

Medical Assistance Handbook for  
Prescribing and Pharmacy  
Providers

**PRIOR AUTHORIZATION  
OF  
PHARMACEUTICAL  
SERVICES**

Department of Public Welfare  
Office of Medical Assistance Programs

MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

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**I. General Requirements for Prior Authorization of Prescriptions**

A. Prescriptions That Require Prior Authorization

Prescriptions that meet any of the following conditions must be prior authorized:

1. A prescription for a non-preferred drug. See Preferred Drug List (PDL) Chapter for the list of preferred drugs and Chapter relating to the specific therapeutic class of drugs.
2. A prescription for a preferred drug as set forth in the Chapter relating to the specific therapeutic class of drugs. (Example – Oral Antifungals)
3. A prescription for a drug when the prescribed quantity exceeds the quantity limit. See Quantity Limits Chapter for the list of drugs subject to quantity limits and the quantity limits.
4. A prescription for a drug within a therapeutic class of drugs not included in the (PDL) that requires prior authorization. See the Chapter relating to the specific therapeutic class of drugs.
5. A prescription for a multisource brand name drug that has an A-rated generic equivalent available for substitution.

EXCEPTIONS: Prescriptions exempt from prior authorization are noted in each Chapter relating to the specific therapeutic class of drugs or the specific requirement for prior authorization.

GRANDFATHER PROVISION: Provisions for grandfathering certain prescriptions in order to avoid any potential disruption in therapy are noted in each Chapter relating to the specific therapeutic class of drugs or the specific requirement for prior authorization.

If the PROMISe Point-Of-Sale On-Line Claims Adjudication System indicates that a prior authorization is required and the prescription or the refill has not been prior authorized, the pharmacist should notify the recipient and the prescriber that the prescription now requires prior authorization.

B. Emergency Supplies

The Department will allow the pharmacist to dispense an emergency supply of the prescribed medication without prior authorization if, in the

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professional judgment of the pharmacist, the recipient has an immediate need for the medication such as, the recipient cannot take any other alternative medication during the time the prior authorization is being obtained. In emergency situations, the pharmacist may dispense a 5-day supply of the prescribed medication without prior authorization, unless the pharmacist determines that taking the prescribed medication, either alone or along with other medications(s) that the recipient may be taking, would jeopardize the health and safety of the recipient.

**C. Initiating the Prior Authorization Request**

1. Who May Initiate the Request

The prescriber must request the prior authorization.

The procedures for initiating the request are included for the pharmacy's information to assist the pharmacist in guiding non-participating or out-of-state prescribers on the procedures to requesting prior authorization. Pharmacists may also refer prescribers to the Department's web site:

[www.dpw.state.pa.us/omap/](http://www.dpw.state.pa.us/omap/) for prior authorization procedures.

2. Where and When to Call

The MA Fee-for-Service Program Prior Authorization Unit accepts requests for prior authorization at 1-800-558-4477 between 8:00 AM and 4:30 PM, Monday through Friday.

**THE PHARMACY SHOULD NOT CONTACT THE PRIOR AUTHORIZATION UNIT FOR APPROVAL TO FILL THE PRESCRIPTION. THIS TELEPHONE NUMBER IS RESERVED FOR PRESCRIBERS ONLY.**

**D. Information and Supporting Documentation that Must Be Available for the Prior Authorization Review**

The information required at the time prior authorization is requested includes the following:

1. The name and ACCESS card number of the recipient.
2. The prescriber's license number.
3. The specifics of the prescription, i.e, drug, strength, quantity, directions, days supply, duration.
4. Clinical information to support the medical necessity for the medication.
5. ICD-9-CM Diagnosis Code(s) or diagnosis.

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E. Documentation Supporting the Need for a Prescription That Requires Prior Authorization

The clinical information provided during the course of the review must also be verifiable within the patient's medical record. Upon retrospective review, the Department may seek restitution for the payment of the prescription and any applicable restitution penalties from the prescriber if the medical record does not support the medical necessity for the prescription. (See 55 Pa. Code § 1101.83(b)).

F. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription that requires prior authorization, the determination of whether the requested prescription is medically necessary will take into account the guidelines set forth in the Chapter relating to the specific therapeutic class of drugs and/or the specific requirement for prior authorization.

G. Automated Prior Authorization Approvals

When the PROMISe Point-Of-Sale On-Line Claims Adjudication System can verify that the recipient has a record that documents medical necessity for a prescription that requires prior authorization, the request will be automatically approved. Automated Prior Authorization Approvals are noted in each Chapter relating to the specific therapeutic class of drugs or the specific requirement for prior authorization.

H. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines to assess the medical necessity of the prescription. If the reviewer determines that the request for prior authorization of a prescription meets the medical necessity guidelines, the reviewer will prior authorize the prescription. The reviewer may request documentation from the medical record to assess medical necessity. (See 55 PA Code § 1101.51(d) and (e)). If the reviewer is unable to determine medical necessity, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. The physician reviewer may request documentation from the medical record to determine medical necessity. (See 55 PA Code § 1101.51(d) and (e)). Such a request for prior authorization may be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

I. Long Term Therapy

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The Department will consider requests to authorize multiple refills for a recipient when, in the professional judgment of the reviewer, treatment for the condition is expected to be ongoing. Multiple refills will not exceed six (6) months or five (5) refill supply, whichever ever comes first, from the time of the original filling of the prescription. (See 55 Pa Code § 1121.53(c)).

J. Timeframe of Review

The Department will respond to requests for prior authorization within twenty-four (24) hours of receiving all information reasonably necessary to make a decision of medical necessity.

K. Prior Authorization Number

If the Department approves a request for prior authorization, a 10-digit prior authorization number will be issued. This number should be written on the prescription and in the medical record in the event that the prescriber needs to later refer to the number for the patient or pharmacy.

L. Denials

If the request to approve a prescription that requires prior authorization is denied or approved other than as requested, the recipient has the right to appeal the Department's decision. The recipient has 30 days from the date of the prior authorization notice to submit the appeal in writing to the address listed on the notice. If the recipient has been receiving the drug that is being reduced, changed, or denied and an appeal is hand-delivered or postmarked within 10 days of the date of the notice, the Department will authorize the prescription for the drug until a decision is made on the appeal.

II. Dispensing Considerations

The pharmacist should notify the recipient and call the prescriber to alert the prescriber that the prescription now requires prior authorization if a prescription is presented without a prior authorization number and the PROMISe Point-Of-Sale On-Line Claims Adjudication System indicates that prior authorization is required. The prescriber should not ask the pharmacist to call for the prior authorization number. Prior authorization numbers will be provided only to the prescribing provider.

THE PHARMACY SHOULD NOT CONTACT THE PRIOR AUTHORIZATION UNIT FOR APPROVAL TO FILL THE PRESCRIPTION. THE UNIT WILL ACCEPT REQUESTS ONLY FROM PRESCRIBERS.

### **III. Procedures to Submit Pharmacy Claims**

#### **A. Submission of Claims**

Use NCPDP Version 5.1 to submit a claim for a prescription that requires prior authorization. In the claim segment, place the value of "1" in the prior authorization type code (461-EU) field and then the 10-digit prior authorization number in the prior authorization number submitted (462-EV) field. Transmit the claim to the Department through the PROMISE Point-Of-Sale On-Line Claims Adjudication System.

The authorization number is unique and specific to the prescription authorized and will be verified for validity.

#### **B. Submission of Claims for Emergency Supply**

When submitting a claim for an emergency supply of a prescription that requires prior authorization, place the value "03" in the level of service field (NCPDP field 418). The Department will reject emergency claims if the emergency supply quantity exceeds a 3-day supply.

#### **C. Submission of Claims for Overrides of NCPDP Reject Code-79 Refill Too Soon**

See Chapter on Non-Steroidal Anti-Inflammatory Drugs (NSAIDs); limited to Celebrex

**IV.** Requirements for Prior Authorization of Preferred and Non-Preferred Drugs on the Preferred Drug List (PDL)

A. Prescriptions That Require Prior Authorization

Prescriptions for PDL preferred and non-preferred drugs that meet any of the following conditions must be prior authorized:

1. A prescription for a non-preferred drug, regardless of the quantity prescribed. See Preferred Drug List (PDL) Attachment 1 for the list of preferred drugs by therapeutic class.
2. A prescription for a preferred drug as set forth in the Chapter relating to the specific therapeutic class of drugs.
3. A prescription for a preferred drug with a prescribed quantity that exceeds the quantity limit. See Attachment 1 Quantity Limits List in the Quantity Limits Chapter for the list of drugs with quantity limits.

**MEDICATION ASSISTANCE (K)**  
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**Preferred Drug List (PDL) Attachment 1**

Therapeutic Drug Class	Brand Names	Generics	OTC	Preferred Status	Non-Preferred Status
ACE Inhibitors		Benazepril, -HCTZ		x	
		Captopril, -HCTZ		x	
		Enalapril, -HCTZ		x	
		Fosinopril, -HCTZ			x
		Lisinopril, -HCTZ		x	
	Aceon				x
	Accupril/Accuretic	Quinapril, -HCTZ			x
	Altace				x
	Mavik				x
	Univasc/Uniretic				x
Angiotensin II Receptor Blocker	Atacand, -HCT				x
	Avapro/Avalide			x	
	Benicar, -HCT			x	
	Cozaar/Hyzaar			x	
	Diovan, -HCT			x	
	Micardis, -HCT				x
	Teveten, -HCT			x	
Antiemetics	Anzemet				x
	Emend			x	
	Kytril			x	
	Zofran/ Zofran ODT			x	
Antifungals, Oral		Itraconazole			x
	Lamisil	Terbinafine		x	
Antihistamines, Non-Sedating		Loratadine/ D-12 / D-24	x	x	
	Allegra/ D-12 / D-24	Fexofenadine HCl			x
	Clarinetx/ D-24 hour				x
	Zyrtec/ D-12 hour				x
Antivirals		Acyclovir		x	
	Famvir	Famciclovir			x
	Valtrex	Valacyclovir HCl		x	
Bronchodilators, Beta Agonist		Albuterol Inhaler		x	
		Albuterol oral		x	
		Albuterol Nebulizer (inhalation)		x	
		Metaproterenol inhalation			x
		Metaproterenol oral		x	
		Terbutaline oral		x	
	Accuneb (inhalation)				x
	Alupent Inhaler				x
	Foradil (inhalation)				x
	Maxair (inhalation)			x	
	Serevent Diskus			x	
	Vospire ER (oral)				x
	Xopenex (inhalation)				x

**MEDICAL**      **EH**      **C**  
**PRIOR**      **HORIZAT**      **OF**      **MA**      **I**      **SERVICES**  
**f**      **Dr**      **List**      **≥ 1)**      **h**      **1**

Therapeutic Drug Class	Brand Names	Generics	OTC	Preferred Status	Non-Preferred Status
Cephalosporins		Cefaclor		x	
		Cefadroxil		x	
		Cefpodoxime			x
		Cefuroxime			x
		Cephalexin		x	
		Cephalexin		x	
		Cedax			x
		Cefzil		x	
		Lorabid			x
		Omnicef		x	
		Panixine			x
		Raniclor			x
		Spectracef		x	
		Suprax		x	
Fluoroquinolones, Oral		Ciprofloxacin		x	
		Ofloxacin			x
		Avelox		x	
		Cipro suspension			x
		Cipro XR			x
		Factive			x
		Levaquin			x
		Maxaquin			x
		Noroxin			x
		Tequin			x
Glucocorticoids, Inhaled		Qvar		x	
		Azmacort		x	
		Pulmocort Turbuhaler			x
		Pulmicort Respules		x	
		Aerobid, -M		x	
		Advair Diskus		x	
		Asmanex			x
		Flovent/ Flovent HFA		x	
Hepatitis C Agents		Ribavirin		x	
		Copegus		x	
		Infergen			x
		Pegasys		x	
		Peg-Intron/ Redipen			x
		Rebetol			x
Hypoglycemics, Insulin		Humalog			x
		Humalog Mix			x
		Humulin			x
		Lantus		x	
		Novolin		x	
		Novolog		x	
		Novolog Mix		x	

**ASSISTANCE AND SUPPORT OF CELLULAR**  
**PRIOR OF CELLULAR**  
**Preferred List (1) Attachment 1**

Therapeutic Drug Class	Brand Names	Generics	OTC	Preferred Status	Non-Preferred Status
Hypoglycemics, Meglitinides	Prandin			x	
	Starlix			x	
Hypoglycemics, TZDs	Actos			x	
	Avandia			x	
Hypoglycemics, Metformins		Glyburide-Metformin		x	
		Metformin IR		x	
		Metformin ER		x	
	Avandamet			x	
	Fortamet			x	
	Metaglip				x
	Riomet			x	
Intranasal Rhinitis Agents		Flunisolide		x	
	Beconase AQ				x
	Flonase			x	
	Nasacort AQ				x
	Nasarel				x
	Nasonex			x	
	Rhinocort Aqua				x
Lipotropics, Other		Cholestyramine		x	
		Gemfibrozil		x	
	Antara			x	
	Colestid			x	
	Lofibra				x
	Niaspan			x	
	Tricor				x
	Triglide				x
	Welchol				x
	Zetia				x
Lipotropics, Statins		Lovastatin		x	
	Advicor			x	
	Altoprev			x	
	Crestor				x
	Lescol, -XL			x	
	Lipitor			x	
	Pravachol				x
	Pravigard PAC				x
	Vytorin			x	
	Zocor			x	
Macrolides/ Ketolides		Clarithromycin			x
		Erythromycin		x	
	Biaxin XL				x
	Ketek				x
	Zithromax/Zmax			x	
NSAIDs		Diclofenac		x	
		Diflunisal		x	
		Etodolac			x

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**Preferred Drug List (Phase 1) Attachment 1**

Therapeutic Drug Class	Brand Names	Generics	OTC	Preferred Status	Non-Preferred Status
		Fenoprofen		X	
		Flurbiprofen		X	
		Ibuprofen RX		X	
		Indomethacin		X	
		Ketoprofen			X
		Ketorolac		X	
		Meclofenamate			X
		Nabumetone		X	
		Naproxen		X	
		Oxaprozin		X	
		Piroxicam		X	
		Sulindac		X	
		Tolmetin			X
		Arthrotec			X
		Celebrex			X
		Mobic			X
	Ponstel			X	
	Prevacid Naprapac			X	
Ophthalmic for Allergic Conjunctivitis		Cromolyn sodium		X	
		naphazoline	X	X	
		naphazoline	X	X	
		naphazoline/pheniramine	X	X	
		Acular			X
		Alamast			X
		Alocril			X
		Alomide			X
		Airex			X
		Elestat			X
		Emadine			X
		Optivar			X
		Patanol			X
	Zaditor			X	
Ophthalmics, Beta Blockers		Betaxolol		X	
		Carteolol		X	
		Levobunolol		X	
		Metipranolol		X	
		Timolol		X	
		Betimol		X	
		Betoptic S		X	
		Istalol			X
Ophthalmics, Carbonic Anhydrase Inhibitors		Brimonidine		X	
		Dipivefrin		X	
		Pilocarpine		X	
		Alphagan P		X	
		Azopt		X	
		Cosopt		X	
		Trusopt		X	

**MEDICAL ASSISTANCE ANNUAL**  
**PRIOR HORIZONTAL OF CEILING**  
**of Drug List (Phase 1) Attachment 1**

Therapeutic Drug Class	Brand Names	Generics	OTC	Preferred Status	Non-Preferred Status
Ophthalmics, Prostaglandin Agonists	Lumigan				x
	Travatan			x	
	Xalatan			x	
Proton Pump Inhibitors		Omeprazole Rx			x
	Aciphex				x
	Nexium				x
	Prevacid Delayed Release Capsules			x	
	Prevacid Solutab				x
	Prevacid Suspension				x
	Prilosec OTC			x	x
	Protonix				x
Zegerid				x	

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V. Requirements for Prior Authorization of Prescriptions for Drugs that Exceed the Quantity Limits

A. Prescriptions That Require Prior Authorization

Prescriptions for drugs listed in Quantity Limits Attachment 1 that exceed the quantity limits must be prior authorized.

B. Review of Documentation for Medical Necessity

For Antiemetics

In evaluating a request for prior authorization of a prescription for an Antiemetic in a quantity that exceeds the quantity limit, the determination of whether the requested prescription is medically necessary will take into account the following:

1. Whether the recipient has a diagnosis of HIV/AIDS, Sickle-Cell Anemia or is receiving radiation therapy for a cancer diagnosis.
  
2. Whether the recipient has a chemotherapy regimen:
  - with doses of more than 7 days per 30 days if the prescription is for Anzemet or Kytril.
  

OR

  - with doses of more than two (2) courses per 30 days if the prescription is for Emend.
  

OR

  - that requires a quantity greater than the specified limits listed in Attachment 1.
  
3. Whether the recipient's physician provides documentation from peer-reviewed medical literature for use of a dose greater than the quantity limits.
  
4. Whether the recipient is receiving radiation therapy for a cancer diagnosis.

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5. Whether the recipient has a diagnosis of hyperemesis gravidarum and meets ALL of the following criteria:
- a. Parenteral hydration has already been tried or would otherwise be required

AND

- b. Documentation of the therapeutic failure of on-pharmacological therapies. Non-pharmacological therapies include, but are not limited to, small meals low in fat and high in carbohydrates, bed rest, etc.

AND

- c. Failed treatment with at least two (2) of the following antiemetics:

dimenhydrinate (Dramamine)  
diphenhydramine (Benadryl)  
doxylamine  
promethazine (Phenergan) – oral or per rectum  
prochlorperazine (Compazine)-oral or per rectum  
hydroxyzine (Vistaril)  
meclizine (Antivert)  
metoclopramide (Reglan)  
trimethobenzamide (Tigan)

**For Preferred Drugs Listed in Quantity Limits Attachment 1**

In evaluating a request for prior authorization of a prescription for a preferred drug listed in Attachment 1 with a quantity that exceeds the quantity limit, the determination of whether the requested prescription is medically necessary will take into account the following:

1. Whether the recipient requires a dose that includes half tablets.
  
2. Whether the recipient's dose is being titrated by the practitioner (3 month limit).

3. Whether the recipient has a history of intolerance of a drug administered as a single daily dose.
  
4. Whether the recipient's physician provides documentation from the peer-reviewed medical literature for use of a higher dose.

### **For Non-Preferred Drugs Listed in Quantity Limits Attachment 1**

In evaluating a request for prior authorization of a prescription for a non-preferred drug listed in Attachment 1 with a quantity that exceeds the quantity limit, the determination of whether the requested prescription is medically necessary will be based on the clinical review guidelines set forth in the Chapter of the handbook specific to each therapeutic class of drugs and the clinical review guidelines for quantity limits listed above for preferred drugs.

#### **C. Automated Prior Authorization Approvals**

For Antiemetics - The PROMISE Point-Of-Sale On-Line Claims Adjudication System will verify if the recipient has a record of a diagnosis of HIV/AIDS, Sickle-Cell Anemia or a record of radiation therapy for a cancer diagnosis within the past 180 days. If there is such a record, the request for prior authorization of a prescription for an Antiemetic that exceeds the quantity limits will be automatically approved.

#### **D. Clinical Review Process**

Prior authorization personnel will review the request for prior authorization and apply the clinical review criteria in Section B. above to assess the medical necessity of the request for a prescription that exceeds the established quantity limits. If any of the applicable guidelines in Section B. is met, the reviewer will prior authorize the prescription. If none of the applicable guidelines are met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such requests for service may be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

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**Quantity Limits Attachment 1**

THERAPEUTIC DRUG CLASS	DRUG	QUANTITY LIMIT (QL) PER 30 DAY SUPPLY
<b>Ace Inhibitors</b>	Altace (ramipril) 1.25mg, 2.5mg, 5mg, 10mg	60 units per 30 days <sup>(3)</sup>
	Prinivil (lisinopril) all strengths	30 units per 30 days <sup>(1)</sup>
	Univasc (moexipril) 7.5mg, 15mg	30 units per 30 days <sup>(1)</sup>
	Vasotec (enalapril) all strengths	60 units per 30 days <sup>(3)</sup>
	Zestril (lisinopril) all strengths	30 units per 30 days <sup>(1)</sup>
<b>Angiotensin II Receptor Antagonists</b>	Atacand (candesartan) 4mg, 8mg, 16mg, 32mg	30 units per 30 days <sup>(1)</sup>
	Atacand-HCT (candesartan/HCTZ) 16/12.5mg	60 units per 30 days <sup>(3)</sup>
	Atacand-HCT (candesartan/HCTZ) 32/12.5mg	30 units per 30 days <sup>(1)</sup>
	Avalide (irbesartan/HCTZ) 150/12.5mg	60 units per 30 days <sup>(3)</sup>
	Avalide (irbesartan/HCTZ) 300/12.5mg	30 units per 30 days <sup>(1)</sup>
	Avapro (irbesartan) 75mg, 150mg, 300mg	30 units per 30 days <sup>(1)</sup>
	Benicar (olmesartan) 5mg, 20mg, 40mg	30 units per 30 days <sup>(1)</sup>
	Benicar-HCT (olmesartan/HCTZ)	30 units per 30 days <sup>(1)</sup>
	Cozaar (losartan) 25mg, 50mg, 100mg	30 units per 30 days <sup>(1)</sup>
	Diovan (valsartan) 40mg, 80mg, 160mg, 320mg	30 units per 30 days <sup>(1)</sup>
	Diovan-HCT (valsartan/HCTZ) 80/12.5mg, 160/25mg	30 units per 30 days <sup>(1)</sup>
	Diovan-HCT (valsartan/HCTZ) 160/12.5mg	60 units per 30 days <sup>(3)</sup>
	Hyzaar (losartan/HCTZ) 50/12.5mg, 100/25mg	30 units per 30 days <sup>(1)</sup>
	Micardis (telmisartan) 20mg, 40mg, 80mg	30 units per 30 days <sup>(1)</sup>
	Micardis-HCT (telmisartan/HCTZ) 40/12.5mg, 80/12.5mg, 80/25mg	30 units per 30 days <sup>(1)</sup>
	Teveten (eprosartan) 400mg	60 units per 30 days <sup>(3)</sup>
	Teveten (eprosartan) 600mg	30 units per 30 days <sup>(1)</sup>
Teveten-HCT (eprosartan/HCTZ) 600/12.5mg, 600/25mg	30 units per 30 days <sup>(1)</sup>	
<b>Asthma Agents</b>	Accolate (zafirlukast) 10mg, 20mg	60 units per 30 days <sup>(2)</sup>
	Advair (fluticasone/salmeterol) 100/50, 250/50, 500/50	1 unit per 30 days <sup>(3)</sup>
	Foradil Aerosolizer (formoterol)	1 box of 60 capsules per 30 days <sup>(3)</sup>
	Pulmicort (budesonide)	1 unit per 30 days <sup>(2)</sup>
	Serevent (salmeterol) Diskus	1 box per 30 days <sup>(3)</sup>
	Singulair (montelukast) 4mg, 5mg, 10mg	30 units per 30 days <sup>(1)</sup>
<b>Anticonvulsants</b>	Neurontin (gabapentin) 100mg, 300mg, 400mg, 600mg	180 units per 30 days <sup>(2)</sup>
	Neurontin (gabapentin) 800mg	120 units per 30 days <sup>(2)</sup>
	Neurontin (gabapentin) oral solution	2160ml per 30 days <sup>(2)</sup>
<b>Antidepressants</b>	Celexa (citalopram) 10mg, 20mg, 40mg	30 units per 30 days <sup>(1)</sup>
	Celexa (citalopram) 10mg/5ml solution	600 ml per 30 days <sup>(1)</sup>
	Cymbalta (duloxetine) 20mg	60 units per 30 days <sup>(3)</sup>
	Cymbalta (duloxetine) 30mg, 60mg	30 units per 30 days <sup>(1)</sup>
	Effexor (venlafaxine) 25mg, 37.5mg, 50mg, 75mg, 100mg	90 units per 30 days <sup>(7)</sup>
	Effexor XR (venlafaxine extended release) 37.5mg	30 units per 30 days <sup>(1)</sup>
	Effexor XR (venlafaxine extended release) 75mg	150 units per 30 days <sup>(2)</sup>

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**Quantity Limits Attachment 1**

THERAPEUTIC DRUG CLASS	DRUG	QUANTITY LIMIT (QL) PER 30 DAY SUPPLY
	Effexor XR (venlafaxine extended release) 150mg	60 units per 30 days <sup>(3)</sup>
	*Fluoxetine 10mg, 20mg	30 units per 30 days <sup>(1)</sup>
	*Fluoxetine 20mg/5ml solution	600ml per 30 days <sup>(1)</sup>
	*Fluoxetine 40mg	60 units per 30 days <sup>(3)</sup>
	Lexapro (escitalopram) 5mg, 10mg, 20mg	30 units per 30 days <sup>(1)</sup>
	Lexapro (escitalopram) 5mg/5ml solution	750ml per 30 days <sup>(1)</sup>
	*Paroxetine 10mg, 20mg, 40mg	30 units per 30 days <sup>(1)</sup>
	*Paroxetine 30mg	60 units per 30 days <sup>(3)</sup>
	Paxil (paroxetine) 10mg/5mg suspension	900ml per 30 days
	Paxil (paroxetine) 30mg	60 units per 30 days <sup>(3)</sup>
	Paxil (paroxetine) 10mg, 20mg, 40mg	30 units per 30 days <sup>(1)</sup>
	Paxil CR (paroxetine controlled release) 12.5mg	30 units per 30 days <sup>(1)</sup>
	Paxil CR (paroxetine controlled release) 25mg, 37.5mg	60 units per 30 days <sup>(3)</sup>
	Prozac (fluoxetine) 10mg, 20mg	30 units per 30 days <sup>(1)</sup>
	Prozac (fluoxetine) 20mg/5ml solution	600ml per 30 days
	Prozac (fluoxetine) 40mg	60 units per 30 days <sup>(3)</sup>
	Prozac (fluoxetine) 90mg	4 units per 28 days <sup>(8)</sup>
	Wellbutrin SR (bupropion sustained release) 100mg, 150mg, 200mg	60 units per 30 days <sup>(3)</sup>
	Wellbutrin XL (bupropion extended release) 150mg, 300mg	30 units per 30 days <sup>(1)</sup>
	Zoloft (sertraline) 25mg	30 units per 30 days <sup>(1)</sup>
	Zoloft (sertraline) 50mg & 100mg	60 units per 30 days <sup>(3)</sup>
Antihistamines / Decongestants	Alavert (loratadine)	30 units per 30 days <sup>(1)</sup> per NSA guidelines
	Alavert D (loratadine/pseudoephedrine) 12 hour	60 units per 30 days <sup>(3)</sup> per NSA guidelines
	Allegra (fexofenadine) 30mg & 60mg	60 units per 30 days <sup>(3)</sup> per NSA guidelines
	Allegra (fexofenadine) 180mg	30 units per 30 days <sup>(1)</sup> per NSA guidelines
	Allegra-D (fexofenadine) 12 Hour	60 units per 30 days <sup>(3)</sup> per NSA guidelines
	Clarinet (desloratadine) 5mg & redi-tabs	30 units per 30 days <sup>(1)</sup> per NSA guidelines
	Clarinet (desloratadine) syrup	300 ml per 30 days <sup>(1)</sup> per NSA guidelines
	Claritin (loratadine) syrup	300ml per 30 days <sup>(1)</sup> per NSA guidelines
	Claritin (loratadine) tablets	30 units per 30 days <sup>(1)</sup> per NSA guidelines
	Claritin-D (loratadine/pseudoephedrine) 12 hour	60 units per 30 days <sup>(3)</sup> per NSA guidelines
	Claritin-D (loratadine/pseudoephedrine) 24 hour	30 units per 30 days <sup>(1)</sup> per NSA guidelines

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THERAPEUTIC DRUG CLASS	DRUG	QUANTITY LIMIT (QL) PER 30 DAY SUPPLY
	*Loratadine tablets	30 units per 30 days <sup>(1)</sup> per NSA guidelines
	*Loratadine-D (loratadine/pseudoephedrine) 12 hour	60 units per 30 days <sup>(3)</sup> per NSA guidelines
	*Loratadine-D (loratadine/pseudoephedrine) 24 hour	30 units per 30 days <sup>(1)</sup> per NSA guidelines
	Zyrtec (cetirizine) 5mg, 10mg	30 units per 30 days <sup>(1)</sup> per NSA guidelines
	Zyrtec (cetirizine) syrup	300 ml per 30 days <sup>(1)</sup> per NSA guidelines
	Zyrtec-D (cetirizine/pseudoephedrine) 12 Hour	60 units per 30 days <sup>(3)</sup>
<b>Antilipidemics</b>	Advicor (niacin extended release/lovastatin) all strengths	30 units per 30 days <sup>(1)</sup>
	Altoprev (lovastatin extended release) 10mg, 20mg, 40mg, 60mg	30 units per 30 days <sup>(1)</sup>
	Caduet (amlodipine/atorvastatin) all strengths	30 units per 30 days <sup>(1)</sup>
	Crestor (rosuvastatin) 5mg, 10mg, 20mg, 40mg	30 units per 30 days <sup>(1)</sup>
	Lescol (fluvastatin) 20 mg & 40mg	30 units per 30 days <sup>(1)</sup>
	Lescol XL (fluvastatin extended release) 80 mg	30 units per 30 days <sup>(1)</sup>
	Lipitor (atorvastatin) 10mg, 20mg, 40mg, 80mg	30 units per 30 days <sup>(1)</sup>
	*Lovastatin 10mg, 20mg	30 units per 30 days <sup>(1)</sup>
	*Lovastatin 40mg	60 units per 30 days <sup>(3)</sup>
	Mwacor (lovastatin) 10mg, 20mg	30 units per 30 days <sup>(1)</sup>
	Mevacor (lovastatin) 40mg	60 units per 30 days <sup>(3)</sup>
	Pravachol (pravastatin) 10mg, 20mg, 40mg, 80mg	30 units per 30 days <sup>(1)</sup>
	Pravigard PAC (pravastatin + buffered ASA) all strengths	60 units per 30 days <sup>(1)</sup>
	Vytorin (ezetimibe/simvastatin) 10/10mg, 10/20mg, 10/40mg, 10/80mg	30 units per 30 days <sup>(1)</sup>
	Zetia (ezetimibe) 10mg	30 units per 30 days <sup>(1)</sup>
Zocor (simvastatin) 5mg, 10mg, 20mg, 40mg, 80mg	30 units per 30 days <sup>(1)</sup>	
<b>Antinausea Agents</b>	Anzemet (dolasetron) 50mg, 100mg	14 units per 30 days per Antinausea QL guidelines
	Emend (aprepitant) 80mg, 125mg	5 units per 30 days per Antinausea QL guidelines
	Emend (aprepitant) Trifold	2 packs per 30 days per Antinausea QL guidelines
	Kytril (granisetron) 1mg	14 units per 30 days per Antinausea QL guidelines
	Kytril (granisetron) 2mg/10ml oral solution	60 ml per 30 days per Antinausea QL guidelines
	Zofran, -ODT (ondansetron) 4mg	36 units per 30 days per Antinausea QL guidelines
	Zofran, -ODT (ondansetron) 8mg	21 units per 30 days per Antinausea QL guidelines
	Zofran (ondansetron) 24mg	7 units per 30 days per Antinausea QL guidelines

**MEDICAL NCI B**  
**PRIOR AUTHORIZATION OF SERVICES**  
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THERAPEUTIC DRUG CLASS	DRUG	QUANTITY LIMIT (QL) PER 30 DAY SUPPLY
	Zofran (ondansetron) 4mg/5ml oral solution	150ml per 30 days per Antinausea QL guidelines
<b>Calcium Channel Blockers</b>	Adalat CC (nifedipine) 30mg, 60mg, 90mg	30 units per 30 days <sup>(1)</sup>
	Calan SR (verapamil sustained release) 120mg	30 units per 30 days <sup>(1)</sup>
	Calan SR (verapamil sustained release) 180mg, 240mg	60 units per 30 days <sup>(2)</sup>
<b>Calcium Channel Blockers (Cont.)</b>	Cardene SR (nicardipine sustained release) 30mg, 60mg	60 units per 30 days <sup>(3)</sup>
	Cardene SR (nicardipine sustained release) 45mg	60 units per 30 days <sup>(3)</sup>
	Cardizem CD (diltiazem extended release) 120mg, 180mg, 300mg, 360mg	30 units per 30 days <sup>(1)</sup>
	Cardizem CD (diltiazem extended release) 240mg	60 units per 30 days <sup>(3)</sup>
	Cardizem LA (diltiazem extended release) 120mg, 300mg, 360mg, 420mg	30 units per 30 days <sup>(1)</sup>
	Cardizem LA (diltiazem extended release) 180mg	90 units per 30 days <sup>(7)</sup>
	Cardizem LA (diltiazem extended release) 240mg	60 units per 30 days <sup>(3)</sup>
	Cardizem SR (diltiazem extended release) 60mg, 90mg	60 units per 30 days <sup>(3)</sup>
	Cardizem SR (diltiazem extended release) 120mg	90 units per 30 days <sup>(7)</sup>
	Covera HS (verapamil extended release) 180mg, 240mg	60 units per 30 days <sup>(3)</sup>
	Dilacor XR (diltiazem extended release) 120mg, 180mg	30 units per 30 days <sup>(1)</sup>
	Dilacor XR (diltiazem extended release) 240mg	60 units per 30 days <sup>(3)</sup>
	Dynacirc (isradipine) 2.5mg, 5mg	60 units per 30 days <sup>(3)</sup>
	Dynacirc CR (isradipine controlled release) 5mg	30 units per 30 days <sup>(1)</sup>
	Dynacirc CR (isradipine controlled release) 10mg	60 units per 30 days <sup>(3)</sup>
	Isoptin SR (verapamil sustained release) 120mg	30 units per 30 days <sup>(1)</sup>
	Isoptin SR (verapamil sustained release) 180mg, 240mg	60 units per 30 days <sup>(3)</sup>
	Lotrel (amlodipine/benazapril) 2.5/10mg, 5/10mg, 5/20mg, 10/20mg	30 units per 30 days <sup>(1)</sup>
	Norvasc (amlodipine) 5mg & 10mg	30 units per 30 days <sup>(1)</sup>
	Plendil (felodipine) 2.5mg, 5mg, 10mg	30 units per 30 days <sup>(1)</sup>
	Procardia XL (nifedipine extended release) 30mg	30 units per 30 days <sup>(1)</sup>
	Procardia XL (nifedipine extended release) 60mg	60 units per 30 days <sup>(3)</sup>
	Procardia XL (nifedipine extended release) 90mg	30 units per 30 days <sup>(1)</sup>
	Sular (nisoldipine) 10mg, 20mg, 40mg	30 units per 30 days <sup>(1)</sup>
	Sular (nisoldipine) 30mg	60 units per 30 days <sup>(3)</sup>
	Tarka (trandolapril/verapamil) 1/240mg, 2/180mg, 2/240mg, 4/240mg	30 units per 30 days <sup>(1)</sup>
	Tiazac (diltiazem extended release) 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	30 units per 30 days <sup>(1)</sup>
	Verelan (verapamil sustained release) 120mg, 180mg, 360mg	30 units per 30 days <sup>(1)</sup>
Verelan (verapamil sustained release) 240mg	60 units per 30 days <sup>(3)</sup>	
Verelan PM (verapamil sustained release) 100mg, 300mg	30 units per 30 days <sup>(1)</sup>	
Verelan PM (verapamil sustained release) 200mg	60 units per 30 days <sup>(3)</sup>	
<b>COX-2 Inhibitors</b>	Bextra (valdecoxib) 10mg & 20mg	30 units per 30 days <sup>(1)</sup> per COX-2 guidelines

**MEDICAL CE HANDE**  
**PRIOR AUTHORIZATION OF ARMACEU SERVICES**  
**Quantity Limits Attachment 1**

THERAPEUTIC DRUG CLASS	DRUG	QUANTITY LIMIT (QL) PER 30 DAY SUPPLY
	Celebrex (celecoxib) 100mg, 200mg	60 units per 30 days <sup>(3)</sup> per COX-2 guidelines
	Celebrex (celecoxib) 400mg	30 units per 30 days <sup>(1)</sup> per COX-2 guidelines
Diabetes Agents	Actos (pioglitazone) 15mg, 30mg, 45mg	30 units per 30 days <sup>(1)</sup>
	Avandamet (rosiglitazone/metformin) 1/500mg, 2/500mg, 4/500mg, 2/1000mg, 4/1000mg	60 units per 30 days <sup>(3)</sup>
	Avandia (rosiglitazone) 2mg, 4mg,	60 units per 30 days <sup>(3)</sup>
	Avandia (rosiglitazone) 8mg	30 units per 30 days <sup>(3)</sup>
Gastrointestinal Agents	Lotronex (alosetron) 0.5mg, 1mg	60 units per 30 days <sup>(3)</sup>
	Zelnorm (tegaserod) 2mg, 6mg	60 units per 30 days <sup>(3)</sup>
Incontinence Agents	Oxytrol (oxybutynin)	8 patches per 28 days <sup>(2)</sup>
Low Molecular Weight Heparins	Arixtra (fondaparinux)	20 syringes per 30 days <sup>(4)</sup>
	Fragmin (dalteparin)	20 syringes per 30 days <sup>(4)</sup>
	Innohep (tinzaparin)	10 syringes per 30 days <sup>(4)</sup>
	Lovenox (enoxaparin)	20 syringes per 30 days <sup>(4)</sup>
Migraine	Amerge (naratriptan) 1mg, 2.5mg	9 units per 30 days <sup>(5)</sup>
	Axert (almotriptan) 6.25mg, 12.5mg	6 units per 30 days <sup>(5)</sup>
	Frova (frovatriptan) 2.5mg	9 units per 30 days <sup>(5)</sup>
	Imitrex (sumatriptan) 0.5ml single-dose vials	10 vials per 30 days <sup>(@)</sup>
	Imitrex (sumatriptan) 25mg, 50mg, 100mg tablets	18 units per 30 days <sup>(5)</sup>
	Imitrex (sumatriptan) Injection Kit	4 kits (8 syringes) per 30 days <sup>(5)</sup>
	Imitrex (sumatriptan) Nasal Spray	2 boxes (12 spray bottles) per 30 days <sup>(5)</sup>
	Maxalt 5mg & 10mg, MLT	12 units per 30 days <sup>(5)</sup>
	Migranal Nasal Spray (dihydroergotamine)	3 boxes (12ml) per 30 days <sup>(5)</sup>
	Relpax (eletriptan) 20mg	12 units per 30 days <sup>(9)</sup>
	Relpax (eletriptan) 40mg	6 units per 30 days <sup>(9)</sup>
	Zomig (zolmitriptan) Nasal Spray	6 devices per 30 days <sup>(9)</sup>
	Zomig, -ZMT (zolmitriptan) 2.5mg	12 units per 30 days <sup>(9)</sup>
	Zomig, -ZMT (zolmitriptan) 5mg	6 units per 30 days <sup>(9)</sup>
Narcotic Analgesics	Actiq (fentanyl transmucosal lozenges) all strengths	120 lollipops per 30 days <sup>(2),(6)</sup>
	*Butorphanol Nasal Spray	2 bottles (5ml) per 30 days <sup>(2),(6)</sup>
	Duragesic (fentanyl transdermal) 25mcg, 50mcg, 75mcg, 100mcg	20 patches per 30 days <sup>(2),(6)</sup>
	Oxycontin (oxycodone extended release) 10mg, 20mg, 40mg, 80mg	Per Oxycontin PA guidelines
	Palladone (hydromorphone extended release) all strengths	30 units per 30 days <sup>(1)</sup>
	Stadol (butorphanol) Nasal Spray	2 bottles (5ml) per 30 days <sup>(2),(6)</sup>
NSAIDs	Arthrotec (diclofenac/misoprostol) 50, 75	60 units per 30 days <sup>(3)</sup> per NSAID guidelines
	Mobic (meloxicam) 7.5mg, 15mg	30 units per 30 days <sup>(1)</sup> per NSAID guidelines
	Toradol (ketorolac) 10mg	20 units per 30 days <sup>(2)</sup>

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THERAPEUTIC DRUG CLASS	DRUG	QUANTITY LIMIT (QL) PER 30 DAY SUPPLY
Osteoporosis/Pagets Disease	Actonel (risedronate) 35mg	4 units per 28 days <sup>(2)</sup>
	Fosamax (alendronate) 35mg & 70mg tablets	4 units per 28 days <sup>(2)</sup>
	Fosamax (alendronate) 70mg/75ml solution	300ml per 28 days <sup>(2)</sup>
Premenstrual Dysphoric Disorder	Sarafem (fluoxetine) 10mg, 20mg	30 units per 30 days <sup>(1)</sup>
Proton Pump Inhibitors	Aciphex (rabeprazole) 20mg	30 units per 30 days <sup>(1)</sup> per PPI guidelines
	Nexium (esomeprazole) 20mg, 40mg	30 units per 30 days <sup>(1)</sup> per PPI guidelines
	*Omeprazole 10mg, 20mg	30 units per 30 days <sup>(1)</sup> per PPI guidelines
	Prevacid (lansoprazole) 15mg, 30mg caps & Solutabs	30 units per 30 days <sup>(1)</sup> per PPI guidelines
	Prevacid Naprapac (lansoprazole/naproxen) 375mg, 500mg	30 units per 30 days <sup>(1)</sup> per PPI guidelines
	Prilosec (omeprazole) 10mg, 20mg, 40mg	30 units per 30 days <sup>(1)</sup> per PPI guidelines
	Prilosec OTC (omeprazole magnesium) 20mg	60 units per 30 days <sup>(3)</sup> per PPI guidelines
	Protonix (pantoprazole) 20mg, 40mg	30 units per 30 days <sup>(1)</sup> per PPI guidelines
Psychotropics	Abilify (aripiprazole) 5mg, 10mg, 15mg, 20mg, 30mg	30 units per 30 days <sup>(1)</sup>
	Clozaril (clozapine) 100mg	270 units per 30 days <sup>(2)</sup>
	Clozaril (clozapine) 25mg	90 units per 30 days <sup>(2)</sup>
	FazaClo (clozapine) 100mg	270 units per 30 days <sup>(2)</sup>
	FazaClo (clozapine) 25mg	90 units per 30 days <sup>(2)</sup>
	Geodon (ziprasidone) 20mg, 60mg	90 units per 30 days <sup>(7)</sup>
	Geodon (ziprasidone) 40mg, 80mg	60 units per 30 days <sup>(2)</sup>
	Risperdal (risperidone) 0.25mg, 0.5mg, 1mg, 2mg, 3mg, 4mg	60 units per 30 days <sup>(3)</sup>
	Seroquel (quetiapine) 100mg	90 units per 30 days <sup>(2)</sup>
	Seroquel (quetiapine) 200mg	120 units per 30 days <sup>(2)</sup>
	Seroquel (quetiapine) 25mg	180 units per 30 days <sup>(2)</sup>
	Seroquel (quetiapine) 300mg	60 units per 30 days <sup>(2)</sup>
Symbyax (olanzapine/fluoxetine) all strengths	30 units per 30 days <sup>(1)</sup>	
Sedatives and Hypnotics	Zyprexa (olanzapine) 2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg, - Zydys	30 units per 30 days <sup>(1)</sup>
	Ambien (zolpidem) 5mg, 10mg	30 units per 30 days <sup>(1)</sup>
	Lunesta (eszopiclone) 1mg, 2mg, 3mg	30 units per 30 days <sup>(1)</sup>
	Sonata (zaleplon) 5mg	30 units per 30 days <sup>(1)</sup>
	Sonata (zaleplon) 10mg	60 units per 30 days <sup>(3)</sup>

**MEDICAL ASSISTANCE H**  
**PRIOR AUTHORIZATION OF 11 SERVICES**  
**Quantity Limits Attachment 1**

- (1) Based on FDA-approved once daily dosing
- (2) Based on FDA-approved current package labeling
- (3) Based on FDA-approved 2 units daily or bid dosing
- (4) Based on FDA-approved recommended duration of therapy
- (5) According to the manufacturer, the safety of treating an average of more than four (4) headaches in a 30-day period has not been established. Greater quantities reflect the need for Further evaluation or prophylactic therapy
- (6) Based on high potential for abuse
- (7) Based on FDA-approved 3 units daily or tid dosing
- (8) Based on FDA-approved once weekly dosing
- (9) According to the manufacturer, the safety of treating an average of more than three (3) headaches in a 30-day period has not been established.

\*Generic drug