## ANALGESICS

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lucemyra</td>
<td>NP</td>
<td>Will be approved for patients meeting ALL of the following criteria:</td>
<td>16/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Must be ≥ 18 years of age; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Patient is not pregnant or breast feeding; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Prescriber to provide verbal attestation that if patient is at risk for QT interval prolongation (congestive heart failure, bradyarrhythmias, hepatic impairment, renal impairment, or patients taking other medicinal products that lead to QT prolongation), baseline electrocardiogram (ECG) has been performed; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Patient has tried and failed, had a contraindication to, or experienced an adverse reaction/intolerance to buprenorphine and methadone; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Patient has tried and failed, had a contraindication to, or experienced an adverse reaction/intolerance to clonidine; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Prescriber to provide verbal attestation of a comprehensive treatment plan between provider and patient; <strong>AND</strong></td>
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<td></td>
<td>• In the case of opioid use disorder (OUD), provide verbal attestation that patient:</td>
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<td></td>
<td></td>
<td>• Has a referral to <strong>OR</strong> active involvement in substance abuse counseling; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Is unable to have counseling <strong>AND</strong> provides verbal attestation that patient has been offered medication-assisted treatment (MAT) as part of a comprehensive treatment plan; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Provide verbal attestation that patient is NOT prescribed concurrent opioid medication without explanation (verified by state opioid database, if available); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Provide verbal attestation that the patient is capable of and instructed how to self-monitor for hypotension, orthostasis, bradycardia, and associated symptoms; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Provide verbal attestation that the patient has been provided with a tapering schedule and instructions on when to contact their healthcare provider for further guidance.</td>
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<td></td>
<td><strong>Renewal:</strong></td>
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<td></td>
<td>• See Initial Criteria above.</td>
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<td></td>
<td>• If the renewal is a continuation of the initial approval because additional therapy is needed, approve up to 7 additional days (for a total of 14 days of treatment, including days of treatment received as inpatient, if any).</td>
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<td></td>
<td></td>
<td>• <strong>Note:</strong> Safety and efficacy has not been established in patients &lt; 18 years of age</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### ANALGESICS

**Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.**

<table>
<thead>
<tr>
<th>Medication</th>
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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Buprenorphine and Buprenorphine/Naloxone</strong></td>
<td></td>
<td><strong>TennCare Medication Assisted Therapy (MAT) Providers Network only:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bunavail®</td>
<td>P</td>
<td>Preferred buprenorphine/naloxone products will be approved for recipients who meet ALL of the following criteria:</td>
<td>6.3/1mg: 1/day x 6 months*</td>
<td>Buprenorphine Products PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of opiate addiction</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Buprenorphine will not be approved for treatment of depression or pain.</td>
<td>4.2/0.7mg: 2/day x 6 months then 1/day*;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Buprenorphine will not be approved for recipients whose medication history indicates use of concomitant narcotics or benzodiazepines</td>
<td>2.1/0.3mg: 2/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Quantity limit is as a single daily dose. Twice daily dosing may be approved as clinically necessary.</td>
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<td></td>
<td></td>
<td>• Prior Authorizations will be assigned to the prescribing physician.</td>
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<tr>
<td></td>
<td></td>
<td>• Requests for buprenorphine from a non-MAT Provider Network physician will require a new prior authorization request and documentation that the previous prescribing physician has communicated transfer of care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>See Bunavail® prior authorization criteria</td>
<td>8/2mg: 2/day x 6 months then 1/day*;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Additionally, must be unable to take buprenorphine/naloxone as indicated by ONE of the following:</td>
<td>2/0.5mg: 3/day*</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Patients who are actively pregnant (Note: Buprenorphine without naloxone will not be approved for patients who are breastfeeding)</td>
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<tr>
<td></td>
<td></td>
<td>− Patient is unable to take naloxone containing products due to a contraindication, drug to drug interaction, or history of toxic side effects that caused immediate or long-term damage (Note: Does not include GI intolerance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>See Bunavail® prior authorization criteria</td>
<td>8mg: 2/day x 6 months then 1/day*;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Additionally, a documented allergy to inactive ingredient in preferred product that is not in requested product</td>
<td>2mg: 3/day*</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>See Bunavail® prior authorization criteria</td>
<td></td>
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<tr>
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<td></td>
<td>• Additionally, a documented allergy to inactive ingredient in preferred product that is not in requested product</td>
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<tr>
<td></td>
<td></td>
<td>12/3mg: 1/day x 6 months*</td>
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<td></td>
<td></td>
<td>8/2mg: 2/day x 6 months then 1/day*;</td>
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<td></td>
<td>4/1mg: 2/day</td>
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<td></td>
<td></td>
<td>2/0.5mg: 3/day*</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>See Bunavail® prior authorization criteria</td>
<td>11.4/2.9mg &amp; 8.6/2.1mg: 1/day x 6 months*;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Additionally, a documented allergy to inactive ingredient in preferred product that is not in requested product</td>
<td>5.7/1.4 mg: 2/day x 6 months then 1/day*;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>See Bunavail® prior authorization criteria</td>
<td>2.9/0.71mg: 2/day;</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Additionally, a documented allergy to inactive ingredient in preferred product that is not in requested product</td>
<td>1.4/0.36 mg: 3/day;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>See Bunavail® prior authorization criteria</td>
<td>0.7/0.18 mg:3/day*</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Additionally, a documented allergy to inactive ingredient in preferred product that is not in requested product</td>
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**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
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<tr>
<td><strong>Buprenorphine and Buprenorphine/Naloxone (continued)</strong></td>
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<tr>
<td><strong>All other TennCare Providers:</strong></td>
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<tr>
<td></td>
<td></td>
<td>Preferred buprenorphine/naloxone products will be approved for recipients who meet ALL of the following criteria:</td>
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<td></td>
<td>- Diagnosis of opiate addiction</td>
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<td></td>
<td></td>
<td>- Physician must have completed certification program (DEA begins with “X”)</td>
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<td></td>
<td></td>
<td>- Physician attests they have reviewed the Tennessee Controlled Substances Database for this patient on the date of the prior authorization request to ensure that concomitant narcotic or benzodiazepine use is not occurring.</td>
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<td></td>
<td></td>
<td><strong>Additional Information:</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Buprenorphine will not be approved for treatment of depression or pain.</td>
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<td>- Buprenorphine will not be approved for recipients whose medication history indicates use of concomitant narcotics or benzodiazepines</td>
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<td></td>
<td>- Quantity limit is as a single daily dose. Twice daily dosing may be approved as clinically necessary.</td>
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<td></td>
<td></td>
<td>- Physicians will be asked to provide an anticipated treatment plan for the patient (including anticipated dosing for induction and maintenance phases, anticipated frequency of office visits, and anticipated plan for psychosocial counseling).</td>
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<td></td>
<td>- The “Here to Help” program as an exclusive provider of counseling will not be accepted.</td>
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<td></td>
<td>- Prior Authorizations will be assigned to the prescribing physician.</td>
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<td>- Requests for buprenorphine from a different physician will require a new prior authorization request and documentation that the previous prescribing physician has communicated transfer of care.</td>
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</tr>
<tr>
<td><strong>Bunavail</strong></td>
<td>P</td>
<td>See Bunavail” prior authorization criteria</td>
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<tr>
<td></td>
<td></td>
<td>- Additionally, must be unable to take buprenorphine/naloxone as indicated by ONE of the following:</td>
<td></td>
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<td></td>
<td></td>
<td>- Patients who are actively pregnant (Note: Buprenorphine without naloxone will not be approved for patients who are breastfeeding)</td>
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<td></td>
<td></td>
<td>- Patient is unable to take naloxone containing products due to a contraindication, drug to drug interaction, or history of toxic side effects that caused immediate or long-term damage (Note: Does not include Gi intolerance)</td>
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<td></td>
<td></td>
<td>6.3/1mg: 1/day x 6 months*</td>
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<tr>
<td></td>
<td></td>
<td>4.2/0.7mg: 2/day x 6 months, then /day*;</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>2.1/0.3mg: 2/day</td>
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</tr>
<tr>
<td><strong>buprenorphine</strong></td>
<td>NP</td>
<td>See Bunavail” prior authorization criteria</td>
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<td></td>
<td></td>
<td>- Additionally, a documented allergy to inactive ingredient in preferred product that is not in requested product</td>
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<td></td>
<td>8mg: 2/day x 6 months then 1/day*</td>
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<td></td>
<td></td>
<td>2mg: 3/day*</td>
<td></td>
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<tr>
<td><strong>buprenorphine/naloxone film and tablets</strong></td>
<td>NP</td>
<td>See Bunavail” prior authorization criteria</td>
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<tr>
<td></td>
<td></td>
<td>- Additionally, a documented allergy to inactive ingredient in preferred product that is not in requested product</td>
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<tr>
<td></td>
<td></td>
<td>8/2mg: 2/day x 6 months then 1/day*</td>
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<tr>
<td></td>
<td></td>
<td>2/0.5mg: 3/day*</td>
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<tr>
<td><strong>Suboxone</strong> film</td>
<td>NP</td>
<td>See Bunavail” prior authorization criteria</td>
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<td></td>
<td></td>
<td>Additionally, a documented allergy to inactive ingredient in preferred product that is not in requested product</td>
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<td></td>
<td>12/3mg: 1/day x 6 months*</td>
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<tr>
<td></td>
<td></td>
<td>8/2mg: 2/day x 6 months, then 1/day*</td>
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<td></td>
<td></td>
<td>4/1mg: 2/day</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2/0.5mg: 3/day*</td>
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</tbody>
</table>

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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
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</thead>
<tbody>
<tr>
<td>Buprenorphine and Buprenorphine/Naloxone (continued)</td>
<td></td>
<td></td>
<td>11.4/2.9mg &amp; 8.6/2.1mg: 1/day x 6 months*; 5.7/1.4 mg: 2/day x 6 months, then 1/day*; 2.9/0.71 mg: 2/day; 1.4/0.36 mg: 3/day; 0.7/0.18 mg: 3/day*</td>
<td>Buprenorphine Products PA Form</td>
</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.

All other TennCare Providers:

- **Zubsolv®**
  - NP
  - See Bunavil® prior authorization criteria
  - Additionally, a documented allergy to inactive ingredient in preferred product that is not in requested product

* For children, larger quantities may be approved as medically necessary.

### Cox-II Inhibitors

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>celecoxib 50, 100, &amp; 200 mg</td>
<td>P</td>
<td></td>
<td>2/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Celebrex®</td>
<td>NP</td>
<td></td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>celecoxib 400 mg</td>
<td>NP</td>
<td>Will be approved for prophylaxis of colorectal adenomas.</td>
<td>2/day</td>
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</tr>
</tbody>
</table>

### Naloxone Products

<table>
<thead>
<tr>
<th>Medication</th>
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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narcan® nasal spray</td>
<td>P</td>
<td>Will be approved in recipients meeting the following criteria:</td>
<td>2 each (8mg)/30 days</td>
<td>General PA Form</td>
</tr>
<tr>
<td>naltrexone</td>
<td>P</td>
<td>Trial and failure of at least 2 short acting narcotics, OR</td>
<td>10mg/mL: 4mL/day 20mg/mL: 8mL/day</td>
<td></td>
</tr>
<tr>
<td><strong>Narcotic Agonist/Antagonists</strong></td>
<td></td>
<td>Documented contraindication or intolerance to short acting narcotics, AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td>butorphanol nasal spray</td>
<td>NP</td>
<td>Unable to swallow, OR Unable to absorb medications through the GI tract.</td>
<td>2.5mL/30 days</td>
<td>General PA Form</td>
</tr>
</tbody>
</table>

- Butorphanol nasal spray will be approved in recipients meeting the following criteria:
  - Documented inability to swallow or absorb PO narcotics, OR
  - For the treatment of migraines:
    - Recipient MUST be receiving prophylactic therapy for migraines, AND
    - Recipient has tried and failed, or had an intolerance or contraindication to at least ONE agent in EACH of the following categories:
      - 5HT1 receptor antagonist (triptans)
      - Anti-migraine combinations
      - NSAIDs

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<td></td>
<td></td>
<td><strong>Narcotic Agonist/Antagonists (continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pentazocine/APAP</td>
<td>NP</td>
<td>Will be approved for recipients that meet <strong>ONE</strong> of the following criteria:</td>
<td>6/day</td>
<td>General PA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trial and failure of at least 2 short acting narcotics; <strong>OR</strong></td>
<td>Max: 4g APAP/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Contraindication or intolerance to short acting narcotics;</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Additionally, prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 30 days.</td>
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</tr>
<tr>
<td>pentazocine/naloxone</td>
<td>NP</td>
<td>Will be approved for recipients that meet the following criteria:</td>
<td>12/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Contraindication or intolerance to ALL short acting narcotics</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Additionally, prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 30 days</td>
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<tr>
<td><strong>Narcotics, Long Acting</strong></td>
<td></td>
<td>Approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.</td>
<td></td>
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</tr>
<tr>
<td><strong>Embeda®</strong></td>
<td>P</td>
<td>- Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; AND - Pain agreement required for all PA required agents. Please refer to the Opioid and Controlled Substance Agreement document located at: <a href="https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf">https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf</a> - Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider. - Requests for strengths ≥ 100mg: - Recipient must be opioid tolerant (as demonstrated by at least a week or longer history of: morphine sulfate 60 mg/day or more, oral oxycodone 30 mg/day or more, oral hydromorphone 8 mg/day or more, or an equianalgesic dose of another opioid) - Female of child-bearing age (14-44 years): - Is not pregnant; AND - Using contraception (e.g., barrier, oral contraceptive, rhythm method); OR - Has an intrauterine device (IUD) or implant; OR - Has history of hysterectomy, tubal ligation or endometrial ablation The following should be investigated before a PA is granted: - History of substance abuse - Frequent requests for early refills - Reported frequent instances of lost tablets - Requests for odd quantities which requires fractional dosing - Requests for short-term or prn usage - Medication history indicates concurrent use of other extended-release opioids</td>
<td>2/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Acute Opioid PA Form; Chronic Opioid PA Form</td>
</tr>
<tr>
<td><strong>fentanyl patch</strong> (excluding 37.5, 62.5 &amp; 87.5 mcg/hr)</td>
<td>P</td>
<td>Narcotopic topical patches will be reserved for recipients who meet the following criteria: - See Embeda® prior authorization criteria</td>
<td>10 patches/30 days; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Exceptions Opioid PA Form</td>
</tr>
</tbody>
</table>

**Note:** Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary.

All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### ANALGESICS

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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<td>Approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.</td>
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<td><em><strong><strong>Effective January 16, 2018, edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL were implemented that impact all first-time (acute) and non-chronic opioid users. For details, visit: <a href="https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf">https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf</a></strong></strong></em></td>
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<tr>
<td>Nucynta® ER P</td>
<td>Approval will be authorized for recipients meeting the ALL of the following criteria: Management of severe pain with need for around-the-clock analgesia for an extended period; AND Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; AND Pain agreement required for all PA required agents. Please refer to the Opioid and Controlled Substance Agreement document located at: <a href="https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf">https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf</a> Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider. Female of child-bearing age (14-44 years): Is not pregnant; AND Using contraception (e.g., barrier, oral contraceptive, rhythm method); OR Has an intrauterine device (IUD) or implant; OR Has history of hysterectomy, tubal ligation or endometrial ablation The following should be investigated before a PA is granted: History of substance abuse Frequent requests for early refills Reported frequent instances of lost tablets Requests for odd quantities which requires fractional dosing Requests for short-term or prn usage Medication history indicates concurrent use of other extended-release opioids Recipient must be opioid tolerant (as demonstrated by at least a week or longer history of: morphine sulfate 60 mg/day or more, or oral oxycodone 30 mg/day or more, or oral hydromorphone 8 mg/day or more, or an equianalgesic dose of another opioid) Approval for patients with a known addiction to the drug should be granted only if the prescriber has a documented plan to reduce the dosage and eventually wean the patient off the drug entirely. <strong>Note:</strong> Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary.</td>
<td>2/day; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Acute Opioid PA Form</td>
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<tr>
<td>Arymo ER® NP</td>
<td>See Avinza prior authorization criteria</td>
<td>3/day; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Chronic Opioid PA Form</td>
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| Avinza® NP | Requests for extended release morphine sulfate must meet ALL of the following criteria:  
- Approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (Note: This does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.  
- Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; AND  
- Pain agreement required for all PA required agents. Please refer to the Opioid and Controlled Substance Agreement document located at: https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf  
- Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider.  
- Female of child-bearing age (14-44 years):  
  - Is not pregnant; AND  
  - Using contraception (e.g., barrier, oral contraceptive, rhythm method); OR  
  - Has an intrauterine device (IUD) or implant; OR  
  - Has history of hysterectomy, tubal ligation or endometrial ablation  
- Additionally, for requests for extended-release morphine sulfate ≥ 100mg, recipient must be opioid tolerant (as demonstrated by at least a week or longer history of: morphine sulfate 60mg/day or more, oral oxycodone 30mg/day or more, oral hydromorphone 8mg/day or more, or an equianalgesic dose of another opioid)  
The following should be investigated before a PA is granted:  
- History of substance abuse  
- Frequent requests for early refills  
- Reported frequent instances of lost tablets  
- Requests for odd quantities which requires fractional dosing  
- Requests for short-term or prn usage  
- Medication history indicates concurrent use of other extended-release opioids  
**Note:** Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary. | 1/day;  
^Max Total: Non-Chronic: 60 MME/day;  
Chronic: 200 MME/day | **Acute Opioid PA Form**  
**Chronic Opioid PA Form**  
**Exceptions Opioid PA Form** |
### ANALGESICS

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Approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.

***Effective January 16, 2018, edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL were implemented that impact all first-time (acute) and non-chronic opioid users. For details, visit: https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf***

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| Belbuca® NP | Approval will be authorized for recipients meeting ALL of the following criteria:  
- Diagnosis of moderate to severe pain with need for around-the-clock analgesia for an extended period; AND  
- Prescriber has checked the Tennessee Controlled Substance Database for this patient within the last 7 days; AND  
- Patients who have not been titrated down to no more than 30 mg morphine (or morphine equivalents) per day will NOT be approved; AND  
- Pain agreement required for all PA required agents. Please refer to the Opioid and Controlled Substance Agreement document located at: https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf  
- Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider.  
- Female of child-bearing age (14-44 years):  
  - Is not pregnant; AND  
  - Using contraception (e.g., barrier, oral contraceptive, rhythm method); OR  
  - Has an intrauterine device (IUD) or implant; OR  
  - Has history of hysterectomy, tubal ligation or endometrial ablation  
- Additionally, approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (Note: This does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.  
The following should be investigated before a PA is granted:  
- History of substance abuse  
- Frequent requests for early refills  
- Reported frequent instances of lost tablets  
- Requests for odd quantities which requires fractional dosing  
- Requests for short-term or prn usage  
- Medication history indicates concurrent use of other extended-release opioids  
Note: Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary. | 2/day;  
*^Max Total: Non-Chronic: 60 MME/day;  
Chronic: 200 MME/day | Acute Opioid PA Form  
Chronic Opioid PA Form |
| buprenorphine patch NP | See Belbuca® prior authorization criteria  
Additionally, Butrans® 7.5, 10, 15, and 20 mcg/hr will be approved for opioid-experienced patients only. | 4 patches/28 days;  
*^Max Total: Non-Chronic: 60 MME/day;  
Chronic: 200 MME/day | Exceptions Opioid PA Form |

Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### ANALGESICS

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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<tr>
<td>Butrans® NP</td>
<td></td>
<td>See Belbuca® prior authorization criteria Additionally, Butrans® 7.5, 10, 15, and 20 mcg/hr will be approved for opioid-experienced patients only.</td>
<td>4 patches/28 days; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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<tr>
<td>ConZip® NP</td>
<td></td>
<td>Approval will be authorized for recipients meeting the ALL of the following criteria: Management of severe pain with need for around-the-clock analgesia for an extended period; AND Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; AND Pain agreement required for all PA required agents. Please refer to the Opioid and Controlled Substance Agreement document located at: <a href="https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf">https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf</a> Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider. Female of child-bearing age (14-44 years): - Is not pregnant; AND - Using contraception (e.g., barrier, oral contraceptive, rhythm method); OR - Has an intrauterine device (IUD) or implant; OR - Has history of hysterectomy, tubal ligation or endometrial ablation Additionally, approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (Note: This does not include GI intolerance) with ALL preferred agents, unless otherwise indicated. The following should be investigated before a PA is granted: History of substance abuse - Frequent requests for early refills Reported frequent instances of lost tablets Requests for odd quantities which requires fractional dosing Requests for short-term or prn usage Medication history indicates concurrent use of other extended-release opioids <strong>Note:</strong> Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary.</td>
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<td><strong>Acute Opioid PA Form</strong> <strong>Chronic Opioid PA Form</strong> <strong>Exceptions Opoid PA Form</strong></td>
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<tr>
<td>Dolophine®</td>
<td>NP</td>
<td>See methadone prior authorization criteria</td>
<td>5mg: 8/day; 10mg: 4/day;</td>
<td>Acute Opioid PA Form</td>
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<td></td>
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<td>^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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<tr>
<td>Duragesic®</td>
<td>NP</td>
<td>Narcotic topical patches will be reserved for recipients who meet the following criteria:</td>
<td>10 patches/30 days;</td>
<td>Chronic Opioid PA Form</td>
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<td></td>
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<td>- Opioid tolerant (as demonstrated by at least a week or longer history of: morphine sulfate 60 mg/day or more, oral oxycodone 30 mg/day or more, oral hydromorphone 8 mg/day or more, or an equianalgesic dose of another opioid); <strong>AND</strong></td>
<td>^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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<td>- Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; <strong>AND</strong></td>
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<td>- Pain agreement required for all PA required agents. Please refer to the Opioid and Controlled Substance Agreement document located at: <a href="https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf">https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf</a> <strong>AND</strong></td>
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<td>- Is not pregnant; <strong>AND</strong></td>
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<td>- Using contraception (e.g., barrier, oral contraceptive, rhythm method); <strong>OR</strong></td>
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<td>- Has an intrauterine device (IUD) or implant; <strong>OR</strong></td>
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<td>- Has history of hysterectomy, tubal ligation or endometrial ablation</td>
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**Narcotics, Long Acting (continued)**

Approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.

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<td>Exalgo® NP</td>
<td>NP</td>
<td>Approval will be authorized for recipients meeting the ALL of the following criteria:</td>
<td>1/day;</td>
<td>Acute Opioid PA Form</td>
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<td></td>
<td>• Management of severe pain with need for around-the-clock analgesia for an extended period; <strong>AND</strong></td>
<td>*^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Chronic Opioid PA Form</td>
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<td></td>
<td>• Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; <strong>AND</strong></td>
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<td>Exceptions Opioid PA Form</td>
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<td>• Pain agreement required for all PA required agents. Please refer to the Opioid and Controlled Substance Agreement document located at:</td>
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<td>– Has an intrauterine device (IUD) or implant; <strong>OR</strong></td>
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<td>• History of substance abuse</td>
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<td>• Frequent requests for early refills</td>
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<td>• Reported frequent instances of lost tablets</td>
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<td>• Requests for odd quantities which requires fractional dosing</td>
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<td>• Requests for short-term or prn usage</td>
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<td>• Medication history indicates concurrent use of other extended-release opioids</td>
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<td>• Recipient must be opioid tolerant (as demonstrated by at least a week or longer history of: morphine sulfate 60 mg/day or more, or oral oxycodone 30 mg/day or more, or oral hydromorphone 8 mg/day or more, or an equianalgesic dose of another opioid)</td>
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<td>• Approval for patients with a known addiction to the drug should be granted only if the prescriber has a documented plan to reduce the dosage and eventually wean the patient off the drug entirely.</td>
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<td><strong>Note:</strong> Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary.</td>
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**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### ANALGESICS
Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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<td>Approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated. <em><strong>Effective January 16, 2018, edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL were implemented that impact all first-time (acute) and non-chronic opioid users. For details, visit: <a href="https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf">https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf</a></strong></em></td>
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<tr>
<td>fentanyl patch (37.5, 62.5 &amp; 87.5 mcg/hr)</td>
<td>NP</td>
<td>See Duragesic® prior authorization criteria</td>
<td>10 patches/30 days; **^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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</tr>
<tr>
<td>hydromorphone ER</td>
<td>NP</td>
<td>See Exalgo® prior authorization criteria.</td>
<td>1/day; **^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Acute Opioid PA Form</td>
</tr>
<tr>
<td>Hysingla® ER</td>
<td>NP</td>
<td>See Zohydro ER® prior authorization criteria</td>
<td>1/day; **^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Chronic Opioid PA Form</td>
</tr>
<tr>
<td>Kadian®</td>
<td>NP</td>
<td>See Avinza® prior authorization criteria</td>
<td>130, 150, 200mg: 1/day; all other strengths: 2/day; **^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Exceptions Opioid PA Form</td>
</tr>
</tbody>
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**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
**ANALGESICS**

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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<tr>
<td>methadone</td>
<td>NP</td>
<td>Will be approved for patients meeting ALL of the following criteria:</td>
<td>5mg: 8/day; 10mg: 4/day; 5mg/5mL: 40mL/day; 10mg/5mL: 20mL/day; 10 mg/mL: 4mL/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Acute Opioid PA Form</td>
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<td></td>
<td></td>
<td>• Diagnosis of Metastatic Neoplasia; OR</td>
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<td>Chronic Opioid PA Form</td>
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<td>• Infants up to 1 year of age who are discharged from the hospital on a methadone taper will be approved for up to 30 days; OR</td>
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<td>Exceptions Opioid PA Form</td>
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<td>• Diagnosis of chronic severe pain AND patient has contraindication to all other long-acting opioids; AND</td>
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<td>• Patient is not presently taking any other single entity immediate release or extend release opioids, barbiturates, carisoprodol or meprobamate; AND</td>
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<td>• Patient does not have a history of, or received treatment for, drug dependency or drug abuse; AND</td>
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<td>• Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; AND</td>
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<td>• Pain agreement required for all PA required agents. Please refer to the Opioid and Controlled Substance Agreement document located at: <a href="https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf">https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf</a></td>
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<td></td>
<td></td>
<td>• Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider.</td>
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<td></td>
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<td>• Female of child-bearing age (14-44 years):</td>
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<td></td>
<td></td>
<td>- Is not pregnant; AND</td>
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<td>- Using contraception (e.g., barrier, oral contraceptive, rhythm method); OR</td>
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<td>- Has an intrauterine device (IUD) or implant; OR</td>
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<td>- Has history of hysterectomy, tubal ligation or endometrial ablation</td>
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<td>• Doses &gt; 2.5 mg every 8-12 hours: Patient must be tolerant to other opioids as indicated by ONE of the following:</td>
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<td>- At least 60 mg oral morphine per day for at least one week; OR</td>
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<td>- At least 25 mcg/hr transdermal fentanyl for at least one week; OR</td>
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<td>- At least 30 mg oxycodone per day for at least one week; OR</td>
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<td>- At least 8 mg hydromorphone per day for at least one week; OR</td>
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<td>- At least 25 mg oxymorphone per day for at least one week; OR</td>
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<td>- Equianalgesic dose of another opioid for at least one week</td>
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<td>The following should be investigated before a PA is granted:</td>
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<td>• History of substance abuse</td>
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<td>• Frequent requests for early refills</td>
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<td>• Reported frequent instances of lost tablets</td>
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<td></td>
<td></td>
<td>• Medication history indicates concurrent use of other extended-release opioids</td>
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<tr>
<td>Note:</td>
<td>All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.</td>
<td>5mg: 8/day; 10mg: 4/day; 5mg/5mL: 40mL/day; 10mg/5mL: 20mL/day; 10 mg/mL: 4mL/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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**Note:** 1. TennCare does not cover any form of methadone for the treatment of opioid addiction.

2. Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary.
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<td>Methadose*</td>
<td>NP</td>
<td>See methadone prior authorization criteria</td>
<td>**Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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<tr>
<td>Morphabond® ER</td>
<td>NP</td>
<td>See Avinza® prior authorization criteria</td>
<td>2/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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<tr>
<td>morphine sulfate ER capsules (generic for Kadian®)</td>
<td>NP</td>
<td>See Avinza® prior authorization criteria</td>
<td>2/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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<tr>
<td>morphine sulfate SA</td>
<td>NP</td>
<td>See Avinza® prior authorization criteria</td>
<td>15, 30, 60mg: 3/day; 100mg: 2/day; 200mg: 1/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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<tr>
<td>morphine sulfate SR 24hr (generic for Avinza®)</td>
<td>NP</td>
<td>See Avinza® prior authorization criteria</td>
<td>1/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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<tr>
<td>MS Contin®</td>
<td>NP</td>
<td>See Avinza® prior authorization criteria</td>
<td>15, 30, 60mg: 3/day; 100mg: 2/day; 200mg: 1/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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**Narcotics, Long Acting (continued)**

Approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.

***Effective January 16, 2018, edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL were implemented that impact all first-time (acute) and non-chronic opioid users. For details, visit: https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf***

Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### ANALGESICS

**Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.**

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<td><strong>Narcotics, Long Acting (continued)</strong></td>
<td>Opana ER®</td>
<td><strong>Approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage</strong> <em>(NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.</em></td>
<td><strong>2/day;</strong>&lt;br&gt;^Max Total: Non-Chronic 60 MME/day; Chronic: 200 MME/day</td>
<td><strong>Acute Opioid PA Form</strong>&lt;br&gt;<strong>Chronic Opioid PA Form</strong>&lt;br&gt;<strong>Exceptions Opioid PA Form</strong></td>
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<td>Opana ER®</td>
<td><strong>The prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; AND</strong>&lt;br&gt;<strong>Pain agreement required for all PA required agents. Please refer to the Opioid and Controlled Substance Agreement document located at:</strong> <a href="https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf">https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf</a></td>
<td><strong>2/day;</strong>&lt;br&gt;^Max Total: Non-Chronic 60 MME/day; Chronic: 200 MME/day</td>
<td><strong>Acute Opioid PA Form</strong>&lt;br&gt;<strong>Chronic Opioid PA Form</strong>&lt;br&gt;<strong>Exceptions Opioid PA Form</strong></td>
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<td></td>
<td>Opana ER®</td>
<td>Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider.&lt;br&gt;<strong>Female of child-bearing age (14-44 years):</strong>&lt;br&gt;– Is not pregnant; <strong>AND</strong>&lt;br&gt;– Using contraception (e.g., barrier, oral contraceptive, rhythm method); OR&lt;br&gt;– Has an intrauterine device (IUD) or implant; OR&lt;br&gt;– Has history of hysterectomy, tubal ligation or endometrial ablation&lt;br&gt;<strong>Additionally, approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage</strong> <em>(NOTE: This does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.</em>&lt;br&gt;<strong>Patient must be tolerant to other opioids as indicated by ONE of the following</strong>&lt;br&gt;– At least 60 mg oral morphine per day for at least one week; OR&lt;br&gt;– At least 25 mcg/hr transdermal fentanyl for at least one week; OR&lt;br&gt;– At least 30 mg oxycodone per day for at least one week; OR&lt;br&gt;– At least 8 mg hydromorphone per day for at least one week; OR&lt;br&gt;– At least 25 mg oxymorphone per day for at least one week; OR&lt;br&gt;– Equianalgesic dose of another opioid for at least one week&lt;br&gt;The following should be investigated before a PA is granted:&lt;br&gt;– History of substance abuse&lt;br&gt;– Frequent requests for early refills&lt;br&gt;– Reported frequent instances of lost tablets&lt;br&gt;– Requests for odd quantities which requires fractional dosing&lt;br&gt;– Requests for short-term or prn usage&lt;br&gt;– Medication history indicates concurrent use of other extended-release opioids&lt;br&gt;Note: 1. Due to cross-reactivity with morphine, oxymorphone SR will not be approved for patients with immune-mediated morphine allergy.&lt;br&gt;2. Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary.</td>
<td><strong>2/day;</strong>&lt;br&gt;^Max Total: Non-Chronic 60 MME/day; Chronic: 200 MME/day</td>
<td><strong>Acute Opioid PA Form</strong>&lt;br&gt;<strong>Chronic Opioid PA Form</strong>&lt;br&gt;<strong>Exceptions Opioid PA Form</strong></td>
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**Opana ER® will be approved for patients meeting the following criteria:**

- The prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; AND
- Pain agreement required for all PA required agents. Please refer to the Opioid and Controlled Substance Agreement document located at: [https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf](https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf)
- Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider.
- Female of child-bearing age (14-44 years):
  - Is not pregnant; **AND**
  - Using contraception (e.g., barrier, oral contraceptive, rhythm method); OR
  - Has an intrauterine device (IUD) or implant; OR
  - Has history of hysterectomy, tubal ligation or endometrial ablation
- Additionally, approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage *(NOTE: This does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.*
- Patient must be tolerant to other opioids as indicated by ONE of the following
  - At least 60 mg oral morphine per day for at least one week; OR
  - At least 25 mcg/hr transdermal fentanyl for at least one week; OR
  - At least 30 mg oxycodone per day for at least one week; OR
  - At least 8 mg hydromorphone per day for at least one week; OR
  - At least 25 mg oxymorphone per day for at least one week; OR
  - Equianalgesic dose of another opioid for at least one week

Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### Analgesics

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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| oxycodone ER  | NP  | Approval will be authorized for recipients meeting the ALL of the following criteria:
- Management of severe pain with need for around-the-clock analgesia for an extended period; AND
- The prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; AND
- Pain agreement required for all PA required agents. Please refer to the Opioid and Controlled Substance Agreement document located at: https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf
- Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider.
- Female of child-bearing age (14-44 years):
  - Is not pregnant; AND
  - Using contraception (e.g., barrier, oral contraceptive, rhythm method); OR
  - Has an intrauterine device (IUD) or implant; OR
  - Has history of hysterectomy, tubal ligation or endometrial ablation
- Additionally, approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (Note: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.

The following should be investigated before a PA is granted:
- History of substance abuse
- Frequent requests for early refills
- Reported frequent instances of lost tablets
- Requests for odd quantities which requires fractional dosing
- Requests for short-term or prn usage
- Medication history indicates concurrent use of other extended-release opioids
- Doses of 60mg or 80mg: Recipient must be opioid tolerant (as demonstrated by at least a week or longer history of: morphine sulfate 60mg/day or more, or oral oxycodone 30mg/day or more, or oral hydromorphone 8mg/day or more, or an equianalgesic dose of another opioid)
- Approval for patients with a known addiction to the drug should be granted only if the prescriber has a documented plan to reduce the dosage and eventually wean the patient off the drug entirely.

**Note:** Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary.

**Effective January 16, 2018:** edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL were implemented that impact all first-time (acute) and non-chronic opioid users. For details, visit: [https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf](https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf)

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### ANALGESICS

**Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.**

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<td>*<strong>Effective January 16, 2018, edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL were implemented that impact all first-time (acute) and non-chronic opioid users. For details, visit: <a href="https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf">https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf</a></strong></td>
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</thead>
<tbody>
<tr>
<td>Oxycontin*</td>
<td>NP</td>
<td>See oxycodone ER prior authorization criteria</td>
<td>2/day;</td>
<td>Acute Opioid PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td></td>
</tr>
<tr>
<td>oxymorphone ER</td>
<td>NP</td>
<td>Will be approved for patients meeting the following criteria:</td>
<td>2/day;</td>
<td>Chronic Opioid PA Form</td>
</tr>
</tbody>
</table>
| | | - Trial and failure, contraindication, intolerance or drug-drug interaction with extended release morphine; **AND**
| | | - The prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; **AND**
| | | - Pain agreement required for all PA required agents. Please refer to the Opioid and Controlled Substance Agreement document located at: [https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf](https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf)
| | | - Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider.
| | | - Female of child-bearing age (14-44 years):
| | | - Is not pregnant; **AND**
| | | - Using contraception (e.g., barrier, oral contraceptive, rhythm method); **OR**
| | | - Has an intrauterine device (IUD) or implant; **OR**
| | | - Has history of hysterectomy, tubal ligation or endometrial ablation
| | | - Additionally, approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (**NOTE**: This does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.
| | | - Patient must be tolerant to other opioids as indicated by ONE of the following
| | | - At least 60 mg oral morphine per day for at least one week; **OR**
| | | - At least 25 mcg/hr transdermal fentanyl for at least one week; **OR**
| | | - At least 30 mg oxycodone per day for at least one week; **OR**
| | | - At least 8 mg hydromorphone per day for at least one week; **OR**
| | | - At least 25 mg oxymorphone per day for at least one week; **OR**
| | | - Equianalgesic dose of another opioid for at least one week |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### ANALGESICS

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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<tr>
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<td><strong>Narcotics, Long Acting (continued)</strong></td>
<td></td>
<td>Approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage. (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated. <em><strong>Effective January 16, 2018, edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL were implemented that impact all first-time (acute) and non-chronic opioid users. For details, visit: <a href="https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf">https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf</a></strong></em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>oxymorphone ER (continued)</td>
<td>NP</td>
<td>The following should be investigated before a PA is granted:</td>
<td>2/day;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• History of substance abuse</td>
<td></td>
<td>Acute Opioid PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Frequent requests for early refills</td>
<td>**Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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<tr>
<td></td>
<td></td>
<td>• Reported frequent instances of lost tablets</td>
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<td></td>
<td></td>
<td>• Requests for odd quantities which requires fractional dosing</td>
<td></td>
<td>Exceptions Opioid PA Form</td>
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<tr>
<td></td>
<td></td>
<td>• Requests for short-term or prn usage</td>
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<td></td>
<td></td>
<td>The following should be investigated before a PA is granted:</td>
<td>**Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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<tr>
<td></td>
<td></td>
<td>• Medication history indicates concurrent use of other extended-release opioids</td>
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</table>
|                             |     | **Note:** 1. Due to cross-reactivity with morphine, oxymorphone SR will not be approved for patients with immune-mediated morphine allergy.  
|                             |     | 2. Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary. |             |               |
| tramadol ER (generic for ConZip®) | NP  | See ConZip® prior authorization criteria                                                                   | 1/day;      |               |
|                             |     | **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day                                                  |             | Chronic Opioid PA Form |
| tramadol ER 24hr            | NP  | See ConZip® prior authorization criteria                                                                   | 1/day;      |               |
|                             |     | **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day                                                  |             | Chronic Opioid PA Form |
| Ultram ER®                  | NP  | See ConZip® prior authorization criteria                                                                   | 1/day;      |               |
|                             |     | **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day                                                  |             | Chronic Opioid PA Form |
| Xtampza ER®                 | NP  | See oxycodone ER prior authorization criteria                                                              | 2/day;      |               |
|                             |     | **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day                                                  |             | Chronic Opioid PA Form |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### ANALGESICS

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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<td></td>
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<td>Approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.</td>
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<td><em><strong>Effective January 16, 2018, edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL were implemented that impact all first-time (acute) and non-chronic opioid users. For details, visit: <a href="https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf">https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf</a></strong></em></td>
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| Zohydro ER® | NP | - The prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; AND
- Pain agreement required for all PA required agents. Please refer to the Opioid and Controlled Substance Agreement document located at: [https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf](https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf)
- Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider.
- Female of child-bearing age (14-44 years):
  - Is not pregnant; AND
  - Using contraception (e.g., barrier, oral contraceptive, rhythm method); OR
  - Has an intrauterine device (IUD) or implant; OR
  - Has history of hysterectomy, tubal ligation or endometrial ablation
- Approval of non-preferred agents in the Long-Acting Narcotics class requires: Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.
- The following should be investigated before a PA is granted:
  - History of substance abuse
  - Frequent requests for early refills
  - Reported frequent instances of lost tablets
  - Requests for odd quantities which requires fractional dosing
  - Requests for short-term or prn usage
  - Medication history indicates concurrent use of other extended-release opioids
- For daily doses of 80 mg or more patient must be tolerant to other opioids as indicated by ONE of the following
  - At least 60 mg oral morphine per day for at least one week; OR
  - At least 25 mcg/hr transdermal fentanyl for at least one week; OR
  - At least 30 mg oxycodeone per day for at least one week; OR
  - At least 8 mg hydromorphone per day for at least one week; OR
  - At least 25 mg oxymorphone per day for at least one week; OR
  - Equianalgesic dose of another opioid for at least one week |

**Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.**
### Analgesics

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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| **Narcotics, Long Acting**  |     | **(continued)** Approval of non-preferred agents in the Long-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage**  
  (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.  
  ***Effective January 16, 2018, edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL were implemented that impact all first-time (acute) and non-chronic opioid users. For details, visit: https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf*** |

**Morphine Milligram Equivalent (MME) Criteria:**
- Indication or diagnosis is Cancer pain or Hospice
  - **Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days (document date); AND**
  - Document prescriber’s specialty; **AND**
  - Patient has a written treatment plan with established objectives; **AND**
  - **Patient has a signed Pain Management Agreement; AND**
  - Female of child-bearing age (14-44 years):
    - Is not pregnant; **AND**
    - Using contraception (e.g., barrier, oral contraceptive, rhythm method); **OR**
    - Has an intrauterine device (IUD) or implant; **OR**
    - Has history of hysterectomy, tubal ligation or endometrial ablation

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**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
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| codeine/APAP | P | Will be approved if patient meets ALL of the following criteria:  
- Patient is less than 18 years of age:  
  - Trial and failure of acetaminophen; **AND**  
  - Contraindication to ALL NSAIDs; **AND**  
  - Patient does not have any of the following:  
    - Obesity  
    - Obstructive Sleep Apnea  
    - Severe Lung Disease; **AND**  
- Prescriber is aware of contraindication in patients younger than 12 years of age due to serious risks, including slowed or difficult breathing and death, and agrees to accept risks | 12/day: **^Max Total: Non-Chronic: 60 MME/day;**  
Chronic: 200 MME/day | **Acute Opioid PA Form**  
**Chronic Opioid PA Form**  
**Exceptions Opioid PA Form** |
| Endocet* | P |  
| hydrocodone/ APAP (excluding generic for Xodol®) | P |  
| hydrocodone/ ibuprofen | P |  

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
**ANALGESICS**

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<td><em><strong>Effective January 16, 2018, edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL were implemented that impact all first-time (acute) and non-chronic opioid users. For details, visit: <a href="https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf">https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf</a></strong></em></td>
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<td></td>
</tr>
<tr>
<td>hydromorphone (excluding suppositories and liquid)</td>
<td><strong>P</strong></td>
<td><strong>Note:</strong> Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary.</td>
<td>2mg: 7/day; 4 mg: 3/day; 8 mg: 1/day; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td></td>
</tr>
<tr>
<td>morphine IR (excluding suppositories)</td>
<td><strong>P</strong></td>
<td></td>
<td>6/day; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td></td>
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</table>
| morphine sulfate soln 20 mg/mL | **P** | Will be approved for if patient meets ALL of the following:  
- **Prescriber has checked the Tennessee Controlled Substance Database for this patient within the last 7 days (document date); OR request is for a hospice patient, HIV/AIDS patient, active cancer patient, OR long-term care facility resident (document name of facility); AND**  
- Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider; **AND**  
- Pain agreement required for ALL PA required agents. Please refer to the Opioid and Controlled Substance Agreement located at https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf and **AND**  
- Female of child-bearing age (14-44 years):  
  - Is not pregnant; **AND**  
  - Using contraception; **OR**  
  - Has an intrauterine device (IUD) or implant; **OR**  
  - Has history of hysterectomy, tubal ligation or endometrial ablation **OR**  
- Patient is opioid tolerant as indicated by 1 of the following:  
  - At least 60 mg oral morphine per day for 1 week; **OR**  
  - At least 25 mcg/hr transdermal fentanyl for 1 week; **OR**  
  - At least 30 mg oral oxycodone per day for 1 week; **OR**  
  - At least 8 mg oral hydromorphone per day for 1 week; **OR**  
  - At least 25 mg oral oxymorphone per day for at least 1 week; **OR**  
  - An equianalgesic dose of another opioid for at least 1 week. | Acute Opioid PA Form, Chronic Opioid PA Form, Exceptions Opioid PA Form | |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
**ANALGESICS**

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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>oxycodone tabs</td>
<td>P</td>
<td>5mg, 7.5mg, &amp; 10mg: 8/day; 15mg, 20mg, &amp; 30mg: 4/day; **^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>oxycodone/ APAP</td>
<td>P</td>
<td>soln: 40 mL/day tabs: 16/day: 2.5/325 mg; All others: 8/day; **^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Acute Opioid PA Form</td>
<td></td>
</tr>
<tr>
<td>tramadol</td>
<td>P</td>
<td>8/day; **^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Chronic Opioid PA Form</td>
<td></td>
</tr>
<tr>
<td>tramadol/ APAP</td>
<td>P</td>
<td>12/day; **^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Exceptions Opioid PA Form</td>
<td></td>
</tr>
<tr>
<td>Apadaz*</td>
<td>NP</td>
<td>6.12/325mg: 8/day; 8.16/325mg: 6/day; 4.08/325mg: 12/day Max: 4g APAP/day</td>
<td>See Apadaz*</td>
<td></td>
</tr>
<tr>
<td>benzhydrocodone/APAP</td>
<td>NP</td>
<td></td>
<td></td>
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### ANALGESICS

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<td>butalbital/APAP/caffeine/codeine NP</td>
<td>See butalbital/APAP/caffeine/codeine prior authorization criteria</td>
<td>Max Qty: 20 tabs/caps of butalbital-containing products per 30 days**</td>
<td>Acute Opioid PA Form</td>
<td></td>
</tr>
<tr>
<td>Capital with Codeine NP</td>
<td>See butalbital/APAP/caffeine/codeine prior authorization criteria</td>
<td>150mL/day; **^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Chronic Opioid PA Form</td>
<td></td>
</tr>
<tr>
<td>codeine NP</td>
<td>See butalbital/APAP/caffeine/codeine prior authorization criteria</td>
<td>12/day: 15mg &amp; 30mg; 6/day: 60mg; **^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Opioid PA Form</td>
<td></td>
</tr>
</tbody>
</table>

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**Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.**

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**Effective Date:** December 2, 2019

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**Clinical Criteria, Step Therapy, and Quantity Limits for TennCare Preferred Drug List (PDL)**
**ANALGESICS**

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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| Demerol®                    | NP   | • Approval of non-preferred agents in the Short-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents.  
  • The prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; AND  
  • Pain agreement required for all PA required agents. Please refer to the Opioid and Controlled Substance Agreement document located at: https://tenncare.magellanhealth.com/static/docs/Program_Information/Patient_Med_Management_Agreement.pdf  
  • Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider.  
  • Female of child-bearing age (14-44 years):  
    - Is not pregnant; AND  
    - Using contraception; OR  
    - Has an intrauterine device (IUD) or implant; OR  
    - Has history of hysterectomy, tubal ligation or endometrial ablation  
  Note: Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary. | 12/day: 50 mg; 6/day: 100mg;  
  soln: 60mL/day; **Max Total: Non-Chronic: 60 MME/day;  
  Chronic: 200 MME/day | Acute Opioid PA Form  
  Chronic Opioid PA Form  
  Exceptions Opioid PA Form |
| dihydrocodeine/APAP/caffeine | NP   | See butalbital/APAP/caffeine/codeine prior authorization criteria                                                                                                                                                                    | 8/day: 16mg/356mg/30mg  
  Max: 4g APAP/day | Exceptions Opioid PA Form |
| dihydrocodeine/ASA/caffeine | NP   | See butalbital/APAP/caffeine/codeine prior authorization criteria                                                                                                                                                                   | 8/day                            | Exceptions Opioid PA Form |
| Dilaudid®                   | NP   | See Demerol® prior authorization criteria                                                                                                                                                                                        | 2mg: 7/day;  
  4 mg: 3/day;  
  8 mg: 1/day; Liquid: 15mL/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day | Exceptions Opioid PA Form |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
**ANALGESICS**

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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*(NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.* |                                                                            |                |
| **Fioricet® with codeine**      | NP  | See butalbital/APAP/caffeine/codeine prior authorization criteria         | Max Qty: 20 tabs/caps of butalbital-containing products per 30 days **
Max: 4g APAP/day |                |
| **Fiorinal® with codeine**      | NP  | See butalbital/APAP/caffeine/codeine prior authorization criteria         |                                                                            |                |
| **Hycet®**                      | NP  | See Demerol® prior authorization criteria                                | soln: 120mL/day; **Max Total: Non-Chronic: 60 MME/day;
Chronic: 200 MME/day |                |
| **hydrocodone/AP AP 5/300**     | NP  | See Demerol® prior authorization criteria                                | 12/day; **Max Total: Non-Chronic: 60 MME/day;
Chronic: 200 MME/day | Acute Opioid PA Form |
| **hydrocodone/AP AP 10/300**    | NP  | See Demerol® prior authorization criteria                                | tab: 6/day;
soln: 89mL/day; **Max Total: Non-Chronic: 60 MME/day;
Chronic: 200 MME/day | Chronic Opioid PA Form |
| **hydromorphone liquid**        | NP  | See Demerol® prior authorization criteria                                | 15mL/day;
**Max Total: Non-Chronic: 60 MME/day;
Chronic: 200 MME/day | Exceptions Opioid PA Form |
| **hydromorphone suppositories** | NP  | See Demerol® prior authorization criteria                                | 5/day **Max Total: Non-Chronic: 60 MME/day;
Chronic: 200 MME/day |                |
| **Ibudone®**                    | NP  | See Demerol® prior authorization criteria                                | 10/200mg: 6/day; 5/200g: 12/day; **Max Total: Non-Chronic: 60 MME/day;
Chronic: 200 MME/day |                |

*Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.*
### ANALGESICS

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<tr>
<td>Levorphanol</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>6/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Acute Opioid PA Form</td>
</tr>
<tr>
<td>Lorcet®</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>12/day: 5/325mg; All others: 6/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Chronic Opioid PA Form</td>
</tr>
<tr>
<td>Lortab®</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>tab: 8/day: 5/325mg; All others: 8/day; soln: 89mL/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Exceptions Opioid PA Form</td>
</tr>
<tr>
<td>meperidine</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>tabs: 12/day: 50 mg; 6/day: 100mg; soln: 60mL/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Exceptions Opioid PA Form</td>
</tr>
<tr>
<td>morphine suppositories</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>5mg: 12/day; All others: 6/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Exceptions Opioid PA Form</td>
</tr>
<tr>
<td>Nalocet®</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>12/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Exceptions Opioid PA Form</td>
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<tr>
<td>Norco® NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>12/day: 5/325mg; All others: 6/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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<td>Acute Opioid PA Form</td>
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<tr>
<td>Nucynta® NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>6/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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<td></td>
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<td>Chronic Opioid PA Form</td>
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<tr>
<td>Opana® NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>4/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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<td></td>
<td></td>
<td>Exceptions Opioid PA Form</td>
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<tr>
<td>Oxaydo® NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>8/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>oxycodone caps NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>8/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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<td>oxycodone oral concentrate</td>
<td>NP</td>
<td><strong>Narcotics, Short Acting (continued)</strong>&lt;br&gt;Approval of non-preferred agents in the Short-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.&lt;br&gt;&lt;br&gt;<em><strong>Effective January 16, 2018, edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL were implemented that impact all first-time (acute) and non-chronic opioid users. For details, visit: <a href="https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf">https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_Acute_Opioid_Criteria.pdf</a></strong></em></td>
<td>*^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Acute Opioid PA Form&lt;br&gt;Chronic Opioid PA Form&lt;br&gt;Exceptions Opioid PA Form</td>
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<tr>
<td>oxycodone/ASA</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>8/day; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Acute Opioid PA Form&lt;br&gt;Chronic Opioid PA Form&lt;br&gt;Exceptions Opioid PA Form</td>
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<tr>
<td>oxycodone/IBU</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>8/day; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Acute Opioid PA Form&lt;br&gt;Chronic Opioid PA Form&lt;br&gt;Exceptions Opioid PA Form</td>
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<tr>
<td>oxymorphone</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>4/day; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Acute Opioid PA Form&lt;br&gt;Chronic Opioid PA Form&lt;br&gt;Exceptions Opioid PA Form</td>
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<tr>
<td>Percocet*</td>
<td>NP</td>
<td>See Demerol* prior authorization criteria</td>
<td>12/day: 2.5/325 mg; All others: 8/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td></td>
</tr>
<tr>
<td>Primlev*</td>
<td>NP</td>
<td>See Demerol* prior authorization criteria</td>
<td>8/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td></td>
</tr>
<tr>
<td>Reprexain*</td>
<td>NP</td>
<td>See Demerol* prior authorization criteria</td>
<td>12/day: 2.5/200 mg; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td></td>
</tr>
<tr>
<td>Roxicet*</td>
<td>NP</td>
<td>See Demerol* prior authorization criteria</td>
<td>soln: 40 mL tabs: 8/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Acute Opioid PA Form</td>
</tr>
<tr>
<td>Roxicodone*</td>
<td>NP</td>
<td>See Demerol* prior authorization criteria</td>
<td>4/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Chronic Opioid PA Form</td>
</tr>
<tr>
<td>RoxyBond*</td>
<td></td>
<td></td>
<td>8/day; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Exceptions Opioid PA Form</td>
</tr>
<tr>
<td>Synalgos*- DC</td>
<td>NP</td>
<td>See butalbital/APAP/caff/codeine prior authorization criteria</td>
<td>8/day</td>
<td></td>
</tr>
<tr>
<td>TYLENOL® with codeine</td>
<td>NP</td>
<td>See butalbital/APAP/caff/codeine prior authorization criteria</td>
<td>12/day: 15/300 mg &amp; 30/300 mg; **Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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#### Narcotics, Short Acting (continued)

Approval of non-preferred agents in the Short-Acting Narcotics class requires: contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage

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<tr>
<td>Ultracet*</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>12/day; ^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td></td>
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<tr>
<td>Ultram*</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>8/day; ^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td></td>
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<tr>
<td>Vicodin*</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>12/day: 5/300 mg; ^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td></td>
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<tr>
<td>Vicodin® HP</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>6/day: 10/300 mg; ^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Acute Opioid PA Form, Chronic Opioid PA Form, Exceptions Opioid PA Form</td>
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<tr>
<td>Vicoprofen*</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>8/day; ^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
<td>Exceptions Opioid PA Form</td>
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<tr>
<td>Xartemis® XR</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>6/day; ^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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<tr>
<td>Xodol*</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>12/day: 5/300 mg; All others: 8/day; ^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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<tr>
<td>Zamicet*</td>
<td>NP</td>
<td>See Demerol® prior authorization criteria</td>
<td>89 mL/day; ^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day</td>
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**Quantity Limit Override Criteria for Butalbital-Containing Products:**
Requests for butalbital-containing products for quantities greater than 20 per 30 days will be approved for patients meeting the following criteria:
- Trial and failure of at least 2 prophylactic headache treatments: a tricyclic antidepressant (unless contraindicated) PLUS at least one of the following: divalproex sodium, sodium valproate, topiramate, frovatriptan or beta-blocker

**Morphine Milligram Equivalent (MME) Criteria:**
- Indication or diagnosis is Cancer pain or Hospice
  - Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days (document date); AND
  - Document prescriber’s specialty; AND
  - Patient has a written treatment plan with established objectives; AND
  - Patient has a signed Pain Management Agreement; AND
  - Female of child-bearing age (14-44 years):
    - Is not pregnant; AND
    - Using contraception; OR
    - Has an intrauterine device (IUD) or implant; OR
    - Has history of hysterectomy, tubal ligation or endometrial ablation

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| Abstral®           | NP   | Will be approved for recipients meeting ALL of the following criteria:  
  - Medication is ordered for the treatment of breakthrough cancer pain  
  - Recipient must be receiving around-the-clock scheduled long-acting opioids  
  - Recipient must be tolerant to opioids, defined as one of the following:  
    - ≥ 60 mg oral morphine per day for at least one week without adequate pain relief  
    - ≥ 25 mcg/hr transdermal fentanyl for at least one week without adequate pain relief  
    - ≥ 30 mg oral oxycodone/day for at least one week without adequate pain relief  
    - ≥ 8 mg oral hydromorphone/day for at least one week without adequate pain relief  
    - ≥ 25 mg oral oxymorphone/day for at least one week without adequate pain relief  
    - Equianalgesic dose of another opioid for at least one week without adequate pain relief  
    - Trial and failure, contraindication, intolerance or drug-to-drug interaction with at least two immediate release opioid products  
  Note: Prescription should be written by or in consultation with an oncologist or pain management specialist, unless patient is enrolled in or eligible for hospice care. | 4/day       | General PA Form                                                                                                                                            |
| Actiq®             | NP   | See Abstral® prior authorization criteria                                                                                                                                                                                  | 4/day       |                    |
| fentanyl lozenge   | NP   | See Abstral® prior authorization criteria                                                                                                                                                                                  | 4/day       |                    |
| Fentora®           | NP   | See Abstral® prior authorization criteria                                                                                                                                                                                  | 4/day       |                    |
| Lazanda®           | NP   | See Abstral® prior authorization criteria                                                                                                                                                                                  | 4/day       |                    |
| Subsys®            | NP   | See Abstral® prior authorization criteria                                                                                                                                                                                  | 4/day       |                    |
| Ketorolac          | P    |                                                                                                                                                                                                                           | 20 per 60 days |                    |
| Voltaren® gel      | P    |                                                                                                                                                                                                                           | 10 g/day    |                    |
| diclofenac 1% gel  | NP   |                                                                                                                                                                                                                           | 10 g/day    | General PA Form    |
| diclofenac patch   | NP   | See diclofenac sodium 1.5% prior authorization criteria                                                                                                                                                                   | 2 patches/day|                    |
| diclofenac sodium 1.5% | NP | Will be approved for patients meeting ALL of the following criteria:  
  - Diagnosis of FDA-approved indication; AND  
  - Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents | 387ml/Rx    |                    |
| diclofex DC        | NP   |                                                                                                                                                                                                                           |             |                    |

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) (continued)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flector®</td>
<td>NP</td>
<td>See diclofenac sodium 1.5% prior authorization criteria</td>
<td>2 patches/day</td>
<td></td>
</tr>
<tr>
<td>Pennsaid®</td>
<td>NP</td>
<td>See diclofenac sodium 1.5% prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sprix®</td>
<td>NP</td>
<td>Approval will be granted for the following conditions:</td>
<td>5 bottles/60 days</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Toradol®</td>
<td>NP</td>
<td>Will be approved for patients meeting ALL of the following criteria:</td>
<td>20/60 days</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Vivlodex®</td>
<td>NP</td>
<td>Will ONLY be approved for patients who meet the following criteria:</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>VOPAC MDS Kit</td>
<td>NP</td>
<td>See diclofenac sodium 1.5% prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zorvolex®</td>
<td>NP</td>
<td>Will be approved if recipient meets ALL of the following:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### NSAID/Anti-Ulcer Agents

<table>
<thead>
<tr>
<th>Arthrotec®</th>
<th>NP</th>
<th>For patients less than 60 years old:</th>
<th>50mg/200mcg: 4/day; 75mg/200mccg: 2/day</th>
<th>General PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>– Will be approved for patients who are at high risk for GI side effects as indicated by ANY of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• History of peptic ulcer disease/GI bleed/NSAID gastropathy</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• GERD (gastroesophageal reflux disease) due to conventional NSAIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient on anticoagulants</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Patient on chronic corticosteroids</td>
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<tr>
<td></td>
<td></td>
<td>• History of platelet dysfunction or coagulopathy, including use of clopidogrel or aspirin</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Patient on methotrexate; <strong>AND</strong></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Trial, failure, or intolerance to TWO preferred proton pump inhibitors (PPIs) in combination with a prescription dose NSAID</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• PA not required for patient &gt; 60 years old.</td>
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</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
## ANALGESICS

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NSAID/Anti-Ulcer Agents (continued)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>diclofenac/ misoprostol</td>
<td>NP</td>
<td>See Arthrotec® prior authorization criteria</td>
<td>50mg/200mcg: 4/day;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>75mg/200mccg: 2/day</td>
<td></td>
</tr>
<tr>
<td>Duexis®</td>
<td>NP</td>
<td>Will be approved for patients who are at high risk for GI side effects as indicated by ANY of the following:</td>
<td>3/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• History of peptic ulcer disease/GI bleed/NSAID gastropathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• GERD (gastroesophageal reflux disease) due to conventional NSAIDS</td>
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<td>• Patient on chronic corticosteroids</td>
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<tr>
<td></td>
<td></td>
<td>• History of platelet dysfunction or coagulopathy, including use of clopidogrel or aspirin</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Patient on methotrexate; AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trial, failure, or intolerance to TWO preferred proton pump inhibitors (PPIs) in combination with a prescription dose NSAID; AND</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Provider must provider peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred ibuprofen plus famotidine.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vimovo®</td>
<td>NP</td>
<td>See Duexis® prior authorization criteria</td>
<td>2/day</td>
<td></td>
</tr>
</tbody>
</table>

### Salicylates and Non-Narcotic Combos

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>choline magnesium trisalicylate</td>
<td>P</td>
<td></td>
<td>500mg/5ml (20ml/day)</td>
<td>General PA Form</td>
</tr>
<tr>
<td>salsalate</td>
<td>P</td>
<td></td>
<td>500mg (6/day); 750mg (4/day)</td>
<td>General PA Form</td>
</tr>
<tr>
<td>diflunisal</td>
<td>NP</td>
<td></td>
<td>3/day</td>
<td></td>
</tr>
</tbody>
</table>

Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
**ANTI-INFECTIVES**

*Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.*

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cephalosporins Second Generation</strong></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
| Ceftin® suspension | NP | • No PA required for patients less than 12 years of age.  
• All others: Will be approved for patients unable to swallow tablets. | | General PA Form |

**Cephalosporins Third Generation**

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
</table>
| cefpodoxime suspension | NP | • Will be approved for use in patients less than 12 years of age for genitourinary infections.  
• All other indications will be approved for patients unable to swallow solid oral dosage forms. | | General PA Form |

**Glycopeptides**

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
</table>
| Firvanq® | NP | Approval will be granted for individuals meeting the following criteria:  
• Patient has a diagnosis of enterocolitis caused by methicillin-resistant Staphylococcus aureus; OR  
• Patient has a diagnosis of pseudomembranous colitis caused by C. difficile; AND  
• If patient is > 12 years of age, patient must be unable to swallow capsules. | 25mg/ml: 80ml/day (2000mg); 50mg/ml: 40mL/day (2000 mg) | General PA Form |

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
</table>
| vancomycin caps | NP | Approval will be granted for individuals meeting the following criteria:  
• Diagnosis of enterocolitis caused by methicillin-resistant Staphylococcus aureus, OR  
• Diagnosis of pseudomembranous colitis caused by C. difficile  
**Note:** Individuals started on vancomycin oral therapy in the hospital for the above diagnoses will be approved for this agent following hospital discharge in order to allow for completion of the course of therapy. | | General PA Form |

**Ketolides**

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
</table>
| Ketek® | NP | Approved for treatment of community-acquired pneumonia in patients with previous trial (within 28 days) and failure of at least TWO of the following: a penicillin, cephalosporin, sulfonamide, advanced macrolide, quinolone, or doxycycline.  
**Note:** Individuals started on Ketek® therapy in the hospital will be approved for this agent following hospital discharge in order to allow for completion of the course of therapy. | | General PA Form |

**Lincosamides**

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
</table>
| clindamycin pediatric solution | P | • No PA required for patients less than 12 years of age.  
• All others: will be approved for patients unable to swallow capsules. | | General PA Form |
| Cleocin® Pediatric granules | NP | Will be approved for patients unable to swallow capsules. | | Form |

*Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.*
## ANTI-INFECTIVES

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>azithromycin single dose powder for suspension (1 g)</td>
<td>P</td>
<td>Difcid® will be approved for recipients meeting the following criteria:</td>
<td>2g per Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Clostridium difficile (C. diff) associated diarrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trial and failure of oral vancomycin within the past 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difcid®</td>
<td>NP</td>
<td>Note: Individuals started on Difcid® therapy in the hospital will be approved for this agent following hospital discharge in order to allow for completion of the course of therapy.</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>azithromycin tablets</td>
<td>P</td>
<td></td>
<td>250mg: 12 per Rx</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>600mg: 8/month</td>
<td></td>
</tr>
<tr>
<td>Biaxin® XL</td>
<td>NP</td>
<td></td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>clarithromycin ER/XL</td>
<td>NP</td>
<td></td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>Zithromax 600®</td>
<td>NP</td>
<td></td>
<td>8/month</td>
<td></td>
</tr>
<tr>
<td>Zithromax®</td>
<td>NP</td>
<td></td>
<td>250 mg: 12 per Rx</td>
<td></td>
</tr>
<tr>
<td>Zithromax® single dose powder for suspension (1 g)</td>
<td>NP</td>
<td></td>
<td>2g per Rx</td>
<td></td>
</tr>
</tbody>
</table>

### Miscellaneous UTI Agents

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monurol®</td>
<td>NP</td>
<td>Will be authorized if the recipient has a previous failure, contraindication, intolerance or resistance to at least 2 of the following agents:</td>
<td>1 packet (3 g) per course of therapy</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sulfamethoxazole/trimethoprim</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Quinolones</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Nitrofurantoin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Nitrofurans

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>nitrofurantoin suspension</td>
<td>P</td>
<td>• No PA required for patients less than 12 years of age.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• All others: Will be approved for patients unable to swallow capsules.</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td>Furadantin®</td>
<td>NP</td>
<td>Will be approved for patients unable to swallow capsules.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ANTI-INFECTIVES

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Absorbable Rifamycins</strong></td>
<td></td>
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</tr>
<tr>
<td>Aemcolo*</td>
<td>P</td>
<td>Will be approved if the following is met:</td>
<td>4/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient is being treated for traveler’s diarrhea PLUS trial and failure, contraindication, intolerance, drug-drug interaction or resistance to a fluoroquinolone or azithromycin.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Xifaxan*</td>
<td>NP</td>
<td>Authorized if being used for <strong>ONE</strong> of the following:</td>
<td>3/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- <strong>Rifaximin 200mg strength tablets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Treatment of traveler’s diarrhea PLUS trial and failure, contraindication, intolerance, drug-drug interaction or resistance to a fluoroquinolone or azithromycin</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- <strong>Rifaximin 550mg strength tablets:</strong></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>- Treatment of hepatic encephalopathy for patients who do not adequately respond to lactulose; <strong>OR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Treatment of diarrhea-predominant IBS PLUS trial and failure, contraindication or intolerance to ALL preferred antidiarrheals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oxazolidinones</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>linezolid suspension</td>
<td>NP</td>
<td>For oral therapy, the patient must have been diagnosed as follows:</td>
<td>60mL/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Vancomycin Resistant Enterococcus faecium infections, <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Vancomycin Resistant Enterococcus faecalis infections, <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Healthcare-associated Methicillin-Resistant Staph Aureus (MRSA) infections or community-acquired MRSA with poly-resistance. <strong>Please note the following:</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- The patient must have culture documentation of diagnoses</td>
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<tr>
<td></td>
<td></td>
<td>- Individuals started on therapy in the hospital will be approved for this agent following hospital discharge in order to allow for completion of the course of therapy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>linezolid tablets</td>
<td>NP</td>
<td>Will be approved for patients meeting <strong>ALL</strong> of the following criteria:</td>
<td>2/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Diagnosis of acute bacterial skin and skin structure infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Culture documenting one of the following susceptible gram-positive cocci as causative organism:</td>
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<tr>
<td></td>
<td></td>
<td>- Enterococcus faecalis</td>
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<tr>
<td></td>
<td></td>
<td>- Staphylococcus aureus (MRSA)</td>
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<tr>
<td></td>
<td></td>
<td>- Staphylococcus aureus (MSSA)</td>
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<tr>
<td></td>
<td></td>
<td>- Streptococcus agalactiae (group B streptococci)</td>
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<tr>
<td></td>
<td></td>
<td>- Streptococcus anginosus</td>
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<td>- Streptococcus constellatus</td>
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<td>- Streptococcus intermedius</td>
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<td>- Streptococcus pyogenes (group A beta-hemolytic streptococci)</td>
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<tr>
<td></td>
<td></td>
<td>- Patient must be resistant to or have a contraindication or intolerance to all other treatment options. <strong>Note:</strong> Individuals started on therapy in the hospital will be approved for the agent following discharge in order to allow for completion of the course of therapy.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**ANTI-INFECTIVES**

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<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>Oxazolidinones (continued)</strong></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>
| Zyvox* | NP | For oral therapy, the patient must have been diagnosed as follows:  
- Vancomycin Resistant Enterococcus faecium infections, **OR**  
- Vancomycin Resistant Enterococcus faecalis infections, **OR**  
- Healthcare-associated Methicillin-Resistant Staph Aureus (MRSA) infections or community-acquired MRSA with poly-resistance.  
Please note the following:  
- The patient must have culture documentation of diagnoses  
- Individuals started on therapy in the hospital will be approved for this agent following hospital discharge in order to allow for completion of the course of therapy. | oral: 2 tabs/day or 60mL/day | **General PA Form** |
| **Quinolones** | | | | |
| Baxdela* | NP | Will be approved if the following is met:  
- Patient age ≥ 18 years of age; **AND**  
- Patient has a diagnosis of an acute bacterial skin and skin structure infection (ABSSSI) that is proven or strongly suspected to be caused by bacteria susceptible to delafloxacin; **AND**  
- Patient has no hypersensitivity to delafloxacin, any of its components, or any of the fluoroquinolone class of antibacterial drugs; **AND**  
- Patient does not have end stage renal disease (ESRD) (eGFR < 15 mL/min/1.73 m²); **AND**  
- Patient has no history of myasthenia gravis; **AND**  
- Delafloxacin is not ordered to treat the same infection for which it or another fluoroquinolone has already been used and treatment was insufficient (e.g., incomplete infection resolution/treatment failure); **AND**  
- Patient is continuing therapy from an inpatient hospital stay (to facilitate transition to outpatient for completion of therapy); **OR**  
- Patient has a clinically valid reason as to why preferred agents FDA-approved for ABSSSI cannot be used (should not be approved if patient has failed another fluoroquinolone) [lab documentation is required for resistance to preferred PDL agents] | 2/day (Max 14-day supply) | **General PA Form** |
| Cipro® suspension | NP | See prior authorization criteria for ciprofloxacin suspension. | | |
| ciprofloxacin suspension | NP | Will be approved for patients unable to swallow tablets. | | |
| ciprofloxacin ER | NP | | 1/day | |
| Levofloxacin solution | NP | Will be approved for patients unable to swallow tablets | | |
| moxifloxacin | NP | Individuals started on moxifloxacin therapy in the hospital will be approved for the agent following hospital discharge in order to allow for completion of the course of therapy. | | |

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<table>
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<tr>
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<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sulfonamides</strong></td>
<td></td>
<td>Will be approved for the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sulfadiazine</td>
<td>P</td>
<td>• Treatment of <em>Toxoplasma gondii</em> encephalitis in combination with pyrimethamine; OR</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Rheumatic fever prophylaxis in patients who have a contraindication or intolerance to penicillin</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tetracyclines</strong></td>
<td></td>
<td></td>
<td>3/day: 50mg;</td>
<td></td>
</tr>
<tr>
<td>Doxycycline hyclate</td>
<td>P</td>
<td></td>
<td>2/day: All others</td>
<td></td>
</tr>
<tr>
<td>50 &amp; 100mg</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Doxycycline monohydrate</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50 &amp; 100mg caps</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Adoxa*</td>
<td>NP</td>
<td>Will be approved without requiring trial of a preferred agent if being used for the treatment of SIADH.</td>
<td>3/day: 50mg;</td>
<td></td>
</tr>
<tr>
<td>Demecycline</td>
<td>NP</td>
<td></td>
<td>2/day: All others</td>
<td></td>
</tr>
<tr>
<td>Doxyx*</td>
<td>NP</td>
<td></td>
<td>3/day: 50mg;</td>
<td></td>
</tr>
<tr>
<td>2/day</td>
<td></td>
<td></td>
<td>2/day: All others</td>
<td></td>
</tr>
<tr>
<td>Doxycycline hyclate</td>
<td>NP</td>
<td>Will be approved when BOTH of the following conditions are met:</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td>20mg</td>
<td></td>
<td>• When used as an adjunct to scaling and root planting to promote attachment level gain and to reduce pocket depth for adult periodontitis.</td>
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<tr>
<td></td>
<td></td>
<td>• In patients with any of the following:</td>
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<tr>
<td></td>
<td></td>
<td>– Multiple sites unresponsive to mechanical debridement</td>
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<tr>
<td></td>
<td></td>
<td>– Acute infections</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>– Medically compromised patients</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>– Tissue-invasive organisms and ongoing disease progression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doxycycline monohydrate</td>
<td>NP</td>
<td>Will be approved for the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75 &amp; 150 mg caps</td>
<td></td>
<td>• For patients age 12 &amp; under: will be approved for patient with diagnosis of tick-borne diseases</td>
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<tr>
<td></td>
<td></td>
<td>• All other patients: will only be approved for patients unable to swallow capsules</td>
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</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### ANTI-INFECTIVES

*Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.*

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
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<tbody>
<tr>
<td><strong>Tetracyclines (continued)</strong></td>
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</tbody>
</table>
| minocycline ER NP | Will be approved if ALL of the following are true:  
• Diagnosis is for the treatment of non-nodular moderate to severe acne vulgaris with inflammatory lesions.  
• Recipient has failed, has an intolerance, contraindication or adverse reaction to at least two of the following topical agents:    
  – Metronidazole (Metrogel™)  
  – Azelaic acid (Azelex®, Finacea™)  
  – Erythromycin (A/T/S™ solution, gel)  
  – Clindamycin (Cleocin T™)  
  – Topical keratolytic agents (such as benzoyl peroxide, salicylic acid preparations)    
• Recipient requires long-term therapy with an oral tetracycline  
• Recipient must be less than 21 years old  
• Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred minocycline capsules. | 1/day       |         |
| Minolira® ER NP | See minocycline ER prior authorization criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1/day       | General PA Form |
| Morgidox® NP | Will be approved if ALL of the following are true:  
• Diagnosis is for the treatment of non-nodular moderate to severe acne vulgaris with inflammatory lesions.  
• Recipient has failed, has an intolerance, contraindication or adverse reaction to at least two of the following topical agents:    
  – Metronidazole (Metrogel™)  
  – Azelaic acid (Azelex®, Finacea™)  
  – Erythromycin (A/T/S™ solution, gel)  
  – Clindamycin (Cleocin T™)  
  – Topical keratolytic agents (such as benzoyl peroxide, salicylic acid preparations)    
• Recipient must be less than 21 years old  
• Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred doxycycline capsules. | 1 kit/Rx    |         |

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### ANTI-INFECTIVES

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<td><strong>Tetracyclines (continued)</strong></td>
<td></td>
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</tbody>
</table>
| Nuzyra* | NP | • Patient must be ≥ 18 years of age; **AND**  
  • If patient is female and of childbearing potential, it has been confirmed patient is NOT pregnant; **AND**  
  • Patient has one of the following diagnoses:  
    – Community-acquired bacterial pneumonia (CABP) caused or suspected by one of the following susceptible organisms: Staphylococcus pneumoniae, Staphylococcus aureus [methicillin-susceptible isolates; MSSA], Haemophilus influenzae, Haemophilus parainfluenzae, Klebsiella pneumoniae, Legionella pneumophila, Mycoplasma pneumoniae, and Chlamyphilia pneumoniae; **OR**  
    – Acute bacterial skin and skin structure infections (ABSSSI) caused or suspected by one of the following susceptible organisms: S. aureus [methicillin-susceptible and -resistant isolates], Staphylococcus lugdunensis, Streptococcus pyogenes, Streptococcus anginosus group [includes S. anginosus, S. intermedius, and S. constellatus], Enterococcus faecalis, Enterobacter cloacae, and K. pneumoniae; **AND**  
  • Continuing treatment from an acute care facility/hospital discharge; **OR**  
  • Patient meets one of the following conditions:  
    – If C & S report is available, patient has tried/failed, has a Contraindication or adverse effect to at least two preferred antibiotic agents susceptible to the isolated pathogen; **OR**  
    – If provider is unable to provide a C&S report, patient has tried/failed, has a contraindication or adverse reaction to at least 2 preferred antibiotics indicated for the member’s diagnosis; **AND**  
  • Patient’s total treatment duration does not exceed 14 days; **AND**  
  • Patient dosing follows FDA-approved dosing instructions | 3/day | General PA Form |
| | | **Renewal Criteria** | | | |
| | | • Patient continues to meet above criteria; **AND**  
  • Patient’s symptoms are clinically improving, as documented by provider; **AND**  
  • Prescriber documents that patient is adherent to administration of oral therapy; **AND**  
  • Treatment duration does not exceed a total 14 days (which includes previous treatment received in the past 7 days)  
  • Patient has not experienced treatment-limiting adverse effects (e.g., Clostridium difficile associated diarrhea, severe photosensitivity, etc.). | | |
| Oracea* | NP | May be approved when:  
  • Patient is **under** 21 years of age; **AND**  
  • Patient requires treatment for inflammatory lesions (papules and pustules) of rosacea; **AND**  
  • Patient requires long-term therapy (greater than 3 months) with an oral antibiotic; **AND**  
  • Patient has tried and failed, has a contraindication, experienced intolerance/adverse reaction to at least one of the following topical agents:  
    – Metronidazole (e.g., MetroGel®, MetroCream®)  
    – Azelaic Acid (e.g., Azelex®, Finacea®)  
    – Erythromycin gel, solution | 2/day | |
<p>| Periostat* | NP | See doxycycline hyclate 20mg prior authorization criteria | 2/day | |</p>
<table>
<thead>
<tr>
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<td></td>
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<tr>
<td><strong>Tetracyclines (continued)</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Solodyn® NP</td>
<td></td>
<td>See minocycline ER prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Vibramycin®</td>
<td></td>
<td></td>
<td>3/day: 50mg;</td>
<td>Scatter Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2/day: All others</td>
<td></td>
</tr>
<tr>
<td>Ximino® ER NP</td>
<td></td>
<td>See minocycline ER prior authorization criteria</td>
<td>1/day</td>
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<tr>
<td><strong>Antifungals: Oral</strong></td>
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<td></td>
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</tr>
<tr>
<td>Fluconazole suspension P</td>
<td></td>
<td>• No PA required for patients less than 12 years of age.</td>
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<tr>
<td></td>
<td></td>
<td>• All others: Will be approved for patients unable to swallow tablets.</td>
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<tr>
<td>Fluconazole tablets P</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Terbinafine P</td>
<td></td>
<td>• Terbinafine will not be approved for cosmetic use.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Terbinafine will be authorized for the treatment of nail fungal infections (onychomycosis) if the following are present:</td>
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<tr>
<td></td>
<td></td>
<td>Positive diagnostic microbiological or histological test (i.e., KOH preparation, periodic acid Schiff (PAS) stain, or lab culture).</td>
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<tr>
<td></td>
<td></td>
<td>Underlying disease (i.e., diabetes, peripheral vascular disease, poor circulation, immunocompromised recipients)</td>
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<tr>
<td></td>
<td></td>
<td>Length of authorization: up to 3 months</td>
<td></td>
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<tr>
<td>Ancobon® NP</td>
<td></td>
<td>See flucytosine prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cresemba® oral NP</td>
<td></td>
<td>Will be approved for patients with the following diagnoses:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Treatment of invasive aspergillosis OR mucormycosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> If started as an inpatient hospital regimen and this is a continuation of therapy, then the drug is approvable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diflucan® suspension NP</td>
<td></td>
<td>Will be approved for patients unable to swallow tablets.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diflucan® tablets NP</td>
<td></td>
<td></td>
<td>150mg (4 per 26 days)</td>
<td></td>
</tr>
<tr>
<td>Flucytosine NP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Itraconazole NP</td>
<td></td>
<td>• Itraconazole is unrestricted for Blastomycosis, Histoplasmosis, Aspergillosis, Cryptococcosis, Coccidiomycosis, febrile neutropenia, oropharyngeal/esophageal candidiasis, Candida krusei infections, and any other systemic fungal infection.</td>
<td>4/day; soln: 40mL/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Also, unrestricted for prevention of histoplasmosis or any other invasive fungal infection (including cryptococcosis, coccidiomycosis) in HIV or immunocompromised patients.</td>
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<tr>
<td></td>
<td></td>
<td>For onychomycosis will be authorized if ALL of the following are true:</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Positive diagnostic microbiological or histological test (including KOH preparation, periodic acid Schiff (PAS) stain, or lab culture).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Underlying disease (i.e., diabetes, peripheral vascular disease, poor circulation, immunocompromised recipients, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recipient has tried and failed or has an intolerance or contra-indication to terbinafine.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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## ANTI-INFECTIVES

