<table>
<thead>
<tr>
<th>BRAND NAME</th>
<th>GENERIC NAME</th>
<th>CRITERIA</th>
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| ACTONEL         | Risedronate         | 1. Treatment of Osteoporosis. Treatment and prevention of glucocorticoid-induced Osteoporosis.* Prevention of Osteoporosis in postmenopausal women with one or more additional risk factors besides menopause. Treatment of Paget's disease of bone, AND  
   *Documentation of bone mineral density (BMD) is required prior to initiating therapy for prevention of glucocorticoid-induced osteoporosis.  
2. Member has documented ineffectiveness, intolerance, or contraindication to alendronate or ibandronate. Note: If a claim cannot be verified in member's prescription history a copy of the Prescriber’s chart note documenting the intolerance must be submitted for review  
Quantity limited to:  
Actonel 35 mg: 4 tablets per month  
Actonel 75 mg: 2 tablets per month  
Actonel 150 mg: 1 tablet per month |
| TESTOSTERONE REPLACEMENTS |                      |                                                                                                                                                                                                 |
| AXIRON          | Testosterone topical solution |                                                                                                                                                                                                 |
| FORTESTA        | Testosterone topical gel       | 1. For male members18 years or older with a documented diagnosis of primary hypogonadism (congenital or acquired) or secondary hypogonadism (congenital or acquired), and  
2. Clinical documentation (laboratory value) of two (2) early morning (prior to 10am) testosterone lab values that confirm low testosterone (<300ng/dL) within the past 18 months, and  
3. Member does not have prostate carcinoma or breast carcinoma  
Quantity limited to:  
Axiron®: 2 x 90ml pumps per 30 days  
Fortesta®: 2 x 60g canisters per 30 days |
| ALBENZA         | Albendazole          | Diagnosis only: cystic hydatid disease, or neurocysticercosis                                                                                                                                       |
| ANTINEOPLASTIC AGENTS |                      | Must meet FDA-approved indications and prescriber is an Oncologist  
The indicated diagnosis (including any applicable labs and/or tests) and medication usage must be supported by documentation from the member's medical records.  
Authorization and Limitations:  
- If FDA approved indication and prescriber specialty are met, initial authorizations is 3 months.  
- Prescriber must provide documentation of disease progression for consideration of continuation of treatment. If disease progression is not submitted, therapy may not be continued.  
- Quantity is limited to a maximum of a 30-day supply per fill. |
| ARICEPT         | Donepezil            | Treatment of mild, moderate, or severe Alzheimer's disease. For 23mg oral tabs: Members have been on a dosage of donepezil 10 mg once daily for at least 3 months  
Quantity is limited to 1 tablet per day |
| BIOTECHNOLOGY AGENTS | Including: Interferons, ribavirin Growth Hormone (Tev-Tropin) | Prior authorization of these agents may require completion of specific forms which will be automatically faxed to the prescriber under the standard prior authorization procedure. Distribution may be limited to specialty pharmacy at the discretion of Molina.
