

Authorization

Authorization does not guarantee payment.

All administrative requirements (client eligibility, claim timeliness, etc.)
must be met before HRSA reimburses.

Who determines authorization status for drugs in HRSA's drug file? [Refer to WAC 388-530-3100(1)]

For drugs in therapeutic classes included in the Washington Preferred Drug List (PDL), authorization status is determined by its designation as preferred or non-preferred.

For drugs **not** in therapeutic classes included in the Washington PDL, HRSA pharmacists, medical consultants, and the Drug Use Review Team evaluate drugs to determine authorization status on the drug file. HRSA may consult with an evidence-based practice center, the Drug Use Review (DUR) Board, and/or participating HRSA providers in this evaluation.

How is authorization status determined for drugs in HRSA's drug file? [Refer to WAC 388-530-3200(2) and (3)]

Drug manufacturers who wish to facilitate the evaluation process for a drug product may send the HRSA pharmacist(s) a written request and the following supporting documentation:

- Background data about the drug;
- Product package information;
- Any pertinent clinical studies;
- Outcome and effectiveness data using the Academy of Managed Care Pharmacy's drug review submission process; and
- Any additional information the manufacturer considers appropriate.

HRSA evaluates a drug based on, but not limited to, the following criteria:

- Whether the manufacturer has signed a federal drug rebate contract agreement;
- Whether the drug is a less-than-effective drug;
- The drug's risk/benefit ratio;
- Whether like drugs are on HRSA's drug file and there are less costly therapeutic alternative drugs;
- Whether the drug falls into one of the categories authorized by federal law to be excluded from coverage;
- The drug's potential for abuse; and
- Whether outcome data demonstrate that the drug is cost effective.

What authorization status may be assigned to a drug?

HRSA may determine that a covered drug is:

- Covered without restriction;
- Requires authorization; or
- Requires authorization when HRSA-determined limitations have been exceeded.

Decisions regarding restrictions are based on, but are not limited to:

- Client safety;
- FDA-approved indications;
- Quantity;
- Client age and/or gender; and
- Cost.

To view HRSA's current List of Limitations on Certain Drugs

go to: <http://maa.dshs.wa.gov/pharmacy>

If you do not have access to the Internet, you may obtain a hard copy of HRSA's List of Limitations of Certain Drugs by:

Emailing:

MACSC
providerinquiry@dshs.wa.gov

Faxing:

MACSC
360.725.2144

Writing to:

MACSC
PO Box 45562
Olympia, WA 98504-5562

Calling:

MACSC
800.562.3022, Option 2

Physicians and pharmacists should monitor the use of these drugs and counsel patients when the limits are exceeded. Authorization is required in order to exceed these limits.

How are drugs added to HRSA's drug file?

[Refer to WAC 388-530-3000(2) and (3)]

HRSA's drug file is maintained by Medispan (a drug file contractor). Manufacturers must report their products to Medispan for them to be included in HRSA's drug file for potential coverage and reimbursement.

Authorization

When does HRSA require authorization? [Refer to WAC 388-530-3000(2)]

Pharmacists are required to obtain authorization for some drugs and drug-related supplies *before* providing them to the client. Other drugs require authorization only when specific limits on dosage, quantity, utilization, or duration of use are exceeded. HRSA may also require *situational* authorization that is not directly related to the product being dispensed. These situations include, but are not limited to:

- Early refills;
- Therapeutic duplications;
- Client's whose utilization patterns are under review;

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- More than four prescriptions or prescription refills per calendar month for the same product in any of the following categories:
 - ✓ Antibiotics;
 - ✓ Anti-asthmatics;
 - ✓ Schedule II & III drugs;
 - ✓ Anti-neoplastic agents;
 - ✓ Topical preparations; or
 - ✓ Propoxyphene, propoxyphene napsylate, and all propoxyphene combinations; and
- More than two prescriptions or prescription refills per calendar month for any other product.

HRSA reviews authorization requests for medical necessity. The requested service or item must be covered within the scope of the client's program.

Exception:

In emergency situations, pharmacists may fill prescription drugs that require authorization without receiving an authorization number prior to dispensing.

To receive reimbursement, justification for the emergency fill must be provided to HRSA no later than 72 hours after the fill date (excluding weekends and Washington State holidays).

How do I obtain authorization?

To obtain authorization for drug products requiring authorization, providers may:

- Fax a Prescription Drug Authorization Fax Request Form [DSHS 13-798] to HRSA at 360.725.2141. This form is available for electronic download at: <http://www1.dshs.wa.gov/msa/forms/eforms.html> (see *Important Contacts* for more information).
- Call HRSA at 800.848.2842 (option 2).

What information must a pharmacist have ready before calling HRSA for an authorization number?

When calling for an authorization number, pharmacists must have the following information ready:

- Previous authorization number, if available;
- Pharmacy NCPDP #;
- Rx #;
- Quantity and days supply;
- Tried and failed;
- Client's Patient Identification Code (PIC);
- National Drug Code (NDC) being dispensed;
- Prescriber's name and specialty (if known);
- Prescriber's phone and fax number;
- Date(s) of dispense; and
- Justification for the requested service:
 - ✓ The medical need for the drug and/or dosing (sig);
 - ✓ The diagnosis or condition of the client; and
 - ✓ Other therapies that have been tried and failed in treatment of the same condition.

HRSA may request additional information, depending on the drug product.

Drugs that do not Require Authorization

To check the reimbursement status of a drug, go to:

<http://maa.dshs.wa.gov/pharmacy>

If you do not have access to the Internet, you may obtain a hard copy of this list by:

Emailing:

Provider Relations
providerinquiry@dshs.wa.gov

Faxing:

Provider Relations
360.725.2144

Writing to:

Provider Relations
626 8th Ave SE
Olympia 98504-5505

Calling:

Provider Relations
800.562.3022, option 2

IMPORTANT: Products on this list are **subject to all other coverage rules.**

What are the criteria for early refills?

[Refer to WAC 388-530-2000(5)(b)(iii)]

The following circumstances are justification for early refills:

- If a client's prescription is lost, stolen, or destroyed (only once every six months, per medication).
- If a client needs a refill sooner than originally scheduled due to a prescriber dosage change. (The pharmacist must document the dosage change.)
- If a client is suicidal, at-risk for potential drug abuse, or being monitored by the prescriber.
- If a client needs a take-home supply of medication for school or camp, or for skilled nursing facility clients.

For any other circumstance, the provider must contact HRSA's Pharmacy Authorization Section to request approval and an authorization number (see *Important Contacts* section).

Pharmacy providers have the right to ask clients for documentation relating to reported theft or destruction, (e.g., fire, earthquake, etc.). If clients residing in a skilled nursing facility (SNF) have their prescription lost or stolen, the replacement prescription is the responsibility of the SNF. Clients who experience difficulties in managing their drug therapy should be considered for the use of compliance devices (e.g., Medisets).

BILLING

Hard copy billers must enter one of the following justification descriptions in the *Justification/Comments* field on the Pharmacy Statement [DSHS 13-714].

Point-of-Sale billers must enter one of the following codes in the *Claims Segment, Prior Authorization Code* field.

<u>Justification Description</u>	<u>Code</u>
"Lost or Stolen Drug Replacement"	5
"School or Camp"	8
"Monitoring"	8
"Suicidal Risk (SR)"	8
"Take Home Supply (Skilled Nursing Facility Client)"	8

Brand Name Drugs

Prescribers and pharmacies should prescribe and dispense the generic form of a drug whenever possible. Authorization may be required for reimbursement of brand name drugs at brand name pricing when a generic equivalent is available. If the brand name drug is prescribed instead of a generic equivalent, the prescriber must provide medical justification for the use of the brand name drug to the pharmacist. Authorization is based on medical need, such as clinically demonstrated, observed, and documented adverse reactions which have occurred when the generic drug has been used.

Substitute generic drugs for listed brand name drugs when:

- They are approved by the FDA as therapeutically equivalent drugs; and
- They are permitted by the prescribing physician under current state law.

To request authorization, call HRSA’s Drug Use and Review at 800.848.2842 (option 2).

Expedited Authorization (EA) [Refer to WAC 388-530-3200(4)]

What is the EA process?

HRSA's EA process is designed to eliminate the need to request authorization from HRSA. 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 HRSA 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.

BILLING

Hardcopy billers must enter the EA Number in the *Authorization Number* field on the Pharmacy Statement [DSHS 13-714].

Point of Sale billers must enter the EA Number in the *Claims Segment, Prior Authorization Number Submitted* field.

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).

Pharmacists are reminded that EA numbers are only for those drugs listed *on the following pages*. They are not valid for:

- Other drugs requiring authorization through the Prescription Drug Program;
- Waiving the S-MAC or A-MAC price; or
- 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 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:
 - ✓ Calling 800.848.2842, option 2; or
 - ✓ Faxing 360.725.2141.

- **Documentation** - Dispensing pharmacists must write 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.

Expedited Authorization Codes and Criteria Table

Drug	Code	Criteria
Accutane[®] <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.
Aggrenox[®] <i>(aspirin/ dipyridamole)</i>	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 all of the following: a) The patient has tried and failed aspirin or dipyridamole alone; and b) The patient has no sensitivity to aspirin.
Aloxi[®] Injection <i>(palonosetron)</i>	129	Administered as a single dose in conjunction with cancer chemotherapy treatment.

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Drug	Code	Criteria
Altace® (ramipril)	020	Patients with a history of cardiovascular disease.
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.
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.
Angiotensin Receptor Blockers (ARBs)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor. 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) Hyzaar® (losartan potassium/HCTZ) Micardis® (telmisartan) Micardis HCT® (telmisartan/HCTZ) 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 at a loading dose of 100mg per day for three days and then up to 20mg daily thereafter.
Avinza® (morphine sulfate)	040	Diagnosis of cancer-related pain.

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Drug	Code	Criteria
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.
Calcium w/Vitamin D Tablets	126	Confirmed diagnosis of osteoporosis, osteopenia, or osteomalacia.
Campral[®] (acamprosate sodium)	041	<p>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:</p> <ul style="list-style-type: none"> 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). <p>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://www1.dshs.wa.gov/msa/forms/eforms.html.</p>
Celebrex[®]	062	<p>All of the following must apply:</p> <ul style="list-style-type: none"> a) An absence of a history of ulcer of gastrointestinal bleeding; and b) An absence of a history of cardiovascular disease.
Clarinet[®] syrup (desloratadine)	012	Patient is at least 6 months, but less than 2 years, of age.
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).
Coreg[®] (carvedilol)	057	Diagnosis of congestive heart failure.
Cymbalta[®] (duloxetine)	063	Treatment of diabetic peripheral neuropathy.

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Drug	Code	Criteria
Dolophine® <i>(methadone HCl)</i>	040	Diagnosis of cancer-related pain.
Duragesic® <i>(fentanyl)</i>	040	Diagnosis of cancer-related pain.
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.
Exforge® <i>(amlodipine/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.
Gabitril® <i>(tiagabine HCl)</i>	036	Treatment of seizures.
Geodon® IM Injection <i>(ziprasidone mesylate)</i>	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.		
Glycolax Powder® <i>(polyethylene glycol)</i>	021	Treatment of occasional constipation. Must have tried and failed a less costly alternative.

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Drug	Code	Criteria
Humira® (<i>adalimumab</i>)	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.
Infergen® (<i>interferon alphcon-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.
	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.
Kadian® (<i>morphine sulfate</i>)	040	Diagnosis of cancer-related pain.
Keppra™ (<i>levetiracetam</i>)		See criteria for Gabitril®.
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.
Kytril® (<i>granisetron HCl</i>)	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.

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Drug	Code	Criteria
Lamisil[®] (<i>terbinafine HCl</i>)		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.
Levorphanol	040	Diagnosis of cancer-related pain.
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; <u>or</u> b) Calcium channel blocker alone; <u>or</u> c) ACE inhibitor and a calcium channel blocker as two separate concomitant prescriptions.
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.
Lyrica[®] (<i>pregabalin</i>)	035	Treatment of post-herpetic neuralgia.
	036	Treatment of seizures.
	063	Treatment of diabetic peripheral neuropathy.
	066	Treatment of fibromyalgia.
Miralax[®] (<i>polyethylene glycol</i>)		See criteria for Glycolax Powder [®] .
MS Contin[®] (<i>morphine sulfate ER</i>)	040	Diagnosis of cancer-related pain.
Nasonex[®] (<i>mometasone furoate</i>)	015	Patient is 2 to 6 years of age.
Naltrexone		See criteria for ReVia [®] .

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Drug	Code	Criteria
Nephrocaps[®], Nephro-Fer[®], Nephro-vite[®], Nephro-Vite[®] Rx, Nephro-vite[®] +Fe, and Nephron[®] FA	096	Treatment of patients with renal disease.
Neurontin[®] (gabapentin)	035	Treatment of post-herpetic neuralgia.
	036	Treatment of seizures.
	063	Treatment of diabetic peripheral neuropathy.
Non-Steroidal Anti- Inflammatory Drugs (NSAIDs)	141	An absence of a history of ulcer or gastrointestinal bleeding.
<p> Arthrotec[®] (<i>diclofenac/misoprostol</i>) diclofenac potassium diflunisal diclofenac sodium SR/ER/EC etodolac /XL fenoprofen flurbiprofen ibuprofen ibuprofen/hydrocodone (Vicoprofen[®]) indomethacin /SA ketoprofen /SA ketorolac meclofenamate meloxicam nabumetone naproxen /EC naproxen sodium /ER oxaprozin piroxicam Ponstel[®] (<i>mefenamic acid</i>) salsalate sulindac tolmetin </p>		

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Drug	Code	Criteria
Opana ER[®] (<i>Oxymorphone HCl ER</i>)	040	Diagnosis of cancer-related pain.
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).
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.
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.
Plavix[®] (<i>clopidogrel bisulfate</i>)	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.

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Drug	Code	Criteria
Pravastatin	039	Patient has a clinical drug-drug interaction with other statin-type cholesterol-lowering agents.
Prevacid[®] SoluTab[™] <i>(lansoprazole)</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.
Raptiva[®] <i>(efalizumab)</i>	027	Treatment of plaque psoriasis when prescribed by a dermatologist for patients 18 years or older. Weekly dose is not to exceed 200mg subcutaneously.
Rebetol[®] <i>(ribavirin)</i>		See criteria for Copegus [®] .
Rebetron[®] <i>(ribavirin/ interferon alpha-2b, recombinant)</i>	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[®] <i>(infliximab)</i>	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[®] <i>(folic acid/vit B comp W-C)</i>	096	Treatment of patients with renal disease.

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Drug	Code	Criteria
ReVia® (<i>naltrexone HCl</i>)	067	<p>Diagnosis of past opioid dependency or current alcohol dependency.</p> <p>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:</p> <ul style="list-style-type: none"> a) Acute liver disease; and b) Liver failure; and c) Pregnancy.
<p>Note: A ReVia® (<i>Naltrexone</i>) Authorization Form [DSHS 13-677] must be on file with the pharmacy before the drug is dispensed. To download a copy, go to: http://www1.dshs.wa.gov/msa/forms/eforms.html</p>		
Ribavirin		See criteria for Copegus®.
Risperdal® Consta® IM Injection (<i>risperidone microspheres</i>)	059	<p>All of the following must apply:</p> <ul style="list-style-type: none"> 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).
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.
Roferon-A® (<i>interferon alpha-2a recombinant</i>)	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.

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Drug	Code	Criteria
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 b) Hepatitis; and c) Concurrent retinoid therapy.
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.

Drug	Code	Criteria
Suboxone[®] <i>(buprenorphine/ naloxone)</i>	019	<p>Before this code is allowed, the patient must meet <u>all</u> of the following criteria. The patient:</p> <ul style="list-style-type: none"> a) — Is 16 years of age or older; b) — Has a <u>DSM IV TR</u> diagnosis of opioid dependence; c) — Is psychiatrically stable or is under the supervision of a mental health specialist; d) — Is not abusing alcohol, benzodiazepines, barbiturates, or other sedative hypnotics; e) — Is not pregnant or nursing; f) — Does not have a history of failing multiple previous opioid agonists treatments and multiple relapses; g) — Does not have concomitant prescriptions of azole antifungal agents, macrolide antibiotics, protease inhibitors, phenobarbital, carbamazepine, phenytoin, and rifampin, unless dosage adjusted appropriately; and h) — Is enrolled in a state certified intensive outpatient chemical dependency treatment program. See WAC 388-805-610. <p>Limitations:</p> <ul style="list-style-type: none"> • — No more than 14 day supply may be dispensed at a time; • — Urine drug screens for benzodiazepines, amphetamine/methamphetamine, cocaine, methadone, opiates, and barbiturates must be done before each prescription is dispensed. <i>The prescriber must fax the pharmacy with confirmation that the drug screen has been completed to release the next 14-day supply. The fax must be retained in the pharmacy for audit purposes;</i> • — Liver function tests must be monitored periodically to guard against buprenorphine induced hepatic abnormalities; and • — Clients may receive up to 6 months of buprenorphine treatment for detoxification and stabilization. <p>Note: A Buprenorphine Suboxone Authorization Form (DSHS 13-720) must be on file with the pharmacy before the drug is dispensed. To download a copy, go to: http://www1.dshs.wa.gov/msa/forms/eforms.html.</p>
Symbyax[®] <i>(olanzapine/ fluoxetine HCl)</i>	048	<p>All of the following must apply:</p> <ul style="list-style-type: none"> a) Diagnosis of depressive episodes associated with bipolar disorder; and b) Patient is 6 years of age or older.

Prescription Drug Program

Drug	Code	Criteria
Talacen[®] <i>(pentazocine HCl/acetaminophen)</i> Talwin NX[®] <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.
Toprol XL[®] <i>(metoprolol succinate)</i>	057	Diagnosis of congestive heart failure.
Topamax[®] / Topamax[®] Sprinkle <i>(topiramate)</i>	036	Treatment of Seizures.
	045	Migraine prophylaxis.
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).
Vitamin E	105	Confirmed diagnosis of tardive dyskinesia or is clinically necessary for Parkinsonism and all of the following: a) Caution is addressed for concurrent anticoagulant treatment; and b) Dosage does not exceed 3,000 IU per day.
Wellbutrin SR[®] and XL[®] <i>(bupropion HCl)</i>	014	Treatment of depression.
Zofran[®] <i>(ondansetron HCl)</i>		See criteria for Kytril [®] .
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.

Prescription Drug Program

Drug	Code	Criteria
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[®] IM Injection <i>(olanzapine)</i>	060	All of the following must apply: <ul style="list-style-type: none"> 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.
Zyvox[®] Injectable <i>(linezolid)</i>	013	Treatment of vancomycin resistant infection.
Zyvox[®] Oral <i>(linezolid)</i>	013	Treatment of vancomycin resistant infection
	016	Outpatient treatment of methacillin resistant staph aureus (MRSA) infections when IV vancomycin is contraindicated, such as: <ul style="list-style-type: none"> a) Allergy; or b) Inability to maintain IV access.

Prescription Drug Program

Drug	Code	Criteria
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