

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 May 1, 2017, the agency will implement the following changes:

Product	Code	Criteria
Estrace® vaginal cream	101	Diagnosis of labial adhesions in children under 5 years in age.
Premarin® vaginal cream	101	Diagnosis of labial adhesions in children under 5 years in age.
Riomet®	050	Inability to swallow oral tablets or capsules.
SymlinPen®	267	Diagnosis of type 1 diabetes.

What is expedited authorization (EA)?

(WAC [182-530-3200\(4\)](#))

The agency's EA process is designed to eliminate the need to request authorization from the agency. The intent is to establish authorization criteria and associate these criteria with specific codes, enabling providers to create an "EA" number when appropriate.

How is an EA number created?

To bill the agency for drugs that meet the expedited authorization criteria on the following pages, the pharmacist must create an 11-digit EA number. The first 8 digits of the EA number must be 85000000. The last 3 digits must be the code number of the diagnosis/condition that meets the EA criteria.

Example: The 11-digit EA number for Accutane (for the treatment of "severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy") would be **85000000002** (85000000 = first eight digits, 002 = diagnosis/condition code).

Prescription Drug Program

Reminder: EA numbers are only for drugs listed in this table. EA numbers are not valid for any of the following:

- Other drugs requiring authorization through the Prescription Drug Program
- Waiving the State Maximum Allowable Cost (SMAC) or Automated Maximum Allowable Cost (AMAC) price.
- Authorizing the third or fifth fill in the month.

Note: Use of an EA number does not exempt claims from edits, such as per-calendar-month prescription limits or early refills.

EA guidelines:

Diagnoses - Diagnostic information may be obtained from the prescriber, client, client's caregiver, or family member to meet the conditions for EA. Drug claims submitted without an appropriate diagnosis/condition code for the dispensed drug are denied.

Unlisted Diagnoses - If the drug is prescribed for a diagnosis/condition, or age that does not appear on the EA list, additional justification is required. The pharmacist must request authorization by either one of the following:

- ✓ Phone 1-800-562-3022
- ✓ Fax 1-866-668-1214

Documentation - Dispensing pharmacists must write both of the following on the original prescription:

- ✓ The full name of the person who provided the diagnostic information
- ✓ The diagnosis/condition and/or the criteria code from the attached table

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. Clonidine equivalent dose: 1mg guanfacine = 0.1mg clonidine.
<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.
Anoro Ellipta® (<i>umeclidinium-vilanterol</i>)	150	Diagnosis of COPD.
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.

Prescription Drug Program

Drug	Code	Criteria
Arcapta™ Neohaler™ <i>(indacaterol)</i>	150	Diagnosis of COPD.
Atacand® <i>(candesartan cilexetil)</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Atacand HCT® <i>(candesartan cilexetil-HCTZ)</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Second Generation Antipsychotics (Atypical Antipsychotics) (Generics First) Abilify® <i>(aripiprazole) aripiprazole clozapine</i> Clozaril® <i>(clozapine)</i> Fanapt® <i>(iloperidone)</i> Geodon® <i>(ziprasidone HCl)</i> Invega™ <i>(paliperidone)</i> Latuda® <i>(lurasidone HCl) olanzapine quetiapine</i> Risperdal® <i>(risperidone)M-tab risperidone</i> Saphris® <i>(asenapine)</i> Seroquel® <i>(quetiapine) /XR ziprasidone</i> Zyprexa® <i>(olanzapine) /Zydis®</i>	400	Continuation of therapy.
	401	Patient is not a new start.
	402	History of hyperprolactinemia.
	403	History of extrapyramidal symptoms (EPS).
	404	Pharmacy has chart note on file documenting patient'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.

Prescription Drug Program

Drug	Code	Criteria
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.
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.
Bevespi Aerosphere™ (<i>glycopyrrolate- formoterol fumarate</i>)	150	Diagnosis of COPD.
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	Patient 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.

Prescription Drug Program

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

Prescription Drug Program

Drug	Code	Criteria
<i>duloxetine</i>	163	Treatment of diabetic peripheral neuropathy.
	166	Treatment of fibromyalgia.
	171	Treatment of chronic musculoskeletal pain
Dulera® <i>(mometasone furoate-formoterol fumarate)</i>	151	Diagnosis of moderate to severe asthma.
Duragesic® <i>(fentanyl)</i>	040	Diagnosis of cancer-related pain.
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.
<i>eprosartan mesylate</i>	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Estrace® vaginal cream <i>(estradiol)</i>	101	Diagnosis of labial adhesions in children under 5 years in age.
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
Exforge® <i>(amlodipine besylate-valsartan)</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.
Exforge HCT® <i>(amlodipine besylate-valsartan/HCTZ)</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.
<i>fentanyl</i>	040	Diagnosis of cancer-related pain.
Focalin®/XR <i>(dexmethylphenidate)</i>	075	Diagnosis of attention deficit hyperactivity disorder (ADHD) or Attention deficit disorder (ADD)

Prescription Drug Program

Drug	Code	Criteria
Foradil® Aerolizer® <i>(formoterol)</i>	150	Diagnosis of COPD.
<i>gabapentin</i>	035	Treatment of post-herpetic neuralgia.
	036	Treatment of seizures.
	063	Treatment of diabetic peripheral neuropathy.
Gabitril® <i>(tiagabine HCl)</i>	036	Treatment of seizures.
Hormones Prescribed for Gender Dysphoria Alora® <i>(estradiol)</i> Androderm® <i>(testosterone)</i> Androgel® <i>(testosterone)</i> Aveed® <i>(testosterone, undecanoate)</i> Axiron® <i>(testosterone)</i> Climara® <i>(estradiol)</i> Delestrogen® <i>(estradiol valerate)</i> Depo-Estradiol® <i>(estradiol cypionate)</i> Depo-Testost® <i>(testosterone cypionate)</i> Divigel® <i>(estradiol)</i> Elestrin® <i>(estradiol)</i> Enjuvia® <i>(estrogens, conjugated)</i> Estrace® <i>(estradiol estradiol estradiol valerate)</i> Estrasorb® <i>(estradiol)</i>	100	Diagnosis of gender dysphoria.

Prescription Drug Program

Drug	Code	Criteria
<p>Hormones Prescribed for Gender Dysphoria cont. <i>estriol</i> Estrogel® <i>(estradiol)</i> <i>estrone</i> <i>estropipate</i> Ethinyl® (<i>ethinyl estradiol</i>) Evamist® <i>(estradiol)</i> Fortesta® (<i>testosterone</i>) Menest® (<i>esterified estrogens</i>) Menostar® <i>(estradiol)</i> Minivelle® <i>(estradiol)</i> Natesto® <i>(testosterone)</i> Ortho-Est® <i>(estropipate)</i> Premarin® <i>(estrogens, conjugated)</i> Striant® <i>(testosterone)</i> Testim® <i>(testosterone)</i> Testone Cik® <i>(testosterone cypionate)</i> Testopel® <i>(testosterone)</i> <i>testosterone</i> <i>testosterone cypionate</i> <i>testosterone enanthate</i> Vivelle-Dot® <i>(estradiol)</i> Vogelxo® <i>(testosterone)</i></p>	<p>100</p>	<p>Diagnosis of gender dysphoria.</p>

Prescription Drug Program

Drug	Code	Criteria	
<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 alfacon-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.
<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.	

Prescription Drug Program

Drug	Code	Criteria
<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 etretinate 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.
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	Patient had diabetes prior to pregnancy

Prescription Drug Program

Drug	Code	Criteria
Lantus®/ Solostar® (<i>insulin glargine</i>)	267	Diagnosis of type 1 diabetes.
<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.
Levemir®/ Flextouch® (<i>insulin detemir</i>)	267	Diagnosis of type 1 diabetes.
<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.
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.

Prescription Drug Program

Drug	Code	Criteria
<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® <i>/XR/chewable/solution</i>	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, 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) Arthrotec® <i>(diclofenac-misoprostol)</i> Cambia® <i>(diclofenac pot.)</i> <i>diclofenac potassium</i> <i>diclofenac sodium</i> <i>SR/ER/EC</i> <i>diflunisal</i> <i>etodolac /ER</i> <i>fenoprofen</i> Flector® <i>(diclofenac epolamine)</i> <i>flurbiprofen</i> <i>ibuprofen</i> <i>ibuprofen-hydrocodone</i> <i>indomethacin /SR</i> <i>ketoprofen /SR</i> <i>ketorolac</i> <i>meclofenamate</i> <i>mefenamic acid</i> <i>meloxicam</i> <i>nabumetone</i> <i>naproxen /EC</i> <i>naproxen sodium /ER</i> <i>oxaprozin</i> <i>piroxicam</i> Ponstel® <i>(mefenamic acid)</i> <i>salsalate</i> <i>sulindac</i> <i>tolmetin</i> Vicoprofen® <i>(ibuprofen-hydrocodone)</i> Voltaren® <i>(diclofenac sodium)</i></p>	<p align="center">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 oral solution</i>	071	Inability to swallow oral tablets or capsules for patients age 18 and older. Max dose 24mg/day.
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: 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.
OxyContin® <i>(oxycodone HCl)</i>	040	Diagnosis of cancer-related pain.
<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.

Prescription Drug Program

Drug	Code	Criteria
<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.
Premarin® vaginal cream <i>(estrogens, conjugated)</i>	101	Diagnosis of labial adhesions in children under 5 years in age.
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).
Riomet® <i>(metformin) oral solution</i>	050	Inability to swallow oral tablets or capsules.
<i>rivastigmine</i>	015	Treatment of mild to moderate dementia associated with Parkinson's disease.
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.

Prescription Drug Program

Drug	Code	Criteria
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: a) Current pregnancy or pregnancy which may occur while undergoing treatment; and b) Hepatitis; and c) Concurrent retinoid therapy.
Spiriva® Handihaler® (<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.
SymlinPen® (<i>pramlintide acetate</i>)	267	Diagnosis of type 1 diabetes.
<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.
<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.

Prescription Drug Program

Drug	Code	Criteria
Toujeo Solostar® (<i>insulin glargine</i>)	267	Diagnosis of type 1 diabetes.
<i>tiagabine HCl</i>	036	Treatment of seizures.
Tresiba® Flextouch® (<i>insulin degludec</i>)	267	Diagnosis of type 1 diabetes.
Tribenzor® (<i>olmesartan-amlodipine-hctz</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® Pressair® (<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.
Zofran® oral solution (<i>ondansetron HCl</i>)	071	Inability to swallow oral tablets or capsules for patients 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.
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.

Prescription Drug Program

Drug	Code	Criteria
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.