*Molina Staff: Refer to MCGs |
| BILTRICIDE | Praziquantel | Treatment of infections caused by the following: all species of schistosoma (eg, Schistosoma mekongi, S. japonicum, S. mansoni, S. hematobium) and the liver flukes |
| BYETTA | Exenatide | Diagnosis of type 2 diabetes mellitus and meets one of the following criteria:
1. Hemoglobin A1C is <9 but still not at goal while on metformin in combination with a TZD and/or DPP4,
2. All three classes of medications (metformin, sulfonylureas, and thiazolidinediones) are contraindicated for this patient (e.g., due to drug-drug or drug-disease interactions or because the patient was unable to tolerate treatment).
*Not approved for convenience or if non-compliance with other therapies.
*Not recommended as first-line therapy for patients who have inadeq glycem control on diet and exercise.
*Requests for weight loss are not approvable |
| CARAC | fluorouracil 0.5% cream | Topical treatment of multiple actinic or solar keratoses. Prescribed by dermatologist; members 18 years of age or older. Documented failure, intolerance or contraindication to fluorouracil (Efudex generic) cream. |
| COMBIPATCH | estradiol/norethindrone | 1. Treatment of moderate to severe vasomotor symptoms in menopause, vulvar/vaginal atrophy; treatment of hypoestrogenisms due to hypogonadism, castration, or primary ovarian failure, AND
2. Documented failure to formulary estrogen/progestin combination products (e.g., Prempro or Premphase), OR history of failure to Provera or Intolerance to oral progestin formulation due to GI malabsorption
Quantity limited to: 8 patches per month |
<p>| DAYTRANA *CARVED OUT FOR MEDICAID | Methylphenidate patch | Treatment of ADHD in patients 6 yr and older who are unable to take oral formulations due to specific medical condition. &quot;Unable to swallow&quot; justification must have prior failure to formulations with sprinkle capability (i.e., Metadate CD, Adderall XR) |
| DDAVP Nasal Spray | Desmopressin Acetate 0.01%, nasal spray | Diagnosis of central diabetes insipidus. Ineffective for the treatment of nephrogenic diabetes insipidus. |
| EFUDEX | Fluorouracil Cream (5% strength) | Treatment of superficial basal cell carcinomas when conventional methods are impractical, such as with multiple lesion sites. |
| EXELON PATCH | | Diagnosis of Alzheimers or vascular dementia or Dementia associated with Parkinson's disease or dementia with Lewy bodies (DLB) and a failure to rivastigmine capsules. |</p>
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Generic Name</th>
<th>Description</th>
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</table>
| FORTEO            | Teriparatide (Recombinant) | For the treatment of postmenopausal women with osteoporosis who are at high risk of fracture or men with primary or hypogonadal osteoporosis who are at high risk for fracture and meet the following criteria (a, b and c):  
  a. Have a bone mineral density (BMD) that is 2.5 standard deviations or more below the mean (T-score at or below -2.5).  
  b. Member has tried and failed a bisphosphonate for a 24 month period except when:  
     • contraindication to a bisphosphonate (such as a stricture or achalasia, inability to stand or sit upright for at least 30 minutes and increased risk of aspiration).  
     OR  
     • documented intolerance to a bisphosphonate  
  c. Documentation of trial and failure to alendronate, ibandronate, or risedronate; or documented intolerance to alendronate, ibandronate, or risedronate.  

