



Preferred Drug List (PDL) and Drugs Requiring Prior Authorization (PA)

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 column. Any drug not listed as preferred in any of the included categories requires Prior Authorization.

Phone Numbers for Vermont Medicaid PBM Program

GHS/Emdeon
PRESCRIBER Call Center:
PA Requests
Tel: 1-844-679-5363; Fax: 1-844-679-5366
Note: Fax requests are responded to within 24 hrs.
For Urgent requests, please call GHS/Emdeon Directly

DVHA Pharmacy Administration:
Director of Pharmacy Services
Nancy Hogue, Pharm. D.
Tel: 802-879-5611
Fax: 802-879-5651

GHS/Emdeon
PHARMACY Call Center:
PA Requests
Tel: 1-844-679-5362
Available for assistance with claims processing

DVHA Pharmacy Unit Staff:
Stacey Baker
Tel: 802-879-5912
Fax: 802-879-5651
E-Mail: stacey.baker@state.vt.us

GHS/Emdeon Sr. Account Manager:
Clinical Pharmacy Manager
Michael Ouellette R.Ph
Tel: 1-802-922-9614
E-Mail: mouellette@ghsinc.com

DVHA Medical Staff:
Medical Director
J. Scott Strenio, M.D.
Tel: 802-871-3194



VERMONT PREFERRED DRUG LIST and DRUGS REQUIRING PRIOR AUTHORIZATION (includes Clinical Criteria)

CATEGORY	PREFERRED DRUGS	NON-PREFERRED DRUGS	PA Required	Criteria
General Criteria for all PDL categories: For more information or help using the PDL, providers may call 1-xxx-xxx-xxxx; members should call 1-xxx-xxx-xxxx. To access PDL and PA materials via the internet: dvha.vermont.gov				
ACNE AGENTS				
ORAL AGENTS	DOXYCYCLINE CAP DOXYCYCLINE TAB E.E.S ERY-TAB ERYTHROMYCIN BASE ERYTHROMYCIN ETHYLSUCCINATE ISOTRETINOIN CAP MINOCYCLINE TETRACYCLINE CAP	ADOXA (doxycycline monohydrate) TAB ABSORICA (isotretinoin) CAPS DYNACIN (minocycline) CAP, TAB ERYPED (erythromycin ethylsuccinate) ERYTHROCIN (erythromycin stearate) MINOCIN (minocycline) CAP MONODOX (doxycycline monohydrate) CAP ORACEA (doxycycline monohydrate) CAP PCE DISPRTAB (erythromycin base) PERIOSTAT (doxycycline hyclate) TAB VIBRAMYCIN (doxycycline calcium) SYRUP VIBRAMYCIN (doxycycline hyclate) CAP, SUSP ALL OTHER DOXYCYCLINE BRANDS ALL OTHER ERYTHROMYCIN BRANDS ALL OTHER ISOTRETINOIN BRANDS ALL OTHER MINOCYCLINE BRANDS ALL TETRACYCLINE BRANDS		Brand name minocycline products: 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 & Vibramycin Suspension): 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: patient has a diagnosis of Rosacea AND patient has had a documented side effect, allergy, or treatment failure with doxycycline, minocycline, and tetracycline. Vibramycin Suspension, Syrup: patient has a medical necessity for a liquid dosage form. Brand name erythromycin products: patient has had a documented side effect or treatment failure with one preferred erythromycin product. Brand name tetracycline products: 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 and DR products (brand and generic) not covered. Adoxa Pak and doxycycline monohydrate Pak specialty packaging dosage form not covered. Adoxa 150mg cap and doxycycline monohydrate 150mg cap (brand and generic) not covered.
TOPICAL ANTI-INFECTIVES	BENZOYL PEROXIDE 2.5%, 4%, 5%, 8%, 10% GEL 2.5%, 4%, 5%, 7%, 8%, 10% WASH 3.5%, 5.5%, 8.5% CREAM 3%, 4%, 5%, 6%, 8%, 9% LOTION 3%, 6%, 9% PADS CLINDAMYCIN 1% SOL, GEL, LOT, PADS ERYTHROMYCIN 2% SOL, GEL, PADS ERYTHROMYCIN/BENZOYL PEROXIDE SODIUM SULFACETAMIDE 10% LOT SODIUM SULFACETAMIDE/SULFUR LOT SODIUM SULFACETAMIDE/SULFUR WASH	ACZONE (dapsone 5% gel) AKNE-MYCIN (erythromycin 2% ointment) AVAR (sodium sulfacetamide/sulfur gel) AVAR LS (sulfacetamide/sulfur wash) AVAR-E LS (sulfacetamide/sulfur cream) AZELEX (azelaic acid 20% cream) BENZAC AC 2.5%, 5%, 10% GEL, WASH BENZACLIN (clindamycin/benzoyl peroxide) BENZAMYCIN (erythromycin/benzoyl peroxide) BENZASHAVE 5%, 10% CREAM BREVOXYL 4%, 8% WASH GEL, LOTION CLEOCIN-T (clindamycin 2% gel) CLINAC BPO 7% GEL CLINDAGEL (clindamycin 1% gel) DESQUAM-EIX 2.5%, 5%, 10% GEL; 5%, 10% WASH DUAC (clindamycin/benzoyl peroxide) GEL, KIT ERYGEL (erythromycin 2% gel) INOVA 4% PADS KLARON (sodium sulfacetamide 10% lotion) PACNEX HP/LP 4.25%, 7% PADS PANOXYL/AQ 2.5%, 5%, 10% GEL; 5%, 10% BAR PENZOYL PEROXIDE 10% LOTION PLEXION/SUMAXIN TS (sulfacetamide/sulfur solution, cream, lotion) ROSAC (sulfacetamide/sulfur wash) ROSULA (sulfacetamide/sulfur wash) SULFACET-R (sodium sulfacetamide/sulfur lotion) SULFOXYL (erythromycin/benzoyl peroxide) TRIAZ 3%, 6%, 9% GEL; 3% 6% 9% PADS ZACLIR 8% LOTION		Brand name single ingredient products: patient has had a documented side effect, allergy, or treatment failure with a preferred generic benzoyl peroxide, clindamycin, erythromycin, and sodium sulfacetamide (from within the same sub-category). (If a product has an AB rated generic, there must have been a trial of the generic.) Brand name combination products: 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, there must have been a trial of the generic.) AND 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 AND 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) Benzefoam and Riax Foam not covered. Other topical generic benzoyl peroxide preparations preferred. Clindamycin Aerosol (Foam) and Evoclin not covered. Other topical generic clindamycin preparations preferred. Sodium sulfacetamide/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. Parscion FC and Plexion (sodium sulfacetamide/sulfur) pads/cloths dosage form not covered. Other topical generic sodium sulfacetamide/sulfur preparations preferred.

		Z-CLINZ (clindamycin/benzoyl peroxide) ZODERM (urea/benzoyl peroxide) CREAM, GEL ALL OTHER BENZOYL PEROXIDE BRANDS ALL OTHER BRANDS ALL OTHER CLINDAMYCIN BRANDS ALL OTHER ERYTHROMYCIN BRANDS ALL OTHER SODIUM SULFACETAMIDE BRANDS ALL OTHER sulfacetamide/sulfur COMBO BRANDS All other brands any topical acne anti-infective medication	
TOPICAL - RETINOIDS	TRAZORAC 0.05%, 0.1% CREAM,GEL TRETINOIN 0.025%, 0.05%, 0.1% CREAM TRETINOIN 0.01%, 0.025% GEL	ALL BRAND TRETINOIN PRODUCTS ADAPALENE (Differin) 0.01% CREAM, 0.3% GEL AVAGE (tazarotene) DIFFERIN (adapalene) 0.1% CREAM, GEL, LOTION; 0.3% GEL RENOVA (tretinoin) SOLAGE (tretinoin/mequinol) TRETINOIN MICROSPHERE (Retin-A Micro) TRI-LUMA (tretinoin/hydroquinone/fluocinolone)	Brand name tretinoin products and generic tretinoin microsphere: diagnosis or indication is acne vulgaris, actinic keratosis, or rosacea AND patient has had a documented side effect, allergy, or treatment failure with a preferred generic topical tretinoin product. If a product has an AB rated generic, the trial must be the generic formulation. Differin (brand) and adapalene (generic): diagnosis or indication is acne vulgaris, actinic keratosis, or rosacea AND patient has had a documented side effect, allergy, or treatment failure with a preferred generic topical tretinoin product AND the request is for teh brand product, the patiien has had a documented intolerance to a generic adapalene product. Tretinoin (age < 10 or > 34): 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.) (i.e. Avage, Renova, Solage, Tri-Luma). Epiduo Gel, Ziana - these combinations not covered, individual components may be prescribed separately. Fabior (tazarotene) Foam not covered. Tazorac cream and gel preferred.
TOPICAL - ROSACEA	METRONIDAZOLE 0.75% CREAM, GEL, LOT	ALL BRAND METRONIDAZOLE PRODUCTS FINACEA (azelaic acid) 15% GEL METRONIDAZOLE 1% GEL	Brand name metronidazole products, metronidazole 1% gel (generic) and Finacea: diagnosis or indication is roacea AND patient has had a documented side effect, allergy or treatment failure with a preferred generic topical metronidazole product. If a product has an AB rated generic, there must have also been a trial of the generic formulation. Limitations: The use of Mirvaso (brimonidine topical gel) for treating skin redness is considered cosmetic. Medications used for cosmetic purposes are excluded from coverage. Mirvaso topical gel has not been shown to improve any other symptom of roacea (e.g. pustules, papules, flushing, etc) or to alter the course of the disease.
ADHD AND NARCOLEPSY/CATAPLEXY MEDICATIONS			
ADHD age >12: patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization). OR patient has a documented treatment failure, due to lack of efficacy, to 2 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 1 long-acting CNS stimulant. AND patient has had a documented side-effect, allergy, or treatment failure to Strattera. 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. 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.			
SHORT/INTERMEDIATE ACTING	AMPHETAMINE/DEXTROAMPHETAMINE DEXTROAMPHETAMINE IR METADATE ER METHYLIN METHYLIN ER METHYLPHENIDATE METHYLPHENIDATE SR	ADDERALL (amphetamine/dextroamphetamine) DESOXYN (methamphetamine) DEXMETHYLPHENIDATE (Focalin) FOCALIN (dexmethylphenidate) METHAMPHETAMINE (Desoxyn) PROCENTRA (dextroamphetamine sulfate) 1MG/ML ORAL SOLUTION RITALIN (methylphenidate) RITALIN SR (methylphenidate SR) ZENZEDI (dextroamphetamine IR) TABLETS	Dexmethylphenidate and Focalin: patient has a diagnosis of ADD, ADHD or narcolepsy AND patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patiens is also on Focalin XR and teh prescriber is adding a shorter acting dosage form. OR 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. Ritalin and Ritalin SR: patient has a diagnosis of ADD, ADHD, or narcolepsy. AND 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: patient has a diagnosis of ADD, ADHD, or narcolepsy. AND 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 treatmetn alternatives. In addition, for approval of brand name Desoxyn, the patient must have had a documented intolerance to generic methamphetamine. Procentra, dextroamphetamine oral solution: patient has a medical necessity for an oral liquid dosage form. (eg. Swallowing disorder). AND if the request is for Procentra, the patient has a documented intolerance to the generic equivalent. Zenzedi: the prescriber provides clinical rationale explaining why other generic dextroamphetamine oral tablet products are not suitable alternatives.
LONG ACTING	ADDERALL XR DAYTRANA DEXTROAMPHETAMINE 24HR SR FOCALIN XR METHYLPHENIDATE SA OSM IR/ER (CONCERTA) QUILLIVANT XR VYVANSE	AMPHETAMINE/DEXTOAMPHETAMINE SR 24 HR IR/ER (Adderall XR) CONCERTA (methylphenidate SA OSM IR/ER) DEXEDRINE CR (dextroamphetamine 24 hr SR) DEXMETHYLPHENIDATE SR 24 HR IR/ER (Focalin XR) METADATE CD (methylphenidate CR, IR/ER) METHYLPHENIDATE CR, IR/ER (Metadate CD) METHYLPHENIDATE SR 24 HR IE/ER (Ritalin LA) RITALIN LA (methylphenidate SR 24 HR IR/ER)	Metadate CD, Ritalin LA, Methylphenidate CR, Methylphenidate SR 24 HR: patient has a diagnosis of ADD, ADHD or narcolepsy. AND patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR patient has had a documented side-effect, allergy, or treatment failure on Focaline XR or Methylphenidate SR OSM. AND for approval of generic methylphenidate CR or methylphenidate SR 24 HR , the patient must have had a documented intolerance to the brand equivalent. Concerta: patient has a diagnosis of ADD, ADHD, or narcolepsy. AND patient has had a documented intolerance to generic Methylphenidate SA OSM. Dexedrine CR: patient has a diagnosis of ADD, ADHD, or narcolepsy. AND patient has had a documented intolerance to the preferred generic equivalent. Amphetamine/dextroamphetamine SR 24 HR (generic) dexmethylphenidate SR 25 HR IR/ER (generic): patient has a diagnosis of ADD, ADHD, or narcolepsy. AND patient must have a documented intolerance to the brand name equivalent.
MISCELLANEOUS STIMULANTS		MODAFINIL (Provigil) NUVIGIL (armodafinil) PROVIGIL (modafinil) XYREM (sodium oxybate) ORAL SOLUTION	Nuvigil: Narcolepsy, excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome (adjunct to standard treatment): patient is > 17 years old. AND patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has had a documented side-effect, allergy or treatmetn 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: patient has been started and stabilized on the requested medication. (Note: samples are not considered adqequate justification for stabilization.) OR patient has had a documented side-effect, allergy or treatmetn failure to a CNS stimulant or has a contraindication for use of these agents (e.g. substance abuse history). AND if teh request is for modafinil, the patient has a documented intolerance to brand Provigil Xyrem: patient has a diagnosis of narcolepsy with cataplexy. AND patient will not be using alcohol or receiving central nervous systme (CNS) depressant drugs. AND patient has a documented side-effect, allergy, treatmetn failure, or contraindication to at least TWO agents from the following classes: selective serotonin inhibitor (SSRIs), venlafaxine or tricyclic antidepressant (e.g. protriptyline, clomipramine). OR patient has a diagnosis of narcolepsy with Excessive Daytime Sleepiness (EDS). AND patient will not be using alcohol or receiving central nervous systme (CNS) depressant drugs. AND patients has had a documented side-effect, allergy, treatmetn failure, or contraindication to both of ONE preferred sympathomimetics CNS stimulant (e.g. amphetamine, methylphenidate) and Provigil.
NON-STIMULANTS		CLONIDINE EXTENDED RELEASE (Kapvay)	

		<p>INTUNIV (guanfacine extended release) KAPVAY (clonidine extended release) STRATTEA (atomoxetine)</p>	<p>Intuniv: patient has a diagnosis of ADD or ADHD AND patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR patient has a documented treatment failure, due to lack of efficacy, to 2 long-acting CNS stimulants (Metadate CD, Ritalin XR, Focalin XR, Adderall XR, Methylphenidate SA OSM, Vyvanse, and Daytrana) OR patient has had a documented side-effect, allergy, or direct contraindication (e.g. comorbid tics, moderate-to-severe anxiety) to 1 long-acting CNS stimulant (Metadate CD, Ritalin XR, Focalin XR, Adderall XR, Methylphenidate SA OSM, Vyvanse or Daytrana) OR there is a question of substance abuse with the patient or family of the patient. OR family will choose to decline therapy if a stimulant must be trialed. OR patient has been trialed on immediate release guanfacine with good response but needs a dosage form with extended duration of therapy.</p> <p>Kapvay, Clonidine ER: patient has a diagnosis of ADD or ADHD. AND patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization). OR patient has a documented treatment failure, due to lack of efficacy, to 2 long-acting CNS stimulants (Metadate CD, Ritalin LA, Focaline XR, Adderall XR, Methylphenidate SA OSM, Vyvanse and Daytrana) OR patient has had a documented side-effect, allergy, or direct contraindication (e.g. comorbid tics, moderate-to-severe anxiety) to 1 long-acting CNS stimulant (Metadate CD, Ritalin LA, Focalin XR, Adderall XR, Methylphenidate SA OSM, Vyvanse or 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 extended duration formulation to maximize the clinical benefit. AND for approval of generic clonidine ER, patient must have had a documented intolerance to the brand equivalent.</p> <p>Strattera: patient has a diagnosis of ADD or ADHD. AND patients has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has a documented treatment failure, due to lack of efficacy, to 2 long-acting CNS stimulants (Metadate CD, Ritalin LA, Focalin XR, Adderall XR, Methylphenidate SA OSM, Vyvanse and Daytrana) OR patient has had a documented side effect, allergy, or direct contraindication (e.g. comorbid tics, moderate-to-severe anxiety) to 1 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 family will choose to decline therapy if a stimulant must be trialed. OR patient's need for drug therapy is primarily in early AM and evenings in the home environment.</p> <p>Limitations: Kapvay dose pack not covered - prescribe multiple strengths individually.</p>
ALPHA₁ - PROTEINASE INHIBITORS			
		<p>ARALAST NP GLASSIA PROLASTIN PROLASTIN-C ZEMAIRA</p>	<p>**Maximum days supply per fill for all drugs is 14 days**</p> <p>Criteria for Approval: The indication for use is treatment of alpha₁-proteinase inhibitor deficiency-associated lung disease when all of the following criteria are met: Patient's alpha₁-antitrypsin (ATT) concentration < 80 mg per dl [or < 11 micromolar] AND patient has obstructive lung disease as defined by a forced expiratory volume in one second (FEV₁) OF 30 - 65% of predicted or a rapid decline in lung function defined as a change in FEV₁ 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.</p>
ALZHEIMER'S MEDICATIONS			
CHOLINESTERASE INHIBITORS	<p>DONEPEZIL EXELON CAPS EXELON ORAL SOLUTION EXELON PATCH</p>	<p>ARICEPT (donepezil) TAB ARICEPT ODT (donepezil) DONEPEZIL ODT (Aricept ODT) GALANTAMINE (Razadyne) ORAL SOLUTION GALANTAMINE ER CAP (Razadyne ER) GALANTAMINE TAB (Razadyne) RAZADYNE (galantamine) ORAL SOLUTION RAZADYNE (galantamine) TAB RAZADYNE ER (galantamine) CAP RIVASTIGMINE (Exelon) Cap</p>	<p>Galantamine Tablet, Galantamine ER Capsule, Razadyne Tablet, Razadyne ER Capsule: diagnosis or indication for the requested medication is Alzheimer's disease. AND patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR patient had a documented side effect, allergy or treatment failure to donepezil and Exelon. AND if the product has an AB rated generic, the patient has a documented intolerance to the generic.</p> <p>Aricept: diagnosis or indication for the requested medication is Alzheimer's disease. AND the patient has a documented intolerance to the generic product.</p> <p>Galantamine Oral Solution, Razadyne Oral Solution: diagnosis or indication for the requested medication is Alzheimer's disease. AND 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.</p> <p>Aricept ODT, Donepezil ODT: 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.</p> <p>Rivastigmine Oral Capsule: diagnosis or indication for the requested medication is Alzheimer's disease. AND patient has a documented intolerance to the brand Exelon product.</p>
NMDA RECEPTOR ANTAGONIST	<p>NAMENDA ORAL SOLUTION NAMENDA TAB NAMENDA XR CAP</p>		
COX-2 INHIBITORS			
		<p>CELEBREX (celecoxib)</p>	<p>Celebrex: patient does not have a history of a sulfonamide allergy. AND patient has had a documented side effect, allergy, or treatment failure to two or more preferred generic NSAIDs. OR patient is not a candidate for therapy with a preferred generic NSAID due to one of the following: 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.</p>
ANALGESICS			
MISCELLANEOUS: Transdermal Patch		<p>LIDOCAINE 5% PATCH (Lidoderm) LIDODERM PATCH (lidocaine 5%) QUTENZA PATCH (capsaicin 8%)</p>	<p>Lidoderm, Lidocaine Patch: diagnosis or indication is neuropathic pain/post-herpetic neuralgia AND patient has had a documented side effect, allergy, treatment failure or contraindication to 2 drugs in the tricyclic antidepressant (TCA) class and/or anticonvulsant class AND patient has had a documented side effect, allergy, treatment failure or contraindication to Lyrica, OR patient has a medical necessity for a transdermal formulation (ex. dysphagia, inability to take oral medications), AND if the request is for generic lidocaine patch, the patient has had a documented intolerance to the brand product.</p> <p>Qutenza: diagnosis or indication is post-herpetic neuralgia AND patient has had a documented side effect, allergy, treatment failure or contraindication to 2 drugs in the tricyclic antidepressant (TCA) class and/or anticonvulsant class AND patient has had a documented side effect, allergy, treatment failure or contraindication to Lyrica AND patient has had a documented side effect, allergy treatment failure or contraindication to Lidoderm OR patient has a medical necessity for transdermal formulation (ex. dysphagia, inability to take oral medications) AND patient has had a documented side effect, allergy, treatment failure or contraindication to Lidoderm.</p>
OPIOIDS: Short Acting Quantity Limits may Apply	<p>APAP W/CODEINE APAP W/HYDROCODONE APAP W/OXYCODONE ASPIRIN W/CODEINE ASPIRIN W/OXYCODONE BUTALBITAL COMP. W/CODEINE CODEINE SULFATE DIHYDROCODEINE COMPOUND</p>	<p>ABSTRAL (fentanyl) SUBLINGUAL TABLETS ACTIQ (fentanyl lozenge on a stick) ANEXSIA (apap w/hydrocodone) APAP W/ CODEINE: all branded products APAP W/HYDROCODONE (Xodol) APAP W/HYDROCODONE: all branded products APAP W/OXYCODONE: all branded products BUTORPHANOL NASAL SPRAY</p>	<p>Butorphanol Nasal Spray: documented side effect, allergy, treatment failure, or contraindication to codeine, hydrocodone, morphine, & oxycodone (all 4 generic entities) as single or combination products. OR is unable to use tablet or liquid formulations.</p> <p>Abstral, Actiq, fentanyl transmucosal, Fentora, Lazanda, Subsys: indication of cancer breakthrough pain AND patient is opioid tolerant AND is on a long acting opioid formulation AND is 18 years of age or older (Actiq 16 years of age or older) AND prescriber is registered in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy (REMS) Access program AND member has had a documented treatment failure with or intolerance to 2 of the following 3 immediate release treatment options: morphine, hydromorphone or oxycodone. OR is unable to use tablet or liquid formulations AND if the request is for brand name Actiq, member has a documented intolerance to generic fentanyl transmucosal.</p> <p>Dilaudid - 5 Oral Solution, Hydromorphone Oral Solution: member has had a documented side effect, allergy or treatment failure with oxycodone oral solution and morphine oral solution OR has been started and stabilized on another dosage form of hydromorphone AND if the request is for the branded product, patient has a documented intolerance to the generic product.</p>

	<p>ENDOCET ENDODAN HYDROCODONE HYDROMORPHONE MEPERIDINE MORPHINE SULFATE OXOCYDONE W/IBUPROFEN OXYCODONE OXYCODONE W/APAP ROXICET TRAMADOL TRAMADOL/APAP ZAMICET</p>	<p>CAPITAL W/CODEINE (apap w/codeine) COCET/COCET PLUS (apap w/codeine) COMBUNOX (apap w/ibu) DEMEROL (meperidine) DILAUDID TABS (hydromorphone) DILAUDID-5 ORAL SOLN (hydromorphone) FENTORA (fentanyl citrate buccal tablets) FIORICET W/CODEINE (butalbital/apap/caffeine/codeine) HYDROCODONE-APAP SOL 10-325MG/15ML HYDROMORPHONE ORAL SOLN (Dilaudid-5 Soln) IBUDONE (hydrocodone w/ibu) LAZANDA (fentanyl) NASAL SPRAY LIQUICET (hydrocodone w/apap) LORCET, LORCET HD, LORCET PLUS (hydrocodone w/apap) LORTAB (hydrocodone w/apap) MAGNACET (oxycodone w/apap) MAXIDONE (hydrocodone w/apap) MEPERIDINE NORCO (hydrocodone w/apap) NUCYN TA (tapentadol) OPANA (oxymorphone) OXYECTA OXYCODONE CAPS OXYMORPHONE (Opana) PANLOR DC (apap/caffeine/dihydrocodeine) PENTAZOCINE W/APAP PENTAZOCINE W/NALOXONE PERCOCET (oxycodone w/apap) PERCODAN (oxycodone w/aspirin) REPREXAIN (hydrocodone w/ibu) ROXANOL (morphine sulfate) RYBIX ODT (tramadol ODT) SUBSYS (fentanyl) SUBLINGUAL SPRAY SYNALGOS DC (dihydrocodeine compound) TALWIN (pentazocine) and branded combinations TREZIX (apap/caffeine/dihydrocodeine) TYLENOL #3, #4 (apap w/codeine) TYLOX (oxycodone w/apap) ULTRACET (tramadol w/apap) ULTRAM (tramadol) VICODIN (hydrocodone w/apap) VICOPROFEN (hydrocodone w/ibu) XARTEMIS XR (oxycodone w/apap) XODOL (hydrocodone w/apap) XOLOX (oxycodone w/apap) ZYDONE (hydrocodone w/apap)</p>	<p>Nucynta, Opana, Oxymorphone: 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 Opana, member has a documented intolerance to generic oxymorphone.</p> <p>Oxycodone (generic) Capsules: member has a documented intolerance to generic oxycodone tablets.</p> <p>Oxecta: prescriber provides a clinically valid rationale why the generic immediate release oxycodone cannot be used AND member has a documented side effect, allergy, or treatment failure to at least 2 other preferred short acting narcotic analgesics. NOTE: a history of substance abuse does not warrant approval of Oxecta (oxycodone IR) since a clear advantage of this product over preferred short acting opioids in this population has not been established.</p> <p>Ultram, Ultracet: member has a documented intolerance to the generic formulation</p> <p>Rybix ODT: member has a medical necessity for a disintegrating tablet formulation (i.e. swallowing disorder)</p> <p>Xartemis XR: diagnosis is acute pain AND member has a documented side effect, allergy, or treatment failure to at least 2 short acting opioids not requiring prior approval, one of which is oxycodone w/ apap AND prescriber must provide a compelling clinical reason why an extended release product is required for treatment of acute pain.</p> <p>Other Short acting Opioids: member has had a documented side effect, allergy, or treatment failure to at least 2 medications not requiring prior approval. (If a product has an AB rated generic, one trial must be the generic)</p> <p>PA Requests to Exceed QL for Oxycodone IR or Hydromorphone IR: if dose consolidation is not possible (i.e. use of higher strength dosage form), all requests will be referred to the DVHA Medical Director for review unless the medication is being prescribed for pain related to an oncology diagnosis which will be approved by the Clinical Call Center.</p> <p>Limitations: APAP containing products: daily doses that result in > 4 grams of apap/day will reject for PA; Meperidine 75mg/ml injection no longer available - 25mg/ml, 50mg/ml and 100mg/ml available. Brand name Demerol 75mg/ml and 100mg/2ml not covered - no generic equivalents. Roxicodone (oxycodone) tablets not covered - product does not offer Federal rebate.</p>
<p>OPIOIDS: Long Acting Quantity limits may Apply</p>	<p>FENTANYL PATCH MORPHINE SULFATE CR 12HR</p>	<p>AVINZA (morphine sulfate beads SR 24hr) CAP BUPRENORPHINE (all products require PA) BUTRANS TRANSDERMAL SYSTEM CONZIP (tramadol ER) DOLOPHINE (methadone) TAB DURAGESIC (fentanyl patch) EMBEDA (morphine sulfate/naltrexone hydrochloride) CAP EXALGO (hydromorphone XR) TAB</p>	<p>CLINICAL CONSIDERATIONS: Long acting opioid 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. LA opioids should be prescribed for patients with a diagnosis or condition that requires a continuous, around-the-clock analgesic. LA opioids should be reserved for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. LA opioids are NOT intended for use as 'prn' analgesic. LA opioids 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. LA opioids are not intended to be used in a dosage frequency other than FDA approved regimens. Patients should not be using other extended release opioids 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 opioids.</p> <p>Brand Duragesic Fentanyl Patches: patient has a diagnosis of severe pain that requires daily, around-the-clock, long-term treatment and for which alternative treatment options are inadequate AND the</p>

