From:	Elliott, Arlene
Sent:	Monday, July 25, 2016 10:01 AM EDT
To:	\"\"Craig\"\",\"\" Sara; \" \"Williams\"\",\"\" Susan C.; Sara.Craig@ahca.myflorida.com; Susan.Williams@ahca.myflorida.com
Subject:	FW: Hormone Research
Attachments:	Article_TG Youth_Endocrine Considerations.pdf, Transgender-PGACG-6-17-16.pdf, Clinical management of gender identity disorder in adolescents_ a protoc....html, image002.png, image003.jpg, image004.png

I sent the 3 attachments as the 3 you will summarize. Please discuss which one each of you will work with or you can work together. Please summarize the main points of each article using bullets. Thanks.

Arlene Elliott - AGENCY FOR HEALTH CARE ADMINISTRATOR-SES

Bldg. 3, Rm. 2332A - BUREAU OF MEDICAID POLICY
2727 MAHAN DR TALLAHASSEE, FL 32308
412-4152 (Office)
Arlene.Elliott@ahca.myflorida.com

From: Elliott, Arlene
Sent: Monday, July 25, 2016 9:59 AM
To: Johnson, Monique <Monique.Johnson@ahca.myflorida.com>; Allman, Heather <Heather.Allman@ahca.myflorida.com>; McGillen, Charles <Charles.McGillen@ahca.myflorida.com>; Craig, Sara <Sara.Craig@ahca.myflorida.com>; Pickle, Devona <Devona.Pickle@ahca.myflorida.com>; Clayton, Natasha <Natasha.Clayton@ahca.myflorida.com>; Williams, Susan C. <Susan.Williams@ahca.myflorida.com>
Subject: RE: Hormone Research

Arlene Elliott - AGENCY FOR HEALTH CARE ADMINISTRATOR-SES

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From: Johnson, Monique
Sent: Monday, July 25, 2016 9:35 AM

Pl. Trial Ex. 250

To: Allman, Heather <Heather.Allman@ahca.myflorida.com>; McGillen, Charles <Charles.McGillen@ahca.myflorida.com>; Elliott, Arlene <Arlene.Elliott@ahca.myflorida.com>; Craig, Sara <Sara.Craig@ahca.myflorida.com>; Pickle, Devona <Devona.Pickle@ahca.myflorida.com>; Clayton, Natasha <Natasha.Clayton@ahca.myflorida.com>
Subject: Hormone Research

Good Morning Everyone,
There has been a desire expressed to know what articles other people are reviewing and summarizing so that people are not working on the same article. If you could just shoot a quick note about what articles you have worked on, are currently working on, and have in your cue to review next that would be much appreciated.

Monique:
- Endocrine society guidelines
- NAMD guidance
- Case law from Iowa
- Case law from Medicare
- Case law from NY
- Empirical study on medical treatment of GD in children and adolescents.

Heather:
Chuck:
Devon:
Natasha:

Arlene:

https://www.apa.org/practice/guidelines/transgender.pdf

http://www.autism.com/dysphoria

Sara/Susan:
Three attached

Thank you,

Monique Johnson, RN, BSN, CPN
Program Administrator
Bureau of Medicaid Policy
Agency for Health Care Administration
2727 Mahan Drive, MS 20
Tallahassee, Florida 32308
Phone: 850.412.4212
Fax: 850.414.1721

From:	Floyd, Erica
Sent:	Wednesday, August 17, 2016 4:31 PM EDT
To:	\"\"Floyd\"\",\"\" Erica; Erica.Floyd@ahca.myflorida.com
Subject:	FW: Assistance is needed for a time sensitive project
Attachments:	image001.png, image002.jpg

From: Elliott, Arlene
Sent: Wednesday, August 17, 2016 4:07 PM
To: Floyd, Erica <Erica.Floyd@ahca.myflorida.com>
Cc: Johnson, Monique <Monique.Johnson@ahca.myflorida.com>
Subject: RE: Assistance is needed for a time sensitive project

Criteria:

In Colorado, Services for Medicaid clients who have a diagnosis of gender dysphoria (GD) or a history of a diagnosis of GD include: behavioral health care, gonadotropin-releasing hormone (GnRH) analogs/agonists, cross-sex hormone therapy, gender confirmation surgery, and pre- and post-operative care. Maryland approves GnRH treatment at the pharmacy point of sale if the recipient has GD diagnosis. Rhode Island covered services for members diagnosed with GD and less than 18 years of age include: behavioral and medical heath, pharmacological and hormonal therapy to delay physical changes of puberty (requires prior authorization), and pharmacological and hormonal therapy that is non-reversible and produces masculinization or feminization (requires prior authorization). In June 2015, Washington State expanded its GD treatment services to include: mental health services, puberty-blocking therapy for youths, hormonal therapy and gender reassignment surgery.

Arlene Elliott - AGENCY FOR HEALTH CARE ADMINISTRATOR-SES

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412-4152 (Office)

From: Elliott, Arlene
Sent: Wednesday, August 17, 2016 3:08 PM
To: Floyd, Erica <Erica.Floyd@ahca.myflorida.com>
Cc: Johnson, Monique <Monique.Johnson@ahca.myflorida.com>
Subject: RE: Assistance is needed for a time sensitive project

Lupron Depot Ped (leuprolide acetate, a gonadotropin releasing hormone)

Pl. Trial Ex. 250

Dosages: 7.5mg, 11.25mg or 15mg intramuscular once a month
11.25mg or 30mg intramuscular every 3 months

Supprelin LA (histrelin acetate, a gonadotropin releasing hormone)

Dosage: 50mg subcutaneous implant every 12 months

Sentence for page 7 :

However, four states reported they cover treatment for pre-puberty suppression with gonadotropin releasing hormone agents for pre-puberty suppression. These states are Colorado, Maryland, Washington State, and Rhode Island.

Arlene Elliott - AGENCY FOR HEALTH CARE ADMINISTRATOR-SES

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2727 MAHAN DR TALLAHASSEE, FL 32308
412-4152 (Office)
Arlene.Elliott@ahca.myflorida.com

From: Floyd, Erica
Sent: Wednesday, August 17, 2016 2:26 PM
To: Elliott, Arlene <Arlene.Elliott@ahca.myflorida.com>
Cc: Harris, Shevaun <Shevaun.Harris@ahca.myflorida.com>; Johnson, Monique <Monique.Johnson@ahca.myflorida.com>
Subject: Assistance is needed for a time sensitive project

Good afternoon Arlene,

Would you please assist us with completing a time sensitive GAPMS report. Your clinical expertise is needed to be able to finalize the report. There are two sections of the report that have been tabbed for your review. Thank you for your help
Erica

From: Elliott, Arlene
Sent: Thursday, July 28, 2016 9:30 AM EDT
To: \"\"Torning\"\",\"\" Kate; Kate.Torning@ahca.myflorida.com
Subject: GD
Attachments: Re ADURS Gender Dysphoria.eml, RE ADURS Gender Dysphoria.eml, RE ADURS Gender Dysphoria.eml, RE ADURS Gender Dysphoria.eml, RE ADURS Gender Dysphoria.eml, RE ADURS Gender Dysphoria.eml

Thank you!

Mainly list the services they pay for (or not). (i.e. puberty suppression, hormone therapy, surgery, etc)

Pl. Trial Ex. 250

From:	Reid, Catherine (DHHS)
Sent:	Thursday, July 28, 2016 8:43 AM EDT
To:	Elliott, Arlene; Paul Holly -DHMH-; Littlejohn Newman, Kelli; clemice.hurst@medicaid.alabama.gov; Narus, Erin Y (HSS); Wall, Rebecca M (HSS); Berman, Suzanne; Pauline.Chan@dhcs.ca.gov; Lodge, Robert; Robert.page@ucdenver.edu; NILOUFAR.MAHYARI@UCDENVER.EDU; gina.moore@ucdenver.edu; Gott, Jason T.; Heather Kissinger (heather.kissinger@hidesigns.com); Herman.Kranc@ct.gov; Fecondo, Fury; Fairfax, Charlene (DHCF); Emily Baker; D'Alba, Peter; Gray, Gilletta; Afzal Mistry; Kang-Kaulupali, Kathleen; Gennrich, Jane - Medicaid; Tami Eide; Johnson, Chris K.; Patty.Steward@illinois.gov; Christina.Petrykiw@illinois.gov; John.Ross@fssa.IN.gov; Parker, Susan; Smith, Pamela; Liane Larson; Ariane Casey; Samantha McKinley; Gilbert, Julie; Melwyn Wendt; humble@ulm.edu; jan.yorks-wright@maine.gov; Ouellette, Michael; rachel.boyer@hidesigns.com; Dixit Shah -DHMH-; Palumbo, Vincent; Reinke, Mary Beth (DHS); Sara L. Noble; Benjamin F. Banahan; Shannon Hardwick; Terri R. Kirby; Calloway, Stephen; Rhonda Driver; Dave Campana; Lisa Sather; Marcia Mueting; Minchow, Jenny; Mary Griffith; margaret.clifford@dhhs.state.nh.us; Holmes, Raquel; LFarrand@dhhs.state.nh.us; Gene Azoia; Diana Moya; ADURSNY@health.state.ny.us; krista.kness@dhhs.nc.gov; Brendan Joyce; amurphy@nd.gov; Candace Rieth; Griffith, Jill; Patricia.Nussle@medicaid.ohio.gov; Margaret Scott; Nancy.Nesser@okhca.org; burl.beasley@okhca.org; Rhonda Cothran; American Drug Utilization Review Society ADURS; Jacobs, Elgene W.; Shellie-Keast@ouhsc.edu; bethany-holderread@ouhsc.edu; CITRON Roger A; Engen David; ted.d.williams@state.or.us; c-tcathers@pa.gov; c-khoover@pa.gov; Mariano, Karen; Matthew Waldrop; Bryan Amick; Correll, Lisa B.; Mike Jockheck; Helgeland, Dave; jgjohnson@magellanhealth.com; Raymond McIntire; Assadi,Nahid (HHSC); Chad Hope; Robyn Seely; Hogue, Nancy; Cain, Rachel (DMAS); Donna Sullivan; Thompson, Brian M; Julia Rollins; lynn.radmer@wisconsin.gov; Jacqueline Nash; Aimee L. Lewis; Cori Cooper; Pamela Ford-Bowen
Subject:	RE: ADURS: Gender Dysphoria
Attachments:	image001.png, image002.jpg

Michigan is trying to establish some. We basically modelled ours on WPATH criteria (World Professional Association for Transgender Health), it seems to be what everyone uses. Aetna has pretty good guidelines and they follow WPATH.

We've had things ready for months but can't get upper administration approval to move forward yet (this is still a politically sensitive issue).

As you probably know, Medicare is covering transgender services now but are a little cagey about the absolute compliance deadline. It's listed as January 2017 but on a CMS SOTA call last week they seem to expect Medicaid programs to start adopting it now.

I don't think I can share our unapproved criteria but I'd be happy to answer any questions. We've spent a lot of time on this.

Catherine Reid, MD
Office of Medical Affairs
Michigan Dept. of Health and Human Services
(517) -335-5181

From: Elliott, Arlene [mailto:Arlene.Elliott@ahca.myflorida.com]
Sent: Wednesday, July 27, 2016 4:30 PM
To: Paul Holly -DHMH- <paul.holly@maryland.gov>; Littlejohn Newman, Kelli <kelli.littlejohn@medicaid.alabama.gov>; clemice.hurst@medicaid.alabama.gov; Narus, Erin Y (HSS) <erin.narus@alaska.gov>; Wall, Rebecca M (HSS) <rebecca.wall@alaska.gov>; Berman, Suzanne <suzanne.berman@azahcccs.gov>; Pauline.Chan@dhcs.ca.gov; Lodge, Robert <robert.lodge@state.co.us>; Robert.page@ucdenver.edu; NILOUFAR.MAHYARI@UCDENVER.EDU; gina.moore@ucdenver.edu; Gott, Jason T. <Jason.Gott@ct.gov>; Heather Kissinger

Pl. Trial Ex. 250

(heather.kissinger@hidesigns.com) <heather.kissinger@hidesigns.com>; Herman.Kranc@ct.gov; Fecondo, Fury <fury.fecondo@hpe.com>; Fairfax, Charlene (DHCF) <charlene.fairfax@dc.gov>; Emily Baker <emily.baker@nhc-llc.com>; D'Alba, Peter <peter.dalba@dch.ga.gov>; Gray, Gilletta <ggray@dch.ga.gov>; Afzal Mistry <Afzal.Mistry@nhc-llc.com>; Kang-Kaulupali, Kathleen <kkang-kaulupali@dhs.hawaii.gov>; Gennrich, Jane - Medicaid <gennricj@dhw.idaho.gov>; Tami Eide <eidet@dhw.idaho.gov>; Johnson, Chris K. <JohnsonC4@dhw.idaho.gov>; Patty.Steward@illinois.gov; Christina.Petrykiw@illinois.gov; John.Ross@fssa.IN.gov; Parker, Susan <sparker2@dhs.state.ia.us>; Smith, Pamela <pasmith@ghsinc.com>; Liane Larson <llarson@kdheks.gov>; Ariane Casey <ariane.casey@hidesigns.com>; Samantha McKinley <Samantha.mckinley@ky.gov>; Gilbert, Julie <jagilbert@magellanhealth.com>; Melwyn Wendt <melwyn.wendt@la.gov>; humble@ulm.edu; jan.yorks-wright@maine.gov; Ouellette, Michael <mouellette@ghsinc.com>; rachel.boyer@hidesigns.com; Dixit Shah -DHMH- <dixit.shah@maryland.gov>; Palumbo, Vincent <vincent.palumbo@umassmed.edu>; Reid, Catherine (DHHS) <ReidC2@michigan.gov>; Reinke, Mary Beth (DHS) <mary.beth.reinke@state.mn.us>; Sara L. Noble <sara.noble@medicaid.ms.gov>; Benjamin F. Banahan <benb3@olemiss.edu>; Shannon Hardwick <sphardwi@olemiss.edu>; Terri R. Kirby <Terri.Kirby@medicaid.ms.gov>; Calloway, Stephen <Stephen.Calloway@dss.mo.gov>; Rhonda Driver <driverr@ohsu.edu>; Dave Campana <dcampana@mt.gov>; Lisa Sather <lsather@mpqhf.org>; Marcia Mueting <marcia@npharm.org>; Minchow, Jenny <jenny.minchow@nebraska.gov>; Mary Griffith <mary.griffith@dhcfp.nv.gov>; margaret.clifford@dhhs.state.nh.us; Holmes, Raquel <rholmes@magellanhealth.com>; LFarrand@dhhs.state.nh.us; Gene Azoia <Eugene.M.Azoia@dhs.state.nj.us>; Diana Moya <DianaJ.Moya@state.nm.us>; ADURSNY@health.state.ny.us; krista.kness@dhhs.nc.gov; Brendan Joyce <bjoyce@nd.gov>; amurphy@nd.gov; Candace Rieth <candace.rieth@hidinc.com>; Griffith, Jill <jgriffith@ghsinc.com>; Patricia.Nussle@medicaid.ohio.gov; Margaret Scott <MARGARET.SCOTT@medicaid.ohio.gov>; Nancy.Nesser@okhca.org; burl.beasley@okhca.org; Rhonda Cothran <terry-cothran@ouhsc.edu>; American Drug Utilization Review Society ADURS <adurs.inc@gmail.com>; Jacobs, Elgene W. <elgenejacobs@yahoo.com>; Shellie-Keast@ouhsc.edu; bethany-holderread@ouhsc.edu; CITRON Roger A <roger.a.citron@state.or.us>; Engen David <david.engen@state.or.us>; ted.d.williams@state.or.us; c-tcathers@pa.gov; c-khoover@pa.gov; Mariano, Karen <karen.mariano@hpe.com>; Matthew Waldrop <matthew.waldrop@hidesigns.com>; Bryan Amick <Bryan.Amick@scdhhs.gov>; Correll, Lisa B. <LBCorrell@magellanhealth.com>; Mike Jockheck <mike.jockheck@state.sd.us>; Helgeland, Dave <dave.helgeland@sdstate.edu>; jgjohnson@magellanhealth.com; Raymond McIntire <raymond.mcintire@tn.gov>; Assadi,Nahid (HHSC) <nahid.assadi@hhsc.state.tx.us>; Chad Hope <chope@utah.gov>; Robyn Seely <rmseely@utah.gov>; Hogue, Nancy <nancy.hogue@vermont.gov>; Cain, Rachel (DMAS) <rachel.cain@dmas.virginia.gov>; Donna Sullivan <Donna.Sullivan@hca.wa.gov>; Thompson, Brian M <Brian.M.Thompson@wv.gov>; Julia Rollins <julia.rollins@molinahealthcare.com>; lynn.radmer@wisconsin.gov; Jacqueline Nash <Jacqueline.Nash@hidesigns.com>; Aimee L. Lewis <alewis13@uwyo.edu>; Cori Cooper <cori.cooper@wyo.gov>; Pamela Ford-Bowen <pamela.ford-bowen@dhs.arkansas.gov>

Subject: ADURS: Gender Dysphoria

Hi all,

Do any states have criteria/policy on gender dysphoria? Any info will be greatly appreciated.

Arlene Elliott - AGENCY FOR HEALTH CARE ADMINISTRATOR-SES

Bldg. 3, Rm. 2332A - BUREAU OF MEDICAID POLICY
2727 MAHAN DR TALLAHASSEE, FL 32308
412-4152 (Office)
Arlene.Elliott@ahca.myflorida.com

From: Elliott, Arlene
Sent: Thursday, August 4, 2016 4:11 PM EDT
To: \"\"Johnson\"\",\"\" Monique; Monique.Johnson@ahca.myflorida.com
CC: Torning, Kate; Williams, Susan C.
Subject: Fwd: Gender Dysphoria
Attachments: genderdys.xlsx, ATT00001.htm

I found the email Kate had sent me. Kate was already gone when I sent the email.

Sent from my iPhone

Begin forwarded message:

From: "Torning, Kate" <Kate.Torning@ahca.myflorida.com>
Date: July 28, 2016 at 3:39:27 PM EDT
To: "Elliott, Arlene" <Arlene.Elliott@ahca.myflorida.com>
Subject: Gender Dysphoria

Arlene –
Attached is what I have so far, but if I'm going to include Colorado which you just sent me, I won't get this done today. Let me know if you want Colorado added in the spreadsheet.

Kate Torning
Pharmacy Services
Government Analyst II
Room 2358
850 412 4158

Pl. Trial Ex. 250

	MARYLAND	GEORGIA	MINNESOTA	RHODE ISLAND	DISTRICT OF COLUMBIA	MASSACHUSETTS
Outpatient psychotherapy/mental health services for gender dysphoria	X	No set policy for gender dysphoria. Reviewed on a case by case basis and requires Prior Authorization	X		Utilizes medical necessity criteria and standards of care as outlined in WPATH (World Professional Association for Transgender Health)	X
Continuous hormone replacement therapy	X		X	X		X
Outpatient laboratory testing to monitor hormone therapy	X			X		
Orchiectomy	X		X	X		X
Penectomy	X			X		X
Clitoroplasty	X		X	X		X
Labiaplasty	X					X
Vaginoplasty	X		X	X		X
Thyroid chondroplasty	X			X		
Vaginectomy	X		X	X		X
Hysterectomy	X		X	X		X
Mastectomy	X		X	X		X
Salpingo-oophorectomy	X		X	X		X
Ovariectomy	X					
Metoidioplasy	X			X		
Phalloplasty	X			X		X
Scrotoplasty	X		X			X
Placement of testicular protheses	X		X	X		X
Urethroplasty	X		X	X		X
Penile prosthesis			X			
Vulvectomy			X			
Plastic repair introitus			X			
Perineoplasty			X			
Construction artificial vagina			X			
Laparoscopy			X			
Penile prosthesis			X			X
Vulvoplasty				X		X
Colovaginectomy				X		
Breast aumentation				X		X
General statements: More than one state cites WPATH standard of care as a guideline. There is a cost associated in obtaining that, so it is not included. Most states also list reversal of gender reassignment surgery as not covered as well as thyroid reduction and voice modification procedures. Additionally, just because a procedure is NOT checked does not necessarily mean it is NOT covered in that state. This spreadsheet is the best interpretation of the information found for each state listed.						

Worksheet: Sheet1

Pl. Trial Ex. 250

Florida MCOs Clinical Criteria

Magellan Complete Care of Florida;
Community Care Plan (effective July 15, 2016) formerly South Florida Community Care Network

Revised: August 18, 2016

TABLE OF CONTENTS

Pl. Trial Ex. 250

PLAN SUMMARY

- First Coast Advantage (since May 1, 2014); terminated December 1, 2014.
- Magellan Complete Care of Florida (since June 1, 2013).
- Community Care Plus (effective July 15, 2016) formerly South Florida Community Care Network (since July 1, 2014).

BACKDATING OF PRIOR AUTHORIZATIONS

- Backdating will only be allowed in cases where eligibility was made retroactive by the plan or there was a delay in billing that occurred due to billing/delay with a primary payer.
- Review is subject to criteria in place at the time of dispensing.
- Requests for backdating Prior Authorizations will be entered into FirstTrax℠ as a "technical denial": Notes will be entered as an Informational PA.
- No letters will be sent with regards to these backdated Prior Authorization denials since they do not reflect a denial based on clinical criteria.

BRAND / GENERIC CLASSIFICATION

Magellan Medicaid Administration will use the Generic Name Drug Code (also known as the Generic Name Indicator) as a guideline for determining brand/generic classifications on all formulary database changes. This will ensure that there is consistency between POS and the formulary database during claims adjudication.
The Generic Name Drug Code (provided to Magellan Medicaid via FDB) uses the following parameters to classify a product as either brand or generic:

- A drug is identified as generic if the Generic Name Drug Code = 0 (Non-Drug Item)
- A drug is identified as generic if the Generic Name Drug Code = 1 (generic)
- A drug is identified as brand if the Generic Name Drug Code = 2 (brand)

BRAND NAME MEDICALLY NECESSARY

If the provider writes a prescription for a brand name product and there is a generic available (with an applicable SMAC or FUL), the provider must complete a **Miscellaneous Prior Authorization** form ***and*** a **Request for Multi-Source Brand Drug** form. The completed **Multi-Source Brand Drug** form describing the problem and difference in therapeutic response and the **Miscellaneous Prior Authorization** form should be faxed to MRx at the fax number listed on the forms. **Note:** The same documentation is required for brand name medically necessary therapy continuation requests, as well.
CPhTs may approve properly documented requests. CPhTs should escalate any that they feel uncomfortable with.

CODING ERRORS

Anytime that a pharmacy is processing a claim using a drug that is coded non-PDL, but there are other NDCs (within that same GSN) that are preferred, you should override for date of service.
Enter a date of service override using the initiative "PDL: Non-Preferred Drug Override" and use PA Reason Code "System Problem: Unspecified".
This information should be then forwarded to Plan Admin c/o Amy Strahan and copied to Lloyd Bryant.
See also DRUGS CODED AS "N" in the next section.

CONTINUED ON NEXT PAGE

CONTINUITY OF CARE (CoC)

Continuity of Care (CoC) is intended to cover claims for any ongoing course of treatment for members for the first 60 days after the plan's go-live, to cover claims for any ongoing course of treatment for all newly enrolled members for the first 60 days of their enrollment, and to cover claims for any ongoing course of treatment for all re-enrolled members for the first 60 days after re-enrollment due to a break/interruption in coverage. **Any request that comes to us that meets these criteria** qualify for CoC approval based on confirmation from the prescriber that the requested med is in fact a current med for the member (within the last 180 days). A request that meets these criteria would be approved and a prior authorization entered for the BALANCE of the applicable 60 days of the plan's go-live date or the member's enrollment/re-enrollment with a break in coverage/eligibility.

The approval range is NOT necessarily a total of 60 days; the end date should never be beyond the 60th day of the plan's go-live date or the member's enrollment/re-enrollment with a break in coverage/eligibility. It is critical to check the member's eligibility begin date since new consecutive eligibility segments may be entered. The begin date of a new consecutive segment would NOT represent the start date of the member's enrollment/eligibility. HOWEVER, if there is a break in enrollment/eligibility, then the member qualifies for CoC again based on the new starting date.

All Prior Authorization required drugs with any of the following Formulary (Prior Authorization Code) indicators qualify:

- **B**-PDL and Clinical PA,
- **J**-Non-PDL Clinical PA,
- **L**-AutoPA Drug,
- **N**-New Drug(Non-PDL),
- **P**-Clinical PA,
- **R**-Non PDL
- **T**-Covered

We can also use this additional information to help confirm a current med:

- Claim Fill Number > 0

  OR

- There is at least one fill of the incoming drug (based on GSN) found in patient history within the past 90 days **AND**
- The recipient has received less than a 60 days' supply of the med on the incoming claim in the past 180 days

AND ONLY the following, NCPDP Error Codes (EC) qualify:

- NCPDP EC 75 – Prior Authorization Required;
- NCPDP EC 76 – Plan Limitations exceeded;
- NCPDP EC 60 – Product/Service Not Covered For Patient Age;
- NCPDP EC 56 – Non-matched prescriber ID
- NCPDP EC 78 – Cost Exceeds Maximum

CONTINUED ON NEXT PAGE

COURT ORDERS

Court ordered prior authorization requests must be reviewed in accordance to the criteria and handled in the same manner as any of prior authorization request submission. These requests should not be approved automatically.

COVER MY MEDS AND OTHER THIRD PARTY AGENTS

Only PA requests submitted by physicians are accepted.

COVERAGE INDICATOR ON THE FORMULARY FILE TAB IN FIRSTTRAX℠

Please note that additional drug coverage detail based on these codes may be found on MRx Docs in the Weekly Comprehensive Drug List. The List may provide covered NDCs within the same GSN; not all package sizes are automatically covered.
http://mmadocs.fhsc.com/Rx/MAP_Criteria_PDL/MAP_Clinical_Criteria.asp → Florida Managed Care Plans (Common Documents) → Florida Weekly Comprehensive Drug List
A product must have a formulary record to be payable: FirstTrax℠ contact detail →Drug tab →Display ALL NDCs set to **Formulary** →Formulary tab → Formulary ID = **PHARMACISTFL1** and Province/State = **FL – Florida**.
First check the **Coverage Code** indicator which will determine if the product is covered for a specific group. The indicators are as follows:

Field	Value	Description
Coverage Code (ST_COVERAGE_CD)	H	All Programs [Product is covered for all coverage codes excluding **I - drug not covered for any plan**]
	I	Drug Not Cov'd for any plan
	L	Family Planning & TXIX [Family planning and Title 19 product - product is reimbursable for recipients with a family planning benefit or Title 19 benefit]
	T	Covered [TXIX Only – Title 19]
	SPC	Specialty drug restrict to Magellan Spclty Pharm.

Next field to check is the **State Drug Class Code**. The indicators are as follows:

	Value	Description
State Drug Class (ST_DRUG_CLASS)	1	Drug Not Covered
	2	DME Drug Exclusions [Product is not reimbursable through POS. Product is covered through durable medical equipment]
	3	Not Covered for LTC [Product is reimbursable for recipients in long term care]
	4	DME and LTC Exclusions [Product is excluded product for LTC pt's or is considered as a DME product covered by the facility.]
	7	Negative Formulary (MAC Override) [Product is on the Florida negative formulary. AHCA bypasses state maximum allowable cost.]
	B	Bypass FUL Pricing [This indicator bypasses the Federal Upper Limit pricing on GSN]
	D	None [This is a placeholder because all formulary must be populated in order to adjudicate a claim.]
	U	LTC Exclusions and Medicare D [Product is not reimbursable for LTC and Medicare Part D recipient.]
	W	Standard Drug Exclusions and Medicare B & D [Product is an inner packaging NDC of a box/carton]
	Y	Medicaid Cov'd for Part D [Product is reimbursable through POS. It is not covered by Medicare Part D.]
	Z	Medicare B and D [Product is an outer packaging NDC of a box/carton]

CONTINUED ON NEXT PAGE

Next field to check is the **Prior Authorization Code**. The indicators are as follows:

Field	Value	Description
Prior Authorization (ST_PRIOR_AUTH_CD)	A	Regranex (LTC PA Required) [PA required for recipients in LTC]
	B	PDL and Clinical PA [Product is preferred but requires a clinical prior authorization reviewed by Magellan Medicaid Administration]
	D	No Prior Auth Required [This is a placeholder because all formulary must be populated in order to adjudicate a claim.]
	F	REMS/RDDS (PDL) [Restricted Drug Distribution Drug]
	J	Non – PDL Clinical PA [Product is non-preferred and requires a clinical prior authorization reviewed by Magellan Medicaid Administration]
	L	Auto PA Drug (PA Required) [Automated PA drug]
	M	Physician services billed drug [Product is billed by the physicians and is not reimbursable through POS]
	N	New Drug (Non-PDL) [Addl info in Section "Drugs Coded as "N"] [Product is a new NDC into the database and awaiting coverage from AHCA]
	P	Clinical PA [Product requires a clinical PA and is reviewed by Magellan]
	R	Non-PDL [Product is non-preferred]
	S	PDL [Product is preferred]

Next field to check is the **State Maximum Quantity Code**. The indicators are as follows:

Field	Value	Description
State Maximum Quantity Code (ST_MAX_QTY_CD)	0.3 – Max 0.3 per day	0.3
	P34 – Max 0.34 per day	0.34
	0.5 – Max 0.5 per day	0.5
	0.6 – Max 0.6 per day	0.6
	1 – Max of 1 per day	1
	O2 – Max 1.186 per day	1.186
	2 – Max 2 per day	2
	2.5 – Max 2.5 per day	2.5
	GRA – Max 2.963 per day	2.963
	3 – Max 3 per day	3
	4 – Max 4 per day	4
	5 – Max 5 per day	5
	6 – Max 6 per day	6
	8 – Max 8 per day	8
	9 – Max 9 per day	9
	10 – Max 10 per day	10
	12 – Max 12 per day	12
	OSE – Max 12.5 per day	12.5
	O32 – Max of 14.815 per day	14.815
	15 – Max 15 per day	15
	16 – Max 16 per day	16
	20 – Max 20 per day	20
	24 – Max 24 per day	24
	30 – Max 30 per day	30
	36 – Max 36 per day	36

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The last indicator to check is the **Formulary Indicator**. The indicators are as follows:

Field	Value	Description
(Medicaid State) Formulary Indicator (FORMULARY_IND)	9	OTC [Over the counter product]
	D	Dialysis (Med Cert 8) [Product is used for dialysis patients]
	F	FP (Med Cert 6) [Product is considered a family planning product]
There will always be a value in this field.	M	Maintenance Drug [Product is a generic maintenance medication which may be billed for > 34 days' supply]
The 'X – Other' value is the default value for this field.	X	Other

DENIALS (INITIAL REVIEWS), APPEALS, AND PEER-TO-PEER REQEUSTS

- Initial denials will be entered by Magellan Rx (MRx) pharmacists. Physician-level review, except for clearly identified edits (particularly psych edits for < 18 years old), is NOT involved.
- See Appendix B for PA Reason Codes/Letter Drops Ins/CTIs for these plans' member letters for initial denials: **APPENDIX B: PA REASON CODES & DROPS INS AND LETTER CODES FOR INITIAL DENIALS**.
- See Appendix C for more information on Letters: **APPENDIX C: INITIAL DENIAL AND APPEAL LETTER STATUS**.
- PA REASON CODES, CLINICAL RATIONALE (ON THE PA SCREEN), AND CTIs ARE CRITICAL FOR REQUIRED LETTER GENERATION. Please make sure that the correct PA Reason Code and suitable Clinical Rationale have been entered before creating rules.
- CONTACT DETAILS WITH APPROVED OR DENIED INITIAL REVIEW OR APPEAL PA DECISIONS MUST BE RESOLVED ON THE DAY OF THE DECISION SO THAT THE APPROPRIATE LETTER IS GENERATED.
- Peer-to-Peer requests to initial denials and Appeals to initial denials that cannot be approved (initial denial overturned on appeal by RPh) by MRx pharmacists will be escalated for physician review.
  - **Appeals may be initiated BY THE MEMBER, THE MEMBER'S AUTHORIZED/DESIGNATED AGENT, AND/OR THE PRESCRIBER. This is a clarification from the Plan as of February 2016.**
  - **The contact detail used for the appeal:**
    - Shall not use a claim record because this populates incorrect information on any resulting letter.
    - The **Date of Service** field on the Contact Detail shall be manually populated with the date of receipt of the appeal request (Fax Requests: Date of Service field should show the date received for the fax requesting the appeal; Phone Requests: Date of Service field should show the date received for the phone call requesting the appeal. This is critical for the correct info on any resulting letter.
    - Member's address must be populated.
    - Prescribing physician's address must be populated.

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DENIALS (INITIAL REVIEWS) AND APPEALS *(CONTINUED)*

- MCC-FL: To MCC-FL physician staff per Outlook e-mail template (in the Glen Allen Pharmacists Procedures folder on the Call Center's Shared Document SharePoint site):

  http://teams2-mma/sites/CallCenter/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FCallCenter%2FShared%20Documents%2FGlen%20Allen%20Pharmacists%20Procedures&FolderCTID=0x0120009A501F956290854BBE917EAD779A0EDD&View={1BE16282-E74C-4A1C-9786-BC915D6DE6AE}

  - Magellan Complete Care – Florida (MCC-FL) / Magellan Rx (MRx)

Request for MCC-FL / MRx Initial Denial Appeal Review

- Members, their authorized/designated agent, and/or the prescriber have 30 days from the date of the denial letter to appeal a denial.
- **Expedited Appeal:** Decision is required within 72 clock hours (including weekends and holidays) of receipt.
- **Standard Appeal:** Decision is required within **30 calendar days** of receipt of the appeal request.
- MCC-FL may choose to have the AllMed physician service process an appeal review.
  - We still forward the request per the e-mail template noted above. MCC-FL will attach the AllMed decision to the **Reply To All** back to us.
  - The AllMed physician's review notes must be copied over into our clinical notes.
  - The appropriate PA Reason Code for an appeal must be chosen (Expedited/Standard versions are listed)
  - The AllMed physician's review notes will also contain a statement for the member that we can use in the Clinical Rationale field.
  - The AllMed reviewing physician and the physician's board certification will appear on the decision. If the physician is not listed as an option within the Reviewer Name field's pop-up choices on the Activity tab in FirstTrax℠, forward the info to Grant and Carol ASAP so that they can add the name and info to the list BEFORE you Resolve and Save the Contact Detail so that the letter will generate.

- CCP/SFCCN: To MRIoA physician service (via FirstTrax℠ MAP: Physician queue; they monitor this queue).
  - Members have 30 days from the date of their denial letter to appeal a denial.
  - Expedited Appeal: Decision is required within 72 clock hours (including weekends and holidays) of receipt.
  - **Standard Appeal:** Decision is required within **45 calendar days** of receipt of the appeal request.
  - RPhs: document in clinical notes the reason for denial, page(s) in criteria, and appeal review deadline.

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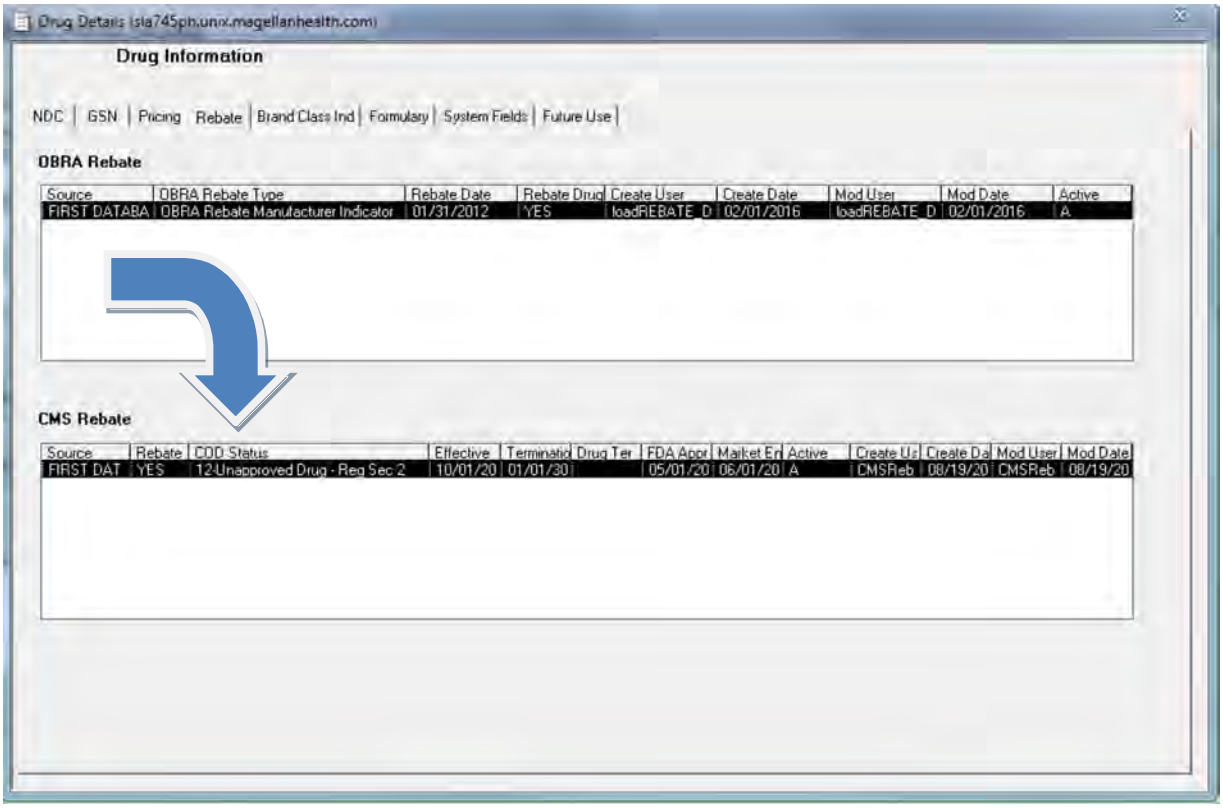
DESI (COD STATUS INDICATORS); NON-REBATE; OBSOLETE

COD Indicators that are now used to identify DESI status have been brought into FirstTrax℠. FDB sends them with the CMS Rebate information, so you will find this information on the Rebate tab in the second table, "CMS Rebate," in the "COD Status" field. While the values will always be the same for any one drug, client-level exclusions vary.



The COD Status is a category that identifies whether or not a product meets the statutory definition of a covered outpatient drug in accordance with the Social Security Act. The following list identifies all COD Status values:

- 01 = Abbreviated New Drug Application (ANDA)
- 02 = Biological License Application (BLA)
- 03 = New Drug Application (NDA)
- 04 = NDA Authorized Generic
- 05 = DESI 5* – LTE (Less Than Effective)/IRS drug for all indications
- 06 = DESI 6* – LTE (Less Than Effective)/IRS drug withdrawn from market
- 07 = Prescription Pre-Natal Vitamin or Fluoride
- 08 = Prescription Dietary Supplement/Vitamin/Mineral (Other than Prescription Pre-Natal Vitamin or Fluoride)
- 09 = OTC Monograph Tentative
- 10 = OTC Monograph Final
- 11 = Unapproved Drug – Drug Shortage
- 12 = Unapproved Drug – Per 1927(k)(2)(A)(ii)
- 13 = Unapproved Drug – Per 1927(k)(2)(A)(iii)

*NDCs with a COD Status of DESI 5/6 are not eligible for coverage or rebates under the Medicaid Drug Rebate Program. However, pricing is required and URAs are calculated.

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DROPPED CALLS

- If enough info is documented in the clinical notes to render a fair decision, then the agent will enter the applicable prior authorization, notify the requester by callback and/or by fax, and resolve.
- If enough info is NOT documented in the clinical notes to render a decision, the agent will call the office back or fax the office back, and proceed based on regular plan-specific protocol.
- If enough info is NOT documented in the clinical notes to render a decision, and the agent chooses to not call the office back or fax the office back, then the agent will resolve the issue with the CTI for Hang Up.

DRUGS CODED AS "N"

When a drug has a Prior Authorization indicator = "N – New Drug (Non-PDL)" that means that it is a new NDC that has been loaded and no decision has been made if it is going to be PDL or non-PDL. It may be practical for the pharmacy to choose another NDC until this NDC has been assigned an indicator (takes about a week from the time the new NDC is loaded into our system…a month at the most).

Additional info in Section "Coverage Indicator on the Formulary File Tab in FirstTrax℠"

Please complete a GSN search and follow the below directive:

- If the drug is coded "N" and all the other drugs in the same GSN are "R Non-PDL," the drug may not be overridden.
- If the drug is coded "N" without other drugs in that category, the drug may not be overridden.
- If a preferred NDC is found, even if the preferred manufacturer is obsolete, please approve x 3 months using the information below:

Pharmacists and Technicians:

- Use the PDL: Non-Preferred Drug Override
- Use the PA reason code: System Problem: Unspecified
- Duration: Enter the prior authorization approval for three months
- Prior authorization request may be granted by the Prescriber or Pharmacy.

Note: There is no need to ask the provider to switch to the same drug by another manufacturer.

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DRUGS WITH NO CRITERIA

CPTs and RPhs should perform a GSN search to see if there is a preferred alternative.

- Primary preferred drug list: http://ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml
- If ***no preferred*** alternative generic equivalents are found after a GSN search, escalate to RPh for further review.
  - RPhs should check the **Preferred Drug List** (link below and on MRx Docs) and the **Weekly Comprehensive Drug List** (on MRx Docs) to search for a covered alternative; you may want to search by the HIC3. Ex. Non-preferred Protopic finds preferred Elidel.
  - RPhs may refer the prescriber to the website also.
- If a ***preferred brand or generic equivalent*** is found via GSN search, please note the following:
  - **Generic:** When the generic name of the medication is preferred by the MCO, please have the pharmacy submit the claim with the generic name medication, and the claim should pay without a prior authorization being required.
  - **Brand:** When the brand name of the medication is preferred by the MCO, please have the pharmacy submit the claim with the brand name medication and a DAW code of "0" or if a generic is available use a DAW of "5," and the claim should pay without a prior authorization being required. If this is a Brand Medically Necessary request, please follow the instructions under **Brand Name Medically Necessary in the Plan Summary**.

EXAMPLES OF PREFERRED BRAND/GENERIC ALTERNATIVES

PREFERRED MEDICATION	NON-PREFERRED MEDICATION
Catapres – TTS	Clonidine patches
Pulmicort	Budesonide
Differin	Adapaline
Latuda	Lurasidone
Valcyte	Valganciclovir
Tobradex	Tobramycin/Dexamethasone

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DRUG EXCEPTION REQUEST PROCEDURE: MCC FL ONLY

1. Process-specific CTIs have been created to accommodate these requests and to make sure that when letters are needed that they are generated accurately.
2. The requested medications would generally be exclusions and have NO CRITERIA. Exceptions are requests for drugs that do NOT exist on the MCC FL drug formulary (Weekly Comprehensive Drug List posted on MRx Docs). Any drug on the formulary, whether it is preferred or non-preferred, is not eligible for an exception review but rather should follow the normal prior authorization process.
3. A drug exception request may be requested by the Member either through completing an on-line form or calling the Member Services desk or by the prescribing physician calling to request a drug exception.
4. If a member calls Member Services, the CPhT answering the phone will open a case in FirstTrax℠ and include all the available information; at a minimum member name, member cardholder ID, medication name, prescriber name and phone number as well as reason the member feels they are entitled to an exception. The CPhT will use the CTIs:
   - Call Category: MAP Exception Inquiry
   - Call Type: MAP Exclusion Exception
   - Response Code: In Progress Exception
5. Afterwards, the CPhT will place the request in the Prior Authorization RPhs work queue.
6. When a request is submitted by a member, the Clinical Team will conduct an outreach to the prescribing physician to obtain the medical justification for an exception as well as any clinical documentation that is required to support a prior authorization review.
7. When a request is submitted by a prescriber, the prescriber must specifically make the request in terms of an **Exception**; otherwise, the regular PA process occurs.
8. When the request is made directly to the Clinical Contact Center, the Magellan Rx Management CPhT will set up the contact detail for the request and will document all basic information for the member, the prescriber, the medication, and any information the prescriber wishes to provide. The contact detail/call will then be escalated to the RPh queue.
9. If a Magellan Rx Management RPh cannot approve the request **and the prescriber or member specifically makes the request in terms of an Exception**, then a Peer-to-Peer will be set-up with MCC-FL physician.
10. Magellan Rx Management RPh will use internal Outlook template to process the request to MCC-FL staff. The Outlook template itemizes the necessary information for the review and can be found at this link to the Call Center Shared site. http://teams2-mma/sites/CallCenter/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2FCallCenter%2FShared%20Documents%2FGlen%20Allen%20Pharmacists%20Procedures&FolderCTID=0x0120009A501F956290854BBE917EAD779A0EDD&View={1BE16282-E74C-4A1C-9786-BC915D6DE6AE}
11. MCC-FL staff will review the requested phone and time information and will contact the prescriber if adjustments are needed prior to the main conversation.
12. MCC-FL physician will conduct the review and reply back to the Magellan Rx Management RPh via the original e-mail with their decision.
13. FirstTrax℠ will use the **following CTIs** for recording purposes and to insure that all applicable letters are generated.
    - Call Category = MAP Exception Inquiry;
    - Call Type = MAP Exclusion Exception;
    - Response Code = various options depending on the what point in time in the review process.
14. All requests shall be completed within 5 business days and specifically excludes weekends and holidays unless the prescriber cannot be available for the peer-to-peer within the 5 business days.
15. For additional information related to this process refer to the procedure: Requesting Exception to Drug Not on Formulary (SC-12) in the Magellan Rx Procedure Library: http://teams2-mrx/sites/FHSCDocMgmt/PnP/Documents/Forms/AllItems.aspx

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DRUG SHORTAGES AND BACKORDERS

- Standard Drug Availability Surveillance (DAS) team protocol applies.
- Overrides due to drug shortages should only be made when the shortage has been confirmed and documented by the DAS (Drug Availability Surveillance) Committee or by direct notice from the MCC-FL/CCP/SFCCN Sr. RPh or Clinical Account Manager. The override will be entered for date of service only. Note the following in your clinical notes in FirstTrax℠, "shortage has been confirmed and documented by DAS (Drug Availability Surveillance)". With this documentation, the Plan, upon review of your clinical notes, can confirm that the shortage is indeed a true shortage and not just a pharmacy/wholesaler that is currently out of the medication.
- Here is the link to the DAS form for submitting requests
- http://mmadocs.fhsc.com/Clinical/DAS/das.asp

DURABLE MEDICAL EQUIPMENT (DME; I.E., DIABETIC SUPPLIES, TEST STRIPS, ETC.): MCC-FL ONLY

Length of Authorization:	Continuity of Care - The ***balance*** of the first 60 days of eligibility
Initiative:	MAP: NDC Not Covered (2211 / 70 – GSN; 2641 / 76 – GSN)

- All products with Formulary Indicator State Drug Class = "2" are billed to DME.
- The following DME vendors are available to MCC-FL members.
  - Coastal – 1-855-481-0505: Insulin Pumps and other DME, but excluding diabetic testing supplies like test strips, lancets, etc.
  - Liberty (phone number will be noted here as soon as I get it from acct managmenet): diabetic testing supplies like test strips, lancets, etc which Coastal does not process.
- DME products are noted in several places throughout this document.
- Effective 09/09/2014 this POS/Supplemental Transaction message, *DME: if COC contact PBM at 800-327-8613 opt. 4 then opt. 2 for an override,* will be deployed to production for MCC FL client (IE 2211 / NCPDP 70). Per this message and the policy behind it, products that reject with this message occur during the member's CoC eligibility, and during this time, we are authorized and are expected to enter the CoC based approval (for the ***balance*** of the first 60 days of eligibility). Once the member's CoC eligibility period expires, DME products must be billed to either of these two vendors. Please note that other edits such as quantity (e.g., IE 2614 / NCPDP 76) may also apply and would also be approved for the same time frame per this policy.

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EMERGENCY 120-HOUR (5 DAYS) SUPPLY FOR NON-PREFERRED PDL DRUGS

If a drug has a State Prior Auth Code Formulary indicator "R-Non PDL" [Non-Preferred drugs: Formulary Indicator = R] the pharmacy can submit the claim with a Prior Auth Type Code "1" and Level of Service "3" and the claim will pay at point of sale. The claim must be submitted with a days' supply no greater than five, and there is a limit of two emergency overrides every 30 days. Claims submitted with a Prior Auth Type Code "1" and for a quantity greater than a 5 days' supply will deny and display "5 Maximum Days Exceeded" in the Supplemental transaction Message field. If the claim is not for an emergency supply, the pharmacy should not be submitting with a Prior Auth Type Code "1."
This procedure is not applicable to drugs that require a clinical PA [Formulary Indicators of B, J, or P]. The full list of indicators used is listed here in the Plan Summary under subsection **COVERAGE INDICATOR ON THE FORMULARY FILE TAB IN FIRSTTRAX℠** . The following entry is from the QC:
Emergency (120 Hour) Protocols (from QuikChek):

- Limit 2 emergency fills per recipient, per GSN per 30 rolling days.
- If more than five days supply, do not approve the claim unless the medication cannot be broken.
- Emergency PA overrides are not allowed for drugs that require a clinical authorization.
- Emergency PAs are allowed only for non-PDL drugs.

Note: Emergency PAs override only NCPDP 75.

EXCLUSIONS (MCC-FL ONLY)

- See APPENDIX A: DRUG LIMITATIONS FROM THE CSA – Standard/Legend Drug Exclusions

FAX FORMS AND FAXBACK MESSAGING

- http://www.magellancompletecareoffl.com/fl-site/providers/preferred-drug-list/pharmacy-prior-authorizations.aspx
- https://sfchp.magellanpharmacysolutions.com/pharmacy/CCP/SFCCN/source/pa_help.shtml

HEMOPHILIA PROGRAM FOR FACTOR MEDICATIONS AND RELATED PRODUCTS

- All factor drugs (including but not limited to HIC3s M0E, M0F, and M0O, and HICLs 017973 and 041559, and GSN 022139) should be billed directly to FL Medicaid. MCC-FL and CCP/SFCCN will not reimburse for these claims.

HOSPITAL OR SIMILAR FACILITY DISCHARGE POLICY

- Criteria to Approve: If requested medication is continuation of therapy upon hospital discharge, approval is to be entered for the duration of the current prescription (this includes authorized refills) not to exceed the regular approval interval for the med. Plan Excluded products are not included.

INTERNAL ERROR 7007 – NUMBER OF FILLS LIMIT EXCEEDED

- Internal Error 7007 is a quantity limit related internal error code that is used in coding for some edits that are based on an edit-specific number of fills/refills:
  - For the CII - CV fills limit (MAP: CII-CV Fill Limit Override (76 / 7007 – GSN)); **AND**
  - For Synagis quantity (MAP: Error Code 7007 Override (76 / 7007 – GSN; 76 / 2641 – GSN)); **AND**
  - For CCP/SFCCN when the pharmacy submits a claim that violates the coding for Med Part D / Medicaid Dual Eligible.

NEWBORN CHILDREN

- If the newborn's Medicaid number is not active or the baby cannot be found in the system, the pharmacy or physician may fax the "Newborn Activation Form" (link below) to 877-231-2170 to have the coverage activated.
- http://ahca.myflorida.com/Medicaid/Newborn/pdf/newborn_activation_form_07072010_accessible.pdf
- The baby's Medicaid coverage will be activated within two business days. If there is an emergency and this process needs to be expedited, please refer the caller to their local Medicaid area office. Link to area office phone numbers:
- http://portal.flmmis.com/flpublic/Provider_AreaOffices/tabid/37/Default.aspx

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PLAN SUMMARY (CONTINUED)

OBSOLETE DATES; HCFA TERM DATES (GRACE PERIODS)

- 543 days past the obsolete date
- No grace period for HCFA term date

OMBUDSMAN PROGRAM

As a result of a settlement agreement in the Hernandez vs. Medows lawsuit, effective May 14, 2004, Florida Medicaid began providing the services of an Ombudsman to facilitate the timely resolution of claim reimbursement rejections, when the problems cannot be resolved through self-help by the recipient or intervention by the pharmacy or the prescriber. Information Pamphlets in English and Spanish, along with pharmacy guidelines, have been provided to Medicaid pharmacy providers explaining in detail who should receive the pamphlets and what rights a recipient has if a prescription claim is denied by Medicaid, as well as what the recipient's responsibilities are, and what the prescriber's responsibilities are. A toll free number is included in the pamphlets for the recipient to contact an Ombudsman if all conditions are met and the recipient continues to believe the claim should be approved by Medicaid.

In addition to providing the Information Pamphlets, Medicaid pharmacy providers are also required to post in a conspicuous location within each pharmacy both English and Spanish language signs which include the Ombudsman's toll free telephone number (1-866-490-1901). The Ombudsman is prepared to handle calls for both fee-for-service Medicaid and Medicaid prepaid health plans.

Please note that the phone number listed is a general number.

Plan Specific phone and fax numbers:

- MCC-FL: (P): 800-424-7973, (F): 800-424-7982
- CCP/SFCCN: (P): 800-424-3249; (F): 800-424-7913

PRIOR AUTHORIZATION TYPE CODE (PATC) = 1; 3 MAXIMUM DAYS EXCEEDED (IE 2614 / NCPDP 76)

When the pharmacy submits a claim with a "1" in the Prior Authorization Type Code (PATC) field and the claim is not meant to be an emergency supply (submitted for more than a 5-days' supply), the claim may deny for quantity related error code (IE 2614 / 76). Check the Prior Auth Type field. If there is a "1" in the PATC field and the claim is not an emergency supply claim, have the pharmacy remove the 1, and then resubmit the claim. If there is a "1" in the PATC field and the claim is an emergency supply claim, have the pharmacy change the quantity and/or days' supply fields to fall within the EMERGENCY 120-HOUR (5 DAYS) SUPPLY FOR NON-PREFERRED PDL DRUGS.

PHARMACY NOT IN OUR NETWORK

Internal Error = 3005: Pricing price rule not found / Reject Code (NCPDP) = M8: Host provider file error: This means that the pharmacy submitting the claim is not in our network; not being able to find pricing (since it is determined by a pharmacy panel) is like a fatal error that stops adjudication from even getting to validating the pharmacy itself.

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PLAN SUMMARY (CONTINUED)

PHYSICIAN SERVICES BILLING / MEDICAL BILLING

- FirstTrax℠ contact detail →Drug tab →Display ALL NDCs set to **Formulary** →Formulary tab →Prior Authorization field; "M – Physician services billed drug."
- Unless the drug file indicates coverage restricts the med to physician service billing, and if the criteria do not specifically note that physician billing is the ONLY way that it can be billed, then injectable meds, regardless of place of administration, may be processed at POS. And if a PA is required or other edits apply that we traditionally process show up, then we handle them just like any POS request.
- MCC-FL Requests: The requester may be referred to Magellan Complete Care @ 800-327-8613. They should choose Option 4 (Provider) and then Option 3 (Authorization). MCC-Fl staff should then be able to direct the request as necessary.
- Pharmacies not registered to bill POS Pharmacy claims: We have processed PA requests (MCC-FL) for at least one pharmacy, Univita, which is not registered to bill POS Pharmacy; they are only registered to bill Medical/Home Infusion. If these requests are identified early enough in the process, then the requester can be redirected to pursue the PA through Medical billing.
  - For MCC-FL, the requester may be referred to Magellan Complete Care @ 800-327-8613 as noted in the preceding bullet.
  - For CCP/SFCCN, the requester may be referred to CCP/SFCCN Medical Provider Services @ 800-424-7897 (P) and/or 800-424-7913 (F).

NON-REBATEABLE NDCS: NON-REBATE NDCS ARE NOT COVERED

NON-REIMBURSABLE MEDICATIONS

- If a medication is coded I- Drug not covered for any plan, State drug class 1- Drug not covered, this generally means not reimbursable through 'Pharmacy Services'. However, it is possible the medication can be reimbursed through Physician Services, hospital, etc.

PLAN SPECIFIC STAFF CONTACTS

When taking calls or requests directly from someone at one of these plans (staff, client, patient representative), please choose "Client" as the *Requester Type.* Please document at a minimum the staff's *first name, last name, and phone number*. Please clearly document the encounter either in clinical notes (if a PA is entered) or in the Work Log (if no PA is entered). This is critical for client inquiries into member concerns/complaints, etc.

- To ensure accurate PA billing, you must use "Client Requests Override" as the PA Reason Code if a PA is entered.
- MCC-FL Health Services Team Members are Magellan employees. Callers representing themselves as MCC-FL staff can be verified by accessing the Magellan Corporate Directory on Magnet: http://stlmoweb20/OrgChart/
- CCP/SFCCN: AS of October 1, 2015, CCP/SFCCN staff have been advised to use the 'password' CCP/SFCCN14.

PRACTITIONER LOCKOUTS: MCC-FL ONLY

- FirstRx℠ will deny all incoming POS claims (NCPDP EC 71 – Prescriber ID is Not Covered with additional message, "*Prescriber ID Ineligible by Plan*. ") submitted with a prescribers ID containing an active Specialty segment equal to "SUS – Ineligible Prescriber." The Specialty segment will include an effective and termination date. There will be no overrides allowed at the call center level. The status is displayed on the Physician tab in the Physician Specialty field.

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PREFERRED DRUG LIST WEBSITE AND PDL STATUS CHANGES

Preferred Drug List Website:
http://ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml
PDL Status Changes:

- For medications that change from Preferred to Non-Preferred grandfathering would generally not be implemented by MCC-FL or CCP/SFCCN since FL FFS does not generally grandfather. Adherence to or positive therapeutic outcomes from therapy with a preferred med that has been changed to non-preferred is not a reason for automatically granting an approval for continuation of therapy. The plans will accept an approval for continuation of therapy if the patient meets the traditional step-therapy criteria requirements: tried/failed preferred alternatives preferred med(s) is/are contraindicated, and/or the patient has had an adverse reaction to the current preferred alternatives.
- Please note that patients adherent to antipsychotics are EXCLUDED from this requirement to meet criteria by going back to another med. This is due in large part to the fact that AHCA and the MCO plans are very aware of the sensitive nature of these therapies once established and working.

SAMPLE MEDICATIONS

Trials and trials/failures using sample medications are NOT acceptable.

TOTAL PARENTERAL NUTRITION (TPN)

The Plans reimburse for total parenteral nutrition (TPN) for recipients in their homes when supplied by pharmacies that are equipped and licensed to prepare sterile intravenous products. TPN must be billed as a compounded product; separate claims for the TPN components are not allowed. Interdialytic parenteral nutrition administered during a dialysis session is not covered.

TRANSGENDER HORMONE DRUG REQUESTS: MCC FL ONLY

For MCC-FL ONLY: Requests for hormonal therapy (i.e., Depo-Estradiol, Premarin, et al) for members for whom we can document that they are in the midst of or have completed gender reassignment, shall be approved for a gender to drug edit; other edits would still apply.

WEBSITES

https://fca.magellanpharmacysolutions.com
http://www.magellancompletecareoffl.com/fl-site/about-complete-care/welcome.aspx
http://sfchp.magellanpharmacysolutions.com
http://ccpcares.org (effective July 15, 2016 when SFCCN's name changes to Community Care Plus)
http://ccpcares.magellanrx.com Magellan Rx Member Portal (effective July 15, 2016 when SFCCN's name changes to Community Care Plus)

WEEKLY COMPREHENSIVE DRUG LIST INTERNAL WEBSITE (MRX DOCS)

http://mmadocs.fhsc.com/Rx/MAP_Criteria_PDL/MAP_Clinical_Criteria.asp → Florida Managed Care Plans (Common Documents) → Florida Weekly Comprehensive Drug List

ACETAMINOPHEN (APAP) ACCUMULATION EDIT USING HIC3 = H3E (ACETAMINOPHEN CONTAINING PRODUCTS)

Length of Authorization:	See Review Criteria below
Initiative:	MAP: APAP Accumulation Limit (2709 / 76)

Intent: Create an acetaminophen (APAP) accumulation edit using HIC3 = H3E (acetaminophen containing products) to limit the accumulated dose of APAP across all acetaminophen products to 4 grams/day. Once the calculated daily dose of APAP from all products **exceeds 4,000 mg (4gm)**, the claim will deny for **NCPDP 76 – Plan Limitations Exceeded.** A call center override will be necessary. Coding will use an accumulation tolerance of 3 days.

- Limitation: Chronic doses above 4 grams of APAP daily have been shown to cause serious toxicity to the liver. As a result, the drugs listed below will be added to a reject for accumulated doses over 4 grams/day.

REVIEW CRITERIA: Clinical Pharmacist professional judgment; these will likely be DENIED unless there are clear circumstances to the contrary.

ACNE MEDICATIONS

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason the Patient cannot be changed to preferred medications? Acceptable reasons include
   - ☐ Allergy to all unrelated preferred medications
   - ☐ Contraindication to or drug-to-drug interaction with preferred medications
   - ☐ History of unacceptable/toxic side effects to preferred medications
2. Has there been a failure to respond to a therapeutic trial of at least one week each of at least TWO preferred medications? Document details.

TOPICAL AGENTS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Azelex® (azelaic acid)	Acanya Gel® (benzoyl peroxide/clindamycin) *
Clindamycin 1% soln/lotion/gel/ pledgets/ foam*	Aczone® (dapsone) *
Clindamycin Palmitate soln *	Akne-Mycin® (erythromycin)*
Erythromycin 2% gel/soln/ pads/pledgets *	Benzamycin® (benzoyl peroxide/erythromycin) *
	BenzaClin® (benzoyl peroxide/clindamycin) *
	Benzoyl Peroxide (all formulations)
	Cleocin T® gel/solution
	Clindacin® Pac Kit/ETZ Pledget/ETZ Kit (clindamycin phos; Kit adds Skin Cleanser) *
	Clindagel® (clindamycin 1%) *
	Clindamycin 1% foam
	Clindareach® (clindamycin 1%)
	Cleocin Palmitate solution
	Duac® Gel (benzoyl peroxide/clindamycin) *
	Epiduo® (benzoyl peroxide/adapalene) **
	EpiDuo Forte® gel w/pump (benzoyl peroxide/adapalene)*
	Ery Pads®
	Erythromycin 2% pledgets
	Erythromycin/Benzoyl Gel
	Evoclin® (clindamycin 1%) foam
	Inova® (benzoyl peroxide) pads
	Lavoclen® (benzoyl peroxide) wash
	Neuac® gel/kit (clindamycin phos/benzoyl peroxide/kit adds emollient) *
	NuOx® (benzoyl peroxide/sulfur)
	Onexton® gel (clindamycin phos/benzoyl peroxide) *
	Sodium Sulfacetamide
	Z-Clinz®
	Ziana® Gel (clindamycin/tretinoin)

*Min age = 12 yrs. ** Min age = 9 yrs

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ACNE MEDICATIONS (CONTINUED)

TOPICAL RETINOIDS (VITAMIN A DERIVATIVES)

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Differin® (*adapalene*) – cream	Adapalene gel and gel/pump (generic Differin®)
Retin-A® cream (*tretinoin*)	Atralin® **
	Avage® *(tazarotene)* - cream
	Avita® (*tretinoin*) – gel/cream (available generically) *
	Differin® gel and gel pump *(adapalene)* *
	Fabior® 0.1% Foam *
	Retin-A® gel (*tretinoin*) *
	Retin-A Micro® gel/pump (*tretinoin*) *
	Tazorac® *(tazarotene)* - gel and cream [30/29]
	Tretinoin gel/cream (generic for Retin-A®)
	Tretinoin microsphere gel (0.04%, 0.1%) (Generic for Retin-A Micro® gel/pump)

*Min age = 12 yrs. ** Min age = 10 yrs

ORAL RETINOIDS (VITAMIN A DERIVATIVES)

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Amnesteem® (Isotretinoin)	Absorica® (isotretinoin) capsules- - 10mg, 20mg, 25mg, 30mg, 35mg, 40mg
Clavaris® (isotretinoin) capsules- 10mg, 20mg, 30mg, 40mg	Accutane® (Isotretinoin)
Myosorian® (isotretinoin) capsules- 10mg, 20mg, 30mg, 40mg	
Zenatane® (isotretinoin) capsules- 10mg, 20mg, 30mg, 40mg	

RENOVA®

Not FDA indicated for the treatment of acne. Renova® is considered for "cosmetic use" and not reimbursable under the Plan. All requests should be forwarded to a pharmacist for review.

VELTIN® (CLINDAMYCIN AND TRETINOIN)

- ☐ Do not approve request for Veltin®.
- ☐ Please offer the individual components separately as a Change In Therapy. This drug is covered as single entities: clindamycin and Retin-A Micro Gel separately.

ARCALYST® (RILONACEPT)

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL INDICATIONS

- ☐ Patient must be receiving treatment for Cryopyrin-Associated Periodic Syndromes (CAPS).
- ☐ Patient must be age 12 years or older

DENIAL MESSAGE

- ☐ TBD

ACTEMRA® (TOCILIZUMAB)

Length of Authorization:	Up To One Year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

RHEUMATOID ARTHRITIS

- ☐ Patient must be 18 years of age or older
- ☐ Patient has a documented diagnosis of moderate to severe rheumatoid arthritis
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to one or more non-biologic- DMARDs (i.e., methotrexate, leflunomide, sulfasalazine, hydroxychoroquine) for at least 3 consecutive months; **AND**
- ☐ Patient has had an inadequate response, intolerance, or has contraindications to: Xeljanz® and Humira®

POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA)

- ☐ Patient must be 2 years of age or older.
- ☐ Patient has a documented diagnosis of polyarticular juvenile idiopathic arthritis
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) with the following:
  - ☐ One or more non-steroidal anti-inflammatory-NSAIDS; **AND**
  - ☐ One or more non-biologic- DMARDs (i.e. methotrexate, sulfasalazine [in patients six and older])

  AND
  - ☐ Trial and failure of preferred alternative Humira®

SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA)

- ☐ Patient must be 2 years of age or older
- ☐ Patient has a documented diagnosis of systemic juvenile idiopathic arthritis
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapy) with one or more non-steroidal anti-inflammatory-NSAIDS

CONTINUATION OF THERAPY

- ☐ Documentation showing current patients are stable (have low RA disease activity or are in clinical remission) will be taken into consideration during the prior authorization review process regarding continuation of therapy with the same agent.

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ACTEMRA® (TOCILIZUMAB) (CONTINUED)

DOSING AND ADMINISTRATION

- **Rheumatoid Arthritis:**
  - Recommended Adult Intravenous (IV) Dosage:
    - When used in combination with DMARDs or as monotherapy the recommended starting dose (IV) is 4 mg per kg every 4 weeks followed by an increase to 8 mg per kg every 4 weeks based on clinical response.
  - Recommended Adult Subcutaneous (SC) Dosage:
    - Patients less than 100 kg weight: 162 mg administered subcutaneously every other week, followed by an increase to every week based on clinical response
    - Patients at or above 100 kg weight: 162 mg administered subcutaneously every week
- **Polyarticular Juvenile Idiopathic Arthritis:**
  - Recommended SJIA Dosage Every 4 Weeks:
    - Patients less than 30 kg weight: 10 mg per kg
    - Patients at or above 30 kg weight: 8 mg per kg
- **Systemic Juvenile Idiopathic Arthritis:**
  - Recommended SJIA Dosage Every 2 Weeks:
    - Patients less than 30 kg weight: 12 mg per kg intravenously
    - Patients at or above 30 kg weight: 8 mg per kg intravenously
- **General Dosing Information:**
  - It is recommended that Actemra not be initiated in patients with an absolute neutrophil count (ANC) below 2000 per mm^3, platelet count below 100,000 per mm^3, or who have ALT or AST above 1.5 times the upper limit of normal (ULN).
  - Doses exceeding 800 mg per infusion are not recommended in RA patients.
  - **ACTEMRA for subcutaneous injection is only indicated in the treatment in patients with adult RA and is not indicated for the treatment of patients with PJIA or SJIA. ACTEMRA for subcutaneous injection is not intended for intravenous drip infusion**

DOSAGE FORM

- **Single-use vials of ACTEMRA (20 mg per mL) for intravenous administration:**
  - 80 mg per 4 mL
  - 200 mg per 10 mL
  - 400 mg per 20 mL
- **Prefilled Syringe (PFS) for subcutaneous administration:**
  - A single use PFS providing 162 mg of Actemra in 0.9 mL.

ABSTRAL®/ACTIQ®/FENTORA®/LAZANDA®/ONSOLIS®/SUBSYS® (FENTANYL ORAL TRANSMUCOSAL LOZENGE/BUCCAL TABLET/BUCCAL SOLUBLE FILM/SUBLINGUAL TABLET/SUBLINGUAL SPRAY)

Length of Authorization:	Maximum Approval Length Is For 6 Months
Initiative:	MAP: Actiq / Fentanyl (75 / 2462 – GSN)
Fax Form:	Abstral®/Actiq®/Fentora®/Lazanda®/Onsolis®/Subsys®

APPROVAL INDICATIONS (MUST MEET ALL CRITERIA FOR APPROVAL)

These may have qty and/or age limitations documented in the Summary of Limitations section.

1. Must be greater than or equal to 18 years of age; **AND**
2. Must have a confirmed diagnosis of cancer; **AND**
3. Must be opioid tolerant and currently receiving around the clock opioids for background pain (over the past 30 days). These opioids must include a minimum of one long-acting narcotic and one short-acting narcotic; **AND**
4. Patient are considered opioid tolerant if they are taking at least 60 mg morphine/day, 25 mcg transdermal fentanyl/hour, 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, or an equianalgesic dose of another opioid for at least a week; **AND**
5. Patient must have had a 30-day minimum trial and failure of an oral immediate-release formulation of morphine, hydromorphone, or oxycodone.
   a. Failure is defined as an allergy, intolerance, or hypersensitivity.
   b. If the prescriber or patient indicates that these medications were ineffective, the reviewer must first evaluate for use of optimal dose; **AND**
6. Prescribing practitioner specialty must be Oncology or Pain Management related to oncology; **AND**
7. Request must be submitted with a copy of the patient prescriber agreement form verifying enrollment in the TIRF REMS Access Program for either product.

DENIAL INDICATIONS

1. Abstral, Actiq, Fentora, Lazanda, Onsolis, and Subsys are not covered for the management of acute or postoperative pain; or for patients who are not tolerant to and are not on opioid therapy.
2. Nursing home patients should not (for any reason) receive an approval override for these medications.

DENIAL MESSAGE

- TBD

ADCETRIS® (BRENTUXIMAB VEDOTIN)

Length of Authorization:	One cycle at a time up to a maximum of 16 individual cycles
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Patient must be ≥18 years old
- ☐ Diagnosis of Hodgkin lymphoma after failure of stem cell transplantation or failure of at least two prior multi-agent chemotherapy regimens in patients who aren't candidates for stem cell transplantation; **OR**
- ☐ Diagnosis of Hodgkin lymphoma at high risk of relapse or progression as post stem cell transplantation consolidation
- ☐ Diagnosis of systemic anaplastic large cell lymphoma after failure of at least one prior multi-agent chemotherapy regimen

DENIAL MESSAGE

- ☐ TBD

AGE LIMIT OVER MAXIMUM (LIQUID DOSAGE FORMS)

Length of Authorization:	1 year (Unless the request is for an antibiotic. In these cases, the override should be entered for the amount of days specified on the Rx).
Initiative:	MAP: Age Limit Over Maximum (60 / 2194 – GSN; 60 / 2624 – GSN; 76 / 2641 – GSN)

The intent of this edit is to find out why someone over the applicable med's age limit needs a liquid dosage form when a solid dosage form is available.

Approvals may be granted for requests for PDL liquid products (including powders/granules for suspension) that have a max age limit for patients that have NG-Tubes, G-Tubes, PEG-Tubes, or J-tubes. Tube placement/status must be confirmed and noted in our clinical notes.

REQUIRED DOCUMENTATION

- ☐ Technicians: If there is no evidence of tube placement/status provided, please escalate the request to an RPh and document in your clinical notes.
- ☐ Pharmacists: Please verify the dose prescribed as the physician may have requested the liquid formulation due to the prescribed dosage. Please redirect the provider to the tablet/capsule formulations where applicable.
- ☐ ANY REQUEST OUTSIDE OF THE ABOVE CRITERIA should be referred to a pharmacist for review and potential denial.

DENIAL MESSAGE

- ☐ TBD

AGE LIMITATIONS

Length of Authorization:	Up to one year
Initiative:	MAP: Age Limit Over Maximum (2194 / 60 – GSN; 2641 / 76 – GSN; 2624 / 60 – GSN) MAP: Age Limit Under Minimum (2193 / 60 – GSN; 2641 / 76 – GSN; 2623 / 60 – GSN)

Technicians: Escalate all age limitation override requests to a pharmacist for review unless otherwise specified in the criteria.

Pharmacists: Please use your clinical judgment when handling these requests. It may be necessary to request that the physician submit clinical documentation (i.e., clinical literature/journal articles, clinical trial results, etc.) to substantiate the request. Please remember that you must explain in detail the rationale used in making your final determination.

DENIAL MESSAGE

- TBD

ALBUMIN

Length of Authorization:	Duration of the prescription
Initiative:	MAP: Albumin (75 / 2462 – GSN; 76 / 2641 – GSN)
Fax Form:	Albumin

APPROVED INDICATIONS

- ☐ Hypoalbuminemia due to acute liver failure
- ☐ Hepatic Cirrhosis
- ☐ Nephrotic Syndrome
- ☐ Tuberculosis
- ☐ Trauma
- ☐ Burns

Do not approve for caloric supplementation or as an additive to TPN.

DENIAL MESSAGE

- ☐ TBD

ALDURAZYME® (LARONIDASE)

Length of Authorization:	Up to one year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Patient must be ≥ 6 months of age.
- ☐ Must have a diagnosis of Hurler Syndrome or Mucopolysaccharidosis (MPS) I.

DENIAL MESSAGE

- ☐ TBD

ALINIA® (NITAZOXANIDE)

REVIEW CRITERIA

DIARRHEA CAUSED BY *GIARDIA LAMBLIA*

- ☐ Redirect provider to metronidazole or escalate to a pharmacist.

DIARRHEA CAUSED BY CRYPTOSPORIDIUM PARVUM

- ☐ May approve in the immunocompromised patient (i.e., HIV+, cancer, organ transplant) for
  - ☐ Children 1 to 3 years of age: 100mg orally twice daily for 3 days;
  - ☐ Children 4 to 11 years of age: 200mg twice daily for 3 days;
  - ☐ Children ≥ 12 years of age and adults: 500mg orally twice daily for 3 days

DIARRHEA CAUSED BY CLOSTRIDIUM DIFFICILE

- ☐ Redirect provider to metronidazole or vancomycin or escalate to a pharmacist.

DENIAL MESSAGE

- ☐ TBD

ALPAH-1-PROTEASE INHIBITORS

ARALAST NP® (ALPHA-1-PROTEASE INHIBITOR HUMAN)

Length of Authorization:	Up to one year
Initiative:	☐ MAP: AP: AAT Deficiency ☐ PDL: Non-Preferred Drug Override (NOTE: AutoPA approval does NOT override the Non-PDL edit) ☐ ENTER PA USING (MG) UNITS AS OPOSED TO NUMBER OF VIALS AS UNITS.

REVIEW CRITERIA

- Patient must be ≥ 18 years of age.
- Must have confirmed history of alpha1-proteinase inhibitor (A1-PI) deficiency with emphysema per clinical notes or diagnosis codes

DOSING AND ADMINISTRATION

- The recommended dosage of Aralast NP is 60 mg/kg body weight administered once weekly by intravenous infusion. Dose ranging studies using efficacy endpoints have not been performed.
- Aralast NP should be administered at a rate not exceeding 0.08 mL/kg body weight/minute.

DOSAGE FORM

- Aralast NP is supplied as a sterile, non-pyrogenic, lyophilized powder in single–dose vials. The following product packages are available: 0.5 g and 1 g

CONTINUED ON NEXT PAGE

PROLASTIN C® (ALPHA-1-PROTEASE INHIBITOR HUMAN)

Length of Authorization:	Up to one year
Initiative:	• MAP: AP: AAT Deficiency • PDL: Non-Preferred Drug Override (NOTE: AutoPA approval does NOT override the Non-PDL edit) ☐ ENTER PA USING (MG) UNITS AS OPOSED TO NUMBER OF VIALS AS UNITS.

REVIEW CRITERIA

- Patient must be ≥ 18 years of age.
- Must have confirmed history of alpha1-proteinase inhibitor (A1-PI) deficiency with emphysema per clinical notes or diagnosis codes

DOSING AND ADMINISTRATION

- Prolastin-C should be given intravenously at a rate of approximately 0.08 mL/kg/min as determined by the response and comfort of the Patient.
- The recommended dosage is 60 mg/kg.
- Dosage Form: Prolastin-C is supplied in 1000 mg single use vials with a separate 20 mL vial of Sterile Water for Injection.

CALCULATIONS (EXAMPLE)

Rx: Prolastin- C 60mg/kg
Sig: 5,880mg (+/- 10%) IV weekly
Qty: 1 month supply

Step 1: Determine the total dose received over 4 weeks.

$$\frac{5{,}880\text{mg}}{\text{Week}} \times \frac{X}{4\text{ weeks}} = 23{,}520\text{mg}$$

Step 2: Extrapolate the dose to a 30-day supply.

$$\frac{23{,}520\text{mg}}{28\text{ days}} \times \frac{X}{30\text{ days}} = 25{,}200\text{mg}$$

Step 3: Calculate the 10% differential.

25,200mg x 0.1(or 10%) = 2,520mg

Step 4: Add the dosage differential calculated to the total dose.

25,200mg + 2,520 = 27,720mg

PA entry: 27720/30

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ZEMAIRA® (ALPHA-1-PROTEASE INHIBITOR HUMAN)

Length of Authorization:	Up to one year
Initiative:	• MAP: AP: AAT Deficiency • PDL: Non-Preferred Drug Override (NOTE: AutoPA approval does NOT override the Non-PDL edit) ☐ ENTER PA USING (MG) UNITS AS OPOSED TO NUMBER OF VIALS AS UNITS.

REVIEW CRITERIA

- Patient must be ≥ 18 years of age.
- Must have confirmed history of alpha1-proteinase inhibitor (A1-PI) deficiency with emphysema per clinical notes or diagnosis codes

DOSING AND ADMINISTRATION

- Administered intravenously at a rate of approximately 0.08 mL/kg/min as determined by the response and comfort of the patient
- The recommended dose is 60 mg/kg body weight administered once weekly.

DOSAGE FORM

- Zemaira is supplied in 1,000 mg single use vials with a separate 20 mL vial of Sterile Water for Injection

ALPHA ANTITRYPSIN (AAT) DEFICIENCY AUTOMATION LOGIC

Alpha Antitrypsin (AAT) Deficiency Automation

Automated PA approval satisfies L= AutoPA drug edit

Automated PA approval will NOT Override R= Non-PDL edit

AAT Deficiency Drug List		
Generic Name	**Brand Name**	**Drug Code**
Alpha-1 Proteinase Inhibitor	Aralast Aralast NP	HSN = 004529
	Glassia	
	Prolastin C	
	Zemaira	

Step 1: If incoming drug in <AAT deficiency List> and prior authorization code = L, look back 730 days in the patient's health conditions for an *ICD-9 = 273.4* **OR** an *ICD-10 = E88.01* (Alpha-antitrypsin deficiency) if found, NO PA REQUIRED. Otherwise, deny for PRIOR AUTHORIZATION REQUIRED NCPDP EC 75 with supplemental message: *"RECEPIENT DOESN'T HAVE REQ DIAGNOSIS ON FILE."*

Approvable ICD-9 Code	
273.4	Alpha Antitrypsin (AAT) Deficiency or Alpha -1 Antitrypsin Deficiency
Approvable ICD-10 Code	
E88.01	Alpha Antitrypsin (AAT) Deficiency or Alpha -1 Antitrypsin Deficiency

ALTABAX® (RETAPAMULIN OINTMENT 1%)

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Must have a diagnosis of impetigo
- ☐ Trial and failure or mupirocin (Bactroban) ointment for a minimum of 3 days **OR** a minimum of a 7-day trial of an oral antibiotic.
  - ☐ Oral antibiotics may include one of the following dicloxacillin, cephalexin, clarithromycin, erythromycin, clindamycin, azithromycin, or tetracycline.
  - ☐ Questions related to whether a particular oral antibiotic is appropriate should be directed to a Pharmacist.
- ☐ Requests that have not met the above criteria or that offer rationale as to why the above mentioned therapies would not be appropriate may be escalated to a pharmacist for review.

LIMITS

- ☐ Maximum of 15g every 30 days and two prescription fills every 60 days.
- ☐ No reimbursement for the 5g or the 30g package.

DENIAL MESSAGE

- ☐ TBD

ALZHEIMER'S AGENTS

Length of Authorization:	1 year
Initiative:	☐ PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN) ☐ MAP: AP: Dose Optimization (75 / 2462 – GSN; 76 / 2641 – GSN) (DONEPEZIL ONLY)

1. Is there any reason the Patient cannot be changed to preferred medications? Acceptable reasons include:
   - ☐ Allergy to all unrelated preferred medications
   - ☐ Contraindication to or drug-to-drug interaction with preferred medications
   - ☐ History of unacceptable/toxic side effects to two preferred medications
2. Has there been a failure to respond to a therapeutic trial of *at least 60 days* of ***TWO*** preferred medications? **Document details.**

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the Beneficiary has renal dysfunction, Razadyne would not be indicated.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Exelon® (*rivastigmine*) – patches **(min age = 18)**	Aricept® (*donepezil*)
Memantine (generic for Namenda®)	Aricept ODT® (*donepezil*)
Pyridostigmine*	Donepezil (generic Aricept®) [*5 mg]
	Donepezil ODT (generic Aricept ODT®)
	Exelon® (*rivastigmine*) – capsules and solution
	Namenda® (*memantine*)
	Rivastigmine (generic Exelon®)
	Razadyne® (*galantamine*) – tablets and solution **(min age = 18)**
	Razadyne ER® (*galantamine*) – tablets **(min age = 18)**

NOTE

*Products will deny when the daily dose equals "2" or the daily dose exceeds "3." Daily dose is calculated by taking the metric quantity on the incoming claim and dividing it by the days supply on the claim. The valid range for 2 per day is >= 1.8, but <= 2.2. To exceed a daily dose of 3, the value must be >= 3.8. Use MAP: Dose Optimization initiative.

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NAMENDA XR (MEMANTINE HYDROCHLORIDE, EXTENDED RELEASE)

Length of Authorization:	One year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

INITIATION OF THERAPY

- ☐ Alzheimer's disease
  - ☐ Patient must be ≥18 years old
  - ☐ Patient must have a confirmed diagnosis of Alzheimer's Disease (ICD9=331.0)(ICD10=G30*)
  - ☐ Trial and response to therapy of Namenda IR® is required prior to consideration of Namenda XR®.

CONTINUATION OF THERAPY

- ☐ Patient continues to meet above initial criteria

DENIAL MESSAGE

- ☐ TBD

AMITIZA® (LUBIPROSTONE)

Length of Authorization:	Up to 6 months
Initiative:	MAP: Amitiza (75 / 2462 – GSN; 76 / 2191 – GSN; 73 / 2641 – GSN; 60 / 2193 – GSN)

REVIEW CRITERIA

CHRONIC IDIOPATHIC CONSTIPATION

- ☐ Patient must be ≥ 18 years old.
- ☐ Chronic Idiopathic (from an unknown cause) Constipation as evidenced by:
  - ☐ Less than three spontaneous bowel movements per week along with at least a recent (within past year) six-month history of very hard stools, sensation of incomplete evacuation or straining with defecation (constipation).
  - ☐ The provider must attempt to treat constipation related to a known cause by correcting the known cause (i.e., reducing or discontinuing opioid medication).
- ☐ The patient must have a history of trial and failure of over-the-counter laxatives (including MiraLAX [polyethylene glycol 3350]) and lactulose (a prescription medication) within the past month.
- ☐ Submission must contain documentation from a digestive disease specialist (i.e., results of colonoscopy, etc.).

IRRITABLE BOWEL SYNDROME (IBS) WITH CONSTIPATION

- ☐ Patient must be a woman ≥ 18 years old.
- ☐ Diagnosis of IBS with constipation as evidenced by abdominal pain or discomfort occurring over at least 6 months with two or more of the following:
  - ☐ Relieved with defecation;
  - ☐ Onset associated with a change in stool frequency (<3 spontaneous bowel movements per week); and
  - ☐ Onset associated with a change in stool form (associated with straining).
- ☐ Submission must contain documentation from a digestive disease specialist (i.e., results of colonoscopy, etc.)

DENIAL MESSAGE

- ☐ TBD

AMPYRA (DALFAMPRIDINE)

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Must have a diagnosis Multiple Sclerosis (MS); **AND**
- ☐ Verify that there is no history of seizures. If seizures are noted in history, escalate to a pharmacist for review with recommendation to deny "due to seizure history"; **AND**
- ☐ Verify that there is no history of moderate to severe renal impairment (creatinine clearance of 50mL/min. or less). If moderate to severe renal impairment is noted in history, escalate to a pharmacist for review with recommendation to deny "due to history of renal failure."
- ☐ Verify that patient is not taking any compounded formulation of this drug: (4-aminopyridine, 4-AP, fampridine).

DENIAL MESSAGE

- ☐ TBD

ANALGESICS – SHORT-ACTING NARCOTIC

Length of Authorization:	1 year
Initiative:	☐ PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN) ☐ Maximum day supply = 30 ☐ MAP: Error Code 7001 Override (76 / 7001 – GSN) [Polypharmacy edit] [Hyperlink to Summary of Drug Limitations]

POLYPHARMACY EDIT FOR SHORT-ACTING AND LONG-ACTING NARCOTICS (ADDED 12/09/2015)

INTENT

- ☐ Create a limit (per 28 days to prevent polypharmacy and abuse potential) of either
  - ☐ 2 short acting analgesics **OR**
  - ☐ 1 long-acting analgesic + 1 short-acting analgesic
- ☐ Drug Names **<Short Acting Opioids List>**: Codeine IR or Codeine + APAP or Codeine/Butalbital Combos; Buprenorphine; Butorphanol NS; Dihydrocodeine comb (Synalgos DC); Morphine IR; Opana (oxymorphone); Percocet (oxycodone + APAP); Percodan (oxycodone + ASA); Nucynta IR; Hydrocodone (and combos); Dilaudid (hydromorphone); Fentanyl, oral & transmucosal; Fentanyl, buccal tab; Fentanyl, buccal film; Fentanyl SL; Fentanyl, intranasal (Lazanda).
- ☐ Brand / Generic: Both
- ☐ NCPDP Error Code: 76
- ☐ Limitation: fills per 28 days OR 1 Long acting Opioid + 1 Short acting Opioid per 28 days
- ☐ AutoPA Coding:
  - ☐ **Step 1:** If the incoming claim is for a drug from the **<Long Acting Opioids List>** or the **<Short Acting Opioids List>** and patient age >/= 18, go to Step 2. If not, Stop.
  - ☐ **Step 2:** Does recipient have history of >/= 2 fills of another drug from the **<Short Acting Opioids List>** (excluding incoming HICL) within the past 28 days? If yes, deny NCPDP EC 76-Plan limitations exceeded. If no, go to Step 3.
  - ☐ **Step 3:** Does recipient have history of >/= 1 fill of a drug from the **<Long Acting Opioids List>** (excluding incoming HICL)? If yes, go to Step 4. If no, claim falls out of the auto-PA process and continues on through adjudication.
  - ☐ **Step 4:** Is the incoming claim for a drug in list **<Long Acting Opioids List>**? If yes, deny NCPDP EC 76-Plan limitation exceeded. If no, go to Step 5.
  - ☐ **Step 5:** Does recipient have history of >/= 1 fills of a drug from the **<Short Acting Opioids List>**? If yes, deny NCPDP EC 76-Plan limitations exceeded. If no, claim falls out of the auto-PA process and continues on through adjudication.
- ☐ NOTE: Coding is based on 28 days with small tolerance for the next fill/refill.

POLYPHARMACY REVIEW CRITERIA [MAP: ERROR CODE 7001 OVERRIDE (76 / 7001)]

Requests where there are two hits, but the hits are the same drug with claim dates that are an appropriate number of days apart, including allowing for standard refill tolerance, and reflecting compliant therapy, should be approved, as these types of claims do NOT violate the intent of the edit. For all other requests, it is expected that the prescriber should be able to provide reasoning.

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REVIEW CRITERIA FOR OVERALL PDL EDIT

1. Is there any reason the Patient cannot be changed to preferred medications? Acceptable reasons include
   - ☐ Allergy to preferred medications
   - ☐ Contraindication to or drug-to-drug interaction with preferred medications
   - ☐ History of serious reaction to preferred medications (e.g., seizures, arrhythmias, etc.)
2. Has there been a failure to respond to a therapeutic trial of *at least 1 week* each of at least *TWO* preferred medications? If yes, allow the prior authorization. **Document details.**

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Acetaminophen w/codeine	Butalbital compound w/codeine
Belladonna-opium	Butorphanol tartrate (generic for Stadol®) [2.5/30]
Codeine sulfate (except oral solution)	Capital w/codeine® (APAP/codeine)
Hydrocodone/Ibuprofen (generic for Vicoprofen®)	Codeine Solution (Oral)
Hydrocodone/APAP (generic for Vicodin®)	Co-Gesic® (hydrocodone/APAP)
Hydromorphone HCL (generic for Dilaudid®) tablet	Demerol® (*meperidine*)
Morphine sulfate IR	Dilaudid® (*Hydromorphone*)
Oxycodone (generic for Oxy IR®)	Endocet® (*oxycodone/APAP*)
Oxycodone w/acetaminophen (generic for Percocet®)	Fioricet w/codeine® (*APAP/butalbital/caff/codeine*)
Pentazocine/APAP (generic for Talacen®)	Hycet® (*hydrocodone w/APAP*)
Percolone® (*oxycodone/aspirin*)	Hydromorphone (generic Dilaudid®) – supp, syr, vial/ampule
	Hydromorphone/NS
	Maxidone® (*hydrocodone w/APAP*)
	Meperidine (generic for Demerol®)
	Meperitab (*meperidine*)
	Morphine (IR) suppository
	Nucynta® (*tapentadol*) (see specific criteria)
	Oxycodone Oral Conc 20mg/ml
	Oxycodone w/Aspirin (generic for Percodan®)
	Oxycodone w/ibuprofen (generic for Combunox®)
	Opana® IR (*oxymorphone*)
	Oxymorphone (generic Opana®)
	Oxy IR® (*oxycodone*)
	Pentazocine and Naloxone (generic for Talwin NX®)
	Percocet® (*oxycodone/APAP*)
	Percodan® (*Oxycodone/aspirin*)
	Reprexain (*Hydrocodone/Ibuprofen*)
	Talacen® (*Pentazocine/APAP*)
	Talwin® Cmpd (*Pentazocine/APAP*); Talwin NX (*pentazocine and naloxone*)
	Roxicodone® (*Oxycodone HCl) (generic for Oxy IR®*)
	Roxicet® (*oxycodone/APAP*)
[#/X] = quantity limit per X days	Zydone® (*Hydrocodone w/APAP*)

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NUCYNTA® (TAPENTADOL) AND NUCYNTA ER® (TAPENTADOL ER)

Length of Authorization:	One month
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ The patient must be 18 years of age or older.
- ☐ Documentation must be submitted which shows previous trial and failure of a minimum of 2 narcotic analgesic medications on the PDL (short-acting for Nucynta®; long-acting for Nucynta ER®)

DENIAL MESSAGE

- ☐ TBD

ANALGESICS – LONG-ACTING NARCOTIC

Length of Authorization:	Up to 6 months Maximum day supply = 30
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN) MAP: Error Code 7001 Override (76 / 7001 - GSN) [Polypharmacy edit] [Hyperlink to Summary of Drug Limitations]

1. Is there any reason the Patient cannot be changed to preferred medications? Acceptable reasons include
   - ☐ Allergy to preferred medications
   - ☐ Contraindication to or drug-to-drug interaction with preferred medications
   - ☐ History of serious reaction to preferred medications
2. Has there been a failure to respond to a therapeutic trial of at least **TWO** preferred medications?
   (Some medications within this class may have specific criteria).

POLYPHARMACY EDIT FOR LONG-ACTING AND SHORT-ACTING NARCOTICS (ADDED DECEMBER 9, 2015)
MAP: ERROR CODE 7001 OVERRIDE (76 / 7001 — GSN)

INTENT

- ☐ Create a limit (per 28 days to prevent polypharmacy and abuse potential) of either
  - ☐ 2 short acting analgesics **OR**
  - ☐ 1 long-acting analgesic + 1 short-acting analgesic
- ☐ Drug Names **<Long Acting Opioids List>**: Avinza; Butrans patch; Dolophine (methadone); Duragesic (fentanyl) patch; Embeda ER; Exalgo; Kadian; MS Contin; Nucynta ER; Opana ER; OxyContin (oxycodone ER); Zohydro ER.
- ☐ Brand / Generic: Both
- ☐ NCPDP Error Code: 76
- ☐ Limitation: fills per 28 days OR 1 Long acting Opioid + 1 Short acting Opioid per 28 days
- ☐ AutoPA Coding:
  - ☐ **Step 1:** If the incoming claim is for a drug from the <Long Acting Opioids List> or the <Short Acting Opioids List> and patient age >/= 18, go to Step 2. If not, Stop.
  - ☐ **Step 2:** Does recipient have history of >/= 2 fills of another drug from the <Short Acting Opioids List> (excluding incoming HICL) within the past 28 days? If yes, deny NCPDP EC 76-Plan limitations exceeded. If no, go to Step 3.
  - ☐ **Step 3:** Does recipient have history of >/= 1 fill of a drug from the <Long Acting Opioids List> (excluding incoming HICL)? If yes, go to Step 4. If no, claim falls out of the auto-PA process and continues on through adjudication.
  - ☐ **Step 4:** Is the incoming claim for a drug in list <Long Acting Opioids List>? If yes, deny NCPDP EC 76-Plan limitation exceeded. If no, go to Step 5.
  - ☐ **Step 5:** Does recipient have history of >/= 1 fills of a drug from the <Short Acting Opioids List>? If yes, deny NCPDP EC 76-Plan limitations exceeded. If no, claim falls out of the auto-PA process and continues on through adjudication.
- ☐ NOTE: Coding is based on 28 days with small tolerance for the next fill/refill.

POLYPHARMACY REVIEW CRITERIA (MAP: ERROR CODE 7001 OVERRIDE (76 / 7001)):

Requests where there are two hits, but the hits are the same drug with claim dates that are an appropriate number of days apart, including allowing for standard refill tolerance, and reflecting compliant therapy, should be considered as one drug and thus may allow the request to be approved, as these types of claims do NOT violate the intent of the edit. For all other requests, it is expected that the prescriber should be able to provide reasoning.

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LONG-ACTING NARCOTIC ANALGESICS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Butrans® Patch (buprenorphine)	Duragesic ® Patch (Fentanyl) [10/28] **(Criteria below)**
Embeda ER® (morphine sulfate/naltrexone) caps [2/day]	Exalgo® (hydromorphone)
Fentanyl Patch (generic for Duragesic) [10/28]	Hysingla ER® tabs (hydrocodone)
	Opana ER® (Oxymorphone ER)
	Oxymorphone ER (generic for Opana ER)
	Zohydro ER® (hydrocodone) caps
Hyperlink to Methadone criteria	
Hyperlink to Morphine Sulfate ER criteria	

FENTANYL TRANSDERMAL SYSTEM (PATCHES)

- ☐ No approvals are allowed for the brand product except in conditions of medication shortages. (Must be verified and have direct approval from AHCA with the date span for which approvals can be granted.)
  - ☐ Adhesive issues:
    PA requests should be denied and provider referred to proper application technique on package insert of medication.
    Previous therapy with the brand product is NOT an indicator for approval.

FENTANYL THERAPY REQUESTS OUTSIDE OF THE RECOMMENDED Q72H FREQUENCY

- ☐ Previous trial and failure with Q72H application of **generic** must have occurred.
- ☐ May approve up to 100mcg Q48H of generic (if rationale is something other than an adhesive issue). If it is an adhesive issue, the prior authorization request should be denied and requestor referred to proper application technique on drug insert.

BUPRENEX INJECTION (MIXED OPIATE AGONISTS/ANTAGONISTS)

- ☐ All new requests should be escalated to an MPS Pharmacist for review.
- ☐ All continuation of therapy request should be escalated to an MPS Pharmacist for review.

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OXYCONTIN® AND OXYCODONE ER

Length of Authorization:	Pain related to cancer: 6 months Chronic Non-Malignant Pain (CNMP): 6 months
Initiative:	MAP: AP: OxyContin (75 / 2462 – GSN; 76 / 2641 – GSN)

DRUGS IN CLASS FOR REVIEW

OxyContin® and Oxycodone Hydrochloride ER (Build PA for the generic unless request is received as Brand Medically Necessary on a Request for Multi-source brand form)

LENGTH OF AUTHORIZATION (SEE BELOW)

- ☐ Pain related to cancer – six months approval
- ☐ Chronic non-malignant pain (CNMP) – three to six months approval. Pharmacists may use "clinical judgment" for determining approval length for CNMP

APPROVAL INDICATIONS

Condition	Submitted ICD-9/ICD-10 Diagnoses	Inferred Drugs	Automated Date Range Look Back
Cancer	140 – 239.xx	NA	2 years
	N/A	Antineoplastics^	1 year
Therapeutic Failure (applies to Cancer and CNMP)	N/A	NA	>2 long acting narcotic analgesics or OxyContin claim in the last 90 days
Chronic nonmalignant pain (CNMP):	See ICD-9 and ICD-10 Diagnosis Codes and Descriptions on the following pages.	NA	1 year

^Excludes BCG Vaccine, Goserelin, Leuprolide, Megace, hydroxyurea and Oral Methotrexate.

APPROVAL INDICATIONS [ADDITIONAL CRITERIA]

Continues on the pages following the ICD-9/ICD-10 Chart

DENIAL CRITERIA

Continues on the pages following the ICD-9/ICD-10 Chart

ADDITIONAL INFORMATION

Continues on the pages following the ICD-9/ICD-10 Chart

FLORIDA MCOS' AUTO PA STEP EDITS (OXYCONTIN®)

Continues on the pages following the ICD-9/ICD-10 Chart

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Chronic Non-Malignant Pain ICD-9 and ICD-10 Diagnoses				
ICD-9	Description		ICD-10	Description
282.5	Sickle-cell trait		D57.3	Sickle-cell trait
282.6	Sickle-cell disease		D57.1	Sickle-cell disease without crisis
334.2	Primary cerebellar degeneration Cerebellar ataxia: Marie's Sanger-Brown Dyssynergia cerebellaris myoclonica Primary cerebellar degeneration: NOS hereditary sporadic		G11.0	Congenital nonprogressive ataxia
			G11.2	Late-onset cerebellar ataxia
334.8	Other spinocerebellar diseases Ataxia-telangiectasia [Louis-Bar syndrome] Corticostriatal-spinal degeneration		G11.3	Cerebellar ataxia with defective DNA repair
			G11.8	Other hereditary ataxias
335	Werdnig-Hoffmann disease		G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]
335.1	Spinal muscular atrophy, unspecified		G12.9	Spinal muscular atrophy, unspecified
335.11	Kugelberg-Welander disease Spinal muscular atrophy: familial juvenile		G12.1	Other inherited spinal muscular atrophy
335.19	Other Adult spinal muscular atrophy		G12.8	Other spinal muscular atrophies and related syndromes
335.2	Motor neuron disease		G12.21	Amyotrophic lateral sclerosis
335.21	Progressive muscular atrophy Duchenne-Aran muscular atrophy Progressive muscular atrophy (pure)		G12.21	Amyotrophic lateral sclerosis
336	Syringomyelia and syringobulbia		G95.0	Syringomyelia and syringobulbia
336.3	Myelopathy in other diseases classified elsewhere Code first underlying disease, as: myelopathy in neoplastic disease (140.0-239.9)		G99.2	Myelopathy in diseases classified elsewhere
336.8	Other Myelopathy: drug-induced radiation-induced Use additional E code to identify cause		G95.89	Other specified diseases of spinal cord
336.9	Unspecified disease of spinal cord compression NOS Myelopathy NOS		G95.9	Disease of spinal cord, unspecified
337.2	Reflex sympathetic dystrophy		G90.59	Complex regional pain syndrome I of other specified site
337.21	Reflex sympathetic dystrophy of the upper limb Complex regional pain syndrome type I of the upper limb		G90.519	Complex regional pain syndrome I of unspecified upper limb
337.22	Reflex sympathetic dystrophy of the lower limb Complex regional pain syndrome type I of the lower limb		G90.529	Complex regional pain syndrome I of unspecified lower limb
337.29	Reflex sympathetic dystrophy of other specified site Complex regional pain syndrome type I of other specified site		G90.59	Complex regional pain syndrome I of other specified site
340	Multiple sclerosis Disseminated or multiple sclerosis: NOS brain stem cord generalized		G35	Multiple sclerosis
341	Neuromyelitis optica		G36.0	Neuromyelitis optica [Devic]
341.1	Schilder's disease Balo's concentric sclerosis Encephalitis periaxialis: concentrica [Balo's] diffusa [Schilder's]		G37.0	Diffuse sclerosis of central nervous system
			G37.5	Concentric sclerosis [Balo] of central

Chronic Non-Malignant Pain ICD-9 and ICD-10 Diagnoses				
ICD-9	Description		ICD-10	Description
				nervous system
341.2	Acute (transverse) myelitis NOS		G37.3	Acute transverse myelitis in demyelinating disease of central nervous system
341.21	Acute (transverse) myelitis in conditions classified elsewhere Code first underlying condition		G37.3	Acute transverse myelitis in demyelinating disease of central nervous system
341.22	Idiopathic transverse myelitis		G37.3	Acute transverse myelitis in demyelinating disease of central nervous system
341.8	Demyelinating diseases of central nervous system Central demyelination of corpus callosum Central pontine myelinosis Marchiafava (-Bignami) disease		G37.1	Central demyelination of corpus callosum
			G37.2	Central pontine myelinolysis
			G37.8	Other specified demyelinating diseases of central nervous system
341.9	Demyelinating disease of central nervous system, unspecified		G37.9	Demyelinating disease of central nervous system, unspecified
344	Quadriplegia, unspecified		G82.50	Quadriplegia, unspecified
344.1	Paraplegia Paralysis of both lower limbs Paraplegia (lower)		G82.20	Paraplegia, unspecified
344.6	Cauda equina syndrome without mention of neurogenic bladder		G83.4	Cauda equina syndrome
344.8	Other specified paralytic syndromes		N/A	See specific G83.xx
344.81	Locked-in state		G83.5	Locked-in state
344.89	Locked-in state		G83.81	Brown-Séquard syndrome OR
			G83.84	Todd's paralysis (postepileptic) OR
			G83.89	Other specified paralytic syndromes
344.9	Paralysis, unspecified		G83.9	Paralytic syndrome, unspecified
353.6	Phantom limb (syndrome)		G54.6	Phantom limb syndrome with pain
			G54.7	Phantom limb syndrome without pain
356	Hereditary peripheral neuropathy Déjérine-Sottas disease		G60.0	Hereditary motor and sensory neuropathy
357	Acute infective polyneuritis Guillain-Barre syndrome Postinfectious polyneuritis		G61.0	Guillain-Barre syndrome
357.1	Polyneuropathy in collagen vascular disease Code first underlying disease, as: disseminated lupus erythematosus (710.0) polyarteritis nodosa (446.0) rheumatoid arthritis (714.0)		G63.	Polyneuropathy in diseases classified elsewhere
721.1	Cervical spondylosis with myelopathy		M47.12	Other spondylosis with myelopathy, cervical region
721.4	Thoracic or lumbar spondylosis with myelopathy		M47.14	Other spondylosis with myelopathy, thoracic region
721.41	Spondylosis with myelopathy, thoracic region		M47.14	Other spondylosis with myelopathy, thoracic region
721.42	Spondylosis with myelopathy, lumbar region		M47.16	Other spondylosis with myelopathy, lumbar region
721.5	Kissing spine		M48.20	Kissing spine, site unspecified
721.6	Ankylosing vertebral hyperostosis		M48.10	Ankylosing hyperostosis [Forestier], site unspecified
721.8	Other allied disorders of spine		M48.9	Spondylopathy, unspecified

Chronic Non-Malignant Pain ICD-9 and ICD-10 Diagnoses				
ICD-9	Description		ICD-10	Description
721.91	Spondylosis of unspecified site, with myelopathy		M47.10	Other spondylosis with myelopathy, site unspecified
722	Displacement of cervical intervertebral disc without myelopathy		M50.20	Other cervical disc displacement, unspecified cervical region
722.1	Displacement of lumbar intervertebral disc without myelopathy		M51.26	Other intervertebral disc displacement, lumbar region
722.11	Displacement of thoracic intervertebral disc without myelopathy		M51.24	Other intervertebral disc displacement, thoracic region
722.2	Displacement of intervertebral disc, site unspecified, without myelopathy		M51.9	Unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder
722.47	Degeneration of cervical intervertebral disc		M50.30	Other cervical disc degeneration, unspecified cervical region
722.5	Degeneration of thoracic or lumbar intervertebral disc		M51.34	Other intervertebral disc degeneration, thoracic region OR
722.51	Degeneration of thoracic or thoracolumbar intervertebral disc		M51.35	Other intervertebral disc degeneration, thoracolumbar region
722.52	Degeneration of lumbar or lumbosacral intervertebral disc		M51.36	Degeneration of lumbar or lumbosacral intervertebral disc OR
			M51.37	Other intervertebral disc degeneration, lumbosacral region
722.6	Degeneration of intervertebral disc, site unspecified		M51.34	Other intervertebral disc degeneration, thoracic region OR
			M51.35	Other intervertebral disc degeneration, thoracolumbar region OR
			M51.36	Degeneration of lumbar or lumbosacral intervertebral disc OR
			M51.37	Other intervertebral disc degeneration, lumbosacral region
722.7	Intervertebral disc disorder with myelopathy, unspecified region		M51.9	Unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder
722.71	Intervertebral disc disorder with myelopathy, cervical region		M50.00	Cervical disc disorder with myelopathy, unspecified cervical region
722.72	Intervertebral disc disorder with myelopathy, thoracic region		M51.04	Intervertebral disc disorders with myelopathy, thoracic region OR
			M51.05	Intervertebral disc disorders with myelopathy, thoracolumbar region
722.73	Intervertebral disc disorder with myelopathy, lumbar region		M51.06	Intervertebral disc disorders with myelopathy, lumbar region
722.8	Postlaminectomy syndrome, unspecified region		M96.1	Postlaminectomy syndrome, not elsewhere classified
722.81	Postlaminectomy syndrome, cervical region		M96.1	Postlaminectomy syndrome, not elsewhere classified
722.82	Postlaminectomy syndrome, thoracic region		M96.1	Postlaminectomy syndrome, not elsewhere classified
722.83	Postlaminectomy syndrome, lumbar region		M96.1	Postlaminectomy syndrome, not elsewhere classified
722.9	Other and unspecified disc disorder, unspecified region		M51.9	Unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc disorder
722.91	Other and unspecified disc disorder, cervical region		M50.80	Other cervical disc disorders, unspecified cervical region OR
			M50.90	Cervical disc disorder, unspecified, unspecified cervical region

Chronic Non-Malignant Pain ICD-9 and ICD-10 Diagnoses				
ICD-9	Description		ICD-10	Description
722.92	Other and unspecified disc disorder, thoracic region		M46.45	Discitis, unspecified, thoracolumbar region OR
			M51.84	Other intervertebral disc disorders, thoracic region OR
			M51.85	Other intervertebral disc disorders, thoracolumbar region
722.93	Other and unspecified disc disorder, lumbar region		M46.47	Discitis, unspecified, lumbosacral region OR
			M51.86	Other intervertebral disc disorders, lumbar region OR
			M51.87	Other intervertebral disc disorders, lumbosacral region
723	Other disorders of cervical region		M48.02	Spinal stenosis, cervical region
723.4	Brachial neuritis or radiculitis NOS		M54.12	Radiculopathy, cervical region OR
			M54.13	Radiculopathy, cervicothoracic region
723.6	Panniculitis specified as affecting neck		M54.02	Panniculitis affecting regions of neck and back, cervical region
723.7	Ossification of posterior longitudinal ligament in cervical region		M67.88	Other specified disorders of synovium and tendon, other site
724	Spinal stenosis, unspecified region		M48.00	Spinal stenosis, site unspecified
724.01	Spinal stenosis, thoracic region		M48.04	Spinal stenosis, thoracic region
724.02	Spinal stenosis, lumbar region, without neurogenic claudication		M48.06	Spinal stenosis, lumbar region
724.03	Spinal stenosis, lumbar region, with neurogenic claudication		M48.06	Spinal stenosis, lumbar region
724.09	Spinal stenosis, other region		M48.08	Spinal stenosis, sacral and sacrococcygeal region
724.4	Thoracic or lumbosacral neuritis or radiculitis, unspecified		M54.14	Radiculopathy, thoracic region OR
			M54.15	Radiculopathy, thoracolumbar region OR
			M54.16	Radiculopathy, lumbar region OR
			M54.17	Radiculopathy, lumbosacral region
733.7	Algoneurodystrophy		M89.00	Algoneurodystrophy, unspecified site

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APPROVAL INDICATIONS

- ☐ Age ≥ 18 years of age
- ☐ Diagnosis of Cancer within last 2 years or history of antineoplastic agent in the last 12 months

  -OR-

  Documented failure on two different other sustained released narcotic analgesics or a previous history of OxyContin® in the last 90 days **-AND-**

  Diagnosis of chronic nonmalignant pain (CNMP) within the last 365 days.
- ☐ Patients receiving no more than two tabs per day of OxyContin® 10mg, 15mg, 20mg, 30mg, or 40mg.
- ☐ Patients receiving no more than two tabs per day of OxyContin® 60mg and have had > 7 days of opioid therapy in the most recent 30 days of claims history.
- ☐ Patients receiving no more than four tabs per day of OxyContin® 80mg and have had > 7 days of opioid therapy in the most recent 30 days of claims history.
- ☐ Must be dosed every 12 hours. (Patients who experience breakthrough pain may require dosage adjustment or rescue medication.)

DENIAL CRITERIA

- ☐ Patients < 18 years of age
- ☐ Patients currently receiving another different Oxycodone SR GSN; Evaluation period of 30 days
- ☐ Patient has not failed two other long acting narcotics or has not received OxyContin® in the last 90 days
- ☐ Patient does not have a supporting diagnosis of Cancer (ICD-9/ICD-10 or inferred) in the last 2 years or CNMP in the last 365 days
- ☐ Claim for greater than 60 tablets (> 2 tabs per day) for OxyContin 10mg, 15mg, 20mg, 30mg, 40mg, and 60mg strengths; Claims for greater than 120 tablets (> 4 tabs per day) for OxyContin 80mg strength
- ☐ Strengths ≥ 60mg are denied if Patient does not have > 7 days of opioid therapy in the most recent 30 days of claims history.

ADDITIONAL INFORMATION

- ☐ Florida Medicaid will allow one strength of OxyContin® per 30-day period and a maximum of two tablets per day within a 30-day period of the following strengths: 10 mg, 15 mg, 20 mg, 30 mg, 40 mg and 60 mg. Doses greater than two tablets per day of these strengths will reject for dose optimization. A maximum of four tablets per day within a 30-day period is allowed for OxyContin® 80mg tablets.
- ☐ Must be dosed twice a day (q12h) for non-malignant pain.
- ☐ Strength of tablets used in dosing should be reasonable; i.e., if the Patient is taking 320 mg per day, it is not reasonable for the Patient to take 16 of the 20 mg tablets; however, 4 of the 80mg tablets would be appropriate
- ☐ Other insurances, pharmacy printout, and medication assistance programs (supplied by the manufacturer) *are not* valid documentation for determining prior OxyContin®/Oxycodone ER trials.
- ☐ Acceptable claim history consists of progress/clinical notes stating trial and failure of 2 PDLs (methadone, Fentanyl, or morphine ER) or OxyContin® in last 90 days via FL Medicaid/ FL Medicaid HMO (encounter claims. The Patient still has to meet the diagnosis criteria for OxyContin® as well.

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ANALGESICS – LONG-ACTING NARCOTIC (CONTINUED)

FLORIDA MCOs' Auto PA Step Edits (OxyContin®)	
OxyContin® Automated PA approval satisfies Non-PDL edit (updated 4-2-2015)	**Step 1:** If incoming claim is for OxyContin (and generics if available) GSNs: 24504 & 072862 (10mg), 63515 & 072863 (15mg), 24505 & 072864 (20mg), 63516 & 072865 (30mg), 24506 & 072866 (40mg), 63517 & 072867 (60mg), 25702 & 072868 (80mg), is patient >/=18 years of age? • If yes, proceed to step 2. If no, deny for age (NCPDP EC 75). **Step 2:** Look back in drug history for 30 days for a different strength of oxycodone CR (GSNs: 24504 & 072862 (10mg), 63515 & 072863 (15mg), 24505 & 072864 (20mg), 63516 & 072865 (30mg), 24506 & 072866 (40mg), 63517 & 072867 (60mg), 25702 & 072868(80mg) • If not found, proceed to step 3. If found, deny for therapeutic duplication which requires a PA (NCPDP EC 75) **Step 3:** Look back in medical claims history 730 days for ICD-9s 140 – 239.xx. • If found, proceed to step 7. If not found, proceed to step 4. **Step 4:** Look back in drug history 365 days for any drug in HICL 001063 (Leucovorin), 011043 (Fusilev) or any drug in HIC3s V1W, V3C, V3I, V3L, Q5N, V1A, V1B, V1C, V1D, V1E, V1F, V1J, V1K, V1M, V1N, V1O, V1Q, V1R, V1T, V1U, V1V, V1X, V3A, V3D, V3E, V3F, V3H, V1I, V3M, Z2G, Z2W (antineoplastics) EXCLUDING HSN 006025 (Alferon), 006068 (Actimmune), GSN 031099 (Aldara), GSN 066038, 068613 (Zyclara), GSN 036872, 045266 (Oral methotrexate) • If found, proceed to step 7. If not found proceed to step 5. **Step 5:** Look back in drug history 90 days for 2 different chemical entity long acting narcotics Duragesic) – GSN 059102 (12mcg), 015880 (25mcg), 015881 (50mcg), 015882 (75mcg), 015883 (100mcg); Avinza – GSN 050219 (120mg), 050220 (90mg), 064740 (75mg), 064739 (45mg), 050221 (60mg), 050222 (30mg); Kadian – GSN 060355 (10mg), 060356 (20mg), 060357 (50mg), 060358 (100mg), 061722 (80mg), 061748 (30mg), 061749 (60mg), 062358 (200mg), 069899 (40mg), 069900 (70mg), 069901 (130mg), 069903 (150mg); MS Contin– GSN 004096 (30mg), 004097 (60mg), 011886 (100mg), 011887 (15mg), 016522 (200mg); Opana ER – GSN 061091 (5mg), 061092 (10mg), 063783 (15mg), 061093 (20mg), 063784 (30mg), 061094 (40mg), 063782 (7.5mg); Methadone – HSN 001745 excluding GSN 004236 – powder; Oramorph – GSN 004096 (30mg), 004097 (60mg), 011886 (100mg), 011887 (15mg); Embeda – HSN 036577, Exalgo – GSN 066200 (12mg), 069889 (16mg), 065093 (8mg), 069860 (32mg); Butrans – HSN 023438; Nucynta ER – GSN 067267 (100mg), 067268 (150mg), 067266 (50mg), 067270 (200mg), 067271 (250mg) OR OxyContin (GSNs: 24504 & 072862 (10mg), 63515 & 072863 (15mg), 24505 & 072864 (20mg), 63516 & 072865 (30mg), 24506 & 072866 (40mg), 63517 & 072867 (60mg), 25702 & 072868 (80mg), • If found, proceed to step 6. If not found, deny for missing prerequisite drug therapy NCPDP EC 75

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FLORIDA MCOs' Auto PA Step Edits (OxyContin® continued)	
OxyContin® v3.32 Automated PA approval satisfies Non-PDL edit	**Step 6:** Look back in medical claims history 365 days for ICD-9s: 282.5, 282.6, 334.2, 334.8, 335.9, 335.0, 335.0, 335.1, 335.11, 335.19, 335.2, 335.21, 336.0, 336.1, 336.2, 336.3, 336.8, 336.9, 337.2, 337.21, 337.22, 337.29, 340, 341, 341.1, 341.2, 341.21, 341.22, 341.8, 341.9, 344.00, 344.1, 344.2, 344.3, 344.4, 344.5, 344.6, 344.8, 344.9, 353.6, 356.0, 357.0, 357.1, 721.1, 721.4, 721.41, 721.42, 721.5, 721.6, 721.8, 721.91, 722.0, 722.1, 722.11, 722.2, 722.47, 722.5, 722.51, 722.52, 722.6, 722.7, 722.71, 722.72, 722.73, 722.8, 722.81, 722.82, 722.83, 722.9, 722.91, 722.92, 722.93, 723.0, 723.4, 723.6, 723.7, 724.00, 724.01,724.02, 724.03, 724.09, 724.4, 733.7 • If found, proceed to step 7. If not found, deny for missing approvable diagnosis NCPDP EC 75 **Step 7:** If incoming claim is for OxyContin 10mg, 15mg, 20mg, 30mg or 40mg, (see GSNs above) proceed to step 8. If incoming claim is for OxyContin 60mg (see GSN above), proceed to step 9. If incoming claim is for OxyContin 80mg (see GSN above), proceed to step 10. **Step 8** If incoming claim is for OxyContin 10mg, 15mg, 20mg, 30mg or 40mg (see GSN above)and quantity does not exceed 2 tablets per day (60 tablets per 30 days) across all strengths • If yes, claim passes and pays without a prior authorization. If no, claim denies for plan limitations exceeded NCPDP EC 76 **Step 9:** If incoming claim is for OxyContin 60mg (see GSN above) and quantity does not exceed 2 tablets per day (60 tablets per 30 days) • If yes, proceed to step 11. If no, claim denies for plan limitation exceeded NCPDP EC 76 **Step 10:** If incoming claim is for OxyContin 80mg (see GSN above) and quantity does not exceed 4 tablets per day (120 tablets per 30 days) • If yes, proceed to step 11. If no, claim denies for plan limitation exceeded NCPDP EC 76 **Step 11:** If incoming claim is for OxyContin 60mg or 80mg (see GSN above), Look back in drug history for the last 30 days. Does patient have >7 days of any drug in HIC3 H3A and DEA code = 2? • If YES, claim passes and pays. If NO, claim denies NCPDP EC 75 for patient is not opiate tolerant

ANALGESICS – NON-NARCOTIC

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason the Patient cannot be changed to a preferred medication? Acceptable reasons include
   - ☐ Allergy to at least two unrelated preferred medications
   - ☐ Contraindication to or drug-to-drug interaction with preferred medications
   - ☐ History of serious reaction to preferred medications (e.g., seizures, arrhythmias, etc.)
2. Has there been a failure to respond to a therapeutic trial of **at least one week** each of at least TWO preferred medications? **Document details.**

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Butalbital-APAP-Caffeine (generic for Fioricet) [qty limit across all butalbital products]	Be-flex® (APAP/phenyltoloxamine)
Butalbital-ASA-Caffeine (generic for Fiorinal) [qty limit across all butalbital products]	Butalbital-APAP [qty limit across all butalbital products]
Butalbital compound [qty limit across all butalbital products]	Cafgesic® (*APAP/Salicylamide/Phenyltoloxamine/Caffeine*)
Salsalate (generic for Disalcid)	Choline mag trisalicylate liquid
Tramadol (generic for Ultram) [8 tabs/day]	Diflunisal (generic for Dolobid)
	Disalcid® (*salsalate*)
	Orbivan® (Butalbital/APAP) [qty limit across all butalbital products]
	Orbivan CF® (Butalbital-APAP-Caffeine) [qty limit across all butalbital products]
	Tramadol/APAP (generic for Ultracet)* (**See Notes Below**)
	Tramadol Extended Release
	Ultram® (*tramadol*) [8 tabs/day]
	Ultram ER® (*tramadol*) [4 tabs/day]

NOTES

- ☐ [#/X] = quantity limit per X days
- ☐ Tramadol/APAP (generic for Ultracet):
  - ☐ No approval is allowed for this combination product.
  - ☐ Please recommend the use of both agents individually.

DENIAL MESSAGE

- ☐ TBD

ANALGESICS – NSAIDS

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason the Patient cannot be changed to preferred medications? **Document clinically compelling information.** Acceptable reasons include
   - ☐ Allergy to all unrelated preferred medications
   - ☐ Contraindication to or drug-to-drug interaction with preferred medications
   - ☐ History of serious reaction to preferred medications (e.g., seizures, arrhythmias, etc.)
2. The requested medication may be approved if both of the following are true:
   - ☐ If there has been a therapeutic failure to no less than a one-month trial, each of at least two preferred medications; **AND**
   - ☐ The requested medication's corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.
3. If the Patient diagnosis does not fit the approved indications for the preferred medications, then document details and refer to a Pharmacist.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Celecoxib (generic for Celebrex®)	Anaprox®, Anaprox DS (*naproxen*)
Diclofenac potassium (generic for Cataflam®)	Ansaid® (*flurbiprofen*)
Diclofenac sodium (generic for Voltaren®)	Arthrotec® (*diclofenac & misoprostol*)
Ibuprofen (generic for Motrin®)	Cambia® *(diclofenac potassium for oral susp)*
Indomethacin (generic for Indocin®)	Cataflam® (*diclofenac potassium*)
Ketorolac tab/inj (generic for Toradol®)	Celebrex® *(celecoxib)*
Meloxicam (generic for Mobic®)	Clinoril® (*sulindac*)
Nabumetone (generic for Relafen®)	Daypro® (*oxaprozin*)
Naproxen (generic for Naprosyn®)	Diflunisal (generic for Dolobid®)
	Etodolac (generic for Lodine®)
	Feldene® (*piroxicam*)
	Fenoprofen calcium (generic for Nalfon®)
	Flurbiprofen (generic for Ansaid®)
	Indocin® (*indomethacin*) Cap; Susp
	Ketoprofen (generic for Oruvail®, Orudis®)
	Lodine® (*etodolac*)
	Meclofenamate (generic for Meclomen®)
	Mefenamic acid (generic for Ponstel®)
	Motrin® (*ibuprofen*)
	Nalfon® (*fenoprofen*)
	Naprelan® (*naproxen*)
	Naprosyn® (*naproxen*)
	Naproxen sodium (generic for Anaprox®)
	Oxaprozin (generic for Daypro®)
	Piroxicam (generic for Feldene®)
	Ponstel® (*mefenamic acid*)
	Salsalate (generic for Disalcid®)
	Sulindac (generic for Clinoril®)
[#] = qty limit per 30 days	Voltaren XR® (*diclofenac sodium extended release*)

ANALGESIC/ANTIPYRETICS – SALICYLATES

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason the Patient cannot be changed to preferred medications? **Document clinically compelling information.** Acceptable reasons include
   - ☐ Allergy to all unrelated preferred medications
   - ☐ Contraindication to or drug-to-drug interaction with preferred medications
   - ☐ History of serious reaction to preferred medications (e.g., seizures, arrhythmias, etc.)
2. Has there been a failure to respond to a therapeutic trial of *at least one week* each of two preferred medications? If yes, allow the prior authorization. **Document details.**

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Acetaminophen w/butalbital	Alagesic LQ® (*APAP/butalbital/caff*)
Butalbital/APAP/Caffeine	Esgic Plus® (*APAP/butalbital/caff*)
	Esgic® tablets and capsules
	Phrenilin Forte® (*APAP/butalbital*)
	Promacet® (*APAP/butalbital*)
	Dolgic Plus® (*APAP/butalbital/caff*)
	Esgic tablets and capsules®
	Zebutal® (*APAP/butalbital/caff*)

DENIAL MESSAGE

☐ TBD

ANALGESIC/ANESTHETICS – TOPICALS

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)
	MAP: Quantity Limits: IE 7001 (76 / 7001 – GSN)

1. Is there any reason the Patient cannot be changed to preferred medications? **Document clinically compelling information**. Acceptable reasons include
   - ☐ Allergy to preferred medications
   - ☐ Contraindication to or drug-to-drug interaction with preferred medications
   - ☐ History of serious reaction to preferred medications (e.g., seizures, arrhythmias, etc.)
2. Has there been a failure to respond to a therapeutic trial of *at least a 30-day trial* of Voltaren® Gel? If yes, allow the prior authorization. **Document details.**

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Voltaren 1%® (*diclofenac sodium topical gel*) [MCC-FL: 400gm/30 days; CCP/SFCCN: 500gm/30days] [Age ≥ 18 yrs old]	Flector® (*diclofenac sodium topical patch*)
	Lidoderm® (*lidocaine transdermal patch*) – AutoPA (refer to coding below)

AUTO PA CODING

Lidoderm®: Automated PA approval satisfies Non-PDL edit.

Lidoderm List		
Generic Name	**Brand Name**	**Drug Code**
Lidocaine	Lidoderm Adh Patch	GSN= 043256 and generic drug name code= 2

Other Neuropathic Pain Medication List		
Generic Name	**Brand Name**	**Drug Code**
Amitriptyline	Elavil	HICL= 001643
Gabapentin	Neurontin, Gralise	HICL= 008831
Pregabalin	Lyrica	HICL= 026470
Duloxetine	Cymbalta	HICL= 026521
Milnacipran	Savella	HICL= 021229
Capsaicin	Qutenza	HICL= 036916
Tapentadol	Nucynta/ER	HICL= 036411

Step 1: If incoming drug is for Lidoderm Adhesive Patch <Lidoderm Drug List>, look back 730 days in the patient's medical history for a diagnosis of herpes zoster or post herpetic neuralgia (ICD 9: 052.0 – 053.9) if found: CLAIM PAYS. Otherwise, proceed to Step 2.
Step 2: Look back 730 days in the patient's medical history for a diagnosis of neuralgia (ICD 9: 729.2, ICD 10: M54.10, M54.18, M79.2), diabetic neuropathy (ICD 9: 250.60-250.63, ICD 10: E10.40, E10.41, E10.42, E10.43, E10.49, E11.40, E11.41, E11.42, E11.43, E11.49, E13.40, E13.41, E13.42, E13.43, E13.49), diabetic peripheral autonomic neuropathy (ICD 9: 337.1, ICD 10:G99.0), or diabetic polyneuropathy (ICD 9: 357.2,ICD 10: E08.40, E08.41, E08.42, E08.43, E08.49) if found, Proceed to Step 3. Otherwise, deny for prior authorization required (75) with supplemental message: "M/I Diagnosis Code."
Step 3: Look back in patient's drug therapy 365 days for 1or more fills of amitriptyline, gabapentin, pregabalin, Savella, duloxetine, Qutenza, or Nucynta/ER <Other Neuropathic Pain List>, if found: **CLAIM PAYS**. Otherwise, **DENY** for NCPDP EC 75 PRIOR AUTHORIZATION REQUIRED with supplemental messaging: *"missing prerequisite drug therapy."*
Note: Lidoderm quantity limitation of 90 patches per 30 days applies prior to claim payment.

ANTIANXIETY AGENTS

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)
Qty limits:	☐ 90 tablets/capsules every 30 days. Note: Some anti-anxiety agents have additional limits, refer to the summary of drug limitations table.

1. Is there any reason the Patient cannot be changed to a medication not requiring prior approval? **Document clinically compelling information.** Acceptable reasons include
   - ☐ Allergy to preferred medications
   - ☐ Contraindication to or drug-to-drug interaction with preferred medications
   - ☐ History of unacceptable/toxic side effects to preferred medications
2. Has there been a failure to respond to a therapeutic trial of *at least one week* each of **TWO** preferred medications? If yes, allow the prior authorization. **Document details.**

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Alprazolam (generic for Xanax®) [150/30]	Alprazolam Intensol
Alprazolam Intensol	Alprazolam XR (generic for Xanax XR®) [30/30]
Bupropion (generic for Wellbutrin®)	Ativan® (*lorazepam*) [150/30] (Please see additional information below.)
Buspirone (generic for BuSpar®)	BuSpar® (*buspirone*)
Chlordiazepoxide (generic for Librium®) [120/30]	Diazepam 5mg/ml syringe & 5mg/ml vial
Clorazepate dipotassium (generic for Tranxene®) [120/30]	Meprobamate
Diazepam oral, soln, oral conc. (generic for Valium®) (see quantity limit and specific criteria below [120/30]	Niravam® (*alprazolam*)
Lorazepam Intensol [90/30]	Valium® (*diazepam*) [120/30] (Please see additional information below.)
Lorazepam (generic for Ativan®) [150/30]	Xanax® (*alprazolam*) [150/30]
Oxazepam (generic for Serax®) [120/30]	Xanax XR® (*alprazolam ER*) [30/30]

ADDITIONAL INFORMATION FOR ATIVAN® AND VALIUM®: PHARMACISTS ONLY

- ☐ Please refer all requests for Brand Ativan and Brand Valium to a pharmacist review. Overrides cannot be entered for Brand Valium as none of the NDCs listed in FDB/FirstTrax℠ are rebateable. Therefore, this medication is not reimbursable.
- ☐ Please refer to the 'Exceeding Benzodiazepine Quantity Limits' criteria for to aid in the review of quantity limit override requests.

DENIAL MESSAGE

- ☐ TBD

ANTIBIOTICS – GENERAL INFORMATION

INITIAL REQUEST OMISSION OF CULTURE AND SENSITIVITY REPORT

If you receive a request for a non-PDL antibiotic and the provider omits to fax in a culture and sensitivity report, please escalate the request to a pharmacist. Pharmacists, please consider appropriate preferred alternatives and request a copy of the culture and sensitivity report for further consideration of the Non-PDL antibiotic (Examples: Zyvox, Tygacil, etc.)

SUBSEQUENT REQUEST OMISSION OF CULTURE AND SENSITIVITY REPORT

Upon the second request if the provider omits to fax in the culture and sensitivity report, please ***do not deny*** *or* ***fax back another CIT***, please forward the request to a pharmacist. Please place in your clinical notes that the physician has omitted to fax in C/T result upon second request.

DENIAL MESSAGE

- TBD

ANTIBIOTICS – CEPHALOSPORINS

Length of Authorization:	Date of Service (3-day range)
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to preferred medications? Acceptable reasons include
   - ☐ Allergy to medication formulation; i.e., dyes, fillers
   - ☐ If an allergy to the medication class, question request
   - ☐ Contraindication to all preferred medications
   - ☐ History of unacceptable side effects
2. Is the infection caused by an organism resistant to the preferred cephalosporin medications? If so, document and allow the prior authorization. **Note diagnosis, any culture, and sensitivity reports. (Refer to RPh for culture/sensitivity report clarification.)**
3. Has the Patient had a therapeutic trial (duration = 3 days) that has failed with at least **TWO** preferred cephalosporin medications? If so, document and allow the prior authorization.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

A non-preferred medication which was initiated in the hospital may be authorized for the course of therapy.

FIRST GENERATION

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Cephalexin capsules (generic for Keflex®)	Cefadroxil (generic for Duricef®)
	Cephalexin tablets 250mg, 500mg
	Keflex® (*cephalexin*)

SECOND GENERATION

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Cefprozil (generic for Cefzil®)	Cefaclor capsules and susp (generic for Ceclor®)
Cefuroxime Axetil (generic for Ceftin®)	Ceftin® (cefuroxime)

THIRD GENERATION

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Cefdinir (generic for Omnicef®)	Cedax® (*ceftibuten*)
Suprax® (*cefixime*) oral suspension	Cefditoren (generic for Spectracef®)
Tazicef® (*ceftazidime*)	Cefpodoxime (generic for Vantin®)
	Claforan® (*cefotaxime*)
	Omnicef capsules and susp.® (*cefdinir*)
	Spectracef® (*cefditoren pivoxil*)
	Suprax® (*cefixime*) chewable tablets

FOURTH GENERATION

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Cefepime	Cefepime-Dextrose IV piggyback

ANTIBIOTICS – MACROLIDES

Length of Authorization:	Date of Service (3 Day Range)
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to a preferred medication? Acceptable reasons include
   - ☐ Allergy to medication formulation (i.e., dyes, fillers)
   - ☐ If allergy to medication class, then question request
   - ☐ Contraindication to preferred medications
   - ☐ History of unacceptable side effects
2. Is the infection caused by an organism resistant to the preferred macrolide medications? If so, document and allow the prior authorized medication. Note diagnosis and any culture and sensitivity reports. **(Refer to RPh for culture/sensitivity report clarification.)**
3. Has the Patient had therapeutic trials (*duration = 3 days*) that have failed with at least **TWO** preferred macrolide medications? If so, document and allow the prior authorization.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the Patient is completing a course of therapy with a non-preferred medication which was initiated in the hospital, you may authorize this medication for the course of therapy.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Azithromycin (generic for Zithromax®)	Biaxin® (*clarithromycin*)
Azithromycin 1gm powder packet (generic for Zithromax®)	Biaxin XL® (*clarithromycin XL*)
Clarithromycin (generic for Biaxin®)	EES 400
Clarithromycin ER tab (generic for Biaxin®)	ERYC
Erythromycin EC 250mg capsules	EryPed Chew (200mg)
Erythromycin Estolate	EryPed Drops (100mg/2.5ml)
Erythromycin EC 500mg	EryPed Granules (200mg and 400mg)
Erythromycin w/Sulfisoxazole	EryPed Susp (200mg and 400mg)
Erythromycin Ethylsuccinate (EES susp/tabs)	Erytab EC
Erythromycin Base 250mg tablet	Erythrocin 250mg Filmtab
	Ketek® (*Telithromycin*)
	PCE 333 (*erythromycin*)
	Zithromax 1gm powder packet
	Zithromax® 250mg and 500mg tablets
	Zithromax 100mg/5ml suspension
	Zmax® (*azithromycin*)

ANTIBIOTICS – QUINOLONES

Length of Authorization:	Date of Service (3-Day Range)
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to a preferred medication? Acceptable reasons include
   - ☐ Allergy to all preferred medications
   - ☐ Contraindication to all preferred medications
   - ☐ History of unacceptable side effects
2. Is the infection caused by an organism resistant to the preferred quinolone medications? If so, document and allow the prior authorization. Note diagnosis, any culture, and sensitivity reports. **(Refer to RPh for culture/sensitivity report clarification.)**
3. Has the Patient had therapeutic trials (duration = 3 days) of at least **TWO** preferred quinolone medications that have failed? If so, document and allow the prior authorization.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the Patient is completing a course of therapy with a non-preferred medication, which was initiated in the hospital, you may authorize this medication for the course of therapy.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Cipro® (*ciprofloxacin*) **suspension** Only preferred for pts under 12 years old	Avelox® (moxifloxacin) I.V.
Ciprofloxacin tablets, injectable (generic for Cipro®)	Avelox® (*moxifloxacin*) tablets
Levofloxacin (generic Levaquin®) oral suspension **(max age 11)**	Cipro XR® tablets (*ciprofloxacin*)
Levofloxacin (generic for Levaquin ®) tablets	Cipro® tablets (*ciprofloxacin*)
Levofloxacin - D5W (generic Levaquin®) sol'n	Ciprofloxacin ER tablets (generic for Cipro®)
	Ciprofloxacin XR 1000mg
	Factive® (*gemifloxacin*) [7/27]
	Floxin® (*ofloxacin*)
	Levaquin® (*levofloxacin*) tablets
	Levaquin® (*levofloxacin*) oral suspension **(max age 11)**
	Levaquin® - D5W (levofloxacin) sol'n
	Levofloxacin (generic Levaquin®) vials for inj
	Noroxin® (*norfloxacin*)
	Ofloxacin (generic for Floxin®)

[#/X] = quantity limit per X days

ANTIBIOTIC – TOPICAL

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason the Patient cannot be changed to a preferred medication? Acceptable reasons include
   - ☐ Allergy to at least two unrelated preferred medications
   - ☐ Contraindication to or drug-to-drug interaction with preferred medications
   - ☐ History of unacceptable/toxic side effects to preferred medications
2. Has there been a failure to respond to a therapeutic trial of at least **TWO** preferred medications? **Document details**.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Mupirocin (generic Bactroban® ointment) [44/30]	Bacitracin
Bactroban® nasal ointment (mupirocin) [10 grams/30 days]	Bactroban® cream (*mupirocin*) [60 grams/30 days]
Bacitracin with Zinc	Bactroban® ointment (*mupirocin*)
	Centany® (generic for Mupirocin®)
	Gentamycin

[#/X] = quantity limit per X days

ANTICONVULSANTS – AUTO PA

Length of Authorization:	1 year
Initiative:	MAP: AP: Anticonvulsants (75 / 2462 – GSN; 76 / 2641 – GSN)

APPROVABLE SEIZURE DIAGNOSIS CODES

ICD-9 Code	Description		ICD-10 Code	Description
310 – 310.9	Brain Injury Syndromes		G25.3	Myoclonus
317 – 319	Mental Retardation		ICD 10 Disease Group: G80	Cerebral Palsy
333.2	Progressive Myoclonic (Familial)		ICD 10 Disease Group: G40	Epilepsy
343 – 343.9	Mental Retardation		ICD 10 Disease Group: G45, G46	Transient cerebral ischemic attacks and related syndromes
345 – 345.91	Epilepsy		ICD 10 Disease Block: I60-I69	Cerebrovascular Disease
434 – 438.89	Cerebrovascular Disease (Stroke)		G90.1	Familial dysautonomia [Riley –Day]
742 – 742.9	Congenital Structural Abnormalities of the Brain		ICD 10 Disease Block: Q00-Q07	Congenital Malformations of the brain, spinal cord, nervous system
780.31 – 780.33	Convulsions		ICD 10 Disease Group: R56.00	Convulsions, not elsewhere classified
851 – 854.19	Intracranial Injury		ICD 10 Disease Group: S06	Intracranial Injury
959.01	Head injury, unspecified		T74.12XA, T74.12XD, T74.12XS, T74.4XXA, T74.4XXD, T74.4XXS, T76.12XA, T76.12XD, T76.12XS.	Child physical abuse, confirmed/suspected, initial encounter. Shaken infant syndrome, initial encounter
995.54 – 995.55	Child Abuse Syndromes (Including Shaken Baby)		ICD 10 Disease Group: F07, F48	Personality change due to known physiological condition and non-psychotic mental disorders
			ICD 10 Disease Block: F70 – F79	Intellectual Disabilities
			S09.8XXA, S09.8XXD, S09.8XXS, S09.90XD, S09.90XS	Other/unspecified injuries of the head, initial encounter

APPROVAL CRITERIA: AUTO PA EDIT

ANTICONVULSANT DRUG LIST A

Technicians:

- ☐ Approve if you are provided (fax or phone) with any of the diagnoses in the "APPROVABLE SEIZURE DIAGNOSIS CODES" chart above. (AutoPA coding looks back 730 days in the Patient's medical history for a seizure diagnosis.)
- ☐ If the ICD-9/ICD-10 provided is not in the chart, then forward to a pharmacist.

Pharmacists:

- ☐ If no approvable ICD-9/ICD-10 code can be provided, then deny for **Recipient doesn't have a required diagnosis on file for this medication.** This is also the Transaction Message on denied claims where the system does not find an ICD code.

ANTICONVULSANT DRUG LIST A – AUTO PA

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
N/A	Celontin® (Methsuximide)
	Gabitril® (Tiagabine)
	Peganone® (Ethotoin)
	Vimpat® (Lacosamide)

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ANTICONVULSANTS – LIST B

Technicians

- Approve if you are provided (fax or phone) with any of the diagnoses in the "APPROVABLE SEIZURE DIAGNOSIS CODES" chart on the previous page **and** if the patient has been on the same drug (HICL – different strength and brand or generic is okay).
- If the ICD-9/ICD-10 provided is not in the chart then forward to a pharmacist.
- If the ICD-9/ICD-10 provided is in the chart but the patient has not been on the same drug (HICL – different strength and brand or generic is okay) then forward to a pharmacist.

Pharmacists

- If no approvable ICD-9/ICD-10 code can be provided, then deny for **Recipient does not have a required diagnosis on file for this medication.** This is also the Transaction Message on denied claims where the system does not find an ICD code.
- If an approvable ICD-9/ICD-10 code is found but the patient has not been on the med within the last 365 days, then deny for **Recipient does not have required drug use supporting this medication.** This is also the Transaction Message on denied claims where the system does not find an ICD code.

ANTICONVULSANTS DRUG LIST B – AUTO PA

PREFERRED – NO PA REQUIRED	NON-PREFERRED– PA REQUIRED
Carbamazepine ER	Carbatrol
Carbamazepine IR	Depakene
Carbamazepine SR	Depakene syrup
Divalproex Sodium	Depakote/Depakote Sprinkle
Divalproex Sodium DR & ER	Depakote ER
Ethosuximide	Dilantin Infatab
Felbamate	Dilantin Suspension
Gabapentin caps/tabs	Dilantin/Phenytek
Gabapentin oral solution	Epitol®
Lamictal	Felbatol
Levetiracetam See directive below for Keppra/levetiracetam oral solution	Keppra solution (pricing verbiage please see miscellaneous section of criteria)
Levetiracetam ER	Keppra XR
Oxcarbazepine tabs & oral susp	Lamotrigine
Phenytoin chewable tabs; susp	Luminal
Phenytoin Sodium ER caps	Mysoline
Primidone	Neurontin
Topiramate tabs & sprinkles	Neurontin oral solution
Valproic Acid caps & soln	Tegretol, Tegretol XR
Valproate Sodium	Topamax
Zonisamide	Trileptal (approve in multiples of 250ml for suspension)
	Zarontin
	Zonegran

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FOR DIAGNOSIS OTHER THAN CODES IN THE ABOVE TABLES ON THE FIRST PAGE (RPH ONLY)

If a Patient has a history of a trial with the generic equivalent or Brand anticonvulsant, the request may be considered based on the medical records submitted detailing failure on the generic or why the generic formulation cannot be considered. Otherwise, the pharmacist must deny with note indicating that the generic is preferred. (Please confirm that there is a generic equivalent).

ANTICONVULSANT QUANTITY LIMIT (EFFECTIVE 01/05/2011)

- **88/280-HD:** All **88/280-HD** requests should be referred to a pharmacist for review.

  Pharmacist: If you receive an Anticonvulsant rejected claim for **88/280-HD**, please complete the following
  - The medications within the Anticonvulsants listing do not have a state quantity limit. This class only has an FDB (First DataBank) limit which will only reject for **88/280-HD**.
  - See the section elsewhere in the criteria document for **HIGH DOSE GUIDELINES**.
- **7001/76 or 2641/76**

  Pharmacist: If you receive an Anticonvulsant rejected claim for **7001/76 or 2641/76**, please complete the following:
  - Make sure the patient meets the criteria.
  - Check the PA history tab to see if there is an approved PA on file.
  - If PA is found, end the PA (which should kill any previous quantity limit rules) and have the provider reprocess the claim (the claim will now pay).
  - If there is no PA on file and the Anticonvulsant rejects for **7001-76 or 2461/76**, please notify Plan Admin.

ANTICONVULSANT EARLY REFILL REJECTION (EFFECTIVE 08/02/2010)

Please approve request for ER override rejections for Brand Anticonvulsants if the provider states the recipient had an adverse reaction to the generic regardless of if there is a dosage increase or not. Please approve using the below information:

- Use the “MAP: Early Refill” initiative.
- Use the “Date of Service” PA reason code.
- Duration: DOS (3 days)
- Prior authorization request may be granted for a request by the Prescriber or Pharmacy.

  Note: Please verify the trial of the generic and the seizure diagnosis code.

ANTICONVULSANTS – NON AUTOPA

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

NON-AUTO PA ANTICONVULSANTS

Preferred Generic – No PA Required	Non-Preferred Brand – PA Required	Comments
Clonazepam	Klonopin	Limit of #90 per 30 days (if Patient has seizure diagnosis code, system will bypass quantity limit.) See Benzodiazepine quantity criteria to exceed limits of Clonazepam. Deny request for Brand Klonopin if Change In Therapy is not accepted.
Diazepam	Valium	Limit of #120 per 30 days (see Benzodiazepine quantity criteria to exceed limits for Diazepam). See specific criteria for Diastat. Deny request for Brand Valium if Change In Therapy is not accepted.
Lorazepam	Ativan	Limit of #150 per 30 days (see Benzodiazepine quantity criteria to exceed limits for Lorazepam) Deny request for Brand Ativan if Change In Therapy is not accepted.
Topiramate ER capsules	Qudexy XR	See specific criteria below for Qudexy XR
Valproic Acid	Stavzor Capsules	Deny request for Brand Stavzor if Change In Therapy is not accepted.
No generic available	Aptiom	See specific criteria below for Aptiom
No generic available	Banzel	See specific criteria below for Banzel
No generic available	Onfi	See specific criteria below for Onfi
No generic available	Fycompa	See specific criteria below for Fycompa
No generic available	Oxtellar XR	See specific criteria below for Oxtellar XR
No generic available	Potiga	See specific criteria below for Potiga
No generic available	Sabril	See specific criteria for Sabril
No generic available	Trokendi XR	See specific criteria below for Trokendi XR

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APTIOM® (ESLICARBAZEPINE)

Length of Authorization:	Up to 12 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥18 years old.
- ☐ Patient must have a seizure diagnosis verified by supporting documentation or diagnoses codes.
- ☐ Patient must have a history of trial and failure of at least two preferred medications. Trial of oxcarbazepine (brand or generic) is required.
  - ☐ Failure may be identified by a history of breakthrough seizures while on a dose of oxcarbazepine within an optimized range of 1200 – 2400 mg/day.
  - ☐ Lack of response to therapy due to noncompliance *should not be considered* failure.
- ☐ *Hypersensitivity* (allergy) *or adverse response* to oxcarbazepine therapy is *not* a reason for approval. **The provider should try a different preferred agent.**
- ☐ Requests for neuralgia, bipolar disorder, or migraines must be referred to oxcarbazepine (brand or generic) or other preferred alternatives.

BANZEL® (RUFINAMIDE)

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Patient must be ≥ 1 year old
- ☐ Must have a diagnosis of Lennox-Gastaut Syndrome.
- ☐ Patients with a diagnosis of Lennox-Gastaut Syndrome must be currently on an antiepileptic regimen.
  - ☐ The regimen must include one of the following: a Valproate, Topamax, Clonazepam, or Lamictal.
- ☐ If a patient meets the age requirement, but does not have a diagnosis of Lennox Gastaut they:
  - ☐ Must have a diagnosis of seizures and medical documentation verifying a history of inadequately controlled seizures.
  - ☐ Must be on other anticonvulsant medication.
  - ☐ Banzel must be prescribed by a neurologist.

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CARBATROL®/EQUETRO® (CARBAMAZEPINE EXTENDED RELEASE)

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

CARBATROL®

- ☐ History of seizures
- ☐ Drug history within past 365 days of Carbatrol

Note: Requests for 100mg and 300mg strengths of Carbatrol may be approved with a diagnosis of seizure or bipolar disorder (if the dose cannot be optimized to the 200 mg or 400 mg strength of the generic carbamazepine ER). All other Carbatrol requests should be declined with an informational referral to carbamazepine ER.

EQUETRO®

- ☐ Diagnosis of Bipolar Disorder.
- ☐ All other diagnoses refer to carbamazepine ER or to a clinical pharmacist.

FYCOMPA® (PERAMPANEL)

Length of Authorization:	Up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

WARNING: SERIOUS PSYCHIATRIC AND BEHAVIORAL REACTIONS

- ☐ Serious or life-threatening psychiatric and behavioral adverse reactions including aggression, hostility, irritability, anger, and homicidal ideation and threats have been reported in patients taking Fycompa.
- ☐ Providers should monitor patients for these reactions as well as for changes in mood, behavior, or personality that are not typical for the patient, particularly during the titration period and at higher doses.
- ☐ Fycompa should be reduced if these symptoms occur and should be discontinued immediately if symptoms are severe or are worsening.

REVIEW CRITERIA

- ☐ Patient must be ≥12 years old
- ☐ Patient must have supporting documentation or diagnoses codes to verify a history of intractable (refractory) seizures.
- ☐ Patient must have a history of trial and failure of:
  - ☐ At least 2 concomitant Antiepileptic Drugs OR
  - ☐ At least 3 different Antiepileptic Drugs OR
  - ☐ History of Vagal Nerve Stimulator (VNS) implantation or lobectomy.

DOSING & ADMINISTRATION

- ☐ Dosage: Start at 2mg at bedtime. May increase by increments of 2mg once daily at weekly intervals. For generalized tonic-clonic seizures, the maintenance dose is 8mg at bedtime. For partial-onset seizures, the maintenance dose range is 8mg-12mg.

Dosage Form Tablets: 2 mg, 4 mg, 6 mg, 8 mg, 10 mg, and 12 mg; 0.5mg/ml oral suspension

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LAMICTAL XR® (LAMOTRIGINE) EXTENDED RELEASE TABLETS

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Patient must be ≥13 years old
- ☐ Patient must have a seizure diagnosis verified by supporting documentation or billed diagnoses codes
- ☐ Patient must have a history of trial and failure of three preferred alternatives. Trial of lamotrigine (brand or generic) is required.
  - ☐ Failure may be identified by a history of breakthrough seizures while on dose within an optimized range (refer to prescribing information or information resource).
    - ☐ Hypersensitivity (allergy) or adverse response to lamotrigine therapy is not a reason for approval. The provider should try a different ingredient preferred agent.
  - ☐ Lack of response to therapy due to noncompliance should not be considered failure.
- ☐ Requests for neuralgia, bipolar disorder, or migraines must be referred to lamotrigine (brand or generic) or other preferred alternatives.

Note: Build PAs for generic Lamotrigine ER unless a request is received as Brand Medically Necessary on a Request for Multi-Source Brand prior authorization form for review.

ONFI® (CLOBAZAM)

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Patient must be ≥2 years old
- ☐ Must have a diagnosis of Lennox-Gastaut Syndrome.
- ☐ Patients with a diagnosis of Lennox-Gastaut Syndrome must be currently on an antiepileptic regimen
  - ☐ Regimen must include one the following: a Valproate, Clonazepam, Felbamate, Topamax, or Lamictal.
  - ☐ Must have trial and failure of two preferred alternatives.
- ☐ If a patient meets the age requirement, but does not have a diagnosis of Lennox Gastaut they:
  - ☐ Must have a diagnosis of seizures and medical documentation verifying a history of inadequately controlled seizures.
  - ☐ Must have a history of trial and failure of multiple (at least 3) anticonvulsant medications including benzodiazepines.
  - ☐ Onfi must be prescribed by a neurologist.
- ☐ Note: Onfi is a Medicare Part D exempt drug.

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OXTELLAR XR® (OXCARBAZEPINE)

Length of Authorization:	12 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Patient must be ≥6 years old
- ☐ Patient must have a seizure diagnosis verified by supporting documentation or patient health conditions
- ☐ Patient must have a history of trial and failure with three preferred alternatives. Trial of oxcarbazepine (brand or generic) is required.
  - ☐ Failure may be identified by a history of breakthrough seizures while on dose within an optimized range of 1200–2400mg/day (for adults) and approaching 60mg/kg/day (for children).
  - ☐ *Hypersensitivity* (allergy) *or adverse response* to oxcarbazepine therapy is *not* a reason for approval. The provider should try a different ingredient preferred agent.
  - ☐ Lack of response to therapy due to noncompliance *should not* be considered failure.
- ☐ Requests for neuralgia, bipolar disorder, or migraines must be referred to oxcarbazepine (brand or generic) or other preferred alternatives.

POTIGA® (EZOGABINE)

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Patient must be ≥18 years old
- ☐ Must have a diagnosis of seizures
  - ☐ Patient medical records or health conditions must indicate that the patient has had a baseline eye examination for ***initiation of therapy.*** *(Reviewer must indicate approximate date of exam.)*
    - ☐ If patient is blind, no examination history required.
    - ☐ For continuation of therapy, patient medical records or health conditions must indicate that the patient has received an eye examination within six months of last eye exam *(reviewer must document approximate date)*.
      - ☐ If no indication of eye examination found in submission or health conditions, the reviewer may approve Potiga for one month and request resubmission of documentation demonstrating recent history of eye examination

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QUDEXY XR® (TOPIRAMATE) EXTENDED-RELEASE CAPSULES

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

CLINICAL NOTES

QUDEXY XR is an antiepileptic drug indicated for:

- Partial Onset Seizures or Primary Generalized Tonic-Clonic Seizures - initial monotherapy in patients 2 years of age and older with partial onset or primary generalized tonic-clonic seizures and adjunctive therapy in patients 2 years of age and older with partial onset or primary generalized tonic-clonic seizures
- Lennox-Gastaut Syndrome (LGS) - adjunctive therapy in patients 2 years of age and older with seizures associated with Lennox-Gastaut syndrome

REVIEW CRITERIA

- Patient must be ≥ 2 years old for Lennox-Gastaut Syndrome or adjunctive therapy with partial onset or primary generalized tonic-clonic seizures
- Patient must be ≥ 10 years old for monotherapy with the diagnosis of partial onset or primary generalized tonic- clonic seizures
- Patient must have a history of trial and failure of three preferred alternatives. Trial of topiramate (brand or generic) is required.
- Requests for neuralgia, bipolar disorder, or migraines must be referred to topiramate or other preferred alternatives.

DOSING AND ADMINISTRATION

- **Monotherapy in** partial onset seizures and primary generalized tonic-clonic seizures:
  - Adults and pediatric patients 10 years and older: 400 mg orally once daily
- Adjunctive Therapy:
  - Adults with partial onset seizures or LGS: 200-400 mg once daily
  - Adults with primary generalized tonic-clonic seizures: 400 mg once daily
  - Pediatric Patients 2 years and older with partial onset seizures, primary generalized tonic clonic seizures, LGS: 5 mg/kg to 9 mg/kg once daily
- Dosage Form: 25mg, 50mg, 100mg, 150mg, 200mg extended release capsules
- Capsules may be swallowed whole or opened and sprinkled on a spoonful of soft food.

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SABRIL® (VIGABATRIN)

Length of Authorization:	3 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Diagnosis of Refractory Complex Partial Seizures or Infantile Spasms.
- ☐ Beneficiaries with diagnosis of Refractory Complex Partial Seizures must be of the age 10 years or older and trial and failure of three preferred medications are required.
- ☐ Beneficiaries with diagnosis of Infantile Spasms must have an age of one month to two years.
- ☐ The prescribing provider must be a specialist in the neurology field of study.
- ☐ Must have official verification of compliance with the Sabril REMS Program:
  - ☐ Submit a copy of the completed SABRIL REMS Program/Parent/Legal Guardian-Physician Agreement Form.
  - ☐ Ensure that periodic vision monitoring, as described in the Prescribing Information, is performed on an ongoing basis for each patient (baseline, no later than 4 weeks after starting Sabril and at least every 3 months while on therapy. Vision testing is also recommended about 3 to 6 months after the discontinuation of Sabril therapy)

DOSING

- ☐ **Refractory Complex Partial Seizures in pediatrics 10 to 16 years of age (25kg-60kg):** Initially 250 mg PO twice daily, may increase dose at weekly intervals. The recommended maintenance dose is 1000 mg twice daily. Patients weighing more than 60 kg should be dosed according to adult recommendations.
- ☐ **Refractory Complex Partial Seizures in >16 years of age**: Initially, 500 mg PO twice daily. Titrate the dose in 500 mg/day increments at weekly intervals depending on patient response; the recommended dose is 1.5 g PO twice daily. Use the lowest dose and shortest duration necessary to achieve cli nical goals.
- ☐ **Vigabatrin** should be discontinued if a significant clinical response is not achieved within 3 months of initiation or if clinical failure is obvious earlier.
- ☐ **Infantile Spasms**: Initially, 50 mg/kg/day PO given in 2 divided doses. Titrate the dose in 25 —50 mg/kg/day increments every 3 days as needed for clinical response; do not exceed 150 mg/kg/day. Use the lowest dose and shortest duration necessary to achieve clinical goals. **Vigabatrin should be discontinued if a significant clinical response is not achieved within 2 to 4 weeks of initiation or if clinical failure is obvious earlier**.

