

Use Criteria for Selected Prior Authorization (PA) Drugs

Note: This list is not comprehensive and only contains the most commonly prescribed drugs that require PA for CareOregon's Oregon Health Plan members.

<u>Actos</u>	<u>Fentanyl Transdermal Patch</u>	<u>Non-sedating Antihistamines</u>	<u>Spiriva</u>
<u>Adderall XR</u>	<u>Focalin XR</u>	<u>Ondansetron</u>	<u>Subutex, Suboxone</u>
<u>Avandia</u>	<u>Lyrica</u>	<u>Oral Nutritional Supplement</u>	<u>Topamax</u>
<u>Benicar, Benicar HCT</u>	<u>Marinol</u>	<u>OxyContin</u>	<u>Trileptal</u>
<u>Byetta</u>	<u>Metadate CD</u>	<u>Pegylated Interferon-</u>	<u>Valtrex</u>
<u>Cozaar, Hyzaar</u>	<u>Mirapex</u>	<u>Ribivirin</u>	<u>Vyvase</u>
<u>Celebrex</u>	<u>Nasal Corticosteroids</u>	<u>Proton Pump Inhibitors</u>	<u>Zetia</u>
<u>Concerta</u>	<u>Nicotine Replacement Products</u>	<u>Singulair</u>	
<u>DDAVP</u>			
<u>Famciclovir</u>			

Medication	Authorization Criteria	Comments
Thiazolidinediones (TZDs) Actos® (Pioglitazone; Formulary with PA Required) Avandia® (Rosiglitazone; Non-formulary)	<p style="text-align: center;"><i>Applies to new starts only*</i></p> 1. Type 2 Diabetes and 2a. Requires > 100 units of insulin per day or 2b. Failed ≥ 3 month trial of sulfonylurea and metformin combination therapy or 2c. Contraindication to metformin such as: serum creatinine > 1.5mg/dL, metabolic acidosis, or heart failure requiring treatment * New members who are stabilized on Avandia® or Actos® and meeting HbA1c goals are approved for continuation of therapy.	<ul style="list-style-type: none"> • Failure of sulfonylurea-metformin combination therapy is defined as failure to achieve HbA1c < 7%. • TZDs may exacerbate heart failure and are contraindicated in Class III and IV CHF. • TZDs produce similar glycemic control to sulfonylureas and there is no evidence to support their use over 1st line agents such as metformin. • There is insufficient evidence that TZDs reduce microvascular or macrovascular complications. • A meta-analysis of 42 clinical trials suggests rosiglitazone may be associated with increased risk of myocardial ischemic events including angina and MI. Current evidence is inconclusive. Use caution in patients with

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		<p>high cardio-vascular event risk. Co-administration with insulin and nitrates may increase the risk of myocardial ischemia and is not recommended.</p> <ul style="list-style-type: none"> • Use of TZDs in the treatment of "metabolic syndrome" is considered investigational. Lifestyle modifications and treatment of individual syndrome components have established benefits. • For more information on the role of TZDs in the treatment of diabetes, please refer to the evidence review at http://www.ohsu.edu/ohsuedu/research/policycenter/customcf/derp/product/Diabetes_final_report_original.pdf.
Adderall XR® (Dextroamphetamine and Amphetamine extended release)	<p>PA is not required if:</p> <ul style="list-style-type: none"> • Member age is < 19 years and • Quantity is < #30 tablets per month <p>*Exception requests for age > 19 years and/or doses greater than #30 tablets per month are reviewed for medical necessity.</p>	<ul style="list-style-type: none"> • Adderall XR is covered without PA for age < 19 years to avoid the need for multiple-daily dosing during school hours. If an afternoon or evening dose is required for rebound, homework or after-school behavior, please consider the addition of a short-acting product. BID dosing of once-daily products is not covered. • If age > 19 years, consider the following formulary alternatives: methylphenidate, methylphenidate SR, mixed amphetamine salts and dexmethylphenidate. • Vyvase® and Focalin XR® are non-formulary agents, and require the failure of or contraindication to formulary agents before a formulary exception is considered.

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<p>Angiotensin Receptor Blockers</p> <p>Benicar® (Olmesartan)</p> <p>Benicar HCT® (Olmesartan/HC TZ)</p> <p>Cozaar® (Losartan)</p> <p>Hyzaar® (Losartan/HCTZ)</p>	<p>Documentation of failure of or intolerance to at least one formulary ACE-Inhibitor:</p> <ul style="list-style-type: none"> • Benazepril • Captopril • Enalapril • Fosinopril • Lisinopril • Quinapril 	<ul style="list-style-type: none"> • Some patients who experience persistent dry cough with one ACE-Inhibitor do not experience the same symptoms when switched to a different ACE-Inhibitor, instead of starting an ARB. If the patient is switched to an ARB, however, and cough does not improve, consider trying a different ACE-Inhibitor. • Use caution with patients who experience angioedema with an ACE inhibitor since this is also a risk with ARBs. • The following are non-formulary and require documentation of failure or intolerance to both formulary ARBs: Avapro®, Atacand®, Diovan®, Micardis®, Tevetan®. • In patients with hypertension, high cardiovascular risk factors, recent MI, heart failure or nephropathy, there is no data to suggest that one ARB is superior to another for efficacy or safety. For more information refer to www.oregon.gov/OHPPR/HRC/docs/HRC.Reports/AIIRA.3.2006.pdf
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Byetta® (Exenatide)	<ol style="list-style-type: none"> 1. Type 2 Diabetes and 2. Documentation of HbA1c > 7% and 3. Documentation of failure of, intolerance to, or contraindications to all of the following at maximally tolerated doses: <ol style="list-style-type: none"> a. Metformin + sulfonylurea b. Metformin + thiazolidinedione <i>Note: TZDs also require PA</i> c. Insulin and 4. Does not meet any of the following exclusion criteria: <ol style="list-style-type: none"> a. Gastroparesis b. ESRD or CrCl < 30 ml/min c. Concurrent use with pramlintide, acarbose, miglitol, tegaserod or metoclopramide 	<ul style="list-style-type: none"> • Exenatide offers modest HbA1c-lowering and lacks long-term outcomes data in contrast to first line agents. Metformin, sulfonylureas and insulin combined with lifestyle modifications offer the best value. Exenatide should not be considered a replacement for insulin. • The use of exenatide is considered investigational when used for weight loss. Although exenatide was associated with reductions in weight in 30-week clinical trials, the average weight loss achieved with the highest dose was a modest 1.6 – 2.8 kg and there is no evidence that the weight loss is clinically relevant or confers long-term benefits. • <u>Renewal criteria:</u> Has reached target HbA1c < 7% or has ≥ a 10% reduction in HbA1c from baseline
Concerta® (Methylphenidate SA)	<p>PA is not required if:</p> <ul style="list-style-type: none"> • Member age is < 19 years and • Quantity is < #30 tablets per month <p>*Exception requests for age > 19 years and/or doses greater than #30 tablets per month are reviewed for medical necessity.</p>	<ul style="list-style-type: none"> • Concerta is covered without PA for age < 19 years to avoid the need for multiple-daily dosing during school hours. If an afternoon or evening dose is required for rebound, homework or after-school behavior, please consider the addition of a short-acting product. BID dosing of once-daily products is not covered. • If age > 19 years, consider the following formulary alternatives: methylphenidate, methylphenidate SR, mixed amphetamine salts and dexmethylphenidate.

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		<ul style="list-style-type: none"> • <u>Maximum recommended dose:</u> Ages 6-12 = 54mg qd Ages 13-17 = 72mg qd or 2mg/kg/day • Vyvase® and Focalin XR® are non-formulary agents, and require the failure of or contraindication to formulary agents before a formulary exception is considered.
Celebrex® (Celecoxib)	<ol style="list-style-type: none"> 1. Osteoarthritis or rheumatoid arthritis and 2. History of GI bleed or perforation or active peptic ulcer confirmed by endoscopy and 3. Not currently on aspirin or aspirin-containing products or a proton pump inhibitor 	<ul style="list-style-type: none"> • Celecoxib may increase INR and may increase the risk of bleeding when used concurrently with warfarin. In patients on warfarin, consider prescribing acetaminophen. • Formulary alternatives for members at risk for NSAID-induced GI toxicity include acetaminophen, salsalate, or a non-selective NSAID with omeprazole. • The formulary alternative for members taking aspirin for cardioprotection is a non-selective NSAID with omeprazole. • The formulary alternative for members who are currently taking a PPI for other indications is a non-selective NSAID. • For more information, refer to www.oregon.gov/OHPPR/HRC/docs/HRC.Reports/NSAID2.2007.Update3.pdf • <u>Quantity limits:</u> <ol style="list-style-type: none"> a) 100mg: #30 caps per month b) 200mg: #60 caps per month

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DDAVP (Desmopressin acetate)	Diabetes Insipidus	Treatment of nocturnal enuresis is not covered by the OHP.
Antivirals Famciclovir Valtrex® (Valacyclovir)	<p>Acute Herpes zoster or Acute Genital Herpes Simplex prophylaxis:</p> <p>1a. Immunocompromised status (HIV, cancer, transplant, etc.) or</p> <p>1b. One of the following complications: gingivostomatitis, keratitis, encephalopathy or</p> <p>1c. Age < 2 years and</p> <p>2a. Failure of acyclovir or</p> <p>2b. HIV with CD4 < 200 and/or have disseminated zoster, multi-dermal zoster or facial/genital outbreaks</p> <p>HSV Prophylaxis:</p> <p>1a. Last trimester of pregnancy or</p> <p>1b. Immunocompromised status (HIV, cancer, transplant, etc.) and</p> <p>2a. Failure of acyclovir or</p> <p>2b. HIV with CD4 < 200 and/or have disseminated zoster, multi-dermal zoster or facial/genital outbreaks</p>	<ul style="list-style-type: none"> • Uncomplicated herpes simplex and herpes zoster are not covered by the OHP. • Acyclovir is available on formulary without restrictions.

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Fentanyl Transdermal Patch	<p>1. Chronic pain condition covered by the OHP*, excluding chronic headache and migraine and</p> <p>2. Not currently on another long-acting opioid and</p> <p>3. Unable to take oral medication such as morphine sulfate ER</p> <p>* The following diagnoses are not covered for treatment by the OHP: chronic low back pain, neck pain, joint pain, chest pain, abdominal pain, pelvic pain; sciatica; degenerative disc disease without neurologic impairment; fibromyalgia; myofascial pain syndrome; complex regional pain syndrome</p>	<ul style="list-style-type: none"> • Concurrent use of two or more long-acting opioids is not covered. • There is insufficient evidence to support differences in efficacy or adverse effects among long-acting opioids. For information refer to www.oregon.gov/OHPPR/HRC/docs/HRC.Reports/OPIOID.5.2005.Update2.pdf • True allergic reactions to opioids are rare. All opioids can cause histamine release that may result in urticaria, pruritus, sneezing and exacerbation of asthma in predisposed patients. Histamine reactions can be avoided by premedication with diphenhydramine. • For prescribing information including opioid conversions and managing adverse effects, refer to www.careoregon.org/provider/documents/Opioids_Pain_Management.pdf • <u>Quantity limit:</u> 10 patches per month
Lyrica® (Pregabalin)	<p>1. Partial seizure disorder or</p> <p>2a. Diabetic peripheral neuropathy (DPN) or postherpetic neuralgia (PHN) and</p> <p>2b. Documentation of failure of or contraindications to at least one tricyclic antidepressant (TCA) and gabapentin</p>	<ul style="list-style-type: none"> • Treatment of fibromyalgia is not covered by the OHP. • Current evidence does not support the use of pregabalin for conditions other than the covered diagnoses. • There is no evidence that pregabalin is more effective than either gabapentin or TCAs for treatment response in DPN and PHN. • <u>Renewal criteria for DPN and PHN:</u>

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		documentation of a reduction in specific, objective pain symptoms. <ul style="list-style-type: none"> • <u>Quantity limit</u>: #90 caps per month
Marinol® (Dronabinol)	1a. Intractable nausea and vomiting or cachexia associated with cancer and 1b. Currently receiving chemotherapy or radiation and 1c. Documentation of failure of or contraindications to at least two of the following: dimenhydrinate, meclizine, metoclopramide, promethazine, prochlorperazine, or trimethobenzamide and ondansetron or 2a. Intractable nausea and vomiting or cachexia associated with HIV/AIDS and 2b. Documentation of failure of or contraindications to at least two of the following: dimenhydrinate, meclizine, metoclopramide, promethazine, prochlorperazine, or trimethobenzamide and 2c. Not currently on Megace® (megestrol) or ondansetron	<u>Quantity limit</u> : #60 caps per month
Metadate CD® (Methylphenidate Extended Release)	1. ADD or ADHD and 2. Age < 19 years and 3. Documentation of failure of, or intolerance to, formulary alternatives: dexamethylphenidate, mixed amphetamine salts, methylphenidate SR, Concerta® and Adderall XR®	<ul style="list-style-type: none"> • Metadate CD is covered without PA for age < 19 years to avoid the need for multiple-daily dosing during school hours. If an afternoon or evening dose is required for rebound, homework or after-school behavior, please consider the addition of a short-acting product. BID dosing of once-daily products is not covered. • If age > 19 years, use the following

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		<p>formulary alternatives: methylphenidate, methylphenidate SR, mixed amphetamine salts and dexamethylphenidate.</p> <ul style="list-style-type: none"> • Vyvase® and Focalin XR® are non-formulary agents, and require the failure of or contraindication to formulary agents before a formulary exception is considered. • <u>Quantity Limit</u>: #30 caps per month
Mirapex® (Pramipexole)	Parkinson's Disease	<ul style="list-style-type: none"> • Treatment of fibromyalgia is not covered by the OHP. • Treatment of restless legs syndrome is not covered by the OHP.
Nasal Corticosteroids Flunisolide Nasal Spray Fluticasone Nasal Spray	<p>1a. Allergic rhinitis and comorbid asthma and</p> <p>1b. Documentation of asthma prescription for a beta-agonist, oral inhaled corticosteroid, or Singulair in the past 90 days or</p> <p>2. Allergic rhinitis and one of the following complications: a) Periorbital inflammation or other ocular complications b) History of sinus surgery or frequent sinus procedures (e.g. fistula drainage) c) Wegener's granulomatosis or</p> <p>3. Chronic sinusitis and one of the following: a) ≥ 3 episodes of acute rhinosinusitis in one year b) One episode lasting > one month c) Nasal polyposis causing or contributing to chronic sinusitis</p>	<ul style="list-style-type: none"> • Allergic rhinitis in the absence of persistent asthma requiring beta-agonists or oral inhaled corticosteroids, or other comorbidities listed on the OHP Prioritized List is not covered by OHP. As a value-added benefit to our members, CareOregon does cover chlorpheniramine, diphenhydramine and loratadine for members who do not meet OHP coverage criteria. • The following are non-formulary: Rhinocort® AQ, Beconase® AQ, Nasonex®, Nasacort® AQ, Omnaris, and Veramyst. • <u>Quantity Limit</u>: 1 canister per month by package size

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<p>Nicotine Replacement Products</p> <p>Nicotine Oral Inhaler</p> <p>Nicotine Nasal Spray</p>	<p>1. Documentation of failure of or significant contraindication to bupropion SR 12hr and at least one nicotine transdermal product and</p> <p>2. Confirmation of enrollment in a smoking cessation counseling program</p>	<p>Nicotine Transdermal and Nicotine Polacrilex do NOT require prior authorization within the following benefit limitations:</p> <ul style="list-style-type: none"> • 14-day supply per Rx • Benefit maximum of 98-day supply per year
<p>Non-sedating antihistamines</p> <p>Cetirizine</p> <p>Fexofenadine</p>	<p>1a. Allergic rhinitis and comorbid asthma and</p> <p>1b. Documentation of asthma drug therapy in the past 90 days that included a beta-agonist, ICS or Singulair or</p> <p>2. Allergic rhinitis and any of the following complications:</p> <ul style="list-style-type: none"> a) Periorbital inflammation or other ocular complications b) History of sinus surgery or frequent sinus procedures (e.g. fistula drainage) c) Wegener's Granulomatosis d) Chronic sinusitis (three or more episodes of acute rhinosinusitis in one year or one episode lasting more than one month) e) Nasal polyps <p>and</p> <p>4. Documentation of failure of or intolerance to a minimum 30-day trial of loratadine (for cetirizine) or loratadine and cetirizine (for fexofenadine).</p>	<ul style="list-style-type: none"> • Allergic rhinitis in the absence of persistent asthma requiring beta-agonists or oral inhaled corticosteroids, or other comorbidities listed on the OHP Prioritized List, is not covered by OHP. As a value-added benefit to our members, CareOregon does cover chlorpheniramine, diphenhydramine and loratadine for members who do not meet OHP coverage criteria. • Antihistamine-decongestant combination products such as Zyrtec-D®, Allegra-D® and Claritin-D® (loratadine/-pseudoephedrine) are not covered. • Loratadine (≤ #30 tabs or chew tabs per month and syrup) is covered and does not require prior authorization. • Cetirizine OTC is preferred over fexofenadine. • Requests for non-formulary agents require documentation of failure of loratadine OTC, cetirizine OTC and fexofenadine.

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Ondansetron	Treatment with moderately or highly emetogenic chemotherapy or total body, upper hemi-body or abdominal irradiation	<ul style="list-style-type: none"> • <u>Quantity Limit: Chemotherapy</u> <ul style="list-style-type: none"> ➢ 4mg - #18 per cycle; max #72 per month ➢ 8mg - #9 per cycle; max #36 per month ➢ 24mg - #3 per cycle; max #12 per month ➢ Solution - 90ml per cycle; max 360ml per month • <u>Quantity Limit: Radiation</u> 1 dose for each day of radiotherapy per month
Oral Nutritional Supplements	<p>OHP Standard:</p> <ul style="list-style-type: none"> • Oral nutritional supplements must be the member's sole source of nutrition and • Members must meet the following additional criteria for OHP Plus: <p>OHP Plus: Age > 6 years</p> <ol style="list-style-type: none"> 1. Total protein < 5.6 or albumin < 3.4 <li style="text-align: center;">or 2a. RD assessment in the past three months indicates sufficient caloric/protein intake cannot be met through regular, liquefied or pureed foods <li style="text-align: center;">or 2b. One of the following criteria: <ul style="list-style-type: none"> • Prolonged history (years) of malnutrition and diagnosis or symptoms of cachexia and member resides in LTC facility 	<ul style="list-style-type: none"> • Does not include infant formulas that are covered by WIC program • Nutritional formulas, when administered enterally (e.g. g-tube), require prior authorization under the DME benefit. • <u>Quantity limit:</u> 21,330 ml per month

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	<ul style="list-style-type: none"> • Prolonged history (years) of malnutrition and diagnosis or symptoms of cachexia and member lives in an SNF and does not consume meals or food <p>and</p> <p>3. Unplanned weight loss of $\geq 10\%$ and one of the following criteria:</p> <ul style="list-style-type: none"> • Severe trauma resulting in increased metabolic need • Malabsorption difficulty (e.g., short-gut syndrome, bowel resection, fistula, cystic fibrosis, renal dialysis, severe traumatic burn) • Ongoing cancer treatment • Advanced HIV/AIDS • Pulmonary insufficiency, e.g. end-stage emphysema or end-stage COPD <p>OHP Plus: Age ≤ 6 years</p> <p>1. Diagnosis of FTT</p> <p>and</p> <p>2a. Total protein < 5.6 or albumin < 3.4</p> <p>or</p> <p>2b. RD assessment in the past three months indicates sufficient caloric/protein intake is not obtainable through regular, liquefied or pureed foods</p> <p>or</p> <p>2c. One the following criteria:</p> <ul style="list-style-type: none"> • Severe trauma resulting in increased metabolic need • Malabsorption difficulty (e.g., short-gut syndrome, bowel resection, fistula, cystic fibrosis, renal dialysis 	
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	<p>or severe traumatic burn)</p> <ul style="list-style-type: none"> • Ongoing cancer treatment • Advanced HIV/AIDS • Pulmonary insufficiency: e.g. end-stage emphysema or end-stage COPD 	
<p>OxyContin® (Oxycodone sustained release)</p>	<ol style="list-style-type: none"> 1. Chronic pain condition covered by the OHP*, excluding chronic headache and migraine and 2. Documentation of failure of or contraindication to morphine SR <p>*The following diagnoses are not covered for treatment by the OHP: chronic low back pain, neck pain, joint pain, chest pain, abdominal pain, pelvic pain, sciatica, degenerative disc disease without neurologic impairment, fibromyalgia, myofascial pain syndrome and complex regional pain syndrome.</p>	<ul style="list-style-type: none"> • Concurrent use of two or more long-acting opioids is not covered. • There is insufficient evidence to support differences in efficacy or adverse effects among long-acting opioids. For more information, refer to www.oregon.gov/OHPPR/HRC/docs/HRC.Reports/OPIOID.5.2005.Update2.pdf • True allergic reactions to opioids are rare. All opioids can cause histamine release that may result in urticaria, pruritus, sneezing and exacerbation of asthma in predisposed patients. Histamine reactions can be avoided by premedication with diphenhydramine. • Morphine and oxycodone are in the same chemical class and thus have a higher potential for cross-reactivity in patients with a true allergy. • For prescribing information including opioid conversions and managing adverse effects, refer to www.careoregon.org/provider/documents/Opioids_Pain_Management.pdf



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Proton Pump Inhibitors Prevacid®	1. One of the following diagnoses: <ul style="list-style-type: none"> • Acute gastric or duodenal ulcer • Acute GI bleed in the past 6 months • Erosive esophagitis • H.Pylori infection • Symptomatic GERD • Zollinger-Ellison syndrome and 2a. Documentation of failure of formulary alternatives omeprazole 20mg BID or Prilosec OTC 20mg BID if member is able to swallow or not on a G – tube or NG – tube or 2b. Documentation failure of cimetidine liquid or ranitidine syrup and omeprazole suspension if member is unable to swallow or on a G – tube or NG – tube	<ul style="list-style-type: none"> • Omeprazole and Prilosec OTC are covered and do not require prior authorization. • Aciphex®, Nexium® and Zegerid® are non-formulary. • There is no evidence to support differences in efficacy or adverse effects among PPIs for the treatment of GERD, peptic ulcer, non-steroidal ulcer, duodenal ulcer or eradication of Helicobacter Pylori. For more information refer to www.oregon.gov/OHPPR/HRC/docs/HRC.Reports/PPI.7.2006.Update4.pdf • <u>Quantity Limit</u>: Once-daily dosing
Singulair® (Montelukast)	Asthma	Allergic rhinitis in the absence of comorbid asthma requiring drug therapy is not covered by the OHP.
Spiriva® (Tiotropium)	1. COPD or emphysema and 2a. On chronic oxygen or 2b. Spirometry test indicating FEV ₁ /FVC < 70% and FEV ₁ at least < 80% predicted	<ul style="list-style-type: none"> • Ipratropium is a formulary alternative that does not require PA. • <u>Quantity Limit</u>: #30 caps per month

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<p>Subutex® (Buprenorphine)</p>	<p>Initial:</p> <ol style="list-style-type: none"> 16 years and older with opioid dependence diagnosis based on DSM-IV-TR criteria and Not pregnant or likely to become pregnant and Does not have comorbid dependence on benzodiazepines or alcohol and Does not have significant, untreated psychiatric comorbidity and Failed with or unable to go to a methadone maintenance therapy (MMT) or have a documented history of severe adverse reaction or hypersensitivity to methadone and Adequate psychosocial support for office-based therapy <p>Renewal Criteria:</p> <ol style="list-style-type: none"> Documentation of patient is compliant with provider visits and have negative toxicology screens in the past month 	<ul style="list-style-type: none"> Buprenorphine is not covered for the treatment of chronic pain. <u>Initial approval duration:</u> 1 month <u>Renewal duration:</u> every 3 months pursuant to adequate PCP support and negative toxicology. <u>Quantity Limit:</u> #90 per month
<p>Suboxone® (Buprenorphine/ Naloxone)</p>		

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Topamax® (Topiramate)	1. Seizure disorder or 2a. Bipolar disorder and 2b. Documentation of failure of or contraindications to ALL of the following: carbamazepine, lithium and divalproex sodium or 3a. Migraine prophylaxis and 3b. Documentation of failure of or contraindication to two of the following: tricyclic antidepressant, beta blocker, divalproex sodium and calcium channel blocker.	<ul style="list-style-type: none"> • Topamax is not covered when used to promote weight loss consistent with OHP funding. • <u>Quantity Limits</u>:* <ul style="list-style-type: none"> 25mg - #120 per month 50mg - #90 per month 100mg - #90 per month 200mg - #240 per month Sprinkles 15/25mg - #120 per month <p>*Use the next higher strength if exceeding the qty limits.</p>
Trileptal® (Oxcarbazepine)	1. Seizure disorder or 2a. Bipolar Disorder and 2b. Documented failure of or contraindication to all of the following drugs: carbamazepine, lithium and divalproex sodium. or 3a. Trigeminal neuralgia and 3b. Documentation of failure of or contraindication to carbamazepine and gabapentin	
Zetia® (Ezetimibe)	1. Homozygous sitosterolemia or hyperlipidemia and 2. Documentation of contraindication to statins or failure to achieve LDL goal with a statin + niacin or bile acid sequestrant	<ul style="list-style-type: none"> • Formulary statins include lovastatin, pravastatin and simvastatin. • No available evidence shows that ezetimibe reduces the risk of cardiovascular events.