		<p>HYDROMORPHONE (all products require PA)</p> <p>HYDROMORPHONE XR</p> <p>KADIAN (morphine sulfate XR)</p> <p>METHADONE (all products require PA)</p> <p>MORPHINE SULFATE SR 24HR CAP (Kadian)</p> <p>MORPHINE SULFATE SR BEADS 24HR (Avinza)</p> <p>MS CONTIN (morphine sulfate CR 12hr) TAB</p> <p>NUCYNIA ER (tapentadol ER)</p> <p>OPANA ER (oxymorphone ER) (crush resistant)</p> <p>OXYCODONE (all products require PA)</p> <p>OXYCONTIN (oxycodone ER)</p> <p>OXYMORPHONE (all products require PA)</p> <p>TAPENTADOL (all products require PA)</p> <p>TRAMADOL (all products require PA)</p> <p>ULTRAM ER (tramadol SR 24hr)</p>	<p>patient has had a documented intolerance to generic tentanyl patches.</p> <p>Butrans Transdermal System: patient has a diagnosis of severe pain that requires daily, around-the-clock, long term opiod treatment and for which alternative treatment options are inadequate AND patient has had a documented side effect, allergy, or treatment failure to morphine sulfate CR 12hr tablet (generic) AND generic fentanyl patch OR prescriber provides compelling clinical information for case specific discussion with DVHA Meclal Director who will determine PA decision.</p> <p>Methadone Tablet: patient has a diagnosis of severe pain that requires daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. (Note: Methadone products, when used for treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed ONLY by certified opioid treatment programs as stipulated in 42 CFR 8.12, NOT retail pharmacy) AND patient has been started and stabilized on the requested medication OR patient has a diagnosis of severe pain that requires daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. (Note: Methadone products, when used for treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed ONLY by certified opioid treatment programs as stipulated in 42 CFR 8.12, NOT retail pharmacy) AND patient has had a documented side effect, allergy, or treatment failure to morphine sulfate CR 12 hr tablets AND the initial methadone daily dose does not exceed 30mg AND for approval of brand Dolophine tablets, the patient must have a documented intolerance to the equivalent generic tablet.</p> <p>Methadone Liquid: patient has a diagnosis of severe pain that requires daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. (Note: Methadone products, when used for treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed ONLY by certified opioid treatment programs as stipulated in 42 CFR 8.12, NOT retail pharmacy) AND the patient has been started and stabilized on the requested oral liquid medication OR patient has a diagnosis of severe pain that requires daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. (Note: Methadone products, when used for treatment of opioid addiction in detoxification or maintenance programs, shall be dispensed ONLY by certified opioid treatment programs as stipulated in 42 CFR 8.12, NOT retail pharmacy) AND the initial methadone daily dose does not exceed 30mg AND the patient must have a medical necessity for an oral liquid (i.e. swallowing disorder, inability to take oral medications).</p> <p>Conzip, Tramadol ER biphasic-release Capsule, Tramadol ER biphasic-release Tablet, Tramadol ER/SR, Ultram ER: 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.</p> <p>Oral Non-Preferred (except methadone & tramadol containing products): patient has a diagnosis of severe pain that requires daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate AND the patient has had a documentd side effect, allergy, or treatment failure to morphine sulfate CR 12hr tablet (generic) 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 Opana ER (crush resistant) since a clear advantage of this product over preferred lono-actino ooids in this oopulation has not been established.</p> <p>Limitations: Methadone 40mg dispersible tablet not approved for retail dispensing. Methadone 2mg/ml oral solution not covered - use 1mg/ml generic oral solution. Opana ER (crush resistant): a history of substance abuse does not warrant approval of Opana ER (crush resistant) since a clear advantage of this product over preferred long-acting opioids in this population has not been established.</p>
NSAIDs	<p>DICLOFENAC POTASSIUM</p> <p>DICLOFENAC SODIUM</p> <p>DIFLUNISAL</p> <p>ETODOLAC</p> <p>FLURBIPROFEN</p> <p>IBUPROFEN</p> <p>INDOMETHACIN</p> <p>KETOPROFEN</p> <p>KETOPROFEN ER</p> <p>KETOROLAC</p> <p>MECLOFENAMATE SODIUM</p> <p>MELOXICAM</p> <p>NABUMETONE</p> <p>NAPROXEN</p> <p>NAPROXEN ENTERIC COATED</p> <p>NAPROXEN SODIUM</p> <p>OXAPROZIN</p> <p>PIROXICAM</p> <p>SULINDAC</p> <p>TOLMETIN SODIUM</p>	<p>ANAPROX (naproxen sodium)</p> <p>ANAPROX DS (naproxen sodium)</p> <p>ANSAID (flurbiprofen)</p> <p>ARTHROTEC (diclofenac sodium w/misoprostol)</p> <p>CAMBIA (diclofenac potassium) packet for oral solution</p> <p>CATAFLAM (diclofenac potassium)</p> <p>CLINORIL (sulindac)</p> <p>DAYPRO (oxaprozin)</p> <p>DICLOFENAC (Pennsaid) 1.5% TOPICAL SOLUTION</p> <p>DICLOFENAC SODIUM W/MISOPROSTOL (Arthrotec)</p> <p>DUEXIS (ibuprofen/famtidine)</p> <p>EC-NAPROSYN (naproxen sodium enteric coated)</p> <p>FELDENE (piroxicam)</p> <p>FENOPROFEN 600MG TAB (Nalfon)</p> <p>FLECTOR (diclofenac) 1.3% PATCH</p> <p>INDOCIN (indomethacin) SUSPENSION</p> <p>INDOCIN SR (indomethacin) CAPS</p> <p>MEFENAMIC ACID CAPS (Ponstal)</p> <p>MELOXICAM SUSPENSION</p> <p>MOBIC (meloxicam) SUSPENSION</p> <p>MOBIC (meloxicam) TABLETS</p> <p>MOTRIN (ibuprofen)</p> <p>NALFON (fenopropfen) 400MG TABS</p> <p>NAPRELAN (naproxen sodium)</p> <p>NAPROSYN (naproxen sodium)</p> <p>PENNSAID (diclofenac) 1.5% or 2% TOPICAL SOLUTION</p> <p>PONSTEL (mefenamic acid)</p> <p>SPRIX (ketorolac) NASAL SPRAY</p> <p>VIMOVO (naproxen/esomeprazole)</p> <p>VOLTAREN (diclofenac sodium)</p> <p>VOLTAREN (diclofenac) 1% GEL</p> <p>VOLTAREN XR (diclofenac sodium)</p>	<p>Arthrotec, diclofenac/misoprostol, Duexis: patient has a documented side effect or treatment failure to 2 or more preferred genreic NSAIDs OR patient is nto a candidate for therapy with a preferred generic NSAID mono-therapy due to one of the following: patients 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 patient is unable to take the individual components separately AND if the request is for brand Arthrotec, the patien has a documented intolerance to the generic equivalent.</p> <p>Cambia: drug is being prescribed for treatment of acute migraine attacks AND patietn has had a documented side effect or treatment failure to 2 or more preferred generic NSAIDs, one of which must be generic diclofenac OR drug is being prescribed for treatment of acute migraine attacks AND patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications) AND patient has had a documented side effect or treatmetn failure with the generic ibuprofen suspension and the generic naproxen suspension.</p> <p>Flector Patch, Pennsaid, Diclofenac 1.5% Topical Solution: diagnosis or indication is osteoarthritis or acute pain caused by minor strains, sprains, and contusions AND patient has had a documented side effect or inadequate response to Voltaren gel OR patient is not a candidate for therapy with a preferred generic NSAID due to one of the following: 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 patient has a documented medical necessity for a topical/transdermal formulation (ex. dysphagia, inability to take oral medicaions), AND for approval of Pennsaid 1.5%, the patient has had a documented intolerance to the generic equivalent.</p> <p>Sprix: indication or diagnosis is moderate to moderately severe pain. AND patient has had a documented inadequate response or intolerance to generic ketorolac tablets. OR patient has a documented medical necessity for the specialty dosage form (i.e. inability to take medication orally (NPO)).</p> <p>Voltaren Gel: diagnosis or indication is osteoarthritis or acute pain caused by minor strains, sprains, and contusions. AND patient has had a documetned side effect or treatmetn failure with at least 2 preferred generic NSAIDs. OR patient is not a candidate for therapy with a preferred generis NSAID due to one of the following: 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 patient is unable to take naproxen and a preferred proton pump inhibitor, separately.</p> <p>Zipsor, Zorvolex: patient has had a documented intolerance to diclofenac tablets. AND patient has had a documented side effect, allergy, or treatment failure to 4 or more preferred generic NSAIDs.</p> <p>All other PA requiring NSAIDs: patient has had a documented side effect or treatmetn failure or 2 or more preferred generic NSAIDs. (If a product has an AB rated generic, one trial must be the generic.)</p>

		ZIPSOR (diclofenac potassium) ZORVOLEX (diclofenac) CAPS	
ANEMIA: HEMATOPOIETIC/ERYTHROPOIETIC AGENTS			
	ARANESP (darbepoetin alfa) PROCRIPT (epoetin alpha)	EPOGEN (epoetin alpha)	<p>Aranesp, Procrit: 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</p> <p>Epoegen: 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 patient has had a documented side effect, allergy, or treatment failure to both Aranesp and Procrit.</p> <p>Limitations: Omontys (peginesatide) is available only to dialysis units at this time and so will not be available through the pharmacy benefit. As of 2/23/2013 Omontys is not being marketed due to new post marketing reports of serious hypersensitivity reactions.</p>
ANKYLOSING SPONDYLITIS: INJECTABLES			
NOTE: Ankylosing Spondylitis Self-Injectables (Enbrel, Cimzia, Humira, and Simponi) must be obtained and billed through our speciality pharmacy vendor, Briova. Please see the Enbrel, Cimzia, Humira, or Simponi Prior Authorization/Patient Enrollment Form for instructions. Briova may supply Remicade upon request or you may continue to obtain through your usual supplier.			
	ENBREL (etanercept) HUMIRA (adalimumab)	CIMZIA (certolizumab pegol) REMICADE (infliximab) SIMPONI (golimumab) SUBCUTANEOUS	<p>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.</p> <p>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.</p> <p>Cimzia: patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on Cimzia. 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.</p> <p>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.</p> <p>Simponi: patient has a diagnosis of ankylosing spondylitis (AS) and has already been stabilized on Simponi. OR patient age ≥ 18 years. AND diagnosis is AS, and patient has documentation of an inadequate response, adverse reaction or allergic response to methotrexate, or if ethotrexate 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.</p> <p>* Patients with 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 NSAID trial and a DMARD trial are required (unless otherwise contraindicated) prior to receiving Humira, Cimzia, Enbrel, Remicade, or Simponi.</p>
ANTI-ANXIETY: ANXIOLYTICS			
BENZODIAZEPINE	CHLORDIAZEPOXIDE CLONAZEPAM CLORAZEPATE COMAZEPAM ODT DIAZEPAM LORAZEPAM OXAZEPAM	ALPRAZOLAM (Xanax) ALPRAZOLAM ER, XR (Xanax) ALPRAZOLAM ODT (Niravam) ALPROZOLAM INTENSOL (alprazolam concentrate) ATIVAN (lorazepam) DIAZEPAM INTENSOL (diazepam concentrate) KLONOPIN (clonazepam) LORAZEPAM INTENSOL (lorazepam concentrate) NIRAVAM (alprazolam ODT) TRANXENE T (clorazepate tabs) VALIUM (diazepam) XANAX (alprazolam) XANAX XR (alprazolam XR)	<p>Non-preferred Benzodiazepines (except for alprazolam ODT, Klonopin Wafers, Niravam & Intensol Products): patient has a documented side effect, allergy, or treatment failure to at least 2 preferred benzodiazepine medications. (If a product has an AB rated generic, there must also be a trial of the generic formulation)</p> <p>Alprazolam ODT and Niravam: patient has a documented side effect, allergy, or treatment failure to at least 2 preferred benzodiazepine medications. (If a product has an AB rated generic, there must also be a trial of the generic formulation). OR patient has a medical necessity for disintegrating tablet administration (i.e. inability to swallow tablets) AND patient has a documented side effect, allergy or treatment failure to clonazepam ODT.</p> <p>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.</p>
NON-BENZODIAZEPINE	BUSPIRONE HYDROXYZINE HCL HYDROXYZINE PAMOATE (except 100mg) MEPROBAMATE	HYDROXYZINE PAMOTE 100MG (Vistaril) VISTARIL (hydroxyzine pamote)	<p>Hydroxyzine Pamote 100mg strength ONLY: patient is unable to use generic 50mg capsules</p> <p>Vistaril: patient has a documented intolerance to the generic formulation.</p> <p>PA Requests to Exceed QL: all requests will be referred to the DVHA Medical Director for review unless (a) the medication is being prescribed for acute alcohol withdrawal for a maximum 10 day supply or (b) the patient has been started and stabilized on the requested quantity for treatment of a seizure disorder.</p>
ANTICOAGULANTS			
ORAL	VITAMIN K ANTAGONIST DIRECT THROMBIN INHIBITOR FACTOR Xa INHIBITOR	COUMADIN (warfarin) ELIQUIS (apixaban) XARELTO 15MG & 20MG	<p>Coumadin: patient has been started and stabilized on the requested medication OR patient has had a documented intolerance to generic warfarin.</p> <p>Eliquis: diagnosis or indication is nonvalvular atrial fibrillation</p> <p>*Pradaxa: diagnosis or indication is nonvalvular atrial fibrillation</p>

	PRADAXA (dabigatran etexilate)* WARFARIN XARELTO 10MG		Xarelto 15mg & 20mg: diagnosis or indication is nonvalvular atrial fibrillation AND patient has been started and stabilized on the requested medication OR patient has had documented side effect, allergy, or contraindication (i.e. drug interactions) to warfarin therapy OR 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 prescriber has provided another clinically valid reason why generic warfarin cannot be used OR indication is treatment of DVT or PE or reduction of risk of recurrent DVT or PE AND patient has been started and stabilized on the requested medication OR the prescriber has provided a clinically valid reason why low molecular weight heparins, fondaparinux, or generic warfarin cannot be used. Note: Xarelto 10mg for the diagnosis of the need for thromboprophylaxis following knee and hip replacement surgery is available without PA in the limited durations require for these indications.
INJECTABLE	FONDAPARINUX FRAGMIN HEPARIN LOVENOX	ARIXTRA (fondaparinux) ENOXAPARIN (Lovenox) INNOHEP (tinzaparin)	Arixtra: patient has a documented intolerance to generic fondaparinux. Enoxaparin: patient has a documented intolerance to brand Lovenox Innohep: diagnosis is treatment of acute, symptomatic deep vein thrombosis (DVT) with or without pulmonary embolism, administered in conjunction with warfarin sodium AND patient does not have a bleeding disorder or documented heparin-induced thrombocytopenia (HIT) AND prescriber must provide a clinically valid reason why one of Lovenox, Fragmin, or fondaparinux cannot be used OR patient has been started and stabilized on the requested medication in conjunction with warfarin

ANTICONVULSANTS

ORAL	CARBAMAZEPINE, XR CARBATROL CELONTIN CHLORAZEPATE CLONAZEPAM, ODT DEPAKOTE SPRINKLES DIAZEPAM DILANTIN DIVALPROEX SODIUM, ER EPITOL ETHOSUXAMIDE GABAPENTIN CAP, TAB, SOL GABITRIL LAMOTRIGINE CHEW, TABS LEVETIRACETAM TABS, SOL OXCARBAZEPINE TABS PEGANONE PHENYTEK PHENYTOIN PHENYTOIN EX CAP PRIMIDONE TEGRETOL XR 100MG TOPIRAMATE TAB, SPRINKLE CAPS TRILEPTAL SUSP VALPROIC ACID ZONISAMIDE	APITOM (eslicarbazine acetate) BENZEL (rufinamide) TAB, SUSP DEPAKENE (valproic acid) DEPAKOTE (divalproex sodium) DEPAKOTE ER (divalproex sodium) DIVALPROEX SODIUM CAP (Depakote Sprinkles) FELBAMATE (Felbatol) FELBATOL (felbamate) FYCOMPA (perampanel) TABS KEPPRA TABS, SOL, XR (levetiracetam, XR) KLONOPIN (clonazepam) LAMICTAL TAB, CHEW TAB, ODT, XR (lamotrigine) LAMOTRIGINE ER (Lamictal XR) LEVETIRACETAM ER (Keppra XR) LYRICA CAP, SOL (pregabalin) MYSOLINE (primidone) NEURONTIN CAPS, TABS, SOL (gabapentin) ONFI (clobazam) TAB, SOL OXCARBAZEPINE SUSP (Trileptal) OXTELLAR XR (oxcarbazepine ER) TAB POTIGA (ezogabine) TAB SABRIL (vigabatrin) STAVZOR (valproic acid delayed release) TEGRETOL (carbamazepine) TEGRETOL XR 200MG & 400MG (carbamazepine) TIAGABINE (Gabitril) TOPAMAX (Topiramate) TABS, SPRINKLE CAPS TRANXENE-T (clorazepate) TABS TRILEPTAL TABS (oxcarbazepine) TROKENDI XR (topiramate SR 24hr) CAPS VALIUM (diazepam) VIMPAT (acosamide) TABS, SOL ZARONTIN (ethosuxamide) ZONEGRAN (zonisamide)	Depakene, Depakote, Depakote ER, Keppra tabs or oral solution, Klonopin, Klonopin Wafers, Lamictal tabs or chew tabs, Mysline, Neurontin caps, tabs, sol, Tegrretol XR (200mg & 400mg), Topamax tabs, Topamax sprinkles, Trileptal tabs, Zarontin, Zonegran: patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization) OR patient has had a documented intolerance to the generic equivalent of the requested medication. Benzel: diagnosis or indication is treatment of Lennox-Gastaut Syndrome. AND 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, patient must be unable to use Benzel tabs (i.e. swallowing disorder) Felbamate, Felbatol: patient information/consent describing aplastic anemia and liver injury has been completed AND patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization). Additionally, if brand is requested, the patient has a documented intolerance to the generic product. OR diagnosis is adjunctive therapy of partial-onset seizures or Lennox-Gastaut syndrome 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. Divalproex sodium capsules (sprinkles), tiagabine, Oxcarbazepine oral suspension (generics): patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization). OR patient has had a documented intolerance to the brand name product. Keppra XR, Lamictal XR, lamotrigine ER, levetiracetam ER, Oxtellar XR, Trokendi XR: patient has been unable to be compliant with or tolerate twice daily dosing of the immediate release product. Additionally, if brand Keppra XR or Lamictal 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 tabs cannot be used. Lyrice caps, Lyrice oral solution: patient has a diagnosis of epilepsy OR 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). AND if the request is for the oral solution, the patient is unable to use Lyrice capsules (i.e. swallowing disorder) Onfi: patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR diagnosis or indication is adjunctive treatment of Lennox-Gastaut Syndrome. AND 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 diagnosis or indication is adjunctive treatment of refractory epilepsy (may include different types of epilepsy) AND patient has had a documented side effect, allergy, treatment failure/inadequate response or a contraindication to at least THREE preferred anticonvulsants. Fycompa, Potiga: patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR diagnosis is adjunctive therapy or 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. Sabril: prescriber and patient are registered with the SHARE program AND diagnosis is infantile spasms OR patient is \geq 16 years old and the indication is adjunctive therapy in refractory complex partial seizures and failure of THREE other preferred anticonvulsants. Stavzor: patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR patient has had a documented intolerance to divalproex sodium. Vimpat: patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR 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). PA Requests to Exceed QL for clonazepam/clonazepam ODT or Klonopin: all requests will be referred to the DVHA Medical Director for review unless the patient has been started and stabilized on the requested quantity for treatment of a seizure disorder.
RECTAL	DIASTAT (diazepam rectal gel)	DIAZEPAM RECTAL GEL	Diazepam Rectal Gel: patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization) OR patient has had a documented intolerance to Diastat rectal gel.

ANTI-DEPRESSANTS

MAO INHIBITORS Duration of need for mental health indication; 1 year for other indications Recommended dose limits and quantity limits may apply	PHENELZINE SULFATE TRANLYCYPROMINE	EMSAM (selegiline) MARPLAN (isocarboxazid) NARDIL (phenylzine) PARNATE (tranylcypromine)	Marplan: patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization). OR patient has had a documented side effect, allergy, or treatment failure to phenelzine and tranylcypromine. Nardil, Parnate: patient has had a documented intolerance to generic equivalent product. EMSAM: 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 patient is unable to tolerate oral medication. Limitations: Chlordiazepoxide/amitriptyline and amitriptyline/perphenazine combinations are not covered. Generic agents may be prescribed separately.
ANTIDEPRESSANTS - MISCELLANEOUS: *	BUDEPRION SR, XL	APLENZIN (bupropion hcl) ER TABS	Aplenzin: The patient has had a documented inadequate response to Bupropion XL (bupropion XL) AND the patient has had a documented side effect, allergy, or

<p>Duration of need for mental health indication; 1 year for other indications</p> <p>Recommended dose limits and quantity limits may apply</p>	<p>BUPROPION</p> <p>BUPROPION SR, XL</p> <p>MAPROTILINE</p> <p>MIRTAZAPINE, RDT</p> <p>NEFAZADONE</p> <p>TRAZODONE HCL</p>	<p>BRINTELLIX TABS</p> <p>FORFIVO XL (bupropion SR 24hr) TABS</p> <p>OLEPTRO (trazodone) ER TABS</p> <p>REMERON (mirtazapine)*</p> <p>REMERON SOL TAB (mirtazapine RDT)*</p> <p>VIIBRYD TABS</p> <p>WELLBUTRIN (bupropion)*</p> <p>WELLBUTRIN SR (bupropion SR)*</p> <p>WELLBUTRIN XL (bupropion XL)*</p>	<p>Aripiprazole: The patient has had a documented inadequate response to bupropion 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)</p> <p>Forfivo XL: The patient is unable to take the equivalent dose as generic bupropion XL</p> <p>Olepro: 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.</p> <p>Remeron, Remeron SoTab, Wellbutrin, Wellbutrin SR, Wellbutrin XL: The patient has had a documented intolerance to the generic formulation of the requested medication.</p> <p>Brintellix, Viibryd: The diagnosis or indication is 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)</p> <p>Document clinically compelling information supporting the choice of a non-preferred agent on a General Prior Authorization Form.</p> <p>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 lookback through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.</p>
<p>ANTIDEPRESSANTS - SNRI * Duration of need for mental health indication; 1 year for other indications</p> <p>§ Indicates drugs is managed via automated Step Therapy</p> <p>Recommended dose limits and quantity limits may apply</p>	<p>VENLAFAXINE ER CAPSULE</p>	<p>CYMBALTA (duloxetine) CAPS</p> <p>DESVENLAFAXINE ER (desvenlafaxine base SR)</p> <p>DULOXETINE</p> <p>EFFEXOR XR (venlafaxine XR) CAPS</p> <p>FETZIMA CAPS</p> <p>FETZIMA CAPSULE TITRATION PACK</p> <p>KHEDEZLA (desvenlafaxine base SR)</p> <p>PRISTIQ (desvenlafaxine succinate SR)</p> <p>VENLAFAXINE ER</p> <p>VENLAFAXINE IR (previously Effexor)</p>	<p>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).</p> <p>Venlafaxine ER tablet (generic), Venlafaxine ER tablet (brand), Effexor XR Capsule (brand): The patient has had a documented intolerance to generic venlafaxine ER caps.</p> <p>Fetzima, Pristiq: The patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR The diagnosis or indication is Major Depressive Disorder (MDD) AND The patient has had a documented side effect, allergy, or inadequate response to at least 3(three) different antidepressants from the SSRI, SNRI, TCA and/or Miscellaneous Antidepressant categories, one of which must be venlafaxine ER capsule (may be preferred or non-preferred).</p> <p>Desvenlafaxine ER, Khedezla: 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) AND The patient has had a documented intolerance with Pristiq.</p> <p>Cymbalta, Duloxetine:</p> <p>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). AND If the request is for duloxetine, the patient has had a documented intolerance with brand Cymbalta</p> <p>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. AND If the request is for duloxetine, the patient has had a documented intolerance with brand Cymbalta</p> <p>Neuropathic pain: The patient has had a documented side effect, allergy, or treatment failure to TWO drugs in the tricyclic antidepressant (TCA) class and/or anticonvulsant class. (this indication not processed via automated step therapy).AND If the request is for duloxetine, the patient has had a documented intolerance with brand Cymbalta.</p> <p>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) AND If the request is for duloxetine, the patient has had a documented intolerance with brand Cymbalta.</p> <p>Fibromyalgia: The patient has had a documented side effect, allergy, or treatment failure to TWO drugs from the following: gabapentin, tricyclic antidepressant, SSRI antidepressant, SNRI antidepressant, miscellaneous antidepressant, cyclobenzaprine, Lyrica® or Savella®.(this indication not processed via automated step therapy) AND If the request is for duloxetine, the patient has had a documented intolerance with brand Cymbalta</p> <p>Document clinically compelling information supporting the choice of a non-preferred agent on a General Prior Authorization Form.</p> <p>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 lookback through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.</p>
<p>ANTIDEPRESSANTS - SSRI * For brand name products when generic equivalent preferred, length of authorization is 1 year.</p> <p>Recommended dose limits and quantity limits may apply</p>	<p>CITALOPRAM</p> <p>FLUOXETINE</p> <p>FLUVOXAMINE</p> <p>PAROXETINE</p> <p>SERTRALINE</p>	<p>BRISDELL</p> <p>CELEXA (citalopram)</p> <p>ESCITALOPRAM (Lexapro)</p> <p>FLUOXETINE (pmd)</p> <p>FLUOXETINE 60MG TABS</p> <p>FLUOXETINE 90MG (Prozac Weekly)</p> <p>FLUVOXAMINE CR (Luvox CR)</p> <p>LEXAPRO (escitalopram)</p> <p>LUVOX CR (fluvoxamine CR)</p> <p>PAROXETINE CR (Paxil CR)</p> <p>PAROXETINE SUSPENSION (Paxil Susp)</p> <p>PAXIL * (paroxetine)</p> <p>PAXIL CR (paroxetine CR)</p> <p>PAXIL SUSPENSION (paroxetine)</p>	<p>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.)</p> <p>Brisdelle: The indication for use is moderate to severe vasomotor symptoms (VMS) associated with menopause. AND The patient has tried and failed generic paroxetine.</p> <p>Luvox CR, fluvoxamine CR: The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. (One trial must be generic fluvoxamine IR.) If the request is for the brand product, the patient also has a documented intolerance to the generic equivalent.</p> <p>Pexva, 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.</p> <p>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.</p> <p>Sarafem, Selfemra, Fluoxetine 60mg tablet, Fluoxetine (pmd): The patient had a documented side effect, allergy, or treatment failure with 2 preferred SSRIs. (One trial must be generic fluoxetine (regular, not pmd).) In addition, for approval of Sarafem, either Selfemra or fluoxetine pmd must have been tried.</p> <p>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 Lexapro, the patient has a documented intolerance with generic escitalopram</p>

