The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

	Opuneu 1700/2015
ADD/ADHD/	See CNS Stimulants and Atomoxetine Prior Authorization Criteria.
NARCOLEPSY	
AGENTS	
Use CNS Stimulants and	
Atomoxetine PA form	
Alpha <sub>2</sub> Agonists,	Prior authorization is required for extended-release alpha <sub>2</sub> agonists. Payment will be considered for patients when the following is met:
Extended-Release	1. The patient has a diagnosis of ADHD and is between 6 and 17 years of age; and
	2. Previous trial with the preferred immediate release product of the same chemical entity at a therapeutic dose that resulted in a
Intuniv TM	partial response with a documented intolerance; and
<i>Kapvay</i> <sup>™</sup>	3. Previous trial and therapy failure at a therapeutic dose with one preferred amphetamine and one preferred
11.13	non-amphetamine stimulant; and
Use Alpha <sub>2</sub> Agonists,	4. Previous trial and therapy failure at a therapeutic dose with atomoxetine (Strattera <sup>®</sup> ).
Extended-Release PA	The required trials may be overridden when documented evidence is provided that the use of these agents would be medically
form	contraindicated.
Alpha <sub>1.</sub> -Proteinase	Prior authorization is required for Alpha <sub>1</sub> -Proteinase Inhibitor enzymes. Payment will be authorized only for cases in which there is a
Inhibitor Enzymes	diagnosis of congenital alpha <sub>1</sub> -proteinase inhibitor (alpha <sub>1</sub> -PI; alpha1-antitrypsin) deficiency with clinically demonstrable panacinar
-	emphysema. Payment for a non-preferred Alpha <sub>1</sub> -Proteinase Inhibitor enzyme will be authorized only for cases in which there is
Use Miscellaneous PA	documentation of previous trial and therapy failure with a preferred agent.
form	
Amylino Mimetic	Prior authorization is required for amylino mimetics (Symlin®). Payment will be considered under the following conditions: 1)
(Symlin <sup>®</sup> )	Diagnosis of Type 1 or Type 2 diabetes mellitus, 2) Concurrent use of insulin therapy, 3) Documentation of blood glucose monitoring
	three or more times daily, 4) Inadequate reduction in HbgA1C despite multiple titration with basal/bolus insulin dosing regiments.
Use Amylino Mimetic	Initial authorizations will be approved for six months; additional prior authorizations will be considered on an individual basis after
(Symlin <sup>®</sup> ) form	review of medical necessity and documented improvement in HbgA1C since the beginning of the initial prior authorization period.
Angiotensin Receptor	Payment for Angiotensin Receptor Blockers (ARB) and Angiotensin Receptor Blocker Combinations will only be considered for cases
Blocker Before ACE	in which there is a contraindication or therapy failure with at least one ACE-I or ACE-I Combination. A completed prior authorization
Inhibitor	form will need to be submitted if a trial with an ACE-I or ACE-I Combination of at least 30 days in length is not found in the point-of-
	sale system and/or unless evidence is provided that use of an ACE-I or ACE-I Combination would be medically contraindicated. Prior
Use Angiotensin	authorization is required for all non-preferred ARBs and ARB Combinations the first day of therapy. Payment for a non-preferred ARB
Receptor Blocker Before	or ARB Combination will be considered following documentation of recent trials and therapy failures with a preferred ACE-I or ACE-I
ACE Inhibitor PA form	Combination AND a preferred ARB or ARB Combination.
v	

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

	Opanica 1/00/2015
Anti-Acne	Prior authorization is required for all prescription topical acne products. Payment for the treatment of mild to moderate acne vulgaris
	will be considered under the following conditions:
	1. Previous trial and therapy failure with a preferred over-the-counter benzoyl peroxide product, which is covered by the program without prior authorization.
	2. Payment for non-preferred topical acne products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred topical agents of a different chemical entity.
	3. If the patient presents with a preponderance of comedonal acne, topical retinoid products may be utilized as first line agents with prior authorization (use Topical Retinoids PA form).
	4. Requests for non-preferred combination products may only be considered after documented separate trials and therapy failures with the individual ingredients.
	The required trials may be overridden when documented evidence is provided that the use of these agents would be medically
Use Anti-Acne PA form	contraindicated.
Antidepressants	Prior authorization is required for non-preferred antidepressants subject to clinical criteria. Requests for doses above the manufacturer recommended dose will not be considered. Payment will be considered for patients when the following criteria are met:
Aplenzin	1. The patient has a diagnosis of Major Depressive Disorder (MDD) and is 18 years of age or older; and
Brintellix	2. Documentation of a previous trial and therapy failure at a therapeutic dose with two preferred generic SSRIs; and
Fetzima	3. Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SNRI; and
Khedezla	4. Documentation of a previous trial and therapy failure at a therapeutic dose with one non-SSRI/SNRI generic antidepressant
Pristiq	5. If the request is for an isomer, prodrug or metabolite of a medication indicated for MDD, one of the trials must be with the
Viibryd	preferred parent drug of the same chemical entity that resulted in a partial response with a documented intolerance.  The required trials may be overridden when documented evidence is provided that the use of these agents would be medically
Use Antidepressants PA	contraindicated.
form	Contraindicated.
Anti-Diabetics, Non-	Prior authorization is required for preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered
Insulin Agents	under the following conditions:
ingum rigenes	1. A diagnosis of Type 2 Diabetes Mellitus, and
	2. Patient is 18 years of age or older, and
	3. The patient has not achieved HgbA1C goals after a minimum three month trial with metformin at maximally tolerated dose, unless
	evidence is provided that use of this agent would be medically contraindicated.
	Payment for a non-preferred anti-diabetic, non-insulin agent subject to clinical criteria will be authorized only for cases in which there is documentation of previous trials and therapy failures with metformin, a preferred DPP-4 Inhibitor or DPP-4 Inhibitor Combination and
	a preferred Incretin Mimetic at maximally tolerated doses, unless evidence is provided that use of these agents would be medically
	contraindicated.
Use Anti-Diabetics, Non-	Initial authorizations will be approved for six months. Additional prior authorizations will be considered on an individual basis after
Insulin PA form	review of medical necessity and documented continued improvement in HgbA1C.
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The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Antiemetic-5HT3	Prior authorization is requ	ired for preferred Antiemetic-5HT3 F	Receptor Antagonists/Substance P Neurokinin medications for quantities
Receptor Antagonists/	exceeding the following dosage limits per month. Payment for Antiemetic-5HT3 Receptor Agonists/ Substance P Neurokinin Agents		
Substance P	beyond this limit will be considered on an individual basis after review of submitted documentation.		
Neurokinin Agents	Prior authorization will be	e required for all non-preferred Antien	netic-5HT3 Receptor Antagonists/Substance P Neurokinin medications
	beginning the first day of	therapy. Payment for non-preferred m	edications will be authorized only for cases in which there is
	documentation of previou	s trial(s) and therapy failure with a pro	eferred agent in this class. Note: Aprepitant (Emend) will only be
			(5-HT3 medication and dexamethasone) for patients receiving highly
	emetogenic cancer chemo	therapy.	
	Aprepitant (N)/Emend (	N):	Ondansetron (P)/Zofran (N):
		4 – 125mg capsules	12 – 4mg tablets
		8 – 80mg capsules	12 – 8mg tablets
	Dolasetron (N)/Anzeme		4 – 24mg tablets
		5 - 50 mg / 100 mg tablets	4 – 20mL vials (2mg/mL)
		4 vials (100mg/5mL)	8 – 2mL vials (2mg/mL)
		8 ampules (12.5mg/0.625mL)	Ondansetron ODT (P)/Zofran ODT (N):
	Granisetron (N):		12 – 4mg tablets
		8 − 1mg tablets	12 – 8mg tablets
Use Antiemetic-5HT3		8 vials (1mg/mL)	Ondansetron Oral Solution (N)/ Zofran Oral Solution (N)
Receptor Antagonists/		2 vials (4mg/mL)	50mL/month – oral solution (4mg/5mL)
Substance P Neurokinin	Akynzeo (N):		Palonosetron (N)/ Aloxi (N):
Agents form		2 – 300/0.5mg capsules	4 vials (0.25mg/5mL)
Anti-Fungal			herapy for a cumulative 90 days of therapy per 12-month period per
			d oral antifungal therapy beginning the first day of therapy. Payment for
			s in which there is documentation of previous trial and therapy failure
			beyond a cumulative 90 days of therapy per 12-month period per patient
Use Anti-Fungal PA			an immunocompromised condition or a systemic fungal infection. This
form	prior authorization require	ement does not apply to nystatin.	

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Antihistamines	Prior authorization is required for all non-preferred oral antihistamines.
	Patients 21 years of age and older must have three unsuccessful trials with antihistamines that do not require prior authorization, prior to the approval of a non-preferred oral antihistamine. Two of the trials must be with cetirizine and loratedine.
	Patients 20 years of age and younger must have unsuccessful trials with cetirizine and loratedine prior to the approval of a non-preferred oral antihistamine.
Use Antihistamine PA form	The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

#### Apixaban (Eliquis<sup>®</sup>)

Prior authorization is required for apixaban (Eliquis<sup>®</sup>). Payment will be considered for patients under the following conditions:

- 1. Patient does not have a mechanical prosthetic heart valve; and
- 2. Patient does not have active pathological bleeding; and

#### **Atrial Fibrillation**

- Patient has a diagnosis of non-valvular atrial fibrillation; with
- Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum 6 month trial); and
- Presence of at least one additional risk factor for stroke, with a CHADS<sub>2</sub> score  $\geq 1$ .
- Requests will be considered for the following dosing:
  - o 5mg twice daily; or
  - o 2.5mg twice daily in patients with any two (2) of the following:
    - Age  $\geq 80$  years
    - Body weight  $\leq$  60 kg
    - Serum creatinine  $\geq 1.5$  mg/dL.

#### Treatment and Prevention of DVT or PE

- Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum 6 month trial).
- Requests will be considered for the following dosing:
  - o Initial treatment of DVT or PE: 10mg twice daily for 7 days, followed by 5mg twice daily up to 12 months of treatment.
  - Prevention of DVT or PE following initial therapy with standard anticoagulation therapy for 6 to 12 months of treatment for DVT or PE: 2.5mg twice daily.

# Prophylaxis of DVT following hip or knee replacement surgery

- Requests will be considered when the patient has contraindications to use of the preferred agent(s).
- Requests will be considered for the following dosing:
  - Hip replacement: 2.5mg twice daily for up to 35 days following hip replacement; or
  - o Knee replacement: 2.5mg twice daily for up to 12 days following knee replacement

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

## Use Apixaban (Eliquis®) PA form

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Apremilast (Otezla®)	Prior authorization is required for apremilast (Otezla®). Payment will be considered under the following conditions:
_	1. Patient is 18 years of age or older; and
	2. Patient has a diagnosis of active psoriatic arthritis ( $\geq 3$ swollen joints and $\geq 3$ tender joints); or
	3. Patient has a diagnosis of moderate to severe plaque psoriasis; and
	4. Prescribed by a rheumatologist or a dermatologist; and
	5. Patient does not have severe renal impairment (CrCl < 30 mL/min).
	Psoriatic Arthritis
	<ul> <li>Patient has documentation of a trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and</li> </ul>
	<ul> <li>Patient has documentation of trials and therapy failures with two preferred biological agents used for psoriatic arthritis.</li> </ul>
	Plaque Psoriasis
	<ul> <li>Patient has documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine; and</li> </ul>
	<ul> <li>Patient has documentation of trials and therapy failures with two preferred biological agents.</li> </ul>
	The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Becaplermin	Prior authorization is required for Regranex <sup>®</sup> . Payment for new prescriptions will be authorized for ten weeks for patients who meet the
(Regranex <sup>®</sup> )	following criteria:
	1. Diagnosis of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond
	2. Inadequate response to 2 weeks of wound debridement and topical moist wound dressing
	Longer than 10 weeks will be authorized for patients who meet the following criteria:
Use Regranex <sup>®</sup> PA form	Wound has decreased in size by 30% after 10 weeks

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Dongodiogoninos	Prior authorization is required for non-preferred benzodiazepines. Payment for non-preferred benzodiazepines will be authorized in
Benzodiazepines	
	cases with documentation of previous trial and therapy failure with two preferred products. Requests for clobazam (ONFI) will be
	considered for a diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS) in patients 2 years of age and older when used
	as an adjunctive treatment. Prior authorization will be approved for up to 12 months for documented:
	1. Generalized anxiety disorder.
	2. Panic attack with or without agoraphobia.
	3. Seizure.
	4. Non-progressive motor disorder.
	5. Dystonia.
	If a long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested
	benzodiazepine.
	Prior authorization requests will be approved for up to a three-month period for all other diagnoses related to the use of
Use Benzodiazepine PA	benzodiazepines.
form	The required trials may be overridden when documented evidence is provided that use of these agents would be medically
Joint	contraindicated.
Biologicals for	Prior authorization is required for biologicals used for ankylosing spondylitis. Payment will be considered following inadequate
Ankylosing Spondylitis	responses to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses, unless there are
Adalimumab (Humira®)	
	documented adverse responses or contraindications to NSAID use. These trials should be at least three months in duration. Patients with
Certolizumab Pegol	symptoms of peripheral arthritis must also have failed a 30-day treatment trial with at least one conventional disease modifying
(Cimzia <sup>®</sup> )	antirheumatic drug (DMARD), unless there is a documented adverse response or contraindication to DMARD use. DMARDs include
Etanercept (Enbrel®)	sulfasalazine and methotrexate.
Infliximab (Remicade®)	
Golimumab (Simponi <sup>™</sup> )	Payment for non-preferred biologicals for ankylosing spondylitis will be considered only for cases in which there is documentation of
	previous trials and therapy failures with two preferred biological agents.
Use Biologicals for	
Ankylosing Spondylitis	
PA form	

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

# **Biologicals for Arthritis**

Abatacept (Orencia®)
Adalimumab (Humira®)
Anakinra (Kineret®)
Certolizumab Pegol
(Cimzia®)
Etanercept (Enbrel®)
Infliximab (Remicade®)
Golimumab (Simponi™)
Tocilizumab (Actemra®)
Ustekinumab (Stelara®)

Prior authorization is required for biologicals used for arthritis. Patients initiating therapy with a biological agent must:

- 1. Be screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage;
- 2. Have not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent;
- 3. Not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class Ill or IV and with an ejection fraction of 50% or less; and
- 4. Be screened for latent TB infection, patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment.

Payment will be considered under the following conditions:

- 1. A diagnosis of rheumatoid arthritis (RA):
- A trial and inadequate response to two preferred disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxycholoroquine, sulfasalazine, leflunomide, or minocycline).
- Upon an unsuccessful methotrexate trial in patients with established RA, the combination trial with a second DMARD may be overridden if there is evidence of severe disease documented by radiographic erosions.
- 2. A diagnosis of moderate to severe psoriatic arthritis:
  - A trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).
- 3. A diagnosis of moderate to severe juvenile idiopathic arthritis:
  - A trial and inadequate response to intraarticular glucocorticoid injections and the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated

Payment for non-preferred biologicals for arthritis will be considered only for cases in which there is documentation of a previous trials and therapy failures with two preferred biological agents.

# Use Biologicals for Arthritis PA form

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

Biologicals for Inflammatory Bowel Disease	Prior authorization is required for biologicals used for inflammatory bowel disease. Payment for non-preferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.
Adalimumab (Humira <sup>®</sup> ) Certolizumab Pegol (Cimzia <sup>®</sup> ) Golimumab (Simponi <sup>™</sup> ) Infliximab (Remicade <sup>®</sup> )	<ul> <li>Crohn's Disease – Payment will be considered following an inadequate response to two preferred conventional therapy including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate.</li> <li>Ulcerative colitis (moderate to severe) – Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates and azathioprine/6-mercaptopurine.</li> </ul>
Use Biologicals for Inflammatory Bowel Disease PA form	
Biologicals for Plaque Psoriasis Alefacept (Amevive®) Adalimumab (Humira®) Etanercept (Enbrel®) Infliximab (Remicade®) Ustekinumab (Stelara®) Use Biologicals for Plaque Psoriasis PA	Prior authorization is required for biologicals used for plaque psoriasis. Payment will be considered following an inadequate response to phototherapy, systemic retinoids (oral isotretinoin), methotrexate, or cyclosporine. Payment for non-preferred biologicals for plaque psoriasis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents.
form BRAF Inhibitors	Prior authorization is required for BRAF inhibitors. Payment will be considered for patients when the following criteria are met:
Tafinlar® Zelboraf®	<ol> <li>Patient is 18 years of age or older; and</li> <li>Has a diagnosis of unresectable or metastatic melanoma with BRAF<sup>V600E</sup> mutation as detected by an FDA- approved test; and</li> <li>Prescriber is an oncologist.</li> <li>If the criteria for coverage are met, authorizations will be given at three (3) month intervals. Updates on disease progression must be</li> </ol>
Use BRAF Inhibitors PA form	provided with each renewal request. If disease progression is noted, therapy will not be continued.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Prior authorization is required for Butrans Payment will be considered when the following conditions are met:  1. Previous trials and therapy failures at a therapeutic dose with two long acting opioids. The preferred trials must allow for adequate dose titration and show use of a short acting narcotic for breakthrough pain.  2. A trial and therapy failure with fentanyl patch at maximum tolerated dose.    Prior authorization is required for buprenorphine (Butrans)   Transdermal System PA form
1. Previous trials and therapy failures at a therapeutic dose with two long acting opioids. The preferred trials must allow for adequate dose titration and show use of a short acting narcotic for breakthrough pain.   2. A trial and therapy failure with fentanyl patch at maximum tolerated dose.   3. A trial and therapy failure with fentanyl patch at maximum tolerated dose.   4. A projected treatment plan is provided, including:   ■ Anticipated maintenance dose,   ■ Anticipated maintenance dose with two long acting opioids. The preferred trials must allow for adequate dose with two long acting opioids. The preferred trials must allow for adequate dose attengency in adequate dose itration and show use of a short acting narcotic for breakthrough pain.   2. A trial and therapy failure with a preferred agents would be medically contraindicated. Payment provided that use of these agents would be medically contraindicated. Payment will be considered for patients when the following is met:    1. Patient has a diagnosis of opioid dependence and is 16 years of age or older: AND   2. Prescriber meets qualification criteria to prescribe buprenorphine/naloxone for opioid dependence and has a "X" DEA number; AND   3. Patient is participating in and compliant with formal substance abuse counseling/psychosocial therapy: AND   4. A projected treatment plan is provided, including:   ■ Anticipated maintenance dose,   ■ Anticipated maintenance dose   ■ Anticipated maintenance   ■ Anticipated maintenance   ■ Anticipated maintenan
adequate dose titration and show use of a short acting narcotic for breakthrough pain.  2. A trial and therapy failure with fentanyl patch at maximum tolerated dose.  The required trials may be overridden when documented evidence it provided that use of these agents would be medically contraindicated.  Buprenorphine/ Naloxone  Prior authorization is required for buprenorphine or buprenorphine/naloxone. Requests for doses above 24mg per day or greater than once daily dosing will not be considered. Initial requests will be considered for up to 3 months. Requests for maintenance doses above 16mg per day will not be considered on a long-term basis. Concomitant use with opioids, tramadol and hypnotics will be prohibited. Benzodiazepines will be allowed up to a cumulative 30 days per 12 month period. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. Payment will be considered for patients when the following is met:  1. Patient has a diagnosis of opioid dependence and is 16 years of age or older: AND  2. Prescriber meets qualification criteria to prescribe buprenorphine/naloxone for opioid dependence and has a "X" DEA number; AND  3. Patient is participating in and compliant with formal substance abuse counseling/psychosocial therapy: AND  4. A projected treatment plan is provided, including:  ■ Anticipated induction/stabilization dose,  ■ Anticipated maintenance dose,
Use Buprenorphine (Butrans → Transdermal System PA form  Buprenorphine/ Naloxone  The required trials may be overridden when documented evidence it provided that use of these agents would be medically contraindicated.  Prior authorization is required for buprenorphine or buprenorphine/naloxone. Requests for doses above 24mg per day or greater than once daily dosing will not be considered. Initial requests will be considered for up to 3 months. Requests for maintenance doses above 16mg per day will not be considered on a long-term basis. Concomitant use with opioids, tramadol and hypnotics will be prohibited. Benzodiazepines will be allowed up to a cumulative 30 days per 12 month period. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. Payment will be considered for patients when the following is met:  1. Patient has a diagnosis of opioid dependence and is 16 years of age or older: AND  2. Prescriber meets qualification criteria to prescribe buprenorphine/naloxone for opioid dependence and has a "X" DEA number; AND  3. Patient is participating in and compliant with formal substance abuse counseling/psychosocial therapy: AND  4. A projected treatment plan is provided, including:  • Anticipated induction/stabilization dose,  • Anticipated maintenance dose,
Use Buprenorphine (Butrans™) Transdermal System PA form  The required trials may be overridden when documented evidence it provided that use of these agents would be medically contraindicated.  Buprenorphine/ Naloxone  Prior authorization is required for buprenorphine or buprenorphine/naloxone. Requests for doses above 24mg per day or greater than once daily dosing will not be considered. Initial requests will be considered for up to 3 months. Requests for maintenance doses above 16mg per day will not be considered on a long-term basis. Concomitant use with opioids, tramadol and hypnotics will be prohibited. Benzodiazepines will be allowed up to a cumulative 30 days per 12 month period. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent will be considered for patients when the following is met:  1. Patient has a diagnosis of opioid dependence and is 16 years of age or older: AND  2. Prescriber meets qualification crit
Transdermal   System PA form   Transdermal   System PA form   System PA form   The required trials may be overridden when documented evidence it provided that use of these agents would be medically contraindicated.
System PA form  Contraindicated.  Prior authorization is required for buprenorphine or buprenorphine/naloxone. Requests for doses above 24mg per day or greater than once daily dosing will not be considered. Initial requests will be considered for up to 3 months. Requests for maintenance doses above 16mg per day will not be considered on a long-term basis. Concomitant use with opioids, tramadol and hypnotics will be prohibited. Benzodiazepines will be allowed up to a cumulative 30 days per 12 month period. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. Payment will be considered for patients when the following is met:  1. Patient has a diagnosis of opioid dependence and is 16 years of age or older: AND  2. Prescriber meets qualification criteria to prescribe buprenorphine/naloxone for opioid dependence and has a "X" DEA number; AND  3. Patient is participating in and compliant with formal substance abuse counseling/psychosocial therapy: AND  4. A projected treatment plan is provided, including:  Anticipated induction/stabilization dose,  Anticipated maintenance dose,
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Benzodiazepines will be allowed up to a cumulative 30 days per 12 month period. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. Payment will be considered for patients when the following is met:  1. Patient has a diagnosis of opioid dependence and is 16 years of age or older: AND  2. Prescriber meets qualification criteria to prescribe buprenorphine/naloxone for opioid dependence and has a "X" DEA number; AND  3. Patient is participating in and compliant with formal substance abuse counseling/psychosocial therapy: AND  4. A projected treatment plan is provided, including:  Anticipated induction/stabilization dose,  Anticipated maintenance dose,
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<ol> <li>Patient has a diagnosis of opioid dependence and is 16 years of age or older: AND</li> <li>Prescriber meets qualification criteria to prescribe buprenorphine/naloxone for opioid dependence and has a "X" DEA number; AND</li> <li>Patient is participating in and compliant with formal substance abuse counseling/psychosocial therapy: AND</li> <li>A projected treatment plan is provided, including:         <ul> <li>Anticipated induction/stabilization dose,</li> <li>Anticipated maintenance dose,</li> </ul> </li> </ol>
<ul> <li>2. Prescriber meets qualification criteria to prescribe buprenorphine/naloxone for opioid dependence and has a "X" DEA number; AND</li> <li>3. Patient is participating in and compliant with formal substance abuse counseling/psychosocial therapy: AND</li> <li>4. A projected treatment plan is provided, including: <ul> <li>Anticipated induction/stabilization dose,</li> <li>Anticipated maintenance dose,</li> </ul> </li> </ul>
<ul> <li>3. Patient is participating in and compliant with formal substance abuse counseling/psychosocial therapy: AND</li> <li>4. A projected treatment plan is provided, including: <ul> <li>Anticipated induction/stabilization dose,</li> <li>Anticipated maintenance dose,</li> </ul> </li> </ul>
<ul> <li>4. A projected treatment plan is provided, including:</li> <li>Anticipated induction/stabilization dose,</li> <li>Anticipated maintenance dose,</li> </ul>
<ul> <li>Anticipated induction/stabilization dose,</li> <li>Anticipated maintenance dose,</li> </ul>
<ul> <li>Anticipated maintenance dose,</li> </ul>
inposted frequency of office visits, and
<ul> <li>Expected frequency of counseling/psychosocial therapy visits.</li> </ul>
5. Requests for renewal must include:
<ul> <li>An updated treatment plan, including consideration of a medical taper to the lowest effective dose based on a self-</li> </ul>
assessment scale,
<ul> <li>Documentation the Iowa Prescription Monitoring Program website has been reviewed for the patient's use of</li> </ul>
controlled substances since the last prior authorization request,
<ul> <li>Documentation of a current, negative drug screen,</li> </ul>
Use Buprenorphine/  Documentation the patient has been compliant with office visits and counseling/psychosocial therapy visits.
Naloxone PA form 6. Requests for buprenorphine will only be considered for pregnant patients.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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Prior authorization is required for ceritinib (Zykadia <sup>™</sup> ). Payment will be considered under the following conditions:
1. Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive as
detected by an FDA-approved test (attach copy of results); and
2. Patient is 18 years of age or older; and
3. Prescribed by an oncologist; and
4. Patient has documentation of treatment with crizotinib and the disease has progressed while on treatment or is intolerant to
treatment.
5. Liver function tests (ALT, AST, and total bilirubin) will be monitored at least monthly while on ceritinib.
If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of therapy will be considered with
documentation patient has not experienced disease progression or unacceptable toxicity.
A prior authorization is required for pregabalin (Lyrica®) and milnacipran (Savella™). These drugs will be considered for their FDA
indications(s) and other conditions as listed in the compendia. Requests for doses above the manufacturer recommended dose will not be
considered. For patients with a chronic pain diagnosis who are currently taking opioids, as seen in pharmacy claims, a plan to decrease
and/or discontinue the opioid(s) must be provided with the initial request. Initial authorization will be given for three (3) months. There
must be a significant decrease in opioid use or discontinuation of opioid(s) after the initial three (3) month authorization for further
approval consideration. Additional prior authorizations will be considered with documentation of a continued decrease in opioid
utilization. Payment will be considered under the following conditions:
1. A diagnosis of fibromyalgia (Lyrica <sup>®</sup> and Savella <sup>™</sup> )
a. a trial and therapy failure at a therapeutic dose with gabapentin plus one of the following preferred generic agents: tricyclic
antidepressant or SNRI WITH
b. documented non-pharmacologic therapies (cognitive behavior therapies, exercise, etc.)
2. A diagnosis of post-herpetic neuralgia (Lyrica®)
A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant, topical
lidocaine, or valproate.
3. A diagnosis of diabetic peripheral neuropathy (duloxetine and Lyrica®)
A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant, duloxetine or
topical lidocaine.
4. A diagnosis of partial onset seizures, as adjunct therapy (Lyrica®)

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

# CNS Stimulants and Atomoxetine

Prior authorization (PA) is required for CNS stimulants and atomoxetine for patients 21 years of age or older. Prior to requesting prior authorization for any covered diagnosis, the prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website at <a href="https://pmp.iowa.gov/IAPMPWebCenter/">https://pmp.iowa.gov/IAPMPWebCenter/</a>. Payment for CNS stimulants and atomoextine will be considered under the following conditions:

- Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and
  confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV). Symptoms must have been present
  before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more current
  environments (social, academic, or occupational). Documentation of a recent clinical visit that confirms the patient continues to
  require medication to treat the symptoms of ADD/ADHD will be required for renewals or patients newly eligible that are
  established on medication to treat ADD/ADHD.
- 2. Narcolepsy with diagnosis confirmed with a recent sleep study (ESS, MSLT, PSG).
- 3. Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS) with documentation of non-pharmacological therapies tried (weight loss, position therapy, CPAP at maximum titration, BiPAP at maximum titration or surgery) and results from a recent sleep study (ESS, MSLT, PSG) with the diagnosis confirmed by a sleep specialist.
- 4. Binge Eating Disorder (Vyvanse only)
  - Patient is 18 to 55 years of age; and
  - Patient meets DSM-5 criteria for Binge Eating Disorder (BED); and
  - Patient has documentation of moderate to severe BED, as defined by the number of binge eating episodes per week (number of episodes must be reported); and
  - Patient has documentation of non-pharmacologic therapies tried, such as cognitive-behavioral therapy or interpersonal therapy, for a recent 3 month period, that did not significantly reduce the number of binge eating episodes; and
  - Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with topiramate and fluvoxamine.
  - Prescription is written by a psychiatrist or psychiatric nurse practitioner; and
  - Patient has a BMI of 25 to 45; and
  - Patient does not have a history of cardiovascular disease; and
  - Patient has no history of substance abuse; and
  - Is not being prescribed for the treatment of obesity or weight loss; and
  - Doses above 70mg per day will not be considered.
  - Initial requests will be approved for 12 weeks.
  - Requests for renewal must include documentation of a change from baseline at week 12 in the number of binge days per week.

#### DSM-5 Criteria

- i. Recurrent episodes of binge eating, including eating an abnormally large amount of food in a discrete period of time and has a feeling of lack of control over eating; and
- ii. The binge eating episodes are marked by at least three of the following:

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

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1. Eating more rapidly than normal
2. Eating until feeling uncomfortably full
3. Eating large amounts of food when not feeling physically hungry
4. Eating alone because of embarrassment by the amount of food consumed
5. Feeling disgusted with oneself, depressed, or guilty after overeating; and
iii. Episodes occur at least 1 day a week for at least 3 months; and
iv. No regular use of inappropriate compensatory behaviors (e.g. purging, fasting, or excessive
exercise) as are seen in bulimia nervosa; and
v. Does not occur solely during the course of bulimia nervosa or anorexia nervosa.
Moderate to Severe BED
Based on the number of binge eating episodes per week:
Moderate - 4 to 7
<i>Severe – 8 to 13</i>
Extreme – 14 or more
Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. *If a non-preferred long-acting medication is requested, a trial with the preferred immediate release and extended release product of the same chemical entity (methylphenidate class) or chemically related agent (amphetamine class) is
required.  The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Prior authorization is not required for colchicine (Colcrys®) for the treatment of acute gout for three (3) tablets per 60-day period. Prior authorization is required for colchicine (Colcrys®) for the treatment of chronic hyperuricemia/gout prophylaxis or Familial Mediterranean fever. Payment will be considered under the following conditions:
1. Chronic hyperuricemia/gout prophylaxis following a trial and therapy failure at a therapeutic dose with allopurinol or
probenecid. A quantity limit of sixty (60) tablets per thirty (30) days will be applied, when criteria for coverage are met.
2. Familial Mediterranean fever. A maximum quantity of 120 tablets per thirty (30) days will be applied for this diagnosis.
The required trials may be overridden when documented evidence is provided that the use of these agents would be medically
contraindicated.
A prior authorization is required for concurrent long acting injectable and oral antipsychotic medications after 12 weeks (84 days) of
concomitant treatment. Consideration of concomitant therapy beyond 12 weeks (84 days) will require documentation of medical
necessity. Prior authorization is required for all non-preferred antipsychotics as indicated on the Iowa Medicaid Preferred Drug List
necessity. Prior authorization is required for all non-preferred antipsychotics as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

	Opulica 7/00/2015
Crizotinib (Xalkori®)	Prior authorization is required for Xalkori® (crizotinib). Payment will be considered for patients when the following is met:
	1. Diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive
	as detected by an FDA-approved test (attach copy of results); and
Use Xalkori® PA form	2. Is prescribed by an oncologist.
Dabigatran (Pradaxa®)	Prior authorization is required for dabigatran (Pradaxa <sup>®</sup> ). Payment will be considered for patients under the following conditions:
	1. Patient does not have a mechanical prosthetic heart valve; and
	2. Patient does not have active pathological bleeding; and
	Patient has a diagnosis of non-valvular atrial fibrillation; and
	3. Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, recurrence of DVT/PE, or inability to maintain a
	therapeutic INR with a minimum 6 month trial); and
	Non-valvular atrial fibrillation (in addition to the above)
Use Dabigatran	<ul> <li>Presence of at least one additional risk factor for stroke, with a CHADS₂ score ≥ 1; and</li> </ul>
(Pradaxa®) PA form	<ul> <li>Patient does not have severe renal impairment (CrCl &lt; 15mL/min) or is not on dialysis.</li> </ul>
	Treatment and prevention of DVT or PE (in addition to the above)
	• Patient does not have a CrCl < 30mL/min or is not on dialysis
	• For patients with current DVT/PE, in addition to warfarin trial, patient must have documentation of 5 to 10 days of parenteral
	anticoagulation prior to initiation of dabigatran.
	The required trials may be overridden when documented evidence is provided that use of these agents would be medically
	contraindicated.
Dalfampridine	Prior authorization is required for dalfampridine (Ampyra <sup>™</sup> ). Payment will be considered under the following conditions:
(Ampyra <sup>TM</sup> )	1. For patients that have a gait disorder associated with MS.
	2. Initial authorizations will be approved for 12 weeks with a baseline Timed 25-foot Walk (T25FW) assessment.
	3. Additional prior authorizations will be considered at 6 month intervals after assessing the benefit to the patient as measured by a
Use Dalfampridine	20% improvement in the T25FW from baseline. Renewal will not be approved if the 20% improvement is not maintained.
$(Ampyra^{TM}) PA form$	Prior authorizations will not be considered for patients with a seizure diagnosis or in patients will moderate to severe renal impairment.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

#### Deferasirox (Exjade®)

Prior authorization is required for deferasirox. Payment will be considered under the following conditions:

- 1. Patient does not have a serum creatinine greater than 2 times the age-appropriate upper limit of normal or creatinine clearance < 40mL/min; and
- 2. Patient does not have a poor performance status; and
- 3. Patient does not have a high-risk myelodysplastic syndrome; and
- 4. Patient does not have advanced malignancies; and
- 5. Patient does not have a platelet count  $< 50 \times 10^9/L$ .

#### **Transfusional Iron Overload**

## **Initiation of Therapy**

- 1. Patient is 2 years of age or older; and
- 2. Patient has documentation of iron overload related to anemia (attach documentation); and
- 3. Patient has documentation of a recent history of frequent blood transfusions that has resulted in chronic iron overlaod; and
- 4. Serum ferritin is consistently > 1000 mcg/L (attach lab results dates within the past month); and
- 5. Starting dose does not exceed 20mg/kg/day. Calculate dose to the nearest whole tablet.
- 6. Initial requests will be considered for up to 3 months.

## Continuation of Therapy

- 1. Serum ferritin has been measured within 30 days of continuation of therapy request (attach documentation); and
- 2. Ferritin levels are > 500mcg/L; and
- 3. Dose does not exceed 40mg/kg/day.

#### Non-Transfusional Iron Overload

#### Initiation of Therapy

- 1. Patient is 10 years of age or older; and
- 2. Patient has documentation of iron overload related to anemia (attach documentation); and
- 3. Serum ferritin and liver iron concentration (LIC) has been measured within 30 days of initiation (attach lab results); and
- 4. Serum ferritin levels are > 300mcg/L; and
- 5. LIC are > 3mg Fe/g dw; and
- 6. Dose does not exceed 10mg/kg/day (if LIC is < 15mg Fe/g dw), or 20mg/kg/day (if LIC is > 15mg Fe/g dw).
- 7. Initial authorization will be considered for up to 6 months.

#### Continuation of Therapy

- 1. Serum ferritin and LIC have been measured within 30 days of continuation of therapy request; and
- 2. Serum ferritin levels are > 300mcg/L; and
- 3. LIC is > 3mg Fe/g dw; and
- 4. Dose does not exceed 10mg/kg/day (if LIC is 3 to 7 mg Fe/g dw) or 20mg/kg/day (if LIC is > 7mg Fe/g dw).

Use Deferasirox (Exjade®) PA form

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

	Updated 7/06/2015
Dextromethorphan and	Prior authorization is required for Nuedexta <sup>™</sup> . Payment will be considered under the following conditions:
Quinidine (Nuedexta <sup>™</sup> )	1. Patients must have a diagnosis of pseudobulbar affect (PBA) secondary to a neurological condition.
	2. A trial and therapy failure at a therapeutic dose with amitriptyline or an SSRI; and
	3. Patient has documentation of a current EKG (within the past 3 months) without QT prolongation.
	4. Initial authorizations will be approved for 12 weeks with a baseline Center for Neurologic Studies Lability Scale (CNS-LS) questionnaire.
Use Dextromethorphan and Quinidine	5. Subsequent prior authorizations will be considered at 6 month intervals with documented efficacy as seen in an improvement in the CNS-LS questionnaire.
(Nuedexta <sup>™</sup> ) PA form	The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Dornase Alfa	Prior authorization is required for Pulmozyme <sup>®</sup> . Payment will be authorized only for cases in which there is a diagnosis of cystic
(Pulmozyme®)	fibrosis.
-	
Use Miscellaneous PA	
form	
<b>Duloxetine</b> (Cymbalta®)	See Chronic Pain Syndromes Prior Authorization Criteria.
Use Chronic Pain	
Syndromes PA form	
Eplerenone	Prior authorization is required for Inspra®. Payment will be authorized only in cases where there is documented trial and therapy failure
(Inspra <sup>®</sup> )	on Aldactone® or documented cases of gynecomastia from Aldactone® therapy.
Use Miscellaneous PA	
form	
Erythropoiesis	Prior authorization is required for erythropoiesis stimulating agents prescribed for outpatients for the treatment of anemia. Payment for
<b>Stimulating Agents</b>	non-preferred erythropoiesis stimulating agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.
	Patients who meet all of the following criteria may receive prior authorization for the use of erythropoiesis stimulating agents:
	1. Hemoglobin less than 10g/dL. If renewal of prior authorization is being requested, a hemoglobin less than 11g/dL (or less than 10g/dL)
	for patients with Chronic Kidney Disease (CKD) not on dialysis) will be required for continued treatment. Hemoglobin laboratory values
	must be dated within four weeks of the prior authorization request.
	2. Transferrin saturation greater than or equal to 20 percent (transferrin saturation is calculated by dividing serum iron by the total iron
	binding capacity), ferritin levels greater than or equal to 100 mg/ml, or on concurrent therapeutic iron therapy. Transferrin saturation or
Use Erythropoesis	ferritin levels must be dated within three months of the prior authorization request.
Stimulating Agent PA	3. For HIV-infected patients, the endogenous serum erythropoietin level must be less than or equal to 500 mU/ml to initiate therapy.
form	4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.
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The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

