# Department of Vermont Health Access
# Pharmacy Benefit Management Program

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

# Clinical Criteria Manual

## August 21, 2012

# 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:

- 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.
- The therapeutic classes of drugs which have Clinical Criteria for Prior Authorization may or may not be subject to a preferred agent.
- Within both of these categories there may be drugs or even drug classes that are subject to Quantity Limit Parameters.

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

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# Acne Drugs: Oral

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Brand name minocycline products:**

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

**Brand name doxycycline products (see below for Oracea® and Vibramycin® Suspension),:**

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

**Oracea®:**

- The patient has a diagnosis of Rosacea.

**AND**

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

**Vibramycin® Suspension, Syrup:**

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

**Brand name erythromcyin products:**

- The patient has had a documented side effector treatment failure with one preferred erythromycin product.

**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.

**LIMITATIONS:**

Minocycline SR products and doxycycline SR products (brand and generic) not covered. Adoxa® Pak and doxycycline monohydrate Pak specialty packaging dosage form not covered. Adoxa® 150mg cap and doxycycline monohydrate 150 mg cap (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<br>Monodox®* (doxycycline monohydrate) 50 mg, 100 mg cap<br>Oracea® (doxycycline monohydrate) 40 mg cap<br>Periostat®* (doxycycline hyclate) 20 mg<br>Vibramycin®* (doxycycline hyclate) 50 mg, 100 mg cap<br>Vibramycin® (doxycycline hyclate) suspension<br>Vibramycin® (doxycycline calcium) syrup<br>Vibratab®* (doxycycline hyclate) 100 mg tab<br>All other brands |
| E.E.S®† (erythromycin ethylsuccinate)<br>ERY-TAB® (erythromycin base, delayed release)<br>ERYTHROCIN† (erythromycin stearate)<br>ERYTHROMYCIN BASE†<br>ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S®, Eryped®) | Eryped®* (erythromycin ethylsuccinate)<br>PCE Dispertab® (erythromycin base)<br>All other brands |
| MINOCYCLINE† 50 mg, 75 mg, 100 mg | Minocin®* (minocycline) 50 mg, 75 mg, 100 mg cap<br>Dynacin®* (minocycline) 50 mg, 75 mg, 100 mg cap/tab<br>All other brands |
| TETRACYCLINE† 250 mg, 500 mg cap | All brands |
| ISOTRETINOIN† 10 mg, 20 mg, 40 mg cap (SOTRET, CLARAVIS, AMNESTEEM) | All other brands |

# Acne Drugs: Topical-Anti-infectives

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Brand name single ingredient products:**

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

**Brand name combination products:**

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

AND

- The patient has had a documented side effect or treatment failure on combination therapy with the separate generic ingredients of the requested combination product, if applicable.

**Azelex®**

- The diagnosis or indication is acne or rosacea.

AND

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

**LIMITATIONS:**

Kits with non-drug products are not covered.
Benzoyl Peroxide Aerosol (Foam) and Benzefoam® not covered. Other topical generic benzoyl peroxide preparations preferred.
Clindamycin Aerosol (Foam) and Evoclin® not covered. Other topical generic clindamycin preparations preferred.
Sodium sulfacetamine/Sulfur Aerosol (Foam), Rosula® and Clarifoam® not covered. Other topical generic sodium sulfacetamide/sulfur preparations preferred.
Epiduo® (adapalene/benzoyl peroxide) combination not covered. Agents may be prescribed separately**.**
SE BPO® (benzoyl peroxide) foaming cloths dosage form not covered. Other topical generic benzoyl peroxide preparations preferred.

**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†<br>2.5%, 4%, 5%, 8%, 10% *G*,<br>*2.5%, 4%, 5%, 7%, 8%, 10% W*;<br>3.5%, 5.5%, 8.5% *C*;<br>3%, 4%, 5%, 6%, 8%, 9%, *L*;<br>3%, 6%, 9% *P* | Benzac AC® 2.5%, 5%, 10% *G*, *W*<br>Benzashave® 5%, 10% *C*<br>Benzoyl peroxide® 10% L<br>Brevoxyl® 4%, 8% W; 4%, 8%G; 4%, 8% *L*<br>Clinac BPO® 7% *G*<br>Desquam-E/X® 2.5%, 5%, 10% G; 5%, 10% *W*<br>Inova 4% *P*<br>Panoxyl/AQ 2.5%, 5%, 10% *G*; 5%, 10% *B*<br>Pacnex HP/LP 4.25%, 7% *P*<br>Triaz® 3%, 6%, 9% *G*; 3%, 6%, 9% *P*<br>Zaclir®* 8% *L*<br>All other brands |
| **CLINDAMYCIN PRODUCTS** | |
| CLINDAMYCIN 1% *S, G, L, P* † | Cleocin-T®* (clindamycin 2% *G*)<br>Clindagel® (clindamycin 1% *G*)<br>All other brands |
| **ERYTHROMYCIN PRODUCTS** | |
| ERYTHROMYCIN 2% *S, G, P* † | Akne-Mycin® (erythromycin 2% *O*)<br>Erygel®* (erythromycin 2% *G*)<br>All other brands |
| **SODIUM SULFACETAMIDE PRODUCTS** | |
| SODIUM SULFACETAMIDE 10% *L* † | Klaron®* (sodium sulfacetamide 10% *L*)<br>All other brands |
| **COMBINATION PRODUCTS** | |
| ERYTHROMYCIN / BENZOYL PEROXIDE† | Benzaclin® (clindamycin/benzoyl peroxide)<br>DUAC® (clindamycin/benzoyl peroxide) gel, kit<br>Benzamycin®* (erythromycin/benzoyl peroxide)<br>Sulfoxyl (erythromycin/benzoyl peroxide)<br>Z-Clinz® (clindamycin/benzoyl peroxide kit)<br>All other brands |
| SODIUM SULFACETAMIDE / SULFUR *L* †<br>SODIUM SULFACETAMIDE / SULFUR *W* † | Avar® (sodium sulfacetamide/sulfur *G*)<br>Avar-E LS® (sulfacetamide/sulfur *C)*<br>Avar LS® (sulfacetamide/sulfur *W)*<br>Plexion® / Sumaxin TS® (sulfacetamide/sulfur *S*)<br>Rosac®* (sulfacetamide/sulfur *W*)<br>Rosula®* (sulfacetamide/sulfur *W*)<br>Sulfacet-R®* (sodium sulfacetamide/sulfur *L*)<br>All other brands |
| | Zoderm® (urea/benzoyl peroxide) cream, gel |
| **OTHER** | |
| | Azelex® (azelaic acid 20% *C*)<br>Aczone® (dapsone 5% G)<br>All other brands any topical anti-infective acne medication |

*C=cream, E=emulsion, 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(brand) and adapalene(generic):**

- 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.

  AND
- If the request is for the brand product, the patient has had a documented intolerance to a generic adapalene 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, Ziana** – These combinations 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**.

## Acne Drugs: Topical - Retinoids

*Length of Authorization: 1 year*

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

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

*C=cream, G=gel*

# Acne Drugs: Topical - Rosacea

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Brand name metronidazole products and Finacea:**

- The diagnosis or indication is acne or rosacea.

**AND**

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

**DOCUMENTATION:**

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

## Acne Drugs: Topical – Rosacea

*Length of Authorization: 1 year*

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

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

*C=cream, G=gel, L=lotion*

# Alpha$_1$-Proteinase Inhibitors

**LENGTH OF AUTHORIZATION:** 6 months

**CRITERIA FOR APPROVAL:**

The indication for use is treatment of alpha$_1$-proteinase inhibitor deficiency-associated lung disease when all of the following criteria are met:

- Patient's alpha$_1$-antitrypsin (AAT) concentration < 80 milligrams per deciliter (mg/dl) [or <11 micromolar (µM)]

**AND**

- Patient has obstructive lung disease as defined by a forced expiratory volume in one second ($FEV_1$) of 30 – 65 % of predicted or a rapid decline in lung function defined as a change in $FEV_1$ of > 120 mL/year.

**AND**

- Medication is being administered intravenously (inhalation administration will not be approved).

**AND**

- Patient is a non-smoker.

**OR**

- Patient meets above criteria except lung function has deteriorated beneath above limits while on therapy.

**DOCUMENTATION:**

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.
- ✓ All requests for alpha$_1$-proteinase inhibitors (whether billed through the pharmacy or medical benefit (J0256 – all except Glassia® or J0257 - Glassia®)) require Prior Authorization through the MedMetrics Clinical Call Center.

| **Alpha$_1$-Proteinase Inhibitors** | *Length of Authorization: 6 months* |
|---|---|
| **NO PA REQUIRED** | **PA REQUIRED** |
| | Aralast NP®<br>Glassia®<br>Prolastin®<br>Prolastin-C®<br>Zemaira®<br><br>****Maximum days supply per fill for all drugs is 14 days**** |

# 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.

**Donepezil:**

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

**AND**

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

**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.

**Aricept ODT, donepezil ODT:**

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

**AND**

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

**AND**

- If the request is for donepezil ODT, the patient has a documented intolerance to the brand product.

**Rivastigmine Oral Capsule:**

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

**AND**

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

**DOCUMENTATION:**

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

## Alzheimer's: Cholinesterase Inhibitors/NMDA Receptor Antagonists

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **CHOLINESTERASE INHIBITORS** | |
| ARICEPT® (donepezil) Tablet<br>*(QL = 1 tablet/day)*<br>EXELON® (rivastigmine) Capsule<br>*(QL = 2 capsules/day)* | Cognex® (tacrine) Capsule §<br>donepezil† (compare to Aricept®) tablet *(QL = 1 tablet/day)*<br>galantamine† tablet § (compare to Razadyne®)<br>galantamine ER† capsule § (compare to Razadyne ER®)<br>Razadyne® (galantamine) Tablet<br>Razadyne ER® (galantamine) Capsule<br>rivastigmine† (compare to Exelon®) capsule<br>*(QL = 2 capsules/day)* |
| | Aricept® ODT (donepezil)<br>*(QL = 1 tablet/day)*<br>donepezil ODT† (compare to Aricept® ODT)<br>*(QL = 1 tablet/day)* |
| EXELON® (rivastigmine) Oral Solution | galantamine† (compare to Razadyne®) Oral Solution<br>Razadyne® (galantamine) Oral Solution |
| EXELON® (rivastigmine transdermal) Patch<br>*(QL = 1 patch/day)* | |
| **NMDA RECEPTOR ANTAGONIST** | |
| NAMENDA® (memantine) Tablet | |
| NAMENDA® (memantine) Oral Solution | |

# Analgesics: COX IIs and NSAIDs

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

**Arthrotec, Duexis:**

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

**OR**

- The patient is not a candidate for therapy with a preferred generic NSAID mono-therapy due to one of the following:
  - The patient is 60 years of age or older
  - Patient has a history of GI bleed
  - Patient is currently taking an oral corticosteroid
  - Patient is currently taking methotrexate

**AND**

- The patient is unable to take the individual components separately.

**Cambia:**

- The drug is being prescribed for treatment of acute migraine attacks.

**AND**

- The patient has had a documented side effect or treatment failure to two or more preferred generic NSAIDS, one of which must be generic diclofenac.

**OR**

- The drug is being prescribed for treatment of acute migraine attacks.

**AND**

- The patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications)

**AND**

- The patient has had a documented side-effect or treatment failure with the generic ibuprofen suspension **and** the generic naproxen suspension.

**Celebrex:**

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

**AND**

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

**OR**

- The patient is not a candidate for therapy with a preferred generic NSAID due to one of the following
  - The patient is 60 years of age or older
  - Patient has a 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, Pennsaid:**

- The diagnosis or indication is osteoarthritis or acute pain caused by minor strains, sprains, and contusions.

**AND**

- The patient has had a documented side-effect or inadequate response to Voltaren gel.

**AND**

- The patient has had a documented side effect or treatment failure with at least two preferred generic NSAIDS.

**OR**

- The patient is not a candidate for therapy with a preferred generic NSAID due to one of the following:
  - The patient is 60 years of age or older
  - Patient has a history of GI bleed
  - Patient is currently taking an oral corticosteroid
  - Patient is currently taking methotrexate

**OR**

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

**Sprix:**

- The indication or diagnosis is moderate to moderately severe pain.

**AND**

- The patient has had a documented inadequate response or intolerance to generic ketorolac tablets.

**OR**

- The patient has a documented medical necessity for the specialty dosage form (i.e inability to take medication orally (NPO)).

**Voltaren Gel:**

- The diagnosis or indication is osteoarthritis or acute pain caused by minor strains, sprains, and contusions.

**AND**

- The patient has had a documented side effect or treatment failure with at least two preferred generic NSAIDS.

**OR**

- The patient is not a candidate for therapy with a preferred generic NSAID due to one of the following:
  - The patient is 60 years of age or older
  - Patient has a history of GI bleed
  - Patient is currently taking an oral corticosteroid
  - Patient is currently taking methotrexate

**OR**

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

**Vimovo:**

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

**OR**

- The patient is not a candidate for therapy with a preferred generic NSAID mono-therapy due to one of the following:
  - The patient is 60 years of age or older
  - Patient has a history of GI bleed
  - Patient is currently taking an oral corticosteroid
  - Patient is currently taking methotrexate

**AND**

- The patient is unable to take naproxen and a preferred proton pump inhibitor, separately.

**Zipsor:**

- The patient has had a documented intolerance to diclofenac tablets.

**AND**

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

**All other PA requiring NSAIDs:**

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

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

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

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

# Analgesics: COX IIs AND NSAIDs

*Length of Authorization: 1 year*

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

**NSAIDs**

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **ORAL** | |
| **SINGLE AGENT** | |
| DICLOFENAC POTASSIUM† (compare to Cataflam®) | Anaprox®* (naproxen sodium) |
| DICLOFENAC SODIUM† (compare to Voltaren®) | Anaprox DS®* (naproxen sodium) |
| DIFLUNISAL† (formerly Dolobid®) | Cambia® (diclofenac potassium) packet for oral solution *(QL = 9 packets/month))* |
| ETODOLAC† (formerly Lodine®) | Cataflam®* (diclofenac potassium) |
| FLURBIPROFEN† (formerly Ansaid®) | Clinoril®* (sulindac) |
| IBUPROFEN† (compare to Motrin®) | Daypro®* (oxaprozin) |
| INDOMETHACIN† (formerlyIndocin®, Indocin SR®) | EC-Naprosyn®* (naproxen sodium enteric coated) |
| KETOPROFEN† | Feldene®* (piroxicam) |
| KETOPROFEN ER† | Fenoprofen 600 mg tablets |
| KETOROLAC† (formerly Toradol®) *(QL = 20 doses/5 day supply every 90 days)* | Indocin® (indomethacin) susp |
| MECLOFENAMATE SODIUM† (formerly Meclomen®) | Indocin SR®* (indomethacin) caps |
| MELOXICAM† **tabs** (compare to Mobic®) | mefenamic acid† capsules (compare to Ponstel®) |
| NABUMETONE† (formerly Relafen®) | meloxicam suspension |
| NAPROXEN† (compare to Naprosyn®) | Mobic® (meloxicam) suspension |
| NAPROXEN ENTERIC COATED† (compare to EC-Naprosyn®) | Mobic®* (meloxicam) tablets |
| NAPROXEN SODIUM† (compare to Anaprox®, Anaprox DS®, Naprelan®) | Motrin®* (ibuprofen) |
| OXAPROZIN† (compare to Daypro®) | Nalfon® (fenoprofen) 200 & 400 mg capsules |
| PIROXICAM† (compare to Feldene®) | Naprelan®* (naproxen sodium) |
| SULINDAC† (compare to Clinoril®) | Naprosyn®* (naproxen soiun) |
| TOLMETIN SODIUM† (formerly Tolectin®) | Ponstel® (mefenamic acid) |
| | Voltaren®* (dicofenac sodium) |
| | Voltaren XR®* (diclofenac sodium SR) |
| | Zipsor® (diclofenac potassium) |
| **INJECTABLE** | |
| KETOROLAC † Injection (formerly Toradol®) *(QL = 1 dose per fill)* | |
| **NASAL SPRAY** | Sprix® (ketorolac) Nasal Spray *(QL = 5 bottles/5 days – once every 90 days)* |
| **TOPICAL/TRANSDERMAL** | Flector® (diclofenac) Patch *(QL = 2 patches/day)*<br>Pennsaid® (diclofenac) Topical Solution<br>Voltaren® (diclofenac) Gel |
| **NSAID/ANTI-ULCER** | Arthrotec® (diclofenac sodium w/misoprostol)<br>Duexis® (ibuprofen/famotidine) *(QL = 3 tablets/day)*<br>Vimovo® (naproxen/esomeprazole) *(QL = 2 tablets/day)* |

**COX II Inhibitors**

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| | Celebrex® (celecoxib) (Quantity limit all strengths = 2 capsules/day) |

Note: Please refer to "Dermatologicals: Actinic Keratosis Therapy" for Solaraze®

# Analgesics: Miscellaneous: Transdermal Patch

**LENGTH OF AUTHORIZATION**: 6 months

**CRITERIA FOR APPROVAL:**

LIDODERM®

- The diagnosis or indication is neuropathic pain/post-herpetic neuralgia.
  **AND**
- The patient has had a documented side effect, allergy, treatment failure or contraindication to TWO drugs in the tricyclic antidepressant (TCA) class and/or anticonvulsant class
  **AND**
- The patient has had a documented side effect, allergy, treatment failure or contraindication to Lyrica
  **OR**
- The patient has a medical necessity for a transdermal formulation (ex. dysphagia, inability to take oral medications)

QUTENZA®

- The diagnosis or indication is 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
  **AND**
- The patient has had a documented side effect, allergy, treatment failure or contraindication to Lidoderm
  **OR**
- The patient has a medical necessity for a transdermal formulation (ex. dysphagia, inability to take oral medications)
  **AND**
- The patient has had a documented side effect, allergy, treatment failure or contraindication to Lidoderm

**DOCUMENTATION:**

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

| **Analgesics: Miscellaneous: Transdermal Patch** *Length of Authorization: 6 months* | |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| | Lidoderm® Patch (lidocaine 5 %)<br>*Quantity Limit = 3 patches/day*<br><br>Qutenza® Patch (capsaicin 8 %)<br>*Quantity Limit =4 patches/90 days* |

Note: Please refer to "Analgesics: Long Acting Narcotics" for Duragesic® and fentanyl patch
Please refer to "Analgesics: COX IIs and NSAIDs" for Flector® patch

# Analgesics: Narcotics: Short Acting

**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.

Abstral®, Actiq®, fentanyl transmucosal, Fentora®, Onsolis®

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

AND

- Documentation that the patient is opioid tolerant (oral morphine ≥ 60 mg/day, transdermal fentanyl 25 mcg/hr, oral oxycodone ≥ 30 mg/day, oral hydromorphone ≥ 8 mg/day or an equianalgesic dose of another opioid for ≥ 1 week)

AND

- The member is on a long-acting opioid formulation

AND

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

OR

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

AND

- If the request is for brand name Actiq®, the member has a documented intoleranceto generic fentanyl transmucosal.

Dilaudid®-5 Oral Solution, Hydromorphone Oral Solution

- The member has had a documented side effect, allergy or treatment failure with oxycodone oral solution and morphine oral solution.

OR

- The member has been started and stabilized on another dosage form of hydromorphone.

AND

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

AND

- If the request is for the branded product, the patient has a documented intolerance to the generic product.

Nucynta®, Opana®, Oxymorphone

- 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.

AND

- If the request is for brand name Opana®, the member has a documented intolerance to generic oxymorphone.

Oxycodone (generic) Capsules

- The member has a documented intolerance to generic oxycodone tablets.

Ultram®, Ultracet®

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

Rybix ODT®

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

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. Brand name Demerol 75 mg/ml and 100 mg/2 ml not covered – no generic equivalents.

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

## Analgesics: Narcotics: Short Acting

*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®)<br>ACETAMINOPHEN W/HYDROCODONE† (compare to Vicodin®, Lorcet®, Maxidone®, Norco®, Zamicet®, Zydone®) *(QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day; 10/325 = 185 ml/day)*<br>ACETAMINOPHEN W/OXYCODONE† (compare to Percocet®) *(QL 10/650 = 6 tablets/day)*<br>ASPIRIN W/CODEINE†<br>ASPIRIN W/OXYCODONE† (compare to Percodan®)<br>BUTALBITAL COMPOUND W/ CODEINE† (compare to Fiorinal® w/codeine)<br>CODEINE SULFATE†<br>DIHYDROCODEINE COMPOUND† (compare to Synalgos-DC®)<br>ENDOCET® (oxycodone w/ acetaminophen)<br>ENDODAN® (oxycodone w/ aspirin)<br>FIORTAL W/ CODEINE #3® (butalbital w/ codeine)<br>HYDROCODONE† (plain, w/acetaminophen or w/ibuprofen) (some excpetions apply)<br>HYDROMORPHONE† (compare to Dilaudid®)<br>MEPERIDINE† (compare to Demerol®) (Maximum 30 tabs or 5 day supply)<br>MORPHINE SULFATE†<br>MORPHINE SULFATE SOLN† (compare to Roxanol®)<br>OXYCODONE† (plain, w/acetaminophen or w/ibuprofen)<br>PENTAZOCINE† (compare to Talwin®)<br>ROXICET® (oxycodone w/ acetaminophen)<br>ROXICODONE INTENSOL® (oxycodone)<br>ROXICODONE® (oxycodone HCL)<br>TRAMADOL† (compare to Ultram®) *(Qty Limit = 8 tablets/day)*<br>TRAMADOL/APAP† (compare to Ultracet®) *(Qty Limit = 8 tablets/day)*<br><br>Note: Acetaminophen containing products: (Preferred and PA Required)<br>Maximum daily dose acetaminophen = 4 grams | Abstral® (fentanyl) Sublingual Tablets<br>Acetaminophen w/codeine: *all branded products*<br>Acetaminophen w/hydrocodone: *all branded products*<br>*(QL 5/500 = 8 tablets/day, 10/500 = 8 tablets/day, 7.5/750 = 5 tablets/day)*<br>Acetaminophen w/hydrocodone (compare to Xodol®) *(QL=13 tablets/day)*<br>Acetaminophen w/oxycodone: *all branded products*<br>*(QL 10/650 = 6 tablets/day)*<br>Actiq® (fentanyl citrate transmucosal)<br>Anexsia®* (acetaminophen w/hydrocodone)<br>Butorphanol Nasal Spray† (Qty Limit = 2 bottles/month)<br>Capital® w/codeine* (acetaminophen w/codeine)<br>Cocet®/ Cocet Plus® (acetaminophen w/codeine) *(QL 30/650 or 60/650 = 6 tablets/day)*<br>Combunox®* (oxycodone w/ ibuprofen)<br>Dazidox®* (oxycodone)<br>Demerol* (meperidine)<br>Dilaudid®*(hydromorphone)<br>Dilaudid-5®(hydromorphone) oral solution<br>fentanyl citrate transmucosal† (compare to Actiq®)<br>Fentora® (fentanyl citrate buccal tablets)<br>Fioricet® w/codeine*(butalbital/acetaminophen/caffeine/codeine)<br>Hydromorphone† oral solution (compare to Dilaudid-5®)<br>Ibudone®* (hydrocodone w/ ibuprofen)<br>Liquicet® (hydrocodone w/ acetaminophen)<br>Lorcet®* (also HD, PLUS) (hydrocodone w/ acetaminophen)<br>Lortab®*(hydrocodone w/ acetaminophen)<br>Magnacet® (oxycodone w/ acetaminophen)<br>Maxidone®*(hydrocodone w/ acetaminophen)<br>Meperidine† (Qty > 30 tabs or 5 day supply)<br>Norco®*(hydrocodone w/ acetaminophen)<br>Nucynta® (tapentadol)<br>Onsolis®(fentanyl buccal soluble film)<br>Opana® (oxymorphone)<br>Oxycodone† (plain) capsules<br>Oxyfast®*(oxycodone)<br>OxyIR®*(oxycodone)<br>Oxymorphone† (compare to Opana®)<br>Panlor DC® (acetaminophen/caffeine/dihydrocodeine)<br>Pentazocine w/acetaminophen†<br>Pentazocine w/naloxone†<br>Percocet®*(oxycodone w/ acetaminophen)<br>Percodan®* (oxycodone w/aspirin)<br>Reprexain®* (hydrocodone w/ ibuprofen)<br>Roxanol®*(morphine sulfate)<br>Rybix® ODT (tramadol ODT) *(Qty Limit = 8 tablets/day)*<br>Synalgos DC®*(dihydrocodeine compound)<br>Talwin®* (pentazocine) and branded combinations<br>Trezix® (acetaminophen/caffeine/dihydrocodeine)<br>Tylenol® #3*,#4*(acetaminophen w/codeine)<br>Tylox®*(oxycodone w/ acetaminophen)<br>Ultracet® (tramadol w/ acetaminophen) *(Qty Limit = 8 tablets/day)*<br>Ultram®* (tramadol) *(Qty Limit = 8 tablets/day)*<br>Vicodin®*(hydrocodone w/acetaminophen)<br>Vicoprofen®*(hydrocodone w/ ibuprofen)<br>Xodol® (hydrocodone w/acetaminophen)<br>Xolox® (oxycodone w/ acetaminophen)<br>Zamicet®*/ Zydone®* (hydrocodone w/ acetaminophen) |

# Analgesics: Narcotics: Long Acting

**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.
- Prescribers should consult the VPMS (Vermont Prescription Monitoring System) to review a patient's Schedule II – IV medication use before prescribing long acting narcotics

**CRITERIA FOR APPROVAL:**

**Transdermal:**

**Brand Duragesic 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 generic fentanyl patches.

**Butrans Transdermal System**

- The patient has a diagnosis of moderate to severe pain, requiring a continuous, around-the-clock analgesic for an extended period of time.

AND

- The patient has had a documented side effect, allergy, or treatment failure to morphine sulfate SR 12 hr **AND** generic fentanyl patch.

OR

- The prescriber provides compelling clinical information for case specific discussion with DVHA Medical Director who will determine PA decision.

**Oral:**

**Conzip®, Ryzolt®, Tramadol ER biphasic-release Capsule, Tramadol ER biphasic-release Tablet, Tramadol ER/SR, Ultram ER®**

- The member has had a documented treatment failure to a preferred short-acting tramadol product. In addition, for approval of tramadol ER biphasic-release capsule or tablet or Ultram ER®, the patient must have a documented intolerance to generic tramadol ER/SR. For approval of Ryzolt® the patient must have a documented intolerance to generic tramadol ER/SR and generic tramadol ER biphasic –release tablet.

**Oral Non-Preferred (non tramadol containing products):**

- 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 **AND** generic fentanyl patch. (If a product has an AB rated generic, there must have been a trial of the generic) **Note:** A history of substance abuse does not warrant approval of Embeda® or Opana ER® (crush resistant) since a clear advantage of this product over preferred long-acting opioids in this population has not been established.

**LIMITATIONS:**

(1) Methadone 40 mg dispersible tablet not approved for retail dispensing.
(2) Embeda, Opana ER (crush resistant): A history of substance abuse does not warrant approval of Embeda® or Opana ER® (crush resistant) since a clear advantage of this product over preferred long-acting opioids in this population has not been established.

**DOCUMENTATION:**

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

# Analgesics: Narcotics: Long Acting

*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 |
|---|---|
| **TRANSDERMAL** | |
| **Buprenorphine**<br>**All products require PA.** | Butrans (buphrenorphine) Transdermal System<br>*(QL = 2 patches/14 days)(Maximum 14 day fill)* |
| **Fentanyl**<br>Fentanyl Patch† (compare to Duragesic®)<br>12 mcg/hr, 25 mcg/hr, 50 mcg/hr<br>(*QL=15 patches/30 days)* | Duragesic®* (fentanyl patch)<br>12 mcg/hr, 25 mcg/hr, 50 mcg/hr,<br>*(QL=15 patches/30 days)* |
| Fentanyl Patch† (compare to Duragesic®)<br>75 mcg/hr, 100 mcg/hr<br>(*QL=30 patches/30 days)* | Duragesic®* (fentanyl patch)<br>75 mcg/hr, 100 mcg/hr<br>*(QL= 30 patches/30 days)* |
| **ORAL** | |
| **Hydromorphone**<br>**All products require PA.** | Exalgo® (hydromorphone XR) tablet<br>(*QL= 30 tablets/30 days (8 mg tabs), 90 tablets/30 days (12 mg tabs), 120 tablets/30 days (16 mg tabs))* |
| **Methadone**<br>METHADONE† (compare to Dolophine®)<br>5 mg, 10 mg | Dolophine®* (methadone) |
| **Morphine**<br>MORPHINE SULFATE SR 12 hr† (compare to MS Contin®, Oramorph SR®)<br>(*QL=90 tablets/strength/30 days)* | Avinza® (morphine sulfate XR)<br>*(QL= 30 capsules/strength/30 days)*<br>Embeda® (morphine sulfate/naltrexone hydrochloride) Capsules *(QL=2 capsules/day)*<br>Kadian® (morphine sulfate XR*)*<br>*(QL= 60 capsules/strength/30 days)*<br>MS Contin®* (morphine sulfate SR 12 hr)<br>(*QL=90 tablets/strength/30 days)*<br>Morphine sulfate SR 24hr† capsule (compare to Kadian®) *(QL= 60 capsules/strength/30 days)*<br>Oramorph SR®* (morphine sulfate SR 12 hr<br>*(QL=90 tablets/strength/30 days)* |
| **Oxycodone**<br>**All products require PA.** | OxyContin® (Oxycodone ER) *(QL= 90 tablets/strength/30 days)* |
| **Oxymorphone**<br>**All products require PA.** | Opana ER® (oxymorphone ER)(crush resistant) *(QL=60 tablets/strength/30 days)*<br>Oxymorphone ER *(QL=60 tablets/strength/30 days)* |
| **Tapentadol**<br>**All products require PA.** | Nucynta ER® (tapentadol ER) *(QL=2 tablets/day)* |
| **Tramadol**<br>**All products require PA.** | Conzip® (tramadol ER biphasic release) Capsule *(QL = 1 capsule/day)*<br>Ryzolt® (tramadol ER biphasic-release) *(Qty Limit = 1 tablet/day)*<br>Tramadol SR† (compare to Ultram ER®) *(Qty Limit = 1 tablet/day)*<br>Tramadol ER biphasic-release® Capsule *(Qty Limit = 1 capsule/day)(150 mg strength)*<br>Tramadol ER biphasic-release† tablet (compare to Ryzolt®) *(Qty Limit = 1 tablet/day)*<br>Ultram ER® (tramadol SR 24 hr) *(Qty Limit = 1 tablet/day)* |

VERMONT

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

*Agency of Human Services*

# ~ LONG ACTING NARCOTICS~

Prior Authorization Request Form

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

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

**Prescribing physician:**

Name:_____

Phone #:_____

Fax #:_____

Address:_____

**Beneficiary:**

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Contact Person at Office:_____

Drug Requested:

Please indicate: □ Brand Name or □ Generic Equivalent

Dose /Frequency and Length of Therapy:

Diagnosis or Indication for Use:

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

| ***Check all that apply:*** | ***Response, check all that apply:*** |
|---|---|
| □ Fentanyl Patches | □ side-effect □ non-response □ allergy |
| □ Methadone | □ side-effect □ non-response □ allergy |
| □ Morphine Sulfate SR 12 hr | □ side-effect □ non-response □ allergy |

For tramadol products, has the member previously tried the following preferred medication?

| ***Check if applicable:*** | ***Response, check all □□at□apply:*** |
|---|---|
| □ Tramadol immediate release | □ side-effect □ non-response □ allergy |

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

Prescriber comments:

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

# Anemia Medications: Hematopoietic/Erythropoietic Agents

**LENGTH OF AUTHORIZATION:** 3 months initially, 6 months subsequent requests

**CRITERIA FOR APPROVAL:**

**Aranesp®, Procrit®**

- The diagnosis or indication for the requested medication is anemia due to one of the following:
  - Chronic kidney disease/renal failure
  - Post-renal transplant
  - Use of zidovudine for the treatment of human immunodeficiency virus (HIV) (other causes of anemia, such as iron/folate/vitamin B12 deficiency have been eliminated)
  - Surgery patients at high risk for perioperative blood loss
  - Cancer chemotherapy
  - Use of ribavirin or interferon therapy for Hepatitis C
  - Myelodysplastic syndrome

- Hemoglobin level at initiation of therapy is <10 g/dL

  OR
- For patients currently maintained on therapy, hemoglobin level is ≤11 g/dL in dialysis patients with chronic kidney disease, ≤10 g/dL in non-dialysis patients with chronic kidney disease, or ≤12 g/dL in patients treated for other indications.

**Epogen®**

- The diagnosis or indication for the requested medication is anemia due to one of the following:
  - Chronic kidney disease/renal failure
  - Post-renal transplant
  - Use of zidovudine for the treatment of human immunodeficiency virus (HIV) (other causes of anemia, such as iron/folate/vitamin B12 deficiency have been eliminated)
  - Surgery patients at high risk for perioperative blood loss
  - Cancer chemotherapy
  - Use of ribavirin or interferon therapy for Hepatitis C
  - Myelodysplastic syndrome

- Hemoglobin level at initiation of therapy is <10 g/dL

  OR
- For patients currently maintained on therapy, hemoglobin level is ≤11 g/dL in dialysis patients with chronic kidney disease, ≤10 g/dL in non-dialysis patients with chronic kidney disease, or ≤12 g/dL in patients treated for other indications.

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

**DOCUMENTATION:**

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

## Anemia: Hematopoietic/Erythropoietic Agents

*Length of Authorization:* ***3 months initially, 6 months subsequent request***

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

| PREFERRED AFTER CLINICAL CRITERIA ARE MET | PA REQUIRED |
|---|---|
| ARANESP® (darbepoetin alfa)<br>PROCRIT® (epoetin alpha) | Epogen® (epoetin alpha) |

# Ankylosing Spondylitis Medications: Injectables

***NOTE*: Ankylosing Spondylitis Self-Injectables (Enbrel®, Humira® and Simponi®) must be obtained and billed through our specialty pharmacy vendor, Ascend. Please see the Enbrel, Humira or Simponi Prior Authorization/Patient Enrollment Form for instructions. Ascend 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:**

**Humira®**

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

**OR**

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

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

**Enbrel®**

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

**OR**

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

**Remicade®**

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

**OR**

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

**AND**

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

**Simponi®**

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

**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® or Enbrel® cannot be used.

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

**DOCUMENTATION:**

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

- ✓ All requests for infliximab (Remicade®) (whether billed through the pharmacy or medical benefit (J1745)) require Prior Authorization through the MedMetrics Clinical Call Center.

## Ankylosing Spondylitis: Injectables

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

| PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET | NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET |
|---|---|
| ENBREL® (etanercept) *(Quantity limit = 4 syringes/28 days(50 mg), 8 syringes/28 days (25 mg))*<br><br>HUMIRA® (adalimumab) (*Quantity limit = 2 syringes/28 days)* | Remicade® (infliximab)<br><br>Simponi® (golimumab)<br>*(Quantity Limit = 1 syringe/28 days)* |

# Anti-Anxiety: Anxiolytics

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL**

**Non-preferred Benzodiazepines (except for alprazolam ODT, Klonopin Wafers®,Niravam® and Intensol Products):**

- 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®, and Niravam®:**

- 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.

**Alprazolam Intensol, Diazepam Intensol, Lorazepam Intensol**

- Patient has a medical necessity for the specialty dosage form (i.e. swallowing disorder)

**AND**

- The medication cannot be administered by crushing oral tablets.

**Vistaril®:**

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

**DOCUMENTATION:**

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

**MANAGEMENT OF MENTAL HEALTH DRUGS**: See page 170 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**

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

# Anticoagulants

**LENGTH OF AUTHORIZATION:** Xarelto**:** 6 months (or duration of need if less)

All Others: 6 months

**CRITERIA FOR APPROVAL:**

**Arixtra®**

- The patient has a documented intolerance to generic fondaparinux.

**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.

**Enoxaparin**

- The patient has a documented intolerance to brand Lovenox®.

**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.

**Pradaxa®**

- The diagnosis or indication is atrial fibrillation.

**Xarelto® 15 mg and 20 mg**

- The diagnosis or indication is atrial fibrillation.

**AND**

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

**OR**

- The patient has had a documented side effect, allergy, or contraindication (i.e. drug interactions) to warfarin therapy.

**OR**

- The patient has not been able to be adherent to coagulation monitoring or has not been able to achieve optimal INR control [INR 2-3] with warfarin therapy, despite dose titration attempts.

**OR**

- The prescriber has provided another clinically valid reason why generic warfarin cannot be used.

**Note:** Xarelto 10 mg for the diagnosis of the need for thromboprophylaxis following knee and hip replacement surgery is available without PA in the limited durations required for these indications.

**DOCUMENTATION:**

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

| **Anticoagulants** *Length of Authorization: 6 months*<br>**Key: † Generic product, *Indicates generic equivalent is available without a PA** | |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| **ORAL**<br>**Vitamin K Antagonist**<br>WARFARIN † (compare to Coumadin®)<br><br>**Direct Thrombin Inhibitor**<br><br>**Factor Xa Inhibitor**<br>Xarelto® (rivaroxaban) 10 mg<br>*(Quantity Limit = 1 tablet/day, maximum 30 day supply to complete total 35 days/every 180 days)* | <br><br>Coumadin®* (warfarin)<br><br>Pradaxa® (dabigatran etexilate)<br>*(Quantity Limit = 2 capsules/day)*<br><br>Xarelto® (rivaroxaban) 15 mg and 20 mg<br>*(Quantity Limit = 1 tablet/day)* |
| **UNFRACTIONATED HEPARIN**<br>HEPARIN † | |
| **LOW MOLECULAR WEIGHT HEPARINS**<br>FRAGMIN® (dalteparin)<br>LOVENOX® (enoxaparin)<br>*(QL = 2 syringes/day calculated in ml volume)* | Enoxaparin † (compare to Lovenox®)<br>*(QL = 2 syringes/day calculated in ml volume)*<br>Innohep® (tinzaparin) |
| **SELECTIVE FACTOR XA INHIBITOR**<br>Fondaparinux† (compare to Arixtra®) | Arixtra®* (fondaparinux) |

# Anticonvulsants

**LENGTH OF AUTHORIZATION**: lifetime for seizure disorders*♠; 1 year for other indications

**CRITERIA FOR APPROVAL:**

**Depakene®, Depakote®, Depakote ER®, Keppra® tablets or oral solution, Klonopin®, Klonopin Wafers®, Lamictal® tablets or chewable tablets, Mysoline®, Neurontin® capsules/tablets/oral solution, Tegretol®, Tegretol® XR (200 & 400 mg), Topamax® tablets, Topamax® Sprinkles, Trileptal® tablets, Zarontin®, Zonegran®**

- 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®**

- 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 used for the treatment of Lennox-Gastaut syndrome (topiramate, lamotrigine, valproic acid)

**AND**

- For approval of the oral suspension, the patient must be unable to use Banzel tablets (i.e. swallowing disorder)

**Felbamate, Felbatol®**

- 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. Additionally, if brand is requested, the patient has a documented intolerance to the generic product.

**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. Additionally, if brand is requested, the patient has a documented intolerance to the generic product.

**Diazepam rectal gel**

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

**OR**

- The patient has had a documented intolerance to Diastat rectal gel.

**Divalproex sodium capsules (sprinkles), Oxcarbazepine oral suspension (generics)**

- 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®, Lamictal XR®, levetiracetam ER**

- The patient has been unable to be compliant with or tolerate twice daily dosing of the immediate release product. Additionally, if brand Keppra XR is requested, the patient has a documented intolerance to the generic product.

**Lamictal ODT®**

- 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)

**Onfi®**

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

OR

- The diagnosis or indication is adjunctive 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 used for the treatment of Lennox-Gastaut syndrome (topiramate, lamotrigine, valproic acid)

OR

- The diagnosis or indication is adjunctive treatment of refractory epilepsy (may include different types of epilepsy)

AND

- The patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least THREE preferred anticonvulsants

**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

**AND**

- If the request is for the oral solution, the patient is unable to use Vimpat tablets (eg. swallowing disorder).

**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*♠; 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 |
|---|---|
| **ORAL** | |
| CARBAMAZEPINE† (compare to Tegretol®) | Banzel® (rufinamide) |
| CARBAMAZEPINE EXTENDED RELEASE† (compare to Tegretol XR®) | *QL = 8 tabs/day (400 mg) and 16 tabs/day (200 mg)* |
| CARBATROL® (carbamazepine) | Banzel® (rufinamide) oral suspension |
| CELONTIN® (methsuxamide) | *QL = 80 ml/day (3,200 mg/day)* |
| CLONAZEPAM† (compare to Klonopin®) | Depakene®* (valproic acid) |
| CLONAZEPAM ODT† (compare to Klonopin Wafers®) | Depakote®* (divalproex sodium) |
| DEPAKOTE SPRINKLES® (divalproex sodium caps) | Depakote ER®* (divalproex sodium) |
| | divalproex sodium capsules† (compare to Depakote Sprinkles®) |
| DILANTIN® (phenytoin) | felbamate (compare to Felbatol®) |
| DIVALPROEX SODIUM † (compare to Depakote®) | Felbatol® (felbamate) |
| DIVALPROEX SODIUM ER† (compare to Depakote ER®) | Keppra®* (levetiracetam) tablets, oral solution |
| EPITOL† (carbamazepine) | Keppra XR® (levetiracetam extended release) |
| ETHOSUXAMIDE† (compare to Zarontin®) | Klonopin®* (clonazepam) |
| GABAPENTIN† 100 mg, 300 mg, 400 mg capsules, 600 mg, 800 mg tablets, 250 mg/5 ml oral solution (compare to Neurontin®) | Klonopin Wafers®* (clonazepam ODT) |
| GABITRIL® (tiagabine) | Lamictal®* tabs (lamotrigine tabs) |
| LAMOTRIGINE† chew tabs (compare to Lamictal® chew tabs) | Lamictal®* chew tabs (lamotrigine chew tabs) |
| LAMOTRIGINE† tabs (compare to Lamictal® tabs) | Lamictal ODT® (lamotrigine orally disintegrating tablets) |
| LEVETIRACETAM† tabs (compare to Keppra® tabs) | Lamictal XR® tablets (lamotrigine extended release) |
| LEVETIRACETAM† oral soln (compare to Keppra® oral soln) | levetiracetam ER (compare to Keppra XR®) |
| OXCARBAZEPINE† tablets (compare to Trileptal®) | Lyrica® (pregabalin) § *(Quantity Limit = 3 capsules/day)* |
| PEGANONE® (ethotoin) | Mysoline®* (primidone) |
| PHENYTEK® (phenytoin extended) | Neurontin®* (gabapentin) capsules, tablets and oral solution |
| PHENYTOIN† (compare to Dilantin®) | Onfi® (clobazam) Tablets *(Quantity Limit = 2 tablets/day)* |
| PHENYTOIN EX† cap (compare to Phenytek®) | Oxcarbazepine † oral suspension (compare to Trileptal®) |
| PRIMIDONE† (compare to Mysoline®) | Sabril® (vigabatrin) |
| TEGRETOL® XR (carbamazepine) 100 mg ONLY | Stavzor® (valproic acid delayed release) |
| TOPIRAMATE† tabs (compare to Topamax® tabs) | Tegretol®* (carbamazepine) |
| TOPIRAMATE† sprinkle caps (compare to Topamax® Sprinkles) | Tegretol XR®* (carbamazepine) (200 and 400 mg strength) |
| TRILEPTAL® oral suspension (oxcarbazepine) | Topamax®* (topiramate) tablets |
| VALPROIC ACID† (compare to Depakene®) | Topamax®* (topiramate) Sprinkle Capsules |
| ZONISIMIDE† (compare to Zonegran®) | Trileptal®* tablets (oxcarbazepine) |
| | Vimpat® (lacosamide) tablets, oral solution |
| | Zarontin®* (ethosuxamide) |
| | Zonegran®* (zonisamide) |
| **RECTAL** | |
| DIASTAT® (diazepam rectal gel) | |
| | Diazepam rectal gel |

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

# Anti-Depressants: Miscellaneous

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

**CRITERIA FOR APPROVAL:**

**Aplenzin:**

- The patient has had a documented inadequate response to Budeprion XL/bupropion 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)

**Oleptro:**

- The diagnosis for use is MDD (major depressive disorder).

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/inadequate response to immediate release trazodone.

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

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

**Viibryd:**

- The diagnosis or indication is Major Depressive Disorder (MDD)

AND

- The patient has had a documented side effect, allergy, or inadequate response (defined by at least 4 weeks of therapy) to at least 3 different antidepressants from the SSRI, SNRI and/or Miscellaneous Antidepressant categories (may be preferred or non-preferred)

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

## Anti-Depressants: Miscellaneous

*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 |
|---|---|
| BUDEPRION® SR/BUPROPION SR† (compare to Wellbutrin SR®)<br>*FDA maximum recommended dose = 400 mg/day*<br>BUDEPRION XL/BUPROPION XL† (compare to Wellbutrin XL®)<br>*FDA maximum recommended dose = 450 mg/day*<br>BUPROPION† (compare to Wellbutrin®)<br>*FDA maximum recommended dose = 450 mg/day*<br>MAPROTILINE† (previously Ludiomil®)<br>*FDA maximum recommended dose = 225 mg/day*<br>MIRTAZAPINE† (compare to Remeron®)<br>*FDA maximum recommended dose = 45 mg/day*<br>MIRTAZAPINE RDT† (compare to Remeron Sol-Tab®)<br>*FDA maximum recommended dose = 45 mg/day*<br>NEFAZADONE† (previously Serzone®)<br>*FDA maximum recommended dose = 600 mg/day*<br>TRAZODONE HCL† (previously Desyrel®)<br>*FDA maximum recommended dose = 600 mg/day* | Aplenzin® (bupropion hydrobromide) ER tablets<br>*Quantity Limit = 1 tablet/day*<br>Oleptro® (trazodone) ER tablets<br>*Quantity Limit = 2 tablets/day (150 mg) or 1 tablet/day (300 mg)*<br>Remeron®* (mirtazapine)<br>*FDA maximum recommended dose = 45 mg/day*<br>Remeron Sol Tab®* (mirtazapine RDT)<br>*FDA maximum recommended dose = 45 mg/day*<br>Viibryd® (vilazodone) Tablet<br>*Quantity Limit = 1 tablet/day*<br>Wellbutrin®* (bupropion)<br>*FDA maximum recommended dose = 450 mg/day*<br>Wellbutrin SR®* (bupropion SR)<br>*FDA maximum recommended dose = 400mg/day*<br>Wellbutrin XL®* (bupropion XL)<br>*FDA maximum recommended dose = 450 mg/day* |

* For brand name products when generic equivalent preferred, length of authorization is 1 year.

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

# Anti-Depressants: SNRIs

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

**CRITERIA FOR APPROVAL:**

**Effexor, Venlafaxine IR:**

- 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).

AND

- The patient has had a documented intolerance to the generic product (for Effexor)

**Venlafaxine ER tablet (generic), Venlafaxine ER tablet (brand), Effexor XR capsule (brand):**

- The patient has had a documented intolerance to generic venlafaxine ER capsule

**Pristiq:**

- 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, one of which must be venlafaxine ER capsule (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, one of which must be venlafaxine ER capsule (may be preferred or non-preferred).

*Generalized Anxiety Disorder:*

- 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 TWO different antidepressants from the SSRI, SNRI and/or TCA categories (may be preferred or non-preferred) or ONE antidepressant from the SSRI, SNRI and/or TCA categories (may be preferred or non-preferred) and buspirone.

*Neuropathic pain:*

- The patient has had a documented side effect, allergy, or treatment failure to TWO drugs in the tricyclic anrtidepressant (TCA) class and/or anticonvulsant class. (this indication not processed via automated step therapy).

*Non-neuropathic musculoskeletal pain (osteoarthritis, chronic low back pain):*

- The patient has had a documented side effect, allergy, inadequate response or contraindication to acetaminophen (Tylenol®) AND at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs) (oral and/or topical). (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 anrtidepressant, 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 170 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 |
|---|---|
| Venlafaxine ER† capsule (compare to Effexor XR®)<br>*FDA maximum recommended dose = 225 mg/day,*<br>*Quantity limit = 1 capsule/day (37.5 mg & 75 mg)* | Cymbalta® **§** (duloxetine)<br>*FDA maximum recommended dose = 60 mg/day*<br>Effexor® (venlafaxine IR)<br>*FDA maximum recommended dose = 225 mg/day*<br>Effexor XR® (venlafaxine XR) capsule<br>*FDA maximum recommended dose = 225 mg/day,*<br>*Quantity limit = 1 capsule/day (37.5 mg & 75 mg)*<br>Pristiq® **§** (desvenlafaxine)<br>*FDA maximum recommended dose = 400 mg/day,*<br>*Quantity limit = 1 tablet/day (50 mg tablet only)*<br>Venlafaxine ER®† tablet<br>*FDA maximum recommended dose = 225 mg/day,*<br>*Quantity limit = 1 tablet/day (37.5 mg & 75 mg)*<br>Venlafaxine ER† tablet<br>*FDA maximum recommended dose = 225 mg/day,*<br>*Quantity limit = 1 tablet/day (37.5 mg & 75 mg)*<br>venlafaxine IR **†§** (compare to Effexor®)<br>*FDA maximum recommended dose = 225 mg/day* |

* For brand name products when generic equivalent preferred, length of authorization is 1 year.

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

# Anti-Depressants: SSRIs

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

**CRITERIA FOR APPROVAL**

**Celexa, Paxil tablet, 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.)

**AND**

- If the request is for Paxil CR, the patient has a documented intolerance to paroxetine CR.

**Paroxetine suspension, Paxil 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 60 mg Tablet, 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).) In addition, for approval of Sarafem, either Selfemra or fluoxetine pmdd must have been tried.

**Lexapro, escitalopram:**

- 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. (One trial must be generic citalopram).

**AND**

- If the request is for escitalopram, the patient has a documented intolerance with brand Lexapro.

**Fluoxetine 90 mg, 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.

**AND**

- If the request is for Prozac Weekly, the patient has a documented intolerance of fluoxetine 90 mg capsules.

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

## Anti-Depressants: SSRI

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

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| CITALOPRAM† (compare to Celexa®)<br>*FDA maximum recommended dose = 40 mg/day*<br>FLUOXETINE† (compare to Prozac®)<br>*FDA maximum recommended dose = 80 mg/day*<br>FLUVOXAMINE† (previously Luvox®)<br>*FDA maximum recommended dose = 300 mg/day*<br>PAROXETINE tablet† (compare to Paxil®)<br>*FDA maximum recommended dose = 60 mg/day*<br>SERTRALINE† (compare to Zoloft®)<br>*FDA maximum recommended dose = 200 mg/day, Quantity limit = 1.5 tabs/day (25 mg & 50 mg tabs)* | Celexa®* (citalopram)<br>*FDA maximum recommended dose = 40 mg/day*<br>escitalopram† (compare to Lexapro®)<br>*FDA maximum recommended dose = 20 mg/day, Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)*<br>fluoxetine† (pmdd)<br>*FDA maximum recommended dose = 80 mg/day*<br>Fluoxetine® 60 mg Tablet<br>*FDA maximum recommended dose = 80 mg/day*<br>fluoxetine† 90 mg (compare to Prozac Weekly®)<br>*FDA maximum recommended dose = 90 mg/week*<br>Lexapro® (escitalopram)<br>*FDA maximum recommended dose = 20 mg/day, Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)*<br>Luvox CR® (fluvoxamine CR)<br>*FDA maximum recommended dose = 300 mg/day, Quantity limit = 2 capsules/day*<br>paroxetine suspension† (compare to Paxil® susp)<br>*FDA maximum recommended dose = 60 mg/day*<br>Paroxetine CR† (compare to Paxil CR®)<br>*FDA maximum recommended dose = 75 mg/day*<br>Paxil®* (paroxetine)<br>*FDA maximum recommended dose = 60 mg/day*<br>Paxil® suspension (paroxetine)<br>*FDA maximum recommended dose = 60 mg/day*<br>Paxil CR® (paroxetine CR)<br>*FDA maximum recommended dose = 75 mg/day*<br>Pexeva® (paroxetine)<br>*FDA maximum recommended dose = 60 mg/day*<br>Prozac®* (fluoxetine)<br>*FDA maximum recommended dose = 80 mg/day*<br>Prozac Weekly® (fluoxetine)<br>*FDA maximum recommended dose = 90 mg/week*<br>Sarafem® (fluoxetine pmdd)<br>*FDA maximum recommended dose = 80 mg/day*<br>Selfemra®† (fluoxetine pmdd)<br>*FDA maximum recommended dose = 80 mg/day*<br>Zoloft®* (sertraline)<br>*FDA maximum recommended dose = 200 mg/day, Quantity limit = 1.5 tabs/day (25 mg & 50 mg tabs)* |

* For brand name products when generic equivalent preferred, length of authorization is 1 year.

# Anti-Depressants: Tricyclics & MAOIs

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

**CRITERIA FOR APPROVAL:**

**Tricyclics (TCAs) (Brands with generic equivalents):**

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

**OR**

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

**AND**

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

**MAOIs:**

**Marplan®**

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

**OR**

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

**Nardil®, Parnate®**

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

**EMSAM®**

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

**OR**

- The patient is unable to tolerate oral medications.

**LIMITATIONS:**

Chlordiazepoxide/amitriptyline and amitriptyline/perphenazine combinations not covered. Generic agents may be prescribed separately**.**

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

## Anti-Depressants: Tricyclics & MAOIs

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

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **TRICYCLICS** | |
| AMITRIPTYLINE† (previously Elavil®)<br>*FDA maximum recommended dose = 300 mg/day*<br>AMOXAPINE† (previously Asendin®)<br>CLOMIPRAMINE† (compare to Anafranil®)<br>DESIPRAMINE† (compare to Norpramin®)<br>DOXEPIN† (previously Sinequan®)<br>IMIPRAMINE† (compare to Tofranil®)<br>*FDA maximum recommended dose = 300 mg/day*<br>IMIPRAMINE PAMOATE† (compare to Tofranil PM®)<br>NORTRIPTYLINE† (previously Aventyl®, compare to Pamelor®)<br>PROTRIPTYLINE† (compare to Vivactil®)<br>TRIMIPRAMINE (compare to Surmontil®) | Anafranil®* (clomipramine)<br>Norpramin®* (desipramine)<br>Pamelor®* (nortriptyline)<br>Surmontil®* (trimipramine)<br>Tofranil®* (imipramine)<br>*FDA maximum recommended dose = 300 mg/day*<br>Tofranil PM®* (imipramine pamoate)<br>Vivactil®* (protriptyline) |
| **MAOIs** | |
| PHENELZINE SULFATE (compare to Nardil®)<br>*FDA maximum recommended dose = 90 mg/day*<br>TRANYLCYPROMINE (compare to Parnate®)<br>*FDA maximum recommended dose = 60 mg/day* | EMSAM® (selegiline) *(QL = 1 patch/day)*<br>Marplan® (isocarboxazid)<br>Nardil®* (phenelzine)<br>*FDA maximum recommended dose = 90 mg/day*<br>Parnate®* (tranylcypromine)<br>*FDA maximum recommended dose = 60 mg/day* |
| | |

* For brand name products when generic equivalent preferred, length of authorization is 1 year.

# Anti-Diabetics: Insulin

**LENGTH OF AUTHORIZATION:** lifetime

**CRITERIA FOR APPROVAL:**

**Apidra®**

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

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

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

**DOCUMENTATION:**

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

| **Insulins** | *Length of Authorization: lifetime* |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| **RAPID-ACTING INJECTABLE**<br>NOVOLOG® (Aspart)<br>HUMALOG® (insulin lispro) | Apidra® (insulin glulisine) |
| **SHORT-ACTING INJECTABLE**<br>HUMULIN R® (Regular)<br>NOVOLIN R® (Regular) | ReliOn R® (Regular) |
| **INTERMEDIATE-ACTING INJECTABLE**<br>HUMULIN N® (NPH)<br>NOVOLIN N® (NPH) | ReliOn N® (NPH) |
| **LONG-ACTING ANALOGS INJECTABLE**<br>LANTUS® (insulin glargine)<br>LEVEMIR® (insulin detemir) | |
| **MIXED INSULINS INJECTABLE**<br>HUMULIN 70/30® (NPH/Regular)<br>NOVOLIN 70/30® (NPH/Regular)<br>NOVOLOG MIX 70/30® (Protamine/Aspart)<br>HUMALOG MIX 75/25® (Protamine/Lispro)<br>HUMALOG MIX 50/50® (Protamine/Lispro) | ReliOn 70/30® (NPH/Regular) |

# Anti-Diabetics: Oral

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

**ALPHA GLUCOSIDASE INHIBITORS**

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

**BIGUANIDES AND COMBINATIONS**

*Fortamet, Glucophage XR, Glumetza, Metformin ER Osmotic*

- The patient has had a documented intolerance to generic metformin XR. (If a product has an AB rated generic, there must have also been a trial of the generic.)

*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**

***Actos*** *(pioglitazone),* ***Actoplus Met*** *and* ***Duetact***

- 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.

***Actoplus Met XR***

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

OR

- The patient has had a documented treatment failure with generic metformin XR.

OR

- The patient has had a documented treatment failure or has been unable to be adherent to a twice daily dosing schedule of Actoplus Met® resulting in a significant clinical impact.

***Avandia*** *(rosiglitazone) and combinations*

- The patient has been started and stabilized on the requested medication and appears to be benefiting from it and the patient acknowledges that they understand the risks,

OR

- The patient is unable to achieve glycemic control using other medications (including a documented side effect, allergy, contraindication or treatment failure with metformin) and, in consultation with their health care professional, decide not to take pioglitazone for medical reasons and the patient acknowledges that they understand the risks.

- Note: Rosiglitazone single and combination products may only be obtained through specially certified pharmacies participating in the Avandia-Rosiglitazone Medicines Access (REMS) Program.

**DIPEPTIDYL PEPTIDASE (DPP-4) INHIBITORS**

*Januvia, Onglyza, Tradjenta*

- 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.

*Janumet XR*

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

OR

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

AND

- The patient is unable to take Januvia and metformin/metformin XR as the individual separate agents.

*Jentadueto*

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

OR

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

AND

- The patient is unable to take Tradjenta and metformin as the individual separate agents.

*Juvisync:*

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

AND

- The patient has been started and stabilized on Januvia and simvastatin combination therapy as individual agents.

*Kombiglyze XR*

- The patient has had an inadequate response with Onglyza or metformin/metformin XR monotherapy.

OR

- The patient has been started and stabilized on Onglyza and metformin/metformin XR combination therapy.

**WELCHOL®**

- See Lipotropics: Bile Acid Sequestrants

**DOCUMENTATION:**

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

# Anti-Diabetics: Oral

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **ALPHA GLUCOSIDASE INHIBITORS** | |
| ACARBOSE† (compare to Precose®)<br>GLYSET® (miglitol) | Precose®* (acarbose) |
| **BIGUANIDES AND COMBINATIONS** | |
| **SINGLE AGENT**<br>METFORMIN† (compare to Glucophage®)<br>METFORMIN XR† (compare to Glucophage XR®)<br>RIOMET® (metformin oral solution) | Fortamet® (metformin ER Osmotic)<br>Glucophage®* (metformin)<br>Glucophage XR®* (metformin extended-release)<br>Glumetza® (metformin extended-release)<br>Metformin ER Osmotic† (compare to Fortamet®) |
| **COMBINATION**<br>GLIPIZIDE/METFORMIN†(compare to Metaglip®)<br>GLYBURIDE/METFORMIN† (compare to Glucovance®) | Glucovance®* (glyburide/metformin)<br>Metaglip®*(glipizide/metformin) |
| **MEGLITINIDES** | |
| **SINGLE AGENT**<br>STARLIX® (nateglinide) | Nateglinide† (compare to Starlix®)<br>Prandin® (repaglinide) |
| **COMBINATION** | Prandimet® (repaglinide/metformin) |
| **SULFONYLUREAS SECOND GENERATION** | |
| GLIMEPIRIDE† (compare to Amaryl®)<br>GLIPIZIDE† (compare to Glucotrol®)<br>GLIPIZIDE ER† (compare to Glucotrol XL®)<br>GLYBURIDE† (compare to Diabeta®)<br>GLYBURIDE MICRONIZED† (compare to Glynase® PresTab®) | Amaryl®* (glimepiride)<br>Diabeta®* (glyburide)<br>Glucotrol®* (glipizide)<br>Glucotrol XL®* (glipizide extended-release)<br>Glynase® PresTab®* (glyburide micronized) |
| **THIAZOLIDINEDIONES AND COMBINATIONS (after clinical criteria are met)** | |
| **SINGLE AGENT**<br>ACTOS® (pioglitazone) § | Avandia® (rosiglitazone) |
| **COMBINATION**<br>ACTOPLUS MET® (pioglitazone/metformin) §<br>DUETACT® (pioglitazone/glimepiride) §<br>*(Quantity Limit = 1 tablet/day)* | Actoplus Met XR (pioglitazone/metformin ER)<br>Avandamet® (rosiglitazone/metformin)<br>Avandaryl® (rosiglitazone/glimeperide) |
| **DIPEPTIDYL PEPTIDASE (DPP-4) INHIBITORS AND COMBINATIONS (after clinical criteria are met)** | |
| **SINGLE AGENT**<br>JANUVIA® (sitagliptin)§ *(Quantity limit=1 tab/day)*<br>ONGLYZA® (saxagliptin)§ *(Quantity limit=1 tab/day)*<br>TRADJENTA® (linagliptin) § *(Quantity limit=1 tab/day)* | |
| **COMBINATION**<br>JANUMET® (sitagliptin/metformin)§ *(Quantity limit=2 tabs/day)*<br>KOMBIGLYZE XR® (saxagliptin/metformin ER) § *(Quantity limit=1 tab/day)* | Janumet XR® (sitagliptin/metformin ER) *(Quantity limit=1 tab/day)*<br>Jentadueto® (linagliptin/metformin) *(Quantity limit=2 tabs/day)*<br>Juvisync® (sitagliptin/simvastatin) *(Quantity limit=1 tab/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 with metformin.

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.

VICTOZA:

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

**DOCUMENTATION:**

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

## Anti-Diabetics: Peptide Hormones

*Length of Authorization: 1 year*

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

| PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET | PA REQUIRED |
|---|---|
| **Incretin Mimetics**<br>BYETTA® (exenatide) §<br>*(Quantity Limit=1 pen/30 days)*<br><br>**Amylinomimetics**<br>SYMLIN® (pramlintide) §<br>*(No quantity limit applies)* | Victoza® (liraglutide)<br>*(Quantity Limit=3 pens/30 days)* |

# Anti-Emetics: 5-$HT_3$ Receptor Antagonists

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

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

Anzemet®

- The patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy.

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

Granisetron, Granisol®

- The patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy or radiotherapy.

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

Zofran®

- The patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy, radiotherapy or hyperemesis gravadarum.

  AND
- 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 has a diagnosis of nausea and vomiting associated with cancer chemotherapy, radiotherapy or hyperemesis gravadarum.

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

Ondansetron 24 mg

- The patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy.

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

Sancuso®

- 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.

Zuplenz®

- The patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy or radiotherapy.

  AND
- The prescriber provides documentation of medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia) AND a clinical rationale as to why ondansetron ODT is not a suitable option for the patient.

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

Ondansetron/Zofran 4 mg and 8 mg tablets and ODT, Zuplenz

- For nausea and vomiting associated with chemotherapy or radiation therapy, 3 tablets for each day of chemotherapy/radiation and 3 tablets for each day for 2 days after completion of chemotherapy/radiation may be approved.

Ondansetron/Zofran 4 mg and 8 mg tablets and ODT

- For hyperemesis gravadarum, three tablets per day of 4 mg or 8 mg may be approved for 3 months.

Anzemet®

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

Granisetron

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

Sancuso®

- 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**.

## Anti-Emetics: 5-$HT_3$ Receptor Antagonists

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

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| Ondansetron Tablet and Orally Disintegrating Tablet† (compare to Zofran®) 4 mg, 8 mg *Quantity Limit = 12 tablets/28 days (4 mg), 6 tablets/28 days (8 mg)*<br><br>Ondansetron Injection† (compare to Zofran®) | Anzemet® (dolasetron) *Quantity Limit = 4 tablets/28 days (50 mg), 2 tablets/28 days (100 mg)*<br><br>Granisetron† (formerly Kytril®) *Quantity Limit = 6 tablets/28 days*<br><br>Granisetron† (formerly Kytril® ) Injectable<br><br>Granisol® (granisetron ) Oral Solution<br><br>Ondansetron Solution† (compare to Zofran®)<br><br>Ondansetron† 24 mg tablet (previously Zofran®) *Quantity Limit = 1 tablet/28 days or per course of chemotherapy*<br><br>Sancuso® 3.1 mg/24 hrs Transdermal Patch (granisetron)<br>*Quantiy Limit = 1 patch/28 days*<br><br>Zofran®* (ondansetron) Tablet and Orally Disintegrating Tablet *Quantity Limit = 12 tablets/28 days (4 mg), 6 tablets/28 days (8 mg)*<br><br>Zofran®* (ondansetron) Injection<br><br>Zofran® (ondansetron) Solution<br><br>Zuplenz® (ondansetron) Oral Soluble Film<br>*Quantity Limit =12 films/28 days (4 mg),*<br>*6 films/28 days (8 mg)* |

# Anti-Emetics: NK1 Antagonists

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

**CRITERIA FOR APPROVAL WHEN QUANTITY LIMIT IS EXCEEDED:**

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

- The medication will be prescribed by an oncology practitioner.

**AND**

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

**AND**

- The requested quantity does not exceed one 125 mg and two 80 mg capsules OR one Tri-Fold Pack per course of chemotherapy. Patients with multiple courses of chemotherapy per 28 days 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 28 day period will be approved quantities sufficient for the number of surgeries or courses of anesthesia.

**DOCUMENTATION:**

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

| **Anti-Emetics: NK1 Antagonists** | *Length of Authorization: up to 1 year* |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| EMEND® (aprepitant) 40 mg (Qty Limit =1 cap/28 days)<br>♣ EMEND® (aprepitant) 80 mg (Qty Limit = 2 caps/28 days)<br>♣ EMEND® (apreptiant) 125 mg (Qty Limit = 1 cap/28 days)<br>♣ EMEND® (aprepitant) Tri-fold Pack (Qty Limit = 1 pack/28 days)<br>♣ *To be prescried byoncology pratitioners ONL* | |

# Anti-Emetics: Other

**LENGTH OF AUTHORIZATION:** 3 months

**PHARMACOLOGY:**

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

**CRITERIA FOR APPROVAL:**

Dronabinol, Marinol

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

  AND
- The patient has had a documented side effect, allergy, or treatment failure to **at least 2** antiemetic agents, of which, one must be a **preferred** 5HT3 receptor antagonist. If the request is for Marinol, the patient must additionally have a documented intolerance to generic dronabinol.

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

  AND
- The patient has had an inadequate response, adverse reaction, or contraindication to megestrol acetate. If the request is for Marinol, the patient must additionally have a documented intolerance to generic dronabinol.

Cesamet

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

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

**DOCUMENTATION:**

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

## Anti-Emetics: Other

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| | Dronabinol† (compare to Marinol®)<br><br>Marinol® (dronabinol)<br><br>Cesamet® (nabilone) |

# Anti-Hyperkinesis and Anti-Narcolepsy/Cataplexy

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

**CRITERIA FOR APPROVAL:**

**STIMULANTS**

Dexmethylphenidate and Focalin®

- 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 is also on Focalin XR and the prescriber is adding a shorter acting dosage form.

**OR**

- The patient has had a documented side-effect, allergy, or treatment failure on Methylin® or methylphenidate.

**AND**

- In addition, for approval of brand name Focalin®, the patient must have had a documented intolerance to generic dexmethylphenidate.

Metadate CD®, Ritalin LA®, Methylphenidate SR 24 HR

- 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® or Methylphenidate SA OSM.

**AND**

- For approval of generic methylphenidate SR 24 HR, the patient must have had a documented intolerance to brand Ritalin LA®.

Concerta

- The patient has a diagnosis of ADD, ADHD or narcolepsy.

**AND**

- The patient has had a documented intolerance to generic Methylphenidate SA OSM.

Ritalin® and Ritalin SR®

- 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® these are Methylin® ER, Metadate ER® or methylphenidate SR. For Ritalin these are Methylin® or methylphenidate.

Adderall® and Dexedrine CR®

- The patient has a diagnosis of ADD, ADHD or narcolepsy.

**AND**

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

Methamphetamine and Desoxyn®

- Given the high abuse potential of methamphetamine and Desoxyn®, the patient must have a diagnosis of ADD, ADHD or narcolepsy and have failed all preferred treatment alternatives. In addition, for approval of brand name Desoxyn®, the patient must have had a documented intolerance to generic methamphetamine.

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®.

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®

- 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®, Ritalin LA®, Focalin XR®, Adderall XR®, Methylphen idate SA OSM, Vyvanse® and Daytrana®)

**OR**

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

**OR**

- There is a question of substance abuse with the patient or family of the patient.

**OR**

- The family will choose to decline therapy if a stimulant must be trialed.

**OR**

- The patient has been trialed on immediate release guanfacine with good response but needs a dosage form with extended duration of therapy.

Kapvay®

- 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®, Ritalin LA®, Focalin XR®, Adderall XR®, Methylphen idate SA OSM, Vyvanse® and Daytrana®)

**OR**

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

**OR**

- There is a question of substance abuse with the patient or family of the patient.

**AND**

- The patient has been trialed on clonidine IR with at least a partial response but needs an extended duration formulation to maximize the clinical benefit.

Strattera®

- 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®, Ritalin LA®, Focalin XR®, Adderall XR®, Methylphen idate SA OSM, Vyvanse® and Daytrana®)

**OR**

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

**OR**

- There is a question of substance abuse with the patient or family of the patient.

**OR**

- The family will choose to decline therapy if a stimulant must be trialed.

**OR**

- The patient's need for drug therapy is primarily in early AM and evenings in the home environment.

Nuvigil®

**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® **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®, Modafinil

**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).

**AND**

- And if the request is for modafinil, the patient has a documented intolerance to brand Provigil.

**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®.

**AND**

- And if the request is for modafinil, the patient has a documented intolerance to brand Provigil.

Provigil® /Modafinil **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 170 for a description of the management of mental health drugs.

# Anti-Hyperkinesis and Anti-Narcolepsy/Cataplexy

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

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **AMPHETAMINE-LIKE STIMULANTS** | |
| **Short/Intermediate-Acting Methylphenidate Preps**<br>METADATE ER® (compare to Ritalin® SR)<br>METHYLIN® (compare to Ritalin® )<br>METHYLIN® ER (compare to Ritalin® SR)<br>METHYLPHENIDATE † (compare to Ritalin®)<br>METHYLPHENIDATE SR † (compare to Ritalin® SR) | Dexmethylphenidate † (compare to Focalin®)<br>Focalin® (dexmethylphenidate)<br>Ritalin®* (methylphenidate)<br>Ritalin SR®* (methylphenidate SR) |
| **Long-Acting Methylphenidate Preps**<br>**Oral**<br>FOCALIN XR® (dexmethylphenidate SR 24 HR IR/ER, 50:50%)<br>METHYLPHENIDATE SA OSM IR/ER, 22:78%† (compare to Concerta®) | Concerta® (methylphenidate SA OSM IR/ER, 22:78%)<br>Metadate CD® (methylphenidate CR, IR/ER, 30:70%)<br>Methylphenidate SR 24 HR, IR/ER, 50:50% † (compare to Ritalin LA®)<br>Ritalin LA® (methylphenidate SR 24 HR, IR/ER, 50:50%) |
| **Transdermal Patch**<br>DAYTRANA® (methylphenidate patch) (*QL = 1 patch/day)* | |
| **Short/Intermediate-Acting Amphetamine Preps**<br>AMPHETAMINE/DETROAMPHETAMINE† (compare to Adderall®)<br>DEXTROAMPHETAMINE † (previously Dexedrine®)<br>DEXTROAMPHETAMINE SR† (compare to Dexedrine CR®)<br>DEXTROSTAT † (dextroamphetamine) | Adderall®* (amphetamine/detroamphetamine)<br>Desoxyn® (methamphetamine)<br>Dexedrine CR®* (dextroamphetamine SR)<br>Methamphetamine † (compare to Desoxyn®) |
| **Long-Acting Amphetamine Preps**<br>ADDERALL XR® (amphetamine/dextroamphetamine SR 24 HR, IR/ER, 50:50%)<br>VYVANSE® (lisdexamfetamine) *(QL = 1 capsule/day)* | Amphetamine/dextroamphetamine SR 24 HR, IR/ER, 50:50%† (compare to Adderall XR®) |
| ***CNS stimulants*** *(all forms short- & long-acting): PA for beneficiaries < **3** yrs* | |
| *Table continued on next page* | |

| **NON-STIMULANTS** | |
|---|---|
| | Intuniv® (guanfacine extended release) Tablet<br>*Qty limit = 1 tablet/day*<br><br>Kapvay® (clonidine extended release) Tablet<br>*Qty limit = 4 tablets/day*<br><br>Modafinil (compare to Provigil® ) **(not approvable for ADHD in children age ≤12)** ***(Max days supply = 30 days)***<br>*Qty limit: 100 mg = 1.5 tablets/day*<br>*200 mg = 2 tablets/day*<br>*Maximum Daily Dose = 400 mg*<br><br>Nuvigil® (armodafinil)<br>*Qty limit: 50 mg = 2 tablets/day*<br>*150 mg/250 mg = 1 tablet/day*<br><br>Provigil® (modafinil) **(not approvable for ADHD in children age ≤12)** ***(Max days supply = 30 days)***<br>*Qty limit: 100 mg = 1.5 tablets/day*<br>*200 mg = 2 tablets/day*<br>*Maximum Daily Dose = 400 mg*<br><br>Strattera® (atomoxetine)<br>*FDA maximum recommended dose = 100 mg/day*<br><br>Xyrem® (sodium oxybate) |

* For brand name products when generic equivalent preferred, 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.

**LIMITATIONS:**

Captopril/hydrochlorothiazide combination not covered. Agents may be prescribed separately**.**

**DOCUMENTATION:**

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

## Anti-Hypertensives: ACE Inhibitors and ACEI Combinations

*Length of Authorization: 1 year*

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

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

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

**LENGTH OF AUTHORIZATION:** 3 years

**CRITERIA FOR APPROVAL:**

**Avapro, Benicar, , Diovan, Losartan, Micardis, Avalide, Benicar HCT, Diovan HCT, Losartan HCT, Micardis HCT, 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, Edarbi, Eprosartan, 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.

**AND**

- If brand name product with generic available, the patient has had a documented intolerance with the generic product.

**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.

**Cozaar, Hyzaar (Brands)**

- 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.

**AND**

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

**Irbesartan, Irbesartan/hydrochlorothiazide (generics)**

- 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.

**AND**

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

**Azor®, Tribenzor®, Twynsta®**

- 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.

**AND**

- The patient is unable to take the individual components separately.

**Valturna**

- The patient is NOT a diabetic

**AND**

- The patient has a diagnosis of hypertension.

**AND**

- 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.

**OR**

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

**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)**

| PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET | NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET |
|---|---|
| **ANGIOTENSIN RECEPTOR BLOCKERS:** | |
| AVAPRO® (irbesartan) §<br>BENICAR® (olmesartan) §<br>DIOVAN® (valsartan) §<br>LOSARTAN† (compare to Cozaar®)§<br>MICARDIS® (telmisartan) § | Atacand® (candesartan) §<br>Cozaar® (losartan)<br>Edarbi® (azilsartan) Tablet<br>*(Qty Limit = 1 tablet/day)*<br>Eprosartan† (compare toTeveten®) §<br>Irbesartan† (compare to Avapro®)<br>Teveten® (eprosartan) |
| **ANGIOTENSIN RECEPTOR BLOCKER/HYDROCHLOROTHIAZIDE:** | |
| AVALIDE® (irbesartan/hydrochlorothiazide) §<br>BENICAR HCT® (olmesartan/hydrochlorothiazide) §<br>DIOVAN HCT® (valsartan/hydrochlorothiazide) §<br>LOSARTAN/HYDROCHLOROTHIAZIDE † (compare to Hyzaar®)§<br>MICARDIS HCT® (telmisartan/hydrochlorothiazide) § | Atacand HCT®(candesartan/hydrochlorothiazide)§<br>Hyzaar® (losartan/hydrochlorothiazide)<br>Irbesartan/hydrochlorothiazide† (compare to Avalide®)<br>Teveten HCT® (eprosartan/hydrochlorothiazide) § |
| **ANGIOTENSIN RECEPTOR BLOCKER/CALCIUM CHANNEL BLOCKER:** | |
| EXFORGE® (valsartan/amlodipine) § *(QL = 1 tab/day)* | Azor®(olmesartan/amlodipine)<br>*(QL = 1 tablet/day)*<br>Twynsta® (amlodipine/telmisartan)<br>*(QL = 1 tablet/day)* |
| **ANGIOTENSIN RECEPTOR BLOCKER/RENIN INHIBITOR:** | |
| | Valturna® (aliskiren/valsartan)<br>*(Qty Limit = 1 tablet/day)* |
| **ANGIOTENSIN RECEPTOR BLOCKER/CALCIUM CHANNEL BLOCKER/HYDROCHLOROTHIAZIDE:** | |
| EXFORGE HCT® (amlodipine/valsartan/hydrochlorothiazide) § *(QL = 1 tab/day)* | Tribenzor® (amlodipine/olmesartan/hydrochlorothiazide)<br>*(QL = 1 tablet/day)* |

# Anti-Hypertensives: Beta-Blockers

**LENGTH OF AUTHORIZATION:** 3 years

**CRITERIA FOR APPROVAL**

**Non-preferred drugs (except Coreg CR®):**

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

**Coreg CR®:**

Indication: Heart Failure

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

**OR**

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

**AND**

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

Indication: Hypertension

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

**OR**

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

**DOCUMENTATION:**

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

## 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 |
|---|---|
| **SINGLE AGENT** | |
| ACEBUTOLOL† (compare to Sectral®) | Betapace®* (sotalol) |
| ATENOLOL† (compare to Tenormin®) | Betapace AF®* (sotalol) |
| BETAXOLOL† (compare to Kerlone®) | Bystolic® (nebivolol) *(QL = 1 tablet/day for 2.5 mg, 5 mg and 10 mg tablet strengths, 2 tablets/day for 20 mg)* |
| BISOPROLOL FUMARATE† (compare to Zebeta®) | Coreg®* (carvedilol) |
| CARVEDILOL† (compare to Coreg®) | Coreg CR® (carvedilol CR) *(QL = 1 tablet/day)* |
| LABETALOL† (compare to Trandate®) | Corgard®* (nadolol) |
| METOPROLOL† (compare to Lopressor®) | Inderal®* (propranolol) |
| METOPROLOL XL† (compare to Toprol XL®) | Inderal LA®* (propranolol ER) |
| NADOLOL† (compare to Corgard®) | InnoPran XL® (propranolol SR) |
| PINDOLOL† (formerly Visken®) | Kerlone®* (betaxolol) |
| PROPRANOLOL† (compare to Inderal®) | Levatol® (penbutalol) |
| PROPRANOLOL ER† (compare to Inderal LA®) | Lopressor®* (metoprolol) |
| SOTALOL† (compare to Betapace®, BetapaceAF®) | Sectral®* (acebutolol) |
| TIMOLOL† (formerly Blocadren®) | Tenormin®* (atenolol) |
| | Toprol XL®* (metoprolol succinate XL) |
| | Trandate®* (labetaolol)) |
| | Zebeta®* (bisoprolol) |
| **BETA-BLOCKER/DIURETIC COMBINATION** | |
| ATENOLOL/CHLORTHALIDONE† (compare to Tenoretic®) | Corzide®* (nadolol/bendroflumethiazide) |
| BISOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Ziac®) | Lopressor HCT®* (metoprolol/hydrochlorothiazide) |
| METOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Lopressor HCT®) | Propranolol/hydrochlorothiazide† (formerly Inderide®) |
| NADOLOL/BENDROFLUMETHIAZIDE† (compare to Corzide®) | Tenoretic®* (atenolol/chlorthalidone) |
| | Ziac®* (bisoprolol/hydrochlorothiazide) |

# Anti-Hypertensives: Calcium Channel Blockers

**LENGTH OF AUTHORIZATION:** 3 years except Caduet® and amlodipine/atorvastatin = 1 year only

**CRITERIA FOR APPROVAL (except as noted below):**

- 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.)

**Amlodipine/atorvastatin, Caduet®**

- The prescriber must provide a clinically valid reason for the use of the requested medication. For approval of Caduet, the patient must have also had a documented intolerance to the generic equivalent.

**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.

**Azor®, Tribenzor®, Twynsta®**

- 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.

**AND**

- The patient is unable to take the individual components separately.

**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 |
|---|---|
| **SINGLE AGENT** | |
| **Dihydropyridines** | |
| AFEDITAB® CR † (nifedipine SR, compare to Adalat® CC)<br>AMLODIPINE † (compare to Norvasc®)<br>FELODIPINE ER† (previously Plendil®)<br>NICARDIPINE † (formerly Cardene®)<br>NIFEDIAC® CC † (nifedipine SR, compare to Adalat® CC)<br>NIFEDICAL® XL † (nifedipine SR osmotic, compare to Procardia® XL)<br>NIFEDIPINE IR † (compare to Procardia®)<br>NIFEDIPINE SR osmotic † (compare to Procardia® XL)<br>NIFEDIPINE SR † (compare to Adalat® CC )<br>NIMODIPINE † (compare to Nimotop®) | Adalat® CC* (nifedipine SR)<br>Cardene® SR (nicardipine SR) (no AB rated generic)<br>Dynacirc® CR (isradipine CR) (no AB rated generic)<br>Isradipine® (formerly Dynacirc®)<br>Nimotop®* (nimodipine)<br>Nisoldipine ER† (compare to Sular®)<br>Norvasc®* (amlodipine)<br>Procardia®* (nifedipine IR)<br>Procardia XL®* (nifedipine SR osmotic)<br>Sular® (nisoldipine) |
| **Miscellaneous** | |
| CARTIA® XT † (diltiazem SR, compare to Cardizem® CD)<br>DILT-CD® † (diltiazem SR, compare to Cardizem® CD)<br>DILT-XR® † (diltiazem SR, compare to Dilacor® XR)<br>DILTIAZEM† (compare to Cardizem®)<br>DILTIAZEM ER† (formerly Cardizem® SR)<br>DILTIAZEM ER† (compare to Tiazac®)<br>DILTIAZEM SR † (compare to Cardizem®CD)<br>DILTIAZEM SR † (compare to Dilacor®XR)<br>TAZTIA® XT † (diltiazem ER, compare to Tiazac®)<br>VERAPAMIL† (compare to Calan®)<br>VERAPAMIL CR† (compare to Calan SR®, Isoptin® SR)<br>VERAPAMIL SR† 120 mg, 180 mg 240 mg and 360 mg (compare to Verelan®)<br>VERAPAMIL SR† 100 mg, 200 mg, 300mg (compare to Verelan PM®) | Calan®* (verapamil)<br>Calan® SR* (verapamil CR)<br>Cardizem®* (diltiazem)<br>Cardizem® CD* (diltiazem SR)<br>Cardizem® LA (diltiazem SR)<br>Covera-HS® (verapamil SR) (no AB rated generic)<br>Dilacor® XR* (diltiazem SR)<br>Diltiazem ER† /Matzin LA† (compare to Cardizem® LA)<br>Isoptin® SR* (verapamil CR)<br>Tiazac®* (diltiazem ER)<br>Verelan®* (verapamil SR 120 mg, 180 mg, 240 mg and 360 mg)<br>Verelan® PM* (100 mg, 200 mg and 300 mg) |
| **CALCIUM CHANNEL BLOCKER/OTHER COMBINATION**<br>**(preferred after clinical criteria are met)**<br>EXFORGE® (valsartan/amlodipine) §<br>*(QL = 1 tablet/day)*<br>EXFORGE HCT®<br>(amlodipine/valsartan/hydrochlorothiazide) §<br>*(QL = 1 tab/day)* | Azor® (olmesartan/amlodipine)<br>*(QL = 1 tablet/day)*<br>Tribenzor®<br>(amlodipine/olmesartan/hydrochlorothiazide)<br>*(QL = 1 tablet/day)*<br>Twynsta® (amlodipine/telmisartan)<br>*(QL = 1 tablet/day)*<br>Amlodipine/atorvastatin † (compare to Caduet®)<br>*(Qty Limit = 1 tablet/day)*<br>Caduet® (amlodipine/atorvastatin)<br>*(Qty Limit = 1 tablet/day)* |

# Anti-hypertensives: Central Alpha Agonists

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Catapres®, Tenex®:**

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

**Nexiclon XR® tablet**:

- The patient has a diagnosis of hypertension.

AND

- The patient has had a documented side effect, allergy, or treatment failure to at least TWO agents (either separately or as a combination product) from the following antihypertensive classes: a thiazide diuretic, a beta blocker, an angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or a calcium channel blocker (CCB).

AND

- The patient has been unable to be adherent to or tolerate twice daily dosing of the generic clonidine immediate-release tablets.

**Nexiclon XR® oral suspension:**

- The patient has a diagnosis of hypertension.

AND

- The patient has had a documented side effect, allergy, or treatment failure to at least TWO agents (either separately or as a combination product) from the following antihypertensive classes: a thiazide diuretic, a beta blocker, an angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), or a calcium channel blocker (CCB).

AND

- The patient has a medical necessity for a specialty dosage form (i.e. dysphagia, swallowing disorder).

**Clonidine patches (generic):**

- The patient has a medical necessity for a specialty topical dosage form (i.e. dysphasia, swallowing disorder, compliance, nausea/vomiting).

**Catapres-TTS® patches:**

- The patient has a medical necessity for a specialty topical dosage form (i.e. dysphasia, swallowing disorder, compliance, nausea/vomiting).

AND

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

**DOCUMENTATION:**

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

| **Anti-hypertensives: Central Alpha Agonists** | *Length of Authorization: 1 year* |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| **ORAL**<br>**Tablet**<br>CLONDIDNE IR† Tablets (compare to Catapress®)<br>GUANFACINE IR† Tablets (compare to Tenex®)<br>METHYLDOPA† Tablets | Catapres®* (clonidine) Tablet<br>Nexiclon XR® (clonidine) Extended Release Tablets<br>*(Quantity Limit = 3 tablets/day)*<br>Tenex®* (guanfacine) Tablets |
| **Suspension** | Nexiclon XR® (clonidine) Extended Release Suspension |
| **TRANSDERMAL** | Catapres-TTS® (clonidine) Transdermal Patch<br>*(Qty Limit = 1 patch/7 days)*<br>Clonidine (compare to Catapres-TTS) Transdermal Patch<br>*(Qty Limit = 1 patch/7 days)* |

# Anti-hypertensives: Renin Inhibitors

**LENGTH OF AUTHORIZATION:** 3 years

**CRITERIA FOR APPROVAL:**

**Tekturna®:**

- The patient is NOT a diabetic who will continue on therapy with an ACEI or ARB

**AND**

- 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.

**Amturnide®, Tekalmo®, Tekturna HCT®:**

- The patient is NOT a diabetic who will continue on therapy with an ACEI or ARB

**AND**

- 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.

**Valturna®:**

- The patient is NOT a diabetic

**AND**

- The patient has a diagnosis of hypertension.

**AND**

- 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.

**OR**

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

**DOCUMENTATION:**

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

| **Anti-hypertensives: Renin Inhibitors** | *Length of Authorization: 3 years* |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| | **Single Agent**<br>Tekturna® (aliskiren) *(Qty Limit = 1 tablet/day)*<br><br>**Combination**<br>Amturnide® (aliskiren/amlodipine/hydrochlorothiazide)<br>*(Qty Limit = 1 tablet/day)*<br>Tekamlo® (aliskiren/amlodipine)<br>*(Qty Limit = 1 tablet/day)*<br>Tekturna HCT® (aliskiren/hydrochlorothiazide)<br>*(Qty Limit = 1 tablet/day)*<br>Valturna® (aliskiren/valsartan)<br>*(Qty Limit = 1 tablet/day)* |

# Anti-Infectives: Antibiotics: Cephalosporins

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

**CRITERIA FOR APPROVAL:**

**Cephalexin Tablets:**

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

**Keflex®:**

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

**Cefaclor ER Tablets:**

- The patient has had a documented intolerance to cefaclor capsules.

**Ceftin® tablets:**

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

**Ceftin suspension:**

- The patient has had a documented side effect, allergy, or treatment failure to the following medications: cefprozil suspension and cefuroxime suspension.

**Spectracef® tablet, Cedax® 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 cefdinir.

**AND**

- If the request is for Spectracef®, the patient has a documented intolerance with generic cefditoren tablets

**Cedax®suspension, Suprax® 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 cefdinir and cefpodoxime suspension.

**DOCUMENTATION:**

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

## Anti-Infectives: Antibiotics: Cephalosporins

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

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **1st GENERATION:** | |
| TABLETS/CAPSULES<br>CEFADROXIL† Capsules, Tablets (formerly Duricef®)<br>CEPHALEXIN† Capsules (compare to Keflex®)<br><br>SUSPENSION<br>CEFADROXIL† Suspension (formerly Duricef®)<br>CEPHALEXIN† Suspension (formerly Keflex®)<br><br>IV drugs are not managed at this time. | Cephalexin® Tablets<br>Keflex®* (cephalexin) Capsules |
| **2nd GENERATION:** | |
| TABLETS/CAPSULES<br>CEFACLOR† CAPSULE<br>CEFPROZIL† (formerly Cefzil®) TABLET<br>CEFUROXIME † (compare to Ceftin®) TABLET<br><br>SUSPENSION<br><br>CEFPROZIL† (formerly Cefzil®) SUSPENSION<br>CEFUROXIME† (compare to Ceftin®) SUSPENSION<br><br>IV drugs are not managed at this time. | Cefaclor® ER Tablet<br>Ceftin®* (cefuroxime) tablet<br><br>Ceftin®* (cefuroxime) suspension |
| **3rd GENERATION:** | |
| CAPSULES/TABLETS<br>CEFDINIR† (formerly Omnicef®) CAPSULE<br>CEFPODOXIME PROXETIL† (formerly Vantin®) TABLET<br><br>SUPRAX® (cefixime) TABLET<br><br>SUSPENSION<br>CEFDINIR† (formerly Omnicef®) SUSPENSION<br>CEFPODOXIME PROXETIL† (formerly Vantin®) SUSPENSION<br><br>IV drugs are not managed at this time. | Cedax® (ceftibuten) capsule<br>Cefditoren† (compare to Spectracef®) tablet<br>Spectracef® (cefditoren) tablet<br><br>Cedax® (ceftibuten) suspension<br>Suprax® (cefixime) suspension |

# Anti-Infectives: Antibiotics: Ketolides

**LENGTH OF AUTHORIZATION**: Date of service only, no refills

**CRITERIA FOR APPROVAL:**

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

OR

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

AND

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

AND

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

AND

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

AND

- The member has had a documented therapeutic failure with all clinically appropriate alternatives.

AND

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

**DOCUMENTATION:**

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

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

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

# Anti-Infectives: Antibiotics: Macrolides

**LENGTH OF AUTHORIZATION**: for the date of service, only; no refills (azithromycin/Zithromax packets)

Up to 6 months: refills permissible with extended duration PA approvals (other medications).

**NON-PREFERRED AGENTS(EXCEPT AS BELOW):**

- 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.

**BRAND NAME ERYTHROMCYIN PRODUCTS:**

- The patient has had a documented side effect or treatment failure with one preferred erythromycin product.

**AZITHROMYCIN/ZITHROMAX PACKETS:**

- Is there a clinically valid reason why the dose cannot be obtained using generic azithromycin tablets?

**AND**

- If the request is for brand Zithromax, the patient has a documented intolerance to the generic product.

**AZITHROMYCIN > 5 DAY SUPPLY:**

- The patient has a diagnosis of Lyme Disease AND has had a documented side effect, allergy, or treatment failure to at least two of the following: doxycycline, amoxicillin, or a 2nd generation cephalosporin. For early Lyme disease, without neurologic or rheumatologic (arthritis) complications, the length of authorization is up to 10 days. For neurologic or rheumatologic Lyme disease, the length of authorization is up to 28 days

**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.(length of authorization up to 6 months)

**OR**

- The patient has a diagnosis of bacterial sinusitis AND has had a documented side effect, allergy, or treatment failure to penicillin, amoxicillin, or sulfamethoxazole/trimethoprim (Bactrim). (length of authorization up to 10 days)

**OR**

- The patient has a diagnosis of severe bronchiectasis with frequent exacerbations (length of authorization up to 6 months)

**DIFICID:**

- The patient's diagnosis or indication is Clostridium difficile associated diarrhea (CDAD)

**AND**

- The patient has had a side-effect, allergy, treatment failure or contraindication to metronidazole.

**OR**

- The prescriber provides a clinically compelling rationale why metronidazole is not appropriate for the patient. (E.g. patient has severe Clostridium difficile infection, history of recurrent infections).

**AND**

- The patient has had a side-effect, allergy, treatment failure or contraindication to oral vancomycin capsules (Vancocin®).

**DOCUMENTATION:**

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

## Anti-Infectives: Antibiotics: Macrolides

*Length of Authorization: Date of service, only; no refills for generic and brand azithromycin packets; up to 6 months (others)Refills permissible with extended duration PA approvals*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **Azithromycin**<br>AZITHROMYCIN† tabs, liquid (≤ 5 day supply) (compare to Zithromax®)<br>(Maximum 10 days therapy/30 days) | azithromycin† tablets and liquid (if > 5 day supply) (compare to Zithromax®)<br>(Maximum 10 days therapy/30 days)<br>Azithromycin† packet (compare to Zithromax®)<br>*(QL = 2 grams/fill)*<br>Zithromax®* (azithromycin) tablets and liquid<br>*QL = 5 days supply/RX, maximum 10 days therapy/30 days*<br>Zithromax® (azithromycin) packet<br>*(QL=2 grams/fill)*<br>Zmax® Suspension (azithromycin extended release for oral suspension)<br>*QL = 5 days supply/RX, maximum 10 days therapy/30 days* |
| **Clarithromycin**<br>CLARITHROMYCIN† (compare to Biaxin®) | Biaxin®* (clarithromycin)<br>Biaxin XL® (clarithromycin SR)<br>Clarithromycin SR† (compare to Biaxin® XL) |
| **Erythromycin**<br>E.E.S®† (erythromycin ethylsuccinate)<br>ERY-TAB® (erythromycin base, delayed release)<br>ERYTHROCIN† (erythromycin stearate)<br>ERYTHROMYCIN BASE†<br>ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S®)<br>ERYTHROMYCIN W/SULFISOXAZOLE† (compare to Pediazole®) | Eryped® (erythromycin ethylsuccinate)<br>PCE Dispertab® (erythromycin base)<br>Pediazole®* (erythromycin-sulfisoxazole) |
| **Fidaxomicin** | Dificid® (fidaxomicin) tablet<br>*(Quantity limit =2 tablets per day, 10 day supply per 30 days)* |
| IV drugs are not managed at this time. | |

# Anti-Infectives: Antibiotics: Oxazolidinones

**LENGTH OF AUTHORIZATION:** 28 days

**CRITERIA FOR APPROVAL:**

- The patient has been started on intravenous or oral linezolid in the hospital and will be finishing the course of therapy in an outpatient setting

**OR**

- The patient has a documented blood, tissue, sputum, or urine culture that is positive for Vancomycin-Resistant Enterococcus (VRE) species.

**OR**

- The patient has a documented blood or sputum culture that is positive for Methicillin-Resistant Staphylococcus species

**OR**

- The patient has a documented tissue or urine culture that is positive for Methicillin-Resistant Staphylococcus species

**AND**

- The patient has had a documented treatment failure with trimethoprim/sulfamethoxazole **OR** there is a clinically valid reason that the patient cannot be treated with trimethoprim/sulfamethoxazole.

**DOCUMENTATION:**

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

## Anti-Infectives: Antibiotics: Oxazolidinones

*Length of authorization: 28 days*

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| IV form of this medication not managed at this time | Zyvox® (linezolid) *QL = 56 tablets per 28 days*<br><br>Zyvox® (linezolid) suspension *QL = 60 ml/day, maximum 28 days supply* |

# Anti-infectives: Antibiotics: Penicillins (Oral)

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

**CRITERIA FOR APPROVAL:**

**Augmentin:**

- The patient has had a documented intolerance 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.

**Amoxicillin/Clavulanate ER, Augmentin XR, Moxatag:**

- The prescriber must provide a clinically valid reason for the use of the requested medication. Additionally, for approval of brand Augmentin XR, the patient must have a documented intolerance to generic Amoxicillin/Clavulanate ER

**LIMITATION**

Brand Augmentin® Chewable tablets do not offer Federal Rebate and therefore cannot be provided.

**DOCUMENTATION**

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

## Anti-Infectives: Antibiotics: Penicillins (oral)

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

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **SINGLE ENTITY AGENTS** | |
| **Natural Penicillins** | |
| PENICILLIN V POTASSIUM† (formerly Veetids®) tablets, oral solution | |
| **Penicillinase-Resistant Penicillins** | |
| DICLOXACILLIN† Capsules | |
| **Aminopenicillins** | |
| AMOXICILLIN† (formerly Amoxil®) capsules, tablets, chewable tablets, suspension<br>AMPICILLIN† (formerly Principen®) capsules, suspension | Moxatag® (amoxicillin extended release) tablet<br>*QL =1 tablet/day* |
| **COMBINATION PRODUCTS** | |
| AMOXICILLIN/CLAVULANATE† (compare to Augmentin®) tablets, chewable tablets, suspension<br>AMOXICILLIN/CLAVULANATE† 600-42.9mg/5ml (formerly Augmentin ES®) suspension | Amoxicillin/clavulanate† ER (compare to Augmentin XR®) tablets<br>Augmentin®*♣ (amoxicillin/clavulanate) tablets, suspension<br>Augmentin XR® (amoxicillin/clavulanate) tablets<br><br>♣ PA will be granted for 125 mg/5 mL strength for patients < 12 weeks of age |

# Anti-Infectives: Antibiotics: Quinolones

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

**CRITERIA FOR APPROVAL:**

**Noroxin®:**

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

**OR**

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

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

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

**AND**

- If the request is for Cipro XR, the patient has had a documented intolerance to generic ciprofloxacin ER.

**Avelox®, Factive®:**

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

**OR**

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

**Levaquin® (brand):**

- The patient has a documented intolerance with the generic levofloxacin

**DOCUMENTATION:**

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

## Anti-Infectives: Antibiotics: Quinolones

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

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

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

# Anti-Infectives: Antibiotics: Rifamycins

**LENGTH OF AUTHORIZATION:** Per indication, up to 1 year

Hepatic Encephalopathy: 1 year
Traveller's Diarrhea: for the date of service only
SIBO: 30 days
Irritable Bowel Syndrome: 14 days
Inflammatory Bowel Disease: Crohn's Disease: 3 months
Inflammatory Bowel Disease: Ulcerative Colitis: 1month
*Clostridium difficile* diarrhea: 14 days

Recertification for all of the above indications is contingent upon documentation of a clinical response.

**CRITERIA FOR APPROVAL: Based on Indication**

**Hepatic Encephalopathy (Xiafan 550 mg Tablets Only):**

- The patient has a diagnosis of hepatic encephalopathy.

**AND**

- Patient has had a documented side effect, allergy, treatment failure or contraindication to lactulose.

**AND**

- Quantity limit is 2 tablets/day (550 mg tablets only).

**Traveller's Diarrhea (Xiafan 200 mg Tablets Only):**

- The patient has a diagnosis of traveller's diarrhea caused by noninvasive strains of *Escherichia coli*.

**AND**

- Patient has had a documented side effect, allergy, treatment failure or contraindication with a fluoroquinolone.

**AND**

- Quantity limit is 9 tablets/RX (200 mg tablets only).

**Small Intestinal Bacterial Overgrowth (Xiafan 550 mg or 200 mg Tablets):**

- The patient has a diagnosis of SIBO.

**AND**

- Patient has attempted dietary modification and has had a documented side effect, allergy, treatment failure or contraindication to (alone or in combination) one of the following: Amoxicillin-clavulanate, cephalosporin, metronidazole, fluoroquinolone, tetracycline, trimethoprim-sulfamethoxazole.

**AND**

- Quantity limit is 800 mg to 1,200 mg/day.

**Irritable Bowel Syndrome (Xiafan 550 mg or 200 mg Tablets):**

- The patient has a diagnosis of irritable bowel syndrome without constipation or with symptoms of bloating.

**AND**

- Patient has attempted dietary modification and has had a documented side effect, allergy, treatment failure or contraindication to two of the following classes (one of which must be an antibiotic):
  • Antibiotics (alone or in combination: amoxicillin-clavulanate, cephalosporin, metronidazole, fluoroquinolone, tetracycline, trimethoprim-sulfamethoxazole)
  • SSRIs
  • TCAs
  • Antispasmodics
  • Antidiarrheals
  • Cholestyramine resin

**AND**

- Quantity limit is 1,200 mg to 1,650 mg/day.

**Inflammatory Bowel Disease: Crohn's Disease (Xiafan 550 mg or 200 mg Tablets):**

- The patient has a diagnosis of Crohn's Disease.

**AND**

- Patient has had a documented side effect, allergy, treatment failure or contraindication to two of the following: 6-mercaptopurine, aminosalicylates, azathioprine, corticosteroids, fluoroquinolone and/or metronidazole.

**AND**

- Quantity limit is 600 mg to 1,600 mg/day.

**Inflammatory Bowel Disease: Ulcerative Colitis (Xiafan 200 mg Tablets):**

- The patient has a diagnosis of Ulcerative Colitis.

**AND**

- Patient has had a documented side effect, allergy, treatment failure or contraindication to two of the following: 6-mercaptopurine, aminosalicylates, azathioprine, corticosteroids, fluoroquinolone and/or metronidazole.

**AND**

- Quantity limit is 800 mg/day (4 x 200 mg tablets/day).

***Colstridium difficile* Diarrhea (Xiafan 200 mg Tablets):**

- The patient has a diagnosis of *C. difficile* diarrhea.

**AND**

- Patient has had a documented side effect, allergy, treatment failure or contraindication to metronidazole.

**AND**

- Quantity limit is 800 mg/day (4 x 200 mg tablets/day).

**DOCUMENTATION:**

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

## Anti-Infectives: Antibiotics: Rifamycins

*Length of Authorization: Up to 1 year*

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| | Xifaxan ® (rifaximin) 200 mg Tablets<br>*(Qty limit = as above per indication)*<br><br>Xifaxan ® (rifaximin) 550 mg Tablets<br>*(Qty limit = as above per indication)* |

# Anti-Infectives: Antibiotics: Vancomycin

**LENGTH OF AUTHORIZATION**: Date of service only, no refills

**CRITERIA FOR APPROVAL:**

- The patient's diagnosis or indication is enterocolitis caused by *Staphylococcus aureus.*

OR

- The patient's diagnosis or indication is antibiotic-associated pseudomembranous colitis caused by *Clostridium difficile*

AND

- The patient has had a therapeutic failure, adverse reaction or contraindication to metronidazole.

OR

- The prescriber provides a clinically compelling rationale why metronidazole is not appropriate for the patient. (e.g. patient has severe *Clostridium difficile* infection, history of recurrent infections).

AND

- For approval of brand Vancocin, the patient must meet the above criteria and have a documented intolerance to the generic.

**DOCUMENTATION:**

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

## Anti-Infectives: Antibiotics: Vancomycin

*Length of Authorization: Date of Service Only; no refills*

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| IV vancomycin products are not managed at this time | Vancocin® (vancomycin) Capsules<br>Vancomycin (compare to Vancocin®) Capsules |

# Anti-Infectives: Antifungals: Allylamines

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

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

Tinea capitis: 6 weeks
Tinea pedis/Tinea cruris/Tinea corporis: up to 250 mg/day for up to 1 month (30 tabs/month)
Other indications: 3 months

**CRITERIA FOR APPROVAL**

**Terbinafine Tablets:**

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

**AND**

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

**AND**

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

**OR**

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

**AND**

- The quantity requested does not exceed 30 tablets per month for a maximum of 6 weeks.

**OR**

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

**AND**

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

**AND**

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

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

**Lamisil Granules:**

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

**AND**

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

**AND**

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

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

**DOCUMENTATION:**

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

## Anti-Infectives: Antifungals: Allylamines

*Length of Authorization: Up to 3 months*

**Key: † Generic product**

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| | terbinafine† (compare to Lamisil®) tablets *(QL: 30 tab/month post PA approval)*<br><br>Lamisil® (terbinafine) granules *(QL: 125 mg packet (1 or 2 per day depending on dose) 187.5 mg packet (1 per day) post PA approval)*<br><br>Lamisil® tablets (terbinafine) *(QL: 30 tab/month post PA approval)* |

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

# Anti-Infectives: Antifungals: Azoles

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

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

Other medications/indications: 3 months

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

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

**OR**

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

**OR**

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

**OR**

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

- For approval of Sporanox®capsules, the patient must have a documented intolerance to generic itraconazole. For approval of Sporanox® solution, the patient must have a medical necessity for a liquid dosage form.

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

**CRITERIA FOR APPROVAL OF VORICONAZOLE/VFEND®:**

- Patient has a diagnosis t 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.

- For approval of Vfend® tablets, the patient must have a documented intolerance to generic voriconazole. For approval of Vfend® solution, the patient must have a medical necessity for a liquid dosage form.

**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 DIFLUCAN® (BRAND):**

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

**CRITERIA FOR APPROVAL OF ORAVIG:**

- The indication for use is treatment of oropharyngeal candidasis.

**AND**

- The patient has had a documented side effect, allergy, treatment failure/inadequate response to both nystatin suspension and clotrimazole troche.

**OR**

- The patient is unable to be compliant with the nystatin suspension and/or clotrimazole troche dosing schedules.

**DOCUMENTATION:**

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

## Anti-Infectives: Antifungals: Azoles

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

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| FLUCONAZOLE† (compare to Diflucan®) tabs, suspension<br>KETOCONAZOLE† (formerly Nizoral®) tabs<br>CLOTRIMAZOLE Troche† (compare to Mycelex®)<br>IV drugs are not managed at this time. | Diflucan®* (fluconazole) tabs, suspension<br>itraconazole† (compare to Sporanox®) caps<br>Noxafil® (posaconazole)<br>Oravig® (miconazole) buccal tabs *(QL=1 tab/day; 14 tabs per RX ONLY)*<br>Sporanox® (itraconazole) caps, solution<br>VFend® (voriconazole) tabs, suspension<br>voriconazole† (compare to VFend®) tabs |

# Anti-Infectives: Antimalarials: Quinine

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

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

AND

- If the request is for brand Qualaquin®, the patient has a documented intolerance to the generic equivalent.

**DOCUMENTATION:**

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

| **Anti-Infectives: Antimalarials: Quinine** | *Length of Authorization: 1 year* |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| | Quinine sulfate† (compare to Qualaquin®)<br>Qualaquin® (quinine sulfate) |

# Anti-Infectives: Antivirals: Herpes: Oral

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

**CRITERIA FOR APPROVAL:**

**Famvir, Zovirax**

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

**Famciclovir**

- The patient has a documented side effect or allergy, or treatment failure (at least one course of ten or more days) with acyclovir **AND** valacyclovir.
  AND
- The patient has a documented intolerance to brand name Famvir®.

**Valtrex**

- The patient has a documented intolerance to generic valacyclovir.

**DOCUMENTATION:**

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

## Anti-Infectives: Antivirals: Herpes: Oral

*Length of Authorization: up to 6 months*

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

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

# Anti-Infectives: Antivirals: Influenza Medications

**Dosing information below is to be used in combination with the CDC and Vermont Department of Health recommendations:**

http://www.cdc.gov/flu/

http://healthvermont.gov/prevent/flu/index.aspx

**Antiviral medications with activity against influenza viruses are an important adjunct to influenza vaccine in the control of influenza.**

- Influenza antiviral prescription drugs can be used to **treat** influenza or to **prevent influenza**.
- Two FDA-approved influenza antiviral medications are recommended for use in the United States during the 2012-2013 influenza season: **oseltamivir** (Tamiflu®) and **zanamivir** (Relenza®).
- Oseltamivir and zanamivir are chemically related antiviral medications known as neuraminidase inhibitors that have activity against both influenza A and B viruses.
- The greatest benefit is when antiviral treatment is started within 48 hours of influenza illness onset.
- Antiviral treatment may still be beneficial in patients with severe, complicated, or progressive illness, and in hospitalized patients when administered more than 48 hours from illness onset.
- Annual influenza vaccination is the best way to prevent influenza because vaccination can be given well before influenza virus exposures occur, and can provide safe and effective immunity throughout the influenza season. However, antiviral medications are **70%** to **90%** effective in preventing influenza and are useful adjuncts to vaccination.
- CDC does not recommend widespread or routine use of antiviral medications for chemoprophylaxis so as to limit the possibilities that antiviral resistant viruses could emerge.

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

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

Tamiflu 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 (6 mg/ml): 180 ml (3 bottles) per 30 days

**Antiviral Medication Dosing Recommendations for Treatment and Chemoprophylaxis of Influenza, 2011 – 2012 Influenza Season**.

| Agent, group | | **Treatment (5 days)** | **Chemoprophylaxis (7 days, 14 days or longer in long term care)** |
|---|---|---|---|
| **Oseltamivir (Tamiflu®)** | | | |
| **Adult** | | 75-mg capsule twice per day | 75-mg capsule once per day |
| **Children ≥ 12 months** | ≤15 kg | 30 mg twice daily | 30 mg once per day |
| | >15-23 kg | 45 mg twice daily | 45 mg once per day |
| | >23-40 kg | 60 mg twice daily | 60 mg once per day |
| | >40 kg | 75 mg twice daily | 75 mg once per day |
| **Zanamivir (Relenza®)*** | | | |
| **Adult** | | 10 mg (two 5 mg inhalations) twice daily | 10 mg (two 5-mg inhalations) once daily |
| **Children** | | 10 mg (two 5 mg inhalations) twice daily (for **7 years or older**) | 10 mg (two 5-mg inhalations) once daily (for **5 years or older**) |

***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.

**LIMITATIONS:**
Amantadine, Flumadine® and rimantadine are not CDC recommended for use in influenza treatment or chemoprophylaxis at this time and are not covered for this indication. For information regarding amantadine see "Parkinsons Medications". Flumadine®/rimantadine is not covered for any indication.

**DOCUMENTATION:**

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

## Anti-Infectives: Antivirals: Influenza Medications

*Length of Authorization: up to 6 weeks*

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

| PREFERRED DRUGS | PA REQUIRED |
|---|---|
| RELENZA® (zanamivir)(QL= 20 blisters/30 days)<br>TAMIFLU® (oseltamivir)(QL = 10 caps/30 days (45 mg & 75 mg caps), 20 caps/30 days (30 mg caps), 180 ml (6 mg/ml)/30 days (suspension)) | |

# Anti-Infectives: Antivirals: Influenza Vaccines

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

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

| Age Group | Vaccination Status | Dosage Schedule |
|---|---|---|
| Children age 2 –8 years | Not previously vaccinated with seasonal influenza vaccine or received only one dose in 2010/11 and it was first time vaccination | 2 doses (0.2 mL* each at least one month apart) |
| Children age 2 – 8 years | Previously vaccinated with seasonal influenza vaccine | 1 dose (0.2 mL*) per season |
| Children & Adults age 9-49 | Not Applicable | 1 dose (0.2 mL*) per season |

***** administered as 0.1 mL per nostril

**DOCUMENTATION:**

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

## Anti-Infectives: Antivirals: Influenza Vaccines

*Length of Authorization: up to 6 weeks*

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **SEASONAL Influenza Vaccine Injection (Trivalent Inactivated Vaccine) (includes H1N1 for 2012-2013)**<br>AFLURIA® 2012- 2013 Injection<br>FLUARIX® 2012- 2013 Injection<br>FLULAVAL® 2012- 2013 Injection<br>FLUVIRIN® 2012- 2013 Injection<br>FLUZONE® 2012 - 2013 Injection | |
| **SEASONAL Influenza Nasal Vaccine (Live Attenuated InfluenzaVaccine) (includes H1N1 for 2012-2013)** | FluMist® Nasal |

# Anti-Migraine: Triptans

**LENGTH OF AUTHORIZATION:** 6 months

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

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

- The patient has had a documented side-effect, allergy or treatment failure to Sumatriptan, Naratriptan and Maxalt-MLT.

**Maxalt-MLT:**

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

**Naratriptan:**

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

**Nasal Spray or Injection: Sumatriptan**

- The patient has had a documented intolerance to brand Imitrex®.

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

- The patient is taking a medication for migraine prophylaxis

**LIMITATIONS:**

Sumavel DosePro® not covered as no Federal Rebate offered.

**DOCUMENTATION:**

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

## Anti-Migraine: Triptans

*Length of Authorization: 6 months*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **SINGLE AGENT** | |
| **ORAL** | |
| SUMATRIPTAN† (compare to Imitrex®)<br>*Quantity Limit = 18 tablets/month (25 mg), 9 tablets/month (50 mg, 100 mg),* | Amerge® (naratriptan)<br>*Quantity Limit = 9 tablets/month*<br><br>Axert® (almotriptan)<br>*Quantity Limit = 6 tablets/month*<br><br>Frova® (frovatriptan)<br>*Quantity Limit = 9 tablets/month*<br><br>Imitrex®* (sumatriptan)<br>*Quantity Limit = 18 tablets/month (25 mg), 9 tablets/month (50 mg, 100 mg),* |
| **After Sumatriptan Trial**<br><br>NARATRIPTAN† (compare to Amerge®)<br>(*Quantity Limit = 9 tablets/month)* | |
| **After Sumatriptan and Naratriptan Trials**<br><br>MAXALT-MLT® (rizatriptan ODT)<br>*Quantity Limit = 12 tablets/month* | Maxalt® (rizatriptan) tablet<br>*Quantity Limit = 12 tablets/month*<br><br>Relpax® (eletriptan)<br>*Quantity Limit = 12 tablets/month*<br><br>Zomig® (zolmitriptan)<br>*Quantity Limit = 12 tablets/month (2.5 mg tablets or orally disintegrating tablets), 6 tablets/month (5 mg tablets or orally disintegrating tablets)* |
| **NASAL SPRAY**<br>IMITREX® (sumatriptan)<br>*Quantity Limit =12 units/month (5 mg nasal spray), 6 units/month (20 mg nasal spray)* | Sumatriptan† (compare to Imitrex®)<br>*Quantity Limit =12 units/month (5 mg nasal spray), 6 units/month (20 mg nasal spray)*<br><br>Zomig® (zolmitriptan)<br>*Quantity Limit =, 12 units/month (5 mg nasal spray)* |
| **INJECTABLE**<br>IMITREX® (sumatriptan)<br>*Quantity Limit =4 injections/month (4 or6 mg injection)* | sumatriptan† (compare to Imitrex®)<br>*Quantity Limit =4 injections/month (4 or 6 mg injection)* |
| **COMBINATION PRODUCT** | Treximet® (sumatriptan/naproxen)<br>*Quantity Limit = 9 tablets/month* |

# Anti-Obesity Agents

Effective 10/12/2011, anti-obesity agents (weight loss agents) are no longer a covered benefit for all Vermont Pharmacy Programs. This change is resultant from Drug Utilization Review (DUR) Board concerns regarding safety and efficacy of these agents.

# Antipsychotics: Atypical and Combination

**LENGTH OF AUTHORIZATION:** Duration of need *♠ (except as noted below)
Quetiapine/Seroquel ≤ 50 mg/day = 1 year

**CRITERIA FOR APPROVAL: (Adult Patients ≥ 18 years old)**

**NON-PREFERRED TABLETS:**

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

OR
- The indication for use is the treatment of schizophrenia/schizoaffective disorder or bipolar disorder.

AND
- The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics).

**Invega®**:
- The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) (Prior therapy with injectable Invega Sustenna® is not considered to be started and stabilized for oral Invega. Patients transferring to oral therapy from Invega Sustenna® should transition to oral risperidone unless patient previously failed such treatment)

OR
- The indication for use is the treatment of schizophrenia/schizoaffective disorder.

AND
- The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics), one of which is risperidone.

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

OR
- The indication for use is the treatment of schizophrenia/schizoaffective disorder or bipolar disorder.

AND
- The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics).

**Clozaril®, Geodon®, Risperdal®:**
- The patient has a documented intolerance to the generic equivalent.

**Latuda®**:
- The patient is pregnant and the diagnosis is schizophrenia/schizoaffective disorder.

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

OR
- The indication for use is schizophrenia/schizoaffective disorder.

AND
- The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics), one of which is ziprasidone.

OR
- The patient has had a documented side effect, allergy or treatment failure with ziprasidone and the prescriber feels that neither risperidone nor quetiapine would be appropriate alternatives for the patient because of pre-existing medical conditions such as obesity or diabetes.

**Quetiapine/Seroquel® < or = 50 mg/day (Adults 18 years and older):**

- The patient is being prescribed > 50 mg/day with combinations of tablet strengths.

OR

- The indication for use is Adjunct treatment of Major Depressive Disorder (MDD) and the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes (SSRI, SNRI, and/or Miscellaneous Antidepressant categories). Trazodone dosed at < 150 mg/day would not be considered a trial for this indication.

OR

- The indication for use is Adjunct treatment of any anxiety disorder (panic, agoraphobia, social phobia, obsessive-compulsive disorder, PTSD, Acute Stress Disorder, Generalized Anxiety Disorder) and the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes (SSRI, SNRI, and/or Miscellaneous Antidepressant categories) or at least 2 antidepressants from the SSRI, SNRI, and/or Miscellaneous Antidepressant categories and buspirone. Trazodone dosed at < 150 mg/day and bupropion would not be considered trials for this indication.

OR

- The indication for use is a mental health indication (other than the two above indications or a sleep disorder).

AND

- If the request if for brand Seroquel, the patient has a documented intolerance to generic quetiapine.

**Note: Quetiapine in doses of ≤ 50 mg/day will not be approved for indications of insomnia, for sleep or as an hypnotic.**

**Seroquel XR®:**

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

OR

- The indication for use is schizophrenia/schizoaffective disorder or bipolar disorder (bipolar mania, bipolar depression, bipolar maintenance).

OR

- The indication for use is Adjunct treatment of Major Depressive Disorder (MDD) and the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes (SSRI, SNRI, and/or Miscellaneous Antidepressant categories). Trazodone dosed at < 150 mg/day would not be considered a trial for this indication.

OR

- The indication for use is Adjunct treatment of any anxiety disorder (panic, agoraphobia, social phobia, obsessive-compulsive disorder, PTSD, Acute Stress Disorder, Generalized Anxiety Disorder) and the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes (SSRI, SNRI, and/or Miscellaneous Antidepressant categories) or at least 2 antidepressant from the SSRI, SNRI, and/or Miscellaneous Antidepressant categories and buspirone. Trazodone dosed at < 150 mg/day and bupropion would not be considered trials for this indication.

AND

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

**Abilify®:**

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

OR

- The indication for use is schizophrenia/schizoaffective disorder or bipolar disorder.

AND

- The patient has had a documented side effect, allergy or treatment failure with at least three preferred products (typical or atypical antipsychotics)

OR

- The patient has had a documented side effect, allergy or treatment failure with ziprasidone and the prescriber feels that neither risperidone nor quetiapine would be appropriate alternatives for the patient because of pre-existing medical conditions such as obesity or diabetes.

OR

- The indication for use is Adjunct treatment of Major Depressive Disorder (MDD) and the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes (SSRI, SNRI, and/or Miscellaneous Antidepressant categories). Trazodone dosed at < 150 mg/day would not be considered a trial for this indication.

OR

- The indication for use is Adjunct treatment of any anxiety disorder (panic, agoraphobia, social phobia, obsessive-compulsive disorder, PTSD, Acute Stress Disorder, Generalized Anxiety Disorder) and the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes (SSRI, SNRI, and/or Miscellaneous Antidepressant categories) or at least 2 antidepressant from the SSRI, SNRI, and/or Miscellaneous Antidepressant categories and buspirone. Trazodone dosed at <150 mg/day and bupropion would not be considered trials for this indication.

AND

- The patient has had a documented side effect, allergy or treatment failure with one preferred atypical antipsychotic product being used as adjunctive therapy.

OR

- The indication for use is treatment of aggression, psychosis, or agitation secondary to Alzheimer's disease or other dementias AND the patient has had a documented side effect, allergy or treatment failure with two preferred products (typical or atypical antipsychotics). (**Note:** Please consider FDA Black Box Warning)

OR

- The indication or use is treatment of irritability associated with autistic disorder AND the patient has had a documented side effect, allergy or treatment failure with risperidone.

OR

- The indication or use is treatment of Tourette's syndrome AND the patient has had a documented side effect, allergy or treatment failure with guanfacine or clonidine and also risperidone.

**Olanzapine:**

- The patient has a documented intolerance to brand Zyprexa®.

**NON-PREFERRED ORAL SOLUTIONS**

**Abilify®:**

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

OR

- The indication for use is Adjunct treatment of Major Depressive Disorder (MDD) and the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes (SSRI, SNRI, and/or Miscellaneous Antidepressant categories). Trazodone dosed at < 150 mg/day would not be considered a trial for this indication.

OR

- The indication for use is Adjunct treatment of any anxiety disorder (panic, agoraphobia, social phobia, obsessive-compulsive disorder, PTSD, Acute Stress Disorder, Generalized Anxiety Disorder) and the patient has had a documented inadequate response to at least 3 different antidepressants from 2 different classes (SSRI, SNRI, and/or Miscellaneous Antidepressant categories) or at least 2 antidepressant from the SSRI, SNRI, and/or Miscellaneous Antidepressant categories and buspirone. Trazodone dosed at <150 mg/day and bupropion would not be considered trials for this indication.

AND

- The patient has had a documented side effect, allergy or treatment failure with preferred risperidone oral solution being used as adjunctive therapy.

OR

- The indication for use is schizophrenia/schizoaffective disorder or bipolar disorder.

OR

- The indication for use is treatment of aggression, psychosis, or agitation secondary to Alzheimer's disease or other dementias. (**Note:** Please consider FDA Black Box Warning)

OR

- The indication or use is treatment of irritability associated with autistic disorder.

OR

- The indication or use is treatment of Tourette's syndrome AND the patient has had a documented side effect, allergy or treatment failure with guanfacine or clonidine.

AND

- The patient has had a documented side effect, allergy or treatment failure with preferred risperidone oral solution.

**Risperdal®:**

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

**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. In addition, for approval of Zyprexa® IM, the patient must have had a documented intolerance to generic olanzapine IM.

**LONG-ACTING INJECTIONS:**

- Medical necessity for a specialty dosage form has been provided (swallowing disorder, non-compliance with oral medications, etc.)
- For approval of Zyprexa Relprevv®, the prescriber must also provide clinical rationale why Risperdal Consta® or Invega Sustenna® is not a suitable option for this patient.

**ORALLY DISINTEGRATING TABLETS:**

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

AND

- If the request is for a generic product with a brand equivalent, the patient has a documented intolerance to brand product.

**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 (ziprasidone, risperidone, and quetiapine).

OR

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

AND

- If the request is for brand product, 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**.

✓ Document clinically information supporting the prescribing of Quetiapine in doses of ≤ 50 mg/day on a **Quetiapine 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 170 for a description of the management of mental health drugs.

## Antipsychotics: Atypical and Combination *Length of authorization: Duration of Need*♠*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **TABLETS/CAPSULES** | |
| CLOZAPINE† (compare to Clozaril®)<br>*FDA maximum recommended dose = 900 mg/day*<br>RISPERIDONE† (compare to Risperdal®)<br>*FDA maximum recommended dose = 16 mg/day*<br>QUETIAPINE† (compare to Seroquel®) > 50 mg/day<br>QUETIAPINE† (compare to Seroquel®) ≤ 50 mg/day (children < 18 years old)<br>*FDA maximum recommended dose = 800 mg/day*<br>ZIPRASIDONE† (compare to Geodon®)<br>*FDA maximum recommended dose = 160 mg/day*<br>ZYPREXA® (olanzapine)<br>*FDA maximum recommended dose = 20 mg/day,*<br>*Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs)* | Abilify® (aripiprazole)<br>*FDA maximum recommended dose = 30 mg/day,*<br>*Quantity limit = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)*<br>Clozaril®* *(clozapine)*<br>*FDA maximum recommended dose = 900 mg/day*<br>Fanapt® (iloperidone)<br>*FDA maximum recommended dose = 24 mg/day*<br>*Quantity limit = 2 tablets/day*<br>Geodon® (ziprasidone)<br>*FDA maximum recommended dose = 160 mg/day*<br>Invega® (paliperidone)<br>*FDA maximum recommended dose = 12 mg/day*<br>*Quantity limit = 1 tab/day (3mg, 9mg), 2 tabs/day (6mg)*<br>Latuda® (lurasidone)<br>*FDA maximum recommended dose = 160 mg/day*<br>*Quantity limit = 1 tablet/day all strengths except 80 mg = 2 tablets/day*<br>Olanzapine† (compare to Zyprexa®)<br>*FDA maximum recommended dose = 20 mg/day,*<br>*Quantity limit = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg & 10 mg tabs)*<br>Quetiapine† (compare to Seroquel®) ≤ 50 mg/day (adults ≥ 18 years old)<br>Risperdal®* (risperidone)<br>*FDA maximum recommended dose = 16 mg/day*<br>Saphris® (asenapine) sublingual tablet<br>*FDA maximum recommended dose = 20 mg/day*<br>Seroquel® (quetiapine)<br>*FDA maximum recommended dose = 800 mg/day*<br>Seroquel XR® (quetiapine XR)<br>*FDA maximum recommended dose = 800 mg/day Quantity Limit = 1 tab/day (150 mg & 200 mg tablet strengths), 2 tabs/day (50 mg strength)* |
| **ORAL SOLUTIONS** | |
| RISPERIDONE† (compare to Risperdal®) oral solution<br>*FDA maximum recommended dose = 16 mg/day* | Abilify® (aripiprazole) oral solution<br>*FDA maximum recommended dose = 25 mg/day*<br>Risperdal® (risperidone) oral solution<br>*FDA maximum recommended dose = 16 mg/day* |
| **SHORT-ACTING INJECTABLE PRODUCTS** | |
| GEODON® IM (ziprasidone intramuscular injection)<br>*FDA maximum recommended dose = 40 mg/day*<br><br>*Table continued on next page* | Abilify® IM (aripiprazole intramuscular injection)<br>*FDA maximum recommended dose = 30 mg/day*<br>Olanzapine† IM (compare to Zyprexa® IM)<br>*FDA maximum recommended dose = 30 mg/day*<br>Zyprexa® IM (olanzapine intramuscular injection)<br>*FDA maximum recommended dose = 30 mg/day*<br><br>*Table continued on next page* |

| | |
|---|---|
| **LONG-ACTING INJECTABLE PRODUCTS** | |
| | Invega Sustenna® (paliperidone palmitate)<br>*FDA maximum recommended dose = 234 mg/month*<br>Risperdal Consta® (risperidone microspheres)<br>*FDA maximum recommended dose = 50 mg/14 days*<br>Zyprexa Relprevv® (olanzapine pamoate)<br>*FDA maximum recommended dose = 600 mg/month*<br>*Quantity limit = 1 vial/28 days (405 mg) or 2 vials/month (210 or 300 mg)* |
| **ORALLY DISINTEGRATING TABLETS** | |
| | Abilify® Discmelt (aripiprazole)<br>*FDA maximum recommended dose = 30 mg/day,*<br>*Quantity limit = 2 tabs/day (10 mg & 15 mg tabs)*<br>FazaClo® (clozapine orally disintegrating tablets)<br>*FDA maximum recommended dose = 900 mg/day*<br>Olanzapine orally disintegrating tablets† (compare to Zyprexa Zydis®)<br>*FDA maximum recommended dose = 20 mg/day,*<br>*Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)*<br>Risperdal® M-Tab (risperidone orally disintegrating tablets)<br>*FDA maximum recommended dose = 16 mg/day*<br>Risperidone† ODT (compare to Risperdal® M-Tab)<br>*FDA maximum recommended dose = 16 mg/day*<br>Zyprexa Zydis® (olanzapine orally disintegrating tablets)<br>*FDA maximum recommended dose = 20 mg/day,*<br>*Quantity limit = 1.5 tabs/day (5 mg & 10 mg tabs)* |
| **COMBINATION PRODUCTS** | |
| | olanzapine/fluoxetine† (compare to Symbyax®)<br>*FDA maximum recommended dose = 18 mg/75 mg (per day)*<br>Symbyax® (olanzapine/fluoxetine)<br>*FDA maximum recommended dose = 18 mg/75 mg (per day)* |

* For brand name products when generic equivalent preferred, 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® 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 170 for a description of the management of mental health drugs.

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

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **ORAL TABLETS/CAPSULES** | |
| CHLORPROMAZINE† (formerly Thorazine®) | Haldol®* (haloperidol) |
| FLUPHENAZINE† (formerly Prolixin®) | Loxitane®* (loxapine) |
| HALOPERIDOL† (compare to Haldol®) | Navane®* (thiothixene) 2 mg, 5 mg, 10 mg |
| LOXAPINE† (compare to Loxitane®) | |
| NAVANE® (thiothixene) (20 mg ONLY) | |
| PERPHENAZINE† (formerly Trilafon®) | |
| THIORIDAZINE† (formerly Mellaril®) | |
| THIOTHIXENE† (compare to Navane®) | |
| TRIFLUOPERAZINE† (formerly Stelazine®) | |
| **LONG ACTING INJECTABLE PRODUCTS** | |
| fluphenazine decanoate† (formerly Prolixin® decanoate) | |
| haloperidol decanoate † (compare to Haldol® decanoate) | Haldol® decanoate* (haloperidol decanoate) |

* For brand name products when generic equivalent preferred, length of authorization is 1 year.

# Bone Resorption Inhibitors

**LENGTH OF AUTHORIZATION**: 3 years except Forteo® (2 years only, no renewal)

**CRITERIA FOR APPROVAL:**

**Actonel®, Actonel® w/calcium:**

- The patient has a diagnosis/indication of Paget's Disease

AND

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

OR

- The patient has a diagnosis/indication of postmenopausal osteoporosis**,** osteoporosis in men or glucocorticoid induced osteoporosis.

AND

- The patient has had a documented side effect, allergy, or treatment failure (at least a 1 year trial) to generic alendronate. Treatment failure is defined as documented continued bone loss or fracture after one or more years despite treatment with an oral bisphosphonate.

**Altelvia®, Boniva® Oral, Ibandronate**

- The patient has a diagnosis/indication of postmenopausal osteoporosis**.**

AND

- The patient has had a documented side effect, allergy, or treatment failure (at least a 1 year trial) to generic alendronate®. Treatment failure is defined as documented continued bone loss or fracture after one or more years despite treatment with an oral bisphosphonate.

AND

- If the request is for brand Boniva®oral, the patient has also had a documented intolerance to generic Ibandronate.

**Calcitonin Nasal Spray (generic), Fortical®:**

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

**Fosamax® Tablet:**

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

**Fosamax Plus D®:**

- There is a clinical reason why the patient is unable to take generic alendronate and vitamin D separately.

**Didronel®, Etidronate, Skelid®:**

- The patient has a diagnosis/indication of Paget's Disease

AND

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

**Forteo®:**

- The patient has a dignosis/indication of postmenopausal osteoporosis in females, primary or hypogonadal osteoporosis in males or glucocorticoid induced osteoporosis.

  AND
- The patient has had a documented side effect, allergy, or treatment failure to an oral bisphosphonate. Treatment failure is defined as documented continued bone loss or fracture after one or more years despite treatment with an oral 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 with a lifetime maximum duration of treatment of 2 years.

**Boniva®Injection:**

- The patient has a diagnosis/indication of postmenopausal osteoporosis**.**

  AND
- The patient has had a documented side effect or treatment failure to a preferred bisphosphonate. Treatment failure is defined as documented continued bone loss or fracture after one or more years despite treatment with an oral bisphosphonate.

  AND
- The quantity requested does not exceed four (4) 3 mg doses per year.

**Prolia® Injection:**

- The diagnosis or indication is osteopenia in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer

  OR
- The diagnosis or indication is osteopenia in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer

  OR
- The patient has a diagnosis/indication of postmenopausal osteoporosis

  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 an oral bisphosphonate.

  AND
- The quantity requested does not exceed 1 syringe per 6 months.

**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 or fracture after one or more years despite treatment with an oral bisphosphonate.

  AND
- The quantity requested does not exceed a single 5 mg dose per year.

**Xgeva® Injection:**

- The diagnosis or indication is bone metastases from solid tumors (e.g. prostate, breast, thyroid, non-small lung cancer)

**DOCUMENTATION:**

- ✓ Document clinically compelling information supporting the choice of Boniva IV, Forteo, Prolia, Reclast or Xgeva on a **Bone Resorption Inhibitor Injectable Prior Authorization Request Form**.
- ✓ Document clinically compelling information supporting the choice of other non-preferred agents on a **General Prior Authorization Request Form**
- ✓ All requests for denosumab (Prolia® or Xgeva®) (whether billed through the pharmacy or medical benefit (J0897)) require Prior Authorization through the MedMetrics Clinical Call Center.

## Bone Resorption Inhibitors

*Length of Authorization:3 years(Forteo® 2 years only, no renewal)*

**Key: † Generic product,**

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **ORAL BISPHOSPHONATE**<br><br>**TABLETS/CAPSULES**<br>ALENDRONATE† (compare to Fosamax®) | Actonel® (risedronate)<br>Actonel® w/calcium (risedronate/calcium)<br>Altelvia (risedronate) Delayed Release Tablet<br>*(Quantity Limit = 4 tablets/28 days)*<br>Boniva® (ibandronate) *(Quantity Limit = 150 mg tablet/1 tablet per 28 days )*<br>Didronel® (etidronate)<br>Etidronate† (compare to Didronel®)<br>Fosamax®* (alendronate)<br>Fosamax Plus D® (alendronate/vitamin D)<br>Ibandronate† (compare to Boniva®) *(Quantity Limit = 150 mg tablet/1 tablet per 28 days)*<br>Skelid® (tiludronate) |
| **INJECTABLE BISPHOSPHONATE** | Boniva Injection (ibandronate)<br>*(QL=3 mg/3 months (four doses)/year)*<br>Reclast® Injection (zoledronic acid)<br>*(QL=5 mg (one dose)/year)* |
| **ESTROGEN AGONIST/ANTAGONIST**<br><br>EVISTA® (raloxifene) Tablet *(QL = 1 tablet/day)* | |
| **INJECTABLE RANKL INHIBITOR** | Prolia® Injection (denosumab)<br>*(QL=60 mg/6 months (two doses)/year)*<br>Xgeva® (denosumab) (*QL=120 mg/28 days*) |
| **CALCITONIN NASAL SPRAY**<br><br>MIACALCIN® (calcitonin) | Calcitonin† Nasal Spray (compare to Miacalcin®)<br>Fortical®† (calcitonin) |
| **PARATHYROID HORMONE INJECTION** | Forteo® (teriparatide)<br>*(Quantity Limit = 1 pen (3 ml)/28 days*<br>*(Lifetime max duration of treatment = 2 years)* |

VERMONT

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

*Agency of Human Services*

# ~ BONE RESORPTION INHBITORS INJECTABLE ~

Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of injectable bone resorption inhibitors. For beneficiaries to receive coverage for these agents, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

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

**Prescribing physician:**

Name:_____

Phone #:_____

Fax #:_____

Address:_____

**Beneficiary:**

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

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:_____

**Drug requested:** ☐ Boniva IV ☐ Forteo ☐ Prolia ☐ Reclast ☐ Xgeva

**Dose & frequency:** _____

**Diagnosis/indication:**

☐ Treatment of postmenopausal osteoporosis ☐ Treatment of male osteoporosis

☐ Paget's Disease ☐ Treatment of glucocorticoid induced osteoporosis

☐ Bone metastases from solid tumors (tumor type: _____)

☐ Other (Please Explain) _____

**Has the member previously tried the following preferred medication?**

| ***Drug:*** | ***Response:*** |
|---|---|
| ☐ Alendronate Oral | ☐ side-effect ☐ treatment failure* dates of use: _____ |

*Treatment failure is defined as documented continued bone loss or fracture after one or more years despite treatment with the bisphosphonate.

Prescriber comments: _____

_____

_____

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

# Botulinum Toxins

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

**CRITERIA FOR APPROVAL:**

**BOTOX (onabotulinumtoxinA),:**

- The indication for use is:
  - Strabismus and blepharospasm associated with dystonia, including essential blepharospasm, VII cranial nerve disorders/hemifacial spasm
  - Focal dystonias, including cervical dystonia, spasmodic dysphonia, oromandibular dystonia
  - Limb spasticity (e.g., due to cerebral palsy, multiple sclerosis, or other demyelinating CNS diseases)
  - Focal spasticity (e.g., due to hemorrhagic stroke, anoxia, traumatic brain injury)
  - Axillary Hyperhidrosis (if member has failed an adequate trial of topical therapy)
  - Overactive bladder or detrusor overactivity (if member has failed an adequate trial of at least TWO urinary antispasmodics (either short- or long-acting formulations)
  - Chronic migraine (>15 days per month with headache lasting 4 hours a day or longer) and the member has failed or has a contraindication to an adequate trial of at least TWO medications for migraine prophylaxis from at least two different classes (tricyclic antidepressants, beta-blockers, calcium channel blockers or anticonvulsants)

**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, chronic migraine or overactive bladder/detrusor overactivity.

**Dysport (abobotulinumtoxinA):**

- The patient has a diagnosis of cervical dystonia or spasmodic torticollis

**AND**

- The patient is ≥18 years of age

**AND**

- The patient has had a treatment failure with BOTOX®.

**Myobloc (rimabotulinumtoxinB):**

- The patient has a diagnosis of focal dystonias, including cervical dystonia, spasmodic dysphonia, oromandibular dystonia

**AND**

- The patient is ≥16 years of age

**Xeomin (incobotulinumtoxinA):**

- The patient has a diagnosis of cervical dystonia or blepharospasm.

**AND**

- The patient is ≥18 years of age

**AND**

- The patient has had a documented intolerance or treatment failure with BOTOX®.

**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® 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® (onabotulinumtoxinA, formerly type A )does not equal one unit of Myobloc® (rimabotulinumtoxinB, formerly type B) does not equal one unit of Dysport (abobotulinumtoxinA) does not equal one unit of Xeomin (incobotulinumtoxinA). 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**.
- ✓ All requests for botulinum toxin (whether billed through the pharmacy or medical benefit) require Prior Authorization through the MedMetrics Clinical Call Center: Botox (J0585), Dysport (J0586), Myobloc (J0587) or Xeomin (J0588)

## Botulinum Toxins

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| | BOTOX® (onabotulinumtoxinA)<br>Myobloc® (rimabotulinumtoxinB)<br><br>**Available after a BOTOX® treatment failure for select indications:**<br>Dysport® (abobotulinumtoxinA)<br>Xeomin® (incobotulinumtoxinA) |

# BPH Agents

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Alpha Blockers**

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

**Androgen Hormone Inhibitors**

- **Avodart:** The patient has a diagnosis of BPH (benign prostatic hypertrophy) AND the patient has a documented side effect, allergy or treatment failure to generic finasteride.
- **Proscar:** The patient has a diagnosis of BPH (benign prostatic hypertrophy) AND the patient has a documented intolerance to generic finasteride.
- **Finasteride for males age < 45:** The patient has a diagnosis of BPH (benign prostatic hypertrophy)

**Combination Product**

- **Jalyn:** The patient has a diagnosis of BPH (benign prostatic hypertrophy) AND the patient has a documented treatment failure/inadequate response to combination therapy with generic tamsulosin and finasteride.

**LIMITATIONS:**
Coverage of androgen hormone inhibitors will not be approved for cosmetic use in men or women (male-pattern baldness/alopecia or hirsutism). (This includes Propecia® (finasteride) whose only FDA approved indication is for treatment of male pattern hair loss.)

**DOCUMENTATION:**

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

## BPH Agents

*Length of authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **ALPHA BLOCKERS** | |
| DOXAZOSIN† (compare to Cardura®)<br>TAMSULOSIN† (compare to Flomax®)<br>*Quantity Limit = 2 capsules/day*<br>TERAZOSIN† (previously Hytrin®) | Cardura®* (doxazosin)<br>Cardura XL® (doxazosin)<br>*Quantity Limit = 1 tablet/day*<br>Flomax®* (tamsulosin)<br>*Quantity Limit = 2 capsules/day*<br>Rapaflo® (silodosin) *Quantity Limit = 1 capsule/day*<br>Uroxatral® (alfuzosin)<br>*Quantity Limit = 1 tablet/day* |
| **ANDROGEN HORMONE INHIBITORS** | |
| FINASTERIDE† (compare to Proscar®) *(QL = 1 tablet/day)* | Avodart® (dutasteride) (*QL = 1 capsule/day)*<br>finasteride† (compare to Proscar®) females; males age < 45 *(QL = 1 tablet/day)*<br>Proscar® *(finasteride) *(QL = 1 tablet/day)* |
| **COMBINATION PRODUCT** | |
| | Jalyn® (dutasteride/tamsulosin) (*QL = 1 capsule/day)* |

# Cardiac Glycosides

**LENGTH OF AUTHORIZATION:** not applicable

**CRITERIA FOR APPROVAL:** not applicable

## Cardiac Glycosides

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| DIGOXIN†<br>DIGOXIN† Oral Solution<br>LANOXIN® (digoxin) | |

# Chemical Dependency: Alcohol and Opiate Dependency

**LENGTH OF AUTHORIZATION:** Vivitrol - 6 months, no renewal

All others – Up to 1 year

**CRITERIA FOR APPROVAL:**

**Alcohol/Opiate Dependency: Revia, Antabuse**

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

**Alcohol/Opiate Dependency: Vivitrol**

- Diagnosis of alcohol dependency

  AND
- An inadequate response, adverse reaction, or contraindication to 1 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

  OR
- Diagnosis is prevention of relapse to opioid dependency

  AND
- The patient has failed Suboxone therapy or is not a candidate for Suboxone therapy (eg. Patient is opiate free and prescriber wishes to prevent relapse to opioid dependence without using maintenance therapy) or patient requires injectable therapy (compliance, tolerance, etc).

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

  ALSO
- 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)

**Opiate Dependency: Suboxone, Buprenorphine**

- 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
- A "Pharmacy Home" for all prescriptions has been selected (Pharmacy located or licensed in VT)

  AND
- Patients new to Suboxone (no claims in last 60 days) will be prescribed Suboxone Film (not SL tablet).

  AND
- Patients new to Suboxone (no claims in last 60 days) will be subject to a quantity limit of 16 mg/day.

  AND
- Requests for Suboxone SL tablet after documented intolerance of Suboxone Film must include a completed MedWatch form that will be submitted by DVHA to the FDA.

  AND
- If buprenorphine (formerly Subutex) is being requested,
  - Patient is either pregnant and history (copy of positive pregnancy test) has been submitted (duration of PA will be one 1 month post anticipated delivery date)

    OR
  - Patient is breastfeeding a methadone or morphine dependent baby and history from the neonatologist or pediatrician has been submitted.

**Smoking Cessation Products**: See "Smoking Cessation Therapies"

**DOCUMENTATION:**

- ✓ Document clinically compelling information supporting the use of Vivitrol® or Suboxone®/buprenorphine 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 up to 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **ALCOHOL DEPENDENCY**<br>CAMPRAL® (acamprosate)<br>DISULFIRAM† 250 mg, 500 mg tab (compare to Antabuse®)<br>NALTREXONE oral † (compare to Revia®) | Antabuse®* (disulfiram)<br>Revia®* (naltrexone oral)<br>Vivitrol® (naltrexone for extended-release injectable suspension) *(QL = 1 injection (380 mg) per 30 days)* |
| **OPIATE DEPENDENCY**<br><br>NALTREXONE oral † (compare to Revia®)<br><br>**Preferred Agent after Clinical Criteria are Met**<br><br>SUBOXONE® sublingual FILM (buprenorphine/nalaxone)<br>*QL = 2 films per day (8 mg strength)*<br>*or 3.5 films per day (2 mg strength)*<br>*(Maximum daily Dose = 16 mg/day)*<br><br>***Maximum days supply for Suboxone is 14 days***<br><br>Note: Methadone for opiate dependency may only be prescribed through a Methadone Maintenance Clinic | buprenorphine† sublingual TABLET(formerly Subutex®)<br>*QL = 3 tablets per day (2 mg strength)*<br>*or 2 tablets/day (8 mg strength)*<br>*(Maximum Daily Dose = 16 mg/day)*<br><br>Revia®* (naltrexone oral)<br><br>Suboxone® sublingual TABLET (buprenorphine/nalaxone)<br>*QL = 2 tablets per day (8 mg strength)*<br>*or 3.5 tablets per day (2 mg strength)*<br>*(Maximum daily Dose = 16 mg/day)*<br><br>****Maximum days supply for Suboxone/buprenorphine is 14 days****<br><br>**For Prevention of Relapse to Opioid Dependency**<br><br>Vivitrol® (naltrexone for extended-release injectable suspension) *(QL = 1 injection (380 mg) per 30 days)* |

VERMONT

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

*Agency of Human Services*

# ~BUPRENORPHINE ~

Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of buprenorphine/Suboxone®). These criteria are based on concerns about safety and the potential for abuse and diversion. All requests must be submitted using this fax form.

## Submit request via Fax (only): 1-866-767-2649

**Prescribing physician:**

Name:_____

Phone #:_____

Fax #:_____

Address:_____

**Beneficiary:**

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Contact Person at Office: _____

► Please answer the following questions:

| | |
|---|---|
| Is buprenorphine being prescribed for opiate dependency? | ☐ Yes ☐ No |
| Does the prescriber signing this form have a DATA 2000 waiver ID number ("X-DEA license")? | ☐ Yes ☐ No |
| Has the prescriber queried the VPMS (Vermont Prescription Monitoring System) to review patient's scheduled II-IV medication history? | ☐ Yes ☐ No<br>☐ Not signed up |
| A "Pharmacy Home" for **ALL** prescriptions has been selected **AND** discussed with patient? (Pharmacy must be located/licensed in VT)<br>Pharmacy Name:_____<br>Pharmacy Phone #: _____ | ☐ Yes ☐ No |
| Has patient filled a Suboxone RX in last 60 days | ☐ Yes ☐ No ☐ Don't know |
| Request is for the following medication: Sublingual **FILM** | ☐ Suboxone® (buprenorphine/naloxone) |
| Request is for the following medication: Sublingual **TABLET** | ☐ Suboxone® (buprenorphine/naloxone)<br>☐ Buprenorphine (formerly Subutex®) |
| Anticipated maintenance dose/frequency: (target dose of no more than 16 mg/day) (maximum 14 day supply per prescription fill)<br>Dose:_____ Frequency:_____ (recommended once daily) | |
| If this request is for Buprenorphine (formerly Subutex®), please answer the following questions:<br>Is the member pregnant? (please provide positive pregnancy test copy)<br>If yes, anticipated date of delivery: _____ | ☐ Yes ☐ No |
| Is the member breastfeeding a methadone or morphine dependent baby? (please provide history from neonatologist or pediatrician) | ☐ Yes ☐ No |
| Would you have referred your patient to a methadone clinic if this option was conveniently located and available? | ☐ Yes ☐ No |
| Additional clinical information to support PA request: | |

**Prescriber Signature: _____ (stamps not acceptable)**

**Prescriber X-DEA License #: _____ Date of request: _____**

VERMONT

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

*Agency of Human Services*

# ~VIVITROL~

Prior Authorization Request Form

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

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

**Prescribing physician:**

Name:_____

Phone #:_____

Fax #:_____

Address:_____

**Beneficiary:**

Name:_____

Medicaid ID #:_____

Date of Birth:_____Sex:_____

Contact Person at Office: _____

**Administering physician:**

Name: _____ Address: _____

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

### QUALIFICATIONS

| | |
|---|---|
| **MDs** | Prescribers must secure direct delivery of Vivitrol from the pharmacy to the physician's office. Pharmacies may not dispense Vivitrol directly to the patient. Vivitrol **may not** be billed through the Medical Benefit as a J-Code J2315. |

### PROCESS

► Please answer the following questions:

| | |
|---|---|
| Patient diagnosis ? | □ Alcohol dependence □ Prevention of relapse to opioid dependency |
| Has the patient been opiate free for > 7 – 10 days | □ Yes □ No |
| **For alcohol dependence:**<br>**(1)** Has the patient tried any of the following? Please document below.<br>oral naltrexone: □ side-effect □ non-response □ allergy<br>acamprosate: □ side-effect □ non-response □ allergy<br>disulfiram: □ side-effect □ non-response □ allergy | □ Yes □ No |
| **(2)** Has patient had a recent hospital admission for alcohol detoxification? | □ Yes □ No<br>If yes, date: ____/_____/____ |
| **For prevention of relapse to opioid dependency**<br>**(1)** Has the patient failed buprenorphine therapy?<br>**(2)** Is the patient not a candidate for buprenorphine therapy?<br>**(3)** Patient requires injectable therapy? | □ Yes □ No<br>□ Yes □ No<br>□ Yes □ No |
| Comments and additional patient history: | |

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

# Compounded Products

**Review Guidelines for Appropriateness of Compounded Products**

Compounding of medication may be allowed:

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

A compound drug will only be covered if it is

- Considered medically necessary according to specified criteria as detailed below **and**
- Commercially available alternative agents have been previously tried with therapeutic failure or patient intolerance (Exception: Compounded injections of 17-alpha hydroxyprogesterone caproate are covered due to physicians' prior success with this compounded product and the FDA and CMS allowance)

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). (see also exception for 17-alpha hydroxyprogesterone caproate injection above)
- 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 this practice is acceptable to the FDA.

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

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

Relistor: 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**.

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

*Length of Authorization:* Amitiza: Initial PA of 3 months, and 12 months thereafter , Relistor: *3 months*

**Key: † Generic product**

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **Bulk-Producing Laxatives**<br>PSYLLIUM† | Amitiza® (lubiprostone) *(Qty limit = 2 caps/day)* |
| **Osmotic Laxatives**<br>LACTULOSE†<br>POLYETHYLENE GLYCOL 3350 (PEG)†<br>(compare to Miralax®) | Relistor® (methylnatrexone) |
| **Stimulant Laxative**<br>BISACODYL†<br>SENNA† | |
| **Stool Softener**<br>DOCUSATE† | |

# Contraceptives: Vaginal Ring

**LENGTH OF AUTHORIZATION:** not applicable

**CRITERIA FOR APPROVAL:** not applicable

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

# Coronary Vasodilators/Antianginals: Oral and Topical

**LENGTH OF AUTHORIZATION**: 3 years

**CRITERIA FOR APPROVAL:**

**Dilatrate-SR®, Imdur®:**

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

**Ismo®, Isordil®, Monoket®, Isosorbide dinitrate SL tablet:**

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

**Nitro-Dur®:**

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

**Bidil®:**

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

**Ranexa®:**

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

**AND**

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

**AND**

- The patient does not have any of the following conditions:
  - Hepatic insufficiency
  - Concurrent use of medications which may interact with Ranexa®:
    - 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®.

**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 |
|---|---|
| **ORAL** | |
| ISOSORBIDE DINITRATE† tab (compare to Isordil®)<br>ISOSORBIDE DINITRATE† ER tablet<br>ISOSORBIDE MONONITRATE† tab (compare to, Ismo®, Monoket®)<br>ISOSORBIDE MONONITRATE† ER tab (compare to Imdur®)<br>NITROGLYCERIN† SL tablet<br>NITROGLYCERIN† ER capsule<br>NITROLINGUAL PUMP SPRAY®<br>NITROGLYCERIN SPRAY LINGUAL† (compare to Nitroglycerin Pump Spray®)<br>NITROMIST® Lingual Spray<br>NITROQUICK® (nitroglycerin SL tablet)<br>NITROSTAT® (nitroglycerin SL tablet)<br>NITRO-TIME® (nitroglycerin ER capsule) | Dilatrate-SR® (isosorbide dinitrate SR cap)<br>Imdur®* (isosorbide mononitrate ER tablet)<br>Ismo®* (isosorbide mononitrate tablet)<br>Isosorbide dinitrate SL tablet<br>Isordil®* (isosorbide dinitrate tab)<br>Monoket®* (isosorbide mononitrate tablet)<br><br>BiDil® (isosorbide dinitrate/hydralazine)<br><br>Ranexa® (ranolazine) *(QL = 3 tablets/day (500 mg), 2 tablets/day (1000 mg))* |
| **TOPICAL** | |
| NITREK® (nitroglycerin transdermal patch)<br>NITRO-BID® (nitroglycerin ointment)<br>NITROGLYCERIN TRANSDERMAL PATCHES† (compare to Nitro-Dur®) | Nitro-Dur®* (nitroglycerin transdermal patch) |

# Corticosteroids: Oral

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL (NON-PREFERRED):**

**Entocort EC®:**

- The patient had a documented intolerance to the generic budesonide 24 hr capsules.

**All Others:**

- 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**.

## Corticosteroids: Oral

*Length of authorizations: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| BUDESONIDE 24HR (compare to Entocort EC®) | Celestone® (betamethasone) oral solution |
| CORTISONE ACETATE† | Cortef®* (hydrocortisone) |
| DEXAMETHASONE† | Entocort EC®* (budesonide 24 hr cap) |
| DEXPAK® tabs (dexamethasone taper pack) | Flo-Pred® (prednisolone) oral suspension |
| HYDROCORTISONE† (compare to Cortef®) | Medrol®* (methylprednisolone) |
| METHYLPREDNISOLONE† (compare to Medrol®) | Millipred® (prednisolone) oral solution |
| ORAPRED® oral solution/ODT (prednisolone sod phosphate) (age < 12 yrs) | Orapred® oral solution* (prednisolone) (age ≥ 12 yrs) |
| PREDNISOLONE† tablets/liquid (compare to Pediapred®, Prelone®) | Orapred® ODT (prednisolone) (age ≥ 12 yrs) |
| PREDNISONE† | Pediapred®* (prednisolone) |
| | Prelone®* (prednisolone) |
| | Veripred® 20 oral solution (prednisolone sodium phosphate) |

# Cough and Cold Preparations

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

**CRITERIA FOR APPROVAL:**

**Tussionex®, TussiCaps®, Hydrocodone/chlorpheniramine suspension (generic)**

- The patient has had a documented side effect, allergy, or treatment failure to two of the following generically available cough or cough/cold products: hydrocodone/homatropine (compare to Hycodan®), promethazine/codeine (previously Phenergan® with Codeine), guaifenesin/codeine (Cheratussin AC®).or benzonatate.

AND

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

AND

- The quantity requested does not exceed 60 ml (Tussionex®) or 12 capules (TussiCaps®).

AND

- If the request is for Tussionex®, the patient has a documented intolerance to generic hydrocodone/chlorpheniramine suspension.

**All Other Brands**

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

**DOCUMENTATION:**

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

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

**Key: † Generic product**

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| All generics<br>MUCINEX® (guaifenesin)<br><br>PA required for Age < 2 years old for all products (brand and generic) | Hydrocodone/chlorpheniramine (compare to Tussionex® ) *(QL = 60 ml)*<br><br>Tussionex® (hydrocodone/chlorpheniramine) *(QL = 60 ml)*<br>TussiCaps® (hydrocodone/chlorpheniramine) *(QL = 12 capsules/RX)*<br>All other brands<br><br>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®) or > 12 years old (Arcalyst®)

AND

- If the request is for Arcalyst®, the patient must have a documented side effect, allergy, treatment failure or a contraindication to Ilaris® (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® or Ilaris® on a **General Prior Authorization Form**.
- ✓ All requests for canakinumab (Ilaris®) (whether billed through the pharmacy or medical benefit (J0638)) or rilonacept (Arcalyst®) (whether billed through the pharmacy or medical benefit (J2793)) require Prior Authorization through the MedMetrics Clinical Call Center.

## CAPS Injectables

*Length of Authorization: 1 year*

| PREFERRED AFTER CLINICAL CRITERIA ARE MET | PA REQUIRED |
|---|---|
| Ilaris® (canakinumab) *(QL=1 vial/56 days)* | Arcalyst® (rilonacept) *(QL = 2 vials for loading dose, then 1 vial per week)* |

# Cystic Fibrosis: Medications

***NOTE*: Kalydeco®, TOBI® and Pulmozyme®must be obtained and billed through our specialty pharmacy vendor, Ascend. Please see the Cystic Fibrosis Prior Authorization/Patient Enrollment Form for instructions. Ascend will not be supplying Cayston® at this time (obtainable through several other specialty pharmacies).**

**LENGTH OF AUTHORIZATION:** Kalydeco®: 3 months initial, then 1 year

All others: 1 year

**CRITERIA FOR APPROVAL:**

**Cayston®, Pulmozyme®:**

- The diagnosis or indication is cystic fibrosis.

**Kalydeco®:**

- The patient has a diagnosis of Cystic Fibrosis with documented G551D mutation (documentation provided).

  AND
- The patient is ≥ 6 years old.

Note: Renewal of Prior Authorization will require documentation of member response.

**DOCUMENTATION:**

- ✓ Document clinically compelling information supporting the choice of **Cayston** on a **General Prior Authorization Request Form**.
- ✓ Document clinical information for **Pulmozyme®** and **TOBI®** on its **Prior Authorization/Patient Enrollment Form.**
- ✓ Document clinical information for **Kalydeco®** on a **General Specialty Prior Authorization/Patient Enrollment Form.**

| **Cystic Fibrosis: Medications** | *Length of Authorization: 1 year* |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| TOBI® (tobramycin) inhalation solution<br>*(Quantity Limit = 56 vials/56 days; maximum days' supply = 56 days)(2 vials/day for 28 days, then 28 days off)* | Cayston® (aztreonam) inhalation solution<br>*(Quantity Limit = 84 vials/56 days; maximum days' supply = 56 days)(3 vials/day for 28 days, then 28 days off)*<br><br>Kalydeco® (ivacaftor) tablets<br>*(Quantity Limit = 2 tablets/day, maximum days' supply = 30 days)*<br><br>Pulmozyme® (dornase alfa) inhalation solution<br>*(Quantity Limit =60/30 days; maximum days' supply=30 days)* |

VERMONT

**CYSTIC FIBROSIS MEDICATION – 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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

Please Note: Cayston® and pancreatic enzymes are not obtained though Ascend Specialty Pharmacy.

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**Department of Vermont Health Access**

## PRIOR AUTHORIZATION REQUEST/PRESCRIPTION

### CYSTIC FIBROSIS INHALATION MEDICATION

**Patient Diagnosis:**

☐ Cystic Fibrosis ☐ Other:_____

(Requires Review by DVHA Medical Director)

**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: Actinic Keratosis Therapy

**LENGTH OF AUTHORIZATION:** 16 weeks

**CRITERIA FOR APPROVAL:**

**Imiquimod (generic) cream:**

- The patient has had a documented intolerance to brand Aldara®.

**Efudex:**

- The patient has had a documented intolerance with generic topical fluorouracil 5% cream or solution
.

**Solaraze Gel:**

- The diagnosis or indication is actinic keratosis

**AND**

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

**Zyclara Cream:**

- The diagnosis or indication is actinic keratosis on the face or scalp

**AND**

- The patient has had a documented side effect, allergy, or treatment failure with 5-fluorouracil and Aldara® or generic imiquimod 5% cream.

**OR**

- The treatment area is greater than 25 $cm^2$ on the face or scalp.

**AND**

- The patient has had a documented side effect, allergy, or treatment failure with 5-fluorouracil.

**DOCUMENTATION:**

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

## Dermatological Agents: Actinic Keratosis Therapy

*Length of Authorization: 16 weeks*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| ALDARA® (imiquimod) 5 % Cream<br>FLUOROURACIL† (compare to Efudex®) 5% cream, 5%, 2% solution<br>CARAC® (fluorouracil) 0.5% cream<br>FLUOROPLEX® (fluorouracil) 1% cream | Efudex®* (fluorouracil) 5% cream, solution<br>Imiquimod† (compare to Aldara®) 5 % cream<br>Solaraze® (diclofenac sodium) 3 % Gel<br>*Qty Limit = 1 tube/30 days*<br>Zyclara (imiquimod) 3.75 % Cream<br>*Qty Limit = 56 packets/6 weeks*<br>Zyclara (imiquimod) 3.75 % Cream Pump<br>*Qty Limit = 2 pumps/8 weeks* |

# Dermatological Agents: Antibiotics: Topical

**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 ointment

AND

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

**Bactroban® Cream or Ointment:**

- The patient has had a documented intolerance with mupirocin ointment

**Cortisporin® Cream or Ointment, Gentamicin Cream or Ointment:**

- The patient has had a documented side-effect, allergy or treatment failure with at least one preferred generic topical antibiotic

**Neosporin®/ Polysporin®:**

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

**DOCUMENTATION:**

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

## Dermatological Agents: Antibiotics: Topical

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

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **Single Agent** | |
| BACITRACIN† | Altabax® (retapamulin) *QL = 1 tube* |
| MUPIROCIN OINTMENT† (compare to Bactroban®) | Bactroban® (mupirocin) Cream or Ointment<br>Gentamicin Cream or Ointment |
| **Combination Products** | |
| BACITRACIN-POLYMYXIN† | |
| NEOMYCIN-BACITRACIN-POLYMYXIN† | Cortisporin® Cream (neomycin-polymyxin-hydrocortisone)<br>Cortisporin® Ointment(bacitracin-neomycin-polymyxin-hydrocortisone)<br>Neosporin®* (neomycin-bacitracin-polymyxin)<br>Polysporin®* (bacitracin-polymixin) |
| | **All other branded products** |

Note: Bactroban® Nasal Ointment is not included in this managed category.

# Dermatological Agents: Antifungals: Onychomycosis

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL (CICLOPIROX/PENLAC SOLUTION):**

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

**AND**

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

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

**LIMITATIONS:**
Coverage of Onychomycosis agents will **NOT be approved solely for cosmetic purposes.**
Kits with multiple drug products or non-drug items not covered.

**DOCUMENTATION:**

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

## Dermatological Agents: Antifungals: Onychomycosis

*Length of Authorization: 1 year*

**Key: † Generic product**

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

# Dermatological Agents: Antifungals: Topical

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

**All drugs (except Vusion):** All indications: 3 months
**Vusion:** Diaper dermatitis: up to 50 g/month (1 tube) for up to 1 month

**CRITERIA FOR APPROVAL:**

**All Brands (except Vusion):**

- The patient has had a documented side effect, allergy, or treatment failure to at least TWO different preferred generic topical antifungal agents. (If a product has an AB rated generic, one trial must be the generic equivalent of the requested product.)

OR

- The patient has a contraindication that supports the need for a specific product or dosage form of a brand topical antifungal.

**Ketoconazole Foam:**

- The patient has had a documented side effect, allergy, or treatment failure to at least TWO different preferred generic topical antifungal agents.

**Vusion®:**

- The patient has a diagnosis of diaper dermatitis complicated by documented candidiasis

AND

- The patient is at least 4 weeks of age.

AND

- The patient has had two trials (with two different preferred antifungal agents) used in combination with a zinc oxide diaper rash product resulting in documented side effects, allergy, or treatment failures.

**DOCUMENTATION:**

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

## Dermatological Agents: Antifungals: Topical *Length of Authorization: up to 3 months*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **Single Agent**<br>CICLOPIROX † (compare to Loprox®) 0.77% C, Sus, G; 1%Sh<br>CLOTRIMAZOLE†(formerly Lotrimin®) 1% C, S<br>ECONAZOLE † (formerly Spectazole®) 1% C<br>KETOCONAZOLE † (compare to Kuric®, Nizoral®) 2% C, 2% Sh<br>MICONAZOLE † all generic/OTC products<br>NYSTATIN † O, C, P (compare to Mycostatin®, Nystop®, Pedi-Dri®, Nyamyc®)<br>TOLNAFTATE † (compare to Tinactin®) 1% C, P, Sp, S | Ertaczo® (sertaconazole) 2% C<br>Exelderm® (sulconazole) 1% C, S<br>Extina® (ketoconazole) 2% F<br>Ketoconazole† (compare to Extina®) 2 % Foam<br>Kuric®* (ketoconazole) 2% C<br>Lamisil RX/OTC® (terbinafine) 1% C, S, Sp, G<br>Loprox®* (ciclopirox) 0.77% C, S, G; 1% Sh<br>Lotrimin AF®* OTC (clotrimazole) 1% C, S, L<br>Mentax®/ Lotrimin Ultra® OTC (butenafine) 1% C<br>Mycostatin®* (nystatin) C, P<br>Naftin® (naftifine) 1% & 2% C, 1% G<br>Nizoral®* (ketoconazole) 2% Sh<br>Nizoral A-D® OTC (ketoconazole) 1% Sh<br>Nystop®, Pedi-Dri®, Nyamyc®* (nystatin) P<br>Oxistat® (oxiconazole) 1% C, L<br>Tinactin®/Tinactin AT OTC* (tolnaftate) 1% C, P, Sp, S<br>Xolegel® (ketoconazole) 2% G<br><br>**All other branded products** |
| **Combination Products**<br>CLOTRIMAZOLE W/BETAMETHASONE † (compare to Lotrisone®) C, L<br>NYSTATIN W/TRIAMCINOLONE † (formerly Mycolog II®) C, O | Lotrisone®* (clotrimazole w/betamethasone) C, L<br>Vusion® (miconazole w/zinc oxide) O<br>*(QL=50 g/30 days)*<br><br>**All other branded products** |

*C=cream, F=foam, G=gel, L=lotion, P=powder, S=solution, Sh=shampoo, Sp=spray, Sus=suspension*

**Note**: Please refer to "Anti-Infectives: Antifungals: Topical: Onychomycosis" for ciclopirox solution and Penlac® Nail Lacquer

# Dermatological Agents: Antivirals: Topical

**LENGTH OF AUTHORIZATION:** 6 months

**CRITERIA FOR APPROVAL:**

**Denavir®:**

- The patient has a diagnosis of oral herpes simplex infection.

**Zovirax®:**

- If prescribed for the treatment of oral herpes simplex infection, the patient has had a documented side effect, allergy, or treatment failure (at least one course of four or more days) with Denavir®.

**LIMITATIONS:**

Xerese® (acyclovir/hydrocortisone) 5-1% cream combination not covered. Agents may be prescribed separately.

** Topical antiviral therapy offers minimal clinical benefit in the treatment of genital herpes and its use is discouraged by the CDC so topical antiviral therapy will not be approved for this indication. **

**DOCUMENTATION:**

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

**Dermatological Agents: Antivirals: Topical** *Length of Authorization: 6 months*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| ABREVA OTC (docosanol) 10% C | Denavir® (penciclovir) 1% C<br>Zovirax® (acyclovir) 5% C, O |

*C=cream, O=ointment*

# Dermatological Agents: Corticosteroids

**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**.

# Dermatological Agents: Corticosteroids

*Length of Authorization: up to 6 months*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **LOW POTENCY**<br><br>ALCLOMETASONE 0.05% C, O† (compare to Aclovate®)<br>DESONIDE† 0.05% C, L, O (compare to DesOwen®)<br>FLUOCINOLONE 0.01% C, S oil† (Derma-Smoothe, formerly Synalar®)<br>HYDROCORTISONE† 0.5%, 1%, 2.5% C; 1%, 2.5% L, 0.5%, 1%, 2.5% O<br>HYDROCORTISONE ACETATE† 1% C; 1% O (all generics) | Aclovate®* (alclometasone) 0.05% C, O<br>Capex® (fluocinolone) 0.01% shampoo<br>Derma-Smoothe®* (fluocinolone 0.01%) oil<br>Desonate® (desonide) 0.05% G<br>DesOwen®* (desonide) 0.05% C, L, O<br>Nucort 2% lotion (hydrocortisone acetate)<br>Verdeso® (desonide) 0.05% F<br>All other brands |
| **MEDIUM POTENCY**<br><br>BETAMETHASONE DIPROPIONATE† 0.05% L (formerly Diprosome®)<br>BETAMETHASONE VALERATE† 0.1% C, L (formerly Beta-Val®)<br>FLUOCINOLONE† 0.025% C, O (formerly Synalar®)<br>FLUTICASONE † 0.05% C; 0.005% O (compare to Cutivate®)<br>HYDROCORTISONE BUTYRATE† 0.1% C, O, S (compare to Locoid®)<br>HYDROCORTISONE VALERATE† 0.2% C, O (compare to Westcort®)<br>MOMETASONE FUROATE† 0.1% C, L, O (compare to Elocon®)<br>TRIAMCINOLONE ACETONIDE† 0.025%, 0.1% C, L, O (formerly Aristocort®, Kenalog®) | Cloderm® (clocortolone) 0.1% C<br>Cordran® (all products)<br>Cutivate®*(fluticasone) 0.05% C; 0.005% O<br>Cutivate®(fluticasone) 0.05% L<br>Dermatop® (prednicarbate) 0.1% C, O<br>desoximetasone 0.05% C, O (compare to Topicort®)<br>Elocon®* (all products)<br>fluticasone† (compare to Cutivate®) 0.05% L<br>Locoid®* (hydrocortisone butyrate) 0.1% C, O, S<br>Locoid® (hydrocortisone butyrate) 0.1% L<br>Luxiq® (betamethasone valerate) F<br>prednicarbate† (compare to Dermatop®) 0.1% C, O<br>Topicort®* (desoximetasone) 0.05% C, O<br>Trianex®* (triamcinolone) 0.05% O<br>Westcort®* (hydrocortisone valerate) all products<br>All other brands |
| **HIGH POTENCY**<br><br>AMCINONIDE† (formerly Cyclocort®)<br>AUGMENTED BETAMETHASONE† 0.05% C (compare to Diprolene® AF)<br>BETAMETHASONE VALERATE† 0.1% O (formerly Beta-Val®)<br>DESOXIMETASONE† 0.05% G; 0.25% C, O (compare to Topicort®)<br>FLUOCINONIDE† 0.05% C, G, O, S (formerly Lidex®)<br>TRIAMCINOLONE ACETONIDE† 0.5% C, O (formerly Aristocort®) | Apexicon E® (diflorasone) 0.05% C<br>Diflorasone diacetate 0.05% C (compare to Apexicon E®)<br>Diprolene® AF* (augmented betamethasone) 0.05% C<br>Halog® (halcinonide) all products<br>Topicort®* (desoximetasone) 0.05% G; 0.25% C, O<br>All other brands |
| **VERY HIGH POTENCY**<br><br>ALPHATREX (augmented betamethasone) 0.05% G<br>APEXICON (diflorasone) 0.05% O<br>AUGMENTED BETAMETHASONE† 0.05% L, O (compare to Diprolene®), 0.05% G<br>CLOBETASOL PROPIONATE† (compare to Temovate®/Cormax®)<br>CLOBETASOL PROPIONATE† 0.05% F (compare to Olux®)<br>CORMAX (clobetasol propionate) 0.05% C, O, S<br>DIFLORASONE DIACETATE† 0.05% O (compare to Apexicon®, formerly Psorcon E®)<br>HALOBETASOL PROPRIONATE† (compare to Ultravate®) | Clobetasol propionate† (compare to Clobex®) 0.05% L, Sh<br>Clobex® (clobetasol propionate) 0.05% L, shampoo, spray<br>Diprolene®* (augmented betamethasone) 0.05% L, O<br>Olux® * /Olux E® (clobetasol propionate) 0.05% F<br>Temovate®* (clobetasol propionate) 0.05% C, G, O, S<br>Vanos® (fluocinonide) 0.1% C<br>Ultravate®* (halobetasol propionate) 0.05% C, O<br>All other brands |

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

# Dermatological Agents: Genital Wart Therapy

**LENGTH OF AUTHORIZATION**: up to 16 weeks

Veregen, imiquimod: up to 16 weeks

Zyclara: up to 8 weeks

All other products: up to 1 month

**CRITERIA FOR APPROVAL:**

**Condylox® gel, Veregan®:**

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

**Condylox®* solution:**

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

**Imiquimod (generic) cream:**

- The patient has had a documented intolerance to brand Aldara®.

**Zyclara® cream:**

- The diagnosis or indication is external genital/perianal warts or condyloma acuminata

AND

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

**DOCUMENTATION:**

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

| **Dermatological Agents: Genital Wart Therapy** *Length of Authorization: up to 16 weeks*<br>**Key: † Generic product, *Indicates generic equivalent is available without a PA** | |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| ALDARA® (imiquimod 5%) | Imiquimod† 5 %(compare to Aldara®) cream |
| PODOFILOX SOLUTION† (compare to Condylox®) | Condylox® Gel (podofilox gel)<br>Condylox®* solution (podofilox solution)<br><br>Veregan® (sinecatechins ointment)<br>*(Quantity limit = 15 grams (1 tube)/per 30 days)*<br><br>Zyclara® (imiquimod 3.75%) Cream<br>*(Quantity limit = 56 packets/per 8 weeks)*<br>Zyclara® (imiquimod 3.75%) Cream Pump<br>*(Quantity limit = 2 pumps/per 8 weeks)* |

# Dermatological Agents: Immunomodulators

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

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

**CRITERIA FOR APPROVAL:**

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

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

**Dermatological Agents: Immunomodulators** *Length of Authorization: up to 1 year*

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

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

# Dermatological Agents: Scabicides and Pediculicides

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

**CRITERIA FOR APPROVAL:**

- The patient has had a documented side effect or allergy to permethrin or treatment failure with two treatments of permethrin.
- For approval of Elimite® Cream or Ovide® 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**.

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

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

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

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

# 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

**AND**

- If the request is for brand DDAVP, the patient has a documented intolerance to generic desmopressin spray or solution.

**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**.

## Desmopressin: Intranasal

*Length of Authorization: 2 years*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **Intranasal** | |
| | DDAVP® (desmopressin) Nasal Solution or Spray 0.01%<br>Desmopressin † Nasal Solution or Spray 0.01 % (compare to DDAVP®)<br>Minirin † (desmopressin) Nasal Spray 0.01%<br>Stimate® (desmopressin) Nasal Solution 1.5 mg/ml |
| **Oral** | |
| 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.

**LIMITATIONS:**
Talking monitors are not covered under the pharmacy benefit.

**DOCUMENTATION:**

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

| **Diabetic Testing Supplies** | *Length of Authorization:5 years* |
|---|---|
| **PREFERRED PRODUCTS (No PA Required)** | **PA REQUIRED** |
| **DIABETIC MONITORS/METERS** | |
| FREESTYLE LITE® SYSTEM KIT<br>FREESTYLE FLASH® SYSTEM KIT<br>FREESTYLE FREEDOM® SYSTEM KIT<br>FREESTYLE FREEDOM LITE® SYSTEM KIT<br>FREESTYLE INSULINX® METER<br>*QL – 1 meter/3 years* | Accucheck®<br>Ascensia®<br>Assure®<br>Exactech®<br>Prodigy® |
| ONE TOUCH® ULTRA 2 KIT<br>ONE TOUCH® ULTRA MINI KIT<br>ONE TOUCH® ULTRA SMART KIT<br>PRECISION XTRA® METER | All other brands and store brands |
| **DIABETIC TEST STRIPS** | |
| FREESTYLE®*<br>FREESTYLE INSULINX®*<br>FREESTYLE LITE®*<br>ONE TOUCH® BASIC*<br>ONE TOUCH® SURESTEP*<br>ONE TOUCH® FAST TAKE*<br>ONE TOUCH® UL®TRA*<br>PRECISION XTRA®*<br>PRECISION XTRA® BETA KETONE (10 count) | Accucheck®<br>Ascensia®<br>Assure®<br>Exactech®<br>Prodigy® |
| | All other brands and store brands |

* 50 and 100 count package sizes

# Estrogens: Vaginal

**LENGTH OF AUTHORIZATION:** not applicable

**CRITERIA FOR APPROVAL:** not applicable

| Estrogens: Vaginal | |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| **Estradiol**<br>ESTRACE VAGINAL® Cream<br>ESTRING® Vaginal Ring<br>VAGIFEM® Vaginal Tablets<br><br>**Conjugated Estrogens**<br>PREMARIN VAGINAL® Cream<br><br>**Estradiol Acetate**<br>FEMRING® 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**.

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

**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-Injectables (Humira® and Cimzia®) must be obtained and billed through our specialty pharmacy vendor, Ascend. Please see the Humira and Cimzia Prior Authorization/Patient Enrollment Form for instructions. Ascend may supply Remicade® upon request or you may continue to obtain through your usual supplier. Ascend will not be supplying Tysabri® at this time – please continue to obtain through your usual supplier.**

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

**CRITERIA FOR APPROVAL:**

**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.

**Cimzia®:**

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

**OR**

Patient age > 18 years

**AND**

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 prescriber must provide a clinically valid reason why Humira® cannot be used.

**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** or **Cimzia®** on its **Prior Authorization/Patient Enrollment Form** or **Tysabri®** on a **General Prior Authorization Request Form**.

- ✓ All requests for infliximab (Remicade®) (whether billed through the pharmacy or medical benefit (J1745)) or natalizumab (Tysabri®) (whether billed through the pharmacy or medical benefit (J2323)) require Prior Authorization through the MedMetrics Clinical Call Center.

## Crohn's Disease: Injectables

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

| PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET | NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET |
|---|---|
| HUMIRA® (adalimumab)<br>*Quantity limit = 6 syringes/28 days for the first month (Crohn's starter kit);2 syringes/28 days subsequently*<br>REMICADE® (infliximab) | Cimzia® (certolizumab pegol)<br>*Quantity limit = 1 kit/28 days (starter X 1, then regular)*<br>Tysabri® (natalizumab) |

# Gastrointestinals: Histamine-2 Receptor Antagonists

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

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

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

**Axid® Oral Solution, Famotidine Oral Suspension, Nizatidine Oral Solution, Pepcid® Oral Suspension, Zantac® Effervescent, Zantac® 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®) tablet<br>FAMOTIDINE† (compare to Pepcid®) tablet<br>RANITIDINE† (compare to Zantac®) tablet | Axid® (nizatidine) capsule §<br>nizatidine† (compare to Axid®) capsule §<br>Pepcid®* (famotidine) tablet§<br>ranitidine† capsule §<br>Tagamet®* tablet §<br>Zantac®* tablet § |
| **SYRUP & SPECIAL DOSAGE FORMS**<br>CIMETIDINE † ORAL SOLUTION<br>RANITIDNE † syrup (compare to Zantac®) | Axid® (nizatidine) Oral Solution §<br>famotidine† (compare to Pepcid®) oral suspension §<br>Nizatidine †Oral Solution (compare to Axid®)<br>Pepcid® (famotidine) Oral Suspension §<br>Zantac (ranitidine) Effervescent® §<br>Zantac®* (ranitidine) Syrup§ |

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

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Azulfidine®*, Colazal®*, Rowasa®*:**

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

**Asacol HD®:**

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

**Sfrowasa®:**

- The patient has had a documented intolerance to mesalamine enema.

**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**.

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

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **MESALAMINE PRODUCTS** | |
| **Oral** | |
| APRISO® (mesalamine capsule extended-release) | Asacol HD® (mesalamine tablet delayed release) |
| ASACOL® (mesalamine tablet delayed-release) | |
| LIALDA® (mesalamine tablet extended-release) | |
| PENTASA® (mesalamine cap CR) | |
| **Rectal** | |
| CANASA® (mesalamine suppository) | Rowasa®* (mesalamine enema) |
| MESALAMINE ENEMA† (compare to Rowasa®) | Sfrowasa® (mesalamine enema sulfite free) |
| **OTHER** | |
| BALSALAZIDE† (compare to Colazal®) | Azulfidine®* (sulfasalazine) |
| DIPENTUM® (olsalazine) | Colazal®* (balsalazide) |
| SULFASALAZINE† (compare to Azulfidine®) | |

# Gastrointestinals: Prokinetic Agents

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

**CRITERIA FOR APPROVAL:**

**Metozolv ODT®**

- The patient has a medical necessity for a disintegrating tablet formulation (i.e. swallowing disorder, inability to take oral medications)

**AND**

- Generic metoclopramide oral solution cannot be used

**Reglan®**

- The patient has had a documented intolerance to generic metoclopramide tablets.

**DOCUMENTATION:**

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

| **Gastrointestinals: Prokinetic Agents** ***Length of Authorization: up to 3 months*** | |
|---|---|
| Key: † Generic product, *Indicates generic equivalent is available without a PA | |
| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
| **Tablets**<br>METOCLOPRAMIDE† tabs (compare to Reglan®) | Reglan®* (metoclopramide) |
| **Oral Solution**<br>METOCLOPRAMIDE† (formerly Reglan®) oral solution | |
| **Orally Disintegrating Tablets** | Metozolv ODT® (metoclopramide) *(QL= 4 tabs/day)* |

# Gastrointestinals: Proton Pump Inhibitors

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

**CRITERIA FOR APPROVAL:**

**lansoprazole ODT, Nexium powder for suspension, Prevacid Solutabs (for patients ≥ 12 years old), Prilosec packet, Protonix packet**

- The patient has a requirement for an oral liquid dosage form. In addition, for approval of lansoprazole ODT, the patient has a documented intolerance to brand Prevacid Solutabs.

**Other non-preferred medications:**

- The member has had a documented side effect, allergy, or treatment failure to Dexilant capsules, Omeprazole RX 20 mg or 40 mg generic capsules AND Pantoprazole generic 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.

**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.

**LIMITATIONS:**

Zegerid® (omeprazole/sodium bicarbonate) RX capsules, powder for suspension not covered as no Federal Rebate offered.

**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 |
|---|---|
| **ORAL CAPULES/TABLETS** | |
| DEXILANT® (dexlansoprazole) capsules *(Quantity limit=1 cap/day)*<br>OMEPRAZOLE† 20 mg or 40 mg RX capsule (compare to Prilosec®)<br>*(Quantity limit = 1 capsule/day)*<br>PANTOPRAZOLE† tablets (compare to Protonix®) *(Quantity limit=1 tab/day)* | Aciphex® (rabeprazole) tablets § *(Quantity limit=1 tab/day)*<br>lansoprazole generic RX (compare to Prevacid®) capsules *(Quantity limit = 1 cap/day)*<br>Nexium® (esomeprazole) capsules § *(Quantity limit=1 cap/day)*<br>omeprazole †♣ generic 10 mg RX (compare to Prilosec®) capsules § *(Quantity limit=1 cap/day)*<br>omeprazole †♣ generic OTC tablets § *(Quantity limit=1 tab/day)*<br>omeprazole magnesium† generic OTC 20 mg capsules§ *(Quantity limit=1 cap/day)*<br>omeprazole/sodium bicarb) capsules RX (compare to Zegerid®RX)§ *(Quantity limit=1 cap/day)*<br>Prevacid® RX (lansoprazole) capsules § *(Quantity limit=1 cap/day)*<br>Prevacid® 24 hr OTC (lansoprazole) capsules *(Quantity limit=1 cap/day)*<br>Prilosec OTC® 20mg (omeprazole magnesium) tablets *(Quantity limit = 1 tablet/day)*<br>Prilosec®* RX (omeprazole) capsules § *(Quantity limit=1 cap/day)*<br>Protonix®* (pantoprazole) tablets *(Quantity limit=1 tab/day)*<br>Zegerid OTC® (omeprazole/sodium bicarb)caps § *(Quantity limit=1 cap/day)* |
| **SUSPENSION & SPECIAL DOSAGE FORMS** | |
| PREVACID SOLUTABS®♠ (lansoprazole) *(Quantity limit=1 tab/day)* | lansoprazole ODT† generic RX (compare to Prevacid® Solutabs) *(Quantity limit=1 tab/day)*<br>Nexium® (esomeprazole) powder for suspension *(Quantity limit=1 packet/day)*<br>Prilosec (omeprazole magnesium) packet *(Quantity limit=2 packets/day)*<br>Protonix® (pantoprazole) packet *(Quantity limit=1 packet/day)* |
| **COMBINATION** | |
| PREVPAC® (lansoprazole w/ H.pylori anti-bacterials) *(No Quantity limit applies)* | |

♣No PA required for patients < 16 years

♠ No PA required for patients < 12 years

# Gastrointestinals: Ulcerative Colitis Medications: Injectables

***Ascend Specialty 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.**
- ✓ All requests for infliximab (Remicade®) (whether billed through the pharmacy or medical benefit (J1745)) require Prior Authorization through the MedMetrics Clinical Call Center.

## Gastrointestinals: Ulcerative Colitis Medications: Injectables

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

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

# Gaucher Disease Medications

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

**CRITERIA FOR APPROVAL:**

- The diagnosis or indication is Gaucher disease (GD) type I.

AND

- The diagnosis has been confirmed by molecular or enzymatic testing.

**DOCUMENTATION:**

✓ Document clinically compelling information supporting the choice of a PA required agent on a **General Prior Authorization Request Form**.

## Gaucher Disease Medications

*Length of Authorization: initial approval 6 months, subsequent approval 1 year*

| NO PA REQUIRED | PA REQUIRED |
|---|---|
| | Cerezyme® (imiglucerase for injection)<br><br>Vpriv® (velaglucerase alfa for injection)<br><br>****Maximum days supply per fill for all drugs is 14 days**** |

# Gout Agents

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

**Colcrys®:**

- The diagnosis or indication for the requested medication is Familial Mediterranean Fever (FMF)

**OR**

- The diagnosis or indication for the requested medication is gout

**AND**

- The patient has had a documented side effect or treatment failure with at least one drug from the NSAID class.

**OR**

- The patient is not a candidate for therapy with at least one drug from the NSAID class due to one of the following:
  - The patient is 60 years of age or older
  - Patient has a 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

**Krystexxa®:**

- The diagnosis or indication is treatment of chronic gout.

**AND**

- The patient has had a documented side effect, allergy, treatment failure or a contraindication to BOTH allopurinol and febuxostat. 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.

Note: after preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval.

**Uloric®:**

- 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®:**

- 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**.
- ✓ All requests for pegloticase (Krystexxa®) (J2507) (must be billed through the medical benefit) require Prior Authorization through the MedMetrics Clinical Call Center.

## Gout Agents:

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **SINGLE INGREDIENT COLCHICINE** | Colcrys® (colchicine) tablet<br>*QL = 3 tablets/day (gout) or 4 tablets/day (FMF)* |
| **SINGLE INGREDIENT URICOSURIC AGENTS**<br>PROBENECID† | |
| **XANTHINE OXIDASE INHIBITORS**<br>ALLOPURINOL† (compare to Zyloprim®) | Uloric® (febuxostat) *QL (40 mg tablets) = 1 tablet/day*<br>Zyloprim®* (allopurinol) |
| **COMBINATION PRODUCTS**<br>COLCHICINE/PROBENECID† | |
| **PEG-URICASE AGENTS** | Krystexxa (pegloticase) Vials for IV Infusion<br>*QL = 2 vials/28 days* |

Note: Please see Analgesics: Cox-II Inhibitors and NSAID for preferred NSAID options

# Growth Stimulating Agents

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

***GROWTH HORMONE***

►See next pages for growth hormone products.

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

**CRITERIA FOR APPROVAL:**

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

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

OR

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

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

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

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

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

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

OR

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

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

**GENOTROPIN®, HUMATROPE®, NUTROPIN®, NUTROPIN® AQ, OMNITROPE®, SAIZEN®, TEV-TROPIN®**

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

- **INCRELEX®**

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

**LENGTH OF AUTHORIZATION:** 6 months

**CRITERIA FOR APPROVAL:**

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

- **SEROSTIM®**

**INDICATION:** AIDS associated wasting/anorexia

**LENGTH OF AUTHORIZATION:** 6 months

**CRITERIA FOR APPROVAL:**

- A diagnosis of AIDS associated wasting/anorexia

- **ZORBTIVE®**

**INDICATION:** Short Bowel Syndrome

**LENGTH OF AUTHORIZATION:** 4 weeks

**CRITERIA FOR APPROVAL:**

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

**DOCUMENTATION:**

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

| **Growth Stimulating Agents** | *Length of Authorization: up to1 year* |
|---|---|
| **PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET** | **NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET** |
| NORDITROPIN® | Genotropin®<br>Humatrope®<br>Nutropin®/Nutropin® AQ<br>Omnitrope®<br>Saizen®<br>Tev-Tropin®<br><br>**Specialized Indications – See Specific Criteria**<br>Increlex® (mecasermin)<br>Serostim®<br>Zorbtive® |

VERMONT

# 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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

## 3 Department of Vermont Health Access
## GROWTH STIMULATING AGENTS
### PRIOR AUTHORIZATION REQUEST

Patient Diagnosis:

Requested DVHA **PREFERRED** Growth Stimulating Agent

☐ Norditropin®

| 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® ☐ Omnitrope® ☐ Saizen® ☐ Tev-Tropin®

Medical justification: _____

_____

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

☐ Increlex® ☐ Serostim® ☐ Zorbtive®

Other information/ Prescriber comments:

## 4 PRESCRIPTION

☐ Norditropin® FlexPro 5 mg/1.5 ml ☐ Norditropin® FlexPro 10 mg/1.5 ml

☐ Norditropin® FlexPro 15 mg/1.5 ml ☐ Norditropin® NordiFlex 30 mg/3 ml

☐ 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:** _____

VERMONT

**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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

## 3 Department 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, Ascend. Please see Hepatitis C Medications (Peg-Interferon/Ribavirin) Prior Authorization/Enrollment Form and Hepatitis C Protease Inhibitors Prior Authorization/Enrollment Form for instructions.**

**LENGTH OF AUTHORIZATION:** Ribavirin/Peg-interferon = 48 weeks; Incivek = 12 weeks; Victrelis = 44 weeks (Ascend Specialty will monitor lab results and determine final duration of therapy)

**CRITERIA FOR APPROVAL:**

**Preferred Ribavirin and Pegasys**

- 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 diagnosis or indication for the requested medication is Hepatitis.

AND

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

**Rebetol® Oral Solution**

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

AND

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

**Peg-Intron® or Infergen® or Intron-A®**

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

AND

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

**Incivek® (telaprevir)**

- The diagnosis or indication for the requested medication is hepatitis C (genotype 1) infection and the patient has already been started and stabilized on the requested medication in combination with pegylated interferon and ribavirin. (Note: samples are not considered adequate justification for started and stabilized).

**OR**

- The patient has a confirmed diagnosis of chronic hepatitis C (genotype 1) infection

**AND**

- The patient is ≥ 18 years of age

**AND**

- The prescriber is, or has consulted with, a Hepatologist, Gastroenterologist, or Infectious Disease Specialist.

**AND**

- The patient has not previously failed therapy with Incivek or Victrelis

**AND**

- The requested medication will be used in combination with pegylated interferon and ribavirin.

**Victrelis® (boceprevir)**

- The diagnosis or indication for the requested medication is hepatitis C (genotype 1) infection and the patient has already been started and stabilized on the requested medication in combination with pegylated interferon and ribavirin. (Note: samples are not considered adequate justification for started and stabilized).

**OR**

- The patient is ≥ 18 years of age

**AND**

- The patient has a confirmed diagnosis of chronic hepatitis C (genotype 1) infection

**AND**

- The prescriber is, or has consulted with, a Hepatologist, Gastroenterologist, or Infectious Disease Specialist.

**AND**

- The patient has not previously failed therapy with Incivek or Victrelis

**AND**

- The patient has or will be pre-treated with ribavirin and peginterferon therapy for at least 4 weeks prior to initiating Victrelis

**AND**

- The requested medication will be used in combination with pegylated interferon and ribavirin.

**DOCUMENTATION:**

✓ Document information for the indication of the use of these medications on a **Hepatitis C Medications (Peg-Interferon/Ribavirin) Prior Authorization/Patient Enrollment Form** and **Hepatitis C Protease Inhibitors Prior Authorization/Patient Enrollment Form**.

## Hepatitis C Medications

*Length of Authorization: up to 48 weeks*

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

| PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET | NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET |
|---|---|
| **RIBAVIRIN** | |
| **Tablets/Capsules**<br>RIBAVIRIN† 200 mg tablets or capsules<br>RIBASPHERE† 200 mg tablets or capsules | Copegus®* (ribavirin 200 mg tablet)<br>Ribapak® 400 mg/600 mg, 200 mg/400 mg Dose Pack (ribavirin)<br>Rebetol®* (ribavirin 200 mg capsule)<br>Ribasphere® (ribavirin) 400 mg, 600 mg tablet<br>All other strengths/brands of ribavirin tablets/capsules |
| **Oral Solution** | Rebetol® (ribavirin 40 mg/ml) oral solution |
| **INTERFERON** | |
| PEGASYS® (peg-interferon alpha-2a) (*QL = 4 vials/28 days)*<br>PEGASYS CONVENIENCE PACK® (peg-interferon alfa-2a) (*QL = 1 kit/28 days)*<br>PEGASYS PROCLICK® (peg-interferon alfa-2a) (*QL = 4 autoinjectors/28 days)* | Peg-Intron®/ Peg-Intron Redipen® (peg-interferon alpha-2b) *(QL=4 pens per 28 days)*<br>Peg-Intron Redipen Pak 4® (peg-interferon alpha-2b) *(QL=1 kit (4 pens) per 28 days)*<br>Infergen® (interferon alphacon-1)<br>Intron-A® (interferon alfa-2b) |
| **HEPATITIS C PROTEASE INHIBITORS** | |
| INCIVEK® (telaprevir) (*QL = 6 tablets/day)*<br>VICTRELIS® (boceprevir) (*QL = 12 capsules/day)* | |

VERMONT

# HEPATITIS C MEDICATIONS – Peg-Interferon/Ribavirin

**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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

## 3 Department of Vermont Health Access
## HEPATITIS C MEDICATIONS– Peg-Interferon/Ribavirin
### PRIOR AUTHORIZATION REQUEST

Patient Diagnosis: | Genotype:

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

Specialist name: _____ Specialist Type: _____

Most recent HCV-RNA level: _____IU/mL Date: ____/____/_____

Requested DVHA **PREFERRED** Oral Hepatitis C Product?

☐ Ribavirin 200 mg Tab (compare to Copegus®) ☐ Ribavirin 200 mg Cap (compare to Rebetol®)

Product: _____ or Medical justification: _____

Requested DVHA **PREFERRED** Injectable Hepatitis C Product?

☐ Pegasys® Prefilled Syringe ☐ Pegasys® Single Dose Vial ☐ Pegasys® Proclick

Product: _____ or Medical justification: _____

Patient will also be receiving (Please complete Hepatitis C Protease Inhibitors PA Form)

☐ Incivek® ☐ Victrelis® ☐ Neither

## 4 PRESCRIPTION

**Oral:**

☐ Ribavirin 200 mg ☐ Tablet or ☐ Capsule

or

☐ Other (Specify): _____

Dose: _____ Frequency: _____ Qty: 28 days supply Refill X:_____

**Injectable:**

☐ Pegasys® Prefilled Syringe 180 mcg/0.5 ml "Convenience Kit" (4 syringes/box)

or

☐ Pegasys® 180 mcg/1 ml Single Dose Vial

or

☐ Pegasys® ProClick ☐ 180 mcg/0.5 ml or ☐ 135 mcg/0.5 ml

or

☐ Other (specify): _____

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:** _____

VERMONT

# HEPATITIS C PROTEASE INHIBITORS (INCIVEK®/VICTRELIS®)

**- 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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

## 3 Department of Vermont Health Access
## HEPATITIS C PROTEASE INHIBITORS
### PRIOR AUTHORIZATION REQUEST

| Patient Diagnosis: | Genotype: |
|---|---|

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

Specialist name: _____ Specialist Type: _____

Requested Hepatitis C Protease Inhibitor?

☐ Incivek®: 375 mg tablet ☐ Victrelis®: 200 mg capsule

Patient is treatment naiive? ☐ **Yes** ☐ **No**

If no, previous response to peg-interferon/ribavirin

☐ Null responder ☐ Partial responder ☐ Relapser

Patient has had previous therapy with Incivek® or Victrelis®? ☐ **Yes** ☐ **No**

If yes, please specify: _____(agent) ___/___/____ (date) _____(response)

Most recent HCV-RNA level: _____IU/mL Date: ____/____/_____

Patient has cirrhosis? ☐ **Yes** ☐ **No**

Ribavirin/peg-interferon will be used concomitantly ☐ **Yes** ☐ **No**

Ribavirin/peg-interferon PA form included ☐ **Yes** ☐ **No**

or

Patient has started Ribavirin/peg-interferon therapy ☐ **Yes** ☐ **No**

If yes, date therapy initiated: ____/_____/_____

Prescriber Additional Comments:

## 4 PRESCRIPTION

☐ Incivek®: 375 mg tablet Sig: 750 mg PO TID with food Qty: 168 tablets (28 days)

☐ Victrelis®: 200 mg capsule Sig: 800 mg PO TID with food Qty: 336 capsules (28 days)

Refill X _____ Note: TID is q 7 – 9 hours

**** HCV-RNA levels will be required per protocol (required for certain refills) ****

Deliver product to: ☐ Patient's home ☐ MD office ☐ Clinic

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

# Hereditary Angioedema Medications

***NOTE*: *Firazyr® must be obtained and billed through our specialty pharmacy vendor, Ascend.***

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

**CRITERIA FOR APPROVAL:**

**Berinert:**

- The diagnosis or indication is **treatment** of an acute Hereditary Angioedema (HAE) attack. (Approval may be granted so that 2 doses may be kept on hand).

**Cinryze:**

- 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).

**OR**

- The medication is to be used for the **treatment** of an acute Hereditary Angioedema (HAE) attack.

**Firazyr:**

The diagnosis or indication is **treatment** of an acute Hereditary Angioedema (HAE) attack.

**Kalbitor:**

- The diagnosis or indication is **treatment** of an acute Hereditary Angioedema (HAE) attack. (Approval may be granted so that 2 doses may be kept on hand).

**DOCUMENTATION:**

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

## Hereditary Angioedema Medications

*Length of Authorization: initial approval 6 months, subsequent approval 1 year*

| NO PA REQUIRED | PA REQUIRED |
|---|---|
| | Berinert® (human C1 inhibitor)<br><br>Cinryze® (human C1 inhibitor)<br>*(QL = 16 vials/28 days for prophylaxis; 4 vials per fill for acute attacks)*<br><br>Firazyr® (icatibant) Prefilled Subcutaneous Syringe<br>*(QL = 3 syringes (9 ml)/fill)*<br><br>Kalbitor® (ecallantide)<br>*(QL = 6 vials (2 packs) per fill* |

# Lipotropics: Bile Acid Sequestrants

**LENGTH OF AUTHORIZATION:** 3 years

**CRITERIA FOR APPROVAL:**

**Questran®***

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

**Questran Light®***

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

**Colestid®***

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

**Welchol®**

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

**OR**

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

**DOCUMENTATION:**

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

## Lipotropics: Bile Acid Sequestrants

*Length of Authorization: 3 years*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| CHOLESTYRAMINE† powder (compare to Questran®)<br>CHOLESTYRAMINE LIGHT† powder (compare to Questran Light®)<br>PREVALITE† powder (cholestyramine light) | Questran®* powder (cholestyramine)<br>Questran Light®* powder (cholestyramine light) |
| COLESTIPOL† tablets, granules (compare to Colestid®) | Colestid®* tablets, granules (colestipol)<br>Welchol® (colesevelam) |

# Lipotropics: Fibric Acid Derivatives

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

**Lopid®***

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

**Tricor®, TriLipix®**

- The patient has been started and stabilized on either Tricor® or TriLipix® (Note: samples are not considered adequate justification for stabilization.)

**OR**

- The patient is taking a statin concurrently.

**OR**

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

**Antara®, fenofibrate, fenofribrate micronized, fenofibric acid, Fenoglide®, Fibricor®, Lipofen®, Lofibra® and Triglide®**

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

## Lipotropics: Fibric Acid Derivatives

*Length of Authorization: 1 year.*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| GEMFIBROZIL† (compare to Lopid®) 600 mg<br><br>**On statin concurrently or after gemfibrozil trial**<br><br>TRICOR® (fenofibrate nanocrystallized) § 48 mg, 145 mg<br>*Quantity Limit = 1 tablet/day*<br>TRILIPIX (fenofibric acid) § 45 mg, 135 mg delayed release capsule<br>*Quantity Limit = 1 capsule/day* | Antara® (fenofibrate micronized) § 43 mg, 130 mg<br>fenofibrate tablets†(compare to Lofibra® tablets) § 54 mg, 160 mg<br>fenofibrate micronized capsule†(compare to Lofibra® capsules) § 67 mg, 134 mg, 200 mg<br>fenofibric acid § 35 mg, 105 mg<br>*Quantity Limit = 1 capsule/day*<br>Fenoglide® (fenofibrate MeltDose) § 40 mg, 120 mg<br>Fibricor® (fenofibric acid) § 35 mg, 105 mg<br>*Quantity Limit = 1 capsule/day*<br>Lipofen® (fenofibrate) § 50 mg, 150 mg<br>Lofibra® (fenofibrate micronized) Capsules § 67mg, 134 mg, 200 mg<br>Lofibra® (fenofibrate) Tablets § 54 mg, 160 mg<br>Lopid®* (gemfibrozil) § 600 mg<br>Triglide® (fenofibrate ) § 50 mg, 160 mg |

# Lipotropics: Nicotinic Acid Derivatives

**LENGTH OF AUTHORIZATION:** not applicable

**CRITERIA FOR APPROVAL:** not applicable

## Lipotropics: Nicotinic Acid Derivatives

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| | |
| **Immediate Release Products**<br>NIACIN†<br>NIACOR®† (niacin)<br><br>**Extended Release Products**<br>NIASPAN® (niacin extended release) | |

# Lipotropics: Statins

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

HIGH POTENCY STATINS

**Crestor®**

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

OR

- The patient has had an inadequate response to a six week trial of simvastatin 40 mg OR requires LDL reduction of ≥ 45%

**Atorvastatin, Lipitor®, Livalo®**

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

AND

- If the request is for atorvastatin, the patient has had a documented intolerance to brand Lipitor.

OR

- The patient has had an inadequate response to a six week trial of simvastatin 40 mg OR requires LDL reduction of at least 45%

AND

- The patient has had a documented side effect, allergy or inadequate response to a six week trial of at least 20 mg per day of Crestor®

AND

- If the request is for atorvastatin, the patient has had a documented intolerance to brand Lipitor.

**Simvastatin 80 mg Tablets**

- The patient has been taking this dose for 12 or more months without evidence of muscle toxicity.

**Zocor®**

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

OTHER STATINS

**Altoprev®, fluvastatin, Lescol®, Lescol® XL, Mevacor®, Pravachol®**

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

AND

- If the request is for Lescol, the patient has had a documented intolerance to generic fluvastatin.

**DOCUMENTATION:**

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

## Lipotropics: Statins

*Length of Authorization: 1 year* **Key: †**

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

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **HIGH POTENCY STATINS** | |
| SIMVASTATIN† (compare to Zocor®) *(QL = 1 tablet/day of 5 mg, 10 mg, 20 mg and 40 mg)*<br><br>**AFTER GENERIC SIMVASTATIN TRIAL (6 week trial of simvastatin of 40 mg/day)**<br>CRESTOR® (rosuvastatin calcium) **§**<br>*(QL = 1 tablet/day)* | Atorvastatin† (compare to Lipitor®)<br>*(QL = 1 tablet/day)*<br>Lipitor® (atorvastatin) *(QL = 1 tablet/day)*<br>Livalo (pitavastatin) *(QL = 1 tablet/day)*<br>Simvastatin† 80 mg tablets (compare to Zocor®)<br>*(QL = 1 tablet/day)*<br>Zocor®* (simvastatin) *(QL = 1 tablet/day)* |
| **OTHER STATINS** | |
| LOVASTATIN† (compare to Mevacor®) *(QL = 1 tab/day (10 & 20 mg), 2 tab/day (40 mg))*<br><br>PRAVASTATIN† (compare to Pravachol®) ) *(QL = 1 tablet/day* | Altoprev® (aka: Altocor®) (lovastatin) *(Ql = 1 tablet/day)*<br>fluvastatin† (compare to Lescol® ) *(QL = 1 tablet/day)*<br>Lescol® (fluvastatin) *(QL = 1 tablet/day)*<br>Lescol® XL (fluvastatin XL) *(QL = 1 tablet/day)*<br>Mevacor®* (lovastatin) ) *(QL = 1 tab/day (10 & 20 mg), 2 tabs/day (40 mg))*<br>Pravachol®* (pravastatin) *(QL = 1 tab/day* |

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

# Lipotropics: Miscellaneous/Combinations

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

**Lovaza®**

- The patient has 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.

**Amlodipine/atorvastatin, Caduet®**

- The prescriber must provide a clinically valid reason for the use of the requested medication. For approval of Caduet, the patient must have also had a documented intolerance to the generic equivalent.

**Advicor®**

- The patient is unable to take the individual drug components separately.

**Juvisync®**

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

**AND**

- The patient has been started and stabilized on Januvia and simvastatin combination therapy as individual agents.

**Vytorin®**

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

**AND**

- If the request is for Vytorin 10/80, the patient has been taking this dose for 12 or more months without evidence of muscle toxicity.

**Zetia®**

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

**OR**

- The patient has a diagnosis of homozygous sitosterolemia.

**OR**

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

**DOCUMENTATION:**

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

## Lipotropics: Miscellaneous/Combination

*Length of Authorization: 1 year*

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **MISCELLANEOUS** | |
| | Lovaza® (omega-3-acid ethyl esters) |
| **CHOLESTEROL ABSORPTION INHIBITORS/COMBINATIONS** | |
| | Vytorin® (ezetimibe/simvastatin)<br>*(QL = 1 tablet/day)*<br>Zetia® (ezetimibe)<br>*(Qty Limit = 1 tablet/day)* |
| **OTHER STATIN COMBINATIONS** | |
| SIMCOR® (simvastatin/extended release niacin)<br>*(Qty Limit = 1 tablet/day)* ± | Advicor® (lovastatin/extended release niacin)<br>*(Qty Limit = 1 tablet/day)*<br>Amlodipine/atorvastatin † (compare to Caduet®)<br>*(Qty Limit = 1 tablet/day)*<br>Caduet® (atorvastatin/amlodipine)<br>*(Qty Limit = 1 tablet/day)*<br>Juvisync® (sitagliptin/simvastatin)<br>*(Qty limit = 1 tablet/day)* |

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

# Management of Mental Health Medications

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

   Patients of any age who were using:

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

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

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

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

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

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

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

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

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

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

## Miscellaneous: Benlysta® (for Systemic Lupus Erythematosus (SLE))

**LENGTH OF AUTHORIZATION:** initial approval 2 months, subsequent approval 1 year

**CLINICAL CONSIDERATIONS:**

How supplied: 120 mg or 400 mg single use vials for injection
Dose: initial, 10 mg/kg at 2-week intervals for first 3 doses; maintenance, 10 mg/kg at 4-week intervals

**CRITERIA FOR APPROVAL:**

- The diagnosis or indication is active systemic lupus erythematosus (SLE)

**AND**

- The patient is positive for autoantibodies (anti-nuclear antibody (ANA) and/or anti-double-stranded DNA (anti-dsDNA).

**AND**

- The patient has had a documented inadequate response or intolerance to at least TWO of the following agents: NSAIDs, hydroxychloroquine, prednisone, azathioprine, methotrexate, mycophenolate.

**DOCUMENTATION:**

- ✓ Document clinically compelling information supporting the choice of a Benlysta® on a **General Prior Authorization Request Form**.
- ✓ All requests for Benlysta® (belimumab) (whether billed through the pharmacy or medical benefit (J0490)) require Prior Authorization through the MedMetrics Clinical Call Center.

Note: The efficacy of Benlysta® has not been evaluated in patients with severe active lupus nephritis or severe active central nervous system lupus. Benlysta® has not been studied in combination with other biologics or intravenous cyclophosphamide. Use of Benlysta® is not recommended in these situations.

### Miscellaneous: Benlysta®

*Length of Authorization: initial approval 2 months, subsequent approval 1 year*

| NO PA REQUIRED | PA REQUIRED |
|---|---|
| | Benlysta® (belimumab) Vials<br>Maximum days supply = 28 days |

# Miscellaneous: Carbaglu®

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

- The diagnosis or indication for the requested medication is hyperammonemia due to N-acetylglutamate synthetase (NAGS) deficiency

**AND**

- The prescriber is a specialist in metabolic disorders (e.g., medical geneticist) or prescriber is in consultation with a specialist

Note: after preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval.

**DOCUMENTATION:**

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

| **Miscellaneous: Carbaglu®** | *Length of Authorization: 1 year* |
|---|---|
| **NO PA REQUIRED** | **PA REQUIRED** |
| | Carbaglu® dispersible tablets (carglumic acid)<br>*(Maximum days supply per fill = 14 days)* |

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

**LENGTH OF AUTHORIZATION:** 1 year

**CLINICAL CONSIDERATIONS:**

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

**CRITERIA FOR APPROVAL:**

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

**DOCUMENTATION:**

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

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

## Miscellaneous; Elaprase®

*Length of Authorization: 1 year*

| NO PA REQUIRED | PA REQUIRED |
|---|---|
| | Elaprase® (idursulfase) *(QL = calculated weekly dose)* |

# Miscellaneous: Glycopyrrolate

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Cuvposa®:**

- The diagnosis or indication for the requested medication is Sialorrhea or a neurologic condition associated with excessive drooling (e.g. cerebral palsy, mental retardation, Parkinson's disease).

**AND**

- The dose cannot be obtained from the tablet formulation.

**AND**

- (For patients >18 years of age) The patient has had a documented side effect, allergy, treatment failure, or a contraindication to scopolamine patches.

**Robinul®, Robinul Forte®:**

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

**DOCUMENTATION:**

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

| **Miscellaneous: Glycopyrrolate** | *Length of Authorization: 1 year* |
|---|---|
| **NO PA REQUIRED** | **PA REQUIRED** |
| GLYCOPYRROLATE 1 mg, 2 mg tablets (compare to Robinul®, Robinul Forte®) | Cuvposa® oral solution (glycopyrrolate)*<br>**Maximum days supply per fill is 30 days**<br><br>Robinul® 1 mg tablet (glycopyrrolate)<br><br>Robinul® Forte 2 mg tablet (glycopyrrolate) |

# Miscellaneous: Lysteda®

**LENGTH OF AUTHORIZATION:** 1 year

**CLINICAL CONSIDERATIONS:**

Dose: Lysteda is dosed as two 650 mg tablets three times daily for up to 5 days during menstruation.

**CRITERIA FOR APPROVAL:**

- The diagnosis or indication is clinically significant heavy menstrual bleeding

**AND**

- The patient has been started and stabilized on oral tranexamic acid within the previous 360 days

**OR**

- The patient does not have a contraindication to therapy with oral tranexamic acid (i.e., active thrombotic disease, history of thrombosis/thromboembolism, or an intrinsic risk of thrombosis/thromboembolism), and if oral tranexamic acid is to be used concomitantly with an estrogen containing hormonal contraceptive product, the risks of combination therapy have been discussed with the patient.

**AND**

- The patient has had a documented side effect, allergy, contraindication, or an inadequate response with at least one oral contraceptive or progestin containing product despite an adequate trial of at least 90 days, or a rationale for why these products cannot be used (e.g. actively attempting to conceive).

**AND**

- The patient has had a documented side effect, allergy, contraindication, or an inadequate response with at least one regulary scheduled (not PRN) NSAID or a rationale for why these products cannot be used (e.g. actively attempting to conceive).

**DOCUMENTATION:**

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

| **Miscellaneous: Lysteda®** | *Length of Authorization: 1 year* |
|---|---|
| **NO PA REQUIRED** | **PA REQUIRED** |
| | Lysteda® tablets (tranexamic acid)<br>*Quantity limit = 30 tablets/28 days* |

# Miscellaneous: Nuedexta®

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

- The diagnosis or indication is pseudobulbar affect (PBA) secondary to amyotrophic lateral sclerosis (ALS) or multiple sclerosis (MS)

**AND**

- The patient does not have any contraindications to use:

| |
|---|
| Concomitant use with quinidine, quinine, or mefloquine |
| History of quinidine, quinine or mefloquine-induced thrombocytopenia, hepatitis |
| MAOI use within 14 days of starting Nuedexta |
| Prolonged QT interval, congenital long QT syndrome, Torsades de Pointes, or heart failure |
| Complete atrioventricular (AV) block or patients at high risk for AV block |
| Concomitant use with drugs that prolong QT interval and are metabolized by CYP2D6 (eg. thioridazine, pimozide) |

**DOCUMENTATION:**

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

| **Miscellaneous: Nuedexta®** | *Length of Authorization: 1 year* |
|---|---|
| **NO PA REQUIRED** | **PA REQUIRED** |
| | Nuedexta® capsules (dextromethorphan/quinidine)<br>*Quantity limit = 2 capsules/day* |

# Miscellaneous: Samsca® (for Hyponatremia)

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

**CLINICAL CONSIDERATIONS:**

How supplied: 15 or 30 mg tablets

Dose: Initial, 15 mg once daily;
After at least 24 hours, titrate dose up to 30 mg once daily to a maximum of 60 mg once daily to achieve desired sodium level;
Maximum dose, 60 mg once daily

Patients should be in a hospital for initiation and reinitiation of tolvaptan therapy to evaluate its therapeutic response. Doses can be administered without regard to meals. Avoid fluid restriction during the first 24 hours of therapy. Patients taking tolvaptan should be advised to continue ingesting fluids in response to thirst.

| Initiate and Reinitiate in a Hospital and Monitor Serum Sodium |
|---|
| Samsca® should be initiated and reinitiated in patients only in a hospital where serum sodium can be monitored closely. Too rapid correction of hyponatremia (e.g., >12 mEq/L/24 hours) can cause osmotic demyelination resulting in dysarthria, mutism, dysphagia, lethargy, affective changes, spastic quadriparesis, seizures, coma and death. In susceptible patients, including those with malnutrition, alcoholism or advanced liver disease, slower rates of correction may be advisable. |

**CRITERIA FOR APPROVAL:**

- The agent is being used for the treatment of euvolemic or hypervolemic hyponatremia

AND

- Despite optimal fluid restriction, the patient's serum sodium < 120 mEq/L or the patient is symptomatic with a serum sodium < 125 mEq/L.

AND

- The treatment will be initiated or is being reinitiated in a hospital setting where serum sodium can be monitored

**DOCUMENTATION:**

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

| **Miscellaneous: Samsca®** *Length of Authorization: 1 month initially, subsequent approvals up to 1 year* | |
|---|---|
| **NO PA REQUIRED** | **PA REQUIRED** |
| | Samsca® tablets (tolvaptan)<br>*Quantity limit = 15 mg tablets (1 tablet/day), 30 mg tablets (2 tablets/day)* |

## Miscellaneous: Solesta®

**LENGTH OF AUTHORIZATION:** Up to 2 months

**CRITERIA FOR APPROVAL:**

- The diagnosis or indication is treatment of fecal incontinence.

AND

- The patient is 18 years of age or older

AND

- The patient has had an inadequate response with conservative therapy, including diet, fiber supplementation, and anti-diarrheal medication

**DOCUMENTATION:**

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

**Miscellaneous: Solesta®** *Length of Authorization: Up to 2 months*

| NO PA REQUIRED | PA REQUIRED |
|---|---|
| | Solesta® submucosal injection gel 50 mg/15 ml<br>*(Quantity Limit = 4 syringes/28 days)* |

# Miscellaneous: Soliris® (Paroxysmal Nocturnal Hemoglobinuria Injectable)

**LENGTH OF AUTHORIZATION:** initial approval 3 months, subsequent approval 1 year

**CLINICAL CONSIDERATIONS:**

How supplied: 10 mg/mL (30 mL)
Dose: 600 mg IVF every 7 days x 4 weeks, followed by 900 mg IVF 7 days later and 900 mg IVF every 14 days thereafter

**CRITERIA FOR APPROVAL:**

- The patient has a diagnosis of paroxysmal nocturnal hemoglobinuria documented by flow cytometry.

**AND**

- The patient has received the meningococcal vaccine prior to therapy.

**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 28 days with recertification approvals.

**DOCUMENTATION:**

- ✓ Document clinically compelling information supporting the choice of a non-preferred agent on a **General Prior Authorization Request Form**.
- ✓ All requests for eculizumab (whether billed through the pharmacy or medical benefit (J1300)) require Prior Authorization through the MedMetrics Clinical Call Center.

## Miscellaneous: Soliris®

*Length of Authorization: initial approval 3months, subsequent approval 1 year*

| NO PA REQUIRED | PA REQUIRED |
|---|---|
| | Soliris® (eculizumab) *(Quantity Limit = 20 vials total/12 weeks initially; 6 vials/28 days subsequently)* |

# Miscellaneous: Somatuline® (Acromegaly Injectable)

**LENGTH OF AUTHORIZATION:** 1 year

**CLINICAL CONSIDERATIONS:**

How supplied: 60, 90 or 120 mg pre-filled syringes
Dose: initial dose is 90 mg deep subcutaneous every 4 weeks x 3 months, then dose adjusted to between 60 mg and 120 mg every 4 weeks based on lab values and symptoms

**CRITERIA FOR APPROVAL:**

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

**DOCUMENTATION:**

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

This drug must be billed through the DVHA POS prescription processing system using NDC values.
**J code or other code will NOT be accepted for processing through medical benefit.**

| **Miscellaneous: Somatuline®** | *Length of Authorization: 1 year* |
|---|---|
| **NO PA REQUIRED** | **PA REQUIRED** |
| | Somatuline® Depot Injection (lanreotide)<br>*(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))* |

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

**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 ≥ 18 years.

**DOCUMENTATION:**

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

| **Miscellaneous: Xenazine®** *Length of Authorization: 1 month initially, subsequent approvals up to 1 year* | |
|---|---|
| **NO PA REQUIRED** | **PA REQUIRED** |
| | Xenazine® tablets (tetrabenazine)<br>*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)*<br>*Maximum 1 month supply per fill* |

## 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 170 for a description of the management of mental health drugs.

**Mood Stabilizers** *Length of authorization: Duration of Need**

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| LITHIUM CARBONATE† (formerly Eskalith®)<br>LITHIUM CARBONATE SR† (compare to Lithobid®, formerly Eskalith CR® )<br>LITHIUM CITRATE SYRUP† | Equetro® (carbamazepine SR)<br>Lithobid ®* (lithium carbonate SR) |

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

# Mucosal Coating Agents

**LENGTH OF AUTHORIZATION:** 6 months

**CRITERIA FOR APPROVAL:**

**MuGard**

- Patient is receiving radiation and/or chemotherapy.

**AND**

- The patient has had a documented side effect, allergy or treatment failure with at least one oral mucosal coating agent (e.g. aluminum hydroxide suspension, Mylanta®) or a topical anesthetic (e.g. viscous lidocaine or diphenhydramine solutions) or combinations of similar agents.

**DOCUMENTATION:**

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

## Mucosal Coating Agents

*Length of Authorization: 6 months*

**Key: † Generic product**

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| ALUMINUM HYDROXIDE† (formerly Amphojel®)<br>GELCLAIR® (povidone sodium hyaluronate glycyrrhetinic acid gel)<br>MYLANTA/DIPHENYDRAMINE/LIDOCAINE VISCOUS (aka "Magic Mouthwash")<br><br>Or other similar single or combination products | MuGard® (mucoadhesive oral wound rinse)<br>*(QL = 4 bottles/month)* |

# Multiple Sclerosis Medications

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

**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:**

**Ampyra®**

Patient has a diagnosis of multiple sclerosis.

**AND**

Patient age ≥ 18 years.

**Extavia®**

Patient has a diagnosis of multiple sclerosis.

**AND**

The provider provides a clinical reason why Betaseron cannot be prescribed.

**Gilenya®**

Patient has a diagnosis of relapsing multiple sclerosis.

**AND**

The patient has had a documented side effect, allergy, inadequate response, or contraindication to at least one preferred self-injectable MS drug.

**AND**

Patient has tolerated first dose under observation for a minimum of 6 hours with hourly pulse and blood pressure measurement and pre and post electrocardiogram.

**Tysabri®**

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

**OR**

Diagnosis is relapsing multiple sclerosis and the patient has a documented side effect, allergy, treatment failure, or contraindication to at least two preferred drugs.

**OR**

Diagnosis is relapsing multiple sclerosis and the patient has a documented side effect, allergy, treatment failure, or contraindication to one preferred drug and has tested negative for anti-JCV antibodies.

**DOCUMENTATION:**

- ✓ Document clinically compelling information supporting the choice of Ampyra® or Tysabri® on a **General Prior Authorization Request Form**.

- ✓ Document clinical information for **Gilenya®** on its **Prior Authorization/Patient Enrollment Form**
- ✓ All requests for natalizumab (Tysabri®) (whether billed through the pharmacy or medical benefit (J2323)) require Prior Authorization through the MedMetrics Clinical Call Center.

## Multiple Sclerosis Medications

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **INJECTABLES**<br>**Interferons**<br>AVONEX® (interferon beta-1a)<br>BETASERON® (interferon beta-1b)<br>REBIF® (interferon beta-1a) | Extavia® (interferon beta-1b) |
| **Other**<br>COPAXONE® (glatiramer) *(QL = 1 kit/30 days)* | Tysabri® (natalizumab) |
| **ORAL**<br>**PREFERRED AFTER CLINICAL CRITERIA ARE MET**<br>Ampyra® (dalfampridine) tablet<br>*(QL = 2 tablets/day, maximum 30 day supply per fill)* | Gilenya® (fingolimod) capsule<br>*(QL = 1 capsule/day, maximum 28 day supply per fill)* |

VERMONT

**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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

## 3 Department of Vermont Health Access
## PRESCRIPTION
## MULTIPLE SCLEROSIS SELF INJECTABLES

**Patient Diagnosis:**

**Product:**

☐ Avonex 30 mcg/0.5 ml Prefilled Syringe (4 per box)

☐ Avonex 30 mcg Kit (Single Dose Vials) (4 per box)

☐ Betaseron 0.3 mg Prefilled Syringe

☐ Copaxone 20 mg Prefilled Syringe (30 per kit)

☐ Rebif Titration Pack X 1 **(Therapy initiation ONLY-No Refills)**
(contains 6 - 8.8 mcg and 6 – 22 mcg Prefilled Syringes)

☐ Rebif 22 mcg/0.5 ml Prefilled Syringes

☐ Rebif 44 mcg/0.5 ml Prefilled Syringes

(Please Note: This form not to be used for Tysabri PA request or ordering)

| **Quantity:** | **Refills:** |
|---|---|
| | |

Dose / Route/ Frequency Instructions (Sig):

Deliver product to: ☐ Patient's home ☐ MD office ☐ Clinic

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

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

# Nutritionals: Enteral

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**EleCare®, EleCare® Jr**

- The patient is an infant or child who needs an amino acid-based medical food or who cannot tolerate intact or hydrolyzed protein.

AND

- The product is being requested for the dietary management of protein maldigestion, malabsorption, severe food allergies, short-bowel syndrome, eosinophilic GI disorders, GI-tract impairment, or other conditions for which an amino acid-based diet is required.

**All others:**

- Requested nutritional supplement will be administered via tube feeding.

**OR**

- Patient has one of the following conditions where feeding is difficult or malabsorption or maldigestion occurs.

| | | |
|---|---|---|
| AIDS | Cognitive Impairment | Inflammatory Bowel Disease |
| Cancer | Cystic Fibrosis | Parkinson's |
| Celiac Disease | Dementia (includes Alzheimer's) | Short Gut |
| Cerebral Palsy | Developmental Delays | |
| Chronic Diarrhea | Difficulty with chewing/swallowing food | |

**OR**

- 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) (albumin $\leq$3.5 g/dL /pre-albumin $\leq$15 mg/dL)

| **Unplanned Weight Loss/Low Weight** | |
|---|---|
| **Adult** | • Involuntary loss of $\geq$ 10 % of body weight within 6 months<br>• Involuntary loss of $\geq$ 5% of body weight within 1 month<br>• Loss of $\geq$ 2% of body weight within one week<br>• BMI of $\leq$ 18.5 kg/m$^2$ |
| **Elderly: ( $\geq$ 65)** | • Involuntary loss of $\geq$ 10 % of body weight within 6 months<br>• Involuntary loss of $\geq$ 5 % of body weight within 3 months<br>• Loss of $\geq$ 2 % of body weight within one month<br>• BMI of $\leq$ 18.5 kg/m$^2$ |
| **Children** | • < 80 % of expected weight-for-height<br>• < 90 % of expected height-for-age<br>• Mid-upper arm circumference/head circumference ratio < 0.25 |

**LIMITATIONS:**

Infant formulas are not covered under the pharmacy benefit. Please contact WIC.

**DOCUMENTATION:**

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

| **Nutritionals: Enteral** | *Length of authorization: 1 year* |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| | All<br>Note: Nutritional supplements administered via tube feeds may be provided through the Medical Benefit. |

VERMONT

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

*Agency of Human Services*

# ~NUTRITIONALS ~

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 appropriate use and medical necessity. 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: _____

Nutritional supplement will be administered via Tube Feeding? ☐ Yes ☐ No **(Proceed to diagnosis question)**

Patient Diagnosis/Condition:

☐ AIDS ☐ Chronic Diarrhea ☐ Dementia (includes Alzheimer's) ☐ Inflammatory Bowel Disease
☐ Cancer ☐ Cognitive Impairment ☐ Developmental Delays ☐ Parkinson's
☐ Celiac Disease ☐ Cystic Fibrosis ☐ Difficulty with chewing/swallowing food ☐ Short Gut
☐ Cerebral Palsy ☐ Request is for weight loss/low weight or low serum protein **(complete appropriate section below)**
☐ Other: _____

Unplanned Weight Loss/Extremely Low Weight:

Baseline: Date: ___/___/____ Height: _____ Weight: _____ BMI: _____

Current: Date: ___/___/____ Height: _____ Weight: _____ BMI: _____

Children: Mid-Upper Arm Circumference: _____ Head Circumference: _____

Laboratory Values: Date: ___/___/____ Albumin: _____ Pre-Albumin:_____

Additional clinical information to support PA request:

Requested Supplement: _____

Strength & Frequency: _____

Anticipated duration of supplementation: _____

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

VERMONT

**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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

## 3 Department 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 |
|---|---|---|---|
| ☐GLEEVEC | | | |
| ☐HEXALEN | | | |
| ☐LUPRON DEPOT* | | | |
| ☐MERCAPTOPURINE* | | | |
| ☐MESNEX | | | |
| ☐NEULASTA* | | | |
| ☐NEUPOGEN* | | | |
| ☐REVLIMID* | | | |
| Authorization # _____ | | New RX Required every 28 days | |
| ☐SPRYCEL | | | |
| ☐SUTENT | | | |
| ☐TARCEVA | | | |
| ☐TEMODAR | | | |
| ☐XELODA | | | |
| **Other:** | | | |
| | | | |
| | | | |
| **Additional RX Instructions:** | | | |

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

* Not required to use Ascend

# Ophthalmics: Antibiotics

**LENGTH OF AUTHORIZATION:** duration of therapy requested

**CRITERIA FOR APPROVAL:**

**Aminoglycosides:**

- **Single Agent:** The patient has had a documented side effect, allergy or treatment failure with at least ONE preferred ophthalmic aminoglycoside. (If a product has an AB rated generic, there must have also been a trial of the generic formulation)
- **Combination Product:** The patient has had a documented intolerance with generic tobramycin/dexamethasone ophthalmic.

**Macrolides:**

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

**Miscellaneous Antibiotics:**

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

**Quinolones:**

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

AND

- If the request is for Quixin, the patient also has a documented intolerance to generic levofloxacin 0.5 %.

OR

- The request is for Vigamox or Zymar as part of a regimen to prevent postoperative infection in patients receiving any ophthalmologic surgery.

**DOCUMENTATION:**

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

## Ophthalmics: Antibiotics

*Length of Authorization: duration of therapy requested*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **QUINOLONES**<br>CIPROFLOXACIN HCL† (compare to Ciloxan®) solution<br>OFLOXACIN† (compare to Ocuflox®) solution | Besivance® (besifloxacin) suspension<br>Ciloxan®*(ciprofloxacin) ointment, solution<br>Iquix® (levofloxacin 1.5 %) (preservative free) soln<br>levofloxacin† 0.5 % (compare to Quixin®) soln<br>Moxeza® (moxifloxacin 0.5%) (preservative free) soln<br>Ocuflox®*(ofloxacin) solution<br>Quixin® (levofloxacin 0.5 %) solution<br>Vigamox® (moxifloxacin 0.5%) (preservative free) solution<br>Zymar® (gatifloxacin 0.3%) solution<br>Zymaxid® (gatifloxacin 0.5%) solution |
| **MACROLIDES**<br>ERYTHROMYCIN† ointment<br>ILOTYCIN† (erythromycin) ointment | Azasite®(azithromycin) solution<br>All other brands |
| **AMINOGLYCOSIDES**<br>**Single Agent**<br>AK-TOB† (tobramycin) solution<br>GARAMYCIN† (gentamicin) ointment<br>GENTAK† (gentamicin) ointment, solution<br>GENTAMICIN† ointment, solution<br>TOBRAMYCIN † sol (compare to Tobrex®) | Garamycin® (gentamicin) solution<br>Tobrex® sol* (tobramycin)<br>Tobrex® ointment (tobramycin) |
| **Combination**<br>TOBRAMYCIN W/DEXAMETHASONE† (compare to Tobradex®) suspension | Tobradex®* (tobramycin/dexamethasone) susp<br>Tobradex® (tobramycin/dexamethasone) oint<br>TobraDex ST®(tobramycin/dexamethasone) susp<br>Zylet® (tobramycin/loteprednol) suspension<br>Pred-G® (gentamicin/prednisolone) suspension<br>Pred-G® S.O.P. (gentamicin/prednisolone) oint<br>All other brands |
| **MISCELLANEOUS**<br>**Single Agent**<br>BACITRACIN ointment<br>SULFACETAMIDE SODIUM† (compare to Bleph-10®) solution | Bleph-10®* (sulfacetamide) solution<br>All other brands |
| **Combination**<br>AK-POLY-BAC† (bacitracin/polymyxin) ointment<br>BACITRACIN ZINC W/POLYMYXIN B† (formerly Polysporin®) ointment<br>NEOMYCIN/BACITRACIN/POLYMYXIN (formerly Neosporin®) ointment | Blephamide® (sulfacetamide/prednisolone acetate) suspenion<br>Blephamide® S.O.P. (sulfacetamide/prednisolone acetate) oint |
| NEOMYCIN/POLYMYXIN W/DEXAMETHASONE† (compare to Maxitrol®) ointment, suspension | Maxitrol®* (neomycin/polymyxin/dexamethasone) suspension, ointment |
| NEOMYCIN/POLYMYXIN W/GRAMICIDIN† soln (compare to Neosporin®) | Neosporin®* (neomycin/polymyxin/gramicidin) soln |
| NEOMYCIN/POLYMYXIN W/HYDROCORTISONE suspension<br>NEOMYCIN/POLYMYXIN/BACITRACIN/ HYDROCORTISONE† ointment | Poly-pred® (neomycin/polymyxin B/prednisolone acetate) suspension |
| POLYMYXIN B W/TRIMETHOPRIM† (compare to Polytrim®) solution | Polytrim®* (polymyxin B/trimethoprim) soln |
| SULFACETAMIDE W/PREDNISOLONE SOD PHOSPHATE solution | All other brands |

# Ophthalmics: Antihistamines

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Pataday®/Patanol®**

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

**Azelastine, Bepreve®, Elestat®, Epinastine, Optivar ®**

- The patient has had a documented side effect, allergy, or treatment failure to Pataday® or Patanol®.
- If the product has a generic equivalent, the patient must also have had a documented intolerance to the generic equivalent.

**Lastacaft®, Emadine®**

- The patient is pregnant and the diagnosis is allergic conjunctivitis

OR

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

AND

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

**DOCUMENTATION:**

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

## Ophthalmics: Antihistamines

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| KETOTIFEN† 0.025 % (eg. Alaway®, Zaditor® OTC, others)<br>*(QL = 1 bottle/month)* | |
| **After trial of ketotifen 0.025 %** | |
| PATADAY® § (olopatadine 0.2%)/PATANOL®§ (olopatadine 0.1%) *(QL = 1 bottle/month)* | Azelastine † (compare to Optivar®) *(QL = 1 bottle/month)*<br>Bepreve® (bepotastine besilate) *(QL = 1 bottle/month)*<br>Elestat® (epinastine) *(QL = 1 bottle/month)*<br>Epinastine† (compare to Elestat®) *(QL = 1 bottle/month)*<br>Emadine® (emedastine) *(QL = 2 bottles/month)*<br>Lastacaft® (alcaftadine) *(QL = 1 bottle/month)*<br>Optivar® (azelastine) *(QL = 1 bottle/month)* |

# Ophthalmics: Corticosteroids: Topical

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

**CRITERIA FOR APPROVAL:**

**Lotemax® ointment:**

- The patient has had a documented side effect, allergy, or treatment failure with one preferred generic ophthalmic corticosteroid.

OR

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

**All Others:**

- 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**.

## Ophthalmics: Corticosteroids: Topical

*Length of Authorization: up to 3 months*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| DEXAMETHASONE SODIUM PHOSPHATE 0.1% Sol†<br>FLUOROMETHOLONE 0.1% S†<br>PREDNISOLONE ACETATE 1% S† | Alrex® (loteprednol) 0.2% S<br>Durezol® (difluprednate) 0.05% E<br>FML® (fluorometholone) 0.1% O<br>FML Forte® (fluorometholone) 0.25% S<br>FML Liquifilm®/Flarex® (fluorometholone) 0.1% S<br>Lotemax® (loteprednol) 0.5% O (pres. free)<br>Lotemax® (loteprednol) 0.5% S<br>Pred Forte®/Omnipred® (prednisolone acetate) 1% S<br>Pred Mild® (prednisolone acetate) 0.12% S<br>Vexol® (rimexolone) 1% S<br><br>All other brands |

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

# Ophthalmics: Glaucoma Agents / Miotics

**LENGTH OF AUTHORIZATION**: 1 year

**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 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 beta blocker.

**PROSTAGLANDIN INHIBITORS (Latanoprost, 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 beta blocker.

**AND**

- The patient has had a documented side effect, allergy or treatment failure with Lumigan and Travatan/Travatan Z.

**AND**

- If the request is for Latanoprost, the patient has a documented intolerance to the brand product.

**CARBONIC ANHYDROUS INHIBITORS**

**Single Agent:**

- The patient has had a documented side effect, allergy or treatment failure with a preferred carbonic anhydrous inhibitor.

**Combination Product:**

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

**MISCELLANEOUS**

- The patient has had a documented side effect, allergy or treatment failure with a preferred miscellaneous ophthalmic agent. If a product has an AB rated generic, there must have also 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**.

## Ophthalmics: Glaucoma Agents / Miotics

*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 2 ADRENERGIC** | |
| **Single Agent** | |
| ALPHAGAN P® 0.1 %, 0.15 % (brimonidine tartrate)<br>BRIMONIDINE TARTRATE† 0.2 % ( formerly Alphagan®) | apraclonidine† (compare to Iopidine®) (no PA required for patients ≤ 10 years of age)<br>brimonidine tartrate 0.15 % † (compare to Alphagan P®)<br>Iopidine® (apraclonidine) (no PA required for patients ≤ 10 years of age) |
| **Combination** | |
| COMBIGAN® (brimonidine tartrate/timolol maleate) | |
| **BETA BLOCKERS** | |
| BETAXOLOL HCL† (formerly Betoptic®)<br>BETOPTIC S® (betaxolol suspension)<br>CARTEOLOL HCL† (compare to Ocupress®)<br>LEVOBUNOLOL HCL† (compare to Betagan®)<br>METIPRANOLOL† (compare to Optipranolol®)<br>TIMOLOL MALEATE† (compare to Istalol®, Timoptic®)<br>TIMOLOL MALEATE †gel (compare to Timotic XE®) | Betagan®* (levobunolol)<br>Betimol® (timolol)<br>Istalol®* (timolol)<br>Optipranolol®* (metipranolol)<br>Timoptic®* (timolol maleate)<br>Timoptic XE®* (timolol maleate gel) |
| **PROSTAGLANDIN INHIBITORS** | |
| *NOTE: COVERAGE OF A 'PREFERRED' PI AGENT IS CONTINGENT UPON A 1ST-LINE TRIAL OF AT LEAST ONE PREFERRED BETA-BLOCKER.. 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.* | |
| LUMIGAN® 0.01 %/0.03 % (bimatoprost) §<br>TRAVATAN®/TRAVATAN Z® (travoprost) § | Latanoprost† (compare to Xalatan®)<br>Xalatan® (latanoprost) |
| **CARBONIC ANHYDROUS INHIBITORS** | |
| **Single Agent** | |
| DORZOLAMIDE 2 % (compare to Trusopt®) | Azopt® (brinzolamide 1%)<br>Trusopt®* (dorzolamide 2 %) |
| **Combination** | |
| DORZOLAMIDE w/TIMOLOL (compare to Cosopt®) | Cosopt®* (dorzolamide w/timolol) |
| **MISCELLANEOUS** | |
| DIPIVEFRIN HCL† (compare to Propine®)<br>ISOPTO® CARBACHOL (carbachol)<br>ISOPTO® CARPINE (pilocarpine)<br>PILOCARPINE HCL† (formerly Pilocar®)<br>PILOPINE® (pilocarpine)<br>PHOSPHOLINE IODIDE® (echothiophate)<br>PROPINE® (dipivefrin) | Miochol-E® (acetylcholine)<br>Miostat® (carbachol) |

# Ophthalmics: Immunomodulators

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

- The patient has a diagnosis of moderate to severe keratoconjunctivitis sicca (dry eye syndrome)
  AND
- The patient has had a documented side effect, allergy, or treatment failure to an artificial tear product.

**DOCUMENTATION:**

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

| **Ophthalmics: Immunomodulators** | *Length of Authorization: 1 year* |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| | Restasis® (cyclosporine ophthalmic emulsion) 0.05% (*QL=60 vials per 30 days).* |

# Ophthalmics: Mast Cell Stabilizers

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

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

**DOCUMENTATION:**

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

## Ophthalmics: Mast Cell Stabilizers

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| CROMOLYN SODIUM † (compare to Crolom®) | Alamast® (pemirolast potassium)<br>Alocril® (nedocromil sodium)<br>Alomide® (lodoxamide)<br>Crolom®* (cromolyn sodium) |

# 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.

Bromday®, Bromfenac, Diclofenac, Nevanac®, Voltaren®, Xibrom®,

- The patient has had a documented side effect, allergy, or treatment failure to Acular® or Acular LS®. In addition, if a product has an AB rated generic, there must have also been a trial of the generic formulation.

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**.

## Ophthalmics: NSAIDs

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| ACULAR® (ketorolac 0.5% ophthalmic sol.)<br>ACULAR LS ® (ketorolac 0.4% ophthalmic sol.)<br><br>FLURBIPROFEN 0.03% ophthalmic sol. †<br>(compare to Ocufen®) | Acuvail (ketorolac 0.45 %) Ophthalmic Solution<br>*(Quantity Limit = 30 unit dose packets/15 days)*<br>Bromday® ophthalmic sol (bromfenac 0.09%)<br>Bromfenac 0.09 % ophthalmic sol (compare to Xibrom®)<br>Diclofenac† 0.1% ophthalmic sol (compare to Voltaren®)<br>Ketorolac † 0.4 % ophthalmic sol (compare to Acular LS®)<br>Ketorolac † 0.5 % ophthalmic sol (compare to Acular®)<br>Nevanac® ophthalmic susp. (nepafenac 0.1%)<br>Ocufen®* ophthalmic sol. (flurbiprofen 0.03%)<br>Voltaren® (diclofenac 0.1% ophthalmic sol.)<br>Xibrom® ophthalmic sol. (bromfenac 0.09%) |

# Otic: Anti-Infectives

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

**Cetraxal®**

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

**Cipro-HC®, Coly-Mycin S®, Cortisporin TC®**

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

**Cortisporin® Otic:**

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

**Acetasol HC, Acetic Acid/Hydrocortisone†, Auralgan®, Myoxin, Otic Care®, Otic Edge®, PR Otic®, Treagan®, TriOxin®, Zinotic®/Zinotic ES®:**

- The patient has had a documented side effect, allergy, or treatment failure to at least TWO preferred otic anti-infectives.

**Vosol HC®:**

- The patient has had a documented side effect, allergy, or treatment failure to at least TWO preferred otic anti-infectives. In addition, the patient has had a documented intolerance to a generic acetic acid/hydrocortisone product.

**DOCUMENTATION:**

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

# Otic: Anti-Infectives

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **Anti-infective Single Agent** | |
| OFLOXACIN† 0.3% Otic Soln (previously Floxin®) | Cetraxal (ciprofloxacin 0.2%) otic solution<br>*(Quantity limit = 14 unit dose packages/7 days)* |
| **Anti-infective/Corticosteroid Combination** | |
| CIPRODEX® (ciprofloxacin 0.3%/dexamethasone 0.1%) otic suspension | Cipro-HC® (ciprofloxacin 0.2%/hydrocortisone 1%) otic suspension |
| NEOMYCIN/POLYMYXIN B SULFATE/HYDROCORTISONE† (compare to Cortisporpin otic®)<br>CORTOMYCIN† (neomycin/polymyxin B sulfate/hydrocortisone) Otic soln, susp | Coly-Mycin S®/Cortisporin TC® (neomycin/colistin/thonzium/hydrocortisone)<br><br>Cortisporin otic®* (neomycin/polymyxin B sulfate /hydrocortisone) otic solution/suspension |
| **Miscellaneous Agents** | |
| ACETIC ACID† Otic soln<br>ACETIC ACID-ALUMINUM ACETATE† Otic soln<br>VOSOL® (Acetic Acid 2%) Otic soln | Acetasol HC† (acetic acid 2%/hydrocortisone 1% otic soln)<br><br>Acetic Acid/Hydrocortisone† Otic Soln<br><br>Auralgan®/Otic Care®/ Otic Edge®/PR Otic® /Treagan® (acetic acid/antipyrine/benzocaine/polycosanol)<br><br>TriOxin®/ Myoxin (benzocaine/chloroxylenol/hydrocortisone susp)<br><br>Vosol HC® (acetic acid 2%/hydrocortisone 1% otic soln)<br><br>Zinotic®/Zinotic ES® (chloroxylenol/glycerin/pramoxine/zinc acetate) |

VERMONT

# Over-the-Counter (OTC) Drug Class Coverage

Department of Vermont Health Access

| Managed on Preferred Drug List (PDL)<br>Refer to PDL categories listed below for details | Limited to Generics Only | Class Not Covered |
|---|---|---|
| Anti-diabetics: Insulin | Analgesics, Oral | Alternative Medicines |
| Analgesics: NSAIDs | Antacids | Analgesics - Topical |
| Cough and Cold Preparations | Antidiarheals | Anesthetics - Local, Topical & Oral |
| Acne Drugs: Topical Anti-infectives | Antiemetics | Antiflatulents |
| Dermatological Agents: Antivirals: Topical | Anytipruritics - Topical | Antihistamines -Topical |
| Dermatological Agents: Corticosteroids | Antiseptics, topical (Chlorine/Iodine) | Anti-infectives-Throat |
| Dermatological Agents: Antifungals: Topical | Decongestants, Nasal & Oral | Anti-Obesity Agents (All*) |
| Dermatological Agents: Antibiotics: Topical | Digestive Enzymes (example; Acidophilus) | Antiseborrheic Products |
| Dermatological Agents: Scabicides and Pediculocides | Emollient/Keratolytic/Antimitotic Agents | Antiseptics - Mouth/Throat |
| Diabetic Testing Supplies | Fluoride Dental Products | Antiseptics & Disinfectives |
| Gastrointestinals: Histamine-2 Receptor Antagonists | Glucosamine-Chondroitin | Bulk Chemicals |
| Gastrointestinals: Proton Pump Inhibitors | Hematopoietic Agents - Folic Acid/Folates | Charcoal Antidote |
| Nutritionals, Oral Liquid | Iron Preparations - Ferrous Sulfate/Ferrous Gluconate | Contact Lens Solution |
| Ophthalmics: Antihistamines | Laxatives | Depigmenting Agents |
| Pulmonary: Antihistamines: 1st Generation | Melatonin (as a Single Agent only) | Hair Growth Agents |
| Pulmonary: Antihistamines: 2nd Generation | Minerals | Hematopoietic Agents - Cobalamins & Mixtures |
| Smoking Cessation Therapies | Calcium | Homeopathic Products |
| Vitamins: Prenatal Vitamins | Magnesium/Magnesium SR (brand Mag Tab SR* OK) | Infant Foods (refer to WIC) |
| | Sodium | Liniments |
| | Ophthalmics | Minerals |
| | Artificial Tears and Lubricants | Manganese |
| | Decongestants | Potassium (OTC) |
| | Hyperosmolar Products | Trace Minerals |
| | Oral Electrolyte Solution | Zinc |
| | Otic Agents - Miscellaneous | Mouthwashes |
| | Proteins/Amino Acids | Nutritional Substances, Miscellaneous |
| | Rectal Local Anesthetics | Nutritional Substitutes - Sweeteners |
| | Sleep Aids | Pigmenting Agents |
| | Tar Products | Scar Treatment Products |
| | Vaginal Anti-infectives | Shampoos |
| | Vitamins | Skin Cleansers |
| | Multiple Vitamins with Minerals | Skin Protectants |
| | Multivitamins (see next line) | Soaps |
| | (Aquadek*, Source CF* and Vitamax* brands covered) | Sunscreens |
| | Pediatric Vitamins | Throat Lozenges |
| | Vitamin B Complex, B1, B2, B3, B5, B6, B12 (some strengths) | Topicals, Miscellaneous |
| | Vitamin D | Vitamins |
| | | Vitamin A |
| | | B-Complex with Minerals, B7 |
| | | Bioflavanoids |
| | | Biotin |
| | | Vitamin C |
| | | Vitamin E |
| | | Wound Dressings |

Last Updated 03/20/2012

# Pancreatic Enzyme Products

**LENGTH OF AUTHORIZATION:** not applicable

**CRITERIA FOR APPROVAL:** not applicable

| Pancreatic Enzyme Products | |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| CREON® 3,000 (lipase units) DR Capsule<br>CREON® 6,000 (lipase units) DR Capsule<br>CREON® 12,000 (lipase units) DR Capsule<br>CREON® 24,000 (lipase units) DR Capsule<br>PANCREAZE® 4,200 (lipase units) DR Capsule<br>PANCREAZE® 10,500 (lipase units) DR Capsule<br>PANCREAZE® 16,800 (lipase units) DR Capsule<br>PANCREAZE® 21,000 (lipase units) DR Capsule<br>ZENPEP® 3,000 (lipase units) DR Capsule<br>ZENPEP® 5,000 (lipase units) DR Capsule<br>ZENPEP® 10,000 (lipase units) DR Capsule<br>ZENPEP® 15,000 (lipase units) DR Capsule<br>ZENPEP® 20,000 (lipase units) DR Capsule<br>ZENPEP® 25,000 (lipase units) DR Capsule | |

Abbreviations: DR=delayed release

# Parkinson's Medications

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Sinemet®, Sinemet® CR, Mirapex®, Parcopa®, Parlodel®, Requip®, Eldepryl®**

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

**Amantadine tablets**

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

**Azilect®**

- The diagnosis or indication is Parkinson's disease.

**AND**

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

**AND**

- The dose requested does not exceed 1 mg/day

**carbidopa/levodopa/entacapone**

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

**Mirapex ER®, Requip XL®, ropinirole XL**

- 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 immediate release product.

**OR**

- The patient has not been able to be adherent to a three times daily dosing schedule of the immediate release release product resulting in a significant clinical impact.

**AND**

- If the requested product has an AB rated generic, the patient has a documented intolerance to the generic product.

**Tasmar®**

- The diagnosis or indication is Parkinson's disease.

**AND**

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

**Zelapar®**

- The diagnosis or indication is Parkinson's disease.

**AND**

- The patient is on current therapy with levodopa/carbidopa.

**AND**

- Medical necessity for disintegrating tablet administration is provided (i.e. inability to swallow tablets or drug interaction with oral selegiline).

**AND**

- The dose requested does not exceed 2.5 mg/day.

**LIMITATIONS:**

To prevent the use of amantadine in influenza treatment/prophylaxis, days supply $\leq$ 10 days will require PA.

**DOCUMENTATION:**

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

## Parkinson's Medications

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **DOPAMINE PRECURSOR/DOPA DECARBOXYLASE INHIBITORS**<br>CARBIDOPA/LEVODOPA† (compare to Sinemet®)<br>CARBIDOPA/LEVODOPA† ER (compare to Sinemet® CR)<br>CARBIDOPA/LEVODOPA† ODT (compare to Parcopa®) | Parcopa®* (carbidopa/levodopa ODT)<br>Sinemet®* (carbidopa/levodopa)<br>Sinemet CR®*(carbidopa/levodopa ER) |
| **DOPAMINE AGONISTS (ORAL)**<br>BROMOCRIPTINE† (compare to Parlodel®)<br>PRAMIPEXOLE † (compare to Mirapex®)<br>ROPINIROLE† (compare to Requip®) | Mirapex®* (pramipexole)<br>Mirapex ER® (pramipexole ER)<br>*QL = 1 tab/day*<br>Parlodel®* (bromocriptine)<br>Requip®* (ropinirole)<br>Requip XL® (ropinirole XL)<br>*QL = 1 tab/day (all strengths except 12 mg), QL = 2 tabs/day (12 mg)*<br>ropinirole XL† (compare to Requip XL® )<br>*QL = 1 tab/day (all strengths except 12 mg), QL = 2 tabs/day (12 mg)* |
| **COMT INHIBITORS**<br>COMTAN® (entacapone) | Tasmar® (tolcapone) |
| **MAO-B INHIBITORS**<br>SELEGILINE† (compare to Eldepryl®) | Azilect® (rasagiline) *(QL = 1 mg/day)*<br>Eldepryl®* (selegiline)<br>Zelapar® (selegiline ODT) *(QL = 2.5 mg/day)* |
| **OTHER**<br>AMANTADINE†capsules (formerly Symmetrel®)<br>(PA required for ≤ 10 day supply)<br>STALEVO® (carbidopa/levodopa/entacapone) | Amantadine† tablets (formerly Symmetrel®) (Quantity limit PA also required for ≤ 10 day supply)<br>carbidopa/levodopa/entacapone† (compare to Stalevo®) |

ODT = orally disintegrating tablets

# Phosphodiesterase-4 (PDE-4) Inhibitor Medications

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

- The indication for the requested medication is treatment to reduce the risk of COPD exacerbations in patients with severe COPD associated with chronic bronchitis and a history of exacerbations.

**AND**

- The patient has had a documented side effect, allergy, treatment failure, or a contraindication to at least one inhaled long-acting anticholinergic AND at least one inhaled long-acting beta-agonist.

**AND**

- The patient has had a documented side effect, allergy, treatment failure, or a contraindication to at least one inhaled corticosteroid.

**DOCUMENTATION:**

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

| **Phosphodiesterase-4 (PDE-4) Inhibitors** | *Length of Authorization: 1 year* |
|---|---|
| **NO PA REQUIRED** | **PA REQUIRED** |
| | Daliresp® tablet (roflumilast)<br>*Quantity limit = 1 tablet/day* |

# 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**: Revatio IV: Date of service

All Others: 1 year

**CRITERIA FOR APPROVAL**:

Adcirca® (tadalafil) 20 mg, Revatio® (sildenafil citrate) 20 mg:

- Clinical diagnosis of pulmonary hypertension

  **AND**
- No concomitant use of organic nitrate-containing products

Viagra® (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

Revatio IV®

- Clinical diagnosis of pulmonary hypertension

  **AND**
- No concomitant use of organic nitrate-containing products

  **AND**
- The patient has a requirement for an injectable dosage form.

  **AND**
- Arrangements have been made for IV bolus administration outside of an inpatient hospital setting.

**DOCUMENTATION:**

- ✓ Document clinical information supporting the choice of agent on a **General Prior Authorization Request Form**.

| **Phosphodiesterase 5 (PDE-5)Inhibitors** | |
|---|---|
| | *Length of Authorization:Date of Service or 1 year* |
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| | Adcirca® (tadalafil)<br>*(Quantity Limit = 2 tablets/day)*<br>Revatio® (sildenafil citrate) tablet<br>*(Quantity Limit = 3 tablets/day)*<br>Revatio® (sildenafil citrate) vial<br>*(Quantity Limit = 3 vials/day, maximum 14 days supply per fill)*<br>Viagra® (sildenafil citrate)<br>*(Quantity Limit = 3 tablets/day)* |

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

# Platelet Inhibitors

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

**Agrylin®, Persantine®, Plavix®, Pletal®:**

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

**Brilinta®:**

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

OR

- The patient has had a documented side effect, allergy, inadequate response or has a contraindication to at least one preferred platelet inhibitor.

**LIMITATIONS:**

Plavix®/clopidogrel 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**.

| **Platelet Inhibitors** *Length of Authorization: 1 year*<br>**Key: † Generic product, *Indicates generic equivalent is available without a PA** | |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| AGGREGATION INHIBITORS<br>CILOSTAZOL† (compare to Pletal®)<br>EFFIENT® (prasugrel) Tablet *QL = 1 tablet/day*<br>CLOPIDOGREL 75 mg (compare to Plavix®)<br>TICLOPIDINE† (previously Ticlid®)<br><br>OTHER<br>AGGRENOX® (dipyridamole/Aspirin)<br>ANAGRELIDE† (compare to Agrylin®)<br>ASPIRIN†<br>DIPYRIDAMOLE† (compare to Persantine®) | Brilinta® (ticagrelor) Tablet *QL = 2 tablets/day*<br>Plavix® 75 mg (clopidogrel bisulfate)<br>Pletal®* (cilostazol)<br><br>Agrylin®* (anagrelide)<br>Persantine®* (dipyridamole) |

# Post-herpetic Neuralgia Agents

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

**Gralise®**:

- The patient has a diagnosis of post-herpetic neuralgia (PHN)

**AND**

- The patient has had a documented side effect, allergy, contraindication or treatment failure with at least one drug from the tricyclic antidepressant class.

**AND**

- The patient has had an inadequate response to the generic gabapentin immediate-release.

**DOCUMENTATION:**

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

| **Post-herpetic Neuralgia Agents** | *Length of Authorization: 1 year* |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| | Gralise® (gabapentin) tablet, starter pack<br>*Quantity Limit = 3 tablets/day*<br>*(Maximum 30 day supply per fill)* |

**Note**: Please refer to "Analgesics: Miscellaneous: Transdermal Patch" for clinical criteria for **Lidoderm®** and **Qutenza®**, "Anticonvulsants" for clinical criteria for **Lyrica®** and "Anti-Depressants – SNRIs" for clinical criteria for **Cymbalta®**.

# Psoriasis Medications: Injectables

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

**LENGTH OF AUTHORIZATION:** Initial PA of 3 months (Stelara 4 months), and 12 months thereafter upon recertification

**CRITERIA FOR APPROVAL:**

**Enbrel®**

The prescription must be written by a dermatologist

**AND**

The patient has a documented diagnosis of moderate to severe plaque psoriasis and has already been stabilized on Enbrel®

**OR**

The prescription must be written by a dermatologist

**AND**

The patient has a documented diagnosis of moderate to severe plaque psoriasis affecting > 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 different categories of therapy [i.e. at least 2 topical agents and at least 1 oral systemic agent, (unless otherwise contraindicated)] from the following categories:

**Topical agents**: emollients, keratolytics, corticosteroids, calcipotriene, tazarotene, etc.
**Systemic agents**: methotrexate, sulfasalazine, azathioprine, cyclosporine, tacrolimus, mycophenylate mofetil, etc.
**Phototherapy**: ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA, narrow band ultraviolet B (NUVA), etc.

**Humira®**

The prescription must be written by a dermatologist

**AND**

The patient has a documented diagnosis of moderate to severe plaque psoriasis and has already been stabilized on Humira®

**OR**

The prescription must be written by a dermatologist

**AND**

The patient has a documented diagnosis of moderate to severe plaque psoriasis affecting > 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 different categories of therapy [i.e. at least 2 topical agents and at least 1 oral systemic agent, (unless otherwise contraindicated)] from the following categories:

**Topical agents**: emollients, keratolytics, corticosteroids, calcipotriene, tazarotene, etc.
**Systemic agents**: methotrexate, sulfasalazine, azathioprine, cyclosporine, tacrolimus, mycophenylate mofetil, etc.
**Phototherapy**: ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA, narrow band ultraviolet B (NUVA), etc.

**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.

**Stelara®**

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 Stelara®

**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®**, **Humira® or Stelara®** 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**.

- ✓ All requests for infliximab (Remicade®) (whether billed through the pharmacy or medical benefit (J1745)) or ustekinumab (Stelara®) (whether billed through the pharmacy or medical benefit (J3357)) or alefacept (Amevive®) (J0215) (billed through the medical benefit) require Prior Authorization through the MedMetrics Clinical Call Center.

## Psoriasis Medications: Injectables

*Length of authorization: Initial PA of 3 months (Stelara 4 months); 12 months thereafter*

| PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET | NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET |
|---|---|
| ENBREL® (etanercept)<br>*Quantity limit = 8 syringes/28 days for the first 3 months; then 4 syringes/28 days(50 mg) or 8 syringes/28 days (25 mg) subsequently*<br><br>HUMIRA® (adalimumab)<br>*Quantity limit = 4 syringes/28 days for one month month; 2 syringes/28 days subsequently* | Amevive® (alefacept)<br><br>Remicade® (infliximab)<br><br>Stelara® (ustekinumab)<br>*(Quantity limit = 45 mg (0.5 ml) or 90 mg (1 ml) per dose)*<br>*(90 mg dose only permitted for pt weight > 100 kg)* |

# Psoriasis: Non-Biologics

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

**Calcitrene Ointment**

- The patient has a documented intolerance to Calcipotriene ointment.

**Dovonex Solution**

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

**Taclonex Ointment or Scalp Suspension**

- The patient has had an inadequate response to a 24 month trial of a betamethasone dipropionate product and Dovonex (or generic calcipotriene), simultaneously, with significant non-adherence issues.

**AND**

- The patient has had a documented side effect, allergy, or treatment failure with Tazorac 0.05% or 0.1% cream or gel.

  Note: If approved, initial fill of Taclonex® will be limited to 60 grams.

**Vectical Ointment, Calcitriol 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

**AND**

- If the request is for brand Vectical, the patient has hads a documented intolerance to the generic product.

**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**.

## Psoriasis: Non-Biologics

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **ORAL** | |
| CYCLOSPORINE† (all brand and generic)<br>METHOTREXATE† (all brand and generic)<br>OXSORALEN-ULTRA® (methoxsalen)<br>SORIATANE® (acitretin) capsules | |
| **TOPICAL** | |
| CALCIPOTRIENE† Solution (compare to Dovonex®)<br>CALCIPOTRIENE® OINTMENT (formerly Dovonex®)<br>DOVONEX® (calcipotriene cream)<br>PSORIATEC®, DRITHO-SCALP® (anthralin cream)<br>TAZORAC® (tazarotene cream, gel) | Calcitrene® (calcipotriene) ointment<br>calcitriol† (compare to Vectical®) Ointment<br>*(Quantity Limit = 200 g (2 tubes)/week)*<br>Dovonex®* Solution (calcipotriene)<br>Taclonex® (calcipotriene/betamethasone ointment/scalp suspension)<br>*(QL for initial fill = 60 grams)*<br>Vectical® Ointment (calcitriol)<br>*(Quantity Limit = 200 g (2 tubes)/week)* |

# 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**.

## Pulmonary: Anticholinergics

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **METERED DOSE INHALER (SINGLE AGENT)**<br>ATROVENT HFA® (ipratropium)<br>*Quantity Limit = 2 inhalers/25 days*<br>SPIRIVA® (tiotropium)<br>*Quantity Limit = 1 capsule/day* | |
| **NEBULIZER (SINGLE AGENT)**<br>IPRATROPIUM SOLN FOR INHALATION | |
| **METERED DOSE INHALER (COMBINATION)**<br>COMBIVENT® (ipratropium/albuterol)<br>*Quantity Limit = 2 inhalers/30 days* | |
| **NEBULIZER (COMBINATION)**<br>IPRATROPIUM/ALBUTEROL† (compare to Duoneb®) | Duoneb®* (ipratropium/albuterol) |

# Pulmonary: Antihistamines: Intranasal

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

ASTELIN, ASTEPRO, AZELASTINE, 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.

**AND**

- If the request is for azelastine (generic), the patient has had a documented intolerance to brand Astelin.

**DOCUMENTATION:**

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

| **Pulmonary: Antihistamines: Intranasal** | *Length of Authorization: 1 year* |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| | Astelin® (azelastine) Nasal Spray<br>*Quantity Limit = 1 bottle (30 ml)/25 days*<br><br>azelastine (compare to Astelin®) Nasal Spray<br>*Quantity Limit = 1 bottle (30 ml)/25 days*<br><br>Astepro® (azelastine) Nasal Spray<br>*Quantity Limit = 1 bottle (30 ml)/25 days*<br><br>Patanase® (olopatadine 0.6%) Nasal Spray<br>*Quantity Limit = 1 bottle (31 gm)/25 days* |

# Pulmonary: Antihistamines: 1st Generation

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

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

**DOCUMENTATION:**

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

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

# Pulmonary: Antihistamines: 2nd Generation

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

**SINGLE AGENT TABLET**

FEXOFENADINE 60MG/180 MG 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).

CLARINEX TABLETS, CLARITIN TABLETS, DESLORATADINE TABLETS, LEVOCETIRIZINE TABLETS, XYZAL 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.

**AND**

- If the request is for Clarinex or Xyzal, the patient must also have a documented intolerance to the generic equivalent tablets.

**CHEWABLE/ORALLY DISINTEGRATING TABLET**

CERTIRIZINE CHEWABLE TABLETS, CLARINEX REDITABS, CLARITIN CHEWABLE TABLETS, CLARITIN REDITABS, ZYRTEC ALLERGY OTC DISINTEGRATING 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 or requires less than a 10 mg dose of loratadine.

**SINGLE AGENT ORAL LIQUID**

CLARINEX SYRUP, CLARITIN OTC SYRUP, LEVOCETIRIZINE SOLUTION, XYZAL SOLUTION, ZYRTEC CHILDREN'S ALLERGY ORAL LIQUID

- 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 cetirizine syrup.

**AND**

- If the request is for Xyzal, the patient must also have a documented intolerance to levocetirizine solution.

**COMBINATION WITH PSEUDOEPHEDRINE**

CETIRIZINE D, CLARINEX-D, CLARITIN-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).

**LIMITATIONS:**

Many Allegra® and Zyrtec® brand products as well as Claritin® capsules are not covered as no Federal Rebate is offered. Fexofenadine/pseudoephedrine combination products) (brand and generic) are 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**.

## Pulmonary: Antihistamines: 2nd Generation

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **SINGLE AGENT TABLET**<br><br>LORATADINE † (OTC) (Allergy Relief®, Alavert®) (compare to Claritin®) 10 mg tablet<br>CETIRIZINE† OTC (formerly Zyrtec®) 5 mg, 10 mg tablets<br><br>**After loratadine OTC and cetirizine OTC trials**<br>FEXOFENADINE † 60 mg, 180 mg (OTC) tablets (formerly Allegra®) | Clarinex® (desloratadine) 5 mg tablet<br>Claritin®* tablets OTC (loratadine) 10 mg<br>desloratadine† (compare to Clarinex®) 5 mg tablet<br>Levocetirizine† (compare to Xyzal®) 5 mg tablet<br>Xyzal® (levocetirizine) 5 mg tablet<br><br>All other brands |
| **COMBINATION WITH PSEUDOEPHEDRINE**<br><br>LORATADINE/PSEUDOEPHEDRINE SR 12hr 5 mg/120 MG † (OTC) (Alavert Allergy/Sinus®) (compare to Claritin D® 12 hr)<br><br>LORATADINE/PSEUDOEPHEDRINE SR 24hr 10 mg/240 MG † (OTC) (compare to Claritin D® 24 hr) | Cetirizine/Pseudoephedrine SR 12hr 5 mg/120 mgOTC†<br>Clarinex-D® 12 hr (desloratadine/pseudoephedrine 2.5 mg/120 mg)<br>Clarinex-D® 24 hr (desloratadine/pseudoephedrine 5 mg/240 mg)<br>Claritin-D 12 hr®*§ (loratadine/pseudoephedrine 5 mg/120 mg)<br>Claritin-D 24 hr®*§ (loratadine/pseudoephedrine 10 mg/240 mg)<br><br>All other brands |
| **SINGLE AGENT ORAL LIQUID**<br><br>LORATADINE † (OTC) syrup (Allergy Relief®) (compare to Claritin®)<br>CETIRIZINE † (OTC, RX) syrup | Clarinex Syrup® (desloratadine)<br>Claritin OTC Syrup®* (loratadine)<br>Levocetirizine (compare to Xyzal®) Solution<br>Xyzal® (levocetirizine) Solution<br>Zyrtec®* Children's Allergy (cetirizine) (only one NDC)<br><br>All other brands |
| **CHEWABLE/ORALLY DISINTEGRATING TABLET**<br><br>LORATADINE † (OTC) (Allergy Relief®, Alavert®) rapidly disintegrating tablet (RDT) (compare to Claritin®) 10 mg | Certirizine † OTC Chewable Tablets 5 mg, 10 mg<br>Clarinex Reditabs®§ (desloratadine) 2.5 mg, 5 mg<br>Claritin (loratadine) OTC Chewable Tablets®§ 5 mg<br>Claritin (loratadine) OTC Reditabs®§ 5 mg, 10 mg*<br>Zyrtec Allergy® OTC (cetirizine orally disintegrating tablet) 10 mg<br><br>All other brands |

# Pulmonary: Beta-Adrenergic Agents

**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 an inhaled corticosteroid as 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.
  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.

**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

**Metaproterenol tablets/syrup**

- The patient has had a documented side effect, allergy or treatment failure with generic albuterol tablets/syrup.

**Terbutaline, Brethine® tablets**

- The medication is not being prescribed for the prevention/treatment of preterm labor.
  AND
- If Brethine is requested, 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**

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

# Pulmonary: Corticosteroids/Combinations: Inhaled

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL**:

**Metered-dose inhalers (single agent):**

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

**OR**

- The patient has had a documented side effect, allergy, or treatment failure to at least two preferred agents.

**Budesonide Inh Suspension (all ages):**

- The patient requires a nebulizer formulation.

**AND**

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

**Pulmicort Respules® (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: Corticosteroids/Combinations: Inhal

*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 |
|---|---|
| **METERED-DOSE INHALERS (SINGLE AGENT)** | |
| ASMANEX® 110 or 220 mcg/inh (mometasone furoate) *(QL =3 inhalers/90 days)*<br>FLOVENT DISKUS® (fluticasone propionate) *(QL = 3 inhalers/90 days)*<br>FLOVENT HFA® (fluticasone propionate) *(QL = 36 gm (3 inhalers)/90 days)*<br>PULMICORT FLEXHALER® (budesonide) *(QL = 6 inhalers/90 days)*<br>QVAR® 40 mcg/inh (beclomethasone) *(QL = 17.4 gm (2 inhalers)/90 days)*<br>QVAR® 80 mcg/inh (beclomethasone) *(QL = 58.4 gm (8 or 6 inhalers)/90 days)* | Alvesco® (ciclesonide) *(QL = 18.3 gm (3 inhalers)/90 days)) (80 mcg/inh)*<br>*(QL =36.6 gm (6 inhalers)/90 days)) (160 mcg/inh)* |
| **METERED-DOSE INHALERS (COMBINATION PRODUCT)** | |
| ADVAIR® DISKUS (fluticasone/salmeterol) *(QL = 3 inhalers/90 days)*<br>ADVAIR® HFA (fluticasone/salmeterol) *(QL = 36 gm (3 inhalers)/90 days)*<br>DULERA® (mometasone/formoterol) *(QL = 39 gm (3 inhalers)/90 days)*<br>SYMBICORT® (budesonide/formoterol) *(QL = 30.6 gm (3 inhalers)/90 days)* | |
| **NEBULIZER SOLUTIONS** | |
| PULMICORT RESPULES® (budesonide) (age ≤ 12 yrs) | Budesonide Inh Suspension (compare to Pulmicort Respules®) (all ages)<br>Pulmicort Respules® (budesonide) (age > 12 years) |

# Pulmonary: Corticosteroids: Intranasal

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL**:

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

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

**DOCUMENTATION:**

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

## Pulmonary: Corticosteroids: Intranasal

*Length of Authorization:* *1 year*

**Key: † Generic product**

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| FLUTICASONE Propionate† (compare to Flonase®)<br>*QL = 16 gm (1 inhaler)/30 days*<br>NASACORT AQ® (triamcinolone)<br>*QL = 16.5 gm (1 inhaler)/30 days*<br>NASONEX® (mometasone)<br>*QL = 17 gm (1 inhaler)/30 days* | Beconase AQ® (beclomethasone)<br>*QL =50 gm (2 inhalers)/30 days*<br>Flonase®* (fluticasone propionate)<br>*QL = 16 gm (1 inhaler)/30 days*<br>flunisolide † 25 mcg/spray (previously Nasalide®)<br>*QL = 50 ml (2 inhalers)/30 days*<br>flunisolide† 29 mcg/spray (formerly Nasarel®)<br>*QL = 50 ml (2 inhalers)/30 days*<br>Omnaris® (ciclesonide)<br>*QL = 12.5 gm (1 inhaler)/30 days*<br>Rhinocort Aqua® (budesonide)<br>*QL = 8.6 gm (1 inhaler)/30 days*<br>triamcinolone † (compare to Nasacort AQ®)<br>*QL = 16.5 gm (1 inhaler)/30 days*<br>Veramyst® (fluticasone furoate)<br>*QL = 10 gm (1 inhaler)/30 days* |

# Pulmonary: Leukotriene Modifiers

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

**Montelukast, Singulair®**

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

  **OR**
- 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 a second generation non-sedating antihistamine **AND** a nasal corticosteroid.

  **OR**
- The diagnosis or indication for the requested medication is urticaria.

  **AND**
- The patient has had a documented side effect, allergy, or treatment failure to at least TWO preferred 2nd generation antihistamines (i.e. loratadine (OTC), cetirizine (OTC), fexofenadine).

  **AND**
- If the request is for brand Singulair tablets or chew tablets, the patient has a documented intolerance to the generic equivalent montelukast preparation.

**Zafirlukast, Accolate®**

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

  **AND**
- If the request is for Accolate, the patient has a documented intolerance to generic zafirlukast.

**Zyflo CR®**

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

  **AND**
- The patient has had a documented side effect, allergy, or treatment failure to Accolate® or Singulair®.

**DOCUMENTATION:**

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

## Pulmonary: Leukotriene Modifiers

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| *Note: Children 5 years old and under not subject to PA criteria for Singulair®.* | Accolate® (zafirlukast)<br>*Quantity Limit = 2 tablets/day*<br><br>Montelukast sodium† (compare to Singulair®) tablets, chew tabs **§**<br>*Quantity Limit = 1 tablet per day*<br><br>Singulair® (montelukast sodium) **§** tablets, chew tabs, granules<br>*Quantity Limit = 1 tablet or packet per day*<br><br>zafirlukast (compare to Accolate®) **§**<br>*Quantity Limit = 2 tablets/day*<br><br>Zyflo CR® (zileuton SR)<br>*Quantity Limit = 4 tablets/day* |

Asthma Diagnosis: POS looks back for beta agonist rescue inhaler or inhaled coticosteroids/corticosteroid combinations for inferred diagnosis.
Allergic Rhinitis Diagnosis: POS looks back for second generation non-sedating antihistamine and nasal corticosteroid.

# Pulmonary: Synagis®

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

**LENGTH OF AUTHORIZATION:** Only one dose (based on recipient weight) will be approved per thirty-day period. Dose is given once monthly between November 1st and 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 under 12 monthsof age with either: (dosing continues in the RSV season through the end of the month the infant reaches 12 months old -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 DVHA 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**.

SYNAGIS® PALIVIZUMAB

VERMONT RSV Season 2011-2012

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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 MEDICAL

Wilcox Home Infusion
250 Stratton Road
Rutland, Vermont 05701
A subsidiary of bioscrip

Form Last Updated 09/2010

**Fax Completed Form to:**

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

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

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

| Gestational Age: weeks: days: | Current Weight: (kg) | Dose: 15mg / kg (weight verified monthly) |
|---|---|---|

Diagnosis:

☐ 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)

☐ 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 tart 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 or 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)

☐ Treatment: ☐ Dates of Use:

☐ Children under 24 months of age with hemodynamically significant cyanotic or acyanotic heart disease(CHD)

☐ Receiving medication to control congestive heart failure

☐ Moderate to severe pulmonary hypertension (maximum 5 doses)

☐ Have cyanotic heart disease

☐ Infants under 12 months of age with either: (dosing continues in the RSV season through the end of the month the infant reaches 12 months old – maximum 5 doses)

☐ Congenital abnormalities of the airways

☐ Neuromuscular condition compromising handling of respiratory tract secretions

☐ 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: Xolair® (for Persistent Asthma)

**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 (with or without chronic oral corticosteroid therapy) *or* has a contraindication to an inhaled corticosteroid.

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 or blood test (i.e.: RAST, CAP, intracutaneous test).

AND

- Patient has an IgE level ≥ 30 and ≤ 700 IU/ml prior to beginning therapy with Xolair®.

This drug must be billed through the DVHA 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**.

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

VERMONT

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

*Agency of Human Services*

# ~ 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 | | |
| Chronic Oral Corticosteroid | | |
| Leukotriene Receptor Antagonist | | |
| Long-Acting Beta Agonist | | |

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

Is the member's IgE level ≥ 30 and ≤ 700 IU/ml? ☐**Yes** ☐ **No** Please provide IgE level: _____

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

# Pulmonary Arterial Hypertension Medications

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

Flolan®

- Clinical diagnosis of pulmonary hypertension

AND

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

| **Pulmonary Arterial Hypertension Medications** *Length of Authorization: N/A*<br>**Key: † Generic product, *Indicates generic equivalent is available without a PA** | |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| **ENDOTHELIAN RECEPTOR ANTAGONISTS**<br><br>LETAIRIS® (ambrisentan) Tablet<br>*Quantity Limit = one tablet/day*<br>TRACLEER® (bosentan) Tablet<br>*Quantity Limit = 2 tablets/day* | |
| **PROSTANOIDS**<br><br>**Injection**<br>EPOPROSTENOL † ( compare to Flolan®)<br>REMODULIN® (treprostinil sodium injection)<br>VELETRI® (epoprostinil)<br><br>**Inhalation**<br>TYVASO® (treprostinil inhalation solution)<br>VENTAVIS® (iloprost inhalation solution) | Flolan®* (epoprostenol) |
| ****Maximum days supply for all drugs is 30 days**** | |

Note: Please refer to "Phosphodiesterase Inhibitor Medications" for Adcirca® and Revatio®.

# Renal Disease: Phosphate Binders

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

**Eliphos, PhosLo**

- The patient must have a documented intolerance to the generic equivalent calcium acetate tablet or capsule.

**Phoslyra**

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

**Renvela Oral Suspension Packet**

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

**Renvela tablet**

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

**DOCUMENTATION:**

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

| **Renal Disease: Phosphate Binders** *Length of Authorization: 1 year*<br>**Key: † Generic product, *Indicates generic equivalent is available without a PA** | |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| CALCIUM ACETATE † (compare to PhosLo®) capsule<br>CALCIUM ACETATE † (compare to Eliphos®) tablet<br>FOSRENOL® (lanthanum carbonate)<br>RENAGEL® (sevelamer hydrochloride) tablet | Eliphos® (calcium acetate) tablet<br>PhosLo®* (calcium acetate) capsule<br>Phoslyra® (calcium acetate) oral solution<br>Renvela® (sevelamer carbonate) Oral Suspension packet *(QL = 2 packs/day (0.8 g strength only))*<br>Renvela® (sevelamer carbonate) tablet |

# Restless Leg Syndrome Medications

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL:**

**Mirapex®, Requip®**

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

**Horizant®**:

- The patient has a diagnosis of restless legs syndrome (RLS).

**AND**

- The patient has had a documented side effect, allergy, contraindication or treatment failure to generic immediate release ropinirole AND pramipexole.

**AND**

- The patient has had an inadequate response or adverse reaction to generic gabapentin immediate-release.

**LIMITATIONS:**

Requests for Mirapex ER® and Requip XL® will not be approved for Restless Leg Syndrome (RLS).

**DOCUMENTATION:**

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

## Restless Leg Syndrome Medications

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **DOPAMINE AGONISTS (ORAL)**<br>PRAMIPEXOLE † (compare to Mirapex®)<br>ROPINIROLE† (compare to Requip®) | Mirapex®* (pramipexole)<br>Requip®* (ropinirole) |
| **GAMMA-AMINOBUTYRIC ACID ANALOG** | Horizant®(gabapentin enacarbil) 600 mg ER Tablet<br>*(Quantity Limit = 1 tablet/day)* |

# Rheumatoid, Juvenile Idiopathic & Psoriatic Arthritis Medications: Injectables

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

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

**OR**

Diagnosis is RA, juvenile idiopathic arthritis or psoriatic arthritis, and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD¶ *should be tried prior to approving Humira®.

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

**Enbrel®**

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

**OR**

Diagnosis is RA, JRA, or psoriatic arthritis, and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD¶ * should be tried prior to approving Enbrel®.

**Actemra®**

Patient has a diagnosis of RA or juvenile RA (JRA) and has already been stabilized on Actemra®

**OR**

Patient age ≥ 18 years (RA) or ≥ 2 years (JRA).

**AND**

Diagnosis is RA or juvenile RA (JRA) and patient has documentation of an inadequate response, adverse reaction or allergic response to methotrexate, or if methotrexate is contraindicated, at least 1 other 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® or Enbrel® cannot be used. For RA, patient must have had an inadequate response to one or more TNF inhibitors.

**Cimzia®**

Patient has a diagnosis of RA and has already been stabilized on Cimzia®

**OR**

Patient age ≥ 18 years

**AND**

Diagnosis is RA 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® or Enbrel® cannot be used.

**Remicade®**

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

**OR**

Diagnosis is RA or psoriatic arthritis, and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD* should be tried prior to approving Remicade®.

**AND**

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

**Simponi®**

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

**OR**

Patient age ≥ 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® or Enbrel® cannot beused.

**Kineret®**

Patient has a diagnosis of RA and has already been stabilized on Kineret®

**OR**

Diagnosis is RA or psoriatic arthritis, and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried prior to approving Kineret®.

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

**AND**

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

**Orencia® Intravenous Infusion**

Patient has a diagnosis of RA or juvenile RA (JRA) and has already been stabilized on Orencia®

**OR**

Diagnosis is RA or juvenile RA (JRA) and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD¶ should be tried prior to approving Orencia®. **Note:** Orencia® may be used as monotherapy or concomitantly with DMARDs, other than TNF antagonists. Orencia® should not be administered concomitantly with TNFantagonists (i.e. Enbrel®, Humira®, or Remicade®) and is not recommended for use with Kineret®.

**AND**

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

**AND**

If the diagnosis is RA, there is a clinically valid reason why Orencia® Subcutaneous cannot be used.

**Orencia® Subcutaneous**

Patient has a diagnosis of RA and has already been stabilized on Orencia®

**OR**

Diagnosis is RA and methotrexate therapy resulted in an adverse effect, allergic reaction, inadequate response, or treatment failure. If methotrexate is contraindicated, another DMARD should be tried prior to approving Orencia®. **Note:** Orencia® may be used as monotherapy or concomitantly with DMARDs, other than TNF antagonists. Orencia® should not be administered concomitantly with TNFantagonists

(i.e. Enbrel®, Humira®, or Remicade®) and is not recommended for use with Kineret®.

**AND**

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

¶ Patients with systemic juvenile arthritis (SJRA/SJIA) and fever are not required to have a trial of a DMARD, including methotrexate. Patients with systemic juvenile arthritis without fever should have a trial of methotrexate, but a trial of another DMARD in case of a contraindication to methotrexate, is not required before Enbrel®, Humira®, Actemra®, or Orencia® is approved.

***** 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®, Enbrel®, Remicade®.or Simponi®

**DOCUMENTATION:**

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

- ✓ All requests for infliximab (Remicade®) (whether billed through the pharmacy or medical benefit (J1745)) or tocilizumab (Actemra®) (J3262) or abatacept (Orencia Intravenous Infusion) (J0129) (both are billed through the medical benefit) require Prior Authorization through the MedMetrics Clinical Call Center.

## Rheumatoid, Juvenile Idiopathic and Psoriatic Arthritis: Injectables

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

| PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET | NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET |
|---|---|
| ENBREL® (etanercept)<br>*(Quantity limit = 4 syringes/28 days(50 mg) and 8 syringes/28 days (25 mg))* | Actemra® (tocilizumab)<br>*(Qty limit = 4 vials/28 days (80 mg vial), 3 vials/28 days (200 mg vial) or 2 vials/28 days (400 mg vial))* |
| HUMIRA® (adalimumab)<br>(*Quantity limit = 4 syringes/28 days)* | Cimzia® (certolizumab pegol)<br>*(Quantity limit = 1 kit/28 days (starter X 1, then regular))* |
| | Kineret® (anakinra)<br>*(Quantity limit = 1 syringe/day)* |
| | Orencia® (abatacept) Subcutaneous Injection<br>*(Quantity limit = 4 syringes/28 days)* |
| | Orencia® (abatacept) Intravenous Infusion |
| | Remicade® (infliximab) |
| | Simponi® (golimumab)<br>*(Qty limit = 1 syringe/28 days)* |

# Saliva Stimulants

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

SALAGEN®

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

**DOCUMENTATION:**

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

## Saliva Stimulants

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| PILOCARPINE† (compare to Salagen®)<br>EVOXAC® (cevimeline) | Salagen®* (pilocarpine) |

# Sedative Hypnotics: Benzodiazepine

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

The patient has had a documented side effect, allergy, or treatment failure with two preferred benzodiazepine sedative/hypnotics. If a product has an AB rated generic, one trial must be the generic.

**DOCUMENTATION:**

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

**MANAGEMENT OF MENTAL HEALTH DRUGS**: See page 170 for a description of the management of mental health drugs.

## Sedative Hypnotics: Benzodiazepine

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| ESTAZOLAM† (compare to Prosom®)<br>FLURAZEPAM† (formerly Dalmane®)<br>TEMAZEPAM 15 mg, 30 mg † (compare to Restoril®) | Doral® (quazepam)<br>Halcion® (triazolam)<br>Prosom®* (estazolam)<br>Restoril®* (temazepam)<br>temazepam† 7.5 mg, 22.5 mg (compare to Restoril®)<br>triazolam † (compare to Halcion®) |

# Sedative Hypnotics: Non-benzodiazepine, Non-barbiturate

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

**Ambien®:**

The patient has had a documented intoleranceto generic zolpidem.

**Ambien CR®, Lunesta®, Zolpidem CR:**

The patient has had a documented side effect, allergy or treatment failure to generic zolpidem. If the request is for Ambien CR 6.25 mg, there has also been a documented intolerance to the generic. If the request is for Zolpidem CR 12.5 mg, there has also been a documented intolerance to the brand product.

**Edluar®:**

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

**AND**

The patient has a documented intolerance to Zolpimist®.

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

**OR**

There is a question of substance abuse with the patient or family of the patient.

Note: If approved, initial fill of Rozerem® will be limited to a 14 day supply.

**Silenor®:** The patient has had a documented side effect, allergy, contraindication or treatment failure to generic zolpidem.

**AND**

The patient has had a documented intolerance with generic doxepin or there is another clinically valid reason why a generic doxepin (capsule or oral solution) cannot be used.

**Somnote®:** The patient has had a documented side effect, allergy, or treatment failure with two preferred medications from the sedative hypnotic: benzodiazepine and/or sedative hypnotic: non-benzodiazepine, non-barbiturate classes.

**Sonata®:**

The patient has had a documented intolerance to generic zaleplon

**Zolpimist®:**

The patient has a medical necessity for a non-oral dosage form (i.e. swallowing disorder).

.

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

## Sedative Hypnotics: Non-benzodiazepine, Non-barbiturate

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| CHLORAL HYDRATE † syrup<br><br>ZOLPIDEM † (compare to Ambien®)<br>*(Quantity Limit = 1 tab/day)*<br><br>ZALEPLON † (compare to Sonata®)<br>*(Quantity limit = 1 capsule/day (5 mg) or 2 capsules/day (10 mg))* | Ambien®* (zolpidem) *(Quantity Limit = 1 tab/day)*<br>Ambien CR® (zolpidem) *(Quantity Limit = 1 tab/day)*<br>Edluar® (zolpidem) sublingual tablet *(Quantity Limit = 1 tab/day)*<br>Lunesta® (eszopiclone) *(Quantity Limit = 1 tab/day)*<br>Rozerem® (ramelteon) *(Quantity Limit = 1 tab/day)*<br>Silenor® (doxepin) *(Quantity limit = 1 tab/day)*<br>Somnote® (chloral hydrate capsule)<br>Sonata® (zaleplon) *(Quantity limit = 1 cap/day (5 mg) or 2 caps/day (10 mg))*<br>Zolpidem CR† (compare to Ambien CR®)<br>*(Quantity Limit = 1 tab/day)*<br>Zolpimist® (zolpidem) Spray (5 mg/spray)<br>*(Quantity Limit = 1 canister/30 days)* |

# Skeletal Muscle Relaxants: Oral

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

MUSCULOSKELETAL AGENTS:

**Amrix, cyclobenzaprine ER, cyclobenzaprine 7.5 mg, Fexmid**

- The prescriber must provide a clinically valid reason why a preferred generic cyclobenzaprine cannot be used. For approval of Fexmid, the patient must also have a documented intolerance to the generic equivalent.

**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, metaxolone, Skelaxin:**

- 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.

**Lorzone**

- The patient has had a documented side effect, allergy or treatment failure with two different preferred musculoskeletal agents.

**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.

**Tizanadine capsules, Zanaflex capsules:**

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

AND

- If the request is for Zanaflex capsules, the patient must have a documented intolerance to generic tizanadine capsules.

**DOCUMENTATION:**

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

## Skeletal Muscle Relaxants: Oral

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **Musculoskeletal Agents** | |
| **Single Agent**<br>CHLORZOXAZONE† (compare to Parafon Forte DSC®)<br>CYCLOBENZAPRINE† (compare to Flexeril®)<br>METHOCARBAMOL† (compare to Robaxin®)<br>ORPHENADRINE CITRATE ER† (previously Norflex®) | Amrix®(cyclobenzaprine sustained-release)<br>carisoprodol 250 mg<br>carisoprodol†350 mg (compare to Soma®)<br>cyclobenzaprine ER† (compare to Amrix®)<br>cyclobenzaprine 7.5 mg† (compare to Fexmid®)<br>Fexmid® (cyclobenzaprine)<br>Flexeril®* (cyclobenzaprine)<br>Lorzone® (chlorzoxazone) tablets<br>metaxalone† (compare to Skelaxin®)<br>Parafon Forte DSC®* (chlorzoxazone)<br>Robaxin®* (methocarbamol)<br>Skelaxin® (metaxalone)<br>Soma® (carisoprodol) |
| **Combination Product**<br><br>*ASA = aspirin* | carisoprodol, ASA† (previously Soma Compound®)<br>carisoprodol, ASA, codeine† (previously Soma Compound with Codeine®)<br>Orphenadrine, ASA, caffeine† (previously Norgesic®, Norgesic Forte®) |
| **Antispasticity Agents** | |
| BACLOFEN† (previously Lioresal®)<br>DANTROLENE† (compare to Dantrium®)<br>TIZANIDINE† (compare to Zanaflex®) tablets | Dantrium®* (dantrolene)<br>tizanidine† (compare to Zanaflex®) capsules<br>Zanaflex® (tizanidine) capsules<br>Zanaflex®* (tizanidine) tablets |

# 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:**

**Nicoderm CQ patch**
- The patient has had a documented intolerance to generic nicotine patch.

**Nicorette gum**
- The patient has had a documented intolerance to generic nicotine gum.

**nicotine lozenge**
- The patient has had a documented side effect or allergy to Nicorette lozenge or Commit lozenge.

**Nicotrol Inhaler**
- The patient has had a documented treatment failure with BOTH generic nicotinepatch and generic nicotine 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 intolerance to generic 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)**

**LIMITATIONS:**

Nicotine System Kit® not covered – prescribe multiple strengths separately.

**DOCUMENTATION:**

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

| **Smoking Cessation Therapies** *Length of Authorization: see table*<br>**Key: † Generic product, *Indicates generic equivalent is available without a PA** | |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| **NICOTINE REPLACEMENT (Maximum duration is 16 weeks (2 x 8 weeks)/365 days)♠** | |
| NICOTINE GUM†<br>NICOTINE PATCH OTC†<br>COMMIT LOZENGE®<br>NICORETTE LOZENGE® | Nicoderm CQ Patch®<br>Nicorette Gum®<br><br>Nicotine lozenge†<br>Nicotrol inhaler®<br>Nicotrol Nasal Spray® |
| **ORAL THERAPY** | |
| BUPROPION SR† (compare to Zyban®)<br>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)<br>(maximum duration 24 weeks (2 x 12 weeks)/365 days)♠ |

♠ For approval of therapy beyond the established maximum duration, the prescriber must provide evidence that the patient is engaged in a smoking cessation counseling program.

# Testosterone: Topical

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

**Andoderm®, Axiron®, Fortesta®, Testim®**

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

**LIMITATIONS:**
Coverage of testosterone products is limited to males.

**DOCUMENTATION:**

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

| **Testosterone: Topical** | *Length of Authorization: 1 year* |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| ANDROGEL® GEL<br>(testosterone 1% gel packets)<br>*Quantity limit = 2.5 gm packet (1 packet/day)*<br>*5 gm packet (2 packets/day)*<br>ANDROGEL® PUMP (testosterone pump bottles)<br>*Quantity limit = 1 % (4 bottles/30 days)*<br>*1.62% (2 bottles/30days)*<br><br>*** Maximum days supply all products is 30 days *** | Androderm® Transdermal 2 mg, 2.5 mg, 4 mg, 5 mg (testosterone patch)<br>*Quantity limit = 1 patch/day/strength*<br>Axiron (testosterone 2% solution) 90 ml Pump Bottle<br>*Quantiy limit = 2 bottles/30 days*<br>Fortesta® (testosterone 2 % Gel) 60 gm Pump Bottle<br>*Quantity limit = 2 bottles/30 days*<br>Testim® Gel 5 gm (testosterone 1% gel tube)<br>*Quantity limit = 2 tubes/day*<br><br>*** Maximum days supply all products is 30 days *** |

# Thrombopoietin Receptor Agonists

**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/µL (< 30 x $10^9$/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**

- ✓ All requests for romiplostim (Nplate®) (J2796) (billed ONLY through the medical benefit) require Prior Authorization through the MedMetrics Clinical Call Center.

## Thrombopoietin Receptor Agonists

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| | Nplate® (romiplostim) Subcutaneous Injection<br>Promacta® (eltrombopag) Oral Tablets |

# Urinary Antispasmodics

**LENGTH OF AUTHORIZATION:** 1 year

**CRITERIA FOR APPROVAL: (for patients >21 and <65 years of age):**

***Please note: Patients <21 years of age are exempt from all 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, Enablex, Vesicare**

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

**Detrol, Detrol LA, Ditropan XL, Oxybutynin XL, Sanctura, Sanctura XR, tolterodine (generic), trospium (generic), Toviaz**

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

**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)<br>Flavoxate † (formerly Urispas®) |
| **LONG-ACTING AGENTS (after clinical criteria are met)** | |
| **<u>Twice Daily</u>** ***(Qty Limit = 2 per day)*** | Detrol® (tolterodine)<br>Sanctura® (trospium)<br>tolterodine (compare to Detrol®)<br>Trospium† (Sanctura®) |
| **<u>Once Daily</u>** ***(Qty Limit = 1 per day)***<br>ENABLEX® (darifenacin)<br>VESICARE® (solifenacin) | Detrol LA® (tolterodine)<br>Ditropan XL® (oxybutynin XL)<br>oxybutynin XL† (compare to Ditropan® XL)<br>Sanctura XR® (trospium)<br>Toviaz® (fesoterodine) |
| **<u>Transdermal/Topical</u>** | Gelnique® (oxybutynin topical gel)<br>*(Qty limit = 1 sachet/day)*<br>Oxytrol® (oxybutynin transdermal)<br>*(Qty limit = 8 patches/28 days)* |
| *Note:*<br>♦*Patients under the age of 65 must fail an adequate trial of generic oxybutynin before approval will be granted for either Vesicare® or Enablex®.*<br>♦ *A therapeutic failure on two preferred long acting products is required before a PA will be approved on any non-preferred long acting medication.*<br>♦*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®:**

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

**Metrogel Vaginal®:**

- The patient has had a documented side effect, allergy, or treatment failure to generic metronidazole vaginal gel 0.75 % or Vandazole.

**DOCUMENTATION:**

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

## Vaginal Anti-Infectives

*Length of Authorization: 1 year*

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

| PREFERRED DRUGS (No PA Required) | PA REQUIRED |
|---|---|
| **CLINDAMYCIN** | |
| CLINDAMYCIN VAGINAL† (clindamycin vaginal cream 2%) | Cleocin®* (clindamycin vaginal cream 2%)<br>Cleocin® Vaginal Ovules (clindamycin vaginal suppositories) |
| **METRONIDAZOLE** | |
| METRONIDAZOLE VAGINAL GEL 0.75%†<br>VANDAZOLE† (metronidazole vaginal 0.75%) | Metrogel Vaginal®* (metronidazole vaginal gel 0.75%) |

# Vitamins: Prenatal Multivitamins

**LENGTH OF AUTHORIZATION**: 1 year

**CRITERIA FOR APPROVAL:**

**All Non-Preferred**

- The prescriber must provide a clinically valid reason for the use of the requested medication including reasons why any of the preferred 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**.

| **Vitamins: Prenatal Multivitamins** | *Length of Authorization: 1 year* |
|---|---|
| **PREFERRED DRUGS (No PA Required)** | **PA REQUIRED** |
| PRENAPLUS®<br>PRENATAL PLUS/IRON®<br>PRENATAL PLUS®<br>PRENATE PLUS® | All others |

## *II. Prior Authorization Request & Specialty Pharmacy Order Forms*

- **Bone Resorption Inhibitors Injectable** Prior Authorization Request Form
- **Buprenorphine** Prior Authorization Request Form
- **Cimzia®** Prior Authorization Request/Order Form
- **Cystic Fibrosis** Medication Order Form
- **Enbrel®** Prior Authorization Request/Order Form
- **General** Prior Authorization Request Form
- **General SPECIALTY** Prior Authorization Request/Order Form
- **Gilenya®** Prior Authorization Request/Order Form
- **Growth Stimulating Agents** Prior Authorization Request/Order Form
- **Hemophilia Factors** Order Form
- **Hepatitis C (Peg-Interferon/Ribavirin)**Prior Authorization Request/Order Form
- **Hepatitis C Protease Inhibitors** Prior Authorization Request/Order Form
- **Humira®** Prior Authorization Request/Order Form
- **Kineret®** 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
- **Quetiapine** Prior Authorization Request Form
- **Remicade®** Prior Authorization Request/Order Form

- **Simponi®** Prior Authorization Request/Order Form
- **Stelara®** Prior Authorization Request/Order Form
- **Synagis®** Prior Authorization Request/Order Form
- **Vivitrol®** Prior Authorization Request Form
- **Xolair®** Prior Authorization Request Form

VERMONT

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

*Agency of Human Services*

# ~ BONE RESORPTION INHBITORS INJECTABLE ~

Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of injectable bone resorption inhibitors. For beneficiaries to receive coverage for these agents, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

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

**Prescribing physician:**

Name:_____

Phone #:_____

Fax #:_____

Address:_____

**Beneficiary:**

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

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:_____

**Drug requested:** ☐ Boniva IV ☐ Forteo ☐ Prolia ☐ Reclast ☐ Xgeva

**Dose & frequency:** _____

**Diagnosis/indication:**

☐ Treatment of postmenopausal osteoporosis ☐ Treatment of male osteoporosis

☐ Paget's Disease ☐ Treatment of glucocorticoid induced osteoporosis

☐ Bone metastases from solid tumors (tumor type: _____)

☐ Other (Please Explain) _____

**Has the member previously tried the following preferred medication?**

| ***Drug:*** | ***Response:*** |
|---|---|
| ☐ Alendronate Oral | ☐ side-effect ☐ treatment failure* dates of use: _____ |

*Treatment failure is defined as documented continued bone loss or fracture after one or more years despite treatment with the bisphosphonate.

Prescriber comments:_____

_____

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

VERMONT

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

*Agency of Human Services*

# ~BUPRENORPHINE ~

Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of buprenorphine/Suboxone®. These criteria are based on concerns about safety and the potential for abuse and diversion. All requests must be submitted using this fax form.

## Submit request via Fax (only): 1-866-767-2649

**Prescribing physician:**

Name:_____

Phone #:_____

Fax #:_____

Address:_____

**Beneficiary:**

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Contact Person at Office: _____

► Please answer the following questions:

| | |
|---|---|
| Is buprenorphine being prescribed for opiate dependency? | ☐ Yes ☐ No |
| Does the prescriber signing this form have a DATA 2000 waiver ID number ("X-DEA license")? | ☐ Yes ☐ No |
| Has the prescriber queried the VPMS (Vermont Prescription Monitoring System) to review patient's scheduled II-IV medication history? | ☐ Yes ☐ No<br>☐ Not signed up |
| A "Pharmacy Home" for **ALL** prescriptions has been selected **AND** discussed with patient? (Pharmacy must be located/licensed in VT)<br>Pharmacy Name:_____<br>Pharmacy Phone #: _____ | ☐ Yes ☐ No |
| Has patient filled a Suboxone RX in last 60 days | ☐ Yes ☐ No ☐ Don't know |
| Request is for the following medication: Sublingual **FILM** | ☐ Suboxone® (buprenorphine/naloxone) |
| Request is for the following medication: Sublingual **TABLET** | ☐ Suboxone® (buprenorphine/naloxone)<br>☐ Buprenorphine (formerly Subutex®) |
| Anticipated maintenance dose/frequency: (target dose of no more than 16 mg/day) (maximum 14 day supply per prescription fill)<br>Dose:_____ Frequency:_____ (recommended once daily) | |
| If this request is for Buprenorphine (formerly Subutex®), please answer the following questions:<br>Is the member pregnant? (please provide positive pregnancy test copy)<br>If yes, anticipated date of delivery: _____ | ☐ Yes ☐ No |
| Is the member breastfeeding a methadone/morphine dependent baby? (please provide history from neonatologist or pediatrician) | ☐ Yes ☐ No |
| Would you have referred your patient to a methadone clinic if this option was conveniently located and available? | ☐ Yes ☐ No |
| Additional clinical information to support PA request: | |

**Prescriber Signature: _____ (stamps not acceptable)**
**Prescriber X-DEA License #: _____ Date of request: _____**

VERMONT

**CIMZIA® (certolizumab pegol) - Prior Authorization/Prescription/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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

3

**Department of Vermont Health Access**

**CIMZIA® (certolizumab pegol)**

**PRIOR AUTHORIZATION REQUEST**

Patient Diagnosis:

☐ Rheumatoid Arthritis ☐ Crohn's Disease

If requesting prescriber is not a Rheumatologist 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)

| Therapy (and dates) | Reason for discontinuation |
|---|---|
| | |
| | |
| | |
| | |
| | |

Prescriber Additional Comments:

4

## PRESCRIPTION

**Dosage Form and Quantity:**

☐ Cimzia 200 mg/1 ml prefilled syringe (kit) Dispense Quantity: 1 (2 syringes)

or

☐ Cimzia 200 mg lyophilized vial (kit)
(for Health Care Professional administration) Dispense Quantity: 1 (2 vials)

or

☐ Cimzia 200 mg/1 ml prefilled syringe (Starter kit-6) Dispense Quantity: 1 (6 syringes)
400 mg (given as two subcutaneous injections of 200 mg) initially, and at Weeks 2 and 4

Sig: Dose/Route/Frequency:

☐ As above or

☐ 400 mg (given as two subcutaneous injections of 200 mg) every four weeks (Crohn's or RA) or

☐ 200 mg (given as one subcutaneous injection) every two weeks (RA)

Refill X:_____

Deliver product to: ☐ Patient's home ☐ MD office ☐ Clinic

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

VERMONT

**CYSTIC FIBROSIS MEDICATION – 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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

Please Note: Cayston® and pancreatic enzymes are not obtained though Ascend Specialty Pharmacy.

3

**Department of Vermont Health Access**

## PRIOR AUTHORIZATION REQUEST/PRESCRIPTION

### CYSTIC FIBROSIS INHALATION MEDICATION

**Patient Diagnosis:**

☐ Cystic Fibrosis ☐ Other:_____

(Requires Review by DVHA Medical Director)

**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:** _____

VERMONT

**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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

## 3 Department 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:** _____

VERMONT

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

*Agency of Human Services*

# ~ GENERAL ~

## Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

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

Prescribing physician:

**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:_____

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:**_____

VERMONT

**"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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221** 🖷

**Phone Number: 866-843-3604** ☎

3

**Department 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:** _____

VERMONT

**GILENYA® (fingolimod) - 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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

## 3 Department of Vermont Health Access GILENYA® (fingolimod) PRIOR AUTHORIZATION REQUEST

Patient Diagnosis:

☐ Relapsing Multiple Sclerosis

List previous self-injectable medication tried and failed for this condition:

| Medication (and dates) | Reason for discontinuation |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Date of observed first dose: _____/_____/_____

Prescriber Additional Comments:

## 4 PRESCRIPTION

☐ Gilenya 0.5 mg capsule Dispense Quantity: 28

Sig: Take one capsule once daily.

Refill X:_____

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

VERMONT

# 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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

## 3 Department of Vermont Health Access GROWTH STIMULATING AGENTS PRIOR AUTHORIZATION REQUEST

Patient Diagnosis:

Requested DVHA **PREFERRED** Growth Stimulating Agent

☐ Norditropin®

| | | |
|---|---|---|
| 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® ☐ Omnitrope® ☐ Saizen® ☐ Tev-Tropin®

Medical justification: _____

_____

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

☐ Increlex® ☐ Serostim® ☐ Zorbtive®

Other information/ Prescriber comments:

## 4 PRESCRIPTION

☐ Norditropin® FlexPro 5 mg/1.5 ml ☐ Norditropin® FlexPro 10 mg/1.5 ml

☐ Norditropin® FlexPro 15 mg/1.5 ml ☐ Norditropin® NordiFlex 30 mg/3 ml

☐ 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:** _____

VERMONT

**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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221** 🖷

**Phone Number: 866-843-3604** ☎

## 3 Department 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:** _____

VERMONT

# HEPATITIS C MEDICATIONS – Peg-Interferon/Ribavirin

**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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

## 3 Department of Vermont Health Access
## HEPATITIS C MEDICATIONS– Peg-Interferon/Ribavirin
### PRIOR AUTHORIZATION REQUEST

| Patient Diagnosis: | Genotype: |
|---|---|

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

Specialist name: _____ Specialist Type: _____

Most recent HCV-RNA level: _____IU/mL Date: ____/____/_____

Requested DVHA **PREFERRED** Oral Hepatitis C Product?

☐ Ribavirin 200 mg Tab (compare to Copegus®) ☐ Ribavirin 200 mg Cap (compare to Rebetol®)

Product: _____ or Medical justification: _____

Requested DVHA **PREFERRED** Injectable Hepatitis C Product?

☐ Pegasys® Prefilled Syringe ☐ Pegasys® Single Dose Vial ☐ Pegasys® Proclick

Product: _____ or Medical justification: _____

Patient will also be receiving (Please complete Hepatitis C Protease Inhibitors PA Form)

☐ Incivek® ☐ Victrelis® ☐ Neither

## 4 PRESCRIPTION

**Oral:**

☐ Ribavirin 200 mg ☐ Tablet or ☐ Capsule

or

☐ Other (Specify): _____

Dose: _____ Frequency: _____ Qty: 28 days supply Refill X:_____

**Injectable:**

☐ Pegasys® Prefilled Syringe 180 mcg/0.5 ml "Convenience Kit" (4 syringes/box)

or

☐ Pegasys® 180 mcg/1 ml Single Dose Vial

or

☐ Pegasys® ProClick ☐ 180 mcg/0.5 ml or ☐ 135 mcg/0.5 ml

or

☐ Other (specify): _____

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:** _____

VERMONT

# HEPATITIS C PROTEASE INHIBITORS (INCIVEK®/VICTRELIS®)

**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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

## 3 Department of Vermont Health Access HEPATITIS C PROTEASE INHIBITORS PRIOR AUTHORIZATION REQUEST

| Patient Diagnosis: | Genotype: |
|---|---|

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

Specialist name: _____ Specialist Type: _____

Requested Hepatitis C Protease Inhibitor?

☐ Incivek®: 375 mg tablet ☐ Victrelis®: 200 mg capsule

Patient is treatment naiive? ☐ **Yes** ☐ **No**

If no, previous response to peg-interferon/ribavirin

☐ Null responder ☐ Partial responder ☐ Relapser

Patient has had previous therapy with Incivek® or Victrelis®? ☐ **Yes** ☐ **No**

If yes, please specify: _____(agent) ___/___/____ (date) _____(response)

Most recent HCV-RNA level: _____IU/mL Date: ____/____/_____

Patient has cirrhosis? ☐ **Yes** ☐ **No**

Ribavirin/peg-interferon will be used concomitantly ☐ **Yes** ☐ **No**

Ribavirin/peg-interferon PA form included ☐ **Yes** ☐ **No**

or

Patient has started Ribavirin/peg-interferon therapy ☐ **Yes** ☐ **No**

If yes, date therapy initiated: ____/_____/_____

Prescriber Additional Comments:

## 4 PRESCRIPTION

☐ Incivek®: 375 mg tablet Sig: 750 mg PO TID with food Qty: 168 tablets (28 days)

☐ Victrelis®: 200 mg capsule Sig: 800 mg PO TID with food Qty: 336 capsules (28 days)

Refill X _____ Note: TID is q 7 – 9 hours

**** HCV-RNA levels will be required per protocol (required for certain refills) ****

Deliver product to: ☐ Patient's home ☐ MD office ☐ Clinic

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

VERMONT

**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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

3

**Department 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 (Crohn's Starter kit-6) Dispense Quantity: 6 (1 kit) Inject 4 pens (160 mg) subcutaneously on day 1 followed by 2 pens (80 mg) on day 15, then one pen (40 mg) every other week.

☐ Humira 40 mg/0.8 ml (Psoriasis Starter kit-4) Dispense Quantity: 4 (1 kit) Inject 2 pens (80 mg) subcutaneously on day 1, one (1) pen (40 mg) on day 8, then one pen (40 mg) every other week.

☐ Humira 40 mg/0.8 ml prefilled syringe Dispense Quantity: 2 or 4 Inject 1 syringe (40 mg) subcutaneously ☐every other week ☐every week (select RA ONLY)

☐ Humira PEN 40 mg/0.8 ml Dispense Quantity: 2 or 4 Inject 1 pen (40 mg) subcutaneously ☐every other week ☐every week (select RA ONLY)

☐ Humira PED 20 mg/0.4 ml prefilled syringe Dispense Quantity: 2 Inject 1 syringe (20 mg) subcutaneously every other week

Refill X:_____

Deliver product to: ☐ Patient's home ☐ MD office ☐ Clinic

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

VERMONT

**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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221** 🖷

**Phone Number: 866-843-3604** ☎

## 3 Department 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 inje 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:** _____

VERMONT

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

*Agency of Human Services*

# ~ LONG ACTING NARCOTICS ~

Prior Authorization Request Form

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

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

**Prescribing physician:**

Name:_____

Phone #:_____

Fax #:_____

Address:_____

**Beneficiary:**

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Contact Person at Office:_____

Drug Requested:

Please indicate: Brand Name □ or Generic Equivalent □

Dose /Frequency and Length of Therapy:

Diagnosis or Indication for Use::

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

| ***Check al that apply:*** | ***Re p nse, c ck all that apply:*** |
|---|---|
| Fentanyl Patches | side-effect non-response allergy |
| Methadone | side-effect non-response allergy |
| Morphine Sulfate SR 12 hr | side-effect non-response allergy |

For tramadol products, has the member previously tried the following preferred medication?

| ***Check if applicable:*** | ***Response, check all that apply:*** |
|---|---|
| Tramadol immediate release | side-effect non-response allergy |

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

Prescriber comments:

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

VERMONT

## 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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

### 3 Department 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:** _____

VERMONT

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

*Agency of Human Services*

# ~NUTRITIONALS ~

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 appropriate use and medical necessity. 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: _____

Nutritional supplement will be administered via Tube Feeding? ☐ Yes ☐ No **(Proceed to diagnosis question)**

Patient Diagnosis/Condition:

☐ AIDS ☐ Chronic Diarrhea ☐ Dementia (includes Alzheimer's) ☐ Inflammatory Bowel Disease
☐ Cancer ☐ Cognitive Impairment ☐ Developmental Delays ☐ Parkinson's
☐ Celiac Disease ☐ Cystic Fibrosis ☐ Difficulty with chewing/swallowing food ☐ Short Gut
☐ Cerebral Palsy ☐ Request is for weight loss/low weight or low serum protein **(complete appropriate section below)**
☐ Other: _____

Unplanned Weight Loss/Extremely Low Weight:

Baseline: Date: ___/___/____ Height: _____ Weight: _____ BMI: _____

Current: Date: ___/___/____ Height: _____ Weight: _____ BMI: _____

Children: Mid-Upper Arm Circumference: _____ Head Circumference: _____

Laboratory Values: Date: ___/___/____ Albumin: _____ Pre-Albumin:_____

Additional clinical information to support PA request:

Requested Supplement: _____

Strength & Frequency: _____

Anticipated duration of supplementation: _____

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

VERMONT

**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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

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MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

## 3 Department 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 |
|---|---|---|---|
| ☐GLEEVEC | | | |
| ☐HEXALEN | | | |
| ☐LUPRON DEPOT* | | | |
| ☐MERCAPTOPURINE* | | | |
| ☐MESNEX | | | |
| ☐NEULASTA* | | | |
| ☐NEUPOGEN* | | | |
| ☐REVLIMID* | | | |
| Authorization # _____ | | New RX Required every 28 days | |
| ☐SPRYCEL | | | |
| ☐SUTENT | | | |
| ☐TARCEVA | | | |
| ☐TEMODAR | | | |
| ☐XELODA | | | |
| **Other:** | | | |
| | | | |
| | | | |
| **Additional RX Instructions:** | | | |

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

* Not required to use Ascend

VERMONT

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

*Agency of Human Services*

# ~QUETIAPINE ~

Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of quetiapine when used in doses of 50 mg/day or less. These criteria are based on concerns about safety and cost. The prescriber must telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

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

**Prescribing physician:**

Name:_____

Phone #:_____

Fax #:_____

Address:_____

**Beneficiary:**

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Diagnosis:_____

Contact Person at Office: _____

Request is for: Quetiapine _____ mg (strength) _____ (frequency/directions for use)

**Patient Clinical Information to Support Quetiapine Prior Authorization Request**

☐ **Indication for use is schizophrenia.** ☐ **Indication for use is bipolar disorder.**

☐ **Indication for use is adjunct treatment of Major Depressive Disorder (MDD).**

**Patient initiated therapy with quetiapine for this indication on ___/___/____**

**Patient has responded inadequately to the antidepressants listed below (at least 3 from 2 different classes):**

| Medication Name and Dose | Dates |
|---|---|
| | |
| | |
| | |

☐ **Indication for use is an anxiety disorder.**

**Patient initiated therapy with quetiapine for this indication on ___/___/____**

**Patient has responded inadequately to the antidepressants listed below (at least 3 from 2 different classes):**

| Medication Name and Dose | Dates |
|---|---|
| | |
| | |
| | |

**Or two antidepressants above and ☐ buspirone (dates:_____)**

☐ **Indication for use is another mental health disorder (not approved for insomnia).**

**Please specify: _____**

**Patient initiated therapy with quetiapine for this indication on ___/___/____**

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

VERMONT

**Department of Vermont Health Access** *Agency of Human Services*
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

# ~ 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: _____

**Beneficiary:**

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

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:_____

**Remicade Infusion:** Dose: _____ Frequency:_____Length of therapy:_____

**Indication:**

☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Rheumatoid Arthritis

☐ Ankylosing Spondylitis ☐ Psoriasis (Plaque) ☐ Psoriatic 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:**_____

VERMONT

**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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

## 3 Department 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:** _____

VERMONT

**STELARA® (ustekinumab) - 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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 |
|---|---|
| | |

Ascend SpecialtyRx®

MedMetrics Health Partners
an SXC company

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

3

**Department of Vermont Health Access**

**STELARA® (ustekinumab)**

**PRIOR AUTHORIZATION REQUEST**

| Patient Diagnosis: | Patient Weight: |
|---|---|
| ☐ Plaque Psoriasis | _____ (kg) |

If requesting prescriber is not a Dermatologist, has one been consulted on this case?

☐ **Yes** ☐ **No**

Specialist name: _____ Specialist Type: _____

☐ Initial Request (please complete remainder of form below)

☐ Subsequent Request: Response/tolerability to Stelara_____

_____

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 oral, injectable,topical, phototherapy etc.)

| Therapy (and dates) | Reason for discontinuation |
|---|---|
| | |
| | |
| | |

Prescriber Additional Comments:

4

## PRESCRIPTION

**Dosage Form and Quantity:** (90 mg dose only permitted for patients > 100 kg)

☐ Stelara 45 mg/0.5 ml prefilled syringe Dispense Quantity: 0.5 ml

or

☐ Stelara 90 mg/1 ml prefilled syringe Dispense Quantity: 1 ml

Sig: Dose/Route/Frequency:_____

Refill X:_____

**Note: Dosed as initial dose, then 4 weeks later, then every 12 weeks.**

Deliver product to: ☐ MD office ☐ Clinic (Self administration not permitted at this time)

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

SYNAGIS® PALIVIZUMAB

VERMONT RSV Season 2011-2012

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 ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ 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 MEDICAL

Wilcox Home Infusion
250 Stratton Road
Rutland, Vermont 05701
A subsidiary of bioscrip

Form Last Updated 09/2010

**Fax Completed Form to:**

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

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

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

| Gestational Age: weeks: days: | Current Weight: (kg) | Dose: 15mg / kg (weight verified monthly) |
|---|---|---|

Diagnosis:

☐ Infants born at 28 weeks of gestation or earlier (i.e., ≤ 28 wee□s, 6 days) and under 12 months of age at the□□t□□t of the RSV □eason (maximum 5 doses)

☐ Infants born at 29 - 32 weeks (i.e., between 29 weeks, 0 days and 31 weeks, 6 da□s) of gestation and under 6 months of age at the start of the RSV season (maximum 5 □oses)

☐ 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 or 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)

☐ Treatment: ☐ Dates of Use:

☐ Children under 24 months of age with hemodynamically significant cyanotic or acyanotic heart disease(CHD)

☐ Receiving medication to control congestive heart failure

☐ Moderate to severe pulmonary hypertension (maximum 5 doses)

☐ Have cyanotic heart disease

☐ Infants under 12 months of age with either: (dosing continues in the RSV season through the end of the month the infant reaches 12 months old – maximum 5 doses)

☐ Congenital abnormalities of the airways

☐ Neuromuscular condition compromising handling of respiratory tract secretions

☐ 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.

VERMONT

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

*Agency of Human Services*

# ~VIVITROL~

Prior Authorization Request Form

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

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

**Prescribing physician:**

Name:_____

Phone #:_____

Fax #:_____

Address:_____

**Beneficiary:**

Name:_____

Medicaid ID #:_____

Date of Birth:_____Sex:_____

Diagnosis:_____

Contact Person at Office: _____

**Administering physician:**

Name: _____ Address: _____

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

### QUALIFICATIONS

| | |
|---|---|
| **MDs** | Prescribers must secure direct delivery of Vivitrol from the pharmacy to the physician's office. Pharmacies may not dispense Vivitrol directly to the patient. Vivitrol **may not** be billed through the Medical Benefit as a J-Code J2315. |

### PROCESS

► Please answer the following questions:

| | |
|---|---|
| Patient diagnosis ? | □ Alcohol dependence □ Prevention of relapse to opioid dependency |
| Has the patient been opiate free for > 7 – 10 days | □ Yes □ No |
| **For alcohol dependence:**<br>**(1)** Has the patient tried any of the following? Please document below.<br>oral naltrexone: □ side-effect □ non-response □ allergy<br>acamprosate: □ side-effect □ non-response □ allergy<br>disulfiram: □ side-effect □ non-response □ allergy | □ Yes □ No |
| **(2)** Has patient had a recent hospital admission for alcohol detoxification? | □ Yes □ No<br>If yes, date: ____/_____/____ |
| **For prevention of relapse to opioid dependency**<br>**(1)** Has the patient failed buprenorphine therapy?<br>**(2)** Is the patient not a candidate for buprenorphine therapy?<br>**(3)** Patient requires injectable therapy? | □ Yes □ No<br>□ Yes □ No<br>□ Yes □ No |
| Comments and additional patient history: | |

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

VERMONT

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

*Agency of Human Services*

# ~ 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 | | |
| Chronic Oral Corticosteroid | | |
| Leukotriene Receptor Antagonist | | |
| Long-Acting Beta Agonist | | |

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

Is the member's IgE level ≥ 30 and ≤ 700 IU/ml? ☐**Yes** ☐ **No** Please provide IgE level: _____

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