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## Blue Cross Blue Shield of MI Prior Authorization/Step Therapy Program July 2009

BCBSM monitors the use of certain medications to ensure our members receive the most appropriate and cost-effective drug therapy. **Prior authorization** for these drugs means that certain clinical criteria must be met before coverage is provided. In the case of drugs requiring **step therapy**, for example, previous treatment with one or more formulary drugs may be required. Drugs that must meet clinical criteria are identified in the formulary list with (PA) or (ST). Your physician can contact our pharmacy help desk to request prior authorization for these drugs.

The criteria for authorization are based on current medical information and the recommendations of the Blues' Pharmacy and Therapeutics Committee, a group of physicians, pharmacists and other experts. You may be required to pay the full cost of the drug if your physician does not obtain prior authorization.

When your doctor prescribes a brand-name drug that's nonformulary, requires prior authorization or is not covered under your drug rider, it may not be a covered benefit. BCBSM reviews all physician and member requests to determine if the drug is medically necessary and that there aren't equally effective alternative drugs on the formulary.

Please call the Customer Service number on the back of your BCBSM ID card if you have questions about your drug coverage, a drug claim or filing a benefit exception.

### Prior Authorization/Step Therapy Drug Categories (CLINICAL FORMULARY)

MEDICATION/ DRUG CLASS	CRITERIA
<b>Amitiza<sup>®</sup></b> (lubiprostone) <i>Nonformulary</i>	Approval of lubiprostone requires the following: <ol style="list-style-type: none"> <li>1. Patient must be age 18 years or older</li> <li>2. Diagnosis of chronic idiopathic constipation</li> <li>3. Documented failure within the last 12 months using               <ol style="list-style-type: none"> <li>a. One fiber laxative <b>AND</b></li> <li>b. Two stimulant laxative products</li> </ol> </li> <li>4. Drug-induced constipation must be ruled out</li> </ol>
<b>Anabolic Steroids</b> Oxandrin <sup>®</sup> [g] (oxandrolone)  <i>Nonformulary:</i> Anadrol-50 <sup>®</sup> (oxymetholone) Deca-Durabolin <sup>®</sup> (nandrolone decanoate)	<u>Oxandrin<sup>®</sup> [g]:</u> Approved when used as an adjunct therapy to promote weight gain in patients who have had extensive surgery, chronic infection, or severe trauma <b>or</b> for therapy to offset protein catabolism associated with prolonged use of corticosteroids <b>or</b> for bone pain associated with osteoporosis <b>or</b> if prophylactic therapy is needed in patients with hereditary angioedema.  <u>Anadrol-50<sup>®</sup> (oxymetholone) and Deca-Durabolin<sup>®</sup> (nandrolone decanoate):</u> Approved for the treatment of clinically diagnosed anemia (documentation must support the trial of standard supportive measures for treating anemia including: transfusion, correction of iron, folic acid, vitamin B12, or pyridoxine deficiency, antibacterial therapy, and the appropriate use of corticosteroids) <b>OR</b> for the treatment of HIV-associated wasting <b>OR</b> if prophylactic therapy is needed in patients with hereditary angioedema.
<b>Arcalyst<sup>™</sup></b> (rilonacept)	Only FDA-approved for treatment of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) in adults and children 12 years and older.
<b>Bisphosphonates:</b> Fosamax <sup>®</sup> [g] (alendronate) Fosamax <sup>®</sup> [g] weekly Actonel <sup>®</sup> (risedronate)  <i>Nonformulary:</i> Boniva <sup>®</sup> (ibandronate)	Approval of Actonel <sup>®</sup> (risedronate) requires documentation that the member has tried and failed/not tolerated treatment with Fosamax <sup>®</sup> [g].  Approval of Boniva <sup>®</sup> (ibandronate) requires documentation that the member has tried and failed/not tolerated treatment with both Fosamax <sup>®</sup> [g] and Actonel <sup>®</sup> (risedronate).

