PHARMACY PRIOR AUTHORIZATION CRITERIA
MOLINA HEALTHCARE OF UTAH MEDICAID/CHIP/MARKETPLACE

BRAND NAME	GENERIC NAME	CRITERIA
AGGRENOX	Aspirin/Dipyridamole	Prior history of transient ischemia attack or ischemic stroke and has trial and failure to clopidogrel AND aspirin.
ALBENZA	Albendazole	Diagnosis of enterobiasis (pinworm infection) AND has trial and failure to Pin-X or Reese's (pyrantel pamoate)
ALDARA	Imiquimod	Diagnosis of superficial basal cell carcinoma, external genital or perianal warts, or actinic keratosis
ALLEGRA	Fexofenadine (30 and 60 mg)	Failure on loratadine and cetirizine (*can let provider know 180 mg tablets are covered without PA*)
ALTABAX **MARKETPLACE ONLY*	Retapamulin	Failure on cephalexin
AMICAR **MARKETPLACE ONLY*	Aminocaproic Acid	Prescribed for the treatment of hemorrhage or for surgical bleeding prophylaxis. If for bleeding prophylaxis, must have trial and failure to oral tranexamic acid.
AMITIZA **MARKETPLACE ONLY*	Lubiprostone	Diagnosis of chronic idiopathic constipation or irritable bowel syndrome with constipation AND member has failed a trial of 2 preferred laxatives (eg, bisacodyl, lactulose) OR Miralax OR request is for continuation of treatment after an initial 12 weeks of therapy.
AMPYRA	Dalfampridine	Refer to Medical Clinical Policy MCP-082
ANCEF *MARKETPLACE ONLY	Cefazolin	Prescribed for an FDA-approved indication
ANTINEOPLASTIC AGENTS GLEEVEC SPRYCEL TYKERB NEXAVAR SUTENT	 Imatinib Dasatinib Lapatinib Ditosylate sorafenib Sunitinib	Must meet an FDA-approved indication and prescriber must be 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 authorization 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.
ARIXTRA	Fondaparinux	Diagnosis of DVT or PE and trial and failure of or intolerance to heparin or LMWH OR Used for prophylaxis after orthopedic or abdominal surgery and trial and failure of or intolerance to heparin or LMWH OR Diagnosis of heparin-induced thrombocytopenia (HIT) and trial and failure of or intolerance to enoxaparin.

ATYPICAL ANTIPSYCHOTICS **CARVED OUT FOR MEDICAID* ABILIFY FANAPT INVEGA LATUDA SAPHRIS SEROQUEL 25 mg SEROQUEL XR	 Aripiprazole Aripiprazole Iloperidone Paliperidone Paliperidone Palmitate Lurasidone Asenapine Quetiapine 25 mg Quetiapine XR Risperidone injection	Prescribed for an FDA approved indication OR an indication supported in the compendia of current literature AND: 1. If for Abilify, must be unable to take at least 2 generic atypical antipsychotics due to inadequate treatment response, intolerance, or contraindication [tech note: risperidone, quetiapine, and clozapine are the formulary agents. The preferred next steps agents are olanzapine and ziprasidone] If for depression, must have trial and failure of 2 antidepressants and quetiapine. OR 2. For other agents, must be unable to take generic risperidone AND quetiapine due to inadequate treatment response, intolerance, or contraindication. OR 3. Patient has a clinical condition for which there is no generic alternative or the listed generic alternatives are not recommended based on guidelines OR 4. Patient requires use of a specific dosage form that is not available in the general alternatives (eg, suspension, solution, injection). If for quetiapine 25 mg, must be prescribed for an FDA approved indication
ATYPICAL ANTIPSYCHOTICS (LONG-ACTING) ABILIFY MAINTENA ARISTADA INVEGA SUSTENNA INVEGA TRINZA RISPERDAL CONSTA ZYPREXA RELPREVV	 Aripiprazole Aripiprazole Paliperidone Paliperidone Risperidone Olanzapine	History of in-patient hospitalization; history of non-compliance with antipsychotic medication per the prescribing psychiatrist; and request meets the specific product initiation and maintenance requirements in the labeling (eg, dosing, age, etc); OR documentation that member is currently stable on medication or is being discharged from a facility on this medication.
AVONEX	Interferon beta-1a	Refer to Medical Clinical Policy MCP-152
AZELASTINE	Azelastine	Failure on ketotifen
BACTROBAN NASAL	Mupirocin Nasal	Documented diagnosis of nasal bacterial colonization of methicillin-resistant *Staphylococcus aureus* (MRSA) AND lives or works among high-risk patients during an institutional (eg, hospital, nursing home, etc.) outbreak of infections with this bacteria
BANZEL	Rufinamide	Prescribed for adjunctive treatment of seizures associated with Lennox-Gastaut syndrome and does NOT have a diagnosis of Familial Short QT Syndrome OR documentation that member is currently stable on this medication.
BIAXIN	Clarithromycin ER	Failure on clarithromycin IR, erythromycin, and azithromycin
BUTRANS **MARKETPLACE ONLY*	Buprenorphine	Trial and failure of fentanyl (requires prior authorization), morphine sulfate ER, methadone, Nucynta ER (requires prior authorization), and oxymorphone ER (requires prior authorization)
BYETTA	Exenatide	Diagnosis of type 2 diabetes with a hemoglobin A1c that is between 7 and 8.5 percent AND an inadequate treatment response, contraindication or intolerance to all of the following: metformin 1000 mg twice daily, a sulfonylurea, DPP-IV inhibitor (eg, alogliptin), AND an SGLT2 inhibitor (eg, Jardiance).

