
Ohio Health Plans Fee-For-Service

Pharmacy Benefit Management Program

Preferred Drug List



Effective October 1, 2009

Ohio Department of Job and Family Services

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Analgesic Agents: COX-2 Inhibitors

LENGTH OF AUTHORIZATIONS: 1 year, except as specified in items (2) and (3)

INDICATIONS AND DOSING:

- Osteoarthritis – 200mg daily or 100mg BID
- Rheumatoid arthritis in adults – 100mg to 200mg BID
- Ankylosing spondylitis – 200mg daily or 100mg BID; if no response after 6 weeks, can try 400mg daily
- Acute pain in adults – 400mg initially, additional 200mg dose if needed on first day; 200mg BID as needed on subsequent days
- Primary dysmenorrhea – 400mg initially, additional 200mg dose if needed on first day; 200mg BID as needed on subsequent days
- Familial adenomatous polyposis (FAP) – 400mg BID with food

Is there any reason the patient cannot be changed to a medication not requiring prior approval?
Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval. Acceptable contraindications include:
 - Concurrent or history of a GI event (perforation, ulcer, bleed)
 - Other risks for treatment with non-selective NSAIDs:
 - Coagulation disorders (i.e. hemophilia, chronic liver disease), erosive esophagitis
 - Documented NSAID-induced ulcer
 - Peptic ulcer disease (PUD)
 - Patient on anticoagulants (warfarin or heparin)
 - Patient on oral corticosteroids
 - Patient on methotrexate
- History of unacceptable/toxic side effects to medications not requiring prior approval

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ADDITIONAL INFORMATION

1. The requested medication may be approved if both of the following are true:
 - If there have been therapeutic failures to no less than a one-month trial of at least two non-COX 2 NSAID medications not requiring prior approval.
 - If there is a specific indication for medication requiring prior approval, for which medications not requiring prior approval are not indicated, then document details and refer to RPh (i.e. Celebrex[®] utilization in the treatment of various cancer treatment protocols).
2. COX-2 medications may be approved for patients who are undergoing surgical or other medical procedures that may predispose them to potential bleeding complications. Authorization will be for a 2-month time period.
3. A patient who is being treated for H.pylori may be given authorization for a COX-2 medication for a 30-day period.

CRITICAL INFORMATION TO CONSIDER

1. If the patient is 60 years of age or older, Celebrex[®] does not require prior approval.
2. If the patient is allergic to one NSAID or aspirin, the patient may be allergic to other NSAIDS.
3. If allergic to sulfonamides, a patient is not to receive prior approval for Celebrex[®].

CRITERIA FOR SYSTEMATIC PRIOR AUTHORIZATION

1. Patient age equal to or over 60 years; or
2. Patient has claims history of warfarin, heparin, or heparin-related agents in past 120 days; or
3. Patient has claims history of oral corticosteroid in past 120 days; or
4. Patient has claims history of methotrexate in past 120 days; or
5. Patient has claims history of aspirin in past 120 days; or
6. If there have been therapeutic failures to no less than a one-month trial of at least two non-COX 2 NSAID medications not requiring prior approval.

ANALGESIC AGENTS: COX-2 INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CELEBREX [®] (no PA required for age 60 or older)	CELEBREX [®] (PA required for under age 60)

Analgesic Agents: Opioids

LENGTH OF AUTHORIZATIONS: 6 months

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to at least two unrelated medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there have been inadequate clinical responses to no less than one-week trials of at least two unrelated medications not requiring prior approval, then may approve the requested medication.
3. Patient must have failed the generic product (if covered by the state) before brand is authorized, in addition to the above.

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ANALGESICS AGENTS: OPIOIDS – Long-Acting Oral

NO PA REQUIRED “PREFERRED”	PA REQUIRED
Extended Release Morphine Products	
KADIAN [®] MORPHINE SULFATE ER (generic of MS Contin [®]) ORAMORPH SR [®]	AVINZA [®]
Extended Release Oxycodone Products	
OXYCODONE ER (generic of Oxycontin [®]) OXYCONTIN [®]	
Extended Release Tramadol Products	
	ULTRAM ER [®] RYZOLT ER [®]
Extended Release Oxymorphone Products	
	OPANA ER [®]

ANALGESIC AGENTS: OPIOIDS – Long-Acting Topical

NO PA REQUIRED “PREFERRED”	PA REQUIRED
DURAGESIC [®] PATCH FENTANYL PATCH (generic of Duragesic [®])	

ANALGESIC AGENTS: OPIOIDS – Immediate-Release Single Entity

NO PA REQUIRED “PREFERRED”	PA REQUIRED
Codeine Products	
CODEINE SULFATE TABLETS	
Hydromorphone Products	
HYDROMORPHONE HCL TABLETS (generic of Dilaudid [®])	
Meperidine Products	
MEPERIDINE TABLETS (generic of Demerol [®])	

Methadone Products	
METHADONE TABLETS (generic of Dolophine®)	
Morphine Products	
MORPHINE SULFATE: IMMEDIATE-RELEASE TABLETS (generic of MSIR®)	
Oxycodone Products	
ROXICODONE® (OXYCODONE): IMMEDIATE-RELEASE TABLETS (generic of M-OXY®) OXYCODONE HCL TABLETS OXYCODONE HCL: IMMEDIATE-RELEASE CAPSULES (generic of OxyIR®)	
Oxymorphone Products	
	OPANA®

ANALGESIC AGENTS: OPIOIDS – Immediate-Release Combination

NO PA REQUIRED “PREFERRED”	PA REQUIRED
Codeine Combinations	
ACETAMINOPHEN w/CODEINE TABLETS (generic of Tylenol #2®, Tylenol #3®, Tylenol #4®) ASPIRIN w/CODEINE NO. 3 and NO. 4 TABLETS (generic of Empirin w/Codeine No.3® and No.4®)	
Dihydrocodeine Combinations	
	PANLOR DC® DIHYDROCODEINE/ACETAMINOPHEN/ CAFFEINE (generic of Panlor SS®)
Hydrocodone Combinations	
HYDROCODONE/ACETAMINOPHEN all strengths (generic of Anexsia, Lortab, Lorcet, Maxidone, Norco, Vicodin)	DOLACET® HYDROCODONE/ IBUPROFEN (generic of Vicoprofen®) IBUDONE® MARGESIC H® REPREXAIN® XODOL® ZYDONE®
Oxycodone Combinations	
OXYCODONE W/ ACETAMINOPHEN TABLETS all strengths (generic of Percocet®) OXYCODONE W/ ACETAMINOPHEN CAPSULES (generic of Tylox®) OXYCODONE W/ ASPIRIN TABLETS 4.5mg/325mg (generic of Percodan®) ROXICET® 5mg/325mg	OXYCODONE W/ IBUPROFEN (generic of Combunox®) ROXICET® 5mg/500mg
Propoxyphene Combinations	
PROPOXYPHENE (generic of Darvon-N®, Darvon®) PROPOXYPHENE 65 HCL w/ACETAMINOPHEN 650 (generic of Wygesic®) PROPOXYPHENE NAPSYLATE 100 and APAP 650 (generic of Darvocet-N-100®)	PROPOXYPHENE 100 W/ACETAMINOPHEN 325 (generic of Balacet 325®) DARVOCET-N-50® PROPOXYPHENE 100MG and APAP 500MG (generic of Darvocet A500®)

Pentazocine Combinations	
<i>Not advocated for use</i>	PENTAZOCINE and NALOXONE (generic of Talwin NX®) PENTAZOCINE HCL and ACETAMINOPHEN (generic of Talacen®)

ANALGESIC AGENTS: CENTRAL, WITH OPIOID ACTIVITY

NO PA REQUIRED “PREFERRED”	PA REQUIRED
Tramadol Products	
TRAMADOL (generic of Ultram®)	NUCYNTA® TRAMADOL/ACETAMINOPHEN (generic of Ultracet®)

ANALGESIC AGENTS: OPIOIDS – Liquids and Oral Syrup Immediate-Release (Single Entity)

NO PA REQUIRED “PREFERRED”	PA REQUIRED
DILAUDID-5® 1mg/ml liquid MEPERIDINE HCL SYRUP: 50 mg/5ml (generic of Demerol Oral Syrup®) METHADONE HCL SOLN 5mg/5ml, 10mg/5ml METHADONE HCL ORAL CONCENTRATE and METHADONE INTENSOL® 10mg/ml MORPHINE SULFATE SOLN: 10 mg/5ml, 20mg/5ml, 20mg/ml (generic of MSIR Soln® and Roxanol Soln®) ROXICODONE® (Oxycodone oral solution) 5mg/5ml (generic of Oxydose®) ROXICODONE INTENSOL® (Oxycodone oral solution concentrate: 20 mg/ml) (generic of Oxyfast®)	

ANALGESIC AGENTS: OPIOIDS – Liquids and Oral Syrup Immediate-Release (Combination)

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ACETAMINOPHEN w/CODEINE ORAL SOLN 120mg-12mg/5ml (generic of Tylenol w/Codeine Elixir®) HYDROCODONE BITARTRATE w/ ACETAMINOPHEN ELIXIR 2.5mg-167mg/5ml (generic of Lortab Elixir®) ROXICET ORAL SOLN® (5mg Oxycodone-325mg APAP/5ml)	CAPITAL w/CODEINE ORAL SUSP 12mg codeine-120mg APAP/5ml HYDROCODONE/ACETAMINOPHEN ORAL SOLUTION 10mg-325mg/15ml (generic of Zamacet®)

ANALGESIC AGENTS: OPIOIDS – Nasal Inhalers

NO PA REQUIRED “PREFERRED”	PA REQUIRED
BUTORPHANOL TARTRATE NS (generic of Stadol NS®)	

ANALGESIC AGENTS: OPIOIDS – Transmucosal System

NO PA REQUIRED “PREFERRED”	PA REQUIRED
	FENTANYL CITRATE (generic of Actiq®)* FENTORA®*

* Note: Clinical criteria must be met for Actiq®, Fentanyl Citrate transmucosal, and Fentora® – approvable only for cancer pain.

Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents

LENGTH OF AUTHORIZATIONS: Dependent on diagnosis

All products in this class require clinical prior authorization:

Approval of epoetin alfa or darbepoetin:

Diagnosis	Hemoglobin Level	Approval Length
Anemia due to chronic renal failure, patient on dialysis	<=11	12 months
Anemia due to chronic renal failure, patient not on dialysis	<=11	12 months
Chemotherapy-induced anemia	<=10	3 months
Anemia in myelodysplastic syndrome	<=11	6 months

Approval of epoetin alfa only (not darbepoetin):

Diagnosis	Hemoglobin Level	Approval Length
Autologous blood donation, patient will require blood transfusions	>10, <=13	1 month
Anemia of prematurity, age <=6 months	N/A	6 weeks
Anemia associated with chronic inflammatory disorders (e.g., rheumatoid arthritis)	<=11	6 months
Anemia associated with ribavirin combination therapy in hepatitis C-infected patient	<=11	6 months
Anemia in zidovudine-treated HIV-infected patients	<=11	6 months

PDL criteria:

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to all medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Has the patient failed therapeutic trials of two weeks with medications not requiring prior approval? If so, document and approve the requested medication.

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BLOOD AGENTS: HEMATOPOIETIC AGENTS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ARANESP® SYRINGE OR VIAL PROCRI®	EPOGEN®

Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations

LENGTH OF AUTHORIZATIONS: Varies based on criteria below

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to all medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Has the patient failed therapeutic trials of two weeks with medications not requiring prior approval? If so, document and approve the requested medication.

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DURATION OF THERAPY LIMIT: 35 days

Guidelines from the American College of Chest Physicians limit duration of therapy in the outpatient setting for most indications to less than five weeks. Patients should be transitioned to oral warfarin as soon as possible.

1. Is there any reason the patient cannot be changed to oral warfarin? Acceptable reasons include:
 - patients with cancer (approved up to 6 months),
 - pregnant women (approved up to 40 weeks), or
 - patients unable to take warfarin (approved up to 6 months).

BLOOD AGENTS: HEPARIN-RELATED PREPARATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ARIXTRA® FRAGMIN® SYRINGE FRAGMIN® VIAL INNOHEP® LOVENOX® AMPULE LOVENOX® PREFILLED SYRINGE LOVENOX® VIAL	

Blood Formation, Coagulation, and Thrombosis Agents: Platelet Aggregation Inhibitors

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to all medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Has the patient failed therapeutic trials of two weeks with medications not requiring prior approval? If so, document and approve the requested medication.

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BLOOD AGENTS: PLATELET AGGREGATION INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AGGRENOLX® CILOSTAZOL (generic of Pletal®) DIPYRIDAMOLE (generic of Persantine®) PLAVIX® TICLOPIDINE (generic of Ticlid®)	

Cardiovascular Agents: Hypertension & Heart Failure

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if both of the following are true:
 - If there has been a therapeutic failure to no less than a one-month trial of at least one medication within the same class not requiring prior approval
 - The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated

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ADDITIONAL INFORMATION TO AID IN FINAL DECISION

- If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then may approve the requested medication (e.g., Altace[®] may be authorized for reducing risk of heart attack and stroke, as shown in the HOPE study; or Toprol XL[®] may be authorized for treating diagnosis of heart failure, or if patient's compliance would be compromised by change). This medication should be reviewed for need at each request for reauthorization.

CARDIOVASCULAR AGENTS: ACE INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BENZAEPRI (generic of Lotensin [®])	ACEON [®]
CAPTOPRIL (generic of Capoten [®])	RAMIPRIL (generic of Altace [®])
ENALAPRIL (generic of Vasotec [®])	FOSINOPRIL (generic of Monopril [®])
LISINOPRIL (generic of Zestril [®] , Prinivil [®])	MOEXIPRIL (generic of Univase [®])
	QUINAPRIL (generic of Accupril [®])
	TRANDOLAPRIL (generic of Mavik [®])

CARDIOVASCULAR AGENTS: ACE INHIBITORS/CCB Combination

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LOTREL [®] (Amlodipine and Benazepril)	AMLODIPINE/BENZAEPRI (generic of Lotrel [®])
TARKA [®] (Verapamil and Trandolapril)	

CARDIOVASCULAR AGENTS: ACE INHIBITORS/DIURETIC Combination

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BENZAEPRI/HCTZ (generic of Lotensin HCT [®])	FOSINOPRIL/HCTZ (generic of Monopril HCT [®])
CAPTOPRIL/HCTZ (generic of Capozide [®])	MOEXIPRIL/HCTZ (generic of Uniretic [®])
ENALAPRIL/HCTZ (generic of Vaseretic [®])	QUINAPRIL/HCTZ (generic of Accuretic [®])
LISINOPRIL/HCTZ (generic of Zestoretic [®] , Prinzide [®])	

CARDIOVASCULAR AGENTS: ALPHA-BETA BLOCKERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CARVEDILOL (generic of Coreg [®]) LABETALOL (generic of Trandate [®])	COREG CR [™]

CARDIOVASCULAR AGENTS: ANGIOTENSIN II RECEPTOR ANTAGONISTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AVAPRO [®] BENICAR [®] COZAAR [®] DIOVAN [®] MICARDIS [®]	ATACAND [®] TEVETEN [®]

CARDIOVASCULAR AGENTS: ANGIOTENSIN II RECEPTOR ANTAGONISTS/DIURETIC Combination

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AVALIDE [®] BENICAR HCT [®] DIOVAN HCT [®] HYZAAR [®] MICARDIS HCT [®]	ATACAND HCT [®] TEVETEN HCT [®]

CARDIOVASCULAR AGENTS: ANGIOTENSIN II RECEPTOR ANTAGONISTS/CALCIUM CHANNEL BLOCKER Combination

NO PA REQUIRED "PREFERRED"	PA REQUIRED
EXFORGE [®] (Amlodipine/Valsartan) AZOR [®] (Amlodipine/Olmesartan)	

CARDIOVASCULAR AGENTS: ANGIOTENSIN II RECEPTOR ANTAGONISTS/CALCIUM CHANNEL BLOCKER/DIURETIC Combination

NO PA REQUIRED "PREFERRED"	PA REQUIRED
EXFORGE HCT [®]	

CARDIOVASCULAR AGENTS: BETA-BLOCKERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACEBUTOLOL (generic of Sectral [®]) ATENOLOL (generic of Tenormin [®]) BETAXOLOL (generic of Kerlone [®]) BISOPROLOL FUMARATE (generic of Zebeta [®]) METOPROLOL TARTRATE (generic of Lopressor [®]) NADOLOL (generic of Corgard [®]) PINDOLOL (generic of Visken [®]) PROPRANOLOL (generic of Inderal [®]) PROPRANOLOL ER (generic of Inderal LA [®]) SOTALOL (generic of Betapace [®]) SOTALOL AF (generic of Betapace AF [®]) TIMOLOL (generic of Blocadren [®]) TOPROL XL [®]	BYSTOLIC [®] INNOPRAN XL [®] LEVATOL [®] METOPROLOL SUCCINATE (generic of Toprol XL [®])

CARDIOVASCULAR AGENTS: BETA-BLOCKERS/DIURETIC COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ATENOLOL/CHLORTHALIDONE (generic of Tenoretic [®]) BISOPROLOL/HCTZ (generic of Ziac [®]) PROPRANOLOL/HCTZ (generic of Inderide [®])	NADOLOL/BENDROFLUMETHIAZIDE (generic of Corzide [®]) METOPROLOL/HCTZ (generic of Lopressor HCT [®])

CALCIUM CHANNEL BLOCKERS

There are two main classes of Calcium Channel Blockers (each with different actions on the peripheral vasculature and cardiac tissue) :

1. Dihydropyridine Calcium Channel Blockers (DHPCCB)
2. Non-Dihydropyridine Calcium Channel Blockers (NDHPCCB)

CARDIOVASCULAR AGENTS: CALCIUM CHANNEL BLOCKERS- DIHYDROPYRIDINE (DHPCCB)

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AMLODIPINE (generic of Norvasc [®]) DYNACIRC CR [®] FELODIPINE (generic of Plendil [®]) NICARDIPINE (generic of Cardene [®]) NIFEDIPINE ER (generic of Procardia XL [®] , Adalat CC [®])	CARDENE SR [®] ISRADIPINE (generic of Dynacirc [®]) NIFEDIPINE IMMEDIATE RELEASE (generic of Procardia [®]) NIMODIPINE (generic of Nimotop [®]) NISOLDIPINE (generic of Sular [®]) SULAR [®]

Nimotop[®] CRITERIA to APPROVE

- Nimotop[®]: Indicated for the improvement of neurological outcome by reducing the incidence and severity of ischemic deficits in patients with subarachnoid hemorrhage from ruptured intracranial berry aneurysms regardless of the post-ictus neurological condition (Hunt and Hess grades I-V). This agent is usually dosed every 4 hours for 21 days; therapy should begin within 96 hours after the subarachnoid hemorrhage.

NIFEDIPINE IMMEDIATE RELEASE CRITERIA

Nifedipine Dose and Schedule	RESPONSE	NOTES
Nifedipine on PRN schedule – when used for Hypertensive episodes (any dose 10mg or 20 mg prn)	<ul style="list-style-type: none"> • Change to Clonidine 0.1 mg prn SBP/DBP (same parameters as Nifedipine sig) 	<ul style="list-style-type: none"> • DO NOT OFFER CHANGE TO A Calcium Channel Blocker of any class • If there is a contraindication to Clonidine then authorize the Nifedipine • Note if patient is already on scheduled Clonidine or Catapres[®] – the addition of the PRN Clonidine is acceptable and will not be accepted as a reason not to change • Nifedipine when used as a PRN agent is not appropriate for the ambulatory patient
Nifedipine scheduled doses > 21 mg/day	<ul style="list-style-type: none"> • Change to once daily long-acting DHPCCB: Nifedipine ER, Dynacirc CR[®] 	<ul style="list-style-type: none"> • DO NOT OFFER CHANGE TO Non-Dihydropyridine Calcium Channel Blocker
Nifedipine scheduled doses > 21 mg/day in patients with swallowing difficulties or tubed patients	<ul style="list-style-type: none"> • Offer change to an equivalent dose of Norvasc (Amlodipine) 	<ul style="list-style-type: none"> • DO NOT RECOMMEND/OFFER change to a Non-Dihydropyridine Calcium Channel Blocker • Of the Dihydropyridine Calcium Channel Blockers (DHPCCB) only Norvasc[®] can be crushed for tube administration or for patients with swallowing difficulties – thus only conversion applicable is that to Norvasc[®] • Sular[®], Nifedipine ER, Dynacirc CR[®], Cardene SR[®] and Plendil[®] cannot be crushed, Cardene[®] IR requires multiple daily administrations and is NOT appropriate
Nifedipine scheduled doses < 21 mg/day (ie10mg PO/SL BID) in tubed/non tubed patients	<ul style="list-style-type: none"> • Authorize 	<ul style="list-style-type: none"> • This dose cannot be converted adequately to other DHPCCB and thus should NOT be changed • DO NOT OFFER CHANGE TO Non-Dihydropyridine Calcium Channel Blocker

CARDIOVASCULAR AGENTS: CALCIUM CHANNEL BLOCKERS- NON-DIHYDROPYRIDINE (NDHPCCB)

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DILTIAZEM (generic of Cardizem®) DILTIAZEM ER (generic of Cardizem CD® q24h, Tiazac®) DILTIAZEM SR (generic of Cardizem SR® q12h) VERAPAMIL (Generic of Calan®) VERAPAMIL SR/ER (Generic of Calan SR®, Isoptin SR®, Verelan®)	CARDIZEM LA® COVERA HS® VERAPAMIL ER PM (generic of Verelan PM®)

CARDIOVASCULAR AGENTS: DIRECT RENIN INHIBITORS*

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
TEKTURNA®	

* Note: Step therapy required for direct renin inhibitors – patient must have a claim for an alternative anti-hypertensive agent within the last 120 days.

CARDIOVASCULAR AGENTS: DIRECT RENIN INHIBITOR/DIURETIC COMBINATION*

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
TEKTURNA HCT®	

* Note: Step therapy required for direct renin inhibitors – patient must have a claim for an alternative anti-hypertensive agent within the last 120 days.

CARDIOVASCULAR AGENTS: HEART FAILURE – NITRATE/VASODILATOR COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	BIDIL® (Hydralazine/Isosorbide Dinitrate)

CARDIOVASCULAR AGENTS: LIPOTROPICS - STATINS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LESCOL [®] LESCOL XL [®] LIPITOR [®] LOVASTATIN (generic of Mevacor [®]) PRAVASTATIN (generic of Pravachol [®]) SIMVASTATIN (generic of Zocor [®])	ALTOPREV [®] CRESTOR [®]

CARDIOVASCULAR AGENTS: LIPOTROPICS – STATIN/NIACIN COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ADVICOR [®] (Lovastatin and Niacin) SIMCOR [®] (Simvastatin and Niacin)	

CARDIOVASCULAR AGENTS: LIPOTROPICS - FIBRIC ACID DERIVATIVES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
GEMFIBROZIL (generic of Lopid [®]) TRICOR [®] TRILIPIX [®]	ANTARA [®] FENOFIBRATE FENOGLIDE [®] LIPOFEN [®] LOFIBRA [®] TRIGLIDE [®]

CARDIOVASCULAR AGENTS: LIPOTROPICS - NICOTINIC ACID DERIVATIVES

NO PA REQUIRED PREFERRED"	PA REQUIRED
NIACIN NIASPAN [®]	

CARDIOVASCULAR AGENTS: LIPOTROPICS - OMEGA-3 POLYUNSATURATED FATTY ACIDS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	LOVAZA (formerly Omacor [®])

CARDIOVASCULAR AGENTS: LIPOTROPICS - SELECTIVE CHOLESTEROL ABSORPTION INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ZETIA [®]	

CARDIOVASCULAR AGENTS: LIPOTROPICS – STATIN / SELECTIVE CHOLESTEROL ABSORPTION INHIBITOR COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
VYTORIN [®] (Simvastatin/Ezetimibe)	

CARDIOVASCULAR AGENTS: LIPOTROPIC/HYPERTENSION COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CADUET [®] (Amlodipine/Atorvastatin) *	

* Caduet[®] is indicated in patients for whom treatment with both amlodipine and atorvastatin is appropriate. Both components are available separately without a PA.

Central Nervous System (CNS) Agents: Alzheimer's Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval

2. The requested medication may be approved if the following is true:
 - If there has been a therapeutic failure to no less than a one-month trial of at least one medication within the same class not requiring prior approval

Document clinically compelling information

CNS AGENTS: ALZHEIMER'S AGENTS

NO PA REQUIRED PREFERRED"	PA REQUIRED
ARICEPT®	GALANTAMINE (generic of Razadyne™)
ARICEPT® ODT	GALANTAMINE ER (generic of Razadyne™ ER)
COGNEX®	
EXELON®	
EXELON® patch	
EXELON® 2mg/ml solution	
NAMENDA®	
NAMENDA® 10mg/5ml solution	
RAZADYNE™	
RAZADYNE™ 4mg/ml solution	
RAZADYNE™ ER	

Central Nervous System (CNS) Agents: Anti-Migraine Agents

LENGTH OF AUTHORIZATIONS: 6 months

Serotonin 5HT₁ receptor agonists, commonly referred to as "Triptans" by their affinity for various 5-hydroxytryptamine₁ or serotonin receptor subtypes, cause cranial vessel constriction and inhibition of pro-inflammatory neuropeptide release, which correlates with the relief of migraine.

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to at least two medications not requiring prior approval
 - Contraindication to all medications not requiring prior approval
 - History of unacceptable/toxic side effects to at least two medications not requiring prior approval
2. Has the patient failed therapeutic trials of two weeks with two medications not requiring prior approval? If so, document and approve the requested medication.

Document clinically compelling information

CLINICAL CONSIDERATIONS:

1. All agents and dosage forms: Acute treatment of migraine headache with or without aura in adults.
2. Prior Authorization will not be given for prophylactic therapy of migraine headache unless the patient has exhausted or has contraindications to all other "controller" migraine medications (i.e., beta-blockers, neuroleptics, calcium channel blockers, etc.)

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. In addition to utilizing a preferred agent when applicable, the number of tablets/doses allowed per month is restricted based on the manufacturer's package insert.
2. Prior authorization should not be given to patients with a history of ischemic heart disease.
3. The recipient's profile must NOT contain an MAOI (monoamine oxidase inhibitor – Parnate[®], Marplan[®] or Nardil[®]) if receiving Maxalt[®] (rizatriptan), Imitrex[®] (sumatriptan) or Zomig[®] (zolmitriptan).

CNS AGENTS: ANTI-MIGRAINE AGENTS – SEROTONIN 5-HT1 RECEPTOR AGONISTS – “Fast” Onset

NO PA REQUIRED PREFERRED	PA REQUIRED
AXERT [®] IMITREX [®] INJECTION IMITREX [®] NASAL SPRAY IMITREX [®] TABLETS MAXALT [®] MAXALT-MLT [®] RELPA [®]	SUMATRIPTAN INJECTION (generic of Imitrex [®]) SUMATRIPTAN NASAL SPRAY (generic of Imitrex [®]) SUMATRIPTAN TABLETS (generic of Imitrex [®]) ZOMIG [®] ZOMIG [®] NASAL SPRAY ZOMIG ZMT [®]

Relpax[®] Special Considerations:

Relpax[®] (Eletriptan) is metabolized by the CYP3A4 enzyme.

- Do not use eletriptan within at least 72 hours of treatment with the following potent CYP3A4 inhibitors: Fluconazole, ketoconazole, itraconazole, nefazodone, toleandomycin, erythromycin, clarithromycin, ritonavir, nelfinavir, verapamil.
- Do not use eletriptan within 72 hours with drugs that have demonstrated potent CYP3A4 inhibition and have this potent effect.

CNS AGENTS: ANTI-MIGRAINE AGENTS – SEROTONIN 5-HT1 RECEPTOR AGONISTS - “Slow” Onset

NO PA REQUIRED “PREFERRED”	PA REQUIRED
AMERGE [®] FROVA [®]	

CNS AGENTS: ANTI-MIGRAINE AGENTS – SEROTONIN 5-HT1 RECEPTOR AGONIST/NSAID COMBINATION

NO PA REQUIRED “PREFERRED”	PA REQUIRED
TREXIMET [®] (Sumatriptan 85mg/Naproxen 500mg)	

Central Nervous System (CNS) Agents: Antidepressants

GRANDFATHERING:

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug through the automated PA system. Patients who have taken the drug in the previous 120 days, but do not have claims history (new to Medicaid, samples, etc.), will be approved for PA after prescriber contact.

PSYCHIATRIST EXEMPTION:

Physicians who are registered with Ohio Health Plans as having a specialty in psychiatry are exempt from prior authorization of any non-preferred antidepressant in the standard tablet/capsule dosage forms. Other dosage forms may still require prior authorization by a psychiatrist. The exemption will be processed by the claims system when the pharmacy has submitted the prescriber on the claim using the individual identifier for the psychiatrist.

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- For orally disintegrating tablet dosage forms, the patient is unable or unwilling to swallow the standard tablet/capsule dosage form.

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if the following are true:

- If there has been a therapeutic failure to no less than a one-month trial of at least two medications not requiring prior approval.
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.
- If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then may approve the requested medication (e.g., Cymbalta[®] may be authorized for diabetic peripheral neuropathic pain or fibromyalgia). This medication should be reviewed for need at each request for reauthorization.

ANTIDEPRESSANTS: SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CITALOPRAM tablets (generic of Celexa®) CITALOPRAM solution 10mg/5ml (generic of Celexa®) FLUOXETINE HCL 10mg, 20mg (generic of Prozac®) FLUOXETINE HCL 20mg/5ml solution (generic of Prozac®) FLUVOXAMINE MALEATE (generic of Luvox®) LEXAPRO® tablet LEXAPRO® 5mg/5ml solution PAROXETINE HCL (generic of Paxil®) PAROXETINE HCL 10mg/5ml solution (generic of Paxil®) SERTRALINE (generic of Zoloft®) SERTRALINE 20mg/ml oral concentrate (generic of Zoloft®)	FLUOXETINE HCL (generic of Prozac®) 40mg LUVOX CR® PAROXETINE ER (generic of Paxil CR®) PEXEVA® PROZAC WEEKLY® SELFEMRA (generic of Sarafem®)

*Patients on current regimens will be grandfathered.

ANTIDEPRESSANTS: SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CYMBALTA® EFFEXOR XR® VENLAFAXINE (generic of Effexor®) VENLAFAXINE ER tablet	PRISTIQ®

*Patients on current regimens will be grandfathered.

ANTIDEPRESSANTS: NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIBITORS: NDRI*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BUPROPION HCL (generic of Wellbutrin®) BUPROPION SR (generic of Wellbutrin SR®) WELLBUTRIN XL®	APLENZIN™ BUPROPION XL (generic of Wellbutrin XL®)

*Patients on current regimens will be grandfathered.

ANTIDEPRESSANTS: ALPHA-2 RECEPTOR ANTAGONISTS*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
MIRTAZAPINE (generic of Remeron®) MIRTAZAPINE rapid dissolve (generic of Remeron® Sol-Tab)	

*Patients on current regimens will be grandfathered.

ANTIDEPRESSANTS: MONOAMINE OXIDASE INHIBITORS (MAOI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	EMSAM® MARPLAN® NARDIL® PARNATE®

*Patients on current regimens will be grandfathered.

Central Nervous System (CNS) Agents: Antipsychotics, Second Generation, Oral

GRANDFATHERING:

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug through the automated PA system. Patients who have taken the drug in the previous 120 days, but do not have claims history (new to Medicaid, samples, etc.), will be approved for PA after prescriber contact.

PSYCHIATRIST EXEMPTION:

Physicians who are registered with Ohio Health Plans as having a specialty in psychiatry are exempt from prior authorization of any non-preferred second generation antipsychotic in the standard tablet/capsule dosage forms. Other dosage forms may still require prior authorization by a psychiatrist. The exemption will be processed by the claims system when the pharmacy has submitted the prescriber on the claim using the individual identifier for the psychiatrist.

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- For orally disintegrating tablet dosage forms, the patient is unable or unwilling to swallow the standard tablet/capsule dosage form.

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a fourteen-day trial of at least one medication not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

ANTIPSYCHOTICS, SECOND GENERATION *

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ABILIFY [®] ABILIFY [®] 1mg/ml solution GEODON [®] RISPERDAL [®] 1mg/ml solution RISPERIDONE tablet (generic of Risperdal [®]) SEROQUEL [®] SEROQUEL XR [®]	ABILIFY DISCMELT [®] CLOZAPINE (generic of Clozaril [®]) CLOZARIL [®] FAZACLO [®] INVEGA [®] RISPERIDONE M-TAB (generic of Risperdal M-tab [®]) RISPERIDONE 1mg/ml solution (generic of Risperdal [®]) ZYPREXA [®] ZYPREXA ZYDIS [®]

*Patients on current regimens will be grandfathered.

ANTIPSYCHOTICS, SECOND GENERATION and SSRI COMBINATION *

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	SYMBYAX [®]

*Patients on current regimens will be grandfathered.

Central Nervous System (CNS) Agents: Multiple Sclerosis Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - If allergy to drug class, should question medication request
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval

2. The requested medication may be approved if there has been a therapeutic failure to no less than a one-month trial on at least one medication not requiring prior approval.

Document clinically compelling information

CNS AGENTS: MULTIPLE SCLEROSIS AGENTS *

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AVONEX® BETASERON® COPAXONE® REBIF® titration pack REBIF® syringe	

*Patients on current regimens will be grandfathered.

Central Nervous System (CNS) Agents: Parkinson's Agents

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval?
Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

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ADDITIONAL INFORMATION

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a one-month trial of at least one medications not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

PARKINSON'S AGENTS – COMT Inhibitor

NO PA REQUIRED "PREFERRED"	PA REQUIRED
COMTAN [®]	TASMAR [®]

PARKINSON'S AGENTS – Dopamine Receptor Agonists, Non-Ergot, Injectable

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	APOKYN [®]

PARKINSON'S AGENTS – Dopamine Receptor Agonists, Non-Ergot, Oral

NO PA REQUIRED "PREFERRED"	PA REQUIRED
REQUIP XL [®] ROPINIROLE (generic of Requip [®])	MIRAPEX [®]

PARKINSON'S AGENTS – Dopaminergic Agents, Oral

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CARBIDOPA/LEVODOPA (generic of Sinemet [®]) CARBIDOPA/LEVODOPA CR (generic of Sinemet [®] CR) SELEGELINE (generic of Eldepryl [®]) STALEVO [®] (Carbidopa/Levodopa/Entacapone)	AZILECT [®] CARBIDOPA/LEVODOPA DISPERSIBLE TABLETS (generic of Parcopa [®]) ZELAPAR [®] ODT

Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate

LENGTH OF AUTHORIZATIONS: 6 months

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there has been a therapeutic failure to an agent not requiring prior approval, then may approve the requested medication.

Document clinically compelling information

CNS AGENTS: SEDATIVE-HYPNOTICS, NON-BARBITURATE

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ESTAZOLAM (generic of Prosom [®])	AMBIEN [®] CR
FLURAZEPAM (generic of Dalmane [®])	DORAL [®]
ROZEREM [®]	LUNESTA [®]
TEMAZEPAM 15mg, 30mg (generic of Restoril [®])	TEMAZEPAM 7.5mg & 22.5mg (generic of Restoril [®])
ZOLPIDEM (generic of Ambien [®])	7.5mg & 22.5mg
	ZALEPLON (generic of Sonata [®])

Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval

2. If there has been a therapeutic failure to an agent not requiring prior approval, then may approve the requested medication.

3. Dantrium[®] may be approved without a trial on another agent for any of the following diagnoses:
 - Cerebral palsy
 - Prader Willi
 - Spasticity secondary to brain injury with cognitive impairment

Document clinically compelling information

CNS AGENTS: SKELETAL MUSCLE RELAXANTS - ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BACLOFEN (generic of Lioresal [®]) CHLORZOXAZONE (generic of Parafon Forte [®]) CYCLOBENZAPRINE (generic of Flexeril [®]) METHOCARBAMOL (generic of Robaxin [®]) TIZANIDINE (generic of Zanaflex [®])	AMRIX [®] CARISOPRODOL (generic of Soma [®]) * CARISOPRODOL COMPOUND (generic of Soma Compound [®]) * DANTROLENE (generic of Dantrium [®]) ORPHENADRINE (generic of Norflex [®]) ORPHENADRINE COMPOUND (generic of Norgesic [®]) ORPHENADRINE COMPOUND FORTE (generic of Norgesic Forte [®]) SKELAXIN [®]

* Note: Clinical criteria must be met for Soma[®]/Carisoprodol products– approvable only if no other muscle relaxant or agent to treat fibromyalgia, or any musculoskeletal condition, would serve the clinical needs of the patient.

Central Nervous System (CNS) Agents: Smoking Deterrents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there has been a therapeutic failure to an agent not requiring prior approval, then may approve the requested medication.

Document clinically compelling information

CNS AGENTS: SMOKING DETERRENTS – NICOTINE REPLACEMENT

NO PA REQUIRED "PREFERRED"	PA REQUIRED
COMMIT™ lozenge NICODERM® CQ patch NICOTINE patch (generics) NICORETTE® gum NICOTINE gum (generic of Nicorette®) NICOTINE lozenge (generic of Commit™) NICOTROL® inhaler NICOTROL® nasal spray	

CNS AGENTS: SMOKING DETERRENTS – NON-NICOTINE PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BUPROPION (generic of Zyban®) CHANTIX	

Electrolyte Depletor Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a one-week trial of at least one medication not requiring prior approval.

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CLINICAL INFORMATION

PhosLo[®] contains calcium acetate and may lead to hypercalcemia. This agent is recommended in patients with normal serum calcium levels.

ELECTROLYTE DEPLETERS FOR HYPERPHOSPHATEMIA

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CALCIUM CARBONATE FOSRENOL [®] MAGNEBIND [®] PHOSLO [®] RENAGEL [®]	CALCIUM ACETATE (generic of PhosLo [®] gelcap) ELIPHOS [®] RENVELA [®]

Endocrine Agents: Diabetes Adjunctive Therapy

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
 - Condition is difficult to control (i.e. prone to ketoacidosis, hypoglycemia)

2. The requested medication may be approved if there has been a therapeutic failure to at least one medication within the same class not requiring prior authorization.

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ENDOCRINE AGENTS: DIABETES – AMYLIN ANALOGS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
SYMLIN [®]	

ENDOCRINE AGENTS: DIABETES – INCRETIN MIMETICS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
BYETTA [™]	

Endocrine Agents: Diabetes – Insulin

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
 - Condition is difficult to control (i.e. prone to ketoacidosis, hypoglycemia)
2. The requested medication may be approved if there has been a therapeutic failure to at least one medication within the same class not requiring prior authorization.

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CLINICAL INFORMATION

If Humalog[®] is approved and the patient is to mix with Humulin[®] (any product), then approve the Humulin[®] product(s).

ENDOCRINE AGENTS: DIABETES - INSULINS - Rapid and Short Acting*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
HUMALOG [®] HUMULIN R [®] HUMULIN R 500-U [®] NOVOLIN R [®] NOVOLOG [®]	APIDRA [®] RELION R [®]

* Patients on current insulin regimens will be grandfathered.

ENDOCRINE AGENTS: DIABETES - INSULINS - Intermediate Acting*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
HUMALOG MIX 50/50, 75/25 [®] HUMULIN 50/50 [®] HUMULIN 70/30 [®] HUMULIN N [®] NOVOLIN 70/30 [®] NOVOLIN N [®] NOVOLOG MIX 70/30 [®]	RELION 70/30 [®] RELION N [®]

* Patients on current insulin regimens will be grandfathered.

ENDOCRINE AGENTS: DIABETES - INSULINS - Long Acting*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LANTUS [®]	LEVEMIR [®]

* Patients on current insulin regimens will be grandfathered.

Endocrine Agents: Diabetes – Oral Hypoglycemics

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication within the same class not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to at least two trials of thirty days each with medications not requiring prior approval.

Document clinically compelling information

ENDOCRINE AGENTS: DIABETES – ORAL HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
GLYSET® ACARBOSE (generic of Precose®)	

ENDOCRINE AGENTS: DIABETES – ORAL HYPOGLYCEMICS, BIGUANIDES

NO PA REQUIRED “PREFERRED”	PA REQUIRED
METFORMIN (generic of Glucophage®) METFORMIN ER (generic of Glucophage XR®)	FORTAMET® GLUMETZA™ RIOMET® 500mg/5ml (Metformin)

ENDOCRINE AGENTS: DIABETES – ORAL HYPOGLYCEMICS, BIGUANIDES COMBINATION

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ACTOPLUS MET® AVANDAMET® GLYBURIDE/METFORMIN (generic of Glucovance®) JANUMET™	GLIPIZIDE/METFORMIN (generic of Metaglip®) PRANDIMET®

ENDOCRINE AGENTS: DIABETES – DIPEPTIDYL PEPTIDASE-4 INHIBITOR

NO PA REQUIRED “PREFERRED”	PA REQUIRED
JANUVIA®	

ENDOCRINE AGENTS: DIABETES – ORAL HYPOGLYCEMICS, MEGLITINIDES

NO PA REQUIRED “PREFERRED”	PA REQUIRED
STARLIX®	PRANDIN®

**ENDOCRINE AGENTS: DIABETES – ORAL HYPOGLYCEMICS, SULFONYLUREAS
SECOND GENERATION**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
GLIMEPIRIDE (generic of Amaryl [®]) GLIPIZIDE (generic of Glucotrol [®]) GLIPIZIDE ER (generic of Glucotrol XL [®]) GLYBURIDE (generic of Diabeta [®] , Micronase [®]) GLYBURIDE MICRONIZED (generic of GlynasePressTabs [®])	

**ENDOCRINE AGENTS: DIABETES – ORAL HYPOGLYCEMICS,
THIAZOLIDINEDIONES**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ACTOS [®] AVANDIA [®]	

**ENDOCRINE AGENTS: DIABETES – ORAL HYPOGLYCEMICS,
THIAZOLIDINEDIONES / SULFONYLUREAS COMBINATION**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
AVANDARYL [®] DUETACT [®]	

Endocrine Agents: Growth Hormones

LENGTH OF AUTHORIZATIONS: 1 year

All products in this class require clinical prior authorization:

- Diagnosis of one of the following:
 - Classic Growth Hormone Deficiency
 - Growth Hormone Deficiency Associated With Chronic Renal Function Before Transplant
 - Growth Hormone Deficiency Due to Somatropin Deficiency
 - Congenital Absence of Pituitary
 - Pituitary Gland Removal
 - Growth Hormone Deficiency Due to Radiation Therapy
 - Small for Gestational Age
 - Prader-Willi Syndrome
 - Turner's Syndrome
 - Krause-Kivlin Syndrome
 - AIDS Wasting
 - Short Bowel Syndrome

PDL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a three-month trial of at least one medication not requiring prior approval

GROWTH HORMONES

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
GENOTROPIN [®] CARTRIDGE	HUMATROPE [®] CARTRIDGE
GENOTROPIN [®] MINIQUICK	HUMATROPE [®] VIAL
NUTROPIN AQ [®] PEN CARTRIDGE	NORDITROPIN NORDIFLEX [®]
NUTROPIN AQ [®] VIAL	NORDITROPIN [®] CARTRIDGE
NUTROPIN [®] VIAL	NORDITROPIN [®] VIAL
SAIZEN [®] VIAL	OMNITROPE [®] VIAL
SAIZEN [®] CARTRIDGE	SEROSTIM [®] VIAL
TEV-TROPIN [®] VIAL	ZORBTIVE [®] VIAL

Endocrine Agents: Osteoporosis – Bone Ossification Enhancers

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. There are two (2) classes of drugs in this category of Ossification Enhancers
 - a. Bisphosphonates
 - b. Calcitonin-Salmon

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CRITICAL INFORMATION

- Patients should only be on ONE (1) of the above therapeutic classes (bisphosphonates, calcitonin-salmon).

ENDOCRINE AGENTS: OSTEOPOROSIS - BONE OSSIFICATION ENHANCERS - ORAL BISPHOSPHONATES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACTONEL [®] ALENDRONATE (generic of Fosamax [®]) BONIVA [®]	ACTONEL [®] WITH CALCIUM ETIDRONATE (generic of Didronel [®]) FOSAMAX [®] ORAL SOLN 70mg/75ml FOSAMAX PLUS D [™] SKELID [®]

ENDOCRINE AGENTS: OSTEOPOROSIS - BONE OSSIFICATION ENHANCERS - CALCITONIN-SALMON

NO PA REQUIRED "PREFERRED"	PA REQUIRED
MIACALCIN [®]	CALCITONIN-SALMON (generic of Miacalcin [®]) FORTICAL [®]

Gastrointestinal Agents: Anti-Emetics

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

GASTROINTESTINAL AGENTS: ANTI-EMETIC AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
EMEND® EMEND® TRIFOLD ONDANSETRON Tabs (generic of Zofran®) ONDANSETRON ODT (generic of Zofran®) ONDANSETRON Oral Solution (generic of Zofran®)	ANZEMET® GRANISETRON tablet (generic of Kytril®) GRANISETRON solution (generic of Kytril®) SANCUSO® patch

Gastrointestinal Agents: Chronic Constipation Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a one-week trial of at least one medication not requiring prior approval.

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ADDITIONAL INFORMATION TO AID IN FINAL DECISION

- If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then may approve the requested medication. This medication should be reviewed for need at each request for reauthorization.

GASTROINTESTINAL AGENTS: CHRONIC CONSTIPATION AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AMITIZA [®]	

Gastrointestinal Agents: Pancreatic Enzymes

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval?
Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

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ADDITIONAL INFORMATION

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a one-month trial of at least [number to be discussed by P&T Committee if any non-preferred drugs are added] medications not requiring prior approval

PANCREATIC ENZYMES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CREON® PANCREASE MT® PANCRECARB-MS® PANCRELIPASE® ULTRASE® ULTRASE MT® VIOKASE®	

Gastrointestinal Agents: Proton Pump Inhibitors

LENGTH OF AUTHORIZATIONS: 6 months, except as listed under clinical criteria

1. All medical criteria for the approval of GI medications as found in any previously existing prior approval criteria must also be met.
2. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
 - Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.
3. If there has been a therapeutic failure to no less than a one-month trial of at least one medication in the same class not requiring prior approval, then may approve the requested medication.
4. If a medication requiring prior approval was initiated in the hospital for the treatment of a condition such as a GI bleed, then may approve the requested medication.
5. For a diagnosis of cystic fibrosis, may approve doses above the acute dosage recommendations.

ADDITIONAL INFORMATION

- No PA needed on preferred PPI at once-daily dosing
- No PA needed for up to 40mg daily dosing of omeprazole capsules
- No PA needed on preferred PPI at any dose for age under 21
- Length of authorization dependent on diagnosis
- Must have therapeutic failure on preferred agent before PA of non-preferred

CLINICAL CRITERIA FOR PPI DOSES GREATER THAN ONCE DAILY

1. For diagnosis of H. Pylori, BID dosing may be authorized for 1 month
2. For diagnosis of COPD, Dyspepsia, Gastritis, Gastroparesis, Symptomatic Uncomplicated Barrett's Esophagus, Carcinoma of GI tract, Crest Syndrome, Esophageal Varices, Scleroderma, Systemic Mastocytosis, Zollinger Ellison Syndrome:
 - Length of authorization: 1 year
 - Criteria for approval: Must have failed QD dosing

Document clinically compelling information

GASTROINTESTINAL AGENTS: PPIs

NO PA REQUIRED "PREFERRED"	PA REQUIRED
<p>NEXIUM[®] Capsules OMEPRAZOLE 10mg, 20mg capsules (generic of Prilosec[®]) PREVACID SOLUTAB[®] (No PA required for age 6 or under)</p>	<p>ACIPHEX[®] NEXIUM[®] Packets KAPIDEX[®] OMEPRAZOLE tablets (generic of Prilosec OTC[®]) OMEPRAZOLE 40mg capsules (generic of Prilosec[®]) PANTOPRAZOLE (generic of Protonix[®]) PREVACID[®] Capsules PREVACID GRANULES[®] for suspension PREVACID NAPRA-PAC[®] PREVACID SOLUTAB[®] (PA required for age over 6)</p>

Genitourinary Agents: Benign Prostatic Hypertrophy

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindications to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Patient must have a therapeutic failure to no less than a one-month trial on at least one medication not requiring prior approval.

Document clinically compelling information

GENITOURINARY AGENTS: BENIGN PROSTATIC HYPERTROPHY AGENTS – ALPHA-1 ADRENERGIC BLOCKERS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
DOXAZOSIN (generic of Cardura®) FLOMAX® PRAZOSIN (generic of Minipress®) TERAZOSIN (generic of Hytrin®) UROXATRAL®	CARDURA® XL RAPAFLO®

GENITOURINARY AGENTS: BENIGN PROSTATIC HYPERTROPHY AGENTS – 5-ALPHA REDUCTASE INHIBITORS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
AVODART® FINASTERIDE (generic of Proscar®)	

Genitourinary Agents: Urinary Antispasmodics

LENGTH OF AUTHORIZATIONS: 1 year

3. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindications to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval

2. Patient must have a therapeutic failure to no less than a one-month trial on at least one medication not requiring prior approval.

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GENITOURINARY AGENTS: URINARY ANTISPASMODICS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ENABLEX [®] FLAVOXATE (generic of Urispas [®]) OXYBUTYNIN tablets (generic of Ditropan [®]) OXYBUTYNIN 5mg/5ml syrup (generic of Ditropan [®]) SANCTURA [®] SANCTURA XR [®] VESICARE [®]	DETROL [®] DETROL [®] LA GELNIQUE [®] OXYBUTYNIN ER (generic of Ditropan [®] XL) OXYTROL [®] TOVIAZ [®]

Infectious Disease Agents: Cephalosporins – Oral

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to product formulation (i.e. dyes, fillers)
 - If allergy to drug class, should question medication request
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication. Document details.
 - Note diagnosis and any culture and sensitivity reports
3. If there have been therapeutic failures to no less than a three-day trial of at least one medication not requiring prior approval, then may approve the requested medication.

Document clinically compelling information

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

INFECTIOUS DISEASE AGENTS: CEPHALOSPORINS, FIRST GENERATION – Oral Capsules and Tablets

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CEFADROXIL 500mg (generic of Duricef®) CEPHALEXIN (generic of Keflex®)	CEFADROXIL 1 gram (generic of Duricef®) KEFLEX 750mg capsule VELOSEF® (Cephadrine)

INFECTIOUS DISEASE AGENTS: CEPHALOSPORINS, FIRST GENERATION – Oral Suspensions and Liquids

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CEPHALEXIN suspension (generic of Keflex® Suspension)	CEFADROXIL suspension (generic of Duricef®)

**INFECTIOUS DISEASE AGENTS: CEPHALOSPORINS, SECOND GENERATION –
Oral Capsules and Tablets**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CEFACLOR (generic of Ceclor [®]) CEFPROZIL (generic of Cefzil [®]) CEFUROXIME (generic of Ceftin [®])	CEFACLOR ER (generic of Ceclor CD [®])

**INFECTIOUS DISEASE AGENTS: CEPHALOSPORINS, SECOND GENERATION –
Oral Suspensions and Liquids**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CEFACLOR suspension (generic of Ceclor [®]) CEFTIN [®] suspension (no PA required for age 12 or under)	CEFTIN [®] suspension (PA required for age over 12) CEFUROXIME suspension (generic of Ceftin [®]) CEFPROZIL suspension (generic of Cefzil [®])

**INFECTIOUS DISEASE AGENTS: CEPHALOSPORINS, THIRD GENERATION –
Oral Capsules and Tablets**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CEDAX [®] CEFDINIR (generic of Omnicef [®])	CEFPODOXIME (generic of Vantin [®]) SPECTRACEF [®] SUPRAX [®]

**INFECTIOUS DISEASE AGENTS: CEPHALOSPORINS, THIRD GENERATION –
Oral Suspensions and Liquids**

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CEDAX [®] suspension CEFDINIR suspension (generic of Omnicef [®])	SUPRAX [®] suspension CEFPODOXIME suspension (generic of Vantin [®])

Infectious Disease Agents: Macrolides – Oral

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to product formulation (i.e. dyes, fillers)
 - If allergy to drug class, should question medication request
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication. Document details.
 - Note diagnosis and any culture and sensitivity reports
3. If there has been a therapeutic failure to no less than a three-day trial of at least one medication not requiring prior approval, then may approve the requested medication.

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ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

INFECTIOUS DISEASE AGENTS: MACROLIDES - ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AZITHROMYCIN tablets and suspension (generic of Zithromax [®])	PCE [®]
CLARITHROMYCIN tablets and suspension (generic of Biaxin [®])	ZMAX [™] (Azithromycin E.R) for oral suspension
CLARITHROMYCIN ER (generic of Biaxin XL [®])	
ERY-TAB [®]	
ERYPED [®]	
ERYTHROCIN STEARATE [®]	
ERYTHROMYCIN BASE	
ERYTHROMYCIN ETHYLSUCCINATE	
ERYTHROMYCIN W/SULFISOXAZOLE	

Infectious Disease Agents: Quinolones – Oral

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication.
 - Note diagnosis and any culture and sensitivity reports
3. If there has been a therapeutic failure to at least a three-day trial of at least one medication not requiring prior approval, then may approve the requested medication.

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ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.
2. If the prescriber expresses concern over safety issues of a preferred agent (e.g., cardiotoxicity associated with Avelox[®]), a non-preferred agent may be approved.

INFECTIOUS DISEASE AGENTS: QUINOLONES, SECOND GENERATION - ORAL

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CIPROFLOXACIN (generic of Cipro [®]) CIPRO [®] suspension (no PA required for age 12 or under)	CIPROFLOXACIN ER (generic of Cipro [®] XR) CIPRO [®] suspension (PA required for age over 12) NOROXIN [®] OFLOXACIN (generic of Floxin [®]) PROQUIN [®] XR

INFECTIOUS DISEASE AGENTS: QUINOLONES, THIRD GENERATION - ORAL

NO PA REQUIRED “PREFERRED”	PA REQUIRED
AVELOX [®] AVELOX ABC PACK [®]	LEVAQUIN [®]

INFECTIOUS DISEASE AGENTS: QUINOLONES, FOURTH GENERATION - ORAL

NO PA REQUIRED “PREFERRED”	PA REQUIRED
	FACTIVE [®]

Infectious Disease Agents: Anti-Virals – Herpes

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

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

INFECTIOUS DISEASE AGENTS: ANTIVIRALS - HERPES

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ACYCLOVIR (generic of Zovirax [®]) ACYCLOVIR 200mg/5ml suspension (generic of Zovirax [®]) VALTREX [®]	FAMCICLOVIR (generic of Famvir [®])

Infectious Disease Agents: Agents for Onychomycosis & Systemic Infections

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

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval:
 - Drug interactions (inhibition of CYP450 system)
 - Ketoconazole > Itraconazole > Voriconazole > Fluconazole
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the patient has a serious illness that causes them to be immunocompromised [i.e. AIDS, cancer, organ (solid or non-solid) transplant] then may approve the requested medication.

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ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring prior approval, then may approve the requested medication.
2. If the request is for a diagnosis other than fungal infection, please refer the case to a pharmacist. An off label use (see Facts and Comparisons) may be approvable for a medication such as Nizoral[®] for advanced prostate cancer or for Cushing's Syndrome when standard treatments have failed.

INFECTIOUS DISEASE AGENTS: AGENTS FOR ONYCHOMYCOSIS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
GRIFULVIN [®] V tablets GRISEOFULVIN suspension (generic of Grifulvin [®] V) GRIS-PEG [®] CICLOPIROX solution (generic of Penlac [®]) TERBINAFINE (generic of Lamisil [®])	CICLOPIROX kit (generic of CNL [®] Nail lacquer kit) ITRACONAZOLE (generic of Sporanox [®]) LAMISIL Granules SPORANOX [®] 100mg/10ml oral solution

INFECTIOUS DISEASE AGENTS: AGENTS FOR SYSTEMIC INFECTIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
FLUCONAZOLE suspension (generic of Diflucan [®]) FLUCONAZOLE (generic of Diflucan [®]) KETOCONAZOLE (generic of Nizoral [®])	ITRACONAZOLE CAPSULES (generic of Sporanox [®]) NOXAFIL [®] SPORANOX [®] 100mg/10ml oral solution

Infectious Disease Agents: Hepatitis C Agents – Pegylated Interferons & Ribavirins

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to a medication within the same class which does not require prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

- Pegylated Interferons have a Black Box Warning which indicates that a patient should be monitored closely with periodic clinical and laboratory evaluations.
- Ribavirins are contraindicated in women who are pregnant and in their male partner(s). At least two reliable forms of contraception must be used during therapy.

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INFECTIOUS DISEASE AGENTS: HEPATITIS C - PEGYLATED INTERFERONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
PEGASYS® PEGASYS CONV. PACK® PEG-INTRON® PEG-INTRON REDIPEN®	

HEPATITIS C - RIBAVIRINS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
RIBASPHERE® RIBAVIRIN (generic of Rebetol®)	COPEGUS® REBETOL®

Injectable Antirheumatic Agents

LENGTH OF AUTHORIZATIONS: 1 year

All products in this class require clinical prior authorization:

- No current infection; and
- Prior non-biologic therapy appropriate for diagnosis; and
- Diagnosis of one of the following:
 - Rheumatoid Arthritis
 - Psoriatic Arthritis
 - Polyarticular Juvenile Idiopathic Arthritis
 - Crohn's Disease
 - Ankylosing Spondylitis
 - Psoriasis

PDL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

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ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a three-month trial of at least one medication not requiring prior approval

ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
CIMZIA® SYRINGE ENBREL KIT® ENBREL SURECLIK SYRINGE® ENBREL SYRINGE® HUMIRA PEN® HUMIRA CROHN'S STARTER PACK® HUMIRA SYRINGE®	SIMPONI™

ANTI-INFLAMMATORY INTERLEUKIN-1 RECEPTOR ANTAGONIST

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
KINERET® SYRINGE	

Ophthalmic Agents: Antibiotic Drops and Ointments

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills for acute infection. Refills for up to 14 days may be authorized for patients undergoing surgery.

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - If allergy to drug class, should question medication request
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication.
 - Note diagnosis and any culture and sensitivity reports

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a three-day trial of at least two medications not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

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OPHTHALMIC AGENTS: ANTIBACTERIAL - QUINOLONES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CIPROFLOXACIN drops (generic of Ciloxan®) VIGAMOX® drops	BESIVANCE® drops CILOXAN® ointment IQUIX® drops OFLOXACIN drops (generic of Ocuflor®) QUIXIN® drops ZYMAR® drops

OPHTHALMIC AGENTS: ANTIBACTERIAL – NON-QUINOLONE

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BACITRACIN ointment BACITRACIN-POLYMYXIN ointment (generic of Polysporin®) ERYTHROMYCIN ointment (generic of Ilotycin®) GENTAMICIN drops (generic of Garamycin®) GENTAMICIN ointment (generic of Garamycin®) NEOMYCIN/POLYMYXIN/BACITRACIN ointment (generic of Neosporin®) NEOMYCIN/POLYMYXIN/GRAMICIDIN drops (generic of Neosporin®) POLYMYXIN/TRIMETHOPRIM drops (generic of Polytrim®) TOBRAMYCIN drops (generic of Tobrex®) TOBREX® ointment	AZASITE® drops

Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindications to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Patient must have a therapeutic failure to at least one of the preferred agents.

Document clinically compelling information

OPHTHALMIC AGENTS: ANTIHISTAMINES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	EMADINE®

OPHTHALMIC AGENTS: ANTIHISTAMINE/MAST CELL STABILIZERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ALAWAY® OPTIVAR® PATADAY™ PATANOL® ZADITOR® OTC	ALAMAST® ELESTAT® KETOTIFEN (generic of Alaway®, Zaditor®)

Ophthalmic Agents: Glaucoma Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindications to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a one-month trial of at least one medication within the same class not requiring prior approval.

Document clinically compelling information

OPHTHALMIC AGENTS: GLAUCOMA AGENTS – BETA BLOCKERS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
BETAXOLOL (generic of Betoptic®) BETIMOL® CARTEOLOL (Generic of Ocupress®) LEVOBUNOLOL (generic of Betagan®) METIPRANOLOL (generic of Optipranolol®) TIMOLOL solution (generic of Timoptic®) TIMOLOL gel solution (generic of Timoptic-XE®)	ISTALOL™ BETOPTIC®S

OPHTHALMIC AGENTS: GLAUCOMA AGENTS – PROSTAGLANDIN INHIBITORS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
LUMIGAN™ TRAVATAN™ TRAVATAN®Z XALATAN®	

OPHTHALMIC AGENTS: GLAUCOMA AGENTS – ALPHA ADRENERGIC AGONISTS/SYPATHOMIMETICS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ALPHAGAN®P BRIMONIDINE (generic of Alphagan®) DIPIVEFRIN (generic of Propine®)	IOPIDINE®

OPHTHALMIC AGENTS: GLAUCOMA AGENTS – CARBONIC ANHYDRASE INHIBITORS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
AZOPT® TRUSOPT®	DORZOLAMIDE (generic of Trusopt®)

OPHTHALMIC AGENTS: GLAUCOMA AGENTS – COMBINATION BETA BLOCKER AND ALPHA ADRENERGIC AGONIST

NO PA REQUIRED “PREFERRED”	PA REQUIRED
COMBIGAN [®] (Brimonidine/Timolol)	

OPHTHALMIC AGENTS: GLAUCOMA AGENTS – COMBINATION BETA BLOCKER AND CARBONIC ANHYDRASE INHIBITORS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
COSOPT [®] (Dorzolamide/Timolol)	DORZOLAMIDE/TIMOLOL (generic of Cosopt [®])

Ophthalmic NSAIDs

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills for acute use.
 Refills for up to 14 days may be authorized for patients undergoing surgery.

Is there any reason the patient cannot be changed to a medication not requiring prior approval?
 Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a three-day trial of at least one medication not requiring prior approval
- The requested medication’s corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

OPHTHALMIC NSAIDs

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ACULAR LS [®] ACULAR PF [®] ACULAR [®] DICLOFENAC (generic of Voltaren [®]) FLURBIPROFEN (generic of Ocufen [®])	NEVANAC [®] XIBROM [®]

Otic Agents: Antibacterial and Antibacterial/Steroid Combination Drops

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills for acute infection.

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication.
 - Note diagnosis and any culture and sensitivity reports

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a one-week trial of at least one medication not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

Document clinically compelling information

OTIC AGENTS: ANTIBACTERIAL – STERIOD COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CIPRO HC [®] suspension (ciprofloxacin with hydrocortisone)	CETRAXAL [®] solution
CIPRODEX [®] suspension (ciprofloxacin with dexamethasone)	CORTISPORIN-TC [®] suspension (neomycin and colistin with hydrocortisone)
COLY-MYCIN-S [®] suspension (neomycin and colistin with hydrocortisone)	PEDIOTIC [®] suspension (neomycin and polymyxin B with hydrocortisone)
NEOMYCIN-POLYMYXIN B WITH HYDROCORTISONE solution (generic of Cortisporin [®] solution)	
NEOMYCIN-POLYMYXIN B WITH HYDROCORTISONE suspension (generic of Cortisporin [®] suspension)	

OTIC AGENTS: ANTIBACTERIAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
OFLOXACIN drops (generic of Floxin Otic [®])	FLOXIN [®] singles

Respiratory Agents: Antihistamines – Second Generation

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there have been therapeutic failures after courses of treatment (e.g., one month for allergic rhinitis) with medication not requiring prior approval, then may approve the requested medication.

ADDITIONAL INFORMATION

- Fexofenadine is indicated for patients 6 years of age and older
- Loratadine is indicated for patients 2 years of age and older
- Clarinex[®] and cetirizine are indicated for patients 6 months of age and older

Document clinically compelling information

RESPIRATORY AGENTS: ANTIHISTAMINES: SECOND GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LORATADINE tablets (generic of Claritin [®])	ALAVERT [®] rapid dissolve
LORATADINE syrup (generic of Claritin [®] Syrup)	ALAVERT [®] tablets
LORATADINE rapid dissolve (generic of Claritin [®] Redi-tabs)	ALLEGRA [®] ODT
CETIRIZINE chewable (generic of Zyrtec [®]) (no PA required for age 6 or under)	ALLEGRA [®] suspension
CETIRIZINE syrup (generic of Zyrtec [®]) (no PA required for age 6 or under)	CETIRIZINE chewable (generic of Zyrtec [®]) (PA required for over age 6)
CETIRIZINE tablets (generic of Zyrtec [®])	CETIRIZINE syrup (generic of Zyrtec [®]) (PA required for over age 6)
	CLARINEX [®] tablets
	CLARINEX REDI-TABS [®]
	CLARINEX [®] syrup
	FEXOFENADINE (generic of Allegra [®])
	XYXAL [®]

RESPIRATORY AGENTS: ANTIHISTAMINE/DECONGESTANT COMBO: SECOND GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LORATADINE-D (generic of Claritin-D [®] -12HR and 24HR)	ALAVERT D-12HR [®]
	ALLEGRA-D 12 HOUR [®]
	ALLEGRA-D 24 HOUR [®]
	CETIRIZINE/PSEUDOEPHEDRINE (generic of Zyrtec- D [®])
	CLARINEX-D 24 HOUR [®]
	CLARITIN-D 12 HOUR [®]
	CLARITIN-D 24 HOUR [®]

Respiratory Agents: Beta-Adrenergic Agonists – Inhaled, Short Acting

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a two-week trial of at least one medication not requiring prior approval within the same class and formulation. (i.e., nebulizers for nebulizers).

Document clinically compelling information

ADDITIONAL INFORMATION

- Allergic reactions are rare. There is a small population of patients allergic to CFC inhalers (traditional press and breathe metered-dose inhalers) in whom Albuterol Sulfate HFA, Proventil HFA[®] or Ventolin HFA[®] inhalers will be approved.

RESPIRATORY AGENTS: BETA-ADRENERGIC, SHORT-ACTING Metered Dose Inhalers or Other Devices

NO PA REQUIRED “PREFERRED”	PA REQUIRED
PROAIR [®] HFA VENTOLIN HFA [®]	MAXAIR AUTOHALER [®] PROVENTIL HFA [®] XOPENEX HFA [®]

MAXAIR AUTOHALER[®] (Pirbuterol) will only be approved if the following is true:

- If there is an inability to use other press-and-breathe Meter Dose Inhalers due to poor technique/skill due to age or physical factors (e.g., arthritis) then Maxair Autohaler[®] will be approved.

RESPIRATORY AGENTS: BETA-ADRENERGIC, SHORT-ACTING Nebulizers

NO PA REQUIRED “PREFERRED”	PA REQUIRED
ACCUNEB [®] (Albuterol – pediatric dosing of premixed nebs) (no PA required for ages 12 and under) ALBUTEROL 0.42mg/ml, 0.63mg/ml (generic of Accuneb [®]) (no PA required for ages 12 and under) ALBUTEROL (generic of Proventil [®] , Ventolin [®]) 0.083% Premixed nebulizers, 0.5% Concentrated Solution)	ACCUNEB [®] (Albuterol – pediatric dosing of premixed nebs) (PA required for over age 12) ALBUTEROL 0.42mg/ml, 0.63mg/ml (generic of Accuneb [®]) (PA required for over age 12) XOPENEX [®]

Respiratory Agents: Beta-Adrenergic Agonists – Inhaled, Long Acting

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a two-week trial of at least one medication not requiring prior approval within the same class and formulation. (i.e., nebulizers for nebulizers).

Document clinically compelling information

Step therapy required for all long-acting beta agonists and combinations:

Criteria	Approval Length
>= 3 claims for LABA (formoterol or salmeterol alone or in combination with steroid) in previous 6 months	6 months
>= 1 claim for anticholinergic (ipratropium, tiotropium, ipratropium/albuterol) in previous 6 months	12 months
>= 3 claims for inhaled corticosteroid (beclomethasone, budesonide, flunisolide, fluticasone, mometasone, triamcinolone) in previous 12 months	6 months
>= 3 claims for leukotriene modifier (montelukast, zafirlukast, zileuton) in previous 12 months	6 months
>= 3 claims for theophylline in previous 12 months	6 months
>= 3 claims for oral corticosteroid in previous 4 months	6 months
Diagnosis is COPD or exercise-induced bronchospasm	12 months
Diagnosis is moderate persistent or severe persistent asthma, or partly controlled or uncontrolled asthma (see classification below)	6 months
Patient scored <= 19 on Asthma Control Test™	6 months

RESPIRATORY AGENTS: BETA-ADRENERGIC, LONG-ACTING Metered Dose Inhalers / DPIs

STEP THERAPY REQUIRED “PREFERRED”	PA REQUIRED
SEREVENT DISKUS®	FORADIL®

RESPIRATORY AGENTS: BETA-ADRENERGIC, LONG-ACTING Nebulizer Solution

STEP THERAPY REQUIRED “PREFERRED”	PA REQUIRED
	BROVANA™ PERFOROMIST®

RESPIRATORY AGENTS: BETA-ADRENERGIC Combinations

STEP THERAPY REQUIRED “PREFERRED”	PA REQUIRED
ADVAIR DISKUS® and HFA (Salmeterol/Fluticasone) SYMBICORT® (Formoterol/Budesonide)	

Respiratory Agents: COPD Anticholinergic Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a two-week trial of at least one medication not requiring prior approval within the same class and formulation. (i.e., nebulizers for nebulizers).

Document clinically compelling information

RESPIRATORY AGENTS: COPD ANTICHOLINERGICS

NO PA REQUIRED “ PREFERRED”	PA REQUIRED
ATROVENT HFA [®] (Ipratropium) COMBIVENT MDI [®] (Ipratropium/Albuterol) IPRATROPIUM nebulizer solution (generic of Atrovent [®]) IPRATROPIUM/ALBUTEROL nebulizer solution (generic of Duoneb [®]) SPIRIVA [®] (Tiotropium)	

Respiratory Agents: Glucocorticoid Agents – Inhaled

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
 - Patient’s condition is clinically unstable--patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days--changing to a medication not requiring prior approval might cause deterioration of the patient’s condition.
2. If there have been therapeutic failures to no less than one-month trials of at least two medications not requiring prior approval, then may approve the requested medication.

Document clinically compelling information

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. If a medication requiring prior approval was initiated in the hospital, then may approve the requested medication. Document details.
2. If the patient is a child under 13 years old or a patient with a significant disability, and unable to use an inhaler which does not require prior approval, or is non-compliant on an inhaler not requiring prior approval because of taste, dry mouth, infection; then may approve the requested medication. Document details.

RESPIRATORY AGENTS: GLUCOCORTICOIDS – Inhaled

NO PA REQUIRED “PREFERRED”	PA REQUIRED
AEROBID® AEROBID-M® ASMANEX® AZMACORT® FLOVENT® HFA QVAR®	ALVESCO® PULMICORT FLEXHALER®

RESPIRATORY AGENTS: GLUCOCORTICOIDS – Nebulizers *

NO PA REQUIRED “PREFERRED”	PA REQUIRED
PULMICORT® NEBULIZER SOLUTION (no PA required for age 8 or under)	PULMICORT® NEBULIZER SOLUTION (PA required for over age 8)

*Patients on current regimens will be grandfathered.

Respiratory Agents: Leukotriene Receptor Modifiers and Inhibitors

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there has been a therapeutic failure to the agent not requiring prior approval, then may approve the requested medication.

Document clinically compelling information

RESPIRATORY AGENTS: LEUKOTRIENE RECEPTOR ANTAGONISTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACCOLATE® SINGULAIR® CHEWABLE TABLETS SINGULAIR® TABLETS SINGULAIR® ORAL GRANULES	ZYFLO CR®

Respiratory Agents: Nasal Preparations

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there have been therapeutic failures to no less than one-month trials of at least two medications not requiring prior approval, then may approve the requested medication.

Document clinically compelling information

RESPIRATORY AGENTS: NASAL PREPARATIONS - GLUCOCORTICOIDS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
FLUTICASONE (generic of Flonase®) NASONEX®	BECONASE®AQ FLUNISOLIDE (generic of Nasarel®) NASACORT®AQ NASAREL™ OMNARIS® RHINOCORT®AQ VERAMYST™

RESPIRATORY AGENTS: NASAL PREPARATIONS - ANTIHISTAMINES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ASTELIN® ASTEPRO® PATANASE®	

RESPIRATORY AGENTS: NASAL PREPARATIONS - ANTICHOLINERGICS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
IPRATROPIUM (generic of Atrovent®)	

Topical Agents: Acne Preparations

LENGTH OF AUTHORIZATIONS: 1 year

CLINICAL CRITERIA:

All topical retinoids require prior authorization for patients over age 23:

- Patient diagnosis psoriasis – may approve tazarotene (Tazorac®)
- Patient diagnosis acne vulgaris – may approve retinoid if the patient has a history of at least 30 days of therapy with alternative therapy (benzoyl peroxide, sodium sulfacetamide or antibiotic) in the previous 90 days
- Patient diagnosis skin cancer – may approve retinoid

PDL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a one-month trial of at least one medication in the same class not requiring prior approval

ANTIBIOTIC PRODUCTS

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CLINDAMYCIN gel (generic of Cleocin T®, Clindamax®)	AKNE-MYCIN® ointment
CLINDAMYCIN lotion (generic of Cleocin T®, Clindamax®)	CLINDAGEL®
CLINDAMYCIN pledgets (generic of Cleocin T®)	ERY PADS®
CLINDAMYCIN solution (generic of Cleocin T®)	EVOCLIN® foam
ERYTHROMYCIN gel (generic of Erygel®)	
ERYTHROMYCIN solution (generic of A/T/S®, Akne-Mycin®)	

BENZOYL PEROXIDE AND COMBINATION PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BENZACLIN [®] gel (benzoyl peroxide and clindamycin)	BENZAMYCINPAK [®] gel (benzoyl peroxide and erythromycin)
BENZOYL PEROXIDE cleanser (generic of Oscion [®] , Triaz [®])	BENZOYL PEROXIDE pads (generic of Oscion [®] , Triaz [®])
BENZOYL PEROXIDE gel (generic of Benzac AC [®] , Benzagel [®] , Desquam-X [®])	BENZOYL PEROXIDE MICROSPHERES cream (generic of Neobenz Micro [®])
BENZOYL PEROXIDE lotion (generic of Zaclir [®])	BENZOYL PEROXIDE-UREA cleanser (generic of Zoderm [®])
BENZOYL PEROXIDE wash (generic of Benzac AC [®] , Benzac W [®] , Brevoxyl [®] , Desquam-X [®])	BENZOYL PEROXIDE-UREA cream (generic of Zoderm [®])
ERYTHROMYCIN-BENZOYL PEROXIDE gel (generic of Benzamycin [®])	BENZOYL PEROXIDE-UREA gel (generic of Zoderm [®])
NEOBENZ MICRO [®] cream	BENZOYL PEROXIDE-UREA pads (generic of Zoderm [®] redi-pads)
ZACLIR [®] lotion	BENZOYL PEROXIDE-UREA wash (generic of Zoderm [®] hydrating wash)
ZODERM [®] cream	DUAC CS [®] kit (benzoyl peroxide and clindamycin)
	DUAC [®] gel (benzoyl peroxide and clindamycin)
	NEOBENZ MICRO [®] wash
	NEOBENZ MICRO SD [®] cream

OTHER PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AZELEX [®] cream	ACZONE [®] gel (dapsone)
	FINACEA [®] gel

RETINOID AND COMBINATION PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DIFFERIN [®] cream	ATRALIN [®] gel
DIFFERIN [®] gel	EPIDUO [®] gel (adapalene and benzoyl peroxide)
TAZORAC [®] cream	TRETINOIN cream (generic of Avita [®] , Retin-A [®])
TAZORAC [®] gel	TRETINOIN gel (generic of Avita [®] , Retin-A [®])
RETIN-A [®] cream	
RETIN-A [®] gel	
RETIN-A MICRO [®] gel	
ZIANA [®] gel (clindamycin and tretinoin)	

SODIUM SULFACETAMIDE AND COMBINATION PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
KLARON [®] lotion	AVAR [®] gel SODIUM SULFACETAMIDE cream (generic of Ovace [®]) SODIUM SULFACETAMIDE gel (generic of Ovace [®]) SODIUM SULFACETAMIDE lotion (generic of Klaron [®]) SODIUM SULFACETAMIDE wash (generic of Ovace [®]) SODIUM SULFACETAMIDE cream (generic of Avar-E [®]) SODIUM SULFACETAMIDE-SULFUR cleanser kit SODIUM SULFACETAMIDE-SULFUR lotion (generic of Sulfacet-R [®]) SODIUM SULFACETAMIDE-SULFUR pads (generic of Plexion [®] cleansing cloths) SODIUM SULFACETAMIDE-SULFUR suspension (generic of Plexion [®] TS) SODIUM SULFACETAMIDE-SULFUR wash (generic of Avar [®] cleanser, Plexion [®] cleanser, Rosac [®] wash) SODIUM SULFACETAMIDE-SULFUR-AVOBENZONE cream (generic of Rosac [®] cream) SODIUM SULFACETAMIDE-SULFUR-UREA cleanser (generic of Rosula [®] cleanser) SODIUM SULFACETAMIDE-SULFUR-UREA gel (generic of Rosula [®] aqueous gel) SODIUM SULFACETAMIDE-SULFUR-UREA wash (generic of Rosula [®] clarifying wash) SODIUM SULFACETAMIDE-SULFUR-UREA WITH SUNSCREEN kit (generic of Rosula [®] CLK) SODIUM SULFACETAMIDE-SULFUR-WITCH HAZEL cream (generic of Plexion [®] SCT cream) SODIUM SULFACETAMIDE-UREA pads (generic of Rosula [®] NS medicated pads)

Topical Agents: Anti-Fungals

LENGTH OF AUTHORIZATIONS: Duration of the prescription (up to 6 months)

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to at least two medications not requiring prior approval
 - Contraindication to all medications not requiring prior approval
 - History of unacceptable/toxic side effects to at least two medications not requiring prior approval

2. Is the infection caused or presumed to be caused by an organism resistant to medications not requiring prior approval? If so, document (including diagnosis and location) and approve the requested drug.

3. Has the patient failed therapeutic trials of two weeks with two medications not requiring prior approval? If so, document and approve the requested medication.

Document clinically compelling information

INFECTIOUS DISEASE AGENTS: ANTI-FUNGALS – Topical

NO PA REQUIRED “PREFERRED”	PA REQUIRED
CICLOPIROX cream, topical suspension (generic of Loprox [®]) CLOTRIMAZOLE (generic of Lotrimin [®]) CLOTRIMAZOLE/BETAMETHASONE (generic of Lotrisone [®]) KETOCONAZOLE Cream & Shampoo (generic of Kuric [®] , Nizoral [®]) LOPROX [®] MICONAZOLE MICRO-GUARD [®] powder NAFTIN [®] NYSTATIN (generic of Nystop [®] , Mycostatin [®] , Nilstat [®]) NYSTATIN W/TRIAMCINOLONE (generic of Mytrex [®]) OXISTAT [®] TERBINAFINE (generic of Lamisil [®]) TOLNAFTATE (generic of Tinactin [®]) VUSION [®]	CICLOPIROX gel (generic of Loprox [®]) ECONAZOLE (generic of Spectazole [®]) ERTACZO [®] EXELDERM [®] MENTAX [®] PEDI-DRI [®] powder XOLEGEL [™]

Topical Agents: Anti-Parasitics

LENGTH OF AUTHORIZATIONS: 2 weeks

Is there any reason the patient cannot be changed to a medication not requiring prior approval?
Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

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ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a one-month trial of at least one medication not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

ANTI-PARASITICS, TREATMENT OF SCABIES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
EURAX [®] cream PERMETHRIN cream (generic of Elimate [®])	EURAX [®] lotion LINDANE lotion

ANTI-PARASITICS, TREATMENT OF LICE

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LICE kit [piperonyl butoxide-pyrethrins shampoo, comb, permethrin home spray] (generic of Rid [®] complete kit) OVIDE [®] lotion PERMETHRIN lotion (generic of Nix [®] cream rinse) PIPERONYL BUTOXIDE-PYRETHRINS lotion PIPERONYL BUTOXIDE-PYRETHRINS shampoo (generic of Rid [®] shampoo)	LINDANE [®] shampoo MALATHION lotion (generic of Ovide [®]) ULESFIA [®] lotion

Topical Agents: Immunomodulators

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there has been a therapeutic failure to an agent not requiring prior approval, then may approve the requested medication.

Document clinically compelling information

CLINICAL INFORMATION

- Indicated for short-term and intermittent long-term treatment of atopic dermatitis if:
 - Alternative, conventional therapies (such as topical corticosteroids) are deemed inadvisable because of potential risks, or
 - There has been inadequate response or intolerance to alternative, conventional therapies (such as topical corticosteroids)
- Elidel[®] and Protopic[®] 0.03% are indicated in patients 2 years old or older. Protopic[®] 0.1% is indicated in adults only

TOPICAL IMMUNOMODULATORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ELIDEL [®] * PROTOPIC [®] *	

* Elidel[®] & Protopic[®] have age restriction of 2 years or older

Topical Agents: Pleuromutilin Derivatives

LENGTH OF AUTHORIZATIONS: for the date of service only. Approval should be for 5g or 10g tube size; 15g tube may only be approved for large areas of infection (100cm²).

Is there any reason the patient cannot be changed to a medication not requiring prior approval?
Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Note: alternative therapy may be oral or topical antibiotic therapy

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a [length of trial to be discussed] trial of at least [number of medications to be discussed] medications not requiring prior approval

PLEUROMUTILIN DERIVATIVES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ALTABAX [®] 5 gram and 10 gram tubes	ALTABAX [®] 15 gram tube

Topical Agents: Post-Herpetic Neuralgia

LENGTH OF AUTHORIZATIONS: 3 months

Is there any reason the patient cannot be changed to a medication not requiring prior approval?
Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

ADDITIONAL INFORMATION

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a one-month trial of at least two oral medications used for post-herpetic neuralgia.

POST-HERPETIC NEURALGIA, TOPICAL AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LIDODERM®	