



Midwest Health Plan does not cover brand name products with generic available. Please use the generic equivalent.

Midwest Health Plan PA Grid

Updated on 09-21-10

Brand Name	Criteria for Approval	Standard Response
Accolate Step Therapy Zero days for ICS or SABA	Step therapy: For Asthma diagnosis, Concurrent use of albuterol or inhaled corticosteroid is required. Not covered for allergy diagnosis.	For Asthma diagnosis: Concurrent use of Albuterol or inhaled corticosteroid is required. For Allergy diagnosis: Accolate is not covered for Allergic Rhinitis, Please consider formulary agents, diphenhydramine, cetirizine or loratadine.
Accu-Chek strip	Only cover Bayer products	Please consider formulary products: Bayer Test Strips (Contour and Breeze). Thank you
Accutane (Claravis)	Acne Tiers: 1. Topical benzoyl peroxide and topical antibiotics 2. Topical tretinoin 3. Other topical medications (Differin, Tazorec or Axelex) 4. Oral isotretinoin MUST FAIL (ALL) Benzoyl Peroxide, Topical antibiotic, Tretinoin and Differin Minimum 6 weeks treatment with each agent	Acne Tiers: 1. Topical benzoyl peroxide and topical antibiotics 2. Topical tretinoin 3. Other topical medications (Differin, Tazorec or Axelex) 4. Oral isotretinoin MUST FAIL (ALL) Benzoyl Peroxide, Topical antibiotic, Tretinoin and Differin Minimum 6 weeks treatment with each agent

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	Dx: Cystic acne; max duration of 20 weeks Patient will need to be off Accutane for 8 weeks before additional renewals. Renewal after 8 weeks, if 70% reduction in nodules was achieved. Must meet FDA criteria.	Accutane can be approved if the patient has a diagnosis of cystic acne. Must meet FDA criteria. Please resubmit the prior authorization request with documentation showing patient's progress; must be prescribed by Dermatologist.
Aceon	Use Formulary agents	Please consider formulary agents enalapril and lisinopril.
Aciphex	PPI Tiers: <ol style="list-style-type: none"> 1. Omeprazole 2. Prevacid OTC 3. Pantoprazole 4. Brand PPI Must fail trial of all Tiers (1, 2 and 3) before consideration of branded PPI	Please consider Omeprazole 20mg capsule.
Actiq Medical Director Review	Prior Authorization required. <u>Send request to Medical Director for Review.</u>	Use Geq Vicodin, Norco, or morphine sulfate IR
Actonel/ with Calcium	Use formulary agent Alendronate (generic Fosamax).	Please use formulary agent Alendronate (generic Fosamax)
Actos/ Actoplus Met Step Therapy	Prior use of sulfonylurea or metformin per step therapy guidelines.	Please consider formulary agents sulfonylurea (glyburide or glipizide) or metformin.
Acyclovir injection, solution	Requires PA	Dosage form not covered
Advair Step Therapy	Prior use of inhaled corticosteroids (Asmanex, Flovent, Qvar or Leukotriene inhibitor per step therapy guidelines.	Please consider formulary agents Asmanex, Flovent, Qvar or Leukotriene inhibitor per step therapy guidelines.
Advicor	Use two separate agents	Please consider generic niacin and lovastatin as separate agents.
Aggrenox	Use two separate agents	Please consider generic dipyridamole and aspirin as separate agents.
Albuterol 8mg ER tablet	Requires PA	Dosage form not covered
Aldara	Ok for Genital Condyloma if patient failed podofilox	Please consider first line formulary agent podofilox

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	solution then gel.	solution and second line agent podofilox gel, which also requires prior authorization. Aldara has a non-FDA-approved indication for Verruca Papules. Please consider using alternative treatment regimens, such as, topical salicylic acid.
Allegra /D	Use OTC loratadine, diphenhydramine, or cetirizine. Use Loratadine D for combination product.	Please consider formulary alternatives diphenhydramine, cetirizine and loratadine. Use Loratadine D for combination product.
Allegra Suspension	Use formulary agents.	Please consider loratadine syrup.
Alphagan P	Use generic brimonidine solution 0.2%, no exceptions.	Please consider formulary alternative generic brimonidine solution 0.2%.
Altoprev	Refer to HMG-CoA conversion chart. Formulary alternatives are lovastatin, simvastatin, or pravastatin.	Please consider formulary alternatives generic lovastatin, simvastatin, or pravastatin. Thank you
Amerge	Must have failed trial of 1) Imetrex 100mg AND 2) 90 day continuous use of migraine prophylaxis (SSRI, beta blocker, antihistamine, anticonvulsant, or calcium channel blocker) per pharmacy profile	Use preferred formulary agent Imitrex 100 mg with quantity limit of 9 tablets per 30 days. Consider adding migraine prophylaxis
Amnesteem	Acne Tiers: <ol style="list-style-type: none"> 1. Topical benzoyl peroxide and topical antibiotics 2. Topical tretinoin 3. Other topical medications (Differin, Tazorec or Axelex) 4. Oral isotretinoin <p>MUST FAIL (ALL) benzoyl peroxide, topical antibiotic, tretinoin and other topical</p> <p>Minimum 6 weeks treatment with each agent</p> <p>Dx: Cystic acne; max duration of 20 weeks Patient will need to be off Amnesteem for 8 weeks before additional renewals. Renewal after 8 weeks, If 70% reduction in nodules was achieved. Must meet FDA criteria.</p>	Acne Tiers: <ol style="list-style-type: none"> 1. Topical benzoyl peroxide and topical antibiotics 2. Topical tretinoin 3. Other topical medications (Differin, Tazorec or Axelex) 4. Oral isotretinoin <p>MUST FAIL (ALL) benzoyl peroxide, topical antibiotic, tretinoin and other topical</p> <p>Minimum 6 weeks treatment with each agent</p> <p>Can be approved if the patient has a diagnosis of cystic acne; must meet FDA criteria. Please resubmit the prior authorization request with documentation showing patient's progress. Must be prescribed by a Dermatologist.</p>
Amoxicillin Chew, Tablet, Drop	Requires PA	Dosage form not covered, use capsule or suspension

Brand Name	Criteria for Approval	Standard Response
(50mg/ml)		
Ampicillin injection	Requires PA	Dosage form not covered
Androgel/ Androderm Medical Director Review	PA required. Send to Medical Director Review.	Dosage form not covered
Anexsia (Hydrocodone- Acetaminophen Tab 7.5-325 Mg)	Requires PA	Dosage Form Not Covered
Anzemet	Prior Authorization required. Ondansetron tablet is preferred formulary agent for short-term treatment of nausea and/or vomiting associated with emetogenic cancer chemotherapy. Limited to 9 tabs per month *All Claims will reject for members on Prenatal Vitamins. Ok for a maximum of 6 months at a time.	Use formulary alternative Ondansetron tablets. QL is 9 tabs/ month.
Aricept	Ok for Alzheimer's disease diagnosed by Neurologist.	Aricept can be approved for the diagnosis of Alzheimer's disease confirmed by a Neurologist. Please re-submit this prior authorization request with chart notes indicating patient's diagnosis confirmed by a Neurologist.
Ascencia (Bayer Contour and Bayer Breeze) test strips and test disks	QL=50 is approved QL=100 requires electronic history of insulin QL>/=150, send request to MDR.	Quantities greater than 50 test strips/ disks require history of insulin .
Atacand/Atacand HCT	ARB/ARB HCT Tiers: 1. Cozaar/Hyzaar 2. Benicar/Benicar HCT 3. Other branded ARB/ARB HCT Must fail trial of all Tiers (1 and 2) before consideration of other branded ARB/ARB HCT	Please us ACEI as first line drug, followed by preferred ARB/ARB HCT: Cozaar/Hyzaar.
Augmentin Chew, XR tab	Require PA	Dosage form not covered
Avalide	ARB/ARB HCT Tiers: 1. Cozaar/Hyzaar	Please us ACEI as first line drug, followed by preferred ARB/ARB HCT: Cozaar/Hyzaar.

Brand Name	Criteria for Approval	Standard Response
	2. Benicar/Benicar HCT 3. Other branded ARB/ARB HCT Must fail trial of all Tiers (1 and 2) before consideration of other branded ARB/ARB HCT	
Avandia/ Avandamet/ Avandaryl Step Therapy	Prior use of sulfonylurea or metformin per step therapy guidelines.	Please consider formulary agents sulfonylurea (glyburide or glipizide) or metformin.
Avapro	ARB/ARB HCT Tiers: 1. Cozaar/Hyzaar 2. Benicar/Benicar HCT 3. Other branded ARB/ARB HCT Must fail trial of all Tiers (1 and 2) before consideration of other branded ARB/ARB HCT	Please us ACEI as first line drug, followed by preferred ARB/ARB HCT: Cozaar/Hyzaar.
Avelox (Step Therapy)	Patient must have 5 days of 1st line antibiotic within the last 30 days. (e.g. amoxicillin, cephalexain, penicillin, macrolides, cipro)	Use marcrolide
Avinza Medical Director Review	Prior Authorization required, <u>Send request to Medical Director for Review.</u>	Use Geq Vicodin, Norco, or morphine sulfate IR
Axert	Must have failed trial of 1) Imetrex 100mg AND 2) 90 day continuous use of migraine prophylaxis (SSRI, beta blocker, antihistamine, anticonvulsant, or calcium channel blocker) per pharmacy profile	Use preferred formulary agent Imitrex 100 mg with quantity limit of 9 tablets per 30 days. Consider adding migraine prophylaxis
Azithromycin Susp 2Gram (Zmax)	Requires PA	Dosage form not covered
Azelex	Acne Tiers: 1. Topical benzoyl peroxide and topical antibiotics 2. Topical tretinoin 3. Other topical medications (Differin, Tazorec or Azelex) 4. Oral isotretinoin MUST FAIL (ALL) BPO, Topical antibiotic, and Tretinoin	Acne Tiers: 1. Topical benzoyl peroxide and topical antibiotics 2. Topical tretinoin 3. Other topical medications (Differin, Tazorec or Azelex) 4. Oral isotretinoin MUST FAIL (ALL) BPO, Topical antibiotic, and Tretinoin

Brand Name	Criteria for Approval	Standard Response
	Minimum 6 weeks treatment with each agent Maximum age 19 years	Minimum 6 weeks treatment with each agent Maximum age 19 years
Azor	Use separate agents	Use two separate agents: Norvasc (geq) and benicar (geq)
Benicar/ Benicar HCT	ARB/ARB HCT Tiers: 1. Cozaar/Hyzaar 2. Benicar/Benicar HCT 3. Other branded ARB/ARB HCT Must fail trial of Cozaar/Hyzaar	Please us ACEI as first line drug, followed by preferred ARB/ARB HCT: Cozaar/Hyzaar.
Benzoyl Peroxide Gel 2.5%, 4%,8% Liquid 5%, 10%, Lotion 4%, 8%	Requires PA	Dosage form not covered. Please use Benzoyl Peroxide 5% gel or 10% gel
Boniva	Use formulary agent Alendronate (generic Fosamax).	Please use formulary agent Alendronate (generic Fosamax)
Caduet	Use separate agents	Please consider combination of Amlodipine (generic Norvasc) and a generic statin. Thank you
Cardene SR	Requires PA	Use Nifedipine SR
Cardizem LA tablet and ER (beads cap)	Requires PA	Dosage form not covered
Catapress TTS patch	Patients must have 30 Days of clonidine tablets in the last 120 days.	Please consider formulary agent generic clonidine tablets.
Ceclor (Cefaclor) Step Therapy	Patient must have 5 days of 1st line antibiotic within the last 30 days. (e.g. amoxicillin, cephalixin, penicillin)	Please consider formulary agents amoxicillin, sulfamethoxazole/trimpethoprim, Cephalixin, ampicillin, dicloxacillin, macolide, or generic augmentin.
Cefaclor Chew Tab, ER tab	Requires PA	Dosage form not covered
Cefadroxil Syrup, 1gm Tab	Requires PA	Dosage form not covered
Cefzil (cefprozil) Step Therapy	Patient must have 5 days of 1st line antibiotic within the last 30 days. (e.g. amoxicillin, cephalixin, penicillin)	Please consider formulary agents amoxicillin, sulfamethoxazole/trimpethoprim, Cephalixin, ampicillin, dicloxacillin, macolide, or generic augmentin.
Cefprozil Susp	Requires PA	Dosage form not covered
Ceftin	Patient must have 5 days of 1st line antibiotic within the	Please consider formulary agents amoxicillin,

Brand Name	Criteria for Approval	Standard Response
Step therapy	last 30 days.	sulfamethoxazole/trimethoprim, Cephalexin, ampicillin, dicloxacillin, macolide, or generic augmentin.
Cefuroxime Susp, Injection	Requires PA	Dosage form not covered
Celebrex Medical Director Review	Age greater than 65 years and prior use of 2 formulary NSAIDs and concurrent use of Omeprazole 20mg capsule. Any response back from Doctor, send to Medical Director for review.	Please consider formulary agents such as naproxen or sulindac as single agents or in combination with Omeprazole 20mg capsule.
Cephalexin Tab For Oral Susp	Requires PA	Dosage form not covered
Cetirizine Syrup	Requires PA	Dosage form not covered
Cetirizine – Pseudoephedrine	Requires PA	Use Loratidine D
Chloroquine 500mg	Requires PA	Dosage form not covered. Use Chloroquine 250 mg
Ciprofloxacin injection, 500mg ER and 1000mg ER tablet	Requires PA	Dosage form not covered, use ciprofloxacin 500mg or 250mg tablet
Claravis	Acne Tiers: <ol style="list-style-type: none"> 1. Topical benzoyl peroxide and topical antibiotics 2. Topical tretinoin 3. Other topical medications (Differin, Tazorec or Axelex) 4. Oral isotretinoin <p>MUST FAIL (ALL) benzoyl peroxide, Topical antibiotic, Tretinoin and other topical</p> <p>Minimum 6 weeks treatment with each agent</p> <p>Dx: Cystic acne, max duration of 20 weeks, Patient will need to be off Claravis for 8 weeks before additional renewals. Renewal after 8 weeks, If 70% reduction in</p>	Acne Tiers: <ol style="list-style-type: none"> 1. Topical benzoyl peroxide and topical antibiotics 2. Topical tretinoin 3. Other topical medications (Differin, Tazorec or Axelex) 4. Oral isotretinoin <p>MUST FAIL (ALL) benzoyl peroxide, Topical antibiotic, Tretinoin and other topical</p> <p>Minimum 6 weeks treatment with each agent</p> <p>Claravis can be approved if patient has a diagnosis of cystic acne for a maximum of 20 weeks at a time. Please resubmit the prior authorization request with documentation</p>

Brand Name	Criteria for Approval	Standard Response
	nodules was achieved. Must meet FDA criteria	showing patient's progress. Must be prescribed by Dermatologist. Diagnosis must meet FDA criteria.
Clarinex	Use loratadine , diphenhydramine, or cetirizine.	Please consider formulary alternatives: , diphenhydramine, cetirizine or loratadine
Clarithromycin Susp, XL, ER tablet	Requires PA	Dosage form not covered. Use Clarithromycin 250 or 500mg tablet
Clinidamycin 300mg cap, 75mg cap and solution	Requires PA	Dosage form not covered. Use Clindamycin 150 mg.
Clindamycin (Topical) 1% Foam, 1% Gel, 1% Lotion	Requires PA	Dosage form not covered. Use Clindamycin 1% Solution
Clobetasol Gel, Foam, Lotion, Spray, and Cream	Requires PA	Dosage form not covered. Please use ointment or solution.
Colcrys	Requires PA	Dosage form not covered
Combigan	Use separate agents	Use generic Brimonodine and Timolol as separate agents
Comtan	Requires prior use with formulary agent Sinemet (geq).	Please consider formulary alternative generic Sinemet. Thank you
Condylox	Ok for Genital Chondyloma if patient failed podofilox solution then gel.	Please consider formulary alternatives podofilox solution then gel.
Cosopt	Use Trusopt plus generic Timoptic (timolol)	Please consider formulary alternatives Trusopt and Timolol,
Covera-HS	Requires PA	Dosage form not covered
Cozaar Step Therapy	Per MHP guidelines, first line therapy is ACEI. If patient has failure/ intolerance to ACEI, then use preferred ARB: Cozaar/Hyzaar .	Must fail ACEI/ HCTZ combo, then use preferred ARB: Cozaar/Hyzaar
Crestor	PA required. Refer to HMG-CoA conversion chart. Formulary alternatives are lovastatin, simvastatin, or pravastatin.	Please consider formulary alternatives generic lovastatin, simvastatin, or pravastatin.
Daypro	Patients must have a two-week trial of two formulary NSAID's within the last 180 days, and concurrent use of Omeprazole 20mg capsule.	Please consider formulary agents such as naproxen or sulindac as single agents or in combination with Omeprazole 20mg capsule.

Brand Name	Criteria for Approval	Standard Response
Depo-Provera	Generic is formulary. 150 mg is covered for contraception, 400mg is covered for endometriosis.	MHP is a mandatory generic plan. Please consider generic Depo-Provera.
Desloratadine	Requires PA	Use Cetirizine or Loratadine
Desloratadine & Pseudoephedrine	Requires PA	Use Cetirizine or Loratadine
Desmopressin/ DDAVP NS Medical Director Review	Approve for diabetes insipidus, hemophilia A or von Willebrand's disease. All other diagnosis, send to MDR.	
Detrol (LA) Step Therapy	Patient must have 1 fill of oxybutynin in the past 120 days	Use Oxybutynin (ER)
Differin Topical	Acne Tiers: 1. Topical benzoyl peroxide and topical antibiotics 2. Topical tretinoin 3. Other topical medications (Differin, Tazorec or Axelex) 4. Oral isotretinoin MUST FAIL (ALL) BPO, Topical antibiotic, and Tretinoin Minimum 6 weeks treatment with each agent Maximum age 19 years	Acne Tiers: 1. Topical benzoyl peroxide and topical antibiotics 2. Topical tretinoin 3. Other topical medications (Differin, Tazorec or Axelex) 4. Oral isotretinoin MUST FAIL (ALL) BPO, Topical antibiotic, and Tretinoin Minimum 6 weeks treatment with each agent Maximum age 19 years
Diovan/Diovan HCT	ARB/ARB HCT Tiers: 1. Cozaar/Hyzaar 2. Benicar/Benicar HCT 3. Other branded ARB/ARB HCT Must fail trial of all Tiers (1 and 2) before consideration of other branded ARB/ARB HCT	Please use ACEI as first line drug, followed by preferred ARB/ARB HCT: Cozaar/Hyzaar.
Diphenhydramine (Injection, syrup, tab)	Requires PA	Dosage form not covered. Use capsules or elixir.
Dovonex	Patient must have a trial of 2 formulary agents. Formulary agents are hydrocortisone, triamcinolone.	Please consider formulary agents generic hydrocortisone and triamcinolone.
Doxycycline Hyclate	Requires PA	Dosage form not covered. Use capsules (non-DR and

