UPHP MEDICAID - 2ND GEN ANTIHISTAMINES

MEDICATION(S)
ALLERGY RLF(CETRZN) 10 MG SFGL, CVS ALLERGY(CETRZN) 10 MG SFGL, CETIRIZINE HCL 10 MG CHEW TAB, CETIRIZINE HCL 5 MG CHEW TAB, CETIRIZINE HCL 5 MG/5 ML CUP, CHILD CETIRIZINE 10 MG CHEW TB, CHILD CETIRIZINE 5 MG CHEW TAB, CLARINEX, DESLORATADINE, LEVOCETIRIZINE 2.5 MG/5 ML SOL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTIHISTAMINES – 2ND GENERATION
Drug Class: Antihistamines – 2nd Generation

Preferred Agents: No Prior Authorization required
cetirizine tablets
cetirizine 1mg/ml solution
fexofenadine suspension
fexofenadine tablets
levocetirizine tablets
loratadine / loratadine ODT

Non-Preferred Agents: Prior Authorization Criteria below
cetirizine chewable tabs

cetirizine 5mg/5ml solution cups
Clarinex®
desloratadine
levocetirizine solution

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Trial and failure on one preferred second-generation antihistamine or clinical rationale why they cannot be tried

Duration of Approval: 1 year
Effective 10/1/20, Updated 8/1/21
Updated 8/1/22

MEDICATION(S)
AVODART, DUTASTERIDE-TAMSULOSIN, JALYN, PROSCAR

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
BPH AGENTS – 5-ALPHA REDUCTASE (5AR) INHIBITORS
Drug Class: BPH Agents – 5-Alpha Reductase (5AR) Inhibitors

Preferred Agents: No Prior Authorization required
Dutasteride capsule
finasteride 5mg tablet (generic for Proscar®)

Non-Preferred Agents: Prior Authorization Criteria below
Avodart® softgel
dutasteride/tamsulosin capsule
Jalyn® capsule
Proscar® tablet

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications

•History of unacceptable side effects
•Therapeutic failure with a one-month trial with one preferred medication

Duration of Approval: 1 year
Effective 10/1/20

MEDICATION(S)
ACCUPRIL, ACCURETIC, ALTACE, CAPTOPRIL 100 MG TABLET, CAPTOPRIL 12.5 MG TABLET, CAPTOPRIL 25 MG TABLET, CAPTOPRIL 50 MG TABLET, CAPTOPRIL-HYDROCHLOROTHIAZIDE, ENALAPRIL 1 MG/ML ORAL SOLN, EPANED, FOSINOPRIL SODIUM, FOSINOPRIL-HYDROCHLOROTHIAZIDE, LOTENSIN, LOTENSIN HCT, MOEXIPRIL HCL, PERINDOPRIL ERBUMINE, QBRELIS, QUINAPRIL HCL, QUINAPRIL-HYDROCHLOROTHIAZIDE, TRANDOLAPRIL, VASERETIC, VASOTEC, ZESTORETIC, ZESTRIL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ACE INHIBITORS
Drug Class: ACE Inhibitors

Preferred Agents: No Prior Authorization required
benazepril/ benazepril HCT
enalapril/ enalapril HCT tablet
lisinopril/ lisinopril HCT
ramipril

Non-Preferred Agents: Prior Authorization Criteria below
Accupril® tablet

Accuretic® tablet
Altace® capsule
captopril/ captopril HCT tabs
enalapril solution (generic Epaned)
Epaned® solution
fosinopril/ fosinopril HCT tab
Lotensin®/ Lotensin HCT® tab
moexipril
Monopril® / Monopril HCT®
perindopril tablet
Qbrelis® solution
quinapril / quinapril HCT tab
trandolapril tablet
Vasotec® / Vaseretic® tablet
Zestril® / Zestoretic® tablet

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Patient is clinically stable and switching would cause a deterioration in condition
•Therapeutic failure on one preferred medication
•See additional medication-specific criteria below:

EPANED® (enalapril solution)
•PDL criteria may be bypassed if patient is unable to swallow tablets.

QBRELIS®
•PDL criteria may be bypassed if patient is unable to swallow tablets.

Duration of Approval: 1 year
Effective 10/1/20
Updated 9/1/21

MEDICATION(S)
LOTREL, TRANDOLAPR-VERAPAM ER 2-180 MG, TRANDOLAPR-VERAPAM ER 2-240 MG, TRANDOLAPR-VERAPAM ER 4-240 MG

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTIHYPERTENSIVE COMBINATIONS: ACEI
Drug Class: Antihypertensive Combinations: ACEI

Preferred Agents: No Prior Authorization required
amlodipine / benazepril capsule

Non-Preferred Agents: Prior Authorization Criteria below
Lotrel® capsule
Prestalia®
trandolapril / verapamil tablet

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR

•Therapeutic failure with one-month trial of one preferred medication

Duration of Approval: 1 year
Effective 10/1/20

MEDICATION(S)
METHYLDOPA-HYDROCHLOROTHIAZIDE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ALPHA ADRENERGIC AGENTS
Drug Class: Alpha Adrenergic Agents

Preferred Agents: No Prior Authorization required
clonidine tablet
clonidine ER
clonidine transdermal patch
guanfacine tablet
methyldopa tablet

Non-Preferred Agents: Prior Authorization Criteria below
methyldopa / HCTZ tablet

Non-Preferred Agent PA Criteria:
• Allergy to the preferred medications
• Contraindication or drug to drug interaction with the preferred medications

• History of unacceptable side effects
• Therapeutic failure on one preferred medication

Duration of Approval: 1 year
Updated 7/1/2021
Updated 9/1/22
Updated 11/1/22

MEDICATION(S)
CARDURA, CARDURA XL, FLOMAX, MINIPRESS, RAPAFLO, SILODOSIN

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
BPH AGENTS – ALPHA BLOCKERS

Drug Class: BPH Agents – Alpha Blockers

Preferred Agents: No Prior Authorization required
Alfuzosin tablet
Doxazosin tablet
Prazosin capsule
Tamsulosin capsule
Terazosin capsule

Non-Preferred Agents: Prior Authorization Criteria below
Cardura® tablet
Cardura XR® tablet
Flomax® capsule
Minipress® capsule

Rapaflo® capsule
Silodosin (generic for Rapaflo) capsule

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Therapeutic failure with a one-month trial with one preferred medication

Duration of Approval: 1 year, unless otherwise noted in drug-specific criteria

Effective 10/1/20

MEDICATION(S)
ADLARITY, ARICEPT, DONEPEZIL HCL 23 MG TABLET, GALANTAMINE ER, GALANTAMINE HYDROBROMIDE, MEMANTINE HCL ER, NAMENDA, NAMENDA XR, NAMZARIC, RIVASTIGMINE 13.3 MG/24HR PTCH, RIVASTIGMINE 4.6 MG/24HR PATCH, RIVASTIGMINE 9.5 MG/24HR PATCH

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ALZHEIMER'S DEMENTIA
Drug Class: Alzheimer's Dementia

Preferred Agents: No Prior Authorization required
donepezil tabs, ODT
Exelon® patch
galantamine immediate release tablet
memantine immediate release tabs, solution
rivastigmine capsules

Non-Preferred Agents: Prior Authorization Criteria below
Adlarity
Aricept® tablet
donepezil 23 mg® tablet

galantamine ER caps, solution
memantine ER capsule
Namenda® tablet
Namenda XR® capsule
Namzaric® capsule
rivastigmine patch

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Therapeutic failure with one-month trial of one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

MEDICATION(S)
DALFAMPRIDINE ER

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
AMPYRA® / DALFAMPRIDINE

Drug Class: Multiple Sclerosis Agent – Potassium Channel Blocker
FDA-approved uses: Indicated as a treatment to improve walking in patients with multiple sclerosis (MS).

Available dosage forms: 10 mg Extended-Release Tablet
Coverage Criteria/Limitations for initial authorization
Diagnoses: Documented diagnosis of multiple sclerosis with impaired walking ability
Duration of Approval:
Initial Authorization: 6 months
Continuation of Therapy: 1 year
Prescriber Specialty: Prescribed by a neurologist
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oPatient must not be wheelchair-bound
oPatient must not have a history of seizures
oPatient must not have moderate to severe renal impairment (Crcl less than 50 ml/min)

oPatient must be on disease modifying therapy for MS/confirmed diagnosis of MS
oDocumentation of significant and continuous walking impairment that impairs ability to complete normal activities of daily living (such as meal preparation, household chores, etc.) attributable to ambulation or functional status despite optimal treatment for Multiple Sclerosis
oAnd, Baseline 25-ft walking test between 8 and 45 seconds
OR
oMember is ambulatory* AND has an Expanded Disability Status Scale (EDSS)** score greater than or equal to 4.5 but less than 7
*Does not require the use of a wheelchair (bilateral assistance is acceptable, such as a brace, cane, or crutch, as long as the patient can walk 20 meters without resting)

**The Expanded Disability Status Score (EDSS) quantifies disability in eight functional systems: pyramidal, cerebellar, brainstem, sensory, bowel and bladder, visual, cerebral, and other. EDSS scores 1.0 to 4.5 refer to people with multiple sclerosis who are fully ambulatory. EDSS scores 5.0 to 9.5 are defined by increasing impairment to ambulation.
Quantity: 2 per day
Age: Patient is between 18 and 70 years old
Route of Administration: Oral

Criteria for continuation of therapy
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oMember currently meets ALL initial coverage criteria confirmed by documentation
oAdherence to therapy at least 85% of the time as verified by Prescriber and member's medication fill history
oFunctional impairment resolved as a result of increased speed of ambulation resulting in the member being able to complete instrumental activities of daily living (such as meal preparation, household chores, etc.)
AND
oImprovement of at least 20% in timed walking speed as documented by the T25FW (timed 25-foot walk) from pre-treatment baseline:

Contraindications/Exclusions/Discontinuation:
•Patient does NOT have a diagnosis of spinal cord injury, myasthenia gravis, demyelinating peripheral neuropathies (such as Guillain-Barré syndrome), Alzheimer's disease, and Lambert Eaton myasthenic syndrome.
•Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Effective 10/1/20

MEDICATION(S)
ANDRODERM, ANDROGEL, FORTESTA, NATESTO, TESTIM, TESTOSTERONE 1% (25MG/2.5G) PK, TESTOSTERONE 1% (50 MG/5 G) PK, TESTOSTERONE 1.62% (2.5 G) PKT, TESTOSTERONE 1.62% GEL PUMP, TESTOSTERONE 1.62%(1.25 G) PKT, TESTOSTERONE 10 MG GEL PUMP, TESTOSTERONE 12.5 MG/1.25 GRAM, TESTOSTERONE 30 MG/1.5 ML PUMP, TESTOSTERONE 50 MG/5 GRAM GEL, TESTOSTERONE 50 MG/5 GRAM PKT, VOGELXO

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANDROGENIC AGENTS (TOPICAL)
Drug Class: Androgenic Agents (topical)

Preferred Agents: Clinical Prior Authorization below
testosterone gel pump (generic for Androgel)

Clinical PA Criteria:
•Serum testosterone levels less than 300 ng/dL
•For requests submitted for gender dysphoria
oINITIAL REQUEST
Patient has had an initial evaluation completed by a health care provider experienced in gender dysphoria that specializes in treatment and evaluation of gender disorders (including health history, physical exam,

desired treatment goals and relevant lab testing), AND
Persistent well documented gender dysphoria, AND
Patient has the ability to make a fully informed decision and consent of treatment, AND
Prior consent for treatment including potential adverse health effects, expected benefits/effects including future body image changes and potential effects on fertility, AND
No significant medical or mental health concerns and, if so, they been addressed and been deemed to not be a contraindication to therapy
oRENEWAL REQUEST
Patient has had ongoing follow-up and monitoring following standard guidelines including addressing mental health concerns (for example, Version 7 WPATH Standards of Care or 2017 Clinical Practice Guideline, Endocrine Society https://doi.org/10.1210/jc.2017-01658
•Contraindications:
Severe renal or cardiac diseases
Benign prostatic hyperplasia with obstruction
Prostate cancer
Undiagnosed genital bleeding
Breast cancer
Pregnancy

Non-Preferred Agents: Prior Authorization Criteria below
Androderm®
Androgel® packet and gel pump
Fortesta®
Natesto
Testim®
testosterone
Vogelxo®

Non-Preferred Agent PA Criteria:
•Trial and failure with one preferred medication is required
•Decreased testosterone levels
•Contraindications:
Severe renal or cardiac diseases
Benign prostatic hyperplasia with obstruction
Prostate cancer
Undiagnosed genital bleeding
Breast cancer
Pregnancy

Duration of Approval: 1 year

MEDICATION(S)
ADIPEX-P, BENZPHETAMINE HCL, DIETHYLPROPION 25 MG TABLET, DIETHYLPROPION HCL ER, LOMAIRA, ORLISTAT 120 MG CAPSULE, PHENDIMETRAZINE TARTRATE, PHENDIMETRAZINE TARTRATE ER, PHENTERMINE 15 MG CAPSULE, PHENTERMINE 30 MG CAPSULE, PHENTERMINE 37.5 MG CAPSULE, PHENTERMINE 37.5 MG TABLET, SAXENDA, WEGOVY, XENICAL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTI-OBESITY AGENTS

Drug Class: Anti-Obesity Agents

Preferred Agents: Clinical Prior Authorization below

Pancreatic Lipase Inhibitors:
Xenical (orlistat)
orlistat

GLP-1 Agonists:
Saxenda (liraglutide)
Wegovy (semaglutide)

Combination Products:
Contrave (bupropion/naltrexone)

Noradrenergic Sympathomimetic Agents:
benzphetamine (only available as generic), C-III
diethylpropion (only available as generic), C-IV
Adipex-P (phentermine), C-IV
Lomaira (phentermine), C-IV
phentermine, C-IV
phendimetrazine (only available as generic), C-III

Clinical Prior Authorization
Initial
?Patient age ?18 years must have an initial body mass index [BMI] ? than 30 kg/m2, OR
?Patient age ?18 years must have an initial body mass index [BMI] ? than 27 kg/m2 but less than30 kg/m2 and at least one of the following risk factors:
o hypertension, coronary artery disease, diabetes, dyslipidemia, or sleep apnea, OR
•Patient age ?12 years to less than18 years must have an initial BMI per CDC growth charts at the 95th percentile or greater for age and sex (obesity), OR
•Patient age ?12 years to less than18 years with BMI in the 85th – 94th percentile (overweight) per CDC growth charts and has at least one of the following weight-related coexisting conditions:
odiabetes, sleep apnea, hypertension, or dyslipidemia, AND
?Patient age ?12 years (Wegovy, Xenical, Saxenda), OR
?Patient age ?18 years (Contrave, benzphetamine, diethylpropion, phentermine, phendimetrazine), AND
?For patients with an eating disorder, prescriber attests that treatment has been optimized and confirms the safety and appropriateness of this anti-obesity treatments, AND
?Prescriber attests that metabolic or other reason(s) for obesity/symptoms have been ruled out or diagnosed and treated (e.g., thyroid dysfunction, diabetes, sleep apnea, etc.), AND
?Prescriber attests to patient’s absence of any contraindications to use of the requested product, including pregnancy, lactation, a personal or family history of medullary thyroid cancer or multiple endocrine neoplasia type II, AND
?Prescriber attests medication therapy is part of a total treatment plan including diet and exercise/activity as appropriate for the patient’s ability, AND
?Prescriber attests that patient has been informed weight may return with cessation of medication unless healthy lifestyle diet and activity changes, as appropriate for the patient’s ability, are permanently adopted.

MDHHS recommends that prescribers consider the benefits of a diabetes prevention program for their

patients.

Renewal
•For adults age ?18 years, prescriber provides clinical documentation showing that the patient has maintained a weight loss of ? 5% from baseline weight at initiation of therapy.
•For patient’s age ?12 years to less than18 years, prescriber provides clinical documentation showing that the patient has maintained or improved BMI percentile per CDC growth charts from baseline weight at initiation of therapy.

?Duration of Approval: Initial = 6 months, Renewal = 6 months

MEDICATION(S)
TOBI, TOBRAMYCIN 300 MG/4 ML AMPULE, TOBRAMYCIN PAK 300 MG/5 ML

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTIBIOTICS – INHALED
Drug Class: Antibiotics – Inhaled

Preferred Agents: No Prior Authorization required
Bethkis® ampule
Cayston® inhalation solution
Kitabis® pak
Tobi-Podhaler®
tobramycin solution (generic for Tobi inhalation solution)

Non-Preferred Agents: Prior Authorization Criteria below
tobramycin pak (generic for Kitabis pak)
TOBI inhalation solution
tobramycin ampule (generic for Bethkis ampule)

Non-Preferred Agent PA Criteria:

•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•Trial and failure with one month with one preferred medication

Duration of Approval: 1 year
Effective 10/1/20

UPHP MEDICAID - ANTICOAGULANTS

MEDICATION(S)
ARIXTRA, DABIGATRAN ETEXILATE 75 MG CAP, FONDAPARINUX SODIUM, FRAGMIN 10,000 UNIT/ML SYRINGE, FRAGMIN 12,500 UNIT/0.5 ML SYR, FRAGMIN 15,000 UNIT/0.6 ML SYR, FRAGMIN 18,000 UNIT/0.72 ML, FRAGMIN 2,500 UNIT/0.2 ML SYR, FRAGMIN 5,000 UNIT/0.2 ML SYR, FRAGMIN 7,500 UNIT/0.3 ML SYR, FRAGMIN 95,000 UNIT/3.8 ML VL, LOVENOX, PRADAXA 110 MG PELLET PACK, PRADAXA 150 MG PELLET PACK, PRADAXA 20 MG PELLET PACK, PRADAXA 30 MG PELLET PACK, PRADAXA 40 MG PELLET PACK, PRADAXA 50 MG PELLET PACK, SAVAYSA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTICOAGULANTS

Drug Class: Anticoagulants

Preferred Agents: No Prior Authorization required
Eliquis® tablet
enoxaparin syringe, vial
Jantoven® tablet
Pradaxa® capsule
warfarin tablet
Xarelto®/ Xarelto® Dose Pack tablet

Non-Preferred Agents: Prior Authorization Criteria below
Arixtra® syringe
Bevyxxa® capsule
dabigatran etexilate
fondaparinux syringe
Fragmin® syringes and vials
Lovenox® syringe
Pradaxa oral pellets
Savaysa® tablet

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•Therapeutic failure on one preferred medication
•See additional medication-specific criteria below:

Pradaxa Oral Pellets (dabigatran)
Patient must be less than or equal to 11 years old
When used for VTE prophylaxis, attestation that parenteral anticoagulation has been used for at least 5 days

BEVYXXA® (BETRIXABAN)
•Patient age: ?18 years
•Patient has received Bevyxxa during hospitalization and will be continuing therapy following discharge from the hospital
•Patient at increased risk for VTE
•Quantity limit: 43 caps per 42 days
•Length of approval: 1 fill

SAVAYSA®
•Trial on Xarelto®, AND
•Patient must be 18 years or older

Duration of Approval: Current prescription up to 6 months

Effective 10/1/20
Update 8/1/22

MEDICATION(S)
AKYNZEO 300-0.5 MG CAPSULE, APREPITANT, EMEND 125 MG POWDER PACKET, EMEND TRIPACK, SANCUSO

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTIEMETICS
Drug Class: Antiemetics

Preferred Agents: No Prior Authorization required
Emend® 80mg
granisetron
ondansetron

Non-Preferred Agents: Prior Authorization Criteria below
Akynzeo®
Aprepitant
Emend Pack®
Sancuso® patch

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•Therapeutic failure with 48-hour trial with one preferred medication
•See additional medication-specific criteria below:

AKYNZEO
•May only be approved for highly emetogenic regimens or regimens including anthracyclines and cyclophosphamide that are not considered highly emetogenic and
•Therapeutic failure on a preferred 5-HT3 receptor antagonist (granisetron, ondansetron) and a preferred substance P receptor agonist (Emend)

QUANTITY LIMITS
Akynzeo® (netupitant/palonosetron)1 per fill
Emend® (aprepitant) tab125mg/80mg dose pack - 3 tablets per claim – billed by the tablet, not by the pack
40mg, 125mg tablet - 1 tablet per claim 80mg tablet - 2 tablets per claim
granisetron (Kytril®) 1mg tab15 per fill
granisetron (Kytril®) 1mg/5ml oral soln150 mL per fill
ondansetron (Zofran®)4mg, 8mg tab – 15 per fill
24mg tab – 10 per fill
ODT – 15 per fill
4mg/5ml oral solution - 75mL per fill
Sancuso® (granisetron) transdermal patch1 patch every 5 days
rolapitant (Varubi®)2 tablets per 7 days

Duration of Approval: 1 year
Effective 10/1/20
Update 8/15/22

MEDICATION(S)
COLCHICINE 0.6 MG CAPSULE, COLCRYS, FEBUXOSTAT, GLOPERBA, MITIGARE, ULORIC, ZYLOPRIM

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTIHYPERURICEMIC AGENTS
Drug Class : Antihyperuricemic Agents

Preferred Agents: No Prior Authorization required
allopurinol tablet
colchicine tablets (generic for Colcrys)
probenecid/colchicine tablet
probenecid tablet

Non-Preferred Agents: Prior Authorization Criteria below
colchicine capsules (generic for Mitigare)
Colcrys (colchicine) tablet
febuxostat tablet
Mitigare® (colchicine capsules)
Uloric (febuxostat) tablet

Zyloprim (allopurinol) tablet
Gloperba (colchicine) Oral Solution

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure after one-month trial of one preferred agent
•See additional medication-specific criteria below:

COLCRYS® (COLCHICINE) TABLETS
•PDL criteria may be bypassed for diagnosis of treatment of an acute gout flare or Familial Mediterranean Fever prophylaxis.

GLOPERBA® (COLCHICINE) ORAL SOLUTION
•Patient has difficulty swallowing tablets or has an enteral tube feeding

Duration of Approval: 1 year
Effective 10/1/20
Updated 11/1/21

MEDICATION(S)
BROMOCRIPTINE 2.5 MG TABLET, BROMOCRIPTINE 5 MG CAPSULE, KYNMOBI, MIRAPEX ER, NEUPRO, PARLODEL, PRAMIPEXOLE ER, ROPINIROLE ER

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTIPARKINSON'S AGENTS – DOPAMINE AGONISTS
Drug Class: AntiParkinson's Agents – Dopamine Agonists

Preferred Agents: No Prior Authorization required
Pramipexole tablet
Ropinirole tablet

Non-Preferred Agents: Prior Authorization Criteria below
Bromocriptine tablet, capsule
Kynmobi SL Film
Mirapex® tablet
Mirapex ER® tablet
Neupro® patch
Parlodel® tablet, capsule
pramiprexole ER tablet

ropinirole ER tablet

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Therapeutic failure of one month with one preferred medication
•Patients using bromocriptine for indications other than Parkinson’s do not need to meet non-preferred agent criteria
•See additional medication-specific criteria below:

KYNMOBI® (APOMORPHINE)
• Patient is experiencing acute intermittent hypomobility (defined as “off” episodes characterized by muscle stiffness, slow movements, or difficulty starting movements) despite optimized oral Parkinson’s therapy, AND
• Patient is currently receiving levodopa and adjunctive therapy with anti-Parkinson’s agents
• Patient is NOT concurrently taking a 5-HT3 antagonist [i.e., Zofran® (ondansetron), Kytril® (granisetron), Anzemet® (dolasetron), Aloxi® (palonosetron), and Lotronex® (alosetron)], AND
• Patient has a concurrent prescription order for trimethobenzamide to pre-medicate for the initial doses of apomorphine as needed

NEUPRO® (ROTIGOTINE)
•Quantity Limit (all strengths): 30 patches per 30 days

Duration of Approval: 1 year
Effective 10/1/2020
Updated 5/1/21

MEDICATION(S)

AMANTADINE 100 MG TABLET, AZILECT, CARBIDOPA 25 MG TABLET, CARBIDOPA-LEVO 10-100 MG ODT, CARBIDOPA-LEVO 25-100 MG ODT, CARBIDOPA-LEVO 25-250 MG ODT, CARBIDOPA-LEVODOPA-ENTACAPONE, COMTAN, DHIVY, DUOPA, ENTACAPONE, GOCOVRI, INBRIJA, LODOSYN, NOURIANZ, ONGENTYS, OSMOLEX ER 129 MG TABLET, OSMOLEX ER 193 MG TABLET, OSMOLEX ER 258 MG TABLET, RASAGILINE MESYLATE 0.5 MG TAB, RASAGILINE MESYLATE 1 MG TAB, RYTARY, SELEGILINE HCL 5 MG CAPSULE, SELEGILINE HCL 5 MG TABLET, SINEMET 10-100, SINEMET 25-100, STALEVO 100, STALEVO 125, STALEVO 150, STALEVO 200, STALEVO 50, STALEVO 75, TASMAR, TOLCAPONE, XADAGO, ZELAPAR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIPARKINSON’S AGENTS – OTHER
Drug Class: AntiParkinson’s Agents – Other

Preferred Agents: No Prior Authorization required (except rasagiline)
amantadine capsule, syrup
benztropine tablet (*Carve Out)
carbidopa/levodopa IR tablets
entacapone
rasagiline

trihexyphenidyl tablet (*Carve Out)

Rasagiline (AZILECT)
patient is 18 years or older

Non-Preferred Agents: Prior Authorization Criteria below
amantadine tablet
Azilect® tablet
carbidopa tablet
carbidopa tablet / levodopa ER, ODT
carbidopa/levodopa/entacapone tablet
Comtan® tablet
Dhivy®
Duopa® suspension
Gocovri® capsule
Inbrija® inhalation cap
Lodosyn® tablet
Nourianz® tablet
Ongentys
Osmolex ER® tablet
rasagiline tablet
Rytary® capsule
selegiline capsule, tablet
Sinemet®, Sinemet CR® tablet
Stalevo® tablet
Tasmar® tablet
tolcapone tablet
trihexyphenidyl elixir (*Carve Out)
Xadago® tablet
Zelapar® tablet

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure of one month with one preferred medication
•See additional medication-specific criteria below:

AZILECT® (RASAGILINE)
•Patient is greater than 18 years of age

GOCOVRI® (AMANTADINE EXTENDED-RELEASE)
•Diagnosis of dyskinesia associated with Parkinson’s disease, OR
•Experiencing Off-episodes of Parkinson’s disease, AND
•The patient is receiving concomitant levodopa-based therapy, AND
•Patient has failure, contraindication or intolerance to immediate-release amantadine

INBRIJA® (LEVODOPA INHALATION)
•Prescribed by or in consultation with a neurologist, AND
•Medication will be used concomitantly with levodopa/carbidopa

ONGENTYS® (OPICAPONE)
• Patient has a diagnosis of Parkinson’s Disease, AND
• Patient is experiencing ‘off’ time on levodopa/carbidopa therapy, AND
• Medication will be used concomitantly with levodopa/carbidopa and will not be used as monotherapy.

RYTARY® (CARBIDOPA/LEVODOPA)
•Patient is 18 years of age or older AND
•Prescribed by or in consultation with a neurologist

XADAGO® (SAFINAMIDE)
•Patient must be 18 years or older
•Patient is experiencing ‘off’ time on levodopa/carbidopa therapy, AND
•Medication will be used concomitantly with levodopa/carbidopa and will not be used as monotherapy.

Duration of Approval: Up to 1 year
Effective 10/1/20
Updated 2/1/22

MEDICATION(S)
CALCIPOTRIENE 0.005% CREAM, CALCIPOTRIENE 0.005% OINTMENT, CALCIPOTRIENE 0.005% SOLUTION

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
DOVONEX® / CALCIPOTRIENE
Drug Class: Dermatological - Antipsoriatics
FDA-approved uses: The relief of Psoriasis
Available dosage forms: 0.005% Cream, Ointment and Solution

Coverage Criteria/Limitations for initial authorization
Diagnoses: Psoriasis
Duration of Approval
oInitial Authorization: 6 months
oContinuation of Therapy: 12 months
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oPrescribed to treat an FDA approved indication for Topical Vitamin D analogs AND
oDocumented trial, failure or intolerance of at least one high potency or very high potency topical steroid OR
Route of Administration: For Topical Use Only

Criteria for continuation of therapy:
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oRequires a positive response to therapy

Contraindications/Exclusions/Discontinuation:
Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy

Effective 10/1/20

UPHP MEDICAID - ANTIVIRALS - HERPES

MEDICATION(S)
SITAVIG, VALTREX, ZOVIRAX 200 MG/5 ML SUSP

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTIVIRALS – HERPES
Drug Class: Antivirals – Herpes

Preferred Agents: No Prior Authorization required
acyclovir tablets, capsules, suspension
famciclovir tablet
valacyclovir tablet

Non-Preferred Agents: Prior Authorization Criteria below
Sitavig® tablet
Valtrex® caplet
Zovirax® suspension

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications

•History of unacceptable side effects
•Trial and failure on ten days of two preferred medications

Duration of Approval: For the duration of the prescription up to 6 months
Effective 10/1/20

UPHP MEDICAID - ANTIVIRALS - INFLUENZA

MEDICATION(S)
FLUMADINE, TAMIFLU

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTIVIRALS – INFLUENZA
Drug Class: Antivirals – Influenza

Preferred Agents: No Prior Authorization required
Oseltamivir
Relenza®
Rimantadine
Xofluza®

Non-Preferred Agents: Prior Authorization Criteria below
Flumadine®
Tamiflu®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR

•History of unacceptable side effects, OR
•Therapeutic failure with a five-day trial with two preferred medications

QUANTITY LIMITS
Tamiflu® and solution (oseltamivir) – brand & genericCapsules – 14 per fill
12 mg/mL solution – 50 mL per fill
6 mg/mL – 120 mL per fill

Duration of Approval: For the duration of the prescription up to 6 months
Effective 10/1/20
Updated 5/1/21
Updated 8/1/22
Updated 8/15/22

UPHP MEDICAID - ARB COMBINATIONS

MEDICATION(S)
AZOR, EXFORGE, EXFORGE HCT, OLMESARTAN-AMLODIPINE-HCTZ, TELMISARTAN-AMLODIPINE, TRIBENZOR

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTIHYPERTENSIVE COMBINATIONS: ARB

Drug Class : Antihypertensive Combinations: ARB

Preferred Agents: No Prior Authorization required
amlodipine/olmesartan tablet
amlodipine/valsartan tablet
amlodipine/valsartan/HCTZ tablet

Non-Preferred Agents: Prior Authorization Criteria below
Azor® tablet
amlodipine/olmesartan/HCTZ tablet
Exforge® / Exforge HCT® tablet
telmisartan/amlodipine tablet
Tribenzor® tablet

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Therapeutic failure with one-month trial of one preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 5/1/21

MEDICATION(S)
ATACAND, ATACAND HCT, AVALIDE, AVAPRO, BENICAR, BENICAR HCT, CANDESARTAN CILEXETIL, CANDESARTAN-HYDROCHLOROTHIAZID, COZAAR, DIOVAN, DIOVAN HCT, EDARBI, EDARBYCLOR, EPROSARTAN MESYLATE, HYZAAR, IRBESARTAN, IRBESARTAN-HYDROCHLOROTHIAZIDE, MICARDIS, MICARDIS HCT, TELMISARTAN, TELMISARTAN-HYDROCHLOROTHIAZID

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANGIOTENSIN RECEPTOR ANTAGONISTS
Drug Class: Angiotensin Receptor Antagonists

Preferred Agents: No Prior Authorization required
losartan/ losartan HCT tablet
olmesartan, olmesartan HCT tablet
valsartan/ valsartan HCT tablet

Non-Preferred Agents: Prior Authorization Criteria below
Atacand® / Atacand HCT® tablet
Avapro®/ Avalide® tablet
Benicar®/ Benicar HCT® tablet

candesartan/ candesartan HCT tablet
Cozaar® tablet
Diovan®/ Diovan HCT® tablet
Edarbi® tablet
Edarbyclor® tablet
eprosartan tablet
Hyzaar® tablet
irbesartan/ irbesartan HCT tablet
Micardis® / Micardis HCT® tablet
telmisartan/ telmisartan HCT tablet

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Patient is clinically stable, and switching would cause a deterioration in condition
•Therapeutic failure on one preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 5/1/21

UPHP MEDICAID - AUSTEDO (DEUTETRABENAZINE)

MEDICATION(S)
AUSTEDO

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
AUSTEDO/ DEUTETRABENAZINE
Drug Class Movement Disorder Therapy - Tardive Dyskinesia, Huntington's Disease
FDA-approved uses: Tardive Dyskinesia, Chorea associated with Huntington’s

Available dosage forms: Tablets: 6mg, 9mg, 12mg, XR 6mg, XR 12mg, XR 24mg

Coverage Criteria/Limitations for initial authorization:
Diagnoses: Diagnosis of chorea associated with Huntington’s disease, OR Tardive Dyskinesia secondary to use of a dopamine antagonist (i.e., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.)
Duration of approval:
oInitial authorization: 1 year
oContinuation of Therapy: 1 year
Prescriber Specialty: Prescribed by or in consultation with a neurologist or psychiatrist
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
For tardive dyskinesia attestation that a baseline AIMS test has been completed

Age: Patient is 18 years of age or older

Criteria for continuation of therapy:
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
Attestation that a follow-up AIMS test has been completed and there has been a positive response to therapy

Effective 7/1/21

MEDICATION(S)
BENZNIDAZOLE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
BENZNIDAZOLE
Drug Class: Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents, TNF=alpha set

Background:
Benznidazole, a nitroimidazole antimicrobial, is indicated in pediatric patients 2 to 12 years of age for the treatment of Chagas disease (American trypanosomiasis), caused by Trypanosoma cruzi.1
Antiparasitic treatment is indicated for all cases of acute or reactivated Chagas disease and for chronic Trypanosoma cruzi (T. cruzi) infection in children up to 18 years old. Congenital infections are considered acute disease. Treatment is strongly recommended for adults up to 50 years old with chronic infection who do not already have advanced Chagas cardiomyopathy. For adults older than 50 years with chronic T. cruzi infection, the decision to treat with antiparasitic drugs should be individualized, weighing the potential benefits and risks for the patient. Physicians should consider factors such as the patient’s age, clinical status, preference, and overall health.2

Authorization:
Diagnosis of Chagas disease (American trypanosomiasis) due to Trypanosoma cruzi

Authorization will be issued for 60 days.

References:
Benznidazole [prescribing information]. Laboratorios Liconsa S.A., Guadalajara, Spain. August 2017.
CDC Guidelines. Parasites – American Trypanosomiasis (also known as Chagas Disease). https://www.cdc.gov/parasites/chagas/. December 2017.

Effective 10/1/20

MEDICATION(S)

ACEBUTOLOL 200 MG CAPSULE, ACEBUTOLOL 400 MG CAPSULE, BETAPACE 120 MG TABLET, BETAPACE 160 MG TABLET, BETAPACE 80 MG TABLET, BETAPACE AF, BETAXOLOL 10 MG TABLET, BETAXOLOL 20 MG TABLET, BISOPROLOL FUMARATE 10 MG TAB, BISOPROLOL FUMARATE 5 MG TAB, COREG, COREG CR, CORGARD, HEMANGEOL, INDERAL LA, INDERAL XL, INNOPRAN XL, KAPSPARGO SPRINKLE, LOPRESSOR, METOPROLOL-HYDROCHLOROTHIAZIDE, NADOLOL 20 MG TABLET, NADOLOL 40 MG TABLET, NADOLOL 80 MG TABLET, NEBIVOLOL HCL, PINDOLOL, PROPRANOLOL-HYDROCHLOROTHIAZID, SOTYLIZE, TENORETIC 100, TENORETIC 50, TENORMIN, TIMOLOL MALEATE 10 MG TABLET, TIMOLOL MALEATE 20 MG TABLET, TIMOLOL MALEATE 5 MG TABLET, TOPROL XL, ZIAC

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

BETA BLOCKERS
Drug Class: Beta Blockers

Preferred Agents: No Prior Authorization required
atenolol
atenolol / chlorthalidone
bisoprolol fumarate HCT
Bystolic®

Coreg CR
carvedilol
labetalol
metoprolol / metoprolol XL
metoprolol succinate
metoprolol tartrate
propranolol
propranolol LA
sorine tablet
sotalol / sotalol AF

Non-Preferred Agents: Prior Authorization Criteria below
acebutolol
Betapace® / Betapace AF®
betaxolol
bisoprolol fumarate
carvedilol ER
Coreg® tablet
Corgard®
Corzide®
Hemangeol oral solution®
Inderal LA®/ Inderal XL®
Innopran XL®
Kapspargo®
Lopressor®
metoprolol HCT
nadolol
nadolol/bendroflumethiazide
nebivolol
pindolol
propranolol HCT
Sotylize®
Tenormin®/ Tenoretic®
timolol maleate
Toprol XL®
Ziac®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR

•History of unacceptable side effects, OR
•Patient is clinically stable, and switching would cause a deterioration in condition, OR
•Therapeutic failure with one-month trial of one preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 9/15/21

UPHP MEDICAID - BILE SALTS

MEDICATION(S)
RELTONE, URSO, URSO FORTE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
BILE SALTS
Drug Class: Bile Salts

Preferred Agents: No Prior Authorization required
ursodiol capsules (generic for Actigall)
ursodiol tablets

Non-Preferred Agents: Prior Authorization Criteria below
Actigall®
Reltone®
Urso®/Urso Forte®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR

•Therapeutic failure on a one-month trial of one preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 11/1/21
Updated 9/1/22

UPHP MEDICAID - BPH AGENTS - ALPHA BLOCKERS

MEDICATION(S)
CARDURA, CARDURA XL, ENTADFI, FLOMAX, MINIPRESS, RAPAFLO, SILODOSIN

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
BPH AGENTS – ALPHA BLOCKERS
Drug Class: BPH Agents – Alpha Blockers

Preferred Agents: No Prior Authorization required
Alfuzosin tablet
Doxazosin tablet
Prazosin capsule
Tamsulosin capsule
Terazosin capsule

Non-Preferred Agents: Prior Authorization Criteria below
Cardura® tablet
Cardura XR® tablet
Flomax® capsule
Minipress® capsule
Rapaflo® capsule

Silodosin (generic for Rapaflo) capsule
Entadfi

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Therapeutic failure with a one-month trial with one preferred medication
•see additional medication specific criteria below

ENTADFI (FINASTERIDE/TADALAFIL)
•Prescriber attests that Entadfi is not being used for erectile dysfunction (ED)
•length of approval 26 weeks

Duration of Approval: 1 year (unless specified in drug specific criteria)
Effective 10/1/20

UPHP MEDICAID - BRONCHITOL/MANNITOL

MEDICATION(S)
BRONCHITOL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
BRONCHITOL® / MANNITOL

Drug Class (ETC_Name): Mucolytic agent

FDA-approved uses: BRONCHITOL is a sugar alcohol indicated as add-on maintenance therapy to improve pulmonary function in adult patients 18 years of age and older with cystic fibrosis.

Available dosage forms: BRONCHITOL (mannitol) inhalation powder, 40mg of mannitol per capsule supplied in cartons containing 10, 140 or 560 capsules in blister packs co-packaged with 1, 1, and 4 inhalers respectively in a carton.

Coverage Criteria/Limitations for initial authorization:
Diagnoses: Cystic fibrosis
Duration of approval:
oInitial authorization: 1 year
oContinuation of Therapy: for up to 1 year

Prescriber Specialty: pulmonologist
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oPrescriber attestation that the Bronchitol Tolerance Test (BTT) has been performed to confirm the patient is suitable for Bronchitol therapy,
oTrial and failure of hypertonic saline,
oBronchitol will be used as add-on maintenance therapy to improve pulmonary function

Quantity: Maximum 560 capsules per 28 days
Age: 18 years and older
Gender: Male and Female
Route of Administration: Oral
Place of Service: N/A

Criteria for continuation of therapy:
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oProvider attestation that member has had positive response to treatment,
oPatient did not experience event of hemoptysis (coughing up blood)

Contraindications/Exclusions/Discontinuation:
•Non-FDA-approved indications
•Hypersensitivity to mannitol or to any of the capsule components
•Failure to pass the BRONCHITOL Tolerance Test (BTT)
Other special considerations:
•Patient is also using bronchodilator (A short-acting bronchodilator should be administered 5-15 minutes before every dose of Bronchitol)

Effective 11/1/21

MEDICATION(S)
CAMZYOS

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
CAMZYOS/MAVACAMTEN
Drug Class: Cardiac Myosin Inhibitors

FDA-approved uses: CAMZYOS is a cardiac myosin inhibitor indicated for the treatment of adults with symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM) to improve functional capacity and symptoms.

Available dosage forms: Tablets 2.5mg, 5mg, 10mg and 15mg

Coverage Criteria/Limitations for initial authorization:
?Diagnoses:
oDiagnosis of symptomatic New York Heart Association (NYHA) class II or III obstructive hypertrophic cardiomyopathy (HCM)
?Duration of Approval:
o Initial authorization: 6 months
oContinuation of Therapy: 1 year

?Prescriber Specialty:
oPrescribed by a cardiologist, OR
oPrescribed in consultation with a cardiologist: Identify Cardiologist Name & NPI:_____
_____
?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oMember has a left ventricular ejection fraction (LVEF) of ? 55%, AND
oPrescriber attests that the member will not be prescribed disopyramide, ranolazine, or combination therapy of beta blocker and calcium channel blocker, while the member is receiving Camzyos, AND
oFor females of childbearing potential, a pregnancy test is performed and is negative before starting therapy. AND
oAttestation provided of patient, provider, and pharmacy enrollment in Camzyos Risk Evaluation and Mitigation Strategy (REMS) Program
?Quantity: 30 capsules per 30 days
?Age: ? 18 years of age

Criteria for continuation of therapy:
?Documentation Requirements (e.g., Labs, Medical Record, Special Studies):
oPrescribed by a cardiologist, OR
oPrescribed in consultation with a cardiologist: Identify Cardiologist Name & NPI:_____
_____
•Prescriber attests to positive clinical response or stable disease, AND
•Prescriber attests that the member will not be prescribed disopyramide, ranolazine, or combination therapy of beta blocker and calcium channel blocker, while the member is receiving Camzyos, AND
•Prescriber attests that the member is not pregnant, AND
•LVEF is ? 50%

Contraindications/Exclusions/Discontinuation:
•Concomitant use of moderate to strong CYP2C19 inhibitors or strong CYP3A4 inhibitors,
•Concomitant use of moderate to strong CYP2C19 inducers or moderate to strong CYP3A4 inducers
•Pregnancy

Other special considerations:
•REMS program: Prescribers must be certified by enrolling in the REMS program. Patients must also enroll in the REMS program and comply with monitoring requirements. Pharmacies must be certified to dispense medication by enrolling in the REMS program.
•Verify pregnancy status prior to treatment initiation, pregnancy should be excluded prior to treatment initiation.

UPHP MEDICAID - CCB DIHYDROPYRIDINE

MEDICATION(S)
FELODIPINE ER, ISRADIPINE, KATERZIA, LEVAMLODIPINE MALEATE 5 MG TAB, NICARDIPINE 20 MG CAPSULE, NICARDIPINE 30 MG CAPSULE, NISOLDIPINE, NORLIQVA, NORVASC, SULAR

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
CALCIUM CHANNEL BLOCKERS - DIHYDROPYRIDINE
Drug Class: Calcium Channel Blockers - Dihydropyridine

Preferred Agents: No Prior Authorization required
amlodipine besylate
nifedipine tablet / nifedipine SA

Non-Preferred Agents: Prior Authorization Criteria below
felodipine ER
isradipine
Katerzia®
Nicardipine
nisoldipine
Norvasc®
Procardia XL®

Sular®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•Patient is clinically stable, and switching would cause a deterioration in condition OR
•Therapeutic failure with one-month trial of one preferred medication
•See additional medication-specific criteria below:

KATERZIA® SUSPENSION (AMLODIPINE)
•Patient age of 6 years or greater
•Allow if patient has swallowing difficulties

NORLIQVA® SUSPENSION (AMLODIPINE)
•Patient age of 6 years or greater
•Allow if patient has swallowing difficulties

Duration of Approval: 1 year
Effective 10/1/20
Update 11/1/22

MEDICATION(S)

CALAN SR 240 MG TABLET, CARDIZEM, CARDIZEM CD, CARDIZEM LA, DILTIAZEM 24H ER(LA) 180 MG TB, DILTIAZEM 24H ER(LA) 240 MG TB, DILTIAZEM 24H ER(LA) 300 MG TB, DILTIAZEM 24H ER(LA) 360 MG TB, DILTIAZEM 24H ER(LA) 420 MG TB, MATZIM LA, TIADYLT ER, TIAZAC, VERAPAMIL ER 120 MG CAPSULE, VERAPAMIL ER 180 MG CAPSULE, VERAPAMIL ER 240 MG CAPSULE, VERAPAMIL ER PM, VERAPAMIL SR, VERELAN, VERELAN PM

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

CALCIUM CHANNEL BLOCKERS – NON-DIHYDROPYRIDINE
Drug Class: Calcium Channel Blockers – Non-Dihydropyridine

Preferred Agents: No Prior Authorization required
Diltiazem tablet / diltiazem XR / diltiazem ER capsule
Taztia XT® capsule
verapamil / verapamil ER tablet

Non-Preferred Agents: Prior Authorization Criteria below
Calan® tablet/ Calan SR® caplet
Cardizem® tablet / Cardizem LA® tablet / Cardizem CD® capsule
diltiazem LA tablet

Matzim LA® tablet
Tiadylt ER® capsule
Tiazac® capsule
verapamil ER capsules
Verelan® / Verelan PM® pellet capsules
verapamil cap 24-hr pellet capsules

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Patient is clinically stable, and switching would cause a deterioration in condition
•Therapeutic failure with one-month trial of one preferred medication

Duration of Approval: 1 year
Effective 10/1/20

MEDICATION(S)
CEFACLOR, CEFACLOR ER, CEFADROXIL 1 GM TABLET, CEFIXIME 100 MG/5 ML SUSP, CEFIXIME 200 MG/5 ML SUSP, CEFPODOXIME PROXETIL, SUPRAX

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
CEPHALOSPORINS
Drug Class:
Cephalosporins - 1st Generation
Cephalosporins - 2nd Generation
Cephalosporins - 3rd Generation

CEPHALOSPORINS - 1ST GENERATION
Preferred Agents: No Prior Authorization required
cefadroxil capsules
cefadroxil suspension
cephalexin

Non-Preferred Agents: Prior Authorization Criteria below
cefadroxil tablets
Keflex®

CEPHALOSPORINS - 2ND GENERATION
Preferred Agents: No Prior Authorization required
Cefuroxime
cefprozil tablet
cefprozil suspension

Non-Preferred Agents: Prior Authorization Criteria below
Cefaclor
cefaclor ER

CEPHALOSPORINS - 3RD GENERATION
Preferred Agents: No Prior Authorization required
Cefdinir
cefixime capsules
Suprax® capsules

CEPHALOSPORINS - 3RD GENERATION, continued
Non-Preferred Agents: Prior Authorization Criteria below
cefixime suspension
cefpodoxime tablets
cefpodoxime suspension
Suprax® chew tabs, suspension

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Infection caused by an organism resistant to the preferred cephalosporins
•Therapeutic failure (duration = 3 days) with any two preferred cephalosporins medications

QUANTITY LIMITS
cefaclor caps (Ceclor®)42 per fill
cefaclor ER tabs (Ceclor CD®)42 per fill
cefadroxil caps/tabs (Duricef®)28 per fill
cefdinir tabs (Omnicef®)28 per fill
cefpodoxime tabs (Vantin®)28 per fill
cefprozil tabs (Cefzil®)28 per fill
ceftibuten caps (Cedax®)14 per fill
cefuroxime tabs (Ceftin®)42 per fill

Duration of Approval: Date of service
Effective 10/1/20
Updated 8/1/21
Updated 5/1/22

MEDICATION(S)
ELYXYB, NURTEC ODT, REYVOW, UBRELVY, ZAVZPRET

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTIMIGRAINE AGENTS, ACUTE TREATMENT - OTHER
Drug Class: Antimigraine Agents, Acute Treatment - Other

Preferred Agents for Acute Migraines: Clinical Prior Authorization below
Nurtec ODT®

Clinical PA Criteria for Acute Migraines:
•Patient has a diagnosis of migraine with or without aura, AND
•Patient is greater than or equal to 18 years of age, AND
•Patient must have tried and failed, or have contraindication to one preferred triptan medication

NURTEC ODT® (RIMEGEPANT) – Quantity Limit: 54 tablets per 90 days

Non-Preferred Agents for Acute Migraines: Prior Authorization Criteria below
Elyxyb®
Reyvow

Ubrelvy
Zavzpret

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure after a one-month trial of the preferred medication

ELYXYB (CELECOXIB) - Quantity limit: 14 doses per 30 days
REYVOW® (LASMIDITAN) – Quantity Limit: 8 tablets per 30 days
UBRELVY® (UBROGEPANT) – Quantity Limit: 16 tablets per 30 days
ZAVZPRET® (ZAVEGEPANT) – Quantity Limit: 8 nasal spray devices per 30 days

Duration of Approval: 1 year
Effective 10/1/20
Updated 1/1/22
Updated 8/1/22
Updated 12/15/22

MEDICATION(S)
AIMOVIG AUTOINJECTOR, AJOVY AUTOINJECTOR, AJOVY SYRINGE, EMGALITY PEN, EMGALITY 120 MG/ML SYRINGE, EMGALITY 300 MG (100 MG X3SYR), NURTEC ODT, QULIPTA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTIMIGRAINE AGENTS, PREVENTIVE TREATMENT
Drug Class: Antimigraine Agents, Preventive Treatment

Preferred Agents for Migraine Prevention: Clinical Prior Authorization below
Aimovig®
Emgality®
Nurtec ODT®
Ajovy®

Clinical PA Criteria for Migraine Prevention:
•For initial requests:
oPatient has a diagnosis of migraine with or without aura, AND
o Patient is 18 years of age or older, AND
oPatient has greater than or equal to four migraine days per month for at least three months, AND
oPatient has tried and failed greater than or equal to one-month trial of any two of the following oral

medications:
?Antidepressants (e.g., amitriptyline, venlafaxine)
?Beta blockers (e.g., propranolol, metoprolol, timolol, atenolol)
?Anti-epileptics (e.g., valproate, topiramate)
?Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan), OR
oDiagnosis of cluster headaches (Emgality only)
•For Renewal requests:
oPatient demonstrated significant decrease in the number, frequency, and/or intensity of headaches

Non-Preferred Agents for Migraine Prevention: Prior Authorization Criteria below
Qulipta®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure after a one-month trial of one preferred medication
•See additional medication-specific criteria below:

QUANTITY LIMITS
Emgality® (galcanezumab-gnlm) 120 mg/mL Pen, Syringe3 mL per 90 days
Emgality 300 mg Dose (3 x 100 mg/mL syringes)9 mL per 90 days
Aimovig® (erenumab-aooe) 140 mg/mL Autoinjector3 mL per 90 days
Aimovig® (erenumab-aooe) 70 mg/mL Autoinjector6 mL per 90 days
Nurtec® ODT (rimegepant) 75mg Tablet54 tablets per 90 days
Ajovy® (fremanezumab-vfrm) 225 mg/1.5 mL Autoinjector, Syringe4.5 mL per 90 days
Qulipta® (atogepant) tablets90 tablets per 90 days
An override will be approved for requests which demonstrate that prescribed loading dose will exceed the maintenance quantity limit in table above.

Duration of Approval: 6 months, Renewal = 12 months
Updated 1/1/22
Updated 5/1/22

UPHP MEDICAID - COLONY STIMULATING FACTORS

MEDICATION(S)
FULPHILA, FYLNETRA, GRANIX, LEUKINE, NEULASTA, NEULASTA ONPRO, NIVESTYM, RELEUKO, UDENYCA, ZARXIO, ZIEXTENZO

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
COLONY STIMULATING FACTORS
Drug Class: Colony Stimulating Factors

Preferred Agents: No Prior Authorization required
Neupogen®
Nyvepria®

Non-Preferred Agents: Prior Authorization Criteria below
Fulphila®
Granix®
Leukine®
Neulasta® syringe, Neulasta® Onpro Kit
Nivestym®
Releuko
Stimufend

Udenyca®
Zarxio®
Ziextenzo®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure with a one-month trial with one preferred medication
•See additional medication-specific criteria below:

Quantity Limitations:
Fulphila 6mg/0.6mL syringe 0.6 mls per 14 days
Fylnetra 6mg/0.6mL Syringe 0.6 mls per 14 days
Neulasta 6mg/0.6ml Syringe0.6 mls per 14 days
Neulasta Onpro 6mg/0.6ml Kit0.6 mls per 14 days
Nyvepria 6mg/0.6ml Syringe0.6 mls per 14 days
Stimufend 6mg/0.6mL syringe 0.6 mls per 14 days
Fulphila 6mg/0.6ml Syringe0.6 mls per 14 days
Udenyca 6mg/0.6ml Syringe0.6 mls per 14 days
Ziextenzo 6mg/0.6ml Syringe0.6 mls per 14 days
Zarxio 480mcg/0.8ml Syringe45 mls per 30 days
Zarxio 300mcg/0.5ml Syringe45 mls per 30 days

Duration of Approval: 1 year
Effective 10/1/20
Updated 11/1/21
Updated 11/1/22

UPHP MEDICAID - COMBO BPO + CLINDAMYCIN

MEDICATION(S)
ACANYA, NEUAC, ONEXTON

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
COMBINATION BENZOYL PEROXIDE AND CLINDAMYCIN
Drug Class: Combination Benzoyl Peroxide and Clindamycin

Preferred Agents: No Prior Authorization Required
clindamycin / benzoyl peroxide pumps and tubes (generic for Benzaclin and Duac)
clindamycin / benzoyl peroxide (generic for Acanya)

Non-Preferred Agents: Prior Authorization Criteria below
Acanya® gel and pump
Benzaclin® tube and pump
Duac® tube and pump
Neuac 1.25% kit®
Onexton® gel

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications

•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Therapeutic failure with one preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 12/8/20 P&T

MEDICATION(S)
CORLANOR

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
CORLANOR/IVABRADINE

Drug Class (ETC_Name): Hyperpolarization-activated cycle nucleotide-gated channel blocker

FDA-approved uses: Heart failure, chronic, and heart failure, chronic, due to dilated cardiomyopathy

Available dosage forms:
-Oral solution 1mg/1ml
-Oral tablet: 5mg. 7.5mg

Coverage Criteria/Limitations for initial authorization:
?Diagnoses: Heart failure
?Duration of approval: 12 months
?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oDiagnosis of stable symptomatic chronic heart failure (NYHA class II, III or IV) AND
oLeft ejection fraction less than 35% AND

oThe patient is in sinus rhythm AND
oPatient has a resting heart rate greater than 70 beats per minute AND
oOne of the following:
?Patient is on maximum tolerated doses of beta-blockers (e.g. carvedilol, metoprolol, succinate, bisoprolol)
OR
?Patient has a contraindication to or intolerance to beta-blocker therapy
OR
oPediatric patients ages 6 months and older:
?Diagnosis of stable symptomatic heart failure due toot dilated cardiomyopathy (DCM) AND
?Patient is in sinus rhythm AND
?Patient has an elevated heart rate for age

Criteria for continuation of therapy:
?Attestation to positive clinical response to therapy

Contraindications/Exclusions/Discontinuation:

Other special considerations:

Effective 8/1/22

UPHP MEDICAID - DARAPRIM/PRYIMETHAMINE

MEDICATION(S)
PYRIMETHAMINE 25 MG TABLET

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
DARAPRIM® / PYRIMETHAMINE

Drug Class: Antimalarials
FDA-approved uses:
Treatment of toxoplasmosis: Daraprim is indicated for the treatment of toxoplasmosis when used conjointly with a sulfonamide.
Treatment of acute Malaria: Daraprim is indicated for the treatment of acute malaria. It should not be used alone to treat acute malaria. Fast-acting schizonticides such as chloroquine or quinine are indicated and preferable for the treatment of acute malaria. However, conjoint use of Daraprim with a sulfonamide will initiate transmission control and suppression of susceptible strains of plasmodia.
Malaria prophylaxis: Daraprim is indicated for the chemoprophylaxis of malaria due to susceptible strains of plasmodia. However, resistance to pyrimethamine is prevalent worldwide. It is not suitable as a prophylactic agent for travelers to most areas.
Available dosage forms: 25mg Tablet

Coverage Criteria/Limitations for initial authorization:

Diagnoses:
oTreatment of Toxoplasmosis
oSecondary prevention of Toxoplasmosis in patients with HIV
oPrevention of pneumocystis pneumonia in patients with HIV
Duration of Approval:
Initial Authorization:
Toxoplasmosis – 6 weeks
Pneumocystis prophylaxis – 3 months
oContinuation of Therapy:
Toxoplasmosis – 6 months
Pneumocystis – 3 months
Prescriber Specialty: infectious disease
Documentation Requirements: (e.g. Labs, Medical Record, Special Studies):
oFor Pneumocystis diagnosis ONLY: TMP/SMX, atovaquone, and dapsone
oFor Pneumocystis prophylaxis (ONE of the following):
CD4 count less than 200 cells/microL
Oropharyngeal candidiasis
CD4 count percentage less than 14 percent
CD4 cell count between 200 and 250 cells/microL IF frequent monitoring (eg, every three months) of CD4 cell counts is not possible

Quantity:
Toxoplasmosis (induction-dose): 90 tablets per 30 days
Toxoplasmosis (maintenance-dose): 60 tablets per 30 days
Pneumocystis prophylaxis: 12 tablets per 28 days
Gender: male and female
Route of Administration: oral
Place of Service: outpatient

Criteria for continuation of therapy:
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oFor Toxoplasmosis prophylaxis, after initial 6 weeks of induction treatment (ONE of the following):
Patient remains symptomatic
Patient is NOT receiving antiretroviral therapy (ART)
Patient has a detectable HIV viral load
Patient has maintained a CD4 count greater than 200 cells/microL for less than six months
oFor Pneumocystis prophylaxis (ONE of the following):
CD4 count less than 200 cells/microL
Oropharyngeal candidiasis
CD4 count percentage less than 14 percent

CD4 cell count between 200 and 250 cells/microL IF frequent monitoring (eg, every three months) of CD4 cell counts is not possible

Contraindications/Exclusions/Discontinuation:
•Megaloblastic anemia due to folate deficiency
•Secondary prophylaxis of Toxoplasmosis in patients with a CD4 count greater than 200 cells/microL for longer than 6 months and a sustained HIV viral load
•Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:
•Daraprim is no longer recommended for malaria treatment or prophylaxis and treatment of malaria is very individualized.
•Refer to the CDC website for recommendations for treatment and prevention of malaria.

References
1.Gandhi RT. Toxoplasmosis in HIV-infected patients. Waltham, MA: UptoDate, Last modified September 21, 2015. http://www.uptodate.com/contents/toxoplasmosis-in-hiv-infected-patients?source=search_result&search=daraprim&selectedTitle=6%7E47. Accessed September 25, 2015.
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References, continued
2.Thomas CF, Limper AH. Treatment and prevention of Pneumocystis pneumonia in non-HIV-infected patients. Waltham, MA: UptoDate, Last modified January 6, 2015. http://www.uptodate.com/contents/treatment-and-prevention-of-pneumocystis-pneumonia-in-non-hiv-infected-patients?source=search_result&search=pneumocystis&selectedTitle=4%7E150. Accessed September 25, 2015.
3.Sax PE. Treatment and prevention of Pneumocystis infection in HIV-infected patients. Waltham, MA: UptoDate, Last modified August 27, 2015. http://www.uptodate.com/contents/treatment-and-prevention-of-pneumocystis-infection-in-hiv-infected-patients?source=search_result&search=pneumocystis&selectedTitle=2%7E150#H2384560994. Accessed September 25, 2015.

Effective 10/1/20

MEDICATION(S)
DESMOPRESSIN 0.01% SOLUTION, DESMOPRESSIN 10 MCG/0.1 ML SPR

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
DESMOPRESSIN NASAL SPRAY
Drug Class: Antidiuretic and vasopressor hormones

FDA-approved uses:
Diabetes Insipidus – Desmopressin Nasal Spray

Available dosage forms:
Desmopressin Nasal Spray – 0.1 mg/ml solution, 10 mcg/0.1 ml spray

Coverage Criteria/Limitations for initial authorization
Diagnoses:
o Diabetes Insipidus
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
o Documentation of Diabetes Insipidus
•Documented inadequate response to a 3-month trial of a maximum tolerated dose or clinical contraindication of Desmopressin tablets

Route of Administration: various

Contraindications/Exclusions/Discontinuation:
•Contraindicated in individuals with known hypersensitivity to desmopressin acetate or to any of its components.
•Contraindicated in patients with moderate to severe renal impairment (defined as a creatinine clearance below 50ml/min).
- Contraindicated in patients with hyponatremia or a history of hyponatremia.

•Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
•As of 2007, the intranasal formulation is no longer FDA-approved for the treatment of primary nocturnal enuresis.

Effective 10/1/20
Updated 11/1/21

UPHP MEDICAID - DIRECT RENIN INH

MEDICATION(S)
ALISKIREN, TEKTURNA, TEKTURNA HCT

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
DIRECT RENIN INHIBITORS
Drug Class: Direct Renin Inhibitors

Preferred Agents: No Prior Authorization required

Non-Preferred Agents: Prior Authorization Criteria below
aliskiren
Tekturna® / Tekturna HCT®

Non-Preferred Agent PA Criteria:
•Trial/failure on an ACE inhibitor or an ARB or clinical rationale why neither is appropriate.

Duration of Approval: 1 year
Effective 10/1/20

UPHP MEDICAID - DOVONEX/CALCIPOTRIENE

MEDICATION(S)
CALCIPOTRIENE 0.005% OINTMENT, CALCIPOTRIENE 0.005% SOLUTION

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
DOVONEX® / CALCIPOTRIENE
Drug Class: Dermatological - Antipsoriatics
FDA-approved uses: The relief of Psoriasis
Available dosage forms: 0.005% Cream, Ointment and Solution

Coverage Criteria/Limitations for initial authorization
Diagnoses: Psoriasis
Duration of Approval
oInitial Authorization: 3 months
oContinuation of Therapy: 6 months
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oDiagnosis of Psoriasis
oFailure of two Topical Steroids, at least one of which must be high potency or very high potency
Route of Administration: For Topical Use Only

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oRequires a positive response to therapy

Contraindications/Exclusions/Discontinuation:
Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy

Effective 10/1/20

UPHP MEDICAID - ELECTROLYTE DEPLETERS

MEDICATION(S)
AURYXIA, CALCIUM ACETATE 667 MG CAPSULE, CALCIUM ACETATE 667 MG GELCAP, FOSRENOL, LANTHANUM CARBONATE, PHOSLYRA, RENAGEL, RENVELA, SEVELAMER CARBONATE, SEVELAMER HCL, VELPHORO

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ELECTROLYTE DEPLETERS
Drug Class: Electrolyte Depleters

Preferred Agents: Clinical Prior Authorization below
calcium acetate capsules and tablets
sevelamer carbonate tablets (generic for Renvela)

Clinical PA Criteria:
•Diagnosis of chronic kidney disease

Non-Preferred Agents: Prior Authorization Criteria below
Auryxia®
Eliphos®
Fosrenol® / Fosrenol® powder pak

lanthanum
Phoslo®
Phoslyra®
Renagel®
Renvela powder pkts and tablets
sevelamer carbonate powder pkts (generic for Renvela)
sevelamer tablets (generic for Renagel)
Velphoro®

Non-Preferred Agent PA Criteria:
•Diagnosis of chronic kidney disease
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Therapeutic failure with one month with one preferred medication

VELPHORO®
•Trial on two preferred medications.

Duration of Approval: 1 year
Effective 10/1/20

MEDICATION(S)
ELMIRON

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ELMIRON® / PENTOSAN POLYSULFATE SODIUM
Drug Class: Urinary tract analgesic agents
FDA-approved uses: indicated for the relief of bladder pain or discomfort associated with interstitial cystitis.
Available dosage forms: 100mg Capsules

Coverage Criteria/Limitations for initial authorization
Diagnoses: interstitial cystitis
Duration of Therapy
oInitial Approval: 3 months
oContinuation of Therapy: 3 months
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oDiagnosis of interstitial cystitis confirmed
Criteria for continuation of Therapy
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oIf pain has not improved after 3 months of therapy and if limiting adverse events have not occurred, pentosan may be continued for an additional 3 months. The clinical benefit of treatment beyond 6 months

for patients whose pain has not improved is not known.

Contraindications/Exclusions/Discontinuation:
•Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Effective 10/1/20

UPHP MEDICAID - ENDARI/L-GLUTAMINE

MEDICATION(S)
ENDARI

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ENDARI / L-GLUTAMINE

Drug Class: Sickle Cell Anemia Agents (N1H)

FDA-approved uses:
Endari is an amino acid indicated to reduce the acute complications of sickle cell disease in adult and pediatric patients 5 years of age and older.

Available dosage forms:
Oral Powder: 5 grams of L-glutamine powder per paper-foil-plastic laminate packet.
Coverage Criteria/Limitations for initial authorization:
?Diagnoses: Sickle Cell Disease
?Duration of approval:
oInitial authorization: 1-year duration upon approval
?Documented diagnosis of sickle cell disease AND
?Request is for an FDA approved dose AND

?Patient has had an inadequate response to a maximally tolerated dose of hydroxyurea OR
?Justification provided regarding intolerance, contraindication, or patient/family refusal to the use of hydroxyurea
oContinuation of Therapy: 1-year approval
?Prescriber attestation that member is tolerating current therapy AND
?Member continues on an FDA approved dose.
?Prescriber Specialty: Must be prescribed by, or in consultation, with a hematologist or other specialist with expertise in the diagnosis and management of sickle cell disease
?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oMedical Record indicating
?Sickle Cell Disease
?Quantity: Maximum of 180 packets/30 days
?Age: 5 years of age and older
?Route of Administration: Oral
?Place of Service: Outpatient pharmacy

Contraindications/Exclusions/Discontinuation:
•No contraindications to report at this time.
•Warnings/Precautions: Use with caution in patients with hepatic and/or renal impairment. No specific dosage adjustments are documented.
•Safety has not been established in patients younger than 5 years old.

Effective 10/1/20
Updated 5/1/22

MEDICATION(S)
ENSPRYNG

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ENSPRYNG/ SATRALIZUMAB-MWGE
Drug Class: Interleukin-6 (IL-6) Receptor Inhibitor

FDA-approved uses: Neuromyelitis optica spectrum disorder, Anti-aquaporin-4 (AQP4) antibody positive

Available dosage forms: Subcutaneous injection: 120mg/ml single-dose prefilled syringe

Coverage Criteria/Limitations for initial authorization:

?Diagnoses: Neuromyelitis optica spectrum disorder
?Duration of approval:
oInitial authorization: 12 months
oContinuation of Therapy: 12 months
?Prescriber Specialty: Prescribed by, or in consultation with, a neurologist or other provider who specializes in the treatment of NMOSD
?Documentation Requirements:

oMember has a diagnosis of anti-aquaporin-4 (AQP4) antibody positive NMOSD, AND
oClinical evidence of at least 1 documented relapse (including first attack) in last 12 months, AND
oPrescriber attests that the member has been assessed for the following baseline values prior to first dose:
?Hepatitis B virus
?Tuberculosis
?Liver transaminase levels
?Neutrophil Count, AND
oPrescriber attests that the member has or will avoid vaccinations within recommended time frames prior to initiation of Enspryng (see below), AND
oDocumented trial and failure or medical contraindication to one of the following:
?Rituximab
?Azathioprine
?Mycophenolate mofetil
?Quantity: 120 mg/mL by subcutaneous (SQ) injection at Weeks 0, 2, and 4, followed by a maintenance dosage of 120 mg every 4 weeks.
?Age: 18 years and older
?Route of Administration: Subcutaneous Injection
?Place of Service: Self-administered at home

Criteria for continuation of therapy:
?Documentation that the prescriber has evaluated the member and recommends continuation of therapy (clinical benefit)
?Request is for an FDA approved/medically accepted dose
Contraindications/Exclusions/Discontinuation:
?Prescriber attests that member has not received (or will not receive) live or attenuated-live virus vaccines within 4 weeks prior to initiation of Enspryng and non-live vaccines at least 2 weeks prior to initiation of Enspryng.

Other special considerations:
?Pregnancy Category: Fetal risk cannot be ruled out.
?Breast Feeding: Infant risk cannot be ruled out.

Effective 5/1/21

UPHP MEDICAID - ENTOCORT EC/BUDESONIDE EC

MEDICATION(S)
BUDESONIDE DR, BUDESONIDE EC

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ENTOCORT EC® / BUDESONIDE EC
Drug Class: Crohn disease - Oral

FDA-approved uses: Crohn disease (mild to moderate)

Available dosage forms: 3mg EC Capsule

Coverage Criteria/Limitations for initial authorization:
Diagnoses: active Crohn disease
Duration of approval:
oInitial authorization: 16 weeks of 9mg once daily
oContinuation of Therapy: 3 months of 6mg once daily, followed by a 3mg one daily for one month
Prescriber Specialty: Gastrointestinal (or in collaboration with GI)
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oIntolerance to or history of unacceptable side effects to prednisone (or other systemic steroids)
Quantity: 270 for 3 months, then 210 for 3 months

- 16 weeks/4months – 9mg once daily (induction)
- 3 months – 6mg once daily (maintenance)
- 1 month – 3mg once daily (taper)

MEDICATION(S)
AUVI-Q, EPINEPHRINE 0.15 MG AUTO-INJCT, EPINEPHRINE 0.3 MG AUTO-INJECT, SYMJEPI

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
EPINEPHRINE INJECTABLE
Drug Class: Epinephrine Injectable

Preferred Agents: No Prior Authorization required
Epi Pen®, Epi Pen Jr®

Non-Preferred Agents: Prior Authorization Criteria below
epinephrine (generic for Adrenaclick®)
epinephrine (generic for Epi Pen®)
Symjepi®
AUVI-Q

Non-Preferred Agent PA Criteria:
•Therapeutic failure with preferred medication

QUANTITY LIMITS

Adrenaclick® (epinephrine)4 per fill
epinephrine4 per fill
Epipen® (epinephrine)4 per fill
Epipen Jr® (epinephrine)4 per fill
AUVI-Q 4 per fill

Duration of Approval: 1 year
Effective 10/1/20
Updated 11/1/22

UPHP MEDICAID - EXSERVAN FILM, TIGLUTIK SUSPENSION, RILUZOLE

MEDICATION(S)
EXSERVAN, TIGLUTIK

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
EXSERVAN FILM, TIGLUTIK SUSPENSION / RILUZOLE
Drug Class: ALS Agent - Benzathiazoles

FDA-approved uses: treatment of amyotrophic lateral sclerosis (ALS)

Available dosage forms: Exservan 50 mg Film, Tiglutik 50mg/10ml Suspension

Coverage Criteria/Limitations for initial authorization:
Diagnoses: ALS
Duration of approval:
oInitial authorization: 1 year
oContinuation of Therapy: 1 year
Prescriber Specialty: Prescribed by or in consultation with a neurologist
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oPatient cannot swallow tablets,
Age: Greater than or equal to 18 years old

Criteria for continuation of therapy:
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oPatient is receiving clinical benefit from therapy

Effective 11/17/2021

UPHP MEDICAID - GASTROINTESTINAL ANTIBIOTICS

MEDICATION(S)
AEMCOLO, DIFICID 200 MG TABLET, FLAGYL, METRONIDAZOLE 375 MG CAPSULE, NITAZOXANIDE 500 MG TABLET, VANCOCIN HCL, VANCOMYCIN 250 MG/5ML ORAL SOL, XIFAXAN

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
GASTROINTESTINAL ANTIBIOTICS
Drug Class: Gastrointestinal Antibiotics

Preferred Agents: No Prior Authorization required
Dificid
Firvanq®
metronidazole tablets
neomycin tablet
tinidazole
vancomycin capsules

Non-Preferred Agents: Prior Authorization Criteria below
Aemcolo®
Flagyl® tablet and capsule
metronidazole capsule

nitazoxanide tablet
Vancocin®
Vancomycin solution
Xifaxan® 200mg
Xifaxan® 550mg

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure of one month with one preferred medication
•See additional medication-specific criteria below:

AEMCOLO® (RIFAMYCIN)
•Travelers' diarrhea caused by noninvasive strains of E. coli and age ?18 years of age (PDL criteria do not apply), AND
•The patient has had an inadequate response, intolerance or contraindication to azithromycin or a fluoroquinolone
•Quantity Limit: 12 tablets
•Length of authorization: 3 days

DIFICID®
•C. difficile and 10-day trial of oral vancomycin or contraindication.
•Length of authorization = 30 days

NITAZOXANIDE (ALINIA®) (PDL criteria do not apply)
• Tablets:
o For treatment of diarrhea caused by Cryptosporidium parvum or Giardia lamblia AND
o The patient has had a trial on metronidazole or a clinical reason why it cannot be tried
o length of authorization = 1 month
o Quantity limit = 6 tablets per rolling 30 days

XIFAXAN®
•200 mg tabs:
oTravelers' diarrhea caused by noninvasive strains of E. coli and age greater than 12 years of age
oThe patient has had an inadequate response, intolerance, or contraindication to azithromycin or a fluoroquinolone.
•550 mg tabs:
oReduction in risk of overt hepatic encephalopathy recurrence in patients greater than 18 years of age (PDL criteria do not apply)

oDiagnosis of irritable bowel syndrome with diarrhea (IBS-D) in patients greater than or equal to 18 years of age (PDL criteria do not apply)

Duration of Approval: 1 year, unless otherwise noted in drug-specific criteria
Effective 10/1/20
Updated 2/1/22

UPHP MEDICAID - GI MOTILITY, CHRONIC

MEDICATION(S)

ALOSETRON HCL, LOTRONEX, LUBIPROSTONE, MOTEGRITY, MOVANTIK, RELISTOR 12 MG/0.6 ML SYRINGE, RELISTOR 12 MG/0.6 ML VIAL, RELISTOR 8 MG/0.4 ML SYRINGE, SYMPROIC, TRULANCE, VIBERZI

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

GI MOTILITY, CHRONIC
Drug Class:
GI Motility, Chronic - Chronic idiopathic constipation (CIC)
GI Motility, Chronic - Irritable bowel syndrome with constipation (IBS-C)
GI Motility, Chronic - Irritable bowel syndrome with diarrhea (IBS-D)
GI Motility, Chronic - Opioid-induced constipation (OIC)

GI MOTILITY, CHRONIC - CHRONIC IDIOPATHIC CONSTIPATION (CIC)
Preferred Agents:
Amitiza® capsule
Linzess® capsule

Non-Preferred Agents: Prior Authorization Criteria below
Motegrity® tablet

Trulance® tablet
lubiprostone capsule (generic Amitiza)

GI MOTILITY, CHRONIC - IRRITABLE BOWEL SYNDROME WITH CONSTIPATION (IBS-C)
Preferred Agents:
Amitiza® capsule
Linzess® capsule

Non-Preferred Agents: Prior Authorization Criteria below
Ibsrela®
Trulance® tablet
lubiprostone capsule (generic Amitiza)

GI MOTILITY, CHRONIC - IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D)
Preferred Agents: Clinical Prior Authorization below
diphenoxylate/atropine (generic Lomotil®)
loperamide (generic Imodium®)

Non-Preferred Agents: Prior Authorization Criteria below
alosetron tablet
Lotronex® tablet
Viberzi® tablet

GI MOTILITY, CHRONIC - OPIOID-INDUCED CONSTIPATION (OIC)
Preferred Agents:
Amitiza® capsule

Non-Preferred Agents: Prior Authorization Criteria below
Relistor® syringe, vial
Symproic® tablet
lubiprostone capsule (generic Amitiza)
Movantik®

PA Criteria:
Non-Preferred Agents
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•See additional medication-specific criteria below:

Medication-Specific Criteria

IBSRELA® (TENAPANOR)

•Diagnosis of irritable bowel syndrome with constipations (IBS-C): AND

•Patient is greater than or equal to 18 years of age AND

•Therapeutic failure after one-month trial of one preferred agent of IBS-C

•Quantity Limit = 2 tablets/day

LOTRONEX® (ALOSETRON)

- Diagnosis of irritable bowel syndrome with diarrhea (IBS-D) AND
- Therapeutic failure after one-month trial of diphenoxylate/atropine or loperamide
- Member is female

MOTEGRITY® (PRUCALOPRIDE)

- Diagnosis of chronic idiopathic constipation (CIC), AND
- Prescribed by or in consultation with a gastroenterologist, AND
- Therapeutic failure after one-month trial of one preferred agent for CIC

RELISTOR® (METHYLNALTREXONE)

- Diagnosis of opioid induced constipation (OIC), AND
- Therapeutic failure after one-month trial of one preferred agent for OIC

SYMPROIC® (NALDEMEDINE TOSYLATE)

- Diagnosis of opioid induced constipation (OIC), AND
- Therapeutic failure after one-month trial of one preferred agent for OIC

TRULANCE® (PLECANATIDE)

- Diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C), AND
- Therapeutic failure after one-month trial of one preferred agent for CIC or IBS-C

VIBERZI® (ELUXADOLINE)

- Diagnosis of irritable bowel syndrome with diarrhea (IBS-D) AND
- Therapeutic failure after one-month trial of diphenoxylate/atropine or loperamide
- Quantity limit = 2 tablets/day

Duration of Approval: Up to 1 year

Effective 10/1/20

Updated 11/1/21
Updated 2/24/22
Updated 11/1/22

MEDICATION(S)

ALPHAGAN P, APRACLONIDINE HCL, BETAXOLOL HCL 0.5% EYE DROP, BETIMOL, BIMATOPROST 0.03% EYE DROPS, BRIMONIDINE TARTRATE 0.1% DROP, BRIMONIDINE TARTRATE 0.15% DRP, BRIMONIDINE TARTRATE-TIMOLOL, COSOPT, COSOPT PF, DORZOLAMIDE-TIMOLOL 2%-0.5%, IOPIDINE, ISTALOL, LEVOBUNOLOL HCL, LUMIGAN, TAFLUPROST, TIMOLOL 0.5% EYE DROP, TIMOLOL MALEATE 0.5% EYE DROP, TIMOPTIC, TIMOPTIC OCUDOSE, TIMOPTIC-XE, TRAVATAN Z, TRAVOPROST, VYZULTA, XALATAN, XELPROS, ZIOPTAN 0.0015% EYE DROPS

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

GLAUCOMA
Drug Class:
Glaucoma – Alpha-2 Adrenergics
Glaucoma – Beta Blockers
Glaucoma – Carbonic Anhydrase Inhibitors
Glaucoma – Combination Alpha-2 Adrenergic-Beta Blocker
Glaucoma – Prostaglandin Analogues
Glaucoma – Rho Kinase Inhibitors

GLAUCOMA – ALPHA-2 ADRENERGICS
Preferred Agents: No Prior Authorization required

Apraclonidine
brimonidine tartrate 0.2%

Non-Preferred Agents: Prior Authorization Criteria below
Alphagan P®
brimonidine tartrate 0.1%
brimonidine tartrate 0.15%
Iopidine®

GLAUCOMA – BETA BLOCKERS
Preferred Agents: No Prior Authorization required
Betoptic S®
Carteolol
timolol maleate (generic for Timoptic®)

Non-Preferred Agents: Prior Authorization Criteria below
Betaxolol
Betimol®
Istalol®
Levobunolol
timolol maleate (generic for Istalol®)
Timoptic®
Timoptic XE®

GLAUCOMA – CARBONIC ANHYDRASE INHIBITORS
Preferred Agents: No Prior Authorization required
Azopt®
dorzolamide
dorzolamide / timolol (generic Cosopt)
Simbrinza®

Non-Preferred Agents: Prior Authorization Criteria below
Brinzolamide
Cosopt®/ Cosopt PF®
dorzolamide/timolol PF (generic Cosopt PF)

GLAUCOMA – COMBINATION ALPHA-2 ADRENERGIC-BETA BLOCKER
Preferred Agents: No Prior Authorization required
Combigan®

Non-Preferred Agents: Prior Authorization Criteria below
brimonidine-timolol

GLAUCOMA – PROSTAGLANDIN ANALOGUES
Preferred Agents: No Prior Authorization required
latanoprost

Non-Preferred Agents: Prior Authorization Criteria below
bimatoprost (generic for Lumigan)
Lumigan®
tafluprost (generic for Zioptan)
Travatan Z®
travoprost (generic for Travatan®)
Vyzulta®
Xalatan®
Xelpros®
Zioptan®

GLAUCOMA – RHO KINASE INHIBITORS
Preferred Agents: No Prior Authorization required
Rhopressa®
Rocklatan®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure with a one-month trial with one preferred medication within the same subclass

Duration of Approval: 1 year
Effective 10/1/20
Updated 1/27/22

MEDICATION(S)
ADLYXIN, BYDUREON BCISE, BYETTA, MOUNJARO, OZEMPIC, RYBELSUS, SOLIQUA 100-33, TRULICITY, VICTOZA 2-PAK, VICTOZA 3-PAK, XULTOPHY 100-3.6

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
INCRETIN MIMETICS AND COMBINATIONS

Drug Class:
?Incretin Mimetics
?Incretin Mimetics - Combinations

?INCRETIN MIMETICS
Preferred Agents: Clinical Prior Authorization below

Byetta®
Trulicity®
Victoza®

Clinical Preferred Agent PA criteria:

- Patient has diagnosis of type 2 diabetes AND
- Discontinuation of other GLP-1 agonists

Non-Preferred Agents: Prior Authorization Criteria below

Bydureon Bcise®
Mounjaro®
Ozempic®
Rybelsus®

?INCRETIN MIMETICS – COMBINATIONS
Non-Preferred Agents: Prior Authorization Criteria below

Soliqua®
Xultophy®

Non-Preferred Agent PA Criteria:
•Diagnosis of type 2 diabetes AND
•Discontinuation of other GLP-1 agonists AND
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•Trial and failure with one preferred medication within same subgroup
•See additional medication-specific criteria below:

SOLIQUA® (INSULIN GLARGINE/LIXISENATIDE)
•One-month trial and failure with one of the preferred medications in each subgroup of the components (basal insulin and GLP-1 agonist)

XULTOPHY® (INSULIN DEGLUDEC/LIRAGLUTIDE)
- One-month trial and failure with one of the preferred medications in each subgroup of the components (basal insulin and GLP-1 agonist)

QUANTITY LIMITS

Adlyxin 10-20mcg starter pack 6mL per 28 days

Adlyxin 20mcg maintenance pack 6mL per 28 days

Bydureon Bcise 2mg Auto Inject3.4 mls per 28 days (4 doses per 28 days)

Byetta Dose Pen Injector10mcg - 2.4 mls per 30 days

5mcg - 1.2 mls per 30 days

Mounjaro Pens2 mls per 28 days

Ozempic Pens3 mls per 28 days

Rybelsus Tablets1 per day

Soliqua 100 unit-33mcg/ml Pen15 mls per 25 days

Trulicity Pens2 mls per 28 days

Victoza Pens2-Pak 18mg/3ml - 6 mls per 30 days

3-Pak 18mg/3ml - 9 mls per 30 days

Xultophy 100 unit-3.6mg/ml Pen 15 mls per 30 days

?Duration of Approval: Up to 1 year

UPHP MEDICAID - GLUCAGON AGENTS

MEDICATION(S)
GLUCAGON 1 MG EMERGENCY KIT, GVOKE, GVOKE PFS 1-PACK SYRINGE, GVOKE PFS 2-PACK SYRINGE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
GLUCAGON AGENTS
Drug Class: Glucagon Agents

Preferred Agents: No Prior Authorization required
Baqsimi®
Glucagen Hypokit
Glucagon Emergency Kit (Lilly)
Gvoke Pen®
Zegalogue

Non-Preferred Agents: Prior Authorization Criteria below
Glucagon Emergency Kit (Fresenius)
Gvoke® Syringe, Kit, Vial

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•History of trial and failure with one preferred medication

Quantity Limitations:
BAQSIMI 2 devices per 30 days
GVOKE HYPOPEN, SYRINGES2 syringes per 30 days
GVOKE VIALS2 vials per 30 days

Duration of Approval: 1 year
Updated 1/1/22
Updated 11/1/22

MEDICATION(S)
ALVESCO, ARNUITY ELLIPTA, ASMANEX HFA, FLOVENT DISKUS, PULMICORT, PULMICORT FLEXHALER, QVAR REDIHALER

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
INHALED GLUCOCORTICOIDS

Drug Class: Inhaled Glucocorticoids

Preferred Agents: No Prior Authorization required
Asmanex® Twisthaler (DPI)
budesonide 0.25 and 0.5mg nebulizer solution
budesonide 1mg nebulizer solution (generic for Pulmicort Respules)
Flovent HFA®2 (MDI)

Non-Preferred Agents: Prior Authorization Criteria below
Alvesco® (MDI)
Arnuity Ellipta® (DPI)
Asmanex HFA® (DPI)
Flovent Diskus® (DPI)

Pulmicort Flexihaler® (DPI)
Pulmicort® 1mg Respules nebulizer solution
Pulmicort® 0.25mg and 0.5mg Respules
QVAR Redihaler® (MDI)

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Therapeutic failure with a one-month trial with two preferred medications
•For children less than 13 years of age or a patient with a significant disability: inability to use the inhaler on preferred medications, or non-compliance because of taste, dry mouth
•See additional medication-specific criteria below:

ALVESCO® (CICLESONIDE)
•Requests submitted referencing exception due to compatibility with spacer/chamber will require trial only on Flovent® HFA

ASMANEX® HFA (MOMETASONE)
•Requests submitted referencing exception due to compatibility with spacer/chamber will require trial only on Flovent® HFA

ARNUITY ELLIPTA® (FLUTICASONE)
•Therapeutic failure on all preferred agents

PULMICORT FLEXHALER® (FLUTICASONE)
•Pregnancy (approval for duration of pregnancy)

?Duration of Approval: 1 year

Effective 10/1/20

MEDICATION(S)
GENOTROPIN, HUMATROPE 12 MG CARTRIDGE, HUMATROPE 24 MG CARTRIDGE, HUMATROPE 6 MG CARTRIDGE, NORDITROPIN FLEXPRO, NUTROPIN AQ NUSPIN, OMNITROPE, SAIZEN, SAIZEN-SAIZENPREP, SEROSTIM, SKYTROFA, SOGROYA, ZOMACTON

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
GROWTH HORMONES
Drug Class: Growth Hormones

Preferred Agents: Clinical Prior Authorization below
Genotropin®
Norditropin®
Norditropin Flexpro®

Non-Preferred Agents: Prior Authorization Criteria below
Humatrope®
Nutropin AQ®
Omnitrope®
Saizen®
Serostim®

Sogroya®
Skytrofa®
Zomacton®

PA Criteria:
•Allergy to inactive ingredients in the preferred medications
•Requests must be submitted by an endocrinologist or nephrologist.
•Panhypopituitarism – Cachexia, pituitary, Necrosis of pituitary (postpartum), Pituitary insufficiency NOS, Sheehan's syndrome, Simmond's disease.
•Pituitary dwarfism – Isolated deficiency of (human) growth hormone [HGH], Lorain-Levi dwarfism).
•Endocrine disorders – Other specified endocrine disorders: Pineal gland dysfunction, Progeria, Werner's syndrome.
•Indeterminate sex and pseudohermaphroditism – Gynandrism, Hermaphroditism, Ovotestis, Pseudohermaphroditism (male, female), Pure gonadal dysgenesis
•Gonadal dysgenesis – Turner's Syndrome (female only), XO syndrome, Ovarian dysgenesis
•Noonan Syndrome – Norditropin® is the only medication with this indication.
• Prader-Willi Syndrome – Genotropin®, Norditropin FlexPro and Omnitrope are the only medications with this indication
•For Dx of Idiopathic Short Stature, individual medical record and necessity review will be required.
• CKD – stage 1, 2 or 3 (CRI): Nutropin® is the only medication with this indication
•CKD – stage 4 or 5 (CRF or ESRD)
•SHOX: Humatrope® is the only medication with this indication

REQUIRED TESTING INFORMATION:
•Growth hormone stimulation testing:
oPituitary dwarfism: the patient must have failed two kinds of growth hormone stimulation tests for the diagnosis. Testing is required for pediatric, adolescent, and adult patients. For adolescent patients whose epiphyseal growth plates are closed and for adult patients, testing must be done after growth hormone therapy has been suspended for at least 3 months.
oRequester should document the kinds of stimulation tests performed, the result (lab value), reference range and date.
•Bone age x-rays (required regardless of diagnosis, x-ray does not have to be performed within a specific time frame):
oPediatric patients - bone x-ray report is required unless the prescriber is a (pediatric) endocrinologist
oAdolescent patients (13 to 19 years of age)– bone x-ray report is required UNLESS the prescriber is a (pediatric) endocrinologist, the requester must also note whether or not the epiphyseal growth plates have closed.
oAdult patients – bone x-ray report is NOT required.
Papilledema
1.Clinical documentation that a baseline funduscopic examination has been performed within the previous 6

month and papilledema is not present AND
2.Provider attestation that periodic funduscopic examinations will be performed after initiation of therapy to assess for papilledema
o For Idiopathic Short Stature, individual medical record and necessity review will be required.

oRequests that do not meet clinical criteria will require further review and must include the patient's diagnosis including ICD-10, if available. Growth charts should be provided, if available, at time of review (ensure that the correct chart is being submitted based on the patient's age – i.e., 0–3 vs 2–20) in addition to documentation of small for gestational age at birth, if appropriate.

Sogroya (somapacitanib-BECO)
Quantity limit: 8mg per week

Duration of Approval: 1 year
Effective 10/1/2020
Updated 5/1/22
Updated 9/1/22

UPHP MEDICAID - H. PYLORI

MEDICATION(S)
BISMUTH-METRONIDAZOLE-TETRACYC, LANSOPRAZOL-AMOXICIL-CLARITHRO, OMECLAMOX-PAK, TALICIA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
H. PYLORI TREATMENT
Drug Class: H. pylori Treatment

Preferred Agents: No Prior Authorization required
Pylera®

Non-Preferred Agents: Prior Authorization Criteria below
bismuth-metronidazole/tetracycline
lansoprazole/amoxicillin/clarithromycin
Omeclamox-PAK®
Talicia DR 10-250-12.5 mg

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR

•History of unacceptable side effects OR
•Therapeutic failure after one-month trial of the preferred agent

Duration of Approval: 1 year
Effective 10/1/20

UPHP MEDICAID - HEMATOPOIETIC AGENTS

MEDICATION(S)
ARANESP, EPOGEN, PROCRIT, RETACRIT

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
HEMATOPOIETIC AGENTS
Drug Class: Hematopoietic Agents

Preferred Agents: Clinical Prior Authorization below
Aranesp®
Epogen®
Retacrit®

Non-Preferred Agents: Prior Authorization Criteria below
Procrit®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Therapeutic failure after one-month trial with one preferred medication

•See additional medication/diagnoses-specific criteria below:

CHRONIC KIDNEY DISEASE STAGE 3, STAGE 4 [CRF - CHRONIC RENAL FAILURE] AND STAGE 5 [ESRD END STAGE RENAL DISEASE] (EPOGEN®, PROCRIT®, RETACRIT® AND ARANESP®):
•Hemoglobin level less than 10 g/dL before treatment with Epogen®, Procrit®, Retacrit®, Aranesp® or transfusions
•RENEWAL: CURRENT hemoglobin level less than 12 g/Dl

KIDNEY TRANSPLANT PATIENTS - TRANSPLANTED KIDNEY IS NOTED AS NOT YET FUNCTIONING TO ANTICIPATED POTENTIAL (EPOGEN®, PROCRIT®, RETACRIT® AND ARANESP®):
•Less than 1-year post transplant
•CURRENT hemoglobin level less than 12 g/dL
•Length of Authorization: 6 months

CHEMOTHERAPY OR RADIATION THERAPY CONFIRMED AS CURRENT (EPOGEN®, PROCRIT®, RETACRIT® AND ARANESP® ONLY):
•Hemoglobin level less than 10 g/dL before beginning treatment with Epogen®, Procrit®, Retacrit®, Aranesp, or transfusions
•RENEWAL: CURRENT hemoglobin level less than 12 g/dL
ANEMIA IN AIDS PATIENTS: (EPOGEN®, PROCRIT®, RETACRIT® ONLY)
•Hemoglobin level less than 10 g/dL

ANEMIC PATIENTS SCHEDULED TO UNDERGO NON-CARDIAC, NON-VASCULAR SURGERY TO DECREASE NEED FOR TRANSFUSIONS: (EPOGEN®, PROCRIT®, RETACRIT® ONLY).
•Clinical rationale why alternative approaches such as donating own blood prior or transfusion is not an option.
•CURRENT hemoglobin level less than 10 g/dL

MYELODYSPLASIA AND MYELODYSPLASTIC SYNDROME (EPOGEN®, PROCRIT®, RETACRIT® ONLY):
•CURRENT hemoglobin level less than 10 g/dL

HEPATITIS C WITH CURRENT INTERFERON TREATMENT (EPOGEN®, PROCRIT®, RETACRIT® ONLY):
•Beginning hemoglobin level less than 10 g/dL
•RENEWAL: CURRENT hemoglobin level less than 12 g/dL

Duration of Approval: For the duration of the prescription up to 6 months, unless otherwise noted in Medication/Diagnoses-Specific Information
Effective 10/1/20

MEDICATION(S)
HYFTOR

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
HYFTOR/SIROLIMUS
Drug Class: mTOR (mammalian target of rapamycin) inhibitor immunosuppressant

FDA-approved uses: Indicated for the treatment of facial angiofibroma associated with tuberous sclerosis in adults and pediatric patients ? 6 years old

Available dosage forms: Available in 10-gram tubes as 2 mg per gram (0.2%) topical gel.

Coverage Criteria/Limitations for initial authorization:
?Patient is ? 6 years old, AND
?Patient has a documented diagnosis of facial angiofibroma associated with tuberous sclerosis AND
?Prescribed by, or in consultation with, either a dermatologist or neurologist
?Length of approval:
oInitial Authorization: 3 months
oContinuation of therapy: 1 year
?Route of Administration: Topical

?Quantity:
oAges 6-11 years: Up to 2 tubes (20 grams) per 30 days
oAge 12 years and older: Up to 3 tubes (30 grams) per 30 days

Criteria for continuation of therapy
?Documentation Requirements (e.g., Labs, Medical Record, Special Studies):
oPrescriber attests to positive symptom improvement based on size and redness of facial angiofibroma

UPHP MEDICAID - ICS/LABA INHALER COMBINATIONS

MEDICATION(S)
AIRDUO DIGIHALER, AIRDUO RESPICLICK, BUDESONIDE-FORMOTEROL FUMARATE, FLUTICASONE-SALMETEROL 113-14, FLUTICASONE-SALMETEROL 232-14, FLUTICASONE-SALMETEROL 55-14, FLUTICASONE-VILANTEROL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
BETA ADRENERGIC AND CORTICOSTEROID INHALER COMBINATIONS
Drug Class: Beta Adrenergic and Corticosteroid Inhaler Combinations

Preferred Agents: No Prior Authorization required
Advair Diskus® (DPI)
Advair HFA® (MDI)
Dulera® (MDI)
Symbicort® (MDI)
Wixela® (DPI) (generic for Advair Diskus)
fluticasone/salmeterol (generic for Advair HFA)
fluticasone/salmeterol (generic for Advair Diskus)

Non-Preferred Agents: Prior Authorization Criteria below
AirDuo Digihaler

AirDuo Respiclick® (DPI)
Breo Ellipta® (DPI)
budesonide/formoterol (generic for Symbicort)
Fluticasone/Vilanterol (generic for Breo Ellipta)
fluticasone/salmeterol (generic for AirDuo)

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•Therapeutic failure after a two-week trial with one preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 8/1/22

MEDICATION(S)
BREZTRI AEROSPHERE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
BETA ADRENERGIC / ANTICHOLINERGIC / CORTICOSTEROID INHALER COMBINATIONS
Drug Class: Beta Adrenergic / Anticholinergic Combinations / Corticosteroid Inhalers Combinations

Preferred Agents: No Prior Authorization required
Trelegy Ellipta

Non-Preferred Agents: Prior Authorization Criteria below
Breztri Aerosphere

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medication, OR
•Contraindication or drug to drug interaction with the preferred medication, OR
•History of unacceptable side effects, OR
•The patient’s condition is clinically stable such that switching medications would cause deterioration in the condition, OR
•Therapeutic failure after a two-week trial with the preferred medication

Duration of Approval: 1 year
Effective 8/1/21

UPHP MEDICAID - INGREZZA (VALBENAZINE)

MEDICATION(S)
INGREZZA, INGREZZA INITIATION PACK

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
INGREZZA/ VALBENAZINE
Drug Class Movement Disorder Therapy - Tardive Dyskinesia, Huntington’s Disease

FDA-approved uses: Tardive Dyskinesia, Chorea associated with Huntington’s

Available dosage forms: Capsules: 40mg, 60mg, 80mg, Initiation Pack

Coverage Criteria/Limitations for initial authorization:
?Diagnoses:
oDiagnosis of chorea associated with Huntington’s disease OR
oDiagnosis of tardive dyskinesia secondary to use of a dopamine antagonist (i.e., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.)
?Duration of approval:
oInitial authorization: 1 year
oContinuation of Therapy: 1 year
?Prescriber Specialty: Prescribed by or in consultation with a neurologist or psychiatrist

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oFor tardive dyskinesia attestation that a baseline AIMS test has been completed
?Age: Patient is 18 years of age or older

Criteria for continuation of therapy:
?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oAttestation of patient’s improvement in symptoms associated with their condition AND
oFor tardive dyskinesia attestation that a follow-up AIMS test has been completed and there has been a positive response to therapy

Effective 7/1/21

UPHP MEDICAID - INHALED GLUCOCORTICOIDS

MEDICATION(S)
ARMONAIR DIGIHALER, ARNUITY ELLIPTA, ASMANEX HFA, FLOVENT DISKUS, PULMICORT, PULMICORT FLEXHALER, QVAR REDIHALER

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
INHALED GLUCOCORTICOIDS
Drug Class: Inhaled Glucocorticoids

Preferred Agents: No Prior Authorization required
Alvesco (MDI)
Asmanex® Twisthaler (DPI)
budesonide 0.25 and 0.5mg nebulizer solution
budesonide 1mg nebulizer solution (generic for Pulmicort Respules)
Flovent HFA® (MDI)
Fluticasone Prop HFA (Generic Flovent HFA)

Non-Preferred Agents: Prior Authorization Criteria below
Arnuity Ellipta® (DPI)
Armonair Digihaler
Asmanex HFA® (DPI)

Flovent Diskus® (DPI)
fluticasone prop diskus (generic Flovent Diskus)
Pulmicort Flexihaler® (DPI)
Pulmicort® 1mg Respules nebulizer solution
Pulmicort® 0.25mg and 0.5mg Respules
QVAR Redihaler® (MDI)

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•Therapeutic failure with a two-week trial with one preferred medication
•For children less than 13 years of age or a patient with a significant disability: inability to use the inhaler on preferred medications, or non-compliance because of taste, dry mouth
•See additional medication-specific criteria below:

ALVESCO® (CICLESONIDE)
•Requests submitted referencing exception due to compatibility with spacer/chamber will require trial only on Flovent® HFA

ASMANEX® HFA (MOMETASONE)
•Requests submitted referencing exception due to compatibility with spacer/chamber will require trial only on Flovent® HFA

ARNUITY ELLIPTA® (FLUTICASONE)
•Therapeutic failure on all preferred agents

PULMICORT FLEXHALER® (BUDESONIDE)
•Pregnancy (approval for duration of pregnancy)

Duration of Approval: 1 year
Effective 10/1/20
Updated 8/1/21
Updated 7/1/22
Updated 9/7/22

UPHP MEDICAID - INSULIN SUPPRESSANTS

MEDICATION(S)
DIAZOXIDE 50 MG/ML ORAL SUSP

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
INSULIN SUPPRESSANTS

Drug Class: Insulin Suppressants

Preferred Agents: No Prior Authorization required

Proglycem

Non-Preferred Agents: Prior Authorization Criteria below

diazoxide (generic for Proglycem)

Non-Preferred Agent PA Criteria:

•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•History of trial and failure with one preferred medication

?Duration of Approval: 1 year

Effective 11/1/22

MEDICATION(S)

ADMELOG, ADMELOG SOLOSTAR, AFREZZA, BASAGLAR KWIKPEN U-100, FIASP, FIASP FLEXTOUCH, FIASP PENFILL, HUMALOG KWIKPEN U-200, HUMULIN N KWIKPEN, INSULIN ASPART PENFILL, INSULIN DEGLUDEC, INSULIN DEGLUDEC PEN (U-100), INSULIN DEGLUDEC PEN (U-200), INSULIN GLARGINE SOLOSTAR U100, INSULIN GLARGINE-YFGN, LYUMJEV, LYUMJEV KWIKPEN U-100, LYUMJEV KWIKPEN U-200, NOVOLIN 70-30 100 UNIT/ML VIAL, NOVOLIN 70-30 FLEXPEN, NOVOLOG 100 UNIT/ML VIAL, NOVOLOG 100 UNIT/ML FLEXPEN, NOVOLOG MIX 70-30 VIAL, NOVOLOG MIX 70-30 FLEXPEN, NOVOLOG PENFILL, REZVOGLAR KWIKPEN, SEMGLEE (YFGN), SEMGLEE (YFGN) PEN, TOUJEO MAX SOLOSTAR, TOUJEO SOLOSTAR, TRESIBA, TRESIBA FLEXTOUCH U-100, TRESIBA FLEXTOUCH U-200

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

INSULINS
Drug Class:
Insulins, Mixes
Insulins, Basal
Insulins, Rapid Acting
Insulins, Traditional

INSULINS, MIXES

Preferred Agents: No Prior Authorization required
Humalog® 50/50 pens, vials
Humalog® 75/25 pens, vials
Humulin® 70/30 Kwikpens, vials
insulin aspart 70/30 pens, vials

Non-Preferred Agents: Prior Authorization Criteria below
insulin lispro mix 75-25 Kwikpen
Novolin® 70/30 pens, vials
Novolog® 70/30 pens vials

INSULINS, BASAL
Preferred Agents: No Prior Authorization required
Lantus® pens, vials
Levemir® pens, vials

Non-Preferred Agents: Prior Authorization Criteria below
Basaglar® pens
Semglee® pens , vials
insulin degludec pens, vials
insulin glargine-YFGN pens , vials (biosimilar for Semglee®)
insulin glargine Solostar U100 pens, vials (biosimilar for Lantus®)
Rezvoglar
Toujeo Solostar® pens
Tresiba Flextouch® pens, vials

INSULINS, RAPID ACTING
Preferred Agents: No Prior Authorization required
Apidra® pens, vials
Humalog® U-100 cartridges, pens, vials
insulin aspart pens, vials
insulin lispro U-100 Kwikpens, vials (gen for Humalog)
Novolog® cartridges

Non-Preferred Agents: Prior Authorization Criteria below
Admelog® vials, Admelog Solostar® pens
Afrezza® inhalation cartridges
Fiasp® pens, vials, pumpcart

Humalog® U-200 Kwikpens
insulin aspart cartridges
Lyumjev, Kwikpens, Tempo pens
Novolog pens, vials

INSULINS, TRADITIONAL
Preferred Agents: No Prior Authorization required
Humulin® R U-500 pens, vials
Humulin® N vials
Humulin® R vials
Novolin® N vials
Novolin® R vials

Non-Preferred Agents: Prior Authorization Criteria below
Humulin® N Kwikpens

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Therapeutic failure with one preferred medication within same subgroup
•See additional medication-specific criteria below:

LYUMJEV™ (INSULIN LISPRO-AABC)
• Quantity limit = 90 per fill

Rezvoglar (insulin glargine-AGLR)
• Quantity limit = 90 per fill
TOUJEO SOLOSTAR® (INSULIN GLARGINE)
• Trial and failure on both preferred medications in this class

Duration of Approval: 1 year
Effective 10/1/20
Updated 10/7/21
Updated 6/1/22
Updated 6/9/22
Updated 10/1/22

UPHP MEDICAID - ISOTRETINOIN

MEDICATION(S)
AMNESTEEM, CLARAVIS, ISOTRETINOIN 10 MG CAPSULE, ISOTRETINOIN 20 MG CAPSULE, ISOTRETINOIN 30 MG CAPSULE, ISOTRETINOIN 40 MG CAPSULE, MYORISAN, ZENATANE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
CLARAVIS® / ISOTRETINOIN
AMNESTEEM® / ISOTRETINOIN
MYORISAN™ / ISOTRETINOIN
ZENATANE™ / ISOTRETINOIN
Drug Class: Acne Therapy Systemic - Retinoids & Derivatives

FDA-approved uses: Treatment of severe (multiple locations) recalcitrant nodular acne unresponsive to conventional therapy including conventional antibiotics

Available dosage forms: Claravis Capsule 10 mg, 20 mg, 30 mg, and 40 mg, Amnesteem Capsule 10mg, 20mg and 40mg, Myorisan Capsule 10mg, 20mg, 30mg and 40mg, Zenatane Capsule 10mg, 20mg, 30mg and 40mg
Coverage Criteria/Limitations for initial authorization:
Diagnoses: severe (multiple locations) recalcitrant nodular acne unresponsive to conventional therapy including conventional antibiotics

Duration of Approval
oInitial Authorization: 5 months, with monthly office visits
oContinuation of Therapy: Reviewed for coverage after a period of 2 months or more off therapy, and if warranted by persistent or recurring severe nodular acne
Prescriber Specialty: Dermatologist
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oProper diagnosis of an FDA approved indication OR
oIf request is for a non-FDA Approved indication, the request must be for a “medically accepted indication” as noted in the following Compendia:
American Hospital Formulary Drug Service (AHFS-DI)
Micromedex DrugDex
Clinical Pharmacology
oMust be prescribed by a dermatologist
oCurrent chart notes detailing the diagnosis, including laboratory tests as appropriate for diagnosis
oDocumentation of dose, dates of therapy, and clinical outcomes as appropriate
oFailed/intolerant to at least 2 oral antibiotics (must have used consistently for 6 months)
oFailed/intolerant to topical retinoid product (must have used consistently for 6 months)
oFailed/intolerant to Benzoyl Peroxide wash (must have used consistently for 6 months)
oFailed/intolerant to Clindamycin and/or Erythromycin topical therapy (must have used consistently for 6 months)
oNegative pregnancy test
oMust select 2 forms of effective contraception simultaneously
oMust meet requirements of the iPledge Program

Not approved If:
oPatient has any contraindications to the use of isotretinoin
oPatient is not compliant with current therapy?
Dosing:
oAdult Acne, severe recalcitrant nodular:
Oral: 0.5-1 mg/kg/day in 2 divided doses for 15-20 weeks
May discontinue earlier if the total cyst count decreases by 70%
Adults with very severe disease/scarring or primarily involves the trunk may require dosage adjustment up to 2 mg/kg/day
A second course of therapy may be initiated after a period of ? 2 months off therapy
A dose of less than or equal to 0.5 mg/kg/day may be used to minimize initial flaring
oPediatric Acne, severe recalcitrant nodular:
Children 12-17 years:
•Oral: 0.5-1 mg/kg/day in 2 divided doses for 15-20 weeks
•May discontinue earlier if the total cyst count decreases by 70%
•A second course of therapy may be initiated after a period of greater than or equal to 2 months off therapy

•A dose of less than or equal to 0.5 mg/kg/day may be used to minimize initial flaring
Age: 12 years and older
Route of Administration: Oral

Criteria for continuation of therapy:
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oOffice visit every month with verified compliance and improvement or stability on drug

Contraindications/Exclusions/Discontinuation:
•Patient is noncompliant with medical or pharmacologic therapy
•No demonstrable of improvement in clinical condition has occurred after initiation of drug therapy

References:
a.American Academy of Pediatrics Committee on Drugs, “Retinoid Therapy for Severe Dermatological Disorders,” Pediatrics, 1992, 90(1 Pt 1):119-20.
b.Claravis [package insert]. Sellersville PA: Teva Pharmaceuticals USA, January 2015.
c.Facts & Comparisons. (2012). Claravis. Retrieved from http://0-online.factsandcomparisons.com.libcat.ferris.edu/MonoDisp.aspx?monoID=fandc-hcp1943&quick=159351%7c5&search=159351%7c5&isstemmed=True.
d.Mitchell AA, Van Bennekom CM, Louik C, et al, “A Pregnancy-Prevention Program in Women of Childbearing Age Receiving Isotretinoin,” N Engl J Med, 1995, 333(2):101-6.
e.iPledge. (2015). Claravis iPledge Program. www.ipledgeprogram.com
f.Graber E, et al “Treatment of Acne Vulgaris,” UptoDate, November, 10, 2015.

Effective 10/1/20

MEDICATION(S)
JYNARQUE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
JYNARQUE (TOLVAPTAN)

CLINCIAL CRITERIA FOR INITIAL APPROVAL
Diagnosis of Autosomal Dominant Polycystic Kidney Disease [ADPKD]
- Patient is at least 18 years of age, AND
- Confirmation the patient does not have liver disease (including cirrhosis), AND
- Patient will not be on concomitant therapy with strong CYP3A–inhibitors (e.g., ketoconazole, nefazodone, clarithromycin, etc.), AND
- Patient will not be on concomitant therapy with a V2-agonist (e.g., desmopressin (DDAVP)), AND
- Patient will not be on concomitant therapy with a strong CYP3A– inducers (e.g., carbamazepine, phenobarbital, phenytoin, rifampin, etc), AND

•Patient will not be on concomitant therapy with any of the following, or if therapy is unavoidable, the patient will be monitored closely for adverse reaction and/or dose modifications will be implemented:
•Moderate CYP3A–inhibitors (e.g., atazanavir, ciprofloxacin, erythromycin, grapefruit juice, fluconazole, etc), AND
•Patient is able to sense or respond to thirst, AND

•Patient does not have hypovolemia or hypovolemic hyponatremia, AND
•Patient does not have anuria, AND
•Patient has confirmed ADPKD as diagnosed using ultrasonography (patient meets the modified Ravine diagnostic criteria), or using CT-scanning or MRI, AND
•Used to slow kidney function decline in patients at risk of rapidly progressing disease, defined as one or more of the following:
•Increase in total kidney volume of at least 5% per year
•Decrease in eGFR of at least 5 mL/min in 1 year
•Decrease in eGFR of at least 2.5 mL/min per year over 5 years, AND
•Patient has a baseline total kidney volume measurement, AND
•Patient does not have uncorrected urinary outflow obstructions, AND
•Both patient AND prescriber are enrolled in the Jynarque REMS program

CLINCIAL CRITERIA FOR RENEWAL
•Absence of unacceptable toxicity from the drug (e.g., osmotic demyelination, liver injury or ALT/AST ever exceeded 3 times the ULN during treatment, dehydration, hypovolemia), AND
•Patient has shown an improvement to therapy based on one or more of the following:
•Stabilization or improvement from baseline in total kidney volume (TKV), OR
•Stabilization or improvement in the rate of kidney function decline, OR
•Improvement in signs and/or symptoms of disease (e.g., medically significant kidney pain, hypertension, albuminuria)

Length of Authorization: 6 months, may be renewed

Effective 5/1/22

MEDICATION(S)
KERENDIA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
MHP Common Formulary Prior Authorization Criteria
KERENDIA/FINERENONE
Drug Class: Mineralocorticoid (Aldosterone) Receptor Antagonists
FDA-approved uses: chronic kidney disease (CKD) with type 2 diabetes
Available dosage forms: 10mg, 20mg tablets
Coverage Criteria/Limitations for initial authorization:
Diagnoses: diagnosis of chronic kidney disease (CKD) with type 2 diabetes
Duration of approval:
o Initial authorization: 1 year
o Continuation of Therapy: 1 year
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
o Member is currently receiving a maximally tolerated dosage of an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) OR has a contraindication to ACE inhibitor or ARB therapy AND
o Member is not taking any strong CYP3A4 inhibitors AND
o Member at baseline member meets all of the following:

Estimated glomerular filtration rate (eGFR) greater than25ml/min/1.73m2 AND
Urine albumin-to-creatinine ratio greater than30mg/g AND
Serum potassium level less than5.0mEq/L
Quantity: 1 per day
Age: minimum 18 years
Criteria for continuation of therapy:
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
o Member has eGFR greater than25ml/min/1.73m2 AND
o Member serum potassium level less than5.0mEq/L
Contraindications/Exclusions/Discontinuation: concomitant strong CYP3A4 inhibitors, adrenal insufficiency

MEDICATION(S)
KRINTAFEL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
KRINTAFEL®/ TAFENOQUINE
Drug Class: Antimalarials
FDA-approved uses:
Indicated for the radical cure (prevention of relapse) of Plasmodium vivax malaria in patients aged 16 years and older who are receiving appropriate antimalarial therapy for acute P. vivax infection. It is not indicated for the treatment of acute P. vivax malaria

Available dosage forms: 150 mg tablet

Coverage Criteria/Limitations for initial authorization:
Diagnoses: Prevention of Plasmodium vivax
Duration of approval:
oInitial authorization:
Plasmodium vivax – one-time single dose
oContinuation of Therapy:
A repeat dose should be given if vomiting occurs within 1 hour after dosing. Re-dosing should not be

attempted more than once.
Prescriber Specialty: infectious disease
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oMedical record
oMust be tested negative for glucose-6-phosphate dehydrogenase (G6PD) deficiency prior to prescribing
oNegative pregnancy test result in all women of reproductive potential
oBreastfeeding an infant found to be G6PD deficient or unknown status is contraindicated
Quantity: Two (2), 150 mg tablets per 365 days
Age: 16 years of age and older
Gender: males and non-pregnant and non-lactating females
Route of Administration: Oral
Place of Service: Outpatient

Criteria for continuation of therapy:
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oUpdated medical record

Contraindications/Exclusions/Discontinuation:
•Glucose-6-phosphate dehydrogenase (G6PD) deficiency or unknown G6PD status
•May cause hemolytic anemia for patients when administered to pregnant woman with a G6PD-deficient fetus. A G6PD-deficient infant may be at risk for hemolytic anemia from exposure through breast milk. Check infant's G6PD status before breastfeeding begins
•Patients with known hypersensitivity to tafenoquine, other 8-aminoquinolines, or any component of Krintafel

Other special considerations:
• Refer to the CDC website for recommendations for treatment and prevention of Plasmodium vivax malaria.

Effective 10/1/20

MEDICATION(S)
BROVANA, FORMOTEROL 20 MCG/2 ML NEB VL, PERFOROMIST, STRIVERDI RESPIMAT

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
BETA ADRENERGICS – LONG ACTING
Drug Class: Beta Adrenergics – Long Acting

Preferred Agents: No Prior Authorization required
Serevent® (DPI)

Non-Preferred Agents: Prior Authorization Criteria below
Arcapta® (DPI)
Brovana® nebulizer solution
formoterol nebulizer solution
Perforomist® nebulizer solution
Striverdi Respimat® (ISI)

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications

•History of unacceptable side effects
•Therapeutic failure after a two-week trial with one preferred medication
•See additional medication-specific criteria below:

BROVANA® (ARFORMOTEROL) NEBULIZER SOLUTION
•Bypass PDL criteria if patient requires long-acting beta-adrenergic medication and cannot use a dry powder dose inhaler

PERFOROMIST® (FORMOTEROL) NEBULIZER SOLUTION
•Bypass PDL criteria if patient requires long-acting beta-adrenergic medication and cannot use a dry powder inhaler

STRIVERDI RESPIMAT® (OLODATEROL) INHALER
•Diagnosis of COPD (must not be used for asthma or acute exacerbations) inhaler

Duration of Approval: 1 year
Effective 10/1/20
Updated 5/1/21

MEDICATION(S)
DUAKLIR PRESSAIR

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
BETA ADRENERGIC AND ANTICHOLINERGIC COMBINATIONS
Drug Class: Beta Adrenergic and Anticholinergic Combinations

Preferred Agents: No Prior Authorization required
Anoro Ellipta® (DPI)
Bevespi Aerosphere® (MDI)
Combivent RESPIMAT® (ISI)
ipratropium/albuterol nebulizer solution
Stiolto Respimat® (ISI)

Non-Preferred Agents: Prior Authorization Criteria below
Duaklir Pressair® (DPI)
Utibron Neohaler® (DPI)

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications

•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•The patient’s condition is clinically stable such that switching medications would cause deterioration in the condition
•Therapeutic failure after a two-week trial with one preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 8/1/21

MEDICATION(S)
LONHALA MAGNAIR REFILL, LONHALA MAGNAIR STARTER, TIOTROPIUM BROMIDE, TUDORZA PRESSAIR, YUPELRI

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTICHOLINERGIC AGENTS – LONG ACTING
Drug Class: Anticholinergic Agents – Long Acting

Preferred Agents: No Prior Authorization required
Incruse Ellipta® (DPI)
Spiriva® (DPI)
Spiriva Respimat® (ISI)

Non-Preferred Agents: Prior Authorization Criteria below
Lonhala Magnair nebulizer solution
tiotropium (DPI)
Seebri Neohaler® (DPI)
Tudorza Pressair® (DPI)
Yupelri® nebulizer solution

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•The patient’s condition is clinically stable such that switching medications would cause deterioration in the condition OR
•Therapeutic failure after a two-week trial with one preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 8/1/21
Updated 8/15/22

MEDICATION(S)
MEFLOQUINE HCL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
LARIAM® / MEFLOQUINE
Drug Class: Antimalarial
FDA-approved uses:
Treatment of Acute Malaria Infections: Mefloquine is indicated for the treatment of mild to moderate acute malaria caused by mefloquine-susceptible strains of P. falciparum (both chloroquine-susceptible and resistant strains) or by P. vivax.
Prevention of Malaria: Mefloquine is indicated for the prophylaxis of P. falciparum and P. vivax malaria infections, including prophylaxis of chloroquine-resistant strains of P. falciparum.

Available dosage forms: 250mg Tablets
Coverage Criteria/Limitations for initial authorization [30 days for acute treatment, 3 months for prophylaxis]:
Diagnoses: treatment or prevention of malaria
Duration of Approval:
oInitial Authorization:
Acute Treatment: 30 days
Prophylaxis: 3 months

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oCountry/region where the patient will be traveling
oFor Acute Treatment:
cultures and sensitivities to support malaria diagnosis
For Malaria Prophylaxis:
date and duration of travel
Use of doxycycline
Quantity: 5 tablets per 30 days
Gender: male or female
Route of Administration: oral
Place of Service: outpatient

Contraindications/Exclusions/Discontinuation:
•Mefloquine should not be prescribed for prophylaxis in patients with active depression, a recent history of depression, generalized anxiety disorder, psychosis, schizophrenia or other major psychiatric disorders, or with a history of convulsions.
•Mefloquine is contraindicated with the use of ketoconazole.
•Mefloquine should be used with caution with potent CYP3A4 inhibitors and medications that prolong the QTc interval.
•In addition, therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Effective 10/1/20

MEDICATION(S)
ACCOLATE, MONTELUKAST SOD 4 MG GRANULES, SINGULAIR, ZAFIRLUKAST, ZILEUTON ER, ZYFLO

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
LEUKOTRIENE INHIBITORS
Drug Class: Leukotriene Inhibitors

Preferred Agents: See Age Criteria for chew tablets below
montelukast tablets, 4mg chew tabs, 5mg chew tabs

Non-Preferred Agents: Prior Authorization Criteria below
Accolate®
montelukast granules
Singulair® tablets, 4mg chew tabs, 5mg chew tabs, granules
zafirlukast
Zileuton ER®
Zyflo®

Non-Preferred Agent PA Criteria:

•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Trial and failure with one month with one preferred medication

MONTELUKAST (SINGULAIR®)
•clinical rationale why the (swallow) tablet dosage form inappropriate for the following age limits:
o4mg chew tabs – prior authorization (PA) required for patients greater than 5
o5mg chew tabs – PA required for patients greater than 14
oGranules – PA required for patients greater than 5

Duration of Approval: 1 year
Effective 10/1/20

UPHP MEDICAID - LIDOCAINE 5% PATCH

MEDICATION(S)
LIDOCAINE 5% PATCH

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
LIDOCAINE 5% PATCH
Drug Class: Dermatological - Topical Local Anesthetic Amides

FDA-approved uses: Post-herpetic neuralgia (PHN)

Available dosage forms: Lidocaine 5% patch
Coverage Criteria/Limitations for initial authorization:
Diagnoses: (any of the following)
Post-herpetic neuralgia (PHN) or
Diabetic neuropathic pain or
Peripheral polyneuropathy not due to post-herpetic neuralgia, diabetes, or cancer with history of substance abuse disorder SUD or
SUD related concerns

Duration of Approval:
o Initial Authorization:

PHN: Up to 90 days
Neuropathic pain: initially 2 months
Pain with SUD related concerns: Up to 6 months

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
o For diabetic neuropathic pain only: Trial of at least 2 of the following or contraindication to all of the following: gabapentin, tricyclic antidepressant, nerve block, trigger point injection, SNRIs, TENS unit

Quantity: Max 3 patches per day (may be cut to cover areas of most severe pain)

Criteria for continuation of therapy:
Requires positive response to use of the patch
Duration of approval: Up to 12 months

Contraindications/Exclusions/Discontinuation:
• Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Effective 5/1/2021
Updated 8/1/2021

UPHP MEDICAID - LIPOTROPICS - BILE ACID SEQUESTRANTS

MEDICATION(S)
COLESEVELAM HCL, COLESTID, COLESTIPOL HCL GRANULES, COLESTIPOL HCL GRANULES PACKET, QUESTRAN, QUESTRAN LIGHT, WELCHOL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
LIPOTROPICS: NON-STATINS - BILE ACID SEQUESTRANTS
Drug Class: Lipotropics: Non-Statins - Bile Acid Sequestrants

Preferred Agents: No Prior Authorization required
cholestyramine/ cholestyramine light
colestipol tablets, packets
Prevalite powder, packets

Non-Preferred Agents: Prior Authorization Criteria below
Colestid® tablet
colestipol granules
colesevelam tablet, packet
Questran®/ Questran Light®
Welchol® powder and tablets

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Patient is clinically stable, and switching would cause a deterioration in condition
•Therapeutic failure with one-month trial of one preferred medication

Duration of Approval: 1 year
Effective 10/1/20

UPHP MEDICAID - LIPOTROPICS - FIBRIC ACID DERIVATIVES

MEDICATION(S)
FENOFIBRATE 120 MG TABLET, FENOFIBRATE 130 MG CAPSULE, FENOFIBRATE 150 MG CAPSULE, FENOFIBRATE 30 MG CAPSULE, FENOFIBRATE 40 MG TABLET, FENOFIBRATE 43 MG CAPSULE, FENOFIBRATE 50 MG CAPSULE, FENOFIBRATE 90 MG CAPSULE, FENOFIBRIC ACID 105 MG TABLET, FENOFIBRIC ACID DR 135 MG CAP, FENOFIBRIC ACID DR 45 MG CAP, FENOGLIDE, LIPOFEN, LOPID, TRICOR, TRILIPIX

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
LIPOTROPICS: FIBRIC ACID DERIVATIVES
Drug Class: Lipotropics: Fibric Acid Derivatives

Preferred Agents: No Prior Authorization required
fenofibrate, nanocrystallized (generic for Tricor®)
fenofibric acid capsules (generic for Lofibra® caps)
fenofibrate tablets (generic for Lofibra tablets)
gemfibrozil tablet

Non-Preferred Agents: Prior Authorization Criteria below
Antara® capsule
fenofibrate, micronized capsules (generic for Antara)

fenofibrate, nanocrystallized (generic for Triglide®)
fenofibric acid (generic for Fibricor)
fenofibric acid (generic for Trilipix®)
Fenoglide® tablet
Fibricor® tablet
Lopid® tablet
Lipofen® capsule
Tricor® tablet
Triglide® tablet
Trilipix® capsule

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Patient is clinically stable, and switching would cause a deterioration in condition
•Therapeutic failure with one-month trial of one preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 11/5/21

UPHP MEDICAID - LIPOTROPICS - NIACIN DERIVATIVES

MEDICATION(S)
NIACIN ER 500 MG TABLET, NIACIN ER

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
LIPOTROPICS: NIACIN DERIVATIVES
Drug Class: Lipotropics: Niacin Derivatives

Preferred Agents: No Prior Authorization required
niacin tablet (OTC)
niacin ER tablets (OTC)
niacin ER capsules (OTC)

Non-Preferred Agents: Prior Authorization Criteria below
Niacin ER generic for Niaspan)

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•Patient is clinically stable, and switching would cause a deterioration in condition OR

•Therapeutic failure with one-month trial of one preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 8/1/22

UPHP MEDICAID - LIPOTROPICS - OTHERS

MEDICATION(S)
ICOSAPENT ETHYL 1 GRAM CAPSULE, LOVAZA, NEXLETOL, NEXLIZET, OMEGA-3 ACID ETHYL ESTERS, VASCEPA, ZETIA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
LIPOTROPICS: OTHERS
Drug Class: Lipotropics: Others

Preferred Agents: No Prior Authorization required

ezetimibe

Non-Preferred Agents: Prior Authorization Criteria below
icosapent ethyl 1 gm capsule
Lovaza®
Nexletol®
Nexlizet®
omega-3 acid ethyl esters capsule (generic for Lovaza)

Vascepa®
Zetia®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Patient is clinically stable, and switching would cause a deterioration in condition, OR
•Therapeutic failure with one-month trial of one preferred medication
•See additional medication-specific criteria below:

LOVAZA® (OMEGA-3 ACID ETHYL ESTERS) – PDL CRITERIA DO NOT APPLY
•Adjunct to diet to reduce severe triglyceride (TG) levels (hypertriglyceridemia) in adult patients.
•Triglyceride levels greater than or equal to 500 mg/Dl

NEXLETOL® (BEMPEDOIC ACID) – PDL CRITERIA DO NOT APPLY
•Patient is greater than or equal to 18 years of age, AND
•Established atherosclerotic cardiovascular disease (ASCVD), OR
•Heterozygous familial hypercholesterolemia, AND
•Failure to achieve target LDL-C on maximally tolerated doses of statins, AND
•Therapy will used in conjunction with maximally tolerated doses of a statin

NEXLIZET® (BEMPEDOIC ACID/EZETIMIBE) – PDL CRITERIA DO NOT APPLY
•Patient is greater than or equal to 18 years of age, AND
•Established atherosclerotic cardiovascular disease (ASCVD), OR
•Heterozygous familial hypercholesterolemia, AND
•Failure to achieve target LDL-C on maximally tolerated doses of statins, AND
•Therapy will used in conjunction with maximally tolerated doses of a statin

VASCEPA® (ICOSAPENT ETHYL) – PDL CRITERIA DO NOT APPLY
•Adjunct to diet to reduce severe triglyceride (TG) levels (hypertriglyceridemia) in adult patients, AND
•Triglyceride levels greater than or equal to 500 mg/dL, OR
•Adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization in adult patients with elevated triglyceride (TG) levels greater than 150 mg/dL, AND
oEstablished cardiovascular disease, OR
oDiabetes mellitus and 2 or more additional risk factors for cardiovascular disease (i.e., men greater than55 years and women greater than65 years, cigarette smoker or stopped smoking within the past 3 months, hypertension (pretreatment blood pressure greater than 140mmHg systolic or greater than 90mmHg diastolic)

?Duration of Approval: 1 year

Effective 10/1/20
Updated 12/8/20 P&T
Updated 11/1/22

MEDICATION(S)
REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
LIPOTROPICS: PCSK9 INHIBITORS
Drug Class: Lipotropics: PCSK9 Inhibitors

Preferred Agents: Clinical Prior Authorization below

Praluent®
Repatha®

REPATHA® (EVOLOCUMAB) AND PRALUENT® (ALIROCUMAB)
Initial Request
•Diagnosis of atherosclerotic cardiovascular disease (ASCVD), heterozygous familial hypercholesterolemia (HeFH) or homozygous familial hypercholesterolemia (HoFH)
•Treatment failure with the highest available dose or maximally tolerated dose of high intensity statin

(atorvastatin or rosuvastatin) for at least 8 weeks.
•If intolerant to statins, this must be supported by submitted chart notes/labs.
•Patient has failed to reach target LDL-C levels (document lab values):
—ASCVD: LDL-C is less than 70 mg/dL
—HeFH or HoFH: LDL-C is less than 100 mg/dL
Length of Authorization: Initial – 12 months, Renewal – 12 months

Renewal Criteria: Lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating medication

Quantity Limits:
PRALUENT®: 2 pens/syringes per 28 days
REPATHA®: 140 mg/mL pen/syringe – 2 pens/syringes per 28 days, 420 mg/3.5 mL Pushtronex® – 3.5 mL per 28 days, (for diagnosis of HoFH, Quantity Limit of 7mls per 28 days)

Duration of Approval: 1 year
Updated 4/1/21
Updated 5/1/22

MEDICATION(S)
ALTOPREV, AMLODIPINE-ATORVASTATIN, ATORVALIQ, CADUET, CRESTOR, EZALLOR SPRINKLE, EZETIMIBE-SIMVASTATIN, FLUVASTATIN ER, FLUVASTATIN SODIUM, LESCOL XL, LIPITOR, LIVALO, VYTORIN, ZOCOR, ZYPITAMAG

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
LIPOTROPICS: STATINS
Drug Class: Lipotropics: Statins

Preferred Agents: No Prior Authorization required
Atorvastatin tablet
Lovastatin tablet
Pravastatin tablet
Rosuvastatin tablet
Simvastatin tablet

Non-Preferred Agents: Prior Authorization Criteria below
amlodipine / atorvastatin tablet
Altoprev® tablet
Atorvaliq

Caduet® tablet
Crestor® tablet
Ezallor® Sprinkle capsule
ezetimibe/simvastatin tablet
fluvastatin capsule / fluvastatin ER tablet
Lescol XL® tablet
Lipitor® tablet
Livalo® tablet
pitavastatin
Pravachol® tablet
Vytorin® tablet
Zocor® tablet
Zypitamag® tablet

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Patient is clinically stable, and switching would cause a deterioration in condition
•Therapeutic failure with one-month trial of one preferred medication
•Quantity limit (all products) = one per day
•See additional medication-specific criteria below:

Atorvaliq (atorvastatin)
•Patient cannot swallow whole tablets
•Quantity limit: 20 mL per day

EZALLOR® SPRINKLE (rosuvastatin)
Patient cannot swallow whole tablets

Duration of Approval: 1 year
Effective 10/1/20

MEDICATION(S)
LITFULO

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
LITFULO/ RITLECITINIB

Drug Class: Janus Kinase (JAK) Inhibitors / TEC family kinase inhibitor

FDA-approved uses: Indicated for the treatment of severe alopecia areata in adults and adolescents 12 years and older.

Available dosage forms: 50mg Capsule

Coverage Criteria/Limitations for initial authorization:
?Diagnoses: Severe alopecia areata
?Duration of approval:
oInitial authorization: 6 months
oContinuation of Therapy: for up to 1 year
?Prescriber Specialty: Prescribed by or in consultation with a dermatologist
?Documentation Requirements (e.g., Labs, Medical Record, Special Studies):

oSeverity of Alopecia Tool (SALT) score of ?50 (range: 0 to 100, with 0 representing no scalp hair loss and 100 complete scalp hair loss) AND
oCurrent AA episode lasting at least 6 months without spontaneous regrowth AND
oDocumentation of inadequate response to a 3-month trial of at least one of the following:
?intralesional corticosteroid therapy OR
?prescription topical corticosteroid therapy (e.g., betamethasone dipropionate) OR
?systemic immunomodulator therapy (e.g., corticosteroids, methotrexate, cyclosporine)
?Quantity: 1 capsule per day
?Age: 12 years of age or older

Criteria for continuation of therapy:
?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
o Provider documentation of clinical improvement in hair regrowth as indicated by improvement in post-treatment SALT score

Contraindications/Exclusions/Discontinuation:
•Not covered for patients with a diffuse hair loss pattern or other forms of alopecia such as androgenetic alopecia (Hamilton-Norwood classification system grade IV or greater) or chemotherapy-induced hair loss
•Cannot be used in combination with other JAK inhibitors, biologic immunomodulators, cyclosporine, or other potent immunosuppressants (e.g., methotrexate, azathioprine)

UPHP MEDICAID - LIVTENCITY

MEDICATION(S)
LIVTENCITY

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
LIVTENCITY/MARIBAVIR

Drug Class: CMV Antiviral Agent

FDA-approved uses: Livtencity is a cytomegalovirus (CMV) pUL97 kinase inhibitor indicated for the treatment of adults and pediatric patients (12 years of age and older and weighing at least 35 kg) with post-transplant CMV infection/disease that is refractory to treatment (with or without genotypic resistance) with ganciclovir, valganciclovir, cidofovir or foscarnet.

Available dosage forms: Tablets 200mg

Coverage Criteria/Limitations for initial authorization:
?Diagnoses:
oPatient 12 years of age and older and weighing at least 35 kg, AND
oPatient is a recipient of a hematopoietic stem cell or solid organ transplant, AND
oActive Cytomegalovirus (CMV) infection/disease, AND

oPatient is refractory to treatment (with or without genotypic resistance) with ganciclovir, valganciclovir, cidofovir or foscarnet.

?Duration of approval:
oInitial authorization: 6 months

Other special considerations:
o If co-administered with carbamazepine arbamazepine: 1,600 mg daily
o If co-administered with phenytoin or phenobarbital: 2,400 mg daily

Effective 8/1/22

MEDICATION(S)
CLARITHROMYCIN ER, E.E.S. 200, E.E.S. 400, ERY-TAB, ERYPED 200, ERYPED 400, ERYTHROMYCIN 250 MG TABLET, ERYTHROMYCIN 500 MG TABLET, ERYTHROMYCIN DR 250 MG CAP, ERYTHROMYCIN DR 250 MG TABLET, ERYTHROMYCIN DR 333 MG TABLET, ERYTHROMYCIN DR 500 MG TABLET, ERYTHROMYCIN 400 MG/5 ML SUSP, ZITHROMAX 1 GM POWDER PACKET, ZITHROMAX 100 MG/5 ML SUSP, ZITHROMAX 200 MG/5 ML SUSP, ZITHROMAX 250 MG TABLET, ZITHROMAX 250 MG Z-PAK TABLET, ZITHROMAX 500 MG TABLET, ZITHROMAX TRI-PAK

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
MACROLIDES
Drug Class: Macrolides

Preferred Agents: No Prior Authorization required
Azithromycin
Clarithromycin
erythromycin ethylsuccinate tablets
erythromycin ethylsuccinate 200mg suspension
Erythrocin®

Non-Preferred Agents: Prior Authorization Criteria below

clarithromycin ER
E.E.S.® tablet, suspension
EryPed®
Ery-Tab®
Erythromycin base
erythromycin ethylsuccinate 400mg suspension
Zithromax® tablets, suspension

Non-Preferred Agent PA Criteria
Allergy to the preferred medications
Contraindication or drug to drug interaction with the preferred medications
History of unacceptable side effects
Infection caused by an organism resistant to the preferred macrolide medications
Therapeutic failure (duration = 3 days) with two preferred medications

Quantity Limitations:
azithromycin (Zithromax®)
500mg – 3 per fill
600mg – 12 per fill
1g packet - 2 per fill
clarithromycin tabs (Biaxin®)28 per fill
Zithromax® (azithromycin)
500mg – 3 per fill
600mg – 12 per fill
1g packet - 2 per fill

Duration of Approval: Date of service
Effective 10/1/20
Update 8/1/21

UPHP MEDICAID - MARINOL/DRONABINOL

MEDICATION(S)
DRONABINOL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
MARINOL ®/DRONABINOL
Drug Class: Antiemetic - Cannabinoids
FDA-approved uses:
Appetite stimulation in AIDS patients
Chemotherapy-induced nausea and vomiting

Available dosage forms: Capsules: 2.5 mg, 5 mg, 10 mg,

Coverage Criteria/Limitations for initial authorization:
Diagnosis: chemotherapy induced nausea and vomiting
Duration of Approval:
oInitial Authorization: duration of the chemotherapy treatment
oContinuation of Therapy: limited time -- determined based on the plan of care developed utilizing the chemotherapeutic agents
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oPatient must be receiving chemotherapy and meet the following criteria:

Intolerant or refractory to first line agents such as Zofran
Patient must be under close supervision during the initial use and during dose adjustments due to its potential for altered mental status
The number of pills approved will be limited to the amount necessary for a single cycle of chemotherapy.
oFor antiemetic purposed: trial and failure, intolerance, or contraindication to an emetic regimen that includes a serotonin antagonist (ondansetron, granisetron), dexamethasone, promethazine, or prochlorperazine
oFor cancer: trial and failure, intolerance, or contraindication to an emetic regimen consistent with NCCN guidelines
Age restrictions: adults and pediatrics
Prescriber Specialty: Oncologist

Criteria for continuation of therapy:
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oDecreased episodes of nausea and vomiting.

Effective 10/1/20

UPHP MEDICAID - MEPRON/ATOVAQUONE

MEDICATION(S)
ATOVAQUONE 750 MG/5 ML SUSP, ATOVAQUONE 750 MG/5ML SUSP CUP

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
MEPRON® / ATOVAQUONE
Drug Class: Antiprotozoal Agents - Other
FDA-approved uses: Pneumocystis jiroveci pneumonia:
Prophylaxis: Prevention of P. jiroveci pneumonia (PCP) in adults and adolescents 13 years and older who are intolerant to trimethoprim-sulfamethoxazole (TMP-SMZ).
Treatment:
Acute oral treatment of mild to moderate PCP in adults and adolescents 13 years and older who are intolerant to trimethoprim-sulfamethoxazole.
Available dosage forms: 750mg/5ml Oral Suspension

Coverage Criteria/Limitations for initial authorization:
Diagnoses: FDA approved uses as listed above
Prescriber Specialty: Infectious Disease
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
Failure or contraindication to TMP-SMZ
Quantity: 21 day supply

Age: 13 years or older
Route of Administration: Oral

Contraindications/Exclusions/Discontinuation:
•Patient is noncompliant with medical or pharmacologic therapy.
•No demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
•Hypersensitivity to atovaquone or any component of the formulation.

Effective 10/1/20

UPHP MEDICAID - MULTIPLE SCLEROSIS AGENTS

MEDICATION(S)
AUBAGIO, BAFIERTAM, COPAXONE 40 MG/ML SYRINGE, EXTAVIA, GILENYA, GLATIRAMER ACETATE, GLATOPA, KESIMPTA PEN, MAVENCLAD, MAYZENT, PLEGRIDY, PLEGRIDY PEN, PONVORY, REBIF, REBIF REBIDOSE, TASCENSO ODT, TECFIDERA, TERIFLUNOMIDE, VUMERITY, ZEPOSIA 0.92 MG CAPSULE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
MULTIPLE SCLEROSIS AGENTS
Drug Class: Multiple Sclerosis Agents

Preferred Agents: No Prior Authorization required
Avonex® vial, kit
Betaseron® vial / Betaseron® Kit
Copaxone 20 mg syringe
dimethyl fumarate (generic for Tecfidera)
fingolimod (generic for Gilenya)
teriflunomide (generic for Aubagio)

Non-Preferred Agents: Prior Authorization Criteria below

Aubagio® tablet
Bafiertam
Copaxone® 40 mg syringe
Extavia® vial, kit
fingolimod (generic for Gilenya)
glatiramer 20 mg/ml and 40 mg/ml syringe
Glatopa® syringe
Gilenya
Kesimpta
Mavenclad® tablet
Mayzent® tablet, starter pack
Plegridy® pen, syringe
Ponvory
Rebif® syringe, titration pack / Rebif Rebidose® syringe, pack
Tecfidera®
teriflunomide
Vumerity capsules
Zeposia

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure of one month with one preferred medication
•See additional medication-specific criteria below:

BAFIERTAM™ (MONOMETHYL FUMARATE)
• Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS), AND
• Prescribed by or in consultation with a neurologist, AND
• Attestation that Bafiertam will be used as single agent monotherapy
• Quantity limit: 120 per 30 days
Initial length of authorization: 6 months
• Renewal criteria:
Attestation of tolerance to maintenance dose.
Attestation of a CBC, including lymphocyte count, serum aminotransferase, ALP, and total bilirubin levels
Length of authorization: 1 year

KESIMPTA® (OFATUMUMAB)

• Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS), AND
• Prescribed by or in consultation with a neurologist, AND
• Attestation that Kesimpta will be used as single agent monotherapy
• Attestation that the first injection will be monitored by a healthcare professional
• Length of authorization: 1 year

PLEGRIDY® (PEGINTERFERON BETA-1A)
•Therapeutic failure on two preferred medications required.

PONVORY® (PONESIMOD)
•Patient age between 18 years and 55 years, AND
•Patient has a diagnosis of a relapsing form of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) or active secondary progressive disease (SPMS), AND
•Prescribed by or in consultation with a neurologist, AND
•Patient has obtained a baseline electrocardiogram (ECG), AND
•Prescriber attestation that first-dose monitoring, as clinically indicated, will occur, AND
•Patient does NOT have an active infection, including clinically important localized infections, AND
•Patient has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy, AND
•For patients with a history of uveitis and/or diabetes ONLY: A baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment, AND
•Prescriber attestation that ponesimod will NOT be used in combination with anti-neoplastic, immunosuppressive, or immune-modulating therapies, or, if therapy is unavoidable, the patient will be monitored closely for adverse reactions and/or dose modifications, AND
•Therapeutic failure of one month trial of at least two preferred medications

MAVENCLAD® (CLADRIBINE)
•Diagnosis of relapsing forms of multiple sclerosis (MS) to include relapsing-remitting disease and active secondary progressive disease, AND
•Prescribed by or in consultation with a neurologist
•Therapeutic failure of one month trial of at least two preferred medications

MAYZENT® (SIPONIMOD)
•Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS), AND
•Prescribed by or in consultation with a neurologist, AND
•Patient CYP2C9 variant status has been tested to determine genotyping (required for dosing), AND
•Patient has obtained a baseline electrocardiogram (ECG), AND
•Patient has been tested for antibodies to the varicella zoster virus (VZV) or has completed immunization

series for VZV prior to beginning therapy, AND
•For patients with a history of uveitis and/or diabetes ONLY: A baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment, AND
•Therapeutic failure of one month trial of at least two preferred medications

TASCENSO ODT® (FINGOLIMOD)
oDiagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS) AND
oPatient age is 11 and up
oPrescribed by or in consultation with a neurologist AND
oPatient is unable to use generic fingolimod capsules or brand Gilenya capsules due to swallowing difficulties.
oLength of approval: 1 year

VUMERITY® (DIROXIMEL FUMARATE)
•Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS), AND
• Prescribed by or in consultation with a neurologist, AND
•Therapeutic failure of one month trial of at least two preferred medications

ZEPOSIA®(OZANIMOD)
•Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS)AND
•Prescribed by or in consultation with a neurologist, OR
•Diagnosis of moderately or severely active ulcerative colitis (UC), AND
•Prescribed by or in consultation with a gastroenterologist, AND
•Patient has obtained a baseline electrocardiogram (ECG) AND
•Patient does NOT have an active infection, including clinically important localized infections AND
•Patient has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy AND
•For patients with a history of uveitis and/or diabetes ONLY: A baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment AND
•Prescriber attests that a CBC with lymphocyte count, ALT, AST, and total bilirubin have been obtained for the patient in the past 6 months, AND
•For MS, therapeutic failure of one month trial of at least two preferred MS medications.
•For UC, may bypass PDL criteria.

Quantity Limitations:
AVONEX®4 per 34 days

BAFIERTAM®120 per 30 days

Duration of Approval: 1 year
Effective 10/1/20
Updated 11/1/21
Updated 6/1/22

MEDICATION(S)
XYWAV

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
NARCOLEPSY AGENTS
SODIUM OXYBATE
XYWAV/ CALCIUM, MAGNESIUM, POTASSIUM, SODIUM OXYBATE

Drug Class: Narcolepsy Agents

Agents: Prior Authorization Criteria below

Xywav® - Rationale for lower sodium needed for approval of Xywav except when the indication is for idiopathic hypersomnia in adults.
Sodium Oxybate
FDA-approved uses: Excessive daytime sleepiness/cataplexy: Treatment of excessive daytime sleepiness and cataplexy in patients with narcolepsy: Idiopathic hypersomnia in adults.
Available dosage forms: Oral solution, 500 mg per mL
Coverage Criteria/Limitations for initial authorization:
?Diagnoses:

oType 1 Narcolepsy (cataplexy in narcolepsy)
oType 2 Narcolepsy [narcolepsy without cataplexy, excessive daytime sleepiness (EDS) in narcolepsy]
oIdiopathic hypersomnia (Xywav only)
?Duration of approval:
oInitial authorization: 3 months
oContinuation of Therapy: for up to 6 months
?Prescriber Specialty: Board-certified Sleep Medicine Specialist, neurologist, pulmonologist, or psychiatrist. Submit consultation notes if applicable.
?Documentation Requirements (e.g. Labs, Medical Record, Special Studies, Pharmacy claims, Physician attestation):
oDaily excessive daytime sleepiness for at least 3 months (AASM ICSD-3 Criteria)
oNocturnal polysomnography (PSG) confirmation
?Overnight polysomnography to rule out other conditions and confirm adequate sleep before first Multiple Sleep Latency Test (MSLT)
oPositive MSLT* including:
?Mean Sleep Latency ? 8 minutes
?2 or more sleep onset rapid eye movement (REM) periods less than 15 minutes
EXCEPTION to positive MSLT test for Type 1 Narcolepsy (cataplexy in narcolepsy): Hypocretin-1 less than or equal to 110 pg/mL (or less than 1/3 of mean normal control values) may be alternative to MSLT sleep study
EXCEPTION 2 For Idiopathic Hypersomnia, the number of sleep-onset rapid eye movement sleep periods (SOREMPs) is less than two
oMember is not currently on a sedative hypnotic agent (examples include but are not limited to: Lunesta (eszopiclone), Ambien (zolpidem), Sonata (zaleplon), Restoril (temazepam), Halcion (triazolam), or Belsomra (suvorexant))?
oMember is not currently on other prescription or non-prescription sedatives, including but not limited to excessive alcohol or marijuana use.
oMetabolic and psychiatric causes have been evaluated and ruled out, if present, attestation that treatment has been optimized.Provider attests that patient is enrolled in the Xywav/sodium oxybate REMS program.
oType 1 Narcolepsy (cataplexy in narcolepsy)
?Member has cataplexy defined as more than one episode of generally brief (less than 2 minutes) usually bilaterally symmetrical, sudden loss of muscle tone with retained consciousness.
oType 1 Narcolepsy (cataplexy in narcolepsy), continued
?Member did not achieve treatment goals or experienced inadequate clinical response after an adherent trial at maximum therapeutic dose, persistent intolerable adverse effects or contraindication to at least ONE (1) medication from BOTH of the following: [BOTH: 1 AND 2]
•Non-amphetamine stimulant OR Amphetamine-based stimulant or a methylphenidate-based stimulant:
?Non-amphetamine stimulant: modafanil (Provigil) or armodafanil (Nuvigil)
?Amphetamine-based products: amphetamine/dextroamphetamine mixed salts, amphetamine/dextroamphetamine mixed salts extended-release, dextroamphetamine extended-release

?Methylphenidate-based products: methylphenidate, methylphenidate extended-release, dexmethylphenidate
•Tricyclic Antidepressants (TCA) OR Selective Serotonin Reuptake Inhibitors (SSRIs) or Serotonin-norepinephrine Reuptake Inhibitor (SNRI):
?TCA: imipramine, nortriptyline, protriptyline, clomipramine, etc.
?SSRI/SNRI: fluoxetine, venlafaxine, atomoxetine, etc.

oType 2 Narcolepsy [narcolepsy without cataplexy]
?Other conditions that cause EDS have been ruled out or treated, including (but not limited to): shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, effects of sedating medications, idiopathic hypersomnolence, insufficient sleep at night (sleep deprivation), obstructive sleep apnea, central sleep apnea, periodic limb movement disorder (including restless legs syndrome), depression, Circadian rhythm disorders (including delayed sleep phase syndrome), and sedating medications.
?Member did not achieve treatment goals or experienced inadequate clinical response after a documented adherent trial at maximum therapeutic dose, persistent intolerable adverse effects or contraindication to at least ONE (1) medication from ALL of the following: [1,2, 3, 4, AND 5]
•Non-amphetamine stimulant:
?Modafanil (Provigil)
?Armodafanil (Nuvigil)
•Amphetamine-Based Products: amphetamine/dextroamphetamine mixed salts, amphetamine/dextroamphetamine mixed salts extended-release, dextroamphetamine extended-release
•Methylphenidate based products: methylphenidate, methylphenidate extended-release, dexmethylphenidate
•Dopamine and norepinephrine reuptake inhibitor (DNRI): Sunosi (solriamfetol)
•Histamine-3 (H3) receptor antagonist/inverse agonist: Wakix (pitolisant)
oIdiopathic Hypersomnia (must meet all):
oDiagnosis of Idiopathic Hypersomnia
oRequest for Xywav
oPrescribed by or in consultation with a neurologist or sleep medicine specialist
oAge greater than 18 years
oExclusion of all of the following:
?Narcolepsy of cataplexy
?Narcolepsy of EDS
?Insufficient sleep syndrome

?Quantity: Maximum Dose: 9 grams per day, 18 mL per day OR 540 mL per 30 days
?Age: greater than or equal to 7 years old and greater than 20 kg

oFor idiopathic hypersomnia must be greater than 18 years of age
?Gender: Male and Female
?Route of Administration: Oral

Criteria for continuation of therapy:
?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oConsultation notes must be submitted for initial request and for continuation of treatment requests at least ONCE annually
oAdherence to therapy at least 85% of the time as verified by Prescriber and member's medication fill history (review Rx history for compliance), including:
?Adherent to the prescribed medication regimen
?Tolerance to therapy
?No severe adverse reactions or drug toxicity
oDocumentation of efficacy and positive response to therapy as evidenced by response of decreasing cataplexy events and improvement in score for appropriate test (e.g. Epworth Sleepiness Scale, Clinical Global Impression of Change, etc.) for EDS [ALL APPLICABLE]
?Decrease or reduction in the frequency of cataplexy events/attacks associated with therapy for Type 1 Narcolepsy
?Decrease or reduction in symptoms of excessive daytime sleepiness associated with therapy
?For excessive daytime sleepiness (EDS): Improvement in the Epworth Sleepiness Scale (ESS), Clinical Global Impression of Change or Maintenance of Wakefulness Test (MWT) for Type 1 and 2 Narcolepsy
oA documented attempt to decrease dose or step down to alternative drugs

Contraindications/Exclusions/Discontinuation:
•Non-FDA approved indications
•Hypersensitivity to Xyrem (sodium oxybate) or any ingredient in the formulation
•Co-administration with CNS depressant anxiolytics, sedatives, and hypnotics or other sedative CNS depressant drugs
oAdministration with alcohol or other psychoactive drugs can potentiate the effects of sodium oxybate.
•Co-administration with alcohol (ethanol)
oEthanol is contraindicated in patients using sodium oxybate. The combined use of alcohol (ethanol) with sodium oxybate may result in potentiation of the CNS-depressant effects of sodium oxybate and alcohol.
•Succinic Semialdehyde Dehydrogenase Deficiency
oThis rare disorder is an in?born error of metabolism and variably characterized by mental retardation, hypotonia, and ataxia.
•History of drug abuse
oSodium oxybate is a CNS depressant with potential for misdirection and abuse and patients should be evaluated for a history of drug abuse.
•Uncontrolled hypertension (due to sodium content)

Other special considerations:
•Patients with Hepatic Impairment Dosing
oReduce the initial dosage by 50%

References
1.Xyrem (sodium oxybate) [prescribing information]. Palo Alto, CA: Jazz Pharmaceuticals, Decemeber 2018.
2.Micromedex Healthcare Series. DrugDex. [Micromedex Web site]. Available at: http://www.thomsonhc.com/micromedex2/librarian [via subscription only].
3.Drug Facts and Comparisons. Drug Facts and Comparisons 4.0 [online]. 2018. Available from Wolters Kluwer Health, Inc. [via subscription only]
4.Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc., 2018. URL: http://www.clinicalpharmacology.com. [via subscription only]

Effective 10/1/20
Updated 5/1/21
Updated 5/1/22
Updated 8/1/22

MEDICATION(S)

BELBUCA, CONZIP, DISKETS, HYDROCODONE ER 10 MG CAPSULE, HYDROCODONE ER 15 MG CAPSULE, HYDROCODONE ER 20 MG CAPSULE, HYDROCODONE ER 30 MG CAPSULE, HYDROCODONE ER 40 MG CAPSULE, HYDROCODONE ER 50 MG CAPSULE, HYDROMORPHONE ER, HYSINGLA ER, METHADONE 10 MG/5 ML SOLUTION, METHADONE 10 MG/ML ORAL CONC, METHADONE 40 MG TABLET DISPR, METHADONE 5 MG/5 ML SOLUTION, METHADONE HCL 10 MG TABLET, METHADONE HCL 5 MG TABLET, METHADONE INTENSOL, METHADOSE, MORPHINE SULFATE ER 10 MG CAP, MORPHINE SULFATE ER 100 MG CAP, MORPHINE SULFATE ER 120 MG CAP, MORPHINE SULFATE ER 20 MG CAP, MORPHINE SULFATE ER 30 MG CAP, MORPHINE SULFATE ER 45 MG CAP, MORPHINE SULFATE ER 50 MG CAP, MORPHINE SULFATE ER 60 MG CAP, MORPHINE SULFATE ER 75 MG CAP, MORPHINE SULFATE ER 80 MG CAP, MORPHINE SULFATE ER 90 MG CAP, MS CONTIN, NUCYNTA ER, OXYCODONE HCL ER, OXYCONTIN, OXYMORPHONE HCL ER, TRAMADOL HCL ER 100 MG CAPSULE, TRAMADOL HCL ER 200 MG CAPSULE, TRAMADOL HCL ER 300 MG CAPSULE, XTAMPZA ER

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OPIOIDS – LONG ACTING

Drug Class: OPIOIDS – Long Acting

Preferred Agents: Clinical Prior Authorization for codeine and tramadol containing products only

morphine sulfate ER tablets
tramadol ER tablets

Preferred Agent PA Criteria:
Greater than or equal to 12 years of age (for codeine and tramadol containing products only)

Non-Preferred Agents: Prior Authorization Criteria below
Belbuca®
buprenorphine film
Conzip ER®
Diskets
hydrocodone ER capsules (generic Zohydro ER®)
hydrocodone ER tablets (generic Hysingla ER®)
hydromorphone ER®
Hysingla ER®
Kadian®
Methadone
Methadose tablet dispersible, oral concentrate
morphine sulfate ER caps (generic Avinza®)
morphine sulfate ER caps (generic Kadian®)
MS Contin®
Nucynta ER®
Oramorph SR®
Oxycontin®
oxycodone ER
oxymorphone ER
Ultram ER®
Xtampza ER®
Zohydro ER®

Non-Preferred Agent PA Criteria:
•Greater than or equal to 12 years of age (for codeine and tramadol containing products only) AND
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•Therapeutic failure of one week with one preferred medication
•See additional medication-specific criteria below:

BELBUCA® (BUPRENORPHINE BUCCAL FILM)

•Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia, AND
•Patient greater than 18 years old

XTAMPZA ER® (OXYCODONE)
•Diagnosis of severe chronic pain requiring around the clock opioid analgesia, AND
•Patient greater than 18 years old, AND
•Alternative treatment options have been ineffective, not tolerated or inadequate for controlling pain
Quantity Limitations:
Belbuca® (buprenorphine)60 per 30 days
buprenorphine film 60 per 30 days
Oxycontin® ER 10mg (oxycodone-controlled release tab)180 per 30 days
Oxycontin® ER 15mg (oxycodone-controlled release tab)120 per 30 days
Oxycontin® ER 20 mg (oxycodone-controlled release tab)90 per 30 days
Oxycontin® ER 30mg (oxycodone-controlled release tab)60 per 30 days
Oxycontin® ER 40mg (oxycodone-controlled release tab)45 per 30 days
Oxycontin® ER 60 mg (oxycodone-controlled release tab)30 per 30 days
Oxycontin® ER 80mg (oxycodone-controlled release tab)22 per 30 days

Duration of Approval: 6 months for Zohydro® ER, 1 year for all other medications

Chronic Opioid Management with High Morphine Milligram Equivalents (MME)
*Note: High MME applies to all opioids (i.e. short acting, long, acting, transdermal)

Initial High MME Exceptions: If any are “True”, no further information is required and member meets the requirements for this section. If all are “False” then proceed to the remaining requirements under Additional High MME Criteria.
1.Does the patient have documented “current” cancer-related pain?
2.Does the patient have pain related to sickle cell disease?
3.Is the patient in hospice or palliative care?
4.Patient resides in a long-term care or other facility that is exempt from reporting to or checking the State Prescription Drug Monitoring Program (i.e. MAPS) (NOTE: upon discharge from long-term care member must meet the additional high MME Criteria below).
Additional High MME Criteria:
•Provider must attest to all of the following:
oRisk assessment has been performed
oPain Medication Agreement with informed consent has been reviewed with, completed and signed by the patient
oMAPS/NarxCare report has been reviewed by prescriber in last 30 days. (Please do not submit the MAPS report.) Concurrently prescribed drugs have been reviewed and that based on prescriber’s assessment the drugs and doses are safe for the member.

oConcurrently prescribed drugs have been reconciled and reviewed for safety
oThe following Non-opioid pain interventions have been recommended and/or utilized:
Non-opioid medications
Adjuvant therapies such as physical therapy (PT), occupational therapy (OT), behavioral therapies, or weight loss
oA toxicology screen (urine or blood) from a commercial lab has been performed at appropriate intervals. Results from toxicology screen showed expected results.
oPatient has been counseled on obtaining and the appropriate utilization of a Narcan (naloxone) kit.
oIf applicable, the patient has been counselled on the potential increased risk of adverse effects when opioids are taken concomitantly with opioid potentiators (e.g. benzodiazepines/sedative hypnotics, stimulants, gabapentinoids, muscle relaxers).

•Additional documentation:
oCurrent documentation provided outlining pain related history and physical(s) including clinical justification supporting need for exceeding high MME
oRecent non-opioid medications utilized for pain management or rationale these cannot be used
oDocumentation includes list of all current opioid medications (long and short-acting) and when the regimen was initiated.
oDuration of current opioid therapy and current daily Morphine Milligram Equivalent
Opioid Oral MME conversion factor table can be found under the following resources:
If differences exist in language, the more current MME guidelines will be followed:
CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR
•https://www.hhs.gov/guidance/document/opioid-oral-morphine-milligram-equivalent-mme-conversion-factors-0
o
oIf patient is currently pregnant, must provide the name and location of the OB/GYN following this high-risk pregnancy

Criteria for Continuation of Therapy:
oMust continue to meet high MME criteria and provide all required documentation
oDocumentation of taper plan or rationale why taper is not appropriate

Effective 10/1/20
Updated 8/1/21
Updated 11/1/22

MEDICATION(S)

ACETAMIN-CAFF-DIHYDROCODEINE, ACTIQ, ASA-BUTALB-CAFFEINE-CODEINE, ASCOMP WITH CODEINE, BUTALB-ACETAMINOPH-CAFF-CODEIN, BUTALBITAL COMPOUND-CODEINE, BUTORPHANOL 10 MG/ML SPRAY, DILAUDID 2 MG TABLET, DILAUDID 4 MG TABLET, DILAUDID 5 MG/5 ML ORAL LIQUID, DILAUDID 8 MG TABLET, FENTANYL CIT 100 MCG BUCCAL TB, FENTANYL CIT 200 MCG BUCCAL TB, FENTANYL CIT 400 MCG BUCCAL TB, FENTANYL CIT 600 MCG BUCCAL TB, FENTANYL CIT 800 MCG BUCCAL TB, FENTORA, FIORICET WITH CODEINE, HYDROCODONE-IBUPROFEN, HYDROMORPHONE 3 MG SUPPOS, LEVORPHANOL 2 MG TABLET, LEVORPHANOL 3 MG TABLET, MEPERIDINE 50 MG TABLET, MEPERIDINE 50 MG/5 ML SOLUTION, NUCYNTA, OXAYDO, OXYCODONE HCL (IR) 20 MG TAB, OXYCODONE HCL (IR) 30 MG TAB, OXYCODONE HCL (IR) 5 MG CAP, OXYCODONE HCL 100 MG/5 ML CONC, OXYMORPHONE HCL, PENTAZOCINE-NALOXONE HCL, PERCOCET, ROXICODONE, ROXYBOND, SEGLENTIS, TRAMADOL HCL 25 MG/5 ML CUP, ULTRACET, ULTRAM

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OPIOIDS – SHORT AND INTERMEDIATE ACTING
Drug Class: OPIOID – Short and Intermediate Acting

Preferred Agents: Clinical Prior Authorization for codeine and tramadol containing products only.

codeine
codeine / acetaminophen
Endocet
hydrocodone / acetaminophen
hydromorphone oral tablets
morphine sulfate tablets, solution, suppository
oxycodone tabs (5mg, 10mg, 15mg)
oxycodone oral solution
oxycodone / acetaminophen
tramadol / acetaminophen
tramadol

Non-Preferred Agents: Prior Authorization Criteria below

Actiq®
butorphanol
codeine / acetaminophen /caffeine /butalbital
codeine / aspirin /caffeine /butalbital
Demerol® tablets, solution
Dilaudid® all forms
fentanyl citrate buccal
Fentora®
Fioricet w/ Codeine®
Fiorinal w/ Codeine®
hydrocodone/ ibuprofen
hydromorphone suppository
levorphanol
Lorcet®, Lorcet HD®, Lorcet Plus®
Lortab®
meperidine tablets, solution
Nucynta®
Oxaydo®
oxycodone / aspirin
oxycodone capsule
oxycodone tabs (20mg, 30mg)
oxycodone oral conc soln
oxycodone oral syringe

oxycodone/ibuprofen
oxymorphone
pentazocine/naloxone
Percocet®
Roxicodone®
Seglentis®
Tramadol Oral Solution (generic Qdolo Soln)

Preferred Agent PA Criteria:
•greater than or equal to 12 years of age (for codeine and tramadol containing products only) AND

SHORT ACTING OPIOID 7-DAY LIMIT
Claims submitted for short acting opioids for more than a 7-day supply for opioid naïve patients (i.e., those with no claim for an opioid medication within the past 180 days) will deny for prior authorization.

Non-Preferred Agent PA Criteria:
•greater than or equal to 12 years of age (for codeine and tramadol containing products only) AND
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure of one week each with two preferred medications
•See additional medication-specific criteria below:

SHORT ACTING OPIOID 7-DAY LIMIT
Claims submitted for short acting opioids for more than a 7-day supply for opioid naïve patients (i.e., those with no claim for an opioid medication within the past 180 days) will deny for prior authorization.

FENTANYL – ORAL (ABSTRAL®, ACTIQ®, FENTORA®)
•Management of breakthrough cancer pain in patients established on immediate release and long-acting opioid therapy.
•Requests for controlled substances must be under the name and ID of the prescribing physician.
•greater than 18 years of age
•Medication must be prescribed by a physician who is experienced in the use of Schedule II opioids
•Current dosage regimen of the long acting and regularly prescribed immediate release narcotics must be maximally optimized.
•No concomitant use of other inducers of cytochrome P450
•No concomitant use of other inhibitors of cytochrome P450

SEGLENTIS (CELECOXIB/TRAMADOL)
•Patient age is 12 years and older, AND
• Prescriber attests that Seglentis will not be used for postoperative management in children younger than 18 years of age following tonsillectomy and/or adenoidectomy, AND
•Quantity Limit=120 tablets per 30 days

TRAMADOL (QDOLO®) ORAL SOLUTION
•Patient age is 12 years and older, AND
•Allow if patient has difficulty swallowing tablets
•Quantity limit = 80 ml per day (400mg/day)

Quantity Limitations:
ACTIQ120 units/30 days for each strength
BUTORPHANOL 10MG/ML NASAL SPRAY15 mL per 30 days
CODEINE SULFATE 15 MG TAB180 per 30 days
CODEINE SULFATE 30MG TAB180 per 30 days
CODEINE SULFATE 60 MG TAB180 per 30 days
FENTORA – all strengths120 every 24 days
HYDROMORPHONE HCL 1 MG/ML ORAL CONC120ml per 30 days
HYDROMORPHONE HCL 2MG TAB180 per 30 days
HYDROMORPHONE HCL 4MG TAB135 per 30 days
HYDROMORPHONE HCL 8MG TAB67 per 30 days
MEPERIDINE HCL 50MG TAB120 per 30 days
MEPERIDINE HCL 50 MG/5ML SOLN240ml per 30 days
MORPHINE SULFATE 10 MG /5ML SOLN240ml per 30 days
MORPHINE SULFATE 100 MG/5ML SOLN120 per 30 days

Quantity Limitations, continued
MORPHINE SULFATE 15 MG TAB180 per 30 days
MORPHINE SULFATE 20 MG/5ML SOLN240ml per 30 days
MORPHINE SULFATE 30 MG TAB90 per 30 days
OXYCODONE HCL 5 MG CAP90 per 30 days
OXYCODONE HCL 5MG TAB90 per 30 days
OXYCODONE HCL 5MG/5ML SOLN240ml per 30 days
OXYCODONE HCL 20MG/ML SOLN90ml per 30 days
OXYCODONE HCL 10MG TAB90 per 30 days
OXYCODONE HCL 15 MG TAB90 per 30 days
OXYCODONE HCL 20 MG TAB90 per 30 days
OXYCODONE HCL 30 MG TAB60 per 30 days

OXYMORPHONE HCL 5MG TAB120 per 30 days
OXYMORPHONE HCL 10MG TAB90 per 30 days
ROXYBOND 5MG TAB 90 PE R30 DAYS
ROXYBOND 15MG TAB 90 PER 30 DAYS
ROXYBOND 30MG TAB 60 PER 30 DAYS
SEGLENTIS 56 MG - 44 MG TAB120 per 30 days
TRAMADOL SOLUTION 25MG/5ML (QDOLO)80 per day (400mg)

Duration of Approval: 14 days for Adapaz®, 1 year for all other medications

Chronic Opioid Management with High Morphine Milligram Equivalents (MME)
*Note: High MME applies to all opioids (i.e. short acting, long, acting, transdermal)

Initial High MME Exceptions: If any are “True”, no further information is required and member meets the requirements for this section. If all are “False” then proceed to the remaining requirements under Additional High MME Criteria.
1.Does the patient have documented “current” cancer-related pain?
2.Does the patient have pain related to sickle cell disease?
3.Is the patient in hospice or palliative care?
4.Patient resides in a long-term care or other facility that is exempt from reporting to or checking the State Prescription Drug Monitoring Program (i.e. MAPS) (NOTE: upon discharge from long-term care member must meet the additional high MME Criteria below).

Additional High MME Criteria:
•Provider must attest to all of the following:
oRisk assessment has been performed
oPain Medication Agreement with informed consent has been reviewed with, completed and signed by the patient
oMAPS/NarxCare report has been reviewed by prescriber in last 30 days. (Please do not submit the MAPS report.) Concurrently prescribed drugs have been reviewed and that based on prescriber’s assessment the drugs and doses are safe for the member.
oConcurrently prescribed drugs have been reconciled and reviewed for safety
oThe following Non-opioid pain interventions have been recommended and/or utilized:
?Non-opioid medications
?Adjuvant therapies such as physical therapy (PT), occupational therapy (OT), behavioral therapies, or

weight loss
oA toxicology screen (urine or blood) from a commercial lab has been performed at appropriate intervals. Results from toxicology screen showed expected results.
oPatient has been counseled on obtaining and the appropriate utilization of a Narcan (naloxone) kit.
oIf applicable, the patient has been counselled on the potential increased risk of adverse effects when opioids are taken concomitantly with opioid potentiators (e.g. benzodiazepines/sedative hypnotics, stimulants, gabapentinoids, muscle relaxers).

•Additional documentation:
oCurrent documentation provided outlining pain related history and physical(s) including clinical justification supporting need for exceeding high MME
oRecent non-opioid medications utilized for pain management or rationale these cannot be used
oDocumentation includes list of all current opioid medications (long and short-acting) and when the regimen was initiated.
oDuration of current opioid therapy and current daily Morphine Milligram Equivalent
?Opioid Oral MME conversion factor table can be found under the following resources:
•If differences exist in language, the more current MME guidelines will be followed:
•CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR
•https://www.hhs.gov/guidance/document/opioid-oral-morphine-milligram-equivalent-mme-conversion-factors-0
o
oIf patient is currently pregnant, must provide the name and location of the OB/GYN following this high-risk pregnancy

Criteria for Continuation of Therapy:
oMust continue to meet high MME criteria and provide all required documentation
oDocumentation of taper plan or rationale why taper is not appropriate

Effective 10/1/20
Updated 1/1/22
Updated 2/22/22
Updated 5/1/22
Updated 11/1/22

UPHP MEDICAID - NARCOTICS - TRANSDERMAL

MEDICATION(S)
BUPRENORPHINE, FENTANYL 37.5 MCG/HR PATCH, FENTANYL 62.5 MCG/HR PATCH, FENTANYL 87.5 MCG/HR PATCH

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
OPIOIDS – TRANSDERMAL
Drug Class: Opioids – Transdermal

Preferred Agents: No Prior Authorization required
Butrans® patches
fentanyl patches 12, 25, 50, 75, and 100 mcg only (generic only)

Non-Preferred Agents: Prior Authorization Criteria below
buprenorphine patches
Duragesic® patches
fentanyl generic patches 37.5 mcg, 62.5 mcg and 87.5 mcg only

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medication

•History of unacceptable side effects
•Therapeutic failure of one week with the preferred medication

Quantity Limitations:
Butrans® (buprenorphine patch)6 per 28 days
Duragesic® (fentanyl)10 per fill
fentanyl patch (Duragesic®)10 per fill

Duration of Approval: 1 year

Chronic Opioid Management with High Morphine Milligram Equivalents (MME)
*Note: High MME applies to all opioids (i.e. short acting, long, acting, transdermal)

Initial High MME Exceptions: If any are “True”, no further information is required and member meets the requirements for this section. If all are “False” then proceed to the remaining requirements under Additional High MME Criteria.
1.Does the patient have documented “current” cancer-related pain?
2.Does the patient have pain related to sickle cell disease?
3.Is the patient in hospice or palliative care?
4.Patient resides in a long-term care or other facility that is exempt from reporting to or checking the State Prescription Drug Monitoring Program (i.e. MAPS) (NOTE: upon discharge from long-term care member must meet the additional high MME Criteria below).

Additional High MME Criteria:
•Provider must attest to all of the following:
oRisk assessment has been performed
oPain Medication Agreement with informed consent has been reviewed with, completed and signed by the patient
oMAPS/NarxCare report has been reviewed by prescriber in last 30 days. (Please do not submit the MAPS report.) Concurrently prescribed drugs have been reviewed and that based on prescriber’s assessment the drugs and doses are safe for the member.
oConcurrently prescribed drugs have been reconciled and reviewed for safety
oThe following Non-opioid pain interventions have been recommended and/or utilized:
Non-opioid medications
Adjuvant therapies such as physical therapy (PT), occupational therapy (OT), behavioral therapies, or weight loss
oA toxicology screen (urine or blood) from a commercial lab has been performed at appropriate intervals. Results from toxicology screen showed expected results.
oPatient has been counseled on obtaining and the appropriate utilization of a Narcan (naloxone) kit.
oIf applicable, the patient has been counselled on the potential increased risk of adverse effects when

opioids are taken concomitantly with opioid potentiators (e.g. benzodiazepines/sedative hypnotics, stimulants, gabapentinoids, muscle relaxers).
•Additional documentation:
oCurrent documentation provided outlining pain related history and physical(s) including clinical justification supporting need for exceeding high MME
oRecent non-opioid medications utilized for pain management or rationale these cannot be used
oDocumentation includes list of all current opioid medications (long and short-acting) and when the regimen was initiated.
oDuration of current opioid therapy and current daily Morphine Milligram Equivalent
Opioid Oral MME conversion factor table can be found under the following resources:
•If differences exist in language, the more current MME guidelines will be followed:
•CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR
•https://www.hhs.gov/guidance/document/opioid-oral-morphine-milligram-equivalent-mme-conversion-factors-0
o
oIf patient is currently pregnant, must provide the name and location of the OB/GYN following this high-risk pregnancy

Criteria for Continuation of Therapy:
oMust continue to meet high MME criteria and provide all required documentation
oDocumentation of taper plan or rationale why taper is not appropriate

Duration of Approval: 1 year
Effective 10/1/20
Updated 8/1/21

UPHP MEDICAID - NASAL ANTIHISTAMINES

MEDICATION(S)
OLOPATADINE 665 MCG NASAL SPRY, PATANASE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
NASAL ANTIHISTAMINES
Drug Class: Nasal Antihistamines
Preferred Agents: No Prior Authorization required
Azelastine spray

Non-Preferred Agents: Prior Authorization Criteria below
Olopatadine spray
Patanase Nasal® spray

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Trial and failure on one preferred medication

Duration of Approval: 1 year

UPHP MEDICAID - NASAL CORTICOSTEROIDS

MEDICATION(S)
24 HOUR NASAL ALLERGY, ALLERGY RELIEF 50 MCG SPRAY, EQ ALLERGY RELIEF 50 MCG SPRAY, FT ALLERGY RELIEF 50 MCG SPRAY, HM ALLERGY RELIEF 50 MCG SPRAY, QC ALLERGY RELIEF 50 MCG SPRAY, SM ALLERGY RELIEF 50 MCG SPRAY, BECONASE AQ, BUDESONIDE 32 MCG NASAL SPRAY, CVS BUDESONIDE 32 MCG SPRAY, GNP BUDESONIDE 32 MCG SPRAY, RA BUDESONIDE 32 MCG SPRAY, CHILDREN'S FLONASE ALLERGY RLF, FLUNISOLIDE 0.025% SPRAY, MOMETASONE FUROATE 50 MCG SPRY, NASAL ALLERGY, OMNARIS, QNASL, QNASL CHILDREN, TRIAMCINOLONE 55 MCG NASAL SPR, XHANCE, ZETONNA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
NASAL CORTICOSTEROIDS
Drug Class: NASAL CORTICOSTEROIDS

Preferred Agents: No Prior Authorization required
fluticasone (Rx)

Non-Preferred Agents: Prior Authorization Criteria below
Beconase AQ®
budesonide
Flonase OTC®

Flonase Sensimist®
flunisolide
fluticasone (OTC)
mometasone
Nasonex 24hr (OTC)
Omnaris®
Qnasl®
Ticanase®
triamcinolone
Xhance®
Zetonna®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Therapeutic failure with a one-month trial with a preferred medication
•See additional medication-specific criteria below:

XHANCE® (FLUTICASONE)
•Diagnosis of nasal polyps
•Therapeutic failure with a three-month trial with a preferred medication

Duration of Approval: 1 year
Effective 10/1/20

MEDICATION(S)
GRALISE ER 300 MG TABLET, GRALISE ER 600 MG TABLET, HORIZANT

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
NEUROPATHIC PAIN
Drug Class: Neuropathic Pain

Preferred Agents: No Prior Authorization required
Cymbalta® capsule (*Carve Out)
Drizalma Sprinkles® capsule (*Carve Out)
duloxetine (generic for Cymbalta) capsule (*Carve Out)
duloxetine (generic for Irenka) capsule (*Carve Out)
gabapentin capsule, tablet, solution (*Carve Out)
Lyrica®, Lyrica CR® capsule (*Carve Out)
Neurontin® capsule, tablet, solution (*Carve Out)
Pregabalin capsule, solution (*Carve Out)
Savella® tablet

GABAPENTIN DOSAGE LIMIT (*Carve Out)
•Maximum daily dosage limit = 3600 mg across all strengths

•Length of authorization: determined by MDHHS

LYRICA (PREGABALIN) DOSAGE LIMIT (*Carve Out)
•Maximum daily dosage limit = 600 mg across all strengths
•Length of authorization: determined by MDHHS

Quantity Limitations:
Lyrica® (pregabalin)25 mg - 3 per day
50 mg - 3 per day
75 mg – 3 per day
100 mg – 3 per day
150 mg – 3 per day
200 mg – 3 per day
225 mg – 2 per day
300 mg – 2 per day
20 mg/ml – 20 ml per day

Savella® (milnacipran) all strengths - 2 per day

Non-Preferred Agents: Prior Authorization Criteria below
Gralise® tablet
Horizant® tablet

Non-Preferred Agent PA Criteria:
GRALISE® (GABAPENTIN)
•Diagnosis of postherpetic neuralgia, neuropathy, diabetic neuropathy or chronic pain.
•Dosage limit = 1800 mg/day

HORIZANT® (GABAPENTIN ENACARBIL)
•Diagnosis of restless leg syndrome, AND
•Therapeutic failure on a one-month trial of pramipexole (Mirapex®), ropinirole (Requip®) or levodopa/carbidopa (Sinemet®): OR
•Diagnosis of postherpetic neuralgia (PHN)
•Dosage limit = 1200 mg/day

Duration of Approval: 1 year unless otherwise specified
Effective 10/1/20

MEDICATION(S)
CELEBREX

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
NON-STEROIDAL ANTI-INFLAMMATORY – COX II INHIBITORS
Drug Class: NON-STEROIDAL ANTI-INFLAMMATORY – COX II INHIBITORS
Preferred Agents: No Prior Authorization required (ST is required)
celecoxib

Non-Preferred Agents: Prior Authorization Criteria below
Celebrex®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Therapeutic failure of one month each with two preferred NSAIDS

See additional medication-specific criteria below:

CELEBREX®(CELECOXIB)•
Therapeutic failure of one month each with two preferred NSAIDs (unless specifically contraindicated), including generic celecoxib

Quantity Limitations:
Celebrex 50mg, 100mg, 200mg caps 2 per day
Celebrex 400mg 1 per day
celecoxib 50mg, 100mg, 200mg caps 2 per day
celecoxib 400mg 1 per day

Duration of Approval: For the duration of the prescription up to 1 year
Effective 10/1/20
Update 5/1/21

MEDICATION(S)

ARTHROTEC 50, ARTHROTEC 75, DAYPRO, DICLOFENAC EPOLAMINE, DICLOFENAC POT 50 MG TABLET, DICLOFENAC 2% SOLUTION PUMP, DICLOFENAC SODIUM ER, DIFLUNISAL 500 MG TABLET, DUEXIS, EC-NAPROXEN, ETODOLAC, ETODOLAC ER, FELDENE, FENOPROFEN 400 MG CAPSULE, FENOPROFEN 600 MG TABLET, FLURBIPROFEN 100 MG TABLET, IBUPROFEN-FAMOTIDINE, INDOCIN 25 MG/5 ML SUSPENSION, INDOMETHACIN 25 MG/5 ML SUSP, INDOMETHACIN ER, KETOPROFEN 50 MG CAPSULE, KETOPROFEN 75 MG CAPSULE, KETOPROFEN ER 200 MG CAPSULE, KETOROLAC 15.75 MG NASAL SPRAY, LICART, LOFENA, MECLOFENAMATE 100 MG CAPSULE, MECLOFENAMATE 50 MG CAPSULE, MEFENAMIC ACID 250 MG CAPSULE, MELOXICAM 10 MG CAPSULE, MELOXICAM 5 MG CAPSULE, NALFON, NAPRELAN, NAPROXEN DR 375 MG TABLET, NAPROXEN DR 500 MG TABLET, NAPROXEN SODIUM 550 MG TAB, NAPROXEN-ESOMEPRAZOLE MAG, OXAPROZIN 600 MG CAPLET, OXAPROZIN 600 MG TABLET, PENNSAID, PIROXICAM 10 MG CAPSULE, PIROXICAM 20 MG CAPSULE, RELAFEN DS, SPRIX, TOLMETIN SODIUM 200 MG TAB, VIMOVO, ZIPSOR, ZORVOLEX

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS)
Drug Class: NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS)

Preferred Agents: No Prior Authorization required

diclofenac
diclofenac topical gel 1% (generic Voltaren Gel®)
diclofenac topical gel 1% (OTC)
diclofenac topical solution 1.5%
ibuprofen
indomethacin
ketorolac tablets
meloxicam tablets
nabumetone
naproxen OTC
naproxen (generic for Naprosyn®)
sulindac

Non-Preferred Agents: Prior Authorization Criteria below
Arthrotec®
Daypro®
diclofenac 2% pump (generic Pennsaid)
diclofenac epolamine 1.3% patch
diclofenac ER
diclofenac-misoprostol
diclofenac potassium
diflunisal
dual action pain (OTC ibuprofen/apap)
Duexis®
EC-Naprosyn®
EC-naproxen
etodolac / etodolac ER
Feldene®
fenoprofen
Flector Patch®
flurbiprofen
ibuprofen-famotidine
Indocin® oral suspension
indomethacin ext release, oral suspension
ketoprofen ext release
ketoprofen immediate release
Licart Patch
Lofena®
meclofenamate sodium
mefenamic acid

meloxicam capsule
Nalfon®
Naprelan CR®
naproxen (generic for Anaprox)
naproxen delayed release
naproxen/esomeprazole (generic for Vimovo)
oxaprozin
Pennsaid®
piroxicam
Qmiiz ODT®
Relafen DS®
Sprix®
Tivorbex®
tolmetin sodium
Vimovo®
Vivlodex®
Voltaren® gel
Zipsor®
Zorvolex®

Non-Preferred Agent PA Criteria:
Allergy to the preferred medications OR
Contraindication or drug to drug interaction with the preferred medications OR
History of unacceptable side effects OR
Therapeutic failure of one month each with two preferred medications
See additional medication-specific criteria below:

LICART® (DICLOFENAC EPOLAMINE PATCHES)
•Length of authorization – 2 months

SPRIX®
Contraindication to oral dosage forms (i.e., inability to swallow)
Length of authorization – 30 days.

VIMOVO® (NAPROXEN/ESOMEPRAZOLE) AND DUEXIS®(IBUPROFEN/FAMOTIDINE)
History of or active GI bleed/ulcer OR
Risk for bleed/ulcer –
Therapeutic failure with one preferred medication

ZORVOLEX®(diclofenac submicronized)

•Trial on a preferred diclofenac product and one other preferred NSAID.

Quantity Limitations:
Flector Patch® (diclofenac transdermal patch)2 per day
Toradol® (ketorolac) tablets 21 per fill
Licart (diclofenac epolamine) 15 patches (1 package) per 30 days

Duration of Approval: For the duration of the prescription up to 1 year, unless otherwise noted in Medication-Specific Information
Effective 10/1/20
Updated 6/15/22
Updated 11/18/21
Updated 9/7/22

UPHP MEDICAID - OPHTHALMIC ANTI-INFLAMMATORY/IMMUNOMODULATOR

MEDICATION(S)
CEQUA, CYCLOSPORINE 0.05% EYE EMULS, EYSUVIS, MIEBO, TYRVAYA, VERKAZIA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
OPHTHALMIC ANTI-INFLAMMATORY/IMMUNOMODULATOR

Drug Class: Ophthalmic Anti-Inflammatory/Immunomodulator

Preferred Agents: No Prior Authorization required

Restasis®
Xiidra®

Non-Preferred Agents: Prior Authorization Criteria below

Cequa®
cyclosporine (generic Restasis®)
Eysuvis®

Miebo
Tyrvaya®
Verkazia®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure with a six-week trial with one preferred medication
•See additional medication-specific criteria below:

EYSUVIS® (LOTEPREDNOL):
•For Renewal: Patient has had an examination under magnification (e.g., slit lamp) and evaluation of the intraocular pressure (IOP)
•Renewal length of approval: 2 weeks

MIEBO® (PERFLUOROHEXYLOCTANE/PF)
•Patient is 18 years of age or older AND
•Quantity Limit: 3.0 mls per 30 days

VERKAZIA (CYCLOSPORINE): PDL criteria do not apply
•Patient is 4 years of age or older AND
•Diagnosis of moderate to severe vernal keratoconjunctivitis AND
•Trial and failure, contraindication, or intolerance to one of the following:
oTopical ophthalmic “dual-action” mast cell stabilizer and antihistamine (e.g., olopatadine, azelastine) OR
oTopical ophthalmic mast cell stabilizers (e.g., cromolyn), AND
•Prescribed by or in consultation with an ophthalmologist or optometrist

QUANTITY LIMITS
Restasis (cyclosporine) single-use containers60 per 30 days
Restasis multi-dose vial 5.5ml (1 vial) per 30 days
Xiidra60 single-use containers per 30 days
Cequa60 single-use containers per 30 days

Eysuvis8.3ml (1 bottle) per 14 days
Verkazia 120 single dose vials per 30 days
Tyrvaya8.4ml (2 bottles) per 30 days

Duration of Approval: 1 year (except Eysuvis – 2 weeks)

Effective 8/1/21
Updated 5/1/22 (criteria name change to Ophthalmic Anti-Inflammatory/Immunomodulator per 3/8/22 P&T)

UPHP MEDICAID - OPHTHALMIC ANTIHISTAMINES

MEDICATION(S)
ALREX, BEPREVE, EPINASTINE HCL, PATADAY ONCE DAILY RELIEF, PATADAY TWICE DAILY RELIEF, ZERVIATE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
OPHTHALMIC ANTIHISTAMINES
Drug Class: OPHTHALMIC ANTIHISTAMINES

Preferred Agents: No Prior Authorization required
azelastine
ketotifen fumarate (OTC Only)
olopatadine
Zaditor®

Non-Preferred Agents: Prior Authorization Criteria below
Alrex®
Bepreve®
epinastine
Lastacaft®
Pataday®

Zerviate

Non-Preferred Agent PA Criteria:
Allergy to the preferred medications OR
Contraindication or drug to drug interaction with the preferred medications OR
History of unacceptable side effects OR
Therapeutic failure with a one-month trial with one preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 5/1/21

UPHP MEDICAID - OPHTHALMIC FLUOROQUINOLONES

MEDICATION(S)
BESIVANCE, CILOXAN, GATIFLOXACIN, LEVOFLOXACIN 0.5% EYE DROPS, MOXIFLOXACIN 0.5% EYE DROPS, OCUFLOX, ZYMAXID

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
OPHTHALMIC FLUOROQUINOLONES
Drug Class: Ophthalmic Fluoroquinolones

Preferred Agents: No Prior Authorization required
ciprofloxacin
ofloxacin
Vigamox

Non-Preferred Agents: Prior Authorization Criteria below
Besivance® eye drops
Ciloxan® eye drops
gatifloxacin eye drops
levofloxacin eye drops
moxifloxacin (generic for Moxeza®) eye drops
moxifloxacin (generic for Vigamox®) eye drops

Ocuflox® eye drops
Zymaxid® eye drops

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•Therapeutic failure with one preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 8/1/22

UPHP MEDICAID - OPHTHALMIC MACROLIDES

MEDICATION(S)
AZASITE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
OPHTHALMIC MACROLIDES
Drug Class: Ophthalmic Macrolides

Preferred Agents: No Prior Authorization required
erythromycin 0.5% eye ointment

Non-Preferred Agents: Prior Authorization Criteria below
Azasite® eye drops

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Therapeutic failure with one preferred medication

Duration of Approval: 1 year

UPHP MEDICAID - OPHTHALMIC MAST CELL STABILIZERS

MEDICATION(S)
ALOCRIL, ALOMIDE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
OPHTHALMIC MAST CELL STABILIZERS
Drug Class: OPHTHALMIC MAST CELL STABILIZERS

Preferred Agents: No Prior Authorization required
cromolyn sodium drops

Non-Preferred Agents: Prior Authorization Criteria below
Alocril® drops
Alomide® drops

Non-Preferred Agent PA Criteria:
Allergy to the preferred medications
Contraindication or drug to drug interaction with the preferred medications
History of unacceptable side effects
Therapeutic failure with a one-month trial with one preferred medication

Duration of Approval: 1 year
Effective 10/1/20

UPHP MEDICAID - OPHTHALMIC NSAIDS

MEDICATION(S)
ACULAR, ACULAR LS, ACUVAIL, BROMFENAC SODIUM 0.09% EYE DRP, BROMSITE, ILEVRO, KETOROLAC 0.4% OPHTH SOLUTION, NEVANAC 0.1% DROPTAINER, PROLENSA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
OPHTHALMIC NSAIDS
Drug Class: Ophthalmic NSAIDS

Preferred Agents: No Prior Authorization required
diclofenac
flurbiprofen
ketorolac

Non-Preferred Agents: Prior Authorization Criteria below
Acular®
Acular LS®
Acuvail®
bromfenac
Bromsite®
Ilevro®

ketorolac LS
Nevanac®
Prolensa®

Non-Preferred Agent PA Criteria:
• Allergy to the preferred medications
• Contraindication or drug to drug interaction with the preferred medications
• History of unacceptable side effects
• Medical necessity of lower strength dosages for post-operative pain relief
• Therapeutic failure with a trial with one preferred medication

Duration of Approval: 1 year
Updated 5/1/21

MEDICATION(S)

ANCOBON, BREXAFEMME, CRESEMBA 186 MG CAPSULE, DIFLUCAN, FLUCYTOSINE 250 MG CAPSULE, FLUCYTOSINE 500 MG CAPSULE, GRISEOFULVIN MICRO 500 MG TAB, GRISEOFULVIN ULTRAMICROSIZE, ITRACONAZOLE 10 MG/ML SOLUTION, ITRACONAZOLE 100 MG CAPSULE, NOXAFIL 300 MG POWDERMIX SUSP, NOXAFIL 40 MG/ML SUSPENSION, NOXAFIL DR 100 MG TABLET, ORAVIG, POSACONAZOLE 200 MG/5 ML SUSP, POSACONAZOLE DR 100 MG TABLET, SPORANOX 10 MG/ML SOLUTION, TOLSURA, VFEND, VIVJOA, VORICONAZOLE 200 MG TABLET, VORICONAZOLE 40 MG/ML SUSP, VORICONAZOLE 50 MG TABLET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIFUNGALS – ORAL
Drug Class : Antifungals – Oral

Preferred Agents: No Prior Authorization required
clotrimazole troches
fluconazole
griseofulvin oral suspension
ketoconazole
nystatin oral susp, tablets
terbinafine tablet

Non-Preferred Agents: Prior Authorization Criteria below
Ancobon
Brexafemme®
Cresemba®
Diflucan®
flucytosine
griseofulvin tablet
griseofulvin microsize tablets
griseofulvin ultramicrosize tab
itraconazole
Noxafil®
Noxafil DR®
Oravig®
posaconazole
Sporanox®
Tolsura®
Vfend®
Vivjoa
voriconazole

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Trial and failure with one month with one preferred medication, OR
•Serious illness resulting immunocompromised status
•See additional medication-specific criteria below:

BREXAFEMME®
•Diagnosis of vulvovaginal candidiasis OR
• Patient has diagnosis of recurrent vulvovaginal candidiasis with 3 or more episodes of vulvovaginal candidiasis (VVC) in a 12 month period AND
• attestation that the provider has confirmed a negative pregnancy test or that the patient is not of childbearing potential
•Quantity Limit: Treatment = 4 tablets, Maintenance = 24 tablets
•Length of approval: Treatment: one time, Maintenance = 6 months

VFEND®
•Aspergillosis – no trial/failure required

SPORANOX®
•Onychomycosis with previous failure on or contraindication to terbinafine: length of approval - toenails 12 weeks, fingernails - 6 weeks.
•Below diagnoses without previous trial:
Aspergillosis
Blastomycosis
Febrile neutropenia
Histoplasmosis

CRESEMBA®
•Diagnosis of aspergillosis, AND
•Patient is 18 years or older, AND
•Trial on voriconazole/Vfend or amphotericin B - approve without trials if intolerant to prerequisite meds or renal dysfunction

VIVJOA
•Patient has diagnosis of recurrent vulvovaginal candidiasis with ?3 episodes of vulvovaginal candidiasis (VVC) in a 12-month period AND
•Patient is a biological female who is postmenopausal or has another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy) AND
•Patient has tried and failed or has a contraindication or intolerance to maintenance antifungal therapy with oral fluconazole.
•Quantity limit: 18 tablets per treatment course
•Length of approval: one time

QUANTITY LIMITS
Brexfemme Tablets Treatment = 4 tablets, Maintenance = 24 tablets
Diflucan® 150 mg tab (fluconazole) 2 per fill
fluconazole 150 mg tabs (Diflucan®) 2 per fill
Lamisil® tabs (terbinafine) 84 per fill
Sporanox® (itraconazole) – brand & generic 100 mg – 120 per 30 days
250 mg kit – 34 per fill
Solution – 840 per fill
terbinafine tabs (Lamisil®) 84 per fill
Vivjoa - 18 per treatment course

Duration of Approval: For the duration of the prescription up to 6 months, unless otherwise noted in Medication specific information

MEDICATION(S)
AMARYL, GLUCOTROL XL, GLYNASE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ORAL HYPOGLYCEMICS – 2ND GENERATION SULFONYLUREAS
Drug Class: Oral Hypoglycemics – 2nd Generation Sulfonylureas

Preferred Agents: No Prior Authorization required
glimepiride tablet
glipizide / glipizide ER tablet
glyburide tablet
glyburide micronized tablet

Non-Preferred Agents: Prior Authorization Criteria below
Amaryl® Tablet
Glucotrol® / Glucotrol XL® tablet
Glynase® Tablet

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR

•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure with a one-month trial with two preferred medications within the same class

Duration of Approval: 1 year
Effective 10/1/20
Updated 9/1/22

UPHP MEDICAID - ORAL HYPOGLYCEMICS - ALPHA-GLUCOSIDASE INH

MEDICATION(S)
PRECOSE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ORAL HYPOGLYCEMICS – ALPHA-GLUCOSIDASE INHIBITORS
Drug Class: Oral Hypoglycemics – Alpha-Glucosidase Inhibitors

Preferred Agents: No Prior Authorization required
Acarbose tablets
Miglitol tablets

Non-Preferred Agents: Prior Authorization Criteria below
Precose® tablets

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure with a one-month trial with two preferred medications within the same class

Duration of Approval: 1 year
Effective 10/1/20
Update 9/1/22

UPHP MEDICAID - ORAL HYPOGLYCEMICS - BIGUANIDES

MEDICATION(S)
GLUMETZA, METFORMIN ER GASTRIC, METFORMIN ER OSMOTIC, METFORMIN HCL 500 MG/5 ML CUP, METFORMIN HCL 500 MG/5 ML SOLN, RIOMET, RIOMET ER

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ORAL HYPOGLYCEMICS – BIGUANIDES
Drug Class: Oral Hypoglycemics – Biguanides

Preferred Agents: No Prior Authorization required
metformin / metformin XR tablets

Non-Preferred Agents: Prior Authorization Criteria below
Glumetza® tablets
metformin ER (generic for Fortamet)
metformin (generic for Glumetza) tablets
metformin solution (generic for Riomet)
Riomet®
Riomet ER®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure with a one-month trial with a preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 6/1/22
Updated 9/1/22

MEDICATION(S)
ACTOPLUS MET, ALOGLIPTIN-METFORMIN, ALOGLIPTIN-PIOGLITAZONE, DUETACT, GLIPIZIDE-METFORMIN, GLYXAMBI, INVOKAMET XR, JENTADUETO XR, KAZANO, KOMBIGLYZE XR, OSENI, PIOGLITAZONE-GLIMEPIRIDE, PIOGLITAZONE-METFORMIN, QTERN, SAXAGLIPTIN-METFORMIN ER 5-500, SAXAGLIPTIN-METFORMN ER 5-1000, SEGLUROMET, STEGLUJAN, SYNJARDY XR, TRIJARDY XR

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ORAL HYPOGLYCEMICS – COMBINATIONS
Drug Class: Oral Hypoglycemics – Combinations

Preferred Agents: No Prior Authorization required
glyburide / metformin
Invokamet®
Janumet®/Janumet XR®
Jentadueto®
Synjardy®
Xigduo®

QUANTITY LIMITS

Janumet® (sitagliptin / metformin)2 tabs per day

Non-Preferred Agents: Prior Authorization Criteria below
Actoplus Met®
alogliptin/metformin
alogliptin/pioglitazone
Duetact®
glipizide / metformin
Glyxambi®
Invokamet XR®
Jentadueto XR®
Kazano®
Kombiglyze XR®
Oseni®
pioglitazone/glimepride
pioglitazone/metformin
Qtern®
saxagliptin/metformin ER
Segluromet®
Steglujan®
Synjardy XR
Trijardy XR

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure with a one-month trial with two preferred medications within the same class

Duration of Approval: 1 year
Effective 10/1/20
Updated 11/1/21
Updated 9/1/22
Updated 11/1/22

UPHP MEDICAID - ORAL HYPOGLYCEMICS - DPP4 INH

MEDICATION(S)
ALOGLIPTIN, NESINA, ONGLYZA, SAXAGLIPTIN HCL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ORAL HYPOGLYCEMICS – DPP4 INHIBITORS
Drug Class: Oral Hypoglycemics – DPP4 Inhibitors

Preferred Agents: No Prior Authorization required
Januvia®
Tradjenta®

QUANTITY LIMITS
Januvia® (sitagliptin phosphate) 100mg/day max daily dose limit, qty limit of 1 tab - any strength - per day]

Non-Preferred Agents: Prior Authorization Criteria below
alogliptin
Nesina®
Onglyza®
saxagliptin

Non-Preferred Agent PA Criteria:

•Allergy to the preferred medications OR

•Contraindication or drug to drug interaction with the preferred medications OR

•History of unacceptable side effects OR

•Therapeutic failure with a one-month trial with two preferred medications within the same class

Duration of Approval: 1 year

Effective 10/1/20

UPHP MEDICAID - ORAL HYPOGLYCEMICS - SGLT2 INHIBITORS

MEDICATION(S)
INPEFA, STEGLATRO

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ORAL HYPOGLYCEMICS – SGLT2 INHIBITORS
Drug Class: Oral Hypoglycemics – SGLT2 Inhibitors
Preferred Agents: No Prior Authorization required
Farxiga® tablets
Invokana® tablets
Jardiance® tablets

Non-Preferred Agents: Prior Authorization Criteria below
Inpefa
Steglatro® tablets

Non-preferred Agent PA Criteria:
• Allergy to the preferred medications OR
• Contraindication or drug to drug interaction with the preferred medications OR
• History of unacceptable side effects OR
• Therapeutic failure with a one-month trial with two preferred medications within the same

class

Duration of Approval: 1 year

Effective 2/01/2022

MEDICATION(S)
ACTOS

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ORAL HYPOGLYCEMICS – THIAZOLIDINEDIONES
Drug Class: Oral Hypoglycemics – Thiazolidinediones

Preferred Agents: No Prior Authorization required
pioglitazone tablets

Non-Preferred Agents: Prior Authorization Criteria below
Actos® tablets

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure with a one-month trial with a preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 9/1/22

UPHP MEDICAID - OSTEOPOROSIS - BISPHOSPHONATES

MEDICATION(S)
ACTONEL, ALENDRONATE SOD 70 MG/75 ML, ATELVIA, BONIVA, FOSAMAX, IBANDRONATE SODIUM 150 MG TAB, RISEDRONATE SODIUM, RISEDRONATE SODIUM DR

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
OSTEOPOROSIS AGENTS: BISPHOSPHONATES
Drug Class: OSTEOPOROSIS AGENTS: BISPHOSPHONATES

Preferred Agents: No Prior Authorization required
alendronate sodium

Non-Preferred Agents: Prior Authorization Criteria below
Actonel®
alendronate sodium oral solution
Atelvia®
Boniva®
Fosamax®
Fosamax Plus D®
Ibandronate
risedronate (Actonel)

risedronate (Atelvia)

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Trial and failure with six months with one preferred medication
•Unique FDA approved indication not included in preferred medications
•See additional medication-specific criteria below:

DIDRONEL® (ETIDRONATE)
•Diagnosis of hypertrophic ossification secondary to hip replacement or spinal cord injury.

Quantity Limitations:
Atelvia® (risedronate) – brand & generic4 per 30 days
Actonel® (risedronate)75mg - 2 per 28 days
35mg - 4 per 28 days

Duration of Approval: 1 year
Effective 10/1/20
Effective 8/1/22

UPHP MEDICAID - OSTEOPOROSIS - OTHER

MEDICATION(S)
FORTEO, TERIPARATIDE, TYMLOS

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
OSTEOPOROSIS AGENTS: OTHER
Drug Class: OSTEOPOROSIS AGENTS: OTHER

Preferred Agents: No Prior Authorization required
calcitonin nasal spray

Non-Preferred Agents: Prior Authorization Criteria below
Forteo®
teriparatide
Tymlos®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•Trial and failure with six months with one preferred medication

•Unique FDA approved indication not included in preferred medications
•See additional medication-specific criteria below:

FORTEO® (TERIPARATIDE) – PDL CRITERIA DOES NOT APPLY
•Treatment of osteoporosis in postmenopausal women who are at high risk for fractures
•Increase of bone mass in men with primary or hypogonadal osteoporosis who are at high risk for fractures
•Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture

TYMLOS® (ABALOPARATIDE) – PDL CRITERIA DOES NOT APPLY
•Treatment of osteoporosis in postmenopausal women who are at high risk for fractures
•Treatment of osteoporosis in men who are at high risk for fractures

Duration of Approval: 1 year
Effective 10/1/20

UPHP MEDICAID - OSTEOPOROSIS - SERM

MEDICATION(S)
EVISTA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
OSTEOPOROSIS AGENTS: SERMS
Drug Class: OSTEOPOROSIS AGENTS: SERMS

Preferred Agents: No Prior Authorization required
raloxifene

Non-Preferred Agents: Prior Authorization Criteria below
Evista®

Non-Preferred Agent PA Criteria:
Allergy to the preferred medications
Contraindication or drug to drug interaction with the preferred medications
History of unacceptable side effects
Trial and failure with six months with one preferred medication
Unique FDA approved indication not included in preferred medications

Duration of Approval: 1 year
Effective 10/1/20

UPHP MEDICAID - OTIC QUINOLONES

MEDICATION(S)
CIPRO HC, CIPROFLOXACIN 0.2% OTIC SOLN, CIPROFLOXACIN HCL-FLUOCINOLONE, OTOVEL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
OTIC QUINOLONES
Drug Class: Otic Quinolones

Preferred Agents: No Prior Authorization required
Ciprodex®
ciprofloxacin-dexamethasone (generic for Ciprodex)
ofloxacin otic

Non-Preferred Agents: Prior Authorization Criteria below
ciprofloxacin otic
ciprofloxacin-fluocinolone (generic for Otovel)
Cipro HC®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR

•History of unacceptable side effects OR
•Therapeutic failure (duration = 3 days) with one preferred medication

Duration of Approval: 1 year for all other medications
Effective 10/1/20

UPHP MEDICAID - OXAZOLIDINONES

MEDICATION(S)
LINEZOLID 100 MG/5 ML SUSP, ZYVOX 100 MG/5 ML SUSPENSION, ZYVOX 600 MG TABLET

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
OXAZOLIDINONES
Drug Class: Oxazolidinones

Preferred Agents: No Prior Authorization required
Linezolid tablets

Non-Preferred Agents: Prior Authorization Criteria below
Linezolid suspension
Sivextro®
Zyvox®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medication
•Contraindication or drug to drug interaction with the preferred medication
•History of unacceptable side effects
•See additional medication-specific criteria below:

SIVEXTRO® (TEDIZOLID PHOSPHATE)
For diagnosis of non-purulent cellulitis
•Trial, failure or intolerance to first line beta lactam therapy and
•Trial, failure or intolerance to at least two of the following agents: clindamycin, sulfamethoxazole/trimethoprim (SMZ/TMP), tetracycline (minocycline or doxycycline) or
•Culture and sensitivity results demonstrate resistance to first line agents or
•Contraindication or intolerance to all other treatment options
For diagnosis of purulent cellulitis, abscess, or wound infection:
•Trial, failure or intolerance to at least two of the following agents: clindamycin, sulfamethoxazole/trimethoprim (smz/tmp), tetracycline (minocycline or doxycycline) or
•Culture and sensitivity results demonstrate resistance to first line agents or
•Contraindication or intolerance to all other treatment options

Quantity Limitations:
Linezolid tabs (Zyvox®)28 per fill
SDivextro (tedizolid) 14 per fill
Zyvox® tabs (linezolid)28 per fill

Duration of Approval: 2 months
Effective 10/1/20

MEDICATION(S)
OXBRYTA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
OXBRYTA® / VOXELOTOR
Drug Class: Sickle Hemoglobin (HbS) Polymerization Inhibitor

FDA-approved uses: sickle-cell disease
Available dosage forms: 500mg Tablet, 300 mg Tablet for Suspension

Coverage Criteria/Limitations for initial authorization:
Diagnoses: sickle-cell disease
Duration of approval:
oInitial authorization: 12 months
oContinuation of Therapy: 12 months
Prescriber Specialty: Prescribed by, or in consultation, with a hematologist or other specialist with expertise in the diagnosis and management of sickle cell disease
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oBaseline hemoglobin level between 5.5 g/dL and 10.5g/dL AND
Age:

Oxbryta 500mg tablet: greater than or equal to 12 years of age
Oxbryta 300mg tablet: 4 years or greater
Oxbryta 300mg tablet for suspension: greater than or equal to 4 years of age
Quantity: 90 tablets/30 days
Route of Administration: oral
Place of Service: outpatient

Criteria for continuation of therapy:
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oPatient must show an increase in hemoglobin level from initial baseline OR
oProvider attests to other positive clinical response

Effective 10/1/20, Updated 1/1/22

MEDICATION(S)
OXERVATE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
OXERVATETM (CENEGERMIN-BKBJ)
Drug Class: Recombinant human nerve growth factor (rhNGF)

FDA-approved uses: Indicated for the treatment of neurotrophic keratitis
Available dosage forms: Ophthalmic solution, 0.002% (per mL)

Coverage Criteria/Limitations for initial authorization:
Diagnoses: FDA approved indications as listed above
Duration of approval:
oInitial authorization: 56 days
Prescriber Specialty: Prescribed by, or in consultation with, an ophthalmologist
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oAttestation that the patient or caregiver has been counseled on proper administration technique
oDocumentation that the member has a diagnosis of stage 2 (recurrent/persistent epithelial defect) or stage 3 (corneal ulcer) neurotrophic keratitis in affected eye(s)
oDocumentation that the member has tried and failed at least two conventional non-surgical treatments

(e.g. preservative-free artificial tears, lubricant eye ointment, topical antibiotic eye drops, therapeutic contact lenses)
Quantity: 28 vials every 28 days for the treatment of one eye (additional quantities may be approved for the treatment of the second eye when appropriate). Total of 8 kits (1 kit = 7 multi-dose vials) per affected eye per lifetime.
Age: 2 years of age or older
Route of Administration: Topical eye drop

Effective 10/1/20

MEDICATION(S)
ADCIRCA, ADEMPAS, ALYQ, AMBRISENTAN, BOSENTAN, LETAIRIS, LIQREV, OPSUMIT, ORENITRAM ER, ORENITRAM MONTH 1 TITRATION KT, ORENITRAM MONTH 2 TITRATION KT, ORENITRAM MONTH 3 TITRATION KT, REVATIO 10 MG/ML ORAL SUSP, REVATIO 20 MG TABLET, SILDENAFIL 10 MG/ML ORAL SUSP, SILDENAFIL 20 MG TABLET, TADALAFIL 20 MG TABLET, TADLIQ, TRACLEER, TYVASO, TYVASO DPI, TYVASO INSTITUTIONAL START KIT, TYVASO REFILL KIT, TYVASO STARTER KIT, UPTRAVI 1,000 MCG TABLET, UPTRAVI 1,200 MCG TABLET, UPTRAVI 1,400 MCG TABLET, UPTRAVI 1,600 MCG TABLET, UPTRAVI 200 MCG TABLET, UPTRAVI 200-800 TITRATION PACK, UPTRAVI 400 MCG TABLET, UPTRAVI 600 MCG TABLET, UPTRAVI 800 MCG TABLET, VENTAVIS

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
PULMONARY ARTERIAL HYPERTENSION (PAH) AGENTS
Drug Class: Pulmonary Arterial Hypertension (PAH) Agents

Preferred Agents: Prior Authorization Criteria below
Adempas
Alyq®
ambrisentan (generic for Letairis)
Opsumit®

sildenafil suspension (generic for Revatio)
sildenafil tablets (generic for Revatio®)
tadalafil (generic for Adcirca)
Tracleer® tablets
Tyvaso®, Tyvaso DPI®
Uptravi®
Ventavis®

Clinical PA Criteria:
Diagnosis of pulmonary hypertension
Must be prescribed by or in consultation with a cardiologist or pulmonologist

Non-Preferred Agents: Prior Authorization Criteria below
Adcirca®
bosentan tablets (generic for Tracleer)
Letairis®
Liqrev
Orenitram ER®
Revatio suspension
Revatio® tablets
Tadliq
Tracleer® suspension
Tyvaso DPI

Non-Preferred Agent PA Criteria:
Diagnosis of pulmonary hypertension AND
Must be prescribed by or in consultation with a cardiologist or pulmonologist AND
Allergy to the preferred medications OR
Contraindication or drug to drug interaction with the preferred medications OR
History of unacceptable side effects OR
Therapeutic failure with one-month trial of one preferred medication
See additional medication-specific criteria below

Tadliq (tadalavil)
patient is 18 years or older

Duration of Approval: 1 year

MEDICATION(S)
PALFORZIA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
PALFORZIA / PEANUT ALLERGEN POWDER-DNFP
Drug Class: Allergenic Extracts

FDA-approved uses: Mitigation of allergic reactions, including anaphylaxis, that may occur with accidental exposure to peanut

Available dosage forms: Powder for oral administration supplied in 0.5 mg 1 mg, 10 mg, 20 mg and 100 mg Capsules or 300 mg Sachets.

Coverage Criteria/Limitations for initial authorization:
Diagnoses: Peanut allergy
Duration of approval:
oInitial authorization: 1 year
oContinuation of Therapy: 1 year
Prescriber Specialty: Allergy or Immunology specialist
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oDocumented clinical history of allergy to peanuts or peanut-containing foods
oA confirmed peanut diagnosis based on one of the following:
Peanut skin prick test greater than 8mm
Serum IgE to peanut greater than or equal to 14 kUA/L
A reaction that required epinephrine or ED visit
oUsed in conjunction with a peanut-avoidant diet
oPatient has been prescribed and/or has a refill history of epinephrine auto-injector
oPrescriber, health care setting, pharmacy, patient must meet manufacturer's REMS requirements
Age: 4 years to 17 years of age
oPatients who start therapy prior to 18 years of age may continue therapy

Criteria for continuation of therapy:
Positive response to treatment as documented by at least ONE (1) of the following compared to pre-treatment:
oReduction in severe allergic reactions
oReduction in epinephrine use
oReduction in physician/clinic visits due to peanut allergy (physician office/ER visits/hospitalizations)
oImprovement in quality of life or productivity

Contraindications/Exclusions/Discontinuation:
•History of severe or life-threatening episode of anaphylaxis or anaphylactic shock within 60 days
•Uncontrolled asthma

Contraindications/Exclusions/Discontinuation: continued
•History of eosinophilic esophagitis (EoE), other eosinophilic gastrointestinal disease, chronic, recurrent, or severe gastroesophageal reflux disease (GERD), symptoms of dysphagia or recurrent gastrointestinal symptoms of undiagnosed etiology
•History of a mast cell disorder, including mastocytosis, urticarial pigmentosa, and hereditary or idiopathic angioedema
•History of cardiovascular disease, including uncontrolled or inadequately controlled hypertension

Effective 1/1/20

UPHP MEDICAID - PANCREATIC ENZYMES

MEDICATION(S)
PERTZYE, VIOKACE, ZENPEP DR 10,000 UNIT CAPSULE, ZENPEP DR 25,000 UNIT CAPSULE, ZENPEP DR 3,000 UNIT CAPSULE, ZENPEP DR 40,000 UNIT CAPSULE, ZENPEP DR 5,000 UNIT CAPSULE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
PANCREATIC ENZYMES
Drug Class: Pancreatic Enzymes

Preferred Agents: Clinical Prior Authorization below
Creon®
Zenpep®

Clinical PA Criteria:
CREON®, ZENPEP
Cystic fibrosis or chronic pancreatic insufficiency.

Non-Preferred Agents: Prior Authorization Criteria below
Pertzye®
Viokace®

Non-Preferred Agent PA Criteria:
Allergy to the preferred medications OR
Contraindication or drug to drug interaction with the preferred medications OR
History of unacceptable side effects OR
Therapeutic failure after one-month trial of one preferred agent
See additional medication-specific criteria below:
PERTYZE®, VIOKACE®
Must meet both PDL (trial on preferred medication) and clinical criteria

Duration of Approval: 1 year

Effective 10/1/20

MEDICATION(S)
PRALUENT PEN, REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
LIPOTROPICS: PCSK9 INHIBITORS
Drug Class: Lipotropics: PCSK9 Inhibitors
Preferred Agents: Clinical Prior Authorization below
Repatha®

REPATHA®
•Patient is at least 18 years old with a diagnosis of atherosclerotic cardiovascular disease (ASCVD) or heterozygous familial hypercholesterolemia (HeFH) as confirmed by genotyping or by clinical criteria ("definite FH" using either the Simon Broome or WHO/Dutch Lipid Network criteria), OR
•Patient is 13 years of age or older with a diagnosis of homozygous familial hypercholesterolemia (HoFH), AND
•Medication is requested by or in consultation with a specialist (including cardiologists, lipidologists and endocrinologists), AND
•Prior treatment history with highest available dose or maximally-tolerated dose of high intensity statin (atorvastatin or rosuvastatin) AND one other cholesterol lowering agent (such as an alternatively high-intensity statin or ezetimibe) for at least three continuous months (verified in pharmacy claims history) with

failure to reach target LDL-C (70 mg/dL for patients with clinical ASCVD and 100 mg/dL for patients with HeFH and no history of clinical ASCVD), AND
•If the patient is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms, documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the patient experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following:
oMuscle symptoms resolve after discontinuation of statin, AND
oMuscle symptoms occurred when rechallenged at a lower dose of the same statin, AND
oMuscle symptoms occurred after switching to an alternative statin, AND
oDocumentation ruling out non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease), OR
•The patient has been diagnosed with rhabdomyolysis associated with statin use [diagnosis should be supported by acute neuromuscular illness or dark urine AND an acute elevation in creatine kinase (usually greater than 5,000 IU/L or five times the upper limit of normal)]
•Length of Authorization: Initial – 3 months, Renewal – 12 months
•Renewal (may be requested by primary care physician): Lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating med AND continued adherence to maximally tolerated statin dose established prior to the original approval will be required
•Quantity Limit: 140 mg/mL pen/syringe – 2 pens/syringes per 28 days, 420 mg/3.5 mL Pushtronex® – 3.5 mL per 28 days

Non-Preferred Agents: Prior Authorization Criteria below
Praluent®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Patient is clinically stable, and switching would cause a deterioration in condition
•Therapeutic failure with one-month trial of one preferred medication

PRALUENT®
•Patient is at least 18 years old with a diagnosis of atherosclerotic cardiovascular disease (ASCVD) or heterozygous familial hypercholesterolemia (HeFH) as confirmed by genotyping or by clinical criteria (“definite FH” using either the Simon Broome or WHO/Dutch Lipid Network criteria), AND
•Medication is requested by or in consultation with a specialist (including cardiologists, lipidologists and endocrinologists), AND
•Prior treatment history with highest available dose or maximally-tolerated dose of high intensity statin (atorvastatin or rosuvastatin) AND one other cholesterol lowering agent (such as an alternatively high-

intensity statin or ezetimibe) for at least 3 continuous months (verified in pharmacy claims history) with failure to reach target LDL-C (70 mg/dL for patients with clinical ASCVD and 100 mg/dL for patients with HeFH and no history of clinical ASCVD), AND
•If the patient is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms, documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the patient experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following:
oMuscle symptoms resolve after discontinuation of statin, AND
oMuscle symptoms occurred when rechallenged at a lower dose of the same statin, AND
oMuscle symptoms occurred after switching to an alternative statin, AND
oDocumentation ruling out non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease), OR
•The patient has been diagnosed with rhabdomyolysis associated with statin use [diagnosis should be supported by acute neuromuscular illness or dark urine AND an acute elevation in creatine kinase (usually greater than 5,000 IU/L or five times the upper limit of normal)],
•Length of Authorization: Initial – 3 months, Renewal – 12 months
•Renewal (may be requested by primary care physician): Lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating med AND continued adherence to maximally tolerated statin dose established prior to the original approval will be required.
•Quantity Limit – 2 pens/syringes per 28 days

Duration of Approval: 1 year
Effective 10/1/20

MEDICATION(S)
DALIRESP, ROFLUMILAST

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
PHOSPODIESTERASE-4 (PDE-4) INHIBITORS
Drug Class: PHOSPODIESTERASE-4 (PDE-4) INHIBITORS

Preferred Agents:
Roflumilast (generic for Daliresp)

Roflumilast
severe COPD associated with chronic bronchitis and history of exacerbations AND
trial/failure of at least one first-line or second-line agent AND
adjunctive therapy (roflumilast must be used in conjunction with first-line or second-line agent)

Non-Preferred Agents: Prior Authorization Criteria below
Daliresp®
roflumilast

Non-Preferred Agent PA Criteria:

Allergy to the preferred medications OR
Contraindication or drug to drug interaction with preferred medications OR
History of unacceptable adverse effects OR
Therapeutic failure with one preferred medication
See addition medication specific criteria below

Daliresp® (roflumilast)
Severe COPD associated with chronic bronchitis and a history of exacerbations -AND-
Trial/failure on at least one first-line or second-line agent -AND-
Adjunctive therapy (Daliresp® must be used in conjunction with first-line or second-line agent)

Duration of Approval: 1 year
Effective 10/1/20

MEDICATION(S)
ASPIRIN-DIPYRIDAMOLE ER, DIPYRIDAMOLE 25 MG TABLET, DIPYRIDAMOLE 50 MG TABLET, DIPYRIDAMOLE 75 MG TABLET, EFFIENT, PLAVIX

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
PLATELET AGGREGATION INHIBITORS
Drug Class: PLATELET AGGREGATION INHIBITORS

Preferred Agents: No Prior Authorization required
Brilinta®
clopidogrel
prasugrel

Non-Preferred Agents: Prior Authorization Criteria below
aspirin/dipyridamole
dipyridamole
Effient®
Plavix®

Non-Preferred Agent PA Criteria:
Allergy to the preferred medications, OR
Contraindication or drug to drug interaction with the preferred medications, OR
History of unacceptable side effects, OR
Therapeutic failure with one-month trial of one preferred medication

See additional medication-specific criteria below:
EFFIENT®
Due to a black box warning related to increase in risk of bleeds in patients greater than 75
PDL criteria must be met and the MD will need to document medical necessity or clinical rationale for consideration.
ZONTIVITY®
Diagnosis of history of myocardial infarction (MI) or peripheral artery disease (PAD) without a history of stroke, transient ischemic attack (TIA), acute coronary syndrome (ACS), GI bleed or peptic ulcer AND
Concurrent use of aspirin and/or clopidogrel AND
Written by (or in collaboration with) a cardiologist or vascular surgeon

Duration of Approval: 1 year
Effective 10/1/20
Updated 9/1/22
Updated 1/25/22

MEDICATION(S)

ACIPHEX, DEXILANT, DEXLANSOPRAZOLE DR, CVS ESOMEPRAZOLE MAG 20 MG CAP, EQL ESOMEPRAZOLE MAG DR 20 MG, ESOMEPRAZOLE DR 10 MG PACKET, ESOMEPRAZOLE DR 20 MG PACKET, ESOMEPRAZOLE DR 40 MG PACKET, ESOMEPRAZOLE MAG DR 20 MG CAP, ESOMEPRAZOLE MAG DR 40 MG CAP, GNP ESOMEPRAZOLE MAG DR 20 MG, GS ESOMEPRAZOLE MAG DR 20 MG, HM ESOMEPRAZOLE MAG DR 20 MG, QC ESOMEPRAZOLE MAG DR 20 MG, RA ESOMEPRAZOLE MAG DR 20 MG, SM ESOMEPRAZOLE MAG DR 20 MG, KONVOMEP, LANSOPRAZOLE DR 15 MG CAPSULE, LANSOPRAZOLE DR 30 MG CAPSULE, NEXIUM DR 20 MG CAPSULE, NEXIUM DR 40 MG CAPSULE, CVS OMEPRAZOLE DR 20 MG ODT, CVS OMEPRAZOLE DR 20 MG TABLET, EQ OMEPRAZOLE DR 20 MG ODT, EQ OMEPRAZOLE DR 20 MG TABLET, EQL OMEPRAZOLE DR 20 MG ODT, EQL OMEPRAZOLE DR 20 MG TABLET, FT OMEPRAZOLE DR 20 MG TABLET, GNP OMEPRAZOLE DR 20 MG TABLET, GS OMEPRAZOLE DR 20 MG ODT, GS OMEPRAZOLE DR 20 MG TABLET, HM OMEPRAZOLE DR 20 MG TABLET, KRO OMEPRAZOLE DR 20 MG TABLET, OMEPRAZOLE DR 20 MG ODT, OMEPRAZOLE DR 20 MG TABLET, PUB OMEPRAZOLE DR 20 MG TABLET, RA OMEPRAZOLE DR 20 MG TABLET, SM OMEPRAZOLE DR 20 MG TABLET, SW OMEPRAZOLE DR 20 MG TABLET, CVS OMEPRAZOLE MAG DR 20 MG CP, EQ OMEPRAZOLE MAG DR 20.6 MG, GNP OMEPRAZOLE MAG DR 20 MG CP, OMEPRAZOLE MAG DR 20 MG CAP, OMEPRAZOLE MAG DR 20.6 MG CAP, QC OMEPRAZOLE MAG DR 20.6 MG, OMEPRAZOLE-BICARB 20-1,100 CAP, OMEPRAZOLE-BICARB 20-1,680 PKT, OMEPRAZOLE-BICARB 40-1,100 CAP, OMEPRAZOLE-BICARB 40-1,680 PKT, PREVACID DR 30 MG CAPSULE, PRILOSEC, RABEPRAZOLE SOD DR 20 MG TAB, ZEGERID

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

PROTON PUMP INHIBITORS

Drug Class: PROTON PUMP INHIBITORS

Preferred Agents: No Prior Authorization required

Nexium susp pkts

omeprazole (Rx) capsules

pantoprazole tablets

Protonix® tablets, suspension

Non-Preferred Agents: Prior Authorization Criteria below

Aciphex® tabs

Dexilant® caps

dexlansoprazole caps

esomeprazole magnesium capsules, susp pkts

esomeprazole magnesium OTC caps, tabs

Konvomep

lansoprazole caps, ODT

Nexium® capsules

omeprazole OTC caps, tabs, ODT

omeprazole/sodium bicarbonate caps, susp pkts

pantoprazole suspension

Prevacid caps, solutabs

Prilosec® susp

Rabeprazole tabs

Zegerid® caps, susp pkts

Non-Preferred Agent PA Criteria:

•Allergy to the preferred medications, OR

•Contraindication or drug to drug interaction with the preferred medications, OR

•History of unacceptable side effects, OR

•Therapeutic failure after one-month trial with one preferred medication.

Duration of Approval: 1 year

Effective 10/1/20

Update 1/13/22

Update 9/1/22

Update 11/1/22

MEDICATION(S)
PRETOMANID

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
PRETOMANID (FOR CONCURRENT USE WITH BEDAQUILINE & LINEZOLID)
Drug Class: Nitroimidazole Antibiotic

FDA-approved uses: Pretomanid is indicated as part of a combination regimen with bedaquiline and linezolid, for the treatment of adults with pulmonary extensively drug resistant (XDR) treatment-intolerant, or nonresponsive multidrug=resistant (NDR) tuberculosis (TB).
Available dosage forms: 200mg oral tablets, taken with food.

Coverage Criteria/Limitations for initial authorization:
Diagnoses: Pulmonary extensively drug resistant (XDR) or treatment intolerant or nonresponsive multidrug-resistant (MDR) tuberculosis (TB)
Prescriber Specialty: Prescribed by or in consultation with an infectious disesase specialist or pulmonologist.
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
o Diagnosis of pulmonary extensively drug resistant (XDR) or treatment-intolerant or nonresponsive multidrug-resistant (MDR) tuberculosis (TB), AND

o Patient is concomitantly taking bedaquiline (Sirturo) and linezolid (Zyvox) as part of the recommended dosing regimen and use of bedaquiline and linezolid are not contraindicated in patient

Duration of approval: 6 months

UPHP MEDICAID - PROGESTATIONAL AGENTS

MEDICATION(S)
AYGESTIN, CRINONE, PROGESTERONE 500 MG/10 ML VIAL, PROMETRIUM, PROVERA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
PROGESTATIONAL AGENTS
Drug Class: Progestational Agents

Preferred Agents:
medroxyprogesterone (oral)
progesterone (oral)
norethindrone (oral)

Non-Preferred Agents: Prior Authorization Criteria below
Aygestin® (oral)
Crinone® (vaginal)
progesterone (intramuscular)
Prometrium® (oral)
Provera® (oral)

Preferred Agent Criteria
•Confirmation of diagnosis
•See additional medication-specific criteria below:

Non-Preferred Agent PA Criteria:
• Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Therapeutic failure with a one-month trial of a preferred medication for the indication
•See additional medication-specific criteria below:

CRINONE® (PROGESTERONE VAGINAL)
•Excluded for diagnosis of fertility

Duration of Approval: 1 year
Effective 10/1/20
Updated 1/1/22
Updated 6/8/22
Updated 8/1/22
Updated 8/15/22

UPHP MEDICAID - PROGESTINS FOR CACHEXIA

MEDICATION(S)
MEGESTROL 625 MG/5 ML SUSP

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
PROGESTINS FOR CACHEXIA
Drug Class: Progestins for Cachexia

Preferred Agents: No Prior Authorization required
megestrol oral suspension (generic Megace)

Non-Preferred Agents: Prior Authorization Criteria below
megestrol oral suspension (generic Megace ES®)

Non-Preferred Agent PA Criteria:
Allergy to the preferred medications OR
Contraindication or drug to drug interaction with the preferred medications OR
History of unacceptable side effects OR
Therapeutic failure after one-month trial of one preferred medication

Duration of Approval: 1 year

Effective 10/1/20
Updated 8/15/22

MEDICATION(S)
PULMOZYME

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
PULMOZYME® / DORNASE ALPHA
Drug Class: Mucolytics
FDA-approved uses:
In conjunction with standard therapies for the management of cystic fibrosis (CF) patients to improve pulmonary function.
To reduce the risk of respiratory tract infections requiring parenteral antibiotics in CF patients with an FVC ? 40% of predicted.

Available dosage forms: 2.5 mg/2.5 mL in single-use ampules

Coverage Criteria/Limitations for initial authorization:
Diagnoses: cystic fibrosis
Duration of Approval:
oInitial Authorization: 1 year
oContinuation of Therapy: 1 year
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oMedical records to support a diagnosis of CF
Prescriber Specialty:
oPulmonologist
oInfectious disease
Quantity: 30 ampules per 30 days
Age: at least 5 years of age
Gender: male or female
Route of Administration: inhalation
Place of Service: outpatient

Criteria for continuation of therapy:
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oFVC
oMedical records showing stable disease
oMedical records supporting decreased incidence of respiratory infections

Contraindications/Exclusions/Discontinuation:
•Pulmozyme® (dornase alpha) is not authorized for non-FDA-approved indication
•Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:
•Per FDA-approved label: Pulmozyme® (dornase alpha) was studied in patients 3 months to 5 years of age, while clinical trial data are limited in patients less than 5 years, the use of Pulmozyme® (dornase alpha) should be considered for pediatric patients with CF who may experience potential benefit in pulmonary function or who may be at risk of respiratory tract infection.

Effective 10/1/20

MEDICATION(S)
BAXDELA 450 MG TABLET, CIPRO 250 MG TABLET, CIPRO 500 MG TABLET, MOXIFLOXACIN HCL 400 MG TABLET, OFLOXACIN 300 MG TABLET, OFLOXACIN 400 MG TABLET

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
QUINOLONES
Drug Class: QUINOLONES

Preferred Agents: No Prior Authorization required
Cipro suspension, ciprofloxacin tablets, suspension
levofloxacin

Non-Preferred Agents: Prior Authorization Criteria below
Avelox®
Baxdela®
Cipro® tablets
moxifloxacin
ofloxacin

Non-Preferred Agent PA Criteria:

•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Infection is caused by an organism that is resistant to the NO PA REQUIRED quinolone medications
•Trial/failure (duration = 3 days) of any two preferred quinolone medications
•Antibiotic therapy initiated in hospital

Quantity Limitations:
Cipro® tabs (ciprofloxacin)42 per fill
ciprofloxacin (Cipro®)42 per fill
ciprofloxacin XR (Cipro XR®)14 per fill
levofloxacin tabs (Levaquin®)500mg - 14 per fill
750mg - 28 per fill
moxifloxacin (Avelox®)14 per fill

Duration of Approval: Date of service, if needed, longer lengths may be approved for transplant recipients
Effective 10/1/20
Updated 3/11/22

UPHP MEDICAID - RANEXA/RANOLAZINE

MEDICATION(S)
RANOLAZINE ER

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
RANEXA® / RANOLAZINE
Drug Class: Antianginal and Anti-ischemic Agents, Non-hemodynamic

FDA-approved uses: treatment of chronic angina
Available dosage forms: 500 mg and 1000 mg extended release tablets

Coverage Criteria/Limitations for initial authorization:
Diagnoses: chronic stable angina
Duration of Approval:
oInitial Authorization: 6 months
oContinuation of Therapy: 12 months
Prescriber Specialty: prescribed by, or in conjunction with, a cardiologist
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oCurrent progress notes supporting past medication usage, including at least 1 formulary anti-anginal agent from ALL 3 different drug classes:
Beta Blocker: acebutolol, atenolol, carvedilol, metoprolol, nadolol, propranolol

Calcium Channel Blocker: amlodipine, diltiazem, felodipine, isradipine, nifedipine, nicardipine, verapamil
Long Acting Nitrate: isosorbide dinitrate, isosorbide mononitrate, nitroglycerin patch
oLabs and medical records supporting indicated diagnosis of chronic angina
oMedical record detailing that Ranexa will be used in addition (add-on) to another anti-anginal medication (i.e., beta-blocker, calcium channel blocker, long-acting nitrate) or patient has contraindications to beta-blockers, calcium channel blockers AND long-acting nitrates
Quantity: 60 tablets every 30 days (500 mg PO BID initially, may increase to 1,000 mg PO BID)
Age: 18 years of age or older
Gender: male or female
Route of Administration: oral
Place of Service: outpatient

Criteria for continuation of therapy:
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oCurrent medical records and labs to determine safety and efficacy of treatment

Contraindications/Exclusions/Discontinuation:
Hepatic impairment (Child-Pugh Classes A and B)
Combined administration with other drugs that are strong inhibitors of CYP3A including ketoconazole, itraconazole, clarithromycin, nefazodone, nelfinavir, ritonavir, indinavir, and saquinavir
Combined administration with other drugs that are inducers of CYP3A including rifampin, rifabutin, phenobarbitol, phenytoin, carbamazepine, and St. John’s wort
Moderate to severe renal impairment CrCl less than 60mL/min

Other special considerations:
Not for initial therapy because it can increase QT interval

Effective 10/1/20

MEDICATION(S)
RELYVRIO

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
RELYVRIO/ SODIUM PHENYLBUTYRATE AND TAURURSODIOL

Drug Class: ALS Agent- Histone deacetylase inhibitor

FDA-approved uses treatment of amyotrophic lateral sclerosis (ALS)

Available dosage forms: Sodium phenylbutyrate 3g/ taurursodiol 1 g packet

Coverage Criteria/Limitations for initial authorization:
?Diagnoses: ALS
?Duration of approval:
oInitial authorization: 1 year
oContinuation of Therapy: 1 year
?Prescriber Specialty: Prescribed by or in consultation with a neurologist
?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oDiagnosis of ALS as determined by revised El Escorial criteria

oInitiation of drug is within 18 months of symptom onset
oSlow vital capacity (SVC) exceeding 60% of the predicted
oCurrent use or has failed previous treatment with riluzole
?Age: 18 years old and older
?QL: 60 packets per 30 days

Criteria for continuation of therapy:
?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oProvider attestation of positive clinical response
oMedication is prescribed at an FDA approved dose

MEDICATION(S)
ALBUTEROL SULFATE HFA, LEVALBUTEROL CONCENTRATE, LEVALBUTEROL HCL, LEVALBUTEROL TARTRATE HFA, PROAIR DIGIHALER, PROAIR RESPICLICK, XOPENEX HFA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
BETA ADRENERGICS – SHORT ACTING
Drug Class: Beta Adrenergics – Short Acting

Preferred Agents: No Prior Authorization required
Albuterol sulfate nebulizer solution
ProAir HFA® (MDI)
Proventil HFA® (MDI)
Ventolin HFA® (MDI)
Xopenex HFA (MDI)

Non-Preferred Agents: Prior Authorization Criteria below
albuterol HFA (MDI)
levalbuterol HFA (MDI)
levalbuterol nebulizer solution
ProAir Digihaler® (DPI)

ProAir Respiclick® (DPI)

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•Therapeutic failure after a two-week trial with one preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 8/1/21

MEDICATION(S)
OCTREOTIDE 1,000 MCG/5 ML VIAL, OCTREOTIDE 1,000 MCG/ML VIAL, OCTREOTIDE 5,000 MCG/5 ML VIAL, OCTREOTIDE ACET 0.05 MG/ML VL, OCTREOTIDE ACET 100 MCG/ML AMP, OCTREOTIDE ACET 100 MCG/ML VL, OCTREOTIDE ACET 200 MCG/ML VL, OCTREOTIDE ACET 50 MCG/ML AMP, OCTREOTIDE ACET 50 MCG/ML VIAL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
SANDOSTATIN® / OCTREOTIDE
Administration Disclaimer: The following criteria set is for the retail pharmacy benefit. This criteria set DOES NOT apply for administration as a medical benefit (“buy and bill”).
Drug Class: Somatostatic Agents
FDA-approved uses:
Acromegaly
Octreotide Acetate Injection is indicated to reduce blood levels of growth hormone and IGF-I (somatomedin C) in acromegaly patients who have had inadequate response to or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine mesylate at maximally tolerated doses.
Carcinoid Tumors
Octreotide Acetate Injection is indicated for the symptomatic treatment of patients with metastatic carcinoid tumors where it suppresses or inhibits the severe diarrhea and flushing episodes associated with the disease.

Vasoactive Intestinal Peptide Tumors (VIPomas)
Octreotide Acetate Injection is indicated for the treatment of the profuse watery diarrhea associated with VIP-secreting tumors.
Available dosage forms: Vial 50 mcg/mL, 100 mcg/mL, 200 mcg/mL, 1000 mcg/mL

Coverage Criteria/Limitations for initial authorization:
Diagnoses:
oAcromegaly
oMetastatic VIP
oChemo/radiation
oHIV/AIDS-induced diarrhea
oMetastatic carcinoid tumors
oCarcinoid tumors
Duration of Approval:
oInitial Authorization: 6 months
oContinuation of Therapy: 1 year
Prescriber Specialty: Prescribed by, or in consultation with, an endocrinologist
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oDiagnosis confirmed
oPrescribed by, or in consultation with, an endocrinologist
Age: 18 years of age or older
Route of Administration: Subcutaneous, intramuscular injection

Criteria for continuation of therapy:
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oThe above criteria has been met
oRequires decreased or normalized IGF-1 levels

Effective 10/1/20

MEDICATION(S)
CINACALCET HCL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
SENSIPAR® / CINACALCET
Drug Class: Calcimimetic, Parathyroid Calcium Receptor Sensitivity Enhancer

FDA-approved uses:
Hyperparathyroidism, primary: Treatment of severe hypercalcemia in adult patients with primary hyperparathyroidism for who parathyroidectomy would be indicated on the bases of serum calcium levels, but who are unable to undergo parathyroidectomy.
Hyperparathyroidism, secondary: Treatment of secondary hyperparathyroidism in adult patients with chronic kidney disease (CKD) on dialysis.
Limitation of use: Not indicated for use in patients with CKD who are not on dialysis
(due to increased risk of hypocalcemia)
Parathyroid carcinoma: Treatment of hypercalcemia in adult patients with parathyroid carcinoma.

Available dosage forms: Tablet 30 mg, 60 mg, 90 mg

Coverage Criteria/Limitations for initial authorization:

Diagnoses: FDA Approved Indication as listed above
Duration of Approval:
o Initial Approval: 6 months
o Continuation of Therapy: 12 months
Prescriber Specialty: Nephrologist, Endocrinologist or Oncologist prescriber in consultation with specialist
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
o For Secondary hyperparathyroidism due to CKD on dialysis:
•Patient is at least 18 years of age, AND
•Trial, failure, or intolerance to an approved formulary phosphate binder trial AND
Trial, failure, or intolerance to calcitriol or Vitamin D analogs for a minimum of a three month trial

o Labs:
iPTH, calcium, renal function, serum phosphorus. iPTH levels must be greater than 300 (biPTH greater than 160) and Ca greater than 8.4 in order to initiate therapy.

o For Parathyroid carcinoma (PC):
•Patient is at least 18 years of age, AND
o Labs:
Confirmation the patient has hypercalcemia as defined by baseline serum calcium (Ca) greater than 10mg/dL (corrected for albumin),

For Primary hyperparathyroidism:
•Patient is at least 18 years of age, AND
•Confirmatiiton the patathyroidectomy is indicated by patient is unable to undergo parathyroidectomy
o Labs:
Severe hypercalcemia as defined by baseline (pre-treatment) serum calcium (Ca) greater than 12 mg/dL (corrected for albumin)

Criteria for continuation of therapy:
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
Absence of unacceptable toxicity from the drug (e.g., hypocalcemia, seizures, hypotension, worsening heart failure,
arrhythmia, adynamic bone disease), AND

Secondary Hyperparathyroidism (HPT)
•Adequate documentation of disease response as indicated by improvement of intact parathyroid hormone (iPTH) levels from baseline, AND
•Current intact parathyroid hormone (iPTH) greater than 150 pg/ml, AND
•Current serum calcium (Ca) greater than 7.5 mg/dL and the patient does not have symptoms of hypocalcemia

Parathyroid Carcinoma (PC)
•Adequate documentation of disease response as indicated by improvement of serum calcium (Ca) from baseline, AND
•Current serum calcium (Ca) greater than 8.4 mg/dL
Primary Hyperparathyroidism (HPT)
•Adequate documentation of disease response as indicated by improvement of serum calcium (Ca) from baseline, AND
•Current serum calcium (Ca) greater than 8.4 mg/dL

Contraindications/Exclusions/Discontinuation:
- Hypersensitivity to any components of Sensipar
- Hypocalcemia

•In addition, drug therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Effective 10/1/20
Updated 5/1/21

MEDICATION(S)
SIRTURO

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
Drug Name: Sirutro (bedaquiline)
Drug Class Antitubercular - Diarylquinoline Antibiotics
FDA-approved uses: Multi-drug resistant tuberculosis (MDR-TB)

Available dosage forms: Tablets: 20mg, 100mg

Coverage Criteria/Limitations for initial authorization:
?Diagnoses: Multi-drug resistant tuberculosis (MDR-TB)
?Duration of approval:
oInitial authorization: 6 months
?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oPatient must be under observed therapy

MEDICATION(S)
AMRIX, BACLOFEN 5 MG/5 ML SOLUTION, CHLORZOXAZONE, CYCLOBENZAPRINE HCL ER, DANTRIUM 25 MG CAPSULE, DANTROLENE SODIUM 100 MG CAP, DANTROLENE SODIUM 25 MG CAP, DANTROLENE SODIUM 50 MG CAP, FEXMID, FLEQSUVY, LORZONE, LYVISPAH, METAXALONE, NORGESIC FORTE, ORPHENADRN-ASA-CAF 25-385-30MG, SKELAXIN, TIZANIDINE HCL 2 MG CAPSULE, TIZANIDINE HCL 4 MG CAPSULE, TIZANIDINE HCL 6 MG CAPSULE, ZANAFLEX

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
SKELETAL MUSCLE RELAXANTS
Drug Class: SKELETAL MUSCLE RELAXANTS

Preferred Agents: No Prior Authorization required (except baclofen solution)
baclofen tablets, solution
cyclobenzaprine
methocarbamol
orphenadrine citrate
tizanidine tablets

BACLOFEN ORAL SOLUTION
Allow if patient has swallowing difficulties

Non-Preferred Agents: Prior Authorization Criteria below
Amrix®
baclofen suspension (generic Fleqsuvy)
chlorzoxazone
cyclobenzaprine ER
Dantrium®
dantrolene sodium
Fexmid®
Fleqsuvy®
Lorzone®
Lyvispah
metaxalone
Norgesic Forte®
orphenadrine-aspirin-caffeine
Robaxin®
tizanidine capsules
Zanaflex® capsules and tablets

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•Therapeutic failure with two preferred medications
•Non-preferred criteria does not apply to dantrolene if diagnosis is cerebral palsy
•See additional medication-specific criteria below

FLEQSUVY ORAL SOLUTION (BACLOFEN)
•Bypass PDL criteria if the patient has difficulty swallowing.
•Trial and failure with preferred oral solution

LYVISPAH ORAL SOLUTION (BACLOFEN) (PDL criteria do not apply)
•Trial and failure with preferred oral solution

Duration of Approval: 1 year

Effective 10/1/20
Updated 5/1/22
Updated 11/1/22

UPHP MEDICAID - SORIATANE/ACITRETIN

MEDICATION(S)
ACITRETIN

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
SORIATANE® / ACITRETIN

Drug Class: Dermatological - Antipsoriatic Agents Systemic, Vitamin A Derivatives
FDA-approved uses: Severe Psoriasis
Available dosage forms: Capsules 10 mg, 17.5 mg, 25 mg
Coverage Criteria/Limitations for initial authorization:
Diagnoses: Moderate to Severe Psoriasis
Duration of Approval:
oInitial Authorization: 3 months
oContinuation of Therapy: 1 year
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
o90 day trial of methotrexate AND
o90 day trial of high dose topical steroid (e.g. betamethasone augmented, clobetasol, halobetasol)
Prescriber Specialty: Dermatology
Quantity: Max 2 capsules per day
Route of Administration: Oral

Criteria for continuation of therapy
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oRequires a positive response to therapy

Contraindications/Exclusions/Discontinuation:
•Soriatane must not be used by females who are pregnant, or who intend to become pregnant during therapy or at any time for at least 3 years following discontinuation of therapy.
•Soriatane is contraindicated in patients with impaired liver or kidney function and in patients with chronic abnormally elevated blood lipid values.
•Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:
•Pregnancy Category X.
•Soriatane should not be taken with methotrexate or tetracyclines.
•Soriatane should not be used in patients with known alcohol abuse.

Effective 10/1/20

MEDICATION(S)
SYNAGIS

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
SYNAGIS® / PALIVIZUMAB
Administration Disclaimer: The following criteria set is for the retail pharmacy benefit. This criteria set DOES NOT apply for administration as a medical benefit (“buy and bill”).
Drug Class: Immunological Agent/Monoclonal Antibody

FDA-approved uses: Prevention of RSV for children less than 2yo at high risk of RSV disease
Respiratory syncytial virus (RSV) prophylaxis with palivizumab (Synagis®) may be considered medically necessary in the following infants and children to a maximum of five monthly doses per RSV season:

Prematurity:
oInfants who are younger than 12 months of age at the start of RSV season and are born before 29 weeks 0 days gestation.
Chronic Lung Disease (CLD):
oPreterm infants younger than 12 months of age who develop CLD of prematurity (defined as gestational age less than 32 weeks, 0 days) and required greater than 21% oxygen for at least the first 28 days after birth.

oInfants between 12 and 24 months of age who developed CLD of prematurity as defined above and who continue to require medical support (chronic corticosteroid therapy, diuretic therapy, supplemental oxygen or bronchodilator therapy) within 6 months of the start of RSV season.
Heart Disease:
oInfants who are 12 months of age or younger with hemodynamically significant Congenital Heart Disease (CHD). Those children with CHD who are most likely to benefit from immunoprophylaxis include those with:
acyanotic heart disease who are receiving medication to control congestive heart failure (documentation required) and will require cardiac surgical procedures or
moderate to severe pulmonary hypertension, or
cyanotic heart disease (if recommended by a pediatric cardiologist).
oAdditionally, children younger than 24 months who undergo cardiac transplantation during the RSV season may be considered for prophylaxis.
Immune prophylaxis for RSV is considered not medically necessary for
oInfants and children with hemodynamically insignificant heart disease including but not limited to:
secundum atrial septal defect,
small ventricular septal defect,
pulmonic stenosis,
uncomplicated aortic stenosis,
mild coarctation of the aorta,
patent ductus arteriosus
Lesions adequately corrected by surgery unless they continue to require medication for congestive heart failure.
Infants with mild cardiomyopathy who are not receiving medical therapy for the condition.
Note: Because a mean decrease in palivizumab serum concentration of 58% was observed after surgical procedures that involve cardiopulmonary bypass, for children who are receiving prophylaxis and who continue to require prophylaxis after a surgical procedure, a post-operative dose of palivizumab (15mg/kg) should be considered after cardiac bypass or at the conclusion of extra-coporeal membrane oxygenation for infants and children younger than 24 months.

Neuromuscular disease, congenital airway anomaly or pulmonary abnormality
oInfants under 12 months of age with neuromuscular disease, congenital anomalies of the airway or pulmonary abnormalities that impair the ability to clear secretions from the upper airway because of ineffective cough.
Immunocompromised
oInfants and children, who are 24 months of age or younger, who are profoundly immunocompromised because of chemotherapy or other conditions during the RSV season.

Available dosage forms: Solution: 50 mg/0.5 ml vial, 100 mg/ml vial for IM injection

Coverage Criteria/Limitations for initial authorization:

Diagnoses: Medically necessary FDA-approved uses as listed above
Duration of Approval
oInitial Approval: Maximum of 5 doses per RSV season. Typically RSV season is October 1- May 1. This must be confirmed on an annual basis.
oContinuation of Therapy: Considered in a case by case basis by each plan.
If any infant or young child receiving monthly Synagis prophylaxis experiences a breakthrough RSV hospitalization, monthly prophylaxis should be discontinued because of the extremely low likelihood of a second RSV hospitalization in the same season (less than 0.5%).

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
o Children who have not had a dose of Beyfortus (niresevimab) in the current RSV season AND
o Mother did not received vaccination against RSV in teh 2nd or 3rd trimester AND
o Infants who are younger than 12 months of age at the start of the Synagis season and who are born before 29 weeks, 0 days' gestation.
oInfants in the first 12 months of life, who are diagnosed with CLD (chronic lung disease) of prematurity defined as birth at less than 32 weeks, 0 days' gestation and a requirement for greater than 21% oxygen for at least 28 days after birth.
oInfants in the second year of life who are diagnosed with CLD (as per above criteria) AND who continue to require medical intervention (supplemental oxygen, chronic corticosteroid, or diuretic therapy) within the 6-month period before the start of the second RSV season.
oChildren who are 12 months or younger with hemodynamically significant CHD as evidenced by: acyanotic heart disease and are receiving medication to control congestive heart failure, and will require cardiac surgical procedures
Documentation Requirements continued (e.g. Labs, Medical Record, Special Studies):
oInfants with moderate to severe pulmonary hypertension. Children with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airways may be considered for prophylaxis in the first year of life.
oChild younger than 24 months who will be profoundly immunocompromised during the RSV season.
Quantity:
oThe recommended dose of Synagis is 15mg/kg body weight administered intramuscularly. Because 5 monthly doses of palivizumab at 15 mg/kg per dose will provide more than 6 months (greater than 24 weeks) of serum palivizumab concentrations above the desired level for most children. For qualifying infants up to 5 doses per RSV season must be allowed. Qualifying infants born during the RSV season may require fewer doses.
Age: 24 months and younger, See criteria for authorization for age specific indications.
Route of Administration: Intramuscular

Criteria for continuation of therapy:
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oRequests for coverage outside of RSV season will require authorization.

Contraindications/Exclusions/Discontinuation:
•History of severe prior reaction to palivizumab or any component of the formulation.
•In addition, drug therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:
•Routine use in cystic fibrosis and Down Syndrome is not recommended.
•The clinical reviewer, in his or her professional judgment, will override criteria when the requested item is medically necessary. In addition, because there is no definite evidence for the treatment of patients undergoing stem cell transplant or infants and children with Cystic Fibrosis, the approval of Synagis for these patients will be done on a case by case basis by the clinical reviewer.

References
The American Academy has issued updated guidance for the 2021-2022 season.
Updated Guidance: Use of Palivizumab Prophylaxis to Prevent Hospitalization From Severe Respiratory Syncytial Virus Infection During the 2021-2022 RSV Season (aap.org)

To see RSV virology trends by state/region, please click the link below:
https://www.cdc.gov/surveillance/nrevss/rsv/state.html

Effective 10/1/20
Updated 1/3/22

UPHP MEDICAID - TOPICAL ANTIBIOTICS

MEDICATION(S)
CENTANY, CENTANY AT, MUPIROCIN 2% CREAM, XEPI

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
TOPICAL ANTIBIOTICS
Drug Class: Topical Antibiotics

Preferred Agents: No Prior Authorization required
mupiricin ointment

Non-Preferred Agents: Prior Authorization Criteria below
Centany®
mupiricin cream
Xepi Cream

Non-Preferred Agent PA Criteria:
Allergy to the preferred medications
Contraindication or drug to drug interaction with the preferred medications
History of unacceptable side effects
Therapeutic failure after one month with one preferred medication

See additional medication-specific criteria below:

XEPI® CREAM (OZENOXACIN)
•Quantity Limit = 2 tubes per month
•Length of authorization – 1 month

Duration of Approval: 1 year
Effective 10/1/20

MEDICATION(S)
BUTENAFINE HCL 1% CREAM, CICLODAN, CICLOPIROX 0.77% GEL, CICLOPIROX 0.77% TOPICAL SUSP, CICLOPIROX 1% SHAMPOO, CICLOPIROX 8% TREATMENT KIT, CLOTRIMAZOLE-BETAMETHASONE LOT, ECONAZOLE NITRATE 1% CREAM, ERTACZO, EXTINA, JUBLIA, KERYDIN, KETOCONAZOLE 2% FOAM, KETODAN, LOPROX, LOTRIMIN AF 1% CREAM, LULICONAZOLE, LUZU, MENTAX, MICONAZOLE-ZINC OXIDE-PETROLTM, MYCOZYL AC, NAFTIFINE HCL 1% CREAM, NAFTIFINE HCL 2% CREAM, NAFTIN, OXISTAT, TAVABOROLE, VUSION

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTIFUNGALS – TOPICAL
Drug Class: Antifungals – Topical

Preferred Agents: No Prior Authorization required
ciclopirox 8% soln (generic Ciclodan)
ciclopirox 0.77% cream (generic for Loprox and Ciclodan)
clotrimazole OTC cream, solution
clotrimazole Rx cream
clotrimazole/betamethasone cream
ketoconazole
miconazole nitrate

nystatin
nystatin/triamcinolone cream, ointment
tolnaftate cream, powder

Non-Preferred Agents: Prior Authorization Criteria below
butenafine
Ciclodan®
ciclopirox suspension (generic for Loprox)
ciclopirox gel, shampoo, kit
clotrimazole / betamethasone lotion
econazole nitrate
Ertaczo®
Extina®
Fungoid-D®
Jublia ®
Kerydin®
ketoconazole foam
Ketodan®
Loprox®
Lotrimin AF®
luliconazole
Luzu®
Mentax®
miconazole/zinc oxide/petrolatum
Mycozyl AC
Naftin®
naftifine
Oxistat®
tavaborole
Vusion®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•Trial and failure with two weeks with two preferred medications OR
•Organism resistant to the preferred medications OR
•See additional medication-specific criteria below:

JUBLIA®(efinaconazole)
•Diagnosis of toenail onychomycosis, and patient age 6 years or older, and trial and failure on ciclopirox or allergy to ciclopirox
KERYDIN®(tavaborole)
•Diagnosis of toenail onychomycosis, and patient must be 6 years or older, and documented trial and failure on ciclopirox or allergy to ciclopirox (applies to brand and generic)

Duration of Approval: For the duration of the prescription up to 6 months
Effective 10/1/20
Updated 8/1/21
Updated 5/1/22

UPHP MEDICAID - TOPICAL ANTIVIRALS

MEDICATION(S)
ACYCLOVIR 5% CREAM, PENCICLOVIR 1% CREAM, XERESE, ZOVIRAX 5% OINTMENT

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTIVIRALS – TOPICAL
Drug Class: Antivirals – Topical

Preferred Agents: No Prior Authorization required
acyclovir ointment
Denavir®
Zovirax® cream

Non-Preferred Agents: Prior Authorization Criteria below
acyclovir cream
penciclovir (generic for Denavir)
Xerese® cream
Zovirax® ointment

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications -OR-

•Contraindication or drug to drug interaction with the preferred medications -OR-
•History of unacceptable side effects -OR-
•Therapeutic failure with a one-month trial with one preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 8/1/21
Updated 6/1/22

UPHP MEDICAID - TOPICAL STEROIDS - HIGH POTENCY

MEDICATION(S)
AMCINONIDE 0.1% CREAM, BETAMETHASONE DIPROP AUGMENTED, DESOXIMETASONE 0.05% CREAM, DESOXIMETASONE 0.05% GEL, DESOXIMETASONE 0.05% OINTMENT, DESOXIMETASONE 0.25% CREAM, DESOXIMETASONE 0.25% OINTMENT, DESOXIMETASONE 0.25% SPRAY, DIFLORASONE DIACETATE, DIPROLENE, FLUOCINONIDE, FLUOCINONIDE-E, HALCINONIDE, HALOG 0.1% CREAM, HALOG 0.1% OINTMENT, KENALOG, SERNIVO, TOPICORT, TRIAMCINOLONE 0.147 MG/G SPRAY, TRIANEX, VANOS

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
TOPICAL STEROIDS – HIGH POTENCY
Drug Class: TOPICAL STEROIDS – HIGH POTENCY

Preferred Agents: No Prior Authorization required
betamethasone dipropionate cream, gel, lotion, oint.
betamethasone valerate cream
betamethasone valerate ointment
betamethasone valerate lotion
triamcinolone acetonide cream
triamcinolone acetonide ointment
triamcinolone acetonide lotion

Non-Preferred Agents: Prior Authorization Criteria below
amcinonide cream, lotion
betamethasone diproprionate/propylene glycol cream, lotion and ointment
DermacinRx Silapak®
Dermasorb TA®
desoximetasone cream, ointment, gel, and spray
diflorasone diacetate cream and ointment
Diprolene® ointment
Ellzia PAK®
fluocinonide cream, ointment and gel
fluocinonide emollient and solution
Halog® cream and ointment
Kenalog® aerosol
Psorcon cream
SanadermRx Skin Repair Solution
Sernivo® Spray
Silaczone-II® Kit
Topicort® cream, ointment, gel, and spray
Triamcinolone spray
Trianex® ointment
Vanos®

Non-Preferred Agent PA Criteria:
Allergy to the preferred medications
Contraindication or drug to drug interaction with the preferred medications
History of unacceptable side effects
For medium potency and high potency medications, trial and failure of 14 days with both of the preferred medications
For immunocompromised patients, trial and failure of 14 days with one preferred topical steroid
Duration of Approval: For the duration of the prescription up to 6 months

Effective 10/1/20

UPHP MEDICAID - TOPICAL STEROIDS - LOW POTENCY

MEDICATION(S)
DERMA-SMOOTHE-FS, DESONIDE 0.05% CREAM, DESONIDE 0.05% LOTION, DESONIDE 0.05% OINTMENT, FLUOCINOLONE 0.01% BODY OIL, FLUOCINOLONE 0.01% SCALP OIL, PROCTOCORT 1% CREAM, TEXACORT

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
TOPICAL STEROIDS – LOW POTENCY
Drug Class: TOPICAL STEROIDS – LOW POTENCY

Preferred Agents: No Prior Authorization required
hydrocortisone acetate cream
hydrocortisone acetate ointment
hydrocortisone/aloe
hydrocortisone cream
hydrocortisone lotion
hydrocortisone ointment

Non-Preferred Agents: Prior Authorization Criteria below
aclometasone dipropionate ointment and cream
Derma-smooth – FS ®

Desonate® gel
Desonide® ointment, cream, lotion
fluocinolone 0.01% oil
Micort-HC®
Pediaderm TA®, Pediaderm HC®
Scalpicin®
Texacort ®

Non-Preferred Agent PA Criteria:
Allergy to the preferred medications
Contraindication or drug to drug interaction with the preferred medications
History of unacceptable side effects
For low potency and very high potency medications, trial and failure of 14 days with one of the preferred medications
For immunocompromised patients, trial and failure of 14 days with one preferred topical steroid

Duration of Approval: For the duration of the prescription up to 6 months
Effective 10/1/20

UPHP MEDICAID - TOPICAL STEROIDS - MEDIUM POTENCY

MEDICATION(S)
BESER, BESER KIT, BETAMETHASONE VALER 0.12% FOAM, CLOCORTOLONE PIVALATE, CLODERM, FLUOCINOLONE 0.01% CREAM, FLUOCINOLONE 0.01% SOLUTION, FLUOCINOLONE 0.025% CREAM, FLUOCINOLONE 0.025% OINTMENT, FLURANDRENOLIDE, FLUTICASONE PROP 0.05% LOTION, HYDROCORT BUTY 0.1% LIPO CREAM, HYDROCORTISONE BUTY 0.1% CREAM, HYDROCORTISONE BUTYR 0.1% LOTN, HYDROCORTISONE BUTYR 0.1% OINT, HYDROCORTISONE BUTYR 0.1% SOLN, HYDROCORTISONE VALERATE, LOCOID, LOCOID LIPOCREAM, PANDEL, PREDNICARBATE, SYNALAR, SYNALAR TS

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
TOPICAL STEROIDS – MEDIUM POTENCY
Drug Class: TOPICAL STEROIDS – MEDIUM POTENCY

Preferred Agents: No Prior Authorization required
fluticasone propionate cream
fluticasone propionate ointment
mometasone furoate ointment
mometasone furoate cream
mometasone furoate solution

Non-Preferred Agents: Prior Authorization Criteria below
Beser kit
betamethasone valerate foam
Cloderm®
fluocinolone acetonide cream, solution
Cordran® tape
clocortolone cream
Cutivate® cream and lotion
Dermatop® cream and ointment
flurandrenolide cream, lotion, and ointment
fluocinolone acetonide cream, solution
fluticasone propionate lotion
hydrocortisone butyrate cream, lotion, ointment, solution
hydrocortisone valerate cream and ointment
Locoid® cream, lotion, solution
Locoid Lipocream®
Pandel®
prednicarbate cream and ointment
Synalar® solution, cream and ointment
Synalar TS® kit

Non-Preferred Agent PA Criteria:
Allergy to the preferred medications
Contraindication or drug to drug interaction with the preferred medications
History of unacceptable side effects
For medium potency and high potency medications, trial and failure of 14 days with both of the preferred medications
For immunocompromised patients, trial and failure of 14 days with one preferred topical steroid

Duration of Approval: For the duration of the prescription up to 6 months
Effective 10/1/20

UPHP MEDICAID - TOPICAL STEROIDS - VERY HIGH POTENCY

MEDICATION(S)
APEXICON E, BRYHALI, CLOBETASOL EMOLLIENT, CLOBETASOL EMULSION, CLOBETASOL 0.05% SHAMPOO, CLOBETASOL 0.05% TOPICAL LOTN, CLOBETASOL PROP 0.05% FOAM, CLOBETASOL PROP 0.05% SPRAY, CLOBEX, CLODAN, LEXETTE, OLUX, TEMOVATE, TOVET EMOLLIENT, TOVET KIT, ULTRAVATE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
TOPICAL STEROIDS – VERY HIGH POTENCY
Drug Class: TOPICAL STEROIDS – VERY HIGH POTENCY

Preferred Agents: No Prior Authorization required
clobetasol propionate solution
clobetasol propionate cream
clobetasol propionate ointment
halobetasol propionate cream
halobetasol propionate ointment

Non-Preferred Agents: Prior Authorization Criteria below
Apexicon E®
Bryhali®

clobetasol emollient and lotion
clobetasol propionate foam, gel, spray and shampoo
Clobex® lotion, spray and shampoo
Clodan® shampoo and kit
Lexette®
Olux®
Temovate® cream, emollient, ointment
Tovet Kit
Tovet Emollient
Ultravate® cream, lotion and ointment
Ultravate X PAC® cream and ointment

Non-Preferred Agent PA Criteria:
Allergy to the preferred medications
Contraindication or drug to drug interaction with the preferred medications
History of unacceptable side effects
For low potency and very high potency medications, trial and failure of 14 days with one of the preferred medications
For immunocompromised patients, trial and failure of 14 days with one preferred topical steroid

Duration of Approval: For the duration of the prescription up to 6 months
Effective 10/1/20

MEDICATION(S)
ALMOTRIPTAN MALATE, AMERGE, ELETRIPTAN HBR, FROVA, FROVATRIPTAN SUCCINATE, IMITREX 100 MG TABLET, IMITREX 25 MG TABLET, IMITREX 4 MG/0.5 ML CARTRIDGES, IMITREX 4 MG/0.5 ML PEN INJECT, IMITREX 50 MG TABLET, IMITREX 6 MG/0.5 ML CARTRIDGES, IMITREX 6 MG/0.5 ML PEN INJECT, IMITREX 6 MG/0.5 ML VIAL, MAXALT, MAXALT MLT, NARATRIPTAN HCL, RELPAX, SUMATRIPTAN 20 MG NASAL SPRAY, SUMATRIPTAN 5 MG NASAL SPRAY, SUMATRIPTAN SUCC-NAPROXEN SOD, TOSYMRA, ZEMBRACE SYMTOUCH, ZOLMITRIPTAN, ZOLMITRIPTAN ODT, ZOMIG

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ANTIMIGRAINE AGENTS, TRIPTANS
Drug Class: Antimigraine Agents, Triptans

Preferred Agents: No Prior Authorization required
Imitrex nasal spray
rizatriptan tab and ODT
sumatriptan tablets, injection

Non-Preferred Agents: Prior Authorization Criteria below
almotriptan

eletriptan
Frova®
frovatriptan
Imitrex®
naratriptan
Maxalt®/ Maxalt MLT®
Relpax
sumatriptan-naproxen
sumatriptan nasal spray
Tosymra®
Zembrace Symtouch®
Zolmitriptan, zolmitriptan ODT, zolmitriptan nasal spray
Zomig® tablet/ Zomig ZMT®
Zomig Nasal Spray

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications OR
•Contraindication or drug to drug interaction with the preferred medications OR
•History of unacceptable side effects OR
•Therapeutic failure with treatment for three migraine episodes with use of two of the preferred agents

QUANTITY LIMITS
almotriptan (Axert)9 per fill
Frova® (frovatriptan)18 per fill
Imitrex® (sumatriptan)18 per fill
Imitrex Injection® (sumatriptan)Vial – 2 per fill
Kit and Injection – 4 per fill
Imitrex® Nasal Spray (sumatriptan)6 per fill
Maxalt®/ Maxalt MLT® (rizatriptan)18 per fill
naratriptan (Amerge®)9 per fill
Relpax® (eletriptan)12 per fill
rizatriptan (Maxalt®/ Maxalt MLT®)18 per fill
sumatriptan (Imitrex®)18 per fill
sumatriptan Injection (Imitrex®) Vial – 2 per fill
Injection – 4 per fill
sumatriptan Spray, Nasal (Imitrex®, Tosymra®)6 per fill
zolmitriptan (Zomig®/ Zomig ZMT®)12 per fill
Zomig®/Zomig ZMT® (zolmitriptan)12 per fill

Duration of Approval: 6 months

Effective 10/1/20
Update 7/1/21
Updated 8/1/22

UPHP MEDICAID - ULCERATIVE COLITIS - ORAL

MEDICATION(S)
ASACOL HD, AZULFIDINE, BALSALAZIDE DISODIUM, BUDESONIDE ER, COLAZAL, DELZICOL, DIPENTUM, MESALAMINE 800 MG DR TABLET, MESALAMINE DR 1.2 GM TABLET, MESALAMINE DR, MESALAMINE ER, PENTASA, UCERIS 9 MG ER TABLET

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ULCERATIVE COLITIS – ORAL
Drug Class: Ulcerative Colitis – Oral

Preferred Agents: No Prior Authorization required
Apriso®
Lialda®
sulfasalazine/ sulfasalazine DR

Non-Preferred Agents: Prior Authorization Criteria below
Asacol HD®
Azulfidine DR®
Balsalazide
Budesonide ER
Colazal®

Delzicol®
Dipentum®
Giazo®
mesalamine (generic for Apriso)
mesalamine (generic for Delzicol)
mesalamine (generic for Lialda)
mesalamine (generic for Pentasa)
Pentasa®
Uceris®

Non-Preferred Agent PA Criteria:
Allergy to the preferred medications
Contraindication or drug to drug interaction with the preferred medications
History of unacceptable side effects
Therapeutic failure after one-month trial with one preferred medication

Duration of Approval: 1 year
Effective 10/1/20
Updated 6/15/22

MEDICATION(S)
DARIFENACIN ER, DETROL, DETROL LA, DITROPAN XL, FESOTERODINE FUMARATE ER, FLAVOXATE HCL, GELNIQUE, GEMTESA, MYRBETRIQ, OXYTROL, TOLTERODINE TARTRATE, TOLTERODINE TARTRATE ER, TROSPIUM CHLORIDE, TROSPIUM CHLORIDE ER, VESICARE, VESICARE LS

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
URINARY TRACT ANTISPASMODICS
Drug Class: Urinary Tract Antispasmodics

Preferred Agents: No Prior Authorization required
oxybutynin / oxybutynin ER
solifenacin
Toviaz®

Non-Preferred Agents: Prior Authorization Criteria below
darifenacin ER
Detrol®/ Detrol LA®
Ditropan XL®
fesoterodine ER

flavoxate HCL
Gelnique®
Gemtesa®
Myrbetriq®
Oxytrol®
tolterodine/ tolterodine ER
trospium/ trospium ER
Vesicare®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure with a one-month trial of one preferred medication
•See additional medication-specific criteria below:

GELNIQUE
•Clinical rationale why preferred agents inappropriate: inability to swallow, etc.

Duration of Approval: 1 year

Effective 10/1/20
Updated 11/1/21
Updated 8/1/22
Updated 9/1/22

UPHP MEDICAID - UTERINE DISORDER TREATMENTS

MEDICATION(S)
MYFEMBREE, ORIAHNN, ORILISSA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
UTERINE DISORDER TREATMENTS
Drug Class: Uterine Disorder Treatments

Preferred Agents: Clinical Prior Authorization below
Myfembree®
Oriahnn®
Orilissa®

ORIAHNN®(ELAGOLIX/ESTRADIOL/NORETHINDRONE)
•Patient greater than or equal to 18 years old AND
•Patient is premenopausal AND
•Confirmed diagnosis of uterine leiomyomas (fibroids) with heavy menstrual bleeding AND
•Failure on an adequate trial of hormonal contraceptives (including oral or transdermal formulations, vaginal ring or intrauterine device) AND
•Prescribed by or in consultation with an obstetrics/gynecology or reproductive specialist AND
•Pregnancy is excluded prior to treatment AND

•Patient will use effective non-hormonal contraception during treatment with requested medication and one week after stopping therapy AND
•Patient does not have osteoporosis AND
•Patient does not have severe hepatic impairment (Child Pugh C) AND
•Patient has not completed a previous course of hormonal treatment that could contribute to bone loss AND
•Quantity limit: 56 tablets per 28 days

ORILISSA®(ELAGOLIX) 150mg
•Patient greater than or equal to 18 years old AND
•Confirmed diagnosis of endometriosis AND
•Failure on an adequate trial of the following therapies:
oNon-steroidal anti-inflammatory drugs (NSAIDs)AND
oHormonal contraceptives (including oral or transdermal formulations, vaginal ring or intrauterine device) AND
•Prescribed by or in consultation with an obstetrics/gynecology or reproductive specialist AND
•Pregnancy is excluded prior to treatment AND
•Patient will use effective non-hormonal contraception during treatment with requested medication and one week after stopping therapy AND
•Patient does not have osteoporosis AND
•Patient does not have severe hepatic impairment (Child Pugh C) AND
•Patient has not completed a previous course of hormonal treatment that could contribute to bone loss AND
•Quantity limit: 28 tablets per 28 days

ORILISSA® (ELAGOLIX) 200MG
•Patient ? 18 years old AND
•Confirmed diagnosis of endometriosis with dyspareunia AND
•Failure on an adequate trial of the following therapies:
oNon-steroidal anti-inflammatory drugs (NSAIDs) AND
oHormonal contraceptives (including oral or transdermal formulations, vaginal ring or intrauterine device) AND
•Prescribed by or in consultation with an obstetrics/gynecology or reproductive specialist AND
•Pregnancy is excluded prior to treatment AND
•Patient will use effective non-hormonal contraception during treatment with requested medication and one week after stopping therapy AND
•Patient does not have osteoporosis AND
•Patient does not have severe hepatic impairment (Child Pugh C) AND
•Patient has not completed a previous course of hormonal treatment that could contribute to bone loss AND
•Treatment duration of Orilissa 200mg twice daily has not exceeded a total of 6 months AND
•Quantity limit: 56 tablets per 28 days

MYFEMBREE® (RELUGOLIX/NORETHINDRONE)
•Confirmed diagnosis of
oUterine leiomyomas (fibroids) with heavy menstrual bleeding OR
oModerate to severe pain associated with endometriosis AND

•Patient greater than or equal 18 years old, AND
•Patient is premenopausal, AND
•Failure on an adequate trial of hormonal contraceptives (including oral or transdermal formulations, vaginal ring or intrauterine device), AND
•Prescribed by or in consultation with an obstetrics/gynecology or reproductive specialist, AND
•Pregnancy is excluded prior to treatment, AND
•Patient will use effective non-hormonal contraception during treatment with requested medication and one week after stopping therapy, AND
•Patient does not have osteoporosis, AND
•Patient does not have severe hepatic impairment (Child Pugh C)

Duration of Approval: 1 year (maximum total duration of 24 months)
Effective 10/1/20
Updated 2/1/22
Updated 11/1/22

UPHP MEDICAID - VAGINAL ANTIBIOTICS

MEDICATION(S)
CLEOCIN 2% VAGINAL CREAM, VANDAZOLE, XACIATO

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
VAGINAL ANTIBIOTICS
Drug Class: Vaginal Antibiotics

Preferred Agents: No Prior Authorization required
Cleocin (clindamycin) Ovules
Clindamycin (generic for Cleocin) 2% cream
Clindesse (clindamycin 2% cream)
metronidazole (generic for Metro-Gel and Vandazole) 0.75% gel
Nuvessa (metronidazole) 1.3% Gel

Non-Preferred Agents: Prior Authorization Criteria below
Cleocin (clindamycin) 2% Cream
Vandazole (metronidazole) 0.75% Gel
Xacialto

Non-Preferred Agent PA Criteria:

•Allergy to the preferred medications
•Contraindication or drug to drug interaction with the preferred medications
•History of unacceptable side effects
•Therapeutic failure with one preferred medication
•See additional medication-specific criteria below

XACIATO (CLINDAMYCIN)
Patient is age 12 or older

Duration of Approval: 6 months
Effective 10/1/20
Update 8/1/21

MEDICATION(S)
VALGANCICLOVIR 450 MG TABLET

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
VALCYTE® / VALGANCICLOVIR
Drug Class: CMV Antiviral Agent – Nucleotide Analogs
FDA-approved uses: VALCYTE is a cytomegalovirus (CMV) nucleoside analogue DNA polymerase inhibitor indicated for:
Adult Patients
oTreatment of CMV retinitis in patients with acquired immunodeficiency syndrome (AIDS).
oPrevention of CMV disease in kidney, heart, and kidney-pancreas transplant patients at high risk.
Pediatric Patients
oPrevention of CMV disease in kidney and heart transplant patients at high risk.
Available dosage forms: Tablets- 450 mg

Coverage Criteria/Limitations for initial authorization
Diagnoses:
oCytomegalovirus (CMV) retinitis in HIV-infected patient
oCMV infection prophylaxis for those at high risk of CMV disease following transplantation of the heart, kidney-pancreas, or kidney

Duration of Approval:
oInitial Approval: 1 year
oContinuation of Therapy: 1 year
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oCytomegalovirus (CMV) retinitis in HIV-infected patient AND
Documented use in combination with Vitrasert (ganciclovir intraocular implant), OR
oCMV infection prophylaxis for those at high risk of CMV disease following transplantation of the heart, kidney-pancreas, or kidney

Criteria for continuation of therapy:
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oPatient tolerating and responding to treatment

Contraindications/Exclusions/Discontinuation:
•Hypersensitivity to valganciclovir or ganciclovir
•patient is noncompliant with medical or pharmacologic therapy
•No demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Effective 10/1/20

UPHP MEDICAID - VEMLIDY/TENOFOVIR ALAFENAMIDE

MEDICATION(S)
VEMLIDY

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
VEMLIDY/ TENOFOVIR ALAFENAMIDE

Drug Class: Anti-Retroviral – Nucleotide Reverse Transcriptase Inhibitor

FDA-approved uses: Treatment of Chronic Hepatitis B Infection

Available dosage forms: Tablet 25 mg

Coverage Criteria/Limitations for initial authorization:

?Diagnoses: Chronic Hepatitis B Infection
?Duration of approval:
a.Initial authorization: 6 months
b.Continuation of Therapy: 12 months

? Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

a.Diagnosis of Chronic Hepatitis B infection with compensated liver disease” “ AND
b.Trial, failure, or contraindication to Entecavir” “ AND
c.Trial of tenofovir disoproxil fumarate unless one of the following conditions are met:
i.History of osteoporosis or osteopenia
ii.Renal impairment defined by creatinine clearance (CrCl) less than 50 mL/min or history of chronic renal disease.
iii.Trial of tenofovir disoproxil fumarate is inappropriate” “ OR
d.Persistent viremia or breakthrough infection while taking lamivudine or adefovir [NOTE: lamivudine and adefovir are no longer recommended in current guidelines]” “ AND
e. Attestation: Confirmation of no HIV risk or negative HIV status

?Quantity: 30 tablets per 30 days
?Age: 12 and older

Criteria for continuation of therapy:

1.Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
a.Confirmation of positive clinical response.
b.Confirmation of continued monitoring according to available guidelines (i.e. HBV DNA, ALT, etc.)
c.CrCl remains ? 15 mL/min

Contraindications/Exclusions/Discontinuation:
1.HIV and HBV coinfection: Should not be used as a single agent for the treatment of HIV due to resistance development risk
2.If HIV positive - provide further justification
3.For females: There have been no data reported to the antiretroviral registry related to the use of this drug in pregnancy. The Health and Human Services (HHS) Perinatal HIV Guidelines note data are insufficient to recommend tenofovir alafenamide for initial therapy in antiretroviral-naive pregnant women. Tenofovir disoproxil fumarate (Viread) preferred in pregnant women.
4.Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

UPHP MEDICAID - VERQUVO/VERICIGUAT

MEDICATION(S)
VERQUVO

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
VERQUVO / VERICIGUAT
Drug Class : soluble guanylate cyclase (sGC) stimulator

FDA-approved uses: To reduce the risk of cardiovascular death and heart failure (HF) hospitalization following a hospitalization for heart failure or need for outpatient IV diuretics, in adults with symptomatic chronic HF and ejection fraction less than 45%.

Available dosage forms: 2.5 mg, 5 mg, 10 mg tablets

Coverage Criteria/Limitations for initial authorization:
Diagnoses: Symptomatic chronic heart failure with ejection fraction less than 45%
Duration of approval:
oInitial authorization: 6 months
oContinuation of Therapy: 12 months
Prescriber Specialty: Cardiology, or prescribed in consult with cardiology
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oDocumentation that member has chronic heart failure, New York Heart Association [NYHA] Class II-IV who has had a decompensation while on standard therapy for heart failure
oDocumentation of a left ventricular ejection fraction (LVEF) of less than 45%
oDocumentation that member is currently taking or has a contraindication to ALL of the following:
ACE inhibitor or ARB or Entresto
Beta blocker
Oral diuretic (not applicable if member had IV diuretics in previous 3 months)
oHistory of hospitalization for heart failure in the previous 6 months or required outpatient IV diuretics for heart failure in the previous 3 months.
oFor female patients of childbearing potential: Documentation of a negative pregnancy test in the previous 30 days and provider attestation that member has been counseled on the risks and advised to use contraception throughout treatment with and one month following Verquvo administration.
oPrescriber attestation that member is not or will not be using VERQUVO concomitantly with other soluble guanylate cyclase (sGC) stimulators (e.g. riociguat) or PDE-5 inhibitors (e.g. sildenafil, tadalafil, vardenafil and avanafil).

Quantity: maintenance dosing, 30 tablets per 30 days
Age: 18 years or older
Route of Administration: Oral

Criteria for continuation of therapy:
Documentation that member has had no intolerable adverse effects from treatment
Documentation that member is responding positively to treatment demonstrated by improvement or slowing of decline in signs and symptoms of heart failure.
Contraindications/Exclusions/Discontinuation:
VERQUVO is contraindicated in patients with concomitant use of other soluble guanylate cyclose (sGC) stimulators. VERQUVO is contraindicated in pregnancy.

Other special considerations:
Obtain a pregnancy test in females of reproductive potential prior to initiating treatment with VERQUVO in females of reproductive potential. Based on data from animal reproduction studies, VERQUVO may cause fetal harm when administered to a pregnant woman. Advise females of reproductive potential to use effective contraception during treatment with VERQUVO and for at least one month after the final dose. Concomitant use of VERQUVO with PDE-5 inhibitors is not recommended because of the potential for hypotension.

Effective 8/1/21

UPHP MEDICAID - VTAMA (TAPINAROF)

MEDICATION(S)
VTAMA

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
VTAMA / TAPINAROF

Drug Class: Dermatological - Antipsoriatic Agents Topical

FDA-approved uses:
•An aryl hydrocarbon receptor agonist indicated for the topical treatment of plaque psoriasis in adults.

Available dosage forms:
•Cream, 1% (10mg/gram)

Coverage Criteria/Limitations for initial authorization:
oDiagnoses: Plaque psoriasis
oDuration of approval:
oInitial authorization: 6 months
oContinuation of Therapy: for up to 12 months
oPrescriber Specialty: Prescribed by, or in consultation with, a dermatologist

oDocumentation Requirements (e.g. Labs, Medical Record, Special Studies):
oPrescribed to treat an FDA approved indication for topical Tapinarof AND
oDocumented trial, failure, or intolerance to at least one high potency or very high potency topical steroid AND
oDocumented trial, failure, or intolerance to topical calcipotriene, calcitriol, tazarotene, or combination products containing prior stated ingredients OR
oClinical documentation as to why therapies listed above are not appropriate AND
oPrescribed volume is appropriate for treating the estimated body surface area affected or prescriber attests that the volume is necessary for up to a 34-day supply per fill.
?Quantity: See criteria
?Age 18 AND OVER
?Route of Administration: Topical

Criteria for continuation of therapy:
?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oAttestation that topical tapinarof has contributed to a positive response or patient is stable on therapy.

MEDICATION(S)
XATMEP

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
XATMEP®/ METHOTREXATE
Drug Class: Folate Analog Metabolic Inhibitor

FDA-approved uses:
Treatment of pediatric patients with acute lymphoblastic leukemia (ALL) as a component of a combination chemotherapy maintenance regimen
Management of pediatric patients with active polyarticular juvenile idiopathic arthritis (pJIA) who are intolerant of or had an inadequate response to first-line therapy
Available dosage forms: 2.5 mg/ml Oral Solution

Diagnosis: Treatment of pediatric patients with acute lymphoblastic leukemia (ALL)
Coverage Criteria/Limitations for initial authorization
Diagnoses: Cancer
Duration of Approval:
oInitial Authorization: 3 months
oContinuation of Therapy: 3-month increments

Prescriber Specialty: Oncologist
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oProper diagnosis of an FDA Approved Indication OR
oIf request is for a non-FDA Approved indication, the request must be for a “medically accepted indication” as noted in the following Compendia:
American Hospital Formulary Drug Service (AHFS-DI)
NCCN Drugs and Biologic Compendium/ NCCN Guidelines
•Categories 1, 2a, and 2b will be accepted. (See Table 1 for explanation of Categories)
Micromedex DrugDex
Clinical Pharmacology
oMember must be under the care of an Oncologist
oDocumentation of dose and dates of all previous therapy and the resulting outcomes
oDocumentation that the proper succession of the therapies has been tried and failed (i.e. intolerance, contraindication, or progression)
oChart notes detailing the member’s current clinical status
oRelated lab work, test results, or clinical markers supporting the diagnosis and or continuing treatment
Not Approved If:
oPatient has any contraindications to the use of any requested ingredients
oRequest is for experimental/investigational use
oMember is enrolled in a clinical trial
Dosing:
oAs noted in Package Insert
oAs noted in Above described Compendium

Diagnosis: Treatment of pediatric patients with acute lymphoblastic leukemia (ALL), continued
Criteria for continuation of therapy
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oCurrent chart notes detailing response and compliance to therapy
oDocumented clinically significant improvements in the disease state, and stability on the medication

Contraindications/Exclusions/Discontinuation:
•Hypersensitivity to the requested agent or any component of the formulation
•Member at risk through drug-drug interactions of contraindications noted in the package insert
•Patient is noncompliant with medical or pharmacologic therapy
•No demonstrable clinically significant improvement in condition has occulted after initiation of drug therapy

References:
•National Comprehensive Cancer Network® (NCCN), “Clinical Practice Guidelines in Oncology™: Available at http://www.nccn.org

Table 1: NCCN Categories of Evidence and Consensus.

Diagnosis: Management of pediatric patients with active polyarticular juvenile idiopathic arthritis (pJIA)
Coverage Criteria/Limitations for initial authorization:
Duration of approval:
oInitial authorization: 6 months
oContinuation of Therapy: 1 year
Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oPatient must try or have a documented reason that they cannot tolerate oral tablets
Criteria for continuation of therapy:
Requires a positive response to therapy
Patient continues to be unable to tolerate oral tablets

Effective 10/1/20
Updated 11/1/21

UPHP MEDICAID - ZORYVE

MEDICATION(S)
ZORYVE

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
ZORYVE / ROFLUMILAST

Drug Class: Dermatological - Antipsoriatic Agents Topical

FDA-approved uses:
•Zoryve Cream - A phosphodiesterase 4 (PDE-4) inhibitor indicated for topical treatment of plaque psoriasis, including intertriginous areas, in patients 6 years of age and older.
•Zoryve Foam - A phosphodiesterase 4 (PDE-4) inhibitor indicated for seborrheic dermatitis in patients 9 years of age and older.

Available dosage forms:
•Cream, 0.3% (3mg/gram)
•Foam, 0.3% (3mg/gram)

Coverage Criteria/Limitations for initial authorization:
?Diagnoses:

oPlaque psoriasis (Zoryve Cream)
oSeborrheic dermatitis (Zoryve Foam)
?Duration of approval:
oInitial authorization: 6 months
oContinuation of Therapy: for up to 12 months
?Prescriber Specialty: Prescribed by, or in consultation with, a dermatologist
?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oAll requests
?Prescribed to treat an FDA approved indication for topical Roflumilast AND
?Prescribed volume is appropriate for treating the estimated body surface area affected or prescriber attests that the volume is necessary for up to a 34-day supply per fill. AND
?Additional diagnosis-specific criteria below:
oFor Plaque psoriasis
?Documented trial, failure, or intolerance to at least one high potency or very high potency topical steroid AND
?Documented trial, failure, or intolerance to topical calcipotriene, calcitriol, tazarotene, or combination products containing prior stated ingredients OR
?Clinical documentation as to why therapies listed above are not appropriate
oFor Seborrheic dermatitis
?Documented trial, failure, or intolerance to at least one topical steroid AND
?Documented trial, failure, or intolerance to at least one topical antifungal OR
?Clinical documentation as to why prerequisite therapies listed above are not appropriate.
?Quantity: See criteria
?Age:
oCream ? 6 years old
oFoam ? 9 years old
?Route of Administration: Topical
Criteria for continuation of therapy:
?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oAttestation that topical roflumilast has contributed to a positive response or patient is stable on therapy.

UPHP MEDICAID COMBINATION NASAL SPRAYS

MEDICATION(S)
AZELASTINE-FLUTICASONE, DYMISTA, RYALTRIS

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
COMBINATION NASAL SPRAYS

Drug Class: Combination Nasal Sprays

Preferred Agents:

Non-Preferred Agents: Prior Authorization Criteria below

azelastine/fluticasone spray
Dymista®
Ryaltris®

Non-Preferred Agent PA Criteria:

•1 month trial and failure of one ¬preferred nasal antihistamine; AND

•1 month trial and failure of one preferred nasal corticosteroid

Duration of Approval: 1 year

MEDICATION(S)

ACTEMRA 162 MG/0.9 ML SYRINGE, ACTEMRA ACTPEN, ADBRY, CIMZIA 2X200 MG/ML SYRINGE KIT, CIMZIA 2X200 MG/ML(X3)START KT, CYLTEZO(CF), CYLTEZO(CF) PEN, CYLTEZO(CF) PEN CROHN'S-UC-HS, CYLTEZO(CF) PEN PSORIASIS-UV, DUPIXENT PEN, DUPIXENT SYRINGE, ELIDEL, ENTYVIO, ENTYVIO PEN, EUCRISA, FASENRA PEN, HADLIMA, HADLIMA PUSHTOUCH, HADLIMA(CF), HADLIMA(CF) PUSHTOUCH, HULIO(CF), HULIO(CF) PEN, HYRIMOZ(CF), HYRIMOZ(CF) PEDIATRIC CROHN'S, HYRIMOZ(CF) PEN, IDACIO(CF), IDACIO(CF) PEN, IDACIO(CF) PEN CROHN'S-UC, IDACIO(CF) PEN PSORIASIS, ILUMYA, KEVZARA, OLUMIANT, OPZELURA, ORENCIA 125 MG/ML SYRINGE, ORENCIA 50 MG/0.4 ML SYRINGE, ORENCIA 87.5 MG/0.7 ML SYRINGE, OTEZLA 28 DAY STARTER PACK, OTEZLA 30 MG TABLET, PIMECROLIMUS, PROTOPIC, RINVOQ, SILIQ, SIMPONI, SKYRIZI 150 MG/ML SYRINGE, SKYRIZI 75 MG/0.83 ML SYRINGE, SKYRIZI (2 SYRINGES) KIT, SKYRIZI ON-BODY, SKYRIZI PEN, SOTYKTU, STELARA 45 MG/0.5 ML SYRINGE, STELARA 90 MG/ML SYRINGE, TACROLIMUS 0.03% OINTMENT, TACROLIMUS 0.1% OINTMENT, TALTZ AUTOINJECTOR, TALTZ AUTOINJECTOR (2 PACK), TALTZ AUTOINJECTOR (3 PACK), TALTZ SYRINGE, TREMFYA, XELJANZ, XELJANZ XR, YUFLYMA(CF) 40 MG/0.4 ML SYRNG, YUFLYMA(CF) 40MG/0.4ML AUTOINJ, YUSIMRY(CF) PEN

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

IMMUNOMODULATORS

Drug Class:
oAgents to Treat Asthma
oAgents to Treat Atopic Dermatitis
oAgents to Treat Chronic Idiopathic Urticaria
oAgents to Treat Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)
oAgents to Treat Eosinophilic Esophagitis (EoE)
oAgents to Treat Eosinophilic Granulomatosis with Polyangiitis (EGPA)
oAgents to Treat Hypereosinophilic Syndrome (HES)
oAgents to Treats Nonsegmental Vitiligo
oAgents to Treat Prurigo Nodularis (PN)
Biologic Immunomodulators:
oAgents to Treat Ankylosing Spondylitis
oAgents to Treat Crohn's Disease
oAgents to Treat Hidradenitis Suppurativa
oAgents to Treat Juvenile Idiopathic Arthritis
oAgents to Treat Non-radiographic Axial Spondyloarthritis
oAgents to Treat Plaque Psoriasis
oAgents to Treat Psoriatic Arthritis
oAgents to Treat Rheumatoid Arthritis
oAgents to Treat Ulcerative Colitis
oAgents to Treat Uveitis

oAGENTS TO TREAT ASTHMA

Preferred Agents: Clinical Prior Authorization below

Dupixent®
Fasenra® pen
Xolair® syringes

Clinical PA Criteria for Asthma Indications:
•Patient's asthma symptoms have not been adequately controlled by at least three months of an asthma treatment regimen that must include an inhaled corticosteroid, AND
•Prescribed by or in consultation with an allergist, immunologist, or pulmonologist

DUPIXENT® (DUPILUMAB):
?Note:
oA 56-day supply will be allowed for patients requiring dosing once every 28 days (every 4 weeks)

oThe pre-filled PEN is for use in adult and pediatric patients aged 2 years and older.
oThe pre-filled SYRINGE is for use in adult and pediatric patients aged 6 months and older.
•Patient must have moderate to severe asthma diagnosed as ONE of the following types:
oAsthma with eosinophilic phenotype with eosinophil count ? 150 cells/mcL, OR
oOral corticosteroid dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months, AND
oPatient must be 6 years of age or older

FASENRA® (BENRALIZUMAB):
•Patient must have severe asthma, AND
oEosinophil blood count of ? 150 cells/µL within last 6 weeks or ? 300 cells/µL within the last 12 months, AND
oPatient must be 12 years of age or older

XOLAIR® (OMALIZUMAB)
•Moderate to severe asthma, AND
oPatient is 6 years of age or older, AND
oPatient has a positive skin test or in vitro testing (RAST, etc.) for allergen specific IgE antibodies for one or more seasonal aeroallergens, AND
oBaseline IgE level is ? 30 IU/ml

Non-Preferred Agents: Prior Authorization Criteria below

Nucala® syringe, auto-injector
Tezspire® pen

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•Therapeutic failure after a one-month trial of one preferred medication
•See additional medication-specific criteria below:

NUCALA® (MEPOLIZUMAB):
•Patient must have severe asthma, AND
oEosinophil blood count of ? 150 cells/µL within last 6 weeks or ? 300 cells/µL within the last 12 months, AND
oPatient must be 6 years of age or older

TEZSPIRE® (TEZEPELUMAB-EKKO)
•Patient must have severe asthma, AND
oPatient is 12 years of age or older, AND
oPatient has been trained to self-administer this product, AND
oMember will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Tezspire

?Duration of Approval: 1 year
?AGENTS TO TREAT ATOPIC DERMATITIS

Preferred Agents: Clinical Prior Authorization below

Adbry®
Dupixent®
Elidel®
Eucrisa®

Clinical PA Criteria For Atopic Dermatitis Indications For Each Agent
•Diagnosis of atopic dermatitis
ODupixent®: moderate to severe for ages ? 6 months
oElidel®: mild to moderate for ages greater than 2 years
oEucrisa®: mild to moderate for ages ? 3 months

Non-Preferred Agents: Prior Authorization Criteria below

Cibinqo®
Opzelura®
pimecrolimus (generic for Elidel)
Protopic®
Rinvoq ER®
tacrolimus

Non-Preferred Agent PA Criteria:
•Diagnosis of atopic dermatitis
•Allergy to the preferred medication, OR
•Contraindication or drug to drug interaction with the preferred medication, OR

•History of unacceptable side effects, OR
•Therapeutic failure after a one-month trial of one preferred medication
•Additional disease severity and age limits:
opimecrolimus: mild to moderate for ages greater than 2 years
oProtopic®/ Tacrolimus 0.03%: moderate to severe for ages greater than 2 years
OProtopic®/ Tacrolimus 0.1%: moderate to severe for ages greater than 16 years
ORinvoq ER®: moderate to severe for ages ? 12 years
•See additional medication-specific criteria below:

ADBRY® (TRALOKINUMAB-LDRM)
•Diagnosis of moderate to severe atopic dermatitis, AND
oPatient age greater than or equal to 12 years old
oQuantity limit: 4 syringes per 28 days (with special allowance for initial dose)

CIBINQO® (ABROCITINIB)
•Diagnosis of moderate to severe atopic dermatitis, AND
oPatient age ? 12 years old

DUPIXENT® (DUPILUMAB)
? Note:
oA 56-day supply will be allowed for patients requiring dosing once every 28 days (every 4 weeks)
oThe pre-filled PEN is for use in adult and pediatric patients aged 2 years and older.
oThe pre-filled SYRINGE is for use in adult and pediatric patients aged 6 months and older.
•Diagnosis of moderate to severe atopic dermatitis AND
oPatient ? 6 months old

OPZELURA® (RUXOLITINIB PHOSPHATE)
•Diagnosis of mild to moderate atopic dermatitis, AND
oPatient has atopic dermatitis estimated to affect ? 20% of the body surface area, AND
oPatient age ? 12 years old,

QUANTITY LIMITS
Adbry® (tralokinumab-ldrm)4 syringes per 28 days (with special allowance for initial dose)
Elidel® (pimecrolimus)30gm per 30 days
Eucrisa® (crisaborole)100 gm per 30 days
Opzelura® (ruxolitinib phosphate)240gm (4 x 60gm) per 30 days

Protopic® (tacrolimus)30gm per 30 days

?Duration of Approval: 6 months for FDA approved diagnosis noted above, unless otherwise noted in Medication/Diagnosis-Specific Criteria

?AGENTS TO TREAT CHRONIC IDIOPATHIC URTICARIA

Preferred Agents: Clinical Prior Authorization below

Xolair® syringes

Clinical PA Criteria for Chronic Idiopathic Urticaria Indications:
XOLAIR® (OMALIZUMAB)
•Diagnosis of Chronic Idiopathic Urticaria, AND
oPatient is 12 years of age or older, AND
oPrescribed by or in consultation with an allergist, immunologist, or dermatologist, AND
oPatient has had urticaria for at least 6 weeks with symptoms present despite an adherent trial of at least 2 weeks duration of an H1-antihistamine

?Duration of Approval: 1 year

?AGENTS TO TREAT CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP)

Preferred Agents: Clinical Prior Authorization below

Dupixent®

Xolair® syringes

Clinical PA Criteria for chronic rhinosinusitis with nasal polyposis (CRSwNP) Indications:
DUPIXENT® (DUPILUMAB):
?Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP), AND
oPatient ? 18 years old, AND
oPatient has inadequate response after 3 consistent months use of intranasal steroids or oral corticosteroids, AND
oPatient is concurrently treated with intranasal corticosteroids

XOLAIR® (OMALIZUMAB)
?Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP), AND
oPatient is 18 years of age or older, AND
oPrescribed by or in consultation with an allergist, immunologist or otolaryngologist, AND
oPatient has not been adequately controlled by at least three months of treatment with an intranasal steroids or oral corticosteroids, AND
oPatient is concurrently treated with intranasal corticosteroids
Non-Preferred Agents: Prior Authorization Criteria below

Nucala® syringe, auto-injector

Non-Preferred Agent PA Criteria:
?Allergy to the preferred medication, OR
?Contraindication or drug to drug interaction with the preferred medication, OR
?History of unacceptable side effects, OR
?Therapeutic failure after a one-month trial with the preferred medication
?See additional medication-specific criteria below:

NUCALA (MEPOLIZUMAB)
•Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP), AND
oPatient ? 18 years old AND
oPatient has inadequate response after 3 consistent months use of intranasal steroids or oral corticosteroids, AND
oPatient is concurrently treated with intranasal corticosteroids

?Duration of Approval: 1 year

?AGENTS TO TREAT EOSINOPHILIC ESOPHAGITIS (EOE)

Preferred Agents: Clinical Prior Authorization below

Dupixent®

Clinical PA Criteria for chronic rhinosinusitis with nasal polyposis (CRSwNP) Indications:
DUPIXENT® (DUPILUMAB):
?Diagnosis of eosinophilic esophagitis (EoE), AND
oPatient 1 year of age or older AND
oPatient weighs 15kg or over AND
oPrescribed by or consultation with an allergist or gastroenterologist, AND
oPatient did not respond clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor

?Duration of Approval: 1 year

?AGENTS TO TREAT EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA)

Non-Preferred Agents: Prior Authorization Criteria below

Nucala® syringe, auto-injector

Non-Preferred Agent PA Criteria:
NUCALA® (MEPOLIZUMAB):
•Diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA), AND
oPatient is 18 years of age or older

?Duration of Approval: 1 year

?AGENTS TO TREAT HYPEREOSINOPHILIC SYNDROME (HES)

Non-Preferred Agents: Prior Authorization Criteria below

Nucala® syringe, auto-injector
Non-Preferred Agent PA Criteria:
NUCALA® (MEPOLIZUMAB):
•Diagnosis of hypereosinophilic syndrome (HES), AND

oPatient is 12 years of age or older

?Duration of Approval: 1 year

?AGENTS TO TREATS NONSEGMENTAL VITILIGO

Non-Preferred Agents: Prior Authorization Criteria below

Opzelura®

Non-Preferred Agent PA Criteria:
OPZELURA® (RUXOLITINIB PHOSPHATE)
•Diagnosis of nonsegmental vitiligo, AND
oPatient has vitiligo involvement estimated to affect ? 10% of the body surface area, AND
oPatient is ?12 years old, AND
oPrescribed by or in consultation with a dermatologist

?Duration of Approval: 1 year
?AGENTS TO TREAT PRURIGO NODULARIS (PN)

Preferred Agents: Clinical Prior Authorization below

Dupixent®

Clinical PA Criteria for chronic rhinosinusitis with nasal polyposis (CRSwNP) Indications:
DUPIXENT® (DUPILUMAB):
?Diagnosis of prurigo nodularis (PN), AND
oPatient ?18 years old, AND
oPrescribed by or in consultation with a dermatologist, allergist, or immunologist

?Duration of Approval: 1 year

BIOLOGIC IMMUNOMODULATORS

?AGENTS TO TREAT ANKYLOSING SPONDYLITIS

Preferred Agents: No Prior Authorization required

Cosentyx®
Enbrel®
Humira®

Non-Preferred Agents: Prior Authorization Criteria below

Amjevita®
Cimzia®, Cimzia Kit®
Rinvoq ER®
Simponi®, Simponi ARIA®

Taltz®
Xeljanz®, Xeljanz XR®

?AGENTS TO TREAT CROHN'S DISEASE

Preferred Agents: No Prior Authorization required

Humira®

Non-Preferred Agents: Prior Authorization Criteria below

Amjevita®
Cimzia®, Cimzia Kit®
Entyvio®
Rinvoq ER®
Skyrizi®
Stelara®

?AGENTS TO TREAT HIDRADENITIS SUPPURATIVA

Preferred Agents: No Prior Authorization required

Cosentyx
Humira®

Non-Preferred Agents: Prior Authorization Criteria below

Amjevita®
?AGENTS TO TREAT JUVENILE IDIOPATHIC ARTHRITIS

Preferred Agents: No Prior Authorization required

Enbrel®
Humira®

Non-Preferred Agents: Prior Authorization Criteria below

Actemra® SC
Amjevita®
Orencia® SC
Simponi ARIA®
Xeljanz® tabs, solution

?AGENTS TO TREAT NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS

Preferred Agents: No Prior Authorization required

Cosentyx®

Non-Preferred Agents: Prior Authorization Criteria below

Cimzia®, Cimzia Kit®
Rinvoq ER®
Taltz®

?AGENTS TO TREAT PLAQUE PSORIASIS

Preferred Agents: No Prior Authorization required

Cosentyx®
Enbrel®
Humira®

Non-Preferred Agents: Prior Authorization Criteria below

Amjevita®
Cimzia®, Cimzia Kit®
Ilumya®
Otezla®
Siliq®

Skyrizi®
Sotyktu®
Stelara®
Taltz®
Tremfya®

?AGENTS TO TREAT PSORIATIC ARTHRITIS

Preferred Agents: No Prior Authorization required

Cosentyx®
Enbrel®
Humira®

Non-Preferred Agents: Prior Authorization Criteria below

Amjevita®
Cimzia®, Cimzia Kit®
Orencia® SC
Otezla®
Rinvoq ER®
Simponi®, Simponi ARIA®
Stelara®
Skyrizi®
Taltz®
Tremfya®
Xeljanz®, Xeljanz XR®

?AGENTS TO TREAT RHEUMATOID ARTHRITIS

Preferred Agents: No Prior Authorization required

Enbrel®
Humira®

Non-Preferred Agents: Prior Authorization Criteria below

Actemra® SC
Amjevita®
Cimzia®, Cimzia Kit®
Kevzara®
Kineret®
Olumiant®
Orencia® SC
Rinvoq ER®
Simponi®, Simponi ARIA®
Xeljanz®, Xeljanz XR®

?AGENTS TO TREAT ULCERATIVE COLITIS

Preferred Agents: No Prior Authorization required

Humira®

Non-Preferred Agents: Prior Authorization Criteria below

Amjevita®
Entyvio®
Rinvoq ER®

Simponi®
Stelara®
Xeljanz®, Xeljanz XR®

?AGENTS TO TREAT UVEITIS

Preferred Agents: No Prior Authorization required

Humira®

Non-Preferred Agents: Prior Authorization Criteria below

Amjevita®

Non-Preferred Agent PA Criteria:
•Allergy to the preferred medications, OR
•Contraindication or drug to drug interaction with the preferred medications, OR
•History of unacceptable side effects, OR
•The patient's condition is clinically stable at this time, so that switching medications would cause deterioration in their condition, OR
•Therapeutic failure with one preferred medication in the same subclass
•Bypass PDL criteria of failure with a preferred agent in cases when the non-preferred product has a unique FDA approved indication.
•See additional medication-specific criteria below:

AMJEVITA® (ADALIMUMAB-ATT0)
•Patient is 2 years of age or older, AND
oDiagnosis of moderate to severe polyarticular juvenile idiopathic arthritis, OR
•Patient is 6 years of age or older, AND
oDiagnosis of moderate to severe Crohn's disease, OR
•Patient is 18 years of age or older, AND
oDiagnosis of moderate to severe rheumatoid arthritis, OR
oDiagnosis of psoriatic arthritis, OR
oDiagnosis of ankylosing spondylitis, OR
oDiagnosis of moderate to severe ulcerative colitis, OR

oDiagnosis of moderate to severe plaque psoriasis, OR
o Diagnosis of moderate to severe hidradenitis suppurativa, OR
oDiagnosis of non-infectious intermediate, posterior, or panuveitis

ENTYVIO® (VEDOLIZUMAB)
•Diagnosis of Crohn's disease, OR
•Diagnosis of ulcerative colitis, AND
•Patient must be 18 years or older, AND
•Trial and failure on one medication from each of the following classes:
oAminosalicylate [i.e., mesalamine (Asacol®HD, Pentasa®, Lialda®, Apriso®, Delzicol®), olsalazine (Dipentum®), balsalazide (Colazal®, sulfasalazine (Azulfidine®)]
oOral steroid
oThiopurine [i.e., azathioprine (Imuran®), mercaptopurine (Purinethol®)]
oTNF (tumor necrosis factor) blocker [i.e., infliximab (Remicade®, etanercept (Enbrel®)]
OLength of authorization: Initial approval = 14 weeks, renewal = 1 year

ILUMYA® (TILDRAKIZUMAB)

•Diagnosis of moderate to severe plaque psoriasis, AND
OPatient must be 18 years or older

KEVZARA® (SARILUMAB) – PDL CRITERIA DO NOT APPLY FOR POLYMYALGIA RHEUMATICA
•Diagnosis of Polymyalgia Rheumatica (PMR), OR
•Diagnosis of moderately to severely active rheumatoid arthritis (RA), AND
OPatient must be 18 years or older

OLUMIANT® (BARICITINIB) – PDL CRITERIA DO NOT APPLY FOR ALOPECIA AREATA
•Diagnosis of moderate to severe rheumatoid arthritis, OR
•Diagnosis of severe alopecia areata, AND
OPatient must be 18 years or older

OTEZLA® (APREMILAST)
•Diagnosis of psoriatic arthritis with 3 or more swollen and tender joints, OR
•Diagnosis of plaque psoriasis, OR
•Diagnosis of oral ulcers associated with Behcet's Disease, AND
OMust be prescribed by or in consultation with a rheumatologist or dermatologist
RINVOQ ER® (UPADACITINIB)
•Diagnosis of moderate to severe rheumatoid arthritis, OR
•Diagnosis of ankylosing spondylitis, OR

•Diagnosis of psoriatic arthritis, OR
•Diagnosis of non-radiographic axial spondyloarthritis (nr-axSpA), OR
•Diagnosis of moderately to severely active Crohn’s disease, OR
•Diagnosis of moderately to severely active ulcerative colitis, AND
OPatient must be 18 years or older

SILIQ® (BRODALUMAB)
•Diagnosis of plaque psoriasis, AND
oPatient must be 18 years or older

SKYRIZI® (RISANKIZUMAB)
•Diagnosis of moderate to severe plaque psoriasis or diagnosis of active psoriatic arthritis, AND
OPrescribed by or in consultation with a dermatologist or rheumatologist, OR
•Diagnosis of Crohn’s Disease, AND
OPrescribed by or in consultation with a gastroenterologist or rheumatologist

SOTYKTU® (DEUCRAVACITINIB)
•Diagnosis of moderate to severe plaque psoriasis, AND
oPatient ?18 years of age: AND
oMust be prescribed by or in consultation with a dermatologist, AND
oQuantity Limit: 1 per day

TALTZ® (IXEKIZUMAB)
•Patient must be 6 years of age or older with a diagnosis of moderate to severe plaque psoriasis, OR
•Patient must be 18 years or older, AND
•Diagnosis of psoriatic arthritis, OR
•Diagnosis of active ankylosing spondylitis, OR
•Diagnosis of non-radiographic axial spondyloarthritis (nr-axSpA), AND
•Must be prescribed by a rheumatologist or dermatologist or asthma/allergy specialist

TREMFYA® (GUSELKUMAB)
•Diagnosis of moderate to severe plaque psoriasis, OR
•Diagnosis of psoriatic arthritis, AND

OPatient must be 18 years or older

XELJANZ® (TOFACITINIB)
•Diagnosis of rheumatoid arthritis (RA) or psoriatic arthritis (PsA), or polyarticular juvenile idiopathic arthritis (pJIA) or ankylosing spondylitis (AS), AND
OFailure or inadequate response to methotrexate, AND
oMust be prescribed by or in consultation with a rheumatologist or dermatologist, OR
•Diagnosis of ulcerative colitis, AND
oPrescribed by or in consultation with a gastroenterologist
•Xeljanz Solution is only approved for Polyarticular Course Juvenile Idiopathic Arthritis (pJIA)

?Duration of Approval: 1 year, unless otherwise noted in Medication-Specific Information

UPHP MEDICAID TAZAROTENE

MEDICATION(S)
TAZAROTENE 0.05% GEL, TAZAROTENE 0.1% CREAM, TAZAROTENE 0.1% GEL

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
TAZORAC/TAZAROTENE

Drug Class (ETC_Name): Dermatological - Antipsoriatic Agents Topical

FDA-approved uses:
•Indicated for the topical treatment of plaque psoriasis and acne vulgaris

Available dosage forms:
Formulary:
•Tazarotene Cream, 0.1%
•Tazarotene Gel, 0.05% and 0.1%
Non-Formulary:
•Tazorac 0.05% Cream, Tazorac 0.1% Cream
•Tazorac 0.05% Gel, Tazorac 0.1% Gel

Coverage Criteria/Limitations for initial authorization:
?Diagnoses: Psoriasis or acne vulgaris
?Duration of approval:
oInitial authorization: 6 months
oContinuation of Therapy: for up to 12 months
?Prescriber Specialty: N/A
?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oPrescribed to treat an FDA approved indication for Tazarotene AND
oDiagnosis specific requirements:
?For the treatment of psoriasis
•Documented trial, failure, or intolerance to at least one high potency or very high potency topical steroid
•OR
•Documented, trial, failure or intolerance of one low or medium potency topical steroid and justification for avoidance of a higher potency topical steroid OR
•Topical steroid avoidance due to pediatric age AND
•Documented trial, failure or intolerance to a topical vitamin D analogue (i.e. calcipotriene or calcitriol) or a clinical reason why both cannot be used.
?For the treatment of acne vulgaris
•Documented trial, failure or intolerance to one of the following:
oTopical adapalene
oTopical tretinoin
oRequest for a non-formulary Tazarotene product requires trial of formulary Tazarotene product and justification for an inability to utilize a formulary product.
?Quantity: Appropriate amount to cover affected area for up to 34 days based on provider estimate or body surface area (BSA) estimate.
oPrescribing information recommends a “thin layer” defined as 2 mg/cm2 for approved diagnoses.
?Age:
oTreatment of acne vulgaris: patients ? 12 years old
oTreatment of psoriasis:
?Cream – patients ? 18 years old
?Gel – patients ? 12 years old
?Gender: N/A
?Route of Administration: Topical
?Place of Service: N/A

Criteria for continuation of therapy:
?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
oAttestation that tazarotene has contributed to a positive response or patient is stable on therapy.

Contraindications/Exclusions/Discontinuation:

?Warning of embryofetal toxicity:
oUse of topical retinoids should be avoided during pregnancy.
?Females of child-bearing potential should have a negative pregnancy test within 2 weeks prior to initiating treatment and use an effective method of contraception during treatment.
?If member is pregnant, Tazarotene is contraindicated and alternate therapy should be utilized.
?For the treatment of psoriasis in children, using the gel form, it is recommended to limit application to ? 20% of BSA.

Other special considerations: