Prior Authorization Criteria

AS OF OCTOBER 2015

SAN FRANCISCO HEALTH PLAN
Here for you

Prior Authorization Criteria

The following is the listing of SFHP prior authorization criteria that will be used to evaluate prior authorization requests. SFHP's pharmacy prior authorization criteria are based on clinical monographs and National Pharmacy and Therapeutics guidelines (P&T) and have been approved by SFHP Pharmacy and Therapeutics (P&T) Committee. Prior Authorization Criteria will be updated regularly to reflect ongoing changes and is subject to change without notice.

Prior Authorization Requests for Non-Preferred Medications

Non-preferred medications may be authorized when there is clinical justification for doing so. Clinicians can submit a prior authorization (PA) request for a non-preferred medication in one of three different ways:

1. **Download and fax** Prior Authorization Request Form to **(855)811-9330** for standard requests or **(855)811-9331** for urgent requests.
2. **Call our Pharmacy Benefits Manager** (PBM) PerformRx at **(888)989-0091** to submit a verbal request.
3. **Submit Online** using the Online Pharmacy Prior Authorization Request Form.

Prior Authorization Request Form and Online Pharmacy Prior Authorization Request Form can be accessed from our website at http://www.sfhp.org/providers/formulary/prior-authorization-requests/.

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Abiraterone (Zytiga®) Last updated: July 2013 Last reviewed: January 2015	• Diagnosis of metastatic prostate cancer AND • Patient has castration-resistant disease (defined by tumor growth/disease progression, rise in PsA levels, new metastases). AND • Zytiga (abiraterone) will be used in combination with prednisone	1 year	Lack of disease progression per PA request with clinic notes attached	250 mg: #4 per day
ACE Inhibitors Fosinopril(Monopril®), Moexipril (Univasc®), Perindopril (Aceon®), Ramipril (Altace®) Last updated: May 2013 Last reviewed: January 2015	Trial and failure or inability to use of ALL of the formulary ACE Inhibitors: • Benazepril • Captopril • Enalapril • Lisinopril • Quinapril	2 years	Therapeutic response and continued clinical need per PA request	Fosinopril, Perindopril, Ramipril: #1 per day Moexipril: #2 per day
Acyclovir (Zovirax) 5% cream Penciclovir (Denavir) 1% cream	**Herpes labialis (cold sore)** • Patient is > 12 years of age AND	1 fill per year	Therapeutic response and continued medical need per PA request	5 gm per 30 days

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Created: January 2015 Updated: April 2015	• Trial and failure or inability to use ALL of the following: o Oral acyclovir and docosanol (Abreva®) 10% cream as first line therapy o Oral valacyclovir or oral famciclovir AND penciclovir (Denavir) 1% cream as second line therapy			
Acyclovir (Zovirax) 5% ointment Created: January 2015 Reviewed: April 2015	**Genital herpes or herpes simplex infections in immuno-compromised patients** Trial and failure or inability to use at least two oral antivirals (i.e. acyclovir, valacyclovir, famciclovir)	1 fill per year	Therapeutic response and continued medical need per PA request	15 gm per 30 days
ADHD Amphetamine Salts ER capsules (Adderall XR®), Atomoxetine (Straterra®), Dextroamphetamine SR capsules (Dexedrine®), Methylphenidate ER osmotic release tablets (Concerta®), Methylphenidate CD capsules (Metadate CD®), Methylphenidate LA	Amphetamine Salts ER capsules (Adderall XR®), Dextroamphetamine SR capsules (Dexedrine®), Methylphenidate ER osmotic release tablets (Concerta®), Methylphenidate CD capsules (Metadate CD®), Methylphenidate LA capsules (Ritalin LA®) • Diagnosis of ADHD AND • For patients > 18 years of age: prescriber is a psychiatrist	1 year	Therapeutic response and continued clinical need per PA request *NOTE: requests for non-formulary medications (e.g. Focalin XR®, Vyvanse®) will be modified to a preferred product if one has not been tried*	#1 per day for all formulations except #2 per day for dextroamphetamine SR (Dexedrine®)

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capsules (Ritalin LA®) Created: January 2014 Last updated: April 2014 Last reviewed: January 2015	<u>Atomoxetine (Strattera ®)</u> • Diagnosis of ADHD AND • <u>For patients ≤ 18 years of age</u>: trial and failure or inability to use at least 2 stimulants (e.g. due to potential of substance abuse) • <u>For patients > 18 years of age</u>: trial and failure or inability to use: o at least 2 stimulants (e.g. due to potential for substance abuse) **AND** o bupropion, clonidine IR or guanfacine IR AND • For patients > 18 years of age: prescriber is a psychiatrist			
Albuterol HFA (Proair® HFA, Proventil® HFA)	Trial and failure or inability to use preferred agents specified in the order below: 1. Ventolin® HFA 2. Proair® HFA (Step therapy with Ventolin® HFA) 3. Proventil® HFA (Step therapy with Proventil® HFA)	2 years	Therapeutic response and continued clinical need for PA request	# 2 inhalers/30 days

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Created: May 2013 Last updated: April 2015 Last reviewed: April 2015				
Antiemetics Ondansetron solution (Zofran®) Granisetron tablets (Kytril®) Last updated: July 2013 Last reviewed: January 2015	<u>Ondansetron solution:</u> **Nausea/vomiting** • Inability to swallow AND • Trial and failure or inability to use ondansetron oral disintegrating tablet <u>Granisetron tablets:</u> **Chemotherapy related nausea/vomiting (CINV)** Trial and failure or inability to use ondansetron	6 months	<u>Ondansetron solution</u> Therapeutic response per PA request and continued inability to use oral tablets <u>Granisetron</u> Therapeutic response and active chemotherapy treatment	<u>Ondansetron solution</u> #10ml/day <u>Granisetron</u> #12/30 days
Antihistamines – Second generation Desloratadine (Clarinex®) 5 mg tabs Created: May 2013	**Allergic rhinitis WITHOUT nasal congestion** Trial and failure or inability to use at least three formulary antihistamines (e.g. loratadine, cetirizine, fexofenadine) **Allergic rhinitis WITH nasal congestion**	2 years	Therapeutic response and continued medical need per PA request	#1/day

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Last updated: January 2015	Trial and failure or inability to use ALL of the following: • At least 3 formulary antihistamines (e.g. loratadine, cetirizine, fexofenadine) • At least 1 inhaled corticosteroid (e.g. fluticasone, flunisolide, Nasacort OTC)			
Antimalarial Agents Malarone (Atovaquone-Proguanil) 250/100 mg, 62.5/25 mg Created: October 2014 Last reviewed: January 2015	<u>Prevention or treatment of Malaria:</u> • Member is travelling to area of resistance to preferred formulary chloroquine, mefloquine, and doxycycline OR • Member is < 8 years old or pregnant and tried/failed or unable to use preferred formulary chloroquine and mefloquine OR • Member has tried and failed or unable to use preferred formulary chloroquine, mefloquine, and doxycycline	As stated per request	Therapeutic response and continued clinical need per PA request	#1 per day
Antiplatelet Agents <u>Formulary</u>: Cilostazol (Pletal) Clopidogrel (Plavix) 75	***Effient*** • Trial and failure or inability to use clopidogrel 75 mg ***Non-formulary drugs***	5 years	Therapeutic response and continued clinical need per PA request	<u>Formulary:</u> Ciclostazol: #2/day <u>Step-therapy:</u> Prasugrel: #1/day

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mg Dipyridamole (Persantine) <u>Step-therapy:</u> Prasugrel (Effient) <u>Non-formulary</u>: Aspirin/extended-release dipyridamole (Aggrenox) Anagrelide HCl** (Agrylin) Clopidogrel (Plavix) 300mg Ticagrelor (Brilinta) Voraxapar (Zontivity) Last updated: July 2015	• Trial and failure or inability to use clopidogrel 75 mg as a first line preferred product AND • Trial and failure or inability to use Effient as the second line preferred product **NOTE: Vorapaxar cannot be used in patients with history of stroke or TIA* 1.			<u>Nonformulary:</u> Ticagrelor: #2/day Voraxapar: #1/day Aggrenox: #2/day Anagrelide: #2/day
Antispasmodics Oxybutynin XL (Ditropan XL®), Oxybutynin patch (Oxytrol®), Tolterodine (Detrol®), Tolterodine LA (Detrol LA®),Trospium (Sanctura®), Darifenacin	**Overactive bladder** Trial and failure or inability to use preferred agents specified in the order below: 1. Oxybutynin IR 2. Oxybutynin XL 3. Tolterodine 4. Tolterodine LA 5. Trospium, Darifenacin, Solifenacin, Oxybutynin	2 years	Therapeutic response and continued clinical need per PA request	Oxybutynin XL: #1/day Tolterodine: #2/day Tolterodine LA: #1/day Trospium: #2/day Darifenacin: #1/day Solifenacin: #1/day

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(Enablex®), Solifenacin (Vesicare®) Last updated: May 2013 Last reviewed: January 2015	patch			Oxybutynin patch: #8 patches/30 days
Antivirals, Oral Formulary: Acyclovir #150/30 days Valacyclovir #90/30 days PA requried: Famciclovir (Famvir) Last updated: July 2015	***Famciclovir*** Trial and failure or inability to use acyclovir or valacyclovir	1 year	Therapeutic response and continued clinical need per PA request	Famciclovir: #3/day
Aprepitant (Emend®) Last updated: January 2015	• Patient is on highly emetogenic chemotherapy (e.g. cisplatin)** OR • Patient is on moderately emetogenic chemotherapy with documentation of trial and failure of standard antiemetic regimen or risk factors for chemotherapy induced nausea and	6 months or duration of chemotherapy	Patient is still on chemotherapy	#3 per 21 days

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	vomiting**			
ARBs Formulary: irbesartan losartan valsartan Step therapy: candesartan Non-formulary: azilsartan (Edabri) eprosartan olmesartan (Benicar) telmisartan **ARBS combos** Formulary: losartan/HCTZ irbesartan/HCTZ valsartan/HCTZ valsartan/amlodipine Step therapy: candesartan/HCTZ Non-formulary: azilsartan/chlorthalidone (Edarbyclor)	**ARBs** ***Candesartan***: trial and failure or inability to use irbesartan, losartan, AND valsartan ***Non-formulary products***: trial and failure or inability to use candesartan, irbesartan, losartan AND valsartan **ARBs combos** ***Candesartan/HCTZ***: trial and failure or inability to use irbesartan/HCTZ , losartan/HCTZ , valsartan/HCTZ AND valsartan/amlodipine ***Non-formulary products***: trial and failure or inability to use candesartan/HCTZ, irbesartan/HCTZ, losartan/HCTZ , valsartan/HCTZ AND valsartan/amlodipine	5 years	Therapeutic response and continued clinical need per PA request	#1 per day

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eprosartan/HCTZ (Teveveten HCT) olmesartan/HCTZ (Benicar HCT) olmesartan/amlodipine (Azor) olmesartan/amlodipine /HCTZ (Tribenzor) telmisartan/HCTZ (Micardis HCT) telmisartan/amlodipine (Twynsta) valsartan/amlodipine/ HCTZ (Exforge HCT) Last updated: May 2013 Last updated: July 2015				
Azelaic Acid (Azelex®, Finacea®) Last updated: January 2015	**Acne vulgaris** Trial and failure or inability to use of ALL of the following: • Benzoyl peroxide • Topical clindamycin or erythromycin • Topical tretinoin **Papulopustular Rosacea** • Trial and failure or inability to use topical	2 years	Therapeutic response and continued medical need per PA request	Azelex®: #30gm/30 days Finacea®: #50 gm/30 days

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	metronidazole			
Bile Acid Sequestrants Colesevelam (Welchol®), Colestipol (Colestid®) Created: May 2013 Updated: January 2015	Trial and failure or contraindication of cholestyramine powder	2 years	None	Colesevelam granules: #1 packet/day Colesevelam tablets: #6/day Colestipol granules: 30 gm/day Colestipol tablets: #16/day
Biologics * Adalimumab (Humira®), Etanercept (Enbrel®) **Abatacept (Orencia®), Anakinra (Kineret®),*	<u>Rheumatoid Arthritis</u> • Patient is 18 years of age or older** AND • Patient has a diagnosis of moderate to severe rheumatoid arthritis AND • Drug has been prescribed by or is currently being	**Initiation of therapy:** 6 months (8 weeks for ulcerative colitis) **Continuation of therapy:** 1	• The member has been receiving the medication and documentation was provided that the prescriber has evaluated the patient and recommends continuation of therapy	**<u>Enbrel</u>®** <u>Rheumatoid arthritis, Juvenile Idiopathic Arthritis*, Psoriatic arthritis, Ankylosing spondylitis</u> • 25 mg #8 (syringes) or 4.08 ml (8 vials) per 28 days (25 mg

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Certolizumab Pegol (Cimzia®), *Golimumab (Simponi®), Tofacitinib (Xeljanz®), Tocilizumab (Actemra®), Ustekinumab (Stelara®) are non-formulary and require trial and failure with or inability to use Humira® AND Enbrel® prior to approval* Created: May 2013 Last updated: January 2015	supervised by a rheumatologist AND • Documented trial and failure with at least two synthetic DMARDS (e.g. methotrexate, hydroxychoroquine, sulfasalazine, or leflunomide) or medical reason (intolerance, hypersensitivity, contraindication, etc) for not using DMARD agents OR • Early RA [less than 6 months from diagnosis] with poor prognosis (e.g. boney erosions, rheumatoid nodules, positive rheumatoid factor, and severe functional limitation) AND • Patient was evaluated for active or latent TB infection (e.g. tuberculin skin test) <u>Ankylosing Spondylitis</u> • Patient is 18 years of age or older** AND • Patient has a diagnosis of ankylosing spondylitis	year	AND • Documentation submitted indicates that the member has obtained significant clinical benefit from the medication.	2x/week dosing) OR • 50 mg 3.92 ml per 28 days (1 kit, 4 syringes/pen injectors) (50 mg once weekly dosing) *NOTE: for Juvenile Idiopathic Arthritis, dose should be 0.8 mg/kg once weekly (max 50 mg/dose) or 0.4 mg/kg 2x/week (max 25 mg/dose)* <u>Plaque Psoriasis</u> • Up to 50 mg 7.84 ml per 28 days (2 kits, 8 syringes/pen injectors) for the first 3 months (50 mg 2x/week dosing) • Then 50 mg 3.92 ml per 28 days (1 kit, 4

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	AND • Drug has been prescribed by or is currently being supervised by a rheumatologist AND • Patient has documented treatment failure with at least 2 NSAIDs or medical reason (intolerance, hypersensitivity, contraindication, etc) for not using NSAIDs AND • Patient was evaluated for active or latent TB infection (e.g. tuberculin skin test) <u>Crohn's Disease</u> • Patient is 18 years of age or older** AND • Patient has a diagnosis of moderate to severe Crohn's Disease AND • Drug has been prescribed by or is currently being supervised by a gastroenterologist or			syringes/pen injectors) (50 mg once weekly dosing) <u>**Humira®**</u> **Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis:** • #2 per 28 days (1 kit or #2 syringes/vials) OR • #4 per 28 days (2 kits or #4 syringes/vials) with documented treatment failure of 40 mg every other week (16 weeks of continuous therapy AND medical reason for not using methotrexate) **Juvenile Idiopathic**

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	rheumatologist AND • Patient has a documented failure of one or more conventional therapies for Crohn's Disease such as corticosteroids, azathioprine, mercaptopurine, methotrexate, or mesalamine AND • Patient was evaluated for active or latent TB infection (e.g. tuberculin skin test) <u>Polyarticular Juvenile Idiopathic Arthritis</u> • Patient is 17 years of age or younger** AND • Patient has a documented clinical diagnosis of juvenile idiopathic arthritis AND • Drug has been prescribed by or is currently being supervised by a rheumatologist AND • Patient has documented trial and failure of at			**Arthritis:** #2 per 28 days (1 kit or 2 syringes, 20mg/0.4ml if 15-30kg in weight or 40mg/0.8ml if >=30kg weight) **Plaque Psoriasis:** • #4 per 28 days x 1 month (Psoriasis starter package, 4 x 40mg syringes) • then #2 per 28 days (#1 kit/#2 syringes/pens) **Crohn's Disease and Ulcerative Colitis:** • 40 mg #6 per 28 days x 1 month (Crohn's Disease starter package, contains 6 x 40mg syringes)

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	least 2 months with at least one DMARD (e.g. methotrexate) or has a documented medical reason (e.g. intolerance, hypersensitivity) for not utilizing DMARDs AND • Patient was evaluated for active or latent TB infection (e.g. tuberculin skin test) <u>Systemic Juvenile Idiopathic Arthritis</u> • Patient is 17 years of age or younger** AND • Patient has a documented clinical diagnosis of juvenile idiopathic arthritis AND • Drug has been prescribed by or is currently being supervised by a rheumatologist AND • Patient was evaluated for active or latent TB infection (e.g. tuberculin skin test)			• then 40 mg #2 per 28 days (#1 kit, #2 syringes/vials)

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	Psoriasis • Patient is 18 years of age or older** AND • Patient has a diagnosis of chronic moderate to severe plaque psoriasis AND • Drug is being prescribed by a dermatologist AND • Trial and failure or inability to use at least 3 of the following: o Topical steroids o Topical medications [i.e. Dovonex® (calcipotriene), Tazorac® (tazorotene), anthralin or a coal tar preparation] o Methotrexate (inability to use examples include but not limited to history of liver or kidney disease, pregnancy, severe cytopenia, alcoholism) o Cyclosporine o Acitretin (Soriatane®)			

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	o UVB phototherapy or PUVA (psoralen – oral or topical methoxsalen plus UVA therapy) (inability to use examples include but not limited to pregnancy, skin cancer, hypersensitivity due to preexisting disease state - e.g. systemic lupus erythematus, cataracts) AND • Patient was evaluated for active or latent TB infection (e.g. tuberculin skin test) <u>Psoriatic Arthritis</u> • Patient is 18 years of age or older** AND • Diagnosis of psoriatic arthritis AND • Drug is being prescribed by a rheumatologist or dermatologist AND • Documented trial and failure with at least one DMARD (e.g. methotrexate 25-30 mg per week			

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	for 3 months) or inability to use DMARD (e.g. liver toxicity with methotrexate) OR Predominantly axial symptoms (i.e. spinal column or sacral involvement) or active enthesitis (tendon swelling) and/or dactylitis (toe/finger swelling) with trial and failure of NSAIDS or steroids AND • Trial and failure with methotrexate at maximum doses for 3 months or inability to use methotrexate (e.g. predominantly axial symptoms, liver toxicity) AND • Patient was evaluated for active or latent TB infection (e.g. tuberculin skin test) <u>Ulcerative Colitis</u> • Patient is 18 years of age or older** AND			

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	• Drug is being prescribed by a gastroenterologist AND • Trial and failure or inability to use (e.g. GI intolerance, hypersensitivity) sulfasalazine (3 to 6 g/day for 3 months), mesalamine (1.2 to 2.4 g/day for 3 months), azathioprine (2 to 2.5 mg/kg/day), 6-mercaptopurine (1.5 to 2 mg/kg/day) or oral corticosteroids AND • Patient was evaluated for active or latent TB infection (e.g. tuberculin skin test)			
Bisphosphonates Risedronate (Actonel®) Ibandronate (Boniva®) Risedronate (Atelvia®) Created: May 2013 Updated: January 2015	<u>Osteoporosis or Paget's disease</u> Trial and failure or inability to use preferred agents specified in the order below: 1. Alendronate 2. Ibandronate 3. Risedronate	2 years	Therapeutic response and continued medical need per PA request	Ibandronate 150 mg: #1/30 days Risedronate 5 mg: #1/day Risedronate 35 mg: #4/30 days Risedronate 150 mg: #1/30 days
Bosutinib (Bosulif®)	• Diagnosis of Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML)	1 year	Lack of disease progression	100, 500 mg: #1 per day

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Last updated: May 2013	AND • Patient is 18 years of age or older** AND • Patient has documented treatment failure to prior therapy (e.g. Gleevec, Sprycel or Tasigna) or has a documented clinically significant medical reason (intolerance, hypersensitivity, contraindication, etc) for not taking prior therapy			
Brand Name Medications Requests **SFHP has a mandatory generic policy and requires generic substitution when an equivalent generic product is available.* Created: October 2015	• Trial and failure of at least 2 generic versions of the requested drug by different manufacturers per claims history or documentation (e.g. dates tried, reason for trial and failure) from the provider OR • Inability to use at least 2 generic versions of the requested drug by the different manufacturers (e.g. 2 generic versions are not available) AND • Documented trial and failure or inability to use up to three preferred medications (if available) used to treat the documented diagnosis provided there is no evidence supporting use of the requested non-preferred medication compared to preferred agents. OR The requested drug is in one of the following classes: anti-epileptics, immunosuppressants	See drug-specific PA criteria OR <u>5 years</u>: for anti-epileptics and immunosuppressants OR <u>2 years for the following indications</u>: asthma/COPD, HTN, ESRD (e.g. phosphate	• See drug-specific PA criteria OR Therapeutic response and continued medical need per PA request for drugs without criteria	• See drug-specific PA criteria OR As requested not to exceed FDA approved or off-label dos

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		binders), testosterone replacement, BPH, overactive bladder hypercholesterolemia, depression/anxiety/mood disorders, diabetes, osteoporosis OR 1 year: for all other medications		
Budesonide capsule (Entocort®) 3 mg capsule Updated: October 2013	• Patient is 21 years of age or older** AND • Diagnosis of mild to moderate active or remissive Crohn's disease involving the ileum and/or the ascending colon AND • Prescription written by a gastroenterologist	Active Crohn's disease or recurring episode of active disease 8 weeks Remissive	Evaluation of progress notes and rationale for why continuation is needed	#90 per 30 days

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	AND • Documented trial and failure with 16 weeks of therapy at therapeutic doses of at least two preferred agents (eg. sulfasalazine, mesalamine, and prednisone)	Crohn's Disease 3 months		
Budesonide ER tablet (Uceris®) 9 mg tabs Last updated: October 2013	• Patient is 21 years of age or older** AND • Indication of induction of remission of active mild to moderate ulcerative colitis AND • Prescription written by a gastroenterologist AND • Documented trial and failure with 16 weeks of therapy at therapeutic doses of at least two preferred agents (eg. mesalamine, balsalazide or olsalazine)	8 weeks	Evaluation of progress notes and rationale for why continuation is needed	#30 per 30 days
Budesonide respules (Pulmicort®) Last updated: July 2013	Trial and failure or inability to use any inhaled corticosteroid multi-dose inhaler **on formulary for patients < 8 years old*	1 year	Therapeutic response per PA request	#360 ml/90 days

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Butorphanol (Stadol NS®) Last updated: May 2013	<u>Acute pain (moderate to severe) or migraine</u> • Trial and failure of 3 or more formulary pain medications AND • Followed by a Migraine specialist, Neurologist, or Pain Management specialist	Initial Authorization: 6 months Reauthorization: 1 year	Therapeutic response per PA request	#1 unit/30 days
Calcipotriene (Dovonex) Created: January 2015	<u>Plaque psoriasis:</u> Trial and failure or inability to use at least two medium or high potency steroids	2 years	Therapeutic response and continued medical need per PA request	60 gm per 30 days
Capecitabine (Xeloda®) Last updated: July 2013	• The member has a diagnosis of metastatic colorectal cancer OR • The member has a diagnosis of Dukes' C colon cancer **AND** has undergone complete resection of the primary tumor OR • The member has a diagnosis of metastatic breast cancer, **AND** capecitabine is being used: o In combination with docetaxel after failure	1 year	Lack of disease progression per PA request with clinic notes attached	1250 mg/m^2 twice daily for 2 weeks, every 21 days *(patient's BSA must be provided on the PA request)*

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	of prior anthracycline-containing therapy **OR** As monotherapy in patients resistant to both paclitaxel and an anthracycline-containing regimen (or for whom further anthracycline therapy is not indicated)			
Cardio: CHF Neprilysin & ARB PA Required Sacubitril/Valsartan (Entresto®) Created October 2015	• Patient is ≥ 21 years of age** AND • Drug is prescribed by (or in consultation with) a cardiologist AND • Diagnosis of chronic heart failure (NYHA class II, III, or IV) and reduced ejection fraction AND • Cannot be used concomitantly with an ACE inhibitor AND • Cannot be used with ACEI or aliskiren in patients with diabetes AND • On a maximum tolerated dose of beta-blocker or diuretic AND Documentation of titration schedule	36 months	Therapeutic response and continued clinical need per PA request	Initial quantity and duration based on provided titration schedule Maintenance: #60 per 30 days *FDA approved dosing*: 24/26 mg: #2/day for 2 or 4 weeks duration 49/51 mg: #2/day for 2 or 4 weeks duration 97/103 mg: #2/day for 4 weeks Maximum 12 week titration *To continue lower dose beyond 8 weeks, statement that maximum tolerated dose has been*

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
				reached is needed
Carvedilol CR (Coreg CR®) Last updated: January 2015	<u>Congestive Heart Failure stage B,C, or D or left ventricular dysfunction following a myocardial infarction</u> • Trial and failure or inability to use generic carvedilol	2 years	None	#1/day
Celecoxib (Celebrex®) Last updated: May 2013	Trial and failure or inability to use 2 or more NSAIDs OR One of the following: • Over the age of 60 • Concurrent proton pump inhibitor therapy • Concurrent aspirin or warfarin therapy • Concurrent oral corticosteroid therapy • History of GI ulcer, GI bleed, GI intolerance with NSAIDs or H. Pylori infection **Familial adenomatous polyposis** Approvable condition	1 year	None	#2/day
Cholinesterase Inhibitors	Trial and failure or inability to use formulary donepezil	1 year	None	Razadyne

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Galantamine (Razadyne®, Razadyne ER®), Rivastigmine (Exelon®), Donepezil ODT (Aricept ODT®) Last updated: May 2013	OR For ODT and patch formulations: Intolerance to oral medications or issues with compliance			#2/day Razadyne ER #1/day Rivastigmine #2/day Rivastigmine patches #1/day Donepezil ODT #1/day
Ciclesonide (Alvesco®)	**Asthma** Trial and failure of all of the following: • Beclomethasone (Qvar®) • Budesonide (Pulmicort®)	2 years	None	#1 unit/40 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Last updated January 2015	Fluticasone (Flovent®)			
Ciprofloxacin-Dexamethasone Otic Suspension (Ciprodex®) Last updated: July 2013	Trial and failure or intolerance to ciprofloxacin otic solution or ofloxacin otic solution OR • Patient has inflammation, pruritus or ear pain	1 fill	None (1 time approval)	7.5 ml for 1 fill
Clobazam (Onfi®) Created: February 2013 Last updated: January 2015	• Diagnosis is Lennox-Gastaut Syndrome or epilepsy AND • Patient is using at least 1 other antiepileptic medication AND • Trial and failure of 2 or more anticonvulsants AND Initially prescribed or being followed by a neurologist	5 years	Therapeutic response and continued clinical need per PA request	#1 per day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Clonidine patches (Catapres-TTS®) Last updated: January 2015	Hypertension • Approvable if the member is unable to swallow or has issues with compliance	2 years	None	#4 patches per 28 days
Clostridium Difficile Agents Vancomycin capsules (Vancocin®) Fidaxomicin (Dificid®) Created: October 2014	C. difficile-associated diarrhea (CDAD): Vancomycin (Vancocin®) • Trial and failure of inability to use metronidazole (ie. Pregnancy in first trimester) Fidaxomicin (Difcid®) • Trial and failure of inability to use metronidazole (ie. Pregnancy in first trimester) AND Trial and failure of inability to use oral vancomycin	Quantity as requested by provider at no more than 30 day supply	Therapeutic response and continued clinical need per PA request	Vancomycin (Vancocin®) #40 per 10 days, 2 fills per year Fidaxomicin (Difcid®) #20 per 10 days, 1 fill per year
CNS stimulants:	**Narcolepsy:**	1 year	Therapeutic response	#1 per day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Modafinil (Provigil®) Armodafinil (Nuvigil®) Created: January 2015	• Patient is ≥ 21 years of age* AND • Trial and failure or inability to use methylphenidate or dextroamphetamine/amphetamine AND • For Nuvigil: trial and failure or inability to use modafinil **Excessive sleepiness due to obstructive sleep apnea/hypopnea syndrome (OSAHS)** • Patient is ≥ 21 years of age* AND • Trial and failure or inability to use continuous positive airway pressure (CPAP) therapy AND • For Nuvigil: trial and failure or inability to use modafinil		and continued medical need per PA request	

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	Shift work sleep disorder (SWSD), or fatigue/sleepiness due to multiple sclerosis (MS): • Patient is ≥ 21 years of age* AND For Nuvigil: trial and failure or inability to use modafinil			
Colchicine (Colcrys®) Created: April 2014 Last updated: January 2015	Acute gout attack • Trial and failure of maximum doses of one NSAID (e.g. naproxen 500 mg TID, indomethacin 50 mg TID) or inability to use NSAIDs (e.g. age>65, GFR < 30 ml/min, history of GI bleed) Chronic gout • Trial and failure or inability to use urate lowering therapy (allopurinol or febuxostat) at maximum tolerated dose (allopurinol 800 mg or fexobustat 80 mg) or dose adjusted for renal function OR • Symptomatic gout with serum uric acid level is <	Acute gout attack 1 fill Chronic gout 1 year Acute gout flare prevention during initiation of urate lowering	Acute gout attack Lack of symptomatic relief Chronic gout Signs and symptoms of gout after 6 months of Colcrys therapy while on maximum tolerated dose of urate lowering therapy (allopurinol) Acute gout flare prevention during	Acute gout attack #30 per fill (1.2 mg initially, then 0.6 mg one hour later, followed by 0.6 BID until attack resolution with 14 days between therapy) Chronic gout #2 per day Acute gout flare

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	6 mg/dl Acute gout flare prevention during initiation of urate lowering therapy • Trial and failure of maximum doses of one NSAID (e.g. naproxen 500 mg TID, indomethacin 50 mg TID) or inability to use NSAIDs (e.g. age>65, GFR < 30 ml/min, history of GI bleed) AND • Member is starting urate lowering therapy and has history of recent gout attack Familial Mediterranean Fever (FMF) Member is 4 years of age or older Acute psuedogout (acute calcium pyrophosphate crystal arthritis) Trial and failure or inability to use NSAIDs ((e.g. age >65, on oral anticoagulant, GFR < 30 ml/min, history	therapy 6 months Familial Mediterranean Fever 1 year Acute pseudogout 3 months Chronic pseudogout 1 year Pericarditis 6 months	initiation of urate lowering therapy Signs and symptoms of gout OR Serum uric acid level is > 6 mg/dl and urate lowering therapy is still being titrated Familial Mediterranean Fever Evaluation of recent progress notes Acute pseudogout, chronic pseudogout, acute idiopathic or viral pericarditis Therapeutic response and continued medical	prevention during initiation of urate lowering therapy #2 per day Familial Mediterranean Fever #4 per day Acute pseudogout, chronic pseudogout, acute idiopathic or viral pericarditis: #60 per 30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	of GI issues (e.g. GI bleed/ulcer), side effects from prior trial of NSAIDs) <u>Chronic pseudogout</u> History of three or more attacks annually <u>Acute idiopathic or viral pericarditis</u> • Colchicine therapy is being used in combination with NSAIDs		need per PA request	
Criteria for non-FDA approved or off-label uses Created: October 2015	• No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia* AND • Medication is being requested for an accepted off-label use and is listed in the standard clinical decision support resources (e.g. UpToDate, Micromedex, etc) OR • Requested use can be supported by least two citations of published clinical trials *Medical compendia consists of the following: the Food and Drug Administration (FDA) approved	1 year	Therapeutic response and continued medical need per PA request	Not to exceed common off-label dose or dose used in published trials

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	indication(s) (Drug Package Insert), Micromedex, American Hospital Formulary Service (AHFS), DrugPoints (formerly known as USPDI).			
Criteria for non-specialty non-formulary or PA required medications without drug-specific criteria Created: October 2015	• Drug-specific PA criteria does not exist for the requested drug AND • Appropriate diagnosis/Indication for requested non-formulary or PA required medication AND • Appropriate dose of medication based on age (i.e. pediatric and elderly populations) and indication AND • In the absence of evidence supporting use of requested medication compared to preferred agents, documented trial and failure or inability to use up to three preferred medications (if available) used to treat the member's condition. OR • No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia*. OR • All other formulary medications are contraindicated based on the patient's diagnosis, other medical conditions, or other medication therapy.	1 year	Therapeutic response and continued medical need per PA request for drugs without criteria	As requested not to exceed FDA approved or off-label dose

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	*Medical compendia consists of the following: the Food and Drug Administration (FDA) approved indication(s) (Drug Package Insert), Micromedex, American Hospital Formulary Service (AHFS), DrugPoints (formerly known as USPDI).			
Cyclosporine Ophthalmic (Restasis®) Last updated: May 2013	Keratoconjunctivitis sicca (KCS) or dry eye disease Trial and failure or inability to use artificial tears OR Initially prescribed or being followed by an ophthalmologist	1 year	Therapeutic response and continued need per PA request	2 packages (60 vials)/30 days
Cystic Fibrosis PA required: Aztreonam (Cayston®) Dornase alfa (Pulmozyme) Ivacaftor (Kalydeco) Lumacaftor/Ivacaftor (Orkambi) Tobramcyin (Tobi) 300 mg/5 ml solution Non-formulary:	Kalydeco (Ivacaftor): • The patient is 2 years or older** • The medication is for the treatment of a CF patient who has an FDA approved indication for treatment of the patient's genotype (there is a FDA cleared CF mutation test that can be used to determine genotype if unknown). • MD is pulmonologist • Copy of the FDA-cleared CF mutation test has been provided with request • The patient is not a homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.	5 years	Therapeutic response per PA request with clinic notes attached	Kalydeco: 56 tablets per 28 days Cayston: 7056 ml per 56 days (28 days on therapy followed by 28 days off therapy) Pulmozyme: 70 ml per 28 days Bethkis: 224 ml per 56 days (28 days on therapy followed by 28 days off therapy)

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Tobramycin (Bethkis, Kitabis Pak, Tobi Podhaler) Created: April 2015 Last updated: October 2015	• Documentation of current ALT/AST levels (within 60 days of request). (Ivacaftor is contraindicated for ALT and AST levels 5 times over upper limit of normal. If ALT and AST levels are 5 times over the upper limit of normal or higher, ivacaftor should not be started until the levels are below this range.) • The medication is being prescribed at a dose that is within FDA approved guidelines. • For patients 2-6 years of age: documentation of weight is required to determine appropriate dosing <u>Tobi, Tobi Podhaler, Bethkis, Kitabis Pak (tobramycin):</u> • Patient is 21 years of age or older** • The medication is being prescribed for the treatment of a cystic fibrosis patient colonized with Pseudomonas aeruginosa • The medication is being prescribed at a dose that is within FDA approved guidelines. • MD is pulmonologist • <u>For Tobi® Podhaler™, Kitabis Pak, or Bethkis</u>: trial and failure or inability to use generic tobramycin 300 mg/5 ml <u>Pulmozyme (Dornase Alfa)</u> • The patient is 5 years or older** • The medication is not being used as			<u>Kitabis pak/Tobramycin</u>: 280 ml per 56 days (300 mg/5ml BID, 28 days on therapy followed by 28 days off therapy) <u>Tobi Podhaler</u>: 224 capsules per 56 days (28 days on therapy followed by 28 days off therapy) <u>Orkambi</u>: 112 tablets per 28 days (2 tablets every 12 hours)

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	monotherapy. • MD is pulmonologist • The medication is being prescribed at a dose that is within FDA approved guidelines. <u>Cayston (Aztreonam Lysine)</u> • Patient is 21 years of age or older** • The medication is being prescribed for the treatment of a cystic fibrosis patient colonized with Pseudomonas aeruginosa. • MD is pulmonologist • The medication is being prescribed at a dose that is within FDA approved guidelines. <u>Orkambi (lumacaftor/ivacaftor)</u> • The patient is 21 years of age or older** • The patient IS homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene. • Copy of the FDA-cleared CF mutation test has been provided with request. • Documentation of current ALT/AST and bilirubin levels (within 60 days of request). • The medication is being prescribed at a dose that is within FDA approved guidelines			
Dalfampridine (Ampyra®)	• Patient has a documented diagnosis of multiple sclerosis (MS) AND	Initiation of therapy: 3 months	Therapeutic response per PA request with clinic notes attached	10 mg tablets: 2 tablets per day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Last updated: May 2013	• Patient is ambulatory (able to walk at least 25 feet) AND • Patient has walking impairment AND • Patient does not have any of the following contraindications to therapy: o History of seizure o Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute) AND Patient is not currently using any other forms of 4-aminopyridine (i.e., 4-AP, fampridine)	Continuation of therapy: 1 year		

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Darbepoetin alfa (Aranesp®) Last updated: May 2013	• Patient is ≥21 years of age** AND • Patient is diagnosed wtih anemia due to end stage renal disease/kidney disease, or chemotherapy, or myelodysplastic syndrome (MDS), or Hepatitis C treatment AND • Hemoglobin less than 10g/dL	3 months	• Hemoglobin less than 12g/dL	#4 vials or syringes per 30 days
Dasatinib (Sprycel®)	Patient is 18 years of age or older** AND Patient has one of the following: • Newly diagnosed Philadelphia chromosome positive chronic myelogenous leukemia (Ph+ CML) in the chronic phase • Ph+ CML with resistance or intolerance to prior therapy • Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL)* *Use of Sprycel (dasatinib) as frontline therapy in Ph+ ALL is a compendial use • Gastrointestinal stromal tumors (GIST) after disease progression on Gleevec (imatinib) or	1 year	Lack of disease progression per PA request with clinic notes attached	20 mg, 50 mg, 70 mg, 80 mg, 100 mg, 140 mg: #30 per 30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Last updated: July 2013	Sutent (sunitinib)† • † Compendial use			
Deferasirox (Exjade®) Last updated: May 2013	All following must be met: • Patient is transfusion dependent and between 2 and 65 years old • Initially prescribed or being followed by an hematologist • Diagnosis of chronic iron overload (serum ferritin consistently greater than 1000 mcg/L) • Treatment failure, contraindication or significant intolerance to deferoxamine treatment • Not being used in combination with other iron chelator therapies Starting dose is greater than 20 mg/kg per day or maintenance dose is greater than 30 mg/kg per day	3 months	Serum ferritin is not consistently below 500 mcg	Determined by request

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Diabetic Test Strips Formulary: Accu-Chek SmartView (for Nano) and Accu-Chek Aviva Plus test strips #4 per day for all members except #8 per day for members with gestational diabetes Non-formulary: all other test strip brands Last updated: April 2015	**SFHP will check California Children's Services Eligibility for members < 21 years of age **Contour Test Strips** Test trips will be used with an insulin pump **Other non-formulary test strips** Trial and failure or inability to use formulary Accu-Check SmartView (for Nano) or Accu-Check Aviva Plus test strips **Accu-Check SmartView (for Nano) or Accu-Check Aviva Plus test strips over formulary quantity limit** • Medical need for more frequent glucose monitoring that four times daily or eight times daily for gestational diabetes (e.g. frequent incidents of hypoglycemia, etc)	**Gestational diabetes**: 2 months after estimated delivery date, up to 11 months **Other indications**: 2 years	Therapeutic response and continued medical need per PA request	**Contour Test Strips for insulin pump:** #8 per day **Other non-formulary test strips**: #4 per day or #8 per day for gestational diabetes

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Diabetes: **DPP-4 Inhibitors** Step Therapy: Sitagliptin (Januvia®), Linagliptin (Tradjenta®), Saxagliptin (Onglyza®), Sitagliptin/Metformin (Janumet®), Sitagliptin/Metformin (Janumet XR®), Saxagliptin/Metformin (Kombiglyze®) Non-formulary: Alogliptin (Nesina®), Alogliptin/Metformin, (Kazano®), Alogliptin/Pioglitazone (Oseni®) Last updated: October 2015	**Diabetes Mellitus – type 2** Januvia, Onglyza, Tradjenta, Janumet, Janumet XR, Kombiglyze: • Trial and failure or inability to use metformin for at least 3 months Nesina, Kazano, Oseni: • Trial and failure or inability to use metformin for at least 3 months AND • Trial and failure or inability to use Januvia, Onglyza AND Tradjenta	2 years	Therapeutic response and continued medical need per PA request	**Januvia, Onglyza, Tradjenta, Janumet XR, Kombiglyze:** #90/90 days **Janumet:** #180/90 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Diabetes: **SGLT2 Inhibitors** Step Therapy: Canagliflozin (Invokana®), Dapagliflozin (Farxiga®), Empagliflozin (Jardiance®), Canagliflozin/Metformin (Invokamet®), Dapagliflozin/Metformin (Xigduo XR®), Empagliflozin/Metformin (Synjardy ®) PA required: Empagliflozin/Linagliptin (Glyxambi®) Last updated: October 2015	**Diabetes Mellitus – type 2** Invokana, Farxiga, Jardiance, Invokamet, Xigduo XR, Synjardy: • Trial and failure or inability to use metformin for at least 3 months Glyxambi: • Trial and failure or inability to use metformin AND SGLT2 or DPP-4 inhibitor concurrently or as dual therapy for at least 3 months	2 years	Therapeutic response and continued medical need per PA request	**Invokana, Farxiga, Jardiance, Xigduo XR, Glyxambi:** #90/90 days **Invokamet, Synjardy:** #180/90 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Diabetes: GLP-1 Receptor Agonists **Step Therapy**: Liraglutide (Victoza®), Albiglutide (Tanzeum®) **Non-Formulary**: Exenatide (Byetta®, Bydureon®), Dulaglutide (Trulicity®) Last updated: October 2015	**Diabetes Mellitus – type 2** Victoza, Tanzeum: • Trial and failure or inability to use metformin for at least 3 months Exenatide (Byetta®, Bydureon®), Dulaglutide (Trulicity®): • Trial and failure or inability to use Victoza and Tanzeum for at least 3 months	2 years	Therapeutic response and continued medical need per PA request	**Victoza 18mg/3ml**: up to 27 ml per 90 days (1.8 mg (0.3 ml) per day) **Tanzeum:** up to 6 mL per 90 days (0.5 mL per 30 mg or 50 mg weekly dose)

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Dronabinol (Marinol®) PA required Created: January 2015 Updated: October 2015	HIV related anorexia and cachexia • Severe weight loss (e.g. BMI <18.5 in the last 4 months, BMI < 18.5-22 AND weight loss ≥ 10% in the last 6 months) AND • Trial and failure or inability to use megestrol acetate 400-800mg daily Chemotherapy induced nausea and vomiting (CINV) Trial and failure or inability to use at least 3 of the following: • Dopamine receptor antagonists (e.g. prochlorperazine, promethazine, or metoclopramide) • 5HT3 receptor antagonists (e.g. ondansetron 8 mg BID) • BZDs (e.g. lorazepam 0.5 mg Q4-6hrs) • Antihistamines (e.g. diphenhydramine 20-50 mg Q4-6hrs) • Atypical antipsychotic (e.g. olanzapine 10 mg/day) HIV associated nausea and vomiting (off-label indication) Trial and failure or inability to use at least 2 alternative therapies (e.g. 5-Hydroxytryptamine (5-HT3) (e.g. ondansetron), prochlorperazine, promethazine, metoclopramide, lorazepam	HIV related anorexia and wasting 2 years CINV 6 months or duration of chemotherapy HIV associated nausea and vomiting 2 years	HIV related anorexia and wasting Therapeutic response and continued medical need per PA request CINV Response to therapy AND patient is still on chemotherapy HIV associated nausea and vomiting Therapeutic response and continued medical need per PA request	HIV related anorexia and wasting 2.5, 5 mg: #3 per day 10 mg: #2 per day CINV #3 per day HIV associated nausea and vomiting #3 per day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Duloxetine (Cymbalta®) Last updated: January 2015	<u>Depression or mood disorder</u> • Trial and failure or inability to use at least 2 preferred formulary antidepressants – fluoxetine, paroxetine, citalopram, sertraline, fluvoxamine, bupropion SR/XL or mirtazapine AND • Trial and failure or inability to use venlafaxine immediate or extended release for at least two months <u>Peripheral neuropathy</u> • Trial and failure or inability to use ALL of the following: at least one tricyclic antidepressant, gabapentin 1800 mg/day and venlafaxine immediate or extended release for at least 2 months. <u>Fibromyalgia</u> • Trial and failure or inability to use at least one tricyclic antidepressant AND gabapentin 1800 mg day	2 years	Therapeutic response and continued medical need per PA request	Max #2 per day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	<u>Depression/mood disorder AND neuropathic pain</u> • Trial and failure or inability to use venlafaxine immediate or extended release for at least two months			
Dutasteride (Avodart®) Last updated: July 2013	• Trial and failure or inability to use finasteride AND tamsulosin	2 years	Therapeutic response per PA request	#1/day
Eltrombopag (Promacta®) Created: January 2015	<u>Chronic immune (idiopathic) thrombocytopenia (ITP):</u> • Member is 21 years of age or older** AND • Diagnosis of chronic ITP (i.e. > 3 months duration) AND • Trial and failure or inability to use glucocorticoids, intravenous immune globulin (IVIG) or splenectomy AND Platelet level < 20,000/mm3 OR < 30,000/mm3 with bleeding	12 months	Therapeutic response and continued medical need per PA request	#30 per 30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Enteral Nutrition Products Created: January 2015	San Francisco Health Plan will follow California Department of Health Care Services Medical Criteria for Enteral Nutrition Products **Standard enteral products** (e.g. Ensure, Jevity, Osmolite, PediaSure, Boost, Compleat, Isosource, Nutren) • Documentation must be dated within 3 months at the time of request. AND • Member must meet one of the following criteria: o A documented medical diagnosis requiring enteral nutrition products administered via feeding tube o A documented chronic medical diagnosis **AND** unable to meet nutritional needs with soft/pureed foods. There must be clinical indicators identified member is nutritionally at risk. OR • For members 21 years of age and older, a medical diagnosis and documentation that member is nutritionally at risk with one of the following measures:	6 months	Therapeutic response and continued medical need per request	Liquid #21,330 mL per 30 days Powder #4540 grams per 30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	o Involuntary weight loss ≥10% of usual body weight within 6 months o Involuntary weight loss ≥7.5% of usual body weight within 3 months o Involuntary weight loss ≥5% of usual body weight in 1 month o BMI < 18.5kg/m^2 OR • Transitioning from parenteral or enteral tube feeding to oral diet OR • If member is less than 21 years of age, there is documentation of clinical signs and symptoms indicating nutritional risk (such as stunting, wasting or underweight). For children: o Weight ≤ 3rd percentile OR o Weight ≤ 5th percentile AND one of the following: ▪ product is recommended by GI specialist or dietician OR ▪ patient has a physiological or behavioral disorder responsible for low weight			

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	OR • Documentation of severe swallowing or chewing difficulty due to one of the following: o cancer in the mouth/throat or esophagus o injury, trauma, surgery or radiation therapy in head or neck o chronic neurological disorders o severe craniofacial anomalies **Specialized enteral products** (e.g. Glucerna, Nepro, Pulmocare, Proteinex, Boost Glucose Control, Nepro with Carb Steady, Pulmocare) • Member must meet criteria for standard enteral products listed above AND • For **carbohydrate modular products** – documentation of inability to meet caloric nutritional need with current use of standard enteral product • For **lipid(fat) modular products** – documentation of **one** of the following: o inability to digest or absorb conventional			

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	fats o diagnosis of uncontrolled seizure disorder that cannot be medically managed • For **protein modular products** – documentation of inability to meet protein requirement with current use of high protein enteral nutrition product **Elemental and semi-elemental enteral products** (e.g. PediaSure Peptide, EleCare Jr, Perative, Pivot, Vital, Impact, Peptamen, Vivonex, Neocate Jr) • Documentation must be dated within 3 months at the time of request. AND • Member must have documentation of one of the following: o Intestinal malabsorption diagnosis (ICD-9-CM codes 579.0 – 579.9) o Chronic medical diagnosis with trial and failure or contraindication to specialized disease-specific enteral nutrition product **AND** inability to absorb nutrients or tolerate intact protein that cannot be medically managed			

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	Metabolic enteral products (PhenylAde, Lophlex, Milupa, PKU) • Documentation must be dated within 6 months at the time of request. AND • Member must have diagnosis of inborn errors of metabolism. •			
Enteral Nutrition Products: Specialty Infant Enteral Products (e.g. Similac, Enfamil, Human Milk Fortifier, Expert Care Alimentum, Pregestimil, Nutramigen) Created: January 2015	**Premature infants:** • Documentation of gestational age (< 37 weeks) or birth weight less than 3500 grams AND • Member is less than one year of corrected age AND • <u>For Alimentum, Pregestimil, Nutramigen</u>: documentation of cow milk protein allergy or intolerance to breast milk and infant formula (e.g. eczema) **Cow milk protein allergy** (Alimentum, Pregestimil,	**Premature infants** <u>Initial</u>: up to 6 months of corrected age <u>Re-auth</u>: up to 1 year of corrected age **Cow milk protein allergy:** up to 1 year of age	Therapeutic response and continued medical need per request	Liquid #42660 mL per 30 days Powder #9080 grams per 30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	Nutramigen): • Member is less than one year of age AND Documentation of cow milk protein allergy or intolerance to breast milk and infant formula (e.g. eczema)			
Enzalutamide (Xtandi®) Last updated: May 2013	• Patient is 18 years of age or older** AND • Patient has a diagnosis of metastatic castration-resistant prostate cancer AND • Patient is male AND • Patient has received prior chemotherapy containing docetaxel	12 months	Lack of disease progression	#4 per day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Epoetin alfa (Epogen®, Procrit®) Last updated: May 2013	• Patient is 18 years of age or older** AND • Patient's anemia is due to one of the following: end stage renal disease, chemotherapy, complication of Hepatitis C treatment, anemia due to zidovudine therapy AND • Hemoglobin < 10 g/dL	**ESRD** Initial and continuing therapy: 3 months **Chemotherapy** Initial therapy: duration of chemotherapy **Zidovudine therapy** Initial and continuing therapy: 12 months	Hemoglobin < 12 g/dL	**ESRD and chemotherapy** #4 vials or syringes per 30 days **Zidovudine therapy** 2,000U/mL, 3,000U/mL, 4,000U/mL and 10,000U/mL vials: #12 vials per month 20,000U/mL, 20,000U/mL vials and 40,000U/mL vials: #4 vials per month.

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Erlotinib (Tarceva®)	**Non-small cell lung cancer** • Patient is 18 years of age or older** AND • Patient has a diagnosis of locally advanced or metastatic (Stage III or IV) non-small cell lung cancer (NSCLC) with either: o Failure with at least one prior chemotherapy regimen **AND** Tarceva (erlotinib) will be used as monotherapy **OR** o No evidence of disease progression after four cycles of first-line platinum-based chemotherapy **AND** Tarceva (erlotinib) will be used as maintenance treatment **AND** Tarceva (erlotinib) will be used as monotherapy **OR** o Patient has known active epidermal growth factor receptor (EGFR) mutation or gene amplification **AND** Tarceva (erlotinib) will be used first-line **Pancreatic cancer**	12 months	Lack of disease progression	25, 100, 150 mg: #1 per day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Last updated: May 2013	• Patient is 18 years of age or older** AND • Patient has a diagnosis of locally advanced, unresectable, or metastatic pancreatic cancer AND • Tarceva (erlotinib) will be used in combination with gemcitabine			
Everolimus (Afinitor®, Afinitor® disperz)	**Afinitor (everolimus) tablets only:** **Renal Cell Carcinoma** • Patient is ≥18 years of age** AND • Patient has a diagnosis of advanced/metastatic renal cell carcinoma (RCC) AND	Initiation of therapy: 1 year Continuation of therapy: 1 year	Lack of progression	2.5-mg-8 tablets/day 5 mg- 4 tablets/day 7.5 mg- 2 tablets/day 10 mg- 2 tablets/day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	• Patient has failed therapy (disease progressed) with sunitinib [SUTENT] or sorafenib [NEXAVAR] **Progressive Pancreatic Neuroendocrine Tumors** • Patient is ≥ 18 years of age** AND • Patient has a diagnosis of progressive neuroendocrine tumors of pancreatic origin (pNET) that are unresectable, locally advanced, or metastatic **Renal angiomyolipoma with TSC** • Patient is ≥ 18 years of age** AND • Patient has a diagnosis of renal angiomyolipoma and TSC AND • Patient does not require immediate surgery			

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	Breast Cancer • Patient is a postmenopausal woman AND • Patient has a diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer AND • Patient has failed treatment with letrozole [Femara] or anastrozole [Arimidex] AND • Afinitor will be used in combination with exemestane [Aromasin] **Afinitor (everolimus) tablets and tablets for oral suspension:** **Subependymal Giant Cell Astrocytoma (SEGA)** • Patient is ≥ 21 years* of age AND • Patient has SEGA associated with tuberous sclerosis complex (TSC) that requires therapeutic intervention but is not a candidate for curative			

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Last updated: May 2013	surgical resection • **Check California Children's Services (CCS) eligibility for patients < 18 years of age*			
Extended cycle contraceptives Levonorgestrel/Ethinyl Estradiol and Ethinyl Estradiol (Seasonique®) Levonorgestrel/Ethinyl Estradiol (Seasonale®) Levonorgestrel/Ethinyl Estradiol (Lybrel®) Last updated: July 2013	Trial and failure or inability to use formulary contraceptives (Cyclessa, Ortho Novum, Ortho Tri-cyclen, Loestrin) AND Patient is not compliant with formulary contraceptives due to packaging	1 year	See criteria for initiation of therapy	#1/day
Ezetimibe (Zetia®)	**Homozygous sitosterolemia** Approvable condition	2 years	Therapeutic response and continued medical need per PA request	#1/day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Last updated: May 2013	**Hyperlipidemia** • Contraindication to statins (muscle pain or elevated liver enzymes) OR Failed atorvastatin 80 mg or maximum tolerated doses of formulary statins for at least 3 months			
Febuxostat (Uloric®) Last updated: April 2014	• Intolerance or adverse event with allopurinol (ie. hypersensitivity or rash) OR • Inadequate response to allopurinol (failure to achieve serum uric acid levels of < 6 mg/dl when using maximum tolerated doses of allopurinol) •	1 year	Therapeutic response and continued medical need per PA request	#1/day
Fenofibrate (Fenoglide®, Lipofen®, Lofibra®, Triglide®)	Trial and failure or inability to use formulary statins OR Concurrent therapy to statins, or gemfibrozil, generic	1 year	Therapeutic response and continued medical need per PA request	#1/day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Fenofibrate Micronized (Lofibra®, Antara®) Fenofibrate Nanocrystallized (Tricor®) Last updated: May 2013	fenofibrate tablets or fenofibrate micronized capsules			
Filgrastim (Neupogen®) Pegfilgrastim (Neulasta®) Last updated: May	• Patient is 18 years of age or older** AND • Prescription written or currently being supervised by a hematologist or an oncologist AND • Patient being treated for febrile neutropenia, associated with the administration of cancer chemotherapy OR Patient is receiving cancer chemotherapy and being treated prophylactically for the prevention of febrile neutropenia associated with cancer chemotherapy	3 months or course of treatment based upon chemotherapy cycle	See criteria for initiation of therapy	

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
2013				
Fluoroquinolones, oral Ciprofloxacin 250 mg/5 ml, 500 mg/5 ml suspension Levofloxacin 250 mg/10 ml, 500 mg/20 ml solution Moxifloxacin Created: April 2015	Ciprofloxacin suspension, Levofloxacin solution: Trial and failure or inability to use tablet formulation (e.g. inability to swallow) Moxifloxacin: Trial and failure or inability to use levofloxacin (e.g. culture results indicating resistance to levofloxacin, respiratory pneumococcal infection, complicated intra-abdominal infection) •	Moxifloxacin: Up to 12 months for chronic use Ciprofloxacin susp, levofloxacin soln: Based on indication, up to 14 days	Therapeutic response per PA request with clinic notes attached	Moxifloxacin: #1 per day Ciprofloxacin: 10 ml per day Levofloxacin 250 mg/10 ml: 10 ml per day Levofloxacin 500 mg/20 ml: 20 ml per day
GLP-1 Receptor Agonists Exenatide (Byetta®, Bydureon®), Liraglutide (Victoza®)	**Diabetes Mellitus – type 2** Trial and failure or inability to use of ALL of the following: Maximum dose of metformin (2000 mg/day) Maximum dose of sulfonylureas Pioglitazone (If HgA1c is less than 8.5) Insulin (If HgA1c is greater than 8.5) For Liraglutide and Exenatide ER requests: trial and	2 years	None	

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Last updated: January 2015	failure with Exenatide			
Growth Hormone Somatropin (Genotropin®, Humatrope®, Norditropin®, Norditropin Flexpro®, Norditropin NordiFlex®, Nutropin®, Nutropin AQ®, Nutropin AQ NuSpin®, Omnitrope®, Saizen®, Serostim®, Tev-Tropin®, Zorbtive®) Last updated: July 2013	**Idiopathic Short Stature (not growth hormone-deficient short stature)**** NOT AN APPROVED INDICATION **Pediatric growth hormone deficiency (GHD)**** • Medication is being prescribed by an endocrinologist or pediatric endocrinologist AND • The diagnosis has been confirmed by at least one subnormal provocative stimulation test (i.e., insulin-induced hypoglycemia, arginine, ARG-GHRH, ARG-LDOPA, GHRH) AND • Diagnosis has been confirmed by one of the following: GHD with: o Severe short stature (defined as patient's height at ≥ 2 standard-deviation [SD] below the population mean) o Patient's height ≥ 1.5 SD below the midparental height (average of mother's	Pediatric growth hormone deficiency (GHD) Initial therapy: 6 months **Re-auth:** 1 year **Growth Failure due to Chronic Renal Insufficiency** 1 year **Short stature associated with Turner Syndrome and Prader-**	**Pediatric growth hormone deficiency (GHD)** Response to growth hormone therapy (i.e., increase in height, increase in height velocity, IGF-1 level normalization) **Growth Failure due to Chronic Renal Insufficiency** • Response to therapy defined as gain of growth velocity by > 2 cm compared with that observed during the previous year OR • Patient is less than 50th percentile for target height following	**All indications:** Approved as requested if weight-based dosing is within FDA approved range *(patient's weight must be provided on the PA request)*

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	and father's heights) o Patient's height≥ 2 SD below the mean and a 1-year height velocity more than 1 SD below the mean for chronologic age or (in children 2 years of age or older) a 1- year decrease of more than 0.5 SD in height o In the absence of short stature, a 1-year height velocity more than 2 SD below the mean or a 2-year height velocity more than 1.5 SD below the mean (may occur in GHD manifesting during infancy or in organic, acquired GHD) o Signs indicative of an intracranial lesion o Signs of multiple pituitary hormone deficiencies o Neonatal symptoms and signs of GHD AND • Patient's epiphysis has NOT closed (as confirmed by radiograph of the wrist and hand) or patient has NOT reached final height **<u>Growth Failure due to Chronic Renal Insufficiency**</u>** • Medication is being prescribed by a nephrologist	**Willi Syndrome** **Initial therapy**: 6 months **Re-auth**: 1 year **HIV/AIDS-wasting syndrome** 3 months **<u>Short Bowel Syndrome</u>** 4 weeks	growth hormone therapy **<u>Short stature associated with Turner Syndrome and Prader-Willi Syndrome</u>** Response to the first 6 months of growth hormone therapy (i.e., increase in height, increase in growth velocity, IGF-1 level normalization) **<u>HIV/AIDS-wasting syndrome</u>** Therapeutic response per PA request with attached clinic notes showing an increase in muscle mass and weight from growth hormone replacement therapy	

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	AND • Patient has undergone renal transplantation AND • Patient's epiphysis has NOT closed (as confirmed by radiograph of the wrist and hand) AND • Patient's height at is ≥ 2 standard-deviations (SD) below the mean height for normal children of the same age and gender **Short stature associated with Turner Syndrome and Prader-Willi Syndrome**** • Medication is being prescribed by an endocrinologist or pediatric endocrinologist AND • Patient has short stature as defined as ONE of the following: o For Turner's Syndrome, height is below the 5th percentile of normal growth curve o For Prader Willi Syndrome, height at ≥ 2 standard-deviation (SD) below the mean height for normal children of the same		**Short Bowel Syndrome** Not approvable (administration for more than 4 weeks has not been adequately studied).	

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	age and gender AND • Patient's epiphysis has NOT closed (as confirmed by radiograph of the wrist and hand) OR the patient has NOT reached final height **Adult Growth Hormone Deficiency**** • Medication is being prescribed by an endocrinologist AND • For hypopituitarism due to pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma, diagnosis has been confirmed by at least one subnormal provocative stimulation test (i.e., insulin-induced hypoglycemia, arginine, ARG-GHRH, ARG-LDOPA) OR • For childhood-onset growth hormone deficiency (GHD), does the patient have childhood-onset growth hormone deficiency (GHD) due to organic diseases (e.g. craniopharyngioma)?			

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	HIV/AIDS-wasting syndrome** • Patient is on antiviral therapy AND • Patient meets one of the following: o 10% unintentional weight loss over 12 months o 7.5% unintentional weight loss over 6 months o 5% body cell mass (BCM) loss within 6 months o In men: BCM < 35% of total body weight and body mass index (BMI) < 27kg/m2 o In women: BCM < 23% of total body weight and BMI < 27 kg/m2 o BMI < 20kg/m2 AND • Patient has had an inadequate response to previous therapy (i.e., exercise training, nutritional supplements, appetite stimulants or anabolic steroids **Short Bowel Syndrome**** Patient is currently on specialized nutritional support (i.e., consisting of a high carbohydrate,			

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	low-fat diet)			
Hepatitis B PA required: Adefovir (Hepsera) Entecavir (Baraclude) Telbivudine (Tyzeka) Non-formulary: Entecavir monohydrate 0.05mg/ml soln (Baraclude) Excluded (FFS Medi-Cal carve-out): Lamivudine (Epivir-HBV) tablet Lamivudine HBV 5mg/ml soln (Epivir HBV) Tenofovir (Viread) Created: July 2013 Last updated: July 2015	Hepatitis B • Patient is ≥21 years of age** AND • HBV DNA > 20,000 IU/ml (105 copies/ml, 5 log copies/ml) with ALT > 60 for men or > 38 for women within the last 3 months OR • If HBeAg (-): HBV DNA > 2,000 IU/ml with ALT > 60 for men or > 38 for women within the last 3 months OR • HBV DNA > 20,000 IU/ml (105 copies/ml, 5 log copies/ml) with abnormal histology on liver biopsy OR • If HBeAg (-): HBV DNA > 2,000 IU/ml with abnormal histology on liver biopsy AND • For Baraclude oral solution: patient is unable to use tablet formulation (e.g. difficulty swallowing, etc.) Suppression during chemotherapy or immunosuppressant therapy • Patient is ≥21 years of age** AND	Hepatitis B 2 years Suppression during chemotherapy 1 year or throughout chemotherapy course and up to 6 months after chemotherapy discontinuation Suppression during immunosuppressant therapy 2 years	Hepatitis B Therapeutic response and continued medical need per PA request Suppression during chemotherapy Patient is on chemotherapy or needs suppression post chemotherapy discontinuation Suppression during immunosuppressant therapy Patient is on immunosuppressant therapy	Baraclude: 0.5, 1 mg tab – 1 per day, 0.05 mg/ml soln 600 ml per 30 days Hepsera: 10 mg – 1 per day Tyzeka: 600 mg – 1 per day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	• Patient is currently on chemotherapy or needs additional therapy post-chemotherapy discontinuation OR • Patient is currently on immunosuppressant therapy			
Hepatitis C PA Required: Daclatasvir (Daklinza®) Ledipasvir/Sofosbuvir (Harvoni®) Ombitasvir/Paritaprevir/Ritonavir and Dasabuvir (Viekira Pak®) Sofosbuvir (Sovaldi®) Ombitasvir/Paritaprevir/Ritonavir (Technivie®) Ribavirin 200 mg tabs + caps	*San Francisco Health Plan follows California Department of Health Care Services Utilization and Treatment Policy for Simeprevir and Sofosbuvir in the Management of Hepatitis C. The policy can be accessed at http://www.dhcs.ca.gov/Pages/HepatitisC.aspx.*	**Genotype 1a**: Naïve/Experienced no Cirrhosis Harvoni: 12 weeks Viekira Pak: 12 weeks Daklinza + Sovaldi: 12 weeks Naïve with Cirrhosis Harvoni: 12 weeks Viekira Pak: 24 weeks Daklinza + Sovaldi: 24 weeks	Not applicable, entire duration is approved at time of approval. *NOTE: therapy will not be restarted in cases where it was discontinued due to non-compliance*	**Harvoni, Daklinza and Sovaldi**: 12 weeks #14/14 days + 5 refills 16 weeks #14/14 days + 7 refills 24 weeks #14/14 days + 11 refills **Viekira Pak**: 12 weeks 1 pack (#112)/28 days + 2 refills 24 weeks 1 pack (#112)/28 days + 5 refills **Technivie:** 12 weeks 1 pack (#56)/28 days + 2 refills **Ribavirin 200 mg**: #140-168 (1000-1200 mg/day)

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Non-Formulary: Boceprevir (Victrelis®), Telaprevir (Incivek®), Simeprevir (Olysio®), Peginterferon Alfa-2a (Pegasys®, Pegasys® Proclick), ribavirin 400 mg tab,ribavirin 600 mg tab, ribavirin 200-400 mg tab/600-400 mg tab (Ribapak®) Created: April 2014 Updated: October 2015		Experienced with Cirrhosis Harvoni: 24 weeks Harvoni + Rbv: 12 weeks Viekira Pak: 24 weeks Daklinza + Sovaldi: 24 weeks **Genotype 1b**: Naïve/Experienced no Cirrhosis Harvoni: 12 weeks Viekira Pak: 12 weeks Daklinza + Sovaldi: 12 weeks Naïve with Cirrhosis Harvoni: 12 weeks		per 28 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
		Viekira Pak: 12 weeks Daklinza + Sovaldi: 24 weeks <u>Experienced with Cirrhosis</u> Harvoni: 24 weeks Harvoni + Rbv: 12 weeks Viekira Pak + Rbv: 12 weeks Daklinza + Sovaldi: 24 weeks **Genotype 2**: <u>Naïve no Cirrhosis</u> Sovaldi + Rbv: 12 weeks Daklinza + Sovaldi: 12 weeks		

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
		Naïve with Cirrhosis Sovaldi + Rbv: 16 weeks Daklinza + Sovaldi: 16 weeks Experienced Sofosbuvir + Rbv: 16-24 weeks **Genotype 3**: Naïve no Cirrhosis Daklinza + Sovaldi: 12 weeks Sovaldi + Rbv: 24 weeks Naïve with Cirrhosis Daklinza + Sovaldi: 24 weeks		

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
		Experienced no Cirrhosis Daklinza + Sovaldi: 12 weeks Experienced with Cirrhosis Daklinza + Sovaldi + Rbv: 24 weeks Sovaldi + Rbv: 24 weeks Sovaldi + Peg-IFN + Rbv: 12 weeks **Genotype 4**: Naïve/Experienced Harvoni: 12 weeks Technivie + Rbv: 12 weeks Sovaldi + Rbv: 24		

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
		weeks <u>Experienced</u> Sovaldi + Rbv + PegIFN: 12 weeks **Genotype 5, 6**: <u>Naïve/Experienced</u> Harvoni: 12 weeks *Where Genotype 1 subtype is unknown, treat as 1a ** "Experienced" as it is used here refers only to prior treatment with Peg-IFN and Ribavirin, not prior treatment with		

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
		other HCV agents. Refer to AASLD/IDSA guidelines for specific information at: http://www.hcvguidelines.org/full-report-view		
Imatinib (Gleevec®) Last updated: July 2013	**FDA approved indications** Patient is 18 years of age or older** AND Patient has one of the following: • Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) • Ph+ acute lymphoblastic leukemia (Ph+ ALL)* *Use of Gleevec (imatinib) as frontline therapy in Ph+ ALL is a compendial use • Gastrointestinal stromal tumor (GIST): o Patient has documented c-KIT (CD117) positive unresectable or metastatic malignant GIST, **OR**	FDA approved indications: 1 year Off-label indications: Initial: 6 months Re-auth: 1 year	FDA approved indications: Lack of disease progression per PA request with clinic notes attached Off-label indications: Documentation from medical charts indicating significant clinical benefit from the medication	400 mg: 60 per 30 days 600 mg: 30 per 30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	o Patient had resection of c-KIT (CD117) positive GIST and imatinib will be used as an adjuvant therapy • Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic • Hypereosinophilic syndrome or chronic eosinophilic leukemia • Myelodysplastic syndrome (MDS) or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements • Aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status unknown • Synovial tissue pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT)† • Desmoid tumors (aggressive fibromatosis)† † Compendial uses <u>Pediatric indications (patient must be at least two years of age)**</u>			

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	• Documented Ph+ CML that is newly diagnosed in the chronic phase **Other off-label indications:** • The medication is recommended and prescribed by a specialist • The medication is prescribed for a non-FDA approved indication but is considered to be a medically accepted per the medical compendia (i.e. Micromedex, DrugPoints and AHFS drug information) as defined by the Social Security Act or the NCCN or ASCO standard of care guidelines. • Documentation was submitted indicating that the patient has a documented (consistent with pharmacy claims data, OR for new patients to the health plan consistent with medical chart history) adequate trial (including dates, doses of medications) of all first line medical therapies as recommended by the medical compendia and standard care guidelines or has another documented medical reason (i.e. intolerance, contraindications, etc.) for not receiving or trying all first line medical treatment(s). The medication is prescribed at a medically accepted			

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	dose per the medical compendia as defined by the Social Security Act or per the NCCN or ASCO standard of care guidelines.			
Hydroxyprogesterone caproate 250 mg/mL intramuscular oil (Makena®) Created: April 2015	Must meet ALL of the following criteria: • Patient is 16 years of age or older • Current singleton pregnancy (not carrying twins, triples, etc) • History of previous singleton spontaneous preterm birth before 37 weeks gestation • Treatment to be started between 16 weeks 0 days gestation and 20 weeks 6 days gestation • Documented expected delivery date provided with request •	Up to 37 weeks of gestation	None (one-time approval)	#5 ml per 35 days
Immunosuppressants Cyclosporine 25, 100 mg caps, 100 mg/ml solution (Sandimmune®) Cyclosporine, Modified 100 mg/ml	**Tablet/capsule formulation:** • Patient is 21 years of age or older** AND • Patient is using the medication for prevention of transplant rejection*** AND • Formulary immunosuppressants are not appropriate for the indication ****requests for other indications will be reviewed on*	5 years	Therapeutic response and continued medical need per PA request	Dose consolidation may be required depending on medication and regimen

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
solution (Neoral®) Everolimus 0.25, 0.5, 0.75 mg (Zortress®) Mycophenolate mofetil 200 mg/ml suspension (CellCept®) Mycophenolate delayed release tab 180 mg, 360 mg (Myfortic®) Sirolimus 0.5,1, 2mg tabs 1 mg/ml solution (Rapamune®) Tacrolimus 5 mg/ml soln (Prograf®)	*a case by case basis* **Solution/suspension formulation:** • Patient is 21 years of age or older** AND Inability to use tablet/capsule formulation			

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Created: October 2013				
Insulin Detemir (Levemir®) Last updated: Jan 2015	Trial and failure or inability to use Insulin glargine OR • Patient is pregnant	2 years	Therapeutic response and continued medical need per PA request	Up to 90 day supply
Isotretinoin (Accutane®, Amnesteem®, Claravis®, Sotret®) Last updated: July 2013	<u>Severe recalcitrant nodular acne vulgaris or severe recalcitrant rosacea</u> Approvable condition <u>Acne rosacea</u> Trial and failure or intolerance to topical metronidazole AND oral antibiotic <u>Moderate nodular acne vulgaris</u> Trial and failure or inability to use ALL of the following: • Topical retinoid • Topical benzoyl peroxide Oral antibiotic	5 months	Therapeutic response per PA request	None

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Ivermectin (Stromectol®) Last updated: May 2013	Scabies Trial and failure or inability to use topical permethrin 5% cream Strongyloidiasis Approvable condition Onchocerciasis Approvable condition •	2 fills	Therapeutic response and continued medical need per PA request	#10 tablets/ 1 day x 2 fills
Ketorolac (Toradol®) Last updated: May 2013	Acute, moderate-severe pain Approvable for up to 10 mg #30/5 days, if switching from ketorolac injection	1 fill	None	#30/5 days
Lacosamide (Vimpat®) Last updated: January 2015	Partial onset seizures • Trial and failure of 2 or more anticonvulsants AND • Initially prescribed or being followed by a neurologist	5 years	Therapeutic response and continued medical need per PA request	#2/day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	AND Patient is ≥17 years of age			
Lapatinib (Tykerb®) Last updated: May 2013	• Patient is 18 years of age or older** AND • Patient has breast cancer whose tumors overexpress human epidermal growth factor receptor 2 (HER 2) AND • Tykerb (lapatanib) will be used in combination with Xeloda (capecitabine) in a patient with advanced metastatic disease AND the patient has received prior therapy including an anthracycline, a taxane and trastuzumab OR • Tykerb (lapatanib) will be used in combination with Femara (letrozole) for the treatment of a postmenopausal woman with hormone receptor positive metastatic disease for whom hormonal therapy is indicated OR • Tykerb (lapatanib) will be used in combination with Herceptin (trastuzumab) (without cytotoxic	12 months	Lack of disease progression	#6 per day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	therapy) as second-line treatment of HER2+ recurrent or metastatic breast cancer* • *Compendial use			
Lenalidomide (Revlimid®) Last updated: May 2013	• Patient is 18 years of age or older** AND • Drug is being prescribed by Hematologist or Oncologist AND • Patient has a diagnosis transfusion-dependent anemia due to low or intermediate-a-risk myelodysplastic syndromes associated with a deletion o5q cytogenetic abnormality with or without additional cytogenetic abnormalities OR Indication of multiple myeloma, in combination with dexamethasone, for patients who have received at least one prior therapy; VAD (vincristine, adriamycin, dexamethasone), MP (melphalan, prednisolone) or other chemotherapy	Anemia Initial therapy: 8 weeks Continuing therapy: 1 year Multiple myeloma 1 year	Anemia Patient has become transfusion independent or requires ≤2 transfusions within the last year OR Hemoglobin increased more than 2gms/dL Multiple myeloma n/a	5 mg, 10 mg: 2 per day 15, 25 mg: 1 per day
Step therapy Levalbuterol (Xopenex®, Xopenex	• Trial and failure or inability to use albuterol	2 years	None	Levalbuterol #9 ml (3 boxes)/30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
HFA®) Last updated: January 2015				Levalbuterol HFA® #2 units/30 days
Lidocaine 5% patches (Lidoderm®) Created: May 2013 Updated: October 2015	<u>Post-Herpetic Neuralgia or Neuropathic Pain</u> Trial and failure or inability to use ALL of the following: • At least 2 of the following oral agents: o tricyclic antidepressants (e.g. due to presence of cardiovascular disease, age greater than 70 years, drug-drug interactions) o gabapentin 1800 mg/day or side effects at lower dose (e.g. somnolence) o venlafaxine or duloxetine • At least one of the following topical agents: o capsaicin (e.g. topical capsaicin 0.025%,0.075% and 0.1% cream), o topical menthol and/or salicylate products o diclofenac 1% gel (Voltaren) o lidocaine 5% ointment <u>Chronic Non-Cancer Pain (other than neuropathic)</u> Trial and failure or inability to use ALL of the following: • Oral agents in at least 2 of the following groups:	1 year	Therapeutic response and continued medical need per PA request	#30 per 30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	○ tricyclic antidepressants ○ SSRIs (e.g. fluoxetine, sertraline) or SSNRIs (e.g. venlafaxine, duloxetine) ○ Anticonvulsants (e.g. gabapentin) ○ NSAIDs and/or acetaminophen ○ Opioids (e.g. tramadol, hydrocodone/APAP) *NOTE: Schedule II-IV opioids are not recommended for chronic pain but if patient has already taken at least one, then meets criteria)* • At least one of the following topical agents: ○ capsaicin (e.g. topical capsaicin 0.025%,0.075% and 0.1% cream), ○ topical menthol and/or salicylate products ○ diclofenac 1% gel (Voltaren) ○ lidocaine 5% ointment			
Lipid Disorder: PCSK-9 Inhibitors Prior Authorization: Praluent ® (alirocumab) Repatha® (evolocumab) Last updated: October 2015	Praluent® and Repatha® • Patient is ≥ 21 years of age** AND • Prescriber must be cardiologist or specialist in the treatment of lipid disorders. AND • Documentation of 2 fasting lipid panel laboratory reports within the past 12 months with abnormal LDL cholesterol levels > 70mg/dL	Initial: 4 months Continuation: 6 months	• Documentation submitted indicates that the member has obtained clinical benefit from the medication including repeat fasting lipid panel lab report, and the member has had at least a 40% reduction in LDL. AND	Praluent® #2mL per 30 days Repatha® #3mL per 30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	AND • Documentation submitted indicates the patient is a non-smoker AND • Documented claim history or chart notes showing consistent therapy and trial with at least two high-intensity statin therapy atorvastatin 40 - 80mg OR Crestor (Rosuvastatin) 20mg – 40mg with inadequate response still requiring additional LDL lowering or a documented medical reason (e.g. intolerance, hypersensitivity) for not utilizing all of these therapies AND • If request indicates that the patient is "statin intolerant", documentation was provided including description of the side effects, duration of therapy, "wash out", re-trial, and then change of agents. Patient should have documentation of trial and failure of at least two statin therapies. AND • Patient must have a confirmed diagnosis of		• The patient's claim history shows consistent therapy (i.e. monthly fills).	

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	heterozygous familial hypercholesterolemia (HeFH) with chart notes or clinical labs with **one** of the following: o documented strong (first and second degree relatives) family history of high levels of LDL and/or heart attack and relationship to member o documented chart notes of clinical manifestations of FH such as xanthomas or inflamed tendons o Autosomal Dominant Hypercholesterolemia Genetic Testing Reflex Panel (ADHP Panel) OR • Confirmed diagnosis of primary hyperlipidemia with chart notes and documentation of atherosclerotic cardiovascular disease (e.g. heart attack or stroke) or at increased risk for cardiovascular events OR • Confirmed diagnosis of homozygous familial hypercholesterolemia for Repatha®			
Long-Acting Beta Agonists (LABA) Salmeterol	<u>Asthma/Bronchospasm</u> • LABA therapy is not being used as monotherapy AND	2 years	Therapeutic response and continued clinical need per PA request	#60 per 30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
(Serevent®) Formoterol (Foradil ®) Created: January 2015	• Trial and failure of combination Dulera, Symbicort AND Advair Diskus or Advair HFA <u>COPD</u> Diagnosis of COPD			
Long-Acting Opiates: Fentanyl transdermal (Duragesic®) Oxycodone ER (Oxycontin®) Oxymorphone ER (Opana ®ER) Morphine sulfate ER caps (Kadian®) Last updated: April 2015	• Trial and failure of morphine sulfate ER tablets at an adequate (equianalgesic) dose, in the last 12 months for at least 2 months OR inability to use morphine sulfate ER tablets due to a contraindication or intolerance AND <u>For morphine sulfate ER caps, oxycodone ER, oxymorphone ER:</u> trial and failure or inability to use fentanyl	1 year	Therapeutic response and continued medical need per PA request	Fentanyl: #15 patches per 30 days Morphine sulfate caps: #60 per 30 days Oxycodone ER: #60 per 30 days Oxymorphone ER: #60 per 30 days
Malathion (Ovide®) Last updated: January	• Trial and failure or inability to use permethrin (Nix®, Acticin®, Elimite®) or pyrethrin/piperonyl (Rid®, Pronto®)	1 fill (59 ml)	None	1 fill (59 ml)

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
2014				
Memantine (Namenda®) Last updated: May 2013	Alzheimer's disease Trial and failure or inability to use a cholinesterase inhibitor (donepezil, rivastigmine, or galantamine) OR Patient is to use for concurrent therapy with another cholinesterase inhibitor	1 year	Therapeutic response and continued medical need per PA request	Memantine tablets #2/day Memantine solution #10 ml/day
Metoclopramide ODT (Metozolv®) Last updated: May 2013	Gastroesophageal reflux, Gastroparesis, Nausea/Vomiting Trial and failure or inability to use metoclopramide tablets and solution (eg. intolerance to liquid or difficulty swallowing)	1 year	Therapeutic response per PA request	#4/day
Multiple Sclerosis (INJECTABLE): PA required: Glatiramer Acetate (Copaxone®), Interferon beta -1a (Avonex®) Non-formulary: Interferon beta -1a (Rebif®) Interferon beta -1b	• Patient is ≥ 21 years** of age AND • Patient has relapsing/remitting MS (RRMS) or secondary progressive MS (SPMS) with a relapsing element AND • The medication is being recommended and/or prescribed by a neurologist at an FDA approved dosage AND • **For Rebif**, **Betaseron**, **Extavia** and/or any other newly marketed self-injectable Disease-Modifying	Initiation of therapy: 6 months Continuation of therapy: 1 year	Therapeutic response and continued medical need with clinic notes attached	INJECTABLE: **Avonex**: - vial: #1 kit (4 vials)/30 days - syringe: #2 mL (4 syringes)/30 days - pen: #2 mL (4 pens)/30 days **Copaxone**: 20 mg: #30 mL/30 days 40 mg: #30 mL/30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
(Betaseron®) Interferon beta -1b (Extavia®) **Multiple Sclerosis (ORAL):** <u>PA required</u>: Dimethyl fumarate (Tecfidera®) Fingolimod (Gilenya®) <u>Non-formulary</u>: Teriflunomide (Aubagio®) Last updated: July 2015	Immunomodulating MS Agent, the member has: o a documented treatment failure to 6 months of therapy with **Copaxone and Avonex**, OR o a medical reason (intolerance, hypersensitivity, contraindication, etc) for not taking **Copaxone and Avonex** for a minimum of 6 months • **For Aubagio®** and/or any other newly marketed oral MS Agent, the member has: o a documented treatment failure to 6 months of therapy with **Gilenya OR Tecfidera** a medical reason (intolerance, hypersensitivity, contraindication, etc.) for not taking **Gilenya or Tecfidera** for a minimum of 6 months			**Betaseron**: #1 kit (14 vials)/30 days **Extavia**: #1 kit (15 syringes)/30 days **Rebif**: #6 mL (12 syringes)/30 days <u>ORAL:</u> **Gilenya**: 1 per day **Aubagio**: 1 per day **Tecfidera**: 2 per day
Nasal Steroids Beclomethasone (Beconase AQ®), Budesonide (Rhinocort AQ®), Fluticasone (Veramyst®), Mometasone (Nasonex®), Triamcinolone	Trial and failure or inability to use fluticasone, flunisolide AND triamcinolone OR For patients less than 4 years of age: trial and failure or inability to use triamcinolone •	1 year	Therapeutic response and continued medical need per PA request	#1 unit/30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
(Nasacort AQ®) Last updated: May 2013				
Niacin (Niaspan®) Last updated: July 2013	**Elevated triglycerides** Trial and failure or inability to use of ALL of the following: • OTC niacin CR • Gemfibrozil Fibrates	1 year	Therapeutic response per PA request	#2/day
Nilotinib (Tasigna®)	Patient is 18 years of age or older ** AND Patient has one of the following: • Newly diagnosed Philadelphia chromosome positive chronic myelogenous leukemia (Ph+ CML) in the chronic phase • Ph+ CML with resistance to or intolerance to prior therapy • Gastrointestinal stromal tumors (GIST) after disease progression on Gleevec (imatinib) or	1 year	Lack of disease progression per PA request with clinic notes attached	150, 200 mg: #120 per 30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Last updated: July 2013	Sutent (sunitinib)† • Ph+ acute lymphoid leukemia that is relapsed or refractory† • Systemic mast cell disease† † Compendial use			
Non-formulary topical steroids Created: October 2014 Updated: October 2015	Trial and failure or inability* to use ALL formulary products within the same potency group as listed below **example of inability to use cream, lotion, gel or ointment formulations is need for oil formulation for scalp conditions* **example of inability to use other agents for desoximetasone requests is corticosteroid-induced contact dermatitis (note desoximetasone 0.25% cream preferred)* <u>Ultra High Potency (Group 1)</u> • Betamethasone propionate augmented 0.05% ointment, lotion or gel #60 per 30 grams • Halobetasol propionate 0.05% ointment #60 per 30 grams <u>High Potency (Group 2)</u> • Betamethasone dipropionate 0.05% ointment or	36 months	Therapeutic response and continued clinical need per PA request	**<u>Fluocinolone acetonide 0.01% body and scalp oil</u>:** #118.28 per 30 days **<u>Other products</u>:** 60 grams or ml per 30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	augmented cream #120 per 30 days • Fluocinonide 0.05% ointment, gel, cream or solution #120 per 30 days • Desoximetasone 0.25% cream #60 per 30 days <u>High/Medium Potency (Group 3)</u> • Mometasone furoate 0.1% ointment #60 per 30 days • Triamcinolone acetonide 0.5% ointment or cream#240 per 30 days <u>Medium Potency (Group 4)</u> • Triamcinolone acetonide 0.1% cream #454 per 30 days or ointment #240 per 30 days • Mometasone furoate 0.1% cream #60 per 30 days or solution #240 per 30 days <u>Lower-medium Potency (Group 5)</u> • Betamethasone dipropionate 0.05% lotion #120 per 30 days or betamethasone valerate 0.1% cream #240 per 30 days • Fluocinolone acetonide 0.025% cream #240 per 30 days • Fluticasone propionate 0.05% cream #60 per 30 days • Triamcinolone acetonide 0.1% lotion or 0.025%			

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	ointment #240 per 30 days <u>Low Potency (Group 6)</u> • Betamethasone valerate 0.1% lotion #240 per 30 days • Triamcinolone acetonide 0.025% cream or lotion #240 per 30 days <u>Least Potent (Group 7)</u> • Hydrocortisone (base) 0.5% ointment or cream, 1%, 2.5% ointment, cream or lotion #240 per 30 days			
Omega-3 Fatty Acids (Lovaza®)	**Hypertriglyceridemia** Trial and failure or inability to use formulary statins at maximum tolerated dose AND ALL of the following: • Fibric acids • OTC Omega-3 fatty acids • Nicotinic acid •	1 year	Therapeutic response per PA request	#4/day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Last updated: July 2013				
Ophthalmic Antihistamines Azelastine (Optivar®) Epinastine (Elestat®) Created: April 2014	Azelastine (Optivar®), Epinastine (Elestat®)** Trial and failure or inability to use ketotifen ***all non-formulary agents will require trial and failure or inability to use ketotifen AND azelastine or epinastine* •	1 year	Therapeutic response and continued clinical need per PA request	Azelastine: 6 ml per 30 days Epinastine: 5 ml per 30 days
Ophthalmic NSAIDs Bromfenac (Xibrom®), Ketorolac (Acular®), Nepafenac (Nevanac®)	Trial and failure or inability to use flurbiprofen or diclofenac eye drops OR Prescribed by an ER doctor or diagnosis is either accident or acute injury to the eye(s)	1 fill	Therapeutic response and continued medical need per PA request	1 bottle

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Last updated: May 2013				
Ophthalmic Prostaglandins Travoprost Last updated: July 2014	Glaucoma (open angle) or ocular hypertension • Patient is 21 years of age or older** AND • Has tried and failed or unable to use latanoprost	1 year	Therapeutic response and continued clinical need per PA request	2.5 ml per 30 days
Oral Contraceptives e.g. Amethia®, Beyaz®, Ortho Tri-Cyclen Lo®, Lo Loestrin Fe®, Natazia® Last updated: January 2014	Trial and failure or inability to use 2 or more formulary contraceptives for at least 3 months (i.e. adverse reactions, compliance failure)	1 year	Therapeutic response and continued medical need per PA request	#1/day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
PAH Agents Ambrisentan (Letairis®) Bosentan (Tracleer®)* Riociguat (Adempas®) Sildenafil (Revatio®) Treprostinil (Tyvaso®) **(non-formulary)* Last updated: October 2014	<u>Initial criteria for all agents:</u> 1. Confirmed diagnosis of PAH World Health Organization (WHO) Group 1 by a cardiologist, pulmonologist or credible expert. Must have, at minimum, functional class II for pharmacological intervention. 2. Documented treatment failure, adverse drug event or contraindication to calcium channel blocker (CCB) OR contraindication or negative response to vasoreactivity testing. <u>Sildenafil (Revatio®)</u> • Must meet 1 & 2 in initial criteria <u>Ambrisentan (Letairis®)</u> • Must meet 1 & 2 in initial criteria AND • Documented trial and failure with PDE-5 inhibitor (e.g. sildenafil) monotherapy OR contraindication/inability to use PDE-5 inhibitor (e.g. concurrent nitrate therapy) OR used as add-on therapy for PDE-5 inhibitor <u>Riociguat (Adempas®)</u> • Must meet 1 & 2 in initial criteria	12 months	Therapeutic response and continued clinical need per PA request	<u>Sildenafil (Revatio®)</u> #90 per 30 days <u>Ambrisentan (Letairis®)</u> #30 per 30 days <u>Riociguat (Adempas®)</u> #90 per 30 days <u>Bosentan (Tracleer®)</u>

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	AND • Documented trial and failure with PDE-5 inhibitor (e.g. sildenafil) monotherapy OR contraindication/inability to use PDE-5 inhibitor (e.g. concurrent nitrate therapy) OR used as add-on therapy for PDE-5 inhibitor AND • Documented trial and failure or inability to use/contraindication to Ambrisentan (Letairis®) <u>Bosentan (Tracleer®)</u> • Must meet 1 & 2 in initial criteria AND • Documented trial and failure with PDE-5 inhibitor (e.g. sildenafil) monotherapy OR contraindication/inability to use PDE-5 inhibitor (e.g. concurrent nitrate therapy) OR used as add-on therapy for PDE-5 inhibitor AND • Documented trial and failure or inability to use/contraindication to Ambrisentan (Letairis®) <u>Treprostinil (Tyvaso®)</u> • Must meet 1 & 2 in initial criteria AND • Documented trial and failure with PDE-5 inhibitor			#60 per 30 days <u>Treprostinil (Tyvaso®)</u> • Tyvaso Inhalation Starter Kit (NDC 66302-0206-01) → 81.2mL per 28 days, 1 fill only Tyvaso Inhalation Refill Kit (NDC 66302-0206-02) → 81.2mL per 28 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	(e.g. sildenafil) monotherapy OR contraindication/inability to use PDE-5 inhibitor (e.g. concurrent nitrate therapy) OR used as add-on therapy for PDE-5 inhibitor AND • Documented trial and failure or inability to use/contraindication to Ambrisentan (Letairis®) OR Must be documented as WHO FC III with rapid progression or WHO FC IV. Members in these classes do not need to meet 1&2 in initial criteria.			
Phosphate Binders Sevelamer carbonate (Renvela®) 800 mg tabs Lanthanum (Fosrenol®) 500, 750, 1000 mg chewable tablets Updated: October 2013	• Patient is 21 years of age or older** AND • Patient has phosphate level > 5.5mg/dl on calcium acetate 667mg 3 tablets TID OR • Patient has corrected calcium level > 9.5 mg/dl or CalPhos product > 55 OR • Patient has tried and failed calcium acetate in the past due to hypercalcemia (calcium > 9.5 mg/dl) or intolerance	2 years	Previous therapy for existing members	Fosrenol®: 500 mg #90 per 30 days, 750 mg #90 per 30 days 1000 #90 per 30 days • Renvela® 800 mg tabs: #270 per 30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	OR Patient has calcium level 8.4 -9.5 mg/dl AND adynamic bone disease, low PTH levels or vascular calcification			
Ponatinib (Iclusig®)	<u>Chronic Myelogenous Leukemia</u> • Patient has a diagnosis of chronic myelogenous leukemia AND • Patient is 18 years of age or older** AND • Patient has documented therapeutic failure to TWO first-line tyrosine kinase inhibitors (i.e. Gleevec [imatinib], Sprycel [dasatinib] or Tasigna [nilotinib]) or medical reason (e.g. contraindication, intolerance) why first-line agents cannot be used <u>Philadelphia chromosome-positive acute lymphoblastic leukemia</u> • Patient has a diagnosis of Philadelphia chromosome-positive acute lymphoblastic	1 year	Lack of disease progression	15 mg: 2 per day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Last updated: May 2013	leukemia (Ph+ ALL) AND • Patient is 18 years of age or older ** AND • Patient has documented therapeutic failure to TWO previous tyrosine kinase inhibitors (i.e. Gleevec [imatinib] AND Sprycel [dasatinib]) or medical reason (e.g. contraindication, intolerance) why first-line agents cannot be used			
Pregabalin (Lyrica®) PA required Last updated: July 2015	Trigeminal neuralgia, peripheral neuropathy or post-herpetic neuralgia Trial and failure or inability to use ALL of the following: • one TCA (e.g. amitriptyline, clomipramine, desipramine, doxepin, imipramine, and nortriptyline) • gabapentin up to 1800 mg/day or maximum tolerated dose • one SNRI (e.g. venlafaxine or duloxetine) for at least 2 months	2 years	Therapeutic response and continued medical need per PA request	Fibromyalgia Max #2 per day. Max dose 450 mg per day Other indications Max #3 per day. Max dose 600mg/day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	Fibromyalgia Trial and failure or inability to use ALL of the following: • one TCA (e.g. amitriptyline, clomipramine, desipramine, doxepin, imipramine, and nortriptyline) • gabapentin 1800 mg/day or maximum tolerated dose • duloxetine for at least 2 months Seizure disorder • Trial and failure of 2 or more anticonvulsants AND • Medication is prescribed or recommended by a neurologist			
Prostaglandin Analogs Bimatoprost (Lumigan®), Tafluprost (Zioptan™), Travoprost (Travatan Z®) Last updated: May	• Trial and failure or inability to use formulary Latanoprost OR • Documented allergy to benzalkonium chloride	1 year	None	Determined by requested product size

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
2013				
Proton Pump Inhibitors (PPIs) Formulary: Omeprazole 10, 20, 40 mg caps Pantoprazole tabs Step therapy: Esomeprazole 22.3 mg cap (Nexium 24HR OTC) Lansoprazole 15, 30 mg caps PA required: Lansoprazole (Prevacid SoluTab) tabs Pantoprazole granules (Protonix) Non-formulary: Lansoprazole (Prevacid-OTC) Esomeprazole (Nexium) Omeprazole 20 mg	**Lansoprazole caps and Nexium 24HR (OTC):** Trial and failure or inability to use omeprazole AND pantoprazole **Prevacid® SoluTab™, Protonix® Granules:** • Inability to swallow AND • Trial and failure or inability to use omeprazole capsules opened and sprinkled over food as a first-line product AND lansoprazole capsules opened and sprinkled over food as a second-line product **Omeprazole 20 mg tab:** Trial and failure or inability to use omeprazole 20 mg caps	1 year	Therapeutic response and continued clinical need per PA request	Lansoprazole caps, Prevacid SoluTab: #30 per 30 days Nexium 24HR (OTC): #60 per 30 days Protonix granules: #30 packets per 30 days Omeprazole 20 mg tabs (Prilosec OTC): #30 per 30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
tabs (Prilosec-OTC) Omeprazole granules (Prilosec) Omeprazole/Sodium Bicarbonate (Zegerid) Rabeprazole (Aciphex) *NOTE: dexlansoprazole (Dexilant®), esomeprazole (Nexium®) and rabeprazole (Aciphex®)are non-formulary and require trial and failure or inability to use omeprazole, pantoprazole, lansoprazole and Nexium-24HR (OTC)* Last updated: October 2015				
Raloxifene (Evista®)	Prescribed by a hematologist or oncologist OR	2 years	Therapeutic response and continued medical need per PA request	#1/day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Last updated: January 2015	Trial and failure or inability to use bisphosphonates OR Prescribed for one of the following conditions • Reduction in risk of invasive breast cancer in postmenopausal women with osteoporosis • Reduction in risk of invasive breast cancer in postmenopausal women at high risk for invasive breast cancer Lobular carcinoma in situ (LCIS) or Atypical hyperplasia			
Ranolazine (Ranexa®) Last updated: May 2013	Chronic angina Trial and failure or inability to use at least one anti-anginal agent (beta blocker, amlodipine, nifedipine, isosorbide, or long acting nitroglycerin) •	2 years	Therapeutic response and continued medical need per PA request	#2/day
Rifaximin (Xifaxan®) Last updated: January 2015 Last reviewed: January 2015	Traveler's Diarrhea Trial and failure or inability to use ciprofloxacin (if 18 years of age or older), trimethoprim/sulfamethoxazole AND azithromycin Hepatic Encephalopathy	Traveler's Diarrhea 1 fill Hepatic Encephalopat	Therapeutic response and continued medical need per PA request	Rifaximin 200 mg #3 per day Rifaximin 550 mg #2per day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	Trial and failure or inability to use lactulose <u>Small Intestinal Bacterial Overgrowth (SIBO)</u> Diagnosis of SIBO	<u>hy</u> 1 year <u>SIBO</u> 1 fill		<u>SIBO</u> Rifaximin 550 mg #14 per 7 days
Rosuvastatin (Crestor®) Last updated: April 2015	Trial and failure or inability to use atorvastatin 80mg	1 year	Therapeutic response and continuous medical need per PA request	#1/day
Rufinamide (Banzel®) Last updated: May 2013	<u>Lennox-Fastaut Syndrome</u> • Trial and failure of 2 or more anticonvulsants AND • Initially prescribed or being followed by an neurology AND Patient is ≥4 years of age	5 years	Therapeutic response and continued medical need per PA request	Rufinamide 200 mg #16/day Rufinamide 400 mg #8/day
Ruxolitinib (Jakafi®)	• Patient is ≥ 18 years of age AND	Initial therapy: 6 months	Therapeutic response per PA request with clinic notes attached	

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Last updated: May 2013	• Patient has a diagnosis of intermediate or high-risk primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis defined by two or more of the IWG-MRT IPSS or DIPSS-Plus Criteria (Age > 65 years, Hemoglobin < 10 g/dL, White blood cell count > 25 x 109/L, Peripheral blasts ≥ 1%, Constitutional symptoms, platelet count < 100 x 109/L, red cell transfusion need, and unfavorable karyotype)	Continuing therapy: 1 year		
Scopalamine transdermal patch (Transderm®) Last updated: May 2013	**Preoperative** Approvable condition **Motion sickness** Trial and failure or inability to use of one of the medications from each class: • Promethazine, metoclopramide • Meclizine, diphenhydramine, dimenhydrinate	1 fill	Therapeutic response and continued medical need per PA request	Pre-operative nausea #1/fill Motion sickness #4/fill
Insomnia Agents Formulary: Eszopiclone Temazepam Trazodone	Zolpidem CR trial and failure or inability to use at least 3 of the following: eszopiclone, temazepam, trazodone, zaleplon, zolpidem Ramelteon (Rozerem)	6 months	Therapeutic response and continued medical need per PA request	Tablet formulations: #1 per day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Zaleplon Zolpidem PA required: Ramelteon (Rozerem®) Zolpidem CR Non-formulary: Doxepin (Silenor®) Zolpidem (Edluar®) sublingual tablet Zolpidem (Intermezzo®) sublingual tablet Zolpidem (Zolpimist®) spray pump Last updated: May 2013 Last updated: July 2015	• trial and failure or inability to use at least 3 of the following: eszopiclone, temazepam, trazodone, zaleplon, zolpidem OR • history of substance abuse or current chronic opiate use Doxepin (Silenor) • trial and failure or inability to use at least 3 of the following: eszopiclone, temazepam, trazodone, zaleplon, zolpidem AND • trial and failure or inability to use generic doxepin Zolpidem sublingual tablet, spray pump (Edluar, Intermezzo, Zolpimist) • trial and failure or inability to use at least 3 of the following: eszopiclone, temazepam, trazodone, zaleplon, zolpidem OR • inability to use tablet formulation			
Temozolomide (Temodar®)	Patient is 18 years of age or older** AND Patient has one of the following diagnoses: • Glioblastoma multiforme that is newly diagnosed and temozolomide will be used concomitantly with	1 year	Therapeutic response per PA request with clinic notes attached	200 mg/m2/day for 5-7 days *(patient's BSA must be provided on the PA request)*

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Last updated: July 2013	radiotherapy and then as maintenance treatment Refractory anaplastic astrocytoma that progressed on a drug regimen containing nitrosourea or procarbazine			
ENDOCRINE: Transdermal Testosterone Products Formulary: none *(formulary injectable products are testosterone cypionate 100 mg/mL and 200 mg/mL intramuscular oil; testosterone enanthate 200 mg/mL intramuscular oil)* PA required: Androgel 1% 50 mg	One of the following diagnoses: • Primary (testicular) hypogonadism OR • Secondary (hypogonadotropic) hypogonadism (panhypopituitarism) • Treatment of gender identity disorder AND • Males or female-to-male ≥ 18 y/o AND • For hypogonadism indications: low testosterone level **on at least 2 samples** (e.g. total testosterone level below 280 ng/dL (9.7 nmol/L) for younger men or below 200 ng/dL (6.9 nmol/L) for symptomatic older men (> 40 y/o)); a free serum testosterone level of less than 5pg/mL (174 pmol/L))	1 years	Therapeutic response and continued clinical need per PA request	**Androgel 25mg (1%) gel packet**: #150g (60 packets) per 30 days **Androgel 50mg (1%) gel packet**: #150g (30 packets) per 30 days **Androgel 1% pump**: #150g (2 pumps) per 30 days **Androgel 1.25g (1.62%) gel packet**: #75g (60 packets) per 30 days **Androgel 2.5g (1.62%) gel packet**: #75g (30 packets) per 30 days **Androgel 1.62% pump**: #75g (1 pump) per 30

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
packets Non-formulary: Androderm patch Androgel 1% 25 mg packets, pump Androgel 1.62% gel Axiron solution pump Fortesta 2% gel pump Testim 1% gel tube Vogelxo 1% gel tube/pump Created: April 2015 Updated: October 2015 References: Goodman Neil, et al. American Association of Clinical Endocrinologists and American College of Endocrinology Position Statement On The Association Testosterone and Cardiovascular Risk. Endocrine Practice Vol 21 No.9 September 2015.	AND • Trial and failure or inability to use formulary injectable testosterone (e.g. testosterone cypionate or enanthate) due to contraindication, intolerance or difficulty with self-injections AND • For products other than Androgel 1% gel 50 mg packets: trial and failure or inability to use generic Androgel 1% gel 50 mg packets (e.g. Androgel 1.62% is needed for transgender men) AND • For Axiron: concern for product transfer to close contacts AND trial and failure or inability to use Androderm patches (e.g. skin irritation)			days **Androderm 2mg/24hr**: #30 patches per 30 days **Androderm 4mg/24hr**: #30 patches per 30 days **Axiron 30mg/1.5ml solution**: #90ml (1 pump) per 30 days **Fortesta 2% pump**: #60g (1 pump) per 30 days **Testim/Vogelxo 1% gel**: #150g (30 tubes) per 30 days **Vogelxo 1% pump**: #150g (2 pumps) per 30 days
Tolcapone (Tasmar®)	Parkinson's Disease	1 year	Therapeutic response	#3/day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Last updated: July 2013	Patient is being followed by a neurologist AND Patient is taking carbidopa/levodopa concurrently OR Patient has intolerance/contraindication to Stalevo		per PA request	
Topical Calcineurin Inhibitors Tacrolimus (Protopic) 0.03%, 0.1% ointment Pimecrolimus (Elidel) 1% cream (non-formulary)	• Diagnosis of atopic dermatitis, psoriasis or oral Lichen Planus AND • Trial and failure of at least 1 medium to high potency topical corticosteroids OR inability to use topical corticosteroids due to contraindication or intolerance (e.g. areas involving the face, neck, flexural, genital or intertriginous areas) AND • For Elidel: trial and failure or inability to use tacrolimus ointment	12 months	Therapeutic response and continued clinical need per PA request	30 grams per 30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Last updated: April 2015				
Topical Diclofenac (Solaraze®) Last updated: July 2013	<u>Actinic Keratosis</u> Trial and failure or inability ALL of the following: • Liquid nitrogen cryotherapy, surgical removal or phototherapy Topical 5-fluorouracil or imiquimod	3 months	Therapeutic response per PA request	#100 gm/30 days
Topical NSAIDs **<u>Formulary:</u>** Diclofenac 1% gel (Voltaren®) **Flector® and Pennsaid® are non-formulary and require trial and failure or inability to use Voltaren®*	<u>Osteoarthritis of hand and knee</u> Trial and failure or inability to use at least 2 oral NSAIDs (e.g. age >65, on oral anticoagulant, GFR < 30 ml/min, history of GI issues (e.g. GI bleed/ulcer), side effects from prior trial of NSAIDs) <u>Other pain indications</u> • Trial and failure of at least 2 NSAIDs OR inability to use NSAIDs (e.g. due to. age >65, on oral anticoagulant, GFR < 30 ml/min, history of GI issues (e.g. GI bleed/ulcer), side effects from prior trial of NSAIDs)	12 months	Therapeutic response and continued medical need per PA request	#100 per 30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Created: May 2013 Revised: January 2015	AND • Trial and failure or inability to use topical menthol, capsaicin, or salicylate products			
Topical retinoids Adapalene 0.1% cream, gel Tretinoin 0.01%, 0.025% gel; 0.025%, 0.05%, 0.1% cream Created: January 2015	Adapalene gel: • Diagnosis of acne AND • Trial and failure or inability to use tretinoin Adapalene cream: • Diagnosis of acne AND • Trial and failure or inability to use tretinoin AND adapelene gel Tretinoin: Diagnosis of acne for patients > 30 years of age (formulary for ≤ 30 years of age)	1 year	Therapeutic response and continued clinical need per PA request	Adapalene: #45 gm per 30 days Tretinoin gel: #15 gm per 30 days Tretinoin cream: #20 gm per 30 days
Triptans	• Trial and failure or inability to use sumatriptan	1 year	Documentation of	#9 tablets per 30 days

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	tablets OR Member is between the age of 6 and 18 years old • Member is between the age of 6 and 12 years old OR Member has difficulty or inability to swallow • Member is on migraine prophylaxis treatment if having more than 4 headaches a month AND • Trial and failure or inability to use sumatriptan tablets AND rizatriptan tablets • Diagnosis of migraine with nausea and vomiting OR • Diagnosis of cluster headaches		successful treatment	
Rizatriptan Regular Release (Maxalt®) Rizatriptan ODT (Maxalt MLT®) Non formulary triptan				

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
Sumatriptan Nasal Spray Created: April 2014				1 fill (6 sprays) per 30 days
Vitamin D Analogs Doxercalciferol (Hectorol®) Paricalcitol (Zemplar®) Last updated: July 2013	Trial and failure or inability to use calcitriol	1 year	Therapeutic response per PA request	#1/day
Voriconazole (Vfend®) Last updated: May	Trial and failure or inability to use itraconazole OR	One course of treatment	Therapeutic response and continued medical need per PA request	#2/day

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
2013	Patient is being discharged and continuing therapy from IV voriconazole			
Anticoagulants, Injectable <u>Formulary 10-day supply, 2 fills per year:</u> Enoxaparin (Lovenox) <u>PA required:</u> Dalteparin (Fragmin) Fonadaparinux (Arixtra) Last updated: July 2015	**Note: Enoxaparin within specified quantity and fill limits (10 days supply, 2 fills per year) will pay at point of sale. Below criteria only applies to requests above quantity limits for enoxaparin* <u>Deep vein thrombosis (DVT) and/or pulmonary embolism (PE):</u> • Patient is 21 years of age or older** AND • The medication is being prescribed at a dose that is within FDA approved guidelines based on patient's current weight or standard weight of 70 kg AND • For chronic therapy (greater than 1 month), valid medical reason why oral anticoagulants (e.g. warfarin, Xarelto, Eliquis) cannot be used AND • ***For Fragmin and Arixtra***: trial and failure or inability to use enoxaparin due to contraindication or intolerance <u>Pregnancy</u>: • Indication is prevention and/or treatment of a DVT and/or PE while the member is pregnant AND • Documentation of the patient's current weight	<u>DVT/PE</u> 1 time authorization for up to a 30 days supply, unless supporting documentation for longer therapy is provided, then up to 6 months will be approved <u>DVT/PE and Pregnancy</u> Duration of pregnancy and post partum up to 6 weeks <u>Cancer</u> Initial: 6 months Re-auth: 1	<u>DVT/PE</u> Therapeutic response and continued medical need for chronic therapy per PA request <u>DVT/PE and Pregnancy</u> None (one time authorization) <u>Cancer</u> Therapeutic response and continued medical need for chronic therapy per PA request	30 days per fill; quantity is variable depending on patient's weight and FDA approved dosing guidelines

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	and expected due date (EDD). If the request is to continue LMWH treatment postpartum then documentation of the patient's actual or expected due date and current weight is required AND THEN up to 6 weeks of additional treatment may be authorized. AND • The medication is being recommended and prescribed by an obstetrician or hematologist at a dose that is within FDA approved guidelines and/or is supported by the medical compendium as defined by the Social Security Act. AND • ***For Fragmin and Arixtra***: trial and failure or inability to use enoxaparin due to contraindication or intolerance <u>Cancer</u>: • Indication is prevention and/or treatment of a venous thromboembolism (VTE), a proximal DVT and/or PE for a member with cancer AND • Patient is 21 years of age or older** AND • Prescriber is an oncologist/hematologist AND • The medication is being prescribed at a dose that is within FDA/NCCN/ASCO guidelines based on patient's current weight or standard weight of 70 kg	year		

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
	AND ***For Fragmin and Arixtra***: trial and failure or inability to use enoxaparin due to contraindication or intolerance			
Anticoagulants, Oral Formulary: Apixaban (Eliquis) Rivaroxaban (Xarelto) Warfarin PA required: Edoxaban (Savaysa) Dabigatran (Pradaxa) Created: July 2015	• Patient is ≥21 years of age** AND • Trial and failure or inability to use Eliquis AND Xarelto due to contraindication or intolerance AND For ***Edoxaban (Savaysa)*** • Indication for one of the following: o Nonvalvular atrial fibrillation o Treatment of Deep Vein Thrombosis (DVT) o Treatment of Pulmonary Embolism (PE) For ***Dabigatran (Pradaxa)*** • Indication for one of the following: o Nonvalvular atrial fibrillation o Treatment and reduction in the risk of recurrence of DVT and PE	***Atrial Fibrillation*** 2 years ***Treatment of DVT/PE*** 1 year	Therapeutic response and continued medical need per PA request	Savaysa: #30 per 30 days Pradaxa: #60 per 30 days
Nicotine Replacement Therapy Formulary #360 per 30 days: nicotine gum	***Nicotine nasal solution (Nicotrol NS), nicotine inhalation cartridge (Nicotrol):*** Trial and failure or inability to use[¥] at least 3 formulary products for smoking cessation therapy (i.e. nicotine gum, lozenge or patch, bupropion, Chantix) [¥]*examples could include e.g. due to gastritis or*	6 months (6 fills)	Response to therapy and medical justification for why therapy longer than 6 months is needed	Nicotine nasal solution: up to #120 ml per 30 days (80 sprays/40 mg per day) Nicotine inhalation cartridge: up to #504

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Drug Name	PA Criteria for Initiation of Therapy	Duration of Approval	Criteria for Reauthorization/ continuation of therapy	Quantity Limit*
nicotine lozenge Formulary #30 per 30 days: nicotine patch PA required: nicotine nasal solution (Nicotrol NS), nicotine inhalation cartridge (Nicotrol) Created: July 2015	*esophagitis for nicotine gum and lozenges, rash for nicotine patches* ***Nicotine lozenge, gum, patch over formulary quantity limit:*** Medial justification for why quantity larger than formulary quantity limit is needed			cartridges per 30 days (max 16 cartridges per day; package size of 168 cartridges)
Difluprednate 0.05% emulsion (Durezol®) Created: January 2015	**Anterior uveitis** • Member is 21 years of age or older** AND • Trial and failure or contraindication to fluorometholone 0.1% suspension **Inflammation and pain post ocular surgery** Member is 21 years of age or older**	1 year	Therapeutic response and continued medical need per PA request	5 mL per 30 days
Temazepam 7.5 mg (Restoril®) Last updated: May 2013	Trial and failure or inability to use Zolpidem AND generic Temazepam	1 year	Therapeutic response and continued medical need per PA request	#1/day

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