Brand Name	Criteria for Approval	Standard Response
(DR cap, injection, and Doryx)		tablets).
Doxycycline (Monohydrate tablets and Avidoxy)	Requires PA	Dosage form not covered. Use capsules (non-DR and tablets).
Duragesic Medical Director Review	Prior Authorization required. <u>Send request to Medical Director for Review.</u>	Use Geq Vicodin, Norco, or morphine sulfate IR
Dynacirc/CR	Requires PA	Please consider formulary alternative nifedipine / ER.
Elidel	Use hydrocortisone, betamethasone or triamcinolone (2 week trial in the last 60 days). If approving only approve 30gm per 30 days for 3 months.	Please consider formulary topical steroids including triamcinolone, betamethasone and hydrocortisone.
Elmiron	Approve for interstitial cystitis (IC)	
Elocon	Use Kenalog geq, Synalar geq, Diprosone geq, Topicort geq	Please consider formulary alternatives triamcinolone, betamethasone, and fluocinolone per MHP guidelines.
Erythromycin Ethylsuccinate For Susp 400 Mg/5ml (EryPed)	Requires PA	Dosage form not covered.
Erythromycin (Topical) 2% Pads	Requires PA	Dosage form not covered. Use Erythromycin 2% Gel, 2% Ointment, or 2% Solution.
Estraderm	Use formulary agent Alora 0.05mg/24 hours, 0.075 mg/24 hours and 0.1 mg/24 hours.	Please consider formulary alternative Alora 0.05mg/24 hours, 0.075 mg/24 hours and 0.1 mg/24 hours..
Estradiol Gel	Requires PA	Dosage form not covered.
Exforge (HCT'Z)	Use separate agents	Use separate agents: Norvasc (geq) and Diovan/HCT (geq).
Fentanyl Ot Loz	Prior Authorization required. <u>Send request to Medical Director for Review.</u>	Use Geq Vicodin, Norco, or morphine sulfate IR
Fentora	Prior Authorization required. <u>Send request to Medical Director for Review.</u>	Use Geq Vicodin, Norco, or morphine sulfate IR

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Fexofenadine	Requires PA	Use Cetirizine or Loratadine
Fexofenadine-Pseudoephedrine	Requires PA	Use Loratadine-D
Finasteride (Proscar)	Requires PA	Use Uroxatral after trial of Cardura (geq) or Hytrin (geq)
Flomax	Use First-line agents, doxazosin (generic Cardura) and terazosin (generic Hytrin)	Please consider first line formulary agents doxazosin and terazosin.
Floxin (Eye)	2 ND Line, Patient must have 5 days of 1 st line antibiotic within the last 30 days.	Please use first line agents: erythromycin eye ointment, gentamicin, tobramycin, sulfacetamide (Bleph-10/Sulamyd).
Floxin Otic	3 days of a formulary agent in the last 30 days. Ok if patient has Tubes or Perforated Eardrums. Formulary agents include Acetasol Otic sol, Acetic Acid Otic sol, Acetic Acid/ Vosol, Vosol HC, Domeboro Otic, Cortisporin Otic.	Please consider formulary agents' generic Cortisporin Otic suspension or solution, vosol, vosol HC and domeboro otic.
Fluconazole 40 mg/ml suspension and, injection	Requires PA	Dosage form not covered.
Flunisolide	Requires PA	Use generic Flonase.
Foradil	Formulary alternative is Serevent. Serevent is on Step therapy. Prior use of inhaled steroid (Asmanex, Flovent, Qvar) or leukotriene inhibitor is required.	Please consider formulary alternative Serevent if the patient has tried at least 1 course of inhaled corticosteroid (Qvar, Flovent) or leukotriene inhibitor.
Fortamet Tab	PA required	Dosage form not covered. Use metformin/ER
Fosamax Sol	Requires PA	Dosage form not covered.
Fosamax + D Tab	Requires PA	Use Fosamax (geq)
Fosinopril	Requires PA	Use preferred ACEI (lisinopril, or enalapril)
FreeStyle	Only cover Bayer products	Please consider formulary products: Bayer Test Strips (Contour and Breeze). Thank you
Frova	Must have failed trial of 1) Imetrex 100mg AND 2) 90 day continuous use of migraine prophylaxis (SSRI, beta blocker, antihistamine, anticonvulsant, or calcium channel blocker) per pharmacy profile	Use preferred formulary agent Imitrex 100 mg with quantity limit of 9 tablets per 30 days. Consider adding migraine prophylaxis
Gentamicin Sulfate Ophth Oint	Requires PA	Dosage Form Not Covered. Use gentamicin ophthalmic solution.
Glucagon Kit		Limit to one kit (dose)

Brand Name	Criteria for Approval	Standard Response
Glumetza Tab	Requires PA	Dosage form not covered. Use metformin/ER
Granisol	Prior Authorization required. Ondansetron tablet is preferred formulary agent for short-term treatment of nausea and/or vomiting associated with emetogenic cancer chemotherapy. Limited to 9 tabs per month *All Claims will reject for members on Prenatal Vitamins. Ok for a maximum of 6 months at a time.	Use formulary alternative Ondansetron tablets. QL is 9 tabs/ month.
Hydromorphone Injection, solution Medical Director Review	Prior Authorization required. <u>Send request to Medical Director for Review.</u>	Dosage Form Not Covered. Use Dilaudid tablets (geq)
Hyzaar Step Therapy	Per MHP guidelines, first line therapy is an ACEI/ HCTZ combo. If patient has failure/ intolerance, then use preferred ARB: Cozaar/Hyzaar.	Must fail ACEI/ HCTZ combo, then use preferred ARB: Cozaar/Hyzaar .
Imitrex Injection and Nasal Spray Medical Director Review	Must have failed trial of 1) Imetrex 100mg AND 2) 90 day continuous use of migraine prophylaxis (SSRI, beta blocker, antihistamine, anticonvulsant, or calcium channel blocker) per pharmacy profile	Use preferred formulary agent Imitrex 100 mg with quantity limit of 9 tablets per 30 days. Consider adding migraine prophylaxis
Innopran XL	Requires PA	Dosage form not covered.
Inspra (eplerenone)	Documented hx of formulary potassium sparing diuretic (spironolactone) required	Please consider formulary agent spironolactone.
Isosorbid SL tab	Requires PA	Dosage form not covered.
Januvia/ Janumet Step Therapy	Prior use of sulfonylurea or metformin per step therapy guidelines.	Please consider formulary agents sulfonylurea (glyburide or glipizide) or metformin. Thank you
Kadian Medical Director Review	Prior Authorization required. <u>Send request to Medical Director for Review.</u>	Use Geq Vicodin, Norco, or morphine sulfate IR
Kytril	Please consider formulary alternative generic ondansetron tablets. Approve for short-term treatment of nausea and/or vomiting associated with emetogenic cancer chemotherapy with a quantity limit of 9 tablets per 30 days. All claims will reject for members on Prenatal Vitamins. PA Criteria will not allow for morning sickness or Heperemesis Gravidarum unless Phenergan has been tried/failed.	Please consider formulary alternative Ondansetron tablets. QL is 9 tabs/ month.
Lansoprazole Cap	Requires PA	Use Prevacid OTC as step therapy after failure of Omeprazole 20 mg
Lescol/ Lescol XL	Refer to HMG-CoA conversion chart. Formulary	Please consider formulary alternatives generic lovastatin,

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	alternatives are lovastatin, simvastatin, or pravastatin.	simvastatin, or pravastatin.
Levaquin	Please consider formulary agent Ciprofloxacin	Please consider formulary agent Ciprofloxacin.
Levocetirizine (Xyzal)	Requires PA	Use Cetirizine or Loratadine.
Lidoderm Patch	Trial with formulary agents in the last 60 days. Formulary agents include: lidocaine oint/cream.	Please consider formulary agents generic lidocaine oint/cream. Thank you
Lipitor	Refer to HMG-CoA conversion chart. Formulary alternative is simvastatin.	Please consider formulary alternatives generic statins: lovastatin, pravastatin or simvastatin..
Loprox	Use formulary agents generic Lotrimin, Mycolog, and Mycostatin.	Please consider formulary agents clotrimazole and miconazole.
Lotrel	Use separate agents	Please consider formulary alternatives Norvasc (geq) and plus Lotensin (geq)
Lovaza (formerly Omecor)	Requires PA	Use generic statin: lovastatin, pravastatin, or simvistatin
Malarone Medical Director Review	Send to Medical Director Review.	
Marinol Medical Director Review	Prior Authorization required. <u>Send to Medical Director Review.</u> Approvable for the treatment of anorexia associated with weight loss in HIV patients. Max daily dose 20mg. 90 day grandfather for current utilizers	
Mask (Respiratory supply)		DME benefit
Mavik	Use Formulary alternative	Please consider formulary alternatives, enalapril and lisinopril.
Maxalt/-MLT	Must have failed trial of 1) Imetrex 100mg AND 2) 90 day continuous use of migraine prophylaxis (SSRI, beta blocker, antihistamine, anticonvulsant, or calcium channel blocker) per pharmacy profile	Use preferred formulary agent Imitrex 100 mg with quantity limit of 9 tablets per 30 days. Consider adding migraine prophylaxis
Mefloquine Medical Director Review	Send to Medical Director Review.	
Meperidine	Requires PA	Dosage Form Not Covered.

Brand Name	Criteria for Approval	Standard Response
Injection, solution		
Methadone Solution, injection	Requires PA	Dosage Form Not Covered.
Methyl dopa 125mg	Requires PA	Dosage form not covered. Use methyl dopa 250 mg or 500 mg
Miacalcin	Please consider formulary agent alendronate	Please consider formulary agent alendronate.
Micardis	ARB/ARB HCT Tiers: 1. Cozaar/Hyzaar 2. Benicar/Benicar HCT 3. Other branded ARB/ARB HCT Must fail trial of all Tiers (1 and 2) before consideration of other branded ARB/ARB HCT	Please use ACEI as first line drug, followed by preferred ARB/ARB HCT: Cozaar/Hyzaar.
Minocycline tablet	Requires PA	Dosage form not covered. Use minocycline capsules.
Miralax	Use formulary agents Approve for chronic constipation or encopresis for age 2-14 years.	Please consider formulary agents lactulose, pericolace, Psyllium or Dulcolax.
Metronidazole 375 cap, injection and ER tab	Requires PA	Dosage form not covered
Monopril	Use Formulary alternative	Please consider formulary alternatives, enalapril and lisinopril.
Morphine injection, solution 10mg/5ml, suppo Medical Director Review	Prior Authorization required. <u>Send request to Medical Director for Review</u>	Use Geq Vicodin, Norco, or morphine sulfate IR
Morphine 20mg/ml Medical Director Review	Prior Authorization required. <u>Send request to Medical Director for Review.</u>	Use Geq Vicodin, Norco, or morphine sulfate IR
MS Contin	Prior Authorization required. <u>Send request to Medical Director Review.</u> MHP may approve for Cancer diagnosis only.	Use Geq Vicodin, Norco, or morphine sulfate IR

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Namenda	Prior authorization requires patients to have currently been on Aricept for past 3 months. Aricept must be continued for PA to be extended.	
Nasacort AQ	Requires PA	Use generic Flonase.
Nasarel	Formulary agents are loratadine, cetirizine or generic Flonase	Please consider formulary agent loratadine, cetirizine or generic Flonase.
Nexium	PPI Tiers: <ol style="list-style-type: none"> 1. Omeprazole 2. Prevacid OTC 3. Pantoprazole 4. Brand PPI Must fail trial of all Tiers (1, 2 and 3) before consideration of branded PPI	Please consider formulary alternative Omeprazole 20 mg capsule.
Nicotine Replacement Products	Approve for a maximum of 12 weeks of products per member lifetime. Second time request send to the Plan.	The smoking cessation criteria allow the member to have 1 session of 12 weeks therapy per lifetime.
Niferex-150 forte capsule	Please consider generic ferrous sulfate.	Please consider formulary agents, generic ferrous sulfate.
Nitroglycerin spray	Requires PA	Dosage form not covered.
Nizarol	5 days of formulary agents in the last 30 days.	Please consider formulary agents generic Mycostatin, Mycolog, or Lotrimin.
Noritate 1% cream	PA required.	Please consider formulary alternatives metronidazole 0.75% cream or gel.
Novolin Pen	For Novolin pen users, if they were on it before in the history claims, approve it. But for new users, send for Medical Director review	Please consider formulary agent Novolin vials.
Nutritional Supplements	All nutritional supplements are covered via DME at this time. And they need a referral from the PCP and an auth from the plan.	
Nystatin Topical Powder	Requires PA	Dosage form not covered.
Omacor (new name is Lovaza)	Requires PA	Use generic statin: lovastatin, pravastatin, or simvastatin

Brand Name	Criteria for Approval	Standard Response
Omnicef Step Therapy	Patient must have 5 days of 1 st line antibiotic within the last 30 days.	Please consider formulary agents amoxicillin, sulfamethoxazole/trimpethoprim, cephalexin, ampicillin, dicloxacillin, macrolide, or generic augmentin.
Ondansetron ODT, injection	Requires PA	Dosage Form not covered. Use Ondansetron tablets.
One Touch test strips	Use Bayer products only.	Please consider formulary Bayer products (Contour and Breeze).
Onglyza	Patient must have 1 fill of metformin or sulfonylurea (e.g. glipizide) in the past 120 days	Step Therapy, after Metformin or Glipizide
Opana/ER Medical Director Review	Prior Authorization required. <u>Send request to Medical Director Review.</u>	Use Geq Vicodin, Norco, or morphine sulfate IR
Optivar	Requires PA	Use Ketotifen
Ortho Evra	Use generic contraceptives	MHP is a mandatory generic plan; please consider formulary generic oral contraceptives or generic Depo Provera. Thank you
Oxycodone conc 20mg/ml Medical Director Review	Prior Authorization required. <u>Send request to Medical Director Review.</u>	Dosage Form Not Covered.
Oxycodone tab Medical Director Review	Prior Authorization required. <u>Send request to Medical Director Review.</u>	Use Geq Vicodin, Norco, or morphine sulfate IR
Oxycontin Medical Director Review	Prior Authorization required. <u>Send request to Medical Director Review.</u>	Use Geq Vicodin, Norco, or morphine sulfate IR
Oxytrol Disc	Requires PA	Dosage form not covered.
Pantoprazole Tab	PPI Tiers: 1. Omeprazole 2. Prevacid OTC 3. Pantoprazole Must fail trial of all Tiers (1 and 2) before consideration of Pantoprazole	Please consider formulary alternative Omeprazole 20 mg capsules. Thank you
Patanase	Requires PA Use formulary agents.	Use Ketotifen
Patanol	Requires PA	Use Ketotifen

Brand Name	Criteria for Approval	Standard Response
PEG 3350	Ok for Chronic constipation or Encopresis if patient is 2 – 14 years old.	Please consider formulary agents lactulose, pericolace, Psyllium or Dulcolax.
Peridopril	Requires PA	Use preferred ACEI: lisinopril or , enalapril
Potassium Chloride 8,15, 25meq, injection and powder	Requires PA	Dosage Form Not Covered.
Prandin (nateglinide)	Requires PA	Use glyburide.
Prevacid OTC Step Therapy	Step Therapy after failed trial of Omeprazole	Please consider formulary agents Omeprazole 20 mg capsules.
ProAir HFA	Requires PA	Use Ventolin HFA.
Propoxyhene-N with APAP tablets: 50-325, 65-650 and 100-500	Requires PA	Dosage Form Not Covered. Use Propoxyhene-N with APAP 100-650
Proscar	Formulary alternative is Uroxatral after trial of Hytrin or Cardura.	Formulary alternative is Uroxatral after trial of Hytrin or Cardura.
Protonix (Pantoprazole) Generic Available	PPI Tiers: 1. Omeprazole 2. Prevacid OTC 3. Pantoprazole Must fail trial of all Tiers (1 and 2) before consideration of Pantoprazole	Please consider formulary alternative Omeprazole 20 mg capsules.
Protopic Ointment	Requires PA	Please consider formulary topical steroids including triamcinolone, betamethasone and hydrocortisone
Proventil HFA	Requires PA	Use Ventolin HFA.
Pulmicort inhaler	Use formulary agents Asmanex. If Patient can't use a spacer, give a 6-month approval then have them re-challenge spacer.	Please consider formulary alternatives Asmanex.
Pulmicort (Respules) Suspension	Pulmicort Respules are approved for age 7 and younger.	Pulmicort respule is covered for age 7 and younger.
Ranitidine Syrup		Age Limit: 11 years
Reclast	PA required.	Please consider formulary alternative agent alendronate (generic Fosamax).

Brand Name	Criteria for Approval	Standard Response
Regranex	Ok for up to 10 weeks for diabetic foot ulcer in-patients receiving oral first line antibiotic.	Ok for up to 10 weeks for diabetic foot ulcer in-patients receiving oral first line antibiotic.
Relistor Medical Director Review	Send to Medical Director Review.	
Relpax	Must have failed trial of 1) Imetrex 100mg AND 2) 90 day continuous use of migraine prophylaxis (SSRI, beta blocker, antihistamine, anticonvulsant, or calcium channel blocker) per pharmacy profile	Use preferred formulary agent Imitrex 100 mg with quantity limit of 9 tablets per 30 days. Consider adding migraine prophylaxis
Renagel	One fill of Phoslo in the last 120 days.	Please consider formulary agent Phoslo.
Restasis	One formulary agent in last 30 days. Have to re-meet protocol every time. Formulary agents include: ophthalmic corticosteroids	Please consider formulary alternative ophthalmic corticosteroids.
Retin-A Micro	Dosage form not covered: see tretinoin	Dosage form not covered: see tretinoin
Rhinocort (triamcinolone nasal spray)	Please consider first line formulary agents loratadine, cetirizine or Flonase geq.	Please consider first line formulary agents loratadine, cetirizine or Flonase geq.
Riomet Solution	Requires PA	Dosage form not covered. Use metformin/ER
Ryzolt	Requires PA	Dosage Form Not Covered. Use tramadol tablets 50 mg.
Sancuso	Prior Authorization required. Ondansetron tablet is preferred formulary agent for short-term treatment of nausea and/or vomiting associated with emetogenic cancer chemotherapy. Limited to 9 tabs per month *All Claims will reject for members on Prenatal Vitamins. Ok for a maximum of 6 months at a time.	Use formulary alternative Ondansetron tablets. QL is 9 tabs/ month. Thank you
Sensipar	First st line agent PhosLo, second line agent Renagel. Pt must try and failure both agents. Approvable diagnoses are: secondary parathyroidism due to chronic kidney disease or hypercalcemia associate with parathyroid cancer	Please consider formulary agent Phoslo.
Serevent Step Therapy	Prior or concurrent use of inhaled corticosteroids (Flovent, Asmanex, Qvar, or Leukotriene inhibitor) is required. Can not use concurrently with Advair.	Prior or concurrent use of an inhaled corticosteroid (Flovent, Asmanex, Qvar, or Leukotriene inhibitor is required.
Simcor	Use two separate agents	Please consider formulary alternatives generic niacin with generic statin: lovastatin, simvastatin, or pravastatin. Thank you

Brand Name	Criteria for Approval	Standard Response
Singular Step Therapy	Step therapy: For Asthma diagnosis, Concurrent use of albuterol or inhaled corticosteroids required. Not covered for allergy diagnosis.	For Asthma diagnosis: Concurrent use of Albuterol or inhaled corticosteroid is required. Thank you. For Allergy diagnosis: Singular is not covered for Allergic Rhinitis, Please consider formulary agents, diphenhydramine, loratadine or cetirizine.
Skelaxin	Use formulary agents.	Please consider formulary agents cyclobenzaprine or baclofen.
Sodium Fluoride Chew Tab, gel		Age < 12 years
Soma	Use formulary agents cyclobenzaprine or baclofen. (Never Approve).	Please consider formulary alternative cyclobenzaprine 10mg tab or baclofen.
Soriatane (acitretin)	Dx: Severe psoriasis unresponsive to other therapies. Must be prescribed by a Dermatologist. Must meet FDA criteria.	Soriatane can be approved if there is documentation from a dermatologist that the index case is unresponsive to other therapies for severe psoriasis. Must meet FDA criteria.
Sotret	Acne Tiers: 1. Topical benzoyl peroxide and topical antibiotics 2. Topical tretinoin 3. Other topical medications (Differin, Tazorec or Axelex) 4. Oral isotretinoin MUST FAIL (ALL) BPO, Topical antibiotic, Tretinoin and other topical Maximum age 19 years Dx: Cystic acne, max duration of 20 weeks, Patient will need to be off Claravis for 8 weeks before additional renewals. Renewal after 8 weeks, If 70% reduction in nodules was achieved. Must meet FDA criteria	Acne Tiers: 1. Topical benzoyl peroxide and topical antibiotics 2. Topical tretinoin 3. Other topical medications (Differin, Tazorec or Axelex) 4. Oral isotretinoin MUST FAIL (ALL) BPO, Topical antibiotic, Tretinoin and other topical Minimum 6 weeks treatment with each agent Claravis can be approved if patient has a diagnosis of cystic acne for a maximum of 20 weeks at a time. Please resubmit the prior authorization request with documentation showing patient's progress. Must be prescribed by Dermatologist. Diagnosis must meet FDA criteria.
Sporanox	If patient is immunocompromised approve. If patient is not immunocompromised for nail fungus use generic Lamisil. If systemic give to Pharm review.	Please consider formulary agent generic Lamisil.
Starlix (nateglinide)	Use formulary agents.	Please consider formulary agent glyburide, glipizide.

Brand Name	Criteria for Approval	Standard Response
Sular (nisoldipine)	Requires PA	Use Nifedipine SR
Suprax	Patient must have 5 days of 1 st line antibiotic within the last 30 days. Step therapy exceptions include diagnosis of Uncomplicated Gonorrhea.	Please consider formulary agents amoxicillin, sulfamethoxazole/trimethoprim, Cephalexin, ampicillin, dicloxacillin, macrolide or generic augmentin.
Sure Step test strips	Use Bayer products only .	Please consider formulary Bayer products (Contour and Breeze). Thank you
Symbicort (Step Therapy)	Prior use of inhaled corticosteroids (Asmanex, Flovent, Pulmicort, Qvar or Leukotriene inhibitor). Can not use concurrently with Advair. If electronic hx shows no RX of Advair within the last 30 days, inhaled corticosteroid will adjudicate without restriction.	Please consider formulary agents: Asmanex, Flovent, Qvar or Leukotriene inhibitor
Tazorac Tier for acne mediations	Acne Tiers: 1. Topical benzoyl peroxide and topical antibiotics 2. Topical tretinoin 3. Other topical medications (Differin, Tazorec or Axelex) 4. Oral isotretinoin MUST FAIL (ALL) BPO, Topical antibiotic, and Tretinoin Minimum 6 weeks treatment with each agent Maximum age 19 years	Acne Tiers: 1. Topical benzoyl peroxide and topical antibiotics 2. Topical tretinoin 3. Other topical medications (Differin, Tazorec or Axelex) 4. Oral isotretinoin MUST FAIL (ALL) BPO, Topical antibiotic, and Tretinoin Minimum 6 weeks treatment with each agent Maximum age 19 years
Taztia	Requires PA	Dosage form not covered
Test Strips	Use Bayer products only	Please consider formulary Bayer products (Contour and Breeze). Thank you
Testosterone Inj Medical Director Review	PA required. Send to Medical Director Review.	PA required.
Teveten	ARB/ARB HCT Tiers: 1. Cozaar/Hyzaar 2. Benicar/Benicar HCT	Please us ACEI as first line drug, followed by preferred ARB/ARB HCT: Cozaar/Hyzaar.

Brand Name	Criteria for Approval	Standard Response
	3. Other branded ARB/ARB HCT Must fail trial of all Tiers (1 and 2) before consideration of other branded ARB/ARB HCT	
Theophylline Tab SR 400mg	Requires PA	Dosage form not covered.
Tiazac	Requires PA	Dosage form not covered. Use diltiazem CD.
Tramadol (APAP)	Requires PA	Use tramadol tablets 50 mg
Trandolapril	Requires PA	Use preferred ACEI: lisinopril, or enalapril
Tretinoin	Acne Tiers: 1. Topical benzoyl peroxide and topical antibiotics 2. Topical tretinoin 3. Other topical medications (Differin, Tazorec or Axelex) 4. Oral isotretinoin MUST FAIL (ALL) BPO and Topical antibiotic Minimum 6 weeks treatment with each agent Maximum age 21 years	Acne Tiers: 1. Topical benzoyl peroxide and topical antibiotics 2. Topical tretinoin 3. Other topical medications (Differin, Tazorec or Axelex) 4. Oral isotretinoin MUST FAIL (ALL) BPO and Topical antibiotic Minimum 6 weeks treatment with each agent Maximum age 21 years
Triamcinolone Nasal Spray	Prior use of loratadine, cetirizine and then generic Flonase.	Please consider first line formulary agent Loratadine or cetirizine and second line agents generic Flonase.
Tricor	Use formulary fenofibrate or generic statin.	Please consider formulary fenofibrate or generic statin.
Triglide	Use formulary fenofibrate or generic statin.	Please consider formulary agent fenofibrate or generic statin.
True-Track	Only cover Bayer(Contour and Breeze) products	Please consider formulary products: Bayer Test Strips (Contour and Breeze). Thank you
Uroxatral	Use formulary alternatives doxazosin or terazosin as first line agents.	Please consider formulary agents doxazosin and terazosin.
Valtrex	Use acyclovir as first line agent. Approvable with documentation of more than 3 breakthrough episodes (per year) WHILE on acyclovir treatment OR documented intolerance to acyclovir.	Please consider formulary first line alternative acyclovir.

Brand Name	Criteria for Approval	Standard Response
Verapamil SR 24 hour cap	Requires PA	Dosage form not covered. Use Verapamil CR tablets
VFend Medical Director Review	Send to Medical Director Review.	
Viagra Medical Director Review	Send to Medical Director review to be denied.	Not covered by any program funded by MDCH.
Voltaren gel	PA required.	Use formulary alternatives.
Vytorin	Use lovastatin, pravastatin, or simvastatin.	Please consider the formulary alternative, lovastatin, pravastatin, or simvastatin.
Welchol	Use formulary agents.	Please consider formulary agents cholestyramine and/or colestipol.
Winrho SDF	Requires PA	Dosage form not covered
Xenical	Complete weight loss form. Form must include patients BMI, weight, height, and other agents and methods of weight loss patient has tried and failed. For all renewal requests patient must have a 3% reduction in weight from previous approval.	Complete weight loss form. Form must include patients BMI, weight, height, and other agents and methods of weight loss patient has tried and failed. For all renewal requests patient must have a 3% reduction in weight from previous approval.
Xodol (Hydrocodone-Acetaminophen Tab 5-300 Mg) Medical Director Review	Prior Authorization required. <u>Send request to Medical Director Review.</u>	Dosage Form Not Covered Use Geq Vicodin, Norco, or morphine sulfate IR
Xodol Tab 10-300mg Medical Director Review	Prior Authorization required. <u>Send request to Medical Director Review.</u>	Dosage Form Not Covered Use Geq Vicodin, Norco, or morphine sulfate IR
Zometa	PA required.	Please consider formulary alternative agent alendronate (generic Fosamax).
Xopenex/HFA	Ok if patient is intolerant to generic albuterol inhalation solution due to Tachycardia or tremor per step therapy guidelines.	Please consider formulary agent albuterol
Zanaflex	For all Midwest plans (except Medicare), Pt must tried and failed or has contraindication to Flexeril(cyclobenzaprine) or baclofen.	Please consider formulary alternative cyclovenzaprine 10mg tab or baclofen.

Brand Name	Criteria for Approval	Standard Response
Zegerid	PPI Tiers: 1. Omeprazole 2. Prevacid OTC 3. Pantoprazole 4. Brand PPI Must fail trial of all Tiers (1, 2 and 3) before consideration of branded PPI	Please consider formulary alternative Omeprazole 20 mg capsule.
Zetia	Use lovastatin, pravastatin, or simvastatin as formulary alternatives.	Please consider the formulary alternative, lovastatin, pravastatin, or simvastatin.
Zomig	Must have failed trial of 1) Imetrex 100mg AND 2) 90 day continuous use of migraine prophylaxis (SSRI, beta blocker, antihistamine, anticonvulsant, or calcium channel blocker) per pharmacy profile	Use preferred formulary agent Imitrex 100 mg with quantity limit of 9 tablets per 30 days. Consider adding migraine prophylaxis
Zovirax cream or ointment	PA required.	Please consider formulary alternative acyclovir (oral) per MHP guidelines.
Zydone Tab 10-400mg Medical Director Review	Prior Authorization required. <u>Send request to Medical Director Review.</u>	Dosage Form Not Covered Use Geq Vicodin, Norco, or morphine sulfate IR
Zyvox	Requires PA	Please consider formulary alternative Avelox
Zyzal	Requires PA	Use cetirizine or loratidine
Arixtra	PA is not required for the first 10 days Approve if meet one of the following criteria: 1. Prophylaxis of venous thromboembolism (e.g. DVT or PE) - Approve for 3 months 2. Treatment of venous thromboembolism (e.g. DVT or PE) (warfarin) - Approve for 3 months 3. Diagnosis of cancer with a risk of thrombosis - Approve for 6 months Do not approve for the following: 1. Severe renal impairment (Creatinine clearance <30ml/min) 2. Active major bleeding	PA is not required for the first 10 days of therapy. For additional therapy, please submit diagnosis and the result of renal function test.

Brand Name	Criteria for Approval	Standard Response
Lovenox	<p>PA is not required for the first 10 days</p> <p>Approve if meet one of the following criteria:</p> <ol style="list-style-type: none"> 1. Diagnosis of unstable angina or non-ST segment elevation MI (non-Q wave MI) - Approve for 3 months 2. Prophylaxis of venous thromboembolism (e.g. DVT or PE) - Approve for 3 months 3. Treatment of venous thromboembolism (e.g. DVT or PE) (warfarin) - Approve for 3 months 4. Diagnosis of cancer with a risk of thrombosis - Approve for 6 months 5. Bridge therapy due to high risk of for thromboembolism (e.g. mechanical heart valves, A-fib) - Approve for 1 month. 6. Prophylaxis or treatment for thromboembolic events in a high risk pregnancy (e.g. congenital thrombophilia, antiphospholipid antibodies, prosthetic heart valves, or previous pregnancy complication.) – approve till the due date plus 6 weeks. <p>Do not approve for the following:</p> <ol style="list-style-type: none"> 1. Active major bleeding 	<p>PA is not required for the first 10 days of therapy. For additional therapy, please submit diagnosis.</p>
Emend	<p>Approve if meet both of the following :</p> <ol style="list-style-type: none"> 1. Diagnosis of cancer and receive highly or moderately emetogenic chemotherapy 2. Receive a corticosteroids (dexamethasone) and 5-HT3 antagonists (ondansetron) concurrently <p>Approve for 6 months</p> <p>Dose limit:</p>	<p>For post-op nausea and vomiting, please consider formulary alternative ondansetron tablet.</p> <p>For diagnosis of cancer and with highly or moderately emetogenic chemotherapy, the patient needs to be on a corticosteroids (dexamethasone) and 5-HT3 antagonists (ondansetron) concurrently.</p>
Cellcept (Myfortic, mycophenolate)	<p>Approval criteria;</p> <ol style="list-style-type: none"> 1. History of a kidney, liver, pancreas or heart transplant 2. Diagnosis of proliferative form of Lupus Nephritis and the member is not a candidate for traditional therapy (e.g. cyclophosphamide) or traditional therapy is inadequate. 3. Diagnosis of moderately or severely active 	<p>Cellcept is approved for kidney, liver, pancreas or heart transplant</p> <p>For Lupus Nephritis or Crohn’s disease, please submit diagnosis and history of other immunosuppressants.</p>

Brand Name	Criteria for Approval	Standard Response
	corticosteroid-dependent Crohn's disease.	
Prograf (tacrolimus)	Approval criteria: History of a kidney, liver, pancreas or heart transplant	Prograf is approved for kidney, liver, pancreas or heart transplant
Neoral (gengraf, cyclosporine)	Approvable criteria <ol style="list-style-type: none"> 1. History of a kidney, liver, pancreas or heart transplant 2. Diagnosis of severe, plaque-type psoriasis in immunocompetent patients who failed to respond to at least one systemic therapy (e.g., PUVA, retinoids, methotrexate) or in patients for whom other systemic therapies are contraindicated or cannot be tolerated 	Cyclosporine is approved for kidney, liver, pancreas or heart transplant. For diagnosis of severe, plaque-type psoriasis in immunocompetent patients, please submit history of past-treatment history.
Testosterone injection	Approvable criteria <ol style="list-style-type: none"> 1. Diagnosis of primary hypogonadism (acquired or congenital) 2. Diagnosis of secondary hypogonadism (e.g. gonadotropin or LHRH deficiency) AND <ol style="list-style-type: none"> 3. A confirm low testosterone level (morning total testosterone <300ng/dl; or morning free testosterone <5ng/dl) 	Please submit testosterone level.
Rapamune	Approvable criteria History of a kidney transplant	Rapamune is approved for kidney transplant.

Helpful Hints

1. Plan does NOT allow vacation overrides.
2. PA can be backdated to the date of first PA submission.

3. For Plan B members (ID starts with “B”), any request for PA for a Plan B member should be referred for Medical Director Review.
4. Early refill edit will apply unless there is a change in dose.