

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES
Preferred Drug List (Phase 1 and 2) 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
Analgesics, Narcotic		APAP/Codeine (oral)		x	
		ASA/Codeine (oral)		x	
		Butalbital Compound		x	
		Codeine (oral)		x	
		Fentanyl (transdermal)		x	
		Hydrocodone/APAP		x	
		Hydrocodone/Ibuprofen		x	
		Hydromorphone (oral)		x	
		Levorphanol (oral)		x	
		Meperidine (oral)			x
		Methadone (oral)		x	
		Morphine ER (oral)		x	
		Morphine IR (oral)		x	
		Oxycodone/APAP (oral)		x	
		Oxycodone/ASA		x	
		Oxycodone ER (oral)			x
		Oxycodone IR (oral)		x	
		Panlor DC/SS (oral)		x	
		Pentazocine/APAP		x	
		Pentazocine/Naloxone		x	
		Propoxyphene		x	
		Propoxyphene/APAP		x	
		Tramadol (oral)		x	
		Tramadol/APAP		x	
		Actiq (buccal)			x
		Avinza (oral)			x
		Combunox (oral)			x
		Darvon-N (oral)			x
		Duragesic (transderm)			x
		Kadian (oral)		x	
	Oxycontin (oral)			x	
Angiotensin II Receptor Blocker	Atacand, -HCT				x
	Avapro/Avalide			x	
	Benicar, -HCT			x	
	Cozaar/Hyzaar			x	

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	Diovan, -HCT			x	
	Micardis, -HCT				x
	Teveten, -HCT			x	
Antidepressants, Other		Bupropion (oral)		x	
		Bupropion SR (oral)		x	
		Mirtazapine (oral)		x	
		Nefazodone (oral)			x
		Trazodone (oral)		x	
		Cymbalta (oral)			x
		Effexor IR (oral)			x
		Effexor XR (oral)		x	
	Wellbutrin XL (oral)				x
Antidepressants, SSRIs		Citalopram (oral)		x	
		Fluoxetine (oral)		x	
		Fluvoxamine (oral)		x	
		Paroxetine (oral)		x	
		Lexapro (oral)			x
		Paxil CR (oral)			x
		Pexeva (oral)		x	
		Prozac weekly (oral)			x
		Sarafem (oral)			x
		Zoloft (oral)		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
	Clarinet/ D-24 hour				x
	Zyrtec/ D-12 hour				x
Antimigraine Agents, Triptans	Amerge				x
	Axert			x	
	Frova				x
	Imitrex			x	
	Maxalt				x
	Relpax				x
	Zomig				x
Antivirals		Acyclovir		x	
	Famvir	Famciclovir			x
	Valtrex	Valacyclovir HCl		x	
Atypical Antipsychotics		Clozapine		x	
	Abilify			x	
	Fazaclo			x	

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Therapeutic Drug Class	Brand Names	Generics	OTC	Preferred Status	Non-Preferred Status
	Geodon			x	
	Risperdal			x	
	Risperdal Consta			x	
	Seroquel			x	
	Symbyax				x
	Zyprexa				x
Bone Resorption Suppression and Related Agents	Actonel			x	
	Boniva				x
	Didronel				x
	Evista			x	
	Forteo				x
	Fosamax				x
	Fosamax plus D				x
	Miacalcin			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
	Cephalosporins		Cefaclor		x
		Cefadroxil		x	
		Cefpodoxime			x
		Cefuroxime			x
		Cephalexin		x	
		Cedax			x
		Cefzil		x	
		Lorabid			x
		Omnicef		x	
		Panixine			x
		Raniclor			x
		Spectracef		x	
		Suprax		x	
Cytokine and CAM Agonists	Amevive				x
	Enbrel			x	
	Humira			x	
	Kineret			x	
	Raptiva			x	

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	Remicade				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	
Growth Hormones	Genotropin (injection)			x	
	Humatrope (injection)				x
	Norditropin (injection)			x	
	Nutropin (injection)				x
	Nutropin AQ (injection)			x	
	Saizen (injection)				x
	Serostim (injection)			x	
	Tev-tropin (injection)			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	
Hypoglycemics, Meglitinides	Prandin			x	
	Starlix			x	
Hypoglycemics, TZDs	Actos			x	
	Avandia			x	
Hypoglycemics, Metformins		Glyburide-Metformin		x	

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		Metfomin 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	
Multiple Sclerosis	Avonex			x	
	Betaseron			x	
	Copaxone			x	
	Rebif			x	
NSAIDs		Diclofenac		x	
		Diflunisal		x	
		Etodolac			x
		Fenoprofen		x	

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		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/pheniramine	x	x	
		Acular			x
		Alamast			x
		Alocril			x
		Alomide			x
		Alrex			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	
Ophthalmics, Prostaglandin Agonists		Lumigan			x
		Travatan		x	

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	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
Sedative Hypnotics		Chloral Hydrate (oral/rectal)		x	
		Estazolam (oral)			x
		Flurazepam (oral)			x
		Temazepam (oral)		x	
		Triazolam (oral)			x
		Ambien (oral)			x
		Doral (oral)			x
		Lunesta (oral)			x
		Restoril 7.5 mg (oral)			x
		Sonata (oral)			x
Stimulants and Related Agents		Dextroamphetamine		x	
		Methylphenidate		x	
		Methylphenidate ER		x	
		Mixed salt amphetamines		x	
		Pemoline		x	
		Adderall XR		x	
		Concerta		x	
		Desoxyn			x
		Focalin		x	
		Focalin XR		x	
		Metadate CD		x	
		Provigil			x
		Ritalin LA			x
		Strattera			x

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SECTION II - CONTENTS BY CLASS OF DRUGS

ACE Inhibitors

Analgesics, Narcotic

Angiotensin II Receptor Blockers (ARBs)

Antidepressants, Other

Antidepressants, SSRIs

Antiemetics

Antifungals, Oral

Antihistamines, Non Sedating

Antimigraine Agents, Triptans

Antivirals

Atypical Antipsychotics

Beta Agonist Bronchodilators

Bone Resorption Suppression and Related Agents

Cephalosporins

Cytokine and CAM Agonists

Fluoroquinolones, Oral

Glucocorticoids, Inhaled

Growth Hormones

Hepatitis C Agents

Hypoglycemics, Insulins

Hypoglycemics, Metformins

Intranasal Rhinitis Agents

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Lipotropics, Other Than Statins

Lipotropics, Statins

Macrolides/Ketolides

NSAIDS

Ophthalmic Agents for Allergic Conjunctivitis

Ophthalmic Agents for Glaucoma

Proton Pump Inhibitors (PPIs)

Sedative Hypnotics

Stimulants and Related Agents

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I. Requirements for Prior Authorization of Narcotic Analgesics

A. Prescriptions That Require Prior Authorization

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

1. A prescription for a non-preferred Narcotic Analgesic regardless of the quantity prescribed. See Preferred Drug List (PDL) Attachment 1 in the PDL Chapter for the list of preferred Narcotic Analgesics.
2. A prescription for a preferred Narcotic Analgesic with a prescribed quantity that exceeds the quantity limit. See Quantity Limits Attachment 1 in the Quantity Limits Chapter for the list of drugs with quantity limits.
3. A prescription for Oxycontin that:
 - a. Exceeds a dose of greater than three (3) tablets per day of any single strength of Oxycontin
 - b. Includes more than two (2) different strengths of Oxycontin that are taken concurrently
4. A prescription for either a preferred or non-preferred Narcotic Analgesic when the recipient is taking more than one short acting or more than one long acting Narcotic Analgesic concomitantly.

The PROMISe Point-Of-Sale On-Line Claims Adjudication System will verify if the recipient has a record of a prescription for a short acting or long acting Narcotic Analgesic within the past 60 days.

B. Emergency Supplies

The Department does not consider a delay in the receipt of Oxycontin to present a life threatening emergency and, therefore, will NOT cover emergency supplies of Oxycontin pending approval of a request for prior authorization. Temporary alternative methods of pain relief may be necessary.

C. Early Refills

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Early refills of Oxycontin will not be approved and prior authorization will not be granted for any exceptions. An early refill is defined as dispensing an Oxycontin prescription when more than 25 percent of an earlier dispensed supply remains.

D. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Narcotic Analgesic, the determination of whether the requested prescription is medically necessary will take into account the following:

1. For Actiq - Whether the recipient has a diagnosis of cancer

AND

The prescriber is an American Board of Medical Specialties (ABMS) Certified Oncologist or Pain Specialist

AND

The recipient has a history of a contraindication to the preferred short acting Narcotic Analgesics

2. For Oxycontin – Whether the prescriber is an ABMS Certified Oncologist or Pain Specialist
3. For all other non-preferred Narcotic Analgesics – Whether the recipient has a history of an allergic reaction to the preferred Narcotic Analgesics (single entity or combination products for breakthrough pain)

In addition, if the quantity of a prescription for either a preferred or non-preferred Narcotic Analgesic (other than Oxycontin) exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

If the quantity of a prescription for Oxycontin exceeds the quantity limit, the determination of whether the prescription is medically necessary will take into account the following guidelines:

1. Whether the recipient has a history of pain that includes all of the following:
 - a. Pain arises from a chronic condition

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AND

- b. Pain is moderate to severe in nature

AND

- c. Pain is sustained and persistent rather than brief and intermittent

AND

- d. Pain interferes with the activities of daily living (ADL) such as work, mobility, sleep, eating, personal hygiene and social functioning.

AND

- 2. Whether a narcotic pain reliever is the most appropriate treatment option as documented by one or more of the following:

- a. Pain is inadequately controlled by non-narcotic pain relievers, including non-steroidal anti-inflammatory drugs (NSAIDs), acetaminophen (APAP), and aspirin (ASA)

OR

- b. The recipient has a history of a contraindication, allergic reaction, or adverse reaction to non-narcotic pain relievers

OR

- c. The recipient has a history of an earlier episode of the same pain etiology and nature where management with a non-narcotic medication was inadequate

OR

- d. The pain is so severe that it would be appropriate to initiate pain management with opioids such as pain resulting from metastatic disease or severe orthopedic trauma

- 3. Whether the proposed dosage is the minimum effective dosage. For doses and dosing intervals that exceed the FDA-approved starting dose of 10 mg every twelve (12) hours, there is documentation demonstrating an appropriate upward titration of

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Oxycontin or an appropriate conversion from other opioid-containing medications.

E. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section D. above, to assess the medical necessity of the request for a prescription for a Narcotic Analgesic. If the guidelines in Section D. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

MEDICAL ASSISTANCE HANDBOOK
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I. Requirements for Prior Authorization of Other Antidepressants

A. Prescriptions That Require Prior Authorization

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

1. A prescription for a non-preferred Other Antidepressant regardless of the quantity prescribed. See Preferred Drug List (PDL) Attachment 1 in the PDL Chapter for the list of preferred Other Antidepressants.
2. A prescription for a preferred Other Antidepressant with a prescribed quantity that exceeds the quantity limit. See Quantity Limits Attachment 1 in the Quantity Limits Chapter for the list of drugs with quantity limits.

GRANDFATHER PROVISION – The Department will grandfather prescriptions for non-preferred Other Antidepressants within quantity limits for those recipients currently being prescribed a non-preferred Other Antidepressant. The PROMISe Point-Of-Sale On-Line Claims Adjudication System will verify if the recipient has a record of a prescription for a non-preferred Other Antidepressant within the past 90 days from the date of service of the new claim. If the recipient has a record of a prescription for a non-preferred Other Antidepressant, a prescription or a refill for the same Other Antidepressant within the quantity limits will be automatically approved.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Other Antidepressant, the determination of whether the requested prescription is medically necessary will take into account the following:

1. For Cymbalta - Whether the recipient has a diagnosis of diabetic peripheral neuropathic pain
2. For Wellbutrin XL – Whether the recipient has a history of an allergic reaction from Bupropion products
3. For all other non-preferred Other Antidepressants, whether the recipient has a history of:
 - a. Therapeutic failure of two (2) preferred Other Antidepressants

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OR

- b. A contraindication to the preferred Other Antidepressants (Example: Recipient has hypertension; therefore, Effexor is contraindicated)

OR

- c. Therapeutic failure of the SSRIs

In addition, if a prescription for either a preferred or non-preferred Other Antidepressant is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

C . Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above, to assess the medical necessity of the request for a prescription for an Other Antidepressant. If the guidelines in Section B are met and the prescription is not for Nefazodone, the reviewer will prior authorize the prescription. If the guidelines are not met, or if the prescription is for Nefazodone, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will 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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I. Requirements for Prior Authorization of SSRI Antidepressants

A. Prescriptions That Require Prior Authorization

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

1. A prescription for a non-preferred SSRI Antidepressants, regardless of the quantity prescribed. See Preferred Drug List (PDL) Attachment 1 in the PDL Chapter for the list of preferred SSRI Antidepressants.
2. A prescription for a preferred SSRI Antidepressant with a prescribed quantity that exceeds the quantity limit. See Quantity Limits Attachment 1 in the Quantity Limits Chapter for the list of drugs with quantity limits.

GRANDFATHER PROVISION – The Department will grandfather prescriptions for non-preferred SSRI Antidepressants within quantity limits for those recipients currently being prescribed a non-preferred SSRI Antidepressant. The PROMISe Point-Of-Sale On-Line Claims Adjudication System will verify if the recipient has a record of a prescription for a non-preferred SSRI Antidepressant within the past 90 days from the date of service of the new claim. If the recipient has a record of a prescription for a non-preferred SSRI Antidepressant, a prescription or a refill for the same non-preferred SSRI Antidepressant within the quantity limits will be automatically approved.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred SSRI Antidepressant, the determination of whether the requested prescription is medically necessary will take into account whether the recipient has a history of therapeutic failure or an allergic or adverse reaction to the preferred SSRI Antidepressants. In addition, if a prescription for either a preferred or non-preferred SSRI Antidepressant is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above, to assess the medical necessity of the request for a prescription for an SSRI Antidepressant. If the guidelines in Section B are met, the reviewer will

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prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will 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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I. Requirements for Prior Authorization of Triptan Antimigraine Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Triptan Antimigraine Agents that meet any of the following conditions must be prior authorized:

1. A prescription for a non-preferred Triptan Antimigraine Agent, regardless of the quantity prescribed. See Preferred Drug List (PDL) Attachment 1 in the PDL Chapter for the list of preferred Triptan Antimigraine Agents.
2. A prescription for a preferred Triptan Antimigraine Agent with a prescribed quantity that exceeds the quantity limit. See Quantity Limits Attachment 1 in the Quantity Limits Chapter for the list of drugs with quantity limits; listed as Migraine.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Triptan Antimigraine Agent, the determination of whether the requested prescription is medically necessary will take into account whether the recipient has a history of therapeutic failure of the preferred Triptan Antimigraine Agents. In addition, if a prescription for either a preferred or non-preferred Triptan Antimigraine Agent is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above, to assess the medical necessity of the request for a prescription for a Triptan Antimigraine Agent. If the guidelines in Section B are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will 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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I. Requirements for Prior Authorization of Atypical Antipsychotics

A. Prescriptions That Require Prior Authorization

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

1. A prescription for a non-preferred Atypical Antipsychotic, regardless of the quantity prescribed. See Preferred Drug List (PDL) Attachment 1 in the PDL Chapter for the list of preferred Atypical Antipsychotics.
2. A prescription for a preferred Atypical Antipsychotic with a prescribed quantity that exceeds the quantity limit. See Quantity Limits Attachment 1 in the Quantity Limits Chapter for the list of drugs with quantity limits; listed as Psychotropics.