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Antifungals: Oral (continued)</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>ketocanazole</td>
<td>NP</td>
<td>Will be approved for patients who meet the following criteria:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Treatment of blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis or paracoccidioidomycosis, <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Patient has tried and failed or is intolerant, refractory or resistant to other antifungals</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>3. <strong>Note:</strong> If started as an inpatient hospital regimen and this is a continuation of therapy, then the drug is approvable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lamisil®</td>
<td>NP</td>
<td>Will be approved for patients who meet the following criteria:</td>
<td>84 per year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. See terbinafine prior authorization criteria. Lamisil® granules will be authorized for the treatment of tinea capitis for children ages 4 years and older.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noxafil®</td>
<td>NP</td>
<td>Will be approved if used for <strong>ANY</strong> of the following:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>1. As indicated for the prophylaxis of invasive Aspergillus and/or Candida in patients who are at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with Graft versus Host Disease (GVHD), recipients with hematologic malignancies (leukemia, lymphoma, myelodysplastic syndromes) with prolonged neutropenia from chemotherapy, or recipients with AIDS.</td>
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<td></td>
<td></td>
<td>2. Treatment of Fusariosis disease</td>
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<td></td>
<td></td>
<td>3. Treatment of Zygomycetes disease</td>
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<td></td>
<td></td>
<td>4. Treatment of other fungal infections or molds that are refractory or resistant to, or in patient who have a contraindication or intolerance to, itraconazole or voriconazole</td>
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</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> If started as an inpatient hospital regimen and this is a continuation of therapy, then the drug is approvable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Onmel®</td>
<td>NP</td>
<td>Unrestricted for treatment or prevention of histoplasmosis or any other invasive fungal infection (including cryptococcosis, coccidiomycosis) in HIV or immunocompromised patients.</td>
<td>2/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For onychomycosis will be authorized if ALL of the following are true:</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Positive diagnostic microbiological or histological test (including KOH preparation, periodic acid Schiff (PAS) stain, or lab culture).</td>
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<tr>
<td></td>
<td></td>
<td>2. Underlying disease (i.e., diabetes, peripheral vascular disease, poor circulation, immunocompromised recipients, etc.)</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>3. Recipient has tried and failed or has an intolerance or contra-indication to terbinafine.</td>
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<td></td>
<td></td>
<td>4. Clinically valid reason patient cannot use itraconazole capsules</td>
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</tr>
<tr>
<td>Oravig®</td>
<td>NP</td>
<td>Will be approved if the following are met:</td>
<td>1/day</td>
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<tr>
<td></td>
<td></td>
<td>1. Patient has a contraindication, allergic reaction, or drug-drug interaction to clotrimazole troche, nystatin, and fluconazole</td>
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<tr>
<td>posaconazole</td>
<td>NP</td>
<td>See Noxafil® prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sporanox®</td>
<td>NP</td>
<td>See itraconazole prior authorization criteria</td>
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</tr>
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### Anti-Infectives

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</table>
| Tolsura® | NP | Will be approved for patient meeting the following criteria:  
- Patient is diagnosed with **ONE** of the following fungal infections:  
  - Blastomycosis (pulmonary and extrapulmonary)  
  - Histoplasmosis (including chronic cavitary pulmonary disease, disseminated, or nonmeningeal)  
  - Aspergillosis (pulmonary and extrapulmonary), in patients who are intolerant of or who are refractory to amphotericin B therapy; **AND**  
- Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus other itraconazole products.  
**Note:** Will not be approved for treatment of onychomycosis. | 4/day | General PA Form |
| Vfend® | NP | Vfend® will be approved for the following diagnoses:  
- Treatment of invasive aspergillosis  
- Serious fungal infections caused by S. apiospermum and Fusarium species including F. solani  
- Part of standard anti-fungal regimen in febrile neutropenic patients  
- Other fungal infections that are refractory or resistant to other oral triazole agents (i.e., fluconazole, ketoconazole, itraconazole)  
**Note:** If started as an inpatient hospital regimen and this is a continuation of therapy, then the drug is approvable | | |
| Voriconazole | NP | See Vfend® prior authorization criteria. | | |

### Antifungals: Vaginal

<table>
<thead>
<tr>
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<th>PDL</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miconazole-3 kit</td>
<td>P</td>
<td>1 kit/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Terconazole</td>
<td>P</td>
<td>0.4% cream: 45g/Rx; 0.8% cream: 20 g/Rx; Suppositories: 3/Rx</td>
<td></td>
</tr>
<tr>
<td>AVC® cream</td>
<td>NP</td>
<td>120g/Rx</td>
<td></td>
</tr>
<tr>
<td>Gynazole-1®</td>
<td>NP</td>
<td>5g/Rx</td>
<td></td>
</tr>
<tr>
<td>Miconazole-3 vaginal suppositories</td>
<td>NP</td>
<td>3 suppositories/Rx</td>
<td></td>
</tr>
</tbody>
</table>

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### ANTI-INFECTIVES

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<tr>
<td><strong>Anti-Infectives: Anthelmintics</strong></td>
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</tr>
<tr>
<td>albendazole</td>
<td>P</td>
<td>See Albenza* prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Albenza</strong></td>
<td>NP</td>
<td>Will only be approved for:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Treatment of neurocysticercosis caused by Taenia solium; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>- Must be prescribed by or in consultation with an Infectious Disease specialist; <strong>OR</strong></td>
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<td></td>
<td></td>
<td>- Treatment of cystic hydatid disease caused by Echinococcus granulosus; <strong>OR</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Treatment of hookworm</td>
<td></td>
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</tr>
<tr>
<td><strong>Emverm</strong></td>
<td>NP</td>
<td>Will be approved if the following is met:</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Treatment of Enterobius vermicularis (pinworm) in single or mixed infections; <strong>AND</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Recipient has tried and failed, has an intolerance, OR contraindication to pyrantel pamoate; <strong>OR</strong></td>
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<td></td>
<td></td>
<td>- Treatment of Ancylostoma duodenale (common hookworm) or Necator americanus (American hookworm); <strong>AND</strong></td>
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<td></td>
<td></td>
<td>- Recipient has tried and failed, has an intolerance, OR contraindication to Albenza; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Treatment of Trichuris trichiura (whipworm) or Ascaris lumbricoides (common roundworm); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Recipient has tried and failed, has an intolerance, OR contraindication to ivermectin.</td>
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<td></td>
<td></td>
<td><strong>Length of authorization:</strong> Will be based on FDA indication</td>
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</tr>
<tr>
<td><strong>Miscellaneous Antiprotozoal Agents</strong></td>
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</tr>
<tr>
<td>benznidazole</td>
<td>NP</td>
<td>Will be approved for patients meeting following criteria:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Diagnosis of American trypanosomiasis (Chagas disease); <strong>AND</strong></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>- Patient is not pregnant</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mepron</strong></td>
<td>NP</td>
<td>Mepron* will be authorized if patient meets ALL of the following criteria:</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Diagnosis of prophylaxis against or treatment of Pneumocystis pneumonia (PCP) or Toxoplasmosis gondii encephalitis; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Trial and failure, contraindication, intolerance, or drug-drug interaction to sulfamethoxazole/trimethoprim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>atovaquone</td>
<td>NP</td>
<td>See Mepron* prior authorization criteria</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
## ANTI-INFECTIVES

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anti-Infectives: Oral Nitroimidazoles</strong></td>
<td></td>
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</tr>
<tr>
<td>Solosec®</td>
<td>NP</td>
<td>Will be approved for the following criteria:</td>
<td>1 packet (2gm) per RX</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient has a clinical diagnosis of bacterial vaginosis supported by at least one of the following:</td>
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<tr>
<td></td>
<td></td>
<td>- Off-white/gray vaginal discharge</td>
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<tr>
<td></td>
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<td>- Vaginal pH ≥ 4.7</td>
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<td></td>
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<td>- Clue cells ≥ 20% on microscopy</td>
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<tr>
<td></td>
<td></td>
<td>Positive 10% KOH whiff test; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Nugent score ≥ 4 on gram stain; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Patient does not have a hypersensitivity to nitroimidazole derivatives (e.g., metronidazole, tinidazole); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient does not have in vitro resistance to nitroimidazole derivatives (e.g., metronidazole, tinidazole, secnidazole); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient has tried and failed CDC recommended course of therapy clindamycin for the treatment of bacterial vaginosis; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient has hepatic impairment, <strong>OR</strong> there is a concern with the patient and alcohol consumption</td>
<td></td>
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</tr>
<tr>
<td>rifabutin</td>
<td>P</td>
<td>See Mycobutin® prior authorization criteria</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td>Mycobutin®</td>
<td>NP</td>
<td>Mycobutin® will be approved for recipients meeting the following criteria:</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Prophylaxis against MAC in patients with contraindication or intolerance to clarithromycin AND azithromycin; <strong>OR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Treatment of disseminated MAC in combination with a macrolide and ethambutol.</td>
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</tr>
<tr>
<td>Rifamate®</td>
<td>NP</td>
<td>Recipient must be unable to take the components individually.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rifater®</td>
<td>NP</td>
<td>Recipient must be unable to take the components individually.</td>
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</tr>
<tr>
<td><strong>Antivirals: Cytomegalovirus Agents</strong></td>
<td></td>
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</tr>
<tr>
<td>Prevymis®</td>
<td>NP</td>
<td>Will be approved if the following is met (PA duration = 100 days):</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Must be prescribed in consultation with or by oncology, hematology, ID or transplant specialist; <strong>AND</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Patient is an allogeneic hematopoietic stem cell transplant (HSCT) recipient; <strong>AND</strong></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>- Patient is seropositive for CMV within 1 year before or &lt; 100 days after HSCT; <strong>AND</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Patient is NOT receiving concurrent therapy with any of the following:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Pimozide</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- ergot alkaloids</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- cyclosporine in conjunction with either pitavastatin or simvastatin</td>
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<td></td>
<td></td>
<td><strong>NOTE:</strong> When coadministered with cyclosporine the recommended dose of ilettermovir (Prevymis) is 240mg daily</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### ANTI-INFECTIVES

*Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.*

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antivirals: Hepatitis B</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>entecavir</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Epivir HBV® solution</td>
<td>P</td>
<td></td>
<td>20 mL/day</td>
<td></td>
</tr>
<tr>
<td>lamivudine-HBV</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>adefovir</td>
<td>NP</td>
<td>See Hepsera® prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Baraclude® solution</td>
<td>NP</td>
<td>• No prior authorization required for patient 11 years of age and under</td>
<td>20 mL/day</td>
<td>General PA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patients aged 12 years and older will be approved for patients unable to swallow tablets</td>
<td></td>
<td>Form</td>
</tr>
<tr>
<td>Baraclude® tablets</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Epivir HBV® tablets</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Hepsera®</td>
<td>NP</td>
<td>Hepsera® will be approved for recipients meeting the following criteria:</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Requires inadequate treatment response (detectable HBV DNA level after 24 weeks of therapy),</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>resistance, intolerance or contraindication to entecavir OR tenofovir disoproxil/fumarate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vemlidy®</td>
<td>NP</td>
<td>Will be approved for recipients meeting ALL of the following criteria:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has inadequate treatment response (detectable HBV DNA level after 24 weeks of therapy),</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>virologic breakthrough, resistance, intolerance or contraindication to entecavir OR tenofovir</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>disoproxil fumarate; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Patient is not using tenofovir alafenamide fumarate (Vemlidy) as monotherapy if (HIV)-1</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>positive. (Must have additional antiviral therapy if HIV-1 positive for coverage of both disease</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>states)</td>
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<td></td>
<td></td>
<td><strong>Note:</strong> Will not be approved for patients with decompensated liver disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Antivirals: Hepatitis C Pegylated Interferons</strong></td>
<td></td>
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</tr>
<tr>
<td>Pegasys® syringes</td>
<td>P</td>
<td>PA will be required after 24 weeks of therapy.</td>
<td>4/24 days</td>
<td></td>
</tr>
<tr>
<td>Pegasys Conv. Pack®</td>
<td>P</td>
<td>PA will be required after 24 weeks of therapy.</td>
<td>1/24 days</td>
<td>General PA</td>
</tr>
<tr>
<td>Pegasys® ProClick</td>
<td>P</td>
<td>PA will be required after 24 weeks of therapy.</td>
<td>2/24 days</td>
<td>Form</td>
</tr>
<tr>
<td>Pegasys® vials</td>
<td>P</td>
<td>PA will be required after 24 weeks of therapy.</td>
<td>4/24 days</td>
<td></td>
</tr>
<tr>
<td>Peg–Intron®</td>
<td>NP</td>
<td>Non-Preferred Prior Authorization Criteria applies.</td>
<td>4/24 days</td>
<td></td>
</tr>
<tr>
<td>Peg–Intron Redipen®</td>
<td>NP</td>
<td>• Additionally, a new duration PA is also required if the request exceeds 24 weeks of therapy.</td>
<td>4/24 days</td>
<td></td>
</tr>
</tbody>
</table>

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ANTIVIRALS

Approved NP agents require trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epclusa®</td>
<td>P</td>
<td>Will be approved for patients meeting following criteria:</td>
<td>1/day</td>
<td>Epclusa PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Chronic Hepatitis C, genotype 1, 2, 3, 4, 5, and 6</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>− Patients with OR without compensated cirrhosis (Child-Pugh A) (Total duration – 12 weeks)</td>
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<tr>
<td></td>
<td></td>
<td>− Patients with decompensated cirrhosis (Child-Pugh B or C) AND given in combination with ribavirin (Total duration – 12 weeks)</td>
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<tr>
<td></td>
<td></td>
<td>− If patient has a history of HIV, HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology)</td>
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<td></td>
<td></td>
<td>− If the patient has a prior history of substance or alcohol abuse, then patient has been free of substance and alcohol abuse for previous 6 months.</td>
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<tr>
<td></td>
<td></td>
<td>− Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, approval requires:</td>
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<td></td>
<td></td>
<td>− Documentation of:</td>
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<tr>
<td></td>
<td></td>
<td>• Quantitative HCV RNA level measured 12 weeks after completion of previous treatment</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Previous treatment history</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Genotype testing</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>− Retreatment of HCV with Hepatitis C Direct Acting Antiviral requires escalation</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Patient must not have severe renal failure (CrCl ≤ 30 mL/min) or ESRD</td>
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<tr>
<td></td>
<td></td>
<td>• If administered with ribavirin, patient must not be pregnant.</td>
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<tr>
<td></td>
<td></td>
<td>• Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C</td>
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<tr>
<td></td>
<td></td>
<td>− If screening test for Hepatitis B is positive, then a confirmatory test for Hepatitis B infection has been obtained.</td>
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<td></td>
<td></td>
<td>− NOTE: If criteria is met for immune-tolerant phase or HBeAg-negative immune reactivation phase of HBV infection, then patient should be started on antiviral therapy at the same time (or before) HCV DAA therapy AND if low or undetectable levels of HBV DNA, then patient should either:</td>
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<td></td>
<td></td>
<td>• Receive prophylactic HBV treatment during duration of DAA treatment; OR</td>
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<td></td>
<td></td>
<td>• Have HBV DNA monitoring every 4 weeks to test for HBV reactivation (*Treatment for HBV should be initiated if HBV DNA level increases &gt; 10-fold or is &gt; 1000 IU/mL in a patient with undetectable or unquantifiable HBV DNA prior to DAA treatment)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### ANTI-INFECTIVES

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<tr>
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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antivirals: Hepatitis C Antivirals (continued)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Note: Hepatitis B Virus (HBV) can be &quot;reactivated&quot; in patients with current or prior HBV infection in some hepatitis C patients on direct acting antivirals (DAAs). Patients should be screened for HBV prior to starting any treatment with a hepatitis C DAAs.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Harvoni®</th>
<th>P</th>
<th>Will be approved for patients meeting the following criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Diagnosis of Chronic Hepatitis C, genotype 1</td>
<td></td>
<td>- Patients without cirrhosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Treatment naïve patients with documentation of pre-treatment HCV RNA less than 6 million IU/mL (Total authorization – 8 weeks)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Treatment naïve patients with documentation of pre-treatment HCV RNA greater than 6 million IU/mL (Total duration – 12 weeks)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Treatment experienced patients (defined as patients who have failed treatment with either peginterferon alfa + ribavirin or [telaprevir [Incivek®] or boceprevir [Victrelis®]] + peginterferon alfa + ribavirin <strong>AND</strong> documentation of positive HCV RNA) (Total duration – 12 weeks)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Post-liver transplant patient given in combination with ribavirin (Total duration – 12 weeks)</td>
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<tr>
<td></td>
<td></td>
<td>- Patients with compensated cirrhosis (Child-Pugh A)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Treatment naïve patients (Total duration – 12 weeks)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Treatment experienced patients (defined as patients who have failed treatment with either peginterferon + ribavirin or [telaprevir [Incivek®] or boceprevir [Victrelis®]] + peginterferon alfa + ribavirin <strong>AND</strong> documentation of positive HCV RNA) (Total duration – 24 weeks)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Treatment experienced patients (defined as patients who have failed treatment with either peginterferon + ribavirin or [telaprevir [Incivek®] or boceprevir [Victrelis®]] + peginterferon alfa + ribavirin <strong>AND</strong> documentation of positive HCV RNA) in combination with ribavirin (Total duration – 12 weeks)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Post-liver transplant patient given in combination with ribavirin (Total duration – 12 weeks)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patients with decompensated cirrhosis (Child-Pugh B or C)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Given in combination with ribavirin (Total duration – 12 weeks)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Diagnosis of Chronic Hepatitis C, genotype 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Post-liver transplant patient without cirrhosis; <strong>AND</strong> given in combination with ribavirin (Total duration – 12 weeks)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Post-liver transplant patient with compensated cirrhosis <strong>AND</strong> given in combination with ribavirin (Total duration: 12 weeks)</td>
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<tr>
<td></td>
<td></td>
<td>- All other genotype 4 (Total duration – 12 weeks)</td>
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<tr>
<td></td>
<td></td>
<td>- Diagnosis of Chronic Hepatitis C, genotype 5 (Total duration – 12 weeks)</td>
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<tr>
<td></td>
<td></td>
<td>- Diagnosis of Chronic Hepatitis C, genotype 6 (Total duration – 12 weeks)</td>
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<td></td>
<td></td>
<td>- If patient has a history of HIV, HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- If the patient has a prior history of substance or alcohol abuse, then patient has been free of substance and alcohol abuse for previous 6 months.</td>
</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.

---

**Magellan HEALTH SERVICES**

Effective Date: December 2, 2019

Clinical Criteria, Step Therapy, and Quantity Limits for TennCare Preferred Drug List (PDL)
### ANTI-INFECTIVES

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Antivirals: Hepatitis C Antivirals (continued)</strong> Note: Hepatitis B Virus (HBV) can be &quot;reactivated&quot; in patients with current or prior HBV infection in some hepatitis C patients on direct acting antivirals (DAAs). Patients should be screened for HBV prior to starting any treatment with a hepatitis C DAA.</td>
<td></td>
<td></td>
<td>1/day</td>
<td>Harvoni PA Form</td>
</tr>
</tbody>
</table>
| Harvoni®            | P   | • Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, approval requires:  
  – Documentation of:  
    • Quantitative HCV RNA level measured 12 weeks after completion of previous treatment  
    • Previous treatment history  
    • Genotype testing  
  – Retreatment of HCV with Hepatitis C Direct Acting Antiviral requires escalation  
• Patient has not have severe renal failure (CrCl ≤ 30 mL/min) or ESRD  
• Patient has not previously received treatment with sofosbuvir and/or ledipasvir  
• Patient has been evaluated for potential clinically significant drug interactions, including the following:  
  – Concomitant therapy with the following medications could decrease the effectiveness of ledipasvir: Acid Reducing Agents (antacids, PPIs, H2Blockers), and Antiarrhythmics (digoxin).  
  – Concomitant therapy with ledipasvir could increase concentrations of the following interacting medications: HIV Antiretroviral combinations including tenofovir, and HCV products (simeprevir).  
  – Concomitant therapy with ledipasvir has been shown to interact with the following medications and coadministration is not recommended: Anticonvulsants (carbamazepine, phenytoin, phenobarbital, oxcarbazepine), Antimycobacterials  
  – (rifabutin, rifampin, rifapentine), certain HIV medications (tipranavir/ritonavir, cobicistat/elvitegravir/emtricitabine/tenofovir), certain Herbal Supplements (St John’s wort), and HMG-CoA Reductase Inhibitors (rosuvastatin).  
• Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C  
  – If screening test for Hepatitis B is positive, then a confirmatory test for Hepatitis B infection has been obtained.  
  – NOTE: If criteria is met for immune-tolerant phase or HBeAg-negative immune reactivation phase of HBV infection, then patient should be started on antiviral therapy at the same time (or before) HCV DAA therapy AND if low or undetectable levels of HBV DNA, then patient should either:  
    • Receive prophylactic HBV treatment during duration of DAA treatment; OR  
    • Have HBV DNA monitoring every 4 weeks to test for HBV reactivation (*Treatment for HBV should be initiated if HBV DNA level increases > 10-fold or is > 1000 IU/mL in a patient with undetectable or unquantifiable HBV DNA prior to DAA treatment. |  |  |
# ANTI-INFECTIVES

Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.

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<td></td>
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<td>Note: Hepatitis B Virus (HBV) can be &quot;reactivated&quot; in patients with current or prior HBV infection in some hepatitis C patients on direct acting antivirals (DAAs). Patients should be screened for HBV prior to starting any treatment with a hepatitis C DAAs.</td>
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<tr>
<td><strong>Mavyret®</strong></td>
<td>P</td>
<td>Will be approved for patients meeting following criteria:</td>
<td>3/day</td>
<td>Mavyret PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Chronic Hepatitis C, genotype 1</td>
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<tr>
<td></td>
<td></td>
<td>- Patients without cirrhosis</td>
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<td></td>
<td></td>
<td>• Treatment naïve patients (Total authorization – 8 weeks); OR</td>
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<td></td>
<td></td>
<td>• Treatment-experienced with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A protease inhibitor or NS5A inhibitor (Total authorization – 8 weeks); OR</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Treatment-experienced with regimens containing an NS3/4A protease inhibitor without prior treatment with an NS5A inhibitor (Total duration – 12 weeks); OR</td>
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<tr>
<td></td>
<td></td>
<td>• Treatment-experienced with regimens containing an NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor (Total duration – 16 weeks). OR</td>
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<td></td>
<td></td>
<td>- Patients with compensated cirrhosis (Child-Pugh A)</td>
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<td></td>
<td></td>
<td>• Treatment naïve patients (Total duration – 8 weeks); OR</td>
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<tr>
<td></td>
<td></td>
<td>• Treatment-experienced with regimens containing a NS3/4A protease inhibitor without prior treatment with an NS5A inhibitor (Total duration – 12 weeks); OR</td>
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<tr>
<td></td>
<td></td>
<td>• Treatment-experienced with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor (Total duration – 12 weeks); OR</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Treatment-experienced with regimens containing an NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor (Total duration – 16 weeks). OR</td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of Chronic Hepatitis C, genotypes 2, 4, 5 or 6</td>
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<tr>
<td></td>
<td></td>
<td>- Patients without cirrhosis</td>
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<tr>
<td></td>
<td></td>
<td>• Treatment naïve patients (Total authorization 8 weeks); OR</td>
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<tr>
<td></td>
<td></td>
<td>• Treatment-experienced with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A protease inhibitor or NS5A inhibitor (Total authorization – 8 weeks); OR</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Patients with compensated cirrhosis (Child-Pugh A)</td>
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<tr>
<td></td>
<td></td>
<td>• Treatment naïve patients (Total duration – 8 weeks); OR</td>
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<tr>
<td></td>
<td></td>
<td>• Treatment-experienced with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor (Total duration – 12 weeks); OR</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Antivirals: Hepatitis C Antivirals (continued)

*Note: Hepatitis B Virus (HBV) can be "reactivated" in patients with current or prior HBV infection in some hepatitis C patients on direct acting antivirals (DAAs). Patients should be screened for HBV prior to starting any treatment with a hepatitis C DAA.*

<table>
<thead>
<tr>
<th>Medication</th>
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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
</table>
| Mavyret* (continued) | P | - Diagnosis of Chronic Hepatitis C, genotype 3  
  - Treatment naïve patients (Total authorization – 8 weeks); OR  
  - Treatment-experienced with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NSSA inhibitor (Total duration – 16 weeks)  
  - Patients with compensated cirrhosis (Child-Pugh A)  
  - Treatment naïve patients (Total duration – 8 weeks); OR  
  - Treatment-experienced with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NSSA inhibitor (Total duration – 16 weeks)  
  - If patient has a history of HIV, HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology)  
  - If the patient has a prior history of substance or alcohol abuse, then patient has been free of substance and alcohol abuse for previous 6 months  
  - Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, approval requires:  
    - Documentation of:  
      - Quantitative HCV RNA level measured 12 weeks after completion of previous treatment  
      - Previous treatment history  
      - Genotype testing  
    - Retreatment of HCV with Hepatitis C Direct Acting Antiviral requires escalation  
  - Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C  
    - If screening test for Hepatitis B is positive, then a confirmatory test for Hepatitis B infection has been obtained.  
      - **NOTE:** If criteria is met for immune-tolerant phase or HBeAg-negative immune reactivation phase of HBV infection, then patient should be started on antiviral therapy at the same time (or before) HCV DAA therapy AND if low or undetectable levels of HBV DNA, then patient should either:  
      - Receive prophylactic HBV treatment during duration of DAA treatment; OR  
      - Have HBV DNA monitoring every 4 weeks to test for HBV reactivation (*Treatment for HBV should be initiated if HBV DNA level increases > 10-fold or is > 1000 IU/mL in a patient with undetectable or unquantifiable HBV DNA prior to DAA treatment  
  - Patient has been evaluated for potential clinically significant drug interactions | 3/day | Mavyret PA Form |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
## ANTI-INFECTIVES

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Daklinza®</td>
<td>NP</td>
<td>Will be approved for patients who meet the following:</td>
<td>1/day</td>
<td>Daklinza PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of HCV <strong>genotype 1</strong> infection (Total duration – 12 weeks);</td>
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<tr>
<td></td>
<td></td>
<td>– Patients without cirrhosis; <strong>OR</strong></td>
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<td></td>
<td></td>
<td>– Patients with compensated (Child-Pugh A) cirrhosis; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Must be used in combination with sofosbuvir 400mg tablets daily for the entire 12-week duration; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Patient must have a contraindication or clinically significant drug-drug interaction with BOTH preferred agents</td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of HCV <strong>genotype 1</strong> infection (Total duration – 12 weeks);</td>
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<tr>
<td></td>
<td></td>
<td>– Patients with decompensated (Child-Pugh B or C) cirrhosis:</td>
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<tr>
<td></td>
<td></td>
<td>• Must be used in combination with sofosbuvir 400mg tablets daily + ribavirin for the entire 12-week duration; <strong>AND</strong></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Patient must have contraindication or clinically significant drug-drug interaction with Epclusa®</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of HCV <strong>genotype 1</strong> infection (Total duration – 12 weeks);</td>
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<tr>
<td></td>
<td></td>
<td>– Post-transplant patients; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Must be used in combination with sofosbuvir 400mg tablets daily + ribavirin for the entire 12-week duration</td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of HCV <strong>genotype 3</strong> infection (Total duration – 12 weeks);</td>
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<tr>
<td></td>
<td></td>
<td>– Treatment naïve patient without cirrhosis; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>– Treatment naïve patients with compensated (Child-Pugh A) cirrhosis; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>– Treatment experienced patient (previously treated with interferon + ribavirin) without compensated (Child-Pugh A) cirrhosis; <strong>AND</strong></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>• Must be used in combination with sofosbuvir 400mg tablets daily for the entire 12-week duration; <strong>AND</strong></td>
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<td></td>
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<td>Patient must have a contraindication or clinically significant drug-drug interaction with BOTH preferred agents</td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of HCV <strong>genotype 3</strong> infection (Total duration – 12 weeks);</td>
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<tr>
<td></td>
<td></td>
<td>– Patients with decompensated (Child-Pugh B or C) cirrhosis; <strong>AND</strong></td>
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<td></td>
<td>• Must be used in combination with sofosbuvir 400mg tablets daily for the entire 12-week duration</td>
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<td></td>
<td>• Patient must have a contraindication or clinically significant drug-drug interaction with Epclusa®</td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of HCV <strong>genotype 3</strong> infection (Total duration – 24 weeks);</td>
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<tr>
<td></td>
<td></td>
<td>– Treatment experienced patient (previously treated with Sovaldi® + ribavirin ± interferon) without cirrhosis; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>– Treatment experienced patient (previously treated with Sovaldi + ribavirin OR with interferon + ribavirin) WITH compensated (Child-Pugh A) cirrhosis; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Must be used in combination with sofosbuvir 400mg tablets daily + ribavirin for the entire 24-week duration</td>
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<tr>
<td></td>
<td></td>
<td>• Patient must have a contraindication or clinically significant drug-drug interaction with BOTH preferred agents</td>
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</tr>
</tbody>
</table>

Note: Hepatitis B Virus (HBV) can be "reactivated" in patients with current or prior HBV infection in some hepatitis C patients on direct acting antivirals (DAAs). Patients should be screened for HBV prior to starting any treatment with a hepatitis C DAAs.

Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
**ANTI-INFECTIVES**

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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</table>
| Daklinza\(^\text{a}\) (continued) | NP  | • If patient has a history of HIV, HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology)  
• If the patient has a prior history of substance or alcohol abuse, then patient has been free of substance and alcohol abuse for previous 6 months.  
• Patients requiring retreatment of HCV or 2\(^\text{nd}\) course of therapy with Hepatitis C Direct Acting Antiviral, approval requires:  
  -- Documentation of:  
    • Quantitative HCV RNA level measured 12 weeks after completion of previous treatment  
    • Previous treatment history  
    • Genotype testing  
  -- Retreatment of HCV with Hepatitis C Direct Acting Antiviral requires escalation  
• Patient must not be pregnant  
• Deny if patient taking concomitant therapy with the following contraindicated strong inducers of CYP3A: phenytoin, carbamazepine, rifampin, or St. John’s Wort.  
• Approve 30 mg daily if patient taking concomitant therapy with the following medications that could increase the effectiveness of daclatasvir: atazanavir/ritonavir, clarithromycin, indinavir, itraconazole, ketoconazole, nefazodone, nelfinavir, posaconazole, saquinavir, telithromycin, voriconazole, diltiazem, erythromycin, fluconazole, fosamprenavir, or verapamil.  
• Approve 90 mg daily if patient is taking moderate CYP3A inducers (e.g., bosentan, dexamethasone, efavirenz, etravirine, modafinil, nafcillin, rifapentine)  
• Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C  
  -- If screening test for Hepatitis B is positive, then a confirmatory test for Hepatitis B infection has been obtained.  
  **NOTE:** If criteria is met for immune-tolerant phase or HBeAg-negative immune reactivation phase of HBV infection, then patient should be started on antiviral therapy at the same time (or before) HCV DAA therapy AND if low or undetectable levels of HBV DNA, then patient should either:  
    • Receive prophylactic HBV treatment during duration of DAA treatment; OR  
    • Have HBV DNA monitoring every 4 weeks for HBV reactivation (**Treatment for HBV should be initiated if HBV DNA level increases > 10-fold or is > 1000 IU/mL in a patient with undetectable or unquantifiable HBV DNA prior to DAA treatment**).                                                                                                                                                                                                                                                                                                                                                     | 1/day       | Daklinza PA Form |
| ledipasvir/sofosbuvir             | NP  | See Harvoni\(^\text{a}\) prior authorization criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1/day       | Harvoni PA Form |

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</tr>
</thead>
</table>
| **sofosbuvir/velpatasvir**          | NP  | will be approved for patients meeting the following criteria:  
  - Diagnosis of Chronic Hepatitis C, **genotype 1** (Total duration – 12 weeks);  
    - Used in combination with daclatasvir  
      - Patients without cirrhosis; **OR**  
      - Patients with compensated (Child-Pugh A) cirrhosis; **AND**  
      - Patient must have a contraindication or clinically significant drug-drug interaction with BOTH preferred agents  
    - Used in combination with daclatasvir and ribavirin  
      - Patients with decompensated (Child-Pugh B or C) cirrhosis; **AND**  
      - Patient must have a contraindication or clinically significant drug-drug interaction with Epclusa®; **OR**  
      - Post-transplant patients  
    - Used in combination with ribavirin and peginterferon alf®; **AND**  
      - Patient must have a contraindication or drug-drug interaction with BOTH preferred agents; **AND**  
      - Patients must be treatment naïve to all HCV therapy (including previous therapies with pegylated interferon or ribavirin); **OR**  
      - Patient must be co-infected with HIV  
  - Diagnosis of Chronic Hepatitis C, **genotype 1** (Total duration – 24 weeks)  
    - Used in combination with ribavirin; **AND**  
      - Patient must have a contraindication or drug-drug interaction with BOTH preferred agents; **AND**  
      - Patient has a documented intolerance to interferon (from history of previous exposure) or documented contraindication to interferon; **AND**  
      - Patient must be treatment naïve to all HCV therapy (including previous therapies with pegylated interferon or ribavirin); **OR**  
      - Patient must be co-infected with HIV  
  - Diagnosis of Chronic Hepatitis C, **genotype 2** (Total duration – 12 weeks);  
    - Requires contraindication or drug-drug interaction with BOTH preferred agents; **AND**  
    - Used in combination with ribavirin  
  - Diagnosis of Chronic Hepatitis C, **genotype 3**  
    - Used in combination with Daklinza® (Total duration – 12 weeks);  
      - Requires contraindication or drug-drug interaction with BOTH preferred agents; **AND**  
      - Used in combination with Daklinza®  
    - Used in combination with ribavirin (Total duration – 24 weeks);  
      - Requires contraindication or drug-drug interaction with BOTH preferred agents; **AND**  
      - Used in combination with ribavirin  
  - Diagnosis of Chronic Hepatitis C, **genotype 4** (Total duration – 12 weeks)  
                                                                                                                                                                                                                                                                                                                                                                     | 1/day       | Epclusa PA Form |
| **Sovaldi®**                       | NP  | will be approved for patients meeting the following criteria:  
  - Diagnosis of Chronic Hepatitis C, **genotype 1** (Total duration – 12 weeks);  
    - Used in combination with ribavirin and peginterferon alf®; **AND**  
      - Patient must have a contraindication or drug-drug interaction with BOTH preferred agents; **AND**  
      - Patients must be treatment naïve to all HCV therapy (including previous therapies with pegylated interferon or ribavirin); **OR**  
    - Requires contraindication or drug-drug interaction with BOTH preferred agents; **AND**  
  - Diagnosis of Chronic Hepatitis C, **genotype 2** (Total duration – 24 weeks)  
    - Used in combination with ribavirin; **AND**  
      - Patient must have a contraindication or drug-drug interaction with BOTH preferred agents; **AND**  
      - Patient has a documented intolerance to interferon (from history of previous exposure) or documented contraindication to interferon; **AND**  
      - Patient must be treatment naïve to all HCV therapy (including previous therapies with pegylated interferon or ribavirin); **OR**  
      - Patient must be co-infected with HIV  
  - Diagnosis of Chronic Hepatitis C, **genotype 3**  
    - Used in combination with Daklinza® (Total duration – 12 weeks);  
      - Requires contraindication or drug-drug interaction with BOTH preferred agents; **AND**  
      - Used in combination with Daklinza®  
    - Requires contraindication or drug-drug interaction with BOTH preferred agents; **AND**  
      - Used in combination with ribavirin  
  - Diagnosis of Chronic Hepatitis C, **genotype 4** (Total duration – 12 weeks)  
                                                                                                                                                                                                                                                                                                                                                                     | 1/day       | Sovaldi PA Form |
### ANTI-INFECTIVES

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<tbody>
<tr>
<td>Sovaldi® (continued)</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td>Sovaldi PA Form</td>
</tr>
</tbody>
</table>

### Antivirals: Hepatitis C Antivirals (continued)

Note: Hepatitis B Virus (HBV) can be "reactivated" in patients with current or prior HBV infection in some hepatitis C patients on direct acting antivirals (DAAs). Patients should be screened for HBV prior to starting any treatment with a hepatitis C DAAs.

- Requires contraindication or drug-drug interaction with BOTH preferred agents; **AND**
- Used in combination with ribavirin and peginterferon alfa
- Diagnosis of Hepatocellular Carcinoma awaiting liver transplant (Length of authorization: 48 weeks if below criteria are met);
  - Must be used in combination with ribavirin; **AND**
  - Must meet Milan criteria, defined as:
    - The presence of a tumor 5 cm or less in diameter in subjects with single hepatocellular carcinoma; **AND**
    - No more than three tumor nodules, each 3 cm or less in diameter, in subjects with multiple tumors; **AND**
    - No extrahepatic manifestations of the cancer and no evidence of vascular invasion of the tumor
- If patient has a history of HIV, HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology)
- If the patient has a prior history of substance or alcohol abuse, then patient has been free of substance and alcohol abuse for previous 6 months.
- Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, approval requires:
  - Documentation of:
    - Quantitative HCV RNA level measured 12 weeks after completion of previous treatment
    - Previous treatment history
    - Genotype testing
  - Retreatment of HCV with Hepatitis C Direct Acting Antiviral requires escalation
  - Patient must not be pregnant
  - Patient must not have severe renal failure (CrCl ≤ 30 mL/min) or ESRD
  - Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C
  - If screening test for Hepatitis B is positive, then a confirmatory test for Hepatitis B infection has been obtained. **NOTE:** If criteria is met for immune-tolerant phase or HBeAg-negative immune reactivation phase of HBV infection, then patient should be started on antiviral therapy at the same time (or before) HCV DAA therapy AND if low or undetectable levels of HBV DNA, then patient should either:
    - Receive prophylactic HBV treatment during duration of DAA treatment; **OR**
    - Have HBV DNA monitoring every 4 weeks to test for HBV reactivation (**Treatment for HBV should be initiated if HBV DNA level increases > 10-fold or is > 1000 IU/mL in a patient with undetectable or unquantifiable HBV DNA prior to DAA treatment**)

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### Anti-Infectives

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technivie®</td>
<td>NP</td>
<td>Will be approved for patients who meet the following:</td>
<td>2/day</td>
<td>Technivie PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Chronic Hepatitis C, <strong>genotype 4</strong> (Total duration – 12 weeks);</td>
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<td></td>
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<td>– Patients with compensated cirrhosis or without cirrhosis</td>
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<td></td>
<td></td>
<td>– Will be used in combination with weight-based ribavirin; <strong>AND</strong></td>
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<td></td>
<td>– Patient must have a contraindication or clinically significant drug-drug interaction with BOTH preferred agents</td>
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<td>• If patient has a history of HIV, HBV co-infection, primary history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology)</td>
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<td></td>
<td></td>
<td>• If the patient has a prior history of substance or alcohol abuse, then patient has been free of substance and alcohol abuse for previous 6 months.</td>
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<td></td>
<td></td>
<td>• Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, approval requires:</td>
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<td></td>
<td></td>
<td>– Documentation of:</td>
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<td></td>
<td></td>
<td>• Quantitative HCV RNA level measured 12 weeks after completion of previous treatment</td>
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<td></td>
<td>• Previous treatment history</td>
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<td></td>
<td>• Genotype testing</td>
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<tr>
<td></td>
<td></td>
<td>– Retreatment of HCV with Hepatitis C Direct Acting Antiviral requires escalation</td>
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<tr>
<td></td>
<td></td>
<td>• Patient must not be pregnant</td>
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<tr>
<td></td>
<td></td>
<td>• Patient <strong>has been evaluated</strong> for potential clinically significant drug interactions, including the following:</td>
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<td>– Concomitant therapy with the following strong inducers of CYP3A with Technivie® is contraindicated: alfuzosin, carbamazepine, phenytoin, phenobarbital, rifampin, ergotamine, dihydroergotamine, ergonovine, methylergonovine, ethinyl estradiol-containing medications such as combined oral contraceptives, St. John’s wort, lovastatin, simvastatin, pimozone, efavirenz, and sildenafil (when dosed as Revatio® for the treatment of pulmonary arterial hypertension), triazolam, and orally-administered midazolam.</td>
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<tr>
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<td>– Concomitant therapy with the following medications could increase the concentration of Technivie®: lopinavir/ritonavir, and atazanavir or atazanavir/ritonavir.</td>
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<td></td>
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<td>– Concomitant therapy with Technivie® could increase concentrations of the following interacting medications: digoxin, amiodarone, bepridil, disopyramide, flecainide, lidocaine (systemic), mexiletine, propafenone, quinidine, ketoconazole, quetiapine, amlodipine, fluticasone, furosemide, rilpivirine, pravastatin, cyclosporine, tacrolimus, salmeterol, buprenorphine/naloxone, and alprazolam.</td>
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<td></td>
<td>– Concomitant therapy with Technivie® could decrease concentrations of the following interacting medications: voriconazole, darunavir, and omeprazole.</td>
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</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.

### Anti-Infectives

**Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.**

<table>
<thead>
<tr>
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</thead>
</table>
| **Technivie® (continued)** | NP | • Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C  
  – If screening test for Hepatitis B is positive, then a confirmatory test for Hepatitis B infection has been obtained.  
  **NOTE:** If criteria is met for immune-tolerant phase or HBeAg-negative immune reactivation phase of HBV infection, then patient should be started on antiviral therapy at the same time (or before) HCV DAA therapy AND if low or undetectable levels of HBV DNA, then patient should either:  
  • Receive prophylactic HBV treatment during duration of DAA treatment; OR  
  • Have HBV DNA monitoring every 4 weeks to test for HBV reactivation (*Treatment for HBV should be initiated if HBV DNA level increases > 10-fold or is > 1000 IU/mL in a patient with undetectable or unquantifiable HBV DNA prior to DAA treatment** | 2/day | Technivie PA Form |
| **Viekira®** | NP | Will be approved for patients meeting the following criteria:  
  • Diagnosis of Chronic Hepatitis C, **genotype 1a** (Total duration – 12 weeks);  
    – Patients without cirrhosis; OR  
    – Treatment experienced (previously treated with interferon + ribavirin) prior relapse/partial responder patients WITH cirrhosis; **AND**  
    – Must be given in combination with ribavirin  
    – Patient must have a contraindication or clinically significant drug-drug interaction with BOTH preferred agents  
  • Diagnosis of Chronic Hepatitis C, **genotype 1a** (Total duration – 24 weeks)  
    – Treatment experienced (previously treated with interferon + ribavirin) null responder patients WITH cirrhosis; OR  
    – Treatment naive patients **WITH** cirrhosis; **AND**  
    – Must be given in combination with ribavirin  
    – Patient must have a contraindication or clinically significant drug-drug interaction with BOTH preferred agents  
  • Diagnosis of Chronic Hepatitis C, **genotype 1b** (Total duration – 12 weeks);  
    – Patients without cirrhosis OR patients with compensated cirrhosis  
    – Patient must have a contraindication or clinically significant drug-drug interaction with BOTH preferred agents  
  • If patient has a history of HIV, HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology)  
  • If the patient has a prior history of substance or alcohol abuse, then patient has been free of substance and alcohol abuse for previous 6 months. | 4/day | Viekira PA Form |
### Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTI-INFECTIVES</strong></td>
<td></td>
<td><strong>Antivirals: Hepatitis C Antivirals (continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Hepatitis B Virus (HBV) can be &quot;reactivated&quot; in patients with current or prior HBV infection in some hepatitis C patients on direct acting antivirals (DAAs). Patients should be screened for HBV prior to starting any treatment with a hepatitis C DAAs.</td>
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<tr>
<td><strong>Viekira® (continued)</strong></td>
<td>NP</td>
<td>Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, approval requires: ⋅ Documentation of:  ⋅ Quantitative HCV RNA level measured 12 weeks after completion of previous treatment  ⋅ Previous treatment history  ⋅ Genotype testing  ⋅ Retreatment of HCV with Hepatitis C Direct Acting Antiviral requires escalation  ⋅ Patient must not be pregnant  ⋅ Patient does not have or has never had decompensated cirrhosis (which is defined as Child-Pugh score &gt; 6 [class B or C])  ⋅ Patient has not previously received treatment with dasabuvir/ombitasvir/paritaprevir or any of its components.  ⋅ Patient is not receiving concomitant therapy with any of the following contraindicated medications: alfuzosin, carbamazepine, phenytoin, phenobarbital, gemfibrozil, rifampin, ergotamine, dihydroergotamine, ergonovine, methylergonovine, ethinyl estradiol-containing contraceptives, St. John’s wort, lovastatin, simvastatin, pimozide, efavirenz, sildenafil (when dosed for the treatment of pulmonary arterial hypertension), triazolam, and/or orally administered midazolam.  ⋅ Patient has been evaluated for potential clinically significant drug interactions, including the following:  ⋅ Concomitant therapy with Viekira® could increase concentrations of the following interacting medications: Antiarrhythmics (amiodarone, bepridil, disopyramide, flecainide, lidocaine (systemic), mexiletine, propafenone, quinidine), Antifungals (ketoconazole), Calcium Channel Blockers (amlodipine), Corticosteroids (fluticasone), Diuretics (furosemide), HMG CoA Reductase Inhibitors (rosuvastatin, pravastatin), Immunosuppressants (cyclosporine, tacrolimus), Narcotic Analgesics (buprenorphine), Sedatives/Hypnotics (alprazolam).  ⋅ Concomitant therapy with Viekira® could decrease concentrations of the following interacting medications: Proton Pump Inhibitors (omeprazole).  ⋅ Concomitant therapy with Viekira® has been shown to interact with the following medications and coadministration is not recommended: certain Antifungals (voriconazole), certain HIV Antivirals (darunavir/ritonavir, lopinavir/ritonavir, rilpivirine), and certain Long Acting Beta-Agonists (salmeterol).  ⋅ Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C  ⋅ If screening test for Hepatitis B is positive, then a confirmatory test for Hepatitis B infection has been obtained. NOTE: If criteria is met for immune-tolerant phase or HBeAg-negative immune reactivation phase of HBV infection, then patient should be started on antiviral therapy at the same time (or before) HCV DAA therapy AND if low or undetectable levels of HBV DNA, then patient should either:  ⋅ Receive prophylactic HBV treatment during duration of DAA treatment; OR  ⋅ Have HBV DNA monitoring every 4 weeks to test for HBV reactivation (*Treatment for HBV should be initiated if HBV DNA level increases &gt; 10-fold or is &gt; 1000 IU/mL in a patient with undetectable or unquantifiable HBV DNA prior to DAA treatment</td>
<td>4/day</td>
<td>Viekira PA Form</td>
</tr>
<tr>
<td>Viekira® XR</td>
<td>NP</td>
<td>See Viekira® prior authorization criteria</td>
<td>3/day</td>
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</tr>
</tbody>
</table>
## Anti-Infectives

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

### Medication | PDL | Prior Authorization Criteria | Qty. Limits | PA Form
---|---|---|---|---
Vosevi® | NP | **Antivirals: Hepatitis C Antivirals (continued)**
Note: Hepatitis B Virus (HBV) can be "reactivated" in patients with current or prior HBV infection in some hepatitis C patients on direct acting antivirals (DAAs). Patients should be screened for HBV prior to starting any treatment with a hepatitis C DAAs.

- **Diagnosis of chronic Hepatitis C, genotype 1–6** – (Total duration – 12 weeks)
  - Patient without cirrhosis or with compensated cirrhosis (Child-Pugh A); **AND**
  - Treatment-experienced with an NSSA inhibitor (e.g., daclatasvir, elbasvir, ledipasvir, ombitasvir, or velpatasvir); **AND**
  - Contraindication or Drug-Drug Interaction to MAVYRET

- **Diagnosis of chronic Hepatitis C, genotype 1a or 3** – (Total duration – 12 weeks)
  - Patient without cirrhosis or with compensated cirrhosis (Child-Pugh A); **AND**
  - Treatment-experienced with sofosbuvir without an NSSA inhibitor (e.g., daclatasvir, elbasvir, ledipasvir, ombitasvir, or velpatasvir); **AND**
  - Contraindication or drug-drug interaction to Mavyret®

- If patient has a history of HIV, HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology)

- If the patient has a prior history of substance or alcohol abuse, then patient has been free of substance and alcohol abuse for previous 6 months.

- Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, approval requires:
  - Documentation of:
    - Quantitative HCV RNA level measured 12 weeks after completion of previous treatment
    - Previous treatment history
    - Genotype testing
  - Retreatment of HCV with Hepatitis C Direct Acting Antiviral requires escalation

- **Patient has been evaluated** for potential clinically significant drug interactions, including the following:
  - Concomitant therapy with the following inducers of P-glycoprotein and/or moderate to potent inducers of CYP2B6, CYP2C8, or CYP3A4 could **decrease the concentration of sofosbuvir/velpatasvir/voxilaprevir**; coadministration is **not recommended with** atazanavir, carbamazepine, efavirenz, lopinavir, phenytoin, phenobarbital, oxicarbazepine, rifampin, rifabutin, rifapentine, St. John’s wort, and tipranavir/ritonavir.
  - Concomitant therapy with amiodarone may result in **serious symptomatic bradycardia**; coadministration is not recommended. If unavoidable, cardiac monitoring is recommended. Concomitant therapy with the following medications could **decrease the concentration of sofosbuvir/velpatasvir/voxilaprevir** due to decreased gastric pH: antacids (e.g., aluminum and magnesium hydroxide), H2-receptor antagonists (e.g., famotidine), and proton-pump inhibitors (e.g., omeprazole).

Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
## ANTI-INFECTIVES

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
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<th>Medication</th>
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<th>Prior Authorization Criteria</th>
</tr>
</thead>
</table>
| **Vosevi**
(continued) | NP  | Concomitant therapy with sofosbuvir/velpatasvir/voxilaprevir could **increase concentrations of the following interacting medications**: digoxin, dabigatran, HMG CoA reductase inhibitors (atorvastatin, fluvastatin, pravastatin, pitavastatin, lovastatin, rosuvastatin, and simvastatin), methotrexate, mitoxantrone, imatinib, irinotecan lapatinib, sulfasalazine, tenofovir, and topotecan.  
• Patient NOT be receiving concomitant therapy with other drugs containing sofosbuvir (e.g., sofosbuvir [Sovaldi]).  
• Patient NOT be receiving concomitant therapy with other drugs containing a hepatitis C NSSA inhibitor (e.g., daclatasvir [Daklinza]).  
• Patient does not have severe renal impairment (eGFR < 30 mL/min/1.73m²) or end stage renal disease (ESRD) requiring hemodialysis.  
• Patient is NOT co-infected with HIV.  
• Patient does not have, nor has ever had, decompensated cirrhosis [Child-Pugh score greater than 6 (class B or C)].  
• Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C  
  -- If screening test for Hepatitis B is positive, then a confirmatory test for Hepatitis B infection has been obtained.  
  NOTE: If criteria is met for immune-tolerant phase or HBeAg-negative immune reactivation phase of HBV infection, then patient should be started on antiviral therapy at the same time (or before) HCV DAA therapy AND if low or undetectable levels of HBV DNA, then patient should either:  
  • Receive prophylactic HBV treatment during duration of DAA treatment; **OR**  
  • Have HBV DNA monitoring every 4 weeks to test for HBV reactivation (*Treatment for HBV should be initiated if HBV DNA level increases > 10-fold or is > 1000 IU/mL in a patient with undetectable or unquantifiable HBV DNA prior to DAA treatment.**  

| **Zepatier**
| NP  | Will be approved for patients meeting the following criteria:  
• Diagnosis of Chronic Hepatitis C, **genotype 1** (Total duration – 12 weeks);  
  -- **Genotype 1a without NSSA polymorphism:**  
    • Patient treatment naïve to all HCV therapy (including previous therapies with pegylated interferon or ribavirin); **OR**  
    • Patient failed prior treatment with peginterferon alfa + ribavirin; **AND**  
    • Patient must have a contraindication or drug-drug interaction with BOTH preferred agents;  
  -- **Genotype 1b:**  
    • Patient treatment naïve to all HCV therapy (including previous therapies with pegylated interferon or ribavirin); **OR**  
    • Patient failed prior treatment with peginterferon alfa + ribavirin; **AND**  
    • Patient must have a contraindication or drug-drug interaction with BOTH preferred agents;  
  -- **Genotype 1a or 1b:**  
    • Patient failed prior therapy with peginterferon alfa + ribavirin + HCV NS3/4A protease inhibitor (e.g., boceprevir, telaprevir, or simeprevir); **AND**  
    • Used in combination with ribavirin; **AND**  
    • Patient must have a contraindication or drug-drug interaction with BOTH preferred agents; **1/day**  |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### ANTI-INFECTIVES

**Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.**

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</tr>
</thead>
</table>
| Zepatier® (continued) | NP  | • Diagnosis of Chronic Hepatitis C, **genotype 1a WITH NS5A polymorphism** (Total duration – 16 weeks);  
  - Patient treatment naïve to all HCV therapy (including previous therapies with pegylated interferon or ribavirin); **OR**  
  - Patient failed prior treatment with peginterferon alfa + ribavirin; **AND**  
  - Used in combination with ribavirin; **AND**  
  - Patient must have a contraindication or drug-drug interaction with BOTH preferred agents;  
• Diagnosis of Chronic Hepatitis C, **genotype 4** (Total duration – 12 weeks)  
  - Patient treatment naïve to all HCV therapy (including previous therapies with pegylated interferon or ribavirin); **AND**  
  - Requires contraindication or drug-drug interaction with BOTH preferred agents;  
• Diagnosis of Chronic Hepatitis C, **genotype 4** (Total duration – 16 weeks)  
  - Patient failed prior treatment with peginterferon alfa + ribavirin; **AND**  
  - Used in combination with ribavirin; **AND**  
  - Patient must have a contraindication or drug-drug interaction with BOTH preferred agents;  
• If patient has a history of HIV, HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology)  
• If the patient has a prior history of substance or alcohol abuse, then patient has been free of substance and alcohol abuse for previous 6 months.  
• Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, approval requires:  
  - Documentation of:  
    • Quantitative HCV RNA level measured 12 weeks after completion of previous treatment  
    • Previous treatment history  
    • Genotype testing  
• Retreatment of HCV with Hepatitis C Direct Acting Antiviral requires escalation  
• If requested regimen requires combination therapy with ribavirin, patient must not be pregnant.  
• Documentation of baseline liver function tests.  
• Patient does not have decompensated cirrhosis (which is defined as a Child-Pugh score greater than 6 [class B or C])  
• The patient is not receiving concomitant therapy with an OATP1B1/3 inhibitor such as gemfibrozil and/or cyclosporine  
• The patient is not receiving concomitant therapy with a strong CYP3A inducer such as efavirenz, phenytoin, carbamazepine, rifampin, and/or St. John's wort | 1/day       | Zepatier PA Form |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### ANTI-INFECTIVES

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</table>
| Zepatier® (continued) | NP    | • Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C  
  — If screening test for Hepatitis B is positive, then a confirmatory test for Hepatitis B infection has been obtained.  
  **NOTE:** If criteria is met for immune-tolerant phase or HBeAg-negative immune reactivation phase of HBV infection, then patient should be started on antiviral therapy at the same time (or before) HCV DAA therapy AND if low or undetectable levels of HBV DNA, then patient should either:  
  • Receive prophylactic HBV treatment during duration of DAA treatment; OR  
  • Have HBV DNA monitoring every 4 weeks to test for HBV reactivation (*Treatment for HBV should be initiated if HBV DNA level increases > 10-fold or is > 1000 IU/mL in a patient with undetectable or unquantifiable HBV DNA prior to DAA treatment) | 1/day       | Zepatier PA Form |
| Rebetol® solution | NP    | Rebetol® solution will not require a prior authorization for recipients 6 years of age and younger.  
• All others who are unable to swallow tablets or capsules will require a prior authorization. |             | General PA Form |
| famciclovir     | P     |                                                                                             | 125mg: 20 per 30 days; 250mg: 60 per 30 days; 500mg: 3/day & (21/Rx) |             | General PA Form |
| valacyclovir    | P     |                                                                                             | 500mg (60 per 30 days)1000mg (30/Rx) |             |
| Famvir®         | NP    |                                                                                             | See famciclovir |             |
| Sitavig® buccal tabs | NP |                                                                                             | 2/Rx        |               |
| Valtrex®        | NP    |                                                                                             | See valacyclovir |             |

**Note:** Hepatitis B Virus (HBV) can be "reactivated" in patients with current or prior HBV infection in some hepatitis C patients on direct acting antivirals (DAAs). Patients should be screened for HBV prior to starting any treatment with a hepatitis C DAAs.

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### ANTI-INFECTIVES

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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<tbody>
<tr>
<td>Antivirals: HIV CCR5 Antagonists</td>
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<tr>
<td>Selzentry® tablets P</td>
<td></td>
<td>Will be approved for:</td>
<td>150mg (2/day); 300mg (4/day)</td>
<td>General PA Form</td>
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<tr>
<td></td>
<td></td>
<td>- Diagnosis of CCR5-tropic HIV-1 via a co-receptor tropism; <strong>AND</strong></td>
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<td>- Verification that agent will be administered in combination with other antiretroviral agents.</td>
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<tr>
<td>Selzentry® solution NP</td>
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<td>Will be approved for:</td>
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<td></td>
<td></td>
<td>- Diagnosis of CCR5-tropic HIV-1 via a co-receptor tropism; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Verification that agent will be administered in combination with other antiretroviral agents; <strong>AND</strong></td>
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<td>- Patient is 11 years of age or younger OR patient is unable to swallow tablets.</td>
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<tr>
<td>Antivirals: Cytochrome P450 Inhibitors</td>
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<tr>
<td>Tybost® NP</td>
<td></td>
<td>Will be approved for patients meeting the following criteria:</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Verification that agent will be administered in combination with Prezista® (darunavir) OR Reyataz® (atazanavir); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient has a contraindication to OR has experienced an adverse reaction to ritonavir</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antivirals: HIV Fusion Inhibitors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fuzeon® P</td>
<td></td>
<td>Will be approved upon verification of exposure, contraindication, intolerance or resistance to:</td>
<td>1 kit/30 days (2 vials/day)</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- At least two NRTIs; <strong>AND</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- One of the following: INSTI; NNRTI or PI; <strong>AND</strong></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>- Verification that agent will be administered in combination with other antiretroviral agents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antivirals: HIV Integrase Inhibitors</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Isentress® P</td>
<td></td>
<td>Will be approved upon verification that agent will be administered in combination with other antiretroviral agents.</td>
<td>tabs: 2/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>chewables: 6/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>granules: 2 packs/day</td>
<td></td>
</tr>
<tr>
<td>Tivicay® P</td>
<td></td>
<td>See Isentress® prior authorization criteria</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>Vitekta® P</td>
<td></td>
<td>See Isentress® prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Isentress® HD NP</td>
<td></td>
<td>Approval will be granted upon documentation of ALL of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Diagnosis of an FDA-approved indication; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Juluca® NP</td>
<td></td>
<td>Will be approved if ALL the following is met:</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient has a diagnosis of HIV; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient will Not concurrently take dofetilide or other ART medications; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient does not have any prior history of treatment failure to other HIV agents OR known resistance to the individual components (dolutegravir/rilpivirine); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient is virologically suppressed (HIV-1 RNA &lt; 50 copies/mL) on a current ART regimen for ≥ 6 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### ANTI-INFECTIVES

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antivirals: HIV NNRTIs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>efavirenz</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intelence® P</td>
<td>P</td>
<td>Will be approved if the following is met:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient is treatment-experienced; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient will concomitantly take at least two additional antiretroviral agents; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient has documented non-nucleoside reverse transcriptase inhibitor (NNRTI) resistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>nevirapine</td>
<td>P</td>
<td></td>
<td>200mg (2/day); susp: (40mL/day)</td>
<td></td>
</tr>
<tr>
<td>Pifeltro® P</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sustiva® P</td>
<td>P</td>
<td></td>
<td>50mg (7/day); 200mg (2/day); 600mg (1/day)</td>
<td>General PA Form</td>
</tr>
<tr>
<td>nevirapine ER NP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rescriptor® NP P</td>
<td></td>
<td></td>
<td>100mg: 12/day; 200mg: 6/day</td>
<td></td>
</tr>
<tr>
<td>Viramune® NP P</td>
<td></td>
<td></td>
<td>200mg: 2/day; susp: 40mL/day</td>
<td></td>
</tr>
<tr>
<td>Viramune® XR NP P</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Antivirals: HIV NRTIs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>abacavir</td>
<td>P</td>
<td></td>
<td>tab: 2/day soln: 30mL/day</td>
<td></td>
</tr>
<tr>
<td>didanosine capsules</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Emtriva® P</td>
<td>P</td>
<td></td>
<td>caps: 1/day; soln: 24mL/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Epivir® solution P</td>
<td>P</td>
<td></td>
<td>10mg/mL soln: 30mL/day</td>
<td></td>
</tr>
<tr>
<td>lamivudine tablets</td>
<td>P</td>
<td></td>
<td>100 &amp; 300mg: 1/day; 150mg: 2/day</td>
<td></td>
</tr>
<tr>
<td>stavudine</td>
<td>P</td>
<td></td>
<td>caps: 2/day soln: 80mL/day</td>
<td></td>
</tr>
<tr>
<td>tenofovir</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Videx solution® P</td>
<td>P</td>
<td></td>
<td>40mL/day</td>
<td></td>
</tr>
</tbody>
</table>

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ANTE-INFECTIVES

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antivirals: HIV NRTIs (continued)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ziagen®</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>zidovudine</td>
<td>P</td>
<td></td>
<td>100mg: 6/day; 300mg: 2/day; syrup: 60mL/day</td>
<td></td>
</tr>
<tr>
<td>Epivir® tablets</td>
<td>NP</td>
<td></td>
<td>150mg: 2/day; 300mg: 1/day</td>
<td></td>
</tr>
<tr>
<td>lamivudine solution</td>
<td>NP</td>
<td></td>
<td>5mg/mL soln: 20mL/day; 10mg/mL soln: 30mL/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Retrovir®</td>
<td>NP</td>
<td></td>
<td>see zidovudine</td>
<td></td>
</tr>
<tr>
<td>Videx® capsules</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Viread®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Zerit®</td>
<td>NP</td>
<td></td>
<td>see stavudine</td>
<td></td>
</tr>
<tr>
<td><strong>Antivirals: HIV NRTI Combos</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>abacavir/ lamivudine</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>abacavir/ lamivudine/ zidovudine</td>
<td>P</td>
<td>Approved only for patients who can’t be on an NNRTI-based or a PI-based regimen due to concerns about toxicities or drug interactions.</td>
<td>2/day</td>
<td></td>
</tr>
</tbody>
</table>
| Atripla® | P | Will be approved if the following is met:  
- Patient has a diagnosis of HIV; **AND**  
- Patient has been tested for hepatitis B infection prior to initiation of therapy; **AND**  
- Patient has a creatinine clearance (CrCl) ≥ 30 mL/min; **AND**  
- Patient does NOT meet any of the following:  
  - Patient has moderate to severe hepatic impairment  
  - Concomitantly on other ART medications  
  - Patient will concurrently take dofetilide or rifampin | 1/day | General PA Form |
| Biktarvy® | P |                              | 1/day |         |
| Combivir® | P |                              | 2/day |         |
| Complera® | P |                              | 1/day |         |
| Delstrigo® | P |                              | 1/day |         |

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### Anti-Infectives

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<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descovy*</td>
<td>P</td>
<td>Will be approved if the following is met:</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Genvoya*</td>
<td>P</td>
<td>• Patient has a diagnosis of HIV-1; <strong>AND</strong></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient is not concurrently taking any medications contraindicated with Symtuza; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient is ARV treatment-naïve; <strong>OR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient is ARV treatment-experienced and meets the following requirements:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Virologically suppressed (HIV-1 RNA &lt; 50 copies/mL) on a stable ARV regimen for ≥ 6 months; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Patient has no known substitutions associated with resistance to darunavir or tenofovir; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Patient is switching within class (e.g., another protease inhibitor to darunavir, boosting agent of ritonavir to cobicistat, or another nucleoside reverse transcriptase inhibitors [NRTI] or tenofovir disoproxil fumarate [TDF] to tenofovir alafenamide [TAF]) due adverse effects or documented compliance issues due to pill burden or dosing frequency; <strong>OR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Patient is switching between classes due to adverse effects or documented compliance issues due to pill burden or dosing frequency and activity of every component has been verified.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symtuza*</td>
<td>P</td>
<td>Will be approved if the following is met:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Truumeq*</td>
<td>P</td>
<td>• Patient will not be taking any other antiretroviral ARV medications; <strong>AND</strong></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Trizivir*</td>
<td>P</td>
<td>• Patient will not be taking any other antiretroviral ARV medications contraindicated with Symtuza; <strong>AND</strong></td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>Truvada*</td>
<td>P</td>
<td>• Patient demonstrates documented efficacy (e.g., reduced viral load/improved CD4, remaining virologically suppressed); <strong>AND</strong></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Cimduo*</td>
<td>NP</td>
<td>• Patient does not have any treatment-limiting adverse effects.</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Epizicom*</td>
<td>NP</td>
<td>Approved only for patients who can’t be on an NNRTI-based or a PI-based regimen due to concerns about toxicities or drug interactions.</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Symfi*</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Symfi Lo*</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
</tbody>
</table>

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## ANTI-INFECTIVES

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<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antivirals: HIV Protease Inhibitors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aptivus*</td>
<td>P</td>
<td>Will be approved upon confirmation that patient has had previous exposure to at least one PI indicated for first line therapy.</td>
<td>caps: 4/day; soln: 10mL/day</td>
</tr>
<tr>
<td>atazanavir caps</td>
<td>NP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evotaz*</td>
<td>P</td>
<td></td>
<td>1/day</td>
</tr>
<tr>
<td>fosamprenavir</td>
<td>P</td>
<td></td>
<td>4/day</td>
</tr>
<tr>
<td>Invirase*</td>
<td>P</td>
<td></td>
<td>200mg: 10/day; 500mg: 4/day</td>
</tr>
<tr>
<td>Kaletra*</td>
<td>P</td>
<td></td>
<td>tablets: 6/day; soln: 15mL/day</td>
</tr>
<tr>
<td>Lexiva*</td>
<td>P</td>
<td></td>
<td>700mg: 4/day; susp: 56mL/day</td>
</tr>
<tr>
<td>lopinavir/ritonavir</td>
<td>P</td>
<td></td>
<td>soln: 15mL/day</td>
</tr>
<tr>
<td>Norvir*</td>
<td>P</td>
<td></td>
<td>caps/tabs: 12/day; soln: 15mL/day</td>
</tr>
<tr>
<td>Prezcobix*</td>
<td>P</td>
<td></td>
<td>1/day</td>
</tr>
<tr>
<td>Prezista*</td>
<td>P</td>
<td></td>
<td>800mg: 1/day; All other strengths: 2/day; susp: 12mL/day</td>
</tr>
<tr>
<td>Reyataz* powder</td>
<td>P</td>
<td></td>
<td>5/day</td>
</tr>
<tr>
<td>Viracept*</td>
<td>P</td>
<td></td>
<td>tablets: 4/day</td>
</tr>
<tr>
<td>Crixivan*</td>
<td>NP</td>
<td></td>
<td>6/day</td>
</tr>
<tr>
<td>Norvir* powder pack</td>
<td>NP</td>
<td></td>
<td>12/day</td>
</tr>
<tr>
<td>Reyataz* caps</td>
<td>NP</td>
<td>Will be approved for the following:</td>
<td>300mg: 1/day; 150, 200mg: 2/day;</td>
</tr>
<tr>
<td>ritonavir</td>
<td>NP</td>
<td>– Patient has a diagnosis of HIV-1; <strong>AND</strong></td>
<td>12/day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Patient will be taking in combination with other antiretroviral agents; <strong>AND</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>– Patient is ≤ 18 years of age; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>– Patient has a clinically valid reason as to why the preferred ritonavir (e.g. Norvir) oral solution cannot be used, including patients with polyurethane feeding tubes.</td>
<td></td>
</tr>
</tbody>
</table>

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### Anti-infectives

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<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antivirals: Influenza</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>oseltamivir</td>
<td>P</td>
<td></td>
<td>caps: 20/180 days</td>
<td>Influenza Antiviral PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6 mg/mL susp: 240 mL/180 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>12 mg/mL susp: 100 mL/180 days</td>
<td></td>
</tr>
<tr>
<td>Relenza®</td>
<td>P</td>
<td></td>
<td>40/180 days</td>
<td></td>
</tr>
<tr>
<td>Tamiflu®</td>
<td>NP</td>
<td></td>
<td>See oseltamivir</td>
<td></td>
</tr>
<tr>
<td>Xofluza®</td>
<td>NP</td>
<td>Will be approved if patient has met the following:</td>
<td>2/Rx</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Requires contraindication to both Relenza® and Tamiflu® that is not associated with requested agent; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Area surveillance data that indicates an oseltamivir resistant strain; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Recurrent documented influenza in the same flu season that was previously treated with a preferred agent.</td>
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<td></td>
</tr>
</tbody>
</table>

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CARDBOVASCULAR
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<table>
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<tr>
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<th>Prior Authorization Criteria</th>
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<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE Inhibitors (ACEI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ramipril</td>
<td>P</td>
<td></td>
<td>1.25, 2.5, 5mg: 1/day; 10mg: 2/day</td>
<td></td>
</tr>
<tr>
<td>Aceon®</td>
<td>NP</td>
<td></td>
<td>4 mg: 1/day; 8 mg: 2/day</td>
<td></td>
</tr>
<tr>
<td>Altace®</td>
<td>NP</td>
<td></td>
<td>See ramipril</td>
<td></td>
</tr>
<tr>
<td>captopril</td>
<td>NP</td>
<td>No PA required for patients 18 years of age and younger</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epaned*</td>
<td>NP</td>
<td>No PA required for patients less than 8 years old</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mavik®</td>
<td>NP</td>
<td>For patients ≥ 8 years old, will be approved for patients meeting the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unable to swallow tablets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>moexipril</td>
<td>NP</td>
<td></td>
<td>7.5mg: 1/day; 15mg: 2/day</td>
<td></td>
</tr>
<tr>
<td>perindopril</td>
<td>NP</td>
<td></td>
<td>2 mg, 4 mg: 1/day; 8 mg: 2/day</td>
<td></td>
</tr>
<tr>
<td>Qbrelis® solution</td>
<td>NP</td>
<td>No PA required for patients less than 8 years old</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For patients ≥ 8 years old, will be approved for patients meeting the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unable to swallow tablets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>trandolapril</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Univasc*</td>
<td>NP</td>
<td></td>
<td>See moexipril</td>
<td></td>
</tr>
<tr>
<td>ACEIs/Calcium Channel Blockers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>benazepril/amlodipine</td>
<td>P</td>
<td></td>
<td>5/40mg: 2/day; All others: 1/day</td>
<td></td>
</tr>
<tr>
<td>Lotrel*</td>
<td>NP</td>
<td>Will be authorized in patients who are unable to take the two components separately</td>
<td>5/40mg: 2/day; All others: 1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Prestalia*</td>
<td>NP</td>
<td>Will be authorized in patients who are unable to take the two components separately</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Tarka*</td>
<td>NP</td>
<td>Will be authorized in patients who are unable to take the two components separately</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>trandolapril/verapamil</td>
<td>NP</td>
<td>Will be authorized in patients who are unable to take the two components separately</td>
<td>1/day</td>
<td></td>
</tr>
</tbody>
</table>

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### CARDIOVASCULAR

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<table>
<thead>
<tr>
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<th>PDL</th>
<th>Prior Authorization Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>ACEI/Diuretic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>benazepril/HCTZ</td>
<td>NP</td>
<td>Will be authorized in patients who are unable to take the two components separately</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td><strong>Alpha/Beta Blockers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>carvedilol</td>
<td>P</td>
<td></td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>carvedilol ER</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Coreg*</td>
<td>NP</td>
<td></td>
<td>2/day</td>
<td>Form</td>
</tr>
<tr>
<td>Coreg CR™</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td><strong>Angiotensin II Receptor Antagonists (ARB)</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>irbesartan</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>losartan</td>
<td>P</td>
<td></td>
<td>25mg, 100mg: 1/day; 50mg: 2/day</td>
<td></td>
</tr>
<tr>
<td>olmesartan</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>valsartan</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Atacand*</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Avapro*</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Benicar*</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Diovan*</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>candesartan</td>
<td>NP</td>
<td></td>
<td>4 &amp; 32mg: 1/day; 8mg &amp; 16mg: 2/day</td>
<td></td>
</tr>
<tr>
<td>Cozaar*</td>
<td>NP</td>
<td></td>
<td>25mg, 100mg: 1/day; 50mg: 2/day</td>
<td></td>
</tr>
<tr>
<td>Edarbi™</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>eprosartan</td>
<td>NP</td>
<td></td>
<td>600mg: 1/day</td>
<td></td>
</tr>
<tr>
<td>Micardis*</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>telmisartan</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td><strong>ARB + Calcium Channel Blocker</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>amlodipine/valsartan</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>amlodipine/valsartan/HCTZ</td>
<td>P</td>
<td>Will be approved for patients with a diagnosis of hypertension requiring combination therapy with an ARB and a calcium channel blocker who are unable to take the products individually</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>amlodipine/olmesartan</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>amlodipine/olmesartan/HCTZ</td>
<td>NP</td>
<td>Will be approved for patients with a diagnosis of hypertension requiring combination therapy with an ARB and a calcium channel blocker who are unable to take the products individually</td>
<td>20/5/12.5mg: 2/day; All others:1/day</td>
<td></td>
</tr>
<tr>
<td>Azor®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Exforge*</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Exforge HCT®</td>
<td>NP</td>
<td>See amlodipine/olmesartan/HCTZ prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>telmisartan/amlodipine</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Tribenzor®</td>
<td>NP</td>
<td>See amlodipine/olmesartan/HCTZ prior authorization criteria</td>
<td>20/5/12.5mg: 2/day; All others:1/day</td>
<td></td>
</tr>
<tr>
<td>Twynsta®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td><strong>ARB + Diuretic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>irbesartan/HCTZ</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>losartan/HCTZ</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>olmesartan/HCTZ</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>valsartan/HCTZ</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Atacand HCT®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Avalide®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Benicar HCT®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>candesartan/HCTZ</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Diovan HCT®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Edarbyclor®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Hyzaar®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Micards HCT®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>telmisartan/HCTZ</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
</tbody>
</table>

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### Medication | PDL | Prior Authorization Criteria | Qty. Limits | PA Form |
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>ARB + Neprilysin Inhibitor</strong></td>
<td></td>
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</tr>
</tbody>
</table>
| Entresto® | P | Will be approved for patients meeting ALL of following criteria:  
• Age ≥ 18 years  
• Diagnosis of chronic heart failure (NYHA Class II-IV)  
• Left ventricular ejection fraction ≤ 40%  
• Must be prescribed by, or in consultation with a cardiologist; **AND**  
• Patient must meet **ONE** of the following:  
  – Currently receiving a beta blocker for heart failure (e.g., metoprolol succinate, carvedilol, bisoprolol, or Coreg CR®); **OR**  
  – Patient has a documented contraindication to use beta blocker therapy (e.g., bronchospastic disease such as COPD and asthma, severe hypotension or bradycardia)  
Patients meeting **any of the following will NOT be approved:**  
• History of angioedema related to previous ACE inhibitor or ARB therapy  
• Concomitant use of an ACE inhibitor or Angiotensin II Receptor Blocker (ARB)  
• Patient has diabetes and is taking aliskiren (Tekturna®)  
• Patient is pregnant  
• Patient has severe hepatic impairment (Child-Pugh class C)  
Initial approval: 3 months; Renewal: 1 yr  
**Criteria for Renewal (Duration 1 year):**  
• Requests for renewal will be approved for recipients based on documentation of clinical improvement, as evidenced by at least **ONE** of the following:  
  – Improvement in, or stabilization of, left ventricular ejection fraction or symptomatology  
  – Decrease in hospitalizations attributable to heart failure | 2/day | General PA Form |
| **Antiarrhythmics** |     |                             |             |         |
| dofetilide | P | Multaq will be approved for patients meeting ALL of the following criteria:  
• Not on concurrent Class I or III anti-arrhythmic agent  
• Not hospitalized for exacerbation of heart failure in past 30 days  
• Patient does not have NYHA class IIIb or IV heart failure  
• Trial and failure, contraindication, intolerance or drug-drug interaction to at least **TWO** of the following preferred antiarrhythmic agents:  
  – amiodarone  
  – flecainide  
  – propafenone  
  – sotalol | 2/day | General PA Form |
| Multaq® | NP | **Note:** This requirement is waived if patient has structural heart disease. |
| Tikosyn® | NP | 2/day |         |

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<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beta Blockers and Combinations</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>metoprolol succinate ER</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>bisoprolol</td>
<td>NP</td>
<td>Will be approved without trial and failure of preferred agents for patients with diagnosis of congestive heart failure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Byvalson*</td>
<td>NP</td>
<td>Will be authorized in patients with a diagnosis of hypertension who are unable to take the two components separately.</td>
<td>1/day</td>
<td></td>
</tr>
</tbody>
</table>
| Hemangeol* | NP | Will be approved for patients meeting the following criteria:  
  - Diagnosis of Infantile Hemangioma; **AND**  
  - Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the propranolol solution | | General PA Form |
| Kapsargo® Sprinkle* | NP | Will be approved for recipients with one of the approved diagnoses:  
  - Heart Failure or LVEF ≤ 40%; **OR**  
  - Hypertension; **OR**  
  - Angina Pectoris; **AND**  
  - Patient has documented difficulty swallowing  
  **Note:** Safety and Efficacy has not been established in children less than 6 years of age. | 1/day | |
| InnoPran XL* | NP | | 80mg (2/day); 120mg (1/day) | General PA Form |
| Levatol* | NP | | 2/day | |
| Sotylize* | NP | Will be approved for patients unable to swallow tablets  
  - No PA required for patients 8 years old and younger | | |
| Qbrelis® solution | NP | Will be approved for patients if the following is met:  
  - Unable to swallow tablets  
  **Note:** No PA required for patients < 8 years of age | | |
| Toprol XL* | NP | Will be approved for recipients with one of the approved diagnoses:  
  - Heart Failure or LVEF ≤ 40%; **OR**  
  - Paroxysmal Atrial Fibrillation | 1/day | |
| **Beta Blockers + Diuretics** |
| Dutoprol® | NP | Dutoprol® will be approved for recipients with one of the approved diagnoses:  
  - Heart Failure or LVEF ≤ 40%  
  - Paroxysmal Atrial Fibrillation | 2/day | General PA Form |

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<tbody>
<tr>
<td>Calcium Channel Blockers (DHP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>amlodipine</td>
<td>P</td>
<td></td>
<td>2.5 &amp; 5mg (1.5/day); 10mg (1/day)</td>
<td></td>
</tr>
<tr>
<td>nifedipine ER/SA/XL</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Adalat® CC</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>isradipine</td>
<td>NP</td>
<td></td>
<td>2.5mg (2/day); 5mg (4/day)</td>
<td></td>
</tr>
<tr>
<td>nimodipine</td>
<td>NP</td>
<td>Will be approved for recipients with subarachnoid hemorrhage (SAH).</td>
<td>120 mL/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>nisoldipine</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Norvasc®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Nymalize®</td>
<td>NP</td>
<td>Will be approved if patient meets ALL the following:</td>
<td>120 mL/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Subarachnoid Hemorrhage; AND</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• An allergy or intolerance to an inactive ingredient in nimodipine</td>
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</tr>
<tr>
<td>Procardia® XL</td>
<td>NP</td>
<td></td>
<td>1/day</td>
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</tr>
<tr>
<td>Sular®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Calcium Channel Blockers (Non-DHP)</td>
<td></td>
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</tr>
<tr>
<td>verapamil ER</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>diltiazem ER (generic for Cardizem LA®)</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Calan SR®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Cardizem LA®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Calcium Channel Blocker/Statin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>amlodipine/atorvastatin</td>
<td>NP</td>
<td>Will be approved for recipients meeting ALL of the following:</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of an FDA-approved indication; AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred individual components.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caduet®</td>
<td>NP</td>
<td>See prior authorization for amlodipine/atorvastatin</td>
<td>1/day</td>
<td></td>
</tr>
</tbody>
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<tbody>
<tr>
<td><strong>Carbonic Anhydrase Inhibitors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Keveyis<sup>®</sup> | N/A | Will be approved ONLY for patients meeting following criteria (Initial PA duration: 2 months):  
- Diagnosis of Primary Hyperkalemic Periodic Paralysis; **AND**  
  - Patient has tried and failed or has contraindication or intolerance to acetazolamide AND hydrochlorothiazide; **OR**  
- Diagnosis of Primary Hypokalemic Periodic Paralysis; **AND**  
  - Patient has tried and failed or has contraindication or intolerance to acetazolamide AND spironolactone; **OR**  
- Diagnosis of Variant Periodic Paralysis (e.g., Paramyotonia congenita, Andersen syndrome)  
  - Patient does not have any of the following:  
    - Hepatic insufficiency  
    - Severe pulmonary disease  
    - Sulfonamide allergy  

**Renewal Criteria:**  
Will be approved for patients meeting the following criteria:  
- Clinical documentation that patient has exhibited a reduction in symptoms or attacks; **AND**  
- Patient’s serum potassium and bicarbonate levels are being monitored (e.g., baseline and periodically during treatment)  

**NOTE:** Use of Keveyis<sup>®</sup> is contraindicated with concomitant use of high-dose aspirin (doses exceeding 325 mg/day) | 2/day       | General PA Form |

| **Direct Renin Inhibitors**                                                                                                                                                                                                                                                                                                                                 |             |         |
| aliskiren        | NP  | Will be approved for treatment of hypertension in individuals who have failed to achieve their goal blood pressure (BP) on an adequate trial of, or have a contraindication/intolerance to, an agent from at least two of the following drug classes:  
- ACEI or ARB  
- CCB  
- A thiazide diuretic | 1/day       | General PA Form |
| Tekturna<sup>®</sup> | N/A | See aliskiren prior authorization criteria                                                                                                                                                                                                                                                                                                                                 | 1/day       |         |
| Tekturna HCT<sup>®</sup> | NP  | Will be approved for treatment of hypertension in patients who meet ALL of the following criteria:  
- Have failed to achieve their goal BP on an adequate trial of, or have a contraindication/intolerance to, an agent from **at least two** of the following drug classes:  
  - ACEI or ARB  
  - CCB  
  - A thiazide diuretic  
- Are unable to take the individual components.                                                                                                                                                                                                                                                                                                                                 | 1/day       |         |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### Hemostatics

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>tranexamic acid</td>
<td>P</td>
<td>• For the treatment of acute uterine or cyclic heavy menstrual bleeding, approval of tranexamic acid requires patient must have tried and failed or have contraindication or intolerance to ALL of the following: At least two other forms of hormone therapy (oral, vaginal, topical or injectable estrogen and/or progesterone) Levonorgestrel-releasing IUD • All other diagnoses require trial and failure, intolerance or contraindication to aminocaproic acid.</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td>Lysteda&lt;sup&gt;*&lt;/sup&gt;</td>
<td>P</td>
<td>See tranexamic acid prior authorization criteria</td>
<td>30 per 28 days</td>
<td></td>
</tr>
</tbody>
</table>

### Injectable Anticoagulants

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>enoxaparin</td>
<td>P</td>
<td></td>
<td>40 mg/0.4 mL: 0.4 mL/day; 30 mg/3 mL: 0.6 mL/day; 60 mg/6 mL: 1.2 mL/day; 80 mg/0.8 mL &amp; 120 mg/0.8 mL: 1.6 mL/day; 100 mg/mL &amp; 150 mg/mL: 2 mL/day;</td>
<td>General PA Form</td>
</tr>
<tr>
<td>fondaparinux</td>
<td>P</td>
<td></td>
<td>2.5 mg/0.5 mL: 0.5 mL/day; 5 mg/0.4 mL: 0.4 mL/day; 7.5 mg/0.6 mL: 0.6 mL/day; 10 mg/0.8 mL: 0.8 mL/day;</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Arixtra&lt;sup&gt;*&lt;/sup&gt;</td>
<td>NP</td>
<td></td>
<td>See fondaparinux</td>
<td></td>
</tr>
<tr>
<td>Lovenox&lt;sup&gt;*&lt;/sup&gt;</td>
<td>NP</td>
<td></td>
<td>See enoxaparin</td>
<td></td>
</tr>
</tbody>
</table>

### Lipotropics: Bile Acid Sequestrant

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>colesevelam packets</td>
<td>NP</td>
<td>Will be authorized in patients who are unable to swallow solid oral dosage forms.</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Welchol&lt;sup&gt;*&lt;/sup&gt; packets</td>
<td>NP</td>
<td>Will be authorized in patients who are unable to swallow solid oral dosage forms.</td>
<td></td>
</tr>
</tbody>
</table>

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Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### Lipotropics: Cholesterol Absorption Inhibitors

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
</table>
| ezetimibe           | NP  | Use in combination with a statin will be approved if ONE of the following is met:  
- Patient is currently taking a high-intensity statin (daily dose sufficient to achieve ≥ 50% LDL reduction) and has experienced less than anticipated therapeutic response OR  
- Medical documentation patient is unable to tolerate lower doses of high-intensity therapy  
- Use in combination with a bile acid sequestrant, fibrate, or niacin will be approved.  
- For requests as monotherapy, recipients must have been intolerant to, or have a contraindication to a statin.                                                                                                                                  | 1/day       | General PA Form |
| Zetia*              | NP  | See ezetimibe prior authorization criteria                                                                                                                                                                                                                                                                                                                                                   | 1/day       |         |

#### Lipotropics: Combination Antihyperlipidemic Agents

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
</table>
| Advicor*            | NP  | Will be approved for recipients that meet ONE of the following criteria:  
- Trial and failure of at least 1 preferred single agent statin OR  
- Contraindication or intolerance to a preferred single agent statin                                                                                                                                                                                                                                                  | 2/day       |         |
| ezetimibe/simvastatin | NP | Will only be authorized if recipient has tried and failed a 4-week trial of the specific statin listed below according to the required LDL reduction needed:  
- Recipient requires ≤45% LDL reduction: 4-week trial and failure of both atorvastatin and simvastatin  
- Recipient requires >45% LDL reduction: 4-week trial and failure of atorvastatin                                                                                                                                                                                                                                   | 1/day       | General PA Form |
| Liptruzet*          | NP  | Will be approved for recipients that meet the following criteria:  
- Clinically valid reason why the patient cannot take the two agents separately                                                                                                                                                                                                                                                                                                  | 1000/20mg: (60/30 days); 500/20mg & 750/20mg: (45/30 days); 500/40mg & 1000/40mg: (30/30days) | General PA Form |
| Simcor*             | NP  | See Advicor* prior authorization criteria                                                                                                                                                                                                                                                                                                                                                   |             |         |
| Vytorin*            | NP  | See ezetimibe/simvastatin prior authorization criteria                                                                                                                                                                                                                                                                                                                                     | 1/day       |         |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
**CARDIOVASCULAR**

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lipotropics: Fibric Acid Derivatives</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| fenofibrate (48 mg & 145 mg)        | P   | Preferred fenofibrates will be reserved for those patients who are on concurrent therapy with a sulfonylurea, thiazolidinedione, repaglinide, or a statin.  
  - Recipients who are intolerant to gemfibrozil will be approved for a fenofibrate. |             |         |
| fenofibric acid                     | P   | See fenofibrate prior authorization criteria                                                   |             |         |
| Antara®                             | NP  | Non-preferred fenofibrates will be reserved for those patients who are on concurrent therapy with a sulfonylurea, thiazolidinedione, repaglinide, or a statin.  
  - Recipients who are intolerant to gemfibrozil will be approved for a fenofibrate.  
  - Additionally, approval of a non-preferred fenofibrate product requires trial and failure or intolerance to a preferred fenofibrate product. |             |         |
| fenofibrate (all other strengths)   | NP  | See Antara® prior authorization criteria                                                       |             |         |
| Fenoglise®                          | NP  | See Antara® prior authorization criteria                                                       |             |         |
| Fibricor®                           | NP  | See Antara® prior authorization criteria                                                       |             |         |
| Lipofen®                            | NP  | See Antara® prior authorization criteria                                                       |             |         |
| Lofibra®                            | NP  | See Antara® prior authorization criteria                                                       |             |         |
| TriCor®                             | NP  | See Antara® prior authorization criteria                                                       |             |         |
| Triglide®                           | NP  | See Antara® prior authorization criteria                                                       |             |         |
| Trilipix®                           | NP  | See Antara® prior authorization criteria                                                       |             |         |
| **Lipotropics: Miscellaneous**      |     |                                                                                               |             |         |
| Juxtapid®                           | NP  | Will be approved if ALL of the following criteria is met:  
  - Diagnosis of Homozygous Familial Hypercholesterolemia(HoFH); AND  
  - Member will be concurrently taking other lipid-lowering medications; AND  
  - Trial/failure, contraindication, or adverse effect to evolocumab (Repatha®); AND  
  - If female, documentation patient is not currently pregnant.  
  **Note:** This drug is subject to REMS requirements to ensure that the benefits outweigh its risks. Please visit:  
  [http://www.accessdata.fda.gov/scripts/cder/rems/index.cfm](http://www.accessdata.fda.gov/scripts/cder/rems/index.cfm) for up-to-date REMS information. | 5mg/10mg:  
  (1 cap/day)  
  20 mg:  
  3 caps/day | General PA Form |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### CARDIOVASCULAR

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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<tr>
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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>niacin ER</td>
<td>P</td>
<td>Will be approved for recipients meeting <strong>ONE</strong> of the following criteria:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Triglycerides &gt; 500 mg/dL <strong>AND</strong> patient has tried and failed or has contraindication or intolerance to BOTH gemfibrozil and fenofibrate; <strong>OR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of hyperlipidemia; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Use in combination with a statin will be approved if the dose of the statin tried is considered sufficient to achieve ≥35% LDL reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For requests as monotherapy, recipients must have been intolerant to, or have a contraindication to a statin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Niacor*</td>
<td>NP</td>
<td>See niacin ER prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Niaspan*</td>
<td>NP</td>
<td>See niacin ER prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lipotropics: Omega-3 Fatty Acids</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lovaza*</td>
<td>NP</td>
<td>Approved for individuals with hypertriglyceridemia (defined as triglyceride blood concentrations 500 mg/dL or greater) who have tried and failed an adequate trial of BOTH of the following (unless contraindicated or intolerant to):</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Niaspan*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A fibrate (gemfibrozil, fenofibrate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>omega-3 acid ethyl esters</td>
<td>NP</td>
<td>See Lovaza* prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vascepa*</td>
<td>NP</td>
<td>See Lovaza* prior authorization criteria</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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## CARDIOVASCULAR

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Lipotropics: PCSK-9 Inhibitors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Praluent®

**NP**

Will be approved for patients who meet the following criteria:

- Age ≥ 18 years
- Initial alirocumab request is being made by or in consultation with a specialist (including cardiologists, lipidologists, or endocrinologists)
- Diagnosis of atherosclerotic cardiovascular disease (ASCVD) or heterozygous familial hypercholesterolemia (HeFH) as confirmed by genotyping or by clinical criteria (“definite FH” using either the Simon Broome or WHO/Dutch Lipid Network criteria)
- All secondary causes of hyperlipidemia have been addressed including: diet, other diseases, and concomitant drugs
- Prior treatment history with highest available dose or maximally-tolerated dose of high intensity statin (atorvastatin or rosuvastatin) **AND** ezetimibe for at least three continuous months with failure to reach target LDL-C (at least 50% reduction from baseline OR if no baseline is available: 70 mg/dL for patients with clinical ASCVD and <100 mg/dL for patients with HeFH and no history of clinical ASCVD)
  - If the patient is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms, documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the patient experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following:
    - Muscle symptoms resolve after discontinuation of statin; **AND**
    - Muscle symptoms occurred when rechallenged at a lower dose of the same statin; **AND**
    - Muscle symptoms occurred after switching to an alternative statin; **AND**
    - Documentation ruling out non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease); **OR**
  - The patient has been diagnosed with statin-induced rhabdomyolysis
    - The diagnosis should be supported by acute neuromuscular illness or dark urine **AND** an acute elevation in creatine kinase (usually >5,000 IU/L or five times the upper limit of normal)
  - If the patient failed to reach target LDL-C (at least 50% reduction from baseline OR if no baseline is available: <70 mg/dL for patients with clinical ASCVD and <100 mg/dL for patients with HeFH and no history of clinical ASCVD), adherence to maximally-tolerated statin and ezetimibe has been verified using pharmacy claims data and the patient is determined to be compliant for at least three consecutive months prior to the lipid panel demonstrating suboptimal reduction
    - Maximally-tolerated statin will continue to be used in conjunction with alirocumab
    - Patient has not had a prior trial and failure of an alternative PCSK9 inhibitor
    - Request is being made for the lowest approved alirocumab dose (75 mg every 2 weeks) to adequately treat the patient. Requests for an escalated dose (150 mg every 2 weeks) must contain a lipid panel documenting suboptimal reduction in LDL-C after at least 4 weeks (2 doses) of alirocumab at the lower (75 mg every 2 weeks) dose.

Duration of Initial approval: 3 months

**Renewal criteria**

- Lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating alirocumab
- Continued adherence to maximally-tolerated statin dose established prior to the original alirocumab approval
- Duration of Renewal approval: 6 months

Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
## CARDIOVASCULAR

**Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.**

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipotropics: PCSK-9 Inhibitors (continued)</td>
<td></td>
<td>Will be approved for patients who meet the following criteria:</td>
<td>3/30 days</td>
<td>PCSK9 Inhibitors PA Form</td>
</tr>
</tbody>
</table>

- Age ≥ 18 years if diagnosis is atherosclerotic cardiovascular disease (ASCVD) or primary hyperlipidemia (including heterozygous familial hypercholesterolemia (HeFH)) or ≥ 13 years if diagnosed with homozygous familial hypercholesterolemia (HoFH)
- Initial evolocumab request is being made by or in consultation with a specialist (including cardiologists, lipidologists, or endocrinologists)
- Diagnosis of atherosclerotic cardiovascular disease (ASCVD), primary hyperlipidemia or heterozygous familial hypercholesterolemia (HeFH) as confirmed by genotyping or by clinical criteria ("definite FH" using either the Simon Broome or WHO/Dutch Lipid Network criteria), or HoFH as confirmed by either:
  - Documented DNA test for functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality; **OR**
  - A history of an untreated LDL-C concentration > 500 mg/dL and triglycerides < 300 mg/dL and both parents with documented untreated TC > 250 mg/dL.
- All secondary causes of hyperlipidemia have been addressed including: diet, other diseases, and concomitant drugs
- Prior treatment history with highest available dose or maximally-tolerated dose of high intensity statin (atorvastatin or rosuvastatin) **AND** ezetimibe for at least three continuous months with failure to reach target LDL-C (at least 50% reduction from baseline OR if no baseline is available: 70 mg/dL for patients with clinical ASCVD and <100 mg/dL for patients with primary hyperlipidemia, including HeFH, and no history of clinical ASCVD)
  - If the patient is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms, documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the patient experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following:
    - Muscle symptoms resolve after discontinuation of statin; **AND**
    - Muscle symptoms occurred when rechallenged at a lower dose of the same statin; **AND**
    - Muscle symptoms occurred after switching to an alternative statin; **AND**
    - Documentation ruling out non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease); **OR**
  - The patient has been diagnosed with statin-induced rhabdomyolysis
    - The diagnosis should be supported by acute neuromuscular illness or dark urine **AND** an acute elevation in creatine kinase (usually >5,000 IU/L or five times the upper limit of normal)
    - If the patient failed to reach target LDL-C (at least 50% reduction from baseline OR if no baseline is available: <70 mg/dL for patients with clinical ASCVD and <100 mg/dL for patients with primary hyperlipidemia, including HeFH, and no history of clinical ASCVD), adherence to maximally-tolerated statin and ezetimibe has been verified using pharmacy claims data and the patient is determined to be compliant for at least three consecutive months prior to the lipid panel demonstrating suboptimal reduction

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### CARDIOVASCULAR

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<tr>
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<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipotropics: PCSK-9 Inhibitors (continued)</td>
<td></td>
<td>- Maximally-tolerated statin will continue to be used in conjunction with evolocumab</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient has not had a prior trial and failure of an alternative PCSK9 inhibitor</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient not concomitantly taking lomitapide or mipomersen for diagnosis of HoFH.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repatha* (continued)</td>
<td></td>
<td>Duration of Initial approval: 3 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Renewal criteria</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating evolocumab</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Continued adherence to maximally-tolerated statin dose established prior to the original evolocumab approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Duration of Renewal approval: 6 months</td>
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<td></td>
</tr>
</tbody>
</table>

### Lipotropics: Standard Potency Statins

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Priority Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>lovastatin</td>
<td>P</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>pravastatin</td>
<td>P</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>simvastatin 5, 10, 20, &amp; 40 mg</td>
<td>P</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Altoprev*</td>
<td>NP</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>fluvastatin</td>
<td>NP</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>fluvastatin ER</td>
<td>NP</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Lescol*</td>
<td>NP</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Lescol XL*</td>
<td>NP</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Livalo*</td>
<td>NP</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Mevacor*</td>
<td>NP</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Pravachol*</td>
<td>NP</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Zocor* 5, 10, 20, &amp; 40 mg</td>
<td>NP</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Zypitamag*</td>
<td>NP</td>
<td>1/day</td>
<td></td>
</tr>
</tbody>
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**CARDIOVASCULAR**

*Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.*

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</tr>
</thead>
<tbody>
<tr>
<td>Lipotics: High Potency Statins</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>atorvastatin</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>rosvastatin</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>simvastatin 80 mg</td>
<td>P</td>
<td>Requests for simvastatin 80mg products will be granted approval if the following is met:</td>
<td>1/day</td>
<td>High Potency Statin PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has previously received simvastatin 80mg for 12 months or longer with no evidence of myopathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crestor®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Lipitor®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Zocor® 80 mg</td>
<td>NP</td>
<td>See simvastatin 80 mg prior authorization criteria.</td>
<td>1/day</td>
<td></td>
</tr>
</tbody>
</table>

**Miscellaneous Antianginals**

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Corlanor®</td>
<td>NP</td>
<td>Will be approved for patients who meet the following criteria:</td>
<td>2/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Congestive Heart Failure and documentation of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Left ventricular ejection fraction ≤ 35%; AND</td>
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<td></td>
<td></td>
<td>- In sinus rhythm with resting heart rate ≥ 70 beats per minute; AND</td>
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<td></td>
<td></td>
<td>- Currently taking the maximum tolerated dose of a beta-blocker and still experiencing heart failure symptoms; OR</td>
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<tr>
<td></td>
<td></td>
<td>- Patient has a contraindication, adverse reaction, or drug-drug interaction to a beta-blocker</td>
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<td></td>
<td></td>
<td>Will NOT be approved for patients with any of the following:</td>
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<tr>
<td></td>
<td></td>
<td>• Concomitant use of potent CYP3A inhibitors or inducers (including ketoconazole, itraconazole, clarithromycin, nefazodone, ritonavir, nelfinavir, indinavir, saquinavir, rifampin, rifabutin, rifapentine, barbiturates, carbamazepine, phenytoin and St. John’s Wort)</td>
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</tr>
<tr>
<td>Ranexa®</td>
<td>NP</td>
<td>Will be approved only for individuals with chronic angina with failure to achieve an adequate response to or contraindication or intolerance to at least ONE agent from TWO of the following classes:</td>
<td>2/day</td>
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<tr>
<td></td>
<td></td>
<td>• Beta-blocker</td>
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<td></td>
<td></td>
<td>• Long-acting nitrate</td>
<td></td>
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<td></td>
<td></td>
<td>• Calcium channel blocker</td>
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<td></td>
<td></td>
<td>Should NOT be approved for patients with any of the following:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Liver cirrhosis</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Concomitant use of potent CYP3A inhibitors or inducers (including ketoconazole, itraconazole, clarithromycin, nefazodone, ritonavir, nelfinavir, indinavir, saquinavir, rifampin, rifabutin, rifapentine, barbiturates, carbamazepine, phenytoin and St. John’s Wort)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ranolazine ER</td>
<td>NP</td>
<td>See Ranexa® prior authorization criteria</td>
<td>2/day</td>
<td></td>
</tr>
</tbody>
</table>

*Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.*
# CARDIOVASCULAR

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Miscellaneous Antihypertensives</strong></td>
<td></td>
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</tr>
<tr>
<td>Catapres-TTS®</td>
<td>P</td>
<td>Will be approved only for patients meeting ALL of the following:</td>
<td>0.1, 0.2 mg (4/28 days); 0.3mg (pt &lt; 21: 4/28 days; pt &gt; 21: 8/28 days)</td>
<td>General PA Form</td>
</tr>
<tr>
<td>clonidine weekly patches</td>
<td>NP</td>
<td></td>
<td>see Catapres-TTS®</td>
<td></td>
</tr>
<tr>
<td>minoxidil</td>
<td>NP</td>
<td><strong>Will be approved only for patients meeting ALL of the following:</strong></td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diagnosis of severe hypertension (symptomatic or associated with target organ damage)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Trial and failure to achieve adequate blood pressure control on a diuretic PLUS at least TWO of the following (unless contraindicated or intolerant to):</td>
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<tr>
<td></td>
<td></td>
<td>- ACEI or ARBs</td>
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<tr>
<td></td>
<td></td>
<td>- Beta-blockers</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Calcium channel blockers</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Patient does not have diagnosis of pheochromocytoma (minoxidil may stimulate secretions of catecholamines from the tumor) Note: Minoxidil will not be approved for alopecia.</td>
<td></td>
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</tr>
<tr>
<td>Vecamyl®</td>
<td>NP</td>
<td><strong>Will be approved only for patients meeting ALL of the following criteria:</strong></td>
<td>10/day</td>
<td>General PA Form</td>
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<tr>
<td></td>
<td></td>
<td>Diagnosis of Essential Hypertension or Malignant Hypertension, AND</td>
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<tr>
<td></td>
<td></td>
<td>Trial and failure, contraindication or intolerance to ALL of the following:</td>
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<tr>
<td></td>
<td></td>
<td>- ACE inhibitor or ARB plus a diuretic; AND</td>
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<td></td>
<td></td>
<td>- Beta blocker plus a diuretic; AND</td>
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<td></td>
<td></td>
<td>- Calcium Channel Blocker plus a diuretic; AND</td>
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<td></td>
<td></td>
<td>- Clonidine; AND</td>
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<tr>
<td></td>
<td></td>
<td>- Hydralazine</td>
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<tr>
<td><strong>Nitrites</strong></td>
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<tr>
<td>GoNitro® powder</td>
<td>NP</td>
<td><strong>Will be approved only for patients meeting following criteria:</strong></td>
<td></td>
<td>General PA Form</td>
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<tr>
<td></td>
<td></td>
<td>Diagnosis of an FDA approved indication; AND</td>
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<tr>
<td></td>
<td></td>
<td>Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents; AND</td>
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<tr>
<td></td>
<td></td>
<td>Patient is unable to swallow solid oral form or dissolve sublingual formulation, or use sublingual spray</td>
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</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oral Anticoagulants</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Xarelto® P</strong></td>
<td>Requests for Xarelto® will be approved if patient meets ONE of the following criteria:</td>
<td></td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td>• Thromboprophylaxis following hip replacement surgery-approval duration of 35 days</td>
<td></td>
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<tr>
<td></td>
<td>• Thromboprophylaxis following knee replacement surgery-approval duration of 12 days</td>
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<tr>
<td></td>
<td>• Diagnosis of non-valvular atrial fibrillation deep vein thrombosis, OR pulmonary embolism; AND</td>
<td></td>
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<tr>
<td></td>
<td>– Failure of warfarin therapy due to inability to maintain therapeutic INR; OR</td>
<td></td>
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<tr>
<td></td>
<td>– Recipient does not have access to adequate monitoring services for warfarin therapy; OR</td>
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<tr>
<td></td>
<td>– Non-bleeding related contraindication to warfarin therapy</td>
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<tr>
<td></td>
<td>• Diagnosis of coronary artery disease or peripheral artery disease; AND</td>
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<td></td>
<td>– Will be used in combination with aspirin; AND</td>
<td></td>
<td>1/day: 10 &amp; 20 mg</td>
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<td></td>
<td>– Age ≥ 65; OR</td>
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<td>2/day: 15 mg</td>
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<td></td>
<td>– Age &lt; 65 AND documented atherosclerosis or revascularization involving at least 2 vascular beds (coronary and one additional vascular bed) OR at least 2 additional risk factors:</td>
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<tr>
<td></td>
<td>• Current smoker</td>
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<td></td>
<td>• Diabetes mellitus</td>
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<td></td>
<td>• Renal dysfunction with estimated glomerular filtration rate &lt; 60 ml/min</td>
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<td></td>
<td>• NYHA (heart failure) class I or II, with EF &gt; 30%</td>
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<td></td>
<td>• Non-lacunar ischemic stroke &gt; 1 month ago</td>
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<td></td>
<td><strong>Note:</strong> Xarelto® should be used with caution in patients taking dronedarone, or non-DHP calcium channel blockers, especially in patient with renal impairment due to a potential increase in bleeding risk.</td>
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<tr>
<td><strong>Eliquis® NP</strong></td>
<td>Will be approved for recipients meeting the following criteria:</td>
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<tr>
<td></td>
<td>• Diagnosis of non-valvular atrial fibrillation, deep vein thrombosis, OR pulmonary embolism; AND</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>– Failure of warfarin therapy due to inability to maintain therapeutic INR; OR</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>– Recipient does not have access to adequate monitoring services for warfarin therapy; OR</td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td>– Non-bleeding related contraindication to warfarin therapy; AND</td>
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<tr>
<td></td>
<td>– Contraindication, drug-drug interaction, or adverse reaction to Xarelto®</td>
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<tr>
<td></td>
<td>• Diagnosis of thromboprophylaxis following hip replacement surgery OR knee replacement surgery; AND</td>
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<tr>
<td></td>
<td>– Contraindication, drug-drug interaction, or adverse reaction to Xarelto®</td>
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<tr>
<td><strong>Pradaxa® NP</strong></td>
<td>Will be approved for recipients meeting the following criteria:</td>
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<tr>
<td></td>
<td>• Diagnosis of non-valvular atrial fibrillation, deep vein thrombosis, OR pulmonary embolism; AND</td>
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<td></td>
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<tr>
<td></td>
<td>– Failure of warfarin therapy due to inability to maintain therapeutic INR; OR</td>
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<td></td>
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<tr>
<td></td>
<td>– Recipient does not have access to adequate monitoring services for warfarin therapy; OR</td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td>– Non-bleeding related contraindication to warfarin therapy; AND</td>
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<tr>
<td></td>
<td>– Contraindication, drug-drug interaction, or adverse reaction to Xarelto®</td>
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<tr>
<td></td>
<td>• Diagnosis of thromboprophylaxis following hip replacement surgery; AND</td>
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<tr>
<td></td>
<td>– Contraindication, drug-drug interaction, or adverse reaction to Xarelto®</td>
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</tbody>
</table>
**CARDIOVASCULAR**

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Oral Anticoagulants (continued)</td>
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<tr>
<td>Savaysa®</td>
<td>NP</td>
<td>Will be approved for recipients meeting the following criteria:</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of non-valvular atrial fibrillation, deep vein thrombosis, OR pulmonary embolism; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>– Failure of warfarin therapy due to inability to maintain therapeutic INR; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>– Recipient does not have access to adequate monitoring services for warfarin therapy; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>– Non-bleeding related contraindication to warfarin therapy; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>– Documentation that CrCl NOT ≥ 95 mL/min as calculated by Cockcroft-Gault equation; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>– Contraindication, drug-drug interaction, or adverse reaction to Xarelto®</td>
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<tr>
<td>Pheochromocytoma Agents</td>
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<tr>
<td>Demser®</td>
<td>NP</td>
<td>Will be approved for patients who meet ALL of the following criteria:</td>
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<td>General PA Form</td>
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<tr>
<td></td>
<td></td>
<td>• Documentation of pheochromocytoma diagnosis; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Trial and failure of an alpha and beta blocker</td>
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<tr>
<td>dibenzyline</td>
<td>NP</td>
<td>Will be approved for patients who meet the following criteria:</td>
<td>4/day</td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of pheochromocytoma diagnosis</td>
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<tr>
<td>phenoxybenzamine</td>
<td>NP</td>
<td>See dibenzyline prior authorization criteria</td>
<td>4/day</td>
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<tr>
<td>Platelet Inhibitors</td>
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<tr>
<td>Brilinta®</td>
<td>P</td>
<td>Will be authorized in patients who meet the following criteria:</td>
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<tr>
<td></td>
<td></td>
<td>• History of Myocardial Infarction (MI); <strong>OR</strong></td>
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<td></td>
<td></td>
<td>• ACS initial event (USA, NSTEMI or STEMI) or recurrence within previous 12 months</td>
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<td></td>
<td></td>
<td>• Will not be approved in patients receiving aspirin doses &gt; 100mg per day (including Rx or OTC aspirin or aspirin-containing products).</td>
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<tr>
<td>Durlaza®</td>
<td>NP</td>
<td>Will be approved for patients meeting ALL of the following:</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trial and failure, contraindication or intolerance to 2 preferred platelet inhibitor agents approved for the same indication; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• OTC aspirin</td>
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<tr>
<td>Effient®</td>
<td>NP</td>
<td>Will be approved in patients with unstable angina, NSTEMI, or STEMI who met ALL of the following criteria:</td>
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<td></td>
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<td>• PCI has been performed or PCI is planned</td>
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<td>• Age &lt; 75 years</td>
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<td>• Weight ≥ 60 kg</td>
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<td></td>
<td></td>
<td>• No history of stroke or TIA</td>
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<td></td>
<td></td>
<td>• Contraindication, drug-drug interaction, or intolerance to Brilinta®</td>
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</tr>
<tr>
<td>prasugrel</td>
<td>NP</td>
<td>See Effient® prior authorization criteria</td>
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</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### Platelet Inhibitors (continued)

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Yosprala*</td>
<td>NP</td>
<td>Will be approved if patient meets the following criteria:</td>
<td>1/day</td>
<td>General PA Form</td>
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<tr>
<td></td>
<td></td>
<td>- Diagnosis of:</td>
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<tr>
<td></td>
<td></td>
<td>- Ischemic stroke,</td>
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<td></td>
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<td>- Transient ischemia of the brain,</td>
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<td></td>
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<td>- Previous myocardial infarction,</td>
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<td></td>
<td></td>
<td>- Unstable angina pectoris,</td>
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<td></td>
<td></td>
<td>- Chronic stable angina pectoris; AND</td>
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<td></td>
<td></td>
<td>- Patient has had ONE of the following:</td>
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<tr>
<td></td>
<td></td>
<td>- Coronary Artery Bypass Graft (CABG), OR</td>
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<tr>
<td></td>
<td></td>
<td>- Percutaneous Transluminal Coronary Angioplasty (PTCA); AND</td>
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<td></td>
<td></td>
<td>- Patient meets ALL of the following:</td>
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<td></td>
<td></td>
<td>- Patient is considered a high-risk candidate for aspirin-associated gastric ulcers due to ONE of the following:</td>
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<td></td>
<td></td>
<td>- Age ≥ 55, OR</td>
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<tr>
<td></td>
<td></td>
<td>- Documented history of gastric ulcers; AND</td>
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<td></td>
<td>- Patient had an inadequate treatment response, or intolerance to use of aspirin and omeprazole separately</td>
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<tr>
<td>Zontivity™</td>
<td>NP</td>
<td>Will be approved for patients meeting the following criteria:</td>
<td>1/day</td>
<td>General PA Form</td>
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<td></td>
<td></td>
<td>- Diagnosis of history of MI or PAD</td>
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<td></td>
<td></td>
<td>- Patients must not have a history of stroke, TIA, ACS, GI bleed, or peptic ulcer due to the risk of bleeding</td>
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<td></td>
<td></td>
<td>- Concomitant therapy with clopidogrel, unless patient has a contraindication to clopidogrel, in which case patient must have concomitant therapy with aspirin</td>
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</tr>
</tbody>
</table>

### Potassium-Sparing Diuretics

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>CaroSpir®</td>
<td>NP</td>
<td>No PA required for patients less than 6 years of age</td>
<td>15 mL/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For patients ≥ 6 years old, will be approved for patients unable to swallow tablets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>eplerenone</td>
<td>NP</td>
<td>Will be approved for recipients meeting the following:</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient has a diagnosis of heart failure; AND</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Patient has history of an adequate trial and failure on spironolactone; OR</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Patient has history of inability to tolerate spironolactone due to documented endocrine adverse effects or other adverse drug reactions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inspra®</td>
<td>NP</td>
<td>See eplerenone prior authorization criteria.</td>
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</tr>
</tbody>
</table>

### Pulmonary Arterial Hypertension Agents

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>sildenafil</td>
<td>P</td>
<td>Approval will be granted if ALL of the following criteria are met:</td>
<td>3/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Diagnosis of Pulmonary Arterial Hypertension (PAH)/ Elevated Pulmonary Vascular Resistance or Primary Pulmonary Hypertension (PPH); AND</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- A WHO Functional Class (FC) II-IV or age less than 11 years</td>
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</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
## Pulmonary Arterial Hypertension Agents (continued)

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>tadalafil</td>
<td>P</td>
<td>See sildenafil prior authorization criteria</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>Tracleer®</td>
<td>P</td>
<td>Approval will be granted if ALL of the following criteria are met:</td>
<td>2.9 mL/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Pulmonary Arterial Hypertension (PAH)/Elevated Pulmonary Vascular Resistance or Primary Pulmonary Hypertension (PPH); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A WHO Functional Class (FC) II-IV or age less than 11 years; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient is unable to swallow tablets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tracleer®</td>
<td>P</td>
<td>Approval will be granted if ALL of the following criteria are met:</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Pulmonary Arterial Hypertension (PAH)/Elevated Pulmonary Vascular Resistance or Primary Pulmonary Hypertension (PPH); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A WHO Functional Class (FC) II-IV or age less than 11 years</td>
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</tr>
<tr>
<td>Letairis®</td>
<td>P</td>
<td>Approval will be granted if ALL of the following criteria are met:</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Tyvaso®</td>
<td>P</td>
<td>See sildenafil prior authorization criteria</td>
<td>2.9 mL/day</td>
<td></td>
</tr>
<tr>
<td>Ventavis®</td>
<td>P</td>
<td>See sildenafil prior authorization criteria</td>
<td>3 mL/day</td>
<td></td>
</tr>
<tr>
<td>Adcirca®</td>
<td>NP</td>
<td>Approval will be granted if ALL of the following criteria are met:</td>
<td>2/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Pulmonary Arterial Hypertension (PAH)/Elevated Pulmonary Vascular Resistance or Primary Pulmonary Hypertension (PPH); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Trial of ONE preferred agent with persistent signs or symptoms; <strong>AND</strong></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A WHO Functional Class (FC) II-IV or age less than 11 years</td>
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</tr>
<tr>
<td>Adempas®</td>
<td>NP</td>
<td>Approval will be granted if ALL of the following criteria are met:</td>
<td>3/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Pulmonary Arterial Hypertension (PAH)/Elevated Pulmonary Vascular Resistance or Primary Pulmonary Hypertension (PPH); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Trial of ONE preferred agent with persistent signs or symptoms; <strong>AND</strong></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>• A WHO Functional Class (FC) II-IV or age less than 11 years; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) that is inoperable, or patient has residual post-pulmonary endarterectomy hypertension</td>
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<td></td>
<td></td>
<td><strong>Note:</strong> Use of Adempas® is contraindicated in patients also taking PDE-5 inhibitors</td>
<td></td>
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<tr>
<td>ambrisentan</td>
<td>NP</td>
<td>See Adcirca® prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>bosentan</td>
<td>NP</td>
<td>See Adcirca® prior authorization criteria</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>Opsumit®</td>
<td>NP</td>
<td>Approval will be granted if ALL of the following criteria are met:</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Pulmonary Arterial Hypertension (PAH)/Elevated Pulmonary Vascular Resistance or Primary Pulmonary Hypertension (PPH); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Trial of ONE preferred agent with persistent signs or symptoms; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• A WHO Functional Class (FC) II-IV or age less than 11 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orenitram® ER</td>
<td>NP</td>
<td>See Adcirca® prior authorization criteria</td>
<td>3/day</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
**CARDIOVASCULAR**

*Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.*

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pulmonary Arterial Hypertension Agents (continued)</strong></td>
<td></td>
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</tr>
<tr>
<td>Revatio® tab</td>
<td>NP</td>
<td>Approval will be granted if ALL of the following criteria are met:</td>
<td>3/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Pulmonary Arterial Hypertension (PAH)/ Elevated Pulmonary Vascular Resistance or Primary Pulmonary Hypertension (PPH); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A WHO Functional Class (FC) II-IV or age less than 11 years; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Dosing that will not allow the use of preferred sildenafil tablets to be crushed</td>
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<tr>
<td></td>
<td></td>
<td>See Adcirca® prior authorization criteria</td>
<td></td>
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</tr>
<tr>
<td>Revatio® suspension</td>
<td>NP</td>
<td>Approval will be granted if ALL of the following criteria are met:</td>
<td>6 ml/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Pulmonary Arterial Hypertension (PAH)/ Elevated Pulmonary Vascular Resistance or Primary Pulmonary Hypertension (PPH); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• A WHO Functional Class (FC) II-IV or age less than 11 years; <strong>AND</strong></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Dosing that will not allow the use of preferred sildenafil tablets to be crushed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sildenafil suspension</td>
<td>NP</td>
<td>Approval will be granted if ALL of the following criteria are met:</td>
<td>6 ml/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Pulmonary Arterial Hypertension (PAH)/ Elevated Pulmonary Vascular Resistance or Primary Pulmonary Hypertension (PPH); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A WHO Functional Class (FC) II-IV</td>
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<tr>
<td></td>
<td></td>
<td>See Revatio® suspension prior authorization criteria</td>
<td></td>
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</tr>
<tr>
<td>Uptravi®</td>
<td>NP</td>
<td>Approval will be granted if ALL of the following criteria are met:</td>
<td>2/day; Dose titration pack: 1 pack (200 tabs)/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Pulmonary Arterial Hypertension (PAH)/ Elevated Pulmonary Vascular Resistance or Primary Pulmonary Hypertension (PPH); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trial of ONE preferred agent with persistent signs or symptoms; <strong>AND</strong></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A WHO Functional Class (FC) II-IV</td>
<td></td>
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</tr>
<tr>
<td><strong>Pulmonary Fibrosis</strong></td>
<td></td>
<td>Will be approved for patients who meet the following criteria:</td>
<td>9/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Esbriet®</td>
<td>NP</td>
<td>• Diagnosis of idiopathic pulmonary fibrosis; <strong>AND</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Prescribed by or in consultation with a Pulmonologist (initial approval only)</td>
<td></td>
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</tr>
<tr>
<td>Ofev®</td>
<td>NP</td>
<td>See Esbriet® prior authorization criteria</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td><strong>Thrombopoietin Agonists</strong></td>
<td></td>
<td>Will be approved if ALL the following is met:</td>
<td>15 tabs/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Doptelet®</td>
<td>NP</td>
<td>• Patient is ≥ 18 years old; <strong>AND</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Patient has a diagnosis of Chronic Liver Disease (CLD); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Patient has a platelet count of &lt; 50 x 10⁹/L; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Patient has an upcoming invasive procedure scheduled; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Patient is prescribed a dose according to their baseline platelet count (10 tablets per 5 days ≥ 40 x 10⁹/L or 15 tablets per 5 days for platelets &lt; 40 x 10⁹/L); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Patient is scheduled to take the requested agent 10 to 13 days prior to the procedure, with the procedure occurring 5 to 8 days following the last dose of avatrombopag.</td>
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</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
CARDIOVASCULAR

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<tr>
<th>Medication</th>
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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Thrombopoietin Agonists (continued)</strong></td>
<td></td>
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</tr>
</tbody>
</table>
| Mulpleta* | NP | Will be approved if **ALL** the following is met (PA duration – single course of treatment per scheduled procedure):  
- Patient is ≥ 18 years old; **AND**  
- Patient has a diagnosis of Chronic Liver Disease (CLD); **AND**  
- Patient does NOT have Child-Pugh class C liver disease, absence of hepatopetal blood flow, a prothrombotic condition other than CLD nor a history of splenectomy, partial splenic embolization, or thrombosis; **AND**  
- Patient has a platelet count of < 50 x 10^9/L; **AND**  
- Patient has an upcoming invasive procedure scheduled; **AND**  
- Patient is scheduled to take the requested agent 8 to 14 days prior to the procedure, with the procedure occurring 2 to 8 days following the last dose of lusutrombopag; **AND**  
- Patient is NOT scheduled for a thoracotomy, laparotomy, open-heart surgery, craniotomy, or organ resection. | 7 tabs/Rx | |
| Promacta* | NP | Approval will be granted if **ONE** of the following criteria are met:  
- Diagnosis of idiopathic thrombocytopenia purpura (ITP); **AND**  
  - Documentation of failure or insufficient response to adequate treatment with corticosteroids AND immunoglobulins, OR ITP related splenectomy; **AND**  
  - Documentation that patient’s thrombocytopenia and clinical condition puts the patient at increased risk of bleeding.  
- Diagnosis of thrombocytopenia in patient with chronic hepatitis C; **AND**  
  - Patient receiving (or planning to initiate) interferon-based anti-viral therapy  
- Diagnosis of severe aplastic anemia; **AND**  
  - Patient has tried and failed or has intolerance to immunsuppressive therapy | 1/day | General PA Form |
| Tavalisse* | NP | Will be approved if the following is met:  
- Patient has a diagnosis of chronic immune thrombocytopenia; **AND**  
- Patient has tried/failed at least one other therapy for chronic ITP (and not achieved a platelet count ≥ 50 x 10^9/L):  
  - Corticosteroids;  
  - thrombopoietin receptor antagonists (e.g., Promacta);  
  - azathioprine (Azasan, Imuran), cyclosporine (Neoral, Sandimmune), cyclophosphamide (Cytoxan), mycophenolate mofetil (CellCept), danazol, or rituximab (Rituxan); **AND**  
- Patient is not on concomitant therapy with a strong CYP3A4 inducer; **AND**  
- Patient has received a baseline and will receive ongoing routine monitoring including:  
  - CBC (including platelet & neutrophil count), and LFTs monthly,  
  - Blood pressure every 2 weeks until stable dose established, then monthly.  
**Renewal Criteria**  
- Patient has laboratory values documenting platelet response to therapy (platelet count ≥ 50 x 10^9/L; **AND**  
- Patient has not experienced severe adverse effect as a result of fostamatinib therapy. | 2/day | |

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### CARDIOVASCULAR

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<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Vasodilator/Nitrate Combos</strong></td>
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<tr>
<td>BiDil®</td>
<td>NP</td>
<td>Will be approved for patients who meet <strong>ALL</strong> of the following criteria:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of heart failure</td>
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<td></td>
<td></td>
<td>• Currently on standard therapy for heart failure (loop diuretic, ACE inhibitor/ARB, and beta-blocker)</td>
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<tr>
<td></td>
<td></td>
<td>• Failure to achieve adequate response on concomitant therapy with the individual components</td>
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<tr>
<td><strong>Vasopressors</strong></td>
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</tr>
<tr>
<td>Northera*</td>
<td>NP</td>
<td>Will be approved for patients who meet the following criteria:</td>
<td>100 and 200 mg: 3/day</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of symptomatic neurogenic orthostatic hypotension secondary to primary autonomic failure, dopamine</td>
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<tr>
<td></td>
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<td>beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Trial and failure, contraindication or intolerance to midodrine OR fludrocortisone</td>
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<tr>
<td><strong>Vasopressor Receptor Antagonists</strong></td>
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<tr>
<td>Jynarque*</td>
<td>NP</td>
<td>Will be approved if the following is met: (initial PA duration: 6 months)</td>
<td>2/day</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Patient has a diagnosis of autosomal dominant polycystic kidney disease (ADPKD); <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Patient does not have a known hypersensitivity to tolvaptan; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Patient does not have any of the following:</td>
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<td></td>
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<td>• History of signs or symptoms of significant liver impairment or injury (not including uncomplicated polycystic</td>
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<tr>
<td></td>
<td></td>
<td>liver disease);</td>
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<td></td>
<td>• Uncorrected abnormal blood sodium concentrations;</td>
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<td></td>
<td></td>
<td>• Hypovolemia;</td>
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<td></td>
<td></td>
<td>• Uncorrected urinary outflow obstruction; <strong>OR</strong></td>
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<td></td>
<td></td>
<td>• Anuria; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Patient does not concurrently use a strong CYP 3A inhibitors; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• A baseline alanine aminotransferase (ALT), aspartate aminotransferase (AST), and bilirubin have been performed and are within normal range (results must be within 3 months of request).</td>
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</tr>
<tr>
<td><strong>Renewal Criteria (PA duration: 6 months)</strong></td>
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<td></td>
<td></td>
<td>Patients must:</td>
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<tr>
<td></td>
<td></td>
<td>• Continue to meet the above criteria; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Patient’s most recent ALT, AST, and bilirubin are within normal range (results must be within 3 months of request).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Samsca*</td>
<td>NP</td>
<td>Will be approved for patients who meet the following criteria:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of hyponatremia; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Medication was initiated in a hospital setting</td>
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</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### CENTRAL NERVOUS SYSTEM

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
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</tr>
</thead>
<tbody>
<tr>
<td>gabapentin capsules</td>
<td>P</td>
<td><strong>Agents for Neuropathic Pain</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Cymbalta®                   | NP  | • Provider must submit the patient’s diagnosis/medical description for which the drug is requested; **AND**  
• Provider must provide documentation why the requested drug for the requested indication is the only appropriate choice versus duloxetine capsules (generic for Irenka®) | 2/day                        | SNRI PA Form     |
| DermacinRx®                 | NP  |                                                                                              | 1/day                        | General PA Form  |
| Duloxetine caps (generic for Irenka®) | NP | **Gabalpentin solution** will be approved for recipients who meet ALL of the following criteria:**  
• Inability to swallow solid oral dosage forms; **AND**  
• Inability to open capsule and empty contents in food or drink  
**Note:** Prior authorization criteria are waived for recipients 12 years of age and under. | 72 mL/day  
Max total daily gabapentin dose: 3600mg |                  |
| Gabapentin solution         | NP  | Will be approved for recipients who meet the following criteria:**  
Documented allergy or contraindication to an inactive ingredient in the capsules that is NOT present in the tablets | 100 and 600mg (6/day)  
300 mg (12/day)  
400 mg (9/day)  
800 mg (4.5/day)  
Max total daily gabapentin dose: 3600mg | General PA Form  |
| Gabapentin tablets          | NP  | **Gralise®** will be approved for patients with a diagnosis of post-herpetic neuralgia who have and failed gabapentin **AND** had a failure, contraindication or intolerance to ONE of the following:**  
• A tricyclic antidepressant  
• An anticonvulsant (other than gabapentin)  
**Note:** Prior authorization criteria are waived for recipients 12 years of age and under. | 3/day  
Max total daily gabapentin dose: 3600mg |                  |
| Gralise®                    | NP  | **Horizant®** will be approved for patients meeting the following criteria:**  
• Diagnosis of Restless Leg Syndrome, **AND** trial and failure, contraindication or intolerance to BOTH pramipexole **AND** ropinirole  
• Diagnosis of post-herpetic neuralgia who have and failed gabapentin **AND** had a failure, contraindication or intolerance to ONE of the following:**  
  - A tricyclic antidepressant  
  - An anticonvulsant (other than gabapentin)  
**Note:** Prior authorization criteria are waived for recipients 12 years of age and under. | 1/day  
Max total daily gabapentin dose: 3600mg |                  |

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### CENTRAL NERVOUS SYSTEM

*Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.*

#### Agents for Neuropathic Pain (continued)

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</thead>
</table>
| lidocaine patches   | NP  | Will be approved for patients with a diagnosis of neuropathic pain who have had a failure of, contraindication to, or intolerance of:  
  - One tricyclic antidepressant **AND** one anticonvulsant; **OR**  
  - Two anticonvulsants                                                                                                                                                                                                                                                                                | 2/day       |         |
| Lidoderm*           | NP  | Will be approved for patients with a diagnosis of neuropathic pain who have had a failure of, contraindication to, or intolerance of:  
  - One tricyclic antidepressant **AND** one anticonvulsant; **OR**  
  - Two anticonvulsants                                                                                                                                                                                                                                                                                |             |         |
| Lyrica*             | NP  | Lyrica® will be approved if **ONE** of the following criteria has been met:  
  - Diagnosis of seizure disorder **AND** recipient has tried and failed at least TWO preferred anticonvulsants  
  - Diagnosis of diabetic peripheral neuropathy  
  - Diagnosis of fibromyalgia  
    - Recipient MUST have tried and failed, or have contraindication or intolerance to a tricyclic antidepressant, muscle relaxant, SSRI, SNRI, or gabapentin.  
  - Diagnosis of postherpetic neuralgia, neuropathic pain, or other, non-diabetic peripheral neuropathy  
  
  Recipient MUST have tried and failed, or have contraindication, or intolerance to a tricyclic antidepressant OR gabapentin.                                                                                                                                                                                                 |             |         |
| Lyrica® CR          | NP  | Will be approved if the following has been met:  
  - Diagnosis of postherpetic neuralgia OR neuropathic pain associated with-diabetic peripheral neuropathy; **AND**  
  - Recipient MUST have tried and failed, or have contraindication or intolerance to a tricyclic antidepressant OR gabapentin; **AND**  
    - Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus immediate-release pregabalin                                                                                                                                 | 1/day: 82.5mg & 165mg; 2/day: 330mg | General PA Form |
| Neurontin*          | NP  |                                                                                                                                                                                                                                                                                                                                                           |             |         |
| Neurontin® solution | NP  |                                                                                                                                                                                                                                                                                                                                                           |             |         |
| pregabalin capsules | NP  | See Lyrica® prior authorization criteria                                                                                                                                                                                                                                                                                                                   |             |         |
| pregabalin solution | NP  | See Lyrica® solution prior authorization criteria                                                                                                                                                                                                                                                                                                         |             |         |

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**Effective Date:** December 2, 2019
### CENTRAL NERVOUS SYSTEM

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<tbody>
<tr>
<td><strong>Agents for Restless Leg Syndrome</strong></td>
<td></td>
<td><strong>Pramipexole</strong>&lt;br&gt;Horizant® will be approved for patients meeting the following criteria:&lt;br&gt;- Diagnosis of Restless Leg Syndrome, <strong>AND</strong> trial and failure, contraindication or intolerance to BOTH pramipexole <strong>AND</strong> ropinirole&lt;br&gt;- Diagnosis of post-herpetic neuralgia who have and failed gabapentin <strong>AND</strong> had a failure, contraindication or intolerance to ONE of the following:&lt;br&gt;  - A tricyclic antidepressant&lt;br&gt;  - An anticonvulsant (other than gabapentin)</td>
<td>3/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td><strong>Horizant</strong></td>
<td>NP</td>
<td></td>
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</tr>
<tr>
<td><strong>Mirapex</strong></td>
<td>NP</td>
<td>Neupro® will be approved for patient with a diagnosis of Parkinson’s Disease or Restless Leg Syndrome, <strong>AND</strong>&lt;br&gt;- Trial and failure, contraindication or intolerance to BOTH pramipexole <strong>AND</strong> ropinirole, <strong>OR</strong>&lt;br&gt;- Inability to swallow</td>
<td>3/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td><strong>Neupro</strong></td>
<td>NP</td>
<td></td>
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<tr>
<td><strong>Amyotrophic Lateral Sclerosis (ALS)</strong></td>
<td></td>
<td><strong>Tiglutik</strong>&lt;br&gt;Will be approved for patients who meet the following criteria:&lt;br&gt;- Diagnosis of Amyotrophic Lateral Sclerosis (ALS); <strong>AND</strong>&lt;br&gt;- Patient is unable to swallow tablets</td>
<td>20 mL/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td><strong>Alzheimer’s: Cholinesterase Inhibitors</strong></td>
<td></td>
<td><strong>Donepezil (excluding 23 mg)</strong>&lt;br&gt;Will be approved for patients who are:&lt;br&gt;- Unable to swallow; <strong>OR</strong>&lt;br&gt;- Unable to absorb medications through the GI tract</td>
<td>1/day</td>
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<tr>
<td><strong>Donepezil ODT</strong></td>
<td>P</td>
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<tr>
<td><strong>Exelon® Patch</strong></td>
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<tr>
<td><strong>Aricept</strong></td>
<td>NP</td>
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<tr>
<td><strong>Aricept® 23 mg</strong></td>
<td>NP</td>
<td>Will be approved if patient has been established (at least 3 months) on therapy with Aricept 10mg daily</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td><strong>Aricept® ODT</strong></td>
<td>NP</td>
<td>See donepezil ODT prior authorization criteria.</td>
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<tr>
<td><strong>Donepezil 23 mg</strong></td>
<td>NP</td>
<td>See Aricept® 23 mg prior authorization criteria.</td>
<td>1/day</td>
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<tr>
<td><strong>Galantamine ER</strong></td>
<td>NP</td>
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<tr>
<td><strong>Razadyne® ER</strong></td>
<td>NP</td>
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<tr>
<td><strong>Rivastigmine patch</strong></td>
<td>NP</td>
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<tr>
<td>memantine tablets</td>
<td>P</td>
<td>Will only be approved for patients with a diagnosis of moderate to severe Alzheimer's disease.</td>
<td>5, 10mg (2/day); Titration Pack (1 per Rx);</td>
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</tr>
<tr>
<td>memantine ER</td>
<td>NP</td>
<td>See memantine solution prior authorization criteria</td>
<td>1/day</td>
<td>General PA</td>
</tr>
<tr>
<td>memantine solution</td>
<td>NP</td>
<td>Will only be approved for patients with a diagnosis of moderate to severe Alzheimer's disease.</td>
<td>10mL/day</td>
<td>See memantine</td>
</tr>
<tr>
<td>Namenda*</td>
<td>NP</td>
<td>Will only be approved for patients with a diagnosis of moderate to severe Alzheimer's disease.</td>
<td>1/day</td>
<td>General PA</td>
</tr>
<tr>
<td>Namenda XR*</td>
<td>NP</td>
<td>Will be approved for recipients who meet ALL of the following criteria:</td>
<td>1/day</td>
<td>General PA</td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of moderate to severe Alzheimer's disease; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Documented intolerance or contraindication to an inactive ingredient that is present in the regular-release product, but NOT in the XR product</td>
<td></td>
<td>General PA</td>
</tr>
<tr>
<td>Namzaric*</td>
<td>NP</td>
<td>Will be approved for patients meeting ALL of the following criteria:</td>
<td>1/day</td>
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<td></td>
<td></td>
<td>• Diagnosis of moderate to severe demential associated with Alzheimer's disease</td>
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<td></td>
<td></td>
<td>• Concomitantly taking donepezil and memantine (immediate release or extended release) [≥10mg/day on both agents]</td>
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<td></td>
<td></td>
<td>• Clinical reason why recipient is unable to take the components individually</td>
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<tr>
<td>Gocovri*</td>
<td>NP</td>
<td>Will be approved if ALL the following are met:</td>
<td>68.5 mg (1/day); 137 mg (2/day)</td>
<td>General PA</td>
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<tr>
<td></td>
<td></td>
<td>• Patient has a diagnosis of dyskinesia associated with Parkinson's disease; <strong>AND</strong></td>
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<td></td>
<td>• Patient must be on concomitant levodopa-based therapy; <strong>AND</strong></td>
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<td></td>
<td>• Patient has tried/failed an adequate trial of or is intolerant to amantadine immediate-release; <strong>AND</strong></td>
<td></td>
<td>General PA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient does not have End-stage renal disease (creatinine clearance &lt; 15 mL/min/1.73 m²); <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Patient will NOT receive live vaccines during treatment (inactivated vaccines may be utilized).</td>
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<tr>
<td>Osmolex* ER</td>
<td>NP</td>
<td>Will be approved if the following are met:</td>
<td>1/day: 193mg &amp; 258mg; 2/day: 129mg</td>
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<td>• Patient has a diagnosis of Parkinson's disease or drug-induced extrapyramidal reactions; <strong>AND</strong></td>
<td></td>
<td>General PA</td>
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<td></td>
<td></td>
<td>• Patient does not have a known hypersensitivity to amantadine; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Patient does not have end-stage renal disease (creatinine clearance below 15 mL/min/1.73 m²); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Patient will NOT receive live vaccines during treatment (inactivated vaccines may be utilized); <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Patient has had an adequate trial of or is intolerant to amantadine IR (capsules); <strong>AND</strong></td>
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<td></td>
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<td>• For a diagnosis of Parkinson’s Disease:</td>
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<td></td>
<td>− Patient has a trial/failure, contraindication, or intolerance to at least 2 preferred Parkinson’s disease treatments; <strong>OR</strong></td>
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<td>• For a diagnosis of drug-induced extrapyramidal reactions;</td>
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<td></td>
<td>− Patient has a trial/failure, contraindication or intolerance to at least 2 preferred agents for treatment of the indication.</td>
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<tr>
<td><strong>Renewal Criteria</strong></td>
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<td>• Patient meets the following:</td>
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<td></td>
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<td>• Patient meets initial criteria; <strong>AND</strong></td>
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<td>• Patient has shown documented efficacy as defined by control of Parkinson’s disease symptoms OR decreased extrapyramidal effects; <strong>AND</strong></td>
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<td></td>
<td>• Patient has not experienced any treatment-restricting adverse effects (e.g., falling asleep while engaged in activities of daily living, compulsive behaviors, suicidal ideation, or exacerbation of psychosis).</td>
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</tr>
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**CENTRAL NERVOUS SYSTEM**

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<tr>
<td><strong>Anti-anxiety Agents</strong></td>
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<tr>
<td><strong>CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENT’S WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):</strong></td>
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<tr>
<td>Anti-anxiety agents prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if ONE of the following is met:</td>
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<tr>
<td>• Prescriber has completed the State’s training program on the appropriate use of psychotropic medications for individuals with I/DD:</td>
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<tr>
<td>- Training available at: <a href="https://vkc.mc.vanderbilt.edu/etoolkit/cme/">https://vkc.mc.vanderbilt.edu/etoolkit/cme/</a>;</td>
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<tr>
<td>• Note: 1.5 hours of free continuing medical education units are available upon completion of the 90-minute training. Completion of training is required only once, regardless of the number of patients with I/DD. Training can be completed in 10–15-minute intervals in any order and dispersed per preferences of the reviewer; AND</td>
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<tr>
<td>- Provide signature, module #, and date course was completed; OR</td>
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<tr>
<td>• Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; (a Primary Care Provider Checklist of Behavioral/Emotional Concerns is available at: <a href="http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf">http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf</a>; AND</td>
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<tr>
<td>- Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; AND</td>
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<tr>
<td>- Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers. Example available at: <a href="http://vkc.mc.vanderbilt.edu/etoolkit/wpcontent/uploads/CrisisManagementPlan.pdf">http://vkc.mc.vanderbilt.edu/etoolkit/wpcontent/uploads/CrisisManagementPlan.pdf</a>; OR</td>
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<tr>
<td>• Short-term therapy has been prescribed and meets the following:</td>
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<tr>
<td>- Behavioral symptoms significant enough to place the person at potential risk or needing higher level of care or loss of community placement; AND</td>
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<tr>
<td>- Efficacy and potential side effects to be monitored; AND</td>
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<tr>
<td>- Need for requested medication will be evaluated once other non-pharmacological interventions have been tried; OR</td>
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<tr>
<td>• Short-term therapy has been prescribed, and meets the following:</td>
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<tr>
<td>- Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; AND</td>
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<tr>
<td>- Efficacy and potential side effects to be monitored; AND</td>
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</tr>
<tr>
<td>- Need for requested medication will be evaluated once other non-pharmacological interventions have been tried.</td>
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<tr>
<td><strong>Note the following:</strong></td>
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<tr>
<td>• Duration of short-term therapy is 90 days for Anti-Anxiety Agents</td>
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<tr>
<td>• Patients with disorders related to I/DD AND a concomitant diagnosis specified with drug specific criteria will be subject to the diagnosis specific criteria.</td>
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<tr>
<td>• Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.</td>
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</tr>
<tr>
<td>• The I/DD Worksheet can be found at: <a href="https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf">https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf</a></td>
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<tr>
<td>alprazolam</td>
<td>P</td>
<td>• Diagnosis of anxiety disorder; AND</td>
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<tr>
<td></td>
<td></td>
<td>- Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., Cognitive Behavioral Therapy, Worry Exposure, Applied Relaxation, Muscle Relaxation, Short-term Psychodynamic Psychotherapy, Mindfulness-based Therapy); AND</td>
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<td></td>
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<td>- Recipient has tried and failed, or have a contraindication or intolerance to:</td>
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<tr>
<td></td>
<td></td>
<td>- Two SSRIs (minimum trial duration of 3 weeks each)</td>
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<td></td>
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<td>- Two SNRIs (minimum trial duration of 3 weeks each)</td>
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<td></td>
<td></td>
<td>- Buspirone</td>
<td></td>
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<td></td>
<td></td>
<td>• Due to increased risk of toxicity, patient should not be pregnant OR concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates; AND</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse</td>
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<td></td>
<td></td>
<td>tabs: 3/day</td>
<td></td>
<td>Benzo- diazepine PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>concentrate: 6 mL/day</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### CENTRAL NERVOUS SYSTEM

**Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Anti-anxiety Agents (continued)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>buspirone (excluding 30 mg)</td>
<td>P</td>
<td>• Diagnosis of anxiety disorder; <strong>AND</strong>&lt;br&gt;  - Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., Cognitive Behavioral Therapy, Worry Exposure, Applied Relaxation, Muscle Relaxation, Short-term Psychodynamic Psychotherapy, Mindfulness-based Therapy); <strong>AND</strong>&lt;br&gt;  - Recipient has tried and failed, or have a contraindication or intolerance to:&lt;br&gt;    • Two SSRIs (minimum trial duration of 3 weeks each)&lt;br&gt;    • Two SNRIs (minimum trial duration of 3 weeks each)&lt;br&gt;    • Buspirone&lt;br&gt;  • Due to increased risk of toxicity, patient should not be pregnant <strong>OR</strong> concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates; <strong>AND</strong>&lt;br&gt;  • Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse <strong>OR</strong> pt has diagnosis of acute alcohol withdrawal</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td>chlorpromazine</td>
<td>P</td>
<td>• Diagnosis of seizure disorder <strong>AND</strong> recipient has tried and failed at least <strong>TWO</strong> preferred anticonvulsants AND must be used in conjunction with another anticonvulsant&lt;br&gt;  • Diagnosis of anxiety disorder; <strong>AND</strong>&lt;br&gt;  - Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., Cognitive Behavioral Therapy, Worry Exposure, Applied Relaxation, Muscle Relaxation, Short-term Psychodynamic Psychotherapy, Mindfulness-based Therapy); <strong>AND</strong>&lt;br&gt;  - Recipient has tried and failed, or have a contraindication or intolerance to:&lt;br&gt;    • Two SSRIs (minimum trial duration of 3 weeks each)&lt;br&gt;    • Two SNRIs (minimum trial duration of 3 weeks each)&lt;br&gt;    • Buspirone&lt;br&gt;  • Due to increased risk of toxicity, patient should not be pregnant <strong>OR</strong> concurrently taking CNS stimulants, opiates, carisoprodol/meprobamate, or barbiturates; <strong>AND</strong>&lt;br&gt;  • Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse <strong>OR</strong> pt has diagnosis of acute alcohol withdrawal</td>
<td>4/day</td>
<td>Benzo- diazepine PA Form</td>
</tr>
<tr>
<td>clorazepate</td>
<td>P</td>
<td>• Diagnosis of anxiety disorder; <strong>AND</strong>&lt;br&gt;  - Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., Cognitive Behavioral Therapy, Worry Exposure, Applied Relaxation, Muscle Relaxation, Short-term Psychodynamic Psychotherapy, Mindfulness-based Therapy); <strong>AND</strong>&lt;br&gt;  - Recipient has tried and failed, or have a contraindication or intolerance to:&lt;br&gt;    • Two SSRIs (minimum trial duration of 3 weeks each)&lt;br&gt;    • Two SNRIs (minimum trial duration of 3 weeks each)&lt;br&gt;    • Buspirone&lt;br&gt;  • Due to increased risk of toxicity, patient should not be pregnant <strong>OR</strong> concurrently taking CNS stimulants, opiates, carisoprodol/meprobamate, or barbiturates; <strong>AND</strong>&lt;br&gt;  • Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse <strong>OR</strong> pt has diagnosis of acute alcohol withdrawal</td>
<td>3/day</td>
<td></td>
</tr>
</tbody>
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### CENTRAL NERVOUS SYSTEM

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<td><strong>Anti-anxiety Agents (continued)</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
| diazepam  | P   | • Diagnosis of seizure disorder AND recipient has tried and failed at least TWO preferred anticonvulsants AND must be used in conjunction with another anticonvulant  
  • Diagnosis of muscle spasms  
  • Diagnosis of anxiety disorder, AND  
  – Documented trial (at least three weeks) of non-pharmacological therapies (e.g., Cognitive Behavioral Therapy, Worry Exposure, Applied Relaxation, Muscle Relaxation, Short-term Psychodynamic Psychotherapy, Mindfulness-based Therapy), AND  
  – Recipient has tried and failed, or have a contraindication or intolerance to:  
  • Two SSRIs (minimum trial duration of three weeks each)  
  • Two SNRIs (minimum trial duration of three weeks each)  
  • Buspirone  
  • Due to increased risk of toxicity, patient should not be pregnant OR concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates AND  
  • Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse OR pt has diagnosis of acute alcohol withdrawal | tabs: 4/day soln: 10 mL/day concentrate: 2 mL/day | Benzo-diazepine PA Form |
| lorazepam | P   | • Diagnosis of anxiety disorder; AND  
  – Documented trial (at least three weeks) of non-pharmacological therapies (e.g., Cognitive Behavioral Therapy, Worry Exposure, Applied Relaxation, Muscle Relaxation, Short-term Psychodynamic Psychotherapy, Mindfulness-based Therapy); AND  
  – Recipient has tried and failed, or have a contraindication or intolerance to:  
  • Two SSRIs (minimum trial duration of three weeks each)  
  • Two SNRIs (minimum trial duration of three weeks each)  
  • Buspirone  
  • Patients less than one year of age and completing taper following inpatient hospital use  
  • Due to increased risk of toxicity, patient should not be pregnant OR concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates; AND  
  • Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse | tabs: 3/day concentrate: 3 mL/day | lorazepam PA Form |
| alprazolam ER | NP | See alprazolam prior authorization criteria; AND  
  • Patient must have tried and failed or have an allergy or intolerance to an inactive ingredient in immediate release alprazolam. | 1/day | |
| alprazolam ODT | NP | See alprazolam prior authorization criteria; AND  
  • Patient must be unable to swallow, OR unable to absorb medications through the GI tract | 3/day | |
| Ativan® | NP | See lorazepam prior authorization criteria | 3/day | |

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### CENTRAL NERVOUS SYSTEM

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<tr>
<td>Buspar*</td>
<td>NP</td>
<td></td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td>bupropine 30 mg</td>
<td>NP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>meprobamate</td>
<td>NP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>oxazepam</td>
<td>NP</td>
<td>See chlordiazepoxide prior authorization criteria</td>
<td>4/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Additionally, trial and failure, contraindication or intolerance of TWO preferred agents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Niravam*</td>
<td>NP</td>
<td>See alprazolam ODT prior authorization criteria</td>
<td>3/day</td>
<td>Benzo-diazepine PA Form</td>
</tr>
<tr>
<td>Tranzene-T*</td>
<td>NP</td>
<td>See clorazepate prior authorization criteria</td>
<td>3/day</td>
<td></td>
</tr>
<tr>
<td>Valium*</td>
<td>NP</td>
<td>See diazepam prior authorization criteria</td>
<td>4/day</td>
<td>PA Form</td>
</tr>
<tr>
<td>Xanax*</td>
<td>NP</td>
<td>See alprazolam prior authorization criteria</td>
<td>3/day</td>
<td></td>
</tr>
<tr>
<td>Xanax* XR</td>
<td>NP</td>
<td>See alprazolam ER prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
</tbody>
</table>

### Anticonvulsants

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Aptiom*</td>
<td>P</td>
<td>Will be approved if ONE of the following criteria have been met:</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use as monotherapy for partial onset or complex seizures requires trial and failure with at least ONE other preferred anticonvulsant for the same indication; OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use as adjunctive therapy for partial onset or complex seizures when used in combination with at least ONE other anticonvulsant.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>diazepam rectal gel</td>
<td>P</td>
<td>Prior Authorization will not be required for patients less than 21 years of age.</td>
<td>2 packs/30 days</td>
<td>Benzo-diazepine PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Will be approved for patients 21 years of age and older with a Diagnosis of Seizure Disorder or Epilepsy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>gabapentin capsules</td>
<td>P</td>
<td></td>
<td>100 mg: 6/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>300 mg: 12/day</td>
<td>400 mg: 9/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Max total daily gabapentin dose: 3600mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>phenobarbital</td>
<td>P</td>
<td>Will be approved for use ONLY in patients with diagnosis of seizure disorders.</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td>phenobarbital elixir</td>
<td>P</td>
<td>Will be approved for use ONLY in patients with diagnosis of seizure disorders.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> A PA is not required for patients less than 1 year of age.</td>
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</tr>
</tbody>
</table>

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## CENTRAL NERVOUS SYSTEM

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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</thead>
<tbody>
<tr>
<td><strong>Vimpat</strong> P</td>
<td></td>
<td>Will be approved if <strong>ONE</strong> of the following criteria have been met:&lt;br&gt;• Use as monotherapy for partial onset or complex seizures requires trial and failure with at least <strong>ONE</strong> other preferred anticonvulsant for the same indication; <strong>OR</strong>&lt;br&gt;• Use as adjunctive therapy for partial onset or complex seizures when used in combination with at least <strong>ONE</strong> other anticonvulsant</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Banzel</strong> NP</td>
<td></td>
<td>Will be approved for patients meeting the following criteria:&lt;br&gt;• Used as adjunctive therapy for Lennox-Gastaut Syndrome when used in combination with at least one other anticonvulsant; <strong>AND</strong>&lt;br&gt;• Trial and failure, contraindication or intolerance to clobazam</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td><strong>Briviact</strong> solution NP</td>
<td></td>
<td>See Briviact™ tablets prior authorization criteria&lt;br&gt;• Additionally, patient must be unable to swallow tablets</td>
<td>20 mL/day</td>
<td></td>
</tr>
<tr>
<td><strong>Briviact</strong> tablets NP</td>
<td></td>
<td>Will be approved for patients meeting following criteria:&lt;br&gt;• Patient is ≥ 4 years old; <strong>AND</strong>&lt;br&gt;• Have diagnosis of partial-onset seizures; <strong>AND</strong>&lt;br&gt;• Have tried and failed at least 1 other medication indicated for partial-onset seizures.&lt;br&gt;&lt;strong&gt;NOTE&lt;/strong&gt;: A dosage reduction is required for all stages of hepatic impairment (Child-Pugh A, B, and C) and use is not recommended in end-stage renal disease patients.</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td><strong>clobazam</strong> NP</td>
<td></td>
<td>Will be approved if <strong>ONE</strong> of the following criteria has been met:&lt;br&gt;• Diagnosis of seizure disorder <strong>AND</strong> recipient has tried and failed at least <strong>TWO</strong> preferred anticonvulsants&lt;br&gt;• Diagnosis of panic disorder <strong>AND</strong> recipient has tried and failed, or have a contraindication or intolerance to, at least <strong>THREE</strong> agents from the following classes:&lt;br&gt;   SSRIs (minimum trial duration of 3 weeks each)&lt;br&gt;   SNRIs (minimum trial duration of 3 weeks each)&lt;br&gt;• Additionally, due to increased risk of toxicity,&lt;br&gt;   Patient should not be pregnant <strong>OR</strong>&lt;br&gt;   Concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates; <strong>AND</strong>&lt;br&gt;• Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse</td>
<td></td>
<td>Benzo-diazepine PA Form</td>
</tr>
<tr>
<td><strong>clonazepam ODT</strong> NP</td>
<td></td>
<td>See clonazepam prior authorization criteria; <strong>AND</strong>&lt;br&gt;• Patient must be unable to swallow, OR unable to absorb medications through the GI tract.</td>
<td>3/day</td>
<td></td>
</tr>
<tr>
<td><strong>Diastat</strong> NP</td>
<td></td>
<td>Diagnosis of Seizure Disorder or Epilepsy; <strong>AND</strong>&lt;br&gt;Must have clinically valid reason why preferred equivalent agent cannot be used.</td>
<td>2 packs/30 days</td>
<td></td>
</tr>
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### Anticonvulsants (continued)

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<tr>
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</table>
| Epidiolex<sup>®</sup> | NP  | Will be approved if the following is met:  
  - Patient is ≥ 2 years of age; **AND**  
  - Patient has been diagnosed with Lennox-Gastaut syndrome (LGS) OR Dravet syndrome (DS) by a pediatric neurologist or pediatric epileptologist; if there are no specialists in the area, prescriber to provider written or verbal attestation, including documented history of slow [< 3.0 Hz] spike and wave electroencephalograms may be used; **AND**  
  - Prescriber to provide written or verbal attestation that patient has refractory epilepsy (patient has failed to become seizure-free with adequate trials of 2 antiepileptic drugs [AED]); **AND**  
  - Prescriber to provide written or verbal attestation that Epidiolex will be used in adjunct to ≥ 1 antiepileptic drug; **AND**  
  - Prescriber to provide written or verbal attestation that baseline serum transaminases (ALT and AST) and total bilirubin levels have been completed; **AND**  
  - Prescriber to provide written or verbal attestation that patient is not currently using recreational or medicinal cannabis along with this product.  
  **Renewal Criteria**  
  - Patient continues to meet above criteria; **AND**  
  - Prescriber to provide written or verbal attestation that annual serum transaminases (ALT and AST) and total bilirubin levels have been completed. |
| Felbatol<sup>®</sup> and Felbamate | NP  | Will be approved if ONE of the following criteria has been met:  
  - Used as adjunctive therapy in Lennox-Gastaut Syndrome with a contraindication to, or trial and failure of, **TWO** of the following:  
    - Valproic acid/divalproex sodium  
    - Lamotrigine  
    - Topiramate  
  - Used for the treatment of partial seizures with a contraindication to, or trial and failure of, **THREE** of the following:  
    - Carbamazepine  
    - Oxcarbazepine  
    - Phenytoin  
    - Gabapentin  
    - Lamotrigine  
    - Topiramate  
    - Valproic acid/divalproex sodium  
  **Note:** Will not be approved if there is a history of blood dyscrasia or liver disease unless the prescriber can make a compelling clinical case demonstrating that the benefits of the drug outweigh the risks. |
| Fycompa<sup>®</sup> | NP  | Will be approved if the following criteria have been met:  
  - Diagnosis of partial onset or complex seizure; **AND**  
    - Trial and failure, contraindication, or intolerance to TWO preferred agents, one of which must be Vimpat<sup>®</sup> if patient is at least 4 years of age; **OR**  
  - Diagnosis of primary generalized tonic-clonic (PGTC) seizures; **AND**  
    - Used as adjunctive therapy in combination with at least ONE other anticonvulsant; **AND**  
    - Trial and failure, contraindication, or intolerance to TWO preferred agents |

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### Central Nervous System

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| Gabapentin solution NP | Will be approved for recipients who meet ALL of the following criteria:  
  - Inability to swallow solid oral dosage forms, **AND**  
  - Patient and caregiver are unable to open capsule and empty contents in food or drink  
  **Note:** Prior authorization criteria is waived for recipients 12 years of age and under | 72 mL/day  
Max total daily gabapentin dose: 3600mg |                                |                                |
| Gabapentin tablets NP | Will be approved for recipients who meet the following criteria:  
  - Documented allergy or contraindication to an inactive ingredient in the capsules that is NOT present in the tablets | 100 & 600mg: 6/day;  
800 mg: 4.5/day;  
All other strengths: 3/day  
Max total daily gabapentin dose: 3600mg |                                | [General PA Form](#) |
| Klonopin* NP | See clonazepam prior authorization criteria | 3/day |                                | [Benzodiazepine PA Form](#) |
| Lamictal® ODT NP | Will be approved for patients who are:  
  - Unable to swallow; OR  
  - Unable to absorb medications through the GI tract |                                |                                |                                |
| Lamotrigine ODT NP | Will be approved for patients who are:  
  - Unable to swallow; OR  
  - Unable to absorb medications through the GI tract |                                |                                |                                |
| Lyrica® NP | **Lyrica** will be approved if **ONE** of the following criteria has been met:  
  - Diagnosis of seizure disorder AND recipient has tried and failed at least TWO preferred anticonvulsants  
  - Diagnosis of diabetic peripheral neuropathy  
  - Diagnosis of fibromyalgia  
    - Recipient MUST have tried and failed, or have contraindication or intolerance to a tricyclic antidepressant, muscle relaxant, SSRI, SNRI, or gabapentin.  
  - Diagnosis of postherpetic neuralgia or other non-diabetic peripheral neuropathy  
    - Recipient MUST have tried and failed, or have contraindication, or intolerance to a tricyclic antidepressant or gabapentin. |                                | [General PA Form](#) |

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### Anticonvulsants (continued)

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<tr>
<td>Neurontin*</td>
<td>NP</td>
<td>Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.</td>
<td>100 mg: 6/day; 600 mg: 6/day; All other strengths: 3/day Max total daily gabapentin dose: 3600mg</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Neurontin* solution</td>
<td>NP</td>
<td>See gabapentin solution prior authorization criteria.</td>
<td>72 mL/day Max total daily gabapentin dose: 3600mg</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Onfi*</td>
<td>NP</td>
<td>Will be approved for use as adjunctive therapy for Lennox-Gastaut Syndrome when used in combination with at least one other anticonvulsant.</td>
<td>200 mg: 2/day All other strengths: 1/day</td>
<td>Benzo-diazepine PA Form</td>
</tr>
<tr>
<td>Qudexy® XR</td>
<td>NP</td>
<td>See topiramate ER prior authorization criteria.</td>
<td>200 mg: 2/day All other strengths: 1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Sabril*</td>
<td>NP</td>
<td>Will be approved if ONE of the following criteria has been met:</td>
<td>250, 500, &amp; 1000 mg: 2/day; 750 mg: 4/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Onfi*</td>
<td>NP</td>
<td>Will be approved for use as adjunctive therapy for Lennox-Gastaut Syndrome when used in combination with at least one other anticonvulsant.</td>
<td>200 mg: 2/day All other strengths: 1/day</td>
<td>Benzo-diazepine PA Form</td>
</tr>
<tr>
<td>Simpazan*</td>
<td>NP</td>
<td>Will be approved if the following is met:</td>
<td>2/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>topiramate ER</td>
<td>NP</td>
<td>Will be approved for patients who meet the following criteria:</td>
<td>200 mg: 2/day All other strengths: 1/day</td>
<td>General PA Form</td>
</tr>
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### CENTRAL NERVOUS SYSTEM

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</tbody>
</table>
| Trokendi XR® NP | Will be approved if the following criteria has been met:  
  - Diagnosis of Lennox-Gastaut syndrome:  
    - Will be approved for use as adjunctive therapy when used in combination with at least one other anticonvulsant; AND  
    - Allergy to inactive ingredient in immediate release product that is not in requested product; AND  
    - Trial and failure of topiramate ER  
  - Diagnosis of all other seizure types or epilepsy:  
    - Allergy to inactive ingredient in immediate release product that is not in requested product; AND  
    - Trial and failure of topiramate ER  
  - Migraine Prophylaxis:  
    - Allergy to inactive ingredient in immediate release product that is not in requested product; AND  
    - Trial and failure of topiramate ER |            | General PA Form |
| vigabatrin NP | See Sabril® prior authorization criteria                                                                                                  |            |         |

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CENTRAL NERVOUS SYSTEM

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</thead>
</table>
| Antidepressants: MAOIs |     | **CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENT’S WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):**

Antidepressants prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if **ONE** of the following is met:

- Prescriber has completed the State’s training program on the appropriate use of psychotropic medications for individuals with I/DD:
  - Training available at: [https://cme.mc.vanderbilt.edu/content/appropriate-use-psychotropic-medications-people-idd-helping-individuals-get-best-behavioral](https://cme.mc.vanderbilt.edu/content/appropriate-use-psychotropic-medications-people-idd-helping-individuals-get-best-behavioral)
  - **Note:** 1.5 hours of free continuing medical education units are available upon completion of the 90-minute training. Completion of training is required only once, regardless of the number of patients with I/DD. Training can be completed in 10–15-minute intervals in any order and dispersed per preferences of the reviewer; **AND**
  - Provide signature, module #, and date course was completed; **OR**
- Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; (a Primary Care Provider Checklist of Behavioral/Emotional Concerns is available at: [http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf](http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf)); **AND**
  - Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; **AND**
  - Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers. Example available at: [http://vkc.mc.vanderbilt.edu/etoolkit/wpcontent/uploads/CrisisManagementPlan.pdf](http://vkc.mc.vanderbilt.edu/etoolkit/wpcontent/uploads/CrisisManagementPlan.pdf); **OR**
- Short-term therapy has been prescribed and meets the following:
  - Behavioral symptoms significant enough to place the person at potential risk or needing higher level of care or loss of community placement; **AND**
  - Efficacy and potential side effects to be monitored; **AND**
  - Need for requested medication will be evaluated once other non-pharmacological interventions have been tried; **OR**
- Short-term therapy has been prescribed, and meets the following:
  - Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; **AND**
  - Efficacy and potential side effects to be monitored; **AND**
  - Need for requested medication will be evaluated once other non-pharmacological interventions have been tried.

**Note the following:**

- Duration of short-term therapy is 90 days for Antidepressants
- Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.
- The I/DD Worksheet can be found at: [https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf](https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf)

<table>
<thead>
<tr>
<th>phenelzine</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will be approved if patient meets <strong>ONE</strong> of the following criteria:</td>
<td></td>
</tr>
</tbody>
</table>
- Diagnosis of major depression **AND** refractory or intolerant to an adequate trial (3 weeks at the maximum tolerated dose within the recommended therapeutic range) of an SSRI, SNRI, or TCA |
- Diagnosis of PTSD and refractory or intolerant to an adequate trial (3 weeks at the maximum tolerated dose within the recommended therapeutic range) of an SSRI or TCA |
|6 tabs/day|General PA Form|

<table>
<thead>
<tr>
<th>Emsam*</th>
<th>NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>The recipient will need to have tried and failed, or been intolerant to, at least <strong>THREE</strong> antidepressant agents reflective of <strong>TWO</strong> different categories from any of the following classes:</td>
<td></td>
</tr>
</tbody>
</table>
- Another MAOI |
- SSRIs |
- SNRIs |
- New generation antidepressants |
- TCAs |
|1/day| |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### CENTRAL NERVOUS SYSTEM

**Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.**

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marplan*</td>
<td>NP</td>
<td>See phenelzine prior authorization criteria.</td>
<td>6 tabs/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Nardil*</td>
<td>NP</td>
<td>See phenelzine prior authorization criteria.</td>
<td>6 tabs/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Parnate*</td>
<td>NP</td>
<td>See phenelzine prior authorization criteria.</td>
<td>6 tabs/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>tranylcypromine</td>
<td>NP</td>
<td>See phenelzine prior authorization criteria.</td>
<td>6 tabs/day</td>
<td>General PA Form</td>
</tr>
</tbody>
</table>

**Antidepressants: New Generation**

**CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENT’S WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):**

Antidepressants prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if **ONE** of the following is met:

- Prescriber has completed the State’s training program on the appropriate use of psychotropic medications for individuals with I/DD:
  - Training available at: [https://cme.mc.vanderbilt.edu/content/appropriate-use-psychotropic-medications-people-idd-helping-individuals-get-best-behavioral](https://cme.mc.vanderbilt.edu/content/appropriate-use-psychotropic-medications-people-idd-helping-individuals-get-best-behavioral)
  - **Note:** 1.5 hours of free continuing medical education units are available upon completion of the 90-minute training. Completion of training is required only once, regardless of the number of patients with I/DD. Training can be completed in 10–15-minute intervals in any order and dispersed per preferences of the reviewer; **AND**
  - Provide signature, module #, and date course was completed; **OR**
- Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; (a Primary Care Provider Checklist of Behavioral/Emotional Concerns is available at: [http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf](http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf)); **AND**
  - Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; **AND**
  - Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers. Example available at: [http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/CrisisManagementPlan.pdf](http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/CrisisManagementPlan.pdf); **OR**
- Short-term therapy has been prescribed and meets the following:
  - Behavioral symptoms significant enough to place the person at potential risk or needing higher level of care or loss of community placement; **AND**
  - Efficacy and potential side effects to be monitored; **AND**
  - Need for requested medication will be evaluated once other non-pharmacological interventions have been tried; **OR**
- Short-term therapy has been prescribed, and meets the following:
  - Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; **AND**
  - Efficacy and potential side effects to be monitored; **AND**
  - Need for requested medication will be evaluated once other non-pharmacological interventions have been tried.

**Note the following:**

- Duration of short-term therapy is 90 days for Antidepressants
- Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.
- The I/DD Worksheet can be found at: [https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf](https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf)

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>budeprion SR</td>
<td>P</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>budeprion XL</td>
<td>P</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>bupropion IR/SR</td>
<td>P</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>bupropion XL</td>
<td>P</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### CENTRAL NERVOUS SYSTEM

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
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<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>mirtazapine</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mirtazapine rapids</td>
<td>P</td>
<td>Will be approved for patients who are unable to swallow, OR are unable to absorb medications through the GI tract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>trazodone (excluding 300mg)</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aplenzin*</td>
<td>NP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forfivo XL*</td>
<td>NP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>nefazodone</td>
<td>NP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oleptro*</td>
<td>NP</td>
<td></td>
<td>150mg (1.5/day); 300mg (1/day)</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Remeron*</td>
<td>NP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remeron SolTab*</td>
<td>NP</td>
<td>See mirtazapine rapids prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>trazodone 300mg</td>
<td>NP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellbutrin*</td>
<td>NP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellbutrin SR*</td>
<td>NP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellbutrin XL*</td>
<td>NP</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
Central nervous system

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
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<th>Prior Authorization Criteria</th>
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<th>PA Form</th>
</tr>
</thead>
</table>
| Antidepressants: SNRIs

### Class Prior Authorization Criteria for Patient's with Intellectual and Developmental Disabilities (I/DD):

Antidepressants prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if one of the following is met:

- Prescriber has completed the State’s training program on the appropriate use of psychotropic medications for individuals with I/DD:
  - Training available at: https://cme.mc.vanderbilt.edu/content/appropriate-use-psychotropic-medications-people-idd-helping-individuals-get-best-behavioral
  - **Note**: 1.5 hours of free continuing medical education units are available upon completion of the 90-minute training. Completion of training is required only once, regardless of the number of patients with I/DD. Training can be completed in 10–15-minute intervals in any order and dispersed per preferences of the reviewer; **AND**
  - Provide signature, module #, and date course was completed; **OR**
- Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; (a Primary Care Provider Checklist of Behavioral/Emotional Concerns is available at: http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf); **AND**
  - Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; **AND**
  - Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers. Example available at: http://vkc.mc.vanderbilt.edu/etoolkit/wpcontent/uploads/CrisisManagementPlan.pdf); **OR**
- Short-term therapy has been prescribed and meets the following:
  - Behavioral symptoms significant enough to place the person at potential risk or needing higher level of care or loss of community placement; **AND**
  - Efficacy and potential side effects to be monitored; **AND**
  - Need for requested medication will be evaluated once other non-pharmacological interventions have been tried; **OR**
- Short-term therapy has been prescribed, and meets the following:
  - Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; **AND**
  - Efficacy and potential side effects to be monitored; **AND**
  - Need for requested medication will be evaluated once other non-pharmacological interventions have been tried.

**Note the following:**

- Duration of short-term therapy is 90 days for Antidepressants
- Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.
- The I/DD Worksheet can be found at: https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>venlafaxine ER caps</td>
<td>P</td>
<td>37.5, 75mg: 1/day 150 mg: 2/day <strong>Special Note:</strong> 225mg dose: Must use 150mg &amp; 75mg tabs; 375mg dose: Must use 2-150mg tabs plus 75mg tab</td>
<td>SNRI PA Form</td>
</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### CENTRAL NERVOUS SYSTEM

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
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<th>Prior Authorization Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Antidepressants: SNRIs (continued)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cymbalta®</td>
<td>NP</td>
<td>- Provider must submit the patient’s diagnosis/medical description for which the drug is requested; <strong>AND</strong></td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>duloxetine caps (generic for Irenka®)</td>
<td>NP</td>
<td>- Provider must submit the patient’s diagnosis/medical description for which the drug is requested; <strong>AND</strong></td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>desvenlafaxine</td>
<td>NP</td>
<td>- Provider must submit the patient’s diagnosis/medical description for which the drug is requested; <strong>AND</strong></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>desvenlafaxine ER</td>
<td>NP</td>
<td>- Provided must submit the patient’s diagnosis/medical description for which the drug is requested; <strong>AND</strong></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Effexor XR®</td>
<td>NP</td>
<td>- Provided must submit the patient’s diagnosis/medical description for which the drug is requested; <strong>AND</strong></td>
<td>See venlafaxine ER prior authorization criteria</td>
<td></td>
</tr>
<tr>
<td>Fetzima®</td>
<td>NP</td>
<td>Will be approved if recipient meets <strong>ALL</strong> of the following:</td>
<td>Titration Dose Pack: 1/day (56 tabs/ lifetime)</td>
<td>SNRI PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Diagnosis of Major Depression Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Adequate trial and failure of 3 agents at an appropriate dose (defined as: 3 weeks at the maximum tolerated dose within the recommended therapeutic range) within the following drug classes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- SSRI</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- SNRI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Khedezla®</td>
<td>NP</td>
<td>Will be approved if recipient meets <strong>ALL</strong> of the following:</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Tried and failed a therapeutic course of an SSRI at an appropriate dose (Defined as: 3 weeks at the maximum tolerated dose within the recommended therapeutic range); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Tried and failed ONE preferred SNRI.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pristiq®</td>
<td>NP</td>
<td>Will be approved if recipient meets <strong>ALL</strong> of the following:</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Tried and failed a therapeutic course of an SSRI at an appropriate dose (Defined as: 3 weeks at the maximum tolerated dose within the recommended therapeutic range); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Tried and failed ONE preferred SNRI.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Savella®</td>
<td>NP</td>
<td>Will only be authorized for a diagnosis of fibromyalgia (see Cymbalta prior authorization criteria for fibromyalgia).</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>venlafaxine ER tabs</td>
<td>NP</td>
<td>Will be approved if recipient meets <strong>ALL</strong> of the following:</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Tried and failed a therapeutic course of an SSRI at an appropriate dose (Defined as: 3 weeks at the maximum tolerated dose within the recommended therapeutic range); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Tried and failed ONE preferred SNRI.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
CENTRAL NERVOUS SYSTEM

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
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<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants: SSRI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENT’S WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):

Antidepressants prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if ONE of the following is met:

- Prescriber has completed the State’s training program on the appropriate use of psychotropic medications for individuals with I/DD:
  - Training available at: [https://cme.mc.vanderbilt.edu/content/appropriate-use-psychotropic-medications-people-idd-helping-individuals-get-best-behavioral](https://cme.mc.vanderbilt.edu/content/appropriate-use-psychotropic-medications-people-idd-helping-individuals-get-best-behavioral)
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  - Provide signature, module #, and date course was completed; **OR**
- Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; (a Primary Care Provider Checklist of Behavioral/Emotional Concerns is available at: [http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf](http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf)); **AND**
  - Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; **AND**
  - Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers. Example available at: [http://vkc.mc.vanderbilt.edu/etoolkit/wpcontent/uploads/CrisisManagementPlan.pdf](http://vkc.mc.vanderbilt.edu/etoolkit/wpcontent/uploads/CrisisManagementPlan.pdf); **OR**
- Short-term therapy has been prescribed and meets the following:
  - Behavioral symptoms significant enough to place the person at potential risk or needing higher level of care or loss of community placement; **AND**
  - Efficacy and potential side effects to be monitored; **AND**
  - Need for requested medication will be evaluated once other non-pharmacological interventions have been tried; **OR**
- Short-term therapy has been prescribed, and meets the following:
  - Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; **AND**
  - Efficacy and potential side effects to be monitored; **AND**
  - Need for requested medication will be evaluated once other non-pharmacological interventions have been tried.

**Note the following**:

- Duration of short-term therapy is 90 days for Antidepressants
- Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.
- The I/DD Worksheet can be found at: [https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf](https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf)

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<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>citalopram</td>
<td>P</td>
<td>10 mg, 20 mg: 1.5/day; 40 mg: 1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>escitalopram</td>
<td>P</td>
<td>1.5/day</td>
<td></td>
</tr>
<tr>
<td>escitalopram solution</td>
<td>P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>fluoxetine capsules</td>
<td>P</td>
<td>3/day</td>
<td></td>
</tr>
<tr>
<td>fluoxetine solution</td>
<td>P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>fluvoxamine</td>
<td>P</td>
<td>3/day</td>
<td></td>
</tr>
<tr>
<td>paroxetine</td>
<td>P</td>
<td>10, 20mg: 1/day; 30, 40mg: 2/day</td>
<td></td>
</tr>
</tbody>
</table>

**Note**: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
<table>
<thead>
<tr>
<th>Medication</th>
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</tr>
</thead>
<tbody>
<tr>
<td>sertraline</td>
<td>P</td>
<td><strong>Antidepressants: SSRI (continued)</strong></td>
<td>25mg, 50mg: 1.5/day; 100mg: 2/day</td>
<td></td>
</tr>
<tr>
<td>Brisdelle*</td>
<td>NP</td>
<td>See paroxetine 7.5 mg prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Celexa*</td>
<td>NP</td>
<td></td>
<td>10 mg, 20 mg: 1.5/day 40 mg: 1/day</td>
<td></td>
</tr>
<tr>
<td>fluoxetine tablets</td>
<td>NP</td>
<td>Patient must have documented allergy to inactive ingredient in fluoxetine capsules that is not in requested product</td>
<td>20mg: 3/day; 60mg: 1/day</td>
<td></td>
</tr>
<tr>
<td>fluoxetine weekly</td>
<td>NP</td>
<td>May be approved if recipient has been stabilized at a dose of 20mg/day of fluoxetine for &gt; one month, with valid reason why recipient is unable to continue on fluoxetine 20mg daily.</td>
<td>4/28 days</td>
<td></td>
</tr>
<tr>
<td>fluvoxamine ER</td>
<td>NP</td>
<td></td>
<td>100mg: 3/day; 150mg: 2/day</td>
<td></td>
</tr>
<tr>
<td>Lexapro® solution</td>
<td>NP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lexapro® tablets</td>
<td>NP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Luvox CR*</td>
<td>NP</td>
<td></td>
<td>100mg: 3/day; 150mg: 2/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>paroxetine 7.5 mg</td>
<td>NP</td>
<td>Will be approved for patients meeting the following criteria:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of hot flashes associated with menopause; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trial and failure, contraindication or intolerance to estrogen therapy; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• An allergy or intolerance to an inactive ingredient in paroxetine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>paroxetine CR</td>
<td>NP</td>
<td></td>
<td>12.5, 25mg: 1/day; 37.5mg: 2/day</td>
<td></td>
</tr>
<tr>
<td>Paxil*</td>
<td>NP</td>
<td></td>
<td></td>
<td>See paroxetine</td>
</tr>
<tr>
<td>Paxil CR*</td>
<td>NP</td>
<td></td>
<td></td>
<td>See paroxetine ER</td>
</tr>
<tr>
<td>Pexeva*</td>
<td>NP</td>
<td></td>
<td>10, 20mg: 1/day; 30, 40mg: 2/day</td>
<td></td>
</tr>
<tr>
<td>Prozac*</td>
<td>NP</td>
<td></td>
<td>3/day</td>
<td></td>
</tr>
<tr>
<td>Prozac Weekly*</td>
<td>NP</td>
<td></td>
<td>4/28 days</td>
<td></td>
</tr>
<tr>
<td>Sarafem*</td>
<td>NP</td>
<td></td>
<td>3/day</td>
<td></td>
</tr>
<tr>
<td>Viibryd</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Zoloft*</td>
<td>NP</td>
<td></td>
<td></td>
<td>See sertraline</td>
</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.

---

**Clinical Criteria, Step Therapy, and Quantity Limits for TennCare Preferred Drug List (PDL)**

**Effective Date:** December 2, 2019
CENTRAL NERVOUS SYSTEM

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if ONE of the following is met:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prescriber has completed the State’s training program on the appropriate use of psychotropic medications for individuals with I/DD:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Training available at: <a href="https://cme.mc.vanderbilt.edu/content/appropriate-use-psychotropic-medications-people-idd-helping-individuals-get-best-behavioral">https://cme.mc.vanderbilt.edu/content/appropriate-use-psychotropic-medications-people-idd-helping-individuals-get-best-behavioral</a></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• <strong>Note</strong>: 1.5 hours of free continuing medical education units are available upon completion of the 90-minute training. Completion of training is required only once, regardless of the number of patients with I/DD. Training can be completed in 10–15-minute intervals in any order and dispersed per preferences of the reviewer; <strong>AND</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provide signature, module #, and date course was completed; <strong>OR</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; (a Primary Care Provider Checklist of Behavioral/Emotional Concerns is available at: <a href="http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf">http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf</a>); <strong>AND</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; <strong>AND</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers. Example available at: <a href="http://vkc.mc.vanderbilt.edu/etoolkit/wpcontent/uploads/CrisisManagementPlan.pdf">http://vkc.mc.vanderbilt.edu/etoolkit/wpcontent/uploads/CrisisManagementPlan.pdf</a>); <strong>OR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Short-term therapy has been prescribed and meets the following:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Behavioral symptoms significant enough to place the person at potential risk or needing higher level of care or loss of community placement; <strong>AND</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Efficacy and potential side effects to be monitored; <strong>AND</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Need for requested medication will be evaluated once other non-pharmacological interventions have been tried; <strong>OR</strong></td>
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<td></td>
<td></td>
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<tr>
<td>• Short-term therapy has been prescribed, and meets the following:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; <strong>AND</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Efficacy and potential side effects to be monitored; <strong>AND</strong></td>
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<td></td>
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</tr>
<tr>
<td>• Need for requested medication will be evaluated once other non-pharmacological interventions have been tried. <strong>Note</strong> the following:</td>
<td></td>
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</tr>
<tr>
<td>• <strong>Duration of short-term therapy is 90 days for Antidepressants</strong></td>
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</tr>
<tr>
<td>• <strong>Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• <strong>The I/DD Worksheet can be found at: <a href="https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf">https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf</a></strong></td>
<td></td>
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</tr>
</tbody>
</table>

| Trintellix® | NP | Will be approved for patients meeting the following criteria: |     |         |
|-------------|----|----------------------------------------------------------------|     |---------|
|             |    | • Diagnosis of Major Depression Disorder                         |     |         |
|             |    | • Adequate trial and failure of 3 agents at an appropriate dose (defined as: 3 weeks at the maximum tolerated dose within the recommended therapeutic range) within the following drug classes: |     |         |
|             |    |   • SSRI                                                         |     |         |
|             |    |   • SNRI                                                        |     |         |
|             |    |   • New Generation Antidepressants                               |     |         |
|             |    |   • TCAs                                                        |     |         |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### CENTRAL NERVOUS SYSTEM

**Prior Authorization Criteria**

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antidepressants: Tricyclics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressants prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if ONE of the following is met:</td>
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<td></td>
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<tr>
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<td>- Training available at: <a href="https://cme.mc.vanderbilt.edu/content/appropriate-use-psychotropic-medications-people-idd-helping-individuals-get-best-behavioral">https://cme.mc.vanderbilt.edu/content/appropriate-use-psychotropic-medications-people-idd-helping-individuals-get-best-behavioral</a></td>
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</tr>
<tr>
<td>• Note: 1.5 hours of free continuing medical education units are available upon completion of the 90-minute training. Completion of training is required only once, regardless of the number of patients with I/DD. Training can be completed in 10–15-minute intervals in any order and dispersed per preferences of the reviewer; <strong>AND</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; <strong>AND</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers. Example available at: <a href="http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/CrisisManagementPlan.pdf">http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/CrisisManagementPlan.pdf</a>; <strong>OR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Short-term therapy has been prescribed and meets the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Behavioral symptoms significant enough to place the person at potential risk or needing higher level of care or loss of community placement; <strong>AND</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Efficacy and potential side effects to be monitored; <strong>AND</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Need for requested medication will be evaluated once other non-pharmacological interventions have been tried; <strong>OR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Short-term therapy has been prescribed, and meets the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; <strong>AND</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Efficacy and potential side effects to be monitored; <strong>AND</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Need for requested medication will be evaluated once other non-pharmacological interventions have been tried.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note the following:**

- Duration of short-term therapy is 90 days for Antidepressants
- Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.
- The I/DD Worksheet can be found at: [https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf](https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf)

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>amitriptyline</td>
<td>P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>doxepin</td>
<td>P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>imipramine</td>
<td>P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>nortriptyline</td>
<td>P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>amoxapine</td>
<td>NP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anafranil®</td>
<td>NP</td>
<td>See prior authorization criteria for clomipramine</td>
<td>General PA Form</td>
</tr>
<tr>
<td>clomipramine</td>
<td>NP</td>
<td>Will be approved for patients who meet the following criteria:</td>
<td></td>
</tr>
<tr>
<td>- Diagnosis of obsessive-compulsive disorder; <strong>AND</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Trial and failure of at least:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 2 unique SSRIs; <strong>AND</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1 SNRI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All other diagnoses require trial and failure, contraindication or intolerance of 2 preferred agents</td>
<td></td>
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</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
**CENTRAL NERVOUS SYSTEM**

*Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.*

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>desipramine</td>
<td>NP</td>
<td></td>
<td></td>
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<tr>
<td>imipramine pamoate</td>
<td>NP</td>
<td></td>
<td></td>
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<tr>
<td>maprotiline</td>
<td>NP</td>
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<tr>
<td>Norpramin®</td>
<td>NP</td>
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<td></td>
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<tr>
<td>Pamelor®</td>
<td>NP</td>
<td></td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td>protriptyline</td>
<td>NP</td>
<td></td>
<td></td>
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<tr>
<td>Surmontil®</td>
<td>NP</td>
<td></td>
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<tr>
<td>Tofranil®</td>
<td>NP</td>
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<tr>
<td>Tofranil-PM®</td>
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<tr>
<td>Vivactil®</td>
<td>NP</td>
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</tbody>
</table>

**Antidepressants: Tricyclics (continued)**

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>imipramine (continued)</td>
<td></td>
<td>Will be approved for patients meeting the following criteria:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Agent must not be prescribed by a pain clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient <strong>does not</strong> meet any of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Concurrently taking a sedative, hypnotic, opioid (including buprenorphine), MAOI (monoamine oxidase inhibitor) agent, or meprobamate/carisoprodol.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- No active alcohol or substance abuse for last 3 years, if patient ≥ 21 years of age</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>- Glaucoma</td>
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<td></td>
<td></td>
<td>- Hyperthyroidism</td>
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<td></td>
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<td></td>
<td></td>
<td>- Symptomatic arteriosclerosis, cardiac disease and/or cardiac abnormalities</td>
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<tr>
<td></td>
<td></td>
<td>• Patient has a diagnosis of Attention Deficit Disorder and/or Hyperactivity Disorder (ADD/ADHD); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Documentation that the symptoms affect the patient’s ability to function in daily life tasks in at least 2 major settings (school, work, social settings, and/or home) or creates significant difficulties in at least 2 major settings (school, work, social settings, and/or home); <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Patient has a diagnosis of Narcolepsy supported with documentation of polysomnography; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of Organic Brain Disorder; <strong>OR</strong></td>
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<td></td>
<td></td>
<td>• Diagnosis of treatment resistant Major Depressive Disorder; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Adequate trial and failure of 3 agents at an appropriate dose (defined as: 3 weeks at the maximum tolerated dose within the recommended therapeutic range) from at least 3 distinct drug classes:</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>- SSRI</td>
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<tr>
<td></td>
<td></td>
<td>- SNRI</td>
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<tr>
<td></td>
<td></td>
<td>- New Generation Antidepressants</td>
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<tr>
<td></td>
<td></td>
<td>- TCAs</td>
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<td></td>
<td><strong>Note:</strong> Patients aged 20 years of age and younger will be subject to the above criteria if they exceed 80 mg/day of total amphetamine.</td>
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</tr>
</tbody>
</table>

**Antihyperkinesis: Stimulants**

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>amphetamine salt ER combination</td>
<td>P</td>
<td>Will be approved for patients meeting the following criteria:</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Agent must not be prescribed by a pain clinic</td>
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<td></td>
<td>• Patient <strong>does not</strong> meet any of the following:</td>
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<td>- Documentation that the symptoms affect the patient’s ability to function in daily life tasks in at least 2 major settings (school, work, social settings, and/or home) or creates significant difficulties in at least 2 major settings (school, work, social settings, and/or home); <strong>OR</strong></td>
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<td>• Diagnosis of treatment resistant Major Depressive Disorder; <strong>AND</strong></td>
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<td>- Adequate trial and failure of 3 agents at an appropriate dose (defined as: 3 weeks at the maximum tolerated dose within the recommended therapeutic range) from at least 3 distinct drug classes:</td>
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<td>- New Generation Antidepressants</td>
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<td>- TCAs</td>
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<td><strong>Note:</strong> Patients aged 20 years of age and younger will be subject to the above criteria if they exceed 80 mg/day of total amphetamine.</td>
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**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### CENTRAL NERVOUS SYSTEM

*Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.*

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<thead>
<tr>
<th>Medication</th>
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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amphetamine salt IR combo</strong></td>
<td>P</td>
<td>See amphetamine salt ER combination prior authorization criteria</td>
<td>5, 7.5, 10, &amp; 12.5mg: 4/day 15 &amp; 30mg: 2/day 20mg: 3/day Max total amphetamine dose (Age ≥ 21): 60mg/day</td>
<td>Schedule II</td>
</tr>
</tbody>
</table>

**Aptensio XR**

Will be approved for patients meeting the following criteria:
- Agent must not be prescribed by a pain clinic
- Patient **does not** meet any of the following:
  - Concurrently taking a sedative/hypnotic, opioid (including buprenorphine), MAOI (monoamine oxidase inhibitor) agent, or meprobamate/carisoprodol.
  - No active alcohol or substance abuse for last 3 years, if patient ≥ 21 years of age
  - Glaucoma
  - Hyperthyroidism
  - Symptomatic arteriosclerosis, cardiac disease and/or cardiac abnormalities
- Patient has a diagnosis of Attention Deficit Disorder and/or Hyperactivity Disorder (ADD/ADHD); **AND**
  - Documentation that the symptoms affect the patient's ability to function in daily life tasks in at least 2 major settings (school, work, social settings, and/or home) or creates significant difficulties in at least 2 major settings (school, work, social settings, and/or home); **OR**
- Patient has a diagnosis of Narcolepsy supported with documentation of polysomnography; **OR**
- Diagnosis of Organic Brain Disorder; **OR**
- Diagnosis of treatment resistant Major Depressive Disorder; **AND**
  - Adequate trial and failure of 3 agents at an appropriate dose (defined as: 3 weeks at the maximum tolerated dose within the recommended therapeutic range) from at least 3 distinct drug classes:
    - SSRI
    - SNRI
    - New Generation Antidepressants
    - TCAs

---

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---

**Effective Date:** December 2, 2019

**Clinical Criteria, Step Therapy, and Quantity Limits for TennCare Preferred Drug List (PDL)**
### CENTRAL NERVOUS SYSTEM

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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</tr>
</thead>
<tbody>
<tr>
<td>dextromethorphan tablets</td>
<td></td>
<td>See amphetamine salt ER combination prior authorization criteria</td>
<td>4/day Max total amphetamine dose (Age ≥ 21): 60mg/day</td>
<td>Schedule II</td>
</tr>
<tr>
<td>Focalin XR®</td>
<td></td>
<td>See Aptsio XR® prior authorization criteria</td>
<td>1/day</td>
<td>Stimulant PA Form</td>
</tr>
<tr>
<td>Metadate ER®</td>
<td></td>
<td>See Aptsio XR® prior authorization criteria</td>
<td>10mg: 1/day; 20mg: 3/day</td>
<td></td>
</tr>
<tr>
<td>MethylM® tabs</td>
<td></td>
<td>See Aptsio XR® prior authorization criteria</td>
<td>10mg: 1/day; 20mg: 3/day</td>
<td></td>
</tr>
<tr>
<td>Methylin® tabs</td>
<td></td>
<td>See Aptsio XR® prior authorization criteria</td>
<td>10mg: 1/day; 20mg: 3/day</td>
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<tr>
<td>Methylin® tabs</td>
<td></td>
<td>See Aptsio XR® prior authorization criteria</td>
<td>10mg: 1/day; 20mg: 3/day</td>
<td></td>
</tr>
<tr>
<td>methylphenidate</td>
<td></td>
<td>See Aptsio XR® prior authorization criteria</td>
<td>10mg: 1/day; 20mg: 3/day</td>
<td></td>
</tr>
<tr>
<td>methylphenidate ER</td>
<td></td>
<td>See Aptsio XR® prior authorization criteria</td>
<td>10mg: 1/day; 20mg: 3/day</td>
<td></td>
</tr>
<tr>
<td>methylphenidate SA OSM</td>
<td></td>
<td>See Aptsio XR® prior authorization criteria</td>
<td>See Concerta®</td>
<td></td>
</tr>
<tr>
<td>ProCentra®</td>
<td></td>
<td>See amphetamine salt ER combination prior authorization criteria</td>
<td>20 mL/day Max (Age ≥ 21): 60mg/day</td>
<td></td>
</tr>
<tr>
<td>Quillichew ER®</td>
<td></td>
<td>See Aptsio XR® prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Quillivant XR®</td>
<td></td>
<td>See Aptsio XR® prior authorization criteria</td>
<td>12 mL/day</td>
<td></td>
</tr>
<tr>
<td>Vyvanse® capsules</td>
<td></td>
<td>See amphetamine salt ER combination prior authorization criteria</td>
<td>1/day Max total amphetamine dose (Age ≥ 21): 60mg/day</td>
<td></td>
</tr>
</tbody>
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### CENTRAL NERVOUS SYSTEM

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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| **Adderall***    | NP  | Will be approved for patients meeting the following criteria:  
  - Agent must not be prescribed by a pain clinic  
  - Patient **does not** meet any of the following:  
    - Concurrently taking a sedative, hypnotic, opioid (including buprenorphine), MAOI (monoamine oxidase inhibitor) agent, or meprobamate/carisoprodol.  
    - No active alcohol or substance abuse for last 3 years, if patient ≥ 21 years of age  
    - Glaucoma  
    - Hyperthyroidism  
    - Symptomatic arteriosclerosis, cardiac disease and/or cardiac abnormalities  
  - Patient has a diagnosis of Attention Deficit Disorder and/or Hyperactivity Disorder (ADD/ADHD); **AND**  
    - Documentation that the symptoms affect the patient’s ability to function in daily life tasks in at least 2 major settings (school, work, social settings, and/or home) or creates significant difficulties in at least 2 major settings (school, work, social settings, and/or home); **OR**  
    - Patient has a diagnosis of Narcolepsy supported with documentation of polysomnography; **OR**  
    - Diagnosis of Organic Brain Disorder; **OR**  
    - Diagnosis of treatment resistant Major Depressive Disorder; **AND**  
    - Adequate trial and failure of 3 agents at an appropriate dose (defined as: 3 weeks at the maximum tolerated dose within the recommended therapeutic range) from at least 3 distinct drug classes:  
      - SSRI  
      - SNRI  
      - New Generation Antidepressants  
      - TCAs  
  - Additionally, non-preferred agents require trial and failure, contraindication or intolerance of 2 preferred agents unless otherwise indicated.  
  **Note:** Patients aged 20 years of age & younger will be subject to the above criteria if they exceed 80 mg/day of total amphetamine.                                                                                       |             |         |
| **Adderall* XR** | NP  | See Adderall* prior authorization criteria                                                                                                                                                                                                                                                                                                                 | 5, 10, 15mg:  
  1/day  
  20, 25, & 30mg:  
  2/day  
  Max total amphetamine dose (Age ≥ 21):  
  60mg/day |             |         |
| **Adhansia XR**  | NP  | See Aptensio XR® prior authorization criteria                                                                                                                                                                                                                                                                                                                | 1/day       |         |
| **Adzenys ER® solution** | NP  | See Adderall® prior authorization criteria  
  Additionally, patient must have clinical reason as to why the preferred Quillichew® ER tablets cannot be used.                                                                                                                                                                                                                                 | 10mL/day   |         |
| **Adzenys XR® ODT** | NP  | See Adderall® prior authorization criteria                                                                                                                                                                                                                                                                                                                  | 1/day       |         |
| **amphetamine** | NP  | See Adderall® prior authorization criteria                                                                                                                                                                                                                                                                                                                  |             |         |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
## Central Nervous System

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

### Prior Authorization Criteria

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<tbody>
<tr>
<td><strong>Antihyperkinesis: Stimulants</strong></td>
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<td>Will be approved for patients meeting the following criteria:</td>
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<td>- Patient <strong>does not</strong> meet any of the following:</td>
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<td>- Concurrently taking a sedative/hypnotic, opioid (including buprenorphine) or MAOI (monoamine oxidase inhibitor) agent, or meperbamate/carisoprodol.</td>
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<td>- No active alcohol or substance abuse for last 3 years, if patient ≥ 21 years of age</td>
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<td>Additionally, non-preferred agents require trial and failure, contraindication or intolerance of 2 preferred agents unless otherwise indicated.</td>
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<tr>
<td>Concerta®</td>
<td>NP</td>
<td>Will be approved for patients meeting the following criteria:</td>
<td>18, 27, 54mg: 1/day; 36mg: 2/day</td>
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<td>- Patient must not be prescribed by a pain clinic</td>
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<tr>
<td>Cotempla XR® ODT</td>
<td>NP</td>
<td>See Concerta® prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Daytrana®</td>
<td>NP</td>
<td>See Concerta® prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Desoxyn®</td>
<td>NP</td>
<td>See Adderall® prior authorization criteria</td>
<td>4/day</td>
<td></td>
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<tr>
<td>dextroamphetamine solution</td>
<td>NP</td>
<td>See Adderall® prior authorization criteria</td>
<td>20 mL/day</td>
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<tr>
<td>Dexedrine Spansule®</td>
<td>NP</td>
<td>See Adderall® prior authorization criteria</td>
<td>4/day Max total amphetamine dose (Age ≥ 21): 60mg/day</td>
<td>Schedule II</td>
</tr>
<tr>
<td>dexamylphenidate XR</td>
<td>NP</td>
<td>See Concerta® prior authorization criteria</td>
<td>1/day</td>
<td>Stimulant</td>
</tr>
<tr>
<td>Dyanavel XR®</td>
<td>NP</td>
<td>See Adderall® prior authorization criteria</td>
<td>8 mL/day Max total amphetamine dose (Age ≥ 21): 60mg/day</td>
<td></td>
</tr>
<tr>
<td>Evekeo®</td>
<td>NP</td>
<td>See Adderall® prior authorization criteria</td>
<td>5mg: 3/day Max total amphetamine dose (Age ≥ 21): 60mg/day</td>
<td></td>
</tr>
<tr>
<td>Focalin®</td>
<td>NP</td>
<td>See Concerta® prior authorization criteria</td>
<td>10, 20, 30mg: 1/day; 40, 50, &amp; 60mg: 2/day</td>
<td></td>
</tr>
<tr>
<td>Metadate CD®</td>
<td>NP</td>
<td>See Concerta® prior authorization criteria</td>
<td>1/day</td>
<td>PA Form</td>
</tr>
<tr>
<td>methamphetamine</td>
<td>NP</td>
<td>See Adderall® prior authorization criteria</td>
<td>4/day Max total amphetamine dose (Age ≥ 21): 60mg/day</td>
<td></td>
</tr>
<tr>
<td>Methyl® soln &amp; chew</td>
<td>NP</td>
<td>See Concerta® prior authorization criteria</td>
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<tr>
<td>methylphenidate CR</td>
<td>NP</td>
<td>See Concerta® prior authorization criteria</td>
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<tr>
<td>methylphenidate ER</td>
<td>NP</td>
<td>See Concerta® prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>methylphenidate SR 24 hr</td>
<td>NP</td>
<td>See Concerta® prior authorization criteria</td>
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<tr>
<td><strong>Antihyperkinesis: Stimulants (continued)</strong></td>
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<tr>
<td>Mydayis ER®</td>
<td>NP</td>
<td>See Adderall® prior authorization criteria</td>
<td>1/day</td>
<td></td>
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<tr>
<td>Relexxii® ER</td>
<td>NP</td>
<td>Will be approved for patients meeting the following criteria:</td>
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<td></td>
<td>- Hyperthyroidism</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Symptomatic arteriosclerosis, cardiac disease and/or cardiac abnormalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Additionally, non-preferred agents require trial and failure, contraindication or intolerance of 2 preferred agents unless otherwise indicated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ritalin® LA</td>
<td>NP</td>
<td>See Concerta® prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vyvanse® chewable</td>
<td>NP</td>
<td>See Adderall® prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Max total amphetamine dose (Age ≥ 21): 60mg/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zenzedi®</td>
<td>NP</td>
<td>See Adderall® prior authorization criteria</td>
<td>30 mg: 2/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>All others: 3/day Max total amphetamine dose (Age ≥ 21): 60mg/day</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### CENTRAL NERVOUS SYSTEM

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antihyperkinesis: Non-Stimulants</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>atomoxetine</td>
<td>P</td>
<td></td>
<td>60 mg, 80 mg, 100 mg: 1/day All other strengths: 2/day</td>
<td></td>
</tr>
<tr>
<td>guanfacine ER</td>
<td>P</td>
<td>Approval requires:</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
</tbody>
</table>
| | | - Trial and failure, contraindication or intolerance of 2 preferred Antihyperkinesis agents (agents can be from stimulant or non-stimulant subcategories); **AND**
| | | - Trial and failure of immediate release product **OR** allergy to inactive ingredient in immediate release product that is not in requested product | | |
| Intuniv® | NP | See clonidine ER prior authorization criteria | 1/day | |
| Strattera® | NP | | 60 mg, 80 mg, 100 mg: 1/day All other strengths: 2/day | |

### Agents for Narcolepsy

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>modafinil</td>
<td>P</td>
<td>Will be approved for recipients meeting the following criteria:</td>
<td>2/day</td>
<td>Provigil/ Nuvigil PA Form</td>
</tr>
</tbody>
</table>
| | | - Excessive daytime sleepiness/hypersomnolence with documentation of occurrence of at least 3 times per week over the past 3 months; **AND**
| | | - Prescribed by or in consultation with a Board-Certified Sleep Specialist, Pulmonologist, or Neurologist
| | | - Daytime sleepiness/hypersomnolence **is** associated with one of the following:
| | | - Obstructive sleep apnea/hypopnea syndrome supported by a documented sleep study, **AND** trial and failure (minimum duration of 3 months with documented compliance) of Continuous Positive Airway Pressure (CPAP) or BiPAP device **OR** contraindication to such.
| | | - Diagnosis of Shift Work Sleep Disorder **AND** statement of patient’s work schedule showing a minimum of 6 hours work between the hours of 10 pm and 8 am
| | | - Diagnosis of Narcolepsy
| | | - Hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out. (Note: Requests for patients receiving > 200 mg of morphine equivalent per day will **not** be approved)
| | | - Diagnosis of ADD/ADHD, **AND** contraindication, adverse reaction, or drug-drug interaction to **ALL** preferred Antihyperkinesis agents |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### CENTRAL NERVOUS SYSTEM

**Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.**

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<tr>
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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agents for Narcolepsy (continued)</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**armodafinil NP**

Will be approved for recipients meeting the following criteria, **AND** trial and failure, contraindication or intolerance to modafinil:

- Excessive daytime sleepiness/hypersomnolence with documentation of occurrence of at least 3 times per week over the past 3 months; **AND**
  - Prescribed by or in consultation with a Board-Certified Sleep Specialist, Pulmonologist, or Neurologist
  - Daytime sleepiness/hypersomnolence **is** associated with one of the following:
    - Obstructive sleep apnea/hypopnea syndrome supported by a documented sleep study, **AND** trial and failure (minimum duration of 3 months with documented compliance) of Continuous Positive Airway Pressure (CPAP) or BiPAP device **OR** contraindication to such.
    - Diagnosis of Shift Work Sleep Disorder **AND** statement of patient’s work schedule showing a minimum of 6 hours work between the hours of 10 pm and 8 am
    - Diagnosis of Narcolepsy
      - Hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out. (**Note:** Requests for patients receiving > 200 mg of morphine equivalent per day will **not** be approved)
    - Diagnosis of ADD/ADHD, **AND** contraindication, adverse reaction, or drug-drug interaction to ALL preferred Antihyperkinesis agents

<table>
<thead>
<tr>
<th>Nuvigil® NP</th>
<th>See armodafinil prior authorization criteria</th>
<th>50mg: 2/day 150mg, 200mg, 250mg: 1/day</th>
<th>Provigil/ Nuvigil PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provigil® NP</td>
<td>See armodafinil prior authorization criteria</td>
<td>50mg: 2/day 150mg, 200mg, 250mg: 1/day</td>
<td>Provigil/ Nuvigil PA Form</td>
</tr>
<tr>
<td>Xyrem® NP</td>
<td>Will be approved only for patients meeting the following criteria:</td>
<td>9 grams/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td>- Enrolled in the Xyrem® Success Program (1-866-997-3688); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- No current use of alcohol, sedatives, or other CNS depressants; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Age ≥ 7 years; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Trial and failure, intolerance, or contraindication to modafinil; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Diagnosis of cataplexy associated with narcolepsy; <strong>OR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Diagnosis of excessive daytime sleepiness/hypersomnolence associated with narcolepsy with documentation of occurrence of at least 3 times per week over the past 3 months; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Prescribed by or in consultation with a Board-Certified Sleep Specialist, Pulmonologist, or Neurologist; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out.</td>
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</tr>
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**CENTRAL NERVOUS SYSTEM**

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<tbody>
<tr>
<td><strong>Antimigraine Preparations: Anti-CGRP Monoclonal Antibodies</strong></td>
<td></td>
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</tr>
<tr>
<td>Aimovig®</td>
<td>NP</td>
<td>Will be approved if the following is met:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Age ≥ 18 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has a diagnosis of migraine with or without aura based on International Classification of Headache Disorders (ICHD-III) diagnostic criteria; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medication over-use headache (MOH) has been ruled out; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has ≥ 4 migraine days per month for at least 3 months; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient is utilizing prophylactic intervention modalities (e.g., behavioral therapy, physical therapy, or life-style modifications); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|              |     | • Patient has tried and failed a ≥ 1-month trial of any 2 of the following oral medication classes, unless contraindicated:  
  – Antidepressants (i.e., amitriptyline, venlafaxine)  
  – Beta blockers (i.e., propranolol, metoprolol, timolol, atenolol)  
  – Anti-epileptics (i.e., valproate, topiramate)  

Renewal Criteria:                                                                                                                                                                                                 |             |         |
|              |     | • Patient demonstrated decrease in the number, frequency, and/or intensity of headaches; **AND**                                                                                                                                                                                          |             |         |
|              |     | • Patient has an overall improvement in function with therapy; **AND**                                                                                                                                                                                                                  |             |         |
|              |     | • Patient continues to utilize prophylactic intervention modalities (e.g., behavioral therapy, physical therapy, life-style modification); **AND**                                                                                                                                      |             |         |
|              |     | • Patient has absence of unacceptable toxicity (e.g., intolerable injection site pain or constipation).                                                                                                                                                                                  |             |         |
|              |     | 2 syringes/30 days                                                                                                                                                                                                                                                                       |             |         |
| Ajovy®       | NP  | Will be approved if the following is met:                                                                                                                                                                                                                                                |             |         |
|              |     | • Age ≥ 18 years                                                                                                                                                                                                                                                                                                                                   |             |         |
|              |     | • Agent is being requested by or in consultation with a specialist (including neurologist or pain specialist); **AND**                                                                                                                                                                |             |         |
|              |     | • Patient has a diagnosis of migraine with or without aura based on International Classification of Headache Disorders (ICHD-III) diagnostic criteria; **AND**                                                                                                                            |             |         |
|              |     | • Medication over-use headache (MOH) has been ruled out by trial and failure of titrating off acute migraine treatments in the past; **AND**                                                                                                                                               |             |         |
|              |     | • Patient has ≥ 4 migraine days per month for at least 3 months; **AND**                                                                                                                                                                                                                 |             |         |
|              |     | • Patient has tried and failed a ≥ 1-month trial of any 2 of the following oral medication classes, unless contraindicated:  
  – Antidepressants (i.e., amitriptyline, venlafaxine)  
  – Beta blockers (i.e., propranolol, metoprolol, timolol, atenolol)  
  – Anti-epileptics (i.e., valproate, topiramate)  

Renewal Criteria:                                                                                                                                                                                                 |             |         |
|              |     | • Patient demonstrated decrease in the number, frequency, and/or intensity of headaches; **AND**                                                                                                                                                                                          |             |         |
|              |     | • Patient has an overall improvement in function with therapy; **AND**                                                                                                                                                                                                                  |             |         |
|              |     | • Patient has absence of unacceptable toxicity (e.g., intolerable injection site pain or constipation).                                                                                                                                                                                  |             |         |
|              |     | 3 syringes/90 days                                                                                                                                                                                                                                                                       |             |         |
| Emgality®   | NP  | See Ajovy® prior authorization criteria                                                                                                                                                                                                                                                 |             |         |
|              |     | 1 syringe/month                                                                                                                                                                                                                                                                         |             |         |

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### CENTRAL NERVOUS SYSTEM

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Antimigraine Preparations: Ergotamine Derivatives</strong></td>
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</tr>
</tbody>
</table>
| dihydroergotamine nasal spray | NP | Will be approved for patients with contraindication or therapeutic failure to TWO preferred products in ANY of the following categories:  
- Triptans  
- RX NSAIDS  
- Migraine combination products | 8mL/30 days | General PA Form |
| Ergomar* | NP | See dihydroergotamine nasal spray prior authorization criteria | 20 tabs/30 days | |
| Migranal* | NP | See dihydroergotamine nasal spray prior authorization criteria | 8mL/30 days | |
| **Antimigraine: Combination Agents** | | | | |
| butalbital/APAP | P | Max Qty: 20 tabs/caps of butalbital-containing products per 30 days**  
Max: 4 g APAP/day | | General PA Form |
| butalbital/APAP/caff | P | Max Qty: 20 tabs/caps of butalbital-containing products per 30 days**  
Max: 4 g APAP/day | | General PA Form |
| Cafergot* | P | | 30 tabs/30 days | |
| butalbital/ASA/caff | NP | Will be approved for patients with allergy or intolerance to APAP | Max Qty: 20 tabs/caps of butalbital-containing products per 30 days** | |

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</table>
| butalbital/APAP/caff/codeine         | NP   | Will be approved if patient meets ALL of the following criteria:  
- Patient is less than 18 years of age:  
  - Trial and failure of acetaminophen; AND  
  - Contraindication to ALL NSAIDs; AND  
  - Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL other preferred short-acting narcotic agents (excluding tramadol); AND  
- Patient does not have any of the following:  
  - Obesity  
  - Obstructive Sleep Apnea  
  - Severe Lung Disease; AND  
- Prescriber is aware of contraindication in patients younger than 12 years of age due to serious risks, including slowed or difficult breathing and death, and agrees to accept risks  
- Patients ≥ 18 years of age:  
  - Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred short-acting narcotic agents                                                                                                                                                                                                                                                                  | Max Qty: 20 tabs/caps of butalbital-containing products per 30 days**; Max: 4 g APAP/day |         |
| butalbital/ASA/caff/codeine          | NP   | See butalbital/APAP/caffeine/codeine prior authorization criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Max Qty: 20 tabs/caps of butalbital-containing products per 30 days**         | General PA Form |
| Fioricet® with codeine               | NP   | Max Qty: 20 tabs/caps of butalbital-containing products per 30 days**                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Max Qty: 20 tabs/caps of butalbital-containing products per 30 days**         |         |
| Fiorinal® with codeine               | NP   | Max Qty: 20 tabs/caps of butalbital-containing products per 30 days**                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Max Qty: 20 tabs/caps of butalbital-containing products per 30 days**         |         |

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<tbody>
<tr>
<td><strong>Antimigraine: Combination Agents (continued)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>isomethept/caffeine/APAP</td>
<td>NP</td>
<td>8/day Max: 4 g APAP/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>isomethept/dichloralphenazone/APAP</td>
<td>NP</td>
<td>8/day Max: 4 g APAP/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migergot*</td>
<td>NP</td>
<td>15 suppositories / 30 days</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td>Vanatol LQ*</td>
<td>NP</td>
<td>300 mL/30 days Max Qty: 20 tabs/caps of butalbital-containing products per 30 days**</td>
<td><strong>Quantity Limit Override Criteria for Butalbital-Containing Products:</strong> Requests for butalbital-containing products for quantities greater than 20 per 30 days will be approved for patients meeting the following criteria:</td>
<td></td>
</tr>
<tr>
<td><strong>Antimigraine Preparations: Selective 5-HT1 Agonists</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relpax*</td>
<td>P</td>
<td>6/30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>rizatriptan</td>
<td>P</td>
<td>12/30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>rizatriptan ODT</td>
<td>P</td>
<td>12/30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sumatriptan tabs</td>
<td>P</td>
<td>9/30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sumatriptan vials</td>
<td>P</td>
<td>8 vials/30 days</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td>Zomig® Nasal Spray</td>
<td>P</td>
<td>6/30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amerge*</td>
<td>NP</td>
<td>9/30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>eletriptan</td>
<td>NP</td>
<td>6/30 days</td>
<td></td>
<td></td>
</tr>
</tbody>
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<tbody>
<tr>
<td>Frova®</td>
<td>NP</td>
<td></td>
<td>9/30 days</td>
<td></td>
</tr>
<tr>
<td>frovatriptan</td>
<td>NP</td>
<td></td>
<td>9/30 days</td>
<td></td>
</tr>
<tr>
<td>Imitrex Injectable®</td>
<td>NP</td>
<td></td>
<td>8 vials/30 days</td>
<td></td>
</tr>
<tr>
<td>Imitrex Kit/Cartridge®</td>
<td>NP</td>
<td>Will only be approved for patients with a clinically valid reason clinical reason the patient cannot use the injectable vials. Patient convenience is NOT an approvable reason.</td>
<td>4/30 days</td>
<td></td>
</tr>
<tr>
<td>Imitrex Nasal®</td>
<td>NP</td>
<td></td>
<td>6/30 days</td>
<td></td>
</tr>
<tr>
<td>Imitrex tablets</td>
<td>NP</td>
<td></td>
<td>9/30 days</td>
<td></td>
</tr>
<tr>
<td>Maxalt®</td>
<td>NP</td>
<td></td>
<td>12/30 days</td>
<td></td>
</tr>
<tr>
<td>Maxalt MLT®</td>
<td>NP</td>
<td></td>
<td>12/30 days</td>
<td></td>
</tr>
<tr>
<td>Migranow Kit®</td>
<td>NP</td>
<td>Will be approved for patients meeting <strong>ALL</strong> of the following criteria:</td>
<td>1 kit/30 days</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has a contraindication, allergic reaction, or serious adverse event to ALL preferred Antimigraine: Selective 5-HT1 Agonists; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provider must provide documentation as to why the requested drug for the requested indication is the only appropriate choice versus the preferred agents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>naratriptan</td>
<td>NP</td>
<td></td>
<td>9/30 days</td>
<td></td>
</tr>
<tr>
<td>Onzeta Xsail®</td>
<td>NP</td>
<td>Will be approved if <strong>ALL</strong> of the following are met:</td>
<td>16/30 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has an allergy to an inactive ingredient found in the preferred sumatriptan containing agents; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has a contraindication, allergic reaction, or drug-drug interaction to preferred rizatriptan containing agents; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A clinically valid reason is given as to why the patient requires a nasal powder (<strong>NOTE</strong>: Patient convenience is NOT an approval reason)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sumatriptan kit</td>
<td>NP</td>
<td>Will only be approved for patients with a clinically valid reason clinical reason the patient cannot use the injectable vials. Patient convenience is NOT an approvable reason.</td>
<td>4/30 days</td>
<td></td>
</tr>
<tr>
<td>sumatriptan nasal</td>
<td>NP</td>
<td></td>
<td>6/30 days</td>
<td></td>
</tr>
<tr>
<td>sumatriptan/naproxen</td>
<td>NP</td>
<td></td>
<td>9/30 days</td>
<td></td>
</tr>
</tbody>
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| Sumavel® DosePro™ NP | | PA will be approved if All the following are met:  
- Patient has an allergy to an inactive ingredient found in the preferred sumatriptan containing agents; AND  
- Patient has a contraindication, allergic reaction, or drug-drug interaction to preferred rizatriptan containing agents; AND  
- Will be approved for patients with a clinically valid reason for a needleless injection device  
NOTE: Patient convenience is NOT an approvable reason. | 4 mL/30 days | General PA Form |
| Treximet® NP | | Will be approved if ALL of the following are met:  
- Patient has an allergy to an inactive ingredient found in the preferred sumatriptan containing agents; AND  
- Patient has a contraindication, allergic reaction, or drug-drug interaction to preferred rizatriptan containing agents; AND  
- A clinically valid reason is given as to why the patient requires a transdermal formulation (NOTE: Patient convenience is NOT an approval reason) | 9/30 days | |
| zolmitriptan NP | | | 6/30 days | |
| Zecuity® NP | | Will be approved if ALL of the following are met:  
- Patient has an allergy to an inactive ingredient found in the preferred sumatriptan containing agents; AND  
- Patient has a contraindication, allergic reaction, or drug-drug interaction to preferred rizatriptan containing agents; AND  
- A clinically valid reason is given as to why the patient requires an autoinjector device (NOTE: Patient convenience is NOT an approval reason) | 4/30 days | |
| Zembrace® Symtouch® NP | | Will be approved if ALL of the following are met:  
- Patient has an allergy to an inactive ingredient found in the preferred sumatriptan containing agents; AND  
- Patient has a contraindication, allergic reaction, or drug-drug interaction to preferred rizatriptan containing agents; AND  
- A clinically valid reason is given as to why the patient requires an autoinjector device (NOTE: Patient convenience is NOT an approval reason) | 2 mL/30 days | |
| Zomig® NP | | | 6/30 days | |
| Zomig ZMT® NP | | | 6/30 days | |

Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### CENTRAL NERVOUS SYSTEM

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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<tr>
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<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Atypical Antipsychotic/SSRI Combos</strong></td>
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</tbody>
</table>

#### CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENT’S WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):

Antipsychotics prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if **ONE** of the following is met:

- **Prescriber has completed the State’s training program on the appropriate use of psychotropic medications for individuals with I/DD:**
  - Training available at: [https://cme.mc.vanderbilt.edu/content/appropriate-use-psychotropic-medications-people-idd-helping-individuals-get-best-behavioral](https://cme.mc.vanderbilt.edu/content/appropriate-use-psychotropic-medications-people-idd-helping-individuals-get-best-behavioral)
  - Note: 1.5 hours of free continuing medical education units are available upon completion of the 90-minute training. Completion of training is required only once, regardless of the number of patients with I/DD. Training can be completed in 10–15-minute intervals in any order and dispersed per preferences of the reviewer; **AND**
  - Provide signature, module #, and date course was completed; **OR**
- **Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed;** (a Primary Care Provider Checklist of Behavioral/Emotional Concerns is available at: [http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf](http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf)); **AND**
  - Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; **AND**
  - Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers. Example available at: [http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/CrisisManagementPlan.pdf](http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/CrisisManagementPlan.pdf); **OR**
- **Short-term therapy has been prescribed and meets the following:**
  - Behavioral symptoms significant enough to place the person at potential risk or needing higher level of care or loss of community placement; **AND**
  - Efficacy and potential side effects to be monitored; **AND**
  - Need for requested medication will be evaluated once other non-pharmacological interventions have been tried; **OR**
- **Short-term therapy has been prescribed, and meets the following:**
  - Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; **AND**
  - Efficacy and potential side effects to be monitored; **AND**
  - Need for requested medication will be evaluated once other non-pharmacological interventions have been tried.

**Note the following:**

- **Duration of short-term therapy is 90 days for Antipsychotics**
- **Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.**
- **The I/DD Worksheet can be found at:** [https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf](https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf)

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</thead>
<tbody>
<tr>
<td>Fluoxetine/olanzapine</td>
<td>NP</td>
<td>Will be approved if recipient meets the following criteria:</td>
<td>1/day</td>
<td>Atypical Anti-psychotic PA form</td>
</tr>
<tr>
<td>- For diagnosis of depressive episodes associated with bipolar disorder</td>
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<tr>
<td>- Refractory to treatment with components taken separately</td>
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<tr>
<td>- For diagnosis of major depressive disorder:</td>
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<tr>
<td>- Must have undergone an adequate trial of at least <strong>ONE</strong> agent in THREE of the following classes of antidepressants (unless contraindicated or intolerant to):</td>
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<td>- Selective serotonin reuptake inhibitors (SSRIs)</td>
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<tr>
<td>- Serotonin-norepinephrine reuptake inhibitors (SNRIs)</td>
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<tr>
<td>- New generation antidepressants (including bupropion, mirtazapine, etc.)</td>
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<tr>
<td>- Tricyclic antidepressants (TCAs); <strong>AND</strong></td>
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<tr>
<td>- Refractory to treatment with components taken separately</td>
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<tbody>
<tr>
<td>Symbax®</td>
<td>NP</td>
<td>See fluoxetine/olanzapine prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.

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*Effective Date: December 2, 2019*
CENTRAL NERVOUS SYSTEM

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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<tr>
<td>Atypical Antipsychotics</td>
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CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENT'S WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):
Antipsychotics prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if ONE of the following is met:

- Prescriber has completed the State’s training program on the appropriate use of psychotropic medications for individuals with I/DD:
  - Training available at: [https://cme.mc.vanderbilt.edu/content/appropriate-use-psychotropic-medications-people-idd-helping-individuals-get-best-behavioral](https://cme.mc.vanderbilt.edu/content/appropriate-use-psychotropic-medications-people-idd-helping-individuals-get-best-behavioral)
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  - Provide signature, module #, and date course was completed; OR
- Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; (a Primary Care Provider Checklist of Behavioral/Emotional Concerns is available at: [http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf](http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf)); AND
  - Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; AND
  - Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers. Example available at: [http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/CrisisManagementPlan.pdf](http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/CrisisManagementPlan.pdf); OR
- Short-term therapy has been prescribed and meets the following:
  - Behavioral symptoms significant enough to place the person at potential risk or needing higher level of care or loss of community placement; AND
  - Efficacy and potential side effects to be monitored; AND
  - Need for requested medication will be evaluated once other non-pharmacological interventions have been tried; OR
- Short-term therapy has been prescribed, and meets the following:
  - Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; AND
  - Efficacy and potential side effects to be monitored; AND
  - Need for requested medication will be evaluated once other non-pharmacological interventions have been tried.

**Note the following:**

- Duration of short-term therapy is 90 days for Antipsychotics
- Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.
- The I/DD Worksheet can be found at: [https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf](https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf)

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<tbody>
<tr>
<td>aripiprazole tablets</td>
<td>P</td>
<td>Preferred Atypical Antipsychotics will be approved for the following:</td>
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<td></td>
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<td>• Agitation in dementia</td>
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<td>• Bipolar and manic disorders</td>
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<td>• Bipolar depression, bipolar maintenance, bipolar mania-acute, bipolar mixed states</td>
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<td>• Brief psychotic disorder</td>
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<td>• Delusional disorder</td>
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<td>• Depression with psychotic symptoms</td>
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<td>• Drug-induced psychotic disorder with hallucinations</td>
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<td></td>
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<td>• Impulse control disorders, including Oppositional Defiant Disorder and Intermittent Explosive Disorder</td>
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<td>• Organic psychotic condition</td>
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<td>• Psychosis secondary to a medical condition, psychotic depression, psychotic disorders</td>
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<td></td>
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<td>• Schizoaffective disorder, schizoid/schizotypal personality disorder, schizophrenia, schizophrenic disorders</td>
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<td></td>
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<td>• Substance-induced psychotic disorder, substance-induced withdrawal psychotic disorder</td>
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<td>• Severe refractory OCD or PTSD</td>
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<td>• Tourette’s/Severe tic disorder</td>
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<td><strong>Note:</strong> Following a 4-week trial of a preferred atypical at an appropriate dose, an alternative preferred atypical or non-preferred atypical will be approved.</td>
<td>1/day</td>
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<td>For a diagnosis of major depressive disorder (MDD):</td>
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<td></td>
<td>• Atypicals will be approved only as adjunctive treatment for MDD.</td>
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<td></td>
<td>• Recipients must have undergone an adequate trial of at least one agent in three of the following classes of antidepressants (unless contraindicated or intolerant to):</td>
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<tr>
<td></td>
<td></td>
<td>- SSRI</td>
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<td></td>
<td></td>
<td>- SNRI</td>
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<td>- TCA</td>
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<td>- New generation antidepressants (including bupropion, mirtazapine, etc.)</td>
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<td>For patients without one of the above diagnoses:</td>
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<td></td>
<td></td>
<td>• May be approved if the physician can provide documented clinical evidence supporting the use of the requested medication for the requested indication.</td>
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</tr>
<tr>
<td>aripiprazole ODT</td>
<td>P</td>
<td>See aripiprazole tablets prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Additionally, will only be approved for patients who are unable to swallow, OR unable to absorb medications through the GI tract.</td>
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<tr>
<td>aripiprazole solution</td>
<td>P</td>
<td>See aripiprazole tablets prior authorization criteria</td>
<td>10 mL/day</td>
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<tr>
<td>clozapine</td>
<td>P</td>
<td>See aripiprazole tablets prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Latuda*</td>
<td>P</td>
<td>See aripiprazole tablets prior authorization criteria</td>
<td>1/day</td>
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</tbody>
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## CENTRAL NERVOUS SYSTEM

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<td>olanzapine</td>
<td>P</td>
<td>See aripiprazole tablets prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>olanzapine ODT</td>
<td>P</td>
<td>See aripiprazole ODT prior authorization criteria</td>
<td>1/day</td>
<td></td>
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<tr>
<td>quetiapine</td>
<td>P</td>
<td>See aripiprazole tablets prior authorization criteria</td>
<td>4/day</td>
<td>Atypical Anti-psychotic PA form</td>
</tr>
<tr>
<td>quetiapine ER</td>
<td>P</td>
<td>See aripiprazole tablets prior authorization criteria</td>
<td>2/day</td>
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<tr>
<td>risperidone</td>
<td>P</td>
<td>See aripiprazole tablets prior authorization criteria</td>
<td>2/day</td>
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<tr>
<td>risperidone ODT</td>
<td>P</td>
<td>See aripiprazole ODT prior authorization criteria</td>
<td>2/day</td>
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<tr>
<td>Saphris®</td>
<td>P</td>
<td>See aripiprazole tablets prior authorization criteria</td>
<td>2/day</td>
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<tr>
<td>ziprasidone</td>
<td>P</td>
<td>See aripiprazole tablets prior authorization criteria</td>
<td>2/day</td>
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</tbody>
</table>

**Note:** Approval of non-preferred atypical antipsychotics will require trial and failure of ONE preferred agent.

| Abilify Maintena™ | NP | See Abilify™ tablets prior authorization criteria                                           | 1/30 days   |         |
|                  |    | • Additionally, will only be authorized if the recipient has documented non-compliance with PO atypicals (which must include aripiprazole) OR non-response due to noncompliance. |

| Abilify Mycite® | NP | See Abilify™ tablets prior authorization criteria                                           | 1/day       |         |
|                |    | • Additionally, provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus all other forms of aripiprazole. |

| Abilify® solution | NP | See Abilify™ tablets prior authorization criteria                                           | 10 mL/day   |         |
|                  |    | Will be approved for patients with the following **AND** have tried or failed **ONE** preferred agent: |
|                  |    | • Agitation in dementia                                                                   |
|                  |    | • Bipolar and manic disorders                                                             |
|                  |    | • Bipolar depression, bipolar maintenance, bipolar mania-acute, bipolar mixed states      |
|                  |    | • Brief psychotic disorder                                                                |
|                  |    | • Delusional disorder                                                                    |
|                  |    | • Depression with psychotic symptoms                                                       |
|                  |    | • Drug-induced psychotic disorder with hallucinations                                      |
|                  |    | • Impulse control disorders, including Oppositional Defiant Disorder and Intermittent Explosive Disorder |
|                  |    | • Organic psychotic condition                                                             |
|                  |    | • Psychosis secondary to a medical condition, psychotic depression, psychotic disorders    |
|                  |    | • Schizo-affective disorder, schizoid/schizotypal personality disorder, schizophrenia, schizophrenic disorders |
|                  |    | • Substance-induced psychotic disorder, substance-induced withdrawal psychotic disorder  |
|                  |    | • Severe refractory OCD or PTSD                                                          |
|                  |    | • Tourette’s/Severe tic disorder                                                         |

**Note:** Following a 4-week trial of a preferred atypical at an appropriate dose, an alternative preferred atypical or non-preferred atypical will be approved.

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**CENTRAL NERVOUS SYSTEM**

*Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.*

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| **Abilify** tablets     | NP  | For a diagnosis of major depressive disorder (MDD):  
  • Atypicals will be approved only as adjunctive treatment for MDD.  
  • Recipients must have undergone an adequate trial of at least one agent in three of the following classes of antidepressants (unless contraindicated or intolerant to):  
    - SSRIs  
    - SNRIs  
    - TCAs  
    - New generation antidepressants (including bupropion, mirtazapine, etc.)  
  • For patients without one of the above diagnoses:  
  • May be approved if the physician can provide documented clinical evidence supporting the use of the requested medication for the requested indication. | 1/day             |                              |
| (continued)             |     |                                                                                                                                                                                                                                 |                   |                              |

| **Aristada**            | NP  | See Abilify tablets prior authorization criteria  
  • Additionally, will only be approved if the recipient has documented non-compliance with PO atypicals (which must include aripiprazole) OR non-response due to noncompliance. | 1 injection/30 days |                              |
| **Aristada® Initio**    | NP  | See Aristada prior authorization criteria  
  • Additionally, will only be approved if the recipient has documented non-compliance with PO atypicals (which must include aripiprazole) OR non-response due to noncompliance. | 2.4 mL/60 days    | **Atypical Anti-psychotic PA form** |
| **clozapine ODT**       | NP  | See Abilify tablets prior authorization criteria  
  • Additionally, will only be approved for patients who are unable to swallow, OR unable to absorb medications through the GI tract. | 12.5 & 25mg: 2/day; 100mg: 9/day; 150mg: 6/day; 200mg: 4/day | **Atypical Anti-psychotic PA form** |
| **Clozaril®**           | NP  | See Abilify tablets prior authorization criteria  
  • Additionally, will only be approved for patients who are unable to swallow, OR unable to absorb medications through the GI tract. | 1/day             |                              |
| **Fanapt®**             | NP  | See Abilify tablets prior authorization criteria  
  • Additionally, will only be approved if the recipient has documented non-compliance with PO atypicals (which must include either risperidone or paliperidone) OR non-response due to noncompliance. | 2/day             |                              |
| **FazaClo ODT®**        | NP  | See clozapine ODT prior authorization criteria  
  • Additionally, will only be approved if the recipient has documented non-compliance with PO atypicals (which must include either risperidone or paliperidone) OR non-response due to noncompliance. | 12.5 & 25mg: 2/day; 100mg: 9/day; 150mg: 6/day; 200mg: 4/day |                              |
| **Geodon®**             | NP  | See Abilify tablets prior authorization criteria  
  • Additionally, will only be approved if the recipient has documented non-compliance with PO atypicals (which must include either risperidone or paliperidone) OR non-response due to noncompliance. | 2/day             |                              |
| **Invega®**             | NP  | See Abilify tablets prior authorization criteria  
  • Additionally, will only be approved if the recipient has documented non-compliance with PO atypicals (which must include either risperidone or paliperidone) OR non-response due to noncompliance. | 6 mg: 2/day; All others: 1/day |                              |
| **Invega® Sustenna®**   | NP  | See Abilify tablets prior authorization criteria  
  • Additionally, will only be approved if the recipient has documented non-compliance with PO atypicals (which must include either risperidone or paliperidone) OR non-response due to noncompliance. | 1 syringe/28 days |                              |

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# CENTRAL NERVOUS SYSTEM

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<tr>
<td>Invega® Trinza® NP</td>
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<td>See Invega® Sustenna® prior authorization criteria • Additionally, TennCare prescription claims history must indicate patient has been on Invega® Sustenna™ for 4 months.</td>
<td>1 syringe/76 days</td>
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</tr>
<tr>
<td>Nuplazid® NP</td>
<td></td>
<td>Will be approved for patients who meet ALL of the following criteria: • Hallucinations and/or delusions associated with Parkinson’s disease psychosis; AND • Must be ≥18 years of age; AND • Trial of behavioral modification prior to treatment with pimavanserin; AND • Trial of dose adjustment or withdrawal of antiparkinson medications (anticholinergics, amantadine, dopamine agonists, COMT inhibitors, selegiline) prior to treatment with pimavanserin. <strong>Note:</strong> Coverage will <strong>not</strong> be approved for psychosis not related to Parkinson’s disease.</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>paliperidone NP</td>
<td>NP</td>
<td>See Abilify® tablets prior authorization criteria</td>
<td>6 mg: 2/day; All others: 1/day</td>
<td>Anti-psychotic PA form</td>
</tr>
<tr>
<td>Perseris® ER NP</td>
<td>NP</td>
<td>See Invega® Sustenna® prior authorization criteria</td>
<td>1 kit/month</td>
<td></td>
</tr>
<tr>
<td>Rexulti® NP</td>
<td>NP</td>
<td>See Abilify® tablets prior authorization criteria</td>
<td>1/day</td>
<td>Atypical Anti-psychotic PA form</td>
</tr>
<tr>
<td>Risperdal® Consta® NP</td>
<td>NP</td>
<td>See Invega® Sustenna® prior authorization criteria</td>
<td>2 vials/28 days</td>
<td></td>
</tr>
<tr>
<td>Risperdal® NP</td>
<td>NP</td>
<td>See Abilify® tablets prior authorization criteria</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>Risperdal M-tab® NP</td>
<td>NP</td>
<td>See clozapine ODT prior authorization criteria</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>Seroquel® NP</td>
<td>NP</td>
<td>See Abilify® tablets prior authorization criteria</td>
<td>4/day</td>
<td></td>
</tr>
<tr>
<td>Seroquel® XR NP</td>
<td>NP</td>
<td>See Abilify® tablets prior authorization criteria</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>Versacloz® suspension</td>
<td>NP</td>
<td>See Abilify® tablets prior authorization criteria • Additionally, will be approved for patient meeting the following criteria: – Allergy or intolerance to inactive ingredient in ODT tab (i.e., dye, filler, excipient, etc) – Dose not achievable with ODT tab</td>
<td></td>
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<tr>
<td>Vraylar® NP</td>
<td>NP</td>
<td>See Abilify® tablets prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Zyprexa® Zydis® NP</td>
<td>NP</td>
<td>See clozapine ODT prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Zyprexa® NP</td>
<td>NP</td>
<td>See Abilify® tablets prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
</tbody>
</table>

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### CENTRAL NERVOUS SYSTEM

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
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<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
</table>
| Xadago™    | NP  | Will be approved for patients meeting the following:  
  - Patient has Parkinson’s disease; **AND**
  - Patient is receiving concomitant therapy with carbidopa/levodopa; **AND**
  - Patient is experiencing “off episodes” with monotherapy using carbidopa/levodopa; **AND**
  - Patient does not have severe hepatic impairment (Child-Pugh Score > 9); **AND**
  - Patient is not taking any of the following:
    - dextromethorphan
    - other MAO-I inhibitors or other drugs that are potent inhibitors of monoamine oxidase (e.g., linezolid)
    - other serotonergic drugs (e.g., SNRIs, SSRIs, TCAs, St. John’s wort, cyclobenzaprine)
    - opioid drugs (e.g., meperidine, methadone, propoxyphene, tramadol)
    - sympathomimetic medications (e.g., methylphenidate,amphetamine)
    - Trial and failure, contraindication, or intolerance to preferred MAO-B inhibitor | 1/day | General PA Form |
| Zelapar™   | NP  | Will be approved if patient meets ONE of the following criteria:  
  - Inability to swallow; **OR**
  - Patients who experience adverse reactions to selegiline secondary to the active metabolites, l-amphetamine and l-methamphetamine | | |

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</thead>
<tbody>
<tr>
<td><strong>Miscellaneous CNS Agents</strong></td>
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</tbody>
</table>
| Nuedexta® | NP | Approval will be authorized for recipients meeting ALL of the following criteria:  
- Diagnosis of Pseudobulbar Affect (PBA) with multiple sclerosis (MS) or amyotrophic lateral sclerosis (ALS), AND  
- The following patient circumstances have been excluded:  
  - Heart failure or high grade (second/third degree) atroventricular block (AV) without an implanted pacemaker  
  - Patient receiving drugs that prolong QT interval and are metabolized by CYP2D6 system  
  - Prolonged QT interval (including congenital long QT syndrome) or a history of torsades de pointes  
  - Concomitantly taking monoamine oxidase inhibitors (MAOIs) or have used a MAOI in the past 14 days  
- Consideration will be given for Pseudobulbar affect (PBA) occurring secondary to neurological conditions (e.g., stroke, TBI, or dementia) when ALL of the following have been met:  
  - PBA episodes:  
    - Occur greater than 3 times per day  
    - Are exaggerated or incongruent to inner emotion  
    - Occur spontaneously, with no clear trigger  
  - CNS-LS score of ≥13, documentation required  
  - Depression, Bipolar disorder, or other differential diagnoses have been ruled out  
  - The following patient circumstances have been excluded:  
    - Heart failure or high grade (second/third degree) atroventricular block (AV) without an implanted pacemaker  
    - Patient receiving drugs that prolong QT interval and are metabolized by CYP2D6 system  
    - Prolonged QT interval (including congenital long QT syndrome) or a history of torsades de pointes  
    - Concomitantly taking monoamine oxidase inhibitors (MAOIs) or have used a MAOI in the past 14 days | 2/day | General PA Form |
| **Mood Stabilizers** | | | | |
| Lamictal® ODT | NP | Will be approved for patients who are:  
- Unable to swallow; **OR**  
- Unable to absorb medications through the GI tract | General PA Form |
| pramipexole | P | | 3/day | |
| Mirapex® | NP | | 3/day | |
| Mirapex® ER | NP | | 1/day | General PA Form |
| Neupro® | NP | Neupro® will be approved for patient with a diagnosis of Parkinson’s Disease or Restless Leg Syndrome, **AND**  
- Trial and failure, contraindication or intolerance to BOTH pramipexole AND ropinirole, **OR**  
- Inability to swallow | 1/day | |
| pramipexole ER | NP | | 1/day | |

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### CENTRAL NERVOUS SYSTEM

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<td></td>
<td><strong>Sedative Hypnotics</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENT'S WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):</strong></td>
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<tr>
<td></td>
<td></td>
<td>Sedative Hypnotics prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if ONE of the following is met:</td>
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<tr>
<td></td>
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<td>• Insomnia assessment applicable to history of symptoms (assessment tools available at: <a href="http://www.sleep.pitt.edu/research/lewExternalFiles/PSQI%20Instrument.pdf">http://www.sleep.pitt.edu/research/lewExternalFiles/PSQI%20Instrument.pdf</a>; AND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Mental health assessment applicable to behavioral symptoms to identify underlying diagnosis if applicable; (Primary Care Provider Checklist of Behavioral/Emotional Concerns is available at: <a href="http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf">http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf</a>); AND</td>
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<tr>
<td></td>
<td></td>
<td>- Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and symptoms of insomnia persist; AND</td>
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<td></td>
<td>- Non-pharmacological interventions have been tried and insomnia persist (e.g., stimulus control therapy or relaxation therapy, or a combination of stimulus control therapy and cognitive therapy, and sleep restriction therapy with or without relaxation therapy); (Clinical Guideline for the Evaluation and Management of Chronic Insomnia in Adults is available at: <a href="http://www.aasmnet.org/Resources/clinicalguidelines/040515.pdf">http://www.aasmnet.org/Resources/clinicalguidelines/040515.pdf</a>); AND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Trial and failure, intolerance, or contraindication to melatonin; OR</td>
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<tr>
<td></td>
<td></td>
<td>• Short-term therapy has been prescribed and meets the following:</td>
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<tr>
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<td>- Insomnia and associated daytime dysfunction is significant enough to place the person at potential risk or needing higher level of care or loss of community placement, AND</td>
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<td></td>
<td></td>
<td>- Efficacy and potential side effects to be monitored; AND</td>
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<td></td>
<td></td>
<td>- Need for requested medication will be evaluated once other non-pharmacological interventions have been tried; AND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Trial and failure, intolerance, or contraindication to melatonin; OR</td>
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<tr>
<td></td>
<td></td>
<td>• Short-term therapy has been prescribed, and meets the following:</td>
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<td></td>
<td>- Continuation of existing therapy to address serious and ongoing insomnia and associated daytime dysfunction while other prior authorization criteria are met, AND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Efficacy and potential side effects to be monitor; AND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Need for requested medication will be evaluated once other non-pharmacological interventions have been tried; AND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Trial and failure, intolerance, or contraindication to melatonin.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note the following:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Duration is limited to a one-time, fourteen (14) tablets for a 30-day supply for short-term approvals of Sedative Hypnotics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patients with disorders related to Intellectual and Developmental Disabilities AND a concomitant diagnosis specified with drug specific criteria will be subject to the diagnosis specific criteria.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The I/DD Worksheet can be found at: <a href="https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf">https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>eszopiclone</td>
<td>P</td>
<td>14/30 days*</td>
<td></td>
</tr>
<tr>
<td>Rozerem®</td>
<td>P</td>
<td>14/30 days*</td>
<td></td>
</tr>
<tr>
<td>zaleplon</td>
<td>P</td>
<td>14/30 days*</td>
<td></td>
</tr>
<tr>
<td>zolpidem</td>
<td>P</td>
<td>14/30 days*</td>
<td></td>
</tr>
<tr>
<td>Ambien®</td>
<td>NP</td>
<td>14/30 days*</td>
<td>General PA</td>
</tr>
<tr>
<td>Ambien CR®</td>
<td>NP</td>
<td>14/30 days*</td>
<td></td>
</tr>
<tr>
<td>Belsomra®</td>
<td>NP</td>
<td>14/30 days*</td>
<td></td>
</tr>
<tr>
<td>Edluar™</td>
<td>NP</td>
<td>Approved only for patients with difficulty swallowing/absorption</td>
<td>14/30 days*</td>
</tr>
</tbody>
</table>

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### CENTRAL NERVOUS SYSTEM

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
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<tr>
<th>Medication</th>
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<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>estazolam</td>
<td>NP</td>
<td>See flurazepam prior authorization criteria</td>
<td>14/30 days*</td>
<td></td>
</tr>
</tbody>
</table>
| flurazepam | NP  | Will be approved if ALL of the following criteria is met:  
- Diagnosis of Insomnia; **AND**  
- Medical documentation that rules out other insomnia related disorders (e.g., movement, breathing, psychiatric disorders and medication); **AND**  
- Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., stimulus control, sleep restriction, sleep hygiene measures and relaxation therapy); **AND**  
- Use of 2 preferred agents, unless patient has a contraindication or allergy; **AND**  
- Due to increased risk of toxicity,  
  - Patient should not be pregnant **OR**  
  - Concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate or barbiturates; **AND**  
- Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse; **AND**  
**Note:** Caution is warranted if patient is concurrently taking CYP3A4 inhibitors [e.g., fluvoxamine, itraconazole, ketoconazole] as patient is at increased risk of toxicity. | 14/30 days* |         |
| Halcion*   | NP  | Will be approved if ALL of the following criteria is met:  
- Diagnosis of Insomnia; **AND**  
- Medical documentation that rules out other insomnia related disorders (e.g., movement, breathing, psychiatric disorders & medication/substance use); **AND**  
- Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., stimulus control, sleep restriction, sleep hygiene measures & relaxation therapy); **AND**  
- Use of 2 preferred agents, unless patient has a contraindication or allergy; **AND**  
- Clinical reason as to why patient cannot use generic equivalent; **AND**  
- Due to increased risk of toxicity,  
  - Patient should not be pregnant **OR**  
  - Concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate or barbiturates; **AND**  
- Due to increased risk of dependency,  
- Patient does not have a history of alcohol **OR** drug dependence/abuse  
**Note:** Caution is warranted if patient is concurrently taking CYP3A4 inhibitors [e.g., fluvoxamine, itraconazole, ketoconazole] as patient is at increased risk of toxicity. | 14/30 days* |         |

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### Sedative Hypnotics (continued)

<table>
<thead>
<tr>
<th>Medication</th>
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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
</table>
| Hetlioz*         | NP  | Will be approved if the following is met:  
  • Treatment of non-24-hour sleep wake disorder (non-24 or N24) in members who are unable to distinguish between light and darkness in both eyes; **AND**  
  • Trial and failure or contraindication to melatonin | 14/30 days* | General PA Form |
| Intermezzo*      | NP  |                                                                                                           | 14/30 days* | General PA Form |
| Lunesta*         | NP  |                                                                                                           | 14/30 days* | General PA Form |
| ramelteon        | NP  |                                                                                                           | 14/30 days* | General PA Form |
| Restoril*        | NP  | See Halcion® prior authorization criteria                                                                                                                           | 14/30 days* | General PA Form |
| Silenor®         | NP  | Documented trial/failure (defined as ≥ 1 week) at an appropriate dose of the doxepin 10mg/mL concentrated solution                                                                                                     | 14/30 days* | General PA Form |
| Sonata®          | NP  |                                                                                                           | 14/30 days* | General PA Form |
| temazepam (excludes 7.5 & 22.5mg) | NP  | See flurazepam prior authorization criteria                                                                                                                       | 14/30 days* | General PA Form |
| temazepam (7.5 & 22.5mg) | NP  | Will be approved if **ALL** of the following criteria is met:  
  • Diagnosis of Insomnia; **AND**  
  • Medical documentation that rules out other insomnia related disorders (e.g., movement, breathing, psychiatric disorders and medication); **AND**  
  • Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., stimulus control, sleep restriction, sleep hygiene measures and relaxation therapy); **AND**  
  • Use of 2 preferred agents, unless patient has a contraindication or allergy; **AND**  
  • Due to increased risk of toxicity,  
    – Patient should not be pregnant **OR**  
    – Concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate or barbiturates; **AND**  
  • Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse **AND**  
  • Trial and failure of temazepam 15mg and/or 30mg strength,  
  • **Note:** Caution is warranted if patient is concurrently taking CYP3A4 inhibitors [e.g., fluvoxamine, itraconazole, ketoconazole] as patient is at increased risk of toxicity | 14/30 days* | General PA Form |
| triazolam        | NP  | See flurazepam prior authorization criteria                                                                                                                       | 14/30 days* | General PA Form |
| zolpidem ER      | NP  |                                                                                                           | 14/30 days* | General PA Form |
| zolpidem tartrate SL | NP  |                                                                                                           | 14/30 days* | General PA Form |
| Zolpimist*       | NP  |                                                                                                           | 7.7mL/60 days* | General PA Form |

*For children, larger quantities may be approved as medically necessary.*

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## CENTRAL NERVOUS SYSTEM

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<tbody>
<tr>
<td><strong>Skeletal Muscle Relaxants</strong></td>
<td></td>
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</tr>
<tr>
<td>Amrix ^®</td>
<td>NP</td>
<td>Approval will be granted upon documentation of ALL of the following:</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of an FDA-approved indication; AND</td>
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<tr>
<td></td>
<td></td>
<td>• Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred cyclobenzaprine</td>
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</tr>
<tr>
<td>carisoprodol</td>
<td>NP</td>
<td>Approval will be authorized for recipients meeting the ALL of the following criteria:</td>
<td>4/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Contraindication, drug to drug interaction, or history of toxic side effects that will cause immediate or long-term damage with ALL preferred skeletal muscle relaxants; AND</td>
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<tr>
<td></td>
<td></td>
<td>• Patient does not have a history of, or received treatment for, drug dependency or drug abuse.</td>
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<tr>
<td></td>
<td></td>
<td>• Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 30 days;</td>
<td></td>
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</tr>
<tr>
<td>carisoprodol/ASA</td>
<td>NP</td>
<td>Will be approved if patient meets ALL of the following criteria:</td>
<td>4/day</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Patient is less than 18 years of age:</td>
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<tr>
<td></td>
<td></td>
<td>– Contraindication, drug to drug interaction, or history of toxic side effects that will cause immediate or long-term damage with ALL preferred skeletal muscle relaxants; AND</td>
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<tr>
<td></td>
<td></td>
<td>– Patient does not have a history of, or received treatment for, drug dependency or drug abuse; AND</td>
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<tr>
<td></