

Proton Pump Inhibitors Effective Date: 6/1/2007 Revised : 8/10/2009	Second Generation Antihistamines Effective Date: 5/2008	Brand Name Schedule II Narcotic Opioids Effective Date: 8/2008	Topical Anti-Inflammatory Agents Effective Date : 12/8/2009	<u>Additional Prior Authorization Classes</u>																																	
<p>No PA Required</p> <p>OTC Prilosec 20mg (PAL Preferred) omeprazole 20mg capsules (PAL Preferred) Prevacid Solutab (PAL Preferred If patient cannot swallow pills) pantoprazole – If pt taking Plavix (clopidogrel)</p> <p>PA Required</p> <p>Brand-Name: Aciphex (rabeprazole), Kapidex (dexlansoprazole), Nexium (esomeprazole), Prevacid (lansoprazole), Prilosec (omeprazole), Protonix (pantoprazole), Zegerid(omeprazole/sodium bicarbonate) *Generic Pantoprazole- if pt. NOT taking Plavix</p> <p>Criteria for Use</p> <p>- Failure w/30 day trial of no less than 40mg omeprazole during a 12-mo period.</p> <p>OR</p> <p>- Use of esomeprazole (Nexium®) for erosive esophagitis Grade C or D.</p> <p>OR</p> <p>- Brand name solutab or liquid dosage forms may be used w/documented inability to swallow tablets or capsules</p> <p>OR</p> <p><i>-Patients receiving clopidogrel (Plavix®) concomitantly with pantoprazole are exempt from prior authorization on pantoprazole</i></p> <p>-</p> <p>Procedures</p> <p>RPh can override the prior authorization edit at the point-of-sale if the MD writes on the face of the prescription in his/her own handwriting...</p> <p>- "Failed omeprazole 40mg for 30 days" - "Esophagitis Grade C OR D" for esomeprazole (Nexium®) 40mg prescriptions only - "Cannot swallow tablets or capsules" - "Taking clopidogrel (Plavix®)"</p> <p>-Treatment failure MUST be documented in chart</p> <p>Exemptions</p> <p>PA not required in pregnancy and/or lactation PA not required for patients under 6 year old</p> <p>Approval</p> <p>12 months</p> <p>References</p> <p>Drug class review on PPI's:Final Report Update 5 May 2009 http://derp.phsu.edu/about/final-products.cfm DMA Link to all Prior Authorization Policies: http://www.ncdhhs.gov/dma/pharmacy/rxpa.htm</p>	<p>NO PA Required</p> <p>OTC Loratadine (PAL Preferred) OTC cetirizine (PAL Preferred) OTC Claritin</p> <p>PA Required</p> <p>Brand-Name: Clarinex (desloratadine), Allegra (fexofenadine), Xyzal (levocetirizine) Generic fexofenadine</p> <p>Criteria & Step Approach for use</p> <p>- For generic fexofenadine "Failed loratadine AND cetirizine each for 30 days" during a 12-mo period "Allergy to loratadine AND cetirizine"</p> <p>- For liquid formulations other than loratadine and cetirizine syrup "Failed loratadine AND cetirizine syrup for 30 days" during a 12-mo period "Allergy to loratadine AND cetirizine syrup"</p> <p>- For all other second generation antihistamines "Failed loratadine for 30 days AND failed cetirizine for 30 days AND failed fexofenadine for 30 days" during a 12-mo period "Allergy to loratadine AND cetirizine AND fexofenadine"</p> <p>Procedures</p> <p>- Treatment failure MUST be documented in chart - RPh can override the prior authorization edit at the point-of-sale if the MD writes on the face of the prescription in his/her own handwriting the appropriate italicized phrases highlighted above.</p> <p>Exemptions</p> <p>- Documented contraindication or allergy to loratadine cetirizine or fexofenadine</p> <p>Approval</p> <p>12 months</p> <p>References</p> <p>Drug Class Review on Newer Antihistamines. Final Report Update 1. April 2006 http://derp.phsu.edu/about/final-products.cfm DMA Link to all Prior Authorization Policies: http://www.ncdhhs.gov/dma/pharmacy/rxpa.htm</p>	<p>NO PA Required</p> <p>- Generic Schedule II Narcotics (PAL Preferred)</p> <p>PA Required</p> <p>Brand Name Short-Acting: Actiq, Combunox, Demerol, Dilaudid, Endodan, Fentora, Levo-Dromoran, Lynox, Magnacet, Opana, OxyIR, Percocet, Percodan, Roxicodone, Tylox, Xolox Brand Name Long-Acting: Avinza, Duragesic Patch, Kadian SR, MS Contin, Opana ER, Oxycontin, Oramorph SR, Dolophine, Methadose</p> <p>Criteria for Use</p> <p>Short-acting: Documented failure within past year of a 30-day trial of generic CII at a dose equivalent to brand name CII being prescribed</p> <p>OR</p> <p>Documented contraindication to one or more of the generic ingredients (i.e. dye)</p> <p>Long-Acting: Documented failure within the past year of a 30-day trial of generic CII (Morphine Sulfate ER, Methadone, Oxycodone CR) at a dose equivalent to brand name CII being prescribed</p> <p>OR</p> <p>- Documented contraindication or allergy to generic extended release morphine or methadone</p> <p>AND</p> <p>- Diagnosis of chronic pain syndrome of at least 4 weeks in duration</p> <p>Procedures</p> <p>- Treatment failure MUST be documented in chart - Prescriber must review the NC Medical Board Statement on use of controlled substances for the treatment of pain @ http://www.ncmedicaid.org/Clients/NCBOM/Public/NewsandForum/mg/mt.htm -Provider MUST complete a Brand- Name Schedule II Narcotic Request Form and submit via FAX ONLY to ACS @ 866-246-8507 for authorization consideration. -Request form available online @ http://www.ncmedicaidpbm.com</p> <p>Exemptions</p> <p>PA not required for patients with pain secondary to cancer Changes in strength do not require PA</p> <p>Approval</p> <p>12 months</p> <p>References</p> <p>DMA Link to all Prior Authorization Policies: http://www.ncdhhs.gov/dma/pharmacy/rxpa.htm</p>	<p>NO PA Required</p> <p>Very High Potency Augmented betametasone dipropionate 0.05% ointment (PAL PREFERRED) Clobetasol propionate 0.05% cream or ointment (PAL PREFERRED)</p> <p>High Potency Augmented betametasone dipropionate 0.05% cream (PAL PREFERRED) Fluocinonide 0.05% cream or ointment (PAL PREFERRED)</p> <p>Medium Potency Betamethasone valerate 0.1% cream (PAL PREFERRED) Triamcinolone 0.025% ointment (PAL PREFERRED)</p> <p>Low Potency Hydrocortisone cream 2.5% (PAL PREFERRED)</p> <p>PA Required</p> <p>Elidel (pimecrolimus), Protopic (tacrolimus), Locoid (hydrocortisone butyrate)</p> <p>Criteria for Use</p> <p>ELIDEL AND PROTOPIC 0.3%</p> <p>- For areas other than groin or face, failed 2 generic topical corticosteroids from preferred list in high potency class AND is > 2 yo - For groin and face, failed 2 generic topical corticosteroids from preferred list in any potency class AND is > 2 yo</p> <p>PROTOPIC 0.1%</p> <p>- For areas other than groin or face, failed 2 generic topical corticosteroids from preferred list in high potency class AND is > 18 yo - For groin and face, failed 2 generic topical corticosteroids from preferred list in any potency class AND is > 18 yo</p> <p>LOCOID</p> <p>-Failed 2 topical generic corticosteroids from preferred list in medium potency class</p> <p>Exemptions</p> <p>-documented adverse reaction or contraindication that precludes trial of 2 generic topical corticosteroids from the preferred list.</p> <p>Approval</p> <p>12 months</p> <p>References</p> <p>DMA Link to all Prior Authorization Policies: http://www.ncdhhs.gov/dma/pharmacy/rxpa.htm</p>	<table border="1" style="width:100%; text-align:center;"> <tr> <th colspan="3">Anemia</th> </tr> <tr> <td>Herminics</td> <td>Generic preparations are not available</td> <td>Aranesp, Epogen, Procrit</td> </tr> </table> <table border="1" style="width:100%; text-align:center;"> <tr> <th colspan="3">Insomnia *</th> </tr> <tr> <td>Hypnotics, Non-benzodiazepines</td> <td>Generic preparations available</td> <td>Ambien, Ambien CR, Sonata, Lunesta, Rozerem, Edluar, Zolpidem, Zaleplon</td> </tr> <tr> <td>Benzodiazepine</td> <td>Generic preparations available</td> <td>ProSom, Dalmane, Halicon, Doral, Restoril, Estazolam, Flurazepam, Trazolam, Temazepam</td> </tr> </table> <p>*Generic and brand name quantities greater than 15 units per calendar month require prior authorization</p> <table border="1" style="width:100%; text-align:center;"> <tr> <th colspan="3">Pain</th> </tr> <tr> <td>NSAID</td> <td>Generic preparations are not available</td> <td>Celebrex</td> </tr> </table> <table border="1" style="width:100%; text-align:center;"> <tr> <th colspan="3">Neuromuscular Disorders</th> </tr> <tr> <td>Neuromuscular Blocking Agents</td> <td>Generic preparations are not available</td> <td>Botox Myobloc</td> </tr> </table> <table border="1" style="width:100%; text-align:center;"> <tr> <th colspan="3">RSV</th> </tr> <tr> <td>Monoclonal Antibody</td> <td>Generic preparations are not available</td> <td>Synagis</td> </tr> </table> <p>For a complete reference to these Prior Authorization Policies, please refer to: http://www.ncdhhs.gov/dma/pharmacy/rxpa.htm</p>	Anemia			Herminics	Generic preparations are not available	Aranesp, Epogen, Procrit	Insomnia *			Hypnotics, Non-benzodiazepines	Generic preparations available	Ambien, Ambien CR, Sonata, Lunesta, Rozerem, Edluar, Zolpidem, Zaleplon	Benzodiazepine	Generic preparations available	ProSom, Dalmane, Halicon, Doral, Restoril, Estazolam, Flurazepam, Trazolam, Temazepam	Pain			NSAID	Generic preparations are not available	Celebrex	Neuromuscular Disorders			Neuromuscular Blocking Agents	Generic preparations are not available	Botox Myobloc	RSV			Monoclonal Antibody	Generic preparations are not available	Synagis
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Community Care of Wake and Johnston Counties
 North Carolina Medicaid Prior Authorization Programs

REFERENCE GUIDE- Revised 12/08/09

Effective Tuesday December 8, 2009 the N.C. Medicaid Outpatient Pharmacy Program will require prior authorization on the following class of medications:

**Brand Name Anticonvulsants (Lyrica, Topamax, Lamictal, Trileptal)
 Anti-inflammatory Agents**

Those medication classes placed "ON HOLD" until further notice:

**Leukotriene Modifiers
 Lipotropics (Statins, Zetia)
 Inhaled Corticosteroids**

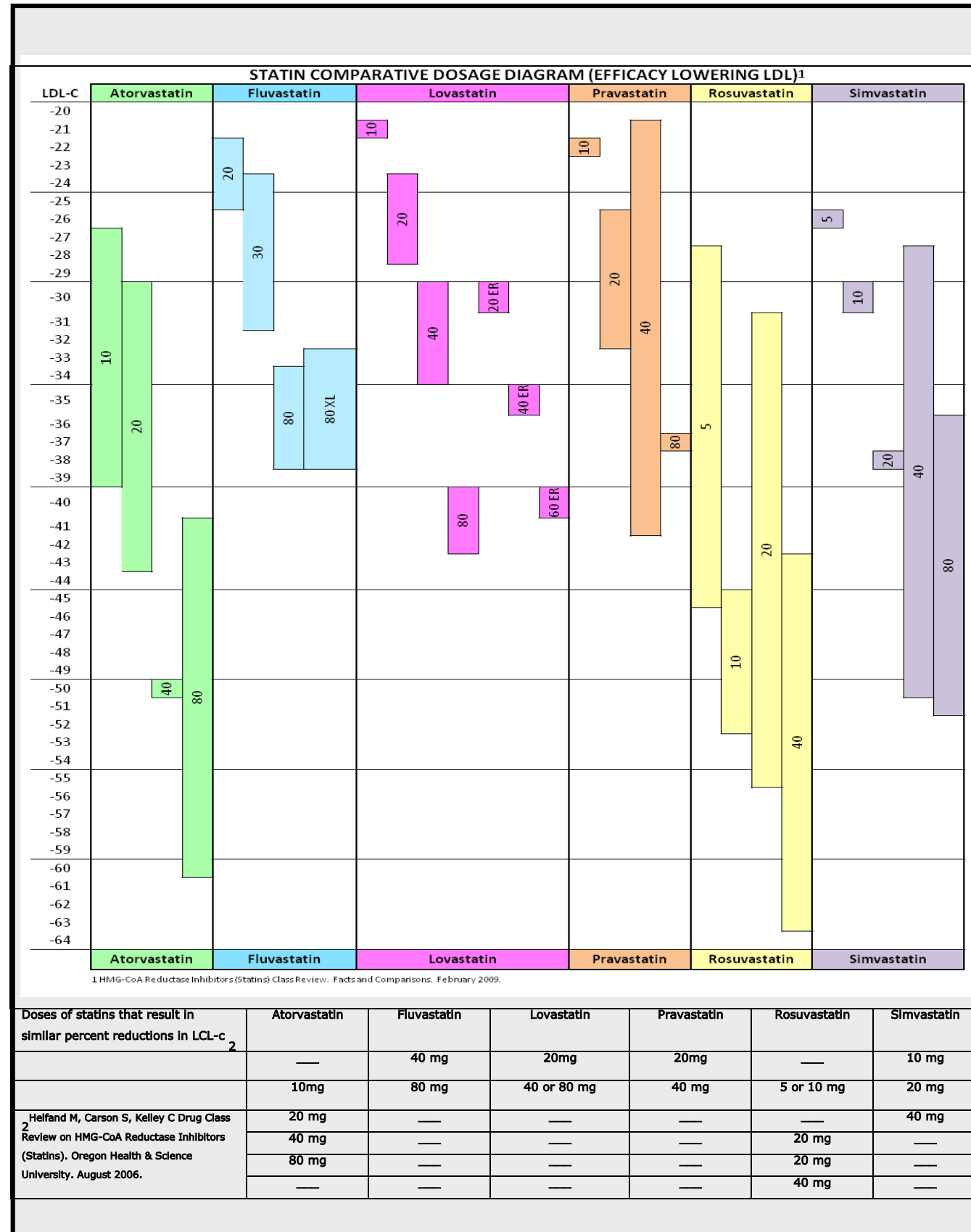
Criteria and PA request forms for these medications are available on the N.C. Medicaid Enhanced Pharmacy Program website at <http://www.ncmedicaidpbm.com>

Prescribers can request prior authorization by contacting ACS at 866-246-8505 (telephone) or 866-246-8507 (fax).

FOR QUESTIONS OR FURTHER ASSISTANCE: Call Community Care of Wake and Johnston County

Prior Authorization SUPPORT Line @ 919-792-3630 or visit us at our website at

www.ccwjc.com



Serotonin 5-HT 1 Receptor Agonists (TRIPTANS) Effective Date: 7/20/2009	Modafinil & Armodafinil Effective Date: 8/10/2009	Brand Name ACEI's, ARB's, & Renin Inhibitors Effective Date : 8/10/2009	Short Acting Inhaled Beta Agonist Effective Date: 9/21/2009	Leukotriene Modifiers 11/24/2009 "ON HOLD" until further notice	Brand Name Statins & Zetia 11/24/2009 "ON HOLD" until further notice
<p>Drug Class:TRIPTANS</p> <p>Amerge, Axert, Frova, Imitrex, Sumatriptan, Maxalt, Maxalt MLT, Relpax, Treximet, Zomig</p> <p>NO PA Required if total dose of a Triptan (oral tablet, nasal spray, or injection) or cumulative dose of different types of Triptans used in a single month is < 12 units (doses)</p> <p>PA Required if total dose of a Triptan (oral tablet, nasal spray, or injection) or cumulative dose of different types of Triptans used in a single month is > 12 units (doses)</p> <p>Criteria for Use</p> <p>Documentation of diagnostic criteria for migraine headache or cluster headache AND > 6 moderate or severe headache days a month AND must have tried and failed NSAIDS within the last year or currently on NSAIDS, unless contraindicated AND concurrently using migraine preventative meds (i.e. beta-blocker, TCA's & anticonvulsants unless contraindicated, adverse effects occurred, or no clinical benefit occurred after at least a 90-day trial at maximum tolerated dose AND NO history, symptoms, or signs of ischemic cardiac, cerebrovascular, or peripheral vascular syndrome; angina pectoris, MI, or strokes, silent myocardial ischemia; transient ischemic attacks; ischemic bowel disease; uncontrolled hypertension; concurrent MAOI therapy(or within 2 weeks of discontinuing MAOI therapy); concurrent use of (or use within 24 hr of) ergotamine-containing or ergot-type medication; concurrent use (within 24 hrs) of another 5-HT 1 agonist or hemiplegic or basilar migraine AND Prescribing clinician has reviewed recommendations below based on evidence based studies</p> <p>Procedures</p> <p>Recommendation 1: For most migraine sufferers, NSAIDS are first line therapy.</p> <p>Recommendation 2: In patients, whose headaches do not respond to NSAIDS, use migraine specific therapy (triptans, dihydroergotamines).</p> <p>Recommendation 3: Select a non oral route for patients whose migraines present early with nausea or vomiting. Treat nausea and vomiting with anti-emetics.</p> <p>Recommendation 4: Evaluate for use of preventative therapy</p> <p>Recommendation 5: First line agents for prevention are Beta-Blocker, Tricyclic Antidepressants, and Anticonvulsants.</p> <p>Recommendation 6: Educate patients on control of acute attacks and preventive therapy and engage them in formulation of a management plan. Re-evaluate on regular basis.</p> <p>Approval</p> <p>12 months</p> <p>References</p> <p>Drug Class Review on Triptan. Final Report 2005 http://derp.ohsu.edu/about/final-products.cfm</p>	<p>NO PA Required</p> <p>Not applicable</p> <p>PA Required</p> <p>Provigil (Modafinil) – maximum dose 400mg Nuvigil (Armodafinil) – maximum dose 250mg</p> <p>Criteria for Use</p> <p>Approval considered as treatment to improve wakefulness for patients who</p> <p>-are at least 16 years old and have a diagnosis of narcolepsy</p> <p>-are at least 16 years old and have excessive sleepiness associated with shift work sleep disorder</p> <p>-require adjunctive treatment for a diagnosis of obstructive sleep apnea/hypoapnea syndrome (OSAHS) with concurrent use of continuous positive airway pressure (CPAP) if CPAP is the treatment of choice</p> <p>Modafinil and Armodafinil are NOT covered for patients under age 16</p> <p>Approval</p> <p>12 months</p>	<p>NO PA Required</p> <p>Generic formulations of the following ACE Inhibitors ...</p> <p>Amlodipine w/ benazepril 2.5/10, 5/10, 5/20, 10/20, 5/40 (Lotrel®) Benazepril (Lotensin®)(Pal Preferred) Benazepril w/ HCTZ (Lotensin HCT®) Captopril (Capoten®) Captopril w/ HCTZ (Capozide®) Enalapril (Vasotec®) (PAL Preferred) Enalapril w/ HCTZ (Vasoretic®) (PAL Preferred) Fosinopril (Monpril®) Fosinopril w/ HCTZ (Monopril HCT®) Lisinopril (Prinivil® or Zestril®) (PAL Preferred) Lisinopril w/ HCTZ (Prinzide® or Zestoretic®) (PAL Preferred) Moexipril (Univasc®) Moexipril w/ HCTZ (Uniretic®) Quinapril (Accupril®) Quinapril w/ HCTZ (Accuretic®) Ramipril (Altace®) Trandolapril (Mavik®)</p> <p>PA Required</p> <p>Brand Name ACEI's: Accupril®, Accuretic®, Aceon®, Altace®, Capoten®, Capozide®, Lexxel®, Lotensin®, Lotensin HCT®, Lotrel® 10/40, Mavik®, Monopril®, Monopril HCT®, Prinivil®, Prinzide®, Quinaretic®, Tarka®, Uniretic®, Univasc®, Vaseretic®, Vasote, Zestoretic®, Zestril®</p> <p>Brand- Name ARB's: Atacand®, Atacand HCT®, Avalide®, Avapro®, Azor®, Benicar®, Benicar HCT®, Cozaar®, Diovan®, Diovan HCT®, Exforge®, Hyzaar®, Micardis®, Micardis HCT®, Teveten®, Teveten HCT®,</p> <p>Brand-Name Renin Inhibitors: Tekurna®, Tekturna, HCT®</p> <p>Criteria for Use</p> <p>-Documented failure within the last 12 months of one generic ACE inhibitor after a period of at least 1 month on the maximum tolerated dose</p> <p>Exemptions</p> <p>-Documented contraindication, allergy or in tolerable side effect to ACE inhibitors.</p> <p>Approval</p> <p>12 months</p> <p>References</p> <p>DMA link to all prior authorization policies: http://www.ncdhhs.gov/dma/pharmacy/rxpa.htm</p>	<p>NO PA Required</p> <p>Generic Albuterol sulfate nebulizer solution for inhalation (PAL Preferred) Generic Albuterol sulfate aerosol for inhalation MDI/HFA (PAL Preferred)</p> <p>Proventil HFA (albuterol sulfate aerosol for inhalation) Ventolin HFA (albuterol sulfate aerosol for inhalation) Generic Albuterol sulfate</p> <p>PA Required</p> <p>Accuneb Inhaler Solution (albuterol sulfate solution for inhalation) Alupent Inhaler (metaproterenol aerosol for inhalation) Maxair Autohaler (pirbuterol acetate aerosol for inhalation) ProAir HFA (albuterol sulfate aerosol for inhalation) Relion Ventolin HFA *(albuterol sulfate aerosol for inhalation) Xopenex HFA (levalbuterol aerosol for inhalation) Xopenex Inhaled Solution (levalbuterol solution for inhalation)</p> <p>Criteria for Use</p> <p>Documented failure within the past 12 months of Proventil HFA, Ventolin HFA or generic Albuterol for a period of at least one month</p> <p>Procedures</p> <p>Treatment failure MUST be documented in chart</p> <p>Exemptions</p> <p>-Documented contraindication or allergy to Proventil HFA, Ventolin HFA, and generic Albuterol Adults and children with hemodynamically significant unstable congenital heart disease</p> <p>Approval</p> <p>12 months</p> <p>References</p> <p>Drug Class Review on Beta-Agonist. Final Report, Nov 2006 http://derp.ohsu.edu/about/final-products.cfm</p> <p>DMA link to all prior authorization policies: http://www.ncdhhs.gov/dma/pharmacy/rxpa.htm</p>	<p>NO PA Required</p> <p>Not applicable</p> <p>PA Required</p> <p>Accolate (zarfirlukast), Singular (montelukast), Zylfo, Zylfo CR (zileuton)</p> <p>Criteria for Use</p> <p>Covered with diagnosis of Asthma:</p> <p>-Recipient has growth suppression due to inhaled corticosteroids</p> <p>OR</p> <p>-Recipient is on medium-dose ICS and needs addition of leukotriene modifier to achieve control (Step 4 or higher of the <i>Stepwise Approach for Managing Asthma from the National Asthma Education and Prevention Program</i>)</p> <p>Covered with a diagnosis of allergic rhinitis (Singular ONLY):</p> <p>-for adults and children who have a documented failure with a 30-day trial of an inhaled nasal steroid and documented failure with a 30-day trial of a non-sedating antihistamine during the last 12 months.</p> <p>Covered for prevention of exercise-induced bronchoconstriction (EIB)(Singular ONLY):</p> <p>-in recipients 15 years of age and older who have documented failure on a short-acting bronchodilator during the last 12 months.</p> <p>Procedures</p> <p>Treatment failure MUST be documented in chart Changes in dose will not require additional Prior authorization</p> <p>Exemptions</p> <p>-Patients with a documented contraindication for, allergy to, or intolerable side effect from inhaled corticosteroids (Asthma) -Patient has a documented contraindication for, allergy to, or intolerable side effect from nasal steroid spray and non-sedating antihistamines (ALLERGIC RHINITIS, SINGULAIR ONLY) -Patient has a documented contraindication for, allergy to, or intolerable side effect from short-acting bronchodilators (EIB, SINGULAR ONLY)</p> <p>Approval</p> <p>12 months</p> <p>DMA Link to all prior authorization policies: http://www.ncdhhs.gov/dma/pharmacy/rxpa.htm</p>	<p>NO PA Required</p> <p>Generic lovastatin (PAL Preferred) Generic pravastatin (PAL Preferred) Generic simvastatin (PAL Preferred)</p> <p>PA Required</p> <p>Advicor (Niacin/atorvastatin), Altoprev (extended-release lovastatin), Caduet (amlodipine/atorvastatin), Crestor (rosuvastatin), Lescol (fluvastatin), Lescol XL (extended-release fluvastatin), Lipitor (atorvastatin), Mevacor (lovastatin), Pravachol (Pravastatin), Simcor (extended-release niacin/simvastatin), Vytorin (ezetimibe/simvastatin), Zetia (ezetimibe), Zocor (simvastatin)</p> <p>Criteria for Use</p> <p>-Documented failure with generic simvastatin, after a period of at least two months on the maximum tolerated dose.</p> <p>Procedures</p> <p>RPh can override the prior authorization edit at the point-of-sale if the MD writes on the face of the prescription in his/her own handwriting... - "Meets PA Criteria"</p> <p>Exemptions</p> <p>-Documented contraindication or allergy or intolerable side effect to simvastatin, lovastatin and pravastatin. -Patients with Coronary Artery Disease or Diabetes who are currently receiving Lipitor 80mg, Crestor 20mg or Crestor 40mg. -Patients with familial hyperlipidemia.</p> <p>Approval</p> <p>12 months</p> <p>References</p> <p>Drug Class Review on HMG-CoA Reductase Inhibitors (Statins). Final Report. August 2006 http://derp.ohsu.edu/about/final-products.cfm</p> <p>DMA link to all Prior Authorization Policies: http://www.ncdhhs.gov/dma/pharmacy/rxpa.htm</p>

Brand Name Fibrates & Lovaza Effective Date 11/17/2009	Inhaled Steroids 11/24/2009 "ON HOLD" until further notice	Brand Name Anticonvulsants (Lyrica, Topamax, Lamictal, Trileptal) Effective Date: 12/08/2009	Quaaluin Effective Date: 11/2008	Nasal Steroids Effective Date: 7/20/2009	Brand Name Muscle Relaxants Effective Date: 7/20/2009
<p>NO PA Required</p> <p>Generic gemfibrozil (PAL Preferred)</p> <p>PA Required</p> <p>Brand Name: Lopid (gemfibrozil) Generic: Fenofibrate</p> <p>Brand Name Fenofibrates: Antara, Fenoglide, Lipofen, Lofibra, , Tricor, and Triglide Brand Name Fenofibric Acid: Trilipix Brand Name Omega-3 FA: Lovaza (omacor)</p> <p>Criteria for Use</p> <p>Generic Fenofibrate: -Documented failure with at least a 60-day trial of generic gemfibrozil within the last 12 months</p> <p>All other fibrates and Omacor -Documented failure with a least a 60-day trial of generic gemfibrozil AND at least a 60-day trial of generic fenofibrate within the last 12 months</p> <p>Exemptions</p> <p>-Documented contraindication to, intolerable side effect from, or drug interaction with generic gemfibrozil or generic fenofibrate -Patients who require Tilipix because they are on a statin medication are exempt from the criteria -Patients who require Lovaza because they have a high triglyceride level (?500mg/dl). -Changes in strength DO NOT require additional PA</p> <p>Approval 12 months</p> <p>References</p> <p>DMA Link to all Prior Authorization Policies: http://www.ncdhhs.gov/dma/pharmacy/rxpa.htm</p>	<p>NO PA Required</p> <p>QVAR (beclomethasone dipropionate) (PAL Preferred)</p> <p>Flovent for children 4 years old up to 5 years old</p> <p>PA Required</p> <p>Advair Diskus, Advair HFA (fluticasone/salmeterol), Aerobid, Aerobid-M (Flunisolide), Alvesco (ciclesonide), Asmanex (mometasone), Azmacort (Triamcinolone) Flovent Diskus, Flovent HFA (Fluticasone), Pulmicort Flexhaler, Pulmicort Respules (Budesonide), Symbicort (budesonide/fomoterol)</p> <p>Criteria for Use</p> <p>Documented failure within the past 12 months of a 60 day trial of QVAR.</p> <p>Procedures</p> <p>Treatment failure MUST be documented in chart</p> <p>Exemptions</p> <p>-Documented contraindication, allergy to, or intolerable side effect from QVAR -Patients requiring long-acting inhaled beta-agonists/steroid combination products to control symptoms -Children under 6 years of age requiring Pulmicort Respules (budesonide inhalation suspension) -Children 4 years old up to 5 years old requiring Flovent (fluticasone)</p> <p>Approval 12 months</p> <p>References</p> <p>Drug Class Review on Inhaled Corticosteroids. Final Report, January 2006 http://derp.ohsu.edu/about/final-products.cfm</p> <p>DMA Link to all Prior Authorization Policies: http://www.ncdhhs.gov/dma/pharmacy/expa.htm</p>	<p>NO PA Required</p> <p>n/a</p> <p>PA Required</p> <p>Brand Name: Lamictal, Lamictal ODT, Lamictal XR (lamotrigine), Lyrica (pregabalin), Topamax (topiramate), Trileptal (oxcarbazepine)</p> <p>Criteria for Use</p> <p>1) diagnosis of <u>seizure disorder</u> 2) diagnosis of <u>neuropathic pain</u> AND documented failure with a 60-day trial of at least (2) of the following in the last 12 months: <i>TCA (tricyclic antidepressant), gabapentin, carbamazepine or valproic acid</i> OR -documented adverse reaction or contraindications that preclude trial of any of the above <i>italicized agents</i>. 3) diagnosis of <u>fibromyalgia</u> AND documented failure with a 60-day trial of at least (2) of the following in the last 12 months: <i>antidepressants (TCA, doxepin, SSRI, SNRI), cyclobenzaprine, or gabapentin</i>. OR -documented adverse reaction or contraindications that preclude trial of any of the above <i>italicized agents</i>. 4) diagnosis of <u>anxiety disorder</u> AND documented failure with a 60-day trial of a <i>SSRI</i> in the past 12 months. OR -documented adverse reaction or contraindications that preclude trial of <i>SSRI</i></p> <p>TOPAMAX</p> <p>1) diagnosis of <u>seizure disorder</u> 2) diagnosis of <u>migraine headache</u> AND documented failure with a 60-day trial of at least 2 of the following in the last 12 months: <i>β-blockers, TCA, divalproex or valproic acid, calcium channel blocker (CCB), or gabapentin</i>. OR --documented adverse reaction or contraindications that preclude trial of any of the above <i>italicized agents</i>.</p> <p>LAMICTAL</p> <p>1) diagnosis of <u>seizure disorder</u> 2) diagnosis of <u>bipolar disorder I or II Depressive or Maintenance Phase</u></p> <p>TRILEPTAL</p> <p>1) diagnosis of <u>seizure disorder</u> 2) diagnosis of <u>trigeminal neuralgia</u> AND documented failure with a 60-day trial of <i>carbamazepine</i> in the past 12 months OR -documented adverse reaction or contraindications that preclude trial of <i>carbamazepine</i></p> <p>Procedures</p> <p>Treatment failure MUST be documented in chart</p> <p>Exemptions</p> <p>Changes in strength will not require additional prior authorization</p> <p>Approval 12 months</p> <p>References</p> <p>DMA Link to all Prior Authorization Policies: http://www.ncdhhs.gov/dma/pharmacy/rxpa.htm</p>	<p>NO PA Required</p> <p>n/a</p> <p>PA Required</p> <p>Quaaluin (Quinine Sulfate)</p> <p>Criteria for Use</p> <p>- Treatment of uncomplicated Malaria</p> <p>Procedures</p> <p>- Prescriptions written for patients with a diagnosis of uncomplicated Malaria (ICD-9 code 084.0) should automatically authorize at the pharmacy at point of sale. - Prescriptions written following a new diagnosis may require providers to contact ACS PA helpdesk @ 866-246-8505 for authorization. - Provider can also complete a Quaaluin Request Form and submit via FAX ONLY to ACS @ 866-246-8507 for authorization consideration. - Request forms available online @ http://www.ncmedicaidpbm.com/</p> <p>Approval 1 month</p>	<p>NO PA Required</p> <p>Generic Fluticasone nasal spray (PAL Preferred) Generic Flunisolide nasal spray (PAL Preferred)</p> <p>PA Required</p> <p>Brand-Name: Beconase AQ (beclomethasone dipropionate), Flonase (fluticasone propionate), Nasacort AQ (triamcinolone acetonide), Nasarel (flunisolide), Nasonex (mometasone furoate monohydrate), Omnaris (ciclesonide), Rhinocort Aqua (budesonide), Veramyst (fluticasone furoate)</p> <p>Criteria for Use</p> <p>- Documented failure with a 4-week trial of generic fluticasone nasal spray AND a 4-week trial of flunisolide nasal spray in the past 24 months</p> <p>Procedures</p> <p>- Treatment failure MUST be documented in chart</p> <p>Exemptions</p> <p>- Documented contraindication or allergy to fluticasone and flunisolide nasal spray - PA not required for patients under 4 years old</p> <p>Approval 24 months</p> <p>References</p> <p>Drug Class Review on Nasal Corticosteroids. Final Report Update 1. June 2008 http://derp.ohsu.edu/about/final-products.cfm DMA Link to all Prior Authorization Policies: http://www.ncdhhs.gov/dma/pharmacy/expa.htm</p>	<p>NO PA Required</p> <p>Generic Muscle Relaxants: carisoprodol (PAL Preferred) chlorzoxazone (PAL Preferred) cyclobenzaprine (PAL Preferred) methocarbamol (PAL Preferred) tizanidine (PAL Preferred)</p> <p>PA Required</p> <p>Brand-Name: Amrix, Fexmid, Parafon Forte DSC, Skelaxin, Soma, Soma compound, Soma compound w/codeine, Zanaflex</p> <p>Criteria for Use</p> <p>- Documented failure within the past year of at least two 14-day trials of two different generic skeletal muscle relaxants.</p> <p>Procedures</p> <p>- Treatment failure MUST be documented in chart</p> <p>Exemptions</p> <p>- Documented contraindication to one or more of the generics ingredients (i.e. dye) - Changes in strength do not require PA</p> <p>Approval 12 months</p> <p>References</p> <p>Drug Class Review on Skeletal Muscle Relaxants. Final Report May 2005 http://derp.ohsu.edu/about/final-products.cfm DMA Link to all Prior Authorization Policies: http://www.ncdhhs.gov/dma/pharmacy/expa.htm</p>