Prior Authorization Criteria

This is NOT an all-inclusive list of medications that require prior authorization. If you are looking for a medication that requires prior authorization that is not on this list, please see:

- The Preferred Drug List (PDL) and navigate to the most current year and version
- The preferred dosage forms list at the end of this document
- Other documents explaining limitations that may cause a prior authorization denial:
    - Preferred Diabetic Supply List (PDSL)
    - Coverage Rules on Medications
    - Drug Utilization Management List

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ACE-Inhibitors

Prior Authorization Form - ACE-I/ARB/Renin Inhibitor

Criteria for non-preferred medication:
EPANED:

- Patient must be less than 7 years of age, or unable to ingest solid dosage form as evidenced by swallow study documentation

QBRELIS:

- Please use Epaned

Combination Medications: (benazepril-hydrochlorothiazide, fosinopril-hydrochlorothiazide):

- Please prescribe individual medication separately or use a different medication combination

Preferred	Non-Preferred
benazepril	benazepril-hydrochlorothiazide
captopril	EPANED (enalapril)
captopril-hydrochlorothiazide	fosinopril-hydrochlorothiazide
enalapril	QBRELIS (lisinopril)
enalapril-hydrochlorothiazide	
fosinopril	
lisinopril	
lisinopril-hydrochlorothiazide	
moexipril	
moexipril-hydrochlorothiazide	
perindopril	
quinapril	
quinapril-hydrochlorothiazide	
ramipril	
trandolapril	

ARBs (Angiotensin Receptor Blockers)

Prior Authorization Form - ACE-I/ARB/Renin Inhibitor

ENTRESTO:

- Please see “Heart Failure-Neprilysin Inhibitor/Angiotensin Receptor Blocker” category on PDL. http://www.hidesigns.com/ndmedicaid/pdl/

Criteria for non-preferred products

Candesartan-hydrochlorothiazide, candesartan, eprosartan:

- Patient must fail three 30 day trials at the highest tolerable therapeutic dose of the following as evidenced by paid claims or pharmacy print outs:
    - Irbesartan
    - Telmisartan
    - Azilsartan
    - Olmesartan
    - Valsartan
    - Losartan

Combination Medications: (valsartan-hydrochlorothiazide, telmisartan-hydrochlorothiazide, Exforge, Exforge Hct, amlodipine-olmesartan, Byvalson):

- Please prescribe individual medication separately or use a different medication combination

Preferred	Non-Preferred
EDARBI (azilsartan)	amlodipine-olmesartan
EDARBYCLOR (azilsartan/chlorothalidone)	BYVALSON (nebivolol/valsartan)
ENTRESTO (sacubitril/valsartan)	candesartan-hydrochlorothiazide
irbesartan	cardesartan
irbesartan-hydrochlorothiazide	eprosartan
losartan	EXFORGE (amlodipine-valsartan)
losartan-hydrochlorothiazide	EXFORGE HCT (amlodipine-valsartan-hydrochlorothiazide)
olmesartan	telmisartan-hydrochlorothiazide
olmesartan-hydrochlorothiazide	valsartan-hydrochlorothiazide
telmisartan	
valsartan	

Renin Inhibitor

Prior Authorization Form - ACE-I/ARB/Renin Inhibitor

Criteria:

- Patient must have failed 30 day trials at the highest tolerable therapeutic dose of two medications in each of the following groups as evidenced by paid claims or pharmacy print outs:

    - ARB: Azilsartan, candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan, valsartan

    - ACE-Inhibitors: Captopril, enalapril, moexipril, ramipril, lisinopril, trandolapril, quinapril, benazepril, perindopril, or fosinopril

Preferred	Non-Preferred
	TEKTURNA (aliskiren)
	TEKTURNA HCT (aliskiren-hydrochlorothiazide)

Acitretin

Prior Authorization Form - Acitretin

Criteria:

- Patient must be male or female permanently unable to bear children

Acne

Prior Authorization Form - Acne

Criteria:

- Patient must be between 12 and 35 years old
- Additional Criteria included under each section

Preferred	Non-Preferred
clindamycin-benzoyl peroxide	
ACANYA (clindamycin-benzoyl peroxide) 1.2%-2.5%	BENZACLIN (clindamycin/benzoyl peroxide) 1%-5%
clindamycin-benzyl peroxide 1.2%-5%	clindamycin/benzoyl peroxide 1%-5%
ONEXTON (clindamycin/benzoyl peroxide) 1.2%-3.75%	
TRETINOIN MICROSPHERES	
RETIN-A MICRO PUMP (tretinoin microspheres) 0.08%	tretinoin microsphere 0.04%
	tretinoin microsphere 0.1%
	tretinoin microsphere with pump 0.04%
	tretinoin microsphere with pump 0.1%
TRETINOIN	
AVITA (tretinoin) CREAM *(brand preferred)*	AVITA (tretinoin) GEL
RETIN-A (tretinoin) CREAM *(brand preferred)*	RETIN-A (tretinoin) GEL
tretinoin gel	tretinoin cream
ADAPALENE	
adapalene gel 0.1%	adapalene cream 0.1%
DIFFERIN (adapalene) GEL W/ PUMP *(brand preferred)*	

adapalene gel 0.3%	
DIFFERIN (adapalene) LOTION	
EPIDUO (adapalene/benzoyl peroxide) 0.1%-2.5%	
EPIDUO FORTE (adapalene/benzoyl peroxide) 0.3%-2.5%	
OTHER	
ACZONE (dapsone) WITH PUMP	ACZONE (dapsone)
AZELEX (azelaic acid)	FABIOR (tazarotene)
clindamycin-tretinoin 1.2%-0.025%	
sulfacetamide	
TETRACYCLINES	
Preferred	Non-Preferred
clindamycin capsule	tetracycline
clindamycin cream	
clindamycin foam	
clindamycin gel	
clindamycin lotion	
doxycycline monohydrate 25 mg/5mL	
doxycycline monohydrate capsule 100 mg	
doxycycline monohydrate capsule 50 mg	
doxycycline monohydrate capsule 75 mg	
doxycycline monohydrate tablet 100 mg	
doxycycline monohydrate tablet 50 mg	
doxycycline monohydrate tablet 75 mg	
doxycycline monohydrate tablet 75 mg	
metronidazole cream	
metronidazole gel	
metronidazole lotion	
minocycline	
VIBRAMYCIN (doxycycline monohydrate) 25 mg/5mL SUSP	
VIBRAMYCIN (doxycycline monohydrate) 50 mg/5mL SYRUP	
Preferred	Non-Preferred
doxycycline monohydrate tablet 100 mg	DORYX DR (doxycycline hyclate) 200mg
doxycycline monohydrate tablet 50 mg	DORYX DR (doxycycline hyclate) 50mg
doxycycline monohydrate tablet 75 mg	DORYX MPC (doxycycline hyclate) 120mg
	doxycyline hyclate tablet DR 100 mg
	doxycycline hyclate tablet DR 50 mg
	doxycycline hyclate tablet DR 75 mg
	doxycycline hyclate tablet 100 mg

	doxycycline hyclate tablet 75 mg
Preferred	Non-Preferred
doxycycline monohydrate tablet 75 mg	doxycycline hyclate tablet 150 mg
	doxycycline monohydrate capsule 150mg
	doxycycline monohydrate tablet 150 mg
	doxycyline hyclate tablet DR 150 mg
Preferred	Non-Preferred
doxycycline monohydrate capsule 100 mg	doxycycline capsule IR-DR 40mg
doxycycline monohydrate capsule 50 mg	doxycycline hyclate capsule 100 mg
doxycycline monohydrate capsule 75 mg	doxycycline hyclate capsule 50 mg
	MORGIDOX (doxycycline hyclate) 100mg
	MORGIDOX (doxycycline hyclate) 50mg
	ORACEA (doxycycline monohydrate) 40 mg
	VIBRAMYCIN (doxycycline hyclate)100 mg
Preferred	Non-Preferred
doxycycline monohydrate capsule 100 mg	doxycyline hyclate tablet DR 200 mg
Preferred	Non-Preferred
minocycline	SOLODYN (minocycline) ER
	minocycline ER

Actinic Keratosis

Prior Authorization Form - Actinic Keratosis

Criteria for non-preferred medication:

- Patient must fail a 6 month trial of imiquimod before receiving a non-preferred product as evidenced by paid claims or pharmacy print outs.