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Extended Release	Payment for a non-preferred extended release formulation will be considered when the following criteria are met:
Formulations	1. Previous trial and therapy failure with the preferred immediate release product of the same chemical entity at a therapeutic dose
	that resulted in a partial response with a documented intolerance and
	2. Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the
	submitted diagnosis.
	The required trials may be overridden when documented evidence is provided that use of these agents would be medically
	contraindicated.
	Prior authorization is required for the following extended release formulation(s):
	Adoxa, Amrix, Augmentin XR, Cardura XL, Cipro XR, Coreg CR, Doryx, Flagyl ER, glipizide er, Glucotrol XL,
Use Extended Release	Keppra XR, Lamictal XR, Lescol XL, Luvox CR, metronidazole sr, Mirapex ER, Moxatag, Paxil CR, Prozac Weekly, Requip XL,
Formulations PA form	Ryzolt, Seroquel XR, Solodyn ER, Tegretol XR, tramadol sr, Ultram ER.
Febuxostat (Uloric®)	Prior authorization is required for febuxostat (Uloric®). Payment for febuxostat (Uloric®) will only be considered for cases in which
, ,	symptoms of gout still persist while currently using 300mg per day of a preferred allopurinol product unless documentation is provided
Use Febuxostat	that such a trial would be medically contraindicated.
(Uloric®) PA form	
Fentanyl, Short Acting	Prior authorization is required for short acting oral fentanyl products. Payment will be considered only if the diagnosis is for
Oral Products	breakthrough cancer pain in opioid tolerant patients. These products carry a <b>Black Box Warning</b> .
	Actiq <sup>®</sup> , Fentora <sup>®</sup> , & Onsolis <sup>™</sup> :
	Are indicated only for the management of breakthrough cancer pain in patients with malignancies already receiving and
Use Short Acting Oral	tolerant to opioid therapy for their underlying persistent cancer pain.
Fentanyl Products PA	Are contraindicated in the management of acute or postoperative pain. Because life-threatening hypoventilation could occur at
form	any dose in patients not taking chronic opiates, do not use in opioid non-tolerant patients.
Fifteen Day Initial	Designated drugs are limited to a fifteen day initial supply. These drugs are identified on the Fifteen Day Initial Prescription Supply
Prescription Supply	Limit list located on the website <a href="www.iowamedicaidpdl.com">www.iowamedicaidpdl.com</a> under the Preferred Drug Lists tab. Providers must submit a prior
Limit	authorization request for override consideration. Documentation of medical necessity, excluding patient convenience, is required for
	consideration of the fifteen day initial supply override.
Use Fifteen Day Initial	
Prescription Supply	
Limit	
PA form	

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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Granulocyte Colony	Prior authorization is required for therapy with granulocyte colony stimulating factor agents. Payment for non-preferred granulocyte
Stimulating Factor	colony stimulating factor agents will be authorized only for cases in which there is documentation of previous trial and therapy failure
Agents	with a preferred agent. Laboratory values for complete blood and platelet count must be obtained as directed by the manufacturer's
	instructions. Dosage reduction and discontinuation of therapy may be required based on the manufacturer's guidelines. Payment shall be
	authorized for one of the following uses:
	1. Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy.
	2. Treatment of neutropenia in patients with malignancies undergoing myeloablative chemotherapy followed by bone marrow
	transplant.
Use Granulocyte Colony	3. Mobilization of progenitor cells into the peripheral blood stream for leukapheresis collection to be used after myeloablative
Stimulating Factor PA	chemotherapy.
form	4. Treatment of congenital, cyclic, or idiopathic neutropenia in symptomatic patients.
Growth Hormone	Prior authorization is required for therapy with growth hormones. Payment for non-preferred growth hormones will be authorized only
Growen Hormone	for cases in which there is documentation of previous trial and therapy failure with a preferred agent. All of the following criteria must
	be met for approval for prescribing of growth hormones:
	1. Standard deviation of 2.0 or more below mean height for chronological age.
	2. No intracranial lesion or tumor diagnosed by MRI.
	3. Growth rate below five centimeters per year.
	4. Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter.
	5. Annual bone age testing is required for the diagnosis of Growth Hormone Deficiency. A Bone age 14 to 15 years or less in females
	and 15 to 16 years or less in males is required.
	6. Epiphyses open.
	Prior authorization will be granted for 12-month periods per patient as needed.
	The following EDA engroyed indications for Growth Hermone thereny are considered not medically necessary and requests will be
	The following FDA approved indications for Growth Hormone therapy are considered not medically necessary and requests will be
	denied: Idiopathic Short Stature (ISS).  If the request is for <b>7 subtine</b> (specifical control of the treatment of Short Boyel
	If the request is for <b>Zorbtive</b> <sup>®</sup> [somatropin (rDNA origin) for injection] approval will be granted for the treatment of Short Bowel
Use Growth Hormone	Syndrome in patients receiving specialized nutritional support. Zorbtive® therapy should be used in conjunction with optimal
PA form	management of Short Bowel Syndrome.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

# **Hepatitis C Treatments**

Prior authorization is required for hepatitis C treatments. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions:

- 1. Patient is 18 years of age or older and has a diagnosis of chronic hepatitis C; and
- 2. Patient has had testing for hepatitis C virus (HCV) genotype; and
- 3. Patient has an active HCV infection verified by a detectable viral load within 12 months of starting treatment; and
- 4. Viral load will be submitted by prescriber 12 weeks after completion of therapy; and
- 5. Patient has advanced liver disease corresponding to a Metavir score of 3 or greater fibrosis as confirmed by one of the the following:
  - Liver biopsy confirming Metavir score  $\geq$  F3; or
  - Transient elastography (FibroScan) score  $\geq 9.5$ kPa; or
  - FibroSURE (FibroTest) score  $\geq 0.58$ ; or
  - APRI score > 1.5; or
  - Radiological imaging consistent with cirrhosis (i.e. evidence of portal hypertension); or
  - Physical findings or clinical evidence consistent with cirrhosis; or
  - Patients at highest risk for severe complications: organ transplant, type 2 or 3 essential mixed cryoglobulinemia with endorgan manifestations (e.g. vasculitis), proteinuria, nephritic syndrome, or membranoproliferative glomerylonephritis.
- 6. Patient's prior treatment history is provided (treatment naïverelapse or treatment experienced); and
- 7. If patient has a history of non-compliance, documentation that steps have been taken to correct or address the causes of non-compliance are provided; and
- 8. Patient has abstained from the use of illicit drugs and alcohol for a minimum of three (3) months as evidenced by a negative urine confirmation test; and
- 9. Patient does not have severe renal impairment (creatinine clearance < 30ml/min) or end stage renal disease requiring hemodialysis; and
- 10. HCV treatment is prescribed by a digestive disease, liver disease, or infectious disease provider practice; and.
- 11. For patients on a regimen containing ribavirin, the following must be documented on the PA form:
  - a) Patient is not a pregnant female or male with a pregnant female partner; and
  - b) Women of childbearing potential and their male partners must use two forms of effective contraception during treatment and for at least 6 months after treatment has concluded; and
  - c) Monthly pregnancy tests will be performed during treatment; and
- 12. Prescriber has reviewed the patient's current medication list and acknowledged that there are no significant drug interactions with the HCV medication.
- 13. Documentation is provided for patients who are ineligible to receive interferon or ribavirin.
- 14. Non-FDA approved or non-compendia indicated combination therapy regimens will not be approved.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

	Opulated 7/00/2015
	15. If patient is recently eligible for Iowa Medicaid, and has been started and stabilized on therapy while covered under a different
	plan, documentation of how long the patient has been on medication will be required. Patient will be eligible for the remainder of
Use Hepatitis C	therapy needed, based on length of therapy for the particular treatment.
Treatments PA form	16. Lost or stolen medication replacement requests will not be authorized.
	17. The 72-hour emergency supply rule does not apply to oral hepatitis C antiviral agents.
Immunomodulators-	Prior authorization is required for topical immunomodulators. Payment for pimecrolimus (Elidel®) or tacrolimus (Protopic®) 0.03%
Topical	will be considered for non-immunocompromised patients two years of age and older and tacrolimus (Protopic®) 0.1% for patients 16
-	years of age and older when there is an adequate trial and therapy failure with two preferred topical corticosteroids. If criteria for
$Elidel^{ ext{ iny B}}$	coverage are met, requests will be approved for one tube per 90 days to ensure appropriate short-term and intermittent utilization of the
Protopic <sup>®</sup>	medication. Quantities will be limited to 30 grams for use on the face, neck, and groin, and 60 grams or 100 grams for all other areas.
-	The required trials may be overridden when documented evidence is provided that use of these agents would be medically
Use Immunomodulators-	contraindicated.
Topical PA form	
Insulin, Pre-Filled Pens	Prior authorization is required for pre-filled insulin pens. Prior authorization is granted when documentation indicates:
	The patient's visual or motor skills are impaired to such that they cannot accurately draw up their own insulin, and
	There is no caregiver available to provide assistance.
Use Pre-filled Insulin Pen	Patient does not reside in a long-term care facility.
PA form	Prior authorization for non-preferred insulin pens will be authorized only for cases in which there is documentation of previous trial
	and therapy failure with a preferred agent.
Isotretinoin (Oral)	Prior authorization is required for oral isotretinoin therapy. Payment will be approved for preferred oral isotretinoin products for acne
	under the following conditions:
	1. There are documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy. Documented trials and
	therapy failures of systemic antibiotic therapy and topical tretinoin therapy are not required for approval for treatment of acne
	conglobata.
	2. Patients and providers must be registered in, and meet all requirements of, the iPLEDGE (www.ipledgeprogram.com) risk
	management program.
	Payment for non-preferred oral isotretinoin products will be authorized only for cases in which there is documentation of trial(s) and
Use Oral Isotretinoin PA	therapy failure with a preferred agent(s). Initial authorization will be granted for up to 20 weeks. A minimum of two months without
	therapy is required to consider subsequent
form	15 1

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

Prior authorization is required for Kalydeco" (ivacaftor). Payment will be considered for patients when the following criteria are met:  1. Patient is 6 years of age or older; and 2. Has a diagnosis of cystic fibrosis with one of the following mutations in the CFTR gener: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, and S549R as detected by a FDA-cleared CF mutation test; and 3. Prescriber is a CF specialist or pulmonologist; and 4. Patient does not have one of the following infections: Burkholderia cenocepacia, Burkholderia dolosa, or Mycobacterium abcessus.  Prior authorization is required for Janus kinase (JAK) inhibitors. Payment will be considered when the following conditions are met: 1. The patient is 18 years of age or older: and 2. Has a diagnosis of moderate to severe rheumatoid arthritis; and 3. Has a documented trial and inadequate response to two preferred oral disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxychloroquine, sulfasalazine, leflunomide, or minocycline); and 4. Has a documented trial and inadequate response to two preferred biological DMARDs or potent immunosuppressants (azathiorpine or cyclosporine); and 4. Has a been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and 5. The patient is not using or planning to use tofacitinib in combination with biological DMARDs or potent immunosuppressants (azathiorpine or cyclosporine); and 6. Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and 7. Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to the manufacturer labeling; and 8. Patient does not have a history of malignancy, except for those successfully treated for non-melanoma skin cancer (NMSC); and 9. Patient is not at an increased risk of gas		Updated 7/06/2015
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G\$51S, \$1251N, \$125SP, \$549N, and \$549R as detected by a FDA-cleared CF mutation test; and 3. Prescriber is a CF specialist or pulmonologist; and 4. Patient does not have one of the following infections: Burkholderia cenocepacia, Burkholderia dolosa, or Mycobacterium abcessus.  Prior authorization is required for Janus kinase (JAK) inhibitors. Payment will be considered when the following conditions are met: 1. The patient is 18 years of age or older: and 2. Has a diagnosis of moderate to severe rheumatoid arthritis; and 3. Has a documented trial and inadequate response to two preferred oral DMARD (hydroxychloroquine, sulfasalazine, leflunomide, or minocycline); and 4. Has a documented trial and inadequate response to two preferred biological DMARDs; and 5. The patient is not using or planning to use tofacitinib in combination with biologic DMARDs or potent immunosuppressants (azathiorpine or cyclosporine); and 6. Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and 7. Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to the manufacturer labeling; and 8. Patient does not have a history of malignancy, except for those successfully treated for non-melanoma skin cancer (NMSC); and 9. Patient is not at an increased risk of gastrointestinal perforation.  The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.  Retorolac  Retorolac diverse as Black Box Warning. Initiate therapy with IV/IM and use oral ketorolac tromethamine only as a continuation therapy to ketorolac tromethamine IV/IM. The combined duration of use of IV/IM and oral is not to exceed five (5) days. Payment will be considered under the following conditions:  1. For oral therapy, documentation of recent IM/IV ketorolac tromethamine injection including administration date and time, and the total number of inject		
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Janus Kinase Inhibitors  4. Patient does not have one of the following infections: Burkholderia cenocepacia, Burkholderia dolosa, or Mycobacterium abcessus.  Prior authorization is required for Janus kinase (JAK) inhibitors. Payment will be considered when the following conditions are met:  1. The patient is 18 years of age or older: and 2. Has a diagnosis of moderate to severe rheumatoid arthritis; and 3. Has a documented trial and inadequate response to two preferred oral disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxychloroquine, sulfasalazine, leflunomide, or minocycline); and 4. Has a documented trial and inadequate response to two preferred biological DMARDs; and 5. The patient is not using or planning to use tofacitinib in combination with biologic DMARDs or potent immunosuppressants (azathiorpine or cyclosporine); and 6. Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and 7. Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to the manufacturer labeling; and 8. Patient does not have a history of malignancy, except for those successfully treated for non-melanoma skin cancer (NMSC); and 9. Patient is not at an increased risk of gastrointestinal perforation.  The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.  Ketorolac  Ketorolac  Ketorolac minor of moderately severe, acute pain. It is NOT indicated for minor or chronic conditions.  This product carries a Black Box Warning, Initiate therapy with IV/IM and use oral ketorolac tromethamine only as a continuation therapy to ketorolac tromethamine IV/IM. The combined duration of use of IV/IM and oral is not to exceed five (5) days. Payment will be considered under the following conditions:  1. For oral therapy, d		G551S, S1251N, S1255P, S549N, and S549R as detected by a FDA-cleared CF mutation test; and
Prior authorization is required for Janus kinase (JAK) inhibitors. Payment will be considered when the following conditions are met: 1. The patient is 18 years of age or older; and 2. Has a diagnosis of moderate to severe rheumatoid arthritis; and 3. Has a documented trial and inadequate response to two preferred oral disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxychloroquine, sulfasalazine, leflunomide, or minocycline); and 4. Has a documented trial and inadequate response to two preferred biological DMARDs; and 5. The patient is not using or planning to use tofacitinib in combination with biologic DMARDs or potent immunosuppressants (azathiorpine or cyclosporine); and 6. Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and 7. Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to the manufacturer labeling; and 8. Patient does not have a history of malignancy, except for those successfully treated for non-melanoma skin cancer (NMSC); and 9. Patient is not at an increased risk of gastrointestinal perforation. The required trials may be overridded when documented evidence is provided that the use of these agents would be medically contraindicated.  Ketorolac  Ketorolac  Ketorolac prior authorization is required for ketorolac tromethamine, a nonsteroidal anti-inflammatory drug indicated for short term (up to five days) management of moderately severe, acute pain. It is NOT indicated for minor or chronic conditions.  This product carries a Black Box Warning. Initiate therapy with IV/IM and use oral ketorolac tromethamine only as a continuation therapy to ketorolac tromethamine IV/IM. The combined duration of use of IV/IM and oral is not to exceed five (5) days. Payment will be considered under the following conditions:  1. For oral therapy, documentation		3. Prescriber is a CF specialist or pulmonologist; and
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2. Has a diagnosis of moderate to severe rheumatoid arthritis; and 3. Has a documented trial and inadequate response to two preferred oral disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxychloroquine, sulfasalazine, leflunomide, or minocycline); and 4. Has a documented trial and inadequate response to two preferred biological DMARDs; and 5. The patient is not using or planning to use tofacitinib in combination with biologic DMARDs or potent immunosuppressants (azathiorpine or cyclosporine); and 6. Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and 7. Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to the manufacturer labeling; and 8. Patient does not have a history of malignancy, except for those successfully treated for non-melanoma skin cancer (NMSC); and 9. Patient is not at an increased risk of gastrointestinal perforation.  The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.  Retorolac  Retorolac  Retorolac  Prior authorization is required for ketorolac tromethamine, a nonsteroidal anti-inflammatory drug indicated for short term (up to five days) management of moderately severe, acute pain. It is NOT indicated for minor or chronic conditions.  This product carries a Black Box Warning. Initiate therapy with IV/IM and use oral ketorolac tromethamine only as a continuation therapy to ketorolac tromethamine IV/IM. The combined duration of use of IV/IM and oral is not to exceed five (5) days. Payment will be considered under the following conditions:  1. For oral therapy, documentation of recent IM/IV ketorolac tromethamine injection including administration date and time, and the total number of injections given.  2. Request falls within the manufacturer's dosin	Janus Kinase Inhibitors	
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		3. Diagnosis indicating moderately severe, acute pain.
Use Ketorolac PA form steroidal anti-inflammatory drugs at therapeutic doses.		Requests for IV/IM and intranasal ketorolac must document previous trials and therapy failures with at least two preferred non-
	Use Ketorolac PA form	steroidal anti-inflammatory drugs at therapeutic doses.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Lidocaine Patch (Lidoderm®)  Use Lidocaine Patch	Prior authorization is required for topical lidocaine patches (Lidoderm <sup>®</sup> ). Payment will be considered for a diagnosis of pain associated with post-herpetic neuralgia following a previous treatment failure with a preferred agent at therapeutic dose from two of the following: tricyclic antidepressant, opioid, gabapentin, carbamazepine, or valproic acid. A maximum of 30 patches may be dispensed with the initial prescription to determine efficacy.
(Lidoderm®) PA form	with the fillian prescription to determine efficacy.
Linezolid (Zyvox®)	Prior authorization is required for Zyvox®. Payment for Zyvox® will be authorized when there is documentation that:  1. Prescriber is an infectious disease (ID) physician or has consulted ID physician (Telephone consultation is acceptable).  2. Patient has an active infection and meets one of the following diagnostic criteria:  • Vancomycin-resistant Enterococcus (VRE) and no alternatice regimens with documented efficacy are available and VRE is not in lower urinary tract**.
	<ul> <li>Methicillin-resistant Staph aureus (MRSA) and patient is intolerant to vancomycin*</li> <li>Methicillin-resistant Staph epidermis (MRSE) and patient is intolerant to vancomycin*</li> <li>*Severe intolerance to vancomycin is defined as:         <ul> <li>Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration</li> <li>Red-man's syndrome (histamine-mediated), refractory to traditional counter measures (e.g., prolonged IV infusion,</li> </ul> </li> </ul>
Use Zyvox® PA form	premedicated with diphenhydramine)  **VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe renal insufficiency exists and/or patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.
Long-Acting Narcotics	Prior authorization is required for all non-preferred long-acting narcotics. Payment will be considered under the following conditions:  1. There is documentation of previous trials and therapy failures with two (2) chemically distinct preferred long-acting narcotics (such as extended-release morphine sulfate, Opana ER and methadone) at therapeutic doses, and  2. A trial and therapy failure with fentanyl patch at maximum tolerated doses, and  3. A signed chronic opioid therapy management plan between the prescriber and patient must be included with the prior authorization,
Use Long-Acting Narcotics PA form	and 4. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website at <a href="https://pmp.iowa.gov/IAPMPWebCenter/">https://pmp.iowa.gov/IAPMPWebCenter/</a> prior to requesting prior authorization. 5. Requests for long-acting narcotics will only be considered for FDA approved dosing. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

1	Opuated 7/00/2013
Methotrexate Injection	Prior authorization is required for non-preferred methotrexate injection. Payment will be considered under the following conditions:
TM	1. Diagnosis of severe, active rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (pJIA) and ALL of the following:
Otrexup <sup>™</sup>	a. Prescribed by a rheumatologist; and
	b. Patient has a documented trial and intolerance with oral methotrexate; and
	c. Patient has a documented trial and therapy failure or intolerance with at least one other non-biologic DMARD
	(hydroxychloroquine, leflunomide, minocycline or sulfasalazine); and
	d. Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate
	injection and there is no caregiver available to provide assistance; and
	e. Patient does not reside in a long-term care facility.
	2. Diagnosis of severe, recalcitrant, disabling psoriasis and ALL of the following:
	a. Patient is 18 years of age or older; and
	b. Prescribed by a dermatologist; and
	c. Patient has documentation of an inadequate response to all other standard therapies (oral methotrexate, topical corticosteroids,
	vitamin D analogues, cyclosporine, systemic retinoids, tazarotene, and phototherapy).
	d. Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate
	injection and there is no caregiver available to provide assistance; and
Use Methotrexate	e. Patient does not reside in a long-term care facility.
Injection PA form	The required trials may be overridden when documented evidence is provided that the use of these agents would be medically
	contraindicated.
Mifepristone (Korlym®)	Prior authorization is required for mifepristone (Korlym <sup>®</sup> ). Payment will be considered for patients when the following is met:
	1. The patient is 18 years of age or older: and
	2. Has a diagnosis of endogenous Cushing's Syndrome with hyperglycemia secondary to hypercortisolism in patients with
	Type 2 Diabetes or glucose intolerance: and
	3. Patient must have failed surgery or is not a candidate for surgery: and
17 14°C	4. Prescriber is an endocrinologist: and
Use Mifepristone	5. Female patients of reproductive age must have a negative pregnancy test confirmed within the last 7 days and must use a non-
(Korlym) PA form	hormonal method of contraception during treatment and for one month after stopping treatment.
Milnacipran (Savella)	See Chronic Pain Syndromes Prior Authorization Criteria.
Use Chronic Pain	
Syndromes PA form	

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

Modified Formulations	Payment for a non-preferred isomer, prodrug, or metabolite will be considered when the following criteria are met:
	1. Previous trial with a preferred parent drug of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance and
	2. Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis if available.
	The required trials may be overridden when documented evidence is provided that use of these preferred agent(s) would be medically contraindicated.
Use Modified Formulations PA form	Prior authorization is required for the following modified dosage forms: Abilify Discmelt, , Aricept ODT, FazaClo, Invega, Metozolv ODT, Risperdal M-Tab, Suboxone Film, Trilipix, Xopenex, Zyprexa Zydis.
Multiple Sclerosis	Prior authorization is required for fingolimod (Gilenya <sup>™</sup> ), teriflunomide (Aubagio <sup>®</sup> ), or dimethyl fumarate (Tecfidera <sup>™</sup> ). Payment will
Agents-Oral	be considered for patients 18 years of age and older under the following conditions:
	1. A diagnosis of relapsing forms of multiple sclerosis; and
	2. A previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis.
	The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
	For patients initiating therapy with fingolimod (Gilenya <sup>™</sup> ), documentation of the following must be provided:
	<ul> <li>Patient does not have a recent (within past 6 months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization or Class Ill/IV heart failure.</li> <li>Patient does not have a history or presence of Mobitz Type Il 2<sup>nd</sup> degree or 3<sup>rd</sup> degree AV block or sick sinus</li> </ul>
	syndrome, unless the patient has a pacemaker.
	<ul> <li>Patient does not have a baseline QTc interval ≥ 500ms.</li> </ul>
	Patient is not being treated with Class la or Class Ill anti-arrythmic drugs.
	For patients initiating therapy with teriflunomide (Aubagio®), documentation of the following must be provided:
	Patient does not have severe hepatic impairment.
	<ul> <li>A negative pregnancy test for females of childbearing age.</li> </ul>
	<ul> <li>Use of a reliable form of contraception for females of childbearing age.</li> </ul>
	Patient is not taking leflunomide.
	For patients initiating therapy with dimethyl fumarate (Tecfidera <sup>™</sup> ), documentation of the following must be provided:
	Patient does not have a low lymphocyte count as documented by a recent (within 6 months) CBC prior to initiating
Han Multiple Colons :	therapy.
Use Multiple Sclerosis	Upon renewal, documentation of an updated CBC.
Agents-Oral PA form	1

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

	<u> </u>
Muscle Relaxants	Prior authorization is required for non-preferred muscle relaxants. Payment for non-preferred muscle relaxants will be authorized only for cases in which there is documentation of previous trials and therapy failures with at least three preferred muscle relaxants. Requests for carisoprodol will be approved for a maximum of 120 tablets per 180 days at a maximum dose of 4 tablets per day when the criteria for coverage are met. * If a non-preferred long-acting medication is requested, one trial must include the preferred immediate release
Use Muscle Relaxant PA form	product of the same chemical entity at a therapeutic dose, unless evidence is provided that use of these products would be medically contraindicated.
Narcotic Agonist- Antagonist Nasal Sprays	Prior authorization is required for narcotic agonist-antagonist nasal sprays. For consideration, the diagnosis must be supplied. If the use is for the treatment of migraine headaches, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications must be provided. There must also be documented treatment failure or contraindication to triptans for the acute treatment of migraines. For other pain conditions, there must be documentation of treatment failure or contraindication to oral administration.
Use Narcotic Agonist/Antagonist Nasal Spray PA form	Payment for non-preferred narcotic agonist-antagonist nasal sprays will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.  Quantities are limited to 2 bottles or 5 milliliters per 30 days. Payment for narcotic agonist-antagonist nasal sprays beyond this limit will be considered on an individual basis after review of submitted documentation.
Nebivolol (Bystolic®)  Use Nebivolol (Bystolic®) PA form	Prior authorization is required for Bystolic <sup>®</sup> . Payment will be considered in cases where there are documented trials and therapy failures with two preferred cardio-selective beta-blockers of a different chemical entity at a therapeutic dose. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

	Spanica 1/00/2015
Nicotine Replacement	Prior Authorization is required for over-the-counter nicotine replacement patches, gum, or lozenges, and prescription nicotine nasal
Therapy	spray or inhaler. Requests for authorization must include:
	1) Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling.
	2) Confirmation of enrollment in the Quitline Iowa counseling program is required for approval. Continuation therapy is
	available only with documentation of ongoing participation in the Quitline Iowa program.
	3) Approvals will only be granted for patients eighteen years of age and older.
	4) The maximum allowed duration of therapy is twelve weeks total combined therapy within a twelve-month period.
	5) Patients may receive nicotine replacement patches in combination with one of the oral nicotine replacement products
	(gum or lozenges). A maximum quantity of 14 nicotine replacement patches and 110 pieces of nicotine gum or 144
	nicotine lozenges may be dispensed with the initial prescription. Subsequent prescription refills will be allowed to be
	dispensed as a 4 week supply at one unit per day of nicotine replacement patches and 330 pieces of nicotine gum or 288
	nicotine lozenges.
	6) Requests for non-preferred nicotine replacement products will be considered after documentation of previous trials and
	intolerance with a preferred oral and preferred topical nicotine replacement product. A maximum quantity of 168 nicotine
Use Nicotine Replacement	inhalers or 40ml nicotine nasal spray may be dispensed with the initial prescription. Subsequent prescription refills will
Therapy PA form	be allowed to be dispensed as a 4 week supply at 336 nicotine inhalers or 80ml of nicotine nasal spray.
	7) The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation.
Non-Parenteral	Prior authorization is required for non-parenteral vasopressin derivatives of posterior pituitary hormone products. Payment for
Vasopressin Derivatives	preferred non-parenteral vasopressin derivatives of posterior pituitary hormone products will be authorized for the following
of Posterior Pituitary	diagnoses:
Hormone Products	1. Diabetes Insipidus.
	2. Hemophilia A.
Use Non-Parenteral	3. Von Willebrand's disease.
Vasopressin Deriv. of	Payment for oral vasopressin derivatives of posterior pituitary hormone products used in the treatment of primary nocturnal enuresis
Posterior Pituitary	will be authorized for patients who are six years of age or older for periods of six months. Approvals will be granted for subsequent
Hormone Products PA	six-month periods only after a drug-free interval to assess the need for continued therapy. Payment for non-preferred non-parenteral
form	vasopressin derivatives will be authorized only for cases in which there is documentation of trial and therapy failure with the preferred
	agent.
Non-Preferred Drug	Prior authorization is required for non-preferred drugs as specified on the Iowa Medicaid Preferred Drug List. Payment for a non-
	preferred medication will be authorized only for cases in which there is documentation of previous trial and therapy failure with the
Use Non-Preferred Drug	preferred agent, unless evidence is provided that use of these agents would be medically contraindicated.
PA form	

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Nonsteroidal Anti- inflammatory Drugs	Prior authorization is required for all non-preferred nonsteroidal anti-inflammatory drugs (nsaids) and COX-2 inhibitors. Prior authorization is not required for preferred nonsteroidal anti-inflammatory drugs or COX-2 inhibitors.  1. Requests for a non-preferred nsaid must document previous trials and therapy failures with at least three preferred nsaids.
	<ol> <li>Requests for a non-preferred issaid must document previous trials and therapy failures with at least three preferred issaids.</li> <li>Requests for a non-preferred COX-2 inhibitor must document previous trials and therapy failures with three preferred issaids, two of which must be a preferred COX-2 preferentially selective issaid.</li> </ol>
	3. Requests for a non-preferred topical nsaid must document previous trials and therapy failures with three preferred nsaids. The trials must include two preferred COX-2 preferentially selective nsaids and the oral drug of the same chemical entity. In addition, the use of a topical delivery system must be deemed medically necessary.
Use Non-Steroidal Anti-	4. Requests for a non-preferred extended release nsaid must document previous trials and therapy failures with three preferred nsaids, one of which must be the preferred immediate release nsaid of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance.
inflammatory Drug PA form	The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

# Omalizumab (Xolair®)

Prior authorization is required for Xolair<sup>®</sup>. Payment for Xolair<sup>®</sup> will be authorized when the following criteria are met:

#### Moderate to Severe Persistent Asthma

- 1. Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and
- 2. Patient is 12 years of age or older; and
- 3. Pretreatment IgE level is between 30 IU/mL and 700 IU/mL; and
- 4. Patient's weight is between 30 kg and 150 kg; and
- 5. History of positive skin or RAST test to a perennial aeroallergen; and
- 6. Prescriber is an allergist, immunologist, or pulmonologist; and
- 7. Patient is currently using a high dose inhaled corticosteroid AND long-acting beta-agonist, is compliant with therapy and asthma symptoms are not adequately controlled after at least three (3) months of therapy.
- 8. Patient must have access to an EpiPen to treat allergic reactions that may occur after administration of Xolair<sup>®</sup>.

If the criteria for coverage are met, the initial authorization will be given for 16 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to Xolair® therapy and for patients who do not continue concurrent use with a high dose corticosteroid and long-acting beta-agonist.

#### Chronic Idiopathic Urticaria

- 1. Patient has a diagnosis of moderate to severe chronic idiopathic urticaria; and
- 2. Patient is 12 years of age or older; and
- 3. Patient has documentation of a trial and therapy failure with at least one second-generation antihistamine, one of which must be cetirizine at a dose up to 20mg per day; and
- 4. Patient has documentation of a trial and therapy failure with at least one first-generation antihistamine; and
- 5. Patient has documentation of a trial and therapy failure with at least one potent H1 receptor antagonist (hydroxyzine and/or doxepin) and:
- 6. Patient has documentation of a trial and therapy failure with a preferred leukotriene receptor antagonist in combination with a first- or second- generation antihistamine.

If criteria for coverage are met, the initial authorization will be given for 12 weeks to assess the need for continued therapy.

# Use Xolair® PA form

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

# Oral Constipation Agents

Prior authorization is required for lubiprostone (Amitiza<sup>®</sup>) and linaclotide (Linzess<sup>™</sup>). Payment will be considered under the following conditions:

- 1. Patient is 18 years of age or older; and
- 2. Patient must have documentation of adequate trials and therapy failures with at least one medication from each of the following categories:
  - a. Saline laxative (milk of magnesia); and
  - b. Osmotic laxative (polyethylene glycol or lactulose); and
  - c. Stimulant laxative (senna); and
- 3. Patient does not have a known or suspected mechanical gastrointestinal obstruction; and
- 4. Patient has one of the following diagnoses:
  - a. A diagnosis of chronic idiopathic constipation (Amitiza® or Linzess™)
    - i. Patient has less than 3 spontaneous bowel movements (SBMs) per week; and
    - ii. Patient has two or more of the following symptoms within the last 3 months:
      - 1. Straining during at least 25% of bowel movements;
      - 2. Lumpy or hard stools for at least 25% of bowel movements; and
      - 3. Sensation of incomplete evacuation for at least 25% of bowel movements; and
    - iii. Documentation the patient is not currently taking constipation causing therapies
  - b. A diagnosis of irritable bowel syndrome with constipation (Amitiza<sup>®</sup> or Linzess<sup>™</sup>)
    - i. Patient is female (Amitiza® only); and
    - ii. Patient has abdominal pain or discomfort at least 3 days per month in the last 3 months associated with two (2) or more of the following:
      - 1. Improvement with defecation;
      - 2. Onset associated with a change in stool frequency; and/or
      - 3. Onset associated with a change in stool form
  - c. A diagnosis of opioid-induced constipation with chronic, non-cancer pain (Amitiza®)
    - i. Patient has been receiving stable opioid therapy for at least 30 days as seen in the patient's pharmacy claims; and
    - ii. Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following:
      - 1. hard to very hard stool consistency;
      - 2. Moderate to very severe straining; and/or
      - 3. Having a sensation of incomplete evacuation

If the criteria for coverage are met, initial authorization will be given for 12 weeks to assess the response to treatment. Requests for continuation of therapy may be provided if prescriber documents adequate response to treatment.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

Oral Immunotherapy	Prior authorization is required for sublingual allergen immunotherapy. Payment will be considered under the following conditions:
	1. Medication is prescribed in consultation with an allergist; and
Grastek®	2. Patient is diagnosed with pollen-induced allergic rhinitis with or without conjunctivitis; and
Ragwitek <sup>®</sup>	3. Patient has documented trials and therapy failures with allergen avoidance and pharmacotherapy (intranasal conrticosteroids and
	antihistamines); and
	4. Patient has a documented intolerance to immunotherapy injections; and
	5. The first dose has been administered under the supervision of a health care provider to observe for allergic reactions (date of
	administration and response required prior to consideration).
	6. If patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT), treatment of allergic rhinitis with
	sublingual allergen immunotherapy (SLIT) will not be approved.
	Short Ragweed Pollen (Ragwitek®) In addition to the above criteria being met:
	Patient is 18 through 65 years of age; and
	• Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to short ragweed pollen.
	• If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of ragweed pollen
	season and continued throughout the season.
	Grass Pollen (Grastek® and Oralair®) In addition to the above criteria being met:
	<u>Oralair®</u>
	• Patient is 10 through 65 years of age; and
Use Oral Immunotherapy	• Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to sweet vernal, orchard/cocksfoot, perennial
PA form	rye, timothy, and Kentucky blue/June grass.
	• If criteria for coverage are met, authorization will be considered at least 4 months prior to the expected onset of each grass
	pollen season and continued throughout the grass pollen season.
	Grastek®
	Patient is 5 through 65 years of age; and
	Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses    Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses)    Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses)    Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses)    Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses)    Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses)    Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses)    Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses)    Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses)    Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses)    Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grasses (pollen-specific IgE antibodies)    Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grasses (pollen-specific IgE antibodies)    Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grasses (pollen-specific IgE antibodies)   Patient IgE antibodies (pollen-specific IgE anti
	such as sweet vernal, orchard/cocksfoot, perennial rye, Kentucky blue/June, meadow fescue, and redtop).
	• If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of each grass
	pollen season.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

## Palivizumab (Synagis<sup>®</sup>)

Respiratory Syncytial Virus (RSV) Season is defined by the centers for disease control and prevention of the United States department of health and human services and described in the RSV surveillance reports published annually in the Morbidity and Mortality Weekly Report (MMWR) and available at http://www.cdc.gov/surveillance/nrevss/rsv/reports.html.

- Medicaid will use virology data provided by the Iowa department of public health (IDPH) to prospectively estimate the start of the RSV season and follow the virology data to the end of the season.
- Medicaid will provide coverage of prescription drugs that protect against RSV consistent with the current American Academy of Pediatrics (AAP) Guidelines for Infants and Children at Risk for Severe Illness due to RSV Infection.
- The start date will begin two weeks prior to the expected season start date for the state of Iowa. The start date will be adjusted to an earlier date by Medicaid if indicated by the virological data. The expected season start date shall be derived from the median start date of the past 5 seasons using Iowa virological data.

Prior authorization is required for therapy with palivizumab. Prior authorizations will be approved for administration during the RSV season for a maximum of five doses per patient. No allowances will be made for a sixth dose. Patients, who experience a breakthrough RSV hospitalization, should have their monthly prophylaxis discontinued, as there is an extremely low likelihood of a second RSV hospitalization in the same season. Payment for palivizumab will be considered for patients who meet one of the following criteria: Chronic Lung Disease (CLD) of Prematurity

- Patient is less than 12 months of age at start of therapy and has CLD of prematurity (defined as gestational age less than 32 weeks and required greater than 21% oxygen for at least the first 28 days after birth).
- Requests for patients during their second year of life (12 months to < 24 months) will be considered for patients meeting the CLD of prematurity definition above and continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the start of the second RSV season.

# Prematurity (without CLD of Prematurity or Congenital Heart Disease)

• Patient is less than 12 months of age at start of therapy with a gestational age of less than 29 weeks.

#### Neuromuscular Disorders or Anatomic Pulmonary Abnormalities

• Patient is 12 months of age or younger at the start of therapy and has either severe neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway due to an ineffective cough.

# Hemodynamically Significant Congenital Heart Disease (CHD)

• Patient is less than 12 months of age at start of therapy and has hemodynamically significant CHD further defined by any of the following: Acyanotic heart disease receiving medication to control congestive heart failure and will require cardiac surgical procedures, moderate to severe pulmonary hypertension, or cyanotic heart defects with documentation of consultation with a pediatric cardiologist that recommends palivizumab prophylaxis.

## Use Palivizumab PA form

#### Immunocompromised Children

• Patient is less than 24 months of age at start of therapy and is profoundly immunocompromised during the RSV season (e.g., severe combined immunodeficiency, advanced acquired immunodeficiency syndrome, receiving chemotherapy).

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

Pregabalin	See Chronic Pain Syndromes Prior Authorization Criteria.
(Lyrica <sup>®</sup> )	
Use Chronic Pain	
Syndromes PA form	
Proton Pump Inhibitors	Prior authorization is not required for preferred proton pump inhibitors (PPI) for doses within the established quantity limits of one unit per day.
	Requests for PPIs exceeding one unit per day for a diagnosis of gastroesophageal reflux disease will be considered after documentation of a therapeutic trial and therapy failure with concomitant use of once daily PPI dosing and a bedtime dose of a histamine H2-receptor antagonist. Upon failure of the combination therapy, subsequent requests for PPIs exceeding one unit per day will be considered on a short term basis (up to 3 months). After the three month period, a retrial of the recommended once daily dosing will be required on an annual basis for those patients continuing to need doses beyond one unit per day.
	Requests for twice daily dosing for a diagnosis of Helicobacter pylori will be considered for up to 14 days of treatment with documentation of active infection.
Use Proton Pump	
Inhibitor PA form	Payment for a non-preferred proton pump inhibitor will be authorized only for cases in which there is documentation of previous trials and therapy failures with three preferred products.
Pulmonary Arterial	Prior Authorization is required for agents used to treat pulmonary hypertension. Payment will be approved under the following
Hypertension Agents	conditions:
	1. Diagnosis of pulmonary arterial hypertension
Use Pulmonary Arterial	
Hypertension Agents PA	
form	
Quantity Limit Override	Designated drugs are limited to specific quantity limitations. These drugs are identified on the Iowa Medicaid Quantity Limit Chart posted on the website <a href="https://www.iowamedicaidpdl.com">www.iowamedicaidpdl.com</a> under the Billing/Quantity Limits tab. Providers should submit a Prior
Use Quantity Limit	Authorization request for override consideration.
Override PA form	
Repository	Prior authorization is required for repository corticotropin injection. Payment will be considered under the following conditions:
Corticotropin Injection	1. Patient is under two years of age and
(H.P. Acthar Gel)	2. Patient has a diagnosis of infantile spasms.
Use Repository	Treatment of compendia indicated steroid-responsive conditions will only be considered upon documented contraindications or
Corticotropin Injection	intolerance to corticosteroids not expected to occur with the use of repository corticotropin injection.
(H.P. Acthar Gel) PA	If criteria for coverage are met, authorization will be provided for up to 30 days of treatment for all indications.
form	

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

#### Rivaroxaban (Xarelto®)

Prior authorization is required for rivaroxaban (Xarelto<sup>®</sup>). Payment will be considered under the following conditions:

- 1. Patient is 18 years of age or older; and
- 2. Patient does not have a mechanical prosthetic heart valve; and
- 3. Patient does not have active bleeding; and
- 4. Patient is not pregnant; and
- 5. Patient does not have severe renal impairment (CrCl < 15mL/min).

#### Atrial Fibrillation

- Patient has a diagnosis of non-valvular atrial fibrillation; and
- Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum 6 month trial); and
- Presence of at least one additional risk factor for stroke, with a CHADS<sub>2</sub> score  $\geq 1$ .
- For a CrCl > 50mL/min a dose of 20mg once daily will be considered; or
- For a CrCl 15 to 50mL/min a dose of 15mg once daily will be considered.

#### Treatment and Prevention of DVT or PE

- Documentation of a previous trial and therapy failure with warfarin (recurrent DVT, recurrent PE, TIA, stroke, or inability to maintain a therapeutic INR with a minimum 6 month trial); and
- Patient does not have a CrCl < 30mL/min; and
- Patient does not have significant liver disease (hepatitis or cirrhosis).
- For treatment of acute DVT or PE a dose of 15mg twice daily for 21 days followed by 20mg once daily for remaining treatment will be considered: or
- For prevention of DVT or PE a dose of 20mg once daily will be considered.

# Prophylaxis of DVT following Hip or Knee Replacement

- Patient does not have a CrCl < 30mL/min; and
- Patient does not have significant liver disease (hepatitis or cirrhosis); and
- For patients undergoing hip replacement, patient is not undergoing staged bilateral total hip replacement
- Requests will be approved for the following dosing:
  - o Hip replacement: 10mg daily for up to 35 days following hip replacement; or
  - o Knee replacement: 10mg daily for up to 12 days following knee replacement.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

#### <u>Use Rivaroxaban</u> (Xarelto<sup>®</sup>) PA form

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

	Opuated 7/00/2015
Roflumilast (Daliresp <sup>™</sup> )	Prior authorization is required for roflumilast (Daliresp <sup>™</sup> ). Payment will be considered for patients 18 years of age or older when the
	following is met:
	1. A diagnosis of severe COPD with chronic bronchitis as documented by spirometry results, and
	2. A smoking history of ≥ 20 pack-years, and
	3. Currently on a long-acting bronchodilator in combination with an inhaled corticosteroid with documentation of inadequate control of symptoms, and
Use Roflumilast	4. A history of at least one exacerbation in the past year requiring treatment with oral glucocorticosteroids.
$(Daliresp^{TM}) PA form$	The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Sedative/Hypnotics-Non- Benzodiazepine	Preferred agents are available without prior authorization (PA) when dosed within the established quantity limits. Requests for doses above the manufacturer recommended dose will not be considered.
-	Prior authorization is required for all non-preferred non-benzodiazepine sedative/hypnotics. Payment for non-preferred non-benzodiazepine sedative/hypnotics will be authorized only for cases in which there is documentation of previous trials and therapy failures with, at a minimum, three (3) preferred agents. Payment for non-preferred non-benzodiazepine sedative/hypnotics will be
	considered when the following criteria are met:
	1) A diagnosis of insomnia; and
	2) Medications with a side effect of insomnia (i.e. stimulants) are decreased in dose, changed to a short acting product, and/or discontinued; and
	3) Enforcement of good sleep hygiene is documented; and
	4) All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses.
	5) In addition to the above criteria, requests for suvorexant (Belsomra) will require documentation of a trial and therapy failure with at least one non-preferred agent, other than suvorexant, prior to consideration of coverage.
Use Sedative/Hypnotics-	6) Non-preferred alternative delivery systems will only be considered for cases in which the use of the alternative delivery
Non-Benzodiazepine PA form	system is medically necessary and there is a previous trial and therapy failure with a preferred alternative delivery system if available.
	The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
	1

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

	Opanica 1700/2013
Selected Brand Name	Prior authorization is required for selected brand-name drugs, as determined by the Department, for which there is available an "A"
Drugs	rated bioequivalent generic product as determined by the Federal Food and Drug Administration, unless the brand drug has been
	designated by the Department as preferred (payable) under the Iowa Medicaid Preferred Drug List (PDL). For prior authorization to be
	considered, the prescriber must submit a completed Selected Brand Name PA form and Iowa Medicaid MedWatch form with:
	1. Documentation of trials and therapy failures with two different generic manufacturers of the same chemical entity. If an allergy to an
	inactive component is suspected, the second trial must be with a generic product that does not contain the allergen, if available.
	2. Documentation of the failure must include the specific adverse reaction as defined by the FDA (See Section B of the MedWatch
Use Selected Brand Name	form). Intolerances, such as nausea or vomiting, to the generic drug will not be considered as a basis for approval.
PA forms	Trials may be overridden when evidence is provided that use of the generic product would be medically contraindicated.
Serotonin 5-HT1-	Prior authorization is required for preferred serotonin 5-HT1-receptor agonists for quantities exceeding 12 unit doses of tablets,
receptor Agonists	syringes or sprays per 30 days. Payment for serotonin 5-HT1-receptor agonists beyond this limit will be considered on an individual
	basis after review of submitted documentation. Prior authorization will be required for all non-preferred serotonin 5-HT1-receptor
	agonists as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred serotonin
	5-HT1-receptor agonists will be authorized only for cases in which there is documentation of previous trials and therapy failures with
	two preferred agents. Requests for non-preferred combination products may only be considered after documented separate trials and
	therapy failures with the individual ingredients. For consideration, the following information must be supplied:
Use Serotonin 5-HT1-	1. The diagnosis requiring therapy.
receptor Agonists PA form	2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different
	prophylactic medications.
<b>Short Acting Narcotics</b>	Prior authorization is required for all non-preferred short acting narcotics. Payment will be considered for cases in which there is
	documentation of previous trials and therapy failures with three (3) chemically distinct preferred short acting narcotics (based on
Use Short Acting	narcotic ingredient only) at therapeutic doses, unless evidence is provided that use of these products would be medically
Narcotics PA form	contraindicated.
Smoking Cessation	Prior Authorization is required for varenicline (Chantix®) or bupropion SR that is FDA approved for smoking cessation. Requests for
Therapy-Oral	authorization must include:
	1) Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling.
<i>Chantix</i> ®	2) Confirmation of enrollment and ongoing participation in the Quitline Iowa counseling program is required for approval
Bupropion SR	and continued coverage.
	3) Approvals will only be granted for patients eighteen years of age and older.
	4) The duration of therapy is initially limited to twelve weeks within a twelve-month period. For patients who have
	successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment will be considered with
	a prior authorization request. The maximum duration of approvable therapy is 24 weeks within a twelve-month period.
	5) Requests for varenicline to be used in combination with bupropion SR that is FDA indicated for smoking cessation or
Use Smoking Cessation	nicotine replacement therapy will not be approved.
Therapy-Oral PA form	6) The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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Sodium Oxybate	Prior authorization is required for sodium oxybate (Xyrem <sup>®</sup> ). Payment will be considered for patients 16 years of age or older under
(Xyrem <sup>®</sup> )	the following conditions:
	1. A diagnosis of cataplexy associated with narcolepsy verified by a recent sleep study (including PSG, MSLT, and ESS) and previous trial and therapy failure with one of the following tricyclic antidepressants: clomipramine, imipramine, or protriptyline.
	2. Patient is enrolled in the Xyrem <sup>®</sup> Success Program.
	3. A diagnosis of excessive daytime sleepiness associated with narcolepsy verified by a recent sleep study (including PSG,
	MSLT, and ESS) and previous trials and therapy failures at a therapeutic dose with a preferred amphetamine and non-amphetamine stimulant.
	4. Patient has been instructed to not drink alcohol when using Xyrem <sup>®</sup> .
	5. Patients with and without a history of substance abuse have been counseled regarding the potential for abuse and dependence and will be closely monitored for signs of abuse and dependence.
	6. Requests for patients with concurrent use of a sedative hypnotic or a semialdehyde dehydrogenase deficiency will not be considered.
Use Sodium Oxybate	7. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website at
(Xyrem <sup>®</sup> ) PA form	https://pmp.iowa.gov/IAPMPWebCenter/ prior to requesting prior authorization.
	The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Step Therapy	Designated therapeutic drug classes are subject to step therapy edits. For these therapeutic drug classes, drugs are assigned to
Requirements	numbered steps and appropriate trials must be made of the drugs assigned to each step before payment will be made for drugs assigned
1	to a subsequent step. These therapeutic classes, as well as the specific step edit requirements, are identified on the Iowa Medicaid
	Preferred Drug List posted on the website <u>www.iowamedicaidpdl.com</u> under the Preferred Drug Lists tab. Providers should submit a
Use Non-Preferred Drug	Prior Authorization request for override consideration.
PA form	Therapeutic Classes Included: Antipsychotics-Atypicals
Tasimelteon (Hetlioz®)	Prior authorization is required for tasimelteon (Hetlioz <sup>®</sup> ). Requests for doses above the manufacturer recommended dose will not be
	considered. Payment will be considered under the following conditions:
	1. Patient has a diagnosis of Non-24-Hour Sleep-Wake Disorder (Non-24), as confirmed by a sleep specialist; and
	2. Patient is 18 years of age or older; and
	3. Documentation the patient is totally blind with no perception of light is provided; and
	4. Patient has a documented trial and therapy failure with at least one preferred sedative/hypnotic-non-benzodiazepine agent; and
	5. Patient has a documented trial and therapy failure with ramelteon (Rozerem <sup>®</sup> ).
<u>Use Tasimelteon</u>	If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of therapy will be considered
(Hetlioz®) PA form	when the patient has received 3 months of continuous therapy and patient has achieved adequate results with tasimelteon (Hetlioz <sup>®</sup> ),
	such as entrainment, significant increases in nighttime sleep, and/or significant decreases in daytime sleep.

**Testosterone Products** Prior authorization is required for testosterone products. Payment will be considered with documentation of a specific testicular or

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

hypothalamic/pituitary disease (primary hypogonadism or hypogonadotropic hypogonadism) that results in classic hypogonadism. Requests for FDA approved indications other than hypogonadism will not be subject to prior authorization criteria with adequate documentation of diagnosis. Payment for non-preferred testosterone products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents. Requests for erectile dysfunction, infertility, and agerelated hypogonadism will not be considered. Payment will be considered under the following conditions:

- 1. Patient is male and 18 years of age or older (or 12 years of age or older for testosterone cypionate); and
- 2. Patient has two (2) morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used (please attach lab results); and
- 3. Patient has primary hypogonadism or hypogonadotropic hypogonadism (further defined below):
  - Primary hypogonadism (congenital or acquired) caused by testicular failure due to one of the following:
    - Cryptorchidism
    - o Bilateral torsion
    - Orchitis
    - Vanishing testes syndrome
    - Orchiectomy
    - o Klinefelter's syndrome
    - Chemotherapy
    - o Toxic damage from alcohol or heavy metals
  - Hypogonadotropic hypogonadism
    - o Idiopathic gonadotropin or luteinizing hormone-releasing (LHRH) deficiency
    - o Pituitary-hypothalamic injury from tumors, trauma, or radiation
- 4. Patient does not have:
  - a. Breast or prostate cancer
  - b. Palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL
  - c. Hematocrit > 50%
  - d. Untreated severe obstructive sleep apnea
  - e. Severe lower urinary tract symptoms
  - f. Uncontrolled or poorly controlled heart failure

If criteria for coverage are met, initial authorization will be given for 3 months. Requests for continuation of therapy will require the following:

- 1. An updated testosterone level (Please attach lab result); and
- 2. Documentation the patient has not experienced a hematocrit > 54% or an increase in PSA > 1.4ng/mL in the past 12 months. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Use TestosteroneProducts PA form

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

	Opualed 7/00/2013
Thrombopoietin	Payment for a preferred thrombopoietin receptor agonist will only be considered for cases in which there is a diagnosis of chronic
Receptor Agonists	immune thrombocytopenic purpura (ITP) including documentation of an insufficient response to a corticosteroid, an immunoglobulin,
	or the patient has undergone a splenectomy.
	Payment for eltromobopag (Promacta <sup>®</sup> ) for the treatment of chronic hepatitis C associated thrombocytopenia will only be considered to
	allow for initiation and/or maintenance of interferon-based therapy with ribavirin when the patient has a baseline platelet count less
	then 75 x 10 <sup>9</sup> L. Requests will not be considered under the following conditions:
	1. Patient taking direct acting antiviral agents for the treatment of chronic hepatitis C genotype 1 infection in addition to interferon-
	based therapy with ribavirin.
	2. Patients taking direct acting antiviral agents used without interferon for treatment of chronic hepatitis C infection.
	3. Patients with decompensated liver disease with a Child-Pugh score > 6 (Class B & C).
	4. Patients with a history of ascites.
	5. Patients with hepatic encephalopathy.
	e. a means with repaire energhness.
	Payment for eltrombopag (Promacta <sup>®</sup> ) for the treatment of severe aplastic anemia will only be considered under the following
	conditions:
	1. Patient has documentation of an insufficient response or intolerance to at least one prior immunosuppressive therapy; and
	2. Patient has a platelet count less than or equal $30 \times 10^9$ /L.
Use Thrombopoietin	3. If criteria for coverage are met, initial authorization will be given for 16 weeks. Documentation of hematologic response after 16
Receptor Agonists PA	weeks of therapy will be required for further consideration.
form	
	Payment for a non-preferred thrombopoietin receptor agonist will be considered following documentation of a recent trial and therapy
	failure with a preferred thrombopoietin receptor agonist unless such a trial would be medically contraindicated.
	Tantare with a preferred anomologorean receptor agoinst amess such a trial would be incurearly contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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mineral supplements.)  Vorapaxar (Zontivity)  Prior authorization is required for vorapaxar (Zontivity). Payment will be considered under the following conditions:  1. Patient has a history of myocardial infarction (MI) or peripheral artery disease (PAD); and  2. Patient does not have a history of stroke, transient ischemic attack (TIA), intracranial bleeding, or active peptic ulcer; and  3. Patient has documentation of an adequate trial and therapy failure with aspirin plus clopidogrel; and  4. Patient will use vorapaxar concurrently with aspirin and/or clopidogrel.  The required trials may be overridden when documented evidence is provided that the use of these agents would be medically		Opuated 7/00/2013
1. Previous trials and therapy failure with a preferred over-the-counter benzoyl peroxide product, and 2. Previous trials and therapy failures with two preferred topical and/or oral antibiotics for the treatment of mild to moderate acne (non-inflammatory) and inflammatory), and drug-induced acne. 3. Payment for non-preferred topical retinoid products will be authorized only for cases in which there is documentation of previous trial and therapy failure will not be required for those patients presenting with a preponderance of comedonal acne. 5. Skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive automatic approval for lifetime use of topical retinoid products. 6. Requests for non-preferred combination products may only be considered after documentation of separate trials and therapy failures with the individual ingredients. 7. Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for Tazorac for a psoriasis diagnosis. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.  Trametinib (Mekinist**) Prior authorization is required for trametinib (Mekinist**). Payment will be considered for patients when the following criteria are met: 1. Patient is 18 years of age or older; and 2. Patient has a documented diagnosis of unresectable or metastatic melanoma with BRAF V600E or BRAF V600K mutation as detected but an FDA-approved test; and 3. Patient has not received prior therapy with a BRAF-inhibitor; and 4. Prescriber is an oncologist.  If the criteria for coverage are met, authorizations will be given at three (3) month intervals. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued.  Payment for vitamins, minerals and multiple vitamins for treatment of specific conditions will be approved when there is a diagnosis of modifier, if that product does not ocnain more than three vitamins/min	Topical Retinoids for	
2. Previous trials and therapy failures with two preferred topical and/or oral antibiotics for the treatment of mild to moderate acne (non-inflammatory) and inflammatory), and drug-induced acne.  3. Payment for non-preferred topical retinoid products will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.  4. Trials and therapy failure will not be required for those patients presenting with a preponderance of comedonal acne.  5. Skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive automatic approval for lifetime use of topical retinoid products.  6. Requests for non-preferred combination products may only be considered after documentation of separate trials and therapy failures with the individual ingredients.  7. Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for Tazorac for a psoriasis diagnosis.  The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.  Trametinib (Mekinist**)  Prior authorization is required for trametinib (Mekinist**). Payment will be considered for patients when the following criteria are met:  1. Patient is 18 years of age or older; and  2. Patient has a documented diagnosis of unresectable or metastatic melanoma with BRAF V600E or BRAF V600K mutation as detected but an FDA-approved test; and  3. Patient has not received prior therapy with a BRAF-inhibitor; and  4. Prescriber is an oncologist.  If the criteria for coverage are met, authorizations will be given at three (3) month intervals. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued multi-vitamins with or witnamins or vitamins, minerals and multiple vitamins for treatment of specific conditions will be approved when there is a diagnosis of specific vitamin or mineral deficiency disease or for patients under 21 years of age i	Acne	
(non-inflammatory and inflammatory), and drug-induced acne.  3. Payment for non-preferred topical retinoid products will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.  4. Trials and therapy failure will not be required for those patients presenting with a preponderance of comedonal acne.  5. Skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive automatic approval for lifetime use of topical retinoid products.  6. Requests for non-preferred combination products may only be considered after documentation of separate trials and therapy failures with the individual ingredients.  7. Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for Tazorac for a psoriasis diagnosis.  7. Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for Tazorac for a psoriasis diagnosis.  8. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.  9. Prior authorization is required for trametinib (Mckinist**). Payment will be considered for patients when the following criteria are met:  1. Patient is 18 years of age or older; and  2. Patient has a documented diagnosis of unresectable or metastatic melanoma with BRAF V600E or BRAF V600K mutation as detected but an FDA-approved test; and  3. Patient has not received prior therapy with a BRAF-inhibitor; and  4. Prescriber is an oncologist.  1. If the criteria for coverage are met, authorizations will be given at three (3) month intervals. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued.  9. Payment for vitamins, mineral and multiple vitamins for treatment of specific conditions will be approved when there is a diagnosis of specific vitamin or mineral deficiency disease or for patients under 21 years of age if there is a diagnose disease which		1. Previous trial and therapy failure with a preferred over-the-counter benzoyl peroxide product, and
3. Payment for non-preferred topical retinoid products will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.  4. Trials and therapy failure will not be required for those patients presenting with a preponderance of comedonal acne.  5. Skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive automatic approval for lifetime use of topical retinoid products.  6. Requests for non-preferred combination products may only be considered after documentation of separate trials and therapy failures with the individual ingredients.  7. Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for Tazorac for a psoriasis diagnosis.  The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.  Prior authorization is required for trametinib (Mckinist**). Payment will be considered for patients when the following criteria are met:  Patient is 18 years of age or older; and  Patient has not received prior therapy with a BRAF-inhibitor; and  Prescriber is an oncologist.  If the criteria for coverage are met, authorizations will be given at three (3) month intervals. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued.  Vitamins, Minerals and Multiple Vitamins  Use Vitamin/Mineral PA form  Vitamin/Mineral PA form  Payment for vitamins, minerals and multiple vitamins for treatment of specific conditions will be approved when there is a diagnosis of modifier, if that product does not contain more than three vitamins/minerals or for products primarily classified as a blood modifier, if that product does not contain more than three vitamins/minerals or for products primarily classified as a blood modifier, if that product does not contain more than three vitamins/minerals or for products primarily classified as a blood modifier, if that product		2. Previous trials and therapy failures with two preferred topical and/or oral antibiotics for the treatment of mild to moderate acne
trial and therapy failure with a preferred agent.  4. Trials and therapy failure will not be required for those patients presenting with a preponderance of comedonal acne.  5. Skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive automatic approval for lifetime use of topical retinoid products.  6. Requests for non-preferred combination products may only be considered after documentation of separate trials and therapy failures with the individual ingredients.  7. Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for Tazorac for a psoriasis diagnosis. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.  7. Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for Tazorac for a psoriasis diagnosis. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.  7. Prior authorization is required for trametinib (Mekinist"). Payment will be considered for patients when the following criteria are met:  1. Patient has a documented diagnosis of unresectable or metastatic melanoma with BRAF V600E or BRAF V600K mutation as detected but an FDA-approved test; and  2. Patient has not received prior therapy with a BRAF-inhibitor; and  4. Prescriber is an oncologist.  1. If the criteria for coverage are met, authorizations will be given at three (3) month intervals. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued.  7. Vitamins, Minerals and Multiple Vitamins  8. Vitamins, Minerals and Multiple Vitamins for treatment of specific conditions will be approved when there is a diagnosis of specific vitamin or mineral deficiency disease (Profice approval is not required for prescribed multi-vitamins with or without iron or vitamin p. Supplements.)  8. Vorapaxar (Zontivity")  1. P		(non-inflammatory and inflammatory), and drug-induced acne.
4. Trials and therapy failure will not be required for those patients presenting with a preponderance of comedonal acne.  S. Skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive automatic approval for lifetime use of topical retinoid products.  6. Requests for non-preferred combination products may only be considered after documentation of separate trials and therapy failures with the individual ingredients.  7. Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for Tazorac for a psoriasis diagnosis.  The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.  Trametinib (Mekinist**)  Prior authorization is required for trametinib (Mekinist**). Payment will be considered for patients when the following criteria are met:  1. Patient is 18 years of age or older; and  2. Patient has a documented diagnosis of unresectable or metastatic melanoma with BRAF V600E or BRAF V600K mutation as detected but an FDA-approved test; and  3. Patient has not received prior therapy with a BRAF-inhibitor; and  4. Prescriber is an oncologist.  If the criteria for coverage are met, authorizations will be given at three (3) month intervals. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued.  Vitamins, Minerals and  Multiple Vitamins  Without iron or vitamin D supplements for patients under 21 years of age if there is a diagnosed disease which inhibits the nutrition absorption process as a secondary effect of the disease. (Prior approval is not required for prescribed multi-vitamins with or without iron or vitamin D supplements for patients under 12 months of age or a prescription product primarily classified as a blood modifier, if that product does not contain more than three vitamins/minerals or for products principally marketed as prenatal vitaminemineral supplements.)  Vorapaxar (Zontivity**)  Prior		3. Payment for non-preferred topical retinoid products will be authorized only for cases in which there is documentation of previous
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The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.   Trametinib (Mekinist**)		failures with the individual ingredients.
The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.   Trametinib (Mekinist**)		7. Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for Tazorac for a psoriasis diagnosis.
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Vitamins, Minerals and Multiple Vitamins for treatment of specific conditions will be approved when there is a diagnosis of age if there is a diagnosed disease which inhibits the nutrition absorption process as a secondary effect of the disease. (Prior approval is not required for prescribed multi-vitamins with or without iron or vitamin D supplements for patients under 12 months of age or a prescription product primarily classified as a blood modifier, if that product does not contain more than three vitamins/minerals or for products principally marketed as prenatal vitamin-mineral supplements.)  Prior authorization is required for vorapaxar (Zontivity) Payment will be considered under the following conditions:  1. Patient has a history of myocardial infarction (MI) or peripheral artery disease (PAD); and 2. Patient does not have a history of stroke, transient ischemic attack (TIA), intracranial bleeding, or active peptic ulcer; and 3. Patient has documentation of an adequate trial and therapy failure with aspirin plus clopidogrel; and 4. Patient will use vorapaxar concurrently with aspirin and/or clopidogrel. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically	(Mekinist <sup>™)</sup> PA form	If the criteria for coverage are met, authorizations will be given at three (3) month intervals. Updates on disease progression must be
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without iron or vitamin D supplements for patients under 12 months of age or a prescription product primarily classified as a blood modifier, if that product does not contain more than three vitamins/minerals or for products principally marketed as prenatal vitamin-mineral supplements.)  Vorapaxar (Zontivity Prior authorization is required for vorapaxar (Zontivity Patient has a history of myocardial infarction (MI) or peripheral artery disease (PAD); and  2. Patient does not have a history of stroke, transient ischemic attack (TIA), intracranial bleeding, or active peptic ulcer; and  3. Patient has documentation of an adequate trial and therapy failure with aspirin plus clopidogrel; and  4. Patient will use vorapaxar concurrently with aspirin and/or clopidogrel.  The required trials may be overridden when documented evidence is provided that the use of these agents would be medically	_	nutrition absorption process as a secondary effect of the disease. (Prior approval is not required for prescribed multi-vitamins with or
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1. Patient has a history of myocardial infarction (MI) or peripheral artery disease (PAD); and 2. Patient does not have a history of stroke, transient ischemic attack (TIA), intracranial bleeding, or active peptic ulcer; and 3. Patient has documentation of an adequate trial and therapy failure with aspirin plus clopidogrel; and 4. Patient will use vorapaxar concurrently with aspirin and/or clopidogrel. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically		mineral supplements.)
1. Patient has a history of myocardial infarction (MI) or peripheral artery disease (PAD); and 2. Patient does not have a history of stroke, transient ischemic attack (TIA), intracranial bleeding, or active peptic ulcer; and 3. Patient has documentation of an adequate trial and therapy failure with aspirin plus clopidogrel; and 4. Patient will use vorapaxar concurrently with aspirin and/or clopidogrel. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically	Vorapaxar (Zontivity <sup>TM</sup> )	Prior authorization is required for vorapaxar (Zontivity <sup>™</sup> ). Payment will be considered under the following conditions:
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Use Vorapaxar (Zontivity)  4. Patient will use vorapaxar concurrently with aspirin and/or clopidogrel.  The required trials may be overridden when documented evidence is provided that the use of these agents would be medically		2. Patient does not have a history of stroke, transient ischemic attack (TIA), intracranial bleeding, or active peptic ulcer; and
Use Vorapaxar (Zontivity)  4. Patient will use vorapaxar concurrently with aspirin and/or clopidogrel.  The required trials may be overridden when documented evidence is provided that the use of these agents would be medically		
PA form The required trials may be overridden when documented evidence is provided that the use of these agents would be medically	Use Vorapaxar (Zontivity)	
	PA form	
contraindence.	-	contraindicated.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 7/06/2015

Vusion To Ointment  Prior Authorization is required for Vusion Ointment. Payment will only be considered for cases in which there is documentation of previous trials and therapy failures with 1) over-the-counter miconazole 2% cream (payable with a prescription) AND 2) nystatin cream or ointment, unless evidence is provided that use of these agents would be medically contraindicated.		Opdated 7/00/2015
Use Vusion™ Ointment PA   cream or ointment, unless evidence is provided that use of these agents would be medically contraindicated.	Vusion <sup>™</sup> Ointment	Prior Authorization is required for Vusion <sup>™</sup> Ointment. Payment will only be considered for cases in which there is documentation of
	Use Vusion <sup>™</sup> Ointment PA form	