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TROKENDI XR® (TOPIRAMATE) EXTENDED-RELEASE CAPSULES

Length of Authorization:	Up to 12 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Patient must be ≥6 years old
- ☐ Patient must have a seizure diagnosis verified by supporting documentation or diagnoses codes
- ☐ Patient must have a history of trial and failure of three preferred alternatives. Trial of topiramate (brand or generic) is required.
  - ☐ Failure may be identified by a history of breakthrough seizures while on dose within an optimized range of 200 to 400 mg/day (for adults) and 5 to 9 mg/kg/day (for children).
  - ☐ *Hypersensitivity* (allergy) *or adverse response* to topiramate therapy is **not** a reason for approval. **The provider should try a different ingredient preferred agent.**
  - ☐ Lack of response to therapy due to noncompliance **should not** be considered failure.
- ☐ Requests for neuralgia, bipolar disorder, or migraines must be referred to topiramate or other preferred alternatives.

ANTIDEPRESSANTS – SSRIS

Length of Authorization:	1 year
Initiative:	MAP: Antidepressants: Age 0-5 Years (60 / 50068 – GSN; 60 / 2193 – GSN; 76 / 2641 –GSN) PDL: Non-Preferred Drug Override (75/2462 – GSN; 76/2641 – GSN; 75/31004 – GSN) **MAP**: Quantity Limits: IE 7001 (76 / 7001 – GSN)
Fax Form:	Antidepressant (< 6 years of age) [REQUIRED for these ages]

NOTE

Antidepressant medications for patients < 6 years old require prior authorization.
Escalate all requests for antidepressant medications for patients < 6 years of age directly to a pharmacist for account-level review c/o Dennis Bibbs. Be prepared to provide Dennis with a copy of any associated documentation.

1. Is there any reason the Patient cannot be changed to a medication not requiring prior approval? **Document clinically compelling information**. Acceptable reasons include
   - ☐ Allergy to preferred medications
   - ☐ Contraindication to or drug-to-drug interaction with preferred medications
   - ☐ History of a serious reaction (e.g., thoughts of suicide, seizures, etc.) to preferred medications
2. The requested medication may be approved if ***both*** of the following are true:
   - ☐ If there has been a therapeutic failure to no less than a two-month trial each of at least **TWO** preferred medications; **AND**
   - ☐ The requested medication's corresponding preferred generic (if a generic is available) has been attempted and failed or is contraindicated.

***MAOIs:** If the Patient is taking a MAOI med (Monoamine Oxidase Inhibitors)* - all SSRIs are contraindicated.

- ☐ Emsam Transdermal Patch® (Selegiline);
- ☐ Marplan tablets® (Isocarboxazid);
- ☐ Nardil® (Phenelzine);
- ☐ Parnate® (Tranylcypromine)

PREFERRED GENERIC – NO PA REQUIRED	NON-PREFERRED BRAND – PA REQUIRED
Citalopram (generic for Celexa)	Celexa® (citalopram)
Citalopram solution [30ml/day] (max age 11)	Escitalopram solution (gen for Lexapro®) [20ml/day] (max age 11)
Escitalopram (generic for Lexapro®)	Fluoxetine tablets, 10mg, 20mg, 60mg
Fluoxetine (generic for Prozac) capsules	Fluoxetine Delayed Release capsules, 90mg
Fluoxetine (generic for Prozac) oral soln (max age 11)	Lexapro® (escitalopram)
Fluvoxamine (generic for Luvox)	Luvox CR® (fluvoxamine)
Lexapro® solution [20ml/day] (max age 11)	Paroxetine Extended Release (generic for Paxil CR®)
Paroxetine (generic for Paxil)	Paxil suspension (max age 11)
Sertraline (generic for Zoloft)	Paxil CR® (paroxetine)
Sertraline (generic for Zoloft®) oral concentrate	Pexeva® (paroxetine)
	Prozac® (fluoxetine)
	Prozac Weekly® (fluoxetine) – limit 4 per 30 days (7001)
	Sarafem®
	Zoloft® (sertraline)

For Qty and Age restrictions, please remember to check the Summary of Drug Limitations.

ANTIDEPRESSANTS – OTHER

Length of Authorization:	1 year
Initiative:	MAP: Antidepressants: Age 0-5 Years (60 / 50068 – GSN; 60 / 2193 – GSN; 76 / 2641 –GSN) PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)
Fax Form	Antidepressant (< 6 years of age) [REQUIRED for these ages]

NOTE

Antidepressant medications for patients < 6 years old require prior authorization.
Escalate all requests for antidepressant medications for patients < 6 years of age directly to a pharmacist for account-level review c/o Dennis Bibbs. Be prepared to provide Dennis with a copy of any associated documentation.

1. Is there any reason the Patient cannot be changed to a medication not requiring prior approval? **Document clinically compelling information.** Acceptable reasons include
   - ☐ Allergy to preferred
   - ☐ Contraindication to or drug-to-drug interaction with preferred
   - ☐ History of a serious reaction (e.g., thoughts of suicide, seizures, etc.) to preferred medications
2. The requested medication may be approved if **both** of the following are true:
   - ☐ If there has been a therapeutic failure to no less than a two-month trial each of at least **TWO** preferred medications; AND
   - ☐ The requested medication's corresponding preferred generic (if a generic is available) has been attempted and failed or is contraindicated.

PREFERRED GENERIC – NO PA REQUIRED	NON-PREFERRED BRAND – PA REQUIRED
Bupropion IR (generic for Wellbutrin®)	Aplenzin® (bupropion extended release tablets) (See specific criteria below)
Bupropion SR (generic for Wellbutrin SR®)	Brintellix® (desvenlafaxine) AUTO PA (See specific criteria below)
Bupropion XL (generic for Wellbutrin XL®)	Budeprion XL (generic for Wellbutrin SR®)
Duloxetine (generic for Cymbalta®)	Cymbalta® (*duloxetine*)
Mirtazapine (generic for Remeron®)	Effexor® (*venlafaxine*)*
Mirtazapine solutab (generic for Remeron Solutab®) [*15mg]	Effexor XR® (*venlafaxine ER*)*
Trazodone (generic for Desyrel®)	Emsam® Patch (*selegiline*)
Venlafaxine (generic for Effexor®)*	Forfivo XL® (bupropion extended release)
Venlafaxine ER **capsules** (generic for Effexor XR®)*	Khedezla ER® (desvenlafaxine)
Viibryd® (vilazodone)	Nefazodone (generic for Serzone®)
	Parnate® (tranylcypromine)
	Pristiq® (desvenlafaxine)
	Remeron® (tablets and solutabs)
	Tranylcypromine (generic for Parnate®)
	Venlafaxine ER tablets*
	Wellbutrin SR® (*bupropion SR*)
	Wellbutrin XL® (*bupropion XL*)

*Products will deny when the daily dose equals "2" or the daily dose exceeds "3." Daily dose is calculated by taking the metric quantity on the incoming claim and dividing it by the days supply on the claim. The valid range for 2 per day is >= 1.8, but <= 2.2. To exceed a daily dose of 3, the value must be >= 3.8. Use MAP: Dose Optimization initiative.

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APLENZIN® (BUPROPION HYDROBROMIDE, EXTENDED RELEASE)

Length of Authorization:	One year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)
Fax Form:	Antidepressant (< 6 years of age) [REQUIRED for these ages]

NOTE

Antidepressant medications for patients < 6 years old require prior authorization.
Escalate all requests for antidepressant medications for patients < 6 years of age directly to a pharmacist for account-level review c/o Dennis Bibbs. Be prepared to provide Dennis with a copy of any associated documentation.

APPROVAL CRITERIA *(ALL OF THE FOLLOWING MUST BE TRUE)*:

INITIATION OF THERAPY

- ☐ Patient must be ≥18 years old **AND**
- ☐ Patient must have a confirmed diagnosis of Major Depressive Disorder or Seasonal Affective Disorder **AND**
- ☐ Trial and failure of at least two other preferred antidepressants within the last 365 days, at least one of which was a preferred bupropion hydrochloride product and claims history documents a minimum of at least two consecutive fills (60-day trial) of the preferred antidepressants.

CONTINUATION OF THERAPY

- ☐ Patient continues to meet all of the initial criteria
- ☐ Claims history indicate patient is compliant with Aplenzin
- ☐ Clinical notes document improvement in patient symptoms

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BRINTELLIX® (VORTIOXETINE)

Length of Authorization:	One year
Initiative:	MAP: AP: Brintellix (75 / 31003 – NDC-9; 75 / 31006 – NDC-9; 75 / 31008 – NDC-9; 76 / 2641 – NDC-9; 76 / 7001 – NDC-9)
Fax Form	Antidepressant (< 6 years of age) [REQUIRED for these ages]

NOTE

Antidepressant medications for patients < 6 years old require prior authorization.
Escalate all requests for antidepressant medications for patients < 6 years of age directly to a pharmacist for account-level review c/o Dennis Bibbs. Be prepared to provide Dennis with a copy of any associated documentation.

APPROVAL CRITERIA (ALL OF THE FOLLOWING MUST BE TRUE):

INITIATION OF THERAPY:

- ☐ Patient must be ≥18 years old
- ☐ Patient must have a confirmed diagnosis of depression
- ☐ Trial and failure with a minimum of two other antidepressant drugs within the past 365 days.
  - ☐ One of these two antidepressants must have been in the SSRI class.
  - ☐ Claims history documents a minimum of at least 2 consecutive fills (60 day trial) of the SSRI.
  (*Failure can be defined as inefficacy or intolerability, **not** non-compliance)*

CONTINUATION OF THERAPY (General)

- ☐ Must have recent claims history (within previous 3 months) of Brintellix and documentation of clinical improvement including stabilization.

CONTINUATION OF THERAPY (Post in-patient treatment)

- ☐ For therapy initiated in an in-patient treatment center, approve for 1 year. CoT (General) applies thereafter.

REFERENCE CHART

REFERENCE CHART				
(SSRIs)	**(SNRIs)**	**Tricyclics**	**MAOIs**	**Others**
☐ Citalopram (Celexa) ☐ Escitalopram (Lexapro) ☐ Fluoxetine (Prozac) ☐ Fluvoxamine (Luvox) ☐ Paroxetine (Paxil) ☐ Sertraline (Zoloft)	☐ Venlafaxine (Effexor) ☐ Desvenlafaxine (Pristiq, Khedezla) ☐ Duloxetine (Cymbalta)	☐ Amitriptyline (Elavil) ☐ Protriptyline (Vivactil) ☐ Clomipramine (Anafranil) ☐ Doxepin (Sinequan) ☐ Imipramine (Tofranil) ☐ Nortriptyline (Pamelor) ☐ Desipramine (Norpramin) ☐ Amoxapine ☐ Maprotiline (Ludiomil)	☐ Isocarboxazid (Marplan) ☐ Phenelzine (Nardil) ☐ Tranylcypromine (Parnate)	☐ Mirtazapine (Remeron) ☐ Bupropion (Wellbutrin) ☐ Trazodone (Desyrel) ☐ Vilazodone (Viibryd) ☐ Nefazodone (Serzone)

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BRINTELLIX – AUTO PA

Edit	Drugs	Steps
Step Therapy for Brintellix Automated PA approval satisfies non-PDL edit (added 4-2-2015)	See tables below	**Step1:** If the incoming claim is for Brintellix <Brintellix Drug List>, look back in the medical claims history 730 days for ICD9 296.2, ICD 10 Disease Group: F32 (major depressive disorder – single episode), ICD9: 296.3, ICD 10 Disease Group: F33 (major depressive disorder – recurrent episodes). If found, proceed to step 2. Otherwise, Deny for PRIOR AUTHORIZATION REQUIRED (75) with supplemental message: "M/I Diagnosis Code." **Step 2:** If incoming claim is for Brintellix <Brintellix Drug List>, look back 180 days in patient's drug history for a claim in <Brintellix Drug List>, If found: CLAIM PAYS. Otherwise, Proceed to Step 3. **Step 3:** If incoming claim is for Brintellix <Brintellix Drug List>, look back 180 days in the patient's drug history for 1 claim of a **generic** SSRI <SSRI> list and a day supply > 24. If found, proceed to step 4. Otherwise, deny for NCPDP EC 75 with supplemental message: *"missing prerequisite drug therapy."* **Step 4:** If incoming claim is for Brintellix <Brintellix Drug List>, look back 180 days in the patient's drug history for 1 claim of other **generic** antidepressant <other antidepressant list> and a day supply >24. If found: **CLAIM PAYS**. Otherwise, deny for NCPDP EC 75 with supplemental message: *"missing prerequisite drug therapy."* **Quantity and age limitations are not a part of the automated prior authorization. (Max quantity = 1 per day; Minimum age = 18 years) **Note**: The meds below do not have an FDA indication for depression thus were omitted from the automation:

Generic Name	Brand Name	Drug Code
Brintellix List		
vortioxetine hydrobromide	Brintellix	HICL = 040637

SSRI LIST		
Citalopram hydrobromide	Celexa	HICL= 010321 and generic drug name = 1
Escitalopram oxalate	Lexapro	HICL =024022 and generic drug name = 1
Fluoxetine HCL	Prozac	HICL = 001655 (excluding GSN 046219, 046216, 065296 – Sarafem) and generic drug name = 1
Paroxetine/ER HCL	Paxil, Paxil CR	HICL =007344and generic drug name = 1
Paroxetine Mesylate	Pexeva	HICL =025796 (excluding GSN 071167 – Brisdelle) and generic drug name = 1
Sertraline HCL	Zoloft	HICL = 006324 and generic drug name code = 1

Other Antidepressants List		
Bupropion Hydrobromide ER	Aplenzin	HICL = 036156 and generic drug name code = 1
Bupropion HCL/SR/XL	Wellbutrin /SR/XL, Budeprion SR/XL	HICL = 001653 (excluding GSN 031439-Buproban/ Zyban) and generic drug name code = 1
Nefazodone HCL	Serzone	HICL = 009612 and generic drug name code = 1
Vilazodone	Viibryd	HICL = 037597 and generic drug name code = 1

Edit	Drugs			Steps
	Antipsychotic/Antidepressant Combinations			
	Generic Name	Brand Name	Drug Code	
	Amitriptyline/ chlordiazepoxide	Limbitrol	HICL = 001656 and generic drug name code = 1	
	Amitriptyline/perphenazine	Etrafon, Triavil	HICL = 013819 and generic drug name code = 1	
	Olanzapine/ fluoxetine	Symbyax	HICL = 025800 and generic drug name code = 1	
	Heterocyclics			
	Amoxapine	N/A	HICL = 001648 and generic drug name code = 1	
	Maprotiline HCL	Ludiomil	HICL = 001651 and generic drug name code = 1	
	Mirtazapine	Remeron	HICL = 011505 and generic drug name code = 1	
	Trazodone HCL/ER	Desyrel, Oleptro ER	HICL = 001652 and generic drug name code = 1	
	MAOIs			
	Isocarboxazid	Marplan	HICL = 001638 and generic drug name code = 1	
	Phenelzine sulfate	Nardil	HICL = 001639 and generic drug name code = 1	
	Tranylcypromine sulfate	Parnate	HICL = 001640 and generic drug name code = 1	
	Selegiline HCL	Emsam	HICL = 033510 and generic drug name code = 1	
	SNRIs			
	Desvenlafaxine ER	Khedezla	HSN = 040202 and generic drug name code = 1	
	Desvenlafaxine succinate ER	Pristiq ER	HSN = 035420 and generic drug name code = 1	
	Desvenlafaxine fumarate	N/A	HSN = 040692 and generic drug name code = 1	
	Duloxetine HCL DR	Cymbalta	HICL = 026521 and generic drug name code = 1	
	Levomilnacipran	Fetzima	HICL = 040632 and generic drug name code = 1	
	Venlafaxine/ER HCL	Effexor, Effexor XR	HICL = 008847 and generic drug name code = 1	

Edit	Drugs			Steps
	TCAs			
	Amitriptyline HCL	Elavil	HICL = 001643 and generic drug name code = 1	
	Desipramine HCL	Norpramin	HICL = 001645 and generic drug name code = 1	
	Doxepin HCL	Silenor, Sinequan	HICL = 001650 (excluding GSN 021715-Prudoxin/Zonalon cream) and generic drug name code = 1	
	Imipramine HCL	Tofranil	HICL = 001641 and generic drug name code = 1	
	Imipramine pamoate	Tofranil PM	HICL = 001642 and generic drug name code = 1	
	Nortriptyline HCL	Aventyl, Pamelor	HICL = 001644 **and generic drug name code = 1**	
	Protriptyline HCL	Vivactil	HICL = 001646 **and generic drug name code = 1**	
	Trimipramine maleate	Surmontil	HICL = 001649 **and generic drug name code = 1**	

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FETZIMA® (LENOMILNACIPRAN) EXTENDED-RELEASE CAPSULES

Length of Authorization:	One year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)
Fax Form	Antidepressant (< 6 years of age) [REQUIRED for these ages]

NOTE

Antidepressant medications for patients < 6 years old require prior authorization.
Escalate all requests for antidepressant medications for patients < 6 years of age directly to a pharmacist for account-level review c/o Dennis Bibbs. Be prepared to provide Dennis with a copy of any associated documentation.

APPROVAL CRITERIA (ALL OF THE FOLLOWING MUST BE TRUE):

INITIATION OF THERAPY:

- ☐ Patient must be ≥18 years old
- ☐ Patient must have a confirmed diagnosis of depression
- ☐ Trial and failure with a minimum of two other antidepressant drugs within the past 365 days.
  - ☐ One of these two antidepressants must have been in the SNRI class; **AND**
  - ☐ Claims history documents a minimum of at least 2 consecutive fills (60-day trial) of the SNRI.

  (*Failure can be defined as inefficacy or intolerability, **not** non-compliance).*

CONTINUATION OF THERAPY (General)

- ☐ Must have recent claims history (within previous 3 months) of Fetzima and documentation of clinical improvement including stabilization.
- ☐ CONTINUATION OF THERAPY (Post in-patient treatment).
- ☐ For therapy initiated in an in-patient treatment center, approve for 1 year. CoT (General) applies thereafter.

REFERENCE CHART

REFERENCE CHART				
(SSRIs)	**(SNRIs)**	**Tricyclics**	**MAOIs**	**Others**
☐ Citalopram (Celexa) ☐ Escitalopram (Lexapro) ☐ Fluoxetine (Prozac) ☐ Fluvoxamine (Luvox) ☐ Paroxetine (Paxil) ☐ Sertraline (Zoloft)	☐ Venlafaxine (Effexor) ☐ Desvenlafaxine (Pristiq, Khedezla) ☐ Duloxetine (Cymbalta)	☐ Amitriptyline (Elavil) ☐ Protriptyline (Vivactil) ☐ Clomipramine (Anafranil) ☐ Doxepin (Sinequan) ☐ Imipramine (Tofranil) ☐ Nortriptyline (Pamelor) ☐ Desipramine (Norpramin) ☐ Amoxapine ☐ Maprotiline (Ludiomil)	☐ Isocarboxazid (Marplan) ☐ Phenelzine (Nardil) ☐ Tranylcypromine (Parnate)	☐ Mirtazapine (Remeron) ☐ Bupropion (Wellbutrin) ☐ Trazodone (Desyrel) ☐ Vilazodone (Viibryd) ☐ Nefazodone (Serzone)

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ANTIDEPRESSANTS – OTHER (CONTINUED)

Edit	Drugs	Steps
Step therapy for Pristiq ER. Automated PA approval satisfies non-PDL edit (updated 04/02/2015)	See table below	Step 1: If incoming claim is for Pristiq <Pristiq ER List>, look back in the medical claims history 730 days for ICD9 296.2, ICD 10 Disease Group: F32 (major depressive disorder – single episode), ICD9: 296.3, ICD 10 Disease Group: F33 (major depressive disorder – recurrent episodes). If found, PROCEED TO STEP 2. Otherwise, Deny for PRIOR AUTHORIZATION REQUIRED (75) with supplemental message: "M/I Diagnosis Code." Step 2: If incoming drug is for Pristiq ER <Pristiq ER List>, look back 180 days in the patient's drug history for a claim in <Pristiq ER List>, If found: CLAIM PAYS. Otherwise, Proceed to step 3. Step 3: Look back 180 days in the patient's drug history for a claim in <venlafaxine/er/XR list> and a day supply >/= 24. If found: PROCEED TO STEP 4. Otherwise, deny for NCPDP EC 75 with supplemental message: "missing prerequisite drug therapy" Step 4: Look back 180 days in the patient's drug history for a claim in <Other Antidepressant List> and a day supply >/= 24. If found: CLAIM PAYS. Otherwise, deny for NCPDP EC 75 with supplemental message: "missing prerequisite drug therapy" Note: The meds below do not have an FDA indication for depression thus were omitted from the automation.

Generic Name	Brand Name	Drug Code
Pristiq ER List		
Desvenlafaxine succinate ER	Pristiq ER	HICL = 035420
Venlafaxine/ Desvenlafaxine ER/XR List		
Desvenlafaxine ER	Khedezla	HICL = 040202
Desvenlafaxine fumarate	N/A	HICL = 040692
Venlafaxine/ER HCL	Effexor, Effexor XR	HICL =008847
Other Antidepressants List		
Bupropion Hydrobromide ER	Aplenzin	HICL = 036156
Bupropion HCL/SR/XL	Wellbutrin /SR/XL, Budeprion SR/XL, Forfivo XL	HICL = 001653 (excluding GSN 031439-Buproban/ Zyban)
Nefazodone HCL	Serzone	HICL = 009612
Vilazodone HCL	Viibryd	HICL = 037597
vortioxetine hydrobromide	Brintellix	HICL = 040637
Heterocyclics		
Amoxapine	N/A	HICL = 001648
Maprotiline HCL	Ludiomil	HICL = 001651
Mirtazapine	Remeron	HICL = 011505
Trazodone HCL/ER	Desyrel, Oleptro ER	HICL = 001652
MAOIs		
Isocarboxazid	Marplan	HICL = 001638
Phenelzine sulfate	Nardil	HICL = 001639
Tranylcypromine sulfate	Parnate	HICL = 001640
Selegiline HCL	Emsam	HICL = 033510
SNRIs		
Duloxetine HCL DR	Cymbalta	HICL = 026521
Levomilnacipran	Fetzima	HICL = 040632

Edit	Drugs			Steps
	Generic Name	Brand Name	Drug Code	
	SSRIs			
	Citalopram hydrobromide	Celexa	HICL = 010321	
	Escitalopram oxalate	Lexapro	HICL = 024022	
	Fluoxetine HCL	Prozac, Prozac Weekly	HICL = 001655 (excluding GSN 046216, 046219, 065296 –Sarafem)	
	Paroxetine/ER HCL	Paxil, Paxil CR	HICL = 007344 (excluding GSN 071167 – Brisdelle)	
	Paroxetine Mesylate	Pexeva	HICL = 025796	
	Sertraline HCL	Zoloft	HICL = 006324	
	TCAs			
	Amitriptyline HCL	Elavil	HICL = 001643	
	Desipramine HCL	Norpramin	HICL = 001645	
	Doxepin HCL	Silenor, Sinequan	HICL = 001650 (excluding GSN 021715-Prudoxin/Zonalon cream)	
	Imipramine HCL	Tofranil	HICL = 001641	
	Imipramine pamoate	Tofranil PM	HICL = 001642	
	Nortriptyline HCL	Aventyl, Pamelor	HICL = 001644	
	Protriptyline HCL	Vivactil	HICL = 001646	
	Trimipramine maleate	Surmontil	HICL = 001649	
	Antipsychotic/Antidepressant Combinations			
	Amitriptyline/ chlordiazepoxide	Limbitrol	HICL = 001656	
	Amitriptyline/ perphenazine	Etrafon, Triavil	HICL = 013819	
	Olanzapine/fluoxetine	Symbyax	HICL = 025800	

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ANTIFUNGALS

Length of Authorization:	For the duration of the prescription up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN) MAP: Quantity Limits: IE 7001 (76 / 7001 – GSN)

1. Is there any reason the Patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include
   - ☐ Allergy to preferred medications.
   - ☐ Contraindication to or drug-to-drug interaction with preferred medications
   - ☐ History of a serious reaction (e.g., anaphylaxis, thrombocytopenia, etc.) to preferred medications
2. The requested medication may be approved if ***both*** of the following are true:
   - ☐ If there has been a therapeutic failure to no less than a one-week trial of at least TWO preferred medication(s); **AND**
   - ☐ The requested medication's corresponding preferred generic (if a generic is available) has been attempted and failed or is contraindicated. **Document details**.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

- ☐ If the Patient is completing a course of therapy with a non-preferred medication, initiated in the hospital, or if the patient has just become FCA eligible and is already on a course of treatment with a non-preferred medication, approve the prior authorization.
- ☐ Technicians: If the request is for a non-fungal diagnosis or if there is any uncertainty about the request based on the diagnosis submitted, please refer case to the Pharmacist.

MEDICATION-SPECIFIC INFORMATION TO AID IN THE FINAL DECISION

Itraconazole may be approved for 6 months (unless noted) if:

- ☐ Diagnosis is Febrile neutropenia
- ☐ Diagnosis is Aspergillus
- ☐ Diagnosis is Blastomycosis
- ☐ Diagnosis is Histoplasmosis
- ☐ Diagnosis is Cryptococcosis
- ☐ Diagnosis is Coccidiomycosis
- ☐ Diagnosis is Oropharyngeal/esophageal candidiasis
- ☐ Diagnosis is Any candida krusei infection
- ☐ Diagnosis is Any other **systemic** fungal infections including (but not limited to): Chronic mucocutaneous candidiasis, Allescheriosis, Chromomycosis, Paracoccidioidomycosis, Sporotrichosis

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MEDICATION-SPECIFIC INFORMATION TO AID IN THE FINAL DECISION *(CONTINUED)*

Noxafil® may be approved for length of therapy or up to 1 year if any of the following:

- ☐ Used for preventative (prophylactic) therapy for or treatment of Invasive Aspergillus
- ☐ Diagnosis of **Candida**
- ☐ Patient is immunocompromised
- ☐ Diagnosis of graft-versus-host disease (GVHD)
- ☐ Patient has a hematologic malignancy (a cancer of the blood, bone marrow, or lymph nodes)
- ☐ Patient has prolonged neutropenia from chemotherapy
- ☐ Diagnosis of **Zygomycosis**
- ☐ Diagnosis of **Fusariosis**
- ☐ Patient has another fungal infection or mold
- ☐ Infection is refractory or resistant to itraconazole or voriconazole, or patient has a contraindication to itraconazole or voriconazole

Voriconazole may be approved for up to 6 months (unless specified) if:

- ☐ Diagnosis of Invasive Aspergillosis
- ☐ Diagnosis of a fungal infection caused by an S. apiospermum or Fusarium species, including F. solani, Approve x length of therapy requested, up to 1 year
- ☐ Patient has a fungal infection or mold (e.g., Exserohilum rostratum) related infection acquired via contaminated intrathecal steroid injections
- ☐ Used as part of standard antifungal regimen in neutropenic patients that have been febrile, Approve x length of therapy requested, up to 1 year
- ☐ Patient has other fungal infections that are not responding to or are resistant to other triazole agents (e.g., fluconazole, ketoconazole, itraconazole)

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Clotrimazole Troche	Ancobon® (*flucytosine*)
Fluconazole susp (generic for Diflucan)	Diflucan® tablets and susp (*fluconazole*)
Fluconazole tablets (generic for Diflucan)	Grifulvin V® tablets (*griseofulvin*)
Griseofulvin V susp (generic for Gris-PEG & Grifulvin-V)	Gris-PEG® (*griseofulvin*)
Nystatin	Itraconazole (generic for Sporanox)
Terbinafine (generic for Lamisil) [84/365]	Ketoconazole (generic for Nizoral)
	Lamisil Granules® (*terbinafine*) [84/365]
	Nizoral® (*ketoconazole*)
	Noxafil® (*posaconazole*)
	Sporanox® (*itraconazole*) [84/365]

[#/X] = quantity limit per X days

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ADDITIONAL CLINICAL INFORMATION TO AID IN FINAL DECISION

Please note that *Griseofulvin* and *Terbinafine* are the only FDA-approved prescription medications used to treat **Tinea Capitis**.

ORAVIG® (MICONAZOLE) BUCCAL TABLETS

Length of Authorization:	14 days
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

PDL Criteria Do Not Apply

- Recipient must be > 16 years of age.
- Must have a confirmed diagnosis of oropharyngeal candidiasis.
- Must have a failed trial of a minimum of two other antifungal agents indicated for treatment of oropharyngeal candidiasis (clotrimazole troche, fluconazole suspension or tablets, or nystatin oral suspension) within the time span of the currently existing infection.
- **Note**: If a Recipient has a hypersensitivity to other azole antifungals, then a hypersensitivity to Oravig is highly likely. In such cases, the Provider should be informed that nystatin oral suspension is a preferred product.

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VFEND® (VORICONAZOLE)

Length of Authorization:	Maximum of 90 days (see the note below for extended therapy requests)
Initiative:	MAP: Vfend (75 / 2462 – GSN; 76 / 2461 – GSN)
Fax Form	Vfend [REQUIRED]

APPROVED INDICATIONS / REVIEW CRITERIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

INVASIVE ASPERGILLOSIS

- ☐ The "Invasive Aspergillosis" diagnosis must be checked.
- ☐ **Initial treatment** will be approved for **1 month** in patients suspected of having a life-threatening invasive Aspergillus infection that meet the following criteria:
  - ☐ Have a diagnosis indicating they are immunocompromised or are currently receiving im munosuppressive drugs, **AND**
  - ☐ Patient has clinical manifestations (symptoms, signs, and radiological features) compatible with the diagnosis of invasive aspergillosis. (**Supporting documentation must accompany request.**)
- ☐ The **remaining 60 days of therapy** may be granted upon receipt of a positive **Platelia Aspergillus EIA test** (detects circulating galactomannan antigen), biopsy, or culture. A copy of the original lab results is required.
- ☐ New test results must accompany request for continuation of therapy **after initial 90 days of therapy**.

TREATMENT FAILURES

- ☐ Patient must have documented treatment failure with one or more of the following (except in the case of invasive aspergillosis):
  - ☐ Amphotericin B (Abelcet®, Fungizone®)
  - ☐ Fluconazole (Diflucan®)
  - ☐ Ketoconazole (Nizoral®)

Indication	PDL Alternatives (Current December 2007)
Invasive Aspergillosis	Abelcet, amphotericin B, Fungizone
Candidemia in non-neutropenic patients	Abelcet, amphotericin B, fluconazole, Fungizone
Candidiasis of the Esophagus	Abelcet, amphotericin B, fluconazole, Fungizone, Ketoconazole
Disseminated candidiasis of the skin, and infections in the bladder wall, abdomen, kidney, and wounds	Abelcet, amphotericin B, fluconazole, Fungizone
Scedosporium apiospermum and *Fusarium* species including *Fusarium solani*	Abelcet, amphotericin B, Fungizone

ANTIFUNGALS – TOPICAL

Length of Authorization:	For the duration of the prescription up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason the Patient cannot be changed to a preferred medication? Acceptable reasons include
   - ☐ Allergy to preferred medications
   - ☐ Contraindication to or drug-to-drug interaction with preferred medications
   - ☐ History of serious reaction (e.g., thrombocytopenia, anaphylaxis, etc.) to preferred medications.
2. The requested medication may be approved if ***both*** of the following are true:
   - ☐ If there has been a therapeutic failure to no less than a one-week trial, of at least **TWO** preferred medication(s); **AND**
   - ☐ The requested medication's corresponding preferred generic (if a generic is available) has been attempted and failed or is contraindicated.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Ciclopirox 8% solution	Bensal HP® (salicylic acid and benzyl acid)
Ciclopirox 0.77% Crm and Topical Susp (generic for Loprox®)	Clotrimazole (generic for Lotrimin)
Clotrimazole/Betamethasone cream (generic for Lotrisone)	Clotrimazole/Betamethasone lotion (generic for Lotrisone)
Ketoconazole (generic for Nizoral) non-foam dosage forms	Ciclopirox 0.77% (Gel and Shampoo)
	Ciclopirox 80% treatment kit
	CNL8®
	Econazole (generic for Spectazole)
	Extina 2%® (ketoconazole)
	Ertaczo (sertaconazole)
	Exelderm® (sulconazole)
	Jublia (efinaconazole) topical solution
	Ketoconazole 2% foam (generic for Nizoral)
	Lamisil® (terbinafine)
	Loprox® (ciclopirox)
	Lotrisone® (clotrimazole/betamethasone)
	Mentax® (butenafine)
	Naftin® (naftifine) cream/gel
	Nizoral cream and shampoo® (ketoconazole)
	Nystatin® (generic for Nystop or Mycostatin)
	Nystatin/Triamcinolone (generic for Mycogen)
	Nystop® (Nystatin)
	Oxistat® (oxiconazole)
	Penlac® (ciclopirox)
	Vusion® (miconazole, zinc oxide, and white petroleum)
	Xolegel® (ketoconazole)

ANTIHISTAMINES: SECOND GENERATION

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to a preferred medication? Acceptable reasons include
   - ☐ Allergy to the preferred medications
   - ☐ Contraindication to all preferred medications
   - ☐ History of unacceptable side effects
2. The requested medication may be approved if **BOTH** of the following are true:
   - ☐ If there has been a therapeutic course of treatment at least **TWO** preferred medications (containing two different antihistamines) for a minimum of 30 days each AND
   - ☐ The requested medication's corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Cetirizine tablets *5mg	Allegra® all formulations (fexofenadine)
Cetirizine liquid/syrup (Generic RX)	Allegra D ODT®
Cetirizine liquid/syrup (Brand OTC)	Cetirizine OTC chewable (5mg & 10mg) tablets
Cetirizine D	Cetirizine OTC Softgel (10mg) caps
Loratadine OTC – all formulations	Cetirizine ODT
Loratadine-D OTC	Cetirizine liquid/syrup (Generic OTC)
Semprex D® (Acrivastine/Pseudoephedrine)	Cetirizine liquid/syrup (Brand RX)
	Clarinex® – all formulations (desloratadine)
	Clarinex-D® – (desloratadine/pseudoephedrine)
	Claritin® – all formulations (loratadine)
	Claritin-D® – all strengths (loratadine /pse)
	Desloratadine (generic for Clarinex®) – all formulations
	Fexofenadine (generic for Allegra®)
	Xyzal® (levocetirizine) **Pharmacist for all requests. See additional information on the following pages.**
	Zyrtec® (cetirizine) [*5 mg]
	Zyrtec D® (cetirizine)

NOTE: *Zyrtec and Cetirizine only: Products will deny when the daily dose equals "2" or the daily dose exceeds "3." Daily dose is calculated by taking the metric quantity on the incoming claim and dividing it by the days supply on the claim. The valid range for 2 per day is >= 1.8, but <= 2.2. To exceed a daily dose of 3, the value must be >= 3.8. Use MAP: Dose Optimization initiative.

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XYZAL® (LEVOCETIRIZINE)

Initiative: ☐ PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW PROTOCOL (RPH REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

Requests should be referred to the preferred alternatives below.

☐ The patient should have previous trial on both loratadine and cetirizine.

☐ Also check to see if the patient has tried nasal corticosteroids and/or Singulair before consideration is granted.

Allergic Rhinitis	Urticaria
Cetirizine	Hydroxyzine (itching)
Loratadine	Diphenhydramine (prescription strength)
Singulair	
Diphenhydramine	
Prednisone	
Patanase (nasal spray)	
Fluticasone (nasal steroid)	
Nasonex (nasal steroid)	

CLARINEX (DESLORATADINE) PA REQUESTS

☐ Please recommend the Physician use Loratadine and Cetirizine as alternate therapy.

☐ If the patient has had previous therapeutic failure to trials with loratadine and cetirizine, also check to see if the patient has tried nasal corticosteroids and/or singular before further consideration is granted.

ANTIMIGRAINE THERAPY (TRIPTANS)

Length of Authorization:	Up to 1 year
Initiative:	MAP: Triptans (75 / 2462 – GSN)

1. Is there any reason that the Patient cannot be switched to a preferred medication? **Document the details.** Acceptable reasons include
   - ☐ Allergy to the preferred medications
   - ☐ Contraindication or drug-to-drug interaction with the preferred medications
   - ☐ History of unacceptable side effects
2. Has there been a therapeutic failure with all preferred medications? **Document the details.**

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Imitrex® (sumatriptan) Vial, Inj, Cart, Nasal Spray	Alsuma® (sumatriptan) Auto-Inj
Imitrex® (sumatriptan) Tab	Amerge® (naratriptan) [9/30]
Rizatriptan (generic for Maxalt®) [12/30]	[for quantity limits by dosage form.]
Sumatriptan (generic for Imitrex®) [see Summary of Drug Limitations for quantity limits by dosage form.]	Frova® (frovatriptan) [9/30]
	Imitrex® (sumatriptan) 25mg, 50mg 100mg Tabs
	Relpax® (eletriptan) [6/30]
	Sumatriptan (generic for Imitrex®) 6mg Vial; 4mg & 6mg Inj, Cart, Refill, Syr [see Summary of Drug Limitations for quantity limits by dosage form.]
	Sumatriptan (generic for Imitrex®) Nasal Spray [see Summary of Drug Limitations
	Sumavel DosePro® (sumatriptan)
	Treximet® (sumatriptan/naproxen) [9/30]: Refer requests to the individual ingredients.
	Zecuity® (sumatriptan) Patch
	Zomig® (zolmitriptan) [6/30]

ANTINAUSEA AGENTS: INJECTABLES

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

Please escalate all non-preferred **Antinausea Injectables** to a pharmacist EXCEPT for Aloxi; Aloxi has approvable criteria noted below. Please make sure to verify that the Provider has submitted all required documentation prior to escalating.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Ondansetron (generic for Zofran®) vials and syringe [32/27]	Aloxi® (palonosetron) [40ml/28] **(PDL criteria do NOT apply. See specific criteria below)**
Promethazine injectable (generic for Phenergan)	Anzemet® (dolasetron) vial 12.5mg [5ml/28], 20mg [40ml/28]
	Emend IV® (*aprepitant*) **Note: Emend IV (intravenous) is available through physician services.**
	Granisetron (generic for Kytril®)
	Metoclopramide
	Phenergan® (promethazine)
	Prochlorperazine
	Tigan® (trimethobenzamide)
	Trimethobenzamide (generic for Tigan®)
	Zofran® *(Ondansetron) vials* [32/27]

ALOXI® (PALONOSETRON)

Length of Authorization:	Up to 1 year
Initiative:	MAP: Antiemetics – 5HT3

APPROVAL CRITERIA

PDL criteria do NOT apply.

- ☐ Documented failure of ondansetron via progress/chart notes.
- ☐ Diagnosis of nausea and vomiting verified via patient health conditions or progress notes.

DOSING

- ☐ **PEDIATRICS:** (1 month to <17 years old): A single dose of 20mcg/kg (max of 1.5mg) intravenously (IV) over 15 minutes beginning approximately 30 minutes before the start of chemotherapy.
- ☐ ADULTS:
- ☐ For the prevention of cancer chemotherapy-induced nausea and vomiting in adults, a single palonosetron dose of 0.25 mg (administered IV over 30 seconds) is given approximately 30 minutes before the start of chemotherapy. Because the safety and efficacy of a repeat dose (e.g., on consecutive or alternate days) of palonosetron have not been established, administration of an additional dose of the drug within a 7-day period currently is *not* recommended.
- ☐ For the prevention of postoperative nausea and vomiting, a single palonosetron dose of 0.075mg administered IV over 10 seconds immediately before induction of anesthesia.

LIMITS

ANTINAUSEA AGENTS: ORAL/RECTAL/TOPICAL

Length of Authorization:	UP to 6 Months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to a preferred medication? **Document the details.** Acceptable reasons include
   - ☐ Allergy to the preferred medications
   - ☐ Contraindication or drug-to-drug interaction with the preferred medications
   - ☐ History of unacceptable side effects
2. Has there been a therapeutic failure after a 48-hour trial with at least **TWO** preferred medications? **Document the details.**

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Emend® (*aprepitant*)	Antivert® (*meclizine*)
Meclizine	Anzemet® (dolasetron)
Metoclopramide (generic for Reglan®) tablet/oral soln	Cesamet® (nabilone)
Ondansetron oral soln [600ml/28] (generic for Zofran®)	Compro® (prochlorperazine)
Ondansetron 4mg and 8mg tabs*[60/30] (generic for Zofran®)	Granisetron tablets [8/28]
Promethazine tabs/suppositories	Granisol® (granisetron) oral solution [80/28]
Transderm Scop® [10/27]	Metozolv ODT (metoclopramide)
	Ondansetron amp 4mg/2ml
	Prochlorperazine
	Promethegan suppositories
	Trimethobenzamide capsules
	Zofran® (Ondansetron) tablets [60/30],
	Zofran® (Ondansetron) oral solution [600/28]

[#/X] = quantity limit per X days

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DICLEGIS® (DOXYLAMINE SUCCINATE AND PYRIDOXINE HCL) DELAYED RELEASE TABLETS

Length of Authorization:	3 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ PDL Criteria Do Not Apply:
  - ☐ Patient must be a female 18 years of age or older.
  - ☐ Patient must have history of nausea and vomiting in pregnancy.
  - ☐ Must have failed conservative management for nausea and vomiting, such as dietary and lifestyle modifications. *(Some examples listed below.)*
    - ☐ Dietary modifications may include advice to eat smaller, more frequent meals and to avoid smells and food textures that cause nausea.
    - ☐ Foods should be bland-tasting, high in carbohydrate, and low in fat. Salty foods may be tolerated early in the morning. Sour and tart liquids (e.g., lemonade) are often better tolerated than water.
    - ☐ Ginger supplementation has also been shown to be useful in reducing symptoms.
  - ☐ Must be prescribed by a related specialist.
  - ☐ Quantity not to exceed 4/day.

SANCUSO® (GRANISETRON TRANSDERMAL PATCH)

Length of Authorization:	Up to 3 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

PDL Criteria Do Not Apply:

- ☐ Trial and failure of a preferred agent documented in progress notes; **AND**
- ☐ Documentation of difficulty swallowing; **AND**
- ☐ Progress notes support patient currently on chemotherapy and is experiencing chemotherapy-induced nausea/vomiting (CINV) or patient is receiving moderately and/or highly emetogenic chemotherapy for up to 5 consecutive days.

ANTIPSYCHOTIC PRIOR AUTHORIZATION (AGE 0–17 YEARS OLD)

Length of Authorization:	Up to 6 months
Initiative:	MAP: Antipsychotic: Age 0–5 Years (60/2193; 60/2623; 75/50081; 76/2641– all at GSN) MAP: Antipsychotic: Age 6–17 Years (60/2193; 75/2462; 75/50081; 76/2641; 76/7025 – all at GSN)
Fax Form:	*Antipsychotic (< 6 Years of Age)* [Form is preferred but not required.]; *Antipsychotic (6 < 18 Years of Age)* [Form is preferred but not required.]

1. Is there any reason the patient cannot be changed to a preferred medication? Acceptable reasons include:
   - ☐ Allergy to preferred medications
   - ☐ Contraindication to preferred medications
   - ☐ History of serious reaction (e.g., Anaphylaxis, seizure) to preferred medications
2. Has there been a failure to respond to a therapeutic trial of at least one month each of two preferred medications?
   - ☐ Medical records/progress notes documenting failure to previous trials must be provided.
   - ☐ The requested medications corresponding generic (if a generic is available and preferred) has been attempted and failed or is contraindicated
3. **PDL Status Changes:** For medications that change from Preferred to Non-Preferred, please note that patients adherent to antipsychotics are EXCLUDED from this requirement to meet criteria by going back to another med. This is due in large part to the fact that AHCA and the MCO plans are very aware of the sensitive nature of these therapies once established and working.

PREFERRED – PA REQUIRED PER HIGH DOSE TABLE	Min Age Yrs	NON-PREFERRED – PA REQUIRED PER Above and HIGH DOSE TABLE	Min Age Yrs
Aripiprazole (generic for Abilify®)	6	Abilify® (aripiprazole)	6
Chlorpromazine tablets/vial	18	Aristada (aripiprazole lauroxil) injection	6
Clozapine (generic for Clozaril®)	6	Clozapine ODT (generic for Fazaclo®)	6
Droperidol	18	Clozaril® (clozapine)	6
Fanapt® (iloperidone)	18	Fazaclo® (clozapine ODT)	6
Fluphenazine Decanoate/Vial	18	Geodon® (ziprasidone) capsules	
Fluphenazine tablets	6	Geodon® (ziprasidone) 20mg powder for injection	
Haloperidone Decanoate/Vial (generic for Haldol®)	18	Lurasidone (generic for Latuda®) Brand Preferred	18
Haloperidone tablets (generic for Haldol®)	6	Olanzapine 10mg vial (generic for Zyprexa® inj)	6
Latuda® (lurasidone)	18	Olanzapine/Fluoxetine (generic for Symbyax®) Brand Preferred	6
Olanzapine tabs/ODT (generic for Zyprexa®/Zyprexa Zydis®)	6	Orap® (pimozide)	18
Perphenazine tablets	6	Rexulti (brexpiprazole) (AutoPA)	
Perphenazine/Amitriptyline tablets	18	Risperdal® (risperidone)	6
Pimozide (generic for Orap®)	18	Risperdal-M® (risperidone)	6
Quetiapine (generic for Seroquel®)	6	Saphris® (asenapine)	18
Risperidone/ & ODT (generic for Risperdal®)	6	Seroquel®(quetiapine)	18
Risperidone M (generic for Risperdal® M)	6	Symbyax® (olanzapine/fluoxetine) PDL: Non-Preferred Brand Required initiative	
Seroquel® XR (quetiapine)	18	Versacloz® (clozapine) 50mg/ml oral suspension	6
Thioridazine	18	Vraylar® (cariprazine) capsules	
Trifluoperazine	18	Zyprexa® & Zyprexa Zydis® (olanzapine)	6
Ziprasidone (generic for Geodon®) capsules		Zyprexa injectable® (olanzapine)	6

Please note that medications listed above with a Plan-default minimum age of 18 years may also have dosing guidelines for ages under 18. Please refer to the ANTIPSYCHOTIC HIGH DOSE TABLE FOR CHILDREN AND ADOLESCENTS

CONTINUED ON NEXT PAGE

MEDICAL REVIEW PROCESS FOR CHILDREN < 18 PRESCRIBED AN ANTIPSYCHOTIC

APPROVAL CRITERIA FOR < 6 YEARS OF AGE (PHARMACIST REVIEW ONLY)

CPhTs:

- ☐ Document all info available to you prior and then escalate to a clinical pharmacist.

RPhs:

- ☐ All Initial requests for members < 6 years of age require psychiatrist review.
- ☐ At the time of a renewal request, we would need to have documentation clearly confirming desired outcomes and adherence to the medication regimen.

APPROVAL CRITERIA FOR 6 < 18 YEARS OF AGE (PHARMACIST REVIEW ONLY)

CPhTs:

- ☐ Document all info available to you prior and then escalate to a clinical pharmacist.

RPhs:

- ☐ If the requested dosage matches the age-specific dosage noted in the Antipsychotic High Dose Table For Children and Adolescents chart:
  - ☐ If the prescriber is a psychiatrist: **Approve**
  - ☐ If the prescriber is not a psychiatrist: The prescriber must provide documentation from a psychiatrist or psychiatry consult specifically documenting an age-specific dosage that matches the age-specific dosage noted in the Antipsychotic High Dose Table For Children and Adolescents chart: **Approve**

OR

- ☐ For new requests for members stable on the requested med based on in-patient treatment, approval shall be granted for three months. At the time of a renewal request after this initial three-month approval, we would need to have documentation clearly confirming desired outcomes and adherence to the medication regimen.

OR

- ☐ For all requests where the requested dosage does NOT match the age-specific dosage noted in the Antipsychotic High Dose Table For Children and Adolescents chart, the request should be forwarded to a clinical pharmacist for client-level review with as much of the information as possible listed under **Documentation Required for Requests That Need Psychiatrist Review**.

NOTE

- ☐ **The following requests for patients < 18 years old must be escalated for child psychiatrist review:**
  - ☐ All high dose requests
  - ☐ Requests for the antipsychotic medications for children ages 0–5
  - ☐ Long-acting injectable antipsychotic medication requests
  - ☐ All Requests for Saphris, Chlorpromazine, Fanapt, Latuda, Invega , Pimozide (Ages 0-17) regardless of the current PDL status or dose prescribed

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DOCUMENTATION REQUIRED FOR PSYCHIATRIST REVIEW

1. PHARMACIST REVIEW ONLY: CPhTs – Document all info available prior to escalation
2. The age-appropriate fax form – **Antipsychotic (< 6 Years of Age)** or **Antipsychotic (6 < 17 Years of Age)** – **is PREFERRED; it is not REQUIRED**.
3. All Initial requests for members < 6 years of age require psychiatrist review.
   - ☐ MCC-FL: forward to Dr. Lazoritz or Dr. Henry per Outlook e-mail template: \\teams2-mma\sites\CallCenter\Shared Documents\Glen Allen Pharmacists Procedures.
     - ☐ Magellan Complete Care – Florida (MCC-FL) / Magellan Rx (MRx)

       Request for MCC-FL / MRx Psychiatrist Review
     - ☐ The physicians' schedule for reviews:

       Dr. Henry: Mon (2nd and 4th), Wed, Fri. (2nd, 4th, and 5th)

       Dr. Lazoritz: Mon (1st and 3rd), Tues., Thurs, Fri. (1st and 3rd)
   - ☐ CCP/SFCCN: forward to Kendra Karagozian, Dennis Bibbs, and Jodi Fredericks per Outlook e-mail template: \\teams2-mma\sites\CallCenter\Shared Documents\Glen Allen Pharmacists Procedures
     - ☐ Community Care Plus (formerly South Florida Community Care Network) (CCP/SFCCN) / Magellan Rx (MRx)

       Request for CCP/SFCCN / MRx Psychiatrist Review
4. Initial requests for members 6 < 18 years of age may be approved if they meet **Approval Criteria for 6 < 18 Years of Age** noted on the previous page.
   - ☐ MCC-FL: requests ***that cannot be approved*** per criteria on the previous page should be forwarded to Dr. Lazoritz or Dr Henry per physicians' review scheduled noted above. All requests must include **Documentation Required for Requests That Need Psychiatrist Review** as noted below.
   - ☐ CCP/SFCCN: requests ***that cannot be approved*** per criteria below should be forwarded to Kendra Karagozian, Dennis Bibbs, and Jodi Fredericks per Outlook e-mail template for Plan-level and/or USF Psychiatry review. All requests must include **Documentation Required for Requests That Need Psychiatrist Review** as noted below.
5. Renewal Requests: we would need documentation clearly confirming desired outcomes and compliance.
6. Appeal Requests:
   - ☐ MCC-FL: requests should be forwarded to **MCC-FL shared mailbox FLMCCAppeals** per **Outlook e-mail template**: \\teams2-mma\sites\CallCenter\Shared Documents\Glen Allen Pharmacists Procedures.
     - ☐ Magellan Complete Care – Florida (MCC-FL) / Magellan Rx (MRx)

       Request for MCC-FL / MRx Initial Denial Appeal Review
   - ☐ CCP/SFCCN: requests should go to MRIoA c/o FirstTrax℠ **MAP: Physicians** work queue.
   - ☐ Appeals to initial request denials: See Denials and Appeals in the Plan Summary for additional information.

DOCUMENTATION REQUIRED FOR REQUESTS THAT NEED PSYCHIATRIST REVIEW

1. PHARMACIST REVIEW ONLY: CPhTs – Document all info available prior to escalation
2. Per the PA fax form: ***REQUIRED FOR REVIEW: Copies of medical records (diagnostic evaluation and recent chart notes), the original prescription, most recent copy of related labs and most recent TD screen.***
3. All requests for review must include the following or the requester's explanation as to why the information is not available. Incomplete requests should be provided one attempt to supply missing info. If the request is resubmitted without all of the following, then it should be forwarded for review noting the info that is missing or incomplete.
   - ☐ PA request form
   - ☐ Medical records (Diagnostic evaluation/chart notes)
   - ☐ Copy of the original prescription
   - ☐ Most recent metabolic/related labs
   - ☐ Most recent tardive dyskinesia (TD) screen
   - ☐ Any other submitted medical records
   - ☐ A printout of past medication history is also helpful (we can screen print from FirstTrax℠).

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ANTIPSYCHOTIC HIGH DOSE TABLE FOR CHILDREN AND ADOLESCENTS

Drug	Age	High Dose Limit
Aripiprazole (Abilify)	0-5	0mg/day
Aripiprazole	6-11	15mg/day
Aripiprazole	12-17	30mg/day
**Asenapine (Saphris)	0-5	0mg/day
**Asenapine	6-11	10mg/day
**Asenapine	12-17	20mg/day
**Chlorpromazine oral	0-5	0mg/day
**Chlorpromazine oral	6-11	200mg/day
**Chlorpromazine oral	12-17	375mg/day
Clozapine (Clozaril)	0-5	0mg/day
Clozapine	6-11	300mg/day
Clozapine	12-17	600mg/day
Fluphenazine (Prolixin)	0-5	0 mg/day
Fluphenazine	6-11	5mg/day
Fluphenazine	12-17	10mg/day
Fluphenazine Decanoate	0-5	0 mg/day
Fluphenazine Decanoate	6-11	0 mg/day
Fluphenazine Decanoate	12-17	0 mg/day
Haloperidol (Haldol)	0-5	0mg/day
Haloperidol	6-11	5mg/day
Haloperidol	12-17	10mg/day
Haloperidol Decanoate	0-5	0 mg/day
Haloperidol Decanoate	6-11	0 mg/day
Haloperidol Decanoate	12-17	0 mg/day
**Iloperidone (Fanapt)	0-5	0mg/day
**Iloperidone	6-11	12mg/day
**Iloperidone	12-17	24mg/day
**Lurasidone (Latuda) to be taken w/food, at least 350 calories.	0-5	0 mg/day
**Lurasidone	6-11	80mg/day
**Lurasidone	12-17	120mg/day
Olanzapine (Zyprexa)	0–5	0mg/day
Olanzapine	6–11	10mg/day
Olanzapine	12–17	20mg/day
**Paliperdone (Invega)	0–5	0 mg/day
**Paliperdone	6–11	6mg/day
**Paliperdone	12–17	12mg/day
Perphenazine (Trilaphon)	0–5	0mg/day
Perphenazine	6–11	12mg/day
Perphenazine	12–17	22mg/day
**Pimozide (Orap)	6–11	2 mg/day
**Pimozide	12–17	2 mg/day (due to cytochrome P450 metabolism/interactions)
Quetiapine (Seroquel)	0–5	0mg/day
Quetiapine	6–11	400mg/day
Quetiapine	12–17	800mg/day
Risperidone (Risperdal)	0–5	0mg/day
Risperidone	6–11	4mg/day
Risperidone	12–17	6mg/day
Risperidone Microspheres	0–5	0mg/day
Risperidone Microspheres	6–11	0mg/day
Risperidone Microspheres	12–17	0mg/day
Ziprasidone (Geodon) administer with meals	0–5	0mg/day
Ziprasidone	6–11	80 mg/day
Ziprasidone	12–17	160 mg/day

ANTIPSYCHOTICS, ADULT HIGH DOSE CRITERIA

Length of Authorization:	1 Year
Initiative:	MAP: Antipsychotic: High Dose (76 / 7025 – GSN; 76 / 7001 – GSN; 76 / 2641 – GSN; 76 / 2709 – GSN)
Fax Form:	Adult High Dose Antipsychotic **[REQUIRED]**

- Hyperlinks are informational only. They are not a part of criteria requirements.
- The High Dose criteria are derived from the Florida Medicaid Adult Psychotherapeutic Medication Guidelines found at the following link: http://medicaidmentalhealth.org/.

TAPERING CONSIDERATIONS:

Antipsychotic high dose prescribing should only be considered in exceptional cases for a time-limited trial after all evidence-based approaches have failed. After a 3-month trial, the high dose should revert to conventional levels unless the clinical benefits outweigh the risks (*for example, a 5% dose reduction every 1–2 weeks may be reasonable*).

REVIEW CRITERIA (ALL OF THE FOLLOWING BELOW IS REQUIRED):

1. Diagnosis must be Treatment Resistant Schizophrenia
2. Age must be ≥18 years
3. Failure of dose optimized, antipsychotic monotherapy:
   - Trials of at least two different agents;
     Adequate trial duration of at least 4 consecutive weeks (*6-8 weeks may be required for optimal response*); **AND**
   - Failure of a long-acting depot antipsychotic; **AND**
   - Failure to respond to clozapine* trial **OR** contraindication to clozapine;
     If partial response to clozapine, then augmentation with a second antipsychotic has been tried.
4. Documented compliance with all antipsychotic trials:
   - Plasma blood levels are within the therapeutic range (if available);
   - Prescription claims history indicates compliance.
5. Rule-out of other causes for non-response in compliant patients, i.e. substance abuse, concurrent use of other medications, and physical health conditions.
6. Safety monitoring plan is documented:
   - http://medicaidmentalhealth.org/monitoringSideEffects.cfm

CLOZAPINE HELP LINE

- Prescribers may call for a free consultation with a clozapine expert, Monday – Friday 8:00 a.m. to 5:00 p.m.
  Phone number: 727-562-6762
- http://medicaidmentalhealth.org/_assets/file/News/49/Florida%20Clozapine%20Hotline%20Number_V21.pdf

ANTIPSYCHOTICS, ATYPICALS (AGE 18+)

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to a preferred medication? Document details. Acceptable reasons include
   - ☐ Allergy to the preferred medications in this class
   - ☐ Contraindication to the preferred medications
   - ☐ History of serious reaction to preferred medications
2. Has the Patient failed a therapeutic trial of **one month** of two preferred medications?
   - ☐ Medical records/progress notes documenting failure to previous trials must be provided.
   - ☐ The requested medications corresponding generic (if a generic is available and preferred) has been attempted and failed or is contraindicated
3. **PDL Status Changes:** For medications that change from Preferred to Non-Preferred, please note that patients adherent to antipsychotics are EXCLUDED from this requirement to meet criteria by going back to another med. This is due in large part to the fact that AHCA and the MCO plans are very aware of the sensitive nature of these therapies once established and working.

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ANTIPSYCHOTICS, ATYPICALS (AGE 18+) (CONTINUED)

PREFERRED – NO PA REQUIRED (WITHIN THE ESTABLISHED AGE/DOSE/QUANTITY LIMITATIONS)	NON-PREFERRED – PA REQUIRED
Aripiprazole (generic for Abilify®)	Abilify® (aripiprazole)
Chlorpromazine tablets/vial (Minimum age = 18 years)	Aristada (aripirazole lauroxil) injection
Clozapine (generic for Clozaril®) (Minimum age =6)*	Clozapine ODT (generic for Fazaclo)*
Droperidol (Minimum age = 18 years)	Clozaril® (clozapine)*
Fanapt® (iloperidone) (Minimum age = 18 years)	Fazaclo® (clozapine ODT)*
Fluphenazine Decanoate/Vial (Minimum age = 18 years)	Geodon® (ziprasidone) capsules
Fluphenazine tablets (Minimum age = 6 years)	Geodon® (ziprasidone) 20mg powder for injection
Haloperidone Decanoate/Vial (generic for Haldol®) (Minimum age = 18 years)	Invega® ER tablets (paliperidone)
Haloperidone tablets (generic for Haldol®) (Minimum age = 6 years)	Lurasidone (generic for Latuda) Brand Preferred
Latuda® (lurasidone) (Minimum age = 18 years)	Olanzapine 10mg vial (generic for Zyprexa® inj)
Olanzapine tabs/ODT (generic for Zyprexa®/Zyprexa Zydis) (Minimum age =6)	Olanzapine/Fluoxetine (generic for Symbyax®) Brand Preferred
Perphenazine tablets (Minimum age = 6 years)	Orap® (pimozide) Minimum age = 18 years
Perphenazine/Amitriptyline tablets (Minimum age = 18 years)	Rexulti (brexpiprazole) **(AutoPA)**
Pimozide (generic for Orap®) (Minimum age = 18 years)	Risperdal® (risperidone)
Quetiapine (generic for Seroquel®) (Minimum age =6)	Risperdal-M® (risperidone)
Risperidone/Risperidone M & ODT (generic for Risperdal®/Risperdal® M) (Minimum age =6)	Saphris® (asenapine) Minimum age = 18
Seroquel® XR (quetiapine) (Minimum age =6)	Seroquel®(quetiapine)**
Thioridazine (Minimum age = 18)	Symbyax® (olanzapine/fluoxetine) Minimum age = 18 years PDL: Non-Preferred Brand Required initiative
Trifluoperazine (Minimum age = 18)	Versacloz (clozapine) 50mg/ml oral suspension*
Ziprasidone (generic for Geodon®) capsules	Vraylar (cariprazine) capsules
	Zyprexa® & Zyprexa Zydis® (olanzapine)
	Zyprexa injectable® (olanzapine)

[#/X] = quantity limit per X days

***Clozapine / Fazaclo® / Clozaril® / Versacloz®:** accumulation quantity limit edit of 27,000mg per 30 days (can be billed every 26 days based on coding tolerance) [Internal Error 76 – Plan limitations exceeded / NCPDP 7025 – Dosage limit exceeded]

****Seroquel®:** accumulation quantity limit edit of 30,000mg per 30 days (can be billed every 26 days based on coding tolerance) [Internal Error 76 – Plan limitations exceeded / NCPDP 7025 – Dosage limit exceeded]

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ABILIFY MAINTENA® (ARIPIPRAZOLE)

Length of Authorization:	Maximum of 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

PDL criteria do NOT apply.

INITIATION OF THERAPY

1. Must have diagnosis of schizophrenia; **AND**
2. Age ≥ 18 years. Requests for patients under age 18 years must be processed according to the **Antipsychotics, (Age < 18 Years old)** criteria; **AND**
3. Must have *documented* non-compliance with oral atypicals or non-response due to non-compliance.
   - ☐ *Hypersensitivity* (allergy) *or adverse response* to oral aripiprazole therapy is *not* a reason for approval. **The provider should try other preferred oral antipsychotic agents [(e.g., Geodon, Zyprexa, Seroquel) or long-acting injectables (e.g., fluphenazine, haloperidol)].**
   - ☐ *Ineffectiveness* of oral aripiprazole therapy is not a reason for approval. **The provider should try other preferred oral antipsychotic agents [(e.g., Geodon, Zyprexa, Seroquel) or long-acting injectables (e.g., fluphenazine, haloperidol].**

CONTINUATION FOLLOWING ACUTE THERAPY

- ☐ Must have diagnosis of schizophrenia; **AND**
- ☐ Age ≥ 18 years; **AND**
- ☐ The recipient must have previously received Abilify Maintena as acute treatment (e.g., during institutionalization or hospitalization) and the provider is requesting continuation of therapy upon discharge.

CONTINUATION FOLLOWING CHRONIC THERAPY

- ☐ Must have diagnosis of schizophrenia; **AND**
- ☐ Age ≥ 18 years; **AND**
- ☐ The beneficiary must have documentation (e.g., paid prescription claims and documented administration history) of uninterrupted (100% compliance) Abilify Maintena therapy during the past 90 days and documented effectiveness.

DOSING AND ADMINISTRATION

- ☐ Abilify Maintena is available in a pre-filled dual chamber syringe for extended-release injectable suspension in single use syringes once monthly for intramuscular deltoid or gluteal injection OR single use vials of intramuscular deltoid or gluteal injection depot formulation of aripiprazole; a sterile lyophilized powder that, when reconstituted with sterile water for injection, forms an injectable suspension that can be administered IM monthly. Both formulations are available in 300mg and 400mg.
- ☐ For patients who have never taken aripiprazole, tolerability should be established with oral aripiprazole prior to initiating treatment.
- ☐ Abilify Maintena is only to be administered by a healthcare professional.
- ☐ The recommended starting and maintenance dose of ABILIFY MAINTENA is 400 mg monthly (no sooner than 26 days after the previous injection).
- ☐ After the first injection, treatment should be continued with oral aripiprazole (10 mg to 20 mg) or other oral antipsychotic for 14 consecutive days to maintain therapeutic antipsychotic concentrations during initiation of therapy.
- ☐ If there are adverse reactions with the 400 mg dosage, the dosage may be reduced to 300 mg once monthly.

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ARISTADA® ER (ARIPIPRAZOLE LAUROXIL)

Length of Authorization:	Maximum of 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

PDL criteria do NOT apply.

INITIATION OF THERAPY

1. Must have diagnosis of schizophrenia; **AND**
2. Age ≥ 18 years. Requests for patients under age 18 years must be processed according to the **Antipsychotics, (Age < 18 Years old)** criteria; **AND**
3. Must have *documented* non-compliance with oral atypicals or non-response due to non-compliance.
   - ☐ *Hypersensitivity* (allergy) *or adverse response* to oral aripiprazole therapy is *not* a reason for approval. **The provider should try other preferred oral antipsychotic agents [(e.g., Geodon, Zyprexa, Seroquel) or long-acting injectables (e.g., fluphenazine, haloperidol)].**
   - ☐ *Ineffectiveness* of oral aripiprazole therapy is not a reason for approval. **The provider should try other preferred oral antipsychotic agents [(e.g., Geodon, Zyprexa, Seroquel) or long-acting injectables (e.g., fluphenazine, haloperidol].**

CONTINUATION FOLLOWING ACUTE THERAPY

- ☐ Must have diagnosis of schizophrenia; **AND**
- ☐ Age ≥ 18 years; **AND**
- ☐ The recipient must have previously received Aristada ER® as acute treatment (e.g., during institutionalization or hospitalization) and the provider is requesting continuation of therapy upon discharge.

CONTINUATION FOLLOWING CHRONIC THERAPY

- ☐ Must have diagnosis of schizophrenia; **AND**
- ☐ Age ≥ 18 years; **AND**
- ☐ The beneficiary must have documentation (e.g., paid prescription claims and documented administration history) of uninterrupted (100% compliance) Aristada ER® therapy during the past 90 days and documented effectiveness.

DOSING AND ADMINISTRATION

- ☐ Aristada ER® is an extended release injectable suspension administered intramuscularly in the deltoid or gluteal muscle administered monthly or every six weeks.
- ☐ For patients who have never taken aripiprazole, tolerability should be established with oral aripiprazole prior to initiating treatment.
- ☐ **Aristada ER® is only to be administered by a healthcare professional.**
- ☐ The initial dose can be 441mg (monthly), 662mg (monthly) or 882mg (monthly or every six weeks), which corresponds to 300mg, 450mg and 600mg of aripiprazole respectively.

ARISTADA DOSES BASED ON ORAL ARIPIPRAZOLE TOTAL DAILY DOSE

Oral Aripiprazole Dose	Intramuscular ARISTADA Dose
10 mg per day	441 mg per month (deltoid or gluteal)
15 mg per day	662 mg per month (gluteal)
20 mg or higher per day	882 mg per month (gluteal)

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INVEGA ER® TABLETS (PALPERIDONE EXTENDED-RELEASE TABLETS)

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

PDL criteria do NOT apply.

INITIATION OF THERAPY

Approvals must be entered for the generic product. ***Otherwise, Brand Medically Necessary criteria must be met.***

- ☐ Must have diagnosis of schizophrenia or schizoaffective disorder; **AND**
- ☐ Age ≥ 18 years. Requests for patients under age 18 years must be processed according to the **Antipsychotics, (Age < 18 Years old)** criteria;

AND

- ☐ Trial and failure of risperidone oral:
  - ☐ Failure is defined as an occurrence of intolerable effect(s) (for example: constipation, extrapyramidals symptoms (EPS), or cardiac events).
  - ☐ Failure may also be defined as "ineffectiveness of risperidone therapy" if the Patient has received a minimum of a 30-day trial on the optimal dose of risperidone (6 mg/day).
  - ☐ Hypersensitivity (allergy) to oral risperidone therapy is not a reason for approval. The provider should try other oral atypical antipsychotic agents (e.g., Abilify, Geodon, Zyprexa, Seroquel XR).

OR

- ☐ If the Patient is initiating Invega Sustenna, an override may be entered for the oral paliperidone to establish tolerability.

CONTINUATION OF THERAPY

- ☐ The beneficiary must have documented uninterrupted (100% compliance) paliperidone therapy during the past 90 days and documented effectiveness; otherwise, the review criteria for initiation of therapy must be applied.

CONTINUED ON NEXT PAGE

INVEGA SUSTENNA® (PALIPERIDONE PALMITATE)

Length of Authorization:	Up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

PDL criteria do NOT apply.

INITIATION OF THERAPY

1. Must have diagnosis of schizophrenia or schizoaffective disorder; **AND**
2. Age ≥ 18 years. Requests for patients under age 18 years must be processed according to the **Antipsychotics, (Age < 18 Years old)** criteria; **AND**
3. Must have established tolerability with oral paliperidone or oral risperidone; **AND**
4. Must have documented non-compliance with oral atypicals or non-response due to non-compliance.

CONTINUATION FOLLOWING ACUTE THERAPY

- ☐ Must have diagnosis of schizophrenia or schizoaffective disorder; **AND**
- ☐ Age ≥ 18 years; **AND**
- ☐ The recipient must have previously received Invega Sustenna as acute treatment (e.g., during institutionalization or hospitalization) and the provider is requesting continuation of therapy upon discharge.

CONTINUATION FOLLOWING CHRONIC THERAPY

- ☐ Must have diagnosis of schizophrenia or schizoaffective disorder; **AND**
- ☐ Age ≥ 18 years; **AND**
- ☐ The recipient must have documentation (e.g., paid prescription claims and documented administration history) of uninterrupted (100% compliance) Invega Sustenna therapy during the past 90 days and documented effectiveness.

DOSING AND ADMINISTRATION

Schizophrenia:

- ☐ Initiate with a dose of 234 mg on treatment day 1 and 156 mg one week later, both should be administered in the deltoid muscle. The recommended monthly maintenance dose is 117 mg. Following the second dose monthly doses can be administered in either the deltoid or the gluteal muscle. Maximum of 234mg per month.

Schizoaffective Disorder:

- ☐ Initiate with a dose of 234 mg on treatment day 1 and 156 mg one week later, both should be administered in the deltoid muscle. The recommended monthly maintenance dose is 78-234 mg. Following the second dose monthly doses can be administered in either the deltoid or the gluteal muscle. Maximum of 234mg per month.

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INVEGA TRINZA® (PALIPERIDONE PALMITATE SUSPENSION FOR INJECTION)

Length of Authorization:	Maximum of 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

PDL criteria do NOT apply.

INITIATION OF THERAPY

- ☐ Patient must be ≥18 years old. Requests for patients under age 18 years must be processed according to the **Antipsychotics, (Age < 18 Years old)** criteria. **AND**
- ☐ Patient must have a confirmed diagnosis of schizophrenia **AND**
- ☐ Patient must have met AHCA established criteria for Invega Sustenna (please refer to Invega Sustenna criteria located at: (http://ahca.myflorida.com/Medicaid/Prescribed_Drug/drug_criteria_pdf/Invega_Sustenna_Criteria.pdf) **AND**
- ☐ Patient has received a minimum of 4 months of monthly injections with Invega Sustenna® with adequate response and acceptable patient tolerance.

CONTINUATION OF THERAPY

- ☐ Patient continues to meet all of the initial criteria
- ☐ Clinical notes document improved or stable patient symptoms

DOSING AND ADMINISTRATION

- It is recommended that the last 2 doses of Invega Sustenna prior to initiating Invega Trinza be the same dosage strength in order to establish a consistent maintenance dose
- Initiate Invega Trinza when the next 1-month Invega Sustenna dose is scheduled. Invega Trinza may be initiated up to 7-days before or after the monthly due date of the next scheduled Invega Sustenna dose.
- Use the equivalent 3.5 fold higher dose to convert to Invega Trinza follows:
  - ☐ Patients stabilized on 39 mg IM monthly of Invega Sustenna: No conversion recommendations available
  - ☐ Patients stabilized on 78 mg IM monthly of Invega Sustenna: Initiate Invega Trinza at 273 mg IM every 3 months
  - ☐ Patients stabilized on 117 mg IM monthly of Invega Sustenna: Initiate Invega Trinza at 410 mg IM every 3 months
  - ☐ Patients stabilized on 156 mg IM monthly of Invega Sustenna: Initiate Invega Trinza at 546 mg IM every 3 months
  - ☐ Patients stabilized on 234 mg IM monthly of Invega Sustenna: Initiate Invega Trinza at 819 mg IM every 3 months

CONVERSION INSTRUCTIONS

- ☐ **Oral Risperidone to Oral Paliperidone**
  - ☐ According to results of a "virtual" comparison, paliperidone ER 6-12 mg/day may be similarly efficacious to risperidone 4-6 mg/day.
- ☐ **Oral Paliperidone to Invega Sustenna Injectable**

Formulation	INVEGA® (Paliperidone) Extended-Release Tablet	INVEGA® SUSTENNA Injection
Dosing Frequency	Once Daily	Once every 4 weeks
Dose (mg)	12 6 3	234 117 39-78

- ☐ **Long-acting Injectable Antipsychotics to Invega Sustenna Injectable**
  - ☐ When switching from previous long-acting injectable antipsychotics, initiate Invega Sustenna therapy in place of the next scheduled injection. Invega Sustenna should then be continued at monthly intervals. The one-week initiation dosing regimen described above is not required.

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RISPERDAL CONSTA® (RISPERIDONE)

Length of Authorization:	Up to one year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

PDL criteria do NOT apply.

INITIATION OF THERAPY

- ☐ Patient must be ≥18 years old. Requests for patients under age 18 years must be processed according to the **Antipsychotics, (Age < 18 Years old)** criteria.
- ☐ Risperdal Consta® will only be authorized if the recipient has documented non-compliance with oral atypicals or non-response due to non-compliance*.

  Non-compliance can be identified by an evident history in claims of the patient not receiving their prescriptions over a period of time (e.g., three months), not just over a one-month period. Therefore, claims may be all you need in determining noncompliance. But, in some cases, you may need the MD's clinical notes to come to that conclusion.

CONTINUATION FOLLOWING ACUTE THERAPY

- ☐ If the beneficiary has previously received Risperdal Consta as acute treatment (e.g., during institutionalization or hospitalization) and the provider is requesting continuation of therapy upon discharge.

CONTINUATION FOLLOWING CHRONIC THERAPY

- ☐ The beneficiary must have confirmed compliance on Risperdal Consta therapy during the past 90 days and documented effectiveness.

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SAPHRIS® (ASENAPINE)

Length of Authorization:	Initial Therapy: Up to 3 months Continuation of therapy: Up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

Initial Review for Pediatric Patients with Bipolar Disorder:

- ☐ Patient must be ≥ 10 years old. Requests for patients under age 18 years must be processed according to the **Antipsychotics, (Age < 18 Years old)** criteria.
- ☐ Patient must have a diagnosis of bipolar disorder
- ☐ Trial of at least two preferred atypical antipsychotics with a minimum 30 day treatment period (i.e., risperidone, aripiprazole)
- ☐ Patient must be capable of following strict administration instructions including sublingual administration and no food or drink for ten minutes after administration

Initial Review Criteria for Adults:

- ☐ Patient must be ≥18 years old.
- ☐ Patient must have a diagnosis of schizophrenia or Bipolar I disorder
- ☐ Patient must be capable of following strict administration instructions including sublingual administration and no food or drink for ten minutes after administration
- ☐ **For the treatment of schizophrenia**, patient must have a history of trial and failure of at least:
  - ☐ Two preferred atypical antipsychotics with a minimum 30-day treatment period with each agent.
- ☐ **For the treatment of Bipolar I disorder**, patient must have failed to respond or be intolerant to an adequate trial (at least 30 days with therapeutic blood levels) of two of the following:
  - ☐ Lithium; **OR**
  - ☐ Valproic Acid; **OR**
  - ☐ Combination of a mood stabilizer and one preferred atypical antipsychotic; **OR**
  - ☐ Combination of two or more mood stabilizers

Continuation of Therapy for Pediatric Patients:

- ☐ Documentation of satisfactory response to asenapine must be submitted.

Continuation of Therapy for Adults:

- ☐ Schizophrenia:
  - ☐ As maintenance therapy in patients with satisfactory response to asenapine in the acute phase who had a previous trial and failure of two other atypical antipsychotics as described above.
- ☐ Bipolar I Disease – Manic or Mixed:
  - ☐ Following remission of an acute bipolar manic or mixed episode, patients may remain at particularly high risk of relapse for a period of up to six months.
  - ☐ Evaluate every 3 months for the need for continuation of therapy after the acute management.
  - ☐ The clinical trials for asenapine in this setting were 3-week long trials.
  - ☐ The best empirical evidence for maintenance treatment of manic or mixed bipolar I patients includes lithium and valproate.
  - ☐ Approve for maintenance therapy of manic or mixed bipolar I disorder only in patients who previously qualified for and received asenapine during the acute phase and are currently receiving lithium and /or valproate without satisfactory results.

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ZYPREXA RELPREVV® (OLANZAPINE)

Length of Authorization:	Maximum of 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

NOTE

Zyprexa Relprevv is available only through a restricted distribution program. Zyprexa Relprevv must not be dispensed directly to a patient. For a patient to receive treatment, the prescriber, healthcare facility, patient, and pharmacy must all be enrolled in the Zyprexa Relprevv Patient Care Program (phone # 877-772-9390).

REVIEW CRITERIA

PDL criteria do NOT apply.

INITIATION OF THERAPY

1. Must have diagnosis of schizophrenia; **AND**
2. Age ≥ 18 years (Requests for patients under age 18 years must be processed according to the **Antipsychotics, (Age < 18 Years old)** criteria; **AND**
3. Must be prescribed by a provider that has enrolled in the Zyprexa Relprevv Patient Care Program. Demonstrated with supporting documentation (signed attestation): http://multivu.prnewswire.com/mnr/lilly/40089/docs/40089-ZyprexaRelprevvPatientCareProgramBackgrounder121409CLEAN(2).pdf
   AND
4. Trial and failure of Risperdal Consta or a recommendation from the first two bulleted statements below if applicable (separate PA submission required if Risperdal Consta recommended):
   - ☐ *Hypersensitivity (allergy)* or *adverse response* to oral olanzapine therapy is not a reason for approval. **The provider should try other preferred antipsychotic agents oral [(e.g., Abilify, Geodon, Seroquel) or long-acting injectables (e.g., fluphenazine, haloperidol].**
   - ☐ *Ineffectiveness* of oral olanzapine therapy is not a reason for approval. The provider should try other oral atypical antipsychotic agents. **The provider should try other preferred antipsychotic agents oral [(e.g. Abilify, Geodon, Seroquel) or long-acting injectables (e.g., fluphenazine, haloperidol].**
   - ☐ *Failure* of Risperdal Consta is defined as an occurrence of intolerable adverse effect(s) (for example: constipation, extrapyramidal symptoms (EPS), or cardiac events).
   - ☐ *Failure* may also be defined as "ineffectiveness of Risperdal Consta therapy" if the patient has received a minimum of a one month trial on the optimal dose of 50 mg every 2 weeks. *(This must be verified in claims history or progress notes.)*

CONTINUATION FOLLOWING ACUTE THERAPY

- ☐ If the beneficiary has previously received Zyprexa Relprevv as acute treatment (e.g., during institutionalization or hospitalization) and the provider is requesting continuation of therapy upon discharge:
  - ☐ If there is no trial history of Risperdal Consta, the request must be denied.
  - ☐ If there is trial of Risperdal Consta (either in documentation or claims history) within the past 365 days, refer to #3 of the review criteria.

CONTINUATION FOLLOWING CHRONIC THERAPY

- ☐ The beneficiary must have documentation (e.g. paid prescription claims and documented administration history) of uninterrupted (100 percent compliance) Zyprexa Relprevv therapy during the past 90 days and documented effectiveness.

ANTIPSYCHOTICS, TYPICALS (AGE 18+)

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to a preferred medication? Document details. Acceptable reasons include
   - ☐ Allergy to the preferred medications in this class;
   - ☐ Contraindication to the preferred medications; and
   - ☐ History of serious reaction to preferred medications.
2. Has the Patient failed a therapeutic trial of *one month* of **two** preferred medications?
3. **PDL Status Changes:** For medications that change from Preferred to Non-Preferred, please note that patients adherent to antipsychotics are EXCLUDED from this requirement to meet criteria by going back to another med. This is due in large part to the fact that AHCA and the MCO plans are very aware of the sensitive nature of these therapies once established and working.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Chlorpromazine	Haldol®
Fluphenazine	Molindone (generic for Moban®)
Haloperidol	
Loxapine	
Moban®	
Perphenazine	
Thiothixene	
Trifluoperazine	

ANTIVIRALS – HERPES AND INFLUENZA

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN) PDL: Non-Preferred Brand Required (75 / 2462 – NDC-9; 76 / 2641 – NDC-9; 22 / 50021 – NDC-9) (for Valtrex®)

1. Is there any reason that the Patient cannot be switched to a preferred medication? **Document details.** Acceptable reasons include

- ☐ Allergy to the preferred medications in this class
- ☐ Contraindication to the preferred medications
- ☐ History of a serious reaction to the preferred medications (e.g., thrombocytopenia, seizures, renal failure, etc.)

2. Has the Patient failed a therapeutic trial of *at least 5 days* with at least **ONE** preferred medication(s)?

HERPES

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Acyclovir Tablets/Capsules (generic for Zovirax®)	Famvir® (famciclovir)
Valacyclovir (generic for Valtrex®)	Famciclovir (generic for Famvir®)
	Sitavig® (acyclovir) buccal tablets
	Valtrex® (*valacyclovir*)
	Zovirax® Tablets/Capsules (*acyclovir*)

CYTOMEGALOVIRUS (CMV)

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Ganciclovir (generic for Cytovene®) see below	Valcyte (see specific clinical criteria on following pages)

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INFLUENZA

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Amantadine (generic for Symmetrel®)	Flumadine (*rimantadine*)
Relenza [2 /365] (Zanamivir powder for inhalation)	Symmetrel (*amantadine*)
Rimantadine (generic for Flumadine®)	
Tamiflu [2/365] Max 10 caps/fill (30mg – max 20 caps/fill); Suspension- Max 180ml/fill 12.5mg/day)	

Note: A beneficiary may fill either: 2 **Tamiflu** or 2 **Relenza** or 1 **Tamiflu** and 1 **Relenza** per 365 days

ZOVIRAX® (ACYCLOVIR) TOPICALS

Length of Authorization:	Up to 7 days
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Acyclovir ointment (generic for Zovirax®)	Zovirax® ointment (acyclovir)
Zovirax® cream (acyclovir)	

- Patient must be ≥ 12 years of age.
- Follow-up prior authorization requests for the cream in a Patient with Herpes Labialis (cold sores) may be approved.

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VALCYTE® (VALGANCICLOVIR)

Length of Authorization:	Maximum of one year (varies with indication)
Initiative:	MAP: Valcyte (75 / 2462 – GSN; 76 / 2641 – GSN)
Fax Form:	Valcyte

CLINICAL CRITERIA

Diagnosis is required.

Lab reports cited should be dated within the past 90 days.

Questions below correspond to the numbering on the Valcyte® fax form.

Question 1:

- ☐ For a patient with a confirmed HIV/AIDS diagnosis: if the CMV retinitis is active. (Approve for 21 days of induction therapy.)
- ☐ For maintenance following induction therapy or in patients with inactive CMV retinitis (e.g., CMV retinitis prophylaxis): approve only if CD4 count is less than 100 cells/mm^3 and the patient is CMV seropositive. (Approve up to 90 days.)
- ☐ For CMV prophylaxis and preemptive therapy in patients at high risk for CMV disease following a liver, heart, kidney, and/or kidney-pancreas transplant. The transplant must be verified by medical documentation. (Approval may be granted up to 200 days post-transplant or until viremia undetectable.)
  - ☐ High Risk = Donor +/Recipient OR = Recipient treated with depleting anti-lymphocyte antibodies.
  - ☐ Intermediate Risk = Donor+/Recipient+ OR = Donor-/Recipient+
- ☐ Prophylaxis in lung transplant - (Approve up to 12 months post transplant)
- ☐ Treatment on CMV disease in hematopoietic stem cell transplant patients:
  - ☐ May approve induction doses for up to 3 weeks
  - ☐ May approve maintenance dosing for up to another 4 weeks until resolution of symptoms and negation of the viral load.
- ☐ Other risk factors:
  - ☐ Increased immunosuppression, directly or indirectly leading to activation of latently infected cells increases risk of CMV disease. Therefore, requests for post-transplant patients (regardless of transplant date) may be considered for approval. (May approve up to one year upon each submission.)
  - ☐ Use of unfiltered blood products that are not leukocyte depleted increases risk of CMV disease. (Approve for 90 days)
  - ☐ Environmental exposure such as being in crowds or public places or in a child care setting increases the risk of CMV for the immunosuppressed transplant patient. (Approve for 90 days)
  - ☐ Other immunomodulatory viruses (HHV-6).
  - ☐ Bone marrow transplant recipients who are seropositive and receive marrow or stem cells from a seronegative individual or with Graft-vs-Host Disease (GvHD). (Approve for 90 days)
  - ☐ Post-transplant patient with any of the following clinical conditions: fever, hepatitis, muscle pain, gastroenteropathy, leukopenia, pneumonitis, thrombocytopenia, and/or retinitis. (The quantitative CMV viral load (PCR) may be useful but not definitive indicator of need for treatment.) (Approve for 90 days)

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VALCYTE® (VALGANCICLOVIR) *(CONTINUED)*

- Early reactivation (within 30 days post-transplant) may be associated with greater risk of reoccurrence. (Approve for 90 days)

- Epstein Barr Virus (EBV)/ Post Transplant Lymphoproliferative Disorder:
  - EBV viremia (EBV DNA detectable in blood by PCR analysis) - (May approve up to six months.)
  - Post-transplant recipient presenting with PTLD symptomatology (refer to clinical notes) - (May approve up to six months.)
  - EBV positive tissue analysis: biopsy with in situ hybridization for EBER (Epstein Barr Encoding RNA) - (May approve up to six months)
- Continuation of Therapy: Therapy is to continue if PCR remains positive (CMV and EBV).

Question 2:

- Is the patient receiving peritoneal hemodialysis?
- If response to question 2 is "YES," then forward to a pharmacist for review.

Question 3 (FOR RPh USE):

- Current or previous therapy to treat infection in the past 90 days?
- Document the Name, Start Date, End Date, and Reason for Discontinuing for each medication.
  - The answers to this question should be used as a reference when there is a potential for alternative therapy (e.g., cases that do not meet the above or below mentioned indications)
  - Other systemic antiviral agents approved for treatment of CMV infection include ganciclovir (po/iv) (PDL) and cidofovir (IV) (Non-PDL).

Question 4:

- Does the patient have any of the following comorbidities? If response is "yes," forward to a pharmacist with recommendation to deny until comorbidities are corrected.
- Platelet count < 25,000/mm^3 (µl)
- Hemoglobin < 8g/dl
- Absolute Neutrophil Count (ANC) < 500/ mm^3 (µl).

5-ASA DERIVATIVES, ORAL PREPARATIONS

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

CRITERIA FOR APPROVAL

1. Is there any reason that the Patient cannot be switched to a preferred medication? **Document details.** Acceptable reasons include
   - ☐ Allergy to preferred medications in this class
   - ☐ Contraindication or drug-to-drug interaction with all preferred medications
   - ☐ History of unacceptable side effects
   - ☐ Indication involves the upper GI tract (in such cases Pentasa may be approved)
2. The requested medication may be approved if **both** of the following are true:
   - ☐ If there has been a therapeutic failure to no less than a two-month trial each, of at least 2 medications within the same class not requiring prior approval **AND**
   - ☐ The requested medication's corresponding generic (if a generic is available) has been attempted and failed or is contraindicated. Approved Indications

APPROVED INDICATIONS

- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Ulcerative proctitis

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Apriso® (mesalamine)	Asacol® HD (mesalamine)
Canasa® *rectal suppository* (mesalamine)	Azulfidine® (sulfasalazine)
Delzicol® Delayed Release Cap (*mesalamine*)	Azulfidine EN® (sulfasalazine DR)
Mesalamine enema	Colazal® (balsalazide)
Sulfasalazine	Dipentum® (olsalazine)
Sulfasalazine DR	Lialda® (mesalamine, 5-ASA)
	Pentasa® (mesalamine, 5-ASA)
	Rowasa® *enema* (mesalamine)
	SfRowasa® *enema* (mesalamine)

ATTENTION DEFICIT DISORDER/NARCOLEPSY

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to a preferred medication? Acceptable reasons include
   - ☐ Allergy to the preferred medications in this class
   - ☐ Contraindication to the preferred medications
   - ☐ History of serious reaction (i.e., angina, seizures, etc.) to preferred medication
2. Has the Patient failed a therapeutic trial of at least 30 days with at least **TWO** preferred medications? **Document details.**

(Some medications within this class may have specific criteria.)

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Adderall XR® (*amphetamine/dextroamphetamine*)	Adderall® (*amphetamine/dextroamphetamine*)
Amphetamine Salt Combo /*Amphetamine/Dextroamphetamine* (generic for Adderall®)	Amphetamine Salt Combo ER (generic for Adderall XR®)
Daytrana® Patch (*methylphenidate*)	Concerta® (*methylphenidate*)
Dexmethylphenidate (generic for Focalin®)	Desoxyn® (*methamphetamine*)
Dextroamphetamine (generic for Dexedrine® tab)	Dexedrine®(Dextroamphetamine) tab
Dyanavel XR (*amphetamine extended release susp*)	Dexedrine Spansules®(Dextroamphetamine ER)
Focalin XR® (*dexmethylphenidate XR*)	Dextroamphetamine ER (generic for Dexedrine Spansule®)
Methylphenidate (generic for Ritalin®) tablets	Focalin® (*dexmethylphenidate HCl*)
Methylphenidate ER (generic for Concerta®) NOTE: Only NDCs for manufacturer Actavis (Labeler # 00591) and AHP (Labeler #68084) are preferred	Methylin (methylphenidate) chewable tablets
Methylphenidate ER (generic for Ritalin SR®) tablets	Methylin (methylphenidate) oral solution
Quillichew ER (methylphenidate ext release chew tab)	Methylphenidate (generic for Methylin®) oral soln
Quillivant XR® (methylphenidate ext release oral soln Minimum age = 6 yrs)	Methylphenidate ER (generic for Concerta®) NOTE: All generic products (except NDCs for manufacturer Actavis (Labeler # 00591) and AHP (Labeler #68084) are non-preferred.
Vyvanse® (*lisdexamfetamine*)	Methylphenidate ER (generic for Ritalin LA®) capsules
	Ritalin SR® (*Methylphenidate ER*) tablets
	Ritalin LA® (*methylphenidate*) capsules

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Guanfacine ER (generic for Intuniv®)	Intuniv® (guanfacine ER)
Strattera® (atomoxetine)	

CONTINUED ON NEXT PAGE

KAPVAY® (CLONIDINE HYDROCHLORIDE) EXTENDED-RELEASE TABLETS

Length of Authorization:	Initial therapy - 3 months; Continuation of therapy - 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL INDICATIONS

- ☐ PDL criteria do NOT apply.
- ☐ Patient must be ≥ 6 years old
- ☐ Must have a diagnosis of attention deficit hyperactivity disorder
- ☐ Minimum trial of one month of a methylphenidate (i.e., Daytrana, Focalin, Methylin, Metadate...) and amphetamine (i.e., Vyvanse, dextroamphetamine...) product. (If stimulant therapy contraindicated no methylphenidate or amphetamine trial required.)
- ☐ Minimum trial of one month of Intuniv.

METADATE CD® (METHYLPHENIDATE, BIPHASIC RELEASE)

Length of Authorization:	Up to one year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN)

AUTHORIZATION CRITERIA

1. Beneficiary must have a diagnosis of attention-deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD).
2. Documented trial and failure of at least two other intermediate-acting methylphenidate preparations within the last 365 days.
   OR
   Recent history of Metadate CD therapy. Claims history or physicians notes must demonstrate compliance on Metadate CD therapy for the past two months.
3. No new therapy will be approved without meeting the above criteria.

DOSING

- ☐ Adults, Adolescents, and Children >= 6 years: Initially, give no more than the total daily dosage of the previous methylphenidate product PO once daily. For example, patients already taking 10 mg of immediate-release methylphenidate twice daily should start with 20 mg Metadate CD once daily; those taking 20 mg twice daily should start with 40 mg Metadate CD. May adjust in 10-20 mg increments at weekly intervals to a maximum of 60 mg/day PO. Maximum recommended daily dose is 60 mg daily. Maximum quantity limit – up to two capsules a day.
- ☐ Children < 6 years: please refer to the Long Acting Stimulants in Children Criteria.

CONTINUED ON NEXT PAGE

PROCENTRA® (DEXTROAMPHETAMINE SULFATE ORAL SOLUTION)

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA (ALL INDICATIONS BELOW MUST BE MET)

- ☐ Age: 3–5 years
- ☐ Diagnosis of Attention Deficit Disorder with Hyperactivity
- ☐ Unable to swallow tablets as indicated by an absence of prescriptions for solid dosage forms (tablet or capsule) in claims history or in medical records.
- ☐ Titration to a maximum dosage ≤ 40mg/day (if > 40 mg/day forward to a pharmacist).
- ☐ Intolerance to methylphenidate products. (Official documentation of adverse response or reaction must be submitted).

-OR-

- ☐ Trial of at least one month of other stimulant to include a methylphenidate product.

AUBAGIO® (TERIFLUNOMIDE)

Length of Authorization:	6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

INITIATION OF THERAPY

- ☐ Patient must be ≥ 18 years old.
- ☐ Must have a diagnosis of a relapsing form of Multiple Sclerosis (RRMS)
- ☐ Previous trial with insufficient response or adverse reaction or contraindication to Copaxone (glatiramer) or an Interferon Beta (e.g., Avonex, Betaseron, Rebif).

CONTINUATION OF THERAPY

- ☐ Patient must be ≥ 18 years old.
- ☐ Must have a diagnosis of a relapsing form of Multiple Sclerosis (RRMS)
- ☐ Requestor must document effectiveness of therapy.

AUTOMATED PRIOR AUTHORIZATIONS (AUTO PA)

The following classes follow the Auto PA logic first.

- Anticonvulsants
- Brintellix
- Dose Optimization
- Dual RAS Blockade DUR Edit
- Duration Edit SMR (Skeletal Muscle Relaxants)
- Gaucher Therapy
- Growth Hormone
- Hepatitis C
- Hereditary Angioedema Products
- HIV Agents
- Hydroxyurea Non-PDL & QL Bypass
- Lidoderm
- Lovaza
  - Coding updated 8-1-2016 for Lovaza for brand product only (Brand HICL 026793; AutoPA coding reinstated
  - Coding updated 7-27-2015 for Lovaza 1g cap (Brand HICL 026793); AutoPA Coding removed.
- Mercaptopurine Non-PDL & QL Bypass
- OxyContin
- Pneumococcal Vaccine
- Pristiq/Khedezla/Desvenlafaxine
- Stelara
- Tobi
- Tybost
- Xeljanz
- Zanaflex (Tizanidine) and Baclofen FDB Limit Bypass

ADDITIONAL INFORMATION

- Automated PA only approves edits not the prior authorization. Drugs are still subject to other edits such as exceeding daily dosing, quantity limits, etc.
- Escalate all Auto PA prior authorization requests to a Pharmacist for review.
- **Automated Prior Authorizations and Bypass Lists (coding) can be found in the Weekly Comprehensive Drug List posted to *MRx Docs:***
  - http://mmadocs.fhsc.com/Rx/MAP_Criteria_PDL/MAP_Clinical_Criteria.asp → Florida Managed Care Plans (Common Documents) → Florida Weekly Comprehensive Drug List

BENLYSTA® (BELIMUMAB)

Length of Authorization:	Up to six months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL INDICATIONS

- ☐ The Provider should initially be informed that the medication can be obtained through Physician Services (Code: J0490). Subsequent requests may be reviewed using the criteria below.
- ☐ Patient must be ≥ 16 years old.
- ☐ Must have a diagnosis of Systemic Lupus Erythematosus (SLE).
- ☐ Must be currently receiving standard therapy (e.g., hydroxychloroquine, corticosteroids [prednisone, etc.] or methotrexate).
- ☐ Must be prescribed by a rheumatology specialist or other specialist treating SLE related conditions.

BERINERT® (C1 ESTERASE INHIBITOR [HUMAN])

Length of Authorization:	One year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥13 years old
- ☐ Must have a diagnosis of Hereditary Angioedema (HAE).
- ☐ Verification of patient education on medication administration **upon initiation of therapy** via supporting documentation or a phone call to the billing specialty pharmacy to determine if home health services have been acquired for medication administration training.
- ☐ Medication must be prescribed by a specialist (e.g., allergist...)

HEREDITARY ANGIOEDEMA (HAE) – AUTO PA

<table>
<tr><th>Edit</th><th>Drugs</th><th>Steps</th></tr>
<tr>
<td>Hereditary Angioedema Auto PA
Automated PA approval satisfies non-PDL edit.</td>
<td>
<table>
<tr><th colspan="3">HAE List</th></tr>
<tr><th>Generic Name</th><th>Brand Name</th><th>Drug Code</th></tr>
<tr><td>Icatibant</td><td>Firazyr</td><td>HICL = 035962</td></tr>
<tr><td rowspan="2">C1 Esterase Inhibitor</td><td>Berinert</td><td rowspan="2">HICL = 018568</td></tr>
<tr><td>Cinryze</td></tr>
<tr><td></td><td>Ruconest</td><td>HICL = 037766</td></tr>
</table>
</td>
<td>
Step 1: If incoming drug is for Firazyr, Berinert or Cinryze or Ruconest <HAE Drug List> and prior authorization code = L, look back 365 days in the patient's health conditions for an ICD-9 = 277.6 OR an ICD-10 = D84.1 (Hereditary Angioedema) if found, NO PA REQUIRED. Otherwise, deny for PRIOR AUTHORIZATION REQUIRED NCPDP EC 75 with supplemental message: "RECIPIENT DOESN'T HAVE REQ DIAGNOSIS ON FILE."
Note: The following quantity limits apply:
<table>
<tr><th colspan="2">Quantity Limits</th></tr>
<tr><td>GSN = 064564 (Firazyr)</td><td>9 mls per 30 days</td></tr>
<tr><td>GSN = 068384 & 069123 (Berinert)</td><td>16 vials per 30 days</td></tr>
<tr><td>GSN = 040429 (Cinryze)</td><td>20 vials per 30 days</td></tr>
<tr><td>GSN = 051912 (Ruconest)</td><td>2 vials per day</td></tr>
</table>
</td>
</tr>
</table>

BETA-AGONISTS: INHALED

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN) MAP: Quantity Limit: IE 2191 (76 / 2191 – GSN)

1. Is there any reason that the Patient cannot be switched to a preferred medication? Acceptable reasons include
   - ☐ Allergy to the preferred medications in this class
   - ☐ Contraindication to the preferred medications
   - ☐ History of serious reaction (i.e., angina, seizures, etc.) to preferred medication
2. Has the Patient failed a therapeutic trial with **TWO** preferred medications? **Document details.**

BETA ADRENERGIC MDI: SHORT ACTING

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
ProAir HFA [17gm/30days] (*albuterol*)	Ventolin HFA [36gm/30days] (*albuterol*)
Proventil HFA [14gm/30days] (*albuterol*)	

BETA ADRENERGIC: SHORT ACTING FOR NEBULIZER

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Albuterol Sulfate Solution for Inhalation: ☐ 2.5mg/3mL ☐ 1.25mg/3mL (AccuNeb generic) ☐ 0.63mg/3mL (AccuNeb generic)	AccuNeb (brand is non-preferred)

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XOPENEX (LEVALBUTEROL) SOLUTIONS FOR INHALATION AND HFA

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Brand Required (75 / 2462 – NDC-9; 76 / 2641 – NDC-9; 22 / 50021 – NDC-9)

REVIEW CRITERIA

PDL criteria do NOT apply.

- ☐ Trial and failure all of the following when request for Xopenex solution for inhalation:
  1. Rescue or maintenance therapy: Trial of the correct therapeutically equivalent dose of racemic albuterol as compared to the requested levalbuterol dose (or a lower concentration if applicable):
     a. 2.5mg/3ml Albuterol = 1.25mg/3ml Xopenex
     b. 1.25mg/3ml Albuterol (generic for AccuNeb) = 0.63mg/3ml Xopenex
     c. 0.63mg/3ml Albuterol (generic for AccuNeb) = 0.31mg/3ml Xopenex
  2. Rescue or maintenance therapy: Reduction of nebulization therapy time of Albuterol Sulfate to 5 minutes.
  3. Maintenance therapy: Combination maintenance therapy (i.e. inhaled corticosteroid, long acting beta agonist, leukotriene inhibitors, steroids, etc.) if request is due to failure of Albuterol therapy in a chronic condition.
- ☐ Trial and failure of the following(as applicable) when request for Xopenex HFA:
  1. Rescue or maintenance therapy: Albuterol HFA with spacer if request is due to failure of Albuterol therapy.
  2. Maintenance therapy: Combination maintenance therapy (i.e. inhaled corticosteroid, long acting beta agonist, leukotriene inhibitors, steroids, etc.) if request is due to failure of Albuterol therapy in a chronic condition.

QUANTITY LIMIT

- ☐ Solution for Inhalation: Maximum of 288 mL per 30 days
- ☐ HFA Inhaler: 2 inhalers/month

BONE RESORPTION INHIBITIOR MEDICATIONS

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason the patient cannot be switched to a preferred medication? Acceptable reasons include:
   - ☐ Allergy to the preferred medications
   - ☐ Contraindication or drug-to-drug interaction with the preferred medications
   - ☐ History of serious reaction (e.g., seizures, tachycardia, osteonecrosis, angioedema, etc.) to preferred medications
2. Has there been a therapeutic trial and failure of at least six months with two preferred agents?
3. Has the Patient failed a therapeutic trial of a non-preferred medication (duration = 6 months for osteoporosis documented by bone density studies)?
4. Is there a specific indication for a non-preferred medication, which the preferred medications do not have?

(Some medications within this class may have specific criteria.)

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Alendronate (generic for Fosamax®)	Actonel® (*risedronate*) 30mg tabs [60/120days], 35mg tabs [4/28]
Calcitonin-Salmon (generic for Miacalcin®) spray **(Min age= 18)**	Atelvia® (*risedronate delayed release*) tablet 35mg
Pamidronate **(Note:** Pamidronate does not have an indication for osteoporosis)	Boniva® Tablet (*ibandronate*)
Zoledronic Acid (generic for Zometa®)	Calcitonin-Salmon (generic for Miacalcin®)
	Etidronate disodium
	Evista® (*raloxifene*)
	Fortical® (*calcitonin-salmon*) **(Min age= 18)**
	Fosamax® (*alendronate*)
	Fosamax oral solution® (*alendronate*)
	Ibandronate (generic for Boniva®) tablets
	Miacalcin® (*calcitonin-salmon*) **(Min age= 18)**
	Skelid® (tiludronate)
	Zometa® (zoledronic acid)

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REFERENCE INFORMATION

For most BMD tests, 1 SD difference in a T-score equals a 10-15 percent decrease in bone density. For example, a person with a T-score of -2.5 has a 10-15 percent lower BMD than a person with a T-score of -1.5.

Below are **treatment guidelines** for postmenopausal women and men age 50 or older (*National Osteoporosis Foundation*):

- Most people with T-scores of -1 and above (normal bone density) do not need to take an osteoporosis medication.
- People with T-scores between -1 and -2.5 (osteopenia) should consider taking an osteoporosis medication when they have certain risk factors.
- All people with T-scores of -2.5 and below (osteoporosis) should consider taking an osteoporosis medication.

RISK FACTORS

Age	Osteoporosis is far more common in the older age than the younger.
Sex	Osteoporosis is more common in women
Family History	History in mother or father increases likelihood
Low Body Weight	People with smaller bones are more predisposed to osteoporosis.
Race and Ethnicity	People in the US who are Caucasian or of Asian or Latino descent are more likely to develop osteoporosis.
History of Broken Bones	People who have broken one or more bones during their adult years are at greater risk for osteoporosis, In fact, they may already have low bone density or osteoporosis
Menopause	Bone loss increases after menopause, when estrogen levels drop sharply.
Low Sex Hormones	Estrogen and testosterone protect bones.
Diet	Vitamins and minerals important in bone health include calcium, vitamin D, phosphorous, magnesium, vitamin K, vitamin B6, and vitamin B12. Too much of the followings items may lower calcium levels: protein, caffeine, sodium, spinach (contains high levels of oxalate), and wheat bran.
Inactive Lifestyle	Bedridden, lack of exercise
Smoking	Smoking negatively impacts bone health in many ways: calcium absorption, alteration in estrogen effects, effect on bone cells.
Alcohol Abuse	Drinking heavily reduces bone formation, calcium supply. It also increases fall risk. Two drinks a day is usually acceptable.

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RISK FACTORS *(CONTINUED)*

Medications that may cause Bone Loss	☐ Aluminum-containing antacids ☐ Antiseizure medications (only some) such as Dilantin® or Phenobarbital ☐ Aromatase inhibitors such as Arimidex®, Aromasin®, and Femara® ☐ Cancer chemotherapeutic drugs ☐ Cyclosporine A and FK506 (Tacrolimus) ☐ Glucocorticoids such as cortisone and prednisone ☐ Gonadotropin releasing hormone (GnRH) such as Lupron® and Zoladex® ☐ Heparin ☐ Lithium ☐ Medroxyprogesterone acetate for contraception (Depo-Provera®) ☐ Methotrexate ☐ Proton pump inhibitors (PPIs) such as Nexium®, Prilosec®, and Prevacid® ☐ Selective serotonin reuptake inhibitors (SSRIs) such as Lexapro®, Prozac®, and Zoloft® ☐ Tamoxifen® (premenopausal use) ☐ Thiazolidinediones (Actos® and Avandia®) ☐ Thyroid hormones in excess
Diseases and Conditions that may cause Bone Loss	AIDS/HIV, Ankylosing spondylitis, Blood and bone marrow disorders, Breast cancer, Cushing's syndrome, Eating disorders, Emphysema, Female athlete triad, Gastrectomy, Gastrointestinal bypass procedures, Hyperparathyroidism, Hyperthyroidism, Idiopathic scoliosis, Inflammatory bowel disease, Diabetes mellitus, Kidney disease, Lupus, Lymphoma and leukemia, Malabsorption syndromes (examples are celiac disease and Crohn's disease), Multiple myeloma, Multiple sclerosis, Organ transplants, Parkinson's disease, Poor diet, Post-polio syndrome, Premature menopause, Prostate cancer, Rheumatoid arthritis, Severe liver disease (including biliary cirrhosis), Spinal cord injuries, Stroke (CVA), Thalassemia, Thyrotoxicosis, Weight loss

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BONIVA® (IBANDRONATE) INJECTION

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

PDL Criteria do NOT apply.

Initiation of Therapy:

- ☐ Documented diagnosis of osteoporosis with A DXA hip (femoral neck) or spine T-score ≤ -2.5 (dated within the past year) *(Must be confirmed in medical records.)*; **OR**
- ☐ History of a fracture of the spine or hip *(Must be confirmed in medical records.)*; **OR**
- ☐ History of T-score between -1.0 and -2.5 if FRAX (WHO Fracture Risk Assessment Tool) major osteoporotic fracture probability is ≥ 20% or hip fracture probability is 3% *(Must be confirmed in medical records.)*.

AND

- ☐ Office notes documenting an intolerance to oral bisphosphonates due to:
  - ☐ Inability to take medications by mouth; **OR**
  - ☐ Severe upper GI disease (e.g., erosive esophagitis, peptic ulcers with history of bleeding)

  OR
- ☐ Office notes documenting a treatment trial (minimum 6 months) and failure of
  - ☐ Boniva oral tablet *monthly administration* as indicated by no change from baseline BMD; **OR**
  - ☐ Failure (after a six-month trial) of the preferred oral bone resorption inhibitor *monthly administration* as indicated by no change from baseline BMD.

Continuation of Therapy (PHARMACIST REVIEW ONLY: CPhTs – Document all info available prior to escalation**):**

- ☐ Medical records must demonstrate a stable BMD (within interventional goals) or an increasing BMD after a minimum trial of one year of therapy.
  - ☐ T-score test results may date back as far as five years.
  - ☐ Depending on level of BMD progression retesting may be done from every one to five years.
  - ☐ Medical records should demonstrate improvement by providing reference to the sequential progression or stability of the BMD.

DOSING / LIMITS

- ☐ *Adults:* 3 mg IV bolus every 3 months. The IV bolus should be administered over 15—30 seconds. Do not administer more often than every 3 months. If the dose is missed, administer the dose as soon as possible and schedule future injections every 3 months from that date. Patients must receive supplemental calcium and vitamin D.
- ☐ ONE INJECTION EVERY 84 DAYS

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FORTEO® (TERIPARATIDE) INJECTION

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

INITIATION OF THERAPY

- ☐ Diagnosis of osteoporosis or osteopenia with a history of fracture of the spine or hip while on bisphosphonate therapy [Fosamax (alendronate), Boniva (ibandronate), Actonel (risedronate), Reclast (zoledronate)] – Approve without trial of Prolia.
- ☐ Documented diagnosis of osteoporosis with A DXA hip (femoral neck) or spine T-score ≤ -2.5 (dated within the past year).**-OR-**
- ☐ History of a fracture of the spine or hip. **-OR-**
- ☐ History of T-score between -1.0 and -2.5 if FRAX (WHO Fracture Risk Assessment Tool) major osteoporotic fracture probability is ≥ 20% or hip fracture probability is 3%.
- ☐ -AND-
- ☐ Trial (minimum of 12 months) and failure of Reclast (zoledronate) if the patient is not at high risk for fracture.
  - ☐ Failure may be defined as a lack of desired improvement in bone mineral density.
  - ☐ High risk may be defined as a history of osteoporotic fracture, or having multiple risk factors for fracture [see risk factor chart below]. DXA test result summaries may assist in determining risk for fracture.)

CONTINUATION OF THERAPY

- ☐ Demonstrated stable BMD (within interventional goals) or an increasing BMD after a minimum trial of one year of therapy.
  - ☐ T-score test results may date back as far as five years.
  - ☐ Depending on level of BMD progression retesting may be done from every one to five years.
  - ☐ Demonstrated improvement by providing reference to the sequential progression or stability of the BMD.

FOSAMAX D

- ☐ Do not approve requests for Fosamax D. Escalate the request to a pharmacist for review to see if the request can be redirected to alendronate.

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PROLIA® (DENOSUMAB) INJECTION

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

INITIATION OF THERAPY:

- ☐ Documented diagnosis of osteoporosis with A DXA hip (femoral neck) or spine T-score ≤ -2.5 (dated within the past year);
- ☐ No Reclast trial required

OR

- ☐ History of a fracture of the spine or hip;
- ☐ No Reclast trial required

OR

- ☐ Trial (minimum of one year) and failure of the bisphosphonate Reclast (zoledronate).
  - ☐ **NOTE:** If the Patient is unable to swallow oral bisphosphonates or unable to maintain an upright position after taking an oral bisphosphonate a trial of IV Reclast is still required.
  - ☐ Failure may be defined as intolerance (adverse reaction, contraindication . . .) to other bisphosphonates or no increase from baseline bone mineral density (BMD) (per T-score history) or recurring fractures (in the absence of major trauma) after at least 1 year of therapy.
  - ☐ If Patient has adverse reaction to other bisphosphonates, a one-year trial is not required
- ☐ AND
  - ☐ History of T-score between -1.0 and -2.5 if FRAX (WHO fracture Risk Assessment Tool) major osteoporotic fracture probability is ≥ 20% or hip fracture probability is 3%.

CONTINUATION OF THERAPY (Pharmacist Review Only: CPhTs – Document all info available prior to escalation**):**

- ☐ Demonstrated stable BMD (within interventional goals) or an increasing BMD after a minimum trial of one year of therapy.
  - ☐ T-score test results may date back as far as five years.
  - ☐ Depending on level of BMD progression retesting may be done from every one to five years.
  - ☐ Demonstrated improvement by providing reference to the sequential progression or stability of the BMD.

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RECLAST® (ZOLEDRONIC ACID) INJECTION

Length of Authorization:	Enter for one month
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

INITIATION OF THERAPY:

- ☐ Diagnosis of Paget's Disease
- ☐ AND
- ☐ Documented intolerance to oral bisphosphonates (e.g., Actonel, alendronate) due to:
  - ☐ Inability to take medications by mouth; **OR**
  - ☐ Severe upper GI disease (e.g., erosive esophagitis, peptic ulcers with history of bleeding)

OR

- ☐ Documented diagnosis of osteoporosis with A DXA hip (femoral neck) or spine T-score ≤ -2.5 (dated within the past year).
- ☐ OR
- ☐ History of a fracture of the spine or hip.
- ☐ OR
- ☐ History of T-score between -1.0 and -2.5 if FRAX (WHO Fracture Risk Assessment Tool) major osteoporotic fracture probability is ≥ 20% or hip fracture probability is 3%.

CONTINUATION OF THERAPY:

- ☐ Demonstrated stable BMD (within interventional goals) or an increasing BMD after a minimum trial of one year of therapy.
  - ☐ T-score test results may date back as far as five years.
  - ☐ Depending on level of BMD progression retesting may be done from every one to five years.
  - ☐ Demonstrated improvement by providing reference to the sequential progression or stability of the BMD.

XGEVA® (DENOSUMAB)

Length of Authorization:	Up to six months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years old.
- ☐ CONFIRMATION OF ONE OF THE FOLLOWING DIAGNOSES:
  - ☐ Bone metastases from solid tumors confirmed by progress notes or medical records.
  - ☐ Giant Cell Tumor of the bone that is unresectable or resection will likely cause severe morbidity.
  - ☐ Hypercalcemia of malignancy refractory to bisphosphonate therapy.

DOSING AND ADMINISTRATION

- ☐ **Bone metastases from solid tumors**: 120 mg every 4 weeks as a subcutaneous injection in the upper arm, upper thigh, or abdomen.
- ☐ **Giant Cell Tumor of Bone and Hypercalcemia of Malignancy:** 120 mg given subcutaneously in the upper arm, upper thigh or abdomen on days 1, 8 and 15 initially, then 120 mg subcutaneous every 4 weeks beginning on day 29.

BOTOX® (ONABOTULINUM TOXIN TYPE A)

Length of Authorization:	1 month
Initiative:	MAP: Botox (75 / 2462 – GSN; 76 / 2641 – GSN)
Fax Form:	Botox®

APPROVAL CRITERIA

1. Is the Patient receiving Botox therapy at a Shriner's Clinic-> YES.

   If no to #1, DO NOT APPROVE. Medicaid coverage is approved for children being treated by the Shriner's Clinic ONLY. Please refer to the header on the progress notes/clinical documentation submitted, prescription, fax cover sheet, etc., to confirm the origin of the request or that treatment is being administered at the Shriner's clinic.

   Refer all other requests to physician services and provide the requestor with the following information. Please use the faxback response below:

   "Medicaid coverage is approved for children being treated by the Shriner's Clinic only. Please contact physician services for further assistance. Thank you."

2. The Patient's diagnosis must be provided. Clinical documentation must be submitted to confirm the diagnosis.
3. The dosage/dosage frequency must be provided.
4. Requested date of therapy must be provided.

NOTE: If a Provider resubmits a request for Botox after a prior informational and the criteria above are not met, forward the request to an MPS pharmacist for review.

BRISDELLE® (PAROXETINE)

Length of Authorization:	Up to 12 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Must be ≥ 18 years of age.
- ☐ Must be female.
- ☐ Must have moderate to severe vasomotor symptoms associated with menopause.
- ☐ Must have a trial and failure of preferred agents with the same indication (i.e., Premarin, estradiol, etc.) or documented contraindication to preferred agents, such as current, past, or suspected breast cancer, estrogen-dependent neoplasia, genital bleeding, endometrial hyperplasia, thromboembolic disease, liver dysfunction, hypersensitivity to menopausal hormone therapy, or porphyria cutanea tarda.

BUPRENORPHINE AGENTS

Length of Authorization:	Initial: up to 6 months; Continuation of Therapy: up to 6 months. Build Approved PAs for the max per day qty for the strength approved.
Initiative:	MAP: Suboxone / Subutex (75 / 2462 – GSN; 76 / 2641 – GSN)
Fax Form:	Suboxone®/Subutex®

REVIEW CRITERIA

APPROVAL INDICATIONS FOR INITIAL THERAPY (MUST MEET ALL CRITERIA FOR APPROVAL)

1. Must be greater than or equal to 16 years of age.
2. Patient must have a confirmed diagnosis of Opioid Dependence (DSM IV-TR criteria) supported by progress notes/induction work-up or the physician's physical evaluation of the patient. Diagnosis of acute or chronic pain is not Medicaid reimbursable.
3. Prescriber must be certified through the Substance Abuse and Mental Health Services Administration (SAMHSA). Provider certification may be verified by one of the following:
4. Must provide an initial drug screen to verify the presence of opiates and other substances or an opiate clinical withdrawal scale.
5. Must be referred to a support group or mental health counselor.
6. Must document a commitment to treatment.
7. Must not have concurrent use of opioids, tramadol, carisoprodol, or illicit substances (review prescription claims history since the last approval to ensure abstinence of these medications).

For single ingredient Buprenorphine: All criteria above must be met AND one of the following:

- ☐ Patient is pregnant or nursing.
- ☐ Day 1 and 2 of induction for patients dependent on methadone or long-acting opioid products

Escalate to an RPh for clinical judgment if any of the following apply:

1. More than one strength are requested
2. Request exceeds quantity limit
3. Buprenorphine single ingredient product required due to contraindication to naloxone
4. Concurrent use with opioids
5. Clinical criteria not met

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CONTINUATION OF THERAPY (MUST MEET ALL CRITERIA FOR APPROVAL) *(CONTINUED)*

1. Must be compliant with pharmacologic therapy.
2. Must provide progress notes since last approval detailing the patient's response to treatment and progress towards goals.
3. Prescriber must address relapse if it occurred.
4. Must not have concurrent use of opioids, tramadol, carisoprodol, or illicit substances (review prescription claims history since the last approval to ensure abstinence of these medications).
5. Must provide all urine drug screen tests since last approval.
6. Must provide documentation of compliance with non-pharmacologic therapy (counseling or group therapy).

Escalate to an RPh for clinical judgment if any of the following apply:

1. More than one strength are requested
2. Request exceeds quantity limit
3. Buprenorphine single ingredient product required due to contraindication to naloxone
4. Concurrent use with opioids.
5. Clinical criteria not met
6. No paid claim for buprenorphine product appears in the last 30 days

THERAPEUTIC DUPLICATION: ALL REQUESTS MUST BE ESCALATED TO AN RPH

- ☐ The Buprenorphine product will reject with a **DUR TD** if
  - ☐ There is a claim for any opioids in the last 30 days
    OR
  - ☐ There is a claim for another buprenorphine strength in the last 30 days
- ☐ **Only the Buprenorphine prescribing physician's office can request these overrides and will be made aware of the narcotic in history.**
- ☐ Date-of-Service (DOS) approvals can be granted if ONE of the following apply:
  - ☐ The prescriber verifies knowledge of the patient's relapse and agrees to increase psychosocial counseling. Please obtain dates of planned counseling sessions. If no planned sessions, then do not approve.
    OR
  - ☐ The narcotic analgesic is being used short-term (30 days of less) for an acute injury leading to acute pain.
- ☐ Requests for two different strengths are considered therapy duplication. Pharmacist may override if total mg/day does not exceed established limits or exceed quantity limits for each specific strength.

QUANTITY LIMITATIONS

☐	Buprenorphine (generic for Subutex®)	2mg & 8mg	3/day or Max of 24mg across ALL
☐	Suboxone® (buprenorphine/naloxone)	8mg/2mg & 2mg/0.5mg	3/day or Max of 24mg across ALL
☐	Suboxone® (buprenorphine/naloxone)	4mg/1mg & 12mg/4mg	2/day or Max of 24mg across ALL

Build Approved PAs for the max per day qty for the strength approved.

COVERED DIAGNOSES

ICD-9 Code: 304.0; 304.01; 304.02; 304.03; 304.7; 304.70; 304.71; 304.72; 304.73

Diagnosis: Opioid Dependence

BUTALBITAL-CONTAINING PRODUCTS

Approval Amount:	FOR IE 7001 QUANTITY LIMIT – UP TO A MAXIMUM OF 120 TABLETS/CAPSULES OR 180 ml (for the liquid) no more frequently than every 365 days. The IE 7001 edit is coded for no more than 120 tabs/caps or 180 mls per 365 days. FOR IE 7002 QUANTITY LIMIT – RPH TO DENY FOR PLAN LIMITATIONS EXCEEDED. The IE 7002 edit is coded for no more than 240 tabs/caps or 360 mls per 365 days.
PA Entry Notes:	☐ ENTER PA USING THIS FORMULA FOR ALL APPROVABLE IE 7001 SUBMISSIONS: ☐ Quantity = 120 ☐ Day supply = 30 ☐ Approval length = One year
Initiative:	MAP: Quantity Limit: IE 7001 (76 / 7001 – GSN) **RPH REVIEW ONLY** MAP: Quantity Limit: IE 7002 (75 / 7002 – GSN) **RPH REVIEW ONLY for Denial as Plan Limitations Exceeded**

CLINICAL CRITERIA

Tensions (Muscle Contraction) Headaches: (for requests exceeding the quantity limit)

- ☐ Must have a chronic history of attacks
- ☐ Must be prescribed or recommended upon consultation with a specialist (e.g., neurologist)
- ☐ Must have had trial and failure of at least three of the four therapies in the past 365 days:
  - ☐ NSAIDs (e.g., ibuprofen, naproxen)
  - ☐ Tricyclics (e.g., amitriptyline)
  - ☐ Muscle relaxants (e.g., tizanidine)
  - ☐ Non-drug Therapies (relaxation training, cognitive behavior therapy, EMG biofeedback)

Migraine Headaches: (for requests exceeding the quantity limit)

- ☐ Must have chronic history of attacks
- ☐ Must have current (within past 30 days) treatment failure of prophylaxis therapy (e.g., metoprolol, topiramate, and amitriptyline).
- ☐ Must be prescribed or recommended upon consultation with a specialist (e.g., neurologist)
- ☐ Must have had trial and failure of at least one medication from each the classes of therapy below in the past 365 days: (the reviewer must verify that the patient was compliant and the dosage was optimized)
  - ☐ NSAIDs (e.g., ibuprofen, naproxen)
  - ☐ Triptans [e.g., Axert (almotriptan), Maxalt (rizatriptan), Imitrex (sumatriptan), Relpax (eletriptan), Treximet (sumatriptan/naproxen), Amerge (naratriptan), Frova (frovatriptan, Zomig (zolmitriptan)]

FROM THE SUMMARY OF DRUG LIMITATIONS CHART

Fioricet (butalbital, acetaminophen, caffeine) Fioricet (butalbital, acetaminophen, caffeine) with codeine Fiorinal (butalbital, aspirin, caffeine) Fiorinal (butalbital, aspirin, caffeine) with codeine	Maximum of 120 capsule/tablets per 365 days

CARBAGLU® (CARGLUMIC ACID)

Length of Authorization:	6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL INDICATIONS

- Must have a confirmed diagnosis or history of hyperammonemia due to the deficiency of the hepatic enzyme N-acetylglutamate synthase.
  - **Initiation of Therapy**: The PA reviewer must document the ammonia level in the FirstTrax℠ PA entry notes.
  - **Continuation of Therapy**: The PA reviewer must document the ammonia level in the FirstTrax℠ PA entry notes.
- Carbaglu may be administered orally or via a nasogastric tube.

CAYSTON® (AZTREONAM FOR INHALATION SOLUTION)

Length of Authorization:	Up to 1 year
Initiative:	MAP: Cayston (75 / 2462 – GSN; 76 / 2641 – GSN)

APPROVAL INDICATIONS (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

- ☐ Patient must be ≥ 7 years old
- ☐ Must have a diagnosis of Cystic Fibrosis
- ☐ Patient medication history should include an inhaled bronchodilator (e.g., Albuterol, DuoNeb, Proventil, AccuNeb, Alupent [Metaproterenol], Xopenex, Ventolin, Maxair, Serevent, Advair, Symbicort, Foradil, Perforomist, Dulera).
- ☐ Documentation (verbal or written) of resistance to tobramycin - **OR**- a need for a different antibiotic during the alternating months when the Patient is not receiving TOBI -**AND/OR**- confirmed colonization (previous history of *Pseudomonas aeruginosa* infection).
- ☐ For **Continuation of Therapy**, culture results positive for Pseudomonas aeruginosa are not required.
- ☐ The PA should be entered as a quantity of 90 with a 30-day supply. HOWEVER, the pharmacy must submit the claim with a quantity of 84 with a 28-day supply.

CENTRAL PRECOCIOUS PUBERTY PROGRAM

LUPRON DEPOT-PED®, LEUPROLIDE ACETATE, SYNAREL®

- Any request received for a CPP medication beyond the approvable age limit (2 to 12 years of age) may not be approved. Lupron Depot- Ped, leuprolide acetate, and Synarel may only be dispensed to children between the ages of 2–12.
- Technicians: Please escalate all requests received for patients < 2 years old or > 12 years old for these medications to a Pharmacist for denial.
- Pharmacists: Please enter a denial as these requests are beyond the approvable age limits. The MAP: Age Limit: Over Maximum or MAP: Age Limit: Under Minimum initiatives should be used depending on the current age of the recipient.
- Please escalate all subsequent requests to a pharmacist for further review.

SUPPRELIN LA® (HISTRELIN ACETATE)

Length of Authorization:	One implant per 12 months
Initiative:	MAP: Supprelin LA (75 / 2462 – GSN; 76 / 2641 – GSN)

APPROVAL CRITERIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

Requests may be approved only if the following criteria are met.

1. Age: Must be less than or equal to age 11 for girls or age 12 for boys, but age 2 or older for all genders.
2. Diagnosis: Must have a diagnosis of Precocious Puberty (ICD-9 259.1, ICD-10 E22.8 – Precocious sexual development and puberty, not elsewhere classified). Diagnosis should be confirmed by all of the following:
   a. Measurement of blood concentrations of total sex steroids (estrogens/testosterone)
   b. Measurement of LH and FSH after stimulation with a GnRH analog
   c. Assessment of bone vs. chronological age
3. Must be evaluated and therapy must be prescribed by a pediatric endocrinologist
4. Trial and failure of either Lupron Ped Depot or intranasal Synarel.

Please escalate all requests for appeal of a previous denial per appeal protocol.

QUANTITY LIMITATION

Maximum of 1 implant per 12 months

CEPROTIN® (PROTEIN C CONCENTRATE [HUMAN])

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Diagnosis of Protein C Deficiency

DOSING AND ADMINISTRATION:

CEPROTIN Dosing Schedule for Acute Episodes/Short-term Prophylaxis and Long-term Prophylaxis			
Initial Dose		**Subsequent 3 Doses**	**Maintenance Dose**
Acute Episode/Short-term Prophylaxis	100–120 IU/kg intravenously (IV)	60–80 IU/kg IV Q 6 hours	45–60 IU/kg IV Q 6 or Q 12 hours
Long-term Prophylaxis	NA	NA	45–60 IU/kg IV Q 12 hours

CEREZYME® (IMIGLUCERASE)

Length of Authorization:	Up to one year
Initiative:	MAP: AP: Gaucher (31008 / 75 – GSN)

APPROVAL CRITERIA

- ☐ Patient must be ≥ 2 years of age.
- ☐ Diagnosis of Gaucher Disease Type I.

AutoPA Coding:

Edit				Steps
Cerezyme Automated PA approval satisfies L=Auto PA drug edit. Automated PA approval will NOT override R=Non-PDL edit	**Drug Name**	**Drug Code**		**Step 1:** If the incoming claim is for a product from the <Gaucher's Therapy Drug List>, look back in the medical claims history 730 days for ICD9 272.7, ICD 10 Disease Group E75 (Lipidoses-Gaucher's). If found, NO PA REQUIRED. Otherwise, Deny for PRIOR AUTHORIZATION REQUIRED (75) with supplemental message "M/I Diagnosis Code)."
	Cerdelga	HICL = 041346		
	Cerezyme vial	HICL = 009022		
	Elelyso	HICL = 039837		
	Vpriv	HICL = 036874		
	Zavesca	HICL = 025098		

CHANTIX® (VARENICLINE)

Length of Authorization:	See below
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

For the FIRST 12-week course of therapy: No PA required if the following are met:

- ☐ Patient must be 18 years of age or older.
- ☐ Patient must have no claims history of Chantix within the past 760 days.

For SECOND 12-week course of therapy *immediately following 'FIRST 12 weeks':*

- ☐ Patient must be 18 years of age or older.
- ☐ The nicotine/cotinine lab test (blood or urine only) must be submitted to verify that the patient is still abstinent from smoking.

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CHANTIX PRODUCTS/PA ENTRY TABLE

Description	NDC	PA Entry
Packs		
Starting Month PAK (First month of therapy): Pack includes 1 card of 0.5 mg x 11 tablets and 3 cards of 1 mg x 14 tablets	NDC 0069-0471-97 ***Discontinued**	**#53/28 (x 1 mo)** *This NDC may be used as part of the first 12-week course only.*
Continuing Month PAK (Continuing months of therapy): Pack includes 4 cards of 1 mg x 14 tablets	NDC 0069-0469-97 ***Discontinued**	**#60/30** *This NDC may be used for the last part of the first 12-week course (x 2 months) or for 3 months to allow the second 12-week course.*
Starting Month Box: 0.5 mg x 11 tablets and 1 mg x 42 tablets	NDC 0069-0471-02	**#53/28 (x1mo)** *This NDC may be used as part of the first 12-week course only*
Continuing Month Box : 1 mg x 56 tablets	NDC 0069-0469-12	**#60/30** *This NDC may be used for the last part of the first 12-week course (x 2 months) or for 3 months to allow the second 12-week course.*
Bottles		
0.5 mg - bottle of 56	NDC 0069-0468-56	**11 tabs for 7 days for first 12-week course only** *This NDC may be used as part of the first 12-week course only*
1 mg - bottle of 56	NDC 0069-0469-56	**#60/30** *This NDC may be used for the last part of the first 12-week course (x 2 months) or for 3 months to allow the second 12-week course.*

CII-CV EDIT OVERRIDES / FILLS LIMIT

Length of Authorization:	Maximum of 30-day supply (or as per the prescription, whichever is less)
Initiative:	MAP: CII-CV Fill Limit Override (76 / 7007 – GSN)

IMPORTANT INFORMATION

In an effort to reduce doctor shopping behaviors, an edit on narcotic prescriptions defined as federal controlled substances, schedule II-V, has been installed to limit six (6) CII-CV prescriptions per month for oncology and sickle cell patients. Patients with any other condition (other than cancer or sickle cell) are limited to four (4) CII-CV prescriptions per month. This enhancement includes all medications and combinations of medications listed in federal schedules CII-CV, including but not limited to narcotic containing cough preparations, benzodiazepines, sleep agents (zolpidem and similar agents), carisoprodol, Lyrica, Suboxone, and Subutex. The edit does not only identify different medications with different names as separate prescriptions, but different strengths of the same medication are identified as separate prescriptions.

APPROVAL CRITERIA

- A denied claim can be overridden for a CANCER PATIENT with a confirmed diagnosis or chemotherapy within the past 365 days **via phone**.
  - The diagnosis may be confirmed by review of ICD-9/ICD-10 codes (within the past year) or by search for chemotherapy in claims history within the past 365 days.
    - If the above information is not found then a complete PA request (medical records, and copy of prescription) must be submitted for review.
  - Only the prescribing physician may request the override. Override requests from pharmacies may not be approved.
  - The reviewer must check claims history for more than one CII-CV prescriber.
    - If there is more than one prescriber the reviewer will communicate that to the provider requesting the override and with his/her permission approval may be granted if provider on phone, otherwise claim may be overridden with notification to the provider of "more than one CII-CV prescriber".
  - If approval is granted the provider should always be advised: "This request exceeds the limit on CII-CVs of six (6) fills per 30 days. The patient's medication regimen should be re-evaluated for appropriateness of therapy."
  - **Nursing home providers should be instructed to use the partial fill functionality. Do not override any claims denying because the provider is dispensing short-day supplies.**
- Requests for **ANY CONDITION (OTHER THAN CANCER)** will require the submission of a complete PA request (appropriate PA form, medical records, and copy of prescription) to fax number 877-614-1078.
  - Only the prescribing physician may request the override.
  - The reviewer must check claims history for more than one CII-CV prescriber. Override requests from pharmacies may not be approved.
    - If there is more than one prescriber the reviewer will deny and communicate that to the provider requesting the override.
    - If there is one prescriber and the medical records submitted indicate a need for the requested medication you may approve for a maximum of one 30 day supply and the provider should be advised: "This request exceeds the limit on CII-CVs of ***(4) or (6)*** fills per 30 days. The patient's medication regimen should be re-evaluated for appropriateness of therapy."
  - **Nursing home providers should be instructed to use the partial fill functionality. Do not override any claims denying because the provider is dispensing short-day supplies.**

CHEMET® (SUCCIMER)

Length of Authorization:	Up to 19 days
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

INITIAL CRITERIA

- ☐ Patient must be ≥12 months of age
- ☐ Patient must be diagnosed with lead poisoning by a toxicologist/ specialist with chelating agents (or in consultation with)
- ☐ Blood levels above 45 mcg/dL for children (<18) and above 70 mcg/dL for adults (18 and older) (supporting labs must be submitted with request)

CONTINUATION OF THERAPY CRITERIA CLINICAL RATIONALE FROM THE PRESCRIBER FOR CONTINUED THERAPY

- ☐ Blood levels above 45 mcg/dL (supporting labs must be submitted with request)

DOSING AND ADMINISTRATION

- ☐ Children (≥ 12 months-< 18 years of age):
- ☐ 10 mg/kg every 8 hours for 5 days, then 10 mg/kg every 12 hours for 14 days
- ☐ Adult patients (≥18 years of age or older) 10 to 30 mg/kg/day for 5 days

CHORIONIC GONADOTROPIN (PREGNYL® AND NOVAREL®)

Length of Authorization:	6 Months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be a minimum of 4 years of age.
- ☐ Patient must have a diagnosis of prepubertal cryptorchidism or hypogonadotropic hypogonadism.
- ☐ If the request is related to fertility treatments (ovulation induction) or weight loss (obesity), the request must be escalated to a pharmacist to be denied.

CIMZIA® (CERTOLIZUMAB PEGOL)

Length of Authorization:	1 Year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

CLINICAL CRITERIA

RHEUMATOID ARTHRITIS

- ☐ Patient must be 18 years of age or older; **AND**
- ☐ Patient has a documented diagnosis of moderate to severe rheumatoid arthritis; **AND**
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to one or more non-biologic- DMARDs (i.e., methotrexate, leflunomide, sulfasalazine, hydroxychoroquine) for at least 3 consecutive months; **AND**
- ☐ Patient has had an inadequate response, intolerance, or has contraindications to: Xeljanz® and Humira®

Continuation of Therapy:

- ☐ Documentation showing current patients are stable (have low RA disease activity or are in clinical remission) will be taken into consideration during the prior authorization review process regarding continuation of therapy with the same agent.

ANKYLOSING SPONDYLITIS:

- ☐ Patient is > 18 years of age; **AND**
- ☐ Patient has a documented diagnosis of ankylosing spondylitis; **AND**
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response previous therapies) with the following:
  - ☐ One or more non-steroidal anti-inflammatory drugs –NSAIDs (trial at maximum dose for at least 2-3 weeks before considering them as failures); **OR**
  - ☐ Analgesic agents (acetaminophen or codeine) if NSAIDs do not completely control the pain; **OR**
  - ☐ Sulfasalazine (if peripheral joint involvement is present)

  AND
  - ☐ Patient has had an inadequate response, intolerance, or has contraindications to Humira®

CROHN'S DISEASE

- ☐ Patient is ≥ 18 years of age; **AND**
- ☐ Patient has a documented diagnosis of moderate to severe Crohn's disease; **AND**
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient has inadequate responses, intolerance, or has contraindications to conventional therapy (clinical documentation must be submitted demonstrating response to previous therapies):
  - ☐ Budesonide, mesalamine, or corticosteroids (i.e., prednisone, methylprednisolone) **OR**
  - ☐ Non-biologic DMARDs (e.g., azathioprine, methotrexate, mercaptopurine)

  AND
  - ☐ Patient has an inadequate response, intolerance, or has contraindications to Humira®

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PSORIATIC ARTHRITIS

- ☐ Patient is > 18 years of age; **AND**
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient has active psoriatic arthritis for at least 6 months defined as:
  - ☐ > 3 swollen joints; **AND**
  - ☐ > 3 tender joints

  AND
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) with the following:
  - ☐ One or more non-steroidal anti-inflammatory drugs –NSAIDs (trial at maximum dose for at least 2-3 weeks before considering them as failures); **AND**
  - ☐ One or more non-biologic disease modifying anti-rheumatic drugs DMARDs (i.e., methotrexate, sulfasalazine, leflunomide, cyclosporine); **AND**
  - ☐ Patient has an inadequate response, intolerance, or has contraindications to Humira®

DOSING AND ADMINISTRATION

- ☐ **Rheumatoid Arthritis**

  400 mg administered by subcutaneous injection initially and at weeks 2 and 4, followed by 200 mg every other week; for maintenance dosing, 400 mg every 4 weeks can be considered
- ☐ **Ankylosing Spondylitis**

  400 mg (given as 2 subcutaneous injections of 200 mg each) initially and at weeks 2 and 4; followed by 200 mg every other week or 400 mg every 4 weeks.
- ☐ **Crohn's Disease**

  400 mg administered by subcutaneous injection initially and at weeks 2 and 4; if response occurs, follow with 400 mg every four weeks
- ☐ **Psoriatic Arthritis**

  400 mg administered by subcutaneous injection initially and at weeks 2 and 4, followed by 200 mg every other week; for maintenance dosing, 400 mg every 4 weeks can be considered.

DOSAGE FORMS:

- ☐ **Cimzia Starter Kit**

  Kit contains three (3) sets of two (2) prefilled glass syringes of one (1) mL each containing Cimzia 200mg/mL. The kit provides sufficient drug supply for the initial three (3) induction doses at the start of treatment. A total of six (6) prefilled glass syringes containing Cimzia 200 mg/mL solution

  NOTE: Dispense quantity is 3 (three); max limit of one fill per 355 days
- ☐ **Cimzia kit for Injection:**

  Pack contains two (2) glass vials containing 200 mg each of lyophilized Cimzia for reconstitution

  NOTE: Dispense quantity is 1 (one); max limit of one fill per 25 days
- ☐ **Prefilled Syringe:**

  Contains two (2) prefilled glass syringes of one (1) mL each containing Cimzia 200 mg/mL

  NOTE: Dispense quantity is 1 (one); max limit of one fill per 25 days

CINRYZE (C1 ESTERASE INHIBITOR [HUMAN])

Length of Authorization:	1 Year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

CLINICAL CRITERIA

- ☐ Patient must be ≥9 years old
- ☐ Must have a diagnosis of Hereditary Angioedema (HAE)
- ☐ Verification of patient education on medication administration upon initiation of therapy.
- ☐ Medication must be prescribed by a specialist (e.g., allergist, immunologist . . .)

HEREDITARY ANGIOEDEMA (HAE) – AUTO PA

<table>
<tr><th>Edit</th><th>Drugs</th><th>Steps</th></tr>
<tr>
<td>Hereditary Angioedema Auto PA
Automated PA approval satisfies non-PDL edit.</td>
<td>
<table>
<tr><th colspan="3">HAE List</th></tr>
<tr><th>Generic Name</th><th>Brand Name</th><th>Drug Code</th></tr>
<tr><td>Icatibant</td><td>Firazyr</td><td>HICL = 035962</td></tr>
<tr><td rowspan="2">C1 Esterase Inhibitor</td><td>Berinert</td><td rowspan="2">HICL = 018568</td></tr>
<tr><td>Cinryze</td></tr>
<tr><td></td><td>Ruconest</td><td>HICL = 037766</td></tr>
</table>
</td>
<td>
Step 1: If incoming drug is for Firazyr, Berinert or Cinryze or Ruconest <HAE List> and prior authorization code = L, look back 365 days in the patient's health conditions for an ICD-9 = 277.6 OR an ICD-10 = D84.1 (Hereditary Angioedema) if found, NO PA REQUIRED. Otherwise, deny for PRIOR AUTHORIZATION REQUIRED NCPDP EC 75 with supplemental message: "RECEPIENT DOESN'T HAVE REQ DIAGNOSIS ON FILE."
Note: The following quantity limits apply:
<table>
<tr><th colspan="2">Quantity Limits</th></tr>
<tr><td>GSN = 064564 (Firazyr)</td><td>9 mls per 30 days</td></tr>
<tr><td>GSN = 068384 and 069123 (Berinert)</td><td>16 vials per 30 days</td></tr>
<tr><td>GSN = 040429 (Cinryze)</td><td>20 vials per 30 days</td></tr>
<tr><td>GSN = 051912 (Ruconest)</td><td>2 vials per day</td></tr>
</table>
</td>
</tr>
</table>

CLINICAL PRIOR AUTHORIZATIONS

The following require clinical prior authorizations. Please see specific pages for criteria.

****PRESCRIBERS MUST FAX THE REQUEST ON THE APPROPRIATE FORM ALONG WITH A COPY OF THE ORIGINAL RX****

Drug	Status	Handled By
Actiq INITIATIVE: MAP: ACTIQ/FENTANYL	Non-PDL (J)	MMA
Albumin INITIATIVE: MAP: ALBUMIN	Clinical PA (P)	MMA
Aranesp/Procrit INITIATIVE: MAP: HEMATOPOIETIC AGENTS	PDL (B)	MMA
Antidepressants (< 6y/o) INITIATIVE: MAP: Antidepressants: Age 0–5	Clinical PA (Q)*	MMA
Atypical Antipsychotics (< 6 y/o) INITIATIVE: MAP: Antipsychotics: Age 0–5	Clinical PA (Q)*	MMA
Atypical Antipsychotics (6 to < 18 y/o) INITIATIVE: MAP: Antipsychotics: Age 6–17	Clinical PA (Q)*	MMA
Botox INITIATIVE: MAP: Botox	PDL (V)	MMA
Cytogam INITIATIVE: MAP: Cytogam	PDL (V)	MMA
Fuzeon INITIATIVE: MAP: Fuzeon		MMA
Growth Hormone-Serostim INITIATIVE: MAP: Serostim	PDL (V)	MMA
IVIG INITIATIVE: INTRAVENOUS IMMUNE GLOBULIN	Clinical PA (P)	MMA
Neupogen/Leukine/Neulasta/Granix INITIATIVE: MAP: GRANULOCYTE CSF	PDL (B)	MMA
Panretin INITIATIVE: MAP: Panretin	Non-PDL (H)	MMA
Orfadin INITIATIVE: MAP: Orfadin	Clinical PA (Q)	MMA
OxyContin INITIATIVE: AP: OXYCONTIN	Non-PDL (J)	MMA

CONTINUED ON NEXT PAGE

CLINICAL PRIOR AUTHORIZATIONS (CONTINUED)

Drug	Status	Handled By
Proleukin INITIATIVE: MAP: Proleukin	PDL (V)	Magellan Rx Management (MRx)
Selzentry INITIATIVE: MAP: Selzentry	PDL (V)	Magellan Rx Management (MRx)
Carisoprodol/Soma INITIATIVE: MAP: CARISOPRODOL	Non-PDL (J) or (H)	Magellan Rx Management (MRx)
Suboxone/Subutex INITIATIVE: MAP: Suboxone/Subutex	Non-PDL (J)	Magellan Rx Management (MRx)
Synagis INITIATIVE: MAP: Synagis	Non-PDL (J)	Magellan Rx Management (MRx)
Targretin INITIATIVE: MAP: Orfadin	PDL (V)	Magellan Rx Management (MRx)
TOBI INITIATIVE: MAP: TOBI	Non-PDL (L)	Magellan Rx Management (MRx)
Valcyte INITIATIVE: MAP: VALCYTE	PDL (B)	Magellan Rx Management (MRx)
Vfend INITIATIVE: MAP: Vfend	Non-PDL (H)	Magellan Rx Management (MRx)

COLCRYS® (COLCHICINE)

Length of Authorization:	Maximum of 6 months
Initiative:	MAP: Quantity Limit: IE 7001 (76 / 7001 – GSN)

APPROVAL CRITERIA

- ☐ Patient must ≥ 4 years of age.
- ☐ If Patient has a diagnosis of Familial Mediterranean Fever (FMF) then approve and verify dose.
- ☐ For initiation of colchicine treatment for gout:
  - ☐ Must have trial and failure of at least 14 days of NSAID therapy (naproxen, ibuprofen, diclofenac, meloxicam, indomethacin, celecoxib) while on urate lowering therapy (allopurinol, probenecid, febuxostat); **OR**
  - ☐ Must have a history of GI bleeding or comorbidities that would not allow trial of NSAIDs.
- ☐ For continuation of colchicine treatment for gout:
  - ☐ Current history of urate lowering therapy with 100% compliance in the past three months (as per claims history)

  AND EITHER
  - ☐ Must have a current history of tophaceous gout (Nodular masses of uric acid crystals [tophi] are deposited in different soft tissue areas of the body)

    OR
  - ☐ Patient has elevated urate level (≥ 6) in the past month.

COMPOUND CLAIMS (MAXIMUM COMPOUNDING LIMIT)

Length of Authorization:	12 Months
Initiative:	

INTENT OF THIS EDIT (EFFECTIVE 5-1-16; PRODUCTION 5-25-16)

To place a maximum total paid amount of $300.00 on compounds excluding compounds that include Synagis and IVIG products. This edit will help to ensure commercially available products are used first line when clinically appropriate.

GENERAL COMPOUND CLAIM INFORMATION

See the QC

APPROVAL CRITERIA

- ☐ Similar commercially available product is not available*;

  ***COMPOUNDED PRODUCTS:** Exception can be made based on cost if FDA approved generically equivalent main ingredient is available in the market and is less costly than the commercially available product (e.g., 17 alphahydroxyprogesterone vs. Makena). Compounded drug(s) meeting this exception is (are) brought to the P&T committee for review and approval for clinical and safety considerations within 6 months.*

  AND
- ☐ The requested drug component is not an excluded medication; **AND**
- ☐ One of the following:
  - ☐ Requested drug component is FDA-approved for the condition being treated; **OR**
  - ☐ If requested for an off-label indication, the off-label guideline approval criteria have been met; **AND**
- ☐ If a drug included in the compound requires prior authorization, all prior a uthorization criteria must also be met; **AND**
- ☐ If chemical entity is no longer available commercially it must not have been withdrawn for safety reasons; **AND**
- ☐ One of the following:
  - ☐ A unique vehicle is required for topically administered compounds; **OR**
  - ☐ A unique dosage form is required for a commercially available product due to patient's age, weight or inability to take a solid dosage form.

  AND
- ☐ Coverage for compounds and bulk powders will NOT be approved for any of the following:
  - ☐ Requested compound contains any of the following ingredients which are available as over-the-counter products:

Cetyl Myristoleate	Lipoic acid	Ascorbic Acid
Coenzyme Q10	Beta Glucan	Melatonin
Methylcobalamin	Ubiquinol	Pyridoxal-5-Phosphate
Hyaluronic Acid	Chrysin	(Vitamin B6)
Nicotinamide	Glutathione	Loperamide
Methyltetrahydrofolate	Lactobacillus	
Ibuprofen	Vitamin E	

OR

CONTINUED ON NEXT PAGE

COMPOUND CLAIMS (MAXIMUM COMPOUNDING LIMIT) (CONTINUED)

- ☐ For topical compound preparations (e.g. creams, ointments, lotions or gels to be applied to the skin for transdermal, transcutaneous or any other topical route), requested compound contains any FDA approved ingredient that is not FDA approved or has no off-label support (per off-label guideline criteria) for TOPICAL use, including but NOT LIMITED TO the following:

Ketamine	Morphine	Pentoxifylline
Diclofenac	Nabumetone	Orphenadrine
Bupivacaine	Oxycodone	Piroxicam
Clonidine	Cyclobenzaprine	Levocetirizine
Gabapentin	Baclofen	Amantadine
Flurbiprofen (topical ophthalmic use not included)	Tramadol	Oxytocin
	Hydrocodone	Sumatriptan
	Meloxicam	Chorionic gonadotropin (human)
Ketoprofen	Amitriptyline	

OR

- ☐ Requested compound contains topical fluticasone. Topical fluticasone will NOT be approved unless:
  1. Topical fluticasone is intended to treat a dermatologic condition. AND
  2. Patient has a contraindication to all commercially available topically fluticasone formulations

OR

- ☐ Requested compound contains any of the following ingredients which are for cosmetic use:

Hydroquinone	PracaSil TM-Plus	PCCA Spira-Wash
Acetyl hexapeptide-8	Chrysaderm Day Cream	Lipopen Ultra
Tocopheryl Acid Succinate	Chrysaderm Night Cream	Versapro

CONTINUATION OF THERAPY

PREFERRED DRUG LIST FORMULARY CHANGES

Drug changes from PDL status to Non-PDL status

- ☐ Recipient is required to try the PDL medication
- ☐ Change in Therapy (CIT) messaging is faxed back to the Provider

NON-PDL CONTINUATION OF THERAPY REQUESTS

1. Recipient with request for continuation of therapy outside of plan limits – deny with notice of limit.
2. Recipient with history of trial of Non-PDL samples – refer request to trial of preferred agents.
3. Recipient is new to Medicaid (this includes HMO, outside/other coverage, and Medicare recipients) refer request to trial of a preferred agents. **Be sure to apply Continuity of Care protocol for the first 60 days of enrollment.**
4. Recipient has previously been approved by "Medicaid Fee for Service" for the medication requested: Escalate to a Pharmacist for review
   - ☐ Non-PDL request for a medication with written criteria must meet all criteria ***except*** trial/failure within the last 365 days and
     1) Requires review of the clinical notes entered with the last PA approval
        a. If medication was approved for acute therapy, then require CIT for PDL trial/failure requirement
        b. If medication was approved for chronic therapy, an approval for continuation of therapy may be considered after the review is completed to include the requirements below:
           i. Review of the Medicaid claims history to determine compliance as appropriate for the medication prescribed - (For example if the medication is a maintenance medication one would expect to see regularly filled claims. However, if the medication is scheduled for "as needed" administration use may be consistent, but not every month.)
           ii. Review for status of condition for which the medication is requested - (Does the condition still require continuation of this treatment? Has the recipient's status changed to the point that a PDL alternative would be just as effective?)
           iii. Review for medication tolerance
     2) Review for medication effectiveness
        a. Verify that Recipient is responding clinically to current dose
        b. If increase in dose is requested, review progress notes and/or labs submitted to support the rationale for increase.

CONTINUED ON NEXT PAGE

NON-PDL CONTINUATION OF THERAPY REQUESTS *(CONTINUED)*

- **Non-PDL request for a medication with no written criteria *requires Pharmacist review for current clinical status***
  1) Requires review of the clinical notes entered with the last PA approval
     a. If medication was approved for acute therapy, then require CIT for PDL trial/failure requirement
     b. If medication was approved for chronic therapy, an approval for continuation of therapy may be considered after the review is completed to include the requirements below:
  2) Review of the claims history to determine compliance as appropriate for the medication prescribed - (For example if the medication is a maintenance medication one would expect to see regularly filled claims. However, if the medication is scheduled for "as needed" administration use may be consistent, but not every month.)
  3) Review for status of condition for which the medication is requested - (Does the condition still require continuation of this treatment? Has the recipient's status changed to the point that a PDL alternative would be just as effective?)
  4) Review for medication tolerance
  5) Review for medication effectiveness
     a. Verify that recipient is responding clinically to current dose
     b. If increase in dose is requested, review progress notes and/or labs submitted to support the rationale for increase

CORIFACT® (FACTOR VIII CONCENTRATE HUMAN)

Length of Authorization:	Up to one year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

 Must have a diagnosis of Congenital Factor XIII deficiency.

COSENTYX® (SECUKINUMAB)

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA (ALL OF THE FOLLOWING MUST BE MET)

PLAQUE PSORIASIS

- ☐ Patient must be 18 years of age or older; **AND**
- ☐ Patient has documented diagnosis of moderate to severe plaque psoriasis for at least 6 months with at least one of the following:
  - ☐ Incapacitation due to plaque location (e.g., head and neck, palms, soles, or genitalia); **OR**
  - ☐ Involvement of at least 10 percent of body surface area (BSA);**OR**
  - ☐ Psoriasis Area and Severity Index (PASI) score of 12 or greater;

  AND
- ☐ Patient is free of any clinically important active infections; **AND**
- ☐ Patient has a negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient did not respond adequately (or is not a candidate) to a 3-month minimum trial of at least 1 systemic agent (e.g., immunosuppressives, retinoic acid derivatives, and/or methotrexate); **AND**
- ☐ Patient did not respond adequately (or is not a candidate) to a 3 month minimum trial of phototherapy
- ☐ (e.g., Psoralens with UVA light (PUVA) OR UVB with coal tar or dithranol; **AND**
- ☐ Patient has had a 3 month minimum trial and failure (inadequate response or intolerance), to Humira®

PSORIATIC ARTHRITIS

- ☐ Patient must be 18 years of age or older
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided
- ☐ Patient has active psoriatic arthritis for at least 6 months defined as
  - ☐ > 3 swollen joints; **AND**
  - ☐ > 3 tender joints; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response previous therapies) with the following:
  - ☐ One or more non-steroidal anti-inflammatory drugs – NSAIDs (trial at maximum dose for at least 2–3 weeks before considering them as failures); **AND**
  - ☐ One or more non-biologic disease modifying anti-rheumatic drugs DMARDs (i.e., methotrexate, sulfasalazine, leflunomide, cyclosporine); **AND**
  - ☐ Trial and failure of preferred alternative Humira®

ANKYLOSING SPONDYLITIS

- ☐ Patient is > 18 years of age; **AND**
- ☐ Patient has a documented diagnosis of ankylosing spondylitis; **AND**
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response previous therapies) with the following:
  - ☐ One or more non-steroidal anti-inflammatory drugs –NSAIDs (trial at maximum dose for at least 2-3 weeks before considering them as failures); **OR**
  - ☐ Analgesic agents (acetaminophen or codeine) if NSAIDs do not completely control the pain; **OR**
  - ☐ Sulfasalazine (if peripheral joint involvement is present)

  AND
  - ☐ Patient has had an inadequate response, intolerance, or has contraindications to Humira®

CUBICIN® (DAPTOMYCIN)

Length of Authorization:	Complicated skin and skin structure infections (cSSSI): Max length of therapy – 14 days Staphylococcus aureus bacteremia: Max length of therapy – 6 weeks
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

INITIAL REVIEW CRITERIA (ALL OF THE FOLLOWING MUST BE TRUE):

- ☐ Patient must be ≥18 years old **AND**
- ☐ Patient has been diagnosed with
  - ☐ Complicated skin and skin structure infection (cSSSI) caused by susceptible isolates of the following gram-positive bacteria:
    - ☐ *Staphylococcus aureus* (including methicillin-resistant isolates), **OR**
    - ☐ *Streptococcus pyogenes,* **OR**
    - ☐ *Streptococcus agalactiae,* **OR**
    - ☐ *Streptococcus dysgalactiae* subsp. *equisimilis,* **OR**
    - ☐ *Enterococcus faecalis* (vancomycin-susceptible isolates only)

  OR

  - ☐ *Staphylococcus aureus* bloodstream infection (bacteremia), including those with right-sided infective endocarditis, caused by methicillin-susceptible and methicillin-resistant isolates

AND

- ☐ Patient must have medical documentation of trial and failure of vancomycin for the current active infection or a culture and sensitivity report indicating the organism is resistant to vancomycin or the patient has a documented intolerance to vancomycin.

