

ANALGESICS

COX-2 Inhibitors

Clinical edit

LENGTH OF AUTHORIZATIONS: 1 year

- 1) The preferred product may be approved for patients if one of the following is true:
 - a) If there has been a therapeutic trial and failure on a minimum of two (2) different non-COX2 NSAIDs (information on history can be determined from one of the options below)
 - b) Electronic look back for history of paid claims for (2) different non-COX2 within the past year
 - c) Or a call from Physician office with history of trial and failure of two (2) different non-COX2
 - d) Concurrent use of anticoagulants (warfarin or heparin)
 - e) Chronic use of oral corticosteroids
 - f) Concurrent use of methotrexate
 - g) History of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc.)
 - h) If there is a specific indication for medication requiring service authorization (SA), for which medications not requiring service approval are not indicated, then document details and refer caller to a clinical pharmacist
 - i) Patients with a diagnosis of familial adenomatous polyposis (FAP) presenting with a prescription for celecoxib (Celebrex[®]) may be approved without any risk factors or trials on NSAIDs.

CRITICAL INFORMATION TO CONSIDER

- 1) Selective cyclooxygenase-2 (COX-2) inhibitors are known to inhibit the production of vascular prostacyclin (PGI₂), an inhibitor of platelet aggregation and a vasodilator. Unlike conventional non-steroidal anti-inflammatory drugs, COX-2 inhibitors do not reduce the endogenous production of thromboxane A₂, a potent platelet activator and aggregator, thereby causing a potentially prothrombotic cascade of events that could lead to a significant increase in the risk for thrombotic cardiovascular events (myocardial infarction, occlusive stroke) in patients receiving celecoxib therapy. Therefore, it is advisable to exercise caution when prescribing celecoxib, a COX-II inhibitors to patients with a higher risk of cardiovascular disease.
- 2) If the patient is allergic to one NSAID or aspirin, the patient may be allergic to other NSAIDs.
- 3) If allergic to sulfonamides, a patient should not receive Celebrex[®].

Cox-2 Inhibitors

Preferred Drugs – No SA Required once Clinical edit met	<i>Non-preferred Drugs - N/A</i>
Celebrex^{®****}	

****Requires a clinical SA

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

NSAIDs

(Non-Steroidal Anti-inflammatory Drugs including Cox-2 Inhibitors)

LENGTH OF AUTHORIZATIONS: 1 year

For COX II clinical edit see page (1)

1) Is there any reason the patient cannot be changed to a medication not requiring service authorization?

Acceptable reasons include:

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

Document clinically compelling information

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

- If there has been a therapeutic failure to no less than a one-month trial of at least two medication(s) within the same class not requiring service approval
- The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.
- If there is a specific indication for a medication requiring service approval, for which medications not requiring service approval are not indicated, then document details and refer to a clinical pharmacist.

Additional information to consider

If the patient is allergic to one NSAID or aspirin, the patient may be allergic to other NSAIDs

See next pages for specific drug lists.

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

NSAIDs
(Non-Steroidal Anti-inflammatory Drugs including Cox-2
Inhibitors) (Continued page 2)

NSAIDs (Non-Steroidal Anti-inflammatory Drugs) including Cox-2 Inhibitors

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>	
Celebrex[®]	<i>Anaprox[®]</i>	<i>Relafen[®]</i>
diclofenac potassium	<i>Anaprox DS[®]</i>	<i>Tolectin DS[®]</i>
diclofenac sodium	<i>Ansaid[®]</i>	<i>Toradol[®]</i>
diflunisal	<i>Arthrotec[®]</i>	<i>Vimovo[®]</i>
etodolac	<i>Cataflam[®]</i>	<i>Voltaren[®]</i>
etodolac SR	<i>Clinoril[®]</i>	<i>Voltaren XR[®]</i>
fenoprofen	<i>Daypro[®]</i>	<i>Zipsor[®]</i>
flurbiprofen	<i>Dolobid[®]</i>	
ibuprofen	<i>Feldene[®]</i>	
indomethacin	<i>Indocin[®]</i>	
indomethacin SR	<i>Indocin SR[®]</i>	
ketoprofen	<i>Lodine[®]</i>	
ketoprofen ER	<i>Lodine XL[®]</i>	
ketorolac	<i>mefenamic</i>	
meclofenamate sodium	<i>Mobic[®]</i>	
meloxicam	<i>Motrin[®]</i>	
nabumetone	<i>Nalfon[®]</i>	
naproxen	<i>Naprelan[®]</i>	
naproxen sodium	<i>Naprosyn[®]</i>	
oxaprozin	<i>Orudis[®]</i>	
piroxicam	<i>Oruvail[®]</i>	
sulindac	<i>Ponstel[®]</i>	
tolmetin sodium	<i>Prevacid Naprapac[®]</i>	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Long Acting Narcotics – Step Therapy

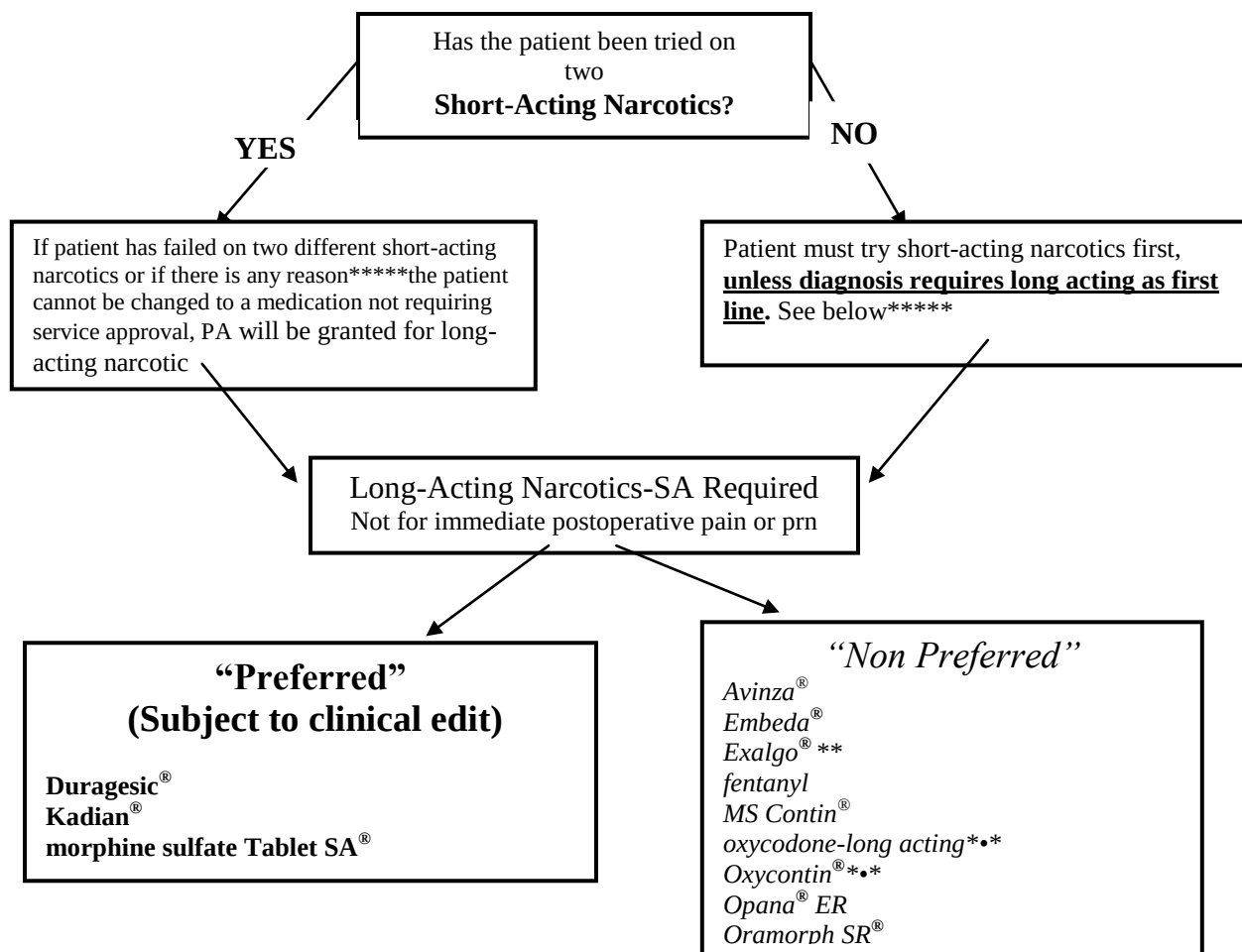
SHORT ACTING NARCOTICS (no SA required for generic and select preferred brands)

acetaminophen-butalbital
acetaminophen w/ codeine
Bupap®
buprenorphine SL
butorphanol tartrate
Cephadyn®
codeine sulfate
codeine w/APAP-Caffeine
codeine w/APAP

hydrocodone w/ASA
hydrocodone w/ Ibuprofen
hydromorphone
levorphanol tartrate
meperidine
morphine sulfate IR
nalbuphine
opium

oxycodone
oxycodone w/APAP
oxycodone w/ASA
oxycodone w/Ibuprofen
pentazocine-Naloxone
tramadol
tramadol w/ APAP
Sedapap®

Step-Therapy



New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Long Acting Narcotics – Step Therapy (Continued)

*******Step-Therapy is not required for those patients that have been stabilized on Long Acting Narcotics or need relief of moderate to severe pain requiring around-the-clock opioid therapy, for an extended period of time. Additional acceptable reasons include:**

- Allergy to medications not requiring service approvals
 - Contraindications to or drug-to-drug interaction with medications not requiring service approval
 - If the patient has a diagnosis that is an approved indication for the medication that requires service approval and this diagnosis is not an indication for the medications that do not require service approval.
 - History of unacceptable/toxic side effects to medications not requiring service approval
- Document clinically compelling information

LENGTH OF AUTHORIZATIONS: 6 months

OxyContin** / Oxycodone-long acting**Guidelines

1. Coverage is limited to those persons 18 years of age or older with a need for a continuous around-the-clock analgesic for an extended period of time for the management of moderate to severe pain.
2. A fax form with diagnosis should accompany each request.
3. The main objective is to verify appropriate use and the following items should be taken into consideration when reviewing an OxyContin request:
 - Dosing frequency greater than bid (tid for an identified, organized pain clinic or pain specialist)
 - Dosing using multiple small strength tablets as opposed to a single higher strength tablets
 - Odd quantities that would result in fractional dosing
 - Patient history of substance abuse
 - Frequent early refill attempts
 - Multiple request pertaining to lost medication
 - Short-term or prn use (OxyContin is not indicated for short-term or prn use)
 - Any suspicious use reported by pharmacies or physicians
 - A rapid increase in dosage
 - 80mg tablets are for opioid tolerant patients only
3. Reasons for denial:
 - Split tablets
 - Greater than tid dosing frequency
 - Concurrent use of other extended release opioids
 - Prn dosing
 - Missing diagnosis on fax form

1997 Medical Society of Virginia and House of Delegates guidelines Virginia code 54.1-2971.01 states:

"In the case of a patient with intractable pain, the attending physician may prescribe a dosage in excess of the recommended dosage of a pain relieving agent if he certifies the medical necessity for such excess dosage in the patient's medical record. Any person who prescribes, dispenses or administers an excess dosage in accordance with this section shall not be deemed to be in violation of the provisions of this title because of such excess dosage, if such excess dosage is prescribed, dispensed or administered in good faith for accepted medicinal or therapeutic purposes. Nothing in this section shall be construed to grant any person immunity from investigation or disciplinary action based on the prescription, dispensing or administration of an excess dosage in violation of this section."

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Short Acting Narcotics

LENGTH OF SERVICE AUTHORIZATIONS: 3 months

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

Document clinically compelling information

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

- If there has been a therapeutic failure of no less than a **one-month trial** of at least **one** medication **within the same class** not requiring service approval
- The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated

****Clinical SA for narcotic lozenges

(Fentanyl citrate, Actiq, Fentora, and Onsolis); both of the following need to be true:

- The patient has a diagnosis of cancer
- The patient is already receiving and tolerant of opioid therapy for their underlying persistent cancer pain. Patients considered opioid tolerant are those who are taking transdermal fentanyl 25 mcg/h, morphine 60 mg/day or more, oxycodone 30 mg/day, oral hydromorphone 8 mg/day, or an equianalgesic dose of another opioid for one week or longer.

ADDITIONAL INFORMATION TO AID IN FINAL DECISION

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

Narcotic Lozenges

Preferred Drugs - No SA Required once Clinical edit met	Non-preferred Drugs - SA Required
fentanyl citrate****	Actiq [®] ****
	Fentora [®] ****
	Onsolis [®] ****

****Requires a clinical SA (see above criteria)

Short-Acting Narcotics

Preferred Drugs – No SA Required	Non-preferred Drugs - SA Required
Generic only class	All Brands require a SA

See next page for more

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Short Acting Narcotics (Continued)

Barbiturate Analgesics & Non-Salicylates Analgesic Combinations

Preferred Drugs – No SA Required	Non-preferred Drugs - SA Required
acetaminophen-butalbital	Phrenilin Forte [®]
Bupap [®]	Sedapap [®]
Cephadyn [®]	

Opioid Dependency

Preferred Drugs – No SA Required	Non-preferred Drugs - SA Required
buprenorphine SL	Subutex [®]
Suboxone [®]	
Suboxone [®] Film	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Topical Agents and Anesthetics

LENGTH OF AUTHORIZATIONS: 1 year

1) Is there any reason the patient cannot be changed to a medication not requiring service authorization?

Acceptable reasons include:

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

Document clinically compelling information

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

- If there has been a therapeutic failure to no less than a one-month trial of at least one medication within the same class not requiring service approval
- The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.
- If there is a specific indication for a medication requiring service approval, for which medications not requiring service approval are not indicated, then document details and refer to a clinical pharmacist.

******Clinical Criteria for Flector[®], Voltaren gel[®], and Pennsaid[®]:**

Approval is based on patient failing the Oral generic of the desired product and at least one other preferred NSAIDs (to equal a total of at least two preferred).

For example, a patient who failed ibuprofen or naproxen will still need to try oral generic diclofenac for approval of Flector.

For Pennsaid topical solution, must also be requested for an FDA approved indication. The only approvable diagnosis is osteoarthritis of the knee.

******Clinical Criteria for Lidoderm[®] Patch:**

Lidoderm[®] - patches can be approved for relief of pain associated with post-herpetic neuralgia.

Topical Agents and Anesthetics

Preferred Drugs - No SA Required once Clinical edit met	Non-preferred Drugs - SA Required
Flector [®] Patch****	Lidoderm [®] Patch****
Voltaren [®] Gel****	Pennsaid [®] **** Topical Solution

**** Clinical Criteria

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Tramadol Agents

LENGTH OF SERVICE AUTHORIZATIONS: 3 months

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

Document clinically compelling information

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

ADDITIONAL INFORMATION TO AID IN FINAL DECISION

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

Tramadol Agents

Preferred Drugs – No SA Required	Non-preferred Drugs - SA Required
tramadol HCL	Ryzolt™
tramadol HCL/APAP	tramadol ER
	Ultracet®
	Ultram®
	Ultram ER®

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Antibiotics-Anti-Infectives

Oral Antifungals for Onychomycosis

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

- 1) Is there any reason the patient cannot be changed to a medication not requiring service authorization?

Acceptable reasons include:

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

Document clinically compelling information

- 2) If the patient has a serious illness that causes them to be immunocompromised (i.e. AIDS, cancer, etc.) then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

- 1) If the patient is completing a course of therapy with a medication requiring service approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring service approval, then may approve the requested medication.
- 2) If the request is for a diagnosis other than fungal infection, please refer to a clinical pharmacist.

Sporanox

If Sporanox is requested for any other FDA approved indication (other than onychomycosis), then approve for 6 months or the duration of the prescription.

Indications: Aspergillosis, Candidiasis (oral or esophageal), Histoplasmosis, Blastomycosis, empiric treatment of febrile neutropenia

PA for Lamisil® granules may be granted if

- Recipient is over 4 years of age
- Diagnosis is tinea capitis

Lamisil® oral granules are FDA approved for the treatment of tinea capitis (also called ringworm of the scalp) in patients 4 years of age and older. (Lamisil® oral tablets (250mg) are FDA approved for the treatment of tinea unguium- onychomycosis but not tinea capitis ringworm).

Oral Antifungals used for Onychomycosis

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
terbinafine Grifulvin V® Tablets Griseofulvin Oral® Suspension Gris-Peg®	<i>itraconazole</i> <i>Sporanox Solution®</i> <i>Lamisil®</i> <i>Sporanox Capsules®</i> <i>Lamisil® Granules (diagnosis tinea capitis)</i>

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Antibiotics: Oral Cephalosporins, Macrolides, Quinolones

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

1) Is there any reason the patient cannot be changed to a medication not requiring service authorization?

Acceptable reasons include:

- Allergy to product formulation (i.e. dyes, fillers). If an allergy to drug class, should question medication request.
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval

Document clinically compelling information

2) If the infection is caused by an organism resistant to medications not requiring service approval, then may approve the requested medication. Document details.

Note diagnosis and any culture and sensitivity reports

3) If there has been a therapeutic failure to no less than a three-day trial of one medication within the same not requiring service approval, then may approve the requested medication.

Document details

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

- 1) If the patient is completing a course of therapy with a medication requiring service authorization, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.
- 2) If the patient requires a service authorized medication based on a specific medical need that is not covered by the FDA indications of the preferred medications, then allow the non-preferred medication. This information should be reviewed at each request for reauthorization.

Second Generation Quinolones

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
ciprofloxacin	Cipro [®] Maxaquin [®] ciprofloxacin Susp Noroxin [®] Cipro XR [®] ofloxacin ciprofloxacin ER Proquin XR [®] Floxin [®]
Cipro[®] Suspension	

Third Generation Quinolones

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Avelox[®]	Factive [®] Proquin XR [®] Levaquin [®] Zagam [®] Levaquin Susp [®]
Avelox[®] ABC PACK	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Virginia Medicaid Preferred Drug List, Effective May 11, 2011

Drug list continues next page

Antibiotics: Oral Cephalosporins, Macrolides, Quinolones		
(Continued page 2)		
Preferred Drugs - No SA Required		Non-Preferred Drugs - SA Required
Second Generation Cephalosporins		
cefaclor capsule	Ceftin [®] tablets	
cefaclor ER	Ceftin [®] suspension	
cefaclor suspension	Cefzil [®]	
cefprozil	Cefzil [®] suspension	
cefprozil Suspension	cefuroxime axetil susp	
cefuroxime tablets		
Raniclor [®]		
Third Generation Cephalosporins		
cefdinir capsule	Cedax Capsule [®]	Omnicef Capsules [®]
cefdinir suspension	Cedax Susp [®]	Omnicef Susp [®]
Spectracef [®]	Cefditoren pivoxil	Vantin [®]
Suprax [®] Suspension	cefpodoxime proxetil	Vantin Susp [®]
	cefpodoxime proxetil susp	
Macrolides and Ketolides		
azithromycin	Biaxin [®]	
azithromycin packet	Biaxin Suspension [®]	
azithromycin suspension	Biaxin XL [®]	
clarithromycin	Dynabac [®]	
clarithromycin suspension	clarithromycin ER	
E.E.S. [®] *.*.*	Ery-tab [®]	
EryC [®] *.*.*	Ketek [®] *****	
Eryped [®] *.*.*	PCE [®]	
erythrocin stearate	Zithromax Suspension [®]	
erythromycin base	Zithromax [®]	
erythromycin ethylsuccinate	ZMAX Suspension [®]	
erythromycin estolate suspension		
erythromycin stearate		
erythromycin / sulfisoxazole		

..* Generics not available in some strengths/dosage forms

*****To receive a PA for Ketek[®], a specific Ketek PA request form must be completed and faxed or mailed to First Health Services with the physician's signature. By signing this request, the physician accepts understanding of the contraindications and warnings with the use of Ketek and acknowledges that the benefits of the drug outweigh the possible risks.

- A copy of the SA form is available at <http://www.viriniamedicaidpharmacyservices.com>.

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Virginia Medicaid Preferred Drug List, Effective May 11, 2011

- The SA may also be completed online at:
<https://webpa.magellanhealthmedicaidadministration.com/webpa> .
- Recipient must be 18 or over and can only be approved for an FDA indication

Otic Quinolones

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

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring service approval
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval
- Patient's condition is clinically unstable; changing to a medication not requiring service approval might cause deterioration of the patient's condition.

Document clinically compelling information

- 2) If there has been a therapeutic failure of a trial of at least one medications not requiring service approval, then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

- 1) If the patient is completing a course of therapy with a medication requiring service approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring service approval, then may approve the requested medication.
- 2) An indication that is unique to a non-preferred agent and is supported by peer-reviewed literature or a FDA-approved indication, or Age specific indication, or Medical co-morbidity, unique patient circumstance, other medical complications, or Clinically unacceptable risk with a change in therapy to preferred agent.

Otic Quinolones

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
Ciprodex[®] (ciprofloxacin/dexamethasone) ofloxacin (generic for Floxin[®])	<i>Cipro HC[®] (ciprofloxacin/hydrocortisone) Cetraxal[®] Floxin[®]</i>

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Topical Antibiotics:

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

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

Document clinically compelling information

- 2) If the infection is caused by an organism resistant to medications not requiring service approval, then may approve the requested medication.

