



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
Effective January 1, 2014



**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, other additional clinical criteria may apply to a respective drug class which could result in 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:
 - If there has been a therapeutic failure of no less than a **one-month trial** of at least **one medication within the same class** not requiring 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.

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				
Narcotics - Long Acting				
	fentanyl patch Kadian ER® *methadone 10 mg/5ml & 5mg/5ml oral soln *methadone 5mg & 10mg tab morphine sulfate tab SA	Avinza® Butrans® Conzip® ER *Dolophine® Duragesic® Embeda® Exalgo® *Methadose® morphine sulfate ER cap MS Contin® Nucynta® ER	Opana® ER Oramorph® SR oxycodone-long acting OxyContin® oxymorphone ER Ryzolt™ tramadol ER Ultram ER® Oxymorphone HCL ER	LENGTH OF AUTHORIZATIONS: 6 months Routine PDL edit ♦ Step Edit – Trial and failure of 2 different short acting narcotics. The step edit is not required for those patients that have been stabilized on Long Acting Narcotics or need relief of moderate to severe pain requiring around-the-clock opioid therapy for an extended period of time. Still subject to PDL criteria edit. ♦ PDL Edit – If patient has failed a preferred narcotic or there is any reason the patient cannot be changed to a medication not requiring service authorization. ♦ *Methadone Clinical Edits – All methadone will 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.
Narcotics - Short Acting				
Barbiturate & Non-Salicylates Analgesic Combinations			LENGTH OF AUTHORIZATIONS: 3 months	
	acetaminophen-butalbital	Orbivan CF® Phrenilin Forte® Sedapap®	Routine PDL edit	
Lozenges- Narcotic			Narcotic Lozenges (only) Clinical Criteria:	
		Actiq® Fentora®	• The patient has a diagnosis of cancer, AND • Is already receiving and tolerant of opioid therapy for their underlying persistent cancer pain. Patients considered opioid tolerant are those who are taking transdermal fentanyl 25 mcg/h, morphine 60 mg/day or more, oxycodone 30 mg/day, oral hydromorphone 8 mg/day, or an equi-analgesic dose of another opioid for one week or longer.	
Opioid Dependency - Methadone products			* Methadone 40mg dispersible tablets & 10mg/ml oral concentrated solution Clinical Criteria:	
	* Diskets® 40mg * methadone 10mg/ml Intensol oral conc soln *methadone 10mg/ml oral conc soln *methadone 40 mg *Methadose® 10mg/ml oral conc soln *Methadose® 40 mg		• FDA approved ONLY for detoxification and maintenance treatment of narcotic addiction • Recipient must be enrolled in a methadone treatment program (opioid treatment program, OTP)	



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	<p>Opioid Dependency - Buprenorphine products</p> <p>**buprenorphine SL **Suboxone tablets[®] Obsolete **Suboxone[®] film **Zubsolv[™]</p> <p>Short-Acting Narcotics</p> <p>codeine codeine/APAP codeine/APAP/caff/butal codeine/ASA codeine/ASA/caff/butal hydrocodone/APAP hydrocodone/ ASA hydrocodone/ ibuprofen hydrocodone bitartrate & APAP hydromorphone meperidine morphine IR nalbuphine oxycodone IR oxycodone/APAP tramadol HCL</p>	<p>** <i>buprenorphine and naloxone tablet</i></p> <p><i>All Brands require a SA</i></p> <p><i>Abstral[®]</i> <i>codeine solution</i> <i>dihydrocodeine / apap / caffeine</i> <i>Nucynta[®]</i> <i>Oxecta[®]</i> <i>oxycodone/ASA</i> <i>oxycodone / ibuprofen</i> <i>oxymorphone HCl</i> <i>Primlev[™]</i> <i>tramadol HCL/APAP</i> <i>Ultracet[®]</i> <i>Ultram[®]</i> <i>Zydone</i> <i>Zolvit[®]</i></p>	<p>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> <p>** Buprenorphine SL, buprenorphine/ naloxone tablets, Suboxone[®] SL/Film & Zubsolv[™] Clinical Criteria: Duration of SA is 3 months for a total of 24 months. The following need to be true:</p> <ul style="list-style-type: none"> ▪ Diagnosis of opiate abuse/dependence. ▪ Prescribed by a qualified physician who has <ul style="list-style-type: none"> ○ A Substance Abuse and Mental Health Services Administration Waiver and has <ul style="list-style-type: none"> ○ 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 physicians by the DATA 2000 waiver ○ The prescriber has reviewed the Virginia Controlled Substance Database on the date of the request. -A copy of the top of page 1 of the PMP report MUST be included with the fax request. ○ showing only: <ul style="list-style-type: none"> ▪ <u>The individuals name</u> ▪ <u>Date of review,</u> ▪ <u>the rest of page 1 SHOULD not visible once faxed.</u> ▪ <u>We do not need or want the list of drugs</u> ▪ Patient is receiving addiction counseling ▪ A chemical dependency assessment has been performed AND ▪ Criteria for chemical dependency is met ▪ Patient is 16 years of age or older (no exceptions allowed); AND ▪ Patient is not pregnant (Suboxone SL/Film, buprenorphine/ naloxone, and Zubsolv[™]). ▪ Max duration is 24 months ▪ Max dose is 16mg/day Suboxone[®]



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			<ul style="list-style-type: none"> The maintenance dose is buprenorphine 11.4 mg/naloxone 2.8 Zubsolv™ 	
Non-Steroidal Anti-Inflammatory Drugs				
	diclofenac potassium etodolac IR ibuprofen indomethacin IR ketoprofen IR ketorolac meloxicam tab nabumetone naproxen naproxen sodium piroxicam sulindac	<i>Anaprox®</i> <i>Anaprox DS®</i> <i>Ansaid®</i> <i>Arthrotec®</i> <i>Cataflam®</i> <i>Celebrex®</i> <i>Clinoril®</i> <i>Daypro®</i> <i>diclofenac sodium SR</i> <i>diclofenac sodium/misoprostol</i> <i>diflunisal</i> <i>Dolobid®</i> <i>Duexis®</i> <i>etodolac SR</i> <i>Feldene®</i> <i>fenoprofen</i> <i>flurbiprofen</i> <i>Indocin® IR & SR®</i> <i>indomethacin IR, SR & rectal</i> <i>ketoprofen ER</i> <i>Lodine® IR & XL</i>	<i>Meclofenamate</i> <i>mefenamic</i> <i>meloxicam susp</i> <i>Mobic®</i> <i>Motrin®</i> <i>Nalfon®</i> <i>Naprelan®</i> <i>Naprosyn®</i> <i>naproxen EC</i> <i>Orudis®</i> <i>Oruvail®</i> <i>oxaprozin</i> <i>Ponstel®</i> <i>Prevacid Naprapac®</i> <i>Relafen®</i> <i>Sprix® nasal spray</i> <i>Tolectin DS®</i> <i>Toradol®</i> <i>tolmetin sodium</i> <i>Vimovo®</i> <i>Voltaren®</i> <i>Voltaren XR®</i> <i>Zipsor®</i> Zorvolex™	<p>LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit with exceptions noted below</p> <p>A one-month trial of at least <u>two medications within the same class</u> not requiring SA is required.</p> <p>* Celebrex® Step edit</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.
Topical Analgesic Agents and Anesthetics				
	*Flector® patch *Voltaren® gel	**Lidoderm® patch ** lidocaine *Pennsaid® topical soln ***Solaraze 3% Topical Gel	<p>LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit * Flector®, Voltaren® & Pennsaid® Clinical Criteria: 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®.</p> <p>Pennsaid® can only be approved for the FDA approved</p>	



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			<p>indication of osteoarthritis of the knee.</p> <p>Quantity limit for Flector® Patch of 30 u per RX <i>(criteria continues on next page)</i></p> <p>** Lidoderm® Patch Clinical Criteria: Lidoderm® patches can be approved for relief of pain associated with post-herpetic neuralgia.</p> <p>***Solaraze® 3% Gel Clinical Criteria:</p> <ul style="list-style-type: none"> • Indicated for the topical treatment of actinic keratosis (AK). • Sun avoidance is indicated during therapy. • Precautions exist for patients with active GI ulceration or bleeding and severe renal or hepatic impairment
Antibiotic-Anti-Infective			
Antibiotics, Inhaled			
	<p>Tobi® *Tobi® Podhaler™</p>	<p><i>Bethkis®</i> <i>Cayston®</i> <i>tobramycin inhalation nebulizer sol</i></p>	<p>LENGTH OF AUTHORIZATIONS: 1 YEAR Routine PDL edit plus</p> <p>1. * Tobi® Podhaler™ (tobramycin inhalation powder)</p> <ul style="list-style-type: none"> • Tobi nebulizer 300mg/5 ml solution is covered without PA; Tobi® Podhaler™ will be covered with a SA after a trial on Tobi nebulizer 300mg/5 ml solution. • Minimum age restriction of 6 years of age • Quantity limit = 8 capsules per day • Tobi nebulizer solution and Tobi Podhaler available only through specialty pharmacies. <p>2. Cayston® & Bethkis® requires the following criteria be met:</p> <ul style="list-style-type: none"> • Diagnosis of Cystic Fibrosis • Previous therapy with tobramycin via nebulizer. • Demonstration of TOBI® compliance <p>The following quantity limits apply:</p> <ul style="list-style-type: none"> • Cayston® 84ml per 28 days • Bethkis® 56 ampules per 28 days
Antibiotics, Vaginal			
	<p>Cleocin® Ovules Metrogel®</p>	<p><i>Cleocin® Cr</i> <i>Clindesse Cr</i></p>	<p>LENGTH OF AUTHORIZATIONS: Date of Service (3-day window)</p>



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	Vandazole gel		Routine PDL edit plus If member is unablunable to insert the Cleocin® Ovules or needs to apply a cream, clindamycin cream.
Antifungals, Oral			
	fluconazole tab/susp Griseofulvin® susp Gris-Peg® ketoconazole nystatin tab/susp terbinafine	*Ancobon® <i>clotrimazole (mucous mem)</i> <i>Diflucan® tab/susp</i> <i>flucytosine</i> <i>Grifulvin V® tab</i> <i>griseofulvin tab</i> <i>griseofulvin ultramicrosize</i> <i>itraconazole</i> **Lamisil® tab/granules ***Onmel® Noxafil® ****Sporanox® cap/soln Terbinex™ kit ***** Vfend® tab/susp <i>voriconazole tab</i>	LENGTH OF AUTHORIZATIONS: Duration of the prescription (up to 12 months) Routine PDL edit plus * Ancobon® Clinical Criteria: <ul style="list-style-type: none"> Indicated for the treatment of : <ul style="list-style-type: none"> Candida: Septicemia, endocarditis, and UTIs Cryptococcus: meningitis, pulmonary infections Can be approved if the patient has a serious illness that leaves them immunocompromised (i.e. AIDS, cancer, organ transplants). **Lamisil® granules Clinical Criteria : <ul style="list-style-type: none"> indication is tinea capitis, AND must be over 4 years of age. ** * Onmel® Clinical Criteria <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 with oral terbinafine, OR Patient has a contraindication to oral terbinafine (i.e. heart failure, hepatic impairment, viral hepatitis). ** **Sporanox® Clinical Criteria: <ul style="list-style-type: none"> indication are Aspergillosis, Candidiasis (oral or esophageal), Histoplasmosis, Blastomycosis, empiric treatment of febrile neutropenia ***** Vfend® Clinical Criteria: <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), Neutropenic Acute Myeloid Leukemia (AML) Graft versus Host Disease (GVHD) Candidemia (candida krusei)



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			<ul style="list-style-type: none"> ○ Esophageal Candidiasis ○ Pulmonary or invasive aspergillosis ○ Blastomycosis ○ 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. ○ Oropharyngeal/esophageal candidiasis refractory to fluconazole. ● Can be approved if the patient has a serious illness that leaves them immunocompromised (i.e. AIDS, cancer, organ transplants).
Cephalosporins, Oral			
Second Generation Cephalosporins			LENGTH OF AUTHORIZATIONS: date of service only; no refills Routine PDL edit
	cefaclor cap cefprozil cap/susp cefuroxime tab	cefaclor ER cefaclor susp Ceftin [®] tab/susp Cefzil [®] tab/susp	Potential reasons for SA are:
Third Generation Cephalosporins			<ul style="list-style-type: none"> ● Infection caused by an organism resistant to medications not requiring service authorization ● A therapeutic failure to no less than a <u>three-day trial of one medication within the same class not</u> requiring service authorization ● The patient is completing a course of therapy with a medication requiring a service authorization, which was initiated in the hospital.
	cefdinir cap/susp Suprax [®] tab/susp	Cedax [®] cap/susp cefditoren pivoxil cefepodoxime proxetil cap/susp ceftibuten Omnicef [®] cap/susp Spectracef [®] Suprax [®] chewable tablet Suprax [®] Cap	
Macrolides, Oral			
Macrolides & Ketolides			LENGTH OF AUTHORIZATIONS: date of service only; no refills Routine PDL edit
	azithromycin pack/susp/tab clarithromycin tab/susp *E.E.S. [®] *EryC [®] *Eryped [®] 400 susp Ery-tab [®] erythrocin stearate erythromycin base erythromycin	Biaxin [®] tab/ susp/XL clarithromycin ER Dynabac [®] *Eryped [®] 200 susp erythromycin base DR cap **Ketek [®] PCE [®] Zithromax [®] tab/susp ZMAX [®] susp	*Generics 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 physician's signature.



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	ethylsuccinate erythromycin estolate susp erythromycin stearate erythromycin/sulfisoxazole		
Quinolones, Oral			
Second Generation Quinolones			LENGTH OF AUTHORIZATIONS: date of service only; no refills Routine PDL edit
Cipro [®] susp ciprofloxacin tab	Cipro [®] IR & XR ciprofloxacin susp/ER Noroxin [®] ofloxacin Proquin XR [®]		
Third Generation Quinolones			
Avelox [®] ABC PACK levofloxacin tab	Avelox [®] Factive [®] Levaquin [®] tab/susp	levofloxacin susp Proquin XR [®]	
Quinolones, Otic			
Ciprodex [®] ofloxacin	Cetraxal [®] Cipro HC [®]		LENGTH OF AUTHORIZATION Date of service only; no refills Routine PDL edit
Topical			
mupirocin ointment	*Altabax [™] Bactroban [®] cream/ointment Centany [®] Centany AT [®] Kit		LENGTH OF AUTHORIZATIONS: Date of service only; no refills Routine PDL edit *Quantity Limit of 15 grams per 34 day
Antivirals			
Hepatitis C Agents			
Interferon			LENGTH OF AUTHORIZATIONS: All products require a Clinical SA ➤ Interferon Clinical Criteria Initial 16 week SA: Initial approval periods limited to 16-weeks and viral titer obtained at week 12 of therapy.
Peg-Intron [®] Peg-Intron Redipen [®]	Pegasys [®] ProClick [™] Pegasys [®] Syringe Pegasys [®] Kit Pegasys [®] Vial		
Protease Inhibitor			Established HCV reactors: 1) Therapy is approvable for a total of 24 weeks in patients that are HCV genotypes 2 or 3 who have achieved a virologic response (either undetectable HCV RNA [<50 IU/mL] or at least a 2-log drop in HCV RNA titer from
*Incivek [®] *Victrelis [®]			



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			<p>baseline) at 12 weeks of treatment.</p> <p>2) Therapy is approvable for total of 48 weeks in HCV genotype 1 or 4 patients who have achieved a virologic response (either undetectable HCV RNA [<50 IU/mL] or at least a 2-log drop in HCV RNA titer from baseline) at 12 weeks of treatment.</p> <p>3) If patient fails to achieve a virologic response by 12 weeks, further treatment is not indicated.</p> <p>➤ <u>*Protease Inhibitor Clinical Criteria</u></p> <p><u>Incivek Clinical Criteria (Triple Therapy)</u></p> <p>1) Confirm diagnosis of HCV with genotype 1, AND concurrent therapy with ribavirin and peginterferon, AND no previous protease inhibitor treatment for Hep C.</p> <p>2) At initial prescription fill, if above criteria are met – approve for 12 weeks. Lab work needs to be done at 4 weeks.</p> <p>3) Course of telaprevir should <i>not</i> be repeated.</p> <p><u>Victrelis Clinical Criteria (Triple Therapy)</u></p> <p>1) Confirm diagnosis of HCV with genotype 1, AND no previous protease inhibitor treatment for Hep C, AND completed ribavirin and peginterferon for at least 4 weeks, AND concurrent therapy with ribavirin and peginterferon</p> <p>2) Evaluate for the following conditions for longer duration of approval:</p> <p>a) cirrhosis – Approve for 44 weeks</p> <p>b) Previous treatment with peginterferon and ribavirin with documented lack of achievement of > 2 log reduction at week 12 in previous treatment – Approve for 44 weeks.</p> <p>c) If none of above in a or b, then evaluate below to determine duration of therapy.</p> <p>3) At initial prescription fill, confirmed diagnosis of HCV with genotype 1 and completed 4 weeks of peginterferon and ribavirin with continuing therapy – approve for 24 weeks.</p> <p>4) After 24 weeks – require labs drawn at weeks 8 and 24. Depending on the result – determine the duration of</p>



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			approval: a) Treatment naïve patients: i. If week 8 and 24 are both undetectable – triple therapy is completed. No further Victrelis therapy. ii. If week 8 results are detectable and week 24 results are undetectable – then approve Victrelis for 8 more weeks. iii. If week 24 results are detectable, discontinue all 3 therapies (Victrelis and peginterferon/ribavirin). b) Previously treated or relapsed patients: i. If week 8 and 24 are both undetectable – approve for 8 more weeks for Victrelis and peginterferon/ribavirin (then discontinue all 3) ii. If week 8 results are detectable and week 24 results are undetectable – then approve Victrelis for 8 more weeks. iii. If week 24 results are detectable, discontinue all 3 therapies (Victrelis and peginterferon/ribavirin). 5) For ALL patients –If at week 12, the HCV-RNA level is > 100 IU/mL, do not approve Victrelis. 6) For ALL patients - If at week 24 HCV-RNA results are detectable, discontinue all 3 therapies (Victrelis and peginterferon/ribavirin). Lab work needs to be done at 8, 12, and 24 weeks.
Herpes Oral			
	acyclovir tab/susp famciclovir valacyclovir	Famvir® Valtrex® Zovirax® tab/susp	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
Herpes Topical			
	Abreva OTC® Zovirax® ointment	acyclovir ointment Denavir® Xerese® cream Zovirax® cream	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit



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	Influenza		
	amantadine tab/syrup Relenza Disk[®] rimantadine Tamiflu [®] cap/susp	amantadine cap Flumadine [®] syrup/tab	LENGTH OF AUTHORIZATIONS: For diagnosis of influenza, the authorization is for the date of service only; no refills Routine PDL edit
Blood Modifiers			
	Berinert[®] (C1-inhibitor) Cinryze[™] (C1-inhibitor) Kalbitor[®] (kallikrein inhibitor)	Firazyr[®] (icatibant)	Length of Authorization: DOS (is allowed one additional supply for emergency use) Routine PDL edit plus <u>Clinical Criteria</u> <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 <ul style="list-style-type: none"> ○ HAE attacks occur at least once monthly ○ Disabled at least 5 days per month ○ History of attacks with airway compromise / hospitalization ○ <u>History of Prior prophylaxis with danazol:</u> Danazol contraindicated (pediatric, hepatic or renal impairment, pregnancy, breast-feeding, abnormal genital bleeding) <ul style="list-style-type: none"> ▪ Developed danazol toxicity ▪ Diminished danazol efficacy <u>FDA indicated Diagnosis Quantity limit</u> <ul style="list-style-type: none"> ○ Berinert[®] Acute abdominal, facial or laryngeal HAE attacks (20 U per kg) 500 Per vial- 4 vials per attack (plus 4 for emergency) ○ Cinryze[™] Prevention of HAE attacks. Cinryze; 1,000 U - IV twice/week (500/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 does (plus one for emergency) ○ Firazyr[®] Acute attacks of (HAE) in adults 18 years of age and older; 30mg/does (plus one for emergency)
Bone Resorption Suppression and Related Agents			
	Bisphosphonates		



