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Explanation of Medicaid Policy

Drugs with Criteria and Limits

Many drugs in the Medicaid pharmacy program do not require a Prior Authorization (PA), but are still subject to restrictions that are outlined in the Medicaid Pharmacy Services Manual and the Medicaid Physician Services Manual. This section serves as a quick reference for the specific policies that govern coverage of these drugs.

In accordance with the Utah Medicaid Provider Manual for Pharmacy Services, SECTION 2, Chapter 4-10, Limits on Certain drugs, some drugs are limited by a quantity in any thirty-day period. These drugs do not qualify for early refills, as stated in Chapter 4-7, Early Refills. The limits listed are those approved by the Medicaid Drug Utilization Review (DUR) Board. Physicians and other prescribers who feel that a patient has specific needs that exceed the limits may appeal to the DUR Board. All medications remain subject to all the other requirements of the Utah Medicaid Pharmacy Program, as described in the Utah Medicaid Manual for Pharmacy Services.

Drugs Requiring Prior Authorization

In accordance with the Utah Medicaid Provider Manual for Pharmacy Services, SECTION 2, Chapter 3, certain drugs that are covered by the Medicaid program may require the patient and physician to meet specific criteria and demonstrate medical necessity in order to receive the requested medication. Detailed information regarding prior approval criteria for individual medications and classes of medications is provided in this manual.

Please note that prior authorization for a medication is client specific, and product specific. Prior authorization cannot be transferred to another product, nor to another strength of a product that has been approved. The prior authorization cannot be transferred to another client.

To initiate a prior authorization request, the physician must obtain the most current criteria sheet from the Medicaid Pharmacy Services Website at https://medicaid.utah.gov/pharmacy/pharmacy-program and gather all of the records that are requested in the criteria set for the medication being prescribed. The requests can be faxed to (855) 828-4992. The criteria sheet must be completely and legibly filled out and must be accompanied by all requested information. Incomplete and illegible requests will be returned to the prescriber without being processed by Medicaid. All injectable products, with the exception of 10ml vials of insulin and anti-Hemophilia factor, require prior authorization under the Non-Traditional Medicaid plan.

Non-Traditional Medicaid has additional restrictions in place. In accordance with the Utah Medicaid Provider Manual for Non-Traditional Medicaid, SECTION 2, Chapter 2-19.2, no lozenges, suckers, rapid dissolve, lollipop, pellets, patches or other unique formulation delivery methodologies developed to garner “uniqueness” will be covered, except where the specific medication is unavailable in any other form (Duragesic and Actiq). Drugs are covered for labeled indications only.

Drugs Requiring ICD.9 Codes

All atypical antipsychotics require a select diagnosis code using the ICD.9 format. Covered diagnoses are determined according to the three following age groups: ages 0 through 6; ages 7 through19; ages >19. Attachments to Section 2 of the Medicaid Pharmacy Provider Manual show covered ICD.9 codes for each age group respectively. All stimulants for the treatment of ADD/ADHD in clients under the age of 19 require the appropriate ICD.9 diagnosis code for payment.

Cumulative limits on long-acting narcotic analgesics and short-acting single entity narcotic analgesics are waived for the treatment of cancer-related pain. Additionally, Fentanyl 100mcg patches, fentanyl lozenges, and fentanyl buccal tablets are covered only for terminal cancer-related pain. The prescriber must provide an appropriate ICD.9 diagnosis code for terminal cancer on prescriptions for these drugs.

It is the prescriber's responsibility to provide the correct ICD.9 code on each prescription for an atypical antipsychotic, ADD/ADHD medication, or narcotic pain medication for cancer pain. The ICD.9 code may be hand-written by the prescriber on the prescription or computer generated by prescribing software. Pharmacy providers may also obtain ICD.9 codes verbally from prescribers, and note the date, time, and name of the physician’s representative providing the ICD.9 code on the original hard-copy prescription. The pharmacist must enter that ICD.9 code into the appropriate diagnoses field when processing a claim.

Additionally, Bupropion products and Cymbalta require an ICD.9 code classification to be entered by the pharmacy when billed through the Pharmacy POS System.

- Bupropion must be classified as smoking cessation (305.1) or depressive disorders (311).
- Cymbalta prescriptions must be classified as neuralgias (729.2) or depressive disorders (311).

As part of normally required counseling pharmacy staff may ask a patient what condition is being treated and categorize the prescription accordingly. For these two drug products, the diagnosis does not need to be written on the prescription by the prescriber.

Exceptions to Policy

All requests for exceptions to policy require a petition to the DUR board. DUR meetings are held on the second Thursday of every month. Petitions to the DUR board must be received one week prior to the monthly meeting. Petitions may be faxed to the prior authorization team.

Drugs with Criteria and Limits	
ADD/ADHD Medications	
Amphetamines	Amphetamines: • Age 0-2: Prior Authorization Required – see Stimulants *(for Children)*. • Age 3-5: Immediate-release Adderall and Dexedrine generic formulations are covered - Valid ICD-9 code must be written on the prescription. • Age 6-18: Covered - Valid ICD-9 code must be written on the prescription. • Age 19+: Prior Authorization Required - see Stimulants *(for Adults)*.
Methylphenidate & Derivatives	Methylphenidate & Derivatives • Age 0-5: Prior Authorization Required – see Stimulants *(for Children)*. • Age 6-18: Covered - Valid ICD-9 code must be written on the prescription • Age 19+: Prior Authorization Required - see Stimulants *(for Adults)*. • Long Acting Methylphenidate is limited to 64 per 30 days. • Daytrana patch is non-covered over age 18 or for Non-Traditional Medicaid clients.
Strattera	Strattera • Covered for ages 6+. • Cumulative limit of 66 capsules in 30 days.
Analgesics	
Tramadol/ Ultracet/ Tramadol ER	Tramadol/Ultracet: • Cumulative limit of 180 tablets in 30 days Tramadol ER • Cumulative limit of 90 tablets in 30 days
Fentanyl Patch	Fentanyl Patch: • Cumulative limit of 15 patches in 30 days • The cumulative limit may be overridden if the prescriber provides a valid ICD-9 diagnosis code for terminal cancer. • The 100mcg Fentanyl Patch is *only* covered with valid ICD-9 diagnosis code for terminal cancer. • Mutually exclusive with methadone and other long-acting opioids. • Unique Fentanyl formulation dosage forms (buccal, nasal, and sublingual) are not covered for Non-Traditional or PCN clients.
Fentanyl Formulations *(Fentora, Actiq, Lazanda, Onsolis, Abstral and Subsys)*	• Only a covered benefit if the prescriber provides a valid ICD-9 diagnosis code for terminal cancer.
Methadone	Methadone : • Cumulative limit of 150 tablets in 30 days.

	• Liquid dosage forms are limited to 2000ml per 30 days. • The cumulative limit may be overridden if the prescriber provides a valid ICD-9 diagnosis code for terminal cancer. • Mutually exclusive with fentanyl patches and long-acting opioids.
Long-Acting Opioids	Long-Acting Opioids: • Cumulative limit of 90 tablets in 30 days. • The cumulative limit may be overridden if the prescriber provides a valid ICD-9 diagnosis code for terminal cancer. • Preferred Drug List applies to this class. • Mutually exclusive with methadone and fentanyl patches.
Short-Acting Opioids	Short-Acting Opioids: • Cumulative limit of 180 tablets in 30 days • Liquid dosage forms are limited to 2000ml per 30 days. • The cumulative limit may be overridden on non-APAP containing short acting opioids if the prescriber provides a valid ICD-9 diagnosis code for terminal cancer (APAP containing short acting opioids may not exceed 180 tablets in 30 days).
Atypical Antipsychotics *(Abilify, Clozaril, Geodon, Invega, Risperidal, Risperdal Consta, Seroquel, Symbyax, Zyprexa)*	• Valid ICD-9 diagnosis code is required on each prescription. • ICD-9 codes may be found in the Utah Medicaid Provider Manual for Physicians Services and Anesthesiology. • ICD-9 code must be correct for the patient's age. • Risperdal Consta non-covered for Non-Traditional or PCN clients.
Benzodiazepines	• Cumulative limit of 120 tablets/capsules in 30 days. • Short acting benzodiazepines that are typically used to treat insomnia are governed by the criteria for sedative-hypnotics.
Bupropion *(Zyban, Wellbutrin)*	• One of two valid ICD-9 diagnosis codes is required on each prescription. • ICD-9 311 indicates depressive disorders. • ICD-9 305.1 indicates smoking cessation. • Pharmacy staff may ask a patient which condition is being treated and categorize the prescription accordingly. The diagnosis does not need to be written on the prescription or provided by the prescriber. • Wellbutrin XL is non-covered under Non-Traditional Medicaid.
Celebrex	• Cumulative limit of 60 capsules in 30 days.
Cymbalta *(duloxetine)*	• One of two valid ICD-9 diagnosis codes is required on each prescription. • ICD-9 311 indicates depressive disorders. • ICD-9 729.2 for neuralgias, etc. • Pharmacy staff may ask a patient which condition is being treated and categorize the prescription accordingly. The diagnosis does not need to be written on the prescription or provided by the prescriber. • The maximum daily dose is 60mg. Monthly quantity limits are set accordingly. • Doses in excess of 60mg per day require an eight-week documented trial and failure of a 60mg daily dose.
Diphenoxylate	• Cumulative limit of 180 tablets in 30 days.

Containing Products	
Flu Vaccine	• Limited to 0.5ml
Inhalers	LIMIT IN ANY 30 DAY PERIOD

The cumulative number of inhalers in any 30-day period is limited for a Medicaid client. The limit is set by class (excepting Foradil and Serevent which are limited by NDC number). This means the highest number in any one class is the maximum. When there are more than two sizes or strengths for a given product, the limit is based on the largest size or strength. There are two groups of inhalers: oral and nasal. For each group, the limits are stated below.

Inhaler Class	Generic Name	Brand Name	Product Size	Dose per Inhaler	Maximum No. In 30 Days
Nasal Anti-inflammatory inhalers	beclomethasone	Beconase AQ	25	200	2
	fluticasone	Flonase	16	120	1
	triamcinolone	Nasacort AQ	16.5	120	2
	triamcinolone	Nasacort HFA	9.3	100	3
	flunisolide	Nasarel	25	200	3
	mometasone	Nasonex	17	120	1
	budesonide	Rhinocort AQUA	8.4	120	2
	albuterol	Proair	8.5 gm	200	4
		Proventil HFA	6.7 gm	200	4
		Ventolin HFA	18 gm	200	4
			8 gm	60	4
	formoterol	Foradil		12	1
				60	2
	metaproterenol	Alupent	14 gm	200	2
	pirbuterol	Maxair	25.6 gm	300	3
		Maxair Autohaler	14 gm	400	1
	salmeterol	Serevent	6.5 gm	60	1
			13 gm	120	1
		Serevent Diskus		60	1
Anticholinergic Inhalers	ipratropium	Atrovent HFA	14 gm	200	2
	ipratropium/albuterol	Combivent	14.7 gm	200	2
	tiotropium	Spiriva	30 caps	30	1
Anti-inflammatory Inhalers	beclomethasone	Qvar 40 mg	7.3 gm	100	2
		Qvar 80 mg	7.3 gm	100	2
	budesonide	Pulmicort Turbuhaler		200	2
	flunisolide	Aerobid, Aerobid-M	7 gm	100	2
	fluticasone MDI	Flovent	13 gm	120	1
				120	1

				120	2
	fluticasone DPI	Flovent Rotadisk 50 mcg, 100 mcg, 250 mcg		60	1
				60	1
				60	4
	triamcinolone MDI	Azmacort	20 gm	240	2
	fluticasone/ salmeterol DPI	Advair Diskus 100/50		60	1
		Advair Diskus 100/50		60	1
		Advair Diskus 250/50		60	1
		Advair Diskus 500/50		60	1
Mast cell stabilizer Inhalers	cromolyn MDI	Intal	8.1 gm	112	3
			14.2	200	2
	nedocromil MDI	Tilade	16.2 gm	112	2

Insulin	• Prescriptions are limited to 60 ml per month. • Higher doses may be overridden if the prescriber furnishes proof of medical necessity of the higher dose. • Preferred Drug List applies to this class.
Laxatives	
Miralax	Miralax: • Cumulative Limit of 1054 gm in 30 days
Lactulose	Lactulose: • Cumulative limit of 6,000 ml in 30 days • Over 6,000 ml in 30 days requires a prior authorization – see Lactulose.
Levothyroxine Products	• Generic use mandated when AB-rated equivalent exists • Use the table below to determine appropriate substitutions: Drug — Rating Unithroid — AB1,AB2, AB3 Mylan Levothyroxine — AB1,AB2,AB3 Levoxyl — AB1, AB3 Synthroid — AB2 Levo-T — AB2, AB3
Metformin	• The maximum daily dose is 2550mg. Dosage limits are set accordingly.
Migraine Medications	
Triptans *(Imitrex, Zomig, Amerge, Axert, Maxalt, Relpax)*	Triptans: • Cumulative limit of 9 dosage units per 30 days - all forms count towards this limit. • Examples of drugs in this class include Imitrex, Maxalt, and Zomig. • Preferred Drug List applies to this class.
Cambia	Cambia: • Cumulative limit of 9 dosage units per 30 days.
Muscle Relaxants	• Cumulative limit of 30 tablets in 30 days. • Dantrolene, Baclofen, and Tizanidine are not included in this 30 day limit policy. • Preferred Drug List applies to this class.

