

Expedited Authorization Codes and Criteria Table

What is new in this version of the expedited authorization list?

Effective for dates of service on and after September 1, 2016, the agency will make the following changes:

Product	Code	Criteria
Aloxi® Injection <i>(palonosetron)</i>	129	Removed
Diclegis® <i>(doxylamine-pyridoxine)</i>	129	Treatment of nausea and vomiting of pregnancy in women who do not respond to conservative management
<i>granisetron</i> <i>tablet/injection</i>	127	Removed
<i>granisetron</i> <i>tablet/injection</i>	128	Removed
Granisol® <i>(granisetron) solution</i>	127	Removed
Granisol® <i>(granisetron) solution</i>	128	Removed

Prescription Drug Program

Drug	Code	Criteria
90-day supply required	090	The prescription is written for less than a 90-day supply.
<i>acitretin</i>	064	Treatment of severe, recalcitrant psoriasis in patients 16 years of age and older. Prescribed by, or in consultation with, a dermatologist, and the patient must have an absence of all of the following: a) Current pregnancy or pregnancy which may occur while undergoing treatment; and b) Hepatitis; and c) Concurrent retinoid therapy.
Adderall®/XR <i>(amphetamine salt combo)</i>	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD).
Alpha-agonists	076	Change in prescribed alpha agonist or change in dose of prescribed alpha agonist. Total dose of all currently prescribed alpha agonists does not exceed: <ul style="list-style-type: none"> • 0.2mg clonidine equivalent dose for patient age 4 – 5 years of age; or • 0.3mg clonidine equivalent dose for patient age 6 - 8 years of age; or • 0.4mg clonidine equivalent dose for patient age 9 - 17 years of age. <p>Clonidine equivalent dose: 1mg guanfacine = 0.1mg clonidine.</p>
Ambien® <i>(zolpidem tartrate)</i>	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Ambien CR® <i>(zolpidem tartrate)</i>	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
<i>amlodipine besylate-benazepril</i>	038	Treatment of hypertension as a second-line agent when blood pressure is not controlled by any: a) ACE inhibitor alone; or b) Calcium channel blocker alone; or c) ACE inhibitor and a calcium channel blocker as two separate concomitant prescriptions.
<i>amphetamine salt combo/XR</i>	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD).
Amitiza® <i>(lubiprostone)</i>	007	Treatment of chronic constipation. Must have tried and failed a less costly alternative.

Prescription Drug Program

Drug	Code	Criteria
Anoro Ellipta® (<i>umeclidinium-vilanterol</i>)	150	Diagnosis of COPD.
Anzemet® (<i>dolasetron mesylate</i>)	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
Arava® (<i>leflunomide</i>)	034	Treatment of rheumatoid arthritis when prescribed by a rheumatologist with or without a loading dose of 100mg per day for 3 days and then up to a maximum of 20mg daily thereafter.
Arcapta™ Neohaler™ (<i>indacaterol</i>)	150	Diagnosis of COPD.
Atacand® (<i>candesartan cilixetil</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Atacand HCT® (<i>candesartan cilixetil-HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.

Prescription Drug Program

Drug	Code	Criteria
Atypical Antipsychotics (Generics First) Abilify® <i>(aripiprazole)</i> <i>aripiprazole</i> <i>clozapine</i> Clozaril® <i>(clozapine)</i> Fanapt® <i>(iloperidone)</i> Geodon® <i>(ziprasidone HCl)</i> Invega™ <i>(paliperidone)</i> Latuda® <i>(lurasidone HCl)</i> <i>olanzapine</i> <i>quetiapine</i> Risperdal® <i>(risperidone)M-tab</i> <i>risperidone</i> Saphris® <i>(asenapine)</i> Seroquel® <i>(quetiapine) /XR</i> <i>ziprasidone</i> Zyprexa® <i>(olanzapine)</i> /Zydis®	400	Continuation of therapy.
	401	Client is not a new start.
	402	History of hyperprolactinemia.
	403	History of extrapyramidal symptoms (EPS).
	404	Pharmacy has chart note on file documenting client's refusal of a generic atypical antipsychotic, or their request for a specific atypical antipsychotic.
	405	Prescribed for a diagnosis which is not FDA indicated for any preferred generic AAP.
	406	Patient in Crisis.
Avalide® <i>(irbesartan/ HCTZ)</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Avapro® <i>(irbesartan)</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Avinza® <i>(morphine sulfate)</i>	040	Diagnosis of cancer-related pain.
Azor® <i>(amlodipine-olmesartan)</i>	093	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor, and must have a history of dihydropyridine calcium channel blocker and/or angiotensin receptor blocker (ARB) therapy.