DOSING AND ADMINISTRATION

- ☐ Administration Duration: Administer intravenously by injection over a 2-minute period or by infusion over a 30-minute period.
- ☐ For cSSSI: Cubicin 4mg/kg administered intravenously in 0.9% sodium chloride once every 24 hours for 7 to 14 days
- ☐ For Staphylococcus aureus bacteremia: Cubicin 6mg/kg administered intravenously in 0.9% sodium chloride once every 24 hours for 2 to 6 weeks
- ☐ Dosage Form: 500 mg lyophilized powder for reconstitution in a single-use vial

CYANOCOBALAMIN® (VITAMIN B-12 INJECTIONS)

Length of Authorization:	Maximum length of approval of is one year.
Initiative:	MAP: Cert Code Bypass (EU / 50167 – GSN; 75 / 2462 – GSN; 76 /2541 – GSN)

NOTES

- Medicaid reimburses cyanocobalamin at the point-of-sale (without prior authorization) for dialysis patients only. However, if the Patient has a diagnosis of pernicious anemia a prior authorization request may be approved.

APPROVAL CRITERIA

- Confirmed diagnosis of Pernicious Anemia

CYRAMZA™ (RAMUCIRUMAB)

Length of Authorization:	Up to three months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years old

AND

- ☐ Patient must have a confirmed diagnosis of
  - ☐ Advanced or metastatic gastric cancer or gastroesophageal junction adenocarcinoma; **AND**
  - ☐ Must have had progressive disease

    OR
  - ☐ Must have been intolerant to first line therapy. First line therapy must have been:
    - ☐ A Fluoropyrimidine (e.g., 5-fluorouracil) based regimen

      OR
    - ☐ A platinum (e.g., Cisplatin, Carboplatin) based regimen.

  OR

- ☐ Metastatic non-small cell lung cancer (NSCLC)
  - ☐ Must have had disease progression on or after platinum (e.g., Cisplatin, carboplatin) based therapy.
  - ☐ NSCLC patients with epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic mutations must have had progressive disease on appropriate targeted therapy (ex. Erlotinib, Crizotinib).

CONTINUATION OF THERAPY

- ☐ Patient must have no evidence of disease progression while receiving ramucirumab
- ☐ Patient must not have intolerable toxicity such as severe bleeding, uncontrollable hypertension, or proteinuria of greater than 3 grams/24 hours, or any other severe adverse event related to ramucirumab.

CYSTADANE® (BETAINE ANHYDROUS FOR ORAL SOLUTION)

Length of Authorization:	Up to one year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Must have confirmed history of homocystinuria.
- ☐ Labs must be submitted indicating either elevated plasma homocysteine levels for initiation of therapy or normal to reduced levels for continuation of therapy.

CYTOGAM® (CYTOMEGALOVIRUS IMMUNE GLOBULIN INTRAVENOUS [HUMAN])

Length of Authorization:	Maximum length of therapy is 16 weeks.
Initiative:	MAP: Cytogam (75 / 2462 – GSN; 76 / 2641 – GSN)
Fax Form:	Cytogam®

REVIEW CRITERIA

Diagnosis of active cytomegalovirus disease associated with transplantation of the kidney, lung, pancreas, or heart.

Transplant organ must come from a cytomegalovirus seropositive donor to a cytomegalics seronegative recipient.

Questions below correspond to the numbering on the Cytogam® fax form.

- ☐ Questions 1:
  - ☐ Indicate which transplant organ the recipient received.
- ☐ Question 2:
  - ☐ Did the transplant organ come from a cytomegalics seropositive donor?
  - ☐ Only acceptable answer is "Yes."
- ☐ Question 3:
  - ☐ Was the recipient at the time of the transplant a cytomegalics seronegative recipient?
  - ☐ Only acceptable answer is "Yes."
- ☐ Question 4:
  - ☐ What was the date of the transplant?
- ☐ Question 5:
  - ☐ What is the patient's weight?
- ☐ Question 6:
  - ☐ What is the date range of therapy?
    Begin Date: _____ End Date: _____
- ☐ Question 7:
  - ☐ What will be the dosage and frequency of dosing?
  - ☐ Any request that falls outside of the above-mentioned indications should be forwarded to a pharmacist for review

DAKLINZA® (DACLATASVIR)

Length of Authorization:	☐ 12 Weeks
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)
Fax Form:	Hepatitis C Agents **[REQUIRED]**

FOR GENOTYPE 1 NEW THERAPY REQUESTS, RESUBMIT FOR PREFERRED VIEKIRA PAK [EXCEPT THOSE WITH DECOMPENSATED CIRRHOSIS (CHILD PUGH B/C])

REVIEW CRITERIA (RPH ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

1. Adult patient age ≥ 18 years old; **AND**
2. Prescribed by or in consultation with a hepatologist, gastroenterologist, infectious disease specialist, or transplant physician; **AND**
3. Patient has no history of daclatasvir (no claims history or reference in medical records to previous trial and failure of this medication) [Refer to **Appendix G** for additional information when reviewing for previous therapy]; **AND**
4. **One of the following:**
   - ☐ Patient has abstained from the use of illicit drugs and alcohol for a minimum of one month as evidenced by negative urine or blood confirmation tests collected within the past 30 days, prior to initiation of therapy (results must be submitted with request);
     - ☐ If the test result submitted is positive the reviewer must review claims history or medical records to determine if medications are prescribed. If so, proceed to next step (#5).

   OR
   - ☐ Patient is receiving substance or alcohol abuse counseling services or seeing an addiction specialist as an adjunct to HCV treatment and it is documented in the medical records; **AND**
5. Baseline HCV RNA must be submitted with a collection date within the past three months. Prescriber must submit lab documentation indicating HCV genotype and quantitative viral load; **AND**
6. Patient meets the diagnosis criteria outlined in Dosing and Administration below; **AND**
7. Patient commits to the documented planned course of treatment including anticipated blood tests and visits, during and after treatment; **AND**
8. Lab results (HCV RNA) are recommended after 4 weeks of therapy and at 12 weeks following completion of therapy. The medication should not be discontinued or interrupted if HCV RNA levels are not available during treatment or are not performed
9. Females of childbearing potential must have a negative pregnancy test collected within 30 days prior to the initiation of therapy with ribavirin; **AND**
10. **No early refills will be allowed due to lost, stolen medications, or vacation override.**
11. For HIV-1 co-infected patients, patients must have the following:
    - ☐ Documented HIV-1 diagnosis, **AND**
    - ☐ CD4 count greater than 500 cells/mm3, if patient is not taking antiretroviral therapy; **OR**
    - ☐ CD4 count greater than 200 cells/mm3, if patient is virologically suppressed (e.g., HIV RNA < 200 copies/mL)

DOSING AND ADMINISTRATION

Dose: 60mg daily, with or without food, taken with sofosbuvir. Reduce the dose to 30mg daily for strong CYP3A inhibitors and increase the dose to 90mg daily for moderate CYP3A inducers.

CONTINUED ON NEXT PAGE

DAKLINZA® (DACLATASVIR) (CONTINUED)

DOSING AND ADMINISTRATION

DIAGNOSIS: **1. HCV** **2. HCV/HIV-1 Co-Infection**	**Genotype 1 (without cirrhosis)**
THERAPY: DAKLINZA + SOVALDI	
Length of Authorization: ☐ 12 Weeks	

DIAGNOSIS: **1. HCV** **2. HCV/HIV-1 Co-Infection**	**Genotype 1 (with Child-Pugh A compensated cirrhosis)**
THERAPY: DAKLINZA + SOVALDI	
Length of Authorization: ☐ 12 Weeks	

DIAGNOSIS: **1. HCV** **2. HCV/HIV-1 Co-Infection**	**Genotype 1 (with Child-Pugh B or C decompensated cirrhosis)**
THERAPY: DAKLINZA + SOVALDI + RIBAVIRIN	
Length of Authorization: ☐ 12 Weeks	

DIAGNOSIS: **1. HCV** **2. HCV/HIV-1 Co-Infection**	**Genotype 1 or 3 (post liver transplant)**
THERAPY: DAKLINZA + SOVALDI + RIBAVIRIN	
Length of Authorization: ☐ 12 Weeks	

DIAGNOSIS: **1. HCV** **2. HCV/HIV-1 Co-Infection**	**Genotype 3 (without cirrhosis)**
THERAPY: DAKLINZA + SOVALDI	
Length of Authorization: ☐ 12 Weeks	

DIAGNOSIS: **1. HCV** **2. HCV/HIV-1 Co-Infection**	**Genotype 3 (with Child-Pugh A compensated cirrhosis or Child-Pugh B or C decompensated cirrhosis)**
THERAPY: DAKLINZA + SOVALDI + RIBAVIRIN	
Length of Authorization: ☐ 12 Weeks	

DENIAL CRITERIA

HCV – Genotype 2, 4, 5 or 6
THERAPY REFERRAL: OTHER HEPATITIS C AGENTS

DALVANCE® (DALBAVANCIN)

Length of Authorization:	Two weeks
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥18 years old **AND**
- ☐ Patient has been diagnosed with a bacterial skin/skin structure infection likely due to a gram-positive organism (examples include cellulitis, wound abscess). Dalvance is not indicated for use in other sites of infection such as urinary tract infections or pneumonia.
- ☐ Patient must have medical documentation of trial and failure of vancomycin for the current active infection or a culture and sensitivity report indicating the gram-positive organism is resistant to vancomycin.

DOSING AND ADMINISTRATION

- Single Dose Regimen: 1500mg IV over 30 minutes
- Two Dose Regimen: 1000 mg IV one time then 500 mg IV one week later.

DOSAGE FORM

- 500 mg powder for injection

DARAPRIM® (PYRIMETHAMINE)

Length of Authorization:	Initial: 2 months Continuation of therapy: up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

INITIAL CRITERIA

MALARIA PROPHYLAXIS

- ☐ Although FDA-approved for the prophylaxis of malaria, the United States Centers for Disease Control and Prevention (CDC) does NOT recommend the use of Pyrimethamine for this indication.
  http://wwwnc.cdc.gov/travel/yellowbook/2016/infectiousdiseases-related-to- travel/malaria#4904
- ☐ Trial and failure of preferred agents (i.e. hydroxychloroquine sulfate, primaquine and mefloquine)

MALARIA TREATMENT

- ☐ Although FDA-approved for the treatment of malaria, the CDC does NOT recommend pyrimethamine for the treatment of malaria.
  http://www.cdc.gov/malaria/resources/pdf/treatmenttable.pdf
- ☐ Trial and failure of preferred agents (i.e. hydroxychloroquine sulfate, primaquine and mefloquine)

TOXOPLASMOSIS-PRIMARY PROPHYLAXIS:

- ☐ Patient must have a diagnosis of HIV/AIDS **AND**
- ☐ Patient must have a CD4 count <100 cells/microL **AND**
- ☐ Patient must test positive for Toxoplasmosis gondii IgG antibodies **AND**
- ☐ Intolerance to recommended first line agent TMP-SMX (trimethoprim- sulfamethoxazole); description of specific intolerance to TMP-SMX must be documented in progress notes **AND**
- ☐ Documentation stating why atovaquone 1500 mg once daily is not acceptable for primary prophylaxis

TOXOPLASMOSIS-AIDS ASSOCIATED-CNS

- ☐ Diagnosis made by an infectious disease specialist, neurologist or HIV specialist **AND**
- ☐ Patient with a diagnosis of HIV/AIDS must have a CD4 count <100 cells/microL **AND**
- ☐ Clinical syndrome of headache, fever and neurological symptoms must be present **AND**
- ☐ Submission of positive serum testing for Toxoplasmosis gondii IgG antibodies (not always present) **AND**
- ☐ Brain imaging (CT or MRI) demonstrating typical radiographic ring-enhancing lesions **AND**
- ☐ If patient is not already receiving antiretroviral treatment; orders to start antiretroviral treatment within at least two-three weeks of toxoplasmosis diagnosis

TOXOPLASMOSIS-AIDS RELATED-CHRONIC MAINTENANCE THERAPY

- ☐ Patient has completed six weeks of active treatment for AIDS-related toxoplasmosis **AND**
- ☐ CT scan or MRI documents improvement in the ring-enhancing lesions prior to initiating maintenance therapy **AND**
- ☐ Patient has documented improvement in clinical symptoms documented in physical exam **AND**
- ☐ Documentation that explains why a non-pyrimethamine based therapy is an inappropriate choice

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DARAPRIM® (PYRIMETHAMINE)

PREVENTION AND TREATMENT OF OPPORTUNISTIC INFECTIONS AMONG HIV-EXPOSED AND HIV-INFECTED CHILDREN

- ☐ Primary Prophylaxis in children with intolerance to first line SMZ-TMP:
- ☐ Pyrimethamine 1 mg/kg (maximum 25 mg) by mouth once daily plus either dapsone and leucovorin
- ☐ Secondary Prophylaxis:
- ☐ Pyrimethamine 1mg/kg or 15mg/m^2 (maximum 25mg) by mouth once daily plus sulfadiazine and leucovorin
- ☐ Treatment: Pyrimethamine 2 mg/kg (maximum 50 mg) by mouth once daily for 2–3 days, then 1 mg/kg (maximum 25 mg) by mouth once daily with leucovorin and sulfadiazine for up to 12 months

TOXOPLASMOSIS-NON-AIDS RELATED: DIAGNOSIS BY AN INFECTIOUS DISEASE SPECIALIST

CONTINUATION OF THERAPY

TOXOPLASMOSIS-PRIMARY PROPHYLAXIS:

- ☐ Compliance to prescribed medication
- ☐ Submit current CD4 counts. Once CD4 count >200 cells/microL for at least 3 months, discontinue.
- ☐ Restart primary prophylaxis if CD4 count <200 cells/microL

TOXOPLASMOSIS-AIDS ASSOCIATED-CNS

- ☐ Compliance to prescribed medication
- ☐ Improvement on brain imaging (CT or MRI)
- ☐ Improvement of clinical symptoms

TOXOPLASMOSIS-AIDS-RELATED CHRONIC MAINTENANCE THERAPY

- ☐ Patient has a detectable HIV viral load AND
- ☐ Patient has a CD4 count ≤ 200 cells/microL AND
- ☐ Patient is compliant with antiretroviral treatment regimen
- ☐ Discontinue chronic maintenance therapy when patient has no signs or symptoms of toxoplasmosis infection and CD4 count > 200 cells/microL for greater than six months while receiving an antiretroviral treatment regimen

DOSING AND ADMINISTRATION

- ☐ Malaria Prophylaxis: 25mg PO once a wk. Continue for 10 wks after exposure only for chloroquine resistant areas.
- ☐ Malaria Treatment: monotherapy-50mg by mouth once daily for 2 days, followed by prophylaxis therapy; combination therapy-25mg by mouth once daily for 2 days followed by prophylaxis therapy
- ☐ Toxoplasmosis-Primary Prophylaxis:
  - ☐ Pyrimethamine 50mg once a week with leucovorin (25mg once weekly) and dapsone (50mg once daily) **OR**
  - ☐ Pyrimethamine 75mg once a week with leucovorin (25mg once weekly) and dapsone (200mg once weekly) **OR**,
  - ☐ Pyrimethamine 25mg once daily with leucovorin (10mg once daily) and atovaquone (1500mg once daily)
- ☐ Toxoplasmosis-AIDS-related CNS:
  - ☐ 200mg by mouth for one dose, then
  - ☐ If less than 60kg: pyrimethamine 50 mg daily by mouth with sulfadiazine 1,000 mg every six hours and leucovorin 10 mg-50 mg once daily
  - ☐ If 60kg or greater: pyrimethamine 75 mg daily by mouth with sulfadiazine 1,500 mg every six hours and leucovorin 10mg -50 mg once daily
  - ☐ Treatment should be given daily for six weeks. If incomplete response at six weeks or clinical or radiological disease is extensive duration may be longer.

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DOSING AND ADMINISTRATION *(CONTINUED)*

- Toxoplasmosis-AIDS related-Chronic Maintenance Therapy
  - Pyrimethamine 25 mg–50 mg once daily with sulfadiazine 2,000 mg to 4,000 mg per day (divided in two to four doses) plus leucovorin 10 mg to 25 mg once daily
- Toxoplasmosis-non-AIDS related
  - Pyrimethamine 50mg–75mg by mouth once daily with sulfadiazine 1,000 mg to 4,000mg daily for one to three weeks then reduce dose for each drug by about one-half and continue for an additional four to five weeks
- Availability:
  - 25 mg tablets

DIASTAT® (DIAZEPAM RECTAL GEL) – AGES 19 YEARS AND ABOVE

Length of Authorization:	Up to one year (refer to criteria below)
Initiative:	☐ MAP: Diastat (60 / 2194 – GSN; 60 / 2624 – GSN) ☐ Diastat is preferred for ages < 19 years ☐ Quantity limit: 2 kits. Quantity limit override requests must be redirected to a pharmacist for review.

APPROVAL CRITERIA

*****Do not approve any request for the generic Diazepam AcuDial*****

- ☐ Must have documentation from physician indicating the intermittent use (as opposed to chronic use) of Diastat to control bouts of increased seizure activity
- ☐ Approved in cases of Febrile Seizures or Breakthrough Seizures:
  - ☐ Febrile Seizures
    - ☐ May approve two boxes a month for up to 3 months
  - ☐ Breakthrough Seizures (while on Antiepileptic maintenance therapy)
    - ☐ May approve two boxes a month for 12 months

NOTE

1 Box = 2 rectal gels (that second gel or device may be used 4–12 hours after the initial dose if needed).

DIBENZYLINE® (PHENOXYBENZAMINE)

Length of Authorization:	1 Year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Must have a diagnosis of a pheochromocytoma

DIFICID® (FIDAXOMICIN)

Length of Authorization:	Date of Service [3-day date range to allow time for the pharmacy to submit the claim]
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Patient must be ≥18 years old
- ☐ Must have a diagnosis of Clostridium difficile-associated diarrhea
- ☐ Must have trial and failure of metronidazole or vancomycin within the prescribed dosage range and length of therapy below:
  - ☐ Metronidazole (Flagyl): 250–500 mg orally/intravenously every 6–8 hours for 10–14 days
  - ☐ Vancomycin HCl (Vancocin): 250–500 mg orally four times daily for 10 days (Note: Vancomycin is not effective for this condition when given IV)

DRUG-TO-GENDER OVERRIDES (ESTROGENS IN MALE GENDER)

Length of Authorization:	6 to 12 months
Initiative:	MAP: Drug to Gender (61 / 2192 – GSN; 61 / 50069 – GSN; 88 / SX – GSN)

APPROVAL CRITERIA

- ☐ Request is to control deviant behavior in male sex offenders; **AND**
- ☐ Recipient is residing in any facility or group home

DENIAL CRITERIA

- ☐ Diagnosis is Gender identity disorder (GID) or gender dysphoria
- ☐ Requests are often seen for recipients undergoing transgender surgeries

EARLY REFILL

Length of Authorization:	Date of Service (3 days)
Initiative:	ADM: Early Refill (88 / ER – GSN)
PA Reason Code	Date of Service PA Approved

- **General Refill Tolerances**
  - Non-controlled: 80% (MCC-FL and CCP/SFCCN)
  - Controlled: 90% (CCP/SFCCN); 80% (MCC-FL)

APPROVAL CRITERIA

1. **Increase in Dosage (CPhTs may process these for all plans):** Approve EXCEPT for the following two scenarios.
   - **Prior Authorization Code = R – Non-PDL:** even if there is an active PA on file for the non-PDL drug, a new request (call or fax) documenting the new dosage must come from the prescriber.
   - **Atypical antipsychotic medications for patients < 18 years old or antidepressants for patients < 6 years old:** even if there is an active PA on file for the drug, a new request (call or fax) documenting the new dosage must come from the prescriber.
2. **Lost, Stolen, Destroyed, Vacation (CPhTs may process these for FCA and MCC-FL; RPh required for CCP/SFCCN: CPhTs are to confirm that the request meets the following and are to document all relevant info available before escalating the request.):**
   - Approve once per rolling 12 months for the same GSN.
   - Days' supply not to exceed 100.
   - Please try to provide some detail for each override approval. However, at this time there are no specific requirements for what to include.
3. **LTC and Foster Care Services:**
   - **Backdating is not a limiting factor for LTC and Foster Care pharmacy billing**
   - **Please approve for the following circumstances:**
     - If the medication is a controlled substance, cream, injectable, MDI, etc.
     - That move from a residential home to a foster care home
     - Physician or social worker must provide documentation of child's placement if they have moved from one foster care home to another.
     - Entering a LTC facility from the community setting.
     - Returning to the community setting from the LTC facility
     - Moving from one LTC facility to another LTC facility and the medication is a controlled substance, cream, injectable, MDI, etc., whether the pharmacy is the same as the previous fill or not.
   - **Please *do not* approve for the following circumstances:**
     - That move from one LTC to another LTC facility and the medication *is not* a controlled substance, cream, injectable, or MDI. The previous pharmacy must partial return the unused quantity which will allow the current pharmacy to bill the medication
     - Request for dosage decrease and the medication is not a controlled substance, cream, injectable, or MDI. The previous pharmacy must partial return the unused quantity which will allow the currently pharmacy to bill the medication.

   FORWARD ALL OTHER REQUESTS TO a pharmacist for review and potential denial; document all relevant info available before escalating the request.

ELAPRASE® (IDURSULFASE)

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Patient must be ≥ 5 years of age
- ☐ Must have a documented diagnosis of Hunter Syndrome or Mucopolysaccharidosis (MPS) II.

ELECTROLYTE DEPLETERS

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

1. Is there any reason that the Patient cannot be switched to preferred medications? **Document clinically compelling details.** Acceptable reasons include
   - ☐ Allergy to all preferred medications
   - ☐ Contraindication to all preferred medications
   - ☐ History of unacceptable side effects
   - ☐ Patient is clinically unstable and switching would cause a deterioration in condition
2. The requested medication may be approved if **both** of the following are true:
   - ☐ If there has been a therapeutic failure to no less than a 60-day trial of TWO preferred medications; **AND**
   - ☐ The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Calcium Acetate 667mg Cap, Gelcap, Tab	Renvela® 400mg & 800mg Tab (sevelamer)
Calcium Acetate 668mg Tab	
Renagel® 400mg & 800mg Tab (sevelamer)	
Renvela® 0.8gm & 2.4gm Powder Packet (max age 11 yrs)	
Sodium Polystyrene Sulfonate 15gm/60ml	
SPS 15gm/60ml Susp (sodium polystyrene sulfonate)	
SPS 30gm/120ml & 50gm/200ml Enema	

ELELYSO® (TALIGLUCERASE ALFA)

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Patient must be ≥ 4 years of age.
- ☐ Must have a documented diagnosis of Gaucher Disease Type I.

QUANTITY LIMIT

Maximum of 82 vials every 28 days.

ELMIRON® (PENTOSAN)

Length of Authorization:	Up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Must provide diagnosis for **interstitial cystitis (IC)**.

ENBREL® (ETANERCEPT)

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

RHEUMATOID ARTHRITIS

- ☐ Patient must be 18 years of age or older
- ☐ Patient has a documented diagnosis of moderate to severe rheumatoid arthritis
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to one or more non-biologic- DMARDs (i.e., methotrexate, sulfasalazine, hydroxychoroquine) for at least 3 consecutive months; **AND**
- ☐ Patient has had an inadequate response, intolerance, or has contraindications to: Xeljanz® and Humira®

CONTINUATION OF THERAPY:

- ☐ Documentation showing current patients are stable (have low RA disease activity or are in clinical remission) will be taken into consideration during the prior authorization review process regarding continuation of therapy with the same agent.

ANKYLOSING SPONDYLITIS

- ☐ Patient must be 18 years of age or older
- ☐ Patient has a documented diagnosis of ankylosing spondylitis
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response previous therapies) with the following:
  - ☐ One or more non-steroidal anti-inflammatory drugs –NSAIDs (trial at maximum dose for at least 2-3 weeks before considering them as failures); **OR**
  - ☐ Analgesic agents (acetaminophen or codeine) if NSAIDs do not completely control the pain; **OR**
  - ☐ Sulfasalazine (if peripheral joint involvement is present); **AND**
  - ☐ Patient has had an inadequate response, intolerance, or has contraindications to Humira®

PLAQUE PSORIASIS

- ☐ Patient must be 18 years of age or older; **AND**
- ☐ Patient has documented diagnosis of moderate to severe plaque psoriasis for at least 6 months with at least one of the following:
  - ☐ Incapacitation due to plaque location (e.g., head and neck, palms, soles, or genitalia); **OR**
  - ☐ Involvement of at least 10 percent of body surface area (BSA);**OR**
  - ☐ Psoriasis Area and Severity Index (PASI) score of 12 or greater; **AND**
- ☐ Patient is free of any clinically important active infections; **AND**
- ☐ Patient has a negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient did not respond adequately (or is not a candidate) to a 3-month minimum trial of at least 1 systemic agent (e.g., immunosuppressives, retinoic acid derivatives, and/or methotrexate); **AND**
- ☐ Patient did not respond adequately (or is not a candidate) to a 3 month minimum trial of phototherapy
- ☐ (e.g., Psoralens with UVA light (PUVA) OR UVB with coal tar or dithranol; **AND**
- ☐ Patient has had a 3 month minimum trial and failure (inadequate response or intolerance) to Humira®

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ENBREL® (ETANERCEPT) (CONTINUED)

POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA):

- ☐ Patient must be 2 years of age or older.
- ☐ Patient has a documented diagnosis of polyarticular juvenile idiopathic arthritis
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) with the following:
  - ☐ One or more non-steroidal anti-inflammatory-NSAIDS; **AND**
  - ☐ One or more non-biologic- DMARDs (i.e. methotrexate, sulfasalazine [in patients six and older]); **AND**
  - ☐ Trial and failure of preferred alternative Humira®

PSORIATIC ARTHRITIS

- ☐ Patient must be 18 years of age or older
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided
- ☐ Patient has active psoriatic arthritis for at least 6 months defined as:
  - ☐ > 3 swollen joints; **AND**
  - ☐ > 3 tender joints; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response previous therapies) with the following:
  - ☐ One or more non-steroidal anti-inflammatory drugs –NSAIDs (trial at maximum dose for at least 2-3 weeks before considering them as failures); **AND**
  - ☐ One or more non-biologic disease modifying anti-rheumatic drugs DMARDs (i.e., methotrexate, sulfasalazine, leflunomide, cyclosporine); **AND**
  - ☐ Trial and failure of preferred alternative Humira®

DOSING AND ADMINISTRATION:

- ☐ **Rheumatoid Arthritis:** 50mg subcutaneously once weekly
- ☐ **Ankylosing Spondylitis:** 50mg subcutaneously once weekly
- ☐ **Plaque Psoriasis:** 50mg subcutaneously twice weekly for three months, then once weekly thereafter
- ☐ **Polyarticular Juvenile Idiopathic Arthritis:** 0.8mg/kg once weekly with a maximum of 50mg once weekly
- ☐ **Psoriatic Arthritis:** 50mg subcutaneously once weekly

DOSAGE FORM AND STRENGTHS:

- ☐ 50 mg Single-use Prefilled Syringe: 0.98 mL of a 50 mg/mL solution of etanercept
- ☐ 50 mg Single-use Prefilled SureClick® Autoinjector: 0.98 mL of a 50 mg/mL solution of etanercept
- ☐ 25 mg Single-use Prefilled Syringe: 0.51 mL of a 50 mg/mL solution of etanercept
- ☐ 25 mg Multiple-use Vial: 25 mg of etanercept

ERWINAZE® (CRISANTASPASE)

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

Reviewer must provide a more than prompt response to prevent any break in therapy.

- ☐ Must have a diagnosis of Acute Lymphoblastic Leukemia; **AND**
- ☐ Medication must be prescribed by an oncologist; **AND**
- ☐ Patient must be currently on therapy (within past 6 months)

OR

- ☐ Must have history of serious adverse reaction (such as systemic rash, bronchospasms, laryngeal edema, hypo tension, etc…) to L-asparaginase (e.g., Oncaspar).

ERIVEDGE® (VISMODEGIB)

Length of Authorization:	6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Patient must be ≥ 18 years old.
- ☐ Must have a diagnosis of basal cell carcinoma.
- ☐ Medication must be prescribed by a specialist (e.g., oncologist, etc.)

ERYTHROMYCIN ORAL (-ETHYLSUCCINATE, -STEARATE, -ESTOLATE, -BASE)

Length of Authorization:	Initial: 3 Months; Continuation of Therapy: One Year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

CLINICAL NOTES

Erythromycin is a macrolide antibiotic active against both gram positive (*streptococcus pneumonia*) and some gram negative (*Neisseria sp*) bacteria as well as several atypical organisms including *mycoplasma pneumoniae.* Newer oral macrolide antibiotics including azithromycin and clarithromycin have largely replaced the use of oral erythromycin for treating most infectious disease indications. Erythromycin is utilized clinically to treat gastric paresis due to its stimulatory effect on bowel motility. Azithromycin and clarithromycin demonstrate much less gastrointestinal toxicity and therefore are not used clinically for gastroparesis.

INITIAL REVIEW CRITERIA

1. For all requests for infectious disease indications: Redirect to preferred agents
2. Erythromycin may be approved if it is being prescribed for use in patients with delayed gastric motility (ex. diabetic gastroparesis, postsurgical gastroparesis, etc).

CONTINUATION OF THERAPY

1. Patient continues to meet initial review criteria
2. Patient continues to respond to erythromycin therapy (Note: The effectiveness of chronic therapy may be limited due to tachyphylaxis as a result of motilin receptor downregulation. Clinical responsiveness to oral erythromycin declines after 4 weeks.)

DOSING AND ADMINISTRATION

- Delayed gastric motility: 250-500 mg three times daily, 30 minutes before meals

ESBRIET® (PIRFENIDONE)

Length of Authorization:	Up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years old
- ☐ Must be prescribed or in consultation with a pulmonologist **AND**
- ☐ Confirmation of idiopathic pulmonary fibrosis through exclusions of other known causes of interstitial lung disease: domestic and occupational environmental exposures, drug toxicity or connective tissue disease **AND**
- ☐ Documentation submitted that the patient is a nonsmoker or has been abstinent for at least six weeks **AND**
- ☐ Confirmation of diagnosis via lung biopsy **OR** high resolution computed tomography **AND**
- ☐ Documented pulmonary function tests within the past 60 days reflecting Forced Vital Capacity(FVC) ≥ 50% **AND**
- ☐ Baseline percent predicted diffusing capacity of the lung for carbon monoxide is ≥ 30% **AND**
- ☐ Patient must obtain a liver function test prior to starting treatment

CONTINUATION OF THERAPY

- ☐ Documentation of improvement or effectiveness of therapy (<200ml decrease in FVC or <10% decline in percent predicted FVC)
- ☐ Clinical documentation that the recipient is tobacco free

DOSING AND ADMINISTRATION

- ☐ Titrate up to three- 267mg capsules (801mg) three times daily with food. Titration schedule: One capsule three times daily with meals on days 1–7. Two capsules three times daily with meals on days 8–14. Three capsules three times daily with meals thereafter.

EXCEEDING BENZODIAZEPINE QUANTITY LIMITS

Length of Authorization:	1 year
Initiative:	MAP: Benzo Quantity Limit Override (76 / 2641 – GSN; 76 / 7001 – GSN)

REVIEW CRITERIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

- ☐ Pharmacists are allowed to use clinical judgment to exceed the state set quantity limit on Benzodiazepines only.
- ☐ Must comply with all of the following procedures to exceed the quantity limit.
- ☐ The physician must provide adequate clinical notes via fax defining the reason to exceed the state's quantity limits.
- ☐ **Note:** Placing "due to clinical judgment" within our clinical notes as justification is not adequate.
- ☐ Request that the Provider submit clinical documentation as to why the Patient may not optimize the dosage.
- ☐ **Example:** Physician is requesting Alprazolam 0.5mg #180 per 30 days: SIG: 2 tablets in the AM, PM, and HS. There must be clinical documentation provided as to why the physician may not use the Alprazolam 1mg #90 per 30 days: SIG: 1 tab in the AM, PM, and HS.
- ☐ The request must not exceed the maximum daily dosage limit set by the manufacturer or clinical reference for the diagnosis supplied.
- ☐ **Note:** To find out the maximum dosage limit, please refer to one of the following provided reference site: **Clinical Pharmacology, Micromedex, or Facts and Comparison**

Benzodiazepine	Limitations
Alprazolam intensol 1mg/ml	Max of 6ml per day
Alprazolam XR/ER 0.5mg, 1mg, 2mg, 3mg (non-PDL)	Max of 30 tabs per 30 days
Alprazolam tabs 0.25mg, 0.5mg, 1mg, 2mg	5/day (150/30 days)
Chlordiazepoxide Caps. 5mg, 10mg, 25mg	4/day (120/30 days)
Clonazepam Tabs 0.5mg, 1mg, 2 mg (for non-seizure pts)	3/day (90/30days)
Clonazepam Rapdis 0.125mg, 0.25mg, 0.5mg, 1mg, 2mg	3/day (90/30 days)
Clorazepate tabs 3.75mg, 7.5mg, 15mg	4/day (120/30 days)
Diazepam Solution 5mg/5ml	Max of 40 ml per day
Diazepam tabs 2mg, 5mg, 10mg	4/day (120/30 days)
Diazepam Oral Concentrated 5mg/1ml	Max of 8 ml per day
Lorazepam tabs 0.5mg, 1mg, 2mg	5/day (150/30 days)
Lorazepam 2mg/ml	Max of 5ml per day
Oxazepam Caps 10mg, 15mg, 30mg	4/day (120/30 days)

EXJADE® AND JADENU® (DEFERASIROX)

Length of Authorization:	Up to 3 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

PREFERRED –PA REQUIRED	NON-PREFERRED – PA REQUIRED
Exjade® (*deferasirox*)	Jadenu® (*deferasirox*)

Type of Iron Overload	Length of Authorization: Initial Therapy	Length of Authorization: Continuation of Therapy
Transfusional	3 months	3 months
Non-Transfusional	3 months	3 months

REVIEW CRITERIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

TRANSFUSIONAL IRON OVERLOAD INITIATION OF THERAPY

- ☐ Trial and failure of Exjade is required prior to consideration of Jadenu. **Disliking the taste of Exjade is not considered "treatment failure."**
- ☐ Patient must be ≥2 years of age on the date of request for Exjade® and Jadenu®.
- ☐ Documentation of iron overload related to anemia found in patient's medical conditions, progress notes, and/or discharge notes.
- ☐ Documentation in medical records (e.g., progress notes, discharge notes. . .) of a recent history of frequent blood transfusions that has resulted in chronic iron overload.
- ☐ Serum ferritin must be consistently >1000 mcg/L. (The most recent lab results should be within the past month.)
- ☐ Starting Dose:
  - ☐ Exjade®: Starting dose must not exceed 20mg/kg/day.
  - ☐ Jadenu®: Starting dose must not exceed 14mg/kg/day.
- ☐ Calculate dose to the nearest whole tablet:
  - ☐ Exjade® (125mg, 250mg, or 500mg) for the oral suspension.
  - ☐ Jadenu® (90mg, 180mg, or 360mg) for the oral suspension.

TRANSFUSIONAL IRON OVERLOAD CONTINUATION OF THERAPY

- ☐ Serum ferritin must have been measured within 30 days of continuation of therapy request (Verify and document source of information).
- ☐ Ferritin levels must be >500mcg/L.
- ☐ Dose must not exceed:
  - ☐ Exjade®: 40mg/kg/day
  - ☐ Jadenu®: 28mg/kg/day. Calculate dose to the nearest whole tablet (90 mg, 180 mg, or 360 mg).
- ☐ Calculate dose to the nearest whole tablet:
  - ☐ Exjade® (125mg, 250mg, or 500mg) for the oral suspension.
  - ☐ Jadenu® (90mg, 180mg, or 360mg) for the oral suspension.

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NON-TRANSFUSIONAL IRON OVERLOAD INITIATION OF THERAPY

- ☐ Trial and failure of Exjade is required prior to consideration of Jadenu. **Disliking the taste of Exjade is not considered "treatment failure."**
- ☐ Patient must be ≥10 years of age on the date of request for Exjade® and Jadenu®.
- ☐ Documentation of iron overload related to anemia found in patient's medical conditions, progress notes, and/or discharge notes.
- ☐ Serum ferritin and liver iron concentration (LIC) must have been measured within 30 days of initiation (verify and document source of verification).
- ☐ Serum ferritin levels must be >300mcg/L.
- ☐ Liver iron concentration (LIC) must be >5 mg Fe/g dried weight (dw)
- ☐ Dose must not exceed (Exjade®):
  - ☐ 10mg/kg/day (if LIC is ≤15 mg Fe/g dw)
  - ☐ 20mg/kg/day (if LIC is > 15 mg Fe/g dw)
- ☐ Starting dose (Jadenu®):
  - ☐ 7mg/kg/day. Calculate dose to the nearest whole tablet (90 mg, 180 mg, or 360 mg).
- ☐ Calculate dose to the nearest whole tablet:
  - ☐ Exjade® (125mg, 250mg, or 500mg) for the oral suspension.
  - ☐ Jadenu® (90mg, 180mg, or 360mg) for the oral suspension.

NON-TRANSFUSIONAL IRON OVERLOAD CONTINUATION OF THERAPY

- ☐ Serum ferritin and liver iron concentration (LIC) must have been measured within 30 days of continuation of therapy request (verify and document source of verification).
- ☐ Serum ferritin levels must be >300mcg/L.
- ☐ Liver iron concentration (LIC) must be ≥3 mg Fe/g dw.
- ☐ Dose must not exceed
  - ☐ Exjade®:
    - ☐ 10mg/kg/day (if LIC is 3 – 7 mg FE/g dw)
    - ☐ 20mg/kg/day (if LIC is >7 mg FE/g dw)
  - ☐ Jadenu®:
    - ☐ 14 mg/kg/day. Calculate dose to the nearest whole tablet (90 mg, 180 mg, or 360 mg).
- ☐ Calculate dose to the nearest whole tablet:
  - ☐ Exjade® (125mg, 250mg, or 500mg) for the oral suspension.
  - ☐ Jadenu® (90mg, 180mg, or 360mg) for the oral suspension.

DOSE CALCULATIONS

- ☐ Strength of tablets used in dosing should be reasonable (i.e., if the patient is taking 1,000mg per day, it is not reasonable for the patient to take 8 of the 125 mg tablets; however, 2 of the 500mg tablets would be appropriate.

Example 1: A request for initiation of therapy is received for a patient for Exjade 500mg, 2 tablets per day. The patient's current weight is 100 lbs (45.5kg).
The max daily dose= 20mg/kg/day x 45.5kg= 910mg/day
Therefore, the PA would be built for a Exjade 500mg, #60 per 30 days.

Example 2: A request for continuation of therapy is received for a patient for Exjade 500mg- 2,275mg daily. The patient's current weight is 125 lbs (56.8kg).
The max daily dose= 40mg/kg/day x 54.8kg= 2,272mg/day
Therefore, two separate PAs would be built for Exjade 500mg (x 4 tabs = 2,000mg), #120 per 30days and Exjade 275mg tablet, #30/30.

FARYDAK® (PANOBINOSTAT)

Length of Authorization:	3 Months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

INITIAL REVIEW CRITERIA (ALL OF THE FOLLOWING MUST BE TRUE)

- ☐ Patient must be ≥18 years old; **AND**
- ☐ Patient must have a diagnosis of relapsed multiple myeloma; **AND**
- ☐ Patient has failed at least two prior therapies, which must have included bortezomib and an immunomodulatory agent (lenalidomide, thalidomide, pomalidomide); **AND**
- ☐ Patient is also receiving concurrent bortezomib and dexamethasone with panobinostat

CONTINUATION OF THERAPY

- ☐ Patient continues to meet all of the initial criteria
- ☐ No evidence of disease progression on the panobinostat/bortezomib/dexamethasone regimen

FABRAZYME® (AGALSIDASE BETA)

Length of Authorization:	Up to one year
Initiative:	MAP: AP: Fabrazyme PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN) (NOTE: AutoPA approval does **NOT** override the Non-PDL edit)

APPROVAL CRITERIA

- Minimum age = 8 years
- Must have a documented (in "health conditions" or medical records) diagnosis of Fabry disease.

DOSING AND ADMINISTRATION

- 1 mg/kg body weight given every two weeks as an IV infusion.
- Patients should receive antipyretics prior to infusion.

FABRAZYME AUTOMATION LOGIC

Fabrazyme Automation

Automated PA approval satisfies L = AutoPA drug edit

Automated PA approval will NOT override R = Non-PDL edit

Generic Name	Brand Name	Drug Code
Agalsidase beta	Fabrazyme	HSN =024861

Step 1: If incoming claims is for HSN <024861> and prior authorization code = L, look back 730 days in the patient's health conditions for an *ICD-9 = 272.7 OR* an *ICD-10 = E75.21* (Fabry – Anderson disease) if found, NO PA REQUIRED. Otherwise, deny for PRIOR AUTHORIZATION REQUIRED NCPDP EC 75 with supplemental message: *"RECEPIENT DOESN'T HAVE REQ DIAGNOSIS ON FILE."*

Approvable ICD 9 Code	
272.7	Lipidoses
Approvable ICD 10 Code	
E75.21	Fabry (Anderson) disease

FERRIPROX® (DEFERIPRONE)

Ferriprox Is Not Approvable Due To Patient Convenience of Oral Dosing Availability

Length of Authorization:	Initial: Up to 3 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

INITIAL THERAPY

1. Patient must have a diagnosis of Thalassemia per medical records or "diagnosis code(s)." (Not to be approved in other diagnoses associated with chronic anemia: sickle cell anemia, aplastic anemia, etc.)
2. Documentation in medical records (e.g., progress notes, discharge notes. . .) of failure of Exjade (after a minimum of 3 months of therapy) as demonstrated by serum ferritin consistently >2500mcg/L (copy of lab results must be submitted), despite maximization of Exjade dosage at 40mg/kg/day.

CONTINUATION OF THERAPY

1. Serum ferritin must have been measured within 30 days of initiation of therapy (*copy of lab results must be submitted*).
2. Ferritin levels must be >500mcg/L.
3. Dose must not exceed 99 mg/kg/day.

DOSING

- The recommended initial dose of Ferriprox is 25 mg/kg, orally, three times per day for a total of 75 mg/kg/day. The maximum dose is 33 mg/kg, three times per day for a total of 99 mg/kg/day.
- Dose adjustments up to 33 mg/kg, orally, three times per day should be tailored to the individual patient's response and therapeutic goals (maintenance or reduction of body iron burden). The maximum recommended total daily dose is 99 mg/kg per day. The dose should be rounded by the prescriber to the nearest 250 mg (half-tablet).
- **Dosage Forms and Strengths:** 500 mg film-coated tablets with a functional score.

FOLBALIN PLUS AND FOLBIC

Length of Authorization:	Up to 4 weeks following the expected date of delivery.
Initiative:	MAP: Cert Code Bypass (EU/ 50167 – GSN; 75 / 2462 – GSN; 76 / 2641 – GSN)

APPROVAL CRITERIA

- Patient must be pregnant and have a diagnosis of Methylenetetrahydrofolate reductase (MTHFR) deficiency.
- These products are approvable only for MTHFR in pregnant women to prevent fetal demise resulting from inability to efficiently metabolize folic acid. MTHFR is the name of the genetic disorder and the enzyme deficiency. The gene mutations related to this disorder are C677T and A1298C. The C677T mutation is the most concerning. MTHFR has been linked to a variety of pregnancy complications such as chromosomal abnormalities, such as Down syndrome, and congenital malformations. This error in metabolism also results in elevated levels of homocysteine that has been associated with placental disease, preeclampsia, and recurrent pregnancy loss. Twenty-one percent (21%) of women with high levels of homocysteine experience recurrent pregnancy loss.

FULYZAQ® (CROFELEMER)

Length of Authorization:	**Initial Therapy** – 6 months **Continuation of Therapy** – 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

INITIAL THERAPY *(ALL OF THE FOLLOWING MUST BE TRUE)*

- ☐ Patient must be ≥18 years old
- ☐ Patient must have a diagnosis of HIV/AIDS
- ☐ Patient is experiencing diarrhea (e.g., one or more watery stools daily for 5 out of 7 days per week)
- ☐ Antiretroviral therapy claims history evident within the past 30 days.
- ☐ Active infection has been ruled out via fecal collection and microbiologic culture
- ☐ Other secondary causes of diarrhea (e.g., irritable bowel syndrome, gluten and lactose intolerance, traveler's diarrhea, functional diarrhea, and antiretroviral therapy associated diarrhea) have been ruled out by complete and appropriate physical and historical examination
- ☐ Patient has tried and failed the preferred antidiarrheals: loperamide, atropine-diphenoxylate

CONTINUATION OF THERAPY *(ALL OF THE FOLLOWING MUST BE TRUE)*

- ☐ Documented reduction in the frequency and quantity of liquid stool volume (e.g., less than 2 watery bowel movements per week) since the initiation of Fulyzaq® therapy
- ☐ Consistent antiretroviral therapy claims history during Fulyzaq® therapy
- ☐ Documented follow-up with patient that includes re-culture for microbiologic agents if breakthrough diarrhea occurs while on Fulyzaq® therapy.

FUZEON® (ENFUVIRITIDE)

Length of Authorization:	Maximum of 6 months
Initiative:	MAP: Fuzeon (75 / 2462 – GSN: 76 / 2641 – GSN)
Fax Form:	Fuzeon®

REVIEW CRITERIA

Patient must have a diagnosis of HIV/AIDS and be treatment experienced with evidence of HIV-1 replication despite ongoing antiretroviral therapy.

Any request that falls outside of the below-mentioned indications should be forwarded to a pharmacist for review.

Questions below correspond to the numbering on the **Fuzeon®** fax form.

Questions:

1. Initiation of Therapy OR Continuation of Therapy
2. Has the patient had a genotype/phenotype completed? (A copy of test results must be submitted for initial therapy).

   Answer: Questions 1 and 2- for initiation of therapy, genotype, and phenotype results should be dated within the past 12 months.

   Note: Genotyping and phenotyping cannot be effectively done if the viral load is less than 1000 copies/mL. Therefore, genotyping and phenotyping is not required for those recipients currently on Fuzeon therapy.
3. Does the patient have a viral load completed in the past 6 months? (A copy of lab results must be submitted)

   Answer: Question 3- Only acceptable response for approval is "Yes."
4. Has the patient had a CD4 count completed in the past 6 months? (A copy of lab results must be submitted).

   Answer: Question 4- Only acceptable response for approval is "Yes."
5. Has the patient been compliant with previous therapy?

   Answer: Question 5- New therapy requires verification of:

   - ☐ Ongoing therapy with other HIV medications
   - ☐ Compliance on previous therapies
   - ☐ Labs that demonstrate CD4 counts and antigen levels consistent with medication failure.

Continuation of therapy requires verification of compliance with other medications. If Fuzeon is working, then CD4 counts should be good and viral antigen levels should be undetectable.

GASTROINTESTINAL – H2RAS

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to preferred medications? **Document clinically compelling details.** Acceptable reasons include
   - ☐ Allergy to all preferred medications
   - ☐ Contraindication to all preferred medications
   - ☐ History of unacceptable side effects
   - ☐ Patient is clinically unstable and switching would cause a deterioration in condition
2. The requested medication may be approved if **both** of the following are true:
   - ☐ If there has been a therapeutic failure to no less than a 60-day trial of TWO preferred medications; **AND**
   - ☐ The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.
3. If a medication requiring prior approval was initiated in the hospital for the treatment of a condition such as a GI bleed, approve the requested medication.
4. For a diagnosis of **cystic fibrosis**, may approve doses above the acute dosage recommendations.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Cimetidine injectable	Axid® solution (*nizatidine*)
Famotidine (*generic for Pepcid®*)	Cimetidine tablets and liquid
Ranitidine tablet/syrup (*generic for Zantac®*)	Nizatidine (*generic for Axid®*)
	Pepcid® Oral Suspension (*famotidine*)*
	Pepcid® tablets (*famotidine*)*
	Ranitidine capsules *(generic for Zantac®)*
	Zantac® tablets/syrup (*ranitidine*)

GASTROINTESTINALS – PROTON PUMP INHIBITORS (PPI)

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to a preferred medication? Acceptable reasons include
   - ☐ Allergy to all preferred medications
   - ☐ Contraindication to all preferred medications
   - ☐ History of serious reaction (e.g., swelling, severe allergic reaction, etc.) to all preferred medications
2. The requested medication may be approved if **both** of the following are true:
   - ☐ If there has been a therapeutic failure to no less than a 60-day trial of TWO preferred medications

   AND
   - ☐ The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated
3. Requests for a non-preferred dosage form should be reviewed based upon specific criteria.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Nexium® (*esomeprazole*) packets [2.5mg, 5mg, 10mg, 20mg, 40mg] **(Max age 11 years: Specific criteria on next page to exceed age limit)**	AcipHex® (*rabeprazole*)
Omeprazole 10mg 20mg, 40mg (Rx generic for Prilosec) [60/30]	Esomeprazole magnesium (generic for Nexium®)* capsules [*20mg, 40mg] **Note:** Omeprazole is therapeutically equivalent to esomeprazole.
Prevacid® 15mg/30mg solutab **(Max age 11 years: Specific criteria on next page to exceed age limit)**	Dexilant® (*dexlansoprazole*)
Pantoprazole (generic for Protonix®) [*20mg, 40mg]	Lansoprazole (generic for Prevacid®) [*15mg, 40mg]
Protonix® 40mg granules for suspension **(Max age 11 years: Specific criteria on next page to exceed age limit. Also, see criteria below for Patients on clopidogrel)**	Nexium® (*esomeprazole*)* capsules [*20mg, 40mg] **Note:** **Note:** Omeprazole is therapeutically equivalent to esomeprazole.
	Nexium® I.V.
	Omeprazole-Sodium Bicarbonate (generic for Zegerid®)
	Prevacid® (*lansoprazole*) [*15mg, 30mg]
	Prevacid® I.V.
	Protonix® (*pantoprazole*) [*20mg, 40mg]
	Protonix® I.V.
	Prilosec® (*omeprazole*) [*10mg, 20mg, 40mg, and suspension]
	Zegerid®

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THERAPEUTIC DUPLICATION PROTON PUMP INHIBITOR (PPI) AUTOPA CODING

Coding effective 05/01/2016 (into production 06/10/2016)

Proton Pump Inhibitors List		
Generic Name	**Brand Name**	**HICL**
rabeprazole	AcipHex	018847
dexlansoprazole	Dexilant	036085
esomeprazole	Nexium	021607
lansoprazole	Prevacid	008993; 025742
omeprazole	Prilosec	011115; 004673
pantoprazole	Protonix	022008
omeprazole/sodium bicarbonate	Zegerid	033512
And generic drug name code = 1 or 2; And Route of Admin = Oral		

- **Automation Logic:**
  - Step 1: If incoming claim from <PPI List> and route of administration = oral, look back 30 days for a fill from <PPI List> excluding itself. If found, claim rejects 76 with additional message "*TD Proton Pump Inhibitor; Review & submit appropriate DUR cd.*" If not found, claim pays.
- **Limitation:**
  - Allow 1 pharmacy level override in 180 days for claims that deny out of the PPI AutoPA. Pharmacy must submit DUR Reason For Service Code: TD-Therapeutic Duplication for pharmacy level override. Deny the second, and subsequent attempts of a pharmacy level overrides (within a rolling 180 days) NCPDP 75 PA required with additional message "*PA Req'd.Max:1 ProtonPumpInhib TD ovr/180dys.FaxPA800-424-7913.*
- **Max Fill Limit:**
  - For incoming claims from <PPI List> and route of administration = oral and a day supply >/= 28, create a maximum fill limit = six fills per 365 days across the HICLs. The seventh attempted fill will reject 76 – Plan limitations exceeded with additional message "*PPI Therapy not indicated for chronic use.*"
  - Excluding recipients with a diagnosis, within 730 days, of Zollinger-Ellison syndrome, Barrett's esophagus, gastric malignancy, cystic fibrosis, or history of gastric bypass as listed below:

ICD-9 CM Code	Description	ICD-10 CM Code	Description
530.85	Barrett Esophagus	K22.710; K22.711; K22.719	Barrett's esophagus with dysplasia
V45.86	Bariatric Surgeries	Z98.84	Bariatric surgeries
V45.3	Gastric Bypass	Z98.0	Gastric Bypass
150.0-150.9	Malignant Neoplasm of esophagus	ICD 10 Disease group: C15	Malignant Neoplasm of esophagus
151.0-151.9	Malignant Neoplasm of stomach	ICD 10 Disease group: C16	Malignant Neoplasm of stomach
251.5	Zollinger-Ellison Syndrome	E16.4	Abnormality of secretion of Gastrin
277.00-277.09	Cystic Fibrosis	ICD-10 Disease Group E84	Cystic Fibrosis

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PATIENTS ON CLOPIDOGREL THERAPY

Please redirect patients on clopidogrel requesting a non-PDL medication to the preferred alternatives Ranitidine, Famotidine, or Protonix.

NOTE

It is unknown how other PPIs may interfere with clopidogrel (Plavix). Zantac (ranitidine), Pepcid (famotidine), Axid (nizatidine), and antacids do not inhibit the CYP2C19 enzyme and are not expected to interfere with the anti-clotting activity of clopidogrel.

NEXIUM® PACKETS (ESOMEPRAZOLE) – PATIENTS >11 YEARS OF AGE
PREVACID® SOLUTABS (LANSOPRAZOLE) – PATIENTS >11 YEARS OF AGE
PROTONIX® SUSPENSION (PANTOPRAZOLE) – PATIENTS >11 YEARS OF AGE

Length of Authorization:	1 year
Initiative:	MAP: Age Limit: Over Maximum (60 / 2194 – GSN; 60 / 2624 – GSN; 76 / 2641 – GSN)

APPROVED INDICATIONS: (ALL CRITERIA MUST BE MET BEFORE APPROVAL.)

1. One of the diagnoses below must be verified per ICD-9 code(s).
   - ☐ Duodenal ulcer
   - ☐ Dyspepsia
   - ☐ Esophagitis
   - ☐ Gastric ulcer
   - ☐ Gastroesophageal reflux disease (GERD)
   - ☐ Helicobacter (H. Pylori) eradication
   - ☐ NSAID-induced ulcer prophylaxis
   - ☐ Pyrosis (heartburn) -OR-
   - ☐ Zollinger-Ellison Syndrome
2. History of difficulty swallowing (dysphagia), or a medical condition that is characterized by difficulty or inability to swallow.
   - ☐ If the Recipient has a g-tube, the request is approvable.
   - ☐ The prescription may serve as a medical record indicating the presence of a g-tube.
   - ☐ The recipient's medication claims history may be used to determine if they require a disintegrating, crushed, or suspension formulations of medication (in such cases the solutab may be approved).
3. Dosage must be within the recommended ranges listed below (next page).

   Technicians: It is not necessary to escalate continuation of therapy requests to a pharmacist for review if the criteria above still apply.

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DOSING

- Nexium:
  - Adults and Elderly – 40 mg/day PO/IV; up to 240 mg/day PO for Zollinger-Ellison syndrome.
  - Adolescents – <= 17 years and weighing >= 55 kg: 40 mg/day PO; 20 mg IV. <= 17 years and weighing < 55 kg: 40mg/day PO; 10 mg IV.
  - Children – >= 12 years and weighing >= 55 kg: 40 mg/day PO; 20 mg/day IV. >= 12 years and weighing < 55 kg: 40mg/day PO; 10 mg/day IV. <= 11 years and weighing >= 55 kg: 20 mg/day PO;20 mg/day IV.
    <= 11 years and weighing 20–54 kg: 20 mg/day PO;10 mg/day IV. Doses up to 2.1 mg/kg/day PO (not to exceed 40 mg/day PO) have been used off-label for nephropathic cystinosis.
    <= 11 years and weighing < 20 kg: 10 mg/day PO; 10 mg/day IV.
  - Infants – 1–< 12 months and weighing > 7.5–12 kg: 10 mg PO; 0.5 mg/kg/day IV.
    1–< 12 months and weighing > 5–7.5 kg: 5 mg PO; 0.5 mg/kg/day IV. 1–< 12 months and weighing 3–5 kg: 2.5 mg PO; 0.5 mg/kg/day IV.
  - Neonates – Safety and efficacy have not been established.
- Prevacid:
  - Adult, Elderly, and Adolescents – up to 30 mg/day PO for most indications; up to 90 mg/day PO for eradication of *H. Pylori (for 10-14 days)*; up to 180 mg/day PO for Zollinger-Ellison syndrome.
  - Children (1-11 years of age) – *> 30 kg:* 30 mg/day PO for GERD or erosive esophagitis, up to 60 mg/day PO has been used for refractory cases; *<= 30 kg:* 15 mg/day PO for GERD or erosive esophagitis, occasionally higher doses used for refractory cases.
  - Infants (1 month to < 1 year of age) – Safety and efficacy have not been established.
  - Neonates - Safety and efficacy have not been established; doses up to 1 mg/kg have been used off-label for GERD.
- Protonix:
  - Adults and Elderly – 40 mg/day PO or IV for most GERD indications; 80 mg/day PO for H. pylori; up to 120 mg/day PO for severe esophagitis or GERD; up to 240 mg/day PO or IV for Zollinger-Ellison syndrome.
  - Adolescents – >= 40 kg: 40 mg/day PO; safety and efficacy have not been established for IV use.
    < 40 kg: 20 mg/day PO; safety and efficacy have not been established for IV use.
  - Children – >= 5 years and >= 40 kg: 40 mg/day PO; safety and efficacy have not been established for IV use.
    >= 5 years and 15 to < 40 kg: 20 mg/day PO; safety and efficacy have not been established for IV use. < 5 years or < 15 kg: Safety and efficacy have not been established.
  - Infants – Safety and efficacy have not been established.

GASTROINTESTINALS - PROTON PUMP INHIBITORS (PPI) - THERAPY BEYOND 6 MONTHS DURATION

Length of Authorization:	6 months
Initiative:	MAP: AP: PPI TD Duration

CLINICAL NOTES

Prescription-only proton pump inhibitors are indicated for treatment and maintenance of duodenal ulcer, gastroesophageal reflux disease, pathological hypersecretory conditions, gastric ulcers and NSAID-induced gastric ulcers. They may also be used in combination with amoxicillin and clarithromycin for the eradication of *H. pylori.*

For the treatment of GERD, package insert labeling supports therapy for up to 8 weeks, for the treatment of erosive esophagitis, labeling supports therapy for up to 8 weeks but an additional 8 weeks may be considered if needed. For the maintenance treatment of erosive esophagitis and pathological secretory conditions, duration of therapy is not stated but studies did not extend beyond 12 months; however, some patients with these conditions have been treated continuously for more than 5 years.

PROTON PUMP INHIBITOR (PPI) DUAL THERAPY AND THERAPY DURATION EDIT:

An automated prior authorization is in place to bypass the maximum 6-month duration of therapy edit for patients with a history of any of the following diagnoses on file: Zollinger-Ellison syndrome, Barrett's esophagus, gastric malignancy, cystic fibrosis, or history of gastric bypass.

REVIEW CRITERIA FOR REQUESTS TO EXTEND PPI THERAPY BEYOND 6 MONTHS OF THERAPY FOR ALL OTHER PATIENTS: (PHARMACIST REVIEW ONLY)

Supporting documentation for one of the following diagnoses/conditions and meets the following criteria:

- Gastroesophageal Reflux Disease[1]:
  - ☐ Patient had initial response to treatment with PPI therapy; **AND**
  - ☐ Patient has experienced recurrent symptoms (heartburn, regurgitation) since discontinuing PPI therapy; **AND**
  - ☐ Patient has documented history of esophagitis; **OR**
  - ☐ If the patient does not have a history of esophagitis, the prescriber indicates PPI will be administered in lowest effective dose, including possible intermittent or PRN therapy
- Patients at high risk of peptic ulcer disease due to concomitant drug therapy[2]:
  - ☐ Patients requiring concomitant therapy with an NSAID and a cardioprotective dose of ASA (<325 mg/day); **OR**
  - ☐ Patients requiring concomitant therapy with ASA and an anticoagulant (including unfractionated heparin, LMWH, warfarin or a novel oral anticoagulant

GATTEX® (TEDUGLUTIDE)

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

INITIAL THERAPY REVIEW CRITERIA

- ☐ Patient must be ≥18 years old.
- ☐ Patient must have a diagnosis of short bowel syndrome-intestinal failure (SBS-IF)
- ☐ Patient must be currently receiving parenteral nutrition or IV fluids on an ongoing basis; patient must have required parenteral nutrition or IV fluids at least three times weekly for a minimum of 12 months (verified by supporting documentation) (Optimization of adjunctive medications and dietary modifications can achieve adequate intestinal rehabilitation in many patients and should be tried prior to initiating teduglutide)

CONTINUATION OF THERAPY REVIEW CRITERIA

- ☐ Patient is still requiring parenteral nutrition/IV fluids but must have achieved a minimum of a 20 percent reduction in the volume of parenteral support since the implementation of teduglutide therapy (verified by supporting documentation)
- ☐ At this time, there is insufficient clinical information to determine if patients who have successfully been weaned completely off parenteral support need to continue teduglutide therapy.

GILENYA® (FINGOLIMOD)

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA (ALL CRITERIA MUST BE MET)

- ☐ Patient must be ≥ 18 years old.
- ☐ Must have a diagnosis of relapsing remitting Multiple Sclerosis (RRMS).
- ☐ Previous trial with insufficient response or adverse reaction or contraindication to Copaxone® (glatiramer) or an Interferon Beta (e.g., Avonex®, Betaseron®, Rebif®).

KURTZKE EXPANDED DISABILITY STATUS SCALE (EDSS)

The Kurtzke Expanded Disability Status Scale (EDSS) is a method of quantifying disability in multiple sclerosis. EDSS steps 1.0 to 4.5 refer to people with MS who are fully ambulatory. EDSS steps 5.0 to 9.5 are defined by the impairment to ambulation.

The clinical meaning of each possible result is the following:

0.0:	Normal Neurological Exam
1.0:	No disability, minimal signs on 1 FS
1.5:	No disability, minimal signs on 2 of 7 FS
2.0:	Minimal disability in 1 of 7 FS
2.5:	Minimal disability in 2 FS
3.0:	Moderate disability in 1 FS; or mild disability in 3 - 4 FS, though fully ambulatory
3.5:	Fully ambulatory but with moderate disability in 1 FS and mild disability in 1 or 2 FS; or moderate disability in 2 FS; or mild disability in 5 FS
4.0:	Fully ambulatory without aid, up and about 12hrs a day despite relatively severe disability. Able to walk without aid 500 meters
4.5:	Fully ambulatory without aid, up and about much of day, able to work a full day, may otherwise have some limitations of full activity or require minimal assistance. Relatively severe disability. Able to walk without aid 300 meters
5.0:	Ambulatory without aid for about 200 meters. Disability impairs full daily activities
5.5:	Ambulatory for 100 meters, disability precludes full daily activities
6.0:	Intermittent or unilateral constant assistance (cane, crutch or brace) required to walk 100 meters with or without resting
6.5:	Constant bilateral support (cane, crutch or braces) required to walk 20 meters without resting
7.0:	Unable to walk beyond 5 meters even with aid, essentially restricted to wheelchair, wheels self, transfers alone; active in wheelchair about 12 hours a day
7.5:	Unable to take more than a few steps, restricted to wheelchair, may need aid to transfer; wheels self, but may require motorized chair for full day's activities
8.0:	Essentially restricted to bed, chair, or wheelchair, but may be out of bed much of day; retains self care functions, generally effective use of arms
8.5:	Essentially restricted to bed much of day, some effective use of arms, retains some self care functions
9.0:	Helpless bed patient, can communicate and eat
9.5:	Unable to communicate effectively or eat/swallow
10.0:	Death due to MS

GLAUCOMA

Length of Authorization:	1 year
Initiative:	☐ PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN) ☐ MAP: Quantity Limits: IE 7001 (76 / 7001 – GSN) (76 / 7001 – GSN)

1. Is there any reason that the Patient cannot be switched to preferred medications? **Document details**. Acceptable reasons include
   - ☐ Allergy to the preferred medications in this class
   - ☐ Contraindication or drug-to-drug interaction with all preferred medications
   - ☐ History of unacceptable side effects
2. The requested medication may be approved if ***both*** of the following are true:
   - ☐ If there has been a therapeutic failure to no less than a one-month trial of ONE preferred medications; **AND**
   - ☐ The requested medication's corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

ALPHA 2 ADRENERGICS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Brimonidine 0.2%	Alphagan P® [10/30] (brimonidine 0.1%, 0.15%)
	Iopidine® (apraclonidine)

BETA BLOCKERS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Betimol® (timolol)	Betagan® (*levobunolol*)
Carteolol HCl	Betaxolol HCl (old Betoptic 0.5%)
Levobunolol HCl (generic for Betagan®)	Betoptic S® (*betaxolol*)
Metipranolol	Istalol® (timolol)
Timolol [15/30] (generic for Timoptic® & Timoptic-XE®)	Timoptic-XE® [15/30] (*timolol*)
	Timoptic® [15/30] (*timolol*)*

PROSTAGLANDIN INHIBITORS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Travatan Z® [5/30] (*travoprost*)	Lumigan® (*bimatoprost*)
Latanoprost (generic Xalatan®)	Xalatan® [5/30] (*latanoprost*)

CARBONIC ANHYDRASE INHIBITORS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Dorzolamide (generic for Trusopt®)	Azopt® (brinzolamide)
Dorzolamide/Timolol (generic for Cosopt®)	Cosopt® [10/27] (dorzolamide / timolol)
	Trusopt® (*dorzolamide*)

[#X] = qty limit per X days

GLUCOCORTICOIDS – ORAL

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to preferred medications? Acceptable reasons include
   - ☐ Allergy to the preferred medications in this class
   - ☐ Contraindication or drug-to-drug interaction with all preferred medications
   - ☐ History of unacceptable side effects
2. Has there been a therapeutic failure of **TWO** preferred medications? Document the details.

ADDITIONAL INFORMATION TO CONSIDER

If the Patient is completing a course of therapy with a non-preferred medication, which was initiated in the hospital, then approve the authorization.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Budesonide EC 3mg capsules (generic Entocort EC®)	Celestone® (betamethasone)
Dexamethasone (generic for Decadron®)	Cortef® Tablets (*hydrocortisone*)
Hydrocortisone (generic for Cortef®)	Cortisone Acetate (generic for Cortone®)
Methylprednisolone (generic for Medrol®)	Entocort EC® 3mg capsules **(for Crohn's Disease only)**
Orapred ODT® (*prednisolone sodium phosphate*)	Flo-Pred® (prednisolone acetate)
Prednisolone (generic for Prelone® solution)	Hydrocortone® (*hydrocortisone*)
Prednisolone Sodium Phosphate (Orapred® Solution)	Kenalog® (*triamcinolone*)
Prednisone tablets/dose pack/oral solution	Medrol® (8mg only) (*methylprednisolone*)
	Millipred® (prednisolone acetate)
	Orapred® Solution (*prednisolone sodium phosphate*)
	Prednisone intensol
	Prelone® (prednisolone)
	Veripred® (prednisolone acetate)

GRANULOCYTE COLONY STIMULATING FACTORS

☐ Leukine® (sargramostim), Neupogen® (filgrastim), Neulasta® (pegfilgrastim)

Length of Authorization:	See below – varies by diagnosis
Initiative:	MAP: Granulocyte CSF (75 / 2462 – GSN; 76 / 2641 – GSN)
Fax Form:	Neupogen Leukine Neulasta Diagnosis [Required]

NEUPOGEN® (FILGRASTIM, G-CSF), ZARXIO® (FILGRASTIM, G-CSF)

CANCER PATIENTS

Absolute Neutrophil Count (ANC) is not required—if they have the indication, *approve*:

1. If Patient has not undergone chemotherapy, but it has been prescribed, no ANC is required.
2. Cancer patients receiving myelosuppressive chemotherapy (approve for 12 months).
3. Cancer patients receiving bone marrow transplants (approve for 12 months).
4. Acute Myeloid Leukemia receiving induction or consolidated chemotherapy (approve for 12 months).
5. Peripheral blood progenitor cell collection and therapy in cancer patients (approve for 12 months).

Note: GCSF is not FDA approved for radiation induced neutropenia.

SEVERE CHRONIC NEUTROPENIA

Absolute Neutrophil Count (ANC) Required. If ANC not met, escalate the request to an MPS RPh for review.

1. All Lab documentation must be on official lab letterhead---handwritten labs are not acceptable.
2. The absolute neutrophil count (ANC) is 1500 or less
3. Congenital, cyclic, or idiopathic. (Approve for 12 months)

AIDS

Absolute Neutrophil Count (ANC) required

1. Severe neutropenia in AIDS patients on antiretroviral therapy
2. *Initial Therapy*: The absolute neutrophil count (ANC) is 1000 or less
3. *Continuation of Therapy*: ANC 1600 or less
4. All Lab documentation must be on official lab letterhead--handwritten labs not acceptable (Approve for 6 months).

NEULASTA® (PEGFILGRASTIM); GRANIX® (TBO-FILGRASTIM)

CHEMOTHERAPY-INDUCED NEUTROPENIA

Cancer patients with non-myeloid malignancies receiving myelosuppressive chemotherapy (Approve for 12 months).
Neulasta is not FDA approved for radiation-induced neutropenia.

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LEUKINE® (SAGRAMOSTIM)

USE FOLLOWING INDUCTION CHEMOTHERAPY IN PATIENTS > 55 YEARS WITH ACUTE MYELOGENOUS LEUKEMIA (AML)

- ☐ (Approve for 1 year)
  - ☐ Safety and efficacy has not been assessed in patients with AML under 55 years of age.

BONE MARROW TRANSPLANTATION: (APPROVE FOR 6 MONTHS)

- ☐ Mobilization of peripheral blood progenitor cells prior to transplant.
- ☐ Use after myeloablative therapy and transplantation of peripheral blood progenitor cells to improve time to engraftment.
- ☐ Use after autologous bone marrow transplantation for patients with non-Hodgkin's lymphoma (NHL), acute lymphoblastic leukemia (ALL), or Hodgkin's disease (HD).
- ☐ Use after allogeneic bone marrow transplantation to accelerate myeloid recovery.
- ☐ Use after allogeneic or autologous bone marrow transplantation in whom engraftment is delayed or has failed.

GROWTH HORMONE TREATMENT IN CHILDREN AND ADULTS

Length of Authorization:	☐ Up to one year
Initiative:	☐ MAP: Growth Hormone (75 / 2462 – NDC-11; 76 / 2641 – NDC-11; 75 / 31005 – NDC-11; 76 / 7001 – NDC-11; 60 / 2194 – NDC-11)
Fax Form:	☐ Human Growth Hormone Diagnosis [REQUIRED: requests from the prescriber only]

Per MCCFL_2016_015_OT_ Preferred GH AP logic removal and CCP/SFCCN_2016_015_OT_ Preferred GH AP logic removal: Discontinue the Preferred Growth Hormone (GH) automation logic due the products being managed by clinical prior authorization (PA) criteria as of 01/01/2016. The clinical PA management strategy was a result of the January 2016 P&T meeting. Due to the above information, the GH automation logic is no longer germane to review the products.

GROWTH HORMONE TREAMENT IN CHILDREN

REVIEW CRITERIA FOR CHILDREN

Required for Approval:

1. Must have an approved diagnosis (see tables below for medication with appropriate indication)

Product Name	FDA Indication
Genotropin® (Preferred)	Prader–Willi Syndrome, Small for gestational age, Turner Syndrome, Idiopathic Short Stature
Genotropin®/Saizen® (Preferred)	Pediatric Growth Hormone deficiency
Humatrope®	Short stature homeobox-containing gene (SHOX)
Norditropin®	Short stature due to Noonan Syndrome
Nutropin®	Growth failure due to chronic renal insufficiency (CRI)
Omnitrope®	**REFER PROVIDER TO GENOTROPIN**

2. Must be ≤ 16 years of age
3. Must be prescribed by an endocrinologist, pediatric endocrinologist, or pediatric nephrologist.

Prader-Willi Syndrome: *Genotropin*
☐ **Growth velocity**: ≥ 2 standard deviations (SD) below the mean for bone age and gender
☐ **Diagnosis**: Confirmed diagnosis of Prader-Willi Syndrome (micro-deletion in the long arm of chromosome 15 or 2 maternal chromosome 15 and no paternal chromosome 15, or nonfunctional paternal chromosome 15)
☐ ICD-9: 759.81
☐ ICD 10: Q87.1
☐ **Epiphyses**: Confirmation of open growth plates

Small for Gestational Age (SGA): *Genotropin*
☐ **Age:** Greater than 2 years old
☐ **Birth weight/Length:** ≥ 2 standard deviations (SD) below the mean for gestational age
☐ **Growth velocity:** Failure to manifest catch-up growth by two years of age, defined as 2 standard deviations (SD) **below the mean f**or bone age and gender
☐ **Epiphyses**: Confirmation of open growth plates
• Associated diagnosis codes for fetal growth retardation:
☐ ICD-9: 764.91-764.99
☐ ICD 10: P05.9

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GROWTH HORMONE AUTOPA (CONTINUED)

Turner Syndrome: *Genotropin*
☐ **Age/Gender:** Females greater than 2 years old
☐ **Growth velocity:** ≥ 2 standard deviations (SD) below the mean for bone age and gender
☐ **Bone age:** Less than 14 years
☐ **Diagnosis:** Confirmed diagnosis of Turner Syndrome *(peripheral blood karyotype showing a 45, XO genotype)*
☐ ICD-9: 758.6
☐ ICD-10: Disease Group = Q96
☐ **Epiphyses**: Confirmation of open growth plates

Idiopathic Short Stature: *Genotropin*
☐ **Growth velocity:** ≥ 2.25 standard deviations (SD) below the mean for bone age and gender
☐ **Bone age:** Minimum of one year behind chronological age
☐ **Epiphyses**: Confirmation of open growth plates
☐ **Diagnostic Evaluation:**
☐ A mixed or normal response >10ng/ml to two Growth Hormone provocation tests (e.g., arginine, clonidine, glucagon, insulin, or levodopa)
☐ Growth velocity must be less than 5cm/year
☐ Other pituitary hormone deficiencies (e.g., hypothyroidism, chronic ischemic disease) have been ruled out .
☐ Submission of a MRI or supporting documentation confirming no expanding intracranial lesion or tumor
• Associated diagnosis codes for idiopathic short stature
☐ ICD-9: 783.43
☐ ICD 10: R62.52

Pediatric Growth Hormone Deficiency (GHD): *Genotropin, Saizen*
☐ **Growth velocity:** ≥ 2 standard deviations (SD) below the mean for bone age and gender (or at less than the 10th percentile)
☐ **Present height:** Less than the 5th percentile for age and sex, or the mid-parental height
☐ **Bone age:** Minimum of one year behind chronological age
☐ **Epiphyses**: Confirmation of open growth plates
☐ **Diagnostic Evaluation:**
☐ Two subnormal responses to GH provocation tests (e.g., arginine, clonidine, glucagon, insulin and levodopa): Confirmation of stimulation test(s) with peak serum GH concentration less than 10 ng/ml; **OR**
☐ One abnormal GH test is sufficient for children with defined CNS pathology, multiple pituitary hormone deficiency (MPHD), history of irradiation, or a genetic defect affecting the GH axis; **OR** One subnormal response to a GH provocation test with peak serum GH concentration less than 10ng/ml); **AND** subnormal serum levels of insulin-like growth factor 1 (IGF-I) and insulin-like growth factor binding protein 3 (IGFBP3), greater than 2 standard deviations below the mean for age and gender, based on specific lab reference values
☐ Idiopathic Short Stature (ISS) has been ruled out (normal birth weight and GH sufficient)
☐ Other pituitary hormone deficiencies (e.g., hypothyroidism, chronic ischemic disease) have been ruled out.
• Endocrine disorders related to GH deficiencies:
☐ ICD-9: 253.2-253.3; 253.7
☐ ICD 10: E23.0, E23.1, E89.3

For short stature in children with SHOX (short stature homeobox-containing gene) deficiency: *Humatrope*
☐ **Growth velocity**: ≥2 standard deviations (SD) below the mean for bone age and gender
☐ **Bone age**: Minimum of one year behind chronological age
☐ **Diagnosis**: Confirmed diagnosis of SHOX Syndrome
☐ ICD-9: 783.43
☐ ICD 10: R62.52
☐ **Epiphyses**: Confirmation of open growth plates

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GROWTH HORMONE AUTOPA (CONTINUED)

For Short Stature in Children with Noonan Syndrome: *Norditropin*
☐ **Growth velocity:** ≥2 standard deviations (SD) below the mean for bone age and gender
☐ **Bone age:** Minimum of one year behind chronological age
☐ **Diagnosis:** Confirmed diagnosis of Noonan Syndrome: ☐ ICD-9: 759.89 ☐ ICD 10: E78.71, E78.72, Q87.2, Q87.3, Q87.5, Q87.81, Q87.89, Q89.8
☐ **Epiphyses:** Confirmation of open growth plates

For Growth Failure Associated with Chronic Renal Failure up to the Time of Transplantation: *Nutropin*
☐ **Renal function:** Documentation of chronic renal insufficiency (serum creatinine < 30mg/dl), up to the time of renal transplant Associated diagnosis codes for renal failure: ☐ ICD-9: 585.1-585.6, 585.9, or 586-587 ☐ ICD 10 Disease Group: N18, N19, N26 (excluding ICD 10:N26.2)
☐ **Growth velocity:** ≥2 standard deviations (SD) below the mean for bone age and gender
☐ **Bone age:** Minimum of one year behind chronological age
☐ **Epiphyses:** Confirmation of open growth plates
☐ Prior to initiation of GH treatment, existing metabolic derangements such as malnutrition, zinc deficiency, and secondary hyperparathyroidism should be corrected.

Discontinuation of Growth Hormone Therapy in Children
☐ Expected final adult height has been reached; **OR**
☐ If there is a poor response to treatment, generally defined as an increase in growth velocity of less than 50% from baseline, in the 1st year of therapy; **OR**
☐ Increase in height velocity is less than 2 cm total growth in 1 year of therapy; **OR**
☐ There are persistent and uncorrectable [problems with adherence to treatment.

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CONTINUATION OF THERAPY – GROWTH HORMONE TREATMENT IN CHILDREN

Criteria for Continuation of Growth Hormone Therapy in Children:
ALL REQUIREMENTS MUST BE MET FOR APPROVAL: ☐ FDA approved diagnosis; **AND** ☐ Prescribed by an endocrinologist, pediatric endocrinologist or pediatric nephrologist; **AND** ☐ Growth velocity ≥ 2.5cm/year; **AND** ☐ Bone age is less than 16 years in males; 14 years in females (indicated in x-ray of fingers, hands, or wrists); **AND** ☐ Growth (epiphyseal) plates must be open (evidenced by x-ray) – linear growth can no longer occur in patients with epiphyseal closure

REFERENCE CHART – GROWTH HORMONE TREATMENT IN CHILDREN

DRUG	DOSAGE	FORMULATION
Genotropin® (somatropin [rDNA origin] for injection), for subcutaneous use	**Pediatric GHD***:* 0.16 to 0.24 mg/kg/week **Prader-Willi Syndrome***:* 0.24 mg/kg/week **Small for Gestational Age***:* Up to 0.48 mg/kg/week **Turner Syndrome***:* 0.33 mg/kg/week **Idiopathic Short Stature**: up to 0.47 mg/kg/week	Genotropin lyophilized powder in a two-chamber color-coded cartridge: ☐ 5 mg (green tip) and 12 mg (purple tip) (with preservative) Genotropin MiniQuick Growth Hormone Delivery Device containing a two chamber cartridge (without preservative): ☐ 0.2 mg, 0.4 mg, 0.6 mg, 0.8 mg, 1.0 mg, 1.2 mg, 1.4 mg, 1.6 mg, 1.8 mg, and 2.0 mg
Humatrope® [somatropin (rDNA ORIGIN)] for injection, for SQ use	***SHOX deficiency****:* 0.35 mg/kg/week (given in divided doses 6 to 7 times per week)	5 mg vial and 5-mL vial of diluent 6 mg (gold), 12 mg (teal) and 24 mg (purple) cartridge, and prefilled syringe
Norditropin® Cartridges [somatropin (rDNA origin) injection], for subcutaneous use	***Noonan Syndrome****:* Up to 0.066 mg/kg/day	Norditropin is preloaded in the Norditropin FlexPro or Norditropin NordiFlex pens, or cartridges for use with the corresponding NordiPens: ☐ 5 mg/1.5 mL (orange): FlexPro and NordiFlex pens, and cartridges ☐ 10 mg/1.5 mL (blue): FlexPro and NordiFlex pens ☐ 15 mg/1.5 mL (green): FlexPro and NordiFlex pens, and cartridges ☐ 30 mg/3 mL (purple): Norditropin NordiFlex pen only
Nutropin® [somatropin (rDNA origin) injection], for subcutaneous use	***Chronic Kidney Disease****:* Up to 0.35 mg/kg/week (divided into daily injections)	Nutropin AQ is a sterile liquid available in the following vial, pen cartridge and NuSpin forms: ☐ Vial: 10 mg/2 mL ☐ Pen Cartridge: 10 mg/2 mL (yellow color band), and 20 mg/2 mL (purple color band). ☐ NuSpin: 5 mg/2 mL (clear device), 10 mg/2 mL (green device), and 20 mg/2 mL (blue device).
Saizen ® [somatropin (rDNA origin) for injection], for subcutaneous injection	**Pediatric GHD**: 0.18 mg/kg/week, divided into equal doses given either on 3 alternate days, 6 times per week or daily	Saizen lyophilized powder in vial: 5 mg and 8.8 mg Saizen click. easy reconstitution device: one vial containing 8.8 mg somatropin and one cartridge diluent containing 1.51 ml 0.3% (w/v) metacresol in sterile water for injection

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GROWTH HORMONE TREATMENT IN ADULTS

Product Name	FDA Indication
Genotropin®	Growth hormone deficiency (GHD)
Saizen®	Growth hormone deficiency (GHD)
Omnitrope®, Nutropin®, Norditropin®, Humatrope®	*(Refer to Genotropin)*

PRADER WILLI

- ☐ Growth hormone therapy is not approved in Prader Willi unless the beneficiary meets the growth hormone deficiency criteria for adults.

REVIEW CRITERIA FOR ADULTS

- ☐ Must have approved diagnosis (see chart above for requested medication).
- ☐ The prescriber of the requested growth hormone must be an endocrinologist.
- ☐ Patients with childhood-onset growth hormone deficiency (COGHD) previously treated with GH replacement in childhood should be retested after final height is achieved and GH therapy discontinued for at least 3 months to ascertain their GH status before considering restarting GH therapy **(at the reduced dose level recommended for growth hormone deficient adults)**. (A repeat stimulation test may be required at the beginning of the next age increment in which a variation of IGF-1 occurs.)
- ☐ For childhood GH treatment of conditions other that GHD, such as Turner's syndrome and idiopathic short stature, there is no proven benefit to continuing GH treatment in adulthood.
- ☐ A negative response to a standard growth hormone stimulation test is a maximum peak of < 5 ng/ml, when measured by radioimmunoassay (RIA) (polyclonal antibody) or < 2.5 ng/ml when measured by immunoradiometric assay (monoclonal antibody).
- ☐ The preferred stimulation test agent is the Insulin Tolerance Test (ITT). Alternative provocative tests may be used in patients with contraindication to ITT. Other alternatives include glucagon, and rarely the arginine test alone. The glucagon stimulation test is associated with good performance and great diagnostic accuracy for GHD diagnosis:
  - ☐ If a **single agent test (arginine)** is used there may be a requirement for a second stimulation test depending on the IGF-1. If the IGF-1 is subnormal with the presentation of a hypothalamic disorder(s) then one stimulation test would be required. However, if the IGF-1 is normal with hypothalamic pituitary disorder(s) then two stimulation tests may be required.
  - ☐ **ITT** is contraindicated in cases with coronary artery disease or seizures, abnormal EKG with history of Ischemic Heart Disease or Cardiovascular Disease, and not advised for those > age 60.
- ☐ Levodopa and Clonidine are not adequate agents for adult testing.
- ☐ The practitioner must correct for TSH deficiency prior to completing a stimulation test.
- ☐ A Growth Hormone stimulation test is not required when there is documented deficiencies of 3-4 pituitary hormones or documented deficiency of two pituitary hormones and IGF-1 < 84ng/ml. The anterior pituitary hormone deficiencies accepted for this exception to stimulation testing include: FSH and/or LH (subnormal results in both FSH and LH, simultaneously, would count as one deficiency), TSH, ACTH, and arginine vasopressin (AVP).
- ☐ Low IGF-1 alone is not an indicator of growth hormone deficiency.

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GROWTH HORMONE TREATMENT IN ADULTS (CONTINUED)

- For diagnosis of short bowel syndrome the prescriber must submit documentation to verify the diagnosis and the use of specialized nutrition support such as a high carbohydrate, low fat diet, enteral feedings, parenteral nutrition, fluid, and micronutrient supplements. Zorbtive® therapy is indicated under these conditions.
  - **NOTE:** Changes to concomitant medications should be avoided during Zorbtive® therapy.
  - Subcutaneous dosage (Zorbtive® only): *Adults and the elderly:* 0.1 mg/kg SC once daily **for 4 weeks**. Do not exceed a maximum of 8 mg/day. Dosage selection for the elderly should usually start at the lower end of the dosage range. In clinical trials, Zorbtive® (plus a specialized oral diet without glutamine) vs. diet alone significantly decreased the total amount of intravenous parenteral nutrition (TPN) by 2.1L/week. The addition of glutamine to the diet/Zorbtive® group resulted in a significant decrease in IPN of 3.9 L/week. Other clinical reports have also documented a reduction in TPN usage.

REFERENCE CHART – GROWTH HORMONE TREATMENT IN ADULTS

DRUG	DOSAGE	FORMULATION
Genotropin®(somatropin [rDNA origin] for injection), for subcutaneous use	**Adult GHD:** Either a non-weight based or a weight based dosing regimen may be followed, with doses adjusted based on treatment response and IGF-I concentrations : - Non-weight based dosing: A starting dose of approximately 0.2mg/day (range 0.15-0.30 mg/day) may be used without consideration of body weight, and increased gradually every 1-2 months by increments of approximately 0.1-0.2 mg/day. - Weight based dosing: The recommended initial dose is not more than 0.04 mg/kg/week; the dose may be increased as tolerated to not more than 0.08 mg/kg/week at 4–8 week intervals.	Genotropin lyophilized powder in a two-chamber color-coded cartridge: - 5 mg (green tip) and 12 mg (purple tip) (with preservative) Genotropin MiniQuick Growth Hormone Delivery Device containing a two chamber cartridge (without preservative): - 0.2 mg, 0.4 mg, 0.6 mg, 0.8 mg, 1.0 mg, 1.2 mg, 1.4 mg, 1.6 mg, 1.8 mg, and 2.0 mg
Saizen ® [somatropin (rDNA origin) for injection], for subcutaneous injection	**Adult GHD:** Either a non-weight based or a weight based dosing regimen may be followed, with doses adjusted based on treatment response and IGF-1 concentrations: - Non-weight based dosing: A starting dose of approximately 0.2 mg/day (range 0.15-0.30 mg/day) may be used without consideration of body weight, and increased gradually every 1 to 2 months by increments of approximately 0.1 to 0.2 mg/day. - Weight based dosing: The recommended initial dose is not more than 0.005 mg/kg/day; the dose may be increased as tolerated to not more than 0.01 mg/kg/day after 4 weeks.	Saizen lyophilized powder in vial: 5 mg and 8.8 mg Saizen click.easy reconstitution device: one vial containing 8.8 mg somatropin and one cartridge diluent containing 1.51 ml 0.3% (w/v) metacresol in sterile water for injection

HARVONI® (LEDIPASIVIR/SOFOSBUVIR)

Length of Authorization:	☐ 8 Weeks, 12 Weeks, or 24 Weeks
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)
Fax Form:	Hepatitis C Agents **[REQUIRED]**

FOR GENOTYPE 1 NEW THERAPY REQUESTS, RESUBMIT FOR PREFERRED VIEKIRA PAK [EXCEPT THOSE WITH DECOMPENSATED CIRRHOSIS (CHILD PUGH B/C]) AND FOR GENOTYPE 4 REQUESTS, RESUBMIT FOR PREFERRED TECHNIVIE

MCC-FL ONLY: All Harvoni® requests must be reviewed by the Plan for consideration of Zepatier® when Zepatier® would be a valid therapeutic option. MRx RPh staff will e-mail Moses Allen and Vanessa Zeilinger (MAllen22@magellanhealth.com; VZeilinger@magellanhealth.com) to notify them whenever we have a Harvoni® request in our FirstTrax™ MCC-FL queue. They will review the request and provide feedback on the action that we should take in the progression of the PA request.

REVIEW CRITERIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

REVIEW CRITERIA

1. Adult patient age ≥ 18 years old; **AND**
2. Prescribed by, or in consultation with, a hepatologist, gastroenterologist, infectious disease specialist, or transplant physician; **AND**
3. Patient has no history of ledipasvir and/or sofosbuvir (no claims history or reference in medical records to previous trial and failure) [Refer to **Appendix G** for additional information when reviewing for previous therapy]; **AND**
4. **One of the following:**
   - ☐ Patient has abstained from the use of illicit drugs and alcohol for a minimum of one month as evidenced by negative urine or blood confirmation tests collected within the past 30 days, prior to initiation of therapy (results must be submitted with request);
     - ☐ If the test results submitted is positive the reviewer must review claims history or medical records to determine if medications are prescribed. If so, proceed to next step (#5).

   OR
   - ☐ Patient is receiving substance or alcohol abuse counseling services or seeing an addiction specialist as an adjunct to HCV treatment and it is documented in the medical records; **AND**
5. Baseline HCV RNA must be submitted with a collection date within the past three months. **Prescriber must submit lab documentation indicating HCV genotype and quantitative viral load.**
6. Patient meets the diagnosis criteria outlined in Dosing and Administration below; **AND**
7. Patient commits to the documented planned course of treatment including anticipated blood tests and visits, during and after treatment; **AND**
8. **No early refills will be allowed due to lost, stolen medications, or vacation override.**
9. Lab results (HCV RNA) are recommended after 4 weeks of therapy and at 12 weeks following completion of therapy. The medication should not be discontinued or interrupted if HCV RNA levels are not available during treatment or are not performed
10. Females of childbearing potential must have a negative pregnancy test collected within 30 days prior to the initiation of therapy with ribavirin; **AND**
11. For HIV-1 co-infected patients, patients must have the following:
    - ☐ Document HIV-1 diagnosis; **AND**
    - ☐ CD4 count greater that 500 cells.mm^3, if patient is not taking antiretroviral therapy; **OR**
    - ☐ CD4 count greater the 200 cells/mm^3, if patient is virologically suppressed (e.g., HIV RNA < 200 copies/mL)

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HEPATITIS C AUTOPA CODING INFO:

- The following medications are included in AutoPA coding list "Hepatitis Therapy List B".
  - Peginterferon alfa-2a (Pegasys®); Peginterferon alfa-2b (Peg-Intron®/Redipen); Ribavirin (Copegus®, Moderiba®, RibaPak®, Ribasphere®, Ribatab®, Rebetol®
- When these medications are used in combination therapy with medications included in AutoPA coding list "Hepatitis Therapy List A" no prior auth is required for medications in "Hepatitis Therapy List B" as long as the "Hepatitis Therapy List A" medication is billed first.
  - Harvoni®, Olysio®, Sovaldi®, and Viekira Pak®
- If the medication in "Hepatitis Therapy List A" is not billed first, then the following error messages will display:
  - IE 31003 – Automated PA; NCPDP 75 – Prior authorization required
  - Transaction Message: "Missing Prerequisite Drug Therapy"
- The Hepatitis C AutoPA coding logic is explained in greater detail here.

DOSING AND ADMINISTRATION:

DIAGNOSIS: **1. HCV** **2. HCV/HIV-1 Co-infection**	**Genotype 1 (treatment-naïve without cirrhosis AND HCV RNA <6 million IU/ml)**
Length of Authorization:	8 Weeks

DIAGNOSIS: **1. HCV** **2. HCV/HIV-1 Co-infection**	**Genotype 1 (treatment naïve with or without cirrhosis or with compensated cirrhosis (Child-Pugh A), treatment experienced* without cirrhosis)**
Length of Authorization:	12 Weeks

DIAGNOSIS: **1. HCV** **2. HCV/HIV-1 Co-infection**	**Genotype 1 (treatment experienced* with compensated cirrhosis (Child-Pugh A))**
THERAPY	HARVONI **OR** HARVONI + RIBAVIRIN
Length of Authorization:	Harvoni Monotherapy: 24 Weeks Harvoni + Ribavirin: 12 Weeks

DIAGNOSIS: **1. HCV** **2. HCV/HIV-1 Co-infection**	**Genotype 1 (treatment naïve and treatment experienced* with decompensated cirrhosis (Child-Pugh B or C)**
THERAPY	HARVONI **OR** HARVONI + RIBAVIRIN
Length of Authorization:	Harvoni Monotherapy: 24 Weeks Harvoni + Ribavirin: 12 Weeks

DIAGNOSIS: **1. HCV** **2. HCV/HIV-1 Co-infection -**	**Genotype 1 or 4 (treatment naïve and treatment experienced* liver transplant recipients without cirrhosis or with compensated cirrhosis (Child-Pugh A)**
THERAPY	HARVONI + RIBAVIRIN
Length of Authorization:	12 Weeks

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HARVONI® (LEDIPASIVIR/SOFOSBUVIR) (CONTINUED)

DIAGNOSIS: 1. HCV 2. HCV/HIV-1 Co-infection -	Genotype 4, 5 or 6 (treatment naïve, treatment experienced* without cirrhosis or with compensated cirrhosis (Child-Pugh A))
Length of Authorization:	12 Weeks

* Treatment experienced is defined as patients who have failed a peginterferon alfa + ribavirin based regimen with or without an HCV protease inhibitor

**Ribavirin dose for patients with compensated cirrhosis (Child-Pugh A) is weight based (1,000 mg for patients less than 75 kg and 1,200 mg for patient greater than or equal to 75 kg) administered in two divided doses.

*** In patient with decompensated cirrhosis, the starting dose of ribavirin is 600 mg and can be titrated to 1,000 mg for patients less that 75 kg and 1,200 mg for those greater than or equal to 75 kg in two divided doses. If the starting dose of ribavirin is not well tolerate, the dosage should be reduced as clinically indicted based on hemoglobin levels.

Harvoni should not be taken concomitantly with any other HCV protease inhibitors

DENIAL CRITERIA

HCV – Genotype 2,3
THERAPY REFERRAL: OTHER HEPATITIS C AGENTS

DENIAL MESSAGE

H.P. ACTHAR GEL (REPOSITORY CORTICOTROPIN INJECTION)

Length of Authorization:	Per titration schedule/prescription
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)
PA Entry Notes:	☐ Volume must be entered in multiples of five. ☐ May require multiple prior authorizations due to titration schedule.

REVIEW CRITERIA

Diagnoses to Approve:

- ☐ Infantile Spasms (West Syndrome):
  - ☐ Patient must be < 2 years old
  - ☐ Must have a diagnosis of West Syndrome (infantile spasms).
  - ☐ Medication must be prescribed by neurologist or a specialist in this field of study.
- ☐ Acute Exacerbations in Adults with Multiple Sclerosis:
  - ☐ Patient must be ≥ 18 years old.
  - ☐ Must have a diagnosis of Multiple Sclerosis.
  - ☐ Patient must have failed corticosteroid therapy (e.g. dexamethasone, hydrocortisone, methylprednisolone, prednisone, etc.).
  - ☐ Medication must be prescribed by neurologist or a specialist in this field of study.
    - ☐ Requests for diagnostic testing of adrenocortical function should be redirected to the preferred agent cosyntropin.
    - ☐ Requests for other diagnoses are considered experimental and investigational, therefore provider should be redirected to alternative PDL trials (non-pharmacist reviewers must consult with a pharmacist).
- ☐ No other diagnoses are to be approved.
  - ☐ Approximately a $68,000.00 drug.
  - ☐ Account Team wants to emphasize how important they feel that it is to be absolutely strict on criteria with this medication.
  - ☐ Do not approve if it does not meet every single criteria. If it is questionable or unclear, Deny and allow the member to appeal. Expectation is heavily in favor of a denial if it does not meet even one of the criteria components. There are many available products on the formulary that can be utilized for 98% of the population instead of this medication.

HEMANGEOL™ (PROPRANOLOL ORAL SUSPENSION)

Length of Authorization:	6 Months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

INITIAL REVIEW CRITERIA

- ☐ Infant has a diagnosis of proliferating infantile hemangioma
- ☐ Infant's age is in the range of 5 weeks (adjusted gestational age) to 5 months
- ☐ Infant weighs a minimum of 2 kilograms
- ☐ Infant has ***none*** of the contraindications as listed below:
  - ☐ Known hypersensitivity to propranolol or excipients
  - ☐ Asthma or history of bronchospasms
  - ☐ Bradycardia (< 80 beats per minute)
  - ☐ Greater than first degree heart block
  - ☐ Decompensated heart failure
  - ☐ Blood pressure < 50/30 mmHg
  - ☐ Pheochromocytoma

RE-TREATMENT REVIEW CRITERIA

- ☐ Patient had initial successful treatment with Hemangeol for 6 months resulting in complete or nearly complete resolution of the target hemangioma but has experienced a recurrence.

HEMATOPOIETIC AGENTS

ARANESP® (DARBEPOETIN ALFA)

Length of Authorization:	Up to 6 months. See below – varies based on diagnosis
Initiative:	MAP: Hematopoietic Agents (75 / 2462 – GSN; 76 / 2641 – GSN)
Fax Form:	Aranesp®

REVIEW CRITERIA: (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

Anemia associated with chronic kidney disease (CKD) if patient is not on dialysis: (Approve for 6 months):

- ☐ Initial Therapy – Patient must meet all requirements below:
  - ☐ Hemoglobin < 10 g/dL
  - ☐ Transferrin saturation ≥ 20% and Serum Ferritin ≥ 100ng/mL
  - ☐ Lab data within 2 months of PA submission
- ☐ Continuation of Therapy - Patient must meet all requirements below:
  - ☐ Hemoglobin ≤ 10 g/dL
  - ☐ Transferrin saturation ≥ 20% and Serum Ferritin ≥ 100ng/mL
  - ☐ Lab data within 2 months of PA submission

Anemia associated with chronic kidney disease (CKD) if patient is receiving home dialysis: (Approve for 6 months):

- ☐ Initial Therapy – Patient must meet all requirements below:
  - ☐ Hemoglobin < 10 g/dL
  - ☐ Transferrin saturation ≥ 20% and Serum Ferritin ≥ 100ng/mL
  - ☐ Lab data within 2 months of PA submission
- ☐ Continuation of Therapy - Patient must meet all requirements below:
  - ☐ Hemoglobin ≤ 11 g/dL
  - ☐ Transferrin saturation ≥ 20% and Serum Ferritin ≥ 100ng/mL
  - ☐ Lab data within 2 months of PA submission

Anemia associated with chemotherapy (Approve for 6 months):

- ☐ Initial Therapy - Patient must meet all requirements below:
  - ☐ No existing history of iron or folate deficiency, hemolysis, or gastrointestinal bleeding
  - ☐ Hemoglobin < 10 g/dL
  - ☐ Transferrin saturation ≥ 20% and Serum Ferritin ≥ 100ng/mL
  - ☐ Providers must submit documentation of enrollment in the ESA APPRISE Oncology Program
  - ☐ Must be on or initiating chemotherapy.
- ☐ Continuation of Therapy - Patient must meet all requirements below:
  - ☐ No existing history of iron or folate deficiency, hemolysis, or gastrointestinal bleeding
  - ☐ Hemoglobin ≤ 10 or lowest level sufficient to avoid transfusion
  - ☐ Transferrin saturation ≥ 20% and Serum Ferritin ≥ 100ng/mL

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PROCRIT®/EPOGEN® (EPOETIN ALFA)

Length of Authorization:	Up to 6 months. See below – varies based on diagnosis
Initiative:	MAP: Hematopoietic Agents (2462/75 – GSN; 2641/76 – GSN) – for Preferred PDL: Non-Preferred Drug Override (2462/75 – GSN; 2641/76 – GSN; 31004/75 – GSN) for Non-Preferred
Fax Form:	Procrit /Aranesp

REVIEW CRITERIA: (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

Anemia associated with chronic kidney disease (CKD) if patient is not on dialysis or is receiving home dialysis: (Approve for 6 months):

- ☐ Initial Therapy – Patient must meet all requirements below:
  - ☐ Hemoglobin < 10 g/dL.
  - ☐ Transferrin saturation ≥ 20% and Serum Ferritin ≥ 100ng/mL.
  - ☐ Lab data within 2 months of PA submission.
- ☐ Continuation of Therapy - Patient must meet all requirements below:
  - ☐ Hemoglobin ≤ 11 g/dL.
  - ☐ Transferrin saturation ≥ 20% and Serum Ferritin ≥ 100ng/mL.
  - ☐ Lab data within 2 months of PA submission.

Anemia associated with chemotherapy (Approve for 6 months):

- ☐ Initial Therapy - Patient must meet all requirements below:
  - ☐ No existing history of iron or folate deficiency, hemolysis, or gastrointestinal bleeding.
  - ☐ Hemoglobin < 10 g/dL.
  - ☐ Transferrin saturation ≥ 20% and Serum Ferritin ≥ 100ng/mL.
  - ☐ Providers must submit documentation of enrollment in the ESA APPRISE Oncology Program.
- ☐ Continuation of Therapy - Patient must meet all requirements below:
  - ☐ No existing history of iron or folate deficiency, hemolysis, or gastrointestinal bleeding.
  - ☐ Hemoglobin ≤ 12 or lowest level sufficient to avoid transfusion.
  - ☐ Transferrin saturation ≥ 20% and Serum Ferritin ≥ 100ng/mL.

Anemia associated with human immunodeficiency virus (Approve for 3 months):

- ☐ Initial Therapy - Patient must meet all requirements below:
  - ☐ No existing history of iron or folate deficiency, hemolysis, or gastrointestinal bleeding.
  - ☐ Hemoglobin < 13 g/dL in men and < 12 g/dl in women.
  - ☐ Transferrin saturation ≥ 20% and Serum Ferritin ≥ 100ng/mL
- ☐ Continuation of Therapy - Patient must meet all requirements below:
  - ☐ Hemoglobin < 13 g/dL in men and < 12 g/dl in women
  - ☐ Transferrin saturation ≥ 20% and Serum Ferritin ≥ 100ng/mL

Anemia associated with Hepatitis C (Approve for 6 months):

- ☐ Initial Therapy - Patient must meet all requirements below:
  - ☐ No existing history of iron or folate deficiency, hemolysis, or gastrointestinal bleeding.
  - ☐ Hemoglobin < 12 g/dL.
  - ☐ Transferrin saturation ≥ 20% and Serum Ferritin ≥ 100ng/mL.
  - ☐ Current HCV therapy with Ribavirin.
- ☐ Continuation of Therapy - Patient must meet all requirements below:
  - ☐ Hemoglobin ≤ 12 g/dl.
  - ☐ Transferrin saturation ≥ 20% and Serum Ferritin ≥ 100ng/mL.
  - ☐ Current HCV therapy with Ribavirin.

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PROCRIT®/EPOGEN® (EPOETIN ALFA) *(CONTINUED)*

To reduce the need for allogenic blood transfusions in anemic patients scheduled to undergo elective, noncardiac, nonvascular surgery (Approve no more than 15 doses):

- Must be unwilling to donate blood.
- Patient must have a hemoglobin > 10 and <= 13 g/dL.
- Must be receiving iron supplementation

PREFERRED – PA REQUIRED	NON-PREFERRED – PA REQUIRED
Procrit®	Epogen®

NOTE

If a Patient is on dialysis and the dialysis takes place at **home,** Magellan Rx Management **may approve** if all other criteria are met. If the dialysis takes place in a **dialysis center,** Magellan Rx Management **may not approve** as the center must bill for the medication.

NOTE

Mircera® (Methoxy polyethylene glycol-epoetin beta (MPG-epoetin beta) or continuous erythropoietin receptor activator [CERA]): Criteria have not been created as this product will be discussed in the June 2015 P&T meeting. In the interim, all requests for Mircera® are to be redirected to Procrit® or Aranesp® as current and similar products that are preferred.

HEPARIN – LOW MOLECULAR WEIGHT

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN) PDL: Non-Preferred Brand Required (75 / 2462 – NDC-9; 76 / 2641 – NDC-9; 22 / 50021 – NDC-9) (for Arixtra® requests only)

1. Is there any reason that the Patient cannot be switched to a preferred medication? **Document details.** Acceptable reasons include
   - ☐ Allergy to all preferred medications
   - ☐ Contraindication to all preferred medications
   - ☐ History of unacceptable side effects
   - ☐ Patient is clinically stable and switching would cause deterioration in condition
2. The requested medication may be approved if ***both*** of the following are true:
   - ☐ If there has been a therapeutic failure to no less than a one-month trial of two preferred medications AND
   - ☐ The requested medication's corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Enoxaparin (generic for Lovenox®)	Arixtra® (*fondaparinux*) **Note:** The MAP: Non-Preferred Brand Required must be used
Fragmin® (*dalteparin*)	Heparin Sodium *
	Lovenox® (*enoxaparin*)

HETLIOZ® (TASIMELTEON)

Length of Authorization:	☐ Initial therapy: 6 months ☐ Continuation of therapy: 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

INITIAL REVIEW CRITERIA (ALL OF THE FOLLOWING MUST BE TRUE):

- ☐ Patient is ≥18 years old (safe and effective use in pediatric patients has not been established)
- ☐ Patient is totally blind
- ☐ Patient has a diagnosis of Non-24-hour sleep-wake disorder ("non-24") documented in clinical notes or health conditions (ICD-9: 327.34)
- ☐ Do NOT approve for insomnia

CONTINUATION OF THERAPY REVIEW CRITERIA:

- ☐ All of the criteria relating to initial therapy are applicable

HIGH DOSE GUIDELINES (DUR – HD)

Length of Authorization:	Up to one year
Initiative:	MAP: High Dose Override (88/ HD – NDC-11; 76 / 2641 – NDC-11)
Fax Form:	Pharmacy – Miscellaneous [Required] (may be labeled as General in our lists)

DIRECTIVE

- Only the prescriber may submit requests; the PA form is required (see above).
- If a pharmacy calls requesting a high dose override:
  - They are to be informed that the prescriber must submit a PA request.
  - They are to be informed of the plan limitation to allow them, in the interim on the patient's behalf, the option to process the claim within the plan limitation to allow time for a PA to be submitted.
  - Our staff should check the claim to verify that the pharmacy is building/billing the claim with the correct quantity and day supply as ordered per the prescription.
- If a member calls requesting a high dose override:
  - Our staff taking the call may redirect the Patient to have the Physician or Pharmacy call MPS at 877-553-7481 so that they can be instructed on how to resolve the issue; **OR**
  - Transfer the call to the Ombudsman staff where a pharmacist will notify the Patient to have the Pharmacist or Physician follow #1 or #2 above.

Technicians:
Resolve incomplete requests by noting to the caller or by returning the fax as to what is needed for review.
ESCALATE ALL properly submitted fax requests for DUR – HD (IE 280 [*DUR reject error*] / NCPDP 88 [*DUR reject error*]) override to a pharmacist.
Pharmacists: Please use your clinical judgment when handling these requests. Approval should be granted on the basis of therapeutic appropriateness for the diagnosis submitted. It may be necessary to request that the physician submit additional clinical documentation (i.e., clinical literature/journal articles, clinical trial results, etc.) to substantiate their request. You must explain in detail the rationale used in making your final determination.

HIV DIAGNOSIS VERIFICATION AND PRE-EXPOSURE PROPHYLAXIS FOR HIV

Length of Authorization:	Varies with indication up to 1 year
Initiative:	☐ MAP: AP: HIV Agents (75 / 2462 – GSN; 75 / 31004 – GSN; 76 / 2641 – GSN) ☐ MAP: AP: Tybost 60/2193 – GSN; 75/31006 – GSN; 76/2641 – GSN) ☐ MAP: AP: Comp/Evo/Prez/Strib/Trimq (75 / 2462 – GSN; 75 / 31008 – GSN; 75 / 31010 – GSN; 76 / 2641 – GSN; 76 / 31027 – GSN) ☐ PDL: Non-Preferred Brand Required (75 / 2462 – NDC-9; 76 / 2641 – NDC-9; 22 / 50021 – NDC-9) (Used for Viramune suspension and Ziagen tablets only. Note: A second PA must also be entered using the MAP: AP HIV Agents initiative for these medications).
Fax Form:	☐ HIV Diagnosis Verification

This chart for Auto PA Step Edits is a visual FYI only. See detailed Criteria on the following pages.

Florida Medicaid Auto PA Step Edits (HIV Therapy) **Not all dosage forms are included in AutoPA coding.**

Automated PA approval satisfies L = Auto PA drug edit.

Automated PA approval will **NOT** override R = Non-PDL or Q = Clinical PA -AHCA edit

List of HIV therapy (can be coded at HIC3 except Epivir Retrovir, and Videx which will have to be done at HSN 010215)

HIC3	Drug Name	HSN
W5C	Crixivan	010683
	Invirase	010232
	Lexiva	025662
	Norvir	010412
	Reyataz	025390
	Viracept	010858
	Evotaz	041722
W5J	Emtriva	002766
	Epivir	010215
	Retrovir (Zidovudine)	004185
	Videx (Didanosine DR)	006510
	Ziagen	018857
	Zerit (Stavudine)	009060
W5K	Edurant	037628
	Intelence	035342
	Rescriptor	012954
	Sustiva	018748
	Viramune (XR)	011592
W5L	Combivir	014014
	Epzicom	026524
	Trizivir	021800
W5M	Kaletra	021582
W5O	Truvada	026515
W5P	Aptivus soln	035849
	Aptivus cap	033003
	Prezista	033842
	Prezcobix	041531
W5Q	Atripla	033888
	Complera	037822
W5U	Isentress	035072
	Tivicay	040533
	Viteka	040834
W5X	Stribild	039543
	Genvoya	042778
W5Z	Triumeq	041355

Additional drug-specific info on the next page.

Step 1: If the incoming claim is from the HIV therapy list (excluding HSN 037628-Edurant, HSN 037822 –Complera, HSN 041722- Evotaz, HSN 042778-Genvoya, HSN 041531-Prezcobix, HIC3 W5X-Stribild, HIC3 W5Z-Triumeq, and HSN 040834 - Vitekta) and the recipient is </= 1 year old or the claim is submitted with a day supply of < 34 days with New/refill code = zero and Refills Authorized = 0: NO PA REQUIRED. Otherwise, PROCEED TO STEP 2.

Step 2: If the incoming claim is from the HIV therapy list, look back in medical claims history 730 days for ICD-9 042, V08, or 079.53, ICD-10 B20, Z21, and B97.35: IF FOUND, PROCEED TO STEP 3. Otherwise, DENY for PRIOR AUTHORIZATION REQUIRED (75), M/I Diagnosis Code (supplemental message).

Step 3: If the incoming claim is for <Edurant>, <Complera>, <Evotaz>, <Genvoya>, <Prezcobix>, <Stribild>, <Triumeq>, or <Vitekta> (and there is no previous history of itself in the past 365 days): PROCEED TO STEP 4. If there is a previous history of itself in the past 365 days proceed to step 6. Otherwise, NO PA REQUIRED.

Step 4: If the incoming claim is <Edurant> and the patient is greater 11 years old: PROCEED TO STEP 5. If the incoming claim is <Genvoya> or <Complera> and the patient is greater than 11 years old: PROCEED TO STEP 6. If the incoming claim is <Evotaz>, <Prezcobix>, <Stribild>, <Triumeq>, or <Vitekta> and the patient is greater than 17 years old: PROCEED TO STEP 6. Otherwise, DENY for PRODUCT SERVICE NOT COVERED FOR PATIENT AGE (60), "Min age >/= 18, (except Complera, Edurant, and Genvoya, min age >/= 12)" (supplemental message).

Step 5: If the incoming claim is <Edurant> and the patient drug history does not contain a fill from the HIV Therapy list for greater than 5 days old but less than 365 days old: PROCEED TO STEP 6. Otherwise, DENY for PRIOR AUTHORIZATION REQUIRED (75), Patient is not treatment naïve (supplemental message).

Step 6: If the incoming claim is <Edurant>, <Complera>, <Genvoya>, <Evotaz>, <Prezcobix>, <Stribild>, <Triumeq>, or <Vitekta> and the quantity on the incoming claim is less than or equal to 1 tablet per day: NO PA REQUIRED. Otherwise, DENY for PLAN LIMITATIONS EXCEEDED (76).

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APPROVED INDICATIONS

HIV DIAGNOSIS VERIFICATION: length of approval = 1 year

1. If Patient is a newborn with an indication for maternal-fetal prophylaxis, the request may be approved immediately. If the Patient is a victim of sexual assault (non-occupational exposure prophylaxis), and the prescription is for less than 34 days of therapy, with no refills, then the request may be approved immediately.
2. **MCC-FL and FCA:** Patients and pharmacy providers that verbally attest to an HIV diagnosis should be allowed a one-month override to allow time for the prescriber to verify an approvable diagnosis. Patient attestations must be received by us from their pharmacy or prescriber (pt may be new to a prescriber who does not yet have records to confirm history or current diagnosis); we do not accept requests directly from the patient.
   CCP/SFCCN (effective 09/12/2014): Pharmacy providers that verbally attest to an HIV diagnosis **shall be allowed a FULL-term one-year approval;** prescribers are **NOT** required to submit a PA request to verify the diagnosis.
3. If the diagnosis of HIV can be confirmed by the prescriber, the request may be approved (if request is for Edurant, do not approve yet, go to #6).
4. If the request is for PrEP, refer to the **Pre-Exposure Prophylaxis (PrEP) for HIV** in the section below
5. If the request is for Edurant, the Patient is treatment naïve (no history of HIV/AIDS related antiretroviral therapy), and a confirmed (per prescriber) HIV/AIDS diagnosis is present, you may approve if #9 (qty limit) and #10 (age limit) are met.
6. Before denying non-treatment naïve requests for Edurant, verify whether #7 (continuation of therapy) or #8 (Complera specific) apply.
7. If the request is for continuation of Edurant, the Patient has documented history of Edurant, and the Patient has a confirmed (per prescriber) HIV/AIDS diagnosis, then go to #9.
8. The quantity for Complera, Edurant, Triumeq, Evotaz, Prezcobix, Vitekta, and Stribild therapy should not exceed one tablet per day (go to #10).
9. Complera, Edurant, Triumeq, Evotaz, Prezcobix, Vitekta, and Stribild may be approved for recipients greater than 17 years of age only.
10. If Complera or Edurant is requested due to treatment failure or an adverse effect as a result of previous therapy, please escalate to a pharmacist. Documentation of the adverse event and labs (CD4 count, etc.) must be included for further consideration.

PRE-EXPOSURE PROPHYLAXIS (PreP) FOR HIV: Approval = 6 months to confirm Testing

- ☐ Creatinine clearance must be ≥ 60 mL per minute (via Cockcroft-Gault Formula) (*the date of the test results should be entered in PA notes*). *For continuation of therapy,* blood urea nitrogen, and serum creatinine should be checked 3 months after initiation of PrEP, then yearly while on medication.
- ☐ Patient must have a negative HIV antibody test before starting PrEP medications (*the date of the test should be entered in PA notes*). *For continuation of therapy,* the antibody test must be repeated every 2-3 mnths and remain negative.
- ☐ Patient should be at high risk for acquiring HIV infection due to behaviors as per the medical records.
- ☐ Prior to initiation of therapy the Patient should be screened for sexually transmitted infections (STI) and treatment for STI started if needed (*the date of the test should be entered in PA notes*). *For continuation of therapy,* the Patient should be tested every 6 months for STI.
- ☐ The next office visit should be within 90 days for re-evaluation, HIV testing, other lab tests, and a new prescription. Every 2–3 months the Patient's risk behaviors should be reassessed and receive risk reduction counseling and condoms. This assessment and counseling must be documented in progress notes.
- ☐ Claims history should be checked to see if the Patient has missed 2 or more refills. If so, deny.

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EDURANT® (FOR TREATMENT EXPERIENCED PATIENTS)

Length of Authorization:	Up to 365 days
Initiative:	MAP: AP: Comp/Evo/Prez/Strib/Trimq (75 / 2462 – GSN; 75 / 31008 – GSN; 75 / 31010 – GSN; 76 / 2641 – GSN; 76 / 31027 – GSN)
Fax Form:	HIV Diagnosis Verification Form; Miscellaneous Pharmacy Prior Authorization Form

REVIEW CRITERIA (RPH REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

Initiation of Therapy:

- ☐ Prior authorization requests related to a lack of a diagnosis code on record or for HIV diagnosis verification may be submitted on the HIV Diagnosis Verification Form. **CCP/SFCCN (effective 09/12/2014):** Pharmacy providers that verbally attest to an HIV diagnosis **shall be allowed a FULL-term one-year approval;** prescribers are **NOT** required to submit a PA request to verify the diagnosis.
- ☐ If patient has a confirmed diagnosis of HIV (per medical records or diagnosis codes), is treatment naïve (no history of HIV/AIDS related antiretroviral (ARV) therapy), and has HIV RNA-1 < 100,000 copies/mL, then approve. If patient has a confirmed diagnosis, but is not treatment naïve, then proceed to #2. Deny if no confirmed diagnosis.

1. Patient must have a viral count (HIV RNA) > 200 copies/mL. (Provider must supply copies of the last two official viral load lab results dated within the past six months.)
2. Patient must have had treatment failure of antiretroviral therapy.
   - ☐ Failure is defined as lack of response as evidenced by viral load.
   - ☐ Failure due to noncompliance is not reason for approval.
   - ☐ Requests due to convenience are not a reason for approval.
   - ☐ Medication intolerance due to adverse side effects may not be a reason to approve the requested therapy. The reviewing pharmacist should look for the patient's tolerance of the current regimen and the severity and duration of side effects. Management strategies for intolerance in the absence of drug resistance may include:
     - ☐ Using symptomatic treatment (e.g., antiemetics, antidiarrheals);
     - ☐ Changing one ARV to another within the same drug class, if needed (e.g., change to tenofovir [TDF] or abacavir [ABC] for zidovudine [ZDV]-related toxicities; change to nevirapine [NVP] or etravirine [ETR] for efavirenz [EFV]-related toxicities);
     - ☐ Changing from one drug class to another (e.g., from a non-nucleoside reverse transcriptase inhibitor [NNRTI] to a protease inhibitor [PI], from enfuvirtide [T-20] to raltegravir [RAL]) if necessary and no prior drug resistance is suspected.
     - ☐ Review food/fasting requirements for each medication. See if patient taking with food or not *(e.g., Adverse effect may be resolved or improved if medication is taken with food.)*
     - ☐ If viral load > 1000 copies/mL, drug resistance tests (dated within the past six months) must be submitted.
   - ☐ If a provider is able to provide this test then it is evident that the patient is being managed for suboptimal viral load reduction.
   - ☐ FYI: Routine genotypic or phenotypic testing (drug resistance testing) gives information relevant for selecting nucleoside reverse transcriptase inhibitors (NRTIs), NNRTIs, and PIs. Additional drug-resistance tests for patients experiencing failure on fusion inhibitors and/or integrase strand transfer inhibitors (INSTIs) and viral tropism tests for patients experiencing failure on a CCR5 antagonist also are available.
     - ☐ The quantity should not exceed one tablet per day.
     - ☐ Recipients must be ≥12 years of age.

Continuation of Therapy:

1. Patient must have had previous history (per claims or medical records history) of medication in the past 365 days.
2. The quantity should not exceed one tablet per day.
3. Recipients must be >12 years of age.

HIV INGREDIENT DUPLICATION DIRECTIVE

Length of Authorization:	Date of Service
Initiative:	MAP: Ingredient Duplication (76 / 2641 – GSN; 88 / ID – GSN)
Reason Code:	Date of Service PA Approved

REVIEW CRITERIA

Requests for the ingredient duplication edit override for reasons listed below may be overridden via phone call or faxed prior authorization request:

- ☐ Change in Formulation/medication dosage form (i.e., solid to liquid)
- ☐ Change in Dose

Requests for reasons other than those listed above will require submission of a prior authorization request with rationale to support duplication of therapy; RPh review required.

INGREDIENT DUPLICATION (ID) NOT ALLOWED BY DISPENSING PHARMACY

The pharmacy will not be able to override the denial of Ingredient Duplication (ID) by utilizing the intervention/ professional service codes, outcome/result of service codes. All of the following HIC3s with duplicate ingredient claims will require an Magellan override.

W5C (excluding HSN 025390)	W5I	W5J	W5K	W5L	W5M	W5N	W5O	W5Q	W5T
W5P (excluding HSN 033842)	W5U	W5X							

HYDROXYPROGESTERONE CAPROATE INJECTION (FROM POWDER) (17-P)

According to the Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook, Florida Medicaid may reimburse for a compounded drug if it is a combination of two or more pharmaceuticals and the finished product is not otherwise commercially available in strength and formulation. Therefore, use of 17-alpha-hydroxyprogesterone caproate (17P) powder should not be treated as an alternative therapy to Makena.

REVIEW CRITERIA

- Requests for compounded product (17-P) must not be approved.
- Submission should be reviewed to determine if criteria for Makena is met. *(Refer to Makena criteria.)*

HYPERTONIC SOLUTION FOR CYSTIC FIBROSIS AUTOPA

GSNs listed in the Hypertonic Solution List are AutoPA coded for lookback 730 days for any listed qualifying ICD code.

Length of Authorization:	1 year
Initiative:	MAP: Non-Preferred Drug Override (75 / 2462 – GSN PatOverride; 76 / 2641 – GSN PatConstraint)

REVIEW CRITERIA

Must have one of the following Cystic Fibrosis diagnoses:

- ☐ **ICD-9 Codes**
  - ☐ 277.00 Cystic fibrosis without mention of meconium ileus
  - ☐ 277.01 Cystic fibrosis with meconium ileus
  - ☐ 277.02 Cystic fibrosis with pulmonary manifestation
  - ☐ 277.03 Cystic fibrosis with gastrointestinal manifestation
  - ☐ 277.09 Cystic fibrosis with other manifestation
- ☐ **ICD-10 Code**
  - ☐ E84 Cystic fibrosis

Edit	Drugs	Steps
Hypertonic Solution Automated PA approval satisfies L=Auto PA drug edit	**Hypertonic Solution List** **Drug Name** / **GSN** Sodium Chloride 3%, vial neb soln — 000588 Sodium Chloride 7% vial neb soln — 062746 Hyper-Sal 7% neb solution Pulmosal 7% neb solution Sodium Chloride 10% vial neb sol — 000587 Hyper-Sal 3.5% neb solution — 068364 Nebusal 6% neb solution — 067053	**Step 1:** If the incoming claim is from the <Hypertonic solution list>, look back in the medical claims history 730 days for ICD9 277.00 (Cystic fibrosis without meconium ileus), 277.01 (Cystic fibrosis with meconium ileus), 277.02 (Cystic fibrosis with pulmonary manifestations), 277.03 (Cystic fibrosis with gastrointestinal manifestations), 277.09 (Cystic fibrosis with other manifestations), OR ICD 10 Disease Group E84 (Cystic Fibrosis). If found, NO PA REQUIRED. Otherwise, Deny for PRIOR AUTHORIZATION REQUIRED (75) with supplemental message "M/I Diagnosis Code." **Approvable ICD 9-CM Codes** 277.00 — Cystic fibrosis without mention of meconium ileus 277.01 — Cystic fibrosis with meconium ileus 277.02 — Cystic fibrosis with pulmonary manifestation 277.03 — Cystic fibrosis with gastrointestinal manifestation 277.09 — Cystic fibrosis with other manifestation **Approvable ICD 10-CM Disease Group** E84 — Cystic fibrosis

HYPOGLYCEMICS – ORAL

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to a preferred medication? Document details. Acceptable reasons include
   - ☐ Allergy to the preferred medications in this class
   - ☐ Contraindication or drug-to-drug interaction with all preferred medications
   - ☐ History of unacceptable side effects
2. The requested medication may be approved if ***both*** of the following are true:
   - ☐ If there has been a therapeutic failure to no less than a two-month trial of two (when more than one are listed) preferred medications within the same group

     AND
   - ☐ The requested medication's corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

ALPHA-GLUCOSIDASE INHIBITORS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Glyset® (miglitol)*	Precose® (acarbose)

BIGUANIDES

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Metformin (generic for Glucophage®)	Fortamet® (metformin ext release)
Metformin ER (generic for Glucophage XR®)*	Glucophage® (metformin)*
	Glucophage XR® (metformin ext release)*
	Glumetza® (metformin ext release)
	Riomet® (metformin suspension)*

BIGUANIDE COMBINATIONS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Glipizide/Metformin	ActoPlus Met® (pioglitazone / metformin)
Glyburide/metformin (Glucovance®)	ActoPlus Met XR ® (pioglitazone / metformin)
Pioglitazone / metformin (generic for ActoPlus Met®)	Avandamet® (rosiglitazone / metformin)
	Glucovance® (glyburide / metformin)

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MEGLITINIDES

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Repaglinide (generic for Prandin®)	Prandimet® (repaglinide and metformin)
Starlix® (nateglinide)	Prandin® (repaglinide)

THIAZOLIDINEDIONES

Actos® and Pioglitazone: Must have a trial/failure on Metformin or a clinical reason not to try Metformin. Coding deployed 12/14/2015 with a retro effective date of 07/1/2015. Transaction message: "Must T/F metformin first."

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
	Actos® (pioglitazone) **[see criteria directly above this chart]**
	Avandaryl® (rosiglitazone/glimepiride)
	Avandamet® (metformin/rosiglitazone)
	Avandia® (rosiglitazone)
	Duetact® (pioglitazone/glimepiride)
	Pioglitazone (generic for Actos®) **[see criteria directly above this chart]**

2ND GENERATION SULFONYLUREAS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Glimepiride (generic for Amaryl®)	Amaryl® (glimepiride)
Glipizide (generic for Glucotrol®)	DiaBeta® (glyburide)
Glipizide ER (generic for Glucotrol XL®)	Glucotrol® and Glucotrol XL® (glipizide)
Glyburide (generic for DiaBeta®, Micronase®)	Glynase PresTab® (glyburide micronized)
Glyburide Micronized (generic for Glynase PresTab®)	

DIPEPTIDYL PEPTIDASE-4 INHIBITORS (DPP-4)

Januvia® and Onglyza®: Must have a trial/failure on Metformin or a clinical reason not to try Metformin. Coding deployed 12/14/2015 with a retro effective date of 07/01/2015. Transaction message: "Must T/F metformin first."

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Janumet® (sitagliptin/metformin)	Januvia® (sitagliptin) **[see criteria directly above this chart]**
Janumet XR® (sitagliptin/metformin)	Kazano® (alogliptin/metformin)
Jentadueto® (linagliptin/metformin)	Nesina® (alogliptin)
	Onglyza® (saxagliptin) **[see criteria directly above this chart]**
	Oseni® (alogliptin/pioglitazone)

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HYPOTENSIVES – ACE INHIBITORS, ARBS, ACTIVE RENIN INHIBITORS, AND COMBINATIONS

Length of Authorization:	1 year
Initiative:	☐ PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN) ☐ MAP: AP: Dose Optimization (75 / 2462 – GSN; 76 / 2641 – GSN) ☐ PDL: Non-Preferred Brand Required (75 / 2462 – NDC-9; 76 / 2641 – NDC-9; 22 / 50021 – NDC-9) ☐ MAP: AP: Dual RAS Blockade (75 / 7008 – GSN; 76 / 50082 – GSN)

1. Is there any reason the Patient cannot be changed to a preferred medication? **Document clinically compelling information.** Acceptable reasons include
   - ☐ Allergy to all preferred medications
   - ☐ Contraindication to all preferred medications
   - ☐ History of unacceptable side effects
2. The requested medication may be approved if **both** of the following are true:
   - ☐ If there has been a therapeutic failure to no less than a two-month trial of TWO preferred medications (when at least two options are available or group-specific guidance is noted) AND
   - ☐ The requested medication's corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

ADDITIONAL INFORMATION TO AID IN FINAL DECISION

- ☐ If a medication requiring prior approval was initiated in the hospital, then approve the requested medication.
- ☐ If the Patient requires a prior authorized medication based on a specific medical need that is not covered by the FDA indications of the medications not requiring prior approval, then allow the non-preferred medication. This should be reviewed for need at each request for reauthorization.

EPANED® (ENALAPRIL) ORAL SOLUTION

Length of Authorization:	One year
Initiative:	☐ MAP: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN) ☐ MAP: Age Limit Over Maximum (60 / 2194 – GSN; 60 / 2624 – GSN; 76 / 2641 – GSN)

REVIEW CRITERIA

PDL Criteria Do Not Apply

1. Patient must have a diagnosis of hypertension, symptomatic heart failure, or asymptomatic left ventricular dysfunction.
2. Patient must be one month to 11 years of age.
3. If the patient is 12 or older, medical records must indicate a history of difficulty swallowing (dysphagia), or a medical condition that is characterized by difficulty or inability to swallow.
   - ☐ If the recipient has a g-tube the request is approvable.
   - ☐ The prescription may serve as a medical record indicating the presence of a g-tube.
     The recipient's medication claims history may be used to determine if they require a disintegrating, crushed, or suspension formulations of medication (in such cases the Epaned oral solution may be approved).

NOTE

1. ACE INHIBITORS AND ARBS FOLLOW THE DOSE OP EDIT

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ACE INHIBITORS AND DIURETIC COMBINATIONS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Benazepril (generic for Lotensin®)	Accupril® and Accuretic® (*quinapril [hctz]*)
Captopril (generic for Capoten®)	Aceon® (*perindopril*)* [*2mg, 4mg, 8mg]
Enalapril (generic for Vasotec®)	Altace® (*ramipril*) Tablets, Capsules - if no dx of CHF
Enalapril/HCTZ (generic for Vaseretic®)	Benazepril HCT (generic for Lotensin HCT®)
Lisinopril (generic Prinivil®, and Zestril®)]	Captopril HCTZ (generic for Capozide®)
Lisinopril HCTZ (generic for Zestoretic®)	Fosinopril (generic for Monopril®) [*10mg, 20mg, 40mg]
Monopril® (*fosinopril*)	Fosinopril [hctz] (generic for Monopril HCT®)
Monopril HCT® (*fosinopril/hctz*)	Lotensin® and Lotensin HCT® (*benazepril hctz]*)
Quinapril (generic for Accupril®)	Mavik® (*trandolapril*)*
Ramipril (generic Altace®)	Moexipril (generic for Univasc®)
	Moexipril/HCTZ (generic for Uniretic®)
	Perindopril (generic for Aceon®) [*2mg, 4mg, 8mg]
	Prinivil® (*lisinopril*)
	Quinapril/HCTZ (generic for Accuretic®)
	Trandolapril (generic for Mavik®)
	Uniretic® (*moexipril / HCTZ*)
	Univasc® (*moexipril*)
	Vasotec® and Vaseretic® (enalapril [hctz])
	Zestril® (*lisinopril*)
	Zestoretic® (*lisinopril/hctz*)

ACE INHIBITOR PLUS CALCIUM CHANNEL BLOCKER COMBINATIONS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Amlodipine/Valsartan (generic for Exforge®)	Amlodipine besylate/Valsartan/ HCTZ (generic for Exforge HCT®)
Azor® (*amlodipine besylate/olmesartan medoxomil*)	Exforge® (*amlodipine besylate/valsartan*)
Benazepril/Amlodipine (generic for Lotrel®)	Exforge HCT® (*amlodipine besylate/valsartan/ HCTZ*)
Enalapril/Felodipine	Lotrel® (*benazepril/amlodipine*)
Entresto® (sacubitril/valsartan)	Tarka® (*trandolapril/verapamil*)
	Tribenzor® (*olmesartan/amlodipine/HCTZ*)

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ANGIOTENSIN II RECEPTOR ANTAGONISTS (ARBS) AND DIURETIC COMBINATIONS**

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Benicar® (*olmesartan*) [*20mg]	Atacand® (*candesartan*) [*4mg, 8mg, 16mg]
Benicar HCT® (*olmesartan/hctz*)	Atacand HCT® (*candesartan/hctz*)
Losartan (generic Cozaar)	Avalide® (*irbesartan / hctz*) – Use PDL: Non-Preferred Brand Required
Losartan/HCTZ (generic Hyzaar)	Avapro® (*irbesartan*) [*75mg, 150mg] – Use PDL: Non-Preferred Brand Required
Micardis® (*telmisartan*) [*20mg, 40mg]	Candesartan (generic for Atacand®)
Micardis HCT® (*telmisartan/hctz*)*	Candesartan/hctz (generic for Atacand HCT®
Valsartan (generic for Diovan®)	Cozaar® (*losartan*) [*25mg, 50mg]
Valsartan/hctz (generic for Diovan HCT®)	Diovan® (*valsartan*)* [*40mg, 80mg, 160mg - if no dx of CHF]
	Diovan HCT® (*valsartan/hctz*)*
	Hyzaar® (*losartan/hctz*)
	irbesartan (generic for Avapro®)
	irbesartan /hctz (generic for Avalide®)
	Teveten® and Teveten HCT® (*eprosartan [hctz]*)

NOTE

*Products will deny when the daily dose equals “2” or the daily dose exceeds “3.” Daily dose is calculated by taking the metric quantity on the incoming claim and dividing it by the days supply on the claim. The valid range for 2 per day is >= 1.8, but <= 2.2. To exceed a daily dose of 3, the value must be >= 3.8. Use MAP: AP: Dose Optimization initiative.

NON-PEPTIDE ACTIVE RENIN INHIBITORS AND COMBINATIONS

For this group that has no **PREFERRED – NO PA REQUIRED** options, pharmacists would apply clinical judgment based on factors including but not limited to therapeutic appropriateness, prior trials/failures, setting therapy was initiated, etc.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
	Amturnide® (aliskiren/amlodipine/HCTZ)
	Tekamlo® (aliskiren/amlodipine)
	Tekturna® (aliskiren)
	Tekturna HCT® (Aliskiren/HCTZ)

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DUAL RAS BLOCKADE DUR EDIT (PRODUCTION 12/14/2015)

Initiative: ☐ MAP: AP: Dual RAS Blockade (75 / 7008 – GSN; 76 / 50082 – GSN)

Intent: Begin denying the first "duplicate" claim at POS for an angiotensin converting enzyme inhibitor (ACE), angiotensin receptor blockers (ARB), or direct renin inhibitor (DRI). The dispensing pharmacist would be allowed to enter a med cert code override twice in a six-month time frame (based on HICL). If an additional (third) "duplicate" claim is submitted within the six-month timeframe, the claim will deny at POS and require a prior authorization. The use of these agents concomitantly is associated with increased risks of hypotension, hyperkalemia, and changes in renal function compared to mono-therapy. The Food and Drug Administration (FDA) released in May 2014 a statement to advise that most patients receiving the combination of two RAS inhibitors do not obtain any additional benefit compared to mono-therapy and in general, the combination of RAS inhibitors should be avoided. The DUR board voted in the September 2014 meeting to implement this edit.

- ☐ Automation Logic:
  - ☐ Step 1: If incoming claim from <RAS Inhibitor List> look back 100 days for fill from <RAS Inhibitor List> excluding itself, that has a day supply >/=84. If found, claim rejects NCPDP 76 with additional message "*TD of Angiotensin drug. Review and submit appropriate DUR cd.*" If not found, proceed to Step #2.
  - ☐ Step 2: If incoming claim from <RAS Inhibitor List> look back 30 days for fill from <RAS Inhibitor List> excluding itself. If found, claim rejects NCPDP 76 with additional message *"TD of Angiotensin drug. Review and submit appropriate DUR cd.*" If not found, claim pays.
- ☐ Limitation: Allow 2 pharmacy level overrides in 180 days for claims that deny out of the RAS Inhibitor AutoPA. Pharmacy must submit DUR Reason For Service Code: TD-Therapeutic Duplication for pharmacy level override. Deny the third, and subsequent attempts of a pharmacy level override (within a rolling 180 days) NCPDP 75 PA required with additional message "PA Req'd.Max:2 Angiotensin TD over/180 days. Fax PA 1-877-614-1078"
- ☐ Drug Names:
  - ☐ Angiotensin Converting Enzyme Inhibitors (ACEIs): Lotensin; Lotensin HCT; Lotreo; Capoten: Capozide; Vasotec/Epaned; Vaseretic; Monopril; Monopril HCTZ; Prinivil/Zestril; Prinzide/Zestoretic; Univasc; Uniretic; Aceon; Prestalia; Accupril; Accuretic/Quinaretic; Altace; Mavik; Tarka.
  - ☐ Angiotensin Receptor Blockers (ARBs): Edarbi; Edarbyclor; Atacand; Atacand HCT; Teveten; Teveten HCT; Avalide; Avapro; Cozaar; Hyzaar; Benicar; Benicar HCT; Azor; Tribenzor; Micardis; Micardis HCT; Twynsta; Diovan; Diovan HCT; Exforge; Exforge HCT; Entresto.
  - ☐ Direct Renin Inhibitors (DRIs): Tekturna; Tekturna HCT; Tekamlo; Amturnide.
- ☐ REVIEW CRITERIA: Clinical pharmacist to use professional judgment.

HYPOTENSIVES – BETA BLOCKERS AND CALCIUM CHANNEL BLOCKERS (CCBS)

Length of Authorization:	1 year
Initiative:	☐ PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN) ☐ MAP: AP: Dose Optimization (2nd Generation CCBs) (75 / 2462 – GSN; 76 / 2641 – GSN)

1. Is there any reason the Patient cannot be changed to a preferred medication? **Document clinically compelling information.** Acceptable reasons include
   - ☐ Allergy to all preferred medications
   - ☐ Contraindication to all preferred medications
   - ☐ History of unacceptable side effects
2. The requested medication may be approved if **both** of the following are true:
   - ☐ If there has been a therapeutic failure to no less than a two-month trial of TWO preferred medications; **AND**
   - ☐ The requested medication's corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

ADDITIONAL INFORMATION TO AID IN FINAL DECISION

If the Patient requires a non-preferred medication based on a specific medical need that is not covered by the FDA indications of the medications not requiring prior approval, then allow the authorization. This should be reviewed for need at each request for reauthorization.

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BETA-BLOCKERS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Acebutolol (generic for Sectral®)	Betaxolol (generic for Kerlone®)
Atenolol (generic for Tenormin®)	Betapace® (*sotalol*)
Atenolol / Chlorthalidone (generic for Tenoretic®)	Betapace AF® (*sotalol*)
Bisoprolol / HCT (generic for Ziac®)	Bisoprolol (generic for Zebeta®)
Carvedilol (generic for Coreg®)	Bystolic® (*nebivolol*)
Labetalol (generic for Trandate®)	Coreg® (*carvedilol*)
Metoprolol (generic for Lopressor®)	Coreg CR® (*carvedilol controlled-release*)
Metoprolol SR (generic for Toprol XL®)	Corgard® (*nadolol*)
Propranolol (generic for Inderal®)	Corzide® (*nadolol/bendroflumethiazide*)
Propranolol ER (generic for Inderal LA®)	Inderal LA® (*propranolol extended-release*)
Propranolol/HCTZ	InnoPran XL (*propranolol extended-release*)
Sotalol (generic for Betapace®)	Kerlone® (*betaxolol*)
Sotalol AF (generic for Betapace AF®)	Levatol® (*penbutolol*)
	Lopressor® (*metoprolol*)
	Lopressor HCT® (*metoprolol/hctz*)
	Metoprolol/HCTZ
	Nadolol (generic for Corgard®)
	Nadolol/bendroflumethiazide - (generic for Corzide®)
	Pindolol (Visken® – brand no longer available)
	Sectral® (*acebutolol*)
	Tenormin® (*atenolol*)
	Tenoretic® (*atenolol/hctz*)
	Timolol
	Toprol XL® (*metoprolol extended-release*)
	Trandate® (*labetalol*)
	Zebeta® (*bisoprolol*)
	Ziac® (*bisoprolol / hctz*)

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CALCIUM CHANNEL BLOCKERS (CCBS): DIHYDROPYRIDINE

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Amlodipine (generic for Norvasc®)* [*2.5mg, 5mg]	Adalat CC® (*nifedipine*)* [*30mg]
Felodipine (generic for Plendil®)* [*2.5mg, 5mg]	Afeditab CR® (*nifedipine*)* [*30mg]
Nicardipine	Cardene SR® (*nicardipine*)
Nifedipine immediate-release	Isradipine
Nifedipine ER & Nifedipine SA (Procardia®, Procardia XL®, Adalat®, Adalat CC®) [*30mg]	Nifediac CC® (*nifedipine extended release*) [*30mg]
	Nifedical XL® (*nifedipine extended release*)* [*30mg]
	Nisoldipine (generic for Sular®)
	Norvasc® (*amlodipine*) [*2.5mg, 5mg]
	Procardia® (*nifedipine*)
	Procardia XL® [*30mg] (*nifedipine*)
	Sular® (*nisoldipine*) [*10mg, 20mg]

CALCIUM CHANNEL BLOCKERS (CCBS): NON-DIHYDROPYRIDINE

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Diltiazem and Diltiazem SR/XR (generics for Cardizem®, Cardizem® SR and CD, Dilacor XR®, Tiazac®)	Calan® and Calan® SR (*verapamil ER*)
Verapamil (generic for Calan®)	Cardizem LA® & CD® (*diltiazem ER*)
Verapamil SR/ER (generic for Calan SR®)	Cardizem® (*diltiazem*)
	Cartia XT® (*diltiazem ER*)
	Dilacor XR® (*diltiazem ER*)
	Diltia XT® (*diltiazem ER*)
	Diltiazem LA (*diltiazem ER*)
	Matzim LA (generic for Cardizem LA®)
	Tiazac® all strengths (*diltiazem ER*)
	Taztia® XT (*diltiazem ER*)
	Verapamil PM (generic for Verelan PM®) – has a MAC
	Verelan/PM® (*verapamil pellet filled capsule*)*

NOTES

*Products will deny when the daily dose equals “2” or the daily dose exceeds “3.” Daily dose is calculated by taking the metric quantity on the incoming claim and dividing it by the days’ supply on the claim. The valid range for 2 per day is >= 1.8, but <= 2.2. To exceed a daily dose of 3, the value must be >= 3.8. Use MAP: AP: Dose Optimization initiative.

HYPOTENSIVES – SYMPATHOLYTICS

Length of Authorization:	1 year
Initiative:	☐ PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN) ☐ MAP: Quantity Limits: IE 7001 (76 / 7001 – GSN)

1. Is there any reason that the Patient cannot be switched to preferred medications**? Document clinically compelling details.** Acceptable reasons include
   - ☐ Allergy to all preferred medications
   - ☐ Contraindication to all preferred medications
   - ☐ History of unacceptable side effects
   - ☐ Patient is clinically unstable and switching would cause deterioration in condition
2. The requested medication may be approved if ***both*** of the following are true:
   - ☐ If there has been a therapeutic failure to no less than a two-month trial of TWO preferred medications AND
   - ☐ The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Catapres TTS® patch [8] (*clonidine patch*)	Catapres® (*clonidine*) tablet
Clonidine (generic for Catapres®) tablet	Clonidine patch (generic for Catapres®)
Clonidine w/Chlorthalidone (generic for Clorpres)	Clorpres® (*clonidine w/Chlorthalidone*)
Guanfacine (generic for Tenex®)	Methyldopate vials
Methyldopa	Reserpine®
Methyldopa/HCTZ	Tenex® (*guanfacine*)

[#] = qty limit per 30 days

ADDITIONAL NOTES

Nitrolingual spray (Cardiovascular Agents/Antianginals)

- ☐ All new requests should be denied by MPS Pharmacist and the Physician redirected to us the preferred sublingual tablets or patches.
- ☐ All continuation of therapy or request after the denial should be forwarded to pharmacist for review.

IBRANCE® (PALBOCICLIB)

Length of Authorization:	Initial and Continuation: 3 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

INITIAL REVIEW CRITERIA (ALL OF THE FOLLOWING MUST BE TRUE):

1. Patient is ≥ 18 years old **AND**
2. Patient has a diagnosis of ER-positive, HER2- negative advanced breast cancer. (Note: advanced breast cancer is defined as distant metastatic disease or locally recurrent disease that is not amenable to surgery) **AND**
3. Patient is receiving either concomitant letrozole or fulvestrant AND
4. Women are post menopausal OR

   (Note: confirmation of postmenopausal status which can include ***any*** of the following):

   - ☐ Prior bilateral oophorectomy
   - ☐ Age ≥ 60 years
   - ☐ Age < 60 years and amenorrheic for 12 or more months in the absence of chemotherapy, tamoxifen, toremifene or ovarian suppression and follicle-stimulating hormone (FSH) and estradiol in the postmenopausal range
   - ☐ If taking tamoxifen or toremifene and age < 60 years, then FSH and plasma estradiol level in postmenopausal ranges
5. Premenopausal or perimenopausal females AND
6. Patient has undergone surgical oophorectomy OR
7. Patient is receiving concomitant luteinizing hormone-releasing hormone (LHRH) agonist

CONTINUATION OF THERAPY

- ☐ Patient continues to meet initial review criteria
- ☐ No evidence of disease progression on therapy as documented by the treating oncologist

ILARIS® (CANAKINUMAB)

Length of Authorization:	NO MORE THAN 6 MONTHS
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- Note: Ilaris is also available through physician services; no PA required in physician services
- For diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), Familial Cold autoinflammatory syndrome (FCAS) or Muckle-Wells Syndrome (MWS):
  - Approve in ages ≥ 4 years of age.
- If request is for diagnosis of Active Systemic onset juvenile chronic arthritis:
  - Must age ≥ 2 years
  - Patient has a documented diagnosis of systemic juvenile idiopathic arthritis
  - Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapy) with one or more non-steroidal anti-inflammatory-NSAIDS
  - Must have a history of trial and failure of Kineret® (anakinra) or Actemra® (tocilizumab).
- All other requests must be referred to preferred alternative: Humira®.

DOSING AND ADMINISTRATION

- **Cryopyrin-Associated Periodic Syndromes, Familial cold autoinflammatory syndrome or Muckle- Wells Syndrome:**
  - 150 mg for patients with body weight greater than 40 kg and 2 mg/kg for patients with body weight greater than or equal to 15 kg and less than or equal to 40 kg. For children 15 to 40 kg with an inadequate response, the dose can be increased to 3 mg/kg. Administer subcutaneously every 8 weeks.
- **Systemic Juvenile Idiopathic Arthritis (SJIA):**
  - 4 mg/kg (with a maximum of 300mg) for patients with a body weight greater than or equal to 7.5kg. Administer subcutaneously every 4 weeks.
- **Dosage Form:**
  - Sterile, single-use, glass vial containing 180 mg of ILARIS as a lyophilized powder for reconstitution

INCIVEK® (TELAPREVIR) AND VICTRELIS® (BOCEPREVIR)

Length of Authorization:	Incivek= 3 months Victrelis= 1 year
Initiative:	MAP:AP: Incivek/Victrelis (75 / 2462 – GSN; 75 / 31001 – GSN; 75 / 31008 – GSN; 76 / 2641 – GSN)

APPROVAL CRITERIA

- ☐ Since there are no data to indicate that Incivek is superior to Victrelis (PDL) OR that either agent can be substituted due to adverse effects or treatment failure requests for Incivek due to failure of Victrelis must not be approved.
  - ☐ If the request is for Incivek the Patient must have no recent claims or current history (within past 365 days) of Victrelis.
  - ☐ If the request is for Victrelis the Patient must have no recent claims or current history (within past 365 days) of Incivek.
- ☐ Patient must be ≥18 years old
- ☐ Must have a diagnosis of Hepatitis C Virus (ICD-9s: 070.41, 070.44, 070.49, 070.51, 070.54, 070.70, or 070.71)

QUANTITY LIMITATIONS (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

- ☐ Incivek 375mg Tab @ 6 per day = 504 tabs per lifetime.
- ☐ Victrelis Cap @ 12 per day = 3.024 caps per 355 days.

ADDITIONAL INFORMATION ON AUTO PA CODING AND LIMITATIONS

- ☐ See the page for Initiative: Incivek/Victrelis
- ☐ See Summary of Drug Limitations

INFERGEN® (INTERFERON ALFACON-1)

Length of Authorization:	Maximum of 1 year
Initiative:	MAP: AP: Infergen (75 / 2462 – GSN; 76 / 2641 – GSN; 88 / HD – GSN)

APPROVAL CRITERIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

- ☐ Must be ≥ 18 years of age
- ☐ Must have a diagnosis of chronic hepatitis C
- ☐ Must have previous history of a minimum of 12 weeks of therapy with peginterferon alfa (Pegasys or Peg-Intron) and ribavirin combination therapy in the past 365 days.
  - ☐ Treatment cessation of the above combination therapy may occur if a HCV RNA concentration < 50 IU/ml or at least a 2 log reduction in the concentration from baseline is not obtained after 12 weeks. *(Goal for HCV RNA is toward normal value of <1.7 logIU/mL.)*

INHALED COPD ANTICHOLINERGICS

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to a preferred medication? **Document details**. Acceptable reasons include
   - ☐ Allergy to the preferred medications in this class
   - ☐ Contraindication or drug-to-drug interaction with all preferred medications
   - ☐ History of unacceptable side effects
2. Patient must have tried and failed TWO preferred medications before a non-preferred medication may be approved.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Atrovent HFA® (Ipratropium bromide)	Anoro Ellipta (umeclidinium/vilanterol) powder for inhalation
Ipratropium /Albuterol nebulizer solution (generic for DuoNeb®)	Combivent Respimat® (Ipratropium bromide/Albuterol); see info below.
Ipratropium nebulizer solution	DuoNeb® (Individual agents are preferred. Albuterol neb and Ipratropium neb.)
Spiriva HandiHaler® (tiotropium bromide monohydrate)	Spiriva Respimat® (tiotropium bromide monohydrate)
	Tudorza Pressair® (aclidinium inhalation powder)

COMBIVENT RESPIMAT® (IPRATROPIUM BROMIDE/ALBUTEROL)

The manufacturer is phasing out Combivent and is marketing Combivent Respimat as its replacement.

If a request is received for Combivent Respimat, advise the requester that ipratropium bromide (Atrovent) and albuterol sulfate (ProAir, Proventil) inhalers are covered as single entities.

TUDORZA PRESSAIR® (ACLIDINIUM INHALATION POWDER)

DIRECTIVE:

- ☐ Requests for Tudorza Pressair should be redirected to Atrovent HFA inhaler (ipratropium bromide) or Spiriva HandiHaler.

INSULINS

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to a preferred medication? **Document clinically compelling information.** Acceptable reasons include
   - ☐ Allergy to the preferred medications in this class
   - ☐ Contraindication or drug-to-drug interaction with all preferred medications
   - ☐ History of unacceptable side effects
2. For approval of non-preferred insulins, the Patient must have tried and failed on the equivalent preferred product. Document Details.

Insulin Syringes (and all products with Formulary Indicator State Drug Class = "2") **are billed to DME.**

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Humalog 50 / 50® PEN and VIAL (*insulin lispro*)	Apidra® (*insulin glulisine*)
Humalog 75 / 25® VIAL, PENS (*insulin lispro*)	Levemir FlexTouch® (*insulin detemir*)
Humalog® (*insulin lispro*)	
Humulin 50 / 50®	
Humulin 70 / 30®	
Humulin R®	
Humulin N®	
Lantus® VIAL and SOLOSTAR (*insulin glargine*)	
Levemir® VIAL and PEN (*insulin detemir*)	
Lantus® CARTRIDGE (*insulin glargine*)	
Novolin 70/30®	
Novolin N®	
Novolin N Innolet®	
Novolin R®	
Novolin R Innolet®	
NovoLog FlexPen & VIAL (*insulin aspart*)	
NovoLog 70/30®	

QUANTITY LIMITS

- ☐ Quantity limit of up to 70mls per month across all insulin vials
- ☐ Quantity limit of up to 30mls per month across all insulin cartridge/pens.

CONTINUED ON NEXT PAGE

INSULINS (CONTINUED)

Type of Insulin and Brand Names	Onset	Peak	Duration	Role in Blood Sugar Management
Rapid-Acting				
Humalog or lispro	15–30 min.	30–90 min	3–5 hours	Rapid-acting insulin covers insulin needs for meals eaten at the same time as the injection. This type of insulin is used with longer-acting insulin.
NovoLog or aspart	10–20 min.	40–50 min.	3–5 hours	
Apidra or glulisine	20–30 min.	30–90 min.	1–2½ hours	
Short-Acting				
Regular (R) humulin or novolin	30 min.–1 hour	2–5 hours	5–8 hours	Short-acting insulin covers insulin needs for meals eaten within 30-60 minutes
Velosulin (for use in the insulin pump)	30 min.–1 hour	2–3 hours	2–3 hours	
Intermediate-Acting				
NPH (N)	1–2 hours	4–12 hours	18–24 hours	Intermediate-acting insulin covers insulin needs for about half the day or overnight. This type of insulin is often combined with rapid- or short-acting insulin.
Lente (L)	1–2½ hours	3–10 hours	18–24 hours	
Long-Acting				
Ultralente (U)	30 min.–3 hours	10–20 hours	20–36 hours	Long-acting insulin covers insulin needs for about one full day. This type of insulin is often combined, when needed, with rapid- or short-acting insulin.
Lantus	1–1½ hour	No peak time; insulin is delivered at a steady level	20–24 hours	
Levemir or detemir	1–2 hours	6–8 hours	Up to 24 hours	
Pre-Mixed*				
Humulin 70/30	30 min.	2–4 hours	14–24 hours	These products are generally taken twice a day before mealtime.
Novolin 70/30	30 min.	2–12 hours	Up to 24 hours	
Novolog 70/30	10–20 min.	1–4 hours	Up to 24 hours	
Humulin 50/50	30 min.	2–5 hours	18–24 hours	
Humalog mix 75/25	15 min.	30 min.–2½ hours	16–20 hours	
*Premixed insulins are a combination of specific proportions of intermediate -acting and short-acting insulin in one bottle or insulin pen (the numbers following the brand name indicate the percentage of each type of insulin).				

INTRANASAL AGENTS TO TREAT RHINITIS

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason the Patient cannot be changed to a medication not requiring prior approval? **Document clinically compelling information.** Acceptable reasons include
   - ☐ Allergy to unrelated preferred medications
   - ☐ Contraindication to or drug-to-drug interaction with all preferred medications
   - ☐ History of unacceptable/toxic side effects to all preferred medications
2. Has there been a failure to respond to a therapeutic trial of at least a *14-day trial* each of ***TWO*** preferred medications? **Document details.**

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Astelin® (*azelastine HCL*) (may no longer be available, but would still count as a preferred med trial)	Atrovent® Nasal spray **(See Next Page)**
Fluticasone (generic for Flonase®)	Azelastine (generic for Astelin® 0.1% and Astepro® 0.15%)
Nasonex® (*mometasone*)	Beconase AQ® (*beclomethasone*)
Patanase® (*olopatadine HCL*)	Flunisolide (generic for Nasarel®)
	Flonase® (*fluticasone*) [32/27]
	Ipratropium Nasal spray (Generic for Atrovent®)(See Specific Criteria Below)
	Nasacort AQ® (*triamcinolone*)
	Omnaris® (*ciclesonide*)
	Qnasl® 40mcg, 80mcg (beclomethasone)
	Rhinocort Aqua® (*budesonide*) [8.6/27] **(See Note Below.)**
	Triamcinolone (generic for Nasacort AQ®)
	Veramyst® (*fluticasone furoate*)
	Zetonna® (*ciclesonide*)

ADDITIONAL INFORMATION

Rhinocort Aqua® – Pregnancy Category B – if requested because the Patient is pregnant, may approve for the duration of the pregnancy

Nasarel® – Nasarel is now manufacturer obsolete. Do not enter an override for any Nasarel request.

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ATROVENT® (IPRATROPIUM BROMIDE) NASAL SPRAY

Length of Authorization:	6 months ☐ (0.03%, 21mcg) – 345 sprays (30ml) ☐ (0.06%, 42mcg) – 165 sprays (15ml)
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

1. **For vasomotor (non-allergic) rhinitis:**
   - ☐ Patient must be ≥ 6 years old.
   - ☐ Must have a diagnosis of vasomotor (non-allergic) rhinitis.
2. **For allergic rhinitis:**
   - ☐ Patient must be ≥ 5 years old.
   - ☐ Must have a diagnosis of allergic rhinitis.
   - ☐ Must have failed therapy with the preferred nasal antihistamines sprays.

INTRATHECAL BACLOFEN (GABLOFEN® AND LIORESAL®)

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

INITIATION OF THERAPY

- ☐ Age > 4 years
- ☐ Must have severe spasticity of spinal or cerebral origin (multiple sclerosis, cerebral palsy, spinal cord injury, or traumatic brain) which has proven unresponsive or ineffective to maximal dosing of oral baclofen OR documentation of unacceptable side effects from or intolerance to oral baclofen at an effective dose.
- ☐ Must have a positive response to a screening trial (for details on a screening trial refer below to DOSAGE and ADMINISTRATION). A positive response is defined as a significant decrease in muscle tone and/or frequency of and/or severity of spasms.
- ☐ Patient is being followed by a neurologist or a related specialist.

CONTINUATION OF INTRATHECAL BACLOFEN THERAPY

- ☐ Medication must be requested by a neurologist or related specialist.

INTRAUTERINE DEVICES: MCC-FL ONLY

Length of Authorization:	N/A
Initiative:	N/A

MCCFL_2016_017_OT_Intrauterine_Device:

- Effective Date = 07/01/2016;
- Production Date = 07/05/2016.

Add all IUD products (HIC3 = X1C) to the pharmacy benefit and bypass all PAs associated with medical billing. There are no stated limitations per the client.

- Ex. products: Liletta®, Mirena®, Paragard®, Skyla®.

IVIG (INTRAVENOUS IMMUNE GLOBULIN)

Length of Authorization:	Varies: See chart Conditions; Indications; Initial Approval Duration (Max)
Initiative:	MAP: Intravenous Immune Globulin (75 / 2462 – GSN; 76 / 2641 – GSN)
Fax Form:	Pharmacy Miscellaneous Prior Authorization [Required]

GENERAL NOTES ON COVERAGE

Florida Medicaid covers immune globulin therapy that is medically necessary and proven effective for treatment of specific humoral immunodeficiencies and certain covered conditions (listed below).

- ☐ The use of immune globulin therapy (including dosage, frequency, site of administration, and duration of therapy) must be clinically appropriate and supported by evidence-based literature.
- ☐ Adjustment(s) of dosage, frequency, site of administration, and duration of therapy must be reasonable and appropriate based on condition and severity, alternative available treatments, and previous response to intravenous immune globulin therapy.
- ☐ The use of immune globulin therapy will not be approved for any use that is considered investigational, is unproven and/or is not supported by evidence-based literature.
- ☐ NOTE: Criteria listed below marked with an asterisk (**) and *printed in italics* describe indications where evidence is lacking or inconclusive but case reports or conflicting data support the use of immune globulin therapy. *These indications are provided as an in-house reference and approval for any of these conditions should be evaluated on a case-by-case basis.*

GENERAL ELIGIBILITY CRITERIA

Medically necessary immune globulin is authorized when General Eligibility Criteria (here) and relevant Condition-Specific Criteria are met:

1. Medical record documentation confirms the recipient has been definitively diagnosed (by an appropriate specialist) with one of the Covered Conditions listed below;
2. The diagnosis is confirmed by evidence-based diagnostic criteria (supported by peer-reviewed, published literature) and supportive testing, and clearly documented in clinical notes;
3. The recipient is closely followed by the prescribing specialist, and treatment response has clearly defined endpoints to measure effectiveness;
4. The use (including requested frequency and dosage) of immunoglobulin is supported by evidence -based literature.

APPROVAL CRITERIA: CONDITION-SPECIFIC CRITERIA

Alloimmune Conditions

- ☐ Neonatal alloimmune thrombocytopenia (NAIT)
- ☐ Neonatal hemochromatosis
- ☐ Post-transfusion purpura
- ☐ ***Hemolytic disease of the newborn*

CONTINUED ON NEXT PAGE

IVIG (INTRAVENOUS IMMUNE GLOBULIN) (CONTINUED)

Autoimmune Disorders

- ☐ Acquired red cell aplasia
- ☐ Autoimmune Hemolytic Anemia
- ☐ Autoimmune mucocutaneous blistering diseases
  - ☐ Pemphigus vulgaris
  - ☐ Pemphigus foliaceus
  - ☐ Bullous pemphigoid
  - ☐ Mucous membrane pemphigoid
  - ☐ Epidermolysis bullosa acquisita
- ☐ Autoimmune Neutropenia
- ☐ Immune or idiopathic thrombocytopenic purpura (ITP)
- ☐ Kawasaki Disease
- ☐ Lambert-Eaton myasthenic syndrome
- ☐ ***Systemic lupus erythematosus (SLE)*
- ☐ ***Acute disseminated encephalomyelitis*
- ☐ ***Birdshot (vitiliginous) retinochoroidopathy*
- ☐ ***Churg-Strauss Syndrome (allergic granulomatosis)*

Collagen-Vascular Diseases

- ☐ Dermatomyositis

Immunodeficiency Disorders or Diseases Caused By Immunodeficiency Disorders

- ☐ HIV-associated thrombocytopenia, pediatric or adult
- ☐ Pediatric Human Immunodeficiency Virus (HIV) Infection
- ☐ Primary Humoral Immunodeficiency Syndromes
  - ☐ CVID (Common Variable Immunodeficiency)
  - ☐ Congenital agammaglobulinemia
  - ☐ Hyper IgM syndromes
  - ☐ Hypogammaglobulinemia
  - ☐ IgM (X-linked Immunodeficiency with Hyperimmunoglobulin)
  - ☐ Immunodeficiency with thymoma (Good syndrome)
  - ☐ SCID (Severe Combined Immunodeficiency)
  - ☐ Selective IgG subclass deficiencies
  - ☐ Wiscott-Aldrich Syndrome
  - ☐ X-linked Agammaglobulinemia

Infectious

- ☐ Enteroviral meningoencephalitis
- ☐ Parvovirus B19 infection, chronic, with severe anemia
- ☐ Staphylococcal toxic shock syndrome
- ☐ Toxic epidermal necrolysis/Stevens Johnson syndrome
- ☐ Toxic shock syndrome or toxic necrotizing fascitis due to group A streptococcus

Malignancies

- ☐ B-cell chronic lymphocytic leukemia (CLL)
- ☐ Hematological malignancy patients who are immunosuppressed
- ☐ Multiple Myeloma
- ☐ Bone marrow transplant
- ☐ Paraneoplastic opsoclonus-myoclonus-ataxia associated with neuroblastoma

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APPROVAL CRITERIA: CONDITION-SPECIFIC CRITERIA (CONTINUED)

Neurological Disorders

- ☐ Chronic Inflammatory Demyelinating Polyneuropathy
- ☐ Guillain-Barré' Syndrome
- ☐ Multifocal motor neuropathy
- ☐ Myasthenia Gravis
- ☐ Opsoclonus Myoclonus Syndrome
- ☐ Polymyositis
- ☐ Rasmussen's encephalitis
- ☐ Relapsing-Remitting Multiple Sclerosis

Transplantation

- ☐ Renal transplantation from live donor with ABO incompatibility or positive cross-match
- ☐ Solid organ transplant recipients who are iatrogenically immunosuppressed to reduce risk of recurrent bacterial or viral infections
- ☐ Solid organ transplantation recipients prior to transplant to suppress anti-human leukocyte antigens (HLA) antibodies
- ☐ Solid organ transplant recipients for treatment of antibody mediated rejection of solid organ transplants
- ☐ Stem cell or bone marrow transplant recipients receiving an allogeneic or syngeneic transplant.

Other Disorders

- ☐ ***Hyperimmunoglobulinemia E syndrome*
- ☐ ***Patients with extensive burns who are immunologically suppressed*
- ☐ ***Patients with extensive surgery who are immunologically suppressed*

CONDITIONS; INDICATIONS; INITIAL APPROVAL DURATION (MAX)

See Chart starting here and continuing on the following pages for:

- ☐ Condition
- ☐ Indication
- ☐ Initial Approval Duration (Max)

Condition	Indications	Initial Approval Duration (Max)
**Acute disseminated encephalomyelitis	Patients who have an insufficient response to intravenous (IV) corticosteroid treatment	1 Month
**Autoimmune hemolytic anemia, refractory	Warm-type autoimmune hemolytic anemia that does not respond to corticosteroids or splenectomy, or those with contraindications to these treatments	5 Weeks
Autoimmune Mucocutaneous Blistering Diseases-pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid, epidermolysis bullosa acquisita	The diagnosis has been proven by biopsy and confirmed by pathology report; **AND** The condition is rapidly progressing, extensive or debilitating; **AND** Corticosteroids, immuno-suppressive agents have failed or the patient has experienced significant complications from standard treatment, such as diabetes or steroid-induced osteoporosis.	6 Months

Condition	Indications	Initial Approval Duration (Max)
Bacterial infection in HIV-infected children	Consistent with recommendations of the Working Group on Antiretroviral Therapy of the National Pediatric HIV Resource Center IVIG is considered medically necessary in children with HIV-infection who meet any of the following criteria: 1. Those with hypogammaglobulinemia, i.e., serum IgG concentration less than 250 mg/dL; 2. Those with recurrent serious bacterial infections, i.e., defined as two or more infections such as bacteremia, meningitis, or pneumonia in a 1-year period; 3. Those who fail to form antibodies to common antigens, such as measles, pneumococcal, and/or Haemophilus influenzae type b vaccine; 4. Those living in areas where measles is highly prevalent and who have not developed an antibody response after two doses of measles, mumps, and rubella virus vaccine live; 5. Single dose for HIV-infected children who are exposed to measles; 6. HIV-infected children with chronic bronchiectasis that is suboptimally responsive to antimicrobial and pulmonary therapy.	1 Year
**Birdshot (vitiliginous) retinochoroidopathy	Not responsive to immunosuppressives (e.g., corticosteroids, cyclosporine)	6 Months
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)	Symmetric or focal neurologic deficits with slowly progressive or relapsing course over 2 months or longer (with neurophysiological abnormalities). **Note:** A meta-analysis comparing the efficacy if IVIG, plasma exchange, and oral glucocorticoids found equivalence between all three, at least within the first 6 weeks of therapy (Van Schaik et al, 2002). IVIG is considered under accepted guidelines as the preferred treatment, particularly in children, when there is difficulty with venous access for plasmapheresis, and those susceptible to the complications of long-term corticosteroid therapy (Orange et al, 2006). Persons typically respond to IVIG or plasma exchange within the first several weeks of treatment and may demonstrate sustained improvement for many weeks or months. Relapses may require periodic isolated treatments with a single dose of IVIG or single plasma exchange. If a person responds successfully to infrequent booster treatments of either IVIG or plasma exchange, it is considered medically necessary to prescribe maintenance therapy with IVIG to prevent relapse, rather than adding corticosteroids or other immunosuppressants.	3 Months
Chronic Lymphocytic Leukemia (CLL)	☐ CLL patients with IgG level less than 600 mg/dL; **AND** ☐ One severe bacterial infection within preceding 6 months or 2 or more bacterial infections in 1 year; **OR** ☐ Evidence of specific antibody deficiency.	1 Year

Condition	Indications	Initial Approval Duration (Max)
Dermatomyositis, Polymyositis (includes juvenile)	Patients presenting at least one item from the 1st criterion (skin lesions) and four items from the 2nd through 9th criteria are said to have dermatomyositis. Patients presenting no items from the 1st criterion and at least four items from the 2nd through 9th criteria are said to have polymyositis. ☐ Skin lesions ☐ Heliotrope rash (red purple edematous erythema on the upper eyelid) ☐ Gottron's sign (red purple keratotic, atrophic erythema, or macules on the extensor surface of finger joints) ☐ Erythema on the extensor surface of extremity joints: slightly raised red purple erythema over elbows or knees ☐ Proximal muscle weakness (upper or lower extremity and trunk) ☐ Elevated serum CK (creatine kinase) or aldolase level ☐ Muscle pain on grasping or spontaneous pain ☐ Myogenic changes on EMG (short-duration, polyphasic motor unit potentials with spontaneous fibrillation potentials) ☐ Positive anti-Jo-1 (histidyl tRNA synthetase) antibody ☐ Non-destructive arthritis or arthralgias ☐ Systemic inflammatory signs (fever: more than 37° C at axilla, elevated serum CRP level or accelerated erythrocyte sedimentation rate (ESR) of more than 20 mm/h by the Westergren method) ☐ Pathological findings compatible with inflammatory myositis (inflammatory infiltration of skeletal evidence of active regeneration may be seen) **AND** ☐ Patient has severe active illness; **and** ☐ Patient is intolerant or refractory to 1st and 2nd line therapies: ☐ First line therapy - Corticosteroids (e.g., prednisone); ☐ Second line therapy - Immunosuppressants (e.g., methotrexate, azathioprine, cyclophosphamide, and cyclosporine).	1 Year
Enteroviral meningocephalitis	In severe cases lacking other therapeutic options	6 Months
Neonatal Alloimmune Thrombocytopenia (NAIT) (aka Fetal Alloimmune Thrombocytopenia (FAIT)	At 20 weeks or later of pregnancy, cordocentesis reveals fetal platelets less than 20 x 1000/mL^3 **OR** Mother has had previous pregnancy affected by FAIT	Based on week of pregnancy or prior history of pregnancy affected by FAIT; approval should cover the pregnancy term
Guillain Barré syndrome (GBS)	☐ Severe GBS with significant weakness such as inability to stand or walk without aid, respiratory or bulbar weakness, or Miller-Fisher syndrome (MFS); AND ☐ The disorder has been diagnosed during the first 2 weeks of the illness; AND ☐ IVIG is initiated within one month of symptom onset. **Note** : Based on the 2003 American Academy of Neurology (AAN)guidelines, IVIG should usually be initiated within 2 weeks and no longer than 4 weeks of onset of neuropathic symptoms.	5 Days

Condition	Indications	Initial Approval Duration (Max)
Hematopoietic Stem Cell Transplant (HSCT) or Bone Marrow Transplant (BMT)	Prophylaxis in allogenic (related donor) or syngeneic (twin donor) transplant recipients within the first 100 days post-transplant After 100 days post-transplant, for patients who are markedly hypogammaglobulinemic (IgG less than 400 mg/dL_), who have a primary immunodeficiency disease, or who have Cytomegalovirus (CMV), Epstein-Barr virus (EBV) or Respiratory Syncytial Virus (RSV) infection Corticosteroid-resistant graft versus host disease (GVHD) in patients 20 years of age or older in the first 100 days post transplant and who are hypogammaglobinemic (IgG level less than 400 mg/dL)	1 Year
HIV-associated thrombocytopenia-Adults	☐ Significant bleeding in thrombocytopenic patients or platelet count less than 20,000/ul; **AND** ☐ Failure of RhIG in Rh-positive patients.	6 Months
HIV-associated thrombocytopenia-Pediatric	Infants and children less than 13 years of age whose IgG level is less than 400 mg/dL; and ☐ Two or more bacterial infections in a 1-year period despite antibiotic chemoprophylaxis with TMP-SMZ or another active agent; **OR** ☐ Child has received 2 doses of measles vaccine and lives in a region with a high prevalence of measles; **OR** ☐ Child has HIV-associated thrombocytopenia despite anti-retroviral therapy; **OR** ☐ Child has chronic bronchiectasis that is suboptimally responsive to antimicrobial and pulmonary therapy; **OR** ☐ T4 cell count is greater than or equal to 200/mm^3	1 Year
**Hyperimmunoglobulin E Syndrome (Job Syndrome, Hyper IgE syndrome)	Recurrent staphylococcal abscesses and markedly elevated serum IgE with normal IgG, IgA and IgM concentrations	3 Months
Idiopathic (or Immune) Thrombocytopenic Purpura (ITP)-Adults	☐ Other causes of thrombocytopenia have been ruled out by history and peripheral smear; AND ☐ Patient is unresponsive to corticosteroid therapy; AND ☐ Requires management of acute bleeding due to severe thrombocytopenia (platelet counts less than 30,000/ul); OR ☐ To increase platelet counts prior to invasive major surgical proced ures (e.g., splenectomy), OR ☐ To defer or avoid splenectomy; OR ☐ In members with severe thrombocytopenia (platelet counts less than 20,000/ul) considered to be at risk for intra-cerebral hemorrhage.	*5 Days*
Idiopathic (or Immune) Thrombocytopenic Purpura (ITP)-Pediatric	**Acute ITP:** ☐ IVIG as initial therapy if platelet count less than 20,000/ul, especially when the patient has emergency bleeding or is at risk for severe life-threatening bleeding; **OR** ☐ Patients with severe thrombocytopenia (platelet counts less than 20,000/ul) considered to be at risk for intracranial hemorrhage (Note: IVIG is not indicated if patient has only mild manifestations of bleeding) **Chronic ITP:** In high-risk patients when the platelet count is low or patient is symptomatic; **AND** ☐ Failure of other therapies, **OR** ☐ Patient is a high risk for post-splenectomy sepsis.	*5 Days*
Idiopathic (or Immune) Thrombocytopenic Purpura, Chronic Refractory	☐ Age of 10 years or older; **AND** ☐ Duration of illness of greater than 6 months; **AND** ☐ No concurrent illness/disease explaining thrombocytopenia; **AND** ☐ Prior treatment with corticosteroids and splenectomy has failed **OR** patient is at high-risk for post-splenectomy sepsis.	6 Months

Condition	Indications	Initial Approval Duration (Max)
Immune Thrombocytopenic Purpura (ITP) in Pregnancy	☐ Refractory to steroids with platelet counts less than 10,000/ul in the 3rd trimester; **OR** ☐ Platelet counts less than 30,000/ul associated with bleeding before vaginal delivery or C-section; **OR** ☐ Pregnant women who have previously delivered infants with autoimmune thrombocytopenia; **OR** ☐ Pregnant women who have platelet counts less than 50,000/ul during the current pregnancy; **OR** ☐ Pregnant women with past history of splenectomy	Initial Approval should correspond to pregnancy term
Immunosuppressed Patients	To prevent or modify recurrent bacterial or viral infections (e.g., CMV) in patients with iatrogenically induced, or disease associated immunosuppression (IgG less than 400 mg/dL) with one of the following: ☐ Solid organ transplants or extensive surgery with immunosuppres sion (**Note**: In particular, IVIG may be medically necessary in persons undergoing multiple courses of plasmapheresis as a treatment for allograft rejection or for other indications; these persons may receive IVIG at the completion of therapy if their IgG le vel is less than 400 mg/dL); OR ☐ Hematological malignancy; OR ☐ ***Extensive burns;* OR ☐ Collagen-vascular disease.	1 Year
Kawasaki Disease (Mucocutaneous Lymph Node Syndrome [MCLS])	Diagnosis must be established -- no specific lab test -- diagnosis is established by meeting the following criteria: ☐ Fever present for at least 5 days; **AND** ☐ Four of the following 5 conditions are met: ☐ Mucous membrane changes such as a red tongue and dry fissured lips; ☐ Swelling of the hands and feet; ☐ Enlarged lymph nodes in the neck; ☐ Diffuse red rash covering most of the body; ☐ Redness of the eyes.	1 Year
Lambert-Eaton Myasthenic Syndrome (LEMS)	No response to anti-cholinesterases and dalfampridine (Ampyra); **AND** ☐ Used as an alternative to plasma exchange if weakness is severe; **OR** ☐ When there is difficulty with venous access for plasmapheresis.	3 months
Myasthenia Gravis	☐ Treatment of acute myasthenic crisis with decompensation (respiratory failure, or disabling weakness requiring hospital admission); **AND** ☐ Other treatments have been unsuccessful or are contraindicated (e.g., azathioprine, cyclosporine, and cyclophosphamide) . **Note**: For management of acute myasthenic crises, IVIG is administered over 2 to 5 days. Use of IVIG as maintenance therapy is considered experimental and investigational.	*5 Days*
**Moersch-Woltmann (Stiff-man) Syndrome	Presence of anti-GAD antibody; **AND** Benzodiazepines (e.g., diazepam) and/or baclofen, phenytoin, clonidine, tizanidine have failed.	3 months
Multifocal Motor Neuropathy with Conduction Block	Progressive, symptomatic multifocal motor neuropathy that has been diagnosed on the basis of electrophysiologic findings that rule out other possible conditions that may not respond to IVIG treatment	1 Year
Multiple Myeloma	☐ "Plateau Phase" multiple myeloma (greater than 3 months since diagnosis); AND ☐ IgG level less than 600 mg/dL; AND ☐ Two or more significant infections in last year or a single life threatening infection; OR Evidence of specific antibody deficiency	1 Year

Condition	Indications	Initial Approval Duration (Max)
Multiple Sclerosis (MS)-Relapsing-Remitting (not primary or secondary progressive MS)	☐ Severe manifestations of relapsing-remitting MS (not primary or secondary progressive MS); **AND** ☐ Standard FDA approved therapies (i.e., interferons, glatiramer, etc) have failed, become intolerable, or are contraindicated	1 Year
Neonatal Hemochromatosis	Pregnant women who have a history of pregnancy ending with documented neonatal hemochromatosis (Note: Dosage should be 1 mg/kg weekly from the 18th week until the end of pregnancy)	6 Months
Neuroblastoma associated paraneoplastic opsoclonus-myoclonus-ataxia syndrome	Opsoclonus-myoclonus-ataxia syndrome in patients diagnosed with neuroblastoma	6 Months
Opsoclonus-myoclonus	Last resort treatment for refractory opsoclonus-myoclonus	6 Months
Parvovirus B19 infection (Erythrovirus), Chronic with severe anemia (pure red cell aplasia)	Severe, refractory anemia with documented Parvo B19 (erythrovirus) viremia	3 Months
Post-transfusion purpura (PTP)	☐ Decreased platelets (usually less than 10,000/ul); **AND** ☐ Two to 14 days post-transfusion with bleeding.	5 Days
Primary Humoral Immunodeficiencies: ☐ Selective IgM Immunodeficiency ☐ Congenital hypogammaglobulinemia ☐ Immunodeficiency with near/normal IgM (absent IgG, IgA) – a.k.a. Hyper IgM syndrome ☐ Other deficiency of humoral immunity ☐ Combined immunodeficiency disorders (e.g., X-SCID, jak3, ZAP70, ADA, PNP, RAG defects, Ataxia Telangiectasia, DiGeorge syndrome, common variable immunodeficiency)	☐ Agammaglobulinemia (total IgG less than 200 mg/dL or infants with BTK gene and/or absence of B lymphocytes)); **OR** ☐ Persistent hypogammaglobulinemia(total IgG less than 400 mg/dL or two standard deviations below the mean for age) with recurrent bacterial infections and/or lack of response to protein or polysaccharide antigens (inability to make IgG antibody against diphtheria and tetanus toxoids, pneumococcal polysaccharide vaccine, or both - see notes below): ☐ Serum antibody titers to tetanus and/or diphtheria should be obtained prior to immunization with diphtheria and/or tetanus vaccine and 3 to 4 weeks after immunization. The protective level for diphtheria is 0.01 to 0.1 international units/mL and for tetanus greater than 0.1 international units/mL. If postv accination titers are above these levels, the patients response to protein antigens is normal ☐ Serum antibody titers to pneumococcus should be measured prior to immunization and 4 to 6 weeks after immunization with polyvalent pneumococcal polysaccharide vac cine (e.g., Pneumovax). A normal response to pneumococcus for children from 24 months to 5 years of age is a conversion of 50% or more of the serotypes tested. For persons aged 6 years of age and older, a normal response is defined as conversion of 70% of the serotypes tested. A normal response for a single serotype present in a pneumococcal vaccine is defined as the conversion from a non protective to a protective titer. A protective (normal or adequate) response to each pneumococcal serotype is defined as a titer equal to or greater than 1.3 mcg/mL antibody. (Note: When reported, the conversion factor for nanograms of antibody nitrogen per milliliter (ng N/mL) to antibody micrograms per milliliter is as follows: 160 ng N/mL - 1.0 mcg/mL); or ☐ Selective IgG subclass deficiencies (see criteria in section of selective IgG subclass deficiency below); **OR** ☐ Normal total IgG levels with severe polysaccharide non-responsiveness and evidence of recurrent severe difficult-to-treat infections (e.g., recurrent otitis media, bronchiectasis, recurrent infections requiring IV antibiotics, multiple antibiotic hypersensitivities, chronic or recurrent sinusitis) with a documented requirement for antibiotic therapy: ☐ Patient has unexplained recurrent or persistent severe bacterial infections despite adequate treatment, including all of the following: ☐ Aggressive management of other conditions predisposing to recurrent sinopulmonary infections (e.g., asthma, allergic rhinitis); ☐ Prophylactic antibiotics; ☐ Increased vigilance and appropriate antibiotic therapy for infections; and	1 Year

Condition	Indications	Initial Approval Duration (Max)
	☐ Immunization with conjugate vaccines in patients who have not responded to polysaccharide vaccines. ☐ Serum antibody titers to pneumococcus should be measured prior to immunization and 4 to 6 weeks after immunization with polyvalent pneumococcal polysaccharide vaccine (e.g., Pneumovax); at least 14 polysaccharide antigens should be tested. ☐ Polysaccharide non-responsiveness is defined as lack of protective antibody titer (specific IgG antibody titer less than 1.3 mcg/ml) in greater than 70 % of antigens tested (more than 50 % in children aged 2 to 5 years). ☐ Further evidence of infection, including sinus and lung imaging, complete blood counts, C-reactive protein measurement, and erythrocyte sedimentation rate (ESR) determination, may be required to support the need for IVIG supplementation. ☐ For children 12 years of age or younger with normal total IgG levels and severe polysaccharide nonresponsiveness, IVIG should be discontinued and the medical necessity of IVIG should be re-evaluated 1 year after initiating therapy and every 2 years thereafter by reassessing immune response to protein and polysaccharide antigens. Immune response should be re-evaluated at least 3 months after discontinuation of IVIG. IVIG should also be discontinued at that time if the number and/or severity of infections have not been reduced, as not all persons with polysaccharide nonresponsiveness benefit from IVIG. The use of IVIG may not be beneficial in certain secondary immunodeficiency states; correction of the underlying condition is the preferred approach.	
Rasmussen Encephalitis	For children whose symptoms do not improve with anti-epileptic drugs and corticosteroids	1 Month
Selective IgG Subclass Deficiency	☐ Deficiency of one or more IgG subclasses to levels less than 2 standard deviations below the age-specific mean (see table below). These levels should be assessed on at least two occasions while the patient is free of infections; **AND** ☐ Patient has unexplained recurrent or persistent severe bacterial infections despite adequate treatment, including **ALL** of the following: ☐ Aggressive management of other conditions predisposing to recurrent sinopulmonary infections (e.g., asthma, allergic rhinitis); ☐ Prophylactic antibiotics; ☐ Increased vigilance and appropriate antibiotic therapy for infections; and ☐ Immunization with conjugate vaccines in patients who have not responded to polysaccharide vaccines; **AND** ☐ Member has demonstrated an inability to mount an adequate response to protein and polysaccharide antigens, as determined by the following criteria: ☐ Member has documented inability to mount an antibody response to protein antigens: Serum antibody titers to tetanus and/or diphtheria should be obtained prior to immunization with diphtheria and/or tetanus vaccine and 3 to 4 weeks after immunization. An inadequate response is defined as a postvaccination titer less than 0.1 international units/mL for diphtheria, and 0.1 international units/mL or less for tetanus; and ☐ Member has documented inability to mount an adequate antibody response to polysaccharide antigens. Serum antibody titers to at least 14 pneumococcus serotypes should be measured prior to immunization and 4 to 6 weeks after immunization with polyvalent pneumococcal polysaccharide vaccine (e.g., Pneumovax). An inadequate response is defined as lack of protective antibody titer (i.e., specific IgG concentration less than 1.3 mcg/mL) in at least	1 Year

Condition	Indications	Initial Approval Duration (Max)
	70% of serotypes tested (in at least 50% of serotypes tested in children aged 2 to 5 years) **Note:** Response to polysaccharide antigens is not reliable in children less than 2 years of age. □ In children 12 years of age or younger, IVIG should be discontinued and the medical necessity of IVIG should be re-evaluated 1 year after initiating therapy and every 2 years thereafter by re-assessing immune response to protein and polysaccharide antigens. Immune response should be re-evaluated at least 3 months after discontinuation of IVIG. IVIG should also be discontinued at that time if the number and/or severity of infections have not been reduced, as not all persons with selective IgG subclass deficiencies benefit from IVIG.	
Staphylococcal Toxic Shock Syndrome	□ Severe cases of toxic shock syndrome that have not responded to fluids and vasopressors	1 Month
**Systemic Lupus Erythematosus (SLE)	Members with severe, active SLE for whom 1st- and 2nd-line therapies have been unsuccessful, have become intolerable, or are contraindicated. **Note**: Standard 1st-line therapy of active SLE includes non-steroidal anti-inflammatory drugs, followed by low-dose corticosteroids and antimalarial compounds; 2nd-line therapeutic alternatives are the cytotoxic agents methotrexate, azathioprine, or cyclophosphamide	6 Months
Toxic epidermal necrolysis and Stevens-Johnson syndrome	Severe cases of toxic epidermal necrolysis and Stevens Johnson syndrome	3 Months
Toxic shock syndrome or toxic necrotizing fascitis due to group A streptococcus	Patients who are sufficiently ill to require critical care unit support and have documented presence of fascitis and microbiological data consistent with invasive streptococcal infection (culture or Gram stain)	1 Month

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IVIG THERAPY CONSIDERED EXPERIMENTAL AND INVESTIGATIONAL FOR THE FOLLOWING

Hematologic/Oncologic Disorders	Immunologic Disorders	Infectious Disorders	Neurologic Disorders	Rheumatologic Disorders	Other Disorders
Acute lymphoblastic leukemia (ALL)	Cellular immunodeficiencies without IgG deficiencies	Chronic mucocutaneous candidiasis (CPHARMACIST)	Amyotrophic lateral sclerosis (ALS)	Behçet's syndrome	Adrenoleukodystrophy
Aplastic Anemia	Complement deficiencies	Chronic sinusitis	Demyelinating optic neuritis	Inclusion body myositis	Asthma
Diamond-Blackfan anemia	Selective IgA deficiency without IgG or IgG subclass deficiency, and impaired antibody response to vaccination	Lyme disease	Epilepsy	Rheumatoid arthritis	Atopic dermatitis
Red cell aplasia (except as noted above due to parvovirus in the setting of immunocompromise)		Post-infectious sequelae	Myasthenia gravis-chronic management	Scleroderma	Chronic fatigue syndrome
Thrombotic thrombocytopenic pupura		Recurrent otitis media	Primary progressive, secondary progressive or progressive relapsing MS	Systemic Lupus Erythematosus (SLE)	Cystic Fibrosis
Hemolytic uremia syndrome		Rheumatic fever	Pediatric autoimmune Neuropsychiatric Disorder associated with Streptococcal Infection (PANDAS),	Vasculitides other than Kawasaki Disease	Diabetes Mellitus
Hematologic/Oncologic Disorders	Immunologic Disorders	Infectious Disorders	Neurologic Disorders	Rheumatologic Disorders	Other Disorders
			Pediatric Acute-Onset Neuropsychiatric Syndrome (PANS)		Idiopathic environmental illness
			Alzheimer's Disease		Organ transplant-cellular rejection
			Autism		Recent onset dilated cardiomyopathy
					Recurrent fetal loss
					Recurrent Spontaneous Abortion or recurrent spontaneous pregnancy loss

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FDA APPROVED INDICATIONS

Brand of Immune Globulin	FDA-Approved Indications
Bivigam (IV)	Primary humoral immunodeficiency
Carimune NF (IV)	Primary immunodeficiencies*, immune thrombocytopenic purpura
Flebogamma (IV)	Primary immunodeficiencies*
Gammagard (IV, SC)	Primary immunodeficiencies*, Multifocal Motor Neuropathy
Gammagard S/D (ID)	Primary immunodeficiencies*, B-cell Chronic Lymphocytic Leukemia, Chronic Idiopathic Thrombocytopenic Purpura, Kawasaki syndrome
Gammaked (IV, SC)	Primary immunodeficiencies*, immune thrombocytopenic purpura, chronic inflammatory demyelinating polyneuropathy
Gammaplex (IV)	Primary immunodeficiencies*
Gammar-P I.V.	Primary immunodeficiencies*
Gamunex-C (IV, SC)	Primary immunodeficiencies*, immune thrombocytopenic purpura, chronic inflammatory demyelinating polyneuropathy
Hizentra (SC)	Primary immunodeficiencies*
HyQvia (SC with recombinant human hyaluronidase)	Primary Immunodeficiency in adults
Iveegam EN (IV)	Primary immunodeficiencies*, Kawasaki syndrome
Octagam (IV)	Primary immunodeficiencies*
Polygam S/D	Primary immunodeficiencies*, immune thrombocytopenic purpura, Kawasaki syndrome, B-cell chronic lymphocytic leukemia
Privigen (IV)	Primary immunodeficiencies*, immune thrombocytopenic purpura

JARDIANCE® (EMPAGLIFLOZIN)

Length of Authorization:	Initiation of therapy - Up to 6 months Continuation of Therapy – Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

INITIAL REVIEW CRITERIA (ALL OF THE FOLLOWING MUST BE TRUE)

- ☐ Patient must be ≥18 years old
- ☐ Patient must have a diagnosis of Type 2 Diabetes
- ☐ Patient must have progress notes or labs to demonstrate failure to achieve HbA1C < 7%
- ☐ Must have trial and failure of combination therapy with metformin and an Incretin Mimetic/GLP-1 (i.e., Bydureon, Byetta, Victoza, Tanzeum, Trulicity, etc) and combination therapy with metformin and another oral agent (i.e., DPP-4 inhibitor [Janumet, Januvia, Jentadueto, Juvisync, Trajenta, Kazano, Kombiglyze, Nesina, Onglyza, Oseni, etc], a sulfonylurea, etc.) in the past two years.

JUXTAPID® (LOMITAPIDE)

Length of Authorization:	Up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥18 years old
- ☐ Patient must have a diagnosis of homozygous familial hypercholesterolemia (HoFH).
- ☐ Must be prescribed by a certified REMS provider demonstrated with supporting documentation (signed attestation)
- ☐ http://www.juxtapidremsprogram.com/

KADCYLA® (ADO-TRASTUZUMAB EMTANSINE)

Length of Authorization:	Up to 90 days
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥18 years old
- ☐ Must have current history of HER2-positive metastatic breast cancer.
- ☐ Patient must have had previous therapy with Herceptin (trastuzumab) and a taxane (examples below):

DRUG NAME	GENERIC NAME
Abraxane	Paclitaxel
Docefrez	Docetaxel
Jevtana	Cabazitaxel
Onxol	Paclitaxel
Taxotere	Docetaxel

KALYDECO® (IVACAFTOR)

Length of Authorization:	6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

CLINICAL CRITERIA

- ☐ Must be ≥ 2 years of age.
- ☐ Must have a diagnosis of cystic fibrosis (CF)
- ☐ Must have genetic testing confirming the presence of the G551D, G1244E, G1349D, G178R, G551S, R117H, S1251N, S1255P, S549N, or S549R mutation.
  - ☐ It is not effective in CF patients with two copies (homozygous) of the *F508del* mutation (*F508del/F508del*) in the CF gene.

KEPIVANCE® (PALIFERMIN)

Length of Authorization:	1 month
PA Entry:	Quantity = 6 Day Supply = 6
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Must be 18 years of age or older.
- ☐ Patient must have hematologic malignancy and receiving chemotherapy and hematopoietic stem cell infusion.
- ☐ Prescribing physician must be a specialist (hematologist/oncologist).

KINERET® (ANAKINRA)

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

RHEUMATOID ARTHRITIS

- ☐ Patient must be 18 years of age or older; **AND**
- ☐ Patient has a documented diagnosis of moderate to severe rheumatoid arthritis; **AND**
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to one or more non-biologic- DMARDs (i.e., methotrexate, leflunomide, sulfasalazine, hydroxychoroquine) for at least 3 consecutive months; **AND**
- ☐ Patient has had an inadequate response, intolerance, or has contraindications to: Xeljanz® and Humira®

MAY APPROVE FOR CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS) – NOMID TYPE

DOSING AND ADMINISTRATION:

- ☐ **Rheumatoid Arthritis (RA):**
  - ☐ The recommended dose of Kineret for the treatment of patients with rheumatoid arthritis is 100 mg/day administered daily by subcutaneous injection. The dose should be administered at approximately the same time every day.
  - ☐ Physicians should consider a dose of 100 mg of Kineret administered every other day for RA patients who have severe renal insufficiency or end stage renal disease (defined as creatinine clearance < 30 mL/min, as estimated from serum creatinine levels).
- ☐ **Cryopyrin-Associated Periodic Syndromes (CAPS):**
  - ☐ The recommended starting dose of Kineret is 1-2 mg/kg daily for NOMID patients. The dose can be individually adjusted to a maximum of 8 mg/kg daily to control active inflammation.
  - ☐ Physicians should consider administration of the prescribed Kineret dose every other day for NOMID patients who have severe renal insufficiency or end stage renal disease (defined as creatinine clearance < 30 mL/min, as estimated from serum creatinine levels).
- ☐ **Dosage Form:**
  - ☐ 100 mg/0.67 mL solution for subcutaneous injection.
  - ☐ Graduated syringe allows for doses between 20 and 100 mg.

CONTINUATION OF THERAPY

- ☐ Documentation showing current patients are stable (have low disease activity or are in clinical remission) will be taken into consideration during the prior authorization review process regarding continuation of therapy with the same agent.

KORLYM® (MIFEPRISTONE)

Length of Authorization:	☐ Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

☐ Patient must be ≥ 18 years old

☐ Must have a diagnosis of hyperglycemia secondary to hypercortisolism related to endogenous (not drug induced) Cushing Syndrome.

KUVAN® (SAPROPTERIN DIHYDROCHLORIDE)

Length of Authorization:	☐ Initiation – 3 months ☐ Continuation – Up to one year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

INITIATION OF THERAPY

- ☐ Patient must be ≥ 1 month old
- ☐ Must have a diagnosis of Phenylketonuria (PKU).
- ☐ Must submit labs demonstrating elevated blood phenylalanine (Phe) levels.

CONTINUATION OF THERAPY

- ☐ Patient must be ≥ 1 month old
- ☐ Must have a diagnosis of Phenylketonuria (PKU).
- ☐ Must submit labs demonstrating a decrease in blood phenylalanine (Phe) levels.

Note: Patients whose blood phenylalanine levels do not decrease after 1 month of treatment *at 20 mg/kg/day* are non-responders, and treatment with KUVAN should be discontinued in these patients.

KYNAMRO® (MIPOMERSEN SODIUM) INJECTION

Length of Authorization:	Up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥18 years old
- ☐ Patient must have a diagnosis of homozygous familial hypercholesterolemia (HoFH).
- ☐ Must be prescribed by a certified REMS provider demonstrated with supporting documentation (signed attestation) http://www.kynamrorems.com

LACRISERT® (HYDROXYPROPYL CELLULOSE OPTHALMIC INSERT)

Length of Authorization:	3 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- ☐ Must have at least **ONE** of the indications below:
  - ☐ Dry eye syndromes
  - ☐ Keratoconjunctivitis sicca
  - ☐ Exposure keratitis
  - ☐ Decreased corneal sensitivity
  - ☐ Recurrent corneal erosions
- ☐ Must be **18 years** of age or older.
- ☐ Previous trial and failure of **Restasis** within the past 60 days.

LENVIMA® (LENVATINIB)

Length of Authorization:	3 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

INITIAL REVIEW CRITERIA

- ☐ Must be ≥ 18 years old **AND**
- ☐ Must have a radioactive iodine-refractory differentiated thyroid cancer that is recurrent or metastatic

CONTINUATION OF THERAPY REVIEW CRITERIA

- ☐ Continues to meet all of the initial criteria **AND**
- ☐ No evidence of disease progression on therapy with lenvatinib

LEUKOTRIENE INHIBITORS

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason the Patient cannot be changed to preferred medications? **Document clinically compelling information.** Acceptable reasons include
   - ☐ Allergy to all preferred medications
   - ☐ Contraindication to all preferred medications
   - ☐ History of unacceptable side effects
2. Did the Patient fail a therapeutic trial of *at least thirty days* each of ***two*** preferred medications from the same group **AND** one of these was the requested medication's corresponding generic (if a generic is available and preferred)?

CLINICAL INFORMATION

- ☐ Accolate® (zafirlukast) has been approved for use in patients five years of age and older.
- ☐ Singulair® (montelukast) has been approved for the treatment of asthma in children 12 months and older, the treatment of allergic rhinitis in children two years of age and older and prevention of exercise-induced broncho-spasm in patients 12 years and older.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Montelukast (generic for Singulair®) tablets	Accolate® (*zafirlukast*)
Montelukast (generic for Singulair®) granules for suspension **(max age = 4)**	Singulair® (*montelukast*) tablets
Zafirlukast (generic for Accolate®)	Singulair® (*montelukast*) granules for suspension **(max age = 4)**
	Zyflo® (zileuton)
	Zyflo CR®(zileuton)

LINZESS® (LINACOTIDE)

Length of Authorization:	Up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

Chronic Idiopathic Constipation:

- ☐ Patient must be ≥ 18 years old.
- ☐ Diagnosis of chronic **idiopathic (from an unknown cause)** constipation as evidenced by:
  - ☐ Less than three spontaneous (without laxative) bowel movements per week along with at least one of the following:
    - ☐ At least a recent three month history (which need not be consecutive) of very hard stools, sensation of incomplete evacuation or straining with defecation (constipation);
    - ☐ The provider must attempt to treat constipation related to a known cause by correcting the known cause (i.e., reducing or discontinuing opioid medication).
- ☐ The patient must have a history of trial and failure of over the counter laxatives (including Miralax [polyethylene glycol 3350]) and lactulose (a prescription medication) within the past month.
- ☐ Submission must contain medical documentation from a digestive disease specialist (i.e., results of colonoscopy . . .).

Irritable Bowel Syndrome (IBS) with constipation:

- ☐ Patient must be ≥ 18 years old.
- ☐ Diagnosis of IBS *with constipation* as evidenced by:
  - ☐ A mean abdominal pain score of at least 3 on a 0-to-10-point numeric rating scale **and**
  - ☐ Recurring or consistent episodes of less than 3 complete spontaneous bowel movements/week within the past 6 months.
- ☐ Submission must contain medical documentation from a digestive disease specialist (i.e., results of colonoscopy. . .).

LIPOTROPICS

Length of Authorization:	1 year
Initiative:	☐ PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN) ☐ MAP: AP: Dose Optimization (STATINS) (75 / 2462 – GSN; 76 / 2641 – GSN)

1. Is there any reason that the Patient cannot be switched to a preferred medication? Acceptable reasons include
   - ☐ Allergy to the preferred medications in this class
   - ☐ Contraindication or drug-to-drug interaction with all preferred medications
   - ☐ History of unacceptable side effects
2. The requested medication may be approved if ***both*** of the following are true:
   - ☐ If there has been a therapeutic failure to no less than a two-month trial of two (when more than one are listed) preferred medications **AND**
   - ☐ The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

Note: If the Provider faxes in labs and the CPhT does not see documented trial and failure to approve, please escalate the request to a pharmacist to evaluate the labs for trial and failure. **Document any clinically compelling information.**

STATINS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Lovastatin (generic for Mevacor®) [*10mg, 20 mg]	Altoprev® (*lovastatin Ext Release*)* [*10mg, 20 mg]
Pravastatin (generic for Pravachol®)[*10mg, 20 mg, 40mg]	Caduet® (*amlodipine/atorvastatin*)
Simvastatin (generic for Zocor®)[*5mg, 10mg, 20 mg, 40mg]	Crestor® (*rosuvastatin*) [*5mg, 10mg, 20mg]
	Lescol® [*20mg, 40 mg] & Lescol XL® (*fluvastatin*)
	Mevacor® (*lovastatin*) [*10mg, 20 mg]
	Pravachol® (*pravastatin*) [*10mg, 20 mg, 40mg]
	Rosuvastatin (generic for Crestor®) ****Do not approve this generic. The brand name Crestor® should be approved if PDL criteria are met.****
	Zocor® (*simvastatin*)* [*5mg, 10mg, 20 mg, 40mg]

STATINS (HIGH POTENCY)

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Atorvastatin (generic for Lipitor®) [*10mg, 20mg, 40mg]	Lipitor® (*atorvastatin*) [*10mg, 20mg, 40mg]*
	Vytorin® (*simvastatin/ezetimibe*)* (see specific criteria next page)

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ADDITIONAL INFORMATION TO AID IN FINAL DECISION: FOR VYTORIN® ONLY

May approve if there has been a trial and failure of Simvastatin **and** Atorvastatin for a minimum of 90 days each with maximum dose titration (see dosage limits below). If the Patient has tried simvastatin, please review profile for trial and failure of atorvastatin. If the patient has tried simvastatin and failed, Vytorin may be approved. (Corresponding labs documenting failure should be received and noted).

- Maximum dosage limits:
  - Simvastatin – *Adults*: 40 mg/day PO for most patients; max 10 mg/day PO if taking gemfibrozil, danazol, or cyclosporine; max 20mg/day PO if taking amiodarone or verapamil
  - Atorvastatin – *Adults*: 80 mg/day PO; max 20mg/day if taking clarithromycin, itraconazole, saquinavir plus ritonavir, darunavir plus ritonavir, or fosamprenavir alone or in combination with ritonavir; max 40mg/day if taking nelfinavir.
- There must be medical documentation (progress notes, labs, etc.) showing that trial medications caused adverse effects. A 90-day trial is not required for adverse side effects or reactions.

STATIN COMBINATION PRODUCTS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
	Advicor® (*lovastatin/niacin*)*
	Liptruzet® (*atorvastatin/ezetimibe*)
	Simcor® (*simvastatin/niacin*)

BILE ACID SEQUESTRANTS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Cholestyramine (generic for Questran®)	Colestipol (generic for Colestid®) granules
Cholestyramine Light (generic for Questran Light®)	Colestid® (*colestipol*)
Colestipol (generic for Colestid®) tablets	Prevalite® (*cholestyramine/aspartame*)
	Questran® (*cholestyramine*)
	Questran Light® (*cholestyramine/aspartame*)
	Welchol® (*colesevelam*)

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OMEGA-3 ACID ETHYL ESTERS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
	Lovaza® (omega-3 fatty acid) (see specific criteria)

FIBRIC ACID DERIVATIVES

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Antara® (fenofibrate, micronized)* capsules (130mg)	Antara® (fenofibrate, micronized)* caps (30mg, 43mg, 90mg)
Gemfibrozil (generic for Lopid®)* tablets (600mg)	Fenofibrate, micronized (generic for Antara®)* capsules (30mg, 43mg, 90mg, 130mg)
Fenofibrate (generic for Tricor®) tablets (48mg, 145mg)	Fenofibrate, micronized (generic for Lofibra®)* capsules (134mg, 200mg)
	Lipofen® (*fenofibrate*) capsules (50mg, 150mg)
	Lofibra® (*fenofibrate, micronized*)* caps (67mg, 134mg, 200mg)
	Fenofibrate tablets (54mg, 160mg)
	Lopid® (*gemfibrozil*) 600mg tablets
	Fenoglide® (fenofibrate) tablets (40mg, 120mg)
	Tricor® (*fenofibrate*)* tablets (48mg, 145mg)
	Trilipix® (*fenofibric Acid*) capsules (45mg, 135mg)
	Triglide® (*fenofibrate*) tablets (50mg, 150mg)

NIACIN DERIVATIVES

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Niacin extended release (generic for Niaspan®)	Niacor® (*niacin*)
	Niaspan® (niacin/niacinamide)

NOTE

*Products will deny when the daily dose equals “2” or the daily dose exceeds “3.” Daily dose is calculated by taking the metric quantity on the incoming claim and dividing it by the days’ supply on the claim. The valid range for 2 per day is >= 1.8, but <= 2.2. To exceed a daily dose of 3, the value must be >= 3.8. Use MAP: Dose Optimization initiative.

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LIPOTROPICS (CONTINUED)

LOVAZA®, FORMERLY OMACOR (OMEGA-3 ACID ETHYL ESTERS)

Length of Authorization:	☐ Initial: Up to 12 weeks (3 months) ☐ Continuation: Up to 1 year
Initiative:	MAP: AP: Lovaza (Statins) (75 / 2462 – GSN; 76 / 2641 – GSN)

REVIEW CRITERIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

Initiation of Therapy

- Min age = 18
- Pt must have 2 or more fills of a drug from the Fibrates List or Nicotinic Acids list

  -OR-

  Patient is intolerant to or is not a candidate for fibrates or nicotinic acids.
- Must have baseline triglycerides values measured within 2 weeks of initial therapy.
- Consistent abnormal triglyceride levels ≥ 500mg/dL as identified by review of labs over the last 365 days.
- Max Qty limit = 4 tabs per day;
- Max Dose: 4 grams/ day PO

Continuation of Therapy

- Submitted labs show a decrease in triglycerides of more than 20% from baseline.
- Medication compliance as demonstrated by claims history

AutoPA Coding documented on the next page.

☐ Per CCMs MCCFL_2016_020_OT_ Lovaza AutoPA update and SFCCN_2016_018_OT_ Lovaza AutoPA update:

☐ To update the Lovaza automation to adjudicate on the Brand product only, while removing Lovaza from the look back of approved drugs and continue to require 2 of a nicotinic acid or fibrate within the last 6 months prior to approval.

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AUTO PA STEP EDITS (LOVAZA)

FLM Auto PA Step Edits (Lovaza) Automated PA approval satisfies Non-PDL edit

STEP 1: If the incoming claim is for Lovaza and the patient is greater than 17 years old: PROCEED TO STEP 2. Otherwise, DENY for PRODUCT SERVICE NOT COVERED FOR PATIENT AGE (60).

STEP 2: If the incoming claim is for Lovaza, look back 180 days in patient drug history for 2 or more fills of a drug from the Fibrates List or Nicotinic Acids List. If found: PROCEED TO STEP 3. Otherwise, DENY for Prior Authorization required (75)

STEP 3: If the incoming drug is in the Lovaza and the quantity on the incoming claim is less than or equal to 4 capsules per day: NO PA REQUIRED. Otherwise, DENY for PLAN LIMITATIONS EXCEEDED (76).

Fibrate List		
HIC3	**Drug Name**	**HSN**
M4E	Fenoglide Lipofen Lofibra	006552
M4E	Tricor	033904
M4E	Antara Lofibra Tricor	020377
M4E	Lopid	002766

Nicotinic Acid List		
HIC3	**Drug Name**	**HSN**
M4E	Niacor Niaspan Niaspan Starter Pack	001064

Quantity Limitations
4/day

LIPOTROPICS (CONTINUED)

ZETIA® (EZETIMIBE)

☐ Step – Edit Denial Review Criteria

Length of Authorization:	1 year
Initiative:	MAP: AP: Zetia (75 / 2462 – GSN; 76 / 2641 – GSN)

REVIEW CRITERIA

☐ Age greater or equal to 10 years old.
☐ Must have supporting documentation of lab values. Lab values should have been measured within 1 month of request for Zetia.
☐ Laboratory documentation is present in the medical record that demonstrates target LDL cholesterol lipid/lipoprotein profile goals have not been met with a 60-day trial period of statin monotherapy and diet modification within the previous 6 months.

OR

☐ The Patient has experienced a documented intolerance to statin therapy evidenced by any of the following:
- ☐ active liver disease
- ☐ documented unexplained persistent elevations of serum transaminases documented hypersensitivity reaction to a statin
- ☐ documented statin related myopathy
- ☐ significant drug interactions
- ☐ severe renal impairment
- ☐ pregnancy

AutoPA Coding documented on the next page.

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AUTO PA STEP EDITS (ZETIA)

FLM Auto PA Step Edits (Zetia) Automated PA approval satisfies Non-PDL edit

STEP 1: If the incoming drug is for Zetia and the patient is greater than or equal to 10 years old: PROCEED TO STEP 2. Otherwise, DENY for PRODUCT SERVICE NOT COVERED FOR PATIENT AGE (60).

STEP 2: If the incoming drug is for Zetia look back 180 days in patient drug history for 2 or more fills of a drug from the Statins list, Statins Combo List, or Zetia. If found: PROCEED TO STEP 3: Otherwise, DENY for Prior Authorization required (75).

STEP 3: If the incoming drug is for Zetia and the quantity on the incoming claim is less than or equal to 1 tablet per day: NO PA REQUIRED. Otherwise, DENY for PLAN LIMITATIONS EXCEEDED (76).

Statins List		
HIC3	**Drug Name**	**HSN**
M4D	Lipitor	012404
M4D	Lescol/XL	008946
M4D	Mevacor	002793
M4D	Pravachol	006227
M4D	Crestor	025009
M4D	Zocor	006312

Statin Combo List		
HIC3	**Drug Name**	**HSN**
M4J	Pravagard PAC	0255401
M4L	Advicor	023090
M4L	Simcor	035395
M4M	Vytorin	026505

Quantity Limitations
1/day
Zetia: HICL= 024459

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MAJOR RISK FACTORS (EXCLUSIVE OF LDL CHOLESTEROL) THAT MODIFY LDL GOALS

- ☐ Cigarette smoking
- ☐ Hypertension (BP 140/90 mmHg or on antihypertensive medication)
- ☐ Low HDL cholesterol (<40 mg/dL)†
- ☐ Family history of premature CHD
  - ☐ CHD in male first degree relative <55 years
  - ☐ CHD in female first degree relative <65 years
- ☐ Age (men 45 years; women 55 years)

† HDL cholesterol = 60 mg/dL counts as "negative" risk factor; its presence removes one risk factor from the total count.

Goals Risk Category	LDL Goal (mg/dL)
CHD and CHD risk equivalents (e.g., diabetes)	<100
Multiple (2+) risk factors	<130
Zero to one risk factor	<160

LDL Cholesterol (mg/dL)

- ☐ <100 Optimal
- ☐ 100–129 Near optimal/above optimal
- ☐ 130–159 Borderline high
- ☐ 160–189 High
- ☐ 190 Very high

HDL Cholesterol (mg/dL)

- ☐ <40 Low
- ☐ 60 High

Total Cholesterol (mg/dL)

- ☐ <200 Desirable
- ☐ 200–239 Borderline high
- ☐ 240 High Primary

LONG-ACTING BETA AGONISTS

Length of Authorization:	☐ Up to one year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

1. Patient must be ≥18 years of age for Arcapta, Brovana, and Perforomist; ≥ 5 years of age for Foradil; and ≥ 4 years of age for Serevent.
2. Must have a documented diagnosis of asthma or chronic obstructive pulmonary disease (COPD) (e.g., chronic bronchitis, emphysema).
3. Patients with diagnosis of asthma (not COPD) must be currently on at least one other asthma controller medication:
   a. Inhaled corticosteroids: Alvesco (ciclesonide), Asmanex (mometasone), Pulmicort (budesonide), Qvar® (beclomethasone)
   b. Extended release theophylline
   c. Mast-cell stabilizers: Cromolyn
   d. Leukotriene modifiers: Singulair (montelukast), Accolate (zafirlukast), Zyflo (zileuton)
   e. If no asthma controller medication is noted the request should be denied and the following statement communicated to the Provider:

   "The use of a single agent long-acting beta agonist is contraindicated without the combination use of a controller medication. Medicaid preferred combination products include Advair and Symbicort.

☐ Arcapta (indacaterol)
☐ Brovana (arformoterol)
☐ Foradil (formoterol)
☐ Perforomist (formoterol)
☐ Serevent (salmeterol)

LONG-ACTING STIMULANTS IN CHILDREN UNDER SIX YEARS OF AGE

Length of Authorization:	☐ Initial review: 3 months ☐ Continuation of Therapy: 6 months
Initiative:	MAP: Age Limit: Under Minimum (60 / 2193 – GSN; 30 / 2623 – GSN; 76 / 2641 – GSN)

Note: The 2014-2015 ADHD Medication Guidelines for Children and Adolescents are specifically written to support Florida Medicaid providers and include a preschool (children less than 6 years of age) guideline. This guideline may be accessed at: http://medicaidmentalhealth.org/ViewGuideline.cfm?GuidelineID=44

INITIAL REVIEW CRITERIA

1. Patient has had an adequate trial of parent training or teacher administered behavioral therapy and has persistent moderate to severe dysfunction as defined by:
   a. Symptoms that have persisted for at least 9 months
   b. Dysfunction that is manifested in both the home and other settings such as preschool or child care
2. Trial and failure of a preferred short acting methylphenidate should be submitted prior to consideration of a long acting agent.
3. Authorization request is for a preferred long acting methylphenidate preparation or the provider has submitted documentation of trial and response to therapy of a preferred methylphenidate preparation.
4. Patient's ability to swallow whole tablets/capsules should be assessed , if patient is unable to swallow whole tablets/capsules and also requires a long acting agent, choices should be limited to those preparations which may be utilized as a sprinkle cap or a liquid or a transdermal patch including:
   a. Ritalin LA, Metadate CD/ generic equivalents
   b. Quillivant XR powder for suspension
   c. Daytrana transdermal patch
   d. Focalin XR/generic equivalent
   e. Dexedrine spansule/generic equivalent
   f. Vyvanse

CONTINUATION OF THERAPY

Patient continues to meet initial review criteria
Documentation supports response of target symptoms with medication
Note: The long acting agents for children less than 6 years old that require review include, but are not limited to:

- ☐ Ritalin LA/Metadate CD/Aptensio XR/generic equivalents
- ☐ Concerta/Metadate ER/Methylin ER/generic equivalents
- ☐ Ritalin SR/generic equivalent
- ☐ Adderall XR/generic equivalent
- ☐ Daytrana
- ☐ Quillivant
- ☐ Focalin XR
- ☐ Vyvanse
- ☐ Dexedrine spansule/generic equivalent

LYNPARZA™ (OLAPARIB)

Length of Authorization:	☐ 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

CLINICAL NOTES

Olaparib is a poly (ADP-ribose) polymerase (PARP) inhibitor. PARP enzymes are involved in DNA transcription, cell cycle regulation, and DNA repair. Olaparib appears to be more active in patients with BRCA1 and BRCA2 mutations as opposed to BRCA-negative patients.

INITIAL REVIEW CRITERIA

- ☐ Patient is > 18 years old; AND
- ☐ Patient is female; AND
- ☐ Patient has a diagnosis of deleterious or suspected deleterious germline BRCA mutated advanced ovarian cancer (as detected by an FDA-approved companion diagnostic test: BRACAnalysis CDx™); AND
- ☐ Patient has received treatment with three or more lines of prior chemotherapy (documentation of previous therapies must be submitted) but is currently receiving no concomitant chemotherapy (olaparib should be given as monotherapy)

CONTINUATION OF THERAPY REVIEW CRITERIA

- ☐ Patient continues to meet all of the initial review criteria; AND
- ☐ No evidence of disease progression on therapy

DOSING AND ADMINISTRATION

- ☐ Lynparza® is available as a 50 mg capsule
- ☐ The dose of olaparib is 400 mg (eight 50 mg capsules) by mouth taken twice daily for a total daily dose of 800 mg. Olaparib is given as monotherapy without any other cytotoxic agents.

MAKENA® (HYDROXYPROGESTERONE CAPROATE INJECTION)

Length of Authorization:	☐ Up to 5 months
Units/Day Supply:	☐ 5 units per 30 –34 days (5 mL multidose vial [250 mg/mL] contains 1250 mg hydroxyprogesterone caproate) ☐ Pharmacies must bill claims for no more than 34 days and no less than 30 days.
Initiative:	MAP: Makena (75 / 2462 – GSN; 76 / 2641 – GSN; 60 / 2193 – GSN; 60 / 2623 – GSN)

CLINICAL NOTES

According to the Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook, Florida Medicaid may reimburse for a compounded drug if it is a combination of two or more pharmaceuticals and . . . the finished product is not otherwise commercially available in strength and formulation . . . . Therefore, use of 17-alpha-hydroxyprogesterone caproate (17-P) powder should not be treated as an alternative therapy to Makena. REQUESTS MUST NOT BE REDIRECTED TO 17-ALPHA-HYDROXYPROGESTERONE CAPROATE (17-P).

APPROVAL CRITERIA

REQUESTS MUST NOT BE REDIRECTED TO 17-ALPHA-HYDROXYPROGESTERONE CAPROATE (17P)

- ☐ Must be ≥ 16 years of age.
- ☐ Must be currently pregnant with only one baby (a singleton pregnancy) at 16 to 37 weeks gestation confirmed by supporting documentation or diagnosis code(s).

DOSAGE AND ADMINISTRATION

- ☐ Form and strength: 5 mL multidose vial (250 mg/mL) contains 1250 mg hydroxyprogesterone caproate.
- ☐ Administer intramuscularly at a dose of 250 mg (1 mL) once weekly. Begin treatment between 16 weeks, 0 days and 20 weeks, 6 days of gestation.
- ☐ Continue administration once weekly until week 37 (through 36 weeks, 6 days) of gestation or delivery, whichever occurs first.

LIMITATIONS

- ☐ Quantity limit: 1 vial per 5 weeks; 5 vials to accommodate approximately 21 weeks of therapy.
- ☐ No early refills allowed.

  Medicaid will not absorb the expense of lost shipments or misused doses. Medicaid recipients may not be denied care because of lost shipments or misused doses, so early refill expense will be borne by the specialty pharmacy and Ther-Rx.

MARINOL® (DRONABINOL)

Length of Authorization:	☐ 6 Months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA:

- ☐ Anorexia due to AIDS
  - ☐ Member has tried and failed (or has a contraindication/intolerance to) megestrol acetate
- ☐ Treatment of refractory chemotherapy-induced nausea and vomiting
  - ☐ Member has a current diagnosis of cancer or a history of cancer diagnosis within the previous 365 days
  - ☐ Member is currently receiving chemotherapy or has a history of chemotherapy within the previous 365 days
  - ☐ Member has failed to respond to conventional antiemetic therapies from the following classes:
    - ☐ **Corticosteroids:** dexamethasone
    - ☐ **Serotonin (5-HT3) Receptor Antagonists:** ondansetron
    - ☐ **Neurokinin-1 Receptor Antagonists:** aprepitant (Emend®)

DOSING AND ADMINISTRATION:

- ☐ Anorexia due to AIDS
  - ☐ 2.5mg by mouth twice daily before lunch and dinner, may reduce to 2.5mg/day at bedtime if intolerable; maximum of 20mg per day
- ☐ Treatment of refractory chemotherapy-induced nausea and vomiting
- ☐ 5mg/m^2 by mouth given 1-3 hours before chemotherapy, then 5mg/m^2 by mouth every 2–4 hours after chemotherapy for a total of 4–6 doses/day; may increase the dose by increments of 2.5mg/m^2; maximum of 15mg/m^2 per dose

MEDICARE PART D / MEDICAID DUAL ELIGIBLE

Length of Authorization:	☐ As determined by client-specific request or as clearly noted below.
Initiative:	ADM: Medicare TPL Override (41 / 50055 – GSN; 41 / 13520 – GSN; 41 / 4501 – GSN; 76 / 2614 – GSN). This initiative builds a max quantity and days' supply limitation based on the days' supply entered on the PA screen. MAP: Quantity Limit: IE 2614 (76 / 2614 – GSN) MAP: Error Code 7007 Override (76 / 7007 – GSN; 76 / 2641 – GSN)

Coding to deny applies to all drugs for Medicare Dual Eligibles except for products with either of these two **Formulary State Drug Class Code** indicators:

- ☐ **Y** = Medicaid Cov'd for Part D **and/or**
- ☐ **U** = LTC Exclusions & Medicare D

MCC-FL

- ☐ Coding to deny applies to Medicare Dual eligible members with:
  - ☐ TPL Other Payor ID = MDCO and Other Payor ID Qualifier = 05.
- ☐ The claim will deny for NCPDP = 41 – Submit bill to other processor or primary payor / IE 50055 – Err List Submit bill *to other primary payor* and Supplemental Transaction Message = *"Bill Medicare"*.
  - ☐ ADM: Medicare TPL Override:
    - ☐ Whenever specifically authorized by account management to enter this override, Call Center staff needs to enter the correct Metric Quantity and Days' Supply on the PA screen when entering the approval. MCC-FL only allows overrides by the call center for a five-day emergency supply unless specifically authorized otherwise by MCC-FL account management.
    - ☐ Staff can only build an Approval or an Informational PA with this Initiative.
  - ☐ The Call Center is authorized to enter a onetime maximum days' supply per GSN per lifetime override in cases where the submitted product cannot be broken. Account management approval is not required.
  - ☐ The Pharmacy must call for the emergency supply override and indicate that the member does not have Medicare Part D.
  - ☐ Call center staff are to e-mail Jennifer Holden (jholden@magellanhealth.com) whenever an emergency supply override is entered from an MCC-FL member. Jennifer will follow up directly with the plan for further action. Provide this info:
    - ☐ Member ID#; Member Name; Drug Name; Quantity and Days' Supply

CCP/SFCCN

- ☐ Coding to deny applies to Medicare Dual eligible members with these eligibility groups:
  - ☐ CCP/SFCCN S110M5F: Dual Eligible under Age 65
  - ☐ CCP/SFCCN S110M5M: Dual Eligible Age 65+
  - ☐ CCP/SFCCN S110V9B: HIV/AIDS Dual Eligible, HIV
  - ☐ CCP/SFCCN S110S9B: HIV/AIDS Dual Eligible, AIDS
  - ☐ CCP/SFCCN S110E9B: LTC- Dual Eligible, Age 65+
  - ☐ CCP/SFCCN S110E8B: LTC- Dual Eligible, Under Age 65
- ☐ The claim will deny for NCPDP = 41 – Submit bill to other processor or primary payor / IE 50055 – Err List Submit bill *to other primary payor* and Supplemental Transaction Message = *"Bill Medicare"*.
- ☐ If the claim is for a refill and the days' supply on the claim is greater than 3, the claim will deny for NCPDP = 76 – *Plan limitations exceeded / IE 2614 – Days supply exceeds plan limit patient pays* and Supplemental Transaction Message = *"3 Maximum Days Exceeded Pt eligible for Part D Call 866-899-4828 for assistance"*.
  - ☐ The pharmacy should edit the claim to no more than the quantity for a 3 days' supply and resubmit.
  - ☐ A onetime maximum 3-day supply per GSN per lifetime override is allowed on refill transactions only.
  - ☐ The Call Center is authorized to enter a onetime maximum days' supply per GSN per lifetime override in cases where the submitted product cannot be broken. Account management approval is not required.
  - ☐ CCP/SFCCN Enrollee Services: 866-899-4828.

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CCP/SFCCN *(CONTINUED)*

- If the claim is for a med that has already paid per this policy (has already used their one-time 3 day supply override), the claim will deny for *NCPDP = 76 – Plan limitations exceeded / IE 7007 – Number of fills limit exceeded* and Supplemental Transaction Message – *"Pt eligible for Part D Call 866-899-4828 for assistance."*
  - Members within the groups listed above will be allowed a onetime maximum 3-day supply per GSN per lifetime on refill transactions only.
  - CCP/SFCCN Enrollee Services: 866-899-4828.

METHADONE

Length of Authorization:	6 Months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

INITIAL REVIEW CRITERIA:

- ☐ Patient is > 18 years old AND
- ☐ Patient is prescribed methadone for the treatment of severe, chronic pain and is NOT being treated with methadone for the management of opioid addiction AND
- ☐ Methadone is prescribed on a scheduled basis (**not** "as needed") AND
- ☐ The plan is to discontinue all other long acting opioids upon initiation of therapy with methadone AND
- ☐ The patient has a diagnosis of metastatic cancer OR
- ☐ The patient has a diagnosis of any non-metastatic cancer or chronic non-malignant pain
  - ☐ If the patient has a diagnosis of metastatic cancer supported by progress notes, discharge notes, or health conditions:
    - ☐ Patient has a contraindication or history of intractable pain or intolerable adverse effects associated with all preferred long-acting opioids AND
    - ☐ Patient is opioid tolerant as evidenced by recent history (within the past two weeks) of receiving daily opioid analgesics at the following minimum doses for at least one week:
      - ☐ 60 mg oral morphine per day for at least one week
      - ☐ 25 mcg/hour of transdermal fentanyl for at least one week
      - ☐ 30 mg oral oxycodone per day for at least one week
      - ☐ 8 mg oral hydromorphone per day for at least one week
      - ☐ 25 mg of oral oxymorphone per day for at least one week
  - ☐ If the patient has a diagnosis of a non-metastatic cancer or chronic non-malignant pain supported by progress notes, discharge notes, or health conditions:
    - ☐ The prescriber has provided a copy of the signed pain management agreement documenting ongoing evaluations utilizing monitoring systems such as drug screens, pill counts, etc., AND
    - ☐ Patient has a contraindication or history of intractable pain or intolerable adverse effects associated with all preferred long-acting opioids AND
    - ☐ Patient is opioid tolerant as evidenced by recent history (within the past two weeks) of receiving daily opioid analgesics at the following minimum doses for at least one week
      - ☐ 60 mg oral morphine per day for at least one week
      - ☐ 25 mcg/hour of transdermal fentanyl for at least one week
      - ☐ 30 mg oral oxycodone per day for at least one week
      - ☐ 8 mg oral hydromorphone per day for at least one week
      - ☐ 25 mg of oral oxymorphone per day for at least one week

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METHADONE (CONTINUED)

CONTINUATION OF THERAPY REVIEW CRITERIA

- ☐ Patient continues to meet all of the initial review criteria AND
- ☐ Patient has been compliant with medication refills AND
- ☐ Patient has no medication fills for any other long acting opioid AND
- ☐ Patient has no medication fills for opioids from any prescriber other than the methadone prescriber AND
- ☐ There is no history of behavior indicative of abuse including requests for early refills

DOSING AND ADMINISTRATION

- ☐ Dosing protocols vary depending on history of previous opioid dosing schedule (consult dose conversion table) but generally begin at no higher than 30 mg–40 mg per day divided into two or three daily doses. Doses may be titrated up or down every 5 to 7 days depending on response and adverse effects. Due to the need to slowly taper off of Methadone, a one month approval may be granted if tapering off is needed.
- ☐ Methadone is available for pain management in the following formulations:
  - ☐ Methadone 10 mg/5 mL solution
  - ☐ Methadone 10 mg/1 mL concentrated solution
  - ☐ Methadone 5 mg/5 mL solution
  - ☐ Methadone 5 mg tablet
  - ☐ Methadone 10 mg tablet
  - ☐ (*Note: the 40 mg dispersible tablet for suspension is **not** reimbursed under the Medicaid pharmacy benefit and is only dispensed by licensed methadone maintenance clinics)

MISCELLANEOUS INFORMATION

XIAFLEX® (COLLAGENASE CLOSTRIDIUM HISTOLYTICUM LYOPHILISATE) DIRECTIVE, EFFECTIVE 03/24/2014

All requests for Xiaflex must be redirected to physician services.

PROCYSBI (CYSTEAMINE BITARTRATE) DIRECTIVE, EFFECTIVE 3/13/2014

Please refer all requests received for Procysbi to preferred Cystagon. These agents both have the same active ingredient (cysteamine bitartrate).

POLYETHYLENE GLYCOL POWDER DIRECTIVE, EFFECTIVE 03/04/2014

Magellan Medicaid Administration may now review requests for quantity limit overrides for Polyethylene Glycol powder (generic MiraLAX). The quantity limit for this medication is 527gm per 30 days. Approvals may be granted for up to twice the quantity limit. Please follow the instructions below:

- **Initiative:** MAP: PDL Quantity Limit
- Length of Authorization: 1 year
- **PA entry:** QTY = 1054/Days' Supply = 30

Approval Criteria (Pharmacist Review Only: CPhTs – Document all info available prior to escalation):
Treatment history. (Note: Response to therapy, tolerability, and treatment compliance/consistency are factors to consider for continuation of therapy).
Progress notes substantiating the patient's treatment course and response to previous trials. (Clinical documentation must be provided)
Therapy appropriateness based on the diagnosis submitted and any other underlying medical condition(s).

BELVIQ® (LORCASERIN) DIRECTIVE (EFFECTIVE 06/18/2013)

Belviq is a non-reimbursable product under Florida Medicaid. If you receive a request for this medication, please resolve as an informational and reference this information in your clinical notes. Please use the fax back response to providers below: "Florida Medicaid does not reimburse for this product."

AVASTIN®: CCP/SFCCN ONLY

- May be approved for diabetic macular edema.
- Coverage is under the Pharmacy benefit.
- Requests for Lucentis® and Eylea® should be escalated to a clinical pharmacist for consideration of Avastin® and/or denial.

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MISCELLANEOUS INFORMATION (CONTINUED)

SYNERA AND EMLA DIRECTIVE (EFFECTIVE 11/21/2011)

Please redirect any requests received for Synera patches or EMLA cream to the preferred agents listed below based on the product/dosage form requested:

Q5H TOPICAL LOCAL ANESTHETICS

- ☐ LIDOCAINE 3% CREAM (LIDOCAINE HCL)
- ☐ LIDOCAINE HCL 3% LOTION (LIDOCAINE HCL)
- ☐ LIDOCAINE-PRILOCAINE CREAM (LIDOCAINE/PRILOCAINE)
- ☐ LIDODERM 5% PATCH (LIDOCAINE)

For example, providers requesting Synera topical patches would be redirected to Lidoderm patches. Providers requesting EMLA cream could be redirected to Lidocaine-Prilocaine cream or one of the other preferred creams, ointment, or lotion.

GRALISE (GABAPENTIN EXTENDED RELEASE) TABLETS DIRECTIVE (EFFECTIVE 08/23/2011)

Gralise is an extended release formulation of gabapentin indicated for the treatment of post-herpetic neuralgia. If you receive a prior authorization request for Gralise, **please redirect providers to generic Gabapentin** until further notice. Please let me know if you have any questions or concerns.

ARICEPT 23 MG DIRECTIVE (EFFECTIVE 08/03/2011)

If you receive a prior authorization request for Aricept 23 mg, please do not approve.

Please redirect the provider to generic donepezil 23mg as this product is preferred.

RHOGAM DIRECTIVE (EFFECTIVE 07/13/2011)

RhoGAM is non-reimbursable under the Plan. HyperRHO is preferred and is the **only** reimbursable product under the Plan. It can be billed via pharmacy or physician services.

EGRIFTA DIRECTIVE (EFFECTIVE 04/29/2011)

Egrifta is not covered by the Plan. Forward to a pharmacist. PA requests for this medication must be forwarded to a pharmacist for review to be denied noting the following:

"Medicaid does not reimburse for this product."

PENTAMIDINE IV VS INHALATION (EFFECTIVE 04/18/2011)

If you receive a prior authorization request for Pentamidine, please check the route of administration and follow the directives below.

- ☐ If the request is for Pentamidine for use by inhalation, Nebupent® powder for inhalation is preferred and does not require a PA.

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MISCELLANEOUS INFORMATION (CONTINUED)

HUMATE-P DIRECTIVE (EFFECTIVE 04/04/2011)

When entering an early refill PA for Humate-P, please round up to the nearest thousand.

BULK CHEMICALS (EFFECTIVE 12/28/2010)

- If you receive a phone/fax request for medications within the HIC3 U6N and U6W please inform the provider that those bulk chemicals are not reimbursable by the Plan.

FAIR HEARING REQUEST (10/13/2010)

Upon request for a non-PDL agent that has been previously approved:

- Click on the All PA Clinical Notes tab under the PA to review all previous clinical notes. This will show you in one place all the comments entered throughout the history of the PA.
- If you see any comments that say this was approved due to a fair hearing decision and you have a completed PA form, Rx (with or without progress notes), and the dosage is the same, please approve it again. ***Make sure to copy previous PA clinical notes and paste in your review***
- If the request includes completed PA form and Rx (with or without progress notes) and the dosage has changed, escalate the request to a pharmacist.

MED CERT CODE 8 "DIALYSIS"

Appendix A: Dialysis Drugs

MAP: Cert Code Bypass (EU / 50167 – GSN; 75 / 2462 – GSN; 76 /2541 – GSN): RPH USE ONLY

- Rejected/denied claim may display the following Internal Error and Reject Code [NCPDP] codes/descriptions:
  - INTERNAL ERROR: 50167 – Error List M/I Prior Authorization Type Code
  - REJECT CODE [NCPDP]: EU – M/I Prior Authorization Type Code
- Check the drug detail Formulary tab for the Formulary Ind. D = Dialysis (Med Cert 8)
- Rejected/denied claim may display this transaction message/rejection: "Dialysis drug claim requires MedCert = 8".
- Is this a dialysis patient?
  - Call?
    - If YES, then the pharmacy should use the med cert code "8."
    - If NO, DO NOT instruct them to use this code. Inform them that coverage for this medication is only for dialysis patients.
  - Fax?
    - This medication is reimbursable for dialysis patients only.
    - If this is a dialysis patient, please have the pharmacy use the med cert code "8" or contact the Help Desk at 1-877-553-7481 for further assistance.

BELBUCA® (BUSPIRONE BUCCAL FILM)

- From the April 1, 2016 Florida Pharmaceutical & Therapeutics Committee Meeting: Effective April 1, 2016 – added as Non-PDL
- Minimum age = 16

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PREFERRED PANCREATIC ENZYMES (EFFECTIVE 05/26/2010)

Payable Pancreatic Enzymes			
Drug Name	**Strength**	**NDC**	**Manufacturer**
Creon	6k-19k-30k	00032120601	Solvay Pharmaceuticals
	6k-19k-30k	00032120607	Solvay Pharmaceuticals
	12K-38K-60K	00032121201	Solvay Pharmaceuticals
	12K-38K-60K	00032121207	Solvay Pharmaceuticals
	24K-76K120K	00032122401	Solvay Pharmaceuticals
	24K-76K120K	00032122407	Solvay Pharmaceuticals
Pancreaze	4.2K-10K	50458034160	Janssen Pharmaceutical
	10.5K-25K	50458034260	Janssen Pharmaceutical
	16.8-40-70K	50458034360	Janssen Pharmaceutical
	21-37-61k	50458034660	Janssen Pharmaceutical
Zenpep	5K-17K-27K	42865010002	Eurand Pharmaceuticals
	10K-34K-55K	42865010102	Eurand Pharmaceuticals
	15K-51K-82K	42865010202	Eurand Pharmaceuticals
	20K-68K-109K	42865010302	Eurand Pharmaceuticals

AUVI-Q

As of late October 2015, Auvi-Q has been recalled (temporarily). We have been authorized to enter a 3-month approval for requests for the non-preferred EpiPen.

Auvi-Q is an epinephrine auto-injector that talks the user through each step of the injection process to facilitate administration. This medication is used to treat life-threatening allergic reactions (anaphylaxis) in people who are at risk for or have a history of these reactions.

Requests for EpiPen / EpiPen Jr. should be redirected to the preferred alternative Auvi-Q.

Suggested Fax back response:

"Auvi-Q products are preferred and do not require prior authorization. Please consider a change to the preferred alternative."

If the physician resubmits the request stating that the preferred Auvi-Q products are not suitable or if you get push back via a phone call, the provider must provide justification as to why the preferred alternative cannot be considered. This information must be submitted via fax. Please consider a faxback message such as the following in these instances:

"If further consideration of EpiPen/EpiPen Jr. is requested, please submit the prior authorization request form, copy of the prescription and progress notes with clinical justification supporting the request for the medication prescribed."

COPAXONE

Copaxone 40mg/ml solution for injection is non-preferred. Copaxone 20mg/ml is preferred and does not require prior authorization.

Note: Copaxone (glatiramer) is indicated for the treatment of relapsing forms of multiple sclerosis (designated an orphan drug by the FDA for this indication):

- Subcutaneous dosage (20 mg/ml solution):
  Adults: 20 mg subcutaneous once daily.
- Subcutaneous dosage (40 mg/ml solution):
  Adults: 40 mg subcutaneous 3 times per week. Administer doses at least 48 hours apart.

Copaxone (glatiramer) 20 mg/mL and 40 mg/mL solutions for injection are NOT interchangeable.

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IMMUNIZATIONS: INFLUENZA VACCINE, PNEUMOCOCCAL VACCINE, SHINGLES VACCINE, ETC.

MCC-FL ONLY:

- Coding updated as of 01/27/2016 (MCCFL_2015_027_OT_Pneumonia_Vax: Remedy 226921:
  - All Zostavax are non-rebateable and need to bypass rebate status
  - All Zostavax are non-PDL and need to bypass non-PDL status
  - Remove the following limitations: Patient must have LTC indicator; OR Patient must have Patient Residence=03–nursing facility or claim will deny NCPDP EC 4X-M/I Patient Res

CCP/SFCCN ONLY:

- Immunizations are available from primary care providers and county health departments (federally qualified health centers and rural health departments). Medicaid prescribed drug services does not reimburse for immunizations and vaccines, except for influenza vaccine (limited to once per year for institutionalized Medicaid recipients who do not have Medicare benefits); pneumococcal vaccine (once per five years per institutionalized recipient who does not have Medicare benefits); shingles vaccine for institutionalized adults age 60-64 years (once per lifetime); and others specified under the topic, "Covered Services and Limitations for Institutionalized Recipients".
- CCP/SFCCN has specific coding in place so that Influenza vaccines will pay ONLY if the member has an LTC attribute on file or if the incoming claim has an attribute to indicate the member's residence as a nursing facility.

Pneumococcal vaccine	**HICL**	**Drug Name**	**Step 1:** If the incoming claim is for Pneumovax, look back in claims history 730 days for paid claim of Prevnar 13: If found, DENY for PRIOR AUTHORIZATION REQUIRED (75) with add'l message "Therapeutic duplication of this medication not allowe d."
	4212	Pneumovax	**Step 2:** If the incoming claim is for Prevnar 13, look back in claims history 730 days for paid claim of Pneumovax: If found, DENY for PRIOR AUTHORIZATION REQUIRED (75) with add'l message "Therapeutic duplication of this medication not allowed."
	36856	Prevnar 13	See **Summary of Drug Limitations** for more info on Pneumovax® and Prevnar 13®

Influenza Vaccine NDCs for the 2015 – 2016 Season: All are "T- Covered" and "D – No PA Required" per Age					
NDC	**LABEL**	**GSN**	**MIN AGE**	**MAX AGE**	**Max Quantity Per Billing Unit**
66521011802	FLUVIRIN 2015-2016	73885	4	999	0.5
66521011812	FLUVIRIN 2015-2016	73885	4	999	0.5
62577061401	FLUCELVAX 2015-2016	73888	18	999	0.5
62577061411	FLUCELVAX 2015-2016	73888	18	999	0.5
49281041550	FLUZONE QUAD 2015-2016	74020	3	999	0.5
49281041588	FLUZONE QUAD 2015-2016	74020	3	999	0.5
58160090341	FLUARIX QUAD 2015-2016	74020	3	999	0.5
58160090352	FLUARIX QUAD 2015-2016	74020	3	999	0.5
49281041510	FLUZONE QUAD 2015-2016	74021	3	999	0.5
49281041558	FLUZONE QUAD 2015-2016	74021	3	999	0.5
42874001501	FLUBLOK 2015-2016	74022	18	999	0.5
42874001510	FLUBLOK 2015-2016	74022	18	999	0.5
49281039765	FLUZONE HIGH-DOSE 2015-2016	74107	65	999	0.5
49281039788	FLUZONE HIGH-DOSE 2015-2016	74107	65	999	0.5
33332001501	AFLURIA 2015-2016	74326	5	999	0.5
33332001502	AFLURIA 2015-2016	74326	5	999	0.5
49281051500	FLUZONE QUAD PEDI 2015-2016	73935	0	999	0.25
49281051525	FLUZONE QUAD PEDI 2015-2016	73935	0	999	0.25
66019030201	FLUMIST QUAD 2015-2016	74099	2	49	
76420051001	SINGLE USE EZ FLU 2015-2016	74635	18	999	

MORPHINE SULFATE, EXTENDED RELEASE (GENERIC)

Length of Authorization:	6 Months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

INITIAL REVIEW CRITERIA

- ☐ Patient is > 18 years old; **AND**
- ☐ Patient has a diagnosis of severe, chronic pain (malignant or chronic non-malignant pain) that requires daily, around-the-clock , long-term opioid treatment as supported by progress notes, discharge notes or health conditions; **AND**
- ☐ Patient has tried and failed or has an intolerance or contraindication to the preferred long-acting oral morphine product formulation; **AND**
- ☐ Morphine sulfate, extended release is prescribed on a scheduled basis (**not** "as needed" dosing); **AND**
- ☐ The prescribed dose does not exceed 15 mg by mouth every 8 to 12 hours; **OR**
- ☐ The patient is opioid tolerant as evidenced by recent history (within the past two weeks) of receiving daily opioid analgesics at the following minimum doses for at least one week:
  - ☐ 60 mg oral morphine per day for at least one week
  - ☐ 25 mcg/hour of transdermal fentanyl for at least one week
  - ☐ 30 mg oral oxycodone per day for at least one week
  - ☐ 8 mg oral hydromorphone per day for at least one week
  - ☐ 25 mg of oral oxymorphone per day for at least one week

CONTINUATION OF THERAPY REVIEW CRITERIA

- ☐ Patient continues to meet all of the initial review criteria AND
- ☐ Patient has been compliant with medication refills AND
- ☐ Patient has no medication fills for any other long acting opioid AND
- ☐ There is no history of behavior indicative of abuse including requests for early refills

DOSING AND ADMINISTRATION

- ☐ For patients who are NOT opioid tolerant (see definition below), initiate treatment with morphine sulfate, extended release 15 mg by mouth every 8 to 12 hours
- ☐ The dose of morphine sulfate, extended release in patients who are opioid-tolerant (see definition below) will vary depending on their previous opioid dose and formulation
- ☐ Definition of opioid tolerant:
  - ☐ Receiving 60 mg oral morphine per day for at least one week OR
  - ☐ Receiving 25 mcg/hour of transdermal fentanyl for at least one week OR
  - ☐ Receiving 30 mg oral oxycodone per day for at least one week OR
  - ☐ Receiving 8 mg oral hydromorphone per day for at least one week OR
  - ☐ Receiving 25 mg of oral oxymorphone per day for at least one week

MYRBETRIQ® (MIRABEGRON)

Length of Authorization:	Initiation – Up to 90 days Continuation – Up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years old.
- ☐ Diagnosis of overactive bladder.
- ☐ The patient must have a history of trial and failure within the past 365 days of at least two other preferred indicated anticholinergic agents.

NAGLAZYME® (GALSULFASE)

Length of Authorization:	Up to one year
Initiative:	MAP: AP: Naglazyme

APPROVAL CRITERIA

- Must have a documented (in "health conditions" or medical records/progress notes) diagnosis of Mucopolysaccharidosis VI.

NAGLAZYME AUTOMATION LOGIC

Naglazyme Automation

Automated PA approval satisfies L = AutoPA drug edit

Automated PA approval will NOT override R = Non-PDL edit

Generic Name	Brand Name	Drug Code
Galsulfase	Naglazyme	HSN = 032963

Step 1: If incoming claims is for HSN <032963> and prior authorization code = L, look back 730 days in the patient's health conditions for an *ICD-9 = 277.5 OR* an *ICD-10 = E76.29* (Mucopolysaccharidosis VI) if found, NO PA REQUIRED. Otherwise, deny for PRIOR AUTHORIZATION REQUIRED NCPDP EC 75 with supplemental message: *"RECEPIENT DOESN'T HAVE REQ DIAGNOSIS ON FILE."*

Approvable ICD 9 Code	
277.5	Maroteaux-Lamy Syndrome Mucopolysaccharidosis VI (MPS VI) Maroteaux-Lamy Syndrome
Approvable ICD 10 Code	
E76.29	Other Mucopolysaccharidoses Maroteaux-Lamy Syndrome Mucopolysaccharidosis VI (MPS VI) Maroteaux-Lamy Syndrome

NATAMYCIN (OPHTHALAMIC)

Length of Authorization:	Up to 21 days
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL CRITERIA

- Must have a diagnosis of a fungal eye infection.

NEUMEGA® (OPRELVEKIN)

Length of Authorization:	6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA *(ALL OF THE FOLLOWING MUST BE TRUE)*

INITIAL THERAPY

- ☐ Patient must be ≥18 years old; safety and efficacy have not been established in pediatric patients
- ☐ Patient must have a confirmed diagnosis of a nonmyeloid malignancy (examples of myeloid malignancies would be any form of leukemia)
- ☐ Clinical notes document patient is at high risk for severe thrombocytopenia based on previous history of severe thrombocytopenia with the same chemotherapeutic regimen (platelet count less than 20,000/µL).
- ☐ Oprelvekin therapy will begin no sooner than six hours following the completion of chemotherapy and will be discontinued at least two days prior to starting the next dose of chemotherapy (duration of therapy is based on monitoring recovery of platelet count and usually is approximately a 10 to 21 day cycle). Dosing beyond 21 days per treatment course is not recommended.

CONTINUATION OF THERAPY

- ☐ Patient continues to receive myelosuppressive chemotherapy for a nonmyeloid malignancy and is tolerating oprelvekin.

PDL: NON-PREFERRED BRAND REQUIRED INITIATIVE (AS OF 05/11/2016)

Please refer to the list of medications below as they all now require the **PDL: Non-Preferred Brand Required** initiative. For these brand and generic products that are BOTH NON-Preferred, refer to prior authorization review criteria the specific medication. **If it is determined that the request is approvable, then enter the approval for the BRAND product.**

Adderall XR***	dextroamphetamine/ amphetamine salts	PDL: Non-Preferred Brand Required initiative for Adderall XR; APPROVE ONLY BRAND NAME
Aggrenox***	aspirin/dipyridamole	PDL: Non-Preferred Brand Required initiative for Aggrenox (PDL); APPROVE ONLY BRAND NAME
Androgel gel pack/pump***	testosterone	PDL: Non-Preferred Brand Required initiative for Androgel; APPROVE ONLY BRAND NAME
Arixtra***	fondaparinux sodium	PDL: Non-Preferred Brand Required initiative for Arixtra; APPROVE ONLY BRAND NAME
Avelox***	moxifloxacin	PDL: Non-Preferred Brand Required initiative for Avelox; APPROVE ONLY BRAND NAME
Axert ***	almotriptan	Brand Non-Preferred Required initiative for Axert; APPROVE ONLY BRAND NAME
Azactam Injectable	aztreonam	Refer requests for generic to brand Azactam (PDL)
Baraclude	entecavir	Refer requests for generic to brand Baraclude (PDL)
Catapres TTS patch	clonidine	Refer requests to brand Catapres TTS {PDL}
Cellcept suspension	mycophenolate mofetil suspension	Refer requests for generic to brand Cellcept suspension (PDL for ages < 11)
Cipro Susp (250mg/5ml & 500mg/5ml)	ciprofloxacin	Refer requests for generic to brand Cipro suspension (PDL for ages < 11)
Copaxone	glatiramer accetate/Glatopa	Refer Glatopa requests to brand Copaxone **20mg** only (PDL)
Crestor***	Rosuvastatin	Brand Non-Preferred Required initiative for Crestor; **APPROVE ONLY BRAND NAME**
Detrol LA	tolterodine extended release	PDL: Non-Preferred Brand Required initiative for Detrol LA
Diastat	diazepam	Refer requests to brand Diastat {PDL} **Note**: The MAP: Diastat initiative must be used for requests for recipients > 18 y/o.
Differin cream	adapalene	Refer requests to brand Differin {PDL}
Epivir **HBV** 100mg tablets	lamivudine 100mg tablets	Refer requests to brand Epivir **HBV** {PDL} (Not to be confused with Epivir, antiretroviral for HIV
Exelon patch	rivastigmine transdermal	Refer requests for generic to brand Exelon patch {PDL}
Focalin XR	dexmehylphenidate ER	Refer requests to brand Focalin XR {PDL}
Gleevec***	Imatinib Mesylate	Brand Non-Preferred Required initiative for Gleevec; APPROVE ONLY BRAND NAME
Imitrex nasal spray	sumatriptan	Refer requests to brand Imitrex nasal spray {PDL}
Imitrex vial	sumatriptan	Refer requests to brand Imitrex vials {PDL}
Kapvay***	clonidine ER	PDL: Non-Preferred Brand Required initiative for Kapvay; APPROVE ONLY BRAND NAME
Latuda***	lurasidone	PDL: Non-Preferred Brand Required initiative for Latuda; APPROVE ONLY BRAND NAME

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PDL: NON-PREFERRED BRAND REQUIRED INITIATIVE (AS OF 05/11/2016) (CONTINUED)

Please refer to the list of medications below as they all now require the **PDL: Non-Preferred Brand Required** initiative:

Lescol	fluvastatin	Refer requests to brand Lescol {PDL}
Lovaza***	omega 3 acid ethyl esters	Brand Non-Preferred Required initiative for Lovaza; APPROVE ONLY BRAND NAME
Mepron Oral Suspension	atovaquone	Refer requests for generic to brand Mepron Suspension {PDL}
Micardis/Micardis HCT	telmesartan/telmisartan HCT	Refer requests to brand Micardis or Micardis HCT {PDL}
Nasonex Spray	mometasone	Refer requests for generic to brand Nasonex {PDL}
Natroba Susp.	spinosad	Refer requests for generic to brand Natroba Suspension {PDL}
Niaspan	niacin extended release	Refer requests to brand Niaspan {PDL}
Orapred ODT	prednisolone sodium phosphate ODT	Refer requests for generic to brand Orapred ODT {PDL for ages < 11}
Ovace 10% shampoo	sulfacetamide sodium 10% shampoo	PDL: Non-Preferred Brand Required initiative for Ovace; APPROVE ONLY BRAND NAME
Patanase	olopatadine	Refer requests for generic to brand Patanase {PDL}
Protopic ointment	tacrolimus	Refer requests for generic to brand Protopic {PDL}
Pulmicort	budesonide	Refer requests to brand Pulmicort {PDL} **Note: If the recipient is ≥ 12 years of age, ONLY the MAP: Age limit over Maximum initiative is required**; Do not override budesonide.
Retin-A **Cream**	tretinoin Cream	Refer requests for generic to Retin-A Cream {PDL}
Soriatane	acitretin	Refer requests to brand Soriatane {PDL}
Suprax suspension	cefixime suspension	Refer requests for generic to brand Suprax susp {PDL}
Symbyax***	olanzapine/fluoxetine	Brand Non-Preferred Required initiative for Symbyax; APPROVE ONLY BRAND NAME
Tasmar***	tolcapone	PDL: Non-Preferred Brand Required initiative for Tasmar; APPROVE ONLY BRAND NAME
Temodar	temozolamide	PDL: Non-Preferred Brand Required initiative for Temodar; APPROVE ONLY BRAND NAME
Tobi	tobramycin nebs	Brand name Auto prior authorization for TOBI SOLUTION (Requests for Tobi Podhaler should be referred to brand TOBI SOLUTION)
Tobradex	Tobramycin/dexamethasone	Refer requests to brand Tobradex {PDL}
Trizivir***	Abacavir/zidovudine/lamivudine	Refer requests to brand Trizivir {PDL}
Valcyte***	valgancyclovir	PDL: Non-Preferred Brand Required initiative for Valcyte; APPROVE ONLY BRAND NAME
Viramune **suspension*** **	nevirapine **suspension**	PDL: Non-Preferred Brand Required initiative for Viramune suspension only, **not tablets;** APPROVE ONLY BRAND NAME

PDL: NON-PREFERRED BRAND REQUIRED INITIATIVE (AS OF 05/11/2016) (CONTINUED)

Please refer to the list of medications below as they all now require the **PDL: Non-Preferred Brand Required** initiative:

Xeloda***	capecitabine	PDL: Non-Preferred Brand Required initiative for Xeloda; APPROVE ONLY BRAND NAME
Xenazine***	tetrabenazine	PDL: Non-Preferred Brand Required initiative for Xenazine; APPROVE ONLY BRAND NAME

*** **Brand and generic products are NON-Preferred-> Refer to prior authorization review criteria**. If it is determined that the request is approvable, then enter an approval for the brand product.

NUEDEXTA® (DEXTROMETHORPHAN AND QUINIDINE SULFATE) CAPSULE

Length of Authorization:	Up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

INITIATION OF THERAPY:

- ☐ Patient must be ≥ 18 years old.
- ☐ Must have a diagnosis of Pseudobulbar affect (PBA) related to a neurologic disorder (e.g., ALS, MS, Parkinson's disease, a stroke, traumatic brain injury…)
- ☐ Documentation of the secondary neurologic disorder must be submitted.
- ☐ Must be prescribed or recommended by a specialist. (If prescriber is not a specialist then the referral notes of the specialist must be submitted.)

CONTINUATION OF THERAPY (applies only after an initial authorization has been granted):

- ☐ Patient must be ≥ 18 years old.
- ☐ Must have a diagnosis of Pseudobulbar affect (PBA) related to a neurologic disorder (e.g., ALS, MS, Parkinson's disease, a stroke, traumatic brain injury…).
- ☐ Progress notes or medical records must demonstrate effectiveness of therapy (via statement in official records or improved score on the CNS-LS).

OFF LABEL USE CRITERIA

Length of Authorization:	Initial: Up to 3 months Continuation of Therapy: up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

INITIAL REVIEW CRITERIA (ALL OF THE FOLLOWING BELOW IS REQUIRED):

1. Documentation submitted with trial and failure or intolerance to all FDA- approved medications for the indication **AND**
2. Phase III clinical studies published in peer review journals to support the non-FDA approved use **AND**
3. Usage supported by publications in peer reviewed medical literature and one or more citations in at least one of the following compendia:
   a. American Hospital Formulary Service Drug Information (AHFS)
   b. United States Pharmacopeia-Drug Information (or its successor publications); and
   c. DRUGDEX Information System

CONTINUATION OF THERAPY

Documentation of clinical response, as measured by applicable laboratory tests, radiologic studies or other markers of disease response, to therapy must be submitted

OFEV® (NINTEDANIB)

Length of Authorization:	Up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years old
- ☐ Must be prescribed or in consultation with a pulmonologist **AND**
- ☐ Confirmation of idiopathic pulmonary fibrosis through exclusions of other known causes of interstitial lung disease: domestic and occupational environmental exposures, drug toxicity or connective tissue disease **AND**
- ☐ Documentation submitted that the patient is a nonsmoker or has been abstinent for at least six weeks **AND**
- ☐ Confirmation of diagnosis via lung biopsy **OR** high resolution computed tomography **AND**
- ☐ Documented pulmonary function tests within the past 60 days reflecting Forced Vital Capacity(FVC) ≥ 50% **AND**
- ☐ Baseline percent predicted diffusing capacity of the lung for carbon monoxide is ≥ 30% **AND**
- ☐ Patient must obtain a liver function test prior to starting treatment

CONTINUATION OF THERAPY

- ☐ Documentation of improvement or effectiveness of therapy (<200ml decrease in FVC or <10% decline in percent predicted FVC)
- ☐ Clinical documentation that the recipient is tobacco free

DOSING AND ADMINISTRATION

- ☐ 150mg by mouth twice daily 12 hours apart with food. Swallow whole with liquid.

OLYSIO® (SIMEPREVIR)

Length of Authorization:	12 Weeks or 24 Weeks
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)
Fax Form:	Hepatitis C Agents **[REQUIRED]**

REVIEW CRITERIA (RPH REVIEW ONLY: CPHTS – DOCUMENT ALL INFO PRIOR TO ESCALATION)

REVIEW CRITERIA

FOR GENOTYPE 1 NEW THERAPY REQUESTS, RESUBMIT FOR PREFERRED VIEKIRA PAK [EXCEPT THOSE WITH DECOMPENSATED CIRRHOSIS (CHILD PUGH B/C] AND FOR GENOTYPE 4 REQUESTS, RESUBMIT FOR PREFERRED TECHNIVIE

1. Adult patient age ≥18 years old; AND
2. Prescribed by or in consultation with a hepatologist, gastroenterologist, infectious disease specialist or transplant physician; AND
3. Patient has no history of simeprevir (no claims history or reference in medical records to previous trial and failure of simeprevir) [Refer to **Appendix G** for additional information when reviewing for previous therapy]; **AND**
4. Prior relapsers or prior non responders and recipients who have failed treatment with peginterferon alfa + ribavirin therapy (Naïve to other Hep C agents); **AND**
5. One of the following:
   - ☐ Patient has abstained from the use of illicit drugs and alcohol for a minimum of one month as evidenced by negative urine or blood confirmation tests collected within the past 30 days, prior to initiation of therapy (results must be submitted with request);
     - ☐ If the test results submitted is positive the reviewer must review claims history or medical records to determine if medications are prescribed. If so, proceed to next step (#5).

   OR
   - ☐ Patient is receiving substance or alcohol abuse counseling services or seeing an addiction specialist as an adjunct to HCV treatment and it is documented in the medical records; AND
6. Patient meets the diagnosis criteria outlined in Dosing and Administration below; **AND**
7. Baseline HCV RNA must be submitted with a collection date within the past three months. Prescriber must submit lab documentation indicating HCV genotype and quantitative viral load.
8. Patient commits to the documented planned course of treatment including anticipated blood tests and visits, during and after treatment; AND
9. Prior to initiating therapy, patients should be screened for NS3 Q80K polymorphism; alternative therapy should be considered in patients with this polymorphism.
10. Females of childbearing potential must have a negative pregnancy test collected within 30 days prior to the initiation of therapy OR Medical records must be submitted documenting pregnancy status.
11. No early refills will be allowed due to lost, stolen medications or vacation override.
12. Lab results (HCV RNA) are recommended after 4 weeks of therapy and at 12 weeks following completion of therapy. The medication should not be discontinued or interrupted if HCV RNA levels are not available during treatment or are not performed
13. For HIV-1 co-infected patients, patients must have the following:
    - ☐ Document HIV-1 diagnosis; **AND**
    - ☐ CD4 count greater that 500 cells.mm^3, if patient is not taking antiretroviral therapy; **OR**
    - ☐ CD4 count greater the 200 cells/mm^3, if patient is virologically suppressed (e.g., HIV RNA < 200 copies/mL)
14. Olysio must not be given as monotherapy.
    Combination regimens for acceptable for approval in patients meeting criteria include:
    - ☐ Olysio + peginterferon + ribavirin
    - ☐ Olysio + sofosbuvir

CONTINUED ON NEXT PAGE

OLYSIO® (SIMEPREVIR) (CONTINUED)

HEPATITIS C AUTOPA CODING INFO:

- The following medications are included in AutoPA coding list "Hepatitis Therapy List B".
  - Peginterferon alfa-2a (Pegasys®); Peginterferon alfa-2b (Peg-Intron®/Redipen); Ribavirin (Copegus®, Moderiba®, RibaPak®, Ribasphere®, Ribatab®, Rebetol®
- When these medications are used in combination therapy with medications included in AutoPA coding list "Hepatitis Therapy List A" no prior auth is required for medications in "Hepatitis Therapy List B" as long as the "Hepatitis Therapy List A" medication is billed first.
  - Harvoni®, Olysio®, Sovaldi®, and Viekira Pak®
- If the medication in "Hepatitis Therapy List A" is not billed first, then the following error messages will display:
  - IE 31003 – Automated PA; NCPDP 75 – Prior authorization required
  - Transaction Message: "Missing Prerequisite Drug Therapy"
- The Hepatitis C AutoPA coding logic is explained in greater detail here.

DOSAGE AND ADMINISTRATION

DIAGNOSIS: 1. HCV 2. HCV/HIV-1 Co-infection	Genotype 1 or 4 (treatment naïve, prior relapsers or prior non responders)
TRIPLE THERAPY: SIMEPREVIR + PEGINTERFERON + RIBAVIRIN	
Length of Authorization: 12 Weeks	

DIAGNOSIS: 1. HCV	Genotype 1 (without cirrhosis)
DUAL THERAPY: SIMEPREVIR + SOFOSBUVIR	
Length of Authorization: 12 Weeks	
Documentation of concurrent (or planning to start) therapy with Olysio when starting SOVALDI for a 12-week duration	

DIAGNOSIS: 1. HCV	Genotype 1 (with cirrhosis)
DUAL THERAPY: SIMEPREVIR + SOFOSBUVIR	
Length of Authorization: 24 Weeks	
Documentation of concurrent (or planning to start) therapy with Sovaldi when starting Olysio for a 24-week duration	

The recommended dose of simeprevir is one 150mg capsule by mouth once daily with food.

DENIAL MESSAGE

OPHTHALMIC ANTIBIOTICS – QUINOLONES

Length of Authorization:	Date of Service; No Refills
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

FOR APPROVAL

1. Is there any reason that the Patient cannot be switched preferred medications? Document details. Acceptable reasons include
   - ☐ Allergy to the preferred medications in this class
   - ☐ Contraindication or drug-to-drug interaction with all preferred medications
   - ☐ History of unacceptable side effects
2. The requested medication may be approved if ***both*** of the following are true:
   - ☐ Has there been a therapeutic failure to two preferred medications?
   - ☐ The requested medication's corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Ofloxacin (generic for Ocuflox®)	Besivance® (*besifloxacin*)
Vigamox® (*moxifloxacin*) [6/27]	Ciloxan® ointment (*ciprofloxacin*)
	Ciprofloxacin (generic for Ciloxan®)
	Ocuflox® (*ofloxacin*)
	Zymaxid® (gatifloxacin)

[#/X] = quantity limit per X days

OPHTHALMIC ANTIHISTAMINES

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

FOR APPROVAL

1. Is there any reason that the Patient cannot be switched to preferred medications? **Document details**. Acceptable reasons include
   - ☐ Allergy to preferred medications in this class
   - ☐ Contraindication or drug-to-drug interaction with all preferred medications
   - ☐ History of unacceptable side effects
2. The requested medication may be approved if **both** of the following are true:
   - ☐ Has there been a therapeutic failure to one preferred medication within the same group?
   - ☐ The requested medication's corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Pataday® (*olopatadine 0.2%*)	Elestat® (*epinastine*)
	Emadine® (*emedastine*)
	Ketotifen (generic for Zaditor)
	Optivar® (*azelastine*)
	Patanol® (*olopatadine 0.1%*)
	Zaditor® (*ketotifen*)

MISCELLANEOUS AGENTS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Cromolyn Sodium	Alocril® (*Nedocromil Sodium*)
	Alomide® (*Lodoxamide*)

OPHTHALMICS – NSAIDS

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason the Patient cannot be changed to preferred medications? **Document clinically compelling information.** Acceptable reasons include
   - ☐ Allergy to at least two unrelated medications not requiring prior approval
   - ☐ Contraindication to or drug-to-drug interaction with medications not requiring prior approval
2. History of unacceptable/toxic side effects to medications not requiring prior approval
   - ☐ Has there been a failure to respond to a therapeutic trial of ***two*** *preferred medications?* **Document details.**

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Diclofenac Sodium soln	Acular LS® 0.4% soln (*ketorolac tromethamine*)
Flurbiprofen soln (generic for Ocufen®)	Acular PF® 0.5% soln (*ketorolac tromethamine*)
Ketorolac 0.4% (generic Acular LS®)	Nevanac® (*nepafenac*)
Ketorolac 0.4% (generic Acular PF®)	
Ilevro® (nepafenac)	

ORAL ONCOLOGY AGENTS

Length of Authorization:	Varies; Maximum of 1 year
Initiative:	☐ MAP: Oral Oncology Non-PDL (75 / 2462 – GSN) ☐ MAP: Oral Oncology Age/Non-PDL (60 / 2193 – GSN; 60 / 2623 – GSN; 75 / 2462 - GSN) ☐ MAP: Oral Oncology Quantity/Age/Non-PDL (60 / 2193 – GSN; 60 / 2623 – GSN; 75 / 2462 - GSN; 76 / 2641 – GSN)
Fax Form:	☐ Oral Oncology Agents [Required]

Anastrozole, Letrozole, and Tamoxifen are preferred.

REVIEW CRITERIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

1. Unless these criteria specifically make an exception for certain specialist(s), requests should be approved/denied accordingly. If however, based on the pharmacist's review he/she feels that clinically the request should be approved based on compendia/available supportive literature, then that should be given consideration as well and rationale documented for the decision.

Drug Name	Indication and Dosage	Age Limit	Quantity per day	Quantity Limit
AFINITOR® (everolimus)	breast cancer; progressive neuroendocrine tumors of pancreatic origin (PNET); advanced renal cell carcinoma (RCC); renal angiomyolipoma and tuberous sclerosis complex (TSC); progressive, well-differentiated, non-functional neuroendocrine tumors (NET) of gastrointestinal (GI) or long origin that are unresectable, locally advanced or metastatic: 10 mg PO daily subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC): 4.5 mg/m^2 PO once daily; adjust dose to attain trough concentrations of 5-15 ng/mL	minimum age = 1	AFINITOR TABLETS: 1 (10mg); 1 (2.5,5,7.5mg)	30 per 27 days (10mg); 30 per 27 days (2.5,5,7.5mg)
AFINITOR DISPERZ® (everolimus)			AFINITOR DISPERZ: 2 (2,5 mg); 3 (3mg)	60 per 27 days (2,5 mg); 90 per 27 day (3mg)
ALECENSA® (alectinib)	Metastatic non-small cell lung cancer (NSCLC) that is ALK-positive after disease progression on crizotinib (Xalkori®): 600 mg PO twice daily	minimum age = 18	8	240 per 27 days
ALKERAN® (melphalan)	multiple myeloma; ovarian cancer (dosing protocols may vary)	minimum age =18	N/A	N/A
AROMASIN® (exemestane)	breast cancer: 25 mg PO daily	minimum age = 18	1 (25mg)	30 per 27 days
BOSULIF® (bosutinib)	chronic, accelerated, or blast phase Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) with resistance, or intolerance to prior therapy: 500-600 mg PO daily	minimum age = 18	1 (500mg); 1(100mg)	30 per 27 days (100 mg, 500mg)
CABOMETYX® (cabozantinib)	Advanced renal cell carcinoma in patients who have received prior antiangiogenic therapy	Minimum age = 18	1 (60mg), 1 (40mg), 1 (20mg)	30 tablets/30 days (60mg, 40mg, 20mg)
CASODEX® (bicalutamide)	prostate cancer: 50 mg PO daily	minimum age = 18	1 (50mg)	30 per 27 days
CAPRELSA® (vandetanib)	medullary thyroid cancer: 300 mg PO daily	minimum age = 18	1 (300mg); 2 (100mg)	30 per 25 days (300mg tab); 60 per 25 days (100mg tab)

Drug Name	Indication and Dosage	Age Limit	Quantity per day	Quantity Limit
CeeNU® (lomustine)	brain tumors; Hodgkin's disease: 130 mg/m^2 PO x1 dose every SIX WEEKS	N/A	DO NOT APPROVE MORE THAN A 1- MONTH (SINGLE- DOSE) SUPPLY OR QUANTITIES THAT EXCEED 1 DOSE FOR A LOMUSTINE PRESCRIPTION	6 per 27 days, and 1 fill per 39 days ***DO NOT APPROVE MORE THAN A 1- MONTH (SINGLE- DOSE) SUPPLY OR QUANTITIES THAT EXCEED 1 DOSE FOR A LOMUSTINE PRESCRIPTION***
COMETRIQ® (cabozantinib)	medullary thyroid cancer: 140 mg PO daily	minimum age =18	N/A	60 mg carton – 84 per 26 days 100 mg carton – 56 per 26 days 140 mg carton – 112 per 26 days
COTELLIC® (cobimetinib)	Unresectable or metastatic melanoma in patients with a BRAF V600 mutation in combination with vemurafenib: 60 mg once daily for 21 days of a 28 day cycle	minimum age = 18	3 tablets/day	63 tablets per 27 days
EMCYT® (estramustine)	prostate cancer: 10-16 mg/kg/day PO divided TID to QID	minimum age = 18	N/A	30 per 27 days
ERIVEDGE® (vismodegib)	basal cell carcinoma: 150 mg PO daily	minimum age = 18	1 (150mg)	30 per 27 days
FARESTON® (toremifene)	Breast cancer: 60 mg PO daily	minimum age = 18	1 (60mg)	30 per 27 days
FARYDAK® (panobinostat)	See specific criteria	minimum age = 18	1 (10mg, 15 mg, 20 mg)	6 per 18 days
EULEXIN® (flutamide)	Prostate cancer: 250 mg PO q8h	minimum age = 18	6 (125mg)	180 per 27 days
GILOTRIF® (afatinib)	See specific criteria	minimum age = 18	1 (40mg); 1 (30mg); 1 (20mg)	30 per 27 days (40mg, 30mg, 20mg)
GLEEVEC® (imatinib)	Philadelphia chromosome positive chronic myeloid leukemia(Ph+ CML): Adults: 400 - 800 mg PO daily; Pediatrics 260-340 mg/m^2/day PO (not to exceed 600 mg/day) Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL): Adults: 600 mg PO daily Pediatrics: 340 mg/m^2/day (not to exceed 600 mg/day) myelodysplastic/ myeloproliferative diseases (MDS/MPD): Adult 400 mg PO daily aggressive systemic mastocytosis(ASM): Adult 100 to 400 mg PO daily hypereosinophilic syndrome (HES): Adult 100 to 400 mg PO daily chronic eosinophilic leukemia (CEL): Adult 100 to 400 mg PO daily dermatofibrosarcoma protuberans (DFSP): Adult 400 mg PO BID *Kit* (CD117) positive gastrointestinal stromal tumors (GIST): Adult 400-800 mg PO daily	minimum age= 1	2 (400 mg) 3 (100 mg)	90 per 27 days
HEXALEN® (altretamine)	ovarian cancer: 260 mg/m^2/day PO divided QID x14 or 21 days; 28-day cycle	minimum age = 18	N/A	126 tablets per 27 days

Drug Name	Indication and Dosage	Age Limit	Quantity per day	Quantity Limit
HYCAMTIN® (topotecan)	small cell lung cancer: 2.3 mg/m /day PO daily on days 1-5 of 21 day cycle	minimum age = 18	3 (0.25mg); 6 (1mg)	20 per 27 days
HYDREA® (hydroxyurea)	chronic myelocytic leukemia (CML): 20-30 mg/kg PO daily head and neck cancer: 80 mg/kg PO x1 dose every 3 days sickle cell : 15-35 mg/kg PO daily		N/A	90 per 27 days
IBRANCE® (palbociclib)	See Specific Criteria	Minimum age =18	1 (75, 100, 125 mg)	21 per 27 days
IMBRUVICA® (ibrutinib)	Chronic lymphocytic leukemia or Waldenström's Macroglobulinemia: 420 mg taken orally once daily Mantle cell lymphoma: 560 mg taken orally once daily	minimum age = 18	4 (140 mg)	120 per 27 days
INLYTA® (axitinib)	See specific criteria	minimum age = 18	4 (1, 5mg)	120 per 27 days
IRESSA® (gefitinib)	Metastatic non-small cell lung cancer: first line therapy in patients whose tumors have exon 19 deletions or exon 21 (L858R) substitution mutations: 250mg PO once daily	minimum age = 18	2 (250 mg)	60 per 27 days
JAKAFI® (ruxolitinib)	See specific criteria	minimum age = 18	2 (10, 15, 20, 25mg)	60 per 27 days
LENVIMA® (lenvatinib)	See specific criteria	minimum age =18	N/A	30 per 27 days (10 mg)' 60 per 27 days (14 mg) 60 per 27 days (20 mg) 90 per 27 days (24 mg)
LONSURF® (trifluridine, tipiracil)	Metastatic colorectal cancer after failure of standard agents: 35 mg/m^2 (based on the trifluridine component) PO twice daily on days 1-5 and 8-12 of a 28-day cycle (Max single dose= 80 mg; Max daily dose = 160 mg)	minimum age = 18		80 per 27 days
LYNPARZA® (olaparib)	See specific criteria	minimum age=18	16 (50mg)	480/27 days
LYSODREN® (mitotane)	Adrenocortical carcinoma: 9-10 g/day PO divided TID to QID; Max: 19 g/day	minimum age = 18	38 (500 mg)	1,140 per 27 days
MATULANE® (procarbazine)	Hodgkin's disease: Adults: 2-6mg/kg/day PO or 100 mg/m2/day PO on days 1-14 of 28-day cycle Pediatrics: 50- 100mg/m^2 /day PO x 10 to 14 days of a 28-day cycle	N/A	N/A	56 per 27 days
MEKINIST® (trametinib)	Unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test: 2 mg PO daily	minimum age = 18	3 (0.5mg); 1 (2mg)	90 per 27 days (0.5mg); 30 per 27 days (2mg)
MYLERAN® (busulfan)	Adults: chronic myelogenous leukemia: 4-12 mg PO daily; Children: 0.06-0.12 mg/kg day or 1.8-4.6 mg/m^2 /day PO as a single dose	N/A	6 (2mg)	180 per 27 days
NEXAVAR® (sorafenib)	Hepatocellular cancer; renal cell cancer; thyroid cancer: 400 mg PO twice daily	minimum age =18	4 (200mg)	120 per 27 days

Drug Name	Indication and Dosage	Age Limit	Quantity per day	Quantity Limit
NILANDRON® (nilutamide)	Metastatic (stage D) prostate cancer: 300 mg PO daily for 30 days, followed thereafter by 150 mg PO daily	minimum age = 18	Regimen: 2 (150mg) per 1st 30 days; then 1 (150mg tab) thereafter Daily Limit: 1 (150mg) (PA will override for 1st 30 days)	30 per 27 days
NINLARO® (ixazomib)	Multiple myeloma in combination with lenalidomide and dexamethasone in patients who have received as least one prior therapy: 4 mg once daily on days 1, 8, and 15 of a 28 day cycle	minimum age = 18	1 (4 mg), 1 (3 mg), 1 (2.3 mg)	3 capsules per 27 days
ODOMZO® (saridegib)	Locally advanced basal cell carcinoma if not candidates for surgery or radiation 200 mg PO daily	minimum age = 18	1 (200 mg)	30 per 27 days
POMALYST® (pomalidomide)	See specific criteria	minimum age =18	1 (4mg); 1(3mg); 1 (2mg); 1 (1mg)	23 per 25 days
PURINETHOL® (mercaptopurine)	Acute lymphatic (lymphocytic, lymphoblastic) leukemia: *Induction*: 2.5-5 mg/kg PO daily; Start: 2.5 mg/kg PO qd, incr. to 5 mg/kg PO qd after 4wk if no improvement; Alt: 100-200 mg PO daily; Info: decrease dose 66-75% if concurrent allopurinol; decrease dose if TPMT-deficient *Maintenance*: 50-75 mg/m^2/day PO daily Info: use w/ methotrexate or other agents for remission maintenance; decrease dose 66-75% if concurrent allopurinol; decrease dose if TPMT- deficient	N/A	N/A	90 (50 mg) per 27 days
PURIXAN® (mercaptopurine oral suspension) **Considered only in patients who cannot swallow tablets**	acute lymphoblastic leukemia (ALL) *Maintenance*:1.5 to 2.5 mg/kg (50 to 75 mg/m^2)PO as a single daily dose	N/A	N/A	**Considered only in patients who cannot swallow tablets** 100 mL/27 days
REVLIMID® (lenalidomide)	See specific criteria	minimum age = 18	1(2.5, 5, 10, 15 and 25 mg)	30 per 27 days
SPRYCEL® (dasatinib)	Ph-positive CML: 100-180mg PO daily Ph-positive ALL: 140-180mg PO daily	minimum age = 18	2 (20,80mg); 1 (50,70,100, 140mg)	60 per 27 days (20,80mg); 30 per 27 days (50,70,100,140mg)
STIVARGA® (regorafenib)	See specific criteria	minimum age = 18	4 (40 mg)	120 per 27 days
SUTENT® (sunitinib)	gastrointestinal stromal tumor (refractory or not responsive to imatinib), renal cell cancer: 50 mg PO daily x4 weeks, off x2 weeks (Max 87.5 mg/day) pancreatic neuroendocrine tumors: 37.5 mg PO daily (Max 62.5 mg/day)	minimum age = 18	1 (12.5, 25, 37.5, 50mg)	30 per 27 days

Drug Name	Indication and Dosage	Age Limit	Quantity per day	Quantity Limit
TABLOID® (thioguanine)	Acute nonlymphocytic leukemia (it is not recommended for use during maintenance therapy or similar long- term continuous treatments due to the high risk of liver toxicity) The dosage which will be tolerated and effective varies according to the stage. and type of neoplastic process being treated: Initial dose -Pediatric patients and adults: approximately 2 mg/kg of body weight per day. (If, after 4 weeks on this dosage, there is no clinical improvement and no leukocyte or platelet depression, the dosage may be cautiously increased to 3 mg/kg/day.)			
TAFINLAR® (dabrafenib)	unresectable or metastatic melanoma with BRAF V600E mutation as detected by an FDA-approved test: 150 mg orally twice daily	minimum age = 18	4 (50mg); 4 (75mg)	120 per 27 days (50mg, 75mg)
TAGRISSO™ (osimertinib)	Metastatic non-small cell lung cancer (NSCLC) that is EGFR T790M mutation positive in patients who have had progressed on or after EGFR tyrosine kinase inhibitor (TKI) therapy: 80 mg PO once daily	minimum age = 18	1 (80 mg) 1 (40 mg)	30 tablets per 27 days
TARCEVA® (erlotinib)	non-small cell lung cancer (NSCLC): 150 mg PO daily pancreatic cancer: 100 mg PO daily	minimum age = 18	1 (25, 100, 150mg)	30 per 27 days
TARGRETIN®(bexarotene)	See specific criteria	minimum age = 18	N/A	60 per 27 days
TASIGNA® (nilotinib)	Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML): 300-400 mg PO BID	minimum age = 18	4 (200mg); 4 (150mg)	120 per 27 days (200mg); 120 per 27 days (150mg)
TEMODAR® (temozolomide)	glioblastoma multiforme: 75 mg/m^2 PO daily for 42 days concomitant with focal radiotherapy followed by maintenance temozolomide for 6 cycles (150 -200 mg/m^2 PO daily for 5 days followed by 23 days without treatment) anaplastic astrocytoma: 150-200 mg/m^2 PO daily for 5 consecutive days per 28-day treatment cycle (*treatment could be continued for a maximum of 2 years, but the optimum duration of therapy is not known*)		N/A	60 per 27 days
VESANOID® (tretinoin)	acute promyelocytic leukemia (APL): 45 mg/m^2/day PO in two divided doses (max of 90 days)	minimum age = 1	N/A	
TYKERB® (lapatinib)	HER2- positive metastatic breast cancer: 1,250-1,500 mg PO daily (*dose modifications may require dosages as high as 5,500mg/day*)	minimum age = 18	6 (250mg)	180 per 27 days

Drug Name	Indication and Dosage	Age Limit	Quantity per day	Quantity Limit
VEPESID® (etoposide)	small cell lung cancer: IV dose: 35 mg/m^2/day to 100 mg/m^2/day given for 3-5 days on a 21- day cycle Oral dose: Two times the IV dose rounded to the nearest 50 mg	N/A	8	40 per 21 days
VOTRIENT® (pazopanib)	renal cell carcinoma (RCC); soft tissue sarcoma (STS): 800mg PO daily	minimum age = 18	4 (200mg)	120 per 27 days
XALKORI® (crizotinib)	See specific criteria	minimum age = 18	2 (200, 250 mg)	60 per 27 days
XELODA® (capecitabine)	metastatic breast cancer; stage III colon cancer: 1,250 mg/m^2 PO bid for 2 weeks and 1 week off therapy for 6 months (8 cycles)	minimum age = 18	N/A	120 per 12 days
XTANDI® (enzalutamide)	castration resistant prostate cancer: 160 mg PO daily	minimum age = 18	4 (40 mg)	120 per 27 days
ZELBORAF® (vemurafenib)	See specific criteria	minimum age = 18	8 (240 mg)	240 per 27 days
ZOLINZA® (vorinostat)	cutaneous T-cell lymphoma (CTCL): 400 mg PO daily	minimum age = 18	4 (100 mg)	120 per 27 days
ZYKADIA™(ceritinib)	See specific criteria	minimum age = 18	5 (150mg)	150 per 27 days
ZYTIGA® (abiraterone)	See specific criteria	minimum age = 18	4 (250 mg)	120 per 27 days

GILOTRIF® (AFATINIB)

Length of Authorization: ☐	Up to 6 months
Initiative: ☐	MAP: Oral Oncology Quantity/Age/Non-PDL (60 / 2193 [Patient Age Less Than Custom State Min Age] – GSN; 60 / 2623 [Patient age less that plan minimum age] – GSN; 75 /2462 - GSN; 76 / 2641 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years old.
- ☐ Must have a diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as confirmed by testing.
- ☐ Medication must be prescribed by a specialist (e.g., oncologist).

DOSING AND ADMINISTRATION

- ☐ Form: 40 mg, 30 mg, and 20 mg tablets
- ☐ Recommended dose: 40 mg orally, once daily
- ☐ Medication dispensed in the original container to protect from exposure to high humidity and light.

CONTINUED ON NEXT PAGE

ICLUSIG® (PONATINIB)

Length of Authorization:	☐ 90 days
Initiative:	☐ MAP: Oral Oncology Quantity/Age/Non-PDL (60 / 2193 [Patient Age Less Than Custom State Min Age] – GSN; 60 / 2623 [Patient age less that plan minimum age] – GSN; 75 /2462 - GSN; 76 / 2641 – GSN)
Specific PA Form Required:	☐ **"Oral Oncology Agents" PA form**

REVIEW CRITERIA

- ☐ Patient must be ≥18 years old
- ☐ One of the following diagnoses verified by progress notes, discharge notes, health conditions or medication claims history:
  - ☐ Must have current history of T315I-positive chronic myeloid leukemia (CML); **OR**
  - ☐ Must have a current history of T315I-positive Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ALL); **OR**
  - ☐ Must have a current history of CML (chronic phase, accelerated phase or blast phase); **AND**
  - ☐ No other TKI (see list below) is indicated.
- ☐ Must have a current history of Ph+ALL and no other TKI (see list below) is indicated:

Tyrosine Kinase Inhibitors
Bosulif (bosutinib)
Gleevec (imatinib)
Sprycel (dasatinib)
Tasigna (nilotinib)

DOSING AND ADMINISTRATION

- ☐ 45 mg taken orally once daily with or without food
- ☐ Dosage Form: Tablets: 15 mg and 45

INLYTA® (AXITINIB)

Length of Authorization:	☐ Up to 6 months
Initiative:	☐ MAP: Oral Oncology Quantity/Age/Non-PDL (60 / 2193 [Patient Age Less Than Custom State Min Age] – GSN; 60 / 2623 [Patient age less that plan minimum age] – GSN; 75 /2462 - GSN; 76 / 2641 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years old.
- ☐ Patient must have a documented history of renal cell carcinoma with history of failure one prior systemic therapy (i.e. chemotherapy).
- ☐ Must be prescribed by oncology specialist.

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INLYTA® (AXITINIB) *(CONTINUED)*

DOSING AND ADMINISTRATION

- The recommended starting oral dose is 5 mg twice daily. Administer doses approximately 12 hours apart with or without food. INLYTA should be swallowed whole with a glass of water.
- Dose increase or reduction is recommended based on individual safety and tolerability. Over the course of treatment, patients who tolerate INLYTA for at least two consecutive weeks with no adverse reactions, are normotensive, and are not receiving anti-hypertension medication, may have their dose increased. When a dose increase from 5 mg twice daily is recommended, the INLYTA dose may be increased to 7 mg twice daily, and further to 10 mg twice daily using the same criteria.
- If dose reduction from 5 mg twice daily is required, the recommended dose is 3 mg twice daily. If additional dose reduction is required, the recommended dose is 2 mg twice daily.
- Dosage form: 1mg and 5 mg tablets

JAKAFI® (RUXOLITINIB)

Length of Authorization:	Up to 6 months
Initiative:	MAP: Oral Oncology Quantity/Age/Non-PDL (60 / 2193 [Patient Age Less Than Custom State Min Age] – GSN; 60 / 2623 [Patient age less that plan minimum age] – GSN; 75 /2462 - GSN; 76 / 2641 – GSN)

REVIEW CRITERIA

- Patient must be ≥ 18 years old.
- Must have a diagnosis of myelofibrosis OR polycythemia vera confirmed via "health conditions" or medical records.
  - If diagnosis is polycythemia vera, patient must have a hx of inadequate response or intolerance to hydroxyurea
- Medication must be prescribed by a specialist (e.g., oncologist …).

DOSING AND ADMINISTRATION

- Form: Tablets - 5 mg, 10 mg, 15 mg, 20 mg and 25 mg.
- MYELOFIBROSIS:
  - The starting dose of Jakafi for the treatment of myelofibrosis is determined by baseline platelet counts:
    - 20 mg given orally twice daily for patients with an initial platelet count greater than 200 X 109/L.
    - 15 mg twice daily for patients with an initial platelet count between 100 X 10_9/L and 200 X 10_9/L.
    - 5 mg twice daily for patients with an initial platelet count between 50-99 x 109/L
- Perform a complete blood count before initiating therapy with Jakafi. Monitor complete blood counts every 2 to 4 weeks until doses are stabilized, and then as clinically indicated. Modify dose for thrombocytopenia.
- Increase dose based on response and as recommended to a maximum of 25 mg twice daily. Discontinue after 6 months if no spleen reduction or symptom improvement.
- POLYCYTHEMIA VERA:
  - Initial dose is 10 mg given orally twice daily
  - Recommended maximum dose is 25 mg given orally twice daily

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TARGRETIN® (BEXAROTENE) GEL 1% AND CAPSULES 75 MG

Length of Authorization: ☐	Up to 6 months
Initiative: ☐	MAP: Oral Oncology Quantity/Age/Non-PDL (60 / 2193 [Patient Age Less Than Custom State Min Age] – GSN; 60 / 2623 [Patient age less that plan minimum age] – GSN; 75 /2462 - GSN; 76 / 2641 – GSN)
Specific PA Form Required: ☐	**"Oral Oncology Agents" PA form**

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years of age.
- ☐ Diagnosis of Cutaneous T-cell Lymphoma.
- ☐ Oral capsules:
  - ☐ The patient must have failed at least one prior systemic therapy [i.e. methoxsalen (8-MOP, Uvadex), interferon alfa 2b (Intron A), methotrexate, vorinostat (Zolinza) …]
- ☐ Topical gel:
  - ☐ The patient must have refractory or persistent disease after other therapies (can be topical or systemic therapies) or who have not tolerated other therapies.
- ☐ Prescriber must be a hematologist/oncologist.

DOSING AND ADMINISTRATION

- ☐ The initial 300 mg/m2/day dose level of Targretin capsules may be adjusted to 200 mg/m2/day then to 100 mg/m2/day, or temporarily suspended, if necessitated by toxicity. If there is no tumor response after eight weeks of treatment and if the initial dose of 300 mg/m2/day is well tolerated, the dose may be escalated to 400 mg/m2/day with careful monitoring.
- ☐ Targretin® gel should be initially applied to affected areas once every other day for the first week. The application frequency should be increased at weekly intervals to once daily, then twice daily, then three times daily and finally four times daily according to individual lesion tolerance.
- ☐ Dosage Form:
  - ☐ Capsules: supplied as 75 mg capsules
  - ☐ Gel: Targretin® gel is supplied in tubes containing 60 g

XALKORI® (CRIZOTINIB)

Length of Authorization: ☐	Up to 6 months
Initiative: ☐	MAP: Oral Oncology Quantity/Age/Non-PDL (60 / 2193 [Patient Age Less Than Custom State Min Age] – GSN; 60 / 2623 [Patient age less that plan minimum age] – GSN; 75 /2462 - GSN; 76 / 2641 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years old.
- ☐ Must have a diagnosis of ALK-positive or ROS1-positive non-small cell lung cancer (NSCLC), metastatic, anaplastic lymphoma kinase-positive confirmed by testing and metastatic non-small cell lung cancer (NSCLC) whose tumors are ROS1-positive.
- ☐ Medication must be prescribed by a specialist (e.g., oncologist …).

DOSING AND ADMINISTRATION

- ☐ Form: 250 mg and 200 mg
- ☐ 250 mg taken orally twice daily with or without food.
- ☐ Dosing interruption and/or dose reduction to 200 mg taken orally twice daily may be required based on individual safety and tolerability, then to 250 mg taken orally once daily if further reduction is necessary.

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ZELBORAF® (VEMURAFENIB)

Length of Authorization: ☐	Up to 6 months
Initiative: ☐	MAP: Oral Oncology Quantity/Age/Non-PDL (60 / 2193 [Patient Age Less Than Custom State Min Age] – GSN; 60 / 2623 [Patient age less that plan minimum age] – GSN; 75 /2462 - GSN; 76 / 2641 – GSN)
Specific PA Form Required: ☐	**"Oral Oncology Agents" PA form**

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years old.
- ☐ Must have a diagnosis of malignant melanoma, unresectable, stage IIIC or metastatic with $BRAF^{V600E}$ mutation confirmed by BRAF testing.
- ☐ Medication must be prescribed by a specialist (e.g., oncologist).

DOSING AND ADMINISTRATION

- ☐ Form: Film-coated tablet: 240 mg
- ☐ Recommended dose: 960 mg orally twice daily.
- ☐ Administer Zelboraf approximately 12 hours apart with or without a meal.
- ☐ Zelboraf should be swallowed whole with a glass of water.
- ☐ Zelboraf should not be chewed or crushed.
- ☐ Management of symptomatic adverse drug reactions may require dose reduction, treatment interruption, or treatment discontinuation of Zelboraf. Dose reductions resulting in a dose below 480 mg twice daily are not recommended.

ZYKADIA® (CERITINIB)

Length of Authorization: ☐	6 months
Initiative: ☐	MAP: Oral Oncology Quantity/Age/Non-PDL (60 / 2193 [Patient Age Less Than Custom State Min Age] – GSN; 60 / 2623 [Patient age less that plan minimum age] – GSN; 75 /2462 - GSN; 76 / 2641 – GSN)
Specific PA Form Required: ☐	**"Oral Oncology Agents" PA form**

CLINICAL NOTES

ZYKADIA is a kinase inhibitor indicated for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) who have progressed on or are intolerant to Xalkori (crizotinib).

APPROVAL CRITERIA

- ☐ Patient must be ≥ 18 years old.
- ☐ Must have tried and failed Xalkori (crizotinib).
- ☐ Medication must be prescribed by a specialist (e.g., oncologist …).

DOSING AND ADMINISTRATION

- ☐ Form: 150 mg
- ☐ 750mg taken orally once daily on an empty stomach until disease progression or unacceptable toxicity (do not administer within 2 hours of a meal).
- ☐ Approximately 60% of patients initiating treatment at the recommended dose required at least one dose reduction and the median time to first dose reduction was 7 weeks.

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ZYTIGA® (ABIRATERONE ACETATE)

Length of Authorization:	☐ Up to 90 days
Initiative:	☐ MAP: Oral Oncology Quantity/Age/Non-PDL (60 / 2193 [Patient Age Less Than Custom State Min Age] – GSN; 60 / 2623 [Patient age less that plan minimum age] – GSN; 75 /2462 - GSN; 76 / 2641 – GSN)
Specific PA Form Required:	☐ **"Oral Oncology Agents" PA form**

REVIEW CRITERIA

- ☐ Patient must be ≥18 years old
- ☐ Must have current history of **metastatic castration-resistant prostate cancer** (CRPC) that can be verified by progress notes, discharge notes, health conditions, or medication claims history.
  - ☐ **NOTE:** Despite being "hormone refractory," men who have not undergone surgical castration with an orchiectomy will likely continue to receive concomitant therapy with a gonadotropin releasing hormone (GnRH) such as leuprolide.
- ☐ The medical records must indicate a plan to administer Zytiga with prednisone.

DOSING AND ADMINISTRATION

- ☐ 1,000 mg administered orally once daily in combination with prednisone 5 mg administered orally twice daily.
- ☐ Taken on an empty stomach. No food should be consumed for at least two hours before and for at least one hour after.
- ☐ For patients with baseline moderate hepatic impairment (Child-Pugh Class B), reduce the starting dose to 250 mg once daily.
- ☐ For patients who develop hepatotoxicity during treatment, hold until recovery. Retreatment may be initiated at a reduced dose.

ORAL ONCOLOGY AGENT BYPASS LISTS (FOR DIAGNOSES OTHER THAN CANCER)

<table>
<tr><th>Edit</th><th>Drugs</th><th>Steps</th></tr>
<tr><td>Mercaptopurine Non-PDL and QL bypass</td><td><table><tr><th>HICL</th><th>Drug Name</th></tr><tr><td>003908</td><td>Mercaptopurine (generic only)</td></tr></table></td><td>If the incoming claim is GENERIC Mercaptopurine (HSN 003908- excluding Brand Purinethol), look back in medical claims history 730 days for ICD-9s: 555.0-555.9, 558.1-558.9, ICD 10 Disease Group: K40, K41, K42, K43, K44, K45, K46, K50, K52 (Crohn's disease), or ICD 9: 556.0-556.9 , ICD 10 Disease Group: K51(Ulcerative colitis): IF FOUND BYPASS THE NON-PDL REQUIREMENT (NO PA REQUIRED) AND BYPASS THE QUANTITY LIMITATION OF 90 per 27 days.</td></tr>
<tr><td>Hydroxyurea Non-PDL and QL bypass</td><td><table><tr><th>HICL</th><th>Drug Name</th><th>GSN</th></tr><tr><td rowspan="4">3897</td><td>Droxia 200mg</td><td>40162</td></tr><tr><td>Droxia 300mg</td><td>40163</td></tr><tr><td>Droxia 400mg</td><td>40164</td></tr><tr><td>Hydroxyurea 500mg (GENERIC ONLY)</td><td>8775</td></tr></table></td><td>Step 1: If the incoming claim is from the < Hydroxyurea Drug List> , look back in medical claims history 730 days for ICD-9s: 238.4 (polycythemia vera), 289.6 (familial polycythemia), 282.4-282.9 (sickle cell), or 238.71 (essential thrombocythemia) or ICD 10: D45(polycythemia vera), D75.0 (familial polycythemia), D47.3 (essential thrombocythemia) , Disease Group D56, D57, D58 (sickle cell): IF FOUND BYPASS THE NON-PDL REQUIREMENT (NO PA REQUIRED) AND BYPASS THE QUANTITY LIMITATION OF 90 per 27 days.</td></tr>
</table>

ORBACT IV® (ORITAVANCIN)

Length of Authorization:	1 day
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years of age.
- ☐ Patient has been diagnosed with a bacterial skin/skin structure infection likely due to a gram positive organism (examples include cellulitis, wound abscess). Orbactiv is not indicated for use in other sites of infection such as urinary tract infections.
- ☐ Patient must have medical documentation of trial and failure of vancomycin for the current active infection or a culture and sensitivity report indicating the gram positive organism is resistant to vancomycin
- ☐ A recent (within past 60 days) culture and sensitivity (C&S) must be submitted.

ORENCIA® (ABATACEPT)

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

RHEUMATOID ARTHRITIS

- ☐ Patient must be 18 years of age or older; **AND**
- ☐ Patient has a documented diagnosis of moderate to severe rheumatoid arthritis; **AND**
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to one or more non-biologic- DMARDs (i.e., methotrexate, leflunomide, sulfasalazine, hydroxychoroquine) for at least 3 consecutive months; **AND**
- ☐ Patient has had an inadequate response, intolerance, or has contraindications to: Xeljanz® and Humira®

JUVENILE IDIOPATHIC ARTHRITIS

- ☐ Patient must be 6 years of age or older; **AND**
- ☐ Must have diagnosis of Juvenile Idiopathic Arthritis (JIA); **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) with the following:
  - ☐ One or more non-steroidal anti-inflammatory-NSAIDS; **AND**
  - ☐ One or more non-biologic- DMARDs (i.e., methotrexate, sulfasalazine); **AND**
  - ☐ Trial and failure of preferred alternative Humira®

DOSING

Intravenous Administration for Adult RA:

- ☐ **Body Weight** — **Dose**
  - ☐ Less than 60 kg — 500 mg
  - ☐ 60 to 100 kg — 750 mg
  - ☐ More than 100 kg — 1000 mg
- ☐ Administer as a 30-minute intravenous infusion
- ☐ Following initial dose, give at 2 and 4 weeks, then every 4 weeks

Subcutaneous Administration for Adult RA:

- ☐ After a single intravenous infusion as a loading dose (as per body weight categories above), 125 mg administered by a subcutaneous injection should be given within a day, followed by 125 mg subcutaneously once a week.
- ☐ Patients who are unable to receive an infusion may initiate weekly injections of subcutaneous Orencia without an intravenous loading dose.
- ☐ Patients transitioning from Orencia intravenous therapy to subcutaneous administration should administer the first subcutaneous dose instead of the next scheduled intravenous dose

Juvenile Idiopathic Arthritis:

- ☐ Pediatric patients weighing less than 75 kg receive 10 mg/kg intravenously based on the patient's body weight. Pediatric patients weighing 75 kg or more should be administered Orencia (abatacept) following the adult intravenous dosing regimen, not to exceed a maximum dose of 1000 mg

CONTINUATION OF THERAPY

- ☐ Documentation showing current patients are stable (have low disease activity or are in clinical remission) will be taken into consideration during the prior authorization review process regarding continuation of therapy with the same agent.

ORFADIN® (NITISINONE)

Length of Authorization:	Varies with indication
Initiative:	MAP: Orfadin (75 / 2462 – GSN; 76 / 2641 – GSN)
Fax Form:	Orfadin

REVIEW CRITERIA (CPHTS – DOCUMENT ALL INFO AVAILABLE IF ESCALATION IS NEEDED)

1. Is the Patient's diagnosis hereditary tyrosinemia type 1?
   - ☐ If YES, length of approval is 1 year. CPhTs may enter these approvals; no escalation is needed.
   - ☐ If NO, forward to a clinical pharmacist for review based on #2 below.
2. For Pharmacist Review: Are there any dietary restrictions of tyrosine and phenylalanine that alone are sufficient to maintain the urinary succinylacetone at or below detectable levels?
   - ☐ If NO, length of approval is 1 year
   - ☐ If YES, do not approve. If the Patient can be maintained on dietary restrictions alone, Oradin is not to be approved.

NOTE

Orfadin is packaged in a high density (HD) polyethylene container of *60 capsules* and cannot be repackaged and dispensed in a different container. *The PA should always be entered in multiples of 60 capsules.*

ORKAMBI™ (LUMACAFTOR; IVACAFTOR)

Length of Authorization:	6 MONTHS
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

CLINICAL NOTES:

Cystic Fibrosis (CF) is an incurable disease inherited through an autosomal recessive pattern. CF causes thick, viscous mucus to form and build up in the lungs, pancreas and other organs leading to severe respiratory and digestive problems as well as other effects. The genetic defect in CF occurs as a result of mutations in the Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) gene. More than 1,800 mutations of the CFTR gene have been identified. The most common mutation involves a deletion that codes for phenylalanine at position 508 in the CFTR protein and is known as an ***F508del***. Approximately 45 percent of all CF patients are **homozygous** for the ***F508del***. Lumacaftor is a CFTR corrector while ivacaftor is a CFTR potentiator. Orkambi® is a combination drug containing lumacaftor and ivacaftor that is indicated for the treatment of cystic fibrosis in patients 12 years of age and older who are **homozygous** for the ***F508del*** mutation in the CFTR gene.

INITIAL REVIEW CRITERIA (ALL OF THE FOLLOWING MUST BE TRUE)

- ☐ Patient must be ≥12 years old; **AND**
- ☐ Patient must have a confirmed diagnosis of Cystic Fibrosis; **AND**
- ☐ Patient must be determined to be homozygous for the F508del mutation in the CFTR gene as confirmed by an FDA-approved CF mutation test; **AND**
- ☐ If the patient is between the ages of 12-18, they must have undergone a baseline ophthalmic examination to monitor for lens opacities/cataracts.
- ☐ Please note clinical experience in patients with percent predicted FEV_1($ppFEV_1$) <40 is limited, and additional monitoring of these patients is recommended during initiation of therapy

CONTINUATION OF THERAPY

- ☐ Patient has stable or improved FEV_1
- ☐ Clinical notes document improvement in patient symptoms
- ☐ Patient has LFTs/bilirubin monitored every 3 months for the first year of treatment and annually thereafter.
- ☐ Serum ALT or AST ≤ 5 times the upper limit of normal (ULN) or ALT or AST ≤ 3 times the ULN with bilirubin ≤ 2 times the ULN
- ☐ Pediatric patients between the ages of 12 and 18 have follow up ophthalmic examinations at least annually

DOSING AND ADMINISTRATION

- ☐ Normal dose: 2 tablets (each containing lumacaftor 200 mg and ivacaftor 125 mg) by mouth every 12 hours with a fat-containing food (such as whole milk, cheese, eggs, nuts, etc) (total daily dose: lumacaftor 800 mg/ ivacaftor 500 mg)
- ☐ Patients with moderate hepatic impairment (Child-Pugh Class B): reduce dose to 2 tablets in the morning and one tablet in the evening (total daily dose: lumacaftor 600 mg/ivacaftor 375 mg)
- ☐ Patients with severe hepatic impairment (Child-Pugh Class C): Maximum dose is one tablet in the morning and one tablet in the evening (total daily dose: lumacaftor 400 mg/ivacaftor 250 mg) and should be used with caution as studies have not been conducted in patients with severe hepatic impairment.
- ☐ Dosage Form: Tablets containing lumacaftor 200 mg/ivacaftor 125 mg

OTEZLA® (APREMILAST)

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

CLINICAL NOTES:

Apremilast (Otezla®) is an oral phosphodiesterase-4 (PDE-4) inhibitor specific for cyclic adenosine monophosphate (cAMP). Apremilast is indicated for the treatment of adult patients with active psoriatic arthritis or for patients with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.

INITIAL REVIEW CRITERIA

PLAQUE PSORIASIS:

- ☐ Adult patient (18 years or older); **AND**
- ☐ Patient has moderate to severe plaque psoriasis for at least 6 months with at least 1 of the following:
  - ☐ Involvement of at least 10 percent of body surface area (BSA); **OR**
  - ☐ Psoriasis Area and Severity Index (PASI) score of 12 or greater; **OR**
  - ☐ Incapacitation due to plaque location (e.g., head and neck, palms, soles, or genitalia);

  AND
- ☐ Patient did not respond adequately (or is not a candidate) to a 3-month minimum trial of phototherapy (e.g., Psoralens with UVA light (PUVA) or UVB with coal tar or dithranol); **AND**
- ☐ Patient did not respond adequately (or is not a candidate) to a 3-month minimum trial of at least 1 systemic agent (e.g., immunosuppressives, retinoic acid derivatives, and/or methotrexate); **AND**
- ☐ Patient has had a 3-month trial and failure (inadequate response or intolerance) to the preferred alternative Humira®.

PSORIATIC ARTHRITIS:

- ☐ Adult patients (18 years or older); **AND**
- ☐ Patient has active psoriatic arthritis for at least 6 months defined as:
  - ☐ 3 swollen joints; **AND**
  - ☐ 3 tender joints; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) with the following:
  - ☐ One or more non-biologic disease modifying anti-rheumatic drugs DMARDS (i.e., methotrexate, sulfasalazine, leflunomide); **AND**
  - ☐ Patient has had an inadequate response, intolerance, or has contraindications to Humira®.

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OTEZLA® (APREMILAST) (CONTINUED)

DOSING AND ADMINISTRATION

- When patients are started on apremilast, they should follow a five-day titration schedule. An apremilast starter pack is available to assist with this titration.
  - Day 1: 10 mg in morning
  - Day 2: 10 mg in morning and 10 mg in evening
  - Day 3: 10 mg in morning and 20 mg in evening
  - Day 4: 20 mg in morning and 20 mg in evening
  - Day 5: 20 mg in morning and 30 mg in evening
  - Day 6 and thereafter: 30 mg in morning and 30 mg in evening
- Apremilast can be administered without regard to meals. The tablets should be swallowed whole; they should not be split, chewed, or crushed.
- Availability:
  - Otezla 10 mg, 20mg and 30mg tablets

OTIC ANTIBIOTICS

Length of Authorization:	Date of Service; No Refills
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to a preferred medication? **Document details.** Acceptable reasons include
   - ☐ Allergy to preferred medications in this class
   - ☐ Contraindication or drug-to-drug interaction with all preferred medications
   - ☐ History of unacceptable side effects
2. The requested medication may be approved if ***both*** of the following are true:
   - ☐ If there has been a therapeutic failure to two medications not requiring prior approval
   - ☐ The requested medication's corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Ciprodex® (*ciprofloxacin/dexamethasone*)	Cipro HC® (*ciprofloxacin/hydrocortisone*)
Neomycin/polymyxin/HC Otic	Cortisporin-TC® (Colistin Sulfate, Hydrocortisone Acetate, Neomycin Sulfate)
Ofloxacin Otic	

OVER-THE-COUNTER (OTC) BENEFITS / EXPANDED BENEFIT PROGRAM [MCC-FL ONLY]

To implement the following proposed Enhanced Benefit program for MCC-FL eligibles to help cover approved OTC drugs from a list with a maximum $25/mo benefit, and with no rollover of unspent funds with only ProDUR ER and DD edits as limitations.

Website link: http://magellancompletecareoffl.com/fl-site/providers/preferred-drug-list/over-the-counter-benefits.aspx

Appendix A: OTC Covered Drugs List

Benefit:

- $25 per household per month to use toward MCC-FL approved OTC drugs with an NDC on the attached list (see under attachments of this document); for design purposes, the cardholder = household
- The balance will be set to $25 the beginning of each month. The balance does not roll over month-to-month.
- A prescription will be required
- No clinical, PA or limitation edits are applied.
- Only the following ProDUR edits apply: Early Refill (ER) and Drug to Drug (DD).
- Covered OTC drugs do not require rebate coverage.
- The OTC list will be reviewed every six months by the MCC-FL UM committee; or on an as-needed basis; any changes will be provided to plan admin via a new CCM.
- Claims are limited to submission via POS (no batch or paper).
- There are no beneficiary submitted claims.
- The beneficiary is responsible for paying any difference between the calculated paid amount and the amount of their remaining credit line (e.g., beneficiary has $10 credit, claim is paid for $15; hence beneficiary to pay $5 difference.)
- Need to accumulate balance within FirstRx℠. Provide message at POS to include patient benefit balance for current month.
- Call center will be able to view the balance in FirstTrax℠ to support calls. Monthly limit is $25; unused portions may NOT rollover into the next month.
- "Lesser of" payment logic applies, using same algorithms for reimbursement per contractual requirements. The dispense fee will also pay per contractual requirements and is part of the $25 limit.
- Any/all Magellan pharmacy network providers may participate in this program.
- Beneficiaries, who are disenrolled during the month, will no longer have access to the benefit for the remainder of that month.
- Use Recipient ID for claim submission.
- Start date for plan is 07/01/14
- On the claim, click the Accum tab and the Pricing tab to find the information for the expanded benefits:
- **Plan Amount Accumulated This Claim**: The amount applied to the $25.00 per month
- **Prior Individual Period Amount:** Dollar amount that has already been billed for this month
- **Remaining Benefit Amount:** available balance for this month

Description		
Co-pay	100%	Out of their expanded benefit credit bucket
Deductible	0	
Out-of-pocket maximum	0	
Benefit maximum	$25/month	Credit limit per month, unused amounts do not rollover
Patient Paid Amount field	If > 0 deny the claim	Deny NCPDP EC – DX. "Patient Paid Amt Must = Zero"

OXANDROLONE (OXANDRIN®)

Length of Authorization:	Up to one year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

HIV Wasting: (Approve as per prescription up to one year)

- ☐ Diagnosis of HIV wasting (cachexia)
- ☐ Note: Patient does not have to fail Megestrol (PDL) for consideration. The above diagnosis is sufficient for approval.

Short Stature: (PHARMACIST REVIEW ONLY: CPhTs – Document all info available prior to escalation) *(Approve for six months)*

- ☐ Initiation of therapy:
  - ☐ Diagnosis of short stature verified in progress notes or actual growth charts and bone age studies submitted:
    - ☐ Short stature = more than two standard deviations below the mean for age and gender based on a growth chart (as per American Association of Clinical Endocrinologists).
    - ☐ The bone age study can help evaluate how fast or slowly a child's skeleton is maturing, which can help doctors diagnose conditions that delay or accelerate physical growth and development.
    - ☐ Linear growth can no longer occur in patients with epiphyseal closure; therefore this medication should only be used in a Patient with open epiphyses in the treatment of short stature.
    - ☐ Bone maturation can be observed or indicated in the x-ray of fingers, hands, or wrists (e.g., bone age study).
    - ☐ The bones are compared to a standard atlas such as Greulich and Pyle.
  - ☐ If the Patient is on stimulant therapy, the Provider must address the effects of stimulant therapy.
  - ☐ Must be prescribed by an Endocrinologist.
- ☐ Continuation of Therapy:
  - ☐ Official documentation must be submitted to show positive response to therapy.
  - ☐ The Prescriber must submit documentation of a recent bone age scan (to demonstrate follow-up and evaluation of medication response)
  - ☐ Patient care must be followed by an Endocrinologist.

PANRETIN® GEL (ALITRETINOIN)

Length of Authorization:	1 year
Initiative:	MAP: Panretin (75 / 2462 – GSN; 76 / 2641 – GSN)
Fax Form:	Panretin

REVIEW CRITERIA (PHARMACIST REVIEW ONLY: CPHTs – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

TOPICAL TREATMENT OF AIDS-RELATED KAPOSI SARCOMA (KS) LESIONS

- ☐ The total number of lesions must be less than 10
- ☐ Lesion size must be between 2 and 3 centimeters
- ☐ Cannot be on systemic KS treatment

PARKINSON'S AGENTS

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to preferred medications? **Document details.** Acceptable reasons include
   - ☐ Allergy to the preferred medications in this class
   - ☐ Contraindication or drug-to-drug interaction with all preferred medications
   - ☐ History of unacceptable side effects
2. The requested medication may be approved if **BOTH** of the following are true:
   - ☐ Has there been a therapeutic failure to two (when more than one are listed) preferred medications within the same group?
   - ☐ The requested medication's corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

COMT INHIBITORS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Carbidopa/Levodopa/Entacapone (generic for Stalevo®)	Comtan® (*entacapone*)
	Stalevo® (*carbidopa/levodopa/entacapone*)
	Tasmar® (*tolcapone*)

DOPAMINE RECEPTOR AGONISTS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Pramipexole (generic for Mirapex®)	Bromocriptine (generic for Parlodel®) (**SEE ADDITIONAL DIAGNOSIS INFOMATION TO AID IN THE FINAL DECISION BELOW**)
Ropinirole (generic for Requip®)	Mirapex® (*pramipexole*)
	Parlodel® (*bromocriptine*)
	Requip® (*ropinirole*) No approval of this brand product (must use generic)
	Requip XL® (*ropinirole XL*)

ADDITIONAL DIAGNOSIS INFORMATION TO AID IN THE FINAL DECISION FOR BROMOCRIPTINE

There have been numerous requests for **Bromocriptine** for the treatment of **pituitary adenoma/pituitary conditions**. Please ***do not*** suggest the PDL anti-parkinson's drugs as alternatives.

The preferred alternative is **Cabergoline** (generic Dostinex). If a Patient has tried for at least 60 days or has a contraindication or an allergy to Cabergoline, then bromocriptine may be approved for 1 year.

CONTINUED ON NEXT PAGE

DOPAMINE REPLACEMENT AGENTS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Carbidopa/Levodopa (IR, ER)	Carbidopa/Levodopa ODT
	Parcopa (carbidopa/levodopa ODT)
	Sinemet® (carbidopa/levodopa)

MAO-B INHIBITORS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Selegiline (generic for Eldepryl®)	Azilect® (*rasagiline*)
	Eldepryl® (*selegiline*)
	Zelapar® ODT (*selegiline*)

MISCELLANEOUS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Amantadine (generic for Symmetrel®)	Apokyn® (apomorphine)- **SEE CRITERIA BELOW**

NEUPRO® (ROTIGOTINE TRANSDERMAL SYSTEM)

Length of Authorization:	Up to one year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥18 years of age.
- ☐ Must have a confirmed diagnosis of Parkinson's disease or Restless Legs Syndrome.
- ☐ In the case of Parkinson's disease, the patient must have a minimum of a 60 day trial of at least three other dopamine agonists [ropinirole (Requip®), pramipexole (Mirapex®), selegiline (Eldepryl®, Zelapar®), carbidopa/levodopa (Sinemet®, Parcopa®)]
- ☐ In the case of Restless Legs Syndrome, the patient must have a minimum of a 60 day trial of at least three other agents [ropinirole, pramipexole, carbidopa/levodopa, gabapentin (Neurontin®)]

APOKYN® (APOMORPHINE)

Length of Authorization:	Up to one year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years of age.
- ☐ Must have diagnosis of Parkinson's disease.
- ☐ The individual dose must not exceed 0.6 ml (6 mg) and total daily dose not to exceed 2.0mL (20mg).

PERJETA® (PERTUZUMAB)

DIRECTIVE

- The Provider is to be informed that the medication must be billed through physician service.

POMALYST® (POMALIDOMIDE)

Length of Authorization:	Up to 3 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥18 years old
- ☐ Patient must have a diagnosis of multiple myeloma (ICD 9: 203.0; ICD 10: C90.0)
- ☐ Patient must have had at least 1 claim for Revlimid and 1 claim for Velcade within the last 12 months, where either Revlimid or Velcade was filled within the last 2 months of PA request for Pomalyst.
- ☐ Must be prescribed by a certified REMS provider.
  https://www.celgeneriskmanagement.com/REMSPortal/rems/portal/REMSPortal.portal

DOSAGE AND ADMINISTRATION

- ☐ Maximum dosage of 4mg per day
- ☐ Dosage Form: 1mg, 2mg, 3mg, 4mg capsules

PRALUENT® (ALIROCUMAB)

Length of Authorization:	☐ Initial: 3 months ☐ Continuation of therapy: 6 months
Initiative:	☐ PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

INITIAL THERAPY

- ☐ Age ≥ 18 years
- ☐ Diagnosis of atherosclerotic cardiovascular disease (ASCVD) or heterozygous familial hypercholesterolemia (HeFH) as confirmed by genotyping or by clinical criteria ("definite FH" using either the Simon Broome or WHO/Dutch Lipid Network criteria)
- ☐ Prior treatment history with highest available dose or maximally-tolerated dose of high intensity statin (i.e. atorvastatin or rosuvastatin) **AND** Zetia for at least three continuous months with failure to reach target LDL-C (70 mg/dL for patients with clinical ASCVD and 100 mg/dL for patients with HeFH and no history of clinical ASCVD)
  - ☐ If the patient is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms, documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the patient experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following:
    - ☐ Muscle symptoms resolve after discontinuation of statin; **AND**
    - ☐ Muscle symptoms occurred when rechallenged at a lower dose of the same statin; **AND**
    - ☐ Muscle symptoms occurred after switching to an alternative statin; **AND**
    - ☐ Documentation ruling out non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease)

  OR

  - ☐ The patient has been diagnosed with statin-induced rhabdomyolysis
    - ☐ The diagnosis should be supported by acute neuromuscular illness or dark urine **AND** an acute elevation in creatine kinase (usually >5,000 IU/L or five times the upper limit of normal)
- ☐ If the patient failed to reach target LDL-C (<70 mg/dL for patients with clinical ASCVD and <100 mg/dL for patients with HeFH and no history of clinical ASCVD), adherence to maximally-tolerated statin and Zetia has been verified using pharmacy claims data and the patient is determined to be compliant for at least three consecutive months prior to the lipid panel demonstrating suboptimal reduction
- ☐ Maximally-tolerated statin will continue to be used in conjunction with alirocumab
- ☐ Patient has not had a prior trial and failure of an alternative PCSK9 inhibitor
- ☐ Request is being made for the lowest approved alirocumab dose (75 mg every 2 weeks) to adequately treat the patient. Requests for an escalated dose (150 mg every 2 weeks) must contain a lipid panel documenting suboptimal reduction in LDL-C after at least 4 weeks (2 doses) of alirocumab at the lower (75 mg every 2 weeks) dose.

CONTINUATION OF THERAPY

- ☐ Lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating alirocumab
- ☐ Continued adherence to maximally-tolerated statin dose established prior to the original alirocumab approval

DOSING AND ADMINISTRATION

- ☐ Recommended dose is 75mg subcutaneously once every 2 weeks. The dosage may be increased to the maximum dosage of 150mg administered every 2 weeks if the LDL cholesterol response is inadequate.

PROLEUKIN® (ALDESLEUKIN FOR INJECTION)

Length of Authorization:	Maximum length of therapy is Three Months
Initiative:	MAP: Proleukin (75 / 2462 – GSN; 76 / 2641 – GSN)
Fax Form:	Proleukin

REVIEW CRITERIA

- ☐ Patient must have a diagnosis of at least one of the following:
  - ☐ Renal Cell Carcinoma
  - ☐ Metastatic Melanoma
  - ☐ Non-Hodgkin's Lymphoma
  - ☐ Acute Myelogenous Leukemia
- ☐ Any request that falls outside of the above-mentioned indications should be forwarded to a pharmacist for review.

PROMACTA® (ELTROMBOPAG)

Length of Authorization:	Up to 6 months for ITP Up to 4 months for Aplastic Anemia
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA (Pharmacist Review Only: CPhTs – Document All Info Available Prior To Escalation)

CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA (ITP)

- ☐ Diagnosis (confirmed by supporting documentation) of an adult or pediatric patients 1 year and older with chronic **immune (idiopathic) thrombocytopenia purpura** with insufficient response to corticosteroids, immunoglobulins or splenectomy.
  - ☐ Documentation should include lab results of platelet count approximating less than 50,000 per microliter and/or signs and symptoms of a low platelet count (Bruising, petechiae, bleeding from nostrils, gums, etc. . .).
- ☐ The beneficiary must have tried and failed intravenous immunoglobulin therapy or corticosteroid therapy, or have had a splenectomy.
  - ☐ (Refer to clinical notes for typical length of therapy).
- ☐ The prescribing practitioner must be a hematologist/oncologist.

THROMBOCYTOPENIA IN PATIENTS WITH CHRONIC HEPATITIS C

- ☐ The use of eltrombopag (Promacta) is indicated for the treatment of thrombocytopenia in patients with chronic hepatitis C to allow the initiation and maintenance of interferon- based therapy. If the patient is not receiving interferon based therapy for the treatment of Hepatitis C, eltrombopag (Promacta) should NOT be approved.

SEVERE APLASTIC ANEMIA

- ☐ Diagnosis (confirmed by supporting documentation) of severe aplastic anemia with insufficient response to immunosuppressive therapy
  - ☐ Documentation should include lab results of:
    - ☐ Platelet count approximating 30,000 per microliter or lower or patient is platelet transfusion dependent
    - ☐ Hemoglobin approximating 8.4 g/dL or lower or patient is dependent on transfusions of red blood cells (RBCs)
    - ☐ Absolute neutrophil count (ANC) approximating 0.5 x 10^9 /L
- ☐ The beneficiary must have tried and failed at least one prior immunosuppressive therapy.
- ☐ The prescribing practitioner must be a hematologist/oncologist.

CONTINUED ON NEXT PAGE

PROMACTA® (ELTROMBOPAG)

CONTINUATION OF THERAPY REVIEW CRITERIA

CHRONIC IMMUNE THROMBOCYTOPENIA

- ☐ Platelet count greater than or equal to 50 x 10^9/L for six out of the last eight weeks of the 26-week treatment period in the absence of rescue medication at any time

SEVERE APLASTIC ANEMIA

- ☐ Patient must meet one or more of the following criteria:
  - ☐ Platelet count increases to 20 x 10^9/L above baseline, or stable platelet counts with transfusion independence for a minimum of 8 weeks
  - ☐ Hemoglobin increase by greater than 1.5 g/dL or a reduction of greater than or equal to 4 units of RBC transfusions for 8 consecutive weeks
  - ☐ ANC increase of 100% or an ANC increase greater than 0.5 x 10^9/L
- ☐ If patient has not met at least one of the above criteria after 16 weeks of treatment, continuation of therapy should NOT be approved.

DOSING AND ADMINISTRATION:

- ☐ **Chronic ITP:** Initiate at 25 mg once daily for pediatric patients aged 1 to 5 years. Initiate at 50mg once daily for most adults and pediatric patients 6 and older. Reduce the initial dose in patients with hepatic impairment and/or patients of East Asian ancestry. Adjust to maintain a platelet count ≥50 x 10^9/L. Do not exceed 75 mg per day.
- ☐ **Chronic Hepatitis C-associated thrombocytopenia:** Initiate at 25 mg once daily for all patients. Adjust to achieve a target platelet count required to initiate antiviral therapy. Do not exceed a daily dose of 100 mg.
- ☐ **Severe Aplastic Anemia:** Initiate at 50 mg once daily. Reduce the initial dose to 25 mg in patients with mild, moderate or severe hepatic impairment or of East Asian ancestry. Adjust to maintain a platelet count ≥50 x 10^9/L. Do not exceed a dose of 150 mg daily
- ☐ **Dosage Form:** 12.5 mg, 25 mg, 50 mg, 75 mg, and 100 mg tablets; 25mg oral suspension

PROVIGIL® (MODAFINIL)

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)
Fax Form:	Provigil

REVIEW CRITERIA

Prior authorizations requests should ONLY be entered for generic Modafinil. Brand Medically Necessary requests should be forwarded to a clinical pharmacist for clinical account manager review. The feeling is that the brand should rarely be approved.

FOR INITIATION OF THERAPY: (All testing should have been done within the past 90 days for initiation of therapy.)

- ☐ Narcolepsy – Diagnosis supported by clinical testing and a Physician's interpretation of these tests confirming the diagnosis.
- ☐ Obstructive Sleep Apnea/Hypopnea Syndrome – This syndrome being confirmed by clinical testing, a Physician's interpretation of the tests supporting the diagnosis, and the confirmation of the Patient's concurrent use of CPAP.
- ☐ Shift Work Sleep Disorder – This disorder being confirmed by a Physician's interpretation of clinical testing (ex. difficulty sleeping; excessive sleepiness; difficulty concentrating; headaches; lack of energy) and documentation by the Patient's supervisor of at least 10 night shifts worked out of the past 30 days.

FOR CONTINUATION OF THERAPY: (If previously approved by Medicaid)

- ☐ Confirmed (within the past 6 months) compliance with treatment plan, including non-pharmacologic therapies (where applicable), such as concurrent use of CPAP and/or lifestyle modifications.
- ☐ If not previously approved by Medicaid the request must be forwarded to a pharmacist for review.

ADDITIONAL INFORMATION

- ☐ The minimum age limit for Provigil is 18 years old.
- ☐ All Nuvigil Prior Authorization requests should be addressed as a change in therapy (CIT) to generic Modafinil if possible. **Brand Medically Necessary requests should be forwarded to a clinical pharmacist for clinical account manager review. The feeling is that the brand should rarely be approved.**

PULMONARY HYPERTENSION AGENTS

Length of Authorization:	Up to 1 year
Initiative:	MAP: Pulmonary Hypertension (75 / 2462 – GSN-9; 76 / 2641 – GSN)

1. Is there any reason the Patient cannot be changed to a preferred medication? Acceptable reasons include
   - ☐ Allergy to at least two unrelated preferred medications
   - ☐ Contraindication to or drug-to-drug interaction with preferred medications
   - ☐ History of unacceptable/toxic side effects to preferred medications
2. Has there been a failure to respond to a therapeutic trial of at least **ONE** preferred medication of the same dosage form? Document details. Please note that some dosage forms may not have preferred options.

REVIEW CRITERIA

For treatment of pulmonary hypertension:

- ☐ Diagnosis must be verified in patient diagnosis code(s) or supporting documentation.
- ☐ Verify that medication is prescribed by a related specialist.
- ☐ Requests for Viagra® (Sildenafil) must be redirected to Revatio® (Sildenafil).
- ☐ Requests for Cialis® (Tadalafil) must be redirected to Adcirca® (Tadalafil).
- ☐ Trial of Ventavis® is required prior to consideration of Tyvaso®.
- ☐ Trial of preferred Epoprostenol is required prior to consideration of the non-preferred agents.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Oral	
	Adcirca® (Tadalafil) 20mg Tab
	Adempas® (Riociguat)
	Letairis® (Ambrisentan)
	Opsumit® (Macitentan)
	Orenitram ER® Tablet (Treprostinil)
	Revatio® (Sildenafil) Vial, Oral Susp., 20mg Tab
	Tracleer® (Bosentan)
	Uptravi® (Selexipag)
Inhaled	
	Tyvaso® (Treprostinil)
	Ventavis® (Iloprost) Soln
Injectable	
Epoprostenol (generic for Flolan® & Veletri®) Vial	Flolan® (Epoprostenol)
	Remodulin® (Treprostinil)
	Veletri® (Epoprostenol)

ADDITIONAL INFORMATION

The Florida MCOs do not cover treatment for Erectile Dysfunction (ED). Sildenafil (generic name for Revatio®) or Tadalafil (generic name for Adcirca®) are covered for Pulmonary Hypertension only; prior authorization is required.

PULMOZYME® FOR CYSTIC FIBROSIS AUTOPA

GSNs listed in the Pulmozyme List are AutoPA coded for lookback 730 days for any listed qualifying ICD code.

Length of Authorization:	1 year
Initiative:	MAP: Non-Preferred Drug Override (75 / 2462 – GSN PatOverride; 76 / 2641 – GSN PatConstraint)

REVIEW CRITERIA

Must have one of the following Cystic Fibrosis diagnoses:

- ☐ **ICD-9 Codes**
  - ☐ 277.00 Cystic fibrosis without mention of meconium ileus
  - ☐ 277.01 Cystic fibrosis with meconium ileus
  - ☐ 277.02 Cystic fibrosis with pulmonary manifestation
  - ☐ 277.03 Cystic fibrosis with gastrointestinal manifestation
  - ☐ 277.09 Cystic fibrosis with other manifestation
- ☐ **ICD-10 Code**
  - ☐ E84 Cystic fibrosis

<table>
<tr><th>Edit</th><th>Drugs</th><th>Steps</th></tr>
<tr>
<td>Pulmozyme Automated PA approval satisfies L=Auto PA drug edit

Automated PA approval will NOT override R = Non-PDL edit.</td>
<td>
<table>
<tr><th colspan="2">Pulmozyme List</th></tr>
<tr><th>Drug Name</th><th>GSN</th></tr>
<tr><td>Pulmozyme 1mg/ml</td><td>HICL = 008832</td></tr>
</table>
</td>
<td>
Step 1: If the incoming claim is from the <Hypertonic solution list>, look back in the medical claims history 730 days for ICD9 277.00 (Cystic fibrosis without meconium ileus), 277.01 (Cystic fibrosis with meconium ileus), 277.02 (Cystic fibrosis with pulmonary manifestations), 277.03 (Cystic fibrosis with gastrointestinal manifestations), 277.09 (Cystic fibrosis with other manifestations), OR ICD 10 Disease Group E84 (Cystic Fibrosis). If found, NO PA REQUIRED. Otherwise, Deny for PRIOR AUTHORIZATION REQUIRED (75) with supplemental message “M/I Diagnosis Code.”
<table>
<tr><th colspan="2">Approvable ICD 9-CM Codes</th></tr>
<tr><td>277.00</td><td>Cystic fibrosis without mention of meconium ileus</td></tr>
<tr><td>277.01</td><td>Cystic fibrosis with meconium ileus</td></tr>
<tr><td>277.02</td><td>Cystic fibrosis with pulmonary manifestation</td></tr>
<tr><td>277.03</td><td>Cystic fibrosis with gastrointestinal manifestation</td></tr>
<tr><td>277.09</td><td>Cystic fibrosis with other manifestation</td></tr>
<tr><th colspan="2">Approvable ICD 10-CM Disease Group</th></tr>
<tr><td>E84</td><td>Cystic fibrosis</td></tr>
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</table>

PYLERA® CAPSULES (BISMUTH SUBCITRATE POTASSIUM, METRONIDAZOLE, TETRACYCLINE HYDROCHLORIDE)

Length of Authorization:	Length of prescription, up to 10 days.

REVIEW CRITERIA

- ☐ Request must be redirected to individual preferred agents: (i.e., omeprazole/Prevacid, amoxicillin, and clarithromycin).

RASUVO® & OTREXUP®(METHOTREXATE AUTO INJECTOR)

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

Rheumatoid Arthritis (severe):

- ☐ Patient is 18 years or older with active rheumatoid arthritis; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to non-steroidal anti-inflammatory drugs NSAIDs; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to methotrexate tablets; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to methotrexate intramuscularly

Psoriasis (Severe) Recalcitrant, disabling

- ☐ Patient is 18 years or older with a diagnosis of severe, recalcitrant disabling psoriasis
- ☐ Patient did not respond adequately (or is not a candidate) to a 3 month minimum trial of phototherapy (e.g., Psoralens with UVA light (PUVA) OR UVB with coal tar or dithranol); **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to methotrexate tablets; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to methotrexate intramuscularly

Juvenile Idiopathic Arthritis:

- ☐ Patient is 2 years old or older with the diagnosis of Juvenile Idiopathic Arthritis; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to NSAIDs; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to methotrexate tablets; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to methotrexate intramuscularly

DOSING AND STRENGTHS

Rheumatoid Arthritis

- ☐ 7.5mg subcutaneously once weekly

Psoriasis (Severe), Recalcitrant, disabling

- ☐ 10 to 25 mg subcutaneously once weekly

Juvenile Idiopathic Arthritis:

- ☐ 10 mg/m^2 subcutaneously once weekly

Rasuvo: Single-dose manually-triggered auto-injector delivering methotrexate in the following dosage strengths:

- ☐ 7.5 mg, 10 mg, 12.5 mg, 15mg, 17.5 mg, 20 mg, 22.5 mg, 25 mg, 27.5 mg, and 30 mg

Otrexup: Single-dose auto-injector delivering 0.4mL of methotrexate in the following dosage strengths:

- ☐ 7.5 mg, 10 mg, 12.5 mg, 15mg, 17.5 mg, 20 mg, 22.5 mg, and 25 mg

RAVICTI® (GLYCEROL PHENYLBUTYRATE) ORAL LIQUID

Length of Authorization:	Up to one year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 2 years old.
- ☐ Patient must have a diagnosis of urea cycle disorder.
- ☐ Patient must be on dietary protein restriction.
- ☐ Patient must have tried and failed Buphenyl (sodium phenylbutyrate) as evidenced by unmanaged chronic hyperammonemia over the past 365 days.
- ☐ Medication must be prescribed by a physician experienced in management of UCDs (e .g., geneticist)

RECTIV® (NITROGLYCERIN OINTMENT 0.4%)

Length of Authorization:	1 tube (30gm); Date of Service
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years old.
- ☐ Patient must have a documented history of an anal fissure [a small tear in the skin that lines the anus].
- ☐ Patient must have a documented history (within past 60 days) of trial of at least two of the more conservative treatments for the underlying cause of the anal fissure. Some conservative treatments may include:
  - ☐ High-fiber diet or fiber supplements
  - ☐ Adequate fluid intake
  - ☐ Sitz baths
  - ☐ Topical analgesia/ medicated creams (e.g., Anusol HC, zinc oxide)
  - ☐ Stool softeners (e.g., Metamucil)

[If the Patient is a candidate for surgery (sphincterotomy, anal advancement flap) and has met the above criteria, then the request may be approved.]

REGRANEX® (BECAPLERMIN)

Length of Authorization:	Up to 4 Months (Maximum of 15 grams per RX)
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ For Long-Term Care (LTC) patients ONLY
- ☐ Patient must have diabetes with lower extremity neuropathic ulcers.
- ☐ Verify history of diabetic medications (oral or insulin).
- ☐ **NOTE**: If the patient is NOT a LTC patient, redirect the provider to Santyl

RELISTOR® (METHYLNALTREXONE BROMIDE)

Length of Authorization:	Up to 4 Months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- Patient must be ≥ 18 years old.
- Patient must have a documented current history of an advanced illness (e.g., cancer) that requires the chronic use of opioids (e.g., morphine, oxycodone).
- Patient with opioid induced constipation in patients with chronic non-cancer pain (e.g., rheumatoid arthritis, neurologic/neuropathic pain for patients who have been taking opioids for a minimum of 4 consecutive weeks).
- Patient must have documented history (within the past month) of trial and failure or intolerance of at least two classes of laxatives -stimulant laxatives and osmotic laxatives [e.g., Milk of Magnesia, magnesium citrate, Miralax (polyethylene glycol 3350)].

DOSING

- The usual schedule is one dose every other day, as needed, but no more frequently than one dose in a 24-hour period for palliative care patients:
  - **Patient Weight** **Dose**
    - <38 kg 0.15 mg/kg SC every other day as needed
    - 38-61 kg 8 mg SC every other day as needed
    - 62–114 kg 12 mg SC every other day as needed
    - >114 kg 0.15 mg/kg SC every other day as needed
- For chronic non-cancer pain patients: 12mg subcutaneously once daily
- Available in the following dosage forms:
  - Single-use vial containing 12 mg/0.6 mL solution for subcutaneous injection.
  - Single-use pre-filled syringe containing 8 mg/0.4 mL solution for subcutaneous injection.
  - Single-use pre-filled syringe containing 12 mg/0.6 mL solution for subcutaneous injection.

REMICADE® (INFLIXIMAB)

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

RHEUMATOID ARTHRITIS

- ☐ Patient must be 18 years of age or older; **AND**
- ☐ Patient has a documented diagnosis of moderate to severe rheumatoid arthritis; **AND**
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to one or more non-biologic- DMARDs (i.e., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) for at least 3 consecutive months; **AND**
- ☐ Patient has had an inadequate response, intolerance, or has contraindications to: Xeljanz® and Humira®

ANKYLOSING SPONDYLITIS

- ☐ Patient must be 18 years of age or older; **AND**
- ☐ Patient has a documented diagnosis of ankylosing spondylitis; **AND**
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response previous therapies) with the following:
  - ☐ One or more non-steroidal anti-inflammatory drugs –NSAIDs (trail at maximum dose for at least 2–3 weeks before considering them as failures); **OR**
  - ☐ Analgesic agents (acetaminophen or codeine) if NSAIDs do not completely control the pain; **OR**
  - ☐ Sulfasalazine (if peripheral joint involvement is present);

  AND
  - ☐ Patient has had an inadequate response, intolerance, or has contraindications to: Humira®

CROHN'S DISEASE

- ☐ Patient must be 6 years of age or older
- ☐ Patient has a documented diagnosis of moderate to severe Crohn's disease
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided
- ☐ Patient has inadequate responses, intolerance, or has contraindications to conventional therapy (clinical documentation must be submitted demonstrating response previous therapies):
  - ☐ Budesonide, mesalamine, or corticosteroids (i.e., prednisone, methylprednisolone) OR
  - ☐ Non-biologic DMARDs (e.g., azathioprine, methotrexate, mercaptopurine) AND
  - ☐ Patient has an inadequate response, intolerance, or has contraindications to Humira®

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REMICADE® (INFLIXIMAB) (CONTINUED)

PLAQUE PSORIASIS

- ☐ Patient must be 18 years of age or older; **AND**
- ☐ Patient has documented diagnosis of moderate to severe plaque psoriasis for at least 6 months with at least one of the following:
  - ☐ Incapacitation due to plaque location (e.g., head and neck, palms, soles, or genitalia); **OR**
  - ☐ Involvement of at least 10 percent of body surface area (BSA); **OR**
  - ☐ Psoriasis Area and Severity Index (PASI) score of 12 or greater; **AND**
- ☐ Patient is free of any clinically important active infections; **AND**
- ☐ Patient has a negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient did not respond adequately (or is not a candidate) to a 3-month minimum trial of at least 1 systemic agent (e.g., immunosuppressives, retinoic acid derivatives, and/or methotrexate); **AND**
- ☐ Patient did not respond adequately (or is not a candidate) to a 3 month minimum trial of phototherapy (e.g., Psoralens with UVA light (PUVA) OR UVB with coal tar or dithranol; **AND**
- ☐ Patient has had a 3 month minimum trial and failure (inadequate response or intolerance), to Humira®

PSORIATIC ARTHRITIS

- ☐ Patient must be 18 years of age or older; **AND**
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient has active psoriatic arthritis for at least 6 months defined as:
  - ☐ > 3 swollen joints; **AND**
  - ☐ > 3 tender joints;

  AND
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response previous therapies) with the following:
  - ☐ One or more non-steroidal anti-inflammatory drugs –NSAIDs (trail at maximum dose for at least 2–3 weeks before considering them as failures) **AND**
  - ☐ One or more non-biologic disease modifying anti-rheumatic drugs DMARDs (i.e., methotrexate, sulfasalazine, leflunomide, cyclosporine) **AND**
  - ☐ Patient has had an inadequate response, intolerance, or has contraindications to: Humira®

ULCERATIVE COLITIS

- ☐ Patient must be 6 years of age or older; **AND**
- ☐ Patient has a documented diagnosis of moderately to severely active ulcerative colitis (UC) ; **AND**
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient has demonstrated corticosteroid dependence; **OR**

  Patient has had an inadequate response (clinical documentation must be submitted demonstrating response to previous therapies) or failed to tolerate oral mesalamine, oral corticosteroids (i.e. prednisone, dexamethasone, methylprednisolone), cyclosporine, azathioprine or 6-mecaptopurine (6-MTP);

  AND
- ☐ Patient has had an inadequate response, intolerance, or has contraindications to: Humira®

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DOSING

- **Ankylosing Spondylitis:** 5mg/kg at 0, 2, and 6 weeks, then every 6 weeks by intravenous infusion.
- **Crohn's Disease:** 5 mg/kg at 0, 2, and 6 weeks, then every 8 weeks by intravenous infusion. Some adult patients, who initially respond to treatment, may benefit from increasing the dose to 10 mg/kg if they later lose their response.
- **Plaque Psoriasis:** 5mg/kg at 0, 2, and 6 weeks, then every 8 weeks by intravenous infusion.
- **Psoriatic Arthritis:** 5mg/kg at 0, 2 and 6 weeks, then every 8 weeks by intravenous infusion
- **Rheumatoid Arthritis:** 3mg/kg at 0, 2, and 6 weeks, then every 8 weeks by intravenous infusion with methotrexate. May increase up to 10mg/kg or 3mg/kg every 4 weeks if incomplete response
- **Ulcerative Colitis:** 5 mg/kg at 0, 2, and 6 weeks, then every 8 weeks by intravenous infusion.

CONTINUATION OF THERAPY

- Documentation showing current patients are stable (have low RA disease activity or are in clinical remission) will be taken into consideration during the prior authorization review process regarding continuation of therapy with the same agent.

REPATHA® (EVOLOCUMAB)

Length of Authorization:	☐ Initial Review: 3 months ☐ Continuation of therapy: 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

INITIAL THERAPY

- ☐ Age ≥ 18 years for diagnosis of atherosclerotic cardiovascular disease (ASCVD) or heterozygous familial hypercholesterolemia (HeFH) or ≥ if diagnosis of homozygous familial hypercholesterolemia (HoFH)
- ☐ Diagnosis of atherosclerotic cardiovascular disease or heterozygous familial hypercholesterolemia as confirmed by genotyping or by clinical criteria ("definite FH" using either the Simon Broome or WHO/Dutch Lipid Network criteria), **OR**
- ☐ Diagnosis of homozygous familial hypercholesterolemia by either:
  - ☐ Documented DNA test for functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality OR
  - ☐ A history of an untreated LDL-C concentration > 500 mg/dL and triglycerides <300 mg/dL and both parents with documented untreated TC >250 mg/dL
- ☐ Prior treatment history with highest available dose or maximally-tolerated dose of high intensity statin (i.e., atorvastatin or rosuvastatin) **AND** Zetia for at least three continuous months with failure to reach target LDL-C (70 mg/dL for patients with clinical ASCVD and 100 mg/dL for patients with HeFH or HoFH and no history of clinical ASCVD)
  - ☐ If the patient is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms, documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the patient experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following:
    - ☐ Muscle symptoms resolve after discontinuation of statin; **AND**
    - ☐ Muscle symptoms occurred when rechallenged at a lower dose of the same statin; **AND**
    - ☐ Muscle symptoms occurred after switching to an alternative statin; **AND**
    - ☐ Documentation ruling out non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease)

  OR
  - ☐ The patient has been diagnosed with statin-induced rhabdomyolysis
    - ☐ The diagnosis should be supported by acute neuromuscular illness or dark urine **AND** an acute elevation in creatine kinase (usually >5,000 IU/L or five times the upper limit of normal)
- ☐ If the patient failed to reach target LDL-C (<70 mg/dL for patients with clinical ASCVD and <100 mg/dL for patients with HeFH or HoFH and no history of clinical ASCVD), adherence to maximally-tolerated statin and Zetia has been verified using pharmacy claims data and the patient is determined to be compliant for at least three consecutive months prior to the lipid panel demonstrating suboptimal reduction
- ☐ Maximally-tolerated statin will continue to be used in conjunction with evolocumab
- ☐ Patient has not had a prior trial and failure of an alternative PCSK9 inhibitor

CONTINUATION OF THERAPY

- ☐ Lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating evolocumab
- ☐ Continued adherence to maximally-tolerated statin dose established prior to the original evolocumab approval

DOSING AND ADMINISTRATION

- ☐ Primary hyperlipidemia with established clinical ASCVD or HeFH: 140mg subcutaneously every 2 weeks or 420mg subcutaneously once monthly in the abdomen, thigh or upper arm
- ☐ HoFH: 420mg subcutaneously once monthly (3 evolocumab injections consecutively within 30 minutes)

REVLIMID® (TOLVAPTAN)

Length of Authorization:	Up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

The provider must submit either a copy of the REVLIMID REMS® Prescriber Registration Form, or a copy of the Patient-Physician Agreement Form, or a copy of the Prescription Form regardless of the diagnosis to ensure compliance with all monitoring parameters including mandatory pregnancy tests in appropriate patients.

MULTIPLE MYELOMA

- ☐ Patient must be ≥ 18 years of age
- ☐ Patient has a documented diagnosis of multiple myeloma
- ☐ Concurrent treatment with dexamethasone or history of steroid intolerance must be documented
- ☐ Prescriber must be a hematologist/oncologist.

MYELODYSPLASTIC SYNDROME (MDS)

- ☐ Patient must be ≥ 18 years of age.
- ☐ Patient has a diagnosis of myelodysplastic syndrome
- ☐ Transfusion-dependent anemia due to low or intermediate-1-risk myelodysplastic syndromes (MDS) associated with a deletion 5q abnormality.
- ☐ Prescriber must be a hematologist/oncologist.

MANTLE CELL LYMPHOMA

- ☐ Patient has a confirmed diagnosis of mantle cell lymphoma (MCL)
- ☐ Patient has experienced relapse or disease progression after two prior therapies
- ☐ One of the prior therapies included bortezomib (Velcade)
- ☐ Prescriber must be a hematologist/oncologist.

REXULTI® (BREXPIPRAZOLE)

Length of Authorization:	Initial: up to 3 months Continuation of Therapy: up to 6 months
Initiative:	MAP: AP: Rexulti (75 / 31003 – GSN; 75 / 31006 – GSN; 75 / 31008 – GSN)

- **MCC-FL ONLY – Requests from Dr. Melnick:** Prior to these criteria from AHCA (December 2015), MCC-FL requests from Dr. Melnick were approved without criteria. Dr. Melnick handles forensic cases and MCC-FL wished to defer to his judgment. For Dr. Melnick's requests with the addition of these criteria from AHCA, we are to apply the criteria to new starts; renewals can be approved continuing to bypass the criteria. It is expected however, that his requests will meet the criteria regardless.
- **ALL OTHER PRESCRIBERS' REQUESTS:** These new criteria will apply in full.

CLINICAL NOTES

- Brexpiprazole (Rexulti®) is an atypical antipsychotic indicated for the treatment of schizophrenia and for use as an adjunctive therapy to antidepressants for the treatment of major depressive disorder (MDD).

INITIAL REVIEW CRITERIA

AutoPA Coding went into production June 8, 2016. Coding will look for diagnosis and qualifying med trials.

- Patient must be ≥18 years old.
- Patient must have a diagnosis of
  - Schizophrenia (AutoPA failure will message: "M/I Diagnosis Code"):
    - ICD9 295.00-295.95 (Schizophrenia), **OR**
    - ICD 10 Disease Group F20 (Schizophrenia).

  OR
  - Major Depressive Disorder (AutoPA failure will message: "M/I Diagnosis Code"):
    - ICD9 296.20-296.26, 296.30-296.36 (major depressive disorder), **OR**
    - ICD 10 Disease Group: F32 (major depressive disorder – single episode), **OR**
    - ICD 10 Disease Group: F33 (major depressive disorder – recurrent episodes).
- For the treatment of schizophrenia, patient must have a history of trial and failure of at least (AutoPA failure will message : "Missing Prerequisite Drug Therapy"):
  - Two preferred atypical antipsychotics with a minimum 24-day treatment period with each agent.
- For the treatment of major depressive disorder, patient must have a history of trial and failure with a minimum of (AutoPA failure will message : "Missing Prerequisite Drug Therapy"):
  - Two antidepressant drugs within the past 365 days, **AND**
  - One antidepressant drug within the past 30 days and documentation that brexpiprazole will be used concurrently with an antidepressant.
- Failure can be defined as inefficacy or intolerability, not non-compliance.

CONTINUATION OF THERAPY

- Schizophrenia:
  - As maintenance therapy in patients with satisfactory response to brexpiprazole who had a previous trial and failure of two other atypical antipsychotics as described above.
- Adjunctive treatment of major depressive disorder
  - As adjunctive therapy in patients with satisfactory response to brexpiprazole used concurrently with an antidepressant.

SAMSCA® (TOLVAPTAN)

Length of Authorization:	Date of service or per prescription (up to 30 days)
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years of age.
- ☐ Must have a diagnosis hyponatremia:
  - ☐ Serum sodium level may be below 125 mEq/L; **OR**
  - ☐ Serum sodium level may be ≥ 125 mEq/L but patient is symptomatic and has resisted correction with fluid restriction

DOSING AND ADMINISTRATION:

- ☐ Patients should be in a hospital for initiation and re-initiation of therapy to evaluate the therapeutic response and because too rapid correction of hyponatremia can cause osmotic demyelination resulting in dysarthria, mutism, dysphagia, lethargy, affective changes, spastic quadriparesis, seizures, coma, and death.
- ☐ The usual starting dose for Samsca is 15 mg administered once daily without regard to meals. Increase the dose to 30 mg once daily, after at least 24 hours, to a maximum of 60 mg once daily, as needed to achieve the desired level of serum sodium.
- ☐ Dosage form: 15mg and 30mg tablets

SCABICIDALS AND PEDICULICIDES

Length of Authorization:	Date of Service
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to a preferred medication? **Document details**. Official documentation is needed to verify these details (ex., Md notes). It is not acceptable if the provider just writes these notes on the PA form. Acceptable reasons include
   - ☐ Allergy to preferred medications in this class
   - ☐ Contraindication or drug-to-drug interaction with preferred medications
   - ☐ History of unacceptable side effects
2. Has there been a failure to respond to a therapeutic trial of at least *one week* of ***two*** preferred medications within the **same** medication class? **Document details**.

PEDICULICIDES (PRODUCTS TO TREAD HEAD LICE)

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Natroba (*spinosad*) suspension	Lindane (*lotion and shampoo*)
Permethrin 1% (OTC permethrin containing products with prescription)	Malathion (generic Ovide®)
	Ovide® (*malathion*)
	Ulesfia® (*benzyl alcohol*) Lotion

SCABICIDALS (PRODUCTS TO TREAT SCABIES)

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Elimite	Eurax (*lotion and cream)*
Permethrin 5% cream	Lindane (*lotion and shampoo*)

NOTE

Ovide® 0.5% Lotion (malathion) – The safety and efficacy of malathion in children younger than 6 years of age have not been established via well controlled trials.

SEDATIVE/HYPNOTIC: NON-BARBITURATE – AGE LIMITS

Length of Authorization:	Up to one year
Initiative:	MAP: Age Limit Over Maximum (2194 / 60 – GSN; 2641 / 76 – GSN; 2624 / 60 – GSN) MAP: Age Limit Under Minimum (2193 / 60 – GSN; 2641 / 76 – GSN; 2623 / 60 – GSN)

SEDATIVE HYPNOTICS: AGE LIMIT DIRECTIVE (EFFECTIVE 03/21/2011)

- ☐ The minimum age limit on the following sedative hypnotics has been changed due to the lack of safety and efficacy in adolescents and children.

LIST OF SEDATIVE / HYPNOTICS MINIMUM AGE 18 YEARS

- ☐ Belsomra
- ☐ Lunesta
- ☐ Rozerem
- ☐ Sonata
- ☐ Temazepam
- ☐ Zolpidem

LIST OF SEDATIVE / HYPNOTICS MINIMUM AGE 15 YEARS

- ☐ Flurazepam

LIST OF SEDATIVE / HYPNOTICS MINIMUM AGE 9 YEARS

- ☐ Clorazepate

LIST OF SEDATIVE / HYPNOTICS MINIMUM AGE 6 YEARS

- ☐ Oxazepam
- ☐ Chlordiazepoxide

SEDATIVE/HYPNOTIC: NON-BARBITURATE

Length of Authorization:	Up to 90 days
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

QUANTITY LIMITS

Sedative Hypnotics: Reimbursement of oral dose forms of any sedative hypnotic will be limited to **no more than 30 units per 27 days**. The 27 days corresponds to a 10% tolerance for refills (IE 7001); basically 30/30.

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Review Sedative Hypnotic Age Limit Criteria	
Lorazepam (generic for Ativan®) [150/30]	Ambien® (*zolpidem*) [*5mg, 10mg]
Temazepam (generic for Restoril®) [15mg and 30mg only]	Ambien® CR (*zolpidem*)
Zolpidem (generic for Ambien®) [*5mg, 10mg]	Ativan® (*lorazepam*) [150/30]
	Belsomra® (suvorexant)
	Chloral Hydrate rectal suppository
	Doral® (*quazepam*)
	Estazolam (generic for Prosom®)
	Flurazepam
	Halcion® (*triazolam*)
	Lunesta® (*eszopiclone*) [*1mg, 2mg, 3mg]
	Midazolam (generic for Versed®)
	Restoril® (*temazepam*) – ALL strengths
	Rozerem® (*ramelteon*)
	Sonata® (*zaleplon*)
	Temazepam (generic for Restoril®) [7.5mg & 22.5mg only]
	Triazolam (generic for Halcion®)
	Zaleplon (generic for Sonata®)

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REVIEW CRITERIA

INITIATION OF THERAPY

- ☐ **If request is for override of current, quantity limit (30 every 30 days) deny request and provide notice of quantity limit.** [***Exception:*** Ativan (lorazepam) quantity limit is 150 every 30 days with maximum of 5 allowed a day]
- ☐ Must be age 18 years or older.
- ☐ Must submit medical records verifying diagnosis of insomnia (difficulty initiating sleep, maintaining sleep, or nonrestorative sleep) for at least one month with significant impairment of daytime functioning
- ☐ Must have documented one month treatment failure (claims history or progress notes) of at least two of the following preferred agents (**zolpidem must be one of those trials**) within the past 90 days:
  - ☐ Lorazepam (generic for Ativan)
  - ☐ Temazepam (except for 7.5mg and 22.5mg)
  - ☐ Zolpidem (generic for Ambien, Edluar, Intermezzo, Zolpimist)
- ☐ Must provide medical documentation verifying cognitive behavior therapy (CBT) within the past 365 days which **must** include education on sleep hygiene (habit) improvements. Other CBT measures may include stimulus control therapy, sleep restriction therapy, and relaxation therapy.
  - ☐ Sleep Hygiene Improvements
    1. Going to bed and rising at the same time every day.
    2. Avoiding stimulants (caffeine, nicotine, methylphenidate, dextroamphetamine, phenylephrine, and pseudoephedrine, etc.)
    3. Avoiding daytime naps
    4. Avoiding alcohol
    5. Setting a comfortable environment (not too hot, cold, or noisy)
    6. No exercise at night
- ☐ If request is for Ambien CR:
  - ☐ Above criteria must be met
  - ☐ Request must be for sleep maintenance
  - ☐ Medication must be prescribed as adjunctive therapy to cognitive behavior therapy

CONTINUATION OF THERAPY

- ☐ If request is for override of current quantity limit (30 every 30 days) deny request and provide notice of quantity limit. [*Exception*: Ativan (lorazepam) quantity limit is 150 every 30 days with maximum of 5 allowed a day]
- ☐ Before continuation of Rozerem and Lunesta is approved the patient must be tapered with a three-month trial of cognitive behavior therapy only. *(Requests for continuation of Rozerem and Lunesta to allow for tapering may be approved for no more than one month.* **-OR-**
- ☐ Two month trial of preferred agents **-OR-**
- ☐ Medical documentation from sleep specialist with recommendation to resume therapy must be submitted.
- ☐ The other non-preferred agents (excluding Rozerem and Lunesta) may be approved only two times within one year (365 days) collectively. *(For example, a patient may not have two authorizations for Doral and two authorizations for Estazolam with the same 365-day period.)*

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DOSING:

Ambien (zolpidem) – adults: 5 or 10 mg PO HS (men), 5 mg (women); elderly: 5 mg PO HS
Ambien CR (zolpidem) – adults: 6.25 or 12.5 mg PO HS (men), 6.25 mg (women); elderly: 6.25mg PO HS
Edluar (zolpidem) – adults: 5 or 10 mg SL HS (men), 5 mg (women)
Intermezzo (zolpidem) – adult: 1.75 mg SL (women), 3.5 mg (men) taken only once per night as needed if a middle-of-the-night awakening (only if the patient has at least 4 hours of bedtime remaining before the planned time of waking).
Lunesta (eszopiclone) – adults: 2 mg PO HS - may increase to 3 mg PO HS; elderly: 1 mg PO HS initially; not to exceed 2 mg PO HS
Prosom (estazolam) – adult: 1-2 mg PO HS; elderly: 0.5-1 mg PO HS
Restoril (temazepam) – adult: 15-30 mg PO HS; elderly 7.5-15 mg PO HS
Rozerem (ramelteon) – adult: 8 mg PO 30 min before bedtime on empty stomach
Doral (quazepam) – adult: initially, 15 mg or 7.5 mg PO HS; elderly: initially, 7.5 PO HS
Dalmane (flurazepam) – adults and adolescents 15 years of age and older: 30 mg PO HS; elderly: initially, 15 mg PO HS
Sonata (zaleplon) – adults: 10 mg PO HS; elderly: 5 mg PO HS (doses over 10 mg are not recommended in elderly)
Zolpimist (zolpidem) – adults: 1-2 (5-10 mg) sprays directly in mouth over tongue HS (men), 1(5mg) spray (women)

SELZENTRY™ (MARAVIROC)

Length of Authorization:	Up to One Year
Initiative:	MAP: Selzentry (75 / 2462 – GSN; 76 / 2641 – GSN)
Fax Form:	Selzentry [REQUIRED]

REVIEW CRITERIA

Questions below correspond to the numbering on the **Selzentry®** fax form. Selzentry PA form must be completed in full.

Question 1:

- ☐ Dose requested
- ☐ 150mg twice daily; 300mg twice daily; OR 600mg twice daily.

Question 2:

- ☐ Has tropism testing been performed?
- ☐ If "No," return the fax for a copy of the Tropism assay report. Tropism testing must be completed. A copy of the assay MUST be provided.
- ☐ If "Yes," verify tropism assay report. The FDA approved Selzentry™ in combination with other antiretroviral agents for treatment experienced adult patients infected with only CCR5-tropic HIV-1 detectables who have evidence of viral replication and HIV-1 strains resistant to multiple antiretroviral agents, August 2007.

Question 3:

- ☐ Is the patient > or = to 16 years of age?
- ☐ Only acceptable response for approval is "Yes." If "No," forward to a pharmacist for MRIoA physician review.

Question 4:

- ☐ Patient is:
  - ☐ Treatment naive, OR
  - ☐ Treatment experienced

Question 5:

- ☐ Current (less than 6 months) lab results must be provided:
  - ☐ Treatment naïve: CD4 Count and Viral Load
  - ☐ Treatment-experienced: CD4 Count and Viral Load and Resistance Testing.

SENSIPAR® (CINACALCET)

Length of Authorization:	Up to one year; See Criteria Below
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

Age: ≥ 18 years of age (Safety and efficacy not established in adolescent, children, and infants)

One of the Following Diagnoses Must Be Met:

- ☐ Secondary Hyperparathyroidism (HPT) due to Chronic Kidney Disease (CKD) **and** patient must be on dialysis
- ☐ Parathyroid Carcinoma resulting in **hypercalcemia** (elevated blood or serum calcium levels)
- ☐ Severe hypercalcemia in patients with primary HPT who are unable to undergo parathyroidectomy.

SEROSTIM® (SOMATROPIN)

Length of Authorization:	Initial approval: 90 days Retreatment: 30 days
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)
Fax Form:	Serostim® [REQUIRED]

CLINICAL CRITERIA

1. The physician must first complete, sign, and date the Serostim PA form.
2. For initial therapy, or request for additional therapy, the physician must answer all the questions addressed on the PA form, in addition to a six-month weight chronicle indicating the most recent weights.
3. Recipient must be 18 years of age or older.
4. Patient has diagnosis of HIV associated wasting or cachexia.
5. Patient is on anti-retroviral therapy (document medications being used).
6. Patient has experienced at least a 7.5% unintentional weight loss within the last 6 months, 10% involuntary weight loss in last 12 months, or has a Body Mass Index (BMI) < 20 for initial approval
7. Alternately, patient may have a Body Cell Mass (BCM) < 35% (male) or <23% (female) of total body weight and a Body Mass Index less than 27. Another qualifier would be a greater than or equal to 5% BCM loss over 6 months.
8. Treatment must also include nutritional assessment and counseling. Total parenteral nutrition is sometimes of benefit in patients with damaged gastrointestinal tracts. Appetite stimulants such as megestrol may promote weight gain; however, most gain with megestrol acetate is in fat rather than BCM.
9. Serostim is contraindicated in patients with active Neoplasia.
10. Length of therapy is 12 weeks; however, if a positive response to therapy (a 2% or greater increase in body weight and/or BCM) occurs but wasting is still evident, treatment may be continued and response reevaluated on a month-by-month basis. **THEREFORE, RETREATMENT WILL BE APPROVED FOR A MAXIMUM OF 30 DAYS AT A TIME.**
11. Physician must submit a new PA form for additional therapies.

SIMPONI® (GOLIMUMAB)

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

RHEUMATOID ARTHRITIS

- ☐ Patient must be 18 years of age or older
- ☐ Patient has a documented diagnosis of moderate to severe rheumatoid arthritis
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to one or more non-biologic- DMARDs (i.e., methotrexate, leflunomide, sulfasalazine, hydroxychoroquine) for at least 3 consecutive months; **AND**
- ☐ Patient has had an inadequate response, intolerance, or has contraindications to: Xeljanz® and Humira®

ANKYLOSING SPONDYLITIS

- ☐ Patient is > 18 years of age; **AND**
- ☐ Patient has a documented diagnosis of ankylosing spondylitis
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) with the following:
  - ☐ One or more non-steroidal anti-inflammatory drugs –NSAIDs (trial at maximum dose for at least 2-3 weeks before considering them as failures); **OR**
  - ☐ Analgesic agents (acetaminophen or codeine) if NSAIDs do not completely control the pain; **OR**
  - ☐ Sulfasalazine (if peripheral joint involvement is present); **AND**
  - ☐ Patient has had an inadequate response, intolerance, or has contraindications to Humira®

PSORIATIC ARTHRITIS

- ☐ Patient is > 18 years of age; **AND**
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided
- ☐ Patient has active psoriatic arthritis for at least 6 months defined as:
  - ☐ > 3 swollen joints; **AND**
  - ☐ > 3 tender joints; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) with the following:
  - ☐ One or more non-steroidal anti-inflammatory drugs – NSAIDs (trial at maximum dose for at least 2-3 weeks before considering them as failures); **AND**
  - ☐ One or more non-biologic disease modifying anti-rheumatic drugs DMARDs (i.e., methotrexate, sulfasalazine, leflunomide, cyclosporine); **AND**
  - ☐ Patient has had an inadequate response, intolerance, or has contraindications to Humira®

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SIMPONI® (GOLIMUMAB) (CONTINUED)

ULCERATIVE COLITIS

- ☐ Patient has a documented diagnosis of moderately to severely active ulcerative colitis (UC); **AND**
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient has demonstrated corticosteroid dependence; **OR**
- ☐ Patient has had an inadequate response (clinical documentation must be submitted demonstrating response to previous therapies) or failed to tolerate oral mesalamine, oral corticosteroids (i.e., prednisone, dexamethasone, methylprednisolone), cyclosporine, azathioprine or 6-mecaptopurine (6-MTP); **AND**
- ☐ Patient has had an inadequate response, intolerance, or has contraindications to Humira®

DOSING AND ADMINISTRATION

Rheumatoid arthritis:

- ☐ 50 mg administered by subcutaneous injection once a month; use with methotrexate

Ankylosing Spondylitis/ Psoriatic arthritis:

- ☐ 50 mg administered by subcutaneous injection once a month

Ulcerative colitis:

- ☐ 200mg administered by subcutaneous initially; followed by 100 mg at 2 weeks; then maintenance dosing of 100 mg every 4 weeks

Dosage forms:

- ☐ 50 mg/0.5 mL in a single dose prefilled SmartJect® autoinjector
- ☐ 50 mg/0.5 mL in a single dose prefilled syringe

CONTINUATION OF THERAPY:

- ☐ Documentation showing current patients are stable (have low disease activity or are in clinical remission) will be taken into consideration during the prior authorization review process regarding continuation of therapy with the same agent.

SIRTURO® (BEDAQUILINE)

Length of Authorization:	24 weeks
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA *(ALL OF THE FOLLOWING MUST BE MET)*:

- ☐ Patient must be ≥18 years old
- ☐ Patient must have a diagnosis of multidrug-resistant tuberculosis (MDR-TB); resistant to at least isoniazid and rifampin
- ☐ Bedaquiline must be used in combination with ≥ 3 drugs to which the organism is susceptible or ≥ 4 drugs to which it is likely to be susceptible if test results are unavailable

SKELETAL MUSCLE RELAXANTS (SMR)

Length of Authorization:	Up to 1 year for PDL
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN) MAP: Error Code 7007 Override (76 / 7007 – GSN; 76 / 2641 – GSN) [see next page]

PDL EDIT

1. Is there any reason the Patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - ☐ Allergy to preferred medications
   - ☐ Contraindication to or drug-to-drug interaction with preferred medications
   - ☐ History of unacceptable/toxic side effects to medications not requiring prior approval
   - ☐ Physicians requesting brand product due to allergy or intolerance to generic must provide supporting medical documentation and "Multi-source Brand" Prior Authorization Form.
2. Has there been a failure to respond to a therapeutic trial of all preferred medications? Document details.
3. Baclofen and Zanaflex duration limitation is dependent upon the diagnosis; please review the logic on the Automated Prior Authorizations criteria on the next page.

ACUTE CONDITIONS

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

PDL PREFERRED – NO PA REQUIRED	PDL NON-PREFERRED – PA REQUIRED
Chlorzoxazone (generic for Parafon Forte®) Tab	Amrix® (extended release cyclobenzaprine) Cap
Cyclobenzaprine (generic for Flexeril®) Tab	Cyclobenzaprine (generic for Flexeril®) 7.5mg Tab
Methocarbamol (generic for Robaxin®) Tab	Dantrium® (dantrolene sodium)
	Dantrolene Sodium (generic for Dantrium®)
	Fexmid® (extended release cyclobenzaprine capsules)
	Lorzone® (chlorzoxazone) Tab
	Methocarbamol (generic for Robaxin®) Vial
	Orphenadrine/orphenadrine compd. (generic for Norflex®)
	Parafon Forte® (chlorzoxazone) Tab
	Robaxin® (methocarbamol) Tab
	Skelaxin® (metaxalone)
	Tizanidine (generic for Zanaflex®) Cap
	Zanaflex® (tizanidine) Tad, Cap
SMR DURATION EDIT *(see next page)*	
Baclofen (generic for Lioresal®) Tab	
Tizanidine (generic for Zanaflex®) Tab	

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DURATION EDIT SMR (SKELETAL MUSCLE RELAXANTS) AND ZANAFLEX® (TIZANIDINE) & BACLOFEN DURATION OF THERAPY BYPASS

Length of Authorization:	Up to 1 year
Initiative:	MAP: Error Code 7007 Override (76 / 7007 – GSN; 76 / 2641 – GSN) **(Please double check 7007 denials to see if the request should be evaluated based on other specific criteria.)**

SKELETAL MUSCLE RELAXANTS (SMR) LIST

Maximum of six fills per rolling 365 days across ALL listed SMRs when the Route of Admin = oral AND the days' supply ≥ 30. Claims for non-oral and/or for days' supply < 30 will NOT count towards the six fills.

Generic Name	Brand Name	Drug Code
Baclofen*	N/A	HICL = 001949
Chlorzoxazone	Lorzone	HICL = 001941
Cyclobenzaprine	Flexeril/Amrix/Fexmid	HICL = 001950
Orphenadrine	N/A	HICL = 001906
Metaxalone	Skelaxin	HICL = 001945
Methocarbamol	Robaxin	HICL = 001938
Tizanidine*	Zanaflex	HICL = 011582

*Products in HICL 001949 (Baclofen) or HICL 011582 (Zanaflex) that have a diagnosis listed (see Auto PA coding chart on the next page for qualifying diagnoses) that is found in history within the past 730 days will bypass the Duration Edit. Forward all requests, excluding Baclofen and Tizanidine HICLs, to a pharmacist for review and denial.

ZANAFLEX® (TIZANIDINE) AND BACLOFEN DURATION OF THERAPY BYPASS

- ☐ Requests for these two HICLs where a qualifying diagnosis is found in the Auto PA coding chart on the next page: This edit excludes members taking Baclofen or Tizanidine and that have a qualifying diagnosis (see Auto PA coding chart on the next page for qualifying diagnoses) which may warrant chronic utilization. Other meds in this group will deny for this duration of therapy edit if the member has received paid claims for 6 or more fills of at least a 30 days' supply each and at a rate of at least every 40 days ACROSS ALL HICLs listed above. The intent is to identify therapy of 6 or more fills of a month's supply over at least 6 consecutive months. Forward all requests, excluding Baclofen and Tizanidine HICLs to a pharmacist for review and denial.
- ☐ Requests for these two HICLs where a qualifying diagnosis is not found in history but is provided by the requesting prescriber's office, may be approved for up to one year: CPhTs are to enter these approvals.
- ☐ Requests for these two HICLs where a qualifying diagnosis is not found in history or is not provided: Forward to a pharmacist for review and an administrative denial.
  - ☐ **Denial PA Reason Code:** *RPh or MD: Admin Denial: Exceeds Quantity*
  - ☐ **Clinical Rationale:** *Your plan covers up to 6 fills for a 30 days' supply or more per 365 days.*

CHRONIC CONDITIONS (see list on the next page for ICD-10 codes	ACUTE CONDITIONS
Multiple Sclerosis	Muscle spasm associated with acute painful musculoskeletal conditions (ex. Generalized back, neck, or shoulder pain and muscle spasms attributed to trauma)
Spasticity	
Cerebral Palsy	
Muscle rigidity as a result of spinal cord/brain injury or disease	

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SKELETAL MUSCLE RELAXANTS (CONTINUED)

SMR List Approvable ICD 10 CM Codes For ONLY Tizanidine and Baclofen for the Duration of Therapy Edit. No Other SMRs Qualify.				
Generic Name	**Brand Name**	**Drug Code**	**Description**	**ICD -10 CM Code**
Baclofen	N/A	HICL = 001949	Hereditary Ataxia:	ICD 10 Disease Group: G11, ICD 10: G32.81
Tizanidine	Zanaflex	HICL = 011582	Motor Neuron disease: Other spinal muscle atrophies and related syndromes	ICD 10: G12.20, G12.21, G12.22, G12.29, G12.8
			Hemiplegia and hemiparesis following unspecified cerebrovascular disease	ICD 10: I69.053, I69.051, I69.052 I69.053,I69.054, I69.059, I69.151, I69.152,I69.153, I69.154, I69.159, I69.251, I69.252, I69.253, I69.254, I69.259, I69.351, I69.352, I69.353, I69.354, I69.359, I69.851, I69.852, I69.853, I69.854, I69.859, I69.951, I69.952, I69.953, I69.954, I69.959
			Monoplegia of upper limb following unspecified cerebrovascular disease	ICD 10: I69.031, I69.032, I69.033, I69.034, I69.039, I69.131, I69.132, I69.133, I69.134, I69.139, I69.231, I69.232, I69.233, I69.234, I69.239, I69.331, I69.332, I69.333, I69.334, I69.339, I69.831, I69.832, I69.833, I69.834, I69.839, I69.931, I69.932, I69.933, I69.934, I69.939
			Monoplegia of lower limb following unspecified cerebrovascular disease	ICD 10: I69.041 I69.042,I69.043, I69.044, I69.049, I69.141,I69.142, I69.143, I69.144, I69.149, I69.241, I69.242, I69.243, I69.244, I69.249, I69.341, I69.342, I69.343,I69.344, I69.349,I69.841, I69.842, I69.843, I69.844, I69.849, I69.949, I69.941, I69.942, I69.943, I69.944, I69.949
			Other paralytic syndrome following unspecified cerebrovascular disease	ICD 10: I69.061, I69.062, I69.063, I69.064, I69.065, I69.069, I69.161, I69.162, I69.163, I69.164 ,I69.165 I69.169, I69.261, I69.262, I69.263, I69.264, I69.265, I69.269, I69.361, I69.362, I69.363, I69.364, I69.365, I69.369, I69.861, I69.862, I69.863, I69.864,I64.865, I69.869, I69.961, I69.962, I69.963, I69.964, I69.965, I69.969
			Unspecified sequelae of unspecified cerebrovascular disease	ICD 10: I69.00, I69.10, I69.20, I69.30, I69.80, I69.90
			Multiple sclerosis	ICD 10: G35
			Other demyelinating diseases of central nervous system	ICD 10 Disease Groups: G36, G37
			Hemiplegia/Hemiparesis	ICD 10 Disease Group: G81
			Cerebral Palsy	ICD 10 Disease Group: G80
			Tetany	ICD 10: R29.0
			Spinal Cord Injury without evidence of spinal bone injury	ICD 10: S14.101A, S14.102A, S14.103A, S14.104A, S14.105A, S14.106A, S14.107A, S14.108A, S14.109A, S14.111A, S14.112A, S14.113A, S14.114A, S14.115A, S14.116A, S14.117A, S14.118A, S14.119A, S14.121A, S14.122A, S14.123A, S14.124A, S14.125A, S14.126A, S14.127A, S14.128A, S14.129A, S14.131A, S14.132A, S14.133A, S14.134A, S14.135A, S14.136A, S14.137A, S14.138A, S14.139A, S14.141A, S14.142A, S14.143A, S14.144A, S14.145A, S14.146A, S14.147A, S14.148A, S14.149A, S14.0XXA, S14.151A, S14.152A, S14.153A, S14.154A, S14.155A , S14.156A, S14.157A, S14.158A, S14.159A, S24.101A, S24.102A, S24.103A, S24.104A, S24.109A, S24.111A, S24.112A, S24.113A, S24.114A, S24. 119A, S24.131A, S24.132A, S24.133A, S24.134A, S24.139A, S24.141A, S24.142A, S24.143A, S24.144A, S24.149A, S24.151A, S24.152A, S24.153A, S24.154A, S24.159A, S24.0XXA, S34.01XA, S34.101A, S34.102A, S34.103A, S34.104A, S34.105A, S34.109A, S34.111A, S34.112A, S34.113A, S34.114A, S34.115A, S34.119A, S34.121A, S34.122A, S34.123A, S34.124A, S34.125A, S34.129A, S34.131A, S34.132A, S34.139A, S34.02XA, S34.3XXA

SOMA® (CARISOPRODOL)/SOMA COMPOUND®

Length of Authorization:	**Enter approval as: date range = 365 days; quantity = 120 & days' supply = 30 (this establishes a max per day rate = 4 using the 76 / 2641)**
Initiative:	MAP: Carisoprodol (75 / 2462 – GSN; 76 / 2641 – GSN)
Fax Form:	Soma

APPROVAL CRITERIA

New Prescriptions

- ☐ Recipients must have failed at least two other skeletal muscle relaxants in the past 365 days. Covered Skeletal Muscle relaxants include (but may not be limited to):
  - ☐ Baclofen 10mg and 20mg tablets
  - ☐ Chlorzoxazone 500 mg tablet
  - ☐ Cyclobenzaprine 5mg and 10mg tablets
  - ☐ Methocarbamol 500mg and 750mg tablets
  - ☐ Tizanidine 2mg and 4mg tablets
- ☐ Limit approval to one-month supply (120 tablets) during a 365-day period.

Current prescriptions (Received medication within past 60 days)

- ☐ Approve a one-month supply (120 tablets) to allow tapering.
- ☐ Optional tapering includes a four or nine day tapering protocol.

DENIAL CRITERIA

New Prescriptions

- ☐ Deny if Recipient has a trial of one or no covered skeletal muscle relaxants.
- ☐ Deny if Recipient has received more than a 30-day supply (120 tablets) in the past 365 days.

Current Prescriptions

- ☐ Deny request for more than a 30-day supply (120 tablets)

SOLIRIS® (ECULIZUMAB)

Length of Authorization:	Up to 1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

1. Supporting documentation indicating a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) or atypical hemolytic uremic syndrome (aHUS).
   - ☐ Supporting documentation are diagnosis codes in claims medical history, progress notes, and/or discharge notes
2. The prescribing physician must be a hematologist.
3. Patient must have been vaccinated against meningococcal infection (*Neisseria meningitidis)*. If Patient has not been previously vaccinated, then the patient must receive a meningococcal vaccination at least 2 weeks prior to first dose of Soliris®.
   - ☐ Verify vaccination via CPT codes in medical claims history, physician progress notes, or vaccination records. Document verification source in clinical notes.

SOVALDI® (SOFOSBUVIR)

Length of Authorization:	12 Weeks, 24 Weeks, or 48 Weeks
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)
Fax Form:	Hepatitis C Agents **[REQUIRED]**

FOR GENOTYPE 1 NEW THERAPY REQUESTS, RESUBMIT FOR PREFERRED VIEKIRA PAK [EXCEPT THOSE WITH DECOMPENSATED CIRRHOSIS (CHILD PUGH B/C], FOR GENOTYPE 3 REQUESTS, RESUBMIT FOR PREFERRED DAKLINZA, AND FOR GENOTYPE 4 REQUESTS, RESUBMIT FOR PREFERRED TECHNIVIE

MCC-FL ONLY: All Sovaldi® requests must be reviewed by the Plan for consideration of Zepatier® when Zepatier® would be a valid therapeutic option. MRx RPh staff will e-mail Moses Allen and Vanessa Zeilinger (MAllen22@magellanhealth.com; VZeilinger@magellanhealth.com) to notify them whenever we have a Sovaldi® request in our FirstTrax℠ MCC -FL queue. They will review the request and provide feedback on the action that we should take in the progression of the PA request.

REVIEW CRITERIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

REVIEW CRITERIA

1. Adult patient age ≥ 18 years old; **AND**
2. Prescribed by or in consultation with a hepatologist, gastroenterologist, infectious disease specialist, or transplant physician; **AND**
3. Patient is sofosbuvir treatment naïve (no claims history or reference in medical records to previous trial and failure) [Refer to **Appendix G** for additional information when reviewing for previous therapy]; **AND**
4. One of the following:
   - ☐ Patient has abstained from the use of illicit drugs and alcohol for a minimum of one month as evidenced by negative urine or blood confirmation tests within the past 30 days, prior to initiation of therapy (results must be submitted with request);
     - ☐ If the test results submitted is positive the reviewer must review claims history or medical records to determine if medications are prescribed. If so, proceed to next step (#5).

   OR
   - ☐ Patient is receiving substance or alcohol abuse counseling services or seeing an addiction specialist as an adjunct to HCV treatment and it is documented in the medical records; **AND**
5. Baseline HCV RNA must be submitted with a collection date within the past three months. **Prescriber must submit lab documentation indicating HCV genotype and quantitative viral load**.
6. Patient meets the diagnosis criteria outlined in Dosing and Administration below; **AND**
7. Patient agreement to complete regimen is documented in medical records submitted; **AND**
8. Patient commits to the documented planned course of treatment including anticipated blood tests and visits, during and after treatment; **AND**
9. Female patients must have a negative pregnancy test collected within 30 days prior to the initiation of therapy. **OR** Medical records must be submitted documenting pregnancy status.
10. For HIV-1 co-infected patients, patients must have the following:
    - ☐ Documented HIV-1 diagnosis, **AND**
    - ☐ CD4 count greater than 500 cells/mm3, if patient is not taking antiretroviral therapy; **OR**
    - ☐ CD4 count greater than 200 cells/mm3, if patient is virologically suppressed (e.g., HIV RNA < 200 copies/mL)
11. No early refills will be allowed due to lost or stolen medications or vacation override.
12. Lab results (HCV RNA) are recommended after 4 weeks of therapy and at 12 weeks following completion of therapy. The medication should not be discontinued or interrupted if HCV RNA levels are not available during treatment or are not performed.

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SOVALDI® (SOFOSBUVIR) (CONTINUED)

HEPATITIS C AUTOPA CODING INFO

- The following medications are included in AutoPA coding list "Hepatitis Therapy List B."
  - Peginterferon alfa-2a (Pegasys®); Peginterferon alfa-2b (Peg-Intron®/Redipen); Ribavirin (Copegus®, Moderiba®, RibaPak®, Ribasphere®, Ribatab®, Rebetol®
- When these medications are used in combination therapy with medications included in AutoPA coding list "Hepatitis Therapy List A" no prior auth is required for medications in "Hepatitis Therapy List B" as long as the "Hepatitis Therapy List A" medication is billed first.
  - Harvoni®, Olysio®, Sovaldi®, and Viekira Pak®
- If the medication in "Hepatitis Therapy List A" is not billed first, then the following error messages will display:
  - IE 31003 – Automated PA; NCPDP 75 – Prior authorization required
  - Transaction Message: "Missing Prerequisite Drug Therapy"
- The Hepatitis C AutoPA coding logic is explained in greater detail here.

DOSING AND ADMINISTRATION

- Dose: 400 mg tablet once daily
- Specific scenarios follow on the next pages

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SOVALDI® (SOFOSBUVIR) (CONTINUED)

DIAGNOSIS: 1.☐ HCV 2.☐ HCV/HIV-1 Co-Infection	Genotype 1 or 4
TRIPLE THERAPY: SOVALDI + peg-interferon alfa + ribavirin	
Length of Authorization: ☐ 12 Weeks	
Documentation of concurrent (or planning to start) therapy with ribavirin and peg-interferon when starting SOVALDI for a 12-week duration	

DIAGNOSIS: 1.☐ HCV 2.☐ HCV/HIV-1 Co-Infection	Genotype 1 or 4 (Interferon *Ineligible*)
DUAL THERAPY: SOVALDI + ribavirin	
Length of Authorization: ☐ 24 Weeks	
☐ Documentation of concurrent (or planning to start) therapy with ribavirin when starting SOVALDI for a 24-week AND ☐ **Interferon Ineligible defined as one of the following:** ☐ Prior intolerance to interferon therapy (urticaria, angioedema, bronchoconstriction, anaphylaxis, or Stevens-Johnson syndrome) ☐ Autoimmune hepatitis and other autoimmune disorders (e.g., dermatomyositis, immune thrombocytopenic purpura, inflammatory bowel disease, interstitial lung disease, interstitial nephritis, polymyositis, psoriasis, rheumatoid arthritis, sarcoidosis, and systemic lupus erythematosus) ☐ Hypersensitivity to peginterferon alfa or any of its components ☐ Decompensated hepatic disease (defined as Child-Pugh score of >6 - Class B or C)- These cases require individual case reviews. ☐ Major uncontrolled depressive illness ☐ History of psychosis, schizophrenia, bipolar disorder, schizoaffective disorder or suicidal ideation ☐ A baseline neutrophil count below 1500/µL, a baseline platelet count below 90,000/µL or baseline hemoglobin below 10 g/dL ☐ A history of pre-existing cardiac disease ☐ Refractory diabetes mellitus ☐ Untreated thyroid disease	

DIAGNOSIS: 1.☐ HCV 2.☐ HCV/HIV-1 Co-Infection	Genotype 2
DUAL THERAPY: SOVALDI + ribavirin	
Length of Authorization: ☐ 12 Weeks	
☐ Documentation of concurrent (or planning to start) therapy with ribavirin when starting SOVALDI for a 12-week duration; AND Note: *Patients who are prior nonresponders and have cirrhosis (defined as METAVIR score of F4 or ISHAK score of 6) may benefit by extension of treatment to 16 weeks.*	

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SOVALDI® (SOFOSBUVIR) (CONTINUED)

DIAGNOSIS: 1. ☐ HCV 2. ☐ HCV/HIV-1 Co-Infection	Genotype 3
DUAL THERAPY: SOVALDI + ribavirin	
Length of Authorization: ☐ 24 Weeks	
☐ Documentation of concurrent (or planning to start) therapy with ribavirin when starting SOVALDI for a 24-week duration	

DIAGNOSIS: ☐ HCV	Genotypes 1, 2, 3, or 4 – Diagnosis of Hepatocellular Carcinoma Awaiting Liver Transplantation
DUAL THERAPY: SOVALDI + ribavirin	
Length of Authorization: ☐ 48 Weeks	
☐ Documentation of concurrent (or planning to start) therapy with ribavirin when starting SOVALDI for a 48-week duration or until the time of liver transplantation, whichever occurs first; **AND** ☐ **One of the following:** ☐ Prescribed by a hepatologist, gastroenterologist, or infectious disease specialist; **OR** ☐ Patient is being managed in a liver transplant center; **AND** ☐ Documentation of hepatocellular carcinoma; **AND** ☐ Patient meets Milan criteria and awaiting liver transplantation; **Milan criteria defined as:** ☐ Presence of a tumor 5 cm or less in diameter in subjects with single hepatocellular carcinoma; **AND** ☐ No more than three tumor nodules, each 3 cm or less in diameter, in subjects with multiple tumors; **AND** ☐ No extrahepatic manifestations of the cancer and no evidence of vascular invasion of the tumor	

DIAGNOSIS: 1. ☐ HCV	Genotype 1 (without cirrhosis)
DUAL THERAPY: SOVALDI + OLYSIO	
Length of Authorization: ☐ Weeks 12	
☐ Documentation of concurrent (or planning to start) therapy with Olysio when starting SOVALDI for a 12-week duration	

DIAGNOSIS: 1. ☐ HCV	Genotype 1 (with cirrhosis)
DUAL THERAPY: SOVALDI + OLYSIO	
Length of Authorization: ☐ 24 Weeks	
☐ Documentation of concurrent (or planning to start) therapy with Olysio when starting SOVALDI for a 24-week duration	

DENIAL CRITERIA

DIAGNOSIS: 1. HCV	Genotype 5 or 6
THERAPY REFERRAL: Other Hepatitis C Agents	
☐ Insufficient data to recommend use in patients with HCV genotypes 5 or 6	

STELARA® (USTEKINUMAB)

Length of Authorization:	2 months PA quantity, day supply for initiation of therapy: ☐ If dose is for 90 mg – Quantity is 1.1 and day supply is 30 ☐ If dose is for 45 mg – Quantity is 0.54 (may round up to the tenth place – 0.6) and day supply is 30
Initiative:	MAP: Stelara (75 / 2462 – GSN; 76 / 2641 – GSN)

REVIEW CRITERIA

PLAQUE PSORIASIS

- ☐ Patient must be 18 years of age or older; **AND**
- ☐ Patient has documented diagnosis of moderate to severe plaque psoriasis for at least 6 months with at least one of the following:
  - ☐ Incapacitation due to plaque location (e.g., head and neck, palms, soles, or genitalia); **OR**
  - ☐ Involvement of at least 10 percent of body surface area (BSA); **OR**
  - ☐ Psoriasis Area and Severity Index (PASI) score of 12 or greater; **AND**
- ☐ Patient is free of any clinically important active infections; **AND**
- ☐ Patient has a negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient did not respond adequately (or is not a candidate) to a 3-month minimum trial of at least 1 systemic agent (e.g., immunosuppressives, retinoic acid derivatives, and/or methotrexate); **AND**
- ☐ Patient did not respond adequately (or is not a candidate) to a 3 month minimum trial of phototherapy (e.g., Psoralens with UVA light (PUVA) OR UVB with coal tar or dithranol; **AND**
- ☐ Patient has had a 3 month minimum trial and failure (inadequate response or intolerance), to both Humira® and Enbrel®

PSORIATIC ARTHRITIS

- ☐ Patient must be 18 years of age or older; **AND**
- ☐ Patient has a documented diagnosis of psoriatic arthritis; **AND**
- ☐ A negative tuberculin test (TB) prior to initiating therapy and results have been provided; **AND**
- ☐ Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response previous therapies) with the following:
  - ☐ One or more non-steroidal anti-inflammatory drugs –NSAIDs (trail at maximum dose for at least 2–3 weeks before considering them as failures); **AND**
  - ☐ One or more non-biologic disease modifying anti-rheumatic drugs DMARDs (i.e., methotrexate, sulfasalazine, leflunomide, cyclosporine); **AND**
  - ☐ Patient has had an inadequate response, intolerance, or has contraindications to both: Humira®and Enbrel®

DOSING

Plaque Psoriasis:

- ☐ *Adults > 100 kg:* Initially, 90 mg SC; repeat dose 4 weeks later. Then, give 90 mg SC every 12 weeks starting at week 16.
- ☐ *Adults <= 100 kg:* Initially, 45 mg SC; repeat dose 4 weeks later. Then, give 45 mg SC every 12 weeks starting at week 16.

Psoriatic Arthritis:

- ☐ 45 mg SC; repeat dose 4 weeks later. Then, give 45 mg SC every 12 weeks starting at week 16

Patients with co-existent Psoriatic Arthritis AND Plaque Psoriasis > 100 kg:

- ☐ 90 mg SC; repeat dose 4 weeks later. Then, give 90 mg SC every 12 weeks starting at week 16

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STELARA® (USTEKINUMAB) (CONTINUED)

WARNINGS AND PRECAUTIONS

- Infections: Serious infections have occurred. Do not start STELARA during any clinically important active infection. If a serious infection develops, stop STELARA until the infection resolves.
- Tuberculosis (TB) evaluation: Evaluate patients for TB prior to initiating treatment with STELARA. Initiate treatment of latent TB before administering STELARA
- Prior to initiating therapy with Stelara, patients should receive all immunizations recommended by current guidelines. Patients being treated with Stelara should not receive live vaccines. BCG vaccines (for tuberculosis) should not be given during treatment or within one year of initiating or discontinuing Stelara.

AUTO PA STEP EDITS (STELARA)

Stelara Automated PA approval satisfies Non-PDL edit	**Stelara 45 mg/0.5 ml (GSNs 064967 and 065993)** **Step 1:** Look back 120 days in pharmacy claims history for 2 or more occurrences of Stelara 45 mg/0.5 ml (may be different GSN). If found, approved. If not found, go to Step 2. **Step 2:** Look back 90 days in pharmacy claims history for 1 or more occurrences of Stelara 45 mg/0.5 ml (may be different GSN). If found, approved. If not found, deny for NCPDP 75. **Stelara 90mg/ml (GSN 065994)** **Step 1:** Look back 120 days in pharmacy claims history for 2 or more occurrences of Stelara 90 mg/ml. If found, approved. If not found, go to Step 2. **Step 2:** Look back 90 days in pharmacy claims history for 1 or more occurrences of Stelara 90 mg/ml. If found, approved. If not found, deny for NCPDP 75. **Quantity Limitations:** Stelara 45mg/0.5ml: 0.5 units every 77 days Stelara 90mg/ml: 1 unit every 77 days

STEROIDS – INHALED

Length of Authorization:	Up to one year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN) MAP: Quantity Limits: IE 7001 (76 / 7001 – GSN) MAP: Age Limit Under Minimum (60 / 2193 – GSN; 76 / 2641 – GSN; 60 / 2623 – GSN)

1. Is there any reason that the Patient cannot be switched to preferred medications? Acceptable reasons include
   - ☐ Allergy to the preferred medications in this class
   - ☐ Contraindication or drug-to-drug interaction with the preferred medications in this class
   - ☐ History of a serious reaction (e.g., angioedema, bronchospasms, etc.) to preferred medications
   - ☐ History of the Patient being at risk clinically – (e.g., at least two hospitalizations or ER visits for asthma in 30 days) despite compliance and combination therapy with long-acting beta agonists (e.g., Serevent and Foradil)
2. Did the Patient fail a therapeutic trial of **TWO** preferred medications?

PDL CHARTS

PDL Charts are on the following page.

MONOTHERAPY EDIT (ADDED DECEMBER 9, 2015)

- ☐ Intent: Allow monotherapy of all inhaled corticosteroids (ICS) of one fill per 26 days. Deny any duplicate ICS as duplicate therapy NCPDP = 76 and DUR = 88 with a Transaction Message "Duplicate therapy"; "Max allowed = 1 inh/30 days"
- ☐ Drug Code: GSNs: 19317, 19318, 19319, 21251, 21253, 21483, 46698, 46699, 51649, 58671, 58672, 59326, 59327, 59328, 62240, 62241, 64010, 64012, 71756, 72722, 72723.
- ☐ Drug Names: Inhaled corticosteroids: Flovent, Flovent HFA, QVAR, Asmanex, Alvesco, Pulmicort, Aerospan, Arnuity Ellipta
- ☐ Brand/Generic: Both
- ☐ NCPDP Error Code(s): 76, 88
- ☐ Supplemental Error Code Message: Return messages: "Duplicate therapy"; "Max allowed=1 inh/30days"
- ☐ Limitation: Age >/= 18 years = Max of 1 fill/26 days of one unique ICS
- ☐ AutoPA Coding:
  - ☐ **Step 1:** If the incoming claim is for a drug from the <Inhaled Corticosteroids List> and patient age >/= 18, go to Step 2. If not, Stop.
  - ☐ **Step 2:** Does recipient have history of >/= 1 fills of another drug from the < Inhaled Corticosteroids List > (excluding incoming HICL) within the past 26 days? If yes, deny NCPDP EC 76-Plan limitations exceeded. If no, claim falls out of the auto-PA process and continues on through adjudication.
- ☐ NOTE: The difference between the messaging and the coding is for the tolerance for a next fill/refill.
- ☐ MONOTHERAPY REVIEW CRITERIA: Clinical pharmacist professional judgment.

CONTINUED ON NEXT PAGE

INHALED GLUCOCORTICOIDS: ORAL

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Asmanex® Twisthaler (*mometasone*) [Min age = 4y/o]	Alvesco® (*ciclesonide*) [Min age = 5y/o]
Flovent® HFA (*fluticasone*) [Min age = 0y/o]	Asmanex® HFA (*mometasone*) [Min age = 12y/o]
Flovent® Diskus (*fluticasone*) [Min age = 4y/o]	Budesonide respules (generic for Pulmicort®)
QVAR® (*beclomethasone*) [33.6/27] [Min age = 5y/o]	Flunisolide (generic for Aerospan® HFA) [Min age = 5y/o]
Pulmicort® Respules* (*budesonide*) Preferred for patients under the age of 11. (See specific criteria below)	Pulmicort® Flexhaler (*budesonide*) [1/27] [Min age = 5y/o]

GLUCOCORTICOIDS AND LONG-ACTING BETA$_2$ ADRENERGIC AGENTS

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Advair Diskus® (*salmeterol/fluticasone*) [Min age = 4y/o]	Breo Ellipta® (fluticasone/vilanterol)
Advair HFA® (*salmeterol/fluticasone*) [Min age = 5y/o]	
Dulera® (*mometasone/formoterol*) [Min age = 12 y/o]	
Symbicort® (*formoterol/fluticasone*) [1/30 w/10% tolerance] [Min age = 5y/o]	

[#/X] = quantity limit per X days

Pulmicort• – Pregnancy Category B – if requested because the Patient is pregnant, may approve for the duration of the pregnancy. Refer to criteria on next page for consideration of recipients > 8 years of age (have turned 9 yrs old).

PULMICORT® RESPULES (BUDESONIDE) NEBULIZER SUSPENSION FOR INHALATION

Length of Authorization:	1 year
Initiative:	MAP: Age Limit Over Maximum (60 / 2194 – GSN; 60 / 2624 – GSN; 76 / 2641 – GSN)

REVIEW CRITERIA

- ☐ No PA is required if under the age of 11 years old.
- ☐ For the treatment of:
  - ☐ Asthma
  - ☐ Bronchospasm prophylaxis
  - ☐ Chronic Obstructive Pulmonary Disease
  - ☐ Cystic Fibrosis
- ☐ History of difficulty or inability to manipulate a hand held device or a medical condition that is characterized by the difficulty or inability to manipulate a hand held device (e.g., cerebral palsy, mental retardation, multiple sclerosis, etc.)

DOSING

4ml (or 2 vials) per day.

STEROIDS – TOPICAL

Length of Authorization:	For the duration of the prescription up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason the Patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include
   - ☐ Allergy to at least two unrelated medications not requiring prior approval
   - ☐ Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - ☐ History of unacceptable/toxic side effects to medications not requiring prior approval
2. Did the Patient fail a therapeutic trial of ***30 days*** with **TWO** preferred medications **AND** one of these was the requested medication's corresponding generic (if a generic is available and preferred)? If so, document and allow the prior authorization
3. For diagnoses of psoriasis, immunocompromised patients, or eczema with no improvement after ***14 days*** with a preferred medication, document and allow the non-preferred medication for a maximum of ***30 days***.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. Was the Patient started on a non-preferred medication in the hospital? If so, approve the medication.
2. Does the Patient have a specific clinical condition that only a non-preferred medication is approved to treat? If so, document and allow the authorization.

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STEROIDS – TOPICAL (CONTINUED)

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Alclometasone dipropionate (generic for Aclovate®) ointment	Alclometasone dipropionate (generic for Aclovate®) cream
Calcipotriene (generic for Dovonex® cream)	Betamethasone dipropionate (augmented) (generic for Diprolene AF®) cream
Fluocinolone (generic for Capex)	Betamethasone dipropionate cream/lotion (generic for Diprolene)
Fluticasone cream (generic for Cutivate)	Betamethasone dipropionate ointment
Halobetasol (generic for Ultravate) cream	Capex® shampoo
Halobetasol (generic for Ultravate) ointment	Dermatop® (*prednicarbate*)
Hydrocortisone (generic for Hytone)	Desonate® (*desonide*)
Hydrocortisone acetate gel	Desonide cream/lotion/ointment
Hydrocortisone valerate (generic for Westcort)	DesOwen® (*desonide*)
Mometasone furoate (generic for Elocon)	Desoximetasone (generic for Topicort)
Triamcinolone	Diflorasone diac (generic for Psorcon) cream, oint
	Diprolene (*betamethasone dipropionate*)
	Dovonex cream & solution (Calcipotriene)
	Elocon® (*mometasone*)
	Fluocinonide cream/ointment
	Fluticasone (generic for Cutivate®) lotion/ointment
	Halog (*halcinonide*)
	Hydrocortisone lotion/ointment
	Hydrocortisone butyrate (generic for Locoid)
	Kenalog (*triamcinolone*)
	Locoid (*hydrocortisone butyrate*)
	Luxiq (*betamethasone valerate*)
	Olux (*clobetasol*)
	Pandel (*hydrocortisone probutate*)
	Prednicarbate (*generic Derma-top*) cream/oint
	Temovate® (all forms) (*clobetasol*)
	Triamcinolone acetonide lotion
	Topicort (*desoximetasone*)
	U-Cort (*hydrocortisone*)
	Ultravate cream/oint (*halobetasol*)
	Vanos® Cream (*fluocinonide*)
	Verdeso (*desonide*)
	Westcort® (*hydrocortisone valerate*)

STIVARGA® (REGORAFENIB)

Length of Authorization:	Up to 6 months
Initiative:	MAP: Oral Oncology Non-PDL (75 / 2462 – GSN)
Specific PA Form Required:	**"Oral Oncology Agents" PA form**

REVIEW CRITERIA

- ☐ Metastatic Colorectal Cancer
  - ☐ Must have a diagnosis of metastatic colorectal cancer.
  - ☐ Patient must have been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy, and anti-VEGF therapy (ex. Bevacizumab (Avastatin), panitumumab (Vectibix), and if KRAS wild type, an anti-EGFR therapy (e.g., cetuximab (Erbitux).
- ☐ Gastrointestinal Stromal Tumor
  - ☐ Must have a diagnosis of unresectable or metastatic gastrointestinal stromal tumor.
  - ☐ Patient must have a trial of imatinib mesylate (Gleevec) and sunitinib (Sutent) malate.

SUMMARY OF DRUG LIMITATIONS

- SEE APPENDICES A (MCC-FL) AND B (CCP/SFCCN) FOR ADDITIONAL QUANTITY, AGE, AND SIMILAR LIMITATIONS (PER EACH PLAN'S CSA DOCUMENT). UNTIL EACH PLAN'S CODING MATCHES AHCA'S SUMMARY OF DRUG LIMITATIONS DOCUMENT, THE SUMMARY OF DRUG LIMITATIONS AND THE CSAs' LISTS WILL BE INCLUDED IN THIS DOCUMENT.
- Some Quantity Limits noted here are in terms of fractions of a tablet or capsule. These coded limits are intended to support a maximum dosage per day of the applicable med, particularly for pediatric dosing (e.g., Adderall XR 20mg 0.75/day for ages 0-5 years).

Length of Authorization:	Varies by edit
Initiative:	MAP: Quantity Limit: IE 2191 (76 / 2191 – GSN; 76 / 2641 - GSN) MAP: Quantity Limit: IE 2614 (76 / 2614 – GSN; 88 / HD – GSN) MAP: Quantity Limit: IE 2637 (76 / 2637 – GSN) MAP: Quantity Limit: IE 2641 (76 / 2641 – GSN) MAP: Quantity Limit: IE 7001 (76 / 7001 – GSN) * **(Please double check the 7001 denials to see if the request should be evaluated based on the Polypharmacy Edit for long-acting or short-acting narcotics.)** MAP: Quantity Limit: IE 7002 (75 / 7002 – GSN) **RPH REVIEW ONLY** MAP: Quantity Limit: IE 7003 (76 / 7003 – GSN; 76 / 2641 – GSN) MAP: Quantity Limit: IE 31027 (76 / 2641 – GSN; 76 /31027 – GSN) MAP: Age Limit Over Maximum (60 / 2194 – GSN; 76 / 2641 – GSN; 60 / 2624 – GSN) MAP: Age Limit Under Minimum (60 / 2193 – GSN; 76 / 2641 – GSN; 60 / 2623 – GSN) MAP: Error Code 7001 Override (76 / 7001) **(Please double check the 7001 denials to see if the request should be evaluated based on the Polypharmacy Edit for long-acting or short-acting narcotics.)** MAP: Error Code 7007 Override (76 / 7007 – GSN; 76 / 2641 – GSN) **(Please double check 7007 denials to see if the request should be evaluated based on more specific criteria.)**

*If a drug is coded as R-Non-PDL AND if it has a rolling quantity limit (IE = 7001) then we will not see a rejection/denial for the 7001/76 error combination until there is a PA in place for the 2462/75.

- If a drug has a State Prior Auth Code Formulary indicator "R-Non PDL" [Non-Preferred drugs: Formulary Indicator = R] and the pharmacy submits the claim with a Prior Auth Type Code "1" and for a quantity greater than a 5 days' supply the claim will deny at point of sale. These claims will display "5 Maximum Days Exceeded" in the Supplemental transaction Message field. If the claim is not for an emergency supply, the pharmacy should not be submitting with a Prior Auth Type Code "1." Have the pharmacy remove the "1" and resubmit the claim. All other edits will still apply.
- **Technicians:** Escalate all requests for quantity limitation override requests to a pharmacist.
- **Pharmacists:** Please use your clinical judgment when handling these requests. Approval should be granted on the basis of therapeutic appropriateness for the diagnosis submitted. It may be necessary to request that the physician submit clinical documentation (i.e. clinical literature/journal articles, clinical trial results, etc.) to substantiate their request. You must explain in detail the rationale used in making your final determination

NOTES

- All limitations are applicable to Brand and Generic formulations
- Separate quantity limits for Xanax, Ativan, and Diazepam tablets
- Accumulation edits are not necessarily included by AHCA in the Summary of Drug Limitations. Be sure to check elsewhere in these criteria for specific medications.

Some medications listed include quantity limits for ages under the stated minimum age given so that that if a request is received for a psychotropic med for a pt below the age limit, the reviewer can confirm whether the request must be escalated to USF for child psychiatry review or if the request can be handled here as long as the max dose/day limitation has not been exceeded.

CONTINUED ON NEXT PAGE

SUMMARY OF DRUG LIMITATIONS (CONTINUED)

Medications listed in this document may or may not require a prior authorization. Please view the Preferred Drug List at: http://ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml

Summary of Drug Limitations (07/31/2016)	
Abilify (aripiprazole) 2mg, 5mg tablets	Minimum age = 6; Maximum of 2 tablets per day for ages = 6 – 17 Maximum of 1 tablet per day for ages =/> 18
Abilify (aripiprazole) 10mg, 15mg tablets (including Discmelt)	Minimum age = 6; Maximum of 15mg per day for ages = 6 – 11; Maximum of 30mg per day for ages = 12-17 Maximum of 1 tablet per day for ages =/> 18
Abilify (aripiprazole) 20mg, 30mg tablets	Minimum age = 6; Maximum of 1 tablet per days for ages =/> 18;
Abilify (aripiprazole) 1mg/ml solution	Minimum age = 6; Maximum of 15ml per day for ages = 6 – 11; Maximum of 30ml per day for ages = 12-17; Maximum of 30ml per day for ages =/>18
Abilify Maintena (aripiprazole) syringe/vial	Minimum age = 18; Maximum of 1 syringe or vial every 25 days
Abilify 9.7mg/1.3ml vial (aripiprazole)	Minimum age = 18; Maximum of 4.02ml per day for ages =/> 18
Abstral (fentanyl citrate) sublingual tablets	Minimum age = 18; Maximum of 4 units per day
Acanya (benzoyl peroxide/clindamycin)Gel, gel pump	Minimum Age= 12
Accolate (zafirlukast) tablets	Maximum of 3 tablets per day
Aciphex (rabeprazole) 5mg, 10mg sprinkle capsules	Minimum age = 1; Maximum age = 11; Maximum of 1 capsule per day
Aciphex (rabeprazole) 20mg tablets	Minimum age = 1; Maximum of 2 tablets per day
Actimmune (Interferon Gamma-1b)	Maximum of 6ml every 28days
Actiq (fentanyl citrate) Lozenges	Minimum age = 18; Maximum of 4 units per day
Actonel (risedronate) 30mg tablets	Maximum of 60 tablets every 120 days
Actonel (risedronate) Weekly	Maximum of 4 tablets every 28 days
Acyclovir oral suspension	Maximum age = 17
Aczone (dapsone) gel	Minimum Age= 12
Adderall (dextroamphetamine/amphetamine) 5mg, 7.5mg	Maximum of 2 tablets per day for ages 0-5 Maximum of 6 tablets per day for ages =/> 18
Adderall (dextroamphetamine/amphetamine) 10mg tablets	Maximum of 1 tablet per day for ages 0-5 Maximum of 6 tablets per day for ages =/> 18
Adderall (dextroamphetamine/amphetamine) 12.5mg, 15mg tablets	Maximum of 1 tablet per day for ages 0-5 Maximum of 4 tablets per day for ages =/> 18
Adderall (dextroamphetamine/amphetamine) 20mg tablets	Maximum of 0.75 tablets per day for ages 0-5 Maximum of 3 tablets per day for ages =/> 18
Adderall (dextroamphetamine/amphetamine) 30mg tablets	Maximum of 0.5 tablets per day for ages 0-5 Maximum of 2 tablets per day for ages =/> 18
Adderall XR (dextroamphetamine/amphetamine) 5mg, 10mg, 15mg capsules	Minimum age =6; Maximum of 1 capsule per day for ages 0-5 Maximum of 1 capsule per day for ages =/> 18
Adderall XR (dextroamphetamine/amphetamine) 20mg capsules	Minimum age =6; Maximum of 0.75 capsules per day for ages 0-5 Maximum of 2 capsules per day for ages =/> 18

Summary of Drug Limitations (07/31/2016)	
Adderall XR (dextroamphetamine/amphetamine) 25mg capsules	Minimum age =6; Maximum of 0.6 capsules per day for ages 0-5 Maximum of 2 capsules per day for ages =/> 18
Adderall XR (dextroamphetamine/amphetamine) 30mg capsules	Minimum age =6; Maximum of 0.5 capsules per day for ages 0-5 Maximum of 2 capsules per day for ages =/> 18
Adzenys (dextroamphetamine/amphetamine) XR-ODT tablets	Minimum age = 6
Advair (fluticasone and salmeterol) diskus, HFA inhaler	Minimum age = 4 (Diskus formulation) Minimum age = 5 (HFA formulation); Maximum of 1 inhaler per 30 days
Aerospan (flunisolide) HFA inhaler	Minimum age = 5
Afinitor (everolimus) 2.5mg, 5mg, 7.5mg , 10mg tablets	Minimum age = 1; Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Afinitor (everolimus) 2mg, 5mg disperz tablet for suspension	Minimum age = 1; Maximum of 2 tablets per day; Maximum of 60 tablets every 30 days
Afinitor (everolimus) 3mg disperz tablet for suspension	Minimum age = 1; Maximum of 3 tablets per day; Maximum of 90 tablets every 30 days.
Akne-Mycin (erythromycin) ointment	Minimum Age= 12
Albuterol HFA inhaler	Maximum of 2 inhalers every 30 days
Albuterol Nebulization (0.63mg/3ml, 1.25mg/3ml, and 2.5mg/3ml)	Maximum of 375ml every 30 days
Albuterol Nebulization (2.5mg/0.5ml)	Maximum of 120ml every 30 days
Albuterol Nebulizations (20ml bottle)	Maximum of 60ml every 30 days
Aldara (imiquimod)	Minimum age = 12; Maximum of 2 boxes per 16 weeks
Alecensa (alectinib) capsules	Minimum age = 18; Maximum of 8 capsules per day
Alkeran (melphalan) tablets	Minimum age = 18
Alora (estradiol) patches	Maximum of 8 patches per 30 days
Aloxi (palonosetron) 0.25mg/5 ml vial	Maximum of 40ml every 28 days
Alphagan P (brimonidine) drops	Maximum of 10ml every 30 days
Alpha-1 Proteinase Inhibitors (Aralast, Aralast NP, Glassia, Prolastin C, Zemaira)	Minimum age = 18
Alprazolam Intensol Solution	Maximum of 6ml per day
Altabax (retapamulin)ointment	Maximum of 15gm every 30 days; Maximum of 2 prescription fills per 60 days
Alvesco (ciclesonide) inhaler	Minimum age = 5
Amaryl (glimepiride) 4mg tablet	Maximum of 2 tablets per day
Ambien/Ambien CR (zolpidem) Tablets	Minimum age = 18
Amerge (naratriptan) tablets	Maximum of 9 tablets every 30 days; Minimum age = 18
Amitiza (lubiprostone) capsules	Minimum age 18; Maximum quantity per fill = 60 tablets
Amitriptyline tablets	Minimum age = 6
Amitriptyline/Chlordiazepoxide tablets	Minimum age = 6
Amoxapine tablets	Minimum age = 6
Anafranil (clomipramine) capsules	Minimum age = 6
Analgesic, narcotics	Maximum days supply = 30

Summary of Drug Limitations (07/31/2016)	
Androgel (testosterone) Transdermal packet, MD pump	Male gender only; Minimum age = 18
Antitussives-expectorants; Cough and Cold Preparations	Maximum age = 20; Maximum of 300ml per 30 days
Antitussive, non-narcotic	Maximum age = 20
Anzemet (dolasetron)50mg and 100mg tablet	Maximum of 8 tablets every 28 days
Anzemet (dolasetron) 12.5mg vial	Maximum of 5ml every 28 days
Anzemet (dolasetron) 20mg/ml vial	Maximum of 40ml every 28 days
Anxiolytic Benzodiazepines**	Maximum of 90 units every 30 days
Aplenzin (bupropion) ER tablets	Minimum age = 6
Aptensio XR (methylphenidate) 10mg, 15mg, 20mg capsules	Minimum age = 6; Maximum of 1 capsule per day for ages 0-5 Maximum of 1 capsule per day for ages >/= 18
Aptensio XR (methylphenidate) 30mg capsules	Minimum age = 6; Maximum of 0.833 capsules per day for ages 0-5 Maximum of 1 capsule per day for ages >/= 18
Aptensio XR (methylphenidate) 40mg capsules	Minimum age = 6; Maximum of 0.625 capsules per day for ages 0-5 Maximum of 1 capsule per day for ages >/= 18
Aptensio XR (methylphenidate) 50mg capsules	Minimum age = 6; Maximum of 0.50 capsules per day for ages 0-5 Maximum of 1 capsule per day for ages >/= 18
Aptensio XR (methylphenidate) 60mg capsules	Minimum age = 6; Maximum of 0.416 capsules per day for ages 0-5 Maximum of 1 capsule per day for ages >/= 18
Aptiom (eslicarbazepine acetate) tablets	Minimum age = 18
Aquadeks (vitamins) Pediatric Solution	Maximum age of 3 years; Maximum of 60mls every 30 days
Aquadeks (vitamins) Softgel & chewable tablets	Minimum age of 4 years; Maximum of 2 per day
Arcalyst (rilonacept) powder for injection	Minimum age = 12
Arcapta (indacaterol) Neohaler, Powder for inhalation	Minimum age = 18; Maximum of 1 fill per 30 days; Maximum of 30 units per fill
Aricept (donepezil)	Minimum age = 18
Arimidex (anastrozole) tablets	Minimum age = 18; Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Aristada (aripiprazole ER) syringe	Minimum age =18
Arnuity Ellipta (fluticasone furoate) inhaler	Minimum age = 12
Aromasin (exemestane) tablets	Minimum age = 18; Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Asmanex (mometasone) inhaler	Minimum age = 4 (Twisthaler formulation) Minimum age = 12 (HFA formulation) Maximum of 1 inhaler per 30 days
Ativan (lorazepam) 0.5mg, 1mg, 2mg tablets	Maximum of 5 tablets per day; Maximum of 150 tablets per 30 days
Ativan (lorazepam intensol)	Maximum of 5ml per day
Atralin (tretinoin) gel	Minimum Age= 10
Atrovent (ipratropium) HFA inhaler	Maximum of 25.8g (2 inhalers) every 30 days
Atrovent (ipratropium)Nasal Spray 0.03%	Maximum of 60ml every 30 days(2 bottles)
Atrovent (ipratropium) Nasal Spray 0.06%	Maximum of 30ml every 30 days(2 bottles)
Aubagio (teriflunomide) tablets	Minimum age = 18
Avinza (morphine sulfate ER) Capsules	Minimum age = 18; Maximum of 1 capsule per day

Summary of Drug Limitations (07/31/2016)	
	(Excluding recipients with a diagnosis of cancer or sickle cell)
Avita (tretinoin) cream, gel	Minimum Age= 12
Avonex (interferon beta-1a) 30mcg/0.5ml dispense syringe, injectable pen	Minimum age = 18; Maximum of 4ml every 28 days
Avonex (interferon beta-1a) 30mcg/0.5ml kit	Minimum age = 18; Maximum of 4 kits every 28 days
Axert (almotriptan) 6.25mg and 12.5mg tablets	Minimum age = 12; Maximum of 6 tablets every 30 days
Azasite drops (azithromycin)	Maximum of 2.5ml every 30 days
Azelex (azelaic acid) Cream	Minimum Age= 12
Baclofen intrathecal (Gablofen IT; Lioresal IT) solution for injection	Minimum age = 4; Maximum days = 120 days
Bactroban (mupirocin)cream	Maximum of 60g every 30 days
Bactroban (mupirocin) Nasal ointment	Maximum of 10g (1box) every 30 days
Bactroban (mupirocin) ointment	Maximum of 44g every 30 days
Banzel (rufinamide) Suspension, tablets	Minimum age = 1
Belbuca (buprenorphine) film	Minimum age = 16
Belsomra (suvorexant) tablets	Minimum age = 18
Benlysta (belimumab)	Minimum age = 16
Benzaclin(benzoyl peroxide /clindamycin) gel pump	Minimum Age= 12
Benzamycin (erythromycin/ benzoyl peroxide) gel	Minimum Age= 12
Benzoyl peroxide based combination acne products	Minimum Age= 12
Berinert kit/vial	Minimum age = 12; Maximum of 16 vials every 28 days
Blephamide (sulfacetamide/prednisolone) drops	Maximum of 10ml every 30 days
Blephamide (sulfacetamide/prednisolone) S.O.P. ointment	Maximum of 3.5g every 30 days
Boniva (ibandronate) 3mg injection	Maximum of 1 injection every 84 days
Bosulif (bosutinib) tablets	Minimum age = 18; Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Breo Ellipta (fluticasone/vilanterol)	Minimum age = 18
Trintellix (vortioxetine) tablets	Minimum age = 18; Maximum of 1 tablet per day
Brisdelle (paroxetine) capsules	Minimum age = 18
Brovana (arformoterol) Nebulizer Solution	Minimum age =18; Maximum of 1 fill every 30 days; Maximum of 120ml per fill
Bunavail (buprenorphine/naloxone) Film	Minimum age = 16; Maximum of 3 film per day
Buprenex (buprenorphine) ampule	Minimum age = 16
Buprenorphine sublingual tablets	Minimum age = 16; Maximum of 3 sublingual tablets per day
Buprenorphine-naloxone sublingual film/tablets	Minimum age = 16; Maximum of 3 sublingual film/tabs per day
Butalbital compounds	Maximum of 120 every 365 days
Butorphanol Tartrate Nasal Spray	Maximum of 2.5ml (1 canister) every 30 days
Butrans (buprenorphine) Transdermal Patch	Minimum age = 18; Maximum of 1 prescription per 28 days; Maximum quantity per fill = 1 box
Cabergoline Tablet	Maximum of 16 tablets every 30 days
Cabometyx (cabozantinib) 20mg, 40mg, and 60mg tablets	Minimum Age= 18 Maximum of 1 tablet per day

Summary of Drug Limitations (07/31/2016)	
	Maximum of 30 tablets every 30 days
Cafcit (caffeine citrate)	Maximum of 90ml every 30 days; Maximum age = 11 months
Cancidas (caspofungin) 50mg	Maximum of 13 vials every 28 days
Cancidas (caspofungin) 70mg	Maximum of 1 vial every 28 days
Caprelsa (vandetanib) 100mg tablets	Minimum age = 18; Maximum of 2 tablets per day; Maximum of 60 tablets every 30 days
Caprelsa (vandetanib) 300mg tablets	Minimum age = 18; Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Casodex (bicalutamide) tablets	Minimum age = 18; Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Catapres-TTS (clonidine) patches	Maximum of 8 patches every 30 days
Cathflo Activase (alteplase) Injection	Maximum of 2 vials per 28 days
Cayston (aztreonam) Powder for neb solution	Minimum age = 7; Maximum of 84 ml every 56 days
Ceenu (lomustine) capsules	Maximum of 6 capsules per fill; Maximum of 1 fill every 42 days
Cefepime 1g/50ml Piggy Back	Maximum of 1500 ml every 30 days
Cefepime 2 gm Piggy Back	Maximum of 3000 ml every 30 days
Cefprozil tablets	Maximum of 4 tablets per day
Cefprozil suspension 250mg/5ml	Maximum of 20ml per day
Ceftriaxone vials	Maximum of 2 vials per day
Celebrex (celecoxib) 50mg, 100mg, 200mg capsules	Maximum of 2 capsules per day
Celebrex (celecoxib) 400mg capsules	Maximum of 1 capsule per day
Celexa (citalopram) solution 10mg/5ml	Maximum of 30ml per day; Minimum age = 6; Maximum age = 11
Celexa (citalopram) tablets	Minimum age = 6; 10mg and 40mg: Maximum of 1 tablet per day 20mg : Maximum of 1.5 tablets per day
Cellcept (mycophenolate mofetil) Suspension	Maximum age = 11
Cephalexin suspension 250mg/5ml	Maximum of 80ml per day
Cerdelga (eliglustat) Capsules	Minimum age = 18; Maximum of 2 capsules per day
Cetirizine Syrup	Maximum age = 11
Chantix (varenicline)	Minimum age = 18; Maximum of 2 tablets per day; Maximum of 90days of therapy every 730 days
Chlordiazepoxide 5mg, 10mg, 25mg tablets	Minimum age = 6; Maximum of 4 tablets per day; Maximum of 120 tablets per 30 days
Chlorpromazine 25/ml ampule	Minimum age = 18; Maximum of 40ml per day for ages =/> 18
Chlorpromazine 10mg, 25mg, 50mg, 100mg tablets	Minimum age = 18; Maximum of 4 tablets per day for ages =/> 18
Chlorpromazine 200mg tablets	Minimum age = 18; Maximum of 5 tablets per day for ages =/> 18
Ciloxan eye ointment (ciprofloxacin)	Maximum quantity per fill = 3.5g
Cimzia (certolizumab) 400mg powder for injection kit, 200mg/ml prefilled syringe	Maximum of 1 injection/kit every 28 days
Cimzia (certolizumab) 200mg/ml starter kit	Maximum of 1 fill every 365 days
Cinryze (c1 esterase inhibitor) Powder for	Minimum age =12;

Summary of Drug Limitations (07/31/2016)	
solution for injection	Maximum of 20 vials every 28 days
Cipro suspension (ciprofloxacin)	Maximum age = 11
Claritin syrup (loratadine)	Maximum age = 11
Cleocin granules (clindamycin)	Maximum age = 11
Climara / Climara Pro (estradiol) patches	Maximum of 4 patches every 30 days
Clindacin (clindamycin) Pac Kit/ ETZ Kit	Minimum Age= 12
Clindagel (clindamycin)	Minimum Age= 12
Clindamycin Phosphate 1% solution, medicated swab, lotion, and gel	Minimum Age= 12
Clozaril (clozapine)12.5mg tablets	Minimum age = 6; Maximum of 12 tablets per day for ages = 6 – 17; Maximum of 2 tablets per day for ages = /> 18
Clozaril (clozapine) 25mg tablets	Minimum age = 6; Maximum of 8 tablets per day for ages = 6 – 17; Maximum of 2 tablets per day for ages =/> 18
Clozaril (clozapine) 50mg tablets	Minimum age = 6; Maximum of 300mg per day for ages = 6 – 11; Maximum of 600mg per day for ages = 12-17; Maximum of 2 tablets per day for ages =/> 18
Clozaril (clozapine) 100mg tablets	Minimum age = 6; Maximum of 300mg per day for ages = 6 – 11; Maximum of 600mg per day for ages = 12-17; Maximum of 9 tablets per day for ages =/> 18
Clozaril (clozapine) 200mg tablets	Minimum age = 6; Maximum of 300mg per day for ages = 6 – 11; Maximum of 600mg per day for ages = 12-17; Maximum of 4 tablets per day for ages =/> 18
Codeine containing products	Minimum age = 6
Colcrys (colchicine) tablets	Minimum age = 4 ; Maximum of 6 tablets every 30 days
Cometriq (cabozantinib) 60mg/day blister card	Minimum age = 18; Maximum of 84 capsules every 28 days
Cometriq (cabozantinib) 100mg/day blister card	Minimum age = 18; Maximum of 56 capsules every 28 days
Cometriq (cabozantinib) 140mg/day blister card	Minimum age = 18; Maximum of 112 capsules every 28 days
Complera (emtricitabine/rilpivirine/ tenofovir)	Minimum age = 12; Maximum of 1 tablet per day
Compound Claims	Maximum of $300.00 Excluding IVIG, Synagis, and TPN Claims
Comtan (entacapone) tablets	Maximum of 8 tablets per day
Concerta (methylphenidate) 18mg tablets	Minimum age = 6; Maximum of 1 tablet per day for ages 0-5 Maximum of 1 tablet per day for ages =/>18
Concerta (methylphenidate) 27mg tablets	Minimum age = 6; Maximum of 0.925 tablets per day for ages 0-5 Maximum of 1 tablet per day for ages =/>18
Concerta (methylphenidate) 36mg tablets	Minimum age = 6; Maximum of 0.694 tablets per day for ages 0-5 Maximum of 2 tablets per day for ages =/>18
Concerta (methylphenidate) 54mg tablets	Minimum age = 6; Maximum of 0.462 tablets per day for ages 0-5 Maximum of 1

Summary of Drug Limitations (07/31/2016)	
	tablet per day for ages =/>18
Condylox (podofilox) gel	Maximum quantity per fill = 3.5g
Conzip (tramadol extended release) capsules	Minimum age = 18; Maximum of 1 capsule per day; Maximum of 30 capsules every 30 days
Copaxone (glatiramer acetate)	Maximum of 1 kit every 28 days
Cosopt (dorzolamide/timolol) drops	Maximum of 10ml every 30 days
Cotellic (cobimetinib) tablets	Maximum of 3 tablets per day; Maximum of 63 tablets every 28 days
Coumadin (warfarin) tablets	Maximum of 4 tablets per day
Cubicin (daptomycin) vials	Maximum of 2 vials per day
Cyanocobalamin (Vitamin B-12) injections	Maximum quantity 2ml per 28 days
Cymbalta (duloxetine) capsules	Minimum age = 6; Maximum of 2 capsules per day
Daklinza (daclatasvir) tablets	Minimum age = 18
Daytrana (methylphenidate) 10mg/9hr, 15mg/9hr, 20mg/9hr patches	Minimum age = 6; Maximum of 30 patches every 30 days for ages 0-5 Maximum of 30 patches every 30 days for ages =/>18
Daytrana (methylphenidate) 30mg/9hr ppatches	Minimum age = 6; Maximum of 0.833 patches per day for ages 0-5 Maximum of 30 patches every 30 days for ages =/>18
Demerol (meperidine)	Maximum of 12 tablets per day (100mg) Maximum of 24 tablets per day (50mg)
Depo-Estradiol (estradiol)	Maximum days supply = 90
Depo-Provera (medroxyprogesterone)	Maximum of 1 unit every 84 days
Depo-SubQ Provera (medroxyprogesterone) 104mg	Maximum of 0.65ml every 84 days
Descovy (emtricitabine/tenofovir) tablets	Minimum age = 12; Maximum of 1 tablet per day
Desipramine tablets	Minimum age = 6
Desoxyn (methamphetamine) 5mg tablets	Maximum of 3 tablets per day for ages 0-5 Maximum of 5 tablets per day for ages =/> 18
Detrol/Detrol LA (tolterodine)	Minimum age = 5 Maximum age = 18
Dexedrine (dextroamphetamine) 5mg tablets	Maximum of 2 tablets per day for ages 0-5 Maximum of 2 tablets per day for ages =/> 18
Dexedrine (dextroamphetamine) 10mg tablets	Maximum of 1 tablet per day for ages 0-5 Maximum of 2 tablets per day for age =/> 18
Dexedrine ER (dextroamphetamine) 5mg capsules	Minimum age = 6; Maximum of 2 capsules per day for ages 0-5 Maximum of 2 capsules per day for ages =/> 18
Dexedrine ER (dextroamphetamine) 10mg capsules	Minimum age = 6; Maximum of 1 capsule per day for ages 0-5 Maximum of 2 capsules per day for ages =/> 18
Dexedrine ER (dextroamphetamine) 15mg capsules	Minimum age = 6; Maximum of 1 capsule per day for ages 0-5 Maximum of 4 capsules per day for ages =/> 18
Dexilant (dexlansoprazole) 30mg, 60mg capsules	Minimum age = 18: Maximum of 1 capsule per day
Diastat (diazepam)	Maximum of 2 kits every 30 days; Maximum age = 18
Diazepam 2mg, 5mg, 10mg tablets	Maximum of 4 tablets per day; Maximum of 120 tablets per 30 days
Diazepam solution 5mg/5ml	Maximum of 40ml per day

Summary of Drug Limitations (07/31/2016)	
Diazepam Intensol solution 5mg/ml	Maximum of 8ml per day
Differin(adapalene) 0.1% cream, gel, gel pump, lotion, pledgets, solution	Minimum Age= 12
Dificid (fidaxomicin) tablets	Minimum age = 18
Diclegis (doxylamine/pyridoxine) tablets	Minimum age = 18; Maximum of 4 tablets per day; Maximum of 120 tablets per 30 days
Diuril (chlorothiazide) solution 250mg/5ml	Maximum age = 11
Doral (quazepam) tablets	Minimum age = 18
Doxepin capsules	Minimum age = 6
Doxepin 10mg/ml solution	Minimum age = 6; Maximum age = 11
Droperidol Solution for Injection	Minimum age = 18
Duac (benzoyl peroxide/clindamycin) gel, CS Convenience Kit	Minimum Age= 12
Dulera (mometasone/formoterol)	Minimum age = 12; Maximum of 1 inhaler per 30 days; Maximum of 13 units per fill
Duragesic (fentanyl) patches	Maximum of 10 patches every 30 days
Dyanavel (dextroamphetamine/amphetamine) XR suspension	Minimum age = 6
Edurant (rilpivirine) tablet	Minimum age = 12; Maximum of 1 tablet per day
Effexor (venlafaxine) IR/ER capsules, tablets	Minimum age = 6
Effient (prasugrel) tablet	Maximum of 1 unit per day
Elelyso (taliglucerase alfa) Vials	Minimum age = 4; Maximum of 82 vials every 28 days
Eligard (leuprolide) Suspension for injection 45mg	Male gender only; Minimum age = 18; Maximum days supply =180 days; Maximum of 1 kit every 175 days
Eligard (leuprolide) Suspension for injection 30mg	Male gender only; Minimum age = 18; Maximum days supply = 120; Maximum of 1 kit every 118 days
Eligard (leuprolide) Suspension for injection 22.5mg	Male gender only; Minimum age = 18; Maximum days supply = 90; Maximum of 1 kit every 84 days
Eligard (leuprolide) Suspension for injection 7.5mg	Male gender only; Minimum age = 18; Maximum of 1 kit every 27 days
Eliquis (apixaban) 2.5mg tablets	Minimum age = 18; Maximum of 2 tablets per day; Maximum of 60 tablets every 30 days
Eliquis (apixaban) 5mg tablets	Minimum age = 18; Maximum of 4 tablets per day; Maximum of 74 tablets every 30 days
Ella (ulipristal) tablets	Minimum age = 12; Maximum of 2 tablets every 30 days
Embeda (morphine sulfate/naltrexone) ER capsules	Minimum age = 18; Maximum of 2 capsules per day (Excluding recipients with a diagnosis of cancer or sickle cell)
Emcyt (estramustine) capsules	Minimum age = 18; Maximum of 30 capsules every 30 days

Summary of Drug Limitations (07/31/2016)	
Emend (aprepitant) 40mg	Maximum of 4 capsules every 28 days
Emend (aprepitant) 80mg	Maximum of 4 capsules every 28 days
Emend (aprepitant) 125mg	Maximum of 2 capsules every 28 days
Emend (aprepitant) Trifold	Maximum of 6 capsules every 28 days
Enemeez (docusate sodium/benzocaine) enema	Minimum age =12
Emla (lidocaine/prilocaine) cream	Maximum of 30g every 30 days
Enbrel (etanercept) 25mg/ kit	Maximum of 2 kits every 28 days
Enbrel (etanercept) 25mg/0.51ml prefilled syringe	Maximum of 4.08ml every 28 days
Enbrel (etanercept) 50mg/ml sureclick, syringe	Maximum of 7.84ml every 28 days
Emsam (selegiline) patches	Minimum age = 12; Maximum of 1 patch per day; Maximum of 30 patches every 30 days
Epaned (enalapril) powder for oral solution	Maximum age = 11
EpiDuo (adapalene/benzoyl peroxide)gel, gel w/pump	Minimum Age= 9
EpiDuo (adapalene/benzoyl peroxide)Forte gel w/ pump	Minimum Age= 12
Epipen / Epipen Jr/ Auvi Q / Twinject (epinephrine) pen	Maximum of 2 pens every 30 days
Equetro (carbamazepine ER)	Minimum age = 6
Erivedge (vismodegib) capsules	Minimum age = 18; Maximum of 1 capsule per day; Maximum of 30 capsules every 30 days
Erythromycin 2% gel,pads, pledgets, solution	Minimum Age= 12
Erythromycin Ethylsuccinate Sulfisoxazole suspension	Maximum age = 11
Estradiol valerate vial	Maximum days supply = 50
Estring (estradiol)	Maximum of 1 unit every 84 days; Maximum day supply = 91
Ethanol (ethyl alcohol) 98% Solution for Injections	Maximum of 1ml per day; Maximum of 30ml per 30 days
Etoposide Capsules	Maximum of 8 capsules per day; Maximum of 40 capsules every 21 days
Evista (raloxifene) Tablets	Minimum age = 18
Evotaz (atazanavir/cobicistat) Tablets	Minimum age = 18; Maximum of 1 tablet per day
Exalgo (hydromorphone) ER Tablets	Minimum age = 18; Maximum of 1 tablet per day (Excluding recipients with a diagnosis of cancer or sickle cell)
Exelon (rivastigmine)	Minimum age = 18
Exjade (deferasirox) Tablets	Minimum age = 2
Gattex (teduglutide) 5mg powder for injection	Minimum age = 18
Fabior (tazarotene) foam	Minimum Age= 12
Fabrazyme (agalsidase beta) vials	Minimum age = 8
Factive (gemifloxacin) tablets	Maximum of 7 tablets every 30 days
Fanapt (iloperidone) 1mg, 2mg, 4mg, 6mg, titration pack/ tablets	Minimum age = 18; Maximum of 2 tablets per day for ages = 6 – 17; Maximum of 2 tablets per day for ages =/> 18
Fanapt (iloperidone) 8mg, 10mg, 12mg tablets	Minimum age = 18; Maximum of 1 tablet per day for ages = 6 – 11; Maximum of 2 tablets per day for ages = 12 – 17; Maximum of 2 tablets per day for ages =/> 18
Farydak (panobinostat) capsules	Minimum age = 18; Maximum of 6 capsules every 21 days
Fareston (toremifene) tablets	Minimum age = 18; Maximum of 1 tablet per day;

Summary of Drug Limitations (07/31/2016)	
	Maximum of 30 tablets every 30 days
Fazaclo (clozapine)12.5mg ODT tablets	Minimum age = 6; Maximum of 12 tablets per day for ages = 6 – 17; Maximum of 2 tablets per day for ages = /> 18
Fazaclo (clozapine) 25mg ODT tablets	Minimum age = 6; Maximum of 8 tablets per day for ages = 6 – 17; Maximum of 4 tablets per day for ages =/> 18
Fazaclo (clozapine) 100mg ODT tablets	Minimum age = 6; Maximum of 300mg per day for ages = 6 – 11; Maximum of 600mg per day for ages = 12-17; Maximum of 2 tablets per day for ages =/> 18
Fazaclo (clozapine) 150mg ODT tablets	Minimum age = 6; Maximum of 300mg per day for ages = 6 – 11; Maximum of 600mg per day for ages = 12-17; Maximum of 6 tablets per day for ages =/> 18
Fazaclo (clozapine) 200mg ODT tablets	Minimum age = 6; Maximum of 300mg per day for ages = 6 – 11; Maximum of 600mg per day for ages = 12-17; Maximum of 4 tablets per day for ages =/> 18
Femara (letrozole) tablets	Minimum age = 18; Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Fentora (fentanyl citrate) Buccal Tablets	Minimum age = 18; Maximum of 4 units per day
Ferrlecit (sod ferric gluc complex/suc)	Maximum age = 18
Fioricet (butalbital, acetaminophen, caffeine) Fioricet (butalbital, acetaminophen, caffeine) with codeine Fiorinal (butalbital, aspirin, caffeine) Fiorinal (butalbital, aspirin, caffeine) with codeine	Maximum of 120 capsule/tablets per 365 days
Firazyr (icatibant) Solution for Injection	Minimum age = 18; Maximum of 9mls every 28 days
Flagyl ER 750(metronidazole) tablets	Female gender only; Maximum quantity per fill = 10; Maximum days supply = 10
Flector (diclofenac) patches	Maximum of 2 patches per day; Maximum of 60 patches every 30 days
Flomax (tamsulosin) capsules	Male gender only; Maximum of 2 capsules per day
Flonase (fluticasone) nasal spray	Maximum of 16g every 30 days
Flovent (fluticasone) HFA inhalers	Maximum of 2 inhalers every 30 days
Flovent (fluticasone) Diskus	Minimum age = 4; Maximum of 2 inhalers every 30 days
Flu vaccines	Maximum of 1 vaccine per 365 days of prefilled syringe or single dose vial; FDA minimum/maximum age limitations apply; LTC residents
Flunisolide nasal spray	Maximum of 25ml every 30 days
Fluoxetine 20mg/5ml solution	Minimum age = 6; Maximum age = 11
Fluphenazine 2.5mg/ml vials	Minimum age = 18;

Summary of Drug Limitations (07/31/2016)	
	Maximum of 8ml per day for ages =/> 18
Fluphenazine 5mg/ml oral concentrate	Minimum age = 6; Maximum of 5mg per day for age = 6-11; Maximum of 10mg per day for ages = 12-17; Maximum of 4mls per day for ages =/>18
Fluphenazine 2.5mg/5ml oral elixir	Minimum age = 6; Maximum of 5mg per day for age = 6-11; Maximum of 10mg per day for ages = 12-17; Maximum of 40mls per day for ages =/> 18
Fluphenazine 1mg, 2.5mg, 5mg tablets	Minimum age = 6; Maximum of 5mg per day for age = 6-11; Maximum of 10mg per day for ages = 12-17; Maximum of 4 tablets per day for ages =/> 18
Fluphenazine 10mg tablets	Minimum age = 6; Maximum of 5mg per day for age = 6-11; Maximum of 10mg per day for ages = 12-17; Maximum of 20mg per day for ages =/> 18
Flurazepam capsules	Minimum age = 15
Flutamide capsules	Minimum age = 18; Maximum of 6 capsules per day; Maximum of 180 capsules every 30 days
Fluvoxamine tablets, solution	Minimum age = 6
Focalin (dexmethylphenidate) 2.5mg, 5mg tablets	Maximum of 2 tablets per day for ages 0-5 Maximum of 2 tablets per day for ages =/> 18
Focalin (dexmethylphenidate) 10mg tablets	Maximum of 1.5 tablets per day for ages 0-5 Maximum of 2 tablets per day for ages =/> 18
Focalin XR (dexmethylphenidate) 5mg, 10mg, 15mg capsules	Minimum age = 6; Maximum of 1 capsule per day for ages 0-5 Maximum of 1 capsule per day for ages =/> 18
Focalin XR (dexmethylphenidate) 20mg capsules	Minimum age = 6; Maximum of 0.75 capsules per day for ages 0-5 Maximum of 1 capsule per day for ages =/> 18
Focalin XR (dexmethylphenidate) 25mg capsules	Minimum age = 6; Maximum of 0.6 capsules per day for ages 0-5 Maximum of 1 capsule per day for ages =/> 18
Focalin XR (dexmethylphenidate) 30mg capsules	Minimum age = 6; Maximum of 0.75 capsules per day for ages 0-5 Maximum of 1 capsule per day for ages =/> 18
Focalin XR (dexmethylphenidate) 35mg capsules	Minimum age = 6; Maximum of 0.428 capsules per day for ages 0-5 Maximum of 1 capsule per day for ages =/> 18
Focalin XR (dexmethylphenidate) 40mg capsules	Minimum age = 6; Maximum of 0.375 capsules per day for ages 0-5 Maximum of 1 capsule per day for ages =/> 18
Foradil (formoterol) Aerolizer kit, Powder for inhalation	Minimum age = 5; Maximum of 1 fill per 30 days; For 12 count: Maximum of 12 units per fill; For 60 count: Maximum of 60 units per fill
Forteo (teriparatide)	Maximum of 1 kit every 30 days
Forfivo (bupropion) XL tablets	Minimum age = 18
Frova (frovatriptan)	Minimum age = 18; Maximum of 9 tablets per 30 days
Fulyzaq (crofelemer) tablets	Minimum age = 18
Fyavolv (norethindrone/ethinyl estradiol) tablets	Minimum age = 18

Summary of Drug Limitations (07/31/2016)	
Fycompa (perampanel) tablets	Minimum age = 12
Gattex (teduglutide) Kit	Minimum age = 18
Genvoya (elvitegravir/cobicistat/emtricitabine/tenofovir) Tablets	Minimum age = 12; Maximum of 1 tablet per day
Geodon (ziprasidone) 20mg capsules	Minimum age = 6; Maximum of 4 capsules per day for ages = 6 - 17; Maximum of 2 capsules per day for ages = /> 18
Geodon (ziprasidone) 40mg , 80mg capsules	Minimum age = 6; Maximum of 80mg per day for ages = 6 – 11; Maximum of 160mg per day for ages = 12-17; Maximum of 2 capsules per day for ages = /> 18
Geodon (ziprasidone) 60mg capsules	Minimum age = 6; Maximum of 80mg per day for ages = 6 – 11; Maximum of 160mg per day for ages = 12-17; Maximum of 4 capsules per day for ages = /> 18
Geodon (ziprasidone) vial	Minimum age = 18
Gilotrif (afatinib) tablets	Minimum age = 18; Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Gleevec (imatinib) 100mg tablets	Minimum age = 1; Maximum of 3 tablets per day; Maximum of 90 tablets every 30 days
Gleevec (imatinib) 400mg tablets	Minimum age = 1; Maximum of 2 tablets per day; Maximum of 60 tablets every 30 days
Glucagon Kit	Maximum quantity per fill = 1
Golytely, Colyte, Nulytely (polytheylene glycol-electrolyte solution)	Maximum quantity per fill = 4000ml; Maximum of 4000ml per day
Golytely packets	Maximum of 1packet per day
Granisetron1mg tablet and 1mg/ml vial	Maximum of 8 tablets/ml every 28 days
Granisol (granisetron) 2mg/10ml solution	Maximum of 80ml every 28 days; Maximum of 2.963ml per day
H2RAs, Acid reducers	Maximum of 2 tablets/capsules per day
Halcion (triazolam) Tablets	Minimum age = 18; Maximum of 2 tablets per day; Maximum of 60 tablets every 30 days
Haldol (haloperidol) decanoate 100mg/ml ampules, vials	Minimum age = 18; Maximum of 4.5ml every 28 days for ages =/> 18
Haldol (haloperidol) decanoate 50mg/ml ampules, vials	Minimum age = 18; Maximum of 3ml every 28 days for ages =/> 18
Haldol (haloperidol) 2mg/ml oral concentrate	Minimum age = 6; Maximum of 5mg per day for ages = 6-11; Maximum of 10 mg per day for ages = 12-17; Maximum of 50ml per day for ages =/> 18
Haldol (haloperidol) 0.5mg, 1mg, 2mg, 5mg, 10mg tablets	Minimum age = 6; Maximum of 5mg per day for ages = 6-11; Maximum of 10 mg per day for ages = 12-17; Maximum of 3 tablets per day for ages =/> 18
Haldol (haloperidol) 20mg tablets	Minimum age = 6; Maximum of 5mg per day for ages = 6-11; Maximum of 10 mg per day for ages = 12-17; Maximum of 5 tablets per day for age =/> 18

Summary of Drug Limitations (07/31/2016)	
Harvoni (ledipasvir/sofosbuvir) tablets	Minimum age = 18
Helidac (bismuth subsalicylate/metronidazole/tetracycline)	Minimum age = 18; Maximum of 1 prescription every 365 days; Maximum of 16 tablets per day
Hetlioz (tasimelteon) capsules	Minimum age = 18; Maximum of 1 capsule per day; Maximum of 30 capsules every 30 days
Hexalen (altretamine) tablets	Minimum age = 18; Maximum of 126 tablets every 30 days
Hizentra 20% (Immune Globulin) Liquid for SQ injection	Minimum age = 2 Maximum age = 16
Hycamtin (topetecan) capsules	Minimum age = 18; Maximum of 20 capsules every 30 days
Hydrea (hydroxyurea) capsules	Maximum of 90 capsules every 30 days
Hyperrho (Rho (D) immune globulin)	Maximum of 2 prescriptions per 365 days
Hysingla (hydrocodone) ER tablets	Minimum age = 18; Maximum of 1 tablet per day (Excluding recipients with a diagnosis of cancer or sickle cell)
Ibrance (palbociclib) capsules	Minimum age = 18; Maximum of 1 capsule per day; Maximum of 21 capsules every 28 days
Iclusig (ponatinib) 15mg tablets	Minimum age = 18; Maximum of 2 tablets per day; Maximum of 60 tablets every 30 days.
Iclusig (ponatinib) 45mg tablets	Minimum age = 18; Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Imbruvica (ibrutinib)	Minimum age = 18; Maximum of 4 capsules per day; Maximum of 120 capsules every 30 days
Imitrex (sumatriptan) 25mg, 50mg and 100mg tablets	Minimum age = 18; Maximum of 9 tablets every 30 days
Imitrex (sumatriptan 4mg/0.5ml pen injection; 6mg/0.5ml kit/vial	Minimum age = 18; Maximum of 3ml every 30 days
Imitrex (sumatriptan) nasal spray	Maximum of 6 units every 30 days; Minimum age = 18
Impavido (miltefosine) 50mg capsules	Minimum age = 12
Increlex (mecasermin) Solution for Injection	Minimum age = 2
Indocin (indomethacin) suspension	Maximum age = 11; Maximum of 300ml every 30 days
Infergen (Interferon Alfacon-1) 9mcg/0.3ml syringe/vial	Minimum age = 18; Maximum of 1 vial per day
Infergen (Interferon Alfacon-1) 15mcg/0.5 ml syringe/vial	Minimum age = 18; Maximum of 1 vial per day
Inlyta (axitinib) tablets	Minimum age = 18; Maximum of 4 tablets per day; Maximum of 120 tablets every 30 days
Insulin Cartridges/Pens	Maximum of 2 boxes per 30 days
Insulin vials	Maximum of 70 mls every 30 days; (excluding Humulin R-U 500) **Humulin R-U500 vial:** Maximum of 20mls every 30 days
Invega (paliperidone) 1.5mg, 3mg tablets	Minimum age = 18; Maximum of 1 tablet per day for ages = 6 – 17; Maximum of 1 tablet per day for ages =/> 18

Summary of Drug Limitations (07/31/2016)	
Invega (paliperidone) 6mg tablet	Minimum age = 18; Maximum of 1 tablet per day for ages = 6 – 11; Maximum of 2 tablets per day for ages = 12 – 17; Maximum of 2 tablets per day for ages =/> 18
Invega (paliperidone) 9mg tablet	Minimum age = 18; Maximum of 0.67 tablet per day for ages = 6 – 11; Maximum of 1 tablet per day for ages = 12 – 17; Maximum of 1 tablet per day for ages =/> 18
Invega Sustenna 234mg/1.5ml prefilled syringe Invega Sustenna 156mg/ml prefilled syringe Invega Sustenna 117mg/0.75ml prefilled syringe Invega Sustenna 78mg/0.5ml prefilled syringe Invega Sustenna 39mg/0.25ml prefilled syringe	Minimum age = 18; Ages =/>18: Maximum of 1 prefilled syringe every 28 days; Maximum of 234mg every 28 days
Invega Trinza 819mg/2.625ml syringe Invega Trinza 546mg/1.75ml syringe Invega Trinza 410mg/1.315ml syringe Invega Trinza 273mg/0.875ml syringe	Minimum age = 18; Ages=/> 18: Maximum of 1 syringe every 84 days; Maximum of 819mg every 84 days
Irenka (duloxetine) capsules	Minimum age = 6
Iressa (gefitinib) tablets	Minimum age = 18; Maximum of 2 tablets per day; Maximum of 60 tablets every 30 days
Jakafi (ruxolitinib) tablets	Minimum age = 18; Maximum of 2 tablets per day; Maximum of 60 tablets every 30 days
Juxtapid (lomitapide) capsules	Minimum age = 18
Kadian (morphine sulfate) ER Capsules	Minimum age = 18; Maximum of 2 capsules per day (Excluding recipients with a diagnosis of cancer or sickle cell)
Kalydeco (ivacaftor) Tablets	Minimum age = 6
Kalydeco (ivacaftor) granules	Minimum age = 2; Maximum age = 5
Kapvay (clonidine ER) tablets	Minimum age = 6
Kepivance (palifermin) vials	Minimum age = 18
Ketorolac tablets/injection	Maximum days supply = 3; Maximum of 4 tablets or 4ml per day; Maximum days of therapy is 30 days per 180 day
Khedezla (desvenlafaxine) tablets	Minimum age = 18
Kitabis (tobramycin) Pak 300mg/5ml nebulizer solution	Maximum of 280ml every 56 days
Klonopin (clonazepam)	Maximum of 90 tablets/wafers per 30 days; Maximum of 3 tablets per day
Korlym (mifepristone) 300mg tablets	Minimum age = 18
Kynamro (mipomersen)	Minimum age = 18
Lacrisert (hyroxypropyl cellulose) ophthalmic	Minimum age = 18
Lactulose	Maximum of 5400ml every 30 days
Lamictal (lamotrigine) dose pack (25mg)	Maximum of 35 tablets (1 dose packet) every 30 days
Lamictal (lamotrigine) dose pack (25-100mg)	Package size 98 - maximum of 98 tablets (1 dose packet) every 30 days; Package size 49 - maximum of 49 tablets (1 dose packet) every 30 days
Lamictal (lamotrigine) dose pack (25-50-100mg ODT)	Maximum of 35 tablets every 30 days
Lamictal (lamotrigine) XR tablets	Minimum age = 13

Summary of Drug Limitations (07/31/2016)	
Lamictal (lamotrigine) dose pack (25-50mg ODT)	Maximum of 28 tablets every 30 days
Lamictal (lamotrigine) dose pack (50-100mg ODT)	Maximum of 56 tablets every 30 days
Lamictal (lamotrigine) dose pack (25-50mg XR)	Minimum age = 13; Maximum of 28 tablets every 30 days
Lamictal (lamotrigine) dose pack (25-50-100mg XR)	Minimum age = 13; Maximum 35 tablets every 30 days
Lamictal (lamotrigine) dose pack (50-100-200mg XR)	Minimum age = 13; Maximum 35 tablets every 30 days
Lamisil (terbinafine)	Maximum of 1 tablet per day; Maximum of 84 tablets every 365 days
Latuda (lurasidone) 20mg, 40mg, 60mg	Minimum age = 18; Maximum of 1 tablet per day for ages = 6-17; Maximum of 1 tablet per day for ages =/> 18
Latuda (lurasidone) 80mg tablets	Minimum age = 18; Maximum of 1 tablet per day for ages = 6-17; Maximum of 2 tablets per day for ages =/> 18
Latuda (lurasidone) 120mg tablets	Minimum age = 18; Maximum of 0.67 tablets per day for ages = 6-11; Maximum of 1 tablet per day for ages = 12-17; Maximum of 1 tablet per day for ages =/> 18
Lazanda (fentanyl citrate) spray/pump	Minimum age = 18; Maximum of 1 unit per day
Lenvima (lenvatinib) 8mg/day capsules	Minimum age= 18; Maximum of 60 capsules every 30 days
Lenvima (lenvatinib) 10mg/day capsules	Minimum age = 18; Maximum of 30 capsules every 30 days
Lenvima (lenvatinib) 14mg/day, 20mg/day capsules	Minimum age = 18; Maximum of 60 capsules every 30 days
Lenvima (lenvatinib) 18mg/day capsules	Minimum age= 18; Maximum of 90 capsules every 30 days
Lenvima (lenvatinib) 24mg/day capsules	Minimum age = 18; Maximum of 90 capsules every 30 days
Leuprolide acetate solution for injection 1mg/0.2ml	Maximum of 2 units per 27 days.
Levaquin (levofloxacin) oral solution	Maximum age = 11
Lexapro (escitalopram) solution 5mg/5ml	Minimum age = 6; Maximum age = 11; Maximum of 20ml per day
Lexapro (escitalopram) tablets	Minimum age = 6; Maximum of 1 tablet per day
Lidocaine 3%, 4%, 5% cream, and 5% ointment	Maximum of 60 grams per 30 days
Lidoderm (lidocaine) patches	Maximum of 90 patches every 30 days
Linzess (linaclotide) capsules	Minimum age = 18
Lipitor (atorvastatin) tablets	Maximum of 1 tablet per day
Lithium (lithium citrate) 8mEq/5ml solution	Minimum age = 6; Maximum age = 11
Lithium carbonate IR/ ER capsules and tablets	Minimum age = 6
Lithobid (lithium carbonate) ER tablets	Minimum age = 6
Livalo (pitavastatin) tablets	Maximum of 1 tablet per day
Lonsurf (tipiracil/trifluridine) tablets	Minimum age = 18; Maximum of 8 tablets per day; Maximum of 80 tablets every 28 days
Lopreeza (estradiol/norethindrone) tablets	Minimum age = 18
Loratadine tablets	Maximum of 1 tablet per day

Summary of Drug Limitations (07/31/2016)	
Loseasonique (ethinyl estradiol/levonorgestrel)	Maximum days supply = 91; Maximum of 91 tablets every 84 days
Lotrisone (betamethasone/clotrimazole) Lotion	Maximum of 60ml every 30 days
Loxitane (loxapine) 5mg, 10mg, 25mg capsules	Minimum age = 18; Maximum of 4 capsules per day for ages =/> 18
Loxitane (loxapine) 50mg capsules	Minimum age = 18; Maximum of 3 capsules per day for ages =/> 18
Lovaza (omega-3 acid ethyl esters)	Minimum age = 18; Maximum of 4g per day
Lovenox (enoxaparin) syringes	Maximum of 2 syringes per day
Lovenox (enoxaparin) vials	Maximum of 1 vial per day
Lunesta (eszopiclone)	Minimum age = 18; Maximum of 90 tablets every 365 days
Lupaneta (leuprolide/norethindrone acetate) 3.75mg/5mg kit	Minimum age = 18; Minimum day supply = 84 days; Maximum day supply = 90 days; Maximum of 1 kit every 27 days; Maximum of 12 months of therapy per lifetime
Lupaneta (leuprolide/norethindrone acetate) 11.25mg/5mg kit	Minimum age = 18; Maximum of 1kit every 84 days; Maximum of 12 months of therapy per lifetime
Lupron (leuprolide) (6 months) Depot 45mg	Male gender only; Minimum age = 18; Maximum day supply =175 days; Maximum of 1 kit every 175 days; Maximum quantity per fill =1
Lupron (leuprolide) (4 months) Depot 30mg	Male gender only; Minimum age = 18; Maximum day supply = 120; Maximum of 1 kit every 118 days; Maximum quantity per fill = 1
Lupron (leuprolide) (3 months) Depot 22.5mg	Male gender only; Minimum age = 18; Maximum day supply = 90; Maximum of 1 kit every 84 days; Maximum quantity per fill = 1
Lupron (leuprolide) (3 months) Depot 11.25mg	Minimum age = 18; Maximum day supply = 90; Maximum of 1 kit every 84 days; Maximum quantity per fill = 1
Lupron (leuprolide) (monthly) Depot 7.5mg	Male gender only; Minimum age = 18; Maximum of 1 kit every 28 days; Maximum quantity per fill = 1
Lupron (leuprolide) (monthly) Depot 3.75mg	Minimum age = 18; Maximum of 1 kit every 28 days; Maximum quantity per fill = 1
Lupron (leuprolide) (3 months) Depot Ped 11.25mg, 30mg	Minimum age = 2; Maximum age = 12; Maximum day supply = 90; Maximum of 1 kit every 84 days; Maximum quantity per fill = 1
Lupron (leuprolide) (monthly) Depot Ped 7.25mg, 11.25mg, 15mg	Minimum age = 2; Maximum age = 12; Maximum of 1 kit every 28 days; Maximum quantity per fill = 1
Luvox (fluvoxamine) CR capsules	Minimum age = 6
Lynparza (olaparib) capsules	Maximum of 16 capsules per day; Maximum of 480 capsules every 30 days
Lyrica (pregabalin) capsules/solution	Maximum of 600mg per day

Summary of Drug Limitations (07/31/2016)	
Lysodren (mitotane) tablets	Minimum age = 18; Maximum of 38 tablets per day; Maximum of 1,140 tablets every 30 days
Lysteda (tranexamic acid)	Maximum of 30 tablets every 28 days
Makena (hyroxyprogesterone caproate) Solution for Injection	Minimum age = 16; Maximum of 1 vial per 5 weeks (35days)
Maprotiline tablets	Minimum age = 6
Matulane (procarbazine) capsules	Maximum of 56 capsules every 30 days
Maxalt (rizatriptan) 5mg, 10mg, 5mgMLT, 10mgMLT	Minimum age = 6; Maximum of 12 tablets every 30 days
Metadate CD (methylphenidate) 10mg, 20mg capsules	Minimum age = 6; Maximum of 1 capsule per day for ages 0-5 Maximum of 1 capsule per day for ages =/> 18
Metadate CD (methylphenidate) 30mg capsules	Minimum age = 6; Maximum of 0.833 capsules per day for ages 0-5 Maximum of 1 capsule per day for ages =/> 18
Metadate CD (methylphenidate) 40mg capsules	Minimum age = 6; Maximum of 0.625 capsules per day for ages 0-5 Maximum of 1 capsule per day for ages =/> 18
Metadate CD (methylphenidate) 50mg capsules	Minimum age = 6; Maximum of 0.5 capsules per day for ages 0-5 Maximum of 1 capsule per day for ages =/> 18
Metadate CD (methylphenidate) 60mg capsules	Minimum age = 6; Maximum of 0.416 capsules per day for ages 0-5 Maximum of 1 capsule per day for ages =/> 18
Metadate ER / Ritalin ER (methylphenidate) 20mg tablets	Minimum age = 6; Maximum of 1 tablet per day for ages 0-5 Maximum of 4.5 tablets per day for ages =/> 18
Metformin 500mg/ 500mg XR tablets	Maximum of 5 tablets per day
Metformin ER 750mg tablets	Maximum of 3.5 tablets per day
Metformin 850mg tablets	Maximum of 3 tablets per day
Metformin 1000mg tablets	Maximum of 2.5 tablets per day
Methadone ODT/tablets/suspension/injection/diskets dispersible tablets	Minimum age = 18
Methotrexate (oral)	Maximum of 300 tablets per 30 days
Methylin (methylphenidate) 2.5mg, 5mg chewable tablets	Maximum of 5 tablets per day for ages 0-5 Maximum of 3 tablets per day for ages =/> 18
Methylin (methylphenidate) 10mg chewable tablets	Maximum of 2 tablets per day for ages 0-5 Maximum of 3 tablets per day for ages =/> 18
Methylin / Ritalin (methylphenidate) 5mg tablets	Maximum of 5tablets per day for ages 0-5 Maximum of 3 tablets per day for ages =/> 18
Methylin / Ritalin (methylphenidate) 10mg tablets	Maximum of 2 tablets per day for ages 0-5 Maximum of 3 tablets per day for ages =/> 18
Methylin / Ritalin (methylphenidate) 20mg tablets	Maximum of 1 tablet per day for ages 0-5 Maximum of 3 tablets per day for ages =/> 18
Methylin (methylphenidate) 5mg/5ml solution	Maximum of 25mls per day for ages 0-5 Maximum of 60mls per day for ages =/> 18
Methylin (methylphenidate) 10mg/5ml solution	Maximum of 12.5mls per day for ages 0-5 Maximum of 30mls per day for ages =/> 18
Methylphenidate ER 10mg	Minimum age = 6; Maximum of 2 tablets per day for ages 0-5 Maximum of 4.5 tablets per day for ages =/> 18

Summary of Drug Limitations (07/31/2016)	
Metrogel (metronidazole) Vaginal	Female gender only
Midazolam oral syringe/syrup	Maximum of 10mls per fill (prescription)
Miacalcin/Fortical (calcitonin)	Minimum age = 18; Maximum of 3.7ml every 28 days
Minivelle (estradiol) patches	Maximum of 8 patches every 30 days
Miralax (polyethylene glycol-electrolyte solution)	Maximum of 527g every 30 days
Mitigare (colchicine) capsules	Maximum of 6 capsules every 30 days
Moderiba (ribavirin) tablets	Minimum age = 5
Molindone Tablets	Minimum age = 18
MS Contin (morphine sulfate ER) tablets	Minimum age = 18; Maximum of 3 tablets per day (Excluding recipients with a diagnosis of cancer or sickle cell)
Mucolytics	Maximum age = 20
Multivitamins with fluoride	Maximum age = 12
Myleran (busulfan) tablets	Maximum of 6 tablets per day; Maximum of 180 tablets every 30 days
Myrbetriq (mirabegron)	Minimum age = 18
Nefazodone tablets	Minimum age = 6
Naglazyme (galsulfase) Solution for Injection	Minimum age = 5
Namenda (memantine) tablets/solution	Minimum age = 18
Namenda XR (memantine) capsules	Minimum age = 18; Maximum of 1 capsule per day
Namzaric (memantine/donepezil) capsules	Minimum age = 18
Nasacort (triamcinolone) AQ	Maximum of 16.5g every 30 days
Nasonex (mometasone furoate)	Maximum of 17g every 30 days
Neuac (benzoyl peroxide/clindamycin) gel, kit	Minimum Age= 12
Nexavar (sorafenib) tablets	Minimum age = 18; Maximum of 4 tablets per day; Maximum of 120 tablets every 30 days
Nexium (esomeprazole) oral suspension packets	Maximum age = 11; Maximum of 30 packets per 30 days
Nexium (esomeprazole) capsules	Maximum of 1 capsule per day
Nexium (esomeprazole) vials	Minimum age = 1; Maximum of 1 vial per day
Nicotine products	Minimum age = 18; Maximum of 168 days (24 weeks) of therapy every 365 days
Nilandron (nilutamide) tablets	Minimum age = 18; Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Nimodipine capsules	Minimum age = 18
Ninlaro (ixazomid) capsules	Minimum age = 18; Maximum of 3 capsules every 28 days
Nitroglycerin patches	Maximum of 1 patch per day
Nitroglycerin SL tablets	Maximum of 16 tablets per day
Nortriptyline 10mg/5ml solution	Minimum age = 6; Maximum age = 11
Norvir (ritonavir) capsules	Maximum days supply = 60
Norvir (ritonavir) solution	Maximum days supply = 90
Nucynta (tapentadol) Tablets	Minimum age = 18
Nucynta (tapentadol) ER Tablets	Minimum age = 18; Maximum of 2 tablets per day
Nuedexta (dextromethorphan/quinidine) Capsules	Minimum age = 18
NuvaRing (etonogestrel/ethinyl estradiol)	Minimum age = 12; Maximum of 1 ring per 21 days; Female gender only
Odomzo (sonidegib) capsules	Minimum age = 18; Maximum of 1 capsule per day; Maximum of 30 capsules every 30 days
Odefsey (emtricitabine/rilpivirine/tenofovir) tablets	Minimum age = 12; Maximum of 1 tablet per day
Oleptro (trazodone ER) tablets	Minimum age = 6
Olysio (simeprevir) capsules	Minimum age = 18
Onexton (benzoyl peroxide/clindamycin) gel/pump	Minimum Age= 12

Summary of Drug Limitations (07/31/2016)	
Onfi (clobazam) tablets	Minimum age = 2
Oral contraceptives	Female gender only; Maximum of 1 tablet per day; Minimum age = 12
Orap (Pimozide) Tablets	Minimum age = 18; Maximum of 1 tablet per day for ages = 6 - 17
Orapred ODT (prednisolone)	Maximum age = 11
Oravig (miconazole nitrate) Buccal Tablet	Minimum age = 17
Ovide (malathion)	Maximum of 60ml every 30 days; Maximum of 2 prescription fills every 60 days
Oxandrin (oxandrolone)	Maximum of 8 tablets per day
Oxazepam capsules	Minimum age = 6; Maximum of 4 capsules per day; Maximum of 120 capsules per 30 days
Oxtellar (carbamazepine XR) tablets	Minimum age = 6
Oxycodone IR	Minimum age = 18; **For 5mg:** Maximum of 12 tablets per day (360 tabs per 30 days) **For 5mg/5ml oral soln:** Maximum of 60ml per day (1800ml per 30 days) **For 7.5mg:** Maximum of 8 tablets per day (240 tabs per 30 days) **For 10mg, 15mg, 30mg:** Maximum of 6 tablets per day (180 tabs per 30 days) **For 20mg tab and 20mg/ml oral soln:** Maximum of 9 tablets/ml per day (270 tabs/ml per 30 days)
Oxycontin (oxycodone SR)	Minimum age = 11; **For 10mg, 15mg,20mg,30mg,40mg ,60mg:** Maximum of 2 tablets per day (60 tabs per 30 days) **For 80mg:** Maximum of 4tablets per day (120 tabs per 30 days)
Oxycodone/Ibuprofen tablets	Maximum of 4 tablets per day; Maximum of 120 tablets every 30 days
Oxymorphone ER Tablets	Minimum age = 18; Maximum of 2 tablets per day (Excluding recipients with a diagnosis of cancer or sickle cell)
Oxytrol (oxybutynin) Patch	Maximum of 8 patches every 30 days
Marplan (isocarboxazid)	Minimum age = 6
Mekinist (trametinib)	Minimum age = 18; **For 0.5mg:** Maximum of 3 tablets per day; Maximum of 90 tablets every 30 days **For 2mg:** Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Methadone Tablets/Solution	Minimum age = 18; Maximum 60mg per day (Excluding recipients with a diagnosis of cancer or sickle cell)
Paclitaxel Solution for Injection	Maximum of 1 prescription every 7 days
Pamelor (nortriptyline) capsules	Minimum age = 6
Paregoric	Maximum of 1200mls every 30 days
Parnate (tranylcypromine) tablets	Minimum age = 6
Paxil (paroxetine) suspension	Minimum age = 6; Maximum age = 11

Summary of Drug Limitations (07/31/2016)	
Paxil (paroxetine) IR/CR tablets	Minimum age = 6; Maximum of 2 tablets per day (excluding the 12.5mg CR strength) **12.5mg CR:** Maximum of 1 tablets per day
Pegasys (Peginterferon Alfa-2a)	Minimum age = 5; Maximum of 1 kit every 28 days
Peg Intron (peginterferon alfa-2b)	Minimum age = 3
Percocet (oxycodone/acetaminophen) 2.5/325, 5/325	Maximum of 12 tablets per day
Percocet (oxycodone/acetaminophen) 7.5/325	Maximum of 8 tablets per day
Percocet (oxycodone/acetaminophen) 10/325	Maximum of 6 tablets per day
Perforomist (formoterol) Neb solution	Minimum age = 18; Maximum of 1 fill per 30 days; Maximum of 120ml per fill.
Perphenazine 2mg Tablets	Minimum age = 6; Maximum of 6 tablets per day for age = 6 – 11; Maximum of 11 tablets per day for ages = 12-17; Maximum of 4 tablets per day for ages =/> 18
Perphenazine 4mg Tablets	Minimum age = 6; Maximum of 3 tablets per day for age = 6 – 11; Maximum of 5.5 tablets per day for ages = 12-17; Maximum of 4 tablets per day for ages =/> 18
Perphenazine 8mg Tablets	Minimum age = 6; Maximum of 1.5 tablets per day for age = 6 – 11; Maximum of 2.75 tablets per day for ages = 12-17; Maximum of 4 tablets per day for ages =/> 18
Perphenazine 16mg Tablets	Minimum age = 6; Maximum of 0.75 tablets per day for age = 6 – 11; Maximum of 1.375 tablets per day for ages = 12-17; Maximum of 4 tablets per day for ages =/> 18
Perphenazine/Amitriptyline 2-10mg Tablets	Minimum age = 18; Maximum of 8 tablets per day for ages =/> 18
Perphenazine/Amitriptyline 2-25mg, 4-10mg, 4-25mg, 4- 50mg tablets	Minimum age = 18; Maximum of 4 tablets per day for ages =/> 18
Pexeva (paroxetine mesylate) tablets	Minimum age = 6
Plan B One Step / Aftera/ Econtra EZ/ FallBack Solo / My Way / Next Choice / Opcicon / Take Action (levonorgestrel)	Minimum age = 12; Maximum of 2 packages every 30 days
Pomalyst (pomalidomide) capsules	Minimum age = 18; Maximum of 1 capsule per day; Maximum of 21 caps every 28 days
Pradaxa (dagibatran etexilate) Capsules	Minimum age = 18
Praluent (alirocumab) syringe/pen injection	Minimum age = 18
Premarin (estrogens, conjugated/equine) Vaginal	Female Gender only; Maximum quantity per fill = 42.5g
Premphase (estrogens, conjugated/equine, and medroxyprogesterone)	Female Gender only; Maximum of 1 tablet per day
Prempro (estrogen, conjugated/equine, and medroxyprogesterone)	Female Gender only; Maximum of 1 tablet per day
Prevacid (lansoprazole) 15mg solutabs/ODT	Minimum age = 1; Maximum age = 11; Maximum of 2 capsules/tablets per day for ages 1-11 Maximum of 3 capsules/tablets per day for ages =/> 12