		PEXEVA (paroxetine) Prozac * (FLUOXETINE) PROZAC WEEKLY (fluoxetine) SARAFEM (fluoxetine pmdd) SELFEMRA (fluoxetine pmdd) ZOLOFT * (sertraline)	Fluoxetine 90mg, 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. Document clinically compelling information supporting the choice of a non-preferred agent on a General Prior Authorization 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 lookback through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.
ANTIDEPRESSANTS - TRICYCLICS * Duration of need for mental health indication; 1 year for other indications Recommended dose limits and quantity limits may apply	AMITRIPTYLINE AMOXAPINE CLOMIPRAMINE DESIPRAMINE DOXEPIN IMIPRAMINE IMIPRAMINE PAMOATE NORTRIPTYLINE NORTRIPTYLINE ORAL SOLUTION PROTRIPTYLINE	ANAFRANIL *(clomipramine) NORPRAMIN *(desipramine) PAMELOR* (nortriptyline) SURMONTIL (trimipramine) TOFRANIL *(imipramine) TOFRANIL PM *(imipramine pamoate) VIVACTIL * (protriptyline)	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. Surmontil: 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 one or more preferred TCAs. Limitation: Chlordiazepoxine/amitriptyline and amitriptyline/perphenazine combinations not covered. Generic agents may be prescribed separately. Document clinically compelling information supporting the choice of a non-preferred agent on a General Prior Authorization 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 lookback through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria.
ANTI-DIABETICS			
ALPHA-GLUCOSIDASE INHIBITORS	ACARBOSE GLYSET	PRECOSE (acarbose)	Precose: patient must have a documented intolerance to generic acarbose
BIGANIDES& COMBINATIONS	GLIPIZIDE/METFORMN GLYBURIDE/METFORMIN METFORMIN METFORMIN XR RIOMET	FORTAMET (metformin ER Osmotic) GLUCOPHAGE (metformin) GLUCOPHAGE XR (metformin XR) GLUCOVANCE (glyburide/metformin) GLUMETZA (metformin ER) METAGLIP (glipizide/metformin)	Fortamet, Glucophage XR, Glumetza, Metformin ER osmotic: patient has had a documented intolerance to generic metformin XR (if product has an AB rated generic, there must have been a trial of the generic) Glucophage, Glucovance, Metaglip: 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)
DIPEPTIDYL PEPTIDASE (DDP-4) INHIBITORS	JANUMET JANUVIA KOMBIGLYZE XR ONGLYZA	JANUMET XR (sitagliptin/metformin ER) JENTADUETO (linagliptin/metformin) JUVISYNC (sitagliptin/simvastatin) KAZANO (alogliptin/metformin) NESINA (alogliptin) OSEN (alogliptin/pioglitazone) TRADJENTA (linagliptin)	Januvia, Onglyza: patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin Nesina, Tradjenta: patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin AND patient has had a documented side effect, allergy OR treatment failure with at least one preferred DDP-4 agent. Janumet: patient has had an inadequate response with Januvia OR Metformin monotherapy OR patient has been started and stabilized on Januvia and Metformin combination therapy. Kazano: patient has had a documented side effect, allergy OR treatment failure with at least one preferred DDP-4 combination agent. Janumet XR: patient has had an inadequate response with Januvia OR Metformin/Metformin XR monotherapy OR patient has been started and stabilized on Januvia and Metformin/Metformin XR combination therapy AND patient is unable to take Januvia and Metformin/Metformin XR as the individual separate agents. Jentaduetto: patient has had an inadequate response with Tradjenta OR Metformin monotherapy OR 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: patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin AND patient has been started and stabilized on Januvia AND Simvastatin combination therapy as individual agents. Kombiglyze XR: patient has had an inadequate response with Onglyza OR Metformin/Metformin XR monotherapy OR Patient has been started and stabilized on Onglyza/Metformin XR combination therapy. Oseni: patient is unable to take Nesina and Actos (pioglitazone) as the individual separate agents (after meeting clinical criteria for each individual agent)
INSULINS	HUMALOG HUMALOG MIX 50/50 HUMALOG MIX 75/25 HUMLIN 70/30 HUMLIN N HUMLIN R LANTUS LEVEMIR LANTUS SOLOSTAR LEVEMIR NOVOLIN 70/30 NOVOLIN N NOVOLIN R NOVOLOG NOVOLOG MIX 70/30	APIDRA RELION 70/30 RELION N RELION R	Apidra: patient has had a documented side effect, allergy OR treatment failure to Novolog or Humalog Relion R, Relion N OR Relion 70/30: patient has had a documented side effect, allergy OR treatment failure to the corresponding Novolin or Humulin product.
MEGLITINIDES	NATEGLINIDE	PRANDIMET (repaglinide/metformin) PRANDIN (repaglinide)	Starlix: patient has had a documented intolerance to generic nateglinide. Prandin, Repaglinide: patient has been started and stabilized on the requested medication OR patient has had a documented side effect, allergy OR treatment failure with Starlix AND if the request is

		REPAGLINIDE (Prandin) STARLIX (nateglinide)	for Prandin, the patient has a documented intolerance with generic repaglinide. Prandimet: patient has been started and stabilized on Prandimet or on stable doses of the separate agents OR patient has had an inadequate response with repaglinide monotherapy.
PEPTIDE HORMONES	VICTOZA	BYDUREON BYETTA SYMLIN	Bydureon: patient has a diagnosis of type 2 diabetes. AND patient is at least 18 years of age. AND patient has had a documented side effect, allergy, contraindication or treatment failure with metformin. AND patient has had a documented side effect or treatment failure to Byetta OR has been unable to be adherent to or tolerate twice daily dosing of Byetta Byetta: patient has a diagnosis of type 2 diabetes. AND patient is at least 18 years of age. AND patient has had a documented side effect, allergy, contraindication or treatment failure with metformin. Symliin: patient has a diagnosis of diabetes mellitus. AND patient is at least 18 years of age. AND patient is on insulin. Victoza: patient has a diagnosis of type 2 diabetes. AND patient is at least 18 years of age. AND patient has had a documented side effect, allergy, contraindication or treatment failure with metformin.
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS	FARXIGA INVOKANA		Patient is 18 years of age or older AND patient has a diagnosis of type 2 diabetes mellitus and has had an inadequate response to diet and exercise alone AND patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin .
SULFONYLUREAS 2ND GENERATION	GLIMEPIRIDE GLIPIZIDE GLIPIZIDE ER GLYBURIDE GLYBURIDE MICRONIZED	AMARYL (glimepiride) DIABETA (glyburide) GLUCOTROL XL (glipizide ER) GLUCOTROL (glipizide) GLYNASE PRESTAB (glyburide micronized) MICRONASE (glyburide)	Patient has had a documented side effect, allergy OR treatment failure with glimepiride, AND glimepiride, AND glipizide/glipizide ER, and glyburide/glyburide micronized.
THIAZOLIDINEDIONES & COMBOS	PIOGLITAZONE PIOGLITAZONE/GLIMEPIRIDE PIOGLITAZONEMETFORMIN	ACTOPLUS MET (pioglitazone/metformin) ACTOPLUS MET XR (pioglitazone/metformin ER) ACTOS (pioglitazone) AVANDAMET (metformin/rosiglitazone maleate) AVANDARYL (glimepiride/rosiglitazone maleate) AVANDIA (rosiglitazone) DUETACT (pioglitazone/glimepiride)	Actos (pioglitazone), Actoplus Met, Duetact, Pioglitazone/Metformin: Patient has been started and stabilized on the requested medication OR patient has had a documented side effect, allergy, contraindication OR treatment failure with metformin AND if the request is for brand Actos Met or Duetact, patient has a documented intolerance to the generic product. Actoplus Met XR: patient has been started AND stabilized on the requested medication OR patient has had a documented treatment failure with generic metformin XR OR 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: 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 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.
ANTIDIARRHEALS: HIV/AIDS			
	DIPHENOXYLATE/ATROPINE LOPERAMIDE	FULZYAQ (crofelemer)	Patient has HIV/AIDS and is receiving anti-retroviral therapy AND Patient is at least 18 years of age AND Patient requires symptomatic relief of noninfectious diarrhea AND Infectious diarrhea (e.g. cryptosporidiosis, c. difficile, etc.) has been ruled out AND Patient has tried and failed at least one anti-diarrheal medication (i.e. loperamide or atropine/diphenoxylate)
ANTI-EMETICS			
5HT3 ANTAGONISTS	ONDANSETRON INJECTION ONDANSETRON ODT 4MG & 8MG ONDANSETRON TABS 4MG & 8 MG	ANZEMET (dolansetron) GRANISETRON (Kytrol) TAB, INJ GRANISOL (granisetron) ORAL SOLUTION ONDANSETRON 24MG TAB ONDANSETRON ORAL SOLUTION 4MG/5ML SANCUSO TRANSDERMAL PATCH ZOFTRAN INJ (ondansetron) ZOFTRAN ORAL SOLUTION (ondansetron) ZOFTRAN ORAL TABS, ODT (ondansetron) ZUPLENZ ORAL SOLUBLE FILM (ondansetron)	Anzemet: has a diagnosis of nausea and vomiting associated with cancer chemotherapy. AND patient has had a documented side effect, allergy, or treatment failure to generic ondansetron. Granisetron, Granisol: patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy or radiotherapy. AND 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, post-operative nausea and vomiting (1 time only) or hyperemesis gravidarum. AND patient must have a documented intolerance to the corresponding generic ondansetron product (tablets, orally disintegrating tablets (ODT), oral solution or injection). If the request is for oral solution, the patient must be unable to use ondansetron ODT or ondansetron tablets. Ondansetron Oral Sol: patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy, radiotherapy, post-operative nausea and vomiting (1 time only) or hyperemesis gravidarum. AND patient is unable to use ondansetron ODT or ondansetron tablets. Ondansetron 24mg: patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy. AND prescriber provides rationale why generic ondansetron 8 mg tablets cannot be used to achieve the desired dose. Sancuso: patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy. AND prescriber provides documentation of medical necessity for the transdermal formulation. OR patient has had a documented side effect, allergy or treatment failure with generic ondansetron. Zuplenz: patient has a diagnosis of nausea and vomiting associated with cancer chemotherapy or radiotherapy. AND 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 gravidarum, 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. OR 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. Limitations: Aloxi and Anzemet injection are not considered outpatient medications for the pharmacy benefit and so are not covered in the pharmacy benefit.
MISCELLANEOUS (PREGNANCY)		DICLEGIS (doxylamine succinate/pyridoxine hcl) DR TABS	Patient has a diagnosis of nausea and vomiting of pregnancy AND Patient has tried and had an inadequate response to conservative management (i.e. change in dietary habits, ginger, or acupressure) AND Patient has tried and had an inadequate response to generic doxylamine and generic pyridoxine (Vitamin B6) AND Patient has tried and had an inadequate response to generic ondansetron.
NK1 ANTAGONISTS	EMEND CAPS EMEND PACK		Emend (aprepitant) 80 mg, 125 mg, Tri-Fold pack: medication will be prescribed by an oncology practitioner. AND 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 40mg: 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.
THC DERIVATIVES		CESAMET (nabilone) DRONABINOL (Marinol) MARINOL (dronabinol)	Pharmacology: Marinol® is a schedule III cannabinoid agent containing the same active ingredient, tetrahydrocannabinol, as marijuana. While its exact mechanism of action is unknown, it is speculated to inhibit medullary activity as well as suppress prostaglandin and endorphin synthesis. Cesamet® is a schedule II synthetic cannabinoid that acts by activating the endocannabinoid receptors, CB1 and CB2, which are involved in nausea/vomiting regulation. Both Marinol® and Cesamet® are FDA-approved for use in chemotherapy associated nausea and vomiting refractory to conventional antiemetics. In addition, Marinol® is indicated for patients with AIDS-related anorexia or wasting syndrome. Dronabinol. Marinol: patient has a diagnosis of chemotherapy-induced nausea/vomiting. AND 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 patient has a diagnosis of AIDS associated anorexia. AND patient has had an adequate 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: patient has a diagnosis of chemotherapy-induced nausea/vomiting. AND 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.
ANTI-HYPERTENSIVES			
ACE INHIBITORS	BENAZEPRIL CAPTOPRIL ENALAPRIL EPANED FOSINOPRIL LISINOPRIL MOEXIPRIL QUINAPRIL RAMIPRIL TRANDOLAPRIL	ACCUPRIL (quinapril) ACEON (perindopril) ALTACE (ramipril) EPANED (enalapril) ORAL SOL (age ≥ 12 years old) LOTENSIN (benazepril) MAVIK (trandolapril) PERINDOPRIL (Aceon) PRINIVIL (lisinopril) UNIVASC (moexipril) VASOTEC (enalapril) ZESTRIL (lisinopril)	Epanded Oral Solution (Patients ≥ 12 years old): patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications). Other ACE Inhibitors: 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 w/HCTZ	BENAZEPRIL/HCTZ ENALAPRIL/HCTZ FOSINOPRIL/HCTZ LISINOPRIL/HCTZ MOEXIPRIL/HCTZ QUINAPRIL/HCTZ	ACCURETIC (quinapril/HCTZ) LOTENSIN HCT (benazepril/HCTZ) PRINZIDE (lisinopril/HCTZ) UNIRETIC (moexipril/HCTZ) VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	ACE Inhibitor/Hydrochlorothiazide combinations: 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. Limitations: Captopril/HCTZ combination not covered. Agents may be prescribed separately
ACE INHIBITOR w/CCB	AMLODIPINE/BENAZEPRIL	LOTREL (amlodipine/benazepril) TARKA (trandolopril/verapamil)	ACE Inhibitor/Calcium Channel Blocker combination: 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.
ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)	BENICAR DIOVAN IRBESARTAN LOSARTAN TELMISARTAN	ATACAND (candesartan) AVAPRO (irbesartan) CANDESARTAN (Atacand) COZAAR (losartan) EDARBI (azilsartan) TAB EPROSARTAN (Teveten) MICARDIS (telmisartan) TEVETEN (eprosartan) VALSARTAN (Diovan)	Benicar, Diovan, Irbesartan, Losartan, Telmisartan: patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR 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, Avapro, Candesartan, Edarbi, Eprosartan, Micardis, Teveten: patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization OR 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. Cozaar (Brand): 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 patient has had a documented intolerance with the generic product. Valsartan: 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 patient has had a documented intolerance with the brand product (Diovan)
ARB/DIURETIC COMBOS	BENICAR HCT IRBESARTAN/HCTZ LOSARTAN/HCTZ TELMISARTAN/HCTZ VALSARTAN/HCTZ	ATACAND HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) CANDESARTAN/HCTZ (Atacand HCT) DIOVAN HCT EDARBYCLOR (azilsartan/chlorthalidone) TABS HYZAAR (losartan/HCTZ) MICARDIS HCT (telmisartan/HCTZ) TEVETEN HCT (eprosartan/HCTZ)	Benicar HCT, Irbesartan/HCTZ, Losartan/HCTZ, Telmisartan/HCTZ, Valsartan/HCTZ: patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR 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. Avalide, Diovan HCT, Micardis HCT: patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization OR 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, candesartan/HCTZ, Teveten HCT: patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure with a preferred ARB/Hydrochlorothiazide combination. AND If the request is for Atacand HCT, the patient has had a documented intolerance with the generic product. Hyzaar: 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 patient has had a documented intolerance with the generic product. Edarbyclor: patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure with a preferred Angiotensin Receptor Blocker (ARB) or ARB combination. AND patient is unable to take the individual components separately
ARB/CCB COMBOS	VALSARTAN/AMLODIPINE EXFORGE (valsartan/amlodipine)*	AMLODIPINE/TELMISARTAN (Twynsta) AZOR (olmesartan/amlodipine)	Valsartan/amlodipine: patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR 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.

		TWYNSTA (amlodipine/telmisartan)	<p>*Exforge: patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization OR 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.</p> <p>Azor, Amlodipine/Telmisartan, 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 patient is unable to take the individual components separately. AND If the request is for Twynsta, the patient has a documented intolerance to generic amlodipine/telmisartan.</p>
ARB/ REIN INHIBITOR COMBO		VALTURNA (aliskiren/valsartan)	<p>Valturna: patient is NOT a diabetic AND patient has a diagnosis of hypertension. AND 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 patient has had a documented treatment failure with Tekturna alone.</p>
ARB/CCB/HCTZ COMBO	EXFORGE HCT (amlodipine/valsartan/HCTZ)	TRIBENZOR (amlodipine/olmesartan/HCTZ)	<p>Exforge HCT: patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR 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.</p> <p>Tribenzor: 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 patient is unable to take the individual components separately.</p>
BETA BLOCKERS	ACEBUTOLOL ATENOLOL ATENOLOL/CHLOROTHALIDONE BETAXOLOL BISOPROLOL FUMARATE BISOPROLOL.HCTZ CARVEDILOL DUTOPROL LABETALOL METOPROLOL SUCCINATE XL METOPROLOL TARTRATE METOPROLOL.HCTZ NADOLOL NADOLOL/BENDROFLUMETHAZIDE PINDOLOL PROPRANOLOL SOTALOL TIMOLOL	BETAPACE (sotalol) BETAPACE AF (sotalol) BYSTOLIC (nebivolol) COREG (carvedilol) COREG CR (carvedilol CR) CORZIDE (nadolol/bendroflumethiazide) INDERAL LA (propranolol ER) INNOPRAN XL (propranolol SR) KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol tartrate) LOPRESSOR HCT (metoprolol/HCTZ) PROPRANOLOL/HCTZ (Inderide) SECTRAL (acebutolol) TENORETIC (atenolol/chlorothalidone) TENORMIN (atenolol) TOPROL XL (metoprolol succinate XL) TRANDATE (labetalol) ZEBETA (bisoprolol) ZIAC (bisoprolol/HCTZ)	<p>Non-preferred drugs (except Coreg CR): 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.)</p> <p>Coreg CR:</p> <p>Indication; Heart Failure: patient has been started and stabilized on Coreg CR. (Note: Samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure to metoprolol SR or bisoprolol. AND patient has been unable to be compliant with or tolerate twice daily dosing of carvedilol IR.</p> <p>Indication; Hypertention: patient has been started and stabilized on Coreg CR. (Note: Samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure to 3(three) preferred anti-hypertensive beta-blockers.</p> <p>Limitation: Inderal XL is not covered as federal rebate is not offered.</p>
CALCIUM CHANNEL BLOCKERS	AFEDITAB CR AMLODIPINE CARTIA XT DILT-CD DILTIAZEM DILTIAZEM ER DILTIAZEM SR DILT-XR EXFORGE HCT FELODIPINE ER NICARDIPINE NIFEDIAC CC NIFEDICAL XL NIFEDIPINE IR NIFEDIPINE SR NIFEDIPINE SR OSMOTIC NIMODIPINE TAZTIA XT VALSARTAN/AMLODIPINE VERAPAMIL VERAPAMIL CR VERAPAMIL SR	ADALAT CC (nifedipine SR) AMLODIPINE/ATORVASTATIN (Caduet) AMLODIPINE/TELMISARTAN (Twynsta) AZOR (olmesartanamlodipine) CADUET (amlodipine/atorvastatin) CALAN (verapamil) CALAN SR (verapamil CR) CARDENE SR (nicardipine SR) (no AB rated generic) CARDIZEM (diltiazem) CARDIZEM LA (diltiazem SR) COVERA-HS (verapamil SR) (no AB rated generic) DILACOR XR (diltiazem SR) DILTIAZEM ER/MATZIN LA (Cardizem LA) DYNACIRC CR (isradipine CR) (no AB rated generic) EXFORGE (valsartan/amlodipine) ISOPTIN SR (verapamil CR) ISRADIPINE (Dynacirc) NIMOTOP (nimodipine) NISOLDIPINE ER (Sular) NORVASC (amlodipine) NYMALIZE (nimodipine) ORAL SOLUTION PROCARDIA (nifedipine IR) PROCARDIA XL (nifedipine SR osmotic) SULAR (nisoldipine) TIAZAC (diltiazem ER)	<p>Criteria for approval (except as noted below): 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.)</p> <p>Amlodipine/atorvastatin, Caduet: 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. For combinations containing 40 mg or 80 mg atorvastatin, the individual generic components are available without PA and should be prescribed.</p> <p>Exforge, Exforge HCT: patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR 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.</p> <p>Azor, Amlodipine/Telmisartan, Tribenzor, Twynsta: 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 patient is unable to take the individual components separately. AND If the request is for Twynsta, the patient has a documented intolerance to generic amlodipine/telmisartan.</p> <p>Nymalize: patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has a medical necessity for a specialty dosage form (i.e. dysphagia, swallowing disorder).</p>

		TRIBENZOR (amlodipine/telmisartan) TWYNSTA (amlodipine/telmisartan) VERELAN (verapamil SR) VERELAN PM (verapamil SR)	
CENTRAL ALPHA AGONISTS	CLONIDINE IR TABS GUANFACINE IR TABS METHYLDOPA TABS	CATAPRES (clonidine) TABS CATAPRES-TTS (clonidine) TRANSDERMAL PATCH CLONIDINE TRANSDERMAL PATCH (Catapres-TTS) NEXICLON XR (clonidine) EXTENDED RELEASE SUSPENSION NEXICLON XR (clonidine) EXTENDED RELEASE TABS TENEX (guanfacine) TABS	Catapres, Tenex: Patient has a documented intolerance to the generic product. Nexiclon XR Tabs: patient has a diagnosis of hypertension. AND 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 patient has been unable to be adherent to or tolerate twice daily dosing of the generic clonidine immediate-release tablets. Nexiclon XR Oral Susp: patient has a diagnosis of hypertension AND 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 patient has a medical necessity for a specialty dosage form (i.e. dysphagia, swallowing disorder). Clonidine Patches (generic): patient has a medical necessity for a specialty topical dosage form (i.e. dysphagia, swallowing disorder, compliance, nausea/vomiting). Catapres-TTS Patches: patient has a medical necessity for a specialty topical dosage form (i.e. dysphagia, swallowing disorder, compliance, nausea/vomiting). AND patient has a documented intolerance to the generic product.
GANGLIONIC BLOCKERS		VECAMEYL (mecamylamine) TABS	Vecamyl tabs: Patient has a diagnosis of moderately severe or severe hypertension AND patient has tried and failed, intolerant to, or contraindicated to at least THREE different antihypertension therapies of different mechanism of actions.
RENIN INHIBITOR		AMTURNIDE (aliskiren/amlodipine/HCTZ) TEKAMLO (aliskiren/amlodipine) TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ) VALTURNA (aliskiren/valsartan)	Tekturma: patient is NOT a diabetic who will continue on therapy with an ACEI or ARB AND patient has a diagnosis of hypertension. AND 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, Tekturma HCT: patient is NOT a diabetic who will continue on therapy with an ACEI or AND patient has a diagnosis of hypertension. AND 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 patient has had a documented treatment failure with Tekturma@ alone. Valturna: patient is NOT a diabetic AND patient has a diagnosis of hypertension. AND 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 patient has had a documented treatment failure with Tekturma@ alone.
ANTI-INFECTIVES ANTIBIOTICS			
CEPHALOSPORINS - 1st GENERATION	CEFADROXIL CAPS, TABS CEFADROXIL SUSP CEPHELEXIN CAPS CEPHELEXIN SUSP	CEPHELEXIN TABS KEFLEX CAPS (cephalexin)	Cephalexin Tabs: patient has had a documented intolerance to cephalexin generic capsules. Keflex: patient has had a documented side effect, allergy, or treatment failure to generic cefadroxil and cephalexin. Limitations: Cephalexin and Keflex 750 mg dosage strength not covered. Use alternative strengths.
CEPHALOSPORINS - 2nd GENERATION	CEFACLOR CAPS CEFPROZIL SUSP CEFPROZIL TABS CEFUROXIME TABS	CEFACTOR ER TABS CEFTIN SUSP (cefuroxime) CEFTIN TABS (cefuroxime)	Cefactor ER Tabs: patient has had a documented intolerance to cefactor capsules. Ceftin Tabs: 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 Susp: patient has had a documented side effect, allergy, or treatment failure to the following medication: cefprozil suspension. OR The indication for use is Lyme disease
CEPHALOSPORINS - 3rd GENERATION	CEFDINIR CAPS CEFDINIR SUSP CEFPODOXIME PROXETIL SUSP CEFPODOXIME PROXETIL TABS SUPRAX TABS	CEDAX CAPS (ceftibuten) CEDAX SUSP (ceftibuten) CEFDITOREN TAS (Spectracef) CEFTIBUTEN CAPS (cedax) CEFTIBUTEN SUSP (Cedax) SPECTRACEF TABS (cefditoren) SUPRAX CAPS (cefixime) SUPRAX CHEW TABS (cefixime) SUPRAX SUSP (cefixime)	Spectracef tablet, Cedax® Capsule, Cefditoren tablet, Ceftributen capsule: patient is completing a course of therapy which was initiated in the hospital. OR 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 Susp, Ceftributen Susp: patient is completing a course of therapy which was initiated in the hospital. OR patient has had a documented side effect or treatment failure to two of cefdinir, cefpodoxime and Suprax suspension.
KETOLIDES		KETEK (telithromycin)	Ketek: member is continuing a course of therapy initiated while an inpatient at a hospital. OR diagnosis or indication for the requested medication is community-acquired pneumonia. AND member is at least 18 years of age at the time of the request. AND 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, Chlamydia pneumoniae, or Mycoplasma pneumoniae AND member has had a documented therapeutic failure with all clinically appropriate alternatives. AND 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 hypomagnesemia, clinically significant bradycardia, a history of therapy with Class IA (e.g. quinidine or procainamide) or Class III (e.g. dofetilide) antiarrhythmic medications.
MACROLIDES	AZITHROMYCIN TABS, LIQUID (≤ 5 day supply) CLARITHROMYCIN E.E.S ERY-TAB ERYTHROMYCIN BASE ERYTHROMYCIN ETHYLSUCCINATE ERYTHROMYCIN W/SULFISOXAZOLE	AZITHROMYCIN PACKET (Zithromax) AZITHROMYCIN TABS, LIQUID (Zithromax) (if > 5 day supply) BIAXIN (clarithromycin) BIAXIN XL (clarithromycin SR) CLARITHROMYCIN SR (Biaxin XL) DIFICID TABS (fidaxomicin) ERYPED (erythromycin ethylsuccinate) ERYTHROCIN (erythromycin stearate) PCE DISPERTAB (erythromycin base)	Non-preferred agents (except as below): 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 patient is completing a course of therapy with the requested medication that was initiated in the hospital. Brand Name Erythromycin Products: 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: 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 patient has a diagnosis of Cystic Fibrosis. (length of authorization up to 6 months) OR 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 patient has a diagnosis of bacterial sinusitis AND has had a documented

		PEDIAZOLE (erythromycin-sulfisoxazole) ZITHROMAX PACKET (azithromycin) ZITHROMAX TABS, LIQUID (azithromycin) ZMAX SUSPENSION (azithromycin ER for oral susp)	side effect, allergy, or treatment failure to penicillin, amoxicillin, or sulfamethoxazole/trimethoprim (Bactrim). (length of authorization up to 10 days) OR patient has a diagnosis of severe bronchiectasis with frequent exacerbations (length of authorization up to 6 months) Difficid: patient's diagnosis or indication is Clostridium difficile associated diarrhea (CDAD) AND patient has had a side-effect, allergy, treatment failure or contraindication to metronidazole. OR 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 patient has had a side-effect, allergy, treatment failure or contraindication to oral vancomycin capsules (Vancocin).
OXAZOLIDINONES	IV form of this medication not managed at this time	ZYVOX SUSP (linezolid) ZYVOX TABS (linezolid)	Criteria for Approval: 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 patient has a documented blood, tissue, sputum, or urine culture that is positive for Vancomycin-Resistant Enterococcus (VRE) species. OR patient has a documented blood or sputum culture that is positive for Methicillin-Resistant Staphylococcus species OR patient has a documented tissue or urine culture that is positive for Methicillin-Resistant Staphylococcus AND 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.
PENICILLINS (ORAL)	AMOX/CLAVULANATE 600-42.9MG/5ML SUSP AMOX/CLAVULANATE TABS, CHEW, SUSP AMOXICILLIN CAPS, TABS, CHEW, SUSP AMPICILLIN CAPS SUSP DICLOXACILLIN CAPS PENICILLIN V POTASSIUM TABS, SOL	AMOX/CLAVULANATE ER TABS (Augmentin XR) AUGMENTIN TABS, SUSP (amox/clavulanate) AUGMENTIN XR TABS (amox/clavulanate) MOXATAG TABS (amoxicillin extended release)	Augmentin: patient has had a documented intolerance to the generic formulation of the requested medication. OR patient is < 12 weeks of age and requires the 125 mg/5 mL strength of Augmentin. Amoxicillin/Clavulanate ER, Augmentin XR, Moxatag: 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 Limitations: Brand Augmentin® Chewable tablets do not offer Federal Rebate and therefore cannot be provided.
QUINOLONES	CLIPRFLOXACIN TABS SUSP LEVOFLOXACIN TABS XOL OFLOXACIN IV drugs are not managed at this time	AVELOX (moxifloxacin HCL) AVELOX ABC PACK (moxifloxacin HCL) CIPRO TABS, SUSP (ciprofloxacin) CIPRO XR (ciprofloxacin) CIPROFLOXACIN ER (Cipro XR) FACTIVE (gemifloxacin) LEVAQUIN TABS, SOL (levofloxacin) MOXIFLOXACIN (Avelox) NOROXIN (norfloxacin) PROQUIN XR (ciprofloxacin)	Noroxin: patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR 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: patient has had a documented side effect, allergy, or treatment failure to generic ciprofloxacin immediate-release tablets or oral suspension. AND If the request is for Cipro XR or Cipro the patient has had a documented intolerance to the generic equivalent. Avelox, Moxifloxacin, Factive: patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR patient has had a documented side effect, allergy, or treatment failure to levofloxacin. AND If the request is for Avelox, the patient has had a documented intolerance to generic moxifloxacin. Levaquin (brand): patient has a documented intolerance with the generic levofloxacin
RIFAMYCINS		XIFAXAN TABS (rifaximin)	Criteria for Approval: Based on Indication: Hepatic Encephalopathy (Xifaxan 550 mg Tablets Only): 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 (Xifaxan 200 mg Tablets Only): 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 (Xifaxan 550 mg or 200 mg Tablets): 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 (Xifaxan 550 mg or 200 mg Tablets): 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 (Xifaxan 550 mg or 200 mg Tablets): 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, aminosaliclates, azathioprine, corticosteroids, fluoroquinolone and/or metronidazole. AND Quantity limit is 600 mg to 1,600 mg/day. Inflammatory Bowel Disease: Ulcerative Colitis (Xifaxan 200 mg Tablets): 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, aminosaliclates, azathioprine, corticosteroids, fluoroquinolone and/or metronidazole. AND Quantity limit is 800 mg/day (4 x 200 mg tablets/day). Clostridium difficile Diarrhea (Xifaxan 200 mg Tablets): 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).
VANCOMYCIN	IV products are not managed at this time	VANCOICIN CAPS (cancomycin) VANCOMYCIN CAPS (Vancocin)	Criteria for Approval: patient's diagnosis or indication is enterocolitis caused by Staphylococcus aureus. OR patient's diagnosis or indication is antibiotic-associated pseudomembranous colitis caused by Clostridium AND patient has had a therapeutic failure, adverse reaction or contraindication to metronidazole OR 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.
ANTI-INFECTIVES ANTIFUNGAL			
ALLYLAMINES		LAMISIL GRANULES (terbinafine) LAMISIL TABS (terbinafine HCL) TERBINAFINE TABS (Lamisil)	Terbinafine Tabs: 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 patient meets at least 1 of the following criteria: o Pain to affected area that limits normal activity o Diabetes Mellitus o Patient is immunocompromised o Patient has diagnosis of systemic dermatosis o Patient has significant vascular compromise AND quantity requested does not exceed 30 tablets per month for a maximum of 3 months OR patient has a diagnosis of a Tinea capitis infection (confirmed with a positive KOH stain, PAS stain, or fungal culture). AND quantity requested does not exceed 30 tablets per month for a maximum of 6 weeks. OR 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 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 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: patient has a diagnosis of a Tinea capitis infection (confirmed with a positive KOH stain, PAS stain, or fungal culture). AND patient has a requirement for an oral liquid dosage form. AND patient had a documented side effect, allergy, or treatment failure with Griseofulvin suspension
AZOLES	CLOTRIMAZOLE TROCHE FLUCONAZOLE TABS, SUSP KETOCONAZOLE TAQBS IV drugs are not managed at this time	DIFLUCAN TABS, SUSP (fluconazole) ITRACONAZOLE CAPS (Sporanox) NOXAFIL DR TABS (posaconazole) NOXAFIL ORAL SUSP (posaconazole) ONMEL 200MG TABS (itraconazole) ORAVIG BUCCAL TABS (miconazole) SPORANOX CAPS, SOL (itraconazole) VFEND TABS, SUSP (voriconazole) VORICONAZOLE TABS, SUSP (Vfend)	Itraconazole 100mg/Sporanox: 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: o Pain to affected area that limits normal activity o Diabetes Mellitus o Patient is immunocompromised o Patient has diagnosis of systemic dermatosis o Patient has significant vascular compromise OR patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR 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. Onmel 200mg: patient has a diagnosis of a 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 there is a clinical reason that itraconazole 100 mg generic capsules cannot be used AND meets at least 1 of the following criteria: o Pain to affected area that limits normal activity o Diabetes Mellitus o Patient has significant vascular compromise Limitations: Coverage of Onychomycosis agents will NOT be approved solely for cosmetic purposes. Voriconazole/Vfend: Patient has a diagnosis of invasive aspergillosis. OR patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR patient has a documented side-effect, allergy, or treatment failure to ONE of the preferred medications AND itraconazole. AND For approval of Vfend@ tablets, the patient must have a documented intolerance to generic voriconazole. AND For approval of voriconazolesuspension, the patient must have a medical necessity for a liquid dosage form. For approval of Vfend@ suspension, the patient must additionally have a documented intolerance to generic voriconazole suspension. Noxafil: 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 Aspergillosis/Candida infections. OR patient is completing a course of therapy with the requested medication that was initiated in the hospital. OR Oral Suspension ONLY 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. Diflucan (brand): For approval of Diflucan brand name product, the patient must have a documented intolerance to generic fluconazole. Oravig: The indication for use is treatment of oropharyngeal candidiasis. AND patient has had a documented side effect, allergy, treatment failure/inadequate response to both nystatin suspension and clotrimazole troche. OR patient is unable to be compliant with the nystatin suspension and/or clotrimazole troche dosing schedules.
ANTI-INEFFECTIVES ANTIMALARIALS			
QUININE		QUALAQUIN (Quinine Sulfate) QUININE SULFATE (Qualaquin)	Criteria for Approval: 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.
ANTI-INEFFECTIVES ANTI-VIRALS			
HERPES (ORAL)	ACYCLOVIR VALACYCLOVIR	FAMCICLOVIR (Famvir) FAMVIR (famciclovir) SITAVIG BUCCAL TABS (acyclovir) ZOVIRAX (acyclovir)	Famciclovir, Zovirax: patient has a documented side effect or allergy, or treatment failure (at least one course of ten or more days) with acyclovir AND valacyclovir. Famvir: 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 patient has a documented intolerance to generic famciclovir. Sitavig: patient has a diagnosis of recurrent herpes labialis (cold sores). AND atient is immunocompetent AND patient has a documented side effect or treatment failure with acyclovir AND valacyclovir. Valtrex: patient has a documented intolerance to generic valacyclovir
INFLUENZA MEDICATIONS	RELENZA (zanamivir) TAMIFLU (oseltamivir)		Taqmiflu, Relenza: Tamiflu and Relenza will NOT require prior-authorization at this time when prescribed within the following quantity limits: Relenza: 20 blisters per 30 days Tamiflu: 75mg or 45mg: 10 caps per 30 day Tamiflu: 30mg: 20 caps per 30 days Tamiflu: Suspension (6mg/ml): 180ml (3 bottles) per 30 days 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.
INFLUENZA VACCINES	AFLURIA INJ FLUARIX INJ FLUARIX QUADRIVALENT INJ FLULAVAL INJ FLULAVAL QUADRIVALENT INJ FLUVIRIN INJ FLUZONE HIGH-DOSE INJ FLUZONE INJ FLUZONE INTRADERMAL INJ FLUZONE QUADRIVALENT INJ SEASONAL Influenza Vaccine INJECTION	FLUBLOK INJ FLUCELVAX INJ FLUMIST QUADRIVALENT INTRANASAL	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 Fluclvax: Fluclvax is being requested for influenza prophylaxis during flu season AND patient is > 18 years old. AND Prescriber provides clinical rationale why one of the preferred influenza vaccines cannot be used. Flublok: Flublok is being requested for influenza prophylaxis during flu season AND patient is between the ages of >18 and < 50 years old. AND patient has an egg allergy.
ANTI-MIGRAINE TRIPTANS			
	IMITREX NASAL SPARY INITREX INJ NARATRIPTAN TABS RIZATRIPTAN ODT SUMATRIPTAN TABS	ALSUMA INJ (sumatriptan) AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) IMITREX TABS (sumatriptan)	Amerge, Axert, Frova, Imitrex, Maxalt, Relpax, Rizatriptan, Zomig, Zomig ZMT, Zolmitriptan, Zolmitriptan ODT: patient has had a documented side effect, allergy, or treatment failure to Sumatriptan, Naratriptan and Rizatriptan ODT. If the request is for brand Maxalt, Zomig, or Zomig ZMT, the patient must also have a documented intolerance to the generic product. Maxalt MLT: patient has had a documented side effect, allergy, or treatment failure with Sumatriptan and the patient must also have a documented intolerance to the generic product. Naratriptan, Rizatriptan ODT: patient has had a documented side effect, allergy, or treatment failure with Sumatriptan. Treximet: patient had a documented side effect, allergy or treatment failure with 2 preferred Triptans, AND patient is unable to take the individual components (sumatriptan and naproxen) separately.

MAXALT TABS (rizatriptan)
 MAXALT-MLT (rizatriptan ODT)
 RELPAX (eletriptan)
 RIZATRIPTAN (Maxalt)
 SUMATRIPTAN INJ (Imitrex Inj)
 SUMATRIPTAN NASAL SPRAY (Imitrex NS)
 SUMAVEL DOSEPRO INJ (sumatriptan)
 TREXIMET TABS (sumatriptan/naproxen)
 ZOLMITRIPTAN (Zomig)
 ZOLMITRIPTAN ODT (Zomig ODT)
 ZOMIG (zolmitriptan)
 ZOMIG NASAL SPRAY (zolmitriptan NS)
 ZOMIG ZMT (zolmitriptan ODT)

Zomig Nasal Spray: patient has had a documented side effect, allergy or treatment failure of Imitrex Nasal Spray
Sumatriptan Nasal Spray: patient has had a documented intolerance to brand Imitrex.
Alsuma, Sumatriptan, Sumavel Dose Pro Injections: patient has had a documented intolerance to brand Imitrex.
To exceed quantity limits: patient is taking a medication for migraine prophylaxis.

ANTI-OBESITY

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

ANTI-PSYCHOTIC

ATYPICAL & COMBINATIONS

CHILDREN < 18 YEARS OLD

OLANZAPINE TABS
 QUETIAPINE TABS
 RISPERIDONE TABS, ORAL SOL
 ZIPRASIDONE CAPS

ABILIFY (aripiprazole) TABS, ORAL SOL, DISCMELT
 CLOZAPINE (Clozaril) TABS
 CLOZAPINE ODT (FazaClo)
 CLOZARIL (clozapine) TABS
 FAZACLO (clozapine ODT)
 GEODON (ziprasidone) CAPS
 INVEGA (paliperidone) TABS
 OLANZAPINE ODT (Zyprexa Zydis)
 RISPERDAL (risperidone) TABS, ORAL SOL
 RISPERDAL M-TAB (risperidone ODT)
 RISPERDONE ODT (Risperdal M-Tab)
 SEROQUEL (quetiapine) TABS
 SEROQUEL XR (quetiapine XR) TABS
 VERSACLOZ (clozapine) ORAL SOL
 ZYPREXA (olanzapine) TABS
 ZYPREXA ZYDIS (olanzapine ODT)

Criteria for approval: (Children < 18 years old) Note: all request for patients < 5 years old will be reviewed by the DVHA Medical Director.

Target symptoms or Diagnosis that will be accepted for approval: Target Symptoms - Grandiosity/euphoria/mania; Obsessions/compulsions; Psychotic symptoms; Tics (motor or vocal). Diagnosis- Autism with Aggression and/or irritability; Bipolar Disorder; Intellectual Disability with Aggression and/or Irritability; Obsessive Compulsive Disorder; Schizophrenia/Schizoaffective Disorder; Tourette's Syndrome.

Preferred after clinical criteria are met: Tablets & Capsules:

Olanzapine, Risperidone, Ziprasidone: patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization). OR medication is being requested for one of the target symptoms or patient diagnoses listed above.

Quetiapine: patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization). OR medication is being requested for one of the target symptoms or patient diagnoses listed above. Note: Quetiapine will not be approved for indication of insomnia, for sleep or as a hypnotic.

Risperidone Oral Sol: patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization). OR medication is being requested for one of the target symptoms or patient diagnoses listed above.

Non-Preferred:

Invega: patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization). OR medication is being requested for one of the target symptoms or patient diagnoses listed above AND patient had had a documented side effect, allergy or treatment failure with at least two preferred after clinical criteria are met products (typical or atypical antipsychotics) (see tables), one of which is risperidone.

Clozaril, Geodon, Risperdal, Seroquel, Zyprexa: patients meets clinical criteria for the generic equivalent AND patient has a documented intolerance to the generic equivalent.

Clozapine: patient has been started and stabilized on the requested medication. (Note samples are not considered adequate justification for stabilization) OR medication is being requested for one of the target symptoms or patient diagnoses listed above AND patient has had a documented side effect, allergy or treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics), two of which are preferred after clinical criteria are met products (see tables)

Seroquel XR: patient has been started and stabilized on the requested medication. (Note samples are not considered adequate justification for stabilization) OR medication is being requested for one of the target symptoms or patient diagnoses listed above AND 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: patient has been started and stabilized on the requested medication. (Note samples are not considered adequate justification for stabilization) OR indication or use is treatment of autism with aggression and/or irritability, intellectual disability with aggression and/or irritability or Tourette's syndrome/tics (motor or vocal) AND the patient has had a documented side effect, allergy or treatment failure with risperidone OR indication or use is treatment of autism with aggression and/or irritability, intellectual disability with aggression and/or irritability or Tourette's syndrome/tics (motor or vocal) AND the prescriber feels that risperidone would not be an appropriate alternative for the patient because of pre-existing medical conditions such as obesity or diabetes. OR medication is being requested for one of the other target symptoms or patient diagnoses listed above. AND patient has had a documented side effect, allergy or treatment failure with at least two preferred after clinical criteria are met products (typical or atypical antipsychoticw) (see table), one of which is risperidone. OR 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.

Abilify Oral Solution: patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization), OR medication is being requested for one of the target symptoms or patient diagnoses listed above AND patient has had a documented side effect, allergy or treatment failure with risperidone oral solution OR prescriber feels that

			<p>risperidone would not be an appropriate alternative for the patient because of pre-existing medical conditions such as obesity or diabetes.</p> <p>Versacloz Oral Solution: patient has been started and stabilized on the requested medication (Note: samples are not considered adequate justification for stabilization) OR medication is being requested for one of the target symptoms or patient diagnoses listed above AND patient has had a documented side effect, allergy or treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics), AND patient is unable to use clozapine orally disintegrating tablets.</p> <p>Risperdal: patient meets clinical criteria for the generic equivalent AND patient has a documented intolerance to the generic product risperidone.</p> <p>Olanzapine ODT, Risperdal M-Tabs, Risperidone ODT, Zyprexa Zydys: patient meets clinical criteria for non-orally disintegrating oral dosage forms of the same medication AND Medical necessity for a specialty dosage form has been provided AND if the request is for Risperdal M-tabs or Zyprexa Zydys, the patient has a documented intolerance to the generic equivalent.</p> <p>Clozapine ODT, FazaClo: patient has been started and stabilized on any form of the requested medication (Note: samples are not considered adequate justification for stabilization) AND Medical necessity for a specialty dosage form has been provided OR medication is being requested for one of the target symptoms or patient diagnoses listed above AND patient has had a documented side effect, allergy or treatment failure with at least three other antipsychotic medications (typical or atypical antipsychotics) AND Medical necessity for a specialty dosage form has been provided AND if the request is for a brand product with a generic equivalent, the patient has a documented intolerance to generic product.</p> <p>Abilify Discmetl: patient has been started and stabilized on any form of the requested medication. (Note: samples are not considered adequate justification for stabilization) AND Medical necessity for a specialty dosage form has been provided OR medication is being requested for one of the target symptoms or patient diagnoses listed above AND patient has had a documented side effect, allergy or treatment failure with Risperdal M-tab OR prescriber feels that risperidone would not be an appropriate alternative for the patient because of pre-existing medical conditions such as obesity or diabetes AND Medical necessity for a specialty dosage form has been provided.</p> <p>Limitations: Approval for use in Children < 18 years old will not be granted for the following medications or dosage forms due to no FDA approval for use in children and little or no literature to support their use in this population. Exceptions will be made for patients who have been started and stabilized on the requested medication or dosage form (Note: samples are not considered adequate justification for stabilization): Fanapt, Latuda, Saphris, Geodon Im, Abilify IM, Olanzapine IM, Zyprexa IM, Abilify Maintena, Invega Sustenna, Risperdal Consta, Zyprexa Relprevv, Symbyax, Olanzapine/fluoxetine.</p>
<p>ATYPICAL & COMBINATIONS</p> <p>CHILDREN ≥ 18 YEARS OLD</p>	<p>CLOZAPINE TABS</p> <p>GEODON IM</p> <p>OLANZAPINE TABS</p> <p>QUETIAPINE TABS > 50mg/day</p> <p>RISPERIDONE ORAL SOLUTION</p> <p>RISPERIDONE TABS</p> <p>ZIPRASIDONE CAPS</p>	<p>ABILIFY (aripiprazole) TABS, ORAL SOL, DISCMLT, IM, MAINTENA</p> <p>CLOZAPINE ODT (FazaClo)</p> <p>CLOZARIL (clozapine) TABS</p> <p>FANAPT (loperidone) TABS</p> <p>FAZACLO (clozapine ODT)</p> <p>GEODON (ziprasidone) CAPS</p> <p>INVEGA (paliperidone) TABS, SUSTENNA</p> <p>LATUDA (lurasidone)</p> <p>OLANZAPINE IM INJ (Zyprexa IM)</p> <p>OLANZAPINE ODT (Zyprexa Zydys)</p> <p>OLANZAPINE/FLUOXETINE (Symbyax)</p> <p>QUETIAPINE TABS ≤ 50mg/day</p> <p>RISPERDAL (risperidone) TABS, ORAL SOL</p> <p>RISPERDAL CONSTA</p> <p>RISPERDAL M-TAB (risperidone ODT)</p> <p>RISPERDONE ODT (Risperdal M-Tab)</p> <p>SAPHRIS (asenapine) SL TAB</p> <p>SEROQUEL (quetiapine) TABS</p> <p>SEROQUEL XR (quetiapine XR) TABS</p> <p>SYMBYAX (olanzapine/fluoxetine)</p> <p>VERSACLOZ (clozapine) ORAL SOL</p> <p>ZYPREXA (olanzapine) TABS</p> <p>ZYPREXA IM (olanzapine IM Inj)</p> <p>ZYPREXA RELPREVV (olanzapine pamoate)</p> <p>ZYPREXA ZYDIS (olanzapine ODT)</p>	<p>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).</p> <p>Invega: 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.</p> <p>Saphris: 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.</p> <p>Clozaril, Geodon, Risperdal, Zyprexa: patient has a documented intolerance to the generic equivalent.</p> <p>Latuda: The patient is pregnant and the diagnosis is schizophrenia/schizoaffective disorder or Bipolar I depression. 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 indication for use is schizophrenia/schizoaffective disorder. AND 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 Bipolar I depression. AND The patient has had a documented side effect, allergy or treatment failure with generic quetiapine. OR The indication for use is Bipolar I depression. AND The prescriber feels that quetiapine would not be an appropriate alternative for the patient because of pre-existing medical conditions such as obesity or diabetes.</p> <p>Quetiapine/Seroquel < or = 50mg/day: 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, tricyclic 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, tricyclic and/or Miscellaneous Antidepressant categories) or at least 2 antidepressants from the SSRI, SNRI, tricyclic 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 is for brand Seroquel, the patient has a documented intolerance to generic quetiapine.</p> <p>Note: Quetiapine in doses of < 50 mg/day will not be approved for indications of insomnia, for sleep or as an hypnotic.</p> <p>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, tricyclic 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, tricyclic and/or Miscellaneous Antidepressant categories) or at least 2 antidepressant from the SSRI, SNRI, tricyclic 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</p> <p>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</p>

			<p>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, tricyclic 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, tricyclic and/or Miscellaneous Antidepressant categories) or at least 2 antidepressant from the SSRI, SNRI, tricyclic 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.</p> <p>Abilify Oral Solutions: 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, tricyclic 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, tricyclic and/or Miscellaneous Antidepressant categories) or at least 2 antidepressant from the SSRI, SNRI, tricyclic 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.</p> <p>Risperdal Oral Solution: The patient has a documented intolerance to the generic product risperidone.</p> <p>Versacloz Oral Solution: The patient has a medical necessity for a non-solid oral dosage form and is unable to use clozapine orally disintegrating tablets.</p> <p>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.</p> <p>Risperdal Consta Inj: The patient has been started and stabilized on the medication OR Medical necessity for a specialty dosage form has been provided (non-compliance with oral medications) AND Tolerability has been established previously with oral risperidone.</p> <p>Invega Sustenna Inj: The patient has been started and stabilized on the medication OR Medical necessity for a specialty dosage form has been provided (non-compliance with oral medications) AND Tolerability has been established previously with oral/injectable risperidone or oral paliperidone.</p> <p>Zyprexa Relprevv: The patient has been started and stabilized on the medication OR Medical necessity for a specialty dosage form has been provided (non-compliance with oral medications) AND Tolerability has been established previously with oral olanzapine.</p> <p>Abilify Maintena: The patient has been started and stabilized on the medication OR 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. Medical necessity for a specialty dosage form has been provided (non-compliance with oral medications) AND Tolerability has been established previously with oral aripiprazole for at least 2 weeks.</p> <p>ORALLY DISINTEGRATING TABLETS: Medical necessity for a specialty dosage form has been provided. AND If the request is for FazaClo, Risperdal M-Tab or Zyprexa Zydys, the patient has a documented intolerance to the generic equivalent.</p> <p>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.</p>
<p>TYPICALS</p>	<p>CHLORPROMAZINE FLUPHENAZINE FLUPHENAZINE DECANOATE HALOPERIDOL HALOPERIDOL DECANOATE LOXAPINE NAVANE 20MG ONLY PERPHENAZINE THIORIDAZINE THIOTHIXENE TRIFLUOPERAZINE</p>	<p>HALDOL (haloperidol) HALDOL DECANOATE (haloperidol decanoate) LOXITANE (loxapine) NAVANE (thiothixene) 2MG, 5MG, 10MG</p>	<p>Criteria for Approval Oral: 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 decanoate, the patient has a documented intolerance to the generic product.</p>
BONE RESORPTION INHIBITORS			
	<p>ALENDRONATE RALOXIFENE</p>	<p>ACTONEL (risedronate) ATELVIA (risedronate) Delayed Release Tablet BINOSTO (alendronate) 70mg effervescent tablet BONIVA (ibandronate) TABS, INJ CALCITONIN NASAL SPRAY (Miacalcin) DIDRONEL (etidronate)</p>	<p>Actonel, Risedronate: patient has a diagnosis/indication of Paget's Disease AND patient has had a documented side effect, allergy, or treatment failure (at least a six-month trial) to generic alendronate OR patient has a diagnosis/indication of postmenopausal osteoporosis, osteoporosis in men or glucocorticoid induced osteoporosis AND 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 Actonel, the patient has also had a documented intolerance to generic risedronate</p> <p>Atelvia, Boniva Oral, Ibandronate: patient has a diagnosis/indication of postmenopausal osteoporosis AND patient has had a documented side effect, allergy or treatment failure (at least 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</p>

		<p>ETIDRONATE (Didronel) EVISTA (raloxifene) FORTEO (teriparatide) INJ FORTICAL (calcitonin) FOSAMAX (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) IBANDRONATE (Boniva) TAB MICALCIN (calcitonin) NASAL SPRAY, INJ PROLIA INJ (denosumab) RECLAST INJ (zoledronic acid) RISEDRONATE (Actonel) SKELID (tiludronate) XGEVA (denosumab) ZOLEDRONIC ACID INJ (Reclast Inj)</p>	<p>Boniva oral, the patient has also had a documented intolerance to generic Ibandronate</p> <p>Binosto: patient has a diagnosis/indication of postmenopausal osteoporosis or osteoporosis in men. AND prescriber provides documentation of medical necessity for the specialty dosage form (i.e. inability to swallow tablets, dysphagia).</p> <p>Calcitonin Nasal Spray (generic), Fortical, Miacalcin Nasal Spray: patient is started and stabilized on the requested medication. If the request is for generic Calcitonin Nasal Spray, the patient has had a documented intolerance to brand Miacalcin. Note: Calcitonin Nasal Spray (brand and generic) no longer recommended for osteoporosis.</p> <p>Miacalcin Injection: patient has a diagnosis/indication of Paget's Disease</p> <p>Evista Tablets: patient has had a documented intolerance to generic raloxifene.</p> <p>Fosamax Tablets: patient has had a documented intolerance to generic alendronate.</p> <p>Fosamax Plus D: there is a clinical reason why the patient is unable to take generic alendronate and vitamin D separately.</p> <p>Didronel, Etidronate, Skelid: patient has a diagnosis/indication of Paget's Disease AND patient has had a documented side effect, allergy, 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.</p> <p>Forteo: patient has a diagnosis/indication of postmenopausal osteoporosis in females, primary or hypogonadal osteoporosis in males or glucocorticoid induced osteoporosis AND 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 prescriber has verified that the patient has been counseled about osteosarcoma risk AND the quantity requested does not exceed 1 pen (3ml) per 28 days with a lifetime maximum duration of treatment of 2 years.</p> <p>Boniva Injection, Ibandronate Injection: patient has a diagnosis/indication of postmenopausal osteoporosis AND 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 quantity requested does not exceed four (4) 3mg doses per year.</p> <p>Prolia Injection: diagnosis or indication is osteopenia in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer OR diagnosis or indication is osteopenia in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer OR patient has a diagnosis/indication of postmenopausal osteoporosis AND 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 quantity requested does not exceed 1 syringe per 6 months.</p> <p>Reclast Injection, Zoledronic Acid Injection: patient has a diagnosis/indication of Paget's disease of bone OR patient has a diagnosis/indication of postmenopausal osteoporosis OR patient is male with a diagnosis of osteoporosis OR patient has a diagnosis of glucocorticoid induced osteoporosis AND 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 quantity requested dose not exceed a single 5mg dose per year AND if the reclast, the patient has a documented intolerance to generic zoledronic acid injection.</p> <p>Xgeva injection: diagnosis or indication is bone metastases from solid tumors (e.g. prostate, breast, thyroid, non-small lung cancer)</p>
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BOTULINUM TOXINS

		<p>BOTOX (onabotulinumtoxin A) MYOBLOC (rimabotulinumtoxinB) Available after a BOTOX trial for select Indications DYSPOrt (abobotulinumtoxinA) XEOMIN (incobotulinumtoxinA)</p>	<p>BOTOX (onabotulinumtoxinA): The indication for use is: o Strabismus and blepharospasm associated with dystonia, including essential blepharospasm, VII cranial nerve disorders/hemifacial spasm o Focal dystonias, including cervical dystonia, spasmodic dysphonia, oromandibular dystonia o Limb spasticity (e.g., due to cerebral palsy, multiple sclerosis, or other demyelinating CNS diseases) o Focal spasticity (e.g., due to hemorrhagic stroke, anoxia, traumatic brain injury) o Axillary Hyperhidrosis (if member has failed an adequate trial of topical therapy) o Overactive bladder or detrusor overactivity (if member has failed an adequate trial of at least TWO urinary antispasmodics (either short- or long-acting formulations) o 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). For re-approval after 3 months, the patient must have had an improvement in symptoms. 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.</p> <p>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.</p> <p>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</p> <p>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.</p> <p>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)</p> <p>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.</p>
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BPH AGENTS

	<p>DOXAZOSIN FINASTERIDE TAMULOSIN TERAZOSIN</p>	<p>ALFUZOSIN ER (Uroxatral) AVODART (dutasteride) CARDURA XL (doxazosin) FINASTERIDE (Proscar) FLOMAX (tamsulosin) JALYN (dutasteride/tamsulosin)</p>	<p>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.</p> <p>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.</p> <p>alfuzosin ER, Rapaflo, Uroxatral: The patient has had a documented side effect, allergy or treatment failure with two preferred alpha blockers. In addition, for approval of Uroxatral, the patient must have a documented intolerance to generic alfuzosin ER.</p> <p>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.</p> <p>Proscar: The patient has a diagnosis of BPH (benign prostatic hypertrophy) AND the patient has a documented intolerance to generic finasteride.</p>
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CARDIAC GLYCOSIDES			
	DIGOXIN DIGOXIN ORAL SOL LANOXIN		
CHEMICAL DEPENDENCY			
ALCOHOL DEPENDENCY	ACAMPROSATE DISULFIRAM NALTREXONE ORAL	ANTABUSE (disulfiram) CAMPRAL (acamprosate) REVIA (naltrexone oral) VIVITROL (naltrexone for extended-release injectable suspension)	Alcohol/Opiate Dependency: Revia, Antabuse, Campral: 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 buprenorphine/buprenorphine-naloxone/Suboxone therapy or is not a candidate for buprenorphine/buprenorphine-naloxone/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/Naloxone, 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 Requests for Buprenorphine/Naloxone 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.
OPIATE DEPENDENCY	NALTREXONE ORAL SUBOXONE SL FILM *Maximum day supply for Suboxone is 14 days*	BUPRENORPHINE SL TAB (Subutex) BUPRENORPHINE/NALOXONE (Suboxone) SL TAB REVIA (naltrexone oral) VIVITROL (naltrexone for extended-release injectable susp) *Maximum day supply for buprenorphine/naloxone or buprenorphine is 14 days*	See Criteria Above:
CONSTIPATION: CHRONIC, IBS-C OR OPIOID INDUCED			
	BISACODYL DOCUSATE LACTULOSE POLYETHYLENE GLYCOL 3350 (PEG) PSYLLIUM SENNA	AMITIZA (lubiprostone) LINZESS (linaclotide) RELISTOR (methylnaltrexone)	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). Linzess: The patient is 18 years of age or older. AND The patient has a diagnosis of chronic idiopathic constipation (CIC) (145 mcg capsules) OR The patient has a diagnosis of irritable bowel syndrome with constipation (IBS-C) (290 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.
CONTRACEPTIVES: VAGINAL RING			
	NUVARING (etonogestrel/ethinyl estradiol vaginal ring)		
CORONARY VASODILATORS/ANTIANGINALS			
ORAL	ISOSORBIDE DINITRATE ISOSORBIDE DINITRATE ER ISOSORBIDE MONONITRATE ISOSORBIDE MONONITRATE ER NITROGLYCERIN ER CAP NITROGLYCERIN SL TAB NITROGLYCERIN SPRAY LINGUAL NITROLINGUAL PUIMP SPRAY NITROMIST LINGUAL SPRAY NITROQUICK NITROSTAT NITRO-TIME	BIDIL (isosorbide dinitrate/hydralazine) DILATRATE-SR (isosorbide dinitrate SR capsule) IMDUR (isosorbide mononitrate ER tablet) ISMO (isosorbide mononitrate tablet) ISORDIL (isosorbide dinitrate tablet) ISOSORBIDE DINATRATE SL TAB MONOKET (isosorbide mononitrate tablet) RANEXA (ranolazine)	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 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: o Hepatic insufficiency o 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).
TOPICAL	NITREK	NITRO-DUR (nitroglycerin transdermal patch)	Nitro-Dur: patient has had a side effect, allergy, or treatment failure to Nitrek or generic nitroglycerin transdermal patches.

	NITRO-BID NITROGLYCERIN TRANSDERMAL PATCHES		
CORTICOSTEROIDS: ORAL			
	CORTISONE ACETATE TAB DEXAMETHASONE tablets, elixir, intensol, solution HYDROCORTISONE TAB MEDROL (methylprednisolone) 2mg tablets METHYLPREDNISOLONE DOSE PACK METHYLPREDNISOLONE tabs ORAPRED ODT (age < 12 yrs) PREDNISOLONE 3 mg/ml oral solution, syrup PREDNISOLONE SOD PHOSPHATE ORAL SOLUTION 6.7mg/5ml PREDNISOLONE SODIUM PHOSPHATE 3 mg/ml oral solution PREDNISOLONE intensol, solution, tablets	CELESTONE (betamethasone) oral solution CORTEF (hydrocortisone) tablets DEXPAK tabs (dexamethasone taper pack) FLO-PRED (prednisolone acetate) oral suspension MEDROL (methylprednisolone) tablets MEDROL DOSE PAK (methylprednisolone) tabs MILLIPRED (prednisolone sodium phos) oral solution MILLIPRED (prednisolone) tablets MILLIPRED DP (prednisolone) dose pack tablets ORAPRED ODT (prednisolone sod phos) (age ≥ 12 yrs) ORAPRED oral solution (prednisolone sod phos) PEDIAPRED (prednisolone sod phosphate) oral solution PREDNISOLONE SODIUM PHOSPHATE ORAL SOLUTION 25MG/5ML RAYOS (prednisone) Delayed Release Tablet VERIPRED 20 oral solution (prednisolone sodium phosphate) All Other Brand Products	Rayos: The patient has had a trial of generic immediate release prednisone and has documented side effects that are associated with the later onset of activity of immediate release prednisone taken in the morning. If the patient has been started and dosed on the requested medication, and the patient has a documented side effect, allergy, or treatment failure with at least one preferred generic formulation, the product has an AB rated generic, one trial must be the generic formulation.
COUGH AND COLD PREPARATIONS			
	All generics MUCINEX (guaifenesin)	HYDROCODONE/CHLORPHENIRAMINE (Tussionex) TUSSICAPS (hydrocodone/chlorpheniramine) TUSSIONEX (hydrocodone/chlorpheniramine) All Other Brands	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 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.
CYSTIC FIBROSIS MEDICATIONS			
	BETHKIS (tobramycin) INHALATION SOLUTION* TOBI (tobramycin) INHALATION SOLUTION*	CAYSTON (aztreonam) INHALATION SOLUTION KALYDECO (ivacaftor) TABLETS PULMOZYME (dornase alfa) INHALATION SOLUTION TOBI (tobramycin) PODHALER CAPSULES FOR INHALATION TOBRAMYCIN INHALATION SOLUTION (Tobi)	Bethkis and TOBI inhalation solution: The diagnosis or indication is cystic fibrosis required for approval. TOBI Podhaler: Trial of one preferred agent required for approval. Causton, Pulmozyme, tobramycin inhalation solution, TOBI Podhaler: The diagnosis or indication is cystic fibrosis required for approval AND documented intolerance to Bethkis or TOBI. Kalydeco: The patient has a diagnosis of Cystic Fibrosis. AND Patient has one of the following mutations on at least one allele in the cystic fibrosis transmembrane conductance regulator gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R (documentation provided). AND The patient is > 6 years old. Note: Renewal of Prior Authorization will require documentation of member response.
DERMATOLOGICAL AGENTS			
ACTINIC KERATOSIS THERAPY	ALDARA CARAC 0.5% CREAM FLUOROPLEX 1% CREAM FLUOROURACIL 0.5% CREAM FLUOROURACIL 5% CREAM, 5%, 2% SOL	DICLOFENAC SODIUM 3% GEL (Solaraze) EFUDEX 5% CREAM, SOL (fluorouracil) IMIQUIMOD 5% CREAM (Aldara) PICATO 0.015% GEL (ingenol mebutate) PICATO 0.05% GEL (ingenol mebutate) SOLARAZE 3% GEL (diclofenac sodium) ZYCLARA 2.5 % & 3.75% CREAM PUMP (imiquimod) ZYCLARA 3.75% CREAM (imiquimod)	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 Picato: The diagnosis or indication is actinic keratosis AND The patient has had a documented side effect, allergy, contraindication or treatment failure with a generic topical fluorouracil product. OR The patient has had a documented side effect, allergy, contraindication or treatment failure with preferred brand Aldara Solaraze Gel, Diclofenac 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 cm2 on the face or scalp. AND The patient has had a documented side effect, allergy, or treatment failure with 5-fluorouracil.
ANTIBIOTICS TOPICAL	BACITRACIN BACITRACIN-POLYMYXIN MUPIROCIN OINT NEOMYCIN-BACITRACIN-POLYMYXIN	ALTABAX (retapamulin) BACTROBAN (mupirocin) Cream BACTROBAN(mupirocin) Ointment CENTANY Ointment (mupirocin) CORTISPORIN Cream (neomycin-polymyxin-hydrocortisone) CORTISPORIN Ointment(bacitracin-neomycin-polymyxin-hydrocortisone) GENTAMICIN Cream or Ointment MUPIROCIN Cream (Bactroban) NEOSPORIN (neomycin-bacitracin-polymyxin) POLYSPORIN (bacitracin-polymixin) All Other Brand Products	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, mupirocin cream, Centany Ointment: The patient has had a documented intolerance with generic mupirocin ointment AND If the request is for brand Bactroban Cream, the patient has also had a documented intolerance to the generic equivalent. 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
ANTIFUNGALS: ONYCHOMYCOSIS		CICLOPIROX 8% SOL (Penlac Nail Lacquer) PENLAC NAIL LACQUER (ciclopirox 8% sol)	Ciclopirox/Penlac Sol: 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: o Pain to affected area that limits normal activity o Diabetes Mellitus o Patient is immunocompromised o Patient has diagnosis of systemic dermatosis o Patient has significant vascular compromise For approval of Penlac®, the patient must have a documented intolerance to generic ciclopirox.

ANTIFUNGALS: TOPICAL	CICLOPIROX 0.77% CR, SUS GEL ;1% SHAMPOO CLOTRIMAZOLE 1% CR, SOL CLOTRIMAZOLE w/BETAMETHASONE CR, LOT ECONAZOLE 1% CR KETOCONAZOLE 2% CR, 2% SHAMPOO MICONAZOLE all generic/OTC products NYSTATIN ONT, CR, POWDER NYSTATIN w/TRIAMCINOLONE CR, OINT TOLNAFTATE 1% CR, POWDER, SPRAY, SOL	ERTACZO (sertaconazole) 2% CR EXELDERM (sulconazole) 1% CR, SOL EXTINA (ketoconazole) 2% Foam KETACONAZOLE (Extinae) 2 % Foam KURIC (ketoconazole) 2% CR LAMISIL RX/OTC (terbinafine) 1% CR, SOL, Spray, Gel LOPROX (ciclopirox) 0.77% CR, SOL, GEL; 1% Shampoo LOTRAMIN AF OTC (clotrimazole) 1% CR, SOL, LOT LOTRISONE (clotrimazole w/betamethasone) CR, LOT LUZU (luliconazole) 1% Cream MENTAX/LOTRIMIN ULTRA OTC (butenafine) 1% CR MYCOSTATIN (nystatin) CR, POWDER NAFTIN (naftifine) 1% & 2% CR, 1%, 2% GEL NIZORAL A-D® OTC (ketoconazole) 1% Shampoo NIZORAL(ketoconazole) 2% Shampoo NYSTOP, PEDI-DRI, NYAMYC (nystatin) POWDER OXISTAT (oxiconazole) 1% CR, LOT TINACTIN/TINACTIN AT OTC* (tolnaftate) 1% CR, POWDER, Spray, SOL XOLEGEL (ketoconazole) 2% GEL VUSION (miconazole w/zinc oxide) OINT All Other Branded Products	LIMITATIONS: Coverage of Onychomycosis agents will NOT be approved solely for cosmetic purposes. Kits with multiple drug products or non-drug items not covered. 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. Limitations: Foam products (e.g. Ecoza (econazole nitrate)) not covered. Other topical dosage preparations preferred.
ANTIVIRALS: TOPICAL	ABREVA OTC 10% CREAM	ACYCLOVIR (Zovirax) 5% OINT DENAVIR (penciclovir) 1% CREAM ZOVIRAX (acyclovir) 5% CR, OINT	Denavir: The patient has a diagnosis of oral herpes simplex infection. Acyclovir, 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. In addition, for approval of Zovirax Ointment, the patient has a documented intolerance to generic acyclovir ointment. 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. **
CORTICOSTEROIDS: LOW POTENCY	ALCLOMETASONE 0.05% CR, ONT DESONIDE 0.05% CR, LOT, ONT FLUOCINOLONE 0.01% CR, SOL, OIL HYDROCORTISONE ACETATE 1% CR; 1% ONT (all generics) HYDROCORTISONE: 0.5%, 1%, 2.5% CR; HYDROCORTISONE: 1%, 2.5% LOT, 0.5%, 1%, 2.5% ONT	ACLOVATE(alclometasone) 0.05% CR, ONT CAPEX (fluocinolone) 0.01% shampoo DERMA-SMOOTH (fluocinolone 0.01%) oil DESONATE (desonide) 0.05% G DESOWEN (desonide) 0.05% CR, LOT, ONT NUCORT 2% LOTION (hydrocortisone acetate) SYNALAR (fluocinolone) 0.01% SOL VERDESO(desonide) 0.05% FOAM All other brands	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.) LIMITATIONS: Corticosteroid spray formulations (eg. Topicort Spray) not covered – use alternate dosage forms.
CORTICOSTEROIDS: MEDIUM POTENCY	BETAMETHASONE DIPROPIONATE 0.05% LOT BETAMETHASONE VALERATE 0.1% CR, LOT FLUOCINOLONE 0.025% CR, ONT FLUTICASONE 0.05% CR; 0.005% ONT HYDROCORTISONE BUTYRATE 0.1% CR,ONT,SOL HYDROCORTISONE VALERATE 0.2% CR,ONT MOMETASONE FUROATE 0.1% CR,LOT,ONT TRIAMCINOLONE ACETONIDE 0.025%, 0.1% CR,LOT,ONT	CLODERM (clocortolone) 0.1% CR CORDRAN (all products) CUTIVATE (fluticasone) 0.05% LOT CUTIVATE (fluticasone) 0.05% CR; 0.005% ONT DERMATOP (prednicarbate) 0.1% CR,ONT DESOXIMETASONE 0.05% CR,ONT (compare to Topicort®) ELOCON (all products) FLUTICASONE (compare to Cutivate®) 0.05% LOT LOCOID (hydrocortisone butyrate) 0.1% CR,ONT,SOL LOCOID (hydrocortisone butyrate) 0.1% LOT LUXIQ (betamethasone valerate) FOAM PREDNICARBATE (compare to Dermatop®) 0.1% CR,ONT SYNALAR (fluocinolone) 0.025% CR,ONT TOPICORT (desoximetasone) 0.05% CR,ONT TRIANEX (triamcinolone) 0.05% ONT WESTCORT (hydrocortisone valerate) all products All other brands	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.) LIMITATIONS: Corticosteroid spray formulations (eg. Topicort®Spray) not covered – use alternate dosage forms.
CORTICOSTEROIDS: HIGH POTENCY	AUGMENTED BETAMETHASONE 0.05% CR BETAMETHASONE VALERATE 0.1% ONT DESOXIMETASONE 0.05% GEL; 0.25% CR,ONT FLUOCINONIDE 0.05% CR,GEL,ONT,SOL	AMCINONIDE (formerly Cyclocort®) APEXICON E (diflorasone) 0.05% CR DIFLORASONE DIACETATE 0.05% CR (compare to Apexicon E®) DIPROLENE AF (augmented betamethasone) 0.05% CR	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.) LIMITATIONS: Corticosteroid spray formulations (eg. Topicort Spray) not covered – use alternate dosage forms.

	TRIAMCINOLONE ACETONIDE 0.5% CR,ONT	HALOG (halcinonide) all products TOPICORT (desoximetasone) 0.05% GEL; 0.25% CR,ONT All other brands	
CORTICOSTEROIDS: VERY HIGH POTENCY	ALPHATREX 0.05% GEL APEXICON 0.05% ONT AUGMENTED BETAMETHASONE 0.05% LOT,ONT,GEL CLOBETASOL PROPIONATE CLOBETASOL PROPIONATE† 0.05% Foam CORMAX 0.05% CR,ONT,SOL DIFLORASONE DIACETATE 0.05% ONT HALOBETASOL PROPIONATE	CLOBETASOL PROPIONATE (compare to Clobex®) 0.05% LOT, Shampoo CLOBETASOL PROPIONATE EMULSION (compare to Olux E®) 0.05% FOAM CLOBEX (clobetasol propionate) 0.05% LOT, Shampoo, SPRAY DIPROLENE (augmented betamethasone) 0.05% LOT, ONT FLUOCINONIDE (compare to Vanos®) 0.1% CR OLUX/OLUX E (clobetasol propionate) 0.05% FOAM TEMOVATE (clobetasol propionate) 0.05% CR,GEL,ONT,SOL ULTRAVATE (halobetasol propionate) 0.05% CR,ONT VANOS (fluocinonide) 0.1% CR All other brands	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.) LIMITATIONS: Corticosteroid spray formulations (eg. Topicort Spray) not covered – use alternate dosage forms.
GENITAL WART THERAPY	ALDARA PODOFILOX SOLUTION	CONDYLOX GEL (podofilox gel) CONDYLOX SOL (podofilox sol) IMIQUIMOD 5% (Aldara) CR VEREGAN (sinecatechins oint) ZYCLARA CR (IMIQUIMOD 3.75%) ZYCLARA CR PUMP (IMIQUIMOD 3.75%)	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
IMMUNOMODULATORS	ELIDEL PROTOPIC	ELIDEL (primecrolimus) (age <2 yrs) PROTOPIC (tacrolimus) (age <2 yrs) TACROLIMIS OINT (Protopic) All Patient Ages	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. AND If the request is for generic tacrolimus ointment, the patient has a documented intolerance to brand Protopic. Criteria for Approval 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. AND If the request is for generic tacrolimus ointment, the patient has a documented intolerance to brand Protopic.
SCABICIDES AND PEDICULOCIDES	ACTICIN CR PERMETHRIN 1% CR, LOT PERMETHRIN 5% CR PIPERONYL BUTOXIDE AND PYRETHRINS GEL, SOL, Shampoo Preferred after clinical criteria are met (1 OTC step via electronic PA) NATAROBA SUSP	EURAX (crotamiton 10%) CR, LOT LINDANE LOT LINDANE SHAMPOO MALATHION LOT (Ovide) SKLICE (Ivermectin .05%) LOT SPINOSAD (Natroba) SUSP ULESFIA (benzyl alcohol 5%) LOT	NON-PREFERRED SCABICIDES: The patient has had a documented side effect or allergy to permethrin cream or treatment failure with two treatments of permethrin cream. Natroba: The patient has had a documented side effect or allergy to OTC permethrin and piperonyl butoxide and pyrethrins or treatment failure with two treatments of OTC permethrin or piperonyl butoxide and pyrethrins. Non-Preferred Pediculicides: The patient has had a documented side effect or allergy to OTC permethrin and piperonyl butoxide and pyrethrins and Natroba or treatment failure with two treatments of OTC permethrin and/or piperonyl butoxide and pyrethrins and one treatment of Natroba. For approval of Ovide® Lotion, the patient must also have a documented intolerance to the generic equivalent product.
DESMOPRESSIN: INTRANASAL/ORAL			
	DESMOPRESSIN	DDAVP (des,pressom) Nasal Solution or Spray 00.01% DESMOPRESSIN NASAL SOLUTION or SPRAY (DDAVP) MINIRIN (desmopressin) NASAL SPRAY 0.01% STIMATE (desmopressin) NASAL SOLLUTION 0.5MG/ML	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.
DIABETIC TESTIN SUPPLIES			
MONITORS/METERS	FREESTYLE FREEDOM LITE SYSTEM KIT FREESTYLE INSULINX SYSTEM KIT FREESTYLE LITE SYSTEM KIT ONE TOUCH ULTRA 2 KIT ONE TOUCH ULTRA 2 MINI KIT ONE TOUCH ULTRA SMART KIT PRECISION XTRA SYSTEM KIT	ACCUCHECK ASCENSIA ASSURE EXACTECH PRODIGY All Other Brands and Store Brands	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.
TEST STRIPS/LANCETS	FREESTYLE FREESTYLE INSULINX SYSTEM KIT FREESTYLE LITE SYSTEM KIT ONE TOUCH ULTRA PRECISION XTRA BETA KETONE (10 COUNT) PRECISION XTRA SYSTEM KIT All Other Brands and Store Brands	ACCUCHECK ASCENSIA ASURE EXACTECH PRODIGY All Other Brands and Store Brands	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.
EPINEPHRINE: AUTO-INJECTOR			

	EPIPEN 2-PACK INJ 0.3MG EPIPEN-JR 2 PAK INJ 0.15MG	All other branded and generic products	CRITERIA FOR APPROVAL: The patient has a documented intolerance to the preferred product.
ESTROGENS: VAGINAL			
	ESTRACE VAGINAL CREAM ESTRING VAGINAL RING FEMRING VAGINAL RING PREMARIN VAGINAL CREAM VAGIFEM VAGINAL TABLETS		
FIBROMYALGIA			
		SAVELLA TABS, TITRATION PACK (milnacipran)	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.
GASTROINTESTINAL			
CHRON'S DISEASE INJECTABLES	HUMIRA (adalimumab) REMICADE (infliximab)	CIMZIA (certolizumab pegol) TYSABRI (natalizumab)	NOTE: Crohn's Disease Self-Injectables (Humira and Cimzia) must be obtained and billed through our specialty pharmacy vendor, Briova. Please see the Humira and Cimzia Prior Authorization/Patient Enrollment Form for instructions. Briova may supply Remicade upon request or you may continue to obtain through your usual supplier. Briova will not be supplying Tysabri at this time – please continue to obtain through your usual supplier. 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): aminosaliclates, 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): aminosaliclates, 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): aminosaliclates, 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.
H.PYLORI COMBINATION THERAPY		HELIDAC (bismuth subsalicylate, metronidazole, tetracycline) LANSOPRAZOLE, AMOXACILLIN, CLARITHROMYCIN (Prevpac) OMECLAMOX-PAK (omeprazole, clarithromycin, amoxicillin) PREVPAC (lansoprazole, amoxicillin, clarithromycin) PYLERA (bismuth subcitrate, metronidazole, tetracycline) CAPS	CRITERIA FOR APPROVAL: The patient has a documented treatment failure with combinations of individual proton pump inhibitors or H2 antagonists given together with two appropriate antibiotics OR The patient has been unable to be compliant with individual agents prescribed separately. AND For approval of brand Prevpac®, the patient has a documented intolerance to the generic equivalent combination product.
H-2 BLOCKERS	CIMETIDINE TABS, ORAL SOL FAMOTIDINE TABS RANITIDINE TABS, ORAL SOL	AXID (nizatidine) ORAL SOL AXID (nizatidine) CAPS FAMOTIDINE (Pepcid) ORAL SOL NIZATIDINE (Axid) CAPS NIZATINE ORAL SOL (Axid) PEPCID (famotidine) TABS RANITIDINE CAPS TAGAMET (cimetidine) TABS ZANTAC (ranitidine) TABS ZANTAC (ranitidine) SYRUP ZANTAC EFFERVESCENT (ranitidine)	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.
INFLAMMATORY BOWEL AGENTS (ORAL & RECTAL PRODUCTS)	APRISO ASACOL BALSALAZIDE BUDESONIDE 24HR CANASA DELZICOL LIALDA MESALAMINE ENEMA SULFASALAZINE UCERIS	ASACOL HD (mesalazine tab delayed release) AZULFIDINE (sulfasalazine) COLAZAL (balsalazide) ENTOCORT EC (budesonide 24hr cap) GIAZO (balsalazide disodium) TABS PENTASA (mesalamine cap CR) SF ROWASA (mesalamine enema sulfite free)	Azulfidine, Colazal: 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. Entocort EC: The patient had a documented intolerance to the generic budesonide 24 hr capsules. Giazo: The diagnosis is ulcerative colitis AND The patient is male and > 18 years old. AND The patient has a documented intolerance to generic balsalazide. Sfrowasa: The patient has had a documented intolerance to mesalamine enema. LIMITATIONS: Kits with non-drug products are not covered.
PROKINETIC AGENTS	METOCLOPRAMIDE TABS, ORAL SOL	METOZOLV ODT (metoclopramide) REGLAN (metoclopramide)	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.
PROTON PUMP INHIBITORS	OMEPRAZOLE 20MG & 40MG RX CAPS PANTOPRAZOLE TABS	ACIPHEX SPRINKLE DR CAPS (rabeprazole) ACIPHEX TABS (rabeprazole)	Nexium powder for suspension, Prevacid Solutabs (for patients > 12 years old), Prilosec packet, Protonix packet: The patient has a requirement for a non-solid oral dosage form (e.g. an oral liquid, dissolving tablet or sprinkle).

		<p>DEXILANT CAPS (dexlansoprazole) ESOMEPRAZOLE STRONTIUM CAPS NEXIUM CAPS (esomeprazole) NEXIUM POWDER FOR SUSP (esomeprazole) OMEPRAZOLE generic 10MG RX CAPS (Prilosec) OMEPRAZOLE generic OTC TABS OMEPRAZOLE MAGNESIUM generic OTC 20MG CAPS OMEPRAZOLE/SODIUM BICARB CAPS (Zegerid OTC) OMEPRAZOLE/SODIUM BICARB CAPS RX (Zegerid) PREVACID 24 HR OTC CAPS (lansoprazole) PREVACID RX CAPS (lansoprazole) PREVACID SOLUTABS (lansoprazole) PRIOLOSEC OTC 20MG TABS (omeprazole magnesium) PRIOLOSEC PACKET (omeprazole magnesium) PRIOLOSEC RX brand CAPS (omeprazole) PROTONIX PACKET (pantoprazole) PROTONIX TABS (pantoprazole) RABEPRAZOLE TABS (Aciphex) ZEGERID OTC CAPS (omeprazole/sodium bicarb)</p>	<p>Aciphex Sprinkle: The patient has a requirement for a non-solid oral dosage form AND The member has had a documented side effect, allergy, or treatment failure to omeprazole capsule opened and sprinkled, omeprazole or lansoprazole suspension or Prevacid solutab.</p> <p>Other non-preferred medications: The member has had a documented side effect, allergy, or treatment failure to Omeprazole RX 20 mg or 40 mg generic capsules AND Pantoprazole generic tablets. If the request is for Prevacid 24 hr OTC or Prevacid RX, the patient must also have a documented intolerance to lansoprazole generic RX capsules. If the request is for brand Zegerid OTC capsules, the patient must also have a documented intolerance to the generic equivalent.</p> <p>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.</p> <p>LIMITATIONS: Zegerid (omeprazole/sodium bicarbonate) RX capsules, powder for suspension not covered as no Federal Rebate offered. First-Lansoprazole® and First-Omeprazole Suspension Kits not covered as Federal Rebate no longer offered. Nexium 24HR OTC (esomeprazole) capsules OTC Plan Exclusion - these products are not covered</p>
ULCERATIVE COLITIS INJECTABLES	HUMIRA (adalimumab) REMICADE (infliximab)	SIMPONI SUB-Q (golimumab)	<p>NOTE: Ulcerative Colitis Self-Injectable (Humira and Simponi) must be obtained and billed through our specialty pharmacy vendor, Briova. Please see the Humira or Simponi Prior Authorization/Patient Enrollment Form for instructions. Briova Specialty may supply Remicade® upon request or you may continue to obtain through your usual supplier.</p> <p>Humira, Remicade: Patient has a diagnosis of Ulcerative Colitis and has already been stabilized on the medication. 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.).</p> <p>Simponi: Patient has a diagnosis of Ulcerative Colitis and has already been stabilized on Simponi OR Patient age > 18 years AND Patient has a diagnosis is Ulcerative Colitis and has demonstrated corticosteroid dependence or has had an inadequate response to or failed to tolerate oral aminosalicylates, oral corticosteroids, azathioprine, or 6-mercaptopurine. AND The prescriber must provide a clinically valid reason why Humira® cannot be used.</p>
GAUCHER'S DISEASE MEDICATIONS			
		CEREZYME (imiglucerase for injection) ELELYSO (taliglucerase alfa for injection) VPRIV (velaglucerase alfa for injection)	<p>CRITERIA FOR APPROVAL: The diagnosis or indication is Gaucher disease (GD) type I. AND The diagnosis has been confirmed by molecular or enzymatic testing.</p>
GOUT AGENTS			
	ALLOPURINOL COLCHICINE/PROBENECID PROBENECID	COLCRYS TABS (colchicine) KRYSTEXXA VIALS for IV INFUSION (pegloticase) ULORIC TABS (febuxostat) ZYLOPRIM (allopurinol)	<p>Colcris: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</p> <p>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.</p> <p>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.</p> <p>Zyloprim: The patient has had a documented intolerance to generic allopurinol</p>
GROWTH STIMULATING AGENTS			
	NORDITROPIN	GENOTROPIN HUMATROPE INCRELEX (mecasermin) NUTROPIN/NUTROPIN AQ OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE	<p>NOTE: These drugs must be obtained and billed through our specialty pharmacy vendor, Briova. Please see Growth Stimulating Agents Prior Authorization/Enrollment Form for instructions.</p> <p>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 (IGR) 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.</p> <p>Criteria for Approval 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</p>

			<p>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.</p> <p>LIMITATIONS: Coverage of Growth Hormone products will not be approved for patients who have Idiopathic Short Stature.</p> <p>GENOTROPIN, HUMATROPE, NUTROPIN, NUTROPIN AQ, OMNITROPE, SAIZEN, TEV-TROPIN: The patient has a documented side effect, allergy, or treatment failure to Norditropin</p> <p>Increlex: 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: o Height standard deviation score < -3 AND o Basal IGF-1 standard deviation score < -3 AND o 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.</p> <p>Serostim: A diagnosis of AIDS associated wasting/anorexia</p> <p>Zorbtive: A diagnosis of short bowel syndrome Concomitant use of specialized nutritional support (specialty IPN) Prescription by gastroenterologist (specialist)</p>
HEMOPHILIA FACTORS			
	ALL FACTORS	NONE	
HEPATITIS C AGENTS			
	OLYSIO 150MG CAPS PEG-INTRON REDIPEN PAK 4 PEG-INTRON/PEG-INTRON REDIPEN RIBASPHERE 200MG TABS RIBAVIRIN 200MG TABS SOVALDI 400MG TABS	COPEGUS (ribavirin 200mg tabs) INCIVEK (telaprevir) MODERIBA 200mg/400mg Dose Pack (ribavirin) PEGASYS PEGASYS CONVENIENCE PACK REBETOL (ribavirin 200mg caps) RIBAPAK 400mg/600mg, 200mg/400mg Dose Pack (ribavirin) RIBASPHERE 200mg CAPS RIBASPHERE 400MG, 600MG TABS (ribavirin) RIBAVIRIN 200MG CAPS VICTRELIS (boceprevir)	<p>NOTE: These drugs must be obtained and used through our specialty pharmacy vendor, Biova. Please see Hepatitis C Medications Prior Authorization Enrollment Form and Hepatitis C Supplemental Clinical Form for instructions. Both forms must be completed and a recent clinical note must accompany the request. All requests will be reviewed on a case by case basis by the DVHA Medical Director. Combination therapy will be either approved or denied in its entirety.</p> <p>Peg-Intron and Telaprevir: The diagnosis or indication for the requested medication is Hepatitis C. AND The patient is, or has been, with a Subspecialty or Medical Director Specialist. AND DVHA Medical Director will review case details to determine eligibility for requested medication.</p> <p>Peg-Intron: The diagnosis or indication for the requested medication is Hepatitis C. AND The patient has had a documented side effect, allergy, or treatment failure to Pegasys</p> <p>Boceprevir (Victrelis): The diagnosis or indication for the requested medication is Hepatitis C. AND The patient is, or has been, with a Subspecialty or Medical Director Specialist. AND DVHA Medical Director will review case details to determine eligibility for requested medication.</p> <p>Telaprevir (Incivek): The diagnosis or indication for the requested medication is Hepatitis C. AND The patient is, or has been, with a Subspecialty or Medical Director Specialist. AND DVHA Medical Director will review case details to determine eligibility for requested medication.</p>
HEREDITARY ANGIOEDEMA MEDICATIONS			
	KALBITOR	BERINERT (human C1 inhibitor) CINRYZE (human C1 inhibitor) FIRAZYR PREFILLED SUB-Q SYRINGE (icatibant)	<p>Beriner: 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).</p> <p>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.</p> <p>Firazyr: The diagnosis or indication is treatment of an acute Hereditary Angioedema (HAE) attack.</p> <p>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).</p>
INTERLEUKIN (IL)-1 RECEPTOR BLOCKERS			
	ILARIS	ARCALYST (rilonacept)	<p>Ilaris: The diagnosis is Cryopyrin-Associated Periodic Syndrome (CAPS) OR The diagnosis 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 OR The diagnosis is systemic juvenile idiopathic arthritis (sJIA) with active systemic features and varying degrees of synovitis with continued disease activity after initial therapy (Initial therapy defined as 1 month of anakinra (Kineret), 2 weeks of glucocorticoid monotherapy (oral or IV) or one month of NSAIDs). AND patient is ≥ 2 years of age.</p> <p>Arcalyst: The diagnosis is Cryopyrin-Associated Periodic Syndrome (CAPS) OR The diagnosis is Familial Cold Autoinflammatory Syndrome (FCAS) OR The diagnosis is Muckle-Wells Syndrome (MWS) AND The patient is > 12 years old AND The patient must have a documented side effect, allergy, treatment failure or a contraindication to Ilaris (canakinumab)</p> <p>Note: Medical Records to support the above diagnosis must accompany the Prior Authorization Request.</p> <p>Authorization for continued use shall be reviewed at least every 12 months to confirm patient has experienced disease stability or improvement while on therapy.</p>
LIPOTROPICS:			
BILE ACID SEQUESTRANTS	CHOLESTYRAMINE POWDER CHOLESTYRAMINE LIGHT POWDER COLESTIPOL TABS, GRANULES PREVALITE POWDER	QUESTRAN POWDER (cholestyramine) QUESTRAN LIGHT POWDER (cholestyramine light) COLESTID TABS, GRANULES (colestipol) WELCHOL (colesevelam)	<p>Questran: The patient has had a documented intolerance to cholestyramine powder</p> <p>Questran Light: The patient has had a documented intolerance to cholestyramine light powder</p> <p>Colestid: The patient has had a documented intolerance to colestipol tablets or granules</p> <p>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 lipid reduction, the patient has had a documented side effect, allergy, or treatment failure to cholestyramine and colestipol.</p>
FIBRIC ACID DERIVATIVES	GEMFIBROZIL 600MG On statin concurrently or after gemfibrozil trial TRICOR 48MG, 145MG TRILIPIX 45MG, 135MG delayed release caps	ANTARA (fenofibrate micronized) 43 mg, 30 mg, 90 mg, 130 mg FENOFIBRATE CAPS (Lipofen) 50 mg, 150 mg FENOFIBRATE MICRONIZED Q(Antara) 43 mg, 130 mg FENOFIBRATE MICRONIZED CAPS(Lofibra capsules) 67 mg, 134mg, 200mg FENOFIBRATE NANOCRYSTALLIZED (Tricor) 48 mg, 145 mg FENOFIBRATE TABS(Lofibra tablets) 54 mg, 160 mg FENOFIBRIC ACID (Trilipix) 45 mg, 135 mg delayed release capsule FENOFIBRIC ACID 35 mg, 105 mg FENOGLIDE (fenofibrate MeltDose) 40 mg, 120 mg FIBRICOR (fenofibric acid) 35 mg, 105 mg LIPOFEN (fenofibrate) 50 mg, 150 mg LOFIBRA (fenofibrate micronized) Capsules 67mg, 134 mg, 200 mg	<p>Lipid: The patient has had a documented intolerance to generic gemfibrozil.</p> <p>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.</p> <p>Antara, fenofibrate, fenofibrate micronized, fenofibric acid, Fenoglide, Fibracor, 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.)</p> <p>Fenofibrate nanocrystallized (generic for Tricor), fenofibric acid (generic for Trilipix): The patient is taking a statin concurrently, OR The patient has had a documented side effect, allergy, or treatment failure to gemfibrozil. AND The patient has had a documented intolerance with the brand equivalent.</p> <p>(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)</p>

		LOFIBRA (fenofibrate) Tablets 54 mg, 160 mg LOPID (gemfibrozil) 600 mg TRIGLIDE (fenofibrate) 50 mg, 160 mg	
HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HoFH) AGENTS		JUXTAPID CAPS (lomitapide) KYNAMRO SYRINGE FOR SUB-Q INJ (mipomersen) Maximum day supply per fill for all drugs is 28 days	CRITERIA FOR APPROVAL: □ Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) AND □ Medication will be used as adjunct to a low-fat diet and other lipid-lowering treatments AND □ Patient does not have any of the following contraindications to therapy: • Pregnancy (Juxtapid) • Concomitant use with strong or moderate CYP3A4 inhibitors (Juxtapid) • Moderate or severe hepatic impairment or active liver disease including unexplained persistent abnormal liver function tests (Juxtapid, Kynamro) AND □ Patient has tried and had an inadequate response, intolerance or contraindication to BOTH atorvastatin and Crestor AND □ After preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. Note: Re-approval requires confirmation that the patient has responded to therapy (i.e. decreased LDL levels) AND the patient does not have any contraindications to therapy.
NICOTINIC ACID DERIVATIVES	NIACIN NIACOR NIASPAN	NIACIN EXTENDED RELEASE (Niaspan)	CRITERIA FOR APPROVAL: The patient has a documented intolerance to the branded product.
High Intensity Statins	ATORVASTATIN 40MG or 80MG CRESTOR 20MG or 40MG	LIPITOR 40MG OR 80MG (atorvastatin)	Lipitor 40 or 80 mg: The patient has had a documented intolerance to generic atorvastatin.
Moderate Intensity Statins	CRESTOR 5MG OR 10MG TABS LOVASTATIN 40MG TABS PRAVASTATIN 40MG OR 80MG TABS SIMVASTATIN 20MG OR 40MG TABS	ALTOPREV 40 or 60 mg (lovastatin SR) ATORVASTATIN 10 or 20 mg (compare to Lipitor) FLUVASTATIN 40 mg (compare to Lescol) LESCOL 40 mg (fluvastatin) LESCOL XL 80 mg (fluvastatin XL) LIPITOR (atorvastatin) 10 or 20 mg LIVALO 2 or 4 mg (pitavastatin) MEVACOR 40 mg (lovastatin) PRAVACHOL 40 or 80 mg (pravastatin) ZOCOR (simvastatin) 20 or 40 mg	Atorvastatin/Lipitor 10 or 20 mg : 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/day AND If the request is for Lipitor, the patient has had a documented intolerance to generic atorvastatin. Altprev 40 or 60 mg, fluvastatin 40 mg BID, Lescol 40 mg BID, Lescol XL, Livalo 2 or 4 mg: The patient has had a documented side effect, allergy, or contraindication to all 3 of generic lovastatin, pravastatin and simvastatin. OR The patient has had inadequate responses to six week trial of each of lovastatin 40 mg/day, pravastatin 80mg/day, simvastatin 40 mg/day and Crestor 10 mg/day. AND If the request is for Lescol, the patient has had a documented intolerance to generic fluvastatin. Mevacor 40 mg, Pravachol 40 or 80 mg, Zocor 20 or 40 mg: The patient has had documented intolerance to the generic equivalent
Low Intensity Statins	LOVASTATIN 10MG OR 20MG TABS PRAVASTATIN 10MG OR 20MG TABS SIMVASTATIN 5MG OR 10MG TABS	ALTOPREV 20 mg (lovastatin SR) FLUVASTATIN 20 or 40 mg (compare to Lescol) LESCOL 20 or 40 mg (fluvastatin) LIVALO 1 mg (pitavastatin) MEVACOR 10 or 20 mg (lovastatin) PRAVACHOL 20 mg (pravastatin) ZOCOR (simvastatin) 5 or 10 mg	Altprev 20 mg, fluvastatin 20 or 40 mg, Lescol 20 or 40 mg, Livalo 1 mg: The patient has had a documented side effect, allergy, or contraindication to all 3 of generic lovastatin, pravastatin and simvastatin. OR The patient has had inadequate responses to six week trial of each of lovastatin 20 mg/day, pravastatin 20 mg/day and simvastatin 10 mg/day. AND If the request is for Lescol, the patient has had a documented intolerance to generic fluvastatin. Mevacor 10 or 20 mg, Pravachol 20 mg, Zocor 5 or 10 mg : The patient has had documented intolerance to the generic equivalent. LIMITATIONS: Simvastatin 80 mg: initiation of simvastatin 80 mg or titration to 80 mg is not recommended by the FDA due to the increased risk of myopathy, including rhabdomyolysis. Patients may only continue on this dose when new to Medicaid if the patient has been taking this dose for 12 or more months without evidence of muscle toxicity. If the request is for Zocor 80 mg, the patient must have met the prior treatment length requirement and have a documented intolerance to the generic equivalent.
MISCELLANEOUS/COMBOS	SIMCOR TABS	LOVAZA (OMEGA-3-ACID ETHYL ESTERS) ADVICOR (lovastatin/extended release niacin) AMLODIPINE/ATORVASTATIN (Caduet) CADUET (amlodipine/atorvastatin) JUVISYNC (sitagliptin/simvastatin) LIPTRUZET (ezetimibe/atorvastatin) OMEGA-3-ACID ETHYL ESTERS (Lovaza) VASCEPA (icosapent ethyl) VYTORIN (ezetimibe/simvastatin) ZETIA (ezetimibe)	Lovaza, Vascepa, Omega-3-acid ethyl esters: 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. AND If the request is for brand Lovaza, the patient has 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. Liptruzet, Vytorin: The patient has had an inadequate response to atorvastatin or 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 atorvastatin or Crestor.
MISCELLANEOUS			
	GLYCOPYRROLATE 1MG & 2MG TABS MAKENA INJ 250MG/ML 5ML VIALS	BENLYSTA VIALS (belimumab) CARBAGLU DISPERSIBLE TABS (carglumic acid) CUVPOSA ORAL SOL (glycopyrrolate) ELAPRASE (idursulfase) GATTEX VIALS (teduglutide) GLYCATE 1.5MG TABS (glycoprolat) HETLIOZ 20MG ORAL CAPS (tasimelteon) KORLYM TABS (mifepristone) LYSTEDA TABS (tranexamic acid) MYALEPT VIAL FOR SUB-Q INJ (metreleptin) NUEDEXTA CAPS (dextromethorphan/quinidine) OTREXUP SINGLE DOSE AUTO INJECTOR FOR SUB-Q USE (METHOTREXATE) RASUVO SINGLE DOSE AUTO INJECTOR FOR SUB-Q USE (METHOTREXATE) ROBINUL 1MG TABS (glycopyrrolate)	Benlysta: 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. 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. Carbaglu: 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. Elaprase (Hunter's Syndrome Injectable): The diagnosis or indication for the requested medication is Hunter's Syndrome Gattex: Patient has a diagnosis of short bowel syndrome AND Patient is receiving specialized nutritional support administered intravenously (i.e. parenteral nutrition) AND Patient is 18 years of age or older AND Patient does not have an active gastrointestinal malignancy (gastrointestinal tract, hepatobiliary, pancreatic), colorectal cancer, or small bowel cancer. AND After preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. Note: Re-approval requires evidence of decreased parenteral nutrition support from baseline. 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

	<p>ROBINUL FORTE 2MG TABS (glycopyrrolate) SAMSCA TABS (tolvaptan) SIGNIFOR AMPS (pasireotide) SOLESTA SUBMUCOSAL INJ GEL 50MG/15ML SOLIRIS (eculizumab) SOMATULINE DEPOT INJ (lanreotide) TRANEXAMIC ACID (Lysteda) XENAZINE TABS (tetrebenazine)</p>	<p>scopolamine patches. Glycate: The indication for use is adjunctive therapy in the treatment of peptic ulcer. AND The patient has had a documented intolerance to generic glycopyrrolate. Robinul, Robinul Forte: The patient has had a documented intolerance to generic glycopyrrolate. Hettioz: Patient has documentation of Non-24-Hour Sleep-Wake Disorder (Non-24) AND Patient has documentation of total blindness AND Patient has had a documented side effect, allergy or treatment failure with Rozerem and at least one OTC melatonin product. Korlym: Patient is ≥18 years of age AND Patient has a diagnosis of endogenous Cushing's syndrome AND Patient is diagnosed with type 2 diabetes mellitus or glucose intolerance AND Patient has hyperglycemia secondary to hypercortisolism AND Patient has failed or is not a candidate for surgery AND Patient has a documented side effect, allergy, treatment failure or contraindication to at least 2 adrenolytic medications (eg. ketoconazole, etomidate) AND Patient does not have any of the following contraindications to Korlym: o Pregnancy (pregnancy must be excluded before the initiation of therapy or if treatment is interrupted for >14 days in females of reproductive potential. Nonhormonal contraceptives should be used during and one month after stopping treatment in all women of reproductive potential) OR o Patient requires concomitant treatment with systemic corticosteroids for serious medical conditions/illnesses (immunosuppression for organ transplant) OR o Patient has a history of unexplained vaginal bleeding OR o Patient has endometrial hyperplasia with atypia or endometrial carcinoma OR o Patient is concomitantly taking simvastatin, lovastatin, or a CYP3A substrate with a narrow therapeutic index (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozone, quinidine, sirolimus, or tacrolimus). Note: after preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. Makena: Patient is 16 years of age or older AND Patient has a history of singleton spontaneous preterm birth AND Patient is having a singleton (single offspring) pregnancy AND Therapy will be started between 16 weeks, 0 days and 27 weeks, 0 days of gestation. AND Therapy will be continued until week 37 (through 36 weeks, 6 days) of gestation or delivery, whichever occurs first. Otrexup, Rasuvo: The patient has a diagnosis of rheumatoid arthritis (RA), polyarticular juvenile idiopathic arthritis (pJIA) or psoriasis. AND The patient has been intolerant to oral methotrexate AND The patient has been unable to be compliant with a non-auto-injector form of injectable methotrexate (includes difficulty with manual dexterity). Myalept: Patient has a diagnosis of congenital or acquired generalized lipodystrophy AND Patient has one or more of the following metabolic abnormalities AND is refractory to current standards of care for lipid and diabetic management : Insuline resistance (defined as requiring > 200 units per day), Hypertriglyceridemia, Diabetes AND Prescription is written by or in consultation with an endocrinologist AND The prescriber is registered in the MYALEPT REMS program. Note: after preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. Reauthorization for continued use criteria: Patient has experienced an objective response to therapy • Sustained reduction in hemoglobin A1c (HbA1c) level from baseline OR • Sustained reduction in triglyceride (TG) levels from baseline Nuedexta: 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, pimozone) Signifor: Patient has a diagnosis of (pituitary) Cushing's disease AND Patient is 18 years of age or older AND Pituitary surgery is not an option or has not been curative AND After preliminary review by the Clinical Call Center, the request will be forwarded to the DVHA Medical Director for final approval. Note: Re-approval requires confirmation that the patient has experienced an objective response to therapy (i.e., clinically meaningful reduction in 24-hour urinary free cortisol levels and/or improvement in signs or symptoms of the disease). Solesta: 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 Soliris: The patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) documented by flow cytometry. AND The patient has received the meningococcal vaccine at least 2 weeks prior to therapy initiation. OR The patient has a diagnosis of atypical hemolytic uremic syndrome (aHUS). AND The patient has received the meningococcal vaccine at least 2 weeks prior to therapy initiation. Authorization for continued use shall be reviewed to confirm that the patient has experienced an objective response to the therapy. Somatuline: The diagnosis or indication for the requested medication is Acromegaly. Lysteda, Tranexamic acid: 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 regular scheduled (not PRN) NSAID or a rationale for why these products cannot be used (e.g. actively attempting to conceive). AND If the request is for brand Lysteda, the patient has had a documented intolerance to the generic product. Xenazine: The diagnosis or indication for the requested medication is Huntington's disease with chorea. AND Age > 18 years.</p>
MOOD STABILIZERS		
	<p>LITHIUM CARBONATE LITHIUM CARBONATE SR LITHIUM CITRATE SYRUP</p>	<p>EQUETRO (carbamazepine SR) LITHOBID (lithium carbonate sr)</p> <p>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</p>
MUCOSAL COATING AGENTS		
	<p>ALUMINUM HYDROXIDE EPISIL GELCLAIR MYLANTA/DIPHENDRAMINE/LIDOCAINE VISCOUS or other similar single or combo products</p>	<p>MUGARD (mucoadhesive oral wound rinse)</p> <p>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.</p>
MULTIPLE SCLEROSIS MEDICATIONS		

	AMPYRA TABS (dalfampridine) AVONEX (interferon B-1a) BETASERON (interferon B-1a) COPAXONE 20MG (glatiramer acetate) REBIF (interferon B-1a) TECFIDERA (dimethyl fumarate)	AUBAGIO (teriflunamide) TABS COPAXONE 40mg (GLATIRAMER) EXTAVIA (interferon beta- 1b) GILENYA (fingolimod) CAPS TYSABRI (natalizumab)	<p>NOTE: Multiple Sclerosis Self-Injectables (Avonex, Betaseron, Copaxone, Extavia and Rebif) must be obtained and billed through our specialty pharmacy vendor, Briova. Please see Multiple Sclerosis Patient Enrollment/Order Form for instructions. Briova will not be supplying Tysabri® at this time – please continue to obtain through your usual supplier. Aubagio, Gilenya and Tecfidera must be obtained and billed through our specialty pharmacy vendor, Briova. Please see Multiple Sclerosis Oral Patient Enrollment/PA Form for instructions. Briova will not be supplying Ampyra at this time.</p> <p>Ampyra: Patient has a diagnosis of multiple sclerosis. AND Patient age > 18 years.</p> <p>Aubagio: Patient is at least 18 years of age or older AND Patient has a diagnosis of relapsing forms of multiple sclerosis (relapsing-remitting multiple sclerosis and progressive-relapsing multiple sclerosis) AND Patient does not have any of the following contraindications to teriflunomide: Severe hepatic impairment. Current treatment with leflunomide (Arava) Patients who are pregnant or women of childbearing potential not using reliable contraception</p> <p>Copaxone 40 mg Syringe : Patient has a diagnosis of multiple sclerosis. AND The patient has a documented side effect, allergy, treatment failure, or contraindication to at least one preferred drug (not Copaxone 20 mg). AND The patient is unable to tolerate or be compliant with Copaxone 20 mg daily dosing.</p> <p>Extavia: Patient has a diagnosis of multiple sclerosis. AND The provider provides a clinical reason why Betaseron cannot be prescribed.</p> <p>Gilenya: Patient has a diagnosis of relapsing multiple sclerosis. 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.</p> <p>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.</p>
NUTRITIONALS, LIQUID ORAL SUPPLEMENTS			
		ALL Note: Nutritional supplements administered via tube feeds may be provided through the Medical Benefit	<p>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.</p> <p>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, Cancer, Celiac Disease, Cerebral Palsy, Chronic Diarrhea, Cognitive Impairment, Cystic Fibrosis, Dementia (includes Alzheimer's), Developmental Delays, Difficulty with chewing/swallowing food, Inflammatory Bowel Disease, Parkinson's, Short Gut. 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 <3.5 g/dL /pre-albumin <15 mg/dL)</p> <p>Unplanned Weight Loss/Low Weight Table:</p> <p>Adult: Involuntary loss of > 10 % of body weight within 6 months Involuntary loss of > 5% of body weight within 1 month Loss of > 2% of body weight within one week BMI of < 18.5 kg/m2</p> <p>Elderly (>65): Involuntary loss of > 10 % of body weight within 6 months Involuntary loss of > 5 % of body weight within 3 months Loss of > 2 % of body weight within one month BMI of < 18.5 kg/m2</p> <p>Children: < 80 % of expected weight-for-height < 90 % of expected height-for-age Mid-upper arm circumference/head circumference ratio < 0.25</p> <p>Limitations: Infant formulas are not covered under the pharmacy benefit. Please contact WIC.</p>
ONCOLOGY: ORAL (select)			
	ALL - see Oncology: Oral order form for details of medication that must be obtained through Briova, DVHA's specialty pharmacy provider		
OPHTHALMICS			
ANTIBIOTICS	CIPROFLOXACIN HCL SOL AK-POLY-BAC OINT AK-TOB SOL BACITRACIN OINT BACITRACIN ZINC W/POLYMYXIN B OINT ERYTHROMYCIN OINT GARAMYCIN OINT GENTAK OINT, SOL GENTAMICIN OINT, SOL ILOTYCIN OIN NEOMYCIN/BACITRACIN/POLYMYXIN OINT NEOMYCIN/POLYMYXIN w/DEXAMETHASONE OINT,SUSP NEOMYCIN/POLYMYXIN w/DEXAMETHASONE OINT,SUSP NEOMYCIN/POLYMYXIN w/GRAMICIDIN SOL NEOMYCIN/POLYMYXIN w/HYDROCORTISONE SUSP NEOMYCIN/POLYMYXIN/BACITRACIN/ HYDROCORT OINT OFOXACIN SOL POLYMYXIN B w/TRIMETHOPRIM SOL SUFACETAMIDE SODIUM SOL SULFACETAMIDE W/PREDNISOLONE SOD PHOS SOL TOBRAMYCIN SOL	AZASITE(azithromycin) SOL BESIVANCE (besifloxacin) SUSP BLEPH-10 (sulfacetamide) SOL BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone acetate) OINT BLEPHAMIDE (sulfacetamide/prednisolone acetate) SUSP CILOXIN(ciprofloxacin) OINT, SOL GARAMYCIN(gentamicin) SOL GATIFLOXACIN 0.5% SOL (compare to Zymaxid) IQIUX (levofloxacin 1.5 %) (preservative free) SOL LEVOFLOXACIN 0.5 % (compare to Quixin) SOL MAXITROL (neomycin/polymyxin/dexamethasone) SUSP, OINT MOXEZA (moxifloxacin 0.5%) (preservative free) SOL NEOSPORIN (neomycin/polymyxin/gramicidin) SOLN OCCUFLOX (ofloxacin) SOL POLY-PRED (neomycin/polymyxin B/prednisolone acetate) SUSP POLYTRIM (polymyxin B/trimethoprim) SOLN PRED-G (gentamicin/prednisolone) SUSP PRED-G S.O.P. (gentamicin/prednisolone) OINT QUIXIN (levofloxacin 0.5 %) SOL TOBRADEX (tobramycin/dexamethasone) SUSP TOBRADEX (tobramycin/dexamethasone) OINT	<p>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.</p> <p>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)</p> <p>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)</p> <p>Limitations: The patient has had a documented side effect, allergy or treatment failure with generic Vigamox or Zymar. The request is for Zymar or Vigamox, the patient also has a documented intolerance to the generic equivalent OR The request is for Vigamox or Zymar as part of a regimen to prevent postoperative infection in patients receiving any ophthalmologic surgery.</p>

	TOBRAMYCIN w/DEXAMETHASONE SUSP	TOBRADEX ST®(tobramycin/dexamethasone) SUSP TOBREX OINT (tobramycin) TOBREX SOL (tobramycin) VIGAMOX (moxifloxacin 0.5%) (preservative free) SOL ZYLET (tobramycin/loteprednol) SUSP ZYMAR (gatifloxacin 0.3%) SOL ZYMAXID (gatifloxacin 0.5%) SOL All other brands	
ANTIHISTAMINES	KETOTIFEN 0.025% PATADAY PATANOL	AZELASTINE(compare to Optivar) BEPREVE (bepotastine besilate) ELESTAT (epinastine) EMADINE (emedastine) EPINASTINE (compare to Elestat) LASTACAFIT (alcaftadine) OPTIVAR (azelastine)	Pataday/Patanol: The patient has had a documented side effect, allergy, or treatment failure to ketotifen. Azelastine, Beprev, 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. Lastacraft, 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
CORTICOSTEROIDS: TOPICAL	DEXAMETHASONE SOD PHOSPHATE 0.1% Sol FLUOROMETHOLONE 0.1% Susp PREDNISOLONE ACETATE 1% Susp	ALREX (loteprednol) 0.2% SUSP DUREZOL (difuprednate) 0.05% EMULSION FML (fluorometholone) 0.1% OINT FML FORTE (fluorometholone) 0.25% SUSP FML LIQUIFILM/ FLAREX (fluorometholone) 0.1% SUSP LOTEMAX (loteprednol) 0.5% GEL, SUSP LOTEMAX (loteprednol) 0.5% OINT (pres. free) PRED FORTE/OMNIPRED (prednisolone acetate) 1% S PRED MILD (prednisolone acetate) 0.12% SUSP VEXOL (rimexolone) 1% SUSUP All other brands	Lotemax Oint: 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)
CYSTARAN		CYSTARAN (cysteamine) 0.44% OPTH SOL	Cystaran: The indication for use is corneal cystine accumulation in patients with cystinosis.
DRY EYE SYNDROME	ARTIFICIAL TEARS OINT ARTIFICIAL TEARS SOL LUBRIFRESH P.M. OINT REFRESH TEARS SOL TEARS NATURALE SOL And all other generics	RESTASIS (cyclosporin ophthalmic emulsion) 0.05%	CRITERIA FOR APPROVAL: The patient has a diagnosis of moderate to severe keratoconjunctivitis sicca (dry eye syndrome) or Sjogren syndrome with suppressed tear production due to ocular inflammation AND The member does not have any of the following contraindications or exclusions to therapy: A) An active ocular infection B) Concurrent topical anti-inflammatory drugs C) Concurrent punctal plug use AND The patient has had a documented side effect, allergy, or treatment failure to two ocular lubricants (e.g., artificial tears, lubricant gels, etc.). Limitations: OTC branded ocular lubricants are not covered (as part of DVHA's comprehensive OTC policy). There is no PA opportunity for branded OTC ocular lubricants.
GLAUCOMA AGENTS/MIOTICS	ALPHAGAN P 0.1%, 0.15% BETAXOL HCL BRIMONIDINE TARTRATE 0/2% CARTEOLOL HCL COMBIGAN DIPIVERFRIN HCL DORZOLAMIDE 2% DORZOLAMIDE w/TIMOLOL ISOPTO CARBACHOL ISOPTO CARPINE LATANOPROST LEVONUNOLOL HCL PHOSPHOLINE IODIDE PILOCARPINE HCL PILOPINE HS PROPINE TIMOLOL MALEATE TIMOLOL MALEATE GEL TRAVATAN Z	APRACLODINE (lopidine) AZOPT (brinzolamide 1%) BETAGAN (levobunolol) BETIMOL (timolol) BETOPTIC S (betaxolol suspension) BRIMONIDINE TARTRATE 0.15% (Alphagan P) COSOPT (dorzolamide w/timolol) COSOPT PF (dorzolamide w/timolol) (pres-free) IOPIDINE (apraclonidine) ISTALOL (timolol) LUMIGAN 0.01%/0.03% (bimatoprost) METIPRANOLOL (Optipranolol) MIOCHOL-E (acetylcholine) RESCULA (unoprostone) SIMBRINZA (brinzolamide 1% and brimonidine 0.2%) Susp SIMBRINZA (brinzolamide 1% and brimonidine 0.2%) Susp TIMOPTIC (timolol maleate) TIMOPTIC XE (timolol maleate gel) TRAVAPROST (travoprost) TRUSOPT (dorzolamide 2%) XALATAN (latanoprost) ZIOPTAN (tafluprost)	ALPHA 2 ADRENERGIC AGENTS: Single Agent: 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%. Combination Product: Simbrinza: The patient has had a documented treatment failure with either an alpha adrenergic agent or a carbonic anhydrase inhibitor. 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, Rescula: 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 generic latanoprost and Travatan Z. Travoprost: The patient has had a documented intolerance to Travatan Z. Zioptan: 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 generic latanoprost and Travatan Z. OR The patient has a sensitivity to preservatives used in ophthalmic preparations Xalatan: The patient has a documented intolerance to the generic product. AND The patient has had a documented side effect, allergy or treatment failure with Travatan Z. CARBONIC ANHYDRASE INHIBITORS Single Agent: The patient has had a documented side effect, allergy or treatment failure with a preferred carbonic anhydrase inhibitor. Combination Product: Cosopt: The patient has had a documented intolerance to the generic equivalent product. Cosopt PF: The patient has had a documented intolerance to the preservatives in the generic combination product. Simbrinza: The patient has had a documented treatment failure with either an alpha adrenergic agent or a carbonic anhydrase inhibitor. 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)
MAST CELL STABILIZERS	CROMOLYN SODIUM	ALOCRIIL (nedocromil sodium) ALOMIDE (lodoxamide)	Criteria for Approval: The patient has had a documented side effect, allergy, or treatment failure with generic cromolyn sodium

NON-STEROIDAL ANIT-INFLAMMATORY DRUGS (NSAIDS)	ACULAR ACULAR LS FLURBIPROFEN 0.03%	ACUVAIL (ketorolac 0.45 %) OPH SOL BROMDAY OPH SOL(bromfenac 0.09%) BROMFENAC 0.09 % OPH SOL(compare to Bromday) BROMFENAC 0.09 % OPH SOL(formerly Xibrom) DICLOFENAC 0.1% OPH SOL(compare to Voltaren) ILEVRO OPH SUSP(nepafenac 0.3%) KETOLORAC 0.4 % OPH SOL(compare to Acular LS) KETOLORAC 0.5 % OPH SOL(compare to Acular) NEVANAC OPH SUSP(nepafenac 0.1%) OCUFEN OPH SOL (flurbiprofen 0.03%) PROLENSA OPH SOL (bromfenac 0.07%) VOLTAREN (diclofenac 0.1%) OPH SOL	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, Ilevro, Nevanac, Prolensa, Voltaren: 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.
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OTIC ANTI-INFECTIVES

	ACETIC ACID OTIC SOLN ACETIC ACID-ALUMINUM ACETATE OTIC SOLN CIPRODEX OTIC SUSP CORTOMYCIN OTIC SOLN, SUSP NEOMYCIN/POLYMYXIN B SULFATE/HYDROCORTISONE OFLOXACIN 0.3% OTIC SOLN VOSOL OTIC SOLN	ACETASOL HC (acetic acid 2%/hydrocortisone 1% otic soln) ACETIC ACID/HYDROCORTISONE OTIC SOLN AURAGLAN/OTIC CARE/OTIC EDGE/PR OTIC/TREAGAN (acetic CIPROFLOXACIN 0.2% OTIC SOLN (Cetraxal) CIPRO-HC OTIC SUSP (ciprofloxacin 0.2%/hydrocortisone 1%) COLY-MYCIN S/CORTISPORTIN TC(neomycin/colistin/thonzium/hydrocortisone) CORTISPORIN OTIC OTIC SOL/SUSP (neomycin/polymyxin B sulfate /hydrocortisone) TRIOXIN/MYOXIN (benzocaine/chloroxylenol/hydrocortisone susp) VOSOL HC (acetic acid 2%/hydrocortisone 1% otic soln)	Ciprofloxacin 0.2%: 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 LIMITATION: Cetraxal no longer covered due to Federal Rebate not offered.
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OVER-THE-COUNTER (OTC) MEDICATIONS

Please refer to the DVHA website for covered OTC categories not already managed on the PDL. Many categories limited to generics ONLY and other categories not covered. No PA process for non-covered OTCs.

PANCREATIC ENZYME PRODUCTS

	CREON DR CAPS ZENPEP CR CAPS	PANCREAZE DR CAPS PANCRELIPASE 5,000 (Zenpep 5,000) PERTZYE DR CAPS ULTRESA DR CAPS VIOKACE DR CAPS	Pancrelipase 5,000 (generic): The patient has a documented intolerance to brand Zenpep 5,000 All others: The patient has been started and stabilized on the requested product. OR The patient has had treatment failure or documented intolerance with both Creon and Zenpep.
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PARKINSON'S: NON-ERGOT DOPAMINE RECEPTOR AGONIST

BROMOCRIPTINE AMANTADINE (PA required for < 10 day supply) CARBIDOPA/LEVODOPA CARBIDOPA/LEVODOPA ER CARBIDOPA/LEVODOPA ODT COMTAN ENTACAPONE PRAMIPEXOLE ROPINIROLE SELEGILINE STALEVO	AMANTADINE TABS (Symmetrel) AZILECT (rasagiline) CARBIDOPA/LEVODOPA/ENTACAPONE (Stalevo) ELDEPRYL (selegiline) MIRAPEX (pramipexole) MIRAPEX ER (pramipexole ER) NEUPRO (rotigotine) transdermal patch PARCOPA (carbidopa/levodopa ODT) PARLODEL (bromocriptine) REQUIP (ropinirole) REQUIP XL (ropinirole XL) ROPINIROLE XL (compare to Requip XL) SINEMET CR (carbidopa/levodopa ER) SINEMET (carbidopa/levodopa) TASMAR (tolcapone) ZELAPAR (selegiline ODT)		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: 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. Neupro: The patient is ≥18 years of age AND The patient has a diagnosis of Parkinson's disease. AND The patient has had a documented side effect, allergy, contraindication or treatment failure to generic immediate release ropinirole or pramipexole AND ropinirole XL or Mirapex ER. OR The prescriber provides medical necessity for the transdermal formulation (eg. swallowing disorder or difficulty taking oral medications). 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 2.5mg/day Limitations: To prevent the use of amantadine in influenza treatment/prophylaxis, days supply < 10 days will require PA.
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PHOSPHODIESTERASE-4 (PDE-4) INHIBITORS

	DALIRESP TBS (roflumilast) OTEZLA TABS Maximum day supply per fill = 30		Daliresp: 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. Otezla: The patient has a diagnosis of psoriatic arthritis AND The patient is 18 years of age or older AND The patient has had inadequate response to, intolerance to, or contraindication to methotrexate.
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PHOSPHODIESTERASE-5 (PDE-5) INHIBITORS

	ADCIRCA (tadalafil) REVATIO VIAL (sildenafil citrate) REVATIO(sildenafil)		Adcirca (tadalafil) 20 mg, Revatio (sildenafil citrate) 20 mg, sildenafil citrate 20 mg: Clinical diagnosis of pulmonary hypertension AND No concomitant use of organic nitrate-containing products AND For approval of Revatio, the patient has a documented intolerance to the generic equivalent. 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
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		SILDENAFIL CITRATE (Revatio) TAB VIAGRA (sildenafil)	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.
PLATELET INHIBITORS			
	AGGRENOX ANAGRELIDE ASPIRIN CILOSTAZOL CLOPIDOGREL 75MG DIPYRIDAMOLE EFFIENT TABS TICLOPIDINE	AGRYLIN (anagrelide) BRILINTA (ticagrelor) TABS PERSANTINE (dipyridamole) PLAVIX 75MG (clopidogrel bisulfate) PLETAL (clostazol) ZONTIVITY TABS (vorapaxar)	Agrylin, Persantine, Plavix, Pletal: The patient has had a documented intolerance to the generic formulation of the medication. Briinta: 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. Zontivity: The patient is started and stabilized on the medication. (Note: samples are not considered adequate justification for stabilization.) OR The patient has a history of myocardial infarction (MI) or peripheral arterial disease (PAD) AND The indication for use is reduction of thrombotic cardiovascular events. AND The medication is being prescribed in combination with aspirin and/or clopidogrel. Limitations: Plavix/clopidogrel 300mg is not an outpatient dose and is not covered in the pharmacy benefit.
POST-HERPETIC NEURALGIA AGENTS			
		GRALISE TAB, STARTER PACK (gabapentin)	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.
PSORIASIS			
INJECTABLES	ENBREL (etanercept) HUMIRA (adalimumab)	REMICADE (infliximab) STELARA (ustekinumab)	NOTE: Psoriasis Self-Injectables (Enbrel and Humira) must be obtained and billed through our specialty pharmacy vendor, Briova. Stelara may either be obtained and billed through our specialty pharmacy vendor, Briova or through the medical benefit. Please see the Enbrel, Humira or Stelara Prior Authorization/Patient Enrollment Form for instructions. Briova may supply Remicade upon request or you may continue to obtain through your usual supplier. 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. 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. 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 topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA), ultraviolet A and oral psoralens (systemic PUVA, narrow band ultraviolet B (NUVA), etc. The prescriber must provide a clinically valid reason why either Enbrel® or Humira® cannot be used.
NON-BIOLOGICS	CALCIPOTRIENE OINT CALCIPOTRIENE SOL CYCLOSPORINE DOVONEX METHOTREXATE METHOXSALEN PSORIATEC, DRITHO-SCALP SORIATANE CAPS TAZORAC	ACITRETIN CAPS (Soriatane) CALCIPOTRIENE CR (Dovonex) CALCIPOTRIENE/BETAMETHASONE OINT (Taclonex) CALCITRENE OINT CALCITRIOL OINT (Vectical) DOVONEX SOL (calcipotriene) OXSORALEN-ULTRA (methoxsalen) SORILUX FOAM (calcipotriene) TACLONEX (calcipotriene/betamethasone oint/scalp susp) VECTICAL OINT (calcitriol)	Acitretin Capsules: The patient has a documented intolerance to brand Soriatane capsules. Calcitrene Ointment: The patient has a documented intolerance to Calcipotriene ointment. Calcipotriene Cream: The patient has a documented intolerance to the brand Dovonex cream. Dovonex Solution: The patient has a documented intolerance to the generic product. Oxsoralen-Ultra: The patient has a documented intolerance to the generic equivalent. Taclonex or calcipotriene/betamethasone dipropionate 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® or calcipotriene/betamethasone dipropionate 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 had a documented intolerance to the generic product.

PULMONARY AGENTS			Limitations: Kits with non-drug or combinations of 2 drug products are not covered.
ANTICHOLINERGICS: INHALED	ATROVENT HFA COMBIVENT COMBIVENT RESPIMAT IPRATROPIUM SOLN FOR INHALATION IPRATROPIUM/ALBUTEROL SPIRIVA TUDORZA PRESSAIR	ANORA ELLIPTA (umeclidinium/vilanterol) DUONEB (ipratropium/albuterol)	Anoro Ellipta: patient has a diagnosis of COPD (not FDA approved for asthma). Duoneb Nebulizer: The patient has a documented intolerance to generic ipratropium/albuterol nebulizer.
ANTI-HISTAMINES: INTRANASAL		ASTELIN NASAL SPRAY (azelastine) ASTEPRO NASAL SPRAY (azelastine 0.15%) AZELASTINE 0.15% NASAL SPRAY (Astepro) AZELASTINE NASAL SPRAY (Astellin) DYMISTA NASAL SPRAY (azelastine/fluticasone) OLOPATADINE 0.6% NASAL SPRAY (Patanase) PATANASE NASAL SPRAY (olopatadine 0.6%)	ASTELIN, ASTEPRO, AZELASTINE, DYMISTA, OLOPATADINE, 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 corticosteroid used in combination. AND If the request is for Astepro, the patient has a documented intolerance to the generic equivalent.
ANTI-HISTAMINES 1st GENERATION	All generic antihistamines All generic antihistamine/decongestant combinations	All brand antihistamines (i.e. Benadryl) All brand antihistamine/decongestant combinations (i.e. Deconamine SR, Rynatan, Ryna-12)	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.
ANTI-HISTAMINES 2nd GENERATION	CETIRIZINE OTC 5mg, 10mg, TABS CETIRIZINE SYR (OTC,RX) FEXOFENADINE 60MG, 180MG (OTC) Tabs LORATADINE (OTC - Allergy Relief, Alavert) 10mg TABS LORATADINE (OTC) RDT (Allergy Relief, Alavert) 10mg LORATADINE (OTC) SYR (Allergy Relief) LORATADINE/PSEUDOEPHEDRINE SR 24HR 10mg/240mg (OTC)	CERTIRIZINE OTC Chewable TABSs 5 mg, 10 mg CETIRIZINE/PSEUDOEPHEDRINE SR 12hr 5 mg/120 mgOTC CLARINEX (desloratadine) 5 mg TABS CLARINEX REDITABS (desloratadine) 2.5 mg, 5 mg CLARINEX-D 12 hr (desloratadine/pseudoephedrine 2.5 mg/120 mg) CLARINEX-D 24 hr (desloratadine/pseudoephedrine 5 mg/240 mg) CLARINIX SYRUP (desloratadine) CLARITIN (loratadine) OTC Chewable TABS 5 mg CLARITIN (loratadine) OTC Reditabs 5 mg, 10 mg* CLARITIN OTC SYRUP (loratadine) CLARITIN TABS OTC (loratadine) 10 mg CLARITIN-D 12 hr (loratadine/pseudoephedrine 5 mg/120 mg) CLARITIN-D 24 hr (loratadine/pseudoephedrine 10 mg/240 mg) DESLORATADINE (compare to Clarinex) 5 mg TABS DESLORATADINE ODT (compare to Clarinex Reditabs) 2.5 mg, 5 mg LEVOCETIRIZINE (compare to Xyzal) 5 mg TABS LEVOCETIRIZINE (compare to Xyzal) SOL XYZAL (levocetirizine) 5 mg TABS XYZAL (levocetirizine) SOL ZYRTEC ALLERGY OTC (cetirizine orally disintegrating tablet) 10 mg ZYRTEC CHILDREN'S ALLERGY (only one NDC) All other brands	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. CETIRIZINE CHEWABLE TABLETS, CLARINEX REDITABS, CLARITIN CHEWABLE TABLETS, CLARITIN REDITABS, DESLORATADINE ODT, 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. AND If the request is for Clarinex Reditabs, the patient must also have a documented intolerance to the generic equivalent tablets 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. 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 suspension not covered as no Federal Rebate is offered. Fexofenadine/pseudoephedrine combination products (brand and generic) are not covered – individual components may be prescribed separately.
BETA-ADRENERGIC AGENTS	ALBUTEROL 0.63MG/3ML & 1.25MG/3ML NEB SOL ALBUTEROL 2.5MG/3ML NEB SOL ALBUTEROL 5MG/ML NEB SOL (age ≤ 12 yrs) ALBUTEROL ER TABS ALBUTEROL TAB/SYRUP FORADIL MAXAIR AUTOHALER PROAIR HFA PROVENTIL HFA SEREVENT DISKUS XOPENEX NEB SOL (age ≤ 12 yrs)	ACCUNEB (albuterol sulf neb sol 0.63mg/ml & 1.25mg/3ml) ARCAPTA NEOHALER (indacaterol) BRETHINE (terbutaline) BROVANA (arformoterol) LEVALBUTEROL NEB SOL (Xopenex) (all ages) METAPROTERENOL TABS SYRUP PERFORMIST (formoterol) TERBUTALINE TABS (Brethine) VENTOLIN HFA (Aalbuterol) VOSPIRE ER (albuterol) XOPENEX HFA (levalbuterol) XOPENEX NEB SOL (age > 12 yrs)	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. Foradil, Serevent: The patient has a diagnosis of COPD OR The patient has a diagnosis of asthma and is prescribed an inhaled corticosteroid as a controller medication. Arcapta: The patient has a diagnosis of COPD (not FDA approved for asthma). AND The patient has a documented side effect, allergy, or treatment failure to either Foradil or Serevent. Accuneb nebulizer solution 0.63 mg/3 ml and 1.25 mg/3 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 Performist 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. Ventolin HFA, Xopenex HFA: The patient must have had a documented side effect, allergy, or treatment failure to ONE preferred short acting metered dose inhaler. Vospire ER tablets: The patient must have had a documented side effect, allergy, or treatment failure to generic albuterol ER tablets.

CORTICOSTEROIDS/COMBINATIONS: INHALED	ADVAIR DISKUS ADVAIR HFA AEROSPAN ASMANEX 110 OR 220MCG/INH DULERA FLOVENT DISKUS FLOVENT HFA PULMICORT FLEXHALER PULMICORT RESPULES (age ≤ 12 yrs) QVAR 40MCG/INH QVAR 80MCG/INH SYMBICORT	ALVESCO (ciclesonide) BREQ ELLIPTA (fluticasone furoate/vilanterol) BUDESONIDE INH SUSPENSION (Pulmicort Respules) (all ages) PULMICORT RESPULES (budesonide) (age > 12 years)	Metered-dose inhalers (single agent): The patient has been started and stabilized on the medication. OR The patient has had a documented side effect, allergy, or treatment failure to at least two preferred agents. Breo Ellipta: The patient has a diagnosis of COPD(Note: Will not be approved for use in asthma). AND The patient has had a documented side effect, allergy, or treatment failure to Advair or Symbicort. 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.
CORTICOSTEROIDS: INTRANASAL	FLUTICASONE PROPIONATE NASONEX	BECONASE AQ (beclomethasone) BUDESONIDE (Rhinocort Aqua) DYMISTA (azelastine/fluticasone) FLONASE (fluticasone propionate) FLUNISOLIDE 25MCG/SPRAY (Nasalide) FLUNISOLIDE 29MCG/SPRAY (Nasarel) NASACORT AQ (triamcinolone) OMNARIS (ciclesonide) QNASL (beclomethasone dipropionate) HFA RHINOCORT AQUA (budesonide) TRIAMCINOLONE (Nasacort AQ) VERAMYST (fluticasone furoate) ZETONNA (ciclesonide)	Beconase AQ, Budesonide, Flonase, Flunisolide 25 mcg/spray, Flunisolide 29 mcg/spray, Nasacort AQ, Omnaris, QNASL, Rhinocort Aqua, triamcinolone, Veramyst, Zetonna: The patient has had a documented side effect, allergy, or treatment failure to BOTH preferred nasal glucocorticoids. If the request is for Nasacort AQ® or Rhinocort Aqua®, the patient has also had a documented intolerance to the generic equivalent. Dymista: The diagnosis or indication 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 corticosteroid used in combination. Limitations: Nasacort Allergy OTC not covered as no Federal Rebate is offered. Nasacort AQ RX available after PA obtained.
LEUKOTRIENE MODIFIERS		ACCOLATE (zafirlukast) MONTELUKAST SODIUM (singulair) TABS, CHEW TABS, GRANULES SINGULAIR (montelukast sodium) TABS, CHEW TABS, GRANULES ZAFIRLUKAST (Accolate) ZYFLO CR (zileuton SR)	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, chew tablets or granules, 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.
SYNAGIS		SYNAGIS (palivizumab)	CRITERIA FOR APPROVAL: <ul style="list-style-type: none"> ▫ 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 1 year of age at the start of the RSV season who develop chronic lung disease of prematurity defined as a requirement for >21% oxygen for at least the first 28 days after birth (maximum 5 doses). ▫ Children under 24 months of age with chronic lung disease of prematurity defined as born at 31 weeks, 6 days or less who required >21% oxygen for at least the first 28 days after birth and continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the start of the second RSV season (maximum 5 doses). ▫ Children under 12 months of age with hemodynamically significant congenital heart disease (CHD) (dosing continues in the RSV season through the end of the month the infant reaches 12 months old - maximum 5 doses): <ul style="list-style-type: none"> o Acyanotic heart disease and receiving medication to control congestive heart failure and will require cardiac surgical procedures o Moderate to severe pulmonary hypertension o Cyanotic heart disease and recommended for Synagis therapy by Pediatric Cardiologist ▫ 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) <ul style="list-style-type: none"> o Congenital abnormalities of the airways that impairs the ability to clear secretions from the upper airway because of ineffective cough o Neuromuscular condition that impairs the ability to clear secretions from the upper airway because of ineffective cough ▫ Infants and children less than 24 months of age who will undergo a heart transplant during the RSV season ▫ Infants and children less than 24 months of age who are profoundly immunocompromised during the RSV season (e.g. undergoing organ or stem cell transplant or receiving chemotherapy). EXCLUDED FROM APPROVAL: <ul style="list-style-type: none"> ▫ Infants and children with hemodynamically insignificant heart disease. ▫ Infants with cardiac 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. ▫ Breakthrough hospitalization for RSV disease (Synagis therapy should be discontinued for the season once hospitalization for RSV has occurred). ▫ Infants and children with Down syndrome unless other indications above are present. ▫ Infants and children with cystic fibrosis unless other specific conditions are present 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.
XOLAIR		XOLAIR (omalizumab) 150mg sub-q inj vial	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 pral 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.
PULMONARY ARTERIAL HYPERTENSION MEDICATIONS			
EPOPROSTENOL LETAIRIS TABS ORENITRAM ER TABS REMODULIN TRACLEER TABS TYVASO VELETRI VENTAVIS *Maximum day supply for all drugs is 30 days*	ADEMPAS TABS (riociguat) FLOLAN (epoprostenol) OPSUMIT TABS (macitentan)		Adempas: The patient has a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II or III. OR The patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH, WHO Group 4) AND the patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy) or has CTEPH which is inoperable. AND The patient is 18 years of age or older AND The patient will not use Adempas concomitantly with the following: Nitrates or nitric oxide donors (such as amyl nitrate) in any form. Phosphodiesterase (PDE) inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline) AND The patient is not pregnant AND Female patients are enrolled in the Adempas REMS Program FloLAN: Clinical diagnosis of pulmonary hypertension AND The patient has had a documented intolerance to the generic epoprostenol. Opsumit: Patient has a diagnosis of PAH WHO Group 1 with NYHA Functional Class II or III AND Patient is not pregnant AND Female patients have been enrolled in the Opsumit REMS Program
RENAL DISEASE: PHOSPHATE BINDERS			
CALCIUM ACETAT TABS CALCIUM ACETATE CAPS FOSRENOL RENAGEL	ELIPHOS TABS (calcium acetate) PHOS LO CAPS (calcium acetate) PHOSLYRA ORAL SOL (calcium acetate) REVELA ORAL SUSP PACKET (sevelamer carbonate) REVELA TABS (sevelamer carbonate) SEVELAMER CARBONATE 800MG TABS (Renvela) VELPHORO CHEW TABS (sucroferriic oxyhydroxide)		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, Sevelamer 800 mg Tablet: The patient must have a documented side effect, allergy, or inadequate response to Renagel (sevelamer hydrochloride). Velphoro Chew Tablet : The patient must have a documented side effect, allergy, or inadequate response to one preferred phosphate binder.
RESTLESS LEG SYNDROME MEDICATIONS			
PRAMIPEXOLE ROPINIROLE	HORIZANT ER TABS (gabapentin enacarbil) MIRAPEX (pramipexole) NEUPRO TRANSDERMAL PATCH (Neupro) REQUIP (ropinirole)		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. Neupro: The patient is ≥ 18 years of age AND The patient has a diagnosis of moderate to severe 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. OR The prescriber provides medical necessity for the transdermal formulation (eg. swallowing disorder or difficulty taking oral medications). Limitations: Requests for Mirapex ER and Requip XL will not be approved for Restless Leg Syndrome (RLS).
RHEUMATOID, JUVENILE & PSORIATIC ARTHRITIS: IMMUNOMODULATORS			
ENBREL (etanercept) HUMIRA (adalimumab)	ACTEMERA SUB-Q (tocilizumab) ACTEMRA INTRAVENOUS INFUSION (tocilizumab) CIMZIA (certolizumab pegol) KINERET (anakinra) ORENCIA INTRAVENOUS INFUSION (abatacept) ORENCIA SUB-Q INJ (abatacept) REMICADE (infliximab) SIMPONI ARIA 50MG/4ML VIAL FOR INTRAVENOUS INFUSION (golimumab) SIMPONI SUB-Q (golimumab) STELERA (ustekinumab) XELJANZ TABS (tofacitinib)		NOTE: Rheumatoid, Juvenile Idiopathic and Psoriatic Arthritis Self-Injectables/Oral (Actemra Subcutaneous, Cimzia, Enbrel, Humira, Kineret, Orenzia Subcutaneous, Simponi, Stelara and Xeljanz) must be obtained and billed through our specialty pharmacy vendor, Briova. Please see the Actemra, Cimzia, Enbrel, Humira, Kineret, Orenzia, Simponi, Stelara or Xeljanz Prior Authorization/Patient Enrollment Form for instructions. Briova may supply Remicade® upon request or you may continue to obtain through your usual supplier. Briova will not be supplying Actemra or Orenzia Intravenous Infusion at this time – please continue to obtain through your usual supplier. 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 Intravenous Infusion: 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. Actemra Subcutaneous: Patient has a diagnosis of RA and has already been stabilized on Actemra (Subcutaneous or Intravenous) OR Patient age > 18 years (RA) 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 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. The patient must have had an inadequate response to one or more TNF inhibitors. Cimzia: Patient has a diagnosis of RA or psoriatic arthritis and has already been stabilized on Cimzia 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 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

			<p>cannot be used.</p> <p>Simponi Aria: Patient has a diagnosis of RA and has already been stabilized on Simponi Aria 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 patient has not responded adequately to Simponi subcutaneous. AND The prescriber must provide a clinically valid reason why either Humira or Enbrel cannot be used.</p> <p>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, 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.</p> <p>Xeljanz: Patient has a diagnosis of RA and has already been stabilized on Xeljanz 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 non-biologic DMARD (other DMARDs include leflunomide, sulfasalazine, hydroxychloroquine, azathioprine, and cyclosporine) AND The prescriber must provide a clinically valid reason why either Humira or Enbrel cannot be used.</p> <p>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 TNF antagonists (i.e. Enbrel, Humira, or Remicade) and is not recommended for use with Kineret. AND The prescriber must provide a clinically valid reason why either Humira or Enbrel cannot be used. AND If the diagnosis is RA, there is a clinically valid reason why Orencia Subcutaneous cannot be used.</p> <p>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 TNF antagonists (i.e. Enbrel, Humira, or Remicade) and is not recommended for use with Kineret. AND The prescriber must provide a clinically valid reason why either Humira or Enbrel cannot be used.</p> <p>Stelara: Patient has a diagnosis of psoriatic arthritis and has already been stabilized on Stelara OR Diagnosis is 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 be used.</p> <p>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 Enbre, 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, Cimzia, Stelara or Simponi</p>
SALIVA STIMULANTS			
	CEVIMELINE EVOXAC PILOCARPINE	SALAGEN (pilocarpine)	Salagen: The patient has had a documented side effect, allergy, or treatment failure to generic pilocarpine
SEDATIVE/HYPNOTICS			
BENZODIAZEPINE	ESTAZOLAM TEMAZEPAM 15MG,30MG	DORAL (quazepam) FLURAZEPAM (Dalmane) HALCION (triazolam) PROSOM (estazolam) QUAZEPAM (Doral) RESTORIL (temazepam) TEMAZEPAM 7.5MG, 22.5MG (Restoril) TRIAZOLAM (Halcion)	must be the generic.
NON-BENZODIAZEPINE NON-BARBITURATE	ZALEPLON ZOLPIDEM	AMBIEN (zolpidem) AMBIEN CR (zolpidem) EDLUAR SL TABS (zolpidem) ESZOPICLONE (Lunesta) INTERMEZZO SL TABS (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon) SILENOR (doxepin) ZOLPIDEM CR (Ambien CR) ZOLPIMIST SPRAY (zolpidem)	<p>Ambien: The patient has had a documented intolerance to generic zolpidem.</p> <p>Ambien CR, Lunesta, eszopiclone, Zolpidem CR: The patient has had a documented side effect, allergy or treatment failure to generic zolpidem. If the request is for brand Ambien CR, there has also been a documented intolerance to the generic. If the request is for generic eszopiclone, there has also been a documented intolerance to the brand Lunesta.</p> <p>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.</p> <p>Intermezzo: The patient has insomnia characterized by middle-of-the night awakening followed by difficulty returning to sleep AND The patient has had a documented inadequate response to zolpidem IR AND zaleplon.</p> <p>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.</p> <p>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.</p> <p>Sonata: The patient has had a documented intolerance to generic zaleplon</p> <p>Zolpimist: The patient has a medical necessity for a non-oral dosage form (i.e. swallowing disorder).</p>
SKELETAL MUSCLE RELAXANTS			
	BACLOFEN CHLORZOXAZONE 500MG TABS	AMRIX (cyclobenzaprine sustained-release) 15 mg, 30 mg CAPS CARISOPRODOL 250 mg TABS	Amrix, 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.

	<p>CYLOBENZAPRINE 5MG, 10MG TABS DANTROLENE METHOCARBAMOL 500MG, 750MG TABS ORPHENADRINE CITRATE ER 100MG TABS TIZANIDINE</p>	<p>CARISOPRODOL 350 mg (compare to Soma®) TABS CARISOPRODOL, ASA (Soma Compound) CARISOPRODOL, ASA CODEINE (Soma Compound w/codeine) CYCLOBENZAPRINE 7.5 mg tab (compare to Fexmid) DANTRIUM (dantrolene) FEXMID (cyclobenzaprine) 7.5 mg TABS FLEXERIL (cyclobenzaprine) 5 mg, 10 mg TABS LORZONE (chlorzoxazone) 375 mg, 750 mg TABS METAXALONE (Skelaxin) 800 mg TABS ORPHENADRINE, ASA, CAFFEINE (Norgesic) PARAFON FORTE DSC (chlorzoxazone) 500 mg TABS ROBAXIN (methocarbamol) 500mg, 750 mg TABS SKELAXIN (metaxalone) 800 mg TABS SOMA (carisoprodol) 250 mg, 350 mg TABS TIZANIDINE (compare to Zanaflex) CAPS ZANAFLEX (tizanidine) CAPS ZANAFLEX (tizanidine) TABS</p>	<p>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).</p> <p>carisoprodol, carisoprodol/ASA, carisoprodol/ASA/codeine, Soma, metaxalone, 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.</p> <p>Lorzone: The patient has had a documented side effect, allergy or treatment failure with two different preferred musculoskeletal agents.</p> <p>orphenadrine/ASA/caffeine: The prescriber must provide a clinically valid reason why generic orphenadrine in combination with aspirin (or another analgesic) cannot be used.</p> <p>Dantrium, Zanaflex tablets: The patient must have a documented intolerance with the AB rated generic product.</p> <p>Tizanidine 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 tizanidine capsules</p>
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SMOKING CESSATION THERAPIES

	<p>BUPROPION SR CHANTIX (limited to 18 years and older) COMMIT LOZENGE NICOTINE GUM NICOTINE PATCH OTC</p>	<p>NICODERM CQ PATCH NICORETTE GUM NICOTINE LOZENGE NICOTROL INHALER NICOTROL NASAL SPRAY ZYBAN (bupropion SR)</p> <p>NICOTINE REPLACEMENT(maximum duration is 16 weeks (2x8 weeks)/365 days for non preferred</p>	<p>Nicoderm CQ patch: The patient has had a documented intolerance to generic nicotine patch.</p> <p>Nicorette gum: The patient has had a documented intolerance to generic nicotine gum.</p> <p>nicotine lozenge: The patient has had a documented side effect or allergy to Nicorette lozenge or Commit lozenge.</p> <p>Nicotrol Inhaler: The patient has had a documented treatment failure with BOTH generic nicotine patch and generic nicotine gum.</p> <p>Nicotrol Nasal Spray: The prescriber must provide a clinically valid reason for the use of the requested medication.</p> <p>Zyban: The patient has had a documented intolerance to generic bupropion SR.</p> <p>*Smoking Cessation Counseling is encouraged with the use of smoking cessation therapies*</p> <p>*The combined prescribing of long acting (patch) and faster acting (gum or lozenge) nicotine replacement therapy is encouraged for greater likelihood of quit success. *</p> <p>Vermont QUIT LINE (available free to all patients) 1-800-QUIT-NOW (1-800-784-8669)</p> <p>GETQUIT™ Support Plan available free to all Chantix® patients 1-877-CHANTIX (242-6849)</p> <p>Limitations: Nicotine System Kit® not covered – prescribe multiple strengths separately</p>
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TESTOSTERONE: TOPICAL

	<p>ANDROGEL GEL 1.25GM PACKET (1.62%) ANDROGEL GEL 2.5MG PACKET (1%) ANDROGEL GEL 5GM PACKET *Maximum day supply all products is 30 days*</p>	<p>ANDRODERM TRANSDERMAL 2.5MG, 5MG (testosterone patch) ANDROGEL GEL 1.62% GEL PACKETS ANDROGEL GEL 2.5GM PACKET (1.62%) ANDROGEL PUMP AXIRON 90ML PUMP (testosterone 2% sol) FORTESTA 60GM PUMP (TESTOSTERONE 2% GEL) TESTIM GEL 5GM (testosterone 1% gel bube) TESTOSTERONE 1% Gel Pump (Androgel, Vogelxo) TESTOSTERONE 1% GEL TUBE (testim gel 5gm, Vogelxo, Androgel) TESTOSTERONE 2% Gel 60GM Pump (Fortesta) VOGELXO 1% GEL, PUMP (testosterone 1%) *Maximum day supply all products is 30 days*</p>	<p>Andoderm, Axiron, Fortesta, Testim Testosterone Gel 1%, Testosterone Gel 2 %: The patient has had a documented side effect, allergy, or treatment failure to AndroGel® Gel or Pump</p> <p>Limitations: Coverage of testosterone products is limited to males.</p>
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THROMBOPOIETIN RECEPTOR AGONISTS

		<p>NPLATE (romiplostim) PROMACTA(eltrombopag)</p>	<p>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 10⁹/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.</p>
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URINARY ANTISPASMODICS

	<p>ENABLEX OXYBUTYNYN VESICARE</p> <p>>NOTE: ▪ Patients under the age of 65 must fail an adequate trial of generic oxybutynin before approval will be granted for either Vesicare or Enablex</p>	<p>DETROL (tolterodine) DETROL LA (tolterodine SR) DITROPAN (oxybutynin) DITROPAN XL (oxybutynin XL) FLAVOXATE (Urispas) GELNIQUE 10% (oxybutynin topical gel) GELNIQUE 3% (oxybutynin topical gel) MYBETRIQ ER TAB (mirabegron) OXYTROL (oxybutynin transdermal) SANCTURA (trospium)</p>	<p>CRITERIA FOR APPROVAL: (for patients >21 and <65 years of age): Please note: Patients <21 years of age are exempt from all ORAL ANTIMUSCARINIC Urinary Antispasmodics PA requirements (Exception: An adequate trial of oxybutynin/oxybutynin XL will be required before approval of Ditropan/Ditropan XL and an adequate trial of tolterodine SR will be required before approval of Detrol LA will be granted for all patients) and patients ≥ 65 years of age are exempt from the short acting oxybutynin trial requirement.</p> <p>Ditropan, flavoxate, Enablex, Vesicare: The patient has had a documented side effect, allergy, or treatment failure with generic oxybutynin</p> <p>Detrol, Detrol LA, Ditropan XL, Oxybutynin XL, Sanctura, Sanctura XR, tolterodine (generic), tolterodine SR (generic), trospium (generic), trospium ER (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.</p> <p>Gelnique 3%, 10%, 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.</p> <p>Myrbetriq: The patient has had a documented side effect, allergy, treatment failure, or contraindication with one preferred long-acting urinary antimuscarinic agent.</p> <p>Limitations: Oxytrol (for Women) OTC not covered. Oxytrol RX is available but subject to prior authorization.</p>
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	<p>▪ A therapeutic failure on two long acting preferred products is required before a PA will be approved on any non-preferred long acting medication. Recipients < 21 years of age are exempt from all ORAL ANTIMUSCARINIC PA Requirements. (Exception: An adequate trial of oxybutinin/oxybutinin XL will be required before approval of Ditropan /Ditropan XL and tolterodine SR before approval of Detrol LA will be granted)</p>	<p>SANCTURA XR (trospium) TOLTERODINE (Detrol) TOLTERODINE SR (Detrol LA) TOVIAZ (fesoterodine) TROSPIUM (Sanctura)</p>	
VAGINAL ANTI-INFECTIVES			
	<p>CLINDAMYCIN VAGINAL CREAM METRONIDAZOLE VAGINAL GEL 0.75% VANDAZOLE</p>	<p>CLEOCIN (clindamycin vaginal cream 2%) CLEOCIN VAGINAL OVULES (clindamycin vaginal suppositories) CLINDESSE (clindamycin vaginal cream 2%) METROGEL VAGINAL (metronidazole vaginal gel 0.75%)</p>	<p>Cleocin, Clindesse: 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.</p>
VITAMINS: PRENATAL MULTIVITAMINS			
	<p>PRENAPLUS PRENATAL PLUS/IRON PRENATAL PLUS/IRON PRENATAL VITAMINS PLUS PRENATE AM TAB 1MG PRENATE CAP ENHANCE PRENATE CAP ESSENTIAL PRENATE CAP RESTORE PRENATE CHEW .6-.4 PRENATE DHA CAP PRENATE MINI CAP</p>	<p>All others including DHA containing products</p>	<p>DHA Containing Prenatal Vitamins: The patient is unable to obtain a sufficient amount of DHA from diet alone All Other 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.</p>

New drugs are initially non-preferred until reviewed by the DUR Committee and the State. According to State policy, any drug requiring specific diagnosis still requires the specific diagnosis unless otherwise noted within this document.