



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
Effective January 1, 2015



**Provider Synergies, an affiliate of Magellan Medicaid Administration,
Virginia Medicaid's Pharmacy Service Administrator**

Phone: 1-800-932-6648 Fax: 1-800-932-6651

General Information:

- The PDL is a list of preferred drugs, by select therapeutic class, for which the Medicaid Fee-for-service program allows payment without requiring service authorization (SA).
- *Please note that not all drug classes are subject to the Virginia Medicaid PDL.* In the designated classes, drug products classified as non-preferred will be subject to SA. In some instances, additional clinical criteria may apply to a respective drug class which may require the need for a SA.
- This list is not all inclusive for non-preferred drugs.
- Fax requests receive a response within 24 hours.
- For urgent requests, please call **1-800-932-6648**.
- Not all medications listed are covered by all DMAS programs. Check individual program coverage.
- All new products included in a PDL class are non-preferred until reviewed by the P&T Committee.

For PDL drug coverage information, visit the following: <http://www.VirginiaMedicaidPharmacyServices.com>. The following “routine” PDL criteria guidelines will be applied to non-preferred drugs requiring a Service Authorization. Some drug classes will have additional criteria that will be listed alongside the drug class.

1. Is there any reason the patient cannot be changed to a medication not requiring service authorization within the same class?
Acceptable reasons include:
 - Allergy to medications not requiring service authorization.
 - Contraindication to or drug-to-drug interaction with medications not requiring service authorization.
 - History of unacceptable/toxic side effects to medications not requiring service authorization.
 - Patient's condition is clinically stable; changing to a medication not requiring service authorization might cause deterioration of the patient's condition.
2. The requested medication may be approved if both of the following are true:
 - 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 service authorization.
 - The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated.

All changes from last posting will be highlighted in yellow.

Teal highlights indicate where a Brand is preferred over a generic

Drugs no longer available have been removed from this list.



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
Analgesics			
	<p>Narcotics – Long Acting (LAN)</p> <p>fentanyl patch Kadian® ER *methadone 10 mg/5mL & 5mg/5mL oral soln *methadone 5mg & 10mg tab morphine sulfate tab SA</p>	<p>Avinza® Butrans® Conzip® ER *Dolophine® Duragesic® Embeda® Exalgo® *Methadose® morphine ER (generic for Avinza®) morphine ER (generic for Kadian® ER) MS Contin® Nucynta® ER Opana® ER Oramorph® SR oxycodone-long acting OxyContin® oxymorphone ER Ryzolt™ tramadol ER Ultram ER® Xartemis™ XR Zohydro ER™</p>	<p><u>LENGTH OF AUTHORIZATIONS:</u></p> <ul style="list-style-type: none"> Up to 6 months after trial and failure of 2 different short acting narcotics OR Up to one year for cancer and sickle cell OR One to three months for chronic non-malignant pain <p><u>Clinical Criteria for LAN</u> If diagnosis is chronic non-malignant pain they must have:</p> <ul style="list-style-type: none"> A treatment plan that includes a diagnosis & goals of therapy, AND Documentation of provision of an assessment of addiction risk with the therapy, AND Attestation from prescriber that the Virginia Board of Pharmacy Prescription Drug Monitoring Program database has been recently reviewed, AND Be aware of the request for possible random urine drug testing, AND A pain management contract that addresses the following: <ul style="list-style-type: none"> The consequences of unexplained loss or shortage of medications, The consequences of obtaining similar prescription medications from other prescribers, An agreement with the patient to only use one pharmacy. <p><u>Additional PDL edit</u></p> <ul style="list-style-type: none"> Approval of non-preferred agents in this class requires: <ul style="list-style-type: none"> Contraindication to all PDL preferred agents, or Drug to drug interaction to all PDL preferred agents, or History of toxic side effects from all PDL preferred agents that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents.



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			<p>*Clinical Criteria for Methadone All methadone agents receive a clinical edit to determine reason for use. Low dose strengths are generally used for pain. Please see criteria for clinical edit for methadone 40mg dispersible tablets and 10mg/mL oral concentrated solution for detoxification and maintenance treatment of narcotic addiction.</p>
Narcotics – Short Acting			
Barbiturate & Non-Salicylates Analgesic Combinations		LENGTH OF AUTHORIZATIONS: 3 months	
	acetaminophen-butalbital	<i>Phrenilin Forte[®]</i>	<p>Routine PDL edit plus</p>
Lozenges - Narcotic		Clinical Criteria for Narcotic Lozenges	
		<p><i>Actiq[®]</i> <i>Fentora[®]</i> <i>fentanyl citrate</i></p>	<ul style="list-style-type: none"> • Diagnosis of breakthrough cancer pain • Patient is receiving around-the-clock scheduled long-acting narcotics; AND • Patient is receiving and tolerant to other opioids as indicated by one of the following: <ul style="list-style-type: none"> ○ At least 60 mg of morphine per day for at least one week without adequate pain relief; OR ○ At least 25 mcg/hr of transdermal fentanyl for at least one week without adequate pain relief; OR ○ At least 30 mg oxycodone per day for at least one week without adequate pain relief; OR ○ At least 8 mg hydromorphone per day for at least one week without adequate pain relief; OR ○ An equianalgesic dose of another opioid for at least one week without adequate pain relief; AND • Patient has tried and failed at least two immediate release opioid products (e.g., oxycodone, immediate-release morphine, hydromorphone) for breakthrough pain OR has a contraindication, intolerance, or drug-to-drug interaction with at least two immediate release opioid products



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	<p>Opioid Dependency - Methadone products</p> <p>* Diskets[®] 40mg *methadone 10mg/mL intensol oral concentrated soln *methadone 40 mg *Methadose[®] 10mg/mL oral concentrated soln *Methadose[®] 40 mg</p>		<p>*Clinical Criteria for methadone 40mg dispersible tablets & 10mg/mL oral concentrated solution</p> <ul style="list-style-type: none"> FDA approved ONLY for detoxification and maintenance treatment of narcotic addiction Patient must be enrolled in a methadone treatment program (opioid treatment program, OTP) Dispensed only by opioid treatment programs (and agencies, practitioners, or institutions by formal agreement with the program sponsor) certified by the Federal Substance Abuse and Mental Health Services Administration and registered by the Drug Enforcement Administration (DEA).
	<p>Opioid Dependency - Buprenorphine products</p> <p>**buprenorphine SL **Suboxone[®] film *** naltrexone tab</p>	<p>**Bunavail[™] **buprenorphine/naloxone tab **Zubsolv[™]</p>	<p>**Clinical Criteria for Bunavail[™], buprenorphine SL, buprenorphine/naloxone tablets, Suboxone[®] SL film, & Zubsolv[™]</p> <ul style="list-style-type: none"> Diagnosis of opiate abuse/dependence, Prescribed by a qualified prescriber who has: <ul style="list-style-type: none"> A Substance Abuse and Mental Health Services Administration Waiver. AND An active “X” DEA number, AND The prescription is written under the “X” DEA number such that this patient counts toward the patient limits established for individual prescribers by the DATA 2000 waiver, AND The prescriber has reviewed the Virginia Controlled Substance Database, AND Patient is receiving addiction counseling, AND, A chemical dependency assessment has been performed, AND Criteria for chemical dependency are met, AND Patient is 16 years of age or older (no exceptions allowed), AND Patient is not pregnant (Bunavail[™] Suboxone[®] SL/Film, buprenorphine/ naloxone, and Zubsolv[™]), Max dose is 16mg/day Suboxone[®].



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			<p>Quantity limit</p> <p>Bunavail-™ 2.1-0.3mg buccal film 34 / 34 days</p> <p>Bunavail™ 4.2-0.7mg buccal film 68 / 34 days</p> <p>Bunavail™ 6.3-1mg buccal film 68 / 34 days</p> <p>buprenorphine/naloxone tablets 2mg 102 / 34 days</p> <p>buprenorphine/naloxone tablets 8mg 68 / 34 days</p> <p>buprenorphine tablets 2mg 102 / 34 days</p> <p>buprenorphine tablets 8mg 68 / 34 days</p> <p>Suboxone® SL film 2mg 102 / 34 days</p> <p>Suboxone® SL film 4mg 68 / 34 days</p> <p>Suboxone® SL film 8mg 68 / 34 days</p> <p>Suboxone® SL film 12mg 68 / 34 days</p> <p>Zubsolv™ 68 / 34 days</p> <p>***Clinical Criteria for naltrexone (oral)</p> <ul style="list-style-type: none"> Must have a diagnosis of : <ul style="list-style-type: none"> Alcohol dependence OR Opioid dependence <p><i>Do not attempt treatment with naltrexone unless, in the medical judgment of the prescriber, there is no reasonable possibility of opioid use within the past 7 to 10 days. If there is any question of occult opioid dependence, perform a naloxone challenge test.</i></p>
	<p>Short-Acting Narcotics</p> <p>codeine/APAP</p> <p>codeine/APAP/caff/butal</p> <p>codeine/ASA</p> <p>hydrocodone/APAP</p> <p>hydrocodone/ibuprofen</p> <p>hydrocodone bitartrate/APAP</p> <p>hydromorphone</p> <p>morphine IR</p> <p>nalbuphine</p> <p>oxycodone IR</p> <p>oxycodone/APAP</p> <p>tramadol HCL</p>	<p><i>All Brands require a SA</i></p> <p><i>Abstral®</i></p> <p><i>codeine tab/soln</i></p> <p><i>butalbital comp with codeine</i></p> <p><i>butorphanol tartrate nasal</i></p> <p><i>dihydrocodeine/APAP/</i></p> <p><i>caffeine</i></p> <p><i>dihydrocodeine/ASA /caffeine</i></p> <p><i>hydromorphone liq/supp</i></p> <p><i>meperidine tab</i></p> <p><i>Nucynta®</i></p> <p><i>Oxecta®</i></p>	<p>Routine PDL edit plus</p> <ul style="list-style-type: none"> Approval of non-preferred agents in this class requires: <ul style="list-style-type: none"> Contraindication to all PDL preferred agents, OR Drug to drug interaction to all PDL preferred agents, OR History of toxic side effects from all PDL preferred agents that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents.



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		<i>oxycodone/ASA</i> <i>oxycodone/ibuprofen</i> <i>oxymorphone HCl</i> <i>pentazocine/naloxone</i> <i>PrimLev™</i> <i>tramadol HCL /APAP</i> <i>Ultracet®</i> <i>Ultram®</i>	
Non-Steroidal Anti-Inflammatory Drugs			
	Children’s ibuprofen susp (OTC) ibuprofen (OTC & RX) Infant’s ibuprofen drops susp OTC meloxicam tab nabumetone naproxen naproxen sodium piroxicam sulindac	<i>Anaprox® IR & DS®</i> <i>Advil®</i> <i>Aleve®</i> <i>Arthrotec®</i> <i>Cataflam®</i> <i>*Celebrex®</i> <i>Daypro®</i> <i>diclofenac potassium</i> <i>diclofenac sodium SR</i> <i>diclofenac sodium/</i> <i>misoprostol</i> <i>diflunisal</i> <i>Duexis®</i> <i>etodolac IR & SR</i> <i>Feldene®</i> <i>fenoprofen</i> <i>flurbiprofen</i> <i>Indocin® supp</i> <i>indomethacin IR, SR & rectal</i> <i>ketoprofen IR & ER</i> <i>ketorolac</i> <i>meclofenamate</i> <i>mefenamic</i> <i>meloxicam susp</i> <i>Mobic®</i> <i>Motrin®</i> <i>Nalfon®</i> <i>Naprelan®</i>	<p><u>LENGTH OF AUTHORIZATIONS:</u> 1 year</p> <p>Routine PDL edit plus</p> <p>A one-month trial of at least <u>two preferred medications within the same class.</u></p> <p>*Step edit required for Celebrex®</p> <ul style="list-style-type: none"> • History of a trial of a minimum of two (2) different non-COX2 NSAIDs within the past year, OR • Concurrent use of anticoagulants (i.e., warfarin, heparin, etc.), methotrexate, oral corticosteroids, OR • History of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc.), OR specific indication for Celebrex®, which medications not requiring Service Authorization are not indicated.



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		<i>Naprosyn[®]</i> <i>naproxen EC</i> <i>oxaprozin</i> <i>Ponstel[®]</i> <i>Prevacid Naprapac[®]</i> <i>Sprix[®] nasal spray</i> <i>tolmetin sodium</i> <i>Vimovo[®]</i> <i>Voltaren[®] XR</i> <i>Zipsor[®]</i> <i>Zorvolex[™]</i>	
Topical Analgesic Agents and Anesthetics			
	*Flector [®] patch *Voltaren [®] gel	**Lidoderm [®] patch **lidocaine 5% patch *Pennsaid [®] top soln & pump ***Solaraze 3% top gel	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit *Clinical Criteria for Topical Analgesic Agents and Anesthetics > *Flector[®], Voltaren[®] & Pennsaid[®]: <ul style="list-style-type: none"> • Approval is based on patient failing the oral generic of the desired product and at least one other preferred NSAID (to equal a total of at least two preferred). For example, a patient who failed ibuprofen or naproxen will still need to try oral generic diclofenac for approval of Flector[®], • Pennsaid[®] can only be approved for the FDA approved indication of osteoarthritis of the knee, • Quantity limit for Flector[®] Patch; 30 patches per RX. > ** Lidoderm[®] Patch: <ul style="list-style-type: none"> • Lidoderm[®] patches can be approved for relief of pain associated with post-herpetic neuralgia. > ***Solaraze[®] 3% Gel Clinical Criteria: <ul style="list-style-type: none"> • Indicated for the topical treatment of actinic keratosis



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Antibiotic-Anti-Infective			
Antibiotics, Inhaled			
	Tobi[®] *Tobi Podhaler [®]	<i>Bethkis[®]</i> <i>Cayston[®]</i> <i>tobramycin inhalation nebulizer sol</i>	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit plus <u>Clinical Criteria for Antibiotics, Inhaled:</u> ➤ *Tobi Podhaler[®] <ul style="list-style-type: none"> • Tobi[®] nebulizer 300mg/5 mL solution is covered without SA; clinical reason as to why Tobi[®] nebulizer 300mg/5 mL solution cannot be used, • Minimum age restriction of 6 years of age. ➤ Cayston[®] and Bethkis[®] <ul style="list-style-type: none"> • Diagnosis of cystic fibrosis, AND • Previous therapy with tobramycin via nebulizer, AND • Demonstration of TOBI[®] compliance. • Quantity limits Tobi [®] = 8 capsules per day Cayston [®] = 84mL per 28 days Bethkis [®] = 56 ampules per 28 days
Antibiotics, Vaginal			
	Cleocin[®] Ovules Metrogel[®] Vandazole[™] gel	<i>Cleocin[®] cr</i> <i>Clindesse[®] cr</i> <i>clindamycin cr</i> <i>metronidazole gel</i>	<u>LENGTH OF AUTHORIZATIONS:</u> Date of Service Routine PDL edit
Antifungals, Oral			
	fluconazole tab/susp Griseofulvin[®] susp griseofulvin ultramicrosize ketoconazole nystatin tab/susp terbinafine	*Ancobon [®] <i>clotrimazole (mucous mem)</i> <i>Diflucan[®] tab/susp</i> <i>flucytosine</i> <i>Grifulvin V[®] tab</i> Gris-Peg[®] <i>griseofulvin tab</i>	<u>LENGTH OF AUTHORIZATIONS:</u> Duration of the prescription (up to 12 months) Routine PDL edit plus



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		itraconazole **Lamisil® tab/granules ***Noxafil® ****Onmel® *****Sporanox® cap/soln Terbinex™ kit *****Vfend® tab/susp voriconazole tab & powder for susp	<p>Clinical Criteria for Antifungals, Oral</p> <p>➤ <u>Ancobon®</u>:</p> <ul style="list-style-type: none"> • Indicated for the treatment of : <ul style="list-style-type: none"> ○ Candida: Septicemia, endocarditis, and UTIs, OR ○ Cryptococcus: meningitis, pulmonary infections, OR • Can be approved if the patient has a serious illness that leaves them immunocompromised (i.e. AIDS, cancer, organ transplants). <p>➤ **<u>Lamisil® granules</u></p> <ul style="list-style-type: none"> • Indication is tinea capitis, AND • Patient must be over 4 years of age. <p>➤ *** <u>Noxafil®</u></p> <ul style="list-style-type: none"> • One of the following indications: <ul style="list-style-type: none"> ○ Used for preventative (prophylactic) therapy for treatment of invasive Aspergillus, OR ○ Diagnosis of Candida, OR ○ Patient is immunocompromised, OR ○ Diagnosis of graft-versus-host disease (GVHD), OR ○ Patient has a hematologic malignancy (a cancer of the blood, bone marrow, or lymph nodes), OR ○ Patient has prolonged neutropenia from chemotherapy, OR ○ Diagnosis of Zygomycosis, OR ○ Diagnosis of Fusariosis, OR ○ Patient has another fungal infection or mold infection is refractory or resistant to itraconazole or voriconazole, or patient has a contraindication to itraconazole or voriconazole. <p>➤ ****<u>Onmel®</u></p> <ul style="list-style-type: none"> • Indicated for the treatment of onychomycosis of the toenail caused by <i>Trichophyton rubrum</i> or <i>T. mentagrophytes</i>, • Patient had a therapeutic trial and treatment failure



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			<p>with oral terbinafine, OR</p> <ul style="list-style-type: none"> • Patient has a contraindication to oral terbinafine (i.e. heart failure, hepatic impairment, viral hepatitis). <p>➤ *****Sporanox®</p> <ul style="list-style-type: none"> • Indicated for the treatment of Aspergillosis, Candidiasis (oral or esophageal), Histoplasmosis, Blastomycosis, empiric treatment of febrile neutropenia. <p>➤ *****Vfend®:</p> <ul style="list-style-type: none"> • Can be approved without failure on the preferred agent if the patient has any of the following diagnoses: <ul style="list-style-type: none"> ○ Myelodysplastic Syndrome (MDS), OR ○ Neutropenic Acute Myeloid Leukemia (AML), OR ○ Graft versus Host Disease (GVHD), OR ○ Candidemia (candida krusei), OR ○ Esophageal Candidiasis, OR ○ Pulmonary or invasive aspergillosis, OR ○ Blastomycosis, OR ○ Oropharyngeal/esophageal candidiasis refractory to fluconazole, OR ○ Serious fungal infections caused by <i>Scedosporium apiospermum</i> (asexual form of <i>Pseudallescheria boydii</i>) and <i>Fusarium</i> spp., including <i>Fusarium solani</i>, in patients intolerant of, or refractory to other therapy, immunocompromised (i.e. AIDS, cancer, organ transplants).
	<p align="center">Cephalosporins, Oral</p>		<p>LENGTH OF AUTHORIZATIONS: Date of service only; no refills</p> <p>Routine PDL edit plus</p> <p><u>Clinical Criteria for Cephalosporins</u></p> <ul style="list-style-type: none"> • Infection caused by an organism resistant to medications not requiring SA, OR
	<p align="center">Second Generation Cephalosporins</p>		
	<p>cefaclor cap cefprozil cap/susp cefuroxime tab</p>	<p><i>cefaclor ER</i> <i>cefaclor susp</i> <i>Ceftin® tab/susp</i></p>	



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			<ul style="list-style-type: none"> • A therapeutic failure to no less than a three-day trial of one medication within the same class not requiring SA, OR • The patient is completing a course of therapy with a medication requiring a SA, which was initiated in the hospital.
	Third Generation Cephalosporins		
	cefdinir cap/susp Suprax[®] susp	<i>Cedax[®] cap/susp</i> <i>ceftibuten</i> <i>cefditoren pivoxil</i> <i>cefpodoxime proxetil</i> <i>cap/susp</i> <i>Spectracef[®]</i> <i>Suprax[®] chewable tab/cap</i>	
Macrolides, Oral			
Macrolides & Ketolides			LENGTH OF AUTHORIZATIONS: Date of service
	azithromycin pack/susp/tab clarithromycin tab/susp *E.E.S.[®] *Eryped[®] 400 susp Ery-tab[®] erythrocin stearate erythromycin base erythromycin ethylsuccinate erythromycin stearate erythromycin/ sulfisoxazole	<i>Biaxin[®] tab/susp/XL</i> <i>clarithromycin ER</i> <i>*Eryped[®] 200 susp</i> <i>erythromycin base DR cap</i> <i>**Ketek[®]</i> <i>PCE[®]</i> <i>Zithromax[®] pac/tab/susp</i> <i>ZMAX[®] susp</i>	only; no refills Routine PDL edit plus <u>Clinical Criteria for Macrolides and Ketolides</u> <ul style="list-style-type: none"> • Infection caused by an organism resistant to medications not requiring SA, OR • A therapeutic failure to no less than a three-day trial of one medication within the same class not requiring SA, OR • The patient is completing a course of therapy with a medication requiring a SA, which was initiated in the hospital. <p>*Generics are not available in some strengths/dosage forms **To receive a SA for Ketek[®], a specific Ketek[®] SA request form must be completed and faxed or mailed to Magellan Medicaid Administration with the prescriber's signature.</p>



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Quinolones, Oral		
Second Generation Quinolones		<u>LENGTH OF AUTHORIZATIONS:</u> Date of service only; no refills Routine PDL edit plus: <u>Clinical Criteria for Quinolones</u> <ul style="list-style-type: none"> Infection caused by an organism resistant to medications not requiring SA, OR A therapeutic failure to no less than a <u>three-day trial of one medication within the same class not</u> requiring SA, OR The patient is completing a course of therapy with a medication requiring a SA, which was initiated in the hospital.
ciprofloxacin susp/tab	<i>Cipro[®] IR & XR and susp</i> <i>ciprofloxacin ER</i> <i>Noroxin[®]</i> <i>ofloxacin</i>	
Third Generation Quinolones		
Avelox[®] ABC PACK levofloxacin tab	<i>Avelox[®]</i> <i>Levaquin[®] tab/susp</i> <i>levofloxacin susp</i> moxifloxacin	
Quinolones, Otic		
Ciprodex[®] ofloxacin	<i>Cetraxal[®]</i> <i>Cipro HC[®]</i>	<u>LENGTH OF AUTHORIZATIONS:</u> Date of service only; no refills Routine PDL edit
Topical		
mupirocin ointment	<i>*AltabaxTM</i> <i>Bactroban[®]</i> <i>cream/ointment</i> <i>Centany[®]</i> <i>Centany AT[®] Kit</i>	<u>LENGTH OF AUTHORIZATIONS:</u> Date of service only; no refills Routine PDL edit *Quantity Limit = 15 grams per 34 days
Antivirals		
Hepatitis C Agents		
Interferon		<u>LENGTH OF AUTHORIZATIONS:</u> Refer to Appendix A for drug criteria for Hepatitis C Agents
Peg-Intron[®] Peg-Intron Redipen[®]	<i>Pegasys[®]</i> <i>Proclick/syringe/kit/ vial</i>	



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	Protease Inhibitor		
	** Victrelis[®]	*** <i>Olysio[™]</i>	
	Nucleotide Analog NS5B Polymerase Inhibitor		
		<i>Sovaldi[®]</i>	
	NS5B & Protease Inhibitor combinations		
		Harvoni[®]	
	Herpes Oral		
	acyclovir tab/susp famciclovir valacyclovir	<i>Famvir[®]</i> Sitavig[®] buccal tab <i>Valtrex[®]</i> <i>Zovirax[®] tab/susp</i>	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
	Herpes Topical		
	Abreva OTC[®] Zovirax[®] ointment	acyclovir oint <i>Denavir[®]</i> <i>Xerese[®] cr</i> <i>Zovirax[®] cr</i>	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
	Influenza		
	amantadine tab/syrup Relenza Disk[®] rimantadine Tamiflu[®] cap/susp	<i>amantadine cap</i> <i>Flumadine[®] tab</i>	LENGTH OF AUTHORIZATIONS: Date of service only Routine PDL edit
	Blood Modifiers		
	Berinert[®] (C1-inhibitor Human) Cinryze[™] (C1-inhibitor Human) Kalbitor[®] (kallikrein inhibitor)	<i>Firazyr[®] (icatibant)</i> Ruconest[®] (C1- inhibitor recombinant)	LENGTH OF AUTHORIZATIONS: Date of service (plus one additional supply for emergency use) Routine PDL edit plus Clinical Criteria for Blood Modifiers <ul style="list-style-type: none"> • Must be prescribed and under direct care by a board-certified allergist, immunologist or hematologist • For prophylaxis must have:



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			<ul style="list-style-type: none"> ○ HAE attacks occur at least once monthly, AND ○ Disabled at least 5 days per month, AND ○ History of attacks with airway compromise / hospitalization AND ○ History of Prior prophylaxis with danazol: <ul style="list-style-type: none"> ▪ danazol contraindicated (pediatric, hepatic or renal impairment, pregnancy, breast-feeding, abnormal genital bleeding), OR ▪ Developed danazol toxicity, OR ▪ Diminished danazol efficacy. <p><u>FDA Indications and Quantity Limits</u></p> <ul style="list-style-type: none"> • Berinert[®] Acute abdominal, facial or laryngeal HAE attacks (20 U per kg) 500 units/ vial- 4 vials per attack (plus 4 for emergency). • Cinryze[™] Prevention of HAE attacks. Cinryze; 1,000 U - IV twice/week (500 units/ vial) 20 vials per 34 days. • Kalbitor[®] Acute HAE attacks in patients 16 years of age and older. (3-10 mL per dose Health care person to administer) 1 dose (plus one for emergency). • Firazyr[®] Acute attacks of (HAE) in adults 18 years of age and older; 30mg/dose (plus one for emergency). • Ruconest[®] acute attacks of hereditary angioedema (HAE) in people over 13 years of age; 2 vials (plus two for emergency).

Bone Resorption Suppression and Related Agents

Bisphosphonates		
	alendronate Fosamax[®] soln	Actonel [®] alendronate soln Atelvia DR [®] Boniva [®] Binosto [™] etidronate Fosamax [®] tablet Fosamax [®] plus D ibandronate
		<p><u>LENGTH OF AUTHORIZATIONS:</u> 1 year</p> <p>Routine PDL edit</p> <p>*Indicated only for treatment of Paget's disease of bone OR prevention and treatment of heterotopic ossification following total hip replacement or spinal cord injury.</p>



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Calcitonins			
	Fortical[®]	<i>calcitonin-salmon nasal</i> <i>Miacalcin[®]</i>	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
Others			
	Evista[®]	<i>Forteo[®]</i> <i>raloxifene</i>	LENGTH OF AUTHORIZATIONS: Initial approval will be for 1 year with ONE renewal if demonstrated compliance. Maximum duration of therapy is 24 months during a patient's lifetime. Routine PDL edit plus Clinical Criteria for Forteo[®] (teriparatide) <ul style="list-style-type: none"> • Treatment of osteoporosis in postmenopausal women who are at high risk for fracture, OR • Increase of bone mass in men with primary or hypogonadal osteoporosis who are at high risk for fractures, OR • Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture, OR • Bone mineral density of -3 or worse, OR • Postmenopausal women with history of non-traumatic fracture(s), OR • Postmenopausal women with two or more of the following clinical risk factors: <ul style="list-style-type: none"> ○ Family history of non-traumatic fracture(s), OR ○ Patient history of non-traumatic fracture(s), OR ○ DXA BMD T-score ≤-2.5 at any site, OR ○ Glucocorticoid use* (≥6 months of use at 7.5 dose of prednisolone equivalent), OR ○ Rheumatoid Arthritis, OR ○ Postmenopausal women with BMD T-score ≤-2.5 at any site with any of the following clinical risk factors: <ul style="list-style-type: none"> ▪ More than 2 units of alcohol per day, OR ▪ Current smoker, OR ▪ Men w/primary or hypogonadal osteoporosis,



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
			OR <ul style="list-style-type: none"> Osteoporosis associated w/sustained systemic glucocorticoid therapy.
Cardiac			
ACE Inhibitors, Angiotensin Receptors Blockers, Beta-Blockers			
	ACE Inhibitors		LENGTH OF AUTHORIZATIONS: 1 year
	benazepril captopril enalapril lisinopril ramipril	Accupril® Altace® Epaned™ soln fosinopril Lotensin® Mavik® moexipril Monopril® perindopril Prinivil® quinapril ramipril trandolapril Univasc® Vasotec® Zestril®	Routine PDL edit
	ACE Inhibitors + Calcium Channel Blocker Combinations		
	amlodipine/ benazepril	Lotrel® Tarka®	
	ACE Inhibitors + Diuretic Combinations		
	benazepril/HCTZ captopril/HCTZ lisinopril/HCTZ	Accuretic® enalapril/HCTZ fosinopril/HCTZ Lotensin HCT® moexipril/HCTZ quinapril/HCTZ Vaseretic® Zestoretic®	



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Angiotensin Receptor Blockers		
Diovan[®] losartan	<i>Atacand[®]</i> <i>Avapro[®]</i> <i>Benicar[®]</i> <i>candesartan</i> <i>Cozaar[®]</i> <i>Edarbi[®]</i> <i>eprosartan mesylate</i> <i>irbesartan</i> <i>Micardis[®]</i> <i>telmisartan/HCTZ</i> <i>Teveten[®]</i>	
Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations		
	<i>Azor[®]</i> <i>Exforge[®]</i> <i>Exforge[®] HCT</i> <i>Tribenzor[®]</i>	
Angiotensin Receptor Blockers + Diuretic Combinations		
losartan/HCTZ valsartan/HCTZ	<i>Atacand HCT[®]</i> <i>Avalide[®]</i> <i>Benicar HCT[®]</i> <i>candesartan/HCTZ</i> <i>Diovan HCT[®]</i> <i>Edarbyclor[®]</i> <i>Hyzaar[®]</i> <i>irbesartan/HCTZ</i> <i>Micardis HCT[®]</i> <i>Teveten HCT[®]</i>	



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	<p align="center">Antihypertensives, Sympatholytics</p> <p>Catapres® -TTS clonidine tab guanfacine methyldopa reserpine</p>	<p><i>Catapres®</i> <i>clonidine (transdermal)</i> <i>Clorpres®</i> <i>methyldopa/hctz</i> <i>Tenex®</i></p>	<p>Clinical Criteria for Antihypertensives, Sympatholytics</p> <ul style="list-style-type: none"> • A therapeutic failure of at least two medication(s) within the same class not requiring prior approval, AND • The requested medication's corresponding generic (if a generic is available and preferred by the State) has been attempted and failed or is contraindicated.
	<p align="center">Beta Blockers</p> <p>atenolol carvedilol labetalol metoprolol tartrate nadolol propranolol tab/soln Sorine® sotalol AF sotalol HCL</p>	<p><i>acebutaolol</i> <i>Betapace® IR & AF®</i> <i>betaxolol</i> <i>bisoprolol</i> <i>Bystolic®</i> <i>Coreg® IR & CR®</i> <i>Corgard®</i> <i>Hemangeol™</i> <i>Inderal® XL</i> <i>Innopran® XL</i> <i>Levatol®</i> <i>Lopressor®</i> <i>metoprolol succinate</i> <i>pindolol</i> <i>propranolol LA</i> <i>Sectral®</i> <i>Tenormin®</i> <i>timolol maleate</i> <i>Toprol XL®</i> <i>Trandate®</i> <i>Zebeta®</i></p>	<p>Clinical Criteria for Hemangeol™</p> <ul style="list-style-type: none"> • Diagnosis treatment of proliferating infantile hemangioma requiring systemic therapy, AND • Age must be between >5weeks and 5 months. <p><i>Hemangeol is contraindicated in the following conditions:</i></p> <ul style="list-style-type: none"> • <i>Premature infants with corrected age < 5 weeks,</i> OR • <i>Infants weighing less than 2 kg, OR</i> • <i>Asthma or history of bronchospasm, OR</i> • <i>Heart rate <80 beats per minute, greater than first degree heart block, or decompensated heart failure,</i> OR • <i>Blood pressure <50/30 mmHg, OR</i> • <i>Pheochromocytoma.</i>



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Beta Blockers + Diuretic Combinations		
atenolol/ chlorthalidone bisoprolol/HCTZ nadolol/ bendroflume - thiazide propranolol/HCTZ	<i>Corzide</i> [®] <i>Dutoprol</i> [®] <i>Lopressor HCT</i> [®] <i>metoprolol/HCTZ</i> <i>Tenoretic</i> [®] <i>Ziac</i> [®]	
Direct Renin Inhibitors (includes combination)		
	<i>Amturnide</i> [™] <i>Tekamlo</i> [®] <i>Tekturna</i> [®] <i>Tekturna HCT</i> [®] <i>Twynsta</i> [®] <i>telmisartan/amlodipine</i>	
Anticoagulants		
Low Molecular Weight Heparin includes FactorXA Inhibitor		<u>LENGTH OF AUTHORIZATIONS:</u> 1 year
Fragmin [®] Syringe Lovenox [®]	<i>Arixtra</i> [®] <i>enoxaparin</i> <i>fondaparinux</i> <i>Fragmin</i> [®] vial	Routine PDL edit plus
Oral Anticoagulants		<u>*Clinical Criteria for Anticoagulant, Oral</u>
warfarin * Pradaxa [®] ** Xarelto [®]	<i>Coumadin</i> [®] *** <i>Eliquis</i> [™]	<ul style="list-style-type: none"> ➤ *Pradaxa <ul style="list-style-type: none"> • May be approved for the following diagnosis <ul style="list-style-type: none"> ○ To reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation, OR ○ For the treatment of deep venous thrombosis (DVT), AND pulmonary embolism (PE) in patients who have been treated with a parenteral anticoagulant for 5-10 days, OR ○ To reduce the risk of recurrence of DVT and PE in patients who have been previously treated.



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			<ul style="list-style-type: none"> ➤ ** Xarelto[®] (rivaroxaban) <ul style="list-style-type: none"> • May be approved for the following diagnosis <ul style="list-style-type: none"> ○ Nonvalvular atrial fibrillation, OR ○ Treatment of deep vein thrombosis (DVT), OR ○ Pulmonary embolism (PE), OR ○ For the reduction in the risk of recurrence of DVT and of PE for the prophylaxis of DVT, in patients undergoing knee or hip replacement surgery. ➤ *** Eliquis[™] <ul style="list-style-type: none"> • May be approved for the following diagnosis: <ul style="list-style-type: none"> ○ Reduction in risk of stroke and systemic embolism in non-valvular atrial fibrillation, OR ○ Prophylaxis of DVT following hip or knee replacement surgery.
Calcium Channel Blockers: Dihydropyridine CCB & Non-Dihydropyridine CCB			
Dihydropyridine Calcium Channel Blockers			LENGTH OF AUTHORIZATIONS: 1 year
Afeditab CR[®] amlodipine Nifedical XL[®] nifedipine nifedipine ER	<i>Adalat CC[®]</i> <i>felodipine ER</i> <i>isradipine</i> <i>nisoldipine</i> <i>nicardipine</i> <i>Norvasc[®]</i> <i>Procardia[®]</i> <i>Procardia XL[®]</i> <i>Sular[®]</i>	Routine PDL edit	
Non-Dihydropyridine Calcium Channel Blockers			
Cartia XT[®] diltiazem IR, ER q 12 hr & 24 hr Taztia XT[®] verapamil tab IR & ER	<i>Calan[®] IR & SR</i> <i>Cardizem[®] IR, CD & LA</i> <i>Isoptin SR[®]</i> <i>Matzim LA</i> <i>Tiazac[®]</i> <i>verapamil ER cap</i> <i>Verelan[®] & Verelan PM[®]</i>		



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
Lipotropics			
Bile Acid Sequestrants			LENGTH OF AUTHORIZATIONS: 1 year
cholestyramine powder reg & light colestipol tab Prevalite[®] Welchol[®] tab		<i>Colestid[®] granule/packet/tab</i> <i>colestipol HCl granules</i> <i>Questran[®] powder/powder Light</i> <i>Welchol[®] packet</i>	Routine PDL edit plus Therapeutic failure to no less than three-month trial of at least one medication not requiring SA.
Cholesterol Absorption Inhibitor (CAI)			
Zetia[®]			
Fibric Acid Derivatives			
gemfibrozil fenofibrate (Tricor[®])		<i>Antara[®]</i> <i>fenofibrate (generic for Antara[®])</i> <i>fenofibrate (generic for Lipofen[®])</i> <i>fenofibric acid</i> <i>Fenoglide[®]</i> <i>Fibricor[®]</i> <i>Lipofen[®]</i> <i>Lofibra[®]</i> <i>Lopid[®]</i> Tricor[®] <i>Triglide[®]</i> <i>Trilipix[™]</i>	
HMG CoA Reductase Inhibitors and Combinations (High Potency Statins)			
atorvastatin simvastatin		<i>amlodipine/ atorvastatin</i> <i>Caduet[®]</i> <i>Crestor[®]</i> <i>Lipitor[®]</i> <i>Liptruzel[®]</i> <i>Livalo[®]</i> <i>Vytorin[®]</i> <i>Zocor[®]</i>	



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	HMG CoA Reductase Inhibitors and Combinations (Statins) lovastatin pravastatin	<i>Advicor</i> [®] <i>Altoprev</i> [®] <i>fluvastatin</i> <i>Lescol</i> [®] <i>Lescol XL</i> [®] <i>Mevacor</i> [®] <i>Pravachol</i> [®]	
	Microsomal Triglyceride Transfer Protein Inhibitor	**Juxtapid [™]	<u>Clinical Criteria for Lipotropics, Other</u> ➤ **Juxtapid [™] <ul style="list-style-type: none"> • Diagnosis of homozygous familial hypercholesterolemia (HoFH), AND • Prescriber must be certified with the Juxtapid[™] REMS program, AND • Minimum age restriction of 18 years of age, AND • Patient has had treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants.
	Niacin Derivatives Niacor [®] Niaspan [®]	niacin ER	
	Niacin Derivatives & HMG CoA Reductase Inhibitors Combination	*Simcor [®]	**Simcor [®] Step edit requires a history of either a niacin or simvastatin product within the past 365 days
	Omega 3 Fatty Acid Agent	***Lovaza [®] ***omega-3 acid ethyl esters Vascepa [®]	➤ ***Lovaza [®] <ul style="list-style-type: none"> • Step edit requires trial and failure of any other lipotropic, AND • SA may also be approved without a documented medication trial if patient has documented high triglycerides of ≥ 500 mg/dL.



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	Oligonucleotide Inhibitor	**** <i>Kynamro™</i>	**** Kynamro™ <ul style="list-style-type: none"> • Diagnosis of homozygous familial hypercholesterolemia (HoFH), AND • Prescriber must be certified with the Kynamro™ REMS program, AND • Minimum age restriction of 18 years of age, AND • Patient has had treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants
Platelet Inhibitors			
	clopidogrel dipyridamole Effient® ticlopidine HCL	Aggrenox® Brilinta® Persantine® Plavix® Zontivity™	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit Clinical Criteria for Zontivity™ <ul style="list-style-type: none"> • Diagnosis of MI (myocardial infarction) or PAD (peripheral arterial disease); AND • Patients must not have a history of stroke, TIA, ICH, GI bleed and peptic ulcer; AND • Must have concomitant therapy with clopidogrel, unless patient has a contraindication to clopidogrel in which case patient must have concomitant therapy with aspirin, AND • 18 or older, AND • Prescribed by a cardiologist, OR • Have a cardiologist consultation.
Pulmonary Arterial Hypertension Agents			
	Inhaled Prostacyclin Analogues		LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
	Tyvaso® Ventavis®		



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Oral Endothelin Receptor Antagonist			
Letairis[®] Tracleer[®]		<i>Opsumit[®]</i>	
Phosphodiesterase 5 Inhibitors (PDE-5)			*Clinical Criteria for PDE-5 <ul style="list-style-type: none"> • Diagnosis of pulmonary hypertension in patients >18 years is required, AND • The requested medication may be approved if the following is true: <ul style="list-style-type: none"> ○ The prescriber is a pulmonary specialist or cardiologist and will be followed by the prescribing physician, AND • Must have a rationale for not taking the oral Revatio[®] to receive a SA for the injectable Revatio[®].
*sildenafil tab		*Adcirca [™] *Revatio [®] tab/susp *Revatio [®] inj	
Prostacyclin Vasodilator			
		<i>Orenitram[™]</i>	
Soluble Guanylate Cyclase Stimulators			
		<i>Adempas[®]</i>	
Central Nervous System			
Alzheimer's Agents			
Cholinesterase Inhibitors			LENGTH OF AUTHORIZATIONS: Length of prescription (up to 3 months) Routine PDL edit
donepezil tab Exelon[®] (transderm)		<i>Aricept[®] ODT, tab & 23 mg tab</i> <i>donepezil ODT & 23mg tab</i> <i>Exelon[®] cap</i> <i>galantamine IR, ER tab/soln</i> <i>Razadyne[®] IR, ER</i> <i>rivastigmine cap</i>	
NMDA Receptor Antagonist			
Namenda[®] soln/tab		<i>Namenda[®] Dose Pack /XR tab</i>	



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	Anticonvulsants		
	Barbiturates		LENGTH OF AUTHORIZATIONS: 1 year
	phenobarbital elixir/ tab primidone	Mysoline[®]	Routine PDL edit plus
	Benzodiazepines		Clinical Criteria for Anticonvulsants:
	clonazepam Diastat[®] rectal Diastat[®] AcuDia[™] rectal	clonazepam ODT Diazepam[®] rectal Diazepam[®] Device rectal Klonopin[®] tab Onfi[®] susp/tab	<ul style="list-style-type: none"> • A therapeutic of at least one preferred medication(s) within the same class, AND • The requested medication's corresponding generic (if a generic is available and preferred by the State) has been attempted and failed or is contraindicated.
	Carbamazepine Derivatives		
	carbamazepine chewable tab, susp, tab carbamazepine ER (generic for Carbatrol[®]) oxcarbazepine tab Tegretol[®] XR Trileptal[®] susp	Aptiom[®] carbamazepine XR Carbatrol[®] oxcarbazepine susp Oxtellar[™] XR Tegretol[®] susp/tab Trileptal[®] tab	<i>If the patient has a documented history of positive results with a non-preferred medication, a trial or failure of a preferred medication is not required</i>
	Hydantoins		
	Dilantin[®] cap/Infatab phenytoin cap/chew tab/susp phenytoin ext cap Phenytek[®]	Dilantin[®] susp Peganone[®]	
	Succinimides		
	ethosuximide cap/syrup	Celontin[®] Zarontin[®] cap/ syrup	



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	Valproic Acid and Derivatives divalproex tab/sprinkle divalproex ER valproic acid	<i>Depakene[®] cap/syrup</i> <i>Depakote[®] sprinkle/tab</i> <i>Depakote[®] ER</i> <i>Stavzor[®]</i>	
	Other Anticonvulsants Felbatol[®] susp/tab Gabitril[®] Lamictal[®] XR lamotrigine tab levetiracetam soln/ tab levetiracetam ER Vimpat[®] soln/tab Topamax[®] sprinkle topiramate tab zonisamide	<i>Banzel[®] susp/tab</i> <i>felbamate susp/tab</i> <i>Fycompa[®]</i> <i>Kepra[®] soln/ tab</i> <i>Kepra[®] XR</i> <i>Lamictal[®] ODT /ODT dose pk</i> <i>Lamictal[®] tab/dose pk</i> <i>Lamictal[®] XR dose pk</i> <i>lamotrigine tab dose pk</i> <i>lamotrigine XR</i> <i>Potiga[®]</i> <i>Qudexy[™] XR</i> <i>Sabril[®] powder pack/tab</i> <i>tiagabine</i> <i>Topamax[®] tab</i> <i>topiramate ER</i> <i>topiramate sprinkle</i> <i>Trokendi[™] XR</i> <i>Zonegran[®]</i>	



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Antidepressants			
Other		LENGTH OF AUTHORIZATIONS: 1 year	
	bupropion IR, SR & XL mirtazapine ODT & tab trazodone venlafaxine IR & ER cap	<i>Aplenzin</i> [®] <i>Brintellix</i> [®] <i>desvenlafaxine ER</i> <i>desvenlafaxine fumarate ER</i> <i>Effexor</i> [®] XR <i>Emsam</i> [®] transdermal <i>Fetzima</i> [®] <i>Forfivo</i> [®] XL <i>Khedezla</i> [™] <i>Marplan</i> [®] <i>Nardil</i> [®] <i>Nefazodone</i> <i>Olepto</i> [®] ER <i>Parnate</i> [®] <i>phenelzine</i> <i>Pristiq</i> [®] <i>Remeron</i> [®] ODT & tab <i>tranylcypromine sulfate</i> <i>venlafaxine ER tab</i> <i>Viibryd</i> [®] tab/dose pk <i>Wellbutrin</i> [®] IR, SR & XL	Routine PDL edit plus Clinical Criteria for Antidepressants: <ul style="list-style-type: none"> • A therapeutic failure of at least two medications within the same class not requiring prior approval, AND • The requested medication's corresponding generic (if a generic is available and preferred by the State) has been attempted and failed or is contraindicated. <p><i>If the patient has a documented history of positive results with a non-preferred medication, a trial or failure of a preferred medication is not required.</i></p>
SSRI			
	citalopram soln/ tab escitalopram tab fluoxetine cap/soln fluvoxamine paroxetine tab sertraline tab	<i>Brisdelle</i> [®] <i>Celexa</i> [®] tab <i>escitalopram soln</i> <i>fluoxetine DR cap/tab</i> <i>fluvoxamine ER</i> <i>Lexapro</i> [®] soln/ tab <i>Luvox</i> [®] CR <i>paroxetine CR</i> <i>Paxil</i> [®] tab/susp & <i>Paxil</i> [®] CR <i>Pexeva</i> [®] <i>Prozac</i> [®] cap/weekly <i>Sarafem</i> [®] <i>sertraline conc</i> <i>Zoloft</i> [®] conc/tab	



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Antimigraine Agents		
Relpax[®] sumatriptan succinate tab/cartridge/nasal/vial/pen rizatriptan tab & MLT	<i>Alsuma[®]</i> <i>Amerge[®]</i> <i>Axert[®]</i> <i>Cambia[®]</i> <i>Frova[®]</i> <i>Imitrex[®] cartridge/ nasal/pen/tab/vial</i> <i>Maxalt[®] tab &MLT</i> <i>naratriptan</i> <i>Sumavel[®] Dosepro</i> <i>Treximet[®]</i> <i>Zomig[®] tab/nasal spray/ZMT</i>	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit
Antipsychotics		
Atypical		
Abilify[®] discmelt/soln/ tab clozapine ODT/ tab Fanapt[®] tab Geodon[®] IM Latuda[®] olanzapine ODT/ tab olanzapine/fluoxetine quetiapine tab risperidone ODT/ soln/ tab Saphris[®] SL Seroquel[®] IR/XR ziprasidone capsule	<i>Abilify[®] IM</i> <i>Clozaril[®]</i> <i>Fanapt[®] titration pk</i> <i>Fazaclo[®]</i> <i>Geodon[®]</i> <i>Invega[®]</i> <i>olanzapine IM</i> <i>Risperdal[®] ODT,/soln /tab</i> <i>Symbyax[®]</i> <i>Versacloz[™]</i> <i>Zyprexa[®] tab/ IM / Zydis</i>	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit plus <u>Clinical Criteria for Antipsychotics:</u> <ul style="list-style-type: none"> • A therapeutic failure of at least one medications within the same class not requiring prior approval, AND • The requested medication's corresponding generic (if a generic is available and preferred by the State) has been attempted and failed or is contraindicated.
Typical		
amitriptyline / perphenazine chlorpromazine fluphenazine elixir/ soln/tab haloperidol tab haloperidol lactate conc/IM loxapine perphenazine trifluoperazine thiothixene thioridazine	<i>haldol (injection)</i> <i>Orap[®]</i>	<i>If the patient has a documented history of positive results with a non-preferred medication, a trial or failure of a preferred medication is not required</i>



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
Non-Ergot Dopamine Receptor Agonist			
	pramipexole ropinirole HCl	Mirapex [®] IR & ER Neupro [®] Requip [®] IR & XR ropinirole HCl ER	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit
Sedatives / Hypnotics			
	temazepam 15 & 30 mg	<i>estazolam</i> <i>flurazepam</i> <i>Halcion[®]</i> <i>Restoril[®]</i> <i>temazepam 7.5 mg / 22.5 mg</i> <i>triazolam</i>	<u>LENGTH OF AUTHORIZATIONS:</u> Length of the prescription (up to 3 months) Routine PDL edit plus
Sedatives / Hypnotics (Non-Benzodiazepine)			
	zolpidem	<i>Ambien[®] IR & CR</i> <i>Elduar[™]</i> <i>eszopiclone</i> <i>*Hetlioz[™]</i> <i>Intermezzo[®]</i> <i>Lunesta[®]</i> <i>Rozerem[®]</i> <i>Silenor[®]</i> <i>Sonata[®]</i> <i>Zaleplon[®]</i> <i>zolpidem CR</i> <i>Zolpimist[™] spray</i>	<u>Clinical Criteria for *Hetlioz[™]</u> <u>Length of Authorization:</u> 6 months. For Renewal - must document therapeutic benefit and confirm compliance <ul style="list-style-type: none"> • For the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24), AND • The patient is completely blind, AND • Patient must be age 18 years of age or older. • Quantity limit = 1 tablet per day.
Skeletal Muscle Relaxants			
	baclofen chlorzoxazone cyclobenzaprine HCL dantrolene sodium methocarbamol tizanidine tab	<i>Amrix[®]</i> <i>*carisoprodol</i> <i>*carisoprodol/ASA</i> <i>*carisoprodol/ASA/codeine</i> <i>cyclobenzaprine ER</i> <i>Dantrium[®]</i> <i>Fexmid[®]</i> <i>Lorzone[®]</i> <i>metaxalone</i>	<u>LENGTH OF AUTHORIZATIONS:</u> <ul style="list-style-type: none"> • 1 year for chronic conditions • Duration of prescription (up to 3 months) for acute conditions • One month per every 6 months carisoprodol products Routine PDL edit plus



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		<i>orphenadrine citrate</i> <i>orphenadrine/ASA/caffeine</i> <i>Parafon Forte[®] DSC</i> <i>Robaxin[®]</i> <i>Skelaxin[®]</i> <i>*Soma[®]</i> <i>tizanidine cap</i> <i>Zanaflex[®]</i>	<p>*Clinical Criteria for Carisoprodol Products</p> <ul style="list-style-type: none"> • The patient is at least 16 years of age, AND • Only approve for ACUTE, painful musculoskeletal conditions. Do not approve for chronic pain. • Quantity limit = 4 tablets per day • Limit approval to one month supply (120 tablets) • Additional authorization will not be granted for at least 6 months following the last day of the previous course of therapy.
Smoking Cessation			
	bupropion SR Chantix [®] Chantix [®] Tab DS PK nicotine gum/ lozenge/ patch	<i>Nicoderm CQ[®] Patch</i> <i>Nicorette[®] Gum/Lozenges</i> <i>Nicotrol[®] Inhaler & NS</i> <i>Zyban[®]</i>	<p>LENGTH OF AUTHORIZATIONS: 6 months</p> <p>Routine PDL edit</p>
Stimulants/ADHD Medications			
Amphetamine Products		LENGTH OF AUTHORIZATIONS: 1 year	
	<p>*Adderall[®] XR</p> amphetamine salts combo dextroamphetamine Vyvanse [®]	<i>Adderall[®] IR</i> <i>amphetamine salts combo XR</i> <i>Desoxyn[®]</i> <i>Dexedrine[®]</i> <i>dextroamphetamine SR & Sol</i> <i>methamphetamine</i> <i>Procentra[®] soln</i> <i>Zenzedi[™]</i>	<p>Routine PDL edit plus</p> <p>Step Edit for*Adderall XR[®]</p> <p>If a trial & failure of a preferred product occurs and the physician requests Adderall XR[®] or amphetamine salts combo XR. The brand Adderall XR[®] is preferred over the generic.</p> <p>** Clinical Criteria for all Stimulants/ADHD Drugs</p> <p>Length of Authorization: 1 year</p> <p>Each product listed below will require an SA for ages less than the FDA/PI indicated age.</p> <p>List on the next page</p>



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<i>Preferred Agents</i>		<i>Non-Preferred Agents</i>	<i>SA Criteria</i>															
			<table border="1"> <thead> <tr> <th>Brand name</th> <th>PI age less than</th> </tr> </thead> <tbody> <tr> <td>Extended-release once-daily products; e.g., Adderall XR, Metadate CD, Concerta[®] Ritalin LA[®] etc.</td> <td>6 years</td> </tr> <tr> <td>Focalin XR[®]</td> <td>6 years</td> </tr> <tr> <td>Intuniv[®]</td> <td>4 years</td> </tr> <tr> <td>Immediate release formulations: e.g., methylphenidate</td> <td>3 years</td> </tr> <tr> <td>Kapvay[®] SR</td> <td>6 years</td> </tr> <tr> <td>Strattera[®]</td> <td>6 years</td> </tr> </tbody> </table>	Brand name	PI age less than	Extended-release once-daily products; e.g., Adderall XR, Metadate CD, Concerta [®] Ritalin LA [®] etc.	6 years	Focalin XR [®]	6 years	Intuniv [®]	4 years	Immediate release formulations: e.g., methylphenidate	3 years	Kapvay [®] SR	6 years	Strattera [®]	6 years	
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Methylphenidate Products																		
	Focalin XR[®] All methylphenidate generic IR tablets methylphenidate SR	Concerta [®] Daytrana [®] dexmethylphenidate IR & XR Focalin [®] Metadate CD [®] Metadate ER [®] Methylin ER [®] Methylin chew [®] Methylin [®] soln methylphenidate soln methylphenidate LA Ritalin [®] Ritalin LA [®] Ritalin SR [®] ***Quillivant [™] XR 25 mg/5 mL susp	***Quillivant[™] XR <ul style="list-style-type: none"> Methylphenidate SR and all methylphenidate IR tablets generic are covered without SA; clinical reason as to why the extended release suspension is required. 															
Miscellaneous Products																		
	Strattera[®]	clonidine ER (Kapvay [®]) Intuniv [®] Kapvay [®] SR 12H ***modafinil ***Nuvigil [™] ***Provigil [®]	***Nuvigil[™]/Provigil[®]/modafinil: Length of Authorizations: 1 year for sleep apnea and narcolepsy; 6 months for shift work sleep disorder. <ul style="list-style-type: none"> Approvable diagnosis include: <ul style="list-style-type: none"> Sleep Apnea: Requires documentation/confirmation via sleep study, OR 															



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			<ul style="list-style-type: none"> ○ Requires documentation that C-PAP has been maximized, OR ○ Narcolepsy: Documentation of diagnosis via sleep study, OR ○ Shift Work Sleep disorder: ONLY APPROVABLE FOR 6 MONTHS, work schedule must be verified and documented. Shift work is defined as working the all night shift. ● Minimum age of 16 years for <u>Provigil</u>[®] ● Minimum age of 17 years for <u>Nuvigil</u>[™]

Dermatologic

Dermatologic Agents		
	<p>Combination Benzoyl Peroxide & Clindamycin for Acne</p> <p>benzoyl peroxide wash/cream/gel/lotion (OTC)\ clindamycin phosphate gel/lotion/soln Panoxyl-4 Acne Creamy Wash OTC</p> <p><i>Acanya™ w/pump</i> <i>Acne Clearing System® OTC</i> <i>Azelex®</i> <i>Benzaclin®</i> <i>Benzefoam™ regular & Ultra™</i> <i>Benzepro</i> <i>benzoyl peroxide wash/cream/gel/lotion/foam/towelette (RX)</i> <i>benzoyl peroxide 6% cleanser OTC</i> <i>BPO Kit</i> <i>Cleocin T®</i> <i>Clindacin™ Pac Kit</i> <i>Clindagel®</i> <i>clindamycin / benzoyl peroxide (Benzaclin) & (Duac) generics</i> <i>clindamycin phosphate foam/lotion/med.swab</i> <i>Delos Lotion™</i> <i>Duac® gel</i> <i>Evoclin™</i> <i>Inova™</i> <i>Lavoclen™ Cleanser & Kit</i></p>	<p><u>LENGTH OF AUTHORIZATIONS:</u> 1 year</p> <p>Routine PDL edit plus</p> <p>Failure to respond to a therapeutic trial of at least two weeks of one preferred medication.</p> <p><u>Clinical Criteria for Dermatologic Acne Agents</u></p> <ul style="list-style-type: none"> ● Prescriptions for patients over the age of 18 years will require a SA to determine diagnosis for treatment, AND ● Products are intended for acne only; a SA for a cosmetic indication cannot be approved



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		<i>NeuacTM topical/kit</i> <i>Pacnex[®] HP & LP</i> <i>Se BPO Wash Kit & cleanser</i>	
	Topical Agents for Psoriasis		
	Dovonex[®] calcipotriene soln	<i>calcipotriene cr/oint</i> <i>Calcitrene[®]</i> <i>calcitriol</i> <i>Micanol[®]</i> <i>SoriluxTM</i> <i>Taclonex[®]</i> <i>Taclonex[®] Scalp</i> <i>Vectical</i>	
	Topical Retinoids/Combinations for Acne		
	Differin[®] tretinoin	<i>adapalene 0.1% cream /gel</i> <i>Atralin</i> <i>Avita[®] cream /gel</i> <i>Epiduo[®]</i> <i>FabiorTM Foam</i> <i>Retin[®] A cream/gel</i> <i>Retin[®]-A Micro gel &Pump</i> <i>Tazorac[®]</i> <i>tretinoin microsphere gel & gel pump</i> <i>Ziana[®]</i>	Clinical Criteria for FabiorTM Foam <ul style="list-style-type: none"> • Patient between the ages of 12 and 18 years of age
	Steroids		
	Steroids, Topical Low Potency		LENGTH OF AUTHORIZATIONS: 1 year
	<i>alclometasone dipropionate cr/oint</i> <i>hydrocortisone/min oil/pet oint</i> <i>hydrocortisone acetate/urea</i> <i>hydrocortisone cr/gel/lot/oint</i> <i>hydrocortisone/aloe gel</i>	<i>aqua glycolic HC</i> <i>Capex[®] shampoo</i> <i>Derma-smoothe-FS</i> <i>desonate gel/cr/lot/oint</i> <i>Desowen[®] lot</i> <i>fluocinolone 0.01% oil</i> <i>Pediaderm[®] HC</i> <i>Pediaderm[®] TA</i> <i>Texacort[®]</i>	Routine PDL edit plus Clinical Criteria for Steroids <ul style="list-style-type: none"> • A therapeutic failure of at least two medication(s) within the same class not requiring prior approval, AND • The requested medication's corresponding generic (if available and preferred by the State) has been tried and failed or is contraindicated.
	Steroids, Topical Medium Potency		



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	fluticasone propionate cr/oint hydrocortisone valerate cr/oint mometasone furoate cr/oint/sol	betamethasone valerate foam clocortolone cr Cloderm [®] Cordran [®] tape Cutivate [®] cr/lot Dermatop [®] cr/oint Elocon [®] cr/oint/soln fluocinolone acetonide cr/oint/soln fluticasone propionate lot hydrocortisone butyrate cr/oint/soln/ emollient Luxiq [®] Momexin [®] Pandel [®] prednicarbate cr/oint Synalar [®] Synalar TS [®]	
	Steroids, Topical High Potency fluocinonide cr/ emollient/gel/ oint/soln triamcinolone acetonide cr/lot/ oint	amcinonide cr/lot/oint betamet diprop & prop gly cr/lot/oint betamethasone dipropionate cr/foam/gel/lot/oint betamethasone valerate cr/lot/oint desoximetasone cr/gel/oint/spray diflorasone diacetate cr/oint Diprolene [®] lot/oint DiproleneAF [®] cr Halog [®] cr/oint Kenalog [®] aerosol Topicort [®] cr/gel/oint/spray Trianex [®] oint Vanos [®] cr	



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Steroids, Topical Very High Potency			
	clobetasol emollient clobetasol propionate cr/gel/ oint/soln halobetasol propionate cr/oint	<i>Apexicon™ E</i> <i>clobetasol lot</i> <i>clobetasol propionate foam</i> <i>clobetasol shampoo</i> <i>Clobex® lot/shampoo/spray</i> <i>Clodan® kit</i> <i>Halonate®</i> <i>Olux®</i> <i>Olux® -E</i> <i>Temovate® oint</i> <i>Ultravate® cr/oint</i> <i>Ultravate® PAC</i> <i>Ultravate® X</i>	
Endocrine and Metabolic Agents			
Androgenic Agents (Testosterone – Topical)			
	Androgel®	<i>Androderm®</i> <i>Axiron® soln</i> <i>Fortesta®</i> <i>Testim®</i> <i>testosterone gel/packet/pump (generic for Vogelxo™)</i> <i>Vogelxo™ gel/packet/pump</i>	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit plus Failure to respond to a therapeutic trial of at least one week of one preferred medication
Antihyperuricemics			
	allopurinol Probenecid® probenecid & colchicine	<i>*Colcrys®</i> <i>Uloric®</i> <i>Zyloprim®</i>	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit *Clinical Criteria for Colcrys™ <ul style="list-style-type: none"> • Diagnosis of Familial Mediterranean Fever; OR • For Acute Gout Flare: <ul style="list-style-type: none"> ○ Trial and failure of one of the following: <ul style="list-style-type: none"> ▪ NSAID or ▪ Corticosteroid



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Contraceptives			
Etonogestrel/Ethinyl Estradiol Vaginal Ring			LENGTH OF AUTHORIZATIONS: 1 year
NuvaRing®			Routine PDL edit
Norelgestromin/Ethinyl Estradiol Transdermal			
Ortho Evra®		<i>Xulane Transdermal Patch™</i>	
Oral Contraceptives			
Apri® Cryselle™ Enpresse® Femcon Fe® Junel Fe® Loestrin® Loestrin Fe® Microgestin® Microgestin Fe® Mircette® Micronor® Norinyl 1+50® Nor-Q-D® Nortrel® Ortho-Novum® Ortho Tri-Cyclen® Ortho Tri-Cyclen Lo® Ovcon® -50 Sprintec® Tri-Sprintec® Trivora-28® Yasmin® 28 Yaz® Zovia® 1-35E & 1-50E		<i>All other oral contraceptives</i>	
Diabetes Hypoglycemics: Injectable Amylin Analogs			
		*SymLin® *SymLin® Pens	LENGTH OF AUTHORIZATIONS: 1 year *Clinical Criteria for Injectable Amylin Analogs



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			<ul style="list-style-type: none"> • Patient must have a history of at least a 90 day trial of insulin. • SymLin[®] is only indicated as adjunct therapy with insulin. • Patient meeting ALL of the following criteria may be approved: <ul style="list-style-type: none"> ○ Diagnosis of Type 1 or 2 diabetes, AND ○ On insulin therapy, AND ○ Failure to achieve adequate glyceimic control (HbA1c ≤ 6.5%).
Diabetes Hypoglycemics: Injectable Incretin Mimetics			
	Byetta[®]	<i>BydureonTM</i> <i>Victoza[®]</i>	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
Diabetes Hypoglycemics: Injectable Insulins			
	Insulin Mix		LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
	Humalog[®] Mix 50/50 vial Humalog[®] Mix 75/25 vial Humulin[®] 70/30 vial Novolog[®] Mix 70/30 pen/ vial	<i>Humalog[®] Mix 50/50 Kwikpen</i> <i>Humalog[®] Mix 75/25 Kwikpen</i> <i>Humulin[®] 70/30 pen (OTC)</i> <i>Novolin[®] 70/30 vial (OTC)</i>	
	Insulin N		
	Humulin[®] N vial (OTC)	<i>Humulin[®] N pen</i> <i>Novolin[®] N vial (OTC)</i>	
	Insulin R		
	Humulin[®] R vial	<i>Novolin[®] R vial (OTC)</i>	
	Long-Acting Insulins		
	Lantus[®] vial Levemir[®] pen/vial	<i>Lantus Solostar[®]/cartridge</i>	



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Rapid-Acting Insulins		
Humulin 500 U/M vial Humalog® vial Novolog® cartridge/ Flexpen/vial	Apidra® cartridge/Solostar/vial Humalog® Cartridge Humalog Kwikpen®	
Diabetes Oral Hypoglycemics		
Oral Hypoglycemics Alpha-Glucosidase Inhibitors		LENGTH OF AUTHORIZATIONS: 1 year
acarbose Glyset®	Precose®	Routine PDL edit
Oral Hypoglycemics Biguanides		
metformin metformin ER (generic for Glucophage® XR)	Fortamet® Glucophage® IR & XR Glutmetza® Riomet® susp metformin ER (generic for (Fortamet®))	
Oral Hypoglycemics Biguanide Combination Products		
glyburide/metformin	glipizide/metformin Glucovance®	
Oral Hypoglycemics DPP-IV Inhibitors and Combination		
Janumet® Janumet XR® Januvia® Jentadueto™ Tradjenta™	Kazano™ Kombiglyze XR™ Nesina™ Onglyza™ Oseni™	
Oral Hypoglycemics Meglitinides		
Starlix®	nateglinide Prandin® PrandiMet™	
Oral Hypoglycemics Second Generation Sulfonylureas		
glimepiride	Amaryl®	



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	glipizide glipizide ER glyburide glyburide micronized	Diabeta [®] Glucotrol [®] Glucotrol XL [®] Glynase [®]	
	Oral Hypoglycemics Sodium Glucose Co-Transporter 2 Inhibitor (SGLT2)		<u>Clinical Criteria for Oral Hypoglycemics: Sodium Glucose Co-Transporter 2 Inhibitor (SGLT2)</u>
		Farxiga [™] Invokana [™]	Length of Authorization: Initial approval for 6 months. Renewals for 1 year.
	Oral Hypoglycemics Thiazolidinediones		
	pioglitazone	Avandia [®] Actoplus Met [®] IR & XR Actos [®] Avandaryl [®] Avandamet [®] Duetact [®] pioglitazone/metformin	<ul style="list-style-type: none"> • Approve for Type 2 diabetics who have been compliant with and have not achieved adequate glycemic control with metformin, OR • Are intolerant to metformin, AND • Minimum age restriction of 18 years of age. • Quantity limit = 1 tablet per day.
	Erythropoiesis Stimulating Proteins: Epogen[®], Procrit[®] (Erythropoietin) & Aranesp[®] (Darbepoetin)		
	Procrit[®]	Aranesp [®] Epogen [®]	<u>LENGTH OF AUTHORIZATIONS:</u> for duration of the prescription up to 6 months Routine PDL edit <i>Omontys[®] is not PDL eligible, may be covered under medical benefit</i>



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Glucocorticoids, Oral			
	<p>dexamethasone soln /tab Entocort[®] EC hydrocortisone methylprednisolone tab ds pk methylprednisolone 4mg tab prednisolone sodium phosphate soln prednisolone soln/tab prednisone soln/tab/tab ds pk</p>	<p>budesonide EC Cortef[®] cortisone acetate dexamethasone elixir/ intensol Dexpak[®] Flo-Pred[®] Medrol[®] Tab ds pk & tab methylprednisolone 8,16 & 32mg tab Millipred DP[®] tab Ds Pk Millipred[®] soln/tab Orapred[®] ODT prednisone intensol Rayos[®] DR tab Veripred[®]</p>	<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edit plus</p> <p>Trial and therapeutic failure of all preferred drugs</p>
Growth Hormone			
	<p>Genotropin[®] Nutropin AQ[®] NuSpin[™]</p>	<p>Humatrope[®] cartridge/vial Norditropin cartridge[®] Norditropin FlexPro[®] & Nordiflex[®] Nutropin[®] Nutropin AQ[®] cartridge/vial Omnitrope[®] Saizen[®] cartridge/vial *Serostim[®] Tev-Tropin[®] **Zorbtive[®]</p>	<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Clinical Criteria for PEDIATRIC Patients (18 years of age and under)</p> <ul style="list-style-type: none"> • Prescriber is an endocrinologist, nephrologist, infectious disease specialist or HIV specialist or one has been consulted on this case, AND • The patient has open epiphysis and one of the following diagnoses <ul style="list-style-type: none"> ○ Turner Syndrome, OR ○ Prader-Willi Syndrome, OR ○ Renal insufficiency, OR ○ Small for gestational age (SGA) - including Russell-Silver variant and patient is < 2 years old, OR ○ Idiopathic Short Stature (for request for renewal only (a) information is required to be approved), OR ○ Growth hormone deficiency (physician should provide the required information below), OR



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			<ul style="list-style-type: none"> ○ Newborn with hypoglycemia and a diagnosis of hypopituitarism or panhypopituitarism. ● 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 ● 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. <p><u>Clinical Criteria for Renewal (pediatrics):</u></p> <ul style="list-style-type: none"> ● 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 ● Patient height is more than 1 standard deviation (2”) below mid-parental height (unless parental height is diminished due to medical or nutritional reasons). <p><u>Clinical Criteria for ADULTS (> 18 years of age)</u></p> <ul style="list-style-type: none"> ● Prescriber is an endocrinologist, AND ● 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); AND



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		<ul style="list-style-type: none"> • 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, OR • 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. <p>*Serostim®</p> <ul style="list-style-type: none"> • Diagnosis of AIDS wasting or cachexia, AND • Has a documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents (both Megace® & Marinol®), AND • *Length of Authorization: 3 months initial; then 1 year. Renewal is contingent upon improvement in lean body mass or weight measurements. <p>**Zorbitive® - Diagnosis of short bowel syndrome</p>
Progestational Agents		
medroxyprogesterone acetate (tablet only) norethindrone acetate progesterone injection Prometrium®	<i>Aygestin®</i> progesterone cap <i>Provera®</i>	<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edit plus</p> <p>Failure to respond to a therapeutic trial of at least one week of one preferred product.</p>
Progestins Used For Cachexia		
megestrol acetate	<i>Megace®</i> <i>Megace® ES</i>	<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edit</p>



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	Vaginal/Oral Estrogens		
	Premarin [®] Vaginal cr Vagifem [®] Vaginal tab	Estrace [®] Vaginal cr Estring [®] Vaginal ring Femring [®] Vaginal ring Osphena [®] tab	LENGTH OF AUTHORIZATIONS: 6 months Routine PDL edit
Gastrointestinal			
	Antiemetic/Antivertigo Agents		
	Cannabinoids (delta-9THC derivatives)		LENGTH OF AUTHORIZATIONS: 6 months
	**dronabinol	*Cesamet [®] **Marinol [®]	Routine PDL edit plus <u>Clinical Criteria for Cannabinoids</u> ➤ *Cesamet[®] <ul style="list-style-type: none"> • Diagnosis of severe, chemotherapy induced nausea and vomiting, AND • Patient has tried and failed, has a contraindication to, an intolerance, or a medical reason not to try the combination of Emend[®] plus a 5HT3 receptor antagonist plus a corticosteroid, AND • Patient has tried and failed megestrol acetate oral suspension OR has a contraindication, intolerance, drug-drug interaction, or medical reason megestrol acetate cannot be used. ➤ **Dronabinol <ul style="list-style-type: none"> • Diagnosis of severe, chemotherapy induced nausea and vomiting, AND • Patient has tried and failed, has a contraindication to, an intolerance, or a medical reason not to try the combination of Emend[®] plus a 5HT3 receptor antagonist plus a corticosteroid, AND • Diagnosis of AIDS-relating wasting Patient has tried and failed megestrol acetate oral



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			<p>suspension OR has a contraindication, intolerance, drug-drug interaction, or medical reason megestrol acetate cannot be used.</p>
	<p>5HT3 Receptor Blockers</p>		<p><u>LENGTH OF AUTHORIZATIONS:</u> 3 months, unless otherwise noted</p> <p>Routine PDL edit plus</p> <p>* <u>Clinical Criteria for 5HT3 Receptor Blockers:</u></p> <ul style="list-style-type: none"> • Nausea or vomiting related to radiation therapy, moderate to highly emetogenic chemotherapy, or post-operative nausea and vomiting, AND • Patient has tried and failed therapeutic doses of, or has adverse effects or contraindications to, 2 different conventional antiemetics (e.g., promethazine, prochlorperazine, meclizine, metoclopramide, dexamethasone, etc.) <p><u>LENGTH OF AUTHORIZATIONS:</u> Length of chemotherapy regimen or a maximum of 6 months</p> <p>Routine PDL edit plus</p> <p><u>Clinical Criteria for NK-1 Receptor Antagonist</u></p> <p>➤ **<u>Emend® (aprepitant)</u></p> <ul style="list-style-type: none"> • Emend® does NOT require treatment failure with preferred drugs when used for moderately or highly emetogenic chemotherapy. <p>Quantity limits: One Emend® BiPack (2-80mg tablets) per chemotherapy treatment or, One Emend® TriPack (1-125mg tablet and 2-80mg tablets) per chemotherapy treatment.</p>
	<p>ondansetron ODT/tab</p>	<p>*Anzemet® *granisetron *Granisol® soln/tab *Kytril® ondansetron soln *Sancuso® patch Zofran®ODT/soln/tab *Zuplenz®film</p>	
	<p>NK-1 Receptor Antagonist</p>		
		<p>**Emend® Bi Pak **Emend® Tri-fold pack</p>	



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Other			<u>LENGTH OF AUTHORIZATIONS:</u> 1 year, unless otherwise noted
meclizine metoclopramide ondansetron tab & ODT prochlorperazine **promethazine	<i>Antivert®</i> <i>Compazine® supp/tab</i> <i>Compro®</i> <i>*Diclegis®</i> <i>dimenhydrinate</i> <i>hydroxyzine</i> <i>Metozolv® ODT</i> <i>**Phenergan®</i> <i>prochlorperazine supp</i> <i>promethazine 50mg Rectal</i> <i>Reglan®</i> <i>Tigan®</i> <i>***Transderm-Scop®</i> <i>trimethobenzamide</i> <i>Vistaril®</i>	Routine PDL edit plus <u>Clinical Criteria for Antiemetics/Antivertigo, Other</u> ➤ *Diclegis® (doxylamine/pyridoxine) <ul style="list-style-type: none"> • Patient must be pregnant ➤ **Promethazine <ul style="list-style-type: none"> • Patient must be 2 years or older ➤ ***Transderm-Scop® may be approved for 3 months if: <ul style="list-style-type: none"> • Tried and failed at least one of the following: meclizine, promethazine, dimenhydrinate, diphenhydramine, or metoclopramide; OR • is unable to swallow or absorb oral medications, OR • will be in an area/situation for an extended period of time where taking short acting agents would not be feasible 	
Bile Salts			
ursodiol 300 mg cap	<i>Actigal®</i> <i>Chenodal®</i> <i>ursodiol tab</i> <i>Urso®</i> <i>Urso® Forte tab</i>		<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit
H. Pylori Treatment			
Pylera® Prevpac®	<i>Omeclamox® -Pak</i> <i>lansoprazole/amoxicillin/</i> <i>clarithromycin</i>		<u>LENGTH OF AUTHORIZATIONS:</u> 14 days Routine PDL edit



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Histamine-2 Receptor Antagonists (H-2 RA)			
	famotidine (OTC & RX) ranitidine tab/syrup (OTC & RX)	cimetidine tab/syrup (OTC/RX) famotidine oral susp (OTC/RX) nizatidine cap/susp Pepcid [®] susp/tab (OTC/RX) ranitidine cap (OTC/RX) Zantac [®] syrup/ tab (OTC/RX)	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
Irritable Bowel Syndrome			
	*Amitiza [®]	**Linzess [™] ***Lotronex [®]	LENGTH OF AUTHORIZATIONS: 6 months Routine PDL edit plus Clinical Criteria ➤ *Amitiza [®] <ul style="list-style-type: none"> • Must be 18 or older, AND • have one of the following diagnoses <ol style="list-style-type: none"> 1. Idiopathic Constipation with treatment failure of at least ONE product from TWO of the following classes: <ul style="list-style-type: none"> ○ Osmotic Laxatives (examples: lactulose, polyethylene glycol (PEG), sorbitol), OR ○ Bulk Forming Laxatives (examples: Metamucil[®] (psyllium), Citrucel[®], fiber), OR ○ Stimulant Laxatives (examples: bisacodyl, senna). 2. Constipation Predominant Irritable Bowel Syndrome (IBS-C) <ul style="list-style-type: none"> ○ Patient is female, AND ○ Treatment failure on at least ONE product from TWO of the following classes: <ul style="list-style-type: none"> ○ Osmotic Laxatives (examples: lactulose, polyethylene glycol (PEG), sorbitol) ○ Bulk Forming Laxatives (examples: Metamucil[®] (psyllium), Citrucel[®], fiber) ○ Stimulant Laxatives (examples:



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			<p>bisacodyl, senna)</p> <p>3. Opioid Induced Constipation in chronic NON-cancer pain</p> <ul style="list-style-type: none"> ○ Patient has tried and failed both PEG (i.e., Miralax[®]) AND lactulose ** <p>➤ **Linzess[®]</p> <ul style="list-style-type: none"> ● Diagnosis of Idiopathic Chronic Constipation or Constipation-Predominant Irritable Bowel Syndrome (IBS), AND ● Patient must be at least 6 years of age, AND ● Treatment failure on at least ONE agent from TWO of the following classes: <ul style="list-style-type: none"> ○ Osmotic Laxatives (examples: lactulose, polyethylene glycol (PEG), sorbitol), OR ○ Bulk Forming Laxatives (examples: Metamucil[®] (psyllium), Citrucel[®], fiber), OR ○ Stimulant Laxatives (examples: bisacodyl, senna). <p>***Lotronex[®]</p> <ul style="list-style-type: none"> ● Diagnosis of severe, diarrhea predominant Irritable Bowel Syndrome, AND ● Patient is female and at least 18 years of age; AND ● Prescriber is enrolled in the Prometheus Prescribing Program for Lotronex[®], AND ● Patient has had chronic IBS symptoms for at least 6 months, AND ● Patient has tried and failed at least three agents from the following <ul style="list-style-type: none"> ○ bulk producing agents (e.g., psyllium, fiber), OR ○ antispasmodic agents (e.g., dicyclomine, hyoscyamine), OR ○ fantidiarrheal agents/opiates (e.g., loperamide, diphenoxylate/atropine, codeine).



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Proton Pump Inhibitors		
<p>pantoprazole Prilosec® OTC</p>	<p><i>Aciphex® DR tab/sprinkle</i> <i>Dexilant®</i> <i>esomeprazole strontium</i> <i>lansoprazole cap</i> <i>Nexium®</i> <i>omeprazole (RX & OTC)</i> <i>omeprazole/sodium bicarbonate</i> <i>Prevacid® RX, OTC & Solutab</i> <i>rabeprazole DR tab</i> <i>Prilosec® Rx & Susp</i> <i>Protonix®</i> <i>Zegerid® cap, OTC & Susp packet</i></p>	<p>LENGTH OF AUTHORIZATIONS: 12 weeks; unless patient meets an exception; then 1 year</p> <p>Routine PDL edit plus</p> <p>Clinical Criteria for PPIs</p> <ul style="list-style-type: none"> • A therapeutic failure of no less than a three-month trial of at least two different medications within the same class not requiring service authorization. <p>Exceptions that allow for a 1 year SA for PPIs (Exceptions apply to the duration of the SA only. PDL edit still prevails before a non-preferred may be approved)</p> <ul style="list-style-type: none"> • Erosive Esophagitis • Active GI Bleed • Zollinger-Ellison Syndrome • Greater than 65 years of age • Under the care of a Gastroenterologist and has ruled out a nonsecretory condition
Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)		
Ulcerative Colitis – Oral		LENGTH OF AUTHORIZATIONS: 1 year
<p>Apriso® Pentasa® sulfasalazine DR & IR</p>	<p><i>Asacol® HD</i> <i>Azulfidine® IR & DR</i> <i>balsalazide disodium</i> <i>Colazal®</i> <i>Delzicol™</i> <i>Dipentum</i> <i>*Giazo™</i> <i>Lialda®</i> <i>Uceris™</i></p>	<p>Routine PDL edit</p> <p>*Giazo is limited to an 8 week supply</p>



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	Ulcerative Colitis – Rectal		
	Canasa [®] rectal supp mesalamine enema	mesalamine kit Rowasa [®] enema/kit SFRowasa [®]	
Genitourinary			
Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)			
Alpha-Blockers for BPH			LENGTH OF AUTHORIZATIONS: 1 year
	alfuzosin tamsulosin HCL	Flomax [®] Rapaflo [®] Uroxatral [®]	Routine PDL edit plus
Androgen Hormone Inhibitors for BPH			*Step edit for Avodart[®] - the generic finasteride must be tried and failed before approval
	*Avodart [®] finasteride	Jalyn [®] Proscar [®]	
Phosphodiesterase (PDE) 5 Inhibitor for BPH			**Step edit for Cialis[®] - must try and fail both Alpha Blockers and Androgen Hormone Inhibitors for BPH and the prescriber must attest that the patient is not on the state list of sex offenders. The patient must have had a consult or been evaluated by an Urologist.
		**Cialis [®]	
Phosphate Binders			
	calcium acetate 667mg cap Fosrenol [®] Renagel [®]	calcium acetate 667mg tab Eliphos [®] Phoslo [®] Phoslyra [®] Renvela [®] powder/tablet sevelamer carbonate Velphoro [®] chewable tablet	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
Urinary Antispasmodics (Bladder Relaxant)			
	oxybutynin tab/syrup Oxytrol [®] transdermal	Detrol [®] & Detrol [®] LA Ditropan [®] & *Ditropan [®] XL	LENGTH OF AUTHORIZATIONS: 1 year



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
	Toviaz™ VESIcare®	<i>Enablex®</i> <i>flavoxate</i> <i>Gelnique™ gel</i> <i>Myrbetriq™</i> <i>*oxybutynin ER</i> <i>trospium IR & ER</i> <i>tolterodine IR & ER</i>	Routine PDL edit *Oxybutynin ER, Ditropan XL®: <ul style="list-style-type: none"> Allow PDL exception for children age 6-18 with a diagnosis of neurogenic bladder.
Immunological Agents			
Atopic Dermatitis: Topical			
	*Elidel®	*Protopic®	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit plus *Clinical Criteria for Atopic Dermatitis, Topical *Elidel® and Protopic® <ul style="list-style-type: none"> Patient must have a FDA approved diagnosis: <ul style="list-style-type: none"> Atopic dermatitis (a type of eczema) 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. Failure to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.)
Multiple Sclerosis			
	Avonex® Avonex® Adm Pack Copaxone Kit® Extavia® Kit & Vial Rebif® SQ	*Ampyra® Aubagio® Betaseron® Copaxone® 40 mg syringe® Gilenya® Rebif® Rebi dose Pen® Tecfidera™	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit plus Gilenya® is to be used as monotherapy ONLY. *Clinical Criteria for AMPYRA® <ul style="list-style-type: none"> The patient has a diagnosis of Multiple Sclerosis and a gait disorder, AND Patient has no history of seizures, AND Patient's Creatinine Clearance [CrCL] ≥ 50 mL/min, AND



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			<ul style="list-style-type: none"> If after 8 week trial the prescriber states that the patient showed improvement or that the drug was effective (by improved Timed 25-foot Walk), the patient may receive authorization for Ampyra® for one year.
Self Administered Drugs for Rheumatoid Arthritis			
	Enbrel® Humira®	<i>Actemra® SQ</i> <i>Cimzia®</i> <i>Cimzia® Syringe Kit</i> <i>Kineret®</i> <i>*Otezla®</i> <i>**Otrexup® inj</i> <i>Orencia®</i> <i>***Rasuvo™inj</i> <i>Simponi®</i> <i>****Xeljanz™</i>	<p>LENGTH OF AUTHORIZATION: 1 year</p> <p>Routine PDL edit plus</p> <p>Clinical Criteria for anti-TNF biologic or non-TNF Biologic for RA Requires an adequate trial of methotrexate generic (unless contraindicated).</p> <p>Clinical Criteria for *Otezla® Length of Authorization: 1 year</p> <ul style="list-style-type: none"> For diagnosis of Psoriatic Arthritis only, AND Have failed ALL preferred agents with same indication (i.e., Enbrel®, Humira®). Quantity Limit = 2 tablets per day for Otezla® 30 mg tablet. Minimum age restriction of 18 years of age. <p>Clinical Criteria for **Otrexup® Length of Authorization: 6 months, then renew for 1 year for RA, if compliant and appropriate monitoring occurs. Approve for 6 months for psoriasis.</p> <ul style="list-style-type: none"> For diagnosis of rheumatoid arthritis or polyarticular juvenile idiopathic arthritis, AND A therapeutic trial and failure on a NSAIDs and/or corticosteroids, OR The patient is not a candidate for these therapies due to disease severity. For diagnosis of psoriasis, AND A therapeutic trial and failure on topical therapies



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			<p>such as topical emollients and/or topical corticosteroids, topical retinoids, topical vitamin D analogs, and topical tacrolimus and pimecrolimus.</p> <p>Clinical Criteria for ***Rasuvo™ Length of Authorization: 6 months, then renew for 1 year for RA, if compliant and appropriate monitoring occurs. Approve for 6 months for psoriasis.</p> <ul style="list-style-type: none"> • Diagnosis of rheumatoid arthritis or polyarticular juvenile idiopathic arthritis, AND • A therapeutic trial and failure on NSAIDs and/or corticosteroids to reduce joint inflammation, OR • The patient is not a candidate for these therapies due to disease severity. • Diagnosis of psoriasis, AND • a therapeutic trial and failure on topical therapies such as topical emollients and/or topical corticosteroids, topical retinoids, topical vitamin D analogs, and topical tacrolimus AND pimecrolimus. <p><i>Quantity Limit = 4 auto-injectors per month</i> <i>For renewal, patient must be followed by a physician for monitoring of renal and hepatic function and complete blood counts with differential and platelet count.</i></p> <p>Clinical Criteria for ****Xeljanz™</p> <ul style="list-style-type: none"> • The patient had a therapeutic trial and treatment failure with ONE of the following preferred drugs: Enbrel®, or Humira®



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Preferred Agents	Non-Preferred Agents	SA Criteria
Ophthalmic		
Antibiotics		
ciprofloxacin drops erythromycin gentamicin drops/oint Moxeza [®] drops neomycin/polymyxin/ gramicidin ofloxacin drops polymyxin/trimethoprim sulfacetamide soln tobramycin Vigamox [®] drops	<i>AzaSite™ drop</i> <i>bacitracin</i> <i>bacitracin/polymyxin b sulfate oint</i> <i>Besivance[®] drops</i> <i>Bleph[®]- 10</i> <i>Ciloxan[®] drops/oint</i> <i>Garamycin[®] drops/oint</i> <i>gatifloxacin 0.5% soln</i> <i>Ilotycin[®]</i> <i>levofloxacin drops</i> <i>Natacyn[®]</i> <i>neomycin/bacitracin/polymyxin oint</i> <i>Neosporin[®]</i> <i>Ocuflox[®] drops</i> <i>Polytrim[®]</i> <i>sulfacetamide oint</i> <i>Tobrex[®] drops/oint</i> <i>Zymaxid[®] drops</i>	<u>LENGTH OF AUTHORIZATIONS:</u> Date of service only; no refills Routine PDL edit
Antibiotic/Steroid Combinations		
neomycin/polymyxin/dexame- thasone oint/susp Tobradex [®] oint/susp	<i>Blephamide[®]</i> <i>Blephamide[®] S.O.P.</i> <i>Maxitrol[®] oint/susp</i> <i>neomycin/bacitracin/poly/HC</i> <i>neomycin/polymyxin/HC</i> <i>Pred-G[®] oint/susp</i> <i>sulfacetamide/prednisolone</i> <i>Tobradex[®] ST</i> <i>Tobramycin/dexamethasone susp</i> <i>Zylet[®]</i>	<u>LENGTH OF AUTHORIZATION:</u> Date of service only; no refills Routine PDL edit



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<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
Antihistamines/Mast Cell Stabilizers		
Antihistamines		LENGTH OF AUTHORIZATIONS: 1 year
Alaway OTC[®] ketotifen fumerate Pataday[®] drops Zaditor[®] OTC drops	<i>azelastine drops</i> <i>Bepreve[®]</i> <i>Elestat[®] drops</i> <i>Emadine[®] drop</i> <i>epinastine 0.05% eye drops</i> <i>*Ilevro[™] 0.3% drops</i> <i>Lastacaft[®] drops</i> <i>Optivar[®] drops</i> <i>Patanol[®] drops</i>	Routine PDL edit *Ilevro [™] is limited to 1 bottle plus 1 refill
Mast Cell Stabilizers		
cromolyn sodium	<i>Alocril[®] drops</i> <i>Alomide[®] drops</i>	
Anti-inflammatory		
NSAIDS		LENGTH OF AUTHORIZATIONS: Date of service only; no refills
diclofenac sodium flurbiprofen sodium ketorolac 0.4% & 0.5% Nevanac[®]	<i>Acular[®] 0.5% & LS[®] 0.4%</i> <i>Acuvail[®]</i> <i>bromfenac 0.09%</i> <i>Ilevro[™] 0.3% drops</i> <i>Ocufen[®]</i> <i>Prolensa[™]</i>	Routine PDL edit *Ilevro [™] is limited to 1 bottle plus 1 refill
Corticosteroids		
Durezol[®] fluorometholone prednisolone acetate dexamethasone	<i>Alex[™]</i> <i>Flarex[®]</i> <i>FML[®]</i> <i>FML Forte[®]</i> <i>FML[®] S.O.P.</i> <i>Lotemax[™] drops/gel/oint</i> <i>Maxidex[®]</i> <i>Omnipred[®]</i>	



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		<i>Pred Forte[®]</i> <i>Pred Mild[®]</i> <i>prednisolone sod phosphate</i> <i>Vexol[®]</i>	
Glaucoma Agents			
Alpha 2 Adrenergic Agents			LENGTH OF AUTHORIZATIONS: 1 year
	Alphagan F[®] 0.1 & 0.15% brimonidine 0.2% Iopidine[®] 0.5% & 1%	<i>apraclonidine 0.5% drops</i> <i>brimonidine tartrate 0.15%</i>	Routine PDL edit
Beta Blockers			
	Betoptic-S[®] 0.25% carteolol 1% levobunolol 0.5% metipranolol 0.3% timolol maleate	<i>Betagan[®] 0.5%</i> <i>betaxolol 0.5%</i> <i>Combigan[®]</i> <i>Istalol[®] 0.5%</i> <i>Timoptic[®] drops 0.25% & 0.5%</i> <i>Timoptic[®] XE 0.25% & 0.5% sol-gel</i>	
Carbonic Anhydrase Inhibitors			
	Azopt[®] 1% dorzolamide dorzolamide/timolol Simbrinza[™]	<i>Cosopt[®] 0.5%-2%</i> <i>Cosopt[®] PF</i> <i>Trusopt[®] 2%</i>	
Prostaglandin Analogs			
	latanoprost Travatan Z[®]	<i>Lumigan[®] 0.03% & 0.01%</i> <i>Rescula[®]</i> <i>travoprost 0.004%</i> <i>Xalatan[®] 0.005%</i> <i>Zioptan[™]</i>	
Respiratory			
Anti-Allergens, Oral			
		<i>*Grastek[®] SL</i> <i>**Oralair[®] SL</i> <i>***Ragwitek[™] SL</i>	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit



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			<p>Clinical Criteria for *Grastek®</p> <ul style="list-style-type: none"> • Age must be between 5 through 65 years, AND • Indicated for grass pollen-induced allergic rhinitis with or without conjunctivitis, AND • Must have evidence of a confirmed by positive skin test or <i>in vitro</i> testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens, AND • Must have had a treatment failure with or contraindication to antihistamines and montelukast, AND • Clinical reason as to why allergy shots cannot be used. • Quantity Limit = 1 sublingual tablet per day. <p>Clinical Criteria for **Oralair®</p> <ul style="list-style-type: none"> • Age must be between 10 through 65 years, AND • Indicated for grass pollen-induced allergic rhinitis with or without conjunctivitis, AND • Must have evidence of a confirmed positive skin test or <i>in vitro</i> testing for pollen-specific IgE antibodies for Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens, AND • Must have had a treatment failure with or contraindication to antihistamines and montelukast, AND • Clinical reason as to why allergy shots cannot be used. <p>Clinical Criteria for ***Ragwitek™</p> <ul style="list-style-type: none"> • Age must be between 18 through 65 years, AND • Indicated for immunotherapy for the treatment of short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis, AND • Must have evidence of a confirmed by positive skin test or <i>in vitro</i> testing for pollen-specific IgE antibodies for short ragweed pollen, AND • Must have had a treatment failure with or



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			<p>contraindication to antihistamines and montelukast, AND</p> <ul style="list-style-type: none"> Clinical reason as to why allergy shots cannot be used.
Antihistamines: First and Second Generation			
First Generation Antihistamines			LENGTH OF AUTHORIZATIONS: 1 year
Generic only class	<i>All Brands require a SA</i>		Routine PDL edit
Second Generation Antihistamines and Combinations			
cetirizine liquid 1mg/1mL (RX/ OTC) cetirizine tabs OTC loratadine tab/syrup OTC	<i>Allegra-D[®]</i> <i>cetirizine chew tab (OTC)</i> <i>cetirizine liquid 5mg/5mL (OTC)</i> <i>cetirizine D tab (OTC)</i> <i>Clarinex[®]</i> <i>Clarinex-D[®]</i> <i>Claritin[®]</i> <i>Claritin[®] D</i> <i>desloratadine ODT</i> <i>fexofenadine</i> <i>fexofenadine/PSE ER</i> <i>levocetirizine</i> <i>loratadine ODT</i> <i>loratadine D 12 & 24 hr</i> <i>Xyzal[®]</i>		
Beta-Adrenergic Agents			
Long Acting Beta Adrenergic agents (LABA) Metered Dose Inhalers or Nebulizers			LENGTH OF AUTHORIZATIONS: 1 year
*Foradil[®] *Serevent Diskus[®]	*Arcapta Neohaler[®] *Brovana[®] *Perforomist[®]		*Clinical Criteria for LABAs Length of Authorization: 3 months for Clinical Criteria Each product listed below will require a SA for ages less than the FDA/PI indicated age.



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>																								
			<table border="1"> <thead> <tr> <th data-bbox="1226 289 1503 321">Brand Name</th> <th data-bbox="1503 289 1885 321">Age where SA is required</th> </tr> </thead> <tbody> <tr> <td data-bbox="1226 321 1503 380">Advair[®] Diskus2 50/50, & 500/50</td> <td data-bbox="1503 321 1885 380">Children < 12 years</td> </tr> <tr> <td data-bbox="1226 380 1503 420">Advair[®] Diskus 100/50</td> <td data-bbox="1503 380 1885 420">Children < 4 years</td> </tr> <tr> <td data-bbox="1226 420 1503 461">Advair[®] HFA</td> <td data-bbox="1503 420 1885 461">Children < 12 years</td> </tr> <tr> <td data-bbox="1226 461 1503 501">Anoro[™] Ellipta</td> <td data-bbox="1503 461 1885 501">Children & Adolescents < 18 years</td> </tr> <tr> <td data-bbox="1226 501 1503 542">Arcapta[®] Neohaler</td> <td data-bbox="1503 501 1885 542">Children & Adolescents < 18 years</td> </tr> <tr> <td data-bbox="1226 542 1503 583">Brovana[®]</td> <td data-bbox="1503 542 1885 583">Children & Adolescents < 18 years</td> </tr> <tr> <td data-bbox="1226 583 1503 623">Dulera[®]</td> <td data-bbox="1503 583 1885 623">Children < 12 years</td> </tr> <tr> <td data-bbox="1226 623 1503 664">Foradil[®] Aerolizer</td> <td data-bbox="1503 623 1885 664">Children < 5 years</td> </tr> <tr> <td data-bbox="1226 664 1503 704">Perforomist[®]</td> <td data-bbox="1503 664 1885 704">Children & Adolescents < 18 years</td> </tr> <tr> <td data-bbox="1226 704 1503 743">Serevent[®] Diskus</td> <td data-bbox="1503 704 1885 743">Children < 4 years</td> </tr> <tr> <td data-bbox="1226 743 1503 784">Symbicort[®]</td> <td data-bbox="1503 743 1885 784">Children < 12 years</td> </tr> </tbody> </table>	Brand Name	Age where SA is required	Advair [®] Diskus2 50/50, & 500/50	Children < 12 years	Advair [®] Diskus 100/50	Children < 4 years	Advair [®] HFA	Children < 12 years	Anoro [™] Ellipta	Children & Adolescents < 18 years	Arcapta [®] Neohaler	Children & Adolescents < 18 years	Brovana [®]	Children & Adolescents < 18 years	Dulera [®]	Children < 12 years	Foradil [®] Aerolizer	Children < 5 years	Perforomist [®]	Children & Adolescents < 18 years	Serevent [®] Diskus	Children < 4 years	Symbicort [®]	Children < 12 years
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	<p data-bbox="487 743 1031 776">Short Acting Metered Dose Inhalers or Devices</p> <p data-bbox="487 776 835 808">Proventil[®] HFA</p>	<p data-bbox="848 776 1031 808"><i>Proair[®] HFA</i></p> <p data-bbox="848 808 1031 841"><i>Ventolin[®] HFA</i></p> <p data-bbox="848 841 1031 873"><i>Xopenex[®] HFA</i></p>																									
	<p data-bbox="487 1024 835 1057">Short Acting Nebulizers</p>																										
	<p data-bbox="487 1057 835 1089">albuterol sulfate all premix</p> <p data-bbox="487 1089 835 1122">metaproterenol</p> <p data-bbox="487 1122 835 1154">Xopenex[®]</p>	<p data-bbox="848 1057 1213 1089"><i>levalbuterol soln</i></p>																									
<p data-bbox="487 1089 1419 1122">COPD: Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors</p>																											
	<p data-bbox="487 1122 835 1154">Atrovent HFA[®]</p> <p data-bbox="487 1154 835 1187">Combivent[®] Respimat</p> <p data-bbox="487 1187 835 1219">ipratropium bromide soln</p> <p data-bbox="487 1219 835 1252">ipratropium/albuterol nebs</p> <p data-bbox="487 1252 835 1284">Spiriva[®]</p>	<p data-bbox="848 1122 1213 1154"><i>Anoro[™] Ellipta</i></p> <p data-bbox="848 1154 1213 1187"><i>Daliresp[®]</i></p> <p data-bbox="848 1187 1213 1219"><i>Tudorza[™]</i></p>	<p data-bbox="1226 1122 1898 1154">LENGTH OF AUTHORIZATION: 1 year</p> <p data-bbox="1226 1154 1898 1187">Routine PDL edit plus</p> <p data-bbox="1226 1187 1898 1219">Clinical Criteria for Daliresp[®]</p> <ul data-bbox="1226 1219 1898 1432" style="list-style-type: none"> <li data-bbox="1226 1219 1898 1268">• If the patient has a diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations, AND <li data-bbox="1226 1268 1898 1317">• Trial/failure on at least one first-line or second-line agent (inhaled anticholinergics, long acting beta agonists or inhaled corticosteroids) , AND <li data-bbox="1226 1317 1898 1432">• Adjunctive therapy (Daliresp[®] must be used in conjunction with first-line or second-line agent). 																								



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
Effective January 1, 2015



<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
Corticosteroids: Inhaled and Nasal Steroids		
Inhaled Corticosteroids: Combination Products (Glucocorticoid and Long Acting Beta Adrenergic)		LENGTH OF AUTHORIZATIONS: 1 year
*Advair [®] Diskus *Dulera [®] *Symbicort [®]	Advair [®] HFA Breo [®] Ellipta [™]	Routine PDL edit
Inhaled Corticosteroids: Metered Dose Inhalers		
Asmanex [®] Flovent [®] Diskus & HFA Pulmicort Flexhaler [®] QVAR [®]	Alvesco [®] Aerospan [™]	
Inhaled Corticosteroids: Nebulizer Solution		
Pulmicort [®] Respules	Budesonide	
Nasal Steroids		
Nasonex [®]	Beconase AQ [®] Dymista [™] Flonase [®] flunisolide fluticasone Omnaris [®] Qnasl [™] Rhinocort Aqua [®] triamcinolone acetonide Veramyst [®] Zetonna [™]	
Cough and Cold products		
Drug Name and GNN	<i>All other Legend cough</i>	LENGTH OF AUTHORIZATION: Date of Service only
Ala-Hist DM brompheniramine/ phenylephrine/ dextromethorphan benzonatate cap codeine/ promethazine Carbetapen cit, carbetap tan, PE HCL	<i>and cold products are non-preferred</i> Tessalon [®] perle	Routine PDL edit Clinical Edit for Cough and Cold Agents – All children under 6 will not be eligible for cough and cold products.



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
Effective January 1, 2015



	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
	PE Tan guaifenesin/codeine phosphate hydrocodone/ homatropine Iophen-C NR <i>guaifenesin/codeine phosphate</i> Lohist-DM syrup <i>brompheniramine/ dextromethorphan/ phenylephrine</i> phenylephrine HCl/promethazine HCl <i>pyrilamine/ phenylephrine/ dihydrocodeine</i> <i>brompheniramine/ phenylephrine/ dihydrocodeine</i> promethazine DM syrup Tusnel[®] Pediatric Drops <i>dextromethorphan/guaifenesin/pseudoephedrine</i>		
Epinephrine, Self-Injected			
	epinephrine Epipen[®] Epipen[®] Jr	AdrenaClick[®] Auvi-Q[™]	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
Intranasal Antihistamines			
	Astepro[®] 0.15% Patanase[®]	azelastine 0.1%	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
Leukotriene Receptor Antagonists			
	Accolate[®] montelukast tabs/chew tabs	Singulair[®] tabs/chew tabs/ granules montelukast granules zafirlukast Zyflo[™] Zyflo CR[™]	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit