

## **Prior Authorization Guidelines**

Please note that any opioids with a dosage higher than 90MME per day and any long acting opioids will require a completed attestation form in addition to any other prior authorization requirements.

**GENERIC:** ACARBOSE

**BRAND:** PRECOSE<sup>®</sup>

**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<sup>®</sup>

**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

**GENERIC:** ACYCLOVIR TOPICAL OINTMENT

**BRAND:** ZOVIRAX<sup>®</sup> 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<sup>®</sup>

**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

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### **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:** KOATE-DVI<sup>®</sup>, FEIBA VH<sup>®</sup>, ECOMBIMATE<sup>®</sup>,  
THROMBATE III<sup>®</sup>

#### **INDICATION:**

- (1) Hemophilia A

#### **Criteria:**

- (a) Diagnosis of Hemophilia A

### **GENERIC: AZELASTINE**

**BRAND:** ASTELIN<sup>®</sup>

#### **INDICATIONS:**

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

#### **Criteria:**

- (a) Patient is  $\geq 5$  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: BRIMONIDINE**

**BRAND:** ALPHAGAN 0.2%<sup>®</sup>, ALPHAGAN P 0.15%<sup>®</sup>

#### **INDICATION:**

- (1) Glaucoma

#### **Criteria:**

- (a) Failure of formulary ophthalmic beta blocker (betaxolol, Timolol, dorzolamide/timolol)

### **GENERIC: BUDESONIDE/FORMOTEROL**

**BRAND:** SYMBICORT<sup>®</sup>

#### **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

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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 4 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 4 months. Once approved, 90-day supplies are allowed.*

### **GENERIC: CALCITONIN-SALMON**

**BRAND:** MIACALCIN<sup>®</sup>

#### **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  $\geq 2.5$  standard deviations below the mean for normal, young adults of same gender (T-score  $\leq -2.5$ ); **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  $< 21 \text{ kg/m}^2$
    - (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  $>7.5\text{mg}$  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  $< -1.0$ )

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

**BRAND:** INVOKANA®

#### **INDICATION:**

(1) Type 2 diabetes mellitus

#### **Criteria:**

- (a) Diagnosis of Type 2 diabetes mellitus
- (b) Has not achieved adequate glycemic control on at least ONE of the following:
  - (1) Metformin (alone or in a combination)
  - (2) Sulfonylurea (alone or in a combination)
  - (3) A preferred DPP-4 (Januvia)
- (c) Contraindication to BOTH metformin and a sulfonylurea
- (d) Contraindication to a preferred DPP-4 inhibitor

### **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

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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 opioid analgesics or topical analgesics (capsaicin, etc.)

### **GENERIC: CHOLINE FENOFIBRATE**

**BRAND:** TRILIPIX<sup>®</sup>

#### **INDICATION:**

- (1) Hypercholesterolemia, Hypertriglyceridemia

#### **Criteria:**

- (a) Failure of generic fenofibrate 48, 54, 154 or 160 mg 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<sup>®</sup>

#### **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.*

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### **GENERIC: DACLATASVIR DIHYDROCHLORIDE**

**BRAND:** DAKLINZA<sup>®</sup>

**INDICATION:**

- (1) Chronic Hepatitis C

**Criteria:**

- (a) Must follow the clinical criteria as set by the Maryland Department of Health and Mental Hygiene
- (b) Must have chronic Hepatitis C, genotype and sub-genotype specified to determine the length of therapy; **and**
- (c) Liver biopsy or other accepted test demonstrating liver fibrosis corresponding to Metavir score of greater than or equal to 2; **and**
- (d) Consult performed and medication prescribed by provider specializing in infectious disease, gastroenterology, hepatology, or Hepatitis C
- (e) Special Hepatitis C PA request forms, treatment plan template, and full criteria can be obtained at <http://www.jaimedicalsystems.com/providers/pharmacy/> or by contacting ProCare at 1-800-555-8513
- (f) Must provide reason preferred agents Zepatier, Epclusa, or Mavyret are not appropriate.

### **GENERIC: DABIGATRAN ETEXILATE MESYLATE**

**BRAND:** PRADAXA<sup>®</sup>

**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<sup>®</sup>

**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,

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Tecfidera or Tysabri)

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

**GENERIC:** DANTROLENE

**BRAND:** DANTRIUM<sup>®</sup>

**INDICATION:**

- (1) Spasticity resulting from upper motor neuron disorders

**Criteria:**

- (a) Demonstrated failure of, or intolerance to, Baclofen (Lioresal<sup>®</sup>).

**GENERIC:** DARBEPOETIN ALFA

**BRAND:** ARANESP<sup>®</sup>

**INDICATIONS:**

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

**Criteria:**

- (a) Ensure patient's iron stores are adequate (Ferritin  $\geq$  100 ng/mL and/or Transferrin saturation  $\geq$  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  $<10\text{g/dL}$ ; **or Anemia due to chemotherapy in cancer:**

- (a) Initiate treatment only if hemoglobin is  $<10\text{g/dL}$ ; **and**

- (b) Anticipated duration of myelosuppressive chemotherapy is  $\geq$  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:** DARIFENACIN

**BRAND:** ENABLEX<sup>®</sup>

**INDICATION:**

- (1) Overactive bladder

**Criteria:**

- (a) Failure of Oxybutynin

**GENERIC:** DESMOPRESSIN

**BRAND:** DDAVP<sup>®</sup>

**INDICATIONS:**

- (1) Central cranial diabetes insipidus (CCDI)

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(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: DICLOFENAC GEL 1%**

**INDICATION:**

- (1) topical non-steroidal anti-inflammatory drug for the relief of pain

**Criteria:**

- (a) Trial and failure OR contraindication to oral diclofenac

**GENERIC: DIMETHYL FUMERATE**

**BRAND: TECFIDERA<sup>®</sup>**

**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, Gilenya, Aubagio or Tecfidera.

**GENERIC: DONEPEZIL**

**BRAND: ARICEPT<sup>®</sup>**

**INDICATION:**

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

**Criteria:**

- (a) Dementia must be confirmed by clinical evaluation

**GENERIC: ELBASVIR-GRAZOPREVR**

**BRAND: ZEPATIER<sup>®</sup>**

**INDICATION:**

- (1) Chronic Hepatitis C

**Criteria:**

- (a) Must follow the clinical criteria as set by the Maryland department of Health and Mental Hygiene
- (b) Must have chronic Hepatitis C, genotype and sub-genotype specified to determine the length of therapy; **and**
- (c) Liver biopsy or other accepted test demonstrating liver fibrosis corresponding to Metavir score of greater than or equal to 2; **and**
- (d) Consult performed and medication prescribed by provider specializing in infectious disease, gastroenterology, hepatology or Hepatitis C



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- (e) Special Hepatitis C PA request forms, treatment plan template, and full criteria can be obtained at <http://www.jaimedicalsystems.com/providers/pharmacy/> or by contacting ProCare at 1-800-555-8513

**GENERIC:** EMPAGLIFLOZIN

**BRAND:** JARDIANCE

**INDICATION:**

- (1) Type II Diabetes Mellitus

**Criteria:**

- (a) Failure of metformin, a sulfonylurea, or pioglitazone

**GENERIC:** EMPAGLIFLOZIN-LINAGLIPTIN

**BRAND:** GLYXAMBI

**INDICATION:**

- (2) Type II Diabetes Mellitus

**Criteria:**

- (a) For use when an SGLT2 and a DPP-4 Inhibitor is appropriate

**GENERIC:** ENTACAPONE

**BRAND:** COMTAN<sup>®</sup>

**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:** EPOGEN<sup>®</sup>

**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  $\geq$  100 mcg/mL and/or Transferrin saturation  $\geq$  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

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duration of myelosuppressive chemotherapy is  $\geq 2$  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  $\leq 13$  g/dL (14 day approval)

### **For renewals:**

### **Chronic kidney disease patients:**

- (a) With dialysis Hgb  $< 11$
- (b) Without dialysis Hgb  $< 10$

### **Anemia due to chemotherapy in cancer patients:**

- (a) Hgb  $< 11$

### **Anemia due to zidovudine in HIV-infected patients:**

- (a) Hgb  $< 11$

## **GENERIC: ETANERCEPT**

**BRAND:** ENBREL<sup>®</sup>

### **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**
- (a) The patient has failed or is intolerant to one formulary DMARD

### **Additional Criteria for Plaque Psoriasis:**

- (a) Involvement of  $\geq 10\%$  body surface area (BSA)

## **GENERIC: EXENATIDE**

**BRAND:** BYETTA<sup>®</sup>

### **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  $\geq 7.0$ ; **and**
- (c) Patient  $\geq 18$  years of age

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**GENERIC:** EZETIMIBE

**BRAND:** ZETIA<sup>®</sup>

**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<sup>®</sup>

**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<sup>®</sup>, TRIGLIDE<sup>®</sup>

**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<sup>®</sup>

**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 TAB

**BRAND:** FIBRICOR<sup>®</sup>

**INDICATIONS:**

- (1) Hypercholesterolemia
- (2) Hypertriglyceridemia

**Criteria:**

- (a) Failure of generic Fenofibrates

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### **GENERIC: FENTANYL TRANSDERMAL PATCH**

**BRAND:** DURAGESIC<sup>®</sup>

**INDICATION:**

- (1) Persistent, moderate to severe chronic pain OR cancer-related pain that requires continuous, around-the-clock opioid (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 opioid 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: FESOTERODINE**

**BRAND:** TOVIAZ<sup>®</sup>

**INDICATION:**

- (1) Overactive bladder

**Criteria:**

- (a) Failure of Oxybutynin

### **GENERIC: FILGRASTIM**

**BRAND:** NEUPOGEN<sup>®</sup>

**INDICATIONS:**

- (1) Prevention of neutropenia in patients receiving myelosuppressive 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.*

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### **GENERIC: FLUCONAZOLE**

**BRAND:** DIFLUCAN<sup>®</sup>

(PA required after 150mg x2 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<sup>®</sup>, RAZADYNE ER<sup>®</sup>

**INDICATION:**

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

**Criteria:**

- (a) Confirmation by clinical evaluation

### **GENERIC: GATIFLOXACIN**

**BRAND:** ZYMAXID<sup>®</sup>

**INDICATION:**

- (1) Bacterial conjunctivitis

**Criteria:**

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

### **GENERIC: GLATIRAMER ACETATE**

**BRAND:** COPAXONE<sup>®</sup>

**INDICATIONS:**

- (1) Relapsing-remitting Multiple Sclerosis
- (2) To prevent or slow the development of clinically definite Multiple Sclerosis in patients who have 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

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**GENERIC:** GLECAPREVIR-PIBRENTASVIR

**BRAND:** MAVYRET<sup>®</sup>

**INDICATION:**

- (1) Chronic Hepatitis C

**Criteria:**

- (a) Must follow the clinical criteria as set by the Maryland department of Health and Mental Hygiene
- (b) Must have chronic Hepatitis C, genotype and sub-genotype specified to determine the length of therapy; **and**
- (c) Liver biopsy or other accepted test demonstrating liver fibrosis corresponding to Metavir score of greater than or equal to 2; **and**
- (d) Consult performed and medication prescribed by provider specializing in infectious disease, gastroenterology, hepatology or Hepatitis C
- (e) Special Hepatitis C PA request forms, treatment plan template, and full criteria can be obtained at <http://www.jaimedicalsystems.com/providers/pharmacy/> or by contacting ProCare at 1-800-555-8513

**GENERIC:** INTERFERON ALFA

**BRAND:** ROFERON-A<sup>®</sup>, INTRON-A<sup>®</sup>, and ALFERON N<sup>®</sup>

**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<sup>®</sup>, BETASERON<sup>®</sup>, REBIF<sup>®</sup>

**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.*

## **Prior Authorization Guidelines**

*formulary.*

**GENERIC:** ISOSORBIDE MONONITRATE

**BRAND:** IMDUR<sup>®</sup>

**INDICATION:**

(1) Prevention of angina pectoris

**Criteria:**

(a) Failure of formulary nitrates.

**GENERIC:** ITRACONAZOLE

**BRAND:** SPORANOX<sup>®</sup>

**INDICATIONS:**

(1) Histoplasmosis infections

(2) Aspergillosis infections

(3) Blastomycosis

**Criteria:**

(a) Any of the above diagnoses.

**GENERIC:** LANSOPRAZOLE

**BRAND:** PREVACID SOLU-TAB<sup>®</sup>

**INDICATION:**

(1) Prevention of angina pectoris

**Criteria:**

(a) Unable to ingest a solid dosage form (e.g. oral tablet or capsule) due to one of the following:

(1) Age

(2) Oral/motor difficulties

(3) Dysphagia

(4) Patient utilizes a feeding tube for medication administration

**GENERIC:** LEDIPASVIR-SOFOSBUVIR

**BRAND:** HARVONI<sup>®</sup>

**INDICATION:**

(1) Chronic Hepatitis C

**Criteria:**

(a) Must follow the clinical criteria as set by the Maryland Department of Health and Mental Hygiene

(b) Must have chronic Hepatitis C, genotype and sub-genotype specified to determine the length of therapy; **and**

(c) Liver biopsy or other accepted test demonstrating liver fibrosis corresponding to Metavir score of greater than or equal to 2; **and**

(d) Consult performed and medication prescribed by provider specializing in infectious disease, gastroenterology, hepatology, or Hepatitis C

(e) Special Hepatitis C PA request forms, treatment plan template, and

## **Prior Authorization Guidelines**

full criteria can be obtained at

<http://www.jaimedicalsystems.com/providers/pharmacy/> or by

contacting ProCare at 1-800-555-8513

- (f) Must provide reason preferred agents Zepatier, Epclusa, or Mavyret are not appropriate.

### **GENERIC: LEUPROLIDE**

**BRAND:** LUPRON<sup>®</sup>

#### **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: LIDOCAINE PATCH 5%**

**BRAND:** LIDODERM PATCH 5%<sup>®</sup>

#### **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; **and**
- (c) Failure, adverse reaction, or contraindication to two prescription analgesics, including lidocaine 4% cream or gel.

### **GENERIC: LIRAGLUTIDE**

**BRAND:** VICTOZA<sup>®</sup>

#### **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**



## **Prior Authorization Guidelines**

- (d) Must have tried and failed or intolerant to treatment with Byetta; **and**
- (e) NO personal or family history of medullary thyroid carcinoma

**GENERIC:** LODOXAMDE TROMETHAMINE OPHTH SOLN 0.1%

**BRAND:** ALOMIDE<sup>®</sup>

**INDICATION:**

- (1) Allergic conjunctivitis

**Criteria:**

- (a) Failure or contraindication of Ketotifen

**GENERIC:** MEMANTINE

**BRAND:** NAMENDA<sup>®</sup>

**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<sup>®</sup>

**INDICATION:**

- (1) Bacterial vaginosis

**Criteria:**

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

**GENERIC:** MILNACIPRAN

**BRAND:** SAVELLA<sup>®</sup>

**INDICATION:**

- (1) Moderate to severe fibromyalgia

**Criteria:**

- (a) Diagnosis of fibromyalgia; **and**
- (b) Documented failure or contraindication to:
  - (1) Pain relievers (e.g. Tramadol); **or**
  - (2) Muscle Relaxants (e.g. cyclobenzaprine, Baclofen)

**GENERIC:** MIRABEGRON

**BRAND:** MYRBETRIQ<sup>®</sup>

**INDICATION:**

- (1) Overactive bladder

**Criteria:**

- (a) Failure of Oxybutynin

## **Prior Authorization Guidelines**

### **GENERIC: MOXIFLOXACIN**

**BRAND:** AVELOX<sup>®</sup>

**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  $\geq$  18 years of age with any of the above listed indications when:

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

### **GENERIC: NAFARELIN**

**BRAND:** SYNAREL<sup>®</sup>

**INDICATIONS:**

- (1) Central precocious puberty
- (2) Endometriosis

**Criteria:**

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

### **GENERIC: NUTRITIONAL SUPPLEMENTS**

**BRAND:** ENSURE<sup>®</sup>, PEDIASURE<sup>®</sup>, BOOST<sup>®</sup>, VIVONEX<sup>®</sup>

**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<sup>®</sup>

**INDICATIONS:**

- (1) Symptomatic treatment of severe diarrhea and flushing episodes associated with metastatic carcinoid tumors

## **Prior Authorization Guidelines**

- (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 cannot 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.*

**GENERIC:** OLODATEROL HCL

**BRAND:** STRIVERDI<sup>®</sup>

**INDICATION:**

- (1) COPD

**Criteria:**

- (a) Patient must be on, and not currently controlled on, an ICS (inhaled corticosteroid)

**GENERIC:** OLOPATADINE HCL OPHTH SOLN 0.2%

**BRAND:** PATADAY<sup>®</sup>

**INDICATION:**

- (1) Allergic conjunctivitis

**Criteria:**

- (a) Failure or contraindication to Ketotifen

**GENERIC:** OLOPATADINE HCL OPHTH SOLN 0.1%

**BRAND:** PATANOL<sup>®</sup>

**INDICATION:**

- (1) Allergic conjunctivitis

**Criteria:**

- (a) Failure or contraindication of Ketotifen

**GENERIC:** OMBITAS-PARITAPRE-RITON & DASAB

**BRAND:** VIEKIRA<sup>®</sup> / VIEKIRA XR<sup>®</sup>

**INDICATION:**

- (1) Chronic Hepatitis C

**Criteria:**

- (a) Must follow the clinical criteria as set by the Maryland department of Health and Mental Hygiene
- (b) Must have chronic Hepatitis C, genotype and sub-genotype specified to determine the length of therapy; **and**
- (c) Liver biopsy or other accepted test demonstrating liver fibrosis

## **Prior Authorization Guidelines**

- corresponding to Metavir score of greater than or equal to 2; **and**
- (d) Consult performed and medication prescribed by provider specializing in infectious disease, gastroenterology, hepatology, or Hepatitis C
  - (e) Special Hepatitis C PA request forms, treatment plan template, and full criteria can be obtained at <http://www.jaimedicalsystems.com/providers/pharmacy/> or by contacting ProCare at 1-800-555-8513
  - (f) Must provide reason preferred agents Zepatier, Epclusa, or Mavyret are not appropriate.

### **GENERIC: OMBITAS-PARITAPREVIR-RITONAVIR**

**BRAND:** TECHNIVIE<sup>®</sup>

#### **INDICATION:**

- (1) Chronic Hepatitis C

#### **Criteria:**

- (a) Must follow the clinical criteria as set by the Maryland department of Health and Mental Hygiene
- (b) Must have chronic Hepatitis C, genotype and sub-genotype specified to determine the length of therapy; **and**
- (c) Liver biopsy or other accepted test demonstrating liver fibrosis corresponding to Metavir score of greater than or equal to 2; **and**
- (d) Consult performed and medication prescribed by provider specializing in infectious disease, gastroenterology, hepatology, or Hepatitis C
- (e) Special Hepatitis C PA request forms, treatment plan template, and full criteria can be obtained at <http://www.jaimedicalsystems.com/providers/pharmacy/> or by contacting ProCare at 1-800-555-8513
- (f) Must provide reason preferred agents Zepatier, Epclusa, or Mavyret are not appropriate.

### **GENERIC: ONDANSETRON SOLUTION**

**BRAND:** ZOFRAN<sup>®</sup>

#### **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 ondansetron tablets

### **GENERIC: OXYCODONE, CONTROLLED-RELEASE**

**BRAND:** OXYCONTIN<sup>®</sup>

#### **INDICATION:**

- (1) Persistent, moderate to severe chronic pain **or** cancer-related pain that requires continuous, around-the-clock opioid (narcotic)

## **Prior Authorization Guidelines**

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 and controlled-release morphine (MS Contin, others)
- (c) For cancer pain, failure intolerance, or contraindication to controlled-release morphine (MS Contin, others)

### **GENERIC: PALIVIZUMAB**

**BRAND:** SYNAGIS<sup>®</sup>

### **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  $\leq$  28 weeks gestation and is  $\leq$  12 months at the start of the RSV season **or**
- (d) Pt born between 29-32 weeks gestation and is  $\leq$  6 months at the start of the RSV season **or**
- (e) Pt  $\leq$  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  $\leq$  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 your Synagis provider. One such provider is Walgreens Specialty pharmacy:**

**Phone** = 866-230-8102

**Fax** = 888-325-6544

## **Prior Authorization Guidelines**

**GENERIC:** PANTOPRAZOLE

**BRAND:** PROTONIX<sup>®</sup>

**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 2 formulary PPIs after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

**GENERIC:** PEGINTERFERON ALFA-2A

**BRAND:** PEGASYS<sup>®</sup>

**INDICATIONS:**

- (1) Use in combination with ribavirin or ribavirin and other Direct-Acting Antivirals for the treatment of chronic Hepatitis C
- (2) Treatment of chronic Hepatitis C in patients coinfecting 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 or ribavirin and other Direct- Acting Antivirals)**

- (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<sup>®</sup>

**INDICATIONS:**

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

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### **Criteria:**

**(In combination with ribavirin or ribavirin and other Direct-Acting Antivirals)**

- (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  $\geq$  3 years
- (d) Liver biopsy (unless contraindicated) indicates some fibrosis and inflammatory necrosis
- (e) If HIV positive, patient is clinically stable.

**GENERIC:** PENTOXIFYLLINE

**BRAND:** TRENTAL<sup>®</sup>

### **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:** PHYTONADIONE 5MG

**BRAND:** MEPHYTON<sup>®</sup>

### **INDICATION:**

- (1) Anticoagulant-induced prothrombin deficiency

### **Criteria:**

- (a) Diagnosis of anticoagulant-induced prothrombin deficiency caused by coumadin or indandione derivatives

**GENERIC:** PIMECROLIMUS

**BRAND:** ELIDEL<sup>®</sup>

### **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<sup>®</sup>

**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<sup>®</sup>

**INDICATION:**

- (1) Indicated **only** in combination with a recombinant interferon alfa-2a or alfa-2b product or in combination with other Direct- Acting Antivirals for the treatment of chronic Hepatitis C.

**Criteria:**

- (a) Diagnosis of chronic Hepatitis C; **and**
- (b) Patient is receiving concomitant recombinant interferon alfa-2a or alfa-2b therapy or other Direct-Acting Antivirals.

**GENERIC:** REPAGLINIDE

**BRAND:** PRANDIN

**INDICATION:**

- (1) Type 2 diabetes mellitus

**Criteria:**

- (a) Diagnosis of Type 2 diabetes mellitus
- (b) Has not achieved adequate glycemic control on at least ONE of the following:
  - (1) Metformin (alone or in combination)
  - (2) A Sulfonylurea (alone or in combination)
  - (3) A preferred DPP-4 inhibitor
- (c) Contraindication of BOTH metformin and a sulfonylurea
- (d) Contraindication to a preferred DPP-4 inhibitor

**GENERIC:** RILUZOLE

**BRAND:** RILUTEK<sup>®</sup>

**INDICATION:**

- (1) Amyotrophic lateral sclerosis (ALS)

**Criteria:**

- (a) Diagnosis of ALS.



## **Prior Authorization Guidelines**

**GENERIC:** RIVASTIGMINE TARTRATE

**BRAND:** EXELON<sup>®</sup>

**INDICATION:**

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

**Criteria:**

- (a) Confirmation by clinical evaluation

**GENERIC:** RIZATRIPTAN

**BRAND:** MAXALT<sup>®</sup>

**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-HT<sub>1</sub> Receptor Agonist.

**GENERIC:** ROPINROLE

**BRAND:** REQUIP<sup>®</sup>

**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<sup>®</sup>

**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.

## **Prior Authorization Guidelines**

**GENERIC:** ROSIGLITAZONE MALEATE/GLIMEPIRIDE

**BRAND:** AVANDARYL<sup>®</sup>

**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<sup>®</sup>

**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<sup>®</sup>

**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<sup>®</sup> / ADVAIR HFA<sup>®</sup>

**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*

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*4 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 4 months. Once approved, 90-day supplies are allowed.*

**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:** SIMEPREVIR

**BRAND:** OLYSIO®

**INDICATION:**

- (1) Chronic Hepatitis C

**Criteria:**

- (a) Must follow the clinical criteria as set by the Maryland Department of Health and Mental Hygiene
- (b) Must have chronic Hepatitis C, genotype and sub-genotype specified to determine the length of therapy; **and**
- (c) Liver biopsy or other accepted test demonstrating liver fibrosis corresponding to Metavir score of greater than or equal to 2; **and**
- (d) Consult performed and medication prescribed by provider specializing in infectious disease, gastroenterology, hepatology, or Hepatitis C
- (e) Special Hepatitis C PA request forms, treatment plan template, and full criteria can be obtained at <http://www.jaimedicalsystems.com/providers/pharmacy/> or by contacting ProCare at 1-800-555-8513
- (f) Must provide reason preferred agents Zepatier, Epclusa, or Mavyret are not appropriate.

**GENERIC:** SIMVASTATIN 80mg

**BRAND:** ZOCOR®

**INDICATIONS:**

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

## **Prior Authorization Guidelines**

coronary event risk

(7) Cerebrovascular accident prophylaxis

**Criteria:**

- (a) Age :S 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: SITAGLIPTIN PHOSPHATE**

**BRAND:** JANUVIA<sup>®</sup>

**INDICATION:**

(1) Type 2 Diabetes Mellitus

**Criteria:**

- (a) Diagnosis of type 2 diabetes mellitus and
- (b) Must be used adjunct to diet and exercise and
- (c) Failure or contraindication to metformin or
- (d) Failure or contraindication of sulfonylurea or thiazolidinedione

**GENERIC: SOFOSBUVIR**

**BRAND:** SOVALDI<sup>®</sup>

**INDICATION:**

(1) Chronic Hepatitis C

**Criteria:**

- (a) Must follow the clinical criteria as set by the Maryland Department of Health and Mental Hygiene
- (b) Must have chronic Hepatitis C, genotype and sub-genotype specified to determine the length of therapy; **and**
- (c) Liver biopsy or other accepted test demonstrating liver fibrosis corresponding to Metavir score of greater than or equal to 2; **and**
- (d) Consult performed and medication prescribed by provider specializing in infectious disease, gastroenterology, hepatology or Hepatitis C
- (e) Special Hepatitis C PA request forms, treatment plan template, and full criteria can be obtained at <http://www.jaimedicalsystems.com/providers/pharmacy/> or by contacting ProCare at 1-800-555-8513
- (f) Must provide reason preferred agents Zepatier, Epclusa, or Mavyret are not appropriate.

**GENERIC: SOFOSBUVIR-VELPATASVIR**

**BRAND:** EPCLUSA<sup>®</sup>

**INDICATION:**

(1) Chronic Hepatitis C

**Criteria:**

## **Prior Authorization Guidelines**

- (a) Must follow the clinical criteria as set by the Maryland department of Health and Mental Hygiene
- (b) Must have chronic Hepatitis C, genotype and sub-genotype specified to determine the length of therapy; **and**
- (c) Liver biopsy or other accepted test demonstrating liver fibrosis corresponding to Metavir score of greater than or equal to 2; **and**
- (d) Consult performed and medication prescribed by provider specializing in infectious disease, gastroenterology, hepatology or Hepatitis C
- (e) Special Hepatitis C PA request forms, treatment plan template, and full criteria can be obtained at <http://www.jaimedicalsystems.com/providers/pharmacy/> or by contacting ProCare at 1-800-555-8513

**GENERIC:** SOLIFENACIN

**BRAND:** VESICARE<sup>®</sup>

**INDICATION:**

- (1) Overactive bladder

**Criteria:**

- (a) Failure of Oxybutynin

**GENERIC:** SOMATROPIN

**BRAND:** HUMATROPE<sup>®</sup>

**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  $\geq 2$  SD below the population mean
    - ii. Patient's height  $\geq 1.5$  SD below the midparental height (average of mother's and father's heights)
    - iii. Patient's height  $\geq 2$  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

## **Prior Authorization Guidelines**

- 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  $\geq 2.25$  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 5<sup>th</sup> 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<sup>®</sup>

#### **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  $> 45$ mcg/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<sup>®</sup>

#### **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: TACROLIMUS**

**BRAND:** PROTOPIC<sup>®</sup>

#### **INDICATION:**

- (1) Moderate to severe atopic dermatitis

#### **Criteria:**

- (a) Patient must be non-immunocompromised **and**
- (b) Must be at least 2 years of age or

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- older for the 0.03% strength; **or**
- (c) 16 years of age or older for 0.1% strength **and**
- (d) Diagnosis of atopic dermatitis
- (e) Documented failure of 2 different topical corticosteroids of medium to high potency in the past 90 days
- (f) Must be prescribed by a dermatologist, allergist, or for children, a pediatrician

**GENERIC:** TERIFLUNOMIDE

**BRAND:** AUBAGIO<sup>®</sup>

**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<sup>®</sup>, TESTIM<sup>®</sup>

**INDICATION:**

- (1) Hypogonadism

**Criteria:**

- (a) Must be prescribed by an Endocrinologist
- (b) Initial therapy: The patient has documented low testosterone concentration
- (c) Renewal: The patient has documented therapeutic concentration to confirm response

**Criteria for transgender members:**

- (a) Referral from mental health professional; **and**
- (b) Persistent, well-documented gender dysphoria; **and**
- (c) Capacity to make fully informed decision and to consent for treatment; **and**
- (d) 18 years of age or older

**GENERIC:** THROMBIN

**BRAND:** THROMBIN

**INDICATION:**

- (1) Hemostasis

**Criteria:**

- (a) Diagnosis of a bleeding disorder

**GENERIC:** TOLTERODINE

**BRAND:** DETROL<sup>®</sup>/DETROL LA<sup>®</sup>

**INDICATION:**

- (1) Overactive bladder

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**Criteria:**

- (a) Failure of oxybutynin

**GENERIC:** TRAMADOL ER

**BRAND:** ULTRAM ER<sup>®</sup>

**INDICATION:**

- (1) Pain, chronic (moderate to severe)

**Criteria:**

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

**GENERIC:** TROSPIMUM

**BRAND:** SANCTURA<sup>®</sup>

**INDICATION:**

- (1) Overactive bladder

**Criteria:**

- (a) Failure of Oxybutynin

**GENERIC:** UMECLIDINIUM BROMIDE/VILANTEROL  
RIFENATATE

**BRAND:** ANORO ELLIPTA<sup>®</sup>

**INDICATION:**

- (1) Chronic obstructive pulmonary disease (COPD): maintenance of airflow obstruction in patients with COPD, including chronic bronchitis and emphysema.

**Criteria:**

- (a) Trial of long acting or short acting inhaled anticholinergic (Spiriva, Tudorza, Atrovent) within the last 120 days without adequate control of symptoms

**GENERIC:** VALSARTAN

**BRAND:** DIOVAN<sup>®</sup>

**INDICATION:**

- (1) Hypertension

**Criteria:**

- (a) Failure or contraindication of 2 formulary ARBs (irbesartan, Losartan)

**GENERIC:** ZOLMITRIPTAN TABLETS

**BRAND:** ZOMIG<sup>®</sup>

**INDICATION:**

- (1) Acute treatment of migraine headache

**Criteria:**

- (a) Failure of, intolerance to, or contraindication to one traditional



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- 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-HT<sub>1</sub> Receptor Agonist