

**ACE Inhibitors, Angiotensin Receptor Blockers,
Beta-Blockers**

LENGTH OF AUTHORIZATION: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?
Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
 Document clinically compelling information

2. The requested medication may be approved if both of the following are true:
 - If there has been a therapeutic failure of no less than a **one-month trial** of at least **one** medication **within the same class** not requiring prior approval
 - The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated

ADDITIONAL INFORMATION TO AID IN FINAL DECISION

If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then may approve the requested medication.

Document details

This medication should be reviewed for need at each request for reauthorization.

ACE Inhibitors

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>	
benazepril	<i>Accupril[®]</i>	<i>Monopril[®]</i>
captopril	<i>Aceon[®]</i>	<i>Prinivil[®]</i>
enalapril	<i>Altace Capsule[®]</i>	<i>quinapril</i>
lisinopril	<i>Altace Tablet[®]</i>	<i>ramipril</i>
	<i>Capoten[®]</i>	<i>trandolapril</i>
	<i>fosinopril</i>	<i>Univasc[®]</i>
	<i>Lotensin[®]</i>	<i>Vasotec[®]</i>
	<i>Mavik[®]</i>	<i>Zestril[®]</i>
	<i>moexipril</i>	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

ACE Inhibitors, Angiotensin Receptor Blockers, Beta-Blockers (continued page 2)

ACE Inhibitors + Diuretic Combinations

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
benazepril/HCTZ	<i>Accuretic</i> [®]	<i>Prinzide</i> [®]
captopril/HCTZ	<i>Capozide</i> [®]	<i>quinapril/HCTZ</i>
enalapril/HCTZ	<i>fosinopril/HCTZ</i>	<i>Quinaretic</i> [®]
lisinopril/HCTZ	<i>Lotensin HCT</i> [®]	<i>Uniretic</i> [®]
	<i>Monopril HCT</i> [®]	<i>Univasc</i> [®]
	<i>moexipril/HCTZ</i>	<i>Vaseretic</i> [®]
		<i>Zestoretic</i> [®]

ACE Inhibitors + Calcium Channel Blocker Combinations

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
amlodipine/benazepril (2.5/10, 5/10, 5/20 & 10/20 generic preferred)	<i>amlodipine/benazepril</i> (5/50 and 10/40)	<i>Tarka</i> [®]
Lotrel [®] (5/40 and 10/40 brand preferred)	<i>Lexxel</i> [®]	<i>Teczem</i> [®]
	<i>Lotrel</i> [®] (2.5/10, 5/10, 5/20 & 10/20)	

Angiotensin Receptor Blockers

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
Cozaar [®]	<i>Atacand</i> [®]	<i>Micardis</i> [®]
Diovan [®]	<i>Avapro</i> [®]	<i>Teveten</i> [®]
	<i>Benicar</i> [®]	

Angiotensin Receptor Blockers + Diuretic Combinations

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
Diovan HCT [®]	<i>Atacand HCT</i> [®]	<i>Micardis HCT</i> [®]
Hyzaar [®]	<i>Avalide</i> [®]	<i>Teveten HCT</i> [®]
	<i>Benicar HCT</i> [®]	

Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
N/A	<i>Azor</i> [®]	<i>Exforge</i> [®]

*New generic, brand, or dose formulation anticipated, will be non-preferred pending review

ACE Inhibitors, Angiotensin Receptor Blockers, Beta-Blockers

(Continued page 3)

Direct Renin Inhibitors

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
N/A	Tecturna [®]	Tecturna HCT [®]

Beta Blockers

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
acebutaolol	Betapace [®]	Levatol [®]
atenolol	Betapace AF [®]	Lopressor [®]
betaxolol	Blockadren [®]	metoprolol succinate
bisoprolol fumarate	Bystolic [®]	propranolol LA
metoprolol tartrate	Cartrol [®]	Normodyne [®]
nadolol	Corgard [®]	Sectral [®]
pindolol	Inderal [®]	Tenormin [®]
propranolol solution	Inderal LA [®]	Toprol XL [®]
propranolol	Innopran XL [®]	Visken [®]
Sorine [®]	Kerlone [®]	Zebeta [®]
sotalol HCL		
sotalol AF		
timolol maleate		

Alpha/Beta Blockers

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
carvedilol	Coreg [®]	Trandate [®]
labetalol	Coreg CR [®]	

Beta Blockers + Diuretic Combinations

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
atenolol/chlorthalidone	Corzide [®]	Tenoretic [®]
bisoprolol/HCTZ	Inderide [®]	Timolide [®]
metoprolol/HCTZ	Lopressor HCT [®]	Ziac [®]
propranolol/HCTZ	nadolol/bendroflumethiazide	

TOPROL XL[®]: Authorize if any of the following are true

<ul style="list-style-type: none"> Toprol XL[®] 25mg po qd will be authorized as it would not be feasible to promote metoprolol 12.5mg po BID. Toprol XL[®] 25mg will be authorized with a quantity limit of 45 tablets per 30 days.
<ul style="list-style-type: none"> Doses >37.5 mg Toprol XL[®] po qd will be offered a change to metoprolol in a total daily dose divided by two and dosed BID
<ul style="list-style-type: none"> If patient compliance is questioned or compromised by change, then the Toprol XL[®] will be authorized

*New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Antibiotics: Oral Cephalosporins, Macrolides, Quinolones

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
 Acceptable reasons include:
 Allergy to product formulation (i.e. dyes, fillers). If an allergy to drug class, should question medication request.
 Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 History of unacceptable/toxic side effects to medications not requiring prior approval
 Document clinically compelling information
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication. Document details.
 - Note diagnosis and any culture and sensitivity reports
3. If there has been a therapeutic failure to no less than a **three-day** trial of **one** medication within the same not requiring prior approval, then may approve the requested medication. Document details.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

If the patient requires a prior authorized medication based on a specific medical need that is not covered by the FDA indications of the preferred medications, then allow the non-preferred medication. This information should be reviewed at each request for reauthorization.

Second Generation Quinolones no change

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>	
ciprofloxacin	<i>Cipro[®]</i>	<i>Maxaquin[®]</i>
Cipro[®] Suspension	<i>ciprofloxacin Susp</i>	<i>Noroxin[®]</i>
	<i>Cipro XR[®]</i>	<i>ofloxacin</i>
	<i>ciprofloxacin ER</i>	<i>Proquin XR[®]</i>
	<i>Floxin[®]</i>	

Third Generation Quinolones no change

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>	
Avelox[®]	<i>Factive[®]</i>	<i>Proquin XR[®]</i>
Avelox ABC PACK[®]	<i>Levaquin[®]</i>	<i>Zagam[®]</i>
	<i>Levaquin Susp[®]</i>	

Drug list continues next page

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antibiotics: Oral Cephalosporins, Macrolides, Quinolones

(Continued page 2)

Second Generation Cephalosporins no change

Preferred Drugs - No PA Required	<i>Non-Preferred Drugs - PA Required</i>
cefaclor capsule	<i>Ceftin[®] tablets</i>
cefaclor suspension	<i>Ceftin[®] suspension</i>
cefaclor ER	<i>Cefzil[®]</i>
cefprozil	<i>Cefzil[®] suspension</i>
cefprozil Suspension	
cefuroxime tablets	
Raniclor [®]	

Third Generation Cephalosporins

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>	
cefdinir capsule	<i>Cedax Capsule[®]</i>	<i>Omnicef Capsules[®]</i>
cefdinir suspension	<i>Cedax Susp[®]</i>	<i>Omnicef Susp[®]</i>
Suprax Suspension [®]	<i>cefepodoxime proxetil</i>	<i>Vantin[®]</i>
Spectracef [®]	<i>cefepodoxime proxetil susp</i>	<i>Vantin Susp[®]</i>
	<i>cefuroxime axetil susp</i>	

Macrolides

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
azithromycin	<i>Biaxin[®]</i>
azithromycin packet	<i>Biaxin Suspension[®]</i>
azithromycin suspension	<i>Biaxin XL[®]</i>
clarithromycin	<i>Dynabac[®]</i>
clarithromycin suspension	<i>clarithromycin ER</i>
<i>EryC^{®***}</i>	<i>Ery-tab[®]</i>
<i>E.E.S. ^{®***}</i>	<i>Ketek[®]</i>
<i>Eryped^{®***}</i>	<i>PCE[®]</i>
erythrocin stearate	<i>Zithromax Suspension[®]</i>
erythromycin base	<i>Zithromax[®]</i>
erythromycin ethylsuccinate	<i>ZMAX Suspension[®]</i>
erythromycin estolate suspension	
erythromycin stearate	
erythromycin / sulfisoxazole	

*** Generics not available in some strengths/dosage forms

** To receive a PA for Ketek[®],

A specific Ketek PA request form must be completed and faxed or mailed to First Health Services with the physician's signature. By signing this request, the physician accepts understanding of the contraindications and warnings with the use of Ketek and acknowledges that the benefits of the drug outweigh the possible risks. A copy of the PA form is available at http://www.dmas.virginia.gov/pharm-pdl_program.htm

- Or at <http://virginia.fhsc.com>. The PA may also be completed online at: <https://webpa.fhsc.com/webpa> .
- Recipient must be 18 or over and can only be approved for an FDA indication

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antibiotics: Topical

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
 Acceptable reasons include:
 Allergy to product formulation (i.e. dyes, fillers). If an allergy to drug class, should question medication request.
 Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 History of unacceptable/toxic side effects to medications not requiring prior approval
 Document clinically compelling information

2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication. Document details.
 - Note diagnosis and any culture and sensitivity reports

3. If there has been a therapeutic failure to no less than a **three-day** trial of **one** medication within the same class not requiring prior approval, then may approve the requested medication. Document details.

Topical Antibiotics

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Mupirocin Ointment	<i>Bactroban Cream</i> [®]
Altabax [®] **	<i>Bactroban Ointment</i> [®]
	<i>Centany</i> [™]

** Has a 5 gram per 34 day quantity limit

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antibiotic: Otic Quinolones

LENGTH OF AUTHORIZATION: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient’s condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient’s condition.

Document clinically compelling information

2. If there has been a therapeutic failure of a trial of at least one medications not requiring prior approval, then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring prior approval, then may approve the requested medication.

An indication that is unique to a non-preferred agent and is supported by peer-reviewed literature or a FDA-approved indication, or Age specific indication, or Medical co-morbidity, unique patient circumstance, other medical complications, or Clinically unacceptable risk with a change in therapy to preferred agent.

Otic Quinolones

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Ciprodex® (ciprofloxacin/dexamethasone)	<i>Cipro HC® (ciprofloxacin/hydrocortisone)</i>
ofloxacin (generic for Floxin®)	<i>Floxin® (ofloxacin)</i>

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antifungals (Oral) for Onychomycosis

LENGTH OF AUTHORIZATIONS: For the duration of the prescription (up to 6 months)

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

If the patient has a serious illness that causes them to be immunocompromised (i.e. AIDS, cancer, etc.) then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring prior approval, then may approve the requested medication.
2. If the request is for a diagnosis other than fungal infection, please refer to a clinical pharmacist.

Sporanox

If Sporanox is requested for any other FDA approved indication (other than onychomycosis), then approve for 6 months or the duration of the prescription.

Indications: Aspergillosis, Candidiasis (oral or esophageal), Histoplasmosis, Blastomycosis, empiric treatment of febrile neutropenia

A PA for Lamisil® granules may be granted if

- Recipient is over 4 years of age
- Diagnosis is *tinea capitis*

Lamisil® oral granules are FDA approved for the treatment of tinea capitis (also called ringworm of the scalp) in patients 4 years of age and older. (Lamisil® oral tablets (250mg) are FDA approved for the treatment of tinea unguium- onychomycosis but not tinea capitis ringworm).

ORAL ANTIFUNGALS USED FOR ONYCHOMYCOSIS

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
terbinafine	itraconazole	Sporanox Solution®
	Lamisil®	Sporanox Capsules®
	Lamisil® Granules (diagnosis tinea capitis)	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Low Sedating Antihistamines: Second Generation

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic failure after a course of treatment (e.g., one month for allergic rhinitis) with one product not requiring prior approval, then may approve the requested medication.

Document details

Second Generation Antihistamines and Combinations

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
Claritin OTC [®]	Allegra [®]	Clarinex- D [®] 24 hr
Claritin OTC [®] syrup	Allegra ODT [®]	Clarinex- D [®] 12 hr
Claritin tablets- Rapids OTC [®]	Allegra suspension [®]	Claritin-D [®] - <i>Rx forms</i>
Claritin-D 24hr OTC [®]	Allegra-D 12 hr [®]	Claritin [®] - <i>Rx forms</i>
Claritin-D 12 hr OTC [®]	Allegra-D 24 hr [®]	fexofenadine
loratadine tablet (represents all OTC names)	cetirizine chew OTC	fexofenadine/PSE
loratadine tab- Rapids (all OTC names)	<i>***cetirizine sol OTC</i>	Xyzal [®]
loratadine syrup (represents all OTC names)	cetirizine tablet OTC	Zyrtec tablet OTC/RX [®]
loratadine D 24hr (represents all OTC names)	cetirizine D tablet OTC	Zyrtec tab chew OTC/RX [®]
loratadine D 12 hr (represents all OTC names)	Clarinex table [®]	*Zyrtec[®] syrup OTC/RX
	Clarinex tablet Rapids [®]	<i>No longer available</i>
	Clarinex [®] syrup	Zyrtec-D [®] OTC/RX
	<i>* **no PA required < 2yrs of age</i>	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antihistamines: Intranasal

LENGTH OF AUTHORIZATION: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient’s condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring prior approval might cause deterioration of the patient’s condition.

Document clinically compelling information

2. If there have been therapeutic failures to no less than one-month trials of at least two medications not requiring prior approval, then may approve the requested medication.

Document details

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If a medication requiring prior approval was initiated in the hospital, and then may approve the requested medication.

Document details

If the patient is a child <13 years old or a patient with a significant disability, and unable to use an inhaler which does not require prior approval, or is non-compliant on an inhaler not requiring prior approval because of taste, dry mouth, infection; then may approve the requested medication.

Document details

Antihistamines: Intranasal

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Astelin[®]	<i>Patanase[®]</i>
Astepro[®]	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antimigraine Medications: Serotonin Receptor Agonists “Triptans”

LENGTH OF AUTHORIZATIONS: 6 months

1. Is there any reason the patient cannot be switched to a non-prior approved medication?

Acceptable reasons include:

- Allergy to **one** of the non-prior approved products
- Contraindication to all non-prior approved product(s)
- History of unacceptable side effects to **one** of the non-prior approved product(s)

Document clinically compelling information

2. Has the patient had therapeutic trial of **one** non-prior authorized drug that failed? If so, document and allow the prior authorized medication.

CLINICAL CONSIDERATIONS:

Prior Authorization will not be given for prophylactic therapy of migraine headache unless the patient has exhausted or has contraindications to all other “controller” migraine medications (i.e., beta-blockers, calcium channel blockers, etc) and the physician and patient are aware of the adverse risk potential.

Triptans

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
Imitrex Cartridge [®]	<i>Amerge</i> [®]	<i>Treximet</i>
Imitrex Nasal [®]	<i>Axeri</i> [®]	<i>Zomig Tablets</i> [®]
Imitrex Pen Kit [®]	<i>Frova</i> [®]	<i>Zomig nasal spray</i> [®]
Imitrex Tablets [®]	<i>Relpax</i> [®]	<i>Zomig ZMT</i> [®]
Imitrex Vial [®]	<i>Sumatriptan Succinate Cartridge</i>	
Maxalt [®]	<i>Sumatriptan Succinate Nasal</i>	
Maxalt MLT [®]	<i>Sumatriptan Succinate Pen</i>	
	<i>Sumatriptan Succinate Tablets</i>	
	<i>Sumatriptan Succinate Vial</i>	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antivirals: Herpes

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient’s condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient’s condition.

Document clinically compelling information

2. If there has been a therapeutic **failure of a trial of at least one medications** not requiring prior approval, then may approve the requested medication.

