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

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

**Clinical Criteria Manual**

**March 16th, 2010**

# **Preferred Drug List and Drugs Requiring Prior Authorization**

The Commissioner for Office of Vermont Health Access shall establish a pharmacy best practices and cost control program designed to reduce the cost of providing prescription drugs, while maintaining high quality in prescription drug therapies. The program shall include:

“A preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic alternatives”

From Act 127 passed in 2002

The following pages contain:

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

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

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## Acne Drugs: Oral

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**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<sup>®</sup>, Vibramycin<sup>®</sup> Suspension, Adoxa<sup>®</sup> 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<sup>®</sup>:**

- 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.

**Vibramycin<sup>®</sup> Suspension:**

- The patient has a medical necessity for a liquid dosage form.

**Adoxa<sup>®</sup> 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<sup>®</sup>:**

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

**LIMITATIONS:**

Minocycline SR products (brand and generic) not covered.

**DOCUMENTATION:**

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

## Acne Drugs: Oral

*Length of Authorization: 1 year*

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

PREFERRED DRUGS (No PA Required)	PA REQUIRED
DOXYCYCLINE† 20mg, 50mg, 75mg, 100mg, tab, cap	Adoxa®* (doxycycline monohydrate) 50 mg, 75 mg, 100 mg tab Adoxa® 150mg cap 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
E.E.S®† (erythromycin ethylsuccinate) ERY-TAB® (erythromycin base, delayed release) ERYTHROCIN† (erythromycin stearate) ERYTHROMYCIN BASE† ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S®, Eryped®) ERYTHROMYCIN STEARATE†	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 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

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## Acne Drugs: Topical-Anti-infectives

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**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<sup>®</sup>**

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

**LIMITATIONS:**

Kits with non-drug products are not covered.

**DOCUMENTATION:**

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

# Acne Drugs: Topical Anti-Infectives

Length of Authorization: 1 year

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

## PREFERRED DRUGS (No PA Required)

## PA REQUIRED

### BENZOYL PEROXIDE PRODUCTS

#### BENZOYL PEROXIDE†

2.5%, 4%, 5%, 8%, 10% *G*,  
2.5%, 4%, 5%, 7%, 8%, 10% *W*;  
3.5%, 5.5%, 8.5% *C*;  
3%, 4%, 5%, 6%, 8%, 9%, 10% *L*;  
3%, 6%, 9% *P*

Benzac AC® 2.5%, 5%, 10% *G, W*  
Benzashave® 5%, 10% *C*  
Brevoxyl® 4%, 8% *W*; 4%, 8%*G*; 4%, 8% *L*  
Clinac BPO® 7% *G*  
Desquam-E/X® 2.5%, 5%, 10% *G*; 5%, 10% *W*  
Inova 4% *P*  
Panoxyl/AQ 2.5%, 5%, 10% *G*; 5%, 10% *B*  
Triaz® 3%, 6%, 9% *G*; 3%, 6%, 9% *P*  
Zaclir®\* 4%, 8% *L*  
All other brands

### CLINDAMYCIN PRODUCTS

#### CLINDAMYCIN 1% *S, G, L, P* †

Cleocin-T®\* (clindamycin 2% *G*)  
Evoclin® (clindamycin 2% *F*)  
Clindagel® (clindamycin 1% *G*)  
All other brands

### ERYTHROMYCIN PRODUCTS

#### ERYTHROMYCIN 2% *S, G, P* †

Akne-Mycin® (erythromycin 2% *O*)  
Erygel®\* (erythromycin 2% *G*)  
All other brands

### SODIUM SULFACETAMIDE PRODUCTS

#### SODIUM SULFACETAMIDE 10% *L* †

Klaron®\* (sodium sulfacetamide 10% *L*)  
All other brands

### COMBINATION PRODUCTS

#### ERYTHROMYCIN / BENZOYL PEROXIDE†

Benzaclin® (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

SODIUM SULFACETAMIDE / SULFUR *L* †  
SODIUM SULFACETAMIDE / SULFUR *W* †

Avar® (sodium sulfacetamide/sulfur *G*)  
Plexion® (sulfacetamide/sulfur *S*)  
Rosac®\* (sulfacetamide/sulfur *W*)  
Rosula®\* (sulfacetamide/sulfur *W*)  
Sulfacet-R®\* (sodium sulfacetamide/sulfur *L*)  
All other brands

Zoderm® (urea/benzoyl peroxide) cream

### OTHER

Azelex® (azelaic acid 20% *C*)  
Aczone® (dapson 5% *G*)  
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*

Note: Please refer to “Acne Drugs: Topical - Retinoids” for Epiduo® Gel

## 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.).

**Epiduo Gel** – This combination not covered, individual components may be prescribed separately.

**DOCUMENTATION:**

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

<b>Acne Drugs: Topical - Retinoids</b>		<i>Length of Authorization: 1 year</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
<p>TRETINOIN† (<i>specific criteria required for ages &lt;10 or &gt;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 Epiduo® (adapalene/benzoyl peroxide) 0.1%/2.5% 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**.

<b>Acne Drugs: Topical – Rosacea</b>		<i>Length of Authorization: 1 year</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
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.

**Galantamine Oral Solution, 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.  
**AND**
- If the product has an AB rated generic, the patient has a documented intolerance to the generic.

**DOCUMENTATION:**

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

<b>Alzheimer's: Cholinesterase Inhibitors/NMDA Receptor Antagonists</b>	
<i>Length of Authorization: 1 year</i>	
<b>Key: § Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
<p><b><u>CHOLINESTERASE INHIBITORS</u></b>                      ARICEPT<sup>®</sup> (donepezil) Tablet  <i>(QL = 1 tablet/day)</i>                      EXELON<sup>®</sup> (rivastigmine) Capsule  <i>(QL = 2 capsules/day)</i>                       ARICEPT<sup>®</sup> ODT (donepezil)  <i>(QL = 1 tablet/day)</i>                      EXELON<sup>®</sup> (rivastigmine) Oral Solution                       EXELON<sup>®</sup> (rivastigmine transdermal) Patch  <i>(QL = 1 patch/day)</i>   <b><u>NMDA RECEPTOR ANTAGONIST</u></b>                      NAMENDA<sup>®</sup> (memantine) Tablet                       NAMENDA<sup>®</sup> (memantine) Oral Solution</p>	<p>Cognex<sup>®</sup> (tacrine) Capsule §                      galantamine† tablet § (compare to Razadyne<sup>®</sup>)                      galantamine ER† capsule § (compare to Razadyne ER<sup>®</sup>)                      Razadyne<sup>®</sup> (galantamine) Tablet                      Razadyne ER<sup>®</sup> (galantamine) Capsule                        galantamine† (compare to Razadyne<sup>®</sup>) Oral Solution                      Razadyne<sup>®</sup> (galantamine) Oral Solution</p>

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## Analgesics: COX II and NSAIDs

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**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**PA required NSAIDs (see specific criteria for Celebrex, Flector Patch and Voltaren Gel):**

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

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

**Flector Patch, Voltaren Gel:**

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

**Zipsor:**

- The patient has had a documented intolerance to diclofenac tablets.
- The patient has had a documented side effect, allergy, or treatment failure to four or more preferred generic NSAIDs.

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

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<sup>1</sup> 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 IIs AND NSAIDs**

*Length of Authorization: 1 year*

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

<b>NSAIDs</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
<p><b><u>ORAL</u></b></p> <p>DICLOFENAC POTASSIUM† (compare to Cataflam®)            DICLOFENAC SODIUM† (compare to Voltaren®)            DIFLUNISAL† (formerly Dolobid®)            ETODOLAC† (formerly Lodine®)            FENOPROFEN† (compare to Nalfon®)            FLURBIPROFEN† (compare to Ansaid®)            IBUPROFEN† (compare to Motrin®)            INDOMETHACIN† (formerly Indocin®, Indocin SR®)            KETOPROFEN†            KETOPROFEN ER†            KETOROLAC† (formerly Toradol®)  <i>(QL = 20 doses/5 day supply every 90 days)</i>            MECLOFENAMATE SODIUM† (formerly Meclomen®)            MELOXICAM† <b>tabs</b> (compare to Mobic®)            NABUMETONE† (formerly Relafen®)            NAPROXEN† (compare to Naprosyn®)            NAPROXEN ENTERIC COATED† (compare to EC-Naprosyn®)            NAPROXEN SODIUM† (compare to Anaprox®, Anaprox DS®, Naprelan®)            OXAPROZIN† (compare to Daypro®)            PIROXICAM† (compare to Feldene®)            SULINDAC† (compare to Clinoril®)            TOLMETIN SODIUM† (formerly Tolectin®)</p> <p><b><u>INJECTABLE</u></b></p> <p>KETOROLAC † Injection (formerly Toradol®)  <i>(QL = 1 dose per fill)</i></p> <p><b><u>TOPICAL/TRANSDERMAL</u></b></p>	<p>Anaprox®* (naproxen sodium)            Anaprox DS®* (naproxen sodium)            Ansaid®* (flurbiprofen)            Arthrotec® (diclofenac sodium w/misoprostol)            Cataflam®* (diclofenac potassium)            Clinoril®* (sulindac)            Daypro®* (oxaprozin)            EC-Naprosyn®* (naproxen sodium enteric coated)            Feldene®* (piroxicam)            Indocin® (indomethacin) susp            Indocin SR®* (indomethacin) caps            meloxicam† susp (compare to Mobic®)            Mobic®* (meloxicam)            Motrin®* (ibuprofen)            Nalfon®* (fenoprofen)            Naprelan®* (naproxen sodium)            Naprosyn®* (naproxen sodium)            Ponstel® (mefenamic acid)            Voltaren®* (diclofenac sodium)            Voltaren XR®* (diclofenac sodium SR)            Zipsor® (diclofenac potassium)</p> <p>Flector® (diclofenac) Patch <i>(QL = 2 patches/day)</i>            Voltaren® (diclofenac) Gel</p>
<b>COX II Inhibitors</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
<p>CELEBREX® (celecoxib) (age ≥ 60 yrs)            (Quantity limit all strengths = 2 capsules/day)</p>	<p>CELEBREX® (celecoxib) (age &lt; 60 yrs)            (Quantity limit all strengths = 2 capsules/day)</p>

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## Analgesics: Local Anesthetics: Transdermal Patch

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**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**.

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

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## **Analgesics: Short Acting Narcotics**

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**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<sup>®</sup>, fentanyl transmucosal, Fentora<sup>®</sup>**

- 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<sup>®</sup>, the member has a documented side effect, allergy, or treatment failure with generic fentanyl transmucosal.

**Nucynta<sup>®</sup>, Opana<sup>®</sup>**

- The member has had a documented side effect, allergy, or treatment failure to at least two of the following 3 immediate release generic short acting narcotic analgesics – morphine, hydromorphone or oxycodone.

**Ultram<sup>®</sup>, Ultracet<sup>®</sup>**

- The member has a documented intolerance to the generic formulation.

**Ryzolt<sup>®</sup>, Tramadol ER, Ultram ER<sup>®</sup>**

- The member has had a documented side effect or treatment failure to a preferred short-acting tramadol product. In addition, for approval of Ryzolt<sup>®</sup> or Ultram ER<sup>®</sup>, the patient must have a documented intolerance to generic tramadol ER.

**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. Meperidine 75 mg/ml injection no longer available – 25 mg/ml, 50 mg/ml and 100 mg/ml available.

**DOCUMENTATION:**

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

## Analgesics: Short Acting Narcotics

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

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

PREFERRED DRUGS (NO PA REQUIRED)	PA REQUIRED
ACETAMINOPHEN W/CODEINE† (compare to Tylenol w/codeine®)	Acetaminophen w/codeine: <i>all branded products</i>
ACETAMINOPHEN W/HYDROCODONE† (compare to Vicodin®, Lorcet®, Maxidone®, Norco®, Zamiset®, Zydone®) (QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day; 10/325 = 185 ml/day)	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)
ACETAMINOPHEN W/OXYCODONE† (compare to Percocet®) (QL 10/650 = 6 tablets/day)	Acetaminophen w/oxycodone: <i>all branded products</i> (QL 10/650 = 6 tablets/day)
ACETAMINOPHEN W/PROPOXYPHENE† (compare to Darvocet-N®) (QL 100/650 = 6 tablets/day)	Actiq® (fentanyl citrate transmucosal)
ASPIRIN W/CODEINE†	Anexsia®* (acetaminophen w/hydrocodone)
ASPIRIN W/OXYCODONE† (compare to Percodan®)	Butorphanol Nasal Spray† (Qty Limit = 2 bottles/month)
BUTALBITAL COMPOUND W/ CODEINE† (compare to Fiorinal® w/codeine)	Capital® w/codeine* (acetaminophen w/codeine)
CODEINE SULFATE†	Cocet® (acetaminophen w/codeine) (QL 30/650 = 6 tablets/day)
DIHYDROCODEINE COMPOUND† (compare to Synalgos-DC®)	Combunox®* (oxycodone w/ ibuprofen)
ENDOCET® (oxycodone w/ acetaminophen)	Darvocet-N®* (propoxyphene-n w/acetaminophen) (QL 100/650 = 6 tablets/day)
ENDODAN® (oxycodone w/ aspirin)	Darvon Compound®*(propoxyphene compound)
FIORTAL W/ CODEINE #3® (butalbital w/ codeine)	Darvon®*/ Darvon-N®* (propoxyphene)
HYDROCODONE† (plain, w/acetaminophen or w/ibuprofen)	Dazidox®* (oxycodone)
HYDROMORPHONE† (compare to Dilaudid®)	Demerol® (meperidine)
MEPERIDINE† (compare to Demerol®) (Maximum 30 tabs or 5 day supply)	Dilaudid®*(hydromorphone)
MORPHINE SULFATE†	fentanyl citrate transmucosal† (compare to Actiq®)
MORPHINE SULFATE SOLN† (compare to Roxanol®)	Fentora® (fentanyl citrate buccal tablets)
OXYCODONE† (plain, w/acetaminophen or w/ibuprofen)	Fioricet® w/codeine*(butalbital/acetaminophen/caffeine/codeine)
PENTAZOCINE† (compare to Talwin®)	Ibudone®* (hydrocodone w/ ibuprofen)
PROPOXYPHENE† (compare to Darvon®)	Liquicet® (hydrocodone w/ acetaminophen)
PROPOXYPHENE COMPOUND† (compare to Darvon Compound®)	Lorcet®* (also HD, PLUS) (hydrocodone w/ acetaminophen)
PROPOXYPHENE N W/ ACETAMINOPHEN†	Lortab®*(hydrocodone w/ acetaminophen)
ROXICET® (oxycodone w/ acetaminophen)	Magnacet® (oxycodone w/ acetaminophen)
ROXICODONE INTENSOL® (oxycodone)	Maxidone®*(hydrocodone w/ acetaminophen)
ROXICODONE® (oxycodone HCL)	Meperidine† (Qty > 30 tabs or 5 day supply)
TRAMADOL† (compare to Ultram®)	Nalbuphine†
TRAMADOL/APAP† (compare to Ultracet®)	Norco®*(hydrocodone w/ acetaminophen)
	Nubain®*(nalbuphine)
	Nucynta® (tapentadol)
	Opana® (oxymorphone)
	Oxyfast®*(oxycodone)
	OxyIR®*(oxycodone)
	Panlor DC® (acetaminophen/caffeine/dihydrocodeine)
	Pentazocine and Naloxone†
	Percocet®*(oxycodone w/ acetaminophen)
	Percodan®* (oxycodone w/aspirin)
	Propoxyphene: <i>all branded products</i> *
	Reprexain®* (hydrocodone w/ ibuprofen)
	Roxanol®*(morphine sulfate)
	Ryzolt® (tramadol SR)
	Synalgos DC®*(dihydrocodeine compound)
	Talacen®*(pentazocine w/acetaminophen)
	Talwin®* (pentazocine) and branded combinations
	Talwin NX®* (pentazocine w/naloxone)
	Tramadol ER† (compare to Ultram ER®) (Qty Limit = 1 tablet/day)
	Trezix® (acetaminophen/caffeine/dihydrocodeine)
	Tylenol® #3*,#4*(acetaminophen w/codeine)
	Tylox®*(oxycodone w/ acetaminophen)
	Ultracet® (tramadol w/ acetaminophen)
	Ultram®*/Ultram ER® (tramadol/tramadol SR) (Qty Limit for ER tab = 1 tablet/day)
	Vicodin®*(hydrocodone w/acetaminophen)
	Vicoprofen®*(hydrocodone w/ ibuprofen)
	Xodol® (hydrocodone w/acetaminophen)
	Xolox® (oxycodone w/ acetaminophen)
	Zamiset®*/ Zydone®* (hydrocodone w/ acetaminophen)

Note: Acetaminophen containing products: (Preferred and PA Required)  
Maximum daily dose acetaminophen = 4 grams

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## **Analgesics: Long Acting Narcotics**

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**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:**

**Transdermal: (generic fentanyl patches)**

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

AND

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

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.

**Oral Non-Preferred:**

- 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 morphine sulfate SR 12 hr (If a product has an AB rated generic, there must have been a trial of the generic).

**LIMITATIONS:**

Methadone 40 mg dispersible tablet not approved for retail dispensing.

**DOCUMENTATION:**

- ✓ Please complete and submit the **Long Acting Narcotics Prior Authorization Request Form**.

## Analgesics: Long Acting Narcotics

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

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

PREFERRED DRUGS (NO PA REQUIRED)	PA REQUIRED
<b><u>TRANSDERMAL</u></b>	
DURAGESIC <sup>®</sup> (fentanyl) 25 mcg/hr, 50 mcg/hr, ( <i>QL=15 patches/30 days</i> )	Duragesic-12 <sup>®</sup> (fentanyl) 12.5 mcg/hr ( <i>QL=15 patches/30 days</i> )
DURAGESIC <sup>®</sup> (fentanyl) 75 mcg/hr, 100 mcg/hr ( <i>QL= 30 patches/30 days</i> )	Fentanyl Patch† (compare to Duragesic <sup>®</sup> ) 12.5 mcg/hr ( <i>QL=15 patches/30 days</i> )
	Fentanyl Patch† (compare to Duragesic <sup>®</sup> ) 25 mcg/hr, 50 mcg/hr, ( <i>QL=15 patches/30 days</i> )
	Fentanyl Patch† (compare to Duragesic <sup>®</sup> ) 75 mcg/hr, 100 mcg/hr, ( <i>QL=30 patches/30 days</i> )
<b><u>ORAL</u></b>	
METHADONE† (compare to Dolophine <sup>®</sup> ) 5 mg, 10 mg	Avinza <sup>®</sup> (morphine sulfate XR) ( <i>QL= 30 capsules/strength/30 days</i> )
	Dolophine <sup>®*</sup> (methadone)
MORPHINE SULFATE SR 12 hr† (compare to MS Contin <sup>®</sup> , Oramorph SR <sup>®</sup> ) ( <i>QL=90 tablets/strength/30 days</i> )	Kadian <sup>®</sup> (morphine sulfate XR) ( <i>QL= 60 capsules/strength/30 days</i> )
	MS Contin <sup>®*</sup> (morphine sulfate SR 12 hr) ( <i>QL=90 tablets/strength/30 days</i> )
	Opana ER <sup>®</sup> (oxymorphone ER) ( <i>QL=60 tablets/strength/30 days</i> )
	Oramorph SR <sup>®*</sup> (morphine sulfate SR 12 hr) ( <i>QL=90 tablets/strength/30 days</i> )
	Oxycodone ER† (compare to Oxycontin <sup>®</sup> ) ( <i>QL=90 tablets/strength/30 days</i> )
	OxyContin <sup>®</sup> (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?

<b><i>Check all that apply:</i></b>	<b><i>Response, check all that apply:</i></b>
<input type="checkbox"/> Duragesic 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 Sulfate SR 12 hr	<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:** \_\_\_\_\_

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## Anemia Medications: Hematopoietic/Erythropoietic Agents

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**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<sup>®</sup> and Procrit<sup>®</sup>.

**DOCUMENTATION:**

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

<b>Anemia: Hematopoietic/Erythropoietic Agents</b> <i>Length of Authorization: 1 year</i>	
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
ARANESP <sup>®</sup> (darbepoetin alfa) PROCRIT <sup>®</sup> (epoetin alpha)	Epogen <sup>®</sup> (epoetin alpha)

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## Ankylosing Spondylitis Medications: Injectables

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***NOTE: Ankylosing Spondylitis Self-Injectables (Enbrel<sup>®</sup>, Humira<sup>®</sup> and Simponi<sup>®</sup>) must be obtained and billed through our specialty pharmacy vendor, ICORE Healthcare. Please see the Enbrel, Humira or Simponi Prior Authorization/Patient Enrollment Form for instructions. ICORE Healthcare may supply Remicade<sup>®</sup> upon request or you may 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:**

**Humira<sup>®</sup>**

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

**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<sup>®</sup>**

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

**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<sup>®</sup>**

Patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on Remicade<sup>®</sup>

**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<sup>®</sup> or Enbrel<sup>®</sup> cannot be used.

**Simponi<sup>®</sup>**

Patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on Simponi<sup>®</sup>

**OR**

Patient age  $\geq$  18 years

**AND**

Diagnosis is AS, and patient has documentation of an inadequate response, adverse reaction or allergic response to methotrexate, or if methotrexate is contraindicated, at least 1 DMARD (other DMARDs include leflunomide, sulfasalazine, gold, antimalarials, minocycline, D-penicillamine, azathioprine, cyclophosphamide and cyclosporine)

**AND**

The prescriber must provide a clinically valid reason why either Humira<sup>®</sup> or Enbrel<sup>®</sup> 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<sup>®</sup>, Enbrel<sup>®</sup>, Remicade<sup>®</sup>.or Simponi<sup>®</sup>

**DOCUMENTATION:**

- ✓ Document clinical information for **Enbrel<sup>®</sup>** or **Humira<sup>®</sup>** on its **Prior Authorization/Patient Enrollment Form** and clinically compelling information supporting the choice of **Simponi<sup>®</sup>** on its **Prior Authorization/Patient Enrollment Form** or **Remicade<sup>®</sup>** on a **Remicade Prior Authorization Request Form**.

<b>Ankylosing Spondylitis: Injectables</b>	
<i>Length of authorization: Initial PA of 3 months; 12 months thereafter</i>	
<b>PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET</b>	<b>NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET</b>
ENBREL <sup>®</sup> (etanercept) HUMIRA <sup>®</sup> (adalimumab)	Remicade <sup>®</sup> (infliximab) Simponi <sup>®</sup> (golimumab) <i>(Qty Limit = 1 syringe/month)</i>

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## Anti-Anxiety: Anxiolytics

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**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL**

**Non-preferred Benzodiazepines (except for alprazolam ODT, Klonopin Wafers<sup>®</sup>, and Niravam<sup>®</sup>):**

- 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.)

**alprazolam ODT, Klonopin Wafers<sup>®</sup>, and Niravam<sup>®</sup>:**

- 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.)

**OR**

- Patient has a medical necessity for disintegrating tablet administration (i.e. inability to swallow tablets)

**AND**

- The patient has a documented side effect, allergy, or treatment failure to clonazepam ODT.

**Buspar<sup>®</sup> and Vistaril<sup>®</sup>:**

- 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 127 for a description of the management of mental health drugs.

**Anti-Anxiety: Anxiolytics***Length of Authorization: 1 year***Key: † Generic product, \*Indicates generic equivalent is available without a PA**

<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
<p><b><u>Benzodiazepine</u></b>  ALPRAZOLAM† (compare to Xanax®)  ALPRAZOLAM ER†, ALPRAZOLAM XR®  (compare to Xanax XR®)  CHLORDIAZEPOXIDE† (compare to Librium®)  CLONAZEPAM† (compare to Klonopin®)  CLONAZEPAM ODT† (compare to Klonopin  Wafers®)  CLORAZEPATE† tabs (compare to Tranxene T®)  DIAZEPAM† (compare to Valium®)  LORAZEPAM† (compare to Ativan®)  OXAZEPAM† (compare to Serax®)</p> <p><b><u>Non-Benzodiazepine</u></b>  BUSPIRONE† (compare to Buspar®)  HYDROXYZINE HYDROCHLORIDE†  (previously Atarax®)  HYDROXYZINE PAMOATE† (compare to  Vistaril®)  MEPROBAMATE† (previously Miltown®)</p>	<p>alprazolam ODT† (compare to Niravam®)  Ativan®* (lorazepam)  Klonopin®* (clonazepam)  Klonopin Wafers®* (clonazepam ODT)  Librium®* (chlordiazepoxide)  Niravam® (alprazolam ODT)  Serax®* (oxazepam)  Tranxene T®* (clorazepate tablets)  Tranxene-SD® (clorazepate SR 24 hr tab)  Valium®* (diazepam)  Xanax®* (alprazolam)  Xanax XR®* (alprazolam XR)</p> <p>Buspar®* (buspirone)  Vistaril®* (hydroxyzine pamoate)</p>

## 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**

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

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## Anticonvulsants

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**LENGTH OF AUTHORIZATION:** lifetime for seizure disorders\*<sup>†</sup>; 1 year for other indications

**CRITERIA FOR APPROVAL:**

**Depakene<sup>®</sup>, Depakote<sup>®</sup>, Keppra<sup>®</sup> tablets or oral solution, Klonopin<sup>®</sup>, Klonopin Wafers<sup>®</sup>, Lamictal<sup>®</sup> tablets or chewable tablets, Mysoline<sup>®</sup>, Neurontin<sup>®</sup> capsules/tablets, Tegretol<sup>®</sup>, Topamax<sup>®</sup> tablets, Trileptal<sup>®</sup> tablets, Zarontin<sup>®</sup>, Zonegran<sup>®</sup>**

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

**OR**

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

**Banzel<sup>®</sup>**

- The diagnosis or indication is treatment of Lennox-Gastaut Syndrome.

**AND**

- The patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least TWO preferred anticonvulsants (topiramate, lamotrigine, valproic acid)

**Felbatol<sup>®</sup>**

- A patient information/consent describing aplastic anemia and liver injury has been completed.

**AND**

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

**OR**

- The diagnosis is adjunctive therapy of partial-onset seizures or Lennox-Gastaut seizures and the patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least THREE preferred anticonvulsants

**Gabarone<sup>®</sup>, Gabapentin 100 mg or 400 mg tablets**

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

**OR**

- The patient has had a documented intolerance to generic gabapentin capsules.

**Carbamazepine XR, Divalproex sodium ER, Divalproex sodium capsules (sprinkles), Oxcarbazepine oral suspension, Topiramate sprinkle caps**

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

**OR**

- The patient has had a documented intolerance to the brand name product.

**Keppra XR<sup>®</sup>, Lamictal XR<sup>®</sup>**

- The patient has been unable to be compliant with or tolerate twice daily dosing of the immediate release product..

**Lamictal ODT<sup>®</sup>**

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

**AND**

- Lamotrigine chewable tablets cannot be used.

**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, cyclobenzaprine or Savella®, if medication is being used for fibromyalgia. (this indication not processed via automated step therapy)

**Sabril®**

- The prescriber and patient are registered with the SHARE program.

**AND**

- The diagnosis is infantile spasms

**OR**

- The patient is  $\geq 16$  years old and the indication is adjunctive therapy in refractory complex partial seizures after failure of THREE other preferred anticonvulsants.

**Stavzor®**

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

**OR**

- The patient has had a documented intolerance to divalproex sodium.

**Vimpat®**

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

**OR**

- The diagnosis is adjunctive therapy of partial-onset seizures and the patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least TWO preferred anticonvulsants

**DOCUMENTATION:**

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

**Anticonvulsants**Length of Authorization: lifetime for seizure disorders\*<sup>^</sup>; 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 <sup>®</sup> )	Banzel <sup>®</sup> (rufinamide)
CARBATROL <sup>®</sup> (carbamazepine)	QL = 8 tabs/day (400 mg) and 16 tabs/day (200 mg)
CELONTIN <sup>®</sup> (methsuxamide)	Carbamazepine extended release † (compare to Tegretol XR <sup>®</sup> )
CLONAZEPAM† (compare to Klonopin <sup>®</sup> )	Depakene <sup>®*</sup> (valproic acid)
CLONAZEPAM ODT† (compare to Klonopin Wafers <sup>®</sup> )	Depakote <sup>®*</sup> (divalproex sodium)
DEPAKOTE ER <sup>®</sup> (divalproex sodium)	divalproex sodium ER† (compare to Depakote ER <sup>®</sup> )
DEPAKOTE SPRINKLES <sup>®</sup> (divalproex sodium caps)	divalproex sodium capsules† (compare to Depakote Sprinkles <sup>®</sup> )
DIASTAT <sup>®</sup> (diazepam rectal gel)	Felbatol <sup>®</sup> (felbamate)
DILANTIN <sup>®</sup> (phenytoin)	Gabapentin† 100mg, 400 mg tablets
DIVALPROEX SODIUM † (compare to Depakote <sup>®</sup> )	Gabarone <sup>®</sup> (gabapentin) tablets
EPITOL† (carbamazepine)	Keppra <sup>®*</sup> (levetiracetam) tablets, oral solution
ETHOSUXAMIDE† (compare to Zarontin <sup>®</sup> )	Keppra XR <sup>®</sup> (levetiracetam extended release)
GABAPENTIN† 100 mg, 300 mg, 400 mg capsules, 600 mg, 800 mg tablets (compare to Neurontin <sup>®</sup> )	Klonopin <sup>®*</sup> (clonazepam)
GABITRIL <sup>®</sup> (tiagabine)	Klonopin Wafers <sup>®*</sup> (clonazepam ODT)
LAMOTRIGINE† chew tabs (compare to Lamictal <sup>®</sup> chew tabs)	Lamictal <sup>®*</sup> tabs (lamotrigine tabs)
LAMOTRIGINE† tabs (compare to Lamictal <sup>®</sup> tabs)	Lamictal <sup>®*</sup> chew tabs (lamotrigine chew tabs)
LEVETIRACETAM† tabs (compare to Keppra <sup>®</sup> tabs)	Lamictal ODT <sup>®</sup> (lamotrigine orally disintegrating tablets)
LEVETIRACETAM† oral soln (compare to Keppra <sup>®</sup> oral soln)	Lamictal XR <sup>®</sup> tablets (lamotrigine extended release)
NEURONTIN <sup>®</sup> oral solution (gabapentin)	Lyrica <sup>®</sup> (pregabalin) § ( <i>Quantity Limit = 3 capsules/day</i> )
OXCARBAZEPINE† tablets (compare to Trileptal <sup>®</sup> )	Mysoline <sup>®*</sup> (primidone)
PEGANONE <sup>®</sup> (ethotoin)	Neurontin <sup>®*</sup> (gabapentin) tablets and capsules
PHENYTEK <sup>®</sup> (phenytoin extended)	Oxcarbazepine † oral suspension (compare to Trileptal <sup>®</sup> )
PHENYTOIN† (compare to Dilantin <sup>®</sup> )	Sabril <sup>®</sup> (vigabatrin)
PHENYTOIN EX† cap (compare to Phenytek <sup>®</sup> )	Stavzor <sup>®</sup> (valproic acid delayed release)
PRIMIDONE† (compare to Mysoline <sup>®</sup> )	Tegretol <sup>®*</sup> (carbamazepine)
TEGRETOL XR <sup>®</sup> (carbamazepine)	Topamax <sup>®*</sup> (topiramate) tablets
TOPAMAX <sup>®</sup> (topiramate) Sprinkle Capsules	Topiramate† sprinkle caps (compare to Topamax <sup>®</sup> Sprinkles)
TOPIRAMATE† tabs (compare to Topamax <sup>®</sup> tabs)	Trileptal <sup>®*</sup> tablets (oxcarbazepine)
TRILEPTAL <sup>®</sup> oral suspension (oxcarbazepine)	Vimpat <sup>®</sup> (lacosamide)
VALPROIC ACID† (compare to Depakene <sup>®</sup> )	Zarontin <sup>®*</sup> (ethosuxamide)
ZONISIMIDE† (compare to Zonegran <sup>®</sup> )	Zonegran <sup>®*</sup> (zonisamide)

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

<sup>^</sup> 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\*<sup>▲</sup>; 1 year for other indications

**CRITERIA FOR APPROVAL:**

**Aplenzin:**

- The patient has had a documented inadequate response to Wellbutrin XL.
- AND
- 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)

**Budeprion XL, Bupropion XL:**

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

**Remeron, Remeron SolTab, Wellbutrin, Wellbutrin SR:**

- The patient has had a documented intolerance to the generic formulation 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 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 127 for a description of the management of mental health drugs.

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

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## Anti-Depressants: SNRIs

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**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, cyclobenzaprine, Lyrica® or Savella®. (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 127 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<sup>®</sup> § (duloxetine)  <i>FDA maximum recommended dose = 60 mg/day</i></p> <p>Effexor<sup>®</sup> (venlafaxine IR)  <i>FDA maximum recommended dose = 225 mg/day</i></p> <p>Effexor XR<sup>®</sup> § (venlafaxine XR)  <i>FDA maximum recommended dose = 225 mg/day,                      Quantity limit = 1 capsule/day (37.5 mg &amp; 75 mg)</i></p> <p>Pristiq<sup>®</sup> § (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<sup>®</sup>)  <i>FDA maximum recommended dose = 225 mg/day</i></p> <p>Venlafaxine ER<sup>®</sup>§ tablet  <i>FDA maximum recommended dose = 225 mg/day,                      Quantity limit = 1 tablet/day (37.5 mg &amp; 75 mg)</i></p>

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

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## Anti-Depressants: SSRIs

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**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 127 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**

<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
<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 &amp; 50 mg tabs)</i></p>	<p>Celexa®* (citalopram)  <i>FDA maximum recommended dose = 40 mg/day</i></p> <p>fluoxetine† (pmd) (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 &amp; 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 &amp; 50 mg tabs)</i></p>

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

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## Anti-Depressants: Tricyclics & MAOIs

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**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

**Chlordiazepoxide/Amitriptyline 10 mg/25 mg or Limbitrol DS**

- The prescriber must provide a clinically valid reason why the individual generic components can not be prescribed.

**MAOIs:**

**Marplan<sup>®</sup>**

- 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<sup>®</sup> and tranylcypromine.

**Parnate<sup>®</sup>**

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

**EMSAM<sup>®</sup>**

- 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 127 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
<b>TRICYCLICS</b>	
AMITRIPTYLINE† (previously Elavil®) <i>FDA maximum recommended dose = 300 mg/day</i> AMITRIPTYLINE/PERPHEN†.(previously Etrafon®, Triavil®) AMOXAPINE† (previously Asendin®) CHLORDIAZEPOXIDE/AMITRIPTYLINE †5mg/12.5mg (compare to Limbitrol®) CLOMIPRAMINE† (compare to Anafranil®) DESIPRAMINE† (compare to Norpramin®) DOXEPIN† (previously Sinequan®) IMIPRAMINE† (compare to Tofranil®) <i>FDA maximum recommended dose = 300 mg/day</i> IMIPRAMINE PAMOATE† (compare to Tofranil PM®) NORTRIPTYLINE† (previously Aventyl®, compare to Pamelor®) PROTRIPTYLINE† (compare to Vivactil®) TRIMIPRAMINE (compare to Surmontil®)	Anafranil®* (clomipramine) Chlordiazepoxide/Amitriptyline † 10 mg/25 mg (compare to Limbitrol DS®) Limbitrol®* (amitriptyline/chlordiazepoxide) Limbitrol DS® (amitriptyline/chlordiazepoxide) Norpramin®* (desipramine) Pamelor®* (nortriptyline) Surmontil®* (trimipramine) Tofranil®* (imipramine) <i>FDA maximum recommended dose = 300 mg/day</i> Tofranil PM®* (imipramine pamoate) Vivactil®* (protriptyline)
<b>MAOIs</b>	
NARDIL® (phenylzine) <i>FDA maximum recommended dose = 90 mg/day</i> TRANYLCPROMINE (compare to Parnate®) <i>FDA maximum recommended dose = 60 mg/day</i>	EMSAM® (selegiline) ( <i>QL = 1 patch/day</i> ) Marplan® (isocarboxazid) Parnate®* (tranylcypromine) <i>FDA maximum recommended dose = 60 mg/day</i>

\* 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.**

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

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## Anti-Diabetics: Oral

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**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**ALPHA GLUCOSIDASE INHIBITORS**

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

**BIGUANIDES AND COMBINATIONS**

*Fortamet, glucophage XR, Glumetza*

- The patient has had a documented intolerance to generic 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**

*Nateglinide*

- The patient has had a documented intolerance to brand Starlix.

*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 Starlix.

*Prandimet*

- The patient has been started and stabilized on Prandimet or on stable doses of the separate agents  
OR
- The patient has had an inadequate response with repaglinide monotherapy

**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, Onglyza*

- 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<sup>®</sup>**

- See Lipotropics: Bile Acid Sequestrants

**DOCUMENTATION:**

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

## Anti-Diabetics: Oral

Length of Authorization: 1 year

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

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

### **PREFERRED DRUGS (No PA Required)**

### **PA REQUIRED**

#### **ALPHA GLUCOSIDASE INHIBITORS**

ACARBOSE† (compare to Precose®)  
GLYSET® (miglitol)

Precose®\* (acarbose)

#### **BIGUANIDES AND COMBINATIONS**

##### **SINGLE AGENT**

METFORMIN† (compare to Glucophage®)  
METFORMIN XR† (compare to Glucophage XR®)  
RIOMET® (metformin oral solution)

Fortamet® (metformin extended-release)  
Glucophage®\* (metformin)  
Glucophage XR®\* (metformin extended-release)  
Glumetza® (metformin extended-release)

##### **COMBINATION**

GLIPIZIDE/METFORMIN† (compare to Metaglip®)  
GLYBURIDE/METFORMIN† (compare to Glucovance®)

Glucovance®\* (glyburide/metformin)  
Metaglip®\* (glipizide/metformin)

#### **MEGLITINIDES**

##### **SINGLE AGENT**

STARLIX® (nateglinide)

Nateglinide† (compare to Starlix®)  
Prandin® (repaglinide)

##### **COMBINATION**

Prandimet® (repaglinide/metformin)

#### **SULFONYLUREAS SECOND GENERATION**

GLIMEPIRIDE† (compare to Amaryl®)  
GLIPIZIDE† (compare to Glucotrol®)  
GLIPIZIDE ER† (compare to Glucotrol XL®)  
GLYBURIDE† (compare to Diabeta®, Micronase®)  
GLYBURIDE MICRONIZED† (compare to Glynase® PresTab®)

Amaryl®\* (glimepiride)  
Diabeta®\* (glyburide)  
Glucotrol®\* (glipizide)  
Glucotrol XL®\* (glipizide extended-release)  
Glynase® PresTab®\* (glyburide micronized)  
Micronase®\* (glyburide)

#### **THIAZOLIDINEDIONES AND COMBINATIONS (after clinical criteria are met)**

##### **SINGLE AGENT**

ACTOS® (pioglitazone) §  
AVANDIA® (rosiglitazone) §

##### **COMBINATION**

ACTOPLUS MET® (pioglitazone/metformin) §  
AVANDAMET® (rosiglitazone/metformin) §  
AVANDARYL® (rosiglitazone/glimeperide) §  
DUETACT® (pioglitazone/glimepiride) §  
(Quantity Limit = 1 tablet/day)

#### **DIPEPTIDYL PEPTIDASE (DPP-4) INHIBITORS AND COMBINATIONS (after clinical criteria are met)**

##### **SINGLE AGENT**

JANUVIA® (sitagliptin)§ (Quantity limit=1 tab/day)  
ONGLYZA® (saxagliptin)§ (Quantity limit=1 tab/day)

##### **COMBINATION**

JANUMET® (sitagliptin/metformin)§ (Quantity limit=2 tabs/day)

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

## Anti-Diabetics: Peptide Hormones

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**BYETTA**

- The patient has a diagnosis of diabetes mellitus.  
AND
- The patient is at least 18 years of age.  
AND
- The patient has had a documented side effect, allergy, or treatment failure to at least one oral anti-diabetic agent.  
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.**

<b>Anti-Diabetics: Peptide Hormones</b>		<i>Length of Authorization: 1 year</i>
<b>Key: § Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)</b>		
<b>PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET</b>	<b>PA REQUIRED</b>	
Byetta <sup>®</sup> (exenatide) § ( <i>Quantity Limit=1 pen/30 days</i> ) Symlin <sup>®</sup> (pramlintide) § ( <i>No quantity limit applies</i> )		

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## Anti-Emetics: 5-HT<sub>3</sub> Receptor Antagonists

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

**CRITERIA FOR APPROVAL (non-preferred agents):**

Aloxi<sup>®</sup>, Anzemet<sup>®</sup>, Granisetron, Kytril<sup>®</sup>

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

Zofran<sup>®</sup>

- 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.

Sancuso<sup>®</sup>

- The patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy.  
AND
- The prescriber provides documentation of medical necessity for the transdermal formulation.  
OR
- The patient has had a documented side effect, allergy or treatment failure with generic ondansetron.

**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, three tablets per day of 4 mg or 8 mg may be approved for 3 months.

Anzemet<sup>®</sup>

- 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<sup>®</sup>

- 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.

Sancuso<sup>®</sup>

- For nausea and vomiting associated with chemotherapy, 1 patch for each chemotherapy cycle 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**.

<b>Anti-Emetics: 5-HT<sub>3</sub> Receptor Antagonists</b>	
<i>Length of Authorization: 6 months for Chemotherapy/Radiotherapy, 1 time Post-Op</i>	
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
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>
	Sancuso® 3.1 mg/24 hrs Transdermal Patch (granisetron) <i>Quantity Limit = 1 patch/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**.

<b>Anti-Emetics: NK1 Antagonists</b>		<i>Length of Authorization: up to 1 year</i>
<b>PREFERRED DRUGS (No PA Required)</b>		<b>PA REQUIRED</b>
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)
* To be prescribed by oncology practitioners ONLY		

## Anti-Emetics: Other

**LENGTH OF AUTHORIZATION:** 3 months

**PHARMACOLOGY:**

Marinol<sup>®</sup> 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<sup>®</sup> 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<sup>®</sup> and Cesamet<sup>®</sup> are FDA-approved for use in chemotherapy associated nausea and vomiting refractory to conventional antiemetics. In addition, Marinol<sup>®</sup> 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**.

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

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## Anti-Hyperkinesia and Anti-Narcolepsy/Cataplexy

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**LENGTH OF AUTHORIZATION:** Duration of need for mental health indications\*<sup>▲</sup>; 1 year for other indications

**CRITERIA FOR APPROVAL:**

**STIMULANTS**

Dexmethylphenidate and Focalin<sup>®</sup>

- The patient has a diagnosis of ADD, ADHD or narcolepsy.
- 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 had a documented side-effect, allergy, or treatment failure on Methylin<sup>®</sup> or methylphenidate. In addition, for approval of brand name Focalin<sup>®</sup>, the patient must have had a documented intolerance to generic dexmethylphenidate.

Metadate CD<sup>®</sup> and Ritalin LA<sup>®</sup>

- The patient has a diagnosis of ADD, ADHD or narcolepsy.
- 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 had a documented side-effect, allergy, or treatment failure on Focalin XR<sup>®</sup> or Concerta<sup>®</sup>.

Ritalin<sup>®</sup> and Ritalin SR<sup>®</sup>

- The patient has a diagnosis of ADD, ADHD or narcolepsy.
- AND**
- The patient has had a documented intolerance to the preferred equivalent. For Ritalin SR<sup>®</sup> these are Methylin<sup>®</sup> ER, Metadate ER<sup>®</sup> or methylphenidate SR. For Ritalin these are Methylin<sup>®</sup> or methylphenidate.

Adderall<sup>®</sup> and Dexedrine CR<sup>®</sup>

- The patient has a diagnosis of ADD, ADHD or narcolepsy.
- AND**
- The patient has had a documented intolerance to the preferred generic equivalent.

Desoxyn<sup>®</sup>

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

Amphetamine/dextroamphetamine SR 24 HR (generic)

- The patient has a diagnosis of ADD, ADHD or narcolepsy.
- AND**
- The patient must have a documented intolerance to the brand name Adderall XR<sup>®</sup>.

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.

## NON-STIMULANTS

### Intuniv<sup>®</sup>, Strattera<sup>®</sup>

- The patient has a diagnosis of ADD or 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<sup>®</sup>, Ritalin LA<sup>®</sup>, Focalin XR<sup>®</sup>, Adderal XR<sup>®</sup>, Concerta<sup>®</sup>, Vyvanse<sup>®</sup> and Daytrana<sup>®</sup>)  
**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<sup>®</sup>, Ritalin LA<sup>®</sup>, Focalin XR<sup>®</sup>, Adderal XR<sup>®</sup>, Concerta<sup>®</sup>, Vyvanse<sup>®</sup> and Daytrana<sup>®</sup>)  
**OR**
- There is a question of substance abuse with the patient or family of the patient.

### Nuvigil<sup>®</sup>

#### **Narcolepsy, excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome (adjunct to standard treatment):**

- The patient is > 17 years old.  
**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 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).

Nuvigil<sup>®</sup> **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** (for any age patient).

### Provigil<sup>®</sup>

#### **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<sup>®</sup>.

Provigil<sup>®</sup> **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**.

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 127 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<sup>®</sup> (compare to Ritalin<sup>®</sup> SR)  
 METHYLIN<sup>®</sup> (compare to Ritalin<sup>®</sup>)  
 METHYLIN<sup>®</sup> ER (compare to Ritalin<sup>®</sup> SR)  
 METHYLPHENIDATE † (compare to Ritalin<sup>®</sup>)  
 METHYLPHENIDATE SR † (compare to Ritalin<sup>®</sup> SR)

Dexmethylphenidate † (compare to Focalin<sup>®</sup>)  
 Focalin<sup>®</sup> (dexmethylphenidate)  
 Ritalin<sup>®\*</sup> (methylphenidate)  
 Ritalin SR<sup>®\*</sup> (methylphenidate SR)

##### Long-Acting Methylphenidate Preps

###### Oral

CONCERTA<sup>®</sup> (methylphenidate SA OSM IR/ER, 22:78%)  
 FOCALIN XR<sup>®</sup> (dexmethylphenidate SR 24 HR IR/ER, 50:50%)

Metadate CD<sup>®</sup> (methylphenidate CR, IR/ER, 30:70%)  
 Ritalin LA<sup>®</sup> (methylphenidate SR 24 HR, IR/ER, 50:50%)

###### Transdermal Patch

DAYTRANA<sup>®</sup> (methylphenidate patch) (*QL = 1 patch/day*)

##### Short/Intermediate-Acting Amphetamine Preps

AMPHETAMINE/DETRIOAMPHETAMINE † (compare to Adderall<sup>®</sup>)  
 DEXTROAMPHETAMINE † (previously Dexedrine<sup>®</sup>)  
 DEXTROAMPHETAMINE SR † (compare to Dexedrine CR<sup>®</sup>)  
 DEXTROSTAT † (dextroamphetamine)

Adderall<sup>®\*</sup> (amphetamine/dextroamphetamine)  
 Desoxyn<sup>®</sup> (methamphetamine)  
 Dexedrine CR<sup>®\*</sup> (dextroamphetamine SR)

##### Long-Acting Amphetamine Preps

ADDERALL XR<sup>®</sup> (amphetamine/dextroamphetamine SR 24 HR, IR/ER, 50:50%)  
 VYVANSE<sup>®</sup> (lisdexamfetamine) (*QL = 1 capsule/day*)

Amphetamine/dextroamphetamine SR 24 HR, IR/ER, 50:50% † (compare to Adderall XR<sup>®</sup>)

**CNS stimulants** (all forms short- & long-acting): PA for beneficiaries < 3 yrs

#### NON-STIMULANTS

Intuniv<sup>®</sup> (guanfacine extended release) Tablet  
*Qty limit = 1 tablet/day*

Nuvigil<sup>®</sup> (armodafinil)  
*Qty limit: 50 mg = 2 tablets/day*  
*150 mg/250 mg = 1 tablet/day*

Provigil<sup>®</sup> (modafinil) (**not approvable for ADHD in children age ≤12**) (*Max days supply = 30 days*)  
*Qty limit: 100 mg = 1.5 tablets/day*  
*200 mg = 2 tablets/day*  
*Maximum Daily Dose = 400 mg*

Strattera<sup>®</sup> (atomoxetine)  
*FDA maximum recommended dose = 100 mg/day*

Xyrem<sup>®</sup> (sodium oxybate)

\*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-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 all available preferred generic ACEI. If a medication has an AB rated generic, there must have been a trial of the generic formulation.

**ACE Inhibitor/Hydrochlorothiazide combinations:**

- The patient has had a documented side effect, allergy, or treatment failure to all available preferred generic ACEI/Hydrochlorothiazide combination. If a medication has an AB rated generic, there must have been a trial of the generic formulation.

**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.**

<b>Anti-Hypertensives: ACE Inhibitors and ACEI Combinations</b>	
<i>Length of Authorization: 1 year</i>	
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA Required</b>
<p><b><u>ACE INHIBITORS:</u></b>            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®)            RAMIPRIL† (compare to Altace®)            TRANDOLAPRIL† (compare to Mavik®)</p>	<p>Accupril®* (quinapril)            Aceon® (perindopril)            Altace®* (ramipril)            Capoten®* (captopril)            Lotensin®* (benazepril)            Mavik®* (trandolapril)            Monopril®* (fosinopril)            perindopril† (compare to Aceon®)            Prinivil®* (lisinopril)            Univasc®* (moexipril)            Vasotec®* (enalapril)            Zestril®* (lisinopril)</p>
<p><b><u>ACE INHIBITOR/HYDROCHLOROTHIAZIDE:</u></b>            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®)            MOEXIPRIL/HCTZ† (compare to Uniretic®)            QUINAPRIL/HCTZ† (compare to Accuretic®)</p>	<p>Accuretic®* (quinapril/HCTZ)            Capozide®* (captopril/HCTZ)            Lotensin HCT®* (benazepril/HCTZ)            Monopril HCT®* (fosinopril/HCTZ)            Prinzide®* (lisinopril/HCTZ)            Uniretic®* (moexipril/HCTZ)            Vaseretic®* (enalapril/HCTZ)            Zestoretic®* (lisinopril/HCTZ)</p>
<p><b><u>ACE INHIBITOR/CALCIUM CHANNEL BLOCKER:</u></b>            amlodipine/benazepril† (compare to Lotrel®)</p>	<p>Lexxel® (enalapril/felodipine)            Lotrel®* (amlodipine/benazepril)            10/40 and 5/40 strengths not available generically            – please prescribe individual generic components            Tarka® (trandolapril/verapamil)</p>

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

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**LENGTH OF AUTHORIZATION:** 3 years

**CRITERIA FOR APPROVAL:**

**Avapro, Benicar, Cozaar, Diovan, Micardis, Avalide, Benicar HCT, Diovan HCT, Hyzaar, Micardis HCT, Azor, Exforge, Exforge 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 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.**

## Anti-Hypertensives: ARBs and ARB Combinations

*Length of Authorization: 3 years*

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

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

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## Anti-Hypertensives: Beta-Blockers

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**LENGTH OF AUTHORIZATION:** 3 years

**CRITERIA FOR APPROVAL**

**Non-preferred drugs (except Coreg CR<sup>®</sup>):**

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

**Coreg CR<sup>®</sup>:**

Indication: Heart Failure

- The patient has been started and stabilized on Coreg CR<sup>®</sup>. (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<sup>®</sup>. (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**.

