COLORADO
Department of Health Care Policy & Financing

Colorado Department of Health Care Policy and Financing
Preferred Drug List (PDL)

Effective January 1, 2016

PA Forms: available online at https://www.colorado.gov/hcpf/provider-forms

The PDL applies to Medicaid fee-for-service members. It does not apply to members enrolled in Rocky Mountain Health HMO or Denver Health Medicaid Choice.

Brand Name Required = BNR, Prior Authorization = PA

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred products will be approved for one year unless otherwise stated.)
ALZHEIMER'S AGENTS *Effective 4/1/2015*	**No PA Required (*Must meet eligibility criteria)** Donepezil tab Donepezil ODT Galantamine Galantamine ER NAMENDA IR	**PA Required** ARICEPT (donepezil) ARICEPT 23mg (donepezil) ARICEPT ODT (donepezil) EXELON (rivastigmine) (cap, soln. and patch) MESTINON (pyridostigmine) (tab, syrup) NAMENDA XR (memantine) NAMZARIC (memantine/donepezil) RAZADYNE (galantamine) (tab, oral soln) RAZADYNE ER (galantamine)	***Eligibility criteria for Preferred Agents –** All preferred products will be approved without PA if the member has a diagnosis of dementia which can be verified by SMART PA. Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) Members currently stabilized on a non-preferred product can receive approval to continue on that agent for one year if medically necessary and if there is a diagnosis of dementia.
ANTICOAGULANTS- ORAL *Effective 10/1/2015*	**No PA Required (*Must meet eligibility criteria)**	**PA Required**	**ELIQUIS®** will be approved if: • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) **OR**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	Warfarin *XARELTO (rivaroxaban) (2nd line)	COUMADIN (warfarin) ELIQUIS (apixaban) PRADAXA (dabigatran) SAVAYSA (edoxaban)	• The member is need of prophylaxis for DVT following knee or hip replacement surgery **OR** • The member has a diagnosis of non-valvular atrial fibrillation **AND** • The member does not have a mechanical prosthetic heart valve **AND** • The member does not have an active pathological bleed **AND** • The member has failed warfarin or is not a candidate for warfarin as defined as meeting one of the following criteria: o The member has a labile INR for reasons other than noncompliance (e.g, member has an INR outside of 2-3 > 60% of the time for a period of two months) **OR** o The member has significant difficulty with complying with monitoring **OR** o The member is on dialysis o The member has an allergy or intolerance to warfarin **AND** • The member has failed a one month trial of Xarelto®. (Failure is defined as : lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **PRADAXA®** will be approved if: • The member is not on dialysis **AND** • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) **OR** • The member has a diagnosis of non-valvular atrial fibrillation **AND** • The member does not have a mechanical prosthetic heart valve **AND** • The member does not have an active pathological bleed **AND** • The member has failed warfarin or is not a candidate for warfarin as defined as meeting one of the following criteria: o The member has a labile INR for reasons other than noncompliance (e.g, member has an INR outside of 2-3 > 60% of the time for a period of two months) **OR** o The member has significant difficulty with complying with monitoring **OR** o The member has an allergy or intolerance to warfarin **AND**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			• The member has failed a one month trial of Xarelto®. (Failure is defined as : lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **SAVAYSA®** will be approved if all the following criteria have been met: • Member is not on dialysis **AND** • Member does not have CrCl > 95 mL/min **AND** • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) **OR** • The member has a diagnosis of non-valvular atrial fibrillation **AND** • The member does not have a mechanical prosthetic heart valve **AND** • The member does not have an active pathological bleed **AND** • The member has failed warfarin or is not a candidate for warfarin as defined as meeting one of the following criteria: o The member has a labile INR for reasons other than noncompliance (e.g, member has an INR outside of 2-3 > 60% of the time for a period of two months) **OR** o The member has significant difficulty with complying with monitoring **OR** o The member has an allergy or intolerance to warfarin **AND** • The member has failed a one month trial of Xarelto®. (Failure is defined as : lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) ***XARELTO®** will be approved if all the following criteria have been met: • The member is not on dialysis **AND** • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) **OR** • The member is in need of a prophylaxis of DVT following knee or hip replacement surgery **OR** • The member has a diagnosis of non-valvular atrial fibrillation **AND** • The member does not have a mechanical prosthetic heart valve **AND**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			• The member does not have an active pathological bleed **AND** • The member has failed warfarin or is not a candidate for warfarin as defined as meeting one of the following criteria: o Labile INR for reasons other than noncompliance (e.g, member has an INR outside of 2-3 > 60% of the time for a period of two months) **OR** o The member has significant difficulty with complying with monitoring **OR** o The member has an allergy or intolerance to warfarin **Grandfathering:** Beginning 10/1/2013, members currently stabilized on a non-preferred agent can receive approval to continue on that agent for one year if medically necessary
ANTI-EMETICS *Effective 1/1/2016*	**No PA Required** Ondansetron tablets Ondansetron ODT tab Ondansetron oral solution (members under 5 years only) DICLEGIS (doxylamine/pyridoxine)	**PA Required** AKYNZEO (netupitant/palensetron) ANZEMET (dolasetron) EMEND (apepritant) KYTRIL (granisetron) SANCUSO (granisetron) VARUBI (rolapitant) ZOFRAN (ondansetron) tabs ZOFRAN (ondansetron) suspension ZOFRAN ODT (ondansetron) ZUPLENZ (ondansetron)	Non-preferred products will be approved for members who have failed treatment with brand or generic ondansetron within the last year. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) **Ondansetron suspension** will be approved for members < 5 years and those members ≥ 5 years of age with a feeding tube. **Diclegis** will be approved if the member has nausea and vomiting associated with **pregnancy.** **Emend** will be approved upon verification that the member is undergoing moderately emetogenic or highly emetogenic chemotherapy as part of a regimen with a corticosteroid and a 5HT3 antagonist. **Verification may be provided from the prescriber or the pharmacy.** **Emend** will be approved for prophylaxis of postoperative nausea and vomiting (one 40mg capsule will be approved). **Verification may be provided from the prescriber or the pharmacy.** Approval for DICLEGIS will be granted if the member has nausea and vomiting associated with pregnancy **AND** The member has failed a trial of doxylamine 10-12.5mg **OR** The member has failed a trial of oral ondansetron 4mg every 8 hours for five days **OR** The member has an intolerance or contraindication to ondansetron

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
ANTI-DEPRESSANTS **Newer Generation Antidepressants** *Effective 1/1/2016*	**No PA Required** Bupropion IR, SR, XL Citalopram Escitalopram Fluoxetine Mirtazipine Paroxetine Sertraline Venlafaxine IR tabs Venlafaxine XR capsules	**PA Required** APLENZIN ER (bupropion ER) BRINTELLIX (vortioxetine) CYMBALTA (duloxetine) Desvenlafaxine succinate Duloxetine EFFEXOR IR EFFEXOR XR FETZIMA (levomilnacipran) Fluvoxamine (generic Luvox) KHEDEZLA (desvenlafaxine base) LEXAPRO (escitalopram) LUVOX CR (fluvoxamine CR) Nefazodone (generic Serzone) OLEPTRO ER (trazodone ER) PRISTIQ (desvenlafaxine succinate) PEXEVA (paroxetine) Paroxetine CR PAXIL CR (paroxetine controlled release)	Non-preferred products will be approved for members who have failed treatment with three Preferred Products with exceptions for Cymbalta (see below). (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **Grandfathering:** Members currently stabilized on a Non-preferred newer generation antidepressant can receive approval to continue on that agent for one year if medically necessary. **Verification may be provided from the prescriber or the pharmacy.** Cymbalta or duloxetine: Members will NOT need to fail on three preferred products if the diagnosis is Diabetic Peripheral Neuropathic Pain. Cymbalta will also be approved for patients with chronic musculoskeletal pain (e.g. osteoarthritis or chronic lower back pain) who have failed a one month consecutive trial of three non-narcotic analgesic agents (e.g. acetaminophen, NSAID, tramadol) at maximally tolerated doses.

<table>
<tr><th>Therapeutic Drug Class</th><th>Preferred Agents</th><th>Non-preferred Agents</th><th>Prior Authorization Criteria
(All Non-preferred Products will be approved for one year unless otherwise stated.)</th></tr>
<tr><td></td><td></td><td>PROZAC Weekly (fluoxetine)

VIIBRYD (vilazodone)

WELLBUTRIN IR, SR, XL</td><td></td></tr>
<tr><td>ANTI-HERPETIC AGENTS

Effective 1/1/2016</td><td>No PA Required

Acyclovir tablet, capsule, suspension (generic)</td><td>PA Required

FAMVIR (famciclovir)

Famcyclovir

SITAVIG (acyclovir)

VALTREX (valacyclovir)

Valacyclovir

VALCYTE (valgancyclovir)

ZOVIRAX (acyclovir)</td><td>Non-preferred products will be approved for members who have failed an adequate trial with acyclovir (dose and duration) as deemed by approved compendium (see below) (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)
<table>
<tr><th>Indication</th><th>Adult</th><th>Pediatric</th></tr>
<tr><td>Genital herpes simplex: Inital</td><td>400 mg orally 3 times daily for 7 to 10 days or 200 mg orally 5 times daily (guideline dosing) for 10 days.</td><td>12 years or older, 1000 to 1200 mg/day orally in 3 to 5 divided doses for 7 to 10 days.</td></tr>
<tr><td>Genital herpes simplex: episodic</td><td>400 mg orally 3 times daily for 5 days or 800 mg orally twice daily for 5 days or 800 mg orally 3 times daily for 2 days (guideline dosing); or 200 mg orally every 4 hours, 5 times daily for 5 days; initiate at earliest sign or symptom of recurrence.</td><td>12 years or older, 1000 to 1200 mg/day orally in 3 divided doses for 3 to 5 days</td></tr>
<tr><td>Genital herpes simplex: Suppressive

An adequate trial of acyclovir for Genital Herpes Simplex (Suppressive)</td><td>400 mg orally twice daily for up to 12 months; alternative dosing, 200 mg orally 3 to 5 times daily.</td><td>12 years or older, 800 to 1200 mg/day orally in 2 divided doses for up to 12 months</td></tr>
</table></td></tr>
</table>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)		
			will be one month.		
			Genital Herpes Simplex with HIV infection: Initial or Recurrent	400 mg ORALLY 3 times daily for 5 to 14 days	< 45 kg: 20 mg/kg (MAX, 800 mg) ORALLY 4 times daily for 7 to 10 days or until no new lesions appear for 48 hours. Adolescents: 400 mg ORALLY twice daily for 5 to 14 days.
			Genital Herpes Simplex with HIV infection: Chronic suppression	400 mg orally twice daily	
			Herpes labialis	400 mg orally 3 times daily for 5 to 10 days	
			Herpes zoster, Shingles	800 mg orally every 4 hours 5 times a day for 7 to 10 days	
			Herpes Zoster, Shingles with HIV infection	800 mg orally 5 times daily for 7 to 10 days	
			Varicella	800 mg orally 4 times a day for 5 days	2 years or older: 20 mg/kg ORALLY 4 times a day for 5 days; over 40 kg, 800 mg ORALLY 4 times a day for 5 days
			Varicella with HIV infection	20 mg/kg (MAX, 800 mg) ORALLY 5 times daily for 5 to 7 days	20 mg/kg (MAX, 800 mg) ORALLY 4 times daily for 7 to 10 days or until no new esions appear for 48 hours.
ANTI-HISTAMINES **Newer Generation Antihistamines**	**No PA Required** Cetirizine (generic OTC Zyrtec) 5mg and 10mg tab, chew tab, syrup	**PA Required** ALAVERT (loratadine) ALLEGRA (fexofenadine)	Non-preferred antihistamines and antihistamine/decongestant combinations will be approved for members who have failed treatment with two preferred products in the last 6 months and have at least one trial with intranasal corticosteroids (for children age 4 and older). Failure		

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
Effective 7/1/2015	Loratadine (generic OTC Claritin) 10mg tab and syrup	CLARINEX (desloratadine) CLARITIN (loratadine) Fexofenadine Levocetirizine Loratadine ODT XYZAL (levocetirizine) ZYRTEC (cetirizine)	is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
Antihistamine/Decongestant Combinations *Effective 7/1/2015*	**No PA Required**	**PA Required** ALLEGRA-D (fexofenadine./PSE) CLARINEX-D (desloratadineD) CLARITIN-D (loratadine-D) Loratadine-D SEMPREX-D (acrivastine-D) ZYRTEC-D (cetirizine-D)	
ANTI-HYPERTENSIVES **Angiotensin Receptor Blockers (ARBs)** *Effective 7/1/2015*	**No PA Required** BENICAR (olmesartan) DIOVAN *BNR* (valsartan) Irbesartan Losartan	**PA Required** ATACAND (candesartan) AVAPRO (irbesartan) COZAAR (losartan) EDARBI (azilsartan) MICARDIS (telmisartan)	Non-preferred ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products will be approved for members who have failed treatment with three preferred products in the last 12 months (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.). Renin inhibitors and combinations will not approved in patients with diabetes. Receiving an ACE-inhibitor, ACE-inhibitor combination, ARB, or ARB-combination in combination with a renin inhibitor is contraindicated.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		TEVETEN (eprosartan) Valsartan	**Grandfathering:** Members currently stabilized on brand name Avapro or Avalide can receive approval to continue on that agent for one year if medically necessary. **Verification may be provided from the prescriber or the pharmacy.**
ARB Combinations *Effective 7/1/2015*	**No PA Required** BENICAR-HCT *BNR* (olmesartan/HCTZ) DIOVAN-HCT *BNR* (valsartan/HCTZ) Losartan/HCTZ	**PA Required** ATACAND-HCT (candesartan/HCTZ) Candesartan/HCTZ AVALIDE (irbesartan/HCTZ) AZOR(amlodipine/olmesartan) EDARBYCLOR (azilsartan/chlorthalidone) EXFORGE (amlodipine/valsartan) Amlodipine/valsartan EXFORGE HCT (amlodipine/valsartan/hctz) Amlodipine/valsartan/hctz HYZAAR HCT (losartan/hctz) Irbesartan/HCTZ MICARDIS-HCT (telmisartan/HCTZ) Telmisartan/HCTZ TEVETEN-HCT (eprosartan/HCTZ)	

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		TRIBENZOR (olmesartan/amlodipine/hctz) TWYNSTA (telmisartan/amlodipine) VALTURNA (aliskiren/valsartan) Valsartan/HCTZ	
Renin Inhibitors & Renin Inhibitor Combinations *Effective 7/1/2015*	**No PA Required**	**PA Required** AMTURNIDE (aliskirin/amlodipine/HCTZ) TEKAMLO (aliskiren/amlodipine) TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ) VALTURNA (aliskiren/valsartan)	
ANTI-PLATELETS *Effective 1/1/2016*	**No PA Required** AGGRENOX (ASA/dipyridamole) ASA/dipyridamole Clopidogrel BRILINTA (tigacrelor)	**PA Required** EFFIENT (prasugrel) PLAVIX (clopidogrel) TICLID (ticlopidine) Ticlopidine ZONTIVITY (vorapaxar)	**EFFIENT®** 5 mg will be approved for patients that have a contraindication or intolerable side effects to Brilinta. • EFFIENT should only be considered for patients < 75 years of age and patients weighing ≥ 60 kg without a known diagnosis of TIA or ischemic stroke. • Grandfathering: Members currently stable on Effient will be granted prior authorization approval. Patients taking BRILINTA must also be taking a maintenance dose of aspirin not exceeding 100 mg/day. Ticlopidine should only be considered for patients who can be monitored for neutropenia and thrombocytopenia during the first four months of therapy. ZONTIVITY will be approved for patients with a diagnosis of myocardial infarction or peripheral artery disease without a history of

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			stroke, transient ischemic attack, intracranial bleeding, or active pathological bleeding. Patients must also be taking aspirin and/or clopidogrel concomitantly.
ATYPICAL ANTI-PSYCHOTICS (oral) *Effective 4/1/2015*	**No PA Required**** ABILIFY *BNR* (aripiprazole) tab Aripiprazole oral solution ABILIFY ODT *BNR* (aripiprazole) Clozapine CLOZARIL (clozapine) GEODON (ziprasidone) LATUDA (lurasidone) Olanzapine Risperidone Risperidone ODT RISPERDAL (risperidone) RISPERDAL M-tab (risperidone ODT) Quetiapine* SEROQUEL IR* (quetiapine) Ziprasidone	**PA Required** Aripiprazole FANAPT (iloperidone) FAZACLO (clozapine ODT) INVEGA (paliperidone) REXULTI (brexpiprazole) RISPERDAL oral soln (risperidone) SAPHRIS (asenapine) SEROQUEL XR (quetiapine) SYMBYAX (olanzapine/fluoxetine) VERSACLOZ susp (clozapine) VRAYLAR (cariprazine) ZYPREXA ZYDIS (olanzapine ODT) *** for injectable Atypical Antipsychotics please see Appendix P for criteria**	**IR quetiapine when given at sub therapeutic doses may be restricted for therapy. Low-dose quetiapine (<150mg/day) is only FDA approved as part of a drug titration schedule to aid patients in getting to the target quetiapine dose. PA will be required for quetiapine < 150mg per day except for utilization (when appropriate) in members 65 years or older.* Non-preferred products will only be approved for their FDA approved indications and age limits and only if the member has failed on three preferred products in the last 5 years. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). See Table 1. **Age Limits: All products including preferred products will require a PA for members younger than the FDA approved age for the agent. Members younger than the FDA approved age for the agent who are currently stabilized on an atypical antipsychotic will be eligible for grandfathering. See Table 3. **New Atypical Antipsychotic prescriptions for members under 5 years of age will be reviewed on an individual basis by a clinical health care professional at the Department. PA approval will be based upon medical necessity, evidence to support therapy, proposed monitoring and additional risk/benefit information supplied by the prescriber. Members under 5 years will be reviewed annually for appropriateness of therapy and proper monitoring.** Grandfathering: Members currently stabilized on a non-preferred atypical antipsychotic can receive approval to continue on that agent for two years even if the member does not meet the age, dosing or FDA approved indication requirements. **Verification may be provided from the prescriber or the pharmacy.** Quantity Limits: All products including preferred products will have quantity limits. In order to receive approval for off-label dosing, the member must have an FDA approved indication and must have tried and failed on the FDA approved dosing regimen. See Table 2.

<table>
<tr><th>Therapeutic Drug Class</th><th>Preferred Agents</th><th>Non-preferred Agents</th><th>Prior Authorization Criteria
(All Non-preferred Products will be approved for one year unless otherwise stated.)</th></tr>
<tr><td></td><td>ZYPREXA (olanzapine)</td><td></td><td>Fazaclo will be approved for the treatment of schizophrenia if the member is 18 years of age or older and has tried and failed treatment with three preferred products (one of which must be generic clozapine) in the last 5 years.

Invega will be approved for the treatment of schizophrenia or schizoaffective disorder if the member is 18 years of age or older (12 years or older for schizophrenia) and has tried and failed treatment with / has had adherence issues with three preferred products in the last 5 years. A maximum of one tablet per day will be approved.

Seroquel XR will be approved if the member is 18 years of age or older, has tried and failed treatment with three preferred products in the last five years and is being treated for one of the FDA approved indications. See Table 1.

If a member has been stabilized on quetiapine for at least 30 days with a positive response but is unable to tolerate the side effects, Seroquel XR may be approved without failure of two additional agents.

Zyprexa Zydis will be approved for the treatment of schizophrenia or bipolar 1 disorder if the member is 13 years of age or older and has tried and failed treatment with three preferred products (one of which must be an olanzapine tablet) in the last 5 years.

For members that are stabilized on Zyprexa tablets with a documented need for occasional supplementation to treat acute symptoms, up to 5 tablets per month will be allowed without three product failures.

Table 1: Approved Indications
<table>
<tr><th>Drug</th><th>Indication</th></tr>
<tr><td>Fanapt®</td><td>• Acute treatment of schizophrenia in adults</td></tr>
<tr><td>Fazaclo®</td><td>• Treatment-resistant schizophrenia
• Reducing the risk of recurrent suicidal behavior in patients with schizophrenia or schizoaffective disorder</td></tr>
<tr><td>Invega®</td><td>• Schizophrenia
• Schizoaffective disorder</td></tr>
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</td></tr>
</table>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)

			<table><tr><td>Saphris®</td><td>• Acute and maintenance of schizophrenia • Bipolar mania, monotherapy • Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex</td></tr><tr><td>Seroquel XR®</td><td>• Treatment of schizophrenia • Acute treatment of manic or mixed episodes associated with bipolar I disorder, as monotherapy or as an adjunct to lithium or divalproex • Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex • Adjunctive treatment of major depressive disorder (MDD)</td></tr></table> Table 2: Quantity Limits <table><tr><th>Brand Name</th><th>Generic Name</th><th>Quantity Limits</th></tr><tr><td>**Abilify**</td><td>**Aripiprazole**</td><td>**Maximum one tablet per day**</td></tr><tr><td></td><td>**Clozapine**</td><td>**Maximum dosage of 900mg per day**</td></tr><tr><td>**Fazaclo**</td><td>**Clozapine**</td><td>**Maximum dosage of 900mg per day**</td></tr><tr><td>**Fanapt**</td><td>**Iloperidone**</td><td>**Maximum two tablets per day**</td></tr><tr><td>**Invega**</td><td>**Paliperidone**</td><td>**Maximum one tablet per day**</td></tr><tr><td>**Latuda**</td><td>**Lurasidone**</td><td>**Maximum one tablet per day**</td></tr><tr><td></td><td>**Olanzapine**</td><td>**Maximum one tablet per day (see Zyprexa Zydis criteria for Zydis information)**</td></tr><tr><td></td><td>**Quetiapine**</td><td>**Maximum three tablets per day**</td></tr><tr><td></td><td>**Risperidone**</td><td>**Maximum two tablets per day except 4mg tablets will be approved for up to 4 tablets per day**</td></tr><tr><td>**Saphris**</td><td>**Asenapine**</td><td>**Maximum two tablets per day**</td></tr><tr><td>**Seroquel XR**</td><td>**Quetiapine XR**</td><td>**Maximum one tablet per day (for 300mg & 400mg tablets max 2 tablets per day)**</td></tr></table>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)

	Ziprasidone	**Maximum two tablets per day**

Table 3: FDA Approved Dosing by Age

Drug	FDA Approved Indication	FDA Approved Age	Maximal FDA Approved Dose
Asenapine (Saphris®)	NOT APPROVED		
Aripiprazole (Abilify®)	Autism/Psychomotor Agitation Bipolar Disorder/Mixed Mania Schizophrenia Gilles de la Torette's syndrom	6-17 years 10-17 years 13-17 years 13-17years 6-17 years	15mg/day 30mgday 30mg/day 30mg/day 20mg/day
Clozapine (Fazaclo®, Clozaril®)	NOT APPROVED		
Iloperidone (Fanapt®)			
Lurasidone (Latuda®)			
Olanzapine (Zyprexa®)	Schizophrenia Bipolar Disorder/Mixed Mania	13-17 years 13-17 years	10mg/day 10mg/day
Olanzapine (Zyprexa Zydis®)			
Paliperidone (Invega ER®)	Schizophrenia	12-17 years	12mg/day
Risperidone (Risperdal®)	Autism/Psychomotor Agitation Bipolar Disorder/Mixed Mania Schizophrenia	5-16 years 10-17 years 13-17 years	3mg/day 6mg/day 6mg/day
Quetiapine Fumarate (Seroquel®)	Schizophrenia Bipolar Disorder/Mixed Mania	13-17 years 10-17 years	800 mg/day 800 mg/day
Quetiapine Fumarate (Seroquel XR®)	NOT APPROVED		

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			Ziprasidone (Geodon®) — NOT APPROVED
BISPHOSPHONATES (oral) *Effective 10/1/2015*	**No PA Required** Alendronate (generic) 5mg, 10mg, 35mg, 70mg tablets	**PA Required** ACTONEL (risedronate) ACTONEL w/Calcium (risedronate w/calcium) ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate) FOSAMAX (alendronate) FOSAMAX (alendronate) oral solution FOSAMAX plus D (alendronate w/D) Etidronate SKELID (tiludronate)	Non-preferred products will be approved for members who have failed treatment with at least one strength of alendronate. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) PA will be approved for etidronate in members with heterotopic ossification without treatment failure. For members who have a low risk of fracture, prior authorization will be required for members exceeding 5 years of either a preferred or non-preferred bisphosphonate. Low risk will be defined as having an osteopenic bone mineral density (most recent T-score between -1 and -2.5) **AND** no history of vertebral fracture.
DIABETES MANAGEMENT CLASSES **Amylin** *Effective 10/1/2015*	**No PA Required (*Must meet eligibility criteria)**	**PA Required** SYMLIN (pramlintide)	Symlin® will only be approved after a member has failed a three month trial of metformin and a DPP4-inhibitor or a GLP-1 analogue. Failure is defined as: lack of efficacy (e.g., hemoglobin A1C $\geq$ 7%) OR the member cannot tolerate metformin, DPP4-inhibitor and GLP-1 analogue due to allergy, intolerable side effects, or a significant drug-drug interaction. **For all products**, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing. PA will be approved for Symlin products for members with Diabetes Mellitus Type 1 without failed treatment
Biguanides *Effective 10/1/2015*	**No PA Required**	**PA Required**	Non-preferred products will be approved for members who have failed treatment with two Preferred Products. (Failure is defined as: lack of

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	Metformin 500mg, 850mg, 1000mg tablets Metformin ER 500mg tablets (generic Glucophage XR)	FORTAMET (metformin) GLUCOPHAGE (brand) (metformin) GLUCOPHAGE XR (brand) (metformin XR) GLUMETZA ER (metformin) Metformin ER 750mg Metformin ER 500 and 1000mg (generic Fortamet) RIOMET 500mg/5ml (metformin)	efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Liquid metformin will be approved for members who meet one of the following: • under the age of 12 • with a feeding tube who have difficulty swallowing
DPP-4 Inhibitor *Effective 10/1/2015*	**No PA Required (*Must meet eligibility criteria)** *TRADJENTA (linagliptin)	**PA Required** JANUVIA (sitagliptin) NESINA (alogliptin) ONGLYZA (saxagliptin)	*Approval for preferred products require a three month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy. **For all products**, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing. Non preferred DPP-4 inhibitors will be approved after a member has failed a three month trial of metformin and Tradjenta®. Failure is defined as lack of efficacy (e.g., hemoglobin A1C ≥ 7%), OR the member cannot tolerate Tradjenta and metformin due to allergy, intolerable side effects, or a significant drug-drug interaction.)
GLP-1 Agonist *Effective 10/1/2015*	**No PA Required (*Must meet eligibility criteria)** *BYETTA (exenatide)	**PA Required** BYDUREON (exenatide) TANZEUM (albiglutide) TRULICITY (dalaglutide) VICTOZA (liraglutide)	*Approval for preferred products require a three month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy. **For all products**, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing. Non preferred GLP-1 agonists will be approved after a member has failed a three month trial of metformin and Byetta®. Failure is defined as lack of efficacy (e.g., hemoglobin A1C ≥ 7%) OR the member cannot

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			tolerate Byetta® and metformin due to allergy, intolerable side effects, or a significant drug-drug interaction. Grandfathering: Members currently stabilized on Victoza® can receive approval to continue on that agent for one year.
Hypoglycemic Combinations *Effective 10/1/2015*	**No PA Required**	**PA Required** ACTOPLUS MET (pioglitazone/metformin) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glimepiride) DUETACT (glipizide/metformin) GLUCOVANCE (brand) (glyburide/metformin) Glyburide/metformin GLYXAMBI (empagliflozin/linagliptin) INVOKAMET (canagliflozin/metformin) JANUMET (sitagliptin/metformin) JENTADUETO (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE (saxaglipin/metformin)	Non-preferred products will be approved for members who have been stable on the two individual ingredients for 3 months and have an adherence issue.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		METAGLIP (glipizide/metformin) OSENI (alogliptin/pioglitazone) PRANDIMET (repaglinide/metformin) Repaglinide/metformin SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozen/metformin)	
Meglitinides *Effective 10/1/2015*	**No PA Required**	**PA Required** PRANDIN (repaglinide) STARLIX (nateglinide)	Non-preferred products will be approved for members who have failed treatment with one Sulfonylurea (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
SGLT-2 Inhibitor *Effective 10/1/2015*	**No PA Required**	**PA Required** FARXIGA (dapagliflozin) INVOKANA (canaglifozin) JARDIANCE (empagliflozin)	The SGLT-2 inhibitors will only be approved after a member has failed a three month trial of two of metformin and a DPP4-inhibitor or a GLP-1 analogue. Failure is defined as: lack of efficacy (e.g., hemoglobin A1C ≥ 7%) OR the member cannot tolerate metformin, a DPP4-inhibitor, and a GLP-1 analogue due to allergy, intolerable side effects, or a significant drug-drug interaction. The SGLT-2 inhibitors will not be approved for members requiring dialysis or those who are pregnant, or have type 1 diabetes, end stage renal disease or severe renal impairment (defined as a creatinine clearance < 45ml/min). **For all products**, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing.
Thiazolidinediones *Effective 10/1/2015*	**No PA Required** Pioglitazone	**PA Required** ACTOS (pioglitazone) AVANDIA (rosiglitazone)	*Note: Agents in this class may be associated with increased cardiovascular risks. Risk/benefit analysis should be considered before initiating therapy. Prior authorizations for rosiglitazone will be manually reviewed by the Department based upon reported risk mitigation, medical justification and contraindication to pioglitazone.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
ERYTHROPOIESIS STIMULATING AGENTS *Effective 10/1/2015*	***Must meet eligibility criteria** EPOGEN (epoetin alfa)*	**PA Required** ARANESP (darbepoetin alfa) MIRCERA (methoxy peg-epoetin beta) PROCRIT (epoetin alfa)	***Eligibility Criteria for all agents in the class** Members must meet all criteria in one of the following four areas: • A diagnosis of cancer, currently receiving chemotherapy, with chemotherapy-induced anemia, and hemoglobin of 10g/dL or lower. • A diagnosis of chronic renal failure, and hemoglobin below 10g/dL • A diagnosis of hepatitis C, currently taking Ribavirin and failed response to a reduction of Ribavirin dose, and hemoglobin less than 10g/dL (or less than 11g/dL if symptomatic). • A diagnosis of HIV, currently taking Zidovudine, hemoglobin less than 10g/dL, and serum erythropoietin level of 500mUnits/mL or less. Hemoglobin results must be from the last 30 days. Medication must be administered in the member's home or long-term care facility. **Non-preferred products:** • Same as above; **and** • Failed treatment with Epogen. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) **Note: The FDA has announced a risk evaluation mitigation strategy for the use of Erythropoeisis Stimulating Agents (ESAs) in patients with cancer, who are currently receiving chemotherapy, and who are experiencing chemotherapy induced anemia. Patients must receive a medication guide outlining the risks and benefits of treatment, and patient consent must be obtained before therapy. Prescribers are required to enroll and register in the ESA APPRISE Oncology program and complete training prior to prescribing ESAs to patients with cancer. For non-cancer indications, the distribution of a medication guide to the patient is the only requirement currently.**
FIBROMYALGIA AGENTS *Effective 7/1/2015*	**No PA Required** LYRICA (pregabalin) Duloxetine	**PA Required** CYMBALTA (duloxetine) SAVELLA (milnacipran)	Non-preferred agents will be approved for fibromyalgia if member has failed an adequate trial (8 weeks) of both Lyrica and duloxetine OR the member has contraindication to Lyrica and duloxetine GENERIC DULOXETINE will be approved if the member has diagnosis for fibromyalgia.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			For members with no epilepsy diagnosis in the last two years (as confirmed by SMART PA), PA will be required for LYRICA prescriptions requiring more than 3 capsules per day or for prescriptions requiring doses greater than 600mg per day.
FLUOROQUINOLONE (oral) *Effective 1/1/2016*	**No PA Required** Ciprofloxacin tablet CIPRO oral suspension (<5 years old) Levofloxacin tablet	**PA Required** AVELOX (moxifloxacin) CIPRO TABLET (ciprofloxacin) FACTIVE (gemifloxacin) LEVAQUIN TABLET (levofloxacin) LEVAQUIN oral solution Levofloxacin oral solution NOROXIN (norfloxacin) Ofloxacin	Non-preferred products will be approved for members who have failed an adequate trial (7days) with at least one preferred product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) CIPRO suspension approved for members < 5 years of age without PA For members ≥ 5 years of age, CIPRO suspension will only be approved for those members who cannot swallow a whole or crushed tablet Levofloxacin solution will be approved for members who require administration via feeding tube **OR** who have failed an adequate trial (7 days) of ciprofloxacin suspension. (Failure is defined as: lack of efficacy, presence of feeding tube, allergy, intolerable side effects, or significant drug-drug interaction.)
GROWTH HORMONES *Effective 4/1/2015*	**No PA Required** GENOTROPIN	**PA Required** HUMATROPE NORDITROPIN NUTROPIN OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE	Non-preferred Growth Hormones will be approved if **both** of the following criteria are met: • Member failed treatment with Genotropin within the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) • Member has a qualifying diagnosis: o Prader-Willi o Chronic renal insufficiency/failure o Turner's Syndrome o Hypopituitarism: as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma o Wasting associated with AIDS or cachexia o Noonan Syndrome Grandfathering: If the member has a diagnosis for short bowel syndrome OR cachexia associated with AIDS, member will be grandfathered and

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			receive approval for a non-preferred agent due to medical necessity based on FDA approved indications.
HEPATITIS C VIRUS TREATMENTS *Effective 10/1/2015*	**Must meet eligibility criteria*** VIEKIRA PAK* (ombitasvir/paritaprevir/ritonavir/ dasabuvir)	**PA Required** DAKLINZA (daclastavir) HARVONI (sofosbuvir/ledipasvir) OLYSIO (Simeprevir) SOVALDI (Sofosbuvir) TECHNIVIE (ombitasvir/paritaprevir/ritonavir)	**Preferred agent criteria:** Requests for **Viekira Pak® (ombitasvir/paritaprevir/ritonavir/dasabuvir)** will be granted prior authorization if the following criteria are met: 1. Physician attests to the member's readiness for adherence AND 2. Physician attests to provide SVR12 and SVR24 timely AND 3. Must have chronic Hepatitis C (HCV) genotype 1a or 1b AND 4. Member is not co-infected with Hepatitis B AND 5. Member is 18 years of age and older AND 6. The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication) AND 7. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment. Initial pregnancy test must be performed not more than 30 days prior to beginning therapy AND 8. Viekira Pak is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist AND 9. Meets one of the following categories based on liver biopsy or other accepted test: • Members with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease; • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A (5-6); or CTP B (7 or greater) and on transplant list with projected time to transplant < 1 year; • Transplant members with fibrosing cholestatic HCV or members who have cirrhosis from recurrent HCV and have been approved for re-transplantation; • Member has a fibrosis score equivalent to METAVIR 3-4 based on biopsy not more than 10 years old. If biopsy is not available, concordant scores among APRI (> 1) and FIB-4 (> 2.2) plus either FibroSure/FibroTest (≥ 0.58kPa) or FibroScan (≥ 9.6kPa) that demonstrate scores equivalent to

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			fibrosis 3-4 must be provided; Unless further evidence of cirrhosis is provided such as varices, pulmonary hypertension, splenomegaly AND 10. Members may be treatment naïve or treatment experienced, except with a direct-acting antiviral (DAA) AND 11. Post-transplant recipients will be evaluated on a case by case basis AND 12. Members may be HIV positive AND 13. Member does not have end stage renal disease requiring hemodialysis AND 14. Member must have baseline levels within 90 days of anticipated start date for: HCV RNA; CBC; CMP; INR; and FibroTest or FibroScan (if applicable) AND 15. Member must be 6 months free of: alcohol; and Schedule I controlled substances (including marijuana); and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate alcohol/drug screens. Members must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Random alcohol/drug screens must be conducted monthly during treatment with Viekira Pak for members that have a history (within the past 2 years) of alcohol/drug abuse AND 16. Member is not taking moderate or strong CYP3A inducers, or strong CYP2C8 inducers or inhibitors AND 17. Member is not taking alfuzosin, amiodarone, carbamazepine, phenytoin, phenobarbital, gemfibrozil, rifampin, ergoamine, dihydroergotamine, ergonovine, methylergonovine, ethinyl estradiol-containing agents, St. John's wort, lovastatin, simvastatin, pimozide, efavirenz, sildenafil dosed for treatment of pulmonary arterial hypertension, triazolam, oral midazolam, voriconazole, fluticasone, darunavir/ritonavir, lopinavir/ritonavir, rilpivirine, salmeterol AND 18. If member is taking amiodarone, disopyramide, flecainide, lidocaine (systemic), mexiletine, propafenone, quinidine, ketoconazole, amlodipine, furosemide, atazanavir/ritonavir, rosuvastatin, pravastatin, cyclosporine, tacrolimus, buprenorphine/naloxone, omeprazole, or alprazolam, provider attests that appropriate dose adjustments have made to ensure safe coadministration AND

<table>
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<tr><td></td><td></td><td></td><td>
19. All approvals will initially be for an 8 week time period, with further approvals dependent on the submission of the HCV RNA level at week 4, week 12, and week 24 to justify continuing drug therapy (see discontinuation criteria) AND
20. If the week 4 HCV RNA is detectable (>25 copies) while on Viekira Pak therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e., >1 log10 IU/ml from nadir) all treatment will be discontinued unless documentation is provided to support continuation of therapy AND
21. Must be in accordance to approved regimens and duration (see Table 1) AND
22. Must be adherent to treatment regimen (see discontinuation criteria) AND prescriber must confirm member enrollment in the proCeed Nurse Connector program (by phone: 1-844-2proCeed or Fax: 1-866-299-1687 or online at: https://www.viekira.com/proceed-program) to re-enforce adherence AND
23. Must have received or in process of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity.

Note*:* Once treated, the Department will only cover a once per lifetime treatment with any DAA.

Table 1. Recommended Regimens and Treatment Duration for Viekira Pak
<table>
<tr><th>HCV Genotype and Comorbidities (Mono-infected and HCV/HIV-1 Co-infected)</th><th>Treatment</th><th>Duration</th></tr>
<tr><td>Members with genotype 1a, without compensated cirrhosis</td><td>Viekira Pak + ribavirin</td><td>12 weeks</td></tr>
<tr><td>Members with genotype 1a, with compensated cirrhosis</td><td>Viekira Pak + ribavirin</td><td>24 weeks</td></tr>
<tr><td>Members with genotype 1b, without compensated cirrhosis</td><td>Viekira Pak</td><td>12 weeks</td></tr>
</table>
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</table>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)

			<table><tr><td>Members with genotype 1b, with compensated cirrhosis</td><td>Viekira Pak + ribavirin</td><td>12 weeks</td></tr><tr><td>Post-transplant members</td><td>Viekira Pak + ribavirin</td><td>24 weeks</td></tr></table> Quantity and Refill Limits: • Quantity Limit: two ombitasvir/paritaprevir/ritonavir 12.5/75/50 mg tablets once daily and one dasabuvir 250 mg tablet twice daily (112 tablets/28days) • Length of authorization: Based on HCV subtype and comorbidities • Refills: Should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill. Discontinuation Criteria: • Members receiving a Viekira Pak-based regimen should have HCV RNA levels assessed at weeks, 4, 6 (if applicable), and 12 (if applicable). If the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued. • Members receiving a Viekira Pak-based regimen should have ALT levels at baseline, 4 weeks, and again as clinically necessary. Members may need to discontinue if ALT levels remain over 10 times ULN, and will need to discontinue if ALT elevation is accompanied with signs or symptoms of liver inflammation, increased conjugated bilirubin, alkaline phosphatase, or INR. • The department will prospectively evaluate medication adherence based on prescription fills. If a member is non-adherent in filling their Viekira Pak prescription (e.g. not filled within 7 days of the end of the previous fill), all treatment will be discontinued. Members with a history of drug or alcohol abuse/misuse within the last 2 years must provide random monthly drug and alcohol screens during treatment to continue receiving treatment for HCV. **Non-Preferred Agents criteria are below:** Requests for **Daklinza® (daclatasvir)** will be granted prior authorization if the following criteria are met: 1. Physician attests to the member's readiness for adherence **AND**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			2. Physician attests to provide SVR12 timely **AND** 3. Member must have chronic Hepatitis C (HCV) genotype 3 **AND** 4. Member is not co-infected with Hepatitis B or Human Immunodeficiency Virus (HIV) **AND** 5. Member is 18 years of age and older **AND** 6. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment. Initial pregnancy test must be performed not more than 30 days prior to beginning therapy **AND** 7. Daclatasvir is prescribed with sofosbuvir **AND** 8. Daclatasvir is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist **AND** 9. Member meets one of the following categories based on liver biopsy, symptoms or other accepted test: • Member with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease; • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A; or CTP B and on transplant list with projected time to transplant < 1 year; • Transplant members with fibrosing cholestatic HCV or members who have cirrhosis from recurrent HCV and have been approved for re-transplantation; • Member has a fibrosis score equivalent to METAVIR 3-4 based on biopsy not more than 10 years old. If biopsy is not available, concordant scores among APRI (> 1) and FIB-4 (> 2.2) plus either FibroSure/FibroTest (≥ 0.58kPa) or FibroScan (≥ 9.6kPa) that demonstrate scores equivalent to fibrosis 3-4 must be provided; Unless further evidence of cirrhosis is provided such as varices, pulmonary hypertension, splenomegaly **AND** 10. Member does not have severe renal impairment (eGFR<30 ml/min/1.73m2), end stage renal disease, on hemodialysis **AND** 11. Member must be 6 months free of: alcohol and Schedule I controlled substances (including marijuana); and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			documented by appropriate alcohol/drug screens. Member must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Random alcohol/drug screens must be conducted monthly during treatment for clients that have a history (within the past 2 years) of alcohol/drug abuse **AND** 12. Member is not taking amiodarone, dabigatran, phenytoin, carbamazepine, rifampin, St. John's wort or other strong CYP3A inducers **AND** 13. If member is taking moderate CYP3A inducers, moderate to strong CYP3A inhibitors, digoxin, or HMG-CoA reductase inhibitors, provider attests that appropriate dose adjustments have made to ensure safe coadministration **AND** 14. Member must have baseline levels within 90 days of anticipated start date for: HCV RNA; CBC; CMP; INR; and FibroTest or FibroScan (if applicable) **AND** 15. All approvals will initially be for a 8 week time period, with further approvals dependent on the submission of the HCV RNA level at week 4, week 12, and week 24 to justify continuing drug therapy (see discontinuation criteria) **AND** 16. If the week 4 HCV RNA is detectable (>25 copies) while on daclatasvir/sofosbuvir therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e. >1 log10 IU/ml from nadir) all treatment will be discontinued unless documentation is provided to support continuation of therapy **AND** 17. Must be in accordance to approved regimens and duration (see Table 1) **AND** 18. Must be adherent to treatment regimen (see discontinuation criteria) **AND** 19. Must have received or in progress of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity. **Note*:*** The Department will only cover a once per lifetime treatment with any DAA. **Table 1. Recommended Regimens and Treatment Duration for Daklinza**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)

HCV Genotype	Daily Treatment	Duration
Genotype 3	Daclatasvir 60mg + 400 mg sofosbuvir	12 weeks
Genotype 3 taking strong CYP3A inhibitors	Daclatasvir 30mg + 400 mg sofosbuvir	12 weeks
Genotype 3 taking moderate CYP3A inducers	Daclatasvir 90mg + 400 mg sofosbuvir	12 weeks

Quantity and Refill Limits:

- Quantity Limit: one daclatasvir 60mg tablet and one sofosbuvir 400mg tablet per day (28 tablets each/28days) and adjusted as indicated in Table 1 above
- Length of authorization: Based on current medication regimen
- Refills: Should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill.

Discontinuation Criteria:

- Members receiving a sofosbuvir based regimen should have HCV RNA levels assessed at weeks, 4, 6 (if applicable), and 12 (if applicable); if the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued.
- The department will prospectively evaluate medication adherence based on prescription fills. If a member is non-adherent in filling their sofosbuvir prescription (e.g. not filled within 7 days of the end of the previous fill), all treatment will be discontinued.
- Members with a history of drug or alcohol abuse/misuse within the last 2 years must provide random monthly drug and alcohol screens during treatment to continue receiving treatment for HCV.

Requests for **Harvoni® (sofosbuvir/ledipasvir)** for genotype 1 will be considered if Viekira Pak® is contraindicated or cannot be used due to documented resistance to protease inhibitors for the treatment of Hepatitis C virus (e.g. Olysio, Victrelis, Incivek). Other genotypes (4, 5,

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			6 will not require a contraindication to Viekira®. Prior authorization may be granted if the following criteria are met: 1. Physician attests to the member's readiness for adherence **AND** 2. Physician attests to provide SVR12 and SVR24 timely **AND** 3. Must have chronic Hepatitis C (HCV) genotype 1a or 1b **AND** 4. Member is 18 years of age and older **AND** 5. Member is not co-infected with Hepatitis B **AND** 6. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment. Initial pregnancy test must be performed not more than 30 days prior to beginning therapy **AND** 7. Harvoni is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist **AND** 8. Meets one of the following categories based on liver biopsy or other accepted test: • Members with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease; • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A; or CTP B and on transplant list with projected time to transplant < 1 year; • Transplant members with fibrosing cholestatic HCV or members who have cirrhosis from recurrent HCV and have been approved for re-transplantation; • Member has a fibrosis score equivalent to METAVIR 3-4 based on biopsy not more than 10 years old. If biopsy is not available, concordant scores among APRI (> 1) and FIB-4 (> 2.2) plus either FibroSure/FibroTest (≥ 0.58kPa) or FibroScan (≥ 9.6kPa) that demonstrate scores equivalent to fibrosis 3-4 must be provided; Unless further evidence of cirrhosis is provided such as varices, pulmonary hypertension, splenomegaly **AND** 9. Members may be treatment naïve or treatment experienced, except with a direct-acting antiviral (DAA) **AND** 10. Member does not have severe renal impairment (eGFR<30 ml/min/1.73m^2), end stage renal disease, on hemodialysis **AND**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			11. Member must be 6 months free of: alcohol; and Schedule I controlled substances (including marijuana), and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate alcohol/drug screens. Member must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Random alcohol/drug screens must be conducted monthly during treatment for members that have a history (within the past 2 years) of alcohol/drug abuse **AND** 12. Member is not taking potent P-gp inducers **AND** 13. Member is not taking amiodarone, carbamazepine, phenytoin, phenobarbital, , rifampin, rifabutin, rifapentine, St. John's wort, tipranavir/ritonavir, elvitegravir, cobicistat, emtricitabine, simepravir, rosuvastatin **AND** 14. If member is taking H_2 receptor antagonist, antacid, proton pump inhibitor, digoxin, efavirenz, HIV protease inhibitor, provider attests that appropriate dose adjustments have been made to ensure safe coadministration **AND** 15. Member must have baseline levels within 90 days of anticipated start date for: HCV RNA; CBC; CMP; INR; and FibroTest or FibroScan (if applicable) **AND** 16. All approvals will initially be for an 8 week time period, with further approvals dependent on the submission of the HCV RNA level at week 4, week 12, and week 24 to justify continuing drug therapy (see discontinuation criteria) **AND** 17. If the week 4 HCV RNA is detectable (>25 copies) while on sofosbuvir/ledipasvir therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e., >1 log10 IU/ml from nadir), all treatment will be discontinued unless documentation is provided to support continuation of therapy **AND** 18. Must be in accordance to approved regimens and duration (see Table 1) **AND** 19. Must be adherent to treatment regimen (see discontinuation criteria) **AND** 20. Must have received or in progress of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity.

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<u>Note</u>: Once treated, the Department will only cover a once per lifetime treatment with any DAA.

Table 1. Recommended Regimens and Treatment Duration for Harvoni
<table>
<tr><th>HCV Genotype and Comorbidities</th><th>Treatment</th><th>Duration</th></tr>
<tr><td>GT1: Treatment naïve with or without compensated cirrhosis</td><td>Harvoni</td><td>12 weeks</td></tr>
<tr><td>GT:1 Treatment-experienced without compensated cirrhosis</td><td>Harvoni</td><td>12 weeks</td></tr>
<tr><td>GT1: Treatment-experienced with compensated cirrhosis</td><td>Harvoni + ribavirin</td><td>12 weeks</td></tr>
<tr><td>GT4, 5, 6 to be determined</td><td>Harvoni</td><td>12 weeks</td></tr>
</table>
Quantity and Refill Limits:
• Quantity Limit: one ledipasvir 90 mg/sofosbuvir 400 mg tablet per day (28 tablets/28days)
• Length of authorization: Based on comorbidities and treatment status
• Refills: Should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill.

Discontinuation Criteria:
• Members receiving a Sofosbuvir-based regimen should have HCV RNA levels assessed at weeks 4, 6 (if applicable), and 12 (if applicable); if the HCV RNA is above the lower limit of
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</table>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			quantification by a validated test at any of these time points, all treatment will be discontinued. • The department will prospectively evaluate medication adherence based on prescription fills. If a member is non-adherent in filling their Harvoni prescription (e.g. not filled within 7 days of the end of the previous fill), all treatment will be discontinued. • Members with a history of drug or alcohol abuse/misuse within the last 2 years must provide random monthly drug and alcohol screens during treatment to continue receiving treatment for HCV. Requests for **Olysio® (simeprevir)** will be granted prior authorization if the following criteria are met: 1. Physician attests to the member's readiness for adherence **AND** 2. Physician attests to provide SVR12 and SVR24 timely **AND** 3. A documented diagnosis of Hepatitis C Genotype 1 with concurrent therapy with ribavirin and pegylated interferon unless in combination with a polymerase inhibitor. 4. Member is not co-infected with HIV or Hepatitis B **AND** 5. Member is 18 years of age and older **AND** 6. The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication) **AND** 7. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment. Initial pregnancy test must be performed not more than 30 days prior to beginning therapy **AND** 8. The patient's previous treatment history and weight are presented at the time of initial request. Meets one of the following categories based on liver biopsy or other accepted test: • Members with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease; • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A (5-6); or CTP B (7 or greater) and on transplant list with projected time to transplant < 1 year;

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			• Transplant members with fibrosing cholestatic HCV or members who have cirrhosis from recurrent HCV and have been approved for re-transplantation; • Member has a fibrosis score equivalent to METAVIR 3-4 based on biopsy not more than 10 years old. If biopsy is not available, concordant scores among APRI (> 1) and FIB-4 (> 2.2) plus either FibroSure/FibroTest (≥ 0.58kPa) or FibroScan (≥ 9.6kPa) that demonstrate scores equivalent to fibrosis 3-4 must be provided; Unless further evidence of cirrhosis is provided such as varices, pulmonary hypertension, splenomegaly **AND** 9. Member must be 6 months free of: alcohol and Schedule I controlled substances (including marijuana); and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate alcohol/drug screens. Member must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Random alcohol/drug screens must be conducted monthly for clients that have a history (within the past 2 years) of alcohol/drug abuse. 10. The patient is not receiving moderate to strong inhibitors (e.g., erythromycin, clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole, voriconazole, delavirdine, and milk thistle) or inducers (e.g., carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifampin, rifabutin, rifapentine, dexamethasone, efavirenz, etravirine, nevirapine, darunavir/ritonavir, ritonavir, and St John's wort) of CYP3A4. 11. The patient has not previously tried and failed therapy with a hepatitis C protease inhibitor (Incivek® or Victrelis®). 12. Olysio® is prescribed in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist. 13. If the week 4 HCV RNA is detectable (>25 copies) while on Viekira Pak therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e., >1 log10 IU/ml from nadir) all treatment will be discontinued unless documentation is provided to support continuation of therapy **AND** 14. For patients with HCV genotype 1a, evidence must be provided that the patient does not have NS3 Q80K polymorphism prior to starting therapy.

<table>
<tr><th>Therapeutic Drug Class</th><th>Preferred Agents</th><th>Non-preferred Agents</th><th>Prior Authorization Criteria
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<tr><td></td><td></td><td></td><td>
15. Must be in accordance to approved regimens and duration (see Table 1) AND
16. Must be adherent to treatment regimen (see discontinuation criteria) <u>AND</u>
17. Must have received or in process of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity.

Table 1. Recommended Regimens and Treatment Duration for Olysio
<table>
<tr><th>HCV Genotype and Comorbidities</th><th>Treatment</th><th>Duration</th></tr>
<tr><td>Treatment naïve or treatment experienced without compensated cirrhosis</td><td>Simeprevir + sofosbuvir</td><td>12 weeks</td></tr>
<tr><td>Treatment naïve or treatment experienced with compensated cirrhosis</td><td>Simeprevir + sofosbuvir</td><td>24 weeks</td></tr>
</table>
Quantity and Refill Limits:
• Quantity Limit: one simeprevir 150 mg tablet once daily and one sofosbuvir 400 mg tablet once daily (28 tablets each /28days)
• Length of authorization: Based on comorbidities and treatment status
• Refills: Should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill.

Discontinuation Criteria:
• Members receiving an Olysio-based regimen should have HCV RNA levels assessed at weeks, 4, 6 (if applicable), and 12 (if applicable). If the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued.
• The department will prospectively evaluate medication adherence based on prescription fills. If a member is non-adherent in filling
</td></tr>
</table>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			their Olysio prescription (e.g. not filled within 7 days of the end of the previous fill), all treatment will be discontinued. • Members with a history of drug or alcohol abuse/misuse within the last 2 years must provide random monthly drug and alcohol screens during treatment to continue receiving treatment for HCV. Requests for **Sovaldi® (sofosbuvir)** will be considered for genotype 1 if Viekira Pak® is contraindicated or cannot be used due to documented resistance to protease inhibitors for the treatment of Hepatitis C virus (e.g. Olysio, Victrelis, Incivek). Prior authorization may be granted if the following criteria are met: 1. Physician attests to the member's readiness for adherence AND 2. Physician attests to provide SVR12 and SVR24 timely AND 3. Member must have chronic Hepatitis C (HCV) genotype 1, 2, 3 or 4 AND 4. Member is not co-infected with Hepatitis B AND 5. Member is 18 years of age and older AND 6. The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication) AND 7. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment. Initial pregnancy test must be performed not more than 30 days prior to beginning therapy AND 8. Sofosbuvir is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist AND 9. Member meets one of the following categories based on liver biopsy, symptoms or other accepted test: • Member with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease; • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A; or CTP B and on transplant list with projected time to transplant < 1 year; • Transplant members with fibrosing cholestatic HCV or members who have cirrhosis from recurrent HCV and have been approved for re-transplantation;

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			• Member has a fibrosis score equivalent to METAVIR 3-4 based on biopsy not more than 10 years old. If biopsy is not available, concordant scores among APRI (> 1) and FIB-4 (> 2.2) plus either FibroSure/FibroTest (≥ 0.58kPa) or FibroScan (≥ 9.6kPa) that demonstrate scores equivalent to fibrosis 3-4 must be provided; Unless further evidence of cirrhosis is provided such as varices, pulmonary hypertension, splenomegaly AND 10. Member does not have severe renal impairment (eGFR<30 ml/min/1.73m2), end stage renal disease, on hemodialysis AND 11. Member must be 6 months free of: alcohol and Schedule I controlled substances (including marijuana); and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate alcohol/drug screens. Member must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Random alcohol/drug screens must be conducted monthly during treatment for clients that have a history (within the past 2 years) of alcohol/drug abuse AND 12. Member is not taking potent P-gp inducers AND 13. Member is not taking amiodarone, carbamazepine, phenytoin, phenobarbital, cyclosporine, rifampin, rifabutin, rifapentine, St. John's wort, tipranavir/ritonavir AND 14. Member must have baseline levels within 90 days of anticipated start date for: HCV RNA; CBC; CMP; INR; and FibroTest or FibroScan (if applicable) AND 15. All approvals will initially be for a 8 week time period, with further approvals dependent on the submission of the HCV RNA level at week 4, week 12, and week 24 to justify continuing drug therapy (see discontinuation criteria) AND 16. If the week 4 HCV RNA is detectable (>25 copies) while on sofosbuvir therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e. >1 log10 IU/ml from nadir) all treatment will be discontinued unless documentation is provided to support continuation of therapy AND 17. Must be in accordance to approved regimens and duration (see Table 1) AND

<table>
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18. Must be adherent to treatment regimen (see discontinuation criteria) AND
19. Must have received or in progress of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity.

Note: Once treated, the Department will only cover a once per lifetime treatment with any DAA.

Table 1. Recommended Regimens and Treatment Duration for Sofosbuvir

<table>
<tr><th>HCV Genotype</th><th>Treatment</th><th>Duration</th></tr>
<tr><td>Genotype 1: interferon eligible</td><td>Sofosbuvir + peginterferon alfa + ribavirin</td><td>12 weeks</td></tr>
<tr><td>Genotype 1: interferon ineligible</td><td>Sofosbuvir + ribavirin</td><td>24 weeks</td></tr>
<tr><td>Genotype 2</td><td>Sofosbuvir + ribavirin</td><td>12 weeks</td></tr>
<tr><td>Genotype 3</td><td>Sofosbuvir + ribavirin</td><td>24 weeks</td></tr>
<tr><td>Genotype 4: interferon eligible</td><td>Sofosbuvir + peginterferon alfa + ribavirin</td><td>12 weeks</td></tr>
<tr><td>Genotype 4: interferon ineligible</td><td>Sofosbuvir + ribavirin</td><td>24 weeks</td></tr>
</table>
</td></tr>
</table>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			Quantity and Refill Limits: • Quantity Limit: one 400mg tablet per day (28 tablets/28days) • Length of authorization: Based on HCV genotype • Refills: Should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill. Interferon Alpha Ineligible defined: • Platelet count <75,000mm3 • Decompensated liver cirrhosis (CTP Class B or C or CTP score ≥ 7) • Documented history of depression or mood disorder, which are not stable on current drug regimen • Autoimmune hepatitis and another autoimmune disorder • Inability to complete a prior treatment course due to a documented interferon-related adverse event. Discontinuation Criteria: • Members receiving a sofosbuvir based regimen should have HCV RNA levels assessed at weeks, 4, 6 (if applicable), and 12 (if applicable); if the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued. • The department will prospectively evaluate medication adherence based on prescription fills. If a member is non-adherent in filling their sofosbuvir prescription (e.g. not filled within 7 days of the end of the previous fill), all treatment will be discontinued. • Members with a history of drug or alcohol abuse/misuse within the last 2 years must provide random monthly drug and alcohol screens during treatment to continue receiving treatment for HCV. Requests for **Technivie® (ombitasvir/paritaprevir/ritonavir)** will be granted prior authorization if the following criteria are met: 1. Physician attests to the member's readiness for adherence AND 2. Physician attests to provide SVR12 and SVR24 timely AND 3. Must have chronic Hepatitis C (HCV) genotype 4 without cirrhosis AND 4. Member is not co-infected with Hepatitis B or Human Immunodeficiency Virus (HIV) AND 5. Member is 18 years of age and older AND

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			6. The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication) AND 7. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment. Initial pregnancy test must be performed no more than 30 days prior to beginning therapy AND 8. Technivie is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist AND 9. Meets one of the following categories based on liver biopsy or other accepted test: • Members with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease; • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A (5-6); or CTP B (7 or greater) and on transplant list with projected time to transplant < 1 year; • Transplant members with fibrosing cholestatic HCV or members who have cirrhosis from recurrent HCV and have been approved for re-transplantation; • Member has a fibrosis score equivalent to METAVIR 3-4 based on biopsy not more than 10 years old. If biopsy is not available, concordant scores among APRI (> 1) and FIB-4 (> 2.2) plus either FibroSure/FibroTest (≥ 0.58kPa) or FibroScan (≥ 9.6kPa) that demonstrate scores equivalent to fibrosis 3-4 must be provided; Unless further evidence of cirrhosis is provided such as varices, pulmonary hypertension, splenomegaly AND 10. Members may be treatment naïve or treatment experienced, except with a direct-acting antiviral (DAA) AND 11. Member does not have end stage renal disease requiring hemodialysis AND 12. Member must have baseline levels within 90 days of anticipated start date for: HCV RNA; CBC; CMP; INR; and FibroTest or FibroScan (if applicable) AND 13. Member must be 6 months free of: alcohol; and Schedule I controlled substances (including marijuana); and cocaine,

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate alcohol/drug screens. Members must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Random alcohol/drug screens must be conducted monthly during treatment with Technivie for members that have a history (within the past 2 years) of alcohol/drug abuse AND 14. Member is not taking moderate or strong CYP3A inducers, or strong CYP2C8 inducers or inhibitors AND 15. Member is not taking alfuzosin, carbamazepine, phenytoin, phenobarbital, ergotamine, dihydroergotamine, ergonovine, methylergonovine, ethinyl estradiol-containing agents, voriconazole, salmeterol, St. John's wort, lovastatin, simvastatin, rifampin, pimozide, efavirenz, atazanavir, darunavir/ritonavir, lopinavir/ritonavir, rilpivirine, sildenafil dosed for treatment of pulmonary arterial hypertension, triazolam, oral midazolam AND 16. If member is taking amiodarone, disopyramide, flecainide, lidocaine (systemic), mexiletine, propafenone, quinidine, digoxin, ketoconazole, quetiapine amlodipine, furosemide, pravastatin, cyclosporine, tacrolimus, buprenorphine/naloxone, omeprazole, or alprazolam, provider attests that appropriate dose adjustments have been made to ensure safe co-administration AND 17. All approvals will initially be for an 8 week time period, with further approvals dependent on the submission of the HCV RNA level at week 4, week 12, and week 24 to justify continuing drug therapy (see discontinuation criteria) AND 18. If the week 4 HCV RNA is detectable (>25 copies) while on Technivie therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e., >1 log10 IU/ml from nadir) all treatment will be discontinued unless documentation is provided to support continuation of therapy AND 19. Must be in accordance to approved regimens and duration (see Table 1) AND 20. Must be adherent to treatment regimen (see discontinuation criteria) AND prescriber must confirm member enrollment in the proCeed Nurse Connector program (by phone: 1-844-

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			2proCeed or Fax: 1-866-299-1687 or online at: https://www.viekira.com/proceed-program) to re-enforce adherence AND 21. Must have received or in process of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity. Note: Once treated, the Department will only cover a once per lifetime treatment with any DAA. Table 1. Recommended Regimens and Treatment Duration for Technivie HCV Genotype and Comorbidities / Treatment / Duration Members with genotype 4 without cirrhosis / Technivie + ribavirin / 12 weeks Quantity and Refill Limits: • Quantity Limit: two ombitasvir/paritaprevir/ritonavir 12.5/75/50 mg tablets once daily • Length of authorization: 12 weeks • Refills: Should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill. Discontinuation Criteria: • Members receiving a Technivie-based regimen should have HCV RNA levels assessed at weeks, 4, 6 (if applicable), and 12 (if applicable). If the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued. • Members receiving a Technivie-based regimen should have ALT levels at baseline, 4 weeks, and again as clinically necessary. Members may need to discontinue if ALT levels remain over 10 times ULN, and will need to discontinue if ALT elevation is accompanied with signs or symptoms of liver inflammation, increased conjugated bilirubin, alkaline phosphatase, or INR.

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			• The department will prospectively evaluate medication adherence based on prescription fills. If a member is non-adherent in filling their Technivie prescription (e.g. not filled within 7 days of the end of the previous fill), all treatment will be discontinued. • Members with a history of drug or alcohol abuse/misuse within the last 2 years must provide random monthly drug and alcohol screens during treatment to continue receiving treatment for HCV.
INSULIN *Effective 4/1/2015* **Rapid Acting**	**No PA Required** NOVOLOG vial and pen	**PA Required** AFREZZA APIDRA all forms HUMALOG vial and pen	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects) AFREZZA (human insulin) will be approved for members with the following criteria: • Member is 18 years or older AND • Member has intolerable side effects or severe allergic reactions to Novolog AND • Member must not have chronic lung disease such as asthma and COPD AND • If member is a type 1 diabetic, must use in conjunction with long-acting insulin AND • Member must not be a smoker
Short Acting	HUMULIN R vial/pen	NOVOLIN R all forms	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)
Intermediate Acting	HUMULIN N vial/ pen	NOVOLIN N all forms	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)
Long Acting	LEVEMIR vial/ pen	LANTUS all forms TOUJEO all forms	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)
Mixtures	HUMULIN 70/30 vial/ pen NOVOLIN 70/30 vial HUMALOG MIX 50/50 vial/ pen	None	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)

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	HUMALOG MIX 75/25 vial/ pen NOVOLOG MIX 70/30 vial/ pen		
INTRANASAL CORTICOSTEROIDS *Effective 4/1/2015*	**No PA Required** fluticasone (generic FLONASE) NASONEX (mometasone)	**PA Required** BECONASE AQ (beclomethasone diproprionate) Budesonide CHILD NASACORT (triamcinolone) DYMISTA (azelastine/ fluticasone propionate) FLONASE (fluticasone) Flunisolide NASAREL (flunisolide) NASACORT AQ (triamcinolone) OMNARIS (ciclesonide) QNASL (beclomethasone diproprionate) RHINOCORT AQ (budesonide) Triamcinolone acetonide VERAMYST (fluticasone furoate) ZETONNA (ciclesonide)	Non-preferred Intranasal Corticosteroids will be approved if the member has failed treatment with 2 preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). • Rhinocort AQ will be approved for pregnant members without failure of preferred products. • Brand name Flonase will require a letter of medical necessity

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
LEUKOTRIENE MODIFIERS *Effective 4/1/2015*	**No PA Required** Montelukast (tab, chewable)	**PA Required** ACCOLATE (zafirlukast) SINGULAIR (montelukast) (tab, chewable tab) Zafirlukast ZYFLO (zileuton) ZYFLO CR (zileuton)	Non-preferred Leukotrienes will be approved if **both** of the following criteria are met: • Member failed treatment with montelukast in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) • Member has a diagnosis of Asthma
MULTIPLE SCLEROSIS AGENTS *Effective 4/1/2015*	**No PA Required** AVONEX (interferon beta 1a) BETASERON (interferon beta 1b) *GILENYA (fingolimid) (2nd line) REBIF (interferon beta 1a) COPAXONE 20MG INJECTION (glatiramer)	**PA Required** AUBAGIO (teriflunomide) AMPYRA (dalfampridine) COPAXONE 40MG INJECTION (glatiramer) EXTAVIA (interferon beta 1b) GLATOPA (glatiramer) PLEGRIDY (peg-interferon beta 1a) TECFIDERA (dimethyl fumarate)	Non-preferred **Interferon** products will be approved if the member has failed treatment with three preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). **Copaxone® 40mg** will be approved for members who have a severe intolerable injection site reactions (e.g, pain requiring local anesthetic, oozing, lipoatrophy, swelling, or ulceration) to Copaxone 20mg. **Ampyra** – Up to a 90 day supply of Ampyra will be approved if all of the following criteria are met: • Member has a diagnosis of MS; • Member is ambulatory and has established a baseline which is defined as ambulating between 8-45 seconds Timed 25-foot Walk (T25FW) assessment; • Member has no history of seizure disorder; • Member has no history of moderate to severe renal dysfunction (CrCl > 50 ml/min); • Prescriber is a neurologist; • The prescribed dose does not exceed 10 mg twice daily. Extended coverage of Ampyra (up to one year) will be approved if documentation shows a 20% improvement in ambulation (measured by T25FW assessment) after three months of therapy. **AUBAGIO** will be approved if member met all the following criteria: • In members **without** a contraindication to GILENYA, member has failed COPAXONE or a preferred interferon product **AND**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			GILENYA. [Failure will be defined as intolerable side effects (3 month trial), drug-drug interaction, or lack of efficacy (6 month trial)] OR • In members **with** a contraindication to GILENYA, has failed COPAXONE or a preferred interferon product. Failure will be defined as intolerable side effects (3 month trial), drug-drug interaction, or lack of efficacy (6 month trial). Lack of efficacy will be defined as one of the following: • On MRI: presence of any new spinal lesions, cerebellar or brain stem lesions, or change in brain atrophy. • On clinical exam, signs and symptoms consistent with functional limitations that last one month or longer AND • Has a diagnosis of a relapsing form of MS AND • Is being prescribed by a neurologist AND • Has no active infections AND • If a female patient of child bearing age, has a negative pregnancy test at baseline and is using a form of highly effective contraceptive AND • Had transaminase and bilirubin levels with ALT<2 times the upper limit of normal within the 6 months prior to initiating therapy AND • Had a complete blood count with differential within the six months prior to initiating therapy AND • Has a documented baseline blood pressure AND • Has been evaluated for active or latent tuberculosis infections by documented test results (purified protein derivative test) or blood test. **TECFIDERA** will be approved if the member has met all the following criteria: • In members without a contraindication to GILENYA, member has failed COPAXONE or a preferred interferon product and GILENYA. Failure will be defined as intolerable side effects (3 month trial), drug-drug interaction, or lack of efficacy (6 month trial) OR • In members with a contraindication to GILENYA, has failed COPAXONE or a preferred interferon product. Failure will be defined as intolerable side effects (3 month trial), drug-drug

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			interaction, or lack of efficacy (6 month trial). Lack of efficacy will be defined as one of the following: • One of the following on MRI: presence of any new spinal lesions, cerebellar or brain stem lesions, or change in brain atrophy • On clinical exam, signs and symptoms consistent with functional limitations that last one month or longer AND • Has a diagnosis of a relapsing form of MS AND • Is being prescribed by a neurologist AND • Has no active infections AND • Had a complete blood count with differential within the six months prior to initiating therapy. ***GILENYA** will be approved if the member has met all the following criteria: • Has failed COPAXONE or a preferred interferon product. Failure will be defined as intolerable side effects (3 month trial), drug-drug interaction, or lack of efficacy (6 month trial). Lack of efficacy will be defined as one of the following: • One of the following on MRI: presence of any new spinal lesions, cerebellar or brain stem lesions, or change in brain atrophy • On clinical exam, signs and symptoms consistent with functional limitations that last one month or longer AND • Has a diagnosis of a relapsing form of MS AND • Is being prescribed by a neurologist AND • Does not have a recent history of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or New York Heat Association Class III-IV heart failure within six months of initiating therapy AND • Does not have a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome unless patient has a pacemaker AND • Has a baseline QTc interval <500 ms prior to starting therapy AND • Is not receiving treatment with a Class Ia or Class III anti-arrhythmic medication AND • Has no active infections AND

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			• Had an ophthalmologic evaluation (ocular coherence test) prior to starting therapy within 3-4 months after starting therapy AND • Had a baseline complete blood count with differential and liver function tests. Grandfathering: Members currently stabilized on GILENYA, TECFIDERA, and AUBAGIO may receive approval to continue on that agent.
OPHTHALMIC ALLERGY *Effective 4/1/2015*	**No PA Required** Cromolyn PATANOL (olopatadine) PATADAY (olopatadine)	**PA Required** ALAMAST (pemirolast) ALAWAY (ketotifen) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) Azelastine BEPREVE (bepotastine) ELESTAT (epinastine) EMADINE (emedastine) LASACRAFT (alcaftadine) Ketotifen OPTICROM (sodium cromoglicate) PAZEO (olopatadine) ZADITOR (ketotifen)	Non-preferred Ophthalmic Allergy medications will be approved if the member has failed treatment with two preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
OPIOIDS **Long Acting – Oral Opioids** *Effective 7/1/2015*	**No PA Required** **FIRST LINE** Fentanyl patches Methadone (generic Dolophine) Morphine ER (generic MS Contin) Tramadol ER	**PA Required** *BUTRANS (buprenorphine) CONZIP (TRAMADOL ER) DOLOPHINE (methadone) DURAGESIC (fentanyl patch) EMBEDA (morphine/naltrexone) HYSINGLA (hydrocodone ER) KADIAN (morphine ER) MS CONTIN (morphine ER) NUCYNTA ER (tapentadol ER) OPANA ER (oxymorphone ER) ORAMORPH SR (morphine ER) OXYCONTIN (oxycodone ER) TARGINIQ ER (oxycodone ER) XARTEMIS XR (oxycodone/acetaminophen) ZOHYDRO ER (hydrocodone ER)	Non-preferred, long-acting oral opioids will be approved for members who have failed treatment with two preferred agents in the last six months. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Fentanyl patches (Duragesic) will require a PA for doses of more than 1 patch/2 days. *Butrans patches will be approved for members who have failed treatment with ONE preferred agent in the last 6 months. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Zohydro ER and Hysingla® ER will be approved for members who have failed treatment with two preferred products, AND at least one other long acting opiate in the past year. Oxycontin®, Opana ER®, Nucynta ER®, and Zohydro ER® will only be approved for twice daily dosing. Hysingla ER® will only be approved for once daily dosing. No more than one long-acting oral opioid will be approved at one time. Medicaid is not mandating that a patient switch from a non-preferred drug to methadone. Methadone requires special training due to its complex pharmacokinetic profile. However, if a patient has tried and failed methadone in the past, it can be considered a trial of one preferred drug. Use of opioid analgesics during pregnancy has been associated with neonatal abstinence syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of neonatal abstinence syndrome. Providers should offer access to contraceptive services when necessary.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
OVERACTIVE BLADDER AGENTS *Effective 10/1/15*	**No PA Required** Oxybutynin tablets (generic) Oxybutynin ER tablets (generic) TOVIAZ (fesoterodine ER)	**PA Required** DETROL (tolterodine) DETROL LA (tolterodine ER) DITROPAN (brand) DITROPAN XL (brand) ENABLEX (darifenacin) Flavoxate GELNIQUE (oxbutynin gel) OXYTROL (oxybutynin patch) SANCTURA (trospium) SANCTURA XL (trospium ER) Tolterodine VESICARE (solifenacin) MYRBETRIQ (mirabegron)	Non-preferred products will be approved for members who have failed treatment with two preferred products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.). Members with hepatic failure can receive approval to receive trospium or trospium extended-release (Sanctura XR) products without a trial on a Preferred product.
PANCREATIC ENZYMES *Effective 1/1/2016*	**No PA Required** CREON (pancrelipase) ZENPEP (pancrelipase)	**PA Required** PANCREAZE (pancrelipase) PANCRELIPASE (pancrelipase) PERTZYE (pancrelipase) ULTRESA (pancrelipase) VIOKACE (pancreatin)	Non-preferred products will be approved for members who have failed an adequate trial (4 weeks) with at least two preferred products. (Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction.) Grandfathering: Members currently stabilized on a Non-preferred pancreatic enzyme can receive approval to continue on that agent for one year if medically necessary.

<table>
<tr><th>Therapeutic Drug Class</th><th>Preferred Agents</th><th>Non-preferred Agents</th><th>Prior Authorization Criteria
(All Non-preferred Products will be approved for one year unless otherwise stated.)</th></tr>
<tr>
<td>PROTON PUMP INHIBITORS
Effective 1/1/2016</td>
<td>*Must meet eligibility criteria

NEXIUM (esomeprazole) capsules and packets BNR

omeprazole generic capsules

pantoprazole tablets

PREVACID solutab BNR (lansoprazole)
(for members under 2)</td>
<td>PA Required

ACIPHEX tab, sprinkles (rabeprazole)

DEXILANT (dexlansoprazole)

KAPIDEX (dexlansoprazole)

Esomeprazole (generic Nexium)

Esomeprazole strontium

lansoprazole capsules

lansoprazole 15mg OTC (currently available as PREVACID 24HR)

NEXIUM 24 hour

PREVACID (lansoprazole) capsules & suspension

PRILOSEC OTC (omeprazole)

PROTONIX (pantoprazole) tablets and suspension

rabeprazole (generic Aciphex)

ZEGERID (omeprazole/Na bicarbonate)</td>
<td>*PA will be required for therapy beyond 60 days of treatment per year for all agents. For members treated for GERD, once 60 days of therapy per year has been exceeded, members must fail an adequate trial of a histamine 2 receptor antagonist before PPI therapy can be reconsidered. An adequate trial is defined as 8 weeks of histamine 2 receptor antagonist at maximum doses listed in the table below.

<table>
<tr><th>Drug</th><th>Maximum Dose</th></tr>
<tr><td>Erbrotidine</td><td>800 mg once daily</td></tr>
<tr><td>Famotidine</td><td>20 mg twice daily</td></tr>
<tr><td>Nizatidine</td><td>150 mg twice daily</td></tr>
<tr><td>Ranitidine</td><td>150 mg twice daily</td></tr>
<tr><td>Roxatidine</td><td>150 mg once daily or 75mg twice daily</td></tr>
</table>

Long-term therapy will be approved for members with Barrett’s Esophagus, Erosive Esophagitis, GI Bleed, post-bariatric surgery; Hypersecretory Conditions (Zollinger Ellison), Recurrent Aspiration Syndrome, chronic NSAID or prednisonetherapy, Spinal Cord Injury members with an acid reflux diagnosis, or children (< 18 years of age) with Cystic Fibrosis, on mechanical ventilation or who have a feeding tube.

In addition, members with continuing, symptomatic GERD or recurrent peptic ulcer disease who have documented failure on step-down therapy to an H2-receptor antagonist will be approved for up to one year of daily PPI therapy.

Non-preferred proton pump inhibitors will be approved if all of the following criteria are met:
• Member failed treatment with three Preferred Products within the last 24 months,
• Member has a qualifying diagnosis, AND
• Member has been diagnosed by an appropriate diagnostic method.

The Qualifying Diagnoses are:
Barrett’s Esophagus, Duodenal Ulcer, Erosive Esophagitis, Gastric Ulcer, GERD, GI Bleed, H. pylori, Hypersecretory Conditions (Zollinger-Ellison), NSAID-Induced Ulcer, Pediatric Esophagitis, Recurrent Aspiration Syndrome or Ulcerative GERD</td>
</tr>
</table>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			The Appropriate Diagnostic Methods are: GI Specialist, Endoscopy, X-Ray, Biopsy, Blood test, or Breath test **Quantity Limits:** Non-preferred agents will be limited to once daily dosing except for the following diagnoses: Barrett's Esophagus, GI Bleed, H. pylori, Hypersecretory Conditions, or Spinal Cord Injury patients with any acid reflux diagnosis. **Age Limits:** Aciphex, Protonix, and Zegerid will not be approved for members less than 18 years of age. Prevacid Solutab will be approved for members less than 2 years old and ≥ 2 years with a feeding tube.
H. Pylori Treatments	NONE	HELIDAC (tetracycline/tripotassium dicitrateobismuthate/metronidazole) OMECLAMOX-PAK (amoxicillin/ omeprazole/ clarithromycin) PREVPAC (amoxicillin/lansoprazole/ clarithromycin) Amoxicillin/lansoprazole/ clarithromycin PYLERA (bismuth subcitrate/ metronidazole/tetracycline)	H. Pylori treatments should be used as individual products unless one of the individual products is not commercially available then a PA for the combination product will be given.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
PULMONARY ARTERIAL HYPERTENSION THERAPIES **Phosphodiesterase Inhibitors** *Effective 1/1/2016*	***Must meet eligibility criteria** Sildenafil **(**generic Revatio)	**PA Required** ADCIRCA (tadalafil) REVATIO (sildenafil)	***Eligibility Criteria for all agents in the class** Approval will be granted for a diagnosis of pulmonary hypertension. **Grandfathering**: Members currently stabilized on Adcirca can receive approval to continue on that agent.
Endothelin Antagonists *Effective 1/1/2016*	**No PA Required** LETAIRIS (ambrisentan)	**PA Required** OPSUMIT (macitentan) TRACLEER (bosentan)	Non-preferred products will be approved for members who have failed treatment with Letairis or for members requiring a dose preparation not available with a preferred product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **Grandfathering:** Members who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication.
Prostanoids *Effective 1/1/2016*	**No PA Required** Epoprostenol (generic) VELETRI (epoprostenol)	**PA Required** FLOLAN (brand) (epoprostenol) ORENITRAM (treprostinil) REMODULIN (treprostinil) TYVASO (treprostinil) VENTAVIS (iloprost)	Non-preferred products will be approved for members who have failed treatment with a Preferred Product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, contraindication to IV therapy or significant drug-drug interaction) **Grandfathering:** Members who have been previously stabilized on a non-preferred product can receive approval to continue on the medication.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
Guanylate Cyclase (sGC) Stimulator *Effective 1/1/2016*	**No PA Required**	**PA Required** ADEMPAS (riociguat)	**Adempas** will be approved for patients who meet the following criteria: • Patient is not a pregnant female and is able to receive monthly pregnancy tests while taking Adempas and one month after stopping therapy. AND • Women of childbearing potential and their male partners must use one of the following contraceptive methods during treatment and one month after stopping treatment (e.g, IUD, contraceptive implants, tubal sterilization, a hormone method with a barrier method, two barrier methods, vasectomy with a hormone method, or vasectomy with a barrier method). AND • Patient is not receiving dialysis or has severe renal failure (e.g, Crcl < 15 ml/min). AND • Patient does not have severe liver impairment (e.g, Child Pugh C). AND • Prescriber must be enrolled with the Adempas REMS Program. AND • Female patients, regardless of reproductive potential, must be enrolled in the Adempas REMS program prior to starting therapy. AND • Patient has a diagnosis of persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4) after surgical treatment or has inoperable CTEPH OR • Patient has a diagnosis of pulmonary hypertension and has failed treatment with a preferred product for pulmonary hypertension. (Failure is defined as a lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions).
RESPIRATORY INHALANTS **Inhaled Anticholinergics & Anticholinergic Combinations** *Effective 7/1/2015*	**No PA Required** **<u>Solutions</u>** albuterol/ipratropium (generic Duoneb) ipratropium (generic Atrovent) **<u>Short-Acting Inhalers</u>** ATROVENT HFA (ipratropium)	**PA Required** **<u>Solutions</u>** ATROVENT (ipratropium) solution DUONEB (albuterol/ipratropium) **<u>Short-Acting Inhalers</u>** **<u>Long-Acting Inhalers</u>** TUDORZA Pressair (aclidinium)	Non-preferred anticholinergic inhalants and anticholinergic combination inhalants will require a brand-name PA stating medical necessity. ATROVENT® solution and DUONEB ® will require a brand-name prior authorization stating medical necessity. Non-preferred anticholinergic agents will be approved for members with a diagnosis of COPD including chronic bronchitis and/or emphysema who have failed treatment with Spiriva Handihaler® (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction or who have a contraindication to Spiriva Handihaler.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	COMBIVENT RESPIMAT (albuterol/ipratropium) **<u>Long-Acting Inhalers</u>** SPIRIVA Handihaler (tiotropium)	INCRUSE ELLIPTA (umeclindinium) ANORO ELLIPTA (umeclininium/vilanterol) SPIRIVA RESPIMAT (tiotropium) STIOLTO Respimat (tiotropium/olodaterol)	Non-preferred combination anticholinergic agents will be approved for members with a diagnosis of COPD including chronic bronchitis and/or emphysema AND has failed treatment with Combivent Respimat® (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction), OR who have a contraindication to Combivent Respimat®.
RESPIRATORY INHALANTS **Inhaled Beta2 Agonists (short acting)** *Effective 7/1/2015*	**No PA Required** **<u>Solutions</u>** albuterol (generic) solution **<u>Inhalers</u>** PROAIR (albuterol) HFA inhaler	**PA Required** **<u>Solutions</u>** ACCUNEB (albuterol) solution AIRET (albuterol) solution ALUPENT (metaproterenol) PROVENTIL (albuterol) soln. VENTOLIN (albuterol) solution XOPENEX (levalbuterol) soln. **<u>Inhalers</u>** ALUPENT (metaproterenol) Inhaler MAXAIR (pirbuterol) autohaler PROAIR Respiclick PROVENTIL (albuterol) HFA inhaler VENTOLIN (albuterol) HFA inhaler XOPENEX (levalbuterol) Inhaler	Non-preferred, short acting beta2 agonists will be approved for members who have failed treatment with one preferred agent. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). **Proair HFA, Proventil HFA, Ventolin HFA**: Quantity limits: 2 inhalers / 30 days (will go into effect late 2015)

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
RESPIRATORY INHALANTS **Inhaled Beta2 Agonists (long acting)** *Effective 7/1/2015*	**No PA Required**	**PA Required** **<u>Solutions</u>** BROVANA (Arformoterol) soln. solution PERFOROMIST (formoterol) solution **<u>Inhalers</u>** ARCAPTA (indacaterol) neohaler FORADIL (formoterol) inhaler SEREVENT (salmeterol) inhaler STRIVERDI RESPIMAT (olodaterol)	Long acting beta-2 agonists will be approved for members with moderate to severe asthma who are currently using an inhaled corticosteroid and require add-on therapy, or for members with moderate to very severe COPD.
RESPIRATORY INHALANTS **Inhaled Corticosteroids** *Effective 7/1/2015*	**No PA Required** **<u>Solutions</u>** budesonide nebules 0.25mg and 0.5mg PULMICORT (budesonide) nebules 1mg **<u>Inhalers</u>** ASMANEX twist (mometasone) FLOVENT (fluticasone) diskus FLOVENT (fluticasone) HFA QVAR (beclomethasone)	**PA Required** **<u>Solutions</u>** PULMICORT (budesonide) nebules 0.25mg and 0.5mg **<u>Inhalers</u>** AEROBID (flunisolide) inhaler AEROSPAN HFA ALVESCO (ciclesonide) ARNUITY ELLIPTA (fluticasone furoate) ASMANEX HFA (mometasone furoate) inhaler AZMACORT (triamcinolone) inhaler PULMICORT (budesonide) flexhaler	Non-preferred inhaled corticosteroids will be approved in members with asthma who have failed an adequate trial of two preferred agents. An adequate trial is defined as at least 6 weeks. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions.) Pulmicort Flexhaler will only be approved without failure on preferred products for female members with asthma who have a new diagnosis of pregnancy. Budesonide nebulizer solution will only be approved for a maximal dose of 2mg/day.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
RESPIRATORY INHALANTS **Inhaled Corticosteroid Combinations** *Effective 7/1/2015*	**No PA Required** ADVAIR Diskus (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA 13gram canister (mometasone/formoterol)	**PA Required** BREO Ellipta (vilanterol/fluticasone furoate) DULERA 8.8 gram canister (mometasone/formoterol) SYMBICORT (budesonide/formoterol)	Non-preferred inhaled corticosteroid combination inhalants will be approved for members meeting the following criteria: • Member has a qualifying diagnosis of asthma or COPD; and • Members with a diagnosis of asthma will have to fail two preferred agents due to lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction. • Members with a diagnosis of COPD will only have to fail one preferred agent due to lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction.
SEDATIVE- HYPNOTICS (non-benzodiazepine) *Effective 4/1/2015*	**No PA Required* (unless duplication criteria apply)** eszopiclone zaleplon zolpidem	**PA Required** AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant) EDLUAR (zolpidem) (sublingual) INTERMEZZO (zolpidem) (sublingual) LUNESTA (eszopiclone) ROZEREM (ramelteon) SONATA (zaleplon) ZOLPIMIST (zolpidem)	Non-preferred sedative hypnotics will be approved for members who have failed treatment with two preferred agents in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) BELSOMRA (suvorexant) will be approved for members that meet the following criteria: • Members who have failed treatment with two preferred agents in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **AND** • Member is not receiving strong inhibitors (e.g, erythmromycin, clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole, voriconazole, delavirdine, and milk thistle) or inducers (e.g, carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifampin, rifabutin, rifapentine, dexamethasone, efavirenz, etravirine, nevirapine, darunavir/ritonavir, ritonavir, and St John's Wort) of CYP3A4 **AND** • Member does not have a diagnosis for narcolepsy Sedative hypnotics will require PA for member's ≥65 years of age exceeding 90 days of therapy. Rozerem will be approved for members with a history/concern of substance abuse or for documented concern of diversion within the household without failed treatment on a preferred agent **Children:** PAs will be approved for members 18 years of age and older.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<u>*Duplications:</u> Only one agent in this drug class will be approved at a time. Approval will not be granted for members currently taking a long-acting benzodiazepine such as clonazepam or temazepam.
SKELETAL MUSCLE RELAXANTS *Effective 7/1/2015*	**No PA Required (if under 65 years of age)*** Baclofen (generic Lioresal) Cyclobenzaprine (generic Flexeril) 5mg and 10mg tabs Tizanidine (generic Zanaflex) 2mg and 4mg tab	**PA Required** AMRIX ER (cyclobenzaprine ER) Carisoprodol Chlorzoxazone Cyclobenzaprine 7.5mg tabs DANTRIUM (dantrolene) Dantrolene FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) Metaxolone Methocarbamol NORFLEX (orphenadrine) Orphenadrine PARAFLEX (chlorzoxazone) PARAFON FORTE (chlorzoxazone) REMULAR (chlozoxone) ROBAXIN (methocarbamol)	All agents in this class will require a PA for members over 65 years of age. Approval will only be given if the member has had at least a 7 day trial with an opiate or has a diagnosis of spasticity. The maximum allowable approval will be for a 7 days' supply. Non-preferred skeletal muscle relaxants will be approved for members who have documented lack of efficacy with two preferred agents in the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions.) Authorization for any carisoprodol product will be given for a maximum 3 week one time authorization for members with acute, painful musculoskeletal conditions who have failed treatment with two preferred products. Tapering: Due to potential withdrawal symptoms, tapering is recommended when discontinuing high doses of carisoprodol. A one month approval will be granted for members tapering off of carisoprodol. *A PA will only be granted for any carisoprodol product for short-term use or tapering.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		SKELAXIN (metaxalone) SOMA (carisoprodal) Tizanidine 2, 4, 6mg caps ZANAFLEX (tizanadine) VANADOM (carisoprodal)	
STATINS *Effective 4/1/2015*	**No PA Required** Atorvastatin CRESTOR (rosuvastatin) Pravastatin Simvastatin*	**PA Required** ALTOPREV (lovastatin ER) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) LIPITOR (atorvastatin) LIVALO (pitavastatin) Lovastatin (generic Mevacor) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR* (simvastatin)	Non-preferred Statin/Statin combinations will be approved if the member has failed treatment with two preferred products in the last 24 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) **Children:** Altoprev, Advicor, Livalo and Vytorin will be approved for members 18 years of age and older. Caduet, fluvastatin and lovastatin will be approved for members 10 years of age and older. *Simvastatin 80mg dose products will only be covered for members who have been stable for more than 12 months at that dose. Providers should consider alternate preferred statins in members who have not met cholesterol goals on simvastatin at doses up to 40mg per day. Please refer to the FDA communication titled, "FDA Drug Safety Communication: New restrictions, contraindications and dose limitations for Zocor (simvastatin) to reduce the risk of muscle injury" for updated guidance on contraindications, dose limits and relative LDL lowering doses of alternatives.
STATIN COMBINATIONS *Effective 4/1/2015*		ADVICOR (niacin ER / lovastatin) CADUET (amlodipine /atorvastatin) JUVISYNC (sitagliptin/ simvastatin) LIPTRUZET (ezetimibe/ atorvastatin) SIMCOR (niacin/simvastatin) VYTORIN* (ezetimibe/simvastatin.)	

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
STIMULANTS and other ADHD agents *Effective 10/1/2015*	**No PA Required (if age, daily dose, diagnosis restrictions met)** ADDERALL IR (mixed-amphetamine salts) ADDERALL XR *BNR* (mixed amphetamine salts ER) FOCALIN IR *BNR* (brand name dexmethylphenidate) FOCALIN XR *BNR* (dexmethylphenidate ER) INTUNIV *BNR* (guanfacine ER) Methylphenidate IR (generic Ritaltin IR) Methylphenidate LA (generic Ritalin LA) Methylphenidate ER (generic Concerta) Mixed-amphetamine salts (generic Adderall IR) RITALIN IR (methylphenidate) RITALIN LA (methylphenidate LA)	**PA Required** APTENSIO XR (methylphenidate XR) CONCERTA (methylphenidate ER) DAYTRANA (methylphenidate transdermal) DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) DEXTROSTAT (dextroamphetamine) Dexmethylphenidate (generic Focalin IR) Dexmethylphenidate (generic Focalin XR) EVEKEO (amphetamine) KAPVAY (clonidine ER) METADATE CD (methylphenidate ER) METADATE ER (methylphenidate ER) METHYLIN SUSPENSION (methylphenidate) Methylphenidate (generic RITALIN)	For beneficiaries with ADD/ADHD or narcolepsy warranting treatment with a stimulant or non-stimulant (either preferred or non-preferred), a diagnosis of ADD/ADHD or narcolepsy must be documented in the beneficiaries medical record at the time of diagnosis and annually. For patients with ADD/ADHD, prior to receiving pharmacotherapy, the beneficiary must have additional documentation through a validated ADHD/ADD instrument. For beneficiaries with ADD/ADHD who are currently receiving a stimulant or non-stimulant but does not have an official diagnosis of ADD/ADHD, the beneficiary will have six months to obtain a diagnosis otherwise the medication will be discontinued. Non-preferred agents will be approved for members who have documented failure with two preferred products in the last 12 months (age six years or older) or documented failure with one preferred products in the last 12 months if ages 3 – 5 years (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). However, certain exceptions exist for Daytrana, Intuniv, Methylin solution, Quillivant XR, Nuvigil and Provigil. Please see the criteria below. **In addition:** Non-preferred agents will only be approved for FDA and official compendium indications. • Provigil will only be approved for Narcolepsy, Obstructive Sleep Apnea/Hypopnea Syndrome, Shift Work Sleep Disorder, Traumatic Brain Injury, Multiple Sclerosis related fatigue or ADHD. Only a maximum of 400mg per day will be approved. • Nuvigil will be approved for obstructive sleep apnea/hypopnea syndrome, narcolepsy and shift work sleep disorder. Beneficiaries with ADD/ADHD must fail a 4 week trial of a preferred stimulant before the use of Nuvigil® will be approved. Only one tablet per day will be approved. • All other Non-preferred products will be approved for members with a diagnosis of ADD, ADHD, Narcolepsy, Multiple Sclerosis related fatigue, traumatic brain injury or severe autism.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	STRATTERA (atomoxetine) *BNR* VYVANSE (lisdexamfetamine)	Mixed-amphetamine salts ER (generic for Adderall XR) Modafanil (generic PROVIGIL) NUVIGIL (armodafinil) PROCENTRA (dextroamphetamine liquid) PROVIGIL (modafinil) QUILLIVANT XR (methylphenidate) ZENZEDI (dextroamphetamine)	• **Daytrana, Methylin solution and Quillivant XR**: Members with documented difficulty swallowing that are unable to utilize alternative dosing with FOCALIN XR, VYVANSE or ADDERALL XR can receive approval without failure on preferred products. Provider must document contraindications. **And** Non-preferred agents will only be approved for FDA approved age limitations. • Provigil will be approved for members 16 years of age and older. • Nuvigil will be approved for members 17 years of age and older. • Adderall IR, Dexedrine and Dextrostat will be approved for members 3 years of age and older. • All other medications in this class will be approved for members 6 years of age and older. Below are the FDA recommended maximum daily doses:

<table>
<tr><th>Therapeutic Drug Class</th><th>Preferred Agents</th><th>Non-preferred Agents</th><th>Prior Authorization Criteria
(All Non-preferred Products will be approved for one year unless otherwise stated.)</th></tr>
<tr><td></td><td></td><td></td><td>
<table>
<tr><th>Drug</th><th>Maximum Daily Dose</th></tr>
<tr><td colspan="2">Preferred</td></tr>
<tr><td>ADDERALL ®</td><td>40 mg/day</td></tr>
<tr><td>ADDERALL XR®</td><td>40mg/day</td></tr>
<tr><td>AMPHETAMINE SALTS</td><td>40 mg/day</td></tr>
<tr><td>DESOXYN ®</td><td>25mg/day</td></tr>
<tr><td>DEXEDRINE ®</td><td>40mg/day</td></tr>
<tr><td>DEXTROSTAT ®</td><td>40mg/day</td></tr>
<tr><td>FOCALIN ®</td><td>20 mg/day</td></tr>
<tr><td>FOCALIN XR ®</td><td>40 mg/day</td></tr>
<tr><td>METHYLPHNIDATE ER</td><td>60 mg/day</td></tr>
<tr><td>INTUNIV ER®</td><td>4 mg/day</td></tr>
<tr><td>RITALIN® IR</td><td>60 mg/day</td></tr>
<tr><td>RITALIN LA ®</td><td>60 mg/day</td></tr>
<tr><td>STRATTERA®</td><td>100 mg/day</td></tr>
<tr><td>VYVANSE ®</td><td>70 mg/day</td></tr>
<tr><td colspan="2">Non preferred</td></tr>
<tr><td>D-AMPHETAMINE ER</td><td>40 mg/day</td></tr>
<tr><td>DAYTRANA ®</td><td>30 mg/day</td></tr>
<tr><td>CONCERTA ER ®</td><td>54 mg/day or 72 mg/day > age 13</td></tr>
<tr><td>KAPVAY ER®</td><td>0.1 mg/day</td></tr>
<tr><td>METHYLIN ER ®</td><td>60 mg/day</td></tr>
<tr><td>METHYLIN</td><td>60 mg/day</td></tr>
<tr><td>METHYLIN SUSPENSION®</td><td>60 mg/day</td></tr>
<tr><td>METADATE CD ®</td><td>60mg/day</td></tr>
<tr><td>METADATE ER ®</td><td>60mg/day</td></tr>
<tr><td>METHYLPHENIDATE</td><td>60 mg/day</td></tr>
<tr><td>PROVIGIL ®</td><td>400 mg/day</td></tr>
<tr><td>NUVIGIL ®</td><td>250 mg/day</td></tr>
<tr><td>QUILLIVANT XR®</td><td>60 g/day</td></tr>
</table>
</td></tr>
<tr><td>TARGETED IMMUNE MODULATORS

Effective 1/1/2016</td><td>No PA Required

ENBREL (etanercept)

HUMIRA (adalimumab)</td><td>PA Required

ACTEMRA (tocilizumab)

CIMZIA (certolizumab)</td><td>Actemra (SQ) will be approved for treatment of RA in members who have had treatment failure with at least one conventional DMARD (e.g, methotrexate, leflunomide, and sulfasalazine), Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects or significant drug-drug interaction.)</td></tr>
</table>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		COSENTYX (secukinumab) KINERET (anakinra) ORENCIA (abatacept) Subcutaneous OTEZLA (apremilast) SIMPONI (golimumab) STELARA (ustekinumab) XELJANZ (tofacitinib) ***for information on IV infused Targeted Immune Modulators for Rheumatoid Arthritis please see Appendix P**	**Cimzia** (all dosage forms) will be approved for treatment of Crohn's disease in members who have had treatment failure with Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Cimzia** (all dosage forms) will be approved for treatment of RA in members who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Cimzia** (all dosage forms) will be approved for treatment of Ankylosing Spondylitis or Psoriatic Arthritis in members who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Cosentyx** will be approved for moderate to severe plaque psoriasis in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects or significant drug-drug interaction). **Kineret** will be approved for treatment of RA in members who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction). **Kineret** will be approved without PA for members with documented neonatal-onset multisystem inflammatory disease (NOMID). **Orencia** will be approved for the treatment of RA in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction). **Orencia** will be approved for the treatment juvenile idiopathic arthritis who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction).

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			Otezla will be approved for treatment of plaque psoriasis in members who have had treatment failure at least one conventional DMARD (e.g, methotrexate, leflunomide, and sulfasalazine), Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects or significant drug-drug interaction.) **Simponi** will be approved (in combination with methotrexate) for treatment of RA in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction). **Simponi** will be approved with or without methotrexate for the treatment of Ankylosing Spondylitis or Psoriatic Arthritis in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects or significant drug-drug interaction). **Simponi** will be approved for treatment of ulcerative colitis in members who have tried and failed Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction). **Stelara** will be approved with or without methotrexate for the treatment of Psoriatic Arthritis in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Stelara** will be approved for moderate to severe plaque psoriasis in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Xeljanz** will be approved for the treatment of RA in members who have had treatment failure with methotrexate, Humira, and Enbrel (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Xeljanz** will be not be approved for combination therapy with a biologic disease modifying agent.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			Quantity Limits: 2 tablets per day or 60 tablets for a 30 day supply
TESTOSTERONE PRODUCTS *Effective 7/1/2015*	**Must meet criteria** ANDROGEL 1.62% (testosterone topical) ANDRODERM (testosterone patch) DEPO TESTOSTERONE (testosterone cypionate injection) Testosterone Cypionate	**PA Required** ANDROGEL 1% AXIRON FORTESTA gel NATESTO STRIANT TESTIM gel Testosterone Enanthate VOGELXO	Preferred androgenic drugs will be approved for members meeting the following: *Hypogonadotropic or Primary Hypogonadism* • Male patient ≥18 years of age • Has a documented diagnosis of hypogonadotropic or primary hypogonadism (Patients with other diagnoses will require a manual review by a state pharmacist) AND • Has two documented low serum testosterone levels below the lower limit of normal range for testing laboratory prior to initiation of therapy AND • Does not have a diagnosis of breast or prostate cancer AND • Does not have a palpable prostate nodule or prostate-specific antigen (PSA) >4ng/ml AND • Has normal liver function tests prior to initiation of therapy *Gender Transition* • Biologically born female patient ≥ 18 years of age* AND • Is undergoing female to male transition AND • Has a negative pregnancy test prior to initiation AND • Has normal liver function test prior to initiation of therapy *For members <18 years of age, a manual review will be required. Non preferred androgenic products will be approved for patients meeting the above criteria with documented failure with an 8 week trial of a preferred androgenic product. (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) **Grandfathering:** Members may be grandfathered on preferred agents without requirement of updated low serum testosterone laboratory testing that meet the following criteria: • Male patient ≥ 18 years of age AND • Has at least one past documented low serum testosterone levels below the lower limit of normal range for testing laboratory prior to initiation of therapy AND

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			• Has documented diagnosis of hypogonadotropic or primary hypogonadism AND • Does not have a diagnosis of breast or prostate cancer AND • Does not have a palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL
TOPICAL IMMUNOMODULATORS *Effective 7/1/2015*	**Must meet criteria** ELIDEL (pimecrolimus)*	**PA Required** PROTOPIC (tacrolimus) Tacroliumus (generic Protopic)	*Elidel will only be approved after a member has had an adequate trial (e.g., one month or longer) of a topical steroid and failed treatment. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). This will be a one-time PA. Protopic will only be approved for a member who had an adequate trial (e.g. one month or longer) of a topical steroid and Elidel and failed treatment. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). This will be a one-time PA. PA is required for children < 2 years of age. PA will be required for members warranting ≥ 6 weeks of therapy with either Elidel or Protopic.
TRIPTANS *Effective 1/1/2016*	**No PA Required (monthly quantity limits may apply)** IMITREX [BNR] (sumatriptan) nasal spray and injection Naratriptan tablets RELPAX [BNR] (eletriptan) Rizatriptan MLT tablets Sumatriptan tablets	**PA Required** AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) IMITREX (sumatriptan) tablets MAXALT MLT tablets (rizatriptan) Maxalt tablets (rizatriptan) SUMAVEL DOSEPRO (sumtriptan) TREXIMET (sumatriptan/ naproxen)	Non-preferred products will be approved for members who have failed treatment with two Preferred Products within the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) **Quantity Limits:** Amerge, Frova, Imitrex, Treximet and Zomig: Max 9 tabs / 30 days. Axert and Relpax: Max 6 tabs / 30 days. Imitrex injection: Max 4 injectors / 30 days Maxalt: Max 12 tabs / 30 days. Zomig nasal spray and Imitrex Nasal Spray: Max 6 inhalers / 30 days. Zequity patch: Max 4 patches /30 days

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		Sumatriptan nasal spray and injection ZEQUITY patch (sumatriptan) ZOMIG (zolmitriptan)	