

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) at <http://www.hidesigns.com/ndmedicaid/pdl/> for PA criteria for medications 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 \(PDSL\)](#)
 - [Concurrent Medications and Step Care](#)
 - [Age Edits](#)
 - [Medical Billing Only](#)
 - [Authorized Generics Preferred](#)
 - [Brand Preferred](#)

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Updates

Interleukin-5 Antagonist – Nucala
NSAIDs

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-Nepriylsin Inhibitor/Angiotensin Receptor Blocker” category on PDL. <http://www.hidesigns.com/ndmedicaid/pdl/>

Criteria for non-preferred products

Olmesartan, olmesartan-hydrochlorothiazide, telmisartan, telmisartan-hydrochlorothiazide:

- Patient must fail a 30 day trial at the highest tolerable therapeutic dose of the following as evidenced by paid claims or pharmacy print outs:
 - Losartan
 - Valsartan

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, Exforge, Exforge Hct, Azor):

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

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

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:	
Patient must fail a 12 week trial of a preferred product before receiving a non-preferred product as evidenced by paid claims or pharmacy print outs. The failure must not be due to side effects.	
ACANYA (clindamycin-benzoyl peroxide) 1.2%-2.5%	clindamycin-benzoyl peroxide 1%-5%
BENZAACLIN (clindamycin/benzoyl peroxide) 1%-5%	
clindamycin-benzyl peroxide 1.2%-5%	
ONEXTON (clindamycin/benzoyl peroxide) 1.2%-3.75%	
TRETINOIN MICROSPHERES:	
Patient must fail a 12 week trial of a preferred product before receiving a non-preferred product as evidenced by paid claims or pharmacy print outs. The failure must not be due to side effects.	
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:	
Tretinoin cream and tretinoin gel 0.025% are brand preferred	
AVITA (tretinoin) CREAM (<i>brand preferred</i>)	
AVITA (tretinoin) GEL 0.03% (<i>brand preferred</i>)	
RETIN-A (tretinoin) CREAM (<i>brand preferred</i>)	
RETIN-A (tretinoin) GEL 0.03% (<i>brand preferred</i>)	
tretinoin 0.01% gel	
tretinoin 0.05% gel	
ADAPALENE:	
Patient must fail a 12 week trial of Adapalene 0.1% before receiving a non-preferred product as evidenced by paid claims or pharmacy print outs. The failure must not be due to side effects.	
adapalene cream	adapalene gel 0.3%
adapalene gel 0.1%	
DIFFERIN (adapalene) GEL W/ PUMP (<i>brand preferred</i>)	
DIFFERIN (adapalene) LOTION	
EPIDUO (adapalene/benzoyl peroxide) 0.1%-2.5% (<i>brand preferred</i>)	
EPIDUO FORTE (adapalene/benzoyl peroxide) 0.3%-2.5%	
OTHER:	
dapsone	
AZELEX (azelaic acid)	
clindamycin-tretinoin 1.2%-0.025%	
sulfacetamide	
TETRACYCLINE:	
Preferred	Non-Preferred
For non-acne diagnosis: patient must fail a 7 day trial of doxycycline or minocycline before receiving a non-preferred product as evidenced by paid claims or pharmacy print outs. The failure must not be due to side effects. Prior Authorization Form - Tetracycline	
For acne diagnosis: patient must fail a 12 week trial of topical metronidazole, clindamycin, minocycline, and doxycycline before receiving a non-preferred product as evidenced by paid claims or pharmacy print outs. The failure must not be due to side effects.	
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	

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)

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	
palonosetron	
ZUPLENZ (ondansetron) FILM	

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}	

Alteplase

[Prior Authorization Form - Alteplase](#)

Criteria:

- Patient must have an FDA approved indication
- Alteplase is indicated for restoration of function to central venous access devices as assessed by the ability to withdraw blood

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:

- Patient must have failed a 30-day trial of the ointment or solutions formulations of the requested product as evidenced by paid claims or pharmacy print outs

Preferred	Non-Preferred
calcipotriene ointment	calcipotriene cream
calcipotriene solution	ENSTILAR (calcipotriene/betamethasone) FOAM

calcipotriene/betamethasone ointment	SORILUX (calcipotriene) FOAM
TACLONEX (calcipotriene/betamethasone) SUSPENSION	

Biltricide

[Prior Authorization Form - Biltricide](#)

Criteria:

- Patient must have one of the following diagnoses:
 - Infection by *Opisthochis viverrini*
 - Chonorchiasis
 - Schistosomiasis
- Patient must not currently be taking any of the following medications as evidenced by paid pharmacy claims
 - Rifampin
 - Phenytoin
 - Fosphenytoin
 - Carbamazepine
 - Dexamethasone

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

Preferred	Non-Preferred
orphenadrine	AMRIX (cyclobenzaprine)
baclofen	carisoprodol-aspirin
chlorzoxazone	carisoprodol-aspirin-codeine
cyclobenzaprine	DANTRIUM (dantrolene)
dantrolene	FEXMID (cyclobenzaprine)
metaxalone	LORZONE (chlorzoxazone)
methocarbamol	METAXALL (metaxalone)
tizanidine	ROBAXIN (methocarbamol)
	SOMA (carisoprodol)
	ZANAFLEX (tizanidine)

Cialis for 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	sildenafil
CARDURA XL (doxazosin)	
doxazosin	
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

[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 has not been studied in women with hyperemesis gravidarum

Preferred	Non-Preferred
meclizine	DICLEGIS (doxyclamine/vitamin B6)
metoclopramide	
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	EDECIN (ethacrynic acid)
bumetanide	ethacrynic acid
toremide	

Elaprase

[Prior Authorization Form - Elaprase](#)

Criteria:

- Patient must have diagnosis of Hunter Syndrome

Fulyzaq

[Prior Authorization Form - Fulyzaq](#)

Criteria:

- Patient must be 18 years of age or older
- Patient must have non-infectious diarrhea
- Patient must have HIV/AIDs and be taking anti-retroviral therapy

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 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

Hetlioz

[Prior Authorization Form - Sedative/Hypnotics](#)

Criteria:

- Patient must have diagnosis of Non-24-Hour Sleep-Wake Disorder (Non-24)
- Patient must be totally blind

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) \geq 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)

Cinqair:

- 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 nubes 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 granulomatosis 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	

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)	ZETONNA (ciclesonide)

Northera

[Prior Authorization Form - Northera](#)

Approval: 1 week

Criteria:

- Patient must have a diagnosis of orthostatic dizziness, lightheadedness, etc.
- Patient must have primary autonomic failure (Parkinson's disease, multiple system atrophy, and pure autonomic failure), dopamine bet-hydroxylase deficiency, and non-diabetic autonomic neuropathy

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
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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

Mefenamic 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	meclofenamate
sulindac	mefenamic acid
	oxaprozin
	piroxicam
	tolmetin

Nuvigil

[Prior Authorization Form - Nuvigil](#)

Criteria:

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

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:
 - Amyotrophic 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

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	

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

Proglycem

[Prior Authorization Form - Proglycem](#)

Criteria:

- Patient must have a diagnosis of hypoglycemia associated with one of the following conditions (based on age)
 - ≥18 years of age
 - Inoperable islet cell adenoma or carcinoma
 - Extrapancreatic malignancy
 - < 18 years of age
 - Extrapancreatic malignancy
 - Islet cell hyperplasia
 - Islet cell adenoma
 - Leucine sensitivity
 - Adenomatosis
 - Nesidioblastosis

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:

Rabeprazole:

- Patient must meet one of the following criteria:
 - Patient is less than 13 years old
 - Patient has a feeding tube that is not a nasogastric tube
 - Patient has a nasogastric tube and has had a 30 day trial of all preferred Non-Solid Dosage Forms (Nexium Packet and Protonix Packet) in the past 2 years
 - Patient has had a 30 day trial of all of the preferred Solid Dosage Forms (lansoprazole, omeprazole, and pantoprazole) 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 Prilosec Packet in the past 2 years

Aciphex Sprinkles:

- 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:

- Patient must NOT have a feeding tube
- Patient must have had a 30 day trial of all of the preferred Solid Dosage Forms (lansoprazole, omeprazole, and pantoprazole) 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
	omeprazole-sodium bicarbonate
	rabeprazole

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

Pulmozyme

[Prior Authorization Form - Pulmozyme](#)

Criteria:

- Patient must have diagnosis of cystic fibrosis

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:

- 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
 - Eszopiclone
 - Silenor
 - Zolpidem IR
 - Zolpidem ER

Temazepam, triazolam, flurazepam, and estazolam:

- 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)
		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

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

Preferred	Non-Preferred
atorvastatin	ALTOPREV (lovastatin) ER
fluvastatin	fluvastatin ER
lovastatin	LIVALO (pitavastatin)
pravastatin	
rosuvastatin	
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	

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:
 - Azithromycin
 - 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

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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	COLYTE
GOLYTELY 227.1-21.5	GAVILYTE-C
GOLYTELY 236-22.74G	GAVILYTE-N
MOVIPREP	NULYTELY
OSMOPREP	PEG 3350-ELECTROLYTE 240-22.72G
PEG-3350 AND ELECTROLYTES 236-22.74G	PEG 3350-ELECTROLYTE 420 G
	PREPOPIK
	SUPREP
	TRILYTE

Brisdelle (paroxetine)

Preferred	Non-Preferred
Paroxetine tablets	BRISDELLE (paroxetine) CAPSULES

Colchicine tablets

Preferred	Non-Preferred
Colchicine capsules	Colchicine 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
	doxycycline 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	doxycycline 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
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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)

Moxatag (amoxicillin)

Amoxicillin 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 onchomycosis

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

Oxaydo (oxycodone)

Preferred	Non-Preferred
Oxycodone	Oxaydo (oxycodone)

Procysbi (cysteamine)

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

Rasuvo/Otrexup (methotrexate)

Trial: 6 weeks

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

Rayos (prednisone)

Trial: 12 –weeks with 2AM dosing

Preferred	Non-Preferred
prednisone	RAYOS (prednisone)

Ribasphere Ribapak (ribavirin)

Copegus (ribavirin)

Moderiba (ribavirin)

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

Tirosint (levothyroxine)

Preferred	Non-Preferred
levothyroxine	TIROSINT (levothyroxine)

Tizanidine Capsules

Preferred	Non-Preferred
Tizanidine tablets	Tizanidine capsules