Summary of Drug Limitations (07/31/2016)	
Prevacid (lansoprazole) 30mg solutabs/ODT	Minimum age = 1; Maximum age = 11; Maximum of 1 capsule/tablet per day for ages 1-11 Maximum of 3 capsules/tablets per day for ages =/> 12
Prevacid (lansoprazole) 15mg capsules	Minimum age = 1; Maximum of 2 capsule/tablet per day for ages 1-11 Maximum of 3 capsules/tablets per day for ages =/> 12
Prevacid (lansoprazole) 30mg capsules	Minimum age = 1; Maximum of 1 capsule/tablet per day for ages 1-11 Maximum of 3 capsules/tablets per day for ages =/> 12
Prevpac (lansoprazole/amoxicillin/clarithromycin)	Maximum of 8 tablets per day; Maximum of 224 tablets/capsules (2 packs)every 28 days
Prevident (fluoride) cream	Maximum quantity per fill = 51g
Prezcobix (darunavir/cobicistat) Tablets	Minimum age = 18; Maximum of 1 tablet per day
Prilosec (omeprazole) 10mg, 20mg, 40mg capsules	Minimum age = 1; Maximum of 1 capsule per day
Prilosec (omeprazole) 2.5mg suspension packet	Minimum age = 1; Maximum of 3 packets per day
Prilosec (omeprazole) 10mg suspension packet	Minimum age = 1; Maximum of 2 packets per day
Primaxin (imipenem/cilastatin) IM 500mg	Maximum of 3 vials per day
Primaxin (imipenem/cilastatin) IV 500mg	Maximum of 8 vials per day
Primaxin (imipenem/cilastatin) IV 250mg	Maximum of 16 vials per day
Pristiq (desvenlafaxine succinate)	Minimum age = 18; Maximum of 1 tablet per day; Maximum of 30 tablets per 30 days
ProAir (albuterol) HFA	Maximum of 2 inhalers every 30 days
Procentra (dextroamphetamine) Solution	Minimum age = 3; Maximum age = 5 Maximum of 15 mls per day for ages 0-5
Prolastin C (alpha-1-proteinase inhibitor human)	Minimum age = 18
Prolia (denosumab) 60mg injection	Maximum of 1 injection (1ml) every 175 days
Proton Pump Inhibitors	Maximum of 1 fill every 30 days; Maximum of 6 fills every 365 days; (excluding recipients with a diagnosis of Zollinger-Ellison syndrome, Barrett's esophagus, gastric malignancy, cystic fibrosis, or history of gastric bypass)
Protonix (pantoprazole) suspension packets	Minimum age = 5; Maximum age = 11; Maximum of 30 packets per 30 days
Protonix (pantoprazole) 20mg tablets	Minimum age = 5; Maximum of 1 tablet per day
Protonix (pantoprazole) 40mg tablets/vials	Minimum age = 5; Maximum of 2 tablets/vials per day
Protopic (tacrolimus) 0.1% ointment	Minimum age = 16
Protriptyline tablets	Minimum age = 6
Proventil (albuterol) HFA	Maximum of 14g (2 inhalers) every 30 days
Provigil (modafinil) tablets	Minimum age = 18
Prozac (fluoxetine) capsules	Minimum age = 6
Prozac (fluoxetine) Weekly	Minimum age = 6; Maximum of 4 capsules every 30 days
Potiga (ezogabine)	Minimum age = 18
Pulmicort (budesonide) Flexhaler	Minimum age = 5; Maximum of 1 inhaler every 30 days
Pulmicort (budesonide) Respules	Maximum age = 11; Maximum of 2 respules per day
Pulmozyme (dornase alpha)	Maximum age = 65; Maximum quantity per fill = 150mls; Maximum of 2 ampules (5ml) per day
Purinethol (mercaptopurine) tablets	Maximum of 90 tablets every 30 days
Purixan (mercaptopurine) suspension	Maximum of 100mls every 30 days
Qnasl 40mcg (beclomethasone) HFA inhaler	Minimum age = 4; Maximum age = 11
Qnasl 80mcg (beclomethasone) HFA inhaler	Minimum age = 12; Maximum age = 17

Summary of Drug Limitations (07/31/2016)	
Quartette (ethinyl estradiol/levonorgestrel) tablets	Maximum days supply = 91; Maximum of 91 tablets every 84 days
Quillichew ER (methylphenidate extended release) chewable tablets	Minimum age = 6
Quillivant XR (methylphenidate extended release) powder for suspension	Minimum age = 6; Maximum of 5 mls per day for ages 0-5 Maximum of 12 mls per day for ages =/> 18
Qvar (beclomethasone) inhaler	Minimum age =5
Ravicti (glycerol phenylbutyrate) 1.1g/ml oral liquid	Minimum age = 2
Razadyne / ER (galantamine)	Minimum age = 18
Reclast (zoledronic acid) 5mg injection	Maximum of 100ml (1 injection) every 355 days
Regranex (becaplermin) Gel	Minimum age = 16; Maximum of 140g every 365 days; Maximum quantity per fill = 15g
Rebif (interferon beta-1a) 22mcg/0.5ml, 44mcg/0.5ml dispense syringes/pens	Maximum of 6 mls every 28 days
Rebif (interferon beta-1a) 8.8-22 mcg titration pack	Maximum of 4.20mls every 28 days
Rebif Rebidose(interferon beta-1a) 8.8-22mcg titration pack	Maximum of 4.20mls every 28 days
Rectiv (nitroglycerin) ointment	Minimum age = 18
Relenza (zanamivir)	Minimum age = 6; Maximum of 2 prescriptions every 365 days; Maximum quantity per fill = 20g
Relpax (eletriptan)	Minimum age = 18; Maximum of 6 tablets every 30 days
Remeron (mirtazapine) tablets and ODT	Minimum age = 6
Renvela (sevelamer) powder for oral suspension	Maximum age = 11
Repatha (evolocumab) Pen Injection/Syringe	Minimum age = 18
Restoril (temazepam) Capsules	Minimum age = 18
Retin-A (tretinoin) 0.01% & 0.025% gel, 0.025%, 0.05%, 0.1% cream, 0.05% liquid/solution	Minimum Age= 12
Retin-A Micro (tretinoin) 0.04% 0.1% gel, gel pump	Minimum Age= 12
Revlimid (lenalidomide) capsules	Minimum age = 18; Maximum of 1 capsule per day; Maximum of 30 capsules every 30 days
Rexulti (brexpirazole) tablets	Minimum age = 18
Rhinocort (budesonide) AQ	Maximum of 8.6g every 30 days
Ribavirin (Rebetol; Virazole) Capsules, Tablets, Oral solution, Powder for nebulizer solution	Minimum age = 5
Risperdal (risperidone) Consta	Minimum age = 18; Maximum of 2 boxes every 28 days
Risperdal (risperidone) 1mg/ml solution	Minimum age = 6; Maximum of 4mls per day for ages = 6 – 11; Maximum of 6mls per day for ages = 12-17; Maximum of 16mls per day for ages =/> 18
Risperdal (risperidone) 0.25mg, 0.5mg tablets (including M/ODT)	Minimum age = 6; Maximum of 8 tablets per day for ages = 6 – 17; Maximum of 2 tablets per day for ages =/> 18
Risperdal (risperidone) 1mg tablets (including M/ODT)	Minimum age = 6; Maximum of 4 tablets per day for ages = 6 – 11; Maximum of 6 tablets per day for ages = 12-17; Maximum of 2 tablets per day for ages =/> 18

Summary of Drug Limitations (07/31/2016)	
Risperdal (risperidone) 2mg tablets (including M/ODT)	Minimum age = 6; Maximum of 2 tablets per day for ages = 6 – 11; Maximum of 3 tablets per day for ages = 12-17 Maximum of 2 tablets per day for ages =/> 18
Risperdal (risperidone) 3mg tablets (including M/ODT)	Minimum age = 6; Maximum of 1.33 tablets per day for ages = 6 – 11; Maximum of 2 tablets per day for ages = 12-17; Maximum of 4 tablets per day for ages =/> 18
Risperdal (risperidone) 4 mg tablets (including M/ODT)	Minimum age = 6; Maximum of 1 tablet per day for ages = 6 – 11; Maximum of 1.5 tablets per day for ages = 12-17; Maximum of 4 tablets per day for ages =/> 18
Ritalin LA (methylphenidate) 10mg, 20mg capsules	Minimum age = 6; Maximum of 1 capsule per day for ages 0-5 Maximum of 1 capsule per day for ages >/= 18
Ritalin LA (methylphenidate) 30mg capsules	Minimum age = 6; Maximum of 0.833 capsules per day for ages 0-5 Maximum of 1 capsule per day for ages >/= 18
Ritalin LA (methylphenidate) 40mg capsules	Minimum age = 6; Maximum of 0.625 capsules per day for ages 0-5 Maximum of 1 capsule per day for ages >/= 18
Ritalin LA (methylphenidate) 60mg capsules	Minimum age = 6; Maximum of 0.416 capsules per day for ages 0-5 Maximum of 1 capsule per day for ages >/= 18
Robinul (glycopyrrolate) vials	Maximum 30ml per day
Rozerem (ramelteon) Tablets	Minimum age = 18 Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Sandostatin LAR Depot (octreotide) kit, Powder for suspension for Injection	Minimum age = 6
Saphris (asenapine) 5mg SL tablets	Minimum age = 10; Maximum of 2 tablets per day for ages 6-17; Maximum of 2 tablets per day for ages =/> 18
Saphris (asenapine) 10mg SL tablets	Minimum age = 10; Maximum of 1 tablet per day for ages 6-11; Maximum of 2 tablets per day for ages 12-17; Maximum of 2 tablets per day for ages =/> 18
Sarafem (fluoxetine) tablet	Minimum age = 6
Savaysa (edoxaban tosylate) tablets	Minimum age = 18; Maximum of 1 tablet per day; Minimum of 30 tablets every 30 days
Schedule II – V controlled substances	Maximum of 4 fills per 30 days **For a diagnosis of Sickle Cell or Cancer:** Maximum of 6 fills per 30 days
Seasonique (ethinyl estradiol/levonorgestrel)	Maximum days supply = 91; Maximum of 91 tablets every 84 days
Sedative Hypnotics, non-barbiturate *** (excluding injectable formulations)	Maximum of 30 tablets/capsules every 30 days
Selzentry (maraviroc) tablets	Minimum age = 16
Sensipar (cinacalcet) Tablets	Minimum age = 18
Serevent (salmeterol) Diskus	Minimum age = 4; Maximum of 1 inhaler every 30 days

Summary of Drug Limitations (07/31/2016)	
Seroquel (quetiapine) 25mg tablets	Minimum age = 6; Maximum of 8 tablets per day for ages = 6 - 17; Maximum of 2 tablets per day for ages =/> 18
Seroquel (quetiapine) 50 mg tablets (including XR)	Minimum age = 6; Maximum of 6 tablets per day for ages = 6 – 17; Maximum of 2 tablets per day for ages =/> 18
Seroquel (quetiapine) 100mg tablets	Minimum age = 6; Maximum of 4 tablets per day for ages = 6 – 11; Maximum of 5 tablets per day for ages = 12 -17; Maximum of 2 tablets per day for ages =/> 18
Seroquel (quetiapine) 150mg XR tablets	Maximum of 2.67 tablets per day for ages = 6-11; Maximum of 5.33 tablets per day for ages = 12-17; Maximum of 5 tablets per day for ages = /> 18
Seroquel (quetiapine) 200mg tablets (including XR)	Maximum of 2 tablets per day for ages = 6 – 11; Maximum of 4 tablets per day for ages = 12 -17; Maximum of 5 tablets per day for ages = /> 18
Seroquel (quetiapine) 300mg tablets (including XR)	Maximum of 1.33 tablets per day for ages = 6-11; Maximum of 2.7 tablets per day for ages = 12-17; Maximum of 3 tablets per day for ages = /> 18
Seroquel (quetiapine) 400mg tablets (including XR)	Maximum of 1 tablets per day for ages = 6 – 11; Maximum of 2 tablets per day for ages = 12 -17; Maximum of 2 tablets per day for ages = /> 18
Serostim (somatropin) 4mg, 5mg, 6mg vials	Minimum age = 18
Setlakin (ethinyl estradiol/levonorgestrel)	Maximum days supply = 91; Maximum of 91 tablets every 84 days
Silenor (doxepin) tablets	Minimum age = 6
Simponi (golimumab) solution for injection	Minimum age = 18
Simponi Aria (golimumab) vial	Minimum age = 18
Singulair (montelukast)	Maximum of 30 tablets every 30 days
Singulair (montelukast) 4mg granules	Maximum age = 4
Skeletal Muscle Relaxants ☐ Baclofen Tablets ☐ Lorzone (chlorzoxazone) Tablets ☐ Amrix/Fexmid (cyclobenzaprine) Capsules/Tablets ☐ Orphenadrine ER Tablets ☐ Robaxin (methocarbamol) Tablets ☐ Zanaflex (tizanidine) Capsules/Tablets	Maximum of 6 fills every 365 days Note: Baclofen and Zanaflex duration limitation is dependent upon the diagnosis; please review the automation logic via : http://ahca.myflorida.com/medicaid/Prescribed_Drug/drug_criteria.shtml
Smoking Deterrents	Minimum age = 18; Maximum of 168 days (24 weeks) of therapy every 365 days
Sodium Fluoride Drops	Maximum days supply = 50
Sonata (zaleplon) Capsules	Minimum age = 18; Maximum of 2 capsules per day; Maximum of 60 capsules every 30 days
Soma (carisoprodol)/ Soma compound	Maximum 120 tablets per 365 days
Somatropin (Genotropin cartridge, miniquick syringes Humatrope cartridge, vials Norditropin cartridge, vials Norditropin Flexpro cartridges Nutropin AQ cartridges, vials Saizen cartridges, vials Tev-Tropin vials, Zomacton vials, Zorbtive vials)	Maximum age = 16
Sovaldi (sofobuvir) tablets	Minimum age = 18

Summary of Drug Limitations (07/31/2016)	
Spiriva (tiotropium) 18mcg capsules with device	Minimum age = 18; Maximum of 30 capsules per 30 days
Sporanox (itraconazole)	Maximum of 6 tablets per day
Sprycel (dasatinib) 50mg, 70mg 100mg, 140mg tablets	Minimum age = 18; Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Sprycel (dasatinib) 20mg, 80mg tablets	Minimum age = 18; Maximum of 2 tablet per day; Maximum of 60 tablets every 30 days
Statins	Maximum of 2 tablets per day [excluding Lipitor (atorvastatin) and Livalo (pitavastatin)]
Stelara (ustekinumab) Solution for Injection	Minimum age = 18
Stivarga (regorafenib) capsules	Minimum age = 18; Maximum of 4 capsules per day; Maximum of 120 capsules every 30 days
Strattera (atomoxetine) capsules	Minimum age = 6
Stribild (elvitegravir/cobicistat/emtricitabine/tenofovir)	Minimum age = 18; Maximum of 1 tablet per day
Subsys (fentanyl) spray	Minimum age = 18; Maximum of 4 units per day; Maximum of 120 units every 30 days
Sumavel System (sumatriptan) DosePro Needless System	Minimum age = 18
Supprelin LA (histrelin) implant	Minimum age =2; Maximum age = 12; Maximum day supply =355 days; Maximum of 1 kit every 355 days; Maximum quantity per fill =1
Surmontil (trimipramine) capsules	Minimum age = 6
Sutent (sunitinib) capsules	Minimum age = 18; Maximum of 1 capsule per day; Maximum of 30 capsules every 30 days
Symbicort (budesonide and formoterol) inhaler	Minimum age = 5 Maximum of 1 inhaler every 30 days; For 6 count: Maximum of 6 units per fill For 6.9 count: Maximum of 6.9 units per fill For 10.2 count: Maximum of 10.2 units per fill
Symbyax (olanzapine/fluoxetine) capsules	Minimum age = 18; Maximum of 1 capsule per day
Synagis (palivizumab)	Maximum age = 2; Maximum of 5 doses between July 1st and April 30th
Synarel (nafarelin) nasal spray	Maximum of 40mg (5 bottles) per 27 days.
Synribo (omacetaxine) vial	Minimum age = 18
Tafinlar (dabrafenib) capsules	Minimum age = 18; Maximum of 4 capsules per day; Maximum of 120 capsules every 30 days
Tagrisso (osimertinib) tablets	Maximum of 1 tablet per day
Tamiflu (oseltamivir) capsules/suspension	Maximum of 2 prescriptions every 365 days; Maximum of 10 capsules per fill (excluding 30mg –maximum of 20 capsules per fill); Maximum age = 18 on suspension; Maximum quantity of 180ml per fill (12.5ml per day)
Tamoxifen 10mg tablets	Minimum age = 18; Maximum of 3 tablets per day; Maximum of 90 tablets every 30 days
Tamoxifen 20mg tablets	Minimum age = 18; Maximum of 2 tablets per day; Maximum of 60 tablets every 30 days

Summary of Drug Limitations (07/31/2016)	
Tarceva (erlotinib) tablets	Minimum age = 18; Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Targretin (bexarotene) capsules	Minimum age = 18; Maximum of 60 capsules every 30 days
Tasigna (nilotinib) 150mg capsules	Minimum age = 18; Maximum of 4 capsules per day; Maximum of 120 capsules every 30 days
Tasigna (nilotinib) 200mg capsules	Minimum age = 18; Maximum of 4 capsules per day; Maximum of 120 capsules every 30 days
Tazorac (tazarotene)	Maximum of 30g every 30 days
Tecfidera (dimethyl fumarate)	Minimum age = 18
Technivie (ombitasvir/paritaprevir/ritonavir) Tablets	Minimum age = 18
Temodar (temozolomide) capsules	Maximum of 60 capsules every 30 days
Terazol (terconazole) 3 cream	Maximum quantity per fill = 20g
Terazol (terconazole) 3 suppository	Maximum quantity per fill = 3
Terazol (terconazole) 7 cream	Maximum quantity per fill = 45g
Thalomid (thalidomide) 50mg, 100mg, 150mg Capsules	Maximum of 1 capsule per day; Maximum of 30 capsules every 30 days
Thalomid (thalidomide) 200mg	Maximum of 2capsules per day; Maximum of 60 capsules every 30 days
Thioridazine 10mg, 25mg, 50mg tablets	Minimum age = 18; Maximum of 4 tablets per day for ages =/> 18
Thioridazine 100mg tablets	Minimum age = 18; Maximum of 8 tablets per day for ages =/> 18
Thiothixene 1mg, 2mg, 5mg capsules	Minimum age = 18; Maximum of 3 capsules per day for ages =/> 18
Thiothixene 10mg capsules	Minimum age = 18; Maximum of 6 capsules per day for ages =/> 18
Timolol drops	Maximum of 15ml every 30 days
Tobramycin drops	Maximum of 10ml every 30 days
Tobi (tobramycin) solution for inhalation 300mg/5ml	Maximum of 280ml every 56 days
Tofranil (imipramine) tablets	Minimum age = 6
Tramadol extended release tablets	Minimum age = 18; Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Trandate (labetalol)	Maximum of 8 tablets per day
Transderm Scop (scopolamine) Patches	Maximum of 10 patches every 30 days
Tranxene (clorazepate) 3.75mg, 7.5mg, 15mg tablets	Minimum age = 9; Maximum of 4 tablets per day; Maximum of 120 tablets per 30 days
Travatan (travoprost) Z drops	Maximum of 5ml every 30 days
Trazodone tablets	Minimum age = 6
Tretinoin capsules	Minimum age = 1
Treximet (sumatriptan/naproxen)	Minimum age = 12; Maximum of 9 tablets every 30 days
Trifluoperazine 1mg, 2mg, 5mg tablets	Minimum age = 18; Maximum of 3 tablets per day for ages =/> 18
Trifluoperazine 10mg tablets	Minimum age = 18 Maximum of 4 tablets per day for ages =/> 18
Triumeq (abacavir/dolutegravir/lamivudine) tablets	Minimum age = 18; Maximum of 1 tablet per day
Trokendi (topiramate XR) capsules	Minimum age = 6
Trospium Tablets, ER	Minimum age = 17

Summary of Drug Limitations (07/31/2016)	
Tybost (cobicistat) tablets	Minimum age = 18; Maximum of 1 tablet per day
Tygacil (tigecyline) powder for injection	Minimum age = 18
Tykerb (lapatinib) tablets	Minimum age = 18; Maximum of 6 tablets per day; Maximum of 180 tablets every 30 days
Tylenol (acetaminophen) containing products	Maximum of 4GM (4000mg) per day
Tylenol (acetaminophen) 160mg chew tablets, disintegrating tablets, elixir, liquid, solution, suspension	Maximum age = 6
Tylenol (acetaminophen) Arthritis	Maximum of 150 tablets every 30 days
Tylenol (acetaminophen) with codeine tablets	Minimum age = 6; Maximum of 12 tablets per day
Tyvaso (treprostinil) nebulizer solution	Maximum of 81.20mls every 28 days
Ulesfia (benzyl alcohol) Lotion	Minimum age = 6 months
Ultracet (tramadol/acetaminophen) tablets	Minimum age = 18; Maximum of 8 tablets per day
Ultram (tramadol) tablets	Maximum of 8 tablets per day; **For ages 0-15 years:** Maximum of 60 tablets every 27 days
Ultram ER (tramadol extended release) tablets	Minimum age = 18; Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Vagifem vaginal tablets (estradiol)	Maximum 1 fill per 28 days; Package size 8 – maximum of 8 tabs per 28 days; Package size 18 – maximum of 18 tabs per 28 days; Female gender only
Vaginal Antibiotics	Female gender only
Vaginal Antifungals	Female gender only
Vaginal Estrogen Preparations	Female gender only
Vaginal Sulfonamides	Female gender only
Vanatol LQ (butalbital/acetaminophen/caffeine) oral solution	180ml per 355 days
Veltin (clindamycin/tretinoin) gel	Minimum Age= 12
Venclexta (Venetoclax) 10-50-100mg Dose Pack	Minimum age= 18; Maximum of 42 tablets every 30 days; Maximum of 1 fill per 365 days
Venclexta (Venetoclax) 10mg tablet	Minimum age= 18; Maximum of 2 tablets per day; Maximum of 14 tablets every 30 days
Venclexta (Venetoclax) 50mg tablet	Minimum age= 18; Maximum of 1 tablet per day; Maximum of 7 tablets every 30 days
Venclexta (Venetoclax) 100 mg tablet	Minimum age= 18; Maximum of 4 tablets per day; Maximum of 120 tablets every 30 days
Ventolin (albuterol) HFA	Maximum quantity of 2 inhalers every 30 days
Veregen (sinecatechins) Ointment	Minimum age = 18
Ventavis (iloprost) nebulizer solution	Maximum of 270ml every 30 days
Versacloz (clozapine) 50mg/ml suspension	Minimum age = 6; Maximum of 300mg per day for ages = 6 – 11; Maximum of 600mg per day for ages = 12-17; Maximum of 18ml per day for ages =/> 18
Viadur (leuprolide/lidocaine) implant Kit	Male gender only; Minimum age = 18
Vibativ (telavancin)	Minimum age = 18

Summary of Drug Limitations (07/31/2016)	
Vicodin (hydrocodone/acetaminphen) 5/300mg	Maximum of 8 tablets per day
Vicodin (hydrocodone/acetaminophen) ES 7.5/300mg	Maximum of 6 tablets per day
Vicodin HP (hydrocodone/acetaminophen) 10/300mg	Maximum of 6 tablets per day
Victoza (liraglutide) Solution for Injection	Minimum age = 18
Viekira (dasabuvir/ombitasvir/paritaprevir/ritonavir) Dose Pak	Minimum age = 18
Vigamox (moxifloxacin) drops	Maximum of 6ml every 30 days
Viibryd (vilazodone) tablets, starter kit	Minimum age = 18
Vitekta (elvitegravir) Tablets	Minimum age = 18; Maximum of 1 tablet per day
Vivelle-Dot (estradiol) patches	Maximum of 8 patches every 30 days
Votrient (pazopanib) tablets	Minimum age = 18; Maximum of 4 tablets per day; Maximum of 120 tablets every 30 days
Vpriv (velaglucerase alfa) Vials	Minimum age = 4; Maximum of 41 vials every 28 days
Vraylar (cariprazine) capsules	Minimum age = 18
Vyvanse (lisdexamfetamine) capsules	Minimum age = 6; Maximum of 1 capsule per day
Wellbutrin (buproprion) IR/SR/ER/XL	Minimum age = 6
WinRho (Rho(D) Immune Globulin)	Maximum of 2 prescriptions every 365 days
Xalatan (latanoprost) drops	Maximum of 5ml every 30 days
Xalkori (crizotinib) Capsules	Minimum age = 18; Maximum of 2 capsules per day; Maximum of 60 capsules every 30 days
Xanax (alprazolam) – not including XR/ER	Minimum age = 7; Maximum of 5 tablets per day; Maximum of 150 tablets per 30 days
Xanax XR (alprazolam ER)	Minimum age = 18; Maximum of 30 tablets every 30 days
Xartemis (oxycodone/acetaminophen) tablets	Maximum of 4 tablets per day
Xeljanz / XR (tofacitinib) tablet	Minimum age = 18
Xeloda (capecitabine) Tablets	Minimum age = 18; Maximum of 120 tablets every 30 days
Xenazine (tetrabenazine) Tablets	Minimum age = 18
Xifaxan (rifaximin) Tablets	Minimum age = 12
Xolair (omalizumab) Powder for Injection	Minimum age = 12
Xopenex (levalbuterol) Nebulizer solution	Maximum of 288ml (4 Boxes) every 30 days
Xopenex (levalbuterol) HFA	Maximum of 30g (2 inhalers) every 30 days
Xtampza ER (oxycodone myristate) capsules	Minimum Age= 18
Xtandi (enzalutamide) Capsules	Minimum age = 18; Maximum of 4 capsules per day; Maximum of 120 capsules every 30 days
Xulane (ethinyl estradiol /norelgestromin) Transdermal Patch	Minimum age = 12; Female gender only
Xyrem (sodium oxybate) Solution	Minimum age = 16
Yervoy (ipilimumab) solution for injection	Minimum age = 18
Zavesca (miglustat) Capsules	Minimum age = 18; Maximum of 3 capsules per day
Zegerid (omeprazole/sodium bicarbonate) capsules/packets	Minimum age = 18; Maximum of 1 capsule/packet per day
Z-Clinz (benzoyl peroxide/clindamycin) 10/5 PAC	Minimum Age= 12

Summary of Drug Limitations (07/31/2016)	
Zelboraf (vemurafenib) Tablet	Minimum age = 18; Maximum of 8 tablets per day; Maximum of 240 tablets every 30 days
Zemaira (alpha-1-proteinase inhibitor human)	Minimum age = 18
Zembrace (sumatriptan) Symtouch pen injectable	Minimum age = 18
Zenzedi (dextroamphetamine) 25mg, 5mg, 7.5mg Tablets	Maximum of 2 tablet per day for ages 0-5 Maximum of 2 tablets per day for ages =/> 18
Zenzedi (dextroamphetamine) 10mg, 15mgTablets	Maximum of 1 tablet per day for ages 0-5 Maximum of 2 tablets per day for ages =/> 18
Zenzedi (dextroamphetamine) 20mg Tablets	Maximum of 0.75 tablets per day for ages 0-5 Maximum of 2 tablets per day for ages =/> 18
Zenzedi (dextroamphetamine) 30mg Tablets	Maximum of 0.5 tablets per day for ages 0-5 Maximum of 2 tablets per day for ages =/> 18
Zepatier (elbasvir/grazoprevir) tablets	Minimum age = 18
Zetia (ezetimibe) Tablets	Minimum age = 10; Maximum of 1 tablet per day; Maximum of 30 tablets every 30 days
Ziana (clindamycin/tretinoin) Gel	Minimum Age= 12
Zofran (ondansetron) 2mg/ml Vial	Maximum of 32ml every 28 days
Zofran (ondansetron)/ODT 4mg, 8mg	Maximum of 60 tablets every 30 days
Zofran (ondansetron) 4mg/5ml Solution	Maximum of 600ml every 28 days
Zohydro (hydrocodone) ER Capsules	Minimum age = 18; Maximum of 2 capsules per day (Excluding recipients with a diagnosis of cancer or sickle cell)
Zoladex (goserelin) implant 3.6mg	Minimum age = 18
Zoladex (goserelin) implant 10.8mg	Minimum age = 18; Male gender only
Zolinza (vorinostat) Capsules	Minimum age = 18; Maximum of 4 capsules per day; Maximum of 120 capsules every 30 days
Zoloft (sertraline) Solution 20mg/ml	Minimum age =6; Maximum age = 11; Maximum of 10ml per day
Zoloft (setratline) Tablets	Minimum age = 6
Zomig (zolmitriptan) 2.5mg, 5mg, 2.5mgZMT, 5mgZMT	Minimum age = 18; Maximum of 6 units every 30 days
Zomig (zolmitriptan) Nasal Spray	Minimum age = 12; Maximum of 6 units every 30 days
Zostavax (varicella virus) vaccination	LTC residents; Minimum age = 50; Maximum age = 64; Maximum of 1 vaccination per lifetime
Zovirax (acyclovir) cream/ointment	Minimum age = 12
Zubsolv (buprenorphine/naloxone) sublingual tablets	Minimum age = 16; Maximum of 3 sublingual tablets per day
Zyban (bupropion) ER tablets	Minimum age = 18; Maximum of 2 tablets per day
Zykadia (ceritinib) capsules	Minimum age = 18; Maximum of 5 capsules per days; Maximum of 150 capsules per 30 days
Zyprexa (olanzapine) tablets (excluding vials)	Minimum age = 6; Maximum of 10mg per day for ages = 6 – 11; Maximum of 20mg per day for ages = 12-17

Summary of Drug Limitations (07/31/2016)	
Zyprexa (olanzapine) tablets (excluding vials and 15mg tablets)	Minimum age = 6; Maximum of 1 tablet per day for age =/> 18
Zyprexa (olanzapine) 15mg tablet	Minimum age = 6; Maximum of 2 tablets (30mg) per day for age =/> 18
Zyprexa Relprevv 210mg, 300mg vials	Minimum age = 18; Maximum of 2 vials every 28 day for ages =/> 18
Zyprexa Relprevv 405mg vials	Minimum age = 18; Maximum of 1 vial every 28 day for ages =/> 18
Zyprexa 10mg vial	Minimum age = 18; Maximum of 3 vials per day for ages =/> 18
Zyprexa (olanzapine) Zydis 5mg, 10mg, 20mg tablets	Minimum age = 6; Maximum of 1 tablet per day for ages = 6 -17; Maximum of 1 tablet per day for ages =/> 18
Zyprexa (olanzapine) Zydis 15mg tablets	Minimum age = 6; Maximum of 1 tablet per day for ages = 6 -17; Maximum of 2 tablet per day for ages =/> 18
Zytiga (abiraterone) tablets	Minimum age = 18; Maximum of 4 tablets per day; Maximum of 120 tablets every 30 days

Plan Unique Drug Limitations Not Necessarily Included in the Master List (AHCA) Below		
Plan	**Drug**	**Limitation**
CCP/SFCCN CCP/SFCCN_2016_004_QL_Lidocaine Eff Date of Change: 4/1/16	Lidocaine cream & ointment, All strengths (Brand & Generic)	Minimum age = 18 years; NCPDP 76: "Max allowed 60 per 30 days" (coding per 27 days for refill tolerance) GSNs: 7407, 7408, 7409, 14476, 40261, 40262, 51771, 53412, 68687, 70753, 71285, 72055, 73097, 73280
MCC-FL MCCFL_2016_003_QL_Lidocaine Eff Date of Change: 4/1/16	Lidocaine cream & ointment, All strengths (Brand & Generic)	Minimum age = 18 years; NCPDP 76: "Age >/= 18 years; Max allowed 60 per 30 days" (coding per 27 days for refill tolerance) GSNs: 7407, 7408, 7409, 14476, 40261, 40262, 51771, 53412, 68687, 70753, 71285, 72055, 73097, 73280

* All limitations are applicable to Brand and Generic formulations

** Separate quantity limits for Xanax, Ativan, and Diazepam tablets

***Separate quantity limits for Halcion, Midazolam, and Sonata

SUMMARY OF SERVICE LIMITATIONS

(Adapted from the Florida Medicaid Prescribed Drug Services Pharmacy Handbook)

For the drugs listed below, the Plan has instructed that the call center inform the provider community by using positive statements concerning service limitations. For example, instead of saying that a product "is not covered for patients over the age of 21", it is recommended to make statements such as "cough/cold products are only covered for recipients < than 21 years of age".

Please inform the provider of the limitation. Forward to a pharmacist if necessary.

Product/Drug Class	Limitation	Examples of Specific Medications
Amphetamines	Medicaid only reimburses for amphetamines when prescribed for an indication other than obesity for example narcolepsy or hyperkinesis. The indication must be on the prescription	Amphetamine salt, dextroamphetamine, etc. HIC3 = J5B
Cough and Cold Medications	Single entity antihistamines that are Rx are covered for all recipients	Cyproheptadine, hydroxyzine, promethazine, etc. HIC3 = Z2P
	Single entity guaifenesin, OTC or Rx, is covered for all recipients	Guaifenesin tabs, guaifenesin syrup, etc. HIC3 = B3J
	Rx antihistamine-decongestant combinations (2 ingredients only) are covered for all recipients when used to treat seasonal allergic rhinitis	Ryna-12 suspension, Histex-SR, etc. HIC3 = Z2N
	All other cough and cold medications including antitussives, decongestants, expectorants other than guaifenesin or any other combination that includes one or more of the above ingredients are limited to recipients under the age of 21. There are no circumstances where any request for a recipient > 21 yrs of age would be approved. There are no provisions made for or exceptions to this limitation; pharmacists would Deny for Service not covered due to maximum age limit exceeded.	Hycodan syrup, Tessalon Perles (benzonatate), Tussionex, etc. HIC3 = B3R, B3Y, B4C, B4D, H6C
Erectile Dysfunction Agents	Medicaid does not approve these agents for ED	Cialis, Levitra, Viagra HIC3 = F2A
Laxatives	Medicaid does not cover laxatives with the exception of Polyethylene Glycol (generic for MiraLAX) for children under the age of 21. Lactulose is covered only when used to treat hyperammonemia or bowel impaction secondary to a chronic condition such as quadriplegia	Includes all laxatives with the exception of what is listed under limitations HIC3 = D6S
Sedative Hypnotics	Reimbursement of oral dose forms of any sedative hypnotic will be limited to no more than 45 units per 25 days (IE 7001)	Lorazepam, triazolam, zolpidem, etc. HIC3 = H2E
Smoking Cessation Products	Reimbursement for these products are limited to twenty-four weeks duration per 365 days, or the manufacturer's recommendation whichever is less	Nicotine patches, nicotine gum, Zyban® HIC3 = H7N, J3A

Please note that all HIC3s provided may not be inclusive.

SYLATRON® (PEGINTERFERON ALPHA-2B)

Length of Authorization:	Per prescription, No more than one year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years of age.
- ☐ Must have a diagnosis consistent with melanoma (skin cancer) involving surgical removal within the past 90 days.
- ☐ Must be prescribed by an Oncology (Cancer) Specialist.

SYNAGIS® (PALIVIZUMAB)

Length of Authorization:	Please refer to specific instructions below for length of authorization and quantity allowed.
PA Entry:	Coverage Period: *July 1st through April 30th. No authorizations for May and June.* July 1st to April 30th (Approvals must be entered with an end date for the first day of the following month [i.e., if the actual PA end date is April 30th, the end date must be entered for May 1st.]) **NOTE: Pharmacies should not submit separate claims for different dosage strength vials to be administered on the same date. Only one compound claim submission will be necessary. For example, if the Synagis dosage is 150 mg the pharmacy should submit a compound claim that lists the two different strength vials (100mg and 50mg).**
Initiative:	MAP: Synagis (75 / 2462 – GSN; 76 / 2641 – GSN) MAP: Error Code 7007 Override (76 / 7007 – GSN; 76 / 2641 – GSN)
Fax Forms:	Synagis – All Florida Regions Combined; Synagis – Weight Change

LENGTH OF AUTHORIZATION AND NUMBER OF DOSES TO ALLOW

For the 2016-2017 season, the maximum number of doses that may be approved has been reduced from 7 to 5. And some scenarios allow only 3 doses.

Coverage Period: *July 1st through April 30th. No authorizations for May and June.*

- ☐ Authorize for a maximum of 5 doses during RSV reason (maximum of 5 monthly doses of 15 mg/kg IM) for all recipients EXCEPT:
- ☐ Authorize a maximum of 3 doses or up to 90 days of age (whichever occurs first) for infants born between 29 weeks 1 day and 34 weeks, 6 days gestational age AND who are currently less than 3 months of age at the start of RSV season AND who have at least one of the following two risk factors:
  - ☐ Recipient has a sibling or other child under age 5 living permanently in their home
  - ☐ Recipient attends child care/day care where multiple children are present
- ☐ In infants and children < 24 months, already on prophylaxis and eligible, one post-op dose can be approved after cardiac bypass or after extracorporeal membrane oxygenation (ECMO).

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SYNAGIS® (PALIVIZUMAB) (CONTINUED)

APPROVAL CRITERIA FOR SYNAGIS

Technicians: If you are uncertain about the patient's medical condition or diagnosis submitted for consideration, please escalate to a pharmacist.

Palivizumab will be approved in the following scenarios:

Infant/Child Age at Start of RSV Season	Criteria
< 12 months (first year of life)	☐ GA< 29 wks, 0 d (otherwise healthy) ☐ CLD of prematurity (GA<32 wks, 0 d and with supplemental O2 for at least the first 28 d after birth) ☐ Anatomic pulmonary abnormalities or neuromuscular disorder, or congenital anomaly that impairs the ability to clear secretions ☐ Profoundly immunocompromised with conditions such as SCID, immunocompromised infant with stem cell transplant, severe acquired immunodeficiency syndrome (AIDS) ☐ CF with CLD and/or nutritional compromise ☐ GA 29 wks 1 d-34 wks, 6 d who are less than 3 months of age at the start of RSV season and have at least one risk factor (siblings or other children ☐ < 5 y living permanently in the home OR recipient attends day care/ child care with multiple children)-Maximum of 3 doses
< 12 months (first year of life)	☐ CHD (hemodynamically significant) with acyanotic* heart disease on medications to control CHF and will require cardiac surgery or infants with moderate to severe PH. For cyanotic* heart defects, a pediatric cardiologist should be consulted.
> 12 months to 23 months	☐ CLD of prematurity (GA < 32 wks, 0 d and supplemental O2 for at least the first 28 d after birth) and medical support (chronic systemic steroids, diuretic therapy, or supplemental O2) within 6 months before start of 2nd RSV season ☐ CF with severe lung disease** or weight for length < 10th percentile
< 24 months (2nd year of life)	☐ Cardiac transplant during RSV season ☐ Already on prophylaxis and eligible; give post-op dose after cardiac bypass or after ECMO ☐ Profoundly immunocompromised with conditions such as SCID, immunocompromised infant with stem cell transplant, severe acquired immunodeficiency syndrome (AIDS)

GA=gestational age; wks=weeks; d=day; CLD=chronic lung disease; SCID= severe combined immune deficiency; CHD=congenital heart disease; O2=oxygen; HD=heart disease; CHF=congestive heart failure; PH=pulmonary hypertension; CF=cystic fibrosis; ECMO=extracorporeal membrane oxygenation

* Examples of acyanotic heart defects include ventricular septal defects, atrial septal defects, pulmonary valve stenosis and aortic valve stenosis. For cyanotic heart defects, a pediatric cardiologist should be consulted

** Examples of severe lung disease: previous hospitalization for pulmonary exacerbation in the 1st year of life, abnormalities on chest radiography [chest X-ray], or chest computed tomography [chest CT] that persist when stable

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DENIAL CRITERIA

Palivizumab will NOT be approved in the following scenarios:

Infant/Child Age at Start of RSV Season	Deny: Not Approvable
> 12 months (2nd year of life)	☐ Based on prematurity alone ☐ CLD without medical support (chronic systemic steroids, diuretic therapy or supplemental O2) ☐ CHD ☐ Otherwise healthy children in 2nd year of life
Any age	☐ Breakthrough RSV hospitalization *** ☐ Hemodynamically *insignificant* CHD **** ☐ CHD lesions corrected by surgery (unless on CHF meds) ☐ CHD and mild cardiomyopathy not on medical therapy ☐ CHD in 2nd year of life
No specific age defined	☐ Asthma prevention ☐ Reduce wheezing episodes ☐ Down Syndrome ☐ CF (otherwise healthy) ☐ Healthcare-associated RSV disease *****

***If any infant or child is receiving palivizumab prophylaxis and experiences a breakthrough RSV hospitalization, discontinue palivizumab, because the likelihood of a second RSV hospitalization in the same season is extremely low.

****Examples of hemodynamically insignificant CHD: secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, patent ductus arteriosus.

***** No rigorous data exist to support palivizumab use in controlling outbreaks of health care-associated disease; palivizumab use is not recommended for this purpose.

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WEIGHT CHANGE CRITERIA FOR SYNAGIS® (PALIVIZUMAB)

- All weights must be verified for dosing accuracy.
- Any dosage increase must have corresponding weight charts and/or progress notes with current weight. (This documentation must be dated and signed by the requesting practitioner.)
- In cases where immediate administration of medication is required, providers should use the currently authorized vial size(s), then submit a weight change request, which will be applied to subsequent dosages only.
- If the dose needed is less than 5 mg over the approved vial size, round down to the nearest vial size. If the dose needed is ≥ 5 mg over the approved vial size, then the new vial size will be approved. For those patients who are expected to gain enough weight to need an additional vial, please schedule a visit to obtain weight and receive approval for dose increase prior to the Synagis® administration date. There are no immediate approvals for "waiting" patients.

Pharmacies should not submit separate claims for different dosage strength vials to be administered on the same date. Only one compound claim submission will be necessary. For example, if the Synagis dosage is 150 mg, the pharmacy should submit a compound claim that lists the two different strength vials (100mg and 50mg).

Note: When approving a PA request for Synagis, the following fax back response must be used: "Coverage Period: July 1st through April 30th only. Maximum of 5 doses."

SYNRIBO® (OMACETAXINE MEPESUCCINATE)

Length of Authorization:	90 days
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥18 years old
- ☐ Must have current history of chronic myeloid leukemia (CML) in chronic phase or accelerated phase that can be verified by progress notes, discharge notes, health conditions, or medication claims history.
- ☐ Patient must have failed therapy with at least two tyrosine kinase inhibitors (TKIs):

Tyrosine Kinase Inhibitors used for the treatment of CML
Bosulif (bosutinib)
Gleevec (imatinib)
Iclusig (ponatinib)
Sprycel (dasatinib)
Tasigna (nilotinib)

TECFIDERA® (DIMETHYL FUMARATE) DELAYED-RELEASE CAPSULES

Length of Authorization:	6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

INITIATION OF THERAPY

- ☐ Patient must be ≥ 18 years old.
- ☐ Must have a diagnosis of a relapsing form of Multiple Sclerosis (RRMS) verified by progress notes, discharge notes, or health conditions.
- ☐ Previous trial with insufficient response or adverse reaction or contraindication to Copaxone (glatiramer) or an Interferon Beta (e.g., Avonex, Rebif).

CONTINUATION OF THERAPY

- ☐ Patient must be ≥ 18 years old.
- ☐ Must have a diagnosis of a relapsing form of Multiple Sclerosis (RRMS) verified by progress notes, discharge notes, or health conditions.
- ☐ Progress notes or medical records must demonstrate effectiveness of therapy.

DOSING AND ADMINISTRATION

- ☐ Dose: Starting dose: 120 mg twice a day orally for 7 days; Maintenance dose after 7 days: 240 mg twice a day orally
- ☐ Available as follows:
  - ☐ 30-day Starter Pack, (NDC 64406-007-03): 7-day bottle 120 mg capsules, quantity 14; 23-day bottle 240 mg capsules, quantity 46
  - ☐ 120 mg capsules: 7-day bottle of 14 capsules (NDC 64406-005-01)
  - ☐ 240 mg capsules: 30-day bottle of 60 capsules (NDC 64406-006-02)

TECHNIVIE® (OMBITASVIR/PARITAPREVIR/RITONAVIR)

Length of Authorization:	12 weeks
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)
Fax Form:	Hepatitis C Agents **[REQUIRED]**

REVIEW CRITERIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

1. Adult patient age ≥ 18 years old; **AND**
2. Prescribed by or in consultation with a hepatologist, gastroenterologist, infectious disease specialist or transplant physician; **AND**
3. Patient has no history of ombitasvir/paritaprevir/ritonavir (no claims history or reference in medical records to previous trial and failure of these medications) [Refer to **Appendix G** for additional information when reviewing for previous therapy]; **AND**
4. Treatment experienced patients are limited to those who have failed treatment with pegylated interferon/ribavirin (pegIFN/RBV)
5. One of the following:
   - ☐ Patient has abstained from the use of illicit drugs and alcohol for a minimum of one month as evidenced by negative urine or blood confirmation tests collected within the past 30 days, prior to initiation of therapy (results must be submitted with request);
     - ☐ If the test results submitted is positive the reviewer must review claims history or medical records to determine if medications are prescribed. If so, proceed to next step (#5).

   OR

   - ☐ Patient is receiving substance or alcohol abuse counseling services or seeing an addiction specialist as an adjunct to HCV treatment and it is documented in the medical records; **AND**
6. Baseline HCV RNA must be submitted with a collection date within the past three months. Prescriber must submit lab documentation indicating HCV genotype and quantitative viral load.
7. Patient meets the diagnosis criteria outlined in Dosing and Administration below; **AND**
8. Patient commits to the documented planned course of treatment including anticipated blood tests and visits, during and after treatment; **AND**
9. **No early refills will be allowed due to lost, stolen medications or vacation override.**
10. Females of childbearing potential must have a negative pregnancy test collected within 30 days prior to the initiation of therapy with ribavirin; **AND**
11. Lab results (HCV RNA) are recommended after 4 weeks of therapy and at 12 weeks following completion of therapy. The medication should not be discontinued or interrupted if HCV RNA levels are not available during treatment or are not performed.

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HEPATITIS C AUTOPA CODING INFO

- The following medications are included in AutoPA coding list "Hepatitis Therapy List B."
  - Peginterferon alfa-2a (Pegasys®); Peginterferon alfa-2b (Peg-Intron®/Redipen); Ribavirin (Copegus®, Moderiba®, RibaPak®, Ribasphere®, Ribatab®, Rebetol®
- When these medications are used in combination therapy with medications included in AutoPA coding list "Hepatitis Therapy List A" no prior authorization is required for medications in "Hepatitis Therapy List B" as long as the "Hepatitis Therapy List A" medication is billed first.
  - Harvoni®, Olysio®, Sovaldi®, and Viekira Pak®
- If the medication in "Hepatitis Therapy List A" is not billed first, then the following error messages will display:
  - IE 31003 – Automated PA; NCPDP 75 – Prior authorization required
  - Transaction Message: "Missing Prerequisite Drug Therapy"
- The Hepatitis C AutoPA coding logic is explained in greater detail here.

DOSING AND ADMINISTRATION

Dose: Two tablets taken orally once daily (in the morning) with a meal without regard to fat or calorie content. Each tablet contains 12.5 mg ombitasvir, 75 mg paritaprevir, and 50 mg ritonavir.

DIAGNOSIS: **1. HCV**	**Genotype 4 (with cirrhosis)**
DUAL THERAPY: TECHNIVIE + RIBAVIRIN	
Length of Authorization: 12 Weeks	

DENIAL CRITERIA

DIAGNOSIS: 1. **HCV**	**Genotype 1, 2, 3, 5, or 6**
***THERAPY REFERRAL*:** OTHER HEPATITIS C AGENTS	

DENIAL MESSAGE

TESTOSTERONE (NON-INJECTABLE FORMULATIONS)

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

INITIAL REVIEW CRITERIA

- ☐ Patient is ≥ 18 years old AND
- ☐ Patient is male AND
- ☐ Patient has a diagnosis of primary or secondary hypogonadism* AND
- ☐ Patient does not have a history of prostate carcinoma or male breast carcinoma AND
- ☐ Prescriber has submitted the results of two separate serum testosterone levels, each drawn in the morning, which indicate a low serum testosterone (normal range: 300 to 1,000 ng/dL) within the last six months

*Causes of hypogonadism are classified as primary which are due to failure of the testes, or secondary, which are due to failure of the hypothalamus or pituitary gland. Either type of hypogonadism, may be caused by an inherited (congenital) or acquired factor.

*Examples of primary male hypogonadism include but are not limited to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchidectomy, chemotherapy, radiation therapy, toxic damage from alcohol or heavy metals, testicular infections (such as mumps) and chromosomal abnormalities such as Klinefelter's Syndrome

*Examples of secondary male hypogonadism include but are not limited idiopathic gonadotropin or luteinizing hormone releasing hormone (LHRH) deficiency and pituitary hypothalamic injury from tumors, trauma, or radiation.

***Safety and efficacy in men "age-related hypogonadism" has not been established.*

PATIENTS WHO MEET CRITERIA SHOULD BE APPROVED FOR THE PREFERRED AGENTS- ANDROGEL GEL PACKET OR ANDROGEL GEL PUMP

PREFERRED –PA REQUIRED	NON-PREFERRED – PA REQUIRED
Androgel® Packet, Pump (*testosterone*)	

CONTINUATION OF THERAPY CRITERIA

- ☐ Patient has been compliant with treatment based on refill history
- ☐ Prescriber submits labs within the last twelve months indicating patient has a normal serum testosterone level on therapy (normal range: 300-1,000 ng/dL)

DOSING AND ADMINISTRATION

- ☐ AndroGel 1%: 5 grams once daily, preferably in the morning (delivers 5 mg systemically); dosing may be increased to 10 mg (by 2.5 mg increments)
- ☐ AndroGel 1.62%: 40.5 mg (1.25 g of gel) once daily. Dosing may be adjusted between 20.25 mg and 81 mg based on levels drawn at 14 and 28 days after start of therapy
  - ☐ Apply to clean, dry intact skin of the shoulders and upper arms; do not apply to the genitals
- ☐ AndroGel 1% is available as:
  - ☐ 2.5, 5 g packets (30 per package)
  - ☐ 75 g pump (2 per package); dispenses 60 metered 1.25 g doses
- ☐ AndroGel 1.62% is available as:
  - ☐ 1.25, 2.5 g packets (contains 20.25 mg or 40.5 mg testosterone, respectively; 30 packets)
  - ☐ 75 g pump with 60 pump actuations delivering 20.25 mg of testosterone per actuation (1.25 g of gel)

TOBI®/KITABIS® (TOBRAMYCIN NEBULIZED)

Length of Authorization:	1 year
Initiative:	Tobi (75 /2462 – GSN; 76 / 2641 – GSN)
Fax Form:	Tobi®

PRIOR AUTHORIZATION CRITERIA: (ALL CRITERIA MUST BE MET FOR APPROVAL)

NOTE: Prior authorization requests must be entered for brand TOBI or Kitabis based on the product requested and *NOT* generic tobramycin.

Must have confirmed diagnosis of cystic fibrosis:

- ☐ Requests for diagnosis other than Cystic Fibrosis must be escalated to a pharmacist for review.
- ☐ Submission of copy of official labs is required (unless otherwise is indicated).
  - ☐ For ***initial therapy***, a positive swab or sputum culture for *Pseudomonas aeruginosa* must be received and dated within past 30 days (Initial therapy is defined as more than 12 months since any treatment).
  - ☐ For ***continuation of therapy***, culture results positive for Pseudomonas aeruginosa are not required. Cultures are required only for initial therapy.
- ☐ Verify prescribing practitioner specialty (Pulmonologist or Infectious Disease Specialist).
- ☐ May verify on prescription or MD office letterhead.
- ☐ Request and/or prescription may be signed/written by ARNP or Physician's Assistant (PA) that works under the authority of Pulmonologist or Infectious Disease Specialist.
- ☐ Escalate the request to a pharmacist if the provider's specialty is not indicated.

TOBI PODHALER

- ☐ Requests will be reviewed by pharmacists on a case-by-case basis.
- ☐ Pharmacists: If there are no extraordinary circumstances that would require the Podhaler as opposed to Tobramycin via nebulizer, then redirect the provider to the nebulizer solution (TOBI).

QUANTITY LIMITS

- ☐ **Tobi®:** Quantity of 280 ml per 56 days
- ☐ **Kitabis®:** Quantity of 280 ml per 56 days

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AUTO PA STEP EDITS (TOBI NEBULIZER SOLUTION)

Tobi nebulizer solution

Automated PA approval satisfies L=Auto PA drug edit

Automated PA approval will NOT override R = Non-PDL edit

Drug Name	Drug Code
Tobi nebulizer solution	GSN = 037042
Kitabis (tobramycin) nebulizer solution	GSN = 073201

Step 1: If the incoming claim is for Tobi Solution (GSN 037042) or Kitabis Solution (GSN 073201), look back in the medical claims history 730 days for ICD9 277.00 (Cystic fibrosis without meconium ileus), 277.01 (Cystic fibrosis with meconium ileus), 277.02 (Cystic fibrosis with pulmonary manifestations), 277.03 (Cystic fibrosis with gastrointestinal manifestations), **OR** 277.09 (Cystic fibrosis with other manifestations), OR ICD 10 Disease Group E84 (Cystic Fibrosis). If found, NO PA REQUIRED. Otherwise, Deny for PRIOR AUTHORIZATION REQUIRED (75) with supplemental message "M/I Diagnosis Code."

Quantity Limitation
280ml per 56 days

Approvable ICD-9 CM Codes	
277.0	Cystic fibrosis without meconium ileus
277.01	Cystic fibrosis with meconium ileus
277.02	Cystic fibrosis with pulmonary manifestations
277.03	Cystic fibrosis with gastrointestinal manifestations
277.09	Cystic fibrosis with other manifestations

Approvable ICD-10 Disease Groups	
E84	Cystic fibrosis

TYGACIL® (TIGECYCLINE)

Length of Authorization:	Length of prescription (no more than 14 days); No refills.
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REQUIRED LABS

Must be submitted with PA request and dated no later than 14 days prior to therapy (e.g., CULTURE AND/OR SENSITIVITY).

REVIEW CRITERIA

1. Patient must be ≥18 years of age.
2. Documentation must show previous trial and failure of a tetracycline product unless resistance is demonstrated. If no previous trial, then clinically compelling documentation must be noted justifying the use of this agent.
3. **Complicated skin and skin structure infections** caused by *Escherichia coli, Enterococcus faecalis (vancomycin-susceptible isolates only), Staphylococcus aureus (MSSA), Staphylococcus aureus (MRSA), Streptococcus agalactiae, Streptococcus anginosus grp., Streptococcus pyogenes, and Bacteroides fragilis*
4. **Complicated intraabdominal infections** caused by *Citrobacter freundii, Enterobacter cloacae, Escherichia coli, Klebsiella oxytoca, Klebsiella pneumoniae, Enterococcus faecalis (vancomycin-susceptible isolates only), Staphylococcus aureus (MSSA), Streptococcus anginosus grp., Bacteroides fragilis, Bacteroides thetaiotaomicron, Bacteroides uniformis, Bacteroides vulgatus, Clostridium perfringens, and Peptostreptococcus micros*
5. **Community-acquired pneumonia** due to penicillin-susceptible Streptococcus pneumoniae (including cases with concurrent bacteremia), beta-lactamase negative Haemophilus influenzae, and Legionella pneumophila

URINARY TRACT ANTISPASMODICS

Length of Authorization:	1 year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

1. Is there any reason that the Patient cannot be switched to preferred medications? **Document details**. Acceptable reasons include
   - ☐ Allergy to the preferred medications in this class
   - ☐ Contraindication or drug-to-drug interaction with all preferred medications
   - ☐ History of serious reaction (e.g., Hallucinations, angioedema, tachycardia, etc.) to preferred medications
2. Has there been a therapeutic failure after a trial of **two** preferred medications?

PREFERRED – NO PA REQUIRED	NON-PREFERRED – PA REQUIRED
Oxybutynin regular release tablets and syrup	Ditropan® (*oxybutynin*)
Toviaz® (*fesoterodine*)	Ditropan® XL (*oxybutynin extended release*)
Vesicare® (*solifenacin*)	Enablex® (*darifenacin*)
	Flavoxate tablets
	Gelnique® (*oxybutynin chloride*) Gel
	Oxybutynin ER (generic for Ditropan® XL)
	Oxytrol® patches [8/27] (*oxybutynin*)
	Sanctura XR® (*trospium*)

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DETROL® (TOLTERODINE)/DETROL LA

Length of Authorization:	Per Prescription; No More Than 1 Year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL INDICATIONS

- ☐ PDL criteria do NOT apply.
- ☐ Patient must be age 5 to 18 years of age.
- ☐ Must have tried and failed oxybutynin within the past 365 days.
- ☐ Must have a diagnosis consistent with an overactive bladder.
- ☐ Requests for ages less than 5 years of age, refer request to pharmacist for review. (Do not refer to preferred alternatives [Vesicare and Toviaz].)
- ☐ Requests for ages > 18 years must be referred to preferred alternatives (i.e., Vesicare, Toviaz, and Oxybutynin). Vesicare and Toviaz are not indicated in children.

SANCTURA® (TROSPIUM CHLORIDE)

Length of Authorization:	Per Prescription; No More Than 1 Year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

APPROVAL INDICATIONS

- ☐ Patient less than 18 years of age. Do not refer to preferred alternatives Vesicare and Toviaz since these are not indicated in children.
- ☐ Must have tried and failed oxybutynin within the past 365 days.
- ☐ Must have a diagnosis consistent with an overactive bladder.
- ☐ Requests for ages > 18 years must be referred to preferred alternatives. Vesicare and Toviaz are not indicated in children.
- ☐ Sanctura® must be prescribed by a specialist (e.g., urologist).

VECAMYL® (MECAMYLAMINE)

Length of Authorization:	6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

INITIAL THERAPY

Hypertension:

- ☐ Diagnosis of moderately severe to severe hypertension; **AND**
- ☐ Use of at least 6 other classes of antihypertensives medications within the last 12 months with documented history of failure to achieve blood pressure goals using maximum tolerated doses; **AND**
- ☐ Prescriber must verify patient does ***NOT*** have any of the following conditions:
  - ☐ Coronary insufficiency
  - ☐ Recent myocardial infarction
  - ☐ Rising/elevated BUN or renal insufficiency
  - ☐ Uremia
  - ☐ Patient receiving concomitant antibiotics or sulfonamides
  - ☐ Glaucoma
  - ☐ Organic pyloric stenosis
  - ☐ Hypersensitivity to mecamylamine

Autism:

- ☐ Patient must have had a trial of two atypical antipsychotics (not at the same time)- e.g. risperidone (Risperdal) aripiprazole (Abilify) , or quetiapine (Seroquel) without satisfactory results; **AND**
- ☐ Patient has also attempted augmentation with a mood stabilizer for aggression (e.g. lamotrigine (Lamictal), divalproex (Depakote) or Lithium).

Tourette's Syndrome (Pharmacist Review Only):

- ☐ The primary treatment modality for Tourette's syndrome has been with antipsychotic medications that block dopamine receptors. These drugs include haloperidol (Haldol), pimozide (Orap), fluphenazine (Prolixin), and the atypical agent risperidone (Risperdal).
- ☐ The alpha-2 agonists, clonidine and guanfacine, are also sometimes used either alone, or in combination with antipsychotics. Fluoxetine (Prozac) has also been used with some success in children with Tourette's syndrome. Please consider an age appropriate preferred medication.
- ☐ In regards to the use of mecamylamine (Vecamyl) in the treatment of Tourette's syndrome larger, controlled studies are warranted and evidence is inconclusive. Safety and efficacy in pediatric patients has not been established.

CONTINUATION OF THERAPY

- ☐ Must have recent claims history (within previous 3 months) for Vecamyl and continue to meet criteria listed for initial therapy.

VEREGEN® (SINECATECHINS) OINTMENT, 15%

Length of Authorization:	16 weeks
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years of age.
- ☐ Must have a diagnosis of external genital warts or perianal warts.
- ☐ Must have trial and failure of imiquimod (16-week trial) and Podofilox (28-day trial)

VIBATIV® (TELEVACIN)

Length of Authorization:	Up to 14 days
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 18 years of age.
- ☐ Patient must have medical documentation of trial and failure of vancomycin for the current active infection.
- ☐ A recent (within past 60 days) culture and sensitivity (C&S) must be submitted.
- ☐ Once daily dosing is not an acceptable rationale for why Vibativ is preferred in a particular case. In such cases, redirect to vancomycin again.

VICTOZA® (LIRAGLUTIDE INJECTION)

Length of Authorization:	up to 6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥18 years old
- ☐ Must have a diagnosis of type 2 diabetes mellitus
- ☐ Must have a minimum three month trial of Byetta (exenatide) or Bydureon (exenatide) with a drug included in one the drug classes listed below:
  - ☐ Thiazolidinedione – rosiglitazone (Avandia); pioglitazone (Actos)
  - ☐ Sulfonylureas
    - ☐ First generation: tolbutamide (Orinase), acetohexamide (Dymelor), tolazamide (Tolinase), Chlorpropamide (Diabinese)
    - ☐ Second generation: glipizide (Glucotrol), glyburide (Diabeta, Micronase, Glynase), glimepiride (Amaryl), gliclazide (Diamicron)
  - ☐ Biguanide – metformin (Glucophage)
- ☐ Hemoglobin A1C ≥ 7% (within last 6 months)

VIEKIRA® (DASABUVIR + OMBITASVIR / PARITAPREVIR / RITONAVIR)

Length of Authorization:	☐ 12 Weeks or 24 Weeks
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)
Fax Form:	Hepatitis C Agents **[REQUIRED]**

REVIEW CRITERIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

For Genotype 1 New Therapy Requests, Resubmit For Preferred Viekira Pak [Except Those With Decompensated Cirrhosis (Child Pugh B/C]) And For Genotype 4 Requests, Resubmit For Preferred Technivie

REVIEW CRITERIA

1. Adult patient age ≥ 18 years old; **AND**
2. Diagnosis of Hepatitis C; **AND**
3. Patient is treatment naïve to all parts of the dasabuvir/ombitasvir/paritaprevir, sofosbuvir with or without ledipasvir, and simeprevir therapy (no claims history or reference in medical records to previous trial and failure of these medications) [Refer to **Appendix G** for additional information when reviewing for previous therapy]; **AND**
4. One of the following:
   - ☐ Patient has abstained from the use of illicit drugs and alcohol for a minimum of one month as evidenced by negative urine or blood confirmation tests within the past 30 days, prior to initiation of therapy (results must be submitted with request);
     - ☐ If the test results submitted is positive the reviewer must review claims history or medical records to determine if medications are prescribed.

   OR

   - ☐ Patient is receiving substance or alcohol abuse counseling services or seeing an addiction specialist as an adjunct to HCV treatment and it is documented in the medical records.
5. Patient meets the diagnosis criteria outlined in Dosing and Administration below; **AND**

HEPATITIS C AUTOPA CODING INFO

- ☐ The following medications are included in AutoPA coding list "Hepatitis Therapy List B."
  - ☐ Peginterferon alfa-2a (Pegasys®); Peginterferon alfa-2b (Peg-Intron®/Redipen); Ribavirin (Copegus®, Moderiba®, RibaPak®, Ribasphere®, Ribatab®, Rebetol®
- ☐ When these medications are used in combination therapy with medications included in AutoPA coding list "Hepatitis Therapy List A" no prior authorization is required for medications in "Hepatitis Therapy List B" as long as the "Hepatitis Therapy List A" medication is billed first.
  - ☐ Harvoni®, Olysio®, Sovaldi®, and Viekira Pak®
- ☐ If the medication in "Hepatitis Therapy List A" is not billed first, then the following error messages will display:
  - ☐ IE 31003 – Automated PA; NCPDP 75 – Prior authorization required
  - ☐ Transaction Message: "Missing Prerequisite Drug Therapy"
- ☐ The Hepatitis C AutoPA coding logic is explained in greater detail here.

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DOSING AND ADMINISTRATION

- ☐ Dose: **VIEKIRA PAK:** (Two ombitasvir, paritaprevir, ritonavir 12.5/75/50mg tablets once daily (in the morning) and one dasabuvir 250 mg tablet twice daily (morning and evening) with a meal without regard to fat or calorie content.
- ☐ Quantity Limit: 112 tablets per 28 days

DIAGNOSIS: 1.☐ HCV 2.☐ HCV/HIV-1 Co-Infection	Genotype 1a (without cirrhosis) treatment naïve or treatment experienced
DUAL THERAPY: VIEKIRA PAK + RIBAVIRIN	
Length of Authorization: ☐ 12 Weeks	

DIAGNOSIS: 1.☐ HCV 2.☐ HCV/HIV-1 Co-Infection	Genotype 1a (with cirrhosis) treatment naïve or experienced prior relapse/partial responder
DUAL THERAPY: VIEKIRA PAK + RIBAVIRIN	
Length of Authorization: ☐ 12 Weeks	

DIAGNOSIS: 1.☐ HCV 2.☐ HCV/HIV-1 Co-Infection	Genotype 1a (with cirrhosis) treatment experienced, null responder
DUAL THERAPY: VIEKIRA PAK + RIBAVIRIN	
Length of Authorization: ☐ 24 Weeks	

DIAGNOSIS: 1.☐ HCV 2.☐ HCV/HIV-1 Co-Infection	Genotype 1b (without cirrhosis) treatment naïve or treatment experienced.
MONO THERAPY: VIEKIRA PAK	
Length of Authorization: ☐ 12 Weeks	

DIAGNOSIS: 1.☐ HCV 2.☐ HCV/HIV-1 Co-Infection	Genotype 1b (with cirrhosis) treatment naïve or treatment experienced
DUAL THERAPY: VIEKIRA PAK	
Length of Authorization: ☐ 12 Weeks	

DIAGNOSIS: 1.☐ HCV	Genotype 1 who have received a liver transplant (regardless of HCV genotype 1 subtype)
DUAL THERAPY: VIEKIRA PAK + RIBAVIRIN	
Length of Authorization: ☐ 24 Weeks	

DENIAL CRITERIA

DIAGNOSIS: 1.☐ Decompensated Cirrhosis (defined as a Child-Pugh score greater that 6 [class B or C])
☐ Safety and efficacy of Viekira have not been established in patients with decompensated cirrhosis.

DIAGNOSIS: 1.☐ HCV – Genotype 2, 3, 4, 5, or 6
☐ Therapy Referral: OTHER HEPATITIS C AGENTS

VIMIZIM® (ELOSULFASE ALPHA)

Length of Authorization:	Up to one year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA (ALL OF THE FOLLOWING MUST BE TRUE)

INITIAL THERAPY

- ☐ Patient must be > 5 years of age
- ☐ The patient has a diagnosis of Mucopolysaccharidosis type IVA (MPS IVA; Morquio A syndrome) confirmed per medical records or patient health conditions.

CONTINUATION OF THERAPY

- ☐ Patient continues to meet above initial criteria

VIMOVO® (NAPROXEN AND ESOMEPRAZOLE MAGNESIUM) DELAYED RELEASE

Initiative: PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

Requests should be referred to the preferred drug list (PDL) single ingredient alternatives:

1. PDL single ingredient naproxen or other PDL alternatives included in HIC3 = S2B and
2. PDL alternatives for esomeprazole which include omeprazole and pantoprazole (HIC3 = D4J).

VIVITROL® (NALTREXONE, IM): MCC-FL ONLY [EFFECTIVE 7-1-2016]

Length of Authorization:	Six months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

INITIAL APPROVAL CRITERIA

- ☐ Patient must be 18 years old or over; **AND**
- ☐ Patient does not have acute hepatitis or liver failure; **AND**

Alcohol dependence:

- ☐ Documented participation in a comprehensive management program including psychosocial support; **AND**
- ☐ Patient has not had an alcoholic drink for 7 days prior to initiation with Vivitrol; **AND**
- ☐ Patient is not taking any opioid medications as evidenced by a urine screen.

Opioid dependence:

- ☐ Patient is in a comprehensive rehabilitation program; **AND**
- ☐ Patient has undergone opioid detoxification for at least 7 days; **AND**
- ☐ Patient has tested negative for opioids as evidenced by a urine screen or naloxone challenge test.

RENEWAL CRITERIA

- ☐ Documented continued clinical benefit to the Patient as defined by complete abstinence from or reduction in the use of alcohol/opioids; **AND**
- ☐ Documented participation in a comprehensive management program including psychosocial support; **AND**
- ☐ Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity includethe following: symptoms or signs of acute hepatitis; severe injection site reactions; eosinophilic (allergic) pneumonia; hypersensitivity reactions, including anaphylaxis; development of depression or suicidal thinking.

DOSING LIMITS

- ☐ Quantity Limit (max daily dose) [Pharmacy Benefit]: 1 syringe (380mg) every 28 days

COVERED DIAGNOSIS CODES (ICD-9 & ICD-10)

ICD-9	ICD-9 Diagnosis Description
303.00	Acute alcoholic intoxication in alcoholism, unspecified
303.01	Acute alcoholic intoxication in alcoholism, continuous
303.02	Acute alcoholic intoxication in alcoholism, episodic
303.03	Acute alcoholic intoxication in alcoholism, in remission
303.90	Other and unspecified alcohol dependence, unspecified
303.91	Other and unspecified alcohol dependence, continuous
303.92	Other and unspecified alcohol dependence, episodic
303.93	Other and unspecified alcohol dependence, in remission
304.00	Opioid type dependence, unspecified
304.01	Opioid type dependence, continuous
304.02	Opioid type dependence, episodic
304.03	Opioid type dependence, in remission

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VIVITROL® (NALTREXONE, IM) (CONTINUED)

Covered Diagnosis Codes (Continued)

ICD-10	ICD-10 Diagnosis Description
F10.20	Alcohol dependence, uncomplicated
F10.21	Alcohol dependence, in remission
F10.220	Alcohol dependence with intoxication, uncomplicated
F10.229	Alcohol dependence with intoxication, unspecified
F11.20	Opioid dependence, uncomplicated
F11.20	Opioid dependence, uncomplicated
F11.21	Opioid dependence, in remission
F11.220	Opioid dependence with intoxication, uncomplicated
F11.221	Opioid dependence with intoxication delirium
F11.222	Opioid dependence with intoxication with perceptual disturbance
F11.229	Opioid dependence with intoxication, unspecified
F11.23	Opioid dependence with withdrawal
F11.24	Opioid dependence with opioid-induced mood disorder
F11.250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11.259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11.281	Opioid dependence with opioid-induced sexual dysfunction
F11.282	Opioid dependence with opioid-induced sleep disorder
F11.288	Opioid dependence with other opioid-induced disorder
F11.29	Opioid dependence with unspecified opioid-induced disorder

VPRIV® (VELAGLUCERASE ALFA)

Length of Authorization:	Up to one year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

- ☐ Patient must be ≥ 4 years of age.
- ☐ Must have a diagnosis of Gaucher Disease Type I.

XARELTO® (RIVAROXABAN)

Length of Authorization:	☐ Nonvalvular Atrial Fibrillation: Six months ☐ Post-op Prophylaxis of DVT: Date of Service per criteria below ☐ Treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE): Six months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

☐ Patient must have diagnosis of atrial fibrillation (per progress notes or "health conditions").

-OR-

☐ Patient must be post-op hip or knee replacement surgery within the past 30 days (per progress notes).

- ☐ Hip replacement – treatment duration no more than 35 days with no refills
- ☐ Knee replacement – treatment duration no more than 12 days with no refills

-OR-

☐ Patient must have a diagnosis or history of deep vein thrombosis (DVT) or pulmonary embolism (PE) (per progress notes or "health conditions").

DOSING AND ADMINISTRATION

Nonvalvular Atrial Fibrillation:

☐ For patients with CrCl >50 mL/min: 20 mg orally, once daily **with the evening meal.**

☐ For patients with CrCl 15 - 50 mL/min: 15 mg orally, once daily **with the evening meal.**

☐ Avoid use in patients with CrCl <15 mL/min.

Prophylaxis of DVT:

☐ 10 mg orally, once daily with or without food.

Treatment of DVT, PE, and Reduction in the Risk of Recurrence of DVT and of PE:

☐ 15 mg orally twice daily with food for the first 21 days for the initial treatment of acute DVT or PE.

☐ After the initial treatment period, 20 mg orally once daily with food for the remaining treatment and the long-term reduction in the risk of recurrence of DVT and of PE.

XENAZINE® (TETRABENAZINE)

Length of Authorization:	Up to six months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

- ☐ Chorea of Huntington's Disease
  - ☐ Must have diagnosis of Huntington's Disease
  - ☐ Age ≥ 18 years
  - ☐ Dose not to exceed 100mg/day
- ☐ Tardive Dyskinesia
  - ☐ Must have diagnosis of Tardive Dyskinesia (TD)
  - ☐ Age ≥ 18 years
  - ☐ Trial and failure of at least two preferred agents in the past 365 days with appropriate dose optimization and trial length (as verified by Reviewing Pharmacist)
  - ☐ Some of the more recent treatments may include but are not limited to atypical antipsychotics, calcium channel blockers, and amantadine. These 'more recent treatments' shall qualify as 'preferred meds'.
  - ☐ Dose not to exceed 100mg/day
- ☐ Tourette's Syndrome
  - ☐ Must have diagnosis of Tourette's Syndrome
  - ☐ Age ≥ 18 years
  - ☐ Trial and failure of haloperidol or Orap (pimozide) in the past 365 days with appropriate dose optimization and trial length (as verified by reviewing pharmacist).
  - ☐ Dose not to exceed 100mg/day

XIFAXAN® (RIFAXIMIN)

Length of Authorization:	See below
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

Diarrhea caused by *E. coli* – length of approval: 3 days:

- ☐ Patient must be ≥ 12 years of age.
- ☐ Patient must not be experiencing fevers and/or bloody stools.
- ☐ Patient must have a documented culture indicating causative microorganism is *E. coli*.

Hepatic Encephalopathy – length of approval up to 6 months:

- ☐ Patient must be ≥ 18 years of age.
- ☐ Patient must have a confirmed (from medical records or diagnosis codes) diagnosis of Hepatic encephalopathy.
- ☐ Patient must be currently taking or have had a documented trial with lactulose.

Irritable Bowel Syndrome (refractory) – length of approval up to 6 weeks:

- ☐ Patient must be ≥ 18 years of age.
- ☐ Patient must have diagnosis of Irritable Bowel Syndrome (IBS) with diarrhea as the predominant symptom, conformed with colonoscopic examination within the previous 2 years (A copy of the colonoscopy results should be submitted or addressed in the MD progress notes).
- ☐ Patient must have had a documented trial of 3 of the treatment options listed below since the diagnosis IBS:
  - ☐ Lifestyle and dietary modifications:
    - ☐ Elimination of caffeine, lactose, or fructose from diet **and/or**
    - ☐ Addition of fiber to diet **and/or**
    - ☐ Use of Probiotics
  - ☐ Antidiarrheals (i.e., loperamide, cholestyramine)
  - ☐ Antispasmodics (i.e., dicyclomine, hyoscyamine)
  - ☐ Tricyclic antidepressants (i.e., desipramine, amitriptyline, doxepin)

DOSING

- ☐ Recommended dose for the treatment of traveler's diarrhea: 200 mg three times daily for 3 days
- ☐ Recommended dose for the treatment of hepatic encephalopathy: 550 mg twice daily
- ☐ Recommended dose for the treatment of IBS: 550 mg three times daily for 14 days. Dose may be repeated up to two additional times (maximum of three total treatment cycles).

XOLAIR® (OMALIZUMAB)

Length of Authorization:	1 year for allergic asthma; 12 weeks initial authorization for chronic urticaria to assess ongoing need/response to therapy, then 1 year.
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

CLINICAL NOTES

Xolair is indicated for adults and adolescents (aged ≥ 6 years) with moderate-to-severe persistent asthma who have a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids.
Xolair is also indicated for the treatment of chronic idiopathic urticaria in adults and adolescents (aged ≥ 12 years) that is symptomatic despite H_1 antihistamine treatment.

SPECIFIC REVIEW CRITERIA FOR ASTHMA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION) (ALL OF THE FOLLOWING MUST BE MET)

1. Verified diagnosis of asthma (progress notes or diagnosis codes); **AND**
2. Must be ≥ 6 years old; **AND**
3. Patient must have a positive skin test or in vitro reactivity to a perennial allergen; **AND**
4. Patient has ongoing symptoms of asthma with a minimum three-month trial of an inhaled corticosteroid PLUS a Long Acting Beta Agonist combination therapy.

SPECIFIC REVIEW CRITERIA FOR CHRONIC IDIOPATHIC URTICARIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION) (ALL OF THE FOLLOWING MUST BE MET)

1. Age ≥ 12 years old; **AND**
2. The patient has urticaria persisting for more than 6 weeks duration and the underlying cause of the patient's condition has been examined and has been found to NOT be any other allergic condition(s); **AND**
3. Trial and failure of a first or second generation antihistamine alone or in combination with a H_2 antagonist; **AND**
4. Trial and failure of cetirizine at a dose up to 20 mg per day; **AND**
5. Trial and failure of a potent antihistamine such as hydroxyzine or doxepin at maximum tolerated doses; **AND**
6. Trial and failure of with a leukotriene receptor antagonist in combination with a first or second-generation antihistamine.

CONTINUATION OF THERAPY:

- ☐ Treatment with omalizumab (Xolair) has resulted in documented clinical improvement. Patients should be periodically reassessed for the need to continue therapy based on the disease severity and/or the level of asthma control. Continued use of inhaled corticosteroid PLUS a Long Acting Beta Agonist combination while on Xolair therapy for asthma is documented.

DOSING AND ADMINISTRATION:

- ☐ Allergic Asthma: 75 mg to 375 mg subcutaneously every two or four weeks. Dose and frequency are determined by serum total IgE level (IU/mL) measured before the start of treatment and body weight.
- ☐ Chronic Idiopathic Urticaria: 150 mg or 300 mg subcutaneously every four weeks. Dosing is not dependent on serum IgE level or body weight.
- ☐ ***Note:*** Xolair is dispensed in single dose vials. Any unused portions must be discarded. For example: If a prior authorization request is submitted for Xolair 150mg vials dosed 250mg every 2 weeks, two vials per dose must be dispensed. Thus, the PA must be built for a quantity of 4.3 for a 30-day supply.

XYREM® (SODIUM OXYBATE)

Length of Authorization:	**Initial therapy** may be approved for up to 3 months **Continuation of therapy** may be approved for up to 6 months.
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)
Max Qty and Days Supply:	540ml/30 days (max. dose of 9gm/night)

REVIEW CRITERIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

INITIATION OF THERAPY

1. Diagnosis of narcolepsy with cataplexy, excessive daytime sleepiness, and/or disrupted nocturnal sleep.
   - ☐ Diagnosis must be confirmed by submission of supporting documentation to include the specialist's interpretation of the Polysomnography (PSG) and Multiple Sleep Latency Test (MSLT) results (reference chart below).
2. For cataplexy, approval may be given if all other criteria are met.
3. For excessive daytime sleepiness, must have tried and failed/intolerant to at least one formulary/preferred **stimulant treatment**, such as methylphenidate or dextroamphetamine.
   - ☐ Trial period is 2 months (60 days).
   - ☐ The PA request must be accompanied by supporting documentation.
   - ☐ Verify that dosage has been maximized. (Refer to dosage chart below)
4. In the case of excessive daytime sleepiness chart notes should provide indication that sleepiness is significantly impacting daytime functioning.
5. Must be greater than or equal to **16 years of age**.
6. Approved for twice nightly **dosing** (first dose at bedtime then next dose 2.5–4 hours later while in bed.
7. The medication must be prescribed by a **sleep specialist** or **neurologist**.

CONTINUATION OF THERAPY

1. The recipient must have a confirmed diagnosis in PA history notes or the required documentation indicated in #1 (above) must be submitted.
2. The requirements of #5, 6, and 7 above must be met.
3. The sleep specialist or neurologist must submit their interpretation of the Epworth Sleepiness Scale (**ESS**) and/or the Maintenance of Wakefulness Test (**MWT**) to demonstrate response to current therapy.
   - ☐ ESS: A subjective Patient questionnaire that evaluates the extent of daytime sleepiness in everyday situations (0-8 normal; 9-12 mild; 13-16 moderate; ≥17 severe).
   - ☐ MWT: An objective measurement of latency to sleep onset (in minutes) or daytime wakefulness following nocturnal polysomnography – higher scores indicate greater wakefulness.

EXCLUSION CRITERIA

- ☐ Not covered with alcohol or other CNS depressants including but not limited to sedative hypnotics.
- ☐ Not covered in Patient with history of controlled substance abuse (the Patient should not be receiving recovery treatment related to substance abuse). Review claims history for controlled substance use that may be contributing to excessive daytime sleepiness.
- ☐ Not covered when dose exceeds 9gm/night.
- ☐ Not covered for diagnosis of fibromyalgia.
- ☐ Not covered if written by a prescriber other than a sleep specialist or neurologist.

YERVOY® (IPILIMUMAB)

DIRECTIVE

The Provider is to be informed that Yervoy must be billed through physician services.

ZAVESCA® (MIGLUSTAT)

Length of Authorization:	6 months
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

REVIEW CRITERIA

☐ Must have a confirmed diagnosis or history of Type 1 Gaucher Disease.

ZEMAIRA® (ALPHA-1-PROTEASE INHIBITOR HUMAN)

Length of Authorization:	Up to one year
Initiative:	☐ PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN) ☐ ENTER PA USING (MG) UNITS AS OPOSED TO NUMBER OF VIALS AS UNITS.

REVIEW CRITERIA

- ☐ Must 18 years of age or older
- ☐ Must have confirmed history of alpha1-proteinase inhibitor (A1-PI) deficiency with emphysema per clinical notes or diagnosis codes

ZEPATIER™ (GRAZOPREVIR / ELBASVIR)

Length of Authorization:	12 Weeks or 16 Weeks
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)
Fax Form:	Hepatitis C Agents **[REQUIRED]**

REVIEW CRITERIA (PHARMACIST REVIEW ONLY: CPHTS – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

REVIEW CRITERIA

FOR GENOTYPE 1 NEW THERAPY REQUESTS, RESUBMIT FOR PREFERRED VIEKIRA PAK [EXCEPT THOSE WITH DECOMPENSATED CIRRHOSIS (CHILD PUGH B/C] AND FOR GENOTYPE 4 REQUESTS, RESUBMIT FOR PREFERRED TECHNIVIE

1. Adult patient age ≥ 18 years old; **AND**
2. Prescribed by or in consultation with a hepatologist, gastroenterologist, infectious disease specialist, or transplant physician; **AND**
3. Patient is sofosbuvir treatment naïve (no claims history or reference in medical records to previous trial and failure) [Refer to **Appendix G** for additional information when reviewing for previous therapy]; **AND**
4. One of the following:
   - ☐ Patient has abstained from the use of illicit drugs and alcohol for a minimum of one month as evidenced by negative urine or blood confirmation tests within the past 30 days, prior to initiation of therapy (results must be submitted with request);
     - ☐ If the test results submitted is positive the reviewer must review claims history or medical records to determine if medications are prescribed. If so, proceed to next step (#5).

   OR

   - ☐ Patient is receiving substance or alcohol abuse counseling services or seeing an addiction specialist as an adjunct to HCV treatment and it is documented in the medical records; **AND**
5. Baseline HCV RNA must be submitted with a collection date within the past three months. **Prescriber must submit lab documentation indicating HCV genotype and quantitative viral load**.
6. For patients with genotype 1a, provider must submit testing for NS5A polymorphisms at amino acid positions 28, 30,31 or 93; **AND**
7. Patient meets the diagnosis criteria outlined in Dosing and Administration below; **AND**
8. Patient commits to the documented planned course of treatment including anticipated blood tests and visits, during and after treatment; **AND**
9. **No early refills will be allowed due to lost or stolen medications or vacation override.**
10. Females of childbearing potential must have a negative pregnancy test collected within 30 days prior to the initiation of therapy with ribavirin; **AND**
11. For HIV-1 co-infected patients, patients must have the following:
    - ☐ Documented HIV-1 diagnosis, **AND**
    - ☐ CD4 count greater than 500 cells/mm3, if patient is not taking antiretroviral therapy; **OR**
    - ☐ CD4 count greater than 200 cells/mm3, if patient is virologically suppressed (e.g., HIV RNA < 200 copies/mL)

DOSING AND ADMINISTRATION

Dose: One tablet once daily with or without food, taken with or without ribavirin.

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ZEPATIER™ (GRAZOPREVIR / ELBASVIR) (CONTINUED)

HCV and HCV/HIV-1 Coinfection- Genotype 1a; treatment-naïve or PegIFN/RBV experienced with or without cirrhosis (without the presence of baseline NS5A polymorphisms)	
THERAPY: ZEPATIER	
Length of Prior Authorization (PA):	12 weeks

HCV and HCV/HIV-1 Coinfection- Genotype 1a; treatment naïve or PegINF/RBV experienced with or without cirrhosis (with the presence of baseline NS5A polymorphisms)	
THERAPY: ZEPATIER + RIBAVIRIN	
Length of Prior Authorization (PA):	16 weeks

HCV and HCV/HIV-1 Coinfection- Genotype 1b; treatment-naïve or PegIFN/RBV experienced with or without cirrhosis	
THERAPY: ZEPATIER	
Length of Prior Authorization (PA):	12 weeks

HCV and HCV/HIV-1 Coinfection- Genotype 1a or 1b (PegIFN/RBV/PI* experienced) with or without cirrhosis	
THERAPY: ZEPATIER + RIBAVIRIN	
Length of Prior Authorization (PA):	12 weeks

HCV & HCV/HIV-1 Coinfection-Genotype 4; treatment-naïve with or without cirrhosis	
THERAPY: ZEPATIER	
Length of Prior Authorization (PA):	12 weeks

HCV & HCV/HIV-1 Coinfection- Genotype 4; PegIFN/RBV experienced with or without cirrhosis	
THERAPY: ZEPATIER + RIBAVIRIN	
Length of Prior Authorization (PA):	16 weeks

*Protease inhibitor (PI) therapies include: boceprevir, telaprevir or simeprevir

DENIAL CRITERIA:

HCV – Genotype 2,3,5 or 6
THERAPY REFERRAL: OTHER HEPATITIS C AGENTS

Child-Pugh Class B or C
THERAPY REFERRAL: OTHER HEPATITIS C AGENTS

Post Liver Transplantation
THERAPY REFERRAL: OTHER HEPATITIS C AGENTS

DENIAL MESSAGE

ZORTRESS® (EVEROLIMUS)

Length of Authorization:	Up to one year
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

CLINICAL NOTES

Zortress is indicated for the prophylaxis of organ rejection in adult kidney or liver transplant patients.

REVIEW CRITERIA

- ☐ Patient must be 18 years of age or older.
- ☐ Patient must be kidney or liver transplant recipient.
- ☐ Patient must take Zortress with the following combinations of therapy (verify in claims history or medical records submitted):
  - ☐ Kidney transplant: in combination with basiliximab, cyclosporine, and corticosteroids
  - ☐ Liver transplant: in combination with tacrolimus and corticosteroids

DOSING AND ADMINISTRATION

- ☐ Kidney transplantation: starting oral dose of 0.75 mg twice daily as soon as possible after transplantation.
- ☐ Liver transplantation: starting oral dose of 1.0 mg twice daily starting 30 days after transplantation.
- ☐ Monitor everolimus concentrations: Adjust maintenance dose to achieve trough concentrations within the 3-8 ng/mL target range (using LC/MS/MS assay method)
- ☐ **Dosage Form**: available as 0.25 mg, 0.5 mg, and 0.75 mg tablets

ZOSTAVAX® VACCINE

Length of Authorization:	Date of Service (approvable as a one-time vaccine) Boosters are not approvable
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

GENERAL INFORMATION

MCC-FL ONLY:

- Coding updated as of 01/27/2016 (MCCFL_2015_027_OT_Pneumonia_Vax: Remedy 226921:
  - All Zostavax are non-rebateable and need to bypass rebate status
  - All Zostavax are non-PDL and need to bypass non-PDL status
  - Remove the following limitations:
    - Patient must have LTC indicator; OR
    - Patient must have Patient Residence = 03 – nursing facility or claim will deny NCPDP EC 4X-M/I Patient Residence

CCP/SFCCN ONLY:

- This vaccine is only covered through pharmacy services for long-term care (LTC) patients within age range 50-64.
- No override is required. The Pharmacy should confirm that the patient is an LTC patient and bill with a patient location code of "03."

ZYVOX® (LINEZOLID)/OXAZOLIDINONES

Length of Authorization:	☐ FOR A MAXIMUM OF 28 day supply, WHICH INCLUDES ANY HOSPITAL COURSE OF THERAPY ☐ Zyvox may be approved for longer than 14 days if appropriate indication requires longer duration of therapy (i.e., VRE endocarditis, MRSA osteomyelitis). The maximum duration of approval will be 28 days. If therapy required is longer than 28 days an additional PA will be needed.
Initiative:	PDL: Non-Preferred Drug Override (75 / 2462 – GSN; 76 / 2641 – GSN; 75 / 31004 – GSN)

QUANTITY LIMITS

- ☐ Zyvox 600mg (Tablets): Two tablets/day
- ☐ Zyvox 100mg/5ml (Suspension): 60 ml/day

APPROVAL CRITERIA (PHARMACIST REVIEW ONLY: CPHTs – DOCUMENT ALL INFO AVAILABLE PRIOR TO ESCALATION)

Patient must have culture and sensitivity results with one of the diagnosis listed below. The organism being treated must be most susceptible to Zyvox as opposed to another drug (i.e., clindamycin).

- ☐ Vancomycin-Resistant Enterococcus faecium infections, including cases with concurrent bacteremia.
- ☐ Nosocomial pneumonia caused by Staphylococcus aureus (methicillin-susceptible and resistant strains), or Streptococcus pneumoniae (including multi-drug resistant strains [MDRSP]).
- ☐ Complicated skin and skin structure infections, including diabetic foot infections, without concomitant osteomyelitis, caused by Staphylococcus aureus (methicillin susceptible and resistant strains), Streptococcus pyogenes, or Streptococcus agalactiae.
- ☐ ZYVOX has not been studied in the treatment of decubitus ulcers.
- ☐ Uncomplicated skin and skin structure infections caused by Staphylococcus aureus (methicillin- susceptible only) or Streptococcus pyogenes.
- ☐ Community-acquired pneumonia caused by Streptococcus pneumoniae (including multidrug resistant strains [MDRSP]), including cases with concurrent bacteremia, or Staphylococcus aureus (methicillin- susceptible strains only).

REQUESTS BEYOND APPROVAL CRITERIA

- ☐ The principle reason for falling outside the criteria is the lack of a positive culture and sensitivity. However, if a patient has the diagnosis, osteomyelitis, for example and has been started on Zyvox in the hospital, then the request **should be approved** to complete the prescribed course, especially if the length of therapy is a maximum of 14 to 28 days. **Requests for therapy >28 days *do require* a culture**; it is possible that a request may be submitted for as many as 60 days of therapy. An Infectious Disease (ID) consult may be required for longer duration requests as well. There are occasionally requests for other diagnoses or other organisms that are not treated with medications available on the PDL and that do not appear in the written criteria; these should be considered for approval if linezolid is known to have activity against that organism.

INITIATIVE: DOSE OPTIMIZATION V3.4

Length of Authorization:	☐ 1 year
Initiative:	MAP: AP: Dose Optimization (75 / 2462 – GSN; 76 / 2641 – GSN)

DRUGS IN CLASS FOR REVIEW

Appendix A: Dose Optimization

CRITERIA (APPROVE EDIT)

1. For all drugs listed in Appendix A below, if the quantity per day on the incoming claim is ≥ 1.8 and ≤ 2.2 or ≥3.8, proceed to step 2. Otherwise, the claim pays without a prior authorization.
2. If the incoming claim is for Valsartan (HSN 012204) or Ramipril (HSN 006080) then proceed to Step 3; otherwise deny claim for NCPDP 76.
3. If claim is for Valsartan (HSN 012204) or Ramipril (HSN 006080), look back in history 720 days for the following ICD-9s (indicate heart failure): 4–8.xx - 428.9x. If ICD-9 found and quantity per day <3.8 claim pays; otherwise claim denies for NCPDP 76.

DENIAL CRITERIA: FORWARD TO A PHARMACIST

☐ Recipients with a Heart Failure diagnosis receiving Diovan or Altace whose dosage exceeds the maximum daily dosage limit.

☐ Recipients exceeding the following dosage unit per day (DACON) specifications for all targeted drugs listed in Appendix A.

AUTO PA STEP EDITS (DOSE OPTIMIZATION)

Dose Optimization v3.4 Approval will NOT override Non-PDL edit	**Step 1**:	For all drugs listed in Appendix A: If the quantity per day on the incoming claim is ≥1.8 and ≤2.2 or ≥3.8, proceed to Step 2; otherwise claim pays without PA.
	Step 2:	If the incoming claim is for Valsartan (HSN 012204) or Ramipril (HSN 006080), then proceed to Step 3; otherwise deny claim for NCPDP 76.
	Step 3:	If claim is for Valsartan (HSN 012204) or Ramipril (HSN 006080), look back in history 720 days for the following ICD-9s (indicate heart failure): 4–8.xx - 428.9x. If ICD-9 found and quantity per day <3.8 claim pays; otherwise claim denies for NCPDP 75.

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AUTO PA STEP EDITS (DOSE OPTIMIZATION) *(CONTINUED)*

Drug Class/Drug	Strength
HMG CoA Reductase Inhibitors	
Atorvastatin (Lipitor)	10mg, 20mg, 40mg
Fluvastatin (Lescol)	20mg, 40mg
Lovastatin Sustained Release (Altoprev)	10mg, 20mg
Lovastatin Immediate Release (Mevacor, Generic)	10mg, 20mg
Pravastatin (Pravachol)	10mg, 20mg, 40mg
Rosuvastatin (Crestor)	5mg, 10mg, 20mg
Simvastatin (Zocor)	5mg, 10mg, 20mg, 40mg
Calcium Channel Blockers-Dihydropyridines	
Amlodipine (Norvasc)	2.5mg, 5mg
Felodipine (Plendil)	2.5mg, 5mg
Nifedipine SR (Procardia XL/Adalat CC)	30mg
Nisoldipine (Sular)	10mg, 20mg
Angiotensin Converting Enzyme Inhibitors	
Fosinopril (Monopril)	10mg, 20mg
Lisinopril (Zestril/Prinivil)	2.5mg, 5mg, 10mg, 20mg
Moexipril (Univasc) – brand formulation only	7.5mg
Perindopril (Aceon)	2mg, 4mg
Ramipril (Altace)*	1.25mg, 2.5mg, 5mg
Trandolapril (Mavik)	1mg, 2mg
Angiotensin Receptor Blockers	
Candesartan (Atacand)	4mg, 8mg, 16mg
Irbesartan (Avapro)	75mg, 150mg
Losartan (Cozaar)	25mg, 50mg
Olmesartan (Benicar)	20mg
Telmisartan (Micardis)	20mg, 40mg
Valsartan (Diovan)*	40mg, 80mg, 160mg

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INITIATIVE: DOSE OPTIMIZATION V3.4 (CONTINUED)

Drug Class/Drug	Strength
Selective Serotonin Reuptake Inhibitors	
Citalopram (Celexa)	10mg, 20mg
Escitalopram (Lexapro)	5mg, 10mg
Paroxetine CR (Paxil CR)	12.5mg
Proton Pump Inhibitors	
Esomeprazole (Nexium)	20mg
Lansoprazole (Prevacid)	15mg
Omeprazole (Prilosec)**	10mg, 20mg
Pantoprazole (Protonix)	20mg
Miscellaneous Agents	
Venlafaxine (Effexor)	25mg, 37.5mg, 50mg, 75mg
Venlafaxine XR (Effexor XR)	37.5mg, 75mg
Sedative Hypnotics	
Zolpidem (Ambien)	5mg
Eszopiclone (Lunesta)	1mg
Cholinesterase Inhibitors	
Donepezil (Aricept)	5mg
Alpha-Adrenergic Blockers	
Doxazosin (Cardura)	1mg, 2mg, 4mg
Terazosin (Hytrin)	1mg, 5mg
Heterocyclic Antidepressants	
Mirtazapine (Remeron)	7.5mg, 15mg, 15mg solutab
Antihistamines	
Cetirizine (Zyrtec)	5mg

** Prilosec 20mg OTC not included; only prescription Prilosec 10mg and Prilosec 20mg are included for Dose Optimization.

INITIATIVE: INFERGEN V1.2

DRUG IN CLASS FOR REVIEW

Infergen

CRITERIA (APPROVE EDIT)

1. Age ≥ 18 years old; if yes, proceed to step 2. Otherwise, the claim denies for NCPDP 60 (age).
2. Check for pharmacy claims for either Pegasys AND Ribavirin or Peg-Intron AND Ribavirin in claims history for a total of 12 weeks (84 days) in the last 365 days. If found, proceed to step 3. Otherwise, the claim denies for NCPDP 75.
3. The claim pays if the dosage does not exceed the maximum daily dosage limit. Otherwise, the claim s=denies for NCPDP 76.

DENIAL CRITERIA

1. Patient < 18 years old.
2. Absence of Pegasys and Ribavirin or Peg-Intron and Ribavirin for 12 weeks in claims history within the past 365 days.
3. Dosage exceeds maximum daily dosage limit

AUTO PA STEP EDITS (INFERGAN)

<table>
<tr>
<td>Infergen v1.2
Automated PA approval satisfies Non-PDL edit.</td>
<td>
New Auto-PA logic as of 10/01/2010:
Step 1: Incoming claim is for Infergen (HSN 015707) and the recipient >/= 18 years of age? If yes, proceed to Step 2. If no, deny for NCPDP 60 (age).
Step 2: Incoming claim for Infergen (HSN 015707), look back in pharmacy claims history 365 days for a total of 12 weeks of therapy of either Peg-Intron (HSN 021367) and Ribavirin (HSN 004184) or Pegasys (HSN 024035) and Ribavirin (HSN 004184). If found, proceed to Step 3. If not found, deny NCPDP 75.
Step 3: If daily dosing on incoming claim is less than or equal to the established daily dosing limits, claim pays; otherwise claims denies for NCPDP 76.
<table>
<tr><th>Drug Name</th><th>Max Quantity Limits</th></tr>
<tr><td>Infergen 15mcg/0.5ml syringe or vial</td><td>0.500ml/day</td></tr>
<tr><td>Infergen 9mcg/0.3ml syringe</td><td>0.300ml/day</td></tr>
</table>
</td>
</tr>
</table>

INITIATIVE: EMEND V1.1

DRUG IN CLASS FOR REVIEW

Emend

CRITERIA (APPROVE EDIT)

1. Look back in medical claims history for 365 days for ICD-9:140-239.xx. If any found, drug pays.
2. If no to 1, look back in pharmacy claims history for 90 days for any drug in HIC3s C7F, N1H, Q5N, V1A, V1B, V1C, V1D, V1E, V1F, V1J, V1K, V1M, V1N, V1O, V1Q, V1R, V1T, V1U, V1V, V1X, V3A, V3C, V3D, V3E, V3F, V3H, V3I, V3M, V1W, Z2G, Z2W, or HSNs 001063, 011043 – antineoplastics, excluding HSN 006025 – Alferon; HSN 006068 – Actimmune; GSN 031099 – Aldara; GSN 066038, 068613 – Zyclara; GSN 036872, 045266 – Oral methotrexate. If found, drug pays.
3. If no to 2, look in medical claims history for 90 days for CPT codes: 77427-77499, 77425, 77300-77399, 77401-77418, 77261-77299, 77520-77525, or 36640, 51720, 96401, 96402 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96450, 96542, 96549. If found, drug pays. If not, deny NCPDP 75.
4. Dosage must not exceed maximum daily allowances.

APPROVED DIAGNOSES

Condition	Submitted ICD-9 Diagnoses*	Inferred Drugs
Cancer	140 – 239.xx	NA
Chemotherapy-induced nausea and vomiting	NA	Antineoplastics^

^Excludes BCG Vaccine, leuprolide, goserelin, hydroxyurea, megestrol and oral methotrexate. Includes both pharmacy claims and procedures codes respective to chemotherapy.

APPROVED PROCEDURES

Condition	Submitted CPT Codes
Radiation-induced nausea and vomiting	77424-77499, 77300-77399, 77401-77418, 77261-77299, 77520-77525, 36640, 51720, 96401, 96402 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96450, 96542, 96549

DENIAL CRITERIA: FORWARD TO A PHARMACIST

1. No medical history for ICD-9: 140-239.xx for past 365 days
2. No pharmacy claims history for any drug in standard class 30 or any of the HIC3s listed above for past 90 days.
3. No medical claims history for CPT codes: 77424-77499, 77300-77399, 77401-77418, 77261-77299, 77520-77525 for past 90 days
4. Quantities exceeds daily dose allowance

CONTINUED ON NEXT PAGE

AUTO PA STEP EDITS (EMEND)

Emendv1.1 Automated PA approval satisfies Non-PDL edit		**Incoming claim for Emend (HSN 025058):** Step 1: Look back in medical claims history 365 days for ICD -9: 140 – 239.xx. If any found, proceed to Step 4. Step 2: If no to Step 1, look in pharmacy claims history for 90 days for any drug in HIC3s V1W, V3C, V3I, V3L, Q5N, V1A, V1B, V1C, V1D, V1E, V1F, V1J, V1K, V1M, V1N, V1O, V1Q, V1R, V1T, V1U, V1V, V1X, V3A, V3D, V3E, V3F, V3H, V3M, Z2G, Z2W – antineoplastics, excluding HSN 006025 – Alferon; HSN 006068 – Actimmune; GSN 031099 – Aldara; GSN 066038, 068613 – Zyclara; GSN 036872, 045266 – Oral methotrexate. Or, HSNs 001063 – Leucovorin, 011043 – Fusilev. If found, proceed to Step 4. Step 3: If Step 2 is no, then look back in medical claims history for 90 days for CPT codes: 77427 -77499, 77425, 77300-77399, 77401-77418, 77261-77299, 77520-77525 or 36640,51720,96401, 96402 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417 96420, 96422, 96423, 96425, 96440, 96450 , 96542,96549. If found, proceed to Step 4. If not found, deny NCPDP 75. Step 4: If quantity of incoming claim is less than or equal to the established daily or yearly dosing limits (s ee table below); claim pays without PA; otherwise claim denies for NCPDP 76.

Quantity Limitations
2 units per 30 days
Emend 125 mg cap
4 units per 30 days
Emend 40mg cap Emend 80 mg cap
6 units per 30 days
Emend Trifold pack

INITIATIVE: HEPATITIS C

Hepatitis C Automation

Automated PA approval satisfies L=Auto PA drug edit

Automated PA approval will NOT override R = Non-PDL edit

Hepatitis Therapy List A	
HSN	Drug Name
041457	Ledipasvir/sofosbuvir (Harvoni)
040771	Simeprevir (Olysio)
040795	Sofosbuvir (Sovaldi)
041644	dasabuvir/ombitasvir/paritaprevir/ ritonavir (Viekira)

Hepatitis Therapy List B	
HSN	Drug Name
024035	Peginterferon alfa-2a (Pegasys)
021367 (excluding GSNs 067283, 067284, 067285-Sylatron)	Peginterferon alfa-2b (peg-Intron/Redipen)
004184 (excluding GSN 009631-Virazole)	Ribavirin (Copegus, Moderiba, Ribapak, Ribasphere, Ribatab, Rebetol)

Step 1: If incoming claim is from the < Hepatitis Therapy List B>, look back 730 days in medical claims history for ICD-9 070.41, 070.44, 070.49, 070.51, 070.54, 070.59, 070.70, 070.71 (Hepatitis C), or ICD-10 Disease Group B17, B18, B19 (Hepatitis C) excluding ICD 10 B17.0, B17.2, B19.1, B19.10, B19.11. IF FOUND, PROCEED TO STEP 3. Otherwise, PROCEED TO STEP 2.

Step 2: If incoming claim is from the < Hepatitis Therapy List B>, look back 730 days in medical claims history for ICD-9 480.1, 079.6 (RSV-respiratory syncytial virus), 070.20, 070.21, 070.22, 070.23, 070.30, 070.31, 070.32, 070.33 (Hepatitis B),172.0-172.9 (Malignant Melanoma),or ICD-10 J12.1, B97.4 (RSV), Disease Group B16, ICD 10 B19.10, B19.11 (Hepatitis B), Disease Group C43, D03 (Malignant Melanoma). IF FOUND, NO PA REQUIRED. Otherwise, DENY for NCPDP EC 75 with supplemental message: *"M/I Diagnosis Code."*

Step 3: If incoming claim is from the < Hepatitis Therapy List B>, look back in drug history 30 days for any drug in < Hepatitis Therapy List A>. IF FOUND, NO PA REQUIRED. Otherwise DENY for NCPDP EC 75 with supplemental message: *"Missing Prerequisite Drug Therapy"*

INITIATIVE: INCIVEK/VICTRELIS

DRUGS IN CLASS FOR REVIEW

Incivek and Victrelis

AUTO PA STEP EDITS (HEP C THERAPY)

Hepatitis C Therapy

HICL	Drug Name	GSN
037629 037609	Incivek	067414 067394
	Victrelis	

Approvable Hepatitis C Diagnosis Codes	
ICD-9 Code	**Description**
70.41	Acute Hepatitis C with Hepatic Coma
70.44	Chronic Hepatitis C with Coma
70.49	Other Viral Hepatitis with Coma
70.51	Acute Hepatitis C without mention of Hepatic Coma
70.54	Chronic Hepatitis C Without Coma
70.7	Unspecified Viral Hepatitis C without Hepatic Coma
70.71	Unspecified Viral Hepatitis C with Hepatic Coma

Step 1: If the incoming claim is for Incivek or Victrelis, look back in medical claims history 365 days for ICD-9s: 070.41, 070.44, 070.49, 070.51, 070.54, 070.70, or 070.71: If found, PROCEED TO STEP 2. Otherwise, DENY for PRIOR AUTHORIZATION REQUIRED (75), M/I Diagnosis Code (supplemental message).

Step 2: If the incoming claim is for Incivek, look back in medical claims history 365 for Victrelis. If not found, pay. If found, DENY PRIOR AUTHORIZATION REQUIRED (75), Therapeutic Duplication of this medication not allowed (supplemental message).

Step 3: If the incoming claim is for Victrelis, look back in medical claims history 365 for Incivek. If not found, pay. If found, DENY PRIOR AUTHORIZATION REQUIRED (75), Therapeutic Duplication of this medication not allowed (supplemental message).

Quantity Limitations	
Accumulation	**Max per day**
504 tablets per lifetime	
Incivek 375mg tablet	6
3,024 capsules per 355 days	
Victrelis	12

APPENDIX A: MCC-FL DRUG LIMITATIONS FROM THE CSA

Standard/Legend Drug Exclusions For all with MCC FL standard coverage		
NCPDP EC# = 70: Product/Service Not Covered		
MESSAGE= Drug not covered		
Drug Code	**Description**	**Current**
B	FERTILITY AGENTS	
F	ANTIOBESITY DRUGS	
U	NON-REIMBURSSABLE COSMETIC INDICATIONS	
D	DIAGNOSTICS	
S	DIABETIC SUPPLIES, MISC.	
O	REUS. SYRINGES W/WO NEEDLES	
G3A	OXYTOCICS	
H2B	GENERAL ANESTHETICS, INHALANT	
L2A (NDC-9 = 008844990 is covered.)	EMOLLIENTS	
L3A	PROTECTIVES	
P0B	FOLLICLE STIM. / LUTEINIZING HORMONES	
U5A	HOMEOPATHIC DRUGS	
U5B	HERBAL DRUGS	
U5F	ANIMAL / HUMAN DERIVED AGENTS	
U6A	PHARMACEUTICAL ADJUVANTS, TABLETING	
U6C	THICKENING AGENTS, ORAL	
U6E	OINTMENT / CREAM BASES	
U6F	HYDROPHILIC CREAM / OINTMENT BASES	
U7A	SUSPENDING AGENTS	
U7D	SURFACTANTS	
U7H	ANTICORROSIVE AGENTS	
U7J	CHELATING AGENTS	
U7K	FLAVORING AGENTS	
U7N	SWEETENERS	
U7P	PERFUMES	
U7Q	COLRING AGENTS AND DYES	

Standard/Legend Drug Exclusions For all with MCC FL standard coverage		
NCPDP EC# = 70: Product/Service Not Covered		
MESSAGE= Drug not covered		
Drug Code	**Description**	**Current**
V1G	RADIOACTIVE THERAPEUTIC AGENTS	
W7B	VIRAL / TUMORIGENIC VACCINES	
W7C	INFLUENZA VIRUS VACCINES	
W7F	MUMPS AND RELATED VIRUS VACCINES	
W7H	ENTERIC VIRUS VACCINES	
W7J	NEUROTOXIC VIRUS VACCINES	
W7L	GRAM POSITIVE COCCI VACCINES	Pneumovax (HSN = 004212 and 021001 covered for recipients who are not Medicare Eligible.)
W7M	GRAM (.) BACILLI (NON-ENTERIC) VACCINES	
W7N	TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS	
W7Q	GRAM NEGATIVE COCCI VACCINES	
W7R	SPIROCHETE VACCINES	
W7S	ANTIVENINS	
W7T	ANTIGENIC SKIN TESTS	
W7U	HYMENOPTERA-DERIVED AGENTS	
W7V	RHUS EXTRACTS (POISON OAK, POISON IVY)	
W7W	ALLERGENIC EXTRACTS, THERAPEUTICS	
W7Z	VACCINE / TOXOID PREPARATIONS, COMBINATIONS	
C5C	INFANT FORMULAS	
C5F	MISC. DIETARY SUPPLEMENT	
C5U	NUTRITIONAL THERAPY, MED COND SPECIAL ELECTROLYTES & MISC. NUTRIENTS	
X1G	OVULATION TESTS	
X1F	PREGNANCY TESTS	
X2A	NEEDLES/NEEDLELESS DEVICES	
X2B	SYRINGES AND ACCESSORIES	
U6F	HYDROPHILIC CREAM/OINTMENT BASES	
Y9A	DIABETIC SUPPLIES	

Standard/Legend Drug Exclusions For all with MCC FL standard coverage		
NCPDP EC# = 70: Product/Service Not Covered		
MESSAGE= Drug not covered		
Drug Code	**Description**	**Current**
M4A	BLOOD SUGAR DIAGNOSTICS	
GSN 006328, 006329, 006330, 006331, 006332	ALBUMIN HUMAN	
GSN 016805	ALDESLEUKIN	
GSN 059424, 059425	CEFTRIAXONE NA/DEXTROSE, ISO	
GSN 022350	CYTOMEGALOVIRUS IMMUNE GLOB	
GSN 009657, 009658, 009659, 009660, 009661, 009662, 009663, 009664, 009665, 019103	IMMU GLOBULIN, GAMMA (IGG)	
GSN 002186, 002187	CALCITRIOL	
GSN 051656, 053296	TADALAFIL	
GSN 051882, 051883, 052964	VARDENAFIL HCL	
GSN 040663	ORLISTAT	
GSN 046222, 046228	SSRIS	
GSN 048801, 006378	FAT EMULSIONS	
GSN 035326, 030474	RETEPLASE	
GSN 045771	BEXAROTENE	
GSN 047315	BOTULINUM TOXIN TYPE B	Covered for children in the Shriner's Network. Requires Clinical Prior Authorization.
GSN 023175	ESTRIOL	
GSN = 023797, 023795, 021742, 023796, 041011, 031755, 031756, 031754, 029186, 051656, 053296, 052964, 051882,029187, 029188, 029189, 029801	DRUGS TO TREAT IMPOTENCY (ALPROSTADIL, CIALIS, LEVITRA)	VIAGRA REQUIRES CLINICAL PRIOR AUTHORIZATION FOR PULMONARY HYPERTENSION.

MAINTENANCE DRUG LIST

Identified by Formulary indicator = "M – Maintenance Drug." Coverage is shown on the Coverage Indicator on the formulary file:

T = Covered
U = Covered OTC
I = Drug Not Covered for any Plan
Z = Drug Not Covered
D = None

Note: Indicators located on the Formulary tab in FirstTrax™.

Maintenance Drugs identified by Formulary indicator = M are allowed a days supply up to 100 per claim.

Maintenance Drugs		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Name	**Coding Level (NDC, HSN, or HIC3)**	**Comments**
ACEBUTOLOL	002107	
ACETAZOLAMIDE	003641	
ALLOPURINOL	001100	
AMANTADINE	001898	
AMILORIDE	003667	
AMINOPHYLLINE	000037	
AMIODARONE	000083	
ATENOLOL	002104	
ATENOLOL/CHLORTHAL	000147	
BENAZEPRIL	006113	
BENAZEPRIL-HCTZ	008962	
BENZTROPINE	001905	
BISOPROLOL-HCTZ	008715	
BUMETANIDE	003664	
CAPTOPRIL	000128	
CAPTOPRIL/HCTZ	000127	
CARBIDOPA-LEVO	013894	
CHLOROTHIAZIDE	003646	
CHLORPROPAMIDE	000800	
CHLORTHALIDONE	003662	
CITRIC ACID/Na CITRATE	003682	
CLONIDINE	000113	

Maintenance Drugs		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Name	Coding Level (NDC, HSN, or HIC3)	Comments
CORTISONE	002860	
DEXAMETHASONE	002889	
DIGOXIN	000004	
DILTIAZEM	000182, 017931	
DISOPYRAMIDE	004718	
DOXAZOSIN	006031	
DYPHYLLIN	000038	
DYPHYLLINE-GG	000053	
ENALAPRIL	000130	
ENALAPRIL-HCTZ	000129	
ERGOLOID	012197	
ESTRADIOL	001421, 025182	
ESTROPIPATE	001431	
FELODIPINE	006205	
FLAVOXATE	002047	
FLECAINIDE	000082	
FOLIC ACID	001062	
FUROSEMIDE	003660	
GLIMEPIRIDE	010485	
GLIPIZIDE	000803	
GLIPIZIDE-METFORMIN	024429	
GLYBURIDE	000802	
GLYBURIDE-METFORMIN	009690	
GUANFACINE	000120	
HYDRALAZINE	000089	
HYDROCHLOROTHIAZIDE	003649	
HYDROCORTISONE	002867	
INDAPAMIDE	003665	
ISOSORBIDE DINITRATE	000166	
K+ SUPPLEMENTS	000553	
LABETALOL	002095	

Maintenance Drugs		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Name	Coding Level (NDC, HSN, or HIC3)	Comments
LEVOTHYROXINE	002849	
LISINOPRIL	000132	
LISINOPRIL-HCTZ	000131	
MEDROXYPROGESTERONE	001442	
METHAZOLAMIDE	003643	
METHIMAZOLE	002855	
METHYLDOPA	000118	
METHYLDOPA/HCTZ	000116	
METHYLPREDNISOLONE	002877	
METOLAZONE	003663	
METOPROLOL	006323, 002102	
METOPROLOL-HCTZ	011205, 000143	
MEXILETINE	000084	
MINOXIDIL	000093	
MULTIVITAMIN (Children)	C6H	
MULTIVIT/FLORIDE/FE	C6H **	
MULTIVITAMIN (Prenatal)	C6F, C6V	
NADOLOL	002103	
NICARDIPINE	000183	
NIFEDIPINE	000181	
NITROGLYCERIN	000159	Oral, sublingual and buccal routes included
OXYBUTYNIN	002048	
PAPAVERINE	000170	
PINDOLOL	002106	
PRAZOSIN	000091	
PREDNISOLONE	002874	
PREDNISONE	002879	

Maintenance Drugs		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Name	Coding Level (NDC, HSN, or HIC3)	Comments
PROCAINAMIDE	000076	
PROPAFENONE	004833	
PROPRANOLOL	002101	
PROPRANOLOL/HCTZ	000142	
QUINIDINE	000074, 000075, 000073, 007631	
SELEGILINE	016483	
SOTALOL	004791	
SPIRONOLACT/HCTZ	002900	
SPIRONOLACTONE	002901	
TERAZOSIN	000094	
THEOPHYLLINE	000025, 000026	
THYROID HORMONE	002848, 002847, 002846, 002843	
TORSEMIDE	008829	
TRIAMTERENE-HCTZ	003647	
TRIHEXYPHENIDYL	001900	
VERAPAMIL	000180	
ALORA	52544047108, 52544047208, 52544047308, 52544088408	Oral Contraceptives
AVIANE-28	00555904558	Oral Contraceptives
CAMILA	00555071558	Oral Contraceptives
CRYSELLE-28	00555904958	Oral Contraceptives
ENPRESSE-28	00555904758	Oral Contraceptives
LESSINA-28	00555901467	Oral Contraceptives
LEVORA-28	52544027928	Oral Contraceptives
LOW-OGESTREL-28	52544084728	Oral Contraceptives
MICROGESTIN	52544095021, 52544095121	Oral Contraceptives
NORTREL	00555900942, 00555901058, 00555901258, 00555900867	Oral Contraceptives
OGESTREL	52544084828	Oral Contraceptives
PORTIA-28	00555902058	Oral Contraceptives
TRINESSA	52544093528	Oral Contraceptives

Maintenance Drugs		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Name	**Coding Level (NDC, HSN, or HIC3)**	**Comments**
TRI-PREVIFEM	00093531528, 00093531581	Oral Contraceptives
TRIVORA-28	52544029128	Oral Contraceptives
* Include oral route only , except as indicated		
** Multivitamins with Fe and Fluoride are all in the Pediatric Multivitamin HIC3 of C6H		

DAYS' SUPPLY OTHER THAN 34 OR 100

Non-standard day supply (package size cannot be broken): Allow days' supply as indicated (other than 34 or 100)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Day Supply**
HIC3 = H3A	Analgesics, Narcotics	30
GSN = 060257	Boniva 3mg/3ml syringe	999
GSNs = 002329	Cyanocobalamin 1,000mcg/ml	90
GSNs = 017584, 026098	Depo-Provera/Medroxyprogesterone 150mg/ml	100
GSN = 058938	Depo-SubQ Provera 104	98 (min. day supply 84)
GSN = 003195	Depo-Estradiol 5mg/ml vial	90
GSN = 003200	Delestrogen/ Estradiol Valerate 40mg/ml vial	50
GSN = 050857	Eligard 22.5mg syringe kit	90
GSN = 051826	Eligard 30mg syringe kit	120
GSN = 058789	Eligard 45mg dispense syringe (1ct)	180
GSN = 022472	Estring 2mg vaginal ring	91
GSN = 038264	Flagyl ER 750mg tab	10
GSN = 066942, 066943, 066944, 069400, 070493, 070494, 070495	Gablofen vial/ disp syrg	120
GSN = 074140, 074141, 074142, 074143	Invega Trinza	90 (min day supply 84)
GSNs = 016404, 022518, 039499, 39500, 031613, 036311, 058308, 058309	Ketorolac 10mg tab, 30mg/ml Carpuject/Isecure, 15, 30, and 60mg vial	3
GSN = 022583	Lioresal IT 10mg/20ml kit	120
GSN = 044964, 44980	Lupron Depot 22.5 and 11.25mg 3-month kit	84
GSN = 044968	Lupron Depot 4-month kit	120
GSN = 067506	Lupron Depot 45 6-month kit	180
GSN = 067737	Lupron Depot Ped 3-month kit	90
GSN = 067738	Lupron Depot Ped 11.25mg and 30mg syr	90
GSN = 053076, 060937, 064935	Jolessa, Quasense, Introvale, Seasonale, Seasonique, Camrese, Amethia, LoSeasonique	91
GSNs = 017179, 022582, 022583	Lioresal Intrathecal	120

Non-standard day supply (package size cannot be broken): Allow days' supply as indicated (other than 34 or 100)		
GSN = 070480	Lupaneta Pack	90 (Min. day supply 84)
GSNs = 002256, 002257, 002258, 002259, 002260, 002262, 002266, 002268, 002270, 002272, 002273, 002274, 002275, 002281, 048450, 063043	Multivit-Fluoride 0.25mg, 0.5/ml drops Multivit-Iron-FL 0.25mg/ml Tri-Vit-Fluor-Iron 0.25mg/ml	50
GSNs = 025080	Norvir 80mg/ml solution	90
GSN = 025081	Norvir 100mg cap	60
HIC3 = C6F	Prenatal Vitamin Preparations	100
HICL = 037012	Prolia 60mg/ml syringe, Xgeva 120mg/1.7ml	999
GSN = 070814	Quartette 0.15mg (91ct) tablets	91 (Min. day supply 84)
GSNs = 002619, 013383	Sodium Fluoride 0.5mg/ml and Fluor-a-day 2.5mg/ml drops	50
NDC-9 = 67979-0002	Supprelin LA	365
NDC-9 = 67979-0500, 55592-0500	Vantas 50mg kit (must bill physician services)	365
HICL = 034717	Zoledronic Acid 5mg/100ml (Reclast/Zometa)	999

OTC COVERED DRUGS

Identified by Formulary indicator = "9," (OTC). Coverage is shown on the Coverage Indicator on the formulary file:

- ☐ **T** = Covered
- ☐ **U** = Covered OTC
- ☐ **I** = Drug Not Covered for any Plan
- ☐ **Z** = Drug Not Covered
- ☐ **D** = None

Note: Indicators located on the Formulary tab in FirstTrax℠.

EXPANDED OTC BENEFIT

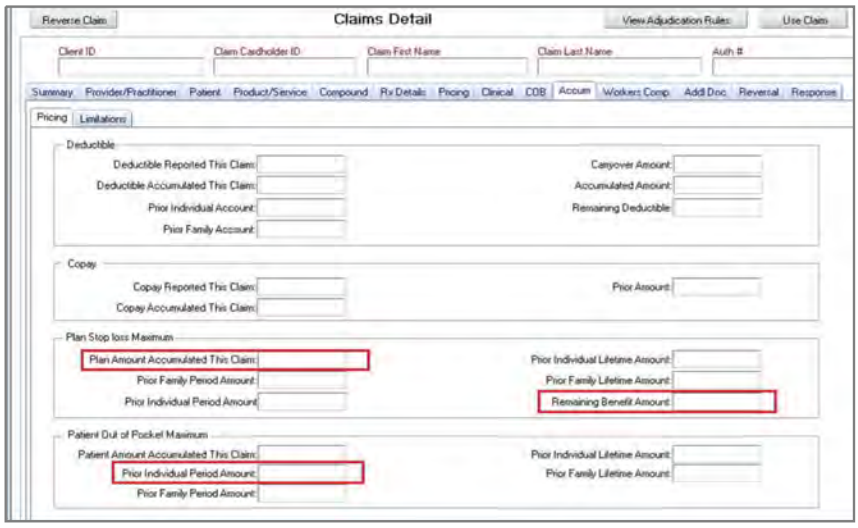
Please direct recipients, providers, and prescribers to our website for a complete list of covered OTC products and a summary of the Over the Counter Benefits (Rx Required = N-No and Prior Auth Type code **does not** = S-PDL).

http://www.magellancompletecareoffl.com/fl-site/providers/preferred-drug-list/over-the-counter-benefits.aspx

- $25.00 per household per month to use toward MCC-FL approved OTC drugs.
- The balance will be set to $25.00 the beginning of each month; the balance does not roll over month-to-month.
- A prescription will be required.
- No clinical, PA, or limitation edits are applied.
- Only the following ProDUR edits apply: Early Refill (ER) and Drug to Drug (DD).
- Covered OTC drugs do not require rebate coverage.
- Claims are limited to submission via POS (no batch or paper); there are no beneficiary submitted claims.
- The beneficiary is responsible for paying any difference between the calculated paid amount and the amount of their remaining credit line (e.g., beneficiary has $10.00 credit, claim is paid for $15.00; hence, the beneficiary has to pay the $5.00 difference. If beneficiary has $0 remaining balance, the patient pay amount will reflect the calculated paid amount of the product.)
- "Lesser of" payment logic applies, using same algorithms for reimbursement per contractual requirements; the dispense fee will also pay per contractual requirements and is part of the $25.00 limit.
- Any/all Magellan pharmacy network providers may participate in this program.
- Beneficiaries who are disenrolled during the month will no longer have access to the benefit for the remainder of that month.
- Use Recipient ID for claim submission.
- Call center will be able to view the balance in FirstTrax℠ to support calls.

On the claim, click on the Accum tab and the Pricing tab to find the information for the expanded benefits:

- **Plan Amount Accumulated This Claim**: The amount applied to the $25.00 per month
- **Prior Individual Period Amount:** Dollar amount that has already been billed for this month
- **Remaining Benefit Amount:** available balance for this month



DIALYSIS DRUGS

Identified by Formulary indicator = "D – Dialysis (Med Cert)." Coverage is shown on the Coverage Indicator on the formulary file:

- ☐ **T** = Covered
- ☐ **U** = Covered OTC
- ☐ **I** = Drug Not Covered for any Plan
- ☐ **Z** = Drug Not Covered
- ☐ **D** = None

Note: Indicators located on the Formulary tab in FirstTrax℠.

For Dialysis drugs indicated by Formulary Indicator = D; Deny NCPDP EC 70-Drug Not Covered if claim is submitted without PA Type Code (NCPDP Field # 461-EU) equal to '8' (both OTC and legend products are covered if '8' is submitted).

QUANTITY/DURATION LISTS

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days ☐ (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 013574	Tamoxifen 20mg	60 per day 27 days
GSN = 015566	Alprazolam 2mg tablets	150 every 27 days
GSN = 015869	Zofran (Ondansetron) 2mg/ml vial	32 every 27 days
GSN = 015880	Fentanyl 25mcg/hr Patch	10 every 26 days
GSN = 015881	Fentanyl 50mcg/hr patch	10 every 26 days
GSN = 015882	Fentanyl 75mcg/hr patch	10 every 26 days
GSN = 015883	Fentanyl 100mcg/hr patch	10 every 26 days
GSN = 015914	Actimmune	6 every 27 days
GSN = 016392	Zofran (Ondansetron) 4 mg	60 every 27 days
GSN = 016393	Zofran (Ondansetron) 8 mg	60 every 27 days
GSN = 016674	Butorphanol Tartrate Nasal Spray	2.5 every 27 days
GSN = 016767	Estradiol 0.025mg patch (Alora and Vivelle-DOT	8 every 25 days
GSN = 017584	Medroxyprogesterone Acetate (Depo-Provera)	1 every 75 days
GSN = 017941	Serevent	34 every 27 days
GSN = 018368	Fluticasone Propionate	16 every 27 days
GSN = 018370	Bactroban Nasal	10 every 27 days
GSN = 018638	Lamisil/Terbinafine	84 every 365 days
GSN = 021251	Flovent 110 mcg	24 every 27 days
GSN = 021253	Flovent 44 mcg	21.2 every 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 021401	Timolol Maleate	15 every 27 days
GSN = 021483	Flovent 220mcg	24 every 27 days
GSN = 022230	Maxair Autohaler 200mcg, Alupent 650mcg aer	28 every 27 days
GSN = 022472	Estring	1 every 84 days
GSN = 023270	Estradiol 0.075mg patch (Alora/Minivelle/Vivelle-D	8 every 25 days
GSN = 002329	Cyanocobalamin 1,000mcg/ml	2 every 28 days
GSN = 023471	Climara / Climara Pro (estradiol patches	4 every 25 days
GSN = 023472	Climara 0.05mg/day patch	4 every 25 days
GSN = 024138	Calcitonin, Salmon, Synth (Miacalcin/Fortical)	4 every 25 days
GSN = 024456	Atrovent (ipratropium) 42mcg nasal	30 every 27 days
GSN = 024457	Atrovent (ipratropium) 21mcg nasal	60 every 27 days
GSN = 024555	Estradiol 0.0375mg patch (Alora/Minivelle/Vivelle-	8 every 25 days
GSN = 025080	Norvir 80mg/ml solution	480 every 24 days
GSN = 025081	Norvir 100mg softgel cap	360 every 24 days
GSN = 025738	Cabergoline 0.5mg tablet	16 every 30 days
GSN = 026098	Medroxyprogesterone Acetate (Depo-Provera)	1 every 75 days
GSN = 026869	Nasacort AQ	16.5 every 27 days
GSN = 027370	Xalatan	5 every 27 days
GSN = 028107	Ondansetron 4mg/5ml solution	600 every 27 days
GSN = 029123	Combivent	29.4 every 27 days
GSN = 029916	Humulin R – U500 vial	20ml every 25 days
GSN = 030763	Granisetron 1mg/5ml oral soln	80 every 27 days
GSN = 030788	Copaxone	1 every 27 days
GSN = 031186	Nasonex	17 every 27 days
GSN = 003202	Estradiol 0.05mg patch (Alora/ Minivelle/Vivelle-D	8 every 25 days
GSN = 003203	Estradiol 0.1mg patch (Alora/Minivelle/Vivelle-DOT	8 every 25 days
GSN = 032174	Climara 0.025mg/day patch	4 every 25 days
GSN = 003267	Makena (hydroxyprogesterone) Soln for Inj	5 every 27 days
GSN = 000343	Catapres-TTS (clonidine) patches	8 every 28 days
GSN = 000344	Catapres-TTS (clonidine) patches	8 every 28 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 000345	Catapres-TTS (clonidine) patches	8 every 28 days
GSN = 034749	Anzemet (dolasetron)50mg tablet	8 every 27 days
GSN = 034750	Anzemet (dolasetron) 100mg tablet	8 every 27 days
GSN = 035495	EMLA Cream	30 every 27 days
GSN = 036872	Methotrexate	300 every 27 days
GSN = 037003	Singulair	30 every 25 days
GSN = 037042	Tobi 300mg/5ml ampul-neb inh.	280 every 53 days
GSN = 037048	Bactroban 2% cream (mupirocin)	60 every 27 days
GSN = 037219	Prevpac	224 every 27 days
GSN = 037223	Regranex	140 every 365 days
GSN = 003734	Chlordiazepoxide 10mg capsules	120 every 27 days
GSN = 003735	Chlordiazepoxide 25mg capsules	120 every 27 days
GSN = 003736	Chlordiazepoxide 5mg capsules	120 every 27 days
GSN = 003744	Clorazepate 15mg tablet	120 every 27 days
GSN = 003745	Clorazepate 3.75mg tablet	120 every 27 days
GSN = 003746	Clorazepate 7.5mg tablet	120 every 27 days
GSN = 003757	Lorazepam 0.5mg tablets	150 every 27 days
GSN = 003758	Lorazepam 1mg tablets	150 every 27 days
GSN = 003759	Lorazepam 2mg tablets	150 every 27 days
GSN = 003766	Diazepam 10mg tablet	120 every 27 days
GSN = 003767	Diazepam 2mg tablets	120 every 27 days
GSN = 003768	Diazepam 5mg tablet	120 every 27 days
GSN = 003773	Alprazolam 0.25mg tablets	150 every 27 days
GSN = 003774	Alprazolam 0.5mg tablets	150 every 27 days
GSN = 003775	Alprazolam 1mg tablets	150 every 27 days
GSN = 039531	Cosopt	10 every 27 days
GSN = 039780	Xeloda 150mg	120 every 27 days
GSN = 039781	Xeloda 500mg	120 every 27 days
GSN = 040279	Thalomid 100mg	30 every 25 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 040294	Actonel 30mg	60 every 120 days
GSN = 040296	Thalomid 50mg	30 every 25 days
GSN = 040366	Climara 0.075mg/day patch	4 every 25 days
GSN = 040429	Cinryze 500 (5ml) vial pkg size=1	20 every 25 days
GSN = 040526	Lidocaine/Prilocaine (EMLA kit)	10 every 27 days
GSN = 040869	Enbrel 25mg kit (pkg size 4)	8 every 25 days
GSN = 041562	Zofran (Ondansetron) 4 mg ODT	60 every 27 days
GSN = 041563	Zofran (Ondansetron) 8 mg ODT	60 every 27 days
GSN = 043010	Temodar 5mg	60 every 27 days
GSN = 043011	Temodar 20mg	60 every 27 days
GSN = 043012	Temodar 100mg	60 every 27 days
GSN = 043013	Temodar 250mg	60 every 27 days
GSN = 043230	Ondansetron 24mg tab	100 every 27 days
GSN = 043256	Lidoderm	90 every 27 days
GSN = 043899	Levonorgestrel	2 every 30 days
GSN = 043901	Caffeine Cit 60mg/3ml vial (Cafcit)	90 every 27 days
GSN = 044226	Rhinocort AQ	8.6 every 27 days
GSN = 044269	Targretin 75mg	60 every 27 days
GSN = 044964	Lupron Depot	1 every 84 days
GSN = 044967	Leuprolide soln for inj 2 wk 1mg/0.2ml kit	2 every 26 days
GSN = 044968	Lupron Depot	1 every 118 days
GSN = 044970	Lupron Depot	1 every 28 days
GSN = 044980	Lupron Depot	1 every 84 days
GSN = 045017	Lupron Depot	1 every 28 days
GSN = 045269	Caffeine Cit 60mg/3ml oral	90 every 27 days
GSN = 004560	Clonazepam 0.5mg tablet	90 every 27 days
GSN = 004561	Clonazepam 1mg tablet	90 every 27 days
GSN = 004562	Clonazepam 2mg tablet	90 every 27 days
GSN = 004704	Transderm-Scop	10 every 27 days
GSN = 004722	Diclegis 10m-10mg tablets DR	120 every 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 047571	Prozac Weekly	4 every 27 days
GSN = 047612	Travatan Z	5 every 27 days
GSN = 047688	Cancidas 50mg vial (caspofungin)	13 every 27 days
GSN = 047689	Cancidas 70mg vial (caspofungin)	1 every 27 days
GSN = 048333	Alphagan P	10 every 27 days
GSN = 048447	Cathflo Activase	2 every 27 days
GSN = 048492	Tussionex Suspension	300 every 30 days
GSN = 048627	Clotrimazole-Betamethasone lotion	60 every 27 days
GSN = 048699	Albuterol Sulfate 1.25mg/3ml soln	375 every 27 days
GSN = 004963	Alupent 4mg/ml Nebs	300 every 27 days
GSN = 004964	Alupent 6mg/ml Nebs	300 every 27 days
GSN = 050035	Rebif 22mcg/0.5ml disp syringe	6 every 25 days
GSN = 050039	Rebif 44mcg/0.5ml disp syringe	6 every 25 days
GSN = 050363	Eligard (leuprolide) 7.5mg syr kit	1 every 25 days
GSN = 050364	Actonel 35mg	4 every 27 days
GSN = 005039	Albuterol 0.083% (2.5mg/3ml) inh soln	375 every 27 days
GSN = 050399	Xanax XR 0.5mg tab (alprazolam)	30 every 27 days
GSN = 005040	Albuterol 5mg/ml inh soln	60 every 27 days
GSN = 050400	Xanax XR 1mg tab (alprazolam)	30 every 27 days
GSN = 050401	Xanax XR 2mg tab (alprazolam)	30 every 27 days
GSN = 050857	Eligard (leuprolide) 22.5mg syr kit	1 every 84 days
GSN = 051483	Forteo 600mcg/2.4ml Pen Inj	2.4 every 28 days
GSN = 051512	Singulair	30 every 25 days
GSN = 051810	Lidocaine-HC 3-0.5% cream / cream kit	98 every 7 days
GSN = 051826	Eligard (leuprolide) 30mg syr kit	1 every 118 days
GSN = 051879	Thalomid 200mg	60 every 25 days
GSN = 051909	Oxytrol (oxybutynin) patch	8 every 27 days
GSN = 051911	Emend 80mg capsules	4 every 27 days
GSN = 051912	Emend 125mg capsules	2 every 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 051913	Emend Trifold Pack	6 every 27 days
GSN = 051983	Clonazepam 0.125mg ODT tablet	90 every 27 days
GSN = 051984	Clonazepam 0.25mg ODT tablet	90 every 27 days
GSN = 051985	Clonazepam 0.5mg ODT tablet	90 every 27 days
GSN = 051986	Clonazepam 1mg ODT tablet	90 every 27 days
GSN = 051987	Clonazepam 2mg ODT tablet	90 every 27 days
GSN = 052050	Vigamox	6 every 27 days
GSN = 052143	Xanax XR 3mg tab (alprazolam)	30 every 27 days
GSN = 052711	Gleevec 400mg	90 every 27 days
GSN = 052712	Gleevec 100mg	90 every 27 days
GSN = 052830	Climara 0.06mg/day patch	4 every 25 days
GSN = 052831	Climara 0.0375mg/day patch	4 every 25 days
GSN = 052934	Risperdal Consta	8 every 28 days
GSN = 052935	Risperdal Consta	8 every 28 days
GSN = 052936	Risperdal Consta	8 every 28 days
GSN = 053383	Climara Pro 0.045mg – 0.015mg/day patch	4 every 25 days
GSN = 053835	Factive	7 every 27 days
GSN = 054687	Albuterol 2.5mg/0.5ml nebs	120 every 27 days
GSN = 058214	Enbrel 50mg/ml syringe (pkg size 0.98)	7.840 every 25 days
GSN = 058374	Tarceva 150mg	30 every 27 days
GSN = 058375	Tarceva 100mg	30 every 27 days
GSN = 058376	Tarceva 25mg	30 every 27 days
GSN = 058482	Lunesta (eszopiclone) 3mg tablet	90 every 365 days
GSN = 058484	Lunesta (eszopiclone) 1mg tablet	90 every 365 days
GSN = 058516	Lamotrigine dose packs (25mg)	35 every 27 days
GSN = 058517	Lamotrigine dose packs (25mg-100mg)	98 every 27 days
GSN = 058518	Lamotrigine dose packs (25mg-100mg)	49 every 27 days
GSN = 058776	Rebif 8.8-22 (6) titration pack	4.20 every 25 days
GSN = 058789	Eligard (leuprolide) 45mg syr kit	1 every 175 days
GSN = 058847	Alprazolam ODT 0.25mg tablets	150 every 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 058848	Alprazolam ODT 0.5mg tablets	150 every 27 days
GSN = 058849	Alprazolam ODT 1mg tablets	150 every 27 days
GSN = 058850	Alprazolam ODT 2mg tablets	150 every 27 days
GSN = 058938	Depo-SubQ Provera 104 syringe	0.65 every 84 days
GSN = 059081	Atrovent 17mcg HFA	25.8 grams per 27 days
GSN = 059102	Fentanyl 12mcg/hr patch	10 every 26 days
GSN = 059404	Reclast	100 every 355 days
GSN = 060230	Revlimid 5mg	30 per 27 days
GSN = 060231	Revlimid 10mg	30 per 27 days
GSN = 060257	Boniva	1 every 84 days
GSN = 060326	Sutent 12.5mg	30 every 27 days
GSN = 060327	Sutent 25mg	30 every 27 days
GSN = 060328	Sutent 50mg	30 every 27 days
GSN = 061099	Sprycel 20mg	60 every 27 days
GSN = 061100	Sprycel 50mg	30 every 27 days
GSN = 061101	Sprycel 70mg	30 every 27 days
GSN = 061113	Revlimid 15mg	30 per 27 days
GSN = 061114	Revlimid 25mg	30 per 27 days
GSN = 061115	Emend 40mg capsules	4 every 27 days
GSN = 061938	Enbrel 50mg/ml syr (pkg size 0.98)	7.840 every 25 days
GSN = 062240	Pulmicort 90mcg Flexhaler	1 every 24 days
GSN = 062241	Pulmicort 180mcg Flexhaler	1 every 24 days
GSN = 062444	Thalomid 150mg	30 every 25 days
GSN = 062535	Temodar 140mg	60 every 27 days
GSN = 062536	Temodar 180mg	60 every 27 days
GSN = 062624	Enbrel 25mg/0.5ml syr (pk sz 0.51)	4.080 every 25 days
GSN = 062828	AzaSite 1% ophthalmic drops	2.5 every 30 days
GSN = 063319	Tasigna 200mg	120 every 27 days
GSN = 063885	Treximet	9 every 28 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 064161	Sprycel 100mg	30 every 27 days
GSN = 064399	Cefepime 1g	1500 every 30 days
GSN = 064400	Cefepime Piggy 2g	3000 every 30 days
GSN = 064410	Hycamtin 0.25mg	20 every 27 days
GSN = 064411	Hycamtin 1mg	20 every 27 days
GSN = 064564	Firazyr 30mg/3ml syr pkg sz 3ml	9 every 25 days
GSN = 064645	Anzemet (dolasetron) 12.5mg vial	5 every 25 days
GSN = 064935	LoSeasonique	91 every 84 days
GSN = 064994	Afinitor 5mg	30 every 27 days
GSN = 064995	Afinitor 10mg	30 every 27 days
GSN = 065170	Lamotrigine pk (25-50-100 ODT)	35 every 27 days
GSN = 065171	Lamotrigine pk (25-50 ODT)	28 every 27 days
GSN = 065172	Lamotrigine pk (50-100 ODT)	56 every 27 days
GSN = 065254	Lamotrigine pk (25-50 XR)	28 every 27 days
GSN = 065255	Lamotrigine pk (50-100-200 XR)	35 every 27 days
GSN = 065256	Lamotrigine pk (25-50-100 XR)	35 every 27 days
GSN = 065913	Cayston	84 every 53 days
GSN = 066336	Lysteda	30 every 27 days
GSN = 066396	Prolia	1 every 175 days
GSN = 066453	Tasigna 150mg	120 every 27 days
GSN = 066495	Afinitor 2.5mg	30 every 27 days
GSN = 066968	Sprycel 80mg	60 every 27 days
GSN = 066969	Sprycel 140mg	30 every 27 days
GSN = 067290	Caprelsa 100mg	60 per day 27 days
GSN = 067291	Caprelsa 300mg	30 per 27 days
GSN = 067356	Lupron Depot 7.5mg	1 every 27 days
GSN = 067506	Lupron Depot 45 (6-month kit)	1 every 175 days
GSN = 067642	Eliquis 2.5mg	60 every 27 days
GSN = 067823	Xalkori 250mg	60 every 27 days
GSN = 067824	Xalkori 200mg	60 every 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 068167	Jakafi 5mg	60 every 27 days
GSN = 068168	Jakafi 10mg	60 every 27 days
GSN = 068169	Jakafi 15mg	60 every 27 days
GSN = 068170	Jakafi 20mg	60 every 27 days
GSN = 068171	Jakafi 25mg	60 every 27 days
GSN = 068497	Inlyta 1mg	120 every 27 days
GSN = 068498	Inlyta 5mg	120 every 27 days
GSN = 068582	Afinitor 7.5mg	30 every 27 days
GSN = 068980	Revlimid 2.5mg	30 per 27 days
GSN = 069928	Bosulif 100mg	30 every 27 days
GSN = 069929	Bosulif 200mg	30 every 27 days
GSN = 070360	Iclusig 15mg tablet	60 every 27 days
GSN = 070361	Iclusig 45mg tablet	30 every 27 days
GSN = 070386	Cometriq 140mg/day blister card	112 every 26 days
GSN = 070387	Cometriq 100mg/day blister card	56 every 26 days
GSN = 070388	Cometriq 60mg/day blister card	84 every 26 days
GSN = 070414	Eliquis 5mg tablets	74 every 27 days
GSN = 070480	Lupaneta Pack 11.25mg-5mg kit syringe tab	1 every 84 days
GSN = 070481	Lupaneta Pack 3.75mg-5mg kit syringe tab	1 every 27 days
GSN = 070569	Pomalyst 1mg	23 every 25 days
GSN = 070570	Pomalyst 2mg	23 every 25 days
GSN = 070571	Pomalyst 3mg	23 every 25 days
GSN = 070572	Pomalyst 4mg	23 every 25 days
GSN = 070586	Rebif Rebidose 8.8-22 (6) titra pack	4.20 every 25 days
GSN = 070587	Rebif Rebidose 22mcg/0.5ml pens	6 every 25 days
GSN = 070588	Rebif Rebidose 44mcg/0.5ml pens	6 every 25 days
GSN = 070814	Quartette 0.15mg (91ct) tablets	91 every 84 days
GSN = 070919	Afinitor 2mg tabs-suspension	60 every 27 days
GSN = 070920	Afinitor 3mg tabs-suspension	90 every 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 070921	Afinitor 5mg tabs-suspension	60 every 27 days
GSN = 071033	Tafinlar 50mg	120 every 25 days
GSN = 071034	Tafinlar 75mg	120 every 25 days
GSN = 071036	Mekinist 0.5mg	90 every 25 days
GSN = 071037	Mekinist 2mg	30 every 25 days
GSN = 071129	Gilotrif 20mg	30 every 25 days
GSN = 071229	Gilotrif (Afatinib Dimaleate)	30 every 25 days
GSN = 071230	Gilotrif 30mg	30 every 25 days
GSN = 071231	Gilotrif 40mg	30 every 25 days
GSN = 071674	Imbruvica 140mg capsule	120 every 25 days
GSN = 072296	Zykadia 150 mg capsules	150 every 25 days
GSN = 072896	Mitigare (Colchicine) 0.6mg capsules	6 every 27 days
GSN = 073484	Lenvima 24mg/day capsules	90 every 27 days
GSN = 073485	Lenvima 14mg/day capsules	60 every 27 days
GSN = 073486	Lenvima 10mg/day capsules	30 every 27 days
GSN = 073487	Lenvima 20mg/day capsules	60 every 27 days
GSN = 007732	Bactroban Ointment	44 every 27 days
GSN = 007911	Blephamide S.O.P (sulfacetamide/prednisolone)	3.5 every 27 days
GSN = 007914	Blephamide (sulfacetamide/prednisolone) drops	10 every 28 days
GSN = 007988	Tobramycin Sulfate	10 every 27 days
GSN = 008334	Colcrys 0.6mg tablets	6 every 27 days
GSN = 008341	Indocin 25mg/5ml susp	300 every 27 days
GSN = 008777	Myleran 2mg	180 every 27 days
GSN = 008831	Lysodren 500mg	1,140 every 27 days
GSN = 008832	Tamoxifen 10mg	90 per 27 days
HSN = 001255	Paregoric	1200 every 30 days
HSN = 001616	Oxazepam	120 every 27 days
HSN = 003338	Malathion 0.5% topical lotion (Ovide)	60 every 27 days
HSN = 003924	Emcyt 140mg	30 every 27 days
HSN = 003928	Matulane	30 every 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
HSN = 003933	Flutamide 125mg capsules	180 every 27 days
HSN = 006041	Hexalen 50mg	126 every 27 days
HSN = 007876	Nilandron 150mg	30 every 27 days
HSN = 010143	Casodex (bicalutamide) 50mg tablet	30 every 27 days
HSN = 010249	Arimidex 1mg	30 per 27 days
HSN = 011632	Fareston 60mg	30 every 27 days
HSN = 012351	Femara 2.5mg	30 per 27 days
HSN = 012998	Aldara	48 every 112 days
HSN = 019858	Xopenex nebs	288 every 27 days
HSN = 020803	Aromasin 25mg	30 every 27 days
HSN = 021103	Synarel 2mg/ml nasal spray	40 every 27 days
HSN = 023721	NuvaRing	1 every 21 days
HSN = 024459	Zetia 10mg	30 every 27 days
HSN = 026287	Ventavis 20mcg/2ml & 10mcg/ml ampul neb sol	270 per 27 days
HSN = 026757	Oxycodone-Ibuprofen (Combunox)	120 every 27 days
HSN = 032814	Xopenex HFA	30 every 27 days
HSN = 033400	Nexavar 200mg	120 every 27 days
HSN = 033451	Polyethylene Glycol-electrolyte soln (MiraLAX)	527 every 30 days
HSN = 034070	Zolinza 100mg	120 every 27 days
HSN = 034541	Tykerb 250mg	180 per 27 days
HSN = 036709	Votrient 200mg	120 every 27 days
HSN = 036856	Prevnar 13 syringe	0.5 per lifetime
HSN = 036874	Vpriv 400 unit vial (pkg size each)	41 every 25 days
HSN = 037571	Zytiga 250mg	120 every 27 days
HSN = 037609	Victrelis	3,024 every 355 days
HSN = 037629	Incivek 375mg tablets	504 per lifetime
HSN = 037837	Zelboraf 240mg	240 every 27 days
HSN = 038455	Erivedge 150mg	30 every 27 days
HSN = 038937	Elelyso 200 unit vial (pkg size each)	82 every 25 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
HSN = 039580	Xtandi 40mg	120 every 27 days
HSN = 039665	Stivarga 40mg	120 every 27 days
HSN = 041672	Savaysa 15, 30 & 60mg tablets	30 every 27 days
HSN = 041725	Ibrance 75, 100, and 125mg capsules	21 every 25 days
HSN = 041794	Farydak 10, 15 and 20mg capsules	6 every 18 days
HSN = 042826	Ninlaro 2.3, 3, and 4mg capsules	3 every 25 days
HICL = 034708 (and package size = 15 and Generic Named Drug Cd = 2-Brand) FLALTABAXQT	Altabax 1% ointment	15 every 27 days
GSN = 051649, 059328, 059327, 059326, 064010, 064012 FLASMANEXQL	Asmanex 110 and 220mcg	1 every 27 days
HSN = 011253 and GSN 049812 FLAVONEXQL	Avonex prefilled syringe 30mcg (4 count) and Avonex Admin pack 30mcg vial (4 count)	4 every 24 days
TC = 17 (Limitation will apply to Rx required products with a dosage form of Drops, Elixir, Liquid, Oral Suspension, Solution, Sus 12H, and Syrup) FLCOUGHII	Cough Preparations/Expectorants	300 every 27 days
TC = 16 (Limitation will apply to Rx required products with a dosage form of Drops, Elixir, Liquid, Oral Susp, Solution, Sus 12H, and Syrup) FLCOUGHQTY	Antitussives – expectorants; Cough and Cold Preparations	Limitation: 300 every 27 days
GSN = 067737, 067738 FLCPPLUP1	Lupron Depot Ped 30mg 3 month kit, Lupron Depot Ped 11.25mg 3 month	1 every 84 days
GSN = 047665, 047666, 047851 FLCPPLUP2	Lupron Depot Ped 11.25 kit, Lupron Depot Ped 7.5 kit , Lupron Depot Ped 15mg kit	1 every 23 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
HSN = 003897 (excluding GSNs 040162, 040163, 040164) FLDL90P27	Hydrea 500mg	90 per 27 days
HSN = 003908 (excluding GSN 52090) FLDL90P27B	Purinethol 50mg	90 per 27 days
GSNs = 074140, 074141, 074142, 074143 FLDLMDS90A	Invega Trinza 273mg/0.875ml Inj Invega Trinza 410mg/1.315ml inj Invega Trinza 546mg/1.75ml inj Invega Trinza 819mg/2.625ml Inj	Age >/= 18: 819mg every 84 days
HSN = 001854, 001713, 001790, 001699, 001858 (excluding GSN 052031) FLDLQ120355	Butalbital-APAP-Caffeine	120 every 355 days (Internal error code 7001) *240 every 355 days (Internal error code 7002)*
GSN = 040221, 040222, 040223, 040224 FLDLQ12281	Maxalt	12 every 28 days
GSN = 053612, 051601 FLDLQ1271	Pegasys	1 every 27 days
GSN = 028090 and package size = 6.7g FLDLQ13427D	Albuterol HFA	13.4 every 27 days
GSN = 028090 and package size = 7g FLDLQ1427	Albuterol HFA	14 every 27 days
GSN = 028090 and package size = 8g FLDLQ1627	Albuterol HFA	16 every 27 days
GSN = 068384, 069123 FLDLQ16VP25	Berinert 500 (10ml) kit/vial	16 every 25 days
GSN = 028090 and package size = 8.5g FLDLQ1727	Albuterol HFA	17 every 27 days
NDC-9 = 679790500, 555920500	Vantas 50mg kit (must bill physician services)	1 every 355 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
FLDLQ1P355		
GSNs = 043899, 065578, 058193 FLDLQ227	Plan B, Ella, Aftera, Econtra EZ, Fallback Solo, My Way, Next Choice One, Opcicon One-Step, Plan B One-Step, Take action	2 every 27 days
GSNs = 016878, 016879, 062449, 062448, 065912, 065145 and package size = 2 FLDLQ2271	EpiPen, EpiPen Jr., Epinephrine, Adrenaclick, Twinject	2 every 27 days (2 kits)
HSN = 001854, 001713, 001790, 001699, 001858 (excluding GSN 052031) FLDLQ240365	Butalbital-APAP-Caffeine	240 every 355 days (Internal error code 7002) *120 every 355 days* *(Internal error code 7001)*
GSN = 034015, 059781, and 059782 FLDLQ2PER27	Diastat 2.5, 5–7.5–10 and 12.5–15–20 kit	2 every 27 days
GSNs = 067760, 067761, 067762, 063422, 063423, 063424, 060274, 043536, 043537, and 068721 FLDLQ30P27	ConZip ER, Ryzolt ER, Ultram ER and Tramadol ER	30 per 27 days
GSNs = 007012, 007013 and pkg size = 30 FLDLQ30P30	Premarin vag cream (30g package size only)	30 per 27 days
GSNs = 060499, 060500 FLDLQ327	Imitrex 4mg/0.5ml pen inject and cartridges	3ml per 27 days
GSNs = 019192, 019193, 019239 FLDLQ3282	Imitrex 6mg/0.5ml syringe kit, vial, and cartridges	3ml per 27 days
GSN = 052031 FLDLQ360365	Alagesic LQ (Butalbital-APAP-Caff)	360 every 355 days
GSN = 028090 and package size = 18g FLDLQ3627	Albuterol HFA	36 every 27 days
GSN = 034748, 052943 FLDLQ40271	Aloxi 0.25 mg/5ml vial, Anzemet 20mg/ml	40 every 27 days
GSNs = 016878, 016879, 062449, 062448, 065912, 065145 and package size = 1 FLDLQ4271	EpiPen, EpiPen Jr., Epinephrine, Adrenaclick, Twinject	4 every 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
HIC3 = H2E (excluding GSNs 003753, 003754, 003755, 003756, 044671, 064334, 064672, 064687, 066565, 068445, 068460, 070876, 070877) FLDLQ45251	Sedative-Hypnotics, Non-Barbiturate	45 every 25 days
GSN = 008078, 008079 FLDLQ50271	Beconase AQ 0.042%/ nasal spray, Flunisolide 0.025% nasal spray	25 every 27 days
HSN = 001396 FLDLQ540027	Lactulose	5400 every 27 days
GSN = 021592, 021693, 063545 FLDLQ8271	Granisetron 1mg tablet, 1mg/ml vial	8 every 27 days
HIC3 = C4G and dosage Form Cd = vial (excluding GSN 029916) FLDLQ7027	Insulin vials	70 every 27 days
GSN = 031492, 038275, 017129, 022479, 023799, 048986 FLDLQ9281	Amerge tablets, Imitrex tablets, and Frova tablets	9 every 27 days
GSN = 030735, 030742, 031027, 037036, 044662, 047424, 048155, 048643, 049605, 049606, 051639 FLDQ6282	Imitrex nasal spray, Zomig nasal spray, Zomig tablets, Zomig ZMT tablets, Axert tablets, and Relpax	6 every 27 days
GSNs = 065500, 065501, 065502 FLDLTYVASO	Tyvaso 1.74mg/2.9ml ampul neb Tyvaso 1.74mg/2.9ml ampul neb Tyvaso 1.74mg/2.9ml ampul neb	81.20ml every 25 days
HIC3 = C4G and dosage Form Cd = cartridge or pen FLINSULIN	Insulin pens/cartridges	30 every 27 days
GSNs = 052882, 067628 FLMAXQTY126	Avonex 30mcg/0.5ml kit and pen inj kit	1 kit per 26 days
GSNs = 053430, 069046 FLMAXQTY226	Avonex 30mcg/0.5ml disp syr and pen inj	2ml per 26 days
HICL = 004212 and patient age >/= 50 and patient age </=64	Pneumovax	0.5 every 1825 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
FLPNEUMOVA1		
HICL = 004212 and patient age >/=65 FLPNEUMOVA2	Pneumovax	0.5 per lifetime
GSN = 053152 and patient age < 16 FLRYBIXL16	Tramadol HCL	60 every 27 days
GSN = 004661, 004662, 004663, 048518, 063097 FLSOMAQTY	Soma	120 every 365 days
GSN = 023139 and patient age < 16 FLTRAMADL16	Tramadol HCL 50mg tablet	60 every 27 days
NDC11 = 13533063102	HyperRHO 1500 units syr	2 every 365 days
NDC11 = 13533063106	HyperRHO 250 units syr	2 every 365 days

Maximum duration (number of scripts): Deny if exceeded for designated number of scripts per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
HICL = 019963	Advair Diskus 100/50, 250/50, and 500/50 Advair HFA inhaler 115-21, 230-21, 45-21	1 fill every 27 days
HICL = 034708 (and package size = 15 and Generic Named Drug Cd = 2-Brand)	Altabax 1% 15gm oint	2 fills every 60 days
HICL = 037011	Arcapta	1 fill every 27 days
HICL = 034087	Brovana	1 fill every 27 days
HICL= 023438	Butrans 5, 10, and 20 mcg/hr patch	1 fill every 27 days
GSN = 027905	Helidac (Bismuth Sal/Metronid/Tetracyc)	1 fill every 365 days
GSN = 008779	CeeNU 10mg	6 capsules per fill; 1 fill every 39 days
GSN = 008781	CeeNU 10mg	6 capsules per fill; 1 fill every 39 days
GSN = 008780	CeeNU 40mg	6 capsules per fill; 1 fill every 39 days
HICL = 035554	Cimzia 200mg/ml	1 fill every 25 days
HICL = 037050	Dulera	1 fill every 27 days
HICL = 010747	Foradil/Perforomist	1 fill every 27 days
GSN = varies per year	Influenza	1 Rx every 365 days
HICL = 003338	Malathion/Ovide 0.5% lotion	2 fills every 60 days
HICL = 007625	Paclitaxel, Semi-Synthetic	1 fill every 5 days
HICL = 004212	Pneumovax	2 fills per lifetime
GSNs = 043119	Relenza 5mg Diskhaler	2 fills every 365 days
HICL = 021993	Symbicort 80-4.5 and 160-4.5mcg inhaler	1 fill every 27 days
GSNs = 043706, 063223, 063224, 047429, 043119, 067561 (List ID FLQLRX2365)	Tamiflu 30, 45, and 75mg cap, 6mg/ml and 12mg/ml susp	2 Rxs every 355 days
GSN = 035383	Vagifem 25mcg vaginal tablets	1 fill every 26 days
GSNs = 065966	Vagifem 10mcg tab	1 fill every 26 days
HSN = 039945	Lupaneta Pack	365 days supply per lifetime
HICL = 004209 and 033506 (List ID FLMAXFILL3)	WinRho/HyperRHO	2 fills every 365 days
GSN = 060910	Zostavax vial	1 fill every lifetime

HSN = 001949, 001941, 001950, 001906, 001945, 001938, 011582 and Route of Admin = Oral and day supply >/= 30	Skeletal Muscle Relaxants: Baclofen 10mg 20mg Chlorzoxazone 250mg,500mg Flexeril 5mg 7.5mg,10mg Amrix 15mg 30mg ER Fexmid 7.mg Orphenadrine ER 100mg Skelaxin 400mg,800mg Robaxin 500mg,750mg Zanaflex 2mg,4mg,6mg	6 fills every 365 days EXCLUDING drugs in HSN 001949 (Baclofen) or HSN 001949 (Zanaflex) that have a diagnosis listed below, in history, within the past 730 days: 343.0-343.9 (Infantile Cerebral Palsy) 342.00-342.92 (Hemiplegia/Hemiparesis) 334.0-334.9 (Spinocerebellar disease) 438.20-438.22 (Hemiplegia/Hemiparesis) 438.30-438.32 (Monoplegia of upper limb) 438.40-438.42 (Monoplegia of lower limb)\ 438.50-438.53 (Other paralytic syndrome) 438.9 (other late effects of cerebrovascular disease) 340 (Multiple sclerosis) 341.0-341.9 (Other demyelinating diseases of central nervous system) 781.7 (Tetany) 952.0-952.9 (Spinal Cord Injury without evidence of spinal bone injury) 335.20-335.29 (Motor Neuron disease)

Limitation Days Supply: Deny if accumulated days supply is exceeded per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
HICL = 039945	Lupaneta Pack11.25mg-5mg kit syringe tab Lupaneta Pack 3.75mg-5mg-kit syringe tab	365 days supply per lifetime

MAXIMUM DURATION CII-CV (NUMBER OF SCRIPTS)

Deny if exceeded for designated 4 fills per rolling 27 days. NCPDP EC #76 – *Plan Limitations Exceeded*.