Preferred	Non-Preferred
imiquimod	PICATO (ingenol mebutate)
	SOLARAZE (diclofenac sodium) GEL
	ZYCLARA (imiquimod)

Albuterol/Levalbuterol Rescue Inhalers

Prior Authorization Form - Albuterol/Levalbuterol Rescue Inhalers
MedWatch Form

Criteria for non-preferred medications:
Ventolin HFA:

- Patient must have failed a trial of all preferred medications, as evidenced by paid claims or pharmacy print outs. The failure must not be due to side effects.

- A MedWatch form documenting the experienced treatment failure for each trial must be provided with authorization request.

Xopenex HFA :

- Patient must have failed a trial of one of the following due to side effects, as evidenced by paid claims or pharmacy printouts
  OR
  Patient must fail a 30 day trial of all of the following, as evidenced by paid claims or pharmacy print outs:
  - Proventil HFA
  - ProAir HFA
  - Ventolin HFA

ProAir RespiClick:

- Patient must fail a 30 day trials of all of the following as evidenced by paid claims or pharmacy print outs:
  - Proventil HFA
  - Ventolin HFA
  - Xopenex HFA
- A MedWatch form documenting the experienced treatment failure for each trial must be provided with authorization request

Preferred	Non-Preferred
PROVENTIL (albuterol) HFA	levalbuterol HFA
PROAIR (albuterol) HFA	PROAIR RESPICLICK (albuterol)
	VENTOLIN (albuterol) HFA
	XOPENEX (levalbuterol) HFA

Allergenic Extracts – Oral

Prior Authorization Form - Allergenic Extracts

Criteria

- Patient must not have severe, unstable, or uncontrolled asthma
- Patient must be an FDA-approved age
- Patient must have an FDA-approved diagnosis of allergic rhinitis due to a pollen contained in the requested product
- Patient's diagnosis must be confirmed by a positive skin test or in vitro testing for pollen-specific IgE antibodies contained in the requested product.

Additional Criteria for Non-Preferred Agent

- Patient must have failed a trial of 2 of the following: oral antihistamines, intranasal antihistamines, intranasal corticosteroids, or leukotriene inhibitors as evidenced by paid claims or pharmacy printouts.

- Patient must have failed a trial of have intolerance to subcutaneous allergen immunotherapy (allergy shots) as evidenced by paid claims or pharmacy printouts.

Preferred	Non-Preferred
GRASTEK (GRASS POLLEN-TIMOTHY, STD)PA	ORALAIR (GR POL-ORC/SW VER/RYE/KENT/TIM)
ODACTRA (MITE,D.FARINAE-D.PTERONYSSINUS) PA	
RAGWITEK (WEED POLLEN-SHORT RAGWEED)PA	

Ampyra

Prior Authorization Form - Ampyra

Approval:

Initial: 3 months
Renewals: 6 months

Initial Criteria:

- Patient must be 18 years or older
- Patient must have a specialist (neurologist or physiatrist) involved in therapy
- Patient must have confirmed diagnosis of multiple sclerosis
- Patient must not have a history of seizures
- Patient's CrCl (creatinine clearance) must be greater than 50mL/min
- Patient must not have experienced any acute exacerbations within the last 60 days
- Patient must have established a baseline ability of walking 25 feet in 8 to 45 seconds

1st Renewal Request Criteria:

- Renewal PA Requests must include patient's baseline and current T25FW
- Current 25 foot walk time must be 20% faster than baseline 25 foot walk time

Subsequent Renewal Request Criteria:

- Renewal PA Requests must include patient's baseline and current T25FW
- Current 25 foot walk time must be faster than baseline 25 foot walk time

Anesthetics - Topical

Prior Authorization Form - Anesthetics - Topical

Criteria:

- Patients must be 12 years of age or older
- Use must be for placement of peripheral or central line or injections through an implanted port

Anticoagulants - Injectable

Prior Authorization Form - Anticoagulants - Injectable

Criteria for non-preferred medication:

- Patient must have FDA Approved Indication
- Patient must have failed a 30 day trial with enoxaparin, as evidenced by paid claims or pharmacy printouts.
    - Patients with Heparin-induced thrombocytopenia (HIT) requesting fondaparinux can bypass enoxaparin trial

Preferred	Non-Preferred
enoxaparin	ARIXTRA (fondaparinux)
	fondaparinux
	FRAGMIN (dalteparin)

Antihistamines

Prior Authorization Form - Antihistamines

Criteria for non-preferred medication:

- Patient must have failed the following 14 day trials, as evidenced by paid claims or pharmacy printouts.
    - loratadine
    - levocetirizine

Preferred	Non-Preferred
cetirizine chew tablet	desloratadine ODT
cetirizine solution	desloratadine tablet
cetirizine tablet	levocetirizine solution
levocetirizine tablet	
loratadine ODT	
loratadine solution	
loratadine tablet	

Antihemophilic Factor Products

Prior Authorization Form - Antihemophilic Factors

Criteria:

- Patient must visit an accredited Hemophilia Treatment Center once per year

- Date of Last Appointment with treatment center must be provided
- Contact information for treatment center must be provided

Criteria for non-preferred medication:

- Medical justification must be given as to why preferred product won't work
- Patient may qualify for non-preferred product if they are stable on current therapy (have had a paid claim for requested therapy in the past 45 days)

Preferred	Non-Preferred
ADVATE	ADYNOVATE
AFSTYLA	ELOCTATE
ALPHANATE	
ALPHANINE SD	
ALPROLIX	
BEBULIN	
BENEFIX	
FEIBA	
HELIXATE FS	
HEMOFIL M	
HUMATE-P	
IDELVION	
IXINITY	
KOATE-DVI	
KOGENATE FS BIO-SET	
KOGENATE FS	
MONOCLATE-P	
MONONINE	
NOVOEIGHT	
NOVOSEVEN	
OBIZURE	
PROFILNINE SD	
RECOMBINATE	
RIXUBIS	
VONVENDI	
WILATE	
XYNTHA	

Antihyperuricemics

Prior Authorization Form - Antihyperuricemics

Criteria for non-preferred medication:

Colchicine tablets:

- Medical justification must be given as to why preferred product won't work

Duzallo:

- Patient must have failed 30-day trials of Uloric and allopurinol, as evidenced by paid claims or pharmacy printouts.

Uloric

- Patient must have failed a 30-day trial of allopurinol, as evidenced by paid claims or pharmacy printouts.

Zurampic:

- Patient must have failed 30-day trials of Uloric and allopurinol, as evidenced by paid claims or pharmacy printouts.
- Zurampic must be used in combination with allopurinol or Uloric

Preferred	Non-Preferred
allopurinol tablet	colchicine tablet
colchicine capsule	DUZALLO (lesinurad/allopurinol)
probenecid-colchicine	ULORIC (febuxostat) TABLET
	ZURAMPIC (lesinurad) TABLET

Antimalarial Agents

Prior Authorization Form - Antimalarial Agents

Preferred and Non-Preferred Agent Criteria:

- Antimalarials are only covered for treatment, *NOT for prophylaxis*

Additional Criteria for Non-Preferred Agent

- Patient must have tried generic quinine in the last 30 days, as evidenced by paid claims or pharmacy print outs
- Patient must be less than 18 years old to qualify for atovaquone/proguanil 62.5-25 MG

Preferred	Non-Preferred
quinine	atovaquone/proguanil
	chloroquine
	COARTEM (artemether/lumefantrine)
	MALARONE (atovaquone/proguanil)
	primaquine

Antipsoriatics – Topical

Prior Authorization Form - Antipsoriatics - Topical

Criteria for non-preferred medication:

- For Foams and Sprays: Patient must have failed a 30-day trial of the preferred solution, foam, and shampoo formulations as evidenced by paid claims or pharmacy print outs
- For Ointments: Patient must have failed a 30-day trial of the preferred ointment formulations as evidenced by paid claims or pharmacy print outs

Preferred	Non-Preferred
calcipotriene ointment	calcipotriene/betamethasone ointment
calcipotriene solution	ENSTILAR (calcipotriene/betamethasone) FOAM
calcipotriene cream	
SORILUX (calcipotriene) FOAM	
TACLONEX (calcipotriene/betamethasone) SUSPENSION	
Preferred	Non-Preferred
Clobetasol Gel	Clobetasol Emollient Foam
Clobetasol Lotion	Clobetasol Foam
Clobetasol Shampoo	Clobetasol Spray
Clobetasol Solution	

