximum recommended dose = 225 mg/day, Quantity limit = 1 capsule/day (37.5 mg & 75 mg)</i></p> <p>Pristiq[®] § (desvenlafaxine) <i>FDA maximum recommended dose = 400 mg/day, Quantity limit = 1 tablet/day (50 mg tablet only)</i></p> <p>venlafaxine IR †§ (compare to Effexor[®]) <i>FDA maximum recommended dose = 225 mg/day</i></p> <p>Venlafaxine ER[®] § tablet <i>FDA maximum recommended dose = 225 mg/day, Quantity limit = 1 tablet/day (37.5 mg & 75 mg)</i></p>

* For brand name products with generic equivalents, 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, 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.)

Luvox CR:

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

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, Fluoxetine (pmdd):

- The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. (One trial must be generic fluoxetine (regular, not pmdd).)

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 121 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
<p>CITALOPRAM† (compare to Celexa®) <i>FDA maximum recommended dose = 40 mg/day</i></p> <p>FLUOXETINE† (compare to Prozac®) <i>FDA maximum recommended dose = 80 mg/day</i></p> <p>FLUVOXAMINE† (previously Luvox®) <i>FDA maximum recommended dose = 300 mg/day</i></p> <p>PAROXETINE tablet† (compare to Paxil®) <i>FDA maximum recommended dose = 60 mg/day</i></p> <p>SERTRALINE† (compare to Zoloft®) <i>FDA maximum recommended dose = 200 mg/day, Quantity limit = 1.5 tabs/day (25 mg & 50 mg tabs)</i></p>	<p>Celexa®* (citalopram) <i>FDA maximum recommended dose = 40 mg/day</i></p> <p>fluoxetine† (pmdd) (compare to Selfemra®) <i>FDA maximum recommended dose = 80 mg/day</i></p> <p>Lexapro® (escitalopram) <i>FDA maximum recommended dose = 20 mg/day, Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)</i></p> <p>Luvox CR® (fluvoxamine CR) <i>FDA maximum recommended dose = 300 mg/day, Quantity limit = 2 capsules/day</i></p> <p>paroxetine suspension† (compare to Paxil® susp) <i>FDA maximum recommended dose = 60 mg/day</i></p> <p>Paroxetine CR† (compare to Paxil CR®) <i>FDA maximum recommended dose = 75 mg/day</i></p> <p>Paxil®* (paroxetine) <i>FDA maximum recommended dose = 60 mg/day</i></p> <p>Paxil CR® (paroxetine CR) <i>FDA maximum recommended dose = 75 mg/day</i></p> <p>Pexeva® (paroxetine) <i>FDA maximum recommended dose = 60 mg/day</i></p> <p>Prozac®* (fluoxetine) <i>FDA maximum recommended dose = 80 mg/day</i></p> <p>Prozac Weekly® (fluoxetine) <i>FDA maximum recommended dose = 90 mg/week</i></p> <p>Sarafem® (fluoxetine) <i>FDA maximum recommended dose = 80 mg/day</i></p> <p>Selfemra® (fluoxetine) <i>FDA maximum recommended dose = 80 mg/day</i></p> <p>Zoloft®* (sertraline) <i>FDA maximum recommended dose = 200 mg/day, Quantity limit = 1.5 tabs/day (25 mg & 50 mg tabs)</i></p>

* 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) (Brands with generic equivalents):

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

OR

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

AND

- The patient has had a documented intolerance to 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 intolerance to generic 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 (Miscellaneous, SNRIs, SSRIs, 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 121 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	
<p>AMITRIPTYLINE† (previously Elavil®) <i>FDA maximum recommended dose = 300 mg/day</i></p> <p>AMITRIPTYLINE/CHLORDIAZ.† (compare to Limbitrol®, Limbitrol DS®)</p> <p>AMITRIPTYLINE/PERPHEN†.(previously Etrafon®, Triavil®)</p> <p>AMOXAPINE† (previously Asendin®)</p> <p>CLOMIPRAMINE† (compare to Anafranil®)</p> <p>DESIPRAMINE† (compare to Norpramin®)</p> <p>DOXEPIN† (previously Sinequan®)</p> <p>IMIPRAMINE† (compare to Tofranil®) <i>FDA maximum recommended dose = 300 mg/day</i></p> <p>IMIPRAMINE PAMOATE† (compare to Tofranil PM®)</p> <p>NORTRIPTYLINE† (previously Aventyl®, compare to Pamelor®)</p> <p>PROTRIPTYLINE† (compare to Vivactil®)</p> <p>TRIMIPRAMINE (compare to Surmontil®)</p>	<p>Anafranil®* (clomipramine)</p> <p>Limbitrol®* (amitriptyline/chlordiazepoxide)</p> <p>Limbitrol DS®* (amitriptyline/chlordiazepoxide)</p> <p>Norpramin®* (desipramine)</p> <p>Pamelor®* (nortriptyline)</p> <p>Surmontil®* (trimipramine)</p> <p>Tofranil®* (imipramine)</p> <p><i>FDA maximum recommended dose = 300 mg/day</i></p> <p>Tofranil PM®* (imipramine pamoate)</p> <p>Vivactil®* (protriptyline)</p>
MAOIs	
<p>NARDIL® (phenylzine) <i>FDA maximum recommended dose = 90 mg/day</i></p> <p>TRANLYCYPROMINE (compare to Parnate®) <i>FDA maximum recommended dose = 60 mg/day</i></p>	<p>EMSAM® (selegiline) (<i>QL = 1 patch/day</i>)</p> <p>Marplan® (isocarboxazid)</p> <p>Parnate®* (tranylcypromine) <i>FDA maximum recommended dose = 60 mg/day</i></p>

* 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

DOCUMENTATION:

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

Insulins		<i>Length of Authorization: lifetime</i>
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
<u>RAPID-ACTING INJECTABLE</u>		
NOVOLOG [®] (Aspart)	Apidra [®] (insulin glulisine) Humalog [®] (insulin lispro)	
<u>SHORT-ACTING INJECTABLE</u>		
NOVOLIN R [®] (Regular)	Humulin R [®] (Regular) ReliOn R [®] (Regular)	
<u>INTERMEDIATE-ACTING INJECTABLE</u>		
NOVOLIN N [®] (NPH)	Humulin N [®] (NPH) ReliOn N [®] (NPH)	
<u>LONG-ACTING ANALOGS INJECTABLE</u>		
LANTUS [®] (insulin glargine) LEVEMIR [®] (insulin detemir)		
<u>MIXED INSULINS INJECTABLE</u>		
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)	

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
<u>ALPHA GLUCOSIDASE INHIBITORS</u>	
ACARBOSE† (compare to Precose®) GLYSET® (miglitol)	PRECOSE®* (acarbose)
<u>BIGUANIDES AND COMBINATIONS</u>	
<u>SINGLE AGENT</u>	
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)
<u>COMBINATION</u>	
GLIPIZIDE/METFORMIN†(compare to Metaglip®) GLYBURIDE/METFORMIN† (compare to Glucovance®)	Glucovance®* (glyburide/metformin) Metaglip®*(glipizide/metformin)
<u>MEGLITINIDES</u>	
STARLIX® (nateglinide)	Prandin® (replaginide)
<u>SULFONYLUREAS SECOND GENERATION</u>	
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)
<u>THIAZOLIDINEDIONES AND COMBINATIONS (after clinical criteria are met)</u>	
<u>SINGLE AGENT</u>	
ACTOS® (pioglitazone) § AVANDIA® (rosiglitazone) §	
<u>COMBINATION</u>	
ACTOPLUS MET® (pioglitazone/metformin) § AVANDAMET® (rosiglitazone/metformin) § AVANDARYL® (rosiglitazone/glimeperide) § DUETACT® (pioglitazone/glimepiride) § (Quantity Limit = 1 tablet/day)	
<u>DIPEPTIDYL PEPTIDASE (DPP-4) INHIBITORS AND COMBINATIONS (after clinical criteria are met)</u>	
<u>SINGLE AGENT</u>	
JANUVIA® (sitagliptin)§ (Quantity limit=1 tab/day)	
<u>COMBINATION</u>	
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		<i>Length of Authorization: 1 year</i>
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) § (<i>Quantity Limit=1 pen/30 days</i>)	Symlin® (pramlintide) (No quantity limit applies)	

Anti-Emetics: 5-HT₃ 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 gravidarum, 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-HT₃ 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 <i>Quantity Limit = 12 tablets/month (4 mg), 6 tablets/month (8 mg)</i>	Aloxi® (palonosetron) <i>Quantity Limit = 2 vials/month</i>
Ondansetron Injection† (compare to Zofran®)	Anzemet® (dolasetron) <i>Quantity Limit = 4 tablets/month (50 mg), 2 tablets/month (100 mg)</i>
	Granisetron† (compare to Kytril®) <i>Quantity Limit = 6 tablets/month</i>
	Granisetron† (compare to Kytril®) Injectable
	Granisetron† (compare to Kytril®) Oral Solution
	Kytril® (granisetron) <i>Quantity Limit = 6 tablets/month</i>
	Kytril® Injectable (granisetron)
	Ondansetron Solution† (compare to Zofran®)
	Ondansetron† 24 mg tablet (previously Zofran®) <i>Quantity Limit = 1 tablet/month</i>
	Zofran®* (ondansetron) Tablet and Orally Disintegrating Tablet <i>Quantity Limit = 12 tablets/month (4 mg), 6 tablets/month (8 mg)</i>
	Zofran®* (ondansetron) Injection
	Zofran® (ondansetron) Solution

Anti-Emetics: NK1 Antagonists

LENGTH OF AUTHORIZATION: up to 1 year

CRITERIA FOR APPROVAL:

EMEND® Injection (fosaprepitant) 115 mg Vial

- 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 patient has a medical necessity for the IV administration (i.e. inability to swallow capsules, dysphagia).
- AND**
- The requested quantity does not exceed one 115 mg vial per course of chemotherapy. Patients with multiple courses of chemotherapy per month will be approved quantities sufficient for the number of courses of chemotherapy.

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		<i>Length of Authorization: up to 1 year</i>
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® (aprepitant) 125 mg (Qty Limit = 1 cap/30 days) * EMEND® (aprepitant) Tri-fold Pack (Qty Limit = 1 pack/30 days)		* EMEND® (fosaprepitant) 115 mg Injection (Qty Limit = 1 vial/30 days)
* <i>To be prescribed by oncology practitioners ONLY</i>		

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 endorphin 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:

Dronabinol, 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. If the request is for Marinol, the patient must additionally have a documented intolerance to generic dronabinol.
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. If the request is for Marinol, the patient must additionally have a documented intolerance to generic dronabinol.

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	
<i>Length of Authorization: Initial approval 3 months, subsequent approval up to 6 months</i>	
PREFERRED DRUGS (No PA Required)	PA REQUIRED
	Dronabinol† (compare to Marinol [®])
	Marinol [®] (dronabinol)
	Cesamet [®] (nabilone)

Anti-Hyperkinesia 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 generic 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 on Methylin[®] ER, Metadate 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 SR, 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 SR, 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®, Vyvanse® and Daytrana®)

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®, Vyvanse® and Daytrana®)

-

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 121 for a description of the management of mental health drugs.

Anti-Hyperkinesia 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[®] (dexmethylphenidate)
 Ritalin^{®*} (methylphenidate)
 Ritalin SR^{®*} (methylphenidate SR)

Long-Acting Methylphenidate Preps

Oral

CONCERTA[®] (methylphenidate IR/ER, 22:78%)
 FOCALIN XR[®] (dexmethylphenidate IR/ER, 50:50%)

Metadate CD[®] (methylphenidate, IR/ER, 30:70%)
 Ritalin LA[®] (methylphenidate, IR/ER, 50:50%)

Transdermal Patch

DAYTRANA[®] (methylphenidate patch) (*QL = 1 patch/day*)

Short/Intermediate-Acting Amphetamine Preps

AMPHETAMINE salt combo† (compare to Adderall[®])
 DEXTROAMPHETAMINE † (previously Dexedrine[®])
 DEXTROAMPHETAMINE SR† (compare to
 Dexedrine CR[®])
 DEXTROSTAT † (dextroamphetamine)

Adderall^{®*} (amphetamine salt combo)
 Desoxyn[®] (methamphetamine)
 Dexedrine CR^{®*} (dextroamphetamine SR)

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)
FDA maximum recommended 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	
<i>Length of Authorization: 1 year</i>	
Key: † Generic product, *Indicates generic equivalent is available without a PA	
PREFERRED DRUGS (No PA Required)	PA Required
<p><u>ACE INHIBITORS:</u> 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[®])</p>	<p>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)</p>
<p><u>ACE INHIBITOR/HYDROCHLOROTHIAZIDE:</u> 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[®])</p>	<p>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)</p>
<p><u>ACE INHIBITOR/CALCIUM CHANNEL BLOCKER:</u> benazepril/amlodipine† (compare to Lotrel[®])</p>	<p>Lexxel[®] (enalapril/felodipine) Lotrel[®]* (benazepril/amlodipine) Tarka[®] (trandolapril/verapamil)</p>

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, Azor, 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.