GRANDFATHER PROVISION – The Department will grandfather prescriptions for non-preferred Atypical Antipsychotics for those recipients currently being prescribed a non-preferred Atypical Antipsychotic. The PROMISe Point-Of-Sale On-Line Claims Adjudication System will verify if the recipient has a record of a prescription for a non-preferred Atypical Antipsychotic within the past 365 days from the date of service of the new claim. If the recipient has a record of a prescription for a non-preferred Atypical Antipsychotic, a prescription or a refill for the same non-preferred Atypical Antipsychotic will be automatically approved.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Atypical Antipsychotic, the determination of whether the requested prescription is medically necessary will take into account the following:

1. Whether the recipient has a history of therapeutic failure of one (1) preferred Atypical Antipsychotic
2. Whether the recipient has a current history (within the past 365 days) of being prescribed the same non-preferred Atypical Antipsychotic

In addition, if a prescription for either a preferred or non-preferred Atypical Antipsychotic is in a quantity that exceeds the quantity limit, the determination of whether the prescription is

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medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

C . Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above, to assess the medical necessity of the request for a prescription for an Atypical Antipsychotic. If the guidelines in Section B are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

NOTE: Approved requests for prior authorization of prescriptions for Symbyax will require the use of two (2) separate prescriptions for Fluoxetine and Zyprexa.

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I. Requirements for Prior Authorization of Bone Resorption Suppression and Related Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Bone Resorption Suppression and Other Related Agents that meet any of the following conditions must be prior authorized:

1. A prescription for a non-preferred Bone Resorption Suppression and Other Related Agent, regardless of the quantity prescribed. See Preferred Drug List (PDL) Attachment 1 in the PDL Chapter for the list of preferred Bone Resorption Suppression and Other Related Agents.
2. A prescription for a preferred Bone Resorption Suppression and Other Related Agent with a prescribed quantity that exceeds the quantity limit. See Quantity Limits Attachment 1 in the Quantity Limits Chapter for the list of drugs with quantity limits; listed as Osteoporosis/Pagets Disease.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Bone Resorption Suppression and Other Related Agent, the determination of whether the requested prescription is medically necessary will take into account the following:

1. For Bisphosphonates - Whether the recipient has a history of therapeutic failure* or adverse reaction to the preferred Bone Resorption Suppression and Other Related Agent indicated for the condition.
2. For Forteo – Whether the recipient:
 - a. Had a bone density test and the T-score is lower than -2.5
 - b. Is a postmenopausal female with a diagnosis of osteoporosis
 - c. Is a male age 18 years or older with a diagnosis of primary or hypogonadal osteoporosis
 - d. Does not have a history of any of the following:
 - i. Paget's Disease of the bone

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- ii. Bone metastases
 - iii. Skeletal malignancies
 - iv. Metabolic bone disease other than osteoporosis
 - v. Prior radiation therapy
- e. Has a history of therapeutic failure* or intolerance of the Bisphosphonates

In addition, if a prescription for either a preferred or non-preferred Bone Resorption Suppression and Related Agent is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

* Therapeutic failure is defined as documented continued bone loss or fracture after two (2) or more years despite treatment with a Bisphosphonate.

C . Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above, to assess the medical necessity of the request for a prescription for a Bone Resorption Suppression and Related Agent. If the guidelines in Section B are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Cytokine and CAM Agonists

A. Prescriptions That Require Prior Authorization

Prescriptions for non-preferred Cytokine and CAM Agonists must be prior authorized. See Preferred Drug List (PDL) Attachment 1 in the PDL Chapter for the list of preferred Cytokine and CAM Agonists.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Cytokine and CAM Agonist, the determination of whether the requested prescription is medically necessary will take into account the following:

1. For Remicade - Whether the recipient has a diagnosis of :

a. Crohn's Disease which has remained active despite treatment with:

1. Corticosteroids

OR

2. 6-mercaptopurine/azathioprine

b. Rheumatoid Arthritis and a history of:

1. An inadequate response of a three (3) or more month trial of:

i. methotrexate

AND

ii. The disease-modifying anti-rheumatic drugs (DMARDS) (cyclosporine, sulfasalazine, mercaptopurine, gold compounds)

OR

iii. Corticosteroids

AND

2. Intolerance to:

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- i. The Preferred Cytokine and CAM Agonists approved for this indication
- OR**
- ii. Methotrexate
- c. Psoriatic Arthritis and a history of:
 - 1. Inadequate response to:
 - i. The non-steroidal anti-inflammatory drugs (NSAIDs), unless contraindicated
 - AND**
 - ii. The disease-modifying anti-rheumatic drugs (DMARDs) (cyclosporine, sulfasalazine, mercaptopurine, gold compounds)
 - OR**
 - iii. Cortisteroids
 - AND**
 - iv. Methotrexate
 - AND**
 - 2. Intolerance to the Preferred Cytokine and CAM Agonists approved for this indication
- d. Ankylosing Spondylitis and Other Spondyloarthropathies and a history of
 - 1. An inadequate response to:
 - i. NSAIDs, unless contraindicated
 - OR**
 - ii. DMARDs (sulfasalazine, methotrexate, azathioprine, cyclosporine, cyclophosphamide)

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AND

- iii. Corticosteroids

AND

- 2. An intolerance to Preferred Cytokine and CAM Agonists approved for this indication
 - e. Moderate to severe ulcerative colitis refractory to one or more of the following standard therapies:
 - 1. Corticosteroids (Example – prednisone, methylprednisolone)
 - 2. 5-aminosalicylic acid agents (Example – sulfasalazine, mesalamine, balsalazide)
 - 3. Immunosuppressants (Example – azathioprine, cyclosporine, mercaptopurine)
 - 2. For Amevive - Whether the recipient:
 - a. Has a history of inadequate response, intolerance, or contraindication to a three (3) or more month trial of one of the following photochemotherapies:
 - 1. Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA)
 - OR**
 - 2. UVB with coal tar or dithranol
 - AND**
 - 3. Preferred Cytokine and CAM Agonists indicated for this diagnosis
- AND**
- b. Recipient does not have a history of receiving Amevive therapy for a duration of 12 months

C . Clinical Review Process

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Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above, to assess the medical necessity of the request for a prescription for a Cytokine and CAM Agonist. If the guidelines in Section B are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Growth Hormones

A. Prescriptions That Require Prior Authorization

Prescriptions for non-preferred Growth Hormones must be prior authorized. See Preferred Drug List (PDL) Attachment 1 in the PDL Chapter for the list of preferred Growth Hormones.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Growth Hormone, the determination of whether the requested prescription is medically necessary will take into account the following:

1. For Pediatrics:

a. Whether the recipient has a diagnosis of pediatric growth hormone deficiency with the following:

- i. Recipient's height is below the third (3rd) percentile for his/her age and gender related height
- ii. Recipient's growth velocity is subnormal (-2 to -3 standard deviations below the age related mean)
- iii. Recipient has delayed skeletal maturation (demonstrated through bone age estimated from an x-ray of the left wrist and hand) equal to or greater than 2 standard deviations below the age/gender related mean
- iv. Epiphyses is confirmed as open in recipients 10 years of age and older
- v. 2 provocative stim tests producing peak growth hormone concentrations < 10ng/ml
- vi. Appropriate imaging (magnetic resonance imaging [MRI] or computed tomography [CT] of the brain with particular attention to the hypothalamic pituitary region to exclude the possibility of a tumor

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- b. Whether the recipient has a diagnosis of pediatric growth failure due to chronic renal failure and the recipient has not undergone a renal transplant
- c. Whether the recipient was born small for gestational age (SGA), defined as having a birth weight < 2500 g at a gestational age of 37 weeks and older, or weight or length at birth below the third (3rd) percentile for gestational age

AND

Recipient fails to manifest catch up growth by 3 years of age, defined as height 2 or more standard deviations below the mean for age and sex

- d. Whether the recipient has a diagnosis of Turner's Syndrome and the pediatric growth failure is due to that Syndrome
- e. Whether the recipient has a diagnosis of Prader-Willi Syndrome and is receiving treatment for that Syndrome
- f. Whether the recipient's growth failure is not due to idiopathic or familial short stature or constitutional delayed growth

NOTE FOR RENEWALS OF PRESCRIPTIONS FOR

PEDIATRICS: Requests for prior authorization of renewals of prescriptions for growth hormones that were previously approved will take into account the following:

- a. Whether the epiphyses is confirmed as open

AND

- b. Whether the recipient demonstrates a growth response equal to or greater than 4.5 cm/yr (pre-pubertal growth rate) or equal to or greater than 2.5 cm/yr (post-pubertal growth rate)

2. For Adults:

- a. Whether the recipient has a diagnosis of adult growth hormone deficiency as a result of one of the following:
 - i. Childhood onset growth hormone deficiency
 - ii. Pituitary or hypothalamic disease

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- iii. Surgery or radiation therapy
- iv. Trauma

AND

- b. Whether the recipient's growth hormone stimulation test demonstrates peak growth hormone concentrations of less than 5ng/ml

AND

- c. Whether the recipient is currently receiving adequate replacement therapy for any other pituitary hormone deficiencies

NOTE FOR RENEWALS OF PRESCRIPTIONS FOR ADULTS:

Requests for prior authorization of renewals of prescriptions for growth hormones that were previously approved will take into account whether there is a presence of a clinical benefit of the growth hormone such as increase in total lean body mass, increase in IGF-1 and IGFBP-3 levels, or increase in exercise capacity

- 3. For Serostim for the treatment of AIDS related cachexia, whether the recipient meets all of the following:

- i. The recipient is 18 years of age or older

AND

- ii. The recipient has a diagnosis of wasting syndrome (*i.e.*, unintentional weight loss of 10 percent or more of body weight) and the wasting syndrome is not attributable to other causes such as depression, MAC, chronic infectious diarrhea, or malignancy (NOTE: Kaposi's sarcoma limited to the skin or mucous membranes is covered)

AND

- iii. Optimal antiretroviral therapy has been attempted

AND

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- iv. The recipient has a history of inadequate response or intolerance to anabolic steroids (e.g. Megace)

NOTE FOR RENEWALS OF PRESCRIPTIONS FOR SEROSTIM FOR THE TREATMENT OF AIDS RELATED CACHEXIA:

Requests for prior authorization of renewals of prescriptions for growth hormones that were previously approved will take into account whether there is a presence of weight stabilization or increase.

C . Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above, to assess the medical necessity of the request for a prescription for a Growth Hormone. If the guidelines in Section B are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

D. Long Term Therapy

For Pediatrics - The Department will consider requests for prior authorization of a Growth Hormone for 12 months. Prescriptions may be refilled as long as the refills do not exceed a six (6) month or five (5) refill supply, whichever comes first, from the time of the original filling of the prescription. See 55 Pa Code § 1121.53(c). Thus, if a recipient receives either a six (6) month or five (5) refill supply, whichever comes first, a new prescription, using the same prior authorization number will be required.

For Adults – The Department will consider requests for prior authorization of a Growth Hormone for six (6) months.

For Serostim for the treatment of AIDS related cachexia – The Department will consider request for prior authorization of a Growth Hormone for three (3) months. Requests for renewals of prescriptions for growth hormones that were previously approved will be considered but may not exceed a maximum of 48 weeks.

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I. Requirements for Prior Authorization of Sedative Hypnotics

A. Prescriptions That Require Prior Authorization

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

1. A prescription for a non-preferred Sedative Hypnotic regardless of the quantity prescribed. See Preferred Drug List (PDL) Attachment 1 in the PDL Chapter for the list of preferred Sedative Hypnotics.
2. A prescription for a preferred Sedative Hypnotic with a prescribed quantity that exceeds the quantity limit. See Quantity Limits Attachment 1 in the Quantity Limits Chapter for the list of drugs with quantity limits.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Sedative Hypnotic, the determination of whether the requested prescription is medically necessary will take into account whether the recipient has a history of one of the following:

1. Therapeutic failure* of Temazepam
2. A contraindication to Benzodiazepines for one of the following reasons:
 - a. A diagnosis of COPD or other respiratory disease

OR

 - b. A diagnosis of Sleep Apnea Syndrome

OR

 - c. The recipient is 65 year of age or older

AND

3. A formal assessment of sleep hygiene

In addition, if a prescription for either a preferred or non-preferred Sedative Hypnotic is in a quantity that exceeds the quantity limit, the

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determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

* Therapeutic Failure is defined as follows:

1. Recipient's insomnia is not treated satisfactorily
2. Recipient feels continued daytime impairment/hangover
3. Recipient developed a tolerance to the drug

C . Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above, to assess the medical necessity of the request for a prescription for a Sedative Hypnotic. If the guidelines in Section B are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Stimulants and Related Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for non-preferred Stimulants and Related Agents must be prior authorized. See Preferred Drug List (PDL) Attachment 1 in the PDL Chapter for the list of preferred Stimulants and Related Narcotic Agents.

GRANDFATHER PROVISION – The Department will grandfather prescriptions for non-preferred Stimulants and Related Agents within quantity limits for those recipients currently being prescribed non-preferred Stimulants and Related Agents. The PROMISe Point-Of-Sale On-Line Claims Adjudication System will verify if the recipient has a record of a prescription for a non-preferred Stimulant and Related Agent within the past 90 days from the date of service of the new claim. If the recipient has a record of a prescription for a non-preferred Stimulant and Related Agent, a prescription or a refill for the same Stimulant and Related Agent within the quantity limits will be automatically approved.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Stimulant and Related Agents, the determination of whether the requested prescription is medically necessary will take into account the following:

1. For Strattera - Whether the recipient has a history of:
 - a. Contraindication to the preferred Stimulants and Related Agents
 - OR**
 - b. Adverse reaction to the preferred Stimulants and Related Agents
 - OR**
 - c. Therapeutic failure of a one (1) month trial of one (1) preferred Stimulant and Related Agent
 - OR**
 - d. A parent or family member with a drug addiction and/or a diversion risk

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OR

- e. Drug addiction and/or a diversion risk

OR

- f. A diagnosis of concomitant tic disorder

- 2. For Provigil – Whether the recipient has a diagnosis of:

- a. Narcolepsy documented by:

- i. A multi-latency sleep test

OR

- ii. A clinical interview if the prescriber is an American Board of Medical Specialties (ABMS) certified psychiatrist/sleep specialist

- b. Obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by a Respiratory Disturbance of >5

AND

Therapeutic failure of Continuous Positive Airway Pressure (CPAP) to resolve excessive daytime sleepiness (documented by either Epworth greater than 10 or Multiple Sleep Latency Test [MSLT] less than 6)

- c. Shift work sleep disorder (SWSD) as documented by:

- i. Recipient's recurring work schedule for one (1) month or longer

OR

- ii. Shift work which results in sleepiness on the job or insomnia at home which interferes with daily living

- d. Multiple sclerosis and is receiving treatment for fatigue associated with multiple sclerosis

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3. For all other non-preferred Stimulants and Related Agents, whether the recipient has a history of therapeutic failure of the preferred Stimulants and Related Agents

C . Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above, to assess the medical necessity of the request for a prescription for a Stimulant and Related Agent. If the guidelines in Section B are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.