



## **Alabama Medicaid Preferred Drug and Prior Authorization Program**

### **Prior Authorization (PA) Criteria Instructions**

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This document contains detailed instructions on completing the Medicaid Prior Authorization Form, Form 369. Instructions for completing the Biological Injectable Prior Authorization Form 373 can be found in the Biological Injectable Prior Authorization Instruction Booklet. Synagis Prior Authorization Form, Form 351, can be found in the Synagis Prior Authorization Instruction Worksheet.

Effective October 1, 2003, as a result of legislation passed in June 2003, the Alabama Medicaid Agency implemented a mandatory Preferred Drug List (PDL). Brand name preferred drugs, generics (unless otherwise specified), and over-the-counter (OTC) drugs for classes reviewed by the Pharmacy and Therapeutics (P&T) Committee and covered by Medicaid are available without prior approval. If, however, a non-preferred drug is prescribed, the practitioner will need to get prior authorization (PA). If approval is given to dispense the non-preferred drug, an authorization number will be given.

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## Section One PA Form: General Information

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### **PDL Drug Classes to Require PA**

The following classes of drugs are on the mandatory preferred drug list.

- [Alzheimer's Agents](#)
- [Antidepressant Agents](#)
- [Antidiabetic Agents](#)
- [Antiemetic Agents](#)
- [Antihistamines \(First Generation\)](#)
- [Antihypertensive Agents](#)
- [Anti-infective Agents](#)
- [Antilipemic Agents](#)
- [Anxiolytics/Sedatives/Hypnotics](#)
- [Cardiac Agents](#)
- [Cerebral Stimulants/Agents used for ADD/ADHD](#)
- [EENT Antiallergic Agents](#)
- [EENT Antibacterial Agents](#)
- [EENT Vasoconstrictor Agents](#)
- [Estrogens](#)
- [Genitourinary Smooth Muscle Relaxants](#)
- [Intranasal Corticosteroids](#)
- [Narcotic Analgesic Agents](#)
- [Platelet-Aggregation Inhibitor Agents](#)
- [Prenatal Vitamins](#)
- [Proton Pump Inhibitors \(PPIs\)](#)
- [Respiratory Agents](#)
- [Selective Serotonin Agonists](#)
- [Skeletal Muscle Relaxants](#)
- [Skin and Mucous Membrane Agents](#)

*Other drug classes may be added as they are reviewed and approved.*

### **Non-PDL Drugs and/or Drug Classes to Require PA**

The following drugs or classes of drugs are not included on the mandatory preferred drug list and do require PA:

- [Antihistamines \(Second Generation\)](#)
- [Antipsychotic Agents](#)
- [Growth Failure Agents](#)
  - [Adults](#)
  - [AIDS Wasting](#)
  - [Children](#)
- [H2 Antagonists](#)
- [NSAIDs](#)
- [Phosphodiesterase Inhibitors](#)
- [Smoking Cessation](#)
- [Specialized Nutritionals](#)
- [Sustained Release Oral Opioid Agonists](#)
- [Xenical](#)
- [Xolair](#)

## **Definitions**

### **Approval Timeframes**

- The approval timeframe is the maximum period of time for which a PA can be approved. This varies from class to class. Refills within the approved timeframe will not require a new PA request.

### **Appropriate Diagnosis**

- Some classes require diagnosis(es) that justifies the drug requested. Diagnosis(es) **or** ICD-9 code(s) may be used. Use of ICD-9 codes provides specificity and legibility and will usually expedite review.

### **Medical Justification**

- Medical justification is documentation to support the physician's choice for the requested course of treatment and may include documentation from the patient record or peer-reviewed literature. Documentation from the patient record (history and physical, tests, past or current medication/treatments, patient's response to treatment, etc) should illustrate and support the physician's request for the drug specified. For example, if a recommended therapy trial is contraindicated by the patient's condition or the patient has a history of allergy to a first-line drug, and the physician wants to prescribe a non-preferred drug, documentation from the patient record would support that decision. Medical justification may be provided under the Clinical Information Section on the request form or included as an attachment.

### **Prior Treatment Trials**

- Prior authorization requires that a designated number of prescribed generic, OTC or brand name drugs have been utilized unsuccessfully relative to efficacy and/or safety within a specified timeframe prior to requesting the PA. For prior therapy requirements for a specific class, refer to the class specific section of the criteria booklet.
- One prior therapy is acceptable in those instances when a class has only one preferred agent, either brand, generic or OTC, for a specific indication.
- The PA request must indicate that the prescribed generic, OTC or brand drugs have been utilized for a specified period of time **unless** there is an adverse/allergic response or contraindication. See class specific section for the specified number of days of therapy required to meet prior treatment trials.

- If the prescribing practitioner feels there is a medical reason for which the patient should not be on a preferred generic, OTC or brand medication, medical justification may be submitted in lieu of previous drug therapy.
  - The classes below require prior treatment trials. Those classes denoted with an asterisk (\*) require that the failed treatment trials be **prescribed and preferred** agents. Those without an asterisk require that the failed therapies be **prescribed**.
- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• <a href="#">Alzheimer's Agents</a>*</li> <li>• <a href="#">Antidepressant Agents</a>*</li> <li>• <a href="#">Antidiabetic Agents</a>*</li> <li>• <a href="#">Antiemetic Agents</a></li> <li>• <a href="#">Antihistamines (First Generation)</a>*</li> <li>• <a href="#">Antihistamines (Second Generation)</a></li> <li>• <a href="#">Antihypertensive Agents</a>*</li> <li>• <a href="#">Anti-infective Agents</a>*</li> <li>• <a href="#">Antilipemic Agents</a>*</li> <li>• <a href="#">Anxiolytics/Sedatives/Hypnotics</a>*</li> <li>• <a href="#">Cardiac Agents</a>*</li> <li>• <a href="#">Cerebral Stimulants/ADD/ADHD</a>*</li> <li>• <a href="#">EENT Antiallergic Agents</a>*</li> <li>• <a href="#">EENT Antibacterial Agents</a>*</li> </ul> | <ul style="list-style-type: none"> <li>• <a href="#">EENT Vasoconstrictor Agents</a>*</li> <li>• <a href="#">Estrogen Agents</a>*</li> <li>• <a href="#">Genitourinary Smooth Muscle Relaxants</a>*</li> <li>• <a href="#">H2 Antagonist Agents</a></li> <li>• <a href="#">Intranasal Corticosteroids Agents</a>*</li> <li>• <a href="#">Narcotic Analgesic Agents</a>*</li> <li>• <a href="#">NSAID Agents</a></li> <li>• <a href="#">Platelet-Aggregation Inhibitor Agents</a>*</li> <li>• <a href="#">Prenatal Vitamins</a>*</li> <li>• <a href="#">Proton Pump Inhibitors</a>*</li> <li>• <a href="#">Respiratory Agents</a>*</li> <li>• <a href="#">Selective Serotonin Agonists</a>*</li> <li>• <a href="#">Skeletal Muscle Relaxants</a>*</li> <li>• <a href="#">Skin and Mucous Membrane Agents</a>*</li> </ul> |
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### **Stable Therapy**

- Stable therapy applies in some classes for patients who have been stable on the same drug and the same strength. Stable therapy applies for all classes listed in the chart on the following page. The application of stable therapy for adults is limited to the specific classes listed under the heading “Stable therapy for all ages”. Consecutive therapy allows approval for patients who have been determined to be stable on the medication for a specified timeframe and who continue to require therapy. For stable therapy timeframe for a specific class, refer to the class specific section of the criteria booklet.
- Documentation of stable therapy is not required for renewal requests if claims history supports stable therapy. For all other requests, documentation must be provided in order to meet stable therapy requirements. Examples of acceptable documentation include pharmacy profile printouts, prescription copies, copies of the medical record medication list or progress notes documenting strength and quantity consistent with consecutive therapy timeframes. The use of medication samples or manufacturer vouchers does not count towards stable therapy requirements.

The chart on the following page outlines the stable therapy guidelines.

### Stable Therapy Guideline Chart

Drug Class	Stable Therapy for All Ages	18 years old and younger
Alzheimer's Agents	√	
Antidepressants	√	
Antidiabetic Agents	√	
Antiemetic Agents		√
Antihistamines (First Generation)		√
Antihistamines (Second Generation)		√
Antihypertensive Agents	√	
Antilipemic Agents		√
Anti-infective Agents	√	
Anxiolytics/Sedatives/Hypnotics		√
Cardiac Agents	√	
Cerebral Stimulants/Agents used for ADD/ADHD	√	
EENT Antiallergic Agents		√
EENT Antibacterial Agents		√
EENT Vasoconstrictor Agents		√
Estrogens		√
Genitourinary Smooth Muscle Relaxants		√
Intranasal Corticosteroids		√
Narcotic Analgesics		√
NSAIDs		√
Platelet-Aggregation Inhibitors	√	
Prenatal Vitamins		√
Prevacid NapraPAC®		√
Proton Pump Inhibitor (PPI) Agents		√
Respiratory Agents		√
Selective Serotonin Agonists		√
Skeletal Muscle Relaxants*	√	
Skin and Mucous Membrane Agents		√
Sustained-release Opioid Agonist (SROA) Agents		√

*\*For Skeletal Muscle Relaxants, stable therapy only applies if the patient has a chronic condition associated with spasticity.*

## **Verbal Requests**

PA requests for drugs that meet previous drug usage requirements will be accepted verbally. Verbal PA requests may be initiated by pharmacists, physicians or their authorized representative. Any drug requiring additional information or medical justification must be submitted on the required PA form.

Drugs that may be requested verbally are:

- [Alzheimer's Agents](#)
- [Antidepressants](#)
- [Antidiabetic Agents](#)
- [Antiemetic Agents](#)
- [Antihistamines \(First Generation\)](#)
- [Antihistamines \(Second Generation\)](#)
- [Anti-infective Agents](#)
- [Antilipemic Agents](#)
- [Anxiolytics/Sedatives/Hypnotics](#)
- [Cardiac Agents](#)
- [Cerebral Stimulants/ADD/ADHD](#)
- [EENT Antiallergic Agents](#)
- [EENT Antibacterial Agents](#)
- [EENT Vasoconstrictor Agents](#)
- [Estrogens](#)
- [Genitourinary Smooth Muscle Relaxants](#)
- [H2 Antagonists](#)
- [Intranasal Corticosteroids](#)
- [Narcotic Analgesics](#)
- [NSAIDs](#)
- [Platelet-Aggregation Inhibitors](#)
- [Prenatal Vitamins](#)
- [Proton Pump Inhibitors](#)
- [Respiratory Agents](#)
- [Selective Serotonin Agonists](#)
- [Skeletal Muscle Relaxants](#)
- [Skin and Mucous Membrane Agents](#)

## **Paper Requests**

Page One (1) of the Prior Authorization Request Form may be submitted alone unless the medication requested is listed on Page Two (2). Synagis and Growth Failure Agents have separate PA Forms.

Check the appropriate box at the top of the form to indicate whether one or both pages are being submitted. Acknowledgement of transmission of the second page will ensure that the reviewer has all completed material needed to review the request.

### **Drugs listed on Page 2 of PA form are:**

- Antipsychotic Agents
- Erectile Dysfunction Drugs
- Specialized Nutritionals
- Sustained Release Oral Opioid Agonists
- Xenical
- Xolair

A separate form will need to be completed for each drug/nutritional requested.

Once the form is completed, the paper request can be submitted via fax or mail.

## **Electronic Requests**

Electronic claims are submitted from the pharmacy and electronic requests may be submitted online by the pharmacy or physician.

**Electronic Prior Authorization Program (EPA)** – Certain classes of drugs are included in the EPA Program. Once the pharmacy sends an electronic claim for a drug in the EPA program, the system reviews medical and pharmacy claims history for the patient. If the criteria are met, the claim is automatically assigned an authorization number and is approved. If the PA criteria are not met, a message is returned to the pharmacy instructing the submitter to submit a manual (paper or online) request.

- An EPA rejected claim does not constitute a PA denial, only a notice to the pharmacy that a manual PA request is needed.

Drug classes included in the EPA program:

- [Alzheimer's Agents](#)
- [Antidepressants](#)
- [Antidiabetic Agents](#)
- [Antiemetic Agents](#)
- [Antihistamines \(First Generation\)](#)
- [Antihistamines \(Second Generation\)](#)
- [Antihypertensive Agents](#)
- [Antilipemics](#)
- [Antipsychotic Agents](#)
- [Anxiolytics/Sedatives/Hypnotics](#)
- [Cardiac Agents](#)
- [Cerebral Stimulants/ADD/ADHD](#)
- [EENT Antiallergic Agents](#)
- [EENT Vasoconstrictor Agents](#)
- [Estrogens](#)
- [Genitourinary Smooth Muscle Relaxants](#)
- [Intranasal Corticosteroids](#)
- [NSAIDs](#)
- [Platelet-Aggregation Inhibitors](#)
- [Respiratory Agents](#)
- [Selective Serotonin Agonists](#)
- [Skeletal Muscle Relaxants](#)
- [Skin and Mucous Membrane Agents](#)
- [Sustained Release Oral Opioid Agonists](#)

## **Online Form Submission**

From the Medicaid website ([www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)), a link can be found for a PA Request Form that can be completed and submitted electronically online. The form can also be found on HID's (Health Information Designs) website at [www.hidmedicaid.com/terms.html](http://www.hidmedicaid.com/terms.html).

Online requests, once submitted, are processed like paper requests and are subject to paper request requirements.

**Section Two**  
**PA Form: Patient Information**

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Below are fields to be completed on the PA Form.

<b>Form States</b>	<b>Your Response</b>
<b>Patient name</b>	Record the patient's name as it appears on their Medicaid card.
<b>Patient Medicaid #</b>	Record patient's Medicaid number.
<b>Patient DOB</b>	Record patient's date of birth.
<b>Patient phone # with area code</b>	Record the patient's phone number including area code.
<b>Nursing home resident</b>	If patient is nursing home resident, indicate yes.

### Section Three PA Form: Prescriber Information

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Below are fields to be completed on the PA Form.

Form States	Your Response
<b>Prescribing practitioner</b>	Record the prescribing practitioner's name.
<b>NPI/License number</b>	Record the prescribing practitioner's NPI or license number.
<b>Phone number with area code</b>	Record the prescribing practitioner's phone number with area code.
<b>Fax number with area code</b>	Record prescribing practitioner's fax number with area code.
<b>Address (optional)</b>	Prescribing practitioner's mailing address is optional
<b>Prescribing practitioner signature/date</b>	The prescriber should sign and date in this section on the prescribing practitioner signature line.*

*\*By signing in the designated space, the practitioner verifies that the request complies with Medicaid's guidelines and that he/she will be supervising the patient during treatment with the requested product. The practitioner further certifies that documentation is available in the patient record to justify the requested treatment.*

## Section Four PA Form: Clinical Information

*(This information is required for all requests.)*

Below are fields to be completed on the PA Form.

