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: 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 severe 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: 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

Prior Authorization Guidelines

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®

INDICATIONS:

(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 claim 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**
(b) 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
(c) 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.

Prior Authorization Guidelines

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

Prior Authorization Guidelines

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, Betaseron, Copaxone, Extavia, Gilenya, Rebif, 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: 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.

Prior Authorization Guidelines

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

Prior Authorization Guidelines

GENERIC: ETANERCEPT
BRAND: ENBREL®
INDICATION:

(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 2 diabetes; **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

Prior Authorization Guidelines

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®

INDICATIONS:
(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:

(b) 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®

INDICATION:
(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, Novantrone, Betaseron, Avonex, Tysabri or Rebif

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

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, Novantrone, Betaseron, Avonex, Tysabri or Rebif

Prior Authorization Guidelines

** 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.*

Prior Authorization Guidelines

GENERIC: LIDOCAINE PATCH 5%
BRAND: LIDODERM ®

INDICATION:

(1) Relief of pain associated with post-herpetic neuralgia

Criteria:

(a) Skin application site is intact **and**
(b) For the relief of pain associated with post-herpetic neuralgia **or**
(c) For non-neuropathic pain, failure, adverse reaction, or contraindication to two prescribed prescription analgesics

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

Prior Authorization Guidelines

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: 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).

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®

INDICATIONS:

(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 = 866-807-0516
Fax =800-784-6283

GENERIC: PANTOPRAZOLE
BRAND: PROTONIX®

INDICATION:

(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 ®

INDICATION:

(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®

INDICATION:

(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.

Prior Authorization Guidelines

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

Prior Authorization Guidelines

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®

INDICATION:

(1) For the treatment of signs and symptoms of idiopathic Parkinson's disease.

(2) Moderate to severe primary Restless Legs 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.

Prior Authorization Guidelines

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 ®

INDICATION:

(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.

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.*

Prior Authorization Guidelines

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: THROMBIN
BRAND: THROMBIN

INDICATION:
(1) Hemostasis

Criteria:
(a) Diagnosis of a bleeding disorder

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