

Prior Authorization Guidelines

Prior Authorization Guidelines

GENERIC: ACAMPROSATE

BRAND: CAMPRAL[®]

INDICATION:

- (1) Maintenance of abstinence for alcohol-dependent patients who are abstinent at treatment initiation.

Criteria:

- (a) Patient must be abstinent at treatment initiation; **and**
- (b) Treatment must be part of a comprehensive management program that includes psychosocial support; **and**
- (c) Patient must be opiate dependent.

GENERIC: ACARBOSE

BRAND: PRECOSE[®]

INDICATION:

- (1) Type 2 diabetes mellitus

Criteria:

- (a) Failure of maximal doses of *one* oral sulfonylurea (e.g., glyburide 20mg daily or equivalent). Failure is defined as Hemoglobin A1c > 7.0.

GENERIC: ACLIDINIUM BROMIDE AEROSOL POWDER

BRAND: TUDORZA PRESSAIR[®]

INDICATION:

- (1) Long-term maintenance treatment of bronchospasm associated with COPD (including bronchitis and emphysema)

Criteria:

- (a) Diagnosis of COPD **and**
- (b) Must be greater than 18 years of age **and**
- (c) Documented inadequate response or intolerance to Spiriva

Prior Authorization Guidelines

GENERIC: ACYCLOVIR TOPICAL OINTMENT

BRAND: ZOVIRAX[®] 5%[®]

INDICATIONS:

- (1) Herpes genitalis
- (2) Oral herpes infection

Criteria:

- (a) Herpes genitalis – for initial episode only; **or**
- (b) Oral herpes infection – for immunocompromised patients *only*.

GENERIC: ADALIMUMAB

BRAND: HUMIRA[®]

INDICATIONS:

- (1) Moderate to severely active rheumatoid arthritis
- (2) Psoriatic arthritis
- (3) Ankylosing spondylitis
- (4) Moderate to severely active Crohn's disease

Criteria:

- (a) The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to Humira therapy; **and**
- (b) The patient does not have a clinically important active infection

Additional Criteria for RA:

- (a) The patient has failed or is intolerant to one formulary NSAID **and**
- (b) The patient has failed or is intolerant to one formulary DMARD

Additional Criteria for Crohn's:

- (a) The patient has failed or is intolerant to infliximab;**or**
- (b) The patient has failed or is intolerant to mesalamine or sulfasalazine;**and**
- (c) The patient has failed or is intolerant to corticosteroids;**and**
- (d) The patient has failed or is intolerant to an immunomodulator (e.g., methotrexate, 6-mercaptopurine or azathioprine)

Prior Authorization Guidelines

GENERIC: ALBUTEROL SULFATE INHALER

BRAND: PROAIR HFA[®]

INDICATION:

Asthma

- (1) Symptomatic management of prevention of bronchospasms in patient 4 years of age and older with reversible obstructive airway disease
- (2) Prevent of exercise-induced bronchospasm in patients 4 years of age and older
- (3) COPD- Symptomatic management of reversible bronchospasm associated with COPD in patients who continue to have evidence of bronchospasm despite regular use of an orally inhaled bronchodilator and who require a second bronchodilator

Criteria:

- (a) Failure or contraindication of Ventolin HFA or Proventil HFA

GENERIC: ANTIHEMOPHILIC FACTORS

BRAND: ALPHANATE[®], FEIBA VH[®], RECOMBIMATE[®], THROMBATE III[®]

INDICATION:

- (1) Hemophilia A

Criteria:

- (a) Diagnosis of Hemophilia A

GENERIC: AZELASTINE

BRAND: ASTELIN[®]

INDICATIONS:

- (1) Allergic conjunctivitis
- (2) Perennial allergic rhinitis
- (3) Seasonal allergic rhinitis

Criteria:

- (a) Patient is ≥ 5 years of age with one of the above diagnoses;
and
- (b) Failure of at least one formulary nasal steroid after a period of at least two months on the maximum dose appropriate and tolerated by the patient

Prior Authorization Guidelines

GENERIC: BOCEPREVIR

BRAND: VICTRELIS[®]

INDICATION:

- (1) Treatment of chronic hepatitis C genotype 1 used in combination with peginterferon alfa and ribavirin in patients with compensated liver disease.

Criteria:

- (a) Diagnosis of chronic hepatitis C genotype 1; **and**
- (b) Diagnosis of compensated liver disease; **and**
- (c) No previous treatment (full or partial course) of Incivek or Victrelis; **and**
- (d) Patient has been counseled on the importance of medication adherence and is willing to adhere to the regimen for the full course of therapy; **and**
- (e) The patient must have completed 4 weeks of peginterferon and ribavirin therapy (treatment weeks 1 through 4); **and**
- (f) HCV-RNA levels must be drawn at treatment weeks 8, 12, and 24 (Victrelis week 4, 8, and 20); **and**
- (g) Females of child bearing potential must meet the following additional parameters:
 - a. A recent negative pregnancy test; **and**
 - b. Been counseled on the teratogenic effects of triple therapy; **and**
 - c. Is willing to practice contraception during and for 6 months after completion of therapy

GENERIC: BUDESONIDE/FORMOTEROL

BRAND: SYMBICORT[®]

INDICATION:

- (1) Maintenance treatment of asthma in patients 12 years of age and older

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Criteria:

- (a) Currently on, but not adequately controlled by an inhaled corticosteroid; **or**
- (b) Maintenance treatment of airflow obstruction in patients with chronic bronchitis and emphysema
- (c) Patients must be reevaluated after 6 months

**For members currently with an approved prior authorization for Symbicort, claims will process as long as the member has filled Symbicort within the last 3 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to Symbicort therapy, or with no claims history of Symbicort within the last 3 months.*

GENERIC: CALCITONIN-SALMON

BRAND: MIACALCIN[®]

INDICATIONS:

- (1) Mild to moderate Paget's disease of bone
- (2) Osteoporosis

Criteria:

- (a) Failure, contraindication or intolerance to adequate trial of oral bisphosphonate; **and**

One of the following:

- (1) Bone density measurement ≥ 2.5 standard deviations below the mean for normal, young adults of same gender (T-score ≤ -2.5); **or**
 - (2) History of an osteoporotic vertebral fracture; **or**
 - (3) Postmenopausal woman with low bone mineral density defined by T-score between -2.0 and -2.5 AND one of the following risk factors for fracture:
 - (a) Thinness or low body mass index defined by weight < 127 lb (57.7 kg) or BMI < 21 kg/m²
 - (b) History of fragility fracture since menopause
 - (c) History of hip fracture in a parent
 - (4) Diagnosis of Paget's disease of bone
- (b) Patients receiving glucocorticoids in daily dosages of ≥ 7.5 mg prednisone daily (see table) AND who have bone density measurement > 1 standard deviations below the mean for normal, young adults of same gender (T-score < -1.0)

Prior Authorization Guidelines

Glucocorticoid Potency Equivalencies			
Glucocorticoid	Approximate equivalent dose (mg)	Relative anti-inflammatory (glucocorticoid) potency	Relative mineralocorticoid potency
<i>Short-acting</i>			
Cortisone	25	0.8	2
Hydrocortisone	20	1	2
<i>Intermediate-acting</i>			
Prednisone	5	4	1
Prednisolone	5	4	1
Triamcinolone	4	5	0
Methylprednisolone	4	5	0
<i>Long-acting</i>			
Dexamethasone	0.75	20-30	0
Betamethasone	0.6-0.75	20-30	0

Table adapted from Facts and Comparisons® 1999:122

** For injectable medications administered by a healthcare professional, please refer to the “Specialty Medication Guidelines” in the beginning of this formulary.*

** If documentation of osteoporosis is available, please submit with PA request.*

GENERIC: CEFDINIR SUSPENSION

BRAND: OMNICEF®

INDICATIONS:

- (1) CAP
- (2) Acute exacerbations of chronic bronchitis
- (3) Acute maxillary sinusitis
- (4) Pharyngitis / Tonsillitis
- (5) Uncomplicated skin and skin structure infections
- (6) Acute bacterial otitis media – pediatrics only

Criteria:

- (a) Recent failure (within 30 days) of at least one standard first-line formulary antibiotic in absence of culture; **or**
- (b) Documentation of cultured organism with sensitivity to only cefdinir, other third generation cephalosporin OR contraindications to all other sensitive antibiotics.

Prior Authorization Guidelines

GENERIC: CELECOXIB

BRAND: CELEBREX[®]

INDICATIONS:

- (1) Relief of signs and symptoms of rheumatoid arthritis (RA) in adults
- (2) Relief of signs and symptoms of osteoarthritis (OA)
- (3) Relief of signs and symptoms of ankylosing spondylitis
- (4) Management of acute pain in adults
- (5) Treatment of primary dysmenorrhea
- (6) To reduce the number of adenomatous polyps in familial adenomatous polyposis, as an adjunct to usual care

Criteria:

- (a) Failure, intolerance, or contraindication to at least 2 formulary NSAIDs; **and**
- (b) One of the following:
 - (1) Age greater than 65; **or**
 - (2) Concomitant use of warfarin or other antiplatelet therapy; **or**
 - (3) Concomitant use of chronic systemic corticosteroid therapy; **or**
 - (4) Documented history of ulcer disease or GI bleed; **or**
 - (5) Documented history of significant GI disease requiring therapy with an H2 antagonist or proton pump inhibitor; **or**
 - (6) Documented history of nonselective NSAID-induced GI adverse effects; **and**
- (c) For OA, therapeutic failure (≥ 21 day trial), intolerance of, or contraindication to at least 1 of the following: acetaminophen or opiod analgesics or topical analgesics (capsaicin, etc.)

GENERIC: CHOLINE FENOFIBRATE

BRAND: TRILIPIX[®]

INDICATION:

- (1) Hypercholesterolemia, Hypertriglyceridemia

Criteria:

- (a) Failure of generic fenofibrate 48, 54, 154 or 160mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

Prior Authorization Guidelines

GENERIC: CLOXACILLIN SODIUM

INDICATION:

- (1) Treatment of infections due to penicillinase-producing staphylococci

Criteria:

- (a) Diagnosis of staphylococcal infection; **and**
- (b) Failure of dicloxacillin sodium.

GENERIC: CYANOCOBALAMIN (HYDROXOCOBALAMIN)

BRAND: VITAMIN B-12[®]

INDICATION:

- (1) Vitamin B-12 deficiency

Criteria:

- (a) Patients who lack intrinsic factor; **or**
- (b) Patients who are on long-term PPI therapy; **or**
- (c) Patients with a partial or complete gastrectomy.

** For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

GENERIC: DABIGATRAN ETEXILATE MESYLATE

BRAND: PRADAXA[®]

INDICATION:

- (1) Reduce the risk of stroke and systemic embolism in patients with non-vascular atrial fibrillation.

Criteria:

- (a) Diagnosis of non-vascular atrial fibrillation; **and**
- (b) Must have recent CrCl levels or Scr and current patient weight; **and**
- (c) No active pathological bleeding; **and**

- (d) Must have tried and failed or intolerant to Warfarin

NOTE: Conversion to Pradaxa:

- (a) From Warfarin: discontinue warfarin and start pradaxa when INR < 2.0
- (b) From Parenteral Anticoagulants: start Pradaxa 0-2 hrs prior to next scheduled dose of parenteral anticoagulant, or at the time of discontinuation of continuous parenteral drug (e.g. heparin)

Prior Authorization Guidelines

GENERIC: DALFAMPRIDINE

BRAND: AMPYRA[®]

INDICATION:

(1) Improved walking speed in patients with multiple sclerosis

Criteria:

- (a) Diagnosis of multiple sclerosis; **and**
- (b) Prescribed by a neurologist; **and**
- (c) Currently taking a disease modifying drug for multiple sclerosis (Avonex, Aubagio, Betaseron, Copaxone, Extavia, Gilenya, Rebif, Tecfidera or Tysabri)

**Renewals will require documented improvement in walking speed (demonstrated improvement in timed 25 foot walk)*

GENERIC: DANTROLENE

BRAND: DANTRIUM[®]

INDICATION:

(1) Spasticity resulting from upper motor neuron disorders

Criteria:

- (a) Demonstrated failure of, or intolerance to, Baclofen (Lioresol[®]).

GENERIC: DARBEPOETIN ALFA

BRAND: ARANESP[®]

INDICATIONS:

(1) Anemia with cancer chemotherapy (nonmyeloid)

(2) Anemia due to chronic renal failure

Criteria:

(a) Ensure patient's iron stores are adequate (Ferritin \geq 100 ng/mL and/or Transferrin saturation \geq 20%) or patient is being treated with iron; **and**

(b) Adequate blood pressure control; **and**

Chronic kidney disease patients:

(a) Initiate treatment when hemoglobin is $<10\text{g/dL}$; **or**

Anemia due to chemotherapy in cancer:

(a) Initiate treatment only if hemoglobin is $<10\text{g/dL}$; **and**

(b) Anticipated duration of myelosuppressive chemotherapy is \geq 2 months

Prior Authorization Guidelines

For renewals:

- (a) **Chronic kidney disease patients:**
 - (1) With dialysis Hbg <11; or
 - (2) Without dialysis Hbg <10
- (b) **Anemia due to chemotherapy in cancer patients:**
 - (1) Hbg <11

GENERIC: DESMOPRESSIN

BRAND: DDAVP[®]

INDICATIONS:

- (1) Central cranial diabetes insipidus (CCDI)
- (2) Primary nocturnal enuresis

Criteria:

- (a) Diagnosis of CCDI; **or**
- (b) For the treatment of enuresis, age 6 to 18 years; **and**
- (c) Failure of behavior modification for 6 months (e.g., alarms, no beverages after 5pm, special diapers etc.).

** Renewals for the indication of nocturnal enuresis will require the documentation of a retrial of behavior modification.*

GENERIC: DIMETHYL FUMERATE

BRAND: TECFIDERA[®]

INDICATION:

- (1) Diagnosis of a relapsing form of Multiple Sclerosis;

Criteria:

- (a) Prescribed by neurologist; and
- (b) Not requesting combination of any 2 agents together:
Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera

GENERIC: DONEPEZIL

BRAND: ARICEPT[®]

INDICATION:

- (1) Alzheimer's disease: for the treatment of dementia.

Criteria:

- (a) Dementia must be confirmed by clinical evaluation

Prior Authorization Guidelines

GENERIC: ENTACAPONE

BRAND: COMTAN[®]

INDICATION:

- (1) As an adjunct to levodopa/carbidopa to treat patients with idiopathic Parkinson's disease

Criteria:

- (a) Diagnosis of idiopathic Parkinson's disease; **and**
- (b) Patient is receiving concomitant levodopa/carbidopa therapy.

GENERIC: EPOETIN ALFA

BRAND: PROCRIT[®], EPOGEN[®]

INDICATIONS:

- (1) Anemia with cancer chemotherapy (nonmyeloid)
- (2) Anemia due to chronic renal failure
- (3) Anemia of HIV infection associated with zidovudine
- (4) Reduction of allogenic blood transfusion for elective, noncardiac, nonvascular surgery

Criteria:

- (a) Patient's iron stores are adequate (Ferritin \geq 100 ng/mL and/or Transferrin saturation \geq 20%) or patient is being treated with iron; **and**
- (b) Adequate blood pressure control

Chronic kidney disease patients:

- (a) Initiate treatment when hemoglobin is <10 g/dL (3 month approval)

Anemia due to chemotherapy in cancer patients:

- (a) Initiate treatment only if hemoglobin <10 g/dL and anticipated duration of myelosuppressive chemotherapy is \geq 2 months

Anemia due to zidovudine in HIV-infected patients:

- (a) Initiate treatment when hemoglobin is <10 g/dL

Surgical procedure - Transfusion of blood product, Allogenic; Prophylaxis:

- (a) Patient's pre-operative Hgb >10 to ≤ 13 g/dL (14 day approval)

For renewals:

Chronic kidney disease patients:

- (a) With dialysis Hgb <11
- (b) Without dialysis Hgb <10

Anemia due to chemotherapy in cancer patients:

- (a) Hgb <11

Anemia due to zidovudine in HIV-infected patients:

- (a) Hgb <11

Prior Authorization Guidelines

GENERIC: ETANERCEPT

BRAND: ENBREL[®]

INDICATIONS:

- (1) Moderate to severely active rheumatoid arthritis
- (2) Moderate to severely active polyarticular juvenile rheumatoid arthritis
- (3) Psoriatic spondylitis
- (4) Ankylosing spondylitis
- (5) Plaque psoriasis

Criteria:

- (a) The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to Enbrel therapy; **and**
- (b) The patient does not have a clinically important active infection

Additional Criteria for RA:

- (a) The patient has failed or is intolerant to one formulary NSAID **and**
- (b) The patient has failed or is intolerant to one formulary DMARD

Additional Criteria for Plaque Psoriasis:

- (a) Involvement of $\geq 10\%$ body surface area (BSA)

GENERIC: EXENATIDE

BRAND: BYETTA[®]

INDICATION:

- (1) Adjunctive therapy of type 2 diabetes mellitus

Criteria:

- (a) Diagnosis of type 2 diabetes; **and**
- (b) Failure or intolerance to sulfonylureas and/or metformin at optimal dosing. Failure defined as Hemoglobin A1c ≥ 7.0 ; **and**
- (c) Patient ≥ 18 years of age

Prior Authorization Guidelines

GENERIC: EZETIMIBE

BRAND: ZETIA[®]

INDICATIONS:

- (1) Hypercholesterolemia
- (2) Sitosterolemia

Criteria:

- (a) Diagnosis of sitosterolemia; **or**
- (b) For the diagnosis of hypercholesterolemia, failure of optimal dosing/duration or intolerance/contraindication to 2 formulary anti-lipid agents (with at least one agent being a statin)

GENERIC: EZETIMIBE/SIMVASTATIN

BRAND: VYTORIN[®]

INDICATION:

- (1) Hypercholesterolemia

Criteria:

- (a) The diagnosis of hypercholesterolemia, failure of optimal dosing/duration or intolerance/contraindication to 2 formulary anti-lipid agents (with at least one agent being a statin)

GENERIC: FENOFIBRATE

BRAND: LIPOFEN[®], TRIGLIDE[®]

INDICATION:

- (1) Hypercholesterolemia, Hypertriglyceridemia

Criteria:

- (a) Failure of generic fenofibrate 48, 54, 154, or 160mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

GENERIC: FENOFIBRATE MICRONIZED

BRAND: ANTARA[®]

INDICATION:

- (1) Hypercholesterolemia, Hypertriglyceridemia

Criteria:

- (a) Failure of generic fenofibrate 54 or 160mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

Prior Authorization Guidelines

GENERIC: FENOFIBRIC ACID

BRAND: TRILIPIX[®]

INDICATION:

- (1) Hypercholesterolemia, Hypertriglyceridemia

Criteria:

- (a) Failure of generic fenofibrate 54 or 160mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

GENERIC: FENTANYL TRANSDERMAL PATCH

BRAND: DURAGESIC[®]

INDICATION:

- (1) Persistent, moderate to severe chronic pain OR cancer-related pain that requires continuous, around-the-clock opioid (narcotic) administration for an extended period of time

Criteria:

- (a) Diagnosis of persistent, moderate to severe chronic or cancer-related pain requiring continuous, around-the-clock opioid administration for an extended period of time; **and**
- (b) Patient unable to take medications by mouth; **or**
- (c) Failure of or intolerance/contraindication to a long-acting oral opiate (narcotic) medication (controlled-release morphine, oxycodone, or oxymorphone)

GENERIC: FILGRASTIM

BRAND: NEUPOGEN[®]

INDICATIONS:

- (1) Prevention of neutropenia in patients receiving myelosuppressive chemotherapy for non-myeloid malignancies
- (2) Patients undergoing peripheral blood progenitor cell collection and therapy
- (3) Patients with severe chronic neutropenia

Prior Authorization Guidelines

Criteria:

- (a) The patient is undergoing peripheral blood progenitor cell collection and therapy; **or**
 - (b) Diagnosis of severe chronic neutropenia with an absolute neutrophil count (ANC) < 1,000; **or**
 - (c) ANC nadir of < 1,000 neutrophils to previous chemotherapy. Once this has been documented, approval will be given to prophylax for all future chemo cycles.
- * For injectable medications administered by a healthcare professional, please refer to the “Specialty Medication Guidelines” in the beginning of this formulary.*
- * Please indicate estimated duration of therapy.*

GENERIC: FLUCONAZOLE

BRAND: DIFLUCAN[®]

(PA required after 1x 150mg tablet dispensed)

INDICATIONS:

- (1) Vaginal candidiasis
- (2) Cryptococcal meningitis
- (3) Serious systemic candidal infections
- (4) Oropharyngeal and esophageal candidiasis

Criteria:

- (a) Any of the above diagnoses; **except**
- (b) For the diagnosis of oropharyngeal candidiasis, failure of nystatin therapy; **and**
- (c) For the diagnosis of vaginal candidiasis, patients who are immunocompromised and/or have recurrent or refractory infections.

GENERIC: GALANTAMINE HYDROBROMIDE

BRAND: RAZADYNE[®], RAZADYNE ER[®]

INDICATION:

- (1) Alzheimer’s disease: for the treatment of dementia

Criteria:

- (a) Confirmation by clinical evaluation

Prior Authorization Guidelines

GENERIC: GATIFLOXACIN

BRAND: ZYMAXID[®]

INDICATION:

- (1) Bacterial conjunctivitis

Criteria:

- (a) Failure of, contraindication to, or intolerance to ciprofloxacin ophthalmic formulation.

GENERIC: GLATIRAMER ACETATE

BRAND: COPAXONE[®]

INDICATIONS:

- (1) Relapsing-remitting Multiple Sclerosis
- (2) To prevent or slow the development of clinically definite Multiple Sclerosis in patients who have experienced a first clinical episode and have MRI features consistent with Multiple Sclerosis

Criteria:

- (a) Prescribed by neurologist; and
- (b) Not requesting combination therapy of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera

GENERIC: INTERFERON ALPHA

BRAND: ROFERON-A[®], INTRON-A[®], and ALFERON N[®]

INDICATIONS:

- (1) Hairy cell leukemia
- (2) AIDS-related Kaposi's sarcoma
- (3) Chronic hepatitis B or C
- (4) Malignant melanoma

Criteria:

- (a) Any of the above diagnoses.

**For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

Prior Authorization Guidelines

GENERIC: INTERFERON BETA

BRAND: AVONEX[®], BETASERON[®], REBIF[®]

INDICATIONS:

- (1) Diagnosis of a relapsing form of Multiple Sclerosis; **or**
- (2) First clinical demyelinating event with MRI evidence consistent with Multiple Sclerosis

Criteria:

- (a) Prescribed by neurologist; **and**
- (b) If patient has a history of or is currently being treated for severe psychiatric disorders, suicidal ideation or severe depression, this condition is well controlled; **and**
- (c) Not requesting combination of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera

** For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

GENERIC: ISOSORBIDE MONONITRATE

BRAND: IMDUR[®]

INDICATION:

- (1) Prevention of angina pectoris

Criteria:

- (a) Failure of formulary nitrates.

GENERIC: ITRACONAZOLE

BRAND: SPORANOX[®]

INDICATIONS:

- (1) Histoplasmosis infections
- (2) Aspergillosis infections
- (3) Blastomycosis

Criteria:

- (a) Any of the above diagnoses.

Prior Authorization Guidelines

GENERIC: LEUPROLIDE

BRAND: LUPRON[®]

INDICATIONS:

- (1) Advanced prostate cancer
- (2) Central precocious puberty
- (3) Endometriosis
- (4) Uterine leiomyomata (fibroids)

Criteria:

- (a) Diagnosis of advanced prostate cancer, precocious puberty or fibroids; **or**
- (b) For the diagnosis of endometriosis, failure of NSAIDS **and** oral contraceptives **or** endometriosis diagnosed by laparoscopy.

**Note: This agent is ordinarily administered at the physician's office. For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

GENERIC: LIRAGLUTIDE

BRAND: VICTOZA[®]

INDICATION:

- (1) Adjunct to diet and exercise to improve glycemic control in patients with type II diabetes mellitus

Criteria:

- (a) Diagnosis of type II diabetes mellitus; **and**
- (b) Must be under the care of a healthcare provider skilled with the use of insulin and supported by a diabetes educator
- (c) Must have tried at least 2 antidiabetic agents such as metformin, sulfonylureas, thiazolidinedione or insulin and not achieved adequate glycemic control despite treatment or intolerant to other antidiabetic medications; **and**
- (d) Must have tried and failed or intolerant to treatment with Byetta; **and**
- (e) NO personal or family history of medullary thyroid carcinoma

Prior Authorization Guidelines

GENERIC: MEMANTINE

BRAND: NAMENDA[®]

INDICATION:

- (1) Alzheimer's disease: for treatment of moderate-to-severe cases of dementia

Criteria:

- (a) Dementia must be confirmed by clinical evaluation; **and**
- (b) Documented dementia is either moderate or severe

GENERIC: METRONIDAZOLE VAGINAL GEL

BRAND: METROGEL[®]

INDICATION:

- (1) Bacterial vaginosis

Criteria:

- (a) Pregnancy; **or**
- (b) Intolerance to oral metronidazole

GENERIC: MILNACIPRAN

BRAND: SAVELLA[®]

INDICATION:

- (1) Moderate to severe fibromyalgia

Criteria:

- (a) Trial of two of the three below agents after a period of at least two months on the maximum dose appropriate and tolerated by the patient:
 - (1) gabapentin
 - (2) venlafaxine
 - (3) one other evidence based effective agent (TCA therapy, SSRIs, tramadol, NSAIDs, cyclobenzaprine)

Prior Authorization Guidelines

GENERIC: MOXIFLOXACIN

BRAND: AVELOX[®]

INDICATION:

- (1) Acute bacterial sinusitis
- (2) Acute bacterial exacerbations of chronic bronchitis
- (3) Mild to moderate pelvic inflammatory disease
- (4) Complicated/Uncomplicated skin and skin structure infections
- (5) Community-acquired pneumonia
- (6) Complicated intra-abdominal infections

Criteria:

In patients ≥ 18 years of age with any of the above listed indications when:

- (a) Cultures show sensitivity to Avelox[®] only; **or**
- (b) Patient discharged on Avelox[®] from the hospital and needs to complete regimen on an outpatient basis

GENERIC: NAFARELIN+

BRAND: SYNAREL[®]

INDICATIONS:

- (1) Central precocious puberty
- (2) Endometriosis

Criteria:

- (a) Diagnosis of central precocious puberty; **or**
- (b) For the diagnosis of endometriosis in patients ≥ 18 years of age, failure of NSAIDs **and** oral contraceptives, **or** endometriosis diagnosed by laparoscopy.

GENERIC: NICOTINE INHALER

BRAND: NICOTROL INHALER[®]

INDICATION:

- (1) Smoking cessation

Criteria:

- (a) Documented failure of gum, lozenge, patches or Chantix for 30 days within the last 120 days

Prior Authorization Guidelines

GENERIC: NICOTINE NASAL SPRAY

BRAND: NICOTROL NASAL SPRAY[®]

INDICATION:

- (1) Smoking cessation

Criteria:

- (a) Documented failure of gum, lozenge, patches or Chantix for 30 days within the last 120 days

GENERIC: NUTRITIONAL SUPPLEMENTS

BRAND: ENSURE[®], PEDIASURE[®], BOOST[®], VIVONEX[®]

INDICATION:

- (1) Nutritional supplementation

Criteria:

- (a) Patient must have enteral access via one of the following: nasogastric (NG) tube, nasoduodenal (ND) tube, nasojejunal (NJ) tube, percutaneous endoscopic gastrostomy (PEG) or percutaneous endoscopic jejunostomy (PEJ).

To obtain nutritional supplements (e.g. Ensure or Pediasure) for members without enteral access, please follow the DME process. For assistance accessing the DME process, please contact Customer Service at 1-888-524-1999.

GENERIC: OCTREOTIDE

BRAND: SANDOSTATIN[®]

INDICATIONS:

- (1) Symptomatic treatment of severe diarrhea and flushing episodes associated with metastatic carcinoid tumors
- (2) Profuse, watery diarrhea associated with vasoactive intestinal peptide (VIP) secreting tumors
- (3) To reduce the blood levels of growth hormone and IGF-I associated with acromegaly

Criteria:

- (a) Any of the above diagnoses; **and**
- (b) For the diagnosis of acromegaly, the patient has had an inadequate response to, or can not be treated with surgical resection, pituitary irradiation **and** bromocriptine at maximally tolerated doses.

For injectable medications administered by a healthcare professional, please refer to the “Specialty Medication Guidelines” in the beginning of this formulary.

Prior Authorization Guidelines

GENERIC: ONDANSETRON ODT AND SOLUTION

BRAND: ZOFRAN[®]

INDICATIONS:

- (1) Chemotherapy induced nausea and vomiting
- (2) Post-operative nausea and vomiting
- (3) Radiation induced nausea and vomiting

Criteria:

- (a) For patients who have a contraindication or failure of regular release ondansetron tablets

GENERIC: OXYCODONE, CONTROLLED-RELEASE

BRAND: OXYCONTIN[®]

INDICATION:

- (1) Persistent, moderate to severe chronic pain **or** cancer-related pain that requires continuous, around-the-clock opioid (narcotic) administration for an extended period of time; not intended as an as-needed analgesic.

Criteria:

- (a) Persistent, moderate to severe chronic pain **or** cancer-related pain that requires around-the-clock analgesia for an extended period of time; **and**
- (b) For chronic pain, failure, intolerance, or contraindication to at least 2 short-acting formulary narcotic analgesics
- (c) For cancer pain, failure intolerance, or contraindication to controlled-release morphine (MS Contin, others)

GENERIC: PALIVIZUMAB

BRAND: SYNAGIS[®]

INDICATION:

- (1) Prevention of serious lower respiratory disease caused by respiratory syncytial virus (RSV)

Criteria:

- (a) Administration within RSV season (Nov-Apr); **and**
- (b) Pt < 2 yrs of age at start of RSV season with chronic lung disease that has required treatment (supplemental oxygen, bronchodilator, diuretic or corticosteroid) within prior 6 months **or**
- (c) Pt born \leq 28 weeks gestation and is \leq 12 months at the start of the RSV season **or**
- (d) Pt born between 29-32 weeks gestation and is \leq 6 months at the start of the RSV season **or**

Prior Authorization Guidelines

- (e) Pt \leq 24 months of age at the start of the RSV season with hemodynamically significant congenital heart disease, including one of the following:
 - (1) Receiving medication to control congestive heart failure; **or**
 - (2) With moderate to severe pulmonary artery hypertension; **or**
 - (3) With cyanotic congenital heart disease; **or**
- (f) Pt born between 32-35 weeks gestation, and is \leq 3 months at the start of the RSV season **and** has one of the following risk factors:
 - (1) Child care attendance; **or**
 - (2) Siblings less than 5 years **and** children born between 32-35 weeks receive a maximum of 3 doses; **or**
- (g) Is the patient born before 35 weeks of gestation and has either congenital abnormalities of the airway or a neuromuscular condition that compromises handling of respiratory secretions during the first year of life?

Once the prior authorization is received, please contact the Synagis line below:

Phone = 866-230-8102

Fax =888-325-6544

GENERIC: PANTOPRAZOLE

BRAND: PROTONIX[®]

INDICATIONS:

- (1) Gastric hypersecretion, pathological conditions including Zollinger-Ellison Syndrome
- (2) Erosive esophagitis - gastroesophageal reflux disease
- (3) Erosive esophagitis, maintenance therapy - gastroesophageal reflux disease

Criteria:

- (a) Failure, intolerance, or contraindication to at least 1 formulary PPI after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

Prior Authorization Guidelines

GENERIC: PEGINTERFERON ALFA-2A

BRAND: PEGASYS[®]

INDICATIONS:

- (1) Use in combination with ribavirin for the treatment of chronic hepatitis C
- (2) Treatment of chronic hepatitis C in patients coinfecting with HIV whose HIV is clinically stable.
- (3) Treatment of patients with HBeAg positive and HBeAg negative chronic hepatitis B

Criteria:

(In combination with ribavirin)

- (a) Diagnosis as indicated above including any applicable labs and/or tests
- (b) Clinically documented chronic hepatitis C with detectable HCV RNA levels > 50 IU/mL
- (c) Age \geq 3 years
- (d) Liver biopsy (unless contraindicated) indicates some fibrosis and inflammatory necrosis
- (e) Intolerant to Peg-Intron
- (f) If HIV positive, patient is clinically stable.

(For chronic Hepatitis B)

- (a) Documented HBeAg positive or negative chronic hepatitis B
- (b) Compensated liver disease
- (c) Evidence of viral replication
- (d) Evidence of liver inflammation
- (e) Not contraindicated

GENERIC: PEGINTERFERON ALFA-2B

BRAND: PEG-INTRON[®]

INDICATIONS:

- (1) Use in combination with ribavirin for the treatment of chronic hepatitis C
- (2) Treatment of chronic hepatitis C in patients coinfecting with HIV whose HIV is clinically stable.

Criteria:

(In combination with ribavirin)

- (a) Diagnosis as indicated above including any applicable labs and/or tests
- (b) Clinically documented chronic hepatitis C with detectable HCV RNA levels > 50 IU/mL
- (c) Age \geq 3 years

Prior Authorization Guidelines

- (d) Liver biopsy (unless contraindicated) indicates some fibrosis and inflammatory necrosis
- (e) Intolerant to Peg-Intron
- (f) If HIV positive, patient is clinically stable.

GENERIC: PENTOXIFYLLINE

BRAND: TRENTAL[®]

INDICATION:

- (1) Intermittent claudication

Criteria:

- (a) Pain on walking **or** ABI < 0.8; **or**
- (b) Diabetic foot ulcer; **or**
- (c) Gangrene; **or**
- (d) Risk of, or existing, amputation.

GENERIC: PIMECROLIMUS

BRAND: ELIDEL[®]

INDICATION:

- (1) Second-line therapy for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children 2 years of age and older, who have failed to respond adequately to other topical prescription treatments, or when treatments are not advisable.

Criteria:

- (a) Documented failure of optimal dosing/adequate duration; **or**
- (b) Intolerance or contraindication to at least one formulary topical corticosteroid; **and**
- (c) Diagnosis of mild to moderate atopic dermatitis; **and**
- (d) Using for short-term and non-continuous treatment.

GENERIC: RALOXIFENE

BRAND: EVISTA[®]

INDICATION:

- (1) Treatment and prevention of osteoporosis in postmenopausal women

Criteria:

- (a) Personal or family history of breast cancer; **or**
- (b) Intolerable side effects to at least one formulary estrogen.

Prior Authorization Guidelines

GENERIC: RIBAVIRIN

BRAND: REBETOL[®]

INDICATION:

- (1) Indicated **only** in combination with a recombinant interferon alfa-2a or alfa-2b product for the treatment of chronic hepatitisC.

Criteria:

- (a) Diagnosis of chronic hepatitis C; **and**
- (b) Patient is receiving concomitant recombinant interferon alfa-2a or alfa-2b therapy.

GENERIC: RILUZOLE

BRAND: RILUTEK[®]

INDICATION:

- (1) Amyotrophic lateral sclerosis (ALS)

Criteria:

- (a) Diagnosis of ALS.

GENERIC: RIVASTIGMINE TARTRATE

BRAND: EXELON[®]

INDICATION:

- (1) Alzheimer's disease: for the treatment of dementia

Criteria:

- (a) Confirmation by clinical evaluation

GENERIC: RIZATRIPTAN

BRAND: MAXALT[®]

INDICATION:

- (1) Acute treatment of migraine headache

Criteria:

- (a) Failure of, intolerance to, or contraindication to one traditional formulary agent (NSAID's, ergotamine, or combination analgesic); **or**
- (b) Unsuccessful concurrent or previous use of migraine prophylaxis medications (e.g., beta-blockers, calcium channel blockers, tri-cyclic antidepressants or anticonvulsants); **and**
- (c) Patient is not currently using ergotamine or another 5-HT1 Receptor Agonist.

Prior Authorization Guidelines

GENERIC: ROPINROLE

BRAND: REQUIP[®]

INDICATIONS:

- (1) For the treatment of signs and symptoms of idiopathic Parkinson's disease.
- (2) Moderate to severe primary Restless Leg Syndrome.

Criteria:

- (a) Diagnosis of idiopathic Parkinson's disease; **or**
- (b) Diagnosis of Restless Leg Syndrome and normal iron stores (serum ferritin and/or iron-binding saturation)

GENERIC: ROSIGLITAZONE MALEATE

BRAND: AVANDIA[®]

INDICATION:

- (1) Type 2 diabetes: As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus

Criteria:

- (a) Blood sugar not controlled with any other antidiabetic medications;**and**
- (b) Failure or contraindication to use an Actos-containing regimen.

GENERIC: ROSIGLITAZONE MALEATE/GLIMEPIRIDE

BRAND: AVANDARYL[®]

INDICATION:

- (1) Type 2 diabetes: As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus

Criteria:

- (a) Blood sugar not controlled with any other antidiabetic medications**and**
- (b) Failure or contraindication to use an Actos-containing regimen.

GENERIC: ROSIGLITAZONE MALEATE/METFORMIN

BRAND: AVANDAMET[®]

INDICATION:

- (1) Type 2 diabetes: As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus

Prior Authorization Guidelines

Criteria:

- (a) Blood sugar not controlled with any other antidiabetic medications **and**
- (b) Failure or contraindication to use an Actos-containing regimen.

GENERIC: ROSUVASTATIN CALCIUM

BRAND: CRESTOR[®]

INDICATION:

- (1) Primary prevention of CV disease in patients with multiple risk factors for CHD, diabetes, peripheral vascular disease, history of stroke, or other cerebrovascular disease.

Criteria:

- (a) Failure of at least two generic formulary statins after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

GENERIC: SALMETEROL/FLUTICASONE

BRAND: ADVAIR/ADVAIR HFA[®]

INDICATION:

- (1) Long-term, twice-daily maintenance treatment of asthma in patients 4 years of age and older.

Criteria:

- (a) Currently on, but not controlled by an inhaled corticosteroid
- (b) Twice daily maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease.

Criteria for the 250/50mg Strength:

- (a) The 250/50mg strength is the only approved strength for COPD **and**
- (b) The patient must be reevaluated after 6 months

**For members currently with an approved prior authorization for Advair, claims will process as long as the member has filled Advair within the last 3 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to Advair therapy, or with no claim history of Advair within the last 3 months.*

Prior Authorization Guidelines

GENERIC: SALMETEROL XINAFOATE

BRAND: SEREVENT DISKUS®

INDICATIONS:

- (1) Maintenance treatment of asthma and prevention of bronchospasm in adults and children 4 years of age and older
- (2) Prevention of exercise-induced bronchospasm in patients 4 years of age and older
- (3) Serevent Diskus® is indicated for the maintenance treatment of bronchospasm associated with chronic obstructive pulmonary disease

Criteria:

- (a) Currently on but not controlled by an inhaled corticosteroid

GENERIC: SIMVASTATIN 80mg

BRAND: ZOCOR®

INDICATIONS:

- (1) Heterozygous or homozygous familial hypercholesterolemia
- (2) Familial type 3 hyperlipoproteinemia
- (3) Hypertriglyceridemia
- (4) Primary hypercholesterolemia, or mixed hyperlipidemia
- (5) Decrease cardiovascular event risk in patients with high coronary event risk
- (6) Cerebrovascular accident prophylaxis

Criteria:

- (a) Age ≤ 65 years
- (b) Male gender (female gender predisposed to myopathy including rhabdomyolysis)
- (c) Controlled hypothyroidism
- (d) Normal renal function
- (e) Documentation of all cholesterol lowering agents tried and failed must be provided.

Prior Authorization Guidelines

GENERIC: SOMATROPIN

BRAND: HUMATROPE[®]

INDICATIONS:

- (1) Growth failure in children due to inadequate growth hormone (GH) secretion
- (2) Idiopathic short stature in children defined by height standard deviation (SD) score less than or equal to -2.25 and growth rate not likely to attain normal adult height
- (3) Short stature in children associated with Turner syndrome

Criteria:

- (a) Patient with open epiphyses (as confirmed by radiograph of wrist and hand) who has not reached final height; **and**
- (b) Medication prescribed by an endocrinologist; **and**
- (c) Patient meets one of the following criteria:
 - (1) Growth Hormone Deficiency (GHD) with diagnosis confirmed by one of the following:
 - i. Severe short stature defined as patient's height at ≥ 2 SD below the population mean
 - ii. Patient's height ≥ 1.5 SD below the midparental height (average of mother's and father's heights)
 - iii. Patient's height ≥ 2 SD below the mean and a 1-year height velocity more than 1 SD below the mean for chronologic age or (in children 2 years of age or older) a 1-year decrease of more than 0.5 SD in height
 - iv. In the absence of short stature, a 1-year height velocity more than 2 SD below the mean or a 2-year height velocity more than 1.5 SD below the mean (may occur in GHD manifesting during infancy or in organic, acquired GHD)
 - v. Signs indicative of an intracranial lesion
 - vi. Signs of multiple pituitary hormone deficiencies
 - vii. Neonatal symptoms and signs of GHD

Prior Authorization Guidelines

- (2) Idiopathic short stature with patient's height at ≥ 2.25 SD below the mean height for normal children of the same age and gender
- (3) Short stature associated with Turner syndrome and height below the 5th percentile of normal growth curve

* *To continue therapy, requests will be reviewed every six months. For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

GENERIC: SUCCIMER

BRAND: CHEMET®

INDICATIONS:

- (1) Treatment of lead poisoning in children with blood lead levels > 45 mcg/dl
- (2) Unlabeled uses: Succimer may be beneficial in the treatment of other heavy metal poisonings

Criteria:

- (a) Diagnosis of lead poisoning with blood levels > 45mcg/dl; **and**
- (b) Child is hospitalized; **or**
- (c) Child was started on the medication in the hospital and needs to continue upon discharge.

GENERIC: SUCRALFATE SUSPENSION

BRAND: CARAFATE®

INDICATIONS:

- (1) Gastric ulcers
- (2) Duodenal ulcers
- (3) Gastritis
- (4) GERD

Criteria:

- (a) For patients who have a contraindication or failure of sucralfate tablets

Prior Authorization Guidelines

GENERIC: TELAPREVIR

BRAND: INCIVEK®

INDICATION:

- (1) Treatment of chronic hepatitis C genotype 1 used in combination with peginterferon alfa and ribavirin

Criteria:

- (a) Diagnosis of chronic hepatitis C genotype 1; **and**
- (b) Diagnosis of compensated liver disease; **and**
- (c) No previous treatment (full or partial course) of Incivek or Victrelis; **and**
- (d) Patient has been counseled on the importance of medication adherence and is willing to adhere to the regimen for the full course of therapy; **and**
- (e) The patient must have completed 4 weeks of peginterferon and ribavirin therapy (treatment weeks 1 through 4); **and**
- (f) HCV-RNA levels must be drawn at treatment weeks 4, 12, and 24
- (g) Females of child bearing potential must meet the following parameters:
 - (1) A recent negative pregnancy test; **and**
 - (2) Been counseled on the teratogenic effects of triple therapy; **and**
 - (3) Is willing to practice contraception during and for 6 months after completion of therapy

GENERIC: TERIFLUNOMIDE

BRAND: AUBAGIO®

INDICATION:

- (1) Diagnosis of a relapsing form of Multiple Sclerosis

Criteria:

- (a) Prescribed by neurologist; and
- (b) Not requesting combination of any 2 agents together:
Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera.

Prior Authorization Guidelines

GENERIC: TESTOSTERONE

BRAND: ANDROGEL[®], TESTIM[®]

INDICATION:

(1) Hypogonadism

Criteria:

- (a) Must be prescribed by an Endocrinologist
- (b) Initial therapy: The patient has documented low testosterone concentration
- (c) Renewal: The patient has documented therapeutic concentration to confirm response

GENERIC: THROMBIN

BRAND: THROMBIN

INDICATION:

(1) Hemostasis

Criteria:

- (a) Diagnosis of a bleeding disorder

GENERIC: TRAMADOL ER

BRAND: ULTRAM ER[®]

INDICATION:

(1) Pain, chronic (moderate to severe)

Criteria:

- (a) For patients who have a contraindication or failure of tramadol regular release tablets

GENERIC: VARENCLINE

BRAND: CHANTIX[®]

INDICATION:

(1) Management of smoking cessation

Criteria:

- (a) Physician has confirmed that the patient has no history of psychiatric illness (including, but not limited to, depression).
- (b) Physician has counseled the patient to self-monitor mood and behavior while on Chantix, and to contact their physician immediately if they experience any changes in mood or behavior.
- (c) Physician must provide evidence that patient has completed smoking cessation class.

Quantity Limit of 12 weeks of therapy per 12-month period

Prior Authorization Guidelines

GENERIC: ZOLMITRIPTAN TABLETS

BRAND: ZOMIG®

INDICATION:

(1) Acute treatment of migraine headache

Criteria:

- (a) Failure of, intolerance to, or contraindication to one traditional formulary agent (NSAID, ergotamine, or combination analgesic); **or**
- (b) Unsuccessful concurrent or previous use of migraine prophylaxis medications (e.g., beta-blockers, calcium channel blockers, tri-cyclic antidepressants or anticonvulsants); **and**
- (c) Patient is not currently using ergotamine or another 5-HT₁ Receptor Agonist