Prescription Drug Program

Drug	Code	Criteria
barbiturates	180	Prescribed for a diagnosis other than cancer, chronic mental health disorders, or epilepsy.
Benicar® (<i>olmesartan medoxomil</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Benicar HCT® (<i>olmesartan meoxomil-HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Blood Glucose Test Strips	263	Gestational Diabetes (up to two months post delivery)
	264	Insulin-dependent diabetic (age 21 and older)
	265	Insulin-dependent diabetic (age 20 and younger)
	266	Client had diabetes prior to pregnancy
Brovana™ (<i>arformoterol</i>)	150	Diagnosis of COPD.
<i>bupropion SR/XL</i>	014	Not for smoking cessation.
<i>candesartan</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
<i>candesartan-HCTZ</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
<i>carbidopa-levodopa</i>	049	Diagnosis of Parkinson's disease and one of the following: a) Must have tried and failed generic carbidopa/levodopa; or b) Be unable to swallow solid oral dosage forms.
Celebrex® (<i>celecoxib</i>)	062	All of the following must apply: a) An absence of a history of ulcer or gastrointestinal bleeding; and b) An absence of a history of cardiovascular disease.
<i>celecoxib</i>	062	All of the following must apply: a) An absence of a history of ulcer or gastrointestinal bleeding; and b) An absence of a history of cardiovascular disease.
Concerta® (<i>methylphenidate HCl</i>)	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD).

Prescription Drug Program

Drug	Code	Criteria
contraceptives (oral, transdermal, and intra-vaginal)	364	Prescriber is unwilling to change dispensed quantity to twelve-month supply.
	365	Client does not want twelve-month supply.
	366	Pharmacy is unwilling to dispense twelve-month supply.
Cozaar® (losartan potassium)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Cymbalta® (duloxetine)	163	Treatment of diabetic peripheral neuropathy.
	166	Treatment of fibromyalgia.
	171	Treatment of chronic musculoskeletal pain.
Daliresp® (roflumilast)	150	Diagnosis of COPD.
Daytrana® (methylphenidate HCl) transdermal patch	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD).
Dexedrine SA® (d-amphetamine)	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD).
<i>dexamethylphenidate /SA</i>	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD).
Dextrostat® (d-amphetamine)	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD).
Diclegis® (doxylamine- pyridoxine)	129	Treatment of nausea and vomiting of pregnancy in women who do not respond to conservative management.
Diovan® (valsartan)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Diovan HCT® (valsartan-HCTZ)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Dolophine® (methadone HCl)	040	Diagnosis of cancer-related pain.
<i>duloxetine</i>	163	Treatment of diabetic peripheral neuropathy.
	166	Treatment of fibromyalgia.
	171	Treatment of chronic musculoskeletal pain.
Dulera® (mometasone furoate-formoterol fumarate)	151	Diagnosis of moderate to severe asthma.
Duragesic® (fentanyl)	040	Diagnosis of cancer-related pain.

Prescription Drug Program

Drug	Code	Criteria
Edarbi® (<i>azilsartan medoxomil</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Edarbyclor (<i>azilsartan medoxomil-clorthalidone</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Enbrel® (<i>etanercept</i>)	017	Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD).
	024	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more DMARD.
	025	Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Dose not to exceed 50mg subcutaneously twice weekly for the first three months of therapy and not to exceed 50mg weekly thereafter.
	026	Treatment of moderately to severely active polyarticular juvenile idiopathic arthritis when prescribed by a rheumatologist for patients ages 2 and older who have had an inadequate response to one or more DMARD. Dose not to exceed 0.8 mg/kg subcutaneously per week and/or 50 mg per week.
<i>eprosartan mesylate</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
<i>eszopiclone</i>	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Exalgo® (<i>hydromorphone ER</i>)	040	Diagnosis of cancer-related pain.
Exelon® capsules/patch /solution (<i>rivastigmine</i>)	015	Treatment of mild to moderate dementia associated with Parkinson's disease

Prescription Drug Program

Drug	Code	Criteria
Exforge® (amlodipine besylate-valsartan)	093	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor, and must have a history of dihydropyridine calcium channel blocker and/or angiotensin receptor blocker (ARB) therapy.
Exforge HCT® (amlodipine besylate-valsartan/HCTZ)	093	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor, and must have a history of dihydropyridine calcium channel blocker and/or angiotensin receptor blocker (ARB) therapy.
<i>fentanyl</i>	040	Diagnosis of cancer-related pain.
Focalin®/XR (dexamethylphenidate)	075	Diagnosis of attention deficit hyperactivity disorder (ADHD) or Attention deficit disorder (ADD)
Foradil® Aerolizer® (formoterol)	150	Diagnosis of COPD.
<i>gabapentin</i>	035	Treatment of post-herpetic neuralgia.
	036	Treatment of seizures.
	063	Treatment of diabetic peripheral neuropathy.
Gabitril® (tiagabine HCl)	036	Treatment of seizures.
Humira® (adalimumab)	022	Treatment of Crohn's disease when prescribed by a gastroenterologist for patients who have tried and failed conventional therapy. 160mg subcutaneous dose to start, 80mg at week 2, and then maximum dose of 40mg subcutaneously every other week.
	023	Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD). Maximum dose is 40mg subcutaneously every other week if taking concomitant methotrexate, and is 40mg per week if patient is not taking methotrexate.
	028	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist for patients who have had an inadequate response to one or more DMARD. Maximum dose is 40mg subcutaneously every other week if taking concomitant methotrexate, and is 40mg per week if patient is not taking methotrexate.

Prescription Drug Program

Drug	Code	Criteria	
Humira® (cont.) (<i>adalimumab</i>)	056	Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Maximum dose is 40mg subcutaneously every other week after the initial single 80mg loading dose.	
	061	Treatment of moderately to severely active polyarticular juvenile idiopathic arthritis when prescribed by a rheumatologist for patients age 4 years and older who have had an inadequate response to one or more DMARD. Maximum dose is 20mg subcutaneously every other week in patients weighing 15kg to <30kg, and 40mg every other week in patients weighing ≥30kg.	
	085	Treatment of moderately to severely active ulcerative colitis when prescribed by a gastroenterologist in those patients who have an inadequate response to immunosuppressants. Maximum maintenance dose is 40 mg every other week after the induction regimen of 160 mg followed by 80 mg two weeks later.	
<i>hydromorphone ER</i>	040	Diagnosis of cancer-related pain.	
Hyzaar® (<i>losartan potassium-HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.	
Incruse Ellipta® (<i>umeclidinium bromide</i>)	150	Diagnosis of COPD.	
Infergen® (<i>interferon alphas-1</i>)	134	Treatment of chronic hepatitis C in patients 18 years of age and older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.	
Intron A® (<i>interferon alpha-2b recombinant</i>)	030	Diagnosis of hairy cell leukemia in patients 18 years of age and older.	
	031	Diagnosis of recurring or refractory condyloma acuminata (external genital/perianal area) for intralesional treatment in patients 18 years of age and older.	
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients 18 years of age and older.	
	033	Diagnosis of chronic hepatitis B in patients 1 year of age and older.	
	Intron A® (cont.) (<i>interferon alpha-2b recombinant</i>)	107	Diagnosis of malignant melanoma in patients 18 years of age and older.
		109	Treatment of chronic hepatitis C in patients 18 years of age and older.
		135	Diagnosis of follicular non-Hodgkin's lymphoma in patients 18 years of age and older.

Prescription Drug Program

Drug	Code	Criteria
<i>irbesartan</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
<i>irbesartan-HCTZ</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
<i>isotretinoin</i>		Must not be used by patients who are pregnant or who may become pregnant while undergoing treatment. The following conditions must be absent : a) Paraben sensitivity; b) Concomitant tretinate therapy; and c) Hepatitis or liver disease.
	001	Diagnosis of severe (disfiguring), recalcitrant cystic acne, unresponsive to conventional therapy.
	002	Diagnosis of severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy.
	003	Diagnosis of severe keratinization disorders when prescribed by, or in consultation with, a dermatologist.
	004	Prevention of skin cancers in patients with xeroderma pigmentosum.
	005	Diagnosis of mycosis fungoides (T-cell lymphoma) unresponsive to other therapies.
<i>itraconazole</i>		Must not be used for a patient with cardiac dysfunction such as congestive heart failure.
	047	Treatment of systemic fungal infections and dermatomycoses.
		Treatment of onychomycosis for up to 12 weeks is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis and has required systemic antibiotic therapy;
	051	Peripheral vascular disease; or
	052	Patient is immunocompromised.
Kadian® <i>(morphine sulfate)</i>	040	Diagnosis of cancer-related pain.
Keppra® /XR <i>(levetiracetam)</i>	036	Treatment of seizures.
Kineret® Injection <i>(anakinra)</i>	029	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients 18 years of age and older who have tried and failed one or more DMARD. Daily dose not to exceed 100mg subcutaneously.

Prescription Drug Program

Drug	Code	Criteria
Lamisil® (<i>terbinafine HCl</i>)		Treatment of onychomycosis for up to 12 weeks is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis and has required systemic antibiotic therapy;
	051	Peripheral vascular disease; or
	052	Patient is immunocompromised.
Lancets	263	Gestational Diabetes (up to two months post delivery).
	264	Insulin-dependent diabetic (age 21 and older).
	265	Insulin-dependent diabetic (age 20 and younger).
	266	Client had diabetes prior to pregnancy.
<i>leflunomide</i>	034	Treatment of rheumatoid arthritis when prescribed by a rheumatologist with or without a loading dose of 100mg per day for 3 days and then up to a maximum of 20mg daily thereafter.
<i>levetiracetam</i>	036	Treatment of seizures.
Levorphanol	040	Diagnosis of cancer-related pain.
<i>linezolid</i> injectable	013	Treatment of vancomycin resistant infection.
<i>linezolid</i> oral	013	Treatment of vancomycin resistant infection.
	016	Outpatient treatment of methacillin resistant staph aureus (MRSA) infections when IV vancomycin is contraindicated, such as: a) Allergy; or b) Inability to maintain IV access.
<i>losartan potassium</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
<i>losartan potassium/HCTZ</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Lotrel® (<i>amlodipine besylate-benazepril</i>)	038	Treatment of hypertension as a second-line agent when blood pressure is not controlled by any: a) ACE inhibitor alone; or b) Calcium channel blocker alone; or c) ACE inhibitor and a calcium channel blocker as two separate concomitant prescriptions.

Prescription Drug Program

Drug	Code	Criteria
Lunesta™ (<i>eszopiclone</i>)	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Metadate CD®/ER (<i>methylphenidate HCl</i>)	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD).
<i>methadone</i>	040	Diagnosis of cancer-related pain.
Methadone HCl Intensol® (<i>methadone</i>)	040	Diagnosis of cancer-related pain.
<i>methadose</i>	040	Diagnosis of cancer-related pain.
<i>methylphenidate /LA/SR/OSM</i>	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD).
Methylin® /XR/chewable/ solution	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD).
Micardis® (<i>telmisartan</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Micardis HCT® (<i>telmisartan-HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
MS Contin® (<i>morphine sulfate ER</i>)	040	Diagnosis of cancer-related pain.
Nephrocaps®, Nephro-Fer®, Nephro-vite®, Nephro-Vite® Rx, Nephro-vite® +Fe, and Nephron® FA	096	Treatment of patients with renal disease.
Neurontin® (<i>gabapentin</i>)	035	Treatment of post-herpetic neuralgia.
	036	Treatment of seizures.
	063	Treatment of diabetic peripheral neuropathy.

Prescription Drug Program

Drug	Code	Criteria
<p>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)</p> <p>Arthrotec® (diclofenac-misoprostol)</p> <p>Cambia® (diclofenac potassium) diclofenac potassium diclofenac sodium SR/ER/EC diflunisal etodolac /ER fenoprofen</p> <p>Flector® (diclofenac epolamine) flurbiprofen ibuprofen ibuprofen-hydrocodone indomethacin /SR ketoprofen /SR ketorolac meclofenamate mefenamic acid meloxicam nabumetone naproxen /EC naproxen sodium /ER oxaprozin piroxicam</p> <p>Ponstel® (mefenamic acid) salsalate sulindac tolmetin</p> <p>Vicoprofen® (ibuprofen-hydrocodone)</p> <p>Voltaren® (diclofenac sodium)</p>	<p>141</p>	<p>An absence of a history of ulcer or gastrointestinal bleeding.</p>

Prescription Drug Program

Drug	Code	Criteria
Nucynta ER® <i>(tapentadol HCL)</i>	040	Diagnosis of cancer-related pain.
Opana ER® <i>(oxymorphone HCl ER)</i>	040	Diagnosis of cancer-related pain.
<i>ondansetron ODT</i> /oral solution	071	Inability to swallow oral tablets or capsules for clients age 18 and older. Max dose 24mg/day.
Orencia® <i>(abatacept)</i>	044	Treatment of rheumatoid arthritis when prescribed by a rheumatologist in patients who have tried and failed one or more DMARDs. Maintenance dose is limited to 1000mg as an intravenous infusion every 4 weeks after the initial 4 weeks of therapy (allowed to be dosed every 2 weeks during first 4 weeks of therapy) or subcutaneous injection of 125mg once weekly.
Oxandrin® <i>(oxandrolone)</i>		Before any code is allowed, there must be an absence of all of the following: a) Hypercalcemia; b) Nephrosis; c) Carcinoma of the breast; d) Carcinoma of the prostate; and e) Pregnancy.
	110	Treatment of unintentional weight loss in patients who have had extensive surgery, severe trauma, chronic infections (such as AIDS wasting), or who fail to maintain or gain weight for no conclusive pathophysiological cause.
	111	To compensate for the protein catabolism due to long-term corticosteroid use.
	112	Treatment of bone pain due to osteoporosis.
<i>oxandrolone</i>		Before any code is allowed, there must be an absence of all of the following: f) Hypercalcemia; g) Nephrosis; h) Carcinoma of the breast; i) Carcinoma of the prostate; and j) Pregnancy.
	110	Treatment of unintentional weight loss in patients who have had extensive surgery, severe trauma, chronic infections (such as AIDS wasting), or who fail to maintain or gain weight for no conclusive pathophysiological cause.
	111	To compensate for the protein catabolism due to long-term corticosteroid use.
	112	Treatment of bone pain due to osteoporosis.

Prescription Drug Program

Drug	Code	Criteria
OxyContin® (<i>oxycodone HCl</i>)	040	Diagnosis of cancer-related pain.
Parcopa® (<i>carbidopa-levodopa</i>)	049	Diagnosis of Parkinson's disease and one of the following: a) Must have tried and failed generic carbidopa/levodopa; or b) Be unable to swallow solid oral dosage forms.
<i>pentazocine HCl-acetaminophen</i>	091	Patient must be 12 years of age or older and has tried and failed two NSAIDs or failed one other narcotic analgesic and is allergic or sensitive to codeine.
<i>pentazocine-naloxone</i>	091	Patient must be 12 years of age or older and has tried and failed two NSAIDs or failed one other narcotic analgesic and is allergic or sensitive to codeine.
Perforomist™ (<i>formoterol fumarate</i>)	150	Diagnosis of COPD.
Prevacid® SoluTab™ (<i>lansoprazole</i>)	050	Inability to swallow oral tablets or capsules.
Protonix® Pak (<i>pantoprazole</i>)	050	Inability to swallow oral tablets or capsules.
Pulmozyme® (<i>dornase alpha</i>)	053	Diagnosis of cystic fibrosis and the patient is 5 years of age or older.
Rectiv® (nitroglycerin)	081	Treatment of anal fissures.
Rena-Vite® Rena-Vite RX® (<i>folic acid-vit B comp W-C</i>)	096	Treatment of patients with renal disease.
Ritalin®/LA/SR (<i>methylphenidate HCl</i>)	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD).
Rituxan® (<i>rituximab</i>)	054	Treatment of non-Hodgkin's lymphoma.
	055	Treatment of rheumatoid arthritis when prescribed by a rheumatologist in combination with methotrexate in patients who have failed another tumor necrosis factor (TNF) inhibitor. Limited to 2 1000mg intravenous infusions separated by 2 weeks.
<i>rivastigmine</i>	015	Treatment of mild to moderate dementia associated with Parkinson's disease.

Prescription Drug Program

Drug	Code	Criteria
Savella® (<i>milnacipran HCl</i>)	066	Treatment of fibromyalgia.
Seebri Neohaler® (<i>glycopyrronium</i>)	150	Diagnosis of COPD.
Serevent® Diskus® (<i>salmeterol</i>)	150	Diagnosis of COPD.
Sonata® (<i>zaleplon</i>)	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Soriatane® (<i>acitretin</i>)	064	Treatment of severe, recalcitrant psoriasis in patients 16 years of age and older. Prescribed by, or in consultation with, a dermatologist, and the patient must have an absence of all of the following: <ul style="list-style-type: none"> a) Current pregnancy or pregnancy which may occur while undergoing treatment; and b) Hepatitis; and c) Concurrent retinoid therapy.
Spiriva® Handihaler® / Respimat® (<i>tiotropium</i>)	150	Diagnosis of COPD.
Sporanox® (<i>itraconazole</i>)		Must not be used for a patient with cardiac dysfunction such as congestive heart failure.
	047	Treatment of systemic fungal infections and dermatomycoses.
		Treatment of onychomycosis for up to 12 weeks is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis and has required systemic antibiotic therapy;
	051	Peripheral vascular disease; or
	052	Patient is immunocompromised.
Stioloto® (<i>tiotropium bromide-olodaterol</i>)	150	Diagnosis of COPD.
Striverdi® (<i>olodaterol</i>)	150	Diagnosis of COPD.
<i>telmisartan</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
<i>telmisartan-HCTZ</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.

Prescription Drug Program

Drug	Code	Criteria
<i>terbinafine HCl</i>		Treatment of onychomycosis for up to 12 weeks is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis and has required systemic antibiotic therapy;
	051	Peripheral vascular disease; or
	052	Patient is immunocompromised.
Teveten® <i>(eprosartan mesylate)</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Teveten HCT® <i>(eprosartan mesylate-HCTZ)</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
<i>tiagabine HCl</i>	036	Treatment of seizures.
Tribenzor ® <i>(olmesartan-amlodipine-hydrochlorothiazide)</i>	093	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor, and must have a history of dihydropyridine calcium channel blocker and/or angiotensin receptor blocker (ARB) therapy.
Tudorza® <i>(aclidinium bromide)</i>	150	Diagnosis of COPD.
Utibron Neohaler® <i>(indacaterol-glycopyrrolate)</i>	150	Diagnosis of COPD.
<i>valsartan</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
<i>valsartan-HCTZ</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Vancomycin oral	069	Diagnosis of clostridium difficile toxin and one of the following: a) The patient has failed to respond after 2 days of metronidazole treatment; or b) The patient is intolerant to metronidazole; or c) Metronidazole is contraindicated due to drug-drug interaction(s).
Vyvanse® <i>(lisdexamfetamine dimesylate)</i>	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD
Wellbutrin SR® and XL® <i>(bupropion HCl)</i>	014	Not for smoking cessation.

Prescription Drug Program

Drug	Code	Criteria
<i>zaleplon</i>	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Zofran® ODT® /oral solution <i>(ondansetron HCl)</i>	071	Inability to swallow oral tablets or capsules for clients age 18 and older. Max dose 24mg/day.
<i>zoledronic acid</i>	011	Diagnosis of Hypercalcemia associated with malignant neoplasms with or without metastases; or multiple myeloma; or bone metastases of solid tumors.
<i>zolpidem</i>	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
<i>zolpidem ER</i>	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Zometa® <i>(zoledronic acid)</i>	011	Diagnosis of Hypercalcemia associated with malignant neoplasms with or without metastases; or multiple myeloma; or bone metastases of solid tumors.
Zyprexa Relprevv® <i>(olanzapine pamoate)</i>	070	All of the following must apply: a) There is an appropriate DSM IV diagnosis with a psychotic disorder; b) Patient is 18 to 65 years of age; c) Patient has established tolerance to oral olanzapine prior to initiating Zyprexa Relprevv®; d) Zyprexa Relprevv ® will be administered only in a registered healthcare facility with ready access to emergency response services, and the patient will be monitored for at least 3 hours after injection for delirium/sedation syndrome prior to release; and e) Dose is not more than 300mg every 2 weeks or 405mg every 4 weeks.
Zyvox® Injectable <i>(linezolid)</i>	013	Treatment of vancomycin resistant infection.
Zyvox® Oral <i>(linezolid)</i>	013	Treatment of vancomycin resistant infection.
Zometa® <i>(zoledronic acid)</i>	016	Outpatient treatment of methacillin resistant staph aureus (MRSA) infections when IV vancomycin is contraindicated, such as: Allergy; or Inability to maintain IV access.