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, 2013, the agency made the following highlighted changes:

Product	Code	Criteria
Arava® *(leflunomide)*	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.
Orencia® *(abatacept)*	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.
Protonix® Pak *(pantoprazole)*	050	Inability to swallow oral tablets or capsules.
Tudorza® (aclidinum bromide)	150	Treatment of COPD

EA Codes and Criteria Table

Drug	Code	Criteria
90-day supply required	090	The prescription is written for less than a 90-day supply.
Abilify® IM injection *(aripiprazole)*	065	All of the following must apply: a) Diagnosis of acute agitation associated with psychotic disorder, including bipolar disorder; b) Patient is 18 to 65 years of age; and c) Maximum dose of 30 mg in a 24 hour period.
Adderall®/XR *(amphetamine salt combo)*	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD).
Aggrenox® *(aspirin/ dipyridamole)*	037	To reduce the risk of stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis, and have no sensitivity to aspirin.
Aloxi® Injection *(palonosetron)*	129	Administered as a single dose in conjunction with cancer chemotherapy treatment.
Ambien® (*zolpidem tartrate***)**	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® (*zolpidem tartrate***)**	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.
amphetamine salt combo/XR	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD).
Amevive® (*alefacept***)**	018	Treatment of plaque psoriasis when prescribed by a rheumatologist or dermatologist in patients who are candidates for systemic or phototherapy. Maximum dose of 7.5mg intravenous bolus or 15mg intramuscular injection once a week.
Amitiza® (*lubiprostone***)**	007	Treatment of chronic constipation. Must have tried and failed a less costly alternative.

Drug	Code	Criteria
Angiotensin Receptor Blockers (ARBs) **Atacand**® *(candesartan cilexetil)* **Atacand HCT**® *(candesartan cilexetil/HCTZ)* **Avalide**® *(irbesartan/HCTZ)* **Avapro**® *(irbesartan)* **Benicar**® *(olmesartan medoxomil)* **Benicar HCT**® *(olmesartan medoxomil/HCTZ)* **Cozaar**® *(losartan potassium)* **Diovan**® *(valsartan)* **Diovan HCT®** *(valsartan/HCTZ)* **Edarbi**® (azilsartan medoxomil) **Edarbyclor(azilsartan medoxomil-clorthalidone)** **Exforge**® (amlodipine besylate-valsartan) **Exforge HCT**® (amlodipine besylate-valsartan/HCTZ) **Hyzaar**® *(losartan potassium/HCTZ)* **Micardis**® *(telmisartan)* **Micardis HCT**® *(telmisartan/HCTZ)*	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.

Drug	Code	Criteria
Teveten® *(eprosartan mesylate)* **Teveten HCT®** *(eprosartan mesylate/ HCTZ)*		
Anzemet® *(dolasetron mesylate)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
Arava® *(leflunomide)*	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.
Atacand® *(candesartan cilexetil)*	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Atacand HCT® *(candesartan cilexetil/HCTZ)*	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Atypical Antipsychotics (Generics First)	400	Continuation of therapy.
	401	Client is not a new start.
	402	History of hyperprolactinemia.
	403	History of extrapyramidal symptoms (EPS).
Abilify® *(aripiprazole)* **Geodon®** *(ziprasidone HCl)* **Invega™** *(paliperidone)* **Risperdal®** *(risperidone)***M-tab** **Seroquel®** *(quetiapine)* **/XR** **Zyprexa®** *(olanzapine)* **/Zydis®** **Clozaril®** *(clozapine)* **Fanapt®** *(iloperidone)* **Risperdal®** *(risperidone)* **Saphris®** *(asenapine)*	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®	092	Must have tried and failed, or have a clinically documented

Drug	Code	Criteria
(irbesartan/ HCTZ)		intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Avapro® *(irbesartan)*	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Avinza® *(morphine sulfate)*	040	Diagnosis of cancer-related pain.
Azor® *(amlodipine/ olmesartan)*	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® *(olmesartan medoxomil)*	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Benicar HCT® *(olmesartan meoxomil/HCTZ)*	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
bupropion/SR/XL	014	Not for smoking cessation.

Drug	Code	Criteria
Campral® *(acamprosate sodium)*	041	Diagnosis of alcohol dependency. Must be used as adjunctive treatment with a Division of Alcohol and Substance Abuse (DASA) state-certified intensive outpatient chemical dependency treatment program. See WAC 388-805-610. Treatment is limited to 12 months. The patient must also meet all of the following criteria: a) Must have finished detoxification and must be abstinent from alcohol before the start of treatment; b) Must not be a poly-substance abuser; and c) Must be able to clear the drug renally (creatinine clearance greater than 30 ml/min).
		Note: A Campral authorization form, DSHS 13-749, must be completed and kept on file with the pharmacy before the drug is dispensed. To download a copy, go to: http://www.dshs.wa.gov/msa/forms/eforms.html.
Celebrex® *(celecoxib)*	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.
Copegus® *(ribavirin)*	010	Diagnosis of chronic hepatitis C virus infection in patients 18 years of age or older. Patient must be on concomitant alpha interferon or pegylated alpha interferon therapy (not to be used as monotherapy).
Concerta® *(methylphenidate HCl)*	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD).
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
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).

Drug	Code	Criteria
dexmethylphenidate /SA	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).
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.
Duragesic® *(fentanyl)*	040	Diagnosis of cancer-related pain.
Enbrel® *(etanercept)*	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.
Exelon® capsules/patch /solution *(rivastigmine)*	015	Treatment of mild to moderate dementia associated with Parkinson's disease
Focalin®/XR *(dexmethylphenidate)*		
gabapentin	035	Treatment of post-herpetic neuralgia.
	036	Treatment of seizures.

Drug	Code	Criteria
	063	Treatment of diabetic peripheral neuropathy.
Gabitril® *(tiagabine HCl)*	036	Treatment of seizures.
Geodon® IM Injection *(ziprasidone mesylate)*	058	All of the following must apply: a) Diagnosis of acute agitation associated with schizophrenia; b) Patient is 18 years of age or older; and c) Maximum dose of 40mg per day and no more than 3 consecutive days of treatment.
Note: Because Geodon® prolongs the QT interval (< Seroquel® > Risperdal® > Zyprexa®), it is contraindicated in patients with a known history of QT prolongation (including a congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval.		
granisetron tablet/injection	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.
Granisol® (*granisetron*) solution	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.
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.
	056	Treatment of plaque psoriasis in patients 18 years of age and

Drug	Code	Criteria
		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.
Hyzaar® *(losartan potassium/HCTZ)*	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Infergen® *(interferon alphcon-1)*	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® *(interferon alpha-2b recombinant)*	030	Diagnosis of hairy cell leukemia in patients 18 years of age and older.
	031	Diagnosis of recurring or refractory condyloma acuminate (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.
	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.
Invega Sustenna® *(paliperidone)* **IM Injection**	068	**All of the following must apply:** • There is an appropriate DSM IV diagnosis with a psychotic disorder; • Patient is 18 to 65 years of age; • Patient has established tolerance to oral or injectable risperdone or oral paliperidone prior to initiating Invega Sustenna ®; and • Dose is not more than 234mg dosed once per month , with the exception of the initial starting dose of 234mg given on day 1 and followed by 156mg one week later.

Drug	Code	Criteria
isotretinoin		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.
Kadian® *(morphine sulfate)*	040	Diagnosis of cancer-related pain.
Keppra® /XR *(levetiracetam)*	036	Treatment of seizures.
Kineret® Injection *(anakinra)*	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.
Lamictal® *(lamotrigine)*	083	Treatment of epilepsy/seizures
	084	Treatment of Bipolar Disorder
Lamisil® *(terbinafine HCl)*		Treatment of onychomycosis for up to 12 months is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis and requiring systemic antibiotic therapy;
	051	Peripheral vascular disease; or
	052	Patient is immunocompromised.
lamotrigine	083	Treatment of epilepsy/seizures
	084	Treatment of Bipolar Disorder
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
levetiracetam	036	Treatment of seizures.
Levorphanol	040	Diagnosis of cancer-related pain.

Drug	Code	Criteria
Lotrel® *(amlodipine-besylate/ benazepril)*	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.
Lunesta™ *(eszopiclone)*	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 *(methylphenidate HCl)*	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD).
methylphenidate /LA/SR/OSM	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® *(telmisartan)*	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Micardis HCT® *telmisartan/HCTZ)*	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
MS Contin® *(morphine sulfate ER)*	040	Diagnosis of cancer-related pain.
naltrexone		Must be used as adjunctive treatment within a state-certified intensive outpatient chemical dependency treatment program. See WAC 388-805-610. For maintenance of opioid-free state in a detoxified person, treatment may be started only after a minimum of 7-10 days free from opioid use. Treatment period must be limited to 12 weeks or less, and the patient must have an absence of all of the following: a) Acute liver disease; and b) Liver failure; and c) Pregnancy.
	067	Diagnosis of past opioid dependency or current alcohol dependency.
Note: A ReVia® (*naltrexone*) Authorization Form, DSHS 13-677, must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:** http://www.dshs.wa.gov/msa/forms/eforms.html		
Nephrocaps®, Nephro-Fer®, Nephro-vite®,	096	Treatment of patients with renal disease.

Drug	Code	Criteria
Nephro-Vite® Rx, Nephro-vite® +Fe, and Nephron® FA		
Neurontin® *(gabapentin)*	035	Treatment of post-herpetic neuralgia.
	036	Treatment of seizures.
	063	Treatment of diabetic peripheral neuropathy.

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

Drug	Code	Criteria
Opana ER® *(Oxymorphone HCl ER)*	040	Diagnosis of cancer-related pain.
ondansetron	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.
Orencia® *(abatacept)*	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® *(oxandrolone)*		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® *(oxycodone HCI)*	040	Diagnosis of cancer-related pain.
Parcopa® *(carbidopa/ levodopa)*	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.
Plavix® *(clopidogrel bisulfate)*	116	When used in conjunction with stent placement in coronary arteries. Supply limited to 9 months after stent placement.
	136	For use in patients with atherosclerosis documented by recent myocardial infarction, recent stroke, or established peripheral artery disease and have failed aspirin. A patient that is considered an aspirin failure has had an atherosclerotic event (MI, stroke, intermittent claudication) after the initiation of once-a-day aspirin therapy.

Drug	Code	Criteria
Prevacid® SoluTab™ *(lansoprazole)*	050	Inability to swallow oral tablets or capsules.
Protonix® Pak *(pantoprazole)*	050	Inability to swallow oral tablets or capsules.
Pulmozyme® *(dornase alpha)*	053	Diagnosis of cystic fibrosis and the patient is 5 years of age or older.
ramipril	020	Patients with a history of cardiovascular disease.
Rebetol® *(ribavirin)*	010	Diagnosis of chronic hepatitis C virus infection in patients 18 years of age or older. Patient must be on concomitant alpha interferon or pegylated alpha interferon therapy (not to be used as monotherapy).
Rebetron® *(ribavirin/ interferon alpha-2b, recombinant)*	008	Treatment of chronic hepatitis C in patients with compensated liver disease who have relapsed following alpha interferon therapy.
	009	Treatment of chronic hepatitis C in patients with compensated liver disease.
Remicade Injection® *(infliximab)*	046	Treatment of ulcerative colitis when prescribed by a gastroenterologist in those patients who have tried and failed conventional therapy. Maximum maintenance dose is 5mg/kg given every 8 weeks after the induction regimen of 5mg/kg given at week 2 and week 6 of therapy.
Rena-Vite® Rena-Vite RX® *(folic acid/vit B comp W-C)*	096	Treatment of patients with renal disease.
ReVia® *(naltrexone HCl)*		Must be used as adjunctive treatment within a state-certified intensive outpatient chemical dependency treatment program. See WAC 388-805-610. For maintenance of opioid-free state in a detoxified person, treatment may be started only after a minimum of 7-10 days free from opioid use. Treatment period must be limited to 12 weeks or less, and the patient must have an absence of all of the following: a) Acute liver disease; and b) Liver failure; and c) Pregnancy.
	067	Diagnosis of past opioid dependency or current alcohol dependency.
Note: A ReVia® (*naltrexone*) Authorization Form, DSHS 13-677, must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:** http://www.dshs.wa.gov/msa/forms/eforms.html		

Drug	Code	Criteria
Ribavirin	010	Diagnosis of chronic hepatitis C virus infection in patients 18 years of age or older. Patient must be on concomitant alpha interferon or pegylated alpha interferon therapy (not to be used as monotherapy).
Risperdal® Consta® IM Injection *(risperidone microspheres)*	059	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 risperidone prior to initiating Risperdal Consta®; and d) Total daily dose is not more than 9mg/day (injectable plus oral at an injectable conversion rate of 25 mg every two weeks IM = 2 mg every day oral).
Ritalin®/LA/SR *(methylphenidate HCl)*	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD).
Rituxan® *(rituximab)*	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.
Roferon-A® *(interferon alpha-2a recombinant)*	030	Diagnosis of hairy cell leukemia in patients **18** years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients **18** years of age and older.
	080	Diagnosis of chronic phase, Philadelphia chromosome (Ph) positive chronic myelogenous leukemia (CML) when treatment started within one year of diagnosis.
	109	Treatment of chronic hepatitis C in patients **18** years of age and older.
Savella® *(milnacipran HCl)*	066	Treatment of fibromyalgia.
Sonata® *(zaleplon)*	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® *(acitretin)*	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

Drug	Code	Criteria
		b) Hepatitis; and c) Concurrent retinoid therapy.
Spiriva® (*tiotropium*)	150	Treatment of COPD
Sporanox® *(itraconazole)*		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 months is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis **and** requiring systemic antibiotic therapy;
	051	Peripheral vascular disease; **or**
	052	Patient is immunocompromised.
Talacen® *(pentazocine HCl/ acetaminophen)* **Talwin NX®** *(pentazocine/ naloxone)*	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.
Teveten® *(eprosartan mesylate)*	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Teveten HCT® *(eprosartan mesylate/HCTZ)*	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Topamax®/ Topamax® Sprinkle *(topiramate)*	036	Treatment of Seizures.
	045	Migraine prophylaxis.
Tribenzor ® *(olmesartan-amlodipine-hydrochlorothiazide)*	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® (aclidinum bromide)	150	Treatment of COPD
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

Drug	Code	Criteria
		b) The patient is intolerant to metronidazole; or c) Metronidazole is contraindicated due to drug-drug interaction(s).
Vyvanse® *(lisdexamfetamine dimesylate)*	075	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder ADD
Wellbutrin SR® and XL® *(bupropion HCl)*	014	Not for smoking cessation.
Zaleplon	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® *(ondansetron HCl)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.
Zolpidem	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® *(zoledronic acid)*	011	Diagnosis of Hypercalcemia associated with malignant neoplasms with or without metastases; or multiple myeloma; or bone metastases of solid tumors.
Zyprexa® IM Injection *(olanzapine)*	060	All of the following must apply: a) Diagnosis of acute agitation associated with psychotic disorder, including bipolar disorder; b) Before any subsequent doses are given, patient has been evaluated for postural hypotension and no postural hypotension is present; c) Patient is 18 to 65 years of age; and d) Maximum dose of 30 mg in a 24 hour period.
Zyprexa Relprevv® (*olanzapine pamoate)*	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.

Drug	Code	Criteria
Zyvox® Injectable *(linezolid)*	013	Treatment of vancomycin resistant infection.
Zyvox® Oral *(linezolid)*	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.