Antivirals: Herpes

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
acyclovir Tablets	<i>famciclovir</i>
acyclovir Susp	<i>Zovirax Susp[®]</i>
Famvir[®]	<i>Zovirax Tablet[®]</i>
Valtrex[®] <i>(Valacyclovir) *</i>	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antivirals: Influenza

LENGTH OF AUTHORIZATIONS:

- For diagnosis of influenza the authorization is for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient’s condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient’s condition.

Document clinically compelling information

2. If there has been a therapeutic **failure of a trial of at least one medications** not requiring prior approval, then may approve the requested medication.

Antivirals: Influenza

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
amantadine	<i>Flumadine®</i>
amantadine Syrup	<i>Flumadine Syrup®</i>
Relenza Disk®	<i>Symmetrel</i> <i>No longer available</i>
rimantadine	<i>Symmetrel Susp</i> <i>No longer available</i>
Tamiflu®	
Tamiflu Susp®	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antivirals: Interferon for Hepatitis C

LENGTH OF AUTHORIZATIONS: SEE BELOW

Clinical PA for initial 16 week PA:

1. Initial approval periods should be limited to 16-weeks and viral titer should be obtained at week 12 of therapy.

Clinical PA for established HCV reactors:

2. Therapy is approvable for a total of 24 weeks in patients that are HCV genotypes 2 or 3 who have achieved a virologic response (either undetectable HCV RNA [<50 IU/mL] or at least a 2-log drop in HCV RNA titer from baseline) at 12 weeks of treatment.
3. Therapy is approvable for total of 48 weeks in HCV genotype 1 or 4 patients who have achieved a virologic response (either undetectable HCV RNA [<50 IU/mL] or at least a 2-log drop in HCV RNA titer from baseline) at 12 weeks of treatment.
4. If patients fail to achieve a virologic response by 12 weeks, further treatment is not indicated.

PDL PA

1. Is there any reason the patient cannot be started on a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to product formulation (i.e. dyes or fillers). If an allergy to drug class, should question medication request.
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. Has there been a therapeutic failure after a reasonable therapeutic trial with use of **one** of the non-prior authorized agents? Document the details, and forward all of these requests to a clinical pharmacist.

Additional Information:

1. **Copegus®** and **Rebetol®** are oral ribavirins. Oral ribavirin therapy is not effective for the treatment of chronic hepatitis C viral infection and should not be used alone for this indication.
2. **Pegasys®** and **PEG-Intron®** are pegylated Interferons.

Antivirals: Interferon

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Pegasys®	
Pegasys Conv.Pack®	
Peg-Intron®	
Peg-Intron Redipen®	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antivirals Topical: Herpes

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient’s condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient’s condition.

Document clinically compelling information

2. If there has been a therapeutic failure of a trial of at least one medications not requiring prior approval, then may approve the requested medication.

Antiviral Topical: Herpes

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Abreva OTC [®]	<i>Denavir[®]</i>
Zovirax oint [®]	<i>Zovirax cream[®]</i>

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Beta-Adrenergic Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **two-week** trial of at least **one** medication not requiring prior approval **within the same class and formulation.** (i.e. nebulizers for nebulizers)

Document details

ADDITIONAL INFORMATION

Patients experience cardiac and central nervous system side effects (i.e. tachycardia, agitation) more often.

Beta Adrenergic Agents

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Short Acting and Combination Metered Dose Inhalers or Devices	
albuterol	<i>Proventil[®]</i>
Alupent MDI	<i>Ventolin[®]</i>
Combivent [®] MDI	<i>Albuterol HFA</i>
Maxair [®] Autohaler	<i>Proair[®] HFA</i>
Proventil [®] HFA	
Ventolin [®] HFA	
Xopenex [®] HFA	
Long Acting Metered Dose Inhalers or Nebulizers	
Foradil [®]	<i>Brovana[®]</i>
Serevent Diskus [®]	<i>Perforomist[®]</i>
Short Acting Nebulizers	
albuterol sulfate premix	<i>Accuneb[®] pediatric dosing, premixed nebs</i>
metaproterenol	<i>Proventil[®]</i>
Xopenex [®]	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Calcium Channel Blockers:
*Dihydropyridine Calcium Channel Blockers and
Non-dihydropyridine Calcium Channel Blockers*

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a one-month trial of at least one medication within the same class not requiring prior approval
- The requested medications corresponding generic (if a generic is available and covered by the state) has been attempted and failed or is contraindicated

CLINICAL NOTES

There are two main classes of Calcium Channel Blockers (each with different actions on the peripheral vasculature and cardiac tissue):

1. Dihydropyridine Calcium Channel Blockers (DHPCCB)
2. Non-Dihydropyridine Calcium Channel Blockers (NDHPCCB)

Vascor is in its own third class of Calcium Channel Blockers and not included under PA requirements on the VA PDL at this time.

See next page for specific drug lists.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Calcium Channel Blockers:
Dihydropyridine Calcium Channel Blockers and
Non-dihydropyridine Calcium Channel Blockers
(Continued page 2)

Calcium Channel Blockers

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>	
Dihydropyridine Calcium Channel Blockers		
Afeditab CR [®]	Adalat [®]	Procardia XL [®]
amlodipine	Adalat CC [®]	Plendil [®]
Dynacirc CR [®]	Cardene [®]	Sular [®]
felodipine ER	Cardene SR [®]	
nicardipine	Dynacirc [®]	
Nifediac CC [®]	Dynacirc CR [®]	
Nifedical XL [®]	isradipine	
nifedipine	nisoldipine	
nifedipine ER	Norvasc [®]	
nifedipine SA	Procardia [®]	
Non-Dihydropyridine Calcium Channel Blockers		
Cartia XT [®]	Calan [®]	Dilacor XR [®]
Diltia XT [®]	Calan SR [®]	diltiazem SR q 12hr dose
diltiazem	Cardizem [®]	Isoptin SR [®]
diltiazem ER q 24hr dose	Cardizem CD [®]	Tiazac [®]
diltiazem ER q 12hr dose	Cardizem LA [®]	Verelan [®]
diltiazem XR	Cardizem SR [®]	Verelan PM [®]
Taztia XT [®]	Covera HS [®]	
verapamil		
verapamil SA		
verapamil 24hr pellets		

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Central Nervous System Stimulants/ADHD Medications

LENGTH OF AUTHORIZATION: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** medication not requiring prior approval, then may approve the requested medication. Document details.

3. The patient must have failed the generic product (if covered by the State) before the brand is authorized.

4. If the patient requires a prior authorized medication based on a specific medical need that is not covered by the FDA indications of the preferred medications, then allow the non-preferred medication. This should be reviewed for need at each request for reauthorization.

ADHD Amphetamine Products

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Adderall XR[®]	<i>Adderall[®]</i>
amphetamine Salts combo	<i>amphetamine Salts combo XR</i>
dextroamphetamine	<i>Desoxyn[®]</i>
dextroamphetamine SR	<i>Dexedrine[®]</i>
Dextrostat[®]	
Vyvanse[®]	

ADHD Methylphenidate Products and ADHD Miscellaneous Products

On the next page

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

**Central Nervous System Stimulants/ADHD Medications
(Continued page 2)**

ADHD Methylphenidate Products

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Concerta[®]	<i>Daytrana[™] Transdermal</i>
Focalin[®]	<i>dexmethylphenidate</i>
Focalin XR[®]	<i>Procentra solution[®]</i>
Metadate CD[®]	<i>Ritalin[®]</i>
Metadate ER[®]	<i>Ritalin SR[®]</i>
Methylin[®]	
Methylin chew[®]	
Methylin ER[®]	
Methylin solution[®]	
methylphenidate	
methylphenidate SR	
Ritalin LA[®]	

ADHD Miscellaneous Products

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
Strattera[®]	<i>Provigil[®]</i>	<i>Nuvigil[™]</i>

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

**Corticosteroids:
Inhaled and Nasal Steroids**

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there have been therapeutic failures to no less than **one-month** trials of at least **two** medications not requiring prior approval, then may approve the requested medication.

Document details

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. If a medication requiring prior approval was initiated in the hospital, and then may approve the requested medication.

Document details

2. If the patient is a child <13 years old or a patient with a significant disability, and unable to use an inhaler which does not require prior approval, or is non-compliant on an inhaler not requiring prior approval because of taste, dry mouth, infection; then may approve the requested medication.

Document details

See next page for specific drug lists.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

**Corticosteroids:
Inhaled and Nasal Steroids
(Continued page 2)**

Inhaled Corticosteroids

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
Metered Dose Inhalers		
Aerobid[®]	<i>Flovent Rotadisk[®]</i>	
Aerobid M[®]	<i>Flovent[®]</i>	
Asmanex[®]	<i>Pulmicort Flexhaler[®]</i>	
Azmacort[®]		
Flovent HFA[®]		
Flovent Diskus[®]		
QVAR[®]		
Nebulizer Solution		
Pulmicort Respules[®]	<i>budesonide</i>	
Combination Products (Glucocorticoid and Beta Adrenergic)		
Advair Diskus	<i>Symbicort[®]</i>	
Advair HFA		

Nasal Steroids

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>	
flunisolide	<i>Allemist[®]</i>	<i>Omnaris[®]</i>
fluticasone	<i>Beconase AQ[®]</i>	<i>Rhinocort AQUA[®]</i>
Nasacort AQ[®]	<i>Flonase[®]</i>	<i>Tri-Nasal[®]</i>
Nasonex[®]	<i>Nasacort[®]</i>	<i>Veramyst[®]</i>
	<i>Nasarel[®]</i>	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

COPD: Anticholinergics

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient’s condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring prior approval might cause deterioration of the patient’s condition.

Document clinically compelling information

2. If there have been therapeutic failures to no less than **one-month** trials of at least **two** medications not requiring prior approval, then may approve the requested medication.

Document details

COPD Anticholinergics

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Atrovent HFA [®]	<i>Atrovent AER[®]</i>
Combivent [®] MDI	<i>Duoneb[®]</i>
ipratropium bromide Solution	<i>Ipratropium/Albuterol nebs</i>
Spiriva [®]	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

COX-2 Inhibitors

Clinical edit

LENGTH OF AUTHORIZATIONS: 1 year

The preferred product may be approved for patients if one of the following is true:

- If there has been a therapeutic trial and failure on a minimum of two (2) different non-COX2 NSAIDs (information on history can be determined from one of the options below)
 - Electronic look back for history of paid claims for (2) different non-COX2 within the past year
 - Or
 - Call from Physician office with history of trial and failure of two (2) different non-COX2
- Concurrent use of anticoagulants (warfarin or heparin)
- Chronic use of oral corticosteroids
- Concurrent use of methotrexate
- History of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc.)
- If there is a specific indication for medication requiring prior approval, for which medications not requiring prior approval are not indicated, then document details and refer caller to a clinical pharmacist
- Patients with a diagnosis of familial adenomatous polyposis (FAP) presenting with a prescription for celecoxib (Celebrex[®]) may be approved without any risk factors or trials on NSAIDs.

CRITICAL INFORMATION TO CONSIDER

1. Selective cyclooxygenase-2 (COX-2) inhibitors are known to inhibit the production of vascular prostacyclin (PGI2), an inhibitor of platelet aggregation and a vasodilator. Unlike conventional non-steroidal anti-inflammatory drugs, COX-2 inhibitors do not reduce the endogenous production of thromboxane A2, a potent platelet activator and aggregator, thereby causing a potentially prothrombotic cascade of events that could lead to a significant increase in the risk for thrombotic cardiovascular events (myocardial infarction, occlusive stroke) in patients receiving celecoxib therapy. **Therefore, it is advisable to exercise caution when prescribing celecoxib, a COX-II inhibitors to patients with a higher risk of cardiovascular disease.**
2. If the patient is allergic to one NSAID or aspirin, the patient may be allergic to other NSAIDs.
3. If allergic to sulfonamides, a patient should not receive Celebrex[®].

Cox-2 Inhibitors

Preferred Drugs - PA Required	Non-preferred Drugs - N/A
Celebrex [®]	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Dermatologic Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. Has there been a failure to respond to a therapeutic trial of at least two weeks of one preferred medication? If yes, allow the prior authorized medication. Document details

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

- Topical retinoids will reject for 21 and older- This can not be over ridden.
- Renova and other products considered to have only a cosmetic indication are not covered by Virginia Medicaid
- If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring prior approval, then the requested medication may be approve.

Combo benzoyl peroxide & Clindamycin

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Duac CS	<i>Benzacilin</i>
	<i>Duac gel</i>

Topical Retinoids/Combinations

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Differin 1%cream,	<i>Altinac</i>
Differin1% & 0.3% gel	<i>Atralin</i>
Retin-A Micro	<i>Retin-A</i>
Retin-A Micro Pump	<i>Tazorac</i>
Tretinoin	<i>Tretin-X</i>
Epiduo	<i>Ziana</i>

Topical Agents For Psoriasis

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>	
Calcipotriene	<i>Anthralin</i>	<i>Taclonex</i>
Dovonex	<i>Dovonex Scalp</i>	<i>Taclonex Scalp</i>
Psoriatec	<i>Micanol</i>	<i>Vectical</i>

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Electrolyte Depleters

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient’s condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient’s condition.

Document clinically compelling information

2. If there has been a therapeutic **failure to at least a one-month trial of at least one medication** not requiring prior approval, then may approve the requested medication.

Electrolyte Depleters

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Fosrenol[®]	<i>Calcium Acetate 66MG</i>
Phoslo[®]	<i>Eliphos[®]</i>
Renagel[®]	<i>Renvela[®]</i>

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Gastrointestinals: Histamine -2 Receptor Antagonists (H-2 RA)

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient’s condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring prior approval might cause deterioration of the patient’s condition.

Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** medication not requiring prior approval, then may approve the requested medication.

Document details

3. If a medication requiring prior approval was initiated in the hospital for the treatment of a condition such as a GI bleed, and then may approve the requested medication.

4. Treatment of warts is not an FDA approved diagnosis or indication for Tagamet / cimetidine and a PA will not be approved for this diagnosis or indication.

H2 Receptor Antagonists

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>	
famotidine	<i>Axid capsule</i> ®	<i>Pepcid oral suspension</i> ®
ranitidine	<i>Axid solution</i> ®	<i>Pepcid tablet</i> ®
ranitidine syrup	<i>cimetidine syrup</i>	<i>Tagamet</i> ®
	<i>cimetidine tablet</i>	<i>Zantac tablet</i> ®
	<i>nizatidine</i>	<i>Zantac</i> ® <i>syrup</i>

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Gastrointestinals: Proton Pump Inhibitors

LENGTH OF AUTHORIZATIONS: dependent on criteria met

- Prilosec[®] OTC, if successful, may be continued with no limitations to duration of therapy
- Protonix[®] (Pantoprazole) to be approved for 120 days (if 60-day trial of Prilosec[®] OTC fails)
- Non-preferred products to be approved for 120 days (with failure of both Prilosec[®] OTC and Protonix[®] or Pantoprazole)
- *For exceptions see criteria for “Proton Pump Inhibitors exception”*

1. Step one requires a therapeutic failure of a **60-day trial** of OTC Prilosec[®] (up to 40mg daily). For exceptions to this see criteria for “Proton pump inhibitors exception”.

Other things to consider when reviewing OTC Prilosec[®]

- Allergy to Omeprazole
- Contraindication to or drug-to-drug interaction with OTC Prilosec[®] (Omeprazole)
- History of unacceptable/toxic side effects to OTC Prilosec[®] (Omeprazole)
- Patient’s condition is clinically unstable; changing to OTC Prilosec[®] might cause deterioration of the patient’s condition.

Document details

2. If has failed step one then move to step two and the other preferred medication, Protonix[®] (Pantoprazole) must be tried. If there is a therapeutic failure of no less than a **one-month trial** with Protonix[®] (Pantoprazole) then may approve the requested medication for duration of 120 days.

Other things to consider when reviewing

Is there any reason the patient cannot be changed to Protonix[®], Acceptable reasons include:

- Allergy to Protonix[®] (Pantoprazole)
- Contraindication to or drug-to-drug interaction with Protonix[®](Pantoprazole)
- History of unacceptable/toxic side effects to Protonix[®] (Pantoprazole)
- Patient’s condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient’s condition.

Document details

Gastrointestinals: Proton Pump Inhibitors exceptions

LENGTH OF AUTHORIZATIONS: If an exception is met, approve desired product and make the duration for 1 year. Step therapy requirements detailed above do not apply.

EXCEPTIONS

- Erosive Esophagitis
- Active GI Bleed
- Zollinger-Ellison Syndrome
- Greater than 65 years of age
- If Failed 120 day trial and is under the care of a Gastroenterologist and has Ruled out a nonsecretory Condition

Document details

See next page for specific drug lists.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Virginia Medicaid Preferred Drug List, Effective July 1, 2009

Gastrointestinals: PPIs (see step edit)

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>	
Protonix[®]	<i>Aciphex[®]</i>	<i>*Prevacid[®] solutab</i>
Prilosec OTC[®] **	<i>Kapidex[®]</i>	<i>Prilosec[®] Rx form</i>
	<i>Nexium[®]</i>	<i>Prilosec Suspension</i>
	<i>*Omeprazole RX&OTC</i>	<i>Zegerid[®] Capsule</i>
	<i>pantoprazole</i>	<i>Zegerid[®] effervescent tab</i>
	<i>*Prevacid[®]</i>	<i>Zegerid[®] susp Packet</i>
	<i>*Prevacid[®] susp</i>	

** is subject to the step edit

**no PA required if age < 12yrs*

SPECIAL CONSIDERATION:

Protonix[®] is a delayed release tablet and cannot be crushed or opened. For tubed patients or patients with swallowing difficulties omeprazole, Prevacid[®], Prevacid Solutab[®], Prilosec[®], Nexium[®] or Prevacid[®] granules (if oral administration) can be used. These Proton Pump Inhibitors may be opened and the intact granules may be mixed in apple sauce or orange juice and administered. Alternatively, the capsules may be opened and the granules may be dissolved in a small amount of sodium bicarbonate to form a compounded suspension for administration. The omeprazole will be the preferred agent for these circumstances and may be approved.

**If therapy is for a child < 12 then Prevacid[®] Susp, Prevacid[®] solutab, Prevacid Caps no PA req age or Omeprazole will not require a PA) If there has been a therapeutic failure on omeprazole or there is a clinical contraindication to omeprazole then another non-preferred agent may be approved.

Aciphex[®] is an extended release tablet and should not be opened or crushed.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Gout Suppressants (Antihyperuricemics)

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?
 Acceptable reasons include:
 - Allergy to medication not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medication not requiring prior approval
 - History of unacceptable/toxic side effects to medication not requiring prior approval
 Document clinically compelling information

2. Has the patient tried and failed a therapeutic trial with a preferred drug within the same class? If so, document and approve the prior authorized drug.

Gout Suppressants

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
allopurinol	<i>Uloric</i>

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Growth Hormone Pediatrics

LENGTH OF AUTHORIZATION (pediatrics): 1 year

PEDIATRICS (18 years of age and under)

Clinical Criteria for Approval:

Prescriber is an endocrinologist, nephrologists, infectious disease specialist or HIV specialist or one has been consulted on this case, the patient has open epiphysis and one of the following diagnoses

- Turner Syndrome
- Prader-Willi Syndrome
- Renal insufficiency
- Small for gestational age (SGA) - including Russell-Silver variant and patient is < 2 years old
- Idiopathic Short Stature (for request for renewal only (**a**) information is required to be approved)
- Growth hormone deficiency (physician should provide the required information below)
- Newborn with hypoglycemia and a diagnosis of hypopituitarism or panhypopituitarism.
 - a. Height is more than 2 SD (standard deviations) below average for the population mean height for age and sex, and a height velocity measured over one year to be 1 SD below the mean for chronological age, or for children over two years of age, a decrease in height SD of more than 0.5 over one year; **AND**
 - b. Growth hormone response of less than 10ng/ml to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine, or glucagon

Requests for Renewal (pediatrics):

- a. For renewal, a response must be documented. Patient must demonstrate improved/normalized growth velocity. (Growth velocity has increased by at least 2 cm in the first year and is greater than 2.5 cm per year), **AND**
- b. Patient height is less than 5' 6" for males or 5' 1" for females, and is more than 1 standard deviation (2") below mid-parental height (unless parental height is diminished due to medical or nutritional reasons).

PDL CRITERIA

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

Has there been a therapeutic failure after a reasonable therapeutic trial with use of **one** of the non-prior authorized agents? Document the details, and forward all of these requests to a clinical pharmacist

See **Growth Hormone for all groups for list of preferred/non-preferred**

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Growth Hormone Adults

LENGTH OF AUTHORIZATION: 1 year (Serostim[®] – 3 months)

ADULTS (> 18 years of age)

Clinical Criteria for Approval:

- Prescriber is an endocrinologist
- Diagnosis of growth hormone deficiency confirmed by growth hormone stimulation tests and rule-out of other hormonal deficiency, as follows: growth hormone response of fewer than five nanograms per mL to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine or glucagon when measured by polyclonal antibody (RIA) or fewer than 2.5 nanograms per mL when measured by monoclonal antibody (IRMA);
- Cause of growth hormone deficiency is Adult Onset Growth Hormone Deficiency (AO-GHD), alone or with multiple hormone deficiencies, such as hypopituitarism, as a result of hypothalamic or pituitary disease, radiation therapy, surgery or trauma
- Other hormonal deficiencies (thyroid, cortisol or sex steroids) have been ruled out or stimulation testing would not produce a clinical response such as in a diagnosis of panhypopituitarism.
- **Zorbitive[®]**
 - Diagnosis of short bowel syndrome
- **Serostim[®]**
 - Diagnosis of AIDS Wasting or cachexia
 - Patient has a documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents (both Megace[®] and Marinol[®])
 - **Length of Authorization (Serostim[®] only):** 3 months initial; then 1 year.
Renewal is contingent upon improvement in lean body mass or weight measurements.

Requests for Renewal (adults)

Renewal is contingent upon prescriber affirmation of positive response to therapy (improved body composition, reduced body fat, and increased lean body mass).

PDL CRITERIA

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. Has there been a therapeutic failure after a reasonable therapeutic trial with use of **one** of the non-prior authorized agents? Document the details, and forward all of these requests to a clinical pharmacist.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Growth Hormone Adults & Pediatrics continued pg 3
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Growth Hormones for all groups

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Genotropin^{®*}	<i>Humatrope Cartridge[®]</i>
Norditropin Cartridge^{®*}	<i>Saizen Vial[®]</i>
Nutropin Aq Cartridge^{®*}	<i>Tev-Tropin[®]</i>
Nutropin^{®*}	<i>Humatrope Vial[®]</i>
Nutropin Aq Vial^{®*}	<i>Saizen Cartridge[®]</i>
Norditropin Nordiflex^{®*}	<i>Omnitrope[®]</i>

*Requires a clinical PA

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Immunomodulators: Topical

LENGTH OF AUTHORIZATION: 1 YEAR

CLINICAL CONSIDERATIONS:

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. A PA may only be given for an FDA approved Diagnosis:

a. **Atopic dermatitis** (a type of eczema) - **FDA approved:**

- **Elidel®**: mild to moderate for **ages > 2 years.**
- **Protopic® 0.03%**: moderate to severe for **ages > 2 years.**
- **Protopic® 0.1%**: moderate to severe for **ages > 18 years.**

b. All other diagnoses (off-label uses) are to be referred to a clinical pharmacist. **All requests** for all other diagnoses are to be denied.

Critical information for review: Black box warnings are in place for both products as well a requirement for a patient guide to be given with each product dispensed.

The FDA recommends that healthcare providers, patients and caregivers consider the following: (Updated from FDA site 8/29/07) **

- Use Elidel and Protopic only as second-line agents for short-term and intermittent treatment of atopic dermatitis (eczema) in patients unresponsive to, or intolerant of other treatments.
- Avoid use of Elidel and Protopic in children younger than 2 years of age. The effect of Elidel and Protopic on the developing immune system in infants and children is not known. In clinical studies, infants and children younger than 2 years old treated with Elidel had a higher rate of upper respiratory infections than did those treated with placebo cream.
- Use Elidel and Protopic only for short periods of time, not continuously. The long term safety of Elidel and Protopic are unknown.
- Children and adults with a weakened or compromised immune system should not use Elidel or Protopic.
- Use the minimum amount of Elidel or Protopic needed to control the patient's symptoms. In animals, increasing the dose resulted in higher rates of cancer.

**<http://www.fda.gov/cder/drug/infopage/protopic/default.htm>

**http://www.fda.gov/cder/drug/advisory/elidel_protopic.htm

Topical Immunomodulators

Preferred Drugs - PA Required	<i>Preferred Drugs - PA Required</i>
Elidel®*	
Protopic®*	

*Requires a clinical PA

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

**Immunomodulators: Injectable
Self Administered Drugs for Rheumatoid Arthritis**

LENGTH OF AUTHORIZATION: **1 year**

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient’s condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient’s condition.

Document clinically compelling information

2. If there has been a therapeutic failure of a trial of at least one medications not requiring prior approval, then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring prior approval, then may approve the requested medication.

An indication that is unique to a non-preferred agent and is supported by peer-reviewed literature or a FDA-approved indication, or Age specific indication, or Medical co-morbidity, unique patient circumstance, other medical complications, or Clinically unacceptable risk with a change in therapy to preferred agent.

Immunomodulators – injectable-Self Administered Drugs for Rheumatoid Arthritis

Preferred Drugs - PA Required	<i>Preferred Drugs - PA Required</i>
Enbrel[®]	<i>Kineret[®]</i>
Humira[®]	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Leukotriene Receptor Antagonists

LENGTH OF AUTHORIZATION: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
 Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
 Document clinically compelling information

2. If there has been a therapeutic failure to the agent not requiring prior approval, then may approve the requested medication.
 Document details

Leukotriene Receptor Antagonists

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Accolate®	Zyflo® <i>No longer available</i>
Singulair®	Zyflo CR™

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Lipotropics

LENGTH OF AUTHORIZATIONS: 1 year

General Guidelines:

Currently there are four classes of medications in the Lipotropics with three classes represented in the PDL. Each class has a different mechanism of action and acts on different components of total cholesterol

- Fibric acid derivatives-& Omega 3 agent
- HMG CoA reductase Inhibitors
- Nicotinic acid derivatives
- Bile Acid Resins (*not included in VA PDL at this time*)

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there have been therapeutic failures to no less than **one-month** trials of at least **one** medication not requiring prior approval, then may approve the requested medication.

Document details

3. If documented very high triglycerides of (≥ 500 mg/dL) in adult patients. Then a PA for Omacor®/Lovaza® can be approved with out any specific preferred medication trials.

Lipotropics – HMG CoA Reductase Inhibitors and Combinations (Statins)

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
lovastatin	<i>Advicor</i> ®	<i>Lescol XL</i> ®
pravastatin	<i>Altoprev</i> ®	<i>Mevacor</i> ®
	<i>Lescol</i> ®	<i>Pravachol</i> ®

Lipotropics – HMG CoA Reductase Inhibitors and Combinations (High Potency Statins)

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
simvastatin	<i>Crestor</i> ®	<i>Vytorin</i> ®
	<i>Lipitor</i> ®	<i>Zocor</i> ®

See next pages for more drug lists.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Virginia Medicaid Preferred Drug List, Effective July 1, 2009

**Lipotropics
(Continued page 2)**

Lipotropics – Fibric Acid Derivatives

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required	
Antara [®]	<i>fenofibrate</i>	<i>Lopid[®]</i>
gemfibrozil	<i>Fenoglide[®]</i>	<i>Triglide[®]</i>
	<i>Lipofen[®]</i>	<i>Tricor[®]</i>
	<i>Lofibra[®]</i>	<i>Trilipix[™]</i>

Lipotropics – Niacin Derivatives

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Niacor [®]	
Niaspan [®]	

Lipotropics – Niacin Derivatives & HMG CoA Reductase Inhibitors (Statins) Combination

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Simcor [®]	

** Requires a history of either a niacin or Simvastatin product within the past 90 days.

Lipotropics - CAI

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Zetia [®]	

Lipotropics – Omega 3 Fatty Acid agent

Preferred Drugs - No PA Required	Non-preferred Drugs – PA Required
N/A	<i>Lovaza[®]</i>

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

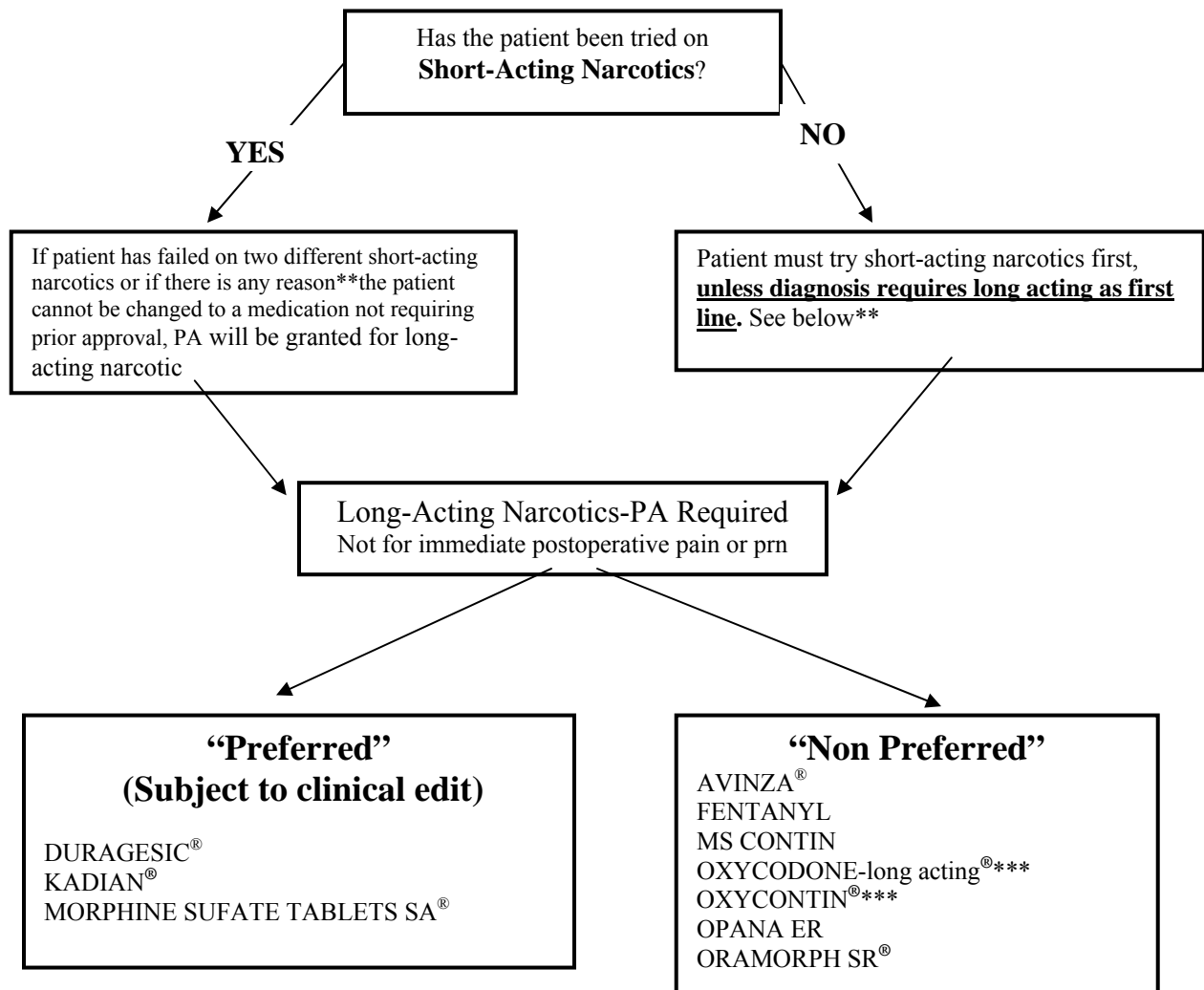
Long Acting Narcotics – Step Therapy

SHORT ACTING NARCOTICS (no PA required)

Butalbital Combinations	Methadone*	Opana
Butalbital w/codeine	Morphine-short acting	
Codeine	Nalbuphine	
Codeine w/APAP	Oxycodone-short acting	
Codeine w/ASA	Oxycodone w/APAP	
Hydrocodone	Oxycodone w/ASA	
Hydrocodone w/APAP	Oxymorphone	
Hydromorphone	Pentazocine combinations	
Levorphanol	Propoxyphene combinations	
Meperidine	Fentora	

**The use of methadone for pain should ideally be done in the context of an organized pain clinic, hospice or with assistance of local pain management experts, including health care providers or pharmacists, who have experience with methadone use.*

Step-Therapy



**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Virginia Medicaid Preferred Drug List, Effective July 1, 2009

****Step-Therapy is not required for those patients that have been stabilized on Long Acting Narcotics or need relief of moderate to severe pain requiring around-the-clock opioid therapy, for an extended period of time. Additional acceptable reasons include:**

- Allergy to medications not requiring prior approvals
- Contraindications to or drug-to-drug interaction with medications not requiring prior approval
- *If the patient has a diagnosis that is an approved indication for the medication that requires prior approval and this diagnosis is not an indication for the medications that do not require prior approval.*
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

LENGTH OF AUTHORIZATIONS: 6 months

OxyContin* / Oxycodone-long acting***Guidelines**

1. Coverage is limited to those persons 18 years of age or older with a need for a continuous around-the-clock analgesic for an extended period of time for the management of moderate to severe pain.

2. There are no diagnosis restrictions here. The main objective is to verify appropriate use and the following items should be taken into consideration when reviewing an oxycontin request:

- Dosing frequency greater than bid (tid for an identified, organized pain clinic or pain specialist)
- Dosing using multiple small strength tablets as opposed to a single higher strength tablets
- Odd quantities that would result in fractional dosing
- Patient history of substance abuse
- Frequent early refill attempts
- Multiple request pertaining to lost medication
- Short-term or prn use (oxycontin is not indicated for short-term or prn use)
- Any suspicious use reported by pharmacies or physicians
- A rapid increase in dosage
- 80mg tablets are for opioid tolerant patients only

3. Reasons for denial:

- Split tablets
- Greater than tid dosing frequency
- Concurrent use of other extended release opioids
- Prn dosing

1997 medical society of Virginia and house of delegates guidelines Virginia code 54.1-2971.01 states:

"In the case of a patient with intractable pain, the attending physician may prescribe a dosage in excess of the recommended dosage of a pain relieving agent if he certifies the medical necessity for such excess dosage in the patient's medical record. Any person who prescribes, dispenses or administers an excess dosage in accordance with this section shall not be deemed to be in violation of the provisions of this title because of such excess dosage, if such excess dosage is prescribed, dispensed or administered in good faith for accepted medicinal or therapeutic purposes. Nothing in this section shall be construed to grant any person immunity from investigation or disciplinary action based on the prescription, dispensing or administration of an excess dosage in violation of this section."

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Multiple Sclerosis

LENGTH OF AUTHORIZATION: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient’s condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient’s condition.

Document clinically compelling information

2. If there has been a therapeutic failure of a trial of at least one medications not requiring prior approval, then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring prior approval, then may approve the requested medication.

An indication that is unique to a non-preferred agent and is supported by peer-reviewed literature or a FDA-approved indication, or Age specific indication, or Medical co-morbidity, unique patient circumstance, other medical complications, or Clinically unacceptable risk with a change in therapy to preferred agent.

Multiple Sclerosis Agents

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Avonex[®]	
Avonex Adm Pack[®]	
Betaseron[®]	
Copaxone[®]	
Rebif[®]	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Non-Ergot Dopamine Receptor Agonist

LENGTH OF AUTHORIZATIONS: **1 year**

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient’s condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient’s condition.

Document clinically compelling information

2. If there has been a therapeutic failure of a trial of at least one medications not requiring prior approval, then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If requested for treatment of Parkinson’s, may approve without the necessary trial of a preferred agent if the patient has swallowing issues that causes them to be unable to use a preferred product OR if the request is for continuation of established therapy.

If requested for treatment of restless legs, forward request to a pharmacist to be denied.

An indication that is unique to a non-preferred agent and is supported by peer-reviewed literature or an FDA-approved indication, or Age specific indication, or Medical co-morbidity, unique patient circumstance, other medical complications, or Clinically unacceptable risk with a change in therapy to preferred agent.

Non-Ergot Dopamine Receptor Agonists

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Mirapex[®]	<i>Requip[®]</i>
ropinirole HCl	<i>Requip Dose Pack[®]</i>

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

NSAIDs
(Non-Steroidal Anti-inflammatory Drugs including Cox-2 Inhibitors)

LENGTH OF AUTHORIZATIONS: 1 YEAR

- For COX II clinical edit see page (3)

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. The requested medication may be approved if **both** of the following are true:

- If there has been a therapeutic failure to no less than a **one-month** trial of at least **two** medication(s) within the same class not requiring prior approval
- The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

3. If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then document details and refer to a clinical pharmacist.

Clinical Criteria for Flector® & Voltaren gel®:

- Approval is based on patient failing the **Oral** generic of the desired product **and** at least 1 other preferred NSAIDs (to equal a total of at least 2 preferred).
- For example, a patient who failed ibuprofen and naproxen will still need to try oral generic diclofenac for approval of Flector

ADDITIONAL INFORMATION TO CONSIDER

If the patient is allergic to one NSAID or aspirin, the patient may be allergic to other NSAIDs

See next pages for specific drug lists.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

NSAIDs
(Non-Steroidal Anti-inflammatory Drugs including Cox-2 Inhibitors)
(Continued page 2)

NSAIDs (Non-Steroidal Anti-inflammatory Drugs) including Cox-2 Inhibitors

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>	
Celebrex [®]	Anaprox [®]	Ponstel [®]
diclofenac potassium	Anaprox DS [®]	Relafen [®]
diclofenac sodium	Ansaid [®]	Tolectin DS [®]
diflunisal	Arthrotec [®]	Toradol [®]
etodolac	Cataflam [®]	Voltaren [®]
etodolac SR	Clinoril [®]	Voltaren XR [®]
fenoprofen	Daypro [®]	Voltaren GEL [®]
flurbiprofen	Dolobid [®]	Indocin [®]
ibuprofen	Feldene [®]	Ponstel [®]
indomethacin	Flector patch [®]	
indomethacin SR	Indocin [®]	
ketoprofen	Indocin SR [®]	
ketoprofen ER	Lodine [®]	
ketorolac	Lodine XL [®]	
meclofenamate sodium	mefenamic	
meloxicam	Mobic [®]	
nabumetone	Motrin [®]	
naproxen	Nalfon [®]	
naproxen sodium	Naprelan [®]	
oxaprozin	Naprosyn [®]	
piroxicam	Orudis [®]	
sulindac	Oruvail [®]	
tolmetin sodium	Prevacid Naprapac [®]	

*New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Ophthalmic Antihistamines/Mast Cell Stabilizers

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to product formulation (i.e. dyes or fillers). If an allergy to drug class, should question medication request.
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **three-day** trial of **one** medication within the same not requiring prior approval, then may approve the requested medication. Document details.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

Ophthalmic Antihistamines

Preferred Drugs - No PA Required	<i>Non-Preferred Drugs - PA Required</i>	
Alaway OTC[®]	<i>Elestat drops[®]</i>	<i>Patanol drops[®]</i>
	<i>Emadine drops[®]</i>	<i>Pataday drops[®]</i>
	<i>ketotifen fumerate</i>	<i>Zaditor OTC drops[®]</i>
	<i>Optivar drops[®]</i>	

Ophthalmic Mast Cell Stabilizers no change

Preferred Drugs - No PA Required	<i>Non-Preferred Drugs - PA Required</i>
Alamast drops[®]	<i>Crolom drops[®]</i>
Alocril drops[®]	
Alomide drops[®]	
cromolyn sodium	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Ophthalmic Anti-inflammatory

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to product formulation (i.e. dyes, fillers). If an allergy to drug class, should question medication request.
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic failure to no less than a 3 **day** trial of **one** medication within the same not requiring prior approval, then may approve the requested medication. Document details.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

Ophthalmic Anti-Inflammatory no change

Preferred Drugs - No PA Required	<i>Non-Preferred Drugs - PA Required</i>
Acular drops[®]	<i>Acular PF droperette[®]</i>
Acular LS drops[®]	<i>Ocufen drops[®]</i>
diclofenac sodium Drops	<i>Voltaren drops[®]</i>
flurbiprofen Sodium Drops	
Nevanac drops Susp[®]	
Xibrom drops[®]	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Ophthalmic Fluoroquinolones

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to product formulation (i.e. dyes, fillers). If an allergy to drug class, should question medication request.
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication. Document details.

- Note diagnosis and any culture and sensitivity reports

3. If there has been a therapeutic failure to no less than a **three-day** trial of **one** medication within the same not requiring prior approval, then may approve the requested medication. Document details.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

Ophthalmic Antibiotics (Fluoroquinolones & Macrolides)

Preferred Drugs - No PA Required	<i>Non-Preferred Drugs - PA Required</i>
ciprofloxacin drops	<i>Ciloxan drops®</i>
ofloxacin drops	<i>Ciloxan oint®</i>
Quixin drops®	<i>Iquix®</i>
Vigamox drops®	<i>Ocuflox drops®</i>
Zymar drops®	<i>AzaSite™</i>

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Ophthalmic- Glaucoma Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
Acceptable reasons include:
 - Allergy to medications not requiring prior approval
 - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
 - History of unacceptable/toxic side effects to medications not requiring prior approval
 Document clinically compelling information
2. The requested medication may be approved if both of the following are true:
If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** medication **within the same class** not requiring prior approval
3. The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated

Glaucoma Agents

Ophthalmic Prostaglandin Analogs	
Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Travatan Z [®] drops	Lumigan [®] 0.03% drops
Travatan [®] 0.0004% drops	
Xalatan [®] 0.005% drops	
Alpha 2 Adrenergic Agents	
Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Alphagan P [®] 0.1% & 0.15% drops	
brimonidine 0.2% drops	
Iopidine [®] 0.5% & 1% drops	
Beta Blockers	
Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
betaxolol 0.5% drops	Betagan [®] 0.25% & 0.5% drops
Betimol [®] 0.25% & 0.5% drops	Istalol [®] 0.5% drops
Betoptic-S [®] 0.25% susp drops	Ocupress [®] 1% drops
carteolol 1% drops	optipranolol 0.3% drops
Combigan [®]	Timoptic [®] drops 0.25% & 0.5% drops
levobunolol 0.25% & 0.5% drops	Timoptic XE [®] 0.25% & 0.5% Sol-Gel
metipranolol 0.3% drops	
timolol maleate drops 0.25% & 0.5% drops	
timolol maleate 0.5 % Sol-Gel	
Carbonic Anhydrase Inhibitors	
Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Azopt [®] 1% drops	dorzolamide
Cosopt [®] 0.5%-2% drops	dorzolamide/timolol
Trusopt [®] 2% drops	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Oral Hypoglycemics

LENGTH OF AUTHORIZATIONS: 1 Year

1. Is there any reason the patient cannot be switched to a non-prior approved medication?

Acceptable reasons include:

- Allergy to the non-prior approved products in this class
- Contraindication or drug to drug interaction with all non-prior approved products
- History of unacceptable side effects

Document clinically compelling information

2. Has the patient tried and failed a therapeutic trial of thirty days with **one** of the non-preferred drugs **within the same class**? If so, document and approve the prior authorized drugs.

Oral Hypoglycemics

Alpha-Glucosidase Inhibitors

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Glyset®	acarbose
Precose®	

Oral Hypoglycemics

Biguanides

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>	
metformin	Fortamet®	Glutmetza®
metformin ER	Glucophage®	Riomet® suspension
	Glucophage XR®	

Oral Hypoglycemics

Biguanide Combination Products

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Avandamet®	Glucovance®
glipizide/metformin	Metaglip®
glyburide/metformin	

Oral Hypoglycemics

DPP-IV inhibitors and combination

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Januvia®	
Janumet®	

Oral Hypoglycemics

Meglitinides

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Starlix®	Prandin®
	PrandiMet® (repaglinide/metformin)

*New generic, brand, or dose formulation anticipated, will be non-preferred pending review

Virginia Medicaid Preferred Drug List, Effective July 1, 2009

**Oral Hypoglycemics
(Continued page 2)**

Oral Hypoglycemics

Thiazolidinediones

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Actos®	Avandaryl®
Avandia®	Duetact®
Actoplus Met®	

Oral Hypoglycemics

Second Generation Sulfonylureas

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
glipizide	Amaryl®
glipizide ER	Diabeta®
glyburide	Glucotrol®
glyburide micronized	Glucotrol XL®
glimepiride	Glynase®
	Micronase®

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Osteoporosis Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medication not requiring prior approval
- Contraindication to or drug-to-drug interaction with medication not requiring prior approval
- History of unacceptable/toxic side effects to medication not requiring prior approval

Document clinically compelling information

2. Has the patient tried and failed a therapeutic trial with a preferred drug **within the same class**? If so, document and approve the prior authorized drug.

Bisphosphonates

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>	
alendronate	<i>Actonel with CA[®]</i>	<i>Actonel[®]</i>
Fosamax [®] solution	Boniva [®]	Fosamax [®]
	Fosamax plus D [®]	

Calcitonins

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Fortical [®]	<i>calcitonin-salmon Nasal</i>
Miacalcin [®]	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

**Phosphodiesterase 5 Inhibitors
Pulmonary Arterial Hypertension**

LENGTH OF AUTHORIZATIONS: 1 year

Diagnosis of Pulmonary Hypertension in patients 18 years of age or older is required.

The requested medication may be approved if both of the following are true:

- The prescribing physician is a pulmonary specialist or cardiologist.
- Client has documented Pulmonary Arterial Hypertension and will be followed by the prescribing physician.

Document clinically supporting information

Contraindications where the PA should not be approved:

- Concurrent use of nitrates (e.g., nitroglycerin)
- Hypersensitivity to Sildenafil.

PD5 Inhibitor

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
Revatio®	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Sedative/ Hypnotics

LENGTH OF AUTHORIZATIONS: Length of the prescription (up to 3 months)

2. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

3. **To receive a non preferred benzodiazepine** there must have been a therapeutic failure to no less than a **one-month** trial of at least **one benzodiazepine** not requiring prior approval, then may approve the requested medication.

Document details

4. **To receive a preferred non benzodiazepine** there must have been a therapeutic failure to no less than a **one-month** trial of a benzodiazepine (*step edit*)

5. **To receive a non preferred non benzodiazepine** there must have been a therapeutic failure to no less than a **one-month** trial of

- First a benzodiazepine (*step edit*)
- Second a therapeutic failure to not less than a **one-month** trial of Rozerem®
- Then may approve the requested medication.

Document details

6. If a request for Ambien® is received for a pregnant patient, approve the Ambien® for the duration of the prescription or the duration of the pregnancy (whichever is shorter).

7. For **patients age 65 and older**, Rozerem®, Ambien® or Lunesta® may be approved after a trial of trazodone (duration = at least one month). It is not necessary for patient's ≥ 65 to try a benzodiazepine if they have had a trial of trazodone.

Sedative Hypnotics (Benzodiazepine)

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>
estazolam	Dalmane®
flurazepam	Doral®
temazepam	Halcion®
triazolam	Prosom®
chloral hydrate Syrup	Restoril®

Sedative Hypnotics (Non-Benzodiazepine) See step edit

Preferred Drugs - No PA Required	<i>Non-preferred Drugs - PA Required</i>	
Rozerem® **	Ambien®	Somnote®
zolpidem	Ambien CR®	Sonata®
	Lunesta®	Zaleplon®

** Must meet Step edit as noted above to receive Rozerem

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Urinary Antispasmodics

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic **failure to at least a one-month trial of at least one medication** not requiring prior approval, then may approve the requested medication.

Urinary Antispasmodics

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Detrol LA [®]	<i>Detrol[®]</i>
Enablex [®]	<i>Ditropan[®]</i>
oxybutynin Tablet	<i>Ditropan XL[®]</i>
oxybutynin Syrup	<i>oxybutynin ER</i>
Oxytrol [®] Transdermal	<i>Toviaz[™]</i>
Sanctura [®]	
Sanctura XR [®]	
Vesicare [®]	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*