Plan B	• Cumulative limit of two kits per month. • OTC products included (prescription required).
Pristiq	• Limit of 30 tablets in 30 days.
Proton Pump Inhibitors	**Hypersecretory Conditions**: Proton Pump Inhibitors are generally FDA-approved for once daily dosing, and only indicated for twice daily dosing in specific cases of hypersecretory conditions or H. pylori infection. • Please write the appropriate hypersecretory condition or H. pylori diagnostic code on the face of the prescription. Twice-daily dosing will be reimbursed at the pharmacy point of sale with no further intervention on your part. **Other Diagnosis**: Peer-reviewed research has demonstrated that, in most cases, switching to a different PPI is as effective as doubling the dose of the original PPI. Also, counsel your patient to take their PPI 30min before breakfast – this regimen increases efficacy ten-fold. If twice daily dosing is desired, please provide the following: • Evidence of failure on an appropriate dosing regimen. • Consultation with a GI, ENT, pulmonary or allergy specialist. **Notes**: Prevacid Solutabs: No prior authorization is required for children under 12 who cannot swallow tablets or capsules or for patients of any age who have a feeding tube. Please inform Medicaid by faxing a note to 855-828-4992. No compounded solutions will be approved, including omeprazole/sodium bicarbonate. **AUTHORIZATION**: 6 months **RE-AUTHORIZATION**: 1 year, with an updated letter of medical necessity
Savella	• Maximum daily dose of 100mg per day. • Doses of 200mg per day may be approved after a minimum two-month trial of the 100mg per day dose.
Sedative Hypnotics for sleep *(Dalmane, Sonata, Somnote, Halcion, Ambien, Doral, Restoril, Lunesta, Rozerem, and their generics)*	• Cumulative limit of 30 units in 30 days. • Benzodiazepines that are typically used to treat insomnia are considered part of this class. • Preferred Drug List applies to this class.
Synera	• Limit of 5 patches per 30 days

Drugs Requiring Prior Authorization	
Adult Acne	• Diagnosis of acne vulgaris AND/OR • Nodular acne AND/OR • Cystic acne. • **AUTHORIZATION**: 6 months. • **RE-AUTHORIZATION**: Documentation indicating patient has had at least a 25% improvement or more from baseline. Re-authorization is then for 6 months.
Amitiza	• Patient must be age 18 or above • Other causes of constipation (including non-opioid drugs) must be ruled out • Diagnosis of Chronic Idiopathic Constipation: ▪ Documented failure within the last 12 months using • One fiber laxative AND • Two stimulant laxative products • Diagnosis of Irritable Bowel Syndrome with Constipation: ▪ Documented failure within the last 12 months using • One fiber laxative AND • One osmotic laxative (magnesium salts or polyethylene glycol based laxatives) • Diagnosis of Opiate-Induced Constipation: ▪ Documented failure within the last 12 months using • One stool softener AND • One stimulant laxative product • **AUTHORIZTION**: 6 months for chronic constipation • **RE-AUTHORIZATION**: Trial off Amitiza, using other laxatives, for at least 30 days.
Ampyra	• Minimum age requirement: 18 years old. • Documented diagnosis of Multiple Sclerosis. • No history of seizures. • No history of moderate to severe renal impairment, as evidenced by a creatinine clearance rate greater than or equal to 51mL/min. • **AUTHORIZATION**: Initial authorization will be granted for three months. Three months is sufficient to assess efficacy in each patient. • **RE-AUTHORIZATION**: Reauthorization period is 1 year. Updated letter of medical necessity indicating: no seizures, current renal function greater than or equal to 51ml/min, and documented treatment efficacy (i.e. an increase in walking speed).
Androgens	Danazol for Females: • Only FDA-approved uses will be considered. Please submit appropriate documentation describing one of the following: ○ Hormone-responsive endometriosis ○ Trial and failure of at least one other treatment for fibrocystic breast disease ○ Trial and failure of at least one other treatment for hereditary angioedema Androgens for males • ≥ 19 years old • Males only • Diagnosis of 253.4 or 257.2

	• Symptoms of testosterone deficiency • Two morning testosterone levels below the individual lab's reference range (different laboratories use different assays and thus may have different ranges which are considered low, optimal, or high) • **AUTHORIZATION**: 6 months • **RE-AUTHORIZATION**: 1 year at a time. • Danazol® for Females: Requests must be accompanied by progress notes or a letter of medical necessity justifying continued therapy. Therapy must be for an FDA-approved use. • Androgens for males: Requests must be accompanied by two morning testosterone levels, drawn on different days while on androgen therapy, in order to verify drug absorption. Labs drawn while off androgen therapy will not be accepted. If labs are not obtained while on androgen therapy, the patient must wait 6 months (androgen free) before re-applying for a new authorization.

Antibiotics *(Injectable)* **for Non-Traditional Medicaid Clients**	• Injectable antibiotics and diluents associated with the preparation and administration of injectable antibiotics are available under the following circumstances:
	  • Continuation of treatment that was started in the hospital;
	  • Documented diagnosis of cellulitis;
	  • Documented diagnosis of osteomyelitis
	• Prior authorization MUST include the anticipated duration of therapy.
	• **AUTHORIZATION**: Prior authorization will be granted for the requested duration of therapy.
	• **RE-AUTHORIZATION**: Updated letter of medical necessity.

Antidiabetic Agents	**NOTE**: Utah Medicaid's pharmacy point of sale system has been programmed to automatically check the patient's records for the following information. If the information is found, an automatic PA will be given at the point of sale, without intervention from the pharmacist or prescriber. If the required information is not found and the claim is rejected, the prescriber can manually request a PA.

DPP-4 inhibitors and combination products	• Age ≥ 18 yrs • Diagnosis of diabetes mellitus type 2 • No diagnosis of pancreatitis • Previous ≥ 90 day trial of metformin OR sulfonylurea OR insulin
GLP-1 Receptor Agonists	• Age ≥ 17 yrs • Diagnosis of diabetes mellitus type 2 • No diagnosis of thyroid tumors • No concurrent short- or intermediate-acting insulins (30 day overlap allowed for therapy switch) • Previous ≥ 90 day trial of metformin OR sulfonylurea OR insulin • Concurrent treatment with metformin OR sulfonylurea OR TZD
TZDs and combination products	• Age ≥ 18yrs • Diagnosis of diabetes mellitus type 2 • No diagnosis of heart failure • Previous ≥ 90 day trial of metformin OR sulfonylurea OR insulin
SGLT2 Inhibitors	• Age ≥ 18yrs • Diagnosis of diabetes mellitus type 2 • No diagnosis of bladder cancer • Diagnosis of diabetes mellitus type 2 • Previous ≥ 90 day trial of metformin OR sulfonylurea OR insulin
Cycloset	**Cycloset**: • Age > 18 years. • Diagnosis of Type 2 Diabetes. • Failure on or contraindication to Metformin. • May not be used concurrently with a TZD (i.e. Avandia or Actos) or by lactating women. • Maximum approved dose is 4.8mg daily. • Initial authorization is for 6 months – renewal periods of 1 year require documentation of improvement of A1C and/or fasting plasma glucose. **NOTES**: This form is for Non-Traditional clients only. Traditional clients may receive this medication without a prior authorization. • **AUTHORIZATION**: 1 year • **RE-AUTHORIZATION**: Updated letter of medical necessity
Insulin Pens	**Meet one or more of the following:** • legal blindness • debilitating rheumatoid or osteoarthritis of one or both arms, hands, and/or one or more fingers • reductive deformities of one or both arms, hands, and/or one or more fingers • Parkinsonism or essential tremor • mental retardation (severe intellectual disability) • any condition that necessitates that a patient, greater-than-or-equal-to the age of 19 years, have a legal guardian other than him/herself **NOTES**: • Patient age of less-than-or-equal-to the age of 18 years is not sufficient justification for approval of insulin pens(s). • Please consider before applying for PA: Utah Medicaid is happy to replace any insulin vials that a patient may break or otherwise render un-usable. • **AUTHORIZATION**: 1 year • **RE-AUTHORIZATION**: Updated letter of medical necessity

Anti-Emetics	
Aloxi	Aloxi: • Prevention of acute or delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy. • Must have failed on Zofran, Anzemet or Kytril (5-HT3's). • No other 5-HT3 medications are allowed as rescue drugs. • **AUTHORIZATION**: 6 months. • **RE-AUTHORIZATION**: Repeat course of chemotherapy following initial 6 months requires a new authorization.
Emend	Emend: • Patients receiving cancer chemotherapy regimens that are classified as high emetic risk may receive Emend as a first-line treatment. • Patients on other cancer chemotherapy regimens require a failure on trial of and ONE of the 5HT3 medications (e.g. Zofran, Anzemet, Kytril or Aloxi) **INFORMATION**: Used in combination with corticosteroid and other 5HT3 agents, is indicated for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy including high dose Cisplatin. • **AUTHORIZATION**: 6 months, 3 doses per chemotherapy session. • **RE-AUTHORIZATION**: Updated letter of medical necessity
Injectable Anti-Emetics for Non-Traditional Clients	• Trial and failure of oral anti-emetics. NOTES: Traditional Medicaid clients do not require clinical prior authorization. Non-Preferred authorization requirements may apply in certain Traditional Medicaid cases. **AUTHORIZATION**: Up to 30 days. **RE-AUTHORIZATION**: Updated letter of medical necessity.
	• **NOTE** **Ondansetron ODT**: No prior authorization is required for children under 12 who cannot swallow pills.
Anti-TNF, Non Anti-TNF. DMARD, and Janus Kinase Inhibitor Medications	
Actemra	Criteria for treatment of Rheumatoid Arthritis, Psoriatic Arthritis or Juvenile Idiopathic Arthritis (see criteria for other indications on different forms) • Diagnoses and age requirements: ▪ diagnosis of moderate to severe rheumatoid or psoriatic arthritis and age ≥ 18 years or ▪ diagnosis of juvenile idiopathic arthritis and age ≥ 2 years • History of treatment failure, incomplete response or intolerance to methotrexate, at least one other DMARD and at least one other anti-TNF • Rheumatology consultation within the last 60 days • Negative TB skin test or history of treatment for latent TB infection • Absence of active bacterial or viral infection, malignancy or immunosuppressive condition • May not be given with other biologic agents, experimental medications or combinations

	NOTES: Infusions are to be administered in the clinic setting only. The provider should bill with HCPCS code J3262 and PA number. Available as a Non-Traditional Medicaid Benefit. **AUTHORIZATION**: 1 year **RE-AUTHORIZATION**: 1 year increments. Fax an updated letter of medical necessity or progress notes showing improvement or maintenance with medication to 855-828-4992.
Arava	**Criteria for treatment of Rheumatoid Arthritis** o Age ≥ 18 years o Diagnoses of moderate to severe rheumatoid or psoriatic arthritis • History of treatment failure, incomplete response or intolerance to methotrexate, at least one other DMARD and at least one other anti-TNF. • Rheumatology consultation within the last 60 days **AUTHORIZATION**: 6 months **RE-AUTHORIZATION:** 1 year increments. Fax an updated letter of medical necessity or progress notes showing improvement or maintenance with medication to 855-828-4992.
Cimzia	**Criteria for treatment of Crohn's Disease** (see criteria for other indications on different forms) • Age ≥ 18 years • Diagnoses of moderately to severely active Crohn's disease • History of treatment failure, incomplete response or intolerance to one or more of the following: 5-aminosalicylate, antibiotics, methotrexate, 6-mercaptopurine, azathioprine, corticosteroids, budesonide or infliximab • Rheumatology consultation within the last 60 days • Negative TB skin test or history of treatment for latent TB infection • Absence of active bacterial or viral infection, malignancy or immunosuppressive condition • May not be given with other biologic agents, experimental medications or combinations **Notes:** If administered in clinic, provider shall bill with HCPCS code J0718 and PA number. Available as a Non-Traditional Medicaid Benefit. **AUTHORIZATION**: 1 year **RE-AUTHORIZATION:** 1 year increments. Fax an updated letter of medical necessity or progress notes showing improvement or maintenance with medication to 855-828-4992.
Cosentyx	**Criteria for Plaque Psoriasis:** • Age requirement: 18 years and older' • Diangosis of moderate to severe plaque psoriasis • Historyof incomplete response or intolerance to one appropriate systemic agent or phototherapy. • Negative TB skin test within the previous 12 months or history of treatment for latent TB infection. • Absence of active bacterial or viral infection, malignancy, or

	immunosuppressive condition. • Dermatology consultation within the last 60 days. • Cosentyx may not be given with other biologic agents such as interferon, experimental medications or combination. **NOTES:** Available as a Non-Traditional Medicaid Benefit. **AUTHORIZATION**: 1 year **RE-AUTHORIZATION:** An updated letter of medical necessity or progress notes showing improvement or maintenance on medication.
	Criteria for treatment of Rheumatoid Arthritis or Psoriatic Arthritis (see criteria for other indications on different forms) • Age ≥ 18 years • Diagnoses of moderate to severe rheumatoid or psoriatic arthritis • History of treatment failure, incomplete response or intolerance to methotrexate, at least one other DMARD and at least one other anti-TNF • Rheumatology consultation within the last 60 days • Negative TB skin test or history of treatment for latent TB infection • Absence of active bacterial or viral infection, malignancy or immunosuppressive condition • May not be given with other biologic agents, experimental medications or combinations **Notes**: If administered in clinic, the provider shall billing using HCPCS code J0718 and PA number. Available as a Non-Traditional Medicaid Benefit. **AUTHORIZATION**: 1 year **RE-AUTHORIZATION:** 1 year increments. Fax an updated letter of medical necessity or progress notes showing improvement or maintenance with medication to 855-828-4992.

Enbrel	**Criteria for treatment of Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Plaque Psoriasis or Juvenile Idiopathic Arthritis**
	(see criteria for other indications on different forms)
	• Diagnosis and age requirements:
	  ○ diagnosis of moderate to severe rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or plaque psoriasis and age ≥ 18 years
	  ○ diagnosis of juvenile idiopathic arthritis and age ≥ 2 years
	• History of treatment failure, incomplete response or intolerance to methotrexate, at least one other DMARD and at least one other anti-TNF (this requirement is waived if the diagnosis is ankylosing spondylitis)
	• Rheumatology consultation within the last 60 days
	• Negative TB skin test or history of treatment for latent TB infection
	• Absence of active bacterial or viral infection, malignancy or immunosuppressive condition
	• May not be given with other biologic agents, experimental medications or combinations

	NOTES: If administered in clinic, provider shall bill with HCPCS code J1438 and PA number. Available as a Non-Traditional Medicaid Benefit. **AUTHORIZATION**: 1 year **RE-AUTHORIZATION:** 1 year increments. Fax an updated letter of medical necessity or progress notes showing improvement or maintenance with medication to 855-828-4992.
Humira	Humira for Juvenile Idiopathic Arthritis: • Age requirement: 4 years old and older. • Diagnosis of Juvenile Idiopathic Arthritis. • Documentation of failed treatment on a least one DMARD. • Negative TB skin test within the past 12 months or history of treatment for latent TB infection. • Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition. • Rheumatology consultation within the last 60 days. • Humira may not be given with other biologic agents such as Interferon, experimental medications, or combinations. • **AUTHORIZATION:** 1 year. • **RE-AUTHORIZATION:** An updated letter of medical necessity or progress notes showing improvement or maintenance on medication.
	Criteria for treatment of Crohn's Disease (see criteria for other indications on different forms) • Age ≥ 18 years • Diagnoses of moderately to severely active Crohn's disease • History of treatment failure, incomplete response or intolerance to one of the following: 5-aminosalicylate, antibiotics, methotrexate, 6-mercaptopurine, azathioprine, corticosteroids, budesonide or infliximab • Negative TB skin test or history of treatment for latent TB infection • Absence of active bacterial or viral infection, malignancy or immunosuppressive condition • Rheumatology consultation within the last 60 days • May not be given with other biologic agents, experimental medications or combinations **NOTES:** If administered in clinic, provider shall bill with HCPCS code J0135 and PA number. Available as a Non-Traditional Medicaid Benefit. **AUTHORIZATION**: 1 year. Initial authorization is for one 6-syringe starter pack and 2 syringe maintenance packs monthly thereafter. **RE-AUTHORIZATION:** Fax an updated letter of medical necessity or progress notes showing improvement or maintenance with medication to 855-828-4992.
	Criteria for treatment of Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis or Plaque Psoriasis (see criteria for other indications on different forms) • Age ≥ 18 years • Diagnosis of moderate to severe rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or plaque psoriasis • History of treatment failure, incomplete response or intolerance to

	methotrexate, at least one other DMARD and at least one other anti-TNF (this requirement is waived if the diagnosis is ankylosing spondylitis) • Rheumatology consultation within the last 60 days • Negative TB skin test or history of treatment for latent TB infection • Absence of active bacterial or viral infection, malignancy or immunosuppressive condition • May not be given with other biologic agents, experimental medications or combinations **NOTES:** If administered in clinic, provider shall bill with HCPCS code J0135 and PA number. Available as a Non-Traditional Medicaid Benefit. **AUTHORIZATION**: 1 year **RE-AUTHORIZATION:** 1 year increments. Fax an updated letter of medical necessity or progress notes showing improvement or maintenance with medication to 855-828-4992.
	Criteria for treatment of Ulcerative Colitis (see criteria for other indications on different forms) • Age ≥ 18 years • Diagnoses of moderate to severe ulcerative colitis o History of treatment failure, incomplete response or intolerance to steroid therapy, including prednisone (oral) or hydrocortisone (enema and/or foam). Please describe the dose(s) tried and any titrations performed. • History of treatment failure, incomplete response or intolerance to one of the following therapies: balsalazide (oral) or mesalamine (oral, enema or suppository) or olsalazine (oral) or sulfasalazine (oral) • Rheumatology consultation within the last 60 days • Negative TB skin test or history of treatment for latent TB infection • Absence of active bacterial or viral infection, malignancy or immunosuppressive condition • May not be given with other biologic agents, experimental medications or combinations **NOTES:** If administered in clinic, provider shall bill with HCPCS codeJ0135 and PA number. Available as a Non-Traditional Medicaid Benefit. **AUTHORIZATION**: 1 year. Initial authorization is for one 6-syringe starter pack and 2 syringe maintenance packs monthly thereafter. **RE-AUTHORIZATION:** Fax an updated letter of medical necessity or progress notes showing improvement or maintenance with medication to 855-828-4992.
Kineret	**Criteria for treatment of Rheumatoid Arthritis** o Age ≥ 18 years • Diagnoses of moderate to severe rheumatoid arthritis • History of treatment failure, incomplete response or intolerance to methotrexate, at least one other DMARD and at least one other anti-TNF. • Rheumatology consultation within the last 60 days • Negative TB test or history of treatment for latent TB infection • Absence of active bacterial or viral infection, malignancy or

	immunosuppressive conditions • May not be given with biologic agents, experimental medications or combinations **NOTES:** If administered in clinic, provider shall bill with the correct HCPCS code (still J3490 as of 12/29/2014) and PA number. Available as a Non-Traditional Medicaid Benefit. **AUTHORIZATION**: 6 months **RE-AUTHORIZATION:** 1 year increments. Fax an updated letter of medical necessity or progress notes showing improvement or maintenance with medication to 855-828-4992.
Orencia	**Criteria for treatment of Rheumatoid Arthritis or Juvenile Idiopathic Arthritis** o Age ≥ 18 years o Diagnoses of moderate to severe rheumatoid or psoriatic arthritis • History of treatment failure, incomplete response or intolerance to methotrexate, at least one other DMARD and at least one other anti-TNF • Rheumatology consultation within the last 60 days • Negative TB test or history of treatment for latent TB infection • Absence of active bacterial or viral infection, malignancy or immunosuppressive conditions May not be given with biologic agents, experimental medications or combinations **NOTES:** If administered in clinic, provider shall bill with HCPCS code J0129 and PA number. Available as a Non-Traditional Medicaid Benefit. **AUTHORIZATION**: 6 months **RE-AUTHORIZATION:** 1 year increments. Fax an updated letter of medical necessity or progress notes showing improvement or maintenance with medication to 855-828-4992.
Raptiva	Raptiva: • **Age requirement**: 18 years old and older • **Diagnosis:** Moderate to severe plaque psoriasis. • History of incomplete response or intolerance to at least one appropriate systemic agent or photo therapy. • Negative TB skin test or history of treatment for latent TB infection • Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition. • Dermatology consultation within the last 60 days • Documented failure on or intolerance to a preferred product (Enbrel, Humira, or Cimzia) • Raptiva may not be given with other biologic agents. **NOTES:** Available to Non-Traditional Medicaid clients • **AUTHORIZATION:** 1 year • **RE-AUTHORIZATION:** An updated letter of medical necessity or progress notes showing improvement or maintenance on medication
Remicade	**Criteria for treatment of plaque psoriasis**

	(see criteria for other indications on different forms)
	• Age ≥ 18 years
	• Diagnosis of plaque psoriasis
	• History of treatment failure, incomplete response or intolerance to:
	  ○ methotrexate and another appropriate systemic agent
	or
	  ○ methotrexate and phototherapy
	• Rheumatology consultation within the last 60 days
	• Negative TB skin test or history of treatment for latent TB infection
	• Absence of active bacterial or viral infection, malignancy or immunosuppressive condition
	• May not be given with other biologic agents, experimental medications or combinations
	
	NOTES: If administered in clinic, provider shall bill with HCPCS code J1745 and PA number. Available as a Non-Traditional Medicaid Benefit.
	
	AUTHORIZATION: 1 year
	RE-AUTHORIZATION: 1 year increments. Fax an updated letter of medical necessity or progress notes showing improvement or maintenance with medication to 855-828-4992.

	Criteria for treatment of Rheumatoid Arthritis, Psoriatic Arthritis or Ankylosing Spondylitis (see criteria for other indications on different forms) • Age ≥ 18 years ○ Diagnosis of moderate to severe rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or plaque psoriasis • History of treatment failure, incomplete response or intolerance to methotrexate, at least one other DMARD and at least one other anti-TNF(this requirement is waived if the diagnosis is ankylosing spondylitis) • Negative TB skin test or history of treatment for latent TB infection • Absence of active bacterial or viral infection, malignancy or immunosuppressive condition • Rheumatology consultation within the last 60 days • May not be given with other biologic agents, experimental medications or combinations **NOTES:** If administered in clinic, provider shall bill with HCPCS code J1745 and PA number. Available as a Non-Traditional Medicaid Benefit. **AUTHORIZATION**: 1 year **RE-AUTHORIZATION:** 1 year increments. Fax an updated letter of medical necessity or progress notes showing improvement or maintenance with medication to 855-828-4992.
Rituxan	**Criteria for treatment of Rheumatoid Arthritis** • Age ≥ 18 years • Diagnoses of moderate to severe rheumatoid arthritis • History of treatment failure, incomplete response or intolerance to

	methotrexate, at least one other DMARD and at least one other anti-TNF • Rheumatology consultation within the last 60 days • Negative TB test or history of treatment for latent TB infection • Absence of active bacterial or viral infection, malignancy or immunosuppressive conditions • May not be given with biologic agents, experimental medications or combinations **NOTES:** If administered in clinic, provider shall bill with HCPCS code J9310 and PA number. Available as a Non-Traditional Medicaid Benefit. **AUTHORIZATION**: 6 months **RE-AUTHORIZATION:** 1 year increments. Fax an updated letter of medical necessity or progress notes showing improvement or maintenance with medication to 855-828-4992.
Simponi	**Criteria for treatment of Rheumatoid Arthritis, Psoriatic Arthritis or Ankylosing Spondylitis,** (see criteria for other indications on different forms) • Age ≥ 18 years • Diagnoses of moderate to severe rheumatoid or psoriatic arthritis • History of treatment failure, incomplete response or intolerance to methotrexate, at least one other DMARD and at least one other anti-TNF(this requirement is waived if the diagnosis is ankylosing spondylitis) • Rheumatology consultation within the last 60 days • Negative TB skin test or history of treatment for latent TB infection • Absence of active bacterial or viral infection, malignancy or immunosuppressive condition • May not be given with other biologic agents, experimental medications or combinations **NOTES:** If administered in clinic, provider shall bill with HCPCS code J1602 and PA number. Available as a Non-Traditional Medicaid Benefit. **AUTHORIZATION**: 1 year **RE-AUTHORIZATION:** 1 year increments. Fax an updated letter of medical necessity or progress notes showing improvement or maintenance with medication to 855-828-4992.
	Criteria for treatment of Ulcerative Colitis (see criteria for other indications on different forms) • Age ≥ 18 years • Diagnoses of moderate to severe ulcerative colitis • Rheumatology consultation within the last 60 days • Negative TB skin test or history of treatment for latent TB infection • Absence of active bacterial or viral infection, malignancy or immunosuppressive condition • May not be given with other biologic agents, experimental medications or combinations

	NOTES: If administered in clinic, provider shall bill with HCPCS code J1602 and PA number. Available as a Non-Traditional Medicaid Benefit. **AUTHORIZATION**: 1 year. **RE-AUTHORIZATION:** Fax an updated letter of medical necessity or progress notes showing improvement or maintenance with medication to 855-828-4992.
Xeljanz	**CRITERIA FOR TREATMENT OF RHEUMATOID ARTHRITIS** • Age ≥ 18 years • Diagnoses of moderate to severe rheumatoid arthritis • History of treatment failure, incomplete response or intolerance to methotrexate, at least one other DMARD and at least one other anti-TNF • Rheumatology consultation within the last 60 days • Negative TB test or history of treatment for latent TB infection • Absence of active bacterial or viral infection, malignancy or immunosuppressive conditions • May not be given with biologic agents, experimental medications or combinations • Quantity limit of 60 tablets per 30 days (10mg daily) **AUTHORIZATION**: 1 year **RE-AUTHORIZATION:** 1 year increments. Fax an updated letter of medical necessity or progress notes showing improvement or maintenance with medication to 855-828-4992.
Avastin	**CRITERIA**: • Minimum age - 18 years old. • Documentation of diagnosis of metastatic carcinoma of colon or rectum or non-squamous, non-small cell lung cancer; OR • Glioblastoma with progressive disease following prior therapy; OR • Metastatic renal cell carcinoma; OR • Macular degeneration. **NOTE**: Avastin is no longer FDA-approved for the treatment of breast cancer, and prior authorization requests will not be approved. **INFORMATION**: To be given in clinic setting only. Provider will bill with J code J9035, NDC number, and PA number. Patients with ACO's will have to make arrangements with their ACO for coverage. **AUTHORIZATION**: Initial prior is for 1 year **RE-AUTHORIZATION**: Subsequent PA is for 1 year, with an updated letter of medical necessity.
Betamethasone topical *(Luxiq)*	• Documented failure on generic formulations of betamethasone valerate creams or ointments within the last 12 months. • **AUTHORIZATION:** 6 months • **RE-AUTHORIZATION:** Updated letter of medical necessity
Botulinum Toxins	For access through a pharmacy:

DRUG	INDICATION	CRITERIA
Botox®, Dysport®, Myobloc®, Xeomin®	Cervical Dysonia	• Age ≥ 16 • Documented disease; provide diagnosis code.
Botox®, Xeomin®	Blepharospasm or Strabismus	• Age ≥ 12 • Documented disease; provide diagnosis

			code • Must fail Botox® before Xeomin® can be approved.
	Botox®	Chronic migraine	• Age ≥ 18 • ≥15 migraines per 30 days • Each migraine lasting ≥ 4 hours
	Botox®	Overactive bladder	• Age ≥ 18 • Documented neurologic disease; provide diagnosis code • Must fail ≥ 1 anticholinergic medication before Botox® can be approved
	Botox®	Upper limb spasticity	• Age ≥ 18 • Spasticity of biceps, flexor carpi radalis, flexor carpi unlaris, flexor digitorum profundus, and/or flexor digitorum sublimis

NOTES:

- Botulinum Toxin is not covered for any cosmetic or off-label uses. These include primary axillary hyperhydrosis, sialorrhea, and gastroparesis.
- These products are available for physician use in the office with the appropriate Jcodes **without** a PA.
- These products may be obtained through a pharmacy with a prior authorization.
- Treatment regimen is every 3 months.
- Maximum approved doses per six month PA period are:

Botox	Dysport	Myobloc	Xeomin
600 units/6 months	2,000 units/6 months	20,000 units/6 months	240 units/6 months

- **AUTHORIZATION**: 6 months
- **RE-AUTHORIZATION**: 6 months with documentation of patient progress.

Brand Name Medication

- Explanation of why treatment was initiated with the branded product

OR

- Details of adverse reaction, allergy, or inadequate response to the generic equivalent.

NOTES:

- Many extended-release branded products do not have extended-release generic equivalents. In these cases, a trial of the short-acting generic product is required.
- Prior authorizations for brand name medications require physician evaluated, charted documentation of an allergic reaction or adverse reaction. Patient complaints of lack of efficacy are not acceptable reasons for failure such as "client said", "client reports", "doesn't work" or "causes nausea."
- This Prior Authorization is only available to clients enrolled in Traditional Medicaid. Clients enrolled in Non-Traditional Medicaid or Primary Care Network must pay full price for brand name medications with available generics.

- **AUTHORIZATION**: one year
- **RE-AUTHORIZATION**: Updated letter of medical necessity

Butalbital Containing Products

CRITERIA

- As established in the U.S. Headache Consortium's evidence-based guidelines for migraine treatment
- Minimum age requirement: 18 years old
- Trial and failure of:
  - one or more non-steroidal anti-inflammatory agent

	AND • one or more triptans (any administration route) AND • intranasal dihydroegotamine AND • butorphanol AND • an acetaminophen-codeine combination product AND • an aspirin-caffeine-acetaminophen combination product • A letter of medical necessity detailing the patient's unsatisfactory response to each agent above. **AUTHORIZATION**: 6 months **RE-AUTHORIZATION**: Written request from physician demonstrating that the patient's response to the butalbital-containing product is positive, AND that the patient's response to the butalbital-containing product is significantly better than to products that do not contain butalbital.

Butrans	• Minimum age requirement: 18 years old.
	• Diagnosis of moderate to severe chronic pain requiring continuous, around-the-clock opioid analgesic for an extended period of time.
	  • Documented trial and failure of ≥ 1 oral non-opioid agent(s).
	  • Documented trial and failure of ≥ 1 oral opioid agent.
	NOTES:
	• Prior authorization will be granted for up to 4 patches per 28 days. Additional quantities may be granted with satisfactory prescriber explanation during the first and last months of therapy to allow for dose titration.
	• Butrans is only available to Traditional Medicaid clients. Butrans is not a covered benefit for Non-Traditional Medicaid or Primary Care Network.
	• **AUTHORIZATION**: Initial authorization period is for 3 months.
	• **RE-AUTHORIZATION**: Reauthorization periods of up to one year require documentation that the patient is using the drug appropriately, and documentation of satisfactory pain control.

Chantix	• Minimum age requirement: 18 years old. • Covered for a diagnosis of nicotine dependence for 24 weeks per 52 week period. • **AUTHORIZATION**: 24 weeks per 52 week period. Consider anniversary years, not calendar years. • **RE-AUTHORIZATION**: Same as initial
Clobetasol Topical *(Olux Foam)*	• **DOCUMENTED** failure on generic formulations of clobetasol propionate creams, ointments, or solutions within the last 12 months • **AUTHORIZATION:** 6 months • **RE-AUTHORIZATION:** Updated letter of medical necessity
Colchicine *(Colcrys, Mitigare)*	Criteria for Gout: • Minimum age requirement: 18 years old. • Documented failure on allopurinol. • Documented failure on or contraindication to corticosteroids and NSAIDS. • Maximum approved dose is 1.8mg every 3 days.
	Colcrys for Familial Mediterranean Fever: • Minimum age requirement: 4 years old. • Documented diagnosis of Familiar Mediterranean Fever.

	• Maximum approved dose is 2.4mg per day. • **AUTHORIZATION** (for both indications): The initial prior authorization will be approved for one year • **RE-AUTHORIZATION** (for both indications): Updated letter of medical necessity
Combunox	• Components must be unavailable separately. • **AUTHORIZATION**: Fax a letter of medical necessity to 855-828-4992. Prescriptions for 4 tablets daily or less, for 7 days only. • **RE-AUTHORIZATION**: Requires new request, neither of the components are available separately. Prescriptions for 4 tablets daily or less for 7 days only.
Cytogam	• For the prophylaxis of cytomegalovirus • DOCUMENTED transplantation of kidney, lung, liver, pancreas, or heart. • **AUTHORIZATION**: 6 months • **RE-AUTHORIZATION**: Updated letter of medical necessity
Depo-Provera *(Non-Traditional Medicaid and Primary Care Network Clients only)*	• Patient or provider requests for injectable medication for family planning. NOTES: This form is for Non-Traditional and Primary Care Network clients only. Traditional clients may receive this medication without a prior authorization. • **AUTHORIZATION**: 1 year • **RE-AUTHORIZATION**: Updated letter of medical necessity
Embeda	• Documented diagnosis of drug abuse; and • Documented history of chronic pain; and • No concomitant use of alcohol; • Pain management contract. **NOTES**: To request an NDC changes please fax a note to 855-828-4992. • **AUTHORIZATION**: Initial 1 year • **RE-AUTHORIZATION**: An updated letter of medical necessity
Emsam	• Physician documentation from charted progress notes of failure with a minimum of three other antidepressants, which may include MAOI. • Previous intolerance to an oral trial of MAOI. • No concurrent antidepressant therapy. **NOTES**: This Prior Authorization is only available to clients enrolled in Traditional Medicaid. Clients enrolled in Non-Traditional Medicaid or Primary Care Network must pay full price for brand name medications with available generics. • **AUTHORIZATION**: 1 year • **RE-AUTHORIZATION**: Updated letter of medical necessity
Enzymes	
Adagen	Adagen: • Documented diagnosis of Adenosine Deaminase Deficiency (ADA) • Copy of prescription from physician. • Dose must be delivered in pre-filled syringe for exact dosing. • Medicaid must be notified of changes in dosage with a copy of new prescription. • **AUTHORIZATION**: 1 year. • **RE-AUTHORIZATION**: Updated letter of medical necessity.
Aldurazyme	Aldurazyme: • Documented and confirmed diagnosis of Hurler and Hurler-Scheie. NOTES: Confirmed diagnosis is defined as Hurler and Hurler Scheie of mucopolysaccharidosis I (MPS I) in patients with Scheie form who have

	severe symptoms. • **AUTHORIZATION**: 6 months. • **RE-AUTHORIZATION**: Updated letter of medical necessity.
Aralast	Aralast: • Diagnosis of emphysema. • Current treatment • Treatment failures. • Explanation of condition that demands augmentation with Aralast. • **AUTHORIZATION**: 6 months • **RE-AUTHORIZATION**: 1 year with documentation of sustained improvement.
Cerezyme/Vpriv	Cerezyme/Vpriv: • Documented diagnosis of Gaucher's Disease. • Medicaid must be notified of changes in dosage with a copy of new prescription. • **AUTHORIZATION**: 6 months • **RE-AUTHORIZATION**: 1 year with documentation of significant improvement.
Fabrazyme	Fabrazyme: • Documented deficient plasma or leukocyte a-galactosidase A (a-gal) OR • Documented a-gal deficiency and/or mutation in the a-gal A gene in heterozygous females. • Covered only for patients with documented ADA deficiency. • **AUTHORIZATION:** 6 months • **RE-AUTHORIZATION**: Updated letter of medical necessity
Prolastin/Zemaira	Prolastin/Zemaira: • **DOCUMENTED** Alpha-1 Antitrypsin deficiency **AND** • **DOCUMENTED** Panacinar Emphysema. • Must have stopped smoking for at least 30 days, as documented by physician. • **AUTHORIZATION:** 6 months • **RE-AUTHORIZATION:** Updated letter of medical necessity
Epinephrine Emergency Kit *(Non-Traditional Clients Only)*	• Patient is at risk for anaphylactic allergic reactions. **NOTES**: This authorization is for Non-Traditional clients only. Traditional clients may receive this medication without prior authorization. • **AUTHORIZATION**: 1 year • **RE-AUTHORIZATION**: Updated letter of medical necessity
Erythropoetins	
Aranesp	Aranesp: • Diagnosis of anemia associated with renal failure or chemotherapy; OR • Diagnosis of Hepatitis C being and being treated with Ribavirin • No GI bleeding. • Hematocrit <33% supported by lab work done in the last 3 months (fax copy of lab-work). • Hemoglobin <11% supported by lab work done in the last 3 months (fax copy of lab-work). • Prescribing authority is limited to hematologist, oncologist, nephrologist, gastroenterologist and infectious disease specialists, or based upon a consult with one of these specialists. **NOTE**: Prior authorization will not be given to patients on dialysis.

	• **AUTHORIZATION**: 6 months • **RE-AUTHORIZATION**: No GI bleeding, not on dialysis, Hematocrit <39%, and Hemoglobin 11-13% supported by lab data done within the past 3 months (fax copy of lab-work).
Neupogen/ Neulasta/ Leukine	Neupogen/Neulasta/Leukine: • Documented: myelosuppressive chemotherapy, bone marrow transplant, peripheral blood progenitor cell collection, severe chronic neutropenia; OR • Documented ANC < 750 cells/microliter in patients with Hepatitis C who are being treated with Interferon. **NOTES:** • Not covered for AIDS, hairy cell leukemia, myelodysplasia, drug-induced congenital agranulocytosis, alloimune neonatalneuropenia. • Available as a Non-Traditional Medicaid benefit. • **AUTHORIZATION:** 6 months • **RE-AUTHORIZATION:** Updated letter of medical necessity
Omontys	Omontys • Diagnosis of anemia associated with chronic kidney disease • Current dialysis therapy • ≥ 18 years old • Hemoglobin <10% supported by lab work done within the past 3 months **(FAX COPY OF LAB-WORK)** • Prescribing authority limited to hematologist, nephrologist, gastroenterologist, and infectious disease specialists, or based upon a consult with one of these specialists. • Must **NOT** be used for patients diagnosed with cancer; request will be automatically denied • **INITIAL AUTHORIZATION:** 6 months • **RE-AUTHORIZATION:** Current dialysis therapy, hemoglobin < 13 supported by lab data done within the past 3 months **(FAX COPY OF LAB-WORK).**

Procrit	Procrit:
	• Diagnosis of anemia associated with renal failure, chemotherapy, or HIV; OR
	• Diagnosis of Hepatitis C and being treated with Ribavirin; OR
	• Blood transfusions, allergenic and anemic surgery patients (approve 1 time only); OR
	• Reduction of allogenic transfusions in anemic surgery patients scheduled to undergo elective nonvascular noncardiac surgery. Procrit is indicated for patients at high risk for perioperative transfusions with significant, anticipated blood loss (approve 1 time only).
	• Patient is not on dialysis.
	• No GI bleeding.
	• Prescribing authority limited to hematologist, oncologist, nephrologist, gastroenterologist and infectious disease specialists, or based upon a consult with one of these specialists.
	• **Submit lab work with your request**:
	  • Hematocrit <33% supported by lab work done in the last 3 months (FAX COPY OF LAB WORK).
	  • Hemoglobin <11% supported by lab work done in the last 3 months (FAX COPY OF LAB WORK).
	NOTES: Available as a Non-Traditional Medicaid benefit.
	• **AUTHORIZATION**: 6 months
	• **RE-AUTHORIZATION:** No GI bleeding, not on dialysis. Hematocrit <39% and Hemoglobin 11-13%, supported by lab data done within the past 3 months.

Forteo	• Available for the following diagnoses at high risk for bone fracture:
	  • Postmenopausal women diagnosed with osteoporosis.
	  • Women and men diagnosed with osteoporosis likely caused by systemic glucocorticoid therapy.
	  • Men diagnosed with osteoporosis (primary or hypogonadal).
	• Quantity limit of one injector every 28 days.
	• **AUTHORIZATION:** 24 months with no renewal option.

Gabapentin Extended Release Products	
Gralise	Gralise: • Minimum age requirement: 18 years old • Documented diagnosis of postherpetic neuralgia • Dose limited to less than or equal to 1,800mg daily. • Documented failure of a trial of regular release gabapentin, at therapeutic dose, for one month. • **AUTHORIZATION:** Initial authorization will be granted for 1 year. • **RE-AUTHORIZATION:** Updated letter of medical necessity
Horizant	Horizant: • Minimum age requirement: 18 years old. • Documented diagnosis of restless leg syndrome. • Dose limited to less than or equal to 600mg daily. • Documented failure of a trial of regular release gabapentin, at a therapeutic dose, for one month. • **AUTHORIZATION:** Initial authorization will be granted for 1 year. • **RE-AUTHORIZATION:** Updated letter of medical necessity

Gilenya	• Minimum age requirement: 18 years old.
	• Diagnosis of relapsing-remitting Multiple Sclerosis.
	• Dose limited to ≤ 0.5mg once daily.
	• A written plan to monitor for bradyarrythmia in office or clinic for six hours following the first dose.
	• Baseline test values (within the preceding six months) within normal limits:
	  • Complete Blood Count (CBC)
	  • WBC between $3.2*10^3$ and $9.8*10^3$ cells/mm^3
	  • Hgb between 12 and 18 g/dL
	  • Hct between 33 and 49%
	  • Platelets between $140*10^3$ and $440*10^3$ cells/microL
	  • Liver Function Test (LFT)
	  • AST and/or ALT between 0 and 35 IU/L
	  • Electrocardiogram (ECG) within normal limits.
	  • Ophthalmic exam within normal limits.
	• **AUTHORIZATION:** Initial authorization will be granted for 3 months. If baseline CBC, LFT, ECG, and/or ophthalmic exam results are not within normal limits, compelling rationale for initiation of therapy must be provided in a detailed letter of medical necessity.
	• **RE-AUTHORIZATION:** Re-authorization requires updated CBC, LFT, ECG, and ophthalmic exam. Reauthorization will be granted if values for CBC, LFT, ECG, and ophthalmic exam remain within normal limits. If updated CBC, LFT, ECG, and/or ophthalmic exam results are not within normal limits, compelling rationale for continuation of therapy must be provided in a detailed letter of medical necessity. Reauthorization will be granted in one-year increments.

Grastek	**CRITERIA:** • Client must be between 5 and 65 years of age • Provide documentation of a grass pollen-induced allergic rhinitis, with or without Conjunctivitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens. • Therapy must be initiated at least 12 weeks before the expected onset of each grass pollen season. (December 5 to January 10) **AUTHORIZATION**: • One year **RE-AUTHORIZATION:** • Client age between 5 and 65 years of age. • Initial therapy was approved and initiated at least 12 weeks prior to expected onset of grass pollen season. • Therapy has been continuous throughout grass pollen season. • If all other criteria has been met GRASTEK may be approved for daily therapy for three consecutive years.
Growth Hormone for Adults *(AIDS Wasting Syndrome Only)*	• Adult age 19 and older. • Adult onset - AIDS Wasting indication only.

	• Body Mass Index is less than 20, BMI = wt. times 704 divided by height squared (in inches) • Patient must be taking antiretroviral medications. • Provide initial height and weight, weight after 60 day trial. • Rule out other causes of weight loss including hypogonadism, opportunistic infections, diarrhea, inadequate nutritional intake, malabsorption, and thyroid abnormalities. • (For men) Rule out hypotestosterone levels since hypogonadism is common among HIV infected individuals. • Patients must be able to maintain 100% of daily nutritional intake. For patients receiving enteral or parenteral nutrition, the patient must be weight stable for 2 months. • Patient must not have an untreated or suspected systemic infection or persistent fever > 101 F during the 30 days prior to evaluation of weight loss. • Patient must not have any signs or symptoms of gastrointestinal malabsorption or blockage unless on total parenteral nutrition. • Patient must not have active malignancy, except for Kaposi's Sarcoma. • **AUTHORIZATION:** Initial trial 60 days. • **RE-AUTHORIZATION:** Fax copy of current prescription and history and physical showing weight gain during trial period. With appropriate progress, the patient may receive an additional four weeks of therapy. If the patient continues to show progress, additional prior authorizations are granted in 6 weeks periods to a maximum of 12 weeks per any 6 month episode.

Growth Hormone
(Children)
	Criteria for Pan hypopituitarism:
	• Approved for ages 0-18; must have started before age 16.
	• Documented diagnosis of panhypopituitarism.
	
	Criteria for Turner Syndrome:
	• Approved for ages 0-18; must have started before age 16.
	• Documented diagnosis of Turner Syndrome.
	
	Criteria for Small Gestational Age:
	• Request made before age 3.
	• Documented diagnosis of small gestational age
	• Child has normal GH blood levels (may have documented GH resistance)
	• Must be under the care of or have extensive endocrinologist consultation.
	• A copy of the prescription signed by the physician must be submitted with application.
	
	Criteria for all other covered diagnoses:
	• Approved for ages 0-18; must have started before age 16.
	• Must have a height stature less than the 5th percentile on the Physical Growth NCHS Percentiles Chart for the correct age and sex.
	• Growth rate must be documented in centimeters for at least 6 months immediately before initiation of growth hormone treatment.
	• Prescribed by endocrinologist or with endocrinology consultation.
	• One of the following diagnoses:
	  • Documented endogenous growth hormone secretion of < 10ng/ml after provocative stimulation; OR
	  • Growth failure associated with documented chronic renal insufficiency up to the time of renal transplantation; OR

	• Long-term treatment of idiopathic short stature, also called non-growth hormone-deficient short stature, defined by height SDS (Standard Deviation) < 2.25 (Humatrope) OR • Treatment of short bowel syndrome in patients receiving specialized nutritional support. • Patients diagnosed with Prader Willi must complete a sleep oximetry study. If the oximetry is abnormal, a full polysomnography study is required. GH is contraindicated in patients with sleep apnea – PA will not be granted to clients that have sleep apnea. **AUTHORIZATION:** 1 year. Maximum covered time period *for small gestational age only* is 2 years. **RE-AUTHORIZATION:** Copy of the current prescription, patient's current weight (kilograms) and height (centimeters), and chart-documented regarding from growth in past year. Treated growth rate must exceed untreated rate by 2 centimeters per year (*this last sentence does not apply to patients being treated for small gestational age*).
Heparin *(Non-Traditional Medicaid Clients Only)*	• PRE-OPERATIVE for 3 days only for patients who must stop Coumadin prior to surgery. • POST-OPERATIVE for patients to be regulated on Coumadin for 5 days only. • POST-operative prevention of DVT in patients with below and including abdomen surgeries (i.e., hip, acute knee, & ankle, not including foot and toes). (Max. 14 days). • DVT/PE treatment in conjunction with Coumadin regulation and treatment. (Max. 10 days). • Unstable Angina: ischemic complications in unstable angina and non-Q-wave MI patients on concurrent aspirin therapy. (Max. 10 days). • Prophylaxis or treatment of active DVT/PE in pregnancy. • Treatment or secondary prevention of DVT/PE in cancer patients (authorized for 12 months). • **RE-AUTHORIZATION**: Based on INR. Considered on an individual basis. **CRITERIA FOR PREGNANCY**: • Past history of DVT/PE, **or** • Active DVT/PE, or • Known hypercoagulability • **AUTHORIZATION:** Authorized for duration of pregnancy • **RE-AUTHORIZATION:** Same as initial
Hepatitis Medications	
Harvoni	Harvoni: • Diagnosis of Chronic Hepatitis C • Patient must undergo Hepatitis C genotype testing and submit a copy of the original testing results. ○ Harvoni will only be approved for patients with genotype 1. • Must complete pre-treatment viral load (HCV RNA) testing and submit a copy of the original testing results. • Trial and failure of previous treatment(s) is NOT a pre-requisite for Approval. However, if previous treatment has been attempted, please indicate if the patient relapsed from, abandoned or failed therapy. Please indicate the drug regimen(s), viral loads and treatment start and end dates for each previous treatment course. • **Initial Authorization Period:** 12 weeks • **Re-Authorization:** Note that the initial approval period above is sufficient

	for a full treatment course. If another authorization is desired, please submit all the above information.
Hepsera	Hepsera: • Diagnosis of hepatitis B. • Failure on Epivir. **INFORMATION:** 10mg/day is the maximum approved dose. • **AUTHORIZATION:** Initial prior is for 12 weeks • **RE-AUTHORIZATION:** 12 months with updated letter of medical necessity
Olysio	Olysio: • Diagnosis of Chronic Hepatitis C • Patient must undergo Hepatitis C genotype testing and submit a copy of the original testing results. o Olysio will only be approved for patients with genotype 1. • Must complete pre-treatment viral load (HCV RNA) testing and submit a copy of the original testing results. • Trial and failure of previous treatment(s) is NOT a pre-requisite for Approval. However, if previous treatment has been attempted, please indicate if the patient relapsed from, abandoned or failed therapy. Please indicate the drug regimen(s), viral loads and treatment start and end dates for each previous treatment course. • **Initial Authorization Period**: 5 weeks. The manufacturer recommends that virologic response be measured at 4 weeks to determine the utility of continuation of therapy. Please test at week 4 and submit the lab results to Utah Medicaid by week 5. • **Re-Authorization Criteria:** Submit a letter of medical necessity and copies of the original testing results for pre-treatment viral load (HCV RNA) and the on-treatment virologic response (HCV RNA). The HVC RNA at week 4 must be less than 25 IU/mL in order to receive re-authorization. • **Re-Authorization Period**: An additional 7 weeks (total of 12 weeks of treatment). Note that treatment with ribavirin (and peginterferon alpha if appropriate) must continue for varying periods after the twelve weeks of Olysio treatment, based upon previous treatments and/or relapses. Please refer to the FDA-approved prescribing information for Olysio.
Pegasys/ PegIntron	Pegasys/PegIntron: • Documented diagnosis of Hepatitis B **AND/OR** • Documented diagnosis of Hepatitis C **NOTES:** Pegasys and PegIntron are available to Non-Traditional Medicaid clients. • **AUTHORIZATION:** Authorization will be given for one 48-week supply. • **RE-AUTHORIZATION:** Coverage may be extended to 72 weeks in patients with documented late viral response (defined as failure to clear the virus until weeks 12-24 of treatment). This means that if a patient's viral load is between 49 and 65,000,000 at any point between weeks 12 and 24, a total of 72 weeks' treatment may be authorized.
Sovaldi	Sovaldi: • Diagnosis of Chronic Hepatitis C • Patient must undergo Hepatitis C genotype testing and submit a copy of the original testing results. o Sovaldi will only be approved for patients with genotype 1, 2, 3 or 4.

	• Must complete pre-treatment viral load (HCV RNA) testing and submit a copy of the original testing results.
	• Trial and failure of previous treatment(s) is NOT a pre-requisite for Approval. However, if previous treatment has been attempted, please indicate if the patient relapsed from, abandoned or failed therapy.
	  ○ Please indicate the drug regimen(s), viral loads and treatment start and end dates for each previous treatment course.
	• **Initial Authorization Period**: 24 weeks
	• **Re-Authorization:** Note that the initial approval period above is sufficient for a full treatment course. If another authorization is desired, please submit all the above information.
	  ○ Note that treatment with ribavirin (and peginterferon alpha if appropriate) must continue for varying periods after the twelve weeks of Sovaldi treatment, based upon previous treatments and/or relapses. Please refer to the FDA-approved prescribing information for Sovaldi.

Viekira Pak	**CRITERIA**: Diagnosis of Chronic Hepatitis C • Patient must undergo Hepatitis C genotype testing and submit a copy of the original testing results. • Viekira Pak will only be approved for patients with genotype 1. • Must complete pre-treatment viral load (HCV RNA) testing and submit a copy of the original testing results. • **Trial and failure of previous treatment(s) is NOT a pre-requisite for Approval**. However, if previous treatment has been attempted, please indicate if the patient relapsed from, abandoned or failed therapy. Please indicate the drug regimen(s), viral loads and treatment start and end dates for each previous treatment course. **Initial Authorization Period**: 24 weeks **Re-Authorization**: Note that the initial approval period above is sufficient for a full treatment course. If another authorization is desired, please submit all the above information.
Hydroxyprogesterone Caproate *(Extemporaneous Compounds and Makena)*	• Approved for the prevention of preterm labor for patients with prior history of preterm delivery • Must be prescribed by OBGYN • Therapy initiated between weeks 16-23 of gestation • The patient must not be in active labor at the time of administration • Pharmacy provider must be certified by Utah Medicaid as compliant with USHP 797 standards for sterile preparation of the injection. Please contact Utah Medicaid for a current list of certified pharmacies. **NOTES:** • If commercially available Makena is requested, the provider must submit justification for using the commercial product in lieu of the compounded product; for example, details of adverse reaction, allergy, or inadequate response to the compounded product. • This prior authorization is only available to clients enrolled in Traditional Medicaid. • **AUTHORIZATION:** For duration of the pregnancy • **RE-AUTHORIZATION:** Same as initial

Increlex	• Patient age >2 and <18; must start therapy prior to age 16 • Diagnosis of growth failure. • Documented diagnosis of Primary IGF-1 Deficiency. • Normal to elevated GH level and IGF-1 level at or below -3.0 standard deviations from normal levels. • Must have a height stature less than the 5th percentile on the Physical Growth NCHS Percentiles Chart for correct age and sex. • Secondary forms of IGF-1 deficiency (e.g. malnutrition, hypothyroidism, chronic anti-inflammatory steroid use) have been ruled out. • **AUTHORIZATION:** 1 year • **RE-AUTHORIZATION:** Documented improvement on the Physician Growth NCHS Percentile Chart for correct age and sex.
Istodax	• Minimum age requirement: 18 years old. • Documented diagnosis of cutaneous or peripheral T-cell lymphoma. • Documentation of at least one other prior systemic therapy. • To be paid through HCPCS code to an infusion center or physician's office. • Initial authorization is for one year. Renewal requests require an updated letter of medical necessity showing maintenance or improvement on Istodax.
Ketorolac (*oral dosage forms only)*	• Minimum age requirement: 18 years old. • Available only as continuation of IV/IM therapy. • Documented failure of at least three other NSAIDS. • Limited to a total of five days of use. **NOTES:** Ketorolac nasal spray (Sprix) is not a benefit for Non-Traditional and Primary Care Network clients. Traditional Medicaid clients must try and fail oral ketorolac before authorization for Sprix will be considered. • **AUTHORIZATION:** Only one authorization will be granted per acute incident. • **RE-AUTHORIZATION:** Same as initial
Krystexxa	**CRITERIA FOR GOUT:** • Minimum age requirement: 18 years old. • Documented failure on, or contraindication to allopurinol • Documented failure on, or contraindication to probenecid. • Documented failure on, or contraindication to colchicine. • Prescribed by a rheumatologist or nephrologist informed about proper procedures. • Completion of a G6PD screen before treatment initiation (please submit results). • Dose not to exceed one 8mg infusion every 14 days. • Description of the anaphylactic measures to be taken prior to infusion. • Description of proper resuscitative procedures in place to treat anaphylaxis **NOTES**: • Krystexxa is NOT indicated to treat asymptomatic gout or prophylaxis of gouty attacks. • Requests for such indications will be denied. • As per indication, treatment to prevent anaphylaxis MUST be given with EACH Krystexxa infusion. • This medication is only payable through J-code J2507 to a physician's office. Patients with ACO's will have to make arrangements with their ACO for coverage.

	AUTHORIZATION: The initial prior authorization will be approved for 3 months. **RE-AUTHORIZATION:** • Documentation from progress notes describing positive response to treatment, and lack of serious anaphylaxis or side effects. • Reathorization will not be given if a patient has more than 2 serum uric acid levels over 6mg/dL after treatment initiation • Reauthorizations will be approved for 6 months
Lactulose	• Documented Chronic liver failure, Hepatic encephalopathy, Chronic portal hypertension, or Spina Bifida. **INFORMATION:** • 6000 ml or less per month does not need a prior authorization. • More than 6000ml's per month requires an authorization. • This drug will not be approved for use as general laxative for over 6000 ml's. • **AUTHORIZATION:** 6 months • **RE-AUTHORIZATION**: Updated letter of medical necessity
Lamisil	• Documented diagnosis of onychomycosis. • Authorized for 16 weeks per 52 week period. • **RE-AUTHORIZATION:** 16 weeks per 52 week period. Consider anniversary years, not calendar years.
LMWH Derivatives	
Arixtra *(For Non-Traditional Medicaid clients)*	Arixtra: • Pre-operative to stop Coumadin prior to surgery, maximum of 3 days AND/OR • Post-operative bridging to Coumadin (to therapeutic INR); Maximum 5 days. AND/OR • Post-operative DVT prevention for surgeries of the abdomen or lower extremities (i.e. hip, knee, and ankle not including foot and toes); maximum of 14 days. OR • Treatment of acute DVT when administered in conjunction with Coumadin; maximum of 10 days. OR • Treatment of acute PE when administered in conjunction with Coumadin, when initial therapy is administered in the hospital; maximum of 10 days. • NOTE: This request form is for Non-Traditional Medicaid. *Clients enrolled in Traditional Medicaid may receive enoxaparin without a Prior Authorization.* Other agents in this class may require a Non-Preferred Authorization for Traditional Medicaid clients. • RE-AUTHORIZATION: Considered on an individual basis (INR).Fax documentation explaining medical necessity to 855-828-4992. Patients diagnosed with cancer will only receive authorization for 6 months of treatment.
Fragmin and Lovenox *(For Non-Traditional Medicaid clients)*	Fragmin and Lovenox: • Pre-operative to stop Coumadin prior to surgery; maximum of 3 days AND/OR • Post-operative bridging to Coumadin (to therapeutic INR); maximum 5 days AND/OR • Post-operative DVT prevention for surgeries of the abdomen or lower extremities (i.e. hip, acute knee, and ankle not including foot and toes); maximum of 14 days

	OR • Treatment of acute DVT and/or PE when administered in conjunction with Coumadin; maximum of 10 days OR • Treatment of ischemic complications of unstable angina and non-Q-wave MI patients on concurrent aspirin therapy; maximum of 10 days OR • Treatment or secondary prevention of DVT and/or PE in cancer patients; authorized for 12 months **NOTES:** This request is for Non-Traditional Medicaid. *Clients enrolled in Traditional Medicaid may receive enoxaparin without a Prior Authorization*. Other agents in this class may require a Non-Preferred Authorization for Traditional Medicaid clients. Authorization for Innohep and Fragmin require a trial and failure of the preferred product, enoxaparin. • **RE-AUTHORIZATION:** Considered on an individual basis (INR). Fax documentation explaining medical necessity to 855-828-4992.
Innohep *(For Non-Traditional Medicaid clients)*	Innohep: • DVT with OR without PE treatment, bridging to Coumadin regulation and treatment. (Max 10 days) **NOTES:** This request is for Non-Traditional Medicaid. Clients enrolled in Traditional Medicaid may receive generic enoxaparin without a Prior Authorization. Other agents in this class may require a Non-Preferred Authorization for Traditional Medicaid clients. • **RE-AUTHORIZATION:** Based on INR. Considered on individual basis.
Metabolic Supplements *(for support of in-born errors of metabolism such as PKU)*	• Documented diagnosis of condition resulting in in-born error of metabolism. • **AUTHORIZATION:** 1 year. • **RE-AUTHORIZATION:** Updated letter of medical necessity
Multiple Sclerosis Biologics *(For Non-Traditional Clients Only) Includes Copaxone, Avonex, BetaSeron, Rebif, and Extavia*	• Documented diagnosis of Multiple Sclerosis. • Extavia requires a documented trial and failure of or contraindication to a preferred product (Avonex, Copaxone, or Rebif). **NOTES:**Traditional Medicaid clients do not require clinical prior authorization. Non-Preferred authorization requirements may apply in certain Traditional Medicaid cases. • **AUTHORIZATION:** 1 year. • **RE-AUTHORIZATION:** Updated letter of medical necessity
Nexavar	• Patient must be age 18 or above. • Diagnosis of advanced renal cell carcinoma, OR • Diagnosis of unresectable hepatocellular carcinoma • **AUTHORIZATION:** 1 year at a maximum dose of 400mg BID. • **RE-AUTHORIZATION:** reauthorization for 1 year via an updated letter of medical necessity
Non-Preferred Combination Product and/or Dosing Kit Authorization Request	**Combination Products:** Utah Medicaid generally requires the use of multiple single-entity products instead of one combination product. Unless a combination product is listed as Preferred on Utah Medicaid's Preferred Drug List, this form must be used to request a combination product. Please provide objective clinical evidence against using the individual agents. **Kits:** Utah Medicaid does not generally reimburse for dosing kits (e.g. therapy initiation dose titration kits). Unless a product is only available in a kit, this form must be used to request a kit. Please provide object clinical evidence regarding

	the necessity of a kit. **NOTE:** Do not use this form for Biologics for Rheumatoid Arthritis. Download the appropriate clinical PA form from the Medicaid website. **AUTHORIZATION:** 1 year **RE-AUTHORIZATION:** Updated letter of medical necessity
Non-Preferred Drug Authorization	**LEAST ONE OF THE FOLLOWING CONDITIONS MUST BE MET:** • A trial and failure of at least one preferred agent in the drug class, including the name of the preferred drug that was tried, the length of therapy, and the reason for discontinuation. • Detailed evidence of a potential drug interaction between current medication and the preferred drug. • Detailed evidence of a condition of contraindication that prevents the use of the preferred drug. • Objective clinical evidence that a patient is at high risk of adverse events due to a therapeutic interchange with a preferred drug. **NOTE:** • Do not use this form for Biologics or for Rheumatoid Arthritis. Download the appropriate clinical PA forms from the Medicaid website. • **AUTHORIZATION:** 1 year • **RE-AUTHORIZATION:** Updated letter of medical necessity
Nucynta	• Must be age 18 or above • Documented failure or GI intolerance to conventional analgesics • No concomitant use of MAOIs **INFORMATION:** Therapy will be authorized for up to ten days of use per acute injury episode • **AUTHORIZATION:** 10 days • **RE-AUTHORIZATION:** Same as initial

Nucynta ER	• Minimum age requirement: 18 years old
	• Description trial and failure of at least two analgesic therapies
	• No concurrent treatment with monoamine oxidase inhibitors
	  • e.g. deprenyl, isocarboxazid, phenelzine, rasagiline, selegiline, tranylcypromine
	• No concurrent treatment with mixed agonist/antagonist opioid analgesics, or opioid antagonists
	  • e.g. buprenorphine/naloxone (Suboxone®), naloxone (Narcan®), naltrexone (Vivatrol®)
	• **AUTHORIZATION:** The initial authorization will be approved for one year
	• **RE-AUTHORIZATION:** Subsequent prior authorizations will be given in one year increments, upon submission of a letter of medical necessity

Nuvigil	• Failure on a $\geq$ 6 week trial of, or contraindication to, modafinil (Provigil)
	• Minimum age requirement: 17 years old
	• Covered for diagnosis:
	  • Narcolepsy, Amphetamines or Methylphenidate must be tried first. Dose limited to 250mg per day.
	  • Daytime somnolence due to Obstructive Sleep Apnea: **must be on CPAP**. Dose limited to 150mg per day.
	  • Shift Work Sleep Disorder, **must be working night shifts**. Provide documentation of a treatment plan that demonstrates excessive sleepiness

	at work, insomnia when the patient should be sleeping. Patient must have a three-month trial of sleep aids. Dose is limited to 150mg/day. **NOTES:** Modafinil (Provigil) and Nuvigil are mutually exclusive. Patients may only have a prior authorization for one of these medications at a time • **AUTHORIZATION:** 1 year • **RE-AUTHORIZATION:** Updated letter of medical necessity
Oxandrin	**CRITERIA** • **First 60 day trial period:** • Age ≥ 18 years • Body Mass Index < 20. Please provide current height, weight and BMI. • Please describe the patient's nutritional intake. Patient must receive at least partial nutrition orally. • Please describe concurrent therapies for weight gain (Oxandrin is not approved for monotherapy). • **Authorization after 60 day trial (may approve for an additional 4 months):** • All criteria above remain effective. (age, BMI, nutrition and pertinent concurrent therapies). • Weight needs to have been maintained or has increased. Please provide current height, weight and BMI. • If weight has not maintained, Oxandrin will not be re-authorized. • If weight is maintained or has increased, the patient may remain on Oxandrin. • **AUTHORIZATION:** 60 day trial, if weight is maintained or has increased, an additional 4 months may be approved. • **RE-AUTHORIZATION:** 6 months.
Pradaxa	• Documentation of one of the following diagnoses: • Atrial fibrillation, OR • Another condition requiring anticoagulation. • Documented failure to maintain a therapeutic INR or warfarin or intolerance to warfarin. • **AUTHORIZATION:** Authorization period is one year, or anticipated duration of treatment if shorter than one year • **RE-AUTHORIZATION:** Updated letter of medical necessity
Provigil	• Pt. must be age 9 years or older • Covered for the following diagnoses: • Narcolepsy - Amphetamines or Methylphenidate must be tried first. Dose limited to 400mg daily • Treatment to offset sedation related to multiple sclerosis treatment modalities. Dose is limited to 200mg daily • Daytime somnolence due to obstructive sleep apnea - **must be on C-pap**. Dose limited to 200mg per day • Shift work sleep disorder **must be working night shifts.** Provide documentation of a treatment plan that demonstrates excessive sleepiness at work, insomnia when patient should be sleeping. Patient must have a three month trial of sleep aids. Dose is limited to 200mg/day **NOTES:** Provigil and Nuvigil are mutually exclusive. Patients may only have a prior authorization for one of these medications at a time • **AUTHORIZATION:** 1 year • **RE-AUTHORIZATION:** Update letter of medical necessity
Qualaquin	• Minimum age requirement: 16 years old

	• Diagnosis of malaria • **AUTHORIZATION:** One 7 day course up to 42 tablets is approved with each PA • **RE-AUTHORIZATION:** Same as initial PA
Ragwitek	**CRITERIA:** • Client must be between 18 and 65 years of age • Provide documentation of a diagnosis of ragweed pollen-induced allergic rhinitis confirmed by positive skin test, or in vitro testing, for pollen-specific IgE antibodies for short ragweed pollen. • Therapy must be initiated at least 12 weeks before the expected onset of each ragweed pollen season. (December 5 to January 10) • First dose must be administered under supervision of a physician with experience in the diagnosis and treatment of allergic diseases. Letter of medical necessity or progress notes must document that patient will be observed, in the office for at least 30 minutes following the initial dose. **AUTHORIZATION**: • Ten months **RE-AUTHORIZATION:** • Client age between 18 and 65 years of age. • Initial therapy was approved and initiated at least 12 weeks prior to expected onset of ragweed pollen season. • Therapy has been continuous throughout ragweed pollen season.
Regranex	• **Rule out venous ulcers and/or arterial ulcers** • Patient must be diabetic, either type I or type II • Not covered for diabetic ulcers above the ankle • Patient must have stage III or IV diabetic foot or ankle ulcer as defined in the International Association of Enterostomal therapy guide to chronic wound staging, 1989 • Not a benefit for patients in long term care facilities, unless that patient is admitted from home or hospital with a pre-existing diabetic ulcer of the lower extremity. LTCF must submit a copy of skin assessment report made within 24 hours of admission • The client must have had a documented failure on a 60 day regimen of good ulcer care that includes but is not limited to: 1. Initial complete sharp debridement 2. A non-weight bearing regimen 3. Systemic treatment for wound-related infections 4. Moist saline dressing changes twice daily 5. Additional debridement if necessary • The subcutaneous diabetic face ulcer may not exceed 3cm in diameter or total surface of 9.42cm^2 (size and shape must be documented) • Total contact casting is an available method of treatment and must be considered and rejected before Regranex is to be considered • **AUTHORIZATION:** 8 weeks (15-30 Grams) • **RE-AUTHORIZATION:** Documentation of 30% reductions in ulcer size must be achieved before a second prior is given. Treatment is limited to a

	maximum of 60 grams of Regranex.
Relistor	• Minimum age requirement 18 years old • Diagnosis of opioid-induced constipation • Rule out mechanical GI obstruction • Patient must be receiving opioids as part of a palliative care regiment for advanced illness • Documented trial and failure of conventional laxative therapy • **AUTHORIZATION:** 4 months • **RE-AUTHORIZATIONS:** Updated letter of medical necessity
Restasis	**I. Approved for the following diagnoses** (ICD.9): • 370.20 Superficial keratitis, unspecified • 370.21 Punctate keratitis • 370.33 Keratoconjunctivitis sicca, not specified as Sjogren's disease • 710.2 (Sicca syndrome - Sjogren's disease) • **Documentation requirements for the above diagnoses:** 1. Diagnosis 2. Documented fluorescein test 3. Request from ophthalmologists or with documented ophthalmologist consult • **AUTHORIZATION:** Prior approval for the above diagnoses is for 1 year • **RE-AUTHORIZATION:** Additional periods require steps 1-3 **II. Restasis for Post Corneal Transplant (ICD.9):** V42.5 Post Corneal Transplant • **Documentation of post corneal transplant:** Diagnosis only • **AUTHORIZATION:** Prior approval is for 1 year • **RE-AUTHORIZATION:** Updated letter of medical necessity **INFORMATION:** Maximum supply is 1 box of 32 dropperettes/month
Retinoids	

Panretin	Panretin:
	• **30-day trial period:**
	  • Diagnosis of cutaneous lesions caused by Kaposi's Sarcoma. Include the following information:
	  • Primary number of KS lesions.
	  • Estimated total square centimeters.
	  • Number of lesions flat on baseline.
	  • Number of lesions raised on baseline.
	  • Systemic anti-KS therapy is not yet required. Panretin is not indicated when systemic anti-KS therapy is required. (e.g., more than 10 new KS lesion in a month, symptomatic lymphedema, symptomatic pulmonary KS, or symptomatic visceral involvement.)
	  • 0.1% Retin-A gel has been tried for a period of 60 days or more and there was less than a 25% improvement of (both Partial Response Area (PRA) and Partial Response Height (PRH)).
	• **60 day treatment period:**
	  • Patient must sustain partial response defined as a 50% or more improvement from base line. Include:
	  • Number of KS lesions.
	  • Estimated total square centimeters.
	  • Partial Response Area.
	  • Partial Response Height.

	• **Continued use of Panretin:**
	  • Updated letter of medical necessity indicating continued improvement. Include:
	  • Number of KS lesions.
	  • Estimated total square centimeters.
	  • Partial Response Area.
	  • Partial Response Height.
	INFORMATION: Assessment of lesions is limited to only the cutaneous lesions treated. Each lesion assessed for height and diameter. The response evaluation of each KS index will be classified according to the following system:
	  • Complete Response (CR): Decreased in lesion area to zero and biopsy documented absence of KS cells.
	  • Clinical Complete Response (CCR): Decrease in lesion area to zero.
	  • Partial Response Area (PRA): Decrease in lesion area by 50% or more from baseline without concurrent increase in height or lesion form flat (macular) at baseline to raised (plaque-like or nodular).
	  • Partial Response Height (PRH): Complete flattening of a lesion raised at baseline (decrease in height f from nodular or plaque-like) without concurrent increase in lesion area by 25% or more from baseline.
	  • Stable Disease (SD): Lesion does not meet evaluation criteria for CR, CCR, PR, or PD.
	  • Progressive Disease (PD): Increase in lesion area by 25% or more from baseline area, or an increase in height from flat (macular) at baseline to raised (Plaque-like or nodular).
	• **AUTHORIZATION:** Initial 30 day trial and 60 day treatment period as described above.
	• **RE-AUTHORIZATION:** 60 day treatment periods are authorized with continued improvement, as described above.

Retin-A	Retin-A:
	• Diagnosis of cutaneous lesions caused by Kaposi's Sarcoma
	  • Pre-panretin use
	  • List number of primary KS lesions
	  • Indicate if lesions are flat or raised
	  • Estimated total square centimeters
	INFORMATION:
	• Not to be used when systemic anti-Kaposi's Sarcoma therapy is required
	• For adult acne diagnoses, use the Adult Acne Prior Authorization form
	• **AUTHORIZATION:** 60 day trial on a topical tretinoin
	• **RE-AUTHORIZATION:** Documentation indicating patient has had at least a 25% improvement or more from the baseline. Re-authorization is then for 6 months

Salagen	**NOTES:** Ophthalmic pilocarpine drops may be administered orally with the same effects and safety profile as oral pilocarpine tablets. Because of the price disparity between the drops and the tablets, Utah Medicaid's Drug Utilization Review Board recommends a trial of ophthalmic pilocarpine, administered orally, before use of oral tablets • Documented trial and failure of ophthalmic pilocarpine drops, administered orally, at an appropriate dose (please indicate administration technique and dose in progress notes) • **AUTHORIZATION:** Initial authorization will be granted for 1 year • **RE-AUTHORIZATION:** Subsequent authorizations will be granted upon

	submission of progress notes re-iterating need and effectiveness

Samsca	• Documentation that therapy was initiated in the hospital
	• Documentation that Samsca is required for hypervolemic or euvolemic hyponatremia associated with heart failure, cirrhosis, or SIADH
	• Documentation that serum sodium ≤ 125mEq/L
	• Documentation that hyponatremia is symptomatic if serum sodium >125mEq/L AND documented failure of other treatments strategies including but not limited to:
	  • Documented failure of fluid restriction
	  • Documented failure of salt administration (for euvolemic hyponatremia only)
	  • Documented failure of demeclocycline (for SIADH only)
	• Evidence is required that the underlying disease state causing the hyponatremia is being adequately treated
	• Dose limited to 60mg daily
	• **AUTHORIZATION:** Initial authorization is for 60 days
	• **RE-AUTHORIZATION:** Subsequent authorizations will only be granted by petition to the DUR Board

Selzentry	• Minimum age: 16 years old • Documentation of co-receptor tropism assay test indicating CCR5-tropic HIV-1 infection • Documentation of optimized background therapy for the treatment of HIV-1 infection • **AUTHORIZATION:** 1 year • **RE-AUTHORIZATION:** Updated letter of medical necessity
Simvastatin	**NOTES:** In June 2011 the FDA issued a statement recommending that the highest approved dose of simvastatin (80 mg) be avoided due to an increased risk of myopathy and rhabdomyolysis, when compared to lower doses of simvastatin, and to other statins. Utah Medicaid has created the following Prior Authorization criteria in support of the FDA's statement **No Prior Authorization is required for simvastastin doses below 41mg per day** • The patient has been received greater than 40 mg of simvastatin daily (either as simvastatin or as Vytorin) for 12 or more months, with no evidence of myopathy. **Please submit medical notes indicating lack of myopathic symptoms. Note that authorization will only be granted to patients established on, and continuing therapy at a dose of greater than 40 mg daily** **AND** • The patient is not receiving any medications which are contraindicated for use with simvastatin (at **any** dose) • Please see the full prescribing information for simvastatin and/or Vytorin®. Contraindicated medications include but are not limited to itraconazole, ketoconazole, posaconazole, erythromycin, clarithromycin, telithromycin, HIV protease inhibitors, nefazodone, gemfibrozil, cyclosporine, danazol, amiodarone, verapamil, diltiazem, amlodipine, and ranolazine • **AUTHORIZATION:** 1 year • **RE-AUTHORIZATION:** Submission of medical notes indicating therapeutic efficacy and continued lack of myopathic symptoms

Sirturo	**NOTES**: • Sirturo is not FDA-approved to treat latent or extra-pulmonary tuberculosis (TB) • Sirturo is FDA-approved for adjunctive treatment or multi-drug resistant TB, not for drug-sensitive TB • Sirturo must be used in combination with at least 3 other agents that are active against the patients specific TB isolate ○ If testing to identify isolate(s) is unavailable, Sirturo must be used in combination with at least 4 other antitubercular agents • Per the FDA, the administration of each Sirturo tablet must be observed by a health care professional (Directly Observed Therapy, DOT) **CRITERIA**: • Age ≥ 18 years • The patient must have active , pulmonary TB • Describe previously tried agents, and the nature of treatment failure • Indicate the three or four agents planned to be used adjunctively with Sirturo • Describe the arrangements for DOT **AUTHORIZATION/ DOSE LIMITATIONS**: Days 1-14: four 100mg tablets (400mg) once daily; 56 tablets per 14 days **RE-AUTHORIZATION**: Subsequent authorizations may only be granted by petition to the DUR Board
Soliris	**CRITERIA**: • Documented diagnosis of atypical hemolytic uremic syndrome (aHUS) OR paroxysmal nocturnal hemoglobinuria (PNH). • Review by the DUR Board. Please include ample clinical information in support of your diagnosis-specific request. **INFORMATION**: • To be given in clinic setting only. Provider will bill with J code J1300, NDC number, and PA number. Patients with ACOs will have to make arrangements with their ACO for coverage. **AUTHORIZATION**: 1 year **RE-AUTHORIZATION:** 1 year with updated letter of medical necessity and documentation of patient progress.
Somavert	• **DOCUMENTED** acromegaly. • **DOCUMENTATION** showing inadequate response to either transsphenoidal adenomectomy or radiotherapy or both. • **DOCUMENTED** trial on at least one Dopamine agonist such as cabergoline (Dostinex) or bromocriptine. • **DOCUMENTATION** that patient has been evaluated for a somatostatin analogue such as octreotide acetate (sandostatin). • **AUTHORIZATION**: 6 months • **RE-AUTHORIZATION**: Updated letter of medical necessity
Stimulants *(for Adults)*	**WHEN PRESCRIBED FOR ADULTS only the following diagnoses are covered:** ADD/ADHD, narcolepsy, organic brain syndrome, traumatic brain injury, treatment resistant depression, severe sedation due to chemotherapeutic medications, severe sedation due to psychotropic medications, or mental retardation if the patient exhibits injurious behavior and/or hyperactivity **ADD or ADHD**

	• Letter of medical necessity, stating current diagnosis, current treatment, and any past or present substance abuse problems. • A copy of the testing that has been done to make the diagnosis of adult ADD: Psychiatric Evaluation that shows the Axis 1 diagnosis of ADD, **OR** a copy of the Wender Utah Rating Scale with a score of 46 or greater, **OR** criteria from the DSM that has been met. **ALL OTHER DIAGNOSIS:** • Letter of medical necessity explaining the patient's diagnosis and situation. • Statement documenting any substance abuse problems past, present or no history. **NOTES:** • The Daytrana patch is not FDA indicated for adults, and Medicaid will not cover it past the age of 18. • Please see the Zenzedi form for Zenzedi requests. **AUTHORIZATION:** 1 year **RE-AUTHORIZATION:** (starting at age 19) a letter of medical necessity explaining the patient's diagnosis and situation, including a statement regarding any current substance abuse issues.
Stimulants *(for Children)*	**WHEN PRESCRIBED FOR CHILDREN the only diagnoses covered are ADD and ADHD** • With a correct ICD code for patients ages 3 through 18, no prior authorization is needed for immediate Adderall IR, Dexedrine or Desoxyn. Consideration for patients under 3 requires an evaluation by a child/adolescent psychiatrist. • With the correct ICD code for patients ages 6 through 18, methylphenidates and Adderall XR may be approved without prior authorization. Consideration for patients under 6 requires an evaluation by a primary care practitioner. **NOTE:** • Please write the child's diagnosis code on the face of the prescription • Please see the "Zenzedi" form for Zenzedi requests **AUTHORIZATION**: 1 year **RE-AUTHORIZATION**: A letter stating current diagnosis, current treatment and any substance abuse issues.
Suboxone / Zubsolv / Bunavail *(buprenorphine/naloxone)*	**INITIAL CRITERIA:** • Minimum age requirement: 16 years old • Documented diagnosis of opioid dependence • Prescribing physician must provide their X-DEA number • Evidence supplied of plans for on-going treatment monitoring that includes drug urine screening, or DOPL reports, or random pill counts • Description of the psychosocial support to be received by patient, as indicated by chart notes or a brief letter of medical necessity • A treatment plan that includes a tapering plan or discontinuation of pharmacotherapy • No concomitant therapy with Vivitrol (naltrexone) • No concomitant therapy with opiate analgesics • **NOTE**: Products containing only buprenorphine are covered under same criteria during pregnancy ONLY. **AUTHORIZATION:** Initial 18-month authorization at a maximum of 24mg-6mg/day (Suboxone), 17.1mg-4.2mg/day (Zubsolv) or 12.6mg-

	2.1mg/day (Bunavail). **REAUTHORIZATION:** Re-authorization period is 18-months at a maximum of 24mg-6mg/day (Suboxone), 17.1mg-4.2mg/day (Zubsolv) or 12.6mg-2.1mg/day (Bunavail) if the following criteria are met: • Letter of explanation detailing why an additional approval is needed • Evidence of psychosocial support received by patient • Evidence that a taper plan has been attempted, and if failed, why • Detailed plans for immediate taper if initial taper failed • A negative urine screen completed within 14 days of reauthorization start date • No concomitant therapy with Vivitrol (naltrexone) • No concomitant therapy with opiate analgesics **Note:** Treatment will only be covered up to 36 months (18 month authorization and 18 month re-authorization). After 36 months, **NO** petitions will be approved under **ANY** circumstances. **NDC Changes:** NDC changes for dosage tapering must be submitted in an updated letter of medical necessity, faxed to 855-828-4992.
Sutent	**CRITERIA:** • Minimum age requirement: 18 years old. • Documentation of advanced renal cell carcinoma; OR • Documentation of Gastrointestinal stromal tumor with disease progression or intolerance to Gleevec. • **INFORMATION:** Dosing: 50mg daily, 4 weeks on and 2 weeks off. Dose increase or reduction is in 12.5mg increments. • **AUTHORIZATION:** 1 year • **RE-AUTHORIZATION:** Updated letter or progress note showing improvement or maintenance on Sutent.

