Colorado Department of Health Care Policy and Financing
Preferred Drug List (PDL)
Effective October 1, 2018

PA Forms: Available online at https://www.colorado.gov/hcpf/pharmacy-resources
PA Requests: Colorado Pharmacy Call Center Phone Number: 800-424-5725 | Colorado Pharmacy Call Center Fax Number: 800-424-5881
The PDL applies to Medicaid fee-for-service members. It does not apply to members enrolled in Rocky Mountain Health HMO or Denver Health Medicaid Choice.

Initiation of pharmaceutical product subject to Prior Authorization:
Please note that starting the requested drug, including a non-preferred drug, prior to a PA request being reviewed and approved, through either inpatient use, by using office "samples", or by any other means, does not necessitate Medicaid approval of the PA request.

Health First Colorado, at 25.5-5-501, requires the generic of a brand name drug be prescribed if the generic is therapeutically equivalent to the brand name drug. Exceptions to this rule are: 1) If the brand name drug is more cost effective than the generic as determined by the Department, 2) If the patient has been stabilized on a brand name drug and the prescriber believes that transition to a generic would disrupt care, and 3) If the drug is being used for treatment of mental illness, cancer, epilepsy, or human immunodeficient virus and acquired immune deficiency syndrome.

Brand Name Required = BNR, Prior Authorization = PA, AutoPA = authorization can be automated at the point of sale transaction if criteria is met
Preferred drug list applies only to prescription (RX) products, unless specified

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred products will be approved for one year unless otherwise stated.)
I. Analgesics		
Therapeutic Drug Class: **NON-OPIOID ANALGESIA AGENTS -Oral** - *Effective 7/1/2018*		
No PA Required Duloxetine 20mg, 30mg, 60mg Gabapentin capsule, tablet, solution	**PA Required** CYMBALTA (duloxetine) Duloxetine 40mg Gralise (gabapentin) Irenka (duloxetine)	Prior authorization for non-preferred oral agents will be approved if member has trialed/failed with an adequate 8-week trial of duloxetine (20mg, 30mg, or 60mg) AND an 8-week trial of gabapentin or Lyrica. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction AND Duloxetine (20mg, 30mg, or 60mg) will be approved for members with a diagnosis of fibromyalgia, neuropathic pain, or chronic musculoskeletal pain (e.g. osteoarthritis or chronic lower back pain) through automated verification (AutoPA) upon claim submission of the corresponding ICD-10 diagnosis code related to indicated use of the medication

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
LYRICA capsules (pregabalin)	LYRICA CR tablets, solution (pregabalin) Neurontin (all forms) SAVELLA (milnacipran)	Prior authorization will be required for Lyrica dosages > 600mg per day (maximum of 3 capsules daily) and gabapentin dosages > 3600mg per day.
Therapeutic Drug Class: **NON-OPIOID ANALGESIA AGENTS -Topical -** *Effective 7/1/2018*		
No PA Required Lidocaine Patch	**PA Required** DermacinRx PHN Pak Lidoderm Patch (lidocaine)	Non-preferred topical products require a trial/failure with an adequate 8-week trial of gabapentin AND Lyrica AND duloxetine AND lidocaine patch. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. Prior authorization will be required for Lidocaine Patch quantities exceeding 90 patches per 30 days (maximum of 3 patches daily).
Therapeutic Drug Class: **NON-STEROIDAL ANTI-INFLAMMATORIES (NSAIDS)- Oral** - *Effective 1/1/2018*		
No PA Required Diclofenac sodium IR tablets, ER tablets Ibuprofen suspension, tablets (RX) Indomethacin capsule, ER Ketorolac tablet** Meloxicam tablet Naproxen EC, suspension, and tablets (RX) Sulindac	**PA Required** ARTHROTEC (diclofenac sodium / misoprostol) tablet CELEBREX (celecoxib) Celecoxib Diclofenac potassium Diclofenac sodium / misoprostol Diflunisal DUEXIS (ibuprofen/famotidine) Etodolac capsule, IR and ER tablet Fenoprofen capsule and tablet INDOCIN (indomethacin) suspension, capsule	Non-preferred oral agents will be approved for members who have trialed 3 preferred agents. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) **DUEXIS** (ibuprofen/famotidine) or **VIMOVO** (naproxen/esomeprazole) will be approved if the member meets the following criteria: • Trial and failure of all preferred NSAIDs at maximally tolerated doses **AND** • Trial and failure of three preferred proton pump inhibitors in combination with NSAID within the last 6 months **AND** • Have a documented history of gastrointestinal bleeding (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) ***CELEBREX** (celecoxib) will be approved if the member meets the following criteria: • Has a diagnosis of one of the following: o Acute Pain o Dysmenorrhea o Ankylosing Spondylitis o Familial Adenomatous Polyposis o Osteoarthritis o Rheumatoid Arthritis o Juvenile Rheumatoid Arthritis **AND** • Has trial and failure of three preferred agents (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Ketoprofen IR, ER LODINE (etodolac tablet) Meclofenamate capsule Mefenamic acid Meloxicam suspension MOBIC (meloxicam tablet) Nabumetone NALFON (fenoprofen capsule) Naproxen CR Oxaprozin Piroxicam TIVORBEX (indomethacin) Tolmetin sodium tablet, capsule VIMOVO (naproxen/esomeprazole) VIVLODEX (meloxicam) VOLTAREN XR (diclofenac sodium ER) tablet ZIPSOR (diclofenac potassium) ZORVOLEX (diclofenac)	**Ketorolac tablets quantity limit: 5 days of therapy for every 30 days = 20 tablets for 30 days

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

Therapeutic Drug Class: **NON-STEROIDAL ANTI-INFLAMMATORIES (NSAIDS)- Non-Oral -** *Effective 1/1/2018*		
No PA Required Voltaren (diclofenac) 1% gel BNR	**PA Required** DERMACINRX LEXITRAL (Diclofenac/capsicum topical kit) Diclofenac sodium 1% (generic Voltaren) gel Diclofenac 1.5% topical solution FLECTOR 1.3% PATCH (diclofenac) PENNSAID (diclofenac solution) 2% Pump, 2% Solution Packet SPRIX (ketorolac nasal spray) VOPAC MDS 1.5% SPRAY KIT (diclofenac) XYRLIX Kit (diclofenac)	Non-preferred topical agents will be approved for members who have failed Voltaren gel. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) **SPRIX** (ketorolac nasal spray) will be approved if the member meets the following criteria: • Unable to tolerate, swallow or absorb oral NSAIDs **OR** • Trial and failure of three preferred oral or topical NSAID agents (failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)

Opioid Utilization Policy (long-acting and short-acting opioids):

Total Morphine Milligram Equivalent Policy Effective 10/1/17:
The maximum allowable morphine milligram equivalent (MME) is 250 MME. Prescriptions for short-acting (SA) and long-acting (LA) opioids are cumulatively included in this calculation. The prescription that exceeds the cumulative MME limit of 250 MME for a member will require prior authorization.

- PA will be granted to allow for tapering
- Prior authorization for 1 year will be granted for diagnosis of sickle cell anemia
- Prior authorization for 1 year will be granted for admission to or diagnosis of hospice or end of life care
- Prior authorization for 1 year will be granted for pain associated with cancer
- Only one LA opioid agent (including different strengths) and one SA opioid agent (including different strengths) will be allowed concomitantly

MME calculation is conducted using conversion factors from the following website: http://agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm

Medicaid provides guidance on the treatment of pain, including tapering, on our webpage under the heading Pain Management Resources and Opioid Use at: https://www.colorado.gov/pacific/hcpf/pain-management-resources-and-opioid-use

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

It is highly encouraged that the healthcare team utilize the Prescription Drug Monitoring Program (PDMP) to aid in ensuring safe and efficacious therapy for members using controlled substances.

Opioid Naïve Policy Effective 8/1/17 (*Update effective 5/29/18 in Italics)*:
Members who have not filled a prescription for an opioid within the past *180* days will be identified as "opioid treatment naïve" and have the following limitations placed on the initial prescription(s):

- The prescription is limited to short-acting opioid agents only. Use of long-acting opioid agents will require prior authorization approval for members identified as opioid treatment naïve.
- The days supply of the first, second, and third prescription for an opioid will be limited to 7 days, the quantity will be limited to 8 dosage forms per day (tablets, capsules), maximum #56 tablets/capsules for a 7 day supply
- The fourth prescription for an opioid will require prior authorization, filling further opioid prescriptions may require a provider to provider telephone consultation with the pain management physician provided by Medicaid at no charge to provider or member
- If a member has had an opioid prescription filled within the past *180* days, then this policy would not apply to that member and other opioid policies would apply as applicable.

Only one long-acting oral opioid agent (including different strengths) and one short-acting opioid agent (including different strengths) will be considered for a prior authorization.

Therapeutic Drug Class: **OPIOIDS, Short Acting -***Effective 7/1/2018*

No PA Required (if criteria is met)*	PA Required	
Hydrocodone/apap tablet	Acetaminophen / codeine elixir, tablets**	*__Tramadol and tramadol-containing products__ will require prior authorization approval to verify that the following criteria are met: • Member is ≥ 12 years of age AND • If member is less than 18 years of age, tramadol is NOT being prescribed for post-surgical pain following tonsil or adenoid procedure AND • If member is between 12 and 18 years of age, member is not obese (BMI greater than 30kg/m2), does not have obstructive sleep apnea or severe lung disease AND • Non-preferred tramadol products will require trial/failure of generic tramadol tablet AND generic tramadol/APAP tablet. Failure is defined as lack of efficacy, intolerable side effects, significant drug-drug interaction, allergy, or significant adverse drug reaction including hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, or angioedema. **Rybix® ODT (tramadol hydrochloride)** will be approved without trial/failure of three preferred agents for members who meet the tramadol products criteria above AND who are unable to swallow oral tablets or absorb oral medications. **__Codeine and codeine-containing products__ will receive prior authorization approval for members meeting the following criteria: • Member is ≥ 12 years of age AND
Hydrocodone/apap solution	Butalbital / caffeine / acetaminophen w/ codeine**	
Hydrocodone/ibuprofen	Butalbital compound w/ codeine**	
Hydromorphone tablet	Butorphanol tartrate (nasal)	
Morphine IR tablet	Carisoprodol compound / codeine**	
Morphine soln	Codeine (all forms)**	
Oxycodone tablet	Dilaudid liquid	
Oxycodone Soln	Fiorinal/codeine**	
Oxycodone/apap tablet	Fioricet / codeine**	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Tramadol* Tramadol/apap tablet*	Hydromorphone liquid Ibudone Lortab Levorphanol Meperidine solution, tablet Morphine concentrated solution Norco Oxaydo oxymorphone Oxycodone / aspirin Oxycodone / acetaminophen solution Oxycodone / ibuprofen Oxycodone capsule, syringe, conc solution Pentazocine / naloxone Percocet Roxicodone tablet Nucynta*** Tylenol w/ codeine Ultracet* Ultram*	• If member is less than 18 years of age, codeine is NOT being prescribed for post-surgical pain following tonsil or adenoid procedure AND • If member is between 12 and 18 years of age, member is not obese (BMI greater than 30kg/m2), does not have obstructive sleep apnea or severe lung disease • Member is not pregnant or breastfeeding AND • Renal function is not impaired (GFR > 50 ml/min) AND • Member is not receiving strong inhibitors of CYP3A4 (e.g, erythmromycin, clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole [≥200mg daily], voriconazole, delavirdine, and milk thistle) AND • Member meets one of the following: o Member has trialed codeine or codeine-containing products in the past no history of allergy or adverse drug reaction to codeine o Member has not trialed codeine or codeine-containing products in the past and the prescriber acknowledges reading the following statement: "Approximately 1-2% of the population metabolizes codeine in a manner that exposes them to a much higher potential for toxicity. Another notable proportion of the population may not clinically respond to codeine. We ask that you please have close follow-up with members newly starting codeine and codeine-containing products to monitor for safety and efficacy." <u>Maximum Doses:</u> *Tramadol maximum dose is 400mg/day **Codeine maximum dose is 360mg/day *****Nucynta® IR (tapentadol)** will be approved for members with history of trial/failure of 7-days utilization of preferred product(s) in the last 21 days. All other Prior authorization approval for Nucynta will require trial/failure of three preferred agents. Failure is defined as lack of efficacy, intolerable side effects, significant drug-drug interaction, allergy, or significant adverse drug reaction including hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, or angioedema. Nucynta IR will have a maximum daily quantity of 6 tablets (180 tabs per 30 days). Prior authorization for all other non-preferred short-acting opioid products will be approved if the member has trialed/failed three preferred products. Failure is defined as lack of efficacy, intolerable side effects, significant drug-drug interaction, allergy, or significant adverse drug reaction including hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, or angioedema.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Zamicet	Quantity Limits: Short-acting opioids will be limited to a total of 120 tablets per 30 days (4/day) per member for members who are not included in the opioid treatment naive policy. Exceptions will be made for members with a diagnosis of a terminal illness (hospice or palliative care) or sickle cell anemia. For members who are receiving more than 120 tablets currently and who do not have a qualifying exemption diagnosis, a 6-month prior authorization can be granted via the prior authorization process for providers to taper members. Please note that if more than one agent is used, the combined total utilization may not exceed 120 units in 30 days. There may be allowed certain exceptions to this limit for acute situations (for example: post-operative surgery, fractures, shingles, car accident). Butorphanol intranasal maximum quantity is 10ml per 30 days (four 2.5ml 10mg/ml package units per 30 days).
Therapeutic Drug Class: **FENTANYL PREPARATIONS (buccal, intranasal, transmucosal, sublingual)** -*Effective 7/1/2018*		
	PA Required Abstral (fentanyl citrate) Actiq (fentanyl citrate) Fentanyl citrate Fentora (fentanyl citrate) Lazanda (fentanyl citrate) Onsolis (fentanyl citrate) Subsys (fentanyl citrate)	Fentanyl buccal, intranasal, transmucosal, and sublingual products: Prior authorization approval will be granted for members experiencing breakthrough cancer pain and those that have already received and are tolerant to opioid drugs for the cancer pain AND are currently being treated with a long-acting opioid drug. The prior authorization may be granted for up to 4 doses per day. For patients in hospice or palliative care, prior authorization will be automatically granted regardless of the number of doses prescribed. Ionsys transdermal system requires administration in the hospital setting and is not covered under the pharmacy benefit
Therapeutic Drug Class: **OPIOIDS, Long Acting** -*Effective 7/1/2018*		
No PA Required **FIRST LINE** Fentanyl patches 12mcg, 25mcg, 50mcg, 75mcg, 100mcg Methadone (generic Dolophine)	**PA Required** **ONE STEP:** BUTRANS (buprenorphine) patch NUCYNTA ER (tapentadol ER) **TWO STEPS:**	One Step: **Butrans** patches and **Nucynta ER** will be approved for members who have failed treatment with ONE preferred agent in the last 6 months. (Failure is defined as lack of efficacy, allergy*, intolerable side effects, or significant drug-drug interaction.) Two Steps: Other Non-preferred, long-acting oral opioids will be approved for members who have failed treatment with two preferred agents in the last six months. (Failure is defined as lack of efficacy, allergy*, intolerable side effects, or significant drug-drug interaction.)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Morphine ER (generic MS Contin) Tramadol ER (generic Ultram ER)	BELBUCA (buprenorphine) buccal film CONZIP (TRAMADOL ER) DOLOPHINE (methadone) DURAGESIC (fentanyl patch) EMBEDA (morphine/naltrexone) EXALGO (hydromorphone ER) Fentanyl patches 37mcg, 62mcg, 87mcg Hydromorphone ER KADIAN (morphine ER capsules) brand and generic MS CONTIN (morphine ER) MORPHABOND (morphine ER) OPANA ER (oxymorphone ER) Tramadol ER (generic Ryzolt and generic Conzip) VANTRELA ER (hydrocodone bitartrate) XARTEMIS XR (oxycodone/acetaminophen) XTAMPZA ER (oxycodone ER) **THREE STEPS:** HYSINGLA (hydrocodone ER) OXYCONTIN (oxycodone ER)	*Allergy: hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, and angioedema Three Steps: **ZOHYDRO ER** and **HYSINGLA® ER** and **OXYCONTIN** (new starts) will be approved for members who have failed treatment with two preferred products, AND at least one other long acting opiate in the past year. **OXYCONTIN®, OPANA ER®, NUCYNTA ER®,** and **ZOHYDRO ER®** will only be approved for twice daily dosing. **HYSINGLA ER®** will only be approved for once daily dosing. **Fentanyl patches** will require a PA for doses of more than 15 patches/30 days (taking one strength) or 30 patches for 30 days (taking two strengths). For fentanyl patch strengths of 37mcg/hr, 62mcg/hr, and 87mcg/hr. Member must trial and fail two preferred strengths of separate patches summing desired dose (i.e. 12mcg/hr + 50mcg/hr =62mcg/hr)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	ZOHYDRO ER (hydrocodone ER)	

II. Anti-Infectives

Therapeutic Drug Class: **ANTI-HERPETIC AGENTS- Oral** -*Effective 1/1/2018*

No PA Required	PA Required	
Acyclovir tablet, capsule Acyclovir suspension (members under 5 years only)	FAMVIR (famciclovir) Famciclovir SITAVIG (acyclovir) VALTREX (valacyclovir) Valacyclovir ZOVIRAX (acyclovir)	Non-preferred products will be approved for members who have failed an adequate trial with acyclovir (diagnosis, dose and duration) as deemed by approved compendium (see table below) (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) For members with a diagnosis of Bell's palsy, valacyclovir 1000 mg three times daily will be approved for 7 days if member presents with severe facial palsy. Acyclovir suspension will be approved for members ≥ 5 years who have a feeding tube.

Acyclovir Dosing Table

Indication	Adult	Pediatric
Genital herpes simplex: initial	400 mg orally 3 times daily for 7 to 10 days or 200 mg orally 5 times daily (guideline dosing) for 10 days.	12 years or older, 1000 to 1200 mg/day orally in 3 to 5 divided doses for 7 to 10 days.
Genital herpes simplex: episodic	400 mg orally 3 times daily for 5 days or 800 mg orally twice daily for 5 days or 800 mg orally 3 times daily for 2 days (guideline dosing); or 200 mg orally every 4 hours, 5 times daily for 5 days; initiate at earliest sign or symptom of recurrence.	12 years or older, 1000 to 1200 mg/day orally in 3 divided doses for 3 to 5 days
Genital herpes simplex: Suppressive An adequate trial of acyclovir for Genital Herpes Simplex (Suppressive) will be one month.	400 mg orally twice daily for up to 12 months; alternative dosing, 200 mg orally 3 to 5 times daily.	12 years or older, 800 to 1200 mg/day orally in 2 divided doses for up to 12 months
Genital Herpes Simplex with HIV infection: Initial or Recurrent	400 mg ORALLY 3 times daily for 5 to 14 days	< 45 kg: 20 mg/kg (MAX, 800 mg) ORALLY 4 times daily for 7 to 10 days or until no new lesions appear for 48 hours. Adolescents: 400 mg ORALLY twice daily for 5 to 14 days.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Genital Herpes Simplex with HIV infection: Chronic suppression	400 mg orally twice daily	
Herpes labialis	400 mg orally 3 times daily for 5 to 10 days OR Topically 5 times daily or every 2 hours while awake for 4 days	12 years of age or older, topically 5 times daily or every 2 hours while awake for 4 days
Herpes zoster, Shingles	800 mg orally every 4 hours 5 times a day for 7 to 10 days	
Herpes Zoster, Shingles with HIV infection	800 mg orally 5 times daily for 7 to 10 days	
Varicella	800 mg orally 4 times a day for 5 days	2 years or older: 20 mg/kg ORALLY 4 times a day for 5 days; over 40 kg, 800 mg ORALLY 4 times a day for 5 days
Varicella with HIV infection	20 mg/kg (MAX, 800 mg) ORALLY 5 times daily for 5 to 7 days	20 mg/kg (MAX, 800 mg) ORALLY 4 times daily for 7 to 10 days or until no new lesions appear for 48 hours.
Therapeutic Drug Class: **ANTI-HERPETIC AGENTS- Topical -***Effective 1/1/2018*		
No PA Required DENAVIR ZOVIRAX CREAM ZOVIRAX OINTMENT **BNR**	**PA Required** Acyclovir ointment XERESE (acyclovir/hydrocortisone)	**Generic Acyclovir ointment** will be approved for members who have failed an adequate trial with Zovirax ointment (diagnosis, dose and duration) as deemed by approved compendium (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **XERESE** (acyclovir/hydrocortisone) prior authorization will be approved for members that meet the following criteria: • Documented diagnosis of recurrent herpes labialis AND • Member is immunocompetent AND • Member has failed treatment of at least 10 days with acyclovir (Failure will be defined as significant drug-drug interaction, lack of efficacy, contraindication to or intolerable side effects) AND • Member has failed treatment of at least one day with famciclovir 1500 mg OR valacyclovir 2 GM twice daily (Failure is defined as significant drug-drug interaction, lack of efficacy, contraindication to or intolerable side effects)
Therapeutic Drug Class: **TETRACYCLINES-** *Effective 7/1/2018*		
No PA Required Doxycycline hyclate capsules Doxycycline hyclate tablets	**PA Required** Demeclocycline Doryx (doxycycline)	Prior authorization for non-preferred tetracycline agents will be approved if member has trialed/failed a preferred doxycycline agent AND preferred minocycline capsules. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Doxycycline monohydrate 50mg, 100mg, capsule Doxycycline monohydrate tablets Minocycline capsules	Doxycycline hyclate tablet DR Doxycycline monohydrate 40mg, 75mg, 150mg, capsule Doxycycline monohydrate Suspension Minocycline ER Minocycline tablets Oracea (doxycycline) Solodyn (minocycline) Tetracycline Vibramycin syrup (doxycycline) Ximino (minocycline)	Prior authorization for liquid oral tetracycline formulations will be approved if member has difficulty swallowing and cannot take solid oral dosage forms. **Oracea® (doxycycline monohydrate DR)** will be approved if the member meets all of the following criteria: • Member has taken generic doxycycline for a minimum of three months and failed therapy in the last 6 months. Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions AND • Member has history of an adequate trial/failure (8 weeks) of 2 other preferred agents (oral or topical). Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions AND • Member is ≥ 18 years of age and has been diagnosed with rosacea with inflammatory lesions
Therapeutic Drug Class: **FLUOROQUINOLONES (Oral)** -*Effective 1/1/2018*		
No PA Required	**PA Required**	Non-preferred products will be approved for members who have failed an adequate trial (7 days) with at least one preferred product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
Ciprofloxacin tablet CIPRO*BNR* oral suspension (<5 years old) Levofloxacin tablet	AVELOX (moxifloxacin) BAXDELA (delafloxacin) CIPRO TABLET (ciprofloxacin) Ciprofloxacin oral suspension LEVAQUIN TABLET (levofloxacin) LEVAQUIN oral solution Levofloxacin oral solution	CIPRO suspension approved for members < 5 years of age without PA For members ≥ 5 years of age, CIPRO suspension will only be approved for those members who cannot swallow a whole or crushed tablet Levofloxacin solution will be approved for members who require administration via feeding tube OR who have failed an adequate trial (7 days) of ciprofloxacin suspension. (Failure is defined as: lack of efficacy, presence of feeding tube, allergy, intolerable side effects, or significant drug-drug interaction.)

<table>
<tr><th>Preferred Agents</th><th>Non-preferred Agents</th><th>Prior Authorization Criteria
(All Non-Preferred Products will be approved for one year unless otherwise stated.)</th></tr>
<tr><td></td><td>Ofloxacin</td><td></td></tr>
<tr><td colspan="3">Therapeutic Drug Class: HEPATITIS C VIRUS TREATMENTS -Effective 1/1/2018</td></tr>
<tr><td colspan="2">PA Required for all agents in this class</td><td rowspan="2">All preferred agents will be granted prior authorization if the following criteria are met:
• Physician attests to provide SVR12 and SVR24; AND
• Member must have received, or be in the process of receiving, full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity; AND
• Members must have genotyping results within 1 year before anticipated therapy start date; AND
• If member is abusing/misusing alcohol or controlled substances, member must be receiving or be enrolled in counseling or a substance use treatment program for at least 1 month prior to starting treatment; AND
• Agent must be prescribed by an infectious disease specialist, gastroenterologist, or hepatologist OR prescribed by any primary care provider in consultation with an infectious disease specialist, gastroenterologist or hepatologist; AND
• Physician attests to the member’s readiness for adherence; AND
o Prescribers may utilize assessment tools to evaluate readiness of the patient for treatment, some examples are available at: http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs or Psychosocial Readiness Evaluation and Preparation for Hepatitis C Treatment (PREP-C) is available at: https://prepc.org/
• Physician attests to member having Chronic HCV infection (Presence of HCV RNA viral load for ≥ 6 months to confirm infection is not acute or evidence that the infection has spontaneously resolved) AND
• The provider must provide the following laboratory tests within 12 weeks of initiating therapy:
o Complete Blood Count (CBC)
o International Normal Ratio (INR)
o Hepatic Function Panel (i.e. albumin, total and direct bilirubin, alanine aminotransferase (ALT), aspartate aminotransferase (AST), and alkaline phosphatase levels)
o Calculated glomerular filtration rate (GFR)
o If cirrhosis is present, calculation of the Child-Turcotte-Pugh (CTP) Score
o Transplant status as applicable (pre-, post-, N/A)

Preferred HCV Agent Treatment Regimens For Adults ≥18 years
GT 1-6 NC / GT 1-6 CC / GT 1-6 DC
Mavyret: 8 weeks / 12 weeks / Not Approved
Epclusa: 12 weeks / 12 weeks / 12 weeks + ribavirin
(GT-Genotype, NC-Non-Cirrhotic, CC-Compensated Cirrhosis, DC-Decompensated Cirrhosis)</td></tr>
<tr><td>MAVYRET (glecaprevir/pibrentasvir)

EPCLUSA (sofosbuvir/velpatasvir)</td><td>DAKLINZA (daclatasvir)

HARVONI (sofosbuvir/ledipasvir)

OLYSIO (simeprevir)

SOVALDI (sofosbuvir)

TECHNIVIE (ombitasvir/paritaprevir/ritonavir)

VIEKIRA PAK, XR (ombitasvir/paritaprevir/ritonavir/dasabuvir)

VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)

ZEPATIER (elbasvir/grazoprevir)</td></tr>
</table>

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

		For ribavirin-containing regimens only:
		• Member is not a pregnant female or a male with a pregnant female partner. Initial pregnancy test must be performed not more than 30 days prior to beginning therapy; **AND**
		• Women of childbearing potential and their male partners must attest that they will use two forms of effective (non-hormonal) contraception during treatment
		• Ribavirin ineligibility criteria:
		  • Pregnant women and men whose female partners are pregnant
		  • Known hypersensitivity to ribavirin
		  • Autoimmune hepatitis
		  • Hemoglobinopathies
		  • Creatinine Clearance < 50mL/min
		  • Coadministered with didanosine
		
		Non-Preferred Agents:
		All non-preferred agents or treatment regimens will be granted prior authorization if the criteria for preferred agents above is satisfied **PLUS** documentation is provided indicating an acceptable rationale for not prescribing a preferred treatment regimen. (Acceptable rationale may include: patient-specific medical contraindications to a preferred treatment, and/or member is 12 years of age or older, or is younger than 12 but weighs 35 kg or more).
		
		Re-treatment:
		All requests for HCV re-treatment for members who have failed therapy with a DAA will be reviewed on a case-by-case basis.
		
		For regimens ≥ 12 weeks in duration:
		• Physician attests that if the week 4 HCV RNA is detectable (>25 copies) while on therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e. >1 log10 IU/ml from nadir) all treatment will be discontinued unless documentation is provided which supports continuation of therapy; **AND**
		• All approvals will initially be for an 8-week time period, with further approvals dependent on the submission of HCV RNA levels at treatment times of 4 weeks, 12 weeks, and 20 weeks as applicable to justify continuing drug therapy; **AND**
		• Refills should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill. Please allow ample time for reauthorization after HCV RNA levels are submitted.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		Grandfathering: Members currently receiving treatment with a non-preferred agent will receive approval to finish their treatment regimen, provided required documentation is sent via normal PAR process. Initial Hepatitis C Treatment requests must be submitted via the Hepatitis C specific PAR form which can be accessed on the Pharmacy Resources page at: https://www.colorado.gov/hcpf/pharmacy-resources
III. Cardiovascular		
Therapeutic Drug Class: **ANGIOTENSIN MODIFIERS** -*Effective 7/1/2018*		
Angiotensin-converting enzyme inhibitors (ACEis)		
No PA Required Benazepril tablet Enalapril tablet Fosinopril tablet Lisinopril tablet Quinapril tablet Ramipril tablet	**PA Required** Captopril Epaned powder* (enalapril) Epaned solution* (enalapril) Qbrelis solution (lisinopril) moexipril perindopril trandolapril	Non-preferred ACE inhibitors, ACE inhibitor combinations, ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products will be approved for members who have failed treatment with three preferred products in the last 12 months (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). ***Epaned® (enalapril)** powder and solution will be approved without trial/failure of three preferred agents for members under the age of 5 years who cannot swallow a whole or crushed tablet.
ACEi Combinations		
No PA Required Enalapril hctz Lisinopril hctz	**PA Required** Benazepril hctz Captopril hctz Fosinopril hctz Quinapril hctz	Non-preferred ACE inhibitors, ACE inhibitor combinations, ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products will be approved for members who have failed treatment with three preferred products in the last 12 months (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction).

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Moexipril hctz	
Angiotensin II receptor blockers (ARBs)		
No PA Required BENICAR (olmesartan) Irbesartan Losartan Olmesartan Valsartan	**PA Required** ATACAND (candesartan) AVAPRO (irbesartan) Candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) Eprosartan MICARDIS (telmisartan) Telmisartan TEVETEN (eprosartan)	Non-preferred ACE inhibitors, ACE inhibitor combinations, ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products will be approved for members who have failed treatment with three preferred products in the last 12 months (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction).
ARB Combinations		
No PA Required BENICAR HCT (olmesartan/HCTZ) Losartan/HCTZ Olmesartan/HCTZ Valsartan/HCTZ	**PA Required** Amlodipine/olmesartan Amlodipine/valsartan Amlodipine/valsartan/hctz ATACAND HCT (candesartan/HCTZ) Candesartan/HCTZ AVALIDE (irbesartan/HCTZ)	Non-preferred ACE inhibitors, ACE inhibitor combinations, ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products will be approved for members who have failed treatment with three preferred products in the last 12 months (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction).

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	AZOR (amlodipine/olmesartan) Byvalson (nebivolol/valsartan) DIOVAN HCT (valsartan/hctz) EDARBYCLOR (azilsartan/chlorthalidone) Eprosartan/HCTZ EXFORGE (amlodipine/valsartan) EXFORGE HCT (amlodipine/valsartan/hctz) HYZAAR HCT (losartan/hctz) Irbesartan/HCTZ MICARDIS-HCT (telmisartan/HCTZ) olmesartan/amlodipine/hctz Telmisartan/HCTZ Telmisartan/amlodipine TEVETEN HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/hctz) TWYNSTA (telmisartan/amlodipine)	
Renin Inhibitors & Renin Inhibitor Combinations		
	PA Required TEKTURNA (aliskiren)	Non-preferred renin inhibitors and renin inhibitor combination products will be approved for members who have failed treatment with three preferred products in the last 12 months (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction).

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	TEKTURNA HCT (aliskiren/HCTZ)	Renin inhibitors and combinations will not be approved in patients with diabetes. Renin inhibitors are contraindicated when used in combination with an ACE-inhibitor, ACE-inhibitor combination, ARB, or ARB-combination.
Therapeutic Drug Class: **PULMONARY ARTERIAL HYPERTENSION THERAPIES** -*Effective 1/1/2018*		
Phosphodiesterase Inhibitors		
***Must meet eligibility criteria** *Sildenafil **(**generic Revatio) *ADCIRCA[BNR] (tadalafil)	**PA Required** REVATIO (sildenafil) Tadalafil	***Eligibility Criteria for all agents in the class** Approval will be granted for a diagnosis of pulmonary hypertension. **Revatio tablet** will be approved for members who have failed treatment with sildenafil AND Adcirca. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **Revatio suspension** will approved for members who are unable to take/swallow tablets
Endothelin Antagonists		
***Must meet eligibility criteria** *LETAIRIS (ambrisentan) *TRACLEER 62.5mg, 125mg (bosentan) tablet	**PA Required** OPSUMIT (macitentan) TRACLEER (bosentan) 32mg tablet for suspension	***Eligibility Criteria for all agents in the class** Approval will be granted for a diagnosis of pulmonary hypertension. **Opsumit** (macitentan) will be approved for members who have failed treatment with Letairis AND Tracleer (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **Grandfathering:** Members who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication.
Prostanoids		
***Must meet eligibility criteria** *Epoprostenol (generic) *ORENITRAM (treprostinil) *VENTAVIS (iloprost)	**PA Required** FLOLAN (brand) (epoprostenol) REMODULIN (treprostinil) TYVASO (treprostinil) VELETRI (epoprostenol) UPTRAVI (selexipag)	***Eligibility Criteria for all agents in the class** Approval will be granted for a diagnosis of pulmonary hypertension. Non-preferred products will be approved for members who have failed treatment with a Preferred Product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, contraindication to IV therapy or significant drug-drug interaction) **Grandfathering:** Members who have been previously stabilized on a non-preferred product can receive approval to continue on the medication.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Guanylate Cyclase (sGC) Stimulator		
	PA Required ADEMPAS (riociguat)	**Adempas** will be approved for patients who meet the following criteria: • Patient is not a pregnant female and is able to receive monthly pregnancy tests while taking Adempas and one month after stopping therapy. AND • Women of childbearing potential and their male partners must use one of the following contraceptive methods during treatment and one month after stopping treatment (e.g, IUD, contraceptive implants, tubal sterilization, a hormone method with a barrier method, two barrier methods, vasectomy with a hormone method, or vasectomy with a barrier method). AND • Patient is not receiving dialysis or has severe renal failure (e.g, Crcl < 15 ml/min). AND • Patient does not have severe liver impairment (e.g, Child Pugh C). AND • Prescriber must be enrolled with the Adempas REMS Program. AND • Female patients, regardless of reproductive potential, must be enrolled in the Adempas REMS program prior to starting therapy. AND • Patient has a diagnosis of persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4) after surgical treatment or has inoperable CTEPH OR • Patient has a diagnosis of pulmonary hypertension and has failed treatment with a preferred product for pulmonary hypertension. (Failure is defined as a lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions).
Therapeutic Drug Class: **STATINS** -*Effective 4/1/2018*		
No PA Required Atorvastatin Pravastatin Rosuvastatin Simvastatin*	**PA Required** ALTOPREV (lovastatin ER) CRESTOR (rosuvastatin) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) LIPITOR (atorvastatin) LIVALO (pitavastatin) Lovastatin (generic Mevacor)	Non-preferred Statin/Statin combinations will be approved if the member has failed treatment with two preferred products in the last 24 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) Children**:** Altoprev, Advicor, Livalo, and Vytorin will not be approved for members < 18 years of age. Caduet, fluvastatin and lovastatin will not be approved for clients < 10 years of age. *Simvastatin 80mg dose products will only be covered for members who have been stable for more than 12 months at that dose. Providers should consider alternate preferred statins in members who have not met cholesterol goals on simvastatin at doses up to 40mg per day. Please refer to the FDA communication titled, "FDA Drug Safety Communication: New restrictions, contraindications and dose limitations for Zocor (simvastatin) to reduce the risk of muscle injury" for updated guidance on contraindications, dose limits and relative LDL lowering doses of alternatives.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	PRAVACHOL (pravastatin) ZOCOR* (simvastatin)	
Therapeutic Drug Class: **STATIN COMBINATIONS** -*Effective 4/1/2018*		
	PA Required amlodipine /atorvastatin CADUDET (amlodipine/atorvastatin) ezetimibe/simvastatin* VYTORIN* (ezetimibe/simvastatin)	Non-preferred Statin/Statin combinations will be approved if the member has failed treatment with two preferred products in the last 24 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) Children: Altoprev, Advicor, Livalo, and Vytorin will not be approved for members < 18 years of age. Caduet, fluvastatin and lovastatin will not be approved for clients < 10 years of age. *Simvastatin 80mg dose products will only be covered for members who have been stable for more than 12 months at that dose. Providers should consider alternate preferred statins in members who have not met cholesterol goals on simvastatin at doses up to 40mg per day. Please refer to the FDA communication titled, "FDA Drug Safety Communication: New restrictions, contraindications and dose limitations for Zocor (simvastatin) to reduce the risk of muscle injury" for updated guidance on contraindications, dose limits and relative LDL lowering doses of alternatives.
IV. Central Nervous System		
Therapeutic Drug Class: **ANTI-CONVULSANTS -Oral-***Effective 10/1/2018*		
No PA Required (*must meet eligibility criteria) Carbamazepine IR tablet, ER tablet, chewable, ER capsule Tegretol (carbamazepine) suspension BNR Clonazepam tablet, ODT Divalproex capsule, IR tablet, ER tablet Dilantin capsules	**PA Required** Aptiom tablet Banzel tablet, suspension Briviact soln, tablet Carbatrol ER capsule Carbamazepine suspension Celontin kapseal Depakene capsule, solution	Preferred Products: • *For preferred barbiturates (phenobarbital and primidone) please see individual sections below • All other preferred agents do not require prior authorization Non-Preferred Products: Members with a diagnosis of seizure disorder or mood disorder that are currently stabilized on any non-preferred product may continue receiving that product through AutoPA with the appropriate ICD-10 diagnosis code verified at time of claims submission **OR** Members currently stabilized on a non-preferred product that is only FDA indicated for use in seizure disorder may continue receiving that product through AutoPA. Verification of ICD-10 diagnosis code is not required. This includes the following products: Aptiom, Banzel, Briviact, Celontin, Dilantin, Fycompa, Gabitril, Keppra, Lamictal XR, Mysoline, Onfi, Oxtellar XR, Sabril, Spritam, Trileptal, Vimpat, Zarontin, Zonegran.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Ethosuxamide capsule, solution Felbatol tablet, suspension BNR Lamotrigine tablet, chewable Oxcarbazepine tablet, suspension Levetiracetam tablet, solution *Phenobarbital elixir, soln, tab Phenytek Phenytoin suspension, chewable, infatab, capsule *Primidone tablet Topiramate tablet, sprinkle cap Valproic Acid capsule, solution Zonisamide capsule	Depakote sprinkle capsule, tablet Dilantin suspension, infatab Felbamate tablet, suspension Fycompa tablet, kit Equetro capsule Gabitril tablet Keppra IR tablet, XR tablet, solution Klonopin tablet Lamictal IR tablet, XR tablet, ODT, start kit Lamotrigine ODT Mysoline tablet Onfi tablet, suspension Oxtellar XR tablet Qudexy XR capsule Spritam tablet Tegretol IR tablet, XR tablet, capsule, chewable Topamax tablet, sprinkle cap Trokendi XR capsule Trileptal tablet, suspension	For all other members, non-preferred medications require prior authorization and may be approved if meeting the following criteria: ○ Medications prescribed for seizure disorder (for Onfi (clobazam) criteria please refer to separate section below): ○ The medication is being prescribed by or in conjunction with a neurologist **AND** ○ The prescription meets the FDA approved minimum age and maximum dosing limits listed in Table 1 below **AND** ○ If medication is FDA indicated as adjunctive therapy it is being used in conjunction with another anticonvulsant medication. • Medications prescribed for all other diagnoses (diagnoses other than seizure disorder): ○ Member has history of trial and failure of eight-week trial of two preferred agents. Failure is defined as lack of efficacy, allergy, intolerable side effects contraindication to, or significant drug-drug interactions **AND** ○ The prescription meets the FDA approved minimum age and maximum dosing limit listed in Table 1 below Note: For members identified as HLA-B*15:02 positive, carbamazepine and oxcarbazepine should be avoided per Clinical Pharmacogenetics Implementation Consortium Guideline. This may be considered a trial for prior authorization approvals of a non-preferred agent. **Onfi®** (clobazam) may be approved for members who meet the following criteria: ○ Member is 1-2 years of age and has a documented diagnosis of Dravet syndrome **OR** ○ Member is > 2 years of age and with a diagnosis of seizure disorder **AND** ○ Medication is being prescribed by or in conjunction with a neurologist **AND** ○ The prescription meets the FDA approved minimum age and maximum dosing limits listed in Table 1 below **AND** ○ Member has failed a one month trial with three anticonvulsant agents. Failure is defined as lack of efficacy, allergy, intolerable side effects contraindication to, or significant drug-drug interactions. ***Phenobarbital** may be approved for seizure disorder without prior authorization through automated verification (AutoPA) of ICD-10 diagnosis code. Prior authorization will be required if not being used for seizure disorder and members may be approved if meeting the following criteria: ○ Phenobarbital is being used to treat sedation or raised intracranial pressure **OR** ○ Phenobarbital is being used to treat neonatal abstinence syndrome and meets the following: • Member has a diagnosis of non-opiate or polysubstance abuse **OR** • Member has first failed methadone for the diagnosis of opiate withdrawal **AND**

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Sabril powder packet and tablet Vimpat tablet, solution, start kit Zarontin capsule, solution Zonegran capsule	• Serum phenobarbital levels are being monitored • Duration of prior authorization approval for neonatal abstinence syndrome is 3 months ***Primidone** may be approved for seizure disorder without prior authorization through AutoPA verification of ICD-10 diagnosis code. Prior authorization will be required if not being used for seizure disorder and may be approved if primidone is being used to treat sedation or raised intracranial pressure.

Table 1: Non-preferred Anticonvulsant Product Table
Shaded rows indicate there is a preferred alternative (brand/generic is preferred)

	Minimum Age**	Maximum Dose**
Mysoline (primidone)		2000 mg per day
Dilantin (phenytoin ER)		1000 mg per loading day 600 mg maintenance dose
Peganone (ethotoin)		3000 mg per day
Celontin (methsuximide)		Not listed
Zarontin (ethosuximide)		Not listed
Klonopin (clonazepam)		
Onfi (clobazam)	1 year	40 mg per day
Aptiom (eslicarbazepine)	4 years	1600 mg per day
Carbatrol (carbamazepine ER)		1600 mg per day
Epitol (carbamazepine)		1600 mg per day
Equetro (carbamazepine ER)		1600 mg per day
Oxtellar XR (oxcarbazepine ER)		Not listed
Tegretol (carbamazepine) all except suspension		Not listed
Tegretol XR (carbazmazepine ER)		Not listed
Trileptal (oxcarbazepine)		Not listed
Depakene (valproic acid)	10 years	
Depakote (divalproex DR)	10 years	
Depakote ER (divalproex ER)	10 years	
Depakote Sprinkle (divalproex DR)	10 years	
Lamictal (lamotrigine)	2 years	400 mg per day
Lamictal ODT (lamotrigine)	2 years	400 mg per day
Lamictal XR (lamotrigine ER)	13 years	600 mg per day
Qudexy XR (topiramate ER)	2 years	400 mg per day

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

		Topamax (topiramate)	400 mg per day
		Trokendi XR (topiramate ER)	6 years 400 mg per day
		Briviact (brivaracetam)	4 years 200 mg per day
		Gabitril (tiagabine)	12 years 64 mg per day
		tiagabine	12 years 64 mg per day
		Vimpat (lacosamide)	4 years 400 mg per day
		Banzel (rufinamide)	1 year 3200 mg per day
		Felbamate	18 years
		Fycompa (perampanel)	12 years 12 mg per day
		Sabril (vigabatrin)	1 month 3000 mg per day
		Spritam (levetiracetam)	4 years 3000 mg per day
		Vigabatrin	1 month 3000 mg per day
		Zonegran (zonisamide)	16 years 600 mg per day
		Keppra (levetiracetam)	4 years 3000 mg per day
		Keppra XR (levetiracetam ER)	12 years 3000 mg per day
		** Limits based on data from FDA package insert. Approval for age/dosing that falls outside of the indicated range may be evaluated on a case-by-case basis	

Therapeutic Drug Class: **Newer Generation Antidepressants** -*Effective 1/1/2018*		
No PA Required	**PA Required**	Non-preferred products will be approved for members who have failed treatment with three Preferred Products with exceptions for duloxetine (see below). (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **Citalopram** doses higher than 40mg/day for ≤60 years of age and 20mg for >60 years of age will require prior authorization. Please see the FDA guidance at: https://www.fda.gov/drugs/drugsafety/ucm297391.htm for important safety information. **Grandfathering:** Members currently stabilized on a Non-preferred newer generation antidepressant can receive approval to continue on that agent for one year if medically necessary. **Verification may be provided from the prescriber or the pharmacy.**
Bupropion IR, SR, XL	APLENZIN ER (bupropion ER)	
Citalopram tablet, solution	CYMBALTA (duloxetine)	
Escitalopram tablet	CELEXA (citalopram)	
Fluoxetine capsules, solution	Desvenlafaxine ER	
Mirtazapine	Desvenlafaxine fumarate ER	
Paroxetine	Duloxetine	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Sertraline Venlafaxine IR tabs Venlafaxine ER capsules	EFFEXOR IR EFFEXOR XR Escitalopram solution FETZIMA (levomilnacipran) Fluoxetine tablets, fluoxetine DR capsules Fluvoxamine (generic Luvox) FORFIVO XL (bupropion ER) IRENKA (duloxetine) KHEDEZLA (desvenlafaxine base) LEXAPRO (escitalopram) LUVOX CR (fluvoxamine CR) Nefazodone (generic Serzone) PRISTIQ (desvenlafaxine succinate) PEXEVA (paroxetine) Paroxetine CR PAXIL CR (paroxetine controlled release) PROZAC Weekly (fluoxetine) REMERON (mirtazapine) SARAFEM (fluoxetine) TRINTELLIX (vortioxetine)	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Venlafaxine ER tablets VIIBRYD (vilazodone) WELLBUTRIN IR, SR, XL (bupropion) ZOLOFT (sertraline)	
Therapeutic Drug Class: **ATYPICAL ANTI-PSYCHOTICS -Oral** -*Effective 4/1/2018*		
No PA Required*	**PA Required**	Non-preferred products will only be approved for their FDA approved indications (Table 1) and age limits (Table 3) AND only if the member has failed on three preferred products in the last 5 years (failure defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). *Age Limits: All products including preferred products will require a PA for members younger than the FDA approved age for the agent (Table 3). Members younger than the FDA approved age for the agent who are currently stabilized on an atypical antipsychotic will be eligible for grandfathering. **New Atypical Antipsychotic prescriptions for members under 5 years of age will be reviewed on an individual basis by a clinical health care professional at the Department. PA approval will be based upon medical necessity, evidence to support therapy, proposed monitoring and additional risk/benefit information supplied by the prescriber. Members under 5 years will be reviewed annually for appropriateness of therapy and proper monitoring.** ****Latuda** will be for the treatment of schizophrenia or bipolar depression if the member has tried and failed treatment with one preferred product (qualifying diagnosis verified by AutoPA). ***Quetiapine IR when given at sub therapeutic doses may be restricted for therapy. Low-dose quetiapine (<150mg/day) is only FDA approved as part of a drug titration schedule to aid patients in getting to the target quetiapine dose. PA will be required for quetiapine < 150mg per day except for utilization (when appropriate) in members 65 years or older. PA will be approved for members 10-17 years of age with approved diagnosis (Table 3) stabilized on <150mg quetiapine IR per day. If a member has been stabilized on quetiapine IR for at least 30 days with a positive response but is unable to tolerate the side effects, quetiapine ER may be approved without failure of two additional agents. Grandfathering: Members currently stabilized on a non-preferred atypical antipsychotic or Latuda can receive approval to continue therapy with that agent for one year.
Aripiprazole tablet, oral solution, ODT Clozapine tablet, ODT LATUDA (lurasidone) 2nd line** Olanzapine tablet Quetiapine IR tablet*** Risperidone tablet, oral soln, ODT Ziprasidone **For injectable Atypical Antipsychotics please see Appendix P for criteria**	Abilify tablet, oral soln, ODT CLOZARIL (clozapine) GEODON (ziprasidone) FANAPT (iloperidone) FAZACLO (clozapine ODT) Iloperidone INVEGA (paliperidone) Olanzapine ODT olanzapine/fluoxetine NUPLAZID (pimavanserin) Paliperidone Quetiapine ER*** REXULTI (brexpiprazole)	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	RISPERDAL (risperidone) tablet, M-tab (ODT), oral solution SAPHRIS (asenapine) SEROQUEL IR (quetiapine IR)*** SEROQUEL XR (quetiapine ER)*** SYMBYAX (olanzapine/fluoxetine) VERSACLOZ (clozapine suspension) VRAYLAR (cariprazine) ZYPREXA (olanzapine) ZYPREXA ZYDIS (olanzapine ODT) **For injectable Atypical Antipsychotics please see Appendix P for criteria**	Quantity Limits: Quantity limits will be applied to all products including preferred products (Table 2). In order to receive approval for off-label dosing, the member must have an FDA approved indication and must have tried and failed on the FDA approved dosing regimen. **Fazaclo** will be approved for the treatment of schizophrenia if the member is 18 years of age or older and has tried and failed treatment with three preferred products (one of which must be generic clozapine) in the last 5 years. **Invega** will be approved for the treatment of schizophrenia or schizoaffective disorder if the member is 18 years of age or older (12 years or older for schizophrenia) and has tried and failed treatment with / has had adherence issues with three preferred products in the last 5 years. A maximum of one tablet per day will be approved. **Nuplazid** will be approved for the treatment of hallucinations and delusions associated with Parkinson disease psychosis and tried and failed either quetiapine or clozapine (Failure will be defined as intolerable side effects, drug-drug interaction, or lack of efficacy). **Zyprexa Zydis** will be approved for the treatment of schizophrenia or bipolar 1 disorder if the member is 13 years of age or older and is unwilling to take or cannot swallow olanzapine tablets. For members that are stabilized on olanzapine with a documented need for occasional supplementation to treat acute symptoms, up to 5 tablets per month of Zyprexa Zydis ODT will be approved without requiring trial of 3 preferred products.

Table 1: Approved Indications

Drug	Indication
Fanapt® (iloperidone)	• Acute treatment of schizophrenia in adults
Fazaclo®, Versacloz® (clozapine)	• Treatment-resistant schizophrenia • Reducing the risk of recurrent suicidal behavior in patients with schizophrenia or schizoaffective disorder
Nuplazid® (pimavanserin)	• hallucinations and delusions associated with Parkinson's disease psychosis
Invega® (paliperidone)	• Schizophrenia • Schizoaffective disorder
Rexulti® (brexpiprazole)	• Adjunctive therapy to antidepressants for the treatment of major depressive disorder • Schizophrenia
Saphris® (asenapine)	• Acute and maintenance of schizophrenia • Bipolar mania, monotherapy • Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

Seroquel XR® (quetiapine)	• Treatment of schizophrenia • Acute treatment of manic or mixed episodes associated with bipolar I disorder, as monotherapy or as an adjunct to lithium or divalproex • Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex • Adjunctive treatment of major depressive disorder (MDD)
Vraylar® (cariprazine)	• Schizophrenia • Bipolar (acute treatment)

Table 2: Quantity Limits

Brand Name	Generic Name	Quantity Limits
Abilify	Aripiprazole	Maximum one tablet per day
Clozaril	Clozapine	Maximum dosage of 900mg per day
Fazaclo	Clozapine	Maximum dosage of 900mg per day
Fanapt	Iloperidone	Maximum two tablets per day
Geodon	Ziprasidone	Maximum two capsules per day
Invega	Paliperidone	Maximum one capsule per day
Latuda	Lurasidone	Maximum one tablet per day (If dosing 160mg for schizophrenia, then max of two tablets per day)
Risperdal	Risperidone	Maximum two tablets per day except 4mg tablets will be approved for up to 4 tablets per day
Rexulti	Brexpiprazole	Maximum of 3mg/day for MDD adjunctive therapy, Maximum of 4mg/day for schizophrenia
Saphris	Asenapine	Maximum two tablets per day
Seroquel	Quetiapine	Maximum three tablets per day
Seroquel XR	Quetiapine XR	Maximum one tablet per day (for 300mg & 400mg tablets max 2 tablets per day)
Vraylar	Cariprazine	Maximum dosage of 6mg/day
Zyprexa	Olanzapine	Maximum one tablet per day
Zyprexa Zydis	Olanzapine ODT	See Zyprexa Zydis criteria above

Table 3: FDA Approved Pediatric Dosing by Age

Drug	FDA Approved Indication	FDA Approved Age	Max FDA App'd Dose

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

Asenapine (Saphris®)	APPROVED FOR ADULTS ONLY		
Aripiprazole (Abilify®)	Autism/Psychomotor Agitation Bipolar Disorder/Mixed Mania Schizophrenia Gilles de la Tourette's syndrome	6-17 years 10-17 years 13-17 years 6-17 years	15mg/day 30mgday 30mg/day 20mg/day
Cariprazine (Vraylar®)	APPVROVED FOR ADULTS ONLY		
Clozapine (Fazaclo®, Clozaril®)			
Iloperidone (Fanapt®)			
Lurasidone (Latuda®)	Schizophrenia Bipolar Depression	13-17 years 10-17 years	80mg/day 80mg/day
Olanzapine (Zyprexa®)	Schizophrenia	13-17 years	10mg/day
Olanzapine (Zyprexa Zydis®)	Bipolar Disorder/Mixed Mania	13-17 years	10mg/day
Paliperidone (Invega ER®)	Schizophrenia	12-17 years	12mg/day
Risperidone (Risperdal®)	Autism/Psychomotor Agitation Bipolar Disorder/Mixed Mania Schizophrenia	5-16 years 10-17 years 13-17 years	3mg/day 6mg/day 6mg/day
Quetiapine Fumarate (Seroquel®)	Schizophrenia Bipolar Disorder/Mixed Mania	13-17 years 10-17 years	800 mg/day 600 mg/day
Quetiapine Fumarate (Seroquel XR®)	APPROVED FOR ADULTS ONLY		
Ziprasidone (Geodon®)	APPROVED FOR ADULTS ONLY		

Therapeutic Drug Class: **NEUROCOGNITIVE DISORDER AGENTS** -*Effective 4/1/2018*		
***Must meet eligibility criteria**	**PA Required**	***Eligibility criteria for Preferred Agents –** All preferred products will be approved without PA if the member has a diagnosis of neurocognitive disorder which can be verified by SMART PA.
*Donepezil 5mg, 10mg tablet *Donepezil ODT	ARICEPT (donepezil) tablets (all strengths), ODT Donepezil 23mg tablet	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
*EXELON (rivastigmine) patch [BNR] *Memantine tablets	EXELON (rivastigmine) cap, soln. Galantamine tablet, soln Galantamine ER capsule Memantine ER capsule, solution MESTINON (pyridostigmine) tab, syrup NAMENDA IR, XR (memantine) NAMZARIC (memantine/donepezil) RAZADYNE (galantamine) tab, oral soln RAZADYNE ER (galantamine) cap Rivastigmine patch	Members currently stabilized on a non-preferred product can receive approval to continue on that agent for one year if medically necessary and if there is a diagnosis of neurocognitive disorder.
Therapeutic Drug Class: **SEDATIVE HYPNOTICS** -*Effective 4/1/2018*		
Non-Benzodiazepines		
No PA Required* (unless age, dose, or duplication criteria apply) Eszopiclone Zaleplon Zolpidem IR tablet	**PA Required** AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant) EDLUAR (zolpidem) sublingual INTERMEZZO (zolpidem) sublingual LUNESTA (eszopiclone) ROZEREM (ramelteon)	Non-preferred non-benzodiazepine sedative hypnotics will be approved for members who have failed treatment with two preferred non-benzodiazepine agents in the last 12 months (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). Children: Prior authorization will be required for all agents for children < 18 years of age Duplications: Only one agent in the sedative hypnotic drug class will be approved at a time (e.g. concomitant use of agents in the same sedative hypnotic class or differing classes will not be approved) All sedative hypnotics will require PA for member's ≥65 years of age exceeding 90 days of therapy. **Belsomra** (suvorexant) will be approved for adult members that meet the following criteria: • Members who have failed treatment with two preferred agents in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **AND**

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	SONATA (zaleplon) Zolpidem ER tablet, sublingual ZOLPIMIST (zolpidem) soln	• Member is not receiving strong inhibitors (e.g, erythmromycin, clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole, voriconazole, delavirdine, and milk thistle) or inducers (e.g, carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifampin, rifabutin, rifapentine, dexamethasone, efavirenz, etravirine, nevirapine, darunavir/ritonavir, ritonavir, and St John's Wort) of CYP3A4 **AND** • Member does not have a diagnosis of narcolepsy **Rozerem** (ramelteon) will be approved for adult members with a history/concern of substance abuse or for documented concern of diversion within the household without failed treatment on a preferred agent Prior authorization will be required if member exceeds FDA recommended dose listed in the table below.
Benzodiazepines		
No PA Required* (unless age, dose, or duplication criteria apply) Temazepam 15mg, 30mg Triazolam	**PA Required** Estazolam Flurazepam Halcion Restoril (all strengths) Temazepam 7.5mg, 22.5mg	**Temazepam 7.5mg and 22.5 mg** will be approved if the member has trialed and failed temazepam 15mg or 30mg AND one other preferred product (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). Non-preferred benzodiazepine sedative hypnotics will be approved for members who have failed treatment with two preferred benzodiazepine agents in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). Children: Prior authorization will be required for all agents for children < 18 years of age Duplications: Only one agent in the sedative hypnotic drug class will be approved at a time (e.g. concomitant use of agents in the same sedative hypnotic class or differing classes will not be approved) All sedative hypnotics will require PA for member's ≥65 years of age exceeding 90 days of therapy. Grandfathering: Members currently stabilized on a non-preferred benzodiazepine medication will receive authorization to continue that medication. Prior authorization will be required if member exceeds FDA recommended dose listed in the table below.

Brand	Generic	FDA Maximum Dose
Non-Benzodiazepines		

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

Ambien CR	Zolpidem CR	12.5 mg/day
Ambien IR	Zolpidem IR	10 mg/day
Belsomra	Suvorexant	20 mg/day
Edluar	Zolpidem sublingual	Men: 10 mg/day Women: 5 mg/day
Intermezzo	Zolpidem sublingual	Men: 3.5mg/day Women:1.75 mg/day
Lunesta	Eszopiclone	3 mg/day
Sonata	Zaleplon	20 mg/day
Rozerem	Ramelteon	8 mg/day
Zolpimist	Zolpidem spray	Men: 10 mg (2 sprays)/day Women: 5 mg (1 spray)/day
Benzodiazepines		
Halcion	Triazolam	0.5 mg/day
Restoril	Temazepam	30 mg/day
-	Estazolam	2 mg/day
-	Flurazepam	30 mg/day
-	Quazepam	15 mg/day

Therapeutic Drug Class: **SKELETAL MUSCLE RELAXANTS** -*Effective 7/1/2018*

No PA Required (if under 65 years of age)*	PA Required	All agents in this class will require a PA for members 65 years of age and older. The maximum allowable approval will be for a 7-day supply.
Baclofen (generic Lioresal)	AMRIX ER (cyclobenzaprine ER)	Non-preferred skeletal muscle relaxants will be approved for members who have failed two preferred agents in the last 6-months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.)
Cyclobenzaprine (generic Flexeril) 5mg and 10mg tablet	Carisoprodol	Authorization for any **CARISOPRODOL** product will be given for a maximum 3-week one-time authorization for members with acute, painful musculoskeletal conditions who have failed treatment with three preferred products.
Tizanidine (generic Zanaflex) 2mg and 4mg tablet	Chlorzoxazone	*__Dantrolene__ will be approved for members 5-17 years of age who have failed one preferred agent and meet the following criteria: • Documentation of age-appropriate liver function tests AND • One of following diagnoses: Multiple Sclerosis, Cerebral Palsy, stroke, upper motor neuron disorder, or spinal cord injury • Dantrolene will be approved for the period of one year
	Cyclobenzaprine 7.5mg tabs	
	DANTRIUM (dantrolene)	
	*Dantrolene	
	FEXMID (cyclobenzaprine)	
	LORZONE (chlorzoxazone)	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	METAXALL (metaxolone) Metaxolone Methocarbamol Orphenadrine PARAFON FORTE (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol) Tizanidine 2, 4, 6mg caps ZANAFLEX (tizanidine)	• If a member is stabilized on dantrolene at <18 years of age, they may continue to receive approval after turning 18 years of age • (Failure is defined as: lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.)
Therapeutic Drug Class: **STIMULANTS AND RELATED AGENTS** -*Effective 10/1/201*8		
***No PA Required (if age, max daily dose, and diagnosis restrictions met)** Atomoxetine (generic Strattera) Mixed-amphetamine salts (generic Adderall IR) Mixed-Amphetamine salts ER (generic Adderall XR) CONCERTA [BNR] (methylphenidate ER) Dexmethylphenidate IR	**PA Required** ADDERALL IR (mixed-amphetamine salts) ADDERALL XR (mixed amphetamine salts ER) ADZENYS ER, XR ODT (amphetamine) APTENSIO XR (methylphenidate XR) Clonidine ER COTEMPLA XR ODT (methylphenidate ER) D-amphetamine spansule	*Preferred medications may be approved through AutoPA for FDA-approved indications (Table 1) with verification of appropriate ICD-10 diagnosis code at time of claims submission. Doses for preferred medications exceeding the maximum doses listed (Table 2) will require prior authorization and must meet criteria for max dose** below. For members without ICD-10 diagnosis on file, prior authorization for preferred medications will be required and approval may be granted for FDA-approved indications (Table 1). Prior authorization for non-preferred medications used for <u>FDA-approved</u> indications (Table 1) may be approved for members meeting the following criteria: • Member has documented failure with two preferred products in the last 12 months if age ≥6 years or documented failure with one preferred product in the last 12 months if age 3 –5 years (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). Trial and failure of preferred agents will not be required for members meeting either of the following: • For Daytrana, Methylin solution, Quillichew, Quillivant XR, and Vyvanse chewable tablet, prior authorization may be approved without failure of preferred products for members with a documented difficulty swallowing that are unable to utilize alternative

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
FOCALIN XR *BNR* (dexmethylphenidate ER) Guanfacine ER Methylphenidate IR (generic Ritalin IR) VYVANSE capsules (lisdexamfetamine)	DAYTRANA (methylphenidate transdermal) DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) DEXTROSTAT (dextroamphetamine) Dexmethylphenidate (generic Focalin IR) Dexmethylphenidate (generic Focalin XR) DYANAVEL XR solution (amphetamine) EVEKEO (amphetamine) FOCALIN IR (dexmethylphenidate) INTUNIV (guanfacine ER) KAPVAY (clonidine ER) METADATE ER (methylphenidate ER) Methylphenidate ER (generic Concerta) Methylphenidate ER (generic Metadate CD, ER, generic Ritalin LA) METHYLIN SUSPENSION (methylphenidate) Modafinil (generic PROVIGIL) NUVIGIL (armodafinil) PROCENTRA (dextroamphetamine liquid)	dosing with Focalin XR, Vyvanse capsules or mixed amphetamine salts ER (generic Adderall XR). Provider must document contraindications **OR** • Non-preferred agents with FDA-approved indications for which there are no preferred agents may be approved without trial of preferred agents (see FDA-approved indications listed in Table 1 below). Prior authorization will be required for all preferred and non-preferred agents when prescribed for use for <u>off-label</u> indications (FDA-approved indications are listed in Table 1 below). Prior authorization may be approved for use for an <u>off-label</u> indication for members meeting the following criteria: • If medication is being used for multiple sclerosis (MS) with associated fatigue, approval may be placed for preferred agents on an annual basis **OR** • The prescriber has provided peer-reviewed literature showing safety and efficacy of the medication used for the prescribed indication **AND** • Non-preferred medications used for off-label indications may be approved if the member has documented failure with two preferred products in the last 12 months for age ≥ 6 years or documented failure with one preferred product in the last 12 months for age 3 –5 years (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). For Daytrana, Methylin solution, Quillichew, Quillivant XR, and Vyvanse chewable tablet, prior authorization may be approved without failure of preferred products for members with a documented difficulty swallowing that are unable to utilize alternative dosing with Focalin XR, Vyvanse capsules or mixed amphetamine salts ER (generic Adderall XR). Provider must document contraindications. ****Max Dose:** Prior authorization will be approved for doses that are higher than the listed maximum dose (Table 2) if member meets all of the following criteria: • Member is taking medication for indicated use listed in table 1 **AND** • Member has 30 day trial or failure of three different preferred or non-preferred agents at maximum doses listed in table 2 **AND** • Documentation of member's symptom response to maximum doses of three other agents is provided **AND** • Member is not taking a sedative hypnotic medication (from sedative hypnotic PDL class, i.e. temazepam, triazolam, zolpidem)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	PROVIGIL (modafinil) QUILLICHEW (methylphenidate) QUILLIVANT XR suspension (methylphenidate) RELEXXII (methylphenidate ER) RITALIN IR (methylphenidate) RITALIN LA (methylphenidate ER (LA)) STRATTERA (atomoxetine) VYVANSE chewable tablets (lisdexamfetamine) ZENZEDI (dextroamphetamine)	

Table 1: FDA-Approved Indications

- Prior authorization will be required for doses that are higher than the FDA approved maximum doses.
- Once all other criteria on the preferred drug list are met, the following may be approved for the following indications:
- **Bolded Drug names are Preferred**

Drug	Indications
Stimulants – Immediate Release	
amphetamine sulfate (Evekeo™)	ADHD (Age ≥ 3 years), Narcolepsy (Age ≥ 6 years)
armodafinil (Nuvigil®)	Excessive sleepiness associated with narcolepsy, OSA, and SWD for age ≥ 17 years
dexmethylphenidate IR (Focalin®)	ADHD (Age ≥ 6 years)
dextroamphetamine IR (Zenzedi™)	ADHD (Age 3 to ≤ 16 years), Narcolepsy (Age ≥ 6 years)
dextroamphetamine solution (ProCentra™)	ADHD (Age 3 to ≤ 16 years), Narcolepsy (Age ≥ 6 years)
methamphetamine (Desoxyn®)	ADHD (Age ≥ 6 years)
methylphenidate IR (Methylin®, Ritalin®)	ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years)
methylphenidate XR ODT (Contempla® XR ODT)	ADHD (Age ≥ 6 years)
mixed amphetamine salts IR (Adderall®)	ADHD (Age ≥ 3 years), Narcolepsy (Age ≥ 6 years)
Stimulants – Extended-Release	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
amphetamine ER (Adzenys® XR-ODT and Adzenys® ER suspension)		ADHD (Age ≥ 6 years)
amphetamine ER (Dyanavel™ XR)		ADHD (Age ≥ 6 years)
dexmethylphenidate ER (**Focalin XR®**)		ADHD (Age ≥ 6 years)
dextroamphetamine ER (Dexedrine®)		ADHD (Age 3 to ≤ 16 years), Narcolepsy (Age ≥ 6 years)
dextroamphetamine ER/amphetamine ER (Mydayis ER®)		ADHD (Age ≥ 13 years)
lisdexamfetamine dimesylate (**Vyvanse® capsule** and Vyvanse® chewable)		ADHD (Age ≥ 6 years), Moderate to severe binge eating disorder in adults (Age ≥ 18 years)
methylphenidate ER OROS (**Concerta**®)		ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years)
methylphenidate SR (Metadate ER®)		ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years)
methylphenidate ER† (Metadate CD®)		ADHD (Age ≥ 6 years)
methylphenidate ER (QuilliChew™ ER)		ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years)
methylphenidate ER (Quillivant XR®)		ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years)
methylphenidate ER (Ritalin LA®)		ADHD (Age ≥ 6 years)
methylphenidate ER (Aptensio XR®)		ADHD (Age ≥ 6 years)
methylphenidate XR ODT (Contempla® XR ODT)		ADHD (Age ≥ 6 years)
Non-Stimulants		
atomoxetine (Strattera®)		ADHD (Age ≥ 6 years)
clonidine ER (Kapvay™)		ADHD (Age ≥ 6 years), Treatment of ADHD as adjunct to stimulants
guanfacine ER (Intuniv™)		ADHD (Age ≥ 6 years), Treatment of ADHD as adjunct to stimulants

Table 2: Max Daily Dose

Drug	Maximum Daily Dose
ADDERALL ®	60 mg/day
ADDERALL XR®	60mg/day
ADZENYS XR-ODT® | ADZENYS ER-SUSPENSION®	18.8 mg/day (age 6-12) | 12.5 mg/day (age >13)
AMPHETAMINE SALTS	40 mg/day
CONCERTA®	54 mg/day or 72 mg/day >age 13
COTEMPLA XR-ODT®	51.8mg/day
DESOXYN ®	25mg/day
DEXEDRINE ®	40mg/day
DEXTROSTAT ®	40mg/day
DYANAVEL XR ®	20mg/day

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

FOCALIN ®	20 mg/day
FOCALIN XR ®	40 mg/day
METHYLPHNIDATE ER	60 mg/day
MYDAYIS ER®	25 mg/day (age 13-17) | 50 mg/day (age ≥ 18)
INTUNIV ER®	4 mg/day
RITALIN® IR	60 mg/day
RITALIN SR®	60 mg/day
RITALIN LA ®	60 mg/day
STRATTERA®	100 mg/day
VYVANSE CAPS AND CHEWABLE ®	70 mg/day
D-AMPHETAMINE ER	40 mg/day
DAYTRANA ®	30 mg/day
EVEKEO ®	40 mg/day
KAPVAY ER®	0.1 mg/day
METHYLIN ER ®	60 mg/day
METHYLIN	60 mg/day
METHYLIN SUSPENSION®	60 mg/day
METADATE CD ®	60mg/day
METADATE ER ®	60mg/day
METHYLPHENIDATE	60 mg/day
PROVIGIL ®	400 mg/day
NUVIGIL ®	250 mg/day
QUILLIVANT ®	60 mg/day
ZENZEDI ®	40 mg/day

Therapeutic Drug Class: **TRIPTANS** -*Effective 1/1/2018*		
No PA Required (monthly quantity limits may apply) Sumatriptan tablets, nasal spray and injection Naratriptan tablets RELPAX **BNR** (eletriptan)	**PA Required** AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) IMITREX (sumatriptan) tablets, nasal spray and injection	Non-preferred products will be approved for members who have failed treatment with two Preferred Products within the last 6 months. One of the preferred medication trials must be of the same formulation as the non-preferred being requested. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions.) **Quantity Limits:** Amerge, Frova, Imitrex, Treximet and Zomig: Max 9 tabs / 30 days. Axert and Relpax: Max 6 tabs / 30 days.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Rizatriptan tablets, MLT tablets	MAXALT MLT tablets (rizatriptan) Maxalt tablets (rizatriptan) ONZETRA nasal powder (sumatriptan) SUMAVEL DOSEPRO (sumatriptan) TREXIMET (sumatriptan/ naproxen) ZECUITY patch (sumatriptan) ZEMBRACE SYMTOUCH injection (sumatriptan) ZOMIG (zolmitriptan)	Imitrex injection: Max 4 injectors / 30 days Maxalt: Max 12 tabs / 30 days. Zomig nasal spray and Imitrex Nasal Spray: Max 6 inhalers / 30 days.