Document details and note diagnosis and any culture and sensitivity reports

- 3) If there has been a therapeutic failure to no less than a three-day trial of one medication within the same class not requiring service approval, then may approve the requested medication.

Document details

Topical Antibiotics

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Mupirocin Ointment	Bactroban [®] Cream
	Bactroban [®] Ointment
	Centany [™]
	Altabax [®] *...*

... Has a 15 gram per 34 day quantity limit

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Antivirals

Interferon for Hepatitis C

LENGTH OF AUTHORIZATIONS: See below

Clinical SA for initial 16 week SA:

- 1) Initial approval periods should be limited to 16-weeks and viral titer should be obtained at week 12 of therapy.

Clinical SA for established HCV reactors:

- 1) Therapy is approvable for a total of 24 weeks in patients that are HCV genotypes 2 or 3 who have achieved a virologic response (either undetectable HCV RNA [<50 IU/mL] or at least a 2-log drop in HCV RNA titer from baseline) at 12 weeks of treatment.
- 2) Therapy is approvable for total of 48 weeks in HCV genotype 1 or 4 patients who have achieved a virologic response (either undetectable HCV RNA [<50 IU/mL] or at least a 2-log drop in HCV RNA titer from baseline) at 12 weeks of treatment.
- 3) If patients fail to achieve a virologic response by 12 weeks, further treatment is not indicated.

PDL SA

- 1) Is there any reason the patient cannot be started on a medication not requiring service approval?

Acceptable reasons include:

- Allergy to product formulation (i.e. dyes or fillers). If an allergy to drug class, should question medication request.
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval

Document clinically compelling information

- 2) Has there been a therapeutic failure after a reasonable therapeutic trial with use of one of the non-service authorized agents? Document the details, and forward all of these requests to a clinical pharmacist.

Additional Information:

- 1) Copegus[®] and Rebetol[®] are oral ribavirins. Oral ribavirin therapy is not effective for the treatment of chronic hepatitis C viral infection and should not be used alone for this indication.
- 2) Pegasys[®] and PEG-Intron[®] are pegylated Interferons.

Antivirals: Interferon****

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Pegasys [®]	
Pegasys Conv.Pack [®]	
Peg-Intron [®]	
Peg-Intron Redipen [®]	

****Requires a clinical SA

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Herpes

LENGTH OF AUTHORIZATIONS: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring service approval
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval
- Patient's condition is clinically unstable; changing to a medication not requiring service approval might cause deterioration of the patient's condition.

Document clinically compelling information

- 2) If there has been a therapeutic failure of a trial of at least one medications not requiring service approval, then may approve the requested medication.

Antivirals: Herpes

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
acyclovir Tablets acyclovir Susp Famvir® Valtrex®	famciclovir valacyclovir Zovirax® Susp Zovirax® Tablet

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Influenza

LENGTH OF AUTHORIZATIONS: For diagnosis of influenza the authorization is for the date of service only; no refills

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring service approval
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval
- Patient's condition is clinically unstable; changing to a medication not requiring service approval might cause deterioration of the patient's condition.

Document clinically compelling information

- 2) If there has been a therapeutic failure of a trial of at least one medication not requiring service approval, then may approve the requested medication.

Antivirals: Influenza

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
amantadine	Flumadine [®]
amantadine Syrup	Flumadine [®] Syrup
Relenza Disk [®]	
rimantadine	
Tamiflu [®]	
Tamiflu [®] Susp	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Antivirals Topical: Herpes

LENGTH OF AUTHORIZATIONS: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring service approval
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval
- Patient's condition is clinically unstable; changing to a medication not requiring service approval might cause deterioration of the patient's condition.

Document clinically compelling information

- 2) If there has been a therapeutic failure of a trial of at least one medications not requiring service approval, then may approve the requested medication.

Antiviral Topical: Herpes

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Abreva OTC [®] Zovirax [®] ointment	Denavir [®] Zovirax [®] cream Xerese [®] cream

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Cardiac

ACE Inhibitors, Angiotensin Receptor Blockers, Beta-Blockers

LENGTH OF AUTHORIZATION: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

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

ADDITIONAL INFORMATION TO AID IN FINAL DECISION

- 1) If there is a specific indication for a medication requiring service approval, for which medications not requiring service approval are not indicated, then may approve the requested medication.
- 2) Document details

This medication should be reviewed for need at each request for reauthorization.

ACE Inhibitors

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
benazepril	Accupril®
captopril	Monopril®
enalapril	Aceon®
lisinopril	perindopril
	Altace Capsule®
	Prinivil®
	Altace Tablet®
	quinapril
	Capoten®
	ramipril
	fosinopril
	trandolapril
	Lotensin®
	Univasc®
	Mavik®
	Vasotec®
	moexipril

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Virginia Medicaid Preferred Drug List, Effective May 11, 2011

	Zestril®
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ACE Inhibitors, Angiotensin Receptor Blockers, Beta-Blockers (continued page 2)

ACE Inhibitors + Diuretic Combinations

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
benazepril/HCTZ captopril/HCTZ enalapril/HCTZ lisinopril/HCTZ	Accuretic® Prinzide® Capozide® quinapril/HCTZ fosinopril/HCTZ Quinaretic® Lotensin HCT®
	Uniretic® Monopril HCT® Univasc® moexipril/HCTZ Vaseretic® Zestoretic®

ACE Inhibitors + Calcium Channel Blocker Combinations

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
amlodipine/benazepril (2.5/10, 5/10, 5/20 & 10/20 generic preferred) Lotrel® (5/40 and 10/40 brand preferred)	amlodipine/benazepril (5/50 and 10/40) Teczem® Lexxel®
	trandolapril/verapamil hydrochloride ER Lotrel® (2.5/10, 5/10, 5/20 & 10/20) Tarka®

Angiotensin Receptor Blockers

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Diovan® * losartan	Atacand® Cozaar® Avapro® Micardis® Benicar® Teveten®

*Step edit requires a trial and failure of losartan

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Virginia Medicaid Preferred Drug List, Effective May 11, 2011

Angiotensin Receptor Blockers + Diuretic Combinations

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Diovan HCT [®] * losartan/HCTZ	Atacand HCT [®] Hyzaar [®] Avalide [®] Micardis HCT [®] Benicar HCT [®] Teveten HCT [®]

*Step edit requires a trial and failure of losartan/HCTZ

Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
N/A	Azor [®] Exforge [®] HCT Exforge [®] Tribenzor [®]

ACE Inhibitors, Angiotensin Receptor Blockers, Beta-Blockers (Continued page 3)

Direct Renin Inhibitors

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
N/A	Tecturna [®] Twynsta Tecturna HCT [®] Valturna [®]

Beta Blockers

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
acebutaolol atenolol bisoprolol fumarate metoprolol tartrate nadolol pindolol propranolol solution propranolol Sorine [®] sotalol HCL sotalol AF timolol maleate	Betapace [®] Levatol [®] Betapace AF [®] Lopressor [®] betaxolol metoprolol succinate Blockadren [®] propranolol LA Bystolic [®] Normodyne [®] Cartrol [®] Sectral [®] Corgard [®] Tenormin [®] Inderal [®] Toprol XL [®] Inderal LA [®] Visken [®]

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Virginia Medicaid Preferred Drug List, Effective May 11, 2011

	Innopran XL [®] Zebeta [®] Kerlone [®]

Alpha/Beta Blockers

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
carvedilol labetalol	Coreg [®] Trandate [®] Coreg CR [®]

Beta Blockers + Diuretic Combinations

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ	Corzide [®] Tenoretic [®] Inderide [®] Timolide [®] Lopressor HCT [®] Ziac [®]

TOPROL XL[®]: Authorize if any of the following are true

Toprol XL[®] 25mg po qd will be authorized as it would not be feasible to promote metoprolol 12.5mg po BID.

Toprol XL[®] 25mg will be authorized with a quantity limit of 45 tablets per 30 days.

Doses >37.5 mg Toprol XL[®] po qd will be offered a change to metoprolol in a total daily dose divided by two and dosed BID

If patient compliance is questioned or compromised by change, then the Toprol XL[®] will be authorized

Calcium Channel Blockers: Dihydropyridine Calcium Channel Blockers and Non-dihydropyridine Calcium Channel Blockers

LENGTH OF AUTHORIZATIONS: 1 year

1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class and formulation?

Acceptable reasons include:

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Virginia Medicaid Preferred Drug List, Effective May 11, 2011

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

Document clinically compelling information

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

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

CLINICAL NOTES

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

- Dihydropyridine Calcium Channel Blockers (DHPCCB)
- Non-Dihydropyridine Calcium Channel Blockers (NDHPCCB)

See next page for specific drug lists.

Calcium Channel Blockers: Dihydropyridine Calcium Channel Blockers and Non-dihydropyridine Calcium Channel Blockers (Continued page 2)

Calcium Channel Blockers

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
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New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Virginia Medicaid Preferred Drug List, Effective May 11, 2011

Dihydropyridine Calcium Channel Blockers	
Afedtab CR[®] amlodipine Dynacirc CR[®] felodipine ER nicardipine Nifediac CC[®] Nifedical XL[®] nifedipine nifedipine ER nifedipine SA	Adalat[®] Procardia XL[®] Adalat CC[®] Plendil[®] Cardene[®] Sular[®] Cardene SR[®] Dynacirc[®] Dynacirc CR[®] isradipine nisoldipine Norvasc[®] Procardia[®]
Non-Dihydropyridine Calcium Channel Blockers	
Cartia XT[®] Diltia XT[®] diltiazem diltiazem ER q 24hr dose diltiazem ER q 12hr dose diltiazem XR Taztia XT[®] verapamil verapamil SA verapamil 24hr pellets	Calan[®] Dilacor XR[®] Calan SR[®] diltiazem SR q 12hr dose Cardizem[®] Isoptin SR[®] Cardizem CD[®] Tiazac[®] Cardizem LA[®] Verelan[®] Cardizem SR[®] Verelan PM[®] Covera HS[®]

Lipotropics

LENGTH OF AUTHORIZATIONS: 1 year

General Guidelines:

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Virginia Medicaid Preferred Drug List, Effective May 11, 2011

Currently there are four classes of medications in the Lipotropics represented on the PDL. Each class has a different mechanism of action and acts on different components of total cholesterol

- Fibric acid derivatives-& Omega 3 agent
- HMG CoA reductase Inhibitors
- Nicotinic acid derivatives
- Bile Acid Sequestrants

1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring service approval
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval
- Patient's condition is clinically unstable; changing to a medication not requiring service approval might cause deterioration of the patient's condition.