Synagis	**All of the Following are Eligible for a Maximum of Five (5) Doses (the last dose must be given on or before April 30, regardless of when treatment began):**
	• Premature infants (born < 29 weeks, 0 days gestation) during their first year of life
	• Premature infants (born < 32 weeks, 0 days) who received > 21% oxygen for at least 28 days immediately after birth
	• Infants < 12 months of age if they have been diagnosed with
	  o congenital abnormalities of the airway
	  o neuromuscular disease that compromise(s) handling of respiratory secretions
	  o acyanotic heart disease AND currently being treated for CHF AND will undergo a cardiac procedure
	  o moderate to severe pulmonary hypertension
	• Children < 24 months of age with chronic lung disease of prematurity and who required at least 28 days of supplemental oxygen immediately after birth and who continue to require medical intervention (supplemental oxygen, chronic corticosteroid, or diuretic therapy).
	• Children younger than 24 months who will be profoundly immunocompromised during the RSV season.
	
	PLEASE NOTE:
	ALL SYNAGIS (DRUG) MUST BE BILLED VIA PHARMACY POINT OF SALE. UTAH MEDICAID CANNOT REIMBURSE PHYSICIANS' OFFICES FOR THE DRUG. NO EXCEPTIONS.

	• The Utah Medicaid Synagis season is December 1st through April 30th. A maximum of five monthly Synagis doses may be given during this five month period. • Synagis is not available to any child with active RSV. • No approval will be given to a child of 24 months or older. • When an infant begins a Synagis series late in the season, they may receive monthly doses until April 30th, as appropriate, according to the criteria above. A child who begins the series and then turns two may receive monthly doses until April 30th, as appropriate, according to the criteria above. • The DUR Board considered recommendations from the American Academy of Pediatrics, the manufacturer, and the FDA approved indications in developing these criteria. Therefore, prescribers seeking approval outside the above criteria must provide literature that demonstrates support for the requested use. Consideration of the request will not proceed without it. NO EXCEPTIONS. Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection. Pediatrics 2014; 134:415. Published online July 28, 2014, at *http://pediatrics.aappublications.org/content/124/415.full.html*

Topical Immunomodulators *(Elidel, Protopic, pimecrolimus, tacrolimus)*	**INITIAL AUTHORIZATION**: 6 weeks
	• Submit all of the following:
	  ○ Diagnosis
	  ▪ If atopic dermatitis, please write the diagnosis code on the face of the prescription
	  ▪ If lichen planus or vitiligo, please indicate if the patient has Hepatitis C
	  ○ Strength, quantity and directions for administration
	  ○ Physical location of affected area(s)
	  ○ Documentation (medical notes) of failure on at least one non-calcineurin-inhibiting agent
	RE-AUTHORIZATION: 6 months
	  ○ Submit updated medical notes indicating improvement while on therapy

Trizivir	**CRITERIA:** • **DOCUMENTED** failure of all three medications (Abacavir, Lamivudine, and Zidovudine) individually. • **AUTHORIZATION:** 1 year • **REAUTHORIZATON:** Updated letter of medical necessity

Tykerb	**CRITERIA**
	• Patient must be age 18 or above
	• Diagnosis of advanced or metastatic breast cancer whose tumor overexpresses HER2.
	• Documentation of prior therapy, including the following agents:
	  • an anthracycline (e.g. danorubicin, doxorubicin, epirubicin, idarubicin, or valrubicin);
	  • a taxane (e.g. paclitaxel, docetaxel, or taxotere); and
	  • trastuzumab.
	• To be given in combination with capecitabine.
	• **AUTHORIZATION:** Initial PA is granted for 1 year
	• **RE-AUTHORIZATION:** granted in one-year increments with an updated letter of medical necessity

Tysabri	**CRITERIA FOR MULTIPLE SCLEROSIS:** • Minimum age requirement: 18 years old.

	• Documented diagnosis of Multiple Sclerosis. • Documented inadequate response or intolerance of a first-line Multiple Sclerosis drug, such as interferon or glatiramer. **CRITERIA FOR CROHNS DISEASE:** • Minimum age requirement: 18 years old. • Documented diagnosis of Crohn's Disease. • Documented inadequate response to conventional therapy (i.e. 5-aminosalicylates, antibiotics, MTX, 6-mercaptopurine, or azathioprine). • Documented inadequate response to at least one Anti-TNF. **NOTES:** • This medication is only payable through J-code J2323 to a physician's office or infusion center. Patients with ACO's will have to make arrangements with their ACO for coverage. • This medication is available as a benefit to Non-Traditional Medicaid clients. **AUTHORIZATION:** Initial authorization will be given for one year. **RE-AUTHORIZATION:** Updated letter of medical necessity indicating continued benefit from Tysabri.
Uloric	**CRITERIA:** • Minimum age requirement: 18 years old. • Documented diagnosis of Gout. • Documented failure, contraindication, or intolerance to allopurinol. • No concomitant use of azathioprine, mercaptopurine, or theophylline. • **AUTHORIZATION:** The initial authorization will be approved for one year • **RE-AUTHORIZATION:** Updated letter of medical necessity
Vectibix	**CRITERIA:** • Minimum age requirement: 18 years old. • Diagnosis of metastatic colorectal cancer. • Disease progression on or following fluoropyrimidine-, oxplatin-, and inrinoteacan-containing chemotherapy regimens. **INFORMATION:** To be given in clinic setting only. Provider will bill with J code J9303, NDC number, and PA number. Patients with ACO's will have to make arrangements with their ACO for coverage. **AUTHORIZATION:** 1 year **RE-AUTHORIZATION:** Updated letter of medical necessity.
Vivitrol	**CRITERIA for Treatment of Alcohol Abuse OR for Prevention of Relapse to Opioid Dependence:** • Diagnosis of alcohol abuse AND/OR Diagnosis of opioid dependence • Negative urine screen for opioids or passed naloxone challenge. • No concomitant treatment with Suboxone or Subutex. • Description of the psychosocial support to be received by patient, as indicated by chart notes or a brief letter of medical necessity. **INFORMATION:** • Negative urine screen for opioids is critical regardless of condition being treated - see Vivitrol's FDA-approved prescribing information, section 5.5 • Vivitrol is to be given by substance abuse treatment providers. Provider will

	bill with J-code J2315, NDC 65757-300-01, and PA number. • This drug is not available to patients with Primary Care Network coverage • **AUTHORIZATION for both indications:** Initial authorization is for 6 months. • **RE-AUTHORIZATION for both indications:** Updated letter of medical necessity
Xanax XR	**CRITERIA:** • Trial and failure of a 6-8 week trial of oral, short acting alprazolam within the last 6 months. • **AUTHORIZATION:** 1 year • **RE-AUTHORIZATION:** Updated letter of medical necessity
Xarelto	**Initial and Re-authorization Criteria per Indication:** • **<u>Reduction in Risk of Stroke in Non-valvular Atrial Fibrillation:</u>** o 20mg daily if creatinine clearance > $50^{ml}/_{min}$ o 15mg daily if creatinine clearance is between $15^{ml}/_{min}$ and $50^{ml}/_{min}$ o Initial authorization is 6 months, with potential reauthorization upon submission of an updated letter of medical necessity • **Prophylaxis of DVT following Hip of Knee Replacement:** o 10mg daily for 35 days following hip replacement o 10mg daily for 12 days following knee replacement o Extended treatment beyond the limited days following hip or knee surgery will not be authorized for the same surgical event. Treatment for subsequent procedures may be given upon receipt of a new prior authorization request. • **Treatment of DVT or PE:** o 30mg daily (15mg BID) for 21 days…*THEN*…20mg daily o Initial authorization is 6 months, with potential reauthorization upon submission of an updated letter of medical necessity. • **Prevention of Recurrence of DVT or PE:** o 20mg daily o Initial authorization is 6 months, with potential reauthorization upon submission of an updated letter of medical necessity.
Xibrom	**CRITERIA:** • **DOCUMENTED** prior trial of any indicated medication (diclofenac, ketorolac, nepafenac, loteprednol, rimexolone, or prednisolone ophthalmic preparations). • **AUTHORIZATION:** Approved for one bottle for a 2 week period following procedure or surgery. • **RE-AUTHORIZATION:** Same as initial authorization
Xifaxan	**CRITERIA:** • **Traveler's Diarrhea**: o Age ≥ 12 years o For treatment, not for prophylaxis o Trial and failure of, or contraindication to, a fluoroquinolone or azithromycin – please describe o Must reasonably be believed to be caused by *Escherichia coli* – please describe o Maximum 200mg three times daily for 3 days • **Overt Hepatic Encephalopathy** o Age ≥ 18 years o For prophylaxis of recurrence – please describe previous occurrences and

	therapies o Trial and failure of, or contraindication to, properly titrated doses of lactulose – please describe o Maximum 550mg twice daily • **AUTHORIZATION** o Traveler's Diarrhea: 3 days o Overt Hepatic Encephalopathy: 1 year • **RE-AUTHORIZATION** o Letter of medical necessity describing treatment efficacy and rational for continuation
Xolair	**CRITERIA:** • Minimum age requirement: 12 years old. • Patient must have tried all other therapies for a time period generously adequate (at least 4 months) to establish indisputable failure of each. • The request must include the following information: o Documentation of all failed therapies tried, and reason for requesting Xolair. o Include the desired starting dose of Xolair in the request. o Include the patient's baseline IgE value and weight in the written request. • If requested for allergic asthma, please confirm that a skin test and/or in vitro reactivity test has/have been done. • NOTES: • This medication is only payable through J-code J2357 to a physician's office. Patients with ACOs must make arrangements with their ACO for coverage. • The patient must have regular appointments to receive the medication in the prescriber's office. • The patient must remain in the office for a minimum of 90 minutes to allow for observation and treatment of anaphylaxis, if necessary. • If/when any change of dose is requested, the prescriber must indicate, in writing, the reasoning for the dose increase. **AUTHORIZATION:** 6 months **RE-AUTHORIZATION:** Updated letter of medical necessity
Xolegel	**CRITERIA:** • Minimum age: 12 years old. • Documented trial and failure of a generic formulation of topical ketoconazole within the last 12 months. • **AUTHORIZATION:** 6 months • **RE-AUTHORIZATION:** Updated letter of medical necessity
Xyrem	**CRITERIA:** • Age requirement: 18 to 65 years old. • **DOCUMENTED** cataplexy associated with narcolepsy. • **DOCUMENTATION** ruling out concomitant use of sedative-hypnotics. • Maximum dose is 9gm/day • **AUTHORIZATION:** 1 year • **RE-AUTHORIZATION:** Updated letter of medical necessity
Zavesca	**CRITERIA:** • Minimum age requirement: 18 years old. • Diagnosis: moderate type I Gaucher's disease. • Documentation that enzyme replacement therapy has failed. • Documentation that hemoglobin is >9g/dL. • Platelet count > 50k/ul (**FAX a copy of the lab work**).

	• Written consultation with a trained specialist (hematologist or geneticist). **INFORMATION:** • Cumulative limit of 90 capsules in 30 days. • DOSAGE: 100mg three times daily recommended. May be decreased to once or twice a day based on side effects • **AUTHORIZATION:** 1 year • **RE-AUTHORIZATION:** Updated letter of medical necessity

Zenzedi	**FOR CHILDREN:**
	• **For the treatment of ADHD:**
	  o For patients ages 3 through 16 years old, only an appropriate diagnosis code is required, and authorization will continue until the child's 16th birthday.
	  o Indicate the diagnosis (ICD) code
	  o Consideration for patients under 3 years old requires an evaluation and letter of medical necessity from a child/adolescent psychiatrist**.**
	• **For the treatment of Narcolepsy:**
	  o Consideration for children ages 6 years and older requires an evaluation and letter of medical necessity from a primary care practitioner.
	  o Consideration will not be given to children under 6 years old**.**
	FOR ADULTS:
	• For the treatment of Narcolepsy:
	  o Consideration requires an evaluation and letter of medical necessity from a primary care practitioner. Please describe any past or current substance abuse issues in the letter.
	NOTES:
	• For any age or indication, please write the diagnosis code on the face of the prescription.
	• Zenzedi's only indication for adults is narcolepsy, and no other diagnosis will be considered.
	AUTHORIZATION: 1 year (see exception above)
	
	RE-AUTHORIZATION: A letter of medical necessity stating current diagnosis, current treatment and any current substance abuse issues.

Ziana	**CRITERIA:** • Age requirement: 12-19 years old. • Patient must try and fail on a combination of both generic tretinoin gel and clindamycin gel. • **AUTHORIZATION:** 1 year • **RE-AUTHORIZATION:** Updated letter of medical necessity
Zovirax Ointment	**CRITERIA:** • Fax a letter of medical necessity to 855-828-4992. • Utah Medicaid patients may only receive one course of treatment with Zovirax ointment per lifetime.

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