| Coverage will NOT be provided in the following situations:  
  1. Concurrent treatment with a bisphosphonate  
  2. Hypercalcemia  
  3. Paget's disease  
  4. Bone metastases or a history of skeletal malignancies  
  5. Metabolic bone disease other than osteoporosis  
  6. Pediatric members or young adults with open epiphyses  
  7. Prior radiation therapy involving the skeleton  

  *Forteo may be authorized for a maximum of two years. |
| GEODON*          | Ziprasidone  | Treatment of schizophrenia or bipolar disorder                               |
| INTUNIV          | Guanfacine Extended Release | For the treatment of attention deficit hyperactivity disorder (ADHD) in members 6 to 17 years of age who have met the following conditions:  
  a. Trial and failure or intolerance to immediate-release guanfacine [Guanfacine (generic)]  
  b. Trial and failure or intolerance of at least TWO (2) formulary stimulants OR Documented condition that contraindicates the use of preferred stimulants (i.e. seizure disorders, significant anxiety, oppositional defiant disorder, Tourette's syndrome or other motor tics) OR Documented personal history of substance abuse or misuse  

  *The recommended dose for 6 to 17 years of age is 1-4 mg once daily. Do not authorize doses exceeding the recommended. |
### PHARMACY PRIOR AUTHORIZATION CRITERIA
**MOLINA HEALTHCARE OF UTAH MEDICAID/CHIP**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Purpose and Criteria</th>
</tr>
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</table>
| **LOVENOX**           | Enoxaparin
Prescribed for an FDA-approved indication AND documentation of ONE of the following:  |
|                       |   * Intolerance or contraindication to warfarin and heparin, or                                          |
|                       |   * Need for bridge to Coumadin, or                                                                      |
|                       |   * Knee or hip arthroplasty.                                                                           |
|                       | *May fill ≤ 7 day supply at retail; continued use – Caremark Specialty Pharmacy                        |
| **LUVOX**             | Fluvoxamine Maleate
Documentation of previous trial and therapy failure with the immediate release product of the same chemical entity, unless evidence is provided that use of the immediate release product would be medically contraindicated. |
| **MIACALCIN**         | calcitonin-salmon injection
Postmenopausal Osteoporosis
1. Failure to a bisphosphonate or selective estrogen-receptor modulator (SERM); AND
2. Failure to Miacalcin Nasal Spray; AND
3. History of vertebral compression fractures, or fractures of the hip or distal radius resulting from minimal trauma, or T score of -2.5 or less.
Paget's Disease
History of failure or intolerance to oral bisphosphonates.
Hypercalcemia
1) Corrected total serum calcium of 12 mg/dl; OR 2) Greater or corrected total serum calcium of 6 mEq/L or greater. Approve only 1 month. |
| **MIACALCIN NASAL SPRAY** | calcitonin (salmon) nasal soln 200 unit/act
Treatment of postmenopausal osteoporosis in females greater than 5 years post-menopause with low bone mass. |
| **NAMENDA**           | Memantine
Treatment of moderate to severe dementia of the Alzheimer type.                                          |
| **ONFI**              | Clobazam
Treatment of seizures related to Lennox-Gastaut Syndrome. Prescribed by board-certified neurologist. Recurrent seizures despite trial of 2 or more medications FDA-approved agents for LGS [such as Lamictal (lamotrigine), Topamax (topiramate), Felbatol (felbamate), Banzel (rufinamide), Klonopin, (clonazepam)] |
| **OXYCONTIN**         | Oxycodone CR
Treatment of severe chronic pain with documented failure on other formulary long-acting analgesics; documented evaluation/recommendation by pain management specialist or oncology; Approved only for QD or BID dosing, no PRN use |
| **PROGESTERONE, Intramuscular** | Progesterone Intramuscular Oil, 50 MG/ML
Amenorrhea and abnormal uterine bleeding: For the treatment of amenorrhea and abnormal uterine bleeding caused by hormonal imbalance in the absence of organic pathology, such as submucous fibroids or uterine cancer. |
| **PROTOPIC**          | Tacrolimus
Treatment of short-term and intermittent long-term therapy of mild to moderate atopic dermatitis in patients > 2 years of age; failure of topical steroids. 30g quantity max. |
| **RAPAMUNE**          | Sirolimus
Prophylaxis of organ rejection in patients receiving allogeneic renal transplants. Patient is at least 13 years of age. |
| **RETIN-A MICRO GEL** | Tretinoin Microsphere
Documented medical necessity why generic tretinoin cannot be used |
| **REVLIIMID**         | lenalidomide
Refer to Medical Coverage Guidance MCG-064 |
| **RISPERDAL**         | risperidone tabs
Treatment of psychotic disorders. Prescribed by a psychiatrist. |
| **RISPERDAL CONSTA**  | risperidone microspheres
Members must be 18 years or older, have a diagnosis of Bipolar Disorder or Schizophrenia, AND be under treatment by or in consultation with a psychiatrist. In addition, documentation must be submitted to demonstrate one of the following: the member has |
### PHARMACY PRIOR AUTHORIZATION CRITERIA

**MOLINA HEALTHCARE OF UTAH MEDICAID/CHIP**

<table>
<thead>
<tr>
<th><strong>PRODUCT</strong></th>
<th><strong>DESCRIPTION</strong></th>
<th><strong>CRITERIA</strong></th>
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<tbody>
<tr>
<td><strong>RISPERIDONE M-TAB</strong></td>
<td>risperidone tablet dispersible</td>
<td>Members who are unable to swallow, OR unable to absorb medications through the GI tract.</td>
</tr>
<tr>
<td><strong>SEROQUEL</strong></td>
<td>Quetiapine</td>
<td>Documented diagnosis of Schizophrenia or Bipolar I disorder AND prescribed by a Psychiatrist.</td>
</tr>
<tr>
<td><strong>SEROQUEL XR</strong></td>
<td>Quetiapine Extended Release 24 Hr</td>
<td>1. For members 18 years or older with a diagnosis of Bipolar Disorder, Major Depressive Disorder (MDD) or Schizophrenia <strong>AND</strong> 2. Documentation that the member has had an inadequate response due to intolerance, side effects, or lack of efficacy. to other atypical antipsychotics (including immediate release quetiapine), or other psychotropic medications used to treat the diagnosis.</td>
</tr>
<tr>
<td><strong>SKELID</strong></td>
<td>Documented diagnosis of Paget's disease AND member has tried and failed a generic alendronate or Boniva, or has a contraindication to the use of generic alendronate or Boniva (for which would not be a contraindication to the use of Skelid). Quantity limited to 2 tablets per day.</td>
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</tr>
<tr>
<td><strong>SMOKING CESSATION AGENTS</strong></td>
<td>Nicotine, Nicotrol products, Chantix</td>
<td>For smoking cessation. Treatment course limited to 3 months. Member must be enrolled in smoking cessation program. Limit of one trial every 52 weeks.</td>
</tr>
<tr>
<td><strong>SYNAREL</strong></td>
<td>nafarelin acetate, nasal solution</td>
<td>Diagnosis of central precocious puberty with the onset of secondary sexual characteristics earlier than 8 years of age in females and 9 years of age in males, OR diagnosis of endometriosis for member greater than 18 years of age.</td>
</tr>
<tr>
<td><strong>STIMATE</strong></td>
<td>Desmopressin Acetate 1.5mg/mL, nasal spray</td>
<td>Diagnosis of hemophilia A with factor VIII coagulant activity levels more than 5% <strong>OR</strong> diagnosis of mild-to-moderate classic von Willebrand's disease (Type I)* with Factor VIII levels &gt; 5% and evidence of an abnormal molecular form of Factor VII antigen *Stimate should not be used in the treatment with Type IIB von Willebrand's disease.</td>
</tr>
<tr>
<td><strong>STRIBILD</strong></td>
<td>cobicistat, elvitegravir, emtricitabine and tenofovir</td>
<td>Prescribed for the treatment of HIV-1 infection in adults who are antiretroviral treatment-naïve (documentation that member has never been on any antiretroviral treatment required). Medical justification must be provided demonstrating why Atripla can not be used instead. Member is age 18 to 65. Prescriber specialty is infectious disease.</td>
</tr>
<tr>
<td><strong>STROMECTOL</strong></td>
<td>ivermectin</td>
<td>Documented diagnosis of strongyloidiasis of the intestinal tract, onchocerciasis, or resistant head and body lice.</td>
</tr>
<tr>
<td><strong>SUBOXONE</strong></td>
<td>buprenorphine HCl-naloxone HCl Dihydrate</td>
<td>Refer to Medical Coverage Guidance MCG-072 for Suboxone criteria.</td>
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<tr>
<td><strong>PHARMACY PRIOR AUTHORIZATION CRITERIA</strong></td>
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<tr>
<td><strong>MOLINA HEALTHCARE OF UTAH MEDICAID/CHIP</strong></td>
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<tr>
<th>Tazorac Gel</th>
<th>tazarotene</th>
<th>Treatment of stable plaque psoriasis. Treatment of cystic acne, prescribed by dermatologist (0.1% only).</th>
</tr>
</thead>
</table>
| Tofranil-PM* | imipramine pamoate | Member has had an intolerance to, or treatment failure of imipramine tablets (Tofranil tablets). A claim in the member’s prescription history for imipramine (Tofranil) or documentation from Prescriber’s chart note indicating the intolerance must be submitted for review.  

*Per the Beers list, imipramine is highly anticholinergic, sedating, and can cause orthostatic hypotension. Avoid use in elderly patients [American Geriatrics Society 2012 Beers Criteria Update Expert Panel]* |
| Topamax sprinkle cap, tabs | topiramate | Treatment of seizures, with therapy initiated by neurology; not approved for psychiatric use.  
or  
The use of topiramate in the acute treatment of migraine headache has not been studied.  
*CARVED OUT FOR MEDICAID* |
| Valcyte | Valganciclovir (450mg tablets only) | Prescribed for one of the following indications:  
1. Prevention of CMV disease in kidney, heart, or kidney-pancreas transplant patients at high risk (Donor CMV seropositive/Recipient CMV seronegative [D+/R−]).  
| Xolox | oxycodone w/ acetaminophen | Treatment of moderate to severe pain when generic Percocet is not an option.  
*CARVED OUT FOR MEDICAID* |
| Zetia | Ezetimibe | For Zetia as monotherapy: member has documented intolerance or contraindication to statin therapy, nicotinic acid, fibrates and bile acid sequestrants.  
For Zetia as combination therapy with statins: Trial and failure of simvastatin 40mg or the maximum dose tolerated of simvastatin or of a comparably dosed statin agent (or a documented adverse reaction, intolerance or contraindication to simvastatin or statin agent), or a combination agent containing simvastatin or statin agent for at least 3 months.  
Documentation of lipid panel within previous 60 days indicating member is not within target LDL goal range according to ATP-III guidelines must be submitted. |
| Zocor 80mg | Simvastatin 80mg | Documentation that member has been on a product containing simvastatin 80 mg for 12 months or more without evidence of muscle toxicity or myopathy.* Coverage will not be authorized for titration to or a new start of an 80 mg daily equivalent of simvastatin.  

*The FDA recommends that simvastatin 80 mg should only be used in patients who have been taking this dose for 12 months or more without evidence of muscle injury (myopathy).
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<tr>
<th>Medication</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>ZYPREXA</strong></td>
<td>Olanzapine</td>
<td>Treatment of Psychotic Disorders and Bipolar Mania; Prescribed by Psychiatrist.</td>
</tr>
<tr>
<td>*CARVED OUT FOR MEDICAID</td>
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</tr>
<tr>
<td><strong>ZYPREXA RELPREVV</strong></td>
<td>Olanzapine Pamoate (suspension/IM)</td>
<td>Member must be 18 years or older, have a diagnosis of Psychotic Disorders and Bipolar Mania; Prescribed by a psychiatrist AND documentation of one of the following: 1) member has already been started and stabilized on this medication, 2) member has a history of non-compliance, or 3) member is unable to swallow oral dosage forms.</td>
</tr>
<tr>
<td>*CARVED OUT FOR MEDICAID</td>
<td></td>
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</tr>
<tr>
<td><strong>ZYPREXA ZYDIS</strong></td>
<td>Olanzapine Tablet Dispersible</td>
<td>For 18 years or older: Prescribed for the adjunctive treatment for Major Depressive Disorder For 13 years or older: Treatment of schizophrenia or bipolar disorder AND Documentation of swallowing difficulty submitted.</td>
</tr>
<tr>
<td>*CARVED OUT FOR MEDICAID</td>
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These guidelines for prior approval are for reference, only. They do not replace the professional judgment of the prescribing physician and do not necessarily apply to all patient-specific situations. All requests are looked at on a case by case basis.

Use of pharmaceutical samples in lieu of Formulary first-line agents does not guarantee authorization.

To request a copy of a prior authorization request form, or to request full-length criteria for a medication listed above (if applicable), call (888) 483-0760.

*Updated 12/2012*