## Anti-Hypertensives: Beta-Blockers

Length of Authorization: 3 years

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

PREFERRED DRUGS (No PA Required)	PA REQUIRED
<p><b><u>SINGLE AGENT</u></b>            ACEBUTOLOL† (compare to Sectral®)            ATENOLOL† (compare to Tenormin®)            BETAXOLOL† (compare to Kerlone®)            BISOPROLOL FUMARATE† (compare to Zebeta®)            CARVEDILOL† (compare to Coreg®)            LABETALOL† (compare to Trandate®)            METOPROLOL† (compare to Lopressor®)            METOPROLOL XL† (compare to Toprol XL®)            NADOLOL† (compare to Corgard®)            PINDOLOL† (formerly Visken®)            PROPRANOLOL† (compare to Inderal®)            PROPRANOLOL ER† (compare to Inderal LA®)            SOTALOL† (compare to Betapace®, BetapaceAF®)            TIMOLOL† (formerly Blocadren®)</p>	<p>Betapace®* (sotalol)            Betapace AF®* (sotalol)            Bystolic® (nebivolol) (QL = 1 tablet/day for 2.5 mg, 5 mg and 10 mg tablet strengths, 2 tablets/day for 20 mg)            Coreg®* (carvedilol)            Coreg CR® (carvedilol CR) (QL = 1 tablet/day)            Corgard®* (nadolol)            Inderal®* (propranolol)            Inderal LA®* (propranolol ER)            InnoPran XL® (propranolol SR)            Kerlone®* (betaxolol)            Levatol® (penbutalol)            Lopressor®* (metoprolol)            Sectral®* (acebutolol)            Tenormin®* (atenolol)            Toprol XL®* (metoprolol succinate XL)            Trandate®* (labetalol)            Zebeta®* (bisoprolol)</p>
<p><b><u>BETA-BLOCKER/DIURETIC COMBINATION</u></b>            ATENOLOL/CHLORTHALIDONE† (compare to Tenoretic®)            BISOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Ziac®)            METOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Lopressor HCT®)            NADOLOL/BENDROFLUMETHIAZIDE† (compare to Corzide®)            PROPRANOLOL/HYDROCHLOROTHIAZIDE† (compare to Inderide®)</p>	<p>Corzide®* (nadolol/bendroflumethiazide)            Inderide®* (propranolol/hydrochlorothiazide)            Lopressor HCT®* (metoprolol/hydrochlorothiazide)            Tenoretic®* (atenolol/chlorthalidone)            Timolide® (timolol/hydrochlorothiazide)            Ziac®* (bisoprolol/hydrochlorothiazide)</p>

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## Anti-Hypertensives: Calcium Channel Blockers

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**LENGTH OF AUTHORIZATION:** 3 years

**CRITERIA FOR APPROVAL (except for Azor<sup>®</sup>, Caduet<sup>®</sup>, Exforge<sup>®</sup> and Exforge HCT<sup>®</sup>):**

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

**Caduet<sup>®</sup>**

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

**Azor<sup>®</sup>, Exforge<sup>®</sup>, Exforge HCT<sup>®</sup>**

- 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.**

**Anti-Hypertensives: Calcium Channel Blockers** *Length of Authorization: 3 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
<b><u>SINGLE AGENT</u></b>	
<b>Dihydropyridines</b>	
AFEDITAB <sup>®</sup> CR † (nifedipine SR, compare to Adalat <sup>®</sup> CC)	Adalat <sup>®</sup> CC* (nifedipine SR)
AMLODIPINE † (compare to Norvasc <sup>®</sup> )	Cardene <sup>®</sup> SR (nicardipine SR) (no AB rated generic)
FELODIPINE † (compare to Plendil <sup>®</sup> )	Dynacirc <sup>®</sup> CR (isradipine CR) (no AB rated generic)
ISRADIPINE † (formerly Dynacirc <sup>®</sup> )	Nimotop <sup>®</sup> * (nimodipine)
NICARDIPINE † (formerly Cardene <sup>®</sup> )	Norvasc <sup>®</sup> * (amlodipine)
NIFEDIAC <sup>®</sup> CC † (nifedipine SR, compare to Adalat <sup>®</sup> CC)	Plendil <sup>®</sup> * (felodipine)
NIFEDICAL <sup>®</sup> XL † (nifedipine SR osmotic, compare to Procardia <sup>®</sup> XL)	Procardia <sup>®</sup> * (nifedipine IR)
NIFEDIPINE IR † (compare to Procardia <sup>®</sup> )	Procardia XL <sup>®</sup> * (nifedipine SR osmotic)
NIFEDIPINE SR osmotic † (compare to Procardia <sup>®</sup> XL)	Sular <sup>®</sup> (nisoldipine)
NIFEDIPINE SR † (compare to Adalat <sup>®</sup> CC )	
NIMODIPINE † (compare to Nimotop <sup>®</sup> )	
<b>Miscellaneous</b>	
CARTIA <sup>®</sup> XT † (diltiazem SR, compare to Cardizem <sup>®</sup> CD)	Calan <sup>®</sup> * (verapamil)
DILT-CD <sup>®</sup> † (diltiazem SR, compare to Cardizem <sup>®</sup> CD)	Calan <sup>®</sup> SR* (verapamil CR)
DILTIA <sup>®</sup> XT † (diltiazem SR, compare to Dilacor <sup>®</sup> XR)	Cardizem <sup>®</sup> * (diltiazem)
DILT-XR <sup>®</sup> † (diltiazem SR, compare to Dilacor <sup>®</sup> XR)	Cardizem <sup>®</sup> CD* (diltiazem SR)
DILTIAZEM † (compare to Cardizem <sup>®</sup> )	Cardizem <sup>®</sup> LA (diltiazem SR) (no AB rated generic)
DILTIAZEM ER † (formerly Cardizem <sup>®</sup> SR)	Covera-HS <sup>®</sup> (verapamil SR) (no AB rated generic)
DILTIAZEM ER † (compare to Tiazac <sup>®</sup> )	Dilacor <sup>®</sup> XR* (diltiazem SR)
DILTIAZEM SR † (compare to Cardizem <sup>®</sup> CD)	Isoptin <sup>®</sup> SR* (verapamil CR)
DILTIAZEM SR † (compare to Dilacor <sup>®</sup> XR)	Tiazac <sup>®</sup> * (diltiazem ER)
TAZTIA <sup>®</sup> XT † (diltiazem ER, compare to Tiazac <sup>®</sup> )	Verelan <sup>®</sup> * (verapamil SR 120 mg, 180 mg, 240 mg and 360 mg)
VERAPAMIL † (compare to Calan <sup>®</sup> )	Verelan <sup>®</sup> PM* (100 mg, 200 mg and 300 mg)
VERAPAMIL CR † (compare to Calan SR <sup>®</sup> , Isoptin <sup>®</sup> SR)	
VERAPAMIL SR † 120 mg, 180 mg 240 mg and 360 mg (compare to Verelan <sup>®</sup> )	
VERAPAMIL SR † 100 mg, 200 mg, 300mg (compare to Verelan PM <sup>®</sup> )	
<b><u>CALCIUM CHANNEL BLOCKER/OTHER COMBINATION</u></b>	
<b>(preferred after clinical criteria are met)</b>	
AZOR <sup>®</sup> (olmesartan/amlodipine) § (QL = 1 tablet/day)	
EXFORGE <sup>®</sup> (valsartan/amlodipine) § (QL = 1 tablet/day)	
EXFORGE HCT <sup>®</sup> (amlodipine/valsartan/hydrochlorothiazide) § (QL = 1 tab/day)	Caduet <sup>®</sup> (amlodipine/atorvastatin)

## Anti-hypertensives: Renin Inhibitors

**LENGTH OF AUTHORIZATION:** 3 years

**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**.

<b>Anti-hypertensives: Renin Inhibitors</b>		<i>Length of Authorization: 3 years</i>
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
	<p><b><u>Single Agent</u></b> Tekturna® (aliskiren) (<i>Qty Limit = 1 tablet/day</i>)</p> <p><b><u>Combination</u></b> Tekturna HCT® (aliskiren/hydrochlorothiazide) (<i>Qty Limit = 1 tablet/day</i>)</p>	

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## Anti-Infectives: Cephalosporins

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

**CRITERIA FOR APPROVAL:**

**Duricef<sup>®</sup>, Keflex<sup>®</sup>:**

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

**Lorabid<sup>®</sup> 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<sup>®</sup> suspension (for the suspension).

**Ceftin<sup>®</sup> tablets, Cefzil<sup>®</sup> 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.

**Ceftin suspension, Cefzil<sup>®</sup> 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 cefuroxime suspension. If a product has an AB rated equivalent that is preferred, one trial must be the preferred formulation.

**Spectracef<sup>®</sup> tablet, Cedax<sup>®</sup> Capsule, Cefditoren tablet:**

- The patient is completing a course of therapy which was initiated in the hospital.
- OR**
- The patient has had a documented side effect, allergy, or treatment failure to both cefpodoxime and Omnicef<sup>®</sup>.
- AND**
- If the request is for Spectracef<sup>®</sup>, the patient has a documented intolerance with generic cefditoren tablets

**Cefdinir capsule or suspension:**

- The patient has had a documented intolerance to brand Omnicef<sup>®</sup>.

**Cefpodoxime suspension, Cedax<sup>®</sup> suspension:**

- The patient is completing a course of therapy which was initiated in the hospital.
- OR**
- The patient has had a documented side effect or treatment failure to both, brand Omnicef<sup>®</sup> and Suprax<sup>®</sup> suspension.

**Vantin<sup>®</sup> suspension:**

- The patient is completing a course of therapy which was initiated in the hospital and the patient is unable to use generic cefpodoxime.
- OR**
- The patient has had a documented side effect or treatment failure to brand Omnicef<sup>®</sup> or Suprax<sup>®</sup> suspension AND cefpodoxime suspension.

**Vantin<sup>®</sup> tablets:**

- The patient is completing a course of therapy which was initiated in the hospital and the patient is unable to use generic cefpodoxime.
- OR**
- The patient has had a documented side effect or treatment failure to both brand Omnicef<sup>®</sup> and cefpodoxime.

**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
<b><u>1<sup>st</sup> GENERATION:</u></b>	
CEFADROXIL† (compare to Duricef®) CEPHALEXIN† (compare to Keflex®)	Duricef®* (cefadroxil) Keflex®* (cephalexin)
IV drugs are not managed at this time.	
<b><u>2<sup>nd</sup> GENERATION:</u></b>	
<b><u>TABLETS/CAPSULES</u></b>	
CEFACLOR† CAPSULE CEFACLOR ER† TABLET CEFPROZIL† (compare to Cefzil®) TABLET CEFUROXIME † (compare to Ceftin®) TABLET	Ceftin®* (cefuroxime) tablet Cefzil®* (cefprozil) tablet Lorabid® (loracarbef) capsule
<b><u>SUSPENSION</u></b>	
CEFACLOR† SUSPENSION CEFPROZIL† (compare to Cefzil®) SUSPENSION CEFUROXIME† (compare to Ceftin®) SUSPENSION	Ceftin®* (cefuroxime) suspension Cefzil®* (cefprozil) suspension Lorabid® (loracarbef) suspension
IV drugs are not managed at this time.	
<b><u>3<sup>rd</sup> GENERATION:</u></b>	
<b><u>CAPSULES/TABLETS</u></b>	
CEFPODOXIME PROXETIL† (compare to Vantin®) TABLET OMNICEF® (cefdinir) CAPSULE SUPRAX® (cefixime) TABLET	Cedax® (ceftibuten) capsule Cefdinir† (compare to Omnicef®) capsule Cefditoren† (compare to Spectracef®) tablet Spectracef® (cefditoren) tablet Vantin®* (cefpodoxime) tablet
<b><u>SUSPENSION</u></b>	
OMNICEF® (cefdinir) SUSPENSION SUPRAX® (cefixime) SUSPENSION	Cedax® (ceftibuten) suspension Cefdinir† (compare to Omnicef®) suspension Cefpodoxime proxetil† (compare to Vantin®) suspension Vantin® (cefpodoxime) suspension
IV drugs are not managed at this time.	

## 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  $\geq 2$  of the following antibiotics: penicillin, 2<sup>nd</sup> generation cephalosporins, macrolides, tetracyclines, and trimethoprim/sulfamethoxazole.

<b>Anti-Infectives: Ketolides</b>		<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 2<sup>nd</sup> 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**.

<b>Anti-Infectives: Macrolides</b>	
<i>Length of Authorization: Date of service only. No refills.</i>	
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
AZITHROMYCIN† tabs (≤ 5 day supply) (compare to Zithromax®)	azithromycin† tablets and liquid (if > 5 day supply) (compare to Zithromax®)
AZITHROMYCIN† liquid (≤ 5 day supply) (compare to Zithromax®)	Biaxin®* (clarithromycin) Biaxin XL® (clarithromycin XL)
CLARITHROMYCIN† (compare to Biaxin®)	Dynabac® (dirithromycin)
E.E.S®† (erythromycin ethylsuccinate)	Eryped® (erythromycin ethylsuccinate)
ERY-TAB® (erythromycin base, delayed release)	PCE Dispertab® (erythromycin base)
ERYTHROCIN† (erythromycin stearate)	Pediazole®* (erythromycin-sulfisoxazole)
ERYTHROMYCIN BASE†	Zithromax®* (azithromycin) tablets and liquid
ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S®)	Zmax® Suspension (azithromycin extended release for oral suspension)
ERYTHROMYCIN STEARATE†	
ERYTHROMYCIN W/SULFISOXAZOLE† (compare to Pediazole®)	
IV drugs are not managed at this time.	

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## Anti-Infectives: Oxazolidinones

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**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**.

<b>Anti-Infectives: Oxazolidinones</b>		<i>Length of authorization: 28 days</i>
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
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, Moxatag:**

- 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**.

<b>Anti-Infectives: Penicillins (oral)</b> <i>Length of Authorization: Date of service only. No refills.</i>	
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
AMOXICILLIN† (compare to Amoxil <sup>®</sup> , Trimox <sup>®</sup> , DisperMox <sup>®</sup> )	Augmentin <sup>®</sup> * (amoxicillin/clavulanate) chewable tablets, tablets, suspension
AMOXICILLIN/CLAVULANATE† (compare to Augmentin <sup>®</sup> )	Augmentin ES <sup>®</sup> * (amoxicillin/clavulanate) suspension
AMPICILLIN† (compare to Principen <sup>®</sup> )	Augmentin XR <sup>®</sup> (amoxicillin/clavulanate) tablets
DICLOXACILLIN†	Moxatag <sup>®</sup> (amoxicillin extended release) tablet
PENICILLIN VK† (compare to Veetids <sup>®</sup> )	<i>QL = 1 tablet/day</i>
	* 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<sup>®</sup>:**

- 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<sup>®</sup>, Cipro XR<sup>®</sup>, ciprofloxacin ER, ProQuin XR<sup>®</sup>:**

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

**Avelox<sup>®</sup>, Factive<sup>®</sup>:**

- 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.**

<b>Anti-Infectives: Quinolones</b>		<i>Length of Authorization: Date of service only. No refills.</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
CIPROFLOXACIN† (compare to Cipro <sup>®</sup> ) CIPRO <sup>®</sup> OS (ciprofloxacin oral solution) LEVAQUIN <sup>®</sup> (levofloxacin) OFLOXACIN†	Avelox <sup>®</sup> (moxifloxacin HCL) Avelox <sup>®</sup> ABC PACK (moxifloxacin HCL) Cipro <sup>®</sup> * (ciprofloxacin) Cipro <sup>®</sup> XR (ciprofloxacin) ciprofloxacin ER† (compare to Cipro <sup>®</sup> XR) Factive <sup>®</sup> (gemifloxacin) Noroxin <sup>®</sup> (norfloxacin) ProQuin XR <sup>®</sup> (ciprofloxacin extended-release)	
IV drugs are not managed this time		

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## Anti-Infectives: Antifungals: Allylamines

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### 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<sup>®</sup>, 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**.

<b>Anti-Infectives: Antifungals: Allylamines</b>	
<i>Length of Authorization: Up to 3 months</i>	
<b>Key: † Generic product</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
	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.

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## Anti-Infectives: Antifungals: Azoles

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**LENGTH OF AUTHORIZATION:** Up to 3 months

Onychomycosis (Sporanox/itraconazole):

Fingernails: 2 capsules (200mg) twice daily for 1 week per month for 2 months (pulse) or  
2 capsules (200mg) per day for 6 weeks

Toenails: 2 capsules (200mg) twice daily for 1 week per month for 3 months (pulse) or  
2 capsules (200mg) per day for 12 weeks

Other medications/indications: 3 months

**CRITERIA FOR APPROVAL (ITRACONAZOLE/ SPORANOX®):**

- The patient has a diagnosis of invasive aspergillosis, blastomycosis, or histoplasmosis  
**OR**
- The patient has a diagnosis of a fingernail/toenail onychomycosis infection (confirmed with a positive KOH stain, PAS stain, fungal culture or physician clinical judgment) **AND** has a documented side-effect, allergy, contraindication, or treatment failure to oral terbinafine **AND** meets at least 1 of the following criteria:
  - Pain to affected area that limits normal activity
  - Diabetes Mellitus
  - Patient is immunocompromised
  - Patient has diagnosis of systemic dermatosis
  - Patient has significant vascular compromise**OR**
- The patient is completing a course of therapy with the requested medication that was initiated in the hospital.  
**OR**
- The patient has a documented side-effect, allergy, or treatment failure to at least **ONE** of the preferred medications.
- For approval of Sporanox®, the patient must have a documented intolerance to generic itraconazole.

**LIMITATIONS:**

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

**CRITERIA FOR APPROVAL OF VFEND:**

- Vfend is being used for the treatment of invasive aspergillosis.  
**OR**
- The patient is completing a course of therapy with the requested medication that was initiated in the hospital.  
**OR**
- The patient has a documented side-effect, allergy, or treatment failure to **ONE** of the preferred medications **AND** itraconazole.

**CRITERIA FOR APPROVAL OF NOXAFIL:**

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

**OR**

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

**OR**

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

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

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

**DOCUMENTATION:**

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

<b>Anti-Infectives: Antifungals: Azoles</b>	
<i>Length of Authorization: Up to 3 months (see above)</i>	
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
FLUCONAZOLE† (compare to Diflucan®) KETOCONAZOLE† (compare to Nizoral®)	Diflucan®* (fluconazole) itraconazole† (compare to Sporanox®) Nizoral®* (ketoconazole) Noxafil® (posaconazole) Sporanox® (itraconazole) VFend® (voriconazole)
IV drugs are not managed at this time.	

## 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<sup>®</sup>, 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**.

<b>Anti-Infectives: Antifungals: Topical: Onychomycosis</b>	
<i>Length of Authorization: 1 year</i>	
<b>Key: † Generic product</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
	ciclopirox† 8 % solution (compare to Penlac <sup>®</sup> Nail Lacquer) ( <i>QL=1 bottle (6.6 ml)/90 days</i> )  Penlac <sup>®</sup> Nail Lacquer (ciclopirox 8 % solution) ( <i>QL=1 bottle (6.6 ml)/90 days</i> )

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## Anti-Infectives: Herpes: Oral

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

**CRITERIA FOR APPROVAL (NON-PREFERRED AGENTS except Valacyclovir):**

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

**Valacyclovir**

- The patient has a documented intolerance to brand name Valtrex®.

**DOCUMENTATION:**

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

<b>Anti-Infectives: Herpes: Oral</b>		<i>Length of Authorization: up to 6 months</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b> <b>§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
ACYCLOVIR† (compare to Zovirax®) VALTREX® (valacyclovir)	Famvir® (famciclovir) § famciclovir† (compare to Famvir®) valacyclovir † (compare to Valtrex®) Zovirax®* (acyclovir) §	

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## Anti-Infectives: Influenza Medications

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**Please consult the following websites for information on who and when to treat and also recommendations for chemoprophylaxis. These websites will be updated as new information becomes available. Dosing information below is to be used in combination with the CDC and Vermont Department of Health recommendations:**

<http://www.cdc.gov/h1n1flu/recommendations.htm>

<http://healthvermont.gov/panflu/SwineFlu.aspx>

As of October 3, 2009, 99% of circulating influenza viruses in the United States were 2009 H1N1 influenza (previously referred to as novel influenza A (H1N1) or swine flu) and were generally susceptible to both oseltamivir and zanamivir but resistant to amantadine and rimantadine. This susceptibility pattern is the same as that observed among seasonal influenza A (H3N2) and B viruses in recent years. Among people who become infected with 2009 H1N1, certain groups appear to be at increased risk of complications and may benefit most from early treatment with antiviral medications. Approximately 70% of persons hospitalized with 2009 H1N1 influenza have had a recognized high risk condition. These groups are similar to those who are at increased risk for seasonal influenza-related complications. (see above websites)

Most healthy persons who develop suspected or confirmed 2009 H1N1 influenza or seasonal influenza who present with an uncomplicated febrile illness generally do not require antiviral treatment. In addition, persons who appear to be recovering from influenza generally do not require antiviral treatment. However, some groups appear to be at increased risk of influenza-related complications. (see above websites)

Antiviral doses recommended for treatment of 2009 H1N1 influenza virus infection in adults or children 1 year of age or older are the same as those recommended for seasonal influenza. The U.S. Food and Drug Administration (FDA) has authorized oseltamivir use for children younger than 1 year old under an Emergency Use Authorization (EUA) in response to the current public health emergency involving 2009 H1N1 influenza virus. The use of oseltamivir is subject to the terms and conditions of the EUA. Dosing for children younger than 1 year old is age-based in the EUA guidance. However, some experts who are currently conducting studies on oseltamivir use in this age group prefer weight based dosing for this age group, particularly for premature or underweight infants.

**LENGTH OF AUTHORIZATION:** for duration of the prescription

**CRITERIA FOR APPROVAL (Tamiflu, Rimantadine, Relenza):**

Tamiflu, Rimantadine and Relenza will **NOT** require prior-authorization **at this time** when prescribed within the following quantity limits:

- Relenza (zanamivir): 20 blisters per 30 days
- 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
- Rimantadine: 100 mg tablets: 20 tablets per 30 days

**Antiviral medication dosing recommendations for treatment or chemoprophylaxis of 2009 H1N1 infection.**

Agent, group		Treatment (5 days)	Chemoprophylaxis (10 days)
<b>Oseltamivir (Tamiflu®)</b>			
<b>Adult</b>		75-mg capsule twice per day	75-mg capsule once per day
<b>Children ≥ 12 months</b>	≤15 kg	30 mg twice daily	30 mg once per day
	16-23 kg	45 mg twice daily	45 mg once per day
	24-40 kg	60 mg twice daily	60 mg once per day
	>40 kg	75 mg twice daily	75 mg once per day
<b>Zanamivir (Relenza®)*</b>			
<b>Adult</b>		10 mg (two 5 mg inhalations) twice daily	10 mg (two 5-mg inhalations) once daily
<b>Children</b>		10 mg (two 5 mg inhalations) twice daily (for <b>7 years or older</b> )	10 mg (two 5-mg inhalations) once daily (for <b>5 years or older</b> )

\*Zanamivir, an inhaled medication, can induce bronchospasm and is not recommended for treatment for patients with underlying pulmonary disease such as asthma or chronic obstructive pulmonary disease.

**Dosing recommendations for Emergency Use Authorization for antiviral treatment or chemoprophylaxis of children younger than 1 year old using oseltamivir (Tamiflu®).**

Age	Recommended treatment dose for 5 days	Recommended prophylaxis dose for 10 days
Younger than 3 months	12 mg twice daily	Not recommended unless situation judged critical due to limited data on use in this age group
3-5 months	20 mg twice daily	20 mg once daily
6-11 months	25 mg twice daily	25 mg once daily

Some experts prefer weight-based dosing for children aged younger than 1 year, particularly for very young or premature infants. If using weight-based dosing for treatment or chemoprophylaxis of infants younger than 1 year old, consider the following regimen as described by Kimberlin et al:

- ≥ 9 months should receive 3.5 mg/kg/dose BID.
- ≤ 9 months should receive 3 mg/kg/dose BID.

When dispensing TAMIFLU® for Oral Suspension for children younger than 1 year of age, the oral dosing dispenser that is included in the Tamiflu package should always be removed. Pharmacists and healthcare providers should provide an oral syringe that is capable of accurately measuring the prescribed dose in milliliters (mL), and counsel the caregiver how to administer the prescribed dose. Oseltamivir (Tamiflu®) 75 mg capsules can also be compounded at most retail pharmacies into a suspension when commercially manufactured Tamiflu® oral suspension is not available. Tamiflu® oral suspension concentration is **12 mg/mL**; the compounded suspension concentration is **15 mg/mL**. Prescribers should include the product name and concentration (e.g. Tamiflu® oral suspension 12mg/mL) if prescribing in mL or teaspoons or to prescribe the dose in milligrams (mg). In all cases, pharmacists should ensure that the dosing instructions given to children younger than 1 year are in milliliters (mL) and can be measured accurately with the provided oral syringe.

**Treatment of influenza when oseltamivir-resistant viruses are circulating**

Oseltamivir resistance is common among seasonal influenza A (H1N1) viruses. These viruses typically remain susceptible to zanamivir, rimantadine, and amantadine. However, since April 2009, very few seasonal H1N1 viruses have circulated in the United States. However, if viral surveillance data indicate that oseltamivir-resistant seasonal H1N1 viruses have become more common or are associated with identified community outbreaks, zanamivir or a combination of oseltamivir and rimantadine or amantadine should be considered for use as empiric treatment for patients who might have oseltamivir-resistant seasonal human influenza A (H1N1) virus infection. Limited oseltamivir-resistant 2009 H1N1 viruses have been identified, typically among persons who develop illness while receiving oseltamivir for chemoprophylaxis or immunocompromised patients with influenza who are being treated. (see websites above)

**CRITERIA FOR APPROVAL (amantadine):**

Amantadine can be substituted for rimantadine but has increased risk of adverse events.

Requests for amantadine will only be approved (and then only in combination with Tamiflu®) in the event of a rimantadine shortage or for the syrup in a patient that requires an oral liquid dosage form (e.g. pediatric patient).

**DOCUMENTATION:**

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

<b>Anti-Infectives: Influenza Medications</b>		<i>Length of Authorization: up to 6 weeks</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS</b>	<b>PA REQUIRED</b>	
RELENZA® (zanamivir)(QL= 20 blisters/30 days)	amantadine† (PA required for ≤ 10 day supply)	
TAMIFLU® (oseltamivir)(QL = 10 caps/30 days (45 mg & 75 mg caps), 20 caps/30 days (30 mg caps), 75 ml/30 days (suspension))	Flumadine®* (rimantadine)	
RIMANTADINE† 100 mg tablets (QL = 20 tabs/30 days) (only approvable in combination with Tamiflu®)	Symmetrel® (amantadine)	
	Note: amantadine and rimantadine are not CDC recommended for use as MONOTHERAPY in influenza	

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## Anti-Infectives: Influenza Vaccines

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### **LENGTH OF AUTHORIZATION:**

**NOTE:** Seasonal 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: Seasonal Influenza Nasal Vaccine**

Seasonal 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.

### **CRITERIA FOR APPROVAL (Flumist):**

- 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<sup>®</sup> 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.***

<b>Age Group</b>	<b>Vaccination Status</b>	<b>Dosage Schedule</b>
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**.

<b>Anti-Infectives: Influenza Vaccines</b>		<i>Length of Authorization: up to 6 weeks</i>
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
<b><u>SEASONAL Influenza Vaccine Injection</u></b> AFLURIA® 2009- 2010 Injection FLUARIX® 2009- 2010 Injection FLULAVAL® 2009- 2010 Injection FLUVIRIN® 2009- 2010 Injection FLUZONE® 2009- 2010 Injection		
<b><u>SEASONAL Influenza Nasal Vaccine</u></b>	FluMist® Nasal	
<b><u>2009 H1N1 (formerly Swine Flu) Vaccine Injection</u></b>	2009 Influenza A H1NI Vaccine Injection (provided free of charge by VT Dept of Health through clinics or prescriber office)	
<b><u>2009 H1N1 (formerly Swine Flu) Nasal Vaccine</u></b>	2009 Influenza A H1NI Spray Vaccine (provided free of charge by VT Dept of Health through clinics or prescriber office)	

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## Anti-Infectives: Miscellaneous

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**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**.

<b>Anti-Infectives: Miscellaneous</b>		<i>Length of Authorization: 1 year</i>
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
	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**

<b>Anti-Infectives: Topical Antibiotics</b> <i>Length of Authorization: for date of service, no refills</i> <b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>	
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

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## Anti-Migraine: Triptans

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**LENGTH OF AUTHORIZATION:**

6 months

**CRITERIA FOR APPROVAL (non-preferred agents):**

**Oral: Amerge, Frova, Imitrex, Maxalt, Relpax, Zomig:**

- The patient has had a documented side-effect, allergy or treatment failure to Axert<sup>®</sup>, Maxalt-MLT<sup>®</sup>, and Sumatriptan.

**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<sup>®</sup> Nasal Spray.

**Nasal Spray or Injection: Sumatriptan**

- The patient has had a documented intolerance to brand Imitrex<sup>®</sup>.

**CRITERIA FOR APPROVAL (to exceed quantity limit):**

- The patient is taking a medication for migraine prophylaxis

**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**

<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
<p><b><u>SINGLE AGENT</u></b></p> <p><b><u>ORAL</u></b>            AXERT® (almotriptan)  <i>Quantity Limit = 6 tablets/month</i></p> <p>MAXALT-MLT® (rizatriptan ODT)  <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><b><u>NASAL SPRAY</u></b>            IMITREX® (sumatriptan)  <i>Quantity Limit = 12 units/month (5 mg nasal spray), 6 units/month (20 mg nasal spray)</i></p> <p><b><u>INJECTABLE</u></b>            IMITREX® (sumatriptan)  <i>Quantity Limit = 4 injections/month (4 or 6 mg injection)</i></p> <p><b><u>COMBINATION PRODUCT</u></b></p>	<p>Amerge® (naratriptan)  <i>Quantity Limit = 9 tablets/month</i></p> <p>Frova® (frovatriptan)  <i>Quantity Limit = 9 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  <i>Quantity Limit = 12 tablets/month</i></p> <p>Relpax® (eletriptan)  <i>Quantity Limit = 12 tablets/month</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>Sumatriptan† (compare to Imitrex®)  <i>Quantity Limit = 12 units/month (5 mg nasal spray), 6 units/month (20 mg nasal spray)</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>

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## Anti-Obesity Agents

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**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:

<b><u>Alli,</u></b> <b><u>Xenical:</u></b>	Malabsorption syndrome, cholestasis, pregnant or lactating, hyperoxaluria, calcium oxalate nephrolithiasis
<b><u>Meridia:</u></b>	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
<b><u>Diethylpropion,</u></b> <b><u>Benzphetamine,</u></b> <b><u>Phendimetrazine,</u></b> <b><u>Phentermine:</u></b>	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**

<b>PREFERRED DRUGS</b>	<b>PA REQUIRED</b>
	Alli <sup>®</sup> (orlistat OTC) ( <i>QL = 3 capsules/day</i> ) benzphetamine† (all forms brand and generic) diethylpropion† (all forms brand & generic) Meridia <sup>®</sup> (sibutramine) phentermine† (all forms brand & generic) phendimetrazine† (all forms brand & generic) Xenical <sup>®</sup> (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: \_\_\_\_\_

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## Antipsychotics: Atypical and Combination

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**LENGTH OF AUTHORIZATION:**      Duration of need \*^

**CRITERIA FOR APPROVAL:**

**NON-PREFERRED TABLETS: (except for Clozaril<sup>®</sup>, Risperdal<sup>®</sup> and Seroquel XR<sup>®</sup>)**

- 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. If the indication for use is Major Depressive Disorder (MDD), the patient has had a documented side effect, allergy or treatment failure with one preferred product.

**Clozaril<sup>®</sup>, Risperdal<sup>®</sup>:**

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

**Seroquel XR<sup>®</sup>:**

- 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<sup>®</sup> immediate release resulting in a significant clinical impact

**NON-PREFERRED ORAL SOLUTIONS (except Risperidone):**

- 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.

**Risperidone:**

- The patient has a documented intolerance to the brand product Risperdal<sup>®</sup>.

**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.)
- In addition, for approval of Invega Sustenna<sup>®</sup>, the patient must also have had a documented side effect, allergy, or treatment failure with Risperdal<sup>®</sup> Consta.

**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, risperidone, 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 127 for a description of the management of mental health drugs.

<b>Antipsychotics: Atypical and Combination</b> <i>Length of authorization: Duration of Need*</i> <sup>▲</sup>	
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
<b>TABLETS/CAPSULES</b>	
<p>CLOZAPINE† (compare to Clozaril®)  <i>FDA maximum recommended dose = 900 mg/day</i></p> <p>GEODON® (ziprasidone)  <i>FDA maximum recommended dose = 160 mg/day</i></p> <p>RISPERIDONE† (compare to Risperdal®)  <i>FDA maximum recommended dose = 16 mg/day</i></p> <p>SEROQUEL® (quetiapine)  <i>FDA maximum recommended dose = 800 mg/day</i></p>	<p>Abilify® (aripiprazole)  <i>FDA maximum recommended dose = 30 mg/day,</i>  <i>Quantity limit = 1.5 tabs/day (5 mg, 10 mg &amp; 15 mg tabs)</i></p> <p>Clozaril®* (clozapine)  <i>FDA maximum recommended dose = 900 mg/day</i></p> <p>Invega® (paliperidone)  <i>FDA maximum recommended dose = 12 mg/day</i>  <i>Quantity limit = 1 tab/day (3mg, 9mg), 2 tabs/day (6mg)</i></p> <p>Risperdal®* (risperidone)  <i>FDA maximum recommended dose = 16 mg/day</i></p> <p>Saphris® (asenapine) sublingual tablet  <i>FDA maximum recommended dose = 20 mg/day</i></p> <p>Seroquel XR® (quetiapine XR)  <i>FDA maximum recommended dose = 800 mg/day</i>  <i>Quantity Limit = 1 tab/day (150 mg &amp; 200 mg tablet strengths), 2 tabs/day (50 mg strength)</i></p> <p>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 &amp; 10 mg tabs)</i></p>
<b>ORAL SOLUTIONS</b>	
<p>RISPERDAL® (risperidone) oral solution  <i>FDA maximum recommended dose = 16 mg/day</i></p>	<p>Abilify® (aripiprazole) oral solution  <i>FDA maximum recommended dose = 25 mg/day</i></p> <p>Risperidone† (compare to Risperdal®) oral solution  <i>FDA maximum recommended dose = 16 mg/day</i></p>
<b>SHORT-ACTING INJECTABLE PRODUCTS</b>	
<p>GEODON® IM (ziprasidone intramuscular injection)  <i>FDA maximum recommended dose = 40 mg/day</i></p>	<p>Abilify® IM (aripiprazole intramuscular injection)  <i>FDA maximum recommended dose = 30 mg/day</i></p> <p>Zyprexa® IM (olanzapine intramuscular injection)  <i>FDA maximum recommended dose = 30 mg/day</i></p>
<b>LONG-ACTING INJECTABLE PRODUCTS</b>	
	<p>Invega Sustenna® (paliperidone palmitate)  <i>FDA maximum recommended dose = 234 mg/month</i></p> <p>Risperdal® Consta (risperidone microspheres)  <i>FDA maximum recommended dose = 50 mg/14 days</i></p>
<b>ORALLY DISINTEGRATING TABLETS</b>	
	<p>Abilify® Discmelt (aripiprazole)  <i>FDA maximum recommended dose = 30 mg/day,</i>  <i>Quantity limit = 2 tabs/day (10 mg &amp; 15 mg tabs)</i></p> <p>FazaClo® (clozapine orally disintegrating tablets)  <i>FDA maximum recommended dose = 900 mg/day</i></p> <p>Risperdal® M-Tab (risperidone orally disintegrating tablets)  <i>FDA maximum recommended dose = 16 mg/day</i></p> <p>Risperidone† ODT (compare to Risperdal® M-Tab)  <i>FDA maximum recommended dose = 16 mg/day</i></p> <p>Zyprexa Zydis® (olanzapine orally disintegrating tablets)  <i>FDA maximum recommended dose = 20 mg/day,</i>  <i>Quantity limit = 1.5 tabs/day (5 mg &amp; 10 mg tabs)</i></p>
<b>COMBINATION PRODUCTS</b>	
	<p>Symbyax® (olanzapine/fluoxetine)  <i>FDA maximum recommended dose = 18 mg/75 mg (per day)</i></p>

\* 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.

## Antipsychotics: Typical

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

**CRITERIA FOR APPROVAL:**

**ORAL**

- 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.)

**LONG ACTING INJECTABLE PRODUCTS**

- For approval of Haldol<sup>®</sup> deconaoate, the patient has a documented intolerance to the generic product.

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

<b>Antipsychotics: Typical</b>		<i>Length of authorization: Duration of need for mental health indication*s</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
<b><u>ORAL TABLETS/CAPSULES</u></b>		
CHLORPROMAZINE† (formerly Thorazine <sup>®</sup> )	Haldol <sup>®</sup> * (haloperidol)	
FLUPHENAZINE† (formerly Prolixin <sup>®</sup> )	Loxitane <sup>®</sup> * (loxapine)	
HALOPERIDOL† (compare to Haldol <sup>®</sup> )	Navane <sup>®</sup> * (thiothixene)	
LOXAPINE† (compare to Loxitane <sup>®</sup> )		
MOBAN <sup>®</sup> (molindone)		
PERPHENAZINE† (formerly Trilafon <sup>®</sup> )		
THIORIDAZINE† (formerly Mellaril <sup>®</sup> )		
THIOTHIXENE† (compare to Navane <sup>®</sup> )		
TRIFLUOPERAZINE† (formerly Stelazine <sup>®</sup> )		
<b><u>LONG ACTING INJECTABLE PRODUCTS</u></b>		
fluphenazine decanoate† (formerly Prolixin <sup>®</sup> decanoate)		
haloperidol decanoate † (compare to Haldol <sup>®</sup> decanoate)	Haldol <sup>®</sup> decanoate* (haloperidol decanoate)	

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

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## Botulinum Toxins

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**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 – **(onabotulinumtoxinA, formerly type A)**
  - Focal dystonias, including cervical dystonia, spasmodic dysphonia, oromandibular dystonia – **(onabotulinumtoxinA, formerly type A and rimabotulinumtoxinB, formerly type B)**
  - Limb spasticity (e.g., due to cerebral palsy, multiple sclerosis, or other demyelinating CNS diseases) – **(onabotulinumtoxinA, formerly type A)**
  - Focal spasticity (e.g., due to hemorrhagic stroke, anoxia, traumatic brain injury) – **(onabotulinumtoxinA, formerly type A)**
  - Axillary Hyperhidrosis (if member has failed an adequate trial of topical therapy) – **(onabotulinumtoxinA, formerly 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.). (BOTOX<sup>®</sup> Cosmetic (onabotulinumtoxinA) is not covered)

**IMPORTANT NOTE:**

*Botulinum neurotoxins are used to treat various disorders of focal muscle spasm and excessive muscle contractions, such as focal dystonias. When injected intramuscularly, botulinum neurotoxins produce a presynaptic neuromuscular blockade by preventing the release of acetylcholine from the nerve endings. As a consequence of the chemistry and clinical pharmacology of each botulinum neurotoxin product, botulinum neurotoxins are not interchangeable, even among same serotype products. Units of biological activity are unique to each preparation and cannot be compared or converted into units of another. It is important that providers recognize there is no safe dose conversion ratio—i.e., one unit of BOTOX<sup>®</sup> (onabotulinumtoxinA, formerly type A) does not equal one unit of Myobloc<sup>®</sup> (rimabotulinumtoxinB, formerly type B). Failure to understand the unique characteristics of each formulation of botulinum neurotoxin can result in under or over dosage. It is expected that use of these products will be based on each product's individual dosing, efficacy and safety profiles.*

**DOCUMENTATION:**

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

<b>Botulinum Toxins</b>	
<i>Length of Authorization: initial approval 3 months, subsequent approval up to 12 months</i>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
	BOTOX <sup>®</sup> (onabotulinumtoxinA) Myobloc <sup>®</sup> (rimabotulinumtoxinB)

## BPH: Alpha Blockers

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

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

**DOCUMENTATION:**

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

<b>Alpha Blockers</b>		<i>Length of authorization: 1 year</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
DOXAZOSIN† (compare to Cardura <sup>®</sup> ) FLOMAX <sup>®</sup> (tamsulosin) <i>Quantity Limit = 2 capsules/day</i> TERAZOSIN† (compare to Hytrin <sup>®</sup> ) UROXATRAL <sup>®</sup> (alfuzosin) <i>Quantity Limit = 1 tablet/day</i>	Cardura <sup>®</sup> * (doxazosin) Cardura XL <sup>®</sup> (doxazosin) <i>Quantity Limit = 1 tablet/day</i> Hytrin <sup>®</sup> * (terazosin) Rapaflo <sup>®</sup> (silodosin) <i>Quantity Limit = 1 capsule/day</i>	

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## BPH: Androgen Hormone Inhibitors

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**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). (This includes Propecia<sup>®</sup> (finasteride) whose only FDA approved indication is for treatment of male pattern hair loss.)

<b>BPH: Androgen Hormone Inhibitors</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
AVODART <sup>®</sup> (dutasteride) ( <i>QL = 1 capsule/day</i> )	Avodart <sup>®</sup> (dutasteride) females; males age < 45 ( <i>QL = 1 capsule/day</i> )
FINASTERIDE <sup>†</sup> (compare to Proscar <sup>®</sup> ) ( <i>QL = 1 tablet/day</i> )	finasteride <sup>†</sup> (compare to Proscar <sup>®</sup> ) females; males age < 45 ( <i>QL = 1 tablet/day</i> )
PROSCAR <sup>®</sup> (finasteride) ( <i>QL = 1 tablet/day</i> )	Proscar <sup>®</sup> (finasteride) females; males age < 45 ( <i>QL = 1 tablet/day</i> )

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## Cardiac Glycosides

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**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<sup>®</sup> (digoxin)

DIGOXIN†

LANOXICAPS<sup>®</sup> (digoxin)

LANOXIN<sup>®</sup> (digoxin)

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## Chemical Dependency: Alcohol and Opiate Dependency

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**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 intolerance 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 that has been witnessed by a health care professional and supported by medical record documentation that is submitted with PA request.

**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: Alcohol and Opiate 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><b>Alcohol Dependency</b>            ANTABUSE<sup>®</sup> (disulfiram)            CAMPRAL<sup>®</sup> (acamprosate)            NALTREXONE oral † (compare to Revia<sup>®</sup>)</p> <p><b>Opiate Dependency</b>            NALTREXONE oral † (compare to Revia<sup>®</sup>)</p> <p>Note: Methadone for opiate dependency may only be prescribed through a Methadone Maintenance Clinic</p>	<p>Revia<sup>®</sup>* (naltrexone oral)            Vivitrol<sup>®</sup> (naltrexone for extended-release injectable suspension) (<i>QL = 1 injection (380 mg) per 30 days</i>)</p> <p>buprenorphine† (compare to Subutex<sup>®</sup>)  <i>QL = 3 tablets per day</i>            Revia<sup>®</sup>* (naltrexone oral)            Suboxone<sup>®</sup> (buprenorphine/nalaxone)  <i>QL = 3 tablets per day</i>            Subutex<sup>®</sup> (buprenorphine)  <i>QL = 3 tablets per day</i></p> <p><b>**Maximum days supply for Suboxone/Subutex/buprenorphine is 30 days**</b></p>

## ~BUPRENORPHINE ~

### Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of buprenorphine (Suboxone<sup>®</sup>, Subutex<sup>®</sup>). These criteria are based on concerns about safety and the potential for abuse and diversion. For beneficiaries to receive coverage for Suboxone<sup>®</sup> or Subutex<sup>®</sup>, 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

<b>MD/DO</b>	Prescribers must have a DATA 2000 waiver ID ('X' DEA license) in order to prescribe.
<b>Patients</b>	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 <sup>®</sup> (buprenorphine/naloxone) <input type="checkbox"/> Subutex <sup>®</sup> (buprenorphine)
Anticipated maintenance dose/frequency:	
Dose: _____	Frequency: _____
If this request is for Subutex <sup>®</sup> , 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 that has been witnessed by a health care professional?	<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

<b>MDs</b>	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 <b>may not</b> be billed through the Medical Benefit as a J-Code J2315.
<b>Patients</b>	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:** \_\_\_\_\_

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## Compounded Products

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### 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.

An ingredients is not covered if it is

- From a manufacturer that does not offer Federal Rebate
- Considered a "bulk chemical or powder". CMS has clarified that bulk products are not considered covered outpatient drugs because they are not prescription drug products approved under section 505,505(j), or 507 of the Federal Food Drug and Cosmetic Act.
- Bulk powders used to compound products for the prevention of pre-term labor will continue to be covered after Prior Authorization when no commercial alternative exists.

## Constipation: Chronic, IBS-C or Opioid-Induced

**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 from the Bulk-Producing Laxative or Osmotic Laxative categories (see below).

**RELISTOR®**

- The patient must have documented opioid-induced constipation and be receiving palliative care
- AND
- The patient must have had documented treatment failure to a 1 week trial of at least 2 preferred laxatives from 2 different laxative classes (see below) used in combination.

**DOCUMENTATION:**

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

<b>Constipation: Chronic, IBS-C or Opioid-Induced</b>	
<i>Length of Authorization: 3 months</i>	
<b>Key: † Generic product</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
<b>Bulk-Producing Laxatives</b> PSYLLIUM†	Amitiza® (lubiprostone) ( <i>Qty limit = 2 caps/day</i> )
<b>Osmotic Laxatives</b> LACTULOSE† POLYETHYLENE GLYCOL 3350 (PEG)† (compare to Miralax®)	Relistor® (methylnatrexone)
<b>Stimulant Laxative</b> BISACODYL† SENNA†	
<b>Stool Softener</b> DOCUSATE†	

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## Contraceptives: Vaginal Ring

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**LENGTH OF AUTHORIZATION:** not applicable

**CRITERIA FOR APPROVAL:** not applicable

<b>Contraceptives: Vaginal Ring</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
NUVARING <sup>®</sup> (etonogestrel/ethinyl estradiol vaginal ring)	

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## **Coronary Vasodilators/Antianginals: Oral and Topical**

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**LENGTH OF AUTHORIZATION:** 3 years

**CRITERIA FOR APPROVAL:**

**Dilatrate-SR<sup>®</sup>, Imdur<sup>®</sup>:**

- 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<sup>®</sup>. If a product has an AB rated generic, one trial must be the generic formulation.

**Ismo<sup>®</sup>, Isordil<sup>®</sup>, Monoket<sup>®</sup>:**

- 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<sup>®</sup>:**

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

**Bidil<sup>®</sup>:**

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

**Ranexa<sup>®</sup>:**

- 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
  - Concurrent use of medications which may interact with Ranexa<sup>®</sup>:
    - CYP450 3A4 inducers (rifampin, rifabutin, rifapentin, phenobarbital, phenytoin, carbamazepine, St. John's wort)
    - 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<sup>®</sup>.

**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: Oral and Topical

*Length of Authorization: 3 years*

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

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

## 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.**

<b>Cough and Cold Preparations</b>		<i>Length of Authorization: date of service only, no refills</i>
<b>Key: † Generic product</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
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)	

## Cryopyrin-Associated Periodic Syndromes (CAPS) Injectables

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

- The diagnosis or indication for the requested medication is Cryopyrin-Associated Periodic Syndrome (CAPS)
- OR
- The diagnosis or indication for the requested medication is Familial Cold Autoinflammatory Syndrome (FCAS)
- OR
- The diagnosis or indication for the requested medication is Muckle-Wells Syndrome (MWS)
- AND
- The patient is > 4 years old (Ilaris<sup>®</sup>) or > 12 years old (Arcalyst<sup>®</sup>)
- AND
- If the request is for Arcalyst<sup>®</sup>, the patient must have a documented side effect, allergy, treatment failure or a contraindication to Ilaris<sup>®</sup> (canakinumab)

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

**DOCUMENTATION:**

- ✓ Document clinically compelling information supporting the choice of Arcalyst<sup>®</sup> or Ilaris<sup>®</sup> 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.**

<b>CAPS Injectables</b>		<i>Length of Authorization: 1 year</i>
<b>PREFERRED AFTER CLINICAL CRITERIA ARE MET</b>	<b>PA REQUIRED</b>	
Ilaris <sup>®</sup> (canakinumab) ( <i>QL=1 vial/56 days</i> )	Arcalyst <sup>®</sup> (rilonacept) ( <i>QL = 2 vials for loading dose, then 1 vial per week</i> )	



**CYSTIC FIBROSIS MEDICATION - 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  
CYSTIC FIBROSIS MEDICATION**

**Patient Diagnosis:**

Cystic Fibrosis

**Product:**

Pulmozyme® (dornase alfa inhalation) 1 mg/ml 2.5 ml ampules

Administer via nebulizer once daily.  
Dispense # 30 Refill \_\_\_\_ times

Administer via nebulizer twice daily.  
Dispense # 60 Refill \_\_\_\_ times

TOBI® (tobramycin solution for inhalation) 300 mg/5 ml ampules

Administer via nebulizer twice daily,  
alternating 28 days on and 28 days off

Dispense # 56 Refill \_\_\_\_ times

Deliver product to:  Patient's home  MD office  Clinic

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## 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<sup>®</sup> gel, Veregan:**

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

**Condylox<sup>®</sup>\* 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**.

<b>Dermatological Agents: Genital Wart Therapy</b> <i>Length of Authorization: up to 16 weeks</i>	
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
<p>ALDARA<sup>®</sup> (imiquimod)</p> <p>PODOFILOX SOLUTION† (compare to Condylox<sup>®</sup>)</p>	<p>Condylox<sup>®</sup> Gel (podofilox gel)                      Condylox<sup>®</sup>* solution (podofilox solution)</p> <p>Veregan<sup>®</sup> (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<sup>®</sup> Cream or Ovide<sup>®</sup> Lotion, the patient must have a documented intolerance to the generic equivalent product.

**DOCUMENTATION:**

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

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

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

## Desmopressin: Intranasal/Oral

**LENGTH OF AUTHORIZATION:** 2 years

**CRITERIA FOR APPROVAL: Intranasal**

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

**CRITERIA FOR APPROVAL: non-preferred oral**

- The diagnosis or indication for the requested medication is (1) Diabetes Insipidus and/or (2) primary nocturnal enuresis

**AND**

- The patient has had a documented intolerance to generic desmopressin tablets

**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**.

<b>Desmopressin: Intranasal</b>		<i>Length of Authorization: 2 years</i>
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
<b><u>Intranasal</u></b>	DDAVP® (desmopressin) Nasal Solution or Spray 0.01% Desmopressin † Nasal Solution or Spray 0.01 % (compare to DDAVP®) Mimirin † (desmopressin) Nasal Spray 0.01% Stimat® (desmopressin) Nasal Solution 1.5 mg/ml	
<b><u>Oral</u></b>  desmopressin†	DDAVP®* (desmopressin) tablets	

## 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.**

<b>Diabetic Testing Supplies</b>		<i>Length of Authorization: 5 years</i>
<b>PREFERRED PRODUCTS (No PA Required)</b>	<b>PA REQUIRED</b>	
<p><b><u>DIABETIC MONITORS/METERS</u></b>            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><b><u>DIABETIC TEST STRIPS</u></b>            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

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## Estrogens: Vaginal

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**LENGTH OF AUTHORIZATION:** not applicable

**CRITERIA FOR APPROVAL:** not applicable

<b>Estrogens: Vaginal</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
<b><u>Estradiol</u></b> ESTRACE VAGINAL <sup>®</sup> Cream ESTRING <sup>®</sup> Vaginal Ring VAGIFEM <sup>®</sup> Vaginal Tablets	
<b><u>Conjugated Estrogens</u></b> PREMARIN VAGINAL <sup>®</sup> Cream	
<b><u>Estradiol Acetate</u></b> FEMRING <sup>®</sup> Vaginal Ring	

## Fibromyalgia Agents

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Savella® :**

- The diagnosis or indication is treatment of fibromyalgia.
- AND**
- 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, cyclobenzaprine or Lyrica®.

**DOCUMENTATION:**

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

<b>Fibromyalgia Agents</b>		<i>Length of Authorization: 1 year</i>
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
	Savella® (milnacipran) tablet, titration pack <i>Quantity Limit = 2 tablets/day</i>	

**Note:** Please refer to “Anticonvulsants” for clinical criteria for **Lyrica®** and “Anti-Depressants – SNRIs” for clinical criteria for **Cymbalta®**.

## Gastrointestinals: Crohn's Disease Medications: Injectables

***NOTE: Crohn's Disease Self-Injectable (Humira®) must be obtained and billed through our specialty pharmacy vendor, ICORE Healthcare. Please see the Humira Prior Authorization/Patient Enrollment Form for instructions. ICORE Healthcare may supply Remicade® upon request or you may continue to obtain through your usual supplier. ICORE Healthcare will not be supplying Cimzia® or 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:**

**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 for **Humira®** on its **Prior Authorization/Patient Enrollment Form** and clinically compelling information supporting the choice of **Remicade®** on a **Remicade Prior Authorization Request Form**, and **Cimzia®** or **Tysabri®** on a **General Prior Authorization Request Form**.

<b>Crohn's Disease: Injectables</b>	
<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)

## Gastrointestinals: Histamine-2 Receptor Antagonists

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Axid<sup>®</sup> capsule, nizatidine capsule, Pepcid<sup>®</sup> tablet, ranitidine capsule, Tagamet<sup>®</sup> tablet, Zantac<sup>®</sup> 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<sup>®</sup> Oral Solution, Nizatidine Oral Solution, Pepcid<sup>®</sup> Oral Suspension, Zantac<sup>®</sup> Effervescent, Zantac<sup>®</sup> Oral Syrup:**

- The patient has had a documented side effect, allergy, or treatment failure to ranitidine syrup or cimetidine oral solution. If a medication has an AB rated generic, there must have been a trial of the generic formulation.

### Gastrointestinals: Histamine-2 Receptor Antagonists

*Length of Authorization: 1 year*

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

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

PREFERRED DRUGS (No PA Required)	PA REQUIRED
CIMETIDINE† (compare to Tagamet <sup>®</sup> ) tablet FAMOTIDINE† (compare to Pepcid <sup>®</sup> ) tablet RANITIDINE† (compare to Zantac <sup>®</sup> ) tablet	Axid <sup>®</sup> (nizatidine) capsule § nizatidine† (compare to Axid <sup>®</sup> ) capsule § Pepcid <sup>®</sup> * (famotidine) tablet§ ranitidine† capsule § Tagamet <sup>®</sup> * tablet § Zantac <sup>®</sup> * tablet §
<p><b><u>SYRUP &amp; SPECIAL DOSAGE FORMS</u></b></p> CIMETIDINE † ORAL SOLUTION RANITIDNE † syrup (compare to Zantac <sup>®</sup> )	Axid <sup>®</sup> (nizatidine) Oral Solution § Nizatidine †Oral Solution (compare to Axid <sup>®</sup> ) Pepcid <sup>®</sup> (famotidine) Oral Suspension § Zantac (ranitidine) Effervescent <sup>®</sup> § Zantac <sup>®</sup> * (ranitidine) Syrup§

## Gastrointestinals: Inflammatory Bowel Agents (Oral and Rectal Products)

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Azulfidine<sup>®\*</sup>, Colazal<sup>®\*</sup>, Rowasa<sup>®\*</sup>, Sfrowasa<sup>®\*</sup>:**

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

**Asacol HD<sup>®</sup>:**

- The patient has had a documented side effect, allergy, or treatment failure with two (2) preferred oral mesalamine products.

**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.**

<b>Gastrointestinals: Inflammatory Bowel Agents (Oral and Rectal Products)</b>	
<i>Length of Authorization: 1 year</i>	
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
<b><u>MESALAMINE PRODUCTS</u></b>	
<b>Oral</b>	
APRISO <sup>®</sup> (mesalamine capsule extended-release)	Asacol HD <sup>®</sup> (mesalamine tablet delayed release)
ASACOL <sup>®</sup> (mesalamine tablet delayed-release)	
LIALDA <sup>®</sup> (mesalamine tablet extended-release)	
PENTASA <sup>®</sup> (mesalamine cap CR)	
<b>Rectal</b>	
CANASA <sup>®</sup> (mesalamine suppository)	Rowasa <sup>®*</sup> (mesalamine enema)
MESALAMINE ENEMA† (compare to Rowasa <sup>®</sup> , Sfrowasa <sup>®</sup> )	Sfrowasa <sup>®*</sup> (mesalamine enema)
<b><u>OTHER</u></b>	
BALSALAZIDE† (compare to Colazal <sup>®</sup> )	Azulfidine <sup>®*</sup> (sulfasalazine)
DIPENTUM <sup>®</sup> (olsalazine)	Colazal <sup>®*</sup> (balsalazide)
SULFASALAZINE† (compare to Azulfidine <sup>®</sup> )	

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## Gastrointestinals: Proton Pump Inhibitors

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**LENGTH OF AUTHORIZATION:** up to 1 year

**CRITERIA FOR APPROVAL:**

**Nexium powder for suspension, Prevacid Solutabs (for patients  $\geq$  12 years old), Prilosec packet, Protonix packet, Zegerid powder for suspension (for patients  $\geq$  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 Kapidex/Dexilant capsules, Prilosec OTC tablets AND Protonix tablets.
- If the request is for Prevacid 24 hr OTC or lansoprazole generic RX capsules, the patient must also have a documented intolerance to brand Prevacid RX.
- If the request is for Prilosec RX capsules, the patient must also have a documented intolerance to omeprazole RX generic 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><b>ORAL CAPULES/TABLETS</b></p> <p>KAPIDEX<sup>®</sup>/DEXILANT<sup>®</sup> (dexlansoprazole) capsules (<i>Quantity limit=1 cap/day</i>)</p> <p>PRILOSEC OTC<sup>®</sup> 20mg (omeprazole magnesium) tablets (<i>No Quantity limit applies</i>)</p> <p>PROTONIX<sup>®</sup> (pantoprazole) tablets (<i>Quantity limit=1 tab/day</i>)</p>	<p>Aciphex<sup>®</sup> (rabeprazole) tablets § (<i>Quantity limit=1 tab/day</i>)</p> <p>lansoprazole generic RX (compare to Prevacid<sup>®</sup>) capsules (<i>Quantity limit = 1 cap/day</i>)</p> <p>Nexium<sup>®</sup> (esomeprazole) capsules § (<i>Quantity limit=1 cap/day</i>)</p> <p>omeprazole †* generic RX (compare to Prilosec<sup>®</sup>) 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>Prevacid<sup>®</sup> RX (lansoprazole) capsules § (<i>Quantity limit=1 cap/day</i>)</p> <p>Prevacid<sup>®</sup> 24 hr OTC (lansoprazole) capsules (<i>Quantity limit=1 cap/day</i>)</p> <p>Prilosec<sup>®</sup> RX (omeprazole) capsules § (<i>Quantity limit=1 cap/day</i>)</p> <p>Zegerid<sup>®</sup> (omeprazole/sodium bicarb) capsules § (<i>Quantity limit=1 cap/day</i>)</p>
<p><b>SUSPENSION &amp; SPECIAL DOSAGE FORMS</b></p> <p>PREVACID SOLUTABS<sup>®</sup>* (lansoprazole) (<i>Quantity limit=1 tab/day</i>)</p>	<p>Nexium<sup>®</sup> (esomeprazole) powder for suspension (<i>Quantity limit=1 packet/day</i>)</p> <p>Prilosec (omeprazole magnesium) packet (<i>Quantity limit=2 packets/day</i>)</p> <p>Protonix<sup>®</sup> (pantoprazole) packet (<i>Quantity limit=1 packet/day</i>)</p> <p>Zegerid<sup>®</sup>* (omeprazole/sodium bicarb) powder for suspension (<i>Quantity limit=1 packet/day</i>)</p>
<p><b>COMBINATION</b></p> <p>PREVPAC<sup>®</sup> (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

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## Gastrointestinals: Ulcerative Colitis Medications: Injectables

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*ICORE Healthcare may supply Remicade® upon request or you may 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:**

**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 clinically compelling information supporting the choice of **Remicade®** on a **Remicade Prior Authorization Request Form**.

<b>Gastrointestinals: Ulcerative Colitis Medications: Injectables</b>	
<i>Length of authorization: Initial PA of 3 months; 12 months thereafter</i>	
<b>PREFERRED AGENTS (No PA Required)</b>	<b>PA REQUIRED</b>
	Remicade® (infliximab)

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## Glucocorticoids: Topical

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**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><b><u>LOW POTENCY</u></b></p> <p>ALCLOMETASONE 0.05% C, O† (compare to Aclovate®)            DESONIDE† 0.05% C, L, O (compare to DesOwen®)            FLUOCINOLONE 0.01% C, S† (formerly Synalar®)            HYDROCORTISONE† 0.5%, 1%, 2.5% C; 1%, 2.5% L, 0.5%, 1%, 2.5% O            HYDROCORTISONE ACETATE† 1% C; 1% O (all generics)</p>	<p>Aclovate®* (acclometasone) 0.05% C, O            Balneol® (hydrocortisone) 0.25% L            Capex® (fluocinolone) 0.01% shampoo            Desonate® (desonide) 0.05% G            DesOwen®* (desonide) 0.05% C, L, O            Hytone®* (hydrocortisone) 1%, 2.5% C            Nucort 2% lotion (hydrocortisone acetate)            Verdeso® (desonide) 0.05% F            All other brands</p>
<p><b><u>MEDIUM POTENCY</u></b></p> <p>BETAMETHASONE DIPROPIONATE† 0.05% L (formerly Diprosome®)            BETAMETHASONE VALERATE† 0.1% C, L (compare to Beta-Val®)            DESOXIMETASONE† 0.05% C (compare to Topicort®)            FLUOCINOLONE† 0.025% C, O (formerly Synalar®)            FLUTICASONE † 0.05% C; 0.005% O (compare to Cutivate®)            HYDROCORTISONE BUTYRATE† 0.1% C, O, S (compare to Locoid®)            HYDROCORTISONE VALERATE† 0.2% C, O (compare to Westcort®)            MOMETASONE FUROATE† 0.1% C, L, O (compare to Elocon®)            TRIAMCINOLONE ACETONIDE† 0.025%, 0.1% C, L, O (compare to Aristocort®; formerly Kenalog®)</p>	<p>Aristocort®* (triamcinolone) 0.1% C            Beta-Val®* (betamethasone valerate) 0.1% C, L            Cloderm® (clocortolone) 0.1% C            Cordran® (all products)            Cutivate®* (fluticasone) 0.05% C; 0.005% O            Cutivate® (fluticasone) 0.05% L            Dermatop® (prednicarbate) 0.1% C, O            Elocon®* (all products)            Locoid®* (hydrocortisone butyrate) 0.1% C, O, S            Locoid® (hydrocortisone butyrate) 0.1% L            Luxiq® (betamethasone valerate) F            prednicarbate† (compare to Dermatop®) 0.1% C, O            Topicort®* (desoximetasone) 0.05% C            Westcort®* (hydrocortisone valerate) all products            All other brands</p>
<p><b><u>HIGH POTENCY</u></b></p> <p>AMCINONIDE† (formerly Cyclocort®)            AUGMENTED BETAMETHASONE† 0.05% C (compare to Diprolene® AF)            BETAMETHASONE VALERATE† 0.1% O (formerly Beta-Val®)            DESOXIMETASONE† 0.05% G; 0.25% C, O (compare to Topicort®)            DIFLORASONE DIACETATE† 0.05% C (compare to Apexicon E®/Psorcon E®*)            FLUOCINONIDE† 0.05% C, G, O, S (compare to Lidex®)            TRIAMCINOLONE ACETONIDE† 0.5% C, O (formerly Aristocort®)</p>	<p>Apexicon E®/Psorcon E®* (diflorasone) 0.05% C            Diprolene® AF* (augmented betamethasone) 0.05% C            Halog® (halcinonide) all products            Lidex®* (fluocinonide) 0.05% C            Topicort®* (desoximetasone) 0.05% G; 0.25% C, O            All other brands</p>
<p><b><u>VERY HIGH POTENCY</u></b></p> <p>AUGMENTED BETAMETHASONE† 0.05% L, O (compare to Diprolene®)            AUGMENTED BETAMETHASONE † 0.05% G (compare to Alphatrex®)            CLOBETASOL PROPIONATE† (compare to Temovate®/Cormax®)            CLOBETASOL PROPIONATE† 0.05% F (compare to Olux®)            DIFLORASONE DIACETATE† 0.05% O (compare to Psorcon E®/Apexicon®)            HALOBETASOL PROPRIONATE† (compare to Ultravate®)</p>	<p>Alphatrex®* (augmented betamethasone) 0.05% G            Apexicon®* (diflorasone) 0.05% O            Clobex® (clobetasol propionate) 0.05% L, shampoo, spray            Cormax®* (clobetasol propionate) 0.05% C, O, S            Diprolene®* (augmented betamethasone) 0.05% L, O            Olux®*/Olux E® (clobetasol propionate) 0.05% F            Psorcon-E®* (diflorasone diacetate) 0.05% C            Temovate®* (clobetasol propionate) 0.05% C, G, O, S            Vanos® (fluocinonide) 0.1% C            Ultravate®* (halobetasol propionate) 0.05% C, O            All other brands</p>

C=cream, F=foam, G=gel, L=lotion, O=ointment, S=solution

## Gout Agents: Xanthine Oxidase Inhibitors

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Uloric<sup>®</sup>:**

- The diagnosis or indication is treatment of gout.
- AND**
- The patient has had a documented side effect, allergy, treatment failure or a contraindication to allopurinol. NOTE: Treatment failure is defined as inability to reduce serum uric acid levels to < 6 mg/dl with allopurinol doses of 600 mg/day taken consistently. Additionally, renal impairment is not considered a contraindication to allopurinol use.

**Zyloprim<sup>®</sup>:**

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

**DOCUMENTATION:**

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

<b>Gout Agents: Xanthine Oxidase Inhibitors</b>		<i>Length of Authorization: 1 year</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
ALLOPURINOL† (compare to Zyloprim <sup>®</sup> )	Uloric <sup>®</sup> (febuxostat) <i>QL (40 mg tablets) = 1 tablet/day</i> Zyloprim <sup>®</sup> * (allopurinol)	

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## Growth Stimulating Agents

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***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<sup>®</sup>, HUMATROPE<sup>®</sup>, NUTROPIN<sup>®</sup>, NUTROPIN<sup>®</sup> AQ, SAIZEN<sup>®</sup>, TEV-TROPIN<sup>®</sup>**

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

➤ **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

➤ **ZORBATIVE®**

**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.**

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



# 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®     Omnitrope®

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®     Nutropin®     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  
 Omnitrope® Cartridge     Omnitrope® MDV  
 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

***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.

**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.**

<b>Hepatitis C Medications</b>		<i>Length of Authorization: 6 months</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET</b>	<b>NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET</b>	
<b><u>RIBAVIRIN</u></b>		
<b>Tablets/Capsules</b> RIBAVIRIN† 200 mg tablets or capsules	Copegus®* (ribavirin 200 mg tablet) Ribapak® 400 mg/600 mg Dose Pack (ribavirin) Rebetol®* (ribavirin 200 mg capsule)	
<b>Oral Solution</b>	All other strengths/brands of ribavirin tablets/capsules  Rebetol® (ribavirin 40 mg/ml) oral solution	
<b><u>INTERFERON</u></b>		
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
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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 <b>PREFERRED</b> 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 <b>NON-PREFERRED</b> Oral Hepatitis C Product or Strength, please explain the medical necessity for this product: Product: _____ Medical justification: _____
Requested OVHA <b>PREFERRED</b> Injectable Hepatitis C Product? <input type="checkbox"/> Pegasys® Prefilled Syringe <input type="checkbox"/> Pegasys® Single Dose Vial
For any OVHA <b>NON-PREFERRED</b> Injectable Hepatitis C Product, please explain the medical necessity for this product: Product: _____ Medical justification: _____

4 PRESCRIPTION
<b>Oral:</b> <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: _____
<b>Injectable:</b> <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
<b>Prescriber's Signature:</b> _____ <b>Date:</b> _____

## 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<sup>®</sup> Cream (pimecrolimus) and Protopic<sup>®</sup> 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<sup>®</sup> and Elidel<sup>®</sup> 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<sup>®</sup> Cream) or moderate to severe (Protopic<sup>®</sup> 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.

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

## Lipotropics: Bile Acid Sequestrants

**LENGTH OF AUTHORIZATION:** 3 years

**CRITERIA FOR APPROVAL:**

**Questran<sup>®\*</sup>**

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

**Questran Light<sup>®\*</sup>**

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

**Colestid<sup>®\*</sup>**

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

**Welchol<sup>®</sup>**

- 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**.

<b>Lipotropics: Bile Acid Sequestrants</b>		<i>Length of Authorization: 3 years</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
CHOLESTYRAMINE† powder (compare to Questran <sup>®</sup> ) CHOLESTYRAMINE LIGHT† powder (compare to Questran Light <sup>®</sup> ) PREVALITE† powder (cholestyramine light)	Questran <sup>®*</sup> powder (cholestyramine) Questran Light <sup>®*</sup> powder (cholestyramine light)	
COLESTIPOL† tablets, granules (compare to Colestid <sup>®</sup> )	Colestid <sup>®*</sup> tablets, granules (colestipol) Welchol <sup>®</sup> (colesevelam)	

## Lipotropics: Fibric Acid Derivatives

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Lopid<sup>®</sup>\***

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

**Tricor<sup>®</sup>, TriLipix<sup>®</sup>**

- The patient has been started and stabilized on either Tricor<sup>®</sup> or TriLipix<sup>®</sup> (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<sup>®</sup>, fenofibrate, fenofibrate micronized, Fenoglide<sup>®</sup>, Fibracor<sup>®</sup>, Lipofen<sup>®</sup>, Lofibra<sup>®</sup> and Triglide<sup>®</sup>**

- The patient is taking a statin concurrently and has had a documented side effect, allergy, or treatment failure with Tricor<sup>®</sup> or TriLipix<sup>®</sup>. (If a product has an AB rated generic, there must have been a trial with the generic formulation.)

**OR**

- The patient has had a documented side effect, allergy, or treatment failure to gemfibrozil and Tricor<sup>®</sup> or TriLipix<sup>®</sup>. (If a product has an AB rated generic, there must have been a trial with the generic formulation.)

(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**.

<b>Lipotropics: Fibric Acid Derivatives</b>		<i>Length of Authorization: 1 year.</i>
<b>Key:</b> † Generic product, *Indicates generic equivalent is available without a PA		
<b>§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
<p>GEMFIBROZIL† (compare to Lopid<sup>®</sup>) 600 mg</p> <p><b>On statin concurrently or after gemfibrozil trial</b></p> <p>TRICOR<sup>®</sup> (fenofibrate nanocrystallized) § 48 mg, 145 mg <i>Quantity Limit = 1 tablet/day</i></p> <p>TRILIPIX (fenofibric acid) § 45 mg, 135 mg delayed release capsule <i>Quantity Limit = 1 capsule/day</i></p>	<p>Antara<sup>®</sup> (fenofibrate micronized) § 43 mg, 130 mg fenofibrate micronized† § 54 mg, 160 mg fenofibrate micronized† § 67 mg, 134 mg, 200 mg Fenoglide<sup>®</sup> (fenofibrate MeltDose) § 40 mg, 120 mg Fibracor<sup>®</sup> (fenofibric acid) § 35 mg, 105 mg <i>Quantity Limit = 1 capsule/day</i></p> <p>Lipofen<sup>®</sup> (fenofibrate) § 50 mg, 150 mg Lofibra<sup>®</sup> (fenofibrate micronized) Capsules § 67mg, 134 mg, 200 mg Lofibra<sup>®</sup> (fenofibrate micronized) Tablets § 54 mg, 160 mg Lopid<sup>®</sup>* (gemfibrozil) § 600 mg Triglide<sup>®</sup> (fenofibrate micronized) § 50 mg, 160 mg</p>	

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## Lipotropics: Niacin

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**LENGTH OF AUTHORIZATION:** not applicable

**CRITERIA FOR APPROVAL:** not applicable

<b>Lipotropics: Niacin</b>	
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
NIACIN† NIASPAN® (niacin extended release)	

## Lipotropics: Statins

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**HIGH POTENCY STATINS**

**Crestor<sup>®</sup>**

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

**Lipitor<sup>®</sup>**

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

**Zocor<sup>®</sup>**

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

**OTHER STATINS**

**Altprev<sup>®</sup>, Lescol<sup>®</sup>, Lescol<sup>®</sup> XL, Mevacor<sup>®</sup>, Pravachol<sup>®</sup>**

- 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**.

<b>Lipotropics: Statins</b>		<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	
<b><u>HIGH POTENCY STATINS</u></b>		
SIMVASTATIN† (compare to Zocor <sup>®</sup> ) (QL = 1 tablet/day)	Lipitor <sup>®</sup> (atorvastatin) (QL = 1 tablet/day) Zocor <sup>®*</sup> (simvastatin) (QL = 1 tablet/day)	
CRESTOR <sup>®</sup> (rosuvastatin calcium) § <b>AFTER GENERIC SIMVASTATIN TRIAL</b> (QL = 1 tablet/day)		
<b><u>OTHER STATINS</u></b>		
LOVASTATIN† (compare to Mevacor <sup>®</sup> ) (QL = 1 tab/day (10 & 20 mg), 2 tab/day (40 mg))	Altprev <sup>®</sup> (aka: Altacor <sup>®</sup> ) (lovastatin) (QL = 1 tablet/day) Lescol <sup>®</sup> (fluvastatin) (QL = 1 tablet/day) Lescol <sup>®</sup> XL (fluvastatin XL) (QL = 1 tablet/day) Mevacor <sup>®*</sup> (lovastatin) (QL = 1 tab/day (10 & 20 mg), 2 tabs/day (40 mg)) Pravachol <sup>®*</sup> (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 <sup>®</sup> ) (QL = 1 tablet/day (10 & 20 mg), 2 tab/day (40 mg))		

Note: Please refer to "Lipotropics: Miscellaneous/Combinations" for statin combinations and Lovaza<sup>®</sup>.

## Lipotropics: Miscellaneous/Combinations

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Lovaza®**

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

<b>Lipotropics: Miscellaneous/Combination</b>		<i>Length of Authorization: 1 year</i>
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
<b><u>MISCELLANEOUS</u></b>	Lovaza® (omega-3-acid ethyl esters)	
<b><u>CHOLESTEROL ABSORPTION INHIBITORS/COMBINATIONS</u></b>	Vytorin® (ezetimibe/simvastatin) ( <i>QL = 1 tablet/day</i> ) Zetia® (ezetimibe) ( <i>Qty Limit = 1 tablet/day</i> )	
<b><u>OTHER STATIN COMBINATIONS</u></b>	Caduet® (atorvastatin/amlodipine) ( <i>Qty Limit = 1 tablet/day</i> )	
ADVICOR® (lovastatin/extended release niacin) ( <i>Qty Limit = 1 tablet/day</i> ) SIMCOR® (simvastatin/extended release niacin) ( <i>Qty Limit = 1 tablet/day</i> ) ±		

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

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## Management of Mental Health Medications

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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.

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## Miscellaneous: Cinryze® (Human C1 Inhibitor) IV Infusion

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**LENGTH OF AUTHORIZATION:** initial approval 6 months, subsequent approval 1 year

**CLINICAL CONSIDERATIONS:**

How supplied: 500 unit vials

Dose (Adult): 1,000 unit (2 vials) IV infusion every 3 or 4 days

**CRITERIA FOR APPROVAL:**

- The diagnosis or indication is **prophylaxis** of Hereditary Angioedema (HAE) attacks.  
**AND**
- The patient has had a documented side effect, allergy, treatment failure or a contraindication to androgen therapy (i.e. danazol).  
**AND**
- The quantity requested does not exceed 16 vials per 28 days.  
**OR**
- The medication is to be used for the **treatment** of an acute Hereditary Angioedema (HAE) attack.  
**AND**
- The quantity requested per fill does not exceed 4 vials.

**DOCUMENTATION:**

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

<b>Miscellaneous: Cinryze®</b>	
<i>Length of Authorization: initial approval 6 months, subsequent approval 1 year</i>	
<b>NO PA REQUIRED</b>	<b>PA REQUIRED</b>
	Cinryze® (human C1 inhibitor) <i>(QL = 16 vials/28 days for prophylaxis; 4 vials per fill for acute attacks)</i>

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**Miscellaneous: Elaprase® (Hunter's Syndrome Injectable)**

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***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.**

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



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## Miscellaneous: Soliris® (Paroxysmal Nocturnal Hemoglobinuria Injectable)

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**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.**

<b>Miscellaneous: Soliris®</b>	
<i>Length of Authorization: initial approval 3months, subsequent approval 1 year</i>	
<b>NO PA REQUIRED</b>	<b>PA REQUIRED</b>
	Soliris® (eculizumab) ( <i>Quantity Limit = 20 vials total/3 months initially; 6 vials/month subsequently</i> )

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## Miscellaneous: Somatuline® (Acromegaly Injectable)

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**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.**

<b>Miscellaneous: Somatuline®</b>		<i>Length of Authorization: 1 year</i>
<b>NO PA REQUIRED</b>	<b>PA REQUIRED</b>	
		Somatuline® Depot Injection (lanreotide) ( <i>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)</i> )

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## Miscellaneous: Xenazine® (for Huntington's Disease with chorea)

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**LENGTH OF AUTHORIZATION:** 1 month initially, subsequent approvals up to 1 year

**CLINICAL CONSIDERATIONS:**

How supplied: 12.5 or 25 mg tablets

Dose: initial dose is 12.5 mg/day increasing by 12.5 mg/day at weekly intervals

**CRITERIA FOR APPROVAL:**

- The diagnosis or indication for the requested medication is Huntington's disease with chorea.

AND

- Age  $\geq$  18 years.

**DOCUMENTATION:**

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

<b>Miscellaneous: Xenazine®</b>		<i>Length of Authorization: 1 month initially,</i>
<i>subsequent approvals up to 1 year</i>		
<b>NO PA REQUIRED</b>	<b>PA REQUIRED</b>	
		Xenazine® tablets (tetrabenazine) <i>Quantity limit = 50 mg/day at initial approval (12.5 mg tablets ONLY), up to 100 mg/day at subsequent approvals (12.5 mg or 25 mg tablets)</i> <i>Maximum 1 month supply per fill</i>

## Mood Stabilizers (See also Anticonvulsants)

**LENGTH OF AUTHORIZATION:** Duration of Need\*

**CRITERIA FOR APPROVAL:**

**Lithobid®:**

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

**Equetro®:**

- The patient has had a documented side effect, allergy, or treatment failure with a carbamazepine product from the anticonvulsant therapeutic drug category

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

<b>Mood Stabilizers</b>		<i>Length of authorization: Duration of Need*</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
LITHIUM CARBONATE† (formerly Eskalith®)	Equetro® (carbamazepine SR)	
LITHIUM CARBONATE SR† (compare to Lithobid®, formerly Eskalith CR®)	Lithobid®* (lithium carbonate SR)	
LITHIUM CITRATE SYRUP†		

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

## Multiple Sclerosis: Injectables

***NOTE: Multiple Sclerosis Self-Injectables (Avonex<sup>®</sup>, Betaseron<sup>®</sup>, Copaxone<sup>®</sup> and Rebif<sup>®</sup>) 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<sup>®</sup> 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<sup>®</sup>**

Patient has a diagnosis of relapsing multiple sclerosis and has already been stabilized on Tysabri<sup>®</sup>.

**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<sup>®</sup> on a **General Prior Authorization Request Form**.

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

<b>Quantity:</b> _____	<b>Refills:</b> _____
------------------------	-----------------------

**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:** \_\_\_\_\_

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## Nutritionals: Enteral (Oral)

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**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: ( $\geq 65$ ):**

- involuntary loss of  $\geq 10\%$  of body weight within 6 months
- involuntary loss of  $\geq 5\%$  of body weight within 3 months
- loss of  $\geq 2\%$  of body weight within one month

**Children:**

- $< 70\%$  of expected weight-for-height
- $< 85\%$  of expected height-for-age
- mid-upper arm circumference/head circumference ratio  $< 0.25$

**DOCUMENTATION:**

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

<b>Nutritionals: Enteral (Oral)</b>		<i>Length of authorization: 6 months</i>
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
	<p>All</p> <p>Note: Nutritional supplements administered via tube feeds are provided through the Medical Benefit. Please see guidelines at <a href="http://ovha.vermont.gov/forproviders/copy_of_GOC13.pdf">http://ovha.vermont.gov/forproviders/copy_of_GOC13.pdf</a></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)
<b>Underlying cause of unplanned weight loss or low serum protein levels:</b> <b>Circle or describe specifics:</b> <ul style="list-style-type: none"> <li>▪ Increased metabolic need resulting from severe trauma (i.e.: burns, infection, major bone fractures)</li> <li>▪ Malabsorption syndrome (as related to cystic fibrosis, renal disease, short gut syndrome, Crohn's disease and other unspecified disorders of the gut)</li> <li>▪ Nutritional wasting due to chronic disease (i.e.: cancer, AIDS, conditions resulting in dysphagia, pulmonary insufficiency, renal disease)</li> </ul>	<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><b>Requested Supplement:</b> _____</p> <p><b>Strength &amp; Frequency:</b> _____</p> <p><b>Anticipated duration of supplementation:</b> _____</p>
--

**Prescriber Signature:** \_\_\_\_\_ **Date of this request:** \_\_\_\_\_



**ORAL ONCOLOGY/SELECT ADJUNCT - 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  
ORAL ONCOLOGY/SELECT ADJUNCT**

Patient Diagnosis: \_\_\_\_\_

BSA(m2) \_\_\_\_\_ Patient height (cm) \_\_\_\_\_ Patient weight(kg) \_\_\_\_\_

Maintenance Therapy # of Refills \_\_\_\_\_

Cycle Specific Therapy NO REFILLS Cycle # \_\_\_\_\_

Treatment / Dosage Change Reason :  Toxicity  Progression of Disease

Change in BSA  Other: \_\_\_\_\_

MEDICATION	Normalized Dose	Strength/ Frequency/ Route of Administration	QTY
<input type="checkbox"/> ARIMIDEX*			
<input type="checkbox"/> AROMASIN*			
<input type="checkbox"/> CASODEX			
<input type="checkbox"/> FEMARA*			
<input type="checkbox"/> GLEEVEC			
<input type="checkbox"/> HEXALEN			
<input type="checkbox"/> LUPRON DEPOT*			
<input type="checkbox"/> MERCAPTOPYRINE*			
<input type="checkbox"/> MESNEX			
<input type="checkbox"/> NEULASTA*			
<input type="checkbox"/> NEUPOGEN*			
<input type="checkbox"/> SPRYCEL			
<input type="checkbox"/> SUTENT			
<input type="checkbox"/> TARCEVA			
<input type="checkbox"/> TEMODAR			
<input type="checkbox"/> TRETINOIN			
<input type="checkbox"/> VESANOID			
<input type="checkbox"/> XELODA			
<b>Other:</b>			

**Additional RX Instructions:** \_\_\_\_\_

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\* Not required to use ICORE

## Ophthalmics: Antihistamines

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Optivar<sup>®</sup>, Pataday<sup>®</sup>/Patanol<sup>®</sup>**

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

**Azelastine, Elestat<sup>®</sup>, Emadine<sup>®</sup>, Zaditor<sup>®</sup> RX**

- The patient has had a documented side effect, allergy, or treatment failure to BOTH Optivar<sup>®</sup> and Pataday<sup>®</sup> or Patanol<sup>®</sup>.

**DOCUMENTATION:**

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

<b>Ophthalmics: Antihistamines</b>		<i>Length of Authorization: 1 year</i>
<b>Key: † Generic product. § Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
<p>KETOTIFEN† 0.025 % (eg. Alaway<sup>®</sup>, Zaditor<sup>®</sup> OTC, others) (<i>QL = 1 bottle/month</i>)</p> <p><b>After trial of ketotifen 0.025 %</b></p> <p>OPTIVAR<sup>®</sup> § (azelastine) (<i>QL = 1 bottle/month</i>) PATADAY<sup>®</sup> § (olopatadine 0.2%)/PATANOL<sup>®</sup> § (olopatadine 0.1%) (<i>QL = 1 bottle/month</i>)</p>	<p>Azelastine † (compare to Optivar<sup>®</sup>) (<i>QL = 1 bottle/month</i>) Elestat<sup>®</sup> (epinastine) (<i>QL = 1 bottle/month</i>) Emadine<sup>®</sup> (emedastine) (<i>QL = 2 bottles/month</i>) Zaditor<sup>®</sup> RX (ketotifen 0.025 %) (<i>QL = 1 bottle/month</i>)</p>	

## Ophthalmics: Corticosteroids: Topical

**LENGTH OF AUTHORIZATION:** up to 3 months

**CRITERIA FOR APPROVAL:**

- The patient has had a documented side effect, allergy, or treatment failure with one preferred generic ophthalmic corticosteroid. (If a product has an AB rated generic, there must have been a trial of the generic formulation)

**DOCUMENTATION:**

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

<b>Ophthalmics: Corticosteroids: Topical</b>		<i>Length of Authorization: up to 3 months</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
DEXAMETHASONE SODIUM PHOSPHATE 0.1% Sol† FLUOROMETHOLONE 0.1% S† PREDNISOLONE ACETATE 1% S†	Alrex® (loteprednol) 0.2% S Durezol® (difluprednate) 0.05% E FML® (fluorometholone) 0.1% O FML Forte® (fluorometholone) 0.25% S FML Liquifilm®/Flarex® (fluorometholone) 0.1% S Lotemax® (loteprednol) 0.5% S Pred Forte®/Omnipred® (prednisolone acetate) 1% S Pred Mild® (prednisolone acetate) 0.12% S Vexol® (rimexolone) 1% S  All other brands	

*E=emulsion, S=suspension, Sol=solution*

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## Ophthalmics: Glaucoma Agents / Miotics

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**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. (If a product has an AB rated generic, there must have also been a trial of the generic formulation)
- If the request is for brimonidine tartrate 0.15%, the patient must have a documented intolerance of brand name Alphagan P 0.15%.

**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.**

## Ophthalmics: 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><b><u>ALPHA 2 ADRENERGIC</u></b></p>	
<p><b><u>Single Agent</u></b>                      ALPHAGAN P<sup>®</sup> 0.1 %, 0.15 % (brimonidine tartrate)                      BRIMONIDINE TARTRATE† 0.2 % (formerly Alphagan<sup>®</sup>)</p> <p><b><u>Combination</u></b>                      COMBIGAN<sup>®</sup> (brimonidine tartrate/timolol maleate)</p>	<p>apraclonidine† (compare to Iopidine<sup>®</sup>) (no PA required for patients ≤ 10 years of age)                      brimonidine tartrate 0.15 % † (compare to Alphagan P<sup>®</sup>)                      Iopidine<sup>®</sup> (apraclonidine) (no PA required for patients ≤ 10 years of age)</p>
<p><b><u>BETA BLOCKERS</u></b></p>	
<p>BETAXOLOL HCL† (compare to Betoptic<sup>®</sup>)                      BETOPTIC S<sup>®</sup> (betaxolol suspension)                      CARTEOLOL HCL† (compare to Ocupress<sup>®</sup>)                      LEVOBUNOLOL HCL† (compare to AKBeta<sup>®</sup>, Betagan<sup>®</sup>)                      METIPRANOLOL† (compare to Optipranolol<sup>®</sup>)                      TIMOLOL MALEATE† (compare to Istalol<sup>®</sup>, Timoptic<sup>®</sup>)                      TIMOLOL MALEATE †gel (compare to Timotic XE<sup>®</sup>)</p>	<p>Betagan<sup>®</sup>*                      Betimol<sup>®</sup>                      Istalol<sup>®</sup>*                      Optipranolol<sup>®</sup>*                      Timoptic<sup>®</sup>* (timolol maleate)                      Timoptic XE<sup>®</sup>* (timolol maleate gel)</p>
<p><b><u>PROSTAGLANDIN INHIBITORS</u></b></p>	
<p><i>NOTE: COVERAGE OF A 'PREFERRED' PI AGENT IS CONTINGENT UPON A 1<sup>ST</sup>-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 AS WELL AS A FAILED TRIAL OF BOTH LUMIGAN AND TRAVATAN/TRAVATAN Z.</i></p>	
<p>LUMIGAN<sup>®</sup> (bimatoprost) §                      TRAVATAN<sup>®</sup>/TRAVATAN Z<sup>®</sup> (travoprost) §</p>	<p>Xalatan<sup>®</sup></p>
<p><b><u>CARBONIC ANHYDROUS INHIBITORS</u></b></p>	
<p><b><u>Single Agent</u></b>                      DORZOLAMIDE 2 % (compare to Trusopt<sup>®</sup>)</p> <p><b><u>Combination</u></b>                      DORZOLAMIDE w/TIMOLOL (compare to Cosopt<sup>®</sup>)</p>	<p>Azopt<sup>®</sup> (brinzolamide 1%)                      Trusopt<sup>®</sup>* (dorzolamide 2 %)</p> <p>Cosopt<sup>®</sup>* (dorzolamide w/timolol)</p>
<p><b><u>MISCELLANEOUS</u></b></p>	
<p>DIPIVEFRIN HCL† (compare to AKPro<sup>®</sup>, Propine<sup>®</sup>)                      EPINEPHRINE† (compare to Epifrin<sup>®</sup>, Glaucon<sup>®</sup>*)                      ISOPTO<sup>®</sup> CARBACHOL (carbachol)                      ISOPTO<sup>®</sup> CARPINE (pilocarpine)                      PILOCARPINE HCL† (compare to Pilocar<sup>®</sup>)                      PILOPINE<sup>®</sup> (pilocarpine)                      PILOPTIC-1/2<sup>®</sup>, PILOPTIC-3<sup>®</sup> (pilocarpine)                      PHOSPHOLINE IODIDE<sup>®</sup> (echothiophate)                      PROPINE<sup>®</sup> (dipivefrin)</p>	<p>Miochol-E<sup>®</sup>                      Miostat<sup>®</sup>                      Pilocar<sup>®</sup>*</p>

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## Ophthalmics: Mast Cell Stabilizers

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**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**.

<b>Ophthalmics: Mast Cell Stabilizers</b>		<i>Length of Authorization: 1 year</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
ALAMAST <sup>®</sup> (pemirolast potassium) CROMOLYN SODIUM † (compare to Crolom <sup>®</sup> , Opticrom <sup>®</sup> )	Alocril <sup>®</sup> (nedocromil sodium) Alomide <sup>®</sup> (iodoxamide) Crolom <sup>®*</sup>	

## Ophthalmics: Non-Steroidal Anti-inflammatory Drugs (NSAIDS)

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

Acuvail®

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

**OR**

- The patient has a documented hypersensitivity to the preservative benzalkonium chloride.

Diclofenac, Nevanac®, Voltaren®, Xibrom®,

- The patient has had a documented side effect, allergy, or treatment failure to Acular® or Acular LS®. In addition, for approval of Voltaren®, the patient must have a documented intolerance to diclofenac ophthalmic solution.

Ketorolac 0.4 %/0.5 %

- The patient has had a documented intolerance to brand Acular®/Acular LS® ophthalmic solution.

Ocufen®

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

**DOCUMENTATION:**

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

<b>Ophthalmics: NSAIDs</b>		<i>Length of Authorization: 1 year</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
ACULAR® (ketorolac 0.5% ophthalmic sol.) ACULAR LS® (ketorolac 0.4% ophthalmic sol.)  FLURBIPROFEN 0.03% ophthalmic sol. † (compare to Ocufen®)	Acuvail (ketorolac 0.45 %) Ophthalmic Solution <i>(Quantity Limit = 30 unit dose packets/15 days)</i> Diclofenac† 0.1% ophthalmic sol (compare to Voltaren®) Ketorolac † 0.4 % ophthalmic sol (compare to Acular LS®) Ketorolac † 0.5 % ophthalmic sol (compare to Acular®) Nevanac® ophthalmic susp. (nepafenac 0.1%) Ocufen®* ophthalmic sol. (flurbiprofen 0.03%) Voltaren® (diclofenac 0.1% ophthalmic sol.) Xibrom® ophthalmic sol. (bromfenac 0.09%)	

## 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**.

<b>Ophthalmics: Quinolone Anti-Infectives</b>	
<i>Length of Authorization: for date of service, no refills</i>	
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
CIPROFLOXACIN HCL† (compare to Ciloxan®) OFLOXACIN† (compare to Ocuflax®)	Besivance® (besifloxacin) Ciloxan®*(ciprofloxacin) Iquix® (levofloxacin 1.5 %) (preservative free) Ocuflax®*(ofloxacin) Quixin® (levofloxacin 0.5 %) Vigamox® (moxifloxacin) (preservative free) Zymar® (gatifloxacin)

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## Ossification Enhancing Agents

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**LENGTH OF AUTHORIZATION:** 3 years

**CRITERIA FOR APPROVAL:**

**Actonel<sup>®</sup>, Actonel<sup>®</sup> w/calcium, Fosamax Plus D<sup>®</sup>:**

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

**Calcitonin Nasal Spray (generic):**

- The patient has had a documented intolerance to brand Miacalcin.

**Fosamax<sup>®</sup> Tablet:**

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

**Fosamax<sup>®</sup> Oral Solution:**

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

**Didronel<sup>®</sup>, Etidronate, Skelid<sup>®</sup>:**

- The patient has had a documented side effect, allergy, or treatment failure (to at least a six-month trial) of Boniva<sup>®</sup> or alendronate. If a medication has an AB rated generic, there must have also been a trial of the generic formulation.

- 

**Forteo<sup>®</sup>:**

- 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 or fracture after one 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<sup>®</sup> 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.
- OR**
- The patient is male with a diagnosis of osteoporosis.
- OR**
- The patient has a diagnosis of glucocorticoid induced 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**

<b>Ossification Enhancing Agents</b>		<i>Length of Authorization: 3 years</i>
<b>Key: † Generic product,</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
<b><u>ORAL BISPHOSPHONATE</u></b>		
<b>TABLETS/CAPSULES</b>		
ALENDRONATE† (compare to Fosamax®)		
BONIVA® (ibandronate) ( <i>Quantity Limit = 150 mg tablet/1 tablet per 28 days</i> )		
<ul style="list-style-type: none"> <li>Actonel® (risedronate)</li> <li>Actonel® w/calcium (risedronate/calcium)</li> <li>Didronel® (etidronate)</li> <li>Etidronate† (compare to Didronel®)</li> <li>Fosamax®* (alendronate)</li> <li>Fosamax Plus D® (alendronate/vitamin D)</li> <li>Skelid® (tiludronate)</li> </ul>		
<b>ORAL SOLUTION</b>		
Fosamax® Oral Solution (alendronate)		
<b><u>INJECTABLE BISPHOSPHONATE</u></b>		
<ul style="list-style-type: none"> <li>Boniva Injection (ibandronate) (<i>QL=3 mg/3 months (four doses)/year</i>)</li> <li>Reclast® Injection (zoledronic acid) (<i>QL=5 mg (one dose)/year</i>)</li> </ul>		
<b><u>CALCITONIN NASAL SPRAY</u></b>		
<ul style="list-style-type: none"> <li>FORTICAL® (calcitonin)</li> <li>MIACALCIN® (calcitonin)</li> </ul>		
Calcitonin† Nasal Spray (compare to Miacalcin®)		
<b><u>PARATHYROID HORMONE INJECTION</u></b>		
Forteo® (teriparatide) ( <i>Quantity Limit = 1 pen (3 ml)/28 days</i> )		

## ~ BISPHTHONATE 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)**

Administering Provider if other than Prescriber: (name): \_\_\_\_\_ NPI #: \_\_\_\_\_

Pharmacy (if known): \_\_\_\_\_ Phone: \_\_\_\_\_ &amp;/or FAX: \_\_\_\_\_

**Drug requested:**  Boniva IV  Reclast

**Dose & frequency:** \_\_\_\_\_

**Diagnosis/indication:**

- Treatment of postmenopausal osteoporosis     Treatment of male osteoporosis  
 Paget's Disease     Treatment of glucocorticoid induced osteoporosis  
 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"/> Alendronate 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:**

**Cetraxal<sup>®</sup>**

- The patient has a documented side effect, allergy, or treatment failure to one of the following: any generic neomycin/polymyxin B/hydrocortisone product, Ciprodex<sup>®</sup> otic suspension, or generic ofloxacin otic solution.

**Cipro-HC<sup>®</sup>, Coly-Mycin S<sup>®</sup>, Cortisporin TC<sup>®</sup>**

- The patient has had a documented side effect, allergy, or treatment failure to neomycin/polymyxin B sulfate/hydrocortisone and one other preferred product.

**Cortisporin<sup>®</sup> Otic, Pediotic<sup>®</sup>, Floxin<sup>®</sup>:**

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

**DOCUMENTATION:**

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

<b>Otic: Anti-Infectives</b>		<i>Length of Authorization: 1 year</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
<b><u>Anti-infective Single Agent</u></b>		
OFLOXACIN† 0.3% Otic Soln (compare to Floxin <sup>®</sup> )	Cetraxal (ciprofloxacin 0.2%) otic solution <i>(Quantity limit = 14 unit dose packages/7 days)</i>  Floxin <sup>®*</sup> (ofloxacin 0.3% otic soln.)	
<b><u>Anti-infective/Corticosteroid Combination</u></b>		
CIPRODEX <sup>®</sup> (ciprofloxacin 0.3%/dexamethasone 0.1%) otic suspension	Cipro-HC <sup>®</sup> (ciprofloxacin 0.2%/hydrocortisone 1%) otic suspension	
NEOMYCIN/POLYMYXIN B SULFATE/HYDROCORTISONE† (compare to Cortisporin otic <sup>®</sup> , Pediotic <sup>®</sup> )	Coly-Mycin S <sup>®</sup> /Cortisporin TC <sup>®</sup> (neomycin/colistin/thonzium/hydrocortisone)  Cortisporin otic <sup>®</sup> /Pediotic <sup>®*</sup> (neomycin/polymyxin B sulfate /hydrocortisone) otic solution/suspension	

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## Pancreatic Enzyme Products

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**LENGTH OF AUTHORIZATION:** not applicable

**CRITERIA FOR APPROVAL:** not applicable

<b>Pancreatic Enzyme Products</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
CREON <sup>®</sup> 5 Capsule-DR, EC, microspheres	
CREON <sup>®</sup> 10 Capsule-DR, EC, microspheres	
CREON <sup>®</sup> 20 Capsule-DR, EC, microspheres	
CREON 6,000 (lipase units) DR Capsule	
CREON 12,000 (lipase units) DR Capsule	
CREON 24,000 (lipase units) DR Capsule	
PANGESTYME <sup>®</sup> CN-10 Capsule-DR, EC granules	
PANGESTYME <sup>®</sup> CN-20 Capsule-DR, EC granules	
PANGESTYME <sup>®</sup> EC Capsule-DR, EC granules	
PANGESTYME <sup>®</sup> MT16 Capsule-DR, EC granules	
PANGESTYME <sup>®</sup> UL12 Capsule-DR, EC granules	
PANGESTYME <sup>®</sup> UL18 Capsule-DR, EC granules	
PANGESTYME <sup>®</sup> UL20 Capsule-DR, EC granules	
PANCRECARB <sup>®</sup> MS-4 Capsule-DR, EC, microspheres	
PANCRECARB <sup>®</sup> MS-8 Capsule-DR, EC, microspheres	
PANCRECARB <sup>®</sup> MS-16 Capsule-DR, EC, microspheres	
ULTRASE <sup>®</sup> Capsule-EC microspheres	
ULTRASE <sup>®</sup> MT12 Capsule-EC minitablets	
ULTRASE <sup>®</sup> MT18 Capsule-EC minitablets	
ULTRASE <sup>®</sup> MT20 Capsule-EC minitablets	
VIOKASE <sup>®</sup> 8 Tablets	
VIOKASE <sup>®</sup> 16 Tablets	

Abbreviations: DR=delayed release, EC=enteric-coated

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## Parkinson's Medications

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**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Sinemet<sup>®</sup>, Sinemet<sup>®</sup> CR, Parcopa<sup>®</sup>, Parlodel<sup>®</sup>, Requip<sup>®</sup>, Eldepryl<sup>®</sup>, Symmetrel<sup>®</sup>**

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

**Azilect<sup>®</sup>**

- 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

**Pramipexole**

- The patient has had a documented intolerance to brand Mirapex<sup>®</sup> product.

**Requip XL<sup>®</sup>**

- The diagnosis or indication is Parkinson's disease. Requests will not be approved for Restless Leg Syndrome (RLS)  
**AND**
- The patient has had an inadequate response (i.e. wearing off effect or "off" time) with the generic ropinirole/Requip<sup>®</sup> IR.  
**OR**
- The patient has not been able to be adherent to a three times daily dosing schedule of ropinirole/Requip<sup>®</sup> IR resulting in a significant clinical impact.

**Tasmar<sup>®</sup>**

- The diagnosis or indication is Parkinson's disease.  
**AND**
- The patient has had a documented side effect, allergy, or treatment failure with Comtan<sup>®</sup>.

**Zelapar<sup>®</sup>**

- 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><b><u>DOPAMINE PRECURSOR/DOPA DECARBOXYLASE INHIBITORS</u></b>            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><b><u>DOPAMINE AGONISTS (ORAL)</u></b>            BROMOCRIPTINE† (compare to Parlodel®)            MIRAPEX® (pramipexole)            ROPINIROLE† (compare to Requip®)</p>	<p>Parlodel®* (bromocriptine)            Pramipexole † (compare to Mirapex®)            Requip®* (ropinirole)            Requip XL® (ropinirole XL)  <i>QL = 1 tab/day (all strengths except 12 mg), QL = 2 tabs/day (12 mg)</i></p>
<p><b><u>COMT INHIBITORS</u></b>            COMTAN® (entacapone)</p>	<p>Tasmar® (tolcapone)</p>
<p><b><u>MAO-B INHIBITORS</u></b>            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><b><u>OTHER</u></b>            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:**

Adcirca<sup>®</sup> (tadalafil) 20 mg, Revatio<sup>®</sup> (sildenafil citrate) 20 mg:

- Clinical diagnosis of pulmonary hypertension
- AND**
- No concomitant use of organic nitrate-containing products

Viagra<sup>®</sup> (sildenafil citrate) 25 mg, 50 mg, and 100 mg:

- 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**.

<b>Phosphodiesterase Inhibitors</b>		<i>Length of Authorization: 1 year</i>
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
	<u>Adcirca<sup>®</sup> (tadalafil)</u> <i>(Quantity Limit = 2 tablets/day)</i> <u>Revatio<sup>®</sup> (sildenafil citrate)</u> <i>(Quantity Limit = 3 tablets/day)</i> <u>Viagra<sup>®</sup> (sildenafil citrate)</u> <i>(Quantity Limit = 3 tablets/day)</i>	

Note: Please refer to “Pulmonary Arterial Hypertension Medications” for Endothelian Receptor Antagonists and Prostanoids.

## Platelet Inhibitors

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Persantine<sup>®</sup>, Pletal<sup>®</sup>, Ticlid<sup>®</sup>:**

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

**LIMITATIONS:**

Plavix<sup>®</sup> 300mg is not an outpatient dose and is not covered in the pharmacy benefit..

**DOCUMENTATION:**

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

<b>Platelet Inhibitors</b>		<i>Length of Authorization: 1 year</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
<u>AGGREGATION INHIBITORS</u> CILOSTAZOL† (compare to Pletal <sup>®</sup> ) EFFIENT <sup>®</sup> (prasugrel) Tablet <i>QL = 1 tablet/day</i> PLAVIX <sup>®</sup> 75 mg (clopidogrel bisulfate) TICLOPIDINE† (compare to Ticlid <sup>®</sup> )	Plavix <sup>®</sup> 300 mg (clopidogrel bisulfate) Pletal <sup>®</sup> * (cilostazol) Ticlid <sup>®</sup> * (ticlopidine)	
<u>OTHER</u> AGGRENOX <sup>®</sup> (dipyridamole/Aspirin) ASPIRIN† DIPYRIDAMOLE† (compare to Persantine <sup>®</sup> )	Persantine <sup>®</sup> * (dipyridamole)	

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## Psoriasis Medications: Injectables

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**NOTE:** Psoriasis Self-Injectables (Enbrel<sup>®</sup> and Humira<sup>®</sup>) must be obtained and billed through our specialty pharmacy vendor, ICORE Healthcare. Please see the Enbrel or Humira Prior Authorization/Patient Enrollment Form for instructions. ICORE Healthcare may supply Remicade<sup>®</sup> upon request or you may continue to obtain through your usual supplier. ICORE Healthcare will not be supplying Amevive<sup>®</sup> at this time – please continue to obtain through your usual supplier.

**LENGTH OF AUTHORIZATION:** Initial PA of 3 months, and 12 months thereafter upon recertification

**CRITERIA FOR APPROVAL:**

**Enbrel<sup>®</sup>**

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<sup>®</sup>

**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<sup>®</sup>**

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<sup>®</sup>

**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® or Humira® 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® or Humira® cannot be used.

**DOCUMENTATION:**

- ✓ Document clinical information for **Enbrel®** or **Humira®** on its **Prior Authorization/Patient Enrollment Form** and clinically compelling information supporting the choice of **Remicade®** on a **Remicade Prior Authorization Request Form**. and **Amevive®** on a **General Prior Authorization Request Form**.

**Psoriasis Medications: Injectables**

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

**PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**

ENBREL® (etanercept)  
HUMIRA® (adalimumab)

**NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**

Amevive® (alefacept)  
Remicade® (infliximab)

## 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<sup>®</sup> will be limited to 60 grams.

**Vectical Ointment**

- The patient ≥ 18 years of age
- AND**
- The patient has a diagnosis of mild-to-moderate plaque psoriasis
- AND**
- The patient has demonstrated inadequate response, adverse reaction or contraindication to calcipotriene

**LIMITATIONS:**

Kits with non-drug products or combinations of 2 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**.

<b>Psoriasis: Non-Biologics</b>		<i>Length of Authorization: 1 year</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
<b><u>ORAL</u></b>		
CYCLOSPORINE† (all brand and generic) METHOTREXATE† (all brand and generic) OXSORALEN-ULTRA <sup>®</sup> (methoxsalen) SORIATANE <sup>®</sup> (acitretin) capsules		
<b><u>TOPICAL</u></b>		
CALCIPOTRIENE† Solution (compare to Dovonex <sup>®</sup> ) DOVONEX <sup>®</sup> (calcipotriene cream/ointment) PSORiatec <sup>®</sup> , DRITHO-SCALP <sup>®</sup> (anthralin cream) TAZORAC <sup>®</sup> (tazarotene cream, gel)	Dovonex <sup>®*</sup> Solution (calcipotriene) Taclonex <sup>®</sup> (calcipotriene/betamethasone ointment/scalp suspension) <i>(QL for initial fill = 60 grams)</i> Vectical <sup>®</sup> Ointment (calcitriol) <i>(Quantity Limit = 200 g (2 tubes)/week)</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**.

<b>Pulmonary: Anticholinergics</b>		<i>Length of Authorization: 1 year</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
<b><u>METERED DOSE INHALER (SINGLE AGENT)</u></b>		
ATROVENT HFA <sup>®</sup> (ipratropium) <i>Quantity Limit = 2 inhalers/25 days</i>		
SPIRIVA <sup>®</sup> (tiotropium) <i>Quantity Limit = 1 capsule/day</i>		
<b><u>NEBULIZER (SINGLE AGENT)</u></b>		
IPRATROPIUM SOLN FOR INHALATION		
<b><u>METERED DOSE INHALER (COMBINATION)</u></b>		
COMBIVENT <sup>®</sup> (ipratropium/albuterol) <i>Quantity Limit = 2 inhalers/30 days</i>		
<b><u>NEBULIZER (COMBINATION)</u></b>		
IPRATROPIUM/ALBUTEROL <sup>†</sup> (compare to Duoneb <sup>®</sup> )	Duoneb <sup>®*</sup> (ipratropium/albuterol)	

## Pulmonary: Antihistamines: Intranasal

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

ASTELIN, ASTEPRO, 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**.

<b>Pulmonary: Antihistamines: Intranasal</b>		<i>Length of Authorization: 1 year</i>
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
	Astelin® (azelastine) Nasal Spray <i>Quantity Limit = 1 bottle (30 ml)/25 days</i>	
	Astepro® (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>	

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## Pulmonary: Antihistamines: 1<sup>st</sup> Generation

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**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.**

<b>Pulmonary: Antihistamines: 1<sup>st</sup> Generation</b>		<i>Length of Authorization: 1 year</i>
Key: † Generic product, *Indicates generic equivalent is available without a PA		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
All generic antihistamines	All brand antihistamines (example: Benadryl <sup>®</sup> )	
All generic antihistamine/decongestant combinations	All brand antihistamine/decongestant combinations (example: Deconamine SR <sup>®</sup> , Rynatan <sup>®</sup> , Ryna-12 <sup>®</sup> )	

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## Pulmonary: Antihistamines: 2<sup>nd</sup> Generation

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**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 CAPSULES, 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, FEXOFENADINE-PSE, 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).  
**AND**
- If the request is for Fexofenadine-PSE, the patient must also have a documented intolerance to Allegra-D 12 hr.

**DOCUMENTATION:**

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

## Pulmonary: Antihistamines: 2<sup>nd</sup> 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 <sup>®</sup> ) CETIRIZINE † OTC (compare to Zyrtec <sup>®</sup> )  FEXOFENADINE † (after loratadine OTC and cetirizine OTC trials)	Allegra <sup>®</sup> (fexofenadine) Clarinex <sup>®</sup> (desloratadine) Claritin <sup>®</sup> capsules (loratadine) Claritin <sup>®</sup> * tablets (loratadine) Xyzal <sup>®</sup> (levocetirizine) Zyrtec RX/OTC <sup>®</sup> * (cetirizine)
LORATADINE-D † (OTC)	Allegra-D <sup>®</sup> (12 HR & 24 HR) § Cetirizine-D SR Clarinex-D <sup>®</sup> (12 HR & 24 HR) § Claritin-D <sup>®</sup> *§ Fexofenadine-PSE † (compare to Allegra-D <sup>®</sup> 12 hr) Zyrtec-D <sup>®</sup> §
LORATADINE † (OTC) syrup CETIRIZINE † (OTC) syrup ZYRTEC OTC SYRUP <sup>®</sup>	Allegra <sup>®</sup> suspension Clarinex Syrup <sup>®</sup> Claritin Syrup <sup>®</sup> * Xyzal <sup>®</sup> (levocetirizine) Syrup Zyrtec RX Syrup <sup>®</sup>
LORATADINE † (OTC) rapidly disintegrating tablet (RDT)	Allegra ODT <sup>®</sup> § Certirizine † Chewable Tablets Clarinex Reditabs <sup>®</sup> § Claritin Chewable Tablets <sup>®</sup> § Claritin Reditabs <sup>®</sup> *§ Zyrtec Chewable Tablets <sup>®</sup> §

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## Pulmonary: Xolair® (for Persistent Asthma)

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**LENGTH OF AUTHORIZATION:**      *3 months initially*, subsequent approvals will be granted for one year upon verification of marked clinical improvement.  
Yearly pulmonologist/allergist/immunologist consult required.

**CRITERIA FOR APPROVAL:**

- Patient must have a diagnosis of moderate to severe persistent asthma.  
AND
- Patient is 12 years of age or older  
AND
- Patient has tried and failed an inhaled oral corticosteroid *or* has a contraindication to an inhaled corticosteroid.  
AND
- Patient has tried and failed an oral second generation antihistamine *or* has a contraindication to an oral second generation antihistamine.  
AND
- Patient has tried and failed a leukotriene receptor antagonist *or* has a contraindication to a leukotriene receptor antagonist.  
AND
- Patient has tried and failed a long acting beta-agonist *or* has a contraindication to a long acting beta-agonist.  
AND
- A pulmonologist/allergist/immunologist consult has been obtained within the past year.  
AND
- Patient has tested positive to at least one perennial aeroallergen by a skin test (i.e.: RAST, CAP, intracutaneous test).  
AND
- Patient has an IgE level  $\geq 30$  and  $\leq 700$  IU/ml prior to beginning therapy with Xolair®.

This drug must be billed through the OVHA POS prescription processing system using NDC values.  
**J codes will NOT be accepted.**

**LIMITATIONS:**

Xolair® use will not be approved if requested for prevention of peanut related allergic reaction.

**DOCUMENTATION:**

- ✓ Document clinically compelling information supporting the choice of Xolair® on the **Xolair Prior Authorization Request Form**.

<b>Pulmonary: Xolair®</b> <i>Length of Authorization: 3 months initially, subsequent approvals for 1 year</i>	
<b>NO PA REQUIRED</b>	<b>PA REQUIRED</b>
	Xolair® (omalizumab) 150 mg subcutaneous injection vial <i>Quantity limit = 6 vials every 28 days</i>

## ~ XOLAIR ~

### Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of Xolair. In order for beneficiaries to receive Medicaid coverage for Xolair, 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 as directed 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: \_\_\_\_\_  
 Specialty: \_\_\_\_\_  
 Contact Person at Office: \_\_\_\_\_

**Beneficiary:**

 Name: \_\_\_\_\_  
 Medicaid ID #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Patient Diagnosis:  Moderate/Severe Persistent Asthma  
 Other: \_\_\_\_\_

**If requesting prescriber is not a pulmonologist, allergist, or immunologist, date of last visit to one (required yearly):**

**Specialist name:** \_\_\_\_\_ **Specialist Type:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- Initial Prior Authorization Request:** Please complete all portions of form below
- Subsequent PA Request:** Has patient shown marked clinical improvement  **Yes**  **No**

**List all previous therapies tried and failed for this condition:**

Therapy	Specific Drug	Reason for Discontinuation
Inhaled Corticosteroid		
2 <sup>nd</sup> Generation Antihistamine		
Leukotriene Receptor Antagonist		
Long-Acting Beta Agonist		

Has the member tested positive to at least one perennial aeroallergen by a skin test (i.e. RAST, CAP, intracutaneous test)?  **Yes**  **No**

Please explain: \_\_\_\_\_

Is the member's IgE level  $\geq 30$  and  $\leq 700$  IU/ml?  **Yes**  **No** Please provide IgE level: \_\_\_\_\_

**Prescriber Signature:** \_\_\_\_\_ **Date of this request:** \_\_\_\_\_

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## Pulmonary: Beta-Adrenergic Agents

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**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Metered Dose Inhalers (Short-Acting)**

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.

**Accuneb® nebulizer solution 0.63 mg/ml and 1.25 mg/ml**

- The patient must have had a documented intolerance to the generic formulation.

**Levalbuterol nebulizer solution (age ≤ 12 years)**

- The patient must have had a documented intolerance to the brand Xopenex nebulizer solution.

**Levalbuterol nebulizer solution (age > 12 years)**

- The patient must have had a documented side effect, allergy, or treatment failure to albuterol nebulizer or metaproterenol nebulizer solution.
- AND
- The patient must have had a documented intolerance to the brand Xopenex nebulizer solution.

**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 albuterol nebulizer or metaproterenol nebulizer 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**.

**Pulmonary: Beta-Adrenergic Agents**

*Length of Authorization: 1 year*

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

<b>PREFERRED DRUGS (No PA Required)</b>		<b>PA REQUIRED</b>
<b><u>METERED-DOSE INHALERS (SHORT-ACTING)</u></b>		
XOPENEX® HFA (levalbuterol)  MAXAIR® Autohaler (pirbuterol)		Alupent® (metaproterenol) Proair® HFA (albuterol) Proventil® HFA (albuterol) Ventolin® HFA (albuterol)
<b><u>METERED-DOSE INHALERS (LONG-ACTING)</u></b>		
SEREVENT® DISKUS (salmeterol) <i>(after criteria for LABA are met)</i> <i>Quantity Limit = 60 blisters/30 days</i> FORADIL® (formoterol) <i>(after criteria for LABA are met)</i> <i>Quantity Limit = 60 capsules/30 days</i>		
<b><u>NEBULIZER SOLUTIONS (SHORT-ACTING)</u></b>		
ALBUTEROL † 0.63 mg/ml and 1.25 mg/ml neb solution (compare to Accuneb®) ALBUTEROL † 0.83 mg/ml neb solution METAPROTERENOL neb solution † XOPENEX® neb solution (levalbuterol) (age ≤ 12 years)		Accuneb®* (albuterol sulfate neb solution 0.63 mg/ml and 1.25 mg/ml) Levalbuterol † neb solution (compare to Xopenex®) (all ages) Xopenex® neb solution (levalbuterol) (age >12 years)
<b><u>NEBULIZER SOLUTIONS (LONG-ACTING)</u></b>		
		Brovana® (arformoterol) <i>QL = 2 vial/day</i> Perforomist® (formoterol) <i>QL = 2 vial/day</i>
<b><u>TABLETS/SYRUP (SHORT-ACTING)</u></b>		
TERBUTALINE tablets † (compare to Brethine®) ALBUTEROL tablets/syrup † METAPROTERENOL tablets/syrup †		Brethine®* (terbutaline)
<b><u>TABLETS (LONG-ACTING)</u></b>		
ALBUTEROL ER tablets †		Vospire ER®* (albuterol)

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## **Pulmonary: Inhaled Glucocorticoids**

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**LENGTH OF AUTHORIZATION:** 1 year

**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 (all ages):**

- The patient requires a nebulizer formulation.
- AND**
- The patient has a documented intolerance to the brand product.

**Pulmicort Respules<sup>®</sup> (age > 12 years):**

- 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**.

## Pulmonary: Inhaled Glucocorticoids/Combinations

*Length of Authorization: 1 year*

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

PREFERRED DRUGS (No PA Required)	PA REQUIRED
<b><u>METERED-DOSE INHALERS (SINGLE AGENT)</u></b>	
<p>ASMANEX<sup>®</sup> 220 mcg/inh (mometasone furoate) (<i>QL = 0.72 gm (3 inhalers)/90 days</i>)</p> <p>ASMANEX<sup>®</sup> 110 mcg/inh (mometasone furoate) (<i>QL = 0.405 gm (3 inhalers)/90 days</i>)</p> <p>AZMACORT<sup>®</sup> (triamcinolone acetonide)</p> <p>FLOVENT DISKUS<sup>®</sup> (fluticasone propionate) (<i>QL = 3 inhalers/90 days</i>)</p> <p>FLOVENT HFA<sup>®</sup> (fluticasone propionate) (<i>QL = 36 gm (3 inhalers)/90 days</i>)</p> <p>PULMICORT FLEXHALER<sup>®</sup> (budesonide) (<i>QL = 6 inhalers/90 days</i>)</p> <p>QVAR<sup>®</sup> 40 mcg/inh (beclomethasone) (<i>QL = 14.6 gm (2 inhalers)/90 days</i>)</p> <p>QVAR<sup>®</sup> 80 mcg/inh (beclomethasone) (<i>QL = 58.4 gm (8 inhalers)/90 days</i>)</p>	<p>Aerobid<sup>®</sup> (flunisolide)</p> <p>Aerobid M<sup>®</sup> (flunisolide/menthol)</p> <p>Alvesco<sup>®</sup> (ciclesonide) (<i>QL = 18.3 gm (3 inhalers)/90 days</i>) (80 mcg/inh) (<i>QL = 36.6 gm (6 inhalers)/90 days</i>) (160 mcg/inh)</p>
<b><u>METERED-DOSE INHALERS (COMBINATION PRODUCT)</u></b>	
<p>ADVAIR<sup>®</sup> DISKUS (fluticasone/salmeterol) (<i>QL = 3 inhalers/90 days</i>)</p> <p>ADVAIR<sup>®</sup> HFA (fluticasone/salmeterol) (<i>QL = 36 gm (3 inhalers)/90 days</i>)</p> <p>SYMBICORT<sup>®</sup> (budesonide/formoterol) (<i>QL = 30.6 gm (3 inhalers)/90 days</i>)</p>	
<b><u>NEBULIZER SOLUTIONS</u></b>	
<p>PULMICORT RESPULES<sup>®</sup> (budesonide) (age ≤ 12 yrs)</p>	<p>Budesonide Inh Suspension (compare to Pulmicort Respules<sup>®</sup>) (all ages)</p> <p>Pulmicort Respules<sup>®</sup> (budesonide) (age &gt; 12 years)</p>

## Pulmonary: Nasal Glucocorticoids

**LENGTH OF AUTHORIZATION:**

1 year

**CRITERIA FOR APPROVAL:**

**Beconase AQ<sup>®</sup>, Flonase<sup>®</sup>, Flunisolide 25 mcg/spray, Flunisolide 29 mcg/spray, Omnaris<sup>®</sup>, Rhinocort Aqua<sup>®</sup>, Veramyst<sup>®</sup>:**

- 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**.

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

<b>Pulmonary: Systemic Oral Glucocorticoids</b>	
<i>Length of authorizations: 1 year</i>	
<b>Key : † Generic product, *Indicates generic equivalent is available without a PA</b>	
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>
CORTISONE ACETATE†	Celestone®
DEXAMETHASONE†	Cortef®*
HYDROCORTISONE† (compare to Cortef®)	Medrol®*
METHYLPREDNISOLONE† (compare to Medrol®)	Millipred® (prednisolone) oral solution
ORAPRED® oral solution/ODT (prednisolone sodium 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)

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## Pulmonary: Leukotriene Modifiers

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**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**.

<b>Pulmonary: Leukotriene Modifiers</b>		<i>Length of Authorization: 1 year</i>
<b>Key: § Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
ACCOLATE® (zafirlukast) <i>Quantity Limit = 2 tablets/day</i>	Zyflo® (zileuton) § <i>Quantity Limit = 4 tablets/day</i>	
SINGULAIR® (montelukast sodium) <i>Quantity Limit = 1 tablet or packet per day</i>	Zyflo CR® (zileuton SR) § <i>Quantity Limit = 4 tablets/day</i>	

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## Pulmonary: Synagis®

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***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 March 31st (up to 5 doses depending on gestational age).

**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 (maximum 5 doses).
- Infants born at 29-32 weeks (i.e., between 29 weeks, 0 days and 31 weeks, 6 days) of gestation and under 6 months of age at the start of the RSV season (maximum 5 doses).
- Infants born at 32-35 weeks (i.e., between 32 weeks, 0 days and 34 weeks, 6 days) of gestation who have at least one of the following risk factors and who have not reached 3 months of age: (dosing continues in the RSV season through the end of the month the infant reaches 3 months old – maximum 3 doses)
  - Infant attends child care
  - One of more siblings (or other child permanently in house) < 5 years of age
- Children under 24 months of age with chronic lung disease of prematurity (bronchopulmonary dysplasia) who have received medical therapy (supplemental oxygen, bronchodilator, diuretic or chronic corticosteroid therapy) within 6 months prior to the start of the RSV season (maximum 5 doses).
- Children under 24 months of age with hemodynamically significant cyanotic or acyanotic heart disease (CHD) (maximum 5 doses):
  - Receiving medication to control congestive heart failure
  - Moderate to severe pulmonary hypertension
  - Have cyanotic heart disease
- Infants born at < 35 weeks (i.e., 34 weeks, 6 days) of gestation and under 12 months of age at the start of the RSV season with either: (maximum 5 doses)
  - Congenital abnormalities of the airways
  - Neuromuscular condition compromising handling of respiratory tract secretions

**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 09/2009

**Fax Completed Form to:**

**Fax Number: 802-775-7824** 

**Phone Number: 800-639-1210** 



CRITICAL HOMECARE SOLUTIONS, INC.  
Growing a Family of Services

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

Gestational Age: weeks: _____ days: _____	Current Weight: (kg) _____	Dose: 15mg / kg (weight verified monthly)
Diagnosis:		
<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 (maximum 5 doses)		
<input type="checkbox"/> Infants born at 29 - 32 weeks (i.e., between 29 weeks, 0 days and 31 weeks, 6 days) of gestation and under 6 months of age at the start of the RSV season (maximum 5 doses)		
<input type="checkbox"/> Infants born at 32 - 35 weeks (i.e., between 32 weeks, 0 days and 34 weeks, 6 days) of gestation who have at least one of the following risk factors and who have not reached 3 months of age: (dosing continues in the RSV season through the end of the month the infant reaches 3 months old – maximum 3 doses)		
<input type="checkbox"/> Infant attends child care <input type="checkbox"/> One or more siblings (or other child permanently in house) < 5 years of age		
<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 chronic corticosteroid therapy) within 6 months prior to the start of the RSV season (maximum 5 doses)		
<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(CHD)		
<input type="checkbox"/> Receiving medication to control congestive heart failure		
<input type="checkbox"/> Moderate to severe pulmonary hypertension (maximum 5 doses)		
<input type="checkbox"/> Have cyanotic heart disease		
<input type="checkbox"/> Infants born at < 35 weeks (i.e., 34 weeks, 6 days) of gestation and under 12 months of age at the start of the RSV season with either: (maximum 5 doses)		
<input type="checkbox"/> Congenital abnormalities of the airways		
<input type="checkbox"/> Neuromuscular condition compromising handling of respiratory tract secretions		
<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 03/2010

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.

## Pulmonary Arterial Hypertension Medications

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Flolan<sup>®</sup>**

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

<b>Pulmonary Arterial Hypertension Medications</b> <span style="float: right;"><i>Length of Authorization: 1 year</i></span> Key: † Generic product, *Indicates generic equivalent is available without a PA	
PREFERRED DRUGS (No PA Required)	PA REQUIRED
<p><b><u>ENDOTHELIAL RECEPTOR ANTAGONISTS</u></b></p> <p>LETAIRIS<sup>®</sup> (ambrisentan) Tablet  <i>Quantity Limit = one tablet/day</i></p> <p>TRACLEER<sup>®</sup> (bosentan) Tablet  <i>Quantity Limit = 2 tablets/day</i></p> <p><b><u>PROSTANOIDS</u></b></p> <p><b>Injection</b>                      EPOPROSTENOL † ( compare to Flolan<sup>®</sup>)                      REMODULIN<sup>®</sup> (treprostinil sodium injection)</p> <p><b>Inhalation</b>                      TYVASO<sup>®</sup> (treprostinil inhalation solution)                      VENTAVIS<sup>®</sup> (iloprost inhalation solution)</p> <p><b>**Maximum days supply for all drugs is 30 days**</b></p>	<p>Flolan<sup>®*</sup> (epoprostenol)</p>

Note: Please refer to “Phosphodiesterase Inhibitor Medications” for Adcirca<sup>®</sup> and Revatio<sup>®</sup>.

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## Renal Disease: Phosphate Binders

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**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<sup>®</sup> (sevelamer hydrochloride).

**DOCUMENTATION:**

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

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

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## Rheumatoid, Juvenile Idiopathic & Psoriatic Arthritis Medications: Injectables

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***NOTE: Rheumatoid, Juvenile Idiopathic and Psoriatic Arthritis Self-Injectables (Enbrel<sup>®</sup>, Humira<sup>®</sup>, Kineret<sup>®</sup> and Simponi) must be obtained and billed through our specialty pharmacy vendor, ICORE Healthcare. Please see the Enbrel, Humira, Kineret or Simponi Prior Authorization/Patient Enrollment Form for instructions. ICORE Healthcare may supply Remicade<sup>®</sup> upon request or you may continue to obtain through your usual supplier. ICORE Healthcare will not be supplying Orencia<sup>®</sup> 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:**

**Humira<sup>®</sup>**

Patient has a diagnosis of rheumatoid arthritis (RA), juvenile idiopathic arthritis or psoriatic arthritis and has already been stabilized on Humira<sup>®</sup>

**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<sup>®</sup>.

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

**Enbrel<sup>®</sup>**

Patient has a diagnosis of RA, juvenile RA (JRA), or psoriatic arthritis and has already been stabilized on Enbrel<sup>®</sup>

**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<sup>®</sup>.

**Remicade<sup>®</sup>**

Patient has a diagnosis of RA or psoriatic arthritis and has already been stabilized on Remicade<sup>®</sup>

**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<sup>®</sup>.

**AND**

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

**Simponi<sup>®</sup>**

Patient has a diagnosis of RA or psoriatic arthritis and has already been stabilized on Simponi<sup>®</sup>

**OR**

Patient age  $\geq$  18 years

**AND**

Diagnosis is RA or psoriatic arthritis, and patient has documentation of an inadequate response, adverse reaction or allergic response to methotrexate, or if methotrexate is contraindicated, at least 1 DMARD (other DMARDs include leflunomide, sulfasalazine, gold, antimalarials, minocycline, D-penicillamine, azathioprine, cyclophosphamide and cyclosporine)

**AND**

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

**Kineret**<sup>®</sup>

Patient has a diagnosis of RA and has already been stabilized on Kineret<sup>®</sup>

**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<sup>®</sup>.

**Note:** Kineret<sup>®</sup> may be used as monotherapy or concomitantly with DMARDs, other than TNF antagonists. Kineret<sup>®</sup> should not be administered concomitantly with any TNF antagonists (i.e. Enbrel<sup>®</sup>, Humira<sup>®</sup>, or Remicade<sup>®</sup>).

**AND**

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

**Orencia**<sup>®</sup>

Patient has a diagnosis of RA and has already been stabilized on Orencia<sup>®</sup>

**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<sup>®</sup>. **Note:** Orencia<sup>®</sup> may be used as monotherapy or concomitantly with DMARDs, other than TNF antagonists. Orencia<sup>®</sup> should not be administered concomitantly with TNF antagonists (i.e. Enbrel<sup>®</sup>, Humira<sup>®</sup>, or Remicade<sup>®</sup>) and is not recommended for use with Kineret<sup>®</sup>.

**AND**

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

\* Patients with psoriatic arthritis with a documented diagnosis of active axial involvement should have a trial of NSAID therapy, but a trial with DMARD is not required before a TNF-blocker is approved. If no active axial skeletal involvement, then an NSAID trial and a DMARD trial are required (unless otherwise contraindicated) prior to receiving Humira<sup>®</sup>, Enbrel<sup>®</sup>, Remicade<sup>®</sup>.or Simponi<sup>®</sup>

**DOCUMENTATION:**

- ✓ Document clinical information for **Enbrel<sup>®</sup>, Humira<sup>®</sup>, Kineret<sup>®</sup> or Simponi<sup>®</sup>** on its **Prior Authorization/Patient Enrollment Form** and clinically compelling information supporting the choice of **Remicade<sup>®</sup>** on a **Remicade Prior Authorization Request Form** or **Orencia<sup>®</sup>** on a **General Prior Authorization Request Form**.

<b>Rheumatoid, Juvenile Idiopathic and Psoriatic Arthritis: Injectables</b>	
<i>Length of authorization: Initial PA of 3 months; 12 months thereafter</i>	
<b>PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET</b>	<b>NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET</b>
ENBREL <sup>®</sup> (etanercept) HUMIRA <sup>®</sup> (adalimumab)	Kineret <sup>®</sup> (anakinra) Orencia <sup>®</sup> (abatacept) Remicade <sup>®</sup> (infliximab) Simponi <sup>®</sup> (golimumab) ( <i>Qty limit = 1 syringe/month</i> )

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## Saliva Stimulants

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**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**.

<b>Saliva Stimulants</b>		<i>Length of Authorization: 1 year</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
PILOCARPINE† (compare to Salagen®) EVOXAC® (cevimeline)	Salagen®* (pilocarpine)	

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## Sedative Hypnotics: Benzodiazepine

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

<b>Sedative Hypnotics: Benzodiazepine</b>		<i>Length of Authorization: 1 year</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
ESTAZOLAM† (compare to Prosom®) FLURAZEPAM† (compare to Dalmane®) TEMAZEPAM 15 mg, 30 mg † (compare to Restoril®)	Dalmane®* (flurazepam) Doral® (quazepam) 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<sup>®</sup>, Ambien CR<sup>®</sup>, Lunesta<sup>®</sup>:**

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

**Edluar<sup>®</sup>:**

The patient has a medical necessity for a disintegrating tablet formulation (i.e. swallowing disorder).

**Rozerem<sup>®</sup>:** 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<sup>®</sup> will be limited to a 14 day supply.

**Somnote<sup>®</sup>:** 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<sup>®</sup>:**

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

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

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## Skeletal Muscle Relaxants: Oral

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**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.

**orphenadrine/ASA/caffeine**

- The prescriber must provide a clinically valid reason why generic orphenadrine in combination with aspirin (or another analgesic) cannot be used.

**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
<b>Musculoskeletal Agents</b>	
<p><b><u>Single Agent</u></b>            CHLORZOXAZONE† (compare to Parafon Forte DSC®)            CYCLOBENZAPRINE† (compare to Flexeril®)            METHOCARBAMOL† (compare to Robaxin®)            ORPHENADRINE CITRATE ER† (previously Norflex®)</p> <p><b><u>Combination Product</u></b></p> <p>ASA = aspirin</p>	<p>Amrix® (cyclobenzaprine sustained-release)            carisoprodol† (compare to Soma®)            Fexmid® (cyclobenzaprine)            Flexeril®* (cyclobenzaprine)            Parafon Forte DSC®* (chlorzoxazone)            Robaxin®* (methocarbamol)            Skelaxin® (metaxalone)            Soma® (carisoprodol)</p> <p>carisoprodol, ASA† (compare to Soma Compound®)            carisoprodol, ASA, codeine† (compare to Soma Compound with Codeine®)            Orphenadrine, ASA, caffeine† (previously Norgesic®, Norgesic Forte®)            Soma Compound® (carisoprodol/ASA)            Soma Compound with Codeine® (carisoprodol/ASA/codeine)</p>
<b>Antispasticity Agents</b>	
<p>BACLOFEN† (previously Lioresal®)            DANTROLENE† (compare to Dantrium®)            TIZANIDINE† (compare to Zanaflex®) tablets</p>	<p>Dantrium®* (dantrolene)            Zanaflex® (tizanidine) capsules            Zanaflex®* (tizanidine) tablets</p>

**\*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**.

<b>Smoking Cessation Therapies</b>		<i>Length of Authorization: see table</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
PREFERRED DRUGS (No PA Required)	PA REQUIRED	
<b>NICOTINE REPLACEMENT (Maximum duration is 16 weeks (2 x 8 weeks)/365 days)♣</b>		
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®	
<b>ORAL THERAPY</b>		
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.

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## Testosterone: Topical

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**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Andoderm<sup>®</sup>, Testim<sup>®</sup>**

- The patient has had a documented side effect, allergy, or treatment failure to AndroGel<sup>®</sup> Gel.

**DOCUMENTATION:**

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

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

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## Thrombopoietin Receptor Agonists

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**LENGTH OF AUTHORIZATION:**      initial approval 3 months, subsequent approvals 6 months

**CRITERIA FOR APPROVAL:**

- The patient is at least 18 years of age.  
**AND**
- The diagnosis or indication is chronic immune (idiopathic) thrombocytopenic purpura (ITP).  
**AND**
- The patient's platelet count is less than 30,000/ $\mu$ L ( $< 30 \times 10^9/L$ ) or the patient is actively bleeding.  
**AND**
- The patient has had a documented side effect, allergy, treatment failure or a contraindication to therapy with corticosteroids.  
**OR**
- The patient has a documented insufficient response following splenectomy.

**DOCUMENTATION:**

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

<b>Thrombopoietin Receptor Agonists</b>	
<i>Length of Authorization: initial approval 3 months, subsequent approvals 6 months</i>	
PREFERRED DRUGS (No PA Required)	PA REQUIRED
	Nplate <sup>®</sup> (romiplostim) Promacta <sup>®</sup> (eltrombopag)

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## Urinary Antispasmodics

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**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 ORAL 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, Enablex, Sanctura XR, Vesicare**

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

**Detrol, Detrol LA, Ditropan XL, Oxybutynin XL, Toviaz**

- 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, there must have also been a trial of the generic formulation.

**Gelnique, Oxytrol**

- The patient is unable to swallow a solid oral formulations (e.g. patients with dysphagia)  
OR
- The patient is unable to be compliant with solid oral dosage forms.

**Sanctura**

- 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 (one of which must be Sanctura XR)

**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*)

Detrol® (tolterodine)  
Sanctura® (trospium)

**Once Daily** (*Qty Limit = 1 per day*)

ENABLEX® (darifenacin)  
SANCTURA XR® (trospium)  
VESICARE® (solifenacin)

Detrol LA® (tolterodine)  
Ditropan XL® (oxybutynin XL)  
oxybutynin XL† (compare to Ditropan® XL)  
Toviaz® (fesoterodine)

### Transdermal/Topical

Gelnique® (oxybutynin topical gel)  
(*Qty limit = 1 sachet/day*)  
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 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 ORAL 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<sup>®</sup>, Clindesse<sup>®</sup>:**

- The patient has had a documented side effect, allergy, or treatment failure to generic clindamycin vaginal (clindamycin vaginal or Clindamax).

**Metrogel Vaginal<sup>®</sup>:**

- 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**.

<b>Vaginal Anti-Infectives</b>		<i>Length of Authorization: 1 year</i>
<b>Key: † Generic product, *Indicates generic equivalent is available without a PA</b>		
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
<b><u>CLINDAMYCIN</u></b>		
CLINDAMYCIN VAGINAL† (clindamycin vaginal cream 2%) CLINDAMAX† (clindamycin vaginal cream 2%)	Cleocin <sup>®*</sup> (clindamycin vaginal cream 2%) Clindesse <sup>®</sup> (clindamycin vaginal cream 2%) Cleocin <sup>®</sup> Vaginal Ovules (clindamycin vaginal suppositories)	
<b><u>METRONIDAZOLE</u></b>		
METRONIDAZOLE VAGINAL GEL 0.75%† VANDAZOLE† (metronidazole vaginal 0.75%)	Metrogel Vaginal <sup>®*</sup> (metronidazole vaginal gel 0.75%)	

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## Vitamins: Prenatal Multivitamins

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**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.**

<b>Vitamins: Prenatal Multivitamins</b>		<i>Length of Authorization: 1 year</i>
<b>PREFERRED DRUGS (No PA Required)</b>	<b>PA REQUIRED</b>	
All generics	All brands	

## ***II. PRIOR AUTHORIZATION REQUEST & SPECIALTY PHARMACY ORDER FORMS***

- ▶ [Anti-Obesity Prior Authorization Request Form](#)
- ▶ [Bisphosphonate Injectable Prior Authorization Request Form](#)
- ▶ [Buprenorphine Prior Authorization Request Form](#)
- ▶ [Cystic Fibrosis Medication Order Form](#)
- ▶ [Enbrel<sup>®</sup> Prior Authorization Request/Order 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](#)
- ▶ [Humira<sup>®</sup> Prior Authorization Request/Order Form](#)
- ▶ [Kineret<sup>®</sup> Prior Authorization Request/Order Form](#)
- ▶ [Long Acting Narcotics Prior Authorization Request Form](#)
- ▶ [Multiple Sclerosis Self Injectables Order Form](#)
- ▶ [Nutritionals Prior Authorization Request Form](#)
- ▶ [Oncology: Oral \(Select Agents\) Order Form](#)
- ▶ [Remicade<sup>®</sup> Prior Authorization Request Form](#)
- ▶ [Simponi<sup>®</sup> Prior Authorization Request/Order Form](#)
- ▶ [Synagis<sup>®</sup> Prior Authorization Request/Order Form](#)
- ▶ [Vivitrol<sup>®</sup> Prior Authorization Request Form](#)
- ▶ [Xolair<sup>®</sup> Prior Authorization Request Form](#)

~ 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: \_\_\_\_\_

## ~ BISPHTHOSPHONATE 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)**

Administering Provider if other than Prescriber: (name): \_\_\_\_\_ NPI #: \_\_\_\_\_

Pharmacy (if known): \_\_\_\_\_ Phone: \_\_\_\_\_ &amp;/or FAX: \_\_\_\_\_

**Drug requested:**  Boniva IV  Reclast

**Dose & frequency:** \_\_\_\_\_

**Diagnosis/indication:**

- Treatment of postmenopausal osteoporosis     Treatment of male osteoporosis  
 Paget's Disease     Treatment of glucocorticoid induced osteoporosis  
 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"/> Alendronate 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<sup>®</sup>, Subutex<sup>®</sup>). These criteria are based on concerns about safety and the potential for abuse and diversion. For beneficiaries to receive coverage for Suboxone<sup>®</sup> or Subutex<sup>®</sup>, 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**

<b>MD/DO</b>	Prescribers must have a DATA 2000 waiver ID ('X' DEA license) in order to prescribe.
<b>Patients</b>	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 <sup>®</sup> (buprenorphine/naloxone) <input type="checkbox"/> Subutex <sup>®</sup> (buprenorphine)
Anticipated maintenance dose/frequency:	
Dose: _____ Frequency: _____	
If this request is for Subutex <sup>®</sup> , 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 that has been witnessed by a health care professional?	<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:** \_\_\_\_\_



**VERMONT**  
**CYSTIC FIBROSIS MEDICATION - 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**  
**CYSTIC FIBROSIS MEDICATION**

**Patient Diagnosis:**

Cystic Fibrosis

**Product:**

Pulmozyme® (dornase alfa inhalation) 1 mg/ml 2.5 ml ampules

Administer via nebulizer once daily.  
Dispense # 30 Refill \_\_\_\_ times

Administer via nebulizer twice daily.  
Dispense # 60 Refill \_\_\_\_ times

TOBI® (tobramycin solution for inhalation) 300 mg/5 ml ampules

Administer via nebulizer twice daily,  
alternating 28 days on and 28 days off

Dispense # 56 Refill \_\_\_\_ times

Deliver product to:  Patient's home  MD office  Clinic

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# ENBREL® (etanercept) - 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  
 ENBREL® (etanercept)  
 PRIOR AUTHORIZATION REQUEST**

Patient Diagnosis:

Rheumatoid Arthritis     Psoriatic Arthritis     Juvenile Idiopathic Arthritis  
 Ankylosing Spondylitis     Plaque Psoriasis

If requesting prescriber is not a Rheumatologist or Dermatologist, has one of these specialties been consulted on this case?  Yes     No

Specialist name: \_\_\_\_\_ Specialist Type: \_\_\_\_\_

List previous medications/therapies tried and failed for this condition: (include oral, injectable, topical, phototherapy etc.)

Therapy (and dates)	Reason for discontinuation
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Prescriber Additional Comments: \_\_\_\_\_

**4 PRESCRIPTION**

**Dosage Form and Quantity:**

Enbrel 25 mg prefilled syringe    Dispense Quantity: \_\_\_\_\_  
 or  
 Enbrel 25 mg multi-use vial    Dispense Quantity: \_\_\_\_\_  
 or  
 Enbrel 50mg prefilled syringe    Dispense Quantity: \_\_\_\_\_  
 or  
 Enbrel 50mg SureClick autoinjector    Dispense Quantity: \_\_\_\_\_

Sig: Dose/Route/Frequency: \_\_\_\_\_  
 Refill X: \_\_\_\_\_

Deliver product to:  Patient's home     MD office     Clinic

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

~ 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)? **(Please check one)**

Administering Provider if other than Prescriber: (name): \_\_\_\_\_ NPI #: \_\_\_\_\_

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

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  
"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®     Omnitrope®

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®     Nutropin®     Saizen®     Tev-Tropin®

Medical justification: \_\_\_\_\_

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

Other information/ Prescriber comments: \_\_\_\_\_

**4 PRESCRIPTION**

Norditropin® Nordiflex     Norditropin® Cartridge  
 Omnitrope® Cartridge     Omnitrope® MDV  
 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 - 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)  
 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:** \_\_\_\_\_



# HUMIRA® (adalimumab) - 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  
 HUMIRA® (adalimumab)  
 PRIOR AUTHORIZATION REQUEST**

Patient Diagnosis:

Rheumatoid Arthritis     Psoriatic Arthritis     Juvenile Idiopathic Arthritis  
 Ankylosing Spondylitis     Plaque Psoriasis     Crohn's Disease

If requesting prescriber is not a Rheumatologist, Dermatologist or Gastroenterologist, has one of these specialties been consulted on this case?     Yes     No

Specialist name: \_\_\_\_\_ Specialist Type: \_\_\_\_\_

List previous medications/therapies tried and failed for this condition: (include oral, injectable, topical, phototherapy etc.)

Therapy (and dates)	Reason for discontinuation
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Prescriber Additional Comments: \_\_\_\_\_

**4 PRESCRIPTION**

**Dosage Form and Quantity:**

Humira 40 mg/0.8 ml prefilled syringe    Dispense Quantity:   2    
 or  
 Humira PEN 40 mg/0.8 ml    Dispense Quantity:   2    
 or  
 Humira 40 mg/0.8 ml (Crohn's Starter kit-6)    Dispense Quantity:   6 (1 kit)    
 or  
 Humira PED 20 mg/0.4 ml prefilled syringe    Dispense Quantity:   2  

Sig: Dose/Route/Frequency: \_\_\_\_\_

Refill X: \_\_\_\_\_

Deliver product to:     Patient's home     MD office     Clinic

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**KINERET® (anakinra) - 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  
KINERET® (anakinra)  
PRIOR AUTHORIZATION REQUEST**

Patient Diagnosis:  
 Rheumatoid Arthritis

If requesting prescriber is not a Rheumatologist, has one been consulted on this case?  
 Yes  No

Specialist name: \_\_\_\_\_ Specialist Type: \_\_\_\_\_

List previous medications/therapies tried and failed for this condition: (include oral and injectable, etc.)

Therapy (and dates)	Reason for discontinuation
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Prescriber Additional Comments:  
 \_\_\_\_\_

**4 PRESCRIPTION**

**Dosage Form and Quantity:**  
 Kineret 100 mg/0.67 ml prefilled syringe

Dispense Quantity:  
 28 syringes

Sig: Dose/Route/Frequency: \_\_\_\_\_

Refill X: \_\_\_\_\_

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"/> Duragesic 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 Sulfate SR 12 hr	<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:** \_\_\_\_\_



**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)
<b>Underlying cause of unplanned weight loss or low serum protein levels:</b> <b>Circle or describe specifics:</b> <ul style="list-style-type: none"> <li>▪ Increased metabolic need resulting from severe trauma (i.e.: burns, infection, major bone fractures)</li> <li>▪ Malabsorption syndrome (as related to cystic fibrosis, renal disease, short gut syndrome, Crohn's disease and other unspecified disorders of the gut)</li> <li>▪ Nutritional wasting due to chronic disease (i.e.: cancer, AIDS, conditions resulting in dysphagia, pulmonary insufficiency, renal disease)</li> </ul>	<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><b>Requested Supplement:</b> _____</p> <p><b>Strength &amp; Frequency:</b> _____</p> <p><b>Anticipated duration of supplementation:</b> _____</p>
--

**Prescriber Signature:** \_\_\_\_\_ **Date of this request:** \_\_\_\_\_



**ORAL ONCOLOGY/SELECT ADJUNCT - 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  
ORAL ONCOLOGY/SELECT ADJUNCT**

Patient Diagnosis: \_\_\_\_\_

BSA(m2) \_\_\_\_\_ Patient height (cm) \_\_\_\_\_ Patient weight(kg) \_\_\_\_\_

Maintenance Therapy # of Refills \_\_\_\_\_

Cycle Specific Therapy NO REFILLS Cycle # \_\_\_\_\_

Treatment / Dosage Change Reason :  Toxicity  Progression of Disease

Change in BSA  Other: \_\_\_\_\_

MEDICATION	Normalized Dose	Strength/ Frequency/ Route of Administration	QTY
<input type="checkbox"/> ARIMIDEX*			
<input type="checkbox"/> AROMASIN*			
<input type="checkbox"/> CASODEX			
<input type="checkbox"/> FEMARA*			
<input type="checkbox"/> GLEEVEC			
<input type="checkbox"/> HEXALEN			
<input type="checkbox"/> LUPRON DEPOT*			
<input type="checkbox"/> MERCAPTOPYRINE*			
<input type="checkbox"/> MESNEX			
<input type="checkbox"/> NEULASTA*			
<input type="checkbox"/> NEUPOGEN*			
<input type="checkbox"/> SPRYCEL			
<input type="checkbox"/> SUTENT			
<input type="checkbox"/> TARCEVA			
<input type="checkbox"/> TEMODAR			
<input type="checkbox"/> TRETINOIN			
<input type="checkbox"/> VESANOID			
<input type="checkbox"/> XELODA			
Other:			

Additional RX Instructions: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\* Not required to use ICORE

**~ REMICADE ~**

**Prior Authorization Request Form**

Vermont Medicaid has established coverage limits and criteria for prior authorization of Remicade. In order for beneficiaries to receive Medicaid coverage for Remicade, 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 Remicade 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: \_\_\_\_\_

Will this medication be billed through the:  **pharmacy benefit** or  **medical benefit** (J-code or other code)?  
**(Please check one)**

Administering Provider if other than Prescriber (name): \_\_\_\_\_ NPI #: \_\_\_\_\_

Pharmacy (if known): \_\_\_\_\_ Phone: \_\_\_\_\_ &/or FAX: \_\_\_\_\_

**Remicade Infusion:** Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Length of therapy: \_\_\_\_\_

**Indication:**

Crohn's Disease     Ulcerative Colitis

Ankylosing Spondylitis     Psoriasis (Plaque)     Psoriatic Arthritis     Rheumatoid Arthritis

**List previous medications tried and failed for this condition:**

Name of medication	Reason for failure	Date(s) attempted
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Please explain why self-injectables (if indicated but not trialed) can not be trialed?**

**Prescriber comments:**

**Prescriber Signature:** \_\_\_\_\_ **Date of this request:** \_\_\_\_\_



# SIMPONI® (golimumab) - 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 SIMPONI® (golimumab) PRIOR AUTHORIZATION REQUEST

Patient Diagnosis:  
 Rheumatoid Arthritis     Psoriatic Arthritis     Ankylosing Spondylitis

If requesting prescriber is not a Rheumatologist or Dermatologist, has one of these specialties been consulted on this case?  Yes     No

Specialist name: \_\_\_\_\_ Specialist Type: \_\_\_\_\_

Initial Request (please complete remainder of form below)  
 Subsequent Request: Response/tolerability to Simponi: \_\_\_\_\_

Please explain outcomes of therapy with Enbrel and/or Humira (OVHA preferred products):

Therapy (and dates)	Reason for discontinuation
_____	_____

List previous medications/therapies tried and failed for this condition:  
(include NSAIDs, DMARDs, TNF Blockers: oral and injectable)

Therapy (and dates)	Reason for discontinuation
_____	_____
_____	_____
_____	_____
_____	_____

Prescriber Additional Comments:

## 4 PRESCRIPTION

**Dosage Form and Quantity:**

Simponi 50 mg/0.5 ml prefilled syringe      Dispense Quantity:   1  

Simponi 50 mg/0.5 ml prefilled autoinjector      Dispense Quantity:   1  

Sig: Administer 50 mg (1 syringe/autoinjector) subcutaneously once monthly.

Refill X: \_\_\_\_\_

Deliver product to:  Patient's home     MD office     Clinic

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_




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 09/2009

**Fax Completed Form to:**

**Fax Number: 802-775-7824** 

**Phone Number: 800-639-1210** 



CRITICAL HOME CARE SOLUTIONS, INC.  
Growing a Family of Services

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

Gestational Age: weeks: _____ days: _____	Current Weight: (kg)	Dose: 15mg / kg (weight verified monthly)
Diagnosis:		
<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 (maximum 5 doses)		
<input type="checkbox"/> Infants born at 29 - 32 weeks (i.e., between 29 weeks, 0 days and 31 weeks, 6 days) of gestation and under 6 months of age at the start of the RSV season (maximum 5 doses)		
<input type="checkbox"/> Infants born at 32 - 35 weeks (i.e., between 32 weeks, 0 days and 34 weeks, 6 days) of gestation who have at least one of the following risk factors and who have not reached 3 months of age: (dosing continues in the RSV season through the end of the month the infant reaches 3 months old – maximum 3 doses)		
<input type="checkbox"/> Infant attends child care <input type="checkbox"/> One or more siblings (or other child permanently in house) < 5 years of age		
<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 chronic corticosteroid therapy) within 6 months prior to the start of the RSV season (maximum 5 doses)		
<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(CHD)		
<input type="checkbox"/> Receiving medication to control congestive heart failure		
<input type="checkbox"/> Moderate to severe pulmonary hypertension (maximum 5 doses)		
<input type="checkbox"/> Have cyanotic heart disease		
<input type="checkbox"/> Infants born at < 35 weeks (i.e., 34 weeks, 6 days) of gestation and under 12 months of age at the start of the RSV season with either: (maximum 5 doses)		
<input type="checkbox"/> Congenital abnormalities of the airways		
<input type="checkbox"/> Neuromuscular condition compromising handling of respiratory tract secretions		
<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 03/2010

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.

### ~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

<b>MDs</b>	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 <b>may not</b> be billed through the Medical Benefit as a J-Code J2315.
<b>Patients</b>	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

Vermont Medicaid has established coverage limits and criteria for prior authorization of Xolair. In order for beneficiaries to receive Medicaid coverage for Xolair, 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 as directed 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: \_\_\_\_\_

Specialty: \_\_\_\_\_

Contact Person at Office: \_\_\_\_\_

**Beneficiary:**

Name: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

 Patient Diagnosis:  Moderate/Severe Persistent Asthma

 Other: \_\_\_\_\_

**If requesting prescriber is not a pulmonologist, allergist, or immunologist, date of last visit to one (required yearly):**

**Specialist name:** \_\_\_\_\_ **Specialist Type:** \_\_\_\_\_ **Date:** \_\_\_\_\_

 **Initial Prior Authorization Request:** Please complete all portions of form below

 **Subsequent PA Request:** Has patient shown marked clinical improvement  **Yes**  **No**

**List all previous therapies tried and failed for this condition:**

Therapy	Specific Drug	Reason for Discontinuation
Inhaled Corticosteroid		
2 <sup>nd</sup> Generation Antihistamine		
Leukotriene Receptor Antagonist		
Long-Acting Beta Agonist		

Has the member tested positive to at least one perennial aeroallergen by a skin test (i.e. RAST, CAP, intracutaneous test)?  **Yes**  **No**

Please explain: \_\_\_\_\_

 Is the member's IgE level  $\geq 30$  and  $\leq 700$  IU/ml?  **Yes**  **No** Please provide IgE level: \_\_\_\_\_

**Prescriber Signature:** \_\_\_\_\_

**Date of this request:** \_\_\_\_\_