Document clinically compelling information

2) If there have been therapeutic failures to no less than three-month trials of at least one medication not requiring service approval, then may approve the requested medication.

Document details

Omacor®/Lovaza®

- Step edit is the trial and failure of any other lipotropic.
- A SA may also be approved without any specific preferred medication trial, if they have documented very high triglycerides of (≥ 500 mg/dL) in adult patients.

Lipotropics – HMG CoA Reductase Inhibitors and Combinations (Statins)

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
lovastatin pravastatin	Advicor® Lescol XL® Altoprev® Mevacor® Lescol® Pravachol®

Lipotropics – HMG CoA Reductase Inhibitors and Combinations (High Potency Statins)

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
simvastatin	Crestor® Vytorin® Lipitor® Zocor® Livalo®

See next pages for more drug lists.

Lipotropics (Continued page 2)

Lipotropics – Fibric Acid Derivatives

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Virginia Medicaid Preferred Drug List, Effective May 11, 2011

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Antara [®] gemfibrozil	fenofibrate Lopid [®] Fenoglide [®] Triglide [®] Lipofen [®] Tricor [®] Lofibra [®] Trilipix [™]

Lipotropics – Niacin Derivatives

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Niacor [®] Niaspan [®]	

Lipotropics – Niacin Derivatives & HMG CoA Reductase Inhibitors (Statins) Combination

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Simcor ^{®**}	

**** Requires a history of either a niacin or Simvastatin product within the past 356 days.**

Lipotropics - CAI

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Zetia [®]	

Lipotropics – Omega 3 Fatty Acid agent

Preferred Drugs - No SA Required	Non-preferred Drugs – SA Required
*Lovaza [®]	

***Step edit requires a trial and failure of any one other Lipotropic**

Lipotropics – Bile Acid Sequestrants

Preferred Drugs - No SA Required	Non-preferred Drugs – SA Required
Cholestyramine	
Cholestyramine Light	
Colestid [®] Granules	
Colestid [®] Packet	
Colestid [®] Tablet	
Colestipol HCl Granules	
Colestipol HCl Packet	
Colestipol HCl Tablet	
Prevalite [®]	
Questran Light [®]	
Questran [®] Tablet	
Welchol [®]	
Welchol Packets [®]	

LOW MOLECULAR WEIGHT HEPARINS

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

**INCLUDES SELECTIVE FACTOR XA INHIBITOR
(FONDAPARINUX)**

LENGTH OF AUTHORIZATION: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

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

- If there has been a therapeutic failure of no less than a one-month trial of at least one medication within the same class not requiring service approval
- The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated

Low Molecular Weight Heparin

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
Arixtra[®]	<i>enoxaparin</i>
Fragmin[®]	<i>Innohep[®]</i>
Lovenox[®]	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Phosphodiesterase 5 Inhibitors Pulmonary Arterial Hypertension

LENGTH OF AUTHORIZATIONS: 1 year

- 1) Diagnosis of Pulmonary Hypertension in patients 18 years of age or older is required.
- 2) The requested medication may be approved if both of the following are true:
 - The prescribing physician is a pulmonary specialist or cardiologist.
 - Client has documented Pulmonary Arterial Hypertension and will be followed by the prescribing physician.
 - Recipient must have a rationale for not taking the oral Revatio to receive a SA for the injectable Revatio.

Document clinically supporting information

Contraindications where the SA should not be approved:

- Concurrent use of nitrates (e.g., nitroglycerin)
- Hypersensitivity to product

PDE5 Inhibitor

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Addirca TM	Revatio injection [®]
Revatio [®]	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Platelet Inhibitors

LENGTH OF AUTHORIZATION: 1 year

1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

- Allergy to at least two unrelated medications not requiring service approval
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval

Document clinically compelling information

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

- If there has been a therapeutic failure of no less than a three-month trial of at least one medication within the same class not requiring service approval
- The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated

Platelet Inhibitors

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Aggrenox [®]	Effient [®] ****
dipyridamole	Persantine [®]
Plavix [®]	
ticlopidine HCL	

****Clinical criteria

******Clinical Criteria for Effient[®]:**

- For new patients, does the patient have a diagnosis of acute coronary syndrome (ACS) and the indication is for reduction of thrombotic cardiovascular events (including stent thrombosis).
- The patient must not have active pathological bleeding or history of transient ischemic attack (TIA) or stroke.
- The patient must be currently managed with Percutaneous Coronary Intervention (PCI).

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Central Nervous System

Non-Ergot Dopamine Receptor Agonist

LENGTH OF AUTHORIZATIONS: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring service approval
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval
- Patient's condition is clinically unstable; changing to a medication not requiring service approval might cause deterioration of the patient's condition.

Document clinically compelling information

- 2) If there has been a therapeutic failure of a trial of at least one medications not requiring service approval, then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

- If requested for treatment of Parkinson's, may approve without the necessary trial of a preferred agent if the patient has swallowing issues that causes them to be unable to use a preferred product OR if the request is for continuation of established therapy.
- If requested for treatment of restless legs, forward request to a pharmacist to be denied.
- An indication that is unique to a non-preferred agent and is supported by peer-reviewed literature or an FDA-approved indication, or Age specific indication, or Medical co-morbidity, unique patient circumstance, other medical complications, or Clinically unacceptable risk with a change in therapy to preferred agent.

Non-Ergot Dopamine Receptor Agonists

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
pramipexole	Mirapex [®]
ropinirole HCl	Mirapex ER [®]
	Requip [®]
	Requip Dose Pack [®]
	Requip XR [®]

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Sedative/ Hypnotics

LENGTH OF AUTHORIZATIONS: Length of the prescription (up to 3 months)

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

- 2) To receive a **non preferred benzodiazepine** there must have been a therapeutic failure to no less than a one-month trial of at least one benzodiazepine not requiring service approval, then may approve the requested medication.

Document details

- 3) To receive a **preferred non benzodiazepine** there must have been a therapeutic failure to no less than a one-month trial of a benzodiazepine (step edit)

- 4) To receive a **non preferred non benzodiazepine** there must have been a therapeutic failure to no less than a one-month trial of

- First a benzodiazepine (step edit)
- Second a therapeutic failure to not less than a one-month trial of Rozerem®

Then may approve the requested medication

Document details

- 5) For patients age 65 and older, Rozerem®, Ambien® or Lunesta® may be approved after a trial of trazodone (duration = at least one month). It is not necessary for patient's ≥ 65 to try a benzodiazepine if they have had a trial of trazodone.

Sedative Hypnotics (Benzodiazepine)

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
estazolam flurazepam temazepam triazolam chloral hydrate Syrup	<i>Dalmane®</i> <i>Doral®</i> <i>Halcion®</i> <i>Prosom®</i> <i>Restoril®</i>

Sedative Hypnotics (Non-Benzodiazepine) See step edit

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Rozerem® *	<i>Ambien®</i>
zolpidem	<i>Somnote®</i>
	<i>Ambien CR®</i>
	<i>Sonata®</i>
	<i>Edluar™</i>
	<i>Zaleplon®</i>
	<i>Lunesta®</i>

* Must meet Step edit as noted above to receive Rozerem

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Serotonin Receptor Agonists “Triptans”

LENGTH OF AUTHORIZATIONS: 6 months

1) Is there any reason the patient cannot be switched to a non-service approved medication?

Acceptable reasons include:

- Allergy to one of the non-service approved products
- Contraindication to all non-service approved product(s)
- History of unacceptable side effects to one of the non-service approved product(s)

Document clinically compelling information

2) Has the patient had therapeutic trial of one non-service authorized drug that failed? If so, document and allow the service authorized medication.

CLINICAL CONSIDERATIONS:

Service Authorization will not be given for prophylactic therapy of migraine headache unless the patient has exhausted or has contraindications to all other “controller” migraine medications (i.e., beta-blockers, calcium channel blockers, etc) and the physician and patient are aware of the adverse risk potential.

Triptans

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Maxalt [®] MLT	Amerge [®]
Relpax [®]	naratriptan
Sumatriptan Succinate Cartridge	Axert [®]
Sumatriptan Succinate Nasal	Cambia [®]
Sumatriptan Succinate Pen	Treximet
Sumatriptan Succinate Tablets	Frova [®]
Sumatriptan Succinate Vial	Zomig Tablets [®]
	Imitrex [®] Cartridge
	Zomig nasal spray [®]
	Imitrex [®] Nasal
	Zomig ZMT [®]
	Imitrex [®] Pen Kit
	Imitrex [®] Tablets
	Imitrex [®] Vial
	Maxalt [®]

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Skeletal Muscle Relaxants

LENGTH OF SERVICE AUTHORIZATIONS:

- 1 year for chronic conditions
- Duration of prescription (up to 3 months) for acute conditions

1. Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

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

ADDITIONAL INFORMATION TO AID IN FINAL DECISION

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

2. Chronic Conditions:

- Multiple Sclerosis
- Spasticity
- Cerebral Palsy
- Muscle rigidity as a result of spinal cord/ brain injury or disease

3. Acute Conditions:

Muscle spasm associated with acute painful musculoskeletal conditions (ex. Generalized back, neck, or shoulder pain and muscle spasms attributed to trauma)

Skeletal Muscle Relaxants

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
baclofen carisoprodol carisoprodol/ASA carisoprodol/ASA/codeine chlorzoxazone cyclobenzaprine HCL dantrolene sodium methocarbamol orphenadrine citrate orphenadrine/ASA/caffeine tizanidine	<i>Amrix[®]</i> <i>Dantrium[®]</i> <i>Fexmid[®]</i> <i>Flexeril[®]</i> <i>metaxalone</i> <i>Norflex[®]</i> <i>Parafon Forte DSC[®]</i> <i>Robaxin[®]</i> <i>Skelaxin[®]</i> <i>Soma[®]</i> <i>Zanaflex[®]</i>

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Smoking Cessation

LENGTH OF SERVICE AUTHORIZATIONS: 6 months

Step edit for Chantix

The patient must have a therapeutic failure of no less than a **one-month trial** of at least **one** medication **within the OTC class** not requiring service approval.

1. Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

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

Smoking Cessation Agents

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
bupropion SR	Chantix [®] *
nicotine gum	Chantix [®] Tab DS PK*
nicotine lozenge	Commit [®] Lozenge
nicotine patch	Nicoderm CQ [®] Patch
	Nicotrol [®]
	Nicotrol [®] NS
	Zyban [®]

* Requires a step edit

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Virginia Medicaid Preferred Drug List, Effective May 11, 2011

Stimulants/ADHD Medications

Length of Authorization: 1 year

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

Acceptable reasons include:

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

Document clinically compelling information

2) If there has been a therapeutic failure to no less than a one-month trial of at least one medication not requiring service approval, then may approve the requested medication.