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
<u>ANGIOTENSIN RECEPTOR BLOCKERS:</u>	
AVAPRO [®] (irbesartan) § BENICAR [®] (olmesartan) § COZAAR [®] (losartan) § DIOVAN [®] (valsartan) § MICARDIS [®] (telmisartan) §	Atacand [®] (candesartan) § Teveten [®] (eprosartan) §
<u>ANGIOTENSIN RECEPTOR BLOCKER/HYDROCHLOROTHIAZIDE:</u>	
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) §
<u>ANGIOTENSIN RECEPTOR BLOCKER/CALCIUM CHANNEL BLOCKER:</u>	
AZOR [®] (olmesartan/amlodipine) § (<i>QL = 1 tablet/day</i>) EXFORGE [®] (valsartan/amlodipine) § (<i>QL = 1 tab/day</i>)	

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
<u>SINGLE AGENT</u>	
ACEBUTOLOL† (compare to Sectral®)	Betapace®*
ATENOLOL† (compare to Tenormin®)	Betapace AF®*
BETAXOLOL† (compare to Kerlone®)	Bystolic® (nebivolol) (<i>QL = 1 tablet/day for 2.5 mg and 5 mg tablet strengths</i>)
BISOPROLOL FUMARATE† (compare to Zebeta®)	Cartrol® (carteolol)
CARVEDILOL† (compare to Coreg®)	Coreg® (carvedilol)
LABETALOL† (compare to Trandate®)	Coreg CR® (<i>QL = 1 tablet/day</i>)
METOPROLOL† (compare to Lopressor®)	Corgard®*
METOPROLOL XL† (compare to Toprol XL®)	Inderal®* (all products)
NADOLOL† (compare to Corgard®)	Inderal LA®
PINDOLOL†	InnoPran XL®
PROPRANOLOL† (compare to Inderal®)	Kerlone®*
SOTALOL† (compare to Betapace®, BetapaceAF®)	Levitol® (penbutalol)
TIMOLOL† (compare to Blocadren®)	Lopressor®* (all products)
	propranolol ER† (compare to Inderal LA®)
	Sectral®*
	Tenormin®*
	Toprol XL®* (metoprolol succinate)
	Trandate®* (all products)
	Zebeta®*
<u>BETA-BLOCKER/DIURETIC COMBINATION</u>	
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®*
	Timolide® (timolol/hydrochlorothiazide)
	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.)

Caduet[®]

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

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

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		<i>Length of Authorization: lifetime</i>
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
	<p><u>Single Agent</u> Tekturna[®] (aliskiren) (<i>Qty Limit = 1 tablet/day</i>)</p> <p><u>Combination</u> Tekturna HCT[®] (aliskiren/hydrochlorothiazide) (<i>Qty Limit = 1 tablet/day</i>)</p>	

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 Omnicel[®].

Cefdinir capsule or suspension:

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

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 Omnicel[®] 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 Omnicel[®] 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 Omnicel[®] 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
<u>1st GENERATION:</u>	
CEFADROXIL † (compare to Duricef [®]) CEPHALEXIN † (compare to Keflex [®]) IV drugs are not managed at this time.	Duricef [®] * Keflex [®] *
<u>2nd GENERATION:</u>	
<u>TABLETS</u> CEFACLOR CAPSULE † CEFACLOR ER TABLET † CEFPROZIL TABLETS † (compare to Cefzil [®]) CEFUROXIME TABLETS † (compare to Cefin [®]) <u>SUSPENSION</u> CEFACLOR SUSPENSION † CEFPROZIL SUSPENSION † (compare to Cefzil [®]) CEFTIN [®] suspension IV drugs are not managed at this time.	Cefin [®] tablets* Cefzil [®] tablets* Lorabid [®] (loracarbef) capsule Cefuroxime † suspension (compare to Cefin [®]) Cefzil [®] suspension* Lorabid [®] (loracarbef) suspension
<u>3rd GENERATION:</u>	
<u>CAPSULES/TABLETS</u> CEFPODOXIME PROXETIL TABS † (compare to Vantin [®]) OMNICEF [®] CAPSULE (cefdinir) SUPRAX [®] TABLET (cefixime) <u>SUSPENSION</u> 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*, *Chlamydomphila 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		<i>Length of Authorization: Date of Service Only; no refills</i>
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		<i>Length of Authorization: Date of service only. No refills.</i>
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† tablets and liquid (if > 5 day supply)	
AZITHROMYCIN† liquid (≤ 5 day supply) (compare to Zithromax [®])	Biaxin ^{®*} Biaxin XL [®]	
CLARITHROMYCIN† (compare to Biaxin [®])	Dynabac [®] (dirithromycin)	
ERY-TAB [®] (erythromycin base, delayed release)	E.E.S ^{®*} (erythromycin ethylsuccinate)	
ERYTHROCIN† (erythromycin stearate)	Eryped ^{®*} (erythromycin ethylsuccinate)	
ERYTHROMYCIN BASE†	PCE Dispertab [®] (erythromycin base)	
ERYTHROMYCIN ESTOLATE†	Pediazole ^{®*} (erythromycin-sulfisoxazole)	
ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S [®] , Eryped [®])	Zithromax ^{®*} tablets and liquid	
ERYTHROMYCIN STEARATE†	Zmax [®] Suspension (azithromycin extended release for oral suspension)	
ERYTHROMYCIN W/SULFISOXAZOLE† (compare to Pediazole [®])		
IV drugs are not managed at this time.		

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		<i>Length of authorization: 28 days</i>
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
IV form of this medication not managed at this time	Zyvox® (linezolid) <i>QL = 56 tablets per 28 days</i>	

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) <i>Length of Authorization: Date of service only. No refills.</i>	
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		<i>Length of Authorization: Date of service only. No refills.</i>
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		

Anti-Infectives: Antifungals: Allylamines

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

Tinea capitis: 6 weeks

Tinea pedis/Tinea cruris/Tinea corporis: up to 250 mg/day for up to 1 month (30 tabs/month)

Other indications: 3 months

CRITERIA FOR APPROVAL

Terbinafine Tablets:

- 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 6 weeks.

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.

Lamisil Granules:

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

AND

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

AND

- The patient had a documented side effect, allergy, or treatment failure with Griseofulvin suspension

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 (<i>QL: 30 tab/month post PA approval</i>) Lamisil® (terbinafine) granules (<i>QL: 125 mg packet (1 or 2 per day depending on dose) 187.5 mg packet (1 per day) post PA approval</i>) Lamisil® tablets (terbinafine) (<i>QL: 30 tab/month post PA approval</i>)

Please Note: Griseofulvin suspension is available without restrictions or PA for treatment of *Tinea Capitis* infections.

Anti-Infectives: Antifungals: Azoles

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:

- Vfenid 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	
<i>Length of Authorization: Up to 3 months (see above)</i>	
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®)	itraconazole† (compare to Sporanox®) Sporanox® (itraconazole) VFend® (voriconazole) Diflucan®* (fluconazole) Nizoral®* (ketoconazole)
IV drugs are not managed at this time.	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	
<i>Length of Authorization: 1 year</i>	
Key: † Generic product	
PREFERRED DRUGS (No PA Required)	PA REQUIRED
	ciclopirox† 8 % solution (compare to Penlac [®] Nail Lacquer) (<i>QL=1 bottle (6.6 ml)/90 days</i>)
	Penlac [®] Nail Lacquer (ciclopirox 8 % solution) (<i>QL=1 bottle (6.6 ml)/90 days</i>)

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		<i>Length of Authorization: up to 6 months</i>
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®)		Famvir® (famciclovir) §
VALTREX® (valacyclovir)		famciclovir (compare to Famvir®)
		Zovirax®* (acyclovir) §

Anti-Infectives: Influenza Medications

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 <i>Length of Authorization: up to 6 weeks</i>	
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:

NOTE: Influenza Nasal Vaccine is provided free of charge and without PA for patients ages 2 – 18 by the Vermont Department of Health. Prescribers should contact the Vermont Department of Health for supply.

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

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 19 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		<i>Length of Authorization: up to 6 weeks</i>
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		<i>Length of Authorization: 1 year</i>
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		<i>Length of Authorization: for date of service, no refills</i>
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) <i>QL = 1 tube</i> Bactroban® Cream	

Anti-Migraine: Triptans

LENGTH OF AUTHORIZATION:

6 months

CRITERIA FOR APPROVAL:

Oral: Amerge, Frova, Relpax, Zomig:

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

Treximet:

- The patient had a documented side effect, allergy, or treatment failure with 2 preferred Triptans
AND
- The patient is unable to take the individual components (sumatriptan and naproxen) separately

Nasal Spray: Zomig:

- The patient has had a documented side-effect, allergy or treatment failure Imitrex[®] Nasal Spray.

Oral or Injection: Sumatriptan

- The patient has had a documented intolerance to brand 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
<p><u>SINGLE AGENT</u></p> <p><u>ORAL</u> AXERT[®] (almotriptan) <i>Quantity Limit = 6 tablets/month</i></p> <p>IMITREX[®] (sumatriptan) <i>Quantity Limit = 18 tablets/month (25 mg), 9 tablets/month (50 mg, 100 mg),</i></p> <p>MAXALT[®] (rizatriptan) tablet or MAXALT-MLT[®] (rizatriptan ODT) <i>Quantity Limit = 12 tablets/month</i></p> <p><u>NASAL SPRAY</u> IMITREX[®] (sumatriptan) <i>Quantity Limit = 12 units/month (5 mg nasal spray), 6 units/month (20 mg nasal spray)</i></p> <p><u>INJECTABLE</u> IMITREX[®] (sumatriptan) <i>Quantity Limit = 4 injections/month (4 or 6 mg injection)</i></p> <p><u>COMBINATION PRODUCT</u></p>	<p>Amerge[®] (naratriptan) <i>Quantity Limit = 9 tablets/month</i></p> <p>Frova[®] (frovatriptan) <i>Quantity Limit = 9 tablets/month</i></p> <p>Relpax[®] (eletriptan) <i>Quantity Limit = 12 tablets/month</i></p> <p>Sumatriptan† (compare to Imitrex[®]) <i>Quantity Limit = 18 tablets/month (25 mg), 9 tablets/month (50 mg, 100 mg),</i></p> <p>Zomig[®] (zolmitriptan) <i>Quantity Limit = 12 tablets/month (2.5 mg tablets or orally disintegrating tablets), 6 tablets/month (5 mg tablets or orally disintegrating tablets)</i></p> <p>Zomig[®] (zolmitriptan) <i>Quantity Limit =, 12 units/month (5 mg nasal spray)</i></p> <p>sumatriptan† (compare to Imitrex[®]) <i>Quantity Limit = 4 injections/month (4 or 6 mg injection)</i></p> <p>Treximet[®] (sumatriptan/naproxen) <i>Quantity Limit = 9 tablets/month</i></p>

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) $\geq 30\text{kg/m}^2$ **OR**
 - 2) $\geq 27\text{kg/m}^2$ 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:

<u>Alli,</u> <u>Xenical:</u>	Malabsorption syndrome, cholestasis, pregnant or lactating, hyperoxaluria, calcium oxalate nephrolithiasis
<u>Meridia:</u>	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
<u>Diethylpropion,</u> <u>Benzphetamine,</u> <u>Phendimetrazine,</u> <u>Phentermine:</u>	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 term 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) (<i>QL = 3 capsules/day</i>) benzphetamine† (all forms brand and generic) diethylpropion† (all forms brand & generic) Meridia [®] (sibutramine) phentermine† (all forms brand & generic) phendimetrazine† (all forms brand & generic) Xenical [®] (orlistat)

~ 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 for Clozaril[®], Risperidone and Seroquel 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 treatment failure with at least two preferred products.

Clozaril[®]:

- The patient has a documented intolerance to the generic equivalent (clozapine).

Risperidone:

- The patient has a documented intolerance to brand Risperdal[®].

Seroquel 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 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. (Note: samples are not considered adequate justification for stabilization.)
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. (Note: samples are not considered adequate justification for stabilization.)
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 121 for a description of the management of mental health drugs.

Antipsychotics: Atypical and Combination	
<i>Length of authorization: Duration of Need*</i>	
Key: † Generic product, *Indicates generic equivalent is available without a PA	
PREFERRED DRUGS (No PA Required)	PA REQUIRED
TABLETS/CAPSULES	
CLOZAPINE† (compare to Clozaril®) <i>FDA maximum recommended dose = 900 mg/day</i> GEODON® (ziprasidone) <i>FDA maximum recommended dose = 160 mg/day</i> RISPERDAL® (risperidone) <i>FDA maximum recommended dose = 16 mg/day</i> SEROQUEL® (quetiapine) <i>FDA maximum recommended dose = 800 mg/day</i>	Abilify® (aripiprazole) <i>FDA maximum recommended dose = 30 mg/day,</i> <i>Quantity limit = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)</i> Clozaril®* (clozapine) <i>FDA maximum recommended dose = 900 mg/day</i> Invega® (paliperidone) <i>FDA maximum recommended dose = 12 mg/day</i> <i>Quantity limit = 1 tab/day (3mg, 9mg), 2 tabs/day (6mg)</i> Risperidone† (compare to Risperdal®) <i>FDA maximum recommended dose = 16 mg/day</i> Seroquel XR® (quetiapine XR) <i>FDA maximum recommended dose = 800 mg/day</i> <i>Quantity Limit = 1 tab/day (200 mg tablet strength only)</i> Zyprexa® (olanzapine) <i>FDA maximum recommended dose = 20 mg/day,</i> <i>Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs)</i>
ORAL SOLUTIONS	
RISPERDAL® (risperidone) oral solution <i>FDA maximum recommended dose = 16 mg/day</i>	Abilify® (aripiprazole) oral solution <i>FDA maximum recommended dose = 25 mg/day</i>
SHORT-ACTING INJECTABLE PRODUCTS	
GEODON® IM (ziprasidone intramuscular injection) <i>FDA maximum recommended dose = 40 mg/day</i>	Abilify® IM (aripiprazole intramuscular injection) <i>FDA maximum recommended dose = 30 mg/day</i> Zyprexa® IM (olanzapine intramuscular injection) <i>FDA maximum recommended dose = 30 mg/day</i>
LONG-ACTING INJECTABLE PRODUCTS	
	Risperdal® Consta (risperdone microspheres) <i>FDA maximum recommended dose = 50 mg/14 days</i>
ORALLY DISINTEGRATING TABLETS	
	Abilify® Discmelt (aripiprazole) <i>FDA maximum recommended dose = 30 mg/day,</i> <i>Quantity limit = 1.5 tabs/day (10 mg & 15 mg tabs)</i> FazaClo® (clozapine orally disintegrating tablets) <i>FDA maximum recommended dose = 900 mg/day</i> Risperdal® M-Tab (risperidone orally disintegrating tablets) <i>FDA maximum recommended dose = 16 mg/day</i> Zyprexa Zydis® (olanzapine orally disintegrating tablets) <i>FDA maximum recommended dose = 20 mg/day,</i> <i>Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)</i>
COMBINATION PRODUCTS	
	Symbyax® (olanzapine/fluoxetine) <i>FDA maximum recommended dose = 18 mg/75 mg (perday)</i>

* 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 121 for a description of the management of mental health drugs.

Antipsychotics: Typical		<i>Length of authorization: Duration of need for mental health indication*s</i>
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	
<i>Length of Authorization: initial approval 3 months, subsequent approval up to 12 months</i>	
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		<i>Length of authorization: 1 year</i>
Key: † Generic product, *Indicates generic equivalent is available without a PA		
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
DOXAZOSIN† (compare to Cardura [®]) FLOMAX [®] (tamsulosin) TERAZOSIN† (compare to Hytrin [®]) UROXATRAL [®] (alfuzosin)	Cardura [®] * Cardura XL [®] Hytrin [®] *	

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) (<i>QL = 1 capsule/day</i>)	Avodart [®] (dutasteride) females; males age < 45 (<i>QL = 1 capsule/day</i>)
FINASTERIDE [†] (compare to Proscar [®]) (<i>QL = 1 tablet/day</i>)	finasteride [†] (compare to Proscar [®]) females; males age < 45 (<i>QL = 1 tablet/day</i>)
PROSCAR [®] (finasteride) (<i>QL = 1 tablet/day</i>)	Proscar [®] (finasteride) females; males age < 45 (<i>QL = 1 tablet/day</i>)

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[®]/Subutex[®] 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
<p>Alcohol Dependency ANTABUSE® (disulfiram) CAMPRAL® (acamprosate) NALTREXONE oral † (compare to Revia®)</p> <p>Opiate Dependency NALTREXONE oral † (compare to Revia®) Note: Methadone for opiate dependency may only be prescribed through a Methadone Maintenance Clinic</p>	<p>Revia®* (naltrexone oral) Vivitrol® (naltrexone for extended-release injectable suspension) (<i>QL = 1 injection (380 mg) per 30 days</i>)</p> <p>Revia®* (naltrexone oral) Suboxone® (buprenorphine/nalaxone) Subutex® (buprenorphine)</p>

~**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:	Beneficiary:
Name: _____	Name: _____
Phone #: _____	Medicaid ID #: _____
Fax #: _____	Date of Birth: _____ Sex: _____
Address: _____	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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the prescriber signing this form have a DATA 2000 waiver ID number ("X-DEA license")?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Request is for the following medication:	<input type="checkbox"/> Suboxone [®] (buprenorphine/naloxone) <input type="checkbox"/> Subutex [®] (buprenorphine)
Anticipated maintenance dose/frequency:	
Dose: _____	Frequency: _____
If this request is for Subutex [®] , please answer the following questions:	
Is the member pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, anticipated date of delivery: _____	
Does the member have a documented allergic reaction to naloxone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide medical records documenting the allergic reaction.	
Additional clinical information to support PA request:	

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

~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: _____
 Contact Person at Office: _____

Beneficiary:

 Name: _____
 Medicaid ID #: _____
 Date of Birth: _____ Sex: _____
 Diagnosis: _____

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the patient tried any of the following? Please document below. oral naltrexone: <input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy acamprosate: <input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy disulfiram: <input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has patient had a recent hospital admission for alcohol detoxification?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: ____/____/____
Has the patient been opiate free for > 7 – 10 days	<input type="checkbox"/> Yes <input type="checkbox"/> 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		<i>Length of Authorization: 3 months</i>
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) (<i>Qty limit = 2 caps/day</i>)	

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 classes: 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
<u>ORAL</u>	
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) (<i>QL = 3 tablets/day (500 mg), 2 tablets/day (1000 mg)</i>)
<u>TOPICAL</u>	
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		<i>Length of Authorization: date of service only, no refills</i>
Key: † Generic product		
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
All generics MUCINEX® (guaifenesin)	Tussionex® (hydrocodone/chlorpheniramine) (<i>QL = 60 ml</i>) All other brands	
PA required for Age < 2 years old for all products (brand and generic)	Age < 2 years old for all products (brand and generic)	

Dermatological Agents: Genital Wart Therapy

LENGTH OF AUTHORIZATION: up to 16 weeks

Veregen: up to 16 weeks

All other products: up to 1 month

CRITERIA FOR APPROVAL:

Condylox[®] gel, Veregan:

- 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 <i>Length of Authorization: up to 16 weeks</i>	
Key: † Generic product, *Indicates generic equivalent is available without a PA	
PREFERRED DRUGS (No PA Required)	PA REQUIRED
<p>ALDARA[®] (imiquimod)</p> <p>PODOFILOX SOLUTION† (compare to Condylox[®])</p>	<p>Condylox[®] Gel (podofilox gel) Condylox[®]* solution (podofilox solution)</p> <p>Veregan[®] (sinecatechins ointment) (<i>Quantity limit = 15 grams (1 tube)/per 30 days</i>)</p>

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 <i>Length of Authorization: date of service only, no refills</i>	
Key: † Generic product, *Indicates generic equivalent is available without a PA	
PREFERRED DRUGS (No PA Required)	PA REQUIRED
EURAX [®] (crotamiton) <i>C, L</i> NIX [®] (permethrin) <i>CR, G, Sp</i> PERMETHRIN† (compare to Elimite [®]) <i>C</i> PERMETHRIN† <i>L</i> PIPERONYL BUTOXIDE AND PYRETHRINS† <i>G, S, Sh</i> RID [®] (piperonyl butoxide and pyrethrins) <i>G, Sh, Sp</i> All other brand and generic Scabicides and Pediculicides	Elimite ^{®*} (permethrin 5 %) <i>C</i> Lindane† <i>L, Sh</i> Ovide [®] (malathion) <i>L</i>

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		<i>Length of Authorization: 2 years</i>
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		<i>Length of Authorization: 5 years</i>
PREFERRED PRODUCTS (No PA Required)	PA REQUIRED	
<p><u>DIABETIC MONITORS/METERS</u> 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</p> <p><u>DIABETIC TEST STRIPS</u> 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)</p>	<p>Accucheck[®] Ascensia[®] Assure[®] Exactech[®] Prodigy[®]</p> <p>All other brands and store brands</p> <p>Accucheck[®] Ascensia[®] Assure[®] Exactech[®] Prodigy[®]</p> <p>All other brands and store brands</p>	

* 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:

Cimzia[®], 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[®] and Cimzia have 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	
<i>Length of authorization: Initial PA of 3 months; 12 months thereafter</i>	
PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET
CIMZIA [®] (certolizumab pegol) HUMIRA [®] (adalimumab) REMICADE [®] (infliximab)	Tysabri [®] (natalizumab)

~ 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:	Beneficiary:
Name: _____	Name: _____
Phone #: _____	Medicaid ID #: _____
Fax #: _____	Date of Birth: _____ Sex: _____
Specialty: _____	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:

- Cimzia** _____ Strength & Frequency: _____ Length of therapy: _____
- 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	
<i>Length of Authorization: 1 year</i>	
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 §
<u>SYRUP & SPECIAL DOSAGE FORMS</u>	
CIMETIDINE † ORAL SOLUTION ZANTAC [®] (ranitidine) SYRUP	Axid [®] (nizatidine) Oral Solution § Pepcid [®] Oral Suspension § ranitidine† syrup§ Zantac Effervescent [®] §

Gastrointestinals: Proton Pump Inhibitors

LENGTH OF AUTHORIZATION: up to 1 year

CRITERIA FOR APPROVAL:

Nexium powder for suspension, Prevacid Solutabs (for patients ≥ 12 years old), Protonix packet, Zegerid powder for suspension (for patients ≥ 16 years old)

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

Other non-preferred medications:

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

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
<p><u>ORAL CAPULES/TABLETS</u></p> <p>PREVACID® (lansoprazole) capsules (<i>Quantity limit=1 cap/day</i>)</p> <p>PRILOSEC OTC® 20mg (omeprazole magnesium) tablets (<i>No Quantity limit applies</i>)</p> <p>PROTONIX® (pantoprazole) tablets (<i>Quantity limit=1 tab/day</i>)</p>	<p>Aciphex® (rabeprazole) tablets § (<i>Quantity limit=1 tab/day</i>)</p> <p>Nexium® (esomeprazole) capsules § (<i>Quantity limit=1 cap/day</i>)</p> <p>omeprazole †* generic RX capsules § (<i>Quantity limit=1 cap/day</i>)</p> <p>omeprazole †* generic OTC tablets § (<i>Quantity limit=1 tab/day</i>)</p> <p>pantoprazole † generic tablets (<i>Quantity limit=1 tab/day</i>)</p> <p>Prilosec® (<i>brand</i>) capsules § (<i>Quantity limit=1 cap/day</i>)</p> <p>Zegerid® (omeprazole) capsules § (<i>Quantity limit=1 cap/day</i>)</p>
<p><u>SUSPENSION & SPECIAL DOSAGE FORMS</u></p> <p>PREVACID® (lansoprazole) packets (<i>Quantity limit=1 packet/day</i>)</p> <p>PREVACID SOLUTABS®* (lansoprazole) (<i>Quantity limit=1 tab/day</i>)</p>	<p>Nexium® (esomeprazole) powder for suspension § (<i>Quantity limit=1 packet/day</i>)</p> <p>Protonix® (pantoprazole) packet (<i>Quantity limit=1 packet/day</i>)</p> <p>Zegerid®* (omeprazole) powder for suspension § (<i>Quantity limit=1 packet/day</i>)</p>
<p><u>COMBINATION</u></p> <p>PREVPAC® (lansoprazole w/ H.pylori anti-bacterials) (<i>No Quantity limit applies</i>)</p>	

*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	
<i>Length of authorization: Initial PA of 3 months; 12 months thereafter</i>	
PREFERRED AGENTS (No PA Required)	PA REQUIRED
	Remicade® (infliximab)

~ **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:	Beneficiary:
Name: _____	Name: _____
Phone #: _____	Medicaid ID #: _____
Fax #: _____	Date of Birth: _____ Sex: _____
Contact Person at Office: _____	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
<p><u>LOW POTENCY</u> ALCLOMETASONE† (compare to Aclovate®) DESONIDE† (formerly Tridesilon®) FLUOCINOLONE 0.01%† (formerly Synalar®) HYDROCORTISONE ACETATE† (all generics)</p>	<p>Aclovate®* Capex® Shampoo (fluocinolone) Desonate® gel (desonide) DesOwen®* Hytone®* Nucort® 2% lotion (hydrocortisone acetate) Verdeso® (desonide foam) All other brands</p>
<p><u>MEDIUM POTENCY</u> BETAMETHASONE DIPROPIONATE† (compare to Alphatrex®*) BETAMETHASONE VALERATE† (compare to Beta-Val®*) DESOXIMETASONE 0.05%† (compare to Topicort®) FLUOCINOLONE 0.025%† (formerly 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®)</p>	<p>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® Topicort® 0.05%* (all products) Westcort®* (all products) All other brands</p>
<p><u>HIGH POTENCY</u> AMCINONIDE† (formerly Cyclocort®) AUGMENTED BETHAMETHASONE CREAM† (compare to Diprolene® AF) DESOXIMETASONE 0.25%† (compare to Topicort®) DIFLORASONE DIACETATE† (compare to Apexicon®) FLUOCINOLONE 0.2%† (formerly Synalar®) FLUOCINONIDE† (compare to Lidex®)</p>	<p>Apexicon® Diprolene® AF* (all products) Halog® (all products) Lidex®* (all products) Topicort® 0.25%* (all products) Vanos® All other brands</p>
<p><u>VERY HIGH POTENCY</u> AUGMENTED BETHAMETHASONE OINT.† (compare to Diprolene®) CLOBETASOL PROPIONATE† (compare to Temovate®) CLOBETASOL PROPIONATE† FOAM (compare to Olux®) DIFLORASONE DIACETATE/EMOLL† (compare to Psorcon-E®) HALOBETASOL PROPIONATE† (compare to Ultravate®)</p>	<p>Clobex® Cormax® Diprolene®* (all products) Olux®/Olux E® Psorcon-E®* Temovate®* (all products) Ultravate®* (all products) All other brands</p>

Growth Stimulating Agents

NOTE: These drugs must be obtained and billed through our specialty pharmacy vendor, ICORE Healthcare. Please see Growth Stimulating Agents Prior Authorization/Enrollment Form for instructions.

GROWTH HORMONE

► See next pages 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.

LIMITATIONS:

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

GENOTROPIN[®], HUMATROPE[®], OMNITROPE[®], SAIZEN[®], TEV-TROPIN[®]

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

➤ **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.

➤ **SEROSTIM®**

INDICATION: AIDS associated wasting/anorexia

LENGTH OF AUTHORIZATION: 6 months

CRITERIA FOR APPROVAL:

- A diagnosis of AIDS associated wasting/anorexia

➤ **ZORBTIVE®**

INDICATION: Short Bowel Syndrome

LENGTH OF AUTHORIZATION: 4 weeks

CRITERIA FOR APPROVAL:

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

DOCUMENTATION:

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

Growth Stimulating Agents		<i>Length of Authorization: up to 1 year</i>
PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET	
NORDITROPIN® NUTROPIN®/NUTROPIN® AQ	Genotropin® Humatrope® Omnitrope® Saizen® Tev-Tropin® <u>Specialized Indications – See Specific Criteria</u> Increlex® (mecasermin) Serostim® Zorbtive®	



GROWTH STIMULATING AGENTS - Prior Authorization and Patient Enrollment Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____			
Street Address		City	
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian		Day Telephone	Night Telephone
Emergency Contact		Relationship	Telephone

2 PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address		City	
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	



Fax Completed Form to:
Fax Number: 866-364-2673
Phone Number: 800-327-1392

**3 Office of Vermont Health Access
 GROWTH STIMULATING AGENTS
 PRIOR AUTHORIZATION REQUEST**

Patient Diagnosis: _____

Requested OVHA **PREFERRED** Growth Stimulating Agent
 Norditropin® Nutropin® Nutropin® AQ

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:		

Please explain the medical necessity for a '**NON-PREFERRED**' product:
 Genotropin® Humatrope® Omnitrope® Saizen® Tev-Tropin®

Medical justification: _____

Request is for a '**SPECIALIZED INDICATION**' product: (Criteria in Clinical Criteria Manual)
 Increlex® Serostim® Zorbtive®

Other information/ Prescriber comments: _____

4 PRESCRIPTION

Norditropin® Nordiflex Norditropin® Cartridge Nutropin® Nutropin® AQ

Other Product: (Please Specify) _____

Dosage Form / Strength: _____

Dose/Route & Frequency (Sig): _____

Dispense Quantity: One month supply or _____ Refill X _____

Needles/syringes: quantity sufficient for drug supply with refills as above

Deliver product to: Patient's home MD office Clinic

Prescriber's Signature: _____ **Date:** _____



HEMOPHILIA FACTORS - Patient Enrollment and Prescription Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____			
Street Address		City	
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian		Day Telephone	Night Telephone
Emergency Contact		Relationship	Telephone

2 PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address		City	
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	



Fax Completed Form to:
Fax Number: 866-364-2673
Phone Number: 800-327-1392

3 Office of Vermont Health Access PRESCRIPTION HEMOPHILIA FACTORS

Patient Diagnosis:	
<input type="checkbox"/> Hemophilia A – Factor VIII Disease	
<input type="checkbox"/> Hemophilia B – Factor IX Disease	
<input type="checkbox"/> von Willebrand Disease	
Patient Weight (kg):	Native Factor Level:
Product Name:	
Dose / Frequency Instructions:	
# of doses ordered: _____ Refills: _____ If doses of different units are ordered, specific number of doses of each	
Reason(s) for Use:	
<input type="checkbox"/> Prophylaxis only <input type="checkbox"/> Episodic only <input type="checkbox"/> Prophylaxis and PRN	
<input type="checkbox"/> Acute Bleeding Episode <input type="checkbox"/> Surgical Prophylaxis <input type="checkbox"/> Dental Procedure	
Recent bleed while on Prophylaxis:	
Date of bleed: ____/____/____	
Location of bleed: _____ Severity of bleed: _____	
# of Doses already administered prior to this order: _____ IU/Dose: _____	
Deliver product to: <input type="checkbox"/> Patient's home <input type="checkbox"/> MD office <input type="checkbox"/> Clinic	
<input type="checkbox"/> Needles/syringes: quantity sufficient for factor supply	
Prescriber's Signature: _____	Date: _____

Hepatitis C Medications

NOTE: These drugs must be obtained and billed through our specialty pharmacy vendor, ICORE Healthcare. Please see Hepatitis C Prior Authorization/Enrollment Form for instructions.

LENGTH OF AUTHORIZATION: 6 months

CRITERIA FOR APPROVAL:

- The diagnosis or indication for the requested medication is Hepatitis.
- AND
- The prescriber is, or has consulted with, a Hepatologist, Gastroenterologist, or Infectious Disease Specialist.

AND

Non-preferred Ribavirin Brands/Strengths

- The patient has a documented intolerance to generic ribavirin 200 mg tablets or capsules.

Rebetol® Oral Solution

- The patient is unable to use generic ribavirin 200 mg tablets or capsules

Peg-Intron® or Infergen®

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

DOCUMENTATION:

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

Hepatitis C Medications		<i>Length of Authorization: 6 months</i>
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	
<u>RIBAVIRIN</u>		
Tablets/Capsules RIBAVIRIN† 200 mg tablets or capsules	Copegus®* (ribavirin 200 mg tablet) Ribapak® 400 mg/600 mg Dose Pack (ribavirin) Rebetol®* (ribavirin 200 mg capsule)	
Oral Solution	All other strengths/brands of ribavirin tablets/capsules Rebetol® (ribavirin 40 mg/ml) oral solution	
<u>INTERFERON</u>		
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)	



HEPATITIS C MEDICATIONS - Prior Authorization and Patient Enrollment Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION			
Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA <u>or</u>			
Street Address			City
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian		Day Telephone	Night Telephone
Emergency Contact		Relationship	Telephone

2 PRESCRIBER INFORMATION			
Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address			City
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	



Fax Completed Form to:
Fax Number: 866-364-2673
Phone Number: 800-327-1392

3 Office of Vermont Health Access HEPATITIS C MEDICATIONS PRIOR AUTHORIZATION REQUEST

Patient Diagnosis: _____
If requesting prescriber is not a Hepatologist, Gastroenterologist or ID Specialist, has one of these specialties been consulted on this case? <input type="checkbox"/> Yes <input type="checkbox"/> No
Specialist name: _____ Specialist Type: _____
Requested OVHA PREFERRED Oral Hepatitis C Product? <input type="checkbox"/> Ribavirin 200 mg Tab (compare to Copegus®) <input type="checkbox"/> Ribavirin 200 mg Cap (compare to Rebetol®)
For any OVHA NON-PREFERRED Oral Hepatitis C Product or Strength, please explain the medical necessity for this product: Product: _____ Medical justification: _____
Requested OVHA PREFERRED Injectable Hepatitis C Product? <input type="checkbox"/> Pegasys® Prefilled Syringe <input type="checkbox"/> Pegasys® Single Dose Vial
For any OVHA NON-PREFERRED Injectable Hepatitis C Product, please explain the medical necessity for this product: Product: _____ Medical justification: _____

4 PRESCRIPTION

Oral: <input type="checkbox"/> Ribavirin 200 mg <input type="checkbox"/> Tablet <u>or</u> <input type="checkbox"/> Capsule <input type="checkbox"/> Other (Specify): _____ Dose: _____ Frequency: _____ Qty: <u>28 days supply</u> Refill X: _____
Injectable: <input type="checkbox"/> Pegasys® Prefilled Syringe 180 mcg/0.5 ml "Convenience Kit" (4 syringes/box) <u>or</u> <input type="checkbox"/> Pegasys® 180 mcg/1 ml Single Dose Vial <u>or</u> <input type="checkbox"/> Other (choose): <input type="checkbox"/> PEG-Intron® RediPen <input type="checkbox"/> PEG-Intron® Kit <input type="checkbox"/> Infergen® Specify Strength of above: _____
Sig: Dose/Route/Frequency: _____ Dispense Quantity: <u>28 days supply</u> Refill X: _____
<input type="checkbox"/> Needles/syringes: quantity sufficient for drug supply with refills as above
Deliver product to: <input type="checkbox"/> Patient's home <input type="checkbox"/> MD office <input type="checkbox"/> Clinic
Prescriber's Signature: _____ Date: _____

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		<i>Length of Authorization: up to 1 year</i>
§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)		
NO PA REQUIRED <i>(For age > 2 after prerequisite trial of one topical corticosteroid)</i>	PA REQUIRED	
ELIDEL[®] Cream (pimecrolimus) § <i>(Quantity Limit = 30 grams/fill and 90 grams/6 months)</i> PROTOPIC[®] Ointment (tacrolimus) § <i>(Quantity Limit = 30 grams/fill and 90 grams/6 months)</i> Note: Protopic ointment concentration limited to 0.03% for age < 16 years old.	Elidel[®] Cream (pimecrolimus) age < 2 years <i>(Quantity Limit = 30 grams/fill and 90 grams/6 months)</i> Protopic[®] Ointment (tacrolimus) age < 2 years <i>(Quantity Limit = 30 grams/fill and 90 grams/6 months)</i> 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		<i>Length of Authorization: lifetime</i>
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: 3 months initially, then 1 year

CRITERIA FOR APPROVAL:

Lopid[®]*

- The patient has had a documented intolerance to generic 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, fenofibrate micronized, Fenoglide[®], Lipofen[®], Lofibra[®] and Triglide[®]

- 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		<i>Length of Authorization: 3 months initially, then 1 year if response shown.</i>
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 [®]) 600 mg ♦TRICOR [®] (fenofibrate) § 48 mg, 145 mg ♦ <i>PA required if patient not on concurrent statin</i>	Antara [®] (fenofibrate micronized) § 43 mg, 130 mg fenofibrate† § 54 mg fenofibrate micronized† § 67 mg, 134 mg, 200 mg Fenoglide [®] (fenofibrate) § 40 mg, 120 mg Lipofen [®] (fenofibrate) § 50 mg, 150 mg Lofibra [®] (fenofibrate micronized) Capsules § 67mg, 134 mg, 200 mg Lofibra [®] (fenofibrate) Tablets § 54 mg, 160 mg Lopid [®] * (gemfibrozil) § 600 mg Triglide [®] (fenofibrate) § 50 mg, 160 mg	

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

Altprev[®], 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		<i>Length of Authorization: 1 year</i>
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	
<u>HIGH POTENCY STATINS</u>		
SIMVASTATIN† (compare to Zocor [®]) (QL = 1 tablet/day)	Lipitor [®] (atorvastatin) (QL = 1 tablet/day) Zocor [®] * (simvastatin) (QL = 1 tablet/day)	
CRESTOR [®] (rosuvastatin calcium) § AFTER GENERIC SIMVASTATIN TRIAL (QL = 1 tablet/day)		
<u>OTHER STATINS</u>		
LOVASTATIN† (compare to Mevacor [®]) (QL = 1 tab/day (10 & 20 mg), 2 tab/day (40 mg))	Altprev [®] (aka: Altacor [®]) (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)	
PRAVASTATIN† (compare to Pravachol [®]) (QL = 1 tablet/day (10 & 20 mg), 2 tab/day (40 mg))		

Note: Please refer to “Lipotropics: Miscellaneous/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		<i>Length of Authorization: 1 year</i>
§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)		
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
<u>MISCELLANEOUS</u>		
	Lovaza [®] (omega-3-acid ethyl esters)	
<u>CHOLESTEROL ABSORPTION INHIBITORS/COMBINATIONS</u>		
ZETIA [®] (ezetimibe) § (AFTER CLINICAL CRITERIA ARE MET) (Qty Limit = 1 tablet/day)	Vytorin [®] (ezetimibe/simvastatin) (QL = 1 tablet/day)	
<u>OTHER STATIN COMBINATIONS</u>		
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
- SNRI Antidepressants
- Miscellaneous Antidepressants
- Tricyclic and MAOI Antidepressants
- Atypical Antipsychotics
- Typical Antipsychotics
- Mood Stabilizers (including some anticonvulsants)
- CNS Stimulants/ADD/ADHD Drugs (Antihyperkinesis medications)
- Sedative Hypnotics
- Anxiolytics

3. The PDL also may include FDA maximum recommended adult daily doses.

With some exceptions, prior authorization will be required if FDA maximum recommended daily doses are exceeded by 25%. These FDA maximum recommended daily doses 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 above these doses.

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: Arcalyst® (Cryopyrin-Associated Periodic Syndromes (CAPS) Injectable)

LENGTH OF AUTHORIZATION: 1 year

CLINICAL CONSIDERATIONS:

How supplied: 220 mg vials (160 mg reconstituted)

Dose (Adult): 320 mg (2 vials) subcutaneous loading dose, then 160 mg (1 vial) subcutaneous every week

CRITERIA FOR APPROVAL:

- The diagnosis or indication for the requested medication is Familial Cold Autoinflammatory Syndrome (FCAS) in patients > 12 years of age

OR

- The diagnosis or indication for the requested medication is Muckle-Wells Syndrome (MWS) in patients > 12 years of age

Note: Medical Records to support the above diagnosis must accompany the Prior Authorization Request.

DOCUMENTATION:

- ✓ Document clinically compelling information supporting the choice of Arcalyst® on a **General Prior Authorization Form.**

This drug must be billed through the OVHA POS prescription processing system using NDC values.

J codes will NOT be accepted in the Medical Benefit.

ARCALYST®		<i>Length of Authorization: 1 year</i>
NO PA REQUIRED	PA REQUIRED	
		Arcalyst® (rilonacept) (QL = 2 vials for loading dose, then 1 vial per week)

Miscellaneous: Elaprase® (Hunter's Syndrome Injectable)

NOTE: Elaprase® must be obtained and billed through our specialty pharmacy vendor, ICORE Healthcare. Please see General Specialty Prior Authorization/Patient Enrollment Form for instructions.

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 Elaprase® on a **General Specialty Prior Authorization/Patient Enrollment Form.**

This drug must be billed through the OVHA POS prescription processing system using NDC values by our specialty pharmacy vendor, ICORE Healthcare.

J code (J1743) will NOT be accepted in the Medical Benefit.

ELAPRASE®		<i>Length of Authorization: 1 year</i>
NO PA REQUIRED		PA REQUIRED
		Elaprase® (idursulfase) (<i>QL = calculated weekly dose</i>)

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®		<i>Length of Authorization: 1 year</i>
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))

Multiple Sclerosis: Injectables

NOTE: Multiple Sclerosis Self-Injectables (Avonex[®], Betaseron[®], Copaxone[®] and Rebif[®]) must be obtained and billed through our specialty pharmacy vendor, ICORE Healthcare. Please see Multiple Sclerosis Patient Enrollment/Order Form for instructions. ICORE Healthcare will not be supplying Tysabri[®] at this time – please continue to obtain through your usual supplier.

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 Tysabri[®] on a **General Prior Authorization Request Form**.

Multiple Sclerosis: Injectables	
<i>Length of authorization: Initial PA of 3 months; 12 months thereafter</i>	
PREFERRED DRUGS (No PA Required)	PA REQUIRED
<p><u>Interferons</u> AVONEX[®] (interferon beta-1a) BETASERON[®] (interferon beta-1b) REBIF[®] (interferon beta-1a)</p> <p><u>Other</u> COPAXONE[®] (glatiramer) (<i>QL = 1 kit/30 days</i>)</p>	<p>Tysabri[®] (natalizumab)</p>



MULTIPLE SCLEROSIS SELF INJECTABLES - Patient Enrollment/Order Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____			
Street Address			City
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian		Day Telephone	Night Telephone
Emergency Contact		Relationship	Telephone

2 PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address			City
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	



Fax Completed Form to:
Fax Number: 866-364-2673
Phone Number: 800-327-1392

**3 Office of Vermont Health Access
PRESCRIPTION
MULTIPLE SCLEROSIS SELF INJECTABLES**

Patient Diagnosis: _____

- Product:**
- Avonex 30 mcg/0.5 ml Prefilled Syringe (4 per box)
 - Avonex 30 mcg Kit (Single Dose Vials) (4 per box)
 - Betaseron 0.3 mg Prefilled Syringe
 - Copaxone 20 mg Prefilled Syringe (30 per kit)
 - Rebif Titration Pack X 1 (**Therapy initiation ONLY-No Refills**)
(contains 6 - 8.8 mcg and 6 - 22 mcg Prefilled Syringes)
 - Rebif 22 mcg/0.5 ml Prefilled Syringes
 - Rebif 44 mcg/0.5 ml Prefilled Syringes
- (Please Note: This form not to be used for Tysabri PA request or ordering)

Quantity: _____ **Refills:** _____

Dose / Route/ Frequency Instructions (Sig): _____

- Deliver product to: Patient's home MD office Clinic
- Needles/syringes: quantity sufficient for drug supply with refills as above

Prescriber's Signature: _____ **Date:** _____

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 $\leq 18.5 \text{ kg/m}^2$

Elderly: (≥ 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)		<i>Length of authorization: 6 months</i>
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
	<p>All</p> <p>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</p>	

~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.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree
Requested nutritional supplement will be taken by <u>mouth</u> (not administered via tube feeding)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oral nutritional supplement is being requested due to:	<input type="checkbox"/> Unplanned weight loss (see complete definition by age in clinical criteria manual) <input type="checkbox"/> 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: <ul style="list-style-type: none"> ▪ Increased metabolic need resulting from severe trauma (i.e.: burns, infection, major bone fractures) ▪ Malabsorption syndrome (as related to cystic fibrosis, renal disease, short gut syndrome, Crohn's disease and other unspecified disorders of the gut) ▪ Nutritional wasting due to chronic disease (i.e.: cancer, AIDS, conditions resulting in dysphagia, pulmonary insufficiency, renal disease) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No

<ul style="list-style-type: none"> ▪ Other: Explain: _____ _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> 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		<i>Length of Authorization: 1 year</i>
Key: † Generic product.		
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
<p>KETOTIFEN 0.025 % (eg. Alaway[®], Zaditor[®] OTC, others) (<i>QL = 1 bottle/month</i>)</p> <p>After trial of ketotifen 0.025 %</p> <p>ELESTAT[®] (epinastine) (<i>QL = 1 bottle/month</i>) PATADAY (olopatadine 0.2%)/PATANOL[®] (olopatadine 0.1%) (<i>QL = 1 bottle/month</i>)</p>	<p>Emadine[®] (emedastine) (<i>QL = 2 bottles/month</i>) Optivar[®] (azelastine) (<i>QL = 1 bottle/month</i>) Zaditor[®] RX (ketotifen 0.025 %) (<i>QL = 1 bottle/month</i>)</p>	

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 anhydrase 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 anhydrase 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 anhydrase 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
<p><u>ALPHA 2 ADRENERGIC</u></p>	
<p><u>Single Agent</u> ALPHAGAN P[®] (brimonidine tartrate) BRIMONIDINE TARTRATE† (compare to Alphagan[®])</p>	<p>Iopidine[®] (no PA required for patients ≤ 10 years of age)</p>
<p><u>Combination</u> COMBIGAN[®] (brimonidine tartrate/timolol maleate)</p>	
<p><u>BETA BLOCKERS</u></p>	
<p>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[®])</p>	<p>Betagan[®]* Betimol[®] Istalol[®]* Optipranolol[®]* Timoptic[®]* Timoptic XE[®]*</p>
<p><u>PROSTAGLANDIN INHIBITORS</u></p>	
<p><i>NOTE: COVERAGE OF A 'PREFERRED' PI AGENT IS CONTINGENT UPON A 1ST-LINE TRIAL OF ANY OTHER PREFERRED BETA-BLOCKER, A-2 ADRENERGIC OR CAI AGENT. COVERAGE OF A 'NON-PREFERRED' PI AGENT IS CONTINGENT UPON A SIMILAR FIRST-LINE TRIAL <u>AS WELL AS</u> A FAILED TRIAL OF BOTH LUMIGAN AND TRAVATAN/TRAVATAN Z.</i></p>	
<p>LUMIGAN[®] (bimatoprost) § TRAVATAN[®]/TRAVATAN Z[®] (travoprost) §</p>	<p>Xalatan[®]</p>
<p><u>CARBONIC ANHYDROUS INHIBITORS</u></p>	
<p><u>Single Agent</u> DORZOLAMIDE 2 % (compare to Trusopt[®])</p>	<p>Azopt[®] (brinzolamide 1%) Trusopt[®]* (dorzolamide 2 %)</p>
<p><u>Combination</u> DORZOLAMIDE w/TIMOLOL (compare to Cosopt[®])</p>	<p>Cosopt[®]* (dorzolamide w/timolol)</p>
<p><u>MISCELLANEOUS</u></p>	
<p>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)</p>	<p>Miochol-E[®] Miostat[®] Pilocar[®]* Propine[®]*</p>

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		<i>Length of Authorization: 1 year</i>
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**.

Ophthalmic: NSAIDs		<i>Length of Authorization: 1 year</i>
Key: † Generic product, *Indicates generic equivalent is available without a PA		
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
ACULAR [®] (ketorolac 0.5% ophthalmic sol.)	Diclofenac† 0.1% ophthalmic sol (compare to Voltaren [®])	
ACULAR LS [®] (ketorolac 0.4% ophthalmic sol.)	Nevanac [®] ophthalmic susp. (nepafenac 0.1%)	
ACULAR [®] PF (ketorolac 0.5% ophthalmic sol.)	Xibrom [®] ophthalmic sol. (bromfenac 0.09%)	
FLURBIPROFEN 0.03% ophthalmic sol. †	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	
<i>Length of Authorization: for date of service, no refills</i>	
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 Ocuflor®)	Ciloxan®* Iquix® (levofloxacin 1.5 %) (preservative free) Ocuflor®* Quixin® (levofloxacin 0.5 %) Vigamox® (moxifloxacin) (preservative free) Zymar® (gatifloxacin)

Ossification Enhancing Agents

LENGTH OF AUTHORIZATION: lifetime

CRITERIA FOR APPROVAL:

Actonel[®], Actonel[®] w/calcium, Fosamax Plus D[®]:

- The patient has had a documented side effect, allergy, or treatment failure (to at least a six-month trial) of Boniva[®] or alendronate[®].

Fosamax[®] Tablet:

- The patient has had a documented intolerance to generic alendronate.

Fosamax[®] Oral Solution:

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

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 alendronate.

Forteo[®]:

- The patient has a diagnosis/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 a preferred bisphosphonate. Treatment failure is defined as documented continued bone loss after two or more years despite treatment with a preferred 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		<i>Length of Authorization: lifetime</i>
Key: † Generic product,		
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
<u>ORAL BISPHOSPHONATE</u>		
TABLETS/CAPSULES		
ALENDRONATE† (compare to Fosamax®)		
BONIVA® (ibandronate) (<i>Quantity Limit = 150 mg tablet/1 tablet per 28 days, 2.5 mg tablet – no QL</i>)		
ORAL SOLUTION		
<u>INJECTABLE BISPHOSPHONATE</u>		
<u>CALCITONIN NASAL SPRAY</u>		
FORTICAL® (calcitonin)		
MIACALCIN® (calcitonin)		
<u>PARATHYROID HORMONE INJECTION</u>		
Forteo® (teriparatide) (<i>Quantity Limit = 1 pen (3 ml)/28 days</i>)		

~ **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: _____ 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)?
(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)

<i>Drug:</i>	<i>Response:</i>
<input type="checkbox"/> Boniva Oral	<input type="checkbox"/> side-effect <input type="checkbox"/> treatment failure* dates of use: _____
<input type="checkbox"/> Fosamax Oral	<input type="checkbox"/> side-effect <input type="checkbox"/> 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		<i>Length of Authorization: 1 year</i>
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	
NEOMYCIN/POLYMYXIN B SULFATE/HYDROCORTISONE†	Coly-Mycin S [®] /Cortisporin TC [®] (neomycin/colistin/thonzium/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, Parcopa[®], Parlodel[®], Requip[®], Eldepryl[®], Symmetrel[®]

- The patient has had a documented intolerance to 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.

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
<p><u>DOPAMINE PRECURSOR</u> CARBIDOPA/LEVODOPA† (compare to Sinemet®) CARBIDOPA/LEVODOPA† ER (compare to Sinemet® CR) CARBIDOPA/LEVODOPA† ODT (compare to Parcopa®)</p>	<p>Parcopa®* (carbidopa/levodopa ODT) Sinemet®* (carbidopa/levodopa) Sinemet CR®* (carbidopa/levodopa ER)</p>
<p><u>DOPAMINE AGONISTS (ORAL)</u> BROMOCRIPTINE† (compare to Parlodel®) MIRAPEX® (pramipexole) ROPINIROLE† (compare to Requip®)</p> <p><u>DOPAMINE AGONISTS (TRANSDERMAL)</u></p>	<p>Parlodel®* (bromocriptine) Requip®* (ropinirole)</p> <p>Neupro® Patch (rotigotine transdermal) <i>(QL = 1 patch/day)</i></p>
<p><u>COMT INHIBITORS</u> TASMAR® (tolcapone) COMTAN® (entacapone)</p>	
<p><u>MAO-B INHIBITORS</u> SELEGILINE† (compare to Eldepryl®)</p>	<p>Azilect® (rasagiline) <i>(QL = 1 mg/day)</i> Eldepryl®* (selegiline) Zelapar® (selegiline ODT) <i>(QL = 2.5 mg/day)</i></p>
<p><u>OTHER</u> AMANTADINE† (compare to Symmetrel®) STALEVO® (carbidopa/levodopa/entacapone)</p>	<p>Symmetrel®* (amantadine)</p>

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		<i>Length of Authorization: 1 year</i>
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
	Revatio® (sildenafil citrate) (<i>Quantity Limit = 3 tabs/day</i>) Viagra® (sildenafil citrate) (<i>Quantity Limit = 3 tabs/day</i>)	

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		<i>Length of Authorization: 3 years</i>
Key: † Generic product, *Indicates generic equivalent is available without a PA		
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
<u>AGGREGATION INHIBITORS</u>		
CILOSTAZOL† (compare to Pletal [®])	Pletal [®] *	
CLOPIDOGREL† (compare to Plavix [®])	Ticlid [®] *	
PLAVIX [®] (clopidogrel bisulfate)		
TICLOPIDINE† (compare to Ticlid [®])		
<u>OTHER</u>		
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	
<i>Length of authorization: Initial PA of 3 months; 12 months thereafter</i>	
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)

~ 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:

Dovonex Solution

- The patient has a documented intolerance to the generic product.

Taclonex Ointment or Scalp Suspension

- The patient has had an inadequate response to a 24 month trial of a betamethasone dipropionate product and Dovonex (or generic calcipotriene), 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		<i>Length of Authorization: 1 year</i>
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		
CALCIPOTRIENE† Solution (compare to Dovonex [®]) DOVONEX [®] (calcipotriene cream/ointment) PSORiatec [®] , DRITHO-SCALP [®] (anthralin cream) TAZORAC [®] (tazarotene cream, gel)	Dovonex ^{®*} Solution (calcipotriene) Taclonex [®] (calcipotriene/betamethasone ointment/scalp suspension) <i>(QL for initial fill = 60 grams)</i>	

Pulmonary: Anticholinergics

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Duoneb Nebulizer

- The patient has a documented intolerance to generic ipratropium/albuterol nebulizer..

DOCUMENTATION:

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

Anticholinergics		<i>Length of Authorization: 1 year</i>
Key: † Generic product, *Indicates generic equivalent is available without a PA		
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
<u>METERED DOSE INHALER (SINGLE AGENT)</u>		
ATROVENT HFA [®] (ipratropium)		
SPIRIVA [®] (tiotropium)		
<u>NEBULIZER (SINGLE AGENT)</u>		
IPRATROPIUM SOLN FOR INHALATION		
<u>METERED DOSE INHALER (COMBINATION)</u>		
COMBIVENT [®] (ipratropium/albuterol)		
<u>NEBULIZER (COMBINATION)</u>		
IPRATROPIUM/ALBUTEROL† (compare to Duoneb [®])		Duoneb ^{®*} (ipratropium/albuterol)

Pulmonary: Antihistamines: Intranasal

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

ASTELIN, PATANASE

- 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) **OR** cetirizine (OTC) **AND** a preferred nasal glucocorticoid.

DOCUMENTATION:

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

Pulmonary: Antihistamines: Intranasal		<i>Length of Authorization: 1 year</i>
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
	Astelin [®] (azelastine) Nasal Spray <i>Quantity Limit = 1 bottle (30 ml)/25 days</i>	
	Patanase [®] (olopatadine 0.6%) Nasal Spray <i>Quantity Limit = 1 bottle (31 gm)/30 days</i>	

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		<i>Length of Authorization: 1 year</i>
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 CHEWABLE TABLETS, 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) rapidly disintegrating 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) rapidly disintegrating tablet (RDT)	Allegra ODT [®] § Certirizine † Chewable Tablets Clarinex Reditabs [®] § Claritin Chewable Tablets [®] § 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.
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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.**

~ 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: _____

Medication must be billed through the pharmacy benefit (NO J codes (J2357) accepted in medical benefit)

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
<u>METERED-DOSE INHALERS (SHORT-ACTING)</u>	
XOPENEX [®] HFA (levalbuterol)	♣albuterol MDI † Alupent [®] (metaproterenol) Maxair [®] Autohaler (pirbuterol) ♣Proair [®] HFA (albuterol) ♣Proventil [®] HFA (albuterol) ♣Ventolin [®] HFA (albuterol) ♣coverage grandfathered for current users
<u>METERED-DOSE INHALERS (LONG-ACTING)</u>	
SEREVENT [®] DISKUS (salmeterol) (after criteria for LABA are met) FORADIL [®] (formoterol) (after criteria for LABA are met)	
<u>NEBULIZER SOLUTIONS (SHORT-ACTING)</u>	
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)
<u>NEBULIZER SOLUTIONS (LONG-ACTING)</u>	
	Brovana [®] (arformoterol) QL = 2 vial/day Perforomist [®] (formoterol) QL = 2 vial/day
<u>TABLETS/SYRUP (SHORT-ACTING)</u>	
TERBUTALINE tablets † (compare to Brethine [®]) ALBUTEROL tablets/syrup † METAPROTERENOL tablets/syrup †	Brethine ^{®*} (terbutaline)
<u>TABLETS (LONG-ACTING)</u>	
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 stabilized on the medication.
- OR**
- The patient has had a documented side effect, allergy, or treatment failure to at least two preferred agents.

Budesonide Inh Suspension (age > 12 yrs):

- The patient has been started and stabilized on the medication.
- OR**
- The patient requires a nebulizer formulation.

Pulmicort Respules® (any age):

- The patient has a documented intolerance to the generic formulation
- AND**
- 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 Glucocorticoids/Combinations		<i>Length of Authorization: 5 years</i>
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	
<u>METERED-DOSE INHALERS (SINGLE AGENT)</u>		
ASMANEX® 220 mcg/inh (mometasone furoate) <i>(QL = 0.72 gm (3 inhalers)/90 days)</i> ASMANEX® 110 mcg/inh (mometasone furoate) <i>(QL = 0.405 gm (3 inhalers)/90 days)</i> AZMACORT® (triamcinolone acetonide) FLOVENT DISKUS® (fluticasone propionate) FLOVENT HFA® (fluticasone propionate) <i>(QL = 36 gm (3 inhalers)/90 days)</i> PULMICORT FLEXHALER® (budesonide)	Aerobid® (flunisolide) § Aerobid M® (flunisolide/menthol) § QVAR® (beclomethasone)	
<u>METERED-DOSE INHALERS (COMBINATION PRODUCT)</u>		
ADVAIR® DISKUS (fluticasone/salmeterol) ADVAIR® HFA (fluticasone/salmeterol) SYMBICORT® (budesonide/formoterol) <i>(QL = 30.6 gm (3 inhalers)/90 days)</i>		
<u>NEBULIZER SOLUTIONS</u>		
BUDESONIDE INH SUSPENSION (compare to Pulmicort Respules®) (age ≤ 12 yrs)	Budesonide Inh Suspension (compare to Pulmicort Respules®) (age > 12 years) Pulmicort Respules® (budesonide)	

Pulmonary: Nasal Glucocorticoids

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Beconase AQ[®], Flonase[®], Flunisolide 25 mcg/spray, Flunisolide 29 mcg/spray, Nasarel[®], Omnaris[®], Rhinocort Aqua[®], Veramyst[®]:

- The patient has had a documented side effect, allergy, or treatment failure to all three preferred nasal glucocorticoids. If a product has an AB rated generic, the generic must additionally be tried before approval of the brand.

DOCUMENTATION:

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

Nasal Glucocorticoids		<i>Length of Authorization: 1 year</i>
Key: † Generic product		
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
FLUTICASONE Propionate† (compare to Flonase [®]) <i>QL = 16 gm (1 inhaler)/30 days</i>	Beconase AQ [®] (beclomethasone) <i>QL = 50 gm (2 inhalers)/30 days</i>	
NASACORT AQ [®] (triamcinolone) <i>QL = 16.5 gm (1 inhaler)/30 days</i>	Flonase ^{®*} (fluticasone propionate) <i>QL = 16 gm (1 inhaler)/30 days</i>	
NASONEX [®] (mometasone) <i>QL = 17 gm (1 inhaler)/30 days</i>	flunisolide † 25 mcg/spray (previously Nasalide [®]) <i>QL = 50 ml (2 inhalers)/30 days</i>	
	flunisolide† 29 mcg/spray (compare to Nasarel [®]) <i>QL = 50 ml (2 inhalers)/30 days</i>	
	Nasarel [®] (flunisolide 29 mcg/spray) <i>QL = 50 ml (2 inhalers)/30 days</i>	
	Omnaris [®] (ciclesonide) <i>QL = 12.5 gm (1 inhaler)/30 days</i>	
	Rhinocort Aqua [®] (budesonide) <i>QL = 8.6 gm (1 inhaler)/30 days</i>	
	Veramyst [®] (fluticasone furoate) <i>QL = 10 gm (1 inhaler)/30 days</i>	

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		<i>Length of authorizations: 1 year</i>
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®*	
	Veripred® 20 oral solution (prednisolone sodium phosphate)	

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 <i>Length of Authorization: 1 year</i>	
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®

NOTE: Synagis® must be obtained and billed through our specialty pharmacy vendor for Synagis®, Wilcox Home Infusion. Please see Synagis Prior Authorization/Enrollment Form for instructions.

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 obtained and billed through our specialty pharmacy vendor for Synagis®, Wilcox Home Infusion, and processed through the OVHA POS prescription processing system using NDC values. Under no circumstances will claims processed through the medical benefit be accepted.

DOCUMENTATION:

Document clinically compelling information supporting the use of Synagis on the **Synagis® Prior Authorization/Patient Enrollment Form**.



Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name		First Name		Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #		
Allergies: <input type="checkbox"/> NKA or _____				
Street Address			City	
State	County	Zip Code		
Parent/Guardian		Day Telephone	Night Telephone	
Emergency Contact		Relationship	Telephone	

2 PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address		City	
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	
Supervising Physician's Name (If Required for Mid-Level Practitioner)		NPI Number	

Wilcox Home Infusion
250 Stratton Road
Rutland, Vermont 05701
Last Updated 10/2008

Fax Completed Form to:
Fax Number: 802-775-7824 ☎
Phone Number: 800-639-1210 ☎



3 Office of Vermont Health Access PRIOR AUTHORIZATION REQUEST SYNAGIS® (PALIVIZUMAB)

weeks:	days:	kg:	15mg/kg=	mg
Gestational Age		Current Weight	Dose	
Diagnosis		Pharmacy	Phone	Fax
<input type="checkbox"/> Infants born at 28 weeks of gestation or earlier (i.e., ≤ 28 weeks, 6 days) and under 12 months of age at the start of the RSV season.				
<input type="checkbox"/> 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.				
<input type="checkbox"/> 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 the RSV season (November 1) who have two of the following risk factors:				
<input type="checkbox"/> Child care attendance <input type="checkbox"/> School-aged siblings <input type="checkbox"/> Congenital abnormalities of the airways <input type="checkbox"/> Severe Neuromuscular Disease <input type="checkbox"/> 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)				
<input type="checkbox"/> 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.				
<input type="checkbox"/> Treatment: _____ <input type="checkbox"/> Dates of Use: _____				
<input type="checkbox"/> Children under 24 months of age with hemodynamically significant cyanotic or acyanotic heart disease:				
<input type="checkbox"/> Currently receiving medication to control heart failure <input type="checkbox"/> Having moderate to severe pulmonary hypertension <input type="checkbox"/> Having cyanotic heart disease				
<input type="checkbox"/> Other: _____				

NICU HISTORY

Did the patient spend time in the NICU?
 Yes No (If yes, please attach the NICU summary)

Was RSV prophylaxis recommended by the NICU/Hospital physician for this patient?
 Yes No

Was a NICU/Hospital /Clinic dose administered?
 Yes, Date(s): _____ No

4 PRESCRIPTION

Synagis (palivizumab) 50 and/or 100 mg vials and supplies for administration.
 Sig: Inject 15 mg/kg IM once every 4 weeks; expected date of first home injection: _____
 Dispense Quantity: Quantity sufficient for prophylaxis thru 04/09
 Deliver product to: MD office Patient's home Clinic
 Home health nurse to administer injection Home Health Agency: _____
 If delivery is to clinic, please give location: _____
 Pediatric Anaphylaxis: Administer 0.01 ml/kg (max 0.3ml) of 1:1000 epinephrine solution subcutaneously or intramuscularly, and contact EMS or physician, as appropriate.
 Other: _____
 Sig: _____
 Physician will monitor patient's response to therapy. Any complications in therapy will be reported to the physician either by the patient's caregiver, or the skilled nursing service (If other than physician's office or Wilcox Home Infusion)

Prescriber's Signature: _____ **Date:** _____

Supervising Physician's Signature: _____

This order is valid for the entire upcoming season if signed prior to the November dose, or for the remainder of the present season if signed after November.

Renal Disease: Phosphate Binders

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Phos Lo

- The patient must have a documented intolerance to generic calcium acetate.

Renvela

- The patient must have a documented side effect, allergy, or inadequate response to Renagel[®] (sevelamer hydrochloride).

DOCUMENTATION:

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

Phosphate Binders		<i>Length of Authorization: 1 year</i>
Key: † Generic product, *Indicates generic equivalent is available without a PA		
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
CALCIUM ACETATE † (compare to Phos Lo [®]) FOSRENOL [®] (lanthanum carbonate) RENAGEL [®] (sevelamer hydrochloride)	Phos Lo ^{®*} (calcium acetate) Renvela [®] (sevelamer carbonate)	

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	
<i>Length of authorization: Initial PA of 3 months; 12 months thereafter</i>	
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)

~ 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:	Beneficiary:
Name: _____	Name: _____
Phone #: _____	Medicaid ID #: _____
Fax #: _____	Date of Birth: _____ Sex: _____
Address: _____	Diagnosis: _____
Contact Person at Office: _____	

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		<i>Length of Authorization: 1 year</i>
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 preferred benzodiazepine sedative/hypnotics. 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 121 for a description of the management of mental health drugs.

Sedative Hypnotics: Benzodiazepine	
<i>Length of Authorization: 1 year</i>	
Key: † Generic product, *Indicates generic equivalent is available without a PA	
PREFERRED DRUGS (No PA Required)	PA REQUIRED
ESTAZOLAM† (compare to Prosom [®])	Dalmane [®] * (flurazepam)
FLURAZEPAM† (compare to Dalmane [®])	Doral [®] (quazepam)
TEMAZEPAM 15 mg, 30 mg † (compare to Restoril [®])	Halcion [®] (triazolam)
	Prosom [®] * (estazolam)
	Restoril [®] * (temazepam)
	temazepam† 7.5 mg, 22.5 mg (compare to Restoril [®])
	triazolam † (compare to Halcion [®])

Sedative Hypnotics: Non-benzodiazepine, Non-barbiturate

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Ambien[®], Ambien CR[®], Lunesta[®]:

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

Rozerem[®]: The patient has had a documented side effect, allergy, or treatment failure to generic zolpidem..

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 preferred medications from the sedative hypnotic: benzodiazepine and/or sedative hypnotic: non-benzodiazepine, non-barbiturate classes.

Sonata[®]:

The patient has had a documented intolerance to generic zaleplon.

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 121 for a description of the management of mental health drugs.

Sedative Hypnotics: Non-benzodiazepine, Non-barbiturate	
<i>Length of Authorization: 1 year</i>	
Key: † Generic product, *Indicates generic equivalent is available without a PA	
PREFERRED DRUGS (No PA Required)	PA REQUIRED
CHLORAL HYDRATE † syrup, suppository	Ambien ^{®*} (zolpidem) (<i>Quantity Limit = 1 tab/day</i>)
ZOLPIDEM † (compare to Ambien [®]) (<i>Quantity Limit = 1 tab/day</i>)	Ambien CR [®] (zolpidem) (<i>Quantity Limit = 1 tab/day</i>)
ZALEPLON † (compare to Sonata [®]) (<i>Quantity limit = 1 capsule/day (5 mg) or 2 capsules/day (10 mg)</i>)	Lunesta [®] (eszopiclone) (<i>Quantity Limit = 1 tab/day</i>)
	Rozerem [®] (ramelteon) (<i>Quantity Limit = 1 tab/day</i>)
	Somnote [®] (chloral hydrate capsule)
	Sonata [®] (zaleplon) (<i>Quantity limit = 1 cap/day (5 mg) or 2 caps/day (10 mg)</i>)

Skeletal Muscle Relaxants: Oral

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 preferred musculoskeletal agents.

Amrix, Fexmid

- The prescriber must provide a clinically valid reason why generic cyclobenzaprine cannot be used.

Brand skeletal muscle relaxants with generics available (Flexeril, Parafon Forte DSC, Robaxin):

- The patient has had a documented side effect, allergy or treatment failure with two different preferred musculoskeletal agents (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 preferred musculoskeletal agents. Additionally, if a brand name product is requested where an AB rated generic exists, the patient must also have had a documented intolerance to the generic product.

ANTISPASTICITY AGENTS:

Dantrium, Zanaflex tablets:

- The patient must have a documented side effect, allergy, or treatment failure with the AB rated generic product.

Zanaflex capsules:

- The prescriber must provide a clinically valid reason why generic tizanidine tablets cannot be used.

DOCUMENTATION:

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

Skeletal Muscle Relaxants: Oral

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®) ORPHENADRINE CITRATE ER† (previously Norflex®) ORPHENADRINE, ASA, CAFFEINE† (previously Norgesic®) <i>ASA = aspirin</i>	Amrix® (cyclobenzaprine sustained-release) carisoprodol† (compare to Soma®) carisoprodol, ASA† (compare to Soma Compound®) carisoprodol, ASA, codeine† (compare to Soma Compound with Codeine®) Fexmid® (cyclobenzaprine) Flexeril®* (cyclobenzaprine) Parafon Forte DSC®* (chlorzoxazone) Robaxin®* (methocarbamol) Skelaxin® (metaxalone) Soma® (carisoprodol) Soma Compound® (carisoprodol/ASA) Soma Compound with Codeine® (carisoprodol/ASA/codeine)
Antispasticity Agents	
BACLOFEN† (previously Lioresal®) DANTROLENE† (compare to Dantrium®) TIZANIDINE† (compare to Zanaflex®) tablets	Dantrium®* (dantrolene) Zanaflex® (tizanidine) capsules Zanaflex®* (tizanidine) tablets

***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		<i>Length of Authorization: see table</i>
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.

Testosterone: Topical

LENGTH OF AUTHORIZATION: 1 year

CRITERIA FOR APPROVAL:

Andoderm[®], Testim[®]

- The patient has had a documented side effect, allergy, or treatment failure to AndroGel[®] Gel.

DOCUMENTATION:

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

Testosterone: Topical		<i>Length of Authorization: 1 year</i>
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
ANDROGEL [®] GEL (testosterone 1% gel packets or pump) <i>Quantity limit = 2.5 gm packet (1 packet/day)</i> <i>5 gm packet (2 packets/day)</i> <i>Pump (4 bottles/30 days)</i>	Androderm [®] Transdermal 2.5 mg, 5 mg (testosterone patch) <i>Quantity limit = 1 patch/day/strength</i> Testim [®] Gel 5 gm (testosterone 1% gel tube) <i>Quantity limit = 2 tubes/day</i>	

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)

Detrol LA® (tolterodine)

OXYBUTYNIN XL† (compare to Ditropan® XL)

Ditropan XL® (oxybutynin XL)

SANCTURA XR® (trospium)

VESICARE® (solifenacin)

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		<i>Length of Authorization: 1 year</i>
Key: † Generic product, *Indicates generic equivalent is available without a PA		
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
<u>CLINDAMYCIN</u>		
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)	
<u>METRONIDAZOLE</u>		
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		<i>Length of Authorization: 1 year</i>
PREFERRED DRUGS (No PA Required)		PA REQUIRED
All generics		All brands

II. PRIOR AUTHORIZATION REQUEST & SPECIALTY PHARMACY ORDER 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](#)
- ▶ [**General SPECIALTY** Prior Authorization Request/Order Form](#)
- ▶ [**Growth Stimulating Agents** Prior Authorization Request/Order Form](#)
- ▶ [**Hemophilia Factors** Order Form](#)
- ▶ [**Hepatitis C** Prior Authorization Request/Order Form](#)
- ▶ [**Long Acting Narcotics** Prior Authorization Request Form](#)
- ▶ [**Methadone 40mg dispersible tablets** Prior Authorization Request Form](#)
- ▶ [**Multiple Sclerosis Self Injectables** Order 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/Order Form](#)
- ▶ [**Ulcerative Colitis Injectable** Prior Authorization Request Form](#)
- ▶ [**Vivitrol[®]** Prior Authorization Request Form](#)
- ▶ [**Xolair[®]** Prior Authorization Request Form](#)

~ **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: _____

~ 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: _____

~ **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: _____
 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)?
(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)

<i>Drug:</i>	<i>Response:</i>
<input type="checkbox"/> Boniva Oral	<input type="checkbox"/> side-effect <input type="checkbox"/> treatment failure* dates of use: _____
<input type="checkbox"/> Fosamax Oral	<input type="checkbox"/> side-effect <input type="checkbox"/> 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:** _____

~**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: _____
 Contact Person at Office: _____

Beneficiary:

 Name: _____
 Medicaid ID #: _____
 Date of Birth: _____ Sex: _____
 Diagnosis: _____

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

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

~ **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:	Beneficiary:
Name: _____	Name: _____
Phone #: _____	Medicaid ID #: _____
Fax #: _____	Date of Birth: _____ Sex: _____
Specialty: _____	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:

- Cimzia** _____ Strength & Frequency: _____ Length of therapy: _____
- 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:** _____



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

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:

Beneficiary:

Name: _____

Name: _____

Phone #: _____

Medicaid ID #: _____

Fax #: _____

Date of Birth: _____ Sex: _____

Address: _____

Contact Person at Office: _____

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: _____



"GENERAL" SPECIALTY - Prior Authorization and Patient Enrollment Form

USE WHEN NO DRUG SPECIFIC FORM EXISTS - Complete form in its entirety and fax to number listed below

PATIENT INFORMATION

Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____			
Street Address		City	
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian		Day Telephone	Night Telephone
Emergency Contact		Relationship	Telephone

PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address		City	
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	



Fax Completed Form to:
Fax Number: 866-364-2673
Phone Number: 800-327-1392

3

**Office of Vermont Health Access
"GENERAL" SPECIALTY MEDICATIONS (Not drug specific)
PRIOR AUTHORIZATION REQUEST**

Patient Diagnosis: _____

Drug Requested: _____

Strength, Route & Frequency: _____

Length of therapy: _____

Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this particular medication: _____

Was patient seen by any other provider for this condition? Yes No

Specialist name: _____ Specialist Type: _____

Medications previously tried and failed for this condition:

Name of medication	Type of failure	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list pertinent laboratory test(s) or procedure(s) if applicable:

Procedure/Test	Findings	Date
_____	_____	_____
_____	_____	_____

Other Information/ comments: _____

4

PRESCRIPTION

Drug Name/Strength: _____

Sig: Dose: _____ Route: _____ Frequency: _____

Qty: _____ Refill X: _____

Deliver product to: Patient's home MD office Clinic

Prescriber's Signature: _____ Date: _____



GROWTH STIMULATING AGENTS - Prior Authorization and Patient Enrollment Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____			
Street Address		City	
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian		Day Telephone	Night Telephone
Emergency Contact		Relationship	Telephone

2 PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address		City	
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	



Fax Completed Form to:
Fax Number: 866-364-2673
Phone Number: 800-327-1392

**3 Office of Vermont Health Access
 GROWTH STIMULATING AGENTS
 PRIOR AUTHORIZATION REQUEST**

Patient Diagnosis: _____

Requested OVHA **PREFERRED** Growth Stimulating Agent
 Norditropin® Nutropin® Nutropin® AQ

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:		

Please explain the medical necessity for a '**NON-PREFERRED**' product:
 Genotropin® Humatrope® Omnitrope® Saizen® Tev-Tropin®

Medical justification: _____

Request is for a '**SPECIALIZED INDICATION**' product: (Criteria in Clinical Criteria Manual)
 Increlex® Serostim® Zorbtive®

Other information/ Prescriber comments: _____

4 PRESCRIPTION

Norditropin® Nordiflex Norditropin® Cartridge Nutropin® Nutropin® AQ

Other Product: (Please Specify) _____

Dosage Form / Strength: _____

Dose/Route & Frequency (Sig): _____

Dispense Quantity: One month supply or _____ Refill X _____

Needles/syringes: quantity sufficient for drug supply with refills as above

Deliver product to: Patient's home MD office Clinic

Prescriber's Signature: _____ **Date:** _____



HEMOPHILIA FACTORS - Patient Enrollment and Prescription Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____			
Street Address		City	
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian		Day Telephone	Night Telephone
Emergency Contact		Relationship	Telephone

2 PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address		City	
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	



Fax Completed Form to:
Fax Number: 866-364-2673
Phone Number: 800-327-1392

**3 Office of Vermont Health Access
 PRESCRIPTION
 HEMOPHILIA FACTORS**

Patient Diagnosis:

Hemophilia A – Factor VIII Disease
 Hemophilia B – Factor IX Disease
 von Willebrand Disease

Patient Weight (kg): _____ Native Factor Level: _____

Product Name: _____

Dose / Frequency Instructions: _____

of doses ordered: _____ Refills: _____
 If doses of different units are ordered, specific number of doses of each

Reason(s) for Use:

Prophylaxis only Episodic only Prophylaxis and PRN
 Acute Bleeding Episode Surgical Prophylaxis Dental Procedure

Recent bleed while on Prophylaxis:

Date of bleed: ____/____/____
 Location of bleed: _____ Severity of bleed: _____
 # of Doses already administered prior to this order: _____ IU/Dose: _____

Deliver product to: Patient's home MD office Clinic

Needles/syringes: quantity sufficient for factor supply

Prescriber's Signature: _____ **Date:** _____



HEPATITIS C MEDICATIONS - Prior Authorization and Patient Enrollment Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____			
Street Address			City
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian		Day Telephone	Night Telephone
Emergency Contact		Relationship	Telephone

2 PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address			City
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	



Fax Completed Form to:
Fax Number: 866-364-2673
Phone Number: 800-327-1392

**3 Office of Vermont Health Access
HEPATITIS C MEDICATIONS
PRIOR AUTHORIZATION REQUEST**

Patient Diagnosis: _____

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: _____

Requested OVHA **PREFERRED** Oral Hepatitis C Product?
 Ribavirin 200 mg Tab (compare to Copegus®) Ribavirin 200 mg Cap (compare to Rebetol®)

For any OVHA **NON-PREFERRED** Oral Hepatitis C Product or Strength, please explain the medical necessity for this product:
 Product: _____ Medical justification: _____

Requested OVHA **PREFERRED** Injectable Hepatitis C Product?
 Pegasys® Prefilled Syringe Pegasys® Single Dose Vial

For any OVHA **NON-PREFERRED** Injectable Hepatitis C Product, please explain the medical necessity for this product:
 Product: _____ Medical justification: _____

4 PRESCRIPTION

Oral:
 Ribavirin 200 mg Tablet or Capsule
 Other (Specify): _____
 Dose: _____ Frequency: _____ Qty: 28 days supply Refill X: _____

Injectable:
 Pegasys® Prefilled Syringe 180 mcg/0.5 ml "Convenience Kit" (4 syringes/box)
or
 Pegasys® 180 mcg/1 ml Single Dose Vial
 Other (choose): PEG-Intron® RediPen PEG-Intron® Kit Infergen®
 Specify Strength of above: _____

Sig: Dose/Route/Frequency: _____
 Dispense Quantity: 28 days supply Refill X: _____

Needles/syringes: quantity sufficient for drug supply with refills as above

Deliver product to: Patient's home MD office Clinic

Prescriber's Signature: _____ **Date:** _____

~ 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?

<i>Check all that apply:</i>	<i>Response, check all that apply:</i>
<input type="checkbox"/> Fentanyl Patches	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> Methadone	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> Morphine ER	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy

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

Prescriber comments:

Prescriber Signature: _____

Date of this request: _____

~ **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: _____



MULTIPLE SCLEROSIS SELF INJECTABLES - Patient Enrollment/Order Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____			
Street Address			City
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian		Day Telephone	Night Telephone
Emergency Contact		Relationship	Telephone

2 PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address			City
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	



Fax Completed Form to:
Fax Number: 866-364-2673
Phone Number: 800-327-1392

**3 Office of Vermont Health Access
PRESCRIPTION
MULTIPLE SCLEROSIS SELF INJECTABLES**

Patient Diagnosis:

- Product:**
- Avonex 30 mcg/0.5 ml Prefilled Syringe (4 per box)
 - Avonex 30 mcg Kit (Single Dose Vials) (4 per box)
 - Betaseron 0.3 mg Prefilled Syringe
 - Copaxone 20 mg Prefilled Syringe (30 per kit)
 - Rebif Titration Pack X 1 (**Therapy initiation ONLY-No Refills**)
(contains 6 - 8.8 mcg and 6 - 22 mcg Prefilled Syringes)
 - Rebif 22 mcg/0.5 ml Prefilled Syringes
 - Rebif 44 mcg/0.5 ml Prefilled Syringes
- (Please Note: This form not to be used for Tysabri PA request or ordering)

Quantity:	Refills:
------------------	-----------------

Dose / Route/ Frequency Instructions (Sig):

- Deliver product to: Patient's home MD office Clinic
- Needles/syringes: quantity sufficient for drug supply with refills as above

Prescriber's Signature: _____ **Date:** _____

~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.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree
Requested nutritional supplement will be taken by <u>mouth</u> (not administered via tube feeding)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oral nutritional supplement is being requested due to:	<input type="checkbox"/> Unplanned weight loss (see complete definition by age in clinical criteria manual) <input type="checkbox"/> 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: <ul style="list-style-type: none"> ▪ Increased metabolic need resulting from severe trauma (i.e.: burns, infection, major bone fractures) ▪ Malabsorption syndrome (as related to cystic fibrosis, renal disease, short gut syndrome, Crohn's disease and other unspecified disorders of the gut) ▪ Nutritional wasting due to chronic disease (i.e.: cancer, AIDS, conditions resulting in dysphagia, pulmonary insufficiency, renal disease) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>▪ Other: Explain:</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
--	--

Additional clinical information to support PA request:

<p>Requested Supplement: _____</p> <p>Strength & Frequency: _____</p> <p>Anticipated duration of supplementation: _____</p>
--

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

~ 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:** _____

~ **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:** _____




Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name		First Name		Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #		
Allergies: <input type="checkbox"/> NKA or _____				
Street Address			City	
State	County	Zip Code		
Parent/Guardian		Day Telephone	Night Telephone	
Emergency Contact		Relationship	Telephone	


2 PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address		City	
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	
Supervising Physician's Name (If Required for Mid-Level Practitioner)		NPI Number	



Wilcox Home Infusion
250 Stratton Road
Rutland, Vermont 05701
Last Updated 10/2008

Fax Completed Form to:
Fax Number: 802-775-7824 ☎
Phone Number: 800-639-1210 ☎



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CRITICAL HOMECARE SOLUTIONS, INC.
Growing a Family of Services

**3 Office of Vermont Health Access PRIOR AUTHORIZATION REQUEST
SYNAGIS® (PALIVIZUMAB)**

weeks:	days:	kg:	15mg/kg=	mg
Gestational Age		Current Weight	Dose	
Diagnosis		Pharmacy	Phone	Fax

- Infants born at 28 weeks of gestation or earlier (i.e., ≤ 28 weeks, 6 days) and under 12 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 the RSV season (November 1) who have **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 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: _____

NICU HISTORY

Did the patient spend time in the NICU?
 Yes No (If yes, please attach the NICU summary)

Was RSV prophylaxis recommended by the NICU/Hospital physician for this patient?
 Yes No

Was a NICU/Hospital /Clinic dose administered?
 Yes, Date(s): _____ No

4 PRESCRIPTION

Synagis (palivizumab) 50 and/or 100 mg vials and supplies for administration.
Sig: Inject 15 mg/kg IM once every 4 weeks; expected date of first home injection: _____
Dispense Quantity: Quantity sufficient for prophylaxis thru 04/09
Deliver product to: MD office Patient's home Clinic
 Home health nurse to administer injection Home Health Agency: _____
If delivery is to clinic, please give location: _____
Pediatric Anaphylaxis: Administer 0.01 ml/kg (max 0.3ml) of 1:1000 epinephrine solution subcutaneously or intramuscularly, and contact EMS or physician, as appropriate.
Other: _____
Sig: _____
Physician will monitor patient's response to therapy. Any complications in therapy will be reported to the physician either by the patient's caregiver, or the skilled nursing service (If other than physician's office or Wilcox Home Infusion)
Prescriber's Signature: _____ **Date:** _____
Supervising Physician's Signature: _____
This order is valid for the entire upcoming season if signed prior to the November dose, or for the remainder of the present season if signed after November.

~ 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:	Beneficiary:
Name: _____	Name: _____
Phone #: _____	Medicaid ID #: _____
Fax #: _____	Date of Birth: _____ Sex: _____
Contact Person at Office: _____	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:** _____

~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: _____
 Contact Person at Office: _____

Beneficiary:

 Name: _____
 Medicaid ID #: _____
 Date of Birth: _____ Sex: _____
 Diagnosis: _____

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

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

~ 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: _____

Medication must be billed through the pharmacy benefit (NO J codes (J2357) accepted in medical benefit)

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: _____