



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
4/1/2016



**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, additional clinical criteria may apply to a respective drug class which may require a SA.
- This list is not all inclusive 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.
- All new products included in a PDL class are 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 alongside 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:
 - 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.

Teal highlights indicate where a Brand is preferred over a generic

Drugs no longer available have been removed from this list.



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
Analgesics		
Narcotics – Long Acting (LAN)		
fentanyl 25 mcg, 50 mcg, 75 mcg, 100 mcg patches Kadian® ER *methadone 10 mg/5 mL & 5mg/5 mL oral soln *methadone 5 mg & 10 mg tab morphine sulfate tab SA	<i>Avinza® (morphine ER cap)</i> <i>Butrans® (buprenorphine)</i> <i>Conzip® ER (tramadol ER)</i> <i>*Dolophine®</i> <i>Duragesic® (fentanyl)</i> <i>Embeda® (morphine ER/ naltrexone)</i> <i>Exalgo® (hydromorphone ER)</i> <i>fentanyl 37.5 mcg, 62.5 mcg, and 87.5 mcg patches</i> <i>Hysingla ER™ (hydrocodone ER)</i> <i>*Methadose®</i> <i>morphine ER (generic for Avinza®)</i> <i>morphine ER (generic for Kadian® ER)</i> <i>MS Contin® (morphine CR)</i> <i>Nucynta® ER (tapentadol ER)</i> <i>Opana® ER (oxymorphone ER)</i> <i>Oramorph® SR® (morphine SR)</i> <i>oxycodone-long acting</i> <i>OxyContin®</i> <i>oxymorphone ER</i> <i>Ryzolt™ (tramadol ER)</i> <i>tramadol ER</i> <i>Ultram ER® (tramadol ER)</i> <i>Xartemis™XR (oxycodone/APAP)</i> <i>Zohydro ER™ (hydrocodone ER)</i>	<u>LENGTH OF AUTHORIZATIONS:</u> <ul style="list-style-type: none">Up to 6 months after trial and failure of 2 different short acting narcotics; ORUp to one year for cancer and sickle cell; OROne to three months for chronic non-malignant pain Routine PDL edit plus <u>Clinical Criteria for LAN</u> <p>If diagnosis is chronic non-malignant pain the patient must have:</p> <ul style="list-style-type: none">A treatment plan that includes a diagnosis & goals of therapy; ANDDocumentation of provision of an assessment of addiction risk with the therapy; ANDAttestation from prescriber that Virginia's Prescription Monitoring Program (PMP) database has been recently reviewed; ANDA pain management contract that addresses the following:<ul style="list-style-type: none">The consequences of unexplained loss or shortage of medications,The consequences of obtaining similar prescription medications from other prescribers,Patient agrees to use only one pharmacy. <p>Member must be aware that random urine drug testing may be requested as part of the treatment plan.</p> <u>Additional PDL edit</u> <ul style="list-style-type: none">Approval of non-preferred agents in this class requires:<ul style="list-style-type: none">Contraindication to PDL preferred agents; ORDrug to drug interaction to PDL preferred agents; ORHistory of toxic side effects from PDL preferred agents that cause immediate or long-term damage (NOTE: this does not include GI intolerance). <u>*Clinical Criteria for Methadone</u> <p>All methadone agents 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 40 mg dispersible tablets and 10 mg/mL oral concentrated solution for detoxification and maintenance treatment of narcotic addiction.</p> <u>Long Acting Narcotics SA Fax Form</u>



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
Narcotics – Short Acting		
Transmucosal Immediate Release Fentanyl		LENGTH OF AUTHORIZATIONS: 3 months Routine PDL edit plus <u>Clinical Criteria for Transmucosal Immediate Release Fentanyl</u> <ul style="list-style-type: none">• Diagnosis of breakthrough cancer pain; AND• Patient is receiving around-the-clock scheduled long-acting narcotics; AND• Patient is receiving and tolerant to other opioids as indicated by one of the following:<ul style="list-style-type: none">○ At least 60 mg of morphine per day for at least one week without adequate pain relief; OR○ At least 25 mcg/hr of transdermal fentanyl for at least one week without adequate pain relief; OR○ At least 30 mg oxycodone per day for at least one week without adequate pain relief; OR○ At least 8 mg hydromorphone per day for at least one week without adequate pain relief; OR○ An equianalgesic dose of another opioid for at least one week without adequate pain relief; AND• Patient has tried and failed at least two immediate release opioid products (e.g., oxycodone, immediate-release morphine, hydromorphone) for breakthrough pain OR has a contraindication, intolerance, or drug-to-drug interaction with at least two immediate release opioid products; AND• Patient is 18 years of age or older (16 years of age for Actiq®); AND• Must be enrolled in the TIRF REMS ACCESS <u>Transmucosal Immediate Release Fentanyl SA Fax Form</u> <u>*Clinical Criteria for methadone 40mg dispersible tablets & 10 mg/mL oral concentrated solution</u> <ul style="list-style-type: none">• FDA approved ONLY for detoxification and maintenance treatment of narcotic addiction; AND• Patient must be enrolled in a methadone treatment program (opioid treatment program; AND• 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). <u>Methadone SA Fax Form</u>
Opioid Dependency - Methadone products		
<ul style="list-style-type: none">* Diskets® 40 mg*methadone 10 mg/mLintensol oral conc soln*methadone 40 mg*Methadose® 10 mg/mLoral concentrated soln*Methadose® 40 mg		



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria																								
Opioid Dependency - Buprenorphine products		**Clinical Criteria for Bunavail™, buprenorphine SL, buprenorphine/naloxone tablets, Suboxone® SL film & Zubsolv™																								
buprenorphine SL **Suboxone® film *naltrexone tab	**Bunavail™ **buprenorphine/naloxone tab **Zubsolv™	<ul style="list-style-type: none">• Diagnosis of opiate abuse/dependence; AND• Prescribed by a qualified prescriber who has:<ul style="list-style-type: none">○ A Substance Abuse and Mental Health Services Administration Waiver; AND○ An active “X” DEA number; AND○ The prescription is written under the “X” DEA number such that this patient counts toward the patient limits established for individual prescribers by the DATA 2000 waiver, AND• The prescriber has reviewed the Virginia Prescription Monitoring Program (PMP) Database; AND• Patient is receiving addiction counseling; AND• A chemical dependency assessment has been performed, AND• Criteria for chemical dependency are met; AND• Patient is 16 years of age or older (no exceptions allowed); AND• Patient is not pregnant (Bunavail™, Suboxone® SL/Film, buprenorphine/naloxone, and Zubsolv™).• Max dose is 16mg/day for Suboxone® Quantity Limits <table><tr><td>Bunavail™ 2.1-0.3mg buccal film</td><td>34 / 34 days</td></tr><tr><td>Bunavail™ 4.2-0.7mg buccal film</td><td>68 / 34 days</td></tr><tr><td>Bunavail™ 6.3-1mg buccal film</td><td>68 / 34 days</td></tr><tr><td>buprenorphine/naloxone tablets 2mg</td><td>102 / 34 days</td></tr><tr><td>buprenorphine/naloxone tablets 8mg</td><td>68 / 34 days</td></tr><tr><td>buprenorphine tablets 2mg</td><td>102 / 34 days</td></tr><tr><td>buprenorphine tablets 8mg</td><td>68 / 34 days</td></tr><tr><td>Suboxone® SL film 2mg</td><td>102 / 34 days</td></tr><tr><td>Suboxone® SL film 4mg</td><td>68 / 34 days</td></tr><tr><td>Suboxone® SL film 8mg</td><td>68 / 34 days</td></tr><tr><td>Suboxone® SL film 12mg</td><td>68 / 34 days</td></tr><tr><td>Zubsolv™</td><td>68 / 34 days</td></tr></table> Buprenorphine (Oral) SA Fax Form	Bunavail™ 2.1-0.3mg buccal film	34 / 34 days	Bunavail™ 4.2-0.7mg buccal film	68 / 34 days	Bunavail™ 6.3-1mg buccal film	68 / 34 days	buprenorphine/naloxone tablets 2mg	102 / 34 days	buprenorphine/naloxone tablets 8mg	68 / 34 days	buprenorphine tablets 2mg	102 / 34 days	buprenorphine tablets 8mg	68 / 34 days	Suboxone® SL film 2mg	102 / 34 days	Suboxone® SL film 4mg	68 / 34 days	Suboxone® SL film 8mg	68 / 34 days	Suboxone® SL film 12mg	68 / 34 days	Zubsolv™	68 / 34 days
Bunavail™ 2.1-0.3mg buccal film	34 / 34 days																									
Bunavail™ 4.2-0.7mg buccal film	68 / 34 days																									
Bunavail™ 6.3-1mg buccal film	68 / 34 days																									
buprenorphine/naloxone tablets 2mg	102 / 34 days																									
buprenorphine/naloxone tablets 8mg	68 / 34 days																									
buprenorphine tablets 2mg	102 / 34 days																									
buprenorphine tablets 8mg	68 / 34 days																									
Suboxone® SL film 2mg	102 / 34 days																									
Suboxone® SL film 4mg	68 / 34 days																									
Suboxone® SL film 8mg	68 / 34 days																									
Suboxone® SL film 12mg	68 / 34 days																									
Zubsolv™	68 / 34 days																									



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
		<p>***Clinical Criteria for naltrexone (oral)</p> <ul style="list-style-type: none"> Must have a diagnosis of <ul style="list-style-type: none"> Alcohol dependence; OR Opioid dependence <p><i>Do not attempt treatment with naltrexone unless, in the medical judgment of the prescriber, there is no reasonable possibility of opioid use within the past 7 to 10 days. If there is any question of occult opioid dependence, perform a naloxone challenge test.</i></p>
Short-Acting Narcotics		Routine PDL edit plus
codeine/APAP codeine/APAP/caff/butal codeine/ASA hydrocodone/APAP hydrocodone/ibuprofen hydrocodone/APAP hydromorphone morphine IR nalbuphine oxycodone IR oxycodone/APAP tramadol HCL	<i>All Brands require a SA</i> <i>Abstral[®]</i> <i>codeine tab/soln</i> <i>butalbital comp with codeine</i> <i>butorphanol tartrate nasal</i> <i>dihydrocodeine/APAP/caffeine</i> <i>dihydrocodeine/ASA/caffeine</i> <i>hydromorphone liq/supp</i> <i>meperidine tab</i> <i>Nucynta[®]</i> <i>OxaydoTM</i> <i>oxycodone/ASA</i> <i>oxycodone/ibuprofen</i> <i>oxymorphone HCl</i> <i>pentazocine/naloxone</i> <i>PrimLevTM</i> <i>Tivorbex[®]</i> <i>tramadol HCL/APAP</i> <i>Ultracet[®]</i> <i>Ultram[®]</i> <i>Zamiset[®] soln</i>	<ul style="list-style-type: none"> Approval of non-preferred agents in this class requires: <ul style="list-style-type: none"> Contraindication to all PDL preferred agents; OR Drug to drug interaction to all PDL preferred agents; OR History of toxic side effects from all PDL preferred agents that cause immediate or long-term damage (NOTE: this does not include GI intolerance).
Non-Steroidal Anti-Inflammatory Drugs		
Children's ibuprofen susp (OTC) ibuprofen (OTC & RX) Infant's ibuprofen drops	<i>Anaprox[®] IR & DS[®]</i> <i>Advil[®]</i> <i>Aleve[®]</i> <i>Arthrotec[®]</i>	<p><u>LENGTH OF AUTHORIZATIONS:</u> 1 year</p> <p>Routine PDL edit plus</p>



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
susp (OTC) meloxicam tab nabumetone naproxen naproxen sodium piroxicam sulindac	<i>Cataflam[®]</i> <i>*Celebrex[®]</i> <i>*celecoxib</i> <i>Daypro[®]</i> <i>diclofenac potassium</i> <i>diclofenac sodium SR</i> <i>diclofenac sodium/misoprostol</i> <i>diflunisal</i> <i>Duexis[®]</i> <i>etodolac IR & SR</i> <i>Feldene[®]</i> <i>fenoprofen</i> <i>flurbiprofen</i> <i>Indocin[®] supp</i> <i>indomethacin IR, SR & rectal</i> <i>ketoprofen IR & ER</i> <i>ketorolac</i> <i>meclofenamate</i> <i>mefenamic</i> <i>meloxicam susp</i> <i>Mobic[®]</i> <i>Motrin[®]</i> <i>Nalfon[®]</i> <i>Naprelan[®]</i> <i>Naprosyn[®]</i> <i>naproxen CR (generic</i> <i>Naprelan[®])</i> <i>naproxen EC</i> <i>oxaprozin</i> <i>Ponstel[®]</i> <i>Prevacid Naprapac[®]</i> <i>Sprix[®] nasal spray</i> <i>Tivorbex[™]</i> <i>tolmetin sodium</i> <i>Vimovo[®]</i> <i>Voltaren[®] XR</i> <i>Zipsor[®]</i> <i>Zorvolex[™]</i>	A one-month trial of at least <u>two</u> preferred medications within the same class. *Step edit required for Celebrex[®] and celecoxib <ul style="list-style-type: none">History of a trial of a minimum of two (2) different non-COX2 NSAIDs within the past year; ORConcurrent use of anticoagulants (i.e., warfarin, heparin, etc.), methotrexate, oral corticosteroids; ORHistory of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc.); ORSpecific indication for Celebrex[®], which medications not requiring service authorization are not indicated.