Document details

3) The patient must have failed the generic product (if covered by the State) before the brand is authorized.

4) If the patient requires a service authorized medication based on a specific medical need that is not covered by the FDA indications of the preferred medications, then allow the non-preferred medication. This should be reviewed for need at each request for reauthorization.

ADHD Amphetamine Products

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
amphetamine Salts combo dextroamphetamine Vyvanse [®]	Adderall [®] Dextrostat [®] Adderall XR [®] methamphetamine amphetamine Salts combo XR Desoxyn [®] Dexedrine [®] dextroamphetamine SR

ADHD Methylphenidate Products

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Concerta [®] Focalin XR [®] All methylphenidate Generic IR	Daytrana [™] Transdermal Methylin solution [®] dexmethylphenidate methylphenidate oral solution Focalin [®] methylphenidate SR Metadate CD [®] Procentra solution [®] Metadate ER [®] Ritalin [®] Ritalin LA [®] Methylin chew [®] Ritalin SR [®] Methylin ER [®]

ADHD Miscellaneous Products

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
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New generic, brand, or dose formulation anticipated, will be non-preferred pending review

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Strattera®	<i>Nuvigil™</i> <i>Provigil®</i>

Dermatologic

Dermatologic Agents

LENGTH OF AUTHORIZATIONS: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring service approval
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval
- Patient's condition is clinically unstable; changing to a medication not requiring service approval might cause deterioration of the patient's condition.

Document clinically compelling information

- 2) Has there been a failure to respond to a therapeutic trial of at least two weeks of one preferred medication? If yes, allow the service authorized medication. Document details.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

- Topical retinoids will reject for 21 and older - this can not be over ridden.
- Renova and other products considered to have only a cosmetic indication are not covered by Virginia Medicaid.
- If the patient is completing a course of therapy with a medication requiring service approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring service approval, then the requested medication may be approve.

Combo benzoyl peroxide & Clindamycin

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required	
benzoyl peroxide	<i>Benzaclin®</i>	<i>Duac CS®</i>
clindamycin	<i>Benzaclin® CareKit</i>	<i>Duac® gel</i>
	<i>Clindamycin 1%/Benzoyl Peroxide 5%</i>	

Topical Retinoids/Combinations

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required	
Differin® cream 0.1%	<i>adapalene 0.1% cream</i>	<i>Epiduo®</i>
Differin® gel 0.1% & 0.3%	<i>adapalene 0.1% topical gel</i>	<i>Retin-® A</i>
Retin®-A Micro	<i>Altinac®</i>	<i>Tazorac®</i>
Retin®-A Micro Pump	<i>atralin</i>	<i>Tretin®-X</i>
Tretinoin	<i>Differin® 0.1% topical lotion</i>	<i>Ziana®</i>

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Virginia Medicaid Preferred Drug List, Effective May 11, 2011

Topical Agents for Psoriasis

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required	
calcipotriene	Anthralin	Taclonex [®]
Dovonex [®]	Dovonex [®] Scalp	Taclonex [®] Scalp
Psoriatic [®]	Micanol [®]	Vectical [®]

Endocrine and Metabolic agents

Androgenic Agents (Testosterone – Topical)

Length of authorization: 1 year

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

Acceptable reasons include:

- Allergy to at least two unrelated medications not requiring service approval
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval

Document clinically compelling information

2. Has there been a failure to respond to a therapeutic trial of at least one week of one non-service authorized medication? If yes, allow the service authorized medication.

Document details

Androgenic Agents

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Androderm [®]	
Androgel [®]	
Testim [®]	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Contraceptives

LENGTH OF SERVICE AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

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

- The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and showed unacceptable/toxic side effects or there is an allergy, contraindication, or drug-to-drug interaction.

ADDITIONAL INFORMATION TO AID IN FINAL DECISION

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

All Oral Contraceptives

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
Generic only class with one exception	<i>All brands except YAZ require a SA</i>
YAZ	

Etonogestrel/Ethinyl Estradiol Vaginal Ring

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
NuvaRing[®]	

Norelgestromin/Ethinyl Estradiol Transdermal

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
Ortho Evra[®]	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Diabetes Hypoglycemics: Injectable Amylin Analogs

Length of authorization: 1 year

Clinical step edit for Symlin® (pramlintide)

The recipient must have a history of at least a 90 day trial of insulin.

Symlin is only indicated as adjunct therapy with insulin. If the claim rejects, and the patient is not using any type of insulin, forward request to a pharmacist

Recipient meeting **ALL** of the following criteria may be approved:

- Diagnosis of Type 1 or 2 diabetes
- On insulin therapy
- Failure to achieve adequate glycemic control ($HbA1c \leq 6.5\%$)

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Diabetes Hypoglycemics: Injectable Incretin Mimetics

LENGTH OF SERVICE AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

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

- If there has been a therapeutic failure of no less than a **one-month trial** of at least **one** medication **within the same class** not requiring service approval
- The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated

ADDITIONAL INFORMATION TO AID IN FINAL DECISION

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

Injectable Incretin Mimetics

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
Byetta[®]	<i>Victoza[®]</i>

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Diabetes Hypoglycemics: Injectable Insulins

Length of authorization: 1 year

1) Is there any reason the patient cannot be switched to a non-service approved medication?

Acceptable reasons include:

- Allergy to the non-service approved products in this class
- Contraindication or drug to drug interaction with all non-service approved products
- History of unacceptable side effects

Document clinically compelling information

2) Therapeutic failure of one non-service authorized medication. For approval of a non-preferred insulin, the patient must have a failure on the equivalent preferred product if one is available (ex. Approval of Humalog® would require a failure on Novolog®).

3) Pens/cartridges should only be approved if there is a physical reason (such as dexterity problems, vision impairment) vials cannot be used. Approvals should not be granted based on issues of convenience or compliance. Will be approved for individuals meeting the following criteria:

- Recipient or caregiver has poor eyesight such that dosing errors may occur
- Recipient or caregiver has problems with manual dexterity which may result in dosing errors (i.e. Parkinson's disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis)
- Recipient is under 18 years of age

Additional information to aid in the final decision:

If Humalog® is authorized and the patient is to mix with Humulin® (any formulation), then approve the Humulin® medication(s).

Long-Acting Insulins

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Levemir Vial	Lantus Solostar
Lantus® Vial	Lantus Cartridge
Levemir® Pen	

Rapid-Acting Insulins

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Humalog® Vial	Apidra Solostar
Humalog® Cartridge	Apidra Cartridge
Humalog® Pen - not available	Apidra Vial
Humalog® Kwikpen	
Novolog® Vial	
Novolog® Cartridge	
Novolog® Flexpen Syringe	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Virginia Medicaid Preferred Drug List, Effective May 11, 2011

Continued on next page

Diabetes Hypoglycemics: Injectable Insulins (Continued page 2)

Insulin Mix

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Humalog® Mix 75/25 Vial	
Humalog® Mix 50/50 Vial	
Humalog Mix 50-50 Kwikpen	
Humalog Mix 75-25 Kwikpen	
Novolog® Mix 70/30 Vial	
Novolog® Mix 70/30 Pen	
~~Humalog® Mix 75/25 Pen~~ - not available	
~~Humalog® Mix 50/50 Pen~~ - not available	

Insulin 70/30

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Humulin® 70/30 Vial	
Humulin® 70/30 Pen	
Novolin® 70/30 Vial	
~~Novolin 70/30 Pen~~ - not available	
~~Novolin 70/30 Cartridge~~ -not available	

Insulin N

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Humulin® N Vial	
Humulin® N Pen	
Novolin® N Vial	
~~Novolin N Pen~~ - not available	

Insulin R

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Humulin® R Vial	
Novolin® R Vial	
~~Humulin N Pen~~ - not available	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Diabetes Oral Hypoglycemics

LENGTH OF AUTHORIZATIONS: 1 Year

4) Is there any reason the patient cannot be switched to a non-service approved medication?

Acceptable reasons include:

- Allergy to the non-service approved products in this class
- Contraindication or drug to drug interaction with all non-service approved products
- History of unacceptable side effects

Document clinically compelling information

5) Has the patient tried and failed a therapeutic trial of thirty days with one of the non-preferred drugs within the same class? If so, document and approve the service authorized drug.

Oral Hypoglycemics Alpha-Glucosidase Inhibitors

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
acarbose	Precose [®]
Glyset [®]	

Oral Hypoglycemics Biguanides

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required	
metformin	Fortamet [®]	Glutmetza [®]
metformin ER	Glucophage [®]	Riomet [®] suspension
	Glucophage [®] XR	

Oral Hypoglycemics Biguanide Combination Products

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Avandamet [®]	Glucovance [®]
glipizide/metformin	Metaglip [®]
glyburide/metformin	

Oral Hypoglycemics DPP-IV inhibitors and combination

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Januvia [®]	
Janumet [®]	
Onglyza [™]	

Oral Hypoglycemics Meglitinides

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required	
Starlix [®]	Nateglinide	PrandiMet [™]
	Prandin [®]	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Continued on next page

Diabetes Oral Hypoglycemics (Continued page 2)

Oral Hypoglycemics Thiazolidinediones

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Actos 15mg [®]	Actos 30mg [®] and Actos 45mg [®]
Avandamet [®]	Actoplus Met [®]
Avandia [®]	Avandaryl [®]
	Duetact [®]

Oral Hypoglycemics Second Generation Sulfonylureas

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
glimepiride	Amaryl [®]
glipizide	Diabeta [®]
glipizide ER	Glucotrol [®]
glyburide	Glucotrol XL [®]
glyburide micronized	Glynase [®]
	Micronase [®]

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Gout Suppressants (Antihyperuricemics)

LENGTH OF AUTHORIZATIONS: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

- 2) Has the patient tried and failed a therapeutic trial with a preferred drug within the same class? If so, document and approve the service authorized drug.

Clinical Criteria For: Colcryst™

Colcryst™ will be approved if any one of the following is true:

- Diagnosis of Familial Mediterranean Fever; OR
- For Acute Gout Flare:
 - Trial and failure of one of the following:
 - NSAID (i.e., indomethacin, naproxen, ibuprofen, sulindac, ketoprofen)
 - Corticosteroid; OR

References

1. Facts and Comparisons on-line. Version 4.0; Wolters Kluwer Health, Inc.; 2010. Accessed September 14, 2010.
2. Thompson MICROMEDEX on-line © 1974-2010. Accessed September 14, 2010.
3. Provider Synergies. Antihyperuricemics Review. May 6, 2010.