Form States	Your Response
<b>Drug requested</b>	Record the name of the drug being requested.
<b>Strength</b>	Record the strength of the drug.
<b>J Code</b>	Enter the J code if the drug requested is to be administered using office medications.
<b>Quantity</b>	Enter the quantity of the drug being requested.
<b>Days supply</b>	Enter the days supply for the quantity requested.
<b>PA refills</b>	Circle the number of refills requested.
<b>Diagnosis or ICD-9 Code</b>	Record diagnosis(es) that justifies the requested drug. Diagnosis(es) <u>or</u> ICD-9 code(s) may be used. Use of ICD-9 codes provides specificity and legibility and will usually expedite review.
<b>Initial/Renewal Request</b>	Indicate if this is an initial request or a renewal request.
<b>Type of therapy requested</b>	For H2 Antagonists and PPIs, specify if therapy is acute or maintenance.
<b>Medical justification</b>	Explain the reason this drug is required, and attach any additional medical justification necessary.*

*\*Medical justification is documentation to support the physician's choice of the requested course of treatment and may include documentation from the patient record or peer-reviewed literature. Documentation from the patient record (history and physical, tests, past or current medication/treatments, patient's response to treatment, etc) illustrates and supports the physician's request for the drug specified. For example, if a recommended therapy trial is contraindicated by the patient's condition or a history of allergy to a first-line drug, and the physician wants to order a non-preferred drug, documentation from the patient record would support that decision.*

**Section Five**  
**PA Form: Drug Specific Information**

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Below are fields to be completed on the PA Form.

<b>Form States</b>	<b>Your Response</b>
<b>Drug class requested</b>	Check the appropriate box for the drug class for the PA being requested.
<b>Previous drug usage</b>	Record the name of the discontinued medication. If there is no previous drug usage, additional medical justification must be provided.
<b>Reason for d/c</b>	Record the reason the medication was discontinued.
<b>Therapy start date</b>	Record the start date of the discontinued medication.
<b>Therapy end date</b>	Record the end date of the discontinued medication.

## **PA Criteria for Drugs/Drug Classes**

The following section outlines class specific information regarding PA criteria.

### **PDL Drug Classes to Require PA:**

- [Alzheimer's Agents](#)
- [Antidepressant Agents](#)
- [Antidiabetic Agents](#)
- [Antiemetic Agents](#)
- [Antihistamines \(First Generation\)](#)
- [Antihypertensive Agents](#)
- [Anti-infective Agents](#)
- [Antilipemic Agents](#)
- [Anxiolytics/Sedatives/Hypnotics](#)
- [Cardiac Agents](#)
- [Cerebral Stimulants/Agents used for ADD/ADHD](#)
- [EENT Antiallergic Agents](#)
- [EENT Antibacterial Agents](#)
- [EENT Vasoconstrictor Agents](#)
- [Estrogens](#)
- [Genitourinary Smooth Muscle Relaxants](#)
- [Intranasal Corticosteroids](#)
- [Narcotic Analgesic Agents](#)
- [Platelet-Aggregation Inhibitor Agents](#)
- [Prenatal Vitamins](#)
- [Proton Pump Inhibitors \(PPIs\)](#)
- [Respiratory Agents](#)
- [Selective Serotonin Agonists](#)
- [Skeletal Muscle Relaxants](#)
- [Skin and Mucous Membrane Agents](#)

## **Alzheimer's Agents**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with at least one other prescribed and preferred Alzheimer's agent in this class, either generic, OTC or brand, within the past 6 months, or have a documented allergy or contraindication to all preferred agents in this class.

### **Stable Therapy**

- Stable therapy for this class is defined as a 90-day or greater timeframe. Approval may be given for those who have documented stable therapy on the requested medication for 90 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Alzheimer's agents are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Antidepressants**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with at least two prescribed and preferred antidepressant agents in this class, either generic, OTC or brand within the past 6 months, or have a documented allergy or contraindication to all preferred agents in this class.

### **Stable Therapy**

- Approval may be given to those who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Antidepressants are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Antidiabetic Agents**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with at least two prescribed and preferred antidiabetic agents, either generic, OTC or brand, within the past 12 months, or have a documented allergy or contraindication to all preferred agents in this class.
- If the request is for Avandia<sup>®</sup>, Avandamet<sup>®</sup>, or Avandaryl<sup>®</sup>, the patient must also have failed a 30-day treatment trial with at least two prescribed and preferred antidiabetic agents (of which one is Actos<sup>®</sup>), either generic, OTC or brand, within the past 6 months.
- If the request is for Symlin<sup>®</sup>, the patient must also be on insulin therapy and have a hemoglobin A1c greater than 7% despite more than 90 days of insulin therapy.

### **Stable Therapy**

- Approval may be given for those who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Antidiabetic agents, excluding Symlin<sup>®</sup>, are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Antiemetic Agents**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 3-day treatment trials with at least two prescribed antiemetics, to include promethazine or a preferred antiemetic agent, either generic, OTC or brand, within the past 6 months, or have a documented allergy or contraindication to all preferred agents in this class.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Antiemetic agents are included in the electronic PA program.
- Through the Electronic PA program, allowances are made for patients with a cancer diagnosis to receive Emend<sup>®</sup>.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Antihistamines (First Generation)**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with at least two prescribed and preferred agents in this class, either generic, OTC or brand, within the past 6 months or have a documented allergy or contraindication to all preferred agents in this class.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Antihistamines are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Antihypertensive Agents**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with at least two prescribed and preferred antihypertensive agents in this class, either generic, OTC or brand, within the past 6 months or have a documented allergy or contraindication to all preferred agents in this class.
- To meet these prior usage requirements, drugs within this specific classification must be judged against others in the same class (AHFS specific). For example, to qualify for a non-preferred beta-blocker, the patient must have met prior usage requirements of 30-day treatment trials with two other preferred beta-blockers, either generic, OTC or brand.
- For fixed-dose combination products containing drugs from 2 different subclasses, prior therapies must include at least 2 prescribed and preferred agents from either or both respective subclasses.
- For Tekturna<sup>®</sup>, prior therapies must include at least two prescribed and preferred angiotensin-converting enzyme inhibitors and/or angiotensin II receptor antagonists.
- For Amturnide<sup>®</sup>, prior therapies must include a prescribed and preferred angiotensin-converting enzyme inhibitor or angiotensin II receptor antagonist, a dihydropyridine and a thiazide diuretic.
- For Exforge HCT<sup>®</sup> and Tribenzor<sup>®</sup>, prior therapies must include a prescribed and preferred dihydropyridine, an angiotensin II receptor antagonist and a thiazide diuretic.
- For BiDil<sup>®</sup>, in lieu of prior usage requirements, approval may be obtained for adjunctive therapy to standard heart failure therapy (including a diuretic, angiotensin converting enzyme inhibitor or angiotensin II receptor antagonist, and beta-blocker) in self-identified black patients.
- For Samsca<sup>®</sup>, patients must have a documented serum sodium <125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction. Patients must also have documentation of being initiated on Samsca<sup>®</sup> in an inpatient setting.

### **Stable Therapy**

- Approval may be given for those who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Antihypertensive agents are included in the electronic PA program.

### **Verbal PA Requests**

- Not Applicable

## **Anti-infective Agents**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed two treatment trials of no less than three-days each, with at least two prescribed and preferred anti-infectives, either generic, OTC or brand, for the above diagnosis within the past 30 days or have a documented allergy or contraindication to all preferred agents for the diagnosis submitted.
- For Incivek<sup>®</sup> and Victrelis<sup>®</sup>, in lieu of prior usage requirements, approval may be obtained for adjunctive therapy to standard hepatitis C therapy (peginterferon alfa and ribavirin) in patients ≥18 years of age with genotype 1 chronic hepatitis C.

### **Stable Therapy**

- Patients on anti-infective therapy while institutionalized once discharged or transferred to another setting or patients having a 60 day consecutive stable therapy may continue on that therapy with supportive medical justification or documentation.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested. Approval may also be given, with medical justification, if the medication requested is indicated for first line therapy when there are no other indicated preferred agents available or if indicated by susceptibility testing or evidence of resistance to all preferred agents.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Not Applicable

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Antilipemic Agents**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with at least two prescribed and preferred lipid lowering agents, either generic, OTC or brand, within the past 6 months, or have a documented allergy or contraindication to all preferred agents in this class.
- For Zetia<sup>®</sup>, if prior usage requirements have not been met, approval may be obtained for adjunctive therapy to a current lipid lowering drug.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 6 months for initial request and up to 12 months for renewal requests.

### **Electronic Prior Authorization (PA)**

- Antilipemic agents are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Anxiolytics/Sedatives/Hypnotics**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with at least two prescribed and preferred agents in this class, either generic, OTC or brand within the past 6 months, or have a documented allergy or contraindication to all preferred agents in this class.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 3 months for initial request and up to 6 months for renewal requests.

### **Electronic Prior Authorization (PA)**

- Anxiolytic, sedative and hypnotic agents are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Cardiac Agents**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with at least two prescribed and preferred cardiac agents in this class, either generic, OTC or brand, within the past 6 months or have a documented allergy or contraindication to all preferred agents in this class.
- To meet these prior usage requirements, drugs within this specific classification must be judged against others in the same class (AHFS specific).
  - For example, to qualify for a non-preferred cardiotonic, the patient must have met prior usage requirements of 30-day treatment trials with two other preferred cardiotonic agents, either generic, OTC or brand.
  - For Ranexa<sup>®</sup>, in lieu of prior usage requirements, approval may be obtained for adjunctive therapy to a current antianginal drug.

### **Stable Therapy**

- Approval may be given for those who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Cardiac agents are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Cerebral Stimulants/Agents Used for ADD/ADHD**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.
- For agents with an FDA-approved indication of Idiopathic hypersomnia in children 18 and under, narcolepsy, or obstructive sleep apnea, the patient must have an appropriate diagnosis supported by documentation in the patient record of appropriate diagnostic testing.

### **Prior Therapy**

- If the request is for a *short- or intermediate-acting* cerebral stimulant/agent used to treat ADD/ADHD, the patient must also have failed 30-day treatment trials with at least two prescribed and preferred short- or intermediate-acting cerebral stimulants/agents used for ADD/ADHD, either generic, OTC or brand, within the past 6 months.
- If the request is for a *long-acting* cerebral stimulant/agent used for ADD/ADHD, the patient must also have failed 30-day treatment trials with at least two prescribed and preferred long-acting cerebral stimulants/agents used for ADD/ADHD, either generic, OTC or brand within the past 6 months.
- If the request is for Strattera<sup>®</sup>, the patient must also have failed 30-day treatment trials with at least two prescribed and preferred cerebral stimulants (short-, intermediate- or long-acting), either generic, OTC or brand within the past 6 months. If prior usage requirements have not been met, approval may be given if there is a history of substance abuse or concern regarding substance abuse in the patient's household.
- If the request is for Intuniv<sup>®</sup>, the patient must also have failed a 30-day treatment trial with immediate-release guanfacine within the past 6 months. In addition, the patient must also have failed 30-day treatment trials with at least two prescribed and preferred cerebral stimulants (short-, intermediate- or long-acting), either generic, OTC or brand within the past 6 months. If prior usage requirements have not been met, approval may be given if there is a history of substance abuse or concern regarding substance abuse in the patient's household.
- If the request is for Kapvay<sup>®</sup>, the patient must also have failed a 30-day treatment trial with immediate-release clonidine within the past 6 months. In addition, the patient must also have failed 30-day treatment trials with at least two prescribed and preferred cerebral stimulants (short-, intermediate- or long-acting), either generic, OTC or brand within the past 6 months. If prior usage requirements have not been met, approval may be given if there is a history of substance abuse or concern regarding substance abuse in the patient's household.
- In lieu of prior usage requirements, approval may be given if there is a documented allergy or contraindication to all preferred agents in this class.

### **Stable Therapy**

- Approval may be given to those who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Cerebral Stimulant/Agent Used for ADD/ADHD agents are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **EENT Antiallergic Agents**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- For ophthalmic products, the patient must also have failed 14-day treatment trials with at least two prescribed and preferred ophthalmic agents in this class, either generic, OTC or brand, within the past 6 months or have a documented allergy or contraindication to all preferred agents in this class.
- For nasal products, the patient must have also failed 14-day treatment trials with at least two prescribed antiallergic agents, to include oral antihistamines, intranasal corticosteroids or intranasal cromolyn, either generic, OTC or brand within the past 6 months or have a documented allergy or contraindication to all preferred or acceptable agents.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- EENT antiallergic agents are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **EENT Antibacterial Agents**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 3-day treatment trials with at least two prescribed and preferred agents in this class, either generic, OTC or brand, within the past 30 days or have a documented allergy or contraindication to all preferred agents in this class.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Not Applicable

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **EENT Vasoconstrictor Agents**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 3-day treatment trials with at least two prescribed and preferred agents in this class, either generic, OTC or brand, within the past 6 months or have a documented allergy or contraindication to all preferred agents in this class.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- EENT vasoconstrictors are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Estrogens**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with at least two prescribed and preferred estrogens in this class, either generic, OTC or brand, within the past 6 months, or have a documented allergy or contraindication to all preferred agents in this class.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Estrogens are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Genitourinary Smooth Muscle Relaxants**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with at least two prescribed and preferred agents in this class, either generic, OTC or brand, within the past 6 months or have a documented allergy or contraindication to all preferred agents in this class.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Genitourinary smooth muscle relaxants are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Intranasal Corticosteroids**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with at least two prescribed and preferred intranasal corticosteroids in this class, either generic, OTC or brand, within the past 6 months or have a documented allergy or contraindication to all preferred agents in this class.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Intranasal corticosteroid agents are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Narcotic Analgesics**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.
- For buprenorphine, Subutex<sup>®</sup> and/or Suboxone<sup>®</sup>, the patient must have a diagnosis of opioid dependence. Treatment must only be prescribed by a licensed physician who qualifies for a waiver under the Drug Addiction Treatment Act (DATA) and has notified the Center for Substance Abuse Treatment of the intention to treat addiction patients and has been assigned a DEA (X) number.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with at least 2 prescribed and preferred narcotic analgesics in this class, either generic, OTC, or brand, within the past 6 months or have a documented allergy or contraindication to all preferred agents in this class.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- For narcotic analgesics, medical justification must include documentation of therapeutic pain management failure with nonsteroidal anti-inflammatory drugs (NSAIDs), acetaminophen, or aspirin and a complete pain evaluation in the medical record. Type of pain (acute versus chronic) and pain intensity (mild, moderate or severe) must be indicated in the Drug/Clinical Information section under Medical Justification. Medical justification may also include peer-reviewed literature, medical record documentation or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 3 months with initial and renewal requests unless one of the qualifying diagnoses is indicated, then approval may be given for up to 6 months. If the patient is a nursing home resident, approval may be given for up to 6 months for initial requests and up to 12 months for renewal requests.

### **Electronic Prior Authorization (PA)**

- Not Applicable

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Platelet-Aggregation Inhibitors**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with at least 2 prescribed and preferred platelet-aggregation inhibitors in this class, either generic, OTC, or brand, within the past 6 months or have a documented allergy or contraindication to all preferred agents in this class.

### **Stable Therapy**

- Approval may be given to those who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Acceptable medical justification consists of specific clinical diagnoses for 1<sup>st</sup> line treatment by certain branded products in lieu of prior usage, allergy, contraindication or intolerance to the use of aspirin, cilostazol, ticlopidine and dipyridamole.
- Clinical literature and guidelines support the use of Aggrenox<sup>®</sup>, Effient<sup>®</sup> and Plavix<sup>®</sup> for specific 1<sup>st</sup> line indications; these indications include acute coronary syndrome, acute myocardial infarction (NSTEMI and STEMI), peripheral arterial occlusive disease (PAD, PVD), transient ischemia or ischemic stroke due to thrombosis/embolism, and percutaneous coronary interventions (balloon angioplasty, laser angioplasty, intra-coronary stents, other catheter devices treating coronary atherosclerosis).

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Platelet-aggregation inhibitors are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Prenatal Vitamins**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with at least two prescribed and preferred agents in this class, either generic, OTC or brand, within the past 6 months or have a documented allergy or contraindication to all preferred agents in this class.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Not Applicable

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Proton Pump Inhibitors (PPI)**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record. Requests must indicate under the Clinical Information Section of the PA Request Form whether medication is for acute or maintenance therapy.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with at least 2 prescribed and preferred PPIs in this class, either generic, OTC, or brand, within the past 6 months or have a documented allergy or contraindication to all preferred agents in this class.
- For Prevpac<sup>®</sup>, the patient must have failed 2 treatment trials of at least 14 days each with lack of healing on an acid suppressor and 2 antibiotics, either generic, OTC or brand, within the past 6 months, or have a documented contraindication to all preferred agents in these classes.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **Uncomplicated Symptomatic GERD (Nonerosive Reflux Disease)**

The patient must meet prior usage requirements. Empirical therapy with a PPI is an appropriate initial management strategy for patients with typical symptoms in the absence of alarm features. A diagnosis of GERD can be made based on a history of classic symptoms and favorable response to antisecretory therapy without further testing.

**For acute therapy**, approval may be given for up to 8 weeks.

**For maintenance therapy**, documentation of appropriate testing (endoscopy, manometry, ambulatory impedance-pH, catheter pH, or wireless pH monitoring) is required for patients who have not responded to an empirical trial of PPI therapy. Approval may be given for up to 12 months. After 12 months, approval will require documentation of persistent symptoms. Retesting is not required for maintenance therapy renewals.

### **Complicated GERD (Erosive Esophagitis)**

The patient must have an appropriate diagnosis confirmed by testing (endoscopy) and meet prior usage requirements.

**For acute therapy**, approval may be given for up to 8 weeks. For patients who do not heal after 8 weeks, an additional 8 weeks may be approved.

**For maintenance therapy**, approval may be given for up to 12 months. Retesting is not required for maintenance therapy renewals.

### **Positive *H. pylori* Infections**

The patient must have a diagnosis of *H. pylori* infection, confirmed by testing (breath test, blood test or tissue biopsy if endoscopic exam done) within the past 30 days, and duodenal ulcer disease, confirmed by testing within the past 12 months, and meet prior usage requirements.

**For acute therapy**, the patient may be approved for up to 14 days of combination therapy.

### **Gastric or Duodenal Ulcers**

The patient must have an appropriate diagnosis confirmed by testing (barium contrast or double contrast radiography, or endoscopy) within the past 12 months and meet prior usage requirements.

**For acute therapy**, approval may be given for up to 8 weeks of therapy.

**For maintenance of healed duodenal ulcers**, maintenance therapy may be approved for up to 12 months (Prevacid®).

**To reduce the risk of NSAID-associated gastric ulcers in patients at risk for developing a gastric ulcer who require the use of an NSAID**, approval may be given for up to 12 weeks (Prevacid®) or 6 months (Nexium®) of therapy.

### **Barrett's Esophagus, Zollinger-Ellison Syndrome, or Other Pathological Hypersecretory Conditions**

The patient must have an appropriate diagnosis confirmed by testing (barium contrast or double contrast radiography, or endoscopy).

**For acute therapy**, approval may be given for up to 12 months of treatment.

**For maintenance therapy**, approval may be given for up to 12 months. Retesting is not required for maintenance therapy renewals.

### **PA Timeframe Approval**

- Approval may be given for up to 12 months for maintenance. Otherwise, please see above.

### **Electronic Prior Authorization (PA)**

- Not Applicable

### **Verbal PA Requests**

- PA requests that meet prior usage requirements for approval may be accepted verbally.

## **Respiratory Agents**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- For a diagnosis of allergic rhinitis, the patient must also have failed 30-day treatment trials with at least two prescribed antiallergic agents, to include oral antihistamines or intranasal corticosteroids either generic, OTC or brand, within the past 6 months or have a documented allergy or contraindication to all preferred agents in this class.
- For all other diagnoses, the patient must also have failed 30-day treatment trials with at least two prescribed and preferred respiratory agents in this class, either generic, OTC or brand, within the past 6 months or have a documented allergy or contraindication to all preferred agents in this class.
- Requests for Pulmicort Respules<sup>®</sup> or Singulair<sup>®</sup> will not require failed therapy for children under age five with a diagnosis of asthma.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Respiratory agents are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Selective Serotonin Agonists**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.
- The request must be for acute treatment, not prophylactic therapy.

### **Prior Treatment Trials**

- The patient must have failed 2-week treatment trials with at least two other prescribed and preferred selective serotonin agonists, either generic, OTC or brand, within the past 6 months or have a documented allergy or contraindication to all preferred agents in this class.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have been stable on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 6 months initially and up to 12 months for renewal requests.

### **Electronic Prior Authorization (PA)**

- Selective serotonin agonists are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Skeletal Muscle Relaxants**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must have also failed 30-day treatment trials with at least two prescribed and preferred skeletal muscle relaxants, either generic, OTC or brand, within the past 6 months or have a documented allergy or contraindication to all preferred agents in this class.

### **Stable Therapy**

- Approval may be given if the patient has been on consecutive 60 day or greater treatment if the skeletal muscle relaxant being requested is for a chronic condition associated with muscle spasticity.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- For chronic conditions associated with muscle spasticity, approval may be given for up to 6 months initially and up to 12 months for renewal requests.
- For acute conditions associated with muscle spasms, approval may be given for up to a 10-day course of medication consistent with current maximum limits when criteria are met.

### **Electronic Prior Authorization (PA)**

- Skeletal muscle relaxant agents are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Skin and Mucous Membrane Agents**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trial**

- The patient must also have failed 30-day treatment trials with at least two prescribed and preferred skin and mucous membrane agents in this class, either generic, OTC or brand, within the past 6 months, or one failed treatment trial when appropriate based on PDL preferred agents, or have a documented allergy or contraindication to all preferred agents in this class.
- For scabicides and pediculicides, the patient must have failed 14-day treatment trials with at least two prescribed and preferred skin and mucous membrane agents in this class, either generic, OTC or brand within the past 6 months or have a documented allergy or contraindication to all preferred agents in this class.
- To meet prior usage requirements, drugs within this specific classification must be judged against others in the same class (AHFS specific).
  - For example, to qualify for a non-preferred topical anti-inflammatory agent, the patient must have met prior usage requirements of 30-day treatment trials with two other topical anti-inflammatory agents, either generic or brand.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have been stable on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Skin and mucous membrane agents are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Non-PDL Drugs and/or Drug Classes to Require PA**

- [Antihistamines \(Second Generation\)](#)
- [Antipsychotic Agents](#)
- [Growth Failure Agents](#)
  - [Adults](#)
  - [AIDS Wasting](#)
  - [Children](#)
- [H2 Antagonists](#)
- [NSAIDs](#)
- [Phosphodiesterase Inhibitors](#)
- [Smoking Cessation](#)
- [Specialized Nutritionals](#)
- [Sustained Release Oral Opioid Agonists](#)
- [Xenical](#)
- [Xolair](#)

## **Antihistamines (Second Generation)**

### **Appropriate Diagnosis**

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with at least two prescribed antihistamines, either generic, OTC or brand within the past 6 months, or have a documented allergy or contraindication to all covered OTC or generic antihistamine agents.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Second generation antihistamines are included in the electronic PA program.

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Antipsychotic Agents**

### **Appropriate Diagnosis/Prescriber Specialty**

- The patient must have an appropriate diagnosis supported by documentation in the patient record, or the prescription may be written by a psychiatrist (adults), a child/adolescent psychiatrist (children), or a mid-level practitioner (CRNP or Physician Assistant) of the respective psychiatrist.

### **Prior Treatment Trials**

- Not Applicable

### **Stable Therapy**

- Approval may be given for children, adolescents and adults (6 years of age and older) who have documented stable therapy on the requested medication for 60 consecutive days or greater.
- If an appropriate diagnosis is not included, requests will be approved for 3 months for adults (>18 years of age) and 6 months for children and adolescents (6 to 18 years of age). Notification (via PA approval letter) will be sent to the prescribing physician notifying him/her that an appropriate diagnosis will be required to approve subsequent requests.
- Stable therapy does not apply to antipsychotic agents for children <6 years of age.

### **Medical Justification**

- For children, adolescents and adults (6 years of age and older), medical justification may include peer-reviewed literature, medical record documentation, request for continuation of therapy after discharge from the hospital, or information specifically requested.
- For children <6 years of age, medical justification must include chart notes with specific symptoms that support the diagnosis, as well as peer-reviewed literature if the antipsychotic agent is being used for an off-label use.
- For children <6 years of age, the prescriber must indicate through attestation that monitoring protocols have been followed. For a list of monitoring protocols, see Attachment C on the Agency website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

### **PA Approval Timeframes**

- Approval may be given for up to 12 months for adults with an appropriate diagnosis and for up to 3 months for adults without an appropriate diagnosis.
- Approval may be given for up to 6 months for children and adolescents (6 to 18 years of age) and for up to 6 months for children <6 years of age.

**Electronic Prior Authorization (PA)**

- Antipsychotic agents are included in the electronic PA program.

**Verbal PA Requests**

- Not Applicable

## Growth Failure Agents in Adults

### Appropriate diagnosis

- The patient must have one of the following primary diagnoses listed below confirmed by a board certified endocrinologist or a board certified gastroenterologist for short bowel syndrome.
  - Childhood onset of growth hormone deficiency
  - Adult onset of growth hormone deficiency with other deficiencies
  - Adult onset of growth hormone deficiency without other pituitary hormone deficiencies
  - Short Bowel Syndrome
- Agents include Genotropin<sup>®</sup>, Humatrope<sup>®</sup>, Norditropin<sup>®</sup>, Nutropin AQ<sup>®</sup>, Nutropin<sup>®</sup>, Saizen<sup>®</sup> and Zorbitive<sup>®</sup>.
- Adult is defined for growth hormone replacement therapy as any patient with closed epiphyses.

### Prior Treatment Trials

- Prior treatment trials do not apply to agents used for growth failure.

### Stable Therapy

- Stable therapy does not apply to agents used for growth failure.

### Medical Justification

- Adults being considered for treatment with growth hormone must be screened prior to initiation of therapy to verify the absence of any malignant condition. If growth failure results from an intracranial tumor, absence of tumor growth or tumor recurrence must be documented for at least 6 months before initiating growth hormone therapy.
- Patients must be tested for normal thyroid function.
- Patients will be denied if they have any of the following contraindications.
  - Pregnancy
  - Proliferative or preproliferative diabetic neuropathy
  - Pseudotumor cerebri or benign intracranial HTN
- For growth hormone deficiency, provocative testing and IGF-1 levels as well as dates must be included. For adults with childhood onset growth hormone deficiency or with additional pituitary hormone deficits, one stimulation test is required. For those with suspected growth hormone deficiency with no other pituitary hormone deficits, 2 stimulation tests are required.
- As provocative testing, Insulin Tolerance Test is **required** unless contraindicated. ITT is contraindicated in patients with seizures, CAD, abnormal EKG with history of IHD or CVD and not advised for those > age 60. If ITT is contraindicated, documentation must be provided and an alternative test performed. Results from

other stimulation tests (arginine, glucagon, L-Dopa, growth hormone-releasing hormone [GHRH], and combinations of these agents, excluding clonidine), may be submitted for those patients with documented contraindication to ITT.

- For patients with short bowel syndrome, the patient must be receiving specialized nutritional support such as dietary adjustments, enteral feedings, parenteral nutrition, and/or fluid and micronutrient supplement.
- The strength, daily dose, patient's height and weight must be included with all requests.
- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- For growth hormone deficiency, approval may be given for up to 6 months. For subsequent requests, the physician must submit progress reports including information regarding efficacy, adverse effect and compliance, and the results of any required lab tests. The report must include the date the patient was last seen by the physician.
- For short bowel syndrome, approval may be granted for up to 4 weeks.

### **Electronic Prior Authorization (PA)**

- Not Applicable

### **Verbal PA Requests**

- Not Applicable

## **Growth Failure Agents in AIDS Wasting**

### **Appropriate diagnosis**

- The patient must have a diagnosis of HIV/AIDS.
- Example agents include Serostim<sup>®</sup>.

### **Prior Treatment Trials**

- Patient must be on antiretroviral therapy. The start date of the antiretroviral must be at least 120 days prior to the initiation of growth failure agent.
- Documentation of failed trial with appetite stimulants or weight gain agents (Periactin<sup>®</sup>, Marinol<sup>®</sup>, Megace<sup>®</sup>, Oxandrin<sup>®</sup>, or androgenic steroid) must be included.

### **Stable Therapy**

- Stable therapy does not apply to agents used for growth failure.

### **Medical Justification**

- Adults being considered for treatment with growth hormone must be screened prior to initiation of therapy to verify the absence of any malignant condition. If growth failure results from an intracranial tumor, absence of tumor growth or tumor recurrence must be documented for at least 6 months before initiating growth hormone therapy.
- Patients will be denied if they have any of the following contraindications.
  - Pregnancy
  - Proliferative or preproliferative diabetic neuropathy
  - Pseudotumor cerebri or benign intracranial HTN
- For approval, documentation of unintentional weight loss of 10% over 12 months, 7.5% over 6 months, or loss of muscle mass (BMI < 20kg/m<sup>2</sup>).
- Weight stabilization or weight gain must be reported to continue therapy.
- The duration of therapy, strength, daily dose, patient's height, weight, and BMI must be included with all requests.
- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 6 months. For subsequent requests, the physician must submit progress reports including information regarding efficacy, adverse effect and compliance, and the results of any required lab tests. The report must include the date the patient was last seen by the physician.

**Electronic Prior Authorization (PA)**

- Not Applicable

**Verbal PA Requests**

- Not Applicable

## **Growth Failure Agents in Children**

### **Appropriate diagnosis**

- The patient must have one of the following primary diagnoses listed below.
  - Documented Growth Hormone Deficiency
  - Turner Syndrome
  - Growth Deficiency due to Chronic Renal Insufficiency (CRI)
  - Prader-Willi Syndrome
  - Severe Primary IGF-1 Deficiency (for mecasermin only)
  - Growth Hormone Gene Deletion (for mecasermin only)
- Example agents include Genotropin<sup>®</sup>, Humatrope<sup>®</sup>, Increlex<sup>®</sup>, Iplex<sup>®</sup>, Norditropin<sup>®</sup>, Nutropin<sup>®</sup>, Nutropin AQ<sup>®</sup>, Omnitrope<sup>®</sup>, Saizen<sup>®</sup>, and Tev-tropin<sup>®</sup>.
- The diagnosis must be confirmed by a board certified endocrinologist. For CRI, diagnosis may be confirmed by a board certified pediatric nephrologist.

### **Prior Treatment Trials**

- Prior treatment trials do not apply to agents used for growth failure.

### **Stable Therapy**

- Stable therapy does not apply to agents used for growth failure.

### **Medical Justification**

- Children being considered for treatment with growth hormone must be screened prior to initiation of therapy to verify the absence of any malignant condition. If growth failure results from an intracranial tumor, absence of tumor growth or tumor recurrence must be documented for at least 6 months before initiating growth hormone therapy.
- Patients will be denied if they have any of the following contraindications.
  - Pregnancy
  - Proliferative or preproliferative diabetic neuropathy (does not apply to mecasermin)
  - Pseudotumor cerebri or benign intracranial HTN (does not apply to mecasermin)
  - Closed epiphyses (after epiphyseal closure, use Adult Growth Failure Therapy criteria)
- For growth hormone (GH) deficiency, provocative testing (for children  $\geq 12$  months of age) and IGF-1 levels as well as dates must be included. Results from at least one (1) stimulation test (arginine, glucagon, L-Dopa, growth hormone-releasing hormone [GHRH], and combinations of these agents, excluding clonidine) are required. GH peak levels of  $\leq 10$  ng/ml after provocative testing support GH deficiency and justify treatment.
- Short stature in girls with Turner Syndrome is not due to GH deficiency, but growth failure due to intrinsic skeletal dysplasia. The decision to treat these

patients is not based on provocative testing but on the diagnosis of Turner Syndrome using karyotyping. For Turner Syndrome, the date and results of karyotyping must be included.

- The following diagnosis specific information is needed for approval of growth failure agents in children:
  - **Documented Growth Hormone Deficiency**
    - Diagnosis by Board Certified Endocrinologist
    - Normal thyroid function
    - Provocative testing
    - IGF-1 level
    - Height less than 5<sup>th</sup> percentile
    - Screening for intracranial malignancy and free from recurrence for at least 6 months
    - Free from following contraindications
      - Pregnancy
      - Proliferative or preproliferative diabetic neuropathy
      - Pseudotumor cerebri or benign intracranial HTN
      - Closed epiphyses (after epiphyseal closure, use Adult Growth Failure Therapy criteria)
  - **Turner Syndrome**
    - Diagnosis by Board Certified Endocrinologist
    - Normal thyroid function
    - Karotyping with 45X (XO) date and results
    - Height less than 5<sup>th</sup> percentile
    - Screening for intracranial malignancy and free from recurrence for at least 6 months
    - Free from following contraindications
      - Pregnancy
      - Proliferative or preproliferative diabetic neuropathy
      - Pseudotumor cerebri or benign intracranial HTN
      - Closed epiphyses (after epiphyseal closure, use Adult Growth Failure Therapy criteria)
  - **Growth Deficiency due to Chronic Renal Insufficiency (CRI)**
    - Diagnosis by Board Certified Pediatric Nephrologist
    - Normal thyroid function
    - GFR and date
    - Height velocity or growth value in standard deviations below the means
    - Screening for intracranial malignancy and free from recurrence for at least 6 months
    - Free from following contraindications
      - Pregnancy
      - Proliferative or preproliferative diabetic neuropathy
      - Pseudotumor cerebri or benign intracranial HTN

- Closed epiphyses (after epiphyseal closure, use Adult Growth Failure Therapy criteria)

➤ **Prader-Willi Syndrome**

- Diagnosis by Board Certified Endocrinologist
- Normal thyroid function
- Height less than 5<sup>th</sup> percentile
- Screening for intracranial malignancy and free from recurrence for at least 6 months
- Free from following contraindications
  - Pregnancy
  - Proliferative or preproliferative diabetic neuropathy
  - Pseudotumor cerebri or benign intracranial HTN
  - Closed epiphyses (after epiphyseal closure, use Adult Growth Failure Therapy criteria)

➤ **Severe Primary IGF-1 Deficiency (for Increlex and Iplex only)**

- Diagnosis by Board Certified Endocrinologist
- Height value or growth velocity
- IGF-1 in standard deviations below the mean
- Growth hormone level
- Screening for intracranial malignancy and free from recurrence for at least 6 months
- Free from following contraindications
  - Pregnancy
  - Closed epiphyses (after epiphyseal closure, use Adult Growth Failure Therapy criteria)
- Age of at least 2 years but less than 18

➤ **Growth Hormone Gene Deletion (for Increlex and Iplex only)**

- Diagnosis by Board Certified Endocrinologist
- Screening for intracranial malignancy and free from recurrence for at least 6 months
- Free from following contraindications
  - Pregnancy
  - Closed epiphyses (after epiphyseal closure, use Adult Growth Failure Therapy criteria)
- Age of at least 2 years but less than 18

- The strength, daily dose, patient's height and weight must be included with all requests.
- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 6 months. For subsequent requests, the physician must submit progress reports including information regarding efficacy, adverse effect and compliance, and the results of any required lab tests. The report must include the date the patient was last seen by the physician.

### **Electronic Prior Authorization (PA)**

- Not Applicable

### **Verbal PA Requests**

- Not Applicable

## **H2 Antagonists**

### **Appropriate Diagnosis**

- Indicate in the clinical information section whether this request is for acute or maintenance therapy.

### **Prior Treatment Trials**

- The patient must also have failed 30-day treatment trials with two prescribed H2 Antagonists in this class, either generic, OTC or brand, within the past 6 months.
- Approval may be given without failed drug trials **if** a relevant diagnosis and documentation of testing with date and results are provided.

### **Stable Therapy**

- Stable therapy does not apply to the H2 antagonist class.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval timeframes are based on acute versus maintenance therapy. Approval may be given for up to 12 months for maintenance therapy.

### **Electronic Prior Authorization (PA)**

- Not Applicable

### **Verbal PA Requests**

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## Nonsteroidal Anti-inflammatory Drugs (NSAIDs)

### Appropriate Diagnosis

- For COX II Inhibitors, the patient must have an appropriate diagnosis supported by documentation in the patient record, as well as any additional diagnoses and any history preventing the use of other NSAIDs.

### Prior Treatment Trials

- The patient must have failed 30-day treatment trials with at least 2 other therapies, either generic, OTC, or brand, within the past 6 months.

### Stable Therapy

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

### Medical Justification

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.
- For **Prevacid NapraPAC<sup>®</sup>** the patient must have a diagnosis of gastric ulcer, diagnosed within the past 12 months, **and** require the use of an NSAID for treatment of the signs and symptoms of rheumatoid arthritis, osteoarthritis, or ankylosing spondylitis. The patient must also have failed two 30-day treatment trials with at least two prescribed NSAIDs while on concomitant H2 or PPI therapy within the past 6 months, either generic, OTC or brand, or have a documented contraindication to all preferred agents in this class.

### PA Approval Timeframes

- Approval may be given for up to 12 months.

### Electronic Prior Authorization (PA)

- Nonsteroidal anti-inflammatory drugs (NSAIDs) are included in the electronic PA program.

### Verbal PA Requests

- PA requests that meet prior usage requirement for approval may be accepted verbally.

## **Phosphodiesterase Inhibitors**

### **Appropriate Diagnosis**

- Phosphodiesterase inhibitors require diagnosis of pulmonary arterial hypertension (defined by a mean pulmonary arterial pressure >25 mm Hg at rest or >30 mm Hg with exercise, by a pulmonary capillary wedge pressure  $\leq$  15 mm Hg and by peripheral vascular resistance > 3 mm Hg/L/min).
- Documentation must be provided of consultation with a specialist experienced in the treatment of pulmonary hypertension patients.
- A sole diagnosis of erectile dysfunction will not be approved.

### **Prior Treatment Trials**

- Documentation must include failure of or contraindication to at least three other available oral conventional therapies.
- Previous therapies may include oral anticoagulants, calcium channel blocking agents, digoxin, diuretics and/or oxygen supplementation.

### **Stable Therapy**

- Stable therapy does not apply to phosphodiesterase inhibitors.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### **PA Approval Timeframes**

- Approval may be given for up to 30 days for initial requests, with up to 3 months allowed for renewal requests.

### **Electronic Prior Authorization (PA)**

- Not Applicable

### **Verbal PA Requests**

- Not Applicable

## **Smoking Cessation**

### **Appropriate Diagnosis**

- The patient must be pregnant or within 60 days postpartum.

### **Prior Treatment Trials**

- Prior treatment trials do not apply to smoking cessation products.

### **Stable Therapy**

- Stable therapy does not apply to smoking cessation products.

### **Medical Justification**

- Medical justification includes pregnant recipients enrolled in the Quitline program in the last 30 days.

### **PA Approval Timeframes**

- Approval timeframe is dependent upon the duration of therapy for the approved medication. Only one course of therapy is allowed per pregnancy.

### **Electronic Prior Authorization (PA)**

- Not Applicable

### **Verbal PA Requests**

- Not Applicable

## **Specialized Nutritionals**

### **Appropriate Diagnosis**

- Patients who, because of illness or trauma, cannot be sustained through oral feedings and must rely on enteral nutrition therapy may qualify for coverage under Medicaid. Enteral nutrition may be administered by nasogastric, jejunostomy, or gastrostomy tubes.
- Specialized nutrition is covered for Medicaid eligible EPSDT recipients less than 21 years of age with nutritional disorders. They do not have to be tube fed, but the specialized feeding must constitute more than 50% of their nutritional needs. A qualifying diagnosis is required.
- Recipients age 21 and over who must rely on enteral feedings as their only source of nutrition may qualify for Medicaid coverage if they have a qualifying diagnosis and meet disease specific criteria.

### **Prior Treatment Trials**

- Prior treatment trials do not apply to nutritional products.

### **Stable Therapy**

- Stable therapy does not apply to nutritional products.

### **Medical Justification**

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.
- Additional Information
  - Current height and weight are required.
  - Current age is required.
  - Route specialized nutritional is administered, along with the duration and number of refills is required.
- Prior authorization is for the nutritional product only and does not include any equipment or supplies necessary to administer the nutrients. Supplies and equipment used in conjunction with nutritional therapy may be covered in the Medical Supplies, Appliances and Durable Medical Equipment Program. For more information on supplies and equipment, see Chapter 14 of the Medicaid Provider Manual or contact Medicaid Provider/Recipient Services at 1-334-353-4753.

### **PA Timeframe Approval**

- Approval may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Not Applicable

### **Verbal PA Requests**

- Not Applicable

## **Sustained Release (SR) Oral Opioid Agonists**

### **Appropriate Diagnosis**

- Approval may be given for the treatment of intractable, chronic pain with oral SR opioid agonists (Avinza<sup>®</sup>, Embeda<sup>®</sup>, Exalgo<sup>®</sup>, Kadian<sup>®</sup>, MS Contin<sup>®</sup>, Opana ER<sup>®</sup>, Oramorph SR<sup>®</sup>, and OxyContin<sup>®</sup>). These medications are narcotic analgesics and Schedule II controlled substances and are not intended for use with acute pain, as a PRN analgesic, or for short-term pain management ( $\leq 10$  days).
- The request form must include duration of therapy, if medication is for PRN use, type of pain, and severity of pain.

### **Prior Treatment Trials**

- The patient must have failed 30-day trials with alternative pain management therapies and non-opioid adjuvant drugs to replace or enhance opioid analgesia, unless the primary diagnosis is an approved cancer diagnosis.

### **Stable Therapy**

- Approval may be given for children age 18 years and under who have been stable on the requested medication for 60 consecutive days or greater who meet the diagnosis requirements.

### **Medical Justification**

- For patients  $\geq 65$  years of age, medical justification may be provided in lieu of non-opioid adjuvant drugs.
- If the patient has a history of substance abuse or addiction, a treatment plan (a plan of action addressing continuing medical monitoring, titration, and a written signed contract for therapy) must be attached to the request, unless the patient is a nursing home resident.
- For nursing home residents with a history of substance abuse or addiction, medical justification may be submitted in lieu of a plan of action, alternate pain management choices and adjuvant therapy.

### **PA Approval Timeframes**

- Approval timeframes are diagnosis dependent and may be given for up to 12 months.

### **Electronic Prior Authorization (PA)**

- Sustained release (SR) oral opioid agonists are included in the electronic PA program.

### **Verbal PA Requests**

- Not Applicable

## Xenical®

### Appropriate Diagnosis

- To receive prior authorization for Xenical®, the patient must be 18 years of age or older and have at least one of the following primary medical diagnoses:
  - Diabetes mellitus
  - Hypertension
  - Hyperlipidemia
- For initial requests the patient's height (in inches), weight (in pounds) and BMI are required.
- Renewal requests require the patient's previous and current weights (in pounds). Continued weight loss must be documented for renewals.
- Dosage requested must not exceed 120 mg TID.

### Prior Treatment Trials

- There must be documentation in the patient record to support failure with prior physician supervised exercise/diet regimen(s) of at least 6 months duration. Documentation must also show that adjuvant therapy is planned.

### Stable Therapy

- Stable therapy does not apply to Xenical®.

### Medical Justification

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### PA Approval Timeframes

- Approval may be given for up to 3 months with initial request, and up to 6 months for each subsequent request to a total approval period not to exceed 2 years for the recipient.

### Electronic Prior Authorization (PA)

- Not Applicable

### Verbal PA Requests

- Not Applicable

## Xolair<sup>®</sup>

### Appropriate Diagnosis

- Prior authorization for treatment with Xolair requires that the patient's course of treatment be recommended by a board certified pulmonologist or a board certified allergist.
- The patient must be 12 years of age or older.
- The patient must have had a positive skin or blood test reaction to a perennial aeroallergen.
- Appropriate IgE to mass ratios must be followed, with the baseline IgE levels between 30 IU/ml and 700 IU/ml.
- The patient must weigh between 30kg and 150kg.

### Prior Treatment Trials

- The patient must be symptomatic despite receiving a combination of either inhaled corticosteroid and leukotriene inhibitor or an inhaled corticosteroid and a long acting beta agonist or the patient must have required 3 or more bursts of oral steroids within the past 12 months.

### Stable Therapy

- Stable therapy does not apply to Xolair<sup>®</sup>.

### Medical Justification

- Medical justification may include peer-reviewed literature, medical record documentation, or other information specifically requested.

### PA Approval Timeframes

- Approval may be given for up to 6 months for initial request and up to 12 months for renewal requests.

### Electronic Prior Authorization (PA)

- Not Applicable

### Verbal PA Requests

- Not Applicable

**Section Six**  
**PA Form: Dispensing Pharmacy Information**

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*(Information in this area may be completed by the pharmacy).*

Below are fields to be completed on the PA Form.

<b>Form States:</b>	<b>Your Response:</b>
<b>Dispensing pharmacy</b>	Enter the pharmacy name.
<b>NPI/Provider number</b>	Enter the pharmacy NPI or provider number.
<b>Phone number with area code</b>	Enter the pharmacy phone number with area code.
<b>Fax number with area code</b>	Enter the pharmacy fax number with area code.
<b>NDC number</b>	Record the NDC number of the drug requested.