bioscrip

JAI MEDICAL SYSTEMS

2014

Therapeutic Formulary

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BioScrip/Jai Medical Systems
Managed Care Organization
2014 Therapeutic Formulary

This formulary describes the circumstances under which pharmacies participating in a particular medical benefit program will be reimbursed for medications dispensed to patients covered by the program. This formulary does not:

a) Require or prohibit the prescribing or dispensing of any medication.
b) Substitute for the independent professional judgment of the physician or pharmacist.
c) Relieve the physician or pharmacist of any obligation to the patient or others.

I. Non-Prescription Medication Policy

This program does not cover most over-the-counter medications (OTC). The only exceptions to this policy are listed within the program formulary. Furthermore, all OTC medications with the exception of OTC emergency contraception can be reimbursed only if it is written on a valid prescription form by a licensed prescriber. OTC emergency contraception may be obtained without a written prescription; see page 5 of the formulary for limitations.

II. Unapproved Use of Formulary Medication

Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications, which are accepted as safe and effective by the balance of current medical opinion and available scientific evidence, may also be covered. BioScrip, utilizing the procedures outlined in section IV, will make decisions about reimbursement for these other indications. Experimental, investigational drugs, and drugs used for cosmetic purposes are not eligible for coverage.

III. Prior Authorization Procedure

To promote the most appropriate utilization of selected high risk and/or high cost medication, a prior authorization procedure has been created. The criteria for this system has been established by the BioScrip/Jai Medical Systems Managed Care Organization program with input from pharmacists and physician practitioners and in consideration of the available medical literature. The Pharmacy and Therapeutics Committee will have final approval responsibility for this list. In order for a dispensed prior authorization medication to be reimbursed to the pharmacy, the patient's prescribing physician must apply for pre-authorization for a specific patient and drug. The physician may phone or fax BioScrip to request prior authorization:

BioScrip
Prior Authorization Desk
2787 Charter Street
Columbus, Ohio 43228
(800) 555-8513
(800) 583-6010 (fax)

Please have patient information, including member I.D. number, complete diagnosis, medication history, and current medications readily available.

These phone lines are dedicated to physicians making requests for prior authorization medication and non-formulary items. Members cannot be assisted if they call the prior-authorization toll-free number. For emergent requests for drugs requiring prior-authorization, a response will be made within 24 hours. For Non-Emergent requests for drugs requiring prior-authorization, a response will be provided within 2 business days of receipt of information. If the necessary information is not received, this process could take up to 7 calendar days. If the request is approved, information in the on-line pharmacy claims processing system will be changed to allow the specific patient to receive this specific drug. A prior authorization number will be issued to the prescribing physician and is to be clearly written on the top of the prescription to inform the dispensing pharmacist of the approval. This number is for identification purposes only and does not need to be submitted for adjudication to occur. If the request is denied, information about the denial will be provided to the prescribing physician along with the patient and the patient's PCP.

In addition to those products that require prior authorization all injectables (except Depo-Provera, Insulin, Glucagon Kit, and Epi-Pen) require prior approval. Questions about injectable drugs administered by homehealth or healthcare providers should be directed to BioScrip at 800-555-8513.

Our prior authorization criteria can be found on our website: **www.jaimedicalsystems.com** as well as in this formulary. Any updates made to our criteria will be posted on the website above within 30 days.

IV. Unique Patient Needs Non-Formulary Medication

This formulary attempts to provide appropriate and cost effective drug therapy to all participants in the BioScrip/Jai Medical Systems Managed Care Organization program. If a patient requires medication that is not covered by the formulary, a request can be made for payment for the non-covered item. It is anticipated that such exceptions will be rare, and that formulary medications will be appropriate to treat the vast majority of medical conditions. Requests for non-formulary medications should be made in writing (on the "Medical Necessity form" if possible) and mailed or faxed to:

BioScrip
Medical Necessity Desk
2787 Charter Street
Columbus, Ohio 43228
(800) 555-8513
(800) 583-6010 (fax)

Appropriate documentation must be provided to support the request. For emergent requests for drugs requiring prior-authorization, a response will be made within 24 hours. For Non-Emergent requests for drugs requiring prior-authorization, a response will be provided within 2 business days of receipt of information. If the necessary information is not received, this process could take up to 7 calendar days. Approval of non-formulary items will be based upon criteria developed by the Pharmacy and Therapeutics Committee of Jai Medical Systems Managed Care Organization and BioScrip.

Physicians are expected to comply with this formulary when prescribing medication for those patients covered by the BioScrip/Jai Medical Systems Managed Care Organization plan. If a pharmacist receives a prescription for a non-formulary medication, the pharmacist should attempt to contact

the prescribing physician to request a change to a product included in this formulary guide.

The pharmacy will not be reimbursed for non-formulary medications. **In an emergency situation outside of BioScrip's regular business hours, where the physician cannot be contacted, the pharmacist is authorized to dispense a 72 hour emergency supply of a medication, unless the medication is classified as a DESI, LTE or specifically excluded drug category (see section VI) product.**

The pharmacist should contact BioScrip's Help Desk at (800) 213-5640 during regular business hours to arrange for reimbursement for the emergency supply.

V. Newly Marketed Products

Newly marketed drug products will not normally be placed on the formulary during their first year on the market. Exceptions to this rule will be made on a case by case basis using the medical necessity procedure.

VI. Specific Exclusions

The following drug categories are not part of the BioScrip/Jai Medical Systems Managed Care Organization formulary and are not covered by the 72-hour emergency supply reimbursement policy:

Antiobesity products
Blood and blood plasma
Cosmetic drugs
Cough and cold products (except those listed in formulary)
DESI drugs
Diagnostic products (except those listed in formulary)
Erectile Dysfunction agents
Medical supplies and durable medical equipment (except certain diabetic supplies)
Most vitamins
Nutritional and dietary supplements
Research drugs
Topical minoxidil

VII. Fee-For-Service Carve-outs

In addition to the above exclusions, the following are also excluded from the formulary, and are covered by the Maryland Department of Health and Mental Hygiene:

HIV drugs
Mental Health drugs (refer to Section VIII. Behavioral Health Medication Policy)

VIII. Behavioral Health Medication Policy

Please refer to the Maryland Department of Health and Mental Hygiene's Mental Health Formulary for a complete listing of behavioral health medications. Any behavioral health medications that are covered by Jai Medical Systems Managed Care Organization are listed in the prescription formulary.

- Kapvay – For recipients 6 -17 years old, Kapvay is part of the mental health formulary and billed fee-for-service. For individuals not in this age range, Kapvay continues to be a part of the MCO pharmacy benefit.

- Intuniv – For recipients 6 -17 years old, Intuniv is part of the mental health formulary and billed fee-for-service. For individuals not in this age range, Intuniv continues to be a part of the MCO pharmacy benefit.

IX. Mandatory Generic Substitution & Therapeutic Interchange

Generic substitution is mandatory when a generic equivalent is available. All branded products that have 3 or more generic equivalents available will be reimbursed at the maximum allowable cost. No other therapeutic interchange is permitted.

X. Specialty Medications

Effective 02/01/2010, specialty medications will be covered under the pharmacy benefit for Jai Medical Systems. All requests will undergo prior authorization review when available drug specific prior authorization criteria will apply. When prior authorization criteria does not exist the request will be reviewed for FDA approved indications according to Jai Medical Systems' approved medical necessity review process. All specialty drug requests should contain the following:

- Drug name, strength, dose and quantity requested
- Diagnosis for use
- Any previous drug therapies tried and failed
- Any additional clinical information pertinent to the drug review

For emergent specialty drug requests, a decision will be made within 24 hours. For non-emergent specialty drug requests, a response will be provided within 2 business days of receipt of the clinical information. If the necessary information is not received, this process could take up to 7 calendar days.

XI. General Parameters

- Valid DEA and NPI numbers are required. Physicians without numbers should contact BioScrip at 1-800-230-8189.
- Refill too soon - 75% of the day's supply must elapse before the prescription can be refilled.
- Maximum allowable quantity is a 30 days supply. The quantity limit on most medications is a 400-unit maximum limit per month. Most narcotics have individualized quantity and dosage form limitations, which are listed on page 13 of the formulary. If necessary, a healthcare provider may request a quantity override by contacting BioScrip's Prior Authorization Department. Prior authorization is also required for concomitant therapy of an opioid and Suboxone. The Prior Authorization procedure can be found on page I-2.
- All generic oral contraceptives (including emergency contraceptives) along with brand oral contraceptives that do not have a generic version available are formulary. Examples are listed on page 4 and 5.
- Covered smoking cessation agents are listed on page 17.
- No vacation fills are allowed.
- No overrides for lost or stolen prescriptions are allowed.

XII. Where to Call?

PHYSICIANS

Formulary Questions:
BioScrip (800) 555-8513

Medical Necessity:
BioScrip (800) 555-8513

Prior Authorization:
BioScrip (800) 555-8513

Provider Relations:
Jai Medical Systems
Managed Care Organization, Inc. (888) JAI-1999

PHARMACISTS

Provider Network Questions:
BioScrip (800) 230-8187

Provider Relations:
BioScrip (800) 213-5640

XIII. Abbreviations

Providers are encouraged to prescribe generically available drugs whenever possible and to prescribe first-line lower cost options when appropriate. Drugs are ranked by cost with the following abbreviations:

*****	=	This product has a MAC price attached to some or all strengths.
$	=	Cost per Rx is <$20
$$	=	Cost per Rx is <$40
$$$	=	Cost per Rx is $40 - $80
$$$$	=	Cost per Rx is $80 - $160
$$$$$	=	Cost per Rx is >$160

XIV. Reference

The formulary is now available online at e-pocrates. This is updated monthly and will have the most up-to-date information. Registration is free and available at:

www.epocrates.com

Links to pdf copies of the most recent printed versions of all Maryland Medicaid Managed Care Organization's formularies can be found on the website listed below:

www.mdmahealthchoicerx.com

A link to a pdf copy of the Jai Medical Systems formulary is also available in the Providers section of our homepage:

www.jaimedicalsystems.com

XV. Copays

Currently, there is no copay for active members of Jai Medical Systems Members Managed Care Organization, Inc.'s HealthChoice Program.

XVI. Step Therapy

Jai Medical Systems offers Step therapy for Advair and Symbicort. For members with a current approved prior authorization, claims will continue to process as long as the member has filled for that medication within the last 3 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to therapy, or with no claim history of that medication within the last 3 months.

Prescription Formulary

Generic Name	*Brand Name*	*Annotation*
I. ANTI-INFECTIVE AGENTS		
PENICILLINS		
$ Amoxicillin*	AMOXIL	*no chewables*
$ Ampicillin*	AMPICILLIN	
$ Penicillin G Benzathine	BICILLIN	
$ Penicillin V Potassium*	PEN VEE K	
Penicillinase-resistant		
$ Dicloxacillin Sodium*	DICLOXACILLIN SODIUM	
$ Oxacillin*	OXACILLIN	
$ Cloxacillin Sodium*	CLOXACILLIN SODIUM	
Prior Authorization Required		
Penicillin Combinations		
$$$ Amox & K Clav*	AUGMENTIN	*no chewables*
CEPHALOSPORINS		
Cephalosporins - 1st Generation		
$ Cephalexin*	KEFLEX	*no tablets*
$ Cephradine*	CEPHRADINE	
Cephalosporins - 2nd Generation		
$$ Cefaclor*	CEFACLOR	
$$$ Cefprozil*	CEFZIL	
$$$ Cefuroxime*	CEFTIN	*oral tablets only*
$$$ Loracarbef	LORABID SUSPENSION	*covered for children under 12 yrs old*
Cephalosporins - 3rd Generation		
$ Cefixime	SUPRAX	*QL = 1 tab*
$$$ Ceftriaxone*	ROCEPHIN	
$$$ Cefdinir*	OMNICEF	*suspension only*
Prior Authorization Required		
MACROLIDE ANTIBIOTICS		
Erythromycins		
$ Erythromycin Base*	ERY-TAB	
$ Erythromycin Estolate*	ERYTHROMYCIN ESTOLATE	
$ Erythromycin Ethylsuccinate*	E.E.S.	
$ Erythromycin Stearate*	ERYTHROCIN	
Lincomycins		
$$ Clindamycin*	CLEOCIN	
Misc. Macrolide Antibiotics		
$$ Azithromycin*	ZITHROMAX	
$$$ Azithromycin suspension*	ZITHROMAX	*QL = 1 single dose packet*
$$$ Clarithromycin*	BIAXIN	
TETRACYCLINES		
$$$ Doxycycline*	VIBRAMYCIN	
$ Tetracycline*	SUMYCIN	*no tablets*
FLUOROQUINOLONES		
$$$ Ciprofloxacin*	CIPRO	
$$$$ Levofloxacin*	LEVAQUIN	
$$$$ Moxifloxacin	AVELOX	*QL 14 per 30 days*
Prior Authorization Required		

Generic Name	*Brand Name*	*Annotation*
ANTIMALARIAL		
$ Chloroquine*	ARALEN	*no 500mg tabs*
$ Hydroxychloroquine*	PLAQUENIL	
$ Pyrimethamine	DARAPRIM	
ANTHELMINTIC		
$$ Albendazole	ALBENZA	
$$ Mebendazole*	MEBENDAZOLE	
$$$$ Pyrantel Pamoate*	PIN - X	*OTC product*
AMINOGLYCOSIDES		
$ Gentamicin Sulfate*	GARAMYCIN	
$ Neomycin Sulfate*	NEOMYCIN	*tablets only*
SULFONAMIDES		
$ Erythromycin/Sulfisoxazole*	ERYTHROMYCIN/SULFISOXAZOLE	
$ Sulfadiazine*	SULFADIAZINE	
$ Sulfasalazine*	AZULFIDINE	*no EN tabs*
$ Sulfisoxazole*	GANTRISIN	
$ Trimethoprim/Sulfamethoxazole*	BACTRIM / DS	
ANTIMYCOBACTERIAL AGENTS		
$$$$ Cycloserine	SEROMYCIN	
$$$ Ethambutol*	MYAMBUTOL	
$$$ Ethionamide	TRECATOR	
$ Isoniazid*	ISONIAZID	
$$$ Pyrazinamide*	PYRAZINAMIDE	
$$$$$ Rifabutin	MYCOBUTIN	
$$$$ Rifampin*	RIFADIN	
MISC. ANTIINFECTIVES		
$ Metronidazole*	FLAGYL	
$ Trimethoprim*	PROLOPRIM	
$$ Chlorhexidine	PERIOGARD	*0.12% oral rinse*
Leprostatics		
$ Dapsone*	DAPSONE	
ANTIFUNGALS		
$ Griseofulvin Microsize	GRIFULVIN V	
$ Griseofulvin Ultramicrosize	GRIS-PEG	
$ Nystatin*	MYCOSTATIN	
Imidazole-Related Antifungals		
$ Ketoconazole*	NIZORAL	
$ Miconazole*	MONISTAT	*OTC product*
$$ Terbinafine*	LAMISIL	
$$ Itraconazole*	SPORANOX	
Prior Authorization Required		
Triazoles		
$ Fluconazole*	DIFLUCAN	
Prior Authorization Required (requires PA after 1 x 150mg dispensed)		
ANTIVIRAL		
Neuraminidase Inhibitors		
$$ Oseltamivir Phosphate	TAMIFLU	*QL=1 course of treatment per calendar year*
$$ Zanamivir	RELENZA	*QL=1 course of treatment per calendar year*
CMV Agents		
$$$$ Ganciclovir*	CYTOVENE	

Generic Name	*Brand Name*	*Annotation*
Hepatic Agents		
$$$$$ Boceprevir	VICTRELIS	
$$$$$ Peginterferon	PEG-INTRON, PEGASYS	
$$$$$ Ribavirin*	REBETOL	
$$$$$ Telaprevir	INCIVEK	
Prior Authorization Required		
Herpes Agents		
$$ Amantadine*	SYMMETREL	
$$$ Acyclovir*	ZOVIRAX	*PA for ointment*

II. BIOLOGICALS

ANTISERA

Antiviral Monoclonal Antibodies		
$$$$$ Palivizumab	SYNAGIS	
Prior Authorization Required		

III. ANTINEOPLASTICS

ANTINEOPLASTICS

Alkylating Agents		
$$$$$ Busulfan	MYLERAN	
Nitrogen Mustards		
$$$$$ Chlorambucil	LEUKERAN	
$$$$$ Cyclophosphamide*	CYTOXAN	
$$$$$ Melphalan	ALKERAN	
Nitrosoureas		
$$$$$ Lomustine	CEENU	
Antimetabolites		
$$$$$ Capecitabine	XELODA	
$$$$ Fluorouracil*	EFUDEX	*2% and 5% cream only*
$$$$$ Mercaptopurine*	PURINETHOL	
$$$$ Methotrexate*	RHEUMATREX	
$$$$$ Thioguanine	TABLOID	
Progestins-Antineoplastic		
$$$$ Megestrol*	MEGACE	
Antiandrogens		
$$$$$ Flutamide*	FLUTAMIDE	
Aromatase Inhibitors		
$$$$$ Letrozole*	FEMARA	
Antineoplastic Hormones Misc.		
$$$$ Tamoxifen*	NOLVADEX	
$$$$$ Leuprolide	LUPRON	
Prior Authorization Required		
Mitotic Inhibitors		
$$$$ Etoposide*	VEPESID	

Generic Name	***Brand Name***	***Annotation***
Antineoplastics Misc.		
$$$$$ Erlotinib	TARCEVA	
$$$$ Hydroxyurea*	HYDREA	
$$$$$ Mitotane	LYSODREN	
$ Procarbazine	MATULANE	
$$$$$ Sorafenib	NEXAVAR	
$$$$$ Interferon Alfa-2A	ROFERON-A	
$$$$$ Interferon Alfa-2B	INTRON-A	
$$$$$ Interferon Alfa-n3	ALFERON N	
$$$$$ Interferon Beta-1a	AVONEX	
$$$$$ Interferon Beta-1a	REBIF	
$$$$$ Interferon Beta-1b	BETASERON	
$$$$$ Glatiramer acetate	COPAXONE	
Prior Authorization Required		

IV. ENDOCRINE & METABOLIC DRUGS

CORTICOSTEROIDS

Glucocorticosteroids		
$ Cortisone*	CORTISONE	
$ Dexamethasone*	DEXAMETHASONE	*no dose paks*
$ Hydrocortisone*	CORTEF	
$ Methylprednisolone*	MEDROL	*no dose paks*
$ Prednisone*	PREDNISONE	
$ Prednisolone*	PRELONE	
$$ Prednisolone Na Phosphate*	PEDIAPRED	
Mineralocorticoids		
$ Fludrocortisone*	FLORINEF	

ANDROGEN-ANABOLIC

Androgens		
$$$ Methyltestosterone	ANDROID	
$$$ Danazol*	DANAZOL	
$$$ Testosterone Gel	ANDROGEL, TESTIM	*Male only*
Priorauthorization Required		

ESTROGENS

$ Estradiol*	ESTRACE	
$$ Esterified Estrogens	MENEST	
$$ Estrogens, Conjugated	PREMARIN	
$$$ Estradiol Patch*	CLIMARA	
Estrogen Combinations		
$$ Conjugated Estrogens & Medroxyprogesterone*	PREMPRO	

CONTRACEPTIVES

All generic oral contraceptives are formulary

Progestin		
$$$ Norethindrone*	NOR-QD, ORTHO MICRON	*Females only*
Combinations		
$$ Desogestral & Ethinyl Estradiol*	DESOGEN, ORTHO-CEPT	*Females only*
$$ Drospirenone & Ethinyl Estradiol*	YASMIN, YAZ	*Females only*
$$ Drospirenone-Eth Estrad Levomefolate	SAFYRAL, BEYAZ	*Females only*
$$ Ethynodiol Diacet & Eth Estrad*	ZOVIA	*Females only*
$$$ Etonogestrel-Ethinyl Estradiol	NUVARING	*QL= 1 ring / month Females only*
$$ Levonorgestrel & Eth Estradiol*	NORDETTE, AVIANE	*Females only*
$$ Norethindrone & Eth Estradiol*	MODICON, BREVICON	*Females only*
$$ Norethindrone Ace-Ethinyl Estrad	LOESTRIN	*Females only*
$$ Norgestrel & Ethinyl Estradiol*	CRYSELLE, OGESTREL	*Females only*
$$ Norgestimate & Ethinyl Estradiol*	ORTHO-CYCLEN	*Females only*
$$ Norethindrone & Ethinyl Estrad FE	FEMCON FE	*Females only*
$$ Norethindrone Ace-Ethinyl Estrad FE	LOESTRIN FE	*Females only*
$$$ Norelgestromin-Ethinyl Estradiol	ORTHO EVRA PATCH	*Females only*

	Generic Name	***Brand Name***	***Annotation***
Biphasic			
$$	Desogest-Eth Estrad & Eth Estrad	MIRCETTE	*Females only*
$$	Norethindrone & Mestranol	NORINYL, NECON	*Females only*
$$	Norethin-Eth Estrad-FE	LO LOESTRIN FE	*Females only*
Triphasic			
$$	Desogest-Ethin Est	CYCLESSA	*Females only*
$$	Levonorgestrel-Eth Estradiol*	TRIVORA	*Females only*
$$	Norethindrone-Ethinyl Estrad*	ORTHO NOVUM 7/ 7/ 7	*Females only*
$$	Norgestimate-Ethinyl Estradiol*	ORTHO TRI-CYCLEN / LO	*Females only*
$$$	Norethindrone Ac-Ethinyl Estrad FE	ESTROSTEP FE	*Females only*
Four Phase			
$$	Estradiol Valerate-Dienogest	NATAZIA	*Females only*
Extended			
$$	Levonorgestrel & Ethinyl Estradiol	SEASONIQUE,QUARTETTE LOSEASONIQUE	*Females only*
Continuous			
$$	Levonorgestrel-Ethinyl Estradiol	AMETHYST	*Females only*
PROGESTINS			
$	Medroxyprogesterone*	PROVERA	*tabs only / females only*
$$$	Medroxyprogesterone Acetate Susp/IM	DEPO-PROVERA DEPO-SQ PROVERA 104	*Females only*
$	Norethindrone*	AYGESTIN	
EMERGENCY CONTRACEPTIVE			
$$	Levonorgestrel*	PLAN B ONE STEP PLAN B	*1 kit / month / 3 kits / yr* *Females only* *No prescription required for OTC formulation*
ANTIDIABETIC			
Thiazolidinediones/Combination			
$$	Pioglitazone*	ACTOS	*QL = 30 tabs / month*
$$$	Pioglitazone-Glimepiride	DUETACT	*QL = 30 tabs / month*
$$$	Pioglitazone-Metformin	ACTOPLUS MET/XR	*QL = 30 tabs / month*
$	Rosiglitazone Maleate	AVANDIA	*QL = 30 tabs / month*
$$	Rosiglitazone Maleate-Metformin	AVANDAMET	*QL = 30 tabs / month*
$$	Rosiglitazone Maleate-Glimperide	AVANDARYL	*QL = 30 tabs / month*
	Prior Authorization Required		
Human Insulin			
$	Insulin Aspart	NOVOLOG	
$	Insulin Isophane	HUMULIN N	
$	Insulin Isophane	NOVOLIN N	
$	Insulin Lispro	HUMALOG	
$	Insulin Reg & Isophane	HUMULIN 50/50	
$	Insulin Reg & NPH	HUMULIN 70/30	
$	Insulin Reg & NPH	NOVOLIN 70/30	
$	Insulin Regular	HUMULIN R	
$	Insulin Regular	NOVOLIN R	
$$	Insulin Glargine	LANTUS	
Sulfonylureas			
$	Glimepiride*	AMARYL	
$$	Glipizide*	GLUCOTROL/XL	
$$	Glyburide*	DIABETA, GLYNASE	
Alpha-Glucosidase Inhibitors			
$$	Acarbose*	PRECOSE	*QL = 90 tabs / month*
	Prior Authorization Required		
Incretin Mimetic			
$$$$	Exenatide	BYETTA	
$$$$	Liraglutide	VICTOZA	
	Prior Authorization Required		
Diabetic Other			
$	Metformin*	GLUCOPHAGE	
$$$	Glucagon	GLUCAGON	

Generic Name	*Brand Name*	*Annotation*

THYROID

Thyroid Hormones

$ Levothyroxine*	LEVOXYL, SYNTHROID	
$ Liothyronine*	CYTOMEL	
$ Thyroid*	THYROID	

Antithyroid Agents

$ Methimazole*	TAPAZOLE	
$ Propylthiouracil*	PROPYLTHIOURACIL	

OXYTOCICS

$ Methylergonovine*	METHERGINE	

MISC. ENDOCRINE

Calcium Regulators

$$$$ Calcitonin (Salmon)	MIACALCIN INJ	
$$$$ Calcitonin (Salmon)*	MIACALCIN NASAL	
Prior Authorization Required		

Hormone Receptor Modulators

$$$ Raloxifene	EVISTA	
Prior Authorization Required		

Gonadotropin Releasing Hormones

$$$$$ Nafarelin	SYNAREL	
Prior Authorization Required		

Growth Hormone

$$$$$ Somatropin	HUMATROPE ONLY	
Prior Authorization Required		

Posterior Pituitary

$$$ Alendronate*	FOSAMAX	
$$$$ Alendronate + Cholecalciferol	FOSAMAX PLUS D	
$$$$ Ibandronate*	BONIVA	
$$$$ Risedronate	ACTONEL	
$$$$ Desmopressin*	DDAVP	*(all dosage forms)*
Prior Authorization Required		

Parathyroid Hormone

$$$$ Teriparatide	FORTEO	

V. CARDIOVASCULAR AGENTS

CARDIOTONICS

Digitalis

$ Digoxin*	LANOXIN	*no caps*

ANTIANGINAL AGENTS

Nitrates

$ Isosorbide Dinitrate*	ISORDIL, ISORDIL TEMBIDS	
$ Nitroglycerin (oral)*	NITROSTAT	
$$$ Nitroglycerin (topical)*	NITRODUR,NITROBID	
$$ Isosorbide Mononitrate*	IMDUR	
Prior Authorization Required		

Antianginals-Other

$ Dipyridamole*	PERSANTINE	

Generic Name	*Brand Name*	*Annotation*
BETA BLOCKERS		
Beta Blockers Non-Selective		
$ Propranolol*	INDERAL/LA	
$ Timolol*	TIMOLOL	
$$$ Sotalol*	BETAPACE	
$$$ Carvedilol*	COREG	
Beta Blockers Cardio-Selective		
$ Atenolol*	TENORMIN	
$ Metoprolol Tartrate*	LOPRESSOR	
$$$ Metoprolol Succinate*	TOPROL XL	
Alpha-Beta Blockers		
$$$ Labetalol*	TRANDATE	
CALCIUM BLOCKERS		
$$$ Amlodipine*	NORVASC	
$$$ Amlodipine & Benazepril*	LOTREL	
$$$ Diltiazem*	CARDIZEM/CD,DILACOR/XR	
$$ Felodipine*	PLENDIL	
$$$ Nifedipine*	ADALAT CC, PROCARDIA XL	
$$ Verapamil*	CALAN, SR	
ANTIARRHYTHMIC		
$$$ Amiodarone*	CORDARONE	
$ Disopyramide*	NORPACE, CR	
$$$ Flecainide*	TAMBOCOR	
$ Procainamide*	PRONESTYL, PROCANBID	
$ Quinidine Sulfate*	QUINIDINE SULFATE	
$$$$ Mexiletine*	MEXILETINE	
$$$$ Propafenone*	RYTHMOL	
ANTIHYPERTENSIVE		
ACE Inhibitors		
$ Captopril*	CAPOTEN	
$$ Benazepril*	LOTENSIN	
$$ Enalapril*	VASOTEC	
$$ Fosinopril*	MONOPRIL	
$$ Lisinopril*	ZESTRIL	
$$ Quinapril*	ACCUPRIL	
$$ Ramipril*	ALTACE	
ACE II Inhibitors		
$$$ Irbesartan*	AVAPRO	*QL = 30 tabs / month*
$$ Losartan potassium*	COZAAR	*QL = 30 tabs / month*
$$$ Valsartan	DIOVAN	*QL = 30 tabs / month*
Adrenolytics - Central		
$ Clonidine*	CATAPRES	*no patches*
$ Guanfacine*	TENEX	
$ Methyldopa*	METHYLDOPA	
Adrenolytics - Peripheral		
$ Reserpine*	RESERPINE	
Alpha Blockers		
$$ Doxazosin*	CARDURA	
$ Prazosin*	MINIPRESS	
$$$$ Tamsulosin*	FLOMAX	
$$$ Terazosin*	HYTRIN	
Vasodilators		
$ Hydralazine*	APRESOLINE	
$ Minoxidil*	MINOXIDIL	

	Generic Name	***Brand Name***	***Annotation***
Beta Blocker Combinations			
$	Atenolol & Chlorthalidone*	TENORETIC	
$$$	Metoprolol & HCTZ*	LOPRESSOR HCT	
$	Propranolol & HCTZ*	INDERIDE	*no LA*
ACE and ACE II Inhibitors & Diazides			
$$$$	Irbesartan & HCTZ*	AVALIDE	*QL = 30 tabs / month*
$$	Lisinopril & HCTZ*	ZESTORETIC	
$$$	Losartan potassium/HCTZ*	HYZAAR	*QL = 30 tabs / month*
$$$$	Valsartan & HCTZ*	DIOVAN HCT	*QL = 30 tabs / month*
Adrenolytics-Central & Thiazides			
$	Methyldopa & HCTZ*	METHYLDOPA & HCTZ	
$$	Clonidine & Chlorthalidone*	CLORPRES	
Vasodilators & Thiazides			
$	Hydralazine & HCTZ*	HYDRALAZINE & HCTZ	
DIURETICS			
Carbonic Anhydrase Inhibitors			
$	Acetazolamide*	DIAMOX	*no sequels*
$$$	Methazolamide*	METHAZOLAMIDE	
Loop Diuretics			
$	Furosemide*	LASIX	
Potassium Sparing Diuretics			
$	Spironolactone*	ALDACTONE	
Thiazides			
$	Chlorothiazide*	DIURIL	
$	Chlorthalidone*	CHLORTHALIDONE	
$	Hydrochlorothiazide*	HYDROCHLOROTHIAZIDE	
$	Methyclothiazide*	METHYCLOTHIAZIDE	
$	Metolazone*	ZAROXOLYN	
$	Indapamide*	INDAPAMIDE	
Combination Diuretics			
$	Spironolactone & HCTZ*	ALDACTAZIDE	
$	Triamterene & HCTZ*	MAXZIDE	
Osmotic Diuretics			
$	Glycerin Supp.*	GLYCERIN	*adult, infant, child*
PRESSORS			
Emergency Kits			
$$$$$	Epinephrine	EPI-PEN, EPI-PEN JR	
ANTIHYPERLIPIDEMIC			
Bile Sequestrants			
$$$	Cholestyramine*	QUESTRAN, LIGHT	*cans only*
$$$	Colestipol*	COLESTID	*cans only*
Misc.			
$	Niacin*	NIACIN	*OTC (slow release)*
$	Niacin CR*	NIASPAN	
$$$	Fenofibrate*	LOFIBRA	*54mg and 160mg*
$$$	Fenofibrate*	TRICOR	*48mg and 145mg*
$$	Gemfibrozil*	LOPID	
$$$$	Omega-3-acid ethyl esters	LOVAZA	
$$$$	Fenofibrate	LIPOFEN, TRIGLIDE	
$$$$	Fenofibrate acid*	TRILIPIX	
$$$$	Fenofibrate micronized	ANTARA	
$$$$	Ezetimibe	ZETIA	

Prior Authorization Required

Generic Name	***Brand Name***	***Annotation***
HMG CoA Reductase Inhibitors		
$$$$$ Amlodipine & Atorvastatin	CADUET	
$$$$ Atorvastatin*	LIPITOR	*QL = 30 tabs / month*
$$$$ Fluvastatin*	LESCOL	*QL = 30 tabs / month*
$$ Lovastatin*	MEVACOR	*QL = 30 tabs / month*
$$$$ Niacin & Lovastatin	ADVICOR	
$ Pravastatin*	PRAVACHOL	*QL = 30 tabs / month*
$ Simvastatin*	ZOCOR	*QL = 30 tabs / month*
$$$ Simvastatin*	ZOCOR	*80mg only / QL = 30 tabs / month*
$$$$ Ezetimibe + Simvastatin	VYTORIN	
$$$$ Rosuvastatin Calcium	CRESTOR	*QL = 30 tabs / month*
Prior Authorization Required		

VI. RESPIRATORY AGENTS

ANTIHISTAMINES

Antihistamines - Ethanolamines		
$ Diphenhydramine*	BENADRYL	*OTC product*
Antihistamines - Non Sedating		
$$ Loratadine*	ALAVERT, CLARITIN	*OTC product*
$$ Loratadine / Pseudoephedrine*	CLARITIN-D 12hr, 24hr	*OTC product*
$$ Cetirizine*	ZYRTEC	*chew tabs/liquid AL ≤ 18*
$$ Cetirizine tabs*	ZYRTEC	
$$ Fexofenadine*	ALLEGRA OTC	*30 or 60 per 30 days*
$$ Fexofenadine / Pseudoephedrine*	ALLEGRA-D OTC 12hr, 24hr	*30 or 60 per 30 days*
Antihistamines - Phenothiazines		
$ Promethazine*	PROMETHAZINE	*tabs only* *AL ≥ 2 years*

SYSTEMIC AND TOPICAL NASAL PRODUCTS

Nasal Antihistamines		
$$$$ Azelastine*	ASTELIN	
Prior Authorization Required		
Nasal Steroids		
$$ Flunisolide*	NASALIDE	
$$ Triamcinolone*	NASACORT AQ	
$$$ Fluticasone*	FLONASE	
$$$$ Mometasone furoate	NASONEX	
Steroid Inhalants		
$$$$ Fluticasone	FLOVENT HFA	
$$$ Triamcinolone	AZMACORT	
$$$$ Budesonide	PULMICORT FLEXHALER	
$$$$ Budesonide*	PULMICORT RESPULES	*AL = 4 years and under* *QL = 1 box / 30 days*
$$$$ Beclomethasone Dipropionate	QVAR	
Mucolytics		
$$ Acetylcysteine*	MUCOMYST	

ANTIASTHMATIC

Anticholinergics		
$$ Ipratropium*	ATROVENT/NASAL	
$$$$ Ipratropium	ATROVENT HFA	
$$$$ Tiotropium	SPIRIVA	
$$$$$ Aclidinium Bromide	TUDORZA PRESSAIR	*QL = 1 inh / 30 days*
Prior Authorization Required		
Anti-Inflammatory Agents		
$$$ Cromolyn (inhalation)*	INTAL	
$ Cromolyn (nasal)*	NASALCROM	

Generic Name	***Brand Name***	***Annotation***
Beta Adrenergics		
$$ Albuterol	PROVENTIL/VENTOLIN HFA	
$$ Albuterol*	ALBUTEROL NEBULIZER SOLUTION	*0.5% (5mg/mL) and 0.083% (2.5mg/3ml)*
$$$ Pirbuterol	MAXAIR AUTOHALER	
$$ Albuterol	PROAIR HFA	
$$$ Salmeterol	SEREVENT DISKUS	
Prior Authorization Required		
Adrenergic Combinations		
$$$$$ Ipratropium-Albuterol	COMBIVENT RESPIMAT	
$$$$ Albuterol-Ipratropium*	DUONEB	
$$$$ Salmeterol-Fluticasone	ADVAIR / ADVAIR HFA	*Step therapy*
$$$$ Budesonide-Formoterol	SYMBICORT	*Step therapy*
Prior Authorization Required		
Sympathomimetic Agents		
$ Pseudoephedrine HCL*	PSEUDOEPHEDRINE	*OTC product*
Mixed Adrenergics		
$$$$ Epinephrine	EPI-PEN, EPI-PEN JR	
Xanthines		
$ Aminophylline*	AMINOPHYLLINE	
$ Theophylline*	THEO-24, UNIPHYL	
Leukotriene Receptor Antagonists		
$$$ Montelukast Sodium*	SINGULAIR	

COUGH/COLD/ALLERGY

Expectorants		
$ Guaifenesin*	GUAIFENESIN	*OTC product*
$ Guaifenesin/DM*	GUAIFENESIN DM	*OTC product*
Cough/Cold/Allergy Combinations		
$ Brompheniramine / Pseudoephedrine*	CVS COLD ALLERGY ELIXIR	
$ Pseudoephedrine HCL soln*	PEDIACARE INFANT	
$ Pseudoephedrine-Bromphen-DM*	CVS COLD ALLERGY DM ELIXIR	
$ Pseudoephedrine-Chlorphen-DM*	CVS TRIACTING MULTI-SYMPTOM LIQUID	
$ Pseudoephedrine-DM liquid*	CVS COUGH FORMULA D	
$ Pseudoephedrine-DM soln*	CVS INFANT DECONGESTANT AND COUGH DROPS	
$ GG/Codeine sol	CHERATUSSIN SYP AC	
$ Benzonatate*	TESSALON, TESSALON PERLES	
$$ Hydrocodone-GG*	HYCOTUSS	
$$ Pseudoephedrine-GG*	DURATUSS	

VII. GASTROINTESTINAL AGENTS

LAXATIVES

Surfactant Laxatives		
$ Docusate Sodium*	COLACE	*OTC product*
Stimulant Laxatives		
$ Bisacodyl*	DULCOLAX	*OTC product*
Bulk Laxatives		
$ Polycarbophil Calcium*	FIBERCON	*OTC product*
Miscellaneous Laxatives		
$ Glycerin*	GLYCERIN	*OTC product*
$ Lactulose*	LACTULOSE	
$ PEG-Electrolyte*	GOLYTELY	

ANTIDIARRHEALS

Antiperistaltic Agents		
$ Diphenoxylate w/ Atropine*	LOMOTIL	
$ Loperamide*	IMODIUM	*OTC product*

Generic Name	*Brand Name*	*Annotation*
Misc Antidiarrheal Agents		
$ Bismuth Subsalicylate*	PEPTO-BISMOL	*no tabs, OTC*
$$$$ Octreotide Acetate*	SANDOSTATIN	
Prior Authorization Required		

ANTACIDS

Antacids - Aluminum Salts		
$ Aluminum Hydroxide Gel*	ALUMINUM HYDROXIDE	*OTC product*
Antacids - Calcium Salts		
$ Calcium Carbonate*	OS-CAL	*OTC product*
Antacid Combinations		
$ Al Hydrox-Mag Carb*	MAALOX	*no tabs, OTC*
$ Aluminum & Magnesium Hydroxide*	MYLANTA	*no tabs, OTC*

ULCER DRUGS

Belladonna Alkaloids		
$ Hyoscyamine Sulfate*	LEVSIN	
Quaternary Anticholinergics		
$ Propantheline Bromide*	PRO-BANTHINE	
Antispasmodics		
$ Dicyclomine*	BENTYL	
H-2 Antagonists		
$ Famotidine*	PEPCID	*tabs only*
$ Ranitidine*	ZANTAC	*no caps*
Proton Pump Inhibitors		
$$ Omeprazole*	PRILOSEC OTC	*OTC*
$$ Lansoprazole*	PREVACID	*OTC*
$$$$ Lansoprazole*	PREVACID	*RX*
$$$ Pantoprazole	PROTONIX	
Prior Authorization Required		
Misc. Anti-Ulcer		
$$ Sucralfate*	CARAFATE TABLETS	
$$$$ Sucralfate*	CARAFATE SUSPENSION	
Prior Authorization Required		

ANTIEMETICS

Antiemetics - Anticholinergic		
$ Meclizine*	ANTIVERT	
$$ Prochlorperazine*	PROCHLORPERAZINE	*no SR*
5-HT3 Receptor Antagonists		
Ondansetron*	ZOFRAN	*tablets only* *QL = 10 tabs per fill*
$$ Ondansetron*	ZOFRAN	*ODT: QL = 10 tabs per fill* *Suspension: QL = 50mls per fill*
Prior Authorization Required		

DIGESTIVE AIDS

Digestive Aids - Mixtures		
$$$$ Pancrelipase (Lip-Prot-Amyl)	VIOKACE	
$$$$ Pancrelipase (Lip-Prot-Amyl) DR	CREON	

MISC. GI

GI Stimulants		
$ Metoclopramide*	REGLAN	*no 5mg tabs*

Generic Name	*Brand Name*	*Annotation*
Inflammatory Bowel Agents		
$$$$ Mesalamine	ASACOL	*400mg tabs*
$$$$ Mesalamine	PENTASA	
$$$$ Mesalamine*	ROWASA	
$ Sulfasalazine*	AZULFIDINE	*no EN tabs*

VIII. GENITOURINARY

URINARY ANTIINFECTIVES

$ Methenamine Mandelate*	MANDELAMINE	
$$$ Nitrofurantoin*	FURADANTIN	
$$ Nitrofurantoin Macrocrystals*	MACROBID	
$ Trimethoprim*	PROLOPRIM	

URINARY ANTISPASMODICS

$ Bethanechol*	URECHOLINE	
$$$ Finasteride*	PROSCAR	
$$$ Flavoxate*	URISPAS	
$ Hyoscyamine*	LEVSINEX	
$ Oxybutynin*	DITROPAN	

VAGINAL PRODUCTS

Vaginal Antiinfectives		
$$ Clindamycin*	CLEOCIN	
$ Nystatin*	NYSTATIN	
$$ Sulfanilamide	AVC	
$$ Metronidazole*	METROGEL-VAGINAL	
Prior Authorization Required		
Imidazole-Related Antifungals		
$ Butoconazole Nitrate*	GYNAZOLE-1	*OTC product*
$ Clotrimazole*	MYCELEX	*OTC product*
$ Miconazole*	MONISTAT	*OTC product*
Vaginal Antiinfective Combinations		
$ Triple Sulfas Vaginal*	TRIPLE SULFAS VAGINAL	

MISCELLANEOUS GENITOURINARY PRODUCTS

Citrates		
$ Sodium Citrate & Citric Acid*	ORACIT	
Urinary Analgesics		
$ Phenazopyridine*	PYRIDIUM	

IX. CENTRAL NERVOUS SYSTEM DRUGS

ANTIPSYCHOTICS

Phenothiazines		
$$ Prochlorperazine*	PROCHLORPERAZINE	*no SR*

HYPNOTICS

Barbiturate Hypnotics		
$ Butabarbital	BUTISOL	
$ Mephobarbital	MEBARAL	
$ Phenobarbital*	PHENOBARBITAL	
Antihistamine Hypnotics		
$ Diphenhydramine*	BENADRYL	*OTC product*

Generic Name	***Brand Name***	***Annotation***

X. ANALGESICS & ANESTHETICS

ANALGESICS - NonNarcotic

Salicylates		
$ Aspirin zero order*	ZORPRIN	
$$ Salsalate*	AMIGESIC	
Salicylate Combinations		
$ Aspirin Enteric Coated*	ECOTRIN	*OTC product*
$ Aspirin with Buffers*	ASPIRIN BUFFERED	*OTC product*
$$ Choline & Mag Salicylate*	CHOLINE & MAG SALICYLATE	
Analgesics Other		
$ Acetaminophen*	TYLENOL	*OTC product*
Analgesics - Sedatives		
$ APAP/Caffeine/Butalbital*	FIORICET	*50/325/40 mg only*
$ Aspirin/Caffeine/Butalbital*	FIORINAL	*50/325/40 mg only*

ANALGESICS - Narcotic

Narcotic Agonists		
$ Codeine Phosphate*	CODEINE PHOSPHATE	
$ Codeine Sulfate*	CODEINE SULFATE	
$$$ Hydromorphone*	DILAUDID	
$ Meperidine*	DEMEROL	
$ Methadone*	METHADONE	
$$$ Morphine Sulfate*	MSIR	
$$$$ Morphine Sulfate SR*	MS CONTIN	*QL = 90 tabs / 30 days*
$$$$ Naltrexone*	REVIA	
$$$ Oxycodone*	OXYIR	*5mg caps*
$$$ Oxycodone*	ROXICODONE	*5mg, 15mg, 30mg tabs and 20mg/mL oral soln*
$$$ Tramadol*	ULTRAM	*QL = 240 tabs / 30 days*
$$$$ Tramadol/APAP*	ULTRACET	*QL = 240 tabs / 30 days*
$$$$$ Tramadol ER*	ULTRAM ER	*QL = 30 tabs / 30 days*
$$$$$ Fentanyl*	DURAGESIC	*QL = 10 patches/ 30 days*
$$$$$ Oxycodone CR*	OXYCONTIN	*QL = 60 tabs / 30 days*
Prior Authorization Required		
Narcotic Agonist-Antagonist		
$$$$$ Buprenorphine HCL-Naloxone HCL	SUBOXONE	*QL = 90 / 30 days Film and Generic tabs*
Opiate Partial Agonist		
$$$$ Buprenorphine HCL*	BUPRENORPHINE HCL	*QL = 1 fill / 6 months*
Narcotic Combinations		
$ Oxycodone w/ Acetaminophen*	PERCOCET	*QL = 120 / 30 days 5/500 tabs and caps 5/325 tabs and soln*
Codeine Combinations		
$ Acetaminophen w/ Codeine*	TYLENOL / CODEINE	
$ Aspirin w/ Codeine*	ASPIRIN / CODEINE	
Hydrocodone Combinations		
$$ Acetaminophen w/ Hydrocodone*	VICODIN, LORTAB, NORCO XODOL	*QL = 180 tabs / 30 days 5/500, 5/325 and 5/300 mg tabs*
Propoxyphene Combinations		
$ Propoxyphene w/ APAP*	PROPOXYPHENE W/ APAP	*100mg tabs*

Generic Name	*Brand Name*	*Annotation*
ANTI-RHEUMATIC		
NSAID's		
$$ Diclofenac*	VOLTAREN	
$$ Etodolac*	ETODOLAC	
$$ Fenoprofen*	NALFON	
$$$ Flurbiprofen*	ANSAID	
$ Ibuprofen*	MOTRIN	
$ Indomethacin*	INDOCIN	*no SR or supp.*
$ Meloxicam*	MOBIC	
$ Naproxen*	NAPROSYN	*no EC*
$ Naproxen Sodium*	ANAPROX	
$ Piroxicam*	FELDENE	
$$ Sulindac*	CLINORIL	
COX-2 Inhibitor		
$$$$$ Celecoxib	CELEBREX	
Prior Authorization Required		
Anti-Rheumatic Antimetabolite		
$$$$ Methotrexate*	RHEUMATREX	
GOUT		
$ Allopurinol*	ZYLOPRIM	
$$$$ Colchicine	COLCRYS	
Uricosurics		
$ Probenecid*	PROBENECID	
LOCAL ANESTHETICS		
$ Lidocaine*	LIDOCAINE	*2% gel only*
$$$$$ Lidocaine*	LIDODERM PATCHES	*QL = 90 patches /30days*
MIGRAINE PRODUCTS		
$$$ Ergoloid mesylates*	HYDERGINE	
$$$$ Ergotamine tartrate	ERGOMAR	
$$$$ Sumatriptan tablets*	IMITREX	*QL = 9 tabs / 30 days*
$$$$ Sumatriptan injection*	IMITREX	*QL = 2 injections/30days (no nasal sprays)*
$$$$$ Sumatriptan-naproxen	TREXIMET	*QL = 9 tabs / 30 days*
$$$$$ Rizatriptan tablets*	MAXALT	*QL = 6 tabs / 30 days*
$$$$ Zolmitriptan tablets*	ZOMIG	*QL = 6 tabs / 30 days tabs only*
Prior Authorization Required		
Migraine Combinations		
$$ Ergotamine w/ Caffeine	CAFERGOT	

XI. NEUROMUSCULAR AGENTS

ANTICONVULSANT		
Hydantoins		
$$ Phenytoin*	DILANTIN	
Succinimides		
$$ Ethosuximide*	ZARONTIN	
Miscellaneous Anticonvulsants		
$$$ Primidone*	MYSOLINE	

Generic Name	*Brand Name*	*Annotation*

ANTIPARKINSONIAN

COMT Inhibitors

$$$ Entacapone*	COMTAN	
Prior Authorization Required		

Dopaminergic

$ Amantadine*	SYMMETREL	
$$$ Bromocriptine*	PARLODEL	*no postpartum use*
$$ Ropinirole*	REQUIP	
Prior Authorization Required		

Levodopa Combinations

$$$ Carbidopa-Levodopa*	SINEMET, CR	*no 100-25 CR*

Monoamine Oxidase Inhibitor

$$$$ Selegiline*	ELDEPRYL	

MUSCULOSKELETAL THERAPY AGENTS

Central Muscle Relaxants

$$ Baclofen*	BACLOFEN	
$ Cyclobenzaprine*	FLEXERIL	
$ Methocarbamol*	ROBAXIN	

Direct Muscle Relaxants

$$$$ Dantrolene*	DANTRIUM	
Prior Authorization Required		

Fibromyalgia

$$$$$ Milnacipran	SAVELLA	
Prior Authorization Required		

Muscle Relaxant Combinations

$ Methocarbamol w/ Aspirin*	METHOCARBAMOL w/ASA	

ANTIMYASTHENIC AGENTS

Antimyasthenic Agents

$$$$ Pyridostigmine*	MESTINON	

Benzothiazoles

$$$$$ Riluzole*	RILUTEK	
Prior Authorization Required		

XII. NUTRITIONAL PRODUCTS

VITAMINS

Water Soluble Vitamins

$ Niacin*	NIACIN	

Oil Soluble Vitamins

$ Vitamin A*	VITAMIN A	

Vitamin D

$$ Calcitriol*	ROCALTROL	*Vitamin D3*
$$ Ergocalciferol*	DRISDOL	*Vitamin D2*

Vitamin K

$$ Mephyton	VITAMIN K	*QL = 5 tabs / 30 days*

Generic Name	*Brand Name*	*Annotation*
MULTIVITAMINS		
$ Folic Acid & Vitamin B Complex*	NEPHROCAPS	
$ Multiple Vitamin*	ONE-A-DAY	*OTC product*
$ Multiple Vitamin w/ Minerals*	BEROCCA PLUS	
$ Pediatric Vitamins*	CHILDS COMPLETE	*OTC product*
$ Pediatric Multivitamins w/Fluoride*	POLY-VI-FLOR	*6mos to 16 years only*
$ Pediatric Multivitamins w/Iron*	ONE-A-DAY KIDS COMPLETE	
$ Prenatal MV & Min w/FE-FA*	PRENATAL-1	
$ Prenatal Vitamins*	PRENATABS RX	
CITRATES		
$ Sodium Citrate & Citric Acid*	ORACIT	
MINERALS & ELECTROLYTES		
Calcium		
$ Calcium Acetate*	PHOSLO	*caps only*
$ Calcium Carbonate*	OS-CAL	*OTC product*
Fluoride		
$ Sodium Fluoride*	LURIDE	
Potassium		
$ Potassium Chloride Capsule*	MICRO-K	
$ Potassium Chloride Liquid*	POTASSIUM CHLORIDE LIQUID	
$ Potassium Chloride Tablet*	KLOR-CON	
Electrolyte Mixtures		
$ Oral Electrolytes*	PEDIALYTE	*OTC product*
DIETARY PRODUCTS		
$$ Infant Foods	LOFENALAC	*OTC product*
$$ Phenyl-Free*	PHENYL-FREE	*OTC product*
MISCELLANEOUS NUTRITIONAL PRODUCTS		
$$ Nutritional Supplements	ENSURE, PEDIASURE, BOOST, VIVONEX	
Prior Authorization Requir		
For enteral access only		
(Nutritional Supplements are not limited to this list)		

XIII. HEMATOLOGICAL AGENTS

HEMATOPOIETIC AGENTS		
Cobalamines		
$ Folic Acid*	FOLIC ACID	
$$$ Leucovorin Calcium*	LEUCOVORIN	
$ Cyanocobalamin*	VITAMIN B-12	
$ Hydroxocobalamin*	HYDROXOCOBALAMIN	
Prior Authorization Required		
Iron		
$ Ferrous Gluconate*	FERGON	*OTC product*
$ Ferrous Sulfate*	FEOSOL	*OTC product*
Hematopoietic Growth Factors		
$$$$ Darbepoetin	ARANESP	*4 injections / month*
Prior Authorization Required		
Erythropoietins		
$$$$$ Epoetin Alfa	EPOGEN, PROCRIT	*2,000U, 3,000U, 4,000U, 10,000 - QL = 12 injections / month* *20,000U, 40,000U - QL = 4 injections / month*
Prior Authorization Required		
Leukocytes		
$$$$$ Filgrastim	NEUPOGEN	*QL = 30 injections / month*
Prior Authorization Required		

Generic Name	*Brand Name*	*Annotation*
ANTICOAGULANTS		
Coumarin Anticoagulants		
$$ Warfarin Sodium*	COUMADIN	
Heparin Agents		
$$$$ Enoxaparin*	LOVENOX	
Thrombin Inhibitors		
$$$$ Dabigatran	PRADAXA	
Prior Authorization Required		
HEMOSTATICS		
Hemostatics - Topical		
$$$ Thrombin	THROMBIN	
Prior Authorization Required		
MISC. HEMATOLOGICAL		
Antihemophilic Products		
$$$$ Antihemophilic Factor (Human)	ALPHANATE	
$$$$ Antihemophilic Factor (Recombinate)	RECOMBINATE	
$$$$ Antiinhibitor Coagulant Complex	FEIBA VH	
$$$$ Antithrombin III (Human)	THROMBATE III	
Prior Authorization Required		
Platelet Aggregation Inhibitors		
$$ Clopidogrel*	PLAVIX	
Hematorheological		
$$ Pentoxifylline*	TRENTAL	
Prior Authorization Required		

XIV. BEHAVIORAL HEALTH AGENTS

MISCELLANEOUS		
Smoking Deterrents		
$$$ Nicotine Patches*	NICODERM CQ	*QL = 30 patches / 30 days*
	NICODERM	*6 months / 365 days*
$$$$ Nicotine Gum*	NICORETTE	*QL = 336 pieces / 30 days 6 months / 365 days*
$$$$$ Nicotine Lozenges*	NICORETTE	*QL = 360 pieces / 30 days*
	COMMIT	*6 months / 365 days*
$$$$$ Nicotine Nasal Spray	NICOTROL NS	*QL = 18 / 6 months*
$$$$$ Nicotine Inhaler	NICOTROL INH	*QL = 336 / 6 months*
$$$$ Varenicline Tartrate	CHANTIX	
Prior Authorization Required		
Reversible Acetylcholinesterase inhibitor		
$$$$ Donepezil*	ARICEPT	
$$$$ Galantamine*	RAZADYNE / RAZADYNE ER	
$$$$ Rivastigmine*	EXELON	
Prior Authorization Required		
Miscellaneous		
$$$ Disulfiram*	ANTABUSE	
$$$$ Acamprosate*	CAMPRAL	
$$$$$ Clonidine*	KAPVAY	*Please refer to Introduction page I-5*
$$$$$ Guanfacine	INTUNIV	*Please refer to Introduction page I-5*
$$$$ Memantine	NAMENDA	
Prior Authorization Required		
ANTICONVULSANT		
Misc. Anticonvulsants		
$$$ Primidone*	MYSOLINE	

Generic Name	*Brand Name*	*Annotation*

XV. TOPICAL AGENTS

OPHTHALMIC

Antibiotics		
$$$ Bacitracin*	AK-TRACIN	
$$$ Ciprofloxacin*	CILOXAN	
$ Erythromycin*	ROMYCIN	
$ Gentamicin Sulfate*	GENTAK	
$ Polymyxin B-Trimethoprim*	POLYTRIM	
$$$ Moxifloxacin Hydrochloride	VIGAMOX	*AL = 18 years*
$$$ Gatifloxacin	ZYMAXID	
Prior Authorization Required		
Anti Allergic		
$$$ Lodoxamine	ALOMIDE	*QL = 20 mls / 30 days*
$$$$ Olopatadine	PATANOL	*QL = 20 mls / 30 days*
Sulfonamides		
$ Sodium Sulfacetamide*	BLEPH-10	
Antivirals		
$$$ Trifluridine*	VIROPTIC	
$ Vidarabine	VIRA-A	
Antiinfective Combinations		
$ Bacitracin-Polymyxin B*	POLYSPORIN	
$ Neomycin-Bac Zn-Polymyxin*	NEOMYCIN-BAC ZN-POLYMIXIN	
$ Neomycin-Polymy-Gramicidin*	NEOSPORIN	
Beta-Blockers		
$$$$ Betaxolol*	BETOPTIC, BETOPTIC S	
$ Timolol*	BETIMOL, TIMOPTIC	*no XE*
Steroids		
$$ Dexamethasone*	DEXAMETHASONE	
$$ Prednisolone Acetate*	PRED FORTE, MILD	
Steroid Combinations		
$ Bacitracin-Polymyxin-Neomycin-HC*	BACITRACIN-POLYMIXIN-NEOMYCIN-HC	
$ Neomycin-Polymyxin-Dexamethasone*	MAXITROL	
$$$ Neomycin-Polymyxin-HC*	CORTISPORIN	
$$$ Sulfacetamide Sod-Prednisolone*	BLEPHAMIDE	
Cycloplegics		
$ Atropine Sulfate*	ISOPTO ATROPINE	
Decongestants		
$ Naphazoline*	NAPHCON	
$$ Phenylephrine*	MYDFRIN	
Ophthalmic NSAID's		
$$ Flurbiprofen*	OCUFEN	
Miotics - Direct Acting		
$ Pilocarpine*	ISOPTO-CARPINE	*no Ocusert*
Prostaglandins		
$$$ Latanoprost*	XALATAN	
Carbonic Anhydrase Inhibitors		
$$ Dorzolamide*	TRUSOPT	

OTIC

Steroids		
$ Hydrocortisone w/Acetic Acid*	ACETASOL HC	*QL = 20 mls / 30 days*

Generic Name	***Brand Name***	***Annotation***
Antibiotics & Steroid-Antibiotic Combinations		
$ Neomycin-Polymyxin-HC*	CORTISPORIN	*QL = 20 mls / 30 days*
Antibiotics		
$$$ Ofloxacin*	FLOXIN	*QL = 20 mls / 30 days*
Anti Infective		
$ Carbamide Peroxide*	DEBROX	
Analgesic Combinations		
$ Benzocaine & Antipyrine*	A/B OTIC	
MOUTH & THROAT (Local)		
Antiinfectives - Throat		
$$$ Clotrimazole*	MYCELEX TROCHE	
$ Nystatin*	NYSTATIN	
ANORECTAL		
Rectal Steroids		
$ Hydrocortisone*	ANUSOL-HC	*2.5% cream*
$$ Hydrocortisone*	PROCTOCREAM	*2.5% cream*
DERMATOLOGICAL		
Antibiotics - Topical		
$$ Bacitracin*	BACITRACIN	*OTC product*
$ Gentamicin Sulfate*	GENTAMICIN	
$$$ Metronidazole	METROGEL	
$$$ Mupirocin*	BACTROBAN	
$ Neomycin Sulfate*	NEOMYCIN	
Antibiotic Mixtures Topical		
$ Neomycin-Bacitracin-Polymyxin*	NEOSPORIN	*OTC product*
Antibiotic Steroid Combinations		
$$ Neomycin-Polymyxin-HC*	CORTISPORIN	
Imidazole-Related Antifungals (Topical)		
$$ Clotrimazole*	LOTRIMIN	*OTC product*
$ Miconazole*	MONISTAT	*OTC product*
Antifungals		
$ Nystatin*	NYSTATIN	*no powder*
Antifungals - Topical Combinations		
$$ Nystatin-Triamcinolone*	NYSTATIN-TRIAMCINOLONE	
Antipsoriatics		
$$$$ Calcipotriene*	DOVONEX	
Antiseborrheic Products		
$ Sulfacetamide Sodium*	SULFACETAMIDE SODIUM	
Burn Products		
$ Silver Sulfadiazine*	SILVADENE	
Tar Products		
$ Coal Tar*	COAL TAR SHAMPOO	*1% only*
Enzymes - Topical		
$$$ Collagenase	SANTYL	
Keratolytics/Antimitotics		
$$$$ Podofilox*	CONDYLOX	
$$$$$ Urea 35%	KERALAC	
$$$$$ Urea 50%	KERALAC NAILSTIK	

Generic Name	***Brand Name***	***Annotation***
Local Anesthetics - Topical		
$ Lidocaine viscous*	XYLOCAINE VISCOUS	
Scabicides & Pediculocides		
$ Lindane*	LINDANE	
$$ Permethrin*	ELIMITE	*OTC product*
$$ Permethrin*	NIX	
Misc. Topical		
$$ Ammonium Lactate	LAC-HYDRIN	*cream & lotion*
$$$ Fluorouracil*	EFUDEX	*2% and 5% cream only*
$$$ Pimecrolimus	ELIDEL	
Prior Authorization Required		
Antiviral Topical		
$$$$ Acyclovir	ZOVIRAX	
Prior Authorization Required		
Corticosteroids - Topical		
$ Betamethasone Dipropionate*	BETAMETHASONE DIPROPIONATE	
$ Betamethasone Valerate*	BETAMETHASONE VALERATE	
$ Clobetasol Propionate*	TEMOVATE	
$ Desonide*	DESOWEN	
$ Fluocinonide*	LIDEX	
$ Fluocinonide Acetonide*	SYNALAR	
$ Hydrocortisone*	HYTONE	*OTC product*
$ Triamcinolone Acetonide*	KENALOG	
$ Triamcinolone Acetonide in Orabase*	TRIAM. ACET. IN ORABASE	
Acne Products		
$ Benzoyl Peroxide*	BENZAC W	
$$$ Tretinoin*	RETIN-A	*Ages 0-21 only / no Micro*
Acne Antibiotics		
$$ Clindamycin Phosphate*	CLEOCIN	
$$ Erythromycin Gel*	ERYGEL	

XVI. MISCELLANEOUS PRODUCTS

ANTIDOTES

$ Ipecac*	IPECAC	*OTC product*

DIAGNOSTIC PRODUCTS

Diagnostic Reagents		
$ Acetone Tablets	ACETEST	
$ Acetone Test*	KETOSTIX	
$ Glucose Urine Test*	CLINITEST	
$$ Glucose Blood*	GLUCOFILM	

MEDICAL DEVICES

Parenteral Therapy Supplies		
$ Disposable Needles & Syringes*	B-D INSULIN SYRINGE	
$ Insulin Pen Needles	Insulin Pen Needles	
Diabetic Supplies		
$$ Blood Glucose Monitoring Tests*	GLUCOMETER	*Only Bayer Contour Ascensia Glucometer*
$ Calibration Solution*	CALIBRATION SOLUTION	
$ Lancet Device	HYPOLET	
$ Lancets*	LANCETS	
Misc. Devices		
$ Alcohol Swabs*	ALCOHOL PADS	

Generic Name	***Brand Name***	***Annotation***
CONTRACEPTIVES		
$ Condoms		
ASSORTED CLASSES		
Chelating Agents		
$$$$ Penicillamine	CUPRIMINE	
$$$$ Succimer	CHEMET	
Prior Authorization Required		
Immunosuppressive Agents		
$$$$$ Cyclosporine Microsize*	NEORAL	
$$$$$ Sirolimus*	RAPAMUNE	
$$$$$ Tacrolimus*	PROGRAF	
Inosine Monophosphate Dehydrogenase Inhibitors		
$$$$$ Mycophenolate Mofetil*	CELLCEPT	
$$$$$ Mycophenolate Sodium*	MYFORTIC	
Mutiple Sclerosis - Adjuvants		
$$$$$ Teriflunomide	AUBAGIO	*QL = 60 tabs / 30 days*
$$$$$ Dimethyl Fumarate	TECFIDERA	*QL = 60 tabs / 30 days*
$$$$$ Dalfampridine	AMPYRA	*QL = 60 tabs / 30 days*
Prior Authorization Required		
Purine Analogs		
$$$ Azathioprine*	IMURAN	
K Removing Resin		
$$$$ Sodium Polystyrene Sulfonate*	KAYEXALATE	
Rheumatology Biologics		
$$$$$ Adalimumab	HUMIRA	
$$$$$ Etanercept	ENBREL	
Prior Authorization Required		

Prior Authorization Guidelines

Prior Authorization Guidelines

GENERIC: ACAMPROSATE
BRAND: CAMPRAL®

INDICATION:

(1) Maintenance of abstinence for alcohol-dependent patients who are abstinent at treatment initiation.

Criteria:

(a) Patient must be abstinent at treatment initiation; **and**
(b) Treatment must be part of a comprehensive management program that includes psychosocial support; **and**
(c) Patient must be opiate dependent.

GENERIC: ACARBOSE
BRAND: PRECOSE®

INDICATION:

(1) Type 2 diabetes mellitus

Criteria:

(a) Failure of maximal doses of *one* oral sulfonylurea (e.g., glyburide 20mg daily or equivalent). Failure is defined as Hemoglobin A1c> 7.0.

GENERIC: ACLIDINIUM BROMIDE AEROSOL POWDER
BRAND: TUDORZA PRESSAIR®

INDICATION:

(1) Long-term maintenance treatment of bronchospasm associated with COPD (including bronchitis and emphysema)

Criteria:

(a) Diagnosis of COPD **and**
(b) Must be greater than 18 years of age **and**
(c) Documented inadequate response or intolerance to Spiriva

Prior Authorization Guidelines

GENERIC: ACYCLOVIR TOPICAL OINTMENT
BRAND: ZOVIRAX® 5%®

INDICATIONS:

(1) Herpes genitalis
(2) Oral herpes infection

Criteria:

(a) Herpes genitalis – for initial episode only; **or**
(b) Oral herpes infection – for immunocompromised patients *only*.

GENERIC: ADALIMUMAB
BRAND: HUMIRA®

INDICATIONS:

(1) Moderate to severely active rheumatoid arthritis
(2) Psoriatic arthritis
(3) Ankylosing spondylitis
(4) Moderate to severely active Crohn's disease

Criteria:

(a) The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to Humira therapy; **and**
(b) The patient does not have a clinically important active infection

Additional Criteria for RA:

(a) The patient has failed or is intolerant to one formulary NSAID **and**
(b) The patient has failed or is intolerant to one formulary DMARD

Additional Criteria for Crohn's:

(a) The patient has failed or is intolerant to infliximab;**or**
(b) The patient has failed or is intolerant to mesalamine or sulfasalazine;**and**
(c) The patient has failed or is intolerant to corticosteroids;**and**
(d) The patient has failed or is intolerant to an immunomodulator (e.g., methotrexate, 6-mercaptopurine or azathioprine)

GENERIC: ALBUTEROL SULFATE INHALER
BRAND: PROAIR HFA®

INDICATION:

Asthma

(1) Symptomatic management of prevention of bronchospasms in patient 4 years of age and older with reversible obstructive airway disease
(2) Prevent of exercise-induced bronchospasm in patients 4 years of age and older
(3) COPD- Symptomatic management of reversible bronchospasm associated with COPD in patients who continue to have evidence of bronchospasm despite regular use of an orally inhaled bronchodilator and who require a second bronchodilator

Criteria:

(a) Failure or contraindication of Ventolin HFA or Proventil HFA

GENERIC: ANTIHEMOPHILIC FACTORS
BRAND: ALPHANATE®, FEIBA VH®, RECOMBINATE®, THROMBATE III®

INDICATION:

(1) Hemophilia A

Criteria:

(a) Diagnosis of Hemophilia A

GENERIC: AZELASTINE
BRAND: ASTELIN®

INDICATIONS:

(1) Allergic conjunctivitis
(2) Perennial allergic rhinitis
(3) Seasonal allergic rhinitis

Criteria:

(a) Patient is ≥ 5 years of age with one of the above diagnoses; **and**
(b) Failure of at least one formulary nasal steroid after a period of at least two months on the maximum dose appropriate and tolerated by the patient

GENERIC: BOCEPREVIR
BRAND: VICTRELIS ®

INDICATION:

(1) Treatment of chronic hepatitis C genotype 1 used in combination with peginterferon alfa and ribavirin in patients with compensated liver disease.

Criteria:

(a) Diagnosis of chronic hepatitis C genotype 1; **and**
(b) Diagnosis of compensated liver disease;**and**
(c) No previous treatment (full or partial course) of Incivek or Victrelis;**and**
(d) Patient has been counseled on the importance of medication adherence and is willing to adhere to the regimen for the full course of therapy; **and**
(e) The patient must have completed 4 weeks of peginterferon and ribavirin therapy (treatment weeks 1 through 4); **and**
(f) HCV-RNA levels must be drawn at treatment weeks 8, 12, and 24 (Victrelis week 4, 8, and 20); **and**
(g) Females of child bearing potential must meet the following additional parameters:
    a. A recent negative pregnancy test; **and**
    b. Been counseled on the teratogenic effects of triple therapy; **and**
    c. Is willing to practice contraception during and for 6 months after completion of therapy

GENERIC: BUDESONIDE/FORMOTEROL
BRAND: SYMBICORT®

INDICATION:

(1) Maintenance treatment of asthma in patients 12 years of age and older

Criteria:

(a) Currently on, but not adequately controlled by an inhaled corticosteroid; **or**

(b) Maintenance treatment of airflow obstruction in patients with chronic bronchitis and emphysema

(c) Patients must be reevaluated after 6 months

**For members currently with an approved prior authorization for Symbicort, claims will process as long as the member has filled Symbicort within the last 3 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to Symbicort therapy, or with no claims history of Symbicort within the last 3 months.*

GENERIC: CALCITONIN-SALMON
BRAND: MIACALCIN®

INDICATIONS:

(1) Mild to moderate Paget's disease of bone

(2) Osteoporosis

Criteria:

(a) Failure, contraindication or intolerance to adequate trial of oral bisphosphonate; **and**

One of the following:

(1) Bone density measurement ≥ 2.5 standard deviations below the mean for normal, young adults of same gender (T-score ≤ -2.5); **or**

(2) History of an osteoporotic vertebral fracture; **or**

(3) Postmenopausal woman with low bone mineral density defined by T-score between -2.0 and -2.5 AND one of the following risk factors for fracture:

(a) Thinness or low body mass index defined by weight < 127 lb (57.7 kg) or BMI < 21 kg/m^2

(b) History of fragility fracture since menopause

(c) History of hip fracture in a parent

(4) Diagnosis of Paget's disease of bone

(b) Patients receiving glucocorticoids in daily dosages of ≥ 7.5mg prednisone daily (see table) AND who have bone density measurement > 1 standard deviations below the mean for normal, young adults of same gender (T-score < -1.0)

Glucocorticoid Potency Equivalencies			
Glucocorticoid	**Approximate equivalent dose (mg)**	**Relative anti-inflammatory (glucocorticoid) potency**	**Relative mineralocorticoid potency**
Short-acting			
Cortisone	25	0.8	2
Hydrocortisone	20	1	2
Intermediate-acting			
Prednisone	5	4	1
Prednisolone	5	4	1
Triamcinolone	4	5	0
Methylprednisolone	4	5	0
Long-acting			
Dexamethasone	0.75	20-30	0
Betamethasone	0.6-0.75	20-30	0

Table adapted from Facts and Comparisons® 1999:122

* *For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

* *If documentation of osteoporosis is available, please submit with PA request.*

GENERIC: CEFDINIR SUSPENSION
BRAND: OMNICEF®

INDICATIONS:

(1) CAP
(2) Acute exacerbations of chronic bronchitis
(3) Acute maxillary sinusitis
(4) Pharyngitis / Tonsillitis
(5) Uncomplicated skin and skin structure infections
(6) Acute bacterial otitis media – pediatrics only

Criteria:

(a) Recent failure (within 30 days) of at least one standard first-line formulary antibiotic in absence of culture; **or**
(b) Documentation of cultured organism with sensitivity to only cefdinir, other third generation cephalosporin OR contraindications to all other sensitive antibiotics.

GENERIC: CELECOXIB
BRAND: CELEBREX®

INDICATIONS:

(1) Relief of signs and symptoms of rheumatoid arthritis (RA) in adults
(2) Relief of signs and symptoms of osteoarthritis (OA)
(3) Relief of signs and symptoms of ankylosing spondylitis
(4) Management of acute pain in adults
(5) Treatment of primary dysmenorrhea
(6) To reduce the number of adenomatous polyps in familial adenomatous polyposis, as an adjunct to usual care

Criteria:

(a) Failure, intolerance, or contraindication to at least 2 formulary NSAIDs; **and**
(b) One of the following:
    (1) Age greater than 65; **or**
    (2) Concomitant use of warfarin or other antiplatelet therapy; **or**
    (3) Concomitant use of chronic systemic corticosteroid therapy; **or**
    (4) Documented history of ulcer disease or GI bleed; **or**
    (5) Documented history of significant GI disease requiring therapy with an H2 antagonist or proton pump inhibitor; **or**
    (6) Documented history of nonselective NSAID-induced GI adverse effects; **and**
(c) For OA, therapeutic failure (≥ 21 day trial), intolerance of, or contraindication to at least 1 of the following: acetaminophen or opiod analgesics or topical analgesics (capsaicin, etc.)

GENERIC: CHOLINE FENOFIBRATE
BRAND: TRILIPIX®

INDICATION:

(1) Hypercholesterolemia, Hypertriglyceridemia

Criteria:

(a) Failure of generic fenofibrate 48, 54, 154 or 160mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

GENERIC: CLOXACILLIN SODIUM

INDICATION:

(1) Treatment of infections due to penicillinase-producing staphylococci

Criteria:

(a) Diagnosis of staphylococcal infection; **and**

(b) Failure of dicloxacillin sodium.

GENERIC: CYANOCOBALAMIN (HYDROXOCOBALAMIN)
BRAND: VITAMIN B-12®

INDICATION:

(1) Vitamin B-12 deficiency

Criteria:

(a) Patients who lack intrinsic factor; **or**

(b) Patients who are on long-term PPI therapy; **or**

(c) Patients with a partial or complete gastrectomy.

** For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

GENERIC: DABIGATRAN ETEXILATE MESYLATE
BRAND: PRADAXA®

INDICATION:

(1) Reduce the risk of stroke and systemic embolism in patients with non-vascular atrial fibrillation.

Criteria:

(a) Diagnosis of non-vascular atrial fibrillation; **and**

(b) Must have recent CrCl levels or Scr and current patient weight; **and**

(c) No active pathological bleeding; **and**

(d) Must have tried and failed or intolerant to Warfarin

NOTE: Conversion to Pradaxa:

(a) From Warfarin: discontinue warfarin and start pradaxa when INR<2.0

(b) From Parenteral Anticoagulants: start Pradaxa 0-2 hrs prior to next scheduled dose of parenteral anticoagulant, or at the time of discontinuation of continuous parenteral drug (e.g. heparin)

GENERIC: DALFAMPRIDINE
BRAND: AMPYRA®

INDICATION:

(1) Improved walking speed in patients with multiple sclerosis

Criteria:

(a) Diagnosis of multiple sclerosis; **and**
(b) Prescribed by a neurologist; **and**
(c) Currently taking a disease modifying drug for multiple sclerosis (Avonex, Aubagio, Betaseron, Copaxone, Extavia, Gilenya, Rebif, Tecfidera or Tysabri)

**Renewals will require documented improvement in walking speed (demonstrated improvement in timed 25 foot walk)*

GENERIC: DANTROLENE
BRAND: DANTRIUM®

INDICATION:

(1) Spasticity resulting from upper motor neuron disorders

Criteria:

(a) Demonstrated failure of, or intolerance to, Baclofen (Lioresol ®).

GENERIC: DARBEPOETIN ALFA
BRAND: ARANESP®

INDICATIONS:

(1) Anemia with cancer chemotherapy (nonmyeloid)
(2) Anemia due to chronic renal failure

Criteria:

(a) Ensure patient's iron stores are adequate (Ferritin ≥ 100 ng/mL and/or Transferrin saturation ≥ 20%) or patient is being treated with iron; **and**
(b) Adequate blood pressure control; **and**

Chronic kidney disease patients:

(a) Initiate treatment when hemoglobin is <10g/dL; **or**

Anemia due to chemotherapy in cancer:

(a) Initiate treatment only if hemoglobin is <10g/dL; **and**
(b) Anticipated duration of myelosuppressive chemotherapy is ≥ 2 months

For renewals:

(a) **Chronic kidney disease patients:**
  (1) With dialysis Hbg <11; or
  (2) Without dialysis Hbg <10

(b) **Anemia due to chemotherapy in cancer patients:**
  (1) Hbg <11

GENERIC: DESMOPRESSIN
BRAND: DDAVP®

INDICATIONS:

(1) Central cranial diabetes insipidus (CCDI)
(2) Primary nocturnal enuresis

Criteria:

(a) Diagnosis of CCDI; **or**
(b) For the treatment of enuresis, age 6 to 18 years; **and**
(c) Failure of behavior modification for 6 months (e.g., alarms, no beverages after 5pm, special diapers etc.).

** Renewals for the indication of nocturnal enuresis will require the documentation of a retrial of behavior modification.*

GENERIC: DIMETHYL FUMERATE
BRAND: TECFIDERA®

INDICATION:

(1) Diagnosis of a relapsing form of Multiple Sclerosis;

Criteria:

(a) Prescribed by neurologist; and
(b) Not requesting combination of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera

GENERIC: DONEPEZIL
BRAND: ARICEPT®

INDICATION:

(1) Alzheimer's disease: for the treatment of dementia.

Criteria:

(a) Dementia must be confirmed by clinical evaluation

GENERIC: ENTACAPONE
BRAND: COMTAN®

INDICATION:

(1) As an adjunct to levodopa/carbidopa to treat patients with idiopathic Parkinson's disease

Criteria:

(a) Diagnosis of idiopathic Parkinson's disease; **and**
(b) Patient is receiving concomitant levodopa/carbidopa therapy.

GENERIC: EPOETIN ALFA
BRAND: PROCRIT®, EPOGEN®

INDICATIONS:

(1) Anemia with cancer chemotherapy (nonmyeloid)
(2) Anemia due to chronic renal failure
(3) Anemia of HIV infection associated with zidovudine
(4) Reduction of allogenic blood transfusion for elective, noncardiac, nonvascular surgery

Criteria:

(a) Patient's iron stores are adequate (Ferritin ≥ 100 ng/mL and/or Transferrin saturation ≥ 20%) or patient is being treated with iron; **and**
(b) Adequate blood pressure control

Chronic kidney disease patients:

(a) Initiate treatment when hemoglobin is <10 g/dL (3 month approval)

Anemia due to chemotherapy in cancer patients:

(a) Initiate treatment only if hemoglobin <10 g/dL and anticipated duration of myelosuppressive chemotherapy is ≥2 months

Anemia due to zidovudine in HIV-infected patients:

(a) Initiate treatment when hemoglobin is <10 g/dL

Surgical procedure - Transfusion of blood product, Allogeneic; Prophylaxis:

(a) Patient's pre-operative Hgb >10 to ≤13 g/dL (14 day approval)

For renewals:

Chronic kidney disease patients:

(a) With dialysis Hbg <11
(b) Without dialysis Hbg <10

Anemia due to chemotherapy in cancer patients:

(a) Hbg <11

Anemia due to zidovudine in HIV-infected patients:

(a) Hbg <11

GENERIC: ETANERCEPT
BRAND: ENBREL®
INDICATIONS:

(1) Moderate to severely active rheumatoid arthritis
(2) Moderate to severely active polyarticular juvenile rheumatoid arthritis
(3) Psoriatic spondylitis
(4) Ankylosing spondylitis
(5) Plaque psoriasis

Criteria:

(a) The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to Enbrel therapy; **and**
(b) The patient does not have a clinically important active infection

Additional Criteria for RA:

(a) The patient has failed or is intolerant to one formulary NSAID **and**
(b) The patient has failed or is intolerant to one formulary DMARD

Additional Criteria for Plaque Psoriasis:

(a) Involvement of ≥ 10% body surface area (BSA)

GENERIC: EXENATIDE
BRAND: BYETTA®

INDICATION:

(1) Adjunctive therapy of type 2 diabetes mellitus

Criteria:

(a) Diagnosis of type 2diabetes; **and**
(b) Failure or intolerance to sulfonylureas and/or metformin at optimal dosing. Failure defined as Hemoglobin A1c ≥ 7.0; **and**
(c) Patient ≥ 18 years of age

GENERIC: EZETIMIBE
BRAND: ZETIA®

INDICATIONS:
(1) Hypercholesterolemia
(2) Sitosterolemia

Criteria:
(a) Diagnosis of sitosterolemia; **or**
(b) For the diagnosis of hypercholesterolemia, failure of optimal dosing/duration or intolerance/contraindication to 2 formulary anti-lipid agents (with at least one agent being a statin)

GENERIC: EZETIMIBE/SIMVASTATIN
BRAND: VYTORIN®

INDICATION:
(1) Hypercholesterolemia

Criteria:
(a) The diagnosis of hypercholesterolemia, failure of optimal dosing/duration or intolerance/contraindication to 2 formulary anti-lipid agents (with at least one agent being a statin)

GENERIC: FENOFIBRATE
BRAND: LIPOFEN®, TRIGLIDE®

INDICATION:
(1) Hypercholesterolemia, Hypertriglyceridemia

Criteria:
(a) Failure of generic fenofibrate 48, 54, 154, or 160mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

GENERIC: FENOFIBRATE MICRONIZED
BRAND: ANTARA®

INDICATION:
(1) Hypercholesterolemia, Hypertriglyceridemia

Criteria:
(a) Failure of generic fenofibrate 54 or 160mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

GENERIC: FENOFIBRIC ACID
BRAND: TRILIPIX®

INDICATION:

(1) Hypercholesterolemia, Hypertriglyceridemia

Criteria:

(a) Failure of generic fenofibrate 54 or 160mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

GENERIC: FENTANYL TRANSDERMAL PATCH
BRAND: DURAGESIC®

INDICATION:

(1) Persistent, moderate to severe chronic pain OR cancer-related pain that requires continuous, around-the-clock opiod (narcotic) administration for an extended period of time

Criteria:

(a) Diagnosis of persistent, moderate to severe chronic or cancer-related pain requiring continuous, around-the-clock opiod administration for an extended period of time; **and**
(b) Patient unable to take medications by mouth; **or**
(c) Failure of or intolerance/contraindication to a long-acting oral opiate (narcotic) medication (controlled-release morphine, oxycodone, or oxymorphone)

GENERIC: FILGRASTIM
BRAND: NEUPOGEN®

INDICATIONS:

(1) Prevention of neutropenia in patients receiving myleosuppressive chemotherapy for non-myeloid malignancies
(2) Patients undergoing peripheral blood progenitor cell collection and therapy
(3) Patients with severe chronic neutropenia

Criteria:

(a) The patient is undergoing peripheral blood progenitor cell collection and therapy; **or**

(b) Diagnosis of severe chronic neutropenia with an absolute neutrophil count (ANC)< 1,000; **or**

(c) ANC nadir of < 1,000 neutrophils to previous chemotherapy. Once this has been documented, approval will be given to prophylax for all future chemo cycles.

***** *For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

***** *Please indicate estimated duration of therapy.*

GENERIC: FLUCONAZOLE
BRAND: DIFLUCAN®

(PA required after 1x 150mg tablet dispensed)

INDICATIONS:

(1) Vaginal candidiasis
(2) Cryptococcal meningitis
(3) Serious systemic candidal infections
(4) Oropharyngeal and esophageal candidiasis

Criteria:

(a) Any of the above diagnoses; **except**

(b) For the diagnosis of oropharyngeal candidiasis, failure of nystatin therapy; **and**

(c) For the diagnosis of vaginal candidiasis, patients who are immunocompromised and/or have recurrent or refractory infections.

GENERIC: GALANTAMINE HYDROBROMIDE
BRAND: RAZADYNE®, RAZADYNE ER®

INDICATION:

(1) Alzheimer's disease: for the treatment of dementia

Criteria:

(a) Confirmation by clinical evaluation

GENERIC: GATIFLOXACIN
BRAND: ZYMAXID®

INDICATION:

(1) Bacterial conjunctivitis

Criteria:

(a) Failure of, contraindication to, or intolerance to ciprofloxacin ophthalmic formulation.

GENERIC: GLATIRAMER ACETATE
BRAND: COPAXONE®

INDICATIONS:

(1) Relapsing-remitting Multiple Sclerosis
(2) To prevent or slow the development of clinically definite Multiple Sclerosis in patients who hae experienced a first clinical episode and have MRI features consistent with Multiple Sclerosis

Criteria:

(a) Prescribed by neurologist; and
(b) Not requesting combination therapy of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri,Rebif, Gilenya, Aubagio, or Tecfidera

GENERIC: INTERFERON ALPHA
BRAND: ROFERON-A®, INTRON-A®, and ALFERON N®

INDICATIONS:

(1) Hairy cell leukemia
(2) AIDS-related Kaposi's sarcoma
(3) Chronic hepatitis B or C
(4) Malignant melanoma

Criteria:

(a) Any of the above diagnoses.

*****_For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary._

GENERIC: INTERFERON BETA
BRAND: AVONEX®, BETASERON®, REBIF®

INDICATIONS:
(1) Diagnosis of a relapsing form of Multiple Sclerosis; **or**
(2) First clinical demyelinating event with MRI evidence consistent with Multiple Sclerosis

Criteria:
(a) Prescribed by neurologist; **and**
(b) If patient has a history of or is currently being treated for severe psychiatric disorders, suicidal ideation or severe depression, this condition is well controlled; **and**
(c) Not requesting combination of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera

** For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

GENERIC: ISOSORBIDE MONONITRATE
BRAND: IMDUR®

INDICATION:
(1) Prevention of angina pectoris

Criteria:
(a) Failure of formulary nitrates.

GENERIC: ITRACONAZOLE
BRAND: SPORANOX®

INDICATIONS:
(1) Histoplasmosis infections
(2) Aspergillosis infections
(3) Blastomycosis

Criteria:
(a) Any of the above diagnoses.

GENERIC: LEUPROLIDE
BRAND: LUPRON®

INDICATIONS:

(1) Advanced prostate cancer
(2) Central precocious puberty
(3) Endometriosis
(4) Uterine leiomyomata (fibroids)

Criteria:

(a) Diagnosis of advanced prostate cancer, precocious puberty or fibroids; **or**
(b) For the diagnosis of endometriosis, failure of NSAIDS **and** oral contraceptives **or** endometriosis diagnosed by laparoscopy.

*****_Note: This agent is ordinarily administered at the physician's office. For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary._

GENERIC: LIRAGLUTIDE
BRAND: VICTOZA®

INDICATION:

(1) Adjunct to diet and exercise to improve glycemic control in patients with type II diabetes mellitus

Criteria:

(a) Diagnosis of type II diabetes mellitus; **and**
(b) Must be under the care of a healthcare provider skilled with the use of insulin and supported by a diabetes educator
(c) Must have tried at least 2 antidiabetic agents such as metformin, sulfonylureas, thiazolidinedione or insulin and not achieved adequate glycemic control despite treatment or intolerant to other antidiabetic medications; **and**
(d) Must have tried and failed or intolerant to treatment with Byetta; **and**
(e) NO personal or family history of medullary thyroid carcinoma

GENERIC: MEMANTINE
BRAND: NAMENDA®

INDICATION:

(1) Alzheimer's disease: for treatment of moderate-to-severe cases of dementia

Criteria:

(a) Dementia must be confirmed by clinical evaluation; **and**
(b) Documented dementia is either moderate or severe

GENERIC: METRONIDAZOLE VAGINAL GEL
BRAND: METROGEL®

INDICATION:

(1) Bacterial vaginosis

Criteria:

(a) Pregnancy; **or**
(b) Intolerance to oral metronidazole

GENERIC: MILNACIPRAN
BRAND: SAVELLA®

INDICATION:

(1) Moderate to severe fibromyalgia

Criteria:

(a) Trial of two of the three below agents after a period of at least two months on the maximum dose appropriate and tolerated by the patient:
    (1) gabapentin
    (2) venlafaxine
    (3) one other evidence based effective agent (TCA therapy, SSRIs, tramadol, NSAIDs, cyclobenzaprine)

GENERIC: MOXIFLOXACIN
BRAND: AVELOX®

INDICATION:

(1) Acute bacterial sinusitis
(2) Acute bacterial exacerbations of chronic bronchitis
(3) Mild to moderate pelvic inflammatory disease
(4) Complicated/Uncomplicated skin and skin structure infections
(5) Community-acquired pneumonia
(6) Complicated intra-abdominal infections

Criteria:

In patients ≥18 years of age with any of the above listed indications when:

(a) Cultures show sensitivity to Avelox® only; **or**
(b) Patient discharged on Avelox® from the hospital and needs to complete regimen on an outpatient basis

GENERIC: NAFARELIN+
BRAND: SYNAREL®

INDICATIONS:

(1) Central precocious puberty
(2) Endometriosis

Criteria:

(a) Diagnosis of central precocious puberty; **or**
(b) For the diagnosis of endometriosis in patients ≥ 18 years of age, failure of NSAIDs **and** oral contraceptives, **or**endometriosis diagnosed by laparoscopy.

GENERIC: NICOTINE INHALER
BRAND: NICOTROL INHALER®

INDICATION:

(1) Smoking cessation

Criteria:

(a) Documented failure of gum, lozenge, patches or Chantix for 30 days within the last 120 days

GENERIC: NICOTINE NASAL SPRAY
BRAND: NICOTROL NASAL SPRAY®
INDICATION:

(1) Smoking cessation
Criteria:
(a) Documented failure of gum, lozenge, patches or Chantix for 30 days within the last 120 days

GENERIC: NUTRITIONAL SUPPLEMENTS
BRAND: ENSURE®, PEDIASURE®, BOOST®, VIVONEX®

INDICATION:
(1) Nutritional supplementation
Criteria:
(a) Patient must have enteral access via one of the following: nasogastric (NG) tube, nasoduodenal (ND) tube, nasojejunal (NJ) tube, percutaneous endoscopic gastrostomy (PEG) or percutaneous endoscopic jejunostomy (PEJ).

To obtain nutritional supplements (e.g. Ensure or Pediasure) for members without enteral access, please follow the DME process. For assistance accessing the DME process, please contact Customer Service at 1-888-524-1999.

GENERIC: OCTREOTIDE
BRAND: SANDOSTATIN®

INDICATIONS:
(1) Symptomatic treatment of severe diarrhea and flushing episodes associated with metastatic carcinoid tumors
(2) Profuse, watery diarrhea associated with vasoactive intestinal peptide (VIP) secreting tumors
(3) To reduce the blood levels of growth hormone and IGF-I associated with acromegaly

Criteria:
(a) Any of the above diagnoses; **and**
(b) For the diagnosis of acromegaly, the patient has had an inadequate response to, or can not be treated with surgical resection, pituitary irradiation **and** bromocriptine at maximally tolerated doses.

For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.

Prior Authorization Guidelines

GENERIC: ONDANSETRON ODT AND SOLUTION
BRAND: ZOFRAN®

INDICATIONS:

(1) Chemotherapy induced nausea and vomiting
(2) Post-operative nausea and vomiting
(3) Radiation induced nausea and vomiting

Criteria:

(a) For patients who have a contraindication or failure of regular release ondansetron tablets

GENERIC: OXYCODONE, CONTROLLED-RELEASE
BRAND: OXYCONTIN®

INDICATION:

(1) Persistent, moderate to severe chronic pain **or** cancer-related pain that requires continuous, around-the-clock opiod (narcotic) administration for an extended period of time; not intended as an as-needed analgesic.

Criteria:

(a) Persistent, moderate to severe chronic pain **or** cancer-related pain that requires around-the-clock analgesia for an extended period of time; **and**
(b) For chronic pain, failure, intolerance, or contraindication to at least 2 short-acting formulary narcotic analgesics
(c) For cancer pain, failure intolerance, or contraindication to controlled-release morphine (MS Contin, others)

GENERIC: PALIVIZUMAB
BRAND: SYNAGIS®

INDICATION:

(1) Prevention of serious lower respiratory disease caused by respiratory syncytial virus (RSV)

Criteria:

(a) Administration within RSV season (Nov-Apr); **and**
(b) Pt < 2 yrs of age at start of RSV season with chronic lung disease that has required treatment (supplemental oxygen, bronchodilator, diuretic or corticosteroid) within prior 6 months **or**
(c) Pt born ≤ 28 weeks gestation and is ≤ 12 months at the start of the RSV season **or**
(d) Pt born between 29-32 weeks gestation and is ≤ 6 months at the start of the RSV season **or**

(e) Pt ≤ 24 months of age at the start of the RSV season with hemodynamically significant congenital heart disease, including one of the following:
  (1) Receiving medication to control congestive heart failure; **or**
  (2) With moderate to severe pulmonary artery hypertension; **or**
  (3) With cyanotic congenital heart disease; **or**

(f) Pt born between 32-35 weeks gestation, and is ≤3 months at the start of the RSV season **and** has one of the following risk factors:
  (1) Child care attendance; **or**
  (2) Siblings less than 5 years **and** children born between 32-35 weeks receive a maximum of 3 doses; **or**

(g) Is the patient born before 35 weeks of gestation and has either congenital abnormalities of the airway or a neuromuscular condition that compromises handling of respiratory secretions during the first year of life?

Once the prior authorization is received, please contact the Synagis line below:

Phone = 866-230-8102
Fax =888-325-6544

GENERIC: PANTOPRAZOLE
BRAND: PROTONIX®

INDICATIONS:

(1) Gastric hypersecretion, pathological conditions including Zollinger-Ellison Syndrome
(2) Erosive esophagitis - gastroesophageal reflux disease
(3) Erosive esophagitis, maintenance therapy - gastroesophageal reflux disease

Criteria:

(a) Failure, intolerance, or contraindication to at least 1 formulary PPI after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

GENERIC: PEGINTERFERON ALFA-2A
BRAND: PEGASYS ®

INDICATIONS:

(1) Use in combination with ribavirin for the treatment of chronic hepatitis C
(2) Treatment of chronic hepatitis C in patients coinfected with HIV whose HIV is clinically stable.
(3) Treatment of patients with HBeAg positive and HBeAg negative chronic hepatitis B

Criteria:

(In combination with ribavirin)

(a) Diagnosis as indicated above including any applicable labs and/or tests
(b) Clinically documented chronic hepatitis C with detectable HCV RNA levels > 50 IU/mL
(c) Age ≥ 3 years
(d) Liver biopsy (unless contraindicated) indicates some fibrosis and inflammatory necrosis
(e) Intolerant to Peg-Intron
(f) If HIV positive, patient is clinically stable.

(For chronic Hepatitis B)

(a) Documented HBeAg positive or negative chronic hepatitis B
(b) Compensated liver disease
(c) Evidence of viral replication
(d) Evidence of liver inflammation
(e) Not contraindicated

GENERIC: PEGINTERFERON ALFA-2B
BRAND: PEG-INTRON®

INDICATIONS:

(1) Use in combination with ribavirin for the treatment of chronic hepatitis C
(2) Treatment of chronic hepatitis C in patients coinfected with HIV whose HIV is clinically stable.

Criteria:

(In combination with ribavirin)

(a) Diagnosis as indicated above including any applicable labs and/or tests
(b) Clinically documented chronic hepatitis C with detectable HCV RNA levels > 50 IU/mL
(c) Age ≥ 3 years

(d) Liver biopsy (unless contraindicated) indicates some fibrosis and inflammatory necrosis
(e) Intolerant to Peg-Intron
(f) If HIV positive, patient is clinically stable.

GENERIC: PENTOXIFYLLINE
BRAND: TRENTAL®

INDICATION:

(1) Intermittent claudication

Criteria:

(a) Pain on walking **or** ABI < 0.8; **or**
(b) Diabetic foot ulcer; **or**
(c) Gangrene; **or**
(d) Risk of, or existing, amputation.

GENERIC: PIMECROLIMUS
BRAND: ELIDEL®

INDICATION:

(1) Second-line therapy for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children 2 years of age and older, who have failed to respond adequately to other topical prescription treatments, or when treatments are not advisable.

Criteria:

(a) Documented failure of optimal dosing/adequate duration;**or**
(b) Intolerance or contraindication to at least one formulary topical corticosteroid; **and**
(c) Diagnosis of mild to moderate atopic dermatitis; **and**
(d) Using for short-term and non-continuous treatment.

GENERIC: RALOXIFENE
BRAND: EVISTA®

INDICATION:

(1) Treatment and prevention of osteoporosis in postmenopausal women

Criteria:

(a) Personal or family history of breast cancer; **or**
(b) Intolerable side effects to at least one formulary estrogen.

GENERIC: RIBAVIRIN
BRAND: REBETOL®

INDICATION:

(1) Indicated **only** in combination with a recombinant interferon alfa-2a or alfa-2b product for the treatment of chronic hepatitisC.

Criteria:

(a) Diagnosis of chronic hepatitis C; **and**
(b) Patient is receiving concomitant recombinant interferon alfa-2a or alfa-2b therapy.

GENERIC: RILUZOLE
BRAND: RILUTEK®

INDICATION:

(1) Amyotrophic lateral sclerosis (ALS)

Criteria:

(a) Diagnosis of ALS.

GENERIC: RIVASTIGMINE TARTRATE
BRAND: EXELON®

INDICATION:

(1) Alzheimer's disease: for the treatment of dementia

Criteria:

(a) Confirmation by clinical evaluation

GENERIC: RIZATRIPTAN
BRAND: MAXALT®

INDICATION:

(1) Acute treatment of migraine headache

Criteria:

(a) Failure of, intolerance to, or contraindication to one traditional formulary agent (NSAID's, ergotamine, or combination analgesic); **or**
(b) Unsuccessful concurrent or previous use of migraine prophylaxis medications (e.g., beta-blockers, calcium channel blockers, tri-cyclic antidepressants or anticonvulsants); **and**
(c) Patient is not currently using ergotamine or another 5-HT1 Receptor Agonist.

GENERIC: ROPINROLE
BRAND: REQUIP®

INDICATIONS:

(1) For the treatment of signs and symptoms of idiopathic Parkinson's disease.
(2) Moderate to severe primary Restless Leg Syndrome.

Criteria:

(a) Diagnosis of idiopathic Parkinson's disease; **or**
(b) Diagnosis of Restless Leg Syndrome and normal iron stores (serum ferritin and/or iron-binding saturation)

GENERIC: ROSIGLITAZONE MALEATE
BRAND: AVANDIA®

INDICATION:

(1) Type 2 diabetes: As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus

Criteria:

(a) Blood sugar not controlled with any other antidiabetic medications;**and**
(b) Failure or contraindication to use an Actos-containing regimen.

GENERIC: ROSIGLITAZONE MALEATE/GLIMEPIRIDE
BRAND: AVANDARYL®

INDICATION:

(1) Type 2 diabetes: As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus

Criteria:

(a) Blood sugar not controlled with any other antidiabetic medications**and**
(b) Failure or contraindication to use an Actos-containing regimen.

GENERIC: ROSIGLITAZONE MALEATE/METFORMIN
BRAND: AVANDAMET®

INDICATION:

(1) Type 2 diabetes: As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus

Criteria:

(a) Blood sugar not controlled with any other antidiabetic medications **and**

(b) Failure or contraindication to use an Actos-containing regimen.

GENERIC: ROSUVASTATIN CALCIUM
BRAND: CRESTOR®

INDICATION:

(1) Primary prevention of CV disease in patients with multiple risk factors for CHD, diabetes, peripheral vascular disease, history of stroke, or other cerebrovascular disease.

Criteria:

(a) Failure of at least two generic formulary statins after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

GENERIC: SALMETEROL/FLUTICASONE
BRAND: ADVAIR/ADVAIR HFA®

INDICATION:

(1) Long-term, twice–daily maintenance treatment of asthma in patients 4 years of age and older.

Criteria:

(a) Currently on, but not controlled by an inhaled corticosteroid

(b) Twice daily maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease.

Criteria for the 250/50mg Strength:

(a) The 250/50mg strength is the only approved strength for COPD **and**

(b) The patient must be reevaluated after 6 months

**For members currently with an approved prior authorization for Advair, claims will process as long as the member has filled Advair within the last 3 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to Advair therapy, or with no claim history of Advair within the last 3 months.*

GENERIC: SALMETEROL XINAFOATE
BRAND: SEREVENT DISKUS®

INDICATIONS:

(1) Maintenance treatment of asthma and prevention of bronchospasm in adults and children 4 years of age and older
(2) Prevention of exercise-induced bronchospasm in patients 4 years of age and older
(3) Serevent Diskus® is indicated for the maintenance treatment of bronchospasm associated with chronic obstructive pulmonary disease

Criteria:

(a) Currently on but not controlled by an inhaled corticosteroid

GENERIC: SIMVASTATIN 80mg
BRAND: ZOCOR®

INDICATIONS:

(1) Heterozygous or homozygous familial hypercholesterolemia
(2) Familial type 3 hyperlipoproteinemia
(3) Hypertriglyceridemia
(4) Primary hypercholesterolemia, or mixed hyperlipidemia
(5) Decrease cardiovascular event risk in patients with high coronary event risk
(6) Cerebrovascular accident prophylaxis

Criteria:

(a) Age ≤ 65 years
(b) Male gender (female gender predisposed to myopathy including rhabdomyolysis)
(c) Controlled hypothyroidism
(d) Normal renal function
(e) Documentation of all cholesterol lowering agents tried and failed must be provided.

Prior Authorization Guidelines

GENERIC: SOMATROPIN
BRAND: HUMATROPE®

INDICATIONS:

(1) Growth failure in children due to inadequate growth hormone (GH) secretion
(2) Idiopathic short stature in children defined by height standard deviation (SD) score less than or equal to -2.25 and growth rate not likely to attain normal adult height
(3) Short stature in children associated with Turner syndrome

Criteria:

(a) Patient with open epiphyses (as confirmed by radiograph of wrist and hand) who has not reached final height; **and**
(b) Medication prescribed by an endocrinologist; **and**
(c) Patient meets one of the following criteria:
    (1) Growth Hormone Deficiency (GHD) with diagnosis confirmed by one of the following:
        i. Severe short stature defined as patient's height at ≥ 2 SD below the population mean
        ii. Patient's height ≥ 1.5 SD below the midparental height (average of mother's and father's heights)
        iii. Patient's height ≥2 SD below the mean and a 1-year height velocity more than 1 SD below the mean for chronologic age or (in children 2 years of age or older) a 1-year decrease of more than 0.5 SD in height
        iv. In the absence of short stature, a 1-year height velocity more than 2 SD below the mean or a 2-year height velocity more than 1.5 SD below the mean (may occur in GHD manifesting during infancy or in organic, acquired GHD)
        v. Signs indicative of an intracranial lesion
        vi. Signs of multiple pituitary hormone deficiencies
        vii. Neonatal symptoms and signs of GHD

(2) Idiopathic short stature with patient's height at ≥ 2.25 SD below the mean height for normal children of the same age and gender
(3) Short stature associated with Turner syndrome and height below the 5th percentile of normal growth curve

* *To continue therapy, requests will be reviewed every six months. For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

GENERIC: SUCCIMER
BRAND: CHEMET®
INDICATIONS:

(1) Treatment of lead poisoning in children with blood lead levels > 45 mcg/dl
(2) Unlabeled uses: Succimer may be beneficial in the treatment of other heavy metal poisonings

Criteria:

(a) Diagnosis of lead poisoning with blood levels > 45mcg/dl; **and**
(b) Child is hospitalized; **or**
(c) Child was started on the medication in the hospital and needs to continue upon discharge.

GENERIC: SUCRALFATE SUSPENSION
BRAND: CARAFATE®

INDICATIONS:

(1) Gastric ulcers
(2) Duodenal ulcers
(3) Gastritis
(4) GERD

Criteria:

(a) For patients who have a contraindication or failure of sucralfate tablets

GENERIC: TELAPREVIR
BRAND: INCIVEK ®

INDICATION:

(1) Treatment of chronic hepatitis C genotype 1 used in combination with peginterferon alfa and ribavirin

Criteria:

(a) Diagnosis of chronic hepatitis C genotype 1; **and**
(b) Diagnosis of compensated liver disease; **and**
(c) No previous treatment (full or partial course) of Incivek or Victrelis; **and**
(d) Patient has been counseled on the importance of medication adherence and is willing to adhere to the regimen for the full course of therapy; **and**
(e) The patient must have completed 4 weeks of peginterferon and ribavirin therapy (treatment weeks 1 through 4); **and**
(f) HCV-RNA levels must be drawn at treatment weeks 4, 12, and 24
(g) Females of child bearing potential must meet the following parameters:
    (1) A recent negative pregnancy test; **and**
    (2) Been counseled on the teratogenic effects of triple therapy; **and**
    (3) Is willing to practice contraception during and for 6 months after completion of therapy

GENERIC: TERIFLUNOMIDE
BRAND: AUBAGIO®

INDICATION:

(1) Diagnosis of a relapsing form of Multiple Sclerosis

Criteria:

(a) Prescribed by neurologist; and
(b) Not requesting combination of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera.

GENERIC: TESTOSTERONE
BRAND: ANDROGEL®, TESTIM®

INDICATION:
(1) Hypogonadism
Criteria:
(a) Must be rescribed by an Endocrinologist
(b) Initial therapy: The patient has documented low testosterone concentration
(c) Renewal: The patient has documented therapeutic concentration to confirm response

GENERIC: THROMBIN
BRAND: THROMBIN

INDICATION:
(1) Hemostasis
Criteria:
(a) Diagnosis of a bleeding disorder

GENERIC: TRAMADOL ER
BRAND: ULTRAM ER®

INDICATION:
(1) Pain, chronic (moderate to severe)
Criteria:
(a) For patients who have a contraindication or failure of tramadol regular release tablets

GENERIC: VARENCLINE
BRAND: CHANTIX®

INDICATION:
(1) Management of smoking cessation
Criteria:
(a) Physician has confirmed that the patient has no history of psychiatric illness (including, but not limited to, depression).
(b) Physician has counseled the patient to self-monitor mood and behavior while on Chantix, and to contact their physician immediately if they experience any changes in mood or behavior.
(c) Physician must provide evidence that patient has completed smoking cessation class.
Quantity Limit of 12 weeks of therapy per 12-month period

Prior Authorization Guidelines

GENERIC: ZOLMITRIPTAN TABLETS
BRAND: ZOMIG ®

INDICATION:

(1) Acute treatment of migraine headache

Criteria:

(a) Failure of, intolerance to, or contraindication to one traditional formulary agent (NSAID, ergotamine, or combination analgesic); **or**

(b) Unsuccessful concurrent or previous use of migraine prophylaxis medications (e.g., beta-blockers, calcium channel blockers, tri-cyclic antidepressants or anticonvulsants); **and**

(c) Patient is not currently using ergotamine or another 5-HT1 Receptor Agonist

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