Arkansas Medicaid

Prescription Drug Program Prior Authorization Criteria

Revised 10/01/2019

This document is an informational listing of the medications requiring a Prior Authorization through the Arkansas Medicaid Pharmacy Program, and a description of the associated criteria. Inclusion in this document does not guarantee market availability and products must meet the Centers for Medicare and Medicaid Services (CMS) definition of a covered outpatient drug and pay CMS rebate to be covered by Arkansas Medicaid. Select covered over the counter medications are covered pursuant to a valid prescription, but are not covered for Long Term Care eligible beneficiaries.
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For assistance on all other drugs, prescribers may call the Magellan Pharmacy Unit at 1-800-424-7895 (toll-free). The appropriate number is indicated with the associated drug.

Please refer to the Arkansas Medicaid Pharmacy Webpage at https://arkansas.magellanrx.com/provider/documents for a complete list of drugs.

Other claim edits for age, gender, quantity, dose and/or cumulative quantity may apply. https://arkansas.magellanrx.com/provider/docs/rxinfo/ClaimEdits.xls
Abemaciclib Tablet (Verzenio)

*Implemented 03/01/2018*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drug that require a manual review for prior authorization

- Verzenio Tablet

Additional criteria

- Age limits apply
- Quantity limits apply

Link to Memorandum

Top of the document
Acalabrutinib Capsule (Calquence)
(Implemented 03/01/2018)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drug that require a manual review for prior authorization
- Calquence 100mg Capsule

Additional criteria
- Age limits apply
- Quantity limits apply

Link to Memorandum
Top of the document
Abiraterone Acetate Tablet (Zytiga)

*(Implemented 12/10/2013)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Zytiga

**Additional criteria**

Quantity limits apply

[Link to Memorandum](#)

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Acitretin Capsule (Soriatane)

(Implemented 03/26/2008)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Soriatane

Link to Memorandum

Top of the document
Acyclovir Cream, Ointment
(Implemented 03/19/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that do not require prior authorization

- Docosanol 10% (Abreva) cream

Drugs that require manual review for prior authorization

- Acyclovir (Zovirax) 5% cream
- Acyclovir (Zovirax) 5% ointment
- Acyclovir-Hydrocortisone (Xerese) 5%-1% cream
- Penciclovir (Denavir) 1% cream 5 gram (Implemented 09/23/2014)

Additional criteria

- Quantity edits apply
Acyclovir Orally Disintegrating Delayed Release Tablet (Sitavig)

(Implemented 09/23/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Sitavig

[Link to Memorandum]

[Top of the document]
Afatinib Dimaleate Tablet (Gilotrif)

(Implemented 12/10/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Gilotrif

Additional criteria
Quantity limits apply

Link to Memorandum

Top of the document
Alagesic Liquid Oral Solution 50-325-40/15ml

*(Implemented 01/18/2011)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- NPO *(Appendix A)* within past 365 days.

Age Edit

- Recipients must be 12 years of age or greater

[Link to Memorandum](#)

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Albuterol Inhalers

(Implemented 1/1/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Preferred

- ProAir HFA- Brand only
- Proventil HFA- Brand only

Non-Preferred

- Ventolin HFA
- Albuterol HFA (generics)
- ProAir RespiClick

QUANTITY LIMITS:

- Maximum quantity of 2 inhalers per 23 days

IMPORTANT NOTICE:

- For the month of August (only), recipients under the age of 18 will be allowed to fill an additional Albuterol HFA inhaler with an approved override. The pharmacy or the physician’s office may request an override via phone or fax. ProAir HFA and Proventil HFA are the preferred products. If an override is needed, please call the Magellan Help Desk at 1-800-424-7895 or fax 1-800-424-7976.
Albuterol Oral Tablets and Syrup

(*Implemented 03/18/2014*)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Albuterol 2mg/5ml Syrup
- Albuterol 2mg IR
- Albuterol 4mg IR
- Albuterol 4mg ER
- Vospire 4mg ER
- Albuterol 8mg ER
- Vospire 8mg ER

Additional criteria

Quantity limits apply

[Link to Memorandum](#)

[Link to Memorandum](#)

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Alectinib (Alecensa) Capsule

(Implemented 07/13/2016)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

• Alecensa

Link to Memorandum

Top of the document
Alirocumab (Praluent)

*(Implemented 02/16/2016)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Praluent

[Link to Memorandum](#)

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Allergan Extracts
(short Ragweed Pollen Allergan Extract) and (Timothy Grass Pollen Allergen Extract)
(Implemented 09/23/2014)
(Updated 07/17/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Ragwitek
- Grastek

Link to Memorandum

Link to Memorandum

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Ammonul 10%-10%Vial

(Updated 05/20/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Ammonul 10%-10%
Angiotensin Receptor Modulators

(Implemented 10/01/2008)
(Updated 01/27/2017)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

PREFERRED

- BENAZEPRIL
- BENAZEPRIL/HCTZ
- ENALAPRIL
- ENALAPRIL/HCTZ
- LISINOPRIL
- LISINOPRIL/HCTZ
- QUINAPRIL
- QUINAPRIL/HCTZ
- RAMIPRIL

NON-PREFERRED

- BENAZEPRIL/AMLODIPINE
- CAPTOPRIL/HCTZ
- FOSINOPRIL
- FOSINOPRIL/HCTZ
- MOEXIPRIL
- MOEXIPRIL/HCTZ
- PERINDOPRIL
- PRESTALIA
- TRANDOLAPRIL
- TRANDOLAPRIL/VERAPAMIL
- ZESTORETIC
- TEKTURNNA
- TEKTURNNA HCT
- ENALAPRIL SOLUTION (EPANED)
- LISINOPRIL SOLUTION (QBRELIS)

NON-PREFERRED WITH CRITERIA STATUS

CAPTOPRIL (point of sale Approval for children ≤ 12 years of age)
Angiotensin II Receptor Blockers (ARB) and ARB Combination Products

PREFERRED- (POS criteria to be removed 1/1/18)
- IRBESARTAN
- IRBESARTAN/HCTZ
- LOSARTAN
- LOSARTAN/HCTZ
- VALSARTAN
- VALSARTAN/HCTZ
- VALSARTAN/AMLODIPINE
- EXFORGE HCT® (BRAND ONLY)

PREFERRED WITH MANUAL REVIEW
Neprilysin Inhibitor/Angiotensin II Receptor Blocker,
- ENTRESTO™ (sacubitril and valsartan tablet)

NON-PREFERRED ARB and ARB Combination Products
- AZILSARTAN (EDARBI)
- AZILSARTAN/CHLORTHALIDONE (EDARBYCLOR)
- AMLODIPINE/OLMESARTAN
- AMLODIPINE/OLMESARTAN/HCTZ
- BYVALSON
- CANDESARTAN
- CANDESARTAN/HCTZ
- EPROSARTAN
- EPROSARTAN/HCTZ
- OLMESARTAN
- OLMESARTAN/AMLODIPINE
- OLMESARTAN/HCTZ
- OLMESARTAN/AMLODIPINE/HCTZ
- TELMISARTAN
- TELMISARTAN/AMLODIPINE
- TELMISARTAN/HCTZ
- VALSARTAN/AMLODIPINE/HCTZ

Link to Memorandum
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Antibiotic Ophthalmic Drops

(Implemented 08/21/2009)
(Updated 5/10/17, Effective 7/1/17)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Preferred Status:

- Polymyxin B /trimethoprim ophthalmic solution drops
- Bacitracin/ polymyxin B ophthalmic solution drops
- Tobramycin 0.3% ophthalmic solution drops
- Gentamicin 0.3% ophthalmic solution drops
- Gentamicin 0.3% ophthalmic ointment
- Erythromycin 0.5% ophthalmic ointment
- VIGAMOX® (Brand Only) moxifloxacin 0.5% ophthalmic solution drops
- Ciprofloxacin ophthalmic solution drops

Non-Preferred Status:

- TOBREX® (tobramycin) 0.3% ointment
- BESIVANCE® (besifloxacin) 0.6% ophthalmic suspension drops
- CILOXAN® (ciprofloxacin) 0.3% ophthalmic solution drops
- CILOXAN® (ciprofloxacin) 0.3% ophthalmic ointment
- ZYMAXID® (gatifloxacin) 0.5% ophthalmic solution drops
- Levofoxacin 0.5% ophthalmic solution drops
- MOXEZA® (moxifloxacin) 0.5% ophthalmic solution drops
- Moxifloxacin (generic Vigamox) 0.5% ophthalmic solution drops
- Ofloxacin 0.3% ophthalmic solution drops
- AZASITE® (azithromycin) 1% ophthalmic solution drops
- Bacitracin ophthalmic ointment 500 units/gm
- NATACYN® (natamycin) 5% ophthalmic suspension drops
- Neomycin/polymyxin B/ bacitracin ophthalmic ointment
- Neomycin/polymyxin B/ gramicidin ophthalmic solution drops
- Sulfacetamide 10% ophthalmic solution drops
Antibiotic-Steroid Fixed-Dose Combination Ophthalmic Drops  
(Cortisporin, Tobradex ST, Zylet)  

*Implemented 10/11/2011*  
*Updated 5/10/17, Effective 7/1/17*

**Preferred Status:**

- Neomycin sulfate /polymyxin B/ dexamethasone ophthalmic ointment
- Neomycin sulfate /polymyxin B/ dexamethasone 0.1% ophthalmic suspension drops
- TOBRADEX® (tobramycin / dexamethasone) 0.3% / 0.1% ophthalmic ointment
- Tobramycin 0.3%/dexamethasone 0.1% ophthalmic suspension drops
- Sulfacetamide sodium 10% / prednisolone sodium phosphate 0.23% ophthalmic solution drops

**Non-Preferred Status:**

- TOBRADEX® ST (tobramycin / dexamethasone) 0.3%/0.05% ophthalmic suspension drops
- Neomycin 3.5 mg/ polymyxin B sulfates 10K / hydrocortisone 1% ophthalmic suspension drops
- Neomycin sulfate/ polymyxin B sulfates/ bacitracin zinc/ hydrocortisone ophthalmic ointment
- ZYLET® (loteprednol 0.5%/tobramycin 0.3%) ophthalmic suspension drops
- PRED-G® (gentamicin sulfate 0.3%/prednisolone acetate 0.6%) ophthalmic ointment
- PRED-G® (gentamicin sulfate 0.3%/prednisolone acetate 1%) ophthalmic suspension drops
- BLEPHAMIDE® S.O.P. (sulfacetamide sodium 10% / prednisolone 0.2%) ophthalmic ointment
- BLEPHAMIDE® (sulfacetamide sodium 10% / prednisolone 0.2%) ophthalmic suspension drops

[Link to Memorandum](#)

[Link to Memorandum](#)

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Antibiotics, Long-acting
Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).
(Implemented 09/21/2009 and 8/17/2010)

Drugs that do not require prior authorization
Generic MAC'd short-acting antibiotics are available without a prior authorization.

Drugs that require manual review for prior authorization
- Amoxicillin ER 775mg (Moxatag ER)
- Ciprofloxacin ER 500mg, 1000mg (Cipro XR, Proquin XR)
- Metronidazole ER 750mg (Flagyl ER)

Link to Memorandum: Clarithromycin XL, Flagyl ER 750 mg
Link to Memorandum: Removal of manual review for Clarithromycin XL

Link to Memorandum: Ciprofloxacin ER, Proquin, Moxatag

Top of the document
Anticoagulants (Oral and LMWH)

(Effective 4/01/2018)
Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

PREFERRED AGENTS

- enoxaparin-generic only, vial or syringe
- warfarin—generic only
- Pradaxa® capsule (dabigatran)
- Eliquis® tablet (apixiban)
- Xarelto® tablet (rivaroxaban)

Approval criteria

- No Therapeutic duplication allowed between different strengths of the same anticoagulant;
- One (1) therapeutic duplication with overlapping days’ supply will be allowed once per 186 days for an inferred change in therapy between a preferred anticoagulant AND
- The claims cannot have the same date of service.

Additional criteria

Quantity limits apply

NONPREFERRED AGENTS

- dalteparin injection (Fragmin®)
- fondaparinux injection (Arixtra®)
- edoxaban tablet (Savaysa®)
- Coumadin® (brand only)
- Lovenox® (brand only)
- Betrixaban - Bevyxxa®

Link to Memorandum
Top of the document
Antidepressants - Second-generation (SGAD)

*(Implemented 01/01/2010)*
*(Updated 01/10/2019)*

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

**Preferred agents with criteria**

- Bupropion HCl regular-release (Wellbutrin)
- Bupropion HCl extended-release (Wellbutrin XL)
- Bupropion HCl sustained-release (Wellbutrin SR)
- Citalopram hydrobromide (Celexa)
- Escitalopram oxalate (Lexapro)
- Fluoxetine HCl 10mg, 20mg capsule, and 20mg/5ml solution (Prozac)
- Fluvoxamine maleate (Luvox)
- Mirtazapine 7.5mg, 15mg, 30mg, 45mg tablet (Remeron)
- Paroxetine HCl regular-release tablet (Paxil)
- Sertraline HCl (Zoloft)
- Venlafaxine HCl extended-release capsule (Effexor ER)
- Venlafaxine HCl regular-release tablet (Effexor)
- Duloxetine (Cymbalta)

**Nonpreferred agents with SGAD criteria**

- Bupropion hydrobromide extended-release tablet (Aplenzin)
- Bupropion HCl extended-release tablet (Forfivo XL)
- Desvenlafaxine extended-release tablet (Khedezla ER)
- Desvenlafaxine fumarate extended-release tablet
- Desvenlafaxine succinate extended-release tablet (Pristiq ER)
- Duloxetine HCl (Irenka DR)
- Fluoxetine HCl 10mg, 15mg, 20mg Tablet; 40mg capsule; and 90mg weekly capsule (Prozac)
- Fluvoxamine maleate extended-release (Luvox CR)
- Levomilnacipran (Fetzima)
- Milnacipran HCl (Savella)
- Mirtazapine orally disintegrating tablet (Remeron SolTab)
- Nefazodone HCl (Serzone)
- Paroxetine (Brisdelle)
- Paroxetine HCl controlled-release tablet, and 10mg/5ml suspension (Paxil)
- Paroxetine mesylate (Pexeva)
- Vilazodone HCl (Viibryd)
- Vortioxetine HBr (Trintellix, Brintellix)
- Venlafaxine HCl extended-release tablet
Nonpreferred agents
- Levomilnacipran HCl extended-release tablet (Fetzima ER)
- Paroxetine mesylate (Brisdelle)

Exempt SGAD combination agents with criteria
Fluoxetine HCL/Olanzapine (Symbyax)

Approval criteria for preferred or exempt agents
Drug daily dose \( \leq \) maximum daily dose (Table 1)

Approval criteria for preferred or exempt agents resulting from a therapeutic duplication
- If applicable for a change in therapy or concomitant therapy of two agents and only one or neither are SSRIs and/or SSNRIs (including combinations) (Table 1.2):
  Drug in history reflects a minimal therapeutic dose (Table 1) for at least four weeks
  OR
- If applicable for a change in therapy for two SSRIs and/or SSNRIs (including combinations) (Table 1.2)
  Drug in history reflects a minimal therapeutic dose (Table 1) for at least four weeks, AND
  No prior therapeutic duplication for two different SSRIs and/or SSNRIs (including combinations) (Table 1.2) within the past 365 days.

Approval criteria for all nonpreferred agents except milnacipran
> 90 days of therapy in the previous 120 days for the same drug, strength, and daily dose with the denial exception of a therapeutic duplication between an SSRI and/or SNRI between incoming claim and history

Denial criteria for all agents
- Preferred agents or exempt agents Therapeutic duplication of three agents
  Therapeutic duplication of two SSRIs and/or SSNRIs (including combinations) (Table 1.2) more than once per 365 days
- Nonpreferred drugs for patients who do not meet criteria of >90 days of therapy in the previous 120 days for the same drug, strength, and daily dose
- See Fibromyalgia agents for additional criteria on select second generation antidepressants

Link to Memorandum

Link to PDL Memorandum: Second Generation Antidepressants

Top of the document
Table 1 – Minimum and maximum dose for second-generation antidepressants

<table>
<thead>
<tr>
<th>Drug</th>
<th>Minimal daily therapeutic dose</th>
<th>Maximum daily dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bupropion</td>
<td>200mg</td>
<td>450mg</td>
</tr>
<tr>
<td>Citalopram</td>
<td>20mg</td>
<td>40mg</td>
</tr>
<tr>
<td>Desvenlafaxine</td>
<td>50mg</td>
<td>100mg</td>
</tr>
<tr>
<td>Duloxetine</td>
<td>40mg</td>
<td>60mg</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>10mg</td>
<td>30mg</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>20mg</td>
<td>80mg</td>
</tr>
<tr>
<td>Fluoxetine/olanzapine*</td>
<td>25mg</td>
<td>75mg</td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>100mg</td>
<td>300mg</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>30mg</td>
<td>60mg</td>
</tr>
<tr>
<td>Nefazodone</td>
<td>300mg</td>
<td>600mg</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>30mg</td>
<td>60mg (CR 62.5mg)</td>
</tr>
<tr>
<td>Sertraline</td>
<td>100mg</td>
<td>200mg</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>150mg</td>
<td>375mg</td>
</tr>
</tbody>
</table>

* Minimum therapeutic dose and maximum dose based on SSRI component of the combination agent.

Table 1.2 – Selective Serotonin (norepinephrine) Reuptake Inhibitors (combinations)

SSRI, SSNRI or SSRI Combinations
- Citalopram
- Desvenlafaxine
- Duloxetine
- Escitalopram
- Fluoxetine
- Fluoxetine/olanzapine
- Fluvoxamine
- Paroxetine
- Sertraline
- Venlafaxine
Antidiabetic Agents
(Implemented 01/01/2009)
(Updated 8/21/17)
(Effective 10/1/17)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents-Manual Review-TZDs

- pioglitazone

Non-Preferred

- Avandia® (rosiglitazone)
- Avandamet® (rosiglitazone/ metformin)
- pioglitazone/ metformin
- brand name Actos (pioglitazone)
- Actoplus Met (pioglitazone/ metformin)
- Actoplus Met XR (pioglitazone/ metformin extended-release)
- Duetact (pioglitazone/ glimepiride)

Preferred agents-Manual Review-SGLT2

- Farxiga® (dapagliflozin)
- Xigduo® XR (dapagliflozin/ metformin ER)
- Jardiance® (empagliflozin)
- Synjardy® (empagliflozin/metformin)

Non-Preferred

- Invokana® (canagliflozin)
- Invokamet® (canagliflozin/ metformin)
- Invokamet® XR (canagliflozin/ metformin)
- Synjardy® XR (empagliflozin/ metformin ER)

Preferred agents-Manual Review-DPP-4

- Janumet® (sitagliptin/metformin)
Non-Preferred

- Nesina (Alogliptin)
- Kazano (alogliptin/metformin)
- Oseni (alogliptin/pioglitazone)
- Glyxambi® (linagliptin/empagliflozin)
- Onglyza® (saxagliptin)
- Kombiglyze® XR (saxagliptin/metformin ER)
- Janumet® XR (sitagliptin/metformin extended release)
- Tradjenta® (linagliptin)
- Jentadueto® (linagliptin/metformin)
- Januvia® (sitagliptin)

Preferred agents-Manual Review-GLP-1

- Byetta® (exenatide)
- Bydureon® Vial & Pen (exenatide ER)
- Victoza® (liraglutide)

Non-Preferred

- Bydureon® BCise (exenatide ER)
- Tanzeum® (albiglutide)
- Trulicity® (dulaglutide)
- Xultophy® (liraglutide/insulin degludec)
- Adlyxin™ (lixisenatide)
- Soliqua™ 100/33 (lixisenatide/insulin glargine)

Preferred agents-Meglitinides

- nateglinide
- repaglinide

Non-Preferred

- repaglinide/ metformin

Preferred agents-Sulfonylureas

- Glimepiride (Amaryl)
- Glipizide (Glucotrol)
- Glipizide extended-release (Glucotrol XL)
• Glipizide/Metformin HCl (Metaglip)
• Glyburide (Diabeta, Glynase Prestab)
• Glyburide/Metformin HCl (Glucovanse)
Antiemetic Agents - (HT3 or NK1 Receptor Antagonists)

*Implemented 09/14/2009*
*Updated 08/18/2015*

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents with criteria

- Ondansetron HCl 4mg, 8mg tablet (Zofran)
- Ondansetron 4mg, 8mg oral-disintegrating tablet (Zofran ODT)
- Ondansetron 4mg/2ml preservative-free vial (Zofran)
- Ondansetron 40mg/20ml vial (Zofran)

Nonpreferred agents

- Aprepitant (Emend)
- Dolasetron (Anzemet)
- Granisetron (Kytril, Sancuso)
- Netupitant-Palonosetron HCl (Akynzeo)
- Palonosetron HCl (Aloxi)
- Ondansetron 24mg tablet (Zofran)
- Ondansetron 32mg/50ml bag (Zofran)
- Ondansetron 4mg/2ml ampule and syringe (Zofran)
- Ondansetron 4mg/5ml solution (Zofran)
- Ondansetron Soluble Film (Zuplenz)

Approval criteria for preferred agents with criteria

No therapeutic duplication with other 5-HT3 receptor antagonists

Additional criteria

Quantity limits apply
Anti-inflammatory Ophthalmic Drops

*(Implemented 01/12/2010)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

History of at least two claims for two different products that do not require prior authorization within the previous 28 days

<table>
<thead>
<tr>
<th>GENERIC NAME</th>
<th>COMMON TRADE NAME*</th>
<th>PA STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dexamethasone Sodium Phosphate 0.1% eye drops</td>
<td>Decadron® 0.1% eye drops</td>
<td>No PA</td>
</tr>
<tr>
<td>Diclofenac 0.1% eye drops</td>
<td>Voltaren® 0.1% eye drops</td>
<td>No PA</td>
</tr>
<tr>
<td>Fluorometholone 0.1% eye drops</td>
<td>FML Liquifilm® 0.1% eye drops</td>
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<td>Fluorometholone 0.25% eye drops</td>
<td>FML Forte® 0.25% eye drops</td>
<td>No PA</td>
</tr>
<tr>
<td>Flurbiprofen 0.03% eye drops</td>
<td>Ocu fen® 0.03% eye drops</td>
<td>No PA</td>
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<tr>
<td>Ketorolac 0.5% eye drops</td>
<td>Acular® 0.5% eye drops</td>
<td>No PA</td>
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<tr>
<td>Ketorolac 0.4% eye drops</td>
<td>Acular LS® 0.4% eye drops</td>
<td>No PA</td>
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<tr>
<td>Prednisolone acetate 1% eye drops</td>
<td>Pred Forte® 1% eye drops</td>
<td>No PA</td>
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<tr>
<td>Prednisolone acetate 0.12% eye drops</td>
<td>Pred Mild® 0.12% eye drops</td>
<td>No PA</td>
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<tr>
<td>Prednisolone sodium 1% eye drops</td>
<td>AK-Pred® 1% eye drops</td>
<td>No PA</td>
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<td>Bromfenac 0.07% eye drops</td>
<td>Prolensa® 0.07% eye drops</td>
<td>PA</td>
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<td>Bromfenac 0.09% eye drops</td>
<td>Bromday® 0.09% eye drops</td>
<td>PA</td>
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<tr>
<td>Dexamethasone 0.1% suspension eye drops</td>
<td>Maxidex® 0.1% suspension eye drops</td>
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<td>Durezol® 0.05% eye drops</td>
<td>PA</td>
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<td>Fluorometholone 0.1% eye drops</td>
<td>Flarex® 0.1% eye drops</td>
<td>PA</td>
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<td>Ketorolac 0.45% eye drops</td>
<td>Acuvail® 0.45% eye drops</td>
<td>PA</td>
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<td>Loteprednol 0.2% eye drops</td>
<td>Airex® 0.2% eye drops</td>
<td>PA</td>
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<td>Loteprednol 0.5% eye drops</td>
<td>Lotemax® 0.5% eye drops</td>
<td>PA</td>
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<tr>
<td>Loteprednol 0.5% eye gel drops</td>
<td>Lotemax® 0.5% eye gel drops</td>
<td>PA</td>
</tr>
<tr>
<td>Loteprednol 1% suspension</td>
<td>Inveltys®</td>
<td>PA</td>
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<tr>
<td>Nepafenac 0.1% eye drops</td>
<td>Nevanac® 0.1% eye drops</td>
<td>PA</td>
</tr>
<tr>
<td>Nepafenac 0.3% eye drops</td>
<td>Il evro® 0.3% eye drops</td>
<td>PA</td>
</tr>
<tr>
<td>Rimexolone 1% eye drops</td>
<td>Vexol® 1% eye drops</td>
<td>PA</td>
</tr>
</tbody>
</table>

*TRADE NAMES ARE FOR REFERENCE ONLY

[Link to Memorandum]
[Top of the document]
Anti-inflammatory Agents (NSAIDs)

(Implemented 06/18/2007)
(Updated 08/14/2015)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDf option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents

• Diclofenac sodium ER 100mg tablet (Voltaren XR)
• Ibuprofen 100mg/5ml suspension; 400mg, 600mg, 800mg tablet (Motrin)
• Indomethacin 25mg, 50mg capsule (Indocin)
• Ketoprofen 50mg, 75mg capsule (Orudis)
• Meloxicam 7.5mg, 15mg tablet (Mobic)
• Naproxen 250mg, 375mg, 500mg tablet (Naprosyn)
• Naproxen 375mg, 500mg enteric-coated tablet (EC-Naprosyn)
• Naproxen sodium 275mg and 550mg tablet (Anaprox)
• Salsalate 750mg (Salflex-750)

Preferred agent with criteria

• Ketorolac tablet (Toradol)

Nonpreferred agents

• Celecoxib (Celebrex)
• Diclofenac epolamine (Flector)
• Diclofenac potassium (Cambia, Cataflam, Zipsor)
• Diclofenac sodium 25mg, 50mg, and 75 mg tablet (Voltaren)
• Diclofenac sodium topical (Pennsaid, Voltaren Gel)
• Diclofenac sodium/Misoprostol (Arthrotec)
• Diclofenac submicronized (Zorvolex)
• Diflunisal (Dolobid)
• Dyloject
• Etodolac (Lodine)
• Fenoprofen (Nalfon)
• Flurbiprofen (Ansaid)
• Ibuprofen 40mg/ml suspension; 50mg,100mg tablet (Motrin)
• Ibuprofen/caffeine/B1/B2/B6/B12 (IC400, IC800 Kit)
• Ibuprofen/famotidine (Duexis)
• Indomethacin 75mg SA Capsule; 50mg suppository; 25mg/5ml suspension (Indocin), 25mg Capsule (Tivorbex), 20mg and 40mg Capsule Tivorbex
• Ketoprofen 200mg extended-release capsule (Oruvail)
• Ketorolac nasal spray (Sprix)
• Meclomenamate sodium (Meclomen)
• Mefenamic acid (Ponstel)
• Meloxicam suspension (Mobiz)
• Meloxicam tablet, orally disintegrating tablet (QMIIZ)
• Nabumetone (Relafen)
• Naproxen/Esomeprazole magnesium (Vimovo)
• Naproxen Suspension (Naprosyn)
• Naproxen sodium 375mg and 500mg extended-release tablet (Naprelan)
• Oxaprozin (Daypro)
• Piroxicam (Feldene)
• Salsalate 500mg (Salflex-500)
• Sulindac (Clinoril)
• Tolmetin sodium (Tolectin)

Nonpreferred agents with criteria
• Diclofenac Sodium 3% Gel (Solaraze)
• Naproxen 125mg/ml suspension (Naprosyn suspension)

Approval criteria for nonpreferred agents with criteria
• Diclofenac Sodium 3% Gel (Solaraze)
  Diagnosis of Actinic Keratosis in the past two months
• Naproxen 125mg/ml suspension (Naprosyn suspension)
  < 7 years of age, OR NPO (Appendix A) in the past year.

Denial criteria for preferred agent with criteria
• Ketorolac
  o History of ketorolac use in the last 60 days, OR
  o NSAID claim in the past 30 days, OR
  o Dose greater than four per day, OR
  o Day supply greater than five, OR
  o Quantity greater than 20, OR
  o Greater than 20 units per 60 days

Link to PDL Memorandum: NSAIDS

Top of the document
Antihistamine Eye Drops, Mast Cell Stabilizers, and Combination Mast Cell Stabilizer-Antihistamine Eye Drops

*Implemented 01/12/2012*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

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<thead>
<tr>
<th>EYE DROPS FOR ALLERGIC CONJUNCTIVITIS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENERIC NAME</strong></td>
</tr>
<tr>
<td>Azelastine HCl 0.05% eye drops</td>
</tr>
<tr>
<td>Cromolyn sodium 4% eye drops</td>
</tr>
<tr>
<td>Ketotifen fumarate 0.025% eye drops</td>
</tr>
<tr>
<td>Ketotifen fumarate 0.025% eye drops</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GENERIC NAME</th>
<th><strong>COMMON TRADE NAME</strong></th>
<th><strong>PA STATUS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcaftadine 0.25% eye drops</td>
<td>Lastacaft® 0.25% eye drops</td>
<td>Manual PA</td>
</tr>
<tr>
<td>Bepotastine besilate 1.5% eye drops</td>
<td>Bepreve® 1.5% eye drops</td>
<td>Manual PA</td>
</tr>
<tr>
<td>Emedastine difumarate 0.05% eye drops</td>
<td>Emadine® 0.05% eye drops</td>
<td>Manual PA</td>
</tr>
<tr>
<td>Epinastine HCl 0.05% eye drops</td>
<td>Elestat® 0.05% eye drops</td>
<td>Manual PA</td>
</tr>
<tr>
<td>Lodoxamide tromethamine 0.1% eye drops</td>
<td>Alomide® 0.1% eye drops</td>
<td>Manual PA</td>
</tr>
<tr>
<td>Nedocromil sodium 2% eye drops</td>
<td>Alocrit® 2% eye drops</td>
<td>Manual PA</td>
</tr>
<tr>
<td>Olopatadine HCl 0.1% eye drops</td>
<td>Patanol® 0.1% eye drops</td>
<td>Manual PA</td>
</tr>
<tr>
<td>Olopatadine HCl 0.2% eye drops</td>
<td>Pataday® 0.2% eye drops</td>
<td>Manual PA</td>
</tr>
<tr>
<td>Olopatadine HCl 0.7% eye drops</td>
<td>Pazeo® 0.7% eye drops</td>
<td>Manual PA</td>
</tr>
</tbody>
</table>

*TRADE NAMES ARE FOR REFERENCE ONLY*

[Link to Memorandum](#)

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Antihyperuricemics

(Implemented 4/1/18)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

PREFERRED AGENTS
  • MITIGARE® capsule-BRAND ONLY
  • allopurinol
  • probenecid
  • probenecid/colchicine

NONPREFERRED AGENTS
  • colchicine tablet (Colcrys®)
  • colchicine capsule-generic
  • febuxostat (Uloric®)
  • lesinurad/allopurinol (Duzallo®)
  • lesinurad (Zurampic®)

Link to Memorandum
Antihistamines (Second-generation)

(Implemented 11/2007)
(updated 2/21/18)
(Effective 4/1/18)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents

- Cetirizine HCl 1 mg/ml solution, 10 mg swallow tablet (Zyrtec)
- Loratadine (Claritin)
- Azelastine HCL nasal spray (Astelin, Astepro)

Nonpreferred agents

- Acrivastine w/Pseudoephedrine (Semprex-D)
- Azelastine/fluticasone nasal spray (Dymista)
- Desloratidine syrup (Clarinex)
- Olopatadine HCl 6% nasal spray (Generic Patanase)
- Olopatadine HCl 6% nasal spray (Brand Patanase)
- Cetirizine 5 mg swallow table, 10 mg chewable tablet (Zyrtec)
- Desloratadine tablet (Clarinex)
- Fexofenadine 180 mg tablet (Allegra)
- Levocetirizine (Xyzal)
Antifungals- Topical
(Implemented 09/21/2009)
(updated 2/13/17)
(Effective 4/1/17)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Preferred Topical Antifungal Agents

- Tolnaftate 1% topical cream OTC
- Tolnaftate 1% topical powder OTC
- Tolnaftate 1% topical solution OTC
- Clotrimazole 1% Rx Cream
- Clotrimazole-Betamethasone Rx Cream
- Ketoconazole 2% Rx Shampoo
- Nystatin ointment, cream, powder

Non-Preferred Topical Antifungal Agents

- Clotrimazole-Betamethasone Rx lotion
- Ketoconazole 2% cream, foam (Extina® Foam),
- Luliconazole cream 1% (Luzu™)
- Oxiconazole 1% cream, lotion (Oxistat®)
- Sertaconazole 2% cream (Ertaczo®)
- Sulconazole 1% solution, cream (Exelderm®)
- Miconazole 0.25%/zinc oxide 15%/white petrolatum ointment 81.35% (Vusion® Ointment)
- Naftifine cream and gel (Naftin®)
- Butenafine 1% cream (Mentax®)
- Nystatin emollient cream (Pediaderm® AF)
- Nystatin/triamcinolone ointment and cream

Non-Preferred Topical Antifungal Agents for Onychomycosis

- ciclopirox 8% topical nail solution (Penlac® Nail Lacquer)
- efinaconazole 10% topical nail solution (Jublia®)
- tavaborole 5% topical nail solution (Kerydin®)

Link to Memorandum
Link to Memorandum

Top of the document
Antipsychotics, Injectable Long-acting

(Implemented 01/12/2010)
(Updated 03/07/2019)
(Effective 10/1/17)

Prescribers may request an override by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred With Criteria

- fluphenazine decanoate
- haloperidol decanoate
- Abilify Maintena® (aripiprazole ER)
- Aristada® (aripiprazole lauroxil ER)
- Zyprexa Relprevv™ (olanzapine)
- Risperdal Consta® (risperidone microspheres)

Non-Preferred

- Invega Sustenna® (paliperidone palmitate)
- Invega Trinza® (paliperidone palmitate)
- Perseris ER® (risperidone) 90 and 120 mg Syringe Kit

Approval criteria

All injectable long acting antipsychotics (Abilify Maintena™, Aristada™ fluphenazine decanoate, haloperidol decanoate, Risperdal® Consta®, Invega® Sustenna®, Zyprexa® Relprevv™):

- Absence of denial criteria
- Age < 18 years requires Manual Review

Additional criteria:

Abilify Maintena™
  - One paid claim for Abilify Maintena™ in the past 45 days

Aristada™ (441mg & 662mg)
  - One paid claim for Aristada™ in the past 45 days (441mg & 662mg)

Aristada™ (882mg)
  - One paid claim for Aristada™ in the past 60 days (882mg)
Aristada™ (1064mg)
• One paid claim for Aristada™ in the past 75 days (1064mg)

Invega® Sustenna®
• One paid claim for Invega® Sustenna® in the past 45 days

Risperdal® Consta®
• One paid claim for Risperdal® Consta® in the past 45 days

Zyprexa® Relprevv™ Injection
• One paid claim for Zyprexa® Relprevv™ in the past 45 days

Invega® Trinza®
• Requires a Manual Review

Denial criteria

All injectable long acting antipsychotics
• Therapeutic duplication with another long acting antipsychotic in the past 23 days

Additional criteria

Quantity limits apply

Link to Memorandum

Link to Memorandum

Link to Memorandum

Top of the document
Antipsychotics, Oral – Preferred Agents for ALL Ages

(Implemented 10/1/2019)

Prescribers may request an override by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred ORAL Antipsychotic Agents with Criteria (ALL AGES)

- First Generation Antipsychotic Agents- Preferred
  - Fluphenazine tablets
  - Haloperidol Lactate Concentrate Solution**
  - Haloperidol tablets
  - Loxapine capsules
  - Perphenazine tablets
  - Perphenazine/Amitriptyline tablets
  - Pimozide tablets
  - Thioridazine tablets
  - Thiothixene capsules
  - Trifluoperazine tablets

- Second Generation Antipsychotic Agents- Preferred*
  - Aripiprazole tablets (Abilify*)
  - Clozapine tablets
  - Quetiapine tablets (Seroquel*)
  - Risperidone tablets, Risperidone solution**, and Risperidone ODT** (Risperdal®)
  - Olanzapine tablets and Olanzapine ODT** (Zyprexa®)
  - Ziprasidone (Geodon*)

* Brand Names are listed for reference unless specifically denoted as “BRAND ONLY” Preferred

** ODT and Solutions are Preferred ONLY for Ages < 7 y/o or patients with a diagnosis of NPO in history
Antipsychotics, Oral – Non-Preferred Agents for ALL Ages
(Implemented 10/1/2019)

Prescribers may request an override by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Non-Preferred ORAL Antipsychotic Agents (ALL AGES)

- First Generation Antipsychotic Agents- Non-Preferred
  - Chlorpromazine tablets
  - Fluphenazine Elixir/Solution
  - Molindone tablets

- Second Generation Antipsychotic Agents – Non-Preferred
  - Abilify Mycite® tablets
  - Aripiprazole ODT and Solution
  - Clozapine ODT tablets (Fazaclo®)
  - Fanapt® tablets
  - Latuda® tablets
  - Paliperidone tablets (Invega®)
  - Quetiapine EXTENDED RELEASE (Seroquel® XR)
  - Rexulti® tablets
  - Saphris® Sublingual
  - Versacloz® Suspension
  - Vraylar® Capsules

Link to Memorandum
Antipsychotics, Oral – Criteria for Adults

(Implemented 10/1/2019)

Prescribers may request an override by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Approval Criteria for Adults ≥ 18 y/o

- New Starts for preferred medications that are below the maximum therapeutic dose (SEE DOSING CHARTS) will process at point-of-sale (POS)

- A beneficiary may continue a drug or dose that is outside of the established criteria (e.g., continue a non-preferred status drug, continue dose higher than the maximum therapeutic dose), or continue therapy with > 2 antipsychotic agents if the beneficiary is “Stable and Compliant” on all antipsychotic drug therapy(-ies).
  - For the purposes of these criteria “Stable and Compliant” is defined as the patient has received at least 90 days of medication therapy (same dose/same drug) out of the previous 120 days based on claims in the patient’s Medicaid drug profile history or submitted documentation

- Preferred Oral liquids and orally disintegrating tablets (ODTs): Patients ≥ 18 y/o must have an NPO diagnosis code (Appendix A) in the past year

Denial Criteria for Adults ≥ 18 y/o

- New starts to non-preferred medications will deny

- New starts above the maximum therapeutic dose of a medication will deny (SEE DOSING CHARTS)

- Therapeutic Duplication
  - TD with three or more oral antipsychotic agents will deny for new starts
  - TD for two or more oral antipsychotics and one long-acting injectable antipsychotic agents

- Failure to meet approval criteria

Link to Memorandum
Top of the document
### ATYPICAL ANTIPSYCHOTIC MAXIMUM THERAPEUTIC DOSING AND QUANTITIES FOR ADULTS (≥ 18 YEARS OLD)

**Aripiprazole (e.g. Abilify®) Tablet Medicaid Max Daily Dose = 30mg**

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aripiprazole (e.g. Abilify®) 2 mg Tablet</td>
<td>8 mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Aripiprazole (e.g. Abilify®) 5 mg Tablet</td>
<td>5 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Aripiprazole (e.g. Abilify®) 10 mg Tablet &amp; Discmelt</td>
<td>10 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Aripiprazole (e.g. Abilify®) 15 mg Tablet &amp; Discmelt</td>
<td>15 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Aripiprazole (e.g. Abilify®) 20 mg Tablet</td>
<td>20 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Aripiprazole (e.g. Abilify®) 30 mg Tablet</td>
<td>30 mg</td>
<td>1</td>
<td>31</td>
</tr>
</tbody>
</table>

**Asenapine (e.g. Saphris®) SL Tablet Medicaid Max Daily Dose = 20mg**

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asenapine (e.g. Saphris®) 2.5mg SL Tablet</td>
<td>5 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Asenapine (e.g. Saphris®) 5mg SL Tablet</td>
<td>10 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Asenapine (e.g. Saphris®) 10mg SL Tablet</td>
<td>20 mg</td>
<td>2</td>
<td>62</td>
</tr>
</tbody>
</table>

**Brexpiprazole (e.g. Rexulti ®) Tablet Medicaid Max Daily dose = 4mg**

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brexpiprazole (e.g. Rexulti ®) 0.25mg Tablet</td>
<td>0.25 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Brexpiprazole (e.g. Rexulti ®) 0.5mg Tablet</td>
<td>0.5 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Brexpiprazole (e.g. Rexulti ®) 1mg Tablet</td>
<td>1 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Brexpiprazole (e.g. Rexulti ®) 2mg Tablet</td>
<td>2 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Brexpiprazole (e.g. Rexulti ®) 3mg Tablet</td>
<td>3 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Brexpiprazole (e.g. Rexulti ®) 4mg Tablet</td>
<td>4 mg</td>
<td>1</td>
<td>31</td>
</tr>
</tbody>
</table>
### Cariprazine (e.g. Vraylar ®) Capsule Medicaid Max Daily Dose = 6mg

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cariprazine (e.g. Vraylar ®) 1.5mg Capsule</td>
<td>1.5 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Cariprazine (e.g. Vraylar ®) 3mg Capsule</td>
<td>3 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Cariprazine (e.g. Vraylar ®) 4.5mg Capsule</td>
<td>4.5 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Cariprazine (e.g. Vraylar ®) 6mg Capsule</td>
<td>6 mg</td>
<td>1</td>
<td>31</td>
</tr>
</tbody>
</table>

### Clozapine (e.g. Clozaril ®) Tablet Medicaid Max Daily Dose = 900mg

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clozapine (e.g. Clozaril ®) 25mg Tablet</td>
<td>75 mg</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>Clozapine (e.g. Clozaril ®) 50mg Tablet</td>
<td>50 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Clozapine (e.g. Clozaril ®) 100mg Tablet</td>
<td>900 mg</td>
<td>9</td>
<td>279</td>
</tr>
</tbody>
</table>

### Iloperidone (e.g. Fanapt ®) Tablet Medicaid Max Daily Dose = 24mg

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iloperidone (e.g. Fanapt ®) 1mg Tablet</td>
<td>2 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Iloperidone (e.g. Fanapt ®) 2mg Tablet</td>
<td>4 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Iloperidone (e.g. Fanapt ®) 4mg Tablet</td>
<td>8 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Iloperidone (e.g. Fanapt ®) 6mg Tablet</td>
<td>12 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Iloperidone (e.g. Fanapt ®) 8mg Tablet</td>
<td>16 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Iloperidone (e.g. Fanapt ®) 10mg Tablet</td>
<td>20 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Iloperidone (e.g. Fanapt ®) 12mg Tablet</td>
<td>24 mg</td>
<td>2</td>
<td>62</td>
</tr>
</tbody>
</table>
### Lurasidone (e.g. Latuda ®) Tablet Medicaid Max Daily Dose = 80mg

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lurasidone (e.g. Latuda ®) 20mg Tablet</td>
<td>20 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Lurasidone (e.g. Latuda ®) 40mg Tablet</td>
<td>40 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Lurasidone (e.g. Latuda ®) 60mg Tablet</td>
<td>60 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Lurasidone (e.g. Latuda ®) 80mg Tablet</td>
<td>80 mg</td>
<td>1</td>
<td>31</td>
</tr>
</tbody>
</table>

### Olanzapine (e.g. Zyprexa ®) Tablet Medicaid Max Daily Dose = 20mg

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olanzapine (e.g. Zyprexa ®) 2.5mg Tablet</td>
<td>2.5 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Olanzapine (e.g. Zyprexa ®) 5mg Tablet &amp; ODT</td>
<td>5 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Olanzapine (e.g. Zyprexa ®) 7.5mg Tablet</td>
<td>7.5 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Olanzapine (e.g. Zyprexa ®) 10mg Tablet &amp; ODT</td>
<td>10 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Olanzapine (e.g. Zyprexa ®) 15mg Tablet &amp; ODT</td>
<td>15 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Olanzapine (e.g. Zyprexa ®) 20mg Tablet &amp; ODT</td>
<td>20 mg</td>
<td>1</td>
<td>31</td>
</tr>
</tbody>
</table>

### Paliperidone ER (e.g. Invega ®) Tablet Medicaid Max Daily dose = 12mg

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paliperidone ER (e.g. Invega ®) 1.5mg Tablet</td>
<td>1.5 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Paliperidone ER (e.g. Invega ®) 3mg Tablet</td>
<td>3 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Paliperidone ER (e.g. Invega ®) 6mg Tablet</td>
<td>12 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Paliperidone ER (e.g. Invega ®) 9mg Tablet</td>
<td>9 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>DRUG NAME</td>
<td>MEDICAID MAX DAILY DOSE BY STRENGTH</td>
<td>MEDICAID MAX DAILY QUANTITY EDIT</td>
<td>MEDICAID MONTHLY MAX CUMULATIVE QTY</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Quetiapine (e.g. Seroquel®) 25mg Tablet</td>
<td>75 mg</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>Quetiapine (e.g. Seroquel®) 50mg Tablet</td>
<td>150 mg</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>Quetiapine (e.g. Seroquel®) 100mg Tablet</td>
<td>200 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Quetiapine (e.g. Seroquel®) 200mg Tablet</td>
<td>400 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Quetiapine (e.g. Seroquel®) 300mg Tablet</td>
<td>600 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Quetiapine (e.g. Seroquel®) 400mg Tablet</td>
<td>800 mg</td>
<td>2</td>
<td>62</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quetiapine ER (e.g. Seroquel XR®) 50mg Tablet</td>
<td>100 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Quetiapine ER (e.g. Seroquel XR®) 150mg Tablet</td>
<td>150 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Quetiapine ER (e.g. Seroquel XR®) 200mg Tablet</td>
<td>200 mg</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>Quetiapine ER (e.g. Seroquel XR®) 300mg Tablet</td>
<td>600 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Quetiapine ER (e.g. Seroquel XR®) 400mg Tablet</td>
<td>800 mg</td>
<td>2</td>
<td>62</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperidone (e.g. Risperdal®) 0.25mg Tablet</td>
<td>0.5 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Risperidone (e.g. Risperdal®) 0.5mg Tablet &amp; ODT</td>
<td>1 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Risperidone (e.g. Risperdal®) 1mg Tablet &amp; ODT</td>
<td>2 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Risperidone (e.g. Risperdal®) 2mg Tablet &amp; ODT</td>
<td>4 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Risperidone (e.g. Risperdal®) 3mg Tablet &amp; ODT</td>
<td>9 mg</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>Risperidone (e.g. Risperdal®) 4mg Tablet &amp; ODT</td>
<td>16 mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Risperidone (e.g. Risperdal®) 1mg/ml Oral Solution (30ml)</td>
<td>4 mg</td>
<td>4 ml</td>
<td>120</td>
</tr>
<tr>
<td>DRUG NAME</td>
<td>MEDICAID MAX DAILY DOSE BY STRENGTH</td>
<td>MEDICAID MAX DAILY QUANTITY</td>
<td>MEDICAID MONTHLY MAX CUMULATIVE QTY</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Ziprasidone (e.g. Geodon®) 20mg Capsule</td>
<td>40 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Ziprasidone (e.g. Geodon®) 40mg Capsule</td>
<td>80 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Ziprasidone (e.g. Geodon®) 60mg Capsule</td>
<td>120 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>Ziprasidone (e.g. Geodon®) 80mg Capsule</td>
<td>160 mg</td>
<td>2</td>
<td>62</td>
</tr>
</tbody>
</table>
## TYPICAL ANTIPSYCHOTIC MAXIMUM THERAPEUTIC DOSING AND QUANTITIES FOR ADULTS

### Chlorpromazine (e.g. Thorazine®) Tablet Medicaid Max Daily Dose = 800mg

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorpromazine (e.g. Thorazine®) 10mg Tablet</td>
<td>40 mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Chlorpromazine (e.g. Thorazine®) 25mg Tablet</td>
<td>75 mg</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>Chlorpromazine (e.g. Thorazine®) 50mg Tablet</td>
<td>200 mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Chlorpromazine (e.g. Thorazine®) 100mg Tablet</td>
<td>700 mg</td>
<td>7</td>
<td>217</td>
</tr>
<tr>
<td>Chlorpromazine (e.g. Thorazine®) 200mg Tablet</td>
<td>800 mg</td>
<td>4</td>
<td>124</td>
</tr>
</tbody>
</table>

### Fluphenazine (e.g. Prolixin®) Tablet Medicaid Max Daily Dose = 40mg

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluphenazine (e.g. Prolixin®) 1mg Tablet</td>
<td>4 mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Fluphenazine (e.g. Prolixin®) 2.5mg Tablet</td>
<td>10 mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Fluphenazine (e.g. Prolixin®) 5mg Tablet</td>
<td>20 mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Fluphenazine (e.g. Prolixin®) 10mg Tablet</td>
<td>40 mg</td>
<td>4</td>
<td>124</td>
</tr>
</tbody>
</table>

### Haloperidol (e.g. Haldol®) Tablet Medicaid Max Daily Dose = 40mg

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol (e.g. Haldol®) 0.5mg Tablet</td>
<td>1.5mg</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>Haloperidol (e.g. Haldol®) 1mg Tablet</td>
<td>3 mg</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>Haloperidol (e.g. Haldol®) 2mg Tablet</td>
<td>6 mg</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>Haloperidol (e.g. Haldol®) 5mg Tablet</td>
<td>15 mg</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>Haloperidol (e.g. Haldol®) 10mg Tablet</td>
<td>30 mg</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>Haloperidol (e.g. Haldol®) 20mg Tablet</td>
<td>40 mg</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>DRUG NAME</td>
<td>MEDICAID MAX DAILY DOSE BY STRENGTH</td>
<td>MEDICAID MAX DAILY QUANTITY EDIT</td>
<td>MEDICAID MONTHLY MAXIMUM CUMULATIVE QTY</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------------</td>
<td>--------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Loxapine (e.g. Loxitane®) 5mg Capsule</td>
<td>20 mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Loxapine (e.g. Loxitane®) 10mg Capsule</td>
<td>60 mg</td>
<td>6</td>
<td>186</td>
</tr>
<tr>
<td>Loxapine (e.g. Loxitane®) 25mg Capsule</td>
<td>100 mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Loxapine (e.g. Loxitane®) 50mg Capsule</td>
<td>250 mg</td>
<td>5</td>
<td>155</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAXIMUM CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perphenazine (e.g. Trilafon®) 2mg Tablet</td>
<td>8 mg</td>
<td>4</td>
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</tr>
<tr>
<td>Perphenazine (e.g. Trilafon®) 4mg Tablet</td>
<td>16 mg</td>
<td>4</td>
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</tr>
<tr>
<td>Perphenazine (e.g. Trilafon®) 8mg Tablet</td>
<td>32 mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Perphenazine (e.g. Trilafon®) 16mg Tablet</td>
<td>64 mg</td>
<td>4</td>
<td>124</td>
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</table>

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAXIMUM CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perphenazine-Amitriptyline (e.g. Etrafon®) 2mg/10mg Tablet</td>
<td>8mg/40mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Perphenazine-Amitriptyline (e.g. Etrafon®) 2mg/25mg Tablet</td>
<td>8mg/100mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Perphenazine-Amitriptyline (e.g. Etrafon®) 4mg/10mg Tablet</td>
<td>16mg/40mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Perphenazine-Amitriptyline (e.g. Etrafon®) 4mg/25mg Tablet</td>
<td>16mg/100mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Perphenazine-Amitriptyline (e.g. Etrafon®) 4mg/50mg Tablet</td>
<td>8mg/100mg</td>
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</table>
### Pimozide (e.g. Orap) Tablet Medicaid Max Daily Dose = 10mg

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pimozide (e.g. Orap) 1mg Tablet</td>
<td>3 mg</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>Pimozide (e.g. Orap) 2mg Tablet</td>
<td>10 mg</td>
<td>5</td>
<td>155</td>
</tr>
</tbody>
</table>

### Thioridazine (e.g. Mellaril®) Tablet Medicaid Max Daily Dose = 800mg

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thioridazine (e.g. Mellaril®) 10mg Tablet</td>
<td>40 mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Thioridazine (e.g. Mellaril®) 25mg Tablet</td>
<td>100 mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Thioridazine (e.g. Mellaril®) 50mg Tablet</td>
<td>200 mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Thioridazine (e.g. Mellaril®) 100mg Tablet</td>
<td>800 mg</td>
<td>8</td>
<td>248</td>
</tr>
</tbody>
</table>

### Thiothixene (e.g. Navane®) Capsule Medicaid Max Daily Dose = 60mg

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thiothixene (e.g. Navane®) 1mg Capsule</td>
<td>3mg</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>Thiothixene (e.g. Navane®) 2mg Capsule</td>
<td>8mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Thiothixene (e.g. Navane®) 5mg Capsule</td>
<td>15mg</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>Thiothixene (e.g. Navane®) 10mg Capsule</td>
<td>60mg</td>
<td>6</td>
<td>186</td>
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</table>

### Trifluoperazine (e.g. Stelazine®) Tablet Medicaid Max Daily Dose = 40mg

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<thead>
<tr>
<th>DRUG NAME</th>
<th>MEDICAID MAX DAILY DOSE BY STRENGTH</th>
<th>MEDICAID MAX DAILY QUANTITY EDIT</th>
<th>MEDICAID MONTHLY MAX CUMULATIVE QTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trifluoperazine (e.g. Stelazine®) 1mg Tablet</td>
<td>3 mg</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>Trifluoperazine (e.g. Stelazine®) 2mg Tablet</td>
<td>8 mg</td>
<td>4</td>
<td>124</td>
</tr>
<tr>
<td>Trifluoperazine (e.g. Stelazine®) 5mg Tablet</td>
<td>15 mg</td>
<td>3</td>
<td>93</td>
</tr>
<tr>
<td>Trifluoperazine (e.g. Stelazine®) 10mg Tablet</td>
<td>40 mg</td>
<td>4</td>
<td>124</td>
</tr>
</tbody>
</table>
Antipsychotics, Oral – Criteria for Children

**PREFERRED AND NONPREFERRED AGENTS APPLY TO PATIENTS < 18 Y/O – PLEASE REFER TO PDL DRUGS ON PAGES 48-49 OF THIS DOCUMENT**

(Implemented 07/11/2009)
(Updated 08/14/2015)
(Updated 10/1/2019)

Prescribers may request an override by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Approval Criteria-Children (< 18 y/o)

- At least one paid claim for an oral antipsychotic in the past 45 days, and monitoring for both glucose and lipid screening in the past 9 months (Table 2.3)
- Typical and Atypical antipsychotics:
  - All new start patients or patients changed to a different chemical entity will require a signed informed consent and a copy of a baseline metabolic lab test data. (Effective 11/8/2011)
  - Medication Informed Consent Document
  - One therapeutic duplication for a change in therapy between two antipsychotics (oral or injectable) with >25% remaining on the last fill on different dates of service allowed per 93 days.
  - PA required through manual review for recipients < 10 years of age.
- Oral liquids and orally disintegrating tablets (ODTs): Patient must have an NPO code (Appendix A) in the past year OR be < 7 years of age AND meet criteria for atypical antipsychotics
- Seroquel XR requires >/= 90 days of Seroquel XR therapy in the past 120 days. Immediate-release quetiapine (Seroquel) is covered via existing criteria.

Additional dose criteria

Atypical antipsychotics

- Requested dose must be an approved dose for age range (Table 2)
- Requested maximum daily dose must be approved for age range (Table 2.2).
### Denial criteria

**Antipsychotics**
- Claims with a therapeutic duplication on the same date of service
- Requests for Loxapine, Thoridazine, Thiothixene, Fanapt®, Latuda®, or Saphris®, Rexulti® for patients <18 years of age
- Requests for combination antipsychotic products for patients <18 years of age
- Failure to meet approval criteria

### Table 2 – Approved doses per age range

<table>
<thead>
<tr>
<th>Drug</th>
<th>Strength</th>
<th>FDA dosing</th>
<th>6-9 y/o</th>
<th>10-12y/o</th>
<th>13-17y/o</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilify®</td>
<td>2 mg</td>
<td>QD</td>
<td>2 tabs</td>
<td>2 tabs</td>
<td>2 tabs</td>
</tr>
<tr>
<td>Abilify®</td>
<td>5 mg</td>
<td>QD</td>
<td>1 tab</td>
<td>1 tab</td>
<td>1 tab</td>
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<tr>
<td>Abilify®</td>
<td>10 mg</td>
<td>QD</td>
<td>1 tab</td>
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</tr>
<tr>
<td>Abilify®</td>
<td>15 mg</td>
<td>QD</td>
<td>1 tab</td>
<td>1 tab</td>
<td>1 tab</td>
</tr>
<tr>
<td>Abilify®</td>
<td>20 mg</td>
<td>QD</td>
<td></td>
<td>1 tab</td>
<td>1 tab</td>
</tr>
<tr>
<td>Abilify®</td>
<td>30 mg</td>
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</tr>
<tr>
<td>Abilify Dismelt®</td>
<td>10 mg</td>
<td>QD</td>
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<td>2 tabs</td>
<td>2 tabs</td>
</tr>
<tr>
<td>Abilify Dismelt®</td>
<td>15 mg</td>
<td>QD</td>
<td>1 tab</td>
<td>1 tab</td>
<td>2 tabs</td>
</tr>
<tr>
<td>Abilify Solution®</td>
<td>1 mg/ml</td>
<td>QD</td>
<td>5 mls</td>
<td>15 mls</td>
<td>20 mls</td>
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<tr>
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</tr>
<tr>
<td>Chlorpromazine</td>
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<td>BID-QID</td>
<td>1 tab</td>
<td>2 tabs</td>
<td>4 tabs</td>
</tr>
<tr>
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<td>BID-QID</td>
<td>1 tab</td>
<td>2 tabs</td>
<td>3 tabs</td>
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<tr>
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<td>1 mg</td>
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<td>2 tabs</td>
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</tr>
<tr>
<td>Fanapt®</td>
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<td>Fanapt®</td>
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<td>2 tabs</td>
</tr>
<tr>
<td>Fanapt®</td>
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<td></td>
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<tr>
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<td>BID-QID</td>
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<td>4 tabs</td>
<td>4 tabs</td>
</tr>
<tr>
<td>Fluphenazine</td>
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<td>BID-QID</td>
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<td>4 tabs</td>
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<tr>
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<td>Fluphenazine Elixir</td>
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<tr>
<td>Fluphenazine Soln</td>
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<td>BID-QID</td>
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<td>1 ml</td>
<td>2 mls</td>
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<tr>
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<td>6-9 y/o</td>
<td>10-12y/o</td>
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<td>Haloperidol</td>
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<td>BID-TID</td>
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<td>3 tabs</td>
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<tr>
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<tr>
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<td>2 caps</td>
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<td>Loxapine</td>
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</tr>
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<tr>
<td>Loxapine</td>
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</tr>
<tr>
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<td>Perphenazine</td>
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<td>2 tabs</td>
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</tr>
<tr>
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<tr>
<td>Risperdal®</td>
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</tr>
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<td>Risperdal®</td>
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</tr>
<tr>
<td>Risperdal®</td>
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<td>BID</td>
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<tr>
<td>Risperdal® M Tab</td>
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<td>BID</td>
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</tr>
<tr>
<td>Risperdal® M Tab</td>
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<td>BID</td>
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<td>Risperdal® M Tab</td>
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<td>BID</td>
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<td>2 tabs</td>
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<tr>
<td>Risperdal® M Tab</td>
<td>3 mg</td>
<td>BID</td>
<td>2 tabs</td>
<td>2 tabs</td>
<td>2 tabs</td>
</tr>
<tr>
<td>Risperdal® M Tab</td>
<td>4 mg</td>
<td>BID</td>
<td>2 tabs</td>
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<td>2 tabs</td>
</tr>
<tr>
<td>Risperdal® Soln</td>
<td>1 mg/ml</td>
<td>BID</td>
<td>2 mls</td>
<td>4 mls</td>
<td>6 mls</td>
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<tr>
<td>Saphris® SL</td>
<td>5 mg</td>
<td>BID</td>
<td>1 tab</td>
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<td>2 tabs</td>
</tr>
<tr>
<td>Saphris® SL</td>
<td>10 mg</td>
<td>BID</td>
<td>1 tab</td>
<td>1 tab</td>
<td>2 tabs</td>
</tr>
<tr>
<td>Saphris®SL</td>
<td>2.5 mg</td>
<td>BID</td>
<td>2 tabs</td>
<td>2 tabs</td>
<td>2 tabs</td>
</tr>
<tr>
<td>Seroquel®</td>
<td>25 mg</td>
<td>TID</td>
<td>3 tabs</td>
<td>3 tabs</td>
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<td>Seroquel®</td>
<td>50 mg</td>
<td>TID</td>
<td>3 tabs</td>
<td>3 tabs</td>
<td>3 tabs</td>
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<td>Strength</td>
<td>FDA dosing</td>
<td>&lt;6* y/o</td>
<td>6-9 y/o</td>
<td>10-12y/o</td>
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<tr>
<td>--------------</td>
<td>----------</td>
<td>-----------</td>
<td>--------</td>
<td>--------</td>
<td>---------</td>
</tr>
<tr>
<td>Seroquel®</td>
<td>100 mg</td>
<td>TID</td>
<td>1 tab</td>
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<td>3 tabs</td>
</tr>
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<td>200 mg</td>
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<td>Seroquel®</td>
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<td>TID</td>
<td>1 tab</td>
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<td>2 tabs</td>
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<td>Seroquel®</td>
<td>400 mg</td>
<td>TID</td>
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<tr>
<td>Seroquel® XR</td>
<td>50 mg</td>
<td>QD</td>
<td>2 tabs</td>
<td>2 tabs</td>
<td>2 tabs</td>
</tr>
<tr>
<td>Seroquel® XR</td>
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<td>1 tab</td>
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<td>QD</td>
<td>1 tab</td>
<td>2 tabs</td>
<td>2 tabs</td>
</tr>
<tr>
<td>Seroquel® XR</td>
<td>400 mg</td>
<td>QD</td>
<td>1 tab</td>
<td>2 tabs</td>
<td>2 tabs</td>
</tr>
<tr>
<td>Thioridazine</td>
<td>10 mg</td>
<td>BID-TID</td>
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<td>3 tabs</td>
<td>3 tabs</td>
</tr>
<tr>
<td>Thioridazine</td>
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<td>3 tabs</td>
<td>3 tabs</td>
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<tr>
<td>Thioridazine</td>
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<td>BID-TID</td>
<td>1 tab</td>
<td>2 tabs</td>
<td>3 tabs</td>
</tr>
<tr>
<td>Thioridazine</td>
<td>100 mg</td>
<td>BID-TID</td>
<td>1 tab</td>
<td>1 tab</td>
<td>2 tabs</td>
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<tr>
<td>Thiothixene</td>
<td>1 mg</td>
<td>TID</td>
<td>3 caps</td>
<td>3 caps</td>
<td>3 caps</td>
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<td>Thiothixene</td>
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<td>3 caps</td>
<td>3 caps</td>
<td>3 caps</td>
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<tr>
<td>Thiothixene</td>
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<td>TID</td>
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<td>1 cap</td>
</tr>
<tr>
<td>Thiothixene</td>
<td>10 mg</td>
<td>TID</td>
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<td></td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>1 mg</td>
<td>QD-BID</td>
<td>1 tab</td>
<td>2 tabs</td>
<td>2 tabs</td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>2 mg</td>
<td>QD-BID</td>
<td>1 tab</td>
<td>2 tabs</td>
<td>2 tabs</td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>5 mg</td>
<td>QD-BID</td>
<td>1 tab</td>
<td>2 tabs</td>
<td></td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>10 mg</td>
<td>QD-BID</td>
<td>1 tab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zyprexa®</td>
<td>2.5mg</td>
<td>QD</td>
<td>1 tab</td>
<td>1 tab</td>
<td>1 tab</td>
</tr>
<tr>
<td>Zyprexa®</td>
<td>5mg</td>
<td>QD</td>
<td>1 tab</td>
<td>1 tab</td>
<td>1 tab</td>
</tr>
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<td>Zyprexa®</td>
<td>7.5mg</td>
<td>QD</td>
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<td>Zyprexa®</td>
<td>10mg</td>
<td>QD</td>
<td>1 tab</td>
<td>1 tab</td>
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</tr>
<tr>
<td>Zyprexa®</td>
<td>15mg</td>
<td>QD</td>
<td>1 tab</td>
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</tr>
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<td>Zyprexa®</td>
<td>20mg</td>
<td>QD</td>
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</tr>
<tr>
<td>Zyprexa® Zyd®</td>
<td>5mg</td>
<td>QD</td>
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<td>QD</td>
<td>1 tab</td>
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<td>Zyprexa® Zyd®</td>
<td>15mg</td>
<td>QD</td>
<td>1 tab</td>
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<tr>
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<td>20mg</td>
<td>QD</td>
<td>1 tab</td>
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</tbody>
</table>

*Prior authorization required through manual review for recipients < 10 years of age.

**Table 2.2 – Max daily doses for age categories < 18 years of age.**

<table>
<thead>
<tr>
<th>Drug</th>
<th>&lt;6* y/o</th>
<th>6*-9 y/o</th>
<th>10-12 y/o</th>
<th>13-17 y/o</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilify®</td>
<td>5 mg daily</td>
<td>15 mg daily</td>
<td>20 mg daily</td>
<td>30 mg daily</td>
</tr>
<tr>
<td>Geodon®</td>
<td>40 mg daily</td>
<td>60 mg daily</td>
<td>80 mg daily</td>
<td>160 mg daily</td>
</tr>
<tr>
<td>Invega®</td>
<td>3 mg daily</td>
<td>3 mg daily</td>
<td>6 mg daily</td>
<td>9 mg daily</td>
</tr>
<tr>
<td>Risperdal®</td>
<td>2 mg daily</td>
<td>4 mg daily</td>
<td>6 mg daily</td>
<td>8 mg daily</td>
</tr>
<tr>
<td>Seroquel®</td>
<td>150 mg daily</td>
<td>300 mg daily</td>
<td>600 mg daily</td>
<td>800 mg daily</td>
</tr>
<tr>
<td>Zyprexa®</td>
<td>5 mg daily</td>
<td>10 mg daily</td>
<td>15 mg daily</td>
<td>20 mg daily</td>
</tr>
</tbody>
</table>

*Prior authorization required through manual review for recipients < 10 years of age.
Table 2.3 – CPT codes for glucose and lipid monitoring.

**Glucose codes:** Criteria require one of the following CPT codes that contain glucose monitoring in the previous 9 months from claim date of in-process claim:
- 83036 (HbA1c), OR
- 80050 (General Health Panel), OR
- 80069 (Renal Function Panel), OR
- 80047 (Basic Metabolic Panel), OR
- 80048 (Basic Metabolic Panel), OR
- 80053 (Comprehensive metabolic panel), OR
- 82962 (Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use) OR
- 82948 (Glucose; blood, reagent strip) OR
- 82947 (Glucose; quantitative, blood),

**AND:** criteria require one of the following lipid panel tests or all of the individual lipid test monitoring codes in previous 9 months from claim date of the in-process claim:

**Lipid codes:**
- 80061 (Lipid panel), OR
- 83701 (High resolution fractionation and quantitation of lipoproteins panel), OR
- 82465 (Cholesterol, serum or whole blood, total), AND 83718 (HDL cholesterol), AND 84478 (Triglycerides), AND 83721 (LDL Cholesterol)

[Link to Memorandum](#)

[Link to Memorandum](#) (Initial Antipsychotic criteria)

[Link to Memorandum](#) (Requirements of informed consent and metabolic monitoring)

[Top of the document](#)
Armodafinil (Nuvigil) & Modafinil (Provigil)

(Implemented 05/27/2009)
(Re-review on 5/10/2018)
(Effective 7/1/18)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Preferred agents that require manual review for prior authorization
- NUVIGIL® (armodafinil) (BRAND ONLY)

NONPREFERRED AGENTS
- PROVIGIL® (modafinil)
- modafinil
- armodafinil (generic only)

Link to Memorandum
Link to Memorandum

Top of the document
Aromatase Inhibitors (Arimidex and Femara)

*(Implemented 09/24/2008)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require prior authorization
- Anastrozole oral tablet [Arimidex]
- Letrozole oral tablet [Femara]

Approval criteria
Medical history for female breast cancer in the past 3 years

Denial criteria
- Diagnosis of Infertility in Medicaid History

[Link to Memorandum](#)
[Link to Memorandum](#)
[Top of the document](#)
Asfotase Alfa (Strepsiq) Injection

(Implemented 07/13/2016)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Strepsiq

Link to Memorandum

Top of the document
Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder (ADD/ADHD) Agents for Children (Less than 18 Years of Age)

(Implemented 07/21/2009)
(Updated 11/27/2017, effective 1/1/18)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents with criteria

- ADDERALL XR (BRAND ONLY)
- AMPHETAMINE SALTS TABLET (generic only)
- ATOMOXETINE (generic only)
- DEXTROAMPHETAMINE 5MG, 10MG TABLET
- FOCALIN (Brand only)
- FOCALIN XR (Brand only)
- VYVANSE CAPSULES
- METHYLPHENIDATE SWALLOW TABLET
- Guanfacine ER (generic only)
- Guanfacine IR
- Clonidine IR

Nonpreferred agents

- AMPHETAMINE SALTS ER CAPSULE (ADDERALL XR) - Generic only
- AMPHETAMINE SALTS ER CAPSULE (ADDERALL XR) - Generic only
- DEXMETHYLPHENIDATE ER CAPSULE (FOCALIN XR) - Generic only
- DEXMETHYLPHENIDATE TABLET (FOCALIN) - Generic only
- CLONIDINE ER SUSPENSION (NEXICLON XR)
- CLONIDINE ER TABLET (KAPVAY ER, NEXICLON XR)
- DEXTROAMPHETAMINE CAPSULE (DEXEDRINE SPANSULE)
- DEXTROAMPHETAMINE SOLUTION (PROCENTRA)
- DEXTROAMPHETAMINE 2.5MG, 7.5MG, 15MG, 20MG, 30MG TABLET (ZENZEDI)
- INTUNIV ER (brand only)
- METHAMPHETAMINE TABLET (DESOXYN)
- METHYLPHENIDATE CHEWABLE TABLET (METHYLIN)
- METHYLPHENIDATE ER CAPSULE (METADATE CD, RITALIN LA, APTENSIO XR)
- METHYLPHENIDATE ER PATCH (DAYTRANA)
- METHYLPHENIDATE ER SUSPENSION (QUILLIVANT XR)
- METHYLPHENIDATE ER TABLET (CONCERTA)
- METHYLPHENIDATE ER TABLET (METADATE ER, RITALIN SR)
- METHYLPHENIDATE SOLUTION (METHYLIN)
- METHYLPHENIDATE (COTEMPLA XR-ODT)
• DEXTROAMPHETAMINE /AMPHETAMINE SALTS CAPSULE, EXTENDED RELEASE (MYDAYIS)
• STRATTERA Brand (ATOMOXETINE)
• VYVANSE CHEWABLE TABS (LISDEXAMFETAMINE CHEWABLE)

Approval criteria for preferred agents with criteria for children:

Less than 18 years of age

All preferred extended-release CII stimulants:
• \( \leq \) One therapeutic duplication between long-acting CII stimulants with 75% of the last fill per 93 days AND
• If a incoming long-acting CII stimulant claim overlaps with a short-acting CII stimulant that was filled at a dose of \( \geq \) to 2 units per day, the long-acting product will require prior authorization

All preferred immediate-release CII stimulants:
• \( \leq \) One therapeutic duplication between short-acting CII stimulants with 75% of the last fill per 93 days AND
• If an incoming short-acting CII stimulant claim overlaps with a long-acting CII stimulant, the short-acting product will only be approved for a dose of one unit per day

Additional criteria
Age and Quantity limits apply

Approval criteria for Daytrana or Concerta for Less than 18 years of age ONLY:
• > 90 days of therapy in the previous 120 days for the same drug, strength, and daily dose

Link to original Memorandum

Link to current Memorandum with new quantity restrictions

Top of the document
Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder (ADD/ADHD) Agents for Adults (18 Years of Age or greater)

(Implemented 01/18/2011)
(Updated 11/27/2017)

Prescribers may request an override by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Manually Reviewed agents for adults: 18 years of age or greater
- ADDERALL XR (BRAND ONLY)
- AMPHETAMINE SALTS TABLET (generic only)
- ATOMOXETINE (generic only)
- DEXTROAMPHETAMINE 5MG, 10MG TABLET
- FOCALIN (Brand only)
- FOCALIN XR (Brand only)
- VYVANSE CAPSULES
- METHYLPHENIDATE SWALLOW TABLET
- Guanfacine ER (generic only)
- Guanfacine IR
- Clonidine IR

Nonpreferred agents (Manually Reviewed 18 years of age or greater)
- AMPHETAMINE SALTS ER CAPSULE (ADDERALL XR) - Generic only
- AMPHETAMINE SALTS ER CAPSULE (ADDERALL XR) - Generic only
- DEXMETHYLPHENIDATE ER CAPSULE (FOCALIN XR) - Generic only
- DEXMETHYLPHENIDATE TABLET (FOCALIN) - Generic only
- CLONIDINE ER SUSPENSION (NEXICLON XR)
- CLONIDINE ER TABLET (KAPVAY ER, NEXICLON XR)
- DEXTROAMPHETAMINE CAPSULE (DEXEDRINE SPANSULE)
- DEXTROAMPHETAMINE SOLUTION (PROCENTRA)
- DEXTROAMPHETAMINE 2.5MG, 7.5MG, 15MG, 20MG, 30MG TABLET (ZENZEDI)
- INTUNIV ER (brand only)
- METHAMPHETAMINE TABLET (DESOXYN)
- METHYLPHENIDATE CHEWABLE TABLET (METHYLIN)
- METHYLPHENIDATE ER CAPSULE (METHADATE CD, RITALIN LA, APTENSIO XR)
- METHYLPHENIDATE ER PATCH (DAYTRANA)
- METHYLPHENIDATE ER SUSPENSION (QUILLIVANT XR)
- METHYLPHENIDATE ER TABLET (CONCERTA)
- METHYLPHENIDATE ER TABLET (METHADATE ER, RITALIN SR)
- METHYLPHENIDATE SOLUTION (METHYLIN)
• METHYLPHENIDATE (COTEMPLA XR-ODT)
• DEXTROAMPHETAMINE /AMPHETAMINE SALTS CAPSULE, EXTENDED RELEASE (MYDAYIS)
• STRATTERA Brand (ATOMOXETINE)
• VYVANSE CHEWABLE TABS (LISDEXAMFETAMINE CHEWABLE)

Link to Memorandum: CII Stimulant for Adults

Link to Memorandum: CII Stimulant for Adults

Link to current Memorandum with new quantity restrictions

Top of the document
Auranofin (Ridaura) Capsule

*(Implemented 09/18/2013)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Ridaura Capsule

[Link to Memorandum](#)
[Top of the document](#)
Axitinib Tablet (Inlyta)
(Implemented 07/09/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Inlyta tablet

Link to Memorandum
Top of the document
Azithromycin (Azithromycin Powder Packets and ZMAX)
(Implemented 04/12/2011)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Azithromycin 1 gm powder packets
- ZMAX 2gm/60ml suspension

Link to Memorandum

Top of the document
Balsalazide Disodium Tablet (Giazo)

(Implemented 07/09/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Giazo

Link to Memorandum
Top of the document
Becaplermin (Regranex)

(Implemented 01/12/2005)
(Updated 09/29/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
  • Submitted diagnosis of diabetes, type I or type II, with neurological manifestations in the previous 365 days, AND
  • Submitted diagnosis of skin ulcer (neuropathic ulcer) in past 180 days

Denial criteria
  • > one claim in past 30 days

Additional criteria
  Quantity limits apply

Link to Memorandum

Top of the document
Bedaquiline Fumarate Tablet (Sirturo)

*(Implemented 12/10/2013)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Sirturo

[Link to Memorandum](#)

[Top of the document](#)
Belimumab (Benlysta)

*Implemented 06/21/2011*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Benlysta

[Link to Memorandum](#)

[Top of the document](#)
Benign Prostatic Hypertrophy (BPH) Drugs

*Implemented 01/12/2012*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

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<th>COMMON TRADE NAME*</th>
<th>PA STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alfuzosin HCl ER 10 mg tablet</td>
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<tr>
<td>Finasteride 5 mg tablet</td>
<td>Proscar 5® mg tablet</td>
<td>See Finasteride</td>
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<tr>
<td>Tamsulosin HCl 0.4 mg capsule</td>
<td>Flomax® 0.4 mg capsule</td>
<td>No PA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GENERIC NAME</th>
<th>COMMON TRADE NAME*</th>
<th>PA STATUS</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Avodart® 0.5 mg softgel</td>
<td>PA</td>
</tr>
<tr>
<td>Dutasteride 0.5 mg-Tamsulosin 0.4 mg capsule</td>
<td>Jalyn® 0.5-0.4 mg capsule</td>
<td>PA</td>
</tr>
<tr>
<td>Silodosin 4 mg capsule</td>
<td>Rapaflø® 4 mg capsule</td>
<td>PA</td>
</tr>
<tr>
<td>Silodosin 8 mg capsule</td>
<td>Rapaflø® 8 mg capsule</td>
<td>PA</td>
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</tbody>
</table>

*TRADE NAMES ARE FOR REFERENCE ONLY*

[Link to Memorandum](#)

[Top of the document](#)
Benznidazole Tablet

(Implemented 03/01/2018)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

• Benznidazole 12.5mg Tablet
• Benznidazole 100mg Tablet

Link to Memorandum

Top of the document
Benzodiazepine Oral Solid Dosage Forms

(Implementation Date 12/07/2010)
(Update 03/08/2016)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval Criteria

- Unless otherwise stated, no therapeutic duplication is allowed between two benzodiazepines with > 10% of the days’ supply remaining on the last fill;
- Unless otherwise stated, the quantity edit of the single highest strength of a benzodiazepine tablet or capsule has been reduced to a maximum daily quantity of 2 units per day or a cumulative quantity of 62 units for a 31-day supply;
- Unless otherwise stated, all other strengths of tablet or capsule forms of benzodiazepines have been reduced to a maximum daily quantity edit of 3 units per day or a cumulative quantity of 93 units for a 31-day supply;
- Onfi tablet requires a Manual PA (See Clobazam [Onfi] Tablet)
- Temazepam 22.5 mg Capsule requires a Manual PA (see Temazepam 22.5 mg)
- Alprazolam XR [Xanax XR] additional approval criteria:
  - >18 years of age, AND
  - >= 90 days of Alprazolam XR therapy in the past 120 days
- Alprazolam oral-disintegrating tablet [Niravam]
  - >18 years of age, AND
  - One of the following:
    - Long Term Care
    - NPO (Appendix A) within past 365 days
- An incoming claim for any benzodiazepine medication will trigger a search of the beneficiary’s Medicaid medical diagnoses history for diagnosis of poisoning or overdose the previous 12 months.
- If a diagnosis for poisoning (overdose) for opioids, narcotics, barbiturates, benzodiazepines, or “unspecified drug or substance” is found in the Medicaid medical history in the previous 12 months, an incoming claim for an opioid pain medication or an incoming claim for a benzodiazepine medication will deny at point of sale.
- Patients who have a diagnosis of malignant cancer in the past 12 months:
  - Are exempt from the diagnosis check for a poisoning (overdose) of opioids, narcotics, barbiturates, benzodiazepines, or unspecified drug or substance.
Additional criteria

- Quantity limits apply

See chart below for summary of maximum daily quantity edits of solid oral dosage forms of benzodiazepines:

<table>
<thead>
<tr>
<th>Generic Name (Brand name reference only)</th>
<th>Strength</th>
<th>Maximum Daily Quantity Edit &amp; Maximum Cumulative Quantity edit per 31-days’ supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alprazolam (Xanax) tablet &amp; ODT</td>
<td>0.25 mg, 0.5 mg, 1 mg</td>
<td>3 units per day, (93)</td>
</tr>
<tr>
<td>Alprazolam (Xanax) tablet &amp; ODT</td>
<td>2 mg</td>
<td>2 units per day, (62)</td>
</tr>
<tr>
<td>Chlordiazepoxide (Librium) Capsule</td>
<td>5 mg, 10 mg</td>
<td>3 units per day, (93)</td>
</tr>
<tr>
<td>Chlordiazepoxide (Librium) Capsule</td>
<td>25 mg</td>
<td>2 units per day, (62)</td>
</tr>
<tr>
<td>Clonazepam (Klonopin) Tablet</td>
<td>0.125 mg, 0.25 mg, 0.5 mg, 1 mg</td>
<td>3 units per day, (93)</td>
</tr>
<tr>
<td>Clonazepam (Klonopin) Tablet</td>
<td>2 mg</td>
<td>2 units per day, (62)</td>
</tr>
<tr>
<td>Clorazepate (Tranxene) Tablet</td>
<td>3.75 mg, 7.5 mg</td>
<td>3 units per day, (93)</td>
</tr>
<tr>
<td>Diazepam (Valium) Tablet</td>
<td>2 mg, 5 mg</td>
<td>3 units per day, (93)</td>
</tr>
<tr>
<td>Diazepam (Valium) Tablet</td>
<td>10 mg</td>
<td>2 units per day, (62)</td>
</tr>
<tr>
<td>Lorazepam (Ativan) Tablet</td>
<td>0.5 mg, 1 mg</td>
<td>3 units per day, (93)</td>
</tr>
<tr>
<td>Lorazepam (Ativan) Tablet</td>
<td>2 mg</td>
<td>2 units per day, (62)</td>
</tr>
<tr>
<td>Oxazepam (Serax) Capsule</td>
<td>10 mg, 15 mg</td>
<td>3 units per day, (93)</td>
</tr>
<tr>
<td>Oxazepam (Serax) Capsule</td>
<td>30 mg</td>
<td>2 units per day, (62)</td>
</tr>
<tr>
<td>Clobazam (Onfi) Tablet</td>
<td>10 mg, 20 mg</td>
<td>2 units per day, (62)</td>
</tr>
<tr>
<td>Alprazolam (Xanax) ER and XR Tablet</td>
<td>0.5 mg, 1 mg, 2 mg, 3 mg</td>
<td>1 unit per day, (31)</td>
</tr>
<tr>
<td>Flurazepam (Dalmane) Capsule</td>
<td>15 mg, 30 mg</td>
<td>1 unit per day (31)</td>
</tr>
<tr>
<td>Temazepam (Restoril) Capsule</td>
<td>7.5 mg, 15 mg, 30 mg, 22.5 mg</td>
<td>1 unit per day (31)</td>
</tr>
<tr>
<td>Triazolam (Halcion) Tablet</td>
<td>0.125 mg, 0.25 mg</td>
<td>1 unit per day (31)</td>
</tr>
<tr>
<td>Estazolam (Prosom) Tablet</td>
<td>1 mg, 2 mg</td>
<td>1 unit per day (31)</td>
</tr>
</tbody>
</table>

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Top of the document
Benzodiazepine Oral Liquid Dosage Forms

(Implementation Date 12/07/2010)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- <7 years of age, OR
- NPO (Appendix A) within the past 365 days

Additional criteria

Quantity limits apply

Exemption criteria

Midazolam 2 mg/ml Syrup
- Claims for 30 ml or less will pay at point-of-sale for any age.

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Beta Adrenergic Blocking Agents

*(Implemented 10/17/2007)*

*(Updated 1/1/2019)*

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents

- Atenolol (Tenormin)
- Metoprolol tartrate (Lopressor)
- Propranolol HCl immediate-release (Inderal)
- Bisoprolol fumarate (Zebeta)
- Carvedilol tablet (Coreg)
- Metoprolol succinate extended-release (Toprol XL)
- Timolol maleate (Blocadren)
- Acebutolol HCl (Sectral)
- Pindolol (Visken)
- Betaxolol HCl (Kerlone)
- Labetalol HCl (Normodyne)
- Propranolol/HCTZ
- Bisoprolol/HCTZ
- Atenolol/Chlorthalidone
- Sotalol
- Propranolol Solution

Nonpreferred agents

- Carvedilol phosphate capsule (Coreg CR)
- Nadolol (Corgard)
- Nebivolol HCl (Bystolic)
- Penbutolol sulfate (Levatol)
- Propranolol HCl extended-release capsule (Inderal LA)
- Propranolol HCl solution (Hemangeol)
- Sotalol (Sotylize)
- Nadolol/bendroflumethiazide
- Metoprolol/HCTZ

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Beta2 Agonist and Corticosteroid Combination (Inhaled Long-Acting)- ICS/LABA

(Implemented 08/11/2009)  
(Effective 1/1/17)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents with criteria

- Budesonide/Formoterol fumarate dihydride inhalation aerosol (Symbicort®)
- Mometasone furoate/Formoterol fumarate dihydride Inhalation Aerosol (Dulera®)
- Fluticasone propionate/Salmeterol inhalation powder (Advair Diskus®) — (BRAND NAME ONLY)

Approval criteria for preferred agents with criteria

Criterion 1: COPD diagnosis in the past two years AND ≥ 40 years old.  
OR
Criterion 2: Paid drug claim in drug history for Advair Diskus®, Advair® HFA, Dulera®, or Symbicort® in the last six months  
OR
Criterion 3: One of the following criteria below:

- ≥ Three inhaled corticosteroid claims in the last 120 days, OR
- ≥ Three oral steroid claims in the last 120 days, OR
- Combination for ≥ three claims (as defined below) in the last 120 days:
  
  One Inhaled Corticosteroid + Two Oral Steroids Two Inhaled Corticosteroids + One Oral Steroids

Non-Preferred agents

- Fluticasone furoate/Vilanterol inhalation powder (Breo® Ellipta®)
- Fluticasone propionate/Salmeterol inhalation aerosol (Advair® HFA)
- Fluticasone/Salmeterol (AirDuo)
- Fluticasone propionate/Salmeterol inhalation powder (Wixela®)
- Fluticasone propionate/ Salmeterol inhalation powder (generic)

Additional criteria

Quantity limits apply

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Betaine (Cystadane) Powder for Oral Solution

(Implementation Date 11/15/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
- Diagnosis of Homocystinuria in the previous 2 years.

Additional criteria
Quantity limits apply

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Bexarotene Gel (Targretin)

*(Implemented 10/01/2004)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Targretin

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Bezlotoxumab (Zinplava) Solution, injection for IV infusion

(Implemented 05/23/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Zinplava 1000mg/40ml (25mg/ml) solution, injection for IV infusion

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Binimetinib (Mektovi 15mg Tablets)

**(Implemented 01/01/2019)**

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**
- Mektovi 15mg Tablets

**Additional Criteria**
- Quantity Limits Apply

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Bosutinib (Bosulif 100mg and 500mg Tablets)
(Implemented 03/19/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Bosulif

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Bowel Prep Agents and Kits

(Implementation Date 10/11/2011)
(Updated 01/01/2019)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Preferred agents
• Colyte Solution, Colyte with flavor Packets, Gavilyte-C
• Nulytely, Gavilyte-N
• Golytely Solution, Gavilyte G
• Moviprep Powder Kit
• PEG-3350 and Electrolytes Solution
• PEG-3350 with Flavor Packs Solution
• Trilyte

Non-preferred agents
• Osmoprep Tablet
• Clenpiq
• Prepopik Powder Packet
• Suprep Bowel Prep Kit
• Plenvu
• Golytely Powder Pack

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Brigatinib (Alunbrig) Tablet

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Alunbrig 30mg and 90mg Tablet

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Bronchodilators, Inhaled Short-Acting

(Effective 1/1/2017)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents
- Albuterol sulfate HFA inhaler (ProAir HFA) (BRAND ONLY)
- Albuterol sulfate HFA inhaler (Proventil HFA) (BRAND ONLY)
- Albuterol sulfate 2.5mg/0.5ml solution
- Albuterol sulfate 100mg/20ml solution
- Albuterol sulfate 2.5/3ml solution

Nonpreferred agents
- Albuterol sulfate HFA inhaler (Ventolin HFA) (BRAND and GENERIC)
- Albuterol sulfate HFA inhaler (GENERIC PROAIR or PROVENTIL)
- Albuterol sulfate 0.63mg/3ml, 1.25/3ml solution
- Albuterol sulfate HFA inhaler (ProAir Respicon)
- Levalbuterol HCl inhalation solution (Xopenex Inhalation Solution)
- Levalbuterol tartrate HFA inhaler (Xopenex HFA)
- Ipratropium/albuterol inhaled nebulizer solution

Preferred agents with criteria
- Ipratropium/albuterol sulfate (Combivent Respimat)
- Ipratropium bromide HFA inhaler (Atrovent HFA)
- Ipratropium bromide inhaled nebulizer solution

Approval criteria for Preferred agents with criteria
One of the following diagnoses or procedures:
- Anoxic brain injury (348.1)
- COPD
- Heart transplant (V421)
- Quadriplegic cerebral palsy (343.2)
- Respiratory insufficiency
  - 518.82 — Other pulmonary insufficiency, not elsewhere classified
  - 518.83 — Chronic respiratory failure
  - 518.84 — Acute and chronic respiratory failure
- Tracheostomy (Appendix B)
- Trachoeomalacia congenital (748.3)
Additional criteria

Quantity limits apply

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Top of the document
 Bronchodilators, Inhaled long acting

(Implemented 08/11/2009)
(Effective 1/1/17)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents with criteria

- Tiotropium bromide inhaler (Spiriva Handihaler) (Click for Spiriva Criteria)
- Salmeterol xiafoate disk with device (Serevent Diskus)

Nonpreferred agents without criteria

- Aclidinium bromide inhaler (Tudorza Pressair)
- Arformoterol tartrate inhalation solution (Brovana)
- Formoterol fumarate inhaler (Foradil)
- Formoterol fumarate inhalation solution (Perforomist)
- Indacaterol maleate inhaler (Arcapta Neohaler)
- Olodaterol inhaler (Striverdi Respimat)
- Umeclidinium bromide inhaler (Incruse Ellipta)
- Umeclidinium-Vilanterol inhaler (Anoro Ellipta)
- Tiotropium bromide-Olodaterol (Stiolto Respimat)
- Glycopyrrolate (Seebri Neohaler)
- Glycopyrrolate (Lonhala Magnair)
- Indacaterol/glycopyrrolate (Utibron Neohaler)
- Formoterol/glycopyrrolate (Bevespi Aerosphere)
- Revefenacin solution (Yupelri)

Nonpreferred Oral agents without criteria

- Roflumilast (Daliresp)

Additional criteria

- Quantity edits apply

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Budesonide Extended-Release 9mg (Uceris)

(Implemented 07/09/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
- Submitted Diagnosis of Ulcerative Colitis in the past 2 years

Additional criteria
Quantity limits apply

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Budesonide EC 3mg Capsule (Entocort EC)

(Implemented 07/09/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

• Submitted Diagnosis of Crohn's Disease in the past 2 years

Additional criteria

Quantity limits apply

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Butalbital Products

(Implemented 01/18/2011)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that do not require a manual PA

- Butalbital-Acetaminophen 50-325 mg TABLET (Marten-Tab)
- Butalbital-Acetaminophen-Caffeine 50-325-40 mg TABLET (Esgic Tablet)

Drugs that require a manual PA

- Butalbital-Acetaminophen 50-300 mg TABLET (Bupap 50-300 mg Tablet)
- Butalbital-Acetaminophen-Caffeine 50-300-40 mg CAPSULE (Fioricet Capsule)
- Butalbital-Acetaminophen-Caffeine 50-325-40 mg CAPSULE (Esgic Capsule)
- Butalbital-Aspirin-Caffeine 50-325-40 mg CAPSULE (Fiorinal Capsule)

Age Edit
Recipient must be at least 12 Years of Age or greater

Quantity Edit

- Solid Oral dosage forms of butalbital products will be limited up to a maximum of 6 units per day
- Solid Oral dosage forms of butalbital products will have a cumulative quantity limit of 93 units per 31 days’ supply
  **Additional information listed under Exemptions**
- The butalbital products that contain 750mg acetaminophen per unit will be limited to a maximum of 5 units per day based on the maximum amount of acetaminophen allowed per day
- Oral liquid forms of butalbital will be limited to 60ml per day or up to 240ml per prescription

Exemptions

- Patients who have a diagnosis of malignant cancer in the past 12 months:
  - Accumulation quantity limit will allow up to a maximum of 124 units of any solid oral short acting opioid paid by Medicaid per the previous 31 calendar days.

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C1 Esterase Inhibitor (Cinryze)

*(Implemented 01/21/2011)*

Prescribers are required to fax a letter of medical necessity and include all supporting documentation for manual review to 800-424-5851.

**Drugs that require manual review for prior authorization**

- Cinryze

A letter of medical necessity must be sent, along with **ALL** necessary documentation substantiating **ALL** of the criteria listed below.

1. Documented diagnosis of hereditary angioedema by an immunologist
   **AND**

2. The recipient’s history of HAE attacks is consistent with two or more abdominal or respiratory attacks per month that require hospital ER intervention with usage of Berinert® or Kalbitor® in the previous 6 consecutive months (ER documentation is required)
   **AND**

3. The Member is NOT concurrently taking an angiotensin converting enzyme (ACE) inhibitor or estrogen replacement therapy
   **AND**

4. The recipient has had an insufficient response or contraindication to **BOTH** of the following classes of medication:
   a. 17α – alkylated androgens (e.g. danazol, stanozolol, oxandrolone, methyltestosterone)
   b. Antifibrinolytic agents (e.g. ε – aminocaproic acid, tranexamic acid)

**Note:**
The Arkansas Medicaid Medical Director will work with hospital emergency departments to ensure the availability of Berinert®, Kalbitor®, or Ruconest® for acute attacks of HAE for authorized recipients.
Cabozantinib Capsule (Cometriq)

(Implemented 07/09/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Cometriq

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Cabozantinib (Cabometyx) Tablet

(Implemented 05/23/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
  - Cabometyx 20mg, 40mg, and 60mg Tablet

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Calcitrol (Vectical), Calcipotriene (Dovonex, Sorilux)

(Implemented 06/19/2006)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

<table>
<thead>
<tr>
<th>Drug</th>
<th>Sorilux</th>
<th>Vectical</th>
</tr>
</thead>
</table>

Approval criteria (New Start)

- Diagnosis of psoriasis in Medicaid history in previous 365 days, AND
- 2 paid claims of a topical corticosteroid in previous 27-60 days, AND
- At least one paid claim for a topical corticosteroid must be from the class 1 potency category.

Approval criteria (Continuation Criteria)

- Diagnosis of psoriasis in Medicaid history in previous 365 days, AND
- The incoming claim matches claim in history in the previous 45 days, AND
- At least two claims of a topical corticosteroid in previous 60 days in drug claim history with at least one topical corticosteroid claim 14-60 days back in history.

Denial criteria Dovonex

- History of Vitiligo in previous two years

[Link to Memorandum]
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Calcipotriene and Betamethasone Dipropionate (Taclonex)
(Implemented 01/09/2008)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- ≥ 18 years of age, AND
- History of three paid claims in the past 90 days for Calcipotriene (Dovonex), AND
- History of three paid claims in the past 90 days for a topical steroid

Denial criteria

- < 18 years of age
- Concurrent use of a topical corticosteroid
- Failure to meet the approval criteria

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Calcium Channel Blockers

(Implemented 07/12/2005)
(Updated 07/20/2015)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents

- Amlodipine besylate (Norvasc)
- Diltiazem HCl extended-release 120mg, 180mg, 240mg capsule (Dilacor XR)
- Diltiazem HCl extended-release 120mg, 180mg, 240mg, and 300mg (Tiazac)
- Nifedipine extended-release (Adalat CC, Procardia XL)
- Verapamil extended-release tablet (Calan SR)
- Valsartan/Amlodipine (Exforge)

Nonpreferred agents

- Amlodipine besylate/Atorvastatin calcium (Caduet)
- Amlodipine besylate/Olmesartan medoxomil* (Azor)
- Amlodipine besylate/Olmesartan medoxomil/Hydrochlorothiazide*
  (Tribenzor)
- Diltiazem HCl extended-release, CD, LA, XR, XT (Cardizem)
- Felodipine extended-release (Plendil)
- Isradipine (Dynacirc)
- Isradipine extended-release (Dynacirc CR)
- Nicardipine HCl (Cardene)
- Nicardipine HCL extended-release (Cardene SR)
- Nisoldipine extended-release (Sular ER)
- Verapamil extended-release capsule (Verelan)
- Valsartan/Amlodipine/HCTZ (Exforge HCT)

*See Angiotensin II Receptor Antagonist criteria
Cannabidiol (CBD) Extract – (Epidiolex Oral Solution)

(Implemented 1/16/2019)

Approval Criteria

- Beneficiary is ≥ 2 years of age
- Beneficiary has documented history of seizures associated with Lennox-Gastaut syndrome or Dravet syndrome
- For Lennox-Gastaut Syndrome: Provider must submit written documentation of electroencephalogram (EEG) showing slow (<3.0 hertz [Hz]) spike-and-wave pattern;
- For Dravet Syndrome: Provider must submit written documentation showing convulsive status epilepticus, alternating hemiconvulsions, OR myoclonic seizures and include genetic testing results for Dravet Syndrome that shows mutations within SCN1A gene.
- Beneficiary has 2 drop seizures each week (NOTE: SEE DRUG TRIAL INCLUSION CRITERIA that stated “Participant had at least 2 drop seizures each week during the first 28 days of the baseline period”)
- Beneficiary is currently adherent to prescribed dose and frequency of antiepileptic drugs and was on stable dose(s) for at least 4 weeks
- Provider must submit chart notes and documentation that beneficiary is refractory to antiepileptic drugs with documented failures on more than 1 anticonvulsant drug (≥2 antiepileptic drugs)
- Provider must submit baseline liver function tests including liver enzyme test results (ALT AST) and total bilirubin
- Initial approval will be for 1 month
- For adult beneficiaries, provider must submit results for urine drug screen (UDS) testing for marijuana and beneficiary must test negative for THC every 3 months
- Beneficiary is not pregnant, planning to become pregnant, or lactating

Denial Criteria:

- Beneficiary does not meet approval criteria
- Beneficiary does not have seizures associated with Lennox-Gastaut syndrome or Dravet syndrome
- Etiology of beneficiary's seizures is a progressive neurologic disease
- Beneficiary has significantly impaired hepatic function, defined as any of the following: alanine aminotransferase (ALT) or aspartate aminotransferase (AST) > 5 × upper limit of normal (ULN); ALT or AST > 3 × ULN and total bilirubin > 2 × ULN or international normalized ratio (INR) > 1.5; ALT or AST > 3 × ULN with the presence of fatigue, nausea, vomiting, right upper quadrant pain or tenderness, fever, rash, and/or eosinophilia (>5%)
- Female beneficiary is pregnant (positive pregnancy test), lactating or planning pregnancy for 3 months thereafter
QUANTITY LIMITS:

- The starting dosage is 2.5 mg/kg twice daily (5 mg/kg/day). After one week, the dosage can be increased to a maintenance dosage of 5 mg/kg twice daily (10 mg/kg/day).
- If further reduction of seizures is necessary, dose may be increased to a maximum of 10 mg/kg twice daily (20 mg/kg/day).
- Prescriber must submit beneficiary’s weight and prescribed dose at every PA request.
- Calculating the dose and the quantity limit for the number of 100 mL bottles per month will be entered at the time of PA approval.
- Dose adjustment is recommended in patients with moderate (Child-Pugh B) hepatic impairment or severe (Child-Pugh C) hepatic impairment and the quantity limit of 100 ml bottles will be implemented at the time of PA approval.
- Per the package insert, it may be necessary to have slower dose titration in patients with moderate or severe hepatic impairment than in patients without hepatic impairment, so quantity limit will be adjusted accordingly.

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Top of the document
Carbidopa (Lodosyn)
(Implemented 01/12/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Approval criteria**
- At least 1 paid Medicaid claim for Sinemet (carbidopa/levodopa) in the previous 60 days, OR
- At least 1 paid Medicaid claim for Stalevo in the previous 60 days.

[Link to Memorandum]

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Carbidopa/Levodopa Enteral Infusion Suspension (Duopa)

*(Implemented 07/22/2015)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Duopa Enteral Infusion

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Carbidopa-Levodopa-Entacapone (Stalevo)
(Implemented 01/12/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- No therapeutic duplication with Comtan.

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Cephalexin 750mg Capsule (Keflex)

(Implemented 07/09/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Keflex 750mg capsule

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Cephalosporins – 3rd Generation
(Implementation Date 3/18/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that do not require prior authorization
- CEFDINIR 300 MG ORAL CAPSULE [OMNICEF]
- CEFDINIR 125 MG/5 ML ORAL SUSPENSION [OMNICEF]
- CEFDINIR 250 MG/5 ML ORAL SUSPENSION [OMNICEF]
- CEFPODOXIME PROXETIL 50 MG/ML ORAL SUSPENSION [VANTIN]
- CEFPODOXIME PROXETIL 100 MG/ML ORAL SUSPENSION [VANTIN]
- CEFPODOXIME PROXETIL 100 MG ORAL TABLET [VANTIN]
- CEFPODOXIME PROXETIL 200 MG ORAL TABLET [VANTIN]

Drugs that require manual review for prior authorization
- CEFIDOREN PIVOXIL 200 MG ORAL TABLET [SPECTRACEF]*
- CEFIDOREN PIVOXIL 400 MG ORAL TABLET [SPECTRACEF]*
- CEFIXIME 400 MG ORAL CAPSULE [SUPRAX]
- CEFIXIME 100 MG ORAL CHEWABLE TABLET [SUPRAX]
- CEFIXIME 200 MG ORAL CHEWABLE TABLET [SUPRAX]
- CEFIXIME 100 MG/5 ML ORAL SUSPENSION [SUPRAX]
- CEFIXIME 200 MG/5 ML ORAL SUSPENSION [SUPRAX]
- CEFIXIME 500 MG/5 ML ORAL SUSPENSION [SUPRAX]
- CEFIXIME 400 MG ORAL TABLET [SUPRAX]
- CEFTIBUTEN DIHYDRATE 400 MG ORAL CAPSULE [CEDAX]
- CEFTIBUTEN DIHYDRATE 180 MG/5 ML ORAL SUSPENSION [CEDAX]

*Being removed from market. Limited availability.
CGRP Antagonists

(Implemented 10/1/2019)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Preferred Agents with Criteria

Emgality® (galcanezumab) injection 120 mg pen and syringe

Non-Preferred Agents

Emgality® (galcanezumab) injection 100 mg pen and syringe
Ajovy (fremanezumab-vfrm) injection 225 mg syringe
Aimovig (Erenumab-aooe) 70 mg and 140 mg autoinjector

Approval Criteria for Preferred Agents with Criteria

- Beneficiary is an adult ≥18 years
- Beneficiary is ≤50 years of age at migraine onset
- Beneficiary has migraines (≥15 days per month with migraine headache lasting 4 hours a day or longer) without aura and/or migraine with visual sensory, speech and/or language retinal or brainstem aura, each lasting ≥ 4 hours OR if shorter, associated with use of a triptan or ergot-derivative on the same calendar day
- Beneficiary has documented history of migraines for ≥ 12 months and has monthly triptan claims
- Beneficiary has documented history of migraines and has monthly claims in Medicaid history of 1st line migraine prophylaxis agents in ≥ 2 different drug classes (1st line prophylaxis agents include propranolol, timolol, amitriptyline, divalproex, sodium valproate, and topiramate)

Denial Criteria for Preferred Agents with Criteria

- Beneficiary does not have a 50% reduction from baseline in monthly migraine days after 3rd month
- Beneficiary is not adherent to prescribed dose
- Beneficiary is > 50 years of age at migraine onset
- Beneficiary has medication overuse headache caused by opiate overuse or other headache medication overuse
- Beneficiary is unable to differentiate migraine from other headaches
- Beneficiary has received Botox for migraine in the previous 3 months
- Beneficiary has active chronic pain syndromes (such as fibromyalgia and chronic pelvic pain);
- Beneficiary is on chronic use of opioid drugs
- Beneficiary has history of seizure disorder or other significant neurological conditions associated with headaches other than migraine
- Beneficiary has severe renal impairment (eGFR < 30 mL/min/1.73m2)
- Beneficiary has had Myocardial infarction (MI), stroke, transient ischemic attack (TIA), unstable angina, or coronary artery bypass surgery or other revascularization procedure within 12 months prior to PA request
- Beneficiary is < 18 years of age or > 65 years of age

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Top of the document
Ceritinib Capsule (Zykadia)
(Implemented 09/23/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
  • Zykadia

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Top of the document
Chlorpheniramine ER 12mg

(Implemented 04/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- $\geq$ 90 days of Chlorpheniramine ER therapy in the past 120 days

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Cholic Acid (Cholbam)

(Updated 05/20/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Cholbam

Top of the document
Chronic GI Motility Agents

(Implemented 06/27/2007)

(Updated 07/17/2015)

(PDL Effective 4/1/18)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

PREFERRED AGENTS

• Lubiprostone capsule (e.g., Amitiza®)

NONPREFERRED AGENTS

• alosetron tablet (Lotronex®)
• eluxadoline (Viberzi™)
• plecanatide tablet (Trulance™)
• methylnaltrexone tablet and injection (Relistor®)
• naldemedine tablet (Symproic®)
• linaclotide capsule (Linzess™)
• naloxegol (Movantik)

Approval criteria for Preferred Agents

Criterion 1:

• >18 years of age, AND
• Paid drug claim for Amitiza (Lubiprostone) within the past 60 days

Criterion 2:

• >18 years of age, AND
• At least one paid Medicaid drug claim in the previous 14 to 60 days for polyethylene glycol (MiraLAX, GlycoLax) or lactulose, AND
• At least one paid Medicaid drug claim in the previous 14 to 60 days for Bisacodyl
• No Therapeutic Duplication (TD) allowed between LINZESS™, RELISTOR® SQ, RELISTOR® tablet, MOVANTIK® tablet, TRULANCE™ tablet, or AMITIZA® capsule or the different strengths of any of these drugs, or new agents to market.
• Amitiza dose of one tablet per day
Denial criteria
- Absence of approval criteria
- History of mechanical gastrointestinal obstruction
- Age < 18 years of age

Additional criteria
Quantity limits apply

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Link to Memorandum
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Cidofovir Injection (Vistide)

(Implemented 04/17/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Vistide

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Cinacalcet (Sensipar)

*Implemented 05/23/2017*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

Criterion 1: POS PA approval criteria for Treatment of Secondary Hyperparathyroidism (HPT) in Adult Patients with Chronic Kidney Disease (CKD) On Dialysis,
• Diagnosis in Medicaid medical history in previous 2 years of BOTH diagnoses codes for:
  • Secondary HTP of renal origin" (ICD-9 code 588.81, or ICD-10 code N25.81),
  • AND
  • “ESRD CKD requiring Chronic Dialysis” (ICD-9 code 585.6 or ICD-10 code N18.6).

Manual review PA will be on a case-by-case basis if either diagnoses code is not found in the Medicaid system for POS approval. Prescriber must submit a letter explaining the medical necessity and submit documentation to support the diagnosis not found.

Criterion 2: POS PA approval criteria for Treatment of Hypercalcemia in Adult Patients with Parathyroid Carcinoma.
• Diagnosis in Medicaid medical history in previous 2 years of BOTH diagnoses codes for:
  • Cancer of the parathyroid gland, ICD-9 code 194.1, or ICD-10 code C75.0
  • AND
  • Hypercalcemia, ICD-9 code 275.41, or ICD-10 code E83.52

Manual review PA will be on a case-by-case basis if either diagnoses code is not found in the Medicaid system for POS approval. Prescriber must submit a letter explaining the medical necessity and submit documentation to support the diagnosis not found.

Criterion 3: Manual review PA criteria will be on a case-by-case basis for treatment of hypercalcemia in adult patients with primary HPT for whom parathyroidectomy would be indicated on the basis of serum calcium levels, but who are unable to undergo parathyroidectomy:
• Manual review on a case-by-case basis. Prescriber must submit a letter explaining the medical necessity and submit documentation to support the diagnosis.

[Link to Memorandum](#)

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Clobazam (Onfi)
(Implemented 07/09/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Onfi suspension
- Onfi tablet
- Sympazan™ - Orally Dissolving Film

Link to Memorandum
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Clonazepam Orally Disintegrating Tablet

(Implemented 10/11/2005)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- < 7 years of age, OR
- NPO (Appendix A) within the past 365 days, OR
- Long Term Care Eligible

Approval criteria

- Up to 93 Units of the 0.125mg, 0.25mg, 0.5mg, or 1mg strengths are allowed per the previous 31 calendar days.
- Up to 62 Units of the 2mg paid by Medicaid per the previous 31 calendar days.

Exemption from accumulation quantity limit

- Diastat AcuDial rectal gel
- Benzodiazepine injectable agents
- Benzodiazepine oral liquid agents.
Clonidine and Guanfacine

(Implemented 07/11/2009)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Approval criteria

Patients ≥ 18 years of age

- All claims are approved

Patients < 18 years of age

- One therapeutic duplication with > 25% remaining on the last fill on different dates of service allowed per 93 days between two clonidine claims, two guanfacine claims, or one clonidine claim and one guanfacine claim

- Cumulative quantity edits will apply (Table 3)

- Maximum daily dose edits will apply (Table 3.1)

Table 3 – Cumulative quantity edits

<table>
<thead>
<tr>
<th>Generic name</th>
<th>Cumulative qty &lt; 18 y/o</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clonidine HCL 0.1mg tablet</td>
<td>124 per 31 days</td>
</tr>
<tr>
<td>Clonidine HCL 0.2mg tablet</td>
<td>62 per 31 days</td>
</tr>
<tr>
<td>Clonidine HCL 0.3mg tablet</td>
<td>31 per 31 days</td>
</tr>
<tr>
<td>Guanfacine 1mg tablet</td>
<td>93 per 31 days</td>
</tr>
<tr>
<td>Guanfacine 2mg tablet</td>
<td>62 per 31 days</td>
</tr>
</tbody>
</table>

Table 3.1 – Maximum daily dose edits

<table>
<thead>
<tr>
<th>Generic name</th>
<th>Dose &lt; 18 y/o</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clonidine HCL 0.1mg tablet</td>
<td>4 tabs per day</td>
</tr>
<tr>
<td>Clonidine HCL 0.2mg tablet</td>
<td>2 tabs per day</td>
</tr>
<tr>
<td>Clonidine HCL 0.3mg tablet</td>
<td>1 tab per day</td>
</tr>
<tr>
<td>Guanfacine 1mg tablet</td>
<td>3 tabs per day</td>
</tr>
<tr>
<td>Guanfacine 2mg tablet</td>
<td>2 tabs per day</td>
</tr>
</tbody>
</table>

[Link to Memorandum]

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Clonidine Vials

(Implemented 07/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Clonidine HCl PF vials 5000mcg/10ml
- Clonidine HCl PF vials 1000mcg/10ml

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Cobimetinib (Cotellic) Tablets

(Implemented 04/26/2016)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Cotellic tablets 20mg

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Colchicine Capsule (Mitigare)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- Diagnosis of gout in the past three years.

Additional criteria

Quantity limits apply

LINK TO PREFERRED GOUT AGENTS
Colony Stimulating Factors
(Reviewed 5/10/18)
(Effective 7/1/18)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

PREFERRED AGENTS
- NEUPOGEN (filgrastim) vial and syringe
- GRANIX (tbo-filgrastim) syringe
- NEULASTA (pegfilgrastim) syringe

NONPREFERRED AGENTS
- LEUKINE (sargramostim) vial
- NEULASTA ONPRO® KIT (pegfilgrastim)
- ZARXIO (filgrastim-sndz) syringe
- FULPHILA (PEGFILGRASTIM-JMDB)
- UDENYCA (PEGFILGRASTIM-CBQV)

Link to Memorandum
Corticosteroids, Nasal Inhaled

*Implemented 11/28/2006*

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

**Preferred agents**
- Fluticasone propionate nasal spray (Flonase)

**Nonpreferred agents**
- Azelastine/fluticasone nasal spray (Dymista)
- Beclomethasone dipropionate AQ nasal spray (Beconase AQ)
- Beclomethasone dipropionate nasal spray (Qnasl)
- Budesonide nasal spray (Rhinocort Aqua)
- Ciclesonide nasal spray (Omnaris, Zetonna)
- Triamcinolone acetonide AQ nasal spray (Nasacort AQ)
- Flunisolide nasal spray

**Nonpreferred agents with criteria**
- Fluticasone furoate nasal spray (Veramyst)
- Mometasone furoate nasal spray (Nasonex)
- Triamcinolone acetonide AQ nasal spray (Generic only)

**Approval criteria for nonpreferred agents with criteria**
- Approvable if the beneficiary is between 2 years through 3 years of age

[Top of the document]
Corticosteroids, Oral Inhaled

(Implemented 08/11/2009)
(Updated 2/22/18)
(Effective 4/1/18)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents with criteria
- Pulmicort Respules brand name only (Budesonide ampules for nebulizer)*
- Fluticasone propionate HFA inhaler (Flovent HFA Inhaler)

Nonpreferred agents
- Budesonide inhaler (Pulmicort Flexhaler)
- Flunisolide inhaler (Aerospan)
- Fluticasone propionate disk with device (Flovent Diskus)
- Fluticasone (Armonair)
- Mometasone furoate (Asmanex Twisthaler, Asmanex HFA)
- Budesonide ampules for nebulizer (generic NDCs)
- Fluticasone furoate inhaler (Arnuity Ellipta )
- Ciclesonide inhaler (Alvesco )
- Beclomethasone dipropionate inhaler (QVAR, QVAR REDIHALER)

Approval criteria for preferred agents with criteria
Claim will deny if there is a diagnosis for COPD in the past two years.

*Approval criteria for Pulmicort Respules
- < 4 years of age

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Top of the document
Corticotropin Gel Injection (Acthar HP)
(Implemented 07/09/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Acthar HP Gel Injection

Link to Memorandum

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Crizotinib Capsule (Xalkori)

(Implemented 04/17/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

Xalkori

Information required for the manual review process

Detection of ALK-positive NSCLC using an FDA-approved test, indicated for this use

Additional criteria

Quantity limits apply

Link to Memorandum

Top of the document
Crofelemer Delayed Release Tablet (Fulyzaq)
(Implemented 07/09/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

• Fulyzaq

Link to Memorandum

Top of the document
Cromolyn Sodium Oral Solution (Gastrocrom)

(Implemented 09/21/2009)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
- Diagnosis of mastocytosis (congenital pigmentary anomalies or malignant mast cell tumors) in the past three years

Additional criteria
Age edit: Approve > 2 years of age

Link to Memorandum
Top of the document
Cyclosporine 0.05% Eye Emulsion (Restasis)

*(Implemented 01/18/2011)*

**Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).**

**Approval criteria**

Diagnosis of one of the following diagnoses associated with dry eye in the past two years:
- Keratoconjunctivitis sicca, non-Sjogren’s syndrome
- Keratoconjunctivitis sicca, Sjogren’s syndrome
- Keratoconjunctivitis, exposure
- Tear film insufficiency, unspecified (Dry eye syndrome)
- Xerosis

**Denial criteria**

Therapeutic duplication with Lacrisert (hydroxypropyl cellulose)

[Link to Memorandum](#)

[Top of the document](#)
Cyclosporine 0.05% Eye Solution (Cequa)
Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drug that requires manual review for prior authorization

- Cequa Ophthalmic Solution
Cyproheptadine 4mg/10ml U.D. Cup

*Implemented 04/08/2014*

**Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).**

**Approval criteria**

Currently LTC

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**Cysteamine 0.44% Ophthalmic Drop (Cystaran)**

*(Implemented 12/10/2013)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Cystaran Ophthalmic Drop

Additional criteria

Quantity limits apply

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Cysteamine DR Capsule (Procysbi)
(Implemented 03/18/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Procysbi 25mg DR Capsule
- Procysbi 75mg DR Capsule

Additional criteria

Quantity limits apply

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Top of the document
Dalfampridine Extended-Release Tablet (Ampyra ER)

(Implemented 09/28/2010)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Ampyra ER 10mg tablet

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Dabrafenib (Tafinlar) Capsules

(Implemented 09/18/2013)
Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Tafinlar

Additional Criteria
- Quantity Limits Apply

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Top of the document
Dacomitinib (Vizimpro)

(Implemented 1/16/2019)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Vizimpro

Approval Criteria

- Beneficiary is > 18 years old
- Beneficiary has diagnosis metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test
- Female beneficiary is not pregnant or breastfeeding
- Beneficiary has at least 12-month disease free interval between previous systemic therapy and recurrence of disease
- Provider must submit baseline lab documentation to show beneficiary has adequate renal, hematologic, and liver function
- ECOG score is 0-2
- PA approval one month

Denial Criteria

- No diagnosis of NSCLC with approved mutation
- Disease progression;
- Interstitial Lung Disease (ILD)
- Use of PPIs concomitantly
- CrCl < 30 mL/min
- ECOG 3 or 4
- History of brain mets or leptomeningeal mets
- Concomitant use of CYP2D6 substrates

QUANTITY LIMITS:

Max of 1 tablet daily and 30 tablets/30 days

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Top of the document
Dasatinib (Sprycel)

(Implemented 01/13/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual PA
- Sprycel

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Top of the document
Deferasirox Tablet (Jadenu)

*(Implemented 04/13/2015)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Jadenu

Top of the document
Deferiprone Tablet (Ferriprox)

(Implemented 07/09/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Ferriprox tablet

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Top of the document
Delafloxacin Meglumine (Baxdela)

_(Implemented 03/14/2018)_

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Baxdela 450mg Tablet
- Baxdela 300mg Vial

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Denosumab- Xgeva

*(Implemented 01/21/2011)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Xgeva

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Desmopressin (DDAVP) Nasal Spray and Solution

(Implemented 03/26/2008)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
Diagnosis in medicaid history of diabetes insipidus in the past three years.

Denial criteria
- Diagnosis in medicaid history of nocturnal enuresis in the past three years.
- Diagnosis in medicaid history of urinary incontinence in the past three years.

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Deutetrabenazine (Austedo) Tablet

(Implemented 11/22/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Austedo 6mg Tablet
- Austedo 9mg Tablet
- Austedo 12mg Tablet

The “INGREZZA™ / AUSTEDO® Statement of Medical Necessity” form is available on the Medicaid Pharmacy Program website at the following link: https://arkansas.magellanrx.com/provider/docs/rxinfo/ARRx_SMN_Form_Ingrezza_Austedo.pdf.

Magellan Medicaid Administration (MMA) Help Desk 1-800-424-7895; fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-7976.

Link to Memorandum

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Duvelisib (Copiktra) Capsule

(Memo 2/14/2019)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Copiktra 15 mg capsule
- Copiktra 25 mg capsule

APPROVAL CRITERIA require all of the following:

- Age > 18 years old;
- Beneficiary has diagnosis of chronic lymphocytic leukemia (CLL), small lymphocytic lymphoma (SLL), OR follicular lymphoma (FL), AND has relapsed or has refractory disease, AND has had at least two prior CLL/SLL therapies or two prior FL systemic therapies;
- Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2;
- Must meet the following laboratory parameters:
  - Serum aspartate transaminase (AST/SGOT) or alanine transaminase (ALT/SGPT) ≤ 3 x upper limit of normal (ULN)
  - Total bilirubin ≤ 1.5 x ULN
  - Serum creatinine ≤ 2.0 x ULN
  - Hemoglobin ≥ 8.0 g/dL with or without transfusion support
  - Platelet count ≥ 10,000 μL with or without transfusion support
- Female beneficiary of childbearing potential must have a current negative pregnancy test at the time of PA request;
- Female beneficiary is not lactating;
- Prescriber has prescribed Trimethoprim-sulfamethoxazole (TMP-SMX), or other appropriate agent, as prophylaxis for jiroveci pneumonia (PJP), formerly known as Pneumocystis carinii pneumonia (PCP);
- Prescriber has prescribed prophylactic antiviral treatment for prevention of cytomegalovirus (CMV) infection or reactivation;
- Initial PA will be approved for 1 month

DENIAL CRITERIA, any one of the following:

- Disease progression;
- Beneficiary is unable to tolerate a minimum dose of 15 mg twice daily;
- Beneficiary does not have a diagnosis of CLL, SLL, or FL;
- Beneficiary has not received 2 previous treatments for CLL, SLL, or FL;
- Beneficiary has Richter syndrome (RS), also called Richter transformation;
- Beneficiary has prolymphocytic leukemia;
- Beneficiary has uncontrolled autoimmune hemolytic anemia (AIHA) or idiopathic thrombocytopenia purpura (ITP) that is uncontrolled or requiring > 20 mg once daily (QD) of prednisone (or equivalent) to maintain hemoglobin > 8.0 g/dL or platelets > 10,000 µL without transfusion support;
- Beneficiary has diagnosis of FL grade 3b;
- Beneficiary has a history of tuberculosis treatment within the preceding two years;
- Beneficiary is pregnant, planning to become pregnant, or breastfeeding;
- Beneficiary does not meet laboratory requirements listed under approval criteria;
- Beneficiary has an ECOG score >2;
- Prior allogenic transplant
- Prior treatment with PI3K or BTK inhibitors
- Ongoing treatment with chronic immunosuppressants (i.e. cyclosporine, prednisone > 20 mg daily, etc.)
- Patient has or has a history of or current HIV, Hepatitis B or C, or history of alcohol abuse or liver disease;
- QTc > 480 msec;
- Beneficiary is unable to receive prophylactic treatment for jiroveci pneumonia (PJP), formerly known as Pneumocystis carinii pneumonia (PCP);

**QUANTITY LIMIT:**
- Strength of capsule will be entered at the time of PA approval;
- Quantity limit of both strengths not to exceed 2 per day and 56 capsules per 28-day supply;
Dexamethasone Dose Pak (DexPak and Zema-Pak)

*(Implemented 10/11/2011)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that do not require prior authorization**
- Dexamethasone 1.5mg Tablet

**Drugs that require manual review for prior authorization**
- Dexpak
- Zema-Pak

[Link to Memorandum](#)

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Dextromethorphan HBr/Quinidine Capsule (Nuedexta)

_(Implemented 06/21/2011)_

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Nuedexta capsule

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Dichlorphenamide (Keveyis)

*(Implemented 02/16/2016)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**
- Keveyis Tablet

[Link to Memorandum](#)

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Digoxin Tablet 187.5mcg and 62.5mcg Tablet (Lanoxin)
(Implemented 07/13/2016)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Lanoxin 187.5mcg
- Lanoxin 62.5mcg

Link to Memorandum

Top of the document
Dihydroergotamine Mesylate Nasal Spray (Migranal)

(Implemented 07/09/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Migranal Nasal Spray

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Disopyramide CR (Norpace CR)
(Implemented 04/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
  - $\geq 90$ days of Disopyramide CR therapy in the past 120 days

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Dornase Alfa inhalation Solution (Pulmozyme)

*Implemented 01/09/2008*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

Diagnosis of cystic fibrosis in medical history

Additional criteria

Quantity limits apply

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Doxepin 5% cream (Zonalon, Prudoxin)

*(Implemented 09/21/2009)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Approval criteria**
History of > two claims for a steroidal product (Class 5 or higher) in the past 60 days

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Doxycycline/Minocycline

*(Implemented 06/19/2008)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that do not require a manual PA**

Generic MAC'd solid dosage forms of doxycycline and minocycline including:

- Doxycycline hyclate 20 mg tablet (Periostat®)
- Doxycycline hyclate 50 mg capsule (Vibramycin®)
- Doxycycline hyclate 100 mg capsule (Vibramycin®)
- Doxycycline hyclate 100 mg tablet (Vibra-tab®)
- Doxycycline monohydrate 50 mg capsule (Monodox®)
- Doxycycline monohydrate 100 mg capsule (Monodox®)
- Minocycline HCl 50 mg capsule (Minocin®)
- Minocycline HCl 75 mg capsule (Dynacin®)
- Minocycline HCl 100 mg capsule (Minocin®)

**Drugs that require manual PA**

- Doxycycline hyclate 75 mg delayed-release capsule & tablet (Doryx®)
- Doxycycline hyclate 100 mg delayed-release capsule & tablet (Doryx®)
- Doxycycline monohydrate 40 mg extended-release capsule (Oracea®)
- Doxycycline hyclate 75 mg tablet
- Doxycycline hyclate 150 mg tablet
- Doxycycline monohydrate 75 mg capsule (Monodox®)
- Doxycycline monohydrate 150 mg capsule (Adoxa®)
- Doxycycline monohydrate 50 mg tablet (Adoxa®)
- Doxycycline monohydrate 75 mg tablet (Adoxa®)
- Doxycycline monohydrate 100 mg tablet (Adoxa®)
- Doxycycline monohydrate 150 mg tablet (Adoxa®)
- Minocycline HCl 50 mg tablet (Dynacin®)
- Minocycline HCl 75 mg tablet (Dynacin®)
- Minocycline HCl 100 mg tablet (Dynacin®)

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Doxylamine 5mg Chewable Tablet (Aldex AN)

(Implemented 09/28/2010)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
Patients $\leq 6$ years of age that cannot swallow a solid oral dosage form.

Additional criteria
Quantity limits apply
Doxylamine Succinate and Pyridoxine (Diclegis DR 10-10)

*(Implemented 09/18/2013)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Diclegis

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Dronabinol (Marinol)

*Implemented 06/27/2007*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

Criterion 1:
- Age > 18 years of age, AND
- Submitted diagnosis HIV within the past 730 days, AND
- Submitted diagnosis for cachexia within the past 730 days, AND
- At least three paid drug claims in history identifying antiretrovirals (either as single entity or combo drug) within the past 31 days, AND
- Paid claim for megestrol acetate (Megace) within the past 31 days (four weeks) (showing concomitant treatment)

Criterion 2:
- Age > 18 years of age, AND
- Submitted diagnosis malignant cancer within the past 365 days AND
  - Procedure code indicating radiation treatment within the past 45 days AND
- Paid drug claim in history within the past 45 days for an oral 5-HT3 (serotonin) receptor antagonist, OR
- Paid drug claim in history within the past 45 days for a NK1 (neurokinin-1) receptor antagonist

Denial criteria

- Absence of approval criteria
- Submitted diagnosis of bipolar in medical history.
- Submitted diagnosis of depression in medical history.
- Submitted diagnosis of schizophrenia in medical history.
- Submitted diagnosis of substance or alcohol abuse in medical history.

Additional criteria

Quantity limits apply

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Droxdopa (Northera) Capsule

(Implemented 01/13/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Northera
Dupilumab (Dupixent)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Dupixent 300mg SQ Injection

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Elagolix (Orilissa) Tablet

(Implemented 01/01/2019)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual PA

- Orilissa 150mg Tablet
- Orilissa 200mg Tablet

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Eliglustat (Cerdelga) Capsule
(Implemented 01/13/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual PA
- Eliglustat (Cerdelga) Capsule

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Eltrombopag Olamine Tablet (Promacta)

*Implemented 07/09/2013*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Promacta

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Emicizumab (Hemlibra) SQ Syringes

(Implemented 03/01/2018)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drug that require a manual review for prior authorization

- Hemlibra SQ Syringes

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Emtricitabine (Emtriva)

(Implemented 01/12/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria for treatment of HIV-1 infection

- A billed diagnosis of HIV/AIDS in the Medicaid history in previous 2 years; OR
- Paid drug claim(s) in Medicaid history of other antiretroviral therapy (ART), such as non-nucleoside reverse transcriptase inhibitors (NNRTI), OR protease inhibitors (PI), OR integrase strand transfer inhibitor (INSTI) in previous 6 months.
- If there is no HIV/AIDS diagnosis in Medicaid history and no records of other ART in the Medicaid drug profile, prescriber will be required to follow the manual review process and submit documentation confirming positive HIV diagnosis.

Denial criteria

- Therapeutic duplication edit: paid claim within previous 30 days for Truvada; OR
- Absence of approval criteria.

Approval criteria for PrEp will require a manual review PA process based upon the following:

- Documentation from prescriber that patient is at high risk for acquiring HIV infection; AND
- Negative HIV test before starting and every 3 months thereafter; AND
- Pregnancy test before starting and every 3 months thereafter. If pregnant, provide documentation of patient understanding of potential risks and benefits of using Truvada®, including contraindication with breastfeeding; AND
- Serum creatinine lab tests obtained prior to initiation, then every 6 months. Creatinine clearance should be >60 mL/min; AND
- Documented testing for Hepatitis B Virus (HBV) and results submitted.

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Enasidenib Mesylate (Idhifa) Tablet

(Implemented 11/22/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Idhifa 50mg Film Coated Tablet
- Idhifa 100mg Film Coated Tablet

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Encorafenib (Braftovi) Capsule

(Implemented 01/01/2019)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Braftovi 50mg Capsule
- Braftovi 75mg Capsule

Additional Criteria

- Quantity Limits Apply

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Entacapone (Comtan)

(Implemented 01/12/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- At least 1 paid Medicaid claim for Sinemet (carbidopa/levodopa) in the past 60 days, AND
- No therapeutic duplication with Stalevo.

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Entecavir (Baraclude)

(Implemented 09/24/2008)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- No history of HIV/AIDS diagnosis in medical history, OR
- HIV/AIDS diagnosis in medical history, AND
- At least one paid Medicaid drug claim for antiretroviral in past 45 days
Enzalutamide (Xtandi)

*Implemented 12/19/2012*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**
- Xtandi

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Eslicarbazepine (Aptiom)
(Implemented 07/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Aptiom 200 mg Tablet
- Aptiom 400 mg Tablet
- Aptiom 600 mg Tablet
- Aptiom 800 mg Tablet

Additional criteria
Quantity limits apply

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Erythropoiesis stimulating agents

(Implemented 03/26/2008)
(Re-review 5/10/18)
(Effective 7/1/18)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

PREFERRED AGENTS THAT REQUIRE MANUAL REVIEW

- EPOGEN® (epoetin alfa) vial
- PROCRIT® (epoetin alfa) vial

NONPREFERRED AGENTS

- ARANESP® (darbepoetin alfa in polysorbat) vial and syringe
- MIRCERA® (methoxy peg-epoetin beta) syringe

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Estrogen-replacement Agents

(Implemented 07/11/2008)
(Updated 10/31/2015)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents
- Estradiol 0.5mg, 1mg, 2mg oral tablet (Etrace)
- Estropipate oral tablet (Ogen)

Nonpreferred agents
- Estradiol acetate tablet (Femtrace)
- Estradiol acetate vaginal ring (Femring)
- Estradiol 1.5mg oral tablet (Etrace)
- Estradiol spray (Evamist)
- Estradiol topical gel (Divigel)
- Estradiol transdermal (Alora, Climara)
- Estradiol vaginal ring (Estring)
- Estradiol vaginal tablet (Vagifem, Yuvarfem)
- Estrogens, conjugated (Cenestin, Ejuvia, Premarin)
- Estrogens, conjugated/Bazedoxifene (Duavee)
- Estrogens, esterified (Menest)

Nonpreferred agents with criteria
- Estradiol/drospirenone (Angeliq)
- Estradiol/levonorgestrel (Climara Pro)
- Estradiol/norethindrone (Activella, Mimvey)
- Estradiol/norgestimate (Prefest)
- Estrogens, conjugated/medroxyprogesterone (Premphase, Prempro)
- Ethinyl estradiol/norethindrone acetate (Femhrt)
- Norethindrone/Estradiol (Jinteli)

Approval criteria for nonpreferred agents with criteria
Non-Preferred Agents with Criteria: ≥ 120 days of therapy in the previous 180 days for the same drug, strength, and dosage form
Everolimus Tablet (Afinitor)

(Implemented 07/23/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drug that requires a manual review for prior authorization

- Afinitor

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Everolimus Tablet (Zortress)
(Implemented 04/10/2019)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Point-of Sale (POS) Approval Criteria

- Beneficiary is age 18 years or greater
  AND
- Diagnosis in Medicaid history of kidney transplant (Z94.0) OR liver transplant (Z94.4) in previous 2 years;
  AND
- No therapeutic duplication between different strengths of ZORTRESS® or between other brand names of everolimus (e.g., AFINITOR®);

QUANTITY LIMITS:
  2 tablets per day AND #60 for 30-day supply
Evolocumab (Repatha)
(Updated 02/16/2016)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drug that requires a manual review for prior authorization
  • Repatha Injection

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Famotidine 40mg/5ml oral suspension (Pepcid)

(Implemented 09/24/2008)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- At least two paid Medicaid drug claims for ranitidine syrup in the past 60 days, AND
- <7 years of age, OR
- NPO (Appendix A) within the past 365 days

Approval criteria (Continuation Criteria)

One or more claims in the previous 60 days for Famotidine Oral Suspension.

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Febuxostat- Uloric

(Implemented 08/17/2010)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that do not require prior authorization

- Allopurinol tablets

Drugs that require manual review for prior authorization

- Uloric tablet

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Fentanyl Buccal Tablet (Fentora and Onsolis)
(Implemented 04/27/2005)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
- >/=<18 years of age, AND
- Opioid Tolerance of a ceiling dose for ≥ seven days during the past 30 days of one of the following: Fentanyl patch, Hydromorphone LA, Morphine LA, or Oxycodone LA AND
- Cancer with malignancies as determined by:
  - Diagnosis in past two years

Denial criteria
- < 18 years of age, OR
- Remaining estimated days supply of fentanyl buccal tablet in history is > 25%
- Therapeutic duplication with Abstral
- Therapeutic duplication with of Actiq
- Therapeutic duplication with other strengths of Fentora
- Therapeutic duplication with other strengths of Onsolis

Additional criteria
Quantity limits apply
Fentanyl Nasal Spray (Lazanda)
(Implemented 09/23/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Lazanda 100mcg Nasal Spray
- Lazanda 400mcg Nasal Spray

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Fentanyl 100mcg Sublingual Tablet (Abstral)
(Implemented 01/31/2011)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
- >/=18 years of age, AND
- Opioid Tolerance of a ceiling dose for ≥ seven days during the past 30 days of one of the following: Fentanyl patch, Hydromorphone LA, Morphine LA, or Oxycodone LA AND
- Cancer with malignancies as determined by:
  - Diagnosis in past two years

Denial criteria
- < 18 years of age, OR
- Remaining estimated days supply of fentanyl buccal tablet in history is > 25%
- Therapeutic duplication with other strengths of Abstral
- Therapeutic duplication with Actiq
- Therapeutic duplication with Fentora
- Therapeutic duplication with Onsolis

Additional criteria
Quantity limits apply
Fentanyl Sublingual Spray (Subsys)

(Implemented 01/31/2011)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
- >/=18 years of age, AND
- Opioid Tolerance of a ceiling dose for ≥ seven days during the past 30 days of one of the following: Fentanyl patch, Hydromorphone LA, Morphine LA, or Oxycodone LA AND
- Cancer with malignancies as determined by:
  - Diagnosis in past two years

Denial criteria
- < 18 years of age, OR
- Remaining estimated days supply of fentanyl sublingual spray in history is > 25%
- Therapeutic duplication with Abstral
- Therapeutic duplication with Actiq
- Therapeutic duplication with Fentora
- Therapeutic duplication with Onsolis

Additional criteria
Quantity limits apply

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Fentanyl citrate oral transmucosal (Actiq)
(Implemented 04/27/2005)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
- >= 16 years of age, AND
- Opioid tolerance of a ceiling dose for ≥ seven days during the past 30 days of one of the following: Fentanyl patch, Hydromorphone LA, Morphine LA, or Oxycodone LA
  AND
- Cancer with malignancies as determined by:
  o Diagnosis in past two years

Denial criteria
- < 16 years of age, OR
- Remaining estimated days supply of fentanyl citrate transmucosal in history is > 25%
- Therapeutic duplication with other strengths of Actiq
- Therapeutic duplication with Fentora
- Therapeutic duplication with Onsolis
- Therapeutic duplication with Abstral

Additional criteria
Quantity limits apply

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Fibromyalgia Agents

(Implemented 09/20/2011)
(Updated 3/7/2019)

The non-preferred antiepileptic medications will be considered non-preferred for treating fibromyalgia and neuropathic pain only. Medications listed as either preferred or non-preferred status in this category may or may not include an FDA approved indication for fibromyalgia or neuropathic pain. Use of these medications for fibromyalgia, neuralgias, and neuropathic pain has been reviewed through the evidence-based review process. Medications listed in this category as either preferred or nonpreferred status are not to be construed as endorsements for marketing of off-label use by the manufacturer or by Medicaid.

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents
- Amitriptyline HCl (Elavil)
- Cyclobenzaprine 10mg tablet (Flexeril)
- Gabapentin 100mg, 300mg, 400mg capsule (Neurontin)
- Nortriptyline HCl (Pamelor)

Preferred agents with criteria
- Citalopram hydrobromide (Celexa) – see Second generation antidepressant
- Fluoxetine 10mg, 20mg capsule, 20mg/5ml solution (Prozac) – see Second generation antidepressant
- Paroxetine HCl immediate-release (Paxil) - Second generation antidepressant

Nonpreferred agents with criteria:
- Buproprion - all dosage forms (Aplenzin, Wellbutrin) – see Second generation antidepressant
- Carbamazepine - all dosage forms (Tegretol) – see Neuropathic pain agents
- Cyclobenzaprine 5mg, 7.5mg tablet (Flexeril) – see Skeletal muscle relaxants
- Desipramine HCl (Norpramin)
- Desvenlafaxine succinate (Pristiq) – see Second generation antidepressant
- Duloxetine HCl (Cymbalta) – see Second generation antidepressant
- Escitalopram oxalate (Lexapro) – see Second generation antidepressant
- Ethotoin (Peganone)
- Fluoxetine HCl 10mg, 15mg, 20mg Tablet; 40mg capsule; and 90mg weekly capsule (Prozac) – see Second generation antidepressant
• Fluvoxamine maleate – all dosage forms (Luvox) – see Second generation antidepressant
• Gabapentin 250mg/5ml solution, 600mg, 800mg tablet – see Neuropathic pain agents
• Imipramine HCl and pamoate (Tofranil)
• Lacosamide (Vimpat) – see Neuropathic pain agents
• Lamotrigine (Lamictal) – see Neuropathic pain agents
• Levetiracetam (Keppra)
• Milnacipran HCl (Savella) – see Second generation antidepressant
• Mirtazapine (Remeron) – see Second generation antidepressant
• Nefazodone HCl (Serzone) – see Second generation antidepressant
• Oxcarbazepine (Trileptal) – see Neuropathic pain agents
• Paroxetine HCl 10mg/5ml suspension – see Second generation antidepressant
• Paroxetine mesylate (Pexeva) – see Second generation antidepressant
• Phenytoin 100mg extended-release capsule (Dilantin)
• Pregabalin (Lyrica) – see Neuropathic pain agents
• Sertraline HCl (Zoloft) – see Second generation antidepressant
• Tiagabine (Gabitril) –
• Valproic Acid (Depakene, Stavzor) – see Neuropathic pain agents
• Zonisamide (Zonegran)

Approval criteria for nonpreferred agents with criteria

• No diagnosis of myalgia and myositis in the past three years
• Drugs with a link to neuropathic pain agents, second generation antidepressants, or skeletal muscle relaxants have additional criteria to meet for approval

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Fidaxomicin (Dificid)

(Implemented 01/12/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- $\geq 18$ years of age, AND
- At least 1 paid claim in Medicaid history for Vancomycin (oral or injectable compounded for oral use) in the previous 10-30 days.

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Finasteride Tablet (Proscar)

(Implemented 07/09/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- Diagnosis of Benign Prostatic Hypertrophy in the past 3 years

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Fluorouracil Solution/Cream (Efudex) (Tolak)

(Implemented 06/21/2011)
(Updated 01/17/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval for Fluorouracil 2% Solution:
- Diagnosis of Actinic Keratosis in Medicaid history in the past 2 months, AND
- No therapeutic duplication with Diclofenac Sodium 3% Gel [Solaraze], OR
- No therapeutic duplication with other strengths of Fluorouracil Cream or Solution [Carac, Efudex], OR
- No therapeutic duplication with Imiquimod Cream [Aldara, Zyclara], OR
- No therapeutic duplication with Ingenol Gel [Picato]

Approval for Fluorouracil 4% Cream:
- Diagnosis of Actinic Keratosis in Medicaid history in the past 2 months, AND
- No therapeutic duplication with Diclofenac Sodium 3% Gel [Solaraze], OR
- No therapeutic duplication with other strengths of Fluorouracil Cream or Solution [Carac, Efudex], OR
- No therapeutic duplication with Imiquimod Cream [Aldara, Zyclara], OR
- No therapeutic duplication with Ingenol Gel [Picato]

Approval for Fluorouracil 5% Cream or Solution:
- Diagnosis of Actinic Keratosis or Basal Cell Carcinoma in Medicaid history in the past 2 months AND
- No therapeutic duplication with Diclofenac Sodium 3% Gel [Solaraze], OR
- No therapeutic duplication with other strengths of Fluorouracil Cream or Solution [Carac, Efudex], OR
- No therapeutic duplication with Imiquimod Cream [Aldara, Zyclara], OR
- No therapeutic duplication with Ingenol Gel [Picato]

Additional criteria Quantity limits apply

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Fluorouracil Cream (Carac 0.5%)

(Updated 01/17/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drug that requires manual review for prior authorization
- Fluorouracil 0.5% Cream (Carac)

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Fosamprenavir Calcium (Lexiva) Tablet

(Implemented 09/18/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval for Lexiva Tablet:

- If the Medicaid recipient does not have a ritonavir claim in Medicaid history in the previous 45 days, a maximum quantity of 4 tablets per day will be allowed and a cumulative quantity of 124 tablets per 31 days.

- If the Medicaid recipient does have a ritonavir claim in Medicaid history in the previous 45 days, a maximum quantity of 2 tablets per day will be allowed and a cumulative quantity of 62 per 31 days.

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Fosamprenavir Calcium (Lexiva) 50mg/5mI Suspension

(Implemented 09/18/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval for Oral suspension 50 mg/5 ml:
  • <7 years of age
  • NPO diagnosis within the past 365 days.

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Galantamine ER (Razadyne ER)
(Implemented 04/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- >= 90 days of Galantamine ER therapy in the past 120 days

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Galantamine Solution (Razadyne)
(Implemented 09/18/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval for Razadyne:
- Age >50 years of age, AND
- Diagnosis of NPO within the past 365 days.

Additional criteria Quantity limits apply

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Glasdegib (Daurismo™)

(Implemented 4/17/2019)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free)

APPROVAL CRITERIA:

- Will require manual review PA on a case-by-case basis
- Age ≥ 75 years old (PI study for ≥ 55 years)
- Must be newly diagnosed with acute myeloid leukemia (AML)
- Must use in combination with low-dose cytarabine
- Must have comorbidities that preclude the use of intensive induction chemo such as severe cardiac disease (LVEF <45%), ECOG =2 (but could have ECOG if met other criteria), or baseline serum creatinine >1.3mg/dL. *
- Must also receive low-dose cytarabine on days 1 to 10 of each 28-day cycle
- Provide the following labs
  - Complete blood counts—initially and then weekly for first month
  - Electrolytes—initially, weekly for first month, then monthly
  - Renal function—initially, weekly for first month, then monthly
  - Hepatic function—initially and then weekly for first month
  - Serum creatine kinase prior to starting DAURISMO™ as baseline
- Initial ECG report—must be repeated one week later after starting DAURISMO™ and then monthly for next two months
- Bone marrow blast count ≥ 20%*
- Approve PA for one month at a time due

DENIAL CRITERIA:

- If does not meet approval criteria above
- QTc interval prolongation with life-threatening arrhythmia
- Platelets less than 10 Gi/L for more than 42 days in the absence of disease
- Neutrophil count less than 0.5 Gi/L for more than 42 days in the absence of disease
- Grade 4 nonhematologic toxicity
- Drug interaction with Strong CYP3A Inducers—avoid use due to decreased effect of Daurismo™ (i.e. Rifampin)
- Drug interaction with other QTc prolonging drugs —avoid use as increased probability for QTc prolongation
- Drug interaction with Strong CYP3A4 Inhibitors—caution use due to increase Daurismo™ level (i.e. Ketoconazole)
- AML M3 Acute Promyelocytic Leukemia (APL) or patients with a t(9:22) cytogenetic translocation.*
- Patients with known active uncontrolled central nervous system (CNS) leukemia. *

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Glaucoma Agents

(Implemented 7/1/17)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Preferred Status only for strengths and package sizes noted:
- Latanoprost 0.005%, 2.5 ml solution drops
- TRAVATAN Z® (travoprost) 2.5 ml, 5 ml solution drops
- LUMIGAN® 0.01% (bimatoprost) solution drops 2.5ml, 5ml
- Levobunolol 0.5% solution drops, 5 ml, 10 ml, 15 ml
- Carteolol 1% solution drops, 5 ml, 10 ml, 15 ml
- Timolol 0.25%, 0.5% solution drops, 5 ml, 10 ml, 15 ml
- Dorzolamide 2% solution drops, 10 ml
- ALPHAGAN® P (brimonidine) 0.15% solution drops (Brand only), 5 ml, 10 ml, 15 ml
- SIMBRINZA® (bromonidine 1%/brinzolamide 0.2%) suspension drops, 8ml
- COMBIGAN® (brimonidine 0.2%/ timolol 0.5%) solution drops 5 ml, 10 ml, 15 ml
- Dorzolamide/timolol 22.3-6.8 mg/ml solution drops, 10 ml

Non-Preferred Status, all package sizes unless otherwise noted:
- LUMIGAN® (bimatoprost) 0.01% solution drops, 7.5 ml
- Bimatoprost 0.03% solution drops
- Pilocarpine 1%, 2%, 4% solution drops
- Brimonidine 0.2%, 0.15% solution drops
- ALPHAGAN® P (brimonidine) 0.1% drops
- Apraclonidine 0.5%, 1% solution drops
- Betaxolol 0.5% solution drops
- BETOPIC S® (betaxolol) 0.25% solution drops
- Metipranolol 0.3% solution drops
- ISTALOL® (timolol maleate) 0.5% solution drops
- Timolol gel forming solution 0.25%, 0.5% (same as TIMOPTIC-XE®)
- Timolol preservative free ocudose 0.25%, 0.5%
- AZOPT® (brinzolamide) suspension drops 1%
- ZIOPTAN® (tafluprost) solution drops 0.0015%
- COSOPT® PF (dorzolamide 2%/timolol 0.5%) solution drops
- RHOPRESSA (netarsudil) 0.02% solution/ drops
- ROCKLATAN® (netarsudil and latanoprost) 0.02%/0.005% solution/ drops
- XELPROS™ (latanoprost) 0.005% solution/drops

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Glutamine Powder (Endari)

(Implemented 03/01/2018)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drug that requires a manual review for prior authorization

- Endari Powder

Additional criteria

- Age limits apply
- Quantity limits apply

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Glycerol Phenylbutyrate Liquid (Ravicti)

(Implemented 07/09/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Ravicti

[Link to Memorandum](#)

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Glycophos 20ml Vial

*(Implemented 09/18/2013)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Glycophos 20ml vial

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Glycopyrrolate 0.2 mg/ml vial

(Implemented 07/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that do not require prior authorization

- Glycopyrrolate 1 mg/5 ml oral solution (Cuvposa)

Drugs that require manual review for prior authorization

- Glycopyrrolate 0.2 mg/ml vial

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Glycopyrrolate 1.5mg Tablet (Glycate)

*(Implemented 03/18/2014)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

### Drug that requires a manual review for prior authorization

- Glycate 1.5mg

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Hemorrhoid Preparations

(Implemented 01/12/2010)
(Updated 08/14/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
History of at least three claims for three different products that do not require prior authorization within the previous 60 days.

<table>
<thead>
<tr>
<th>LABELER CODE</th>
<th>LABEL NAME</th>
<th>PA STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>65649</td>
<td>ANUSOL-HC 2.5% CREAM</td>
<td>No PA</td>
</tr>
<tr>
<td>68220</td>
<td>PROCTOFOAM-HC 1%-1% FOAM</td>
<td>No PA</td>
</tr>
<tr>
<td>10631</td>
<td>PROCTOSOL-HC 2.5% CREAM</td>
<td>No PA</td>
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<tr>
<td>68220</td>
<td>CORTIFOAM 10% AEROSOL</td>
<td>PA</td>
</tr>
<tr>
<td>54766</td>
<td>ANALPRAM HC 2.5-1% CREAM</td>
<td>PA</td>
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<tr>
<td>64980</td>
<td>PROCTOZONE-HC 2.5% CREAM</td>
<td>PA</td>
</tr>
</tbody>
</table>

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Hepatitis C Medications

(Implemented 10/21/2009)
(updated 2/22/2018)
(Effective 4/1/18)

Prescribers are required to complete the HCV Statement of Medical Necessity and fax to 800-424-5851.

Preferred Drugs that require manual review for prior authorization

- Epclusa® (sofosbuvir/velpatasvir)
- Zepatier® (elbasvir/grazoprevir)
- MAVYRET™ tablet (glecaprevir and pibrentasvir)- Effective 4/1/18
- Ribavirin capsule 200mg, Ribavirin tablet 200mg

Nonpreferred agents

- Harvoni® (ledipasvir-sofosbuvir) tablet
- Incivek® (telaprevir) tablet
- Interferon® (interferon alfacon-1) vial
- Moderiba® (ribavirin) dosepack
- Olysio® (simeprevir) capsule
- Pegasys® (peginterferon alpha-2a) pen, vial
- PegIntron® (peginterferon alpha-2b) vial kit
- PegIntron® Redipen® (peginterferon alpha-2b) pen kit
- Rebetol® (ribavirin) solution
- Ribapak® (ribavirin) dosepak
- Sovaldi® (sofosbuvir) tablet
- Technivie® (ombitasvir and ritonavir)
- Victrelis® (beamceprevir) capsule
- Viekira Pak™ (ombitasvir-paritaprevir-ritonavir & dasabuvir) tablet dosepak
- Vosevi® (sofosbuvir, velpatasvir, and voxilaprevir tablet, film coated) tablet
- Daklinza® (daclatasvir tablet)

Link to Hepatitis C prior authorization form—Portable Document Format (.pdf):

Link to Memorandum
Link to Memorandum
Link to Memorandum
Link to Memorandum
Link to Memorandum
Link to Memorandum
Link to Updated Criteria
HMG-CoA Reductase Inhibitors

(Implemented 06/10/2008)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents

- Atorvastatin calcium (Lipitor)
- Pravastatin sodium (Pravachol)
- Simvastatin 5mg, 10mg, 20mg, 40mg (Zocor)

Preferred agents with criteria

- Simvastatin 80mg (Zocor)

Nonpreferred agents

- Atorvastatin calcium/Ezetimibe (Liptruzet)
- Fluvastatin sodium (Lescol)
- Lovastatin (Mevacor)
- Lovastatin/Niacin extended-release (Advicor)
- Pitavastatin calcium (Livalo)
- Rosuvastatin calcium (Crestor)
- Simvastatin/Ezetimibe (Vytorin)
- Simvastatin/Niacin (Simcor)
- Simvastatin/Sitagliptin (Juvisync)

Approval criteria for agents with criteria

Simvastatin 80mg
- Ten or more claims for Simvastatin 80mg within past twelve months

Link to Memorandum

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Hydroxypropyl Cellulose 5mg Eye Insert (Lacrisert)

*Implemented 01/18/2011*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

Diagnosis of one of the following diagnoses associated with dry eye in the past two years:

- Keratoconjunctivits sicca, non-Sjogren’s syndrome
- Keratoconjunctivits sicca, Sjogren’s syndrome
- Keratoconjunctivitis, exposure
- Tear film insufficiency, unspecified (Dry eye syndrome)
- Xerosis

Denial criteria

Therapeutic duplication with Restasis (Cyclosporine)

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Hydroxyurea (Siklos) 100mg Film Coated Tablet

(Implemented 01/01/2019)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drug that requires a manual review for prior authorization**
- Siklos 100mg Film Coated Tablet

**Additional Criteria**
- Quantity Limits Apply

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Ibrutinib (Imbruvica) Capsule

*Implemented 03/18/2014*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drug that requires a manual review for prior authorization**

- Imbruvica 140mg Capsule

**Additional Criteria**

- Quantity Limits Apply

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Icatibant (Firazyr)

(Implemented 01/12/2012)

Providers requesting a Prior Authorization (PA) should call the Medicaid Pharmacy Program, 501-683-4120.

Drugs that require manual review for prior authorization

- Firazyr

Additional criteria

- Quantity limits apply
- Age >17 years of Age

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Top of the document
Icosapent Ethyl Capsule (Vascepa)

(Implemented 07/09/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Vascepa

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Idelalisib (Zydelig) Tablet

(Implemented 01/13/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Zydelig

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Top of the document
Imatinib (100mg and 400mg)

(Implemented 07/13/2016)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Imatinib 100mg (Generic)
- Imatinib 400mg (Generic)
- Brand Name Gleevec 400mg

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**Imiquimod (Aldara)**

*(Implemented 06/27/2007)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Approval criteria**

- > 12 years of age AND,
- Submitted diagnosis for superficial basal cell carcinoma (sBCC) within past two months, OR
- Submitted diagnosis for actinic keratosis (AK) within past two months, OR
- Submitted diagnosis for Condyloma Acuminata (or commonly known as external genital or perianal warts) within past two months, AND
- No Therapeutic Duplication with Diclofenac Sodium 3% gel
- No Therapeutic Duplication with Fluorouracil Cream/Solution Topical
- No Therapeutic Duplication with other strengths of Imiquimod Cream Topical
- No Therapeutic Duplication with Ingenol gel Topical

**Additional criteria**

Quantity limits apply

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Imiquimod (Zyclara)

(Implemented 04/27/2010)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- > 12 years of age, AND
- Submitted diagnosis for actinic keratosis (AK) within past two months, OR
- Submitted diagnosis for Condyloma Acuminata (commonly known as external genital or perianal warts) within past two months, AND
- No Therapeutic Duplication with Diclofenac Sodium 3% gel
- No Therapeutic Duplication with Fluorouracil Cream/Solution Topical
- No Therapeutic Duplication with other strengths of Imiquimod Cream Topical
- No Therapeutic Duplication with Ingenol gel Topical

Additional criteria

Quantity limits apply

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Immunologic Agents (Multiple Sclerosis)

*(Implemented 09/27/2011)*

*(Updated 06/18/2015)*

*(Last reviewed 1/1/17)*

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

**Preferred agents**
- Glatiramer acetate 20 mg injection (Copaxone®)-Brand Only
- Interferon Beta – 1A injection (Avonex®)

**Non-Preferred agents**
- Dimethyl fumarate capsule (Tecfidera®)
- Glatiramer acetate 40 mg injection (Copaxone®)-Brand & Generic
- Glatiramer acetate 20 mg injection (Glatopa®)
- Glatiramer acetate 20 mg injection (Generic Copaxone®)
- Fingolimod HCl capsule (Gilenya®)
- Interferon Beta – 1A/albumin (Rebif®)
- Interferon Beta – 1B injection (Betaseron®)
- Interferon Beta – 1B kit (Extavia®)
- Peginterferon Beta – 1A (Plegridy®)
- Teriflunomide tablet (Aubagio®)
- Cladribine (Mavenclad®)
- Siponimod (Mayzent®)

**Additional criteria**

Quantity limits apply

[Link to Memorandum]

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Inhaled Antibiotics

(Updated 10/01/2016)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents with Criteria
- Tobramycin (Bethkis®)
- Tobramycin (Kitabis Pak®)

Non-Preferred agents
- Aztreonam (Cayston®)
- Tobramycin (Tobi®)
- Tobramycin (Tobi Podhaler®)

Approval criteria
Diagnosis of cystic fibrosis in medical history

Denial criteria
- History of Cayston in the past 50 days
- History of J Code for Tobramycin Injection in the past 60 days

Additional criteria
Quantity limits apply
Ingenol Mebutate (Picato Gel)

*Implemented 03/08/2012*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- >= 18 Years of Age
- Submitted diagnosis for actinic keratosis (AK) within past two months, AND
- No Therapeutic Duplication with Diclofenac Sodium 3% gel
- No Therapeutic Duplication with Fluorouracil Cream/Solution Topical
- No Therapeutic Duplication with Imiquimod Cream Topical
- No Therapeutic Duplication with other strengths of Ingenol gel Topical

Additional criteria

Quantity limits apply
Insulin Degludec Injection (Tresiba)

(Implemented 07/13/2016)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Non-Preferred Drugs that require manual review for prior authorization

- Tresiba

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Insulins

(Implemented 04/08/2014)
(Updated 11/27/17, effective 1/1/18)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

PREFFERED REGULAR/INTERMEDIATE ACTING INSULIN
   o HUMULIN R U-500 VIAL
   o HUMULIN R U-100 VIAL OTC
   o NOVOLIN N U-100 VIAL

PREFFERED LONG ACTING INSULIN
   o LEVEMIR PENS & VIALS
   o LANTUS SOLOSTAR PEN
   o LANTUS VIAL

PREFFERED RAPID ACTING INSULIN
   o HUMALOG VIAL (Brand Only)
   o APIDRA SOLOSTAR PEN
   o APIDRA VIAL
   o NOVOLOG PEN
   o NOVOLOG VIAL
   o NOVOLOG CARTRIDGE
   o HUMALOG PEN

PREFFERED COMBINATION INSULINS
   o HUMALOG MIX VIAL
   o HUMALOG MIX PEN
   o NOVOLOG MIX PEN
   o NOVOLOG MIX VIAL
   o HUMULIN 70/30 VIAL OTC

NON-PREFERRED INSULINS WITH CONTINUATION CRITERIA
   o HUMULIN 70/30 PEN OTC
   o HUMULIN N U-100 PEN OTC
   o HUMULIN R U-500 PEN

NON-PREFERRED INSULINS
   o HUMALOG CARTRIDGE
   o HUMALOG JR QUICKPEN
   o HUMALOG 200 PEN
   o AFREZZA
   o TRESIBA PEN
   o BASAGLAR KWIKPEN
   o TOUJEO SOLOSTAR PEN
   o TRESIBA FLEXTOUCH
   o FIASP
   o NOVOLIN 70/30 VIAL OTC
   o ADEMELOG VIAL
   o INSULIN LISPRO VIAL (generic Humalog)
Approval criteria

- The following **Non-Preferred Insulin Pens** currently have continuation criteria that will remain in effect for those beneficiaries who remain stable and compliant with 90 days of the insulin drug therapy in the Medicaid drug profile in the previous 120 days:
  - HUMULIN 70/30 PEN OTC
  - HUMULIN N U-100 PEN OTC
  - HUMULIN R U-500 PEN
Insulin- Inhaled (Afrezza )

(Implemented 07/22/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Non-Preferred Drug that requires a manual review for prior authorization
• Afrezza

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Intron A (Interferon Alpha-2B)

(Implemented 02/16/2016)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Denial criteria

- Diagnosis of Hepatitis C in Medicaid History

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Isosorbide Dinitrate/Hydralazine (BiDil)

*(Implemented 09/18/2013)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- BiDil

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Isotretinoin

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require a manual PA

- Isotretinoin 10 mg (Amnesteeem, Claravis)
- Isotretinoin 20 mg (Amnesteeem, Claravis, Sotret)
- Isotretinoin 30 mg (Claravis)
- Isotretinoin 40 mg (Amnesteeem, Claravis)
Itraconazole (Onmel) 200mg Tablet

(Implemented 03/19/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Onmel

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Itraconazole Oral Solution (Sporanox)

(Implemented 10/11/2011)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- History of at least two claims for fluconazole (tablets or suspension) in the previous 7-30 days, OR
- One claim each of Nystatin Suspension and fluconazole (tablets or suspension) in the previous 7-30 days, OR
- NPO diagnosis within the past 365 days.

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Ivabradine Tablet (Corlanor)

(Implemented 05/04/2015)
(Updated 01/17/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Corlanor

Additional criteria
Quantity limits apply

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Ivacaftor Tablet (Kalydeco)
(Implemented 07/09/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Kalydeco

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Ixazomib (Ninlaro) capsule

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Ninlaro 2.3 mg
- Ninlaro 3 mg
- Ninlaro 4 mg

APPROVAL CRITERIA:

- NINLARO® will require a manual review PA on a case-by-case basis.
- Each approved PA will to be for a short period of time (e.g., 3 months).
- Prescriber may request additional PAs as long as the disease is not progressing (e.g., spike in serum or urine monoclonal protein, increase in plasma cells in bone marrow, or other signs of progression such as new plasmacytoma, lytic bone lesion, hypercalcemia) or there is not unacceptable toxicity.
- For each PA request, the prescriber must submit documentation that the disease is not progressing.

QUANTITY EDITS

- 3 capsules per 28 days’ supply.

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Kits

*(Implemented 08/17/2010)*

All requests for “kits” or “combo pack” products (products that consist of packaging multiple products under one NDC) require a manual review. The underlined individual active ingredients (listed next to the product) do not require a PA.

**Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).**

**Drugs that require a manual PA**

- **CENTANY AT 2% OINTMENT KIT** *(MUPIROCON 2% OINTMENT – STERILE GAUZE – TAPE)*
- **HALONATE PAC COMBO PACK** *(HALOBETASOL PROPIONATE 0.5% OINTMENT – AMMONIUM LACTATE 12% LOTION)*
- **LIDOCAINE-PRILLOCAINE 2.5%-2.5% CREAM KIT** *(LIDOCAIN- PRILLOCAINE 2.5%-2.5% CREAM – OCCLUSIVE DRESSINGS)*
- **PEDIAERM AF KIT** *(NYSTATIN 100,000 UNITS/GRAM CREAM – EMOLLIENT DIAPER CREAM)*
- **PEDIAERM HC 2% KIT** *(HYDROCORTISONE 2% LOTION – EMOLLIENT DIAPER CREAM)*
- **PEDIAERM TA 0.1% KIT** *(TRIAMCINOLONE ACETONIDE 0.1% CREAM – EMOLLIENT DIAPER CREAM)*
- **ROSADAN 0.75% CREAM KIT** *(METRONIDAZOLE 0.75% CREAM – MOISTURIZING SKIN WASH)*
- **ROSADAN 0.75% GEL KIT** *(METRONIDAZOLE 0.75% GEL – MOISTURIZING SKIN WASH)*
- **ROWASA 4 GM/60 ML ENEMA KIT** *(MESALAMINE 4 GM/60 ML ENEMA – CLEANSING WIPES)*
- **SYNALAR 0.025% CREAM KIT** *(FLUOCINOLONE ACETONIDE 0.025% TOPICAL CREAM – EMOLLIENT CREAM)*
- **SYNALAR 0.025% OINTMENT KIT** *(FLUOCINOLONE ACETONIDE 0.025% TOPICAL OINTMENT – EMOLLIENT CREAM)*
- **SYNAGLAR TS 0.01% KIT** *(FLUOCINOLONE ACETONIDE 0.01% TOPICAL SOLUTION – HAIR & BODY CLEANSER)*
- **TERBINEX KIT** *(TERBINAFINE HCL 250 ORAL TABLETS – HYDROXYPROPYL-CHITOSAN 1% NAIL LACQUER)*
- **ULTRAVATE X CREAM COMBO PACK** *(HALOBETASOL PROPIONATE 0.05% TOPICAL CREAM – AMMONIUM LACTATE 10% MOISTURIZING CREAM)*
- **ULTRAVATE X OINTMENT COMBO PACK** *(HALOBETASOL PROPIONATE 0.05% TOPICAL OINTMENT – AMMONIUM LACTATE 10% MOISTURIZING CREAM)*

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Lamotrigine Kits (Lamictal Start and Patient Titration Kits)  
(Implemented 03/18/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that do not require prior authorization* if being used for approved diagnosis

- Lamotrigine Tablets*

Drugs that require manual review for prior authorization

- Lamictal ODT Start Kit (Blue) contains 25mg and 50mg tablets
- Lamictal ODT Start Kit (Green) contains 50mg and 100mg tablets
- Lamictal ODT Start Kit (Orange) contains 25mg, 50mg, and 100mg tablets
- Lamictal Tablet Start Kit (Blue) contains 25mg tablets
- Lamictal Tablet Start Kit (Green) contains 25mg and 100mg tablets
- Lamictal Tablet Start Kit (Orange) contains 25mg and 100mg tablets
- Lamictal XR Start Kit (Blue) contains 25mg and 50mg extended-release tablets
- Lamictal XR Start Kit (Green) contains 50mg, 100mg, and 200mg extended-release tablets
- Lamictal XR Start Kit (Orange) contains 25mg, 50mg, and 100mg extended-release tablets

Lamictal Start Kits are designed for titration during the first 5 weeks of therapy and contain a single entity drug that typically does not require prior authorization. Daily dosing instructions are determined by the patient's current antiepileptic regimen.

Additional criteria

Quantity limits apply

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Lansoprazole, Amoxicillin, and Clarithromycin combination (Prevpac)
(Implemented 01/12/2005)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

Criterion 1:
- No history of lansoprazole, amoxicillin, and clarithromycin combination (Prevpac) in the last 365 days, AND,
- No history of omeprazole, amoxicillin, and clarithromycin combination (Omeclamox Pak) in the last 365 days, AND,
- No concurrent proton pump inhibitor therapy within the past 30 days.

Criterion 2:
- No history of metronidazole/tetracycline/bismuth combination (Helidac) in the last 365 days, OR
- No history of metronidazole/tetracycline/bismuth combination (Pylera) in the last 365 days.

Additional criteria
Quantity limits apply

Top of the document
Lapatanib 250mg Tablet (Tykerb)

*(Implemented 01/17/2017)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Tykerb 250mg Tablet

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Lenvatinib (Lenvima)

*(Implemented 07/22/2015)*

**Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).**

**Drugs that require manual review for prior authorization**

- Lenvima

[Link to Memorandum](#)

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Letermovir (Prevymis)

(Implemented 03/01/2018)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drug that requires a manual review for prior authorization

- Prevymis

Additional criteria

- Age limits apply
- Quantity limits apply

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Top of the document
Leukotriene Receptor Antagonists

*(Implemented 08/11/2009)*
*(updated 11/27/17)*

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agent with criteria

- Montelukast sodium (Singulair)

Nonpreferred agents

- Zafirlukast (Accolate)
- Zileuton (Zyflo)

Approval criteria for preferred agents

**Criterion 1:**

A. If a paid drug claim in history for an inhaled corticosteroid, long-acting beta₂ agonist/inhaled corticosteroid, or short-acting beta₂ agonist in the last 365 days, then

B. One of the following criteria below:

- ≤ Two claims for short-acting beta₂ in the last 365 days, AND
- ≤ One claim for an oral corticosteroid in the last 183 days OR
- IF the patient exceeds any of the above criteria, then the asthma patient must have a claim for an inhaled asthma controller (ICS or ICS/LABA) in Medicaid drug history in last 45 days.

**OR**

**Criterion 2:**

A. If no paid drug claim in history for an inhaled corticosteroid, long-acting beta₂ agonist/inhaled corticosteroid, or short-acting beta₂ agonist in the last 365 days, then

B. One of the following criteria below:

- > One claim for an inhaled nasal steroid from the 30th day to the 124th day in Medicaid history, OR
- > One claim for a second generation antihistamine from the 30th day to the 124th day in Medicaid history

**OR**

**Criterion 3:**

A. A diagnosis code for COPD in patient history in the past 2 years AND patient is ≥40 years old AND

B. One of the following criteria below:

- > One claim for an inhaled nasal steroid from the 30th day to the 124th day in Medicaid history, OR
> One claim for a second generation antihistamine from the 30th day to the 124th day in Medicaid history

**Denial criteria**
- Failure to meet approval criteria
- Therapeutic duplication with a LTRA other than the one on the incoming claim if >25% of the days supply of the claim in history remains
- An age edit is implemented for the montelukast 10 mg tablet of beneficiary is ≥15 years;
- *maximum* age edit of 16 years on the 4 mg & 5 mg chew tablets; claims for infants ≤ 23 months of age will reject at point of sale for the 4 mg and 5 mg chewable tablets;
- The age edit is implemented for the montelukast 4 mg granule for beneficiary is ≥ 6 months old < 24 months old;
- Claims for pediatric patients < 6 months of age will deny at point of sale.

**Additional criteria**
Quantity limits apply

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Levetiracetam Tablet for Suspension  
(Spritam)  
(Implemented 01/17/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Spritam 250mg Tablet
- Spritam 500mg Tablet
- Spritam 750mg Tablet
- Spritam 1000mg Tablet

Additional criteria
Quantity limits apply

Link to Memorandum
Top of the document
Levodopa (Inbrija™)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Inbrija

APPROVAL CRITERIA:
- Will require manual review PA on a case-by-case basis
- Age ≥ 30 years old and ≤ 85 years old*
- Baseline labs including CBC, BMP and LFTs
- At baseline, beneficiary has at least 2 hours per day of “OFF” time per day excluding wakening each morning with motor fluctuations
- Carbidopa/levodopa medication did not exceed 1600 mg levodopa per day.
- Hoehn and Yahr Stage 1-3 in an “ON” state (see stages below)*
- Must be compliant on current carbidopa/levodopa therapy
- Baseline Unified Parkinson’s Disease Rating Scale (UPDRS) Part III motor score from pre-dose “OFF” state. The UPDRS part III is designed to assess the severity of the cardinal motor findings (e.g., tremor, rigidity, bradykinesia, postural instability) in patients with Parkinson’s disease.
- Provide the medical necessity of adding this medication over increasing current Carbidopa/Levodopa dose

DENIAL CRITERIA:
- Taking a nonselective monoamine oxidase (MAO) inhibitor
- Diagnosed with a major psychotic disorder or suicide ideation/attempt in last year
- Not recommended in patients with asthma, COPD or another chronic lung disease
- Pregnant
- ≤ 2 hours per day of “OFF” time
- Hoehn and Yahr Stage >3 in an “ON” state

Link to Memorandum

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Levetiracetam ER (Keppra ER)

(Implemented 04/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- $\geq$ 90 days of Levetiracetam ER therapy in the past 120 days

Link to Memorandum

Top of the document
Levofloxacin 500mg/20ml U.D. Cup

(Implemented 04/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
Currently LTC

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Top of the document
Levoleucovorin Vial

(Implemented 05/04/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drug that requires prior authorization

- Levoleucovorin

Top of the document
Levothyroxine Capsule (Tirosint)
(Implemented 08/17/2010)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that do not require prior authorization

• All strengths of generic levothyroxine tablet

Drugs that require manual review for prior authorization

• Tirosint Capsule

Link to Memorandum
Top of the document
Levothyroxine Vial

(Implemented 04/17/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Levothyroxine 200 mcg vial
- Levothyroxine 500 mcg vial

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Top of the document
Lidocaine 5% Ointment

*(Implemented 06/29/2017)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Approval criteria**

- Quantity limit to only allow one package size per NDC
- No therapeutic duplication allowed

[Link to Memorandum](#)

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Lidocaine-Prilocaine 2.5%-2.5% Cream (Emla)

(Implemented 07/09/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Additional criteria
Quantity limits apply

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Top of the document
Lidocaine-Tetracaine Patch (Synera)

*(Implemented 01/17/2017)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drug that requires manual review for prior authorization**

- Synera Patch

**Additional criteria**

- Quantity limits apply
- Age restrictions apply

*Link to Memorandum*

*Top of the document*
Lifitegrast Ophthalmic Solution (Xiidra)

(Implemented 01/17/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drug that requires manual review for prior authorization

- Xiidra Ophthalmic Solution

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Lipotropics
(Implemented 01/18/2011)
(Re-review 5/10/18)
(Effective 7/1/18)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Fibric Acid Agents

**PREFERRED AGENTS:**
- gemfibrozil
- fenofibrate tablet 48 mg, 54 mg, 145 mg, 160mg

**NONPREFERRED AGENTS**
- fenofibrate capsule (e.g., Antara®, Lipogen®, Lofibra®) 30 mg, 67 mg, 90 mg, 134 mg, 200 mg
- fenofibrate tablet (e.g., Fenoglide®, Triglide®) 40 mg, 120 mg, 160 mg
- fenofibric acid (e.g., Fibricon®) tablet 35 mg, 105 mg
- fenofibric acid (e.g., Trilipix®) delayed-release capsule 45 mg, 135 mg

Bile Acid Sequestrant Agents

**PREFERRED AGENTS:**
- colestipol tablet
- colestipol granules
- cholestyramine light powder for oral suspension
- cholestyramine powder for oral suspension

**NONPREFERRED AGENTS**
- WELCHOL® (colesevelam) powder pack and tablet

[Link to Memorandum]

[Link to Memorandum]

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Lithium ER or SA
(Implemented 04/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- \( \geq 90 \) days of Lithium ER or Lithium SA therapy in the past 120 days

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Lomitapide Mesylate Capsule (Juxtapid)
(Implemented 07/09/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Juxtapid

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Lomustine (Gleostine) Capsules

(Implemented 04/26/2016)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Gleostine Capsules 100mg, 40mg, 10mg, 5mg

[Link to Memorandum]

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Lorlatinib (Lorbrena®)

(Implemented 1/16/2019)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

LORBRENA® (lorlatinib) tablet will require manual review PA on a case-by-case basis

APPROVAL CRITERIA, requires all of the following:

- Beneficiary is an adult age 18 years or older;
- Beneficiary has a diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC);
- Beneficiary has disease that progressed on
  - crizotinib and at least one other ALK inhibitor for metastatic disease; OR
  - alectinib as the first ALK inhibitor therapy for metastatic disease; OR
  - ceritinib as the first ALK inhibitor therapy for metastatic disease;
- Beneficiary documented ALK rearrangement in tumor tissue as determined by fluorescence in situ hybridization (FISH) assay or by Immunohistochemistry (IHC);
- Beneficiary has an ECOG score of 0, 1, or 2;
- Beneficiary is not pregnant, lactating, or planning to become pregnant;
- Dose and quantity limit entered at time of PA approval;
- Beneficiary is not receiving a strong CYP3A inducer;
- Provider must submit current baseline LFTs and lipid panel;
- Beneficiary is not Child-Pugh B or C;
- Provider must submit kidney function tests and beneficiary does not have severe renal impairment;
- Initial approval 1 month

DENIAL CRITERIA any one of the following:

- Disease progression;
- Beneficiary cannot tolerate 50 mg once daily dose;
- Beneficiary is pregnant or lactating;
- Beneficiary is Child-Pugh B or C;

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Lumacaftor/Ivacaftor (Orkambi)

(Updated 02/16/16)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Orkambi

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Leuprolide/Norethindrone (Lupaneta) 2.5-5mg 1 month kit and 11.25-5mg 3 month kit

(Implemented 07/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- Billed diagnosis of endometriosis or uterine leiomyoma (fibroids) AND
- <12 billed claims of 3.75mg leuprolide injection (which would include Lupaneta®) in the previous 3 year Medicaid history, OR
- <4 billed claims of 11.25mg leuprolide injection (which would include Lupaneta®) in the previous 3 year Medicaid history, AND
- No Therapeutic Duplication with other strengths of Lupron.

Denial Criterion
- Diagnosis of infertility in Medicaid history (3 year look back), OR
- Thrombophlebitis, OR
- Thromboembolic disorders, OR
- Cerebral apoplexy in Medicaid history; OR
- Carcinoma of the breast in Medicaid history.

Additional criteria Quantity limits apply

Link to Memorandum

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Leuprolide- Lupron

*Implemented 06/21/2011*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

<table>
<thead>
<tr>
<th>Drug</th>
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</thead>
<tbody>
<tr>
<td>Lupron depot 11.25 mg 3 mo kit</td>
</tr>
<tr>
<td>Lupron depot 22.5 mg 3 mo kit</td>
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<tr>
<td>Lupron depot 3.75 mg kit</td>
</tr>
<tr>
<td>Lupron depot 7.5 mg kit</td>
</tr>
<tr>
<td>Lupron depot-4 month kit</td>
</tr>
<tr>
<td>Lupron depot-ped 11.25 mg kit</td>
</tr>
<tr>
<td>Lupron depot-ped 15 mg kit</td>
</tr>
<tr>
<td>Lupron depot-ped 7.5 mg kit</td>
</tr>
<tr>
<td>Lupron depot-ped 11.25 mg 3 mo kit</td>
</tr>
<tr>
<td>Lupron depot-ped 30mg 3 mo kit</td>
</tr>
</tbody>
</table>

**Criterion 1 for Lupron-Depot PED® 7.5 mg, 11.25 mg, 15 mg, 11.25 3 mo kit, and 30mg 3 mo kit:**

- Manually Reviewed
  - Prescribers are required to fax a letter of medical necessity and include all supporting documentation for manual review to 800-424-5851.

- Drugs that require manual review for prior authorization:
  - Lupron-Depot PED (All Strengths)

**Criterion 2 for Lupron-Depot® 3.75 mg, and 11.25 mg-3 month**

- Billed diagnosis of endometriosis or uterine leiomyoma (fibroids) AND

- <12 billed claims of 3.75mg leuprolide injection (which would include Lupaneta®) in the previous 3 year Medicaid history, OR

- < 4 billed claims of 11.25mg leuprolide injection (which would include Lupaneta®) in the previous 3 year Medicaid history AND

- No Therapeutic Duplication with other strengths of Lupron.

**Denial Criterion**

- Diagnosis of infertility
**Criterion 3 for Lupron-Depot® 7.5 mg, 22.5 mg-3 month, 30 mg-4 month, 45mg-6 month, and Lupron 2 week Kit**

- Diagnosis in Medicaid History of prostate cancer within last 2 years, AND
- No Therapeutic Duplication with other strengths of Lupron.

**Criterion 4 for Lupron-Depot 3.75 mg, 7.5 mg, 11.25 mg-3 month**

- Diagnosis in Medicaid History of breast cancer or ovarian cancer in the last 2 years, AND
- No Therapeutic Duplication with other strengths of Lupron.

Additional criteria Quantity limits apply

[Link to Memorandum](#)
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Macitentan (Opsumit) Tablet

*(Implemented 03/18/2014)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drug that requires a manual review for prior authorization**

- Opsumit 10 mg

**Additional Criteria**

- Quantity Limits Apply

[Link to Memorandum](#)

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Maraviroc (Selzentry)
(Implemented 04/12/2011)

Prescribers are required to fax a letter of medical necessity and include all supporting documentation for manual review to 800-424-5851.

Drugs that require manual review for prior authorization
- Selzentry

Link to Selzentry Form

Link to Memorandum

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Mecamylamine HCL Tablet (Vecamyl)

*(Implemented 09/18/2013)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Vecamyl

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Meclorethamine HCL Gel (Valchlor)

*(Implemented 03/18/2014)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drug that requires a manual review for prior authorization**
- Valchlor 0.016% Gel

**Additional Criteria**
- Quantity Limits Apply

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Medication Assisted Treatment Medications

(Implemented 04/21/2009)
(Updated September 7, 2018)
(Updated July 1, 2019)

Prescribers are required to fill out the appropriate Statement of Medical Necessity

https://arkansas.magellanrx.com/provider/docs/rxinfo/ARRx_SMN_Form_Buprenorphine_Agents.pdf

https://arkansas.magellanrx.com/provider/docs/rxinfo/ARRx_SMN_Form_VivitrolIM.pdf

Preferred Oral Agents with Criteria

- Suboxone® Film (buprenorphine/naloxone sublingual film)
- Buprenorphine sublingual tablets

Non-Preferred Oral Agents

- Buprenorphine/naloxone buccal film (Bunavail®)
- Buprenorphine/naloxone sublingual (SL) tablets (Zubsolv®)
- Buprenorphine/naloxone SL tablets (generic)

Manual Review MAT Injectables:

- Vivitrol IM (naltrexone for extended-release injectable suspension) *

  + Vivitrol may be billed at point-of-sale in a pharmacy setting or through the patient’s medical benefits.

MAT Medical Program Billing:

- Sublocade SQ Injection (buprenorphine extended-release) *
- Probuphine (buprenorphine implant for subdermal administration) *

  *The PA’s for Sublocade and Probuphine will be reviewed by the State Pharmacy Unit. Please provide the Statement of Medical Necessity for Buprenorphine Agents (see above link). However, Sublocade and Probuphine are NOT billable currently at point-of-sale in a pharmacy setting. They will still need to be coded properly and billed through the medical program.

Additional criteria

Quantity limits apply

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Link to Memorandum
Link to Memorandum

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Medroxyprogesterone  (Depo-Provera)
(Implemented 02/12/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval Criteria

- No Therapeutic Duplication with any other injectable Depo-Provera

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDROXYPROGESTERONE ACETATE 104 MG/0.65 ML SYRINGE</td>
</tr>
<tr>
<td>MEDROXYPROGESTERONE ACETATE 150 MG/ML SYRINGE</td>
</tr>
<tr>
<td>MEDROXYPROGESTERONE ACETATE 150 MG/ML VIAL</td>
</tr>
<tr>
<td>MEDROXYPROGESTERONE ACETATE 400 MG/ML VIAL</td>
</tr>
</tbody>
</table>

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Megestrol (Megace and Megace ES)

*Implemented 10/18/2006*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- History of HIV/AIDS in the past two years, OR
- History of a paid claim for an antiviral: HIV agent in the past 60 days, OR
- History of malignancy in the past two years

Additional criteria

Quantity limits apply

[Link to Memorandum](#)

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Memantine XR (Namenda XR)

(Implemented 04/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- &ge; 90 days of Memantine XR therapy in the past 120 days

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Memantine Solution (Namenda)
(Implemented 09/18/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval Namenda:
- Age > 50 years of age, AND
- Diagnosis of NPO within the past 365 days.

Additional criteria Quantity limits apply

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Meprobamate Tablet (Equanil)

*(Implemented 07/09/2012)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

| Additional criteria | Quantity limits apply |

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Mepron (Atovaquone)
(Implemented 09/21/2009)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that do not require prior authorization
Generic MAC’d sulfamethoxazole-trimethoprim tablets are available without a prior authorization.

Drugs that require manual review for prior authorization
- Mepron suspension

Approval criteria (Continuation Criteria)
One or more claims in the previous 60 days for Mepron Suspension.

Look back in pharmacy claims history 60 days for Mepron Suspension

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Top of the document
Mercaptopurine 20mg/ml Suspension (Purixan)
(Implemented 01/13/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual PA
- Purixan

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Meropenem-Vaborbactam (Vabomere) Injection

*Implemented 03/01/2018*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drug that requires a manual review for prior authorization

- Vabomere Injection

Additional criteria

- Age limits apply
- Quantity limits apply

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Mesalamine 1000mg Suppository (Canasa)

*(Implemented 06/21/2011)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Criteria

Quantity limits apply

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Methoxsalen Capsule (Oxsoralen-Ultra, 8-MOP)

(Implemented 09/23/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Oxsoralen-Ultra
- 8-MOP

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**Metreleptin 11.3mg Vial (Myalept)**

*(Implemented 09/23/2014)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Myalept Vial

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Metformin Oral Solution (Riomet)

_(Implemented 09/21/2009)_

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- Recipient < 7 years of age, OR
- Diagnosis of NPO within the past 365 days (Appendix A).

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Metformin Extended-Release (Fortamet ER, Glumetza ER)

*(Implemented 01/18/2011)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that do not require prior authorization

- Metformin 500 mg
- Metformin 850 mg
- Metformin 1000 mg
- Metformin ER 500 mg
- Metformin ER 750 mg

Drugs that require manual review for prior authorization

- Fortamet ER
- Glumetza ER

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Methotrexate Auto Inj. (Otrexup)

(Implemented 07/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual prior authorization

- Otrexup

Additional criteria

Quantity limits apply

Link to Memorandum

Top of the document
Methotrexate Sodium (Trexall)

*(Implemented 8/17/2010)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that do not require prior authorization**
- Methotrexate 2.5mg tablet

**Drugs that require manual review for prior authorization**
- Trexall 5mg
  - Trexall 7.5mg
  - Trexall 10mg
  - Trexall 15mg

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Methscopolamine (Pamine, Pamine Forte, Pamine FQ)

*(Implemented 06/19/2008)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Approval criteria**

- History of peptic ulcer disease in Medicaid medical history in previous 6 months, **AND**
- CPT code for H.Pylori in procedure history in the past 6 months, **AND**
- At least 112 days of PPI therapy in the last 120 days.

**Denial criteria**

History of glaucoma

[Link to Memorandum]
Metoclopramide Orally Disintegrating Tablet (Metozolv ODT)

(Implemented 01/12/2010)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that do not require prior authorization

Generic MAC'd metoclopramide tablets and syrup are available without a prior authorization.

Drugs that require manual review for prior authorization

- Metozolv ODT tablet
- Metocloproramide ODT

[Link to Memorandum]

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Metronidazole 375 mg capsule (Flagyl)

(Implemented 08/17/2010)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- Diagnosis of NPO (Appendix A) in the previous year, OR
- < 7 years of age

Link to Memorandum

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Metronidazole ER 750mg (Flagyl)

*(Implemented 08/17/2010)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Flagyl 750 mg Tablets

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Metronidazole-Tetracycline-Bismuth (Helidac and Pylera)
(Impemented 01/12/2005)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

Criterion 1:
- No history of lansoprazole, amoxicillin, and clarithromycin combination (Prevpac) in the last 365 days, AND
- No history of omeprazole, amoxicillin, and clarithromycin combination (Omeclamox-Pak) in the last 365 days, AND

Criterion 2:
- No history of metronidazole, tetracycline, and bismuth combination (Helidac) in the last 365 days, OR
- No history of metronidazole, tetracycline, and bismuth combination (Pylera) in the last 365 days.

Denial criteria

Criterion 1:
- History of lansoprazole, amoxicillin, and clarithromycin combination (Prevpac) in the last 365 days, OR
- History of omeprazole, amoxicillin, and clarithromycin combination I (Omeclamox-Pak) in the last 365 days,

Criterion 2:
- History of metronidazole, tetracycline, and bismuth combination (Helidac) in the last 365 days, OR
- History of metronidazole, tetracycline, and bismuth combination (Pylera) in the last 365 days

Top of the document
Miconazole 50mg Buccal Tablet (Oravig)

(Implemented 01/18/2011)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that do not require prior authorization

- Clotrimazole 10mg troches
- Nystatin 100,000 units/ml oral suspension

Drugs that require manual review for prior authorization

- Oravig

Link to Memorandum

Top of the document
Midostaurin (Rydapt) Capsule

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Rydapt 25mg Capsule

Link to Memorandum

Top of the document
Mifepristone 300mg Tablet (Korlym)

*(Implemented 07/23/2012)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Korlym

[Link to Memorandum](#)

[Top of the document](#)
Arkansas Medicaid Prescription Drug Program Prior Authorization Criteria

Migalastat – Galafold
Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
• Galafold

Approval Criteria
• Beneficiary is an adult ≥18 years of age
• Provider must submit documentation that beneficiary has diagnosis of Fabry disease with renal manifestations, AND has an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data, AND the amenable variant must be a disease-causing variant
• Beneficiary is on a low protein diet
• Provider must submit beneficiary’s urine albumin, urinary creatinine, serum creatinine, glomerular filtration rate (GFR), serum BUN, serum electrolytes, plasma globotriaosylysphingosine (lyso-Gb3) for the last 12 months
• Beneficiary must have tried Enzyme Replacement Therapy and provider must submit Medication Administration Records (MARs) and response to therapy for the last 12 months
• Provider must submit patient specific measurable treatment goals for outcomes with GALAFOLD™ and include the treatment plan if the measurable treatment goals are not met and GALAFOLD™ is discontinued
• Initial approval can be for 6 months

Denial Criteria
• Beneficiary does not have Fabry disease with an amenable galactosidase alpha gene (GLA) variant
• The GLA variant is not a disease-causing variant
• Beneficiary did not show positive response to therapy
• Request for doses exceeding 1 capsule every other day

QUANTITY LIMITS
Limited to 1 capsule every 2 days (Dose is 1 capsule every other day)
Quantity limited to 14 capsules for a 28-day supply

Link to Memorandum
Top of the document
Mig Lustat (Zavesca) Capsule  
(Implemented 01/13/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
  • Zavesca

Link to Memorandum

Top of the document
Mipomersen Sodium Syringe (Kynamro)

(Implemented 07/09/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Kynamro

[Link to Memorandum](#)

[Top of the document](#)
Misoprostol (Cytotec)

(Implemented 01/09/2008)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

Criterion 1:
- Female, AND
- Long Term Care, OR
- Current birth control drug claim (within the past 30 days), OR
- Current injectable birth control drug claim, OR
- Medical history of tubal ligation, OR
- Medical history of hysterectomy, OR
- Medical history of menopause, OR
- Hormone replacement therapy in the past 45 days, OR
- Age > 55 AND
- NSAID claim in past 30 days Criterion

Criterion 2:
- Male, AND
- NSAID claim in the past 30 days

Denial criteria

Medical history of current pregnancy

Link to Memorandum

Top of the document
Mupirocin Cream, Mupirocin Nasal Ointment

(Implemented 02/16/2016)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Mupirocin 2% Cream
- Mupirocin 2% Nasal Ointment

Drugs that do not require a prior authorization

- Mupirocin 2% Ointment

Link to Memorandum

Top of the document
Mycophenolate (Myfortic)
(Suspension Implemented 10/11/2011) (Capsules and Tablets Implemented 12/10/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that do not require a PA
- Mycophenolate 250 mg capsules (Cellcept)
- Mycophenolate 500 mg tablets (Cellcept)

Drugs that require manual review for prior authorization
- Mycophenolate 180mg Tablet DR (Myfortic)
- Mycophenolate 360mg Tablet DR (Myfortic)

Approval criteria for Suspension
- Diagnosis of Organ Transplant in Medicaid History in the past 3 years
- < 7 years of age, OR
- NPO (Appendix A) within the past 365 days.

Link to Memorandum
Link to Memorandum
Top of the document
Nabilone (Cesamet)

(Implemented 06/27/2007)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- Age > 18 years of age, AND
- Submitted diagnosis malignant cancer within the past 365 days, AND
  - Procedure code indicating radiation treatment within the past 45 days, AND
- Paid drug claim in history within the past 45 days for an oral 5-HT3 (serotonin) receptor antagonist, OR
- Paid drug claim in history within the past 45 days for a NK1 (neurokinin-1) receptor antagonist, OR
- Paid drug claim in history within the past 45 days for Marinol.

Denial criteria

- Absence of approval criteria
- Submitted diagnosis of bipolar in medical history.
- Submitted diagnosis of depression in medical history.
- Submitted diagnosis of schizophrenia in medical history.
- Submitted diagnosis of substance or alcohol abuse in medical history.

Additional criteria

Quantity limits apply

Link to Memorandum

Top of the document
Nafarelin Nasal Spray (Synarel)

(Implemented 09/21/2009)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- Diagnosis of central precocious puberty (CPP) in the previous three years, OR
- Diagnosis of endometriosis in the previous three years

Denial criteria

Diagnosis of infertility in the previous three years

Link to Memorandum

Top of the document
Nandrolone Decanoate Injection

(Implemented 01/09/2008)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- Diagnosis for anemia secondary to chronic renal failure in the past 90 days, AND
- At least three paid Medicaid claims in the past 90 days for erythropoietin, AND
- No therapeutic duplication with erythropoietin

Additional criteria

Quantity limits apply

[Link to Memorandum](#)

[Top of the document](#)
Neo-Synalar (Neomycin 0.5%, Fluocinolone 0.025%) Cream

(Implemented 07/22/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Neo-Synalar

Link to Memorandum

Top of the document
Neuropathic Pain Agents

(Implemented 06/05/2008)
(Updated 03/07/2019)

The non-preferred antiepileptic medications will be considered non-preferred for treating fibromyalgia and neuropathic pain only. Medications listed as either preferred or non-preferred status in this category may or may not include an FDA approved indication for fibromyalgia or neuropathic pain. Use of these medications for fibromyalgia, neuralgias, and neuropathic pain has been reviewed through the evidence-based review process. Medications listed in this category as either preferred or nonpreferred status are not to be construed as endorsements for marketing of off-label use by the manufacturer or by Medicaid.

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents

- Amitriptyline HCl (Elavil)
- Carbamazepine chewable tablet (Tegretol Chewable)
- Carbamazepine immediate-release tablet (Tegretol)
- Gabapentin 100mg, 300mg, 400mg capsule (Neurontin)
- Nortriptyline HCl (Pamelor)

Preferred agents with criteria

- Venlafaxine HCl regular-release tablet (Effexor) – see Second Generation Antidepressant

Nonpreferred agents:

- Divalproex sodium Extended Release (Depakote ER)
- Gabapentin extended-release capsule (Gralise ER)
- Gabapentin enacarbil extended-release tablet (Horizant ER)
- Carbamazepine extended-release capsule (Carbatrol SA, Equetro)
- Carbamazepine extended-release tablet (Tegretol XR)

Nonpreferred agents with criteria:

- Carbamazepine Suspension (Tegretol)
- Divalproex sodium Delayed Release (Depakote DR)
- Duloxetine HCl (Cymbalta) – see Second Generation Antidepressant
- Gabapentin 250mg/5ml solution (Neurontin)
- Gabapentin 100mg, 200mg, 400mg, 600mg, 800mg tablet (Neurontin)
- Lacosamide (Vimpat)
- Lamotrigine (Lamictal)
- Lidocaine patch (Lidoderm)
- Oxcarbazepine (Trileptal)
• Pregabalin (Lyrica)
• Topiramate (Topamax)
• Valproic acid (Depakene, Stavzor)
• Venlafaxine HCl extended-release capsule (Effexor XR) – see Second Generation Antidepressant
• Venlafaxine HCl extended-release tablet (Effexor XR) – see Second Generation Antidepressant

Approval criteria for pregabalin (Lyrica)
• One or more of the approved diagnosis (Appendix H), AND
• No therapeutic duplication with pregabalin, OR
• One therapeutic duplication (75% overlap of last fill) with different date of service and same prescriber ID between Lyrica GCNs in previous 93 days, AND
• No diagnosis of myalgia and myositis in the past three years

Approval criteria for nonpreferred anti-epileptic agents

Nonpreferred Antiepileptic Agents:

<table>
<thead>
<tr>
<th>Antiepileptic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbamazepine suspension (Tegretol)</td>
</tr>
<tr>
<td>Divalproex sodium (Depakote)</td>
</tr>
<tr>
<td>Gabapentin 250mg/5ml solution (Neurontin)</td>
</tr>
<tr>
<td>Gabapentin 600mg, and 800mg tablet (Neurontin)</td>
</tr>
<tr>
<td>Lamotrigine (Lamictal)</td>
</tr>
<tr>
<td>Oxcarbazepine (Trileptal)</td>
</tr>
<tr>
<td>Pregabalin (Lyrica)</td>
</tr>
<tr>
<td>Topiramate (Topamax)</td>
</tr>
<tr>
<td>Valproic acid (Depakene, Stavzor)</td>
</tr>
</tbody>
</table>

• One or more of the approved diagnoses (Appendix H)
• No diagnosis of myalgia and myositis, unspecified in the past three years – see Fibromyalgia agent criteria

Nonpreferred lamotrigine ODT (Lamictal ODT) and topiramate sprinkle capsules (Topamax Sprinkles)
• One or more of the approved diagnoses (Appendix H), AND
• Age <7 years of age, OR
• NPO (Appendix A) within the past 365 days.
Nonpreferred extended-release products (Carbatrol ER, Depakote ER, Equetro, Gralise ER, Horizant ER, Lamictal XR, Oxtellar, Stavzor XR, Tegretol XR)

- >= 90 days of therapy of the same extended-release product in the past 120 days. Immediate-release products are covered via existing criteria

Approval for an anticonvulsant oral liquid that also comes in a solid oral dosage form will require one of the following:

- Age <7 Years of Age, OR
- Diagnosis of NPO within the past 365 days

<table>
<thead>
<tr>
<th>Oral Liquids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depakine 250mg/5ml Syrup (vaproate sodium)</td>
</tr>
<tr>
<td>Tegretol 100mg/5ml Suspension (Carbamazepine)</td>
</tr>
<tr>
<td>Triletal 300mg/5ml Suspension (oxcarbazepine)</td>
</tr>
<tr>
<td>Carbamazepine 200mg/10ml Oral Susp Oral</td>
</tr>
<tr>
<td>Lacosamide (Vimpat) 20mg/ml Solution Oral</td>
</tr>
<tr>
<td>Valproic Acid (as Sodium Salt) 250mg/5ml Solution Oral</td>
</tr>
<tr>
<td>Valproic Acid (as Sodium Salt) 500mg/10ml Solution Oral</td>
</tr>
<tr>
<td>Gabapentin 300mg/6ml Soln</td>
</tr>
</tbody>
</table>

Approval criteria for nonpreferred topical analgesia

- Submitted diagnosis post-herpetic neuralgia (Table 4) within the past 12 months, OR
- Paid claim in history identifying appropriate antiviral medication (Table 4.2) for post-herpetic neuralgia within the past 30 days

Table 4.2 – Antivirals

<table>
<thead>
<tr>
<th>Antivirals</th>
<th>Acyclovir 200mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acyclovir 200mg Acyclovir</td>
<td></td>
</tr>
<tr>
<td>400mg Acyclovir 800mg</td>
<td></td>
</tr>
<tr>
<td>Famiciclovir 125mg</td>
<td></td>
</tr>
<tr>
<td>Famiciclovir 250mg</td>
<td></td>
</tr>
<tr>
<td>Famiciclovir 500mg</td>
<td></td>
</tr>
<tr>
<td>Valacyclovir 1g caplet</td>
<td></td>
</tr>
<tr>
<td>Valacyclovir 500mg caplet</td>
<td></td>
</tr>
</tbody>
</table>

Link to Memorandum Lamictal ODT

Link to Memorandum Lidoderm Patch

Top of the document
Nevirapine XR (Viramune XR)

(Implemented 04/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- \( \geq 90 \) days of Nevirapine XR therapy in the past 120 days

Link to Memorandum

Top of the document
Nevirapine Oral Suspension (Viramune)  
*(Implemented 09/18/2013)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval Razadyne:
- Age <7 Years of Age
- Diagnosis of NPO within the past 365 days.

Additional criteria Quantity limits apply

[Link to Memorandum](#)

[Top of the document](#)
Nilotinib (Tasigna) Tablet

(Implemented 01/17/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Tasigna 150mg Tablet
- Tasigna 200mg Tablet

**Additional criteria**

Quantity limits apply

[Link to Memorandum](#)

[Top of the document](#)
Nimodipine Solution (Nymalize)

(Implemented 1210/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Nymalize Solution

[Link to Memorandum](#)

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Niraparib (Zejula) 100mg Capsule

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Zejula 100mg Capsule

Link to Memorandum

Top of the document
Nitisinone Capsule (Orfadin)

(Implemented 09/23/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Orfadin Capsule

Link to Memorandum

Top of the document
Nitrofurantoin Suspension (Furadantin)

(Implemented 10/11/2011)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- < 7 years of age, OR
- NPO ([Appendix A](#)) within the past 365 days.

[Link to Memorandum](#)

[Top of the document](#)
Nitroglycerin 0.4% Rectal Ointment (Rectiv)

(Implemented 07/09/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

Reactive Rectal Ointment

Link to Memorandum

Top of the document
Non-benzodiazepine Sedative Hypnotics

(Implemented 03/01/2009)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents with criteria
- Zaleplon (Sonata)
- Zolpidem immediate-release (Ambien)

Nonpreferred agents
- Eszopiclone (Lunesta)
- Doxepin (Silenor)
- Ramelton (Rozerem)
- Suvorexant (Belsomra)
- Zolpidem extended-release (Ambien CR)
- Zolpidem sublingual tablet (Edluar, Intermezzo)

Approval criteria for preferred agents with criteria
No therapeutic duplication with other sedative hypnotics

Top of the document
Nizatidine Oral Solution (Axid)

_(Implemented 12/10/2008)_

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- At least two paid Medicaid drug claims for ranitidine syrup in the past 60 days, AND
- < 7 years of age, OR
- NPO (Appendix A) within the past 365 days.

Approval criteria (Continuation Criteria)

One or more claims in the previous 60 days for Axid Oral Solution.
Noxafil DR Oral Tablet and Noxafil 300mg Vial

(Implemented 07/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Noxafil DR Oral Tablet
- Noxafil 300mg Vial

Link to Memorandum

Top of the document
Omadacycline (Nuzyra®)

*(Implemented 7/17/2019)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

*Nuzyra®*

**APPROVAL CRITERIA:**

- Beneficiary is > 18 years old;
- Beneficiary has a diagnosis of: Community-Acquired Bacterial Pneumonia (CABP) OR Acute Bacterial Skin and Skin Structure Infections (ABSSSI)
- Prescriber should provide culture and susceptibility report if available
- Prescriber must provide explanation of medical necessity for use of this antibiotic over a different agent that does not require prior authorization
- Prescriber must submit documentation of loading dose of IV infusion or loading dose of oral tablets beneficiary received

**DENIAL CRITERIA:**

- No diagnosis of CABP or ABSSSI with an organism listed in the approval criteria;
- Age < 18 years old;
- Tetracycline allergy
- Susceptibility report shows organism is resistant
- Female beneficiary is in 2nd or 3rd trimester of pregnancy or breastfeeding
- Known or suspected healthcare associated infection
- Request is for greater than 14 days of therapy

**QUANTITY LIMITS:**

- Quantity limit for either tablets or vials for length of therapy (7 to 14 days) will be entered at the time of the PA approval
- Length of therapy will not exceed 14 days
Obeticholic Acid (Ocaliva) Tablets

(Implemented 01/17/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Ocaliva 5mg Tablets
- Ocaliva 10mg Tablets

Link to Memorandum

Top of the document
Octreotide Acetate (Sandostatin LAR Depot)

(Implemented 04/10/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Sandostatin LAR Depot

Link to Memorandum

Top of the document
Olaparib Capsule (Lynparza)

(Implemented 04/13/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Lynparza

Additional criteria Quantity limits apply

Link to Memorandum

Top of the document
Omalizumab (Xolair)

(Implemented 08/01/2003)
(Updated 7/16/2014)

Prescribers are required to fax a letter of medical necessity and include all supporting documentation for manual review to 800-424-5851.

Drugs that require manual review for prior authorization

- Xolair

Approval Criteria for Asthma

- Manual review for recipients 6 years of age and older with moderate to severe persistent asthma
- Recipient must have a positive skin test or in vitro reactivity to a perennial aeroallergen
- Provider must fill out the Statement of Medical Necessity
  - Link to Xolair statement of necessity for Asthma—Microsoft Word format (.doc):
  - https://medicaid.mmis.arkansas.gov/Download/provider/forms/pharm/xolair.doc
  - Link to Xolair statement of necessity for Asthma—Portable Document Format (.pdf):
- Recipient must be compliant on TWO Asthma Controller Medications for at least 6 months prior to initiating Xolair
  - One of the two required medications must be an Inhaled Corticosteroid (ICS)
  - Other Asthma Controller medications
    - Leukotriene receptor antagonist (LTRA)
    - Long acting beta₂ agonist (LABA)
    - Cromolyn
    - Theophylline
    - Nedocromil
    - Oral corticosteroid
    - Zileuton
  - Compliance is defined as a minimum of 5 fills of both controller medications in 186 days
- Recipient must be having exacerbations despite compliance on controller medications
- IgE levels must be within dosing parameters provided in the package insert
Approval Criteria for Chronic Idiopathic Urticaria

- Manual Review PA will be required for all requests for Xolair® injection and will be reviewed on a case-by-case basis. The manual review PA criteria for CIU for beneficiaries age 12 years and older will be based on documentation of CIU diagnosis AND
- the baseline Urticaria Activity Score-7 (UAS7) must be greater than 16, AND
- The IgE level must be above the normal range for the testing lab, AND
- Must try a non-sedating H1-antihistamine (nsAH) for a minimum of 2 weeks, AND
- Must try nsAH at 4 times the normal daily dose for a minimum of 4 weeks, AND
- Must try an alternative nsAH at 4 times the normal daily dose for a minimum of 4 weeks, AND
- Must add a Leukotriene receptor antagonist to the nsAH for a minimum of 4 weeks, AND
- Must add cyclosporine to the above treatment dosed at 4 mg/kg (based on ideal body weight) for a minimum of 8 weeks.
Omega-3-acid ethyl esters (Lovaza)

(Implemented 09/18/2013)
Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Lovaza

Additional Criteria

- Quantity Limits Apply

Link to Memorandum

Top of the document
Omeprazole, Amoxicillin, and Clarithromycin combination (Omeclamox-Pak)

(Implemented 05/21/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

Criterion 1:
• No history of lansoprazole, amoxicillin, and clarithromycin combination (Prevpac) in the last 365 days, AND,
• No history of omeprazole, amoxicillin, and clarithromycin combination (Omeclamox-Pak) in the last 365 days, AND,
• No concurrent proton pump inhibitor therapy within the past 30 days.

Criterion 2:
• No history of metronidazole/tetracycline/bismuth combination (Helidac) in the last 365 days, OR
• No history of metronidazole/tetracycline/bismuth combination (Pylera) in the last 365 days.

Denial criteria

Criterion 1:
• History of lansoprazole, amoxicillin, and clarithromycin combination (Prevpac) in the last 365 days, OR
• Current proton pump inhibitor therapy within the past 30 days Criteria.

Criterion 2:
• No history of omeprazole, amoxicillin, and clarithromycin combination (Omeclamox-Pak) in the last 365 days, AND,
• No concurrent proton pump inhibitor therapy within the past 30 days. Criteria.

Criterion 3:
• No history of metronidazole/tetracycline/bismuth combination (Helidac) in the last 365 days, OR
• No history of metronidazole/tetracycline/bismuth combination (Pylera) in the last 365 days.

Additional criteria

Quantity limits apply

Top of the document
Opioids, Long-acting

(Implemented 08/01/2008)
(Updated 08/18/2016)
(Updated 4/1/2019)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents with criteria

- Buprenorphine patch (Butrans)- Brand Only
- Morphine sulfate/naltrexone (Embeda ER)
- Morphine sulfate long-acting tablet (MS Contin, Oramorph)
- Tramadol ER Tablet

Nonpreferred agents with criteria

- Buprenorphine (Belbuca)
- Fentanyl patch (DuraPatch)
- Hydrocodone ER Capsule (Zohydro ER)
- Hydrocodone ER (Hysingla ER)
- Hydromorphone HCl extended-release tablet (Exalgo ER)
- Methadone HCl (Dolophine)
- Morphine sulfate extended-release capsule (Avinza, Kadian)
- Morphine sulfate extended-release tablets (Morphabond ER)
- Oxycodone-Acetaminophen extended-release tablet (Xartemis XR)
- Oxycodone extended-release tablet (Oxycontin)
- Oxycodone extended-release capsule (Xtampza ER)
- Oxymorphone HCl extended-release tablet (Opana ER)
- Tapentadol HCl extended-release tablet (Nucynta ER)

Approval criteria for preferred agents with criteria

- No therapeutic duplication in drug history between long-acting narcotics

Approval criteria for nonpreferred agents with criteria

- Fentanyl patch
  - NPO (Appendix A), OR
  - Currently LTC, OR
    - Cancer with malignancies (Appendix E) in past 12 months
      - AND
    - No therapeutic duplication in drug history between long-acting narcotics
- Morphine sulfate long-acting capsule or oxycodone long acting tablet
  - Currently LTC, OR
Cancer with malignancies (Appendix E) in past 12 months
AND
- No therapeutic duplication in drug history between long-acting narcotics
- Methadone HCl (Dolophine)
  - Cancer with malignancies (Appendix E) in past 12 months
  - No therapeutic duplication in drug history between long-acting narcotics

Methadone oral solution for NAS (Neonatal Abstinence Syndrome):
- The infant’s age is ≤ 90 days of age at the time the drug claim is submitted; AND
- The quantity of methadone oral solution dispensed is not more than 10 ml for a 30-day supply; AND
- The incoming claim and the claim in history will not make the accumulated quantity of methadone oral solution more than 10 ml for the previous 30-day supply; AND
- Methadone oral solution for an infant older than 90 days who does not have malignant cancer diagnosis in the Medicaid diagnosis history, or the methadone oral solution accumulation quantity for a 30-day period will exceed 10 ml, will require manual review PA. The prescriber must send letter explaining medical necessity, quantity requested, dose, and taper plan schedule with the PA request.

An incoming claim for any opioid pain medication will trigger a search of the beneficiary’s Medicaid medical diagnoses history for diagnosis of poisoning or overdose the previous 12 months.

If a diagnosis for poisoning (overdose) for opioids, narcotics, barbiturates, benzodiazepines, or “unspecified drug or substance” is found in the Medicaid medical history in the previous 12 months, an incoming claim for an opioid pain medication or an incoming claim for a benzodiazepine medication will deny at point of sale.

Patients who have a diagnosis of malignant cancer in the past 12 months:
- Are exempt from the diagnosis check for a poisoning (overdose) of opioids, narcotics, barbiturates, benzodiazepines, or unspecified drug or substance.

Denial criteria

Paid claim for Suboxone or Subutex in the past 90 days

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Opioids, Short-acting

(Implemented 11/12/2008)
(Updated 05/10/2017, Effective 7/1/17)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

• Accumulation quantity limit will allow up to a maximum of 93 units of any solid oral short acting opioid paid by Medicaid per the previous 31 calendar days. **Additional information listed under Exemptions**
• No drug claim in the past 90 days for Subutex, OR
• No drug claim in the past 90 days for Suboxone AND
• Therapeutic duplication between short-acting opioids with less than 25% of the days’ supply remaining on the previous claim, OR
• Therapeutic duplication between a short-acting opioid and tramadol IR (Ultram) with less than 25% of the days’ supply remaining on the previous claim, OR
• Therapeutic duplication between a short-acting opioid and tramadol/acetaminophen (Ultracet) with less than 25% of the days’ supply remaining on the previous claim
• Therapeutic duplication between a short-acting opioid and tramadol ODT (Rybix) with less than 25% of the days’ supply remaining on the previous claim

**Additional information listed under Exemptions**

Denial criteria

• Therapeutic duplication between two short-acting opioids with more than 25% of the days’ supply remaining on previous claim
• Therapeutic duplication between a short-acting opioid and tramadol (Utram and Ultracet) with more than 25% of the days’ supply remaining on previous claim
• Therapeutic duplication between a short-acting opioid and tramadol ODT (Rybix) with more than 25% of the days’ supply remaining on previous claim
• Drug claim in history for Subutex
• Drug claim in history for Suboxone
• Solid oral dosage forms for short-acting opioids will reject for children less than 6 years of age.
• Greater than 93 units of any solid oral short acting opioid paid by Medicaid per the previous 31 calendar days.
• An incoming claim for any opioid pain medication will trigger a search of the beneficiary’s Medicaid medical diagnoses history for diagnosis of poisoning or overdose the previous 12 months.
• If a diagnosis for poisoning (overdose) for opioids, narcotics, barbiturates, benzodiazepines, or “unspecified drug or substance” is found in the Medicaid medical
history in the previous 12 months, an incoming claim for an opioid pain medication or an incoming claim for a benzodiazepine medication will deny at point of sale.

**Additional information listed under Exemptions**

Exemptions

- Patients who have a diagnosis of malignant cancer in the past 12 months:
  - Are exempt from the therapeutic duplication requirement.
  - Are exempt from the diagnosis check for a poisoning (overdose) of opioids, narcotics, barbiturates, benzodiazepines, or unspecified drug or substance.
  - Accumulation quantity limit will allow up to a maximum of 124 units of any solid oral short acting opioid paid by Medicaid per the previous 31 calendar days.

Preferred Status only for strengths noted: (Quantity edits, MME edits, accumulation edits, and refill too soon edits apply)

- Acetaminophen-codeine tablet 300-15 mg, 300-30 mg, 300-60 mg
- Acetaminophen-codeine elixir or solution 120 mg-12 mg/5 ml in 118 ml and 473 ml bottle
- Codeine tablet 15 mg, 30 mg, 60 mg,
- Hydrocodone / acetaminophen tablet 5/325 mg, 7.5/325 mg, 10/325 mg
- Hydrocodone/ acetaminophen oral solution 7.5-325 mg/15 ml
- Hydrocodone/ibuprofen tablet 7.5/200 mg
- Hydromorphone tablet 2 mg, 4 mg, 8 mg
- Morphine IR tablet 15 mg, 30 mg,
- Morphine oral solution 10 mg/5 ml, 20 mg/5 ml,
- Morphine concentrated oral solution 100 mg/5 ml
- Meperidine tablet 50 mg
- Meperidine oral solution 50 mg/ 5 ml
- Oxycodone tablet 5 mg, 10 mg, 15 mg, 20 mg, 30 mg
- Oxycodone oral solution 5 mg/ 5 ml
- Oxycodone/ acetaminophen tablet 5 mg-325 mg, 7.5 mg-325mg, 10mg – 325 mg
- Oxycodone/ acetaminophen solution 5-325 mg/ 5 ml
- Tramadol tablet 50 mg
- Tramadol/ acetaminophen tablet 37.5 mg-325 mg

Non-Preferred Status for all strengths unless otherwise noted

- Acetaminophen-codeine elixir or solution 120 mg-12 mg/5 ml unit dose cups, and 300 mg-30 mg/12.5 ml unit dose cups
- Hydrocodone / acetaminophen tablet, 5-300 mg,7.5-300 mg, 10-300 mg, 2.5-325 mg,
- hydrocodone/APAP Oral Solution Unit Dose Cups 7.5-325 mg/15 ml, 5-163 mg/7.5 ml, 10-325 mg/ 15 ml, 2.5-108 mg/ 5 ml, 5-217 mg/ 10 ml,
- ZAMICET® (hydrocodone/APAP) 10 mg-325 mg/15 ml oral solution
- Hydrocodone-ibuprofen tablet 10 mg-200 mg, 5 mg-200 mg
- REPREXAIN™ (hydrocodone/ibuprofen) 2.5 mg-200 mg tablet
- Meperidine tablet 100 mg
- Oxycodone capsule 5 mg
- Oxycodone concentrated oral solution 20 mg/ml
• Oxycodone 10 mg/0.5 ml oral syringe
• Oxycodone/acetaminophen 2.5 mg-325 mg,
• PRIMLEV™ (oxycodone/APAP) 5 mg-300 mg, 7.5 mg-300 mg, 10 mg-300 mg
• Oxycodone/aspirein
• Oxycodone/ibuprofen tablet 5 mg-400 mg
• Hydromorphone 1 mg/1 ml oral solution
• Hydromorphone 3 mg rectal suppository
• OPANA® (oxymorphine) tablets
• NUCYNTA® (tapentadol) tablet and oral solution
• Butorphanol 10 mg/ml nasal spray
• Fiorinal® with codeine No. 3
• butalbital/caffeine/APAP w/codeine 50 mg-325 mg-30 mg, and 50 mg-300 mg-30 mg
• Butalbital compound w/codeine
• pentazocine/naloxone tablet
• Dihydrocodeine/APAP/caffeine 320.5 mg-30 mg
• Carisoprodol Compound w/Codeine
• FIORICET® with CODEINE 50 mg-300 mg-30 mg
• CAPITAL® and CODEINE (acetaminophen with codeine) oral suspension 120 mg-12 mg/5 ml

Additional criteria
Quantity limits apply
Age restrictions apply
Oral Asthma Medications (Metaproterenol syrup 10 mg/5 ml, 10 mg, 20 mg tablet; Terbutaline 2.5 mg, 5 mg tablet, and Terbutaline vials)

(Implemented 01/17/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Metaproterenol Syrup 10mg/5ml
- Metaproterenol 10mg Tablet
- Metaproterenol 20mg Tablet
- Terbutaline 2.5mg Tablet
- Terbutaline 5mg Tablet
- Terbutaline Vials

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Oral Thrombopoietin Receptor Agonists

_(Implemented 01/01/2019)_

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

**ORAL THROMBOPOIETIN RECEPTOR AGONISTS INDICATED FOR THROMBOCYTOPENIA WITH CHRONIC LIVER DISEASE PRIOR TO AN INVASIVE PROCEDURE:**

- DOPTELET® (avatrombopag) Tablet 20 mg
- MULPLETA® (lusutrombopag) 3 mg Tablet, film coated

Additional Criteria

- Quantity Limits Apply

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Oseltamivir Suspension (Tamiflu)

(Implemented 10/11/2011)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- ≤ 12 years of age, AND
- At least 1 year of age

Additional criteria

- Quantity Limits apply

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Osimertinib (Tagrisso) Tablets

*(Implemented 04/26/2016)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Tagrisso Tablets 80mg and 40mg

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Osteoporosis Drugs

(Updated 10/1/2019)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Preferred Osteoporosis Drugs

- Alendronate sodium 5mg daily dose (Fosamax®)
- Alendronate sodium 10mg daily dose (Fosamax®)
- Alendronate sodium 35mg weekly dose (Fosamax®)
- Alendronate sodium 40mg weekly dose (Fosamax®)
- Alendronate sodium 70mg weekly dose (Fosamax®)

Non-Preferred WITH Criteria Osteoporosis Drugs

- Prolia® injection
- Evista® (raloxifene) tablets

Non-Preferred NO Criteria Osteoporosis Drugs

- Actonel® (Risedronate) tablet
- Atelvia® (Risedronate DR) tablet
- Binosto® effervescent (Alendronate) tablet
- Boniva® (Ibandronate) tablet
- Boniva® (Ibandronate) injection
- Calcitonin-Salmon (Miacalcin® and Fortical®)
- Etidronate tablets
- Evenity® injection
- Fosamax® Plus D tablet
- Fosamax® oral solution
- Forteo® injection (Teriparatide)
- Tymlos® injection
Approval Criteria for Non-Preferred WITH Criteria Prolia®

Prolia® will continue to be covered through a manual review PA on a case-by-case basis for the initial dose. POS PA continuation approval criteria for Prolia® will apply as follows:
- 1 Prolia® claim is found in Medicaid drug history in the previous 12 months.
- In addition, a therapeutic duplication edit will reject an incoming Prolia® claim if an Xgeva® (denosumab) claim is found in the medical claims history in previous 6 months.
- A quantity edit for Prolia® of 1 injection per 175 days will be implemented.

Approval Criteria for Non-Preferred WITH Criteria - Evista®

- Diagnosis of post-menopause in the previous 2 years, AND
  - Diagnosis of carcinoma in situ of breast in the previous 2 years, OR
  - Diagnosis of atypical hyperplasia of breast in the previous 2 years, OR
  - Diagnosis of Family History of Malignant Neoplasm of Breast in previous 2 years;
  - OR
- Diagnosis of post-menopause in the previous 2 years, AND
- Diagnosis of osteoporosis in the previous 2 years, AND
  - Diagnosis of esophageal strictures in the previous 2 years, OR
  - Diagnosis of esophageal achalasia in the previous 2 years

Continuation criteria

At least 4 or more claims for raloxifene in the past 186 days

Additional criteria

- Forteo® quantity limits apply

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Link to Memorandum (Prolia)
Otic Preparations

(Implemented 09/21/2009, 01/18/2011)
(Updated 10/01/16, 10/1/2019)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents

- Ciprodex Otic (ciprofloxacin and dexamethasone suspension drops)
- Neomycin/polymyxin HC Otic solution
- Acetic acid 2% Otic
- Acetic acid-hydrocortisone Otic drops
- Ofloxacin Otic

Non-Preferred Agents

- Cipro HC Otic
- Cortisporin-TC Otic
- Coly-Mycin S Otic
- Ciprofloxacin Otic
- Otovel otic
- Otiprio Otic
Overactive-bladder Agents

*(Implemented 07/14/2009, last reviewed 11/9/16)*

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents

- Fesoterodine fumarate (Toviaz)
- Oxybutynin chloride 5mg/5ml Syrup, 5mg tablet (Ditropan)
- Oxybutynin chloride extended-release tablet (Ditropan XL Tablet)
- Solifenacin succinate (Vesicare)

Nonpreferred agents

- Darifenacin hydrobromide (Enablex)
- Flavoxate HCl (Urispas)
- Mirabegron extended-release (Myrbetriq)
- Oxybutynin chloride gel (Gelnique)
- Oxybutynin patch (Oxytrol)
- Tolterodine tartrate tablet (Detrol)
- Tolterodine tartrate extended-release capsule (Detrol LA)
- Trospium chloride extended-release (Sanctura XR)
- Trospium chloride immediate-release (Sanctura)
Oxandrolone (Oxandrin)

(Implemented 01/09/2008)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

Criterion 1:
Diagnosis in the past two years for:
- HIV/AIDS, AND
- Cachexia AND
- Paid drug claims in history for at least three antiretrovirals (either as a single entity or combo drug) within the past 30 days, AND
- Paid drug claim in history for megestrol acetate within the last four weeks Criterion 2:
Diagnosis code in Medicaid history in the past 365 days for one of the following:
- Weight loss secondary to severe trauma (burns, spinal cord injury), OR
- Weight loss due to protein catabolism associated with prolonged administration of high dose corticosteroids.

Criterion 3:
- Diagnosis in Medicaid history for osteoporosis, AND
- Concurrent therapy in the past 45 days for one of the following:
  - Bisphosphonate
  - Didronel (etidronate)
  - Fosamax (alendronate)
    - Aminobisphosphonate
  - Actonel (risedronate)
    - Selective estrogen-receptor modulators
  - Evista (raloxifene)
  - Calcitonin injection, OR
- History of Ibandronate in the past 100 days Criterion 4:
- Diagnosis in Medicaid history for hereditary angioedema in the past three years.

Denial criteria

Diagnosis in Medicaid history for any of the following in the past 365 days:
- Prostate cancer
- Breast cancer – male or female
- Pregnancy
- Nephrosis

Additional criteria

Quantity limits apply

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Oxymetazoline (Rhofade) Topical Cream

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Rhofade Topical Cream

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Oxymetholone (Anadrol—50 tablet)  
(Implemented 01/09/2008)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

Criterion 1:  
- Diagnosis of acquired aplastic anemia in the past 365 days, AND  
- Five claims in the past six months for Cyclosporine Criterion

Criterion 2:  
- Diagnosis of chronic renal failure in the past 365 days, AND  
- History of three paid drug claims of recombinant erythropoietin in the past 90 days

Criterion 3:  
- Diagnosis of Fanconi’s anemia in the past 365 days Criterion

Criterion 4:  
- Diagnosis for congenital refractory pure red cell aplasia in the past 365 days, AND  
- At least 30 days of corticosteroid therapy in the past 90 days

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Pain Medications, Injectable
(Implemented 04/12/2011)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Injectable agents
- Buprenorphine Injectable
- Butorphanol Injectable
- Hydromorphone Injectable
- Levorphanol Injectable
- Meperidine Injectable
- Morphine Injectable
- Nalbuphine Injectable
- Pentazocine Injectable

Approval criteria
- No drug claim in the past 90 days for Subutex, OR
- No drug claim in the past 90 days for Suboxone AND
- Therapeutic duplication between short-acting opioids with less than 25% of the days’ supply remaining on the previous claim, OR
- Therapeutic duplication between a short-acting opioid and tramadol IR (Ultram) with less than 25% of the days’ supply remaining on the previous claim, OR
- Therapeutic duplication between a short-acting opioid and tramadol/acetaminophen (Ultracet) with less than 25% of the days’ supply remaining on the previous claim
- Therapeutic duplication between a short-acting opioid and tramadol ODT (Rybix) with less than 25% of the days’ supply remaining on the previous claim

Denial criteria
- Therapeutic duplication between two short-acting opioids with more than 25% of the days’ supply remaining on previous claim
- Therapeutic duplication between a short-acting opioid and tramadol (Ultram and Ultracet) with more than 25% of the days’ supply remaining on previous claim
- Therapeutic duplication between a short-acting opioid and tramadol ODT (Rybix) with more than 25% of the days’ supply remaining on previous claim
- Drug claim in history for Subutex
- Drug claim in history for Suboxone

Exemptions
Patients who have a diagnosis of malignant cancer in the past 12 months are exempt.

Additional criteria
Quantity limits apply

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Palbociclib (Ibrance)

(Implemented 07/22/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Ibrance

Additional criteria

Quantity limits apply

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Pancreatic Enzymes

*(Implemented 10/01/2016)*

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

**Preferred agents**
- Creon
- Zenpep

**Nonpreferred agents**
- Pancreaze
- Viokace
- Ultresa
- Pertzye

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Panobinostat Lactate (Farydak)
(Implemented 04/20/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Farydak

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Papaverine 30mg/ml
(Implemented 08/10/2007)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Denial criteria

- Submitted diagnosis for erectile dysfunction
- Submitted diagnosis for Impotence

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Parathyroid Hormone for Injection (Natpara)

(Implemented 04/01/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Natpara
Pasireotide Diaspartate (Signifor) Ampule

(Implemented 09/18/2013)
Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Signifor

Additional Criteria
- Quantity Limits Apply

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Patiromer (Veltassa) Powder for Oral Suspension

*Implemented 04/26/2016*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Veltassa Powder for Oral Suspension

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Pazopanib (Votrient)
*(Implemented 10/10/2012)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Votrient

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Peginterferon Alfa-2B (Sylatron)

*(Implemented 05/25/2011)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Denial criteria**

- Submitted diagnosis for Hepatitis C, Acute, Chronic, and Unspecified

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Pegvisomant Injection (Somavert)
(Implemented 04/17/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
No Therapeutic duplication allowed between different strengths of Somavert

Additional criteria
Quantity limits apply

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Penicillamine/Cystine Depleting Agents

*Implemented 09/18/2013*
*Updated 9/7/18*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Preferred**
- potassium citrate ER Tablet 5 mEq., 10 mEq., 15 mEq. (e.g., UROCIT-K)

**Preferred with Manual Review PA Criteria**
- Cuprimine (penicillamine) capsule
- Depen (penicillamine) tablet
- Thiola (tiopronin) tablet

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Perampanel Tablet (Fycompa)

(Implemented 07/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Fycompa

Additional Criteria

- Quantity Limits Apply

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Phenoxybenzamine (Dibenzyline)

(Implemented 05/04/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drug that requires manual review for prior authorization

- Dibenzyline

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Phosphate Removing Agents

(Implemented 07/08/2014)
(Re-review 5/10/18)
(Effective 7/1/18)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

PREFERRED AGENTS

• RENAGEL® (sevelamer HCl) tablet (GENERIC ONLY)
• RENVELA® (sevelamer carbonate) TABLET (BRAND ONLY)
• calcium acetate capsule and tablet

NON-PREFERRED AGENTS

• AURYXIA® (ferric citrate) tablet
• FOSRENOL® (lanthanum carbonate) chewable tablet
• PHOSLYRA® (calcium acetate) 667 mg/5 ml oral solution
• RENAGEL® (sevelamer HCl) tablets (BRAND ONLY)
• RENVELA® (sevelamer carbonate) Powder Pack
• SEVELAMER CARBONATE tablet (GENERIC ONLY)
• VELPHORO® (sucroferric oxyhydroxide) chewable tablet

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Pimecrolimus (Elidel)

(Implemented 03/12/2007)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- No therapeutic duplication with Tacrolimus (Protopic), AND
- At least two paid Medicaid drug claims of topical corticosteroid agents, each containing a different drug entity, AND
- At least one of the claims for the topical corticosteroid being at least class 5 potency or higher filled in the previous 14-45 day period.

Additional criteria

- Age > 2 years of age
- Quantity limits apply

Denial criteria

- History of Psoriasis in previous two years
- History of Vitiligo in previous two years
- Therapeutic duplication with Tacrolimus (Protopic)
- No claim for at least two topical corticosteroids in Medicaid history
- No claim for a class 5 potency or higher topical corticosteroid in the previous 14-45 day period.

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Platelet Aggregation Inhibitors
(Reviewed 5/10/18)
(Effective 7/1/18)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

PREFERRED AGENTS
- AGGRENOX (aspirin/dipyridamole) (BRAND ONLY)
- dipyridamole
- prasugrel
- clopidogrel
- BRILINTA® (ticagrelor) tablet

NONPREFERRED AGENTS
- aspirin/dipyridamole (generic only)
- ticlopidine
- EFFIENT® (prasugrel) (Brand Only)
- PLAVIX® (clopidogrel bisulfate) (Brand Only)
- ZONTIVITY® (vorapaxar sulfate)

Link to Memorandum
Podofilox (Condylox 0.5% topical solution and gel)

(Implemented 01/09/2008)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

Podofilox 0.5% Topical Solution (Condylox)
- ≥ 18 years of age, AND
- No therapeutic duplication with Podofilox 0.5% gel, AND
- Diagnosis of Condyloma Acuminata (commonly known as external genital or perianal warts) within the past two months

Podofilox 0.5% Topical Gel (Condylox)
- ≥ 18 years of age, AND
- No therapeutic duplication with Podofilox 0.5% solution, AND
- Diagnosis of Condyloma Acuminata (commonly known as external genital or perianal warts) within the past two months OR

Denial criteria
- Absence of approval criteria
- < 18 years of age
- Therapeutic duplication of gel/solution

Additional criteria

Quantity limits apply

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Pomalidomide Capsule (Pomalyst)

*(Implemented 07/09/2013)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Pomalyst

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Ponatinib HCl Tablet (Iclusig)

(Implemented 07/09/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Iclusig

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Posaconazole (Noxafil) Suspension

(Implemented 01/09/2008)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

Criterion 1:
Diagnosis code in Medicaid history for at least one of the following in the past 365 days:
- ≥ 13 years of age, AND
- HIV/AIDS
- Organ transplant procedure
- Graft vs. host disease
- Neutropenia Criterion 2:
The following drug claims in Medicaid history in the past 365 days:
- ≥ 13 years of age, AND
- HIV/AIDS pharmacotherapy drug claims in history, OR
- Anti-rejection/Immunosuppression medication Criterion 3:
- ≥ 13 years of age, AND
- At least one paid claim for Fluconazole in the past 30 days, AND
- At least one paid claim for Itraconazole in the past 30 days. Criterion 4:
- ≥ 13 years of age, AND
- History of paid claim for requested drug (Noxafil) in the past 180 days.

Denial criteria

- < 13 years of age
- Absence of approval criteria
- History of a paid drug claim for the any of the following in the last 30 days:
  - Ergot alkaloids
  - Pimozide
  - Quinidine

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Posaconazole (Noxafil DR 100mg Oral Tablet and Noxafil 300mg Vial)

(Implemented 07/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Noxafil DR 100mg Tablet
- Noxafil 300mg Vial

[Link to Memorandum](#)

[Top of the document](#)
Potassium Chloride Capsules, Packets, and Tablets

(Updated 04/14/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that do not require prior authorization

- Potassium chloride 8 mEq extended-release capsule [Micro-K]
- Potassium chloride 10 mEq extended-release capsule [Micro-K]
- Potassium chloride 8 mEq extended release-tablet [Klor-Con 8 mEq tablet]
- Potassium chloride 10 mEq extended-release tablet [Klor-Con M10]
- Potassium chloride 20 mEq extended-release tablet [Klor-Con M20]

Drugs that require manual review for prior authorization

- Potassium chloride 20 mEq powder packet
- Potassium chloride 25 mEq powder packet [Klor-Con 25 mEq packet]

Link to Memorandum

Top of the document
Potassium Chloride Oral Liquid and Effervescent Tablets

(Implemented 01/17/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- < 7 years of age, OR
- NPO (Appendix A) within the past 365 days.

Link to Memorandum

Top of the document
Pramipexole ER (Mirapex ER)

*Implemented 03/19/2013*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- Diagnosis of Parkinson’s Disease in Medicaid history in previous 2 years, AND
- \(>=90\) days of therapy of Pramipexole ER in the past 120 days
Prednisolone

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that do not require prior authorization

- Generic prednisolone sodium phosphate 15mg/5ml (same as Orapred ® Solution) is available without a prior authorization
- Methylprednisolone Dose Pack
- Methylprednisolone tablet
- Prednisone Dose Pack
- Prednisone tablet

Drugs that require manual review for prior authorization

- Flo-Pred 16.7 (15) mg/5 ml suspension – Implemented 07/08/2011
- Millipred 5 mg Dose Pack – Implemented 01/18/2011
- Millipred 5 mg tablet – Implemented 01/18/2011
- Millipred 10 mg/5 ml solution – Implemented 04/21/2009
- Orapred ODT tablet – Implemented 08/17/2010
- Veripred 20 mg/5 ml solution – Implemented 04/21/2009

Link to Memorandum: Millipred Tablets, Dose Pack

Link to Memorandum: Millipred Solution

Link to Memorandum: Orapred ODT

Link to Memorandum: Veripred

Top of the document
Prednisone (Rayos DR)
Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Rayos DR 1mg
- Rayos DR 2mg
- Rayos DR 5mg

Link to Memorandum
Top of the document
Propafenone SR (Rythmol SR)

(Implemented 04/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- \( \geq 90 \) days of Propafenone SR therapy in the past 120 days

Link to Memorandum

Top of the document
Proton Pump Inhibitors

(Implemented 08/17/2010)
(Reviewed 5/8/2019)
(Effective 7/1/2019)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents with criteria
- Omeprazole capsules (Rx Prilosec)
- Pantoprazole sodium tablets (Protonix)

Nonpreferred agents
- Dextansoprazole (Dexilant)
- Esomeprazole magnesium capsule (Nexium)
- Esomeprazole magnesium packet (Nexium Packet)
- Esomeprazole magnesium/Naproxen tablet (Vimovo)
- Esomeprazole strontium capsule
- Omeprazole suspension (Prilosec Suspension)
- Omeprazole/sodium bicarbonate (Zegerid)
- Rabeprazole sodium (Aciphex)

Nonpreferred agents with criteria
- Nexium Packets (Suspension)

Approval criteria for preferred agents with criteria
- Approve up to 93 days of proton pump inhibitor therapy per year for all recipients 15 months or older
- Approve treatment beyond 93 days for recipients 15 months or older who have a diagnosis in history for Zollinger-Ellison Syndrome, Barrett’s esophagus, Esophageal varices, or an endoscopy (Appendix I) in the past 24 months
- Approve treatment beyond 93 days for recipients 15 months or older who have a diagnosis in history for Cystic Fibrosis, pancreatic insufficiency, or pancreatic disease in the past 24 months

Approval criteria for nonpreferred agents with criteria
- Nexium Packets
  - < 1 year of age
- Nexium Packets
  - < 7 years of age
  Seven years of age and older with documented history of NPO (Appendix A) within past 365 days.
Denial criteria

- Nexium packets
  > 1 year of age
- Nexium packets
  ≥ 7 years of age
  No documented history of NPO (Appendix A) within past 365 days
- All Proton Pump Inhibitors
  > 93 days of PPI therapy in the past 365 days for recipients 15 months or older, unless there is a diagnosis in history for Zollinger- Ellison Syndrome, Barrett’s esophagus, Cystic Fibrosis, pancreatic insufficiency, pancreatic disease, or an endoscopy (Appendix I) in the past 24 months

Link to Memorandum

Top of the document
Pulmonary Arterial Hypertension Agents

(Implemented 04/01/2017)
(Updated 11/27/17)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred PAH Agents with PA Criteria

- Sildenafil (Revatio)
- Tadalafil (Adcirca)
- bosentan (Tracleer) BRAND ONLY
- ambrisentan (Letairis) BRAND ONLY

Nonpreferred agents

- sildenafil suspension (Revatio)
- macitentan (Opsumit)
- riociguat (Adempas)
- Selexipag (Uptravi)
- treprostinil (Orenitram)
- iloprost (Ventavis)
- treprostinil (Tyvaso)
- ambrisentan (generic only)
- bosentan (generic only)

Denial Criteria

- THERAPEUTIC DUPLICATION (TD) edit for the preferred drugs to not allow therapeutic duplication within same drug class type (ERA, PDE5, and Prostacyclin) or same pathway (endothelin, NO/cGMP, and prostacyclin).

<table>
<thead>
<tr>
<th>PDL STATUS</th>
<th>DRUG</th>
<th>DRUG CLASS</th>
<th>PATHWAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFERRED</td>
<td>LETAIRIS (ambrisentan) Tablet</td>
<td>ENDOTHELIN RECEPTOR TYPE A (ERA)</td>
<td>endothelin pathway</td>
</tr>
<tr>
<td>PREFERRED</td>
<td>TRACLEER (bosentan) Tablet</td>
<td>ENDOTHELIN RECEPTOR TYPE A (ERA)</td>
<td>endothelin pathway</td>
</tr>
<tr>
<td>PREFERRED</td>
<td>REVATIO (sildenafil) Tablet</td>
<td>phosphodiesterase type 5 (PDE-5is)</td>
<td>NO/cGMP pathway</td>
</tr>
<tr>
<td>PREFERRED</td>
<td>ADCIRCA (tadalafil) Tablet</td>
<td>phosphodiesterase type 5 (PDE-5is)</td>
<td>NO/cGMP pathway</td>
</tr>
</tbody>
</table>

- LETAIRIS® (ambrisentan), TRACLEER® (bosentan), ADCIRCA® (tadalafil), OR generic sildenafil (aka REVATIO®): Deny claim for diagnosis of current pregnancy in Medicaid medical history.
- LETAIRIS®: Deny incoming LETAIRIS claim if diagnosis of idiopathic pulmonary fibrosis (ICD-10 code J84.112) is in Medicaid medical history in previous 2 years.
- TRACLEER®: Deny incoming TRACLEER® claim if beneficiary has a drug claim for glyburide in Medicaid drug history in previous 45 days, and vice-versa (deny incoming claim for glyburide if beneficiary has drug claim for TRACLEER® in Medicaid drug history in previous 45 days.)
- ADCIRCA®: Deny incoming ADCIRCA® claim if beneficiary has a drug claim for ADEMPAS® (riociguat) in Medicaid drug history in previous 45 days.

**Link to Memorandum**

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**Top of the document**
Pyridostigmine Timespan (Mestinon Timespan)

(Implemented 04/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- $\geq 90$ days of Pyridostigmine ER therapy in the past 120 days

Link to Memorandum

Top of the document
Pyrimethamine (Daraprim)

*(Implemented 02/16/2016)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drug that requires a manual review for prior authorization

- Daraprim

*Link to Memorandum*

*Top of the document*
Quinine Sulfate (Qualaquin)

*Implemented 06/27/2007*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- Submitted diagnosis of uncomplicated plasmodium falciparum malaria in the previous 6 months,
  AND
- Concurrent therapy with seven days of Tetracycline, OR
- Concurrent therapy with seven days Doxycycline, OR
- Concurrent therapy with seven days Clindamycin.

Denial criteria

Absence of approval criteria

Additional criteria

Quantity limits apply

Link to Memorandum

Top of the document
Raloxifene (Evista)
(Implemented 08/21/2010)
(Updated 09/30/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Link to Memorandum

Top of the document
Ranolazine (Ranexa)

*Implemented 10/18/2006*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Denial criteria**

Diagnosis of hepatic impairment in the last 12 months

**Additional criteria**

Quantity limits apply

[Link to Memorandum](#)

[Top of the document](#)
Regorafenib (Stivarga) 40mg Tablet

(Implemented 03/19/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Stivarga

[Link to Memorandum]

[Top of the document]
Respiratory Syncytial Virus (RSV) Medications

(Implemented 01/01/1999)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Synagis

PA form

PA Forms available during RSV season at www.medicaid.state.ar.us

Top of the document
Ribociclib (Kisqali) Tablet/Ribociclib and Letrozole (Kisqali Femara Co-Pack)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Kisqali 200mg Tablet
- Kisqali Femara Co-Pack

Link to Memorandum

Top of the document
Rifaximin 550mg Tablets (Xifaxan)
(Implemented 09/28/2010)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
- Diagnosis of Hepatic Encephalopathy in the previous 2 years.

Additional criteria
Quantity limits apply

Link to Memorandum

Top of the document
Rilonacept Injection (Arcalyst)

_(Implemented 07/09/2012)_

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Arcalyst Injection

[Link to Memorandum](#)
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Riociguat Tablet (Adempas)

*(Implemented 03/18/2014)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Adempas 0.5 mg Tablet
- Adempas 1 mg Tablet
- Adempas 1.5 mg Tablet
- Adempas 2 mg Tablet
- Adempas 2.5 mg Tablet

Additional criteria

- Quantity edits apply

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Risedronate DR (Atelvia)

(Implemented 05/26/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Atelvia DR
Rivastigmine Solution (Exelon)

(Implemented 09/18/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval Exelon:
- Age > 50 years of age, AND
- Diagnosis of NPO within the past 365 days.

Additional criteria Quantity limits apply

Link to Memorandum

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Ropinirole XL (Requip XL)
(Implemented 03/19/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
- Diagnosis of Parkinson’s Disease in Medicaid history in previous 2 years AND
- $\geq 90$ days of therapy of Ropinirole XL in the past 120 days

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Rotigotine (Neupro) Patch

(Implemented 03/19/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- Diagnosis of Parkinson’s Disease in Medicaid history in previous 2 years

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Rosacea Treatment  
*(Implemented 06/19/2006)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

<table>
<thead>
<tr>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finacea 15% Gel</td>
</tr>
<tr>
<td>Metrogel 1% Topical</td>
</tr>
<tr>
<td>Mirvaso 0.33% Gel</td>
</tr>
<tr>
<td>Noritata 1% Cream</td>
</tr>
</tbody>
</table>

**Approval criteria**

- Diagnosis of rosacea in Medicaid history in previous 2 years
- 2 paid claims for generic metronidazole 0.75% cream, gel, or lotion in the previous 27-60 days

**Denial criteria**

- History of acne vulgaris in the last 60 days

**Drugs that do not require a PA**

- Metronidazole 0.75% Topical Cream [MetroCream 0.75%]
- Metronidazole 0.75% Topical Gel [Metrogel 0.75%]
- Metronidazole 0.75% Topical Lotion [MetroLotion 0.75%]

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Rucaparib tablet, film coated (Rubraca)

(Memo 5/30/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Rubraca 200 mg
- Rubraca 250 mg
- Rubraca 300 mg

APPROVAL CRITERIA

- RUBRACA™ will require a manual review PA on a case-by-case basis using the package insert data and data available in the clinical trials listed in the package insert to guide approval or denial of the request.
- Prescriber must provide the results of the FoundationFocus™ CDxBRCA diagnostic test, which is the FDA approved-for-selection of patients for RUBRACA™. Even though the result of this specific test, FoundationFocus™ CDxBRCA, is a requirement as part of the Prior Approval review for the drug itself, this requirement does not guarantee approval from Medicaid medical utilization review for the use of the diagnostic test nor does it guarantee payment from Medicaid for the diagnostic test. The provider must contact Medicaid medical utilization review and follow their processes for approval and/or for Medicaid payment for the diagnostic test FoundationFocus™ CDxBRCA.
- Prescribing provider must submit the drug PA request in writing and provide all data to substantiate the request, including but not limited to:
  - chart notes,
  - all data on the prior use of at least two platinum-based chemotherapies,
  - dates for prior chemotherapies,
  - date of initial response to each prior chemotherapy,
  - dates showing progression of disease during the course of the therapy,
  - the treatment-free interval length of time between the therapies.

DENIAL CRITERIA

- Platinum-refractory patients who do not respond to platinum-based chemotherapy and show progression during the course of the platinum-based chemotherapy will not be approved for use of Rubraca

QUANTITY LIMITS

- quantity limit of 4 tablets per day will be applied to all strengths
Ruxolitinib Tablets (Jakafi)

(Implemented 04/17/2012)
(Memo 2/14/2019)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

APPROVAL CRITERIA, requires all of the following:

- Beneficiary is ≥ 18 years of age;
- Beneficiary must have a diagnosis of intermediate or high-risk myelofibrosis (MF), including primary MF, post-polycythemia vera MF or post-essential thrombocythemia MF, or polycythemia vera (PV);
- Beneficiary must have at least 2 hydroxyurea drug claims in Medicaid drug history in previous 3 months in those with diagnoses of post-essential thrombocythemia MF or polycythemia vera (PV); If no hydroxyurea drug claims in Medicaid drug history, provider must submit documentation to substantiate that beneficiary had an inadequate response to or was intolerant of hydroxyurea;
- Provider must submit results of a current complete blood count (CBC) and platelet count before initiating therapy;
- Provider must submit Child-Pugh Class score or all LFTs to calculate (Class A, B, or C);
- Provider must submit baseline lipid panel;
- Approved starting dose will be based on the platelet count and follow all FDA approved dosing recommendations in the package insert;
- Initial PA will be for the specific strength required for dose; approval time will be for 1 month;

DENIAL CRITERIA, any one of the following:

- Beneficiary is <18 years of age;
- Beneficiary does not have appropriate diagnosis;
- Dose increase requested during 1st 4 weeks of therapy;
- After the 1st month of therapy, the dose increase is requested more frequently than every 2 weeks;
- Provider did not submit current lab data – CBC w/ differential, AST/ALT, fasting lipids;
- There is no spleen size reduction (w/ CT or MRI) or symptom improvement after 6 months of therapy;
- Beneficiary has current active bleed requiring intervention;
- For polycythemia vera:
  - Interrupt treatment for hemoglobin less than 8 g/dL, platelet counts less than 50 X 109/L or ANC less than 1.0 X 109/L.
  - After recovery of the hematologic parameter(s) to acceptable levels, dosing may be restarted.
• Restart dose will not exceed drug package insert dose in restarting Jakafi® after a previous interruption;
• Renal impairment:
  o Moderate-severe renal impairment PLUS PLT < 50 X 10^9/L – avoid use for MF;
  o Patients on hemodialysis, regardless of PLT count, may use Jakafi® for either MF or PV;
  o For ESRD without hemodialysis, use is not recommended for either PV or MF;
• Hepatic impairment:
  o PV permits use with any PLT count and Child-Pugh class A, B, or C
  o For MF, avoid use with PLT Less than 50 X 10^9/L and Child-Pugh class A, B, C
  o Beneficiary has active serious infection(s);
  o Beneficiary has positive TB test for either active TB or latent TB;
  o Beneficiary currently receiving fluconazole doses of greater than 200 mg daily;

**QUANTITY LIMIT:**
• Not to exceed 2 tablets per day for each strength tablet;
• Quantity limit of #60/30 days’ supply;

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Sacubitril and Valsartan (Entresto)
(Implemented 02/16/2016)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Preferred Drugs that requires manual review for prior authorization
• Entresto Tablets

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Top of the document
Sapropterin Dihydrochloride (Kuvan)

_(Implemented 04/12/2011)_

Prescribers are required to fax a letter of medical necessity and include all supporting documentation for manual review to 800-424-5851.

**Drugs that requires manual review for prior authorization**

- Kuvan

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Sedative Hypnotics

(Implemented 06/19/2006)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

<table>
<thead>
<tr>
<th>Drug</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estazolam (Prosom) Flurazepam (Dalmame) Quazepam (Doral)</td>
<td></td>
</tr>
<tr>
<td>Temazepam (Restoril) Triazolam (Halcion)</td>
<td></td>
</tr>
</tbody>
</table>

Denial criteria

Therapeutic duplication with any of the following sedative hypnotic

- Estazolam (Prosom)
- Eszopiclone (Lunesta)*
- Flurazepam (Dalmame)
- Quazepam (Doral)
- Ramelteon (Rozerem)*
- Temazepam (Restoril)
- Triazolam (Halcion)
- Zaleplon (Sonata)*
- Zolpidem (Ambien)*
- Zolpidem (Zolpimist)*

Additional criteria

Quantity limits apply

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Selexipag (Uptravi)

(Implemented 07/13/2016)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Uptravi Tablet

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Serostim
(Implemented 10/18/2006)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that requires manual review for prior authorization

- Serostim

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Top of the document
Serotonin 5-HT 1 Receptor Agonists
*(Implemented 07/01/2010)*

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

**Preferred agents**
- Sumatriptan succinate tablet (Imitrex)
- Sumatriptan 20mg nasal spray (Imitrex)
- Sumatriptan 5mg nasal spray (Imitrex)

**Preferred agents with criteria**
- Sumatriptan 4mg/0.5ml kit refill (Imitrex)
- Sumatriptan 6mg/0.5ml kit refill (Imitrex)
- Sumatriptan 6mg/0.5ml kit syringe (Imitrex)
- Sumatriptan 6mg/0.5ml vial (Imitrex)

**Nonpreferred agents**
- Almotriptan malate (Axert)
- Eletriptan HBr (Relpax)
- Frovatriptan succinate (Frova)
- Naratriptan HCl (Amerge)
- Rizatriptan benzoate (Maxalt)
- Sumatriptan 4mg/0.5ml needle free injection (Sumavel Dosepro)
- Sumatriptan 4mg/0.5ml syringe (Non MAC’d)
- Sumatriptan 4mg/0.5ml vial
- Sumatriptan 6mg/0.5ml needle free injection (Sumavel Dosepro)
- Sumatriptan 6mg/0.5ml syringe (Non MAC’d)
- Sumatriptan succinate/naproxen sodium (Treximet)
- Zolmitriptan (Zomig)

**Nonpreferred agents with criteria**
- Rizatriptan benzoate disintegrating (Maxalt MLT)

**Approval criteria for preferred agents with criteria**

**Preferred Injection (Sumatriptan injection 4mg or 6mg)**
- Any serotonin 5-HT 1 receptor agonist within past 365 days

**Approval criteria for nonpreferred agents with criteria:**

**Maxalt MLT tablet**
- Any preferred serotonin 5-HT 1 receptor agonist, Maxalt tablet, or Maxalt MLT tablet within past 365 days
Denial criteria for all agents:
Therapeutic duplication of any serotonin 5-HT 1 receptor agonist

Top of the document
Sildenafil tablets (Revatio)

*(Implemented 10/11/2005)*
*(updated 2/13/17)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- Diagnosis of pulmonary heart disease in the last 365 days, OR
- Diagnosis of persistent fetal circulation in the last 365 days, OR
- Diagnosis of chronic respiratory disease arising in the perinatal period in the last 365 days

Denial criteria

- One of the following diagnoses in the last 180 days:
  - Cavernosal fibros, OR
  - Hypotension, OR
  - Leukemia, OR
  - Life-threatening arrhythmia, OR
  - Malignant hypertension, OR
  - Multiple myeloma, OR
  - Myocardial infarction, OR
  - Peyronie’s disease, OR
  - Retinitis pigmentosa, OR
  - Sickle cell disease, OR
  - Stroke, OR
  - Unstable angina

- History of any of the following in the last 45 days:
  - Alpha-adrenergic blockers
  - Nitrates
  - Tamsulosin

- Concurrent use of any the following:
  - Indinavir
  - Lopinavir-ritonavir
  - Ritonavir

Additional criteria—See PAH section

Pulmonary Arterial Hypertension

Quantity limits apply

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Siltuximab vial (Sylvant)

*(Implemented 09/23/2014)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Sylvant

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Sinecatechins (Veregen ointment 15%)

*(Implemented 06/19/2008)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Approval criteria**

- Diagnosis for of Condyloma Acuminata (commonly known as external genital or perianal warts) within the past two months, AND
- ≤ 124 days of Veregen therapy in the past 365 days

**Additional criteria**

Limited to 18 years and older
Max quantity per claim = 30 grams Limited to 60 grams per 365 days

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[Top of the document]
Skeletal Muscle Relaxants

*(Implemented 03/20/2006)*

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents

- Chlorzoxazone 500 mg tablet (Parafon)
- Cyclobenzaprine HCl 10mg tablet (Flexeril)
- Methocarbamol (Robaxin)
- Baclofen tablet (Lioresal)
- Tizanidine HCl tablet (Zanaflex Tablet)

Nonpreferred agents

- Carisoprodol (Soma)
- Carisoprodol/Aspirin (Soma Compound)
- Carisoprodol/Aspirin/Codeine (Soma Compound w/ Codeine)
- Chlorzoxazone 375 mg, 750 mg tablet (Lorzone)
- Cyclobenzaprine HCl 5mg, 7.5mg tablet (Flexeril, Fexmid)
- Cyclobenzaprine HCl extended-release capsule (Amrix)
- Dantrolene sodium (Dantrium)
- Metaxalone (Skelaxin)
- Orphenadrine citrate (Norflex)
- Orphenadrine/aspirin/caffeine (Norgesic)
- Tizanidine HCl capsule (Zanaflex Capsule)

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Sodium Chloride 7% Inhalation Solution (Hyper-Sal 7%)
(Implemented 05/24/2011)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
• Diagnosis of cystic fibrosis within the past three years

Additional criteria
Quantity limits apply

Top of the document
Sodium Oxybate (Xyrem)
(Implemented 10/10/2012)
(Updated 01/17/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Xyrem Oral Solution

Link to Memorandum

Top of the document
Sodium Zirconium Cyclosilicate (Lokelma)

(Implemented 01/01/2019)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Lokelma 5gm Powder Pack
- Lokelma 10gm Powder Pack

Additional Criteria

- Quantity Limits Apply

Link to Memorandum

Top of the document
Somatropin
(Implemented 01/24/2007)
(Updated 10/01/2016)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred Drugs that require manual review for prior authorization
- GENOTROPIN®

Non-Preferred Agents
- HUMATROPE®
- NORDITROPIN®
- NUTROPIN AQ Pen®
- NUTROPIN DEPOT®
- OMNITROPE®
- SAIZEN®
- ZOMACTON®
- ZORBTIVE®

Denial criteria
- History of any of the following diagnoses:
  - Age > 65 years of age
  - History of malignancy in the past 365 days
  - History of renal transplant in the past 365 days
  - Pregnancy
- History of Prader-Willi Syndrome concurrently with any of the following diagnoses:
  - Severe obesity
  - Sleep apnea
  - History of severe respiratory impairment

Growth Hormone Continuation Criteria
Point-of-sale continuation criteria have been added to the current growth hormone criteria for certain diagnoses. The following point-of-sale continuation criteria were implemented on Nov. 16, 2011:

- For recipients < age 13 years for females and < age 14 for males with a billed diagnosis of pituitary dwarfism within the previous 2 years AND a paid claim in Medicaid history for growth hormone in the previous 6 months.
• For recipients < age 18 years with a billed diagnosis of panhypopituitarism, Turner’s syndrome, Prader-Willi syndrome OR septi-optic dysplasia within the previous 2 years AND a paid claim in Medicaid history for growth hormone within the previous 6 months.

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Top of the document
Sonidegib (Odomzo)

*(Implemented 04/26/2016)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Odomzo 200mg Capsules

[Link to Memorandum](#)

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Sotalol (Sotylize) Solution

(Implemented 07/22/2015)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Sotylize

Link to Memorandum

Top of the document
Spironolactone Suspension (Carospir)

(Implemented 10/18/2017)
(Effective 1/17/2018)

Approval Criteria:

• Beneficiary is an adult age ≥ 18 years of age AND
• Beneficiary has an NPO diagnosis in Medicaid medical history in the previous 365 days

Denial Criteria:

• Hyperkalemia diagnosis in the previous 60 days
  Beneficiary has concomitant administration with potassium supplementation drug claim in previous 60 days OR
• Addison’s disease diagnosis in the previous 2 years OR
• Concomitant use of eplerenone claim in previous 60 days OR
• Beneficiary has lithium drug claim in history in the previous 60 days OR
• Beneficiary is pregnant

Link to Memorandum

Top of the document
Sucralfate Suspension (Carafate)
(Implemented 10/11/2011)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- < 7 years of age, OR
- NPO (Appendix A) within the past 365 days.

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Top of the document
Sulfamethoxazole-Trimethoprim 800-160/20ml U.D. Cup

(Implemented 04/08/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria
Currently LTC

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Top of the document
Sunitinib (Sutent) Capsule

*Implemented 01/13/2015*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Sutent

[Link to Memorandum]

[Top of the document]
Tacrolimus (Astagraf XL)

(Implemented 12/10/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Astagraf XL

Link to Memorandum

Top of the document
Tacrolimus (Protopic)

(Implemented 03/12/2007)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- No therapeutic duplication with other strengths of Tacrolimus (Protopic), AND
- No therapeutic duplication Pimecrolimus (Elidel), AND
- At least two paid Medicaid drug claims of topical corticosteroid agents, each containing a different drug entity, AND
- At least one of the claims for the topical corticosteroid being at least class 5 potency or higher filled in the previous 14-45 day period.

Denial criteria

- History of Psoriasis in previous two years
- History of Vitiligo in previous two years
- Therapeutic duplication with other strengths of tacrolimus (Protopic)
- Therapeutic duplication with pimecrolimus (Elidel)
- No claim for at least two topical corticosteroids in Medicaid history
- No claim for a class 5 potency or higher topical corticosteroid in the previous 14-45 day period.

Additional criteria

- Tacrolimus 0.03%
  - Age > 2 years of age
  - Quantity limits apply
- Tacrolimus 0.1%
  - Age > 16 years of age
  - Quantity limits apply

Denial criteria

- Tacrolimus 0.03%
  - Therapeutic duplication with pimecrolimus (Elidel)
  - Therapeutic duplication with tacrolimus (Protopic) 0.1%
- Tacrolimus 0.1%
  - Therapeutic duplication with pimecrolimus (Elidel)
  - Therapeutic duplication with tacrolimus (Protopic) 0.03%
- History of Psoriasis in previous two years
- History of Vitiligo in previous two years
- No claim for at least two topical corticosteroids in Medicaid history
- No claim for a class 5 potency or higher topical corticosteroid in the previous 14-45 day period.
Tadalafil (Adcirca)

(Implemented 09/15/2009)
(updated 2/13/17)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- Diagnosis of pulmonary heart disease in the last 365 days, OR
- Diagnosis of persistent fetal circulation in the last 365 days, OR
- Diagnosis of chronic respiratory disease arising in the perinatal period in the last 365 days

Denial criteria

- One of the following diagnoses in the last 180 days:
  - Cavernosal fibros, OR
  - Hypotension, OR
  - Leukemia, OR
  - Life-threatening arrhythmia, OR
  - Malignant hypertension, OR
  - Multiple myeloma, OR
  - Myocardial infarction, OR
  - Peyronie’s disease, OR o Retinitis pigmentosa, OR o Sickle cell disease, OR o Stroke, OR
  - Unstable angina
- History of any of the following in the last 45 days:
  - Alpha-adrenergic blockers
  - Nitrates
  - Tamsulosin
- Concurrent use of any the following:
  - Indinavir
  - Lopinavir-ritonavir
  - Ritonavir

Additional criteria-See PAH section

Pulmonary Arterial Hypertension

Quantity limits apply

Link to Memorandum

Top of the document
Talazoparib (Talzenna)
(Implemented 4/17/2019)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Talzenna

Approval criteria
- Will require manual review PA on a case-by-case basis
- Age ≥ 18 years
- Provide documentation that the beneficiary has a diagnosis of deleterious or suspected deleterious germline breast cancer that is locally advanced or metastatic with a BRCA1 or BRCA2 mutation and is HER2 negative based on laboratory findings.
- ECOG 0-2*
- Provide current chart notes
- Provide current labs including CBC, basic metabolic panel and LFTs
- Pregnancy test
- Dosing for patient taking amiodarone, carvedilol, clarithromycin, itraconazole, and verapamil must be 0.75mg once daily
- Dosing for CrCl 30-59 mL/min: 0.75mg once daily
- ≤3 prior cytotoxic chemotherapy regimens for metastatic or locally advanced disease*
- Treatment with an anthracycline and/or a taxane unless contraindicated*

Denial criteria
- Does not meet above approval criteria
- Pregnant
- Moderate to severe hepatic impairment (total bilirubin >1.5 and any AST)
- Severe renal impairment (CrCl <30mL/min)
- Prior treatment of PARP inhibitor (Olaparib)*
- Discontinue if requires >3 dose reductions (minimum of 0.25mg per day)
- Confirmed Myelodysplastic Syndrome or AML

Link to Memorandum

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Tamoxifen 10mg/5ml Oral Solution (Soltamox)
(Implemented 03/19/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Soltamox

Link to Memorandum
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Targeted Immune Modulators

(Implemented 10/17/2007)
(Updated 011/27/2017, effective 1/1/18)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Preferred agents with criteria

- Adalimumab (Humira)
- Etanercept (Enbrel)

Nonpreferred agents

- ABATACEPT (ORENCIA)
- ANAKINRA (KINERET)
- APREMILAST (OTEZLA)
- CERTOLIZUMAB (CIMZIA)
- GOLIMUMAB (SIMPONI)
- INFLIXIMAB (REMICADE, INFLECTRA, RENFLEXIS)
- IXEKIZUMAB (TALTZ)
- SECUKINUMAB (COSENTYX)
- TOCILIZUMAB (ACTEMRA)
- TOFACITINIB (XELJANZ)
- USTEKINUMAB (STELARA)
- GUSELKUMAB (TREMFYA)
- SARILUMAB (KEVZARA)
- BRODALUMAB (SILIQ)
- VEDOLIZUMAB (ENTYVIO)
- CANAKINUMAB (ILARIS)
- RILONACEPT (ARCALYST)
- SKYRIZI (RISANKIZUMAB-RZAA)

Approval criteria for preferred agents with criteria

Approval criteria for Enbrel

Must meet one of the following six criteria:

Criterion 1:
- Submitted diagnosis of psoriasis (Table 5) in the past two years, AND
- Age > 4, AND
- Paid Drug claim for etanercept (Enbrel) in the past 45 days (signifying above criteria previously met)

Criterion 2:
- Submitted diagnosis of psoriasis (Table 5) in the past two years, AND
- Age > 4, AND
- During days 180 to 395 days ago, a total of > 180 days of topical drug therapy with: calcipotriene, corticosteroids, or tazarotene in past 395 days, AND
- During days 1 to 210 ago, a total of > 180 days of systemic drug therapy with: cyclosporine, methotrexate, or acitretin, AND
- Topical drug therapy trial occurred before systemic drug therapy

**Criterion 3:**

Submitted diagnosis of ankylosing spondylosis (*Table 5*) in the past two years

**Criterion 4:**

- Submitted diagnosis of rheumatoid arthritis (*Table 5*) or psoriatic arthropathy (*Table 5*) in the past two years, AND
- >180 days of drug therapy in the past 365 days with any of the following: hydroxychloroquine, methotrexate, sulfasalazine, or leflunomide

**Criterion 5:**

- Submitted diagnosis of rheumatoid arthritis (*Table 5*) or psoriatic arthropathy (*Table 5*) in the past two years, AND
- Paid Drug claim for etanercept (Enbrel) in the past 45 days (signifying above criteria previously met)

**Criterion 6:**

- Submitted diagnosis of rheumatoid arthritis (*Table 5*) in the past two years, AND
- Age < 18

**Approval criteria for Humira**

Must meet one of the following eight criteria:

**Criterion 1:**

- Submitted diagnosis of ankylosing spondylosis (*Table 5*) in the past two years

**Criterion 2:**

- Submitted diagnosis for rheumatoid arthritis (*Table 5*) or psoriatic arthropathy (*Table 5*) in the past two years, AND
- One of the following:
  - > Six claims for any of the following in the past 365 days: hydroxychloroquine, methotrexate, sulfasalazine, or leflunomide, OR
  - Paid Drug claim for adalimumab (Humira) in the past 45 days (signifying above criteria previously met)

**Criterion 3:**

- Age > 18 years, AND
- Submitted diagnosis code for Crohn’s disease (*Table 5*) or regional enteritis (*Table 5*) in the past two years, AND
Submitted diagnosis code for fistula (Table 5) in the past two years

Criterion 4:
- Age > 18 years, AND
- Submitted diagnosis code for Crohn’s disease (Table 5) or regional enteritis (Table 5) in the past two years, AND
- > 180 days drug therapy of one of the following regimens in the past 365 days:
  - concurrent systemic glucocorticoid AND mesalamine therapy, OR
  - mercaptopurine, OR
  - azathioprine

Criterion 5:
- Age > 18 years, AND
- Submitted diagnosis code for Crohn’s disease (Table 5) or regional enteritis (Table 5) in the past two years, AND
  - Drug claim for adalimumab (Humira) in the past 45 days (signifying above criterion previously met)

Criterion 6:
- Submitted diagnosis of psoriasis (Table 5) in the past two years, AND
- Age > 18, AND
- Paid drug claim for adalimumab (Humira) in the past 45 days (signifying above criterion previously met)

Criterion 7:
- Submitted diagnosis of psoriasis (Table 5) in the past two years, AND
- Age > 18, AND
- During days 180 to 395 days ago, a total of ≥180 days of topical drug therapy with:
  - calcipotriene, corticosteroids, or tazarotene in past 395 days, AND
- During days 1 to 210 ago, a total of > 180 days of systemic drug therapy with:
  - cyclosporine, methotrexate, or acitretin, AND
- Topical drug therapy trial occurred before systemic drug therapy

Criterion 8:
- Submitted diagnosis of rheumatoid arthritis (Table 5) in the past two years, AND
- Age < 18

Criterion 9:

POS approval criteria for Crohn’s disease in pediatric beneficiaries age ≥ 6 years < 18 years:

Criteria to infer corticosteroid refractory pediatric patients when inducing remission:
- For children ≥6 years of age but <18 years of age, AND beneficiary has diagnosis of Crohn’s Disease in Medicaid medical history in previous 2 years; AND
- Beneficiary has a minimum of 14-days’ supply in previous 30-days of oral prednisone or prednisolone, or budesonide EC 3 mg capsule.

OR
Criteria to infer failure of maintenance medications when treating Crohn’s disease in pediatric patients:

- For children ≥6 years of age but < 18 years of age, AND beneficiary has diagnosis of Crohn’s Disease in Medicaid medical history in previous 2 years; AND
- ≥30 days of drug therapy in previous 45 days of one of the following: azathioprine or 6-mercaptopurine or methotrexate.

OR

Criteria for fistulising Crohn’s disease with fistula in pediatric beneficiaries:

- For children ≥6 years of age but < 18 years of age, AND submitted diagnosis code for Crohn’s disease or regional enteritis in the past two years, AND submitted diagnosis code for fistula in the past two years;

OR

Criteria for Crohn’s disease continuation criteria after starting HUMIRA®, aka “stable and compliant” criteria:

- For children ≥6 years of age but < 18 years of age, AND Crohn’s disease or regional enteritis in the past two years, AND
- Drug claim for adalimumab (HUMIRA®) in the past 45 days (signifying one of above criteria previously met);

Table 5 – Targeted immune modulator diagnoses

<table>
<thead>
<tr>
<th>Drug</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enbrel</td>
<td>Psoriatic arthropathy</td>
</tr>
<tr>
<td>Enbrel</td>
<td>Other psoriasis</td>
</tr>
<tr>
<td>Enbrel</td>
<td>Rheumatoid arthritis and other inflammatory polyarthropathies</td>
</tr>
<tr>
<td>Enbrel</td>
<td>Ankylosing spondylitis</td>
</tr>
<tr>
<td>Humira</td>
<td>Crohn’s disease</td>
</tr>
<tr>
<td>Humira</td>
<td>Regional enteritis</td>
</tr>
<tr>
<td>Humira</td>
<td>Ulcerative Colitis</td>
</tr>
<tr>
<td>Humira</td>
<td>Anal fistula</td>
</tr>
<tr>
<td>Humira</td>
<td>Peritonitis (acute) generalized</td>
</tr>
<tr>
<td>Humira</td>
<td>Peritoneal abscess</td>
</tr>
<tr>
<td>Humira</td>
<td>Spontaneous bacterial peritonitis</td>
</tr>
<tr>
<td>Humira</td>
<td>Other suppurative peritonitis</td>
</tr>
<tr>
<td>Humira</td>
<td>Retroperitoneal infections</td>
</tr>
<tr>
<td>Humira</td>
<td>Psoas muscle abscess</td>
</tr>
<tr>
<td>Humira</td>
<td>Other retroperitoneal abscess</td>
</tr>
<tr>
<td>Humira</td>
<td>Other retroperitoneal infections</td>
</tr>
<tr>
<td>Humira</td>
<td>Choleperitonitis</td>
</tr>
<tr>
<td>Humira</td>
<td>Sclerosing mesenteritis</td>
</tr>
<tr>
<td>Humira</td>
<td>Other specified peritonitis</td>
</tr>
<tr>
<td>Humira</td>
<td>Fistula of intestine excluding rectum and anus</td>
</tr>
<tr>
<td>Humira</td>
<td>Psoriatic arthropathy</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Humira</td>
<td>Other psoriasis</td>
</tr>
<tr>
<td>Humira</td>
<td>Rheumatoid arthritis and other inflammatory polyarthropathies</td>
</tr>
<tr>
<td>Humira</td>
<td>Ankylosing spondylosis</td>
</tr>
</tbody>
</table>

Link to Memorandum
Link to Memorandum: Humira

Link to Memorandum: Humira

Link to Memorandum: Enbrel

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Tasimelteon Capsule (Hetlioz)

(Implemented 09/23/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Hetlioz Capsule

[Link to Memorandum]

[Top of the document]
Tazarotene Gel/Cream (Tazorac)

(Implemented 06/19/2006)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

<table>
<thead>
<tr>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tazorac</td>
</tr>
</tbody>
</table>

Approval criteria (New Start)

- Diagnosis of psoriasis in Medicaid history in previous 365 days, AND
- 2 paid claims of a topical corticosteroid in previous 27-60 days, AND
- At least one paid claim for a topical corticosteroid must be from the Class 1 potency category.

Approval criteria (Continuation Criteria)

- Diagnosis of psoriasis in Medicaid history in previous 365 days, AND
- The incoming claim matches claim in history in the previous 45 days of Tazorac, AND
- At least two claims of a topical corticosteroid in previous 60 days in drug claim history with at least one topical corticosteroid claim 14-60 days back in history.

Denial criteria

History of acne vulgaris in the last 60 days

Link to Memorandum

Top of the document
Tedizolid (Sivextro)

*(Implemented 01/13/2015)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Approval criteria**

- No therapeutic duplication between a claim of the tablets and claim of the vials within the same month

**Additional criteria**

- Age ≥ 18 years of age
- Quantity Limits apply

[Link to Memorandum](#)

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Teduglutide Vial (Gattex)

(Implemented 07/09/2013)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Gattex

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[Top of the document]
Telithromycin (Ketek)

(Implemented 09/12/2007)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Denial criteria

- Submitted diagnosis myasthenia gravis in the past 730 days.
- Submitted diagnosis hepatitis in the past 730 days.
- Submitted diagnosis hepatic impairment in the past 730 days.

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Telotristat Ethyl (Xermelo) Tablet

(Implemented 11/22/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Xermelo 250mg Tablet

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Temazepam 7.5mg and 22.5mg Capsule (Restoril)  
(Implemented 07/09/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Temazepam 7.5mg capsule
- Temazepam 22.5 mg capsule

Exceptions (Beneficiaries that do not require a Prior Authorization)

- Temazepam 7.5mg capsule
  - Long Term Care Beneficiaries
  - Beneficiaries that are 65 years of age or older

*No PA required for requests for Temazepam 7.5mg Capsule for the Beneficiaries listed above*

Additional criteria

- Daily quantity limits apply

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Top of the document
Tenofovir (Viread)
(Implemented 12/19/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- A billed diagnosis of HIV/AIDS in the Medicaid history in previous 2 years; OR
- Paid drug claim(s) in Medicaid history of other antiretroviral therapy (ART), such as non-nucleoside reverse transcriptase inhibitors (NNRTI), OR protease inhibitors (PI), OR integrase strand transfer inhibitor (INSTI) in previous 6 months.
- A billed diagnosis of Hepatitis B in the Medicaid history in previous 2 years.

Denial criteria

- Therapeutic duplication edit: paid claim within previous 30 days for Truvada; OR
- Absence of approval criteria.

Approval criteria for PrEp will require a manual review PA process based upon the following:

- Documentation from prescriber that patient is at high risk for acquiring HIV infection; AND
- Negative HIV test before starting and every 3 months thereafter; AND
- Pregnancy test before starting and every 3 months thereafter. If pregnant, provide documentation of patient understanding of potential risks and benefits of using Truvada®, including contraindication with breastfeeding; AND
- Serum creatinine lab tests obtained prior to initiation, then every 6 months. Creatinine clearance should be >60 mL/min; AND
- Documented testing for Hepatitis B Virus (HBV) and results submitted.

Link to Memorandum

Top of the document
Tenofovir 300mg/Emtricitabine 200mg (Truvada)

*(Implemented 12/19/2012)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria for treatment of HIV-1 infection

- A billed diagnosis of HIV/AIDS in the Medicaid history in previous 2 years; OR
- Paid drug claim(s) in Medicaid history of other antiretroviral therapy (ART), such as non-nucleoside reverse transcriptase inhibitors (NNRTI), OR protease inhibitors (PI), OR integrase strand transfer inhibitor (INSTI) in previous 6 months.
- If there is no HIV/AIDS diagnosis in Medicaid history and no records of other ART in the Medicaid drug profile, prescriber will be required to follow the manual review process and submit documentation confirming positive HIV diagnosis.

Denial criteria

- Therapeutic duplication edit: paid claim within previous 30 days for Emtriva® (emtricitabine) or Viread® (tenofovir disoproxil fumarate); OR
- Absence of approval criteria.

Approval criteria for PrEp will require a manual review PA process based upon the following:

- Documentation from prescriber that patient is at high risk for acquiring HIV infection; AND
- Negative HIV test before starting and every 3 months thereafter; AND
- Pregnancy test before starting and every 3 months thereafter. If pregnant, provide documentation of patient understanding of potential risks and benefits of using Truvada®, including contraindication with breastfeeding; AND
- Serum creatinine lab tests obtained prior to initiation, then every 6 months. Creatinine clearance should be >60 mL/min; AND
- Documented testing for Hepatitis B Virus (HBV) and results submitted.
Terbinafine 125mg and 187.5mg Granules Packet (Lamisil)

(Implemented 04/12/2011)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- At least one paid claim in Medicaid history for fluconazole suspension in the past 14-90 days, AND
- At least 2 paid claims in Medicaid history for griseofulvin suspension in the previous 14-90 days

AND

- No therapeutic duplication between two different strengths of Lamisil granules.

Additional criteria

- Quantity edits apply

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Testosterone Replacement Products

(Implemented 01/18/2011)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

<table>
<thead>
<tr>
<th>Drug</th>
<th>Testosterone Cypionate</th>
<th>100 mg/ml Injection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Testosterone Cypionate</td>
<td>200 mg/ml Injection</td>
</tr>
<tr>
<td></td>
<td>Testosterone Enanthate</td>
<td>200 mg/ml Injection</td>
</tr>
</tbody>
</table>

Approval criteria

- Male
  - Diagnosis of one of the following diagnoses in the previous 2 years:
    - Hypospadias
    - Klinefelter Syndrome
    - Kallmann Syndrome
    - Panhypopituitarism
    - Prader-Willi Syndrome

Denial criteria

- Female
  - Diagnosis of one of the following diagnoses in the previous 2 years:
    - Decreased libido
    - Impotence
    - Any other sexual dysfunction diagnoses

Exceptions (Request through Manual Review Process)

Approve for women with diagnosis of breast cancer or hormone-responsive tumor in history

Testosterone Products which require a Manual Review

- Androderm 2 mg/24hr Patch
- Androderm 4 mg/24hr Patch
- AndroGel 1% Gel
- Android 10 mg Capsule
- Androxy 10 mg Tablet
- Aveed 750 mg/3 ml Vial
- Axiron 30 mg Actuation Solution
- Fortesta 10 mg Gel Pump
- Methitest 10 mg Tablet
- Natesto Nasal 5.5 mg/0.122 gm
- Striant 30 mg Mucoadhesive
- Testim 1% Gel
- Testred Capsules
• Xyosted (testosterone enanthate inj)

**Additional Criteria**

• Quantity Limits Apply

[Link to Memorandum]

[Link to Updated Criteria]

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Tetrabenazine Tablet (Xenazine)

*(Implemented 09/21/2009)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Approval criteria**

Diagnosis of Huntington’s Disease *with* Chorea in the past 3 years.

**Additional criteria**

Quantity limits apply

[Link to Memorandum](#)

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Tiotropium Bromide Inhaler (Spiriva)
(Implemented 12/19/2012)
Updated 02/13/2017

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Approval criteria
- Diagnosis of COPD in Medicaid history in previous 2 years; AND
- No therapeutic duplication with overlapping days’ supply between Anoro Ellipta, Spiriva, and/or Tudorza; AND
- Medicaid recipient is ≥ 40 years of age

Additional criteria
- Quantity edits apply

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Tiotropium Bromide Inhaler (Spiriva Respimat Metered Inhalation Spray 1.25mcg/Acuation Non-Preferred drug for Asthma)
(Implemented 01/01/2019)

Prescribers may request an override for nonpreferred drugs by calling the Magellan Medicaid Administration (MMA) Help Desk at 1-800-424-7895 (toll-free) and choose PDL option or fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-5739.

Drugs that require manual review for prior authorization

- Spiriva Respimat Metered Inhalation Spray 1.25mcg/Acuation Non-Preferred drug for Asthma

Additional criteria

- Quantity edits apply

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Topical Antiparasitic Medications (Lice Treatment)

(Updated 02/13/2017)
(Effective 4/1/17)
(Updated 10/1/2019)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Preferred Agents

- Permethrin 1% topical liquid OTC (e.g., Lice Killing liquid, Lice Treatment)
- Piperonyl butoxide 4% /Pyrethrum extract 0.33% OTC (e.g., Lice Killing Shampoo, Complete Lice Treatment, Lice Killing shampoo)
- Permethrin 5% cream (Elimite™)
- Natroba 0.9%™ (spinosad suspension) BRAND ONLY

Non-Preferred Agents

- Benzyl alcohol lotion 5% (Ulesfia®)
- Crotamiton Cream/Lotion 10% (Eurax®)
- Ivermectin lotion 0.5% (Sklice®)
- Lindane 1% lotion and shampoo
- Malathion lotion 0.5% (Ovide®)
- Spinosad suspension 0.9% - GENERIC ONLY

**Additional criteria
Quantity limits apply

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Tobacco-cessation Products
(Implemented 11/15/2005)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

**Bupropion (Zyban)**
- Currently pregnant, OR
- < 60 days post partum, OR
- < 187 days of bupropion (Zyban) in the last 365 days.

**Nicotine Replacement Therapy (Nicotine Gum and Patches)**
- Currently pregnant, OR
- < 60 days post partum, OR
- < 187 days of nicotine replacement therapy in the last 365 days.

**Varenicline (Chantix) Implemented 08/01/2007**
- Currently pregnant, OR
- < 60 days post partum, OR
- < 187 days of varenicline in the last 365 days.

Denial criteria

**Bupropion (Zyban)**
- Therapeutic duplication of Chantix.

**Nicotine Replacement Therapy (Gum and Patches)**
- Therapeutic duplication of nicotine gum and nicotine patches.
- Therapeutic duplication of Chantix.

**Varenicline (Chantix)**
- Therapeutic duplication of nicotine gum
- Therapeutic duplication of nicotine patches
- Therapeutic duplication of Zyban

Link to Memorandum

Link to Memorandum for Chantix

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Topical Corticosteroids

*(Implemented 03/26/2008)*
*(Updated 5/10/2017, Effective 7/1/17)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

*Note: all preferred status topical corticosteroids are for generic formulation unless otherwise stated*

The QUANTITY LIMIT for topical corticosteroids, in general, for each topical corticosteroid agent will be limited to one package size for the NDC (e.g., one 15 gm tube, one 30 gm tube, etc.), up to a 240 gm package size if the agent is available in a 240 gm size. Topical solutions and lotions will be limited to the smaller package size available for that drug entity

**Potency Class 1 – Superpotent, Preferred Status only for package sizes noted:**
Clobetasol propionate 0.05% cream-emollient, 15 gm, 30 gm, 60 gm
CLOBEX® (clobetasol propionate) (Brand only) 0.05% topical lotion, 59 ml
Halobetasol propionate 0.05% cream, 15 gm, 50 gm
Halobetasol propionate 0.05% ointment, 15 gm, 50 gm

**Potency Class 1 – Superpotent, Non-Preferred Status, for all package sizes unless otherwise noted:**
Betamethasone dipropionate augmented 0.05% gel,
Betamethasone dipropionate augmented 0.05% oint,
Clobetasol propionate 0.05% cream,
Clobetasol propionate 0.05% gel
Clobetasol propionate 0.05% ointment
Clobetasol propionate 0.05% shampoo
Clobetasol 0.05% solution
clobetasol propionate  0.05% foam
Clobetasol propionate 0.05% emollient foam
Clobetasol propionate 0.05% spray
Clobetasol propionate 0.05% topical lotion, generic 59 ml, brand and generic 118 ml
Diflorasone diacetate 0.05% ointment
Fluocinonide 0.1% cream
Halobetasol propionate 0.01% lotion (Bryhali ™)
Halobetasol propionate 0.05% lotion
Halobetasol propionate 0.05% foam (Lexette™)
Betamethasone dipropionate augmented 0.05% lotion
Desoximetasone 0.25% spray

**Potency Class 2 – Potent, Preferred Status only for package sizes noted:**
Betamethasone dipropionate Aug. 0.05% cream, 15 gm, 50 gm
Fluocinonide 0.05% cream, 15 gm, 30 gm, 60 gm
Fluocinonide 0.05% ointment, 15 gm, 30 gm
Triamcinolone 0.5% ointment, 15 gm
Potency Class 2—Potent, **Non-Preferred Status**, for all package sizes unless otherwise noted:

- Amcinonide 0.1% ointment
- Desoximetasone 0.05% gel
- Desoximetasone 0.25% cream
- Desoximetasone 0.25% oint
- Diflorasone 0.05% cream
- Fluocinonide 0.05% gel
- Fluocinonide 0.05% solution
- Halcinonide 0.1% cream
- Halcinonide 0.1% ointment
- Fluocinonide 0.05% cream, 120 gm
- Fluocinonide 0.05% ointment, 60 gm

Potency Class 3—Upper-Mid Strength, **Preferred Status** only for package sizes noted:

- Betamethasone valerate 0.1% ointment, 15 gm, 45 gm
- ELOCON® (mometasone furoate) (Brand only) 0.1% ointment, 15 gm, 45 gm
- Betamethasone dipropionate 0.05% (not augmented) Lotion, 60 ml
- Triamcinolone 0.5% cream, 15 gm

Potency Class 3—Upper-Mid Strength, **Non-Preferred Status** for all package sizes unless otherwise noted:

- Betamethasone valerate 0.12% foam
- Fluticasone propionate 0.005% ointment
- Triamcinolone 0.1% ointment
- Amcinonide 0.1% cream
- Amcinonide 0.1% lotion
- Betamethasone dipropionate 0.05% cream (not augmented)
- Betamethasone dipropionate 0.05% ointment (not augmented)
- Betamethasone dipropionate 0.05% spray emulsion (not augmented)
- Fluocinonide 0.05% emollient cream

Potency Class 4—Mid Strength, **Preferred Status** only for package sizes noted:

- ELOCON® (Mometasone furoate) 0.1% (Brand only) cream, 15 gm 45 gm
- Mometasone furoate 0.1% solution or lotion, 30 ml
- Fluocinolone 0.025% ointment, 15 gm, 60 gm, 120 gm
- Triamcinolone 0.1% cream, 15 gm, 28.4 gm, 30 gm, 45 gm, 80 gm, 85.2 gm

Potency Class 4—Mid Strength, **Non-Preferred Status** for all package sizes unless otherwise noted:

- Clocortolone pivalate 0.1% cream and cream pump
- Hydrocortisone valerate 0.2% ointment
- Mometasone furoate 0.1% solution or lotion, 60 ml
- Flurandrenolide 0.05% ointment
- Triamcinolone acetonide 0.1% aerosol spray
- Desoximetasone 0.05% cream
Desoximetasone 0.05% ointment
Triamcinolone 0.1% cream, 454 gm, 453.6 gm

**Potency Class 5 – Lower-Mid Strength, Preferred Status only for package sizes noted:**
Fluocinolone 0.01% cream, 15 gm, 60 gm
Betamethasone valerate 0.1% cream, 15 gm, 45 gm
Fluocinolone 0.025% cream, 15 gm, 60 gm, 120 gm
Fluticasone propionate 0.05% cream, 15 gm, 30 gm, 60 gm
Hydrocortisone butyrate 0.1% solution
Triamcinolone 0.025% lotion, 60 ml
Triamcinolone 0.025% ointment 15 gm, 80 gm
Triamcinolone 0.1% lotion, 60 ml

**Potency Class 5 – Lower-Mid Strength, Non-Preferred Status for all package sizes unless otherwise noted:**
Desonide 0.05% lotion
Desonide 0.05% ointment
Flucinolone shampoo
Betamethasone valerate 0.1% lotion
Flurandrenolide 0.05% cream
Flurandrenolide 0.05% lotion
Flurandrenolide 4 mcg/sq. cm tape, small and large size
Fluticasone propionate 0.05% lotion
Hydrocortisone butyrate 0.1% cream
Hydrocortisone butyrate 0.1% cream emollient
Hydrocortisone butyrate 0.1% ointment
Hydrocortisone valerate 0.2% cream
Hydrocortisone probutate 0.1% cream
Prednicarbate 0.1% cream emollient
Prednicarbate 0.1% ointment
Triamcinolone 0.05% ointment, 430 gm
Triamcinolone 0.025% ointment, 453.6 gm, 430 gm

**Potency Class 6 – Mild, Preferred Status only for package sizes noted:**
Alclometasone dipropionate 0.05% ointment, 15 gm, 45 gm, 60 gm
SYNALAR® (fluocinolone) 0.01% (Brand only) solution, 60 ml
Triamcinolone 0.025% cream, 15 gm, 60 gm, 80 gm

**Potency Class 6 – Mild, Non-Preferred Status for all package sizes unless otherwise noted:**
Fluocinolone 0.01% solution, 90 ml
Triamcinolone 0.025% cream, 453.6 gm, 454 gm
Alclometasone dipropionate 0.05% cream
Desonide 0.05% gel
Desonide 0.05% cream
Fluocinolone scalp oil 0.01%
Potency Class 7 – Least Potent, *Preferred Status only for package sizes noted:*
Hydrocortisone acetate 0.5% cream (covered OTC), 28.4 gm
Hydrocortisone 0.5% cream (covered OTC), 28.4 gm, 28.35 gm
Hydrocortisone 0.5% oint (covered OTC), 28.35 gm
Hydrocortisone 1% cream, 28.35 gm, 28.4 gm
Hydrocortisone 1% ointment, 28.35gm, 28.4 gm
Hydrocortisone 2.5% cream, 20 gm, 28 gm, 28.35 gm, 30 gm
Hydrocortisone 2.5% ointment, 20 gm, 28.35 gm, 28.4 gm

Potency Class 7 – Least Potent, *Non-Preferred Status for all package sizes unless otherwise noted:*
Hydrocortisone 1% cream, 453.6 gm
Hydrocortisone 1% ointment, 453.6 gm
Hydrocortisone 2.5% cream 453.6 gm
Hydrocortisone 2.5% ointment, 453.6 gm, 454 gm
Hydrocortisone 1% ointment in absorbase
Hydrocortisone 2.5% lotion
Hydrocortisone 2.5% solution

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Topical Products
Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require a manual PA

**Altabax 1% ointment**
*Implemented 09/21/2009*
  - Generic mupirocin is available without prior authorization

**Bensal® HP (benzoic acid 6%, salicylic Acid 3%, Oak Bark Extract) Ointment**
*Implemented April 6, 2010*

**Nucort lotion (hydrocortisone acetate-aloe vera)**
*Implemented 01/12/2010*
  - Generic hydrocortisone is available without prior authorization

**Nuzon gel (hydrocortisone acetate-aloe vera)**
*Implemented 01/12/2010*
  - Generic hydrocortisone is available without prior authorization

[Link to Memorandum Bensal HP](#)

[Link to Memorandum Altabax](#)

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Topiramate XR Capsules (Qudexy XR and Trokendi XR)

*(Implemented 12/10/2013)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Qudexy XR
  - Trokendi XR

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Tramadol Extended-Release (Conzip Capsule and Ryzolt ER Tablet)

(Implemented 01/12/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Conzip capsule
- Ryzolt ER tablet

Age Edit

≥18 years of age

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Tramadol Immediate-Release (Ulram, Ultracet)

*(Implemented 04/21/2009)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Approval criteria**

- Accumulation quantity limit will allow up to a maximum of 93 units of any solid oral short-acting opioid paid by Medicaid per the previous 31 calendar days. **Additional information listed under Exemptions**
- No drug claim in the past 90 days for Subutex, OR
- No drug claim in the past 90 days for Suboxone AND
- Therapeutic duplication between short-acting opioids with less than 25% of the days’ supply remaining on the previous claim, OR
- Therapeutic duplication between a short-acting opioid and tramadol IR (Ultram) with less than 25% of the days’ supply remaining on the previous claim, OR
- Therapeutic duplication between a short-acting opioid and tramadol/acetaminophen (Ultracet) with less than 25% of the days’ supply remaining on the previous claim
- Therapeutic duplication between a short-acting opioid and tramadol ODT (Rybix) with less than 25% of the days’ supply remaining on the previous claim

**Additional information listed under Exemptions**

**Denial criteria**

- Therapeutic duplication between two short-acting opioids with more than 25% of the days’ supply remaining on previous claim
- Therapeutic duplication between a short-acting opioid and tramadol (Ultram and Ultracet) with more than 25% of the days’ supply remaining on previous claim
- Therapeutic duplication between a short-acting opioid and tramadol ODT (Rybix) with more than 25% of the days’ supply remaining on previous claim
- Drug claim in history for Subutex
- Drug claim in history for Suboxone
- Greater than 93 units of any solid oral short-acting opioid paid by Medicaid per the previous 31 calendar days.

**Additional information listed under Exemptions**
Exemptions

- Patients who have a diagnosis of malignant cancer in the past 12 months:
  - Are exempt from the therapeutic duplication requirement.
  - Accumulation quantity limit will allow up to a maximum of 124 units of any solid oral short acting opioid paid by Medicaid per the previous 31 calendar days.

Additional criteria

Quantity limits apply

Tramadol IR Age Edit

≥17 years of age

Tramadol/APAP Age Edit

≥16 years of age

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Trametinib (Mekinist) Tablets

(Implemented 09/18/2013)
Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Mekinist

Additional Criteria

- Quantity Limits Apply

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Tranexamic Acid (Lysteda)

(Implemented 06/21/2011)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Lysteda

Additional criteria

Quantity limits apply

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Transdermal Scopolamine Patches

(Implemented 03/09/2010)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- ≥ 12 years of age, OR
- History of at least one paid claim in the past 60 days for transderm scopolamine

Additional criteria

Quantity limits apply

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Trazodone HCL (Oleptro ER 150mg & 300mg, Trazodone 300mg) Tablet

(Implemented 07/09/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Oleptro ER 150mg, 300mg tablet
- Trazodone 300mg tablet

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Trientine HCl (Syprine) Capsule

*(Implemented 09/18/2013)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**
- Syprine

**Additional Criteria**
- Quantity Limits Apply

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Trifluridine and Tipiracil Tablets 20mg/8.19 mg and 15 mg/6.14 mg (Lonsurf)
(Implemented 04/26/2016)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization
- Lonsurf

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Valbenazine (Ingrezza) Capsule

(Implemented 11/22/2017)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Ingrezza 40mg Capsule

The “INGREZZA™ / AUSTEDO® Statement of Medical Necessity” form is available on the Medicaid Pharmacy Program website at the following link: https://arkansas.magellanrx.com/provider/docs/rxinfo/ARRx_SMN_Form_Ingrezza_Austedo.pdf.

Magellan Medicaid Administration (MMA) Help Desk 1-800-424-7895; fax letter of medical necessity along with any documentation to substantiate the medical necessity of the request to 1-800-424-7976.

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Valganciclovir Oral Solution (Valcyte)

(Implemented 01/18/2011)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Approval criteria

- Less than 9 years of age, OR
- History of diagnosis of NPO within the past 365 days.

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Vandetanib (Caprelsa) Tablet

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Caprelsa 100mg and 300mg Tablet

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Vorinostat (Zolinza) 100mg Capsule

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Zolinza 100mg Capsule

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Vemurafenib Tablet (Zelboraf)

*(Implemented 04/17/2012)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**
- Zelboraf tablet

**Information required for the manual review process**
- Confirmation of BRAFV600E mutation-positive melanoma as detected by an FDA-approved test
- In addition to requirement of diagnosis and lab results showing BRAFV600E mutation-positive melanoma, the following data will be required for the manual review process:
  - Baseline EKG and then every 3 months thereafter to monitor for QTc
  - Liver function tests baseline and then periodic
  - Baseline and periodic dermatology evaluation for squamous cell carcinomas

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Venetoclax- (Venclexta)

*(Implemented 7/20/2016)*

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

**Drugs that require manual review for prior authorization**

- Venclexta tablet

**Approval Criteria**

- Confirmed diagnosis of CLL with 17p deletion
- Documentation of one prior therapy
- Risk assessment for TLS
- TLS prophylaxis AND monitoring documentation

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Vismodegib Capsule (Erivedge)  
(Implemented 07/09/2012)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Erivedge capsule

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Vorinostat (Zolinza) 100mg Capsule

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Zolinza 100mg Capsule

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Vorapaxar (Zontivity)

(Implemented 09/23/2014)

Prescribers may request an override by calling the Magellan Help Desk at 1-800-424-7895 (toll-free).

Drugs that require manual review for prior authorization

- Zontivity

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Appendix A – Nil per os (NPO)

<table>
<thead>
<tr>
<th>Procedure codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4034, B4035, B4036</td>
<td>Enteral feeding supplies</td>
</tr>
<tr>
<td>B4149, B4150-B4156</td>
<td>Enteral formula</td>
</tr>
<tr>
<td>B4160-B4162</td>
<td>Enteral formula for pediatrics</td>
</tr>
<tr>
<td>96.07</td>
<td>Nasogastric tube insertion</td>
</tr>
<tr>
<td>97.01</td>
<td>Nasogastric tube placement</td>
</tr>
<tr>
<td>43.11</td>
<td>PEG</td>
</tr>
<tr>
<td>46.32</td>
<td>PEJ tube</td>
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</tbody>
</table>

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# Appendix B – Approved Tracheostomy Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V44.0</td>
<td>Tracheostomy status</td>
</tr>
<tr>
<td>V55.0</td>
<td>Attention to tracheostomy</td>
</tr>
<tr>
<td>31.1</td>
<td>Temporary tracheostomy</td>
</tr>
<tr>
<td>31.2X</td>
<td>Permanent tracheostomy</td>
</tr>
<tr>
<td>31.74</td>
<td>Revision of tracheostomy</td>
</tr>
<tr>
<td>519.0X</td>
<td>Tracheostomy complications</td>
</tr>
<tr>
<td>31600</td>
<td>Tracheostomy, planned (separate procedure);</td>
</tr>
<tr>
<td>31601</td>
<td>Tracheostomy, planned (separate procedure); younger than two years</td>
</tr>
<tr>
<td>31603</td>
<td>Tracheostomy, emergency procedure; transtracheal</td>
</tr>
<tr>
<td>31605</td>
<td>Tracheostomy, emergency procedure; cricothyroid membrane</td>
</tr>
<tr>
<td>31610</td>
<td>Tracheostomy, fenestration procedure with skin flaps</td>
</tr>
</tbody>
</table>

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Appendix D – Congestive Heart Failure Diagnoses

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertensive heart disease with heart failure</td>
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<tr>
<td>Hypertensive heart disease with heart failure</td>
</tr>
<tr>
<td>Hypertensive heart disease with heart failure</td>
</tr>
<tr>
<td>Hypertensive heart and renal disease with heart failure</td>
</tr>
<tr>
<td>Hypertensive heart and renal disease with heart and renal failure</td>
</tr>
<tr>
<td>Hypertensive heart and renal disease with heart failure</td>
</tr>
<tr>
<td>Hypertensive heart and renal disease with heart and renal failure</td>
</tr>
<tr>
<td>Hypertensive heart and renal disease with renal failure</td>
</tr>
<tr>
<td>Hypertensive heart and renal disease with heart and renal failure</td>
</tr>
<tr>
<td>Congestive heart failure, unspecified</td>
</tr>
</tbody>
</table>

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# Appendix E – Malignant cancer diagnoses

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant neoplasm of lip</td>
</tr>
<tr>
<td>Malignant neoplasm of major salivary gland</td>
</tr>
<tr>
<td>Malignant neoplasm of oropharynx</td>
</tr>
<tr>
<td>Malignant neoplasm of nasopharynx</td>
</tr>
<tr>
<td>Malignant neoplasm of hypopharynx</td>
</tr>
<tr>
<td>Malignant neoplasm of other and ill-defined sites within the lip, oral cavity, and pharynx</td>
</tr>
<tr>
<td>Malignant neoplasm of esophagus</td>
</tr>
<tr>
<td>Malignant neoplasm of stomach</td>
</tr>
<tr>
<td>Malignant neoplasm of small intestine including duodenum</td>
</tr>
<tr>
<td>Malignant neoplasm of colon</td>
</tr>
<tr>
<td>Malignant neoplasm of rectum rectosigmoid junction</td>
</tr>
<tr>
<td>Malignant neoplasm of liver and intrahep</td>
</tr>
<tr>
<td>Malignant neoplasm of gall bladder and extrahepatic bile duct</td>
</tr>
<tr>
<td>Malignant neoplasm of pancreas</td>
</tr>
<tr>
<td>Malignant neoplasm of retroperitoneum and peritoneum</td>
</tr>
<tr>
<td>Malignant neoplasm of other and ill-defined sites within the digestive organs and peritoneum</td>
</tr>
<tr>
<td>Malignant neoplasm of nasal cavities middle ear and accessory sinuses</td>
</tr>
<tr>
<td>Malignant neoplasm of larynx</td>
</tr>
<tr>
<td>Malignant neoplasm of trachea bronchus and lung</td>
</tr>
<tr>
<td>Malignant neoplasm of pleura</td>
</tr>
<tr>
<td>Malignant neoplasm of thymus, heart, and mediastinum</td>
</tr>
<tr>
<td>Malignant neoplasm of other and ill-defined sites within the respiratory system and intrathoracic organs</td>
</tr>
<tr>
<td>Malignant neoplasm of bone and articular cartilage</td>
</tr>
<tr>
<td>Malignant neoplasm of connective and other soft tissue</td>
</tr>
<tr>
<td>Malignant melanoma of skin</td>
</tr>
<tr>
<td>Malignant neoplasm of female breast</td>
</tr>
<tr>
<td>Malignant neoplasm of male breast</td>
</tr>
<tr>
<td>Kaposis sarcoma</td>
</tr>
<tr>
<td>Malignant neoplasm of uterus, part unspecified</td>
</tr>
<tr>
<td>Malignant neoplasm of cervix uteri</td>
</tr>
<tr>
<td>Malignant neoplasm of placenta</td>
</tr>
<tr>
<td>Malignant neoplasm of body of uterus</td>
</tr>
<tr>
<td>Malignant neoplasm of ovary and other uterine adnexa</td>
</tr>
<tr>
<td>Malignant neoplasm other and unspecified female genital organs</td>
</tr>
<tr>
<td>Malignant neoplasm of prostate</td>
</tr>
<tr>
<td>Malignant neoplasm of testis</td>
</tr>
<tr>
<td>Malignant neoplasm of penis and other male genital</td>
</tr>
<tr>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Malignant neoplasm of bladder</td>
</tr>
<tr>
<td>Malignant neoplasm of kidney and other and unspecified urinary organs</td>
</tr>
<tr>
<td>Malignant neoplasm of eye</td>
</tr>
<tr>
<td>Malignant neoplasm of brain</td>
</tr>
<tr>
<td>Malignant neoplasm other and unspecified parts nervous system</td>
</tr>
<tr>
<td>Malignant neoplasm of thyroid gland</td>
</tr>
<tr>
<td>Malignant neoplasm of other endocrine glands and related structures</td>
</tr>
<tr>
<td>Malignant neoplasm of other and ill-defined sites</td>
</tr>
<tr>
<td>Secondary and unspecified malignant neoplasm of lymph</td>
</tr>
<tr>
<td>Secondary malignant neoplasm of respiratory and digestive</td>
</tr>
<tr>
<td>Secondary malignant neoplasm of other specified sites</td>
</tr>
<tr>
<td>Malignant neoplasm without specification</td>
</tr>
<tr>
<td>Lymphosarcoma and reticulosarcoma</td>
</tr>
<tr>
<td>Hodgkins disease</td>
</tr>
<tr>
<td>Other malignant neoplasms lymphoid and histiocytic tissue</td>
</tr>
<tr>
<td>Multiple myeloma and immunoproliferative neoplasms</td>
</tr>
<tr>
<td>Lymphoid leukemia</td>
</tr>
<tr>
<td>Myeloid leukemia</td>
</tr>
<tr>
<td>Monocytic leukemia</td>
</tr>
<tr>
<td>Other specified leukemia</td>
</tr>
<tr>
<td>Leukemia of unspecified cell type</td>
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Appendix H – Approved diagnoses for nonpreferred antiepileptic agents in neuropathic pain agent class

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Subacute sclerosing panencephalitis</td>
</tr>
<tr>
<td>Herpes simplex meningoencephalitis</td>
</tr>
<tr>
<td>Other lymphatic and hematopoietic tissues</td>
</tr>
<tr>
<td>Diabetes insipidus</td>
</tr>
<tr>
<td>Alcohol withdrawal</td>
</tr>
<tr>
<td>Drug withdrawal syndrome</td>
</tr>
<tr>
<td>Psychotic disorder with delusions in conditions classified elsewhere</td>
</tr>
<tr>
<td>Psychotic disorder with hallucinations in conditions classified elsewhere</td>
</tr>
<tr>
<td>Dementia in conditions classified elsewhere</td>
</tr>
<tr>
<td>Schizoprenic disorders</td>
</tr>
<tr>
<td>Affective psychoses (manic, depressive, bi-polar)</td>
</tr>
<tr>
<td>Psychoses with origin specific to childhood (pervasive developmental disorders)</td>
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<tr>
<td>Panic disorder</td>
</tr>
<tr>
<td>Social phobia</td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
</tr>
<tr>
<td>Neurotic depression</td>
</tr>
<tr>
<td>Chronic depressive personality disorder</td>
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<tr>
<td>Schizoid personality disorder</td>
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<tr>
<td>Obsessive compulsive disorder</td>
</tr>
<tr>
<td>Borderline personality disorder</td>
</tr>
<tr>
<td>Cocaine dependence</td>
</tr>
<tr>
<td>Physiological malfunction arising from mental factors, respiratory</td>
</tr>
<tr>
<td>Tics</td>
</tr>
<tr>
<td>Tension headache</td>
</tr>
<tr>
<td>Predominant psychomotor disturbance</td>
</tr>
<tr>
<td>Adjustment reaction</td>
</tr>
<tr>
<td>Unspecified nonpsychotic mental disorder following organic brain damage</td>
</tr>
<tr>
<td>Depressive disorder</td>
</tr>
<tr>
<td>Disturbance of conduct</td>
</tr>
<tr>
<td>Disturbance of emotions specific to childhood adolescence</td>
</tr>
<tr>
<td>Mild mental retardation</td>
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</table>

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<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Other specified mental retardation</td>
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<tr>
<td>Unspecified mental retardation</td>
</tr>
<tr>
<td>Periodic limb movement disorder</td>
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<tr>
<td>Cerebral lipidoses</td>
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<tr>
<td>Rett's disorder</td>
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<tr>
<td>Parkinson's disease</td>
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<tr>
<td>Other extrapyramidal disease and abnormal movement disorder</td>
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<tr>
<td>Multiple sclerosis</td>
</tr>
<tr>
<td>Epilepsy</td>
</tr>
<tr>
<td>Migraine</td>
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<tr>
<td>Phantom limb syndrome</td>
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<tr>
<td>Myotonic disorder</td>
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<tr>
<td>Psychophysical visual disturbance</td>
</tr>
<tr>
<td>Tinnitis</td>
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<tr>
<td>Rheumatic chorea</td>
</tr>
<tr>
<td>Apraxia</td>
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<tr>
<td>Nephrogenic diabetes insipidus</td>
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<tr>
<td>Premenstrual tension syndromes</td>
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<tr>
<td>Erythrodermic psoriasis</td>
</tr>
<tr>
<td>Prader-willi syndrome</td>
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<tr>
<td>Angelman syndrome</td>
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<tr>
<td>Other and ill defined conditions originating in the perinatal period</td>
</tr>
<tr>
<td>Convulsions, seizures</td>
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<tr>
<td>Abnormal involuntary movements</td>
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<tr>
<td>Symbolic dysfunction, unspecified, other</td>
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<tr>
<td>Hiccough</td>
</tr>
<tr>
<td>Intracranial injury</td>
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<tr>
<td>Schizophrenia</td>
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<tr>
<td>Affective disorders</td>
</tr>
<tr>
<td>Alcoholism</td>
</tr>
<tr>
<td>Other neurological diseases</td>
</tr>
<tr>
<td>Mental retardation</td>
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<tr>
<td>Depression</td>
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<td>Mental retardation</td>
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<tr>
<th>CPT</th>
<th>Procedure</th>
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<tbody>
<tr>
<td>43201</td>
<td>ESPH GSC RGD/FLX DIRED SBMCSL NJX ANY SBST</td>
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<tr>
<td>43234</td>
<td>UPR GI NDSC SMPL PRIM XM SPX</td>
</tr>
<tr>
<td>43235</td>
<td>UPR GI NDSC DX +COLLJ SPEC BR/WA SPX</td>
</tr>
<tr>
<td>43236</td>
<td>UPR GI NDSC DIRED SBMCSL NJX ANY SBST</td>
</tr>
<tr>
<td>43237</td>
<td>UPR GI NDSC NDSC US XM LMTD ESOPH</td>
</tr>
<tr>
<td>43238</td>
<td>UPR GI NDSC TNSC US FINE NDL ASPIR/BX ESOPH</td>
</tr>
<tr>
<td>43239</td>
<td>UPR GI NDSC BX 1/MLT</td>
</tr>
<tr>
<td>43240</td>
<td>UPR GI NDSC TRANSMURAL DRG PSEUDOCST</td>
</tr>
<tr>
<td>43241</td>
<td>UPR GI NDSC TNSC INTRAL TUBE/CATH PLMT</td>
</tr>
<tr>
<td>43242</td>
<td>UPR GI NDSC TNSC US FINE NDL ASPIR/BX W/US XM</td>
</tr>
<tr>
<td>43243</td>
<td>UPR GI NDSC NJX SCLEROSIS ESOPHGL&amp;/GSTR VARC</td>
</tr>
<tr>
<td>43244</td>
<td>UPR GI NDSC BAND LIG ESOPHGL&amp;/GSTR VARC</td>
</tr>
<tr>
<td>43245</td>
<td>UPR GI NDSC DILAT GSTR OUTLET FOR OBSTRCJ</td>
</tr>
<tr>
<td>43246</td>
<td>UPR GI NDSC DIREO PLMT PRQ GASTROSTOMY TUBE</td>
</tr>
<tr>
<td>43247</td>
<td>UPR GI NDSC RMVL FB</td>
</tr>
<tr>
<td>43248</td>
<td>UPR GI NDSC INSJ GD WIRE DILAT ESOP GD WIRE</td>
</tr>
<tr>
<td>43249</td>
<td>UPR GI NDSC BALO DILAT ESOP &lt;30 MM DIAM</td>
</tr>
<tr>
<td>43250</td>
<td>UPR GI NDSC RMVL LES HOT BX/BIPOLAR CAUT</td>
</tr>
<tr>
<td>43251</td>
<td>UPR GI NDSC RMVL TUM POLYP/OTH LES SNARE TQ</td>
</tr>
<tr>
<td>43252</td>
<td>UPR GI NDSC CTRL BLD ANY METH</td>
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<tr>
<td>43253</td>
<td>UPR GI NDSC TNSC STENT PLMT W/PREDILAT</td>
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<tr>
<td>43257</td>
<td>UPR GI NDSC DLVR THERMAL NRG SPHNCTR/CARDIA</td>
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<tr>
<td>43258</td>
<td>UPR GI NDSC ABTJ LES X RMVL FORCEPS/CAUT/SNARE</td>
</tr>
<tr>
<td>43259</td>
<td>UPR GI NDSC W/US XM</td>
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<tr>
<td>43200</td>
<td>Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)</td>
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<td>43201</td>
<td>...with directed submucosal injection(s), any substance</td>
</tr>
<tr>
<td>43202</td>
<td>...with biopsy, single or multiple</td>
</tr>
<tr>
<td>43204</td>
<td>...with injection sclerosis of esophageal varices</td>
</tr>
<tr>
<td>43205</td>
<td>...with band ligation of esophageal varices</td>
</tr>
<tr>
<td>43220</td>
<td>...with balloon dilation (less than 30 mm diameter)</td>
</tr>
<tr>
<td>43226</td>
<td>...with insertion of guide wire followed by dilation over guide wire</td>
</tr>
<tr>
<td>43227</td>
<td>...with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)</td>
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<tr>
<td>43228</td>
<td>...with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique</td>
</tr>
<tr>
<td>43216</td>
<td>... with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery</td>
</tr>
<tr>
<td>43217</td>
<td>...with removal of tumor(s), polyp(s), or other lesion(s) by snare technique</td>
</tr>
<tr>
<td>43219</td>
<td>...with insertion of plastic tube or stent</td>
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<tr>
<td>43231</td>
<td>...with endoscopic ultrasound examination</td>
</tr>
<tr>
<td>43232</td>
<td>...with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)</td>
</tr>
</tbody>
</table>