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	alendronate	<i>Actonel[®]</i> <i>Actonel[®] with CA</i> <i>Alendronate soln</i> <i>Atelvia DR[®]</i> <i>Boniva[®]</i> <i>Binosto[™]</i>	<i>*Didronel[®]</i> <i>etidronate</i> <i>Fosamax[®]</i> <i>Fosamax[®] plus D</i> <i>ibandronate</i>	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit * 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.
Calcitonins				
	Miacalcin[®]	<i>calcitonin-salmon nasal</i> <i>Fortical[®]</i>		<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit
Others				
	Evista[®]	Forteo[®]		<u>LENGTH OF AUTHORIZATION:</u> 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. <u>Forteo[®] (teriparatide): Indications</u> <ul style="list-style-type: none"> • Treatment of osteoporosis in postmenopausal women who are at high risk for fracture • Increase of bone mass in men with primary or hypogonadal osteoporosis who are at high risk for fractures • Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture Forteo is indicated if: <ul style="list-style-type: none"> • 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) ○ Patient history of non-traumatic fracture(s) ○ DXA BMD T-score ≤-2.5 at any site ○ Glucocorticoid use* (≥6 months of use at 7.5 dose of prednisolone equivalent) ○ Rheumatoid Arthritis ○ Postmenopausal women with BMD T-score ≤-2.5 at any site with any of the following clinical risk



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			factors: a. More than 2 units of alcohol per day b. Current smoker c. Men w/primary or hypogonadal osteoporosis d. Osteoporosis associated w/sustained systemic glucocorticoid therapy
Cardiac			
ACE Inhibitors, Angiotensin Receptors Blockers, Beta-Blockers			
	ACE Inhibitors		LENGTH OF AUTHORIZATION: 1 year Routine PDL edit
	benazepril captopril enalapril lisinopril ramipril	<i>Accupril</i> [®] <i>Aceon</i> [®] <i>Altace</i> [®] cap/tab <i>Epaned</i> [™] <i>fosinopril</i> <i>Lotensin</i> [®] <i>Mavik</i> [®] <i>moexipril</i> <i>Monopril</i> [®]	<i>perindopril</i> <i>Prinivil</i> [®] <i>quinapril</i> <i>ramipril</i> <i>trandolapril</i> <i>Univasc</i> [®] <i>Vasotec</i> [®] <i>Zestril</i> [®]
	ACE Inhibitors + Calcium Channel Blocker Combinations		
	amlodipine/benazepril	<i>Lotrel</i> [®] <i>Tarka</i> [®] <i>trandolapril/verapamil hydrochloride ER</i>	
	ACE Inhibitors + Diuretic Combinations		
	benazepril/HCTZ captopril/HCTZ lisinopril/HCTZ	<i>Accuretic</i> [®] <i>enalapril/HCTZ</i> <i>fosinopril/HCTZ</i> <i>Lotensin HCT</i> [®] <i>moexipril/HCTZ</i>	<i>Prinzide</i> [®] <i>quinapril/HCTZ</i> <i>Uniretic</i> [®] <i>Univasc</i> [®] <i>Vaseretic</i> [®] <i>Zestoretic</i> [®]
	Angiotensin Receptor Blockers		



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<i>Preferred Agents</i>		<i>Non-Preferred Agents</i>		<i>SA Criteria</i>
*Diovan[®] losartan		Atacand [®] Avapro [®] Benicar [®] candesartan Cozaar [®] Edarbi [®]	eprosartan mesylate irbesartan Micardis [®] Teveten [®]	*Step edit requires a trial and failure of losartan
Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations				
N/A		Azor [®] Exforge [®]	Exforge [®] HCT Tribenzor [®]	
Angiotensin Receptor Blockers + Diuretic Combinations				
losartan/HCTZ **valsartan/HCTZ		Atacand HCT [®] Avalide [®] Benicar HCT [®] candesartan/HCTZ **Diovan HCT[®] Edarbyclor [®]	Hyzaar [®] irbesartan- hydrochlorothiazide Micardis HCT [®] Teveten HCT [®]	**Step edit requires a trial and failure of losartan/HCTZ
Beta Blockers				
atenolol carvedilol labetalol metoprolol tartrate nadolol propranolol tab/soln Sorine [®] sotalol AF sotalol HCL		acebutaolol Betapace [®] IR / AF [®] betaxolol bisoprolol Bystolic [®] Coreg [®] IR & CR [®] Corgard [®] Innopran [®] XL Kerlone [®] Levatol [®]	Lopressor [®] metoprolol succinate pindolol propranolol LA Sectral [®] Tenormin [®] timolol maleate Toprol XL [®] Trandate [®] Zebeta [®]	
Beta Blockers + Diuretic Combinations				
atenolol/chlorthalidone bisoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ		Corzide [®] Dutoprol [®] Inderide [®] Lopressor HCT [®]	metoprolol/HCTZ Tenoretic [®] Ziac [®]	



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<i>Preferred Agents</i>		<i>Non-Preferred Agents</i>		<i>SA Criteria</i>
Direct Renin Inhibitors (includes combination)				
N/A		<i>Amturnide™</i> <i>Tekamlo®</i> <i>Tekturna®</i>	<i>Tekturna HCl®</i> <i>Twynsta®</i> <i>Valturna®</i>	
Anticoagulants				
Low Molecular Weight Heparin includes FactorXA Inhibitor				LENGTH OF AUTHORIZATION: 1 year Routine PDL edit
<i>Fragmin® Disp Syringe</i> <i>Lovenox®</i>		<i>Arixtra®</i> <i>enoxaparin</i> <i>fondaparinux</i> <i>Fragmin® Vial</i> <i>Innohep®</i>		* Pradaxa® Clinical Criteria: Length of Authorization: 1 year <ul style="list-style-type: none"> • Diagnosis of non valvular atrial fibrillation; • If patient is taking a P-gp inducers such as rifampin; Pradaxa® should not be used, an alternate antithrombotic therapy should be used (new) • If the patient taking a P-gp inhibitors such as; dronedarone (Multaq®) or systemic ketoconazole (Nizoral®, or others) in patients with moderate renal impairment (CrCl 30-50 mL/min): Consider reducing Pradaxa® dose to 75 mg twice daily and in patients with severe renal impairment (CrCl <30mL/min): Pradaxa® use not recommended (new) • Use with caution in people over the age of 75 years • Assess renal function prior to initiation of treatment. Periodically assess renal function as clinically indicated (i.e., more frequently in clinical situations that may be associated with a decline in renal function) and adjust therapy accordingly. • For patients with CrCl 15-30 mL/min: 75 mg orally, bid • For patients with CrCl >30 mL/min: 150 mg orally, bid
Oral Anticoagulants				
<i>warfarin</i> *Pradaxa® **Xarelto®		<i>Coumadin®</i> ***Eliquis™		** Xarelto® Clinical Criteria: Length of authorization: 1 year <ul style="list-style-type: none"> • Prophylaxis of DVT/PE in patients after elective hip or knee replacement surgery OR • Stroke prophylaxis and systemic embolism prophylaxis in patients with nonvalvular atrial fibrillation. • for the treatment of deep vein thrombosis (DVT), pulmonary embolism (PE),



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
			<ul style="list-style-type: none"> • reduction in the risk of recurrence of DVT and of PE • For hip replacement: 35 tablets/35 days • For knee replacement: 12 tablets/12 days • For atrial fibrillation: 30 tablets/30 days. <p><u>Dosage and Administration:</u></p> <p><u>Nonvalvular Atrial Fibrillation:</u></p> <ul style="list-style-type: none"> • If CrCl >50 mL/min: 20 mg PO, QD with evening meal. • If CrCl 15 - 50 mL/min: 15 mg PO, QD with evening meal • Avoid use in patients with CrCl <15 mL/min. <p><u>Treatment of DVT, PE, and Reduction in the Risk of Recurrence of DVT and of PE:</u></p> <ul style="list-style-type: none"> • 15 mg orally twice daily with food for the first 21 days for the initial • Treatment of acute DVT or PE. After the initial treatment period, 20 mg orally, once daily with food for the remaining treatment and the long-term reduction in the risk of recurrence of DVT and of PE <p><u>Prophylaxis of DVT Following Hip or Knee Replacement Surgery:</u></p> <ul style="list-style-type: none"> • 10 mg orally, once daily with or without food <p>*** <u>Eliquis™ Clinical Criteria:</u></p> <p>Length of Authorization: 1 year</p> <ul style="list-style-type: none"> • May be approved for the following diagnosis: nonvalvular atrial fibrillation; for prophylaxis of stroke and systemic embolism • The recommended dose is 5 mg orally twice daily. • In patients with at least 2 of the following characteristics: age ≥80 years, body weight ≤60 kg, or serum creatinine ≥1.5 mg/dL, the recommended dose is 2.5 mg orally twice daily. • The dose of Eliquis™ should be decreased to 2.5 mg twice daily when it is co-administered with drugs that are strong dual inhibitors of CYP3A4 and P-gp, (e.g., ketoconazole, itraconazole, ritonavir, or clarithromycin) • In patients already taking Eliquis™ at a dose of 2.5 mg



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
			<p>twice daily, avoid coadministration with strong dual inhibitors of both CYP3A4 and P-gp</p> <ul style="list-style-type: none"> Avoid concomitant use of Eliquis™ with strong dual inducers of CYP3A4 and P-gp (e.g., rifampin, carbamazepine, phenytoin, St. John's wort) because such drugs will decrease exposure to apixaban.
Calcium Channel Blockers: Dihydropyridine CCB & Non-Dihydropyridine CCB			
Dihydropyridine Calcium Channel Blockers			<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edit</p>
<p>Afeditab CR® amlodipine Nifediac CC® Nifedical XL® nifedipine nifedipine ER nifedipine SA</p>	<p>Adalat® Adalat CC® Cardene® Cardene SR® Dynacirc® IR & CR® felodipine ER isradipine</p>	<p>nisoldipine nicardipine Norvasc® Procardia® Procardia XL® Plendil® Sular®</p>	
Non-Dihydropyridine Calcium Channel Blockers			
<p>Cartia XT® Diltia XT® diltiazem IR, ER q 12hr & 24hr diltiazem XR Taztia XT® verapamil tab IR & ER</p>	<p>Calan® IR & SR Cardizem® IR, CD & LA Dilacor XR® diltiazem SR q 12hr Isoptin SR® Tiazac® verapamil ER cap Verelan® Verelan PM®</p>		
Lipotropics			
Bile Acid Sequestrants			<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edit plus</p> <ul style="list-style-type: none"> Therapeutic failure to no less than three-month trial of at least one medication not requiring service authorization. <p>FDA announced on June 8, 2011 new safety restrictions (including contraindications & dose limitations) for high-dose simvastatin. FDA recommendations:</p> <ul style="list-style-type: none"> Maintain patients on simvastatin 80 mg or Vytorin
<p>cholestyramine powder & light colestipol tab Prevalite® Welchol® tab</p>	<p>Colestid® granule/packet/tab colestipol HCl granules Questran® powder/powder Light Welchol® packet</p>		
Cholesterol Absorption Inhibitor (CAI)			
<p>Zetia®</p>			



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Fibric Acid Derivatives				<p>10/80 mg ONLY if they have been taking this dose chronically (for 12 months or more) <i>without</i> evidence of muscle toxicity.</p> <ul style="list-style-type: none"> Do not start new patients on simvastatin 80 mg or Vytorin 10/80 mg. Place patients who do not meet their LDL-C goal on simvastatin 40 mg or Vytorin 10/40 mg on alternative LDL-C lowering treatment(s) that provides greater LDL-C lowering. Follow the recommendations in the simvastatin-containing medicines labels regarding drugs that may increase the risk for muscle injury when used with simvastatin. Switch patients who need to be initiated on a drug that interacts with simvastatin to an alternative statin with less potential for the drug-drug interaction. <p>*Step edit requires a history of either a niacin or simvastatin product within the past 365 days</p> <p>** Lovaza® Clinical Criteria:</p> <ul style="list-style-type: none"> Step edit requires trial and failure of any other lipotropic. A SA may also be approved without a documented medication trial if they have documented very high triglycerides of (≥ 500 mg/dL) in adult patients. <p>***Juxtapid™ Clinical Criteria:</p> <ul style="list-style-type: none"> Diagnosis of homozygous familial hypercholesterolemia (HoFH). Prescriber must be certified with the Juxtapid™ REMS program. Minimum age restriction of 18 years of age. Patient has had treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants. <p>**** Kynamro™ Clinical Criteria:</p> <ul style="list-style-type: none"> Diagnosis of homozygous familial hypercholesterolemia
gemfibrozil Tricor®	<i>Antara®</i> <i>fenofibrate (Tricor®)</i> <i>fenofibrate (Antara®)</i> <i>fenofibric acid</i> <i>Fenoglide®</i>	<i>Lipofen®</i> <i>Lofibra®</i> <i>Lopid®</i> <i>Triglide®</i> <i>Trilipix™</i>		
HMG CoA Reductase Inhibitors and Combinations (High Potency Statins)				
atorvastatin simvastatin	<i>amlodipine/atorva- statin</i> <i>Caduet®</i> <i>Crestor®</i>	<i>Lipitor®</i> <i>Livalo®</i> <i>Vytorin®</i> <i>Zocor®</i>		
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				
	*** <i>Juxtapid™</i>			
Niacin Derivatives				
Niacor® Niaspan®	<i>niacin ER</i>			
Niacin Derivatives & HMG CoA Reductase Inhibitors Combination				
	* <i>Simcor®</i>			
Omega 3 Fatty Acid Agent				
	** <i>Lovaza®</i>			
Oligonucleotide Inhibitor				
	**** <i>Kynamro™</i>			



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			(HoFH). <ul style="list-style-type: none"> • Prescriber must be certified with the Kynamro™ REMS program. • Minimum age restriction of 18 years of age. • 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®	LENGTH OF AUTHORIZATION: 1 year Routine PDL edit
Pulmonary Arterial Hypertension Agents			
Inhaled Prostacyclin Analogues			LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit * Phosphodiesterase 5 Inhibitors Clinical Criteria: <ul style="list-style-type: none"> • Diagnosis of pulmonary hypertension in patients >18 years is required. • The requested medication may be approved if the following is true: <ul style="list-style-type: none"> ○ The prescribing physician is a pulmonary specialist or cardiologist and will be followed by the prescribing physician. • Must have a rationale for not taking the oral Revatio® to receive a SA for the injectable Revatio®. • PDE-5 contraindications where SA should not be approved: <ul style="list-style-type: none"> ○ Concurrent use of nitrates (e.g., nitroglycerin) ○ Hypersensitivity to product
	Tyvaso® Ventavis®		
Oral Endothelin Receptor Antagonist			
	Letairis® Tracleer®	Opsumit®	
Phosphodiesterase 5 Inhibitors			
	*sildenafil	*Adcirca™ *Revatio injection® *Revatio®	
Central Nervous System			
Alzheimer's Agents			
Cholinesterase Inhibitors			
	donepezil tab Exelon® Transdermal	Aricept® ODT, Tab & 23 mg tab donepezil ODT & 23mg tab Exelon® cap & soln	LENGTH OF AUTHORIZATIONS: Length of the prescription (up to 3 months) Routine PDL edit



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		<i>Galantamine IR, ER tab & soln</i> <i>Razadyne® IR & ER</i> <i>rivastigmine cap</i>		Donepezil ODT (Aricept® ODT) Is the person unable to swallow or absorb oral medications. Aricept® 23mg (donepezil) Is the person currently established on therapy with the 10mg tablet for at least 3 months?
NMDA Receptor Antagonist				
Namenda® Sol & Tab	Namenda® Dose Pack & XR tab			
Antimigraine Agents				
Relpax® sumatriptan succinate cartridge/nasal/pen/tab/vial rizatriptan ODT	<i>Alsuma®</i> <i>Amerge®</i> <i>Axert®</i> <i>Cambia®</i> <i>Frova®</i> <i>Imitrex® cart/nasal/pen/tab/vial</i>	Maxalt® tab & MLT <i>naratriptan</i> <i>rizatriptan tab</i> <i>Sumavel® Dosepro</i> <i>Treximet®</i> <i>Zomig® tab/nasal spray/ZMT</i>	LENGTH OF AUTHORIZATIONS: 6 months Routine PDL edit	
Non-Ergot Dopamine Receptor Agonist				
pramipexole ropinirole HCl	<i>Mirapex® IR & ER</i> <i>Neupro®</i>	<i>Requip® IR & XR</i> <i>ropinirole HCl ER</i>	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit	
Sedatives / Hypnotics				
chloral hydrate syrup flurazepam temazepam 15mg & 30mg	<i>Doral®</i> <i>estazolam</i> <i>Halcion®</i>	<i>Restoril®</i> <i>temazepam 7.5 & 22.5 mg</i> <i>triazolam</i>	LENGTH OF AUTHORIZATIONS: Length of the prescription (up to 3 months) Routine PDL edit	
Sedatives / Hypnotics (Non-Benzodiazepine)				
Rozerem® zolpidem	<i>Ambien® IR & CR</i> <i>Edluar™</i> <i>Intermezzo®</i> <i>Lunesta®</i> <i>Silenor®</i>	<i>Somnote®</i> <i>Sonata®</i> <i>Zaleplon®</i> <i>zolpidem CR</i> <i>Zolpimist™ spray</i>		
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>orphenadrine citrate</i> <i>orphenadrine/ASA/caffeine</i> <i>Parafon Forte® DSC</i> <i>Robaxin®</i> <i>Skelaxin®</i> * <i>Soma®</i>	LENGTH OF AUTHORIZATIONS: <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 * Carisoprodol Clinical Criteria:	



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>		<i>SA Criteria</i>														
		<i>Fexmid[®]</i> <i>Flexeril[®]</i> <i>Lorzone[®]</i> <i>metaxalone</i> <i>Norflex[®]</i>	<i>tizanidine cap</i> <i>Zanaflex[®]</i>	<ul style="list-style-type: none"> • The patient is at least 16 years of age. • 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/ loz/ patch	<i>Nicoderm CQ[®] Patch</i> <i>Nicorette[®] Gum/ Lozenges</i> <i>Nicotrol[®] Inhaler & NS</i> <i>Zyban[®]</i>		LENGTH OF AUTHORIZATIONS: 6 months Routine PDL edit														
**Stimulants/ADHD Medications																		
Amphetamine Products																		
	amphetamine salts combo dextroamphetamine Vyvanse[®]	<i>Adderall[®] IR</i> <i>*Adderall[®] XR</i> <i>amphetamine salts</i> <i>combo XR</i> <i>Desoxyn[®]</i>	<i>Dexedrine[®]</i> <i>dextroamphetamine SR</i> <i>& soln</i> <i>Dextrostat[®]</i> <i>methamphetamine</i> <i>Procentra[®] sol</i> <i>Zenedi[™]</i>	LENGTH OF AUTHORIZATION: 1 year Routine PDL edit *Adderall XR[®] 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.														
Methylphenidate Products																		
	Focalin XR[®] All methylphenidate generic IR tablets methylphenidate SR	<i>Concerta[®]</i> <i>Daytrana[®]</i> <i>dexmethylphenidate</i> <i>Focalin[®]</i> <i>Metadate CD[®]</i> <i>Metadate ER[®]</i> <i>Methylin ER[®]</i> <i>Methylin chew[®]</i>	<i>Methylin[®] soln</i> <i>methylphenidate soln</i> <i>methylphenidate LA</i> <i>Ritalin[®]</i> <i>Ritalin LA[®]</i> <i>Ritalin SR[®]</i> <i>***Quillivant[™] XR</i> <i>25 mg/5 mL Susp</i>	** Stimulants/ADHD Meds Clinical Criteria: Length of Authorization 1 year Each product listed below will require an SA for ages less than the FDA/PI indicated age. <table border="1" data-bbox="1318 1149 1980 1477"> <thead> <tr> <th>Brand Name</th> <th>SA required</th> </tr> </thead> <tbody> <tr> <td>Intuniv[®]</td> <td>Children <4</td> </tr> <tr> <td>Strattera</td> <td>Children < 6</td> </tr> <tr> <td>Kapvay[®] SR (clonidine ER)</td> <td>Children < 6</td> </tr> <tr> <td>Focalin XR[®]</td> <td>Children < 6</td> </tr> <tr> <td>Extended-release once-daily products; e.g., Adderall XR, Metadate CD, Concerta[®] Ritalin LA[®] etc.</td> <td>Children < 6</td> </tr> <tr> <td>Immediate-release formulations; e.g., Ritalin, Methylin, Methylin oral sol,</td> <td>Children < 3</td> </tr> </tbody> </table>	Brand Name	SA required	Intuniv [®]	Children <4	Strattera	Children < 6	Kapvay [®] SR (clonidine ER)	Children < 6	Focalin XR [®]	Children < 6	Extended-release once-daily products; e.g., Adderall XR, Metadate CD, Concerta [®] Ritalin LA [®] etc.	Children < 6	Immediate-release formulations; e.g., Ritalin, Methylin, Methylin oral sol,	Children < 3
Brand Name	SA required																	
Intuniv [®]	Children <4																	
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Immediate-release formulations; e.g., Ritalin, Methylin, Methylin oral sol,	Children < 3																	
Miscellaneous Products																		
	Strattera[®]	<i>clonidine ER</i> <i>Intuniv[®]</i> <i>Kapvay[®] SR 12H</i>																



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		**** <i>modafinil</i> **** <i>Nuvigil TM</i> **** <i>Provigil®</i>	<table border="1" data-bbox="1312 253 1965 289"> <tr> <td data-bbox="1312 253 1780 289">Methylin chewable tab</td> <td data-bbox="1780 253 1965 289"></td> </tr> </table> <p>***Quillivant™ XR Clinical Criteria:</p> <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. <p>**** Nuvigil™/Provigil® Clinical Criteria:</p> <p>Length of Authorization:</p> <ul style="list-style-type: none"> 1 year for sleep apnea and narcolepsy; 6 months for shift work sleep disorder. <p>➤ Approvable diagnosis include:</p> <ul style="list-style-type: none"> Sleep Apnea: Requires documentation/confirmation via sleep study. Requires documentation that C-PAP has been maximized. Narcolepsy: Documentation of diagnosis via sleep study. 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. <p>➤ Minimum age of 16 years for Provigil® (modafinil) Minimum age of 17 years for Nuvigil™ (armodafinil)</p>	Methylin chewable tab	
Methylin chewable tab					
Dermatologic					
Dermatologic Agents					
	Combination Benzoyl Peroxide & Clindamycin for Acne		LENGTH OF AUTHORIZATION: 1 year		



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	benzoyl peroxide clindamycin phosphate gel/soln	<i>AcanyaTM</i> <i>Azelex[®]</i> <i>Benzaclin[®]</i> <i>BenzefoamTM</i> <i>Benzefoam UltraTM</i> <i>BenzaclinTM</i> <i>W/Pump</i> <i>benzoyl peroxide cleanser/Micro- spheres cleanser BPO Kit</i> <i>Cleocin T[®] Gel</i> <i>Cleocin T[®] Lotion</i> <i>Cleocin T[®] Med. Swab</i> <i>ClindacinTM Pac Kit</i> <i>Clindagel[®]</i>	<i>clindamycin</i> <i>1%/Benzoyl Peroxide</i> <i>5%</i> <i>clindamycin phosphate foam/lotion/med.swab</i> <i>Delos LotionTM</i> <i>Duac[®] gel</i> <i>EvoclinTM</i> <i>InovaTM</i> <i>LavoclenTM Cleanser</i> <i>LavoclenTM Kit</i> <i>Pacnex[®]</i> <i>Pacnex[®] HP</i> <i>Pacnex[®] LP</i> <i>Se BPO 7-5.5% Wash Kit</i> <i>Se BPO Cleanser</i>	Routine PDL edit plus Failure to respond to a therapeutic trial of at least two weeks of one preferred medication. <u>Dermatologic Acne Agents Clinical Criteria:</u> <ul style="list-style-type: none"> • Products will automatically pay for children < 18 • All adults over the age of 18 will require a SA to determine diagnosis for treatment • Products are intended for Acne only; a SA for a Cosmetic indication cannot be approved
	Topical Agents for Psoriasis			
	Dovonex[®] Calcipotriene Solution	<i>anthralin</i> <i>calcipotriene cr/oint</i> <i>Calcitrene[®]</i> <i>calcitriol</i> <i>Dovonex[®] Scalp</i>	<i>Micanol[®]</i> <i>SoriluxTM</i> <i>Taclonex[®]</i> <i>Taclonex[®] Scalp</i> <i>Vectical</i>	
	Topical Retinoids/Combinations for Acne			
	Differin[®] cream 0.1% Differin[®] gel 0.1% & 0.3% Differin[®] 0.1% topical lotion tretinoin tretinoin microsphere gel & gel pump	<i>adapalene 0.1% cream</i> <i>adapalene 0.1% topical gel</i> <i>Altinac[®]</i> <i>Atralin</i> <i>Avita[®] cream & Gel</i> <i>Epiduo[®]</i>	<i>Fabior foamTM</i> <i>Retin-[®] A cream/gel</i> <i>Retin[®]-A Micro gel &Pump</i> <i>Tazorac[®]</i> <i>Tretin[®]-X</i> <i>Ziana[®]</i>	



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
Endocrine and Metabolic Agents			
Androgenic Agents (Testosterone – Topical)			
	Androgel[®]	<i>Androderm[®]</i> <i>Axiron[®] soln</i> <i>Fortesta[®]</i> <i>Testim[®]</i>	<u>LENGTH OF AUTHORIZATION:</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 AUTHORIZATION:</u> 1 year Routine PDL edit * Colcrys[™] Clinical Criteria: Approve if one of the following is true: <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 (i.e., indomethacin, naproxen, ibuprofen, sulindac, ketoprofen) OR ▪ Corticosteroid
Contraceptives			
Etonogestrel/Ethinyl Estradiol Vaginal Ring			<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit
NuvaRing[®]			
Norelgestromin/Ethinyl Estradiol Transdermal			
Ortho Evra[®]			
Oral Contraceptives			
Apri[®] Cryselle[™] Enpresse[®] Femcon Fe[®] Junel Fe[®] Loestrin[®] Loestrin Fe[®] Microgestin[®] Microgestin Fe[®]	<i>All other oral contraceptives</i>		



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	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		
Diabetes Hypoglycemics: Injectable Amylin Analogs			
		*Symlin [®] *Symlin [®] Pens	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit * <u>Clinical Criteria: Next Page</u> <ul style="list-style-type: none"> • The recipient must have a history of at least a 90 day trial of insulin. • Symlin[®] is only indicated as adjunct therapy with insulin. • Member meeting ALL of the following criteria may be approved: <ul style="list-style-type: none"> ○ Diagnosis of Type 1 or 2 diabetes ○ On insulin therapy ○ Failure to achieve adequate glycemic control (HbA1c ≤ 6.5%)
Diabetes Hypoglycemics: Injectable Incretin Mimetics			
	Byetta [®]	Bydureon [™] Victoza [®]	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit



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<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
Diabetes Hypoglycemics: Injectable Insulins		
Insulin Mix		LENGTH OF AUTHORIZATION: 1 year Routine PDL edit
Humalog [®] Mix 50/50 vial	Humalog [®] Mix 50/50 Kwikpen	
Humalog [®] Mix 75/25 vial	Humalog [®] Mix 75/25 Kwikpen	
Humulin [®] 70/30/vial	Humulin [®] 70/30 pen otc	
Novolog [®] Mix 70/30 pen/vial		
Novolin [®] 70/30 vial		
Insulin N		
Humulin [®] N vial	Humulin [®] N pen	
Novolin [®] N vial		
Insulin R		
Humulin [®] R vial		
Novolin [®] R vial		
Long-Acting Insulins		
Lantus [®] vial	Lantus Solostar [®] and cartridge	
Levemir [®] pen/vial		
Rapid-Acting Insulins		
Humulin 500 U/M vial	Apidra [®] cartridge, Solostar, and vial	
Humalog [®] vial	Humalog [®] Cartridge	
Novolog [®] cartridge/	Humalog Kwikpen [®]	
Flexpen Syringe/vial		
Diabetes Oral Hypoglycemics		
Oral Hypoglycemics Alpha-Glucosidase Inhibitors		LENGTH OF AUTHORIZATION: 1 year Routine PDL edit
acarbose	Precose [®]	
Glyset [®]		
Oral Hypoglycemics Biguanides		
metformin	Fortamet [®]	
metformin ER	Glucophage [®] IR & XR	Riomet [®] susp
Oral Hypoglycemics Biguanide Combination Products		
glyburide/metformin	glipizide/metformin	
	Glucovance [®]	
	Metaglip [®]	



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
	Oral Hypoglycemics DPP-IV Inhibitors and Combination Janumet [®] Janumet XR [®] Januvia [®] Jentadueto [™] Tradjenta [™]	Juvisync [™] Kazano [™] Kombiglyze XR [™] Nesina [™] Onglyza [™] Oseni [™]	
	Oral Hypoglycemics Meglitinides Starlix [®]	nateglinide Prandin [®]	PrandiMet [™]
	Oral Hypoglycemics Second Generation Sulfonylureas glimepiride glipizide glipizide ER glyburide glyburide micronized	Amaryl [®] Diabeta [®] Glucotrol [®] Glucotrol XL [®] Glynase [®]	
	Oral Hypoglycemics Sodium Glucose Co-Transporter 2 Inhibitor (SGLT2)	Invokana [™]	
	Oral Hypoglycemics Thiazolidinediones Avandamet [®] Avandia [®] pioglitazone	Actoplus Met [®] IR & XR Actos [®] Avandaryl [®] Duetact [®] pioglitazone / metformin	Rosiglitazone REMS Program- After November 18, 2011 rosiglitazone medicines will be withdrawn from local pharmacies, and the distribution of rosiglitazone-containing medicines will be limited to only specially-certified, mail-order pharmacies. To receive a rosiglitazone-containing medicines (Avandia [®] , Avandamet [®] and Avandaryl [®]). The physician must be enrolled in the Avandia [®] -Rosiglitazone Medicines Access Program and adhere to the new restrictions to obtain the products if they wish to prescribe rosiglitazone medicines to outpatients or patients in long-term care facilities after November 18, 2011. <i>These products are not included as preferred or non-preferred on DMAS' PDL.</i>
	Erythropoiesis Stimulating Proteins: Epogen[®], Procrit[®] (Erythropoietin) & Aranesp[®] (Darbepoetin) Procrit [®]	Aranesp [®] Epogen [®]	LENGTH OF AUTHORIZATION: for duration of the prescription up to 6 months Routine PDL edit Clinical Information for Pharmacists: RENEWAL REQUESTS for patients with anemia due to chronic renal failure/end stage renal disease should be



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Preferred Agents	Non-Preferred Agents	SA Criteria
		approved, even if the Hgb or Hct are above the cutoff point. <i>Omontys® is not PDL eligible, medical only</i>
Growth Hormone		
Genotropin® Nutropin AQ® NuSpin™	<i>Humatrope® cartridge/vial</i> <i>Norditropin cartridge®</i> <i>Norditropin FlexPro® & Nordiflex®</i> <i>Nutropin®</i> <i>Nutropin AQ® cartridge/vial</i> <i>Omnitrope®</i> <i>Saizen® cartridge/vial</i> <i>Serostim®</i> <i>Tev-Tropin®</i> <i>Zorbtive®</i>	<p>All Growth Hormones require a clinical SA</p> <p style="background-color: #f2f2f2;">Clinical Criteria for PEDIATRIC Patients (18 years of age and under):</p> <p><u>LENGTH OF AUTHORIZATION</u> (pediatrics): 1 year</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, • The patient has open epiphysis and one of the following diagnoses <ul style="list-style-type: none"> ○ Turner Syndrome ○ Prader-Willi Syndrome ○ Renal insufficiency ○ Small for gestational age (SGA) - including Russell-Silver variant and patient is < 2 years old ○ Idiopathic Short Stature (for request for renewal only (a) information is required to be approved) ○ Growth hormone deficiency (physician should provide the required information below) ○ Newborn with hypoglycemia and a diagnosis of hypopituitarism or panhypopituitarism. • 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>Requests 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



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			<ul style="list-style-type: none"> • 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>Clinical Criteria for ADULTS (> 18 years of age)</p> <p><u>LENGTH OF AUTHORIZATION: 1 year (Serostim® – 3 months * see below)</u></p> <ul style="list-style-type: none"> • Prescriber is an endocrinologist • Diagnosis of growth hormone deficiency confirmed by growth hormone stimulation tests and rule-out of other hormonal deficiency, as follows: growth hormone response of fewer than five nanograms per mL to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine or glucagon when measured by polyclonal antibody (RIA) or fewer than 2.5 nanograms per mL when measured by monoclonal antibody (IRMA); • Cause of growth hormone deficiency is Adult Onset Growth Hormone Deficiency (AO-GHD), alone or with multiple hormone deficiencies, such as hypopituitarism, as a result of hypothalamic or pituitary disease, radiation therapy, surgery or trauma • Other hormonal deficiencies (thyroid, cortisol or sex steroids) have been ruled out or stimulation testing would not produce a clinical response such as in a diagnosis of panhypopituitarism. <p>Zorbitive® - Diagnosis of short bowel syndrome</p> <p>Serostim®</p> <ul style="list-style-type: none"> • Diagnosis of AIDS Wasting or cachexia • Patient has a documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents (both Megace® and Marinol®) <p>*Length of Authorization (Serostim® only): 3 months initial; then 1 year. Renewal is contingent upon improvement in lean body mass or weight measurements.</p> <p><u>Requests for Renewal (adults)</u> Renewal is contingent upon prescriber affirmation of</p>



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			positive response to therapy (improved body composition, reduced body fat, and increased lean body mass).
Progestational Agents			
	medroxyprogesterone acetate (tablet only) norethindrone acetate progesterone injection Prometrium® Provera®	Aygestin® progesterone cap	LENGTH OF AUTHORIZATION: 1 year Routine PDL edit plus Failure to respond to a therapeutic trial of at least one week of one non-service authorized medication
Progestins Used For Cachexia			
	megestrol acetate	Megace® Megace® ES	LENGTH OF AUTHORIZATION: 1 year Routine PDL edit
Vaginal Estrogens			
	Premarin® Vaginal cream Vagifem® Vaginal tab	Estrace® Vaginal cream Estring® Vaginal ring Femring® Vaginal ring	LENGTH OF AUTHORIZATION: 6 months Routine PDL edit
Gastrointestinal			
Antiemetic/Antivertigo Agents			
Cannabinoids (delta-9THC derivatives)			LENGTH OF AUTHORIZATION: 6 months Routine PDL edit plus
	**Marinol®	*Cesamet® **dronabinol	Cannabinoids (delta-9THC derivatives) Clinical Criteria: *Cesamet® • Diagnosis of severe, chemotherapy induced nausea/vomiting • 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 **Dronabinol & Marinol • Diagnosis of severe, chemotherapy induced nausea and vomiting • 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 • Diagnosis of AIDS-relating wasting



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			<ul style="list-style-type: none"> • Patient has tried /failed Megestrol acetate oral suspension OR has a contraindication, intolerance, drug-drug interaction, or medical reason Megestrol acetate cannot be used.
	<p>5HT3 Receptor Blockers</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>LENGTH OF AUTHORIZATION: 3 months, unless other wise noted</p> <p>Routine PDL edit plus</p> <p>* 5HT3 Receptor Blockers Clinical Criteria:</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 • 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.) • Ondansetron solution and Zuplenz® requires a clinical reason the patient cannot use ondansetron ODT. If the patient is taking less than 4 mg per dose <p>LENGTH OF AUTHORIZATION Length of chemotherapy regimen or a maximum of 6 months.</p> <p>Routine PDL edit plus</p> <p>**NK-1 Receptor Antagonist Clinical Criteria:</p>
	<p>NK-1 Receptor Antagonist</p>	<p>**Emend® Bi Pak **Emend® Tri-fold pack</p>	<p>Emend® (aprepitant): Emend® does NOT require treatment failure with preferred drugs when used for moderately or highly emetogenic chemotherapy. Approval may be granted if either of the bulletpoints below apply:</p> <ul style="list-style-type: none"> • May be approved for use in patients receiving highly or moderately emetogenic chemotherapy in addition to dexamethasone and a 5-HT3 antagonist. • This includes patients on the following: AC combination (Doxorubicin or Epirubicin w/Cyclophosphamide), Aldesleukin, Amifostine, Arsenic trioxide, Azacitidine, Bendamustine, Busulfan, Carmustine, Carboplatin, Cisplatin, Clofarabine, Cyclophosphamide, Cyterabine, Dacarbazine, Dactinomycin, Danorubicin, Doxorubicin, Epirubicin, Etoposide, Hexamethylmelamine, Idarubicin, Ifosfamide, Imatinib, Interferon alfa, Ironetecan, Mechlorethamine, Melphalan, Methotrexate, Oxaliplatin,



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
			<p>Procabazine, Streptozocin, Temozolomide.</p> <ul style="list-style-type: none"> May be approved for other uses restricted to patients receiving other chemotherapy who have failed maximum doses of ondansetron combined with dexamethasone. <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>LENGTH OF AUTHORIZATION: 1 year, unless other wise noted</p> <p>Routine PDL edit plus</p> <p>* metoclopramide should be reviewed for need at each request for reauthorization. As a Black box warning placed on product for TARDIVE DYSKINESIA 2/27/2009</p>
	<p>Other</p> <p>meclizine prochlorperazine tab ****promethazine syrup/supp/ tab *metoclopramide</p>	<p>Antivert® Compazine ®supp Compro® ***Diclegis® Dramamine Dimenhydrinate Hydroxyzine ****Phenergan® prochlorperazine supp Tigan® ****Transderm-Scop® trimethobenzamide Vistaril® *Metozolv® ODT *Reglan®</p>	<p>Clinical Criteria:</p> <p>***Diclegis® (doxylamine/pyridoxine)</p> <ul style="list-style-type: none"> Patient must be pregnant <p>****Promethazine – for Patients under 2 years old</p> <ul style="list-style-type: none"> Inform prescriber that promethazine is contraindicated in patients less than 2 years of age due to the risk of fatal respiratory depression. Offer Ondansetron <p>****Transderm-Scop® may be approved for 3 months if:</p> <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 will be in an area/situation for an extended period of time where taking short acting agents would not be feasible.
	Bile Salts		
	<p>ursodiol 300 Mg cap</p>	<p>Actigall ® Chenodal ®</p> <p>ursodiol tab Urso®/Urso® Forte tab</p>	<p>LENGTH OF AUTHORIZATION: 1 year</p> <p>Routine PDL edit</p>
	H. Pylori Treatment		
	<p>Helidac® Pylera® Prevpac®</p>	<p>Omeclamox®-Pak lansoprazole/amoxicillin/clarithromycin</p>	<p>LENGTH OF AUTHORIZATION: 14 days</p> <p>Routine PDL edit</p>



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Histamine-2 Receptor Antagonists (H-2 RA)			
	famotidine (OTC & RX) ranitidine tab/syrup (OTC & RX)	Axid [®] cap/soln (OTC & RX) cimetidine tab/syrup (OTC & RX) famotidine oral susp (OTC & RX) nizatidine cap/susp Pepcid [®] oral susp/tab (OTC & RX) ranitidine cap (OTC & RX) Tagamet [®] (OTC & RX) Zantac [®] syrup/ tab (OTC & RX)	LENGTH OF AUTHORIZATION: 1 year Routine PDL edit
Irritable Bowel Syndrome			
	Amitiza[®]	LinzessTM Lotronex[®]	LENGTH OF AUTHORIZATION: 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 3 Diagnosis <ol style="list-style-type: none"> 1. Idiopathic Constipation <ul style="list-style-type: none"> • Treatment failure of at least ONE agent 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: bisacodyl, senna) 2. Diagnosis of Constipation Predominant Irritable Bowel Syndrome (IBS-C) <ul style="list-style-type: none"> • Patient is female; 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) ○ Bulk Forming Laxatives (examples: Metamucil[®] (psyllium), Citrucel[®], Fiber) ○ Stimulant Laxatives (examples: bisacodyl, senna) 3. Diagnosis of Opioid Induced Constipation in chronic NON-cancer pain <ul style="list-style-type: none"> • Paid claims history confirms use of opioids for at least 150 out the last 180 days; AND



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			<ul style="list-style-type: none"> • Patient has tried both PEG (i.e., Miralax®) AND lactulose without adequate results – trials must be confirmed in paid claim history. **Linzess® • <i>Diagnosis of Idiopathic Chronic Constipation or Constipation-Predominant Irritable Bowel Syndrome (IBS)</i> • 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) ○ Bulk Forming Laxatives (examples: Metamucil® (psyllium), Citrucel®, Fiber) ○ Stimulant Laxatives (examples: bisacodyl, senna) ***Lotronex® • <i>Diagnosis of severe, diarrhea predominant Irritable Bowel Syndrome</i> • 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), ○ antispasmodic agents (e.g., dicyclomine, hyoscyamine), <p>antidiarrheal agents/opiates (e.g., loperamide, diphenoxylate/atropine, codeine)</p>
	Proton Pump Inhibitors		
	<p>pantoprazole Prilosec® OTC</p>	<p><i>Aciphex®</i> <i>Aciphex® Sprinkle™</i> <i>Dexilant®</i> <i>Esomeprazole Strontium</i> <i>Lansoprazole cap & soln (no SA required if age < 12yrs)</i></p>	<p>LENGTH OF AUTHORIZATIONS: 12 weeks; unless recipient meets an exception; then 1 year Routine PDL edit</p> <p>Additional PDL edit criteria The requested medication may be approved if both of the following are true:</p>



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		<i>Nexium[®]</i> <i>omeprazole RX & OTC</i> <i>omeprazole/sodium bicarbonate</i> <i>Prevacid[®] RX, OTC & Solutab (Solutab no SA</i> <i>required if age < 12yrs)</i> <i>Prilosec[®] Rx & Susp</i> <i>Protonix[®]</i> <i>Zegerid[®] cap, OTC & susp packet</i>		<ul style="list-style-type: none"> • If there has been a therapeutic failure of no less than a three-month trial of at least two different medication within the same class not requiring service authorization • The requested medications corresponding generic (if a generic is available and covered) has been attempted and failed or is contraindicated) <p>Exceptions that allow 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				
Asacol[®] Apriso[®] balsalazide disodium Pentasa[®] sulfasalazine DR & IR	<i>Asacol[®]HD</i> <i>Azulfidine[®] DR</i> <i>Azulfidine[®] IR</i> <i>Colazal[®]</i> <i>Delzicol[™]</i>	<i>Dipentum</i> <i>*Giazo[™]</i> <i>Lialda[®]</i> <i>Uceris[™]</i>	LENGTH OF AUTHORIZATION: 1 year Routine PDL edit *Giazo is limited to an 8 week supply	
Ulcerative Colitis – Rectal				
Canasa[®] rectal supp mesalamine enema	<i>Fiv-Asa[®]</i> <i>mesalamine kit</i>	<i>Rowasa[®] enema, kit &</i> <i>rectal supp</i> <i>SFRowasa[®]</i>		
Genitourinary				
Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)				
Alpha-Blockers for BPH				
alfuzosin tamsulosin HCL	<i>Flomax[®]</i> <i>Rapaflo[®]</i> <i>Uroxatral[®]</i>	LENGTH OF AUTHORIZATION: 1 year Routine PDL edit *Step edit for Avodart[®] - the generic finasteride must be tried and failed before approval Cialis[®] - must try and fail both Alpha Blockers and		



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<i>Preferred Agents</i>		<i>Non-Preferred Agents</i>		<i>SA Criteria</i>
Androgen Hormone Inhibitors for BPH				Androgen Hormone Inhibitors for BPH and the physician must attest that the member is not on the state list of sex offenders. The patient must have had a consult or been evaluated by a Urologist.
*Avodart [®] finasteride	Jalyn [®] Proscar [®]			
Phosphodiesterase (PDE) 5 Inhibitor for BPH				
		*Cialis [®]		
Phosphate Binders				
Calcium Acetate 667mg cap Fosrenol [®] Renagel [®]	Calcium Acetate 667mg tab Eliphos [®] Phoslo [®]	Phoslyra [®] Renvela [®] powder/tablet	LENGTH OF AUTHORIZATION: 1 year Routine PDL edit	
Urinary Antispasmodics				
oxybutynin tab/syrup Oxytrol [®] transdermal Sanctura [®] XR Toviaz [™] VESIcare [®]	Detrol [®] & Detrol [®] LA Ditropan [®] & *Ditropan [®] XL Enablex [®] flavoxate Gelnique [™] gel	Myrbetriq [™] *oxybutynin ER Sanctura [®] trospium IR & ER	LENGTH OF AUTHORIZATION: 1 year Routine PDL edit *Oxybutynin ER, Ditropan XL[®]: • Allow PDL exception for children age 6-18 with a diagnosis of neurogenic bladder.	
Immunological Agents				
Atopic Dermatitis: Topical				
*Elidel [®]	*Protopic [®]		LENGTH OF AUTHORIZATION: 1 year Routine PDL edit * Elidel[®] and Protopic[®] Clinical Criteria: <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.) Critical information <ul style="list-style-type: none"> • Black box warnings are in place for both products as well as a requirement for a patient guide to be given with each product dispensed. • Use Elidel[®] and Protopic[®] only as second-line agents for short-term and intermittent treatment of atopic 	



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
			<p>dermatitis (eczema) in patients unresponsive to, or intolerant to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.)</p> <ul style="list-style-type: none"> • Avoid use of Elidel[®] and Protopic[®] in children younger than 2 years of age. The effect of Elidel and Protopic on the developing immune system in infants and children is not known. In clinical studies, infants and children younger than 2 years old treated with Elidel[®] had a higher rate of upper respiratory infections than did those treated with placebo cream. • Use Elidel[®] and Protopic[®] only for short periods of time, not continuously. The long term safety of Elidel[®] and Protopic[®] are unknown • Children and adults with a weakened or compromised immune system should not use Elidel[®] or Protopic[®]. • Use the minimum amount of Elidel[®] or Protopic[®] needed to control the patient's symptoms. In animals, increasing the dose resulted in higher rates of cancer.
Multiple Sclerosis			
	<p>Avonex[®] Avonex[®] Adm Pack Betaseron[®] Copaxone[®] Rebif[®]</p>	<p>*Ampyra[®] Aubagio[®] Extavia[®] Gilenya[®] Rebif[®]/Rebifose[®] Tecfidera[™]</p>	<p><u>LENGTH OF AUTHORIZATION:</u> 1 year <u>Routine PDL edit</u> Gilenya[®] is to be used as monotherapy ONLY.</p> <p>* AMPYRA[®] Clinical Criteria:</p> <ul style="list-style-type: none"> • The patient has a diagnosis of Multiple Sclerosis and a gait disorder or difficulty walking • Patient has no history of seizures • Patient's Creatinine Clearance [CrCL] ≥ 50 mL/min. • If patient has a gait disorder, they may receive an 8 week trial of Ampyra[®] • If after 8 week trial the physician 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. <p><u>LENGTH OF AUTHORIZATION FOR AMPYRA[®]:</u> Initial 8 weeks then, 1 year after successful trial</p>



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>	
Self Administered Drugs for Rheumatoid Arthritis				
	Enbrel[®] Humira[®]	Actemra[®] SQ Cimzia[®] Cimzia[®] SyringeKit Kineret[®] Orencia[®] Simponi[®] * Xeljanz[™]	LENGTH OF AUTHORIZATION: 1 year Routine PDL edit * Xeljanz[™] Clinical Criteria <ul style="list-style-type: none"> For the treatment of moderately to severely active rheumatoid arthritis in patients who have had an inadequate response or intolerance to methotrexate. The patient had a therapeutic trial and treatment failure with ONE of the following preferred drugs: Enbrel[®], or Humira[®], AND Confirm failure of methotrexate therapy, AND Confirm absence of concurrent use of biologic DMARD, azathioprine, and cyclosporine. 	
Ophthalmic				
Antibiotics				
	bacitracin/ polymyxin b sulfate ointment ciprofloxacin drops erythromycin gentamicin drops/oint Moxeza[®] drops neomycin/polymyxin/gramicidin ofloxacin drops polymyxin/trimethoprim sulfacetamide soln tobramycin Vigamox[®] drops	AzaSite[™] drop bacitracin Besivance[®] drops Bleph[®] - 10 Ciloxan[®] drops/ointment Garamycin[®] drops/ointment gatifloxacin Ilotycin[®] levofloxacin drops	Natacyn[®] neomycin/bacitracin/polymyxin ointment Neosporin[®] Ocuflox[®] drops Polytrim[®] sulfacetamide ointment Tobrex[®] drops /ointment Zymaxid[®] drops	LENGTH OF AUTHORIZATION: for the date of service only; no refills Routine PDL edit
Antibiotic/Steroid Combinations				
	neomycin/polymyxin/dexamethasone ointment & susp Tobradex[®] ointment & susp	Blephamide[®] & Blephamide[®] S.O.P. Maxitrol[®] Oint. & Susp neomycin/bacitracin/poly/ HC neomycin/polymyxin/HC Pred-G[®] oint. & susp sulfacetamide / prednisolone Tobradex[®] ST tobramycin / dexamethasone susp Zylet[®]	LENGTH OF AUTHORIZATION: for the 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 AUTHORIZATION: 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% drops</i> <i>Lastacaft[®] drops</i> <i>Optivar[®] drops</i> <i>Patanol[®] drops</i>	Routine PDL edit	
Mast Cell Stabilizers				
cromolyn sodium	<i>Alocril[®] drops</i> <i>Alomide[®] drops</i> <i>Crolom[®] drops</i>			
Anti-inflammatory				
NSAIDS			LENGTH OF AUTHORIZATION: for the 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	<i>Alrex[™]</i> <i>dexamethasone</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> <i>Pred Forte[®]</i> <i>Pred Mild[®]</i> <i>prednisolone Sod phosphate</i> <i>Vexol[®]</i>		
Glaucoma Agents				
Alpha 2 Adrenergic Agents			LENGTH OF AUTHORIZATION: 1 year	
Alphagan P[®] 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				
Betimol[®] 0.25% & 0.5% Betoptic-S[®] 0.25%	<i>Betagan[®] 0.25% & 0.5%</i> <i>betaxolol 0.5%</i>			



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
	carteolol 1% levobunolol 0.25% & 0.5% metipranolol 0.3% timolol maleate 0.25% & 0.5% timolol maleate 0.5 % soln-gel	Combigan[®] <i>Istalol[®] 0.5%</i> <i>optipranolol 0.3%</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 SimbrinzaTM	<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> Rescula[®] <i>travoprost 0.004%</i> <i>Xalatan[®] 0.005%</i> <i>ZioptanTM</i>	
Respiratory			
	Antihistamines: First and Second Generation		
	First Generation Antihistamines		LENGTH OF AUTHORIZATION: 1 year Routine PDL edit
	Generic only class	<i>All Brands require a SA</i>	
	Second Generation Antihistamines and Combinations		
	cetirizine liquid 1mg/1ml (RX & OTC) cetirizine tabs (OTC) loratadine tab & syrup (OTC)	<i>Allegra-D[®] 12 hr</i> <i>cetirizine chew tab(OTC)</i> <i>cetirizine liquid 5mg/5ml OTC</i> <i>cetirizine D tab(OTC)</i> <i>Clarinex[®] syrup/tab</i> <i>Clarinex- D[®] 24 & 12 hr</i> <i>Claritin-D[®] Rx & OTC forms</i> <i>Claritin[®] tab/Chewable (RX & OTC)</i> <i>desloratadine ODT</i> <i>fexofenadine</i> <i>fexofenadine/PSE & 60/120 ER</i> <i>levocetirizine</i> <i>loratadine ODT</i>	



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		loratadine D 12 &24 HR Xyzal [®] Zyrtec [®] tab/chew/syrup(OTC & RX) Zyrtec-D [®] (OTC & RX)																							
Beta-Adrenergic Agents																									
Long Acting Beta Adrenergic agents (LABA) Metered Dose Inhalers or Nebulizers			LENGTH OF AUTHORIZATION: 1 year Routine PDL edit																						
*Foradil [®] *Serevent Diskus [®]		*Arcapta Neohaler [®] *Brovana [®] *Perforomist [®]	*Clinical edit for LABAs Length of Authorization 3 months Each product listed below will require a SA for ages less than the FDA/PI indicated age.																						
Short Acting Metered Dose Inhalers or Devices																									
Proventil[®] HFA		Maxair Autohaler Proair [®] HFA Ventolin [®] HFA Xopenex [®] HFA	<table border="1"> <thead> <tr> <th>Brand Name</th> <th>Age where SA is required</th> </tr> </thead> <tbody> <tr> <td>Advair[®] Diskus2 50/50, & 500/50</td> <td>Children < 12 years</td> </tr> <tr> <td>Advair[®] Diskus 100/50</td> <td>Children < 4 years</td> </tr> <tr> <td>Advair[®] HFA</td> <td>Children < 12 years</td> </tr> <tr> <td>Arcapta[®] Neohaler</td> <td>Children & Adolescents < 18 years</td> </tr> <tr> <td>Brovana[®]</td> <td>Children & Adolescents < 18 years</td> </tr> <tr> <td>Dulera[®]</td> <td>Children < 12 years</td> </tr> <tr> <td>Foradil[®] Aerolizer</td> <td>Children < 5 years</td> </tr> <tr> <td>Perforomist[®]</td> <td>Children & Adolescents < 18 years</td> </tr> <tr> <td>Serevent[®] Diskus</td> <td>Children < 4 years</td> </tr> <tr> <td>Symbicort[®]</td> <td>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	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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Short Acting Nebulizers																									
albuterol sulfate all premix metaproterenol Xopenex[®]		<i>levalbuterol soln</i>	Controller medication should be used first, LABAs must be used for the shortest duration of time required to achieve control of symptoms and discontinued, if possible, once control is achieved. Patients should then be maintained on a controller medication (i.e. inhaled corticosteroid).																						
COPD: Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors																									
Atrovent HFA[®] Combivent[®] MDI-off market Combivent[®] Respimat ipratropium bromide soln ipratropium/albuterol nebs Spiriva[®]		<i>Daliresp[®]</i> <i>Duoneb[®]</i> <i>Tudorza[™]</i>	LENGTH OF AUTHORIZATION: 1 year Routine PDL edit Specific Information for Daliresp[®] <ul style="list-style-type: none"> If the patient has a diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations and 																						



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			<ul style="list-style-type: none"> • Trial/failure on at least one first-line or second-line agent (inhaled anticholinergics, long acting beta agonists or inhaled corticosteroids) <u>and</u> • Adjunctive therapy (Daliresp® must be used in conjunction with first-line or second-line agent)
Corticosteroids: Inhaled and Nasal Steroids			
Inhaled Corticosteroids: Combination Products (Glucocorticoid and Long Acting Beta Adrenergic)		LENGTH OF AUTHORIZATION: 1 year Routine PDL edit	
*Advair® Diskus & HFA *Dulera® *Symbicort®	Breo® Ellipta™		
Inhaled Corticosteroids: Metered Dose Inhalers			
Asmanex® Flovent® Diskus & HFA Pulmicort Flexhaler® QVAR®	Alvesco®		
Inhaled Corticosteroids: Nebulizer Solution			
Pulmicort® Respules	Budesonide		
Nasal Steroids			
Nasonex®	Beconase AQ® Dymista™ Flonase® flunisolide fluticasone Nasarel® Nasacort® AQ Omnaris®	Qnasl™ Rhinocort Aqua® triamcinolone acetonide Tri-Nasal® Veramyst® Zetonna™	
Cough and Cold Agents			
Drug Name and GNN	All other <u>legend</u> cough and cold product are non-preferred		LENGTH OF AUTHORIZATION: Date of Service Routine PDL edit
Ala-Hist DM-brompheniramine/ phenylephrine/ dextromethorphan	Centergy® phenylephrine/ chlorpheniramine		
benzonatate cap	Tessalon ® perle		
Carbatuss-12® Carbetapen Cit, Carbetap Tan, PE HCl, PE Tan			Clinical Edit for Cough and Cold Agents – All children under 6 will not be eligible for cough and cold products.
codeine/ promethazine			
guaifenesin/codeine phosphate			
hydrocodone/ homatropine			



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	iophen-C NR <i>guaifenesin/codeine phosphate</i>		
	Lohist-DM syrup <i>brompheniramine/dextromethorphan/phenylephrine</i>		
	phenylephrine HCl/promethazine HCl		
	poly hist DHC <i>pyrilamine/phenylephrine/dihydrocodeine</i>		
	poly-tussin DHC <i>brompheniramine/phenylephrine/dihydrocodeine</i>		
	promethazine DM syrup		
	Tusnel[®] Pediatric Drops <i>dextromethorphan/guaifenesin/pseudoephedrine</i>		
Intranasal Antihistamines			
	Astelin[®] Astepro[®] 0.15% Patanase[®]	<i>azelastine 0.1%</i>	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit
Leukotriene Receptor Antagonists			
	Accolate[®] montelukast tabs & chew Singulair[®] 4 mg Granules	<i>Singulair[®] tablets and chew tabs</i> <i>zafirlukast</i> <i>Zyflo[™]</i> <i>Zyflo CR[™]</i>	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit