

Expedited Authorization 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 (<i>aripiprazole</i>)	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.
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 have no sensitivity to aspirin.
Aloxi® Injection (<i>palonosetron</i>)	129	Administered as a single dose in conjunction with cancer chemotherapy treatment.

Prescription Drug Program

Drug	Code	Criteria
Ambien® (<i>zolpidem tartrate</i>)	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Ambien CR® (<i>zolpidem tartrate</i>)	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Amevive® (<i>alefacept</i>)	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® (<i>lubiprostone</i>)	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.
<p>Atacand® (<i>candesartan cilexetil</i>) Atacand HCT® (<i>candesartan cilexetil/HCTZ</i>) Avalide® (<i>irbesartan/HCTZ</i>) Avapro® (<i>irbesartan</i>) Benicar® (<i>olmesartan medoxomil</i>) Benicar HCT® (<i>olmesartan medoxomil/HCTZ</i>) Cozaar® (<i>losartan potassium</i>) Diovan® (<i>valsartan</i>) Diovan HCT® (<i>valsartan/HCTZ</i>) Hyzaar® (<i>losartan potassium/HCTZ</i>) Micardis® (<i>telmisartan</i>) Micardis HCT® (<i>telmisartan/HCTZ</i>) Teveten® (<i>eprosartan mesylate</i>) Teveten HCT® (<i>eprosartan mesylate/HCTZ</i>)</p>		
Anzemet® (<i>dolasetron mesylate</i>)	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
Arava® (<i>leflunomide</i>)	034	Treatment of rheumatoid arthritis when prescribed by a rheumatologist at a loading dose of 100mg per day for three days and then up to 20mg daily thereafter.

Prescription Drug Program

Drug	Code	Criteria
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.
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.
Benicar® (<i>olmesartan medoxomil</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Benicar HCT® (<i>olmesartan meoxomil/HCTZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Blood Glucose Test Strips	263	Gestational Diabetes (up to two months post delivery)
	264	Insulin-dependent diabetic (age 21 and older)
	265	Insulin-dependent diabetic (age 20 and younger)
bupropion/SR/XL	014	Not for smoking cessation.

Prescription Drug Program

Drug	Code	Criteria
Campral® (<i>acamprosate sodium</i>)	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® (<i>celecoxib</i>)	062	<p>All of the following must apply:</p> <ul style="list-style-type: none"> a) An absence of a history of ulcer or gastrointestinal bleeding; and b) An absence of a history of cardiovascular disease.
Cetirizine syrup	082	Patient is at least 6 months, but less than 2 years, of age.
Copegus® (<i>ribavirin</i>)	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).
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.
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/HCT Z</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
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.
	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.
Exforge® (<i>amlodipine/valsartan</i>) Exforge® HCT (<i>amlodipine/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.
Exelon® capsules/patch/solution (<i>rivastigmine</i>)	015	Treatment of mild to moderate dementia associated with Parkinson's disease
Gabitril® (<i>tiagabine HCl</i>)	036	Treatment of seizures.

Prescription Drug Program

Drug	Code	Criteria
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.
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.
	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 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.

Prescription Drug Program

Drug	Code	Criteria
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.
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.
Intron A® (<i>interferon alpha-2b recombinant</i>)	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® /XR (<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.
Lamictal® (<i>lamotrigine</i>)	083	Treatment of epilepsy/seizures
	084	Treatment of Bipolar Disorder

Prescription Drug Program

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.
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)
levetiracetam	036	Treatment of seizures.
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; or b) Calcium channel blocker alone; or 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.
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/HC TZ</i>)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Miralax® (<i>polyethylene glycol</i>)		See criteria for Glycolax Powder®.

Prescription Drug Program

Drug	Code	Criteria
MS Contin® <i>(morphine sulfate ER)</i>	040	Diagnosis of cancer-related pain.
Naltrexone		See criteria for ReVia®.
Nephrocaps®, Nephro-Fer®, Nephro-vite®, Nephro-Vite® Rx, Nephro- vite® +Fe, and Nephron® FA	096	Treatment of patients with renal disease.
Neurontin® <i>(gabapentin)</i>	035	Treatment of post-herpetic neuralgia.
	036	Treatment of seizures.
	063	Treatment of diabetic peripheral neuropathy.

Prescription Drug Program

Drug	Code	Criteria
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 diclofenac sodium SR/ER/EC diflunisal etodolac /ER fenoprofen Flector® (<i>diclofenac epolamine</i>) flurbiprofen ibuprofen ibuprofen/hydrocodone (Vicoprofen®) indomethacin /SR ketoprofen /SR ketorolac meclofenamate meloxicam nabumetone naproxen /EC naproxen sodium /ER oxaprozin piroxicam Ponstel® (<i>mefenamic acid</i>) salsalate sulindac tolmetin Voltaren® (<i>diclofenac sodium</i>) gel </p>		

Prescription Drug Program

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.

Prescription Drug Program

Drug	Code	Criteria
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.
Ramipril	020	Patients with a history of cardiovascular disease.
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.

Prescription Drug Program

Drug	Code	Criteria
ReVia® (<i>naltrexone HCl</i>)	067	Diagnosis of past opioid dependency or current alcohol dependency. 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.
<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	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).
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.

Prescription Drug Program

Drug	Code	Criteria
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.
Savella® (<i>milnacipran HCl</i>)	066	Treatment of fibromyalgia.
Sonata® (<i>zaleplon</i>)	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Soriatane® (<i>acitretin</i>)	064	Treatment of severe, recalcitrant psoriasis in patients 16 years of age and older. Prescribed by, or in consultation with, a dermatologist, and the patient must have an absence of all of the following: a) Current pregnancy or pregnancy which may occur while undergoing treatment; and b) Hepatitis; and c) Concurrent retinoid therapy.
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 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.

Prescription Drug Program

Drug	Code	Criteria
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.
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).
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)		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.
Zometa® (zoledronic acid)	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® IM Injection <i>(olanzapine)</i>	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.
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: a) Allergy; or b) Inability to maintain IV access.