V. Dermatological

Therapeutic Drug Class: **ACNE – Topical** -*Effective 7/1/2018*		
No PA Required (if age and diagnosis criteria is met*) *Clindamycin phosphate med swab *Clindamycin phosphate solution *Clindamycin/benzoyl peroxide w/ pump (generic Benzaclin) *Differin gel, gel pump (adapalene) BNR *Erythromycin soln *Retin-A cream BNR	**PA Required** Acanya, Acanya w/ pump Aczone gel, Aczone gel w/ pump Adapalene/ benzoyl peroxide (generic Epiduo) Adapalene cream, gel, gel pump Atralin Avar (all products) Avita cream, gel Azelex	Authorization for all acne agents prescribed solely for cosmetic purposes will not be approved. Preferred topical acne agents prescribed for members > 25 years of age will require prior authorization and will be approved following prescriber verification that the medication is not being utilized for cosmetic purposes AND prescriber verification that the indicated use is for acne vulgaris, psoriasis, cystic acne, disorders of keratinization, neoplasms, or comedonal acne. These medications are only eligible for prior authorization approval for the aforementioned diagnoses. Preferred topical acne agents prescribed for members ≤ 25 years of age will only be approved for members with a diagnosis of acne vulgaris, psoriasis, cystic acne, disorders of keratinization, neoplasms, or comedonal acne. Diagnosis will be verified through automated verification (AutoPA) of the appropriate corresponding ICD-10 diagnosis code related to the indicated use of the medication. Clindamycin topical products will also be approved for members with a diagnosis of hidradenitis suppurativa via a manual PA. Prior authorization for non-preferred topical products will be approved for members meeting all of the following criteria:

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
*Retin-A gel [BNR] *Sodium sulfacetamide/sulfur cleanser, wash	Benzac Benzaclin (all products) Benzoyl peroxide gel, kit, lotion, med pad, microspheres, towelette Benzoyl peroxide / sulfur Clindacin Pac Kit Clindamycin phosphate gel, lotion, foam Clindamycin/benzoyl peroxide (generic Duac) Clindamycin / Tretinoin Dapsone gel Differin cream, lotion (adapalene) Epiduo, Epiduo Forte Gel w/ pump Erythromycin gel, med swab Erythromycin / Benzoyl peroxide Onexton w/ pump Ovace (all products) Retin-A micro, Retin-A micro pump (all strengths) Sulfacetamide Suspension, cleanser Sulfacetamide sodium/ sulfur cream, suspension, lotion, cleanser kit	• Member has trialed/failed three preferred topical products with different mechanisms (i.e. tretinoin, antibiotic, AND benzoyl peroxide). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction AND • Prescriber verification that the medication is being prescribed for one of the following diagnoses: acne vulgaris, psoriasis, cystic acne, disorders of keratinization, neoplasms, or comedonal acne. Member has a diagnosis of acne vulgaris, psoriasis, cystic acne, disorders of keratinization, neoplasms, or comedonal acne

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Tazorac cream, gel Tazarotene cream Tretinoin cream, gel (generic Retin-A, Avita) Tretinoin microspheres gel, gel pump (all strengths)	
Therapeutic Drug Class: **ACNE – ISOTRETINOIN** -*Effective 7/1/2018*		
PA Required for all agents		All preferred and non-preferred oral isotretinoin agents will require prior authorization and will be approved for severe, recalcitrant nodulocystic acne for adults and children ≥ 12 years of age AND Non-preferred oral isotretinoin agents will be approved if member has trialed/failed two preferred agents. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction AND Prior authorization approval for all preferred and non-preferred oral isotretinoin agents will be authorized for 20 weeks and subsequent 20 week prior authorization approvals will require verification of an 8 week medication-free period between 20 week treatment periods prior to approval.
AMNESTEEM capsule CLARAVIS capsule	ABSORICA capsule isotretinoin capsule MYORISAN capsule ZENATANE capsule	
VI. Endocrine		
Therapeutic Drug Class: **ANDROGENIC AGENTS** -*Effective 7/1/2018*		
***Must meet criteria**	PA Required	Hypogonadotropic or Primary Hypogonadism (may be secondary to Klinefelter Syndrome): Preferred androgenic drugs will be approved for members meeting the following: 1. Male patient > 16 years of age AND 2. Has a documented diagnosis of hypogonadotropic or primary hypogonadism (Patients with other diagnoses will require a manual review by a state pharmacist) AND 3. Has two documented low serum testosterone levels below the lower limit of normal range for testing laboratory prior to initiation of therapy AND 4. Does not have a diagnosis of breast or prostate cancer AND 5. Does not have a palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL AND 6. Has normal liver function tests prior to initiation of therapy Gender Transition:
*ANDROGEL 1.62% (testosterone gel) 2.5 gram packet *ANDROGEL 1.62% (testosterone gel) 1.25 gram/actuation pump *ANDRODERM (testosterone) patch	ANDROGEL 1.62% (testosterone gel) 1.25 gram packet ANDROGEL 1% (testosterone gel) ANDROID (methyltestosterone) capsule ANDROXY (fluoxymesterone) tablet	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
*Testosterone cypionate IM injection	AVEED (testosterone undecanoate) IM injection AXIRON (testosterone) topical solution DELATESTRYL (testosterone enanthate) IM injection DEPO TESTOSTERONE (testosterone cypionate) IM injection FORTESTA (testosterone gel) Methitest (methyltestosterone) tablet Methyltestosterone capsule NATESTO (testosterone) topical nasal gel STRIANT (testosterone) buccal TESTIM (testosterone gel) Testone CIK (testosterone cypionate) IM injection Testosterone gel TESTRED (methyltestosterone) capsule Testosterone enanthate IM injection VOGELXO (testosterone gel)	Preferred androgenic drugs will be approved for members meeting the following: 1. Biologically born female patient > 16 years of age* AND 2. Is undergoing female to male transition AND 3. Has a negative pregnancy test prior to initiation AND 4. Has normal liver function tests prior to initiation of therapy *For members < 16 years of age, a manual review will be required. Non-preferred topical androgenic agents will be approved for patients meeting the above criteria with trial/failure of two preferred topical androgen formulations. Failure is defined as lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction. Non-preferred injectable androgenic agents will be approved for patients meeting the above criteria with trial/failure (8 week trial) of a preferred injectable androgenic drug. Failure is defined as lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction. Prior authorization for oral androgen agents (tablet, capsule, buccal) will be approved if member trials/fails a preferred topical agent AND testosterone cypionate injection. Failure is defined as lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction. **Grandfathering:** Members may be grandfathered on preferred agents without requirement of updated low serum testosterone laboratory testing that meet the following criteria: • Male patient > 16 years of age AND • Has at least one past documented low serum testosterone levels below the lower limit of normal range for testing laboratory prior to initiation of therapy AND • Has documented diagnosis of hypogonadotropic or primary hypogonadism AND • Does not have a diagnosis of breast or prostate cancer AND • Does not have a palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL AND • Has normal liver function tests prior to initiation of therapy
Therapeutic Drug Class: **BONE RESORPTION SUPPRESSION AND RELATED AGENTS -***Effective 10/1/2018*		
Bisphosphonates		
No PA Required Alendronate (generic) 5mg, 10mg, 35mg, 70mg tablets	**PA Required** ACTONEL (risedronate)	Non-preferred bisphosphonates will be approved for members who have failed treatment with at least one strength of alendronate at treatment dose (e.g., 10mg/day or 70 mg weekly). (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	ACTONEL w/Calcium (risedronate w/calcium) Alendronate 40mg tab Alendronate oral solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate) FOSAMAX (alendronate) FOSAMAX plus D (alendronate w/D) Etidronate	Prior authorization for alendronate 70mg/75ml solution will be approved if member cannot swallow solid oral dosage forms or has a feeding tube Prior authorization will be approved for **etidronate** in members with heterotopic ossification without treatment failure. • For members who have a low risk of fracture, prior authorization will be required for members exceeding 5 years of either a preferred or non-preferred bisphosphonate. Low risk will be defined as having an osteopenic bone mineral density (most recent T-score between -1 and -2.5) **AND** no history of vertebral facture.
Non-Bisphosphonates		
	PA Required Calcitonin salmon (nasal) Evista (raloxifene) Forteo (teriparatide) Raloxifene Tymlos (abaloparatide)	**Calcitonin salmon (nasal)** will be approved if the member meets the following criteria: • Member has a diagnosis of post-menopausal osteoporosis (BMD T-scores of –2.5 or less) **AND** • Has trial and failure of preferred bisphosphonate for one year (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **OR** • Member cannot swallow solid oral dosage forms or has a feeding tube. Quantity limit of one spray per day **Raloxifene** will be approved if the member meets the following criteria: • Diagnosis of postmenopausal osteoporosis (BMD T-scores of –2.5 or less) AND • Has trial and failure of preferred bisphosphonate for one year (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) Maximum Dose of raloxifene is 60mg oral daily **Forteo (teriparatide)** will be approved if the member meets the following criteria: • Member has one of the following diagnoses:

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		• Osteoporosis, (BMD T-scores of –2.5 or less) primary or hypogonadal in men • Osteoporosis due to corticosteroid use • Postmenopausal osteoporosis AND • Has trial and failure of preferred bisphosphonate for one year (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) • Prior authorization will be given for one year and total exposure of parathyroid hormone analogs (Forteo and Tymlos) shall not exceed two years Maximum dose of Forteo is 20mcg subcutaneous daily **Tymlos (abaloparatide)** will be approved if the member meets the following criteria: • Member has a diagnosis of postmenopausal osteoporosis (BMD T-scores of –2.5 or less) AND • Has trial and failure of preferred bisphosphonate for one year (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) AND • Prior authorization will be given for one year and total exposure of parathyroid hormone analogs (Forteo and Tymlos) shall not exceed two years. Maximum dose of Tymlos is 80 mcg injection daily **Prolia (denosumab)** is a physician administered drug and prior authorization criteria may be found on the Appendix P.
Therapeutic Drug Class: **CONTRACEPTIVE - ORAL** *Effective 10/1/2018*			
No PA Required		**PA Required**	Non-preferred oral contraceptive products will be approved if member fails one-month trial with four preferred agents OR if preferred products with medically necessary ingredients and/or doses are unavailable. (Failure is defined as: allergy, intolerable side effects, or significant drug-drug interaction) Initial fills may be dispensed for three-month supply to establish tolerance (i.e. lack of adverse effects).
Monophasic 28: Aubra 28 0.1-20 Aviane 28 0.1-20 Falmina 28 0.1-20 Larissa 28 0.1-20 Lessina 28 0.1-20 Levonor-Eth Estrad 28 0.1-20 Lutera 28 0.1-20 Orsythia 28 0.1-20 Sronyx 28 0.1-20 Vienva 28 0.1-20 Blisovi 28 FE 1-20 Junel 28 FE 1-20 Larin 28 FE 1-20	Reclipsen 28 0.15-30 Drosperinone-Eth Estradiol 28 3-30 Ocella 28 3-30 Syeda 28 3-30 Zarah 28 3-30 Ethynodiol-Eth Estra 28 1-35 Kelnor 28 1-35 Estarylla 28 0.25-35 Femynor-28 0.25-35 Mono-Linya-28 0.25-35 Mononessa-28 0.25-35 Norg-Ethin Estra 28 0.25-35 Previfem 28 0.25-35 Sprintec 28 0.25-35	All other rebateable products are non-preferred	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)	
Microgestin 28 FE 1-20 Altaverra 28 0.15-30 Kurvelo 28 0.15-30 Levonor-Eth Estrad 28 0.15-30 Levora 28 0.15-30 Lillow 28 0.15-30 Marlissa 28 0.15-30 Portia 28 0.15-30 Cryselle 28 0.3-30 Elinest 28 0.3-30 Low-Ogestrel 28 0.3-30 Blisovi FE 28 1.5-30 Junel FE 28 1.5-30 Larin FE 28 1.5-30 Microgestin FE 28 1.5-30 Apri 28 0.15-30 Cyred 28 0.15-30 Desogest-Eth Estra 28 0.15-30 Emoquette 28 0.15-30 Enskyce 28 0.15-30 Isibloom 28 0.15-30 Juleber 28 0.15-30	Necon 28 1-50 Balziva 28 0.4-35 Philith 28 0.4-35 Vyfemla 28 0.4-35 Necon 28 0.5-35 Nortrel 28 0.5-35 Wera 28 0.5-35 Alyacen 28 1-35 Cyclafem 28 1-35 Dasetta 28 1-35 Nortrel 28 1-35 Pirmella 28 1-35 Ethynodiol-Eth Estra 28 1-50 Nikki 28 3-20 Loryna 28 3-20 Vestura 28 3-20 Junel FE 24 1-20 Larin FE 24 1-20 Minastrin FE 24 1-20		
No PA Required **<u>Monophasic 21:</u>** Junel 21 1-20 Larin 21 1-20 Norethind-Eth Estrad 21 1-20 Junel 21 1.5-30 Larin 21 1.5-30 Nortrel 21 1-35 **<u>Triphasic:</u>** Tri-Lo Estarylla 28 Tri-Lo Marzia 28 Tri-Lo Sprintec 28 Caziant 28 Velivet 28 Enpresse 28	**No PA Required** **<u>Biphasic:</u>** Lo Loestrin FE 28 1-10 Azurette 28 Bekyree 28 Kariva 28 Kimidess 28 Mircette 28 Pimtrea 28 Viorele 28 **<u>Extended Cycle:</u>** Levonorgest-Eth Estrad 91 0.1-10-20 Levonorgest-Eth Estr 91 0.15-20-25-30 Introvale 91 0.15-30 Jolessa 91 0.15-30		

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)	
Levonest 28 Levonor-Eth Estrad Triphasic 28 Myzilra 28 Ortho Tri-Cyclen 28 Tri-Estarylla 28 Tri-Femynor 28 Tri-Linyah 28 **No PA Required** Trinessa 28 Tri-Previfem 28 Tri-Sprintec 28 Alyacen 7-7-7 28 Cyclafem 7-7-7 28 Dasetta 7-7-7 28 Pirmella 7-7-7 28	Quasense 91 0.15-30 Setlakin 91 0.15-30 Ashlyna 91 0.15-10-30 **<u>Continuous Cycle:</u>** Levonorgest-Eth Estrad 28 0.09-20 **No PA Required** **<u>Norethindrone Only:</u>** Camila 28 0.35 Deblitane 28 0.35 Errin 28 0.35 Heather 28 0.35 Jencycla 28 0.35 Jolivette 28 0.35 Lyza 28 0.35 Norethindrone 28 0.35 Norlyda 28 0.35 Ortho Micronor 28 0.35 Sharobel 28 0.35		
Therapeutic Drug Class: **DIABETES MANAGEMENT CLASSES**			
INSULIN Rapid Acting -*Effective 4/1/2018*			
No PA Required	**PA Required**	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy [hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, and angioedema] or intolerable side effects) AFREZZA (human insulin) will be approved for members with the following criteria: • Member is 18 years or older AND • Member has intolerable side effects or severe allergic reactions to Novolog AND • Member must not have chronic lung disease such as asthma and COPD AND • If member is a type 1 diabetic, must use in conjunction with long-acting insulin AND Member must not be a smoker	
NOVOLOG vial/ pen	AFREZZA APIDRA all forms FIASP all forms HUMALOG vial/ pen/ kwikpen HUMALOG Junior kwikpen		
INSULIN Short Acting -*Effective 4/1/2018*			
HUMULIN R vial (OTC)	NOVOLIN R all forms (vial OTC)	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
HUMULIN R concentrated vial (U-500)	HUMULIN R kwikpen	
INSULIN Intermediate Acting *Effective 4/1/2018*		
HUMULIN N vial (OTC)	HUMULIN N kwikpen NOVOLIN N all forms	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)
INSULIN Long Acting *Effective 4/1/2018*		
LEVEMIR vial/ pen (detemir) *LANTUS (2nd line) (glargine) vial/pen	BASAGLAR (glargine) all forms TOUJEO (glargine) all forms TRESIBA (degludec) all forms	Non-preferred products will be approved if the member has failed treatment with Levemir and Lantus (Failure is defined as: allergy or intolerable side effects) *Lantus will be approved if the member has failed treatment with Levemir (Failure is defined as: allergy [hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, and angioedema] or intolerable side effects)
INSULIN Mixtures *Effective 4/1/2018*		
HUMULIN 70/30 vial (OTC) HUMALOG MIX 50/50 vial HUMALOG MIX 75/25 vial NOVOLOG MIX 70/30 vial/ pen	HUMALOG MIX 75/25 pen HUMALOG MIX 50/50 pen HUMULIN 70/30 kwikpen (OTC) NOVOLIN 70/30 vial (OTC)	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)
Amylin *Effective 10/1/208*		
	PA Required SYMLIN (pramlintide)	**Symlin**® will only be approved after a member has failed a three month trial of metformin and a DPP4-inhibitor or a GLP-1 analogue. Failure is defined as: lack of efficacy (e.g., hemoglobin A1C ≥ 7%) OR the member cannot tolerate metformin, DPP4-inhibitor and GLP-1 analogue due to allergy, intolerable side effects, or a significant drug-drug interaction. PA will be approved for Symlin products for members with Diabetes Mellitus Type 1 without failed treatment **For all products**, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing.
Biguanides *Effective 10/1/2018*		
No PA Required	**PA Required** FORTAMET (metformin)	Non-preferred products will be approved for members who have failed treatment with two Preferred Products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)

<table>
<tr><th>Preferred Agents</th><th>Non-preferred Agents</th><th>Prior Authorization Criteria
(All Non-Preferred Products will be approved for one year unless otherwise stated.)</th></tr>
<tr><td>Metformin 500mg, 850mg, 1000mg tablets

Metformin ER 500mg tablets (generic Glucophage XR)</td><td>GLUCOPHAGE (brand) (metformin)

GLUCOPHAGE XR (brand) (metformin XR)

GLUMETZA ER (metformin)

Metformin ER 750mg

Metformin ER 500 and 1000mg (generic Fortamet, generic Glumetza)

RIOMET 500mg/5ml (metformin)</td><td>Liquid metformin will be approved for members who meet one of the following:
under the age of 12 with a feeding tube who have difficulty swallowing</td></tr>
<tr><td colspan="3">DPP-4 Inhibitors Effective 10/1/2018</td></tr>
<tr><td>*Must meet eligibility criteria

*Januvia (sitagliptin)

*Tradjenta (linagliptin)</td><td>PA Required

Alogliptin

Nesina (alogliptin)

Onglyza (saxagliptin)</td><td>*Approval for preferred products require a three month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy.

Non preferred DPP-4 inhibitors will be approved after a member has failed a three month trial of metformin AND a three month trial of Tradjenta® AND a three month trial of Januvia®. Failure is defined as lack of efficacy (e.g., hemoglobin A1C ≥ 7%), allergy, intolerable side effects, or a significant drug-drug interaction.

For all products, prior authorization will be required for dosing above the FDA approved maximum dosing listed in the following table:

<table>
<tr><th>DPP4</th><th>FDA Approved Max Dose (mg/day)</th></tr>
<tr><td>Alogliptin (generic Nesina)</td><td>25 mg/day</td></tr>
<tr><td>Januvia (sitagliptan)</td><td>100 mg/day</td></tr>
<tr><td>Nesina (alogliptan)</td><td>25 mg/day</td></tr>
<tr><td>Onglyza (saxagliptan)</td><td>5 mg/day</td></tr>
<tr><td>Tradjenta (linagliptan)</td><td>5 mg/day</td></tr>
</table>
</td></tr>
</table>

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
DPP-4 Inhibitors – Combination with Metformin *Effective 10/1/2018*		
***Must Meet eligibility criteria** *JANUMET (sitagliptin/metformin) *JANUMET XR (sitagliptin/metformin)	**PA Required** Alogliptin/metformin JENTADUETO (linagliptin/metformin) JENTADUETO XR (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE (saxagliptin/metformin)	Approval for preferred combination agent products require a three month trial of metformin therapy prior to initiation of therapy. Non-preferred combination products will be approved for members who have been stable on the two individual ingredients of the requested combination for three months AND have had adequate three-month trial and failure of a preferred combination agent. Failure is defined as lack of efficacy (e.g., hemoglobin A1C ≥ 7%), allergy, intolerable side effects, or a significant drug-drug interaction.
GLP-1 Analogues *Effective 10/1/2018*		
***Must meet eligibility criteria** *BYETTA (exenatide) *BYDUREON (exenatide ER) **VICTOZA (liraglutide) (second line)	**PA Required** ADLYXIN (lixisenatide) BYDUREON BCISE (exenatide ER) OZEMPIC (semaglutide) TRULICITY (dulaglutide)	*Approval for **Byetta**® OR **Bydureon**® requires a three month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy. Failure is defined as lack of efficacy (e.g., hemoglobin A1C ≥ 7%), allergy, intolerable side effects, or a significant drug-drug interaction. **Prior authorization will be approved for Victoza® after a three month trial or failure to Byetta® OR a three month trial of Bydureon® AND a three month trial of metformin therapy. Member will not require trial of Byetta or Bydureon if member has a diagnosis of diabetes mellitus type 2 AND is at high risk for cardiovascular events [history of myocardial infarction (MI), Coronary Artery Disease (CAD) requiring intervention, unstable angina, stroke, or Peripheral Arterial Disease (PAD)]. Failure is defined as lack of efficacy (e.g., hemoglobin A1C ≥ 7%), allergy, intolerable side effects, or a significant drug-drug interaction. **For all products**, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing. Non-preferred GLP-1 agonists will be approved after a member has failed a three month trial of metformin AND failed a three month trial of three preferred agents. Failure is defined as lack of efficacy (e.g., hemoglobin A1C ≥ 7%), allergy, intolerable side effects, or a significant drug-drug interaction.
Other Hypoglycemic Combinations *Effective 10/1/2018*		

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	PA Required Alogliptin/pioglitazone AVANDARYL (rosiglitazone/glimepiride) DUETACT (pioglitazone/glimepiride) Pioglitazone/glimepiride Glipizide/metformin GLUCOVANCE (glyburide/metformin) Glyburide/metformin GLYXAMBI (empagliflozin/linagliptin) METAGLIP (glipizide/metformin) OSENI (alogliptin/pioglitazone) Soliqua (glargine 100 U and lixisenatide 33 mcg) Steglujan (ertugliflozin/sitagliptin) Xultophy (degludec 100 U and liraglutide 3.6 mg)	Non-preferred products will be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months.
Meglitinides *Effective 10/1/2018*		
	PA Required Nateglinide PRANDIN (repaglinide) Repaglinide	Non-preferred products will be approved for members who have failed treatment with one Sulfonylurea (Failure is defined as: lack of efficacy (e.g., hemoglobin A1C $\geq$ 7%), allergy, intolerable side effects, or significant drug-drug interaction.)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	STARLIX (nateglinide)	
Meglitinides Combination with Metformin *Effective 10/1/2018*		
	PA Required PRANDIMET (repaglinide/metformin) Repaglinide/metformin	Non-preferred products will be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months.
SGLT-2 Inhibitors *Effective 10/1/2018*		
***Must meet eligibility criteria** *FARXIGA (dapagliflozin) *INVOKANA (canagliflozin)	**PA Required** JARDIANCE (empagliflozin) STEGLATRO (ertugliflozin)	*Approval for **Invokana®** or **Farxiga®** requires a three month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy. **Jardiance®** will be approved: • After a member has had a three month trial of metformin and failed a three month trial of Invokana® AND failed a three month trial of Farxiga®. Failure is defined as: lack of efficacy (e.g., hemoglobin A1C ≥ 7%) OR the member cannot tolerate metformin, Invokana®, or Farxiga® due to allergy, intolerable side effects, or a significant drug-drug interaction **OR** • A diagnosis of diabetes mellitus type 2 and are high risk for cardiovascular events [history of myocardial infarction (MI), Coronary Artery Disease (CAD) requiring intervention, unstable angina, stroke, or Peripheral Arterial Disease (PAD)]. Prior authorization will be approved for other non-preferred agents if ALL the following criteria are met: • Member has trialed/failed* a three month trial of metformin • Member has trialed/failed* a three month trial of Invokana® • Member has trialed/failed* a three month trial of Farxiga® *Failure is defined as lack of efficacy (e.g. hemoglobin A1C ≥ 7%), allergy, intolerable side effects, or a significant drug-drug interaction. to **For all products**, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing.
SGLT-2 Inhibitors Combination with Metformin *Effective 10/1/2018*		
	PA Required INVOKAMET (canagliflozin/metformin)	Non-preferred products will be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	SEGLUROMET (ertugliflozin/metformin) SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozin/metformin)	
Thiazolidinediones *Effective 10/1/2018*		
No PA Required Pioglitazone	**PA Required** ACTOS (pioglitazone) AVANDIA (rosiglitazone)	Non preferred TZDs will be approved after a member has failed a three month trial of metformin and failed a three month trial of pioglitazone. Failure is defined as lack of efficacy (e.g., hemoglobin A1C ≥ 7%), OR the member cannot tolerate pioglitazone and metformin due to allergy, intolerable side effects, or a significant drug-drug interaction.
Thiazolidinediones Combination with Metformin *Effective 10/1/2018*		
	PA Required ACTOPLUS MET (pioglitazone/metformin) ACTOPLUS MET XR (pioglitazone/metformin) AVANDAMET (rosiglitazone/metformin) Pioglitazone/metformin	Non-preferred products will be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months.
Therapeutic Drug Class: **GROWTH HORMONES** -*Effective 4/1/2018*		
PA Required (if diagnosis is not met)	**PA Required**	All preferred products will be approved without PA if the member has one of the qualifying diagnoses listed below (diagnosis verified through AutoPA). Non-preferred Growth Hormones will be approved if the following criteria are met: • Member failed treatment with Genotropin OR Norditropin within the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) • Member has a qualifying diagnosis: o Prader-Willi
GENOTROPIN NORDITROPIN	HUMATROPE NUTROPIN AQ OMNITROPE SAIZEN	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	SEROSTIM ZOMACTON ZORBTIVE	○ Chronic renal insufficiency/failure requiring transplantation (defined as Creatinine Clearance < 30mL/min) ○ Turner's Syndrome ○ Hypopituitarism: as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma verified by one of the following: ▪ Has failed at least one GH stimulation test (peak GH level < 10 ng/mL) ▪ Has at least one documented low IGF-1 level (below normal range for patient's age – refer to range on submitted lab document) ▪ Has deficiencies in ≥ 3 pituitary axes (i.e. TSH, LH, FSH, ACTH, ADH) ○ Cachexia associated with AIDS ○ Noonan Syndrome ○ Short bowel syndrome Members currently taking a preferred or non-preferred agent can continue that agent with an ICD-10 code associated with a qualifying diagnosis as verified by autoPA until 04/01/19. After 04/01/2019 all members continuing any Growth Hormone product must fulfill above PA criteria. For chronic renal failure and hypopituitarism diagnoses, a PA will be required after 04/01/2019 to verify that the member meets all criteria listed above. PAs may be submitted prior to 04/01/2019.
VII. Gastrointestinal		
Therapeutic Drug Class: **ANTI-EMETICS** -*Effective 1/1/2018*		
No PA Required Ondansetron tablets Ondansetron ODT tab Ondansetron oral solution (members under 5 years only)	**PA Required** AKYNZEO (netupitant/palonosetron) ANZEMET (dolasetron) DICLEGIS (doxylamine/pyridoxine) Doxylamine 25mg (OTC) Dronabinol EMEND (apepritant) KYTRIL (granisetron) MARINOL (dronabinol)	Non-preferred products will be approved for members who have failed treatment with a preferred product (generic ondansetron) within the last year. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) **Ondansetron suspension** will be approved for members < 5 years and those members ≥ 5 years of age with a feeding tube. **Diclegis** will be approved for 3 months for members who meet the following criteria: • Has nausea and vomiting associated with pregnancy **AND** • Has failed 7-day trial of OTC formulation of pyridoxine (Vitamin B6) at maximally tolerated dose of up to 200mg daily **AND** • Has failed 7-day combination trial of OTC formulations of doxylamine and pyridoxine (Vitamin B6) at maximum daily doses of doxylamine 40mg and pyridoxine 40mg **AND** • Has failed 7 day trial of alternate antihistamine (diphenhydramine, dimenhydrinate, meclizine) **OR**

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Pyridoxine 50mg or 100mg (OTC) SANCUSO (granisetron) VARUBI (rolapitant) ZOFRAN (ondansetron) tabs ZOFRAN (ondansetron) suspension ZOFRAN ODT (ondansetron) ZUPLENZ (ondansetron)	• Has failed 7 day trial of dopamine antagonist (metoclopramide, prochlorperazine, promethazine) **OR** • Has failed 7-day trial of serotonin antagonist (ondansetron, granisetron) (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) **Pyridoxine** and **doxylamine** will be approved for members who have a diagnosis of nausea and vomiting of pregnancy (NVP). Approval will be given for 3 months. **Emend** will be approved upon verification that the member is undergoing moderately emetogenic or highly emetogenic chemotherapy as part of a regimen with a corticosteroid and a 5HT3 antagonist. **Verification may be provided from the prescriber or the pharmacy.** **Emend** will be approved for prophylaxis of postoperative nausea and vomiting (one 40mg capsule will be approved). **Verification may be provided from the prescriber or the pharmacy.** **Grandfathering:** members on dronabinol for treatment of AIDS-associated cachexia can receive approval to continue on that agent for one year if medically necessary. (January 1, 2018)
Therapeutic Drug Class: **GI MOTILITY, CHRONIC** -*Effective 10/1/2018*		
PA Required for all agents in this class		All GI Motility Agents will only be approved for FDA labeled indications and up to FDA approved maximum doses (listed below): Preferred agents will be approved if the member meets the following criteria: • Has diagnosis of Irritable Bowel Syndrome – Constipation (IBS-C), Chronic Idiopathic Constipation (CIC), or Opioid Induced Constipation (OIC) in patients with opioids prescribed for noncancer pain **AND** • Member does not have a diagnosis of GI obstruction **AND** • For indication of OIC, member opioid use must exceed 4 weeks of treatment Non-preferred agents **excluding Viberzi®** will be approved if the member meets the following criteria: • Member meets all listed criteria for preferred agents **AND** • Member has trialed and failed two preferred agents o If indication OIC caused by methadone, then non-preferred agent may be approved after trial of Movantik (Failure is defined as a lack of efficacy for a 7 day trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions) **AND**
AMITIZA (lubiprostone) LINZESS (linaclotide) MOVANTIK (naloxegol)	Alosetron LOTRONEX (Alosetron) RELISTOR (Methylnaltrexone bromide) tablet and syringe SYMPROIC (Naldemedine) TRULANCE (plecanatide) VIBERZI (eluxadoline)	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		• If the member cannot take oral medications, then the member must fail a 7-day trial with a nonphosphate enema. **Viberzi**® (eluxadoline) will be approved for members who meet the following criteria: • Has diagnosis of Irritable Bowel Syndrome – Diarrhea (IBS-D) AND • Member has a gallbladder AND • Member does not have severe hepatic impairment (Child-Pugh C), history of severe constipation, known mechanical gastrointestinal obstruction, biliary duct obstruction, history of pancreatitis or structural disease of the pancreas AND • Member does not drink more than 3 alcoholic drinks per day AND • Member has tried and failed a trial with both loperamide AND dicyclomine OR hyoscamine (Failure is defined as a lack of efficacy for a 7 day trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions) **Lotronex**® (alesotron) and Alesotron will be approved for members who meet the following criteria: • Member is a female with Irritable Bowel Syndrome – Diarrhea (IBS-D) with symptoms lasting 6 months or longer AND • Member does not have severe hepatic impairment (Child-Pugh C), history of severe constipation or ischemic colitis, hypercoagulable state, Crohn's disease or ulcerative colitis, or known mechanical gastrointestinal obstruction AND • Member has tried and failed a trial with Viberzi®, both loperamide AND dicyclomine OR hyoscamine (Failure is defined as a lack of efficacy for a 7 day trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions)

Medication	FDA approved indication	FDA Max Dose
Amitiza (lubiprostone)	IBS-C (females only), CIC, OIC (not caused by methadone)	48mcg/day
Linzess (linaclotide)	IBS-C, CIC	290mcg/day
Movantik (naloxegol)	OIC	25mg/day
Viberzi (eluxadoline)	IBS-D	200mg/day
Alosetron	OIC	2mg/day (females only)
Relistor syringe (methylnaltrexone)	OIC	12mg SQ/day
Relistor oral (methylnaltrexone)	OIC	450mg/day
Lotronex (alosetron)	IBS-D (females only)	2mg/day (females only)
Symproic (Naldemedine)	OIC	0.2mg/day

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

Trulance (plecanatide)	CIC	3mg/day

CIC – chronic idiopathic constipation, OIC – opioid induced constipation, IBS – irritable bowel syndrome, D – diarrhea predominant, C – constipation predominant

Therapeutic Drug Class: **PANCREATIC ENZYMES** -*Effective 1/1/2018*

No PA Required	PA Required	
CREON (pancrelipase)	PANCREAZE (pancrelipase)	Non-preferred products will be approved for members who have failed an adequate trial (4 weeks) with at least two preferred products. (Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction.) Grandfathering: Members currently stabilized on a Non-preferred pancreatic enzyme can receive approval to continue on that agent for one year if medically necessary.
ZENPEP (pancrelipase)	PANCRELIPASE (pancrelipase)	
	PERTZYE (pancrelipase)	
	ULTRESA (pancrelipase)	
	VIOKACE (pancrelipase)	

Therapeutic Drug Class: **PROTON PUMP INHIBITORS** -*Effective 1/1/2018*

Brand Generic Changes effective 3/9/18

*Must meet eligibility criteria	PA Required	
Esomeprazole capsules (generic Nexium) RX	ACIPHEX tab, sprinkles (rabeprazole)	*PA will be required for therapy beyond 60 days of treatment per year for all agents. For members treated for GERD, once 60 days of therapy per year has been exceeded, members must fail an adequate trial of a histamine 2 receptor antagonist (H2A) before PPI therapy can be reconsidered. An adequate trial is defined as 8 weeks of histamine 2 receptor antagonist at optimal doses listed in the table below.
NEXIUM (esomeprazole) packets BNR	DEXILANT (dexlansoprazole)	
Omeprazole generic capsules	KAPIDEX (dexlansoprazole)	
Pantoprazole tablets	Esomeprazole strontium	
PREVACID solutab BNR (lansoprazole) (for members under 2)	Lansoprazole capsules	
	Lansoprazole 15mg OTC (currently available as PREVACID 24HR)	
	NEXIUM capsules (RX)	

Drug	Optimal Dose
Erbrotidine	800 mg once daily
Famotidine	20 mg twice daily
Nizatidine	150 mg twice daily
Ranitidine	150 mg twice daily
Ranitidine	** For children less than 30 kg, max dose is 10mg/kg per day divided in 2 doses
Roxatidine	150 mg once daily or 75mg twice daily

Long-term therapy, without a H2A trial, will be approved for members with Barrett's Esophagus, Erosive Esophagitis, GI Bleed, post-bariatric surgery; Hypersecretory Conditions (Zollinger Ellison),

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	NEXIUM 24 hour (OTC) Omeprazole/Na bicarbonate omeprazole 20mg tabs (OTC) PREVACID (lansoprazole) capsules & suspension PRILOSEC OTC (omeprazole) PROTONIX (pantoprazole) tablets and suspension Rabeprazole (generic Aciphex) ZEGERID (omeprazole/Na bicarbonate)	Recurrent Aspiration Syndrome, chronic NSAID or prednisone therapy, Spinal Cord Injury members with an acid reflux diagnosis, or children (< 18 years of age) with Cystic Fibrosis, on mechanical ventilation or who have a feeding tube. In addition, members with continuing, symptomatic GERD or recurrent peptic ulcer disease who have documented failure on step-down therapy to an H2-receptor antagonist will be approved for up to one year of daily PPI therapy. Non-preferred proton pump inhibitors will be approved if all of the following criteria are met: • Member failed treatment with three Preferred Products within the last 24 months, • Member has a qualifying diagnosis, AND • Member has been diagnosed by an appropriate diagnostic method. **The Qualifying Diagnoses are:** Barrett's Esophagus, Duodenal Ulcer, Erosive Esophagitis, Gastric Ulcer, GERD, GI Bleed, H. pylori, Hypersecretory Conditions (Zollinger-Ellison), NSAID-Induced Ulcer, Pediatric Esophagitis, Recurrent Aspiration Syndrome or Ulcerative GERD **The Appropriate Diagnostic Methods are:** GI Specialist, Endoscopy, X-Ray, Biopsy, Blood test, or Breath test **Quantity Limits:** Non-preferred agents will be limited to once daily dosing except for the following diagnoses: Barrett's Esophagus, GI Bleed, H. pylori, Hypersecretory Conditions, or Spinal Cord Injury patients with any acid reflux diagnosis. **Age Limits:** Aciphex, Protonix, and Zegerid will not be approved for members less than 18 years of age. Prevacid Solutab will be approved for members less than 2 years old and ≥ 2 years with a feeding tube.
Therapeutic Drug Class: **H. Pylori Treatments** -*Effective 1/1/2018*		
	PA Required OMECLAMOX-PAK (amoxicillin/ omeprazole/ clarithromycin) PREVPAC (amoxicillin/lansoprazole/ clarithromycin)	H. Pylori treatments should be used as individual products unless one of the individual products is not commercially available then a PA for the combination product will be given.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	Amoxicillin/lansoprazole/ clarithromycin PYLERA (bismuth subcitrate/ metronidazole/tetracycline)	
VIII. Hematological		
Therapeutic Drug Class: **ANTI-COAGULANTS- ORAL** -*Effective 10/1/2018*		
***Must meet eligibility criteria** Warfarin *XARELTO (rivaroxaban) (2nd line) tablet *PRADAXA (dabigatran) (2nd line)	**PA Required** COUMADIN (warfarin) ELIQUIS (apixaban) SAVAYSA (edoxaban) XARELTO (rivaroxaban) dose pack	***PRADAXA®** (dabigatran) will be approved if the member meets the following criteria: • The member is not considered a candidate for warfarin based on meeting **warfarin eligibility criteria below **AND** • The member is not on dialysis **AND** • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) **OR** • The member is in need of a prophylaxis of deep vein thrombosis (DVT) and pulmonary embolism (PE) following hip replacement surgery **OR** • The member has a diagnosis of non-valvular atrial fibrillation **AND** • The member does not have a mechanical prosthetic heart valve ***XARELTO®** (rivaroxaban) will be approved if all the following criteria have been met: • The member is not considered a candidate for warfarin based on meeting **warfarin eligibility criteria below **AND** • The member is not on dialysis **AND** • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) **OR** • The member is in need of a prophylaxis of DVT following knee or hip replacement surgery **OR** • The member has a diagnosis of non-valvular atrial fibrillation **AND** • The member does not have a mechanical prosthetic heart valve Note: Xarelto (rivaroxaban) dose pack may be approved for members requiring unit-dose packaging due to documented dosing errors or high probability of their occurrence AND the member meets the above Xarelto criteria **ELIQUIS®** (apixaban) will be approved if all the following criteria have been met: • The member is not considered a candidate for warfarin based on meeting **warfarin eligibility criteria below **AND**

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		• The member has failed a one month trial of Xarelto® OR Pradaxa. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **AND** • The member is on dialysis (For members on dialysis, treatment failure with Xarelto or Pradaxa NOT required) **OR** • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) **OR** • The member is in need of prophylaxis for DVT following knee or hip replacement surgery **OR** • The member has a diagnosis of non-valvular atrial fibrillation **AND** • The member does not have a mechanical prosthetic heart valve **SAVAYSA®** (edoxaban) will be approved if all the following criteria have been met: • • The member has failed a one month trial of Xarelto® OR Pradaxa. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **AND** • Member is not on dialysis **AND** • Member does not have CrCl > 95 mL/min **AND** • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) **OR** • The member has a diagnosis of non-valvular atrial fibrillation **AND** • The member does not have a mechanical prosthetic heart valve **Warfarin Eligibility Criteria: Members may be considered not a candidate for warfarin based on meeting any of the following: • The member has DVT of the leg or PE requiring long-term anticoagulation therapy and the member does not have cancer **OR** • The prescriber has determined the use of warfarin is inappropriate in a female member of child-bearing age **OR** • The member has a labile INR for reasons other than noncompliance (e.g, member has an INR outside of 2-3 > 60% of the time for a period of two months) **OR** • The member has significant difficulty with complying with monitoring **OR** • The member has an allergy or intolerance to warfarin Continuation of Care: Members with current prior authorization approval on file for an oral anticoagulant medication may continue to receive approval for that medication up until the expiration date of the prior authorization. Once the prior authorization has expired, members will be subject to meeting current criteria for additional prior authorization approval.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		Bevyxxa® (betrixaban) is not a covered benefit due to its non-rebateable status.
Therapeutic Drug Class: **ANTI-COAGULANTS- PARENTERAL** -*Effective 10/1/2018*		
No PA Required Enoxaparin syringe Lovenox 300mg/3ml vial BNR	**PA Required** Arixtra (fondaparinux) syringe Enoxaparin 300mg/3ml vial (generic Lovenox) Fondaparinux (generic Arixtra) Fragmin (dalteparin) vial and syringe Lovenox syringe	Non-preferred parenteral anticoagulants will be approved if member has trial and failure of one preferred agent. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction **ARIXTRA®** (fondiparinux) will be approved if the following criteria have been met: • Member is 18 years of age or older **AND** • Member has a CrCl > 30 ml/min **AND** • Member weighs > 50 kg **AND** • Member has a documented history of heparin induced-thrombocytopenia **OR** • Member has a contraindication to enoxaparin Grandfathering (Arixtra and Fragmin): Members currently stabilized on Arixtra or Fragmin may receive prior authorization approval to continue on that medication
Therapeutic Drug Class: **ANTI-PLATELETS** -*Effective 1/1/2018*		
No PA Required AGGRENOX (ASA/dipyridamole) **BNR** Cilostazol Clopidogrel BRILINTA (tigacrelor)	**PA Required** ASA/dipyridamole DURLAZA (aspirin ER) EFFIENT (prasugrel) PLAVIX (clopidogrel) PLETAL (cilostazol) TICLID (ticlopidine) ZONTIVITY (vorapaxar)	**EFFIENT®** will be approved for patients that have a contraindication or intolerable side effects to Brilinta. • EFFIENT should only be considered for patients < 75 years of age and patients weighing ≥ 60 kg without a known diagnosis of TIA or ischemic stroke. • **Grandfathering**: Members currently stable on Effient will be granted prior authorization approval. Patients taking **BRILINTA** must also be taking a maintenance dose of aspirin not exceeding 100 mg/day. **Ticlopidine** should only be considered for patients who can be monitored for neutropenia and thrombocytopenia during the first four months of therapy. **ZONTIVITY** will be approved for patients with a diagnosis of myocardial infarction or peripheral artery disease without a history of stroke, transient ischemic attack, intracranial bleeding, or active pathological bleeding. Patients must also be taking aspirin and/or clopidogrel concomitantly. Non-preferred products without criteria will be reviewed on a case by case basis.
Therapeutic Drug Class: **COLONY STIMULATING FACTORS** -*Effective 10/1/2018*		

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
PA Required for all agents in this class		Prior authorization will be approved if member meets the following criteria: • All agents will only be approved for FDA-approved indication (listed in table) AND • All non-preferred agents will require a documented failure of Neupogen® vial or syringe for approval (Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions) • If Neupogen® vial or syringe cannot be used for other reasons, a manual PA will be required
NEUPOGEN (filgrastim) vial, syringe	FULPHILA (pegfilgrastim-jmdb) GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) syringe NIVESYM (filgrastim-aafi) ZARXIO (filgrastim-sndz)	

FDA Approved Indication	
Cancer patient receiving myelosuppressive chemotherapy – to reduce incidence of infection (febrile neutropenia) (Either the post nadir ANC is less than 10,000 cells/mm^3 or the risk of neutropenia for the member is calculated to be greater than 20%)	Neupogen, Zarxio, Neulasta, Granix
Acute Myeloid Leukemia (AML) patients receiving chemotherapy	Neupogen, Zarxio, Leukine
Bone Marrow Transplant (BMT)	Neupogen, Zarxio, Leukine
Peripheral Blood Progenitor Cell Collection and Therapy	Neupogen, Zarxio, Leukine
Hematopoietic Syndrome of Acute Radiation Syndrome	Neupogen, Neulasta
Severe Chronic Neutropenia (Evidence of neutropenia Infection exists or ANC is below 750 cells/mm^3)	Neupogen, Zarxio

Therapeutic Drug Class: **ERYTHROPOIESIS STIMULATING AGENTS** *Effective 10/1/2018*

PA Required for all agents in this class		***Eligibility Criteria for all agents in the class** Members must meet all criteria in one of the following four areas: • A diagnosis of cancer, currently receiving chemotherapy, with chemotherapy-induced anemia, and hemoglobin of 10g/dL or lower. • A diagnosis of chronic renal failure, and hemoglobin below 10g/dL • A diagnosis of hepatitis C, currently taking Ribavirin and failed response to a reduction of Ribavirin dose, and hemoglobin less than 10g/dL (or less than 11g/dL if symptomatic). • A diagnosis of HIV, currently taking Zidovudine, hemoglobin less than 10g/dL, and serum erythropoietin level of 500mUnits/mL or less. Hemoglobin results must be from the last 30 days. Medication must be administered in the member's home or long-term care facility. **Non-preferred products:**
EPOGEN (epoetin alfa)	ARANESP (darbepoetin alfa) MIRCERA (methoxy peg-epoetin beta) PROCRIT (epoetin alfa) RETACRIT (epoetin alfa-epbx)	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		• Same as above; **and** • Failed treatment with Epogen. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
IX. Immunological		
Therapeutic Drug Class: **Newer Generation Antihistamines** -*Effective 7/1/2018*		
No PA Required Cetirizine (generic OTC Zyrtec) 5mg and 10mg tab, syrup Loratadine (generic OTC Claritin) 10mg tab and syrup	**PA Required** ALAVERT (loratadine) ALLEGRA (fexofenadine) Cetirizine chewable tablet (OTC) CLARINEX (desloratadine) CLARITIN (loratadine) Desloratadine Fexofenadine Levocetirizine Loratadine ODT XYZAL (levocetirizine) ZYRTEC (cetirizine)	Non-preferred antihistamines and antihistamine/decongestant combinations will be approved for members who have failed treatment with two preferred products in the last 6 months. For members with respiratory allergies, an additional trial of an intranasal corticosteroid will be required in the last 6 months. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.
Antihistamine/Decongestant Combinations		
	PA Required ALLEGRA-D (fexofenadine/PSE) Cetirizine-D	Non-preferred antihistamines and antihistamine/decongestant combinations will be approved for members who have failed treatment with two preferred products in the last 6 months. For members with respiratory allergies, an additional trial of an intranasal corticosteroid will be required in the last 6 months. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	CLARINEX-D (desloratadine-D) CLARITIN-D (loratadine-D) Loratadine-D SEMPREX-D (acrivastine-D) ZYRTEC-D (cetirizine-D)	
Therapeutic Drug Class: **INTRANASAL CORTICOSTEROIDS -***Effective 4/1/2018*		
Brand Generic changes effective 6/27/18		Non-preferred Intranasal Corticosteroids will be approved if the member has failed treatment with 2 preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). • Rhinocort AQ will be approved for pregnant members without failure of preferred products. • Brand name Flonase will require a letter of medical necessity *Approval will be granted for triamcinolone nasal spray in members from 2-4 years
No PA Required Fluticasone (generic FLONASE) Rx only Mometasone *Triamcinolone acetonide (generic Nasacort) (OTC)	**PA Required** BECONASE AQ (beclomethasone diproprionate) Budesonide CHILD NASACORT (triamcinolone) DYMISTA (azelastine/ fluticasone propionate) Flunisolide NASACORT AQ (triamcinolone) NASONEX (mometasone) OMNARIS (ciclesonide) QNASL (beclomethasone diproprionate) RHINOCORT AQ (budesonide) Ticanase (fluticasone propionate + saline nasal spray) ZETONNA (ciclesonide)	

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
Therapeutic Drug Class: **LEUKOTRIENE MODIFIERS** -*Effective 4/1/2018*		
No PA Required Montelukast (tab, chewable)	**PA Required** ACCOLATE (zafirlukast) SINGULAIR (montelukast) (tab, chewable tab, granules) Montelukast granules ZAFIRLUKAST ZYFLO (zileuton) ZYFLO CR (zileuton)	Non-preferred Leukotrienes will be approved if **both** of the following criteria are met: • Member failed treatment with montelukast in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) • Member has a diagnosis of Asthma **Montelukast granules** will be approved if a member has tried and failed montelukast chewable tablets AND has difficulty swallowing.
Therapeutic Drug Class: **MULTIPLE SCLEROSIS AGENTS** -*Effective 4/1/2018*		
Disease Modifying Therapies		
No PA Required (unless indicated*) AVONEX (interferon beta 1a) BETASERON (interferon beta 1b) REBIF (interferon beta 1a) COPAXONE 20MG INJECTION *BNR (glatiramer) *GILENYA (fingolimid) (30 count bottle) (2nd line)	**PA Required** COPAXONE 40MG (glatiramer) EXTAVIA (interferon beta 1b) GLATOPA (glatiramer 20mg) Glatiramer 20mg, 40mg Gilenya (fingolimid) (7 count box) PLEGRIDY (peg-interferon beta 1a) ZINBRYTA (daclizumab)	Non-preferred **Interferon** products will be approved if the member has failed treatment with three preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). Copaxone® 40mg will be approved for members who have severe intolerable injection site reactions (e.g, pain requiring local anesthetic, oozing, lipoatrophy, swelling, or ulceration) to Copaxone 20mg. For the treatment of EARLY disease, **Gilenya, Tecfidera, or Aubagio** may be approved for members that meet the following criteria: • Documented, diagnosis of multiple sclerosis made by neurologist in the last 3 years AND • Documentation provided by prescribing neurologist, or is prescribed in conjunction with a neurologist, for marked functional decline as demonstrated by *two* of the following: AND • MRI, EDSS scale OR medical chart notes that specify increased burden of disease • Provider attests to shared decision making with respect to risks versus benefits of medical treatment AND Appropriate safety criteria are met below:

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
* TECFIDERA (dimethyl fumarate) (2nd line) * AUBAGIO (teriflunomide) (2nd line)		

Safety Criteria	
Tecfidera	• Has no active infections AND • Had a complete blood count with differential within the six months prior to initiating therapy
Aubagio	• Has no active infections AND • If a female patient of child bearing age, has a negative pregnancy test at baseline and is using a form of highly effective contraceptive (e.g. long acting reversible contraception) AND • Had transaminase and bilirubin levels with ALT < 2 times the upper limit of normal within the 6 months prior to initiating therapy AND • Had a complete blood count with differential within the six months prior to initiating therapy AND • Has a documented baseline blood pressure AND Has been evaluated for active or latent tuberculosis infection by documented test results (purified protein derivative test) or blood test.
Gilenya	• Has no active infections AND Does not have a recent history of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, OR New York Heart Association Class III-IV heart failure within six months of initiating therapy AND • Does not have a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome unless patient has a pacemaker AND • Has a baseline QTc interval < 500 ms prior to starting therapy AND • Is not receiving treatment with a Class Ia or Class III anti-arrhythmic medication AND • Had an ophthalmologic evaluation (ocular coherence test) prior to starting therapy and within 3-4 months follow-up after starting therapy AND Had baseline complete blood count with differential and liver function tests

For members meeting NOT meeting early disease criteria above,
Gilenya, Tecfidera, or Aubagio may be approved for members that meet the following criteria:

- Member has failed COPAXONE or a preferred interferon product. [Failure will be defined as intolerable side effects drug-drug interaction, or lack of efficacy]
- One of the following on MRI: presence of any new spinal lesions, cerebellar or brain stem

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		lesions, or change in brain atrophy ● On clinical exam, signs and symptoms consistent with functional limitations that last one month or longer AND ● Has a diagnosis of a relapsing form of MS AND ● Is being prescribed by a neurologist or is prescribed in conjunction with a neurologist AND ● Appropriate safety criteria are met in table above. Zinbryta will be approved if the member has met all the following criteria: ● Members how have failed three MS therapies which consist of the following: Copaxone, a preferred interferon product, Gilenya, Tecfidera, or Aubagio. Failure will be defined as intolerable side effects, drug-drug interaction, or lack of efficacy. Lack of efficacy will be defined as one of the following: ○ One of the following on MRI: presence of any new spinal lesions, cerebellar or brain stem lesions, or change in brain atrophy ○ On clinical exam, signs and symptoms consistent with functional limitations that last one month or longer ● Has a diagnosis of a relapsing form of MS AND ● Is being prescribed by or in conjunction with a neurologist AND ● Neurologist is enrolled in the REMS program AND ● Has no active infections AND ● If a female patient of child bearing age, has a negative pregnancy test at baseline and is using a form of highly effective contraceptive AND ● Does not have hepatic disease or liver impairment, including AST or ALT > 2 times the upper limit of normal within six months of initiating therapy AND ● Does not have a history of autoimmune hepatitis or other autoimmune disease involving the liver AND ● Has been evaluated for active or latent tuberculosis infection by documented test results (purified protein derivative test) or blood test and is negative AND ● Has been evaluated for hepatitis B and C and has negative tests AND ● Zinbryta will be used as monotherapy Quantity Limits: 150 mg syringe per 28 days Grandfathering: Members currently stabilized on GILENYA, TECFIDERA, and AUBAGIO may receive approval to continue on that agent.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

Symptom Management Therapies		
	PA Required AMPYRA (dalfampridine)	**AMPYRA** – A 3 month supply will be approved if all of the following criteria are met: • Member has a diagnosis of MS; Member is ambulatory and has established a baseline which is defined as ambulating between 8-45 seconds Timed 25-foot Walk (T25FW) assessment OR has established a baseline activities of daily living (ADL); • Member has no history of seizure disorder; • Member has no history of moderate to severe renal dysfunction (CrCl > 50 ml/min); • Prescriber is a neurologist or is prescribed in conjunction with a neurologist; • The prescribed dose does not exceed 10 mg twice daily. Extended coverage of Ampyra (up to one year) will be approved if documentation shows improvement in ambulation (measured by T25FW assessment) or improvement in ADLs after three months of therapy.
Therapeutic Drug Class: **OPHTHALMIC ALLERGY** -*Effective 4/1/2018*		
No PA Required Cromolyn 4% Ketotifen (generic Zaditor) OTC LASTACAFT (alcaftadine) PAZEO (olopatadine 0.7%)	**PA Required** ALAWAY (ketotifen) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) Azelastine BEPREVE (bepotastine) ELESTAT (epinastine) EMADINE (emedastine) epinastine Olopatadine 0.1%, 0.2% PATADAY (olopatadine 0.2%) PATANOL (olopatadine 0.1%)	Non-preferred Ophthalmic Allergy medications will be approved if the member has failed treatment with two preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	ZADITOR (ketotifen 0.025%) OTC	
Therapeutic Drug Class: **OPHTHALMIC IMMUNOMODULATORS -***Effective 10/1/2018*		
No PA Required RESTASIS (cyclosporine 0.05%)	**PA Required** RESTASIS MULTIDOSE (cyclosporine 0.05%) XIIDRA (lifitegrast)	**XIIDRA**® will be approved if all the following is met: • Member is 18 years and older AND • Member has a diagnosis of chronic dry eye AND • Member has failed a 3-month trial of Restasis® (Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions) AND • Prescriber is an ophthalmologist, optometrist or rheumatologist • Maximum quantity 60 single use containers for 30 days **Restasis® multidose** will be approved if member has failed a 3-month trial of Restasis® single dose, a 3-month trial of Xiidra®, and a 3 month trial of non-prescription wetting agent in the form of drops, ointments, or gels.
Therapeutic Drug Class: **TARGETED IMMUNE MODULATORS -***Effective 1/1/2018*		
No PA Required (*Must meet eligibility criteria) ENBREL (etanercept) HUMIRA (adalimumab) *COSENTYX (secukinumab) (second line)	**PA Required** ACTEMRA (tocilizumab) ARCALYST (rilonacept) CIMZIA (certolizumab) ILARIS (canakinumab) Ilumya (tildrakizumab-asmn) KEVZARA (sarilumab) KINERET (anakinra) ORENCIA (abatacept) Subcutaneous OTEZLA (apremilast)	For approval of **Cosentyx**, failure of Humira is required. (Failure is defined as: lack of efficacy of a three-month trial, allergy, intolerable side effects or significant drug-drug interaction.) Non-preferred medications may be approved for the listed indications and trial(s)/failure(s) of other agents shown in Table 1 below. Additional authorization approval criteria not found in Table 1 is listed for specific agents below. **Arcalyst** will be approved with a prior authorization for members ≥ 12 years of age with documented Cryopyrin-Associated Periodic Syndromes (CAPS) including: • Familial Cold Autoinflammatory Syndrome (FCAS) • Muckle-Wells Syndrome (MWS) **Humira** will be approved for members with the following diagnoses: • Moderate to severe hidradenitis suppurativa • Adult members with a diagnosis of uveitis (non-infectious intermediate, posterior and panuveitis) **Ilaris** will be approved with a prior authorization for members meeting any of the following criteria: • ≥ 4 years of age with documented Cryopyrin-Associated Periodic Syndromes (CAPS) including o Familial Cold Autoinflammatory Syndrome (FCAS)

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	SIMPONI (golimumab) STELARA (ustekinumab) TALTZ (ixekizumab) XELJANZ (tofacitinib) XELJANZ XR (tofacitinib) ***for information on IV infused Targeted Immune Modulators for Rheumatoid Arthritis please see Appendix P**	○ Muckle-Wells Syndrome (MWS) • Documented diagnosis of Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) • Documented diagnosis of Mevalonate Kinase Deficiency (MKD) **Kineret** will be approved with a prior authorization for members with documented • Neonatal-onset multisystem inflammatory disease (NOMID) • Familial Mediterranean Fever (FMF) **Taltz** prior authorization approval will be given for an initial 12 weeks and further authorization will be provided based on clinical response **Xeljanz** will be not be approved for combination therapy with a biologic disease modifying agent. Quantity Limits: 2 tablets per day or 60 tablets for a 30 day supply The Department would like to remind providers that many products have patient support programs that assist patients in drug administration, education, and emotional support for our member's diseases.

Table 1: **Targeted Immune Modulators FDA-Approved indications and required trial(s) for PAR approval** (Note, "X" is checked for FDA approved indications)

	Rheumatoid Arthritis	Psoriatic Arthritis	Ankylosing Spondylitis	Plaque Psoriasis	Crohn's Disease	Ulcerative Colitis	Juvenile Idiopathic Arthritis
Humira (adalimumab) ***Preferred***	X	X	X	X	X (≥6 years of age)	X	X (≥ 2 years of age)
Enbrel (etanercept) ***Preferred***	X	X	X	X (≥ 4 years of age)			X (≥ 2 years of age)
Cosentyx (secukinumab) ***Preferred 2nd line***		X (Trial Humira)	X (Trial Humira)	X (Trial Humira)			
Actemra (tocilizumab)	X (Trial 1 **DMARD AND Humira AND Enbrel)						
Cimzia (certolizumab)	X (Trial Humira AND Enbrel)	X (Trial Humira AND Enbrel OR Cosentyx)	X (Trial Humira AND Enbrel OR Cosentyx)	X (Trial Humira AND Enbrel OR Cosentyx)	X (Trial Humira)		
Kineret (anakinra)	X (Trial Humira AND Enbrel)						
Orencia (abatacept)	X (Trial Humira AND Enbrel)	X (Trial Humira AND Enbrel OR Cosentyx)					X (≥2 years of age, Trial Humira AND Enbrel)
Otezla (apremilast)		X (Trial 1 **DMARD AND		X (Trial 1 **DMARD AND			

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

		Humira AND Enbrel OR Cosentyx)		Humira AND Enbrel OR Cosentyx)			
Simponi (golimumab)	X with *MTX (Trial Humira AND Enbrel)	X (Trial Humira AND Enbrel OR Cosentyx)	X (Trial Humira AND Enbrel OR Cosentyx)			X (Trial Humira)	
Stelara (ustekinumab)		X (Trial Humira AND Enbrel OR Cosentyx)		X (Trial Humira AND Enbrel OR Cosentyx)	X (Trial Humira)		
Taltz (ixekizumab)				X (Trial *MTX AND Humira AND Enbrel OR Cosentyx)			
Xeljanz, Xeljanz XR (tofacitinib)	X (Trial Humira AND Enbrel)					X (Trial Humira)	
Ilaris (canakinumab)							X (≥ 2 years of age, Trial Humira AND Enbrel)
Kevzara (sarilumab)	X (Trial Humira AND Enbrel)						
Siliq (brodalumab)				X (Trial Humira AND Enbrel OR Cosentyx)			
Tremfya (guselkumab)				X (Trial Humira AND Enbrel OR Cosentyx)			

*MTX – Methotrexate **DMARD – Disease Modifying Antirheumatic Drug (e.g. Methotrexate, leflunomide, sulfasalazine)

Therapeutic Drug Class: **TOPICAL IMMUNOMODULATORS** – *Effective 7/1/2018*

***Must meet criteria**	**PA Required**	Manual review will be required for members needing ≥ 6 weeks of therapy.
ELIDEL (pimecrolimus)*	PROTOPIC (tacrolimus) Tacrolimus (generic Protopic)	*__ELIDEL__® will only be approved for a member who had an adequate trial (e.g, one month or longer) of a topical steroid and failed treatment. (Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.) **Tacrolimus** will only be approved for a member who had an adequate trial (e.g, one month or longer) of a topical steroid and ELIDEL® and failed treatment. (Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.) For members under 18 years of age, must be prescribed by or in conjunction with a dermatologist or allergist.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

X. Miscellaneous

Therapeutic Drug Class: **EPINEPHRINE PRODUCTS** -*Effective 1/1/2018*

No PA Required	PA Required	
Epinephrine auto-injector (generic Epipen)	EPIPEN ADRENACLICK Epinephrine auto-injector (generic Adrenaclick)	Non-preferred products will be approved if the member has failed treatment with one of the preferred products (Failure is defined as: allergy or intolerable side effects) Quantity limit: 4 auto injectors per year unless used / damaged / lost

Therapeutic Drug Class: **NEWER HEREDITARY ANGIOEDEMA PRODUCTS** -*Effective 10/1/2018*

PA Required for all agents in this class		**Medications Indicated for Routine Prophylaxis:**
Berinert (C1 esterase inhibitor) 500 Unit kit and vial Firazyr (icatibant acetate) 30mg/3ml syringe Haegarda (C1 esterase inhibitor) 2,000 unit and 3,000 unit vial	Cinryze (C1 esterase inhibitor) 500 unit kit Ruconest (C1 esterase inhibitor, recomb) 2,100 unit vial	Members are restricted to coverage of one medication for routine prophylaxis at one time. Prior authorization approval will be for one year. Preferred: **Haegarda®** may be approved for members meeting the following criteria: ○ Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances (C4 level, CI-INH level) **AND** ○ Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND ○ Member meets at least one of the following: ▪ Haegarda® is being used for short-term prophylaxis to undergo a surgical procedure or major dental work **OR** ▪ Haegarda® is being used for long-term prophylaxis and member meets one of the following: ○ History of ≥1 attacks per month resulting in documented ED admission or hospitalization **OR** ○ History of laryngeal attacks **OR** ○ History of ≥2 attacks per month involving the face, throat, or abdomen **AND**

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		○ Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications **AND** ○ Member has received hepatitis A and hepatitis B vaccination **AND** ○ Provider attests to performing annual testing or screening (as appropriate) for HBV, HCV, and HIV Max Dose: 60 IU/kg Minimum Age: 10 years <u>Non-preferred:</u> **Cinryze®** may be approved for members meeting the following criteria: ○ Member has history of trial and failure of Haegarda®. Failure is defined as lack of efficacy allergy, intolerable side effects, or a significant drug-drug interaction **AND** ○ Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances (C4 level, CI-INH level) **AND** ○ Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND ○ Member meets at least one of the following: ▪ Cinryze® is being used for <u>short-term prophylaxis</u> to undergo a surgical procedure or major dental work **OR** ▪ Cinryze® is being used for <u>long-term prophylaxis</u> and member meets one of the following: ○ History of ≥1 attacks per month resulting in documented ED admission or hospitalization **OR** ○ History of laryngeal attacks **OR** ○ History of ≥2 attacks per month involving the face, throat, or abdomen **AND** ○ Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications **AND** ○ Member has received hepatitis A and hepatitis B vaccination **AND** ○ Provider attests to performing annual testing or screening (as appropriate) for HBV, HCV, and HIV. Minimum age: 6 years Max dose: 100 Units/kg **Medications Indicated for Treatment of Acute Attacks:**

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		Members are restricted to coverage of one medication for <u>treatment of acute attacks</u> at one time. Prior authorization approval will be for one year. <u>Preferred:</u> **Firazyr®** may be approved for members meeting the following criteria: o Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances (C4 level, CI-INH level) **AND** o Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema **AND** o Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications Minimum age: 18 years Maximum dose: 30mg ***Berinert®** may be approved for members meeting the following criteria: o Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances (C4 level, CI-INH level) **AND** o Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema **AND** o Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications **AND** o Member has received hepatitis A and hepatitis B vaccination **AND** o Provider attests to performing annual testing or screening (as appropriate) for HBV, HCV, and HIV Minimum age: 6 years Max dose: 20 IU/kg <u>Non-preferred:</u> **Ruconest®**

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
		○ Member has a history of trial and failure of Firazyr® OR Berinert®. Failure is defined as lack of efficacy, allergy, intolerable side effects, or a significant drug-drug interaction **AND** ○ Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances (C4 level, CI-INH level) **AND** ○ Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND ○ Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications **AND** ○ Member has received hepatitis A and hepatitis B vaccination **AND** ○ Provider attests to performing annual testing or screening (as appropriate) for HBV, HCV, and HIV. Minimum age: 13 years Max dose: 4200 Units/dose

Therapeutic Drug Class: **PRENATAL VITAMINS / MINERALS** -*Effective 10/1/2018*

***No PA Required (*if female and age 11-60)**		**PA Required**	Preferred and non-preferred prenatal vitamin products are a benefit for females from 11-60 years of age who are pregnant, lactating, or trying to get pregnant. Prior authorization for non-preferred agents will be approved if member fails 7-day trial with four preferred agents. (Failure is defined as: allergy, intolerable side effects, or significant drug-drug interaction)
CITRANATAL ASSURE combo pack	NESTABS tablets	All other rebateable prescription products are non-preferred	
CITRANATAL 90 DHA combo pack	PNV OB+DHA COMBO PACK PNV		
CITRANATAL B-CALM	Prenatal Plus Multivit tab		
CITRANATAL HARMONY capsule	TRINATAL RX 1		
CITRANATAL DHA pack	TRUST NATAL DHA		
Complete Natal DHA	PRENATAL PLUS-DHA COMBO PACK		
CONCEPT DHA	PRENATAL VITAMIN PLUS LOW IRON		
MACNATAL CN DHA SOFTGEL	Preplus CA-FE 27 MG – FA 1mg tab		
	VIRT-ADVANCE TABLET		

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	VIRT-VITE GT TABLET	

XI. Renal/Genitourinary

Therapeutic Drug Class: **OVERACTIVE BLADDER AGENTS -***Effective 10/1/17*

No PA Required	PA Required	
Oxybutynin tablets (generic) Oxybutynin ER tablets (generic) TOVIAZ (fesoterodine ER)	DETROL (tolterodine) DETROL LA (tolterodine ER) DITROPAN (brand) DITROPAN XL (brand) ENABLEX (darifenacin) Flavoxate GELNIQUE (oxybutynin gel) MYRBETRIQ (mirabegron) Oxybutynin syrup OXYTROL (oxybutynin patch) SANCTURA (trospium) SANCTURA XL (trospium ER) Tolterodine VESICARE (solifenacin)	Non-preferred products will be approved for members who have failed treatment with two preferred products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction, or if a non-solid oral dosage form is needed due to inability to swallow solid oral dosage forms or presence of feeding tube Members with hepatic failure can receive approval for trospium or trospium extended-release (Sanctura XR) products without a trial on a Preferred product.

XII. RESPIRATORY

Therapeutic Drug Class: **RESPIRATORY INHALANTS -***Effective 7/1/2018*

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)

Inhaled Anticholinergics		
No PA Required **Solutions** Ipratropium (generic Atrovent) solution **Short-Acting Inhalers** ATROVENT HFA (ipratropium) **Long-Acting Inhalers** SPIRIVA Handihaler (tiotropium)	**PA Required** **Solutions** ATROVENT (ipratropium) solution Lonhala Magnair (glycopyrrolate) solution **Short-Acting Inhalers** **Long-Acting Inhalers** INCRUSE ELLIPTA (umeclidinium) SEEBRI Neohaler (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) TUDORZA Pressair (aclidinium)	Non-preferred anticholinergic agents will be approved for members with a diagnosis of COPD including chronic bronchitis and/or emphysema who have trialed/failed treatment with two preferred agents, one of which must be Spiriva Handihaler. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. **Spiriva Respimat®** will be approved for members with a diagnosis of asthma who have trialed/failed one preferred single agent corticosteroid product AND two preferred combination corticosteroid products. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. **Lonhala Magnair®** will receive prior authorization approval for members who have trialed/failed two preferred anticholinergic agents. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.
Inhaled Anticholinergic Combinations		
No PA Required **Solutions** Albuterol/ipratropium solution **Short-Acting Inhalers** COMBIVENT RESPIMAT (albuterol/ipratropium)	**PA Required** **Solutions** **Short-Acting Inhalers** **Long-Acting Inhalers** ANORO ELLIPTA (umeclidinium/vilanterol) BEVESPI AEROSPHERE (glycopyrrolate/formoterol fumarate) STIOLTO Respimat (tiotropium/olodaterol)	Non-preferred combination anticholinergic agents will be approved for members with a diagnosis of COPD including chronic bronchitis and/or emphysema who have trialed/failed treatment with two preferred respiratory agents, one of which must be Combivent Respimat® Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
	UTIBRON Neohaler (glycopyrrolate/indacaterol)	
Inhaled Beta2 Agonists (short acting)		
No PA Required **Solutions** Albuterol (generic) solution **Inhalers** PROAIR (albuterol) HFA	**PA Required** **Solutions** PROVENTIL (albuterol) solution XOPENEX (levalbuterol) solution **Inhalers** Levalbuterol HFA PROAIR Respiclick (albuterol) PROVENTIL (albuterol) HFA inhaler VENTOLIN (albuterol) HFA inhaler XOPENEX (levalbuterol) Inhaler	Non-preferred, short acting beta2 agonists will be approved for members who have failed treatment with one preferred agent. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). **Proair HFA, Proventil HFA, Ventolin HFA:** Quantity limits: 2 inhalers / 30 days
Inhaled Beta2 Agonists (long acting)		
***Must meet eligibility criteria** **Solutions** **Inhalers** *SEREVENT DISKUS (salmeterol) inhaler	**PA Required** **Solutions** BROVANA (arformoterol) solution PERFOROMIST (formoterol) solution **Inhalers** ARCAPTA (indacaterol) neohaler FORADIL (formoterol) STRIVERDI RESPIMAT (olodaterol)	**SEREVENT** ® will be approved for members with moderate to very severe COPD. Non-preferred agents will be approved for members with moderate to severe COPD, AND members must have failed a trial of SEREVENT (Failure is defined as: lack of efficacy, allergy, contraindication to, intolerable side effects, or significant drug-drug interaction). **For treatment of members with diagnosis of asthma needing add-on therapy, please refer to preferred agents in combination Long-Acting Beta Agonist/Inhaled Corticosteroid. SEREVENT will not be approved for treatment of asthma in members needing add-on therapy due to safety risks associated with monotherapy.
Inhaled Corticosteroids		

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-Preferred Products will be approved for one year unless otherwise stated.)
No PA Required **Solutions** PULMICORT BNR (budesonide) nebules 0.25mg 0.5mg, 1mg **Inhalers** ASMANEX twisthaler (mometasone) FLOVENT (fluticasone) diskus FLOVENT (fluticasone) HFA	**PA Required** **Solutions** Budesonide nebules 0.25mg 0.5mg, 1mg **Inhalers** AEROSPAN HFA (flunisolide) inhaler ALVESCO (ciclesonide) inhaler ARNUITY ELLIPTA (fluticasone furoate) ASMANEX HFA (mometasone furoate) inhaler PULMICORT (budesonide) flexhaler QVAR Redihaler (beclomethasone)	Non-preferred inhaled corticosteroids will be approved in members with asthma who have failed an adequate trial of two preferred agents. An adequate trial is defined as at least 6 weeks. (Failure is defined as: lack of efficacy, allergy, contraindication to, intolerable side effects, or significant drug-drug interactions.) **Pulmicort Flexhaler** will only be approved for female members with asthma who have a new diagnosis of pregnancy. **Pulmicort** (Budesonide) **nebulizer** solution will only be approved for a maximal dose of 2mg/day.
Inhaled Corticosteroid Combinations		
No PA Required ADVAIR Diskus (fluticasone/salmeterol) DULERA (mometasone/ formoterol) SYMBICORT (budesonide/formoterol) inhaler	**PA Required** ADVAIR HFA (fluticasone/salmeterol) BREO Ellipta (vilanterol/fluticasone furoate) TRELEGY Ellipta (Fluticasone Furoate/Umeclidinium/Vilanterol)	Non-preferred inhaled corticosteroid combinations will be approved for members meeting both of the following criteria: • Member has a qualifying diagnosis of asthma or COPD; AND • Member has failed two preferred agents (Failure is defined as lack of efficacy, allergy, intolerable side effects, significant drug-drug interactions, or dexterity/coordination limitations (per provider notes) that significantly impact appropriate use of a specific dosage form.) **Trelegy Ellipta®** prior authorization will be approved if the member has trialed/failed two preferred inhaled corticosteroid combination products AND Spiriva Handihaler®. Failure is defined as lack of efficacy, allergy, intolerable side effects, significant drug-drug interactions, or dexterity/coordination limitations (per provider notes) that significantly impact appropriate use of a specific dosage form.