MEDICATION/ DRUG CLASS	CRITERIA
<b>Byetta<sup>®</sup></b> (exenatide)  	<p>Approved as adjunctive therapy to improve glycemic control in patients who have a diagnosis of type II diabetes mellitus <b>AND</b> are currently taking or have tried at least 2 of 3 of the following: metformin, a sulfonylurea or a thiazolidinedione (unless contraindicated) <b>AND</b></p> <p>The patient must have documentation of an A1c greater than 7%.</p> <p>Byetta<sup>®</sup> <b>is not</b> covered for the primary indication of weight loss in patients with or without diabetes.</p>
<b>Bystolic<sup>®</sup></b> (nebivolol) <i>Nonformulary</i>	<p>Approval requires documentation that the patient has tried and failed/intolerant to at least 2 of the formulary cardioselective beta blockers: Kerlone<sup>®</sup> [g], Sectral<sup>®</sup> [g], Tenormin<sup>®</sup> [g], Zebeta<sup>®</sup> [g], Lopressor<sup>®</sup> [g] <b>OR</b> Toprol XL<sup>®</sup> [g].</p>
<b>Campral<sup>®</sup></b> (acamprosate calcium) <i>Nonformulary</i>	<p>Approved for maintenance of abstinence from alcohol in patients with alcohol dependence who have been abstinent at treatment initiation for at least 5 days post detoxification. Use of this product requires the patient to be enrolled in a comprehensive alcohol management program which includes psychosocial support.</p>
<b>COX-2 Preferential NSAIDs:</b> Celebrex <sup>®</sup> (celecoxib)	<p>Requires age &gt; 60 <b>OR</b> concomitant use of anticoagulants <b>OR</b> oral steroids <b>OR</b> risk of GI bleed (history of PUD, previous GI bleed, alcoholism).</p>
<b>Cymbalta<sup>®</sup></b> (duloxetine) <i>Nonformulary</i>	<p>Coverage for Cymbalta<sup>®</sup> will be provided for:  <u>Treatment of major depression</u>  Approval requires trial and failure with two formulary antidepressants including one generic SSRI/SNRI.</p> <p><b>OR</b></p> <p><u>Treatment of diabetic neuropathic pain</u>  <i>If patient equal to or greater than 65 years of age:</i>  After a 30-day trial of gabapentin.</p> <p><i>If patient less than 65 years of age:</i>  After a 30-day trial of gabapentin <b>AND</b> a tricyclic antidepressant, such as amitriptyline, desipramine, or imipramine.</p> <p><b>OR</b></p> <p><u>Treatment of Fibromyalgia</u>  Fibromyalgia characterized by pain in all 4 body quadrants, for at least 3 months, with or without fatigue and sleep disturbance <b>AND</b> the patient has tried and experienced intolerance to gabapentin <b>OR</b> had inadequate pain relief at doses of 1200 mg or above <b>AND</b> has tried and experienced intolerance or inadequate pain relief to three of the following: tricyclic antidepressant, SSRI, SNRI, cyclobenzaprine, tramadol.</p>
<b>Erythropoiesis Stimulating Agents (ESA's):</b> Aranesp <sup>®</sup> (darbepoetin alfa) Procrit <sup>®</sup> (epoetin alfa)  <i>Nonformulary:</i> Epogen <sup>®</sup> (epoetin alfa)	<p>Information may need to be submitted describing the use and setting of the drug to make the determination. Approved for use in the following conditions with a hemoglobin less than 12mg/dl: anemia of chronic renal disease (not yet on dialysis), anemia secondary to active chemotherapy of solid tumors, anemia secondary to active zidovudine (AZT) therapy, anemia in myelodysplastic disorders and prophylactic use during some major surgeries. Coverage is not provided in the following conditions: <b>A.</b> Anemia due to folate, vitamin B-12, and iron deficiencies, hemolysis, bleeding, or bone marrow fibrosis, <b>B.</b> Anemia associated with treatment of acute and chronic myelogenous leukemias (CML, AML), or erythroid cancers, <b>C.</b> Anemia due to cancer treatment in patients with uncontrolled hypertension, <b>D.</b> Anemia not associated with cancer treatment or renal disease under inclusion criteria, <b>E.</b> Anemia associated only with radiotherapy, <b>F.</b> Prophylactic use to prevent chemotherapy induced anemia, <b>G.</b> Prophylactic use to reduce tumor hypoxia, <b>H.</b> Patients with Erythropoietin type resistance due to neutralizing antibodies.  Coverage duration = 3 months</p>
<b>Flector<sup>®</sup></b> (diclofenac patch) <i>Nonformulary</i>	<p>Use of this agent will require medical necessity documentation. Alternative is oral diclofenac. Only FDA-approved for short term pain management.</p>

MEDICATION/ DRUG CLASS	CRITERIA
<b>Forteo®</b> (teriparatide)	<p>Forteo® coverage will be provided for the following guidelines:</p> <ol style="list-style-type: none"> <li>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 (<b>a, b and c</b>): <ol style="list-style-type: none"> <li>Have a bone mineral density (BMD) that is 2.5 standard deviations or more below the mean (T-score at or below -2.5).</li> <li>Patient has tried and failed a bisphosphonate (formulary agents include Fosamax® [g] and Actonel®) for a 24 month period except when: <ol style="list-style-type: none"> <li>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).</li> </ol> </li> </ol> <p><b>OR</b></p> <ol style="list-style-type: none"> <li>documented intolerance to a bisphosphonate</li> </ol> </li> <li>Coverage will not be provided in the following situations: <ol style="list-style-type: none"> <li>Concurrent treatment with a bisphosphonate</li> <li>Hypercalcemia</li> <li>Paget's disease</li> <li>Bone metastases or a history of skeletal malignancies</li> <li>Metabolic bone disease other than osteoporosis</li> <li>Pediatric patients or young adults with open epiphyses</li> <li>Prior radiation therapy involving the skeleton</li> </ol> </li> </ol> <p>2. Forteo will be approved for a maximum of two years.</p>
<p><b>Growth Hormone</b>  Nutropin® (somatropin) (all)  Saizen® (somatropin)</p> <p><i>Nonformulary:</i>  Genotropin®  Humatrope®  Norditropin®  Omnitrope®  Serostim®  Tev-Tropin®  Zorbtive™</p>	<p>Coverage will be provided for:  <u>Pediatric Growth Hormone Deficiency</u>  <i>Children (M &lt; 16 years old, F &lt; 15 years old):</i>  <i>Initial Treatment:</i> Req. ≥ 6 months of initial height measurements, Ht &lt; 5<sup>th</sup> percentile for age (based on initial evaluation), abnormal growth velocity based on ≥ 6 mo. of measurement, &lt; 50<sup>th</sup> percentile for age with growth hormone therapy, initial subnormal blood test for growth hormone.</p> <p><i>To continue treatment:</i> must have a documented growth velocity of ≥ 2.5 cm/year during the first 6 mo. of therapy &amp; 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 or patient has reached age 16 years (M) or 15 years (F).</p> <p><u>Adults:</u> Diagnosis of growth hormone deficiency confirmed by laboratory testing (e.g. provocative stimulation), known indication for pituitary disease and multiple pituitary hormone deficiencies. Multiple stimulation tests may be required in certain clinical circumstances. May be approved for AIDS-wasting cachexia and Turner's Syndrome. Growth hormone therapy is <b>NOT</b> covered for anti-aging, obesity or athletic enhancement.</p>
<p><b>H.P. Acthar Gel®</b> (repository corticotropin)</p>	<p>Coverage will be provided for the treatment of infantile spasms, or for the diagnostic testing of adrenocortical function only if use of cosyntropin is contraindicated.</p>
<p><b>Increlex®</b> (mecasermin)  <i>Nonformulary</i></p>	<p>Approval will require the following:</p> <ol style="list-style-type: none"> <li>Medication to be prescribed by a pediatric endocrinologist <b>AND</b></li> <li>Diagnosis of one of the following:  Severe primary IGF-1 deficiency or growth hormone gene deletion or genetic mutation of growth hormone receptor (Laron Syndrome) <b>AND</b></li> <li>Current height measurement at less than 3<sup>rd</sup> percentile for age and sex <b>AND</b></li> <li>IGF-1 level greater than or equal to 3 standard deviations below normal <b>AND</b></li> <li>Normal or elevated growth hormone levels based on at least one growth hormone stimulation test <b>AND</b></li> <li>Open growth plates</li> </ol>

MEDICATION/ DRUG CLASS	CRITERIA
<p><b>Intranasal Steroids</b>  Flonase<sup>®</sup> [g] (fluticasone)  Nasalide<sup>®</sup> [g] (flunisolide)  Nasarel<sup>®</sup> [g] (flunisolide)  Nasacort AQ<sup>®</sup> (triamcinolone)  Nasonex<sup>®</sup> (mometasone)  Rhinocort AQ<sup>®</sup> (budesonide)</p> <p><i>Nonformulary:</i>  Beconase<sup>®</sup> AQ (beclomethasone)  Omnaris<sup>®</sup> (ciclesonide)  Veramyst<sup>®</sup> (fluticasone)</p>	<p>Approval of Nasacort AQ<sup>®</sup>, Nasonex<sup>®</sup>, Rhinocort AQ<sup>®</sup> requires trial and failure/intolerance to Flonase<sup>®</sup> [g] <b>OR</b> Nasarel<sup>®</sup> [g].</p> <p>Approval of nonformulary agents requires trial and failure/intolerance to generic fluticasone (Flonase<sup>®</sup>) <b>OR</b> generic flunisolide (Nasarel<sup>®</sup>) <b>AND</b> trial and failure/intolerance to Nasacort AQ<sup>®</sup>.</p>
<p><b>Januvia<sup>™</sup></b> (sitagliptin)  <b>Janumet<sup>™</sup></b> (sitagliptin/metformin)  <i>Nonformulary</i></p>	<p>Requires documentation that member has tried three (3) of the four (4) therapies recommended by the ADA/EASD consensus treatment guidelines. The therapeutic classes recommended by ADA/EASD guidelines include metformin, basal insulin, sulfonylurea and TZDs.</p> <p>Coverage of nonformulary combination products requires successful treatment of individual agents in combination for at least 90-days as determined by improvements in HbA1c and lack of adverse events.</p>
<p><b>Lotronex<sup>®</sup></b> (alosectron hydrochloride)  <i>Nonformulary</i></p>	<p>Approved for treatment of women <math>\geq</math> 18 years old with severe, diarrhea-predominant Irritable Bowel Syndrome (IBS) who have failed to respond to conventional IBS therapy.</p>
<p><b>Lyrica<sup>®</sup></b> (pregabalin)  <i>Nonformulary</i></p>	<p>Coverage for Lyrica<sup>®</sup> will be provided for:  <u>Adjunctive treatment for adult patients with partial onset of seizures</u>  <b>OR</b>  <u>Treatment of diabetic neuropathic pain or post-herpetic neuralgia</u>  <i>If patient equal to or greater than 65 years of age:</i> After a 30-day trial of gabapentin.</p> <p><i>If patient less than 65 years of age:</i> After a 30-day trial of gabapentin <b>AND</b> a tricyclic antidepressant, such as amitriptyline, desipramine, or imipramine.</p> <p><b>OR</b>  <u>Treatment of Fibromyalgia</u>  Fibromyalgia characterized by pain in all 4 body quadrants, for at least 3 months, with or without fatigue and sleep disturbance <b>AND</b> the patient has tried and experienced intolerance to gabapentin <b>OR</b> had inadequate pain relief at doses of 1200 mg or above <b>AND</b> has tried and experienced intolerance or inadequate pain relief to three of the following: tricyclic antidepressant, SSRI, SNRI, cyclobenzaprine, tramadol.</p>
<p><b>Narcotics</b>  Actiq<sup>®</sup> [g] (fentanyl citrate)</p> <p><i>Nonformulary:</i>  Fentora<sup>™</sup> (fentanyl citrate)</p>	<p>Requires appropriate diagnosis for coverage and tolerance to high doses of narcotics.</p>
<p><b>Non-Sedating Antihistamines (NSA's):</b>  Claritin/-D<sup>™</sup> OTC (loratadine/pseudoephedrine)  Zyrtec/-D<sup>™</sup> OTC (cetirizine/pseudoephedrine)  Allegra<sup>®</sup> [g] (fexofenadine)  Allegra-D<sup>®</sup> (fexofenadine/pseudoephedrine)</p> <p><i>Nonformulary:</i>  Allegra<sup>®</sup> Suspension (fexofenadine)  Allegra<sup>®</sup> ODT (fexofenadine)  Clarinetx/-D<sup>®</sup> (desloratadine/pseudoephedrine)  Xyzal<sup>®</sup> (levocetirizine)</p>	<p><u>Allegra-D<sup>®</sup></u>  Requires failure of or intolerance to over-the-counter (OTC) loratadine/loratadine-D, OTC cetirizine/cetirizine-D, or generic fexofenadine. A valid prescription for OTC loratadine/loratadine-D or OTC cetirizine/cetirizine-D products must be presented for member to receive the OTC medication at their generic co-pay or cost, whichever is less.</p> <p><u>Clarinetx/Clarinetx-D<sup>®</sup> and Xyzal<sup>®</sup></u>  Requires failure of or intolerance to OTC loratadine/loratadine-D <b>AND</b> OTC cetirizine/cetirizine-D, <b>AND</b> generic fexofenadine/Allegra-D<sup>®</sup>.</p> <p><u>Allegra<sup>®</sup> Suspension and Allegra<sup>®</sup> ODT</u>  Requires failure or intolerance to loratadine and cetirizine.</p>
<p><b>Prandimet<sup>™</sup></b> (repaglinide/metformin)  <i>Nonformulary</i></p>	<p>Documentation that the patient has experienced treatment success (documented improvement in HbA1c &amp; lack of adverse events) for at least 3 months with Glucophage<sup>®</sup> (metformin) <b>AND</b> Prandin<sup>®</sup> (repaglinide) as individual agents when taken concurrently.</p>

MEDICATION/ DRUG CLASS	CRITERIA
<b>Promacta<sup>®</sup></b> (eltrombopag)	<p>Initial approval for coverage requires all of the following:</p> <ol style="list-style-type: none"> <li>1. Age greater than 18 years old <b>AND</b></li> <li>2. Diagnosis of chronic immune thrombocytopenia (ITP) and persistent thrombocytopenia (platelet count &lt; 150,000 mcL) for ≥ 2 months <b>AND</b></li> <li>3. Prescribed by a hematologist or in consultation with a hematologist <b>AND</b></li> <li>4. Inadequate response or patient must not be a candidate for corticosteroids, immunoglobulins, or splenectomy <b>AND</b></li> <li>5. Current platelet count is &lt; 30, 000 mcL <b>AND</b></li> <li>6. Dose is ≤ 75mg/day</li> </ol> <p>Renewal approval for Promacta<sup>®</sup> requires recent platelet count of 30,000-150, 000 mcL <b>AND</b> dose is ≤ 75mg/day.</p>
<p><b>Proton Pump Inhibitors (PPI's):</b>            Prilosec OTC™ [g] (omeprazole)            Prilosec<sup>®</sup> [g] (omeprazole)            Protonix<sup>®</sup> [g] (pantoprazole)            Prevacid<sup>®</sup> (lansoprazole)            Prevacid<sup>®</sup> SoluTab™ (lansoprazole)</p> <p><i>Nonformulary:</i>            Aciphex<sup>®</sup> (rabeprazole)            Kapidex™ (dexlansoprazole)            Nexium<sup>®</sup> (esomeprazole)            Zegerid<sup>®</sup> (omeprazole)</p>	<p>Approval of nonformulary medications requires failure of or intolerance to all formulary alternatives: Prilosec<sup>®</sup> [g] <b>OR</b> Prilosec OTC™ [g] <b>AND</b> Protonix<sup>®</sup> [g] <b>AND</b> Prevacid<sup>®</sup>/Prevacid<sup>®</sup> SoluTab™</p>
<p><b>Relistor™</b> (methylnaltrexone bromide) injection</p>	<p>Coverage of Relistor™ will be provided for:</p> <ol style="list-style-type: none"> <li>1. The treatment of opioid-induced constipation in patients with advanced illness who are receiving palliative care, when response to laxative therapy has not been sufficient.</li> <li>2. Patients shall be on stable doses of opioids for greater than 2 weeks.</li> <li>3. Duration of methylnaltrexone therapy shall be limited to 3 months.</li> <li>4. Previous history of treatment for constipation shall include fluids, stool softeners, bulk laxatives, saline laxatives and osmotic laxatives. Laxatives trials shall be of at least 5 days duration.</li> <li>5. Maximum initial regimen shall be 1 box (7 doses). Monthly doses shall not exceed 14.</li> <li>6. Patients experiencing withdrawal symptoms while taking methylnaltrexone should consider using an alternate form of therapy.</li> </ol>
<p><b>Revatio<sup>®</sup></b> (sildenafil citrate)</p>	<p>Approved for members with a diagnosis of Pulmonary Arterial Hypertension (PAH). Coverage for sildenafil (Revatio<sup>®</sup>) <b>in combination</b> with bosentan (Tracleer<sup>®</sup>), epoprostenol (Flolan<sup>®</sup>), treprostinil (Remodulin<sup>®</sup>) or iloprost (Ventavis<sup>®</sup>) <u>is provided</u> after monotherapy with one of these agents has been found to be inadequate in the treatment of the patient's symptoms. Coverage is <u>not provided</u> for sildenafil (Revatio<sup>®</sup>) in situations where patients are receiving nitrate therapy.</p>
<p><b>Sancuso<sup>®</sup></b> (granisetron)  <i>Nonformulary</i></p>	<p>Coverage of Sancuso<sup>®</sup> will be provided for:</p> <ol style="list-style-type: none"> <li>1. Indication for prevention and/or treatment of nausea/vomiting associated with chemotherapy and /or radiation therapy <b>AND</b></li> <li>2. Documented treatment/failure with generic ondansetron (Zofran<sup>®</sup>) <b>AND</b> generic granisetron (Kytril<sup>®</sup>) <b>AND</b></li> <li>3. Not a candidate for IV granisetron therapy</li> </ol>
<p><b>Sandostatin<sup>®</sup></b> (octreotide) [g]  <b>Sandostatin LAR<sup>®</sup></b></p>	<p><u>Sandostatin<sup>®</sup> [g]</u>            Approval requires one of the following (1, 2 or 3):</p> <ol style="list-style-type: none"> <li>1. Clinically diagnosed acromegaly <b>AND</b> one of the following (a, b, <b>or</b> c)               <ol style="list-style-type: none"> <li>a. failure to respond to surgery or radiation <b>OR</b></li> <li>b. not a candidate for surgery or radiation <b>OR</b></li> <li>c. use to shrink tumor prior to surgery</li> </ol> </li> <li>2. Diagnosis of metastatic carcinoid tumor</li> <li>3. Diagnosis of vasoactive intestinal peptide tumors (VIPomas)</li> </ol> <p><u>Sandostatin LAR<sup>®</sup></u>            Approval requires member to have previously tried, responded and tolerated immediate-release octreotide injection <b>AND</b> one of the following (1,2 or 3):</p> <ol style="list-style-type: none"> <li>1. Clinically diagnosed acromegaly <b>AND</b> one of the following (a,b <b>or</b> c)               <ol style="list-style-type: none"> <li>a. failure to respond to surgery or radiation <b>OR</b></li> <li>b. not a candidate for surgery or radiation <b>OR</b></li> <li>c. use to shrink tumor prior to surgery</li> </ol> </li> <li>2. Diagnosis of metastatic carcinoid tumor</li> <li>3. Diagnosis of vasoactive intestinal peptide tumors (VIPomas)</li> </ol>

MEDICATION/ DRUG CLASS	CRITERIA
<p><b>Sedative/Hypnotics</b> Ambien® [g] (zolpidem) Sonata® [g] (zaleplon)</p> <p><i>Nonformulary:</i> Ambien CR™ (zolpidem) Lunesta™ (eszopiclone) Rozerem™ (ramelteon)</p>	<p>Requires documentation that member has experienced failure of or intolerance to Ambien® [g] <b>OR</b> Sonata® [g].</p>
<p><b>Selective Reuptake Inhibitor – antidepressants:</b> Celexa® [g] (citalopram) Effexor® [g] (venlafaxine) Luvox® [g] (fluvoxamine) Paxil® [g] (paroxetine) Paxil CR® [g] (paroxetine) Prozac® [g] (fluoxetine) Remeron® [g] (mirtazapine) Wellbutrin SR® [g] (bupropion) Wellbutrin XL® [g] (bupropion) Zoloft® [g] (sertraline) Lexapro® (escitalopram) Effexor XR® (venlafaxine) Venlafaxine ER</p> <p><i>Nonformulary:</i> Aplenzin® (bupropion hydrobromide) Luvox® CR (fluvoxamine) Pexeva® (paroxetine) Pristiq® (desvenlafaxine) Prozac Weekly® (fluoxetine)</p>	<p>Lexapro®, Effexor XR® and Venlafaxine ER require step therapy with at least one of the following <b>generic</b> formulary alternatives; <i>Celexa® [g], Effexor® [g], Luvox® [g], Paxil/CR® [g], Prozac® [g], Remeron® [g], Wellbutrin/SR® [g], Wellbutrin XL® [g], or Zoloft® [g].</i></p> <p><b>Aplenzin®</b>; requires trial/failure of at least 2 formulary agents plus documentation that continued use of Wellbutrin® [g] will adversely affect the member's mental health. <b>Luvox® CR</b>; requires trial/failure of at least 2 formulary agents plus documentation that continued use of Luvox® [g] will adversely affect the member's mental health. <b>Pexeva®</b>; requires trial/failure of at least two of the above formulary agents <b>PLUS</b> documentation that continued use of Paxil® [g] will adversely affect the member's health. <b>Pristiq®</b>; requires trial/failure of at least 2 formulary agents. <b>Prozac Weekly®</b>; requires trial/failure of at least two of the above formulary agents <b>PLUS</b> documentation that continued use of Prozac® [g] will adversely affect the member's health.</p>
<p><b>Singulair®</b> (montelukast)</p>	<p>Chronic treatment of <u>asthma</u> requiring treatment with asthma medication</p> <p><u>Allergic rhinitis</u> following trial/failure of a formulary nonsedating antihistamine or a formulary intranasal corticosteroid.</p>
<p><b>Strattera®</b> (atomoxetine)</p>	<p><i>For members age 5-21:</i> Requires documentation that member has experienced failure of or intolerance to <b>BOTH</b> a methylphenidate product (such as Ritalin® [g] or Concerta®) <b>AND</b> an amphetamine (such as Adderall® [g]). <i>For members age &gt;21:</i> Requires documentation that the member has experienced failure of or intolerance to <b>EITHER</b> a methylphenidate product <b>OR</b> an amphetamine.</p> <p>Approvable when stimulants are contra-indicated by medical history.</p>
<p><b>Tekturna®</b> (aliskiren) <i>Nonformulary</i></p>	<p>Requires documentation that the member has tried standard effective doses and not reached therapeutic goals or could not tolerate therapy with <b>ALL</b> of the following drug classes:</p> <ol style="list-style-type: none"> <li>1. Diuretic</li> <li>2. Beta-blocker</li> <li>3. ACE-Inhibitor</li> <li>4. Angiotension II Receptor Blocker (ARB)</li> </ol>
<p><b>TNF-alpha agents and related products:</b> Enbrel® (etanercept) Humira® (adalimumab)</p> <p><i>Nonformulary:</i> Kineret® (anakinra)</p>	<p><u>Rheumatoid arthritis, juvenile RA, or psoriatic arthritis:</u> Requires three-month trial with two concurrent DMARDs, (one must be methotrexate unless contraindicated). Examples of DMARDs include: methotrexate, sulfasalazine, azathioprine, hydroxychloroquin/chloroquin, cyclosporine, gold and penicillamine.</p> <p><u>Alkylosing spondylitis:</u> requires therapy is being supervised by a Rheumatologist.</p> <p><u>Moderate to severe psoriasis:</u> Requires 3 months of previous treatment with topical corticosteroids <b>AND</b> 3 months treatment with PUVA (unless PUVA is contraindicated) <b>AND</b> therapy must be supervised by a Dermatologist.</p> <p><u>Crohn's Disease:</u> Coverage for patients age 18 years and older, with a diagnosis of moderately to severely active Crohn's disease with a history of inadequate response to conventional therapy. <b>Applies to Humira® only.</b></p> <p>Kineret is only approved for the treatment of rheumatoid arthritis in adults. <b>Nonformulary agents require documentation that member has experienced treatment failure of or intolerance to formulary agents.</b></p>

MEDICATION/ DRUG CLASS	CRITERIA
<b>Thiazolidinediones (TZDs):</b> Actos® (pioglitazone), Avandia® (rosiglitazone) Avandamet® (rosiglitazone/metformin) Avandaryl® (rosiglitazone/glimepiride) ActoPlus Met® (pioglitazone/metformin) Duetact® (pioglitazone/glimepiride)	Requires documentation that the member has experienced failure with generic metformin (Glucophage®). 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.  Coverage of combination products requires successful treatment of individual agents in combination for at least 90-days as determined by improvements in HbA1c and lack of adverse events.
<b>Tracleer™</b> (bosentan)	Requires a diagnosis of Pulmonary Arterial Hypertension (PAH) in patients with WHO Class III or IV symptoms.
<b>Treximet™</b> (sumatriptan/naproxen sodium) <i>Nonformulary</i>	Requires prior use of Imitrex® [g] and Naprosyn® [g] in combination <b>AND</b> documentation indicating why use of the individual agents is harmful to the member <b>AND</b> documentation of trial and failure of formulary option Maxalt®.
<b>TriLipix™</b> (fenofibric acid) <i>Nonformulary</i>	Requires trial and failure of gemfibrozil [g] <b>AND</b> fenofibrate [g].
<b>Triptans:</b> Imitrex® [g] (sumatriptan) Maxalt® (rizatriptan)  <i>Nonformulary</i> Amerge® (naratriptan) Axert® (almotriptan) Frova® (frovatriptan) Relpax® (eletriptan) Zomig® (zolmitriptan)	The formulary option Maxalt® will require trial and failure of the generic formulary alternative Imitrex® [g].  Approval of the nonformulary triptans, Amerge®, Axert®, Frova®, Relpax®, Zomig®, will require trial and failure of both the formulary options Imitrex® [g] <b>AND</b> Maxalt®.
<b>Vyvanse™</b> (lisdexamfetamine) <i>Nonformulary</i>	Covered for the treatment of ADHD in children and adults 6 years of age and older who have experienced therapeutic failure or intolerance to <b>BOTH</b> an amphetamine-type product <b>AND</b> a methylphenidate product. Maximum dose approved per day will be 70 mg.
<b>Xenazine®</b> (tetrabenazine)	Approval will require diagnosis of chorea associated with Huntington's disease <b>AND</b> for doses above 50mg per day, documentation of the CYP2D6 genotype of the patient will be required.

[g] = generic available