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
Topical Analgesic Agents and Anesthetics		
*Flector [®] patch *Voltaren [®] gel	**Lidoderm [®] patch **lidocaine 5% patch *Pennsaid [®] top soln & pump ***Solaraze 3% top gel	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year <u>Routine PDL edit plus</u> <u>Clinical Criteria for Topical Analgesic Agents and Anesthetics</u> <u>*Flector[®], Voltaren[®] & Pennsaid[®]:</u> <ul style="list-style-type: none">• 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 diclofenac for approval of Flector[®].• Pennsaid[®] can only be approved for the FDA approved indication of osteoarthritis of the knee.• Quantity limit for Flector[®] = 30 patches per RX. <u>** Lidoderm[®] Patch:</u> <ul style="list-style-type: none">• Lidoderm[®] patches can only be approved for the FDA approved indication of pain relief associated with post-herpetic neuralgia. <u>***Solaraze[®] 3% Gel Clinical Criteria:</u> <ul style="list-style-type: none">• Indicated for the topical treatment of actinic keratosis



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
Antibiotic-Anti-Infective		
Antibiotics, Inhaled		
Tobi Podhaler® Bethkis® 300 mg/4 mL Kitabis™ Pak 300 mg/5mL	<i>Cayston®</i> <i>Tobi® inhalation neb soln</i> <i>300 mg/5 mL</i> <i>*tobramycin inhalation neb soln</i> <i>300 mg/5ml</i>	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit plus <ul style="list-style-type: none">Minimum age for use is 6 years for all tobramycin inhalation nebulizer solution (Bethkis®, Kitabis™ Pak, Tobi® and Tobi Podhaler®) and 7 years for Cayston.A clinical reason as to why one of the preferred tobramycin inhalation nebulizer solutions cannot be used (Bethkis® or Kitabis™). Quantity Limits: Bethkis® = 224mL (56 amps) /28 days / 28 days Cayston® = 84 mL / 28 days Kitabis™ Pak = 280mL (56 amps) /28 days Tobi Podhaler® = 224 capsule / 28 day Tobi® inhalation neb = 280mL (56 amps) /28 days tobramycin = 280mL (56 amps) /28 days
Antifungals, Oral		
fluconazole tab/susp Griseofulvin® susp griseofulvin ultramicrosize ketoconazole nystatin tab/susp terbinafine	<i>*Ancobon®</i> <i>clotrimazole (mucous mem)</i> <i>**Cresemba®</i> <i>Diflucan® tab/susp</i> <i>flucytosine</i> <i>Grifulvin V® tab</i> <i>Gris-Peg®</i> <i>griseofulvin tab</i> <i>itraconazole</i> <i>***Lamisil® tab/granules</i> <i>****Noxafil®</i> <i>*****Onmel®</i> <i>*****Sporanox® cap/soln</i> <i>Terbinex™ kit</i> <i>*****Vfend® tab/susp</i> <i>voriconazole tab & powder for susp</i>	LENGTH OF AUTHORIZATIONS: Duration of the prescription (up to 12 months) Routine PDL edit plus Clinical Criteria for Antifungals, Oral *Ancobon®: <ul style="list-style-type: none">Indicated for the treatment of :<ul style="list-style-type: none">Candida: septicemia, endocarditis, and UTIs; ORCryptococcus: meningitis, pulmonary infections; ORCan be approved if the patient has a serious illness that leaves them immunocompromised (i.e. AIDS, cancer, organ transplants). **Cresemba® <ul style="list-style-type: none">Indication is treatment of invasive aspergillosis or mucormycosis; ANDMember must be over 18 years of age



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



	Preferred Agents	Non-Preferred Agents	SA Criteria
			<p>***<u>Lamisil[®]</u> granules</p> <ul style="list-style-type: none">• Indication is tinea capitis; AND• Member must be over 4 years of age. <p>****<u>Noxafil[®]</u></p> <ul style="list-style-type: none">• One of the following indications:<ul style="list-style-type: none">○ Used for preventative (prophylactic) therapy for treatment of invasive Aspergillus; OR○ Diagnosis of Candida; OR○ Patient is immunocompromised; OR○ Diagnosis of graft-versus-host disease (GVHD); OR○ Patient has a hematologic malignancy (a cancer of the blood, bone marrow, or lymph nodes); OR○ Patient has prolonged neutropenia from chemotherapy; OR○ Diagnosis of Zygomycosis; OR○ Diagnosis of Fusariosis; OR○ Patient has another fungal infection or mold infection is refractory or resistant to itraconazole or voriconazole, or patient has a contraindication to itraconazole or voriconazole. <p>*****<u>Onmel[®]</u></p> <ul style="list-style-type: none">• Indicated for the treatment of onychomycosis of the toenail caused by <i>Trichophyton rubrum</i> or <i>T. mentagrophytes</i>; AND• Patient had a therapeutic trial and treatment failure with oral terbinafine; OR• Patient has a contraindication to oral terbinafine (i.e. heart failure, hepatic impairment, viral hepatitis). <p>*****<u>Sporanox[®]</u></p> <ul style="list-style-type: none">• Indicated for the treatment of Aspergillosis, Candidiasis (oral or esophageal), Histoplasmosis, Blastomycosis, empiric treatment of febrile neutropenia. <p>*****<u>Vfend[®]</u>:</p> <ul style="list-style-type: none">• Can be approved without failure on the preferred agent if the patient has any of the following diagnoses:<ul style="list-style-type: none">○ Myelodysplastic Syndrome (MDS); OR○ Neutropenic Acute Myeloid Leukemia (AML); OR○ Graft versus Host Disease (GVHD); OR



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
		<ul style="list-style-type: none"> ○ Candidemia (candida krusei); OR ○ Esophageal Candidiasis; OR ○ Pulmonary or invasive aspergillosis; OR ○ Blastomycosis; OR ○ Oropharyngeal/esophageal candidiasis refractory to fluconazole, OR ○ Serious fungal infections caused by <i>Scedosporium apiospermum</i> (asexual form of <i>Pseudallescheria boydii</i>) and <i>Fusarium</i> spp., including <i>Fusarium solani</i>, in patients intolerant of, or refractory to other therapy, immunocompromised (i.e. AIDS, cancer, organ transplants). <p>Antifungal Oral SA Fax Form</p>
Cephalosporins, Oral		
Second Generation Cephalosporins		LENGTH OF AUTHORIZATIONS: Date of service only; no refills.
cefaclor cap cefprozil cap/susp cefuroxime tab	cefaclor ER cefaclor susp Ceftin [®] tab/susp	Routine PDL edit plus
Third Generation Cephalosporins		Clinical Criteria for Cephalosporins
cefdinir cap/susp Suprax [®] susp	Cedax [®] cap/susp ceftibuten cefixime suspension cefditoren pivoxil cefpodoxime proxetil cap/susp Spectracef [®] Suprax [®] chewable tab/cap	<ul style="list-style-type: none"> • Infection caused by an organism resistant to medications not requiring SA, OR • A therapeutic failure to no less than a three-day trial of one medication within the same class not requiring SA; OR • The patient is completing a course of therapy with a medication requiring a SA which was initiated in the hospital.
Macrolides, Oral		
Macrolides & Ketolides		LENGTH OF AUTHORIZATIONS: Date of service only; no refills
azithromycin pack/susp/tab clarithromycin tab/susp *E.E.S. [®] *Eryped [®] 400 susp Ery-tab [®] erythrocin stearate erythromycin base	Biaxin [®] tab/susp/XL clarithromycin ER *Eryped [®] 200 susp erythromycin base DR cap **Ketek [®] PCE [®] Zithromax [®] pac/tab/susp	Routine PDL edit plus
		Clinical Criteria for Macrolides and Ketolides
		<ul style="list-style-type: none"> • Infection caused by an organism resistant to medications not requiring SA; OR • A therapeutic failure to no less than a three-day trial of one medication within the same class not requiring SA; OR • The patient is completing a course of therapy with a medication requiring a SA which was initiated in the hospital.



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
erythromycin ethylsuccinate erythromycin stearate erythromycin/sulfisoxazole		ZMAX [®] susp	<p>*Generics are not available in some strengths/dosage forms</p> <p>**To receive a SA for Ketek[®], a specific Ketek[®] SA request form must be completed.</p> <p>Ketek SA Fax Form</p>
Otic			
Ciprodex [®] ofloxacin		Cetraxal [®] Cipro HC [®]	<p>LENGTH OF AUTHORIZATIONS: Date of service only; no refills</p> <p>Routine PDL edit</p>
Quinolones, Oral			
Second Generation Quinolones			<p>LENGTH OF AUTHORIZATIONS: Date of service only; no refills</p> <p>Routine PDL edit plus:</p> <p>Clinical Criteria for Quinolones</p> <ul style="list-style-type: none"> • Infection caused by an organism resistant to medications not requiring SA; OR • A therapeutic failure to no less than a three-day trial of one medication within the same class not requiring SA; OR • The patient is completing a course of therapy with a medication requiring a SA which was initiated in the hospital.
ciprofloxacin susp/tab		Cipro [®] IR & XR & susp ciprofloxacin ER Noroxin [®] ofloxacin	
Third Generation Quinolones			
Avelox [®] ABC PACK levofloxacin tab		Avelox [®] Levaquin [®] tab/susp levofloxacin susp moxifloxacin	
Topical			
mupirocin ointment		*Altabax TM Bactroban [®] cr/ointment Centany [®] Centany AT [®] Kit	<p>LENGTH OF AUTHORIZATIONS: Date of service only; no refills</p> <p>Routine PDL edit</p> <p>*Quantity Limit = 15 grams per 34 days</p>
Vaginal			
Cleocin [®] Ovules metronidazole gel		Cleocin [®] cr Clindesse [®] cr	<p>LENGTH OF AUTHORIZATIONS: Date of Service</p>



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents		SA Criteria	
		clindamycin cr Metrogel® Nuversa® Vandazole™ gel		Routine PDL edit	
Antivirals					
Hepatitis C Agents					
Interferon			LENGTH OF AUTHORIZATIONS: 8 weeks (initial approval for all diagnoses)		
Peg-Intron® Peg-Intron Redipen®	Pegasys® Proclick/syringe/kit/vial				
Protease Inhibitor			Routine PDL edit plus		
Victrelis®	Olysio™		<u>Clinical Criteria for Hepatitis C Agents including</u> <ul style="list-style-type: none">Daklinza™ (daclatasvir)Harvoni® (ledipasvir/sofosbuvir)Olysio™ (simeprevir)Sovaldi® (sofosbuvir)Technivie™ (ombitasvir + paritaprevir + pitonavir)Viekira Pak® (ombitasvir/paritaprevir/ritonavir) <ul style="list-style-type: none">All requests will be reviewed for FDA approved label indications and guidelines; ANDPatient must be 18 years of age or older; ANDPrescriber must be a gastroenterologist, hepatologist, infectious disease specialist or transplant specialist or in consultation with one of the above; ANDPatient must have documentation of Disease Severity (Metavir Score F3 - F4) AND/OR Highest Risk for Disease Progression; ANDA baseline HCV-RNA (with in 4 weeks of request) must be obtained before treatment initiation. At TW4, if the HCV RNA is ≥25 IU/mL, or at any time point thereafter, all treatment should be discontinued; ANDPatient must be evaluated for current history of substance and alcohol abuse, attested to by the prescribing physician(s); ANDPatients must be evaluated for decompensated cirrhosis (which is defined as a Child-Pugh score greater than 6 [class B or C]); AND		
Nucleotide Analog NS5A & NS5B Polymerase Inhibitor					
Daklinza®	Sovaldi®				
NS5A, NS3/4A Inhibitor Combinations					
Technivie™ Viekira Pak™					
NS5B & Protease Inhibitor combinations					
	Harvoni®				



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
		<ul style="list-style-type: none"> Patients must be evaluated for severe renal impairment (eGFR <30 mL/min/1.73m²) or end stage renal disease (ESRD) requiring hemodialysis <p>Renewal Criteria</p> <ul style="list-style-type: none"> Patient is compliant with drug therapy regimen (per pharmacy paid claims history); AND Drug is prescribed in accordance to FDA approved label indications and guidelines <p>Prescribers must complete the Hepatitis C service authorization form. Answer all questions. Responses will be provided within 24 hours</p> <p>Hepatitis C Antivirals SA Fax Form</p>
Herpes Oral		
acyclovir tab/susp famciclovir valacyclovir	Famvir [®] Sitavig [®] buccal tab Valtrex [®] Zovirax [®] tab/susp	<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edit</p>
Herpes Topical		
Abreva OTC [®] Zovirax [®] cr	acyclovir oint Denavir [®] Xerese [®] cr Zovirax [®] oint	<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edit</p>
Influenza		
amantadine tab/syrup Relenza Disk [®] rimantadine Tamiflu [®] cap/susp	amantadine cap Flumadine [®] tab	<p>LENGTH OF AUTHORIZATIONS: Date of service only</p> <p>Routine PDL edit</p>
Blood Modifiers		
Bile Salts		
ursodiol 300 mg cap	Actigal [®] Chenodal [®]	<p>LENGTH OF AUTHORIZATIONS: 1 year</p>



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
	<i>Cholbam[®]</i> <i>ursodiol tab</i> <i>Urso[®]</i> <i>Urso[®] Forte tab</i>	Routine PDL edit
Phosphate Binders		
calcium acetate 667mg cap Fosrenol [®] Renagel [®] Renvela [®] tablet	<i>Auryxia[™]</i> <i>calcium acetate 667mg tab</i> <i>Eliphos[®]</i> <i>Ferric citrate</i> <i>Fosrenol[®] Powder Pack</i> <i>Phoslo[®]</i> <i>Phoslyra[®]</i> <i>Renvela[®] powder</i> <i>sevelamer carbonate</i> <i>Velphoro[®] chewable tab</i>	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
Bone Resorption Suppression and Related Agents		
Bisphosphonates		
alendronate	<i>Actonel[®]</i> <i>alendronate soln</i> <i>Atelvia DR[®]</i> <i>Boniva[®]</i> <i>Binosto[™]</i> <i>etidronate</i> <i>Fosamax[®] tablet</i> <i>Fosamax[®] plus D</i> <i>ibandronate</i> <i>risedronate DR</i>	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit Bisphosphonates are indicated only for treatment of Paget's disease of bone OR the prevention and treatment of heterotopic ossification following total hip replacement or spinal cord injury.
Calcitonins		
Fortical [®]	<i>calcitonin-salmon nasal</i> <i>Miacalcin[®]</i>	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
Others		
Evista[®]	*Forteo[®] raloxifene	<p><u>LENGTH OF AUTHORIZATIONS:</u> Initial approval will be for 1 year with ONE renewal if compliance demonstrated. Maximum duration of therapy is 24 months during a patient's lifetime.</p> <p>Routine PDL edit plus</p> <p><u>*Clinical Criteria for Forteo[®] (teriparatide)</u></p> <ul style="list-style-type: none">• Treatment of osteoporosis in postmenopausal women who are at high risk for fracture; OR• Increase of bone mass in men with primary or hypogonadal osteoporosis who are at high risk for fractures; OR• Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture; OR• 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:<ul style="list-style-type: none">○ Family history of non-traumatic fracture(s); OR○ Patient history of non-traumatic fracture(s); OR○ DXA BMD T-score ≤ -2.5 at any site; OR○ Glucocorticoid use* (≥ 6 months of use at 7.5 dose of prednisolone equivalent); OR○ Rheumatoid Arthritis; OR○ Postmenopausal women with BMD T-score ≤ -2.5 at any site with any of the following clinical risk factors:<ul style="list-style-type: none">▪ More than 2 units of alcohol per day; OR▪ Current smoker; OR▪ Men w/primary or hypogonadal osteoporosis; OR▪ Osteoporosis associated w/sustained systemic glucocorticoid therapy. <p><u>Forteo SA Fax Form</u></p>
Cardiac		
Anticoagulants		



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
Low Molecular Weight Heparin includes FactorXA Inhibitor			LENGTH OF AUTHORIZATIONS: 1 year
enoxaparin Fragmin [®] Syringe		Arixtra [®] fondaparinux Fragmin [®] vial Lovenox [®]	Routine PDL edit plus
Oral Anticoagulants			Clinical Criteria for Anticoagulant, Oral
warfarin **Pradaxa [®] ****Xarelto [®]		Coumadin [®] *Eliquis [™] ***Savaysa [™] ****Xarelto Starter Pack	*Eliquis[™] <ul style="list-style-type: none">May be approved for the following:<ul style="list-style-type: none">Reduction in risk of stroke and systemic embolism in non-valvular atrial fibrillation; ORProphylaxis of deep vein thrombosis (DVT), which may lead to pulmonary embolism (PE), in patients who have undergone hip or knee replacement surgery; ORTreatment of DVT and PE, and for the reduction in the risk of recurrent DVT and PE following initial therapy. **Pradaxa <ul style="list-style-type: none">May be approved for the following:<ul style="list-style-type: none">To reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation; ORTreatment of deep venous thrombosis (DVT) OR pulmonary embolism (PE) in patients who have been treated with a Parenteral anticoagulant for 5-10 days; ORTo reduce the risk of recurrence of DVT and PE in patients who have been previously treated. ***Savaysa[™] <ul style="list-style-type: none">May be approved for the following:<ul style="list-style-type: none">To reduce the risk of stroke and systemic embolism in non-valvular atrial fibrillation; ORTreatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) following 5-10 days of initial therapy with a parenteral anticoagulant. **** Xarelto[®] (rivaroxaban) <ul style="list-style-type: none">May be approved for the following:



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
		<ul style="list-style-type: none"> To reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation; OR Treatment of deep vein thrombosis (DVT), pulmonary embolism, (PE), and for the reduction in the risk of recurrence of DVT and of PE; OR Prophylaxis of DVT, which may lead to PE in patients undergoing knee or hip replacement surgery <p>Oral Anticoagulants SA Fax Form</p>
Antihypertensive Agents		
ACE Inhibitors		LENGTH OF AUTHORIZATIONS: 1 year
benazepril captopril enalapril lisinopril ramipril	<i>Accupril[®]</i> <i>Altace[®]</i> <i>Epaned[™] soln</i> <i>fosinopril</i> <i>Lotensin[®]</i> <i>Mavik[®]</i> <i>moexipril</i> <i>Monopril[®]</i> <i>perindopril</i> <i>Prinivil[®]</i> <i>quinapril</i> <i>ramipril</i> <i>trandolapril</i> <i>Univasc[®]</i> <i>Vasotec[®]</i> <i>Zestril[®]</i>	Routine PDL edit
ACE Inhibitors + Calcium Channel Blocker Combinations		
amlodipine/ benazepril	<i>Lotrel[®]</i> <i>Tarka[®]</i> <i>trandolapril-verapamil ER</i>	
ACE Inhibitors + Diuretic Combinations		
benazepril/HCTZ lisinopril/HCTZ	<i>Accuretic[®]</i> <i>captopril/HCTZ</i> <i>enalapril/HCTZ</i> <i>fosinopril/HCTZ</i> <i>Lotensin HCT[®] moexipril/HCTZ</i> <i>quinapril/HCTZ</i>	



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
		Vaseretic [®] Zestoretic [®]	*Clinical Criteria for Entresto™ <ul style="list-style-type: none">• Diagnosis of chronic heart failure (NYHA Class II-IV); AND• Patient must be ≥ 18 years; AND• Left ventricular ejection fraction ≤ 40% Quantity Limit = 2 per day
Angiotensin Receptor Blockers			
Diovan [®] *Entresto™ losartan	Atacand [®] Avapro [®] Benicar [®] candesartan Cozaar [®] Edarbi [®] eprosartan mesylate irbesartan Micardis [®] telmisartan/HCTZ Teveten [®] Valsartan		
Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations			
	Azor [®] amlodipine/valsartan/HCTZ (generic for Exforge [®] HCT) amlodipine/valsartan (generic for Exforge [®]) Exforge [®] Exforge [®] HCT Tribenzor [®]		
Angiotensin Receptor Blockers + Diuretic Combinations			
losartan/HCTZ valsartan/HCTZ	Atacand HCT [®] Avalide [®] Benicar HCT [®] candesartan/HCTZ Diovan HCT [®] Edarbyclor [®] Hyzaar [®]		



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
	<i>irbesartan/HCTZ</i> <i>Micardis HCT[®]</i> <i>Teveten HCT[®]</i>	
Antihypertensives, Sympatholytics		<u>Clinical Criteria for Antihypertensives, Sympatholytics</u>
Catapres[®] -TTS clonidine tab guanfacine methyldopa reserpine	<i>Catapres[®]</i> <i>clonidine (transdermal)</i> <i>Clorpres[®]</i> <i>methyldopa/HCTZ</i> <i>Tenex[®]</i>	<ul style="list-style-type: none">A therapeutic failure of at least <u>two medication(s)</u> within the same class not requiring prior approval; AND
Beta Blockers		<u>*Clinical Criteria for Hemangeol[™]</u>
atenolol carvedilol labetalol metoprolol tartrate nadolol propranolol tab/soln Sorine [®] sotalol AF sotalol HCL	<i>acebutaolol</i> <i>Betapace[®] IR & AF[®]</i> <i>betaxolol</i> <i>bisoprolol</i> <i>Bystolic[®]</i> <i>Coreg[®] IR & CR[®]</i> <i>Corgard[®]</i> <i>*Hemangeol[™]</i> <i>Inderal[®] XL</i> <i>Innopran[®] XL</i> <i>Levatol[®]</i> <i>Lopressor[®]</i> <i>metoprolol succinate</i> <i>pindolol</i> <i>propranolol LA</i> <i>Sectral[®]</i> <i>Sotylize[™]</i> <i>Tenormin[®]</i> <i>timolol maleate</i> <i>Toprol XL[®]</i> <i>Trandate[®]</i> <i>Zebeta[®]</i>	<ul style="list-style-type: none">Diagnosis treatment of proliferating infantile hemangioma requiring systemic therapy; ANDPatient's age must be between 5weeks and 5 months.



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
Beta Blockers + Diuretic Combinations			
atenolol/ chlorthalidone bisoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ		<i>Corzide</i> [®] <i>Dutoprol</i> [®] <i>Lopressor HCT</i> [®] <i>metoprolol/HCTZ</i> <i>Tenoretic</i> [®] <i>Ziac</i> [®]	
Calcium Channel Blockers -Dihydropyridine			LENGTH OF AUTHORIZATIONS: 1 year
Afeditab CR [®] amlodipine Nifedical XL [®] nifedipine nifedipine ER		<i>Adalat CC</i> [®] <i>felodipine ER</i> <i>isradipine</i> <i>nisoldipine</i> <i>nicardipine</i> <i>Norvasc</i> [®] <i>Procardia</i> [®] <i>Procardia XL</i> [®] <i>Sular</i> [®]	Routine PDL edit
Calcium Channel Blockers- Non-Dihydropyridine			
Cartia XT [®] diltiazem IR, ER q 12 hr & 24 hr Taztia XT [®] verapamil tab IR & ER		<i>Calan</i> [®] IR & SR <i>Cardizem</i> [®] IR, CD & LA <i>Isoptin SR</i> [®] <i>Matzim LA</i> <i>Tiazac</i> [®] <i>verapamil ER cap</i> <i>Verelan</i> [®] & <i>Verelan PM</i> [®]	
Direct Renin Inhibitors (includes combination)			
		<i>Tekamlo</i> [®] <i>Tekturma</i> [®] <i>Tekturma HCT</i> [®] <i>Twynsta</i> [®] <i>telmisartan/amlodipine</i>	



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
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 SA.
cholestyramine powder reg & light colestipol tab Prevalite® Welchol® tab		<i>Colestid® granule/packet/tab</i> <i>colestipol HCl granules</i> <i>Questran® powder/powder Light</i> <i>Welchol® packet</i>	
Cholesterol Absorption Inhibitor (CAI)			
Zetia®			
Fibric Acid Derivatives			
gemfibrozil Tricor®		<i>Antara®</i> <i>fenofibrate (generic for Antara®)</i> <i>fenofibrate(generic Fenoglide®)</i> <i>fenofibrate (generic for Lipofen®)</i> <i>fenofibrate (generic Tricor®)</i> <i>fenofibric acid</i> <i>Fenoglide®</i> <i>Fibricor®</i> <i>Lipofen®</i> <i>Lofibra®</i> <i>Lopid®</i> <i>Triglide®</i> <i>Trilipix™</i>	
HMG CoA Reductase Inhibitors and Combo (High Potency Statins)			
atorvastatin simvastatin		<i>amlodipine/atorvastatin</i> <i>Caduet®</i> <i>Crestor®</i> <i>Lipitor®</i> <i>Liptruzet®</i> <i>Livalo®</i> <i>Vytorin®</i> <i>Zocor®</i>	



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
HMG CoA Reductase Inhibitors and Combinations (Statins)		
lovastatin pravastatin	Advicor [®] Altoprev [®] fluvastatin Lescol [®] Lescol XL [®] Mevacor [®] Pravachol [®]	
Microsomal Triglyceride Transfer Protein Inhibitor		Clinical Criteria for Lipotropics, Other
	*Juxtapid [™]	*Juxtapid[™] <ul style="list-style-type: none">• Diagnosis of homozygous familial hypercholesterolemia (HoFH); AND• Prescriber must be certified with the Juxtapid[™] REMS program; AND• Minimum age restriction of 18 years of age; AND• Patient has had treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants. Juxtapid or Kynamro SA Fax Form
Niacin Derivatives		
Niaspan [®]	niacin ER Niacor [®]	
Niacin Derivatives & HMG CoA Reductase Inhibitors Combo		**Simcor[®] <ul style="list-style-type: none">• Step edit requires a history of either a niacin or simvastatin product within the past 365 days
	*Simcor [®]	
Omega 3 Fatty Acid Agent		***Lovaza[®] <ul style="list-style-type: none">• Step edit requires trial and failure of any other lipotropic; OR• Documented high triglycerides of ≥ 500 mg/dL.
	***Lovaza [®] ***omega-3 acid ethyl esters Vascepa [®]	
Oligonucleotide Inhibitor		****Kynamro[™] <ul style="list-style-type: none">• Diagnosis of homozygous familial hypercholesterolemia (HoFH); AND• Prescriber must be certified with the Kynamro[™] REMS program; AND• Patient must be at least 18 years of age; AND• Patient has had treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants
	****Kynamro [™]	



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors	***** <i>Praluent</i> [®] pens/syringes ***** <i>Repatha</i> Sureclick & syringes	<p>Juxtapid or Kynamro SA Fax Form</p> <p>LENGTH OF AUTHORIZATIONS: Three months for initial approval; six months for renewal</p> <p><u>Clinical Criteria for PCSK9</u></p> <p>*****<u>Praluent</u>[®]</p> <p><u>Initial Criteria</u></p> <ul style="list-style-type: none">• Patient is ≥ 18 years of age; AND• Prescribed by or in consultation with a specialist (including cardiologists, lipidologists, or endocrinologists); AND• Diagnosis of atherosclerotic cardiovascular disease (ASCVD); AND• Heterozygous familial hypercholesterolemia (HeFH) as confirmed by genotyping or by clinical criteria (“definite FH” using either the Simon Broome or WHO/Dutch Lipid Network criteria); AND• Prior treatment history with highest available dose or maximally-tolerated dose of high intensity statin (atorvastatin or rosuvastatin) AND ezetimibe for at least three continuous months with failure to reach target LDL-C (70 mg/dL for patients with clinical ASCVD and 100 mg/dL for patients with HeFH and no history of clinical ASCVD)• If the patient is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms, documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the patient experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following:<ul style="list-style-type: none">○ Muscle symptoms resolve after discontinuation of statin; AND○ Muscle symptoms occurred when rechallenged at a lower dose of the same statin; AND○ Muscle symptoms occurred after switching to an alternative statin; AND○ Documentation ruling out non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease); OR○ The patient has been diagnosed with statin-induced rhabdomyolysis• The diagnosis should be supported by acute neuromuscular illness or dark urine AND an acute elevation in creatine kinase (usually >5,000 IU/L or five times the



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



	Preferred Agents	Non-Preferred Agents	SA Criteria
			<p>upper limit of normal)</p> <ul style="list-style-type: none">• If the patient failed to reach target LDL-C (<70 mg/dL for patients with clinical ASCVD and <100 mg/dL for patients with HeFH and no history of clinical ASCVD), adherence to maximally-tolerated statin and ezetimibe has been verified using pharmacy claims data and the patient is determined to be compliant for at least three consecutive months prior to the lipid panel demonstrating suboptimal reduction• Maximally-tolerated statin will continue to be used in conjunction with alirocumab; AND• Patient has not had a prior trial and failure of an alternative PCSK9 inhibitor• Request is being made for the lowest approved alirocumab dose (75 mg every 2 weeks) to adequately treat the patient. Requests for an escalated dose (150 mg every 2 weeks) must contain a lipid panel documenting suboptimal reduction in LDL-C after at least 4 weeks (2 doses) of alirocumab at the lower (75 mg every 2 weeks) dose. <p><u>Renewal Criteria (may be requested by PCP)</u></p> <ul style="list-style-type: none">• Lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating alirocumab; AND• Continued adherence to maximally-tolerated statin dose established prior to the original alirocumab approval <p><u>Quantity Limit</u></p> <ul style="list-style-type: none">• Two pens/syringes per month <p><u>*****Clinical Criteria for Evolocumab (Repatha™) Criteria</u></p> <p><u>LENGTH OF AUTHORIZATIONS:</u> Three months for initial approval; six months for renewal</p> <p><u>INITIAL CRITERIA</u></p> <ul style="list-style-type: none">• Age ≥ 18 years if diagnosis is<ul style="list-style-type: none">○ atherosclerotic cardiovascular disease (ASCVD); AND○ heterozygous familial hypercholesterolemia (HeFH); OR• Age ≥ 13 years if diagnosed with homozygous familial hypercholesterolemia (HoFH); AND• Prescribed by or in consultation with a specialist (including cardiologists,



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
			<p>lipidologists, or endocrinologists); AND</p> <ul style="list-style-type: none">• Diagnosis of ASCVD, HeFH as confirmed by genotyping or by clinical criteria (“definite FH” using either the Simon Broome or WHO/Dutch Lipid Network criteria), or HoFH as confirmed by either:<ul style="list-style-type: none">○ Documented DNA test for functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality OR○ A history of an untreated LDL-C concentration > 500 mg/dL and triglycerides <300 mg/dL and both parents with documented untreated TC >250 mg/dL• Prior treatment history with highest available dose or maximally-tolerated dose of high intensity statin (atorvastatin or rosuvastatin) AND ezetimibe for at least three continuous months with failure to reach target LDL-C (70 mg/dL for patients with clinical ASCVD and 100 mg/dL for patients with HeFH or HoFH and no history of clinical ASCVD)• If the patient is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms, documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the patient experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following:<ul style="list-style-type: none">○ Muscle symptoms resolve after discontinuation of statin; AND○ Muscle symptoms occurred when rechallenged at a lower dose of the same statin; AND○ Muscle symptoms occurred after switching to an alternative statin; AND○ Documentation ruling out non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease); OR• The patient has been diagnosed with statin-induced rhabdomyolysis<ul style="list-style-type: none">○ The diagnosis should be supported by acute neuromuscular illness or dark urine; AND○ an acute elevation in creatine kinase (usually >5,000 IU/L or five times the upper limit of normal)• If the patient failed to reach target LDL-C (<70 mg/dL for patients with clinical ASCVD and <100 mg/dL for patients with HeFH or HoFH and no history of clinical ASCVD), adherence to maximally-tolerated statin and ezetimibe has been verified using pharmacy claims data and the patient is determined to be compliant for at least three consecutive months prior to the lipid panel demonstrating suboptimal reduction



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
			<ul style="list-style-type: none">Maximally-tolerated statin will continue to be used in conjunction with evolocumab; ANDPatient has not had a prior trial and failure of an alternative PCSK9 inhibitor <p>Renewal Criteria (May be requested by PCP)</p> <ul style="list-style-type: none">Lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating evolocumab; ANDContinued adherence to maximally-tolerated statin dose established prior to the original evolocumab approval <p>Quantity Limit</p> <ul style="list-style-type: none">ASCVD or HeFH: Two pens or syringes per monthHoFH: Three pens or syringes per month
Platelet Inhibitors			
clopidogrel dipyridamole Effient® ticlopidine HCL	Aggrenox® ASA/dipyridamole Brilinta® Durlaza Persantine® Plavix® *Zontivity™		<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edit plus</p> <p>*Clinical Criteria for Zontivity™</p> <ul style="list-style-type: none">Diagnosis of MI (myocardial infarction) or PAD (peripheral arterial disease); ANDPatients must not have a history of stroke, TIA, ICH, GI bleed and peptic ulcer; ANDMust have concomitant therapy with clopidogrel, unless patient has a contraindication to clopidogrel in which case patient must have concomitant therapy with aspirin; ANDPatient is 18 years of age or older; ANDPrescribed by or in consultation with a cardiologist
Pulmonary Arterial Hypertension Agents			
Inhaled Prostacyclin Analogues			<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edit</p>
Tyvaso® Ventavis®			



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
Oral Endothelin Receptor Antagonist			<p>*Clinical Criteria for PDE-5</p> <ul style="list-style-type: none"> • Diagnosis of pulmonary hypertension in patients >18 years is required; AND • The prescriber must be a pulmonary specialist or cardiologist; AND • Must have a rationale for not taking the oral Revatio® to receive a SA for the injectable Revatio®.
Letairis® Tracleer®		Opsumit®	
Phosphodiesterase 5 Inhibitors (PDE-5)			
*sildenafil tab		*Adcirca™ *Revatio® tab/susp *Revatio® inj	
Prostacyclin Vasodilator			
		Orenitram™	
Soluble Guanylate Cyclase Stimulators			
		Adempas®	
Central Nervous System			
Alzheimer's Agents			
Cholinesterase Inhibitors			<p>LENGTH OF AUTHORIZATIONS: Length of prescription (up to 3 months)</p> <p>Routine PDL edit</p>
donepezil tab Exelon® (transderm)		Aricept® ODT, tab & 23 mg tab donepezil ODT & 23mg tab Exelon® cap galantamine IR, ER tab/soln Razadyne® IR, ER rivastigmine cap & patch Namzaric® (donepezil/memantine)	
NMDA Receptor Antagonist			
Namenda® soln memantine tab		Namenda® Dose Pack /XR tab Namenda® tab memantine Dose Pack & soln	



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
Anticonvulsants			
Barbiturates		LENGTH OF AUTHORIZATIONS: 1 year	
phenobarbital elixir/ tab primidone	Mysoline®	Routine PDL edit plus	
		Clinical Criteria for Anticonvulsants: <ul style="list-style-type: none">A therapeutic failure of at least one preferred medication(s) within the same class.	
Benzodiazepines			
clonazepam Diastat® rectal Diastat® AcuDial™ rectal	clonazepam ODT diazepam® rectal diazepam® Device rectal Fin® tab Onfi® susp/tab	Onfi SA Fax Form	
Carbamazepine Derivatives			
carbamazepine chewable tab/susp/ tab carbamazepine ER (generic for Carbatrol®) oxcarbazepine tab Tegretol® XR Trileptal® susp	Aptiom® carbamazepine XR Carbatrol® Equetro® cap oxcarbazepine susp Oxtellar™ XR Tegretol® susp/tab Trileptal® tab		
Hydantoins			
Dilantin® cap/Infatab phenytoin cap/susp/chew tab phenytoin ext cap Phenytek®	Dilantin® susp Peganone®		
Succinimides			
ethosuximide cap/syrup	Celontin® Zarontin® cap/syrup		



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
Valproic Acid and Derivatives			
Depakote [®] sprinkle		Depakene [®] cap/syrup	
divalproex tab		Depakote [®] ER	
divalproex ER		divalproex sprinkle	
valproic acid		Stavzor [®]	
Other Anticonvulsants			
felbamate susp/tab		Banzel [®] susp/tab	
Gabitril [®]		Felbatol [®] susp/tab	
Lamictal [®] XR		Fycompa [®]	
lamotrigine tab		Keppra [®] soln/tab	
levetiracetam soln/ tab		Keppra [®] XR	
levetiracetam ER		Lamictal [®] ODT/ODT dose pk	
Vimpat [®] soln/tab		Lamictal [®] tab/dose pk	
Topamax [®] sprinkle		Lamictal [®] XR dose pk	
topiramate tab		lamotrigine tab dose pk	
zonisamide		lamotrigine ODT	
		lamotrigine XR	
		Potiga [®]	
		Qudexy [™] XR	
		Sabril [®] powder pack/tab	
		tiagabine	
		Topamax [®] tab	
		topiramate ER	
		topiramate sprinkle	
		Trokendi [™] XR	
		Zonegran [®]	
Antidepressants			
Other			LENGTH OF AUTHORIZATIONS: 1 year
bupropion IR, SR &XL		Aplenzin [®]	Routine PDL edit plus
mirtazapine ODT & tab		Brintellix [®]	
trazodone		desvenlafaxine ER	Clinical Criteria for Antidepressants <ul style="list-style-type: none">A therapeutic failure of at <u>least two medications within the same class</u> not requiring prior approval.
venlafaxine IR & ER cap		desvenlafaxine fumarate ER	
		Effexor [®] XR	
		Emsam [®] transdermal	
		Fetzima [®]	
		Forfivo [®] XL	



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
	<i>KhedezaTM</i> <i>Marplan[®]</i> <i>Nardil[®]</i> <i>Nefazodone</i> <i>Oleptro[®] ER</i> <i>Parnate[®]</i> <i>phenelzine</i> <i>Pristiq[®]</i> <i>Remeron[®] ODT & tab</i> <i>tranylcypromine sulfate</i> <i>venlafaxine ER tab</i> <i>Viibryd[®] tab/dose pk</i> <i>Wellbutrin[®] IR, SR & XL</i>	
SSRI		
citalopram soln/tab escitalopram tab fluoxetine cap/soln fluvoxamine paroxetine tab sertraline tab	<i>Brisdelle[®]</i> <i>Celexa[®] tab</i> <i>escitalopram soln</i> <i>fluoxetine DR cap/tab</i> <i>fluvoxamine ER</i> <i>Lexapro[®] soln/tab</i> <i>Luvox[®] CR</i> <i>paroxetine CR</i> <i>Paxil[®] tab/susp & Paxil[®] CR</i> <i>Pexeva[®]</i> <i>Prozac[®] cap/weekly</i> <i>Sarafem[®]</i> <i>sertraline conc</i> <i>Zoloft[®] conc/tab</i>	
Antimigraine Agents		
Relpax[®] sumatriptan succinate tab cartridge/nasal/vial/pen rizatriptan tab & MLT	<i>almotriptan</i> <i>Alsuma[®]</i> <i>Amerge[®]</i> <i>Axert[®]</i> <i>Cambia[®]</i> <i>Frova[®]</i> <i>Imitrex[®]</i> <i>cartridge/nasal/pen/tab/vial</i>	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
	<i>Maxalt[®] tab & MLT</i> <i>naratriptan</i> <i>Sumavel[®] Dosepro</i> <i>Treximet[®]</i> <i>Zecuity[®] patch</i> <i>Zomig[®] tab/nasal spray/ZMT</i>	
Antipsychotics		
Atypical		LENGTH OF AUTHORIZATIONS: 1 year
Abilify[®] tab aripiprazole soln clozapine ODT/tab Fanapt[®] tab Geodon[®] IM Latuda[®] olanzapine ODT/tab olanzapine/ fluoxetine quetiapine tab risperidone ODT/ soln/tab Seroquel[®] IR/XR ziprasidone capsule	<i>Abilify[®] IM</i> aripiprazole tab <i>aripiprazole ODT</i> <i>Clozaril[®]</i> <i>Fanapt[®] titration pk</i> <i>Fazaclo[®]</i> <i>Geodon[®]</i> <i>Invega[®]</i> <i>olanzapine IM</i> <i>paliperidone ER</i> <i>Rexulti[®] tab</i> <i>Risperdal[®] ODT/soln/tab</i> <i>Saphris[®] SL</i> <i>Symbyax[®]</i> <i>Versacloz[™]</i> <i>Zyprexa[®] tab/IM/Zydis</i>	Routine PDL edit plus <u>Clinical Criteria for Antipsychotics</u> <ul style="list-style-type: none"> A therapeutic failure of at least one medication within the same class not requiring prior approval. <u>Antipsychotics In Children Less Than 18 Years SA Fax Form</u>
Typical		
amitriptyline/perphenazine chlorpromazine fluphenazine elixir/soln/tab haloperidol tab haloperidol lactate conc/IM loxapine perphenazine trifluoperazine thiothixene thioridazine	<i>haldol (injection)</i> <i>pimozide</i> <i>Orap[®]</i>	
Non-Ergot Dopamine Receptor Agonist		
pramipexole	<i>Mirapex[®] IR & ER</i>	LENGTH OF AUTHORIZATIONS: 1 year



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
4/1/2016



<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
ropinirole HCl	<i>Neupro[®]</i> <i>pramipexole ER</i> <i>Requip[®] IR & XR</i> <i>ropinirole HCl ER</i>	Routine PDL edit
Sedatives / Hypnotics		
temazepam 15 & 30 mg	<i>estazolam</i> <i>flurazepam</i> <i>Halcion[®]</i> <i>Restoril[®]</i> <i>temazepam 7.5 mg / 22.5 mg</i> <i>triazolam</i>	<u>LENGTH OF AUTHORIZATIONS:</u> Length of the prescription (up to 3 months) Routine PDL edit plus
Sedatives / Hypnotics (Non-Benzodiazepine)		<u>*Clinical Criteria for Hetlioz[™]</u> <u>Length of Authorization:</u> 6 months. For Renewal - must document therapeutic benefit and confirm compliance <ul style="list-style-type: none"> For the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24), AND The patient is completely blind, AND Patient must be age 18 years of age or older. Quantity limit = 1 tablet per day.
zolpidem	<i>Ambien[®] IR & CR</i> <i>Belsomra[®]</i> <i>Edluar[™]</i> <i>eszopiclone</i> <i>*Hetlioz[™]</i> <i>Intermezzo[®]</i> <i>Lunesta[®]</i> <i>Rozerem[®]</i> <i>Silenor[®]</i> <i>Sonata[®]</i> <i>Zaleplon[®]</i> <i>zolpidem CR</i> <i>Zolpimist[™] spray</i>	
Skeletal Muscle Relaxants		
baclofen chlorzoxazone cyclobenzaprine HCL dantrolene sodium methocarbamol tizanidine tab	<i>Amrix[®]</i> <i>*carisoprodol</i> <i>*carisoprodol/ASA</i> <i>*carisoprodol/ASA/codeine</i> <i>cyclobenzaprine ER</i> <i>Dantrium[®]</i> <i>Fexmid[®]</i> <i>Lorzone[®]</i> <i>metaxalone</i> <i>orphenadrine citrate</i> <i>orphenadrine/ASA/caffeine</i>	<u>LENGTH OF AUTHORIZATIONS:</u> <ul style="list-style-type: none"> 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 plus <u>*Clinical Criteria for Carisoprodol Products</u> <ul style="list-style-type: none"> The patient is at least 16 years of age; AND Only approve for ACUTE, painful musculoskeletal conditions. Do not approve for chronic pain.



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents		SA Criteria																		
		Parafon Forte® DSC Robaxin® Skelaxin® *Soma® tizanidine cap Zanaflex®		<ul style="list-style-type: none">Quantity limit = 4 tablets per dayLimit 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. Soma/carisoprodol SA Fax Form																		
Smoking Cessation																						
bupropion SR Chantix® Chantix® DS PK nicotine gum/ lozenge/patch		Nicoderm CQ® Patch Nicorette® Gum/Lozenges Nicotrol® Inhaler & NS Zyban®		LENGTH OF AUTHORIZATIONS: 6 months Routine PDL edit																		
Stimulants/ADHD Medications																						
Amphetamine Products			LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit plus																			
*Adderall® XR amphetamine salts combo dextroamphetamine Vyvanse®		Adderall® IR amphetamine salts combo XR Desoxyn® Dexedrine® dextroamphetamine SR & soln Evekeo™ methamphetamine Procentra® soln Zenzedi™		Clinical Criteria for all Stimulants/ADHD Drugs																		
				Age Edits for Stimulants <ul style="list-style-type: none">Patients > 18 years old - a confirmed diagnosis of ADHD, ADD; OR other FDA approved indication is requiredEach product listed below requires an SA for ages less than the FDA/PI indicated age.																		
				<table><tr><th>Brand name</th><th>PI age less than</th></tr><tr><td>Aptensio™ XR</td><td>6 years</td></tr><tr><td>Extended-release once-daily products; e.g., Adderall XR, Metadate CD, Concerta® Ritalin LA® etc.</td><td>6 years</td></tr><tr><td>Focalin XR®</td><td>6 years</td></tr><tr><td>Intuniv®</td><td>4 years</td></tr><tr><td>Immediate release formulations: e.g., methylphenidate</td><td>3 years</td></tr><tr><td>Kapvay® SR</td><td>6 years</td></tr><tr><td>Strattera®</td><td>6 years</td></tr></table>	Brand name	PI age less than	Aptensio™ XR	6 years	Extended-release once-daily products; e.g., Adderall XR, Metadate CD, Concerta® Ritalin LA® etc.	6 years	Focalin XR®	6 years	Intuniv®	4 years	Immediate release formulations: e.g., methylphenidate	3 years	Kapvay® SR	6 years	Strattera®	6 years		
Brand name	PI age less than																					
Aptensio™ XR	6 years																					
Extended-release once-daily products; e.g., Adderall XR, Metadate CD, Concerta® Ritalin LA® etc.	6 years																					
Focalin XR®	6 years																					
Intuniv®	4 years																					
Immediate release formulations: e.g., methylphenidate	3 years																					
Kapvay® SR	6 years																					
Strattera®	6 years																					
				*Step Edit for Adderall XR® If a trial & failure of a preferred product occurs and the physician requests Adderall XR® or amphetamine salts combo XR. The brand Adderall XR® is preferred over the generic																		



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
		<u>Stimulants/ADHD Meds in Children Less Than FDA Indicated Age & Over 18 SA Fax Form</u>
Methylphenidate Products		
Focalin XR[®] All methylphenidate generic IR tablets methylphenidate SR	<i>Aptensio[™] XR</i> <i>Concerta[®]</i> <i>Daytrana[®]</i> <i>dexmethylphenidate IR & XR</i> <i>Focalin[®]</i> <i>Metadate CD[®]</i> <i>Metadate ER[®]</i> <i>Methylin ER[®]</i> <i>Methylin[®] chew & soln</i> <i>methylphenidate chew & soln</i> <i>methylphenidate LA</i> <i>Ritalin[®]</i> <i>Ritalin LA[®] & SR[®]</i> <i>Quillivant[™] XR susp</i>	
Miscellaneous Products		Step Edit for**Kapvay[®] SR 12H If a trial & failure of a preferred product occurs and the physician requests Kapvay[®] SR 12H or clonidine ER then Kapvay[®] SR is preferred over the generic clonidine ER. ***Nuvigil[™]/Provigil[®]/modafinil[®]: Length of Authorizations: 1 year for sleep apnea and narcolepsy; 6 months for shift work sleep disorder. <ul style="list-style-type: none">• Approvable diagnoses include:<ul style="list-style-type: none">○ Sleep Apnea: Requires documentation/confirmation via sleep study or that C-PAP has been maximized; OR○ Narcolepsy: Documentation of diagnosis via sleep study; OR○ 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 years for <u>Provigil[®]</u>• Minimum age of 17 years for <u>Nuvigil[™]</u>
Strattera[®] **Kapvay[®] SR 12H	<i>clonidine ER (generic Kapvay[®])</i> <i>guanfacine ER</i> <i>***modafinil</i> <i>***Nuvigil[™]</i> <i>***Provigil[®]</i> <i>Intuniv[®]</i>	



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
Dermatologic		
Acne		
Combination Benzoyl Peroxide & Clindamycin, Topical		LENGTH OF AUTHORIZATIONS: 1 year
benzoyl peroxide wash/cr/gel/lotion (OTC) Benzaclin[®] Benzaclin[®] Pump clindamycin phosphate gel/lotion/soln Panoxyl-4 Acne Cr Wash (OTC)	<i>Acanya[™] w/pump</i> <i>Acne Clearing System[®] (OTC)</i> <i>Azelex[®]</i> <i>Benzefoam[™] regualr & Ultra[™]</i> <i>Benzepro</i> <i>benzoyl peroxide wash/cr/gel/lotion/foam/towelette (RX)</i> <i>benzoyl peroxide 6% cleanser (OTC)</i> <i>BPO Kit</i> <i>Cleocin T[®]</i> <i>Clindacin[™] Pac Kit</i> <i>Clindagel[®]</i> <i>clindamycin/benzoyl peroxide (Benzaclin[®]) & (Duac[®]) generics</i> <i>clindamycin phosphate foam/lotion/med swab</i> <i>Delos[™] Lotion[™]</i> <i>Duac[®] gel</i> <i>Evoclin[™]</i> <i>Inova[™]</i> <i>Lavoclen[™] Cleanser & Kit</i> <i>Neuac[™] topical/kit</i> <i>Onexton[™]</i> <i>Pacnex[®] HP & LP</i> <i>Panoxyl[®] 3% cr</i> <i>Se BPO Wash Kit & cleanser</i>	Routine PDL edit plus Failure to respond to a therapeutic trial of at least two weeks of one preferred medication. Clinical Criteria for Dermatologic Acne Agents <ul style="list-style-type: none">Prescriptions for patients over the age of 18 years will require a SA to determine diagnosis for treatment; ANDProducts are intended for acne only. SA for a cosmetic indication cannot be approved
Retinoids/Combinations , Topical		
Differin[®] 0.1% cr/gel/lot Differin[®] 0.3% cr/gel/lot tretinoin 0.1% cr/gel tretinoin 0.025% cr/gel	<i>adapalene 0.1% cr/gel/lot</i> <i>adapalene 0.3% gel/gel w/pump</i> <i>Atralin[®] 0.05% gel</i> <i>Avage[®] 0.1% cr</i>	*Clinical Criteria for Fabior[™] Foam <ul style="list-style-type: none">Patient must be between the ages of 12 and 18 years of age



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
tretinoin 0.5% cr	<i>Avita[®] 0.025% cr/gel</i> <i>Epiduo[®]</i> <i>Epiduo[®] Forte Gel</i> <i>*Fabior[™] 01% Foam</i> <i>Renova[®] 0.02% cr/cr pump</i> <i>Retin[®] A (all strengths and dosage forms)</i> <i>Tazorac[®]</i> <i>tretinoin 5% gel (generic Atralin[®])</i> <i>tretinoin microsphere 0.04% & 0.1% gel</i> <i>Veltin[®] gel</i> <i>Ziana[®] gel</i>	
Antifungal Topical		
ciclopirox soln clotrimazole cr (RX) clotrimazole cr (OTC) clotrimazole soln (OTC) clotrimazole-betamethasone cr ketoconazole shampoo ketoconazole cr miconazole oint (OTC) miconazole nitrate (OTC) miconazole powder (OTC) miconazole spray (OTC) miconazole cr (OTC) nystatin oint nystatin Cr nystatin powder nystatin-triamcinolone cr nystatin-triamcinolone oint terbinafine cr (OTC)	<i>Alevazol[®] OTC</i> <i>Azolen[®] Tincture OTC</i> <i>Bensal HP[®]</i> <i>Ciclodan[®] Kit</i> <i>ciclopirox cr/shampoo/gel</i> <i>ciclopirox kit</i> <i>ciclopirox suspension</i> <i>clotrimazole solution RX</i> <i>clotrimazole-betamethasone lotion</i> <i>*CNL 8[®] Kit</i> <i>Desenex[®] Aero Powder (OTC)</i> <i>econazole</i> <i>Ertaczo[®]</i> <i>Exelderm[®] cr</i> <i>Exelderm[®] soln</i> <i>Extina[®]</i> <i>Fungi-Nail[®] (OTC)</i> <i>Fungoid[®] Kit (OTC)</i> <i>Fungoid[®] (OTC)</i> <i>*Jublia[®]</i> <i>*Kerydin[®]</i> <i>Lamisil AT[®] cr (OTC)</i> <i>Lamisil AT[®] gel (OTC)</i>	<p>LENGTH OF AUTHORIZATIONS: 6 MONTHS Routine PDL edit</p> <p><u>*Clinical Criteria for Topical Onychomycosis Agents (ciclopirox/Penlac[®], CNL-8[™], Jublia[®], Kerydin[™])</u></p> <ul style="list-style-type: none"> • Patient must have a diagnosis of onychomycosis AND • A failure of an adequate trial of ONE oral alternative - terbinafine (6 weeks for fingernail infections; 12 weeks for toenail infections); fluconazole (6 months); itraconazole (60 days for fingernail infections; 90 days for toenail); OR • An allergy or contraindication to oral terbinafine, fluconazole or itraconazole;AND • Patient is at least 18 years of age or older <p><u>** Clinical Criteria for Luzu[®] (luliconazole):</u> Length of authorization – 3 months</p> <ul style="list-style-type: none"> • Patient must have a documented diagnosis of athlete's foot (tinea pedis) or ringworm (tinea cruris, tinea corporis); AND • A therapeutic failure with at least two (2) topical antifungal medications; AND



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
tolnaftate cr (OTC) tolnaftate powder (OTC) tolnaftate aero pow (OTC) tolnaftate spray (OTC) tolnaftate soln (OTC)	<i>Lamisil[®] Spray (OTC)</i> <i>Loprox[®] Shampoo</i> <i>Lotrimin AF[®] cr (OTC)</i> <i>Lotrimin AF[®] (OTC)</i> <i>Lotrisone[®] cr</i> <i>Lotrimin Ultra[®] (OTC)</i> <i>**Luzu[®]</i> <i>Mentax[®]</i> <i>Naftin[®] cr</i> <i>Naftin[®] gel</i> <i>Naftifine CR</i> <i>Nizoral A-D[®] Shampoo (OTC)</i> <i>Oxistat[®] cr</i> <i>Oxistat[®] Lotion</i> <i>Pediaderm AF[®]</i> <i>*Penlac[®]</i> <i>Tinactin[®] Aero Powder (OTC)</i> <i>Tinactin[®] Spray (OTC)</i> <i>Vusion[®]</i>	<ul style="list-style-type: none"> • Patient is at least 18 years of age or older • Maximum quantity = 60 grams <p><u>Topical Onychomycosis Agents SA Fax Form</u></p>
Immunomodulators Atopic Dermatitis		
*Elidel[®]	*Protopic[®] tacrolimus	<p><u>LENGTH OF AUTHORIZATIONS:</u> 1 year</p> <p>Routine PDL edit plus</p> <p><u>Clinical Criteria for Atopic Dermatitis, Topical</u></p> <p><u>*Elidel[®] and Protopic[®]</u></p> <ul style="list-style-type: none"> • Patient must have a FDA approved diagnosis: <ul style="list-style-type: none"> ○ Atopic dermatitis ○ 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; AND. • Failure to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.)
Psoriasis, Topical		
Dovonex[®] calcipotriene soln	calcipotriene cr/oint <i>Calcitrene[®]</i> <i>calcitriol</i> <i>Micanol[®]</i>	



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
		Sorilux™ Taclonex® Taclonex® Scalp Vectical	
Steroids			
Steroids, Topical Low Potency			LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit plus Clinical Criteria for Steroids <ul style="list-style-type: none"> A therapeutic failure of at least <u>two medications</u> within the same class not requiring prior approval.
alclometasone dipropionate cr/oint hydrocortisone/min oil/pet oint hydrocortisone acetate/urea hydrocortisone cr/gel/lot/oint hydrocortisone/aloe gel	aqua glycolic HC Capex® shampoo Derma-smoothe-FS desonate gel/cr/lot/oint Desowen® lot fluocinolone 0.01% oil Pediaderm® HC Pediaderm® TA Texacort®		
Steroids, Topical Medium Potency			
fluticasone propionate cr/oint hydrocortisone valerate cr/oint mometasone furoate cr/oint/sol	betamethasone valerate foam clocortolone cr Cloderm® Cordran® tape Cutivate® cr/lot Dermatop® cr/oint Elocon® cr/oint/soln fluocinolone acetonide cr/oint/soln fluticasone propionate lot hydrocortisone butyrate cr/oint/soln/ emollient Luxiq® Momexin® Pandel® prednicarbate cr/oint Synalar® Synalar TS®		
Steroids, Topical High Potency			
fluocinonide cr/oint/gel soln/emollient triamcinolone acetonide	amcinonide cr/lot/oint betamet diprop & prop gly cr/lot/oint		



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
cr/lot/oint		<i>betamet diprop cr/foam/gel/lot/oint</i> <i>betamethasone valerate cr/lot/oint</i> <i>DermacinRx[®] SilaPak[™]</i> <i>DermacinrRX[®] Silazone</i> <i>desoximetasone cr/gel/oint/spray</i> <i>diflorasone diacetate cr/oint</i> <i>Diprolene[®] lot/oint</i> <i>DiproleneAF[®] cr</i> <i>Halog[®] cr/oint</i> <i>Kenalog[®] aerosol</i> <i>Topicort[®] cr/gel/oint/spray</i> <i>Trianex[®] oint</i> <i>triamcinolone spray</i> <i>triamcinolone/dimethicone</i> <i>Vanos[®] cr</i> <i>Whytederm[®] Tdpak</i>	
Steroids, Topical Very High Potency			
clobetasol emollient clobetasol propionate cr/gel/ oint/soln halobetasol propionate cr/oint		<i>Apexicon[™] E</i> <i>clobetasol lot</i> <i>clobetasol propionate foam</i> <i>clobetasol propionate spray</i> <i>clobetasol shampoo</i> <i>Clobex[®] lot/shampoo/spray</i> <i>Clodan[®] kit</i> <i>Halonate[®]</i> <i>Olux[®]</i> <i>Olux[®] -E</i> <i>Temovate[®] oint</i> <i>Ultravate[®] cr/oint</i> <i>Ultravate[®] PAC</i> <i>Ultravate[®] X</i>	



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
4/1/2016



Preferred Agents		Non-Preferred Agents		SA Criteria	
Endocrine and Metabolic Agents					
Androgenic Agents (Testosterone – Topical)					
Androgel®		Androderm® Axiron® soln Fortesta® Natesto Nasal Gel® Testim® testosterone (generic for Androgel®) testosterone gel/packet/pump (generic for Vogelxo™) testosterone (generic for Fortesta®) Vogelxo™ gel/packet/pump	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit plus Failure to respond to a therapeutic trial of at least one week of one preferred medication		
Antihyperuricemics					
allopurinol colchicine tabs Probenecid® probenecid & colchicine		colchicine caps *Colcrys® Uloric® Zyloprim®	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit plus *Clinical Criteria for Colcrys™ <ul style="list-style-type: none">• Diagnosis of Familial Mediterranean Fever; OR• Acute Gout Flare:<ul style="list-style-type: none">○ Trial and failure of one of the following:<ul style="list-style-type: none">▪ NSAID or Corticosteroid		
Contraceptives					
Etonogestrel/Ethinyl Estradiol Vaginal Ring			LENGTH OF AUTHORIZATIONS: 1 year		
NuvaRing®			Routine PDL edit		
Norelgestromin/Ethinyl Estradiol Transdermal					
Xulane Transdermal Patch™					
Oral Contraceptives					
Apri® Cryselle™ Falmina®		All other oral contraceptives Empresse® Loestrin®			



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
Femcon Fe[®] Gianvi[™] Gildess FE[®] Junel Fe[®] Levonest[™] Loestrin Fe[®] Microgestin[®] Microgestin Fe[®] Minastrin 24 FE[®] Necon[®] monophasic Nora-Be[®] Nortrel[®] monophasic Nortrel[®] triphasic Ortho Tri-Cyclen[®] Ortho Tri-Cyclen Lo[®] Ortho-Novum[®] monophasic Ortho-Novum[®] triphasic Orsythia[®] Sprintec[®] Syeda[®] Tri-Sprintec[®] Trivora-28[®] Vestura[®] Viorele[®] Zovia[®] 1-35E & 1-50E		Micronor[®] Mircette[®] Norinyl 1+50[®] Nor-Q-D[®] Yasmin[®] 28 Yaz[®]	
Diabetes Hypoglycemics: Injectable Amylin Analogs			
	*SymLin[®] *SymLin[®] Pens	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year <u>*Clinical Criteria for Injectable Amylin Analogs</u> <ul style="list-style-type: none"> • Patient must have a history of at least a 90 day trial of insulin. • SymLin[®] is only indicated as adjunct therapy with insulin. • Patient meeting ALL of the following criteria may be approved: <ul style="list-style-type: none"> ○ Diagnosis of Type 1 or 2 diabetes; AND ○ On insulin therapy; AND ○ Failure to achieve adequate glycemic control (HbA1c ≤ 6.5%). 	



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
Diabetes Hypoglycemics: Injectable Incretin Mimetics			
Byetta [®]	Bydureon TM Tanzeum TM Trulicity TM Victoza [®]	<u>LENGTH OF AUTHORIZATIONS:</u> Routine PDL edit	1 year
Diabetes Hypoglycemics: Injectable Insulins			
Insulin Mix		<u>LENGTH OF AUTHORIZATIONS:</u> Routine PDL edit	1 year
Humalog [®] Mix 50/50 vial Humalog [®] Mix 75/25 vial Humulin [®] 70/30 vial Novolog [®] Mix 70/30 pen/ vial	Humalog [®] Mix 50/50 Kwikpen Humalog [®] Mix 75/25 Kwikpen Humulin [®] 70/30 pen (OTC) Novolin [®] 70/30 vial (OTC)		
Insulin N			
Humulin [®] N vial (OTC)	Humulin [®] N pen Novolin [®] N vial (OTC)		
Insulin R			
Humulin [®] R vial	Novolin [®] R vial (OTC)		
Long-Acting Insulins			
Lantus [®] vial Levemir [®] pen/vial	Lantus Solostar [®] /cartridge Toujeo [®] Solostar [®]		
Rapid-Acting Insulins			
Humulin 500 U/M vial Humalog [®] vial Novolog [®] cartridge/ Flexpen/vial	Apidra [®] cartridge/Solostar/vial Humalog [®] Cartridge Humalog Kwikpen [®] Afrezza [®] cartridge (inhalation)		
Diabetes Oral Hypoglycemics			
Oral Hypoglycemics Alpha-Glucosidase Inhibitors		<u>LENGTH OF AUTHORIZATIONS:</u> Routine PDL edit	1 year
acarbose	Precose [®]		



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
Glyset [®]			
Oral Hypoglycemics Biguanides			
metformin metformin ER (generic for Glucophage [®] XR)		Fortamet [®] Glucophage [®] IR & XR Glutmetza [®] Riomet [®] susp metformin ER (generic for (Fortamet [®]))	
Oral Hypoglycemics Biguanide Combination Products			
glyburide/metformin		glipizide/metformin Glucovance [®]	
Oral Hypoglycemics DPP-IV Inhibitors & Combination			
Janumet [®] Janumet XR [®] Januvia [®] Jentadueto [™] Tradjenta [™]		Kazano [™] Kombiglyze XR [™] Nesina [™] Onglyza [™] Oseni [™]	
Oral Hypoglycemics Meglitinides			
Starlix [®]		nateglinide Prandin [®] PrandiMet [™]	
Oral Hypoglycemics Second Generation Sulfonylureas			
glimepiride glipizide glipizide ER glyburide glyburide micronized		Amaryl [®] Diabeta [®] Glucotrol [®] Glucotrol XL [®] Glynase [®]	



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
Oral Hypoglycemics Sodium Glucose Co-Transporter 2 Inhibitor (SGLT2)			Clinical Criteria for Oral Hypoglycemics: Sodium Glucose Co-Transporter 2 Inhibitor (SGLT2)
Farxiga TM Xigduo TM XR	Glyxambi [®] Jardiance [®] Invokana TM Invokamet TM Synjardy [®]		<p>Length of Authorization: Initial approval for 6 months. Renewals for 1 year.</p> <ul style="list-style-type: none"> • Approve for Type 2 diabetics who have been compliant with and have not achieved adequate glycemic control with metformin; OR • Are intolerant to metformin; AND • Patient must be > 18 years of age. <p>Quantity Limit = 1 tablet per day</p>
Oral Hypoglycemics Thiazolidinediones			
pioglitazone	Avandia [®] Actoplus Met [®] IR & XR Actos [®] Avandaryl [®] Avandamet [®] Duetact [®] pioglitazone/metformin		
Erythropoiesis Stimulating Proteins: Epogen[®], Procrit[®] (Erythropoietin) & Aranesp[®] (Darbepoetin)			
Procrit [®]	Aranesp [®] Epogen [®] Mircera [®]		<p><u>LENGTH OF AUTHORIZATIONS:</u> for duration of the prescription up to 6 months</p> <p>Routine PDL edit</p> <p><i>Omontys[®] is not PDL eligible, may be covered under medical benefit</i></p>
Glucocorticoids, Oral			
budesonide EC dexamethasone soln/tab hydrocortisone methylprednisolone tab ds pk methylprednisolone 4mg tab prednisolone sodium phosphate soln prednisolone soln/tab prednisone soln/tab/tab ds pk	Cortef [®] cortisone acetate dexamethasone elixir/intensol Dexpak [®] Entocort [®] EC Flo-Pred [®] Medrol [®] Tab ds pk & tab methylprednisolone 8,16 & 32mg tab Millipred DP [®] tab Ds Pk Millipred [®] soln/tab Orapred [®] ODT prednisolone sodium phosphate ODT		<p><u>LENGTH OF AUTHORIZATIONS:</u> 1 year</p> <p>Routine PDL edit plus</p> <p>Trial and therapeutic failure of all preferred drugs</p>



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
	<p><i>prednisone intensol</i> <i>Rayos[®] DR tab</i> <i>Veripred[®]</i></p>	
Growth Hormone		
<p>Genotropin[®] Nutropin AQ[®] NuSpinTM</p>	<p><i>Humatrope[®] cartridge/vial</i> <i>Norditropin cartridge[®]</i> <i>Norditropin FlexPro[®] & Nordiflex[®]</i> <i>Nutropin[®]</i> <i>Nutropin AQ[®] cartridge/vial</i> <i>Omnitrope[®]</i> <i>Saizen[®] cartridge/vial</i> <i>*Serostim[®]</i> <i>Tev-Tropin[®]</i> <i>Zomacton[®]</i> <i>**Zorbtive[®]</i></p>	<p><u>LENGTH OF AUTHORIZATIONS:</u> 1 year</p> <p><u>Clinical Criteria for PEDIATRIC Patients (18 years of age and under)</u></p> <ul style="list-style-type: none"> • Prescriber is an endocrinologist, nephrologist, infectious disease specialist or HIV specialist or one has been consulted on this case; AND • The patient has open epiphysis and one of the following diagnoses <ul style="list-style-type: none"> ○ Turner Syndrome; OR ○ Prader-Willi Syndrome; OR ○ Renal insufficiency; OR ○ Small for gestational age (SGA) - including Russell-Silver variant and patient is < 2 years old; OR ○ Idiopathic Short Stature (for request for renewal only (a) information is required to be approved); OR ○ Growth hormone deficiency (physician should provide the required information below); OR ○ 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. <p><u>Clinical Criteria for Renewal (pediatrics):</u></p> <ul style="list-style-type: none"> • 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 • Patient height is more than 1 standard deviation (2") below mid-parental height (unless parental height is diminished due to medical or nutritional reasons). <p><u>Clinical Criteria for ADULTS (> 18 years of age)</u></p> <ul style="list-style-type: none"> • Prescriber is an endocrinologist; AND



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
			<ul style="list-style-type: none">• 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); AND• 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; OR• 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. <p>*Serostim®</p> <ul style="list-style-type: none">• Diagnosis of AIDS wasting or cachexia; AND• Has a documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents (both Megace® & Marinol®); AND• *Length of Authorization: 3 months initial; then 1 year. Renewal is contingent upon improvement in lean body mass or weight measurements. <p>**Zorbitive® - Diagnosis of short bowel syndrome</p> <p>Growth Hormone SA Fax Form</p>
Hereditary Angioedema (HAE) Agents			
Berinert® Cinryze™ Kalbitor®		Firazyr® Ruconest®	<p><u>LENGTH OF AUTHORIZATIONS:</u> Date of service (plus one additional supply for emergency use)</p> <p>Routine PDL edit plus</p> <p><u>Clinical Criteria for Blood Modifiers</u></p> <ul style="list-style-type: none">• Must be prescribed by and under direct care of a board-certified allergist, immunologist or hematologist; AND• For prophylaxis the patient must:<ul style="list-style-type: none">○ Have HAE attacks that occur at least once monthly; AND○ Be disabled at least 5 days per month; AND○ Have history of attacks with airway compromise / hospitalization AND○ Have history of prior prophylaxis with danazol:



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
			<ul style="list-style-type: none"> danazol contraindicated (pediatric, hepatic or renal impairment, pregnancy, breast-feeding, abnormal genital bleeding); OR Developed danazol toxicity; OR Diminished danazol efficacy. <p>FDA Indications and Quantity Limits</p> <ul style="list-style-type: none"> Berinert[®]: Acute abdominal, facial or laryngeal HAE attacks. Four vials per attack (plus four for emergency). Cinryze[™]: Prevention of HAE attacks. 20 vials per 34 days. Kalbitor[®]: Acute HAE attacks in patients 12 years of age and older. Three vials per attack (plus three vials for emergency). Firazyr[®]: Acute attacks of (HAE) in adults 18 years of age and older. One syringe (plus one for emergency). Ruconest[®]: Acute attacks of hereditary angioedema (HAE) in people over 13 years of age. Two vials (plus two for emergency). <p>Hereditary Angioedema (HAE) SA Fax Form</p>
Pancreatic Enzymes			
pancrelipase Zenpep [®] Creon [®]	Pancreaze [®] Viokace [®] Pertzye [®] Ultresa [®]		<p>LENGTH OF AUTHORIZATION: 1 year</p> <p>Routine PDL edit plus</p> <p>Clinical Criteria for Pancreatic Enzymes Creon[®], Pancrelipase, Zenpep[®]: diagnosis of pancreatic insufficiency due to cystic fibrosis or chronic pancreatitis or pancreatectomy.</p>
Progestational Agents			
medroxyprogesterone acetate (tablet only) norethindrone acetate progesterone injection Prometrium [®]	Aygestin [®] progesterone cap Provera [®]		<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edit plus</p> <p>Failure to respond to a therapeutic trial of at least one week of one preferred product.</p>
Progestins Used For Cachexia			
megestrol acetate	Megace [®] Megace [®] ES megestrol suspension ES		<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edit</p>
Vaginal/Oral Estrogens			
Premarin [®] Vaginal cr	Estrace [®] Vaginal cr		<p>LENGTH OF AUTHORIZATIONS: 6 months</p>



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
4/1/2016



	Preferred Agents	Non-Preferred Agents	SA Criteria
	Vagifem [®] Vaginal tab	Estring [®] Vaginal ring Femring [®] Vaginal ring Osphena [®] tab	Routine PDL edit
Gastrointestinal			
	G I Antibiotics		
	metronidazole tab	*Alinia [®] **Difcid [®] Flagyl [®] cap, tab & ER metronidazole cap ***neomycin paromomycin Tindamax [®] tinidazole Vancocin [®] ****Xifaxan [®] vancomycin capsules vancomycin compounded oral solution	Length of authorization: 1 year Routine PDL edit plus <u>Clinical Criteria for Gastrointestinal Antibiotics</u> *Alinia[®]: <ul style="list-style-type: none">Tablets - For treatment of diarrhea caused by<ul style="list-style-type: none"><i>Cryptosporidium parvum</i> or <i>Giardia lamblia</i> and if the patient has had a trial on metronidazole or oral vancomycin or a clinical reason why it cannot be tried. Length of authorization = date of service Quantity limit = 6 tabs per rolling 30 daysSuspension:<ul style="list-style-type: none">In patients ≥ 12 for treatment of diarrhea caused by <i>Cryptosporidium parvum</i> or <i>Giardia lamblia</i> and if the patient has had a trial on metronidazole or oral vancomycin or a clinical reason why it cannot be tried. Length of authorization = date of service In patients < 12 for treatment of diarrhea caused by <i>Cryptosporidium parvum</i> or <i>Giardia lamblia</i> – no trial on metronidazole or oral vancomycin required. Length of authorization = date of service **Difcid[®]: diagnosis of <i>C. difficile</i> and if the patient has had a 10 day trial of oral vancomycin or metronidazole or a clinical reason why it cannot be tried; length of authorization = 30 days. Patient must be >17 years old. 8**Neomycin: diagnosis of hepatic coma – no preferred trial required. Length of authorization = one year. ****Xifaxan[®] <ul style="list-style-type: none">200mg tabs:<ul style="list-style-type: none">For treatment of travelers' diarrhea caused by noninvasive strains of <i>E. coli</i>, in patients greater than or equal to 12 years of age - no prior authorization is required for up to nine tablets per claim. Length of authorization = 3 days.



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
		<ul style="list-style-type: none">○ For treatment of hepatic encephalopathy – may be approved for patients age 12 and older regardless of quantity requested (document all treatments tried in the past for this diagnosis). Length of authorization = one year.• 550mg tabs:<ul style="list-style-type: none">○ For reduction in risk of overt hepatic encephalopathy recurrence in patients 18 years of age and older – no prior authorization is required for patients > 18 years old; (must document all treatments tried in the past for this diagnosis). Length of authorization = one year.
Antiemetic/Antivertigo Agents		
Cannabinoids (delta-9THC derivatives)		LENGTH OF AUTHORIZATIONS: 6 months
**dronabinol	*Cesamet® **Marinol®	Routine PDL edit plus <u>Clinical Criteria for Cannabinoids</u> *Cesamet® <ul style="list-style-type: none">• Diagnosis of severe, chemotherapy induced nausea and vomiting, AND• Patient has tried and failed, has a contraindication to, an intolerance, or a medical reason not to try the combination of Emend® plus a 5HT3 receptor antagonist plus a corticosteroid; AND• Patient has tried and failed megestrol acetate oral suspension OR has a contraindication, intolerance, drug-drug interaction, or medical reason megestrol acetate cannot be used. **Dronabinol <ul style="list-style-type: none">• Diagnosis of severe, chemotherapy induced nausea and vomiting, AND• Patient has tried and failed, has a contraindication to, an intolerance, or a medical reason not to try the combination of Emend® plus a 5HT3 receptor antagonist plus a corticosteroid; AND• Diagnosis of AIDS-relating wasting Patient has tried and failed megestrol acetate oral suspension OR has a contraindication, intolerance, drug-drug interaction; OR• Medical reason megestrol acetate cannot be used.



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
5HT3 Receptor Blockers			LENGTH OF AUTHORIZATIONS: 3 months, unless otherwise noted
ondansetron ODT/tab		<i>*Anzemet®</i> <i>*Akynzeo®</i> <i>*granisetron</i> <i>*Granisol® soln/tab</i> <i>*Kytril®</i> <i>ondansetron soln</i> <i>*Sancuso® patch</i> <i>Zofran® ODT/soln/tab</i> <i>*Zuplenz® film</i>	Routine PDL edit plus *Clinical Criteria for 5HT3 Receptor Blockers: <ul style="list-style-type: none">Nausea or vomiting related to radiation therapy, moderate to highly emetogenic chemotherapy, or post-operative nausea and vomiting; ANDPatient has tried and failed therapeutic doses of, or has adverse effects or contraindications to, 2 different conventional antiemetics (e.g., promethazine, prochlorperazine, meclizine, metoclopramide, dexamethasone, etc.)
NK-1 Receptor Antagonist			LENGTH OF AUTHORIZATIONS: Length of chemotherapy regimen or a maximum of 6 months
		<i>**Emend® Bi Pak</i> <i>**Emend® Tri-fold pack</i>	Routine PDL edit plus Clinical Criteria for NK-1 Receptor Antagonist **Emend® (aprepitant) <ul style="list-style-type: none">Emend® does NOT require treatment failure with preferred drugs when used for moderately or highly emetogenic chemotherapy. Quantity limits: One (1) Emend® BiPack (2-80mg tablets) per chemotherapy treatment or one (1) Emend® TriPack (1-125mg tablet and 2-80mg tablets) per chemotherapy treatment.
Other			LENGTH OF AUTHORIZATIONS: 1 year, unless otherwise noted
meclizine metoclopramide ondansetron tab & ODT prochlorperazine **promethazine		<i>Antivert®</i> <i>Compazine® supp/tab</i> <i>Compro®</i> <i>*Diclegis®</i> <i>dimenhydrinate</i> <i>hydroxyzine</i> <i>Metozolv® ODT</i> <i>metoclopramide ODT</i> <i>**Phenergan®</i> <i>prochlorperazine supp</i>	Routine PDL edit plus Clinical Criteria for Antiemetics/Antivertigo, Other *Diclegis® (doxylamine/pyridoxine) <ul style="list-style-type: none">Patient must be pregnant **Promethazine <ul style="list-style-type: none">Patient must be 2 years or older ***Transderm-Scop® may be approved for 3 months if patient:



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
	<p>promethazine 50mg Rectal Reglan® Tigan® ***Transderm-Scop® trimethobenzamide Vistaril®</p>	<ul style="list-style-type: none"> has tried and failed at least one of the following: meclizine, promethazine, dimenhydrinate, diphenhydramine, or metoclopramide; OR is unable to swallow or absorb oral medications, OR will be in an area/situation for an extended period of time where taking short acting agents would not be feasible <p>Antiemetic-Antivertigo SA Fax Form</p>
H. Pylori Treatment		
Pylera®	<p>Omeclamox®-Pak lansoprazole/amoxicillin/clarithro mycin Prevpac®</p>	<p>LENGTH OF AUTHORIZATIONS: 14 days</p> <p>Routine PDL edit</p>
Histamine-2 Receptor Antagonists (H-2 RA)		
<p>famotidine (OTC & RX) ranitidine tab/syrup (OTC & RX)</p>	<p>cimetidine tab/syrup (OTC/RX) famotidine oral susp (OTC/RX) nizatidine cap/susp Pepcid® susp/tab (OTC/RX) ranitidine cap (OTC/RX) Zantac® syrup/ tab (OTC/RX)</p>	<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edit</p>
GI Motility, Chronic		
*Amitiza®	<p>***alosetron **Linzess™ ***Lotronex® ****Movantik® *****Relistor®</p>	<p>LENGTH OF AUTHORIZATIONS: 6 months</p> <p>Routine PDL edit plus</p> <p>Clinical Criteria *Amitiza®</p> <ul style="list-style-type: none"> Must be 18 or older, AND have one of the following diagnoses <ul style="list-style-type: none"> Idiopathic Constipation with treatment failure of at least ONE product from TWO of the following classes: <ul style="list-style-type: none"> Osmotic Laxatives (examples: lactulose, polyethylene glycol (PEG), sorbitol); OR Bulk Forming Laxatives (examples: Metamucil® (psyllium), Citrucel®, fiber); OR Stimulant Laxatives (examples: bisacodyl, senna).



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
			<ul style="list-style-type: none">• Constipation Predominant Irritable Bowel Syndrome (IBS-C)<ul style="list-style-type: none">▪ Patient is female; AND▪ Treatment failure on at least ONE product from TWO of the following classes:<ul style="list-style-type: none">▪ Osmotic Laxatives (examples: lactulose, polyethylene glycol (PEG), sorbitol)▪ Bulk Forming Laxatives (examples: Metamucil® (psyllium), Citrucel®, fiber)▪ Stimulant Laxatives (examples: bisacodyl, senna)• Opioid Induced Constipation in chronic NON-cancer pain<ul style="list-style-type: none">▪ Patient has tried and failed both PEG (i.e., Miralax®) AND lactulose <p>**<u>Linzess</u>®</p> <ul style="list-style-type: none">• Diagnosis of Idiopathic Chronic Constipation or Constipation-Predominant Irritable Bowel Syndrome (IBS); AND• Patient must be at least 6 years of age; AND• Treatment failure on at least ONE agent from TWO of the following classes:<ul style="list-style-type: none">○ Osmotic Laxatives (examples: lactulose, polyethylene glycol (PEG), sorbitol); OR○ Bulk Forming Laxatives (examples: Metamucil® (psyllium), Citrucel®, fiber); OR○ Stimulant Laxatives (examples: bisacodyl, senna). <p>***<u>Lotronex</u>® (alosetron)</p> <ul style="list-style-type: none">• Diagnosis of severe, diarrhea predominant Irritable Bowel Syndrome; AND• Patient is female and at least 18 years of age; AND• Prescriber is enrolled in the Prometheus Prescribing Program for Lotronex®; AND• Patient has had chronic IBS symptoms for at least 6 months; AND• Patient has tried and failed at least three agents from the following<ul style="list-style-type: none">○ bulk producing agents (e.g., psyllium, fiber); OR○ antispasmodic agents (e.g., dicyclomine, hyoscyamine); OR○ antidiarrheal agents/opiates (e.g., loperamide, diphenoxylate/atropine, codeine). <p>****<u>Movantik</u>®</p> <ul style="list-style-type: none">• For the treatment of Opioid-Induced Constipation in adult patients with chronic NON-cancer pain with trial on both polyethylene glycol (PEG) AND lactulose



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
		<p>without adequate response; AND</p> <ul style="list-style-type: none"> A therapeutic failure after a trial with Amitiza® OR clinical reason as to why Amitiza cannot be used; AND The patient is 18 years of age or older. <p>*****Relistor®</p> <ul style="list-style-type: none"> Diagnosis of Opioid-Induced Constipation in <ul style="list-style-type: none"> Adult patients with chronic non-cancer pain; OR Adult patients with advanced illness; AND Patient must be ≥ 18 years. <p>Bowel Disorder SA Fax Form</p>
Proton Pump Inhibitors		
omeprazole (RX & OTC) pantoprazole	<i>Aciphex® DR tab/sprinkle</i> <i>Dexilant®</i> <i>esomeprazole magnesium</i> <i>esomeprazole strontium</i> <i>lansoprazole cap</i> <i>Nexium®</i> <i>omeprazole/sodium bicarbonate</i> <i>Prevacid® RX, OTC & Solutab</i> <i>rabeprazole DR tab</i> <i>Prilosec® Rx & Susp</i> <i>Prilosec® OTC</i> (nonrebatale) <i>Protonix®</i> <i>Zegerid® cap, OTC & susp packet</i>	<p>LENGTH OF AUTHORIZATIONS: 12 weeks; unless patient meets an exception; then 1 year</p> <p>Routine PDL edit plus</p> <p>Clinical Criteria for PPIs</p> <ul style="list-style-type: none"> A therapeutic failure of no less than a three-month trial of at least two different medications within the same class not requiring service authorization. <p>Exceptions that allow for 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)</p> <ul style="list-style-type: none"> 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 <p>Proton Pump Inhibitors SA Fax Form</p>
Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)		
Ulcerative Colitis – Oral		LENGTH OF AUTHORIZATIONS: 1 year
Apriso® Pentasa® sulfasalazine DR & IR	<i>Asacol® HD</i> <i>Azulfidine® IR & DR</i> <i>balsalazide disodium</i>	<p>Routine PDL edit</p>



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
		<i>Colazal[®]</i> <i>Delzicol[™]</i> <i>Dipentum</i> <i>*Giazo[™]</i> <i>Lialda[®]</i> <i>Uceris[™]</i>	*Giazo is limited to an 8 week supply
	Ulcerative Colitis – Rectal		
	Canasa[®] rectal supp mesalamine enema	<i>mesalamine kit</i> <i>Rowasa[®] enema/kit</i> <i>SFRowasa[®]</i> <i>Uceris[®]</i>	
Genitourinary			
Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)			
Alpha-Blockers for BPH			<u>LENGTH OF AUTHORIZATIONS:</u> 1 year
alfuzosin tamsulosin HCL	<i>Flomax[®]</i> <i>Rapaflo[®]</i> <i>Uroxatral[®]</i>		Routine PDL edit plus
Androgen Hormone Inhibitors for BPH			
finasteride	<i>Avodart[®]</i> <i>Dutasteride</i> <i>Dutasteride./tamsulosin</i> <i>Jalyn[®]</i> <i>Proscar[®]</i>		
Phosphodiesterase (PDE) 5 Inhibitor for BPH			
	**Cialis[®]		**Step edit for <u>Cialis[®]</u> - must try and fail both Alpha Blockers and Androgen Hormone Inhibitors for BPH and the prescriber must attest that the patient is not on the state list of sex offenders. The patient must have had a consult or been evaluated by an Urologist. Cialis SA Fax Form
Urinary Antispasmodics (Bladder Relaxant)			
oxybutynin tab/syrup Toviaz[™] VESIcare[®]	<i>Detrol[®] & Detrol[®] LA</i> <i>Ditropan[®] & *Ditropan[®] XL</i> <i>Enablex[®]</i> <i>flavoxate</i> <i>Gelnique[™] gel</i>		<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit plus <u>*Clinical Criteria for Oxybutynin ER, Ditropan XL[®]:</u> <ul style="list-style-type: none"> Allow PDL exception for children age 6-18 with a diagnosis of neurogenic



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria
	<i>MyrbetriqTM</i> <i>*oxybutynin ER</i> <i>Oxytrol[®] transdermal</i> <i>tropium IR & ER</i> <i>tolterodine IR & ER</i>	bladder.
Immunological Agents		
Multiple Sclerosis		
Avonex[®] Avonex[®] Adm Pack Betaseron[®] Copaxone 20 mg syringe[®] **Gilenya[®] Rebif[®] SQ	*Ampyra[®] Aubagio[®] Copaxone[®] 40 mg syringe[®] Extavia[®] Kit & Vialfpram GlatopaTM Plegidy[®] Rebif[®] Rebi dose Pen[®] TecfideraTM	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit plus **Gilenya[®] is the preferred oral agent after a trial on a preferred Injectable agent. *Clinical Criteria for AMPYRA[®] <ul style="list-style-type: none"> The patient has a diagnosis of Multiple Sclerosis and a gait disorder, AND Patient has no history of seizures; AND Patient's Creatinine Clearance [CrCL] ≥ 50 mL/min; AND If after 8 week trial the prescriber 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. <u>Ampyra SA Fax Form</u>
Cytokine and CAM Antagonists And Related Agents		
Enbrel[®] Humira[®]	Actemra[®] SQ Cimzia[®] Cimzia[®] Syringe Kit CosentyxTM Kineret[®] Otezla[®] Otrexup[®] inj Orencia[®] RasuvoTMinj Simponi[®] XeljanzTM	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit plus Clinical Criteria (see Appendix B) <u>Cytokine and CAM Antagonists Appendix A</u> <u>Otrexup SA Fax Form</u> <u>Xeljanz SA Fax Form</u>



