Provider Synergies, an affiliate of Magellan Medicaid Administration,
Virginia Medicaid's Pharmacy Service Administrator
Phone: 1-800-932-6648 Fax: 1-800-932-6651

General Information:

- The PDL is a list of preferred drugs, by select therapeutic class, for which the Medicaid Fee-for-service program allows payment without requiring service authorization (SA).
- *Please note that not all drug classes are subject to the Virginia Medicaid PDL*. In the designated classes, drug products classified as non-preferred will be subject to SA. In some instances, other additional clinical criteria may apply to a respective drug class which could result in the need for a SA.
- This is not an all inclusive list for non-preferred drugs.
- Fax requests receive a response within 24 hours.
- For urgent requests, please call **1-800-932-6648.**
- Not all medications listed are covered by all DMAS programs. Check individual program coverage.
- All new products included in a PDL class are automatically non-preferred until reviewed by the P&T Committee.

For PDL drug coverage information, visit the following: http://www.VirginiaMedicaidPharmacyServices.com.

The following "routine" PDL criteria guidelines will be applied to non-preferred drugs requiring a Service Authorization. Some drug classes will have additional criteria that will be listed along side the drug class.

1. Is there any reason the patient cannot be changed to a medication not requiring service authorization within the same class? Acceptable reasons include:
   - Allergy to medications not requiring service authorization
   - Contraindication to or drug-to-drug interaction with medications not requiring service authorization
   - History of unacceptable/toxic side effects to medications not requiring service authorization
   - Patient's condition is clinically stable; changing to a medication not requiring service authorization might cause deterioration of the patient's condition.

2. The requested medication may be approved if both of the following are true:
   - If there has been a therapeutic failure of no less than a **one-month trial** of at least **one** medication **within the same class** not requiring service authorization
   - The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated.

All changes from last posting will be highlighted in Yellow

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Analgesics			
	Narcotics - Long Acting		
	Duragesic® ***will become non-preferred on 9/1/12*** **fentanyl patch** **Kadian ER®** ***methadone 10 mg/5ml & 5mg/5ml oral soln** ***methadone 5mg & 10mg tab** **morphine sulfate tab SA**	*Avinza®* *Butrans®* **Dolophine®* *Embeda®* *Exalgo®* **Methadose®* *morphine sulfate ER cap* *MS Contin®* *Nucynta® ER* *Opana® ER* *Oramorph ® SR* *oxycodone-long acting* *Oxycontin®* *oxymorphone ER*	**LENGTH OF AUTHORIZATIONS**: 6 months **Routine PDL edit** ♦ **Step Edit** – Trial and failure of 2 different short acting narcotics. The step edit is not required for those patients that have been stabilized on Long Acting Narcotics or need relief of moderate to severe pain requiring around-the-clock opioid therapy, for an extended period of time. **Still subject to PDL criteria edit**. ♦ **PDL Edit** – If patient has failed a preferred narcotic or there is any reason the patient cannot be changed to a medication not requiring service authorization. ♦ ***Methadone Clinical Edits** – All methadone will receive a clinical edit to determine reason for use. Low dose strengths are generally used for pain. Please see criteria for clinical edit for methadone 40mg dispersible tablets and 10mg/ml oral concentrated solution for detoxification and maintenance treatment of narcotic addiction.
	Narcotics - Short Acting		
	Barbiturate & Non-Salicylates Analgesic Combinations		**LENGTH OF AUTHORIZATIONS:** 3 months **Routine PDL edit**
	acetaminophen-butalbital **Bupap®** **Cephadyn®**	*Orbivan CF®* *Phrenilin Forte®* *Sedapap®*	
	Lozenges- Narcotic		
	fentanyl citrate	*Actiq®* *Fentora®* *Onsolis®*	**Clinical edit for narcotic lozenges ONLY.** • the patient has a diagnosis of cancer, **AND** • the patient is already receiving and tolerant of opioid therapy for their underlying persistent cancer pain. Patients considered opioid tolerant are those who are taking transdermal fentanyl 25 mcg/h, morphine 60 mg/day or more, oxycodone 30 mg/day, oral hydromorphone 8 mg/day, or an equianalgesic dose of another opioid for one week or longer.

	Preferred Agents	Non-Preferred Agents	SA Criteria
	Opioid Dependency methadone products		***Clinical edit for methadone 40mg dispersible tablets & 10mg/ml oral concentrated solution** • FDA approved ONLY for detoxification and maintenance treatment of narcotic addiction • Recipient must be enrolled in a methadone treatment program (opioid treatment program, OTP) Dispensed only by opioid treatment programs (and agencies, practitioners, or institutions by formal agreement with the program sponsor) certified by the Federal Substance Abuse and Mental Health Services Administration and registered by the Drug Enforcement Administration (DEA).
	** Diskets® 40mg* ** methadone 10mg/ml Intensol oral concentrated soln* **methadone 10mg/ml oral concentrated soln* **methadone 40 mg* **Methadose® 10mg/ml oral concentrated soln* **Methadose® 40 mg*		
	Opioid Dependency buprenorphine products		****Clinical edit for Suboxone® SL/Film & buprenorphine SL tablets** The following need to be true: • Diagnosis of opiate abuse/dependence. • Prescribed by a qualified physician with Substance Abuse and Mental Health Services Administration Waiver • Patient is receiving addiction counseling • A chemical dependency assessment has been performed AND • Criteria for chemical dependency is met • Patient is 16 years of age or older (no exceptions allowed); AND • Patient is not pregnant (**Suboxone only**). • Max duration is 24 months • Max dose is 16mg/day **Duration of SA is 3 months for a total of 24 months.**
	**buprenorphine SL **Suboxone® **Suboxone® film	~~*Subutex®*~~ *off the market*	
	Short-Acting Narcotics		
	codeine **codeine/APAP** **codeine/APAP/caff/butal** **codeine/ASA** **codeine/ASA/caff/butal** **hydrocodone/APAP** **hydrocodone/ ASA** **hydrocodone/ ibuprofen** **hydromorphone** **meperidine** **morphine IR** **nalbuphine** **oxycodone/APAP** **oxycodone/ASA** **oxycodone IR** **tramadol HCL** **tramadol HCL/APAP**	*All Brands require a SA* *Abstral®* *Conzip ® ER* *Nucynta®* *Oxecta®* *oxymorphone HCl* *Ryzolt™* *tramadol ER* *Ultracet®* *Ultram®* *Ultram ER®* *Zolvit®*	

Preferred Agents	*Non-Preferred Agents*		*SA Criteria*
Non-Steroidal Anti-Inflammatory Drugs			
diclofenac potassium **etodolac IR** **ibuprofen** **indomethacin IR** **ketoprofen IR** **ketorolac** **meloxicam tab** **nabumetone** **naproxen** **naproxen sodium** **piroxicam** **sulindac**	*Anaprox®* *Anaprox DS®* *Ansaid®* *Arthrotec®* *Cataflam®* *Celebrex®* *Clinoril®* *Daypro®* *diclofenac sodium SR* *diflunisal* *Dolobid®* *Duexis®* *etodolac SR* *Feldene®* *fenoprofen* *flurbiprofen* *Indocin®* *Indocin SR®* *indomethacin SR and rectal* *ketoprofen ER* *Lodine® IR & XL* *Meclofenamate*	*mefenamic* *meloxicam susp* *Mobic®* *Motrin®* *Nalfon®* *Naprelan®* *Naprosyn®* *naproxen EC* *Orudis®* *Oruvail®* *oxaprozin* *Ponstel®* *Prevacid Naprapac®* *Relafen®* *Sprix® nasal spray* *Tolectin DS®* *Toradol®* *tolmetin sodium* *Vimovo®* *Voltaren®* *Voltaren XR®* *Zipsor®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit with exceptions noted below** A one-month trial of at least two medications within the same class not requiring SA ***Step edit required for Celebrex®** • History of a trial of a minimum of two (2) different non-COX2 NSAIDs within the past year**,** OR • concurrent use of anticoagulants (warfarin/ heparin)**,** methotrexate, oral corticosteroids, OR • history of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc.), OR specific indication for Celebrex®, which medications not requiring Service Authorization are not indicated.
Topical Agents and Anesthetics			
***Flector® patch** ***Voltaren® gel**	***Lidoderm® patch* **Pennsaid® topical soln*		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit** ***Clinical Criteria for Flector®, Voltaren® & Pennsaid®:** Approval is based on patient failing the oral generic of the desired product and at least one other preferred NSAID (to equal a total of at least two preferred). For example, a patient who failed ibuprofen or naproxen will still need to try oral generic diclofenac for approval of Flector®. Pennsaid® can only be approved for the FDA approved indication of osteoarthritis of the knee. **Quantity limit for Flector® Patch of 30 u per RX** ***(criteria continues on next page)***

	Preferred Agents	Non-Preferred Agents	SA Criteria
			<u>Clinical Criteria for Lidoderm® Patch:</u> Lidoderm® patches can be approved for relief of pain associated with post-herpetic neuralgia.
Antibiotic-Anti-Infective			
	Oral Antifungals		
	clotrimazole (mucous mem) **fluconazole tab/susp** **Grifulvin V® tab** **Griseofulvin ® susp** **Gris-Peg®** **ketoconazole** **nystatin tab/susp** **terbinafine**	*Ancobon ®* *Diflucan® tab/susp* *flucytosine* *itraconazole* **Lamisil ® tab/granules* *Noxafil®* ***Sporanox® cap/soln* *Terbinex™ kit* *Vfend® tab/susp* *voriconazole tab*	**<u>LENGTH OF AUTHORIZATIONS</u>**: Duration of the prescription (up to 6 months) **Routine PDL edit plus** ***<u>Lamisil® granules clinical criteria</u>** • indication is tinea capitis, **AND** • patient must be over 4 years of age. ****Sporanox® clinical criteria** • indication are Aspergillosis, Candidiasis (oral or esophageal), Histoplasmosis, Blastomycosis, empiric treatment of febrile neutropenia
	Oral Cephalosporins		
	Second Generation Cephalosporins		**<u>LENGTH OF AUTHORIZATIONS</u>**: date of service only; no refills **Routine PDL edit** Potential reasons for SA are: ○ infection caused by an organism resistant to medications not requiring service authorization ○ a therapeutic failure to no less than a **<u>three-day trial of one medication within the same class not</u>** requiring service authorization ○ the patient is completing a course of therapy with a medication requiring a service authorization, which was initiated in the hospital.
	cefaclor cap/susp **cefprozil cap/susp** **cefuroxime tab** ~~**Raniclor®**~~ *off the market*	*cefaclor ER* *Ceftin® tab/susp* ~~*cefuroxime axetil suspension*~~ *off the market* *Cefzil® tab/ susp*	
	Third Generation Cephalosporins		
	cefdinir cap/susp **Suprax® tab/susp**	*Cedax® cap/susp* *cefditoren pivoxil* *cefpodoxime proxetil cap/susp* *Omnicef ® cap/susp* *Spectracef®*	

<table>
<tr><th></th><th>Preferred Agents</th><th>Non-Preferred Agents</th><th>SA Criteria</th></tr>
<tr><td></td><td colspan="2">Oral Macrolides</td><td rowspan="2"><u>LENGTH OF AUTHORIZATIONS</u>: date of service only; no refills
Routine PDL edit

Potential reasons for SA are:
• infection caused by an organism resistant to medications not requiring service authorization
• a therapeutic failure to no less than a <u>three-day trial of one medication within the same class not</u> requiring service authorization
• the patient is completing a course of therapy with a medication requiring a service authorization, which was initiated in the hospital.

*Generics not available in some strengths/dosage forms

**To receive a SA for Ketek®, a specific Ketek® SA request form must be completed and faxed or mailed to Magellan Medicaid Administration with the physician's signature.</td></tr>
<tr><td></td><td>Macrolides & Ketolides
azithromycin pack/susp/tab
clarithromycin tab/susp
*E.E.S.®
*EryC®
*Eryped® 400 susp
Ery-tab®
erythrocin stearate
erythromycin base
erythromycin ethylsuccinate
erythromycin estolate susp
erythromycin stearate
erythromycin/sulfisoxazole</td><td>Biaxin® tab/ susp/XL
clarithromycin ER
Dynabac®
*Eryped® 200 susp
erythromycin base DR cap
**Ketek®
PCE®
Zithromax® tab/susp
ZMAX® susp</td></tr>
<tr><td></td><td colspan="2">Oral Quinolones</td><td rowspan="3"><u>LENGTH OF AUTHORIZATIONS</u>: date of service only; no refills
Routine PDL edit

Potential reasons for SA are:
• infection caused by an organism resistant to medications not requiring service authorization
• a therapeutic failure to no less than a <u>three-day trial of one medication within the same class not</u> requiring service authorization
• the patient is completing a course of therapy with a medication requiring a service authorization, which was initiated in the hospital.</td></tr>
<tr><td></td><td>Second Generation Quinolones
Cipro® susp
ciprofloxacin tab</td><td>Cipro®
Cipro® XR
ciprofloxacin susp/ER
Floxin®
Maxaquin®
Noroxin®
ofloxacin
Proquin XR®</td></tr>
<tr><td></td><td>Third Generation Quinolones
Avelox® ABC PACK
levofloxacin tab</td><td>Avelox®
Factive®
Levaquin® tab/susp
levofloxacin susp
Proquin XR®
Zagam®</td></tr>
</table>

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Otic Quinolones		
	Ciprodex® **ofloxacin**	*Cetraxal®* *Cipro HC®* ~~*Floxin®*~~ *off the market*	**LENGTH OF AUTHORIZATION** Date of service only; no refills **Routine PDL edit**
	Topical		
	mupirocin ointment	**Altabax™* *Bactroban® cream/ointment* *Centany®* *Centany AT® Kit*	**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edit** *Quantity Limit of 15 grams per 34 day
Antivirals			
	Hepatitis C Agents		
	Interferon		**LENGTH OF AUTHORIZATIONS**: All products require a Clinical SA ➢ **Interferon Clinical SA** **Clinical SA for initial 16 week SA**: Initial approval periods limited to 16-weeks and viral titer obtained at week 12 of therapy. **Clinical SA for established HCV reactors:** 1) Therapy is approvable for a total of 24 weeks in patients that are HCV genotypes 2 or 3 who have achieved a virologic response (either undetectable HCV RNA [<50 IU/mL] or at least a 2-log drop in HCV RNA titer from baseline) at 12 weeks of treatment. 2) Therapy is approvable for total of 48 weeks in HCV genotype 1 or 4 patients who have achieved a virologic response (either undetectable HCV RNA [<50 IU/mL] or at least a 2-log drop in HCV RNA titer from baseline) at 12 weeks of treatment. 3) If patient fails to achieve a virologic response by 12 weeks, further treatment is not indicated. ➢ ***Protease Inhibitor Clinical SA** **Incivek Clinical SA (Triple Therapy)** 1) Confirm diagnosis of HCV with genotype 1, AND
	Pegasys® **Pegasys Conv.Pack®** **Pegasys ProClick®** **Peg-Intron®** **Peg-Intron Redipen®**		
	Protease Inhibitor		
	***Incivek®** ***Victrelis®**		

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			concurrent therapy with ribavirin and peginterferon, AND no previous protease inhibitor treatment for Hep C. 2) At initial prescription fill, if above criteria are met – approve for 12 weeks. Lab work needs to be done at 4 weeks. 3) Course of telaprevir should *not* be repeated. **<u>Victrelis Clinical SA (Triple Therapy)</u>** 1) Confirm diagnosis of HCV with genotype 1, AND no previous protease inhibitor treatment for Hep C, AND completed ribavirin and peginterferon for at least 4 weeks, AND concurrent therapy with ribavirin and peginterferon 2) Evaluate for the following conditions for longer duration of approval: a) cirrhosis – Approve for 44 weeks b) Previous treatment with peginterferon and ribavirin with documented lack of achievement of > 2 log reduction at week 12 in previous treatment – Approve for 44 weeks. c) If none of above in a or b, then evaluate below to determine duration of therapy. 3) At initial prescription fill, confirmed diagnosis of HCV with genotype 1 and completed 4 weeks of peginterferon and ribavirin with continuing therapy – approve for 24 weeks. 4) After 24 weeks – require labs drawn at weeks 8 and 24. Depending on the result – determine the duration of approval: a) Treatment naïve patients: i. If week 8 and 24 are both undetectable – triple therapy is completed. No further Victrelis therapy. ii. If week 8 results are detectable and week 24 results are undetectable – then approve Victrelis for 8 more weeks. iii. If week 24 results are detectable, discontinue all 3 therapies (Victrelis and peginterferon/ ribavirin). b) Previously treated or relapsed patients: i. If week 8 and 24 are both undetectable – approve for 8 more weeks for Victrelis and peginterferon/ribavirin (then discontinue all 3)

	Preferred Agents	*Non-Preferred Agents*		*SA Criteria*
				ii. If week 8 results are detectable and week 24 results are undetectable – then approve Victrelis for 8 more weeks. iii. If week 24 results are detectable, discontinue all 3 therapies (Victrelis and peginterferon/ribavirin). 5) For ALL patients –If at week 12, the HCV-RNA level is > 100 IU/mL, do not approve Victrelis. 6) For ALL patients - If at week 24 HCV-RNA results are detectable, discontinue all 3 therapies (Victrelis and peginterferon/ribavirin). Lab work needs to be done at 8, 12, and 24 weeks.
	Herpes Oral			
	acyclovir tab/susp **famciclovir** **Valtrex®**	*Famvir®* *valacyclovir* *Zovirax® tab/susp*		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
	Herpes Topical			
	Abreva OTC® **Zovirax® ointment**	*Denavir®* *Xerese® cream* *Zovirax® cream*		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit**
	Influenza			
	amantadine cap/syrup **Relenza Disk®** **rimantadine** **Tamiflu® cap/susp**	*amantadine tab* *Flumadine® syrup/tab*		**LENGTH OF AUTHORIZATIONS:** For diagnosis of influenza, the authorization is for the date of service only; no refills **Routine PDL edit**
Bone Resorption Suppression and Related Agents				
	Bisphosphonates			
	alendronate **Fosamax® soln**	*Actonel®* *Actonel® with CA* *Atelvia DR®* *Boniva®* **Didronel®*	*etidronate* *Fosamax ®* *Fosamax® plus D* *ibandronate*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit** * Indicated only for treatment of Paget's disease of bone OR prevention and treatment of heterotopic ossification following total hip replacement or spinal cord injury.

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Calcitonins		
	Miacalcin®	*calcitonin-salmon nasal* *Fortical®*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**
	Others		
	Evista®	*Forteo®*	**LENGTH OF AUTHORIZATION**: Initial approval will be for 1 year with ONE renewal if demonstrated compliance. Maximum duration of therapy is 24 months during a patient's lifetime. **Forteo® (teriparatide): Indications** • Treatment of osteoporosis in postmenopausal women who are at high risk for fracture • Increase of bone mass in men with primary or hypogonadal osteoporosis who are at high risk for fractures • Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture **Forteo is indicated if:** • Bone mineral density of -3 or worse or • Postmenopausal women with history of non-traumatic fracture(s) or • Postmenopausal women with two or more of the following clinical risk factors: o Family history of non-traumatic fracture(s) o Patient history of non-traumatic fracture(s) o DXA BMD T-score ≤-2.5 at any site o Glucocorticoid use* (≥6 months of use at 7.5 dose of prednisolone equivalent) o Rheumatoid Arthritis o Postmenopausal women with BMD T-score ≤-2.5 at any site with any of the following clinical risk factors: a. More than 2 units of alcohol per day b. Current smoker c. Men w/primary or hypogonadal osteoporosis d. Osteoporosis associated w/sustained systemic glucocorticoid therapy

	Preferred Agents	*Non-Preferred Agents*		*SA Criteria*
Cardiac				
	ACE Inhibitors, Angiotensin Receptors Blockers, Beta-Blockers			
	ACE Inhibitors			**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**
	benazepril **captopril** **enalapril** **lisinopril**	*Accupril®* *Aceon®* *Altace® cap/tab* *Capoten®* *fosinopril* *Lotensin®* *Mavik®* *moexipril* *Monopril®*	*perindopril* *Prinivil®* *quinapril* *ramipril* *trandolapril* *Univasc®* *Vasotec®* *Zestril®*	
	ACE Inhibitors + Calcium Channel Blocker Combinations			
	amlodipine/benazepril (2.5/10, 5/10, 5/20 & 10/20) **Lotrel® (5/40 and 10/40)**	*amlodipine/benazepril (5/50,10/40)* *Lexxel®* *Lotrel® (2.5/10, 5/10, 5/20 & 10/20)* *Tarka®* *Teczem®* *trandolapril/verapamil hydrochloride ER*		
	ACE Inhibitors + Diuretic Combinations			
	benazepril/HCTZ **captopril/HCTZ** **enalapril/HCTZ** **lisinopril/HCTZ**	*Accuretic®* *Capozide®* *fosinopril/HCTZ* *Lotensin HCT®* *moexipril/HCTZ* *Monopril HCT®* *Prinzide®*	*quinapril/HCTZ* *Quinaretic®* *Uniretic®* *Univasc®* *Vaseretic®* *Zestoretic®*	
	Angiotensin Receptor Blockers			***Step edit requires a trial and failure of losartan**
	***Diovan®** **losartan**	*Atacand®* *Avapro®* *Benicar®* *Cozaar®*	*Edarbi®* *eprosartan mesylate* *irbesartan* *Micardis®* *Teveten®*	

	Preferred Agents	Non-Preferred Agents		SA Criteria
	Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations			
	N/A	*Azor®* *Exforge®*	*Exforge®HCT* *Tribenzor®*	
	Angiotensin Receptor Blockers + Diuretic Combinations			
	****Diovan HCT®** **losartan/HCTZ**	*Atacand HCT®* *Avalide®* *Benicar HCT®* *Edarbyclor®*	*Hyzaar®* *irbesartan-hydrochlorothiazide* *Micardis HCT®* *Teveten HCT®*	**** Step edit requires a trial and failure of losartan/HCTZ**
	Beta Blockers			
	atenolol **carvedilol** **labetalol** **metoprolol tartrate** **nadolol** **propranolol tab/soln** **Sorine®** **sotalol AF** **sotalol HCL**	*acebutaolol* *Betapace®IR / AF®* *betaxolol* *bisoprolol* *Blockadren®* *Bystolic®* *Cartrol®* *Coreg® IR & CR®* *Corgard®* *Inderal® IR & LA* *Innopran ® XL* *Kerlone®* *Levatol®*	*Lopressor®* *metoprolol succinate* *Normodyne®* *pindolol* *propranolol LA* *Sectral®* *Tenormin®* *timolol maleate* *Toprol XL®* *Trandate®* *Visken®* *Zebeta®*	
	Beta Blockers + Diuretic Combinations			
	atenolol/chlorthalidone **bisoprolol/HCTZ** **nadolol/bendroflumethiazide** **propranolol/HCTZ**	*Corzide®* *Dutoprol®* *Inderide®* *Lopressor HCT®* *metoprolol/HCTZ*	*Tenoretic®* *Timolide®* *Ziac®*	
	Direct Renin Inhibitors (includes combination)			
	N/A	*Amturnide™* *Tekturna®* *Tekturna HCT®*	*Twynsta®* *Valturna®*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Anticoagulants		
	Low Molecular Weight Heparin includes FactorXA Inhibitor		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit** *** Clinical edit Pradaxa®** • Diagnosis of non valvular atrial fibrillation; AND • Patient has at least one risk factor that meets PI • History of stroke, TIA, or systemic embolism; OR • Age ≥ 75 years; OR • Diabetes mellitus; OR • History of left ventricular dysfunction or heart failure; OR • Age ≥65 years with the presence of one of the following: diabetes mellitus, coronary artery disease (CAD), or hypertension; OR Assess renal function prior to initiation of treatment. Periodically assess renal function as clinically indicated (i.e., more frequently in clinical situations that may be associated with a decline in renal function) and adjust therapy accordingly. •**For patients with CrCl >30 mL/min: 150 mg orally, bid** •**For patients with CrCl 15-30 mL/min: 75 mg orally, bid** ****Clinical Edit for Xarelto® (rivaroxaban)** ▪ Prophylaxis of DVT/PE in patients after elective hip or knee replacement surgery **OR** ▪ Stroke prophylaxis and systemic embolism prophylaxis in patients with nonvalvular atrial fibrillation. ▪ For hip replacement: 35 tablets/35 days ▪ For knee replacement: 12 tablets/12 days ▪ For atrial fibrillation: 30 tablets/30 days. Length of authorization: 1 year ▪ Dosage and Administration: *Nonvalvular Atrial Fibrillation*: • **If CrCl >50 mL/min: 20 mg PO, QD with evening meal.** • **If CrCl 15 - 50 mL/min: 15 mg PO, QD with evening meal** • **Avoid use in patients with CrCl <15 mL/min.** *Prophylaxis of DVT:* • 10 mg orally, once daily with or without food.
	Arixtra ® **Fragmin ®** **Lovenox ®**	*enoxaparin* *fondaparinux* *Innohep ®*	
	Oral Anticoagulants		
	warfarin ***Pradaxa®** ****Xarelto®**	*Coumadin®*	

	Preferred Agents	*Non-Preferred Agents*		*SA Criteria*
	Calcium Channel Blockers: Dihydropyridine CCB &Non-Dihydropyride CCB			
	Dihydropyridine Calcium Channel Blockers			**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit** There are two main classes of Calcium Channel Blockers (each with different actions on the peripheral vasculature and cardiac tissue): o Dihydropyridine Calcium Channel Blockers o Non-Dihydropyridine Calcium Channel Blockers
	Afeditab CR® **amlodipine** **Nifediac CC®** **Nifedical XL®** **nifedipine** **nifedipine ER** **nifedipine SA**	*Adalat ®* *Adalat CC®* *Cardene®* *Cardene SR®* *Dynacirc® IR & CR®* *felodipine ER* *isradipine*	*nisoldipine* *nicardipine* *Norvasc®* *Procardia®* *Procardia XL®* *Plendil®* *Sular®*	
	Non-Dihydropyridine Calcium Channel Blockers			
	Cartia XT® **Diltia XT®** **diltiazem** **diltiazem ER q 24hr** **diltiazem ER q 12hr** **diltiazem XR** **Taztia XT®** **verapamil tab** **verapamil tab ER**	*Calan® IR & SR* *Cardizem® IR & CD* *Cardizem LA® & SR* *Covera HS®* *Dilacor XR®* *diltiazem SR q 12hr* *Isoptin SR®*	*Tiazac®* *verapamil ER cap* *Verelan®* *Verelan PM®*	
	Lipotropics			
	Bile Acid Sequestrants			**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit plus** • Therapeutic failure to no less **than three-month trial of at least one medication not requiring service authorization**. **FDA announced on June 8, 2011 new safety restrictions (including contraindications & dose limitations) for high-dose simvastatin. FDA recommendations:** • Maintain patients on simvastatin 80 mg or Vytorin 10/80 mg ONLY if they have been taking this dose chronically (for 12 months or more) *without* evidence of muscle toxicity. • Do not start new patients on simvastatin 80 mg or Vytorin 10/80 mg. • Place patients who do not meet their LDL-C goal on simvastatin 40 mg or Vytorin 10/40 mg on alternative LDL-C lowering treatment(s) that provides greater LDL-C lowering.
	cholestyramine powder **Colestid® packet/tab** **colestipol packet/tab** **Prevalite®** **Welchol ® tab**	*cholestyramine powder light* *Colestid® granule* *colestipol HCl granules* *Questran® powder/powder Light* *Welchol ® packet*		
	Cholesterol Absorption Inhibitor (CAI)			
	Zetia®			
	Fibric Acid Derivatives			
	gemfibrozil **Tricor®**	*Antara®* *fenofibrate* *Fenoglide®* *Lipofen®*	*Lofibra®* *Lopid®* *Triglide®* *Trilipix™*	
	HMG CoA Reductase Inhibitors and Combinations (High Potency Statins)			
	simvastatin	*amlodipine/ atorvastatin* *atorvastatin* *Caduet®*	*Crestor®* *Lipitor®* *Livalo®* *Vytorin®* *Zocor®*	

Preferred Agents	Non-Preferred Agents		SA Criteria
HMG CoA Reductase Inhibitors and Combinations (Statins)			• Follow the recommendations in the simvastatin-containing medicines labels regarding drugs that may increase the risk for muscle injury when used with simvastatin. • Switch patients who need to be initiated on a drug that interacts with simvastatin to an alternative statin with less potential for the drug-drug interaction. * Requires a history of either a niacin or simvastatin product within the past 365 days **Clinical edit for Lovaza® • Step edit is the trial and failure of any other lipotropic. • A SA may also be approved without any specific preferred medication trial, if they have documented very high triglycerides of (≥ 500 mg/dL) in adult patients.
lovastatin **pravastatin**	*Advicor®* *Altoprev®* *fluvastatin* *Lescol®*	*Lescol XL®* *Mevacor®* *Pravachol®*	
Niacin Derivatives			
Niacor® **Niaspan®**			
Niacin Derivatives & HMG CoA Reductase Inhibitors (Statins) Combination			
***Simcor®**			
Omega 3 Fatty Acid Agent			
****Lovaza**			
Platelet Inhibitors			**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**
Aggrenox® **clopidogrel** **dipyridamole** **Effient®** **ticlopidine HCL**	*Brilinta®* *Persantine®* *Plavix®*		

Pulmonary Arterial Hypertension Agents			**LENGTH OF AUTHORIZATIONS**: 1 year
			Routine PDL edit
			
			*** Clinical edit for PD5**
			• Diagnosis of pulmonary hypertension in patients >18 years is required.
			• The requested medication may be approved if the following is true:
			  ○ The prescribing physician is a pulmonary specialist or cardiologist and will be followed by the prescribing physician.
			• Must have a rationale for not taking the oral Revatio® to receive a SA for the injectable Revatio®.
			• PDE-5 contraindications where SA should not be approved:
			  ○ Concurrent use of nitrates (e.g., nitroglycerin)
			  ○ Hypersensitivity to product

Inhaled Prostacyclin Analogues			
Tyvaso® **Ventavis®**			
Oral Endothelin Receptor Antagonist			
Letairis® **Tracleer®**			
Phosphodiesterase 5 Inhibitors			
***Adcirca™** ***Revatio®**	**Revatio injection®*		

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Central Nervous System			
	Antimigraine Agents		
	Maxalt® MLT **Relpax®** **sumatriptan succinate cartridge/nasal/pen/tab/vial**	*Amerge®* *Axert®* *Cambia®* *Frova®* *Imitrex® cartridge/nasal/pen/tab/vial* *Maxalt®* *naratriptan* *Treximet®* *Zomig® tab/nasal spray/ZMT*	**LENGTH OF AUTHORIZATIONS**: 6 months **Routine PDL edit** **Additional Information to aid in SA determination:** Service Authorization will not be given for prophylactic therapy of migraine headache unless the patient has exhausted or has contraindications to all other "controller" migraine medications (i.e., beta-blockers, calcium channel blockers, etc) and the physician and patient are aware of the adverse risk potential.
	Non-Ergot Dopamine Receptor Agonist		
	pramipexole **ropinirole HCl**	*Mirapex®* *Mirapex® ER* *Requip®* ~~*Requip® Dose Pack*~~ *off the market* *Requip® XR* *ropinirole HCl ER*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edit** **Additional Information to aid in SA determination:** • If requested for treatment of Parkinson's, may approve without the necessary trial of a preferred agent if the patient has swallowing issues that causes them to be unable to use a preferred product OR if the request is for continuation of established therapy. • If requested for treatment of restless legs, forward request to a pharmacist to be denied. • An indication that is unique to a non-preferred agent and is supported by peer-reviewed literature or an FDA-approved indication, or age specific indication, or medical co-morbidity, unique patient circumstance, other medical complications, or clinically unacceptable risk with a change in therapy to preferred agent.

	Preferred Agents	*Non-Preferred Agents*		*SA Criteria*
	Sedatives / Hypnotics			
	chloral hydrate syrup **flurazepam** **temazepam 15mg & 30mg**	*Dalmane®* *Doral®* *estazolam* *Halcion®* *Prosom®* *Restoril®* *temazepam 7.5 mg & 22.5 mg* *triazolam*		**LENGTH OF AUTHORIZATIONS**: Length of the prescription (up to 3 months) **Routine PDL edit**
	Sedatives / Hypnotics (Non-Benzodiazepine)			
	Rozerem® **zolpidem**	*Ambien® IR & CR* *Edluar™* *Intermezzo®* *Lunesta®* *Silenor®* *Somnote®*	*Sonata®* *Zaleplon®* *zolpidem CR* *Zolpimist ™ spray*	
	Skeletal Muscle Relaxants			
	baclofen ***carisoprodol** ***carisoprodol/ASA** ***carisoprodol/ASA/codeine** **chlorzoxazone** **cyclobenzaprine HCL** **dantrolene sodium** **methocarbamol** **tizanidine tab**	*Amrix®* *cyclobenzaprine ER* *Dantrium®* *Fexmid®* *Flexeril®* *Lorzone®* *metaxalone* *Norflex®* *orphenadrine citrate* *orphenadrine/ASA/caffeine* *Parafon Forte® DSC* *Robaxin®* *Skelaxin®* **Soma®* *tizanidine cap* *Zanaflex®*		**LENGTH OF AUTHORIZATIONS:** • 1 year for chronic conditions • Duration of prescription (up to 3 months) for acute conditions • One month per every 6 months carisoprodol products **Routine PDL edit** ***Clinical edit for carisoprodol products** • The patient is at least 16 years of age. • Only approve for ACUTE, painful musculoskeletal conditions. Do not approve for chronic pain. • Quantity limit = 4 tablets per day • Limit approval to one month supply (120 tablets) • Additional authorization will not be granted for at least 6 months following the last day of the previous course of therapy. **Additional Information to Aid in SA determination** 1) If there is a specific indication for a medication requiring service authorization, for which medications not requiring

	Preferred Agents	Non-Preferred Agents	SA Criteria
			service authorization are not indicated, then may approve the requested medication. This medication should be reviewed for need at each request for reauthorization. 2) **Chronic Conditions:** • Multiple Sclerosis • Spasticity • Cerebral Palsy • Muscle rigidity as a result of spinal cord/ brain injury or disease 3) **Acute Conditions:** • Muscle spasm associated with acute painful musculoskeletal conditions (ex. Generalized back, neck, or shoulder pain and muscle spasms attributed to trauma)
	Smoking Cessation		
	bupropion SR **Chantix®** **Chantix® Tab DS PK** **Nicotrol® Inhaler & NS** **nicotine gum/ lozenge/ patch**	~~*Commit® Lozenge*~~ *Nicoderm CQ® Patch* *Nicorette® Gum* *Nicorette® Lozenges* *Zyban®*	**LENGTH OF AUTHORIZATIONS:** 6 months **Routine PDL edit**
	Stimulants/ADHD Medications		
	Amphetamine Products		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit** **Additional Information to aid in SA determination:** • If the patient requires a service authorized medication based on a specific medical need that is not covered by the FDA indications of one of the preferred medications, a SA will be granted for a non-preferred medication. • This should be reviewed for need at each request for reauthorization. ***Adderall XR®** **If a trial & failure of a preferred product occurs and the physician requests Adderall XR® or amphetamine salts**
	amphetamine salts combo **dextroamphetamine** **Vyvanse®**	*Adderall® IR* **Adderall® XR (see criteria)* *amphetamine salts combo XR* *Desoxyn®* *Dexedrine®* *dextroamphetamine SR* *Dextrostat®* *methamphetamine* *Procentra® soln*	

	Preferred Agents	Non-Preferred Agents		SA Criteria
				combo XR. The brand Adderall XR®- is preferred over the generic.
	Methylphenidate Products			
	Concerta® ***will become non-preferred on 9/1/12*** **Focalin XR®** **All methylphenidate generic IR tablets** **methylphenidate SR**	*Daytrana™* *dexmethylphenidate* *Focalin®* *Metadate CD®* *Metadate ER®* *Methylin ER®* *Methylin chew®*	*Methylin® soln* *methylphenidate soln* *methylphenidate LA* *Ritalin®* *Ritalin LA®* *Ritalin SR®*	
	Miscellaneous Products			
	Strattera®	*Intuniv®* *Kapvay® SR 12H* **modafinil* **Nuvigil ™* **Provigil®*		***Clinical Criteria for Nuvigil ™/Provigil®:** Length of Authorization: • 1 year for sleep apnea and narcolepsy; • 6 months for shift work sleep disorder. ➢ Approvable diagnosis include: • **Sleep Apnea:** Requires documentation/confirmation via sleep study. • Requires documentation that C-PAP has been maximized. • **Narcolepsy:** Documentation of diagnosis via sleep study. • **Shift Work Sleep disorder: ONLY APPROVABLE FOR 6 MONTHS,** work schedule must be verified and documented. Shift work is defined as working the all night shift. ➢ Minimum age of 16 for **Provigil® (modafanil)** Minimum age of 17 for **Nuvigil ™ (armodafinil)**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Dermatologic			
	Dermatologic Agents		
	Combination Benzoyl Peroxide & Clindamycin for Acne		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit plus** Failure to respond to a therapeutic trial of at least two weeks of one preferred medication. **Clinical Edit for Dermatologic Acne Agents** • Products will automatically pay for children less than 18 • All adults over the age of 18 will require a SA to determine diagnosis for treatment • Products are intended for Acne **only; a SA for a Cosmetic indication can not be approved** **Additional Information to Aid in SA determination** • Topical retinoids will reject for 21 and older - this can not be overridden. • Renova and other products considered to have only a cosmetic indication are not covered by Virginia Medicaid. • If the patient is completing a course of therapy with a medication requiring service authorization, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring service authorization, then the requested medication may be approved.
	benzoyl peroxide **clindamycin** **clindamycin phosphate gel/ lotion /med.swab/soln**	*Acanya™* *Azelex®* *Benzaclin®* *Benzaclin ®CareKit* *Benzefoam™* *Benzefoam Ultra™* *Benziq ™gel* *Benziq™ susp* *benzoyl peroxide towelette* *BPO Kit* *Cleocin T® Gel* *Cleocin T® Lotion* *Cleocin T® Med. Swab* *Clindacin™ Pac Kit* *Clindagel®* *clindamycin 1%/Benzoyl Peroxide 5%* *clindamycin phosphate foam* *Delos Lotion™* *Duac® gel* *Evoclin™* *Inova™* *Lavoclen ™ Cleanser* *Lavoclen™ Kit* *Nuox ™* *Pacnex®* *Pacnex ®HP* *Pacnex® LP* *Se BPO 7-5.5% Wash Kit* *Se BPO Cleanser*	
	Topical Agents for Psoriasis		
	calcipotriene **Dovonex®** ~~**Psoriatec®**~~ off the market	*anthralin* *Calcitrene®* *calcitriol* *Dovonex® Scalp*	*Micanol®* *Taclonex®* *Taclonex® Scalp* *Vectical®*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Topical Retinoids/Combinations for Acne		
	Differin® cream 0.1% **Differin® gel 0.1% & 0.3%** **Differin® 0.1% topical lotion** **Retin®-A Micro** **Retin®-A Micro Pump** **tretinoin**	*adapalene 0.1% cream* *adapalene 0.1% topical gel* *Altinac®* *Atralin* *Avita® Cream* *Avita ®Gel* *Epiduo®* *Retin-®A cream/gel* *Tazorac®* *Tretin®-X* *Ziana®*	
Endocrine and Metabolic Agents			
	Androgenic Agents (Testosterone – Topical)		
	Androderm® **Androgel®**	*Axiron® soln* *Fortesta®* *Testim®*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit plus** Failure to respond to a therapeutic trial of at least one week of one preferred medication
	Antihyperuricemics		
	allopurinol **Probenecid®** **probenecid & colchicine**	**Colcrys®* *Uloric®* *Zyloprim®*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit** ***Clinical Criteria for: Colcrys™** Approve if one of the following is true: • Diagnosis of Familial Mediterranean Fever; OR • For Acute Gout Flare: ○ Trial and failure of one of the following: ▪ NSAID (i.e., indomethacin, naproxen, ibuprofen, sulindac, ketoprofen) OR ▪ Corticosteroid
	Contraceptives		
	Etonogestrel/Ethinyl Estradiol Vaginal Ring		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**
	NuvaRing®		

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Norelgestromin/Ethinyl Estradiol Transdermal		**Additional Information to aid in SA determination:** If there is a specific indication for a medication requiring service authorization, for which medications not requiring service authorization are not indicated, then request may be approved.
	Ortho Evra®		
	Oral Contraceptives		
	Apri® **Cryselle™** **Enpresse®** **Femcon Fe®** **Junel Fe®** **Loestrin®** **Loestrin Fe®** **Microgestin®** **Microgestin Fe®** **Mircette®** **Micronor®** **Norinyl 1+50®** **Nor-Q-D®** **Nortrel ®** **Ortho-Novum®** **Ortho Tri-Cyclen®** **Ortho Tri-Cyclen Lo®** **Ovcon®-50** **Sprintec®** **Tri-Sprintec®** **Trivora-28®** **Yasmin ®28** **Yaz®** **Zovia® 1-35E** **Zovia® 1-50E**	*All other oral contraceptives* *Lo-Ovral-28®* *Ortho-Cyclen®* *Portia®*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Diabetes Hypoglycemics: Injectable Amylin Analogs		
		**Symlin®* **Symlin® Pens*	**LENGTH OF AUTHORIZATION**: 1 year ***Clinical edit** ▪ The recipient must have a history of at least a 90 day trial of insulin. ▪ Symlin® is only indicated as adjunct therapy with insulin. ▪ Member meeting ALL of the following criteria may be approved: ○ Diagnosis of Type 1 or 2 diabetes ○ On insulin therapy ○ Failure to achieve adequate glycemic control (HbA1c ≤ 6.5%)
	Diabetes Hypoglycemics: Injectable Incretin Mimetics		
	Byetta®	*Bydureon™* *Victoza®*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**
	Diabetes Hypoglycemics: Injectable Insulins		
	Insulin Mix		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit** **Additional Information to aid in SA determination:** • Therapeutic failure of one non-preferred medication. For approval of a non-preferred insulin, the patient must have a failure on the equivalent preferred product if one is available (ex. Approval of Humalog® would require a failure on Novolog®). • Pens/cartridges should only be approved if there is a physical reason (such as dexterity problems, vision impairment) vials cannot be used. Approvals should not be granted based on issues of convenience or compliance. SA may be approved for individuals meeting the following criteria: ○ Member or caregiver has poor eyesight such that dosing errors may occur ○ Member or caregiver has problems with manual dexterity which may result in dosing errors (i.e.
	Humalog® Mix 50/50 vial **Humalog® Mix 50-50 Kwikpen** **Humalog® Mix 75/25 vial** **Humalog® Mix 75-25 Kwikpen** **Novolog® Mix 70/30 pen/vial** **Humulin® 70/30 pen/vial** **Novolin® 70/30 vial**		
	Insulin N		
	Humulin® N pen/vial **Novolin® N vial**		
	Insulin R		
	Humulin® R vial **Novolin® R vial**		
	Long-Acting Insulins		
	Lantus® vial **Levemir® pen/vial**	*Lantus Solostar® and cartridge*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Rapid-Acting Insulins		Parkinson's disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis) o Member is under 18 years of age **Additional information to aid in SA determiniation** If Humalog® is authorized and the patient is to mix with Humulin® (any formulation), then approve the Humulin® medication(s).
Humalog® cartridge/ Kwikpen®/vial **Novolog® cartridge/ Flexpen Syringe/vial**	*Apidra® cartridge, Solostar, and vial*	
Diabetes Oral Hypoglycemics		
Oral Hypoglycemics Alpha-Glucosidase Inhibitors		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**
acarbose **Glyset®**	*Precose®*	
Oral Hypoglycemics Biguanides		
metformin **metformin ER**	*Fortamet®* *Glucophage® IR & ®XR* *Glutmetza®* *Riomet® susp*	
Oral Hypoglycemics Biguanide Combination Products		
glipizide/metformin **glyburide/metformin**	*Glucovance®* *Metaglip®*	
Oral Hypoglycemics DPP-IV Inhibitors and Combination		
Janumet® **Janumet XR®** **Januvia®** **Jentadueto™** **Kombiglyze XR™** **Onglyza™** **Tradjenta™**	*Juvisync™*	
Oral Hypoglycemics Meglitinides		
Starlix®	*nateglinide* *Prandin®* *PrandiMet™*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Oral Hypoglycemics Second Generation Sulfonylureas		
	glimepiride **glipizide** **glipizide ER** **glyburide** **glyburide micronized**	*Amaryl*® *Diabeta*® *Glucotrol*® *Glucotrol XL*® *Glynase*®	
	Oral Hypoglycemics Thiazolidinediones		
	Actoplus Met® **Actos**® ~~**Avandamet**~~® ~~**Avandia**~~®	*Actoplus Met XR*® ~~*Avandaryl*~~® *Duetact*®	**Rosiglitazone REMS Program-** After November 18, 2011 rosiglitazone medicines will be withdrawn from local pharmacies, and the distribution of rosiglitazone-containing medicines will be limited to only specially-certified, mail-order pharmacies. To receive a rosiglitazone-containing medicines (*Avandia*®, *Avandamet*®, and *Avandaryl*®). The physician must be enrolled in the Avandia®-Rosiglitazone Medicines Access Program and adhere to the new restrictions to obtain the products if they wish to prescribe rosiglitazone medicines to outpatients or patients in long-term care facilities after November 18, 2011. *These products are not included as preferred or non-preferred on DMAS' PDL.*
	Erythropoiesis Stimulating Proteins: Epogen®, Procrit® (Erythropoietin) & Aranesp® (Darbepoetin)		
	Procrit®	*Aranesp*® *Epogen*® *Omontys*®	**LENGTH OF AUTHORIZATION**: for duration of the prescription up to 6 months **Routine PDL edit** **Clinical Information for Pharmacists**; RENEWAL REQUESTS for patients with anemia due to chronic renal failure/end stage renal disease should be approved, even if the Hgb or Hct are above the cutoff point.

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Growth Hormone		
	Genotropin® **Nutropin AQ® NuSpin™**	*Humatrope® cartridge/vial* *Norditropin cartridge®* *Norditropin FlexPro®& Nordiflex®* *Nutropin®* *Nutropin AQ® cartridge/vial* *Omnitrope®* *Saizen® cartridge/vial* *Serostim®* *Tev-Tropin®* *Zorbtive®*	**All Growth Hormones require a clinical SA** **Clinical Criteria for PEDIATRIC Patients (18 years of age and under:** **LENGTH OF AUTHORIZATION** (pediatrics): 1 year • Prescriber is an endocrinologist, nephrologists, infectious disease specialist or HIV specialist or one has been consulted on this case, • The patient has open epiphysis and one of the following diagnoses o Turner Syndrome o Prader-Willi Syndrome o Renal insufficiency o Small for gestational age (SGA) - including Russell-Silver variant and patient is < 2 years old o Idiopathic Short Stature (for request for renewal only (a) information is required to be approved) o Growth hormone deficiency (physician should provide the required information below) o Newborn with hypoglycemia and a diagnosis of hypopituitarism or panhypopituitarism. • Height is more than 2 SD (standard deviations) below average for the population mean height for age and sex, and a height velocity measured over one year to be 1 SD below the mean for chronological age, or for children over two years of age, a decrease in height SD of more than 0.5 over one year; AND • Growth hormone response of less than 10ng/ml to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine, or glucagon **Requests for Renewal (pediatrics):** o For renewal, a response must be documented. Patient must demonstrate improved/normalized growth velocity. (Growth velocity has increased by at least 2 cm in the first year and is greater than 2.5 cm per year), AND

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			○ Patient height is less than 5’ 6" for males or 5' 1" for females, and is more than 1 standard deviation (2") below mid-parental height (unless parental height is diminished due to medical or nutritional reasons). **Clinical Criteria for ADULTS (> 18 years of age)** **LENGTH OF AUTHORIZATION: 1 year (Serostim® – 3 months * see below)** • Prescriber is an endocrinologist • Diagnosis of growth hormone deficiency confirmed by growth hormone stimulation tests and rule-out of other hormonal deficiency, as follows: growth hormone response of fewer than five nanograms per mL to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine or glucagon when measured by polyclonal antibody (RIA) or fewer than 2.5 nanograms per mL when measured by monoclonal antibody (IRMA); • Cause of growth hormone deficiency is Adult Onset Growth Hormone Deficiency (AO-GHD), alone or with multiple hormone deficiencies, such as hypopituitarism, as a result of hypothalamic or pituitary disease, radiation therapy, surgery or trauma • Other hormonal deficiencies (thyroid, cortisol or sex steroids) have been ruled out or stimulation testing would not produce a clinical response such as in a diagnosis of panhypopituitarism. **Zorbtive®-** Diagnosis of short bowel syndrome **Serostim®** ○ Diagnosis of AIDS Wasting or cachexia ○ Patient has a documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents (both Megace® and Marinol®)

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			***Length of Authorization** (Serostim® only): 3 months initial; then 1 year. Renewal is contingent upon improvement in lean body mass or weight measurements. **Requests for Renewal (adults)** Renewal is contingent upon prescriber affirmation of positive response to therapy (improved body composition, reduced body fat, and increased lean body mass).
	Progestational Agents		
	medroxyprogesterone acetate (tablet only) **norethindrone acetate** **progesterone injection** **Prometrium®** **Provera®**	*Aygestin®* *progesterone cap*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit plus** Failure to respond to a therapeutic trial of at least one week of one non-service authorized medication
	Progestins Used For Cachexia		
	megestrol acetate	*Megace®* *Megace® ES*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**
	Vaginal Estrogens		
	Premarin® Vaginal cream **Vagifem® Vaginal tab**	*Estrace ®Vaginal cream* *Estring® Vaginal ring* *Femring® Vaginal ring*	**LENGTH OF AUTHORIZATION**: 6 months **Routine PDL edit**
Gastrointestinal			
	Histamine-2 Receptor Antagonists (H-2 RA)		
	famotidine (OTC & RX) **ranitidine tab/syrup (OTC & RX)**	*Axid® cap/soln* ***(OTC & RX)*** *cimetidine tab/syrup* ***(OTC & RX)*** *famotidine oral susp* ***(OTC & RX)*** *nizatidine cap/susp* *Pepcid ®oral susp/tab* ***(OTC & RX)*** *ranitidine cap* ***(OTC & RX)*** *Tagamet®* ***(OTC & RX)*** *Zantac® syrup/ tab* ***(OTC & RX)***	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit** **Additional information to aid in SA determination** • Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring service authorization might cause deterioration of the patient's condition. • Approve if treatment was initiated in the hospital for the treatment of a condition such as a GI bleed.

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			•
	Motility Agents – GI Stimulants		
	metoclopramide	*Metozolv® ODT* *Reglan®*	**LENGTH OF AUTHORIZATION**: 12 weeks **Routine PDL edit** This medication should be reviewed for need at each request for reauthorization. **Black box warning placed on product for TARDIVE DYSKINESIA 2/27/2009**
	Proton Pump Inhibitors		
	omeprazole OTC 20mg **pantoprazole** **Prevacid® OTC**	*Aciphex®* *Dexilant®* *lansoprazole* *Nexium®* *omeprazole RX 20mg* *omeprazole/sodium bicarbonate* *Prevacid® RX* ~~*Prevacid® susp (no SA required if age < 12yrs)*~~ *Prevacid® solutab* (no SA required if age < 12yrs) *Prilosec® (Rx **& OTC)*** *Prilosec® susp* *Protonix®* *Zegerid® cap* *Zegerid® OTC* *Zegerid® susp packet*	**LENGTH OF AUTHORIZATIONS**: 12 weeks; unless recipient meets an exception; then 1 year **Routine PDL edit** **Additional PDL edit criteria** The requested medication may be approved if both of the following are true: • If there has been a therapeutic failure of no less than a **three-month trial** of at least **two** different medication **within the same class** not requiring service authorization • The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated) **Exceptions that allow a 1 year SA for PPIs** (Exceptions apply to the duration of the SA only. PDL edit still prevails before a non-preferred may be approved) ○ Erosive Esophagitis ○ Active GI Bleed ○ Zollinger-Ellison Syndrome ○ Greater than 65 years of age ○ Under the care of a Gastroenterologist and has ruled out a nonsecretory condition
	Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)		
	Ulcerative Colitis – Oral		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**
	Asacol ® **Apriso ®** **balsalazide disodium**	*Asacol ®HD* *Azulfidine® DR* *Azulfidine ®IR*	*Colazal®* *Dipentum* *Lialda ®*

	Preferred Agents	Non-Preferred Agents		SA Criteria
	Pentasa® **sulfasalazine DR & IR**			
	Ulcerative Colitis – Rectal			
	Canasa® rectal supp **mesalamine enema**	*Fiv-Asa®* *Rowasa® Enema* *Rowasa® Enema Kit*	*Rowasa® supp. rect* *SFRowasa®*	
Genitourinary				
	Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)			
	Alpha-Blockers for BPH			**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**
	tamsulosin HCL	*alfuzosin* *Flomax®* *Rapaflo®* *Uroxatral®*		
	Androgen Hormone Inhibitors for BPH			***Step edit for** **Avodart®**- the generic finasteride must be tried and failed before approval
	***Avodart®** **finasteride**	*Jalyn®* *Proscar®*		
	Phosphodiesterase (PDE) 5 Inhibitor for BPH			**Cialis®**- must try and fail both Alpha Blockers and Androgen Hormone Inhibitors for BPH and the physician must attest that the recipient is not on the state list of sex offenders. The patient must have had a consult or been evaluated by an Urologist.
		**Cialis®*		
	Phosphate Binders			
	Fosrenol® **Phoslo®** **Renagel®**	*Calcium Acetate 667MG* *Eliphos®* *Phoslyra®* *Renvela® powder/tablet*		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**
	Urinary Antispasmodics			
	Enablex® **oxybutynin tab/syrup** **Oxytrol® transdermal** **Sanctura® XR** **Toviaz™**	*Detrol® & Detrol® LA* *Ditropan® & *Ditropan® XL* *Gelnique™ gel* **oxybutynin ER* *Sanctura®* *trospium* *VESIcare®*		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit** ***Oxybutynin ER, Ditropan XL®:** • Allow PDL exception for children age 6-18 with a diagnosis of neurogenic bladder.

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Immunological Agents			
	Atopic Dermatitis: Topical		

	***Elidel®**	***Protopic®**	**LENGTH OF AUTHORIZATION**: 1 year
			Routine PDL edit
			***Clinical edit for Elidel® and Protopic®**
			• Patient must have a FDA approved diagnosis:
			  ○ Atopic dermatitis (a type of eczema):
			  ○ Elidel®: mild to moderate for ages > 2 years.
			  ○ Protopic® 0.03%: moderate to severe for ages > 2 years.
			  ○ Protopic® 0.1%: moderate to severe for ages > 18 years.
			• Failure to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.)
			Critical information
			• Black box warnings are in place for both products as well as a requirement for a patient guide to be given with each product dispensed.
			• Use Elidel® and Protopic® only as second-line agents for short-term and intermittent treatment of atopic dermatitis (eczema) in patients unresponsive to, or intolerant to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.)
			• Avoid use of Elidel® and Protopic® in children younger than 2 years of age. The effect of Elidel and Protopic on the developing immune system in infants and children is not known. In clinical studies, infants and children younger than 2 years old treated with Elidel® had a higher rate of upper respiratory infections than did those treated with placebo cream.
			• Use Elidel® and Protopic® only for short periods of time, not continuously. The long term safety of Elidel® and Protopic® are unknown
			• Children and adults with a weakened or compromised immune system should not use Elidel® or Protopic®.
			• Use the minimum amount of Elidel® or Protopic® needed to control the patient's symptoms. In animals, increasing the dose resulted in higher rates of cancer.

	Preferred Agents	*Non-Preferred Agents*		*SA Criteria*
	Multiple Sclerosis			
	Avonex® **Avonex® Adm Pack** **Betaseron®** **Copaxone®** **Rebif®**	**Ampyra®* *Extavia®* *Gilenya®*		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit** Gilenya® is to be used as monotherapy ONLY *** Clinical edit for AMPYRA®** • The patient has a diagnosis of Multiple Sclerosis and a gait disorder or difficulty walking • Patient has no history of seizures • Patient's Creatinine Clearance [CrCL] ≥ 50 mL/min. • If patient has a gait disorder, they may receive an 8 week trial of Ampyra® • If after 8 week trial the physician states that the patient showed improvement or that the drug was effective (by improved Timed 25-foot Walk), the patient may receive authorization for Ampyra® for one year. **LENGTH OF AUTHORIZATION FOR AMPYRA®:** Initial 8 weeks then, 1 year after successful trial
	Self Administered Drugs for Rheumatoid Arthritis			
	Enbrel® **Humira®**	*Cimzia®* *Cimzia® SyringeKit* *Kineret®*	*Orencia®* *Simponi®*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Ophthalmic			
	Antibiotics		
	bacitracin/ polymyxin b sulfate ointment **ciprofloxacin drops** **erythromycin** **gentamicin drops/ointment** **Moxeza® drops** **neomycin/polymyxin/ gramicidin** **ofloxacin drops** **polymyxin/trimethoprim** ~~**Quixin® drops**~~ off the market **sulfacetamide soln** **tobramycin** **Vigamox® drops**	*AzaSite™ drop* *bacitracin* *Besivance® drops* *Bleph®- 10* *Ciloxan® drops/ointment* *Garamycin ®Drops* *Garamycin® Oinment* *Ilotycin ®* ~~*Iquix® drops*~~ off the market *levofloxacin drops* *Natacyn ®* *neomycin/bacitracin/polymyxin ointment* *Neosporin ®* *Ocuflox® drops* *Polytrim®* *sulfacetamide ointment* *Tobrex® Drops* *Tobrex ®Ointment* ~~*Zymar® drops®*~~ off the market *Zymaxid® drops*	**LENGTH OF AUTHORIZATION**: for the date of service only; no refills **Routine PDL edit** **Additional information to aid in SA determination** • If the infection is caused by an organism resistant to medications not requiring service authorization, then may approve the requested medication. • Therapeutic failure to no less than a three-day trial of one medication within the same class not requiring service authorization • If the patient is completing a course of therapy with a medication requiring service authorization, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.
	Antihistamines/Mast Cell Stabilizers		
	Antihistamines		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit** **Additional information to aid in SA determination** • Therapeutic failure to no less than a three-day trial of one medication within the same class not requiring service authorization • If the patient is completing a course of therapy with a medication requiring service authorization, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.
	Alaway OTC® **ketotifen fumerate** **Optivar® drops** **Pataday® drops** **Zaditor® OTC drops**	*azelastine drops* *Bepreve®* *Elestat ®drops* *Emadine® drop* *epinastine 0.05% eye drops* *Lastacaft® drops* *Patanol® drops*	
	Mast Cell Stabilizers		
	cromolyn sodium	*Alamast® drops* *Alocril® drops* *Alomide® drops* *Crolom® drops*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Anti-inflammatory		
	diclofenac sodium **flurbiprofen sodium** **ketorolac 0.4%** **ketorolac 0.5%** **Nevanac®**	*Acular®* *Acular LS®* *Acular PF®* *Acuvail®* *Bromday®* *bromfenac 0.09%* *Ocufen®* *Voltaren®*	**LENGTH OF AUTHORIZATION**: for the date of service only; no refills **Routine PDL edit** **Additional information to aid in SA determination** • Therapeutic failure to no less than a three-day trial of one medication within the same class not requiring service authorization. • If the patient is completing a course of therapy with a medication requiring service authorization, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.
	Glaucoma Agents		
	Alpha 2 Adrenergic Agents		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**
	Alphagan P® 0.1 & 0.15% **brimonidine 0.2% ** **Iopidine® 0.5% & 1%**	*apraclonidine 0.5% drops* *brimonidine tartrate 0.15%*	
	Beta Blockers		
	betaxolol 0.5% **Betimol® 0.25% &0.5%** **Betoptic-S® 0.25%** **carteolol 1%** **Combigan®** **levobunolol 0.25% & 0.5%** **metipranolol 0.3%** **timolol maleate 0.25% & 0.5%** **timolol maleate 0.5 % Sol-Gel**	*Betagan® 0.25% & 0.5%* *Istalol® 0.5%* *Ocupress®1%* *optipranolol 0.3% s* *Timoptic® drops 0.25% & 0.5%* *Timoptic® XE 0.25% & 0.5% Sol-Gel*	
	Carbonic Anhydrase Inhibitors		
	Azopt® 1% **dorzolamide** **dorzolamide/timolol**	*Cosopt® 0.5%-2%* *Cosopt® PF* *Trusopt® 2%*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Prostaglandin Analogs		
	latanoprost **Travatan Z®** **Travatan® 0.0004%**	*Lumigan® 0.03%* *Lumigan® 0.01%* *Xalatan® 0.005%* *Zioptan™*	
Respiratory			
	Antihistamines: First and Second Generation		
	First Generation Antihistamines		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**
	Generic only class	*All Brands require a SA*	
	Second Generation Antihistamines and Combinations		
	cetirizine liquid/tabs (OTC) **loratadine tab/Rapidtabs/ syrup (OTC)**	*Allegra® tab/ susp/ ODT* *Allegra-D® 12 h & 24 hr* *cetirizine chew/tab(OTC)* *cetirizine D tab(OTC)* *Clarinex® syrup/tab/Rapid Tab* *Clarinex- D® 24 & 12 hr* *Claritin-D® -Rx & OTC forms* *Claritin® tab/Chewable (RX & OTC)* *fexofenadine* *fexofenadine/PSE & 60/120 ER* *levocetirizine* *loratadine D 12 &24 HR* *Xyzal®* *Zyrtec® tab/chew/syrup(OTC & RX)* *Zyrtec-D® (OTC&RX)*	
	Beta-Adrenergic Agents		
	Long Acting Metered Dose Inhalers or Nebulizers		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit** **Additional information to aid in SA determination** Therapeutic failure to no less than **a two-week trial** of at least one medication not requiring service authorization within the same class and formulation. (i.e. nebulizers for nebulizers)
	Foradil® **Serevent Diskus®**	*Arcapta Neohaler®* *Brovana®* *Perforomist®*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Short Acting Metered Dose Inhalers or Devices		
	Proventil®HFA	*Maxair Autohaler* *Proair® HFA* *Ventolin® HFA* *Xopenex® HFA*	
	Short Acting Nebulizers		
	albuterol sulfate **metaproterenol** **Xopenex®**	*Accuneb® pediatric dosing, premixed nebs* *albuterol sulfate premix* *levalbuterol 0.125%* *Proventil®*	
	COPD: Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors		
	Atrovent HFA® **Combivent® MDI** **ipratropium bromide soln** **Spiriva®**	~~*Atrovent AER®*~~ Removed from market *Daliresp®* *Duoneb®* *ipratropium/albuterol nebs*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit** **Additional information to aid in SA determination** • Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for COPD in the past thirty days—and changing to a medication not requiring service authorization might cause deterioration of the patient's condition. **Specific Information for Daliresp®:** • If the patient has a diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations and • Trial/failure on at least one first-line or second-line agent (inhaled anticholinergics, long acting beta agonists or inhaled corticosteroids) and • • Adjunctive therapy (Daliresp® must be used in conjunction with first-line or second-line agent)
	Corticosteroids: Inhaled and Nasal Steroids		
	Inhaled Corticosteroids: Combination Products (Glucocorticoid and Beta Adrenergic)		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit** **Additional information to aid in SA determination** • Patient's condition is clinically unstable—**patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days**—and changing to a medication not requiring service authorization might cause deterioration of the patient's condition.
	Advair® Diskus & HFA **Dulera®** **Symbicort®**		

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Inhaled Corticosteroids: Metered Dose Inhalers		• Therapeutic failures to no less than **one-month** trials of at **least two medications** not requiring service authorization • If the patient is a child <13 years old or a patient with a significant disability, and unable to use an inhaler which does not require service authorization, or is non-compliant on an inhaler not requiring service authorization because of taste, dry mouth, or infection.
	Aerobid® **Aerobid® M** **Asmanex®** **Azmacort®** **Flovent® Diskus** **Flovent® HFA** **QVAR®**	*Alvesco®* *Flovent®* ~~*Flovent Rotadisk®*~~ *Pulmicort Flexhaler®*	
	Inhaled Corticosteroids: Nebulizer Solution		
	Pulmicort® Respules	*budesonide*	
	Nasal Steroids		
	fluticasone **Nasacort® AQ**	*Beconase AQ®* *Flonase®* *flunisolide* *Nasacort®* *Nasarel®* *Nasonex®* *Omnaris®* *Qnasl™* *Rhinocort Aqua®* *triamcinolone acetonide* *Tri-Nasal®* *Veramyst®*	
	Cough and Cold Agents		
	Drug Name and *GNN*	*All other **legend** cough and cold product are non-preferred* *Tessalon ® perle*	**LENGTH OF AUTHORIZATION**: Date of Service **Routine PDL edit** **Clinical Edit for Cough and Cold Agents – All children under 6 will not be eligible for cough and cold products.**
	Ala-Hist DM *brompheniramine/ phenylephrine/ dextromethorphan*		
	~~**Ala-hist LQ**~~ off the market *phenylephrine/ diphenhydramine*		
	benzonatate cap		
	Carbatuss-12® *Carbetapen Cit, Carbetap Tan, PE HCl, PE Tan*		
	Centergy® *phenylephrine/ chlorpheniramine*		
	codeine/ promethazine *codeine/ promethazine*		
	guaifenesin/ codeine phosphate		

	Preferred Agents	Non-Preferred Agents	SA Criteria
	guaifenesin/ codeine phosphate		
	hydrocodone/ homatropine *hydrocodone/ homatropine*		
	iophen-C NR *guaifenesin/codeine phosphate*		
	lohist-DM syrup *brompheniramine/ dextromethorphan/ phenylephrine*		
	phenylephrine hcl/promethazine hcl *phenylephrine hcl/ promethazine hcl*		
	poly hist DHC *pyrilamine/ phenylephrine/ dihydrocodeine*		
	poly-tussin DHC *brompheniramine/ phenylephrine/ dihydrocodeine*		
	promethazine DM syrup *promethazine/ dextromethorphan*		
	Tusnel® Pediatric Drops *dextromethorphan/, guaifenesin/pseudoephedrine*		
	Intranasal Antihistamines		
	Astelin® ~~**Astepro® 0.1%**~~ off the market	*azelastine 0.1%* *Astepro® 0.15%* *Patanase®*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit** **Additional information to aid in SA determination** Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring service authorization might cause deterioration of the patient's condition. • Therapeutic failures to no less than one-month trials of

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			at least **two medications** not requiring service authorization • If the patient is a **child <13 years** old or a patient with a significant disability, and unable to use an inhaler which does not require service authorization, or is non-compliant on an inhaler not requiring service authorization because of taste, dry mouth, infection The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.
	Leukotriene Receptor Antagonists		
	Accolate® **montelukast** **Singulair® 4 mg Granules**	*Singulair® tablets and chew tabs* *zafirlukast* *Zyflo™* *Zyflo CR™*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**
	Self Injectable Epinephrine		
	EpiPen® **EpiPen® Jr**	~~*Twinject®*~~ off the market ~~*Twinject Jr.®*~~ off the market	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edit**