		OR Patient has been receiving GLP-1 agonist therapy for at least 3 months with an expected reduction in HbA1c since starting GLP-1 agonist therapy
CAMPRAL	Acamprosate	Diagnosis of ethanol dependence and trial and failure to disulfiram.
CARAFATE	Sucralfate suspension	Treatment failure or intolerance to an H2 blocker (eg, ranitidine, famotidine) or preferred PPI (eg, omeprazole, pantoprazole) AND unable to swallow sucralfate tablets due to a medical condition
CEFOTAN *MARKETPLACE ONLY	Cefotetan	Prescribed for an FDA-approved indication
CELEBREX	Celecoxib	Prescribed for an FDA-approved indication and documented trial and failure of two formulary NSAIDs (eg, diclofenac, meloxicam, etodolac or nabumetone) or have a contraindication to NSAIDs (ie, post-operative pain following CABG surgery or active GI bleeding or taking any anticoagulant)
CHANTIX	Varenicline	Failure with a trial of a nicotine replacement product (eg, Nicotine Patch, Nicotine Gum) AND bupropion (Zyban) AND currently participating in a behavioral tobacco cessation program
CLAFORAN **MARKETPLACE ONLY*	Cefotaxime	Prescribed for an FDA-approved indication
COPAXONE	Glatiramer	Refer to Molina Clinical Policy MCP-149

CUVPOSA	Glycopyrrolate	Diagnosis of a condition associated with severe drooling, age greater than or equal to 3 years, AND trial and failure of glycopyrrolate tablets
CYMBALTA **CARVED OUT FOR MEDICAID*	Duloxetine	Prescribed for depression and trial and failure or intolerance to an adequate trial of TWO formulary antidepressants including venlafaxine. OR Prescribed for diabetic neuropathy and trial and failure of or intolerance to an adequate trial of venlafaxine AND a therapeutic dose of 1200 to 2400 mg per day of gabapentin. OR Prescribed for fibromyalgia and trial and failure of a TCA, muscle relaxant, venlafaxine, AND an adequate trial of a therapeutic dose of 1200 to 2400 mg per day of gabapentin. OR Prescribed for generalized anxiety disorder and trial and failure of or intolerance to an adequate trial of TWO formulary antidepressants including buspirone. OR Prescribed for musculoskeletal pain and trial and failure of at least one formulary muscle relaxant AND at least one formulary NSAID medication. OR Prescribed for osteoarthritis and trial and failure of at least TWO formulary NSAID medications.
DEXEDRINE SPANSULE	Dextroamphetamine ER	Trial and failure on dextroamphetamine IR
DDAVP Nasal Spray	Desmopressin Acetate 0.01%, nasal spray	Diagnosis of central diabetes insipidus. *(Ineffective for the treatment of nephrogenic diabetes insipidus).*
DOVONEX	Calcipotriene	Trial and failure on two different formulary corticosteroid products AND prescribed by a dermatologist
DURAGESIC PATCHES	Fentanyl patches	Diagnosis of severe chronic pain and documented failure of or experienced intolerance to morphine sulfate ER.
EFFIENT **MARKETPLACE ONLY*	Prasugrel	Trial and failure on clopidogrel
ELESTAT	Epinastine	Failure on ketotifen
ELIDEL	Pimecrolimus	Treatment of short-term and intermittent long-term therapy of mild to moderate atopic dermatitis in patients > 2 years of age or for psoriasis; failure of generic tacrolimus; failure of one medium or high potency topical steroid or being used on face, body skin folds, genital area, armpit. *30 g quantity max.*

ENBREL	Etanercept	Refer to Molina Clinical Policy MCP-026, -109, -164
ENDOCET 2.5 mg/325 mg **MARKETPLACE ONLY*	Oxycodone/ acetaminophen	Trial and failure on 1 preferred short-acting pain medication (eg, hydrocodone/acetaminophen, morphine sulfate IR)
ENTOCORT EC **MARKETPLACE ONLY*	Budesonide	Prescribed for treatment of active disease (induction therapy) and trial and failure on prednisone Prescribed for maintenance treatment of remission and with trial and failure on sulfasalazine, Apriso, Asacol and methotrexate
EXELON PATCH		Diagnosis of Alzheimer or vascular dementia or Dementia associated with Parkinson disease or dementia with Lewy bodies and a failure to rivastigmine capsules (or unable to take oral rivastigmine due to a Molina condition) AND donepezil or galantamine.
EXTAVIA	Interferon beta-1b	Refer to Molina Clinical Policy MCP-152
EVOXAC **MARKETPLACE ONLY*	Cevimeline	Prescribed for the treatment of xerostomia (dry mouth) associated with Sjogren's Syndrome AND documented trial and failure on pilocarpine.
FIRST-OMEPRAZOLE SUSPENSION **MARKETPLACE ONLY*	Omeprazole	Prescribed for an FDA-approved indication, documentation of inability to swallow oral dosage forms AND trial and failure with ranitidine syrup.

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 For the treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture. Member must meet ALL of the following criteria: a. Member has osteoporosis associated with chronic systemic glucocorticoid therapy (daily dosage equivalent to 5 mg or greater of prednisone) b. Member has "high risk for fracture" defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy. c. Documentation of trial and failure to alendronate, ibandronate, or risedronate; or documented intolerance to alendronate, ibandronate, or risedronate c. 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.*

FRAGMIN	Dalteparin	Member has a documented intolerance or contraindication to an FDA-approved dosing regimen of enoxaparin AND Prescribed for 1 of the following diagnoses: 1. Treatment of DVT 2. History of DVT or PE 3. Prophylaxis for hip replacement or abdominal surgery 4. Immobility secondary to acute illness 5. Diagnosis of unstable angina 6. Non-Q wave myocardial infarction 7. Extended duration (30 days to 6 months) of DVT prophylaxis is required for a member with cancer AND Member's creatinine clearance is greater than 30 mL per minute OR documentation that the member will receive anti-Xa monitoring AND anti-Xa levels are required after 3-4 doses have been given with plan for any dosage change
GABATRIL **MARKETPLACE ONLY*	Tiagabine	Diagnosis of adjunctive therapy in the treatment of partial seizures, age greater than or equal to 12 years, AND documented treatment failure, contraindication or intolerance to at least 2 of the preferred alternatives (eg, carbamazepine, divalproex sodium, gabapentin, levetiracetam, oxcarbazepine or valproic acid)
HARVONI	Sofosbuvir/Ledipasvir	Refer to Molina Clinical Policy MCP-220
HUMIRA	Adalimumab	Refer to Molina Clinical Policy MCP-026, -165, -212, -239
INSULIN PENS	INSULIN PENS	Under 19 years of age or unable to use vials due to physical disability or vision problems.
INVOKAMET **MARKETPLACE ONLY*	Canagliflozin/metformin	Trial and failure on Xigduo (requires step therapy to metformin)
INVOKANA **MARKETPLACE ONLY*	Canagliflozin	Trial and failure on Farxiga and Jardiance (both require step therapy to metformin)
ISOTRETINOIN AMNESTEEM CLARAVIS SOTRET	Isotretinoin	Treatment of severe (ie, many nodules) recalcitrant nodular acne AND member experienced inadequate treatment responses to any topical acne product AND an oral antibiotic
KOMBIGLYZE **MARKETPLACE ONLY*	Saxagliptin/metformin	Trial and failure on 2 of the following preferred agents: alogliptin/metformin, Janumet XR, and Jentadueto (all require step therapy to metformin)
LIDODERM	Lidocaine 5% Patch	Prescribed for Post-Herpetic Neuralgia (shingles pain) and documentation of a one month trial of maximum tolerated dose of gabapentin OR has a contraindication to gabapentin
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, or • DVT prophylaxis in patient with cancer *May fill ≤ 7 day supply at retail; continued use – Caremark Specialty Pharmacy
LUPRON DEPOT LUPRON DEPOT-	Leuprolide	Endometriosis: 8. Diagnosis of endometriosis AND 9. Request is for initial treatment of endometriosis OR

PED		10. Request is for endometriosis retreatment AND a. Previous treatment course is <6 months AND b. Member has recurrence of symptoms AND c. Member is receiving add-back therapy (eg, norethindrone) AND d. Bone mineral density (BMD) is within normal limits. <u>Uterine Fibroids</u>: 1. Lupron Depot will be used in the preoperative setting to facilitate surgery OR 2. Member has a diagnosis of anemia (ie, hematocrit ≤ 30% and/or hemoglobin ≤ 10 g/dL) AND Lupron Depot will be used in conjunction with iron therapy OR 3. Request is for uterine fibroids retreatment and member previously received less than a 3-month retreatment course of therapy AND bone mineral density (BMD) is within normal limits. <u>Ovarian Stromal Tumor(s)</u> Diagnosis of ovarian stromal tumor(s) <u>Epithelial, Ovarian, or Primary Peritoneal Cancer:</u> 1. Member has persistent or recurrent disease AND 2. Lupron Depot will be used as a single agent (monotherapy) <u>Breast Cancer:</u> 1. Member is pre-menopausal AND has hormone-receptor positive disease <u>Prostate Cancer:</u> *Refer to leuprolide-Lupron Depot Molina Universal CAS criteria* <u>Used for a child with growth failure and advancing puberty:</u> 1. Request is for leuprolide acetate injection (NOT depot) and will be used in combination with growth hormone. <u>Central Precocious Puberty:</u> *Refer to leuprolide-Lupron Depot Molina Universal CAS criteria*
LYRICA **CARVED OUT FOR MEDICAID*	Pregabalin	Prescribed for an FDA-approved indication and trial and failure on gabapentin
MARINOL **MARKETPLACE ONLY*	Dronabinol, THC	Prescribed for chemotherapy-induced nausea and vomiting AND failure on at least 2 formulary anti-emetic medications including ondansetron.
MECLOFENAMATE **MARKETPLACE ONLY*	Meclofenamate	Trial and failure on 3 unrestricted NSAIDs not requiring prior authorization.
MEFOXIN **MARKETPLACE ONLY*	Cefoxitin	Prescribed for an FDA-approved indication
MEPRON	Atovaquone	Prescribed for prophylaxis or treatment of an acute *Pneumocystis jiroveci* pneumonia AND trial and failure with sulfamethoxazole and trimethoprim

MIACALCIN (INJECTION)	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.
MORPHINE SULFATE SOLUTION	Morphine sulfate	Diagnosis of moderate to severe pain and documentation of inability to swallow or metabolize oral dosage forms.
8-MOP **MARKETPLACE ONLY*	Methoxsalen	Severe, recalcitrant, disabling psoriasis that is not adequately responsive to other forms of therapy and is diagnosed by biopsy [used in conjunction with phototherapy] OR For treatment of cutaneous T-cell lymphoma (CTCL)
NIMOTOP **MARKETPLACE ONLY*	Nimodipine	Prescribed for subarachnoid hemorrhage
NSAIDS DAYPRO FELDENE	 Oxaprozin Piroxicam	Trial and failure on 3 unrestricted NSAIDs not requiring prior authorization.
NUCYNTA **MARKETPLACE ONLY*	Tapentadol	Documentation of trial and failure of morphine sulfate, hydrocodone/acetaminophen, and oxycodone/acetaminophen
NUCYNTA ER **MARKETPLACE ONLY*	Tapentadol ER	Diagnosis of chronic pain AND documentation of trial and failure on morphine sulfate and methadone
NUVIGIL	Armodafanil	Diagnosis of narcolepsy or obstructive sleep apnea (OSA) confirmed by sleep lab evaluation. If for OSA, must show use of continuous positive airway pressure (CPAP) machine. OR Diagnosis of shift work sleep disorder with supporting documentation showing variable work schedule.
OMNITROPE	Somatropin	Refer to Molina Clinical Policy MCP-004
ONGLYZA **MARKETPLACE ONLY*	Saxagliptin	Trial and failure on 2 of the following preferred agents: alogliptin, Januvia, and Tradjenta (all require step therapy to metformin).

ONFI **CARVED OUT FOR MEDICAID*	Clobazam	Diagnosis of Lennox-Gastaut Syndrome AND age greater than or equal to 2 years
OPANA **MARKETPLACE ONLY*	Oxymorphone	Documentation of trial and failure of morphine sulfate, hydrocodone/acetaminophen, and oxycodone/acetaminophen
OPANA ER **MARKETPLACE ONLY*	Oxymorphone ER	Diagnosis of chronic pain AND documentation of trial and failure on morphine sulfate ER and methadone
POTIGA **MARKETPLACE ONLY*	Ezogabine	Diagnosis of partial onset seizures, prescribed by a neurologist or in consultation with a neurologist, and failure with at least 2 of the following preferred medications: gabapentin, lamotrigine, levetiracetam, topiramate, oxcarbazepine, zonisamide OR request is for continuation of therapy.
PREVACID **MARKETPLACE ONLY*	Lansoprazole	Prescribed for an FDA-approved indication AND documentation of trial and failure on omeprazole or pantoprazole.
PROTOPIC	Tacrolimus	Treatment of short-term and intermittent long-term therapy of mild to moderate atopic dermatitis in patients > 2 years of age or for psoriasis; failure of one medium or high potency topical steroids or being used on face, body skin folds, genital area, armpit. *30g quantity max.*
PROVIGIL	Modafinil	Diagnosis of narcolepsy or obstructive sleep apnea (OSA) confirmed by sleep lab evaluation. If for OSA, must show use of continuous positive airway pressure (CPAP) machine. OR Diagnosis of shift work sleep disorder with supporting documentation showing variable work schedule.
REVLIMID	lenalidomide	Refer to Molina Clinical Policy MCP-064
REBETOL	Ribavirin	Refer to Molina Clinical Policy MCP-096
REMODULIN	Treprostinil	Refer to Molina Clinical Policy MCP-200
REVATIO	Sildenafil	Refer to Molina Clinical Policy MCP-197
RILUTEK **MARKETPLACE ONLY*	Riluzole	Diagnosis of amyotrophic lateral sclerosis (ALS) confirmed by or in consultation with a neurologist AND documentation of baseline CBC and LFT labs.
SENSIPAR **MARKETPLACE ONLY*	Cinacalcet	Diagnosis of primary hyperparathyroidism AND serum calcium level ≥ 8.4 mg/dL OR Diagnosis of secondary hyperparathyroidism with chronic kidney disease (CKD) AND trial and failure to all preferred phosphate binders (eg, calcium carbonate and calcium acetate) [Tech note: if currently on Sensipar therapy, treatment should be withheld until corrected serum calcium levels reach 8 mg/dL] OR Diagnosis of tertiary hyperparathyroidism post-kidney transplant AND serum calcium level ≥ 8.4 mg/dL OR Diagnosis of parathyroid carcinoma

SKELAXIN **MARKETPLACE ONLY*	Metaxalone	Trial and failure on 2 formulary alternatives (eg, baclofen, carisoprodol, cyclobenzaprine, chlorzoxazone, methocarbamol, orphenadrine ER, tizanidine)
SORIATANE **MARKETPLACE ONLY*	Acitretin	Prescribed for psoriasis and trial and failure on topical calcipotriene (requires prior authorization) and either methotrexate or cyclosporine.
SOVALDI	Sofosbuvir	Refer to Molina Clinical Policy MCP-220
SPECTAZOLE **MARKETPLACE ONLY*	Econazole cream	Trial and failure of clotrimazole, miconazole, or ketoconazole
SPECTRACEF **MARKPLACE ONLY*	Cefditoren	Prescribed for an FDA-approved indication
STIMATE **CARVED OUT FOR MEDICAID*	Desmopressin Acetate 1.5 mg/mL, nasal spray	Diagnosis of hemophilia A OR diagnosis of mild-to-moderate classic von Willebrand's disease (Type I) **Stimate should not be used in the treatment with Type IIB von Willebrand's disease,*
SUBOXONE **CARVED OUT FOR MEDICAID*	buprenorphine-naloxone	Refer to Molina Clinical Policy MCP-072 for Suboxone criteria.
SULAR **MARKPLACE ONLY*	nisoldipine	Trial and failure of nifedipine, isradipine, or felodipine
SYMLIN **MARKPLACE ONLY*	pramlintide	Diagnosis of type I or type II diabetes; prescribed by a diabetes specialist or endocrinologist; hemoglobin A1c that is greater than 7 but less than 9 percent; AND documentation of post-prandial blood sugar spikes.
SYNAREL	Nafarelin acetate	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 members greater than 18 years of age

TOBI	Tobramycin	Diagnosis of cystic fibrosis, age greater than or equal to 6 years, and sputum cultures positive for *Pseudomonas aeruginosa* *Note: Coverage for generic tobramycin nebulizer solution product only (not Bethkis or Tobi Podhaler)*
TRACLEER	bosentan	Refer to Molina Clinical Policy MCP-199
TRANSDERM SCOP	Scopolamine Patch	For prevention of nausea and vomiting due to motion sickness: 1. Trial and failure on meclizine OR dimenhydrinate OR 2. Patient is unable to swallow tablets due to medical condition or their age. For drooling or sialorrhea (excess salivation): 1. Trial and failure of, intolerance or contraindication to TWO of the following agents: glycopyrrolate, hyoscyamine, benztropine, atropine ophthalmic (orally administered), and a tricyclic antidepressant (TCA).
TYBOST	Cobicistat	Given in combination with atazanavir or darunavir and must not be given with another protease inhibitor (lopinavir, ritonavir, fosamprenavir, saquinavir, tipranavir) or etravirine or efavirenz.
VALCYTE	Valganciclovir (450 mg tablets only)	Prescribed for one of the following indications: 1. Prevention of cytomegalovirus (CMV) disease in kidney, heart, or kidney-pancreas transplant patients at high risk (Donor CMV seropositive/Recipient CMV seronegative [D+/R−]). 2. Treatment of CMV retinitis in patients with acquired immunodeficiency syndrome (AIDS). 3. Treatment of CMV in immunocompromised children and adolescents. 4. Treatment of congenital CMV in an infant who is symptomatic.
VANCOCIN	Vancomycin oral	Treatment of pseudomembranous colitis due to *Clostridium difficile* and failure on a regimen of metronidazole.
VELPHORO **MARKETPLACE ONLY*	Sucroferric oxyhydroxide	Prescribed for hyperphosphatemia in patients with chronic kidney disease on dialysis AND trial and failure on calcium acetate, calcium carbonate, and Renvela (requires step therapy to calcium acetate)
VIEKIRA PAK	Ombitasvir/paritaprevir/ ritonavir with dasabuvir	Refer to Molina Clinical Policy MCP-220
VIIBRYD **MARKETPLACE ONLY*	vilazodone	Prescribed for the treatment of depression and documentation of trial and failure on 2 formulary antidepressants OR documentation that member is currently stable on this medication.
VIMPAT	Lacosamide	Prescribed for the treatment of partial-onset seizures by a neurologist AND has failed at least two of the following agents: gabapentin, lamotrigine, levetiracetam, topiramate, oxcarbazepine, phenytoin and zonisamide OR documentation that member is currently stable on this medication.
VOLTAREN GEL	Diclofenac gel	Prescribed to be used during the peri-operative period in the setting of coronary artery bypass graft (CABG) surgery OR Prescribed for osteoarthritis pain susceptible to topical treatment AND failure to oral diclofenac or is not a suitable candidate for oral diclofenac (eg, bleeding ulcer, etc.) AND failure on at least 2 other formulary NSAIDs.
VRAYLAR **MARKETPLACE ONLY*	Cariprazine	Prescribed for the treatment of bipolar disorder or schizophrenia AND trial and failure on 2 generic atypical antipsychotics (eg, risperidone, quetiapine) and a preferred Tier 2 agent (eg, Latuda, Saphris [all require prior authorization]) OR chart notes showing you are currently stable on this medication.
XARELTO **MEDICAID ONLY*	Rivaroxaban	Documentation of one of the following: Active pathological bleeding,

		prescribed for deep vein thrombosis prophylaxis for patient undergoing knee or hip replace surgery, patient being discharged from a hospital with an FDA-approved indication, or for an FDA-approved indication and has tried and failed warfarin
XOLAIR	Omalizumab	Refer to Molina Clinical Policy MCP-001 and -0178
XOPENEX **MARKETPLACE ONLY*	Levalbuterol nebulizer	Trial and failure on albuterol nebulizer
XYLON **MARKETPLACE ONLY*	Hydrocodone/ibuprofen 10 mg/200 mg	Trial and failure on 1 preferred short-acting pain medication (eg, hydrocodone/acetaminophen, morphine sulfate IR)
XYREM	Sodium oxybate	Refer to Molina Clinical Policy MCP-154
ZIRGAN GEL **MARKETPLACE ONLY*	Ganciclovir ophthalmic gel	Prescribed for viral keratitis and documentation of trial and failure on topical trifluridine 1% solution AND an oral antiviral agent.
ZOFRAN SOLUTION	Ondansetron solution	Prescribed for an FDA-approved indication and documentation of inability to swallow oral dosage forms.
ZOLADEX	Goserelin	<u>Prostate Cancer:</u> 11. Patient has recurrent disease and experienced biochemical failure after previous therapy; OR 12. Patient has metastatic Prostate Cancer; OR 13. Patient has clinical localized or locally advanced disease; and disease risk stratification of intermediate or high disease; OR 14. Patient's disease risk stratification is very high and patient is a candidate for definitive therapy. <u>Breast Cancer:</u> 1. Patient is pre- or perimenopausal AND breast cancer is hormone receptor-positive (documentation required); has metastatic or recurrent disease; and use with endocrine therapy [tech note; only dose of 3.6 mg is approvable] <u>Dysfunctional Uterine Bleeding:</u> 1. <u>Prescribed to be used prior to endometrial ablation for dysfunctional uterine bleeding [tech note: only dose of 3.6 mg is approvable]</u> <u>Endometriosis:</u> 1. Patient is 18 years of age or older; documentation that pregnancy has been excluded; and patient has not been treated with Zoladex for 6 months or longer [tech note: approvable duration is 6 months. 1 dose per 4 weeks].
ZOVIRAX CREAM, OINTMENT	Acyclovir	The member experienced a failure of or an intolerance (ie, sensitivity, drug allergy, or adverse effect) to treatment with formulary ORAL acyclovir AND the request is for genital herpes OR If the request is for cold sores, and the patient has experienced a failure of or an intolerance (ie, sensitivity, drug allergy, or adverse effect) to treatment with formulary oral antiviral agents OR Abreva
ZYVOX	Linezolid	Previous use of IV linezolid therapy prescribed by an Infectious Disease specialist OR diagnosis of Vancomycin Resistant Enterococcus (VRE) OR Methicillin resistant *Staphylococcus aureus* (MRSA)

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 5/2017