Gout Suppressants

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
allopurinol	Uloric®
colchicine	Colcryst®
Probenecid®	
Probenecid and Colchicine	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Growth Hormone Pediatrics

LENGTH OF AUTHORIZATION (pediatrics): 1 year

PEDIATRICS (18 years of age and under) Clinical Criteria for Approval:

- 1) Prescriber is an endocrinologist, nephrologists, infectious disease specialist or HIV specialist or one has been consulted on this case,.
- 2) The patient has open epiphysis and one of the following diagnoses
 - Turner Syndrome
 - Prader-Willi Syndrome
 - Renal insufficiency
 - Small for gestational age (SGA) - including Russell-Silver variant and patient is < 2 years old
 - Idiopathic Short Stature (for request for renewal only (a) information is required to be approved)
 - Growth hormone deficiency (physician should provide the required information below)
 - Newborn with hypoglycemia and a diagnosis of hypopituitarism or panhypopituitarism.
- 3) 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
- 4) Growth hormone response of less than 10ng/ml to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine, or glucagon

Requests for Renewal (pediatrics):

- 1) 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
- 2) Patient height is less than 5' 6" for males or 5' 1" for females, and is more than 1 standard deviation (2") below mid-parental height (unless parental height is diminished due to medical or nutritional reasons).

PDL CRITERIA

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

- 2) Has there been a therapeutic failure after a reasonable therapeutic trial with use of one of the non-service authorized agents? Document the details, and forward all of these requests to a clinical pharmacist

See Growth Hormone for all groups for list of preferred/non-preferred

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Growth Hormone Adults

LENGTH OF AUTHORIZATION: 1 year (Serostim® – 3 months *** see below)

ADULTS (> 18 years of age) Clinical Criteria for Approval:

1. Prescriber is an endocrinologist
2. 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);
3. 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
4. Other hormonal deficiencies (thyroid, cortisol or sex steroids) have been ruled out or stimulation testing would not produce a clinical response such as in a diagnosis of panhypopituitarism.

Zorbtive®

- Diagnosis of short bowel syndrome

Serostim®

- Diagnosis of AIDS Wasting or cachexia
- Patient has a documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents (both Megace® and Marinol®)

*****Length of Authorization** (Serostim® only): 3 months initial; then 1 year.

Renewal is contingent upon improvement in lean body mass or weight measurements.

Requests for Renewal (adults)

Renewal is contingent upon prescriber affirmation of positive response to therapy (improved body composition, reduced body fat, and increased lean body mass).

PDL CRITERIA

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

- 2) Has there been a therapeutic failure after a reasonable therapeutic trial with use of one of the non-service authorized agents?

Document the details, and forward all of these requests to a clinical pharmacist.

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Growth Hormone Adults & Pediatrics continued pg 3

Growth Hormones for all groups

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Genotropin [®] ****	Humatrope [®] Cartridge
Nutropin AQ [®] NuSpin TM ****	Humatrope Vial [®]
	Norditropin Cartridge [®]
	Norditropin FlexPro [®]
	Norditropin Nordiflex [®]
	Nutropin [®] ****
	Nutropin AQ [®] Cartridge****
	Nutropin AQ [®] Vial****
	Omnitrope [®]
	Saizen Vial [®]
	Saizen Cartridge [®]
	Serostim [®]
	Tev-Tropin [®]
	Zorbtive [®]

**** Requires a clinical SA

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

**Erythropoiesis Stimulating Proteins:
Epogen®, Procrit® (Erythropoietin)
& Aranesp® (Darbepoetin)**

LENGTH OF AUTHORIZATION: for duration of the prescription up to 6 months

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

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

Clinical Information for Pharmacists:

RENEWAL REQUESTS for patients with anemia due to chronic renal failure/end stage renal disease should be approved, even if the Hgb or Hct are above the cutoff point.

Hematopoietic Agents

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Procrit®	Aranesp®
	Epogen®

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Progestational Agents

Length of authorization: 1 year

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

Acceptable reasons include:

- Allergy to at least two unrelated medications not requiring service approval
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval

Document clinically compelling information

2. Has there been a failure to respond to a therapeutic trial of at least one week of one non-service authorized medication? If yes, allow the service authorized medication.

Document details

Progestational Agents

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
medroxyprogesterone acetate	
norethindrone acetate	
progesterone	
Provera [®]	
Prometrium [®]	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Progestins Used For Cachexia

LENGTH OF AUTHORIZATION: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

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

Progestins Used for Cachexia

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
megestrol acetate	Megace [®]
	Megace [®] ES

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Vaginal Estrogens

LENGTH OF SERVICE AUTHORIZATIONS: 6 months

1. Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

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

ADDITIONAL INFORMATION TO AID IN FINAL DECISION

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

Vaginal Estrogens

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Premarin Vaginal Cream	Estrace Vaginal Cream
Vagifem Vaginal Tablets	Estring Vaginal Ring
	Femring Vaginal Ring

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Gastrointestinal

Histamine -2 Receptor Antagonists (H-2 RA)

LENGTH OF AUTHORIZATIONS: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring service approval
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval
- Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring service approval might cause deterioration of the patient's condition.

Document clinically compelling information

- 2) If there has been a therapeutic failure to no less than a one-month trial of at least one medication not requiring service approval, then may approve the requested medication.
- 3) If a medication requiring service approval was initiated in the hospital for the treatment of a condition such as a GI bleed, and then may approve the requested medication.
- 4) Treatment of warts is not an FDA approved diagnosis or indication for Tagamet / cimetidine and a SA will not be approved for this diagnosis or indication.

Document details

H2 Receptor Antagonists

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required	
famotidine	Axid [®] capsule	nizatidine suspension
ranitidine	Axid [®] solution	Pepcid oral suspension [®]
ranitidine syrup	cimetidine syrup	Pepcid [®] tablet
	cimetidine tablet	Tagamet [®]
	famotidine oral suspension	Zantac [®] tablet
	nizatidine	Zantac [®] syrup

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Motility Agents – GI Stimulants

LENGTH OF SERVICE AUTHORIZATIONS: 12 weeks

1. Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

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

- If there has been a therapeutic failure of no less than a **one-month trial** of at least **one** medication **within the same class** not requiring service approval
- The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated

ADDITIONAL INFORMATION TO AID IN FINAL DECISION

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

All products are subject to a 12 week course of use. Black box warning placed on product 2/27/2009

WARNING: TARDIVE DYSKINESIA

Treatment with metoclopramide can cause tardive dyskinesia, a serious movement disorder that is often irreversible. The risk of developing tardive dyskinesia increases with duration of treatment and total cumulative dose.

Metoclopramide therapy should be discontinued in patients who develop signs or symptoms of tardive dyskinesia. There is no known treatment for tardive dyskinesia. In some patients, symptoms may lessen or resolve after metoclopramide treatment is stopped.

Treatment with metoclopramide for longer than 12 weeks should be avoided in all but rare cases where therapeutic benefit is thought to outweigh the risk of developing tardive dyskinesia.

GI Stimulants

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
metoclopramide	Metozolv [®] ODT
	Reglan [®]

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Gastrointestinals: Proton Pump Inhibitors

LENGTH OF AUTHORIZATIONS: dependent on criteria met

Prilosec® OTC or Prevacid® OTC, if successful, may be continued with no limitations to duration of therapy
Protonix® (Pantoprazole) to be approved for 120 days (if 60-day trial of Prilosec® OTC or Prevacid® OTC fails)
Non-preferred products to be approved for 120 days (with failure of both Prilosec® OTC or Prevacid® OTC and Protonix® or Pantoprazole)
For exceptions see criteria for “Proton Pump Inhibitors exception”

- 1) **Step one** requires a therapeutic failure of a 60-day trial of OTC Prilosec® (up to 40mg daily) or Prevacid® OTC. For exceptions to this see criteria for “Proton pump inhibitors exception”.
Other things to consider when reviewing OTC Prilosec® or Prevacid® OTC
 - Allergy to omeprazole or lansoprazole
 - Contraindication to or drug-to-drug interaction with OTC Prilosec® (Omeprazole) or Prevacid® OTC (lansoprazole)
 - History of unacceptable/toxic side effects to OTC Prilosec® (Omeprazole) or Prevacid® OTC (lansoprazole)
 - Patient’s condition is clinically unstable; changing to OTC Prilosec® or Prevacid® OTC might cause deterioration of the patient’s condition.

Document details

- 2) **If has failed step one then move to step two** and the other preferred medication, Protonix® (Pantoprazole) must be tried. If there is a therapeutic failure of no less than a one-month trial with Protonix® (Pantoprazole) then may approve the requested medication for duration of 120 days.

Other things to consider when reviewing

- Is there any reason the patient cannot be changed to Protonix®, Acceptable reasons include:
- Allergy to Protonix® (Pantoprazole)
- Contraindication to or drug-to-drug interaction with Protonix®(Pantoprazole)
- History of unacceptable/toxic side effects to Protonix® (Pantoprazole)
- Patient’s condition is clinically unstable; changing to a medication not requiring service approval might cause deterioration of the patient’s condition.

Document details

Gastrointestinals: Proton Pump Inhibitors exceptions

LENGTH OF AUTHORIZATIONS: If an exception is met, approve desired product and make the duration for 1 year. Step therapy requirements detailed above do not apply.

- Exceptions
- Erosive Esophagitis
- Active GI Bleed
- Zollinger-Ellison Syndrome
- Greater than 65 years of age
- If Failed 120 day trial and is under the care of a Gastroenterologist and has ruled out a nonsecretory condition

Document details

See next page for specific drug lists.

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Gastrointestinals: Proton Pump Inhibitors (Continued)

Gastrointestinals: PPIs (see step edit)

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required	
pantoprazole*	<i>Aciphex[®]</i>	<i>Prilosec[®] Rx form</i>
Prevacid[®] OTC	<i>Dexilant[®]</i>	<i>Prilosec[®] Suspension</i>
Prilosec[®] OTC	<i>Nexium[®]</i>	<i>Protonix[®]</i>
	• <i>omeprazole RX &OTC</i>	<i>Zegerid[®] Capsule</i>
	<i>omeprazole/sodium bicarbonate</i>	<i>Zegerid[®] OTC</i>
	• <i>Prevacid[®] RX</i>	<i>Zegerid[®] susp Packet</i>
	• <i>Prevacid[®] susp</i>	<i>lansoprazole</i>
	• <i>Prevacid[®] solutab</i>	

* is subject to the step edit

•no SA required if age < 12yrs

SPECIAL CONSIDERATION:

○ Protonix[®] is a delayed release tablet and cannot be crushed or opened. ○ For tubed patients or patients with swallowing difficulties omeprazole, Prevacid[®], Prevacid Solutab[®], Prilosec[®], Nexium[®] or Prevacid[®] granules (if oral administration) can be used. These Proton Pump Inhibitors may be opened and the intact granules may be mixed in apple sauce or orange juice and administered. Alternatively, the capsules may be opened and the granules may be dissolved in a small amount of sodium bicarbonate to form a compounded suspension for administration. The omeprazole will be the preferred agent for these circumstances and may be approved. ○ • If therapy is for a child < 12 then Prevacid[®] Susp, Prevacid[®] solutab, Prevacid[®] Caps or Omeprazole will not require a SA) ○ If there has been a therapeutic failure on omeprazole or there is a clinical contraindication to omeprazole then another non-preferred agent may be approved. ○ Aciphex[®] is an extended release tablet and should not be opened or crushed.

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)

LENGTH OF AUTHORIZATION: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

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

- If there has been a therapeutic failure of no less than a one-month trial of at least one medication within the same class not requiring service approval
- The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated

Ulcerative Colitis – Oral

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Apriso[®]	<i>Asacol HD[®]</i>
Asacol[®]	<i>Azulfidine Dr[®]</i>
balsalazide disodium	<i>Azulfidine IR[®]</i>
Pentasa[®]	<i>Azulfidine[®] Susp</i>
sulfasalazine DR	<i>Colazal[®]</i>
sulfasalazine IR	<i>Dipentum</i>
	<i>Lialda[®]</i>

Ulcerative Colitis – Rectal

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Canasa[®] Supp. Rect	<i>Fiv-Asa[®]</i>
mesalamine enema	<i>Rowasa[®] Enema</i>
	<i>Rowasa[®] Enema Kit</i>
	<i>Rowasa[®] Supp. Rect</i>
	<i>SFRowasa[®]</i>

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Genitourinary

Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)

LENGTH OF AUTHORIZATION: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

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

- If there has been a therapeutic failure of no less than a one-month trial of at least one medication within the same class not requiring service approval
- The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated

Alpha-Blockers for BPH

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
tamsulosin HCL	Flomax [®]
	Rapaflo [®]
	Uroxatral [®]

Androgen Hormone Inhibitors for BPH

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Avodart [®]	Jalyn [®]
finasteride	Proscar [®]

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Phosphate Binders

LENGTH OF AUTHORIZATIONS: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring service approval
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval
- Patient's condition is clinically unstable; changing to a medication not requiring service approval might cause deterioration of the patient's condition.

Document clinically compelling information

- 2) If there has been a therapeutic failure to at least a one-month trial of at least one medication not requiring service approval, then may approve the requested medication.

Electrolyte Depleters

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Fosrenol®	Calcium Acetate 667MG
Phoslo®	Eliphos®
Renagel®	Renvela® powder and tablet

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Urinary Antispasmodics

LENGTH OF AUTHORIZATIONS: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

- 2) If there has been a therapeutic failure to at least a one-month trial of at least one medication not requiring service approval, then may approve the requested medication.

Urinary Antispasmodics

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Detrol [®] LA	Detrol [®]
Enablex [®]	Ditropan [®]
oxybutynin Tablet	Ditropan [®] XL
oxybutynin Syrup	Gelnique [™] gel
Oxytrol [®] Transdermal	oxybutynin ER
Sanctura [®]	Toviaz [™]
Sanctura [®] XR	
VESIcare [®]	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Immunological agents

Self Administered Drugs for Rheumatoid Arthritis

LENGTH OF AUTHORIZATION:

1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring service approval
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval
- Patient's condition is clinically unstable; changing to a medication not requiring service approval might cause deterioration of the patient's condition.

Document clinically compelling information

- 2) If there has been a therapeutic failure of a trial of at least one medications not requiring service approval, then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

- If the patient is completing a course of therapy with a medication requiring service approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring service approval, then may approve the requested medication.
- An indication that is unique to a non-preferred agent and is supported by peer-reviewed literature or a FDA-approved indication, or Age specific indication, or Medical co-morbidity, unique patient circumstance, other medical complications, or Clinically unacceptable risk with a change in therapy to preferred agent.

Immunomodulators – Injectable-Self Administered Drugs for Rheumatoid Arthritis

Preferred Drugs – No SA Required	Non-Preferred Drugs - SA Required
Enbrel [®]	Cimzia [®]
Humira [®]	Cimzia [®] SyringeKit
	Kineret [®]
	Simponi [®]

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Multiple Sclerosis

LENGTH OF AUTHORIZATION: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring service approval
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval
- Patient's condition is clinically unstable; changing to a medication not requiring service approval might cause deterioration of the patient's condition.

Document clinically compelling information

- 2) If there has been a therapeutic failure of a trial of at least one medications not requiring service approval, then may approve the requested medication.

******Clinical Edit for Ampyra**

LENGTH OF AUTHORIZATION FOR AMPYRA: Initial 8 weeks then, 1 year after successful trial

Criteria:

- The patient has a diagnosis of MS and a gait disorder or difficulty walking
- Patient has no history of seizures
- Patient's Creatinine Clearance [CrCL] $\geq$ 50 mL/min.
- If patient has a gait disorder, they may receive an 8 week trial of Ampyra
- If after 8 week trial the physician states that the patient showed improvement or that the drug was effective (by improved Timed 25-foot Walk), the patient may receive authorization for Ampyra for one year.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

- If the patient is completing a course of therapy with a medication requiring service approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring service approval, then may approve the requested medication.
- An indication that is unique to a non-preferred agent and is supported by peer-reviewed literature or a FDA-approved indication, or Age specific indication, or Medical co-morbidity, unique patient circumstance, other medical complications, or Clinically unacceptable risk with a change in therapy to preferred agent.

Multiple Sclerosis Agents

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Avonex [®]	Ampyra [®] ****
Avonex [®] Adm Pack	Extavia [®]
Betaseron [®]	
Copaxone [®]	
Rebif [®]	

****Requires a clinical SA as noted above

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Atopic Dermatitis: Topical

LENGTH OF AUTHORIZATION: 1 YEAR

CLINICAL CONSIDERATIONS:

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

- 2) A SA may only be given for an FDA approved Diagnosis:

- Atopic dermatitis (a type of eczema) - FDA approved:
- 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.

- 3) All other diagnoses (off-label uses) are to be referred to a clinical pharmacist. All requests for all other diagnoses are to be denied.

Critical information for review:

- Black box warnings are in place for both products as well a requirement for a patient guide to be given with each product dispensed.
- The FDA recommends that healthcare providers, patients and caregivers consider the following: (Updated from FDA site 8/29/07) *...*
- Use Elidel and Protopic only as second-line agents for short-term and intermittent treatment of atopic dermatitis (eczema) in patients unresponsive to, or intolerant of other treatments.
- Avoid use of Elidel and Protopic in children younger than 2 years of age. The effect of Elidel and Protopic on the developing immune system in infants and children is not known. In clinical studies, infants and children younger than 2 years old treated with Elidel had a higher rate of upper respiratory infections than did those treated with placebo cream.
- Use Elidel and Protopic only for short periods of time, not continuously. The long term safety of Elidel and Protopic are unknown.
- Children and adults with a weakened or compromised immune system should not use Elidel or Protopic.
- Use the minimum amount of Elidel or Protopic needed to control the patient's symptoms. In animals, increasing the dose resulted in higher rates of cancer.

...<http://www.fda.gov/cder/drug/infopage/protopic/default.htm>

...http://www.fda.gov/cder/drug/advisory/elidel_protopic.htm

Topical Immunomodulators

Preferred Drugs - No SA Required once Clinical edit met	Non-Preferred Drugs - SA Required
Elidel®****	Protopic®****

****Requires a clinical SA

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Ophthalmic

Ophthalmic Antihistamines/Mast Cell Stabilizers

LENGTH OF AUTHORIZATIONS: 1 year

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

Acceptable reasons include:

- Allergy to product formulation (i.e. dyes or fillers). If an allergy to drug class, should question medication request.
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval

Document clinically compelling information

2) If there has been a therapeutic failure to no less than a three-day trial of one medication within the same not requiring service approval, then may approve the requested medication.

Document details

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

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

Ophthalmic Antihistamines

Preferred Drugs - No SA Required	Non-Preferred Drugs - SA Required	
Alaway OTC [®]	Elestat [®] drops	Patanol [®] drops
	Emadine [®] drop	Pataday [®] drops
	ketotifen fumerate	Zaditor [®] OTC drops
	Optivar [®] drops	

Ophthalmic Mast Cell Stabilizers (no changes)

Preferred Drugs - No SA Required	Non-Preferred Drugs - SA Required
Alamast [®] drops	Crolom [®] drops
Alocril [®] drops	
Alomide [®] drops	
cromolyn sodium	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Ophthalmic Anti-inflammatory

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

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

Acceptable reasons include:

- Allergy to product formulation (i.e. dyes, fillers). If an allergy to drug class, should question medication request.
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval

Document clinically compelling information

2) If there has been a therapeutic failure to no less than a 3 day trial of one medication within the same not requiring service approval, then may approve the requested medication. Document details.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

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

Ophthalmic Anti-Inflammatory

Preferred Drugs - No SA Required	Non-Preferred Drugs - SA Required
ketorolac 0.4%	<i>Acular[®] drops</i>
ketorolac 0.5%	<i>Acular LS[®] drop</i>
diclofenac sodium drops	<i>Acular PF[®] dropperette</i>
flurbiprofen sodium drops	<i>Acuvail[®] drops</i>
Nevanac[®] drops Susp	<i>Ocufen[®] drops</i>
Xibrom[®] drops	<i>Voltaren[®] drops</i>

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Ophthalmic Antibiotics

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

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

Acceptable reasons include:

- Allergy to product formulation (i.e. dyes, fillers). If an allergy to drug class, should question medication request.
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval

Document clinically compelling information

2) If the infection is caused by an organism resistant to medications not requiring service approval, then may approve the requested medication.

Document details, note diagnosis and any culture and sensitivity reports

3) If there has been a therapeutic failure to no less than a three-day trial of one medication within the same not requiring service approval, then may approve the requested medication.

Document details

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

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

Ophthalmic Antibiotics (Fluoroquinolones & Macrolides)

Preferred Drugs - No SA Required	Non-Preferred Drugs - SA Required
ciprofloxacin drops	<i>AzaSite™ drops</i>
ofloxacin drops	<i>Besivance® drops</i>
Quixin® drops	<i>Ciloxan® drops</i>
Vigamox® drops	<i>Ciloxan® oint</i>
Zymar® drops®	<i>Iquix® drops</i>
	<i>Ocuflox® drops</i>
	<i>Zymaxid® drops</i>

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Ophthalmic- Glaucoma Agents

LENGTH OF AUTHORIZATIONS: 1 year

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

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

Document clinically compelling information

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

- If there has been a therapeutic failure to no less than a one-month trial of at least one medication within the same class not requiring service approval
- The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated

Glaucoma Agents	
Ophthalmic Prostaglandin Analogs	
Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
latanoprost	Lumigan® 0.03% drops
Travatan Z® drops	Xalatan® 0.005% drops
Travatan® 0.0004% drops	
Alpha 2 Adrenergic Agents	
Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Alphagan P® 0.1% & 0.15% drops	Brimonidine tartrate (0.15%)
brimonidine 0.2% drops	
Iopidine® 0.5% & 1% drops	
Beta Blockers	
Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
betaxolol 0.5% drops	Betagan® 0.25% & 0.5% drops
Betimol® 0.25% & 0.5% drops	Istalol® 0.5% drops
Betoptic-S® 0.25% susp drops	Ocupress® 1% drops
carteolol 1% drops	optipranolol 0.3% drops
Combigan®	Timoptic® drops 0.25% & 0.5% drops
levobunolol 0.25% & 0.5% drops	Timoptic® XE 0.25% & 0.5% Sol-Gel
metipranolol 0.3% drops	
timolol maleate drops 0.25% & 0.5% drops	
timolol maleate 0.5 % Sol-Gel	
Carbonic Anhydrase Inhibitors	
Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Azopt® 1% drops	Cosopt® 0.5%-2% drops
dorzolamide	Trusopt® 2% drops
dorzolamide/timolol	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Osteoporosis Agents

Bisphosphonates and Calcitonins

LENGTH OF AUTHORIZATIONS: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

- 2) Has the patient tried and failed a therapeutic trial with a preferred drug within the same class? If so, document and approve the service authorized drug.

Bisphosphonates

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required	
alendronate	Actonel [®] with CA	Actonel [®]
Fosamax [®] solution	Boniva [®]	Fosamax [®]
	Fosamax [®] plus D	

Calcitonins

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Miacalcin [®]	calcitonin-salmon Nasal
	Fortical [®]

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Respiratory

Antihistamines: First and Second Generation

LENGTH OF AUTHORIZATIONS: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

- 2) If there has been a therapeutic failure after a course of treatment (e.g., one month for allergic rhinitis) with one product not requiring service approval, then may approve the requested medication.

Document details

First Generation Antihistamines

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Generic only class	All Brands require an SA

Second Generation Antihistamines and Combinations

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required	
cetirizine syrup OTC/RX	Allegra [®]	Claritin- D [®] 12 hr
Claritin [®] OTC	Allegra ODT [®]	Claritin-D [®] - Rx forms
Claritin [®] OTC syrup	Allegra suspension [®]	Claritin [®] - Rx forms
Claritin [®] tablets- Reditabs OTC	Allegra-D 12 hr [®]	Claritin [®] Chewables
Claritin-D [®] 24 hr OTC	Allegra-D 24 hr [®]	fexofenadine
Claritin-D [®] 12 hr OTC	cetirizine chew OTC	fexofenadine/PSE
loratadine tablet (represents all OTC names)	cetirizine tablet OTC	fexofenadine/PSE 60/120 ER
loratadine tab - Rapids (all OTC names)	cetirizine D tablet OTC	Xyzal [®]
loratadine syrup (represents all OTC names)	‡ cetirizine sol OTC	Zyrtec tablet OTC/RX [®]
loratadine D 24 hr (represents all OTC names)	Clarinet tablet [®]	Zyrtec tab chew OTC/RX [®]
loratadine D 12 hr (represents all OTC names)	Clarinet tablet Rapids [®]	Zyrtec [®] syrup OTC
	Clarinet [®] syrup	Zyrtec-D [®] OTC/RX
	Clarinet- D [®] 24 hr	

‡ no SA required < 2yrs of age

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Beta-Adrenergic Agents

LENGTH OF AUTHORIZATIONS: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class and formulation?

Acceptable reasons include:

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

Document clinically compelling information

- 2) If there has been a therapeutic failure to no less than a two-week trial of at least one medication not requiring service approval within the same class and formulation. (i.e. nebulizers for nebulizers)

Document details

ADDITIONAL INFORMATION

Patients experience cardiac and central nervous system side effects (i.e. tachycardia, agitation) more often.

Beta Adrenergic Agents

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Short Acting and Combination Metered Dose Inhalers or Devices	
Proair[®] HFA	<i>Maxair Autohaler</i>
Proventil[®] HFA	<i>Xopenex[®] HFA</i>
Ventolin[®] HFA	<i>Alupent[®] MDI discontinued</i>
Long Acting Metered Dose Inhalers or Nebulizers	
Foradil[®]	<i>Brovana[®]</i>
Serevent Diskus[®]	<i>Perforomist[®]</i>
Short Acting Nebulizers	
albuterol sulfate	<i>Accuneb[®] pediatric dosing, premixed nebs</i>
metaproterenol	<i>albuterol sulfate premix</i>
Xopenex[®]	<i>Proventil[®]</i>
	<i>Levalbuterol 0.125%</i>

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

COPD: Anticholinergics

LENGTH OF AUTHORIZATIONS: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring service approval
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval
- Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring service approval might cause deterioration of the patient's condition.

Document clinically compelling information

- 2) If there have been therapeutic failures to no less than one-month trials of at least two medications not requiring service approval, then may approve the requested medication.

Document details

COPD Anticholinergics

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
Atrovent HFA[®]	<i>Atrovent AER[®]</i>
Combivent[®] MDI	<i>Duoneb[®]</i>
ipratropium bromide Solution	<i>Ipratropium/Albuterol nebs</i>
Spiriva[®]	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Corticosteroids: Inhaled and Nasal Steroids

LENGTH OF AUTHORIZATIONS: 1 year

- 1) Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring service approval
- Contraindication to or drug-to-drug interaction with medications not requiring service approval
- History of unacceptable/toxic side effects to medications not requiring service approval
- Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring service approval might cause deterioration of the patient's condition.

Document clinically compelling information

- 2) If there have been therapeutic failures to no less than one-month trials of at least two medications not requiring service approval, then may approve the requested medication.

Document details

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

- 1) If a medication requiring service approval was initiated in the hospital, and then may approve the requested medication.

Document details

- 2) If the patient is a child <13 years old or a patient with a significant disability, and unable to use an inhaler which does not require service approval, or is non-compliant on an inhaler not requiring service approval because of taste, dry mouth, infection; then may approve the requested medication.

Document details

See next page for specific drug lists.

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Corticosteroids: Inhaled and Nasal Steroids (Continued page 2)

Inhaled Corticosteroids

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Metered Dose Inhalers	
Aerobid[®]	<i>Flovent Rotadisk[®]</i>
Aerobid[®] M	<i>Flovent[®]</i>
Asmanex[®]	<i>Pulmicort Flexhaler[®]</i>
Azmacort[®]	<i>Alvesco[®]</i>
Flovent[®] HFA	
Flovent[®] Diskus	
QVAR[®]	
Nebulizer Solution	
Pulmicort[®] Respules	<i>budesonide</i>
Combination Products (Glucocorticoid and Beta Adrenergic)	
Advair[®] Diskus	
Advair[®] HFA	
Dulera[®]	
Symbicort[®]	

Nasal Steroids

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required	
fluticasone	<i>Allemist[®]</i>	<i>Nasonex[®]</i>
Nasacort[®] AQ	<i>Beconase AQ[®]</i>	<i>Omnaris[®]</i>
	<i>Flonase[®]</i>	<i>Rhinocort Aqua[®]</i>
	<i>flunisolide</i>	<i>Tri-Nasal[®]</i>
	<i>Nasacort[®]</i>	<i>Veramyst[®]</i>
	<i>Nasarel[®]</i>	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Cough and Cold Agents

LENGTH OF SERVICE AUTHORIZATIONS: Date of Service

1. Is there any reason the patient cannot be changed to a medication not requiring service approval within the same class?

Acceptable reasons include:

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

Document clinically compelling information

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

- If there has been a therapeutic failure of at least **one** medication **within the same class** not requiring service approval.
- The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and showed unacceptable/toxic side effects or there is an allergy, contraindication, or drug-to-drug interaction.

ADDITIONAL INFORMATION TO AID IN FINAL DECISION

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

Antihistamine & Decongestant COMB

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
Generic only class	<i>All Brands require an SA</i>

Antihistamine 1st Generation & Decongestant Combination

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
Generic only class	<i>All Brands require an SA</i>

Decongestant-Expectorant Combination

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
Generic only class	<i>All Brands require an SA</i>

Expectorant

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
Generic only class	<i>All Brands require an SA</i>

Narcotic Antitussive/Decongestants

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
Generic only class	<i>All Brands require an SA</i>

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Cough and Cold Agents Continued

Narcotic Antitussive/Expectorant

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
Generic only class	<i>All Brands require an SA</i>

Non-Narcotic Antitussive

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
Generic only class	<i>All Brands require an SA</i>

Non-Narcotic Antitussive/Decongestants

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
Generic only class	<i>All Brands require an SA</i>

Non-Narcotic Antitussive/1st Generation Antihistamine/Decongestants

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
Generic only class	<i>All Brands require an SA</i>

Non-Narcotic Antitussive/Expectorant

Preferred Drugs - No SA Required	<i>Non-preferred Drugs - SA Required</i>
Generic only class	<i>All Brands require an SA</i>

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Intranasal Antihistamines:

LENGTH OF AUTHORIZATION: 1 year

- 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 unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring service authorization might cause deterioration of the patient's condition.

Document clinically compelling information

- 2) If there have been therapeutic failures to no less than one-month trials of at least two medications not requiring service authorization, then may approve the requested medication.

Document details

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

- 1) If a medication requiring service approval was initiated in the hospital, and then may approve the requested medication.

Document details

- 2) If the patient is a child <13 years old or a patient with a significant disability, and unable to use an inhaler which does not require service approval, or is non-compliant on an inhaler not requiring service approval because of taste, dry mouth, infection; then may approve the requested medication.

Document details

Antihistamines: Intranasal

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Astelin [®]	azelastine 0.1%
Astepro [®] 0.1% and 0.15%	
Patanase [®]	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Leukotriene Receptor Antagonists

LENGTH OF AUTHORIZATION: 1 year

1) Is there any reason the patient cannot be changed to a medication not requiring service authorization?

Acceptable reasons include:

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

Document clinically compelling information

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

Document details

Leukotriene Receptor Antagonists

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
Accolate [®]	Zyflo CR [™]
Singulair [®]	

New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Self Injectable Epinephrine

LENGTH OF AUTHORIZATION: 1 year

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

Document clinically compelling information

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

- If there has been a therapeutic failure of no less than a one-month trial of at least one medication within the same class not requiring service approval
- The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated

Self Injectable Epinephrine

Preferred Drugs - No SA Required	Non-preferred Drugs - SA Required
epinephrine Autoinjector	AdrenaClick®
EpiPen®	Twinject®
EpiPen® Jr	Twinject® Jr

New generic, brand, or dose formulation anticipated, will be non-preferred pending review