ProCare Rx/Jai Medical Systems Managed Care Organization 2022 Therapeutic Formulary

This formulary describes the circumstances under which pharmacies participating in a particular medical benefit program will be reimbursed for medications dispensed to patients covered by the program. This formulary does not:

- a) Require or prohibit the prescribing or dispensing of any medication.
- b) Substitute for the independent professional judgment of the physician or pharmacist.
- c) Relieve the physician or pharmacist of any obligation to the patient or others.

I. Non-Prescription Medication Policy

The only over-the-counter (OTC) medications that are covered by Jai Medical Systems are listed within the program formulary. All OTC medications, with the exception of OTC emergency contraception, can be reimbursed only if it is written on a valid prescription form by a licensed prescriber. OTC emergency contraception may be obtained without a written prescription; see page 6 of the formulary for limitations.

II. Unapproved Use of Formulary Medication

Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications, which are accepted as safe and effective by the balance of current medical opinion and available scientific evidence, may also be covered. The Pharmacy Benefits Manager (PBM), ProCare Rx, utilizing the procedures outlined in Section IV, will make decisions about reimbursement for these other indications. Experimental, investigational drugs and drugs used for cosmetic purposes are not eligible for coverage.

III. Prior Authorization Procedure

To promote the most appropriate utilization of selected high risk and/or high-cost medication, a prior authorization procedure has been created. The criteria for this system have been established by the ProCare Rx/Jai Medical Systems Managed Care Organization program, with input from pharmacists and physician practitioners and in consideration of the available medical literature. The Pharmacy and Therapeutics Committee will have final approval responsibility for this list. In order for a dispensed prior authorization medication to be reimbursed to the pharmacy, the patient's prescribing physician must apply for pre-authorization for a specific patient and drug. The physician may phone or fax the PBM to initiate a request for prior authorization:

ProCare Rx Prior Authorization Desk 1267 Professional Parkway Gainesville, Georgia 30507 (800) 555-8513 (800) 583-6010 (fax) (866) 999-7736 (alternate fax) Please have patient information, including member ID number, complete diagnosis, medication history, and current medications readily available. Special request forms are required for Hepatitis C treatments and for opioids. All forms can be found online at <u>www.jaimedicalsystems.com/providers/pharmacy/</u>.

A completed, signed prior authorization form is needed in order for a request to be approved, but providers may call the ProCare Rx Prior Authorization department for prior authorization request forms and for help with the prior authorization request process. These phone lines are dedicated to physicians making requests for medications that require prior authorization and non-formulary items. Members cannot be assisted if they call the prior authorization toll-free number, but they may call the ProCare Rx Customer Service Department at 800-213-5640 for help getting a prior authorization form faxed to their provider. For all requests for drugs requiring prior authorization, a decision will be provided within 24 hours of receiving the request. That decision will be to either approve, deny, or request more information. The requesting provider will receive a telecommunication response informing them of this decision. If the requested information is not received, this process could take up to 14 calendar days. If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific patient to receive the requested drug. A prior authorization number will be issued to the prescribing physician and may be clearly written on the top of the prescription to inform the dispensing pharmacist of the approval. This number is for identification purposes only and does not need to be submitted for adjudication to occur. If the request is denied, information about the denial will be provided to the prescribing physician along with the patient and the patient's PCP, when appropriate.

Additionally, most injectables (except Depo-Provera, enoxaparin sodium, Makena, insulin, Glucagon Kit, and formulary epinephrine products) require prior approval. Questions about injectable drugs administered by home health or healthcare providers should be directed to ProCare Rx at 800-555-8513. If the medication will be billed on a medical claim rather than through the pharmacy, the provider may contact the Provider Relations or Utilization Management Departments at 888-524-1999 with any questions.

Our prior authorization criteria can be found on our website, <u>www.jaimedicalsystems.com</u>, as well as in this formulary. Any updates made to our criteria will be posted on the website above within 30 days.

IV. Unique Patient Needs Non-Formulary Medication

This formulary attempts to provide appropriate and cost effective drug therapy to all enrollees of the Jai Medical Systems Managed Care Organization program. If a patient requires medication that is not covered by the formulary, a request can be made for payment of the non-covered item. It is anticipated that such exceptions will be rare, and that formulary medications will be appropriate to treat the vast majority of medical conditions. Requests for non-formulary medications should be made in writing (on the prior authorization form, if possible) and mailed or faxed to:

ProCare Rx Prior Authorization Desk 1267 Professional Parkway Gainesville, Georgia 30507 (800) 555-8513 (800) 583-6010 (fax) (866) 999-7736 (alternate fax) Appropriate documentation must be provided to support the request. For all requests for drugs requiring prior authorization, a decision will be provided within 24 hours of receiving the request. That decision will be either to approve, deny, or request more information. The requesting provider will receive a telecommunication response informing them of this decision. If the requested information is not received, this process could take up to 14 calendar days. Approval of non-formulary items will be considered based upon Maryland Medicaid HealthChoice Benefit Coverage, availability and appropriateness of alternative medications on the formulary, and any applicable criteria sourced or developed by the Pharmacy and Therapeutics Committee of Jai Medical Systems Managed Care Organization, Inc. and the PBM, including the FDA-approved prescribing information for the medication and other information sources, such as UpToDate.

Physicians are expected to comply with this formulary when prescribing medication for those patients covered by Jai Medical Systems Managed Care Organization, Inc. If a pharmacist receives a prescription for a non-formulary medication, the pharmacist should attempt to contact the prescribing physician to request a change to a product included in this formulary guide.

The pharmacy will not be reimbursed for non-formulary medications unless they received prior approval from Jai Medical Systems Managed Care Organization, Inc.

In an emergency situation outside of the PBM's regular business hours where the physician cannot be contacted, the pharmacist is authorized to dispense a 72-hour emergency supply of a medication, unless the medication is classified as a DESI, LTE, or specifically excluded drug category (see Section VI) product or is one of the treatments for Hepatitis C, which should not be dispensed until the member has prior authorization to begin treatment.

The pharmacist should contact the PBM's Help Desk at (800) 213-5640 to arrange for reimbursement for the emergency supply.

V. Newly Marketed Products

Standard medications will be reviewed for coverage decisions within 180 calendar days of FDA approval. Priority medications will be reviewed for coverage decisions within 90 calendar days of FDA approval. Newly marketed drug products will not normally be placed on the formulary during their first year on the market. Exceptions to this rule will be made on a case-by-case basis using the medical necessity procedure.

VI. Specific Exclusions

The following drug categories are not part of the Jai Medical Systems Managed Care Organization formulary and are not covered by the 72-hour emergency supply reimbursement policy:

- Antiobesity products
- Blood and blood plasma
- Cosmetic drugs
- Cough and cold products (except those listed in the formulary)
- DESI drugs
- Diagnostic products (except those listed in the formulary)
- Erectile/sexual dysfunction agents

- Medical supplies and durable medical equipment (except certain diabetic supplies)
- Most vitamins (except those listed in the formulary)
- Nutritional and dietary supplements
- Research drugs
- Topical minoxidil
- Fertility treatment medications, such as ovulation stimulants

VII. Fee-for-Service Carve-outs

In addition to the above exclusions, the following are also excluded from the formulary and are covered by the Maryland Department of Health:

- Mental health drugs (refer to Section VIII). A list of Mental Health medications can be found online at: <u>https://health.maryland.gov/mmcp/pap/pages/paphome.aspx</u> under the Mental Health Formulary link
- Substance use disorder medications, including, but not limited to, buprenorphine, buprenorphine/naloxone, Campral[®], Chantix[®], Revia[®], naloxone, Nicotrol[®], nicotine patches, gum, and lozenges. (Refer to Section VIII). A list of substance use disorder medications is available online at:

https://health.maryland.gov/mmcp/pap/pages/paphome.aspx under the Substance Use Disorder Medication Clinical Criteria Final link

VIII. Behavioral Health Medication Policy

Please refer to the Maryland Department of Health's Mental Health Formulary for a complete listing of behavioral health medications. Any behavioral health medications that are covered by Jai Medical Systems Managed Care Organization are listed in the prescription formulary.

- Kapvay For recipients 6 -17 years old, extended-release clonidine (Kapvay) is part of the mental health formulary and billed fee-for-service. For individuals not in this age range, extended-release clonidine continues to be a part of the MCO pharmacy benefit and would require prior authorization.
- Intuniv For recipients 6 -17 years old, extended-release guanfacine (Intuniv) is part of the mental health formulary and billed fee-for-service. For individuals not in this age range, extended-release guanfacine continues to be a part of the MCO pharmacy benefit and would require prior authorization.

IX. Mandatory Generic Substitution & Therapeutic Interchange

Generic substitution is mandatory when a generic equivalent is available, unless the brand is specified as the preferred medication on the formulary. All branded products that have 3 or more generic equivalents available will be reimbursed at the maximum allowable cost. No other therapeutic interchange is permitted.

X. Specialty Medications

Specialty medications will be covered under the pharmacy benefit for Jai Medical Systems. All requests will undergo prior authorization review when available drug-specific prior authorization criteria will apply. When prior authorization criteria do not exist, the request will be reviewed for FDA approved indications according to Jai Medical Systems Managed Care Organization, Inc.'s approved medical necessity review process. All specialty drug requests should contain the following:

- Drug name, strength, dose, and quantity requested
- Diagnosis for use
- Any previous drug therapies tried and failed, or why medications on the drug list are not appropriate
- Any additional clinical information pertinent to the drug review

XI. High Cost, Low Utilization Medications

In accordance with the Maryland Department of Health's High Cost, Low Volume Drug Risk Mitigation Policy and the Social Security Act 1927 (d)(5), Jai Medical Systems **will not pay** for any of the aforementioned high-cost drugs that are not appropriately pre-certified by Jai Medical Systems. The current list of NDCs and J-Codes Covered by High Cost Low Volume Risk Mitigation Policy can be found on our website at <u>https://www.jaimedicalsystems.com/providers/pharmacy/</u> under the High Cost Low Volume Drugs heading and will be updated as Maryland Medicaid updates the list.

Our health plan will not conduct any retrospective review for these drugs; they must be pre-certified and approved by our plan beforehand. Please be advised that this policy includes both Physician Administered Drugs and retail pharmacy drugs.

Please be advised that this list is subject to change. If you are unsure of whether or not a medication requires prior authorization and/or pre-certification, please contact our Utilization Management Department at 1-888-JAI-1999.

XII. General Parameters

- Members must be enrolled in Jai Medical Systems Managed Care Organization, Inc. at the time the medication is dispensed.
- Valid DEA and NPI numbers are required.
- Refill too soon 75% of the days supplied must elapse before the prescription can be refilled. For opioid medications, 85% of the days supplied must have elapsed before the prescription can be refilled.
- The standard maximum allowable quantity is a 30-day supply. The allowed quantity limit for formulary asthma controller medications and certain statins on the drug list (which cost less than \$100 for a 90-day supply and when the member has already received a 30-day supply first) is a 90-day supply. The quantity limit on most medications is a 400-unit maximum limit per month. Most narcotics have individualized quantity and dosage form limitations, which are listed on page 14 of the formulary. If necessary, a healthcare provider may request a quantity override by contacting ProCare Rx's Prior Authorization Department. Even with an override, the quantity may not exceed a 100-day supply, except for contraceptives as described below. Opioid prescriptions cannot exceed a 30-day supply.

- If a member is new to opioid treatment (no pharmacy claims history of any opioid medication in the previous 90 days), their first fill is limited to no more than a 7-day supply. Effective November 1, 2021, after the initial fill members are limited to 14-day supplies for their opioid medications unless their provider requests prior authorization, or unless they were already receiving greater than 14-day supplies when the change was implemented. If a member stops filling opioid medication for 90 days, they will be considered new to treatment and will lose their approval for greater than 14-day supplies and will need to follow the rules about initial fill limits.
- Contraceptives will be available in up to 12-month supplies when ordered by a qualified practitioner.
- All generic oral contraceptives (including emergency contraceptives) and brand oral contraceptives that do not have a generic version available are formulary. Examples are listed on pages 6 and 7.
- Jai Medical Systems covers most common vaccines through the medical benefit and pharmacy benefit, including all COVID-19 vaccines, most flu vaccines, and most other standard age-appropriate vaccines (as determined by Maryland Medicaid.)
- A current listing of HIV medications covered by Jai Medical Systems are listed on page 3.
- Requests for some medications require special forms. All pharmacy prior authorization request forms can be found online at: http://www.jaimedicalsystems.com/providers/pharmacy/.
- Prior authorization is required for all extended-release opioid products as well as methadone prescribed for pain and any other opioids prescribed for quantities greater than 90 MMEs per day. A specialized form is required for these requests and can be found online at <u>http://www.jaimedicalsystems.com/providers/pharmacy/.</u>
- Prior authorization requests for medications for the treatment of Hepatitis C require a special prior authorization request form. While they still require prior authorization, Jai Medical Systems prefers Mavyret, generic Epclusa, generic Harvoni, and Zepatier, unless they are not medically appropriate. These forms and prior authorization criteria can be found at http://www.jaimedicalsystems.com/providers/pharmacy/.
- Vacation fill overrides may be requested by contacting Jai Medical Systems at 1-800-524-1999. Information from the prescribing doctor or primary care provider may be required before the request can be approved. Requests for vacation overrides for opioids are not generally available.
- Overrides for lost or stolen prescriptions may be requested by contacting Jai Medical Systems at 1-800-524-1999. Information from the prescribing doctor or primary care provider may be required before the request can be approved. Requests for override for lost or stolen opioids are not generally available.

XIII. Where to Call?

PHYSICIANS

Formulary Questions: ProCare Rx	(800) 555-8513
Medical Necessity: ProCare Rx	(800) 555-8513
Prior Authorization: ProCare Rx	(800) 555-8513
Provider Relations: Jai Medical Systems Managed Care Organization, Inc.	(888) JAI-1999
PHARMACISTS	
Provider Network Questions: ProCare Rx	(800) 213-5640
Provider Relations: ProCare Rx	(800) 213-5640

XIV. Abbreviations

Providers are encouraged to prescribe generically available drugs whenever possible and to prescribe firstline lower cost options when appropriate. Drugs are ranked by cost with the following abbreviations:

=	This product has a MAC price attached to some or all strengths.
=	Cost per Rx is <\$20
=	Cost per Rx is <\$40
=	Cost per Rx is \$40 - \$80
=	Cost per Rx is \$80 - \$160
=	Cost per Rx is >\$160
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XV. Reference

The formulary is available online at Formulary Navigator. This is updated monthly and will have the most up-to-date information. Formulary access is free and available at: https://client.formularynavigator.com/Search.aspx?siteCode=9386334079

Links to all Maryland Medicaid Managed Care Organization Formulary Navigator pages can be found on the website listed below:

https://health.maryland.gov/mmcp/pap/pages/Weblinks-for-Providers.aspx

A link to a pdf copy of the Jai Medical Systems formulary and copies of our recent formulary change notices is also available in the Providers section of our homepage: http://www.jaimedicalsystems.com/providers/pharmacy/

XVI. Copays

Currently, there is no copay for active members of Jai Medical Systems Managed Care Organization, Inc.'s HealthChoice Program. Copays may be charged for medications covered directly by Maryland Medicaid (refer to Section VII. Fee-for-Service Carve-Outs.) In accordance with State mandate and in order to follow federal parity rules, copays will be implemented 60 days after the end of the federal health emergency that has resulted from the Coronavirus Disease 2019 (COVID-19) pandemic. Pharmacy copays, once they are implemented, will be set as described below:

- \$1 for all generic drugs, preferred brand name drugs, and HIV/AIDS drugs
- \$3 for non-preferred brand name drugs
- Copays do not apply to family planning drugs (such as birth control).
- Due to federal and state statutory requirements, individuals under the age of 21, pregnant women, and Native Americans are not required to pay copays for prescription drugs in HealthChoice.
- Additionally, in accordance with Medicaid fee-for-service regulations (COMAR 10.09.03.03O), pharmacy providers are not permitted to deny services to any Medicaid participant who is unable to pay the copayments.

XVII. Prior Authorization Auto-Renewal

Jai Medical Systems offers automatic prior authorization renewals for Advair, Symbicort, Wixela, and their generic equivalents. For members with a current approved prior authorization, claims will continue to process as long as the member has filled for that medication within the last 4 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to therapy, or with no claim history of that medication within the last 4 months.

XVIII. Notice of Non-Discrimination

Jai Medical Systems Managed Care Organization, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of language, age, race, color, sex, sexual orientation, national origin, disability, medical condition, or religion against members, contracted providers, staff, and/or nonaffiliated individuals. This includes women, individuals of minority and non-minority groups, individuals of the LGBT community, individuals with disabilities, and/or members with limited English proficiency. Jai Medical Systems Managed Care Organization, Inc. does not exclude people or treat them differently because of language, age, race, color, sex or sexual orientation, national origin, disability, medical condition, or religion.

To ensure effective communication for individuals with disabilities, Jai Medical Systems Managed Care Organization, Inc. shall:

- Provide equal access to auxiliary aids and services as necessary for individuals with disabilities, in accordance with applicable law.
- Include taglines for language accessibility in top 15 languages on the website, and in larger significant publications and significant communications.
- Include taglines for language accessibility in two popular languages in significant publications including Member Handbook, and significant communications.
- Provide free language assistance and interpretation services for members with limited English proficiency to communicate effectively.
- Provide free sign language interpretation for members with hearing disabilities.

• Provide free oral language assistance and written translation through Jai Medical Systems Managed Care Organization, Inc.'s multilingual staff, oral interpreters, and translators.

If you need these services, contact our Non-Discrimination Compliance Coordinator at <tyneisha.thornton@jaimedical.com>. Additionally, information is made available in languages other than English upon request.

XIX. Equal Employment Opportunity Statement

Jai Medical Systems Managed Care Organization, Inc. provides equal employment opportunity for everyone regardless of language, age, sex, color, creed, national origin, pregnancy, ancestry, marital status, political belief, genetic information, and physical or mental disability that does not prohibit performance of essential job functions. In addition, Jai Medical Systems Managed Care Organization, Inc. complies with Section 1557 of the Affordable Care Act, all applicable federal, state, and local anti-discrimination laws. This policy is reflected in all of Jai Medical Systems Managed Care Organization, Inc.'s practices and policies regarding hiring, training, promotions, transfers, rates of pay, layoffs, and other forms of compensation. All matters relating to employment are based upon ability to perform the job, as well as dependability and reliability once hired.

If you believe that Jai Medical Systems Managed Care Organization, Inc. has failed to provide these services or discriminated on the basis of language, age, race, color, sex or sexual orientation, national origin, disability, medical condition, or religion, you can file a grievance with:

TyNeisha Smith, Non-Discrimination Compliance Coordinator Jai Medical Systems Managed Care Organization, Inc. 301 International Circle, Hunt Valley, MD 21030 Phone: 410-433-2200 | Fax: 410-433-4615 | Email: <tyneisha.thornton@jaimedical.com>

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Non-Discrimination Compliance Coordinator is available to help you. Grievances must be submitted to the Coordinator within sixty days of the date you become aware of the alleged discrimination.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.https//ocrportal.htttps://ocrportal.htttps//ocrportal.ht

U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 Phone: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

XX. Language Accessibility Statement

Interpreter Services are Available for Free Help is available in your language: 1-888-524-1999 (TTY: 1-800-735-2258). These services are available for free.

Español/Spanish

Hay ayuda disponible en su idioma: 1-888-524-1999 (TTY: 1-800-735-2258). Estos servicios están disponibles gratis.

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እንዛ በ **ቋንቋዎ ማ**ግኘት ይችላሉ፦: 1-888-524-1999 (TTY:

1-800-735-2258)። እነዚህ አባልግሎቶች ያለክፍያ የሚገኙ ነጻናቸው

Arabic/ ال عرب ية

المساعدة متوفرة في لنتك: اتصل على الرقم: متوفرة المعاقين سمعيا: 1-888-524-1999 2258 ذه خلـه مرت خم فخه الـم ا جَ

Français/French

Vous pouvez disposer d'une assistance dans votre langue : 1-888-524-1999 (TTY: 1-800-735-2258). Ces services sont disponibles pour gratuitement.

ગજુ રાતી/Gujarati

તમારી ભાષામાાં મદદ ઉપલબ્ધ છે: 1-888-524-1999 (ટીટીવાય: 1-

800-735-2258). સેવાઓ મફત ઉપલબ્ધ છે

kreyòl ayisyen/Haitian Creole

Gen èd ki disponib nan lang ou: 1-888-524-1999 (TTY: 1-800-735-2258). Sèvis sa yo disponib gratis.

Igbo

Enyemaka di na asusu gi: 1-888-524-1999 (TTY: 1-800-735-2258). Qru ndi a di na enweghi ugwo i ga akwu maka ya.

한국어/Korean 사용하시는 언어로 지원해드립니다: 1-888-524-1999 (TTY: 1-800-735-2258). 무료로 제공 됩니다

Português/Portuguese

A ajuda está disponível em seu idioma: 1-888-524-1999 (TTY: 1-800-735-2258). Estes serviços são oferecidos de graça.

Русский/Russian

Помощь доступна на вашем языке: 1-888-524-1999 (ТТҮ: 1-800-735-2258). Эти услуги предоставляются бесплатно.

中文/Chinese 用您的语言为您提供帮助:1-888-524-1999 (TTY:1-800-735-2258)) 9. 这些服务都是免费 酌

Farsi/فارای

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Tagalog

Makakakuha kayo ng tulong sa iyong wika: 1-888-524-1999 (TTY: 1-800-735-2258). Ang mga serbisyong ito ay libre.

اردو/Urdu

-1-888-524 (ثي ثي والي: 1999 آپ کی زبان میں مدد دستیاب ہے: 1-800-735-2258 ں ے ہا یہ تسد ہے کہ لے کہ تف م تامدخہ

Tiếng Việt/Vietnamese

Hỗ trợ là có sẵn trong ngôn ngữ của quí vị 1-888-524-1999 (TTY: 1-800-735-2258). Những dịch vụ này có sẵn miễn phí.

Yorùbá/Yoruba Irànló wó wà ní àró wó tó ní èdè re: 1-888-524-1999 (TTY: 1-800-735-2258). Awon ise yi wa fun o free.

Generic Name	Brand Name	Annotation
I. ANTI-INFECTIVE AGENTS		
PENICILLINS		
 \$ Amoxicillin* \$ Ampicillin* \$ Penicillin G Benzathine \$ Penicillin V Potassium* 	AMOXIL AMPICILLIN BICILLIN PENICILLIN V POTASSIUM	no chewables
Penicillinase-resistant \$ Dicloxacillin Sodium* \$ Oxacillin*	DICLOXACILLIN SODIUM OXACILLIN	
\$ Cloxacillin Sodium* Prior Authorization Requ	CLOXACILLIN SODIUM Jired	
Penicillin Combinations \$\$\$ Amox & K Clavulanate*	AUGMENTIN	no chewables
CEPHALOSPORINS		
Cephalosporins - 1st Generation \$\$ Cephalexin* \$\$ Cephradine*	KEFLEX CEPHRADINE	no tablets
Cephalosporins - 2nd Generation \$\$ Cefaclor* \$\$\$ Cefprozil* \$\$\$ Cefuroxime* \$\$\$ Loracarbef	CEFACLOR CEFPROZIL CEFTIN LORABID SUSPENSION	oral tablets only covered for children under 12 yrs old
Cephalosporins - 3rd Generation \$ Cefixime \$\$\$ Ceftriaxone* \$\$\$ Cefdinir*	SUPRAX ROCEPHIN CEFDINIR	QL = 1 tab
MACROLIDE ANTIBIOTICS		
Erythromycins \$ Erythromycin Base* \$ Erythromycin Estolate* \$ Erythromycin Ethylsuccinate* \$ Erythromycin Stearate*	ERY-TAB ERYTHROMYCIN ESTOLATE E.E.S. ERYTHROCIN	
Lincomycins \$\$ Clindamycin*	CLEOCIN	
Misc. Macrolide Antibiotics \$\$ Azithromycin* \$\$\$ Azithromycin suspension*	ZITHROMAX ZITHROMAX	QL = 1 single dose packet
\$\$\$ Clarithromycin*	BIAXIN	
TETRACYCLINES \$\$\$ Doxycycline* \$ Tetracycline*	VIBRAMYCIN SUMYCIN	no tablets
FLUOROQUINOLONES		
\$\$\$ Ciprofloxacin* \$\$\$\$ Levofloxacin*	CIPRO LEVAQUIN	
\$\$\$\$ Moxifloxacin* Prior Authorization Requ	AVELOX	QL 14 per 30 days
ANTIMALARIAL		
<pre>\$ Chloroquine* \$ Hydroxychloroquine* \$\$\$\$\$ Pyrimethamine</pre>	ARALEN PLAQUENIL DARAPRIM	no 500mg tabs

<u>Generic Name</u>	Brand Name	<u>Annotation</u>
ANTHELMINTIC		
\$\$ Albendazole \$\$ Ivermectin* \$\$ Pyrantel Pamoate*	ALBENZA STROMECTOL PIN - X	tablets only OTC product
AMINOGLYCOSIDES		
<pre>\$ Gentamicin Sulfate* \$ Neomycin Sulfate*</pre>	GARAMYCIN NEOMYCIN	tablets only
SULFONAMIDES		
 \$ Erythromycin/Sulfisoxazole* \$ Sulfadiazine* \$ Sulfasalazine* \$ Sulfisoxazole* \$ Trimethoprim/Sulfamethoxazole* 	ERYTHROMYCIN/SULFISOXAZOLE SULFADIAZINE AZULFIDINE SULFISOXAZOLE BACTRIM / DS	no EN tabs
ANTIMYCOBACTERIAL AGENTS		
\$\$\$\$ Cycloserine \$\$\$ Ethambutol* \$\$\$ Ethionamide \$ Isoniazid* \$\$\$ Pyrazinamide* \$\$\$\$ Rifabutin* \$\$\$\$ Rifampin*	SEROMYCIN MYAMBUTOL TRECATOR ISONIAZID PYRAZINAMIDE MYCOBUTIN RIFADIN	
MISC. ANTIINFECTIVES		
 \$ Metronidazole* \$ Trimethoprim* \$\$ Chlorhexidine* 	FLAGYL TRIMETHOPRIM PERIOGARD	0.12% oral rinse
Leprostatics \$ Dapsone*	DAPSONE	
ANTIFUNGALS		
 \$ Griseofulvin Microsize* \$ Griseofulvin Ultramicrosize* \$ Nystatin* 	GRIFULVIN V GRIS-PEG NYSTATIN TAB	
Imidazole-Related Antifungals		
<pre>\$ Ketoconazole* \$ Miconazole* \$\$ Terbinafine*</pre>	NIZORAL MONISTAT LAMISIL	OTC product
\$\$ Itraconazole* Prior Authorization Re	SPORANOX quired	
Triazoles		
\$ Fluconazole*	DIFLUCAN	150mg x2 tablets/month is formulary. Authorization required for higher
Prior Authorization Re	quired	quantity or other stengths
ANTIVIRAL		
Neuraminidase Inhibitors \$\$ Oseltamivir Phosphate	TAMIFLU	QL=1 course of treatment
\$\$ Zanamivir	RELENZA	per calendar year QL=1 course of treatment per calendar year
CMV Agents \$\$\$\$ Ganciclovir*	CYTOVENE	

<u>Generic Name</u>	Brand Name	<u>Annotation</u>
Hepatic Agents		
\$\$\$\$\$ Lamivudine HBV	EPIVIR	
\$\$\$\$\$ Tenofovir Disoproxil Fumarate	VIREAD	QL = 30 tabs / month
\$\$\$\$\$ Elbasvir-Grazoprevir	ZEPATIER	Preferred for types 1,4
\$\$\$\$\$ Glecaprevir-Pibrentasvir	MAVYRET	Preferred all types
\$\$\$\$\$ Sofosbuvir-Velpatasvir*	GENERIC EPCLUSA	Preferred all types
\$\$\$\$\$ Sofosbuvir-Velpatasvir-Voxilaprevir	VOSEVI	Retreatment only
\$\$\$\$\$ Peginterferon	PEG-INTRON, PEGASYS	Reactanient only
\$\$\$\$\$ Ribavirin*	REBETOL	
\$\$\$\$\$ Ledipasvir-Sofosbuvir*	GENERIC HARVONI	Preferred for 1,4,5,6
	lease see www.jaimedicalsystems.com/provide	
for forms and full	Maryland Medicaid prior authorization criteria	**
Herpes Agents		
\$\$ Amantadine*	AMANTADINE	
\$\$\$ Acyclovir*	ZOVIRAX	PA for ointment & susp.
LIV (Agonto		
HIV Agents \$\$\$\$\$ Abacavir	ZIAGEN	QL = 60 tabs / month
\$\$\$\$\$ Abacavir-Lamivudine	EPZICOM	QL = 30 tabs / month
\$\$\$\$\$ Abacavir-Lamivudine-Zidovudine	TRIZIVIR	QL = 60 tabs / month
\$\$\$\$\$ Atazanavir Sulfate	REYATAZ	QL = 30 tabs / month
\$\$\$\$\$ Efavirenz / Emtricitabine / TDF	ATRIPLA GENERIC	QL = 30 tabs / month QL = 30 tabs / month
\$\$\$\$\$ Bictegravir / Emtricitabine / TAF	BIKTARVY	QL = 30 tabs / month QL = 30 tabs / month
\$\$\$\$\$ Emtricitabine / Rilpivirine / TDF	COMPLERA	QL = 30 tabs / month QL = 30 tabs / month
\$\$\$\$\$\$ Efavirenz	SUSTIVA	QL = 60 tabs / month
\$\$\$\$\$ Atazanavir and Cobicistat	EVOTAZ	QL = 30 tabs / month
\$\$\$\$\$ Elvitegravir / Cobicistat / FTC / TAF	GENVOYA	QL = 30 tabs / month
\$\$\$\$\$\$ Etravirine	INTELENCE	QL = 60 tabs / month
\$\$\$\$\$ Raltegravir	ISENTRESS	QL = 60 tabs / month
\$\$\$\$\$ Dolutegravir / Rilpivirine	JULUCA	QL = 30 tabs / month
\$\$\$\$\$ Lopinavir / Ritonavir	KALETRA	QL = 120 tabs / month
\$\$\$\$\$ Lamivudine	EPIVIR	QL = 30 tabs / month
\$\$\$\$\$ Lamivudine-Zidovudine	COMBIVIR	QL = 60 tabs / month
\$\$\$\$ Emtricitabine / Rilpivirine / TAF	ODEFSEY	QL = 30 tabs / month
\$\$\$\$\$ Darunavir and Cobicistat	PREZCOBIX	QL = 30 tabs / month
\$\$\$\$\$ Darunavir Ethanolate	PREZISTA	QL = 60 tabs / month
\$\$\$\$\$ Atazanavir	REYATAZ	QL = 30 tabs / month
\$\$\$\$ Elvitegravir / Cobicistat / FTC / TDF	STRIBILD	QL = 30 tabs / month
\$\$\$\$\$ Darunavir / Cobicistat / FTC / TAF	SYMTUZA	QL = 30 tabs / month
\$\$\$\$\$ Emtricitabine / Tenofovir DF	TRUVADA GENERIC	QL = 30 tabs / month
\$\$\$\$\$ Emtricitabine / Tenofovir Alafenamide	DESCOVY	QL = 30 tabs / month
\$\$\$\$\$ Tenofovir Disoproxil Fumarate	VIREAD	QL = 30 tabs / month
\$\$\$\$\$ Dolutegravir	TIVICAY	QL = 30 tabs / month
\$\$\$\$\$ Dolutegravir / Abacavir / Lamivudine	TRIUMEQ	QL = 30 tabs / month
\$\$\$\$\$ Zidovudine	RETROVIR	QL = 60 tabs / month
\$\$\$\$\$ Fosamprenavir	LEXIVA	QL = 60 tabs / month
\$\$\$\$\$ Ritonavir	NORVIR	QL = 30 tabs / month
\$\$\$\$ Nevirapine	VIRAMUNE	QL = 60 tabs / month
\$\$\$\$\$ Stavudine	ZERIT	QL = 60 tabs / month

II. BIOLOGICALS

ANTISERA

Antiviral Monoclonal Antibodies

, and monoclosed at , and		
\$\$\$\$ Palivizumab	SYNAGIS	
Pric	or Authorization Required	

III. ANTINEOPLASTICS

ANTINEOPLASTICS

MYLERAN
LEUKERAN
CYTOXAN
ALKERAN

<u>Generic Name</u>	Brand Name	Annotation
Nitrosoureas		
\$\$\$\$ Lomustine	LOMUSTINE	
Antimetabolites		
\$\$\$\$\$ Capecitabine*	XELODA	
\$\$\$\$ Fluorouracil*	EFUDEX	2% and 5% cream only
\$\$\$\$\$ Mercaptopurine*	PURINETHOL	
\$\$\$\$ Methotrexate*	RHEUMATREX	
\$\$\$\$\$ Thioguanine	TABLOID	
Progestins-Antineoplastic		
\$\$\$\$ Megestrol*	MEGACE	Tabs & Oral Susp
Antiandrogens		
\$\$\$\$\$ Flutamide*	FLUTAMIDE	
Aromatase Inhibitors		
\$\$\$\$\$ Letrozole*	FEMARA	
\$\$\$\$\$ Anastrozole*	ARIMIDEX	
\$\$\$\$ Exemestane*	AROMASIN	
Antineoplastic Hormones Misc.		
\$\$\$\$\$ Bicalutamide*	CASODEX	
\$\$\$\$ Tamoxifen*	TAMOXIFEN	
\$\$\$\$\$ Leuprolide Prior Authorization Re		
Mitotic Inhibitors		
\$\$\$\$ Etoposide*	ETOPOSIDE	
Antineoplastics Misc.		
\$\$\$\$\$ Afatinib Dimaleate	GILOTRIF	
\$\$\$\$\$ Erlotinib	TARCEVA	
\$\$\$\$ Hydroxyurea*	HYDREA	
\$\$\$\$\$ Mitotane	LYSODREN	
\$\$\$\$\$ Procarbazine	MATULANE	
\$\$\$\$ Sorafenib	NEXAVAR	
\$\$\$\$\$ Interferon Alfa-2A	ROFERON-A	
\$\$\$\$\$ Interferon Alfa-2B \$\$\$\$\$ Interferon Alfa-n3	INTRON-A ALFERON N	
Prior Authorization Re		
Prior Authorization Re	quired	

IV. ENDOCRINE & METABOLIC DRUGS

CORTICOSTEROIDS

Glucocorticosteroids		
\$ Cortisone*	CORTISONE	
\$ Dexamethasone*	DEXAMETHASONE	no dose paks
\$ Hydrocortisone*	CORTEF	
\$ Methylprednisolone*	MEDROL	tabs & dose packs
\$ Prednisone*	PREDNISONE	
\$ Prednisolone*	PRELONE	
\$\$ Prednisolone Na Phosphate*	PEDIAPRED	
\$\$ Prednisolone Na Phosphate*	ORAPRED	
\$ Prednisolone Acetate	FLO-PRED	
Mineralocorticoids		
\$ Fludrocortisone*	FLUDROCORTISONE	
ANDROGEN-ANABOLIC		
Androgens		
\$\$\$ Methyltestosterone	ANDROID	
\$\$\$ Danazol*	DANAZOL	
\$\$\$ Testosterone Gel, Injection	ANDROGEL, TESTIM	
Prior Authorization F	Required	

<u>Generic Name</u>	Brand Name	Annotation
ESTROGENS		
 \$ Estradiol* \$\$ Esterified Estrogens \$\$ Estrogens, Conjugated \$\$\$ Estradiol TD Patch* 	ESTRACE MENEST PREMARIN CLIMARA	
Estrogen Combinations \$\$ Conjugated Estrogens & Medroxyprogesterone	PREMPRO	
CONTRACEPTIVES ***All generic oral contraceptives are formula	ry***	
Progestin \$\$\$ Norethindrone* \$\$ Norethindrone*	NOR-QD, ORTHO MICRON LYLEQ	Females only Females only
Combinations \$\$ Desogestrel & Ethinyl Estradiol* \$\$ Drospirenone-Ethinyl Estradiol* \$\$ Drospirenone-Eth Estrad Levomefolate \$\$ Ethynodiol Diacet-Eth Estrad* \$\$\$ Ethongestrel-Ethinyl Estradiol \$\$ Levonorgestrel & Ethinyl Estradiol*	DESOGEN, ORTHO-CEPT YASMIN, YAZ SAFYRAL, BEYAZ ZOVIA NUVARING, ELURYNG NORDETTE, AVIANE, ICLEVIA, DOLISHALE	Females only Females only Females only QL= 1 ring / month, Females only Females only
 \$\$ Norethindrone-Ethinyl Estradiol* \$\$ Norethindrone Ace-Ethinyl Estradiol* \$\$ Norgestrel-Ethinyl Estradiol* \$\$ Norgestimate-Ethinyl Estradiol* \$\$ Norethindrone & Ethinyl Estrad FE* \$\$ Norethindrone Ace-Ethinyl Estrad FE* \$\$ Norethindrone Ace-Ethinyl Estradiol* 	MODICON, BREVICON LOESTRIN CRYSELLE, OGESTREL ORTHO-CYCLEN FEMCON FE LOESTRIN FE XULANE, ZAFEMY	Females only Females only Females only Females only Females only Females only Females only
Biphasic \$\$ Desogest-Eth Estrad & Eth Estrad \$\$ Norethindrone-Mestranol \$\$ Norethindrone-Ethinyl Estradiol FE	MIRCETTE NORINYL, NECON LO LOESTRIN FE	Females only Females only Females only
Triphasic \$\$ Desogest-Ethin Est* \$\$ Levonorgestrel-Eth Estradiol* \$\$ Norethindrone-Ethinyl Estradiol* \$\$ Norgestimate-Ethinyl Estradiol* \$\$ Norethindrone Ac-Ethinyl Estradiol* \$ Norethindrone-Ethinyl Estradiol* \$ Norethindrone-Ethinyl Estradiol* Four Phase	CYCLESSA TRIVORA ORTHO NOVUM 7/7/7 ORTHO TRI-CYCLEN / LO ESTROSTEP FE NYLIA 7/7/7 TRI-NYMYO	Females only Females only Females only Females only Females only Females only Females only
\$\$ Estradiol Valerate-Dienogest	NATAZIA	Females only
Extended \$\$ Levonorgestrel-Ethinyl Estradiol*	SEASONIQUE, QUARTETTE, LOSEASONIQUE	Females only
Continuous \$\$ Levonorgestrel-Ethinyl Estradiol	AMETHYST	Females only
PROGESTINS		,
\$\$\$\$\$ Hydroxyprogesterone	MAKENA	Special prescription form
 \$ Medroxyprogesterone* \$\$ Medroxyprogesterone Acetate \$ Norethindrone Acetate* 	PROVERA DEPO-PROVERA, DEPO-SQ PROVERA 104 AYGESTIN	from manufacturer tabs only / females only Females only Females only
EMERGENCY CONTRACEPTIVE		
\$\$ Levonorgestrel*	PLAN B ONE STEP PLAN B	1 kit / month; 3 kits / yr Females only No prescription required for OTC formulation

<u>Generic Name</u>	Brand Name	<u>Annotation</u>
ANTIDIABETIC		
Thiazolidinediones/Combination		
\$\$\$\$\$ Pioglitazone*	ACTOS	QL = 30 tabs / month
\$\$\$\$ Pioglitazone-Glimepiride*	DUETACT	QL = 30 tabs / month
\$\$\$\$ Pioglitazone-Metformin*	ACTOPLUS MET	QL = 30 tabs / month
\$\$\$\$ Pioglitazone-Metformin SR	ACTOPLUS MET XR	QL = 30 tabs / month
Human Insulin		
\$ Insulin Aspart	NOVOLOG	
\$ Insulin Isophane	HUMULIN N, NOVOLIN N	
\$ Insulin Reg & Isophane	HUMULIN 50/50	
\$ Insulin Reg & NPH	HUMULIN 70/30, NOVOLIN 70/30	
\$ Insulin Regular \$ Insulin Lispro	HUMULIN R, NOVOLIN R HUMALOG, ADMELOG	
\$ Insulin Clargine	LANTUS, BASAGLAR, SEMGLEE, TOUJEO	
+++	,,,, ,, ,, ,	
Sulfonylureas		
\$\$ Glimepiride*	AMARYL	
\$\$ Glipizide* \$\$ Glyburide*	GLUCOTROL/XL DIABETA, GLYNASE	
φφ Olybande		
Alpha-Glucosidase Inhibitors		
\$\$\$\$ Acarbose* Prior Authorization Requ	PRECOSE	QL = 90 tabs / month
The Autorization Requ	11 6 4	
Dipeptidyl Peptidase-4 inhibitors		
\$\$\$\$ Sitagliptin Phosphate Prior Authorization Requ	JANUVIA	
	lieu	
Incretin Mimetic		
\$\$\$\$ Exenatide	BYDUREON	
\$\$\$\$\$ Liraglutide	VICTOZA	
\$\$\$\$ Dulaglutide Prior Authorization Requ	TRULICITY	Brand Only
	lieu	
Sodium-Glucose Cotransporter 2 Inhibitors		
\$\$\$\$ Dapagliflozin	FARXIGA	
\$\$\$\$\$ Empagliflozin	JARDIANCE	
Prior Authorization Requ	irea	
Meglitinides		
\$\$\$\$\$ Repaglinide	PRANDIN	
Prior Authorization Requ	ired	
Diabetic Other		
\$ Metformin*	GLUCOPHAGE	
\$ Metformin Extended Release	GLUCOPHAGE XR	
\$\$\$\$\$ Glucagon	GLUCAGON	
\$\$\$\$\$ Empagliflozin/linagliptin Prior Authorization Regu	GLYXAMBI	
The Autorization Requ	11 6 0	
THYROID		
Thyroid Hormones \$ Levothyroxine*	LEVOXYL, SYNTHROID, THYQUIDITY	
\$ Liothyronine*	CYTOMEL	
\$ Thyroid*	THYROID	
Antithyroid Agents		
<pre>\$ Methimazole* \$ Propylthiouracil*</pre>	TAPAZOLE PROPYLTHIOURACIL	
\$ FTOPytthourach	FILOFTETHIOONACIE	
OXYTOCICS		
\$ Methylergonovine*	METHERGINE	
MISC. ENDOCRINE		
Calcium Regulators		
<pre>\$\$\$\$ Calcitonin (Salmon) \$\$\$\$ Calcitonin (Salmon)*</pre>	MIACALCIN INJ MIACALCIN NASAL	

\$\$\$\$ Calcitonin (Salmon)* MIACALCIN NASAL Prior Authorization Required

<u>Generic Name</u>	Brand Name	Annotation
Hormono Rocontor Modulatoro		
Hormone Receptor Modulators \$\$\$\$\$ Raloxifene*	EVISTA	
Prior Authorization F	Required	
Gonadotropin Releasing Hormones		
\$\$\$\$\$ Nafarelin Prior Authorization I	SYNAREL	
The Autorization	Vequireu	
Growth Hormone		
\$\$\$\$ Somatropin	HUMATROPE ONLY	
Prior Authorization F	Required	
Posterior Pituitary		
<pre>\$\$\$ Alendronate* \$\$\$\$ Alendronate + Cholecalciferol</pre>	FOSAMAX FOSAMAX PLUS D	
\$\$\$\$ Ibandronate*	BONIVA	
\$\$\$\$ Risedronate	ACTONEL	
\$\$\$\$ Desmopressin* Prior Authorization I	DDAVP Required	(all dosage forms)
	•	
Parathyroid Hormone \$\$\$\$\$ Teriparatide	FORTEO	
•		
V. CARDIOVASCULAR AGENTS		
CARDIOTONICS		
Digitalis		
\$ Digoxin*	LANOXIN	no caps
PED Inhibitors \$\$\$\$ Sildenafil Citrate	REVATIO	20mg tablets and
Prior Authorization F	Required	10mg/mL liquid
ANTIANGINAL AGENTS		
Nitrotoo		
Nitrates		
Sosorbide Dinitrate [*]	ISORDIL, ISORDIL TEMBIDS	
<pre>\$ lsosorbide Dinitrate* \$ Nitroglycerin (oral)*</pre>	ISORDIL, ISORDIL TEMBIDS NITROSTAT	
<pre>\$ Nitroglycerin (oral)* \$\$\$ Nitroglycerin (topical)*</pre>	NITROSTAT NITRODUR,NITROBID	
\$ Nitroglycerin (oral)*	NITROSTAT NITRODUR,NITROBID IMDUR	
 \$ Nitroglycerin (oral)* \$\$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate* Prior Authorization F 	NITROSTAT NITRODUR,NITROBID IMDUR	
<pre>\$ Nitroglycerin (oral)* \$\$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate*</pre>	NITROSTAT NITRODUR,NITROBID IMDUR	
 \$ Nitroglycerin (oral)* \$\$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate* Prior Authorization F Antianginals-Other \$ Dipyridamole* 	NITROSTAT NITRODUR,NITROBID IMDUR Required	
 \$ Nitroglycerin (oral)* \$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate* Prior Authorization F Antianginals-Other	NITROSTAT NITRODUR,NITROBID IMDUR Required	
 \$ Nitroglycerin (oral)* \$\$ Nitroglycerin (topical)* \$ Isosorbide Mononitrate* Prior Authorization I Antianginals-Other \$ Dipyridamole* BETA BLOCKERS Beta Blockers Non-Selective	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE	
 \$ Nitroglycerin (oral)* \$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate* Prior Authorization F Antianginals-Other \$ Dipyridamole* BETA BLOCKERS Beta Blockers Non-Selective \$ Propranolol* 	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE INDERAL/LA	
 \$ Nitroglycerin (oral)* \$\$ Nitroglycerin (topical)* \$ Isosorbide Mononitrate* Prior Authorization I Antianginals-Other \$ Dipyridamole* BETA BLOCKERS Beta Blockers Non-Selective	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE	
\$ Nitroglycerin (oral)* \$\$ Nitroglycerin (topical)* \$ Isosorbide Mononitrate* Prior Authorization F Antianginals-Other \$ Dipyridamole* BETA BLOCKERS Beta Blockers Non-Selective \$ Propranolol* \$ Timolol* \$ Betaxolol \$\$ Sotalol*	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE INDERAL/LA TIMOLOL BETAXOLOL BETAXOLOL BETAPACE	
\$ Nitroglycerin (oral)* \$\$ Nitroglycerin (topical)* \$ Isosorbide Mononitrate* Prior Authorization F Antianginals-Other \$ Dipyridamole* BETA BLOCKERS Beta Blockers Non-Selective \$ Propranolol* \$ Timolol* \$ Betaxolol	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE INDERAL/LA TIMOLOL BETAXOLOL	
\$ Nitroglycerin (oral)* \$\$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate* Prior Authorization If Antianginals-Other \$ Dipyridamole* BETA BLOCKERS Beta Blockers Non-Selective \$ Propranolol* \$ Timolol* \$ Betaxolol \$\$\$ Sotalol* \$\$\$ Sotalol* \$\$\$ Carvedilol* Beta Blockers Cardio-Selective	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE INDERAL/LA TIMOLOL BETAXOLOL BETAXOLOL BETAPACE COREG	
\$ Nitroglycerin (oral)* \$\$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate* Prior Authorization I Antianginals-Other \$ Dipyridamole* BETA BLOCKERS Beta Blockers Non-Selective \$ Propranolol* \$ Timolol* \$ Betaxolol \$\$\$ Sotalol* \$\$\$ Sotalol* \$\$\$\$ Carvedilol* Beta Blockers Cardio-Selective \$ Atenolol*	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE INDERAL/LA TIMOLOL BETAXOLOL BETAPACE COREG TENORMIN	
\$ Nitroglycerin (oral)* \$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate* Prior Authorization F Antianginals-Other \$ Dipyridamole* BETA BLOCKERS Beta Blockers Non-Selective \$ Propranolol* \$ Timolol* \$ Betaxolol \$\$\$ Sotalol* \$\$\$ Sotalol* \$\$\$ Carvedilol* Beta Blockers Cardio-Selective \$ Atenolol* \$ Metoprolol Tartrate*	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE INDERAL/LA TIMOLOL BETAXOLOL BETAPACE COREG TENORMIN LOPRESSOR	
 \$ Nitroglycerin (oral)* \$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate* Prior Authorization F Antianginals-Other Dipyridamole* BETA BLOCKERS Beta Blockers Non-Selective \$ Propranolol* \$ Timolol* \$ Betaxolol \$\$\$ Sotalol* \$\$\$ Carvedilol* Beta Blockers Cardio-Selective \$ Atenolol* \$ Metoprolol Tartrate* \$\$\$ Metoprolol Succinate* 	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE INDERAL/LA TIMOLOL BETAXOLOL BETAPACE COREG TENORMIN	
 \$ Nitroglycerin (oral)* \$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate* Prior Authorization F Antianginals-Other Dipyridamole* BETA BLOCKERS Beta Blockers Non-Selective \$ Propranolol* \$ Timolol* \$ Betaxolol \$\$\$ Sotalol* \$\$\$ Sotalol* \$\$\$ Carvedilol* Beta Blockers Cardio-Selective \$ Atenolol* \$ Metoprolol Tartrate* \$\$\$ Metoprolol Succinate* Alpha-Beta Blockers 	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE INDERAL/LA TIMOLOL BETAXOLOL BETAPACE COREG TENORMIN LOPRESSOR TOPROL XL	
 \$ Nitroglycerin (oral)* \$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate* Prior Authorization F Antianginals-Other Dipyridamole* BETA BLOCKERS Beta Blockers Non-Selective \$ Propranolol* \$ Timolol* \$ Betaxolol \$\$\$ Sotalol* \$\$\$ Carvedilol* Beta Blockers Cardio-Selective \$ Atenolol* \$ Metoprolol Tartrate* \$\$\$ Metoprolol Succinate* 	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE INDERAL/LA TIMOLOL BETAXOLOL BETAPACE COREG TENORMIN LOPRESSOR	
 \$ Nitroglycerin (oral)* \$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate* Prior Authorization F Antianginals-Other Dipyridamole* BETA BLOCKERS Beta Blockers Non-Selective \$ Propranolol* \$ Timolol* \$ Betaxolol \$\$\$ Sotalol* \$\$\$ Sotalol* \$\$\$ Carvedilol* Beta Blockers Cardio-Selective \$ Atenolol* \$ Metoprolol Tartrate* \$\$\$ Metoprolol Succinate* Alpha-Beta Blockers 	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE INDERAL/LA TIMOLOL BETAXOLOL BETAPACE COREG TENORMIN LOPRESSOR TOPROL XL	
<pre>\$ Nitroglycerin (oral)* \$\$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate* Prior Authorization F Antianginals-Other \$ Dipyridamole* BETA BLOCKERS Beta Blockers Non-Selective \$ Propranolol* \$ Timolol* \$ Betaxolol \$\$\$ Sotalol* \$\$\$ Sotalol* \$\$\$ Carvedilol* Beta Blockers Cardio-Selective \$ Atenolol* \$ Metoprolol Tartrate* \$\$\$ Metoprolol Succinate* Alpha-Beta Blockers \$\$\$ Labetalol* \$\$\$ Labetalol* \$\$\$\$ \$\$\$\$ \$\$\$ \$\$\$ \$\$\$ \$\$\$ \$\$\$ \$\$\$ \$\$\$</pre>	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE INDERAL/LA TIMOLOL BETAXOLOL BETAPACE COREG TENORMIN LOPRESSOR TOPROL XL	
\$ Nitroglycerin (oral)* \$\$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate* Prior Authorization F Antianginals-Other \$ Dipyridamole* Beta Blockers Beta Blockers Non-Selective \$ Propranolol* \$ Timolol* \$ Betaxolol \$\$\$ Sotalol* \$\$\$ Sotalol* \$\$\$ Carvedilol* Beta Blockers Cardio-Selective \$ Atenolol* \$ Metoprolol Tartrate* \$\$\$ Metoprolol Succinate* Alpha-Beta Blockers \$\$\$ Labetalol* CALCIUM BLOCKERS \$\$\$ Amlodipine* \$\$\$ Amlodipine & Benazepril*	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE INDERAL/LA TIMOLOL BETAXOLOL BETAPACE COREG TENORMIN LOPRESSOR TOPROL XL TRANDATE NORVASC LOTREL	
 \$ Nitroglycerin (oral)* \$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate* Prior Authorization F Antianginals-Other Dipyridamole* BETA BLOCKERS Beta Blockers Non-Selective \$ Propranolol* \$ Timolol* \$ Betaxolol \$\$\$ Sotalol* \$\$\$ Carvedilol* Beta Blockers Cardio-Selective \$ Atenolol* \$ Metoprolol Tartrate* \$\$\$ Metoprolol Succinate* Alpha-Beta Blockers \$\$\$ Labetalol* CALCIUM BLOCKERS \$\$\$ Amlodipine* \$\$\$ Amlodipine* \$\$\$ Diltiazem* 	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE INDERAL/LA TIMOLOL BETAXOLOL BETAPACE COREG TENORMIN LOPRESSOR TOPROL XL TRANDATE NORVASC LOTREL CARDIZEM/CD, DILACOR/XR	
\$ Nitroglycerin (oral)* \$\$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate* Prior Authorization F Antianginals-Other \$ Dipyridamole* Beta Blockers Non-Selective \$ Propranolol* \$ Timolol* \$ Betaxolol \$\$\$ Sotalol* \$\$\$ Sotalol* \$\$\$ Carvedilol* \$ Metoprolol Tartrate* \$\$\$ Metoprolol Succinate* Alpha-Beta Blockers \$\$\$ Labetalol* \$\$\$ Diltiazem* \$\$ Felodipine* \$\$ Felodipine*	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE INDERAL/LA TIMOLOL BETAXOLOL BETAPACE COREG TENORMIN LOPRESSOR TOPROL XL TRANDATE NORVASC LOTREL CARDIZEM/CD, DILACOR/XR FELODIPINE	
 \$ Nitroglycerin (oral)* \$\$ Nitroglycerin (topical)* \$\$ Isosorbide Mononitrate* Prior Authorization F Antianginals-Other Dipyridamole* BETA BLOCKERS Beta Blockers Non-Selective \$ Propranolol* \$ Timolol* \$ Betaxolol \$\$\$ Sotalol* \$\$\$ Carvedilol* Beta Blockers Cardio-Selective \$ Atenolol* \$ Metoprolol Tartrate* \$\$\$ Metoprolol Succinate* Alpha-Beta Blockers \$\$\$ Labetalol* CALCIUM BLOCKERS \$\$\$ Amlodipine* \$\$\$ Amlodipine* \$\$\$ Diltiazem* 	NITROSTAT NITRODUR,NITROBID IMDUR Required PERSANTINE INDERAL/LA TIMOLOL BETAXOLOL BETAPACE COREG TENORMIN LOPRESSOR TOPROL XL TRANDATE NORVASC LOTREL CARDIZEM/CD, DILACOR/XR	

<u>Generic Name</u>	Brand Name	<u>Annotation</u>
ANTIARRHYTHMIC		
<pre>\$\$\$ Amiodarone* \$ Disopyramide* \$\$\$ Flecainide* \$ Procainamide* \$ Quinidine Sulfate* \$\$\$\$ Mexiletine* \$\$\$\$ Propafenone*</pre>	CORDARONE NORPACE, CR TAMBOCOR PROCAINAMIDE QUINIDINE SULFATE MEXILETINE RYTHMOL	
ANTIHYPERTENSIVE		
ACE Inhibitors \$ Captopril* \$\$ Benazepril* \$\$ Enalapril* \$\$ Fosinopril* \$\$ Lisinopril* \$\$ Quinapril* \$\$ Ramipril*	CAPTOPRIL LOTENSIN VASOTEC FOSINOPRIL ZESTRIL ACCUPRIL ALTACE	
ARBs \$\$\$\$ Irbesartan*	AVAPRO	QL = 30 tabs / month
<pre>\$\$\$ Losartan potassium* \$\$\$\$\$ Valsartan Prior Authorization Require</pre>	COZAAR DIOVAN	QL = 30 tabs / month QL = 30 tabs / month
Adrenolytics - Central \$ Clonidine*	CATAPRES	AL = 18 years and over; No patches
	TENEX ne (Kapvay) and extended release guanfacine (In s 6-17 are covered under the mental health bener METHYLDOPA	
Adrenolytics - Peripheral \$ Reserpine*	RESERPINE	
Alpha Blockers \$\$ Doxazosin* \$ Prazosin* \$\$\$\$ Tamsulosin* \$\$\$ Terazosin*	CARDURA MINIPRESS FLOMAX TERAZOSIN	
Vasodilators		
\$ Hydralazine* \$ Minoxidil*	APRESOLINE MINOXIDIL	Topical not covered
Beta Blocker Combinations \$ Atenolol & Chlorthalidone* \$\$\$ Metoprolol & HCTZ* \$ Propranolol & HCTZ*	TENORETIC LOPRESSOR HCT PROPRANOLOL & HCTZ	no LA
ACE and ACE II Inhibitors & Diazides \$\$\$\$ Irbesartan & HCTZ* \$\$ Lisinopril & HCTZ*	AVALIDE ZESTORETIC	QL = 30 tabs / month
<pre>\$\$\$ Losartan potassium/HCTZ* \$\$\$\$ Valsartan & HCTZ*</pre>	HYZAAR DIOVAN HCT	QL = 30 tabs / month QL = 30 tabs / month
Adrenolytics-Central & Thiazides \$ Methyldopa & HCTZ* \$\$ Clonidine & Chlorthalidone*	METHYLDOPA & HCTZ CLORPRES	
Vasodilators & Thiazides \$ Hydralazine & HCTZ*	HYDRALAZINE & HCTZ	
DIURETICS		
Carbonic Anhydrase Inhibitors \$ Acetazolamide* \$\$\$ Methazolamide*	DIAMOX METHAZOLAMIDE	no sequels

<u>Generic Name</u>	Brand Name	<u>Annotation</u>
Loop Diuretics \$ Furosemide*	LASIX	
Potassium Sparing Diuretics \$ Spironolactone*	ALDACTONE	
Thiazides \$ Chlorothiazide* \$ Chlorthalidone* \$ Hydrochlorothiazide* \$ Methyclothiazide* \$ Metolazone* \$ Indapamide*	DIURIL CHLORTHALIDONE HYDROCHLOROTHIAZIDE METHYCLOTHIAZIDE ZAROXOLYN INDAPAMIDE	
Combination Diuretics \$ Spironolactone & HCTZ* \$ Triamterene & HCTZ*	ALDACTAZIDE MAXZIDE	
Osmotic Diuretics \$ Glycerin Supp*	GLYCERIN	adult, infant, child
PRESSORS		
Emergency Kits \$\$\$\$\$ Epinephrine	EPI-PEN, EPI-PEN JR, ADRENACLICK	
ANTIHYPERLIPIDEMIC		
Bile Sequestrants \$\$\$ Cholestyramine* \$\$\$ Colestipol*	QUESTRAN, LIGHT COLESTID	cans only cans only
Misc. \$ Niacin* \$ Niacin CR* \$\$\$ Fenofibrate tablets* \$\$\$ Fenofibrate* \$\$ Gemfibrozil* \$\$\$\$ Omega-3-acid ethyl esters*	NIACIN NIASPAN LOFIBRA TRICOR LOPID LOVAZA	OTC (slow release) 54mg and 160mg 48mg and 145mg
\$\$\$\$ Fenofibrate \$\$\$\$ Fenofibrate acid* \$\$\$\$ Fenofibrate micronized \$\$\$\$ Ezetimibe \$\$\$\$ Fenofibric Acid Prior Authorization Requi	LIPOFEN, TRIGLIDE TRILIPIX ANTARA ZETIA FIBRICOR ired	
HMG CoA Reductase Inhibitors \$\$\$\$ Atorvastatin* \$\$\$ Atorvastatin* \$\$\$ Fluvastatin* \$ Lovastatin* \$\$\$ Niacin & Lovastatin \$ Pravastatin* \$\$\$\$ Niacin-Simvastatin	CADUET LIPITOR LESCOL MEVACOR ADVICOR PRAVACHOL SIMCOR	
<pre>\$\$\$\$ Rosuvastatin Calcium \$\$\$ Simvastatin* \$\$\$\$\$ Sacubitril & Valsartan \$\$\$\$ Simvastatin*</pre>	CRESTOR ZOCOR ENTRESTO ZOCOR	80mg only
<pre>\$\$\$\$ Ezetimibe + Simvastatin PCSK9 Inhibitors \$\$\$\$\$ Evolocumab Prior Authorization Requi</pre>	VYTORIN REPATHA ired	140mg/ml

VI. RESPIRATORY AGENTS

ANTIHISTAMINES

Antihistamines - Ethanolamines \$ Diphenhydramine*

BENADRYL

OTC product

<u>Generic Name</u>	Brand Name	<u>Annotation</u>
Antihistamines - Non Sedating		
\$ Clemastine*	TAVIST	Pediatric formulation
\$\$ Loratadine*	ALAVERT, CLARITIN	OTC product
\$\$ Loratadine / Pseudoephedrine*	CLARITIN-D 12hr, 24hr	OTC product
\$\$ Cetirizine*	ZYRTEC	chew tabs/liquid AL ≤18
\$\$ Cetirizine tabs*	ZYRTEC	
\$\$ Fexofenadine*	ALLEGRA OTC, ALLEGRA SUSP,	30 or 60 per 30 days
	ALLEGRA ODT	
\$\$ Fexofenadine / Pseudoephedrine*	ALLEGRA-D OTC 12hr, 24hr	30 or 60 per 30 days
Antihistamines - Phenothiazines		
\$ Promethazine*	PROMETHAZINE	tabs/liquid
		tabs only AL <u>></u> 2 years
SYSTEMIC AND TOPICAL NASAL PRODUCTS		

Nasal Antihistamines		
\$\$\$\$ Azelastine*	ASTELIN	
Prior Authorization Re	equired	
Nasal Steroids		
\$\$ Flunisolide*	NASALIDE	
\$\$ Triamcinolone*	NASACORT AQ	
\$\$\$ Fluticasone*	FLONASE	
\$\$\$\$ Mometasone furoate	NASONEX	
Mucolytics		
\$\$ Acetylcysteine*	MUCOMYST	
NTIASTHMATIC		
Anticholinergics		
\$\$ Ipratropium*	ATROVENT NASAL	
\$\$\$\$ Ipratropium	ATROVENT HFA	
\$\$\$\$ Tiotropium	SPIRIVA	
\$\$\$\$ Aclidinium Bromide	TUDORZA PRESSAIR	QL = 1 inh / 30 days
Prior Authorization Re	equired	
Anti-Inflammatory Agents		
\$\$\$ Cromolyn (inhalation)*	INTAL	
\$ Cromolyn (nasal)*	NASALCROM	
¢ eremelyn (naear)		
Beta Adrenergics		
\$\$ Albuterol	PROVENTIL HFA, VENTOLIN HFA,	
	PROAIR HFA	
\$\$ Albuterol*	ALBUTEROL NEBULIZER SOLUTION	0.5% (5mg/mL) and 0.083% (2.5mg/3ml)
\$\$\$\$ Olodaterol	STRIVERDI	
\$\$\$ Salmeterol Prior Authorization Re	SEREVENT DISKUS	
	equiled	
Adrenergic Combinations		
\$\$\$\$\$ Ipratropium-Albuterol	COMBIVENT RESPIMAT	
\$\$\$\$ Albuterol-Ipratropium*	DUONEB	
\$\$\$\$ Tiotropium-Olodaterol	STIOLTO	
\$\$ Umeclidinium-Vilanterol	ANORO ELLIPTA	
\$\$\$\$ Salmeterol-Fluticasone	ADVAIR, ADVAIR HFA	
\$\$\$\$ Budesonide-Formoterol	SYMBICORT	
Prior Authorization Re	equired	
Steroid Inhalants \$\$\$\$ Fluticasone	FLOVENT HEA	
\$\$\$\$ Fluticasone \$\$\$\$ Budesonide	PULMICORT FLEXHALER	
		$A = 4 \times 100$
\$\$\$\$ Budesonide*	PULMICORT RESPULES	AL ≤ 4 years; QL = 1 bo> 30 days
	QVAR	50 days
\$\$\$\$ Beclomethasone Dipropionate		
 \$\$\$\$ Beclomethasone Dipropionate Sympathomimetic Agents \$ Pseudoephedrine HCL* 	PSEUDOEPHEDRINE	OTC product
Sympathomimetic Agents \$ Pseudoephedrine HCL*		OTC product
Sympathomimetic Agents \$ Pseudoephedrine HCL* Mixed Adrenergics	PSEUDOEPHEDRINE	OTC product
Sympathomimetic Agents \$ Pseudoephedrine HCL*		OTC product

Generic Name	Brand Name	<u>Annotation</u>
<i>Xanthines</i> \$ Aminophylline* \$\$ Theophylline*	AMINOPHYLLINE THEO-24, THEOCHRON	
Leukotriene Receptor Antagonists \$\$\$ Montelukast Sodium*	SINGULAIR	
COUGH/COLD/ALLERGY		
Expectorants \$ Guaifenesin* \$ Guaifenesin/DM*	GUAIFENESIN GUAIFENESIN DM	OTC product OTC product
Cough/Cold/Allergy Combinations \$ Brompheniramine*		Pediatric formulation
 \$ Brompheniramine / Pseudoephedrine* \$ Chlorpheniramine* \$ Phenylephrine* \$ Pseudoephedrine-Bromphen-DM* \$ Pseudoephedrine-Chlorphen-DM* \$ Pseudoephedrine-DM liquid* \$ Pseudoephedrine-DM soln* \$ GG/Codeine sol* \$ Benzonatate* \$ Pseudoephedrine-GG* \$ Pseudoephedrine HCL* 	BROMPHENIRAMINE / PSEUDOEPHEDRINE CHLORPHENIRAMINE SUDAFED PSEUDOEPHED-BROMPHEN DM PEDIA RELIEF LIQ COUGH/COLD TRIAMINIC AM LIQ CGH/DECON PSEUDOEPHEDRINE-DM SOLN GUIATUSS AC TESSALON, TESSALON PERLES PSEUDOCF/HEDRINE	Pediatric formulation Pediatric formulation

VII. GASTROINTESTINAL AGENTS

LAXATIVES

Osmotic Laxatives \$ Polyethylene Glycol powder*	MIRALAX	
Surfactant Laxatives		
\$ Docusate Sodium*	COLACE	OTC product
Stimulant Laxatives		
\$ Bisacodyl*	DULCOLAX	OTC product / caps only
\$ Sennosides*	SENOKOT	OTC product
\$ Sennosides/Docustate*	SENNA-S	OTC product
Bulk Laxatives		
\$ Polycarbophil Calcium*	FIBERCON	OTC product
\$ Psyllium*	METAMUCIL	OTC product
Miscellaneous Laxatives		
\$ Glycerin*	GLYCERIN	OTC product
\$ Lactulose	LACTULOSE	
\$ Magnesium Citrate*	CITROMA	OTC product
\$ PEG-Electrolyte*	GOLYTELY	
Lubiprostone	AMITIZA	
Prior Authorization R	equired	

ANTIDIARRHEALS

Antiperistaltic Agents \$ Diphenoxylate w/ Atropine*	LOMOTIL		
\$ Loperamide*	IMODIUM	OTC product	
Misc Antidiarrheal Agents			
\$ Bismuth Subsalicylate*	PEPTO-BISMOL	no tabs, OTC	
\$\$\$\$ Octreotide Acetate*	SANDOSTATIN		
Prior Authorization Required			

ANTACIDS

Antacids - Aluminum Salts \$ Aluminum Hydroxide Gel*

ALUMINUM HYDROXIDE

OTC product

<u>Generic Name</u>	Brand Name	Annotation
Antacids - Calcium Salts	00.04	
\$ Calcium Carbonate*	OS-CAL	OTC product
Antacid Combinations \$ Al Hydrox-Mag Carb*	MAALOX	no tabs, OTC
\$ Aluminum & Magnesium Hydroxide*	MYLANTA	no tabs, OTC
ULCER DRUGS		
Belladonna Alkaloids		
\$ Hyoscyamine Sulfate*	LEVSIN	tablets or SL only
Quaternary Anticholinergics		
\$ Propantheline Bromide*	PROPANTHELINE BROMIDE	
Antispasmodics		
\$ Dicyclomine*	BENTYL	
H-2 Antagonists		
\$ Famotidine*	PEPCID	tabs only
\$ Ranitidine*	ZANTAC	no caps
Proton Pump Inhibitors		
\$ Esomeprazole Magnesium	NEXIUM 24 HR OTC	OTC
\$\$ Omeprazole*	PRILOSEC OTC	OTC
\$\$ Lansoprazole*	PREVACID	OTC
\$\$\$\$ Lansoprazole*	PREVACID	RX
\$\$\$ Pantoprazole*	(Generic) PROTONIX	
\$\$\$ Rabeprazole*	ACIPHEX	
\$\$\$\$ Lansoprazole* Prior Authorization Rec	PREVACID SOLU-TAB	
Misc. Anti-Ulcer \$\$ Sucralfate*	CARAFATE TABLETS	
\$\$\$\$ Sucralfate*	CARAFATE SUSPENSION	
Prior Authorization Rec		
ANTIEMETICS		
Antiemetics - Anticholinergic		
\$ Meclizine*	MECLIZINE	
\$\$ Prochlorperazine*	PROCHLORPERAZINE	no SR
5-HT3 Receptor Antagonists		
\$\$\$\$\$ Ondansetron*	ZOFRAN	QL = 10 tabs per fill
\$\$\$\$\$ Ondansetron*	ZOFRAN ODT	QL = 10 tabs per fill
\$\$\$\$ Ondansetron*	ZOFRAN	Suspension: QL = 50mls per fill
Prior Authorization Rec	quired	1111
Neurokinin 1 Receptor		
\$\$\$\$ Aprepitant	EMEND	
Prior Authorization Rec	quired	
DIGESTIVE AIDS		
Digestive Aids - Mixtures		
\$\$\$\$ Pancrelipase (Lip-Prot-Amvl)	VIOKACE	

	\$\$\$\$ Pancrelipase (Lip-Prot-Amyl) \$\$\$\$ Pancrelipase (Lip-Prot-Amyl) DR	VIOKACE CREON, ZENPEP, ULTRESA, PERTZYE PANCREAZE, PANCRELIPASE	
M	ISC. GI		
	GI Stimulants \$ Metoclopramide*	REGLAN	no 5mq tabs
	Inflammatory Bowel Agents		J
	\$\$\$\$\$ Mesalamine	PENTASA	
	\$\$\$\$ Mesalamine*	ROWASA	
	\$ Sulfasalazine*	AZULFIDINE	no EN tabs

Generic Name	Brand Name	Annotation

VIII. GENITOURINARY

URINARY ANTIINFECTIVES

\$	Methenamine Mandelate*	MANDELAMINE
\$\$\$	Nitrofurantoin*	FURADANTIN
\$\$	Nitrofurantoin Macrocrystals*	MACROBID
\$	Trimethoprim*	TRIMETHOPRIM

URINARY ANTISPASMODICS

\$ Bethanechol*		URECHOLINE
\$\$\$ Finasteride*		PROSCAR
\$\$\$ Flavoxate*		FLAVOXATE
\$ Hyoscyamine*		LEVSINEX
\$ Oxybutynin*		DITROPAN
\$\$\$\$ Tolterodine Tar	trate	DETROL
\$\$\$\$ Fesoterodine F	umarate	TOVIAZ
\$\$\$\$ Darifenacin Hyd	drobromide	ENABLEX
\$\$\$\$ Trospium*		TROSPIUM
\$\$\$\$ Solifenacin		VESICARE
\$\$\$\$ Mirabergron		MYRBETRIQ
Pri	or Authorization Requir	ed

VAGINAL PRODUCTS

Vaginal Antiinfectives \$\$ Clindamycin* \$ Nystatin* \$\$ Sulfanilamide \$\$ Metronidazole* Prior Authorization R	CLEOCIN NYSTATIN AVC METROGEL-VAGINAL equired	
Imidazole-Related Antifungals \$ Butoconazole Nitrate* \$ Clotrimazole Vag* \$ Miconazole*	GYNAZOLE-1 MYCELEX MONISTAT	OTC product OTC product OTC product
Vaginal Antiinfective Combinations \$ Triple Sulfas Vaginal*	TRIPLE SULFAS VAGINAL	
MISCELLANEOUS GENITOURINARY PROD	<u>UCTS</u>	
Citrates \$ Sodium Citrate & Citric Acid*	ORACIT	
Urinary Analgesics \$ Phenazopyridine*	PYRIDIUM	
IX. CENTRAL NERVOUS SYSTEM D	RUGS	
ANTIPSYCHOTICS		
Phenothiazines \$\$ Prochlorperazine*	PROCHLORPERAZINE	no SR
HYPNOTICS		
Barbiturate Hypnotics \$ Butabarbital \$ Mephobarbital \$ Phenobarbital*	BUTISOL MEBARAL PHENOBARBITAL	
Antihistamine Hypnotics \$ Diphenhydramine*	BENADRYL	OTC product

Generic Name	Brand Name	Annotation	
X. ANALGESICS & ANESTHETICS			
ANALGESICS - NonNarcotic			
Salicylates			
<pre>\$ Aspirin zero order* \$\$ Salsalate*</pre>	ZORPRIN DISALCID		
Salicylate Combinations			
\$ Aspirin Enteric Coated*	ECOTRIN	OTC product	
\$ Aspirin with Buffers*	ASPIRIN BUFFERED	OTC product	
\$\$ Choline & Mag Salicylate*	CHOLINE & MAG SALICYLATE		
Analgesics Other \$ Acetaminophen*	TYLENOL	OTC product	
Analgesics - Sedatives			
\$ APAP/Caffeine/Butalbital*	FIORICET	50/325/40 mg only	
\$ Aspirin/Caffeine/Butalbital*	FIORINAL	50/325/40 mg only	
ANALGESICS - Narcotic QUANTITY LIMITS APPLY TO ALL NARCOTIC ANALGESICS. PLEASE SEE WEBSITE FOR FULL LIST OF QUANTITY LIMITS: jaimedicalsystems.com/providers/pharmacy. The initial fill of an opioid (initial fill = no opioid fills in the last 90 days) is limited to no more than a 7 day supply. After that it is limited to no more than 14 day supplies unless PA is approved. **PA required for methadone for pain and all extended-release opioid formulations and for quantities greater than 90 MME or to exceed quantitiy limits. Special PA forms are available at jaimedicalsystems.com/providers/pharmacy.**			
Narcotic Agonists			
\$ Codeine Phosphate*	CODEINE PHOSPHATE		
\$ Codeine Sulfate*	CODEINE SULFATE		
\$\$\$ Hydromorphone*	DILAUDID		
\$ Meperidine*			
\$\$\$ Morphine Sulfate* \$\$\$ Oxycodone*	MORPHINE SULFATE OXYCODONE	5mg caps	
\$\$\$ Oxycodone*	ROXICODONE	5mg, 10mg, 15mg, 30mg tabs and 20mg/mL oral soln	
\$\$\$ Tramadol*	ULTRAM		
\$\$\$\$ Tramadol/APAP*	ULTRACET		
\$ Methadone*	METHADONE	Attestation PA only	
\$\$\$\$ Morphine Sulfate SR*	MS CONTIN	Attestation PA only	
\$\$\$\$\$ Tramadol ER*	ULTRAM ER		
\$\$\$\$\$ Fentanyl* \$\$\$\$\$ Oxycodone CR*	DURAGESIC OXYCONTIN		
Prior Authorization Req			
Narcotic Combinations			
\$ Oxycodone w/ Acetaminophen*	PERCOCET	5/500 tabs and caps; 5/325 tabs and soln	
\$ Acetaminophen w/ Codeine*	TYLENOL / CODEINE		
\$ Acetaminophen w/ Codeine Sol*	ACETAMINOPHEN W / COD	120-12 mg / 5ml	
Undersedens Combinations			
Hydrocodone Combinations \$\$ Hydrocodone w/ Acetaminophen*		5/325, 7.5/325, 10/325	
\$\$ Hydrocodone w/ Acetaminophen*	VICODIN, LORTAB, NORCO XODOL	5/300 mg tabs	
ANTI-RHEUMATIC			
NSAID's			
\$\$ Diclofenac*	VOLTAREN		
\$\$ Etodolac*	ETODOLAC		
\$\$ Fenoprofen*	NALFON		
\$\$\$ Flurbiprofen*	FLURBIPROFEN		
\$ Ibuprofen*	MOTRIN		
\$ Indomethacin*		no SR or supp.	
\$ Meloxicam* \$ Naproxen*	MOBIC NAPROSYN	no EC	
\$ Naproxen \$ Naproxen Sodium*	ANAPROX	NO LO	
\$ Piroxicam*	FELDENE		
\$\$ Sulindac*	SULINDAC		

Generic Name	Brand Name	Annotation
COX-2 Inhibitor \$\$\$\$\$ Celecoxib	CELEBREX	
Prior Authorizatio		
Anti-Rheumatic Antimetabolite \$\$\$\$ Methotrexate*	RHEUMATREX	
GOUT		
<pre>\$ Allopurinol* \$\$\$\$ Colchicine</pre>	ZYLOPRIM COLCRYS	
Uricosurics \$ Probenecid*	PROBENECID	
LOCAL ANESTHETICS		
\$ Lidocaine* Lidocaine/Prilocoaine	LIDOCAINE EMLA	2% soln, 3%, 5% cream 2.5/2.5%
\$\$\$\$\$ Lidocaine* Prior Authorization	LIDODERM PATCHES on Required	QL = 90 patches /30 days
MIGRAINE PRODUCTS		
\$\$\$ Ergoloid mesylates*	HYDERGINE	

\$\$\$\$ Sumatriptan tablets*	IMITREX	QL = 9 tabs/30 days
\$\$\$\$ Sumatriptan injection*	IMITREX	QL = 2 injections/30 days
\$\$\$\$ Sumatriptan nasal*	IMITREX	QL = 6 sprays/30 days
\$\$\$\$\$ Sumatriptan-naproxen	TREXIMET	QL = 9 tabs/30 days
\$\$\$\$ Rizatriptan tablets*	MAXALT	QL = 6 tabs/30 days
\$\$\$\$ Zolmitriptan tablets*	ZOMIG	QL = 6 tabs/30 days,
		tabs only

XI. NEUROMUSCULAR AGENTS

ANTICONVULSANT

Hydantoins \$\$ Phenytoin*	DILANTIN
Succinimides \$\$ Ethosuximide*	ZARONTIN
Miscellaneous Anticonvulsants \$\$\$ Primidone*	MYSOLINE

Prior Authorization Required

ANTIPARKINSONIAN

\$\$\$ Entacapone*	COMTAN	
Prior Authorizatio	n Required	
Dopaminergic		
\$ Amantadine*	AMANTADINE	
\$\$\$ Bromocriptine*	PARLODEL	no postpartum use
\$\$ Ropinirole*	REQUIP	
Prior Authorizatio	n Required	
Levodopa Combinations		
\$\$\$ Carbidopa-Levodopa*	SINEMET, CR	no 100-25 CR
Monoamine Oxidase Inhibitor		
\$\$\$\$ Selegiline*	ELDEPRYL	
USCULOSKELETAL THERAPY AGENT	<u>-s</u>	
Central Muscle Relaxants		
\$\$ Baclofen*	BACLOFEN	
\$ Cyclobenzaprine*	CYCLOBENZAPRINE	
\$ Methocarbamol*	ROBAXIN	
Direct Muscle Relaxants		
\$\$\$\$ Dantrolene*	DANTRIUM	

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<u>Generic Name</u>	Brand Name	<u>Annotation</u>
Fibromyalgia		
\$\$\$\$\$ Milnacipran Prior Authorization Requi	SAVELLA ired	
Muscle Relaxant Combinations \$ Methocarbamol w/ Aspirin*	METHOCARBAMOL w/ASA	
ANTIMYASTHENIC AGENTS		
Antimyasthenic Agents \$\$\$\$ Pyridostigmine*	MESTINON	
Benzothiazoles \$\$\$\$\$ Riluzole*	RILUTEK	
Prior Authorization Requi	red	
XII. NUTRITIONAL PRODUCTS		
VITAMINS		
Water Soluble Vitamins \$ Niacin*	NIACIN	
Oil Soluble Vitamins \$ Vitamin A*	VITAMIN A	
Vitamin D \$\$ Calcitriol* \$\$ Ergocalciferol* \$\$ Cholecalciferol*	ROCALTROL DRISDOL VITAMIN D3	Vitamin D3 Vitamin D2
Vitamin K \$\$ Mephyton Prior Authorization Requi	VITAMIN K ired	QL = 5 tabs / 30 days
MULTIVITAMINS		
 \$ Folic Acid & Vitamin B Complex* \$ Multiple Vitamin * \$ Multiple Vitamin w/ Minerals* \$ Pediatric Vitamins* \$ Pediatric Multivitamins w/Iron* \$ Pediatric Multivitamins w/Fluoride* \$ Pediatric Multivitamins w/Fluoride and Iron* \$ Pediatric Vitamin ADC* \$ Pediatric Vitamin ADC w/Iron* \$ Prenatal MV & Min w/FE-FA* \$ Prenatal Vitamins* 	NEPHROCAPS ONE-A-DAY AP-ZEL, BACMIN, CENTRUM PEDIATRIC VITAMINS POLY-VI-SOL POLY-VI-SOL / IRON TRI-VI-FLOR / IRON TRI-VI-SOL TRI-VI-SOL / IRON PRENATAL-1 PRENATABS RX	OTC product OTC product up to 16 years only up to 16 years only
CITRATES		
\$ Sodium Citrate & Citric Acid*	ORACIT	
MINERALS & ELECTROLYTES		
Calcium \$ Calcium Acetate* \$ Calcium Carbonate*	PHOSLO OS-CAL	caps only OTC product
Fluoride \$ Sodium Fluoride*	LURIDE	
Potassium \$ Potassium Chloride Capsule* \$ Potassium Chloride Liquid* \$ Potassium Chloride Tablet*	MICRO-K POTASSIUM CHLORIDE LIQUID KLOR-CON	
Electrolyte Mixtures \$ Oral Electrolytes Packets* \$ Oral Electrolytes*	CERALYTE, CERASPORT PEDIALYTE	OTC product

ProCare/Jai Medical Systems Therapeutic Formulary		
<u>Generic Name</u>	Brand Name	Annotation
DIETARY PRODUCTS		
\$\$ Infant Foods \$\$ Phenyl-Free*	ENFAMIL / SIMILAC PHENYL-FREE	OTC product OTC product
MISCELLANEOUS NUTRITIONAL PRODUCTS		
\$\$ Nutritional Supplements ENSURE, PEDIASURE, BOOST, VIVONEX Prior Authorization Required For enteral access only. For members without enteral access, follow the DME process. (Nutritional Supplements are not limited to this list)		
XIII. HEMATOLOGICAL AGENTS		
HEMATOPOIETIC AGENTS		
Cobalamines \$ Cyanocobalamin* \$ Folic Acid* \$\$\$ Leucovorin Calcium* \$ Thiamine	VITAMIN B-12 FOLIC ACID LEUCOVORIN THIAMINE	1,000mcg tabs only
 Cyanocobalamin* Hydroxocobalamin* Prior Authorization Requi 	VITAMIN B-12 HYDROXOCOBALAMIN	injection
Iron		
<pre>\$ Ferrous Gluconate* \$ Ferrous Sulfate*</pre>	FERGON FEOSOL	OTC product OTC product
Hematopoietic Growth Factors \$\$\$\$ Darbepoetin	ARANESP	QL = 4 injections / month
Prior Authorization Requi		
Erythropoietins		
\$\$\$\$ Epoetin Alfa Prior Authorization Requi	EPOGEN	2,000U, 3,000U, 4,000U, 10,000U - QL = 12 injections / month; 20,000U, 40,000U - QL = 4 injections / month
Leukocytes		
\$\$\$\$\$ Filgrastim Prior Authorization Requi	NEUPOGEN ired	QL = 30 injections / month
ANTICOAGULANTS		
Coumarin Anticoagulants \$\$ Warfarin Sodium*	COUMADIN	
<i>Heparin Agents</i> \$\$\$\$\$ Enoxaparin* \$\$\$\$\$ Apixaban	LOVENOX ELIQUIS	
Thrombin Inhibitors		
\$\$\$\$ Dabigatran Prior Authorization Requi	PRADAXA ired	
HEMOSTATICS		
Hemostatics - Topical		

\$\$\$\$ Thrombin THROMBIN Prior Authorization Required

MISC. HEMATOLOGICAL

Antihemophilic Products	
\$\$\$\$ Antihemophilic Factor (Human)	KOATE-DVI, HP, HEMOFIL M
\$\$\$\$ Antihemophilic Factor (Recombinate)	RECOMBINATE
\$\$\$\$ Antiinhibitor Coagulant Complex	FEIBA VH
\$\$\$\$ Antithrombin III (Human)	THROMBATE III
Prior Authorization Requi	ired

<u>Generic Name</u>	Brand Name	Annotation
Platelet Aggregation Inhibitors		
\$\$\$ Clopidogrel*	PLAVIX	
Phosphodiesterase III Inhibitors		
\$\$\$\$ Cilostazol	PLETAL	
Hematorheological		
\$\$ Pentoxifylline*	TRENTAL	
Prior Authorization Re	quired	

XIV. BEHAVIORAL HEALTH AGENTS

MISCELLANEOUS

ARICEPT RAZADYNE / RAZADYNE ER EXELON uired	
KAPVAY	Please refer to
INTUNIV	Introduction page I-5 Please refer to Introduction page I-5
NAMENDA uired	initiation page i e
MYSOLINE	
AK-TRACIN	
CILOXAN	
	AL ≤ 18 years
uired	
ZADITOR	
ALOMIDE	QL = 20 mls / 30 days
PATANOL	QL = 20 mls / 30 days
PATADAY	•
(GENERIC) OPTIVAR	
uired	
BLEPH-10	
VIROPTIC	
POLYSPORIN	
POLYSPORIN NEOMYCIN-BAC ZN-POLYMIXIN	
POLYSPORIN	
Polysporin Neomycin-bac zn-polymixin Neosporin	
POLYSPORIN NEOMYCIN-BAC ZN-POLYMIXIN NEOSPORIN BETOPTIC, BETOPTIC S	20 YE
Polysporin Neomycin-bac zn-polymixin Neosporin	no XE
POLYSPORIN NEOMYCIN-BAC ZN-POLYMIXIN NEOSPORIN BETOPTIC, BETOPTIC S BETIMOL, TIMOPTIC COSOPT	no XE
POLYSPORIN NEOMYCIN-BAC ZN-POLYMIXIN NEOSPORIN BETOPTIC, BETOPTIC S BETIMOL, TIMOPTIC	no XE
	RAZADYNE / RAZADYNE ER EXELON uired KAPVAY INTUNIV NAMENDA uired MYSOLINE AK-TRACIN CILOXAN ROMYCIN GENTAK VIGAMOX OCUFLOX POLYTRIM ZYMAXID uired ZADITOR ALOMIDE PATANOL PATADAY (GENERIC) OPTIVAR uired

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Generic Name	Brand Name	Annotation
Steroid Combinations \$ Bacitracin-Polymyxin-Neomycin-H \$ Neomycin-Polymyxin-Dexametha \$\$ Tobramycin-Dexamethasone* \$\$\$ Neomycin-Polymyxin-HC* \$\$\$ Sulfacetamide Sod-Prednisolone*	sone* MAXITROL TOBRADEX CORTISPORIN	
Cycloplegics \$ Atropine Sulfate*	ISOPTO ATROPINE	
Decongestants \$ Naphazoline* \$\$ Phenylephrine*	NAPHAZOLINE MYDFRIN	
Ophthalmic NSAID's \$ Diclofenac Sodium* \$\$ Flurbiprofen*	VOLTAREN OCUFEN	
Miotics - Direct Acting \$ Pilocarpine* \$\$ Brimonidine Tartrate	ISOPTO-CARPINE ALPHAGAN 0.2%, ALPHAGAN P 0.15%	no Ocusert
Prior Authorization		
Prostaglandins \$\$\$ Latanoprost*	XALATAN	
Carbonic Anhydrase Inhibitors \$\$ Dorzolamide*	TRUSOPT	
OTIC		
Steroids \$ Hydrocortisone w/Acetic Acid*	ACETASOL HC	QL = 20 mls / 30 days
Antibiotics & Steroid-Antibiotic Combinatio \$ Neomycin-Polymyxin-HC*	ons CORTISPORIN	QL = 20 mls / 30 days
Antibiotics \$\$\$ Ofloxacin*	OFLOXACIN	QL = 20 mls / 30 days
Anti Infective \$ Carbamide Peroxide*	DEBROX	
Analgesic Combinations \$ Benzocaine & Antipyrine*	A/B OTIC	
MOUTH & THROAT (Local)		
Antiinfectives - Throat \$\$\$ Clotrimazole* \$ Nystatin*	CLOTRIMAZOLE TROCHE NYSTATIN	
ANORECTAL		
<i>Rectal Steroids</i> \$ Hydrocortisone* \$\$ Hydrocortisone*	ANUSOL-HC PROCTOCREAM	2.5% cream 2.5% cream
DERMATOLOGICAL		
Antibiotics - Topical \$\$ Bacitracin* \$ Gentamicin Sulfate* \$\$\$ Metronidazole* \$\$\$ Mupirocin* \$ Neomycin Sulfate*	BACITRACIN GENTAMICIN METROGEL BACTROBAN NEOMYCIN	OTC product
Antibiotic Mixtures Topical \$ Neomycin-Bacitracin-Polymyxin*	NEOSPORIN	OTC product
Antibiotic Steroid Combinations \$\$ Neomycin-Polymyxin-HC*	CORTISPORIN	

<u>Generic Name</u>	Brand Name	<u>Annotation</u>	
Imidazole-Related Antifungals (Topical) \$\$ Clotrimazole Topical*	LOTRIMIN	OTC product	
\$ Miconazole*	MONISTAT	OTC product	
Antifungals \$ Nystatin*	NYSTATIN	no powder	
φ Nystaun	NIGIAIN	no powder	
Antifungals - Topical Combinations \$\$ Nystatin-Triamcinolone*	NYSTATIN-TRIAMCINOLONE		
Antipsoriatics \$\$\$\$ Calcipotriene*	DOVONEX		
Antiseborrheic Products			
\$ Sulfacetamide Sodium*	SULFACETAMIDE SODIUM		
Burn Products			
\$ Silver Sulfadiazine*	SILVADENE		
Tar Products			
\$ Coal Tar*	COAL TAR SHAMPOO	1% only	
Enzymes - Topical			
\$\$\$ Collagenase	SANTYL		
Keratolytics/Antimitotics			
\$\$\$\$ Podofilox* \$\$\$\$\$ Urea*			
\$\$\$\$\$ Urea 45%*	KERALAC, UMECTA URAMAXIN GEL 45%		
Local Anesthetics - Topical			
\$ Lidocaine viscous*	LIDOCAINE VISCOUS		
\$\$ Diclofenac*	VOLTAREN	1% gel	
Scabicides & Pediculocides			
\$ Lindane*	LINDANE		
\$\$ Permethrin*	ELIMITE		
\$\$ Permethrin*	NIX	OTC product	
Misc. Topical		0.1.11	
\$\$ Ammonium Lactate*		cream & lotion	
\$\$\$ Fluorouracil* \$\$\$ Tacrolimus oint*	EFUDEX PROTOPIC	2% and 5% cream only	
\$\$\$ Pimecrolimus	ELIDEL		
Prior Authorization Required			

Antiviral Topical

Cointment & suspension
TE
EN
NONIDE
R
CORTISONE OTC product
G Topical and Injectable
ACET. IN ORABASE
W
$AL \leq 32$; no Micro
AL ≤ 21 ; only Gel or
Cream
N
•

<u>Generic Name</u>	Brand Name	<u>Annotation</u>
XVI. MISCELLANEOUS PRODUCTS		
ANTIDOTES		
<pre>\$ lpecac* \$ Charcoal Activated</pre>	IPECAC CHARCOCAPS	OTC product OTC product
DIAGNOSTIC PRODUCTS		
Diagnostic Reagents \$ Acetone Tablets \$ Acetone Test* \$ Glucose Urine Test* \$\$ Glucose Blood* <u>MEDICAL DEVICES</u>	ACETEST KETOSTIX CLINITEST GLUCOSE BLOOD	
Parenteral Therapy Supplies \$ Disposable Needles & Syringes* \$ Insulin Pen Needles	B-D INSULIN SYRINGE Insulin Pen Needles	
Diabetic Supplies \$\$ Blood Glucose Monitoring Tests* \$ Calibration Solution*	GLUCOMETER CALIBRATION SOLUTION	Contour, Contour Next, and Contour Next EZ
\$ Lancet Device \$ Lancets*	GLUCOLET / AUTOLET LANCETS	
Misc. Devices		

Misc. Devices \$ Alcohol Swabs*

ALCOHOL PADS

CONTRACEPTIVES

\$ Condoms

ASSORTED CLASSES

Chelating Agents \$\$\$\$ Penicillamine	CUPRIMINE	
\$\$\$\$ Ferricinarine \$\$\$\$ Succimer	CHEMET	
Prior Authorization Reg		
Immunosuppressive Agents		
\$\$\$\$\$ Cyclosporine Microsize*	NEORAL	
\$\$\$\$\$ Sirolimus*	RAPAMUNE	
\$\$\$\$\$ Tacrolimus*	PROGRAF	
Inosine Monophosphate Dehydrogenase Inhibi	itors	
\$\$\$\$\$ Mycophenolate Mofetil*	CELLCEPT	
\$\$\$\$\$ Mycophenolate Sodium*	MYFORTIC	
Mutiple Sclerosis - Adjuvants		
\$\$\$\$\$ Teriflunomide	AUBAGIO	QL = 60 tabs / 30 days
\$\$\$\$\$ Dimethyl Fumarate	TECFIDERA	QL = 60 tabs / 30 days
\$\$\$\$ Dalfampridine	AMPYRA	QL = 60 tabs / 30 days
\$\$\$\$\$ Interferon Beta-1a	AVONEX	
\$\$\$\$\$ Glatiramer acetate	COPAXONE	
\$\$\$\$\$ Interferon Beta-1a	REBIF	
\$\$\$\$ Interferon Beta-1b	BETASERON	
Prior Authorization Requ	uired	
Purine Analogs		
\$\$\$ Azathioprine*	IMURAN	
K Removing Resin		
\$\$\$\$ Sodium Polystyrene Sulfonate*	KAYEXALATE	
Rheumatology Biologics		
\$\$\$\$\$ Adalimumab	HUMIRA	
\$\$\$\$\$ Etanercept	ENBREL	
Prior Authorization Requ		

GENERIC: <u>ACARBOSE</u>

BRAND: <u>PRECOSE[®]</u>

INDICATION:

(1) Type 2 diabetes mellitus

Criteria:

 (a) Failure of maximal doses of <u>one</u> oral sulfonylurea (e.g., glyburide 20mg daily or equivalent). Failure is defined as Hemoglobin A1c> 7.0.

GENERIC: ACLIDINIUM BROMIDE AEROSOL POWDER

BRAND: <u>TUDORZA PRESSAIR[®]</u>

INDICATION:

(1) Long-term maintenance treatment of bronchospasm associated with COPD (including bronchitis and emphysema)

Criteria:

- (a) Diagnosis of COPD <u>and</u>
- (b) Must be greater than 18 years of age **and**
- (c) Documented inadequate response or intolerance to Spiriva

GENERIC: <u>ACYCLOVIR TOPICAL OINTMENT/SUSPENSION</u> **BRAND:** ZOVIRAX[®] 5%

INDICATIONS:

- (1) Herpes genitalis
- (2) Oral herpes infection

Criteria:

- (a) Herpes genitalis for initial episode only; or
- (b) Oral herpes infection for immunocompromised patients *only*.

Additional Criteria for Suspension:

- (c) Patient is <17 years of age; <u>or</u>
- (d) Unable to ingest solid dosage form (e.g. capsules) due to dysphagia

GENERIC: <u>ADALIMUMAB</u>

BRAND: <u>HUMIRA[®]</u>

INDICATIONS:

- (1) Moderate to severely active rheumatoid arthritis (RA)
- (2) Moderately to severely Active Polyarticular Juvenile Idiopathic Arthritis (JIA)
- (3) Psoriatic arthritis (PsA)
- (4) Ankylosing spondylitis (AS)
- (5) Moderate to severely active Crohn's disease (CD)
- (6) Moderately to Severely Active Ulcerative Colitis (UC)
- (7) Moderately to Severely Active Plaque Psoriasis (Ps)
- (8) Moderately to Severely Active Hidradenitis Suppurativa (HS)
- (9) Uveitis

Criteria:

- (a) The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to Humira therapy; **and**
- (b) The patient does not have a clinically important active infection

Additional Criteria for RA, JIA, and PsA:

(c) The patient has failed or is intolerant to one formulary NSAID and

Prior Authorization Guidelines

(d) The patient has failed or is intolerant to one formulary DMARD

Additional Criteria for AS:

(c) Physician documents that patient failed treatment with at least two NSAIDS for at least three months, except if NSAIDs are contraindicated or if patient has presented toxicity or intolerenace. The patient has failed or is intolerant to infliximab;

Additional Criteria for CD and UC:

- (c) The patient has failed or is intolerant to infliximab; or
- (d) The patient has failed or is intolerant to mesalamine or sulfasalazine; and
- (e) The patient has failed or is intolerant to corticosteroids; and
- (f) The patient has failed or is intolerant to an immunomodulator (e.g., methotrexate,6mercaptopurine or azathioprine)

Additional Criteria for Ps

(c) Document that the patient has an incomplete response or intolerance or contraindicated to one appropriate systemic agent (ex: MTX, cyclosporine, acitretin) or phototherapy or biologic agents.

Additional Criteria for Hs

(c) Documentation of evidence failure with the previous treatment including antibiotics, hormonal therapies or oral retinoid at least for 90 days.

GENERIC: <u>ANTIHEMOPHILIC FACTORS</u>

BRAND: KOATE-DVI[®], FEIBA VH[®], RECOMBINATE[®], THROMBATE III[®]

INDICATION:

(1) Hemophilia A

Criteria:

(a) Diagnosis of Hemophilia A

GENERIC: <u>APREPITANT</u>

BRAND: <u>EMEND[®]</u>

INDICATION:

(1) Nausea and vomiting

Criteria:

- (a) For the prevention of post-operative nausea and vomiting; or
- (b) For the prevention of chemotherapy-induced nausea and vomiting

GENERIC: <u>AZELASTINE NASAL SPRAY</u>

BRAND: <u>ASTELIN[®]</u>

INDICATIONS:

- (1) Perennial allergic rhinitis
- (2) Seasonal allergic rhinitis

Criteria:

- (a) Patient is \geq 5 years of age with one of the above diagnoses; **and**
- (b) Failure of at least one formulary nasal steroid after a period of at least two months on the maximum dose appropriate and tolerated by the patient

Prior Authorization Guidelines

GENERIC: <u>AZELASTINE 0.05% Eye Drops</u>

INDICATION:

(1) Allergic conjunctivitis

Criteria:

- (a) Patient is \geq 3 years of age with the above diagnoses
- (b) Failure of Ketotifen and any various store brands OTC shelf

GENERIC: <u>BRIMONIDINE</u>

BRAND: ALPHAGAN 0.2%[®], ALPHAGAN P 0.15%[®]

INDICATION:

(1) Glaucoma

Criteria:

(a) Failure of formulary ophthalmic beta blocker (betaxolol, Timolol, dorzolamide/timolol)

GENERIC: BUDESONIDE/FORMOTEROL

BRAND: <u>SYMBICORT®</u>

INDICATION:

- (1) Maintenance treatment of asthma in patients 12 years of age and older
- Criteria:
- (a) Currently on, but not adequately controlled by an inhaled corticosteroid; or
- (b) Maintenance treatment of airflow obstruction in patients with chronic bronchitis and emphysema
- (c) Patients must be reevaluated after 6 months
- * For members currently with an approved prior authorization for Symbicort, claims will process as long as the member has filled Symbicort within the last 4 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to Symbicort therapy or with no claims history of Symbicort within the last 4 months. Once approved, 90day supplies are allowed.

GENERIC: CALCITONIN-SALMON

BRAND: <u>MIACALCIN®</u>

INDICATIONS:

- (1) Mild to moderate Paget's disease of bone
- (2) Osteoporosis

Criteria:

- (a) Failure, contraindication or intolerance to adequate trial of oral bisphosphonate; and
- (b) One of the following:
 - Bone density measurement ≥2.5 standard deviations below the mean for normal, young adults of same gender (T-score ≤ -2.5); or
 - (2) History of an osteoporotic vertebral fracture; <u>or</u>
 - (3) Postmenopausal woman with low bone mineral density defined by T-score between -2.0 and -2.5 AND one of the following risk factors for fracture:
 - (a) Thinness or low body mass index defined by weight <127 lb (57.7 kg) or BMI <21 kg/m²
 - (b) History of fragility fracture since menopause
 - (c) History of hip fracture in a parent
 - (4) Diagnosis of Paget's disease of bone

Prior Authorization Guidelines

(c) Patients receiving glucocorticoids in daily dosages of >7.5mg prednisone daily (see table) AND who have bone density measurement > 1 standard deviations below the mean for normal, young adults of same gender (T-score < -1.0)

Glucocorticoid Potency Equivalencies				
Glucocorticoid	Approxima te equivalent dose (mg)	Relative anti- inflammatory (glucocorticoi d) potency	Relative mineralocorticoi d potency	
Short-acting				
Cortisone	25	0.8	2	
Hydrocortisone	20	1	2	
Intermediate-				
acting	5	4	1	
Prednisone	5	4	1	
Prednisolone	4	5	0	
Triamcinolone	4	5	0	
Methylprednisolo				
ne				
Long-acting				
Dexamethasone	0.75	20-30	0	
Betamethasone	0.6-0.75	20-30	0	

Table adapted from Facts and Comparisons® 1999:122

* For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.

* If documentation of osteoporosis is available, please submit with PA request.

GENERIC: CELECOXIB **BRAND:**

CELEBREX[®]

INDICATIONS:

- (1) Relief of signs and symptoms of rheumatoid arthritis (RA) in adults
- (2) Relief of signs and symptoms of osteoarthritis (OA)
- (3) Relief of signs and symptoms of ankylosing spondylitis
- (4) Management of acute pain in adults
- (5) Treatment of primary dysmenorrhea
- (6) To reduce the number of adenomatous polyps in familial adenomatous polyposis, as an adjunct to usual care

Criteria:

- (a) Failure, intolerance, or contraindication to at least 2 formulary NSAIDs; and
- (b) One of the following:
 - (1) Age greater than 65; or
 - (2) Concomitant use of warfarin or other antiplatelet therapy; or
 - (3) Concomitant use of chronic systemic corticosteroid therapy; or
 - (4) Documented history of ulcer disease or GI bleed; or
 - (5) Documented history of significant GI disease requiring therapy with an H2 antagonist or PPI: or
 - (6) Documented history of nonselective NSAID-induced GI adverse effects; and

(c) For OA, therapeutic failure (≥21-day trial), intolerance of, or contraindication to at least 1 of the following: acetaminophen or opioid analgesics or topical analgesics (capsaicin, etc.)

GENERIC: CLOXACILLIN SODIUM

INDICATION:

(1) Treatment of infections due to penicillinase-producing staphylococci

Criteria:

- (a) Diagnosis of staphylococcal infection; and
- (b) Failure of dicloxacillin sodium.

GENERIC: CYANOCOBALAMIN (HYDROXOCOBALAMIN)

BRAND: <u>VITAMIN B-12[®]</u>

INDICATION:

(1) Vitamin B-12 deficiency

Criteria:

- (a) Patients who lack intrinsic factor; or
- (b) Patients who are on long-term PPI therapy; \underline{or}
- (c) Patients with a partial or complete gastrectomy.

* For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.

GENERIC: DABIGATRAN ETEXILATE MESYLATE

BRAND: <u>PRADAXA[®]</u>

INDICATION:

(1) Reduce the risk of stroke and systemic embolism in patients with non-vascular atrial fibrillation.

Criteria:

- (a) Diagnosis of non-vascular atrial fibrillation; and
- (b) Must have recent CrCl levels or Scr and current patient weight; and
- (c) No active pathological bleeding; and
- (d) Must have tried and failed or intolerant to Warfarin
- **NOTE:** Conversion to Pradaxa:
- (a) From Warfarin: discontinue warfarin and start Pradaxa when INR<2.0
- (b) From Parenteral Anticoagulants: start Pradaxa 0-2 hrs prior to next scheduled dose of parenteral anticoagulant, or at the time of discontinuation of continuous parenteral drug (e.g. heparin)

GENERIC: <u>DALFAMPRIDINE</u>

BRAND: <u>AMPYRA[®]</u>

INDICATION:

(1) Improved walking speed in patients with multiple sclerosis

- (a) Diagnosis of multiple sclerosis; and
- (b) Prescribed by a neurologist; **and**
- (c) Currently taking a disease modifying drug for multiple sclerosis (Avonex, Aubagio, Betaseron, Copaxone, Extavia, Gilenya, Rebif, Tecfidera or Tysabri)

* *Renewals will require documented improvement in walking speed (demonstrated improvement in timed 25-foot walk)*

GENERIC: <u>DANTROLENE</u>

BRAND: <u>DANTRIUM®</u>

INDICATION:

- (1) Spasticity resulting from upper motor neuron disorders
- Criteria:
- (a) Demonstrated failure of, or intolerance to, Baclofen (Lioresal[®]).

GENERIC: DAPAGLIFLOZIN

BRAND: <u>FARXIGA[®]</u>

INDICATION:

- (1) Type 2 diabetes mellitus
- (2) To reduce the risk of hospitalization and/or death for heart failure in adults with type 2 diabetes mellitus and either established cardiovascular disease or multiple cardiovascular risk factors or heart failure with reduced ejection fraction (NYHA class II-IV).
- (3) To reduce the risk of sustained eGFR decline, end stage kidney disease, cardiovascular death and hospitalization for heart failure in adults with chronic kidney disease at risk of progression.

Criteria for Type 2 diabetes mellitus:

- (a) Diagnosis of Type 2 diabetes mellitus
- (b) Has not achieved adequate glycemic control on the following:(1) Metformin (alone or in combination)

Criteria for heart failure:

- (a) Diagnosis of heart failure with reduced ejection fraction.
- (b) Has not achieved adequate symptom control with the following: $(1) + CE^{1/4} DE^{1/4} D$
 - (1) ACE/ARB or ARNI, and
 - (2) Beta Blocker

Criteria for Chronic Kidney Disease:

- (a) Diagnosis of Chronic Kidney Disease
- (b) Has not achieved adequate symptom control with the following: (1) ACE/ARB,
- (c) NOT on dialysis

GENERIC: DARBEPOETIN ALFA

BRAND: <u>ARANESP[®]</u>

INDICATIONS:

- (1) Anemia with cancer chemotherapy (nonmyeloid)
- (2) Anemia due to chronic renal failure

Criteria:

- (a) Ensure patient's iron stores are adequate (Ferritin ≥ 100 ng/mL and/or Transferrin saturation $\geq 20\%$) or patient is being treated with iron; **and**
- (b) Adequate blood pressure control; and

Chronic kidney disease patients:

(a) Initiate treatment when hemoglobin is <10g/dL; or

Anemia due to chemotherapy in cancer:

(a) Initiate treatment only if hemoglobin is <10g/dL; and

(b) Anticipated duration of myelosuppressive chemotherapy is ≥ 2 months

For renewals:

- (a) Chronic kidney disease patients:
 - (1) With dialysis Hbg <11; or
 - (2) Without dialysis Hbg <10
- (b) Anemia due to chemotherapy in cancer patients: (1) Hbg <11

GENERIC: DARIFENACIN

BRAND: ENABLEX[®]

INDICATION:

(1) Overactive bladder

Criteria:

(a) Failure of Oxybutynin

GENERIC: DESMOPRESSIN

BRAND: <u>DDAVP®</u>

INDICATIONS:

- (1) Central cranial diabetes insipidus (CCDI)
- (2) Primary nocturnal enuresis

Criteria:

- (a) Diagnosis of CCDI; <u>or</u>
- (b) For the treatment of enuresis, age 6 to 18 years; and
- (c) Failure of behavior modification for 6 months (e.g., alarms, no beverages after 5pm, special diapers, etc.)
- * Renewals for the indication of nocturnal enuresis will require the documentation of a retrial of behavior modification.

GENERIC: <u>DIMETHYL FUMERATE</u>

BRAND: <u>TECFIDERA[®]</u>

INDICATION:

(1) Diagnosis of a relapsing form of Multiple Sclerosis;

Criteria:

- (a) Prescribed by neurologist, and
- (b) Not requesting combination of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Gilenya, Aubagio or Tecfidera.

GENERIC: DONEPEZIL

BRAND: <u>ARICEPT[®]</u>

INDICATION:

 $(1)\,$ Alzheimer's disease: for the treatment of dementia.

Criteria:

(a) Dementia must be confirmed by clinical evaluation

GENERIC: <u>DULAGLUTIDE</u>

BRAND: <u>TRULICITY[®]</u>

INDICATION:

(1) Adjunct to diet and exercise to improve glycemic control in patients with type II diabetes mellitus

Criteria:

- (a) Diagnosis of type II diabetes mellitus; and
- (b) Must be under the care of a healthcare provider skilled with the use of insulin and supported by diabetes educator
- (c) Must have tried at least 2 antidiabetic agents such as metformin, sulfonylureas, thiazolidinedione or insulin and not achieved adequate glycemic control despite treatment or intolerant to other antidiabetic medications

GENERIC: ELBASVIR-GRAZOPREVIR

BRAND: <u>ZEPATIER[®]</u>

INDICATION:

(1) Chronic Hepatitis C

Criteria:

- (a) Preferred for genotypes 1 and 4
- (b) Must follow the clinical criteria as set by the Maryland Department of Health
- (c) Special Hepatitis C PA request forms, treatment plan template, preferred status information, and full criteria can be obtained at <u>http://www.jaimedicalsystems.com/providers/pharmacy/</u> or by contacting ProCare at 1-800-555-8513

GENERIC: <u>EMPAGLIFLOZIN</u>

BRAND: <u>JARDIANCE[®]</u>

INDICATION:

- (1) Type II Diabetes Mellitus
- (2) To reduce the risk of cardiovascular death plus hospitalization for heart failure in adults with heart failure and reduced ejection fraction with or without type 2 diabetes mellitus

Criteria for Type 2 diabetes mellitus:

- (a) Failure of metformin, a sulfonylurea, or pioglitazone
- Criteria for heart failure:
- (a) Diagnosis of heart failure with reduced ejection fraction
- (b) Has not achieved adequate symptom control with the following:
 - (1) ACE/ARB or ARNI, and
 - (2) Beta Blocker

GENERIC: <u>EMPAGLIFLOZIN-LINAGLIPTIN</u>

BRAND: <u>GLYXAMBI[®]</u>

INDICATION:

(1) Type II Diabetes Mellitus

Criteria:

(a) For use when an SGLT2 and a DPP-4 Inhibitor is appropriate.

GENERIC: <u>ENTACAPONE</u>

BRAND: <u>COMTAN[®]</u>

INDICATION:

(1) As an adjunct to levodopa/carbidopa to treat patients with idiopathic Parkinson's disease C

Criteria:

- (a) Diagnosis of idiopathic Parkinson's disease; and
- (b) Patient is receiving concomitant levodopa/carbidopa therapy.

GENERIC: EPOETIN ALFA

BRAND: $\underline{\text{EPOGEN}^{\mathbb{R}}}$

INDICATIONS:

- (1) Anemia with cancer chemotherapy (nonmyeloid)
- (2) Anemia due to chronic renal failure
- (3) Anemia of HIV infection associated with zidovudine
- (4) Reduction of allogenic blood transfusion for elective, noncardiac, nonvascular surgery

Criteria:

- (a) Patient's iron stores are adequate (Ferritin ≥100 mcg/mL and/or Transferrin saturation ≥20%) or patient is being treated with iron; **and**
- (b) Adequate blood pressure control

Chronic kidney disease patients:

(c) Initiate treatment when hemoglobin is <10 g/dL (<u>3-month approval</u>)

Anemia due to chemotherapy in cancer patients:

(c) Initiate treatment only if hemoglobin <10 g/dL and anticipated duration of myelosuppressive chemotherapy is ≥2 months

Anemia due to zidovudine in HIV-infected patients:

(c) Initiate treatment when hemoglobin is <10 g/dL

Surgical procedure - Transfusion of blood product, Allogeneic; Prophylaxis:

(c) Patient's pre-operative Hgb >10 to ≤ 13 g/dL (14-day approval)

For renewals:

Chronic kidney disease patients:

- (a) With dialysis Hbg <11
- (b) Without dialysis Hbg <10
- Anemia due to chemotherapy in cancer patients:
- (a) Hbg <11

Anemia due to zidovudine in HIV-infected patients:

(a) Hbg <11

GENERIC: <u>ETANERCEPT</u>

BRAND: <u>ENBREL®</u>

INDICATIONS:

- (1) Moderate to severely active rheumatoid arthritis
- (2) Moderate to severely active polyarticular juvenile rheumatoid arthritis
- (3) Psoriatic spondylitis
- (4) Ankylosing spondylitis
- (5) Plaque psoriasis

Criteria:

 (a) The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to Enbrel therapy; <u>and</u>

(b) The patient does not have a clinically important active infection **Additional Criteria for RA:**

- (c) The patient has failed or is intolerant to one formulary NSAID and
- (d) The patient has failed or is intolerant to one formulary DMARD

Additional Criteria for Plaque Psoriasis:

(c) Involvement of $\geq 10\%$ body surface area (BSA)

GENERIC: EVOLOCUMAB

BRAND: <u>REPATHA[®]</u>

INDICATION:

- (1) Primary hyperlipidemia
- (2) High cholesterol in the blood
- (3) Heterozygous familial hypercholesterolemia (HeFH)
- (4) Reduce the risk of heart attack, stroke, and certain types of heart surgery in patients.
- (5) Atherosclerotic cardiovascular disease (ASCVD)
- (6) Homozygous familial hypercholesterolemia

Criteria:

- (a) Documentation of positive clinical response
- (b) Comprehensive counseling regarding diet
- (c) Not used in combination with another type 9 (PCSK9) INHIBITOR

GENERIC: <u>EXENATIDE</u>

BRAND: <u>BYDUREON®</u>

INDICATION:

(1) Adjunctive therapy of type 2 diabetes mellitus

Criteria:

- (a) Diagnosis of type 2 diabetes; <u>and</u>
- (b) Failure or intolerance to sulfonylureas and/or metformin at optimal dosing. Failure defined as Hemoglobin A1c ≥ 7.0; and
- (c) Patient ≥ 10 years of age

GENERIC: <u>EZETIMIBE</u>

BRAND: $\underline{ZETIA^{\mathbb{R}}}$

INDICATIONS:

- (1) Hypercholesterolemia
- (2) Sitosterolemia

- (a) Diagnosis of Sitosterolemia; or
- (b) For the diagnosis of hypercholesterolemia, failure of optimal dosing/duration or intolerance/contraindication to 2 formulary anti-lipid agents (with at least one agent being a statin)

GENERIC: <u>EZETIMIBE/SIMVASTATIN</u>

BRAND: <u>VYTORIN[®]</u>

INDICATION:

(1) Hypercholesterolemia

Criteria:

(a) Failure of optimal dosing/duration or intolerance/ contraindication to 2 formulary anti-lipid agents (with at least one agent being a statin)

GENERIC: <u>FENOFIBRATE</u>

BRAND: <u>LIPOFEN[®]</u>, TRIGLIDE[®]

INDICATION:

(1) Hypercholesterolemia, Hypertriglyceridemia

Criteria:

(a) Failure of generic fenofibrate 48, 54, 154, or 160 mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

GENERIC: FENOFIBRIC ACID

BRAND: <u>TRILIPIX[®]</u>

INDICATION:

(1) Hypercholesterolemia, Hypertriglyceridemia

- Criteria:
- (a) Failure of generic fenofibrate 48, 54, 154 or 160 mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

GENERIC: FENOFIBRATE MICRONIZED

BRAND: <u>ANTARA®</u>

INDICATION:

(1) Hypercholesterolemia, Hypertriglyceridemia

Criteria:

(a) Failure of generic fenofibrate 54 or 160 mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

GENERIC: FENOFIBRIC ACID TAB

BRAND: <u>FIBRICOR[®]</u>

INIDCATIONS:

- (1) Hypercholesterolemia
- (2) Hypertriglyceridemia

Criteria:

(a) Failure of generic Fenofibrates

GENERIC: FENTANYL TRANSDERMAL PATCH

BRAND: <u>DURAGESIC®</u>

INDICATION:

(1) Persistent, moderate to severe chronic pain OR cancer-related pain that requires continuous, around-the-clock opioid (narcotic) administration for an extended period of time

Criteria:

- (a) Diagnosis of persistent, moderate to severe chronic or cancer-related pain requiring continuous, around-the-clock opioid administration for an extended period of time; **and**
- (b) Patient unable to take medications by mouth; \underline{or}
- (c) Failure of or intolerance/contraindication to a long-acting oral opiate (narcotic) medication (controlled-release morphine, oxycodone, or oxymorphone)
- (d) Completion of Opioid Prior Authorization/Attestation Form required, available at http://www.jaimedicalsystems.com/providers/pharmacy/

GENERIC: <u>FESOTERODINE</u>

BRAND: $\underline{\text{TOVIAZ}^{\mathbb{R}}}$

INDICATION:

(1) Overactive bladder

Criteria:

(a) Failure of Oxybutynin

GENERIC: <u>FILGRASTIM</u>

BRAND: <u>NEUPOGEN[®]</u>

INDICATIONS:

- (1) Prevention of neutropenia in patients receiving myelosuppressive chemotherapy for nonmyeloid malignancies
- (2) Patients undergoing peripheral blood progenitor cell collection and therapy
- (3) Patients with severe chronic neutropenia

Criteria:

- (a) The patient is undergoing peripheral blood progenitor cell collection and therapy; or
- (b) Diagnosis of severe chronic neutropenia with an absolute neutrophil count (ANC) < 1,000; or
- (c) ANC nadir of < 1,000 neutrophils to previous chemotherapy. Once this has been documented, approval will be given for prophylaxis for all future chemo cycles.

* For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.

* Please indicate estimated duration of therapy.

GENERIC: <u>FLUCONAZOLE</u>

BRAND: <u>DIFLUCAN®</u> (PA required after 150mg x2 tablet dispensed)

INDICATIONS:

- (1) Vaginal candidiasis
- (2) Cryptococcal meningitis
- (3) Serious systemic Candida infections
- (4) Oropharyngeal and esophageal candidiasis

Criteria:

(a) Any of the above diagnoses; except

- (b) For the diagnosis of oropharyngeal candidiasis, failure of nystatin therapy; and
- (c) For the diagnosis of vaginal candidiasis, patients who are immunocompromised and/or have recurrent or refractory infections.

GENERIC: GALANTAMINE HYDROBROMIDE

BRAND: <u>RAZADYNE[®]</u>, <u>RAZADYNE ER[®]</u>

INDICATION:

(1) Alzheimer's disease: for the treatment of dementia

Criteria:

(a) Confirmation by clinical evaluation

GENERIC: <u>GATIFLOXACIN</u>

BRAND: <u>ZYMAXID[®]</u>

INDICATION:

(1) Bacterial conjunctivitis

Criteria:

(a) Failure of, contraindication to, or intolerance to ciprofloxacin ophthalmic formulation.

GENERIC: <u>GLATIRAMER ACETATE</u>

BRAND: <u>COPAXONE[®]</u>

INDICATIONS:

- (1) Relapsing-remitting Multiple Sclerosis
- (2) To prevent or slow the development of clinically definite Multiple Sclerosis in patients who have experienced a first clinical episode and have MRI features consistent with Multiple Sclerosis

Criteria:

- (a) Prescribed by neurologist; and
- (b) Not requesting combination therapy of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera

GENERIC: <u>GLECAPREVIR-PIBRENTASVIR</u>

BRAND: <u>MAVYRET[®]</u>

INDICATION:

(1) Chronic Hepatitis C

Criteria:

- (a) Preferred for genotypes 1, 2, 3, 4, 5 and 6
- (b) Must follow the clinical criteria as set by the Maryland Department of Health
- (c) Special Hepatitis C PA request forms, treatment plan template, preferred status information, and full criteria can be obtained at <u>http://www.jaimedicalsystems.com/providers/pharmacy/</u> or by contacting ProCare at 1-800-555-8513

GENERIC: <u>HYDROXOCOBALAMIN</u> BRAND: <u>HYDROXOCOBALAMIN</u> INDICATION:

(1) Vitamin B-12 deficiency

Criteria:

- (a) Patients who lack intrinsic factor; or
- (b) Patients who are on long-term PPI therapy; or
- (c) Patients with a partial or complete gastrectomy.

GENERIC: INTERFERON ALFA

BRAND: ROFERON-A[®], INTRON-A[®], and ALFERON N[®]

INDICATIONS:

- (1) Hairy cell leukemia
- (2) AIDS-related Kaposi's sarcoma
- (3) Chronic Hepatitis B or C
- (4) Malignant melanoma

Criteria:

(a) Any of the above diagnoses.

* For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.

GENERIC: INTERFERON BETA

BRAND: <u>AVONEX[®]</u>, <u>BETASERON[®]</u>, <u>REBIF[®]</u>

INDICATIONS:

- (1) Diagnosis of a relapsing form of Multiple Sclerosis; or
- (2) First clinical demyelinating event with MRI evidence consistent with Multiple Sclerosis

Criteria:

- (a) Prescribed by neurologist; <u>and</u>
- (b) If patient has a history of or is currently being treated for severe psychiatric disorders, suicidal ideation or severe depression, this condition is well controlled; **and**
- (c) Not requesting combination of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera
- * For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.

GENERIC: ISOSORBIDE MONONITRATE

BRAND: <u>IMDUR[®]</u>

INDICATION:

(1) Prevention of angina pectoris

Criteria:

(a) Failure of formulary nitrates.

GENERIC: <u>ITRACONAZOLE</u>

BRAND: <u>SPORANOX®</u>

INDICATIONS:

- (1) Histoplasmosis infections
- (2) Aspergillosis infections
- (3) Blastomycosis

Criteria:

(a) Any of the above diagnoses.

GENERIC: LANSOPRAZOLE

BRAND: <u>PREVACID SOLU-TAB[®]</u>

INDICATION:

(1) Gastroesophageal reflux disease (GERD), heartburn, gastric ulcer, and duodenal ulcer.

Criteria:

- (a) Unable to ingest a solid dosage form (e.g. oral tablet or capsule) due to one of the following: (1) Age
 - (1) Age(2) Oral/motor difficulties
 - (3) Dysphagia
 - (4) Patient utilizes a feeding tube for medication administration

GENERIC: LEDIPASVIR-SOFOSBUVIR

BRAND: <u>HARVONI®</u>

INDICATION:

(1) Chronic Hepatitis C

Criteria:

- (a) Generic tablet only
- (b) Must follow the clinical criteria as set by the Maryland Department of Health
- (c) Special Hepatitis C PA request forms, treatment plan template, preferred status information, and full criteria can be obtained at <u>http://www.jaimedicalsystems.com/providers/pharmacy/</u> or by contacting ProCare at 1-800-555-8513

GENERIC: <u>LEUPROLIDE</u>

BRAND: <u>LUPRON[®]</u>

INDICATIONS:

- (1) Advanced prostate cancer
- (2) Central precocious puberty
- (3) Endometriosis
- (4) Uterine leiomyomata (fibroids)

Criteria:

- (a) Diagnosis of advanced prostate cancer, precocious puberty or fibroids; or
- (b) For the diagnosis of endometriosis, failure of NSAIDS **and** oral contraceptives **or** endometriosis diagnosed by laparoscopy.
- * Note: This agent is ordinarily administered at the physician's office. For injectable medications administered by a healthcare professional,

Please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.

GENERIC: <u>LIDOCAINE PATCH 5%</u>

BRAND: LIDODERM PATCH 5%[®]

INDICATION:

(1) Relief of pain associated with post-herpetic neuralgia.

Criteria:

- (a) Skin application site is intact, and
- (b) For the relief of pain associated with post-herpetic neuralgia;

and

(c) Failure, adverse reaction, or contraindication to two prescription analgesics, including formulary lidocaine topical cream or gel.

GENERIC:LIRAGLUTIDEBRAND:VICTOZA®

INDICATION:

(1) Adjunct to diet and exercise to improve glycemic control in patients with type II diabetes mellitus

Criteria:

- (a) Diagnosis of type II diabetes mellitus; and
- (b) Must be under the care of a healthcare provider skilled with the use of insulin and supported by a diabetes educator; **and**
- (c) Must have tried at least 2 antidiabetic agents such as metformin, sulfonylureas, thiazolidinedione, or insulin and not achieved adequate glycemic control despite treatment or intolerant to other antidiabetic medications; <u>and</u>
- (d) Must have tried and failed or intolerant to treatment with Byetta; and
- (e) NO personal or family history of medullary thyroid carcinoma

GENERIC:LODOXAMDE TROMETHAMINE OPHTH SOLN 0.1%BRAND:ALOMIDE[®]

INDICATION:

(1) Allergic conjunctivitis

Criteria:

(a) Failure or contraindication of Ketotifen

GENERIC: <u>LUBIPROSTONE</u>

BRAND: $\underline{AMITIZA^{(R)}}$

INDICATION:

- (1) Chronic idiopathic constipation
- (2) Irritable bowel syndrome
- (3) Opioid-induced constipation

Criteria:

- (a) Must have a diagnosis of either chronic idopathic constipation, irritable bowel syndrome, or opioid-induced constipation; and
- (b) Failure of Miralax, Senna-S, and/or lactulose

GENERIC: <u>MEMANTINE</u>

BRAND: NAMENDA[®]

INDICATION:

(1) Alzheimer's disease: for treatment of moderate-to-severe cases of dementia **Criteria**:

- (a) Dementia must be confirmed by clinical evaluation; and
- (b) Documented dementia is either moderate or severe

GENERIC: MEPHYTON

BRAND: <u>VITAMIN K</u>

INDICATION:

(1) Anticoagulant-induced prothrombin deficiency

Criteria:

(a) Diagnosis of anticoagulant-induced prothrombin deficiency caused by coumadin or indandione derivatives

GENERIC: <u>METHADONE</u>

BRAND: <u>METHADONE</u>

INDICATION:

- Persistent, moderate to severe chronic pain that requires around-the-clock opioid (narcotic) administration for an extended period of time; not intended as an as-needed analgesic.
 Criteria:
- (a) Completion of Opioid Prior Authorization/Attestation Form required, available at http://www.jaimedicalsystems.com/providers/pharmacy/

GENERIC: METRONIDAZOLE VAGINAL GEL

BRAND: <u>METROGEL[®]</u>

INDICATION:

(1) Bacterial vaginosis

Criteria:

- (a) Pregnancy; or
- (b) Intolerance to oral metronidazole

GENERIC: <u>MILNACIPRAN</u>

BRAND: <u>SAVELLA[®]</u>

INDICATION:

(1) Moderate to severe fibromyalgia

Criteria:

- (a) Diagnosis of fibromyalgia; <u>and</u>
- (b) Documented failure or contraindication to:
 - (1) Pain relievers (e.g. Tramadol); <u>or</u>
 - (2) Muscle Relaxants (e.g. cyclobenzaprine, Baclofen)

GENERIC: <u>MIRABEGRON</u>

BRAND: <u>MYRBETRIQ[®]</u>

INDICATION:

- (1) Overactive bladder
- (2) Neurogenic detrusor over-activity (NDO) in pediatric patients

- (a) Failure of Oxybutynin
- (b) Age 3 years and older and weighing 35kg or more (NDO)

GENERIC: MORPHINE SULFATE SUSTAINED-RELEASE

BRAND: <u>MS CONTIN®</u>

INDICATION:

(1) Persistent, moderate to severe chronic pain OR cancer-related pain that requires continuous, around-the-clock opioid (narcotic) administration for an extended period of time; not intended as an as needed analgesic

Criteria:

(a) Completion of Opioid Prior Authorization/Attestation Form required, available at http://www.jaimedicalsystems.com/providers/pharmacy/

GENERIC: MOXIFLOXACIN

BRAND: <u>AVELOX[®]</u>

INDICATIONS:

- (1) Acute bacterial sinusitis
- (2) Acute bacterial exacerbations of chronic bronchitis
- (3) Mild to moderate pelvic inflammatory disease
- (4) Complicated/Uncomplicated skin and skin structure infections
- (5) Community-acquired pneumonia
- (6) Complicated intra-abdominal infections

Criteria:

- In patients ≥ 18 years of age with any of the above listed indications when:
- (a) Cultures show sensitivity to Avelox® only; or
- (b) Patient discharged on Avelox® from the hospital and needs to complete regimen on an outpatient basis

GENERIC: <u>NAFARELIN</u>

BRAND: <u>SYNAREL®</u>

INDICATIONS:

- (1) Central precocious puberty
- (2) Endometriosis

Criteria:

- (a) Diagnosis of central precocious puberty; or
- (b) For the diagnosis of endometriosis in patients ≥ 18 years of age, failure of NSAIDs and oral contraceptives, or endometriosis diagnosed by laparoscopy.

GENERIC: <u>NUTRITIONAL SUPPLEMENTS</u>

BRAND: ENSURE[®], PEDIASURE[®], BOOST[®], VIVONEX[®]

INDICATION:

(1) Nutritional supplementation

Criteria:

(a) Patient must have enteral access via one of the following: nasogastric (NG) tube, nasoduodenal (ND) tube, nasojejunal (NJ) tube, percutaneous endoscopic gastrostomy (PEG) or percutaneous endoscopic jejunostomy (PEJ).

To obtain nutritional supplements (e.g., Ensure or Pediasure) for members without enteral access, please follow the DME process. For assistance accessing the DME process, please contact Customer Service at 1-888-524-1999.

GENERIC: <u>OCTREOTIDE</u>

BRAND: <u>SANDOSTATIN®</u>

INDICATIONS:

- (1) Symptomatic treatment of severe diarrhea and flushing episodes associated with metastatic carcinoid tumors
- (2) Profuse, watery diarrhea associated with vasoactive intestinal peptide (VIP) secreting tumors
- (3) To reduce the blood levels of growth hormone and IGF-I associated with acromegaly

Criteria:

- (a) Any of the above diagnoses; <u>and</u>
- (b) For the diagnosis of acromegaly, the patient has had an inadequate response to, or cannot be treated with surgical
- (c) resection, pituitary irradiation **and** bromocriptine at maximally tolerated doses.

For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.

GENERIC: OLODATEROL HCL

BRAND: <u>STRIVERDI[®]</u>

INDCATION:

(1) COPD

Criteria:

(a) Patient must be on, and not currently controlled on, an ICS (inhaled corticosteroid)

GENERIC: OLOPATADINE HCL OPHTH SOLN 0.2%

BRAND: <u>PATADAY[®]</u>

INDCATION:

(1) Allergic conjunctivitis

Criteria:

(a) Failure or contraindication to Ketotifen

GENERIC: OLOPATADINE HCL OPHTH SOLN 0.1%

BRAND: <u>PATANOL[®]</u>

INDICATION:

(1) Allergic conjunctivitis

Criteria:

(a) Failure or contraindication of Ketotifen

GENERIC: ONDANSETRON SOLUTION

BRAND: <u>ZOFRAN®</u>

INDICATIONS:

- (1) Chemotherapy induced nausea and vomiting
- (2) Post-operative nausea and vomiting
- (3) Radiation induced nausea and vomiting

Criteria:

(a) For patients who have a contraindication or failure of ondansetron tablets

GENERIC: <u>OXYCODONE, CONTROLLED-RELEASE</u>

BRAND: <u>OXYCONTIN[®]</u>

INDICATION:

(1) Persistent, moderate to severe chronic pain **or** cancer-related pain that requires continuous, around-the-clock opioid

(narcotic) administration for an extended period of time; not intended as an as-needed analgesic.

Criteria:

- (a) Persistent, moderate to severe chronic pain **or** cancer-related pain that requires around-theclock analgesia for an extended period of time; **and**
- (b) For chronic pain, failure, intolerance, or contraindication to at least 2 short-acting formulary narcotic analgesics and controlled-release morphine (MS Contin, others). For cancer pain, failure intolerance, or contraindication to controlled-release morphine (MS Contin, others).
- (c) Completion of Opioid Prior Authorization/Attestation Form required, available at http://www.jaimedicalsystems.com/providers/pharmacy/

GENERIC: PALIVIZUMAB

BRAND: <u>SYNAGIS®</u>

INDICATION:

(1) Prevention of serious lower respiratory disease caused by respiratory syncytial virus (RSV) **Criteria:**

- (a) Administration within RSV season (Nov-Apr); and
- (b) Pt < 2 years of age at start of RSV season with chronic lung disease that has required treatment (supplemental oxygen, bronchodilator, diuretic, or corticosteroid) within prior 6 months <u>or</u>
- (c) Pt born ≤ 28 weeks gestation and is ≤ 12 months at the start of the RSV season <u>or</u>
- (d) Pt born between 29-32 weeks gestation and is ≤ 6 months at the start of the RSV season <u>or</u>
- (e) $Pt \le 24$ months of age at the start of the RSV season with hemodynamically significant congenital heart disease, including one of the following:
 - (1) Receiving medication to control congestive heart failure; or
 - (2) With moderate to severe pulmonary artery hypertension; or
 - (3) With cyanotic congenital heart disease; <u>or</u>
- (f) Pt born between 32-35 weeks gestation, and is \leq 3 months at the start of the RSV season <u>and</u> has one of the following risk factors:
 - (1) Childcare attendance; or
 - (2) Siblings less than 5 years and children born between 32-35 weeks receive a maximum of 3 doses; or
- (g) Is the patient born before 35 weeks of gestation and has either congenital abnormalities of the airway or a neuromuscular condition that compromises handling of respiratory secretions during the first year of life?

Once the prior authorization is received, please contact your Synagis provider. One such provider is Walgreens Specialty pharmacy:

Phone = 866-230-8102 **Fax** = 888-325-6544

GENERIC: PEGINTERFERON ALFA-2A

BRAND: <u>PEGASYS[®]</u>

INDICATIONS:

- (1) Use in combination with ribavirin or ribavirin and other Direct-Acting Antivirals for the treatment of chronic Hepatitis C
- (2) Treatment of chronic Hepatitis C in patients coinfected with HIV whose HIV is clinically stable.
- (3) Treatment of patients with HBeAg positive and HBeAg negative chronic Hepatitis B **Criteria:**

(In combination with ribavirin or ribavirin and other Direct-Acting Antivirals)

- (a) Diagnosis as indicated above including any applicable labs and/or tests
- (b) Clinically documented chronic Hepatitis C with detectable HCV RNA levels > 50 IU/mL
- (c) Age \geq 3 years
- (d) Liver biopsy (unless contraindicated) indicates some fibrosis and inflammatory necrosis
- (e) Intolerant to Peg-Intron
- (f) If HIV positive, patient is clinically stable.

(For chronic Hepatitis B)

- (a) Documented HBeAg positive or negative chronic Hepatitis B
- (b) Compensated liver disease
- (c) Evidence of viral replication
- (d) Evidence of liver inflammation
- (e) Not contraindicated

GENERIC: <u>PEGINTERFERON ALFA-2B</u>

BRAND: <u>PEG-INTRON[®]</u>

INDICATIONS:

- (1) Use in combination with ribavirin for the treatment of chronic Hepatitis C
- (2) Treatment of chronic Hepatitis C in patients coinfected with HIV whose HIV is clinically stable.

Criteria:

(In combination with ribavirin or ribavirin and other Direct-Acting Antivirals)

- (a) Diagnosis as indicated above including any applicable labs and/or tests
- (b) Clinically documented chronic Hepatitis C with detectable HCV RNA levels > 50 IU/mL
- (c) Age \geq 3 years
- (d) Liver biopsy (unless contraindicated) indicates some fibrosis and inflammatory necrosis
- (e) If HIV positive, patient is clinically stable.

GENERIC: <u>PENTOXIFYLLINE</u>

BRAND: <u>TRENTAL[®]</u>

INDICATION:

(1) Intermittent claudication

- (a) Pain on walking or ABI < 0.8; or
- (b) Diabetic foot ulcer; or
- (c) Gangrene; or
- (d) Risk of, or existing, amputation.

GENERIC: PIMECROLIMUS

BRAND: <u>ELIDEL[®]</u>

INDICATION:

(1) Second-line therapy for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children 2 years of age and older, who have failed to respond adequately to other topical prescription treatments, or when treatments are not advisable.

Criteria:

- (a) Documented failure of optimal dosing/adequate duration; or
- (b) Intolerance or contraindication to at least one formulary topical corticosteroid; and
- (c) Diagnosis of mild to moderate atopic dermatitis; and
- (d) Using for short-term and non-continuous treatment.

GENERIC: <u>RABEPRAZOLE</u>

BRAND: <u>ACIPHEX[®]</u>

INDICATIONS:

- (1) Gastric hypersecretion, pathological conditions including Zollinger-Ellison Syndrome
- (2) Erosive esophagitis gastroesophageal reflux disease
- (3) Erosive esophagitis, maintenance therapy gastroesophageal reflux disease

Criteria:

(a) Failure, intolerance, or contraindication to 2 formulary PPIs after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

GENERIC: <u>RALOXIFENE</u>

BRAND: $\underline{EVISTA^{\mathbb{R}}}$

INDICATION:

- (1) Treatment and prevention of osteoporosis in postmenopausal women **Criteria:**
- (a) Personal or family history of breast cancer; or
- (b) Intolerable side effects to at least one formulary estrogen.

GENERIC: <u>RIBAVIRIN</u>

BRAND: <u>REBETOL[®]</u>

INDICATION:

(1) Indicated **only** in combination with a recombinant interferon alfa-2a or alfa-2b product or in combination with other Direct-Acting Antivirals for the treatment of chronic Hepatitis C.

- (a) Diagnosis of chronic Hepatitis C; and
- (b) Patient is receiving concomitant recombinant interferon alfa-2a or alfa-2b therapy or other Direct-Acting Antivirals.

GENERIC: <u>REPAGLINIDE</u>

BRAND: <u>PRANDIN</u>

INDICATION:

(1) Type 2 diabetes mellitus

Criteria:

- (a) Diagnosis of Type 2 diabetes mellitus
- (b) Has not achieved adequate glycemic control on at least ONE of the following:
 - (1) Metformin (alone or in combination)
 - (2) A Sulfonylurea (alone or in combination)
 - (3) A preferred DPP-4 inhibitor
- (c) Contraindication to metformin, a sulfonylurea, OR a preferred DPP-4 Inhibitor

GENERIC: <u>RILUZOLE</u>

BRAND: <u>RILUTEK[®]</u>

INDICATION:

(1) Amyotrophic lateral sclerosis (ALS)

Criteria:

(a) Diagnosis of ALS.

GENERIC: <u>RIVASTIGMINE TARTRATE</u>

BRAND: $\underline{\text{EXELON}^{\mathbb{R}}}$

INDICATION:

(1) Alzheimer's disease: for the treatment of dementia

Criteria:

(a) Confirmation by clinical evaluation

GENERIC: <u>RIZATRIPTAN</u>

BRAND: $MAXALT^{\mathbb{R}}$

INDICATION:

(1) Acute treatment of migraine headache

Criteria:

- (a) Failure of, intolerance to, or contraindication to one traditional formulary agent (NSAID's, ergotamine, or combination analgesic); **or**
- (b) Unsuccessful concurrent or previous use of migraine prophylaxis medications (e.g., betablockers, calcium channel blockers, tri-cyclic antidepressants or anticonvulsants); **and**
- (c) Patient is not currently using ergotamine or another 5-HT1 Receptor Agonist.

GENERIC: <u>ROPINIROLE</u>

BRAND: $\overline{\text{REQUIP}^{\mathbb{R}}}$

INDICATIONS:

- (1) For the treatment of signs and symptoms of idiopathic Parkinson's disease.
- (2) Moderate to severe primary Restless Leg Syndrome.

- (a) Diagnosis of idiopathic Parkinson's disease; <u>or</u>
- (b) Diagnosis of Restless Leg Syndrome and normal iron stores (serum ferritin and/or ironbinding saturation)

GENERIC: SALMETEROL / FLUTICASONE

BRAND: <u>ADVAIR[®] / ADVAIR HFA[®], WIXELA[®], SALMETEROL / FLUTICASONE</u> **INDICATION:**

- (1) Long-term, twice-daily maintenance treatment of asthma in patients 4 years of age and older.
- (2) Maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease.

Criteria:

- (a) Currently on, but not controlled by an inhaled corticosteroid
- (b) The patient must be reevaluated after 6 months
- * For members currently with an approved prior authorization for Advair, claims will process as long as the member has filled Advair within the last 4 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to Advair therapy, or with no claim history of Advair within the last 4 months. Once approved, 90-day supplies are allowed.

GENERIC: SALMETEROL XINAFOATE

BRAND: <u>SEREVENT DISKUS®</u>

INDICATIONS:

- (1) Maintenance treatment of asthma and prevention of bronchospasm in adults and children 4 years of age and older
- (2) Prevention of exercise-induced bronchospasm in patients 4 years of age and older
- (3) Serevent Diskus® is indicated for the maintenance treatment of bronchospasm associated with chronic obstructive pulmonary disease

Criteria:

(a) Currently on but not controlled by an inhaled corticosteroid

GENERIC: <u>SILDENAFIL</u>

BRAND: <u>REVATIO®</u>

INDICATION:

(1) Pulmonary Arterial Hypertension (PAH)

Criteria:

- (a) For the treatment of PAH; **and**
- (b) Current utilization of nitrates is contraindicated; and
- (c) Age limit of 2 years and younger for the solution

GENERIC: SIMVASTATIN 80mg

BRAND: $\underline{ZOCOR}^{\mathbb{R}}$

INDICATIONS:

- (1) Heterozygous or homozygous familial hypercholesterolemia
- (2) Familial type 3 hyperlipoproteinemia
- (3) Hypertriglyceridemia
- (4) Primary hypercholesterolemia, or mixed hyperlipidemia
- (5) Decrease cardiovascular event risk in patients with high coronary event risk
- (6) Cerebrovascular accident prophylaxis

- (a) Age ≤ 65 years
- (b) Male gender (female gender predisposed to myopathy including rhabdomyolysis)
- (c) Controlled hypothyroidism

- (d) Normal renal function
- (e) Documentation of all cholesterol lowering agents tried and failed must be provided.

GENERIC: <u>SITAGLIPTIN PHOSPHATE</u> BRAND: JANUVIA[®]

D: <u>JANUVIA®</u> INDICATION:

(1) Type 2 Diabetes Mellitus

Criteria:

- (a) Diagnosis of type 2 diabetes mellitus and
- (b) Must be used adjunct to diet and exercise and
- (c) Failure or contraindication to metformin or
- (d) Failure or contraindication of sulfonylurea or thiazolidinedione

GENERIC: SOFOSBUVIR-VELPATASVIR

BRAND: <u>EPCLUSA[®]</u>

INDICATION:

(1) Chronic Hepatitis C

Criteria:

- (a) Generic tablets only
- (b) Preferred for genotypes 1, 2, 3, 4, 5 and 6
- (c) Must follow the clinical criteria as set by the Maryland Department of Health
- (d) Special Hepatitis C PA request forms, treatment plan template, preferred status information, and full criteria can be obtained at <u>http://www.jaimedicalsystems.com/providers/pharmacy/</u> or by contacting ProCare at 1-800-555-8513

GENERIC: <u>SOFOSBUVIR-VELPATASVIR-VOXILAPREVIR</u> **BRAND:** VOSEVI[®]

INDICATION:

(1) Chronic Hepatitis C

Criteria:

- (a) For retreatment only
- (b) Must follow the clinical criteria as set by the Maryland Department of Health
- (c) Special Hepatitis C PA request forms, treatment plan template, preferred status information, and full criteria can be obtained at <u>http://www.jaimedicalsystems.com/providers/pharmacy/</u> or by contacting ProCare at 1-800-555-8513

GENERIC: <u>SOLIFENACIN</u> BRAND: <u>VESICARE®</u> INDICATION: (1) Overactive bladder Criteria:

(a) Failure of Oxybutynin

GENERIC: SOMATROPIN

BRAND: <u>HUMATROPE[®]</u>

INDICATIONS:

- (1) Growth failure in children due to inadequate growth hormone (GH) secretion
- (2) Idiopathic short stature in children defined by height standard deviation (SD) score less than or equal to -2.25 and growth rate not likely to attain normal adult height
- (3) Short stature in children associated with Turner syndrome

Criteria:

- (a) Patient with open epiphyses (as confirmed by radiograph of wrist and hand) who has not reached final height; **and**
- (b) Medication prescribed by an endocrinologist; and
- (c) Patient meets one of the following criteria:
 - (1) Growth Hormone Deficiency (GHD) with diagnosis confirmed by one of the following:
 - i. Severe short stature defined as patient's height at ≥ 2 SD below the population mean
 - ii. Patient's height \geq 1.5 SD below the midparental height (average of mother's and father's heights)
 - iii. Patient's height ≥ 2 SD below the mean and a 1-year height velocity more than 1 SD below the mean for chronologic age or (in children 2 years of age or older) a 1-year decrease of more than 0.5 SD in height
 - iv. In the absence of short stature, a 1-year height velocity more than 2 SD below the mean or a 2-year height velocity more than 1.5 SD below the mean (may occur in GHD manifesting during infancy or in organic, acquired GHD)
 - v. Signs indicative of an intracranial lesion
 - vi. Signs of multiple pituitary hormone deficiencies
 - vii. Neonatal symptoms and signs of GHD
 - (2) Idiopathic short stature with patient's height at \geq 2.25 SD below the mean height for normal children of the same age and gender
 - (3) Short stature associated with Turner syndrome and height below the 5th percentile of normal growth curve
- * To continue therapy, requests will be reviewed every six months. For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.

GENERIC: SUCCIMER

BRAND: <u>CHEMET[®]</u>

INDICATIONS:

(1) Treatment of lead poisoning in children with blood lead levels > 45 mcg/dl

(2) Unlabeled uses: Succimer may be beneficial in the treatment of other heavy metal poisonings **Criteria**:

- (a) Diagnosis of lead poisoning with blood levels > 45mcg/dl; **and**
- (b) Child is hospitalized; <u>or</u>
- (c) Child was started on the medication in the hospital and needs to continue upon discharge.

GENERIC: SUCRALFATE SUSPENSION

BRAND: <u>CARAFATE[®]</u>

INDICATIONS:

- (1) Gastric ulcers
- (2) Duodenal ulcers
- (3) Gastritis
- (4) GERD

Criteria:

(a) For patients who have a contraindication or failure of sucralfate tablets

GENERIC: <u>TACROLIMUS</u>

BRAND: <u>PROTOPIC[®]</u>

INDICATION:

(1) Moderate to severe atopic dermatitis

Criteria:

- (a) Patient must be non-immunocompromised and
- (b) Must be at least 2 years of age or older for the 0.03% strength; or
- (c) 16 years of age or older for 0.1% strength and
- (d) Diagnosis of atopic dermatitis
- (e) Documented failure of 2 different topical corticosteroids of medium to high potency in the past 90 days
- (f) Must be prescribed by a dermatologist, allergist, or for children, a pediatrician

GENERIC: <u>TERIFLUNOMIDE</u>

BRAND: <u>AUBAGIO[®]</u>

INDICATION:

(1) Diagnosis of a relapsing form of Multiple Sclerosis

Criteria:

- (a) Prescribed by neurologist; **and**
- (b) Not requesting combination of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera.

GENERIC: <u>TESTOSTERONE</u>

BRAND: <u>ANDROGEL[®], TESTIM[®]</u>

INDICATION:

(1) Hypogonadism

Criteria:

- (a) Must be prescribed by an Endocrinologist or Urologist
- (b) Initial therapy: The patient has documented low testosterone concentration
- (c) Renewal: The patient has documented therapeutic concentration to confirm response

Criteria for transgender members:

- (a) Referral from mental health professional; and
- (b) Persistent, well-documented gender dysphoria; and
- (c) Capacity to make fully informed decision and to consent for treatment; and
- (d) 18 years of age or older

GENERIC: <u>THROMBIN</u> BRAND: <u>THROMBIN</u> INDICATION: (1) Hemostasis Criteria: (a) Diagnosis of a bleeding disorder

GENERIC: <u>TOLTERODINE</u> BRAND: <u>DETROL®/DETROL LA®</u> INDICATION: (1) Overactive bladder Criteria:

(a) Failure of oxybutynin

GENERIC: TRAMADOL ER

BRAND: <u>ULTRAM ER[®]</u>

INDICATION:

(1) Pain, chronic (moderate to severe)

Criteria:

- (a) For patients who have a contraindication or failure of tramadol regular release tablets
- (b) Completion of Opioid Prior Authorization/Attestation Form required, available at http://www.jaimedicalsystems.com/providers/pharmacy/

GENERIC: <u>TROSPIUM</u>

BRAND: SANCTURA[®]

INDICATION:

(1) Overactive bladder

Criteria:

(a) Failure of Oxybutynin

GENERIC:UMECLIDINIUM BROMIDE/VILANTEROLRIFENATATEBRAND:ANORO ELLIPTA®

INDICATION:

(1) Chronic obstructive pulmonary disease (COPD): maintenance of airflow obstruction in patients with COPD, including chronic bronchitis and emphysema.

Criteria:

(a) Trial of long acting or short acting inhaled anticholinergic (Spiriva, Tudorza, Atrovent) within the last 120 days without adequate control of symptoms

GENERIC: <u>VALSARTAN</u> BRAND: <u>DIOVAN®</u> INDICATION: (2) Hypertension Criteria: (d) Failure or contraindication of 2 formulary ARBs (Irbesartan, Losartan)

GENERIC: ZOLMITRIPTAN TABLETS

BRAND: $\underline{ZOMIG}^{\mathbb{R}}$

INDICATION:

(1) Acute treatment of migraine headache

- (a) Failure of, intolerance to, or contraindication to one traditional formulary agent (NSAID, ergotamine, or combination analgesic); <u>or</u>
- (b) Unsuccessful concurrent or previous use of migraine prophylaxis medications (e.g., betablockers, calcium channel blockers, tri-cyclic antidepressants or anticonvulsants); **and**
- (c) Patient is not currently using ergotamine or another 5-HT1 Receptor Agonist

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Dorzolamide HCL-Timolol Maleate*18ERY-TAB1Dorzolamide*19ERYTHROCIN1DOVONEX20Erythromycin Base*1Doxazosin*8ERYTHROMYCIN ESTOLATE1Doxycycline*1Erythromycin Estolate*1DRISDOL16Erythromycin Ethylsuccinate*1	Dolutegravir / Rilpivirine		Erlotinib	4
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DRISDOL 16 Erythromycin Ethylsuccinate* 1				
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	Drospirenone-Eth Estrad Levometolate	5	Erythromycin Gel*	20

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Nystatin*	19	Pediatric Vitamins*	16
Nystatin* (Topical)	20	PEG-Electrolyte*	11
NYSTATIN-TRIAMCINOLONE	20	Peginterferon	3
Nystatin-Triamcinolone*	20	PEG-INTRON, PEGASYS	3
Octreotide Acetate*	11	Penicillamine	21
OCUFEN	19	Penicillin G Benzathine	1
OCUFLOX	18	PENICILLIN V POTASSIUM	1
ODEFSEY	3	Penicillin V Potassium*	1
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	19 5	Pentoxifylline*	18
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Phenylephrine* Ophthalmic	19	PROAIR HFA	10
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Phenyl-Free*	17	Probenecid*	15
Phenytoin*	15	PROCAINAMIDE	8
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Pilocarpine* Ophthalmic	19	Procarbazine	4
Pimecrolimus	20	PROCARDIA XL	7
PIN - X	2	PROCHLORPERAZINE	12
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Polyethylene Glycol powder	11	Propylthiouracil*	6
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POTASSIUM CHLORIDE LIQUID	16	PSEUDOEPHEDRINE	10
Potassium Chloride Liquid*	16	Pseudoephedrine HCL*	10
Potassium Chloride Tablet*	16	Pseudoephedrine-Bromphen-DM*	11
PRADAXA	17	Pseudoephedrine-Chlorphen-DM*	11
PRANDIN	6	Pseudoephedrine-DM liquid*	11
PRAVACHOL	9	PSEUDOEPHEDRINE-DM SOLN	11
Pravastatin*	9	Pseudoephedrine-DM soln*	11
Prazosin*	8	Pseudoephedrine-GG*	11
PRECOSE	6	PSEUDO-G / PSI	11
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Prednisolone Acetate	4	PULMICORT RESPULES	10
Prednisolone Na Phosphate	4	PURINETHOL	4
Prednisolone	4	Pyrantel Pamoate*	2
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RELENZA	2	Sitagliptin Phosphate	6
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	° 20	Sodium Sulfacetamide* Ophthalmic Sofosbuvir-Velpatasvir*	3
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Ropinirole*	15	Sulfacetamide Sod-Prednisolone* Ophthalmic	19
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