Benign Prostatic Hyperplasia

Prior Authorization Form - Cialis for Benign Prostatic Hyperplasia

Criteria for non-preferred medication:

- Recipient must have diagnosis of benign prostatic hyperplasia (BPH)
- Patient must have failed a 30-day trial of all preferred products, unless contraindicated as evidenced by paid claims or pharmacy print outs

Preferred	Non-Preferred
alfuzosin ER	CARDURA XL (doxazosin)
doxazosin	sildenafil
dutasteride	
finasteride	
prazosin	
silodosin	
tamsulosin	
terazosin	

Dispense as Written (DAW1)

Prior Authorization Form - Dispense As Written (DAW1)
MedWatch Form

Criteria:

- Patient must have failed a 30-day trial of all accessible generic product (s), as evidenced by paid claims or pharmacy print outs
    - A failure is defined as product was not effective at maximum tolerated dose or caused adverse reaction where the branded product is expected to have a different result and other alternatives (e.g. medications in same class) are not an option for the patient
    - Patient or prescriber preference is NOT criteria considered for approval
- A MedWatch form for each manufacturer must be filled out and attached to request
- Product must not have an authorized generic

OR

- Primary insurance requires a ND Medicaid non-preferred branded product

Diclegis/Bonjesta

Prior Authorization Form - Diclegis

Approval: Until two weeks past provided due date
Criteria:

- Patient must have diagnosis of nausea and vomiting of pregnancy
- Patient must have failed a 3 day trial of all preferred products
- Patient's due date must be provided
- Diclegis/Bonjesta has not been studied in women with hyperemesis gravidarum

Preferred	Non-Preferred
meclizine	BONJESTA (doxyclamine/vitamin B6)
metoclopramide	DICLEGIS (doxyclamine/vitamin B6)
ondansetron	

Dificid

Prior Authorization Form - Dificid

Approval: 5 days
Criteria:

- Patient must have diagnosis of *Clostridium difficile*-associated diarrhea (CDAD)
- Patient must be ≥ 18 years of age

Additional Renewal Criteria:

- Must be first recurrence for a patient whose initial episode was treated with Dificid

Preferred	Non-Preferred
metronidazole	DIFICID (fidaxomicin)
vancomycin	

Dihydroergotamine

Prior Authorization Form - Dihydroergotamine

Criteria for non-preferred medications:

- Patient must have a diagnosis of migraine or cluster headache
- Patient must have had two 30 day trials (within the past 2 years) of 'Preferred Agents' and two 30 day trials (within the past 2 years) of 'Non-Preferred Step 1 Agents'

Preferred	Non-Preferred Step 1	Non-Preferred Step 2
eletriptan	sumatriptan nasal spray	CAFERGOT (ergotamine/caffeine) TABLET
rizatriptan	ZOMIG (zolmitriptan) nasal spray	D.H.E.45 (dihydroergotamine) INJECTION
sumatriptan		dihydroergotamine injection
zolmitriptan ODT (requires PA and trial of rizatriptan ODT)		ERGOMAR (ergotamine) SL TABLET
		MIGERGOT (ergotamine/caffeine) RECTAL SUPPOSITORY
		MIGRANAL (dihydrergotamine) SPRAY

Edecrin

Prior Authorization Form - Edecrin

Criteria:

- Patient must have sulfa allergy

OR

- Patient must have failed a 30-day trial of all preferred agents, as evidenced by paid claims or pharmacy print outs

Preferred	Non-Preferred
furosemide	ethacrynic acid
bumetanide	
torsemide	

Emflaza

Criteria:

- Patient must be 5 years of age or older
- Patient must have diagnosis of Duchenne muscular dystrophy (DMD) confirmed by the documented presence of abnormal dystrophin or a confirmed mutation of the dystrophin gene

Additional Initial Criteria: Approval 6 months

- Onset of weakness before 5 years of age
- Must be prescribed by or in consultation with a physician who specializes in the treatment of Duchenne Muscular Dystrophy (DMD) and/or neuromuscular disorders
- Serum creatinine kinase activity at least 10 times the upper limit of normal (ULN) prior to initiating treatment
- Inadequate treatment response, intolerance, or contraindication to a 6 month trial of prednisone
- Obtain a baseline motor milestone score from ONE the following assessments:
    i. 6-minute walk test (6MWT)
    ii. North Star Ambulatory Assessment (NSAA)
    iii. Motor Function Measure (MFM)
    iv. Hammersmith Functional Motor Scale (HFMS)
- Patient must have ONE of the following significant intolerable adverse effects supported by documentation:
    i. Cushingoid appearance
    ii. Central (truncal) obesity
    iii. Undesirable weight gain (>10% of body weight gain increase over 6-month period)
    iv. Diabetes and/or hypertension that is difficult to manage
    v. Severe behavioral adverse effect

Additional Renewal Criteria: Approval 1 year

- Patient must have ONE of the following:
    - Improvement in motor milestone score from baseline from ONE the following assessments:
        i. 6MWT – improvement of 20 meters from baseline
        ii. NSAA – improvement of 2 points from baseline
        iii. MFM – improvement of 2 points from baseline
        iv. HFMS – improvement of 2 points from baseline
    - Patient must have had improvement of adverse effects experienced on prednisone supported by documentation:
        i. Cushingoid appearance
        ii. Central (truncal) obesity
        iii. Undesirable weight gain (>10% of body weight gain increase over 6-month period)
        iv. Diabetes and/or hypertension that is difficult to manage
        v. Severe behavioral adverse effect

Eucrisa

Approval: 3 months
Initial Criteria:

- Patient must be 2 years of age of older
- Patient must have a diagnosis of a FDA-approved indication for use of Eucrisa
- Patient must have had a 6-week trial of at least one of the following, as evidenced by paid claims or pharmacy print-outs:
    - Tacrolimus or Pimecrolimus
- One of the following must be met (A or B):
    A. Patient must have had two 2-week trials of topical corticosteroids of medium or higher potency, as evidenced by paid claims or pharmacy print-outs.
    B. Patient must meet both of the following (1 and 2):
        1. Affected area is be on face, groin, axilla, or under occlusion OR patient is under 12 years of age
        2. Patient must have had two 2-week trials of topical corticosteroids of low or higher potency, as evidenced by paid claims or pharmacy print-outs.

Renewal Criteria:

- Documentation from the prescriber must be provided showing that the patient has achieved a significant reduction in severity of atopic dermatitis.

Hemangeol

Prior Authorization Form - Hemangeol

Criteria:

- Patient must have a diagnosis of proliferating infantile hemangioma requiring systemic therapy
- Patient must be between 5 weeks and 1 year of age
- Patient must weigh 2 kg or greater
- Patient must have not have contraindications:
    - Asthma or history of bronchospasm
    - Bradycardia (<80 beats per minute)
    - Greater than first-degree heart block
    - Decompensated heart failure
    - Blood pressure <50/30 mmHg
    - Pheochromocytoma

Hereditary Angioedema

Prior Authorization - Hereditary Angioedema

Criteria:

- Patient must have diagnosis of hereditary angioedema
- Diagnosis must be confirmed by a specialist

Idiopathic Pulmonary Fibrosis

Prior Authorization Form - Idiopathic Pulmonary Fibrosis

Criteria:

- Patient must be 18 years of age or older
- Patient must have documented diagnosis of idiopathic pulmonary fibrosis
- Patient must have a specialist involved in therapy
- Patient must have forced vital capacity (FVC) ≥ 50% of predicted within prior 60 days

Immune Globulins

Prior Authorization Form - Immune Globulins

Criteria for all products:

- If patient's BMI > 30, adjusted body weight must be provided along with the calculated dose
- The indication has been provided
- Patient may qualify for non-preferred product if they are stable on current therapy (have had a paid claim for requested therapy in the past 45 days)

Product specific criteria:

Gammagard S/D:

- Patient must be intolerant to IgA (i.e., treatment of an autoimmune process in a patient with undetectable levels of igA)

Cuvitru, Hizentra, or Hyqvia:

- Patient must be unable to tolerate IV administration
- Patient failed a trial of two of the following:
    - Gamunex-C
    - Gammaked
    - Gammagard

Other Products:

- Patient failed a trial of two of the following:
    - Gammagard
    - Gamunex-C
    - Privigen

Preferred	Non-Preferred

BIVIGAM (human immunoglobulin gamma)	CUVITRU (human immunoglobulin gamma)
CARIMUNE NF (human immunoglobulin gamma)	GAMMAGARD S-D (human immunoglobulin gamma)
FLEBOFAMMA DIF (human immunoglobulin gamma)	HIZENTRA (human immunoglobulin gamma)
GAMANEX-C (human immunoglobulin gamma)	HYQVIA (human immune globulin G and hyaluronidase
GAMASTAN S-D	
GAMMAGARD LIQUID (human immunoglobulin gamma)	
GAMMAKED (human immunoglobulin gamma)	
GAMMAPLEX (human immunoglobulin gamma)	
OCTAGAM (human immunoglobulin gamma)	
PRIVIGEN (human immunoglobulin gamma)	

Interleukin-5 Antagonist

Cinqair

Nucala

Prior Authorization Form - Interleukin-5 Antagonist

Nucala:

- Patient must have one of the following diagnoses and meet criteria for diagnosis:
  - Asthma
  - Eosinophilic granulomatosis with polyangiitis (EGPA)

Cinquair:

- Patient must have diagnosis of asthma and meet criteria for asthma

Asthma Criteria

- Patient must have a diagnosis of asthma
- Patient must be an FDA approved age
- Patient must have had 2 or more exacerbations in the previous year
- Patient must have had 3 fills of a high dose steroid* and a controller medication** in the past 120 days
  - *High Dose Steroid: Beclomethasone 480 mcg, Budesonide DPI 1080 mcg, Budesonide nubles 2mg, Ciclesonide 640 mcg, Flunisolide 640 mcg, Fluticasone MDI 440 mcg, Fluticasone DPI 500 mcg, Mometasone 440 mcg

- **Controller Medication: Theophylline, montelukast, Serevent, Perforomist, Foradil, Arcapta Neohaler, Brovana, Striverdi Respimat, Zafirulkast

❖ Additional Initial Criteria for asthma:
- Patient must have one of the following blood eosinophils counts:
  - ≥ 150 cells/microliter within the last 6 weeks
  - ≥ 300 cells/microliter within the last 12 months

❖ Additional Renewal Criteria for asthma:
- Patient must have had a decreased frequency of exacerbations (worsening of asthma requiring an increase in ICS dose or treatment with systemic corticosteroids)
- Patient's predicted FEV1 increased from pretreatment baseline

Eosinophilic graulomatosis with polyangiitis (EGPA) Criteria

- Patient must have past history of at least one EGPA relapse requiring one of the following within the past 2 years:
  - increase in oral corticosteroids dose
  - initiation or increased dose of immunosuppressive therapy
  - hospitalization

Juxtapid/Kynamro

Prior Authorization Form - Juxtapid/Kynamro

Criteria:

- Patient must have a diagnosis of Homozygous Familial Hypercholesterolemia (HoFH)
- Patient must be 18 years of age or older
- Patient must have LDL levels of >130 mg/dL after a 90-day trial of the following, as evidenced by paid claims or pharmacy print-outs:
  - A lipid lowering agent other than a statin combined with either Crestor (rosuvastatin) ≥20 mg or Lipitor (atorvastatin) ≥ 40 mg
- Patient meets one of the following:
  - genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus
  - an untreated LDL and total cholesterol level of > 500 mg/dl or >300 mg/dl with cutaneous or tendon xanthoma before 10 years of age
  - an untreated LDL level consistent with Heterozygous Familial Hypercholesterolemia (HeFH) in both parents

Kalydeco

Prior Authorization Form - Kalydeco

Criteria:

- Patient must be 2 years of age or older
- Patient must have one of the following mutations in the cystic fibrosis conductance regulator (CFTR) gene: G1244E, G1349D, G178R, G551D, G551S, R117H, S1251N, S1255P, S549N, S549R, A1067T, A455E, D110E, D110H, D1152H, D1270N, D579G, E193K, E56K, F1052V, F1074L, G1069R, K1060T, L206W, P67L, R1070Q, R1070W, R117C, R347H, R352Q, R74W, S945L, S977F, 2789+5G→A, 3272-26A→G, 3849+10kbC→T, 711+3A→G, E831X

Ketek

Prior Authorization Form - Ketek

Approval: 5 days
Criteria:

- Patient must have a diagnosis of community-acquired pneumonia (of mild to moderate severity) due to Streptococcus pneumoniae
- Patient must be 18 years and older
  OR
  Patient must have an allergy to fluoroquinolones or tetracyclines
- Patient must not have myasthenia gravis
- Patient must have tried another antibiotic in the last 3 months

Kuvan

Prior Authorization Form - Kuvan

Approval:
Initial: 2 months
Renewal: 12 months
Criteria:

- Patient must have a diagnosis of hyperphenylalaninemia
- Patient must be 4 years of age or older
- Patient must be following a PHE restricted diet
- Patient must not have been known to have two null mutations in TRANS
- Patient's weight must be provided

Additional Criteria for initial requests:

- Baseline PHE levels must be attached
  - For females of child bearing potential: PHE levels must be above 360 micromoles/liter
  - For males or females unable to bear children: PHE levels must be above 600 micromoles/liter
- Requested initial dose must be 10 mg/kg or less

Additional Criteria for renewal requests:

- If dose is the same or less than previous trial:
  - PHE level must be between 60 and 360 micromoles per liter
- For a dose increase from previous trial:
  - PHE levels must be attached that were taken after 1 month of previous trial
  - Patient's PHE level must be greater than 360 micromoles per liter
  - For increase > 10 mg/kg - patient must have failed a trial of 1 month of 10 mg/kg

Luzu

Prior Authorization Form - Luzu

Approval: 5 days
Criteria:

- Patient must be 18 years of age or older
- Patient must have a diagnosis of interdigital tinea pedistinea cruris, or tinea corporis caused by the organisms *Trichophyton rubrum* and *Epidermophyton floccosum*
- Patient must have failed a 4-week trial of clotrimazole

Preferred	Non-Preferred
Clotrimazole 1% cream	Luzu 1% Cream

Miacalcin:

Prior Authorization Form - Miacalcin/Tymlos

Criteria:

Patient must have one of the following diagnoses and meet additional criteria for their diagnosis:

- Paget's Disease of the bone
  Additional Criteria:
  - Patient must have failed a 6-month trial of a preferred product (a bisphosphonate)
- Postmenopausal Osteoporosis
  Additional Criteria:
  - Patient must be postmenopausal for ≥ 5 years
  - Patient must have failed a 6-month trial of a preferred product (a bisphosphonate)
- Hypercalcemia

Preferred	Non-Preferred
Alendronate	MIACALCIN (calcitonin)
Ibandronate	TYMLOS (abaloparatide)
Risedronate	

Mifeprex

Prior Authorization Form - Mifeprex

Approval: 1 month
Criteria:

- Patient must not be over 70 days in gestation
- One of the following criteria must be met along with additional criteria:
    - Pregnancy must have resulted from an act of rape or incest
      Additional Criteria: One of the following criteria must be met
        - The provider has provided a signed written statement indicating that the rape or act of incest has been reported to the appropriate law enforcement agency, or in the case of a minor who is a victim of incest, to an agency authorized to receive child abuse and neglect reports. The statement must indicate to whom the report was made.
        - The provider has provided written statement signed by the recipient and the provider that the recipient's pregnancy resulted from rape or incest and by professional judgement, the provider agrees with the woman's statement.
    - The woman must suffer from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would as certified by a provider, place the woman in danger of death unless an abortion is performed
      Additional Criteria:
        - The provider must provide a signed written statement indicating why, in the provider's professional judgement, the life of a woman would be endangered if the fetus were carried to term

Naloxone Rescue Medications

Prior Authorization Form - Naloxone Rescue Medications

Initial Criteria:

Narcan Nasal Spray does NOT require prior authorization for the initial dose

Evzio:

- Provider has provided medical justification explaining why the patient cannot use Narcan Nasal Spray or injectable naloxone
- Patient must have one of the following diagnosis and must meet additional criteria for their diagnosis
    - Diagnosis of opioid use disorder:
      Additional Criteria:
        - Patient has been referred to addiction counseling services

- Diagnosis of overdose with opioid pain treatment:
  Additional Criteria:
  - Patient must have chronic pain issue where benefit outweighs risk of continuing treatment
  - Patient must have had paid opioid claim in the last 30 days

Additional Renewal Criteria:

- The provider has answered if it is known that the previous dose was taken by the patient (and not diverted or given to another patient)
- One of the following criteria must be met:
  - The previous dose has expired
  - The dose was used by patient for illicit drug use
  - The patient is currently taking opioids and meets one of the following criteria:
    - The opioid dose must have been decreased
    - The provider has provided medical justification why the opioid dose as not been decreased

Preferred	Non-Preferred
Naloxone injection	EVZIO (naloxone) AUTO-INJECTOR
NARCAN (naloxone) NASAL SPRAY	

Nausea/Vomiting – Chemo Induced

Prior Authorization Form - NK1 Receptor Antagonists

Prior Authorization Form - Sancuso

Approval: 6 months OR until the last day of chemotherapy
Criteria:

- Patient must have diagnosis of nausea and/or vomiting
- Prescriber must be an oncologist
- Patient must be receiving a moderately or highly emetogenic chemotherapy
- The number of cycles of chemotherapy must be indicated
- The final date of chemotherapy treatment must be indicated

SANCUSO (Additional Criteria):

- Patient must have breast, head/neck, gastrointestinal, or gynecological cancer
- The patient must have inability to tolerate oral medications
  OR
- Patient must have failed ondansetron (tablets and ODT) AND oral granisetron (tablets) in the last 30 days as evidenced by paid claims or pharmacy print outs. The granisetron failure must not be due to side effects.

Preferred	Non-Preferred

ANZEMET (dolasetron)	AKYNZEO (netupitant/palonosetron)
aprepitant	SANCUSO (granisetron) PATCH
Granisetron tablet	VARUBI (rolapitant) TABLET
Ondansetron ODT	
Ondansetron solution	
Ondansetron tablet	
palonestron	
ZUPLENZ (ondansetron) FILM	

Nasal Steroids

Prior Authorization Form - Nasal Steroids

Non-Preferred Agent Criteria:

- Patient must have had 30 day trials (within the past 2 years) of fluticasone and one other preferred agent

Preferred	Non-Preferred
BECONASE AQ (beclomethasone)	flunisolide
Fluticasone	mometasone
OMNARIS (ciclesonide)	QNASL CHILDREN'S (beclomethasone)
QNASL (beclomethasone)	XHANCE (fluticasone)
	ZETONNA (ciclesonide)

Noxafil

Prior Authorization Form - Noxafil

Approval: 2 weeks
Criteria:

- Medication indication must be prophylaxis of invasive Aspergillus and Candida infections or Oropharyngeal Candidiasis
- Patient must have documented history of failure to all preferred agents in last 30 days

Preferred	Non-Preferred
itraconazole	NOXAFIL (posaconazole)
fluconazole	

NSAIDS

Prior Authorization Form - NSAIDs

Criteria:

Oral solid dosage forms

Celecoxib:

- Patient must not be taking aspirin at any dose
- Patient must one of the following criteria:
    - Patient must have failed a 30 day trial of two generic oral NSAID as evidenced by paid claims or pharmacy print outs
    - Patient is on warfarin or corticosteroid therapy
    - Patient has a history of gastric or duodenal ulcer or has comorbidities of GI bleed, perforation, or obstruction
    - Patient has a history of endoscopically documented NSAID induced gastritis with GI bleed
    - Patient has arthritis requiring long term high dosage NSAID treatment and meets the following criteria:
        - At high risk for mucosal injury
        - Failed a 30 day trial of meloxicam, as evidenced by paid claims or pharmacy print outs

Mefanemic acid/meclofenamate:

- Patient must have diagnosis of dysmenorrhea
- Patient must have failed a 30 day trial of an oral generic NSAID, as evidenced by paid claims or pharmacy print outs

Other oral generic NSAIDs:

- Patient must have failed a 30 day trial of 3 oral generic NSAID, as evidenced by paid claims or pharmacy print outs

Generic Solid Oral Dosage Forms	
Preferred	Non-Preferred
flurbiprofen	celecoxib
ibuprofen	diclofenac
indomethacin	diclofenac ER
ketorolac	etodolac
meloxicam	etodolac ER
nabumatone	fenoprofen
naproxen	ketoprofen ER
sulindac	meclofenamate
	mefenamic acid
	oxaprozin
	piroxicam
	tolmetin

Oral Solutions

Indomethacin, meloxicam, or naproxen oral solution:

- Patient must be unable to ingest solid dosage form and included swallow study documentation

Oral Combination Products:

Arthotec:

- Patient must be at high risk of developing NSAID included gastric and duodenal ulcers
- Patient must not be pregnant
- Patient must have failed the following 30 day trials, as evidenced by paid claims or pharmacy print outs:
    - meloxicam
    - a generic oral NSAID in addition to a proton pump inhibitor

Duexis:

- The prescriber must provide medical justification explaining why the patient cannot use individual products (famotidine + ibuprofen)

Vimovo:

- The prescriber must provide medical justification explaining why the patient cannot use individual products (naproxen + esomeprazole)

Topical

Solaraze, Xrylix, or Vopac MDC:

- Please see "Analgesics – NSAIDS - Topical" category on PDL http://www.hidesigns.com/ndmedicaid/pdl/ for Criteria

Nasal

Sprix:

- Patient must be 18 years of age or older
- Patient must have a diagnosis of postoperative nausea and vomiting
- Patient must be unable to tolerate oral medications
- Patient must not have a history of gastric or duodenal ulcer or comorbidities of GI bleed, perforation, or obstruction

Nuedexta

Prior Authorization Form - Nuedexta

Approval: for 3 months
Initial Criteria:

- Patient must be 18 years of age or older

- Patient must not have a prolonged QT interval, heart failure, or complete atrioventricular (AV) block
- The following information must be provided:
    - Baseline Center for Neurological Studies lability (CNS-LS)
    - Baseline weekly PBA episode count
- Patient must have diagnosis of pseudobulbar affect (PBA) due to one of the following neurologic conditions and meet additional criteria for diagnosis:
    - Amytrophic Lateral Sclerosis (ALS)
    - Multiple Sclerosis (MS)
    - Alzheimer's Disease
    - Stroke

Additional initial criteria for a diagnosis of PBA due to alzheimer's disease or stroke:

- Neurologic condition must have been stable for at least 3 months
- Patient must have failed** a 3 month trial, as evidenced by paid claims or pharmacy print outs, of one medication from BOTH classes listed:
    - SSRIs: sertraline, fluoxetine, citalopram and paroxetine
    - Tricyclic Antidepressants: nortriptyline and amitriptyline
- A PBA episode count and CNS-LS score must be provided for before and after each trial

**A failure is defined as one of the following::
- ❖ PBA count decreased less than 75 percent, stayed the same, or increased from baseline in each trial
- ❖ CHS-LS score decreased less than 7 points, stayed the same, or increased from baseline in each trial

Renewal Criteria: Approval for 6 months

- Benefit of renewal must be assessed
- Baseline and current PBA episode count must be included with request
- Current PBA episode count must be a 75 percent decrease from baseline

Additional renewal criteria for a diagnosis of PBA due to alzheimer's disease or stroke:

- Baseline and current Center for Neurological Studies lability (CNS-LS) must be included with request
- Current CNS-LS score must be a 30 percent decrease from baseline

Nuvigil

Prior Authorization Form - Nuvigil

Criteria:

- Patient must have FDA approved diagnosis
- Patient must have failed a 30 day trial of modafinil, as evidenced by paid claims or pharmacy print outs

ODT preparations

Prior Authorization Form - ODT Preparations

Criteria:

- Patient must have tried a more cost-effect dosage form in the last 30 days
- Patient must be unable to ingest solid dosage form as evidenced by swallow study documentation

Onychomycosis

Prior Authorization Form - Onychomycosis

Criteria:

- Patient is 18 years of age or older
- Patient has a diagnosis of onychomycosis of the toenail(s) due to *Trichophyton rubrum* or *Tricophyton mentagrophytes*
- Patient must have confirmed diagnosis by one of the following: KOH prep test, fungal culture, or nail biopsy
- Patient has failed a 12 week trial of all of the preferred agents with enough time since treatment cessation to assess healthy toenail outgrown (at least 6 months)

Preferred	Non-Preferred
Itraconazole capsule	JUBLIA (efinaconazole)
Terbinafine	KERYDIN (tavaborole)

Opioid Analgesic – Short Acting

Prior Authorization Form - Short Acting Opioids

Subsys, Fentora, Lazanda, Actiq, and Abstral:

- Patient must be an FDA approved age
- Patient must have cancer pain
- Patient must currently be on around the clock opioid therapy for at least a week, as evidenced by paid claims or pharmacy print-outs

- The around the clock opioid therapy must be equivalent to 60mg oral morphine daily, 25 mcg transdermal fentanyl/hour, 30mg oxycodone daily, 8 mg of oral hydromorphone daily, or equianalgesic dose of another opioid daily

Oxycodone IR:

- The patient must have chronic pain
- The patient must currently be on a long-acting narcotic, as evidenced by paid claims or pharmacy print-outs
- The prescriber must confirm that they have reviewed the North Dakota PDMP reports for the patient
- The Morphine Equivalent Dose (MED) of the requested oxycodone strength must be less than 15% of the total daily Morphine Equivalent Dose (MED) provided by the long acting narcotic as calculated below (Please use an Opioid Dose Calculator to find the MED for specific products):
  - Oxycodone 15mg tablet: long acting narcotic must provide at least 150mg MED per day
  - Oxycodone 20mg tablet: long acting narcotic must provide at least 200mg MED per day
  - Oxycodone 30mg tablet: long acting narcotic must provide at least 300mg MED per day

Oravig

Prior Authorization Form - Oravig

Approval: 1 week
Criteria:

- Patient must have failed a 30 day trial of one of the preferred agents, as evidenced by paid claims or pharmacy print-outs

Preferred	Non-Preferred
Clotrimazole	ORAVIG (miconazole)
Fluconazole	
Itraconazole	
Nystatin	

Medications that cost over $3000/month

Criteria:

- Patient must have FDA approved diagnosis

DUPIXENT (dupilumab)
FASENRA (benralizumab)
INCRELEX (mecasermin)
MAKENA (hydroxyprogesterone caproate)

PCSK9 Inhibitors

Prior Authorization Form - PCSK9 Inhibitors

Criteria:

- Patient must have one of the following diagnosis:
    - Heterozygous familial hypercholesterolemia
    - Clinical atherosclerotic cardiovascular disease
    - *Diagnosis for Repatha only*: Homozygous familial hypercholesterolemia
- Patient must have failed** all of the following 3-month trials:
    - Crestor 20-40mg
    - Atorvastatin 40-80mg
    - A statin combined with another lipid lowering agent

**A failure is defined as an LDL level that remained 130 mg/DL or greater

Additional initial criteria:

- Patient's LDL level must be 130 mg/DL or greater

Promacta

Prior Authorization Form - Promacta

Criteria:

- Patient must have one of the following diagnoses and meet additional criteria for their diagnosis:
    - Chronic immune (idiopathic) thrombocytopenia
      Additional Criteria:
        - Patient must be 6 years old or older
        - Patient must have had insufficient response to corticosteroids, immunoglobulins, or splenectomy
        - Patient must be at increased risk of bleeding due to degree of thrombocytopenia and clinical condition
    - Hepatitis C infection currently treated or to be treated with interferon-based therapy
      Additional Criteria:
        - Degree of thrombocytopenia must prevent initiation or ability to maintain interferon-based therapy
    - Severe Aplastic Anemia
        - Patient must have had an insufficient response to immunosuppressive therapy

Proton Pump Inhibitor

Prior Authorization Form - Proton Pump Inhibitor

Approval: 6 months
Criteria:

Esomeprazole:

- Patient must meet one of the following criteria:
  - Patient has had a 30 day trial of all of the preferred Solid Dosage Forms (lansoprazole, omeprazole, pantoprazole, and rabeprazole) in the past 2 years

Prevacid Solutab:

- Patient must have feeding tube
- Patient must have had a 30 day trial of all Preferred Non-Solid Dosage forms (Nexium Packet and Protonix Packet) in the past 2 years

Prilosec Packet:

- Patient must have feeding tube
- Patient must have had a 30 day trial of all Preferred Non-Solid Dosage forms (Nexium Packet and Protonix Packet) and Prevacid Solutab in the past 2 years

Aciphex Sprinkes:

- Patient must have feeding tube
- Patient must have had a 30 day trial of all of the Preferred Solid Dosage forms(lansoprazole, omeprazole, and pantoprazole), Dexilant, esomeprazole, and rabeprazole in the past 2 years

Esomeprazole strontium/Omeprazole-sodium bicarbonate:

- The prescriber must provide medical justification explaining why the patient cannot use another proton pump inhibitor
-

Solid Dosage Forms	
Preferred	Non-Preferred
lansoprazole	DEXILANT (dexlansoprazole)
omeprazole	esomeprazole
pantoprazole	esomeprazole strontium
rabeprazole	omeprazole-sodium bicarbonate

Non-Solid Dosage Forms	
Preferred	Non-Preferred
NEXIUM (esomeprazole) PACKET	ACIPHEX SPRINKLE (rabeprazole)
PROTONIX (pantoprazole) PACKET	PREVACID SOLUTAB (lansoprazole)
	PRILOSEC PACKET (omeprazole)

Rosacea

Prior Authorization Form - Rosacea

Criteria:

- Patient must be younger than 18 years of age

Additional Non-Preferred Agent Criteria:

- Patient must have failed a 90 day trial of one of the preferred agents

Preferred	Non-Preferred
FINACEA (azelaic acid)	ORACEA (doxycycline)
Topical metronidazole	

Sedatives/Hypnotics

Prior Authorization Form - Sedative/Hypnotics

Approval:

Initial: 1 month

Renewal:

- Benzodiazepines (temazepam, triazolam, flurazepam, estazolam): 2 weeks
- Others: 6 months

Initial Criteria:

Zolpidem 10mg (prior authorization required for females only):

- Patient must have failed a 25 day trial of zolpidem 5mg within the last 30 days, as evidenced by paid claims or pharmacy print outs

Eszopiclone/ Zaleplon:

- Patient must have failed a 25 day trial of zolpidem within the last 30 days, as evidenced by paid claims or pharmacy print outs

Rozerem:

- Patient's insomnia must be characterized by difficulty with sleep initiation
- Patient must have had the following 25 day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy print-outs
    - Mirtazapine OR Trazodone
    - Silenor

Zolpidem ER:

- Patient's insomnia must be characterized by difficulty with sleep maintenance
- Patient must have had the following 25 day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy print-outs

- Eszopiclone
- Silenor
- Zolpidem IR

Intermezzo, Edluar:

- Patient's insomnia must be characterized by difficulty with middle of the night awakening with more than 4 hours left to sleep
- Patient must have had the following 25-day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy print-outs
  - Eszopliclone
  - Silenor
  - Zolpidem IR
  - Zolpidem ER

Temazepam, triazolam, flurazepam, estazolam, Seconal sodium, Belsomra, and Zolpimist:

- Patient must have had the following 25 day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy print-outs
  - Edluar
  - Eszopiclone
  - Silenor
  - Zaleplon
  - Zolpidem IR
  - Zolpidem ER

Renewal Criteria:

- Confirmation that other conditions causing sleep issues have been ruled out must be provided

Additional renewal criteria for benzodiazepines (temazepam, triazolam, flurazepam, estazolam):

- Patient must require dose tapering

Non-scheduled (non-addictive) options	
Preferred	Non-Preferred
mirtazapine	ROZEREM (ramelteon)
SILENOR (doxepin)	
trazodone	

Preferred	Non-Preferred Step 1	Non-Preferred Step 2
zolpidem 5mg	eszopiclone	BELSOMRA (suvorexant)
zolpidem 10mg (for males)	zaleplon	EDLUAR (zolpidem)
	zolpidem 10mg (for females)	flurazepam
		INTERMEZZO (zolpidem)
		SECONAL SODIUM (secobarbital)
		temazepam

		triazolam
		zolpidem CR
		ZOLPIMIST (zolpidem)

Serostim

Prior Authorization Form - Growth Hormone

Criteria:

- Patient must not have an active malignancy
- Patient must have a diagnosis of treatment of HIV with wasting cachexia
- Prescriber must be experienced in the diagnosis and management of HIV infection
- Patient must be on concomitant antiretroviral therapy
- Patient must have failed a 3 month trial with Megace

Additional Renewal Criteria:

- Lean body mass and body weight must have increased in the past 12 weeks
- Physical endurance must have increased in past 12 weeks
- Patient must not have completed 48 weeks of continuous treatments

Skeletal Muscle Relaxants

Carisoprodol

Prior Authorization Form - Carisoprodol

Approval: 1 week
Criteria for non-preferred medication:

- Recipient must be taking carisoprodol on a chronic basis
- Provider must be weaning patient

Metaxalone

Approval: 3 months
Criteria:

- Patient must have had two 30-day trials of other skeletal muscle relaxants, one of which must be methocarbamol, as evidenced by paid claims or pharmacy print-outs.

Preferred	Non-Preferred
orphenadrine	AMRIX (cyclobenzaprine)
baclofen	carisoprodol-aspirin

chlorzoxazone	carisoprodol-aspirin-codeine
cyclobenzaprine	DANTRIUM (dantrolene)
dantrolene	FEXMID (cyclobenzaprine)
methocarbamol	LORZONE (chlorzoxazone)
tizanidine	METAXALL (metaxalone)
	ROBAXIN (methocarbamol)
	SOMA (carisoprodol)
	ZANAFLEX (tizanidine)
	metaxalone

Spiriva Respimat 1.25 mcg

Prior Authorization Form - Spiriva Respimat 1.25 mcg

Criteria:

- Patient must have a diagnosis of asthma
- Patient must have failed a 30-day trial of a steroid inhaler

Statins

Prior Authorization Form - Statins

Criteria:

Livalo:

- Statin intensity treatment goal must be “moderate” or “low”
- Patients must have failed the following 3 month trials based on their intensity treatment goal, as evidenced by paid claims or pharmacy print outs:
    - “Moderate” treatment goal
        - atorvastatin 10-20mg, rosuvastatin 5-10mg, and one of the following:
            - Simvastatin 20 - 40mg a day
            - Pravastatin 40 - 80mg a day
            - Lovastatin 40mg a day
            - Fluvastatin XL 80mg a day
            - Fluvastatin 40mg twice a day
    - “Low” treatment goal
        - Two of the following:
            - Simvastatin 10mg a day
            - Pravastatin 10 - 20mg a day
            - Lovastatin 20mg a day
            - Fluvastatin 20 - 40mg a day

Combination Medications:

- Ezetimibe/simvastatin:

    - Please prescribe individual medication separately or use a different medication combination
- JUVISYNC (sitagliptin/simvastatin)

Preferred	Non-Preferred
atorvastatin	ALTOPREV (lovastatin) ER
fluvastatin	Ezetimibe/simvastatin
lovastatin	fluvastatin ER
pravastatin	JUVISYNC (sitagliptin/simvastatin)
rosuvastatin	LIVALO (pitavastatin)
simvastatin	

Tardive Dyskinesia

Prior Authorization Form - Tardive Dyskinesia

Criteria:

Austedo/tetrabenzine:

- Patient must have one of the following diagnoses:
    - chorea associated with Huntington's disease
    - tardive dyskinesia
- Patient must not be taking reserpine or a monoamine oxidase inhibitor (MAOI)
- Patient must not have hepatic impairment

Ingrezza:

- Patient must have a diagnosis of tardive dyskinesia
- Patient must have failed a 30 day trial of Austedo, as evidenced by paid claims or pharmacy print-outs

Syndros

Prior Authorization Form - Syndros

Criteria:

- Patient must be less than 7 years of age, or unable to ingest solid dosage form as evidenced by swallow study documentation
- Patient must have one of the following diagnoses and meet required trial for their diagnosis:
    - Loss of appetite due to HIV/AIDS:
        - Patient must have tried and failed a 3 month trial with Megace, as evidenced by paid claims or pharmacy printouts
    - Chemotherapy-induced nausea and vomiting:

- Patient must have tried and failed a 3 day trial of ondansetron ODT in combination with aprepitant suspension and a glucocorticoid if, as evidenced by paid claims or pharmacy printouts

Tobacco Cessation

North Dakota Medicaid has joined forces with the Department of Health to provide free, confidential, telephone based cessation coaching to recipients interested in quitting tobacco. Beginning November 15, 2008, in order to receive smoking cessation products (patches, gum, lozenges, bupropion, or Chantix®), Medicaid recipients must be signed up with NDQuits (1-800-QUIT-NOW or 1-800-784-8669). Once a recipient is enrolled in coaching, they will work with their coach to determine which medications they wish to use. The complete process is described below:

1. Patient calls NDQuits and enrolls in coaching.
2. Coaches guide patient through quitting process.
3. Individualized treatment plan developed.
4. If medications are used, the patient will receive an enrollment letter which will include the NDQuit's standing orders for the specific medication(s).
5. The HID Prior Authorization form will be included with the letter
6. The client must contact their physician and obtain the prescription.
7. The patient, physician or pharmacy must fax the Prior Authorization form and enrollment letter to HID.
8. Patient takes prescription to pharmacy.
9. Pharmacy fills prescription and the claim is paid.

Patients will be limited to a 90 consecutive days supply of therapy for patches, gum, lozenges, and bupropion, every two years.

Chantix is limited to the initial 12 weeks of therapy with an additional 12 weeks (24 consecutive weeks) allowed if the patient has continuously quit for a minimum of one month (since day 56 of therapy). The Chantix regimen will be allowed once every two years.

Nicotrol inhaler requires a smoking cessation trial with nicotine gum, lozenges, or nasal spray.

Prior authorizations will be entered based upon the recipient's Quit Date. This means that the approval date range will be sufficient to allow recipients to pick up medications at least one week prior to their Quit Date. Compliance will be an important aspect of the patient's success.

Please contact Health Information Designs, Inc. at (334) 502-3262 or toll free at 1-800-225-6998, with questions regarding the smoking cessation prior authorization process.

Tymlos

Prior Authorization Form - Miacalcin/Tymlos

Criteria:

- Patient must have a history of osteoporotic fractures
- Patient must have multiple risk factors for fracture
- Patient has not been taking Tymlos for ≥ 2 years
- Patient must have failed a 6-month trial of a preferred product (a bisphosphonate)

Preferred	Non-Preferred
Alendronate	MIACALCIN (calcitonin)
Ibandronate	TYMLOS (abaloparatide)
Risedronate	

Uceris Rectal Foam

Criteria:

- Patient has a diagnosis of ulcerative colitis
- Patient must have failed a 1 month trial of one of the preferred agents

Preferred	Non-Preferred
CANASA (mesalamine) RECTAL SUPPOSITORY	Mesalamine enema kit
Mesalamine enema	ROWASA (mesalamine) ENEMA KIT
SF ROWASA (mesalamine) ENEMA	UCERIS (budesonide) RECTAL FOAM

Vanos

Prior Authorization Form - Vanos

Criteria:

- Patient is 12 years of age or older
- Patient must have failed a 3 month trial of one of the preferred agents

Preferred	Non-Preferred
Clobetasol emollient cream	Fluocinonide cream
Clobetasol cream	
Halobetasol cream	

Vecamyl

Prior Authorization Form - Vecamyl

Criteria:

- Patient must have documented history of failure to achieve blood pressure goals (using maximum tolerated doses of all first and second line agents) as defined by the most recent JNC report.

Xifaxan

Prior Authorization Form - Xifaxan

Approval:

Traveler's Diarrhea: 5 days
All other indications: 12 months

Criteria:

Xifaxan 550mg

- Patient must be 18 years old or older
- Patient must have one of the following diagnosis:
  - Recurrence of overt hepatic encephalopathy
  - Irritable bowel syndrome with diarrhea (Please see "Diarrhea – Irritable Bowel Syndrome" category on PDL http://www.hidesigns.com/ndmedicaid/pdl/ for Criteria)

Xifaxan 200mg

- Patient must have a diagnosis of traveler's diarrhea caused by noninvasive strains of E. coli
- Patient must have failed one following trials in the last 30 days based on patient's age:
  - 12 to 17 years of age:
    - Azithrmycin
  - 18 years of age or older
    - Ciprofloxacin
    - Levofloxacin
    - Norfloxacin

Xyrem

Prior Authorization Form - Xyrem

Criteria:

- Patient must be 18 years of age or older
- Patient must be enrolled in the Xyrem REMS program
- Patient must not be taking any sedative hypnotics, opioids, or muscle relaxants
- Patient must have one of the following diagnoses and additional criteria for diagnosis:
  - Cataplexy in Patient's with Narcolepsy
  - Excessive Daytime Sleepiness
    Additional Criteria:
    - Patient must have failed a 2-month trial of modafinil

Zorbtive

Prior Authorization Form - Growth Hormone

Criteria:

- Patient must not have active malignancy
- Patient must have diagnosis of short bowel syndrome
- Patient must be receiving specialized nutritional support
- Treatment must not be longer than 4 weeks

Preferred Dosage Forms List:

Criteria:

- The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review)
- Patient must have FDA indication
- Patient must not have contraindications to requested product
- Patient must have failed a therapeutic course of all preferred agents
    - Trial must have been within the last 2 years
    - Trials must have been at least 30 days in duration unless otherwise indicated
    - A failure is defined as product was not effective at maximum tolerated dose or patient has a documented intolerance or adverse reaction to inactive ingredients where the non-preferred product is expected to have a different result and other alternatives (e.g. medications in same class) are not an option for the patient

Altoprev (lovastatin) ER

Trial: 3 months

Preferred	Non-Preferred
lovastatin	ALTOPREV (lovastatin) ER

Amrix (cyclobenzaprine)

Preferred	Non-Preferred
Cyclobenzaprine	AMRIX (cyclobenzaprine)

Bowel Prep Agents

Trial: 1 complete dose

Preferred	Non-Preferred
GAVILYTE-G	CLENPIQ
GOLYTELY 227.1-21.5	COLYTE

GOLYTELY 236-22.74G	GAVILYTE-C
MOVIPREP	GAVILYTE-N
OSMOPREP	NULYTELY
PEG-3350 AND ELECTROLYTES 236-22.74G	PEG 3350-ELECTROLYTE 240-22.72G
	PEG 3350-ELECTROLYTE 420 G
	PREPOPIK
	SUPREP
	TRILYTE

Brisdelle (paroxetine)

Preferred	Non-Preferred
Paroxetine tablets	BRISDELLE (paroxetine) CAPSULES

Colchicine tablets

Preferred	Non-Preferred
Cholchicine capsules	Cholchicine tablets

DexPak/Zodex (dexamethasone)

Preferred	Non-Preferred
dexamethasone	DexPak (dexamethasone)
	Zodex (dexamethasone)

Doxycycline

Trial: 12 weeks

Preferred	Non-Preferred
doxycycline monohydrate tablet 100 mg	DORYX DR (doxycycline hyclate) 200mg
doxycycline monohydrate tablet 50 mg	DORYX DR (doxycycline hyclate) 50mg
doxycycline monohydrate tablet 75 mg	DORYX MPC (doxycycline hyclate) 120mg
	doxycycline hyclate tablet DR 100 mg
	doxycycline hyclate tablet DR 50 mg
	doxycycline hyclate tablet DR 75 mg
	doxycycline hyclate tablet 100 mg
	doxycycline hyclate tablet 75 mg
Preferred	Non-Preferred
doxycycline monohydrate tablet 75 mg	doxycycline hyclate tablet 150 mg
	doxycycline monohydrate capsule 150mg
	doxycycline monohydrate tablet 150 mg
	doxycyline hyclate tablet DR 150 mg
Preferred	Non-Preferred
doxycycline monohydrate capsule 100 mg	doxycycline capsule IR-DR 40mg
doxycycline monohydrate capsule 50 mg	doxycycline hyclate capsule 100 mg

doxycycline monohydrate capsule 75 mg	doxycycline hyclate capsule 50 mg
	ORACEA (doxycycline monohydrate) 40 mg
	VIBRAMYCIN (doxycycline hyclate)100 mg
Preferred	Non-Preferred
doxycycline monohydrate capsule 100 mg	doxycyline hyclate tablet DR 200 mg
Preferred	Non-Preferred
minocycline	SOLODYN (minocycline) ER
	minocycline ER

Fluvastatin ER

Trial: 3 months

Preferred	Non-Preferred
fluvastatin	fluvastatin ER

Fortamet (metformin)
Glumetza (metformin)

Preferred	Non-Preferred
Metformin ER	FORTAMET (metformin)
	GLUMETZA (metformin)

Gralise (gabapentin)

Preferred	Non-Preferred
gabapentin	GRALISE (gabapentin)

Horizant (gabapentin)

Preferred	Non-Preferred
gabapentin	HORIZANT (gabapentin)
pramipexole	
ropinirole	

Jadenu (deferasirox)

Preferred	Non-Preferred
EXJADE (deferasirox)	JADENU (deferasirox)

Ketoconazole foam

Preferred	Non-Preferred
ketoconazole cream	ketoconazole foam
ketoconazole shampoo	

Kits

Preferred	Non-Preferred

FDA approved products prescribed separately	DERMACINRX ARM PAK (lidocaine/dimethacone)
	DERMACINRX CINLONE-I CPI (triamcinolone/lidocaine/prilocaine)
	DERMACINRX PHN PAK (lidocaine/emollient cmb No. 102)
	DERMACINRX SILAZONE (triamcinolone/silicones)
	ELLZIA PAK (triamcinolone/dimethicone)
	INFAMMACIN (diclofenac/capsicum)
	MIGRANOW (sumatriptan/menthol/camphor)
	MORGIDOX (doxycycline/skin cleanser No. 19)
	PRO DNA MEDICATED COLLECTION (lidocaine/glycerin)
	QUTENZA (capsaicin/skin cleanser)
	SILAZONE-II (triamcinolone/silicones)
	TICANSE (fluticasone/sodium chloride/sodium bicarbonate)
	XRYLIX (diclofenac/kinesiology tape)

Lorzone (chlorzoxazone)

Preferred	Non-Preferred
chlorzoxazone	LORZONE (chlorzoxazone)

methotrexate

Trial: 6 weeks

Preferred	Non-Preferred
methotrexate	OTREXUP (methotrexate)
	RASUVO (methotrexate)
	TREXALL (methotrexate)

Moxatag (amoxicillin)

Amoxacillin IR	MOXATAG (amoxicillin) ER

Narcotic/APAP Criteria

Preferred	Non-Preferred
hydrocodone-acetaminophen	2.5-325 MG
hydrocodone-acetaminophen	7.5-325 MG
hydrocodone-acetaminophen	10MG-300MG
hydrocodone-acetaminophen	5 MG-300MG
hydrocodone-acetaminophen	7.5-300 MG
oxycodone-acetaminophen	2.5-325 MG

oxycodone-acetaminophen	7.5-325 MG
PRIMLEV (oxycodone-acetaminophen)	5 MG-300MG
PRIMLEV (oxycodone-acetaminophen)	7.5-300 MG
PRIMLEV (oxycodone-acetaminophen)	10MG-300MG

Nitroglycerin Spray

Trial: 1 dose while on preventative medication

Preferred	Non-Preferred
Nitroglycerin sublingual tablets	Nitroglycerin Spray

Nuvessa (metronidazole)

Preferred	Non-Preferred
Clindamycin vaginal 2% cream	NUVESSA (metronidazole) 1.3% GEL
Metronidazole 0.75% vaginal gel	

Onmel (itraconazole)

Trial: 12 weeks with 6 month outgrow following treatment for onchomychosis

Preferred	Non-Preferred
Itraconazole capsule	ONMEL (itraconazole) tablet
Terbinafine	

Oxaydo (oxycodone)

Preferred	Non-Preferred
Oxycodone	Oxaydo (oxycodone)

Prednisolone

Preferred	Non-Preferred
Prednisolone sodium phosphate 5mg/5ml, 15mg/ml, 25mg/ml	Prednisolone sodium phosphate ODT
	Prednisolone sodium phosphate 10mg/5ml, 20mg/5ml solution

Procysbi (cysteamine)

Preferred	Non-Preferred
CYSTAGON (cysteamine)	PROCYSBI (cysteamine)

Rayos (prednisone)

Trial: 12 –weeks with 2AM dosing

Preferred	Non-Preferred
prednisone	RAYOS (prednisone)

Ribavirin

Preferred	Non-Preferred
RIBASPHERE (ribavirin)	COPEGUS (ribavirin)
Ribavirin	MODERIBA (ribavirin)
	RIBASPHERE RIBAPAK (ribavirin)

Testosterone – oral

Preferred	Non-Preferred
ANDROGEL (testosterone) PACKET 1%	METHYLTESTOSTERONE
ANDROGEL (testosterone) PACKET 1.62%	METHITEST (methyltestosterone)
ANDRODERM (testosterone)	

Tirosint (levothyroxine)

Preferred	Non-Preferred
levothyroxine	TIROSINT (levothyroxine)

Tizanidine Capsules

Preferred	Non-Preferred
Tizanidine tablets	Tizanidine capsules

Uceris tablet

Preferred	Non-Preferred
Budesonide EC	UCERIS (budesonide)