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
4/1/2016



<i>Preferred Agents</i>		<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
Ophthalmic			
Antibiotics			
ciprofloxacin drops erythromycin gentamicin drops/oint Moxeza[®] drops neomycin/polymix/gra micidin ofloxacin drops polymyxin/trimethopri m sulfacetamide soln tobramycin Vigamox[®] drops	<i>AzaSite[™] drop</i> <i>bacitracin</i> <i>bacitracin/polymyxin b sulfate oint</i> <i>Besivance[®] drops</i> <i>Bleph[®]-10</i> <i>Ciloxan[®] drops/oint</i> <i>Garamycin[®] drops/oint</i> <i>gatifloxacin 0.5% soln</i> <i>Ilotycin[®]</i> <i>levofloxacin drops</i> <i>Natacyn[®]</i> <i>neomycin/bacitracin/polymyxin oint</i> <i>Neosporin[®]</i> <i>Ocuflox[®] drops</i> <i>Polytrim[®]</i> <i>sulfacetamide oint</i> <i>Tobrex[®] drops/oint</i> <i>Zymaxid[®] drops</i>	<u>LENGTH OF AUTHORIZATIONS:</u> Routine PDL edit	Date of service only; no refills
Antibiotic/Steroid Combinations			
neomycin/polymyxin/d examethasone oint/susp Tobradex[®] oint/susp	<i>Blephamide[®]</i> <i>Blephamide[®] S.O.P.</i> <i>Maxitrol[®] oint/susp</i> <i>neomycin/bacitracin/poly/HC</i> <i>neomycin/polymyxin/HC</i> <i>Pred-G[®] oint/susp</i> <i>sulfacetamide/prednisolone</i> <i>Tobradex[®] ST</i> <i>Tobramycin/dexamethasone susp</i> <i>Zylet[®]</i>	<u>LENGTH OF AUTHORIZATION:</u> Routine PDL edit	Date of service only; no refills
Antihistamines/Mast Cell Stabilizers			
Antihistamines			<u>LENGTH OF AUTHORIZATIONS:</u> 1 year
Alaway OTC[®] ketotifen fumarate Pataday[®] drops	<i>azelastine drops</i> <i>Bepreve[®]</i> <i>Elestat[®] drops</i>	Routine PDL edit <i>*Ilevro[™] is limited to 1 bottle plus 1 refill</i>	



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
Pazeo® Zaditor® OTC drops		Emadine® drop epinastine 0.05% eye drops *Ilevro™ 0.3% drops Lastacafi® drops Optivar® drops Patanol® drops	
Mast Cell Stabilizers			
cromolyn sodium	Alocril® drops Alomide® drops		
Anti-inflammatory			
NSAIDS			<u>LENGTH OF AUTHORIZATIONS:</u> Date of service only; no refills
diclofenac sodium flurbiprofen sodium ketorolac 0.4%& 0.5% Nevanac®		Acular® 0.5% & LS® 0.4% Acuvail® bromfenac 0.09% Ilevro™0.3% drops Ocufen® Prolensa™	Routine PDL edit *Ilevro™ is limited to 1 bottle plus 1 refill
Corticosteroids			
Durezol® fluorometholone prednisolone acetate dexamethasone		Alrex™ Flarex® FML® FML Forte® FML® S.O.P. Lotemax™ drops/gel/oint Maxidex® Omnipred® Pred Forte® Pred Mild® prednisolone sod phosphate Vexol®	
Glaucoma Agents			
Alpha 2 Adrenergic Agents			<u>LENGTH OF AUTHORIZATIONS:</u> 1 year
apraclonidine 0.5% drops Alphagan P® 0.1 & 0.15%		brimonidine tartrate 0.15% Iopidine® 0.5% & 1%	Routine PDL edit



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
brimonidine 0.2%			
Beta Blockers			
Betoptic-S® 0.25%		Betagan® 0.5%	
carteolol 1%		betaxolol 0.5%	
Combigan®		Istalol® 0.5%	
levobunolol 0.5%		Timoptic® drops 0.25% & 0.5%	
metipranolol 0.3%		Timoptic® XE 0.25% & 0.5% sol-gel	
timolol maleate			
Carbonic Anhydrase Inhibitors			
Azopt® 1%		Cosopt® 0.5%-2%	
dorzolamide		Cosopt® PF	
dorzolamide/timolol		Trusopt® 2%	
Simbrinza™			
Prostaglandin Analogs			
latanoprost		bimatoprost	
Travatan Z®		Lumigan® 0.03% & 0.01%	
		Rescula®	
		travoprost 0.004%	
		Xalatan® 0.005%	
		Zioptan™	
Respiratory			
Anti-Allergens, Oral			
	*Grastek® SL **Oralair® SL ***Ragwitek™ SL	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit plus Clinical Criteria for *Grastek® <ul style="list-style-type: none"> Age must be between 5 through 65 years, AND Indicated for grass pollen-induced allergic rhinitis with or without conjunctivitis; AND Must have evidence of a confirmed by positive skin test or <i>in vitro</i> testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens; AND 	



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
			<ul style="list-style-type: none"> Must have had a treatment failure with or contraindication to antihistamines and montelukast; AND Clinical reason as to why allergy shots cannot be used. Quantity Limit = 1 sublingual tablet per day. <p>Clinical Criteria for **Oralair®</p> <ul style="list-style-type: none"> Age must be between 10 through 65 years; AND Indicated for grass pollen-induced allergic rhinitis with or without conjunctivitis; AND Must have evidence of a confirmed positive skin test or in vitro testing for pollen-specific IgE antibodies for Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens; AND Must have had a treatment failure with or contraindication to antihistamines and montelukast; AND Clinical reason as to why allergy shots cannot be used. <p>Clinical Criteria for ***Ragwitek™</p> <ul style="list-style-type: none"> Age must be between 18 through 65 years; AND Indicated for immunotherapy for the treatment of short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis; AND Must have evidence of a confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen; AND Must have had a treatment failure with or contraindication to antihistamines and montelukast; AND Clinical reason as to why allergy shots cannot be used.
Antihistamines: First and Second Generation			
First Generation Antihistamines			LENGTH OF AUTHORIZATIONS: 1 year
Generic only class	<i>All Brands require a SA</i>		Routine PDL edit
Second Generation Antihistamines and Combinations			
cetirizine liquid 1mg/1mL (RX/ OTC)	<i>Allegra-D®</i>		
cetirizine tabs OTC	<i>cetirizine chew tab (OTC)</i>		
loratadine tab/syrup OTC	<i>cetirizine liquid 5mg/5mL (OTC)</i>		
	<i>cetirizine D tab (OTC)</i>		



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents	Non-Preferred Agents	SA Criteria																																							
	Clarinex [®] Clarinex-D [®] Claritin [®] Claritin [®] D desloratadine ODT fexofenadine fexofenadine/PSE ER fexofenadine suspension levocetirizine loratadine ODT loratadine D 12 & 24 hr Xyzal [®]																																								
Beta-Adrenergic Agents																																									
Long Acting Beta Adrenergic agents (LABA) Metered Dose Inhalers or Nebulizers		<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit plus <u>**Clinical Criteria for agents that contain a LABA</u> Length of Authorization: 3 months for Clinical Criteria Each product listed below will require a SA for ages less than the FDA/PI indicated age.																																							
*Foradil [®] *Serevent Diskus [®]	*Arcapta Neohaler [®] *Brovana [®] *Perforomist [®] Striverdi [®] Respimat	<table> <tr> <th>Brand Name</th><th>Age where SA is required</th><th>Drug indicated</th></tr> <tr> <td>Advair[®] Diskus 250/50, & 500/50</td><td>Children < 12</td><td>Asthma & COPD</td></tr> <tr> <td>Advair[®] Diskus 100/50</td><td>Children < 4</td><td>Asthma & COPD</td></tr> <tr> <td>Advair[®] HFA</td><td>Children < 12</td><td>Asthma & COPD</td></tr> <tr> <td>Anoro[™] Ellipta</td><td>Children & Adolescents < 18</td><td>COPD only</td></tr> <tr> <td>Arcapta[®] Neohaler</td><td>Children & Adolescents < 18</td><td>COPD only</td></tr> <tr> <td>Breo[®] Ellipta[™]</td><td>Children < 18 y</td><td>Asthma & COPD</td></tr> <tr> <td>Brovana[®]</td><td>Children & Adolescents < 18</td><td>COPD only</td></tr> <tr> <td>Dulera[®]</td><td>Children < 12</td><td>Asthma only</td></tr> <tr> <td>Foradil[®] Aerolizer</td><td>Children < 5</td><td>Asthma & COPD</td></tr> <tr> <td>Perforomist[®]</td><td>Children & Adolescents < 18</td><td>COPD only</td></tr> <tr> <td>Serevent[®] Diskus</td><td>Children < 4</td><td>Asthma & COPD</td></tr> <tr> <td>Symbicort[®]</td><td>Children < 12</td><td>Asthma & COPD</td></tr> </table>	Brand Name	Age where SA is required	Drug indicated	Advair [®] Diskus 250/50, & 500/50	Children < 12	Asthma & COPD	Advair [®] Diskus 100/50	Children < 4	Asthma & COPD	Advair [®] HFA	Children < 12	Asthma & COPD	Anoro [™] Ellipta	Children & Adolescents < 18	COPD only	Arcapta [®] Neohaler	Children & Adolescents < 18	COPD only	Breo [®] Ellipta [™]	Children < 18 y	Asthma & COPD	Brovana [®]	Children & Adolescents < 18	COPD only	Dulera [®]	Children < 12	Asthma only	Foradil [®] Aerolizer	Children < 5	Asthma & COPD	Perforomist [®]	Children & Adolescents < 18	COPD only	Serevent [®] Diskus	Children < 4	Asthma & COPD	Symbicort [®]	Children < 12	Asthma & COPD
Brand Name	Age where SA is required	Drug indicated																																							
Advair [®] Diskus 250/50, & 500/50	Children < 12	Asthma & COPD																																							
Advair [®] Diskus 100/50	Children < 4	Asthma & COPD																																							
Advair [®] HFA	Children < 12	Asthma & COPD																																							
Anoro [™] Ellipta	Children & Adolescents < 18	COPD only																																							
Arcapta [®] Neohaler	Children & Adolescents < 18	COPD only																																							
Breo [®] Ellipta [™]	Children < 18 y	Asthma & COPD																																							
Brovana [®]	Children & Adolescents < 18	COPD only																																							
Dulera [®]	Children < 12	Asthma only																																							
Foradil [®] Aerolizer	Children < 5	Asthma & COPD																																							
Perforomist [®]	Children & Adolescents < 18	COPD only																																							
Serevent [®] Diskus	Children < 4	Asthma & COPD																																							
Symbicort [®]	Children < 12	Asthma & COPD																																							



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria		
			Striverdi [®] Respimat	Children < 18 years	COPD only
			Stiolto [™] Respimat [®]	Children < 18 years	COPD only
Short Acting Metered Dose Inhalers or Devices					
Proair [®] HFA Proventil [®] HFA	ProAir [®] RespiClick Ventolin [®] HFA Xopenex [®] HFA				
Short Acting Nebulizers					
albuterol sulfate (all premix dosage forms) metaproterenol Xopenex [®]	levalbuterol soln				
COPD: Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors					
Atrovent HFA [®] Combivent [®] Respimat ipratropium bromide soln ipratropium/albuterol nebs Spiriva [®]	Anoro [™] Ellipta [®] Daliresp [®] Incruse [™] Ellipta [®] Tudorza [™] Stiolto Respimat [™] Spiriva [®] Respimat		LENGTH OF AUTHORIZATION: 1 year Routine PDL edit plus Clinical Criteria for Daliresp [®] <ul style="list-style-type: none">If the patient has a diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations; ANDTrial/failure on at least one first-line or second-line agent (inhaled anticholinergics, long acting beta agonists or inhaled corticosteroids); ANDAdjunctive 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 Long Acting Beta Adrenergic)			LENGTH OF AUTHORIZATIONS: 1 year		
*Advair [®] Diskus *Dulera [®] *Symbicort [®]	Advair [®] HFA Breo [®] Ellipta [™]		Routine PDL edit		
Inhaled Corticosteroids: Metered Dose Inhalers					
Asmanex [®] Flovent [®] Diskus & HFA	Alvesco [®] Aerospan [™]				



Virginia Medicaid Preferred Drug List With Service Authorization Criteria

4/1/2016



Preferred Agents		Non-Preferred Agents	SA Criteria
Pulmicort Flexhaler® QVAR®	Arnuity™ Ellipta® Asmanex HFA®		
Inhaled Corticosteroids: Nebulizer Solution			
Pulmicort® Respules	Budesonide		
Nasal Steroids			
Nasonex® fluticasone	Beconase AQ® Budesonide (generic for Rhinocort Aqua) Children's Qnasl™ Dymista™ Flonase® flunisolide Omnaris® Qnasl™ Rhinocort Aqua® triamcinolone acetonide Veramyst® Zetonna™		
Cough and Cold products			
Ala-Hist DM benzonatate cap codeine/ promethazine guaifenesin/codeine phosphate hydrocodone/ homatropine Iophen-C NR Lohist-DM syrup phenylephrine HCl/promethazine HCl promethazine DM syrup Tusnel® Pediatric Drops	All other Legend cough and cold products are non- preferred Tessalon® perle	LENGTH OF AUTHORIZATION: Date of Service Only Routine PDL edit Clinical Edit for Cough and Cold Agents – Children under the age of 6 years are not eligible for cough and cold products.	
Epinephrine, Self-Injected			
epinephrine	Auvi-Q™	LENGTH OF AUTHORIZATIONS: 1 year	



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
4/1/2016



	Preferred Agents	Non-Preferred Agents	SA Criteria
	Epipen [®] Epipen [®] Jr		Routine PDL edit
	Intranasal Antihistamines		
	Patanase [®]	Astepro [®] 0.15% azelastine 0.1% olopatadine	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit
	Leukotriene Receptor Antagonists		
	montelukast tabs/chew tabs	Accolate [®] Singulair [®] tabs/chew tabs/granules montelukast granules zafirlukast Zyflo [™] Zyflo CR [™]	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit