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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.

All injectable products, with the exception of 10ml insulin vials and medroxyprogesterone acetate (Depo-Provera) for family planning, are non-covered under PCN.

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.

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

through 19; ages >19. Attachments to Section 2 of the Medicaid Pharmacy Provider Manual show covered ICD.9 codes for each age group respectively.

Cumulative limits on long-acting narcotic analgesics and short-acting single entity narcotic analgesics are waived for the treatment of cancer-related pain. The prescriber must provide an appropriate ICD.9 diagnosis code for 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: <ul style="list-style-type: none"> • Age 0-2: Prior Authorization Required – 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 - Stimulants (for Adults).
Methylphenidate & Derivatives	Methylphenidate & Derivatives <ul style="list-style-type: none"> • Age 0-5: Prior Authorization Required – Stimulants (for Children). • Age 6-18: Covered - Valid ICD-9 code must be written on the prescription • Age 19+: Prior Authorization Required - 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 <ul style="list-style-type: none"> • Covered for ages 6+. • Cumulative limit of 66 capsules in 30 days.
Analgesics	
Tramadol/ Ultracet/ Tramadol ER	Tramadol/Ultracet: <ul style="list-style-type: none"> • Cumulative limit of 180 tablets in 30 days Tramadol ER <ul style="list-style-type: none"> • Cumulative limit of 90 tablets in 30 days
Fentora	<ul style="list-style-type: none"> • Only a covered benefit if the prescriber provides a valid ICD-9 diagnosis code for terminal cancer.
Methadone	Methadone : <ul style="list-style-type: none"> • Cumulative limit of 150 tablets in 30 days. • The cumulative limit may be overridden if the prescriber provides a valid ICD-9 diagnosis code for terminal cancer. • Mutually exclusive with long-acting opioids.
Long-Acting Opioids (<i>Avinza, Kadian, MS- Contin, Oxycontin & generics</i>)	Long-Acting Opioids: <ul style="list-style-type: none"> • 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.
Short-Acting Opioids	Short-Acting Opioids: <ul style="list-style-type: none"> • Cumulative limit of 180 tablets in 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	<ul style="list-style-type: none"> • Valid ICD-9 diagnosis code is required on each prescription. • ICD-9 codes may be found in the Utah Medicaid Provider Manual for

(Abilify, Clozaril, Geodon, Invega, Risperidal, Seroquel, Symbyax, Zyprexa)	Physicians Services and Anesthesiology.				
	<ul style="list-style-type: none"> • ICD-9 code must be correct for the patient's age. • Risperdal Consta non-covered for Non-Traditional or PCN clients. 				
Benzodiazepines	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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. 				
Celebrex	<ul style="list-style-type: none"> • Cumulative limit of 60 capsules in 30 days. 				
Cymbalta (duloxetine)	<ul style="list-style-type: none"> • 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 Containing Products	<ul style="list-style-type: none"> • Cumulative limit of 180 tablets in 30 days. 				
Inhalers	LIMIT IN ANY 30 DAY PERIOD				
<p>Effective April 1, 2002, 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.</p>					
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
Beta 2 agonists and Sympathomimetic Inhalers	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/ salmeterole 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
Insulin	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> Cumulative Limit of 1054 gm in 30 days 												
Lactulose	Lactulose: <ul style="list-style-type: none"> Cumulative limit of 6,000 ml in 30 days Over 6,000 ml in 30 days requires a prior authorization – see Lactulose. 												
Levothyroxine Products	<ul style="list-style-type: none"> Generic use mandated when AB-rated equivalent exists Use the table below to determine appropriate substitutions: <table border="1" style="margin-left: 40px;"> <thead> <tr> <th><u>Drug</u></th> <th><u>Rating</u></th> </tr> </thead> <tbody> <tr> <td>Unithroid</td> <td>AB1,AB2, AB3</td> </tr> <tr> <td>Mylan Levothyroxine</td> <td>AB1,AB2,AB3</td> </tr> <tr> <td>Levoxyl</td> <td>AB1, AB3</td> </tr> <tr> <td>Synthroid</td> <td>AB2</td> </tr> <tr> <td>Levo-T</td> <td>AB2, AB3</td> </tr> </tbody> </table> 	<u>Drug</u>	<u>Rating</u>	Unithroid	AB1,AB2, AB3	Mylan Levothyroxine	AB1,AB2,AB3	Levoxyl	AB1, AB3	Synthroid	AB2	Levo-T	AB2, AB3
<u>Drug</u>	<u>Rating</u>												
Unithroid	AB1,AB2, AB3												
Mylan Levothyroxine	AB1,AB2,AB3												
Levoxyl	AB1, AB3												
Synthroid	AB2												
Levo-T	AB2, AB3												
Metformin	<ul style="list-style-type: none"> The maximum daily dose is 2550mg. Dosage limits are set accordingly. 												
Migraine Medications													
Triptans (<i>Imitrex, Zomig, Amerge, Axert, Maxalt, Relpax</i>)	Triptans: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Cumulative limit of 9 dosage units per 30 days. 												
Muscle Relaxants	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Cumulative limit of two kits per month. OTC products included (prescription required). 												
Pristiq	<ul style="list-style-type: none"> Limit of 30 tablets in 30 days. 												
Proton Pump Inhibitors	<p>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.</p> <ul style="list-style-type: none"> 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. <p>Other Diagnosis: Peer-reviewed literature demonstrates 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:</p> <ul style="list-style-type: none"> Evidence of failure on an appropriate dosing regimen. Consultation with a GI, ENT, pulmonary or allergy specialist. <p>Notes: Prevacid Solutabs: No prior authorization is required for children under 12 who</p>												

	<p>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</p>
Savella	<ul style="list-style-type: none"> • 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 (<i>Dalmane, Sonata, Somnote, Halcion, Ambien, Doral, Restoril, Lunesta, Rozerem, and their generics</i>)	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Not covered for PCN

Drugs Requiring Prior Authorization	
Adult Acne	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Patient must be age 18 or above. • Diagnosis of Chronic Idiopathic Constipation. <ul style="list-style-type: none"> • Documented failure within the last 12 months using: <ul style="list-style-type: none"> • One fiber laxative AND • Two stimulant laxative products. • Drug induced constipation must be ruled out. • Diagnosis of irritable bowel syndrome <ul style="list-style-type: none"> • Documented failure within the last 12 months using: <ul style="list-style-type: none"> • One fiber laxative AND • One osmotic laxative (magnesium salts or polyethylene glycol-based laxatives) • Other causes of constipation have been ruled out. • AUTHORIZATION: 6 months for chronic constipation or 3 months for irritable bowel syndrome. • RE-AUTHORIZATION: Trial off Amitiza, using other laxatives, for at least 30 days.
Ampyra	<ul style="list-style-type: none"> • 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	<p>Danazol for Females:</p> <ul style="list-style-type: none"> • Only FDA-approved uses will be considered. Please submit appropriate documentation describing one of the following: <ul style="list-style-type: none"> ○ 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 <p>Androgens for males</p> <ul style="list-style-type: none"> • ≥ 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

	<p>(different laboratories use different assays and thus may have different ranges which are considered low, optimal, or high)</p> <ul style="list-style-type: none"> • 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 <u>while on androgen therapy</u>, 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.
Antidiabetic Agents	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<p>Cycloset:</p> <ul style="list-style-type: none"> • 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. <p>NOTES: This form is for Non-Traditional clients only. Traditional clients may receive this medication without a prior authorization.</p> <ul style="list-style-type: none"> • AUTHORIZATION: 1 year

	<ul style="list-style-type: none"> • RE-AUTHORIZATION: Updated letter of medical necessity
Antihistamines, non-sedating (<i>Allegra, Clarinex, Xyzal</i>)	<ul style="list-style-type: none"> • DOCUMENTATION stating when and how OTC cetirizine, fexofenadine and loratadine preparations have failed. • INFORMATION: Non-sedating antihistamines limited to 30 doses/30 days. • AUTHORIZATION: 1 year. • RE-AUTHORIZATION: Updated letter of medical necessity
Anti-Emetics	
Emend	Emend: <ul style="list-style-type: none"> • 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) <p>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.</p> <ul style="list-style-type: none"> • AUTHORIZATION: 6 months, 3 doses per chemotherapy session. • RE-AUTHORIZATION: Updated letter of medical necessity
Butalbital Containing Products	<p>CRITERIA</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • one or more non-steroidal anti-inflammatory agent AND • one or more triptans (any administration route) AND • intranasal dihydroergotamine 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 <u>each</u> agent above. <p>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 <u>not</u> contain butalbital.</p>
Chantix	<ul style="list-style-type: none"> • 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 (<i>Olux</i>)	<ul style="list-style-type: none"> • DOCUMENTED failure on generic formulations of clobetasol propionate

<i>Foam)</i>	creams, ointments, or solutions within the last 12 months <ul style="list-style-type: none"> • AUTHORIZATION: 6 months • RE-AUTHORIZATION: Updated letter of medical necessity
Colchicine (<i>Colcris, Mitigare</i>)	Criteria for Gout: <ul style="list-style-type: none"> • 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.
	Criteria for Familial Mediterranean Fever: <ul style="list-style-type: none"> • Minimum age requirement: 4 years old. • Documented diagnosis of Familial 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	<ul style="list-style-type: none"> • 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.
Depo-Provera	<ul style="list-style-type: none"> • Patient or provider requests injectable medication for family planning. <p>NOTES: This form is for Non-Traditional clients and Primary Care Network only. Traditional clients may receive this medication without a prior authorization.</p> <ul style="list-style-type: none"> • AUTHORIZATION: 1 year • RE-AUTHORIZATION: Updated letter of medical necessity
Embeda	<ul style="list-style-type: none"> • Documented diagnosis of drug abuse; and • Documented history of chronic pain; and • No concomitant use of alcohol; • Pain management contract. <p>NOTES: To request an NDC changes please fax a note to 855-828-4992.</p> <ul style="list-style-type: none"> • AUTHORIZATION: Initial 1 year • RE-AUTHORIZATION: An updated letter of medical necessity
Gabapentin Extended Release Products	
Gralise	Gralise: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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.

	<ul style="list-style-type: none"> • RE-AUTHORIZATION: Updated letter of medical necessity
Gilenya	<ul style="list-style-type: none"> • Minimum age requirement: 18 years old. • Diagnosis of relapsing-remitting Multiple Sclerosis. • Dose limited to $\leq 0.5\text{mg}$ once daily. • A written plan to monitor for bradyarrhythmia in office or clinic for six hours following the first dose. • Baseline test values (within the preceding six months) within normal limits: <ul style="list-style-type: none"> • Complete Blood Count (CBC) <ul style="list-style-type: none"> • WBC between 3.2×10^3 and 9.8×10^3 cells/mm³ • 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) <ul style="list-style-type: none"> • 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.
Hepatitis Medications	
Harvoni	<p>Harvoni:</p> <ul style="list-style-type: none"> • Diagnosis of Chronic Hepatitis C • Patient must undergo Hepatitis C genotype testing and submit a copy of the original testing results. <ul style="list-style-type: none"> ○ 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	<p>Hepsera:</p> <ul style="list-style-type: none"> • Diagnosis of hepatitis B. • Failure on Epivir. <p>INFORMATION: 10mg/day is the maximum approved dose.</p> <ul style="list-style-type: none"> • AUTHORIZATION: Initial prior is for 12 weeks <p>RE-AUTHORIZATION: 12 months with updated letter of medical necessity</p>
Olysio	<p>Olysio:</p> <ul style="list-style-type: none"> • Diagnosis of Chronic Hepatitis C

	<ul style="list-style-type: none"> • Patient must undergo Hepatitis C genotype testing and submit a copy of the original testing results. <ul style="list-style-type: none"> ○ 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. <p>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.</p>
<p style="text-align: center;">Sovaldi</p>	<p>Sovaldi</p> <ul style="list-style-type: none"> • Diagnosis of Chronic Hepatitis C • Patient must undergo Hepatitis C genotype testing and submit a copy of the original testing results. <ul style="list-style-type: none"> ○ 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. <ul style="list-style-type: none"> ○ 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. <p>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.</p>
<p>Ketorolac (<i>oral dosage forms only</i>)</p>	<ul style="list-style-type: none"> • 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. <p>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.</p> <ul style="list-style-type: none"> • AUTHORIZATION: Only one authorization will be granted per acute incident.

	<ul style="list-style-type: none"> • RE-AUTHORIZATION: Same as initial
Lactulose	<ul style="list-style-type: none"> • Documented Chronic liver failure, Hepatic encephalopathy, Chronic portal hypertension, or Spina Bifida. <p>INFORMATION:</p> <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • AUTHORIZATION: 6 months • RE-AUTHORIZATION: Updated letter of medical necessity
Nexavar	<ul style="list-style-type: none"> • 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	<p>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.</p> <p>Kits: Utah Medicaid does not 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 objective clinical evidence regarding the necessity of a kit.</p> <p>NOTE: Do not use this form for Biologics for Rheumatoid Arthritis. Download the appropriate clinical PA form from the Medicaid website.</p> <p>AUTHORIZATION: 1 year RE-AUTHORIZATION: Updated letter of medical necessity</p>
Non-Preferred Drug Authorization	<p>Explain in detail* one of the following:</p> <ul style="list-style-type: none"> • Explain in detail a trial and failure of at least one preferred agent in the class, including name of the preferred product(s) tried, length of therapy, and reason for discontinuation. • Explain in detail evidence of a potential drug interaction between a current medication and the preferred product(s). • Explain in detail evidence of a condition or contraindication that prevents the use of the preferred product(s). • Explain objective clinical evidence that a patient is at high risk of adverse events due to a therapeutic interchange. <ul style="list-style-type: none"> * Prescribers may send documentation from the patient's chart in addition to filling out this form. Save a copy in the patient's chart for audit purposes. A complete list of preferred drugs is available at https://medicaid.utah.gov/pharmacy/pharmacy-program <p>NOTES:</p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Must be age 18 or above

	<ul style="list-style-type: none"> • 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
<p>Nucynta ER</p>	<ul style="list-style-type: none"> • Minimum age requirement: 18 years old • Description trial and failure of at least two analgesic therapies • No concurrent treatment with monoamine oxidase inhibitors <ul style="list-style-type: none"> • e.g. deprenyl, isocarboxazid, phenelzine, rasagiline, selegiline, tranylcypromine • No concurrent treatment with mixed agonist/antagonist opioid analgesics, or opioid antagonists <ul style="list-style-type: none"> • e.g. buprenorphine/naloxone (Suboxone®), naloxone (Narcan®), naltrexone (Vivatro®) • 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
<p>Nuvigil</p>	<ul style="list-style-type: none"> • Failure on a ≥ 6 week trial of, or contraindication to, modafinil (Provigil) • Minimum age requirement: 17 years old • Covered for diagnosis: <ul style="list-style-type: none"> • 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
<p>Oxandrin</p>	<p>CRITERIA</p> <ul style="list-style-type: none"> • First 60 day trial period: <ul style="list-style-type: none"> • 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): <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • If weight has not maintained, Oxandrin will not be re-authorized. • If weight is maintained or has increased, the patient may remain on Oxandrin.

	<ul style="list-style-type: none"> ● AUTHORIZATION: 60 day trial, if weight is maintained or has increased, an additional 4 months may be approved ● RE-AUTHORIZATION: 6 months.
Pradaxa	<ul style="list-style-type: none"> ● Documentation of one of the following diagnoses: <ul style="list-style-type: none"> ● 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	<ul style="list-style-type: none"> ● Pt. must be age 9 years or older ● Covered for the following diagnoses: <ul style="list-style-type: none"> ● 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 <p>NOTES: Provigil and Nuvigil are mutually exclusive. Patients may only have a prior authorization for one of these medications at a time</p> <ul style="list-style-type: none"> ● AUTHORIZATION: 1 year ● RE-AUTHORIZATION: Update letter of medical necessity
Qualaquin	<ul style="list-style-type: none"> ● 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
Regranex	<ul style="list-style-type: none"> ● 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: <ol style="list-style-type: none"> 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

	<p>surface of 9.42cm² (size and shape must be documented)</p> <ul style="list-style-type: none"> • 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.
<p>Restasis</p>	<p>I. Approved for the following diagnoses (ICD.9):</p> <ul style="list-style-type: none"> • 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: <ol style="list-style-type: none"> 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 <p>II. Restasis for Post Corneal Transplant (ICD.9): V42.5 Post Corneal Transplant</p> <ul style="list-style-type: none"> • Documentation of post corneal transplant: Diagnosis only • AUTHORIZATION: Prior approval is for 1 year • RE-AUTHORIZATION: Updated letter of medical necessity <p>INFORMATION: Maximum supply is 1 box of 32 dropperettes/month</p>
<p>Retinoids</p>	
<p>Panretin</p>	<p>Panretin:</p> <ul style="list-style-type: none"> • 30-day trial period: <ul style="list-style-type: none"> • Diagnosis of cutaneous lesions caused by Kaposi’s Sarcoma. Include the following information: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Patient must sustain partial response defined as a 50% or more improvement from base line. Include: <ul style="list-style-type: none"> • Number of KS lesions. • Estimated total square centimeters. • Partial Response Area. • Partial Response Height. • Continued use of Panretin: <ul style="list-style-type: none"> • Updated letter of medical necessity indicating continued improvement. Include: <ul style="list-style-type: none"> • Number of KS lesions.

	<ul style="list-style-type: none"> • Estimated total square centimeters. • Partial Response Area. • Partial Response Height. <p>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:</p> <ul style="list-style-type: none"> • 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	<p>Retin-A:</p> <ul style="list-style-type: none"> • Diagnosis of cutaneous lesions caused by Kaposi’s Sarcoma <ul style="list-style-type: none"> • Pre-panretin use • List number of primary KS lesions • Indicate if lesions are flat or raised • Estimated total square centimeters <p>INFORMATION:</p> <ul style="list-style-type: none"> • 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
Sabril	<ul style="list-style-type: none"> • Minimum age requirement: 16 years old • Documented failure of other therapy • Uncontrolled complex partial seizures • Documented enrollment of both prescriber and patient in the SHARE program • Negative pregnancy test for women of childbearing age <p>OR</p> <ul style="list-style-type: none"> • Age between one month and two years old • Diagnosis of infantile spasms • Documented enrollment of both prescriber and patient in the SHARE program • AUTHORIZATION: The initial prior authorization will be approved for six months to assess safety and efficacy in the individual patient • RE-AUTHORIZATION: Subsequent prior authorizations will be given in one year increments, upon submission of a letter of medical necessity
Salagen	<p>NOTES: Ophthalmic pilocarpine drops may be administered orally with the same</p>

	<p>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</p> <ul style="list-style-type: none"> • 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
<p>Samsca</p>	<ul style="list-style-type: none"> • 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 \leq 125mEq/L • Documentation that hyponatremia is symptomatic if serum sodium $>$125mEq/L AND documented failure of other treatments strategies including but not limited to: <ul style="list-style-type: none"> • 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
<p>Selzentry</p>	<ul style="list-style-type: none"> • 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
<p>Simvastatin</p>	<p>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</p> <p>No Prior Authorization is required for simvastatin doses below 41mg per day</p> <ul style="list-style-type: none"> • 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 <p>AND</p> <ul style="list-style-type: none"> • The patient is not receiving any medications which are contraindicated for use with simvastatin (at any dose) <ul style="list-style-type: none"> • Please see the full prescribing information for simvastatin and/or Vytorin®. Contraindicated medications include but are not limited to

	<p>itraconazole, ketoconazole, posaconazole, erythromycin, clarithromycin, telithromycin, HIV protease inhibitors, nefazodone, gemfibrozil, cyclosporine, danazol, amiodarone, verapamil, diltiazem, amlodipine, and ranolazine</p> <ul style="list-style-type: none"> • AUTHORIZATION: 1 year • RE-AUTHORIZATION: Submission of medical notes indicating therapeutic efficacy and continued lack of myopathic symptoms
<p>Sirturo</p>	<p>NOTES:</p> <ul style="list-style-type: none"> • Sirturo is <u>not</u> FDA-approved to treat latent or extra-pulmonary tuberculosis (TB) • Sirturo is FDA-approved for <u>adjunctive</u> treatment or <u>multi-drug resistant</u> 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 <ul style="list-style-type: none"> ○ 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 <u>each</u> Sirturo tablet must be observed by a health care professional (Directly Observed Therapy, DOT) <p>CRITERIA:</p> <ul style="list-style-type: none"> • 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
<p>Somavert</p>	<ul style="list-style-type: none"> • 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
<p>Stimulants (for Adults)</p>	<p><u>WHEN PRESCRIBED FOR ADULTS only the following diagnoses are covered:</u></p> <p>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</p> <p>ADD or ADHD</p> <ul style="list-style-type: none"> • 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 I diagnosis of ADD, <u>OR</u> a copy of the Wender Utah Rating Scale with a score of 46 or greater, <u>OR</u> criteria from the DSM that has been met.

	<p>ALL OTHER DIAGNOSIS:</p> <ul style="list-style-type: none"> • Letter of medical necessity explaining the patient’s diagnosis and situation. • Statement documenting any substance abuse problems past, present or no history. <p>NOTES:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>
<p>Suboxone / Zubsolv / Bunavail <i>(buprenorphine/naloxone)</i></p>	<p>INITIAL CRITERIA:</p> <ul style="list-style-type: none"> • 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. <p>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).</p> <p>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:</p> <ul style="list-style-type: none"> • 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 <p>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.</p> <ul style="list-style-type: none"> • NDC Changes: NDC changes for dosage tapering must be submitted in an updated letter of medical necessity, faxed to 855-828-4992.
<p>Sutent</p>	<p>CRITERIA:</p> <ul style="list-style-type: none"> • Minimum age requirement: 18 years old. • Documentation of advanced renal cell carcinoma; OR • Documentation of Gastrointestinal stromal tumor who have had disease progression on or are intolerant to Gleevec.

	<ul style="list-style-type: none"> • 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.
Topical Immunomodulators (<i>Elidel, Protopic, pimecrolimus, tacrolimus</i>)	INITIAL AUTHORIZATION: 6 weeks <ul style="list-style-type: none"> • Submit all of the following: <ul style="list-style-type: none"> ○ Diagnosis <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> • DOCUMENTED failure of all three medications (Abacavir, Lamivudine, and Zidovudine) individually. • AUTHORIZATION: 1 year • REAUTHORIZATON: Updated letter of medical necessity
Tykerb	CRITERIA <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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
Uloric	CRITERIA: <ul style="list-style-type: none"> • 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
Xanax XR	CRITERIA: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Reduction in Risk of Stroke in Nonvalvular Atrial Fibrillation:

	<ul style="list-style-type: none"> ○ 20mg daily if creatinine clearance > 50^{ml}/_{min} ○ 15mg daily if creatinine clearance is between 15^{ml}/_{min} and 50^{ml}/_{min} ○ 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: <ul style="list-style-type: none"> ○ 10mg daily for 35 days following hip replacement ○ 10mg daily for 12 days following knee replacement ○ 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: <ul style="list-style-type: none"> ○ 30mg daily (15mg BID) for 21 days... <i>THEN</i>...20mg daily ○ Initial authorization is 6 months, with potential reauthorization upon submission of an updated letter of medical necessity. ● Prevention of Recurrence of DVT or PE: <ul style="list-style-type: none"> ○ 20mg daily ○ Initial authorization is 6 months, with potential reauthorization upon submission of an updated letter of medical necessity.
<p>Xifaxan</p>	<p>CRITERIA:</p> <ul style="list-style-type: none"> ● Traveler’s Diarrhea: <ul style="list-style-type: none"> ○ Age ≥ 12 years ○ For treatment, not for prophylaxis ○ Trial and failure of, or contraindication to, a fluoroquinolone or azithromycin – please describe ○ Must reasonably be believed to be caused by <i>Escherichia coli</i> – please describe ○ Maximum 200mg three times daily for 3 days ● Overt Hepatic Encephalopathy <ul style="list-style-type: none"> ○ Age ≥ 18 years ○ For prophylaxis of recurrence – please describe previous occurrences and therapies ○ Trial and failure of, or contraindication to, properly titrated doses of lactulose – please describe ○ Maximum 550mg twice daily ● AUTHORIZATION <ul style="list-style-type: none"> ○ Traveler’s Diarrhea: 3 days ○ Overt Hepatic Encephalopathy: 1 year ● RE-AUTHORIZATION <ul style="list-style-type: none"> ○ Letter of medical necessity describing treatment efficacy and rational for continuation
<p>Xolegel</p>	<p>CRITERIA:</p> <ul style="list-style-type: none"> ● 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
<p>Xyrem</p>	<p>CRITERIA:</p> <ul style="list-style-type: none"> ● 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

	<ul style="list-style-type: none"> • RE-AUTHORIZATION: Updated letter of medical necessity
Zavesca	<p>CRITERIA:</p> <ul style="list-style-type: none"> • 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). <p>INFORMATION:</p> <ul style="list-style-type: none"> • 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	<p>FOR CHILDREN:</p> <ul style="list-style-type: none"> • For the treatment of ADHD: <ul style="list-style-type: none"> ○ 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. ○ Indicate the diagnosis (ICD) code ○ 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: <ul style="list-style-type: none"> ○ Consideration for children ages 6 years and older requires an evaluation and letter of medical necessity from a primary care practitioner. ○ Consideration will not be given to children under 6 years old. <p>FOR ADULTS:</p> <ul style="list-style-type: none"> • For the treatment of Narcolepsy: <ul style="list-style-type: none"> ○ 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. <p>NOTES:</p> <ul style="list-style-type: none"> • 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. <p>AUTHORIZATION: 1 year (see exception above) RE-AUTHORIZATION: A letter of medical necessity stating current diagnosis, current treatment and any current substance abuse issues.</p>
Ziana	<p>CRITERIA:</p> <ul style="list-style-type: none"> • 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	<p>CRITERIA:</p> <ul style="list-style-type: none"> • 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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