

# Blue Care Network Quality Interchange Program

July 2009

The Blue Care Network Quality Interchange Program helps ensure that safe, high-quality cost-effective drug therapy is prescribed prior to the use of more expensive agents that may not have proven value over current formulary medications. This program makes use of drug utilization management tools including prior authorization and step therapy. If a drug requires prior authorization, certain clinical criteria must be met, or other information must be provided, before coverage is approved. Drugs subject to step therapy require previous treatment with one or more formulary agents prior to coverage. The criteria for approval are based on current medical information and are approved by the BCBSM/BCN Pharmacy and Therapeutics Committee.

Most BCN members do not have coverage for *nonformulary drugs*. Requests for these *nonformulary drugs* will only be considered when the following criteria have been met:

- The member has tried and failed to respond to an adequate trial of the available formulary agents from the same drug class, or the available formulary agents would pose unnecessary risk to the member.
- The prescriber and BCN agree that it is medically necessary.

Authorization requests that do not include documentation of medical necessity and failure of formulary alternatives will be denied.

Brand-name drugs that physicians prescribe or members request to be dispensed as written (DAW), but are available as generics, are covered only when determined to be medically necessary by the physician and approved by BCN. The physician must submit a completed MedWatch form to the FDA with a copy to BCN to document serious adverse events or a quality issue with the covered generic. Information regarding the FDA MedWatch program and online forms are available at [www.accessdata.fda.gov/scripts/medwatch](http://www.accessdata.fda.gov/scripts/medwatch). If a DAW prescription is not authorized, BCN members are required to pay the difference in cost between the brand-name and generic versions in addition to their usual brand-name copay amount.

Quantity limits may also apply to certain drugs. Please visit us online at [MiBCN.com](http://MiBCN.com) for more information.

This information applies to members with a BCN commercial drug benefit. Criteria for BCN Advantage<sup>SM</sup> and BlueCaid<sup>®</sup> members can be viewed on our Web site: [MiBCN.com](http://MiBCN.com).

**(g)=generic available**

ANTI-INFECTIVES	
Quinolones	
<b>Formulary:</b> Cipro <sup>®</sup> XR <b>(g)</b> (ciprofloxacin-betaine)	Approved only for uncomplicated urinary tract infection (cystitis). Alternatives include Cipro <b>(g)</b> 100-250mg BID x 3 days and Bactrim DS <sup>®</sup> <b>(g)</b> BID x 3-5 days.
<b>Nonformulary:</b> Proquin <sup>®</sup> XR	
Tetracyclines	
<b>Nonformulary:</b> Adoxa <sup>®</sup> , CK, TT, Oracea <sup>®</sup> , Solodyn <sup>™</sup>	Requires submission of a completed MedWatch form to the FDA with a copy to BCN to document failure of or intolerance to generic doxycycline or minocycline.
Anti-Fungals	
<b>Nonformulary:</b> Lamisil <sup>®</sup> Granules	Member must be intolerant to/or have tried and failed three months of griseofulvin suspension.

## ANTINEOPLASTICS & IMMUNOSUPPRESSANTS

### Hematopoietic Agents

<b>Formulary:</b> Procrit® (epoetin alfa)  Promacta® (eltrombopag)	<b>Formulary agents:</b> <b>Procrit:</b> Requires documentation that the member has a diagnosis of cancer and is being treated with chemotherapy, or has anemia with end-stage renal disease. A Hgb level of less than 10 mg/dL is required for initial therapy. Dose adjustments are required to maintain Hgb between 10 to 12 mg/dL with discontinuation if Hgb exceeds 12 mg/dL. Other criteria may apply. <b>Promacta:</b> Requires documentation of appropriate diagnosis and treatment failure with standard first-line agents.
<b>Nonformulary:</b> Aranesp®, Epogen®	<b>Nonformulary agents:</b> Also requires documentation that member has experienced failure of or intolerance to formulary epoetin alfa (Procrit).

### Immunomodulators

<b>Formulary:</b> Arcalyst™ (rilonacept)	<b>Formulary agent:</b> <b>Arcalyst:</b> Requires documentation that member has a diagnosis of cryopyrin-associated periodic syndrome.
<b>Nonformulary:</b> Revlimid®	<b>Nonformulary agent:</b> <b>Revlimid:</b> Requires FDA-approved indication, or an indication supported by peer-reviewed literature, or documentation that the member is enrolled in a Phase II-III investigative study approved by an appropriate Investigational Review Board.

### Kinase Inhibitors & Molecular Target Inhibitors

<b>Formulary:</b> Hycamtin® (topotecan), Iressa® (gefitinib), Nexavar® (sorafenib), Sprycel® (dasatinib), Sutent® (sunitinib), Tarceva® (erlotinib), Tykerb® (lapatinib)	Requires FDA-approved indication, or an indication supported by peer-reviewed literature, or documentation that the member is enrolled in a Phase II-III investigative study approved by an appropriate Investigational Review Board.  Some formulary agents require the member to have experienced failure of or intolerance to Gleevec®. <b>Sprycel:</b> Also requires treatment failure of first line chemotherapy for chronic myeloid leukemia or Philadelphia chromosome-positive acute lymphoblastic leukemia. <b>Tykerb:</b> Also requires (for advanced or metastatic breast cancer where the tumors over-express HER2) concurrent use of capecitabine (Xeloda®), and prior therapy including an anthracycline, a taxane, and trastuzumab (Herceptin®).
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### Miscellaneous Antineoplastic Agents

<b>Formulary:</b> Zolinza™ (vorinostat)	Requires documentation of persistent disease after two previous therapies.
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## CARDIOVASCULAR, HYPERTENSION, CHOLESTEROL

### Angiotensin Converting Enzyme Inhibitors (ACE-Inhibitor)

<b>Nonformulary:</b> Altace® Tablets	Requires documentation that member has experienced failure of or intolerance to Altace(g) capsules.
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### Angiotensin II Receptor Blockers (ARBs)

<b>Formulary:</b> Benicar® (olmesartan medoxomil), HCT; Cozaar®/Hyzaar® (losartan)	Requires documentation that the member has experienced intolerance to an ACE-Inhibitor such as Prinivil®/Zestril®(g), Monopril®(g), Lotensin®(g), Vasotec®(g), Accupril®(g), etc.
<b>Nonformulary:</b> Atacand®, HCT; Avapro®/Avalide®; Diovan®, HCT; Micardis®, HCT; Teveten®, HCT Azor®, Exforge®, HCT	<b>Azor, Exforge:</b> Requires successful treatment of at least three months' therapy with the individual agents at the prescribed dosage.

**CARDIOVASCULAR, HYPERTENSION, CHOLESTEROL (Cont.)****Beta Blockers****Nonformulary:**  
Bystolic®, Coreg CR™**Bystolic:** Requires documentation that the patient has tried and failed two unique formulary beta blockers.  
**Coreg CR:** Requires documentation that the member has tried and failed carvedilol immediate release (Coreg™(g)) and Toprol XL®(g).**Cardiovascular Treatment****Nonformulary:**  
Ranexa®

Requires documentation that the member has experienced failure of or intolerance to both a beta-blocker and nitrates. Also requires no history or high risk of cancer.

**Lipid-Lowering Agents****Formulary:**  
Crestor® (rosuvastatin),  
Zetia® (ezetimibe)**Formulary agents:****Crestor:** Requires documentation that member has experienced failure of or intolerance to at least one high dose (≥40mg) generic statin (Mevacor®(g), Zocor®(g), or Pravachol®(g)).**Zetia:** Requires documentation that member has experienced failure of or intolerance to at least two generic statins (Mevacor(g), Zocor(g), or Pravachol(g)) OR approved when added to a high dose (≥ 40mg) generic statin (Mevacor(g), Zocor(g), or Pravachol(g)).**Nonformulary:**

Advicor®, Altoprev®, Caduet®, Lescol®, XL, Lipitor®, Simcor®, TriLipix®, Vytorin®

**Nonformulary agents:** Requires documentation that member has experienced failure of or intolerance to at least one high dose (≥ 40mg) generic statin [Mevacor(g), Zocor(g), or Pravachol(g)] AND one formulary brand agent (Crestor or Zetia).**Additional Criteria:****Advicor & Simcor:** Requires documentation that the patient has had at least three months of treatment with individual agents (Niaspan® and simvastatin) at the prescribed dosage.**TriLipix:** Requires documentation that the member has experienced failure of or intolerance to ALL generic fenofibrates, such as Lofibra®(g) and Lopid®(g), AND supporting evidence for the use of this agent. Concomitant use of a statin does not satisfy criteria.**Miscellaneous Antihypertensives****Nonformulary:**  
Tekturna®, HCT**Tekturna, HCT:** Requires documentation that the member has experienced failure of or intolerance to or treatment failure with ALL of the following drug classes: Diuretics, beta-blockers, ACE-Inhibitors and Angiotension II Receptor Blockers (ARBS).**CENTRAL NERVOUS SYSTEM****Anticonvulsants****Nonformulary:**  
Lyrica®

Requires documentation that the member has at least one of the three listed diagnoses:

- Seizures, and is being treated concurrently with other anticonvulsants OR
- Neuropathic pain associated with either diabetic peripheral neuropathy or post-herpetic neuralgia AND the member has experience treatment failure of or intolerance to:
  - o Members over age 65: gabapentin 1200 mg per day
  - o Members under age 65: gabapentin 1200 mg per day AND a tricyclic antidepressant.
- Fibromyalgia and documentation that member has experienced intolerance to gabapentin OR inadequate relief from gabapentin 1200 mg per day PLUS three of the following: a tricyclic antidepressant, an SSRI, an SNRI, cyclobenzaprine, and tramadol.

**Additional criteria:**

- Approvals are granted only at the specific strength requested.
- Approved dosage is limited to ≤ 300 mg per day for initial treatment and will not exceed 600 mg per day if 300 mg/day tolerated.
- Any previous authorizations are discontinued when a new strength is approved.

CENTRAL NERVOUS SYSTEM (Cont.)	
<b>Anticonvulsants</b>	
<b>Nonformulary:</b> Lamictal® ODT™	Requires documentation that member is unable to swallow or chew the generic tablets.
<b>Antidepressants</b>	
<b>Formulary:</b> Lexapro® (escitalopram), Effexor® XR (venlafaxine), Venlafaxine® ER  <b>Nonformulary:</b> Aplenzin™, Cymbalta®, Luvox CR®, Pexeva™, Pristiq™, Prozac® Weekly, Savella™	<b>Formulary agents:</b> Requires documentation that member has experienced failure of or intolerance to at least <u>one</u> generic agent [e.g., Prozac( <b>g</b> ), Celexa®( <b>g</b> ), Paxil®( <b>g</b> ), Effexor®( <b>g</b> ) or Wellbutrin SR®, XL®( <b>g</b> )].  <b>Nonformulary agents:</b> Requires documentation that the member has experienced failure of or intolerance to at least one generic and one brand name formulary option. <b>Additional Criteria:</b> <b>Aplenzin:</b> Requires all of the above plus documentation that continued use of Wellbutrin XL( <b>g</b> ) will adversely affect the member's mental health. <b>Cymbalta:</b> For post-herpetic neuralgia or diabetic neuropathy; If older than 65 years, requires treatment with gabapentin 1200 mg per day. If under 65 years, requires treatment failure with gabapentin 1200 mg per day and a tricyclic antidepressant. For fibromyalgia: documentation is required to show that the member has experienced intolerance to gabapentin OR inadequate relief from gabapentin 1200 mg per day PLUS three of the following: a tricyclic antidepressant, an SSRI, SNRI, cyclobenzaprine, and tramadol. <b>Luvox CR:</b> Requires all of the above plus documentation that continued use of Luvox( <b>g</b> ) will adversely affect the member's mental health. <b>Pexeva:</b> Requires all of the above plus documentation that continued use of Paxil( <b>g</b> ) will adversely affect the member's mental health. <b>Pristiq:</b> Requires all of the above plus documentation that continued use of Effexor( <b>g</b> ), Effexor XR will adversely affect the member's mental health. <b>Prozac Weekly:</b> Requires prior treatment with at least two months of successful continuous, daily Prozac( <b>g</b> ) and documentation that continued use of daily Prozac( <b>g</b> ) would adversely affect the member's mental health. <b>Savella:</b> For fibromyalgia: documentation is required to show that the member has experienced intolerance to gabapentin OR inadequate relief from gabapentin 1200 mg per day PLUS three of the following: a tricyclic antidepressant, an SSRI, SNRI, cyclobenzaprine, and tramadol.
<b>Antipsychotics</b>	
<b>Nonformulary:</b> Invega™, Seroquel XR®	Requires documentation that the member has tried and failed therapy with formulary atypical antipsychotic options. Maximum dose of Invega is limited to 12 mg per day.
<b>CNS Stimulants</b>	
<b>Formulary:</b> Provigil® (modafinil)	<b>Formulary agents:</b> <b>Provigil:</b> Approved only for members with narcolepsy, obstructive sleep apnea, or an indication supported by peer-reviewed literature. Dosage limited to a maximum of 400mg per day. Shift-work sleep disorder is not covered since treatment is not medically necessary.

## CENTRAL NERVOUS SYSTEM (Cont.)

### CNS Stimulants (Cont.)

**Nonformulary:**

Liquadd™, Nuvigil®, Procentra™, Strattera™, Vyvanse™

**Nonformulary agents:**

**Liquadd, Procentra:** Requires documentation that member has experienced failure of or intolerance to both Metadate CD and Adderall XR; both of which may be sprinkled on food.

**Nuvigil:** Requires documentation that member has experienced failure of or intolerance to Provigil (see above criteria).

**Strattera:** Approvable when stimulants are contraindicated by medical history.

**For BCN members age 5 to 21:**

Requires documentation that member has experienced failure of or intolerance to both a methylphenidate product [such as Ritalin®(g) or Concerta®] and an amphetamine (such as Adderall®(g)).

**For BCN members 21 and older:**

Requires documentation that the member has experienced failure of or intolerance to either a methylphenidate product or an amphetamine.

**Vyvanse:** Requires documentation that the member has experienced failure of or intolerance to both a methylphenidate product (such as Ritalin(g) or Concerta) and an amphetamine [such as Adderall(g)].

### Migraine Therapy

**Formulary:**

Maxalt®, MLT® (rizatriptan)

**Nonformulary:**

Amerge®; Axert®; Frova®; Relpax®; Treximet®; Zomig®, ZMT®, nasal spray

**Formulary agents:**

**Maxalt, MLT:** Requires documentation that member has experienced failure of or intolerance to Imitrex®(g).

**Nonformulary agents:**

Requires documentation that member has experienced failure of or intolerance to both Imitrex(g) and Maxalt.

**Additional criteria:**

**Treximet:** Requires documentation as to why a combination of Imitrex(g) or Maxalt and naproxen do not work for the member AND documentation as to why use of the ingredients individually will be harmful to the member.

### Narcotics

**Formulary:**

Actiq®(g) (fentanyl citrate)

**Nonformulary:**

Fentora™, Nucynta™; Opana®, ER; Oxycontin®

**Actiq(g), Fentora:** Requires a cancer diagnosis for coverage, tolerance to high doses of narcotics, and current use of long-acting narcotic. Approved for breakthrough pain management only.

**Nucynta:** Requires documentation that member has experienced failure of or intolerance to a generic immediate release tramadol plus three formulary immediate release narcotic drugs. If use is to exceed 30 days, must be used in conjunction with a long-acting narcotic, such as MS Contin(g), methadone, or fentanyl.

**Opana:** Member must have tried and failed formulary agents Roxanol®(g) or MSIR®(g).

**Oxycontin, Opana ER:** Member must have tried and failed long acting formulary agents, such as methadone(g), Oramorph®(g), MS Contin®(g), and fentanyl patch (g).

### Narcotic Mixed Agonist/Antagonist

**Formulary:**

Suboxone™ (buprenorphine HCl/naloxone HCl)

**Nonformulary:**

Ryzolt™

**Formulary agent:**

**Suboxone:** Approved only for the treatment of clinically diagnosed opioid dependence. Requires documentation of validated screening tools used to identify the opioid use problem.

**Nonformulary agent:**

**Ryzolt:** Approved only for the treatment of chronic pain syndrome AND member must have had an inadequate response to immediate release tramadol.

## CENTRAL NERVOUS SYSTEM (Cont.)

### Non-Steroidal Anti-Inflammatory Drugs

<b>Nonformulary:</b> Arthrotec <sup>®</sup> ; Celebrex <sup>®</sup> ; Naprelan <sup>®</sup> 375mg, 750mg; Prevacid NapraPAC <sup>™</sup>	<b>Arthrotec, Prevacid NapraPAC:</b> Requires that member's age be above 60 or concomitant use of anticoagulants or oral steroids or risk of GI bleed (history of peptic ulcer disease, previous GI bleed or alcoholism). <b>Celebrex:</b> Requires that member's age be above 60 or oral steroids or risk of GI bleed and no history or evidence of cardiovascular and thromboembolic disease. No concomitant use with an anticoagulant. (Note that Lodine <sup>®</sup> (g) is more selective than Celebrex for the COX-2 enzyme.) <b>Naprelan:</b> Requires documentation of medical necessity, including the reason why a generic formulary alternative cannot be used.
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### Sedatives/Hypnotics

<b>Nonformulary:</b> Ambien CR <sup>™</sup> , Lunesta <sup>™</sup> , Rozerem <sup>™</sup>	Requires documentation that member has experienced failure of or intolerance to an adequate trial of both Ambien <sup>®</sup> (g) and Sonata <sup>®</sup> (g).
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## DERMATOLOGY

### Acne Treatment

<b>Nonformulary:</b> Ziana <sup>™</sup> gel	Requires documentation of medical necessity to identify why individual agents [Cleocin-T <sup>®</sup> (g) plus Retin-A <sup>®</sup> (g)] cannot be used.
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### Antipsoriatic/Antiseborrheic

<b>Formulary:</b> Enbrel <sup>®</sup> (etanercept), Humira <sup>®</sup> (adalimumab)	<b>Formulary agents:</b> <b>Enbrel, Humira:</b> <b>Moderate to Severe Psoriasis:</b> Requires 3 months of previous treatment with topical corticosteroids and 3 months treatment with PUVA.
<b>Nonformulary:</b> Taclonex, Scalp <sup>®</sup>	<b>Nonformulary agent:</b> <b>Taclonex:</b> Requires documentation that the member has experienced treatment failure of or intolerance to treatment for 30 days or more with very high potency corticosteroids [Diprolene <sup>®</sup> ointment(g), Temovate <sup>®</sup> (g), Psorcon <sup>®</sup> (g)] PLUS Dovonex <sup>®</sup> ointment.

### Low Potency Corticosteroids

<b>Nonformulary:</b> Desonate <sup>™</sup> gel, Verdeso <sup>™</sup> foam	Requires documentation that the member has tried and failed two topical steroid formulary options.
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### Miscellaneous Dermatologicals

<b>Formulary:</b> Elidel <sup>®</sup> (pimecrolimus)	Neither Elidel nor Protopic are covered for children younger than 2 years old.
<b>Nonformulary:</b> Protopic <sup>®</sup>	<b>Protopic:</b> Requires documentation that member has experienced failure of or intolerance to Elidel <sup>®</sup> . For members ages 2 to 15, only 0.03% may be used.

### Wound & Burn Therapy

<b>Nonformulary:</b> Regranex <sup>®</sup>	Requires approval by BCN's Care Management team.
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## DIAGNOSTICS & OTHER MISCELLANEOUS

### Diagnostic & Other Miscellaneous

<b>Formulary:</b> Kuvan <sup>™</sup> (sapropterin dihydrochloride)  Xenazine <sup>®</sup> (tetrabenazine)	<b>Formulary agents:</b> <b>Kuvan:</b> Requires documentation that member has a diagnosis of phenylketonuria (PKU) <b>Xenazine:</b> Requires documentation that member has a diagnosis of chorea associated with Huntington's disease.
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## DIAGNOSTICS & OTHER MISCELLANEOUS (Cont.)

### Diagnostic & Other Miscellaneous (Cont.)

**Nonformulary:**

Campral®

Exjade®

**Nonformulary agents:**

**Campral:** Approved for maintenance of abstinence from alcohol in members with alcohol dependence who have been abstinent at treatment initiation for at least 5 days post-detoxification. Member must be enrolled in a comprehensive alcohol management program that includes psychosocial support.

**Exjade:** Requires an FDA-approved indication, and documentation of treatment failure of Desferal®(g) in members 2 years of age or older, or an indication supported by peer-reviewed literature, or documentation that the member is enrolled in a Phase II-III investigative study approved by an appropriate Investigational Review Board.

## ENDOCRINOLOGY

### Growth Hormone & Related Products

**Formulary:**

Nutropin®, AQ (somatotropin), Saizen® (somatotropin)

**Nonformulary:**

Genotropin®, Humatrope®, Norditropin®, Omnitrope®, Serostim®, Tev-Tropin®, Valtropin®, Zorbtive™

Increlex™

**Children (males < 16 years old; females < 15 years old):**

**Initial treatment:** Requires ≥ 6 months of initial height measurements, height < 5<sup>th</sup> percentile for age (based on initial evaluation), abnormal growth velocity based on ≥ 6 months of measurement, < 50<sup>th</sup> percentile for age with growth hormone therapy, and initial subnormal blood test for growth hormone.

**To continue:** Must have documented growth velocity of ≥ 2.5 cm/year during the first 6 months of treatment & documented growth of ≥ 4.5 cm/year for each succeeding 6 month review period. Treatment may continue until final height or epiphyseal closure has been documented.

**Adults:** Requires initial diagnosis based on two growth hormone stimulation tests, and documentation that a member does NOT have edema, arthralgias, or carpal tunnel syndrome. May be approved for AIDS-wasting cachexia and Turner's syndrome.

**Nonformulary agents:** Requires documentation that members has experienced failure of or intolerance to BCN's formulary agents.

**Increlex:** Requires severe IGF-1 deficiency as demonstrated by height standard deviation score ≤ -3 and basal IGF-1 standard deviation score ≤ -3 and normal or elevated growth hormone. Initial approval for 1 year and renewal can be obtained if clinical response with therapy, as demonstrated by an annual growth of > 5cm in the first year.

### Non-Insulin Hypoglycemic Agents

**Formulary:**

Actos® (pioglitazone), Avandia® (rosiglitazone)

**Formulary agents:**

**Actos, Avandia:** Requires documentation that the member has experienced failure with metformin. If the member cannot tolerate metformin or if metformin is contraindicated, physicians are encouraged to prescribe a sulfonylurea, unless contraindicated, prior to treatment with a TZD.

ENDOCRINOLOGY (Cont.)	
Non-Insulin Hypoglycemic Agents (Cont.)	
<p><b>Nonformulary:</b> Actoplus Met™, Avandamet®, Avandaryl™, Byetta®, Duetact™, Januvia™, Janumet™, Prandimet™, Symlin®</p>	<p><b>Nonformulary agents:</b> <b>Actoplus Met, Avandamet, Avandaryl, Duetact, Janumet, Prandimet:</b> Requires documentation that the member has experienced successful treatment with at least three months of combination therapy with the individual agents. <b>Byetta:</b> Requires documentation that the member has a diagnosis of type 2 diabetes and is currently being prescribed metformin, a sulfonylurea, a thiazolidinedione, a combination of metformin and a sulfonylurea or a combination of metformin and a thiazolidinedione (trial of at least two of these three agents is required). In addition, documentation must be provided to demonstrate lack of efficacy with insulin and that insulin will be discontinued. <b>Januvia:</b> Requires documentation that member has experienced failure with or is intolerant to three of the following: metformin, basal insulin, sulfonylurea, and a TZD. <b>Symlin:</b> Requires failure of intensive treatment with insulin alone and concurrent use with an insulin product.</p>
GASTROINTESTINAL AGENTS	
Antiemetics	
<p><b>Nonformulary:</b> Sancuso®</p>	<p>Requires documentation that the member has experienced failure of or intolerance to Kytril®(g) AND Zofran™(g).</p>
Miscellaneous Gastrointestinal Agents	
<p><b>Formulary:</b> Relistor™ (methylnaltrexone)</p> <p><b>Nonformulary:</b> Amitiza®, Cimzia®, Lotronex®</p>	<p><b>Formulary agent:</b> <b>Relistor:</b> Approved for adults that have opioid-induced constipation receiving palliative care. Trials of OTC and oral prescription products required prior to Relistor.</p> <p><b>Nonformulary agents:</b> <b>Amitiza:</b> For chronic constipation (fewer than 3 bowel movements/week): Approved for members between 18 and 65 years of age who are NOT on medications causing constipation and who have failed treatment that include <u>all</u> of the following: dietary advice, trials of bulk laxatives, stool softeners and a short course of stimulant laxatives. A total of 12 weeks can be approved, with renewal, only if improvement in bowel frequency is seen with initial trial. <b>Cimzia:</b> For Crohn's disease: Requires documentation that the member has experienced failure of or intolerance to Humira. <b>Lotronex:</b> Approved for treatment of women at least 18 years old with severe, diarrhea-predominant irritable bowel syndrome who have failed to respond to conventional IBS therapy.</p>
Proton Pump Inhibitors	
<p><b>Formulary:</b> Prevacid® (lansoprazole) capsule/Solutab™, Prilosec®(g) (omeprazole) 40mg, Protonix®(g) (pantoprazole)</p>	<p><b>Formulary agents:</b> <b>Prevacid, Solutab:</b> Requires documentation that the member has experienced failure of or intolerance to Prilosec OTC™ or Prilosec(g). <b>Prilosec 40mg(g):</b> Requires documentation that member has experienced treatment failure with Prilosec OTC or Prilosec(g) (2 x 20mg). <b>Protonix(g):</b> Requires documentation that member has experienced failure of or intolerance to Prilosec OTC or Prilosec(g) unless the member is currently receiving Plavix.</p>

<b>GASTROINTESTINAL AGENTS (Cont.)</b>	
<b>Proton Pump Inhibitors (Cont.)</b>	
<b>Nonformulary:</b> Aciphex <sup>®</sup> , Kapidex <sup>™</sup> , Nexium <sup>®</sup> , Prilosec suspension, Protonix suspension, Zegerid <sup>™</sup>	<b>Nonformulary agents:</b> <b>Aciphex, Zegerid:</b> Requires treatment failure with Prilosec OTC and Prevacid, Solutab. <b>Kapidex, Nexium:</b> Requires documentation that the member has experienced failure of or intolerance to both BCN formulary alternatives [either Prilosec OTC or Prilosec( <b>g</b> ) AND Prevacid], one of which is at a twice daily, high dose regimen. <b>Prilosec, Protonix suspension:</b> Requires documentation that member has had treatment failure or intolerance to Prevacid Solutab.
<b>LIFESTYLE MODIFICATION PRODUCTS</b>	
<b>Impotence</b>	
<b>Formulary:</b> Caverject <sup>®</sup> (alprostadil), Cialis <sup>®</sup> (tadalafil), Muse <sup>®</sup> (alprostadil), Viagra <sup>®</sup> (sildenafil citrate)	Approved (maximum 6 doses/28 days) for men over age 35 with a diagnosis of erectile dysfunction. For men 35 and younger, must provide medical cause of erectile dysfunction. No concomitant nitrates; avoid use of alpha blockers with oral erectile dysfunction agents.
<b>Nonformulary:</b> Edex <sup>®</sup> , Levitra <sup>®</sup>	
<b>Weight Loss Products</b>	
<b>Formulary:</b> phentermine and related products	Requires verification that member's Body Mass Index is 30 or greater (greater than 27 if co-morbidities) and concurrent lifestyle modification plan. Coverage for all anorexiant and related drugs is limited to 3 months. Additional coverage requires documentation of weight loss of at least 2 pounds per month. Maximum benefit is 12 months of treatment per lifetime; 24 months for Xenical.
<b>Nonformulary:</b> Meridia <sup>®</sup> , Xenical <sup>®</sup>	
<b>OTIC &amp; NASAL PREPARATIONS</b>	
<b>Intranasal Steroids</b>	
<b>Formulary:</b> Nasacort AQ <sup>®</sup> (triamcinolone acetonide)	<b>Formulary agent:</b> <b>Nasacort AQ:</b> Requires documentation that member has experienced failure or intolerance to Flonase <sup>®</sup> ( <b>g</b> ) or Nasarel <sup>®</sup> ( <b>g</b> ).
<b>Nonformulary:</b> Beconase AQ <sup>®</sup> , Nasonex <sup>®</sup> , Omnaris <sup>™</sup> , Rhinocort Aqua <sup>®</sup> , Veramyst <sup>™</sup>	<b>Nonformulary agents:</b> Requires documentation that the member has experienced failure or intolerance to at least one Formulary Preferred agent (Flonase <sup>®</sup> ( <b>g</b> ) or Nasarel <sup>®</sup> ( <b>g</b> )) and the Formulary Option (Nasacort AQ).
<b>RESPIRATORY COUGH &amp; COLD</b>	
<b>Antihistamines and Combinations</b>	
<b>Formulary:</b> Allegra-D <sup>®</sup> (p-ephed/fexofenadine)	<b>Formulary agent:</b> <b>Allegra-D:</b> Requires documentation that the member has experienced treatment failure of or intolerance to OTC loratadine D; OTC cetirizine D
<b>Nonformulary:</b> Allegra <sup>®</sup> suspension, Allegra <sup>®</sup> ODT, Clarinex <sup>®</sup> , Clarinex-D <sup>®</sup> , Clarinex Reditabs <sup>®</sup> , Clarinex Syrup <sup>®</sup> , Semprex-D <sup>®</sup> , Xyzal <sup>®</sup> , Xyzal <sup>®</sup> Oral Solution	<b>Nonformulary agents:</b> Requires documentation that the member has experienced treatment failure of or intolerance to OTC loratadine, OTC cetirizine, <u>AND</u> Allegra( <b>g</b> ).
<b>Inhaled Beta-Agonists</b>	
<b>Nonformulary:</b> Brovana <sup>™</sup> , Perforomist <sup>™</sup>	Member must have tried and failed formulary agents (Serevent <sup>®</sup> AND Foradil <sup>®</sup> ).

## RESPIRATORY COUGH & COLD (Cont.)

Miscellaneous Pulmonary Agents	
<b>Formulary:</b> Singulair® (montelukast)  Letairis™ (ambrisentan), Revatio® (sildenafil), Tracleer™ (bosentan), Ventavis® (iloprost)	<b>Formulary agents:</b> <b>Singulair:</b> Approved for members with asthma or reactive airway disease. <b>Additional criteria:</b> <b>Allergic Rhinitis:</b> Requires documentation that the member has experienced a treatment failure with a formulary nasal steroid or a formulary non-sedating antihistamine.  <b>Letairis, Revatio, Tracleer, Ventavis:</b> Requires a diagnosis of Pulmonary Arterial Hypertension (PAH) in members with WHO Class III or IV symptoms.

## RHEUMATOLOGY & MUSCULOSKELETAL

Gout Therapy	
<b>Nonformulary:</b> Uloric®	<b>Uloric:</b> Requires documentation that the member has experienced failure of or intolerance to allopurinol. Uloric 80mg requires documentation that the member has had an inadequate response to the 40mg dose.
Miscellaneous Rheumatologic Agents	
<b>Formulary:</b> Enbrel®(etanercept), Humira® (adalimumab)	<b>Enbrel, Humira, Kineret:</b> Requires four month trial with two concurrent disease modifying antirheumatic drugs (one must be methotrexate unless contraindicated). Examples of DMARDs include: methotrexate, sulfasalazine, azathioprine, hydroxychloroquine/chloroquine, cyclosporine, gold and penicillamine.
<b>Nonformulary:</b> Cimzia®, Kineret®, Simponi™	<b>Cimzia, Simponi:</b> Requires documentation that member has experienced failure of or intolerance to both formulary agents Enbrel and Humira.
Osteoporosis/Bone Resorption Inhibitors	
<b>Formulary:</b> Actonel® (risedronate); Actonel® plus Calcium	<b>Formulary agents:</b> Requires documentation that member has experienced failure or intolerance to Fosamax®(g).
<b>Nonformulary:</b> Boniva®, Forteo™, Fosamax D™	<b>Nonformulary agents:</b> <b>Boniva, Fosamax D:</b> Requires documentation that member has had failure of or intolerance to both Fosamax(g) and Actonel. <b>Forteo:</b> Requires documentation that member has a diagnosis of osteoporosis (T-score <= -2.5) AND has experienced failure of, contraindication to or intolerance to a bisphosphonate.