Sickle cell and cancer patients with an active ICD-9 code in medical claims history (within 365 days from the DOS of the incoming claim) of 140-239.9 or 282.4-282.9 are allowed six Rx fills every 27 days.

Drug Code	Description
HIC3 = H3A (and DEA Code = II)	Narcotic Analgesics
HIC3 = H2X	Tricyclic Antidepressant/Benzodiazepine Combinations
HIC3 = H3W	Narcotic Withdrawal Therapy Agents
HIC3 = H2E (excluding HSNs = 004482 and 001586)	Sedative-Hypnotics, Non-Barbiturate
HIC3 = H2F (excluding HSN = 001620)	Anti-Anxiety Drugs
HSN = 000206	Guaifenesin/Codeine Phos
HSN = 000209	Guaifenesin/Hydrocodone BIT
HSN = 000347	Chlorpheniramine
HSN = 000349	Hydrocodone BIT/Homatropine
HSN = 000352	Hydrocodone/Chlorphen Polis
HSN = 000419	Phenyleph/Codeine/Acetaminp/CP
HSN = 000422	Phenyleph/Hydrocodone/Acetaminp/CP
HSN = 000486	Pseudoephedrine HCL/Codeine

Drug Code	Description
HSN = 001699	Codeine/Butalbital/ASA/Caffeine
HSN = 001702	Cod/ASA/Salicylmd/Acetamn/Caff
HSN = 001711	Aspirin/Codeine Phosphate
HSN = 001713	Codeine/ Butalbital/Acetamin/Caff
HSN = 001717	Acetaminophen With Codeine
HSN = 001720	Codeine Phos/Carisoprodol/ASA
HSN = 001727	Hydrocodone Bit/Aspirin
HSN = 001730	Hydrocodone Bit/Acetaminophen
HSN = 001734	Dihydrocodeine/Aspirin/Caffeine
HSN = 001739	Dhcodeine Bt/Acetaminophn/Caff
HSN = 001777	Butorphanol Tartrate
HSN = 001779	Pentazocine HCL/Aspirin
HSN = 001780	Pentazocine HCL/Acetaminophen
HSN = 001781	Pentazocine HCL/Naloxone HCL
HSN = 001782	Pentazocine Lactate
HSN = 001790	Butalbital/Aspirin/Caffeine
HSN = 001871	Isomethept/Acetaminop/Dichlphn
HSN = 001894	Clonazepam
HSN = 001942	Carisoprodol / Aspirin
HSN = 001944	Carisoprodol
HSN = 014296	Hydrocodone/Ibuprofen
HSN = 023438	Buprenorphine
HSN = 026470	Pregabalin
HSN = 034574	Dihydrocodeine/Aspirin/Caffeine
HSN = 035174	P-Ephed HCL/Codeine/Guaifen
TC = 16 (CIII-V products with the dosage form of drops (SO), elixir (SE), liquid (SL), oral susp (SC), solution (SJ), sus 12H Sr (PJ), syrup (ST))	Cough Preparation/Expectorants
TC = 17 (CIII-V products with the dosage form of drops (SO), elixir (SE), liquid (SL), oral susp (SC), solution (SJ), sus 12H Sr (PJ), syrup (ST))	Cough and Cold Preparations

MAXIMUM DAILY DOSE LIMITATIONS

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)

NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	Description	
GSN = 064712	Abstral 100mcg Tab Subl	4
GSN = 064713	Abstral 200mcg Tab Subl	4
GSN = 064714	Abstral 300mcg Tab Subl	4
GSN = 064715	Abstral 400mcg Tab Subl	4
GSN = 064716	Abstral 600mcg Tab Subl	4
GSN = 064717	Abstral 800mcg Tab Subl	4
GSN = 027962	Accolate 20mg tablet	3
GSN = 022358	Actiq 200mcg Lozenges	4
GSN = 022360	Actiq 400mcg Lozenges	4
GSN = 041339	Actiq 600mcg Lozenges	4
GSN = 041340	Actiq 800mcg Lozenges	4
GSN = 041341	Actiq 1200mcg Lozenges	4
GSN = 041342	Actiq 1600mcg Lozenges	4
GSN = 064994	Afinitor 5mg	1
GSN = 066495	Afinitor 2.5mg	1
GSN = 068582	Afinitor 7.5mg	1
GSN = 064995	Afinitor 10mg	1
GSN = 070919	Afinitor 2mg tabs-suspension	2
GSN = 070920	Afinitor 3mg tabs-suspension	3
GSN = 070921	Afinitor 5mg tabs-suspension	2
GSN = 021523	Alprazolam Intensol 1mg/ml oral conc	6
GSN = 025181	Amaryl (glimepiride) 4mg tablet	2
GSN = 068035	Aquadeks Softgel	2
GSN = 066852	Aquadeks chewable tablet	2
HSN = 010249	Arimidex 1mg	1
HSN = 020803	Aromasin 25mg	1
GSN = 003757	Ativan 0.5mg tablet (Lorazepam)	5
GSN = 003758	Ativan 1mg tablet (Lorazepam)	5
GSN = 003759	Ativan 2mg tablet (Lorazepam)	5
GSN = 016363	Ativan 2mg/ml oral conc (Lorazepam Intensol)	5
GSN = 069928	Bosulif 100mg	1

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 069929	Bosulif 200mg	1
GSN = 067290	Caprelsa 100mg	2
GSN = 067291	Caprelsa 300mg	1
HSN = 010143	Casodex 50mg (Bicalutamide)	1
GSN = 016584	Cefprozil 250mg tab	4
GSN = 016583	Cefprozil 250mg/5ml Susp	20
GSN = 009162	Ceftriaxone 1 gm vial (Rocephin)	2
GSN = 009163	Ceftriaxone 10 gm vial (Rocephin)	2
GSN = 009164	Ceftriaxone 2 gm vial (Rocephin)	2
GSN = 009165	Ceftriaxone 250 mg vial (Rocephin)	2
GSN = 009166	Ceftriaxone 500 mg vial (Rocephin)	2
GSN = 020957	(ceftriaxone sodium/lidocaine) Rocephin 1 gm kit	2
GSN = 020958	(ceftriaxone sodium/lidocaine) Rocephin 500mg kit	2
GSN = 041285	Celebrex 100mg capsules	2
GSN = 041286	Celebrex 200mg capsules	2
GSN = 050832	Celebrex 400mg capsules	1
GSN = 062001	Celebrex 50mg capsules	2
GSN = 046205	Celexa Solution	30
GSN = 046206	Celexa 10mg tablet (Citalopram)	1
GSN = 046203	Celexa 20mg tablet (Citalopram)	1.5
GSN = 046204	Celexa 40mg tablet (Citalopram)	1
GSN = 009046	Cephalexin Suspension 250mg/5ml	80
HSN = 041346	Cerdelga 84mg capsules	2
HSN = 033766	Chantix	2
GSN = 003736	Chlordiazepoxide HCL 5mg capsule	4
GSN = 003734	Chlordiazepoxide HCL 10mg capsule	4
GSN = 003735	Chlordiazepoxide HCL 25mg capsule	4
GSN = 067680	Complera	1
GSN = 041199	Comtan	8

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 067760	ConZip ER 100mg	1
GSN = 067761	ConZip ER 200mg	1
GSN = 067762	ConZip ER 300mg	1
GSN = 006559	Coumadin 10mg (Warfarin)	4
GSN = 006561	Coumadin 2mg (Warfarin)	4
GSN = 014198	Coumadin 1mg (Warfarin)	4
GSN = 006562	Coumadin 5mg (Warfarin)	4
GSN = 006560	Coumadin 2.5mg (Warfarin)	4
GSN = 006563	Coumadin 7.5mg (Warfarin)	4
GSN = 018080	Coumadin 3mg (Warfarin)	4
GSN = 019486	Coumadin 4mg (Warfarin)	4
GSN = 030475	Coumadin 6mg (Warfarin)	4
HSN = 025673	Cubicin 500 mg vial (pkg size 1 vial)	2
HSN = 026521	Cymbalta capsules	2
GSN = 004053	Demerol 50mg	24
GSN = 004052	Demerol 100mg	12
GSN = 003766	Diazepam 10mg tablet	4
GSN = 003767	Diazepam 2 mg tablet	4
GSN = 003768	Diazepam 5 mg tablet	4
GSN = 003764	Diazepam solution	40
GSN = 003765	Diazepam Intensol solution 5mg/ml	8
GSN = 004722	Diclegis 10m-10mg tablets DR	4
GSN = 067413	Edurant tablet	1
HSN = 036159	Effient	1
GSN = 067642	Eliquis 2.5mg tablet	2
GSN = 070414	Eliquis 5mg tablet	4
GSN = 073302	Embeda 20 – 0.8mg ER capsules	2
GSN = 073303	Embeda 30 – 1.2mgER capsules	2
GSN = 073304	Embeda 50 – 2mgER capsules	2
GSN = 073305	Embeda 60 – 2.4mg ER capsules	2

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 073306	Embeda 80 – 3.2mg ER capsules	2
GSN = 073307	Embeda 100 – 4mg ER capsules	2
HSN = 038455	Erivedge 150mg	1
NDC-9 = 005178571	Ethanol (Ethyl Alcohol, Dehydrated) 98% ampul	1
GSN = 011677	Famotidine (Pepcid)	2
GSN = 011678	Famotidine (Pepcid)	2
HSN = 011632	Fareston 60mg	1
HSN = 012351	Femara 2.5mg	1
GSN = 061492	Fentora 100mcg Tablets Eff	4
GSN = 061493	Fentora 200mcg Tablets Eff	4
GSN = 063177	Fentora 300mcg Tablets Eff	4
GSN = 061495	Fentora 400mcg Tablets Eff	4
GSN = 061496	Fentora 600mcg Tablets Eff	4
GSN = 061497	Fentora 800mcg Tablets Eff	4
HSN = 003933	Flutamide 125mg	6
GSN = 071229	Gilotrif 20mg	1
GSN = 071230	Gilotrif 30mg	1
GSN = 071231	Gilotrif 40mg	1
NDC = 5226807001	GoLYTELY packets	1
GSN = 030763	Granisol (Granisetron) 1mg/5ml oral soln	2.963
GSN = 027905	Helidac	16
HSN = 041725	Ibrance 75, 100, & 125mg capsules	1
GSN = 070360	Iclusig 15mg tablet	2
GSN = 070361	Iclusig 45mg tablet	1
GSN = 071674	Imbruvica 140mg capsule	4
HICL = 037629	Incivek	6
GSN = 041445	Interferon Alfacon-1 9mcg/0.3ml vial	0.3
GSN = 041650	Interferon Alfacon-1 15mcg/0.5ml vial	0.5
GSN = 068497	Inlyta 1mg	4

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 068498	Inlyta 5mg	4
GSN = 068167	Jakafi 5mg tablet	2
GSN = 068168	Jakafi 10mg tablet	2
GSN = 068169	Jakafi 15mg tablet	2
GSN = 068170	Jakafi 20mg tablet	2
GSN = 068171	Jakafi 25mg tablet	2
GSN = 016404	Ketorolac Tromethamine	4
GSN = 004560	Klonopin (Clonazepam) 0.5mg	3
GSN = 004561	Klonopin (Clonazepam) 1mg	3
GSN = 004562	Klonopin (Clonazepam) 2mg	3
GSN = 051983	Klonopin (Clonazepam) 0.125mg	3
GSN = 051984	Klonopin (Clonazepam) 0.25mg	3
GSN = 051985	Klonopin (Clonazepam) 0.5mg	3
GSN = 051986	Klonopin (Clonazepam) 1mg	3
GSN = 018638	Lamisil	1
GSN = 030107	Lansoprazole DR 30mg capsule (Prevacid DR)	2
GSN = 053076	Levonorgestrel-Eth Estra 0.15-0.03 mg tablet (Jolessa, Introvale, Quasense)	1
GSN = 051698	Lexapro Solution	20
GSN = 050712	Lexapro 10mg tablet	1
GSN = 050760	Lexapro 20mg tablet	1
GSN = 051642	Lexapro 5mg tablet	1
GSN = 029967	Lipitor 10mg tablet	1
GSN = 029968	Lipitor 20mg tablet	1
GSN = 029969	Lipitor 40mg tablet	1
GSN = 045772	Lipitor 80mg tablet	1
GSN = 066349	Livalo 1mg tablet	1
GSN = 066350	Livalo 2mg tablet	1
GSN = 066351	Livalo 4 mg tablet	1
GSN = 018698	Loratadine 10mg tablet	1

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
HICL = 026793	Omega-3 Acid Ethyl Esters 1 G Capsule (Lovaza)	4
GSN = 065633	Lazanda 100mcg pump/spray	1
GSN = 066764	Lazanda 400mcg pump/spray	1
GSN = 019331	Lovenox 30mg / 0.3ml syringe	0.6
GSN = 039482	Lovenox 40mg / 0.4ml syringe	0.8
GSN = 027993	Lovenox 60mg / 0.6ml syringe	1.2
GSN = 027994	Lovenox 80mg / 0.8ml syringe	1.6
GSN = 044669	Lovenox 120mg / 0.8ml syringe	1.6
GSN = 044668	Lovenox	2
GSN = 027995	Lovenox	2
GSN = 038895	Lovenox 300mg / 3ml syringe	3
GSN = 008831	Lysodren 500mg (mitotane)	38
GSN = 040974	Metformin 1,000mg tablet	2.5
GSN = 016441	Metformin 850mg tablet	3
GSN = 013318	Metformin 500mg tablet	5
GSN = 046754	Metformin XR 500mg tablet	5
GSN = 052080	Metformin ER 750mg	3.5
GSN = 008777	Myleran 2mg	6
HSN = 033400	Nexavar 200mg	4
HSN = 007876	Nilandron 150mg	1
GSN = 000465	Nitroglycerin 0.4mg/HR patch	1
GSN = 000466	Nitroglycerin 0.6mg/HR patch	1
GSN = 000475	Nitroglycerin SL tablets	16
GSN = 011679	Nizatidine 150mg capsule	2
GSN = 065552	Onsolis 200mcg Film (manf obsolete)	4
GSN = 065553	Onsolis 400mcg Film (manf obsolete)	4
GSN = 065554	Onsolis 600mcg Film (manf obsolete)	4
GSN = 065555	Onsolis 800mcg Film (manf obsolete)	4
GSN = 065556	Onsolis 1200mcg Film (manf obsolete)	4

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 003180	Oxandrolone 2.5mg tablet	8
HICL = 001616	Oxazepam 15mg Tab	4
GSN = 071036	Mekinist 0.5mg	3
GSN = 071037	Mekinist 2mg	1
GSN = 004225	Oxycodone HCL 5mg tablet	12
GSN = 024507	Oxycodone HCL 5mg capsule	12
GSN = 004224	Oxycodone HCL 5mg/5ml soln	60
GSN = 068467	Oxecta 7.5mg tablet (Oxycodone HCL)	8
GSN = 013467	Oxycodone HCL 10mg tablet	6
GSN = 046474	Oxycodone HCL 15mg tablet	6
GSN = 046475	Oxycodone HCL 30mg tablet	6
GSN = 045298	Oxycodone HCL 20mg tablet	9
GSN = 015065	Oxycodone HCL 20mg/ml oral conc	9
GSN = 024504 / 072862	OxyContin 10mg tablet	2
GSN = 063515 / 072863	OxyContin 15mg tablet	2
GSN = 024505 / 072864	OxyContin 20mg tablet	2
GSN = 063516 / 072865	OxyContin 30mg tablet	2
GSN = 024506 / 072866	OxyContin 40mg tablet	2
GSN = 063517 / 072867	OxyContin 60mg tablet	2
GSN = 025702 / 072868	OxyContin 80mg tablet	4
HSN = 026757	Combunox (Oxycodone-Ibuprofen)	4
GSN = 027462	Pantoprazole Sod DR 40mg tab (Protonix DR)	2
GSN = 046222	Paxil 10mg tablet (Paroxetine HCL)	2
GSN = 046223	Paxil 20mg tablet (Paroxetine HCL)	2
GSN = 046224	Paxil 30mg tablet (Paroxetine HCL)	2
GSN = 046225	Paxil 40mg tablet (Paroxetine HCL)	2
GSN = 025301	Paxil 40mg tablet (Paroxetine HCL)	2
GSN = 050137	Paxil CR 12.5mg tablet (paroxetine)	1
GSN = 050136	Paxil CR 25mg tablet (paroxetine)	2
GSN = 050138	Paxil CR 37.5mg (paroxetine)	2

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 013998	Percocet 2.5/325 (Oxycodone HCL/Acetaminophen)	12
GSN = 004222	Percocet 5/325 (Oxycodone HCL/Acetaminophen)	12
GSN = 048976	Percocet 7.5/325 (Oxycodone HCL/Acetaminophen)	12
GSN = 048977	Percocet 10/325 (Oxycodone HCL/Acetaminophen)	12
GSN = 070569	Pomalyst 1mg	1
GSN = 070570	Pomalyst 2mg	1
GSN = 070571	Pomalyst 3mg	1
GSN = 070572	Pomalyst 4mg	1
GSN = 040906	Premphase 0.625-5mg tablet	1
GSN = 022647	Prempro 0.625-5mg tablet	1
GSN = 022648	Prempro 0.625-2.5mg tablet	1
GSN = 051653	Prevacid 15mg SoluTab	3
GSN = 037219	Prevpac 30-500-500mg combo pkg	8
GSN = 043136	Prilosec DR 10mg capsule (Omeprazole Dr)	2
GSN = 033530	Prilosec DR 20mg capsule (Omeprazole DR)	2
GSN = 043137	Prilosec DR 40mg capsule (Omeprazole Dr)	2
GSN = 054334	Prilosec DR 20mg capsule (Omeprazole DR)	2
GSN = 013009	Prilosec 20mg capsule (Omeprazole)	2
GSN = 021222	Prilosec 40mg capsule (Omeprazole)	2
GSN = 022270	Prilosec 10mg capsule (Omeprazole)	2
GSN = 009364	Primaxin 250mg vial (imipenem-cilastatin)	16
GSN = 059876	Primaxin 250mg vial	16
GSN = 059877	Primaxin 500mg vial	8
GSN = 009365	Primaxin 500mg vial (imipenem-cilastatin)	8
GSN = 015907	Primaxin I.M. 500mg vial	3
HICL = 035420	Pristiq	1
GSN = 046525	Pulmicort 0.25mg/2ml ampul-neb (budesonide)	4 (2 ampules per day)
GSN = 046526	Pulmicort 0.5mg/2ml ampul-neb (budesonide)	4 (2 ampules per day)
GSN = 018165	Pulmicort 1mg/2ml ampul-neb (budesonide)	4 (2 ampules per day)

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 021416	Pulmozyme	5 (2 ampules per day)
GSN = 040941	Rabeprazole Sod DR 20mg tab (Aciphex DR)	2
GSN = 011674	Ranitidine 300mg tablet (Zantac)	2
GSN = 016224	Ranitidine 300mg capsules	2
GSN = 023987	Ranitidine Bismuth Citrate 4000mg tablet (Tritec)	2
GSN = 060230	Revlimid 5mg	1
GSN = 060231	Revlimid 10mg	1
GSN = 061113	Revlimid 15mg	1
GSN = 061114	Revlimid 25mg	1
GSN = 068980	Revlimid 2.5mg	1
GSN = 004886	Robinul vial (glycopyrrolate)	30
GSN = 004221	Roxicet 5-325/5ml oral soln	60
GSN = 067598	Ruconest	2
GSN = 053152	Rybix ODT 50mg	8
GSN = 065537	Saphris	2
GSN = 065538	Saphris	2
HSN = 041672	Savaysa 15, 30 & 60mg tablets	1
GSN = 016576	Simvastatin 5mg tablet (Zocor)	2
GSN = 066980	Source CF 0.2mg-15mg softgel	2
GSN = 067025	Source CF 1000-800 chew tab	2
GSN = 016949	Sporanox 100mg capsule (itraconazole)	6
GSN = 061100	Sprycel 50mg	1
GSN = 061101	Sprycel 70mg	1
GSN = 064161	Sprycel 100mg	1
GSN = 066969	Sprycel 140mg	1
GSN = 061099	Sprycel 20mg	2
GSN = 066968	Sprycel 80mg	2
HSN = 039665	Stivarga 40mg	4
GSN = 069883	Stribild	1
GSN = 060326	Sutent 12.5mg	1

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 060327	Sutent 25mg	1
GSN = 060328	Sutent 50mg	1
GSN = 053400	Symbyax 6mg-25mg capsule	1
GSN = 053401	Symbyax 6mg-50mg capsule	1
GSN = 053402	Symbyax 12mg-25mg capsule	1
GSN = 053403	Symbyax 12mg-50mg capsule	1
GSN = 071033	Tafinlar 50mg	4
GSN = 071034	Tafinlar 75mg	4
HICL = 042803	Tagrisso 40 & 80mg tablets	1
GSN = 008832	Tamoxifen 10mg	3
GSN = 013574	Tamoxifen 20mg	2
GSN = 027546	Tamulosin (Flomax) 0.4mg capsules	2
GSN = 058376	Tarceva 25mg	1
GSN = 058375	Tarceva 100mg	1
GSN = 058374	Tarceva 150mg	1
GSN = 066453	Tasigna 150mg	4
GSN = 063319	Tasigna 200mg	4
GSN = 040296	Thalomid 50mg	1
GSN = 040279	Thalomid 100mg	1
GSN = 062444	Thalomid 150mg	1
GSN = 051879	Thalomid 200mg	2
GSN = 063422	Tramadol ER 100mg (Ryzolt ER)	1
GSN = 063423	Tramadol ER 200mg (Ryzolt ER)	1
GSN = 063424	Tramadol ER 300mg (Ryzolt ER)	1
GSN = 068721	Tramadol HCL ER 150mg capsule	1
GSN = 005098	Trandate 100mg tablet (labetalol HCl)	8
GSN = 005099	Trandate 200mg tablet (labetalol HCl)	8
GSN = 005100	Trandate 300mg tablet (labetalol HCl)	8
GSN = 003745	Tranxene 3.75mg tablet (clorazepate)	4

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 003746	Tranxene 7.5mg tablet (clorazepate)	4
GSN = 003744	Tranxene 15mg tablet (clorazepate)	4
HSN = 041076	Tybost 150mg tablets	1
HSN = 034541	Tykerb 250mg	6
GSN = 004163	Tylenol #2 (Acetaminophen- Codeine 300mg-15mg)	12
GSN = 004165	Tylenol #3 (Acetaminophen- Codeine 300mg-30mg)	12
GSN = 004169	Tylenol #4 (Acetaminophen- Codeine 300mg-60mg)	12
HSN = 022880	Ultracet 37.5-325mg	8
GSN = 023139	Ultram (tramadol)	8
GSN = 060274	Ultram ER 100mg tablet (tramadol ER)	1
GSN = 043536	Ultram ER 200mg tablet (tramadol ER)	1
GSN = 043537	Ultram ER 300mg tablet (tramadol ER)	1
GSN = 060338	Vicodin 5/300mg (Hydrocodone/Acetaminophen)	8
GSN = 060533	Vicodin 7.5/300mg (Hydrocodone/Acetaminophen)	6
GSN = 057726	Vicodin HP 10/300mg (Hydrocodone/Acetaminophe	6
HSN = 037609	Victrelis 200mg capsule	12
HSN = 036709	Votrient 200mg tablet	4
GSN = 067823	Xalkori 250mg capsule	2
GSN = 067824	Xalkori 200mg capsule	2
GSN = 003773	Xanax 0.25 mg tablet (Alprazolam)	5
GSN = 003774	Xanax 0.5 mg tablet (Alprazolam)	5
GSN = 003775	Xanax 1 mg tablet (Alprazolam)	5
GSN = 015566	Xanax 2 mg tablet (Alprazolam)	5
GSN = 058847	Niravam ODT 0.25 mg tablet (Alprazolam)	5
GSN = 058848	Niravam ODT 0.5 mg tablet (Alprazolam)	5
GSN = 058849	Niravam ODT 1 mg tablet (Alprazolam)	5
GSN = 058850	Niravam ODT 2 mg tablet (Alprazolam)	5
HSN = 039580	Xtandi 40mg	4
HSN = 025098	Zavesca 100mg capsules	3
HSN = 037837	Zelboraf 240mg	8

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
HICL = 024459	Zetia 10mg Tab	1
HSN = 034070	Zolinza 100mg	4
GSN = 046230	Zoloft 20mg/ml soln (sertraline)	10
GSN = 031439	Zyban 150mg tablets ER	2
GSN = 072296	Zykadia 150 mg capsules	5
HSN = 037571	Zytiga 250mg	4
GSN = 062974	Selzentry 150mg tablet	2
GSN = 038451	Singulair	1
GSN = 051820	Restasis 0.05% eye emulsion	2
HICL = 010132	Cefepime vials (Maxipime)	6
HICL = 035848	Cefepime Piggyback	300
HICL = 037021	Cefepime Piggyback	300
GSN = 021279	Colytrol (Belladonna Alkaloids)	1000
GSN = 040364	Derma Smoothe/FS	2
GSN = 003656	Chloral Hydrate	15
GSN = 052050	Vigamox 0.5% eye drops	2
GSN = 015869	Ondansetron 2mg/ml vial	1.186
GSN = 023187	Ondansetron 32mg/50ml piggyback	14.815
GSN = 015908	Primaxin I.M. 750mg vial	2
GSN = 043706	Tamiflu Capsules (oseltamivir)	2
GSN = 063224	Tamiflu Capsules (oseltamivir)	2
GSN = 063223	Tamiflu Capsules (oseltamivir)	4
GSN = 067561	Tamiflu 6mg/ml suspension (oseltamivir)	36ml
GSN = 047429	Tamiflu 12mg/ml oral susp (oseltamivir)	12.5
GSN = 007061	KAO/SAL ACID/ME-SALICYLATE/PEP	2
GSN = 046213	Fluoxetine HCL 10mg capsule (Prozac)	2
GSN = 046216	Fluoxetine HCL 10mg tablet (Sarafem)	2
GSN = 040515	EMLA patch	2
GSN = 021974	Epi-Clenz foam	2

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 015880	Duragesic Patches	0.34
GSN = 015881	Duragesic Patches	0.34
GSN = 015882	Duragesic Patches	0.34
GSN = 015883	Duragesic Patches	0.34
GSN = 059102	Duragesic Patches	0.34

Maximum Daily Dose By Age (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 058594	Abilify 1mg/ml sol	Ages 6–11 = max of 15ml per day Age 12–17 = max of 30ml per day Age 18+ = max of 5ml per day
GSNs = 060225	Abilify 2mg	Ages 6–17 = max of 5 tabs per day Age 18+ = max of 1 tab per day
GSN = 052898	Abilify 5mg	Ages 6–17 = max of 3 tabs per day Age 18+ = max of 1 tab per day
GSNs = 051333 and 060319	Abilify 10mg Abilify Discmelt 10mg	Ages 6–11 = max of 1.5 tabs per day Age 12–17 = max of 3 tabs per day Age 18+ = max of 1 tab per day
GSNs = 051334 and 060322	Abilify 15mg Abilify Discmelt 15mg	Age 6–11 = max of 1 tab per day Age 12–17 = max of 2 tabs per day Age 18+ = max of 1 tab per day
GSN = 051335	Abilify 20mg	Ages 6–11 = max of 0.75 tabs per day Age 12–17 = max of 1.5 tabs per day Age 18+ = max of 1 tab per day
GSN = 051336	Abilify 30mg	Ages 6–11 = max of 0.5 tabs per day Age 12–17 = max of 1 tabs per day Age 18+ = max of 1 tab per day
GSN = 050222	Avinza 30mg capsules	Age 18+ = max of 1 tab per day
GSN = 064739	Avinza 45mg capsules	Age 18+ = max of 1 tab per day
GSN = 050221	Avinza 60mg capsules	Age 18+ = max of 1 tab per day
GSN = 064740	Avinza 75mg capsules	Age 18+ = max of 1 tab per day

Maximum Daily Dose By Age (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 050220	Avinza 90mg capsules	Age 18+ = max of 1 tab per day
GSN = 050219	Avinza 120mg capsules	Age 18+ = max of 1 tab per day
GSN = 003796	Chlorpromazine 10mg	Ages 6-17 = max of 10 tabs per day Age 18+ = max of 4 tabs per day
GSN = 003797	Chlorpromazine 100mg	Ages 6–11 = max of 3 tabs per day Age 12–17 = max of 6 tabs per day Age 18+ = max of 4 tabs per day
GSN = 003798	Chlorpromazine 200mg	Ages 6–11 = max of 1.5 tabs per day Age 12–17 = max of 3 tabs per day
GSN = 003799	Chlorpromazine 25mg	Age 6-17 = max of 10 tabs per day Age 18+ = max of 4 tabs per day
GSN = 003800	Chlorpromazine 50mg	Ages 6–11 = max of 6 tabs per day Age 12–17 = max of 12 tabs per day Age 18+ = max of 4 tabs per day
GSN = 053995	Fazaclo 100mg (including ODT)	Ages 6–11 = max of 3 tabs per day Age 12–17 = max of 6 tabs per day Age 18+ = max of 2 tabs per day
GSN = 013649	Clozapine 100mg	Ages 6–11 = max of 3 tabs per day Age 12–17 = max of 6 tabs per day
GSN = 063031	Fazaclo 12.5mg (including ODT)	Ages 6–17 = max of 12 tabs per day Age 18+ = max of 2 tabs per day
GSN = 053016	Clozapine 12.5mg	Ages 6–17 = max of 12 tabs per day
GSN = 066558	Fazaclo 200mg disp tablets	Ages 6–11 = max of 1.5 tabs per day Age 12–17 = max of 3 tabs per day Age 18+ = max of 4 tabs per day
GSN = 046416	Clozapine 200mg	Ages 6–11 = max of 1.5 tabs per day Age 12–17 = max of 3 tabs per day
GSN = 013648	Clozaril 25mg tablets	Ages 6–17 = max of 8 tabs per day Age 18+ = max of 2 tabs per day
GSN = 053994	Fazaclo 25mg (including ODT)	Ages 6–17 = max of 8 tabs per day Age 18+ = max of 4 tabs per day

Maximum Daily Dose By Age (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 027037	Clozapine 50mg	Ages 6–11 = max of 6 tabs per day Ages 12–17 = max of 12 tabs per day
GSN = 069860	Exalgo 32mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 069889	Exalgo 16mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 069890	Exalgo 8mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 066200	Exalgo 12mg ER tablets	Age 18+ = max of 1 tab per day
HSN = 036778	Fanapt tablets	Ages 6-17 = max of 2 tabs per day Age 18+ = max of 2 tabs per day
HSN = 036778 (excluding GSNs 065905, 065906, 065907)	Fanapt 1mg, 2mg, 4mg, 6mg & titration pack	Ages 6-11 = max of 2 tabs per day
GSN = 065905	Fanapt 8mg tablets	Ages 6–11 = max of 1 tabs per day
GSN = 065906	Fanapt 10mg tablets	Ages 6–11 = max of 1 tabs per day
GSN = 065907	Fanapt 12mg tablets	Ages 6–11 = max of 1 tabs per day
GSN = 066557	Fazaclo 150mg ODT	Ages 6–11 = max of 2 tabs per day Ages 12–17 = max of 4 tabs per day Age 18+ = max of 6 tabs per day
HSN = 020420	Flector Patch 1.3%	Age 18+ = max of 2 tabs per day
GSN = 003821	Fluphenazine 2.5mg/5ml elixir	Ages 6–11 = max of 10mls per day Age 12–17 = max of 20 mls per day
GSN = 003822	Fluphenazine 5mg/ml oral concentrate	Ages 6–11 = max of 1ml per day Age 12–17 = max of 2 mls per day Age 18+ = max of 4 tabs per day
GSN = 003823	Fluphenazine 1mg	Ages 6–11 = max of 5 tabs per day Age 12–17 = max of 10 tabs per day Age 18+ = max of 4 tabs per day
GSN = 003824	Fluphenazine 10mg	Ages 6–11 = max of 0.5 tab per day Age 12–17 = max of 1 tabs per day Age 18+ = max of 2 tabs per day
GSN = 003825	Fluphenazine 2.5mg	Ages 6–11 = max of 2 tabs per day Age 12–17 = max of 4 tabs per day Age 18+ = max of 4 tabs per day

Maximum Daily Dose By Age (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 003826	Fluphenazine 5mg	Ages 6-11 = max of 1 tab per day Age 12-17 = max of 2 tabs per day Age 18+ = max of 4 tabs per day
GSN = 047563	Geodon 20mg	Ages 6–17 = max of 4 caps per day Age 18+ = max of 2 caps per day
GSN = 047564	Geodon 40mg	Ages 12–17 = max of 4 caps per day Age 6–11 = max of 2 per day Age 18+ = max of 2 caps per day
GSN = 047567	Geodon 60mg	Ages 6–11 = max of 1.33 caps per day Age 12–17 = max of 2.7 caps per day Age 18+ = max of 4 tabs per day
GSN = 047568	Geodon 80mg	Ages 6–11 = max of 1 cap per day Age 12–17 = max of 2 caps per day Age 18+ = max of 2 caps per day
GSN = 003971	Haloperidol 2mg/ml conc	Ages 6–11 = max of 2.5 mls per day Age 12–17 = max of 5 mls per day
GSN = 003972	Haloperidol 0.5mg	Ages 6–11 = max of 10 tabs per day Age 12–17 = max of 20 tabs per day Age 18+ = max of 3 tabs per day
GSN = 003973	Haloperidol 1mg	Ages 6–11 = max of 5 tabs per day Age 12–17 = max of 10 tabs per day Age 18+ = max of 3 tabs per day
GSN = 003974	Haloperidol 10mg	Ages 6–11 = max of 0.5 tab per day Age 12–17 = max of 1 tabs per day Age 18+ = max of 3 tabs per day
GSN = 003975	Haloperidol 2mg	Ages 6–11 = max of 2.5 tabs per day Age 12–17 = max of 5 tabs per day Age 18+ = max of 3 tabs per day
GSN = 003976	Haloperidol 20mg	Ages 6–11 = max of 0.25 tab per day Age 12–17 = max of 0.5 tab per day
GSN = 003977	Haloperidol 5mg	Ages 6–11 = max of 1 tab per day Age 12–17 = max of 2 tabs per day Age 18+ = max of 3 tabs per day

Maximum Daily Dose By Age (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 073176	Hysingla 20mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 073177	Hysingla 30mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 073179	Hysingla 40mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 073180	Hysingla 60mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 073181	Hysingla 80mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 073182	Hysingla 100mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 073183	Hysingla 120mg ER tablets	Age 18+ = max of 1 tab per day
HSN = 034343 (excluding GSN 061987)	Invega 1.5, 3 & 6mg tablets	Ages 6-11 = max of 1 tablet per day
HSN = 034343 (excluding GSN 061986)	Invega 1.5, 3, & 9mg ER tablets	Ages 12-17 = max of 1 tablet per day
GSN = 065667	Invega 1.5mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 061985	Invega 3mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 061986	Invega 6mg ER tablets	Ages 12-17 -= max of 2 tablets per day Age 18+ = max of 2 tabs per day
GSN = 061987	Invega 9mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 060355	Kadian ER 10mg capsules	Age 18+ = max of 2 tabs per day
GSN = 060356	Kadian ER 20mg capsules	Age 18+ = max of 2 tabs per day
GSN = 060357	Kadian ER 50mg capsules	Age 18+ = max of 2 tabs per day
GSN = 060358	Kadian ER 100mg capsules	Age 18+ = max of 2 tabs per day
GSN = 061722	Kadian ER 80mg capsules	Age 18+ = max of 2 tabs per day
GSN = 061748	Kadian ER 30mg capsules	Age 18+ = max of 2 tabs per day
GSN = 061749	Kadian ER 60mg capsules	Age 18+ = max of 2 tabs per day
GSN = 069899	Kadian ER 40mg capsules	Age 18+ = max of 2 tabs per day
GSN = 069900	Kadian ER 70mg capsules	Age 18+ = max of 2 tabs per day
GSN = 069901	Kadian ER 130mg capsules	Age 18+ = max of 2 tabs per day
GSN = 069903	Kadian ER 150mg capsules	Age 18+ = max of 2 tabs per day
GSN = 062358	Kadian ER 200mg capsules	Age 18+ = max of 2 tabs per day
GSN = 068448	Latuda 20mg tablets	Age 18+ = max of 1 tab per day
GSN = 066932	Latuda 40mg tablets	Age 18+ = max of 1 tab per day

Maximum Daily Dose By Age (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 071415	Latuda 60mg tablets	Age 18+ = max of 1 tab per day
GSN = 066933	Latuda 80mg tablets	Age 18+ = max of 2 tabs per day
GSN = 069894	Latuda 120mg tablets	Age 18+ = max of 1 tab per day
HSN = 037321 (excluding GSN 069894-Latuda 120mg)	Latuda 20, 40, 60, & 80mg tablet	Ages 6-11 = max of 1 tablet per day
HSN = 037321	Latuda 20, 40, 60, 80 & 120mg tablet	Ages 12-17 = max of 1 tablet per day
GSN = 003983	Loxapine 5mg capsules	Age 18+ = max of 4 tabs per day
GSN = 003982	Loxapine 25mg capsules	Age 18+ = max of 4 tabs per day
GSN = 003981	Loxapine 10mg capsules	Age 18+ = max of 4 tabs per day
GSN = 003984	Loxapine 50mg capsules	Age 18+ = max of 3 tabs per day
GSN = 057799	Lyrica 25mg capsules	Age 18+ = max of 3 tabs per day
GSN = 057800	Lyrica 50mg capsules	Age 18+ = max of 3 tabs per day
GSN = 057801	Lyrica 75mg capsules	Age 18+ = max of 3 tabs per day
GSN = 057802	Lyrica 100mg capsules	Age 18+ = max of 3 tabs per day
GSN = 057803	Lyrica 150mg capsules	Age 18+ = max of 3 tabs per day
GSN = 057804	Lyrica 200mg capsules	Age 18+ = max of 3 tabs per day
GSN = 059401	Lyrica 225mg capsules	Age 18+ = max of 2 tabs per day
GSN = 057805	Lyrica 300mg capsules	Age 18+ = max of 2 tabs per day
HSN = 001637	Orap 1mg & 2mg tablets	Ages 6-17 = max of 1 tablet per day
GSN = 061091, 070397	Oxymorphone Er (Opana) 5mg	Age 18+ = max of 3 tabs per day
GSN = 061092, 070398	Oxymorphone Er (Opana) 10mg	Age 18+ = max of 3 tabs per day
GSN = 061093, 070399	Oxymorphone Er (Opana) 20mg	Age 18+ = max of 3 tabs per day
GSN = 061094, 070401	Oxymorphone Er (Opana) 40mg	Age 18+ = max of 3 tabs per day
GSN = 063782, 070320	Oxymorphone Er (Opana) 7.5mg	Age 18+ = max of 3 tabs per day
GSN = 063783, 070321	Oxymorphone Er (Opana) 15mg	Age 18+ = max of 3 tabs per day
GSN = 063784, 070400	Oxymorphone Er (Opana) 30mg	Age 18+ = max of 3 tabs per day
GSN = 003830	Perphenazine 16mg	Ages 6–11 = max of 0.75 tab per day Age 12–17 = max of 2.5 tabs per day
GSN = 003831	Perphenazine 2mg	Ages 6–11 = max of 6 tabs per day Age 12–17 = max of 20 tabs per day

Maximum Daily Dose By Age (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 003832	Perphenazine 4mg	Ages 6–11 = max of 3 tabs per day Age 12–17 = max of 10 tabs per day
GSN = 003833	Perphenazine 8mg	Ages 6–11 = max of 1.5 tabs per day Age 12–17 = max of 5 tabs per day
HSN = 001627	Perphenazine	Age 18+ = max of 4 tabs per day
GSN = 046185	Perphenazine/Amitriptyline 4-10mg	Age 18+ = max of 4 tabs per day
GSn = 046186	Perphenazine/Amitriptyline 2-25mg	Age 18+ = max of 4 tabs per day
GSN = 046187	Perphenazine/Amitriptyline 4-25mg	Age 18+ = max of 4 tabs per day
GSN = 046188	Perphenazine/Amitriptyline 4-50mg	Age 18+ = max of 4 tabs per day
GSNs = 042922, 042923, 052049, and 065235	Risperidone 0.25mg Risperidone 0.5mg Risperidone M/ODT 0.5mg Risperidone 0.25mg ODT	Ages 6–17 = max of 8 tabs per day
GSNs = 021154 and 051799	Risperidone 1mg Risperidone M/ODT 1mg	Ages 6–11 = max of 4 tabs per day Age 12–17 = max of 6 tabs per day
GSN = 026177	Risperidone 1mg/ml sol.	Ages 6–11 = max of 4mls per day Age 12–17 = max of 6mls per day
GSNs = 021155 and 051800	Risperidone 2mg Risperidone M/ODT 2mg	Ages 6–11 = max of 2 tabs per day Age 12–17 = max of 3 tabs per day
GSNs = 021156 and 059402	Risperidone 3mg Risperidone M/ODT 3mg	Ages 6–11 = max of 1.33 tabs per day Age 12–17 = max of 2 tabs per day Age 18+ = max of 4 tabs per day
GSNs = 021157 and 059403	Risperidone 4mg Risperidone M/ODT 4mg	Ages 6–11 = max of 1 tab per day Age 12–17 = max of 1.5 tabs per day Age 18+ = max of 4 tabs per day
GSN = 034188	Quetiapine (Seroquel) 100mg	Ages 6–11 = max of 4 tabs per day Age 12–17 = max of 5 tabs per day
GSNs = 034189 and 062748	Quetiapine (Seroquel) 200mg Quetiapine (Seroquel) XR 200mg	Ages 6–11 = max of 2 tabs per day Age 12–17 = max of 4 tabs per day
GSN = 064725	Quetiapine (Seroquel) XR 150mg	Ages 6–11 = max of 2.67 tabs per day Age 12–17 = max of 5.34 tabs per day
GSN = 034187	Quetiapine (Seroquel) 25mg	Ages 6–17 = max of 8 tabs per day Age 18+ = max of 12 tabs per day

Maximum Daily Dose By Age (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSNs = 047198 and 062749	Quetiapine (Seroquel) 300mg Quetiapine (Seroquel) XR 300mg	Ages 6–11 = max of 1.33 tabs per day Age 12–17 = max of 2.7 tabs per day
GSNs = 060293 and 062750	Quetiapine (Seroquel) 400mg Quetiapine (Seroquel) XR 400mg	Ages 6–11 = max of 1 tab per day Age 12–17 = max of 2 tabs per day
GSNs = 060292 and 063240	Quetiapine (Seroquel) 50mg Quetiapine (Seroquel) XR 50mg	Ages 6–17 = max of 6 tabs per day
GSN = 021155	Risperdal 2mg tablets	Age 18+ = max of 2 tabs per day
GSN = 051800	Risperdal 2mg M-T tablets	Age 18+ = max of 2 tabs per day
GSN = 021154	Risperdal 1mg tablets	Age 18+ = max of 2 tabs per day
GSN = 042922	Risperdal 0.25mg tablets	Age 18+ = max of 2 tabs per day
GSN = 042923	Risperdal 0.5mg tablets	Age 18+ = max of 2 tabs per day
GSN = 051799	Risperdal 1mg M-T tablets	Age 18+ = max of 2 tabs per day
GSN = 052049	Risperdal 0.5mg M-T tablets	Age 18+ = max of 2 tabs per day
GSN = 065538	Saphris 10mg SL tablet	Ages 6–11 = max of 1 tabs per day Ages 12–17 = max of 2 tabs per day Age 18+ = max of 2 tabs per day
GSN = 065537	Saphris 5mg SL tablet	Ages 6-17 = max of 2 tabs per day Age 18+ = max of 2 tabs per day
GSN = 063240	Seroquel XR 50mg tablets	Age 18+ = max of 2 tabs per day
GSN = 062750	Seroquel XR 400mg tablets	Age 18+ = max of 2 tabs per day
GSN = 060293	Seroquel 400mg tablets	Age 18+ = max of 2 tabs per day
GSN = 060292	Seroquel 50mg tablets	Age 18+ = max of 2 tabs per day
GSN = 034188	Seroquel 100mg tablets	Age 18+ = max of 2 tabs per day
GSN = 034187	Seroquel 25mg tablets	Age 18+ = max of 2 tabs per day
GSN = 062749	Seroquel XR 300mg tablets	Age 18+ = max of 3 tabs per day
GSN = 047198	Seroquel 300mg tablets	Age 18+ = max of 3 tabs per day
HSN = 025800	Symbyax capsules	Age 18+ = max of 1 tab per day
HSN = 001592	Temazepam capsules	Age 18+ = max of 1 tab per day
GSN = 003859	Thioridazine 10mg tablets	Age 18+ = max of 4 tabs per day
GSN = 003864	Thioridazine 25mg tablets	Age 18+ = max of 4 tabs per day

Maximum Daily Dose By Age (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 003865	Thioridazine 50mg tablets	Age 18+ = max of 4 tabs per day
GSN = 003995	Thiothixene 1mg capsules	Age 18+ = max of 3 tabs per day
GSN = 003997	Thiothixene 2mg capsules	Age 18+ = max of 3 tabs per day
GSN = 003999	Thiothixene 5mg capsules	Age 18+ = max of 3 tabs per day
GSN = 003996	Thiothixene 10mg capsules	Age 18+ = max of 6 tabs per day
GSN = 003851	Trifluoperazine 1mg tablets	Age 18+ = max of 3 tabs per day
GSN = 003853	Trifluoperazine 2mg tablets	Age 18+ = max of 3 tabs per day
GSN = 003854	Trifluoperazine 5mg tablets	Age 18+ = max of 3 tabs per day
GSN = 003852	Trifluoperazine 10mg tablets	Age 18+ = max of 4 tabs per day
GSN = 072134	Xartemis XR 7.5-325mg tablet	Age 18+ = max of 4 tabs per day
GSN = 019187	Zolpidem 5mg tablets	Age 18+ = max of 1 tab per day
GSN = 019188	Zolpidem 10mg tablets	Age 18+ = max of 1 tab per day
GSNs = 027960 and 045191	Zyprexa 10mg Zyprexa Zydis 10mg	Ages 6–11 = max of 1 tab per day Age 12–17 = max of 2 tabs per day Age 18+ = max of 1 tab per day
GSNs = 041026 and 047285	Zyprexa 15mg Zyprexa Zydis 15mg	Ages 6–11 = max of 0.7 tabs per day Age 12–17 = max of 1.3 tabs per day Age 18+ = max of 2 caps per day
GSN = 029077	Zyprexa 2.5mg	Ages 6–11 = max of 4 tabs per day Age 12–17 = max of 8 tabs per day Age 18+ = max of 1 tab per day
GSNs = 041027 and 047286	Zyprexa 20mg Zyprexa Zydis 20mg	Ages 6–11 = max of 0.5 tab per day Age 12–17 = max of 1 tab per day Age 18+ = max of 1 tab per day
HSN = 036716	Zyprexa Zydis	Age 18+ = max of 1 tab per day
GSNs = 027961 and 045190	Zyprexa 5mg Zyprexa Zydis 5mg	Ages 6–11 = max of 2 tabs per day Age 12–17 = max of 4 tabs per day Age 18+ = max of 1 tab per day
GSN = 027959	Zyprexa 7.5mg	Ages 6–11 = max of 1.3 tabs per day Age 12–17 = max of 2.7 tabs per day Age 18+ = max of 1 tab per day
GSN = 050386	Zyprexa 10mg vial (package size each	Age 18+ = max of 3 tabs per day

* Verified against Automated PA Opiate Rule.

Maximum Daily Dose By Age		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 050428	Adderall XR 5mg capsules	Age 18+ = max of 1 cap per day
GSN = 048701	Adderall XR 10mg capsules	Age 18+ = max of 1 cap per day
GSN = 050429	Adderall XR 15mg capsules	Age 18+ = max of 1 cap per day
GSN = 045981	Concerta 18mg tablets	Age 18+ = max of 1 cap per day
GSN = 047318	Concerta 54mg tablets	Age 18+ = max of 1 cap per day
GSN = 050172	Concerta 27mg tablets	Age 18+ = max of 1 cap per day
GSN = 059190	Focalin XR 5mg capsules	Age 18+ = max of 1 cap per day
GSN = 059191	Focalin XR 10mg capsules	Age 18+ = max of 1 cap per day
GSN = 059192	Focalin XR 20mg capsules	Age 18+ = max of 1 cap per day
GSN = 065909	Focalin XR 30mg capsules	Age 18+ = max of 1 cap per day
GSN = 066611	Focalin XR 40mg capsules	Age 18+ = max of 1 cap per day
GSN = 061317	Focalin XR 15mg capsules	Age 18+ = max of 1 cap per day
GSN = 067692	Focalin XR 25mg capsules	Age 18+ = max of 1 cap per day
GSN = 067693	Focalin XR 35mg capsules	Age 18+ = max of 1 cap per day
GSN = 053056	Metadate CD 10 mg capsules	Age 18+ = max of 1 cap per day
GSN = 053057	Metadate CD 20 mg capsules	Age 18+ = max of 1 cap per day
GSN = 053058	Metadate CD 30 mg capsules	Age 18+ = max of 1 cap per day
GSN = 060545	Metadate CD 40 mg capsules	Age 18+ = max of 1 cap per day
GSN = 060546	Metadate CD 50 mg capsules	Age 18+ = max of 1 cap per day
GSN = 060547	Metadate CD 60 mg capsules	Age 18+ = max of 1 cap per day
GSN = 053059	Ritalin LA 20mg capsules	Age 18+ = max of 1 cap per day
GSN = 053061	Ritalin LA 40mg capsules	Age 18+ = max of 1 cap per day
GSN = 053974	Ritalin LA 10mg capsules	Age 18+ = max of 1 cap per day
HSN = 034486	Vyvanse 20/30 /40 /50 /60 /70mg	Age 18+ = max of 1 cap per day
GSN = 034359	Adderall 30 mg tablets	Age 18+ = max of 2 tabs per day
GSN = 048702	Adderall XR 20mg capsules	Age 18+ = max of 2 caps per day
GSN = 050430	Adderall XR 25mg capsules	Age 18+ = max of 2 caps per day
GSN = 048703	Adderall XR 30mg capsules	Age 18+ = max of 2 caps per day

Maximum Daily Dose By Age		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 045982	Concerta 36mg tablets	Age 18+ = max of 2 tabs per day
GSN = 071048	Zenzedi 2.5mg tablets	Age 18+ = max of 2 tabs per day
GSN = 005011	Dexedrine 5mg tab, Zenzedi 5mg tab	Age 18+ = max of 2 tabs per day
GSN = 071049	Zenzedi 7.5mg tablets	Age 18+ = max of 2 tabs per day
GSN = 005009	Dexedrine 10mg, Zenzedi 10mg tab	Age 18+ = max of 2 tabs per day
GSN = 005010	Zenzedi 15mg tablets	Age 18+ = max of 2 tabs per day
GSN = 072313	Zenzedi 20mg tablets	Age 18+ = max of 2 tabs per day
GSN = 072314	Zenzedi 30mg tablets	Age 18+ = max of 2 tabs per day
GSN = 005007	Dexedrine ER 5mg capsules	Age 18+ = max of 2 caps per day
GSN = 005005	Dexedrine ER 10mg capsules	Age 18+ = max of 2 caps per day
GSN = 048982	Focalin 2.5mg tablets	Age 18+ = max of 2 tabs per day
GSN = 048983	Focalin 5mg tablets	Age 18+ = max of 2 tabs per day
GSN = 048984	Focalin 10mg tablets	Age 18+ = max of 2 tabs per day
GSN = 053060	Ritalin LA 30mg capsules	Age 18+ = max of 2 caps per day
GSN = 005001	Adderall 20mg tablets	Age 18+ = max of 3 tabs per day
GSN = 054676	Methylin 2.5mg chewable tablets	Age 18+ = max of 3 tabs per day
GSN = 054677	Methylin 5mg chewable tablets	Age 18+ = max of 3 tabs per day
GSN = 054678	Methylin 10mg chewable tablets	Age 18+ = max of 3 tabs per day
GSN = 004028	Methylin /Ritalin 5mg tablets	Age 18+ = max of 3 tabs per day
GSN = 004026	Methylin /Ritalin 10mg tablets	Age 18+ = max of 3 tabs per day
GSN = 047132	Adderall 12.5mg tablets	Age 18+ = max of 4 tabs per day
GSN = 047133	Adderall 15mg tablets	Age 18+ = max of 4 tabs per day
GSN = 005006	Dexedrine ER 15mg capsules	Age 18+ = max of 4 caps per day
GSN = 004029	Metadate ER 20mg, Ritalin SR 20mg	Age 18+ = max of 4.5 tabs per day
GSN = 044072	Methylphenidate 20mg ER tablets	Age 18+ = max of 4.5 tabs per day
GSN = 004999	Adderall 5mg tablets	Age 18+ = max of 6 tabs per day
GSN = 047131	Adderall 7.5mg tablets	Age 18+ = max of 6 tabs per day
GSN = 005000	Adderall 10mg tablets	Age 18+ = max of 6 tabs per day
GSN = 070374	Quillivant XR 5mg/ml	Age 18+ = max of 12 ml per day
GSN = 054680	Methylin 10mg/5ml solution	Age 18+ = max of 30 ml per day

Maximum Daily Dose By Age		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 054679	Methylin 5mg/5ml solution	Age 18+ = max of 60 ml per day

Maximum Duration (Quantity) by Age by Age Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
HSN = 033556	Daytrana (methylphenidate) patches	Age 18+ = max of 30 every 26 days
GSN = 07407, 07408, 07409, 14476, 40261, 40262, 51771, 53412, 68687, 70753, 71285, 72055, 73097, 73280	Lidocaine cream & ointment, all strengths	Age 18+ = max of 60 every 27 days
GSN = 074140	Invega Trinza 273mg/0.875ml inj	Age 18+ = max of 0.875ml every 84 days
GSN = 074141	Invega Trinza 410mg/1.315ml inj	Age 18+ = max of 1.315ml every 84 days
GSN = 074142	Invega Trinza 546mg/1.75 ml inj	Age 18+ = max of 1.75ml every 84 days
GSN = 074143	Invega Trinza 819mg/2.625 ml inj	Age 18+ = max of 2.625ml every 84 days

DOSE OPTIMIZATION

Dose Optimization		
NCPDP EC# = 75 Prior Authorization Required		
All products on this list will deny when the daily dose equals "2" or the daily dose exceeds "3"; daily dose is calculated by taking the metric quantity on the incoming claim and dividing it by the days supply on the claim. The valid range for two per day is >= 1.8, but <= 2.2. To exceed a daily dose of three, the value must be >= 3.8.		
Drug Code	**Description**	**Current**
HICL = 000094 GSN = 000301, 022649, 000304, 022651	Terazosin (Hytrin)	
HICL = 000132 GSN = 017266, 000393, 000390, 000391	Lisinopril (Zestril/Prinivil)	
HICL = 000181 30 mg GSN = 021059	Nifedipine SR (Procardia XL/Adalat CC)	
HICL = 002793 10 mg GSN = 016310, 050555, 20 mg GSN = 006460, 050556	Lovastatin Sustained Release (Altoprev)	
HICL = 002793 10 mg GSN = 016310, 050555, 20 mg GSN = 006460,050556	Lovastatin Immediate Release (Mevacor, Generic)	
HICL = 006031 GSN = 015584, 015585, 015586, 044421	Doxazosin (Cardura)	
HICL = 006106 GSN = 016017, 016018	Fosinopril (Monopril)	
HICL = 006205 5 mg GSN = 016295, 2.5 mg GSN = 021743	Felodipine (Plendil)	
HICL = 006227 10 mg GSN = 016366, 20 mg GSN = 016367, 40 mg GSN = 020741	Pravastatin (Pravachol)	
HICL = 006312 5 mg GSN = 016576, 10 mg GSN = 016577, 20 mg GSN = 016578, 40 mg GSN = 016579	Simvastatin (Zocor)	
HICL = 006494 2.5 mg GSN = 016925, 5 mg GSN = 016926	Amlodipine (Norvasc)	
HICL = 006544 GSN = 024484, 053980	Cetirizine (Zyrtec)	
HICL = 007344 GSN = 050137	Paroxetine CR (Paxil CR)	
HICL = 007842 GSN = 019187	Zolpidem (Ambien)	

Dose Optimization		
NCPDP EC# = 75 Prior Authorization Required		
All products on this list will deny when the daily dose equals "2" or the daily dose exceeds "3"; daily dose is calculated by taking the metric quantity on the incoming claim and dividing it by the days supply on the claim. The valid range for two per day is >= 1.8, but <= 2.2. To exceed a daily dose of three, the value must be >= 3.8.		
Drug Code	**Description**	**Current**
HICL = 008268 10 mg GSN = 024498, 20 mg GSN = 024499	Nisoldipine (Sular)	
HICL = 008847 GSN = 046403, 046404, 064444, 064445	Venlafaxine XR (Effexor XR)	
HICL = 008946 20 mg GSN = 021694, 40 mg GSN = 021695	Fluvastatin (Lescol)	
HICL = 008991 GSN = 026376, 026377	Trandolapril (Mavik)	
HICL = 008993 GSN = 030106, 049296, 051653	Lansoprazole (Prevacid)	
HICL = 009829 GSN = 023381, 023382	Losartan (Cozaar)	
HICL = 009934 GSN = 023591	Moexipril (Univasc) – brand formulation only	
HICL = 010321 GSN = 046206, 046203	Citalopram (Celexa)	
HICL = 011505 GSN = 054009, 046450, 047453	Mirtazapine (Remeron)	
HICL = 012259 GSN = 029335, 059039	Donepezil (Aricept)	
HICL = 013911 GSN = 041337, 033722	Perindopril (Aceon)	
HICL = 018839 GSN = 047126, 040910	Telmisartan (Micardis)	
HICL = 021607 GSN = 047525, 062245	Esomeprazole (Nexium)	
HICL = 022008 GSN = 039545	Pantoprazole (Protonix)	

Dose Optimization		
NCPDP EC# = 75 Prior Authorization Required		
All products on this list will deny when the daily dose equals "2" or the daily dose exceeds "3"; daily dose is calculated by taking the metric quantity on the incoming claim and dividing it by the days supply on the claim. The valid range for two per day is >= 1.8, but <= 2.2. To exceed a daily dose of three, the value must be >= 3.8.		
Drug Code	**Description**	**Current**
HICL = 023490 GSN = 050289	Olmesartan (Benicar)	
HICL = 024022 GSN = 051642, 050712	Escitalopram (Lexapro)	
HICL = 025009 10 mg GSN = 051784, 20 mg GSN = 051785, 40 mg GSN = 051786	Rosuvastatin (Crestor)	
HICL = 026791 GSN = 058484	Eszopiclone (Lunesta)	
HICL =016913 GSN = 037015, 037016, 037017	Candesartan (Atacand)	

CONTINUITY OF CARE

* (CONTINUITY OF CARE EDIT ENDED 10/31/2014 AND IS NO LONGER IN USE)
This edit was terminated and back-dated to 11/01/2014. The intent of the client is that members transitioning in have no abatement of currently used medications, whether it is formulary preferred status or utilization management in place (e.g., PA, QL, ST, etc.) for a period of at least 60 days.

- All Prior Authorization required drugs (Drug that has Formulary indicator = B-PDL & Clinical PA, J-Non-PDL Clinical PA, L-AutoPA Drug, N-New Drug(Non-PDL), P-Clinical PA, R-Non PDL; AND
- Claim Fill Number >0; AND
- The recipient has received < 60 days supply of the med on the incoming claim in the past 180 days

OR

- There is at least one fill of the incoming drug (based on GSN) found in patient history within the past 90 days; AND
- The recipient has received < 60 days supply of the med on the incoming claim in the past 180 days

Bypass:

- NCPDP EC 56 – Non-matched prescriber ID
- NCPDP EC 75 – Prior Authorization Required
- NCPDP EC 76 – Plan Limitations exceeded
- NCPDP EC 60 – Product/Service Not Covered For Patient Age

If the recipient has received >60 days supply of the medication on the incoming claim in the past 180 days, adjudicate the claim as usual (i.e., to deny).

APPENDIX B: CCP/SFCCN DRUG LIMITATIONS FROM THE CSA

Standard/Legend Drug Exclusions For all with CCP/SFCCN standard coverage		
NCPDP EC# = 70: Drug not covered		
MESSAGE = Drug not covered		
Drug Code	**Description**	**Current**
B	FERTILITY AGENTS	
F	ANTIOBESITY DRUGS	
U	NON-REIMBURSSABLE COSMETIC INDICATIONS	
D	DIAGNOSTICS	
S	DIABETIC SUPPLIES, MISC.	
O	REUS. SYRINGES W/WO NEEDLES	
G3A	OXYTOCICS	
H2B	GENERAL ANESTHETICS, INHALANT	
L2A (NDC-9 = 008844990 is covered.)	EMOLLIENTS	
L3A	PROTECTIVES	
P0B	FOLLICLE STIM. / LUTEINIZING HORMONES	
U5A	HOMEOPATHIC DRUGS	
U5B	HERBAL DRUGS	
U5F	ANIMAL / HUMAN DERIVED AGENTS	
U6A	PHARMACEUTICAL ADJUVANTS, TABLETING	
U6C	THICKENING AGENTS, ORAL	
U6E	OINTMENT / CREAM BASES	
U6F	HYDROPHILIC CREAM / OINTMENT BASES	
U7A	SUSPENDING AGENTS	
U7D	SURFACTANTS	
U7H	ANTICORROSIVE AGENTS	
U7J	CHELATING AGENTS	
U7K	FLAVORING AGENTS	
U7N	SWEETENERS	
U7P	PERFUMES	
U7Q	COLRING AGENTS AND DYES	
V1G	RADIOACTIVE THERAPEUTIC AGENTS	
W7B	VIRAL / TUMORIGENIC VACCINES	

Standard/Legend Drug Exclusions For all with CCP/SFCCN standard coverage		
NCPDP EC# = 70: Drug not covered		
MESSAGE = Drug not covered		
Drug Code	**Description**	**Current**
W7C	INFLUENZA VIRUS VACCINES	
W7F	MUMPS AND RELATED VIRUS VACCINES	
W7H	ENTERIC VIRUS VACCINES	
W7J	NEUROTOXIC VIRUS VACCINES	
W7L	GRAM POSITIVE COCCI VACCINES	Pneumovax (HSN = 004212 and 021001 covered for recipients who are not Medicare Eligible.)
W7M	GRAM (.) BACILLI (NON-ENTERIC) VACCINES	
W7N	TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS	
W7Q	GRAM NEGATIVE COCCI VACCINES	
W7R	SPIROCHETE VACCINES	
W7S	ANTIVENINS	
W7T	ANTIGENIC SKIN TESTS	
W7U	HYMENOPTERA-DERIVED AGENTS	
W7V	RHUS EXTRACTS (POISON OAK, POISON IVY)	
W7W	ALLERGENIC EXTRACTS, THERAPEUTICS	
W7Z	VACCINE / TOXOID PREPARATIONS, COMBINATIONS	
C5C	INFANT FORMULAS	
C5F	MISC. DIETARY SUPPLEMENT	
C5U	NUTRITIONAL THERAPY, MED COND SPECIAL ELECTROLYTES & MISC. NUTRIENTS	
X1G	OVULATION TESTS	
X1F	PREGNANCY TESTS	
X2A	NEEDLES/NEEDLELESS DEVICES	
X2B	SYRINGES AND ACCESSORIES	
U6F	HYDROPHILIC CREAM/OINTMENT BASES	
Y9A	DIABETIC SUPPLIES	
M4A	BLOOD SUGAR DIAGNOSTICS	
GSN 006328, 006329, 006330, 006331, 006332	ALBUMIN HUMAN	
GSN 016805	ALDESLEUKIN	
GSN 059424, 059425	CEFTRIAXONE NA/DEXTROSE, ISO	

Standard/Legend Drug Exclusions For all with CCP/SFCCN standard coverage		
NCPDP EC# = 70: Drug not covered		
MESSAGE = Drug not covered		
Drug Code	**Description**	**Current**
GSN 022350	CYTOMEGALOVIRUS IMMUNE GLOB	
GSN 009657, 009658, 009659, 009660, 009661, 009662, 009663, 009664, 009665, 019103	IMMU GLOBULIN, GAMMA (IGG)	
GSN 002186, 002187	CALCITRIOL	
GSN 051656, 053296	TADALAFIL	
GSN 051882, 051883, 052964	VARDENAFIL HCL	
GSN 040663	ORLISTAT	
GSN 046222, 046228	SSRIS	
GSN 048801, 006378	FAT EMULSIONS	
GSN 035326, 030474	RETEPLASE	
GSN 045771	BEXAROTENE	
GSN 047315	BOTULINUM TOXIN TYPE B	Covered for children in the Shriner's Network. Requires Clinical Prior Authorization.
GSN 023175	ESTRIOL	
GSN = 023797, 023795, 021742, 023796, 041011, 031755, 031756, 031754, 029186, 051656, 053296, 052964, 051882,029187, 029188, 029189, 029801	DRUGS TO TREAT IMPOTENCY (ALPROSTADIL, CIALIS, LEVITRA)	VIAGRA REQUIRES CLINICAL PRIOR AUTHORIZATION FOR PULMONARY HYPERTENSION.

DME Drug exclusions (DME Message List) For all with standard coverage		
NCPDP EC# = 70: Drug not covered		
MESSAGE=		
Drug Code	**Description**	**Current**
D	DIAGNOSTICS	
Q	REUSABLE SYRINGES W/WO NEEDLES (INSULIN)	
Y9A	DIABETIC SUPPLIES	
X2A	NEEDLES/NEEDLELESS DEVICES	
M4A	BLOOD SUGAR DIAGNOSTICS	
NDC9 = 083730811	OPTICHAMBER AND PEDIATRIC MASK	

DME Drug exclusions (DME Message List) ☐ For all with standard coverage		
NCPDP EC# = 70: Drug not covered		
MESSAGE=		
Drug Code	**Description**	**Current**
NDC9 = 083730765, 083730800, 591960020, 591960009	INHALER, ASSISTED DEVICES	
NDC9 = 083730755	PEEK FLOW METERS	

MAINTENANCE DRUG LIST

Identified by Formulary indicator = "M – Maintenance Drug." Coverage is shown on the Coverage Indicator on the formulary file:

- ☐ **T** = Covered
- ☐ **U** = Covered OTC
- ☐ **I** = Drug Not Covered for any Plan
- ☐ **Z** = Drug Not Covered
- ☐ **D** = None

Note: Indicators located on the Formulary tab in FirstTrax™.

Maintenance Drugs identified by Formulary indicator = M are allowed a days supply up to 100 per claim.

Maintenance Drugs ☐ Allow days supply or units whichever is greater (both must exceed to deny)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Name	**Coding Level (NDC, HSN, or HIC3)**	**Comments**
ACEBUTOLOL	002107	
ACETAZOLAMIDE	003641	
ALLOPURINOL	001100	
AMANTADINE	001898	
AMILORIDE	003667	
AMINOPHYLLINE	000037	
AMIODARONE	000083	
ATENOLOL	002104	
ATENOLOL/CHLORTHAL	000147	
BENAZEPRIL	006113	
BENAZEPRIL-HCTZ	008962	
BENZTROPINE	001905	
BISOPROLOL-HCTZ	008715	
BUMETANIDE	003664	
CAPTOPRIL	000128	

Maintenance Drugs ☐ Allow days supply or units whichever is greater (both must exceed to deny)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Name	**Coding Level (NDC, HSN, or HIC3)**	**Comments**
CAPTOPRIL/HCTZ	000127	
CARBIDOPA-LEVO	013894	
CHLOROTHIAZIDE	003646	
CHLORPROPAMIDE	000800	
CHLORTHALIDONE	003662	
CITRIC ACID/Na CITRATE	003682	
CLONIDINE	000113	
CORTISONE	002860	
DEXAMETHASONE	002889	
DIGOXIN	000004	
DILTIAZEM	000182, 017931	
DISOPYRAMIDE	004718	
DOXAZOSIN	006031	
DYPHYLLIN	000038	
DYPHYLLINE-GG	000053	
ENALAPRIL	000130	
ENALAPRIL-HCTZ	000129	
ERGOLOID	012197	
ESTRADIOL	001421, 025182	
ESTROPIPATE	001431	
FELODIPINE	006205	
FLAVOXATE	002047	
FLECAINIDE	000082	
FOLIC ACID	001062	
FUROSEMIDE	003660	
GLIMEPIRIDE	010485	
GLIPIZIDE	000803	
GLIPIZIDE-METFORMIN	024429	
GLYBURIDE	000802	
GLYBURIDE-METFORMIN	009690	
GUANFACINE	000120	
HYDRALAZINE	000089	

Maintenance Drugs ☐ Allow days supply or units whichever is greater (both must exceed to deny)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Name	**Coding Level (NDC, HSN, or HIC3)**	**Comments**
HYDROCHLOROTHIAZIDE	003649	
HYDROCORTISONE	002867	
INDAPAMIDE	003665	
ISOSORBIDE DINITRATE	000166	
K+ SUPPLEMENTS	000553	
LABETALOL	002095	
LEVOTHYROXINE	002849	
LISINOPRIL	000132	
LISINOPRIL-HCTZ	000131	
MEDROXYPROGESTERONE	001442	
METHAZOLAMIDE	003643	
METHIMAZOLE	002855	
METHYLDOPA	000118	
METHYLDOPA/HCTZ	000116	
METHYLPREDNISOLONE	002877	
METOLAZONE	003663	
METOPROLOL	006323, 002102	
METOPROLOL-HCTZ	011205, 000143	
MEXILETINE	000084	
MINOXIDIL	000093	
MULTIVITAMIN (Children)	C6H	
MULTIVIT/FLORIDE/FE	C6H **	
MULTIVITAMIN (Prenatal)	C6F, C6V	
NADOLOL	002103	
NICARDIPINE	000183	
NIFEDIPINE	000181	
NITROGLYCERIN	000159	Oral, sublingual and buccal routes included
OXYBUTYNIN	002048	
PAPAVERINE	000170	
PINDOLOL	002106	
PRAZOSIN	000091	
PREDNISOLONE	002874	

Maintenance Drugs

☐ Allow days supply or units whichever is greater (both must exceed to deny)

NCPDP EC# = 76 – Plan Limitations Exceeded

Drug Name	Coding Level (NDC, HSN, or HIC3)	Comments
PREDNISONE	002879	
PROCAINAMIDE	000076	
PROPAFENONE	004833	
PROPRANOLOL	002101	
PROPRANOLOL/HCTZ	000142	
QUINIDINE	000074, 000075, 000073, 007631	
SELEGILINE	016483	
SOTALOL	004791	
SPIRONOLACT/HCTZ	002900	
SPIRONOLACTONE	002901	
TERAZOSIN	000094	
THEOPHYLLINE	000025, 000026	
THYROID HORMONE	002848, 002847, 002846, 002843	
TORSEMIDE	008829	
TRIAMTERENE-HCTZ	003647	
TRIHEXYPHENIDYL	001900	
VERAPAMIL	000180	
ALORA	52544047108, 52544047208, 52544047308, 52544088408	Oral Contraceptives
AVIANE-28	00555904558	Oral Contraceptives
CAMILA	00555071558	Oral Contraceptives
CRYSELLE-28	00555904958	Oral Contraceptives
ENPRESSE-28	00555904758	Oral Contraceptives
LESSINA-28	00555901467	Oral Contraceptives
LEVORA-28	52544027928	Oral Contraceptives
LOW-OGESTREL-28	52544084728	Oral Contraceptives
MICROGESTIN	52544095021, 52544095121	Oral Contraceptives
NORTREL	00555900942, 00555901058, 00555901258, 00555900867	Oral Contraceptives
OGESTREL	52544084828	Oral Contraceptives
PORTIA-28	00555902058	Oral Contraceptives
TRINESSA	52544093528	Oral Contraceptives
TRI-PREVIFEM	00093531528, 00093531581	Oral Contraceptives
TRIVORA-28	52544029128	Oral Contraceptives

Maintenance Drugs ☐ Allow days supply or units whichever is greater (both must exceed to deny)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Name	Coding Level (NDC, HSN, or HIC3)	Comments
* Include oral route only , except as indicated		
** Multivitamins with Fe and Fluoride are all in the Pediatric Multivitamin HIC3 of C6H		

DAYS' SUPPLY OTHER THAN 34 OR 100

Non-standard day supply (package size cannot be broken):

☐ Allow days' supply as indicated (other than 34 or 100)

NCPDP EC# = 76 – Plan Limitations Exceeded

Drug Code	Description	Maximum Day Supply
HIC3 = H3A	Analgesics, Narcotics	30
GSN = 060257	Boniva 3mg/3ml syringe	999
GSNs = 002329	Cyanocobalamin 1,000mcg/ml	90
GSNs = 017584, 026098	Depo-Provera/Medroxyprogesterone 150mg/ml	100
GSN = 058938	Depo-SubQ Provera 104	98 (min. day supply 84)
GSN = 003195	Depo-Estradiol 5mg/ml vial	90
GSN = 003200	Delestrogen/ Estradiol Valerate 40mg/ml vial	50
GSN = 050857	Eligard 22.5mg syringe kit	90
GSN = 051826	Eligard 30mg syringe kit	120
GSN = 058789	Eligard 45mg dispense syringe (1ct)	180
GSN = 022472	Estring 2mg vaginal ring	91
GSN = 038264	Flagyl ER 750mg tab	10
GSN = 066942, 066943, 066944, 069400, 070493, 070494, 070495	Gablofen vial/ disp syrg	120
GSNs = 016404, 022518, 039499, 39500, 031613	Ketorolac 10mg tab, 30mg/ml carpuject/Isecure, 15, 30, and 60mg vial	3
GSN = 022583	Lioresal IT 10mg/20ml kit	120
GSN = 044964, 44980	Lupron Depot 22.5 and 11.25mg 3-month kit	84
GSN = 044968	Lupron Depot 4-month kit	120
GSN = 067506	Lupron Depot 45 (6-month kit)	180
GSN = 067737	Lupron Depot Ped 3-month kit	90
GSN = 067738	Lupron Depot Ped 11.25mg and 30mg syr	90
GSN = 053076, 060937, 064935	Jolessa, Quasense, Introvale, Seasonale, Seasonique, Camrese, Amethia, LoSeasonique	91
GSNs = 017179, 022582, 022583	Lioresal Intrathecal	120
GSN = 070480	Lupaneta Pack	90 (Min. day supply 84)
GSNs = 002256, 002257, 002262, 002271 (GSN = 002281-chewables, EBA only)	Multivit-Fluoride 0.25mg, 0.5/ml drops Multivit-Iron-FL 0.25mg/ml Tri-Vit-Fluor-Iron 0.25mg/ml	50
GSNs = 025080, 025081	Norvir 80mg/ml solution	90
GSN = 025081	Norvir 100mg cap	60
HIC3 = C6F	Prenatal Vitamin Preparations	100

Non-standard day supply (package size cannot be broken):

☐ Allow days' supply as indicated (other than 34 or 100)

NCPDP EC# = 76 – Plan Limitations Exceeded

Drug Code	Description	Maximum Day Supply
HICL = 037012	Prolia 60mg/ml syringe, Xgeva 120mg/1.7ml	999
GSN = 070814	Quartette 0.15mg (91ct) tablets	91 (Min. day supply 84)
GSNs = 002619, 013383	Sodium Fluoride 0.5mg/ml and Fluor-a-day 2.5mg/ml drops	50
NDC-9 = 67979-0002	Supprelin LA	365
NDC-9 = 67979-0500, 55592-0500	Vantas 50mg kit (must bill physician services)	365
HICL = 034717	Zoledronic Acid 5mg/100ml (Reclast/Zometa)	999

Gender Restrictions:

☐ Deny if not equal to appropriate gender

NCPDP EC# = 61 – Product/Service Not Covered for Patient Gender

FL MESSAGE =

Drug Code	Description	
GSNs 052766, 003210, 003211, 003212, 003213, 003214)	Estrogens, Conjugated	Females
GSN = 040888, 062587	Estradiol/Norethindrone Acetate	Females
GSN = 065966	Estradiol	Females
GSN = 017584, 026098, 058938	Medroxyprogesterone Acetate	Females
GSN = 007005	Miconazole Nitrate	Females
GSN = 007008, 007009, 015931	Terconazole	Females
GSN = 016924, 044397	Clindamycin Phosphate	Females
GSN = 013245, 006999	Clotrimazole	Females
NDC9 = 000460975	Prempro	Females
GSN = 038264, 016939	Metronidazole	Females
NDC = 00046257306, 00046257911, 00046257305	Estrogen, Con/M-Progest Acet	Females
GSN = 045802	RHO(D) Immune Globulin	Females
DCC = C	Oral Contraceptives	Females
NDC = 00378334053, 50458019224, 00062192001	Norelgestromin/ethin. Estradiol	Females
NDC = 69543024030, 67112040130	Prenatal vitamin	Females
GSN = 073426, 073427, 073428	Ibrance	Females
GSN = 071167	Brisdelle capsules	Female

Maximum Age Limits: ☐ Deny if recipient is outside of approved age range		
NCPDP EC# = 60 – Product/Service Not Covered for Patient Age		
FL MESSAGE =		
Drug Code	**Description**	**Maximum Age**
HIC3 = H6C	Antitussive, Non-Narcotic	21
HIC3 = J5E	Sympathomimetic Agents	21
HIC3 = B3A	Mucolytics	21
HIC3 = B3R	Non-Narc Antituss-1st Gen. Antihistamine Cold and Cough Preparations	21
HIC3 = B3J	Non-Narc Antituss-1st Gen. Antihistamine Cold and Cough Expectorants	21
HIC3 = B3Y	1st – Gen Antihistamine – Decongestant-Expectorant CMB	21
HIC3 = P1A	Growth Hormones	20
HIC3 = P1H	Growth Hormones Releasing Hormones	20
HIC3 = Z2N	1st – Gen Antihistamine and Decongestant	21
HSN = 018564	Synagis	2
HSN = 010293	Resp Syncytial Vir Immune Glob	3
GSN = 001908	Antihistamines	21
GSN = 041843	Polyethylene Glycol 3350	21
GSN = 045667	Guaifenesin/Codeine Phos	21
GSN = 011606	Pyril Mal/P-Tlox Cl/Diper/Bak	21
GSN = 001046, 001045	Ppa Hcl/Pyril Mal/P-Tlox/Pnm	21
GSN = 001030	Ppa Hcl/Acetaminophen/P-Tlox/Cp	21
GSN = 024471	Car-B-Pen Ta/Phenylephrine/Cp	21
GSN = 060341	Lubiprostone	21
GSN = 046525	Budesonide	9
GSN = 049296, 040887	Lansoprazole	12
GSN = 001068	Ppa Hcl/Chlor-Mal	21
GSN = 008172	Chlorothiazide	5
GSN = 028136	Cetirizine HCL	7
GSN = 041046, 042606	Urinary Tract Antispasmodic/Antiincoi	13
GSN = 021416	Dornase Alfa	65
GSN = 002259, 002258, 002270, 002256, 002268, 002266, 002262, 002274, 002271	Pediatric Vitamins Preparations	13
GSN 002280, 002285, 002284	MULTIVITAMINS W-IRON	13
GSN 002270, 002272, 002273	FLUORIDE ION/MULTIVITS W-FE	13

Maximum Age Limits: ☐ Deny if recipient is outside of approved age range		
NCPDP EC# = 60 – Product/Service Not Covered for Patient Age		
FL MESSAGE =		
Drug Code	**Description**	**Maximum Age**
GSN 002275, 002256, 002257	FLUORIDE ION/MULTIVITAMINS	13
GSN 002279	MULTIVITS W-FE, OTHER MIN	13
GSN 002266, 002268	FLUORIDE ION/VIT A, C&D	13
NDC9 = 522680800	Miralax	21
NDC11 = 00093529925, 00574041202, 00904575526, 10572081002,	Polyethylene Glycol	21
NDC11 = 62175044215	Glycolax	21

Minimum Age Limits: ☐ Deny if recipient is outside of approved age range		
NCPDP EC# = 60 – Product/ Service Not Covered for Patient Age		
FL MESSAGE =		
Drug Code	**Description**	**Minimum Age Limitations**
DCC = J	Smoking Deterrents	18
GSN = 053400, 053403	Symbyax	2
GSN = 043119	Zanamivir	6
GSN = 024138	Calcitonin, Salmon, Synthetic	34
Drug Code	**Description**	**Maximum Age**
GSN = 063946	Amitiza	21
GSN = 060341	Amitiza (males)	21
GSN = 060341	Amitiza (females)	50

PRIOR AUTHORIZATION DRUGS

Clinical PA List PA Required		
NCPDP EC# = 75 – Prior Authorization Required		
FL MESSAGE =		
Drug Code	**Description**	
GSN = 025848, 041478	TX FOR ATTENTION DEFICIT-HYPERACT(ADHD)/NARCOLEPSY	
NDC = 00045081015	Regranex	
GSN = 006331	PLASMA PROTEINS	
HSN = 006070 (NDC = 54868305000 excluded) GSN = 015927, 015928, 029260, 045996, 046004, NDC11 = 55513019001, NDC9 = 555130209	LEUKOCYTE (WBC) STIMULANTS	
GSN = 022655, 018100, 006582	GROWTH HORMONES (Serostim 4mg, 5mg, and 6mg)	
GSN = 041643	TOPICAL ANTINEOPLASTIC & PREMALIGNANT LESION AGNTS	
GSN = 013722, NDC9 = 590750710	NEUROMUSCULAR BLOCKING AGENTS	Botox – Requires Clinical Prior Authorization – Only covered for children in the Shriner's Clinic Network.
GSN = 044269, 045771	SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)	
GSN = 050442, 050443, 050444 and 053774	ANTIFUNGAL AGENTS	
NDC9 = 000040038	ANTIVIRALS, GENERAL	
NDC 11 = 00004038039	ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS	
GSN = 009658, 009661,019103, 021691, 009666, 022350, 029122, 034336, 053134, 059735, 021691, 022350	ANTISERA	
NDC9 = 009440471, 009442620, 641930250, 442060417, 527690268, 619530003, 685161612, 143620115, 527690115, 527690576, 548684193	ANTISERA	
NDC 11 = 00944047169, 00944262001	ANTISERA	
NDC 9 = 539050991	IMMUNOMODULATORS	
HSN 024846	SUBOXONE	
HSN 001747	ACTIQ	
HSN 006330	CYTOGAM	
HSN 023253	ORFADIN	
GSN 024504	OXYCONTIN	

Clinical PA List ☐ PA Required		
NCPDP EC# = 75 – Prior Authorization Required		
FL MESSAGE =		
Drug Code	**Description**	
HSN 001762	SUBONEX/SUBUTEX	
GSN 016805	ALDESLEUKIN	
GSN 025848	PROVIGIL	

OTC COVERED DRUGS

Identified by Formulary indicator = "9," (OTC). Coverage is shown on the Coverage Indicator on the formulary file:

- ☐ **T** = Covered
- ☐ **U** = Covered OTC
- ☐ **I** = Drug Not Covered for any Plan
- ☐ **Z** = Drug Not Covered
- ☐ **D** = None

Note: Indicators located on the Formulary tab in FirstTrax™.

DIALYSIS DRUGS

Identified by Formulary indicator = "D – Dialysis (Med Cert)." Coverage is shown on the Coverage Indicator on the formulary file:

- ☐ **T** = Covered
- ☐ **U** = Covered OTC
- ☐ **I** = Drug Not Covered for any Plan
- ☐ **Z** = Drug Not Covered
- ☐ **D** = None

Note: Indicators located on the Formulary tab in FirstTrax™.

For Dialysis drugs indicated by Formulary Indicator = D; Deny NCPDP EC 70-Drug Not Covered if claim is submitted without PA Type Code (NCPDP Field # 461-EU) equal to '8' (both OTC and legend products are covered if '8' is submitted).

QUANTITY/DURATION LISTS

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 013574	Tamoxifen 20mg	60 per day 27 days
GSN = 015566	Alprazolam 2mg tablets	150 every 27 days
GSN = 015869	Zofran (Ondansetron) 2mg/ml vial	32 every 27 days
GSN = 015880	Fentanyl 25mcg/hr Patch	10 every 26 days
GSN = 015881	Fentanyl 50mcg/hr patch	10 every 26 days
GSN = 015882	Fentanyl 75mcg/hr patch	10 every 26 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 015883	Fentanyl 100mcg/hr patch	10 every 26 days
GSN = 015914	Actimmune	6 every 27 days
GSN = 016392	Zofran (Ondansetron) 4 mg	60 every 27 days
GSN = 016393	Zofran (Ondansetron) 8 mg	60 every 27 days
GSN = 016674	Butorphanol Tartrate Nasal Spray	2.5 every 27 days
GSN = 016767	Estradiol 0.025mg patch (Alora/ Vivelle-DOT)	8 every 25 days
GSN = 017584	Medroxyprogesterone Acetate (Depo-Provera)	1 every 75 days
GSN = 017941	Serevent 21 mcg inhaler	34 every 27 days
GSN = 018368	Fluticasone Propionate 50mcg spray (Flonase)	16 every 27 days
GSN = 018370	Bactroban Nasal 2% ointment	10 every 27 days
GSN = 018638	Terbinafine HCL 250mg tablet (Lamisil)	84 every 365 days
	Flovent 110 mcg/ Flovent HFA 110mcg inhaler	
GSN = 021253	Flovent 44 mcg/ Flovent HFA 44mcg inhaler	21.2 every 27 days
GSN = 021401	Timolol 0.5% gel soln (Timoptic-XE)	15 every 27 days
GSN = 021483	Flovent 220mcg/ Flovent HFA 220mcg inhaler	24 every 27 days
GSN = 022230	Maxair Autohaler 0.2 mg aero	28 every 27 days
GSN = 022472	Estring 2 mg vaginal ring	1 every 84 days
GSN = 023270	Estradiol 0.075mg patch (Alora/Minivelle/Vivelle-D	8 every 25 days
GSN = 002329	Cyanocobalamin 1,000mcg/ml	2 every 28 days
GSN = 023471	Climara / Climara Pro (estradiol patches	4 every 25 days
GSN = 023472	Climara 0.025mg/day patch	4 every 25 days
GSN = 024138	Calcitonin, Salmon, Synth (Miacalcin/Fortical)	4 every 25 days
GSN = 024456	Atrovent (ipratropium) 42mcg nasal	30 every 27 days
GSN = 024457	Atrovent (ipratropium) 21mcg nasal	60 every 27 days
GSN = 024555	Estradiol 0.0375mg patch (Alora/Minivelle/Vivelle-	8 every 25 days
GSN = 025080	Norvir 80mg/ml solution	480 every 24 days
GSN = 025081	Norvir 100mg softgel cap	360 every 24 days
GSN = 025738	Cabergoline 0.5mg tablet	16 every 30 days
GSN = 026098	Medroxyprogesterone Acetate (Depo-Provera)	1 every 75 days
GSN = 026869	Nasacort AQ(triamcinolone 55mcg nasal spray	16.5 every 27 days
GSN = 027370	Latanoprost 0.005% eye drops (Xalatan)	5 every 27 days
GSN = 028107	Ondansetron 4mg/5ml solution	600 every 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 029123	Combivent inhaler	29.4 every 27 days
GSN = 030763	Granisetron 1mg/5ml oral soln	80 every 27 days
GSN = 030788	Copaxone 20mg injection kit	1 every 27 days
GSN = 031186	Nasonex 50mcg nasal spray	17 every 27 days
GSN = 003202	Estradiol 0.05mg patch (Alora/ Minivelle/Vivelle-D	8 every 25 days
GSN = 003203	Estradiol 0.1mg patch (Alora/Minivelle/Vivelle-DOT	8 every 25 days
GSN = 032174	Climara 0.025mg/day patch	4 every 25 days
GSN = 003267	Makena (hydroxyprogesterone) Soln for Inj	5 every 27 days
GSN = 000343	Catapres-TTS (clonidine) patches	8 every 28 days
GSN = 000344	Catapres-TTS (clonidine) patches	8 every 28 days
GSN = 000345	Catapres-TTS (clonidine) patches	8 every 28 days
GSN = 034749	Anzemet (dolasetron)50mg tablet	8 every 27 days
GSN = 034750	Anzemet (dolasetron) 100mg tablet	8 every 27 days
GSN = 035495	lidocaine-prilocaine cream (EMLA Cream)	30 every 27 days
GSN = 036872	Methotrexate 2.5mg tablet	300 every 27 days
GSN = 037003	Montelukast Sod 5mg chew tab (Singulair)	30 every 25 days
GSN = 037042	Tobi 300mg/5ml ampul-neb inh.	280 every 53 days
GSN = 037048	Bactroban 2% cream (mupirocin)	60 every 27 days
GSN = 037219	Lansoprazole-amoxicil-clarithromycin (Prevpac)	224 every 27 days
GSN = 037223	Regranex 0.01% gel	140 every 365 days
GSN = 003734	Chlordiazepoxide 10mg capsules	120 every 27 days
GSN = 003735	Chlordiazepoxide 25mg capsules	120 every 27 days
GSN = 003736	Chlordiazepoxide 5mg capsules	120 every 27 days
GSN = 003744	Clorazepate 15mg tablet	120 every 27 days
GSN = 003745	Clorazepate 3.75mg tablet	120 every 27 days
GSN = 003746	Clorazepate 7.5mg tablet	120 every 27 days
GSN = 073234	Lynparza 50mg capsules	480 every 27 days
GSN = 071671	Sutent 37.5mg capsules	30 every 27 days
GSN = 074547	Odomzo 200mg capsules	30 every 27 days
GSN = 052086	Iressa 250mg tablet	60 every 27 days
GSN = 69994	Purixan (mercaptopurine) 20mg/ml suspension	100 every 27 days
GSN = 8836	Mataulane 50mg (procarbazine) capsules	56 every 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 074822	Lonsurf 20-8.19mg Tablets	80 every 25 days
GSN = 074821	Lonsurf 15-6.14mg tablet	80 every 25 days
GSN= 008838	Etoposide 50mg capsules	40 every 18 days
GSN = 075138	Cotellic 20mg tablet	63 every 25 days
GSN = 003757	Lorazepam 0.5mg tablets	150 every 27 days
GSN = 003758	Lorazepam 1mg tablets	150 every 27 days
GSN = 003759	Lorazepam 2mg tablets	150 every 27 days
GSN = 003766	Diazepam 10mg tablet	120 every 27 days
GSN = 003767	Diazepam 2mg tablets	120 every 27 days
GSN = 003768	Diazepam 5mg tablet	120 every 27 days
GSN = 003773	Alprazolam 0.25mg tablets	150 every 27 days
GSN = 003774	Alprazolam 0.5mg tablets	150 every 27 days
GSN = 003775	Alprazolam 1mg tablets	150 every 27 days
GSN = 039531	dorzolamide-timolol eye drops (Cosopt)	10 every 27 days
GSN = 039780	Xeloda 150mg tablets (capecitabine 150mg)	120 every 27 days
GSN = 039781	Xeloda 500mg (capecitabine 500mg)	120 every 27 days
GSN = 040279	Thalomid 100mg	30 every 25 days
GSN = 040294	Actonel 30mg	60 every 120 days
GSN = 040296	Thalomid 50mg	30 every 25 days
GSN = 040366	Climara 0.075mg/day patch	4 every 25 days
GSN = 040429	Cinryze 500 (5ml) vial pkg size=1	20 every 25 days
GSN = 040526	Lidocaine/Prilocaine (EMLA kit)	10 every 27 days
GSN = 040869	Enbrel 25mg kit (pkg size 4)	8 every 25 days
GSN = 041562	Zofran (Ondansetron) 4 mg ODT	60 every 27 days
GSN = 041563	Zofran (Ondansetron) 8 mg ODT	60 every 27 days
GSN = 043010	Temodar 5mg	60 every 27 days
GSN = 043011	Temodar 20mg	60 every 27 days
GSN = 043012	Temodar 100mg	60 every 27 days
GSN = 043013	Temodar 250mg	60 every 27 days
GSN = 043230	Ondansetron 24mg tab	100 every 27 days
GSN = 043256	Lidoderm 5% patch	90 every 27 days
GSN = 043899	Levonorgestrel 0.75mg (Plan B/Next Choice)	2 every 30 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 043901	Caffeine Cit 60mg/3ml vial (Cafcit)	90 every 27 days
GSN = 044226	Rhinocort Aqua nasal spray (budesonide ns)	8.6 every 27 days
GSN = 044269	Targretin 75mg	60 every 27 days
GSN = 044964	Lupron Depot 22.5mg 3 month kit	1 every 84 days
GSN = 044967	Leuprolide soln for inj 2 wk 1mg/0.2ml kit	2 every 26 days
GSNs = 044968	Lupron Depot -4 month kit	1 every 118 days
GSN = 044970	Lupron Depot 7.5mg kit	1 every 28 days
GSN = 044980	Lupron Depot 11.25mg 3 month kit	1 every 84 days
GSN = 045017	Lupron Depot 3.75mg kit	1 every 28 days
GSN = 045269	Caffeine Cit 60mg/3ml oral	90 every 27 days
GSN = 004560	Clonazepam 0.5mg tablet	90 every 27 days
GSN = 004561	Clonazepam 1mg tablet	90 every 27 days
GSN = 004562	Clonazepam 2mg tablet	90 every 27 days
GSN = 004704	Transderm-Scop	10 every 27 days
GSN = 004722	Diclegis 10m-10mg tablets DR	120 every 27 days
GSN = 047571	Prozac Weekly	4 every 27 days
GSN = 047612	Travatan Z	5 every 27 days
GSN = 047688	Cancidas 50mg vial (caspofungin)	13 every 27 days
GSN = 047689	Cancidas 70mg vial (caspofungin)	1 every 27 days
GSN = 048333	Alphagan P	10 every 27 days
GSN = 048447	Cathflo Activase 2mg vial	2 every 27 days
GSN = 048492	Tussionex Suspension	300 every 30 days
GSN = 048627	Clotrimazole-Betamethasone lotion	60 every 27 days
GSN = 048699	Albuterol Sulfate 1.25mg/3ml soln	375 every 27 days
GSN = 004963	Alupent 4mg/ml Nebs	300 every 27 days
GSN = 004964	Alupent 6mg/ml Nebs	300 every 27 days
GSN = 050035	Rebif 22mcg/0.5ml disp syringe	6 every 25 days
GSN = 050039	Rebif 44mcg/0.5ml disp syringe	6 every 25 days
GSN = 050363	Eligard (leuprolide) 7.5mg syr kit	1 every 25 days
GSN = 050364	Actonel 35mg	4 every 27 days
GSN = 005039	Albuterol 0.083% (2.5mg/3ml) inh soln	375 every 27 days
GSN = 050399	Xanax XR 0.5mg tab (alprazolam)	30 every 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 005040	Albuterol 5mg/ml inh soln (Proventil/Ventolin)	60 every 27 days
GSN = 050400	Xanax XR 1mg tab (alprazolam)	30 every 27 days
GSN = 050401	Xanax XR 2mg tab (alprazolam)	30 every 27 days
GSN = 050857	Eligard (leuprolide) 22.5mg syr kit	1 every 84 days
GSN = 051483	Forteo 600mcg/2.4ml Pen Inj	2.4 every 28 days
GSN = 051512	Montelukast Sod 4mg granules (Singulair)	30 every 25 days
GSN = 051810	Lidocaine-HC 3-0.5% cream / cream kit	98 every 7 days
GSN = 051826	Eligard (leuprolide) 30mg syr kit	1 every 118 days
GSN = 051879	Thalomid 200mg	60 every 25 days
GSN = 051909	Oxytrol (oxybutynin) patch	8 every 27 days
GSN = 051911	Emend 80mg capsules	4 every 27 days
GSN = 051912	Emend 125mg capsules	2 every 27 days
GSN = 051913	Emend Trifold Pack	6 every 27 days
GSN = 051983	Clonazepam 0.125mg ODT tablet	90 every 27 days
GSN = 051984	Clonazepam 0.25mg ODT tablet	90 every 27 days
GSN = 051985	Clonazepam 0.5mg ODT tablet	90 every 27 days
GSN = 051986	Clonazepam 1mg ODT tablet	90 every 27 days
GSN = 051987	Clonazepam 2mg ODT tablet	90 every 27 days
GSN = 052050	Vigamox 0.5% eye drops	6 every 27 days
GSN = 052143	Xanax XR 3mg tab (alprazolam)	30 every 27 days
GSN = 052711	Gleevec 400mg tablet	60 every 27 days
GSN = 047895	Gleevec 100mg capsules	90 every 27 days
GSN = 052712	Gleevec 100mg tablet	90 every 27 days
GSN = 052830	Climara 0.06mg/day patch	4 every 25 days
GSN = 052831	Climara 0.0375mg/day patch	4 every 25 days
GSN = 052934	Risperdal Consta 25mg syr	8 every 28 days
GSN = 052935	Risperdal Consta 37.5mg syr	8 every 28 days
GSN = 052936	Risperdal Consta 50mg syr	8 every 28 days
GSN = 053383	Climara Pro0.045mg-0.015mg/day patch	4 every 25 days
GSN = 053835	Factive 320mg tablet	7 every 27 days
GSN = 054687	Albuterol 2.5mg/0.5ml nebs	120 every 27 days
GSN = 058214	Enbrel 50mg/ml syringe (pkg size 0.98)	7.840 every 25 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 058374	Tarceva 150mg tablet	30 every 27 days
GSN = 058375	Tarceva 100mg tablet	30 every 27 days
GSN = 058376	Tarceva 25mg tablet	30 every 27 days
GSN = 058482	Lunesta (eszopiclone) 3mg tablet	90 every 365 days
GSN = 058484	Lunesta (eszopiclone) 1mg tablet	90 every 365 days
GSN = 058516	Lamotrigine dose packs (25mg)	35 every 27 days
GSN = 058517	Lamotrigine dose packs (25mg-100mg)	98 every 27 days
GSN = 058518	Lamotrigine dose packs (25mg-100mg)	49 every 27 days
GSN = 058776	Rebif 8.8-22 (6) titration pack	4.20 every 25 days
GSN = 058789	Eligard (leuprolide) 45mg syr kit	1 every 175 days
GSN = 058847	Alprazolam ODT 0.25mg tablets	150 every 27 days
GSN = 058848	Alprazolam ODT 0.5mg tablets	150 every 27 days
GSN = 058849	Alprazolam ODT 1mg tablets	150 every 27 days
GSN = 058850	Alprazolam ODT 2mg tablets	150 every 27 days
GSN = 058938	Depo-SubQ Provera 104 syringe	0.65 every 84 days
GSN = 059081	Atrovent 17mcg HFA	25.8 grams per 27 days
GSN = 059102	Fentanyl 12mcg/hr patch	10 every 26 days
GSN = 059404	Zoledronic acid 5mg/100ml soln (Reclast)	100 every 355 days
GSN = 060230	Revlimid 5mg capsule	30 per 27 days
GSN = 060231	Revlimid 10mg capsule	30 per 27 days
GSN = 060257	ibandronate 3mg/3ml syringe (Boniva)	1 every 84 days
GSN = 060326	Sutent 12.5mg capsule	30 every 27 days
GSN = 060327	Sutent 25mg capsule	30 every 27 days
GSN = 060328	Sutent 50mg capsule	30 every 27 days
GSN = 061099	Sprycel 20mg tablet	60 every 27 days
GSN = 061100	Sprycel 50mg tablet	30 every 27 days
GSN = 061101	Sprycel 70mg tablet	30 every 27 days
GSN = 061113	Revlimid 15mg capsule	30 per 27 days
GSN = 061114	Revlimid 25mg capsule	30 per 27 days
GSN = 061115	Emend 40mg capsules	4 every 27 days
GSN = 061938	Enbrel 50mg/ml syr (pkg size 0.98)	7.840 every 25 days
GSN = 062240	Pulmicort 90mcg Flexhaler	1 every 24 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 062241	Pulmicort 180mcg Flexhaler	1 every 24 days
GSN = 062444	Thalomid 150mg	30 every 25 days
GSN = 062535	Temodar 140mg	60 every 27 days
GSN = 062536	Temodar 180mg	60 every 27 days
GSN = 062624	Enbrel 25mg/0.5ml syr (pk sz 0.51)	4.080 every 25 days
GSN = 062828	AzaSite 1% ophthalmic drops	2.5 every 30 days
GSN = 063319	Tasigna 200mg	120 every 27 days
GSN = 063885	Treximet 85-500mg tablet	9 every 28 days
GSN = 064161	Sprycel 100mg tablet	30 every 27 days
GSN = 064399	Cefepime 1g injection	1500 every 30 days
GSN = 064400	Cefepime Piggy 2g	3000 every 30 days
GSN = 064410	Hycamtin 0.25mg	20 every 27 days
GSN = 064411	Hycamtin 1mg	20 every 27 days
GSN = 064564	Firazyr 30mg/3ml syr pkg sz 3ml	9 every 25 days
GSN = 064645	Anzemet (dolasetron) 12.5mg vial	5 every 25 days
GSN = 064935	LoSeasonique/Amethia Lo/Camrese Lo tablets	91 every 84 days
GSN = 064994	Afinitor 5mg tablet	30 every 25 days
GSN = 064995	Afinitor 10mg tablet	30 every 25 days
GSN = 065170	Lamotrigine pk (25-50-100 ODT)	35 every 27 days
GSN = 065171	Lamotrigine pk (25-50 ODT)	28 every 27 days
GSN = 065172	Lamotrigine pk (50-100 ODT)	56 every 27 days
GSN = 065254	Lamotrigine pk (25-50 XR)	28 every 27 days
GSN = 065255	Lamotrigine pk (50-100-200 XR)	35 every 27 days
GSN = 065256	Lamotrigine pk (25-50-100 XR)	35 every 27 days
GSN = 065913	Cayston 75mg inhal. soln.	84 every 53 days
GSN = 066336	Lysteda 650mg tablet (tranexamic acid)	30 every 27 days
GSN = 066396	Prolia 60mg/ml syringe	1 every 175 days
GSN = 066453	Tasigna 150mg capsule	120 every 27 days
GSN = 066495	Afinitor 2.5mg tablet	30 every 25 days
GSN = 066968	Sprycel 80mg tablet	60 every 27 days
GSN = 066969	Sprycel 140mg tablet	30 every 27 days
GSN = 067290	Caprelsa 100mg tablet	60 per day 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 067291	Caprelsa 300mg tablet	30 per 27 days
GSN = 067356	Lupron Depot 7.5mg kit	1 every 27 days
GSN = 067506	Lupron Depot 45 (6-month kit)	1 every 175 days
GSN = 067642	Eliquis 2.5mg	60 every 27 days
GSN = 067823	Xalkori 250mg	60 every 27 days
GSN = 067824	Xalkori 200mg	60 every 27 days
GSN = 068167	Jakafi 5mg	60 every 27 days
GSN = 068168	Jakafi 10mg	60 every 27 days
GSN = 068169	Jakafi 15mg	60 every 27 days
GSN = 068170	Jakafi 20mg	60 every 27 days
GSN = 068171	Jakafi 25mg	60 every 27 days
GSN = 068497	Inlyta 1mg	120 every 27 days
GSN = 068498	Inlyta 5mg	120 every 27 days
GSN = 068582	Afinitor 7.5mg	30 every 25 days
GSN = 068980	Revlimid 2.5mg	30 per 27 days
GSN = 069928	Bosulif 100mg	30 every 27 days
GSN = 069929	Bosulif 200mg	30 every 27 days
GSN = 070360	Iclusig 15mg tablet	60 every 27 days
GSN = 070361	Iclusig 45mg tablet	30 every 27 days
GSN = 070386	Cometriq 140mg/day blister card	112 every 26 days
GSN = 070387	Cometriq 100mg/day blister card	56 every 26 days
GSN = 070388	Cometriq 60mg/day blister card	84 every 26 days
GSN = 070414	Eliquis 5mg tablets	74 every 27 days
GSN = 070480	Lupaneta Pack 11.25mg-5mg kit syringe tab	1 every 84 days
GSN = 070481	Lupaneta Pack 3.75mg-5mg kit syringe tab	1 every 27 days
GSN = 070569	Pomalyst 1mg	23 every 25 days
GSN = 070570	Pomalyst 2mg	23 every 25 days
GSN = 070571	Pomalyst 3mg	23 every 25 days
GSN = 070572	Pomalyst 4mg	23 every 25 days
GSN = 070586	Rebif Rebidose 8.8-22 (6) titra pack	4.20 every 25 days
GSN = 070587	Rebif Rebidose 22mcg/0.5ml pens	6 every 25 days
GSN = 070588	Rebif Rebidose 44mcg/0.5ml pens	6 every 25 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 070814	Quartette 0.15mg (91ct) tablets	91 every 84 days
GSN = 070919	Afinitor 2mg tabs-suspension	60 every 25 days
GSN = 070920	Afinitor 3mg tabs-suspension	90 every 25 days
GSN = 070921	Afinitor 5mg tabs-suspension	60 every 25 days
GSN = 071033	Tafinlar 50mg	120 every 25 days
GSN = 071034	Tafinlar 75mg	120 every 25 days
GSN = 071036	Mekinist 0.5mg	90 every 25 days
GSN = 071037	Mekinist 2mg	30 every 25 days
GSN = 071229	Gilotrif 20mg tablet	30 every 25 days
GSN = 071230	Gilotrif 30mg tablet	30 every 25 days
GSN = 071231	Gilotrif 40mg tablet	30 every 25 days
GSN = 071674	Imbruvica 140mg capsule	120 every 25 days
GSN = 072296	Zykadia 150 mg capsules	150 every 25 days
GSN = 073484	Lenvima 24mg/day capsules	90 every 27 days
GSN = 073485	Lenvima 14mg/day capsules	60 every 27 days
GSN = 073486	Lenvima 10mg/day capsules	30 every 27 days
GSN = 073487	Lenvima 20mg/day capsules	60 every 27 days
GSN = 007732	Bactroban Ointment	44 every 27 days
GSN = 007911	Blephamide S.O.P (sulfacetamide/prednisolone)	3.5 every 27 days
GSN = 007914	Blephamide (sulfacetamide/prednisolone) drops	10 every 28 days
GSN = 007988	Tobramycin Sulfate 0.3% ophthalmic drops	10 every 27 days
GSN = 008334	Colchicine 0.6mg tablet (Colcrys)	6 every 27 days
GSN = 008341	Indocin 25mg/5ml susp	300 every 27 days
GSN = 008777	Myleran 2mg	180 every 27 days
GSN = 008831	Lysodren 500mg	1,140 every 27 days
GSN = 008832	Tamoxifen 10mg	90 per 27 days
HSN = 001255	Paregoric liquid	1200 every 30 days
HSN = 001616	Oxazepam 10mg,15mg,30mg capsules (Serax)	120 every 27 days
HSN = 003338	Malathion 0.5% topical lotion (Ovide)	60 every 27 days
HSN = 003924	Emcyt 140mg	30 every 27 days
HSN = 003928	Matulane 50mg capsules	30 every 27 days
HSN = 003933	Flutamide 125mg capsules	180 every 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
HSN = 006041	Hexalen 50mg	126 every 27 days
HSN = 007876	Nilandron 150mg	30 every 27 days
HSN = 010143	Casodex (bicalutamide) 50mg tablet	30 every 27 days
HSN = 010249	Arimidex 1mg	30 per 27 days
HSN = 011632	Fareston 60mg	30 every 27 days
HSN = 012351	Femara 2.5mg	30 per 27 days
HSN = 012998	Imiquimod 5% cream packet (Aldara/Zyclara)	48 every 112 days
HSN = 019858	Xopenex nebs	288 every 27 days
HSN = 020803	Aromasin 25mg	30 every 27 days
HSN = 021103	Synarel 2mg/ml nasal spray	40 every 27 days
HSN = 023438	Butrans patches	4 every 27 days
HSN = 023721	NuvaRing	1 every 21 days
HSN = 024459	Zetia 10mg	30 every 27 days
HSN = 026287	Ventavis 20mcg/2ml & 10mcg/ml ampul neb sol	270 per 27 days
HSN = 026757	Oxycodone-Ibuprofen (Combunox)	120 every 27 days
HSN = 032814	Xopenex HFA	30 every 27 days
HSN = 033400	Nexavar 200mg	120 every 27 days
HSN = 033451	Polyethylene Glycol-electrolyte soln (MiraLAX)	527 every 30 days
HSN = 033510	Emsam patches	30 every 27 days
HSN = 034070	Zolinza 100mg	120 every 27 days
HSN = 034541	Tykerb 250mg	180 per 27 days
HSN = 036709	Votrient 200mg	120 every 27 days
HSN = 036856	Prevnar 13 syringe	0.5 per lifetime
HSN = 036874	Vpriv 400 unit vial (pkg size each)	41 every 25 days
HSN = 037571	Zytiga 250mg	120 every 27 days
HSN = 037609	Victrelis 200mg capsules	3,024 every 355 days
HSN = 037629	Incivek 375mg tablets	504 per lifetime
HSN = 037837	Zelboraf 240mg	240 every 27 days
HSN = 038455	Erivedge 150mg	30 every 27 days
HSN = 038937	Elelyso 200 unit vial (pkg size each)	82 every 25 days
HSN = 039580	Xtandi 40mg	120 every 27 days
HSN = 039665	Stivarga 40mg	120 every 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
HSN = 041672	Savaysa 15, 30 & 60mg tablets	30 every 27 days
HSN = 041725	Ibrance 75, 100, and 125mg capsules	21 every 25 days
HSN = 041794	Farydak 10, 15 and 20mg capsules	6 every 18 days
HICL = 034708 (and package size = 15 and Generic Named Drug Cd = 2-Brand) FLALTABAXQT	Altabax 1% ointment	15 every 27 days
GSN = 051649, 059328, 059327, 059326, 064010, 064012 FLASMANEXQL	Asmanex 110 and 220mcg	1 every 27 days
HSN = 011253 and GSN 049812 FLAVONEXQL	Avonex prefilled syringe 30mcg (4 count) and Avonex Admin pack 30mcg vial (4 count)	4 every 24 days
TC = 17 (Limitation will apply to Rx required products with a dosage form of Drops, Elixir, Liquid, Oral Suspension, Solution, Sus 12H, and Syrup) FLCOUGHII	Cough Preparations/Expectorants	300 every 27 days
TC = 16 (Limitation will apply to Rx required products with a dosage form of Drops, Elixir, Liquid, Oral Susp, Solution, Sus 12H, and Syrup) FLCOUGHQTY	Antitussives – expectorants; Cough and Cold Preparations	Limitation: 300 every 27 days
GSN = 067737, 067738 FLCPPLUP1	Lupron Depot Ped 30mg 3 month kit, Lupron Depot Ped 11.25mg 3 month	1 every 84 days
GSN = 047665, 047666, 047851 FLCPPLUP2	Lupron Depot Ped 11.25 kit, Lupron Depot Ped 7.5 kit , Lupron Depot Ped 15mg kit	1 every 23 days
HSN = 003897 (excluding GSNs 040162, 040163, 040164) FLDL90P27	Hydrea 500mg	90 per 27 days
HSN = 003908 (excluding GSN 52090) FLDL90P27B	Purinethol 50mg	90 per 27 days
HSN = 001854, 001713, 001790, 001699, 001858 (excluding GSN 052031) FLDLQ120355	Butalbital-APAP-Caffeine	120 every 355 days (Internal error code 7001) 240 every 355 days (Internal error code 7002)
GSN = 040221, 040222, 040223, 040224 FLDLQ12281	Maxalt	12 every 28 days
GSN = 053612, 051601 FLDLQ1271	Pegasys	1 every 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 028090 and package size = 6.7g FLDLQ13427D	Albuterol HFA	13.4 every 27 days
GSN = 028090 and package size = 7g FLDLQ1427	Albuterol HFA	14 every 27 days
GSN = 028090 and package size = 8g FLDLQ1627	Albuterol HFA	16 every 27 days
GSN = 068384, 069123 FLDLQ16VP25	Berinert 500 (10ml) kit/vial	16 every 25 days
GSN = 028090 and package size = 8.5g FLDLQ1727	Albuterol HFA	17 every 27 days
NDC-9 = 679790500, 555920500 FLDLQ1P355	Vantas 50mg kit (must bill physician services)	1 every 355 days
GSNs = 043899, 065578, 058193 FLDLQ227	Plan B, Ella, Aftera, Econtra EZ, Fallback Solo, My Way, Next Choice One, Opcicon One-Step, Plan B One-Step, Take action	2 every 27 days
GSNs = 016878, 016879, 062449, 062448, 065912, 065145 and package size = 2 FLDLQ2271	EpiPen, EpiPen Jr., Epinephrine, Adrenaclick, Twinject	4 every 27 days (2 kits)
HSN = 001854, 001713, 001790, 001699, 001858 (excluding GSN 052031) FLDLQ240365	Butalbital-APAP-Caffeine	240 every 355 days (Internal error code 7002) 120 every 355 days (Internal error code 7001)
GSN = 034015, 059781, and 059782 FLDLQ2PER27	Diastat 2.5, 5–7.5–10 and 12.5–15–20 kit	2 every 27 days
GSNs = 067760, 067761, 067762, 063422, 063423, 063424, 060274, 043536, 043537, and 068721 FLDLQ30P27	ConZip ER, Ryzolt ER, Ultram ER and Tramadol ER	30 per 27 days
GSNs = 007012, 007013 and pkg size = 30 FLDLQ30P30	Premarin vag cream (30g package size only)	30 per 27 days
GSNs = 060499, 060500 FLDLQ327	Imitrex 4mg/0.5ml pen inject and cartridges	3ml per 27 days
GSNs = 019192, 019193, 019239 FLDLQ3282	Imitrex 6mg/0.5ml syringe kit, vial, and cartridges	3ml per 27 days
GSN = 052031 FLDLQ360365	Alagesic LQ (Butalbital-APAP-Caff)	360 every 355 days
GSN = 028090 and package size = 18g FLDLQ3627	Albuterol HFA	36 every 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 034748, 052943 FLDLQ40271	Aloxi 0.25 mg/5ml vial, Anzemet 20mg/ml	40 every 27 days
GSNs = 016878, 016879, 062449, 062448, 065912, 065145 and package size = 1 FLDLQ4271	EpiPen, EpiPen Jr., Epinephrine, Adrenaclick, Twinject	4 every 27 days
HIC3 = H2E (excluding GSNs 003753, 003754, 003755, 003756, 044671, 064334, 064672, 064687, 066565, 068445, 068460, 070876, 070877) FLDLQ45251	Sedative-Hypnotics, Non-Barbiturate	45 every 25 days
GSN = 008078, 008079 FLDLQ50271	Beconase AQ 0.042%/ nasal spray, Flunisolide 0.025% nasal spray	25 every 27 days
HSN = 001396 FLDLQ540027	Lactulose	5400 every 27 days
GSN = 021592, 021693, 063545 FLDLQ8271	Granisetron 1mg tablet, 1mg/ml vial	8 every 27 days
HIC3 = C4G and dosage Form Cd = vial FLDLQ7027	Insulin vials	70 every 27 days
GSN = 031492, 038275, 017129, 022479, 023799, 048986 FLDLQ9281	Amerge tablets, Imitrex tablets, and Frova tablets	9 every 27 days
GSN = 030735, 030742, 031027, 037036, 044662, 047424, 048155, 048643, 049605, 049606, 051639 FLDQ6282	Imitrex nasal spray, Zomig nasal spray, Zomig tablets, Zomig ZMT tablets, Axert tablets, and Relpax	6 every 27 days
HIC3 = C4G and dosage Form Cd = cartridge or pen FLINSULIN	Insulin pens/cartridges	
GSNs = 052882, 067628 FLMAXQTY126	Avonex 30mcg/0.5ml kit and pen inj kit	1 kit per 26 days
GSNs = 053430, 069046 FLMAXQTY226	Avonex 30mcg/0.5ml disp syr and pen inj	2ml per 26 days
HICL = 004212 and patient age >/= 50 and patient age </=64 FLPNEUMOVA1	Pneumovax	0.5 every 1825 days
HICL = 004212 and patient age >/=65 FLPNEUMOVA2	Pneumovax	0.5 per lifetime
GSN = 053152 and patient age < 16 FLRYBIXL16	Tramadol HCL	60 every 27 days

Maximum Duration (Quantity): Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSN = 004661, 004662, 004663, 048518, 063097 FLSOMAQTY	Soma	120 every 365 days
GSN = 023139 and patient age < 16 FLTRAMADL16	Tramadol HCL 50mg tablet	60 every 27 days
NDC11 = 13533063102	HyperRHO 1500 units syr	2 every 365 days
NDC11 = 13533063106	HyperRHO 250 units syr	2 every 365 days

Maximum duration (number of scripts): Deny if exceeded for designated number of scripts per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
HICL = 019963	Advair Diskus 100/50, 250/50, and 500/50 Advair HFA inhaler 115-21, 230-21, 45-21	1 fill every 27 days
HICL = 034708 (and package size = 15 and Generic Named Drug Cd = 2-Brand)	Altabax 1% 15gm oint	2 fills every 60 days
HICL = 037011	Arcapta	1 fill every 27 days
HICL = 034087	Brovana	1 fill every 27 days
HICL= 023438	Butrans 5, 10, and 20 mcg/hr patch	1 fill every 27 days
GSN = 027905	Helidac (Bismuth Sal/Metronid/Tetracyc)	1 fill every 365 days
GSN = 008779	CeeNU 10mg	6 capsules per fill; 1 fill every 39 days
GSN = 008781	CeeNU 10mg	6 capsules per fill; 1 fill every 39 days
GSN = 008780	CeeNU 40mg	6 capsules per fill; 1 fill every 39 days
HICL = 035554	Cimzia 200mg/ml	1 fill every 25 days
HICL = 037050	Dulera	1 fill every 27 days
HICL = 010747	Foradil/Perforomist	1 fill every 27 days
GSN = varies per year	Influenza	1 Rx every 365 days
HICL = 003338	Malathion/Ovide 0.5% lotion	2 fills every 60 days
HICL = 007625	Paclitaxel, Semi-Synthetic	1 fill every 5 days
HICL = 004212	Pneumovax	2 fills per lifetime

Maximum duration (number of scripts): Deny if exceeded for designated number of scripts per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
GSNs = 043119	Relenza 5mg Diskhaler	2 fills every 365 days
HICL = 021993	Symbicort 80-4.5 and 160-4.5mcg inhaler	1 fill every 27 days
GSNs = 043706, 063223, 063224, 047429, 043119, 067561 (List ID FLQLRX2365)	Tamiflu 30, 45, and 75mg cap, 6mg/ml and 12mg/ml susp	2 Rxs every 355 days
GSN = 035383	Vagifem 25mcg vaginal tablets	1 fill every 26 days
GSNs = 065966	Vagifem 10mcg tab	1 fill every 26 days
HICL = 004209 and 033506 (List ID FLMAXFILL3)	WinRho/HyperRHO	2 fills every 365 days
GSN = 060910	Zostavax vial	1 fill every lifetime
HSN = 001949, 001941, 001950, 001906, 001945, 001938, 011582 and Route of Admin = Oral and day supply >/= 30	Skeletal Muscle Relaxants: ☐ Baclofen 10mg, 20mg tablets ☐ Chlorzoxazone 250mg, 500mg tabs ☐ Flexeril 5mg, 7.5mg, 10mg tabs ☐ Amrix 15mg, 30mg caps ER ☐ Fexmid 7.mg tablets ☐ Orphenadrine ER 100 mg ☐ Skelaxin 400mg, 800mg tabs ☐ Robaxin 500mg, 750mg tablets ☐ Zanaflex 2mg, 4mg, 6mg cap/tabs	6 fills every 365 days EXCLUDING drugs in HSN 001949 (Baclofen) or HSN 001949 (Zanaflex) that have a diagnosis listed below, in history, within the past 730 days: 343.0-343.9 (Infantile Cerebral Palsy) 342.00-342.92 (Hemiplegia/Hemiparesis) 334.0-334.9 (Spinocerebellar disease) 438.20-438.22 (Hemiplegia/Hemiparesis) 438.30-438.32 (Monoplegia of upper limb) 438.40-438.42 (Monoplegia of lower limb)\ 438.50-438.53 (Other paralytic syndrome) 438.9 (other late effects of cerebrovascular disease) 340 (Multiple sclerosis) 341.0-341.9 (Other demyelinating diseases of central nervous system) 781.7 (Tetany) 952.0-952.9 (Spinal Cord Injury without evidence of spinal bone injury) or 335.20-335.29 (Motor Neuron disease)

Limitation Days Supply: Deny if accumulated days supply is exceeded per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	
HICL = 039945	Lupaneta Pack11.25mg-5mg kit syringe tab Lupaneta Pack 3.75mg-5mg-kit syringe tab	365 days supply per lifetime

MAXIMUM DURATION CII-CV (NUMBER OF SCRIPTS)

Deny if exceeded for designated 4 fills per rolling 27 days. NCPDP EC #76 – *Plan Limitations Exceeded*.

Sickle cell and cancer patients with an active ICD-9 code in medical claims history (within 365 days from the DOS of the incoming claim) of 140-239.9 or 282.4-282.9 are allowed 6 RXs every 27 days.

Drug Code	Description
HIC3 = H3A (and DEA Code = II)	Narcotic Analgesics
HIC3 = H2X (excluding HSN = 001656)	Tricyclic Antidepressant/Benzodiazepine Combinations
HIC3 = H3W	Narcotic Withdrawal Therapy Agents
HIC3 = H2E (excluding HSNs = 004480, 004482 and 001586)	Sedative-Hypnotics, Non-Barbiturate
HIC3 = H2F (excluding HSN = 001620)	Anti-Anxiety Drugs
HSN = 000206	Guaifenesin/Codeine Phos
HSN = 000209	Guaifenesin/Hydrocodone BIT
HSN = 000347	Chlorpheniramine
HSN = 000349	Hydrocodone BIT/Homatropine
HSN = 000352	Hydrocodone/Chlorphen Polis
HSN = 000419	Phenyleph/Codeine/Acetaminp/CP
HSN = 000422	Phenyleph/Hydocodon/Acetaminp/CP
HSN = 000486	Pseudoephedrine HCL/Codeine
HSN = 001699	Codeine/Butalbital/ASA/Caffeine
HSN = 001702	Cod/ASA/Salicylmd/Acetamn/Caff
HSN = 001711	Aspirin/Codeine Phosphate
HSN = 001713	Codeine/Butalbit/Acetamin/Caff
HSN = 001717	Acetaminophen With Codeine
HSN = 001720	Codeine Phos/Carisoprodol/ASA
HSN = 001727	Hydrocodone Bit/Aspirin
HSN = 001730	Hydrocodone Bit/Acetaminophen
HSN = 001734	Dihydrocodeine/Aspirin/Caffeine
HSN = 001739	Dhcodeine Bt/Acetaminophen/Caff
HSN = 001777	Butorphanol Tartrate
HSN = 001779	Pentazocine HCL/Aspirin
HSN = 001780	Pentazocine HCL/Acetaminophen

Drug Code	Description
HSN = 001781	Pentazocine HCL/Naloxone HCL
HSN = 001782	Pentazocine Lactate
HSN = 001790	Butalbital/Aspirin/Caffeine
HSN = 001871	Isomethept/Acetaminop/Dichlphn
HSN = 001894	Clonazepam
HSN = 001942	Carisoprodol / Aspirin
HSN = 001944	Carisoprodol
HSN = 014296	Hydrocodone/Ibuprofen
HSN = 023438	Buprenorphine
HSN = 026470	Pregabalin
HSN = 034574	Dihydrocodeine/Aspirin/Caffeine
HSN = 035174	P-Ephed HCL/Codeine/Guaifen
HSN = 000347	Chlorpheniramine/Codeine Phos
HSN = 000206	Guaifenesin/Codeine Phosphate
HSN = 000209	Guaifenesin/Hydrocodone
HSN = 000352	Hydrocodone/Chlorphen Polis
HSN = 000349	Hydrocodone/Homatropine
HSN = 000419	PE/Codeine/Acetaminophen/CPM
HSN = 000422	PE/Hydrocodone/Acetaminophen/CPM
HSN = 000486	Pseudoephedrine HCL/Codeine
HSN = 026757	Ibuprofen/Oxycodone HCL
HSN = 001235	Diphenoxylate HCL/Atropine
HSN = 001561	Phenobarbital
HSN = 001619	Midazolam
HSN = 001682	Methylphenidate HCL
HSN = 001955	Dronabinol
HSN = 001865	Acetaminophen/Phenyltolx CIT
HSN = 013449	Dextroamphetamine/Amphetamine
HSN = 035019	Phenobarb/Hyoscy/Atropine/Scop
HSN = 001249	Difenoxin HCL/Atropine Sulfate
HSN = 001255	Paregoric
HSN = 001519	Cocaine HCL
HSN = 001552	Methohexital Sodium
HSN = 001555	Ketamine HCL
HSN = 001560	Phenobarbital Sodium
HSN = 001564	Amobarbital Sodium
HSN = 001566	Butabarbital Sodium
HSN = 001568	Pentobarbital Sodium

Drug Code	Description
HSN = 001570	Secobarbital Sodium
HSN = 001574	Butalbital
HSN = 001578	Chloral Hydrate
HSN = 001516	Diazepam
HSN = 001617	Alprazolam
HSN = 001687	Meperidine
HSN = 001694	Morphine Sulfate
HSN = 001695	Hydromorphone HCL
HSN = 001721	Codeine Phosphate
HSN = 001731	Hydrocodone Bitartrate
HSN = 001742	Oxycodone HCL
HSN = 001743	Levorphanol Tartrate
HSN = 001745	Methadone HCL
HSN = 001747	Fentanyl Citrate
HSN = 001749	Sufentanil Citrate
HSN = 001750	Alfentanil HCL
HSN = 001956	Nabilone
HSN = 002065	Dextroamphetamine Sulfate
HSN = 002067	Methamphetamine HCL
HSN = 002070	Benzphetamine HCL
HSN = 002111	Phentermine HCL
HSN = 002113	Diethylpropion HCL
HSN = 002115	Phendimetrazine Tartrate
HSN = 004741	Dichloralphenazone
HSN = 004846	Lorazepam
HSN = 006438	Fentanyl
HSN = 010329	Midazolam
HSN = 011931	Remifentanil HCL
HSN = 012346	Sodium Oxybate
HSN = 022987	Dexmethylphenidate HCL
HSN = 023438	Buprenorphine
HSN = 024523	Midazolam HCL in 0.9% NACL
HSN = 025386	Fentanyl Citrate/PF
HSN = 025608	Dihydrotestosterone Propionate
HSN = 033311	Androstenedione
HSN = 033556	Methylphenidate
HSN = 034486	Lisdexamfetamine Dimesylate

Drug Code	Description
HSN = 034868	Armodafinil
HSN = 034908	Midazolam HCL/PF
HSN = 036076	Ketamine HCL in 0.9% NACL
HSN = 037358	Phenobarbital/0.9% Sod Chlor
HSN = 037590	IOFLUPANE I 123
HSN = 037726	MethoHexital in Water/PF
HSN = 037909	Midazolam in D5W
HSN = 038148	Midazolam in D5W/PF
HSN = 038614	Midazolam in 0.9% NACL/PF
HSN = 038867	Sufentanil Citrate/PF
HSN = 038961	OPIUM/Tincture
HSN = 039347	Phentermine/Topiramate
HSN = 0340373	Lorcaserin HCL
TC = 16 (CIII-V products with the dosage form of drops (SO), elixir (SE), liquid (SL), oral susp (SC), solution (SJ), sus 12H Sr (PJ), syrup (ST))	Cough Preparation/Expectorants
TC = 17 (CIII-V products with the dosage form of drops (SO), elixir (SE), liquid (SL), oral susp (SC), solution (SJ), sus 12H Sr (PJ), syrup (ST))	Cough and Cold Preparations

MAXIMUM DAILY DOSE LIMITATIONS

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 027962	Accolate 20mg tablet	3
GSN = 064994	Afinitor 5mg	1
GSN = 066495	Afinitor 2.5mg	1
GSN = 068582	Afinitor 7.5mg	1
GSN = 064995	Afinitor 10mg	1
GSN = 070919	Afinitor 2mg tabs-suspension	2
GSN = 070920	Afinitor 3mg tabs-suspension	3
GSN = 070921	Afinitor 5mg tabs-suspension	2
GSN = 021523	Alprazolam Intensol 1mg/ml oral conc	6
GSN = 025181	Amaryl (glimepiride) 4mg tablet	2
GSN = 068035	Aquadeks Softgel	2
GSN = 066852	Aquadeks chewable tablet	2
HSN = 010249	Arimidex 1mg	1

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
HSN = 020803	Aromasin 25mg	1
GSN = 003757	Ativan 0.5mg tablet (Lorazepam)	5
GSN = 003758	Ativan 1mg tablet (Lorazepam)	5
GSN = 003759	Ativan 2mg tablet (Lorazepam)	5
GSN = 016363	Ativan 2mg/ml oral conc (Lorazepam Intensol	5
GSN = 069928	Bosulif 100mg	1
GSN = 069929	Bosulif 200mg	1
GSN = 067290	Caprelsa 100mg	2
GSN = 067291	Caprelsa 300mg	1
HSN = 010143	Casodex 50mg (Bicalutamide)	1
GSN = 016584	Cefprozil 250mg tab	4
GSN = 016583	Cefprozil 250mg/5ml Susp	20
GSN = 009162	Ceftriaxone 1 gm vial (Rocephin)	2
GSN = 009163	Ceftriaxone 10 gm vial (Rocephin)	2
GSN = 009164	Ceftriaxone 2 gm vial (Rocephin)	2
GSN = 009165	Ceftriaxone 250 mg vial (Rocephin)	2
GSN = 009166	Ceftriaxone 500 mg vial (Rocephin)	2
GSN = 020957	(ceftriaxone sodium/lidocaine) Rocephin 1 gm kit	2
GSN = 020958	(ceftriaxone sodium/lidocaine) Rocephin 500mg kit	2
GSN = 041285	Celebrex 100mg capsules	2
GSN = 041286	Celebrex 200mg capsules	2
GSN = 050832	Celebrex 400mg capsules	2
GSN = 062001	Celebrex 50mg capsules	2
GSN = 046205	Celexa Solution	30
GSN = 046206	Celexa 10mg tablet (Citalopram)	1
GSN = 046203	Celexa 20mg tablet (Citalopram)	1.5
GSN = 046204	Celexa 40mg tablet (Citalopram)	1
GSN = 009046	Cephalexin Suspension 250mg/5ml	80
HSN = 041346	Cerdelga 84mg capsules	2
HSN = 033766	Chantix	2
GSN = 003736	Chlordiazepoxide HCL 5mg capsule	4
GSN = 003734	Chlordiazepoxide HCL 10mg capsule	4

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 003735	Chlordiazepoxide HCL 25mg capsule	4
GSN = 075138	Cotellic 20mg tablets	3
GSN = 067680	Complera	1
GSN = 041199	Comtan	8
GSN = 067760	ConZip ER 100mg	1
GSN = 067761	ConZip ER 200mg	1
GSN = 067762	ConZip ER 300mg	1
GSN = 006559	Coumadin 10mg (Warfarin)	4
GSN = 006561	Coumadin 2mg (Warfarin)	4
GSN = 014198	Coumadin 1mg (Warfarin)	4
GSN = 006562	Coumadin 5mg (Warfarin)	4
GSN = 006560	Coumadin 2.5mg (Warfarin)	4
GSN = 006563	Coumadin 7.5mg (Warfarin)	4
GSN = 018080	Coumadin 3mg (Warfarin)	4
GSN = 019486	Coumadin 4mg (Warfarin)	4
GSN = 030475	Coumadin 6mg (Warfarin)	4
HSN = 025673	Cubicin 500 mg vial (pkg size 1 vial)	2
HSN = 026521	Cymbalta capsules	2
GSN = 004053	Demerol 50mg	24
GSN = 004052	Demerol 100mg	12
GSN = 003766	Diazepam 10mg tablet	4
GSN = 003767	Diazepam 2 mg tablet	4
GSN = 003768	Diazepam 5 mg tablet	4
GSN = 003764	Diazepam solution	40
GSN = 003765	Diazepam Intensol solution 5mg/ml	8
GSN = 004722	Diclegis 10m-10mg tablets DR	4
GSN = 067413	Edurant tablet	1
HSN = 036159	Effient	1
GSN = 067642	Eliquis 2.5mg tablet	2
GSN = 070414	Eliquis 5mg tablet	4
GSN = 073302	Embeda 20 - 0.8mg ER capsules	2
GSN = 073303	Embeda 30 - 1.2mgER capsules	2

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 073304	Embeda 50 - 2mgER capsules	2
GSN = 073305	Embeda 60 – 2.4mg ER capsules	2
GSN = 073306	Embeda 80 – 3.2mg ER capsules	2
GSN = 073307	Embeda 100 – 4mg ER capsules	2
GSN = 008838	Etoposide 50mg capsules	8
HSN = 038455	Erivedge 150mg	1
NDC-9 = 005178571	Ethanol (Ethyl Alcohol, Dehydrated) 98% ampul	1
GSN = 011677	Famotidine (Pepcid)	2
GSN = 011678	Famotidine (Pepcid)	2
HSN = 011632	Fareston 60mg	1
HSN = 012351	Femara 2.5mg	1
HSN = 003933	Flutamide 125mg	6
GSN = 071229	Gilotrif 20mg	1
GSN = 071230	Gilotrif 30mg	1
GSN = 071231	Gilotrif 40mg	1
GSN = 047895	Gleevec 100mg capsules	3
GSN = 052712	Gleevec 100mg tablet	3
GSN = 052711	Gleevec 400mg tablet	2
NDC = 5226807001	GoLYTELY packets	1
GSN = 030763	Granisol (Granisetron) 1mg/5ml oral soln	2.963
GSN = 027905	Helidac	16
HSN = 041725	Ibrance 75, 100, & 125mg capsules	1
GSN = 070360	Iclusig 15mg tablet	2
GSN = 070361	Iclusig 45mg tablet	1
GSN = 071674	Imbruvica 140mg capsule	4
HICL = 037629	Incivek	6
GSN = 041445	Interferon Alfacon-1 9mcg/0.3ml vial	0.3
GSN = 041650	Interferon Alfacon-1 15mcg/0.5ml vial	0.5
GSN = 068497	Inlyta 1mg	4
GSN = 068498	Inlyta 5mg	4
GSN = 052086	Iressa 250mg tablet	2
GSN = 068167	Jakafi 5mg tablet	2

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 068168	Jakafi 10mg tablet	2
GSN = 068169	Jakafi 15mg tablet	2
GSN = 068170	Jakafi 20mg tablet	2
GSN = 068171	Jakafi 25mg tablet	2
GSN = 016404	Ketorolac Tromethamine	4
GSN = 004560	Klonopin (Clonazepam) 0.5mg	3
GSN = 004561	Klonopin (Clonazepam) 1mg	3
GSN = 004562	Klonopin (Clonazepam) 2mg	3
GSN = 051983	Klonopin (Clonazepam) 0.125mg	3
GSN = 051984	Klonopin (Clonazepam) 0.25mg	3
GSN = 051985	Klonopin (Clonazepam) 0.5mg	3
GSN = 051986	Klonopin (Clonazepam) 1mg	3
GSN = 018638	Lamisil	1
GSN = 030107	Lansoprazole DR 30mg capsule (Prevacid DR)	2
GSN = 053076	Levonorgestrel-Eth Estra 0.15-0.03 mg tablet (Jolessa, Introvale, Quasense)	1
GSN = 051698	Lexapro Solution	20
GSN = 050712	Lexapro 10mg tablet	1
GSN = 050760	Lexapro 20mg tablet	1
GSN = 051642	Lexapro 5mg tablet	1
GSN = 029967	Lipitor 10mg tablet	1
GSN = 029968	Lipitor 20mg tablet	1
GSN = 029969	Lipitor 40mg tablet	1
GSN = 045772	Lipitor 80mg tablet	1
GSN = 066349	Livalo 1mg tablet	1
GSN = 066350	Livalo 2mg tablet	1
GSN = 066351	Livalo 4 mg tablet	1
GSN = 074822	Lonsurf 20-8.19mg Tablets	8
GSN = 074821	Lonsurf 15-6.14mg Tablets	8
GSN = 018698	Loratadine 10mg tablet	1
GSN = 073234	Lynparza 50mg capsules	16
HICL = 026793	Omega-3 Acid Ethyl Esters 1 G Capsule (Lovaza)	4
GSN = 019331	Lovenox 30mg / 0.3ml syringe	0.6

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 039482	Lovenox 40mg / 0.4ml syringe	0.8
GSN = 027993	Lovenox 60mg / 0.6ml syringe	1.2
GSN = 027994	Lovenox 80mg / 0.8ml syringe	1.6
GSN = 044669	Lovenox 120mg / 0.8ml syringe	1.6
GSN = 044668	Lovenox	2
GSN = 027995	Lovenox	2
GSN = 038895	Lovenox 300mg / 3ml syringe	3
GSN = 008831	Lysodren 500mg (mitotane)	38
GSN = 040974	Metformin 1,000mg tablet	2.5
GSN = 016441	Metformin 850mg tablet	3
GSN = 013318	Metformin 500mg tablet	5
GSN = 046754	Metformin XR 500mg tablet	5
GSN = 052080	Metformin ER 750mg	3.5
GSN = 008777	Myleran 2mg	6
HSN = 033400	Nexavar 200mg	4
HSN = 007876	Nilandron 150mg	1
GSN = 000465	Nitroglycerin 0.4mg/HR patch	1
GSN = 000466	Nitroglycerin 0.6mg/HR patch	1
GSN = 000475	Nitroglycerin SL tablets	16
GSN = 011679	Nizatidine 150mg capsule	2
GSN = 074547	Odomzo 200mg capsules	1
GSN = 003180	Oxandrolone 2.5mg tablet	8
HICL = 001616	Oxazepam 15mg Tab	4
GSN = 071036	Mekinist 0.5mg	3
GSN = 071037	Mekinist 2mg	1
GSN = 004225	Oxycodone HCL 5mg tablet	12
GSN = 024507	Oxycodone HCL 5mg capsule	12
GSN = 004224	Oxycodone HCL 5mg/5ml soln	60
GSN = 068467	Oxecta 7.5mg tablet (Oxycodone HCL)	8
GSN = 013467	Oxycodone HCL 10mg tablet	6
GSN = 046474	Oxycodone HCL 15mg tablet	6
GSN = 046475	Oxycodone HCL 30mg tablet	6

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 045298	Oxycodone HCL 20mg tablet	9
GSN = 015065	Oxycodone HCL 20mg/ml oral conc	9
GSN = 024504 / 072862	OxyContin 10mg tablet	2
GSN = 063515 / 072863	OxyContin 15mg tablet	2
GSN = 024505 / 072864	OxyContin 20mg tablet	2
GSN = 063516 / 072865	OxyContin 30mg tablet	2
GSN = 024506 / 072866	OxyContin 40mg tablet	2
GSN = 063517 / 072867	OxyContin 60mg tablet	2
GSN = 025702 / 072868	OxyContin 80mg tablet	4
HSN = 026757	Combunox (Oxycodone-Ibuprofen)	4
GSN = 027462	Pantoprazole Sod DR 40mg tab (Protonix DR)	2
GSN = 046222	Paxil 10mg tablet (Paroxetine HCL)	2
GSN = 046223	Paxil 20mg tablet (Paroxetine HCL)	2
GSN = 046224	Paxil 30mg tablet (Paroxetine HCL)	2
GSN = 046225	Paxil 40mg tablet (Paroxetine HCL)	2
GSN = 025301	Paxil 40mg tablet (Paroxetine HCL)	2
GSN = 050137	Paxil CR 12.5mg tablet (paroxetine)	1
GSN = 050136	Paxil CR 25mg tablet (paroxetine)	2
GSN = 050138	Paxil CR 37.5mg (paroxetine)	2
GSN = 013998	Percocet 2.5/325 (Oxycodone HCL/Acetaminophen)	12
GSN = 004222	Percocet 5/325 (Oxycodone HCL/Acetaminophen)	12
GSN = 048976	Percocet 7.5/325 (Oxycodone HCL/Acetaminophen)	12
GSN = 048977	Percocet 10/325 (Oxycodone HCL/Acetaminophen)	12
GSN = 070569	Pomalyst 1mg	1
GSN = 070570	Pomalyst 2mg	1
GSN = 070571	Pomalyst 3mg	1
GSN = 070572	Pomalyst 4mg	1
GSN = 040906	Premphase 0.625-5mg tablet	1
GSN = 022647	Prempro 0.625-5mg tablet	1
GSN = 022648	Prempro 0.625-2.5mg tablet	1
GSN = 051653	Prevacid 15mg SoluTab	3
GSN = 037219	Prevpac 30-500-500mg combo pkg	8

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 043136	Prilosec DR 10mg capsule (Omeprazole Dr)	2
GSN = 033530	Prilosec DR 20mg capsule (Omeprazole DR)	2
GSN = 043137	Prilosec DR 40mg capsule (Omeprazole Dr)	2
GSN = 054334	Prilosec DR 20mg capsule (Omeprazole DR)	2
GSN = 013009	Prilosec 20mg capsule (Omeprazole)	2
GSN = 021222	Prilosec 40mg capsule (Omeprazole)	2
GSN = 022270	Prilosec 10mg capsule (Omeprazole)	2
GSN = 009364	Primaxin 250mg vial (imipenem-cilastatin)	16
GSN = 059876	Primaxin 250mg vial	16
GSN = 059877	Primaxin 500mg vial	8
GSN = 009365	Primaxin 500mg vial (imipenem-cilastatin)	8
GSN = 015907	Primaxin I.M. 500mg vial	3
HICL = 035420	Pristiq	1
GSN = 046525	Pulmicort 0.25mg/2ml ampul-neb (budesonide)	4 (2 ampules per day)
GSN = 046526	Pulmicort 0.5mg/2ml ampul-neb (budesonide)	4 (2 ampules per day)
GSN = 018165	Pulmicort 1mg/2ml ampul-neb (budesonide)	4 (2 ampules per day)
GSN = 021416	Pulmozyme	5 (2 ampules per day)
GSN = 040941	Rabeprazole Sod DR 20mg tab (Aciphex DR)	2
GSN = 011674	Ranitidine 300mg tablet (Zantac)	2
GSN = 016224	Ranitidine 300mg capsules	2
GSN = 023987	Ranitidine Bismuth Citrate 4000mg tablet (Tritec)	2
GSN = 060230	Revlimid 5mg	1
GSN = 060231	Revlimid 10mg	1
GSN = 061113	Revlimid 15mg	1
GSN = 061114	Revlimid 25mg	1
GSN = 068980	Revlimid 2.5mg	1
GSN = 004886	Robinul vial (glycopyrrolate)	30
GSN = 004221	Roxicet 5-325/5ml oral soln	60
GSN = 067598	Ruconest	2
GSN = 053152	Rybix ODT 50mg	8
GSN = 065537	Saphris	2
GSN = 065538	Saphris	2

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
HSN = 041672	Savaysa 15, 30 & 60mg tablets	1
GSN = 016576	Simvastatin 5mg tablet (Zocor)	2
GSN = 066980	SourceCF 0.2mg-15mg Softgel	2
GSN = 067025	SourceCF 1000-800 chew tab	2
GSN = 016949	Sporanox 100mg capsule (itraconazole)	6
GSN = 061100	Sprycel 50mg	1
GSN = 061101	Sprycel 70mg	1
GSN = 064161	Sprycel 100mg	1
GSN = 066969	Sprycel 140mg	1
GSN = 061099	Sprycel 20mg	2
GSN = 066968	Sprycel 80mg	2
HSN = 039665	Stivarga 40mg	4
GSN = 069883	Stribild	1
GSN = 060326	Sutent 12.5mg	1
GSN = 060327	Sutent 25mg	1
GSN = 060328	Sutent 50mg	1
GSN = 071671	Sutent	1
GSN = 053400	Symbyax 6mg-25mg capsule	1
GSN = 053401	Symbyax 6mg-50mg capsule	1
GSN = 053402	Symbyax 12mg-25mg capsule	1
GSN = 053403	Symbyax 12mg-50mg capsule	1
GSN = 071033	Tafinlar 50mg	4
GSN = 071034	Tafinlar 75mg	4
GSN = 008832	Tamoxifen 10mg	3
GSN = 013574	Tamoxifen 20mg	2
GSN = 058376	Tarceva 25mg	1
GSN = 058375	Tarceva 100mg	1
GSN = 058374	Tarceva 150mg	1
GSN = 066453	Tasigna 150mg	4
GSN = 063319	Tasigna 200mg	4
GSN = 040296	Thalomid 50mg	1
GSN = 040279	Thalomid 100mg	1

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 062444	Thalomid 150mg	1
GSN = 051879	Thalomid 200mg	2
GSN = 063422	Tramadol ER 100mg (Ryzolt ER)	1
GSN = 063423	Tramadol ER 200mg (Ryzolt ER)	1
GSN = 063424	Tramadol ER 300mg (Ryzolt ER)	1
GSN = 068721	Tramadol HCL ER 150mg capsule	1
GSN = 005098	Trandate 100mg tablet (labetalol HCl)	8
GSN = 005099	Trandate 200mg tablet (labetalol HCl)	8
GSN = 005100	Trandate 300mg tablet (labetalol HCl)	8
GSN = 003745	Tranxene 3.75mg tablet (clorazepate)	4
GSN = 003746	Tranxene 7.5mg tablet (clorazepate)	4
GSN = 003744	Tranxene 15mg tablet (clorazepate)	4
HSN = 041076	Tybost 150mg tablets	1
HSN = 034541	Tykerb 250mg	6
GSN = 004163	Tylenol #2 (Acetaminophen- Codeine 300mg-15mg)	12
GSN = 004165	Tylenol #3 (Acetaminophen- Codeine 300mg-30mg)	12
GSN = 004169	Tylenol #4 (Acetaminophen- Codeine 300mg-60mg)	12
HSN = 022880	Ultracet 37.5-325mg	8
GSN = 023139	Ultram (tramadol)	8
GSN = 060274	Ultram ER 100mg tablet (tramadol ER)	1
GSN = 043536	Ultram ER 200mg tablet (tramadol ER)	1
GSN = 043537	Ultram ER 300mg tablet (tramadol ER)	1
GSN = 060338	Vicodin 5/300mg (Hydrocodone/Acetaminophen)	8
GSN = 060533	Vicodin 7.5/300mg (Hydrocodone/Acetaminophen)	6
GSN = 057726	Vicodin HP 10/300mg (Hydrocodone/Acetaminophen	6
HSN = 037609	Victrelis 200mg capsule	12
HSN = 036709	Votrient 200mg tablet	4
GSN = 067823	Xalkori 250mg capsule	2
GSN = 067824	Xalkori 200mg capsule	2
GSN = 003773	Xanax 0.25 mg tablet (Alprazolam)	5
GSN = 003774	Xanax 0.5 mg tablet (Alprazolam)	5
GSN = 003775	Xanax 1 mg tablet (Alprazolam)	5

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 015566	Xanax 2 mg tablet (Alprazolam)	5
GSN = 058847	Niravam ODT 0.25 mg tablet (Alprazolam)	5
GSN = 058848	Niravam ODT 0.5 mg tablet (Alprazolam)	5
GSN = 058849	Niravam ODT 1 mg tablet (Alprazolam)	5
GSN = 058850	Niravam ODT 2 mg tablet (Alprazolam)	5
HSN = 039580	Xtandi 40mg	4
HSN = 025098	Zavesca 100mg capsules	3
HSN = 037837	Zelboraf 240mg	8
HICL = 024459	Zetia 10mg Tab	1
HSN = 034070	Zolinza 100mg	4
GSN = 046230	Zoloft 20mg/ml soln (sertraline)	10
GSN = 072296	Zykadia 150 mg capsules	5
HSN = 037571	Zytiga 250mg	4
GSN = 062974	Selzentry 150mg tablet	2
GSN = 038451	Singulair	1
GSN = 051820	Restasis 0.05% eye emulsion	2
HICL = 010132	Cefepime vials (Maxipime)	6
HICL = 035848	Cefepime Piggyback	300
HICL = 037021	Cefepime Piggyback	300
GSN = 021279	Colytrol (Belladonna Alkaloids)	1000
GSN = 040364	Derma Smoothe/FS	2
GSN = 003656	Chloral Hydrate	15
GSN = 052050	Vigamox 0.5% eye drops	2
GSN = 015869	Ondansetron 2mg/ml vial	1.186
GSN = 023187	Ondansetron 32mg/50ml piggyback	14.815
GSN = 015908	Primaxin I.M. 750mg vial	2
GSN = 043706	Tamiflu Capsules (oseltamivir)	2
GSN = 063224	Tamiflu Capsules (oseltamivir)	2
GSN = 063223	Tamiflu Capsules (oseltamivir)	4
GSN = 067561	Tamiflu 6mg/ml suspension (oseltamivir)	36ml
GSN = 047429	Tamiflu 12mg/ml oral susp (oseltamivir)	12.5
GSN = 007061	KAO/SAL ACID/ME-SALICYLATE/PEP	2

Maximum Daily Dose (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 046213	Fluoxetine HCL 10mg capsule (Prozac)	2
GSN = 046216	Fluoxetine HCL 10mg tablet (Sarafem)	2
GSN = 040515	EMLA patch	2
GSN = 021974	Epi-Clenz foam	2
GSN = 015880	Duragesic Patches	0.34
GSN = 015881	Duragesic Patches	0.34
GSN = 015882	Duragesic Patches	0.34
GSN = 015883	Duragesic Patches	0.34
GSN = 059102	Duragesic Patches	0.34

* Verified against Automated PA Opiate Rule.

Maximum Daily Dose By Age		
NCPDP EC# = 76 – Plan Limitations Exceeded		
MESSAGE =		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 058594	Abilify 1mg/ml sol	Ages 6–11 = max of 15ml per day Age 12–17 = max of 30ml per day Age 18+ = max of 5ml per day
GSNs = 060225	Abilify 2mg	Ages 6–17 = max of 5 tabs per day Age 18+ = max of 1 tab per day
GSN = 052898	Abilify 5mg	Ages 6–17 = max of 3 tabs per day Age 18+ = max of 1 tab per day
GSNs = 051333 and 060319	Abilify 10mg Abilify Discmelt 10mg	Ages 6–11 = max of 1.5 tabs per day Age 12–17 = max of 3 tabs per day Age 18+ = max of 1 tab per day
GSNs = 051334 and 060322	Abilify 15mg Abilify Discmelt 15mg	Age 6–11 = max of 1 tab per day Age 12–17 = max of 2 tabs per day Age 18+ = max of 1 tab per day
GSN = 051335	Abilify 20mg	Ages 6–11 = max of 0.75 tabs per day Age 12–17 = max of 1.5 tabs per day Age 18+ = max of 1 tab per day
GSN = 051336	Abilify 30mg	Ages 6–11 = max of 0.5 tabs per day Age 12–17 = max of 1 tabs per day Age 18+ = max of 1 tab per day
GSN = 050222	Avinza 30mg capsules	Age 18+ = max of 1 tab per day

Maximum Daily Dose By Age		
NCPDP EC# = 76 – Plan Limitations Exceeded		
MESSAGE =		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 064739	Avinza 45mg capsules	Age 18+ = max of 1 tab per day
GSN = 050221	Avinza 60mg capsules	Age 18+ = max of 1 tab per day
GSN = 064740	Avinza 75mg capsules	Age 18+ = max of 1 tab per day
GSN = 050220	Avinza 90mg capsules	Age 18+ = max of 1 tab per day
GSN = 050219	Avinza 120mg capsules	Age 18+ = max of 1 tab per day
GSN = 003796	Chlorpromazine 10mg	Ages 6–17 = max of 10 tabs per day Age 18+ = max of 4 tabs per day
GSN = 003797	Chlorpromazine 100mg	Ages 6–11 = max of 3 tabs per day Age 12–17 = max of 6 tabs per day Age 18+ = max of 4 tabs per day
GSN = 003798	Chlorpromazine 200mg	Ages 6–11 = max of 1.5 tabs per day Age 12–17 = max of 3 tabs per day
GSN = 003799	Chlorpromazine 25mg	Age 6–17 = max of 10 tabs per day Age 18+ = max of 4 tabs per day
GSN = 003800	Chlorpromazine 50mg	Ages 6–11 = max of 6 tabs per day Age 12–17 = max of 12 tabs per day Age 18+ = max of 4 tabs per day
GSN = 053995	Fazaclo 100mg (including ODT)	Ages 6–11 = max of 3 tabs per day Age 12–17 = max of 6 tabs per day Age 18+ = max of 2 tabs per day
GSN = 013649	Clozapine 100mg	Ages 6–11 = max of 3 tabs per day Age 12–17 = max of 6 tabs per day
GSN = 063031	Fazaclo 12.5mg (including ODT)	Ages 6–17 = max of 12 tabs per day Age 18+ = max of 2 tabs per day
GSN = 053016	Clozapine 12.5mg	Ages 6–17 = max of 12 tabs per day
GSN = 066558	Fazaclo 200mg disp tablets	Ages 6–11 = max of 1.5 tabs per day Age 12–17 = max of 3 tabs per day Age 18+ = max of 4 tabs per day
GSN = 046416	Clozapine 200mg	Ages 6–11 = max of 1.5 tabs per day Age 12–17 = max of 3 tabs per day
GSN = 013648	Clozaril 25mg tablets	Ages 6–17 = max of 8 tabs per day Age 18+ = max of 2 tabs per day
GSN = 053994	Fazaclo 25mg (including ODT)	Ages 6–17 = max of 8 tabs per day Age 18+ = max of 4 tabs per day

Maximum Daily Dose By Age		
NCPDP EC# = 76 – Plan Limitations Exceeded		
MESSAGE =		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 027037	Clozapine 50mg	Ages 6–11 = max of 6 tabs per day Ages 12–17 = max of 12 tabs per day
GSN = 069860	Exalgo 32mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 069889	Exalgo 16mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 069890	Exalgo 8mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 066200	Exalgo 12mg ER tablets	Age 18+ = max of 1 tab per day
HSN = 036778	Fanapt tablets	Ages 6-17 = max of 2 tabs per day Age 18+ = max of 2 tabs per day
HSN = 036778 (excluding GSNs 065905, 065906, 065907)	Fanapt 1mg, 2mg, 4mg, 6mg & titration pack	Ages 6-11 = max of 2 tabs per day
GSN = 065905	Fanapt 8mg tablets	Ages 6–11 = max of 1 tabs per day
GSN = 065906	Fanapt 10mg tablets	Ages 6–11 = max of 1 tabs per day
GSN = 065907	Fanapt 12mg tablets	Ages 6–11 = max of 1 tabs per day
GSN = 066557	Fazaclo 150mg ODT	Ages 6–11 = max of 2 tabs per day Ages 12–17 = max of 4 tabs per day Age 18+ = max of 6 tabs per day
HSN = 020420	Flector Patch 1.3%	Age 18+ = max of 2 tabs per day
GSN = 003821	Fluphenazine 2.5mg/5ml elixir	Ages 6–11 = max of 10mls per day Age 12–17 = max of 20 mls per day
GSN = 003822	Fluphenazine 5mg/ml oral concentrate	Ages 6–11 = max of 1ml per day Age 12–17 = max of 2 mls per day Age 18+ = max of 4 tabs per day
GSN = 003823	Fluphenazine 1mg	Ages 6–11 = max of 5 tabs per day Age 12–17 = max of 10 tabs per day Age 18+ = max of 4 tabs per day
GSN = 003824	Fluphenazine 10mg	Ages 6–11 = max of 0.5 tab per day Age 12–17 = max of 1 tabs per day Age 18+ = max of 20 mg s per day
GSN = 003825	Fluphenazine 2.5mg	Ages 6–11 = max of 2 tabs per day Age 12–17 = max of 4 tabs per day Age 18+ = max of 4 tabs per day
GSN = 003826	Fluphenazine 5mg	Ages 6–11 = max of 1 tab per day Age 12–17 = max of 2 tabs per day Age 18+ = max of 4 tabs per day

Maximum Daily Dose By Age		
NCPDP EC# = 76 – Plan Limitations Exceeded		
MESSAGE =		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 047563	Geodon 20mg	Ages 6–17 = max of 4 caps per day Age 18+ = max of 2 caps per day
GSN = 047564	Geodon 40mg	Ages 12–17 = max of 4 caps per day Age 6–11 = max of 2 per day Age 18+ = max of 2 caps per day
GSN = 047567	Geodon 60mg	Ages 6–11 = max of 1.33 caps per day Age 12–17 = max of 2.7 caps per day Age 18+ = max of 4 caps per day
GSN = 047568	Geodon 80mg	Ages 6–11 = max of 1 cap per day Age 12–17 = max of 2 caps per day Age 18+ = max of 2 caps per day
GSN = 003971	Haloperidol 2mg/ml conc	Ages 6–11 = max of 2.5 mls per day Age 12–17 = max of 5 mls per day
GSN = 003972	Haloperidol 0.5mg	Ages 6–11 = max of 10 tabs per day Age 12–17 = max of 20 tabs per day Age 18+ = max of 3 tabs per day
GSN = 003973	Haloperidol 1mg	Ages 6–11 = max of 5 tabs per day Age 12–17 = max of 10 tabs per day Age 18+ = max of 3 tabs per day
GSN = 003974	Haloperidol 10mg	Ages 6–11 = max of 0.5 tab per day Age 12–17 = max of 1 tabs per day Age 18+ = max of 3 tabs per day
GSN = 003975	Haloperidol 2mg	Ages 6–11 = max of 2.5 tabs per day Age 12–17 = max of 5 tabs per day Age 18+ = max of 3 tabs per day
GSN = 003976	Haloperidol 20mg	Ages 6–11 = max of 0.25 tab per day Age 12–17 = max of 0.5 tab per day
GSN = 003977	Haloperidol 5mg	Ages 6–11 = max of 1 tab per day Age 12–17 = max of 2 tabs per day Age 18+ = max of 3 tabs per day
GSN = 073176	Hysingla 20mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 073177	Hysingla 30mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 073179	Hysingla 40mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 073180	Hysingla 60mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 073181	Hysingla 80mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 073182	Hysingla 100mg ER tablets	Age 18+ = max of 1 tab per day

Maximum Daily Dose By Age		
NCPDP EC# = 76 – Plan Limitations Exceeded		
MESSAGE =		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 073183	Hysingla 120mg ER tablets	Age 18+ = max of 1 tab per day
HSN = 034343 (excluding GSN 061987)	Invega 1.5, 3 & 6mg tablets	Ages 6-11 = max of 1 tablet per day
HSN = 034343 (excluding GSN 061986)	Invega 1.5, 3, & 9mg ER tablets	Ages 12-17 = max of 1 tablet per day
GSN = 065667	Invega 1.5mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 061985	Invega 3mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 061986	Invega 6mg ER tablets	Ages 12-17 -= max of 2 tablets per day Age 18+ = max of 2 tabs per day
GSN = 061987	Invega 9mg ER tablets	Age 18+ = max of 1 tab per day
GSN = 060355	Kadian ER 10mg capsules	Age 18+ = max of 2 tabs per day
GSN = 060356	Kadian ER 20mg capsules	Age 18+ = max of 2 tabs per day
GSN = 060357	Kadian ER 50mg capsules	Age 18+ = max of 2 tabs per day
GSN = 060358	Kadian ER 100mg capsules	Age 18+ = max of 2 tabs per day
GSN = 061722	Kadian ER 80mg capsules	Age 18+ = max of 2 tabs per day
GSN = 061748	Kadian ER 30mg capsules	Age 18+ = max of 2 tabs per day
GSN = 061749	Kadian ER 60mg capsules	Age 18+ = max of 2 tabs per day
GSN = 069899	Kadian ER 40mg capsules	Age 18+ = max of 2 tabs per day
GSN = 069900	Kadian ER 70mg capsules	Age 18+ = max of 2 tabs per day
GSN = 069901	Kadian ER 130mg capsules	Age 18+ = max of 2 tabs per day
GSN = 069903	Kadian ER 150mg capsules	Age 18+ = max of 2 tabs per day
GSN = 062358	Kadian ER 200mg capsules	Age 18+ = max of 2 tabs per day
GSN = 068448	Latuda 20mg tablets	Age 18+ = max of 1 tab per day
GSN = 066932	Latuda 40mg tablets	Age 18+ = max of 1 tab per day
GSN = 071415	Latuda 60mg tablets	Age 18+ = max of 1 tab per day
GSN = 066933	Latuda 80mg tablets	Age 18+ = max of 2 tabs per day
GSN = 069894	Latuda 120mg tablets	Age 18+ = max of 1 tab per day
HSN = 037321 (excluding GSN 069894-Latuda 120mg)	Latuda 20, 40, 60, & 80mg tablet	Ages 6-11 = max of 1 tablet per day
HSN = 037321	Latuda 20, 40, 60, 80 & 120mg tablet	Ages 12-17 = max of 1 tablet per day
GSN = 003983	Loxapine 5mg capsules	Age 18+ = max of 4 tabs per day
GSN = 003982	Loxapine 25mg capsules	Age 18+ = max of 4 tabs per day

Maximum Daily Dose By Age		
NCPDP EC# = 76 – Plan Limitations Exceeded		
MESSAGE =		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 003981	Loxapine 10mg capsules	Age 18+ = max of 4 tabs per day
GSN = 003984	Loxapine 50mg capsules	Age 18+ = max of 3 tabs per day
GSN = 057799	Lyrica 25mg capsules	Age 18+ = max of 3 tabs per day
GSN = 057800	Lyrica 50mg capsules	Age 18+ = max of 3 tabs per day
GSN = 057801	Lyrica 75mg capsules	Age 18+ = max of 3 tabs per day
GSN = 057802	Lyrica 100mg capsules	Age 18+ = max of 3 tabs per day
GSN = 057803	Lyrica 150mg capsules	Age 18+ = max of 3 tabs per day
GSN = 057804	Lyrica 200mg capsules	Age 18+ = max of 3 tabs per day
GSN = 059401	Lyrica 225mg capsules	Age 18+ = max of 2 tabs per day
GSN = 057805	Lyrica 300mg capsules	Age 18+ = max of 2 tabs per day
HSN = 001637	Orap 1mg & 2mg tablets	Ages 6-17 = max of 1 tablet per day
GSN = 061091, 070397	Oxymorphone ER (Opana) 5mg	Age 18+ = max of 3 tabs per day
GSN = 061092, 070398	Oxymorphone ER (Opana) 10mg	Age 18+ = max of 3 tabs per day
GSN = 061093, 070399	Oxymorphone ER (Opana) 20mg	Age 18+ = max of 3 tabs per day
GSN = 061094, 070401	Oxymorphone ER (Opana) 40mg	Age 18+ = max of 3 tabs per day
GSN = 063782, 070320	Oxymorphone ER (Opana) 7.5mg	Age 18+ = max of 3 tabs per day
GSN = 063783, 070321	Oxymorphone ER (Opana) 15mg	Age 18+ = max of 3 tabs per day
GSN = 063784, 070400	Oxymorphone ER (Opana) 30mg	Age 18+ = max of 3 tabs per day
GSN = 003830	Perphenazine 16mg	Ages 6–11 = max of 0.75 tab per day Age 12–17 = max of 2.5 tabs per day
GSN = 003831	Perphenazine 2mg	Ages 6–11 = max of 6 tabs per day Age 12–17 = max of 20 tabs per day
GSN = 003832	Perphenazine 4mg	Ages 6–11 = max of 3 tabs per day Age 12–17 = max of 10 tabs per day
GSN = 003833	Perphenazine 8mg	Ages 6–11 = max of 1.5 tabs per day Age 12–17 = max of 5 tabs per day
HSN = 001627	Perphenazine	Age 18+ = max of 4 tabs per day
GSN = 046185	Perphenazine/Amitriptyline 4-10	Age 18+ = max of 4 tabs per day
GSN = 046186	Perphenazine/Amitriptyline 2-25	Age 18+ = max of 4 tabs per day
GSN = 046187	Perphenazine/Amitriptyline 4-25	Age 18+ = max of 4 tabs per day
GSN = 046188	Perphenazine/Amitriptyline 4-50	Age 18+ = max of 4 tabs per day

Maximum Daily Dose By Age		
NCPDP EC# = 76 – Plan Limitations Exceeded		
MESSAGE =		
Drug Code	**Description**	**Maximum Daily Dosage**
GSNs = 042922, 042923, 052049, and 065235	Risperidone 0.25mg Risperidone 0.5mg Risperidone M/ODT 0.5mg Risperidone 0.25mg ODT	Ages 6–17 = max of 8 tabs per day
GSNs = 021154 and 051799	Risperidone 1mg Risperidone M/ODT 1mg	Ages 6–11 = max of 4 tabs per day Age 12–17 = max of 6 tabs per day
GSN = 026177	Risperidone 1mg/ml sol.	Ages 6–11 = max of 4mls per day Age 12–17 = max of 6mls per day
GSNs = 021155 and 051800	Risperidone 2mg Risperidone M/ODT 2mg	Ages 6–11 = max of 2 tabs per day Age 12–17 = max of 3 tabs per day
GSNs = 021156 and 059402	Risperidone 3mg Risperidone M/ODT 3mg	Ages 6–11 = max of 1.33 tabs per day Age 12–17 = max of 2 tabs per day Age 18+ = max of 4 tabs per day
GSNs = 021157 and 059403	Risperidone 4mg Risperidone M/ODT 4mg	Ages 6–11 = max of 1 tab per day Age 12–17 = max of 1.5 tabs per day Age 18+ = max of 4 tabs per day
GSN = 034188	Quetiapine (Seroquel) 100mg	Ages 6–11 = max of 4 tabs per day Age 12–17 = max of 5 tabs per day
GSNs = 034189 and 062748	Quetiapine (Seroquel) 200mg Quetiapine (Seroquel) XR 200mg	Ages 6–11 = max of 2 tabs per day Age 12–17 = max of 4 tabs per day
GSN = 064725	Quetiapine (Seroquel) XR 150mg	Ages 6–11 = max of 2.67 tabs per day Age 12–17 = max of 5.34 tabs per day
GSN = 034187	Quetiapine (Seroquel) 25mg	Ages 6–17 = max of 8 tabs per day Age 18+ = max of 12 tabs per day
GSNs = 047198 and 062749	Quetiapine (Seroquel) 300mg Quetiapine (Seroquel) XR 300mg	Ages 6–11 = max of 1.33 tabs per day Age 12–17 = max of 2.7 tabs per day
GSNs = 060293 and 062750	Quetiapine (Seroquel) 400mg Quetiapine (Seroquel) XR 400mg	Ages 6–11 = max of 1 tab per day Age 12–17 = max of 2 tabs per day
GSNs = 060292 and 063240	Quetiapine (Seroquel) 50mg Quetiapine (Seroquel) XR 50mg	Ages 6–17 = max of 6 tabs per day
GSN = 021155	Risperdal 2mg tablets	Age 18+ = max of 2 tabs per day
GSN = 051800	Risperdal 2mg M-T tablets	Age 18+ = max of 2 tabs per day
GSN = 021154	Risperdal 1mg tablets	Age 18+ = max of 2 tabs per day
GSN = 042922	Risperdal 0.25mg tablets	Age 18+ = max of 2 tabs per day
GSN = 042923	Risperdal 0.5mg tablets	Age 18+ = max of 2 tabs per day

Maximum Daily Dose By Age		
NCPDP EC# = 76 – Plan Limitations Exceeded		
MESSAGE =		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 051799	Risperdal 1mg M-T tablets	Age 18+ = max of 2 tabs per day
GSN = 052049	Risperdal 0.5mg M-T tablets	Age 18+ = max of 2 tabs per day
GSN = 065538	Saphris 10mg SL tablet	Ages 6–11 = max of 1 tabs per day Ages 12–17 = max of 2 tabs per day Age 18+ = max of 2 tabs per day
GSN = 065537	Saphris 5mg SL tablet	Ages 6-17 = max of 2 tabs per day Age 18+ = max of 2 tabs per day
GSN = 063240	Seroquel XR 50mg tablets	Age 18+ = max of 2 tabs per day
GSN = 062750	Seroquel XR 400mg tablets	Age 18+ = max of 2 tabs per day
GSN = 060293	Seroquel 400mg tablets	Age 18+ = max of 2 tabs per day
GSN = 060292	Seroquel 50mg tablets	Age 18+ = max of 2 tabs per day
GSN = 034188	Seroquel 100mg tablets	Age 18+ = max of 2 tabs per day
GSN = 034187	Seroquel 25mg tablets	Age 18+ = max of 2 tabs per day
GSN = 062749	Seroquel XR 300mg tablets	Age 18+ = max of 3 tabs per day
GSN = 047198	Seroquel 300mg tablets	Age 18+ = max of 3 tabs per day
HSN = 025800	Symbyax capsules	Age 18+ = max of 1 tab per day
HSN = 001592	Temazepam capsules	Age 18+ = max of 1 tab per day
GSN = 003859	Thioridazine 10mg tablets	Age 18+ = max of 4 tabs per day
GSN = 003864	Thioridazine 25mg tablets	Age 18+ = max of 4 tabs per day
GSN = 003865	Thioridazine 50mg tablets	Age 18+ = max of 4 tabs per day
GSN = 003995	Thiothixene 1mg capsules	Age 18+ = max of 3 tabs per day
GSN = 003997	Thiothixene 2mg capsules	Age 18+ = max of 3 tabs per day
GSN = 003999	Thiothixene 5mg capsules	Age 18+ = max of 3 tabs per day
GSN = 003996	Thiothixene 10mg capsules	Age 18+ = max of 6 tabs per day
GSN = 003851	Trifluoperazine 1mg tablets	Age 18+ = max of 3 tabs per day
GSN = 003853	Trifluoperazine 2mg tablets	Age 18+ = max of 3 tabs per day
GSN = 003854	Trifluoperazine 5mg tablets	Age 18+ = max of 3 tabs per day
GSN = 003852	Trifluoperazine 10mg tablets	Age 18+ = max of 4 tabs per day
GSN = 072134	Xartemis XR 7.5-325mg tablet	Age 18+ = max of 4 tabs per day
GSN = 019187	Zolpidem 5mg tablets	Age 18+ = max of 1 tab per day
GSN = 019188	Zolpidem 10mg tablets	Age 18+ = max of 1 tab per day

Maximum Daily Dose By Age		
NCPDP EC# = 76 – Plan Limitations Exceeded		
MESSAGE =		
Drug Code	**Description**	**Maximum Daily Dosage**
GSNs = 027960 and 045191	Zyprexa 10mg Zyprexa Zydis 10mg	Ages 6–11 = max of 1 tab per day Age 12–17 = max of 2 tabs per day Age 18+ = max of 1 tab per day
GSNs = 041026 and 047285	Zyprexa 15mg Zyprexa Zydis 15mg	Ages 6–11 = max of 0.7 tabs per day Age 12–17 = max of 1.3 tabs per day Age 18+ = max of 2 caps per day
GSN = 029077	Zyprexa 2.5mg	Ages 6-11 = max of 4 tabs per day Age 12–17 = max of 8 tabs per day Age 18+ = max of 1 tab per day
GSNs = 041027 and 047286	Zyprexa 20mg Zyprexa Zydis 20mg	Ages 6–11 = max of 0.5 tab per day Age 12–17 = max of 1 tab per day Age 18+ = max of 1 tab per day
HSN = 036716	Zyprexa Zydis	Age 18+ = max of 1 tab per day
GSNs = 027961 and 045190	Zyprexa 5mg Zyprexa Zydis 5mg	Ages 6-11 = max of 2 tabs per day Age 12-17 = max of 4 tabs per day Age 18+ = max of 1 tab per day
GSN = 027959	Zyprexa 7.5mg	Ages 6–11 = max of 1.3 tabs per day Age 12–17 = max of 2.7 tabs per day Age 18+ = max of 1 tab per day
GSN = 050386	Zyprexa 10mg vial	Age 18+ = max of 3 tabs per day

Maximum Daily Dose By Age		
NCPDP EC# = 76 – Plan Limitations Exceeded		
MESSAGE =		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 050428	Adderall XR 5mg capsules	Age 18+ = max of 1 cap per day
GSN = 048701	Adderall XR 10mg capsules	Age 18+ = max of 1 cap per day
GSN = 050429	Adderall XR 15mg capsules	Age 18+ = max of 1 cap per day
GSN = 045981	Concerta 18mg tablets	Age 18+ = max of 1 cap per day
GSN = 047318	Concerta 54mg tablets	Age 18+ = max of 1 cap per day
GSN = 050172	Concerta 27mg tablets	Age 18+ = max of 1 cap per day
GSN = 059190	Focalin XR 5mg capsules	Age 18+ = max of 1 cap per day
GSN = 059191	Focalin XR 10mg capsules	Age 18+ = max of 1 cap per day
GSN = 059192	Focalin XR 20mg capsules	Age 18+ = max of 1 cap per day

Maximum Daily Dose By Age		
NCPDP EC# = 76 – Plan Limitations Exceeded		
MESSAGE =		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 065909	Focalin XR 30mg capsules	Age 18+ = max of 1 cap per day
GSN = 066611	Focalin XR 40mg capsules	Age 18+ = max of 1 cap per day
GSN = 061317	Focalin XR 15mg capsules	Age 18+ = max of 1 cap per day
GSN = 067692	Focalin XR 25mg capsules	Age 18+ = max of 1 cap per day
GSN = 067693	Focalin XR 35mg capsules	Age 18+ = max of 1 cap per day
GSN = 053056	Metadate CD 10 mg capsules	Age 18+ = max of 1 cap per day
GSN = 053057	Metadate CD 20 mg capsules	Age 18+ = max of 1 cap per day
GSN = 053058	Metadate CD 30 mg capsules	Age 18+ = max of 1 cap per day
GSN = 060545	Metadate CD 40 mg capsules	Age 18+ = max of 1 cap per day
GSN = 060546	Metadate CD 50 mg capsules	Age 18+ = max of 1 cap per day
GSN = 060547	Metadate CD 60 mg capsules	Age 18+ = max of 1 cap per day
GSN = 053059	Ritalin LA 20mg capsules	Age 18+ = max of 1 cap per day
GSN = 053061	Ritalin LA 40mg capsules	Age 18+ = max of 1 cap per day
GSN = 053974	Ritalin LA 10mg capsules	Age 18+ = max of 1 cap per day
HSN = 034486	Vyvanse 20 / 30 / 40 / 50 / 60 / 70 mg capsules	Age 18+ = max of 1 cap per day
GSN = 034359	Adderall 30 mg tablets	Age 18+ = max of 2 tabs per day
GSN = 048702	Adderall XR 20mg capsules	Age 18+ = max of 2 caps per day
GSN = 050430	Adderall XR 25mg capsules	Age 18+ = max of 2 caps per day
GSN = 048703	Adderall XR 30mg capsules	Age 18+ = max of 2 caps per day
GSN = 045982	Concerta 36mg tablets	Age 18+ = max of 2 tabs per day
GSN = 071048	Zenzedi 2.5mg tablets	Age 18+ = max of 2 tabs per day
GSN = 005011	Dexedrine 5mg tablets, Zenzedi 5mg tablets	Age 18+ = max of 2 tabs per day
GSN = 071049	Zenzedi 7.5mg tablets	Age 18+ = max of 2 tabs per day
GSN = 005009	Dexedrine 10mg tablets, Zenzedi 10mg tablets	Age 18+ = max of 2 tabs per day
GSN = 005010	Zenzedi 15mg tablets	Age 18+ = max of 2 tabs per day
GSN = 072313	Zenzedi 20mg tablets	Age 18+ = max of 2 tabs per day
GSN = 072314	Zenzedi 30mg tablets	Age 18+ = max of 2 tabs per day
GSN = 005007	Dexedrine ER 5mg capsules	Age 18+ = max of 2 caps per day
GSN = 005005	Dexedrine ER 10mg capsules	Age 18+ = max of 2 caps per day
GSN = 048982	Focalin 2.5mg tablets	Age 18+ = max of 2 tabs per day

Maximum Daily Dose By Age		
NCPDP EC# = 76 – Plan Limitations Exceeded		
MESSAGE =		
Drug Code	**Description**	**Maximum Daily Dosage**
GSN = 048983	Focalin 5mg tablets	Age 18+ = max of 2 tabs per day
GSN = 048984	Focalin 10mg tablets	Age 18+ = max of 2 tabs per day
GSN = 053060	Ritalin LA 30mg capsules	Age 18+ = max of 2 caps per day
GSN = 005001	Adderall 20mg tablets	Age 18+ = max of 3 tabs per day
GSN = 054676	Methylin 2.5mg chewable tablets	Age 18+ = max of 3 tabs per day
GSN = 054677	Methylin 5mg chewable tablets	Age 18+ = max of 3 tabs per day
GSN = 054678	Methylin 10mg chewable tablets	Age 18+ = max of 3 tabs per day
GSN = 004028	Methylin /Ritalin 5mg tablets	Age 18+ = max of 3 tabs per day
GSN = 004026	Methylin /Ritalin 10mg tablets	Age 18+ = max of 3 tabs per day
GSN = 047132	Adderall 12.5mg tablets	Age 18+ = max of 4 tabs per day
GSN = 047133	Adderall 15mg tablets	Age 18+ = max of 4 tabs per day
GSN = 005006	Dexedrine ER 15mg capsules	Age 18+ = max of 4 caps per day
GSN = 004029	Metadate ER 20mg, Ritalin SR 20mg tablets	Age 18+ = max of 4.5 tabs per day
GSN = 044072	Methylphenidate 20mg ER tablets	Age 18+ = max of 4.5 tabs per day
GSN = 004999	Adderall 5mg tablets	Age 18+ = max of 6 tabs per day
GSN = 047131	Adderall 7.5mg tablets	Age 18+ = max of 6 tabs per day
GSN = 005000	Adderall 10mg tablets	Age 18+ = max of 6 tabs per day
GSN = 070374	Quillivant XR 5mg/ml	Age 18+ = max of 12 ml per day
GSN = 054680	Methylin 10mg/5ml solution	Age 18+ = max of 30 ml per day
GSN = 054679	Methylin 5mg/5ml solution	Age 18+ = max of 60 ml per day
HSN = 024800	Humira inj syr, pen, starter pak	Age 18+ = Max of 0.8 per day

Maximum Duration (Quantity) by Age by Age Deny if exceeded for designated quantity per rolling days (When more than one GSN is noted on a line item, the quantity is accumulated across all GSNs.)		
NCPDP EC# = 76 – Plan Limitations Exceeded		
MESSAGE =		
Drug Code	**Description**	**Limitation**
HSN = 033556	Daytrana (methylphenidate) patches	Age 18+ = max of 30 every 26 days
GSN = 070669, 073298, 070670, 073299	Abilify Maintena	Age 18+ = Max of 1 per 25 days across the GSNs
GSN = 065452	Invega Sustenna 234mg/1.5ml syr	Age 18+ = Max of 1.5 per 25 days
GSN = 065451	Invega Sustenna 156mg/1ml syr	Age 18+ = Max of 1 per 25 days
GSN = 065450	Invega Sustenna 117mg/0.75ml syr	Age 18+ = Max of 0.75 per 25 days
GSN = 065449	Invega Sustenna 78mg/0.5ml syr	Age 18+ = Max of 0.5 per 25 days
GSN = 065448	Invega Sustenna 39mg/0.25ml syr	Age 18+ = Max of 0.25 per 25 days
HSN = 025509	Risperdal Consta	Age 18+ = Max of 2 per 25 days
GSN = 018293	Voltaren Gel 1% 100gm tube	Age 18+ = Max of 500 per 27 days
HSN = 001592	Restoril capsules	Age 18+ = Max of 30 per 27 days

GSN = 065795, 065794	Zyprexa relprevv 210mg/300mg vial	Age 18+ = Max of 2 per 25 days across the GSNs
GSN = 065793	Zyprexa relprevv 405mg vial	Age 18+ = Max of 1 per 25 days

Maximum Dosage Accumulation by Age: Incoming claims exceeding the Dose Accumulation edits for the specific recipient age indicated will deny NCPDP EC #76, Plan Limitations exceeded.		
NCPDP EC# = 76 – Plan Limitations Exceeded		
FL MESSAGE =		
Drug Code	**Description**	**Limitation**
HSN = 004834	Fazaclo/Clozaril/Versacloz	Age 18+ : 27,000mg every 26 days
GSNs = 065448, 065449, 065450, 065451, 065452	Invega Sustenna	Age 18+ : 234mg every 25 days
HSN = 014015	Seroquel	Age 18+ : 30,000mg every 26 days
GSNs = 7407, 7408, 7409, 14476, 40261, 40262, 51771, 53412, 68687, 70753, 71285, 72055, 73097, 73280	Lidocaine cream and ointment, all strengths	Age 18 + 60 every 27 days
GSN = 19137, 19318, 19319, 21251, 21253, 21483, 46698, 46699, 51649, 58671, 58672, 59326, 59327, 59328, 62240, 62241, 64010, 64012, 71756, 72722, 72723	Inhaled corticosteroids: Flovent, Flovent HFA, QVAR, Asmanex, Alvesco, Pulmicort, Aerospan, Arnuity Ellipta	Age 18 +1 fill every 26 days of one unique ICS

Maximum Daily Dosage by Age: Incoming claims exceeding the Maximum Daily Dose for the specific recipient age indicated will deny NCPDP EC #76, Plan Limitations exceeded.		
NCPDP EC# = 76 – Plan Limitations Exceeded		
MESSAGE =		
Drug Code	**Description**	**Limitation**
GSN = various	Acetaminophen & Acetaminophen containing products	4,000mg per day

AUTOMATED PA LISTS

Dose Optimization		
NCPDP EC# = 75 Prior Authorization Required		
All products on this list will deny when the daily dose equals "2" or the daily dose exceeds "3," with the exception of Ramipril and Valsartan. (*Indicated with an asterisk in the list below) Daily dose is calculated by taking the metric quantity on the inco ming claim and dividing it by the days supply on the claim. The valid range for two per day is >= 1.8, but <= 2.2. To exceed a daily dose of three, the value must be >= 3.8.		
Drug Code	**Description**	**Current**
HICL = 000094 GSN = 000301, 022649, 000304, 022651	Terazosin (Hytrin)	
GSN = 017266, 000393, 000390, 000391	Lisinopril (Zestril/Prinivil)	
GSN = 016310, 050555, 20 mg GSN = 006460, 050556	Lovastatin Sustained Release (Altoprev)	

Dose Optimization		
NCPDP EC# = 75 Prior Authorization Required		
All products on this list will deny when the daily dose equals "2" or the daily dose exceeds "3," with the exception of Ramipril and Valsartan. (*Indicated with an asterisk in the list below) Daily dose is calculated by taking the metric quantity on the inco ming claim and dividing it by the days supply on the claim. The valid range for two per day is >= 1.8, but <= 2.2. To exceed a daily dose of three, the value must be >= 3.8.		
Drug Code	**Description**	**Current**
GSN = 016310, 050555, 20 mg GSN = 006460,050556	Lovastatin Immediate Release (Mevacor, Generic)	
GSN = 015584, 015585, 015586, 044421	Doxazosin (Cardura)	
GSN = 016017, 016018	Fosinopril (Monopril)	
GSN = 2.5 mg GSN = 021743	Felodipine (Plendil)	
GSN = 016366, 20 mg GSN = 016367	Pravastatin (Pravachol)	
10 mg GSN = 016577, 20 mg GSN = 016578, 40 mg GSN = 016579	Simvastatin (Zocor)	
2.5 mg GSN = 016925, 5 mg GSN = 016926	Amlodipine (Norvasc)	
GSN = 024484, 053980	Cetirizine (Zyrtec)	
GSN = 050137	Paroxetine CR (Paxil CR)	
GSN = 019187	Zolpidem (Ambien)	
10 mg GSN = 024498, 20 mg GSN = 024499	Nisoldipine (Sular)	
GSN = 046403, 046404, 064444, 064445	Venlafaxine XR (Effexor XR)	
20 mg GSN = 021694, 40 mg GSN = 021695	Fluvastatin (Lescol)	
GSN = 026376, 026377	Trandolapril (Mavik)	
GSN = 030106, 049296	Lansoprazole (Prevacid)	
GSN = 023381, 023382	Losartan (Cozaar)	
GSN = 046206, 046203	Citalopram (Celexa)	
GSN = 054009, 046450, 047453	Mirtazapine (Remeron)	
GSN = 029335, 059039	Donepezil (Aricept)	
GSN = 041337, 033722	Perindopril (Aceon)	
GSN = 047126, 040910	Telmisartan (Micardis)	
GSN = 047525, 062245	Esomeprazole (Nexium)	

Dose Optimization		
NCPDP EC# = 75 Prior Authorization Required		
All products on this list will deny when the daily dose equals “2” or the daily dose exceeds “3,” with the exception of Ramipril and Valsartan. (*Indicated with an asterisk in the list below) Daily dose is calculated by taking the metric quantity on the inco ming claim and dividing it by the days supply on the claim. The valid range for two per day is >= 1.8, but <= 2.2. To exceed a daily dose of three, the value must be >= 3.8.		
Drug Code	**Description**	**Current**
GSN = 039545	Pantoprazole (Protonix)	
GSN = 050289	Olmesartan (Benicar)	
GSN = 051642, 050712	Escitalopram (Lexapro)	
10 mg GSN = 051784, 20 mg GSN = 051785, 40 mg GSN = 051786	Rosuvastatin (Crestor)	
GSN = 058484	Eszopiclone (Lunesta)	
GSN = 037015, 037016, 037017	Candesartan (Atacand)	

DEFINITIONS, ACRONYMS, AND ABBREVIATIONS

Term/Acronym/Abbreviation	Definition
ANDA	Abbreviated National Drug Application
AIDS	Acquired Immunodeficiency Syndrome
CHC	Claims History Conversion
COB	Coordination of Benefits
DCF	Department of Children and Families
DD	Drug to Drug
DME	Durable Medical Equipment
DOS	Date of Service
DUR	Drug Utilization Review
ER	Early Refill
ET	Eastern Time
FDB	First Databank
FFS	Fee-for-Service
FTP	File Transfer Protocol
GNI	Generic Number Indicator
GSN	Generic Sequence Number
HIC3	Hierarchical Ingredient Code
HICL	Hierarchical Ingredient Code List
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV	Human Immunodeficiency Virus Infection
HSN	HICL Sequence Number
ID	Identification Number Ingredient Duplication
INNOV	First Databank Innovator Indication
LR	Late Refill
MCO	Managed Care Organization
N/A	Not Applicable
NCPDP	National Council for Prescription Drug Programs
NDA	National Drug Application
NDC	National Drug Code
NDDF	National Drug Data File
NPI	National Provider Identifier
OTC	Over-the-Counter
PA	Prior Authorization
PBM	Pharmacy Benefit Management

Term/Acronym/Abbreviation	Definition
PDL	Preferred Drug List
POS	Point-of-Sale
ProDUR	Prospective Drug Utilization Review
TD	Therapeutic Duration
TPL	Third-Party Liability
U&C	Usual and Customary
UCF	Universal Claim Form
UM	Utilization Management
UOM	Unit of Measure

CONTINUITY OF CARE

*(The CONTINUITY OF CARE CODING ENDED 10/31/2014 AND IS NO LONGER IN USE)

The intent of the client is that members transitioning in have no abatement of currently used medications, whether it is formulary preferred status or utilization management in place (e.g., PA, QL, ST, etc.) for a period of at least 60 days.

- All Prior Authorization required drugs (Drug that has Formulary indicator = B-PDL & Clinical PA, J-Non-PDL Clinical PA, L-AutoPA Drug, N-New Drug(Non-PDL), P-Clinical PA, R-Non PDL; AND
- Claim Fill Number > 0 and The recipient has received < 60 days supply of the med on the incoming claim in the past 180 days

OR

- There is at least one fill of the incoming drug (based on GSN) found in patient history within the past 90 days; AND
- The recipient has received < 60 days supply of the med on the incoming claim in the past 180 days

Bypass:

- NCPDP EC 56 – Non-matched prescriber id
- NCPDP EC 75 – Prior Authorization Required
- NCPDP EC 76 – Plan Limitations exceeded
- NCPDP EC 60 – Product/Service Not Covered For Patient Age

If the recipient has received >60 days supply of the medication on the incoming claim in the past 180 days, adjudicate the claim as usual (i.e., to deny).

SPECIALTY DRUG PROGRAM

- All drugs in Formulary = SPECIALTY and Drug State Limitation = SPR can only be filled at Magellan Specialty Rx Pharmacies (NPIs 1245241884 or 1548390131) or Skymed Pharmacies (NPIs 1821079880 or 1295746790) for CCP/SFCCN recipients. If a pharmacy besides Magellan Rx Specialty or Skymed tries to submit a claim for a drug in Formulary "SPECIALTY" with State Limitation = SPR, the claim should deny NCPDP EC 4W- Fill through Specialty Pharmacy" with additional message "*Use Magellan Rx Specialty Pharmacy. Call 866-554-2673.*"
- Drug Formulary "SPECIALTY" is only to be used for dispensing pharmacy determination. The current Formulary (MCCFL1) will continue to determine drug coverage, PA required, quantity/age limits, etc.
- Exclude drugs in Therapeutic class 77-ANTICOAGULANTS from these rules. Recipients can continue to receive these drugs at any network pharmacy.
- If there is an override in place for 4W to allow a recipient to opt-out of the Specialty program and the claim is for a provider in Panel Id **C CCP/SFCCN SPC-R (CCP/SFCCN-SPECIALTY RESTRICTED),** the claim should deny NCPDP EC 6Z – Provider Not Elig To Perform Serv/Dispense Product" with message "*Use Magellan Rx Specialty Pharmacy, Call 1-866-554-2673.*"
- The following products should be blocked from all pharmacies with the exception of MRx Specialty (NPIs 1245241884 or 1548390131), Skymed (NPIs 1821079880 or 1295746790), and Memorial Regional Outpatient pharmacy (NPI: 1144360991):

Drug Name	GSN/NDC
Genotropin 5mg/ml	GSN = 024494
Genotropin 12mg/ml	GSN = 040471
Genotropin 0.2mg/0.25ml	GSN = 043434
Genotropin 0.4mg/0.5ml	GSN = 043435
Genotropin 0.6mg/0.25ml	GSN = 043436
Genotropin 0.8mg/0.25ml	GSN = 043437
Genotropin 1mg/0.25ml	GSN = 043438
Genotropin 1.2mg/0.25ml	GSN = 045274
Genotropin 1.4mg/0.25ml	GSN = 045275
Genotropin 1.6mg/0.25ml	GSN = 045276
Genotropin 1.8mg/0.25ml	GSN = 045277
Genotropin 2mg/0.25ml	GSN = 045278
Saizen 8.8mg/1.5ml	GSN = 058287
Saizen 8.8mg	GSN = 047675
Saizen 5mg vial	NDC-11 = 44087100502
Saizen 5mg vial	NDC-11 = 54569493000
Vimizim 5mg/5ml vial	GSN = 072018
Makena 1,250mg/5ml vial	GSN = 003267
Avastin vial	GSN = 053713
Exjade 125mg tablet	GSN = 060046
Exjade 250mg tablet	GSN = 060047

Drug Name	GSN/NDC
Exjade 500mg tablet	GSN = 060048

- The following products should be blocked from all pharmacies with the exception of MRx Specialty (NPIs 1245241884 or 1548390131), Skymed (NPIs 1821079880 or 1295746790), Memorial Regional Outpatient pharmacy (NPI: 1144360991), and BHMC Outpatient Pharmacy (NPI 1548288087):

Drug Name	GSN/NDC
Neulasta 6mg/0.6ml dlvry kit	GSN = 073319
Neulasta 6mg/0.6ml syringe	GSN = 049872
Neupogen 300mcg/0.5ml syringe	GSN = 045996
Neupogen 300mcg/ml vial	GSN = 015917
Neupogen 480mcg/0.8ml syringe	GSN = 045997
Neupogen 480mcg/1.6ml vial	GSN = 046004
Rhogam	HSN = 004209

APPENDIX C: PA REASON CODES/DROPS INS AND LETTER CODES FOR INITIAL DENIALS

The complete list of PA Reason Code Descriptions and Drop Ins can be found in the Excel document "**MCC-FL Letter Drop-Ins_effective_20150730**" on the MCC-FL Letters SharePoint website. Please be sure to check for updated documents when accessing the SharePoint site.

MCC-FL Letter Templates and Letter Drop Ins (SharePoint):
http://teams2-mrx/sites/FHSCDocMgmt/Client%20Documentation/Forms/AllItems.aspx?RootFolder=%2Fsites%2FFHSCDocMgmt%2FClient%20Documentation%2FMCC%5FFlorida%2FLetters&FolderCTID=0x012000F3BB35BBC4E190438325BA13CD7F7767&View={E0E5EB7D-B197-423A-8F6F-76EBE20621D2}

Reason Code and Description	Reason Code Drop In	FirstTrax℠ CTI	Letter Code
DEI1: RPh or MD: Initial Denial: Experimental or Investigational	The requested drug was denied because the Food and Drug Administration (FDA) and other medical guidelines have not approved this drug for your medical condition. Our preferred drugs and our medical necessity guidelines are included in the Florida Medicaid Preferred Drug Program's Preferred Drug List and/or Drug Criteria and are located at http://www.ahca.myflorida.com/Medicaid/Prescribed_Drug/preferred_drug.shtml.	Map PA Inquiry - Map PA Request - Denied PA: Medical Necessity	MCFMEDD1
DID1: RPh or MD: Initial Denial: Inconsistent Dose Requested	The requested drug was denied because the requested dose is outside of the Food and Drug Administration (FDA) limits. Our preferred drugs and our medical necessity guidelines are included in the Florida Medicaid Preferred Drug Program's Preferred Drug List and/or Drug Criteria and are located at http://www.ahca.myflorida.com/Medicaid/Prescribed_Drug/preferred_drug.shtml.	Map PA Inquiry - Map PA Request - Denied PA: Medical Necessity	MCFMEDD1
DII1: RPh or MD: Initial Denial: Insufficient Information to Determine Medical Necessity	The requested drug was denied because we do not have enough information from your prescriber that shows that you have either tried our preferred drugs or you have met our medical necessity guidelines. Your provider may fax us additional information that shows you have tried our preferred drugs or that you have met our medical necessity guidelines. Our preferred drugs and our medical necessity guidelines are included in the Florida Medicaid Preferred Drug Program's Preferred Drug List and/or Drug Criteria and are located at http://www.ahca.myflorida.com/Medicaid/Prescribed_Drug/preferred_drug.shtml.	Map PA Inquiry - Map PA Request - Denied PA: Medical Necessity	MCFMEDD1
DMN1: RPh or MD: Initial Denial: Not Medically Necessary	The requested drug was denied because either we do not have enough information from your prescriber that shows that you meet our medical necessity guidelines, or because the information that was provided by your prescriber does not meet our medical necessity guidelines, or because the information provided by your prescriber does not document that you are continuing to take a drug that has been prescribed for you. Our medical necessity guidelines are included in the Florida Medicaid Preferred Drug Program's Preferred Drug List and/or Drug Criteria and are located at http://www.ahca.myflorida.com/Medicaid/Prescribed_Drug/preferred_drug.shtml.	Map PA Inquiry - Map PA Request - Denied PA: Medical Necessity	MCFMEDD1
DPD1: RPh or MD: Initial Denial: Prerequisite Drug Not Tried	The requested drug was denied because we do not have enough information from your prescriber that shows that you have tried our preferred drugs or that you are continuing to take a drug that has been prescribed for you. Our preferred drugs are included in the Florida Medicaid Preferred Drug Program's Preferred Drug List and/or Drug Criteria and are located at http://www.ahca.myflorida.com/Medicaid/Prescribed_Drug/preferred_drug.shtml.	Map PA Inquiry - Map PA Request - Denied PA: Medical Necessity	MCFMEDD1
DPX1: RPh or MD: **Admin Denial:** Plan Benefit Exclusion	The requested drug was denied because it is not covered as a plan benefit. We are unable to approve the requested drug due to plan benefit exclusions. Plan benefit drugs are included in the Florida Medicaid Preferred Drug Program's Preferred Drug List and/or Drug Criteria and are located at http://www.ahca.myflorida.com/Medicaid/Prescribed_Drug/preferred_drug.shtml.	Map PA Inquiry - Map PA Request - Denied PA: Administrative	MCFADMD1
DQT1: RPh or MD: **Admin Denial:** Exceeds Quantity Limits	The requested drug was denied because the amount or number of times a day that your prescriber has prescribed the drug for you exceeds the plans' limits. We will cover the requested drug at a lower dose or frequency within the plans' limits if your prescriber requests it. Plan quantity limits are included in the Florida Medicaid Preferred Drug Program's Preferred Drug List and/or Drug Criteria and are located at http://www.ahca.myflorida.com/Medicaid/Prescribed_Drug/preferred_drug.shtml.	Map PA Inquiry - Map PA Request - Denied PA: Administrative	MCFADMD1

APPENDIX D: MCC-FL AND CCP/SFCCN LETTER STATUS

MCC-FL Letter Templates and Letter Drop Ins (SharePoint):
http://teams2-mrx/sites/FHSCDocMgmt/Client%20Documentation/Forms/AllItems.aspx?RootFolder=%2Fsites%2FFHSCDocMgmt%2FClient%20Documentation%2FMCC%5FFlorida%2FLetters&FolderCTID=0x012000F3BB35BBC4E190438325BA13CD7F7767&View={E0E5EB7D-B197-423A-8F6F-76EBE20621D2}

MCC-FL				
Letter Code	Letter Name	CTI		Automated Letter Generation:
		Standard	Expedited	
MCFADMD1	MCCFL_Initial_NOA_PT_ADMIN-Effective_01-25-15_REV_06-15-15	MAP: PA Inquiry → MAP: PA Request → Denied PA: Administrative	N/A	Yes
MCFMEDD1	MCCFL_Initial_NOA_PT_CLINICAL-Effective_01-25-15_REV_06-15-15	MAP: PA Inquiry → MAP: PA Request → Denied PA: Medical Necessity	N/A	Yes
MCFRQAP1	MCC_FL_Approval_Notice_Provider	MAP: PA Inquiry → MAP: PA Request → Approved: Provider Notice	N/A	Yes
MCFRQLE1	EM.8.MCC_Member_Notice_of_Extension_Initial_Service_Requests_Letter	MAP: PA Inquiry → MAP: PA Request → Approved: Initial Extension	N/A	Manual - No Automation
MCFRQLP1	GS_2_MCC Request for Information_Provider	MAP: PA Inquiry → MAP: PA Request → Request Information: Provider Notice	N/A	Manual - No Automation
MCFAPLRR	EM.8.MCC_Member_Appeal_Acknowledgment_Letter	MAP: PA Inquiry → MAP: PA Appeal → Appeal Request Acknowledged	N/A	Yes
MCFAPLDA	EM.8.MCC_Member_Appeal_Notice_Level_Denial_Admin_Letter	MAP: PA Inquiry → MAP: PA Appeal – Standard → Denial Upheld: Admin	MAP: PA Inquiry → MAP: PA Appeal - Expedited → Denial Upheld: Admin	Yes
MCFAPLDC	EM.8.MCC_Member_Appeal_Notice_Level_Denial_Clinical_Letter	MAP: PA Inquiry → MAP: PA Appeal – Standard → Denial Upheld: Clinical	MAP: PA Inquiry → MAP: PA Appeal – Expedited → Denial Upheld: Clinical	Yes

MCC-FL				
Letter Code	Letter Name	CTI		Automated Letter Generation:
		Standard	Expedited	
MCFAPLA1	EM.8.MCC_Member_Appeal_Overturn_Letter	MAP: PA Inquiry → MAP: PA Appeal – Standard → Denial Overturned by **MD** MAP: PA Inquiry → MAP: PA Appeal – Standard → Denial Overturned by **RPh**	MAP: PA Inquiry → MAP: PA Appeal – Expedited → Denial Overturned by **MD** MAP: PA Inquiry → MAP: PA Appeal – Expedited → Denial Overturned by **RPh**	Yes
MCFAPLRD	EM.8.MCC_Member_Appeal_Rights_Exhausted_Letter	MAP: PA Inquiry → MAP: PA Appeal - Standard → Denial of Appeal: Over 30 Days	MAP: PA Inquiry → MAP: PA Appeal - Expedited → Denial of Appeal: Over 30 Days	Yes
MCFAPLE1	EM.8.MCC_Member_Notice_of_Extension_Appeal_Letter	MAP: PA Inquiry → MAP: PA Appeal – Standard → Appeal Notice: Extension Approved	MAP: PA Inquiry → MAP: PA Appeal – Expedited → Appeal Notice: Extension Approved	Manual - No Automation
MCFAPLRR	MCFAPLRR_Member_Appeal_Acknowledgment_Letter	MAP: PA Inquiry → MAP: PA Appeal – Standard → Appeal Request Acknowledged	N/A	Yes
N/A	N/A	MAP: PA Inquiry → MAP: PA Appeal – Standard → Forward to Appeal Reviewer	MAP: PA Inquiry → MAP: PA Appeal – Expedited → Forward to Appeal Reviewer	N/A
N/A	N/A	MAP: PA Inquiry → MAP: PA Appeal – Standard → Standard Appeal In Progress	MAP: PA Inquiry → MAP: PA Appeal – Expedited → Expedited Appeal In Progress	N/A
N/A	N/A	MAP: PA Inquiry → MAP: PA Appeal – Standard → Patient Must Request	MAP: PA Inquiry → MAP: PA Appeal – Expedited → Patient Must Request	N/A
?	0212APP_ExceptionReqNotQual_01272016_Final	MAP Exception Inquiry → MAP Exclusion Exceptions → Drug Not Eligible Exception Review	N/A	Yes
?	0214APP_DrugExcepAppr_01272016_Final	MAP Exception Inquiry → MAP Exclusion Exceptions → Approved PA	N/A	Yes

APPENDIX C: INITIAL DENIAL AND APPEAL LETTER STATUS (CONTINUED)

CCP/SFCCN Letter Templates (SharePoint):

http://teams2-mrx/sites/FHSCDocMgmt/Client%20Documentation/Forms/AllItems.aspx?RootFolder=%2Fsites%2FFHSCDocMgmt%2FClient%20Documentation%2FCCP/SFCCN%2FLetters&FolderCTID=0x012000F3BB35BBC4E190438325BA13CD7F7767&View={E0E5EB7D-B197-423A-8F6F-76EBE20621D2}

CCP/SFCCN				
Letter Code	Letter Name	CTI		Automated Letter Generation:
		Standard	Expedited	
SFCMEDD 1	CCP/SFCCN_Initial_NOA_PT_CLINICAL_Effective_01-25-15	MAP: PA Request → MAP: PA Inquiry → Denied PA: Medical Necessity	N/A	Yes
SFCADMD 1	CCP/SFCCN_Initial_NOA_PT_ADMIN_Effective_01-25-15	MAP: PA Request → MAP: PA Inquiry → Denied PA: Administrative	N/A	Yes
SFCAPLA1	CCP/SFCCN_GS_3_Appeal_Overturned	MAP: PA Request → MAP: PA Appeal – Standard → Denial Overturned by MD	MAP: PA Request → MAP: PA Appeal – Expedited → Denial Overturned by MD	Yes
SFCAPLD1	CCP/SFCCN_GS_3_Appeal_Upheld	MAP: PA Request → MAP: PA Appeal – Standard → Upheld by MD	MAP: PA Request → MAP: PA Appeal – Expedited → Denial Upheld by MD	Yes
No Letter Template		MAP: PA Request → MAP: PA Appeal – Standard → Appeal Notice: 14 Day Extension Approved	MAP: PA Request → MAP: PA Appeal – Expedited → Appeal Notice: 14 Day Extension Approved	No Letter Template
SFCGRAK	CCP/SFCCN_Grievance_Acknowledgement_Letter	MAP: PA Inquiry → MAP: PA Request → Grievance Request Acknowledged	N/A	Yes
SFCAPLRR	CCP/SFCCN_Appeal_Acknowledgement_Letter	MAP: PA Request → MAP: PA Appeal → Appeal Request Acknowledged	N/A	Yes
No Letter Template		MAP: PA Request → MAP: PA Appeal – Standard → Appeal File Sent	MAP: PA Request → MAP: PA Appeal Expedited → Appeal File Sent	No Letter Template
No Letter Template		MAP: PA Inquiry → MAP: PA Appeal – Standard → Forward to Appeal Reviewer	MAP: PA Inquiry → MAP: PA Appeal – Expedited → Forward to Appeal Reviewer	No Letter Template
No Letter Template		MAP: PA Inquiry → MAP: PA Appeal – Standard → Standard Appeal In Progress	MAP: PA Inquiry → MAP: PA Appeal – Expedited → Expedited Appeal In Progress	No Letter Template
No Letter Template		MAP: PA Inquiry → MAP: PA Appeal – Standard →Patient Must Request	MAP: PA Inquiry → MAP: PA Appeal – Expedited → Patient Must Request	No Letter Template
CCP/SFCCN_Approved_Notice_of_Denial_Reversal				
CCP/SFCCN_Expedited_Appeal_Request_Denied				

APPENDIX E: FIRSTTRAX℠ INITIATIVES

Initiative	SX Rule Type	SX Rule Level	External Reject Code	Internal Error Code
ADM: COB Override: All Drugs	PatOverride	List	41 - Submit bill to other processor or primary payor	13520 - COB CA Pharmacy Not Cost Avoided All Other Payers
ADM: COB Override: All Drugs	PatOverride	List	41 - Submit bill to other processor or primary payor	4501 - Cob submit to primary insurer
ADM: Copay Override	PatCopay	HICL Sequence Number		
ADM: Duplicate Fill Override	PatOverride	GSN	83 - Duplicate paid/Captured claim	2119 - Duplicate fill process
ADM: Duplicate Fill Override	PatOverride	GSN	88 - Dur reject error	ER - Overuse Precaution
ADM: Duplicate RX Override: IE 2120	PatOverride	GSN	16 - M/I Prescription number	2120 - Duplicate Rx Process
ADM: Early Refill	PatOverride	GSN	88 - Dur reject error	ER - Overuse Precaution
ADM: Lock-In Pharmacy Override	PatOverride	GSN	50 - Non_matched pharmacy number	265 - Non matched pharmacy number
ADM: Medicare TPL Override	PatOverride	GSN	41 - Submit bill to other processor or primary payor	13520 - COB CA Pharmacy Not Cost Avoided All Other Payers
ADM: Medicare TPL Override	PatOverride	GSN	41 - Submit bill to other processor or primary payor	4501 - Cob submit to primary insurer
ADM: Medicare TPL Override	PatOverride	GSN	41 - Submit bill to other processor or primary payor	50055 - Err List Submit bill to other primary payor
ADM: Medicare TPL Override	PatConstraint	GSN	76 - Plan limitations exceeded	2614 - Days supply exceeds plan limit patient pays
ADM: Timely Filing Override	PatOverride	GSN	81 - Claim too old	142 - Date of service has passed allowable days
ADM: U&C Less Than Plan's Minimum OPAP	PatOverride	GSN	DV - M/I Other payer amount paid	50139 - Error List M/I Other payer amount paid
MAP: Actiq / Fentanyl	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Actiq / Fentanyl	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per

Initiative	SX Rule Type	SX Rule Level	External Reject Code	Internal Error Code
				day limit
MAP: Age Limit: Over Maximum	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2194 - Patient Age Exceeds Custom State Max Age
MAP: Age Limit: Over Maximum	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2624 - Pat age exceeds plan maximum age
MAP: Age Limit: Over Maximum	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Age Limit: Under Minimum	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2193 - Patient Age Less Than Custom State Min Age
MAP: Age Limit: Under Minimum	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2623 - Pat age less than plan minimum age
MAP: Age Limit: Under Minimum	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Albumin	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Albumin	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Amitiza	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2193 - Patient Age Less Than Custom State Min Age
MAP: Amitiza	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Amitiza	PatOverride	GSN	76 - Plan limitations exceeded	2191 - Quantity Exceeds Custom State Max Bill Quantity
MAP: Amitiza	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Antidepressants: Age 0-5 Years	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2193 - Patient Age Less Than Custom State Min Age
MAP: Antidepressants: Age 0-5 Years	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	50068 - Err List Product Not Covered For Patient Age
MAP: Antidepressants: Age 0-5 Years	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Antipsychotic: Age 0-5 Years	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2193 - Patient Age Less Than Custom State Min Age

Initiative	SX Rule Type	SX Rule Level	External Reject Code	Internal Error Code
MAP: Antipsychotic: Age 0-5 Years	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2623 - Pat age less than plan minimum age
MAP: Antipsychotic: Age 0-5 Years	PatOverride	GSN	75 - Prior authorization required	50081 - Error List Prior authorization required
MAP: Antipsychotic: Age 0-5 Years	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Antipsychotic: Age 6-17 Years	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2193 - Patient Age Less Than Custom State Min Age
MAP: Antipsychotic: Age 6-17 Years	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Antipsychotic: Age 6-17 Years	PatOverride	GSN	75 - Prior authorization required	50081 - Error List Prior authorization required
MAP: Antipsychotic: Age 6-17 Years	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Antipsychotic: Age 6-17 Years	PatOverride	GSN	76 - Plan limitations exceeded	7025 - Dosage Limit Exceeded
MAP: Antipsychotic: High Dose	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Antipsychotic: High Dose	PatOverride	GSN	76 - Plan limitations exceeded	2709 - Calculated Daily Dose Exceeds Limitation
MAP: Antipsychotic: High Dose	PatOverride	GSN	76 - Plan limitations exceeded	7001 - Quantity plan limit exceeded
MAP: Antipsychotic: High Dose	PatOverride	GSN	76 - Plan limitations exceeded	7025 - Dosage Limit Exceeded
MAP: AP: AAT Deficiency	PatOverride	GSN	75 - Prior authorization required	31005 - Automated PA
MAP: AP: Anticonvulsants	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: AP: Anticonvulsants	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: AP: Antiemetics: 5HT3	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: AP: Antiemetics: 5HT3	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit

Initiative	SX Rule Type	SX Rule Level	External Reject Code	Internal Error Code
MAP: AP: Brintellix	PatOverride	NDC-9	75 - Prior authorization required	31003 - Automated PA
MAP: AP: Brintellix	PatOverride	NDC-9	75 - Prior authorization required	31006 - Automated PA
MAP: AP: Brintellix	PatOverride	NDC-9	75 - Prior authorization required	31008 - Automated PA
MAP: AP: Brintellix	PatConstraint	NDC-9	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: AP: Brintellix	PatLimit	NDC-9	76 - Plan limitations exceeded	7001 - Quantity plan limit exceeded
MAP: AP: Comp/Evo/Prez/Strib/Trimq	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	31022 - Automated PA
MAP: AP: Comp/Evo/Prez/Strib/Trimq	PatOverride	GSN	75 - Prior authorization required	31008 - Automated PA
MAP: AP: Comp/Evo/Prez/Strib/Trimq	PatOverride	GSN	75 - Prior authorization required	31010 - Automated PA
MAP: AP: Comp/Evo/Prez/Strib/Trimq	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: AP: Comp/Evo/Prez/Strib/Trimq	PatOverride	GSN	76 - Plan limitations exceeded	31027 - Automated PA
MAP: AP: Complera/Edurant/Stribld/Triumq	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: AP: Complera/Edurant/Stribld/Triumq	PatOverride	GSN	75 - Prior authorization required	31004 - Automated PA
MAP: AP: Complera/Edurant/Stribld/Triumq	PatOverride	GSN	75 - Prior authorization required	31008 - Automated PA
MAP: AP: Complera/Edurant/Stribld/Triumq	PatOverride	GSN	75 - Prior authorization required	31009 - Automated PA
MAP: AP: Complera/Edurant/Stribld/Triumq	PatOverride	GSN	75 - Prior authorization required	31010 - Automated PA

Initiative	SX Rule Type	SX Rule Level	External Reject Code	Internal Error Code
MAP: AP: Dose Optimization	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: AP: Dose Optimization	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: AP: Dual RAS Blockade	PatOverride	GSN	75 - Prior authorization required	7008 - Number of fills prior authorization required
MAP: AP: Dual RAS Blockade	PatOverride	GSN	76 - Plan limitations exceeded	50082 - Error List Plan limitations exceeded
MAP: AP: Emend	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: AP: Emend	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: AP: Gaucher	PatOverride	NDC-9	75 - Prior authorization required	31008 - Automated PA
MAP: AP: Gaucher	PatLimit	GSN	76 - Plan limitations exceeded	7001 - Quantity plan limit exceeded
MAP: AP: HIV Agents	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: AP: HIV Agents	PatOverride	GSN	75 - Prior authorization required	31004 - Automated PA
MAP: AP: HIV Agents	PatOverride	GSN	75 - Prior authorization required	31004 - Automated PA
MAP: AP: HIV Agents	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: AP: Incivek/Victrelis	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: AP: Incivek/Victrelis	PatOverride	GSN	75 - Prior authorization required	31002 - Automated PA
MAP: AP: Incivek/Victrelis	PatOverride	GSN	75 - Prior authorization required	31004 - Automated PA
MAP: AP: Incivek/Victrelis	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: AP: Infergen	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: AP: Infergen	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: AP: Infergen	PatOverride	GSN	88 - Dur reject error	HD - High Dose Alert
MAP: AP: Lovaza	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required

Initiative	SX Rule Type	SX Rule Level	External Reject Code	Internal Error Code
MAP: AP: Lovaza	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: AP: OxyContin	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: AP: OxyContin	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: AP: PPI TD Duration	PatOverride	GSN	75 - Prior authorization required	7008 - Number of fills prior authorization required
MAP: AP: PPI TD Duration	PatOverride	GSN	76 - Plan limitations exceeded	50082 - Error List Plan limitations exceeded
MAP: AP: PPI TD Duration	PatOverride	GSN	76 - Plan limitations exceeded	7007 - Number of fills limit exceeded
MAP: AP: Pristiq/Khedezla/Desvenlafaxine	PatOverride	GSN	75 - Prior authorization required	31003 - Automated PA
MAP: AP: Pristiq/Khedezla/Desvenlafaxine	PatOverride	GSN	75 - Prior authorization required	31004 - Automated PA
MAP: AP: Pristiq/Khedezla/Desvenlafaxine	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: AP: Pulmozyme	PatOverride	GSN	75 - Prior authorization required	31008 - Automated PA
MAP: AP: Rexulti	PatOverride	GSN	75 - Prior authorization required	31003 - Automated PA
MAP: AP: Rexulti	PatOverride	GSN	75 - Prior authorization required	31006 - Automated PA
MAP: AP: Rexulti	PatOverride	GSN	75 - Prior authorization required	31008 - Automated PA
MAP: AP: Tybost	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2193 - Patient Age Less Than Custom State Min Age
MAP: AP: Tybost	PatOverride	GSN	75 - Prior authorization required	31006 - Automated PA
MAP: AP: Tybost	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: AP: Zetia	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: AP: Zetia	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per

Initiative	SX Rule Type	SX Rule Level	External Reject Code	Internal Error Code
				day limit
MAP: APAP Accumulation Limit	PatOverride	GSN	76 - Plan limitations exceeded	2709 - Calculated Daily Dose Exceeds Limitation
MAP: Benzo Quantity Limit Override	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Benzo Quantity Limit Override	PatOverride	GSN	76 - Plan limitations exceeded	7001 - Quantity plan limit exceeded
MAP: Boniva/Prolia/Reclast	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Botox	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Botox	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Brand Non-Preferred Required	PatOverride	NDC-9	22 - M/I Dispense as written code	50021 - Error List M/I Dispense as written code
MAP: Brand Non-Preferred Required	PatOverride	NDC-9	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Brand Non-Preferred Required	PatConstraint	NDC-9	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Caffeine Citrate	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	50068 - Err List Product Not Covered For Patient Age
MAP: Caffeine Citrate	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Carisoprodol / Soma	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Carisoprodol / Soma	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Cayston	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Cayston	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Celebrex	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required

Initiative	SX Rule Type	SX Rule Level	External Reject Code	Internal Error Code
MAP: Celebrex	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Cert Code Bypass	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Cert Code Bypass	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Cert Code Bypass	PatOverride	GSN	EU - M/I Prior Authorization Type Code	50167 - Error List M/I Prior Authorization Type Code
MAP: Chantix	PatOverride	GSN	76 - Plan limitations exceeded	7003 - Days supply limit exceeded
MAP: CII - CV Fill Limit Override	PatOverride	GSN	76 - Plan limitations exceeded	7007 - Number of fills limit exceeded
MAP: Cystic Fibrosis Agents	PatOverride	GSN	75 - Prior authorization required	31004 - Automated PA
MAP: Cystic Fibrosis Agents	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Cytogam	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Cytogam	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Diastat	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2194 - Patient Age Exceeds Custom State Max Age
MAP: Diastat	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2624 - Pat age exceeds plan maximum age
MAP: Drug to Gender	PatOverride	GSN	61 - Product/Service Not Covered For Patient Gender	2192 - Non Mached Custom State Sex Cd
MAP: Drug to Gender	PatOverride	GSN	61 - Product/Service Not Covered For Patient Gender	50069 - Err List Product Not Covered For Patient Gender
MAP: Drug to Gender	PatOverride	GSN	88 - Dur reject error	SX - Drug-Gender Alert
MAP: Error Code 7001 Override	PatOverride	GSN	76 - Plan limitations exceeded	7001 - Quantity plan limit exceeded
MAP: Error Code 7007 Override	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Error Code 7007 Override	PatOverride	GSN	76 - Plan limitations exceeded	7007 - Number of fills limit exceeded
MAP: Fuzeon	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required

Initiative	SX Rule Type	SX Rule Level	External Reject Code	Internal Error Code
MAP: Fuzeon	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Gamunex-C / Hizentra	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Gamunex-C / Hizentra	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Ganulocyte CSF	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Ganulocyte CSF	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Generic Non-Preferred Req	PatOverride	NDC-9	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Generic Non-Preferred Req	PatConstraint	NDC-9	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Growth Hormone	PatOverride	NDC-11	60 - Product/Service Not Covered For Patient Age	2194 - Patient Age Exceeds Custom State Max Age
MAP: Growth Hormone	PatOverride	NDC-11	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Growth Hormone	PatOverride	NDC-11	75 - Prior authorization required	31005 - Automated PA
MAP: Growth Hormone	PatConstraint	NDC-11	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Growth Hormone	PatLimit	NDC-11	76 - Plan limitations exceeded	7001 - Quantity plan limit exceeded
MAP: Hematopoietic Agents	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Hematopoietic Agents	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: High Dose Override	PatConstraint	NDC-11	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: High Dose Override	PatOverride	NDC-11	88 - Dur reject error	HD - High Dose Alert
MAP: Ingredient Duplication	PatOverride	GSN	88 - Dur reject error	ID - Ingredient Duplication
MAP: Intravenous Immune Globulin	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required

Initiative	SX Rule Type	SX Rule Level	External Reject Code	Internal Error Code
MAP: Intravenous Immune Globulin	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Lupron Depot-Ped Age Override	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	50068 - Err List Product Not Covered For Patient Age
MAP: Lupron Depot-Ped Age Override	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Lupron Depot-Ped Age Override	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Makena	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2193 - Patient Age Less Than Custom State Min Age
MAP: Makena	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2623 - Pat age less than plan minimum age
MAP: Makena	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Makena	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: NDC Not Covered	PatOverride	GSN	70 - NDC not covered	2211 - Drug not covered patient pays
MAP: NDC Not Covered	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Non-Preferred Drug Override	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Non-Preferred Drug Override	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Oral Oncology Age/Non-PDL	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2193 - Patient Age Less Than Custom State Min Age
MAP: Oral Oncology Age/Non-PDL	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2623 - Pat age less than plan minimum age
MAP: Oral Oncology Age/Non-PDL	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Oral Oncology Non-PDL	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Oral Oncology Quantity/Age/Non-PDL	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2193 - Patient Age Less Than Custom State Min Age

Initiative	SX Rule Type	SX Rule Level	External Reject Code	Internal Error Code
MAP: Oral Oncology Quantity/Age/Non-PDL	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2623 - Pat age less than plan minimum age
MAP: Oral Oncology Quantity/Age/Non-PDL	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Oral Oncology Quantity/Age/Non-PDL	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Orfadin	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Orfadin	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: PA Req and Age Over Max	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2194 - Patient Age Exceeds Custom State Max Age
MAP: PA Req and Age Over Max	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2624 - Pat age exceeds plan maximum age
MAP: PA Req and Age Over Max	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: PA Req and Age Over Max	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: PA Req and Age Under Max	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2193 - Patient Age Less Than Custom State Min Age
MAP: PA Req and Age Under Max	PatOverride	GSN	60 - Product/Service Not Covered For Patient Age	2623 - Pat age less than plan minimum age
MAP: PA Req and Age Under Max	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: PA Req and Age Under Max	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Panretin	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Panretin	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: PDL Quantity Limit	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: PDL Quantity Limit	PatOverride	GSN	76 - Plan limitations exceeded	7001 - Quantity plan limit exceeded

Initiative	SX Rule Type	SX Rule Level	External Reject Code	Internal Error Code
MAP: PPI Dosing Limits	PatOverride	GSN	76 - Plan limitations exceeded	7025 - Dosage Limit Exceeded
MAP: Price Override	PatOverride	GSN	22 - M/I Dispense as written code	50021 - Error List M/I Dispense as written code
MAP: Price Override	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Price Override	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Proleukin	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Proleukin	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Provigil	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Provigil	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Pulmonary Hypertension	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Pulmonary Hypertension	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Quantity Limit: IE 2191	PatOverride	GSN	76 - Plan limitations exceeded	2191 - Quantity Exceeds Custom State Max Bill Quantity
MAP: Quantity Limit: IE 2191	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Quantity Limit: IE 2614	PatConstraint	GSN	76 - Plan limitations exceeded	
MAP: Quantity Limit: IE 2614	PatOverride	GSN	88 - Dur reject error	HD - High Dose Alert
MAP: Quantity Limit: IE 2637	PatConstraint	GSN	76 - Plan limitations exceeded	2637 - Quantity exceeds plan limit patient pays MDQ
MAP: Quantity Limit: IE 2641	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Quantity Limit: IE 31027	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Quantity Limit: IE 31027	PatOverride	GSN	76 - Plan limitations exceeded	31027 - Automated PA

Initiative	SX Rule Type	SX Rule Level	External Reject Code	Internal Error Code
MAP: Quantity Limit: IE 7001	PatLimit	GSN	76 - Plan limitations exceeded	7001 - Quantity plan limit exceeded
MAP: Quantity Limit: IE 7002	PatLimit	GSN	75 - Prior authorization required	7002 - Quantity prior authorization required
MAP: Quantity Limit: IE 7003	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Quantity Limit: IE 7003	PatOverride	GSN	76 - Plan limitations exceeded	7003 - Days supply limit exceeded
MAP: Ribavirin Approved With Technivie	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Ribavirin Approved With Technivie	PatOverride	GSN	75 - Prior authorization required	31003 - Automated PA
MAP: Selzentry	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Selzentry	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Stelara	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Stelara	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Suboxone / Subutex	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Suboxone / Subutex	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Supprelin LA	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Supprelin LA	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Synagis	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Synagis	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Targretin	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Targretin	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit

Initiative	SX Rule Type	SX Rule Level	External Reject Code	Internal Error Code
MAP: Tobi	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Tobi	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Triptans	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Valcyte	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Valcyte	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
MAP: Vfend	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
MAP: Vfend	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
PDL: Antibiotics	PatOverride	HICL Sequence Number	75 - Prior authorization required	2462 - Patient prior authorization required
PDL: Antibiotics	PatOverride	HICL Sequence Number	75 - Prior authorization required	2462 - Patient prior authorization required
PDL: Antibiotics	PatOverride	HICL Sequence Number	75 - Prior authorization required	31004 - Automated PA
PDL: Antibiotics	PatOverride	HICL Sequence Number	75 - Prior authorization required	31004 - Automated PA
PDL: Antibiotics	PatConstraint	HICL Sequence Number	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
PDL: Antibiotics	PatConstraint	HICL Sequence Number	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
PDL: Cystic Fibrosis Agents	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
PDL: Cystic Fibrosis Agents	PatOverride	GSN	75 - Prior authorization required	31004 - Automated PA
PDL: Cystic Fibrosis Agents	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
PDL: Non-Preferred Brand Required	PatOverride	NDC-9	22 - M/I Dispense as written code	50021 - Error List M/I Dispense as written code
PDL: Non-Preferred Brand	PatOverride	NDC-9	75 - Prior authorization required	2462 - Patient prior authorization required

Initiative	SX Rule Type	SX Rule Level	External Reject Code	Internal Error Code
Required				
PDL: Non-Preferred Brand Required	PatConstraint	NDC-9	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit
PDL: Non-Preferred Drug Override	PatOverride	GSN	75 - Prior authorization required	2462 - Patient prior authorization required
PDL: Non-Preferred Drug Override	PatOverride	GSN	75 - Prior authorization required	31004 - Automated PA
PDL: Non-Preferred Drug Override	PatConstraint	GSN	76 - Plan limitations exceeded	2641 - Metric decimal quantity exceeded per day limit

APPENDIX F: MRIoA HOURS OF OPERATION

1. Hours of operation
   a. Monday – Friday 7:00 AM – 6:00 PM Mountain Time [MT] (9:00 AM – 8:00 PM Eastern Time [ET])
   b. Saturday 8:00 AM – 4:30 PM MT (10:00 AM – 6:30 PM ET)
   c. All other hours: see 3. b. (MRIoA On-Call Protocol).
2. Email addresses: pharmacy@mrioa.com, rxsupervisor@mrioa.com, Byron.Harris@mrioa.com, RxOnCall@mrioa.com.
   Please note that communication to MRIoA **during normal business hours** should be by phone**; outside of normal business hours should be by email**.
3. Contacting MRIoA
   a. Monday – Friday: 7:00 AM – 6:00 PM MT (9:00 AM – 8:00 PM ET) & Saturday: 8:00 AM – 4:30 PM MT (10:00 AM – 6:30 PM ET):
      i. Regular escalations
         - At least 3 hours remaining, during MRIoA's hours, on our 24-hour compliance clock: no special notification is needed
         - Less than 3 hours remaining, during MRIoA's hours, on our 24-hour compliance clock: see 3. a. iii.
      ii. When submitting a case between 5:00 PM and 6:00 PM MT, please e-mail pharmacy@mrioa.com, rxsupervisor@mrioa.com, Byron.Harris@mrioa.com.
      iii. Urgent (With 3 hours or less left on our 24-hour compliance clock) and all escalations **outside of normal business hours**:
         - MRIoA needs AT LEAST 30 MINUTES to process any request. A request marked URGENT by the prescriber does not qualify unless the 3-hour range remaining on our 24-hour compliance clock is applicable.
         - **When an escalation is sent during normal business hours but with a deadline date/time outside of normal business hours,** call MRIoA at 800-654-2422; dial extension 6469 to speak with one of the MRIoA staff directly (you can dial the extension immediately; you do not have to wait for a prompt).
         - **When an escalation is sent outside of normal business hours, email MRIoA at** RXOnCall@MRIOA.com.
   b. MRIoA On-Call Protocol:
      i. Before or After Hours noted above for Monday – Saturday: all requests and/or escalations
      ii. Email RXOnCall@MRIOA.com
      iii. For cases needing review before or after business hours, please provide as much notice as possible.

APPENDIX G: RECIPIENTS WITH INITIAL HEPATITIS C CLAIMS (NOV 2013 – APR 2016)

SFCCN MCO of Florida Recipients With INITIAL Hepatitis-C NDC Claims/Encounters Between November 2013 and April 2016

Some Recipients are listed more than once, to show each NDC they received

Recipient ID	NDC	NDC Description	Original DOS	Original Pay To Prov ID	Original Plan Type	Original NDC Prov Name	Current Prov ID	Current Prov Name
1809178029	00074309328	Viekira Pak	20160407	010833310	MMAC	CCP (formerly SFCCN)	010833310	CCP (formerly SFCCN)
2650619872	61958180101	Harvoni	20150521	010833310	MMAC	CCP (formerly SFCCN)	010833310	CCP (formerly SFCCN)
7417201644	61958180101	Harvoni	20150611	010833310	MMAC	CCP (formerly SFCCN)	010833310	CCP (formerly SFCCN)
7437322749	61958150101	Sovaldi	20140122	015072000	PSNR	R-SO FL COMM CARE/MHS	010833310	CCP (formerly SFCCN)
8202125413	61958150101	Sovaldi	20150312	010833310	MMAC	CCP (formerly SFCCN)	010833310	CCP (formerly SFCCN)
8202125413	61958180101	Harvoni	20150616	010833310	MMAC	CCP (formerly SFCCN)	010833310	CCP (formerly SFCCN)
8251204771	61958180101	Harvoni	20150205	010833310	MMAC	CCP (formerly SFCCN)	010833310	CCP (formerly SFCCN)
8628716050	61958150101	Sovaldi	20140605	015071100	PSNR	R-SO FL COMM CARE/NBHD	010833310	CCP (formerly SFCCN)
8887127239	61958150101	Sovaldi	20150330	010833310	MMAC	CCP (formerly SFCCN)	010833310	CCP (formerly SFCCN)
8889142146	61958150101	Sovaldi	20150624	010833310	MMAC	CCP (formerly SFCCN)	010833310	CCP (formerly SFCCN)
8895955030	61958150101	Sovaldi	20141017	010833310	MMAC	CCP (formerly SFCCN)	010833310	CCP (formerly SFCCN)
8901615762	61958150101	Sovaldi	20140331	015072000	PSNR	R-SO FL COMM CARE/MHS	010833310	CCP (formerly SFCCN)
8906674988	61958150101	Sovaldi	20151001	010833310	MMAC	CCP (formerly SFCCN)	010833310	CCP (formerly SFCCN)
8906674988	00003021501	Daklinza	20151001	010833310	MMAC	CCP (formerly SFCCN)	010833310	CCP (formerly SFCCN)
9500567474	61958150101	Sovaldi	20150209	010833310	MMAC	CCP (formerly SFCCN)	010833310	CCP (formerly SFCCN)

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APPENDIX G: RECIPIENTS WITH INITIAL HEPATITIS C CLAIMS (NOV 2013 – APR 2016) (CONTINUED)

MCC-FL MCO of Florida Recipients With INITIAL Hepatitis-C NDC Claims/Encounters Between November 2013 and April 2016

Some Recipients are listed more than once, to show each NDC they received

Recipient ID	NDC	NDC Description	Original DOS	Original Pay To Prov ID	Original Plan Type	Original NDC Prov Name	Current Prov ID	Current Prov Name
1340509024	61958180101	Harvoni	20150526	010563307	MMASC	MCC-FL	010563307	MCC-FL
2046043022	61958150101	Sovaldi	20140129	000046307	HMOMC	SUNSHINE STATE HEALTH PLAN, INC	010563307	MCC-FL
7333083675	61958150101	Sovaldi	20140213	999999999	FFS	DEFAULT PROVIDER	010563307	MCC-FL
7333528847	61958180101	Harvoni	20160122	010563307	MMASC	MCC-FL	010563307	MCC-FL
7337559950	61958150101	Sovaldi	20150820	010563307	MMASC	MCC-FL	010563307	MCC-FL
7546777739	61958180101	Harvoni	20160418	010563309	MMASC	MCC-FL	010563309	MCC-FL
7596563538	61958180101	Harvoni	20160408	010563309	MMASC	MCC-FL	010563309	MCC-FL
7597434685	00074309328	Viekira Pak	20151117	010563307	MMASC	MCC-FL	010563307	MCC-FL
7713969683	61958150101	Sovaldi	20140312	015005308	HMOMC	AMERIGROUP FLORIDA INC.	010563307	MCC-FL
7768478541	61958150101	Sovaldi	20140715	999999999	FFS	DEFAULT PROVIDER	010563307	MCC-FL
7806509178	61958150101	Sovaldi	20140203	999999999	FFS	DEFAULT PROVIDER	010563307	MCC-FL
7895764888	61958150101	Sovaldi	20140303	373158800	MPASS	BUI DAVID Q	010563307	MCC-FL
7921316581	61958150101	Sovaldi	20140129	015016908	HMOMC	STAYWELL/WELLCARE OF FLORIDA, INC	010563307	MCC-FL
8107387805	61958150101	Sovaldi	20160309	010563307	MMASC	MCC-FL	010563307	MCC-FL
8107387805	00003021501	Daklinza	20160309	010563307	MMASC	MCC-FL	010563307	MCC-FL
8108537240	61958180101	Harvoni	20141205	010563307	MMASC	MCC-FL	010563307	MCC-FL
8121090342	61958150101	Sovaldi	20140131	000046313	HMOMC	SUNSHINE STATE HEALTH PLAN, INC	010563309	MCC-FL
8137138820	61958150101	Sovaldi	20140416	015219613	HMOMC	HUMANA FAMILY	010563309	MCC-FL
8229723281	61958150101	Sovaldi	20150915	010563309	MMASC	MCC-FL	010563309	MCC-FL
8884459451	61958150101	Sovaldi	20150818	010563307	MMASC	MCC-FL	010563307	MCC-FL
8884545242	61958180101	Harvoni	20141210	010563307	MMASC	MCC-FL	010563307	MCC-FL
8896619416	61958180101	Harvoni	20141230	010563309	MMASC	MCC-FL	010563309	MCC-FL
8903244648	00074309328	Viekira Pak	20160316	010563307	MMASC	MCC-FL	010563307	MCC-FL
8905480608	61958180101	Harvoni	20150618	010563307	MMASC	MCC-FL	010563307	MCC-FL
8906274661	61958180101	Harvoni	20150409	010563309	MMASC	MCC-FL	010563309	MCC-FL

Recipient ID	NDC	NDC Description	Original DOS	Original Pay To Prov ID	Original Plan Type	Original NDC Prov Name	Current Prov ID	Current Prov Name
9442772911	61958180101	Harvoni	20160323	010563309	MMASC	MCC-FL	010563309	MCC-FL
1833081021	61958150101	Sovaldi	20140108	271096000	MPASS	JACKSON CONCHITA	010563311	MCC-FL
1833081021	61958180101	Harvoni	20150427	010563311	MMASC	MCC-FL	010563311	MCC-FL
1973210029	59676022528	Olysio	20140916	010563311	MMASC	MCC-FL	010563311	MCC-FL
1973210029	61958150101	Sovaldi	20140917	010563311	MMASC	MCC-FL	010563311	MCC-FL
2141664021	61958180101	Harvoni	20150225	010563311	MMASC	MCC-FL	010563311	MCC-FL
3960848021	61958150101	Sovaldi	20151202	010563311	MMASC	MCC-FL	010563311	MCC-FL
3960848021	00003021501	Daklinza	20151203	010563311	MMASC	MCC-FL	010563311	MCC-FL
7412189859	00074309328	Viekira Pak	20151013	010563310	MMASC	MCC-FL	010563310	MCC-FL
7454274633	61958180101	Harvoni	20151123	010563311	MMASC	MCC-FL	010563311	MCC-FL
7477931533	61958150101	Sovaldi	20141125	010563311	MMASC	MCC-FL	010563311	MCC-FL
7564943751	00074309328	Viekira Pak	20160301	010563310	MMASC	MCC-FL	010563310	MCC-FL
7586643377	61958180101	Harvoni	20150513	010563311	MMASC	MCC-FL	010563311	MCC-FL
8101031197	61958180101	Harvoni	20150402	010563311	MMASC	MCC-FL	010563311	MCC-FL
8132722655	00074309328	Viekira Pak	20160405	010563311	MMASC	MCC-FL	010563311	MCC-FL
8152276677	00074309328	Viekira Pak	20150909	010563311	MMASC	MCC-FL	010563311	MCC-FL
8160159552	61958150101	Sovaldi	20140407	029554000	MPASS	BORINQUEN HEALTH CARE	010563311	MCC-FL
8223696894	61958150101	Sovaldi	20140729	010563310	MMASC	MCC-FL	010563310	MCC-FL
8223696894	59676022528	Olysio	20140729	010563310	MMASC	MCC-FL	010563310	MCC-FL
8886289979	61958150101	Sovaldi	20140416	015061400	REHMO	R-FREEDOM HEALTH BROWARD	010563310	MCC-FL
8888785035	61958150101	Sovaldi	20140206	015082700	PSNR	BETTER HEALTH, LLC	010563310	MCC-FL
8891386936	61958150101	Sovaldi	20150606	010563310	MMASC	MCC-FL	010563310	MCC-FL
8893671433	61958180101	Harvoni	20160420	010563310	MMASC	MCC-FL	010563310	MCC-FL
8897445306	61958150101	Sovaldi	20150420	010717810	MMAC	BETTER HEALTH	010563311	MCC-FL
8900015010	61958180101	Harvoni	20160122	010563310	MMASC	MCC-FL	010563310	MCC-FL
8901869594	61958180101	Harvoni	20150529	010563311	MMASC	MCC-FL	010563311	MCC-FL
8902272044	00074308228	Technivie	20160223	010563310	MMASC	MCC-FL	010563310	MCC-FL
8905805752	61958150101	Sovaldi	20150403	010563310	MMASC	MCC-FL	010563310	MCC-FL

Recipient ID	NDC	NDC Description	Original DOS	Original Pay To Prov ID	Original Plan Type	Original NDC Prov Name	Current Prov ID	Current Prov Name
9477914339	61958180101	Harvoni	20150618	010563311	MMASC	MCC-FL	010563311	MCC-FL
9540346568	61958180101	Harvoni	20160304	010563311	MMASC	MCC-FL	010563311	MCC-FL
3454180023	00074309328	Viekira Pak	20160328	010563305	MMASC	MCC-FL	010563305	MCC-FL
3890747027	61958150101	Sovaldi	20140205	000839702	REHMO	R-SUNSHINE STATE HEALTH PLAN, INC	010563304	MCC-FL
7333569888	61958180101	Harvoni	20160204	010563304	MMASC	MCC-FL	010563304	MCC-FL
7336349234	61958150101	Sovaldi	20140416	060551401	MPASS	BOND COMMUNITY HEALTH CTR., INC	010563302	MCC-FL
7337508760	61958180101	Harvoni	20150608	010563304	MMASC	MCC-FL	010563304	MCC-FL
7337548541	00074309328	Viekira Pak	20150623	010557205	MMAC	SUNSHINE STATE HEALTH PLAN, INC.	010563305	MCC-FL
7425866692	61958150101	Sovaldi	20160408	010563305	MMASC	MCC-FL	010563305	MCC-FL
7425866692	00003021501	Daklinza	20160408	010563305	MMASC	MCC-FL	010563305	MCC-FL
7746591281	00074309328	Viekira Pak	20150928	010563306	MMASC	MCC-FL	010563306	MCC-FL
7794247977	61958180101	Harvoni	20160401	010563304	MMASC	MCC-FL	010563304	MCC-FL
8158232841	61958180101	Harvoni	20150608	010563304	MMASC	MCC-FL	010563304	MCC-FL
8252029451	00074309328	Viekira Pak	20151009	010563304	MMASC	MCC-FL	010563304	MCC-FL
8275251923	00074309328	Viekira Pak	20160217	010563304	MMASC	MCC-FL	010563304	MCC-FL
8656996037	61958150101	Sovaldi	20140109	000046302	HMOMC	SUNSHINE STATE HEALTH PLAN, INC	010563306	MCC-FL
8665931759	61958180101	Harvoni	20160429	010563306	MMASC	MCC-FL	010563306	MCC-FL
8896244463	61958180101	Harvoni	20150521	010563304	MMASC	MCC-FL	010563304	MCC-FL
8897779379	61958180101	Harvoni	20150708	010563304	MMASC	MCC-FL	010563304	MCC-FL
8898164394	61958180101	Harvoni	20160212	010563304	MMASC	MCC-FL	010563304	MCC-FL
8898489528	61958150101	Sovaldi	20140204	015005305	HMOMC	AMERIGROUP FLORIDA INC.	010563305	MCC-FL
8900105850	00074309328	Viekira Pak	20160418	010563304	MMASC	MCC-FL	010563304	MCC-FL
8900325957	61958180101	Harvoni	20151113	010563305	MMASC	MCC-FL	010563305	MCC-FL
8902884406	61958180101	Harvoni	20160316	010563304	MMASC	MCC-FL	010563304	MCC-FL
8902988333	00074309328	Viekira Pak	20151123	010563304	MMASC	MCC-FL	010563304	MCC-FL
8904228212	61958150101	Sovaldi	20140402	999999999	FFS	DEFAULT PROVIDER	010563304	MCC-FL
9469690371	61958150101	Sovaldi	20140623	010563004	MMAC	WELLCARE OF FLORIDA, INC	010563304	MCC-FL
9471688001	61958180101	Harvoni	20141128	010563005	MMAC	WELLCARE OF FLORIDA, INC.	010563305	MCC-FL
9473043872	61958150101	Sovaldi	20140709	010563006	MMAC	WELLCARE OF FLORIDA, INC.	010563306	MCC-FL

REVISION HISTORY

Date	MCC-FL	CCP/SFCCN	Issues / Updates
08/18/2016	X	X	☐ Denials (Initial Reviews) And Appeals updated to include Peer-To-Peer Requests
	X	X	☐ Buprenorphine Agents criteria updated
	X	X	☐ Methylphenidate ER (Generic for Concerta): preferred only for specified manufacturers
08/16/2016	X	X	☐ Kineret criteria updated
	X	X	☐ Xalkori criteria updated
	X	X	☐ Simponi criteria updated
	X	X	☐ Sabril criteria updated
	X	X	☐ Remicade criteria updated
	X	X	☐ Orencia criteria updated
08/12/2016	X		☐ MCC-FL ONLY info added on 08/04/2016 for Delalutin has been removed pending further review clinical and client level reivew.
08/04/2016	X	X	☐ Lovaza AutoPA coding reinstated/updated; Zetia AutoPA coding added.
	X	X	☐ Xolair criteria updated
	X	X	☐ Rasuvo & Otrexup criteria added
	X		☐ MCC-FL ONLY: Info for Delalutin added to the Makena criteria
08/01/2016	X	X	☐ Ulesfia: entry corrected to Non-Preferred per coding change dated 1/18/2016
	X		☐ MCC-FL Plan-contact info added for Harvoni and Sovaldi requests when Zepatier would also be a clinical option.
07/26/2016	X	X	☐ Actemra criteria updated; Ilaris criteria updated; Kineret criteria updated
	X	X	☐ Hypertonic Solution AutoPA Coding for Cystic Fibrosis added
	X	X	☐ Pulmozyme AutoPA Coding for Cystic Fibrosis added
	X	X	☐ Hizentra criteria removed; criteria for IVIG will now apply to Hizentra.
07/22/2016	X	X	☐ Summary of Drug Limitations updated
07/20/2016	X	X	☐ Hep C Requests: Refer to **Appendix G** for additional information when reviewing for previous therapy.
	X	X	☐ Cimzia criteria updated; Cosentyx criteria updated; Enbrel criteria added; Fycompa criteria updated; Ilaris criteria updated; Kineret criteria updated; Simponi criteria updated; Remicade criteria updated; Otezla criteria updated; Orencia criteria updated.
	X	X	☐ GASTROINTESTINALS - Proton Pump Inhibitors (PPI) - Therapy Beyond 6 months Duration criteria added.
	X	X	☐ June 17, 2016 P&T Changes effective July 1(coding production as of 7-19-16): Non-PDL: Vanatol LQ, Prochlorperazine (Rectal), Vraylar (Oral), Nadolol (Oral), Enbrel Kit/Pen/Syringe, Jevantique LO (Oral), Zepatier (Oral), Qnasl (Nasal), Ticanase (Nasal), Niaspan (Oral), Uptravi (Oral and Tab Dose Pack), Finacea Foam (Topical), Silazone-II (Topical), Methylphenidate ER (Oral – generic for Concerta). PDL: Xeljanz XR (Oral), Pioglitazone/Metformin (Oral), Niacin ER (Oral), Dyanavel XR (Oral), Quillichew ER (Oral).
07/15/2016	X	X	☐ Famciclovir moved to Non-Preferred
	X	X	☐ Fabrazyme & Naglazyme criteria updated and Auto PA coding added. Coding targeted for 7-15-2016; effective all the way back to 12-1-2015.
	X	X	☐ Alpa-1-Protease Inhibitors section added. Prolasta moved to this section. Aralast and Zemaira added. Auto PA coding noted (includes Glassia – but no clinical criteria specifically added yet).
	X	X	☐ Kitabis added to criteria with qty limit; TOBI qty limit updated. Targeted for production by 7-26-16.
	X	X	☐ Section added for additional information on meds that use the PDL: Non-Preferred Brand Required initiative

Date	MCC-FL	CCP/SFCCN	Issues / Updates
			☐ ACCUTANE criteria moved to ACNE MEDICATIONS section
	X	X	☐ Growth Hormone criteria updated to add Discontinuation of Growth Hormone
	X	X	Therapy in Children
			☐ Websites updated for change from SFCCN to CCP (effective July 15, 2016)
		X	☐ Appendix G: Recipients with Initial Hepatitis C Claims
	X	X	☐ Per April 1 P&T (effective April 1, 2016):
	X	X	☐ Added as R Non-PDL: Belbuca Buccal Film; Pramasone Oint (topical); Ethyl Chloride (topical); Prestalia (oral)l Varubi (oral); Cresemba (intravenous); Pentam 300 (injection); Enstilar (topical foam); Cholbam (oral); Seebri Neohaler; Envarsus XR (oral); Vivlodex (oral); Durlaza (oral); DemacinRx Silazone (topical)
			☐ Added as NPD: Utibron Neohaler; Tresiba Flextouch
07/05/2016	X	X	☐ Gleevec: clarification added for *Kit* (CD117) positive gastrointestinal stromal tumors (GIST): Adult 400-800 mg PO daily
07/01/2016	X	X	☐ Viekira Pak: Planned AutoPA will not be implemented as planned; AHCA is not requiring it of the Plans at this time.
	X	X	☐ Growth Hormone criteria updated
	X	X	☐ Fetzima criteria updated: correction from SSRI to SNRI for trials.
	X	X	☐ Synagis criteria updated for the 2016-2017 season. Only change is the years' dates.
06/17/2016	X	X	☐ Ketoconazole/Nizoral® changed to Non-Preferred [R-Non PDL; GSN 009544] (eff 5-19-16; production 5-31-16)
	X	X	☐ Age limits added/noted for various Topical Acne agents/Topical Retinoids
	X		☐ Intrauterine Devices: HIC3 = X1C move to Pharmacy benefit as of 7-1-16.
	X		☐ Vivitrol criteria updated to be effective as of 7-1-16.
		X	☐ Viekira Pak criteria updated reinserting criteria for drug/alcohol abuse and/or counseling
	X	X	☐ Growth Hormone Auto PA Coding removed from production
	X	X	☐ TOBI criteria entry for Auto PA coding updated with the addition of Kitabis
06/13/2016	X		☐ Appendix A updated for MCC-FL Limitation per the Plan's CSA document
	X		☐ MCCFL_2016_009_OT_DEET (eff 6-1-16; target prod 6-30-16): add coverage for pesticide DEET (Diethyltoluamide) per client request to address mosquito vectors for Zika virus.
	X	X	☐ Amlodipine besylate/Valsartan/ HCTZ (generic for Exforge HCT®) added as Non-Preferred
	X	X	☐ Marinol criteria updated: 1 year changed to 6 months
	X	X	☐ Therapeutic Duplication PPI AutoPA Coding added
	X	X	☐ Compound Claims (Maximum Compounding Limit) (eff 5-1-16; production 5-25-16)
06/01/2016	X		☐ FirstTrax℠ initiative added for MCC-FL DME CoC approvals.
	X	X	☐ Cabometyx criteria added to Oral Oncology meds.
	X	X	☐ Daklinza, Harvoni, Olysio, Sovaldi, Technivie, Zepatier criteria updated to remove the requirement for evidence of hepatic fibrosis (effective June 1, 2016). Criteria no longer applicable has been struck through; the content will be removed at a later date.
	X	X	☐ Viekira Pak criteria updated to match AutoPA coding for age, diagnosis, treatment naïve, duration of 12 weeks (effective June 1, 2016). Criteria no longer applicable has been struck through; the content will be removed at a later date.

Date	MCC-FL	CCP/SFCCN	Issues / Updates
	X	X	☐ Vecamyl criteria corrected.
	X	X	☐ TOBI criteria updated.
	X	X	☐ Minimum age reminders added to Abilify Maintena, Aristada ER, Invega ER, Invega Sustenna, Invega Trinza, Risperdal Consta, Saphris, Syprexa Relprevv.
05/17/2016	X		☐ Coastal DME added for MCC-FL. Medicor & Neighborhood Diabetes removed.
	X	X	☐ Viekira Pak criteria updated removing Ribavirin from the Genotype 1b (with cirrhosis).
05/16/2016	X	X	☐ Breo Ellipta added as non-preferred.
	X	X	☐ Aristada ER criteria updated to note monthly or every 6 weeks dosing at the 882mg level.
	X	X	☐ Viekira Pak criteria updated with minor punctuation corrections.
	X	X	☐ Immune Globulins – IVIG and SCIg criteria updated to remove approval references for indications where evidence is lacking or inconclusive.
	X	X	☐ Orfadin criteria updated to specify CPhT vs RPh approval allowances.
	X	X	☐ Appendix added to document coding limitations for CCP/SFCCN. Appendix A is for MCC-FL. Appendix B is for CCP/SFCCN. Subsequent Appendices were re-lettered.
05/04/2016	X	X	☐ April 2016 P&T changes (effective 4-28-16): R-Non PDL: Lamotrigine (NDC 11s 00115152608, 00115152668, 00115152808, 00115152815, 00115152908, 00115152915); Lidocaine 0.5% Oint (GSN 014476); Exforge and Exforge HCT (HICLs 034433, 036305); Maprotiline (HICL 001651); Protriptyline (HICL 001646); Avodart (HICL 024485); Granix (HICL 040426); Abilify (HICL 024551). S-PDL: Amlodipine/Valsartan (HICL 034433); Dutasteride (HICL 024485); Zyclara (pump, cream) (GSNs 068613, 069755, 066038); Salicyclic Acid 6% Cream (GSNs 061335, 054607); Erythromycin Lact 500mg IV (GSN 009252); Aripiprazole (HICL 024551)
04/21/2016	X	X	☐ Electrolyte Depleters PDL added.
(04/22/2016)	X	X	☐ Evotaz, Prezcobix, Viteka, Genvoya added to HIV AutoPA Coding steps
	X	X	☐ Antipsychotics: Age under 18: Updated charting to traditional PDL chart; diagnosis has been removed from the edit – edit is based on dose by age; fax form while preferred is not to be required.
	X	X	☐ ERYTHROMYCIN ORAL (-ETHYLSUCCINATE, -STEARATE, -ESTOLATE, -BASE) criteria added
04/14/2016	X	X	☐ Harvoni criteria updated (AHCA dated 3-30-16)
	X	X	☐ Daklinza criteria updated (AHCA dated 3-30-16)
	X	X	☐ MCCFL: Lidocaine cream & ointment, All strengths (Brand & Generic) Qty limit added
	X	X	☐ Orkambi criteria updated (AHCA dated 4-11-16)
	X	X	☐ Xeljanz AutoPA coding noted (Eff 7-1-15; Deployed 10-5-15)
	X	X	☐ Summary of Drug Limitations updated (AHCA 3-31-16)
	X	X	☐ Auto PA Coding updated (AHCA dated 4-8-16). Follow link noted under AUTOMATED PRIOR AUTHORIZATIONS (AUTO PA) ADDITIONAL INFORMATION
04/04/2016	X	X	☐ Esomeprazole capsules added as non-preferred (sync with current AHCA PDL)
	X	X	☐ MAP: Antipsychotic: High Dose (76 / 7025; 76 / 7001; 76 / 2641) initiative added
	X	X	☐ Exclusions MCC-FL: added to the Plan Summary with hyperlink to Appendix A.
	X	X	☐ Aristada ER criteria added
	X	X	☐ Zepatier criteria updated to reflect no longer needing labs since approval is for full course

Date	MCC-FL	CCP/SFCCN	Issues / Updates
	X	X	☐ Daklinza criteria updated with directive for Genotype 1
	X	X	☐ Afinitor® criteria updated.
	X	X	☐ Voltaren Gel Qty Limit clarification: MCC-FL 400gm/30 days; CCP/SFCCN 500gm/30 days.
	X	X	☐ Anticonvulsant AutoPA Coding updated: including ICD 10 codes.
	X	X	☐ Solaraze Gel (brand and generic) removed from the ANALGESIC/ANESTHETICS – TOPICALS PDL chart.
		X	☐ CCP/SFCCN: Lidocaine cream & ointment, All strengths (Brand & Generic) Qty limit added
	X	X	☐ Alprazolam removed from the Sedative/Hypnotic criteria (AHCA dated 11/23/2015)
			☐ Zepatier, Technivie, Harvoni criteria updated.
	X	X	
03/07/2016	X	X	☐ Morphine Sulfate ER criteria updated to remove formulations (AHCA dated 03/03/2016)
	X	X	☐ Ibrance criteria updated (AHCA dated 02/29/2016)
	X	X	☐ Pulmonary Hypertension Agents Review Criteria updated; Uptravi added (AHCA added 02/22/2016)
	X	X	☐ Zepatier criteria added (AHCA added 02/24/2016)
03/02/2016	X		☐ Appeal protocol updated for MCC-FL allowing the prescriber to initiate an appeal
	X	X	☐ Vytorin criteria updated for Simvastatin trial
	X	X	☐ Testosterone (non-injectable formulations) criteria updated (AHCA dated 02/24/2016)
	X	X	☐ Daklinza, Technivie, Viekira Pak, Harvoni, Olysio, Sovaldi criteria updated
	X	X	☐ Abilify Maintena and Invega Sustenna criteria updated (AHCA updated 02/24/2016)
02/19/2016	X	X	☐ Summary Drug Limitations updated (AHCA dated 01/29/2016)
	X	X	☐ Entresto added as Preferred
	X	X	☐ Copaxone added to Miscellaneous Section
02/16/2016	X	X	☐ Updated Antipsychotics, (Age < 18 Years old) Approval Criteria For 6 < 18 Years of Age
	X	X	☐ Initiative added: MAP: AP: Dual RAS Blockade (75 / 7008 – GSN; 76 / 50082 – GSN)
			☐ Cosentyx criteria updated (AHCA dated 08/04/2015; 01/29/2016)
	X	X	☐ The heading of the Suboxone… criteria has been changed from SUBOXONE/
	X	X	SUBUTEX/ ZUBSOLV/ BUNAVAIL to BUPRENORPHINE AGENTS. No changes were made to the actual content of the criteria.
			☐ HGH criteria have been updated to include PA review/approval criteria for
	X	X	preferred agents (Genotropin & Saizen) for claims that do not adjudicate via AutoPA.
			☐ Testosterone (non-injectable formulations) criteria added (AHCA dated
	X	X	02/10/2016)
	X	X	☐ Dalvance criteria updated (AHCA dated 01/29/2016)
	X		☐ Coverage for Prevnar, Pneumovax, and Zostavax updated for MCC-FL
	X	X	☐ Voltaren Gel: Qty limit corrected to 500g instead of 400g for CCP/SFCCN only
		X	☐ Inhaled COPD Anticholinergics updated: Anoro Ellipta, Spiriva Respimat, and Tudorza Pressair added as non-preferred.
		X	☐ Plan Specific Contacts updated to include protocol for CCP/SFCCN
	X	X	☐ Alecensa, Cotellic, Ninlaro, Tagrisson added to Oral Oncology Criteria

Date	MCC-FL	CCP/SFCCN	Issues / Updates
01/20/2016	X	X	Opana ER and generic added as non-preferred
	X	X	Morphine Sulfate ER criteria updated (AHCA/LMS 01/15/2016)
	X	X	Methadone criteria updated (AHCA/LMS 01/15/2016)
01/12/2016	X	X	Removed all references to RDDS/REMS meds since these are not coded for MCC-FL and CCP/SFCCN (confirmed with Plan Admin 01/04/2016).
	X	X	Cubicin criteria added (AHCA dated 12/16/2015)
	X	X	Abilify Maintena criteria updated (AHCA dated 01/06/2016)
	X	X	Automated Prior Authorization Master List updated
01/04/2016	X	X	Metformin t/f added for Januvia, Onglyza, and Actos per coding 12/14/2015.
	X	X	Sumatriptan & Imitrex PDL statuses updated
	X	X	Skeletal Muscle Relaxant PDL and Duration Edit updated.
	X	X	Rexulti criteria updated (AHCA dated 12/11/2015)
	X	X	Polypharmacy Edit Review Criteria for Long-Acting and Short-Acting Narcotics updated
	X	X	Invega Sustenna criteria updated (AHCA dated 12/28/2015)
	X	X	Xolair criteria updated (AHCA dated 12/29/2015)
12/29/2015	X	X	Versacloz added as non-preferred
	X	X	Quantity Accumulation Edit added for Clozaril, Fazaclo, and Versacloz (brand and generic) across all clozapine products.
	X	X	Quantity Accumulation Edit added for Seroquel
	X	X	GRANULOCYTE COLONY STIMULATING FACTORS criteria updated; Zarxio added.
	X	X	Marinol criteria added; Marinol and its generic removed from the ANTINAUSEA AGENTS: ORAL/RECTAL/TOPICAL criteria (AHCA dated 11/25/2015)
	X	X	Methadone criteria added; Methadone removed from the ANALGESICS – LONG-ACTING NARCOTICS (AHCA dated 12/21/2015)
	X	X	Morphine Sulfate ER criteria added; Morphine Sulfate ER removed from the ANALGESICS – LONG-ACTING NARCOTICS (AHCA dated 12/21/2015)
	X	X	Myrbetriq criteria updated (AHCA dated 11/19/2015)
	X	X	Neupro criteria updated (AHCA dated 11/19/2015)
	X	X	Pomalyst criteria updated (AHCA dated 12/18/2015)
	X	X	Procentra criteria updated (AHCA dated 11/20/2015)
	X	X	Prolastin C criteria updated (AHCA dated 11/20/2015)
	X	X	Pulmonary Hypertension Agents (AHCA dated 11/25/2015; no apparent changes)
	X	X	Relistor criteria updated (AHCA dated 11/23/2015)
	X	X	Rexulti criteria added (AHCA dated 12/11/2015).
	X	X	Samsca criteria updated (AHCA dated 11/23/2015)
	X	X	Sedative / Hypnotics: Non-Barbiturates criteria updated (AHCA dated 11/23/2015)
	X	X	Soliris criteria updated (AHCA dated 11/23/2015)
	X	X	Stivarga criteria updated (AHCA dated 11/23/2015)
	X	X	Synribo criteria updated (AHCA dated 11/23/2015)
	X	X	Targretin criteria updated (AHCA dated 11/23/2015)
	X	X	Tecfidera criteria updated (AHCA dated 11/23/2015)
	X	X	Xalkori criteria updated (AHCA dated 11/23/2015)
	X	X	Xgeva criteria updated (AHCA dated 11/23/2015); removed from the BONE RESORPTION INHIBITOR MEDICATIONS criteria.

Date	MCC-FL	CCP/SFCCN	Issues / Updates
	X	X	☐ Xifaxan criteria updated (AHCA dated 11/23/2015)
			☐ Xolair criteria updated (AHCA dated 11/23/2015)
	X	X	☐ Zelboraf criteria updated (AHCA dated 11/23/2015)
	X	X	☐ Zyprexa Relprevv criteria updated (AHCA dated 11/23/2015)
	X	X	☐ Zytiga criteria updated (AHCA dated 11/23/2015)
	X	X	
	X	X	
12/16/2015	X	X	☐ Monotherapy edit added for Inhaled Corticosteroids; Polypharmacy Long-Acting / Short-Acting Narcotics added.
	X	X	☐ DUAL RAS BLOCKADE DUR EDIT added.
	X	X	☐ Acetaminophen Accumulation edit added.
12/10/2015	X	X	☐ Rexulti criteria updated to note review is due in January 2016.
	X	X	☐ Avastin criteria added for CCP/SFCCN.
	X	X	☐ Apokyn criteria added.
	X	X	☐ Forteo criteria updated.
	X	X	☐ Gilenya criteria updated
	X	X	☐ Harvoni criteria updated.
	X	X	☐ Iclusig criteria updated.
	X	X	☐ Ilaris criteria updated.
	X	X	☐ Myrbetriq criteria updated.
	X	X	☐ Prolastin criteria updated.
	X	X	☐ Qudexy XR criteria updated.
	X	X	☐ Relistor criteria updated.
	X	X	☐ Stivarga criteria updated.
	X	X	☐ Targretin criteria updated.
	X	X	☐ Xgeva criteria updated.
	X	X	☐ Xolair criteria updated.
	X	X	☐ Zelboraf criteria updated.
	X	X	☐ Zytiga criteria updated.
	X	X	☐ Butrans criteria removed.
	X	X	☐ Cialis criteria removed.
	X	X	☐ Duexis criteria removed.
	X	X	☐ Extavia criteria removed.
	X	X	☐ Famciclovir criteria removed.
	X	X	☐ Fentanyl Transdermal Patches Criteira updated.
	X	X	☐ Jetrea criteria removed
	X	X	☐ Kyprolis criteria removed
	X	X	☐ Myfortic/Cellcept criteria removed
	X	X	☐ Nplate criteria removed
	X	X	☐ Omontys criteria removed
	X	X	☐ Pradaxa criteria removed
	X	X	☐ Pristiq criteria removed
	X	X	☐ Anticonvulsnats List B auto PA updated
	X	X	☐ Summary of Drug Limitations updated: Prevacid, Regranex, Setlakin, Tylenol
	X	X	☐ Information added under the Hepatitis C meds to help explain part of the Auto PA coding and the IE 31003.

Date	MCC-FL	CCP/SFCCN	Issues / Updates
	X	X	☐ November P&T: ☐ R-NonPDL: Denopezil, Donepezil ODT, Methadone Oral Conc., Methadone Oral Soln., Methadone tabs, Morphine ER tab., Oxycodone Oral Con., Pentazocine/Naltrexone, Gris-PEG, Clotrimazole/Betamethasone LOTION, Econazole 1% CREAM, Cetirizine (softgel OTC cap, OTC chew, ODT), Stalevo, Symbyax, Accolate, EES (400 tab; 200 susp), Eryped (granules, susp, drops, chew), Erytab EC, ERYC, Extavia Kit & Vial, Celebrex, Makena, L-Methyl-MC, Reno Caps ☐ S-PDL: Butrans, Embeda ER, Pyridium, Clotrimzaole/Beamethasone CREAM, Carbidopa/Levodopa/Entacapone, Zonalon 5% cream, Calcitriol 3mcg, Valacyclovir, Actigall, Epinephrine 0.15mg & 0.3mg, Farxiga, Invokana, Xigduo XR, Protopic 0.03% & 0.1%, Zafirlukast, Betaseron Kit & Vial, Celecoxib, Sandostatin LAR Kit, Tobradex ST, Durezol Ophth, Ketorolac LS.
11/20/2015	X	X	☐ Adcetris criteria updated (AHCA dated 11/10/2015)
	X	X	☐ Alinia criteria updated (AHCA dated 11/10/2015)
	X	X	☐ Aloxi criteria updated (AHCA dated 11-10-15)
	X	X	☐ Altabax criteria updated (AHCA dated 11/10/2015)
	X	X	☐ Aptiom criteria updated (AHCA dated 11/12/2015)
	X	X	☐ Atrovent Nasal Spray criteria updated (AHCA dated 11/10/2015)
	X	X	☐ Aubagio criteria updated (AHCA dated 11/10/2015)
	X	X	☐ Boniva criteria updated (AHCA dated 11/13/2015)
	X	X	☐ Ceprotin criteria updated (AHCA dated 11/16/2015)
	X	X	☐ Chorionic Gonadotropin criteria updated (AHCA dated 11/16/2015)
	X	X	☐ C II – C V Edit Overrides criteria updated (AHCA dated 11/16/2015)
	X	X	☐ Daklinza criteria updated (AHCA dated 11/05/2015)
	X	X	☐ Dificid criteria updated (AHCA dated 11/16/2015)
	X	X	☐ Edurant criteria updated (AHCA dated 11/16/2015)
	X	X	☐ Elelyso criteria updated (AHCA dated 11/16/2015)
	X	X	☐ Elmiron criteria updated (AHCA dated 11/16/2015)
	X	X	☐ Epaned criteria updated (AHCA dated 11/04/2015)
	X	X	☐ Qudexy XR criteria updated (AHCA dated 11/12/2015)
	X	X	☐ Skeletal Muscle Relaxant criteria updated (AHCA dated 11/12/2015)
11/06/2015	X	X	☐ Auvi-Q has been recalled. We are authorized to grant a 3-month approval for non-preferred EpiPen.
	X	X	☐ Supprelin criteria updated with length of approval and confirmation of diagnosis
10/26/2015	X	X	☐ Chemet criteria added (AHCA dated 10/15/2015)
	X	X	☐ Daraprim criteria added (AHCA dated 10/08/2015)
	X	X	☐ Esbriet criteria added (AHCA dated 10/21/2015)
	X	X	☐ Ofev criteria added (AHCA dated 10/21/2015)
	X	X	☐ Oral Oncology Chart updated (AHCA dated 10/14/2015)
	X	X	☐ Praluent criteria added (AHCA added 10/08/2015)
	X	X	☐ Promacta criteria updated (AHCA dated 10/09/2015)
	X	X	☐ Repatha criteria added (AHCA added 10/22/2015)
	X	X	☐ Olysio criteria updated (AHCA added 10/15/2015)
10/15/2015	X	X	☐ Continuity of Care policy updated

Date	MCC-FL	CCP/SFCCN	Issues / Updates
	X	X	ICD 10 entries updated in the sections for AutoPA coding.
	X	X	Sanctura criteria updated (AHCA dated 10/08/2015)
	X	X	Viekira Pak criteria updated (AHCA dated 10/08/2015)
	X	X	Jakafi criteria updated (AHCA dated 09/28/2015)
	X	X	Kalydeco criteria updated (AHCA dated 10/08/2015)
09/09/2015	X	X	Otezla criteria updated (AHCA dated 09/04/2015)
	X	X	Qudexy XR® criteria added (AHCA dated 06/23/2015)
	X	X	Daklinza® criteria added (AHCA dated 09/03/2015)
09/04/2015	X	X	Rexulti added with interim criteria until Sep 2015 P&T's decision is made.
	X	X	Namenda moved to non-preferred; Memantine added as preferred: matches the current Comprehensive Drug List.
	X		Updated Exception Request for MCC-FL in the Plan Summary
08/17/2015	X	X	Lynparza criteria updated (AHCA dated 02/27/15)
	X	X	Metadate CD criteria updated (AHCA 08/04/2015)
08/13/2015	X	X	Criteria added for Off Label Use.
	X	X	Anticonvulsants – Auto PA general info added (AHCA dated 08/04/2015)
	X	X	Ferriprox criteria updated. (AHCA dated 08/07/2015)
	X	X	Orkambi criteria updated. (AHCA dated 08/04/2015)
	X	X	Otezla criteria added. (AHCA dated 08/05/2015)
	X	X	Remicade criteria updated. (AHCA dated 08/04/2015)
	X	X	Stelara criteria updated. (AHCA dated 08/04/2015)
	X	X	Technivie criteria added. (AHCA Dated 08/04/2015)
07/31/2015	X	X	Orkambi criteria added
	X	X	PA Reason Code **DMN1 Letter Drop In** updated with expanded verbiage.
07/27/2015	X	X	Praluent status: This drug has not even been loaded into FDB yet. Once it is loaded, it will be coded to not pay until assigned an FMT value. Once an FMT value has been assigned AND criteria approved, NO approvals should be made without escalating them to the account management team. Until criteria is available from AHCA, the Plan will be the ONLY source of approval.
	X	X	Cetirizine liquid/syrup preferred/non-preferred clarified and updated.
	X	X	FirstTrax℠ initiative for Long-Acting Stimulants in Children Under 6 has been corrected.
	X	X	June 2015 P&T Changes effective 07/01/2015 (Coding into production 07/29/2015) **Prior Authorization S-PDL:** Xeljanz (Oral) AutoPA; Acamprosate 333mg (Generic GSN 004459) Clindesse 2% Vaginal Cream (Brand GSN 058439) Savaysa 15mg, 30mg, 60mg (Brand HICL 041672) Viibryd 10mg, 20mg, 40mg, Dosepack (Brand HICL 037597); Clinical criteria removed. AuviQ 0.15/0.15 auto inj (Brand GSN 065912)) AuviQ 0.3/0.3 auto inj (Brand NDC-9 00024-5833-) Imuran 50mg tab (Brand GSN 011682) Qnasl 40mcg & 80mcg (Brand GSNs 073274, 068876) Pazeo 0.7% drops (Brand GSN 073483) Guanfacine ER 1mg, ER 2mg, ER 3mg, ER 4mg (Generic GSNs 065570, 065572,

Date	MCC-FL	CCP/SFCCN	Issues / Updates
			065573, 065574) ☐ Felbamate 600mg/5ml susp, 600mg, 400mg (Generic HICL 008186) ☐ Acyclovir 0.5% ointment (Generic GSN 007670)
	X	X	☐ June 2015 P&T Changes effective 07/01/2015 (Coding into production 07/29/2015) **Prior Authorization R-non PDL:** ☐ Disalcid (Oral); Kytabis Pak (Inhalation); Nuvessa (Vaginal); Rytary (Oral); Sotylize (Oral); Incruse Ellipta (Inhalation); Arcalyst (SubQ); Cosentyx Pen Injctr (SubQ) & Syringe (SubQ); Ilaris (SubQ); Glyxambi (Oral); Afrezza Cartridge (Inhalation); Mycophenolic Acid (Oral); Soolantra (Topical); Evekeo (Oral); ☐ APAP/Butalbital 325mg/50mg (Generic GSN 004459) ☐ Marplan 10mg (Brand GSN 046262) ☐ Fluoxetine Tablets 10mg, 20mg (Generic GSN 046216, 046219) ☐ Dronabinol 2.5mg, 5mg, 10mg (Generic HICL 001955) ☐ Ondansetron amp 4mg/2ml (Geneirc GSN 061528) ☐ Trimethobenzamide cap 250mg, 300mg (Generic GSN 004685, 049940) ☐ Alprazolam Intensol 1mg/ml (Brand GSN 021523) ☐ Diazepam Intensol 5mg/ml (Generic GSN 003765) ☐ Bisoprolol 5mg, 10mg)Generic HICL 007369) ☐ Metoprolol/HCTZ 50/25, 100/25, 100/50 (Geneirc HICL 000143) ☐ Pindolo 5mg, 10mg (Generic GSNs 005144, 005143) ☐ Timolol 5mg, 10mg, 20mg (Generic GSNs 005142, 005140, 005141) ☐ Cefaclor 125mg/5ml, 187mg/5ml, 250mg/5ml, 375mg/5ml (Generic GSNs 009106, 009107, 009108, 009109) ☐ Cephalexin 250mg tab, 500mg tab (Generic GSNs 009048, 009049) ☐ Estadiol 0.05mg patch, 0.1mg patch (Generic GSNs 003202, 003203) ☐ Cortisone 5mg tab, 10mg tab, 25mg tab (Generic GSNs 006686, 006684, 006685) ☐ Hepsera 10mg (Brand HICL 024270) ☐ Tyzeka 600mg (Brnad HICL 034163) ☐ Cimetidine 200mg, 300mg, 400mg, 600mg tabs (Generics GSNs 011665, 011666, 011667, 011668 **AND** RX Indicator = Y) ☐ Cimetidine 300mg/5ml solution (Generic GSN 011664) ☐ Mycophenolic acid 180mg, 360mg (Generic HICL 025201) ☐ Neoral solution 100mg/ml (Brand GSN 023883) ☐ Azelastine 0.1% nasal spray (Generic GSN 029893) ☐ Astepro 0.15%/Azelastine 0.15% (Brand and Generic GSN 065577) ☐ Antara 30mg, 43mg, 90mg (Brand GSNs 071642, 058479, 071643) ☐ Lovaza 1g cap (Brand HICL 026793); AutoPA Coding removed. ☐ Dextroamphetamine Caps ER 5mg, ER 10mg, ER 15mg (Generic GSN 005007, 005005, 005006) ☐ Intuniv 1mg, 2mg, 3mg, 4mg (Brand GSNs 065570, 065572, 065573, 065574) ☐ Methylin 2.5mg chew, 5mg chew, 10mg chew (Brand GSNs 054676, 054677, 054678) ☐ Zovirax 0.5% oint (Brnad GSN 007670)
	X	X	☐ Amoxicillin/ clavulanate potassium chew 400-57mg, chew 200-28.5mg (Generic

Date	MCC-FL	CCP/SFCCN	Issues / Updates
			GSNs 026718, 026719) ☐ June 2015 P&T Changes effective 07/01/2015 (Coding into production 07/29/2015) **Prior Authorization D-none (Non-PDL):** ☐ Epipen/Epipen 2-pack (Brand NDC-9 54868-2804-; 49502-0500-; 68030-9069-) ☐ Epipen Jr/Epipen Jr 2-pack (Brand GSN 016878)
07/13/2015	X X X X X X X	X X X X X X X	☐ Updated July 1, 2015 Summary of Drug Limitations from AHCA's website added. ☐ Makena criteria updated to help clarify quantity limits ☐ Cerezyme criteria updated with updated AutoPA verbiage in Step 1. ☐ **Initiative: Hepatitis C** added ☐ Suboxone criteria updated (minor cleanup). ☐ Harvoni, Olysio, Sovaldi: extra alerts added for compliance and use of Viekira PAK. ☐ H.P. Achtar: extra alerts added for approval/denial.
07/10/2015	X X X X	X X X X	☐ Denial & Appeal protocol updated ☐ Harvoni, Olysio, and Sovaldi criteria tweaked to reinforce requirement for Viekira Pak for new therapies for Genotypes 1A and 1B (in affect since 04/2015). ☐ Sovaldi criteria tweaked to reinforce need for extra documentation for 12-week PAs. ☐ Long-Acting Stimulants in Children criteria added
06/30/2015	X X X X X X X X	X X X X X X X X	☐ Antimigraine criteria updated ☐ Axert criteria removed; Relpax criteria removed. ☐ Fycompa criteria updated. ☐ Namenda XR criteria updated. ☐ Promacta criteria updated. ☐ Qudexy XR criteria added. ☐ Synagis criteria updated. ☐ Xeloda quantity limits corrected.
06/24/2015	X X	X X	☐ Human Growth Hormone Criteria updated. ☐ Stivarga criteria added
06/10/2015	X X X X X X X X X	X X X X X X X X X	☐ Continuity of Care Auto coding removed for both plans between 05/25/2015 (MCC-FL) and 06/15/2015 (CCP/SFCCN). ☐ Stelara criteria updated. ☐ Jadenu criteria added. ☐ Aplenzin criteria added. ☐ Dalvance criteria added ☐ Invega ER Tablets criteria updated ☐ Invega Sustenna criteria updated ☐ Invega Trinza criteria added ☐ Nuedexta criteria updated
05/26/2015	X X X X X X X	X X X X X X X	☐ Updated Summary of Drug Limitations ☐ Exception Request (Prior Authorization) Procedure: MCC-FL Only updated ☐ Medicare Part D Dual Eligible added ☐ Early Refill Tolerance updated for Controlled for CCP/SFCCN. ☐ Buprenorphine criteria updated in reference to PAs and qty/day limits ☐ Kuvan criteria updated

Date	MCC-FL	CCP/SFCCN	Issues / Updates
	X	X	☐ Skeletal Muscle Relaxant Duratin of Therapy criteria and AutoPA added.
	X	X	☐ Adult High Dose Antipsychotic Criteria added.
			☐ Appendix B updated: PA Reason Codes & Drops Ins and Letter Codes for Initial Denials
	X	X	
	X	X	☐ Appendix C added: Initial Denial and Appeal Letter Status
	X	X	☐ Panretin criteria updated.
	X	X	☐ Brisdelle criteria added.
	X	X	☐ Orbact IV criteria added
	X	X	☐ Pulmonary Hypertension Agents criteria updated: Ventavis moved to Non-Preferred
			☐ Pylera criteria updated
05/07/2015	X	X	☐ Antipsychotics (< 6 years) and Antipsychotics (6 < 18 years): criteria updated.
	X	X	☐ Inhaled Corticosteroid Age Limits updated effective 05/01/2015.
	X	X	☐ Kalydeco criteria updated.
	X	X	☐ Lenvima criteria added.
	X	X	☐ Revlimid criteria added.
	X	X	☐ Saphris criteria updated.
	X	X	☐ Olysio criteria updated.
	X	X	☐ Viekira PAK criteria updated.
	X	X	☐ Medicare Dual Eligible info added to Plan Summary
	X	n/a	☐ Transgender Hormone Drug Requests: MCC-FL ONLY added to the Plan Summary
	X	X	☐ Zetonna added to INTRANASAL AGENTS TO TREAT RHINITIS as non-preferred
	X	X	☐ Provigil criteria updated
	X	X	☐ Updated Summary of Drug Limitations
	X	X	☐ Insulins (Dosage Form = Vial) Qty limit updated.
	X	X	☐ MAP: AP: Tybost Initiative added.
	X	X	☐ Cerdelga Qty Limit added in Summary of Drug Limitations (it was not included in AHCA's version but is listed in both plans' CCM for Qty Limits,
04/29/2015	X	X	☐ Eliquis criteria removed: Removed from PA required summer of 2014.
	X	X	☐ Yervoy criteria removed: to be billed through physician services.
	X	X	☐ Tev-Tropin removed from Growth Hormone criteria.
	X	X	☐ Linzess criteria updated
	X	X	☐ Lidoderm AutoPA coding updated.
	X	X	☐ HIV AutoPA coding updated.
	X	X	☐ Updated *Quantity/Duration Lists*
	X	X	☐ Updated *Maximum Daily Dose Limitations*
	X	X	☐ Updated *Continuity of Care*
	X	X	☐ Updated *Denials and Appeals*
	X	X	☐ Updated Preferred/Non-Preferred PDL changes in Plan Summary
	X	X	☐ Cerezyme AutoPA updated
	X	X	☐ March P&T added: Now Non-PDL (non-preferred): Ambisome, Urea Gel 40%, 45%, 50%, Urea Lotion 35%, 40%, 45%, Auryxia, Mircera, Tretinoin cream, Diovan, Prandin, Entocort EC 3mg tab, Tarka, Benazepril/HCTZ, Captopril/HCTZ, Fluocinonide cream, Betamethasone cream, Hydrocortisone butyrate ointment. Now PDL (preferred): brand Retin-A cream, Valsartan, Repaglinide, Budesonide 3mg tab.

Date	MCC-FL	CCP/SFCCN	Issues / Updates
	X	X	Lemtrada: PA Code = M Physician Services
	X	X	Abilify Maintena criteria updated.
	X	X	Aranesp & Procrit criteria updated.
	X	X	Banzel criteria updated
	X	X	Exjade criteria updated
	X	X	Farydak criteria added
	X	X	Harvoni, Olysio, & Sovaldi criteria updated
	X	X	Ibrance criteria added.
	X	X	Pulmonary Hypertension Agents criteria updated.
	X	X	Remicade criteria updated.
	X	X	Sandostatin LAR Depot criteria updated.
	X	X	Suboxone criteria updated.
	X	X	Victoza criteria updated.
	X	X	Xopenex (Solution for inhalation and HFA) criteria updated.
04/08/2015	X	X	Oxycontin AutoPA Coding logic updated. Separate section for AutoPA coding now deleted – all information is in the ANALGESICS: LONG-ACTING NARCOTICS section
			Pristiq AutoPA Coding logic updated.
	X	X	Brintellix AutoPA Coding logic added.
	X	X	Vfend (voriconazole): clarified criteria for diagnosis of **Invasive Aspergillosis**
	X	X	Updated Prior Authorization Exception Process (MCC-FL ONLY)
	X	n/a	Appendix C for MCC-FL Appeal Review, Psych Review, and Exception Review
	X	n/a	Outlook e-mail templates deleted: information has been moved to the Call Center's shared website within the Glen Allen Pharmacists Procedures folder.
03/26/2015	X	X	Appendix B updated with current info for initial denials
	X	n/a	Appendix C added for MCC-FL Appeal Review, Psych Review, and Exception Review Outlook e-mail templates
	X	n/s	Prior Authorization Exception Process (MCC-FL ONLY) added to the Plan Summary
	X	X	Continuity of Care protocol updated to include current meds that may not yet have been filled.
			Antifungals – Topical PDL chart updated
	X	X	Hypoglycemics – Oral updated
	X	X	RDDS meds: noted that all other edits apply
	X	X	Cross-reference for "Consent for Psychotherapeutic Medications for Children < 13 Years Old" removed. This is a technical issue and is addressed in the QC. IE/NCPDP 50167/EU "Acquire consent form Submit with Med Cert 2."
	X	n/a	MCC-FL CoC DME approval policy updated to include approval for other edits such as quantity.
	X	X	CII – CV script fill limit criteria clarified and corrected to remove the limit of once per 365 days.
	X	X	Hemophilia Program for Factor Medications & Related Products: entry added to the Plan Summary.
	X	X	HIV Diagnosis Verification criteria updated to include Evotaz, Prezcobix, Vitekta. Initiative renamed
03/13/2015	X	X	Appendix A added: Drug Limitations Charts from the Customer Service Agreement (CSA) document
	X	X	Cayston criteria updated.

Date	MCC-FL	CCP/SFCCN	Issues / Updates
	X	X	☐ Brand Medically Necessary criteria expanded to note when to allow CPhTs to approve
	X	X	☐ Pulmonary Hypertension criteria updated
	X	X	☐ Appendix B added for plans' PA Reason Codes/Letter Drop Ins/CTIs for member letters
02/18/2015	X	X	☐ Cyramza criteria added. ☐ Edurant criteria updated. ☐ Jardiance criteria added. ☐ Hemangeol criteria added. ☐ Lidoderm AutoPA Edit updated. ☐ Saphris criteria added/updated. ☐ Viekira criteria added. ☐ Xarelto criteria added. ☐ Removed Ceredase criteria (no longer available) ☐ Updated Edurant criteria ☐ Updated Kalydeco criteria ☐ Oxycontin AutoPA Edit updated. ☐ Sancusa criteria added. ☐ Promacta criteria added. ☐ Olysio criteria updated. ☐ Sovaldi criteria updated. ☐ Xeljanz criteria updated. ☐ REMS/RDDS updated. ☐ Antipsychotic For Age < 18 added. ☐ January 9, 2015 FL P&T changes effective January 1, 2015. (PDL: Ipratropium/Albuterol, Zovirax cream/ointment) (Non-PDL: Acyclovir ointment, Adempas, Albuterol 4mg & 2mg tabs, All Tyvaso, Bacitracin opth oint, Betaxolol, Claforan, Clindamycin IVPB, Cubicin, Flurazepam, Letairis, Lindane lotion/shampoo, Lupron Depot, Lysteda, Opsumit, Orenitram ER, Paromomycin, Pegasys, Peg-Intron, Pilocarpine, Ribavirin, Sildenafil, Streptomycin, Sulfacetamide opth oint, Tracleer, Ventavis, Xarelto). ☐ Med Cert 3 notations deleted since coding around these are not in place at this time.
02/06/2015	X	X	☐ Amitiza criteria updated per AHCA's changes dated 01/06/2015 ☐ Cimzia criteria added per AHCA dated 12/01/2014 ☐ Hemangeol criteria added per AHCA dated 12/03/2014 ☐ Criteria added for Viekira PAK ☐ Diovan and Diovan/HCT moved from non-preferred to preferred; generics moved from preferred to non-preferred (criteria entry correction)

Date	MCC-FL	CCP/SFCCN	Issues / Updates
01/07/2015		X	☐ Vaccines: CCP/SFCCN Coverage clarification – age limits for influenza, pneumococcal, and varicella vaccines as well as QLs.
	X	X	☐ Reference to Cover My Meds and other third-party agents added to Plan Summary
	X	X	☐ Gattex criteria updated
	X	X	☐ Harvoni criteria updated
	X	X	☐ Updated Summary of Limitations
	X	X	☐ Updated Kalydeco criteria
12/04/2014	X	X	☐ Harvoni criteria updated

Date	☐ MCC-FL	☐ FCA	☐ CCP/SFCCN	☐ Issues / Updates
11/26/2014	X	X	X	☐ Continuity of Care (CoC) protocol amended for Harvoni, Olysio, and Sovaldi due to cost and reporting.
	X	X	X	☐ NSAID Preferred Med list updated
	X	X	X	☐ Triumeq added as non-AutoPA HIV med that is R – Non-PDL
	X	X	X	☐ Acyclovir Oint added as Preferred; Brand Zovirax Oint & Cr are Non-Preferred.
11/20/2014	X	X	X	☐ Lidoderm AutoPA coding added (target production 12/09/2014) ☐ Auvi Q additional criteria added ☐ Bunavail information added ☐ Harvoni criteria updated ☐ Updated Actemra criteria: approval up to one year form six months ☐ Provigil criteria updated ☐ Updated Simponi criteria: approval up to one year from six months ☐ Synagis criteria updated ☐ Updated Summary of Limitations ☐ P & T Committee Changes: ☐ (PDL: Duloxetine, Extavia, Ilevro, Paricalcitol) ☐ (Non-PDL: B12/Levomefolate calcium/B-6, Betaseron vial or kit, Biaxin suspension, Butalbital compound with codeine, Codeine solution, Cyanocobalamin/FA/B6 (Foltx, Folbic, Folbalm Plus, Folnate Plus, Virt-vite Forte), Cymbalta all strengths, Etodolac all strengths, Fazaclo all strengths, Felbamate all strengths, Fluorometholone 0.1% ophthal drops, Flurbiprofen all strengths, Folbee (Fobalin, Foltx, virt-vite, Nufol), Folbic RF, Hydromorphone liq 1 mg/ml, Indocin suspension, Ketoprofen all strengths, Ketorolac LS 0.4% ophthal drops, Lazanda all strengths, Lescol 20 & 40mg, Lescol XL 80 mg, Levomefolate/algal oil, Lidoderm patch (auto PA), Lotemax gel, Lotemax ointment, Naftin Gel 1%, Naftin Gel 2%, Naproxen EC 375 mg, Naproxen EC 500 mg, Naproxen EC 750 mg, Neomycin/Polymixin/HC ophthal. Drops, Nephrocaps, Nystatin-

Date	MCC-FL	FCA	CCP/SFCCN	Issues / Updates
				TAC cream & ointment, Octreotide all strengths, Oxaprozin 600 mg, Piroxicam 10 & 20mg, Prednisolone sodium phosph opthal. Drops, Saphris 5 & 10 mg SL, Savella all strengths, Sulindac 150 & 200mg, Sulindac 200 mg, Zemplar all strengths).
11/06/2014	X	X	X	☐ Harvoni criteria added: Deny as Plan Exclusion until further notice from account staff and the plans. ☐ Stalevo brand moved to preferred and generic moved to non-preferred. ☐ Flu Vaccines: Coverage clarification – NOT restricted to LTC for FCA and MCC-FL. ☐ Ketorolac LS (Ophth) moved to non-preferred
10/20/2014	X	X	X	☐ Plan-Specific Contact entry in Plan Summary updated ☐ Continuity of Care entry in the Plan Summary updated ☐ CII-CV Edit Overrides/Fills Limit updated to allow requests from LTC pharmacies for LTC members ☐ Covered skeletal muscle relaxants added to Soma criteria ☐ Practitioner Lockout info added for MCC-FL ☐ Update Physician Billing in the Plan Summary ☐ Common ICD-9 codes added for diagnosis of Primary immunodeficiencies ☐ Added Hydrocodone Combination Product Rescheduling Update ☐ Updated Olysio Criteria ☐ Updated Summary of Limitations ☐ Updated Abilify Maintena, Invega Sustenna, Risperdal Consta, and Zyprexa Relprevv criteria ☐ Updated Pristiq criteria to remove diagnosis of major depressive disorder
09/12/2014			X	☐ CCP/SFCCN: Allowance of full-term one-year approvals for HIV meds from pharmacies.
09/10/2014	X	X	X	☐ Pneumococcal Vaccine AuotPA chart added to Immunizations: Influenza Vaccine, Pneumococcal Vaccine, Shingles Vaccine, Etc ☐ Review of documentation of Auto PA edits ☐ Brand Medically Necessary criteria updated. ☐ Xolair criteria updated: new minimum age of 12 years eff. mid 08/2014. ☐ PDL: Non-Preferred Brand Required initiative section deleted from Miscellaneous ☐ Added Aptiom Criteria ☐ Added Hetlioz Criteria ☐ Updated Banzel Criteria ☐ Updated Fycompa Criteria ☐ Updated Lamictal XR Criteria ☐ Updated Antipsychotic High Dose Table

Date	MCC-FL	FCA	CCP/SFCCN	Issues / Updates
				Updated Onfi Criteria Updated Oral Oncology Medication Table Updated Oxtellar XR Criteria Updated Sabril Criteria Updated Trokendi XR Criteria CII-CV Edit Overrides / Fills Limit: clarified as rolling 30 days and not calendar 30 days.
09/09/2014	X			MCC-FL: CoC DME policy implemented
08/27/2014	X	X	X	Review of Pharmacist Review Only edits Review of Auto PA edits
08/20/2014	X	X	X	Hospital discharge policy added for prior auth edits. Updated Actemra Criteria Updated Anticonvulsant AutoPA Criteria Updated Axert Criteria Updated Ilaris Criteria Updated Kineret Criteria Updated Nuedexta Criteria Updated Onfi Criteria Updated Orencia Criteria Updated Relpax Criteria Updated Remicade Criteria Updated Simponi Criteria Updated Sovaldi Criteria Updated Summary of Limitations
08/04/2014	X	X	X	Updated Antipsychotic High Dose Chart Updated Clinical Prior Authorizations Medication List Updated Early Refills Guidelines Updated High Dose Guidelines Updated IVIG Criteria Updated Nuedexta Criteria Added Adcetris Criteria Added Age Limitations Criteria Added Antara Directive Added Chorionic Gonadotropin Criteria Added Cinryze Criteria Added Drug to Gender (Estrogen in Male Gender) Directive Added Farxiga Criteria Added Hydroxyprogesterone Caproate Injection Directive Added Kadcyla Criteria Added “NDC not Covered” Directive Updated Butalbital Containing Products Criteria Updated Granulocyte Colony Stimulating Factors Criteria Updated IVIG Criteria

Date	MCC-FL	FCA	CCP/SFCCN	Issues / Updates
				☐ Updated IV Antiemetics Criteria ☐ Updated Makena Criteria ☐ Updated PDL: Non-Preferred Brand Required Initiative Drug List ☐ Updated Oral Oncology Criteria ☐ Updated Olysio Criteria ☐ Updated Promacta Criteria ☐ Updated Regranex ☐ Updated Sovaldi Criteria ☐ Updated Summary of Limitations ☐ Updated Tobi Podhaler Directive ☐ Updated Triptans Criteria ☐ Updated Valcyte Criteria ☐ Updated Xeljanz Criteria ☐ Updated Xenazine Criteria ☐ Updated Xifaxan Criteria ☐ Updated Xolair Criteria ☐ Updated Xyzal Criteria ☐ Updated Zyvox Criteria ☐ P&T Committee Changes (PDL: Clindesse 2% vaginal cream, Corifact kit, Dronabinol, Ondansetron Vials/syringe, Suprax 400mg caps) (Non PDL: Amoxicillin-clavulanate potassium ER 1000mg/62.5mg, Auvi-Q, Cefalcor, Cefadroxil, Cefditoren, Cimzia, Copaxone 40mg/ml syr, Diazepam, Escitalopram, Marinol, Opsumit, Phenelzine, Pioglitazone/Met, Tranlycypromine)
07/01/2014	X	X	X	☐ Minor formatting changes; Initial document creation for CCP/SFCCN
06/05/2014	X	X		☐ Added Brintellix Criteria ☐ Added Fetzima Criteria ☐ Added Fuzeon Criteria ☐ Added Granix Criteria ☐ Added Growth Hormone Criteria ☐ Added Namenda Criteria ☐ Added Neumega Criteria ☐ Added Selzentry Criteria ☐ Added Serostim Criteria ☐ Added Sirturo Criteria ☐ Added Vecamyl Criteria ☐ Added Vfend Criteria ☐ Added Vimizim Criteria ☐ Updated Olysio Criteria ☐ Updated Sensipar Criteria ☐ Updated Sovaldi Criteria

Date	MCC-FL	FCA	CCP/SFCCN	Issues / Updates
				Updated Summary of Limitations Updated Viibryd Criteria
05/09/2014	X	X		Removed criteria for Dulera (PDL, min age= 12) Updated Kineret Criteria Updated Olysio Criteria Updated Summary of Limitations Updated Sovaldi Criteria Updated PDL: Non-Preferred Brand Required Initiative Drug List P&T Committee Changes (PDL: Dulera) (Non PDL: Benzoyl Peroxide cleanser, Differin gel/pump, Tretinoin gel, Lidocaine/Prilocaine Kit, Lidocaine HCL solution, Fosinopril, Moexipril, Moexipril HCT, Perindopril, Tekturna, Tekturna HCT, Mycamine , Leukine, Amiloride, Levofloxacin vials, Pulmicort Flexhaler, Protopic, Eliphos, Phoslo, Fosrenol, Betamethasone val lot'n/oint, Fluocinonide cream/oint, Triamcinolone ace lotion, Alclometasone dip cr, Capex Shampoo, Desonide cream/ointment, Fluocinolone ace cream/oint., sol'n, Mometasone oint, Halobetasol cr, Amturnide, Tekamlo, Tribenzor).
05/01/2014	X	X		Initial document creation
04/07/2014				Removed Keppra Oral Sol'n Directive (Pts > 11y/o) – An age limitation no longer applies to this product Updated Oral Oncology Criteria Updated PDL: Non-Preferred Brand Required Initiative Drug List Updated Sedative/Hypnotic Criteria Updated Summary of Limitations
03/17/2014	X			Added Invokana Criteria Added Ilaris Criteria Updated Actemra Criteria Updated Kineret Criteria Updated Oral Oncology Agents Table Updated Summary of Limitations
02/28/2014	X			Added Fycompa Criteria Added Trokendi XR Criteria Updated PDL: Non-Preferred Brand Required Initiative Drug List
02/21/2014	X			Added Olysio Criteria Added Sovaldi Criteria Updated PDL: Non-Preferred Brand Required Initiative Drug List
02/07/2014	X			Added Diclegis Criteria Added Epaned Criteria Added Dexmethylphenidate 5mg Shortage Directive Removed Natroba Criteria (medication is now preferred) Updated PDL: Non-Preferred Brand Required Initiative Drug List

Date	MCC-FL	FCA	CCP/SFCCN	Issues / Updates
				☐ Updated Summary of Limitations ☐ P&T changes (PDL: Bydureon, Claforan, Dorzolamide/Timolol, Meropenem, Natroba, Tazicef) (Non PDL: Asacol HD, Cefepime/D5W IVPB, Colcrys, Ovide 0.5%, Proair HFA, Tobramycin 300mg/5ml, Triazolam 0.125mg & 0.5mg tabs, Ventolin HFA)
01/09/2014	X			☐ Updated Pulmonary Hypertension Agent Criteria ☐ Updated PDL: Non-Preferred Brand Required Initiative Drug List
12/10/2013	X			☐ Updated CPP Criteria ☐ Updated Oral Oncology Agents Table ☐ Updated Potiga Criteria ☐ Updated Summary of Limitations
11/04/2013	X			☐ Updated Summary of Limitations
10/24/2013	X			☐ Added Axert Criteria ☐ Added Human Growth Hormone Criteria (per website ☐ Added Korlym Criteria ☐ Added Lamictal XR Criteria ☐ Added Oxtellar XR Criteria ☐ Added Relpax Criteria ☐ Added Viibryd Criteria ☐ Updated Antimigraine Therapy (Triptan) Table ☐ Updated Invega Sustenna Criteria ☐ Updated Makena Criteria ☐ Updated Oral Oncology Agents Table ☐ Updated 'PDL: Non-Preferred Brand Required Initiative' medication list ☐ Added P&T changes (PDL: Rizatriptan, Prudoxin, Fluocinolone 0.01% oil, Simbrinza), (Non PDL: Namenda XR, Dihydrocodeine/APAP/CAFF, Oxycodone/ASA, Oxycodone/IBU, Tobi Podhaler, Diclegis, Clotrimazole-Betamethasone cream, Naftin cream, Relpax, Zonalon, Abilify, Actonel, Fortical, Suclear sol'n, Liptruzet, Simcor, Aubagio, Tecfidera, Fenoprofen, Meloxicam susp, Signifor, Prolensia, Dermotic)
09/10/2013	X			☐ Added Berinert Criteria ☐ Updated Age Limit Over Maximum Criteria (MMA will now override requests for PDL liquid products that have a max age limit for patients that have NG-Tubes, G-Tubes, PEG-Tubes or J-tubes. ☐ Updated 'PDL: Non-Preferred Brand Required Initiative' medication list ☐ Updated Promacta Criteria ☐ Updated Summary of Limitations

Date	MCC-FL	FCA	CCP/SFCCN	Issues / Updates
08/07/2013	X			Removed Brilinta Criteria (Now PDL) Removed Effient Criteria (Now PDL) Updated Summary of Limitations Added P&T changes (PDL: Auvi-Q, Brilinta, Effient, Finacea, Phenelzine, Quillivant XR- min age 6), (Non PDL: Ciprofloxacin otic, Methylphenidate sol'n, Metrogel topical, Nardil, Nizatidine, Noritate, Ranitidine caps)
07/12/2013	X			Updated Summary of Limitations
06/28/2013	X			Updated H.P. Acthar Criteria (Prior authorization requests for this medication are now handled by AHCA only.)
06/17/2013	X			Added Zortress Criteria
06/10/2013	X			Added Corifact Criteria Added Cystadane Criteria Added Gablofen Criteria Added Neupro Criteria Added Pomalyst Criteria Added Relistor Criteria Updated Summary of Limitations
05/03/2013	X			Initial document creation

From:	Craig, Sara
Sent:	Friday, October 28, 2016 11:14 AM EDT
To:	\"\"Glaze\"\",\"\" Tiffany; Sara.Craig@ahca.myflorida.com; Kym.Holcomb@ahca.myflorida.com; Susan.Williams@ahca.myflorida.com
Subject:	FW: criteria/GAPMS
Attachments:	image001.png, image002.jpg, image003.jpg

I don't think the Fallon criteria is listed below, but see if this helps. I'm going to try and use Aetna, Blue Regence, Moda

Sara Craig, PharmD, CPh
Senior Pharmacist
Agency for Health Care Administration
Medicaid Pharmacy Policy
Email: Sara.Craig@ahca.myflorida.com

From: Elliott, Arlene
Sent: Monday, August 29, 2016 10:35 AM
To: Craig, Sara; 'RJBorgert@magellanhealth.com'; Holcomb, Kym; Williams, Susan C.
Cc: 'Moore, Elboni'
Subject: RE: criteria/GAPMS

FYI – criteria ideas

http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=20&ved=0ahUKEwjeharT6ubOAhVH5iYKHZYfAIg4ChAWCF8wCQ&url=http%3A%2F%2Fwww.fchp.org%2Fproviders%2Fmedical-management%2F~%2Fmedia%2FFiles%2FProviderPDFs%2FMedicalPolicies%2FTransgenderServices.ashx&usg=AFQjCNHGumXLS82ivBfVGHDP6bXEeJOdbQ

Aetna considers gonadotropin-releasing hormone medically necessary to suppress puberty in trans identified adolescents if they meet World Professional Association for Transgender Health (WPATH) criteria (see CPB 501 - Gonadotropin-Releasing Hormone Analogs and Antagonists). The 6th (2001) and the 7th (2011) versions of the standards of care for the health of transsexual, transgender, and gender non-conforming people of World Professional Association for Transgender Health (WPATH) recommend that transgender adolescents (Tanner stage 2, [mainly 12 to 13 years of age]) are treated by the endocrinologists to suppress puberty with gonadotropin-releasing hormone (GnRH) agonists until age 16 years old, after which cross-sex hormones may be given. http://www.aetna.com/cpb/medical/data/600_699/0615.html

Treatment of Adolescents http://blue.regence.com/trgmedpol/medicine/med153.pdf

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1. We recommend that adolescents who fulfill eligibility and readiness criteria for gender reassignment initially undergo treatment to suppress pubertal development.
2. We recommend that suppression of pubertal hormones start when girls and boys first exhibit physical changes of puberty (confirmed by pubertal levels of estradiol and testosterone, respectively), but no earlier than Tanner stages 2–3.
3. We recommend that GnRH analogs be used to achieve suppression of pubertal hormones.
4. We suggest that pubertal development of the desired opposite sex be initiated at about the age of 16 year, using a gradually increasing dose schedule of cross-sex steroids.
5. We recommend referring hormone-treated adolescents for surgery when: a. the real-life experience (RLE) has resulted in a satisfactory social role change;
b. the individual is satisfied about the hormonal effects; and
c. the individual desires definitive surgical changes.
6. We suggest deferring surgery until the individual is at least 18 year old.

http://press.endocrine.org/doi/full/10.1210/jc.2009-0345

http://www.imatyfa.org/permanent_files/pubertyblockers101.html

https://www.modahealth.com/pdfs/med_criteria/GenderReassignment.pdf: VI. Treatment of the Adolescent with gender dysphoria may be considered medically appropriate with **ALL** of the following:
a. Psychological assessment of children or adolescents who present with gender dysphoria includes ALL of the following
i. Assessment and guidance is provided by a qualified mental health professional trained in childhood and adolescent psychopathology and competent in diagnosing in a multidisciplinary setting or in consultation with a pediatric endocrinologist. (*See Appendix C*)
ii. Provides family counseling and supportive psychotherapy to assist the child or adolescent with exploring their gender identity
iii. Assess and treat any coexisting mental health concerns of children and adolescents and address them as part of the overall treatment plan
iv. Refer adolescents for additional physical interventions (such as puberty-suppressing hormones) with the appropriate documentation of assessment of gender dysphoria and mental health.
v. Ability to educate and advocate on behalf of the gender dysphoric child, adolescent, and their family in their community.
vi. Provide information and referral for peer support and support groups for parents of gender-nonconforming and transgender children.

http://www.basicrights.org/wp-content/uploads/2015/09/OHP_FAQ_for_CommunityPartners_Mar_2016.pdf

What is covered under the new guidelines for the Oregon Health Plan? Effective January 1, 2015, the State of Oregon has extended coverage for most transition-related healthcare under the State's Medicaid Program, the Oregon Health Plan. These services include coverage for puberty

suppression, primary care and specialist doctor visits, mental health care visits, cross-sex hormones, anti-androgens, lab work and some surgeries.

http://www.bmchp.org/~/media/d86fcbe8c97f4312834b4975caf64c6f.pdf?

Arlene Elliott - AGENCY FOR HEALTH CARE ADMINISTRATOR-SES

Bldg. 3, Rm. 2332A - BUREAU OF MEDICAID POLICY
2727 MAHAN DR TALLAHASSEE, FL 32308
412-4152 (Office)
Arlene.Elliott@ahca.myflorida.com

From: Elliott, Arlene
Sent: Monday, August 29, 2016 8:11 AM
To: Craig, Sara <Sara.Craig@ahca.myflorida.com>; 'RJBorgert@magellanhealth.com' <RJBorgert@magellanhealth.com>; Holcomb, Kym <Kym.Holcomb@ahca.myflorida.com>; Williams, Susan C. <Susan.Williams@ahca.myflorida.com>
Cc: Moore, Elboni <EAMoore@magellanhealth.com>
Subject: criteria/GAPMS

Good morning,

Sara/Becky:

Please work on creating criteria for approval of agents used to suppress puberty in transgender children. Criteria would be for the agents but also needs to be focused in behavioral condition/ treatment. I found an article on Medscape that could be very helpful http://www.medscape.com/viewarticle/718619_2 . We want to bring the criteria to DUR in September.

The generally accepted professional medical standard (GAPMS) study has been finalized for this part of transgender tx. It concluded that it is a generally accepted professional medical standard. However, each case brought to Medicaid will be reviewed under the special services provision in an individualized basis. I have to confirm but I would think that when approvable, we would be approving Lupron rather than an implant, because 1. We would get rebate with Lupron and 2. It can be discontinued easier if the patient would like to reverse that decision. Also, I have to check what the Agency wants the age of these children to be when starting this treatment. The kid in the fair hearing that we have pending started with an implant I think at 8 y/o. The Medscape article talks about 12 y/o.

Susan/Kym/all,

The next GAPMS we need to work is regarding step 2 of the trans treatment: cross-sex hormone treatment. There is info in the Medscape article also but we need to research a lot more. We need to research, print, read, and summarize and then put it all together. Let's all send the links to the articles to Kym so she can keep a list. That way we will make sure we are all not looking at the same articles. Kym can then print the articles. Then we will divide them between all of us and start reading and summarizing. Please make sure the articles are from a solid source. We need to research the AAP, Endocrinology Assoc., Transgender Assoc., guidelines, etc.

We need to start working on this this week. Thanks!

Arlene Elliott - AGENCY FOR HEALTH CARE ADMINISTRATOR-SES

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Arlene.Elliott@ahca.myflorida.com

From: Borgert, Rebecca
Sent: Monday, August 29, 2016 3:03 PM EDT
To: Craig, Sara
CC: Moore, Elboni A.
Subject: FW: guidelines
Attachments: Endocrine Society Guidelines 2009_Transgender_highlighted.pdf, image001.png, image002.jpg

Sara,
Well, it looks like Arlene beat me to the punch. This does seem to be the guideline that AHCA would want to use as a basis for criteria. I was surprised that it was so old (2009) and that it hasn't been updated but I checked the Endocrine Society website and this is the most recent version.

I highlighted the PDF I have attached in terms of things I think would be relevant to consider in the development of the criteria. I'm not sure if you've had a chance to read this or not but in a nutshell they recommend:

- Diagnosis of gender identity disorder (GID) must be made by a mental health professional and confirmed by treating endocrinologists based on the DSM-IV-TR diagnostic criteria for GID
- GnRH therapy to suppress puberty in kids that are at least Tanner stage 2. Table 5 in the document has a list of some other eligibility requirements (adequate psychosocial support, etc) that we may want to include. Definition of Tanner stages is in Table 6
- Giving estradiol or testosterone to induce opposite-sex puberty should be initiated at the age of 16 (Doses are available in Table 9)

Let me know if I can help in any other way.

Thanks,
Becky

From: Elliott, Arlene [mailto:Arlene.Elliott@ahca.myflorida.com]
Sent: Monday, August 29, 2016 2:05 PM
To: Craig, Sara; Borgert, Rebecca
Cc: Williams, Susan C.
Subject: RE: guidelines

Summary of recommendations endocrine society:

http://press.endocrine.org/doi/full/10.1210/jc.2009-0345

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From: Elliott, Arlene
Sent: Monday, August 29, 2016 1:33 PM
To: Craig, Sara <Sara.Craig@ahca.myflorida.com>; 'RJBorgert@magellanhealth.com' <RJBorgert@magellanhealth.com>
Cc: Williams, Susan C. <Susan.Williams@ahca.myflorida.com>
Subject: guidelines

http://transhealth.ucsf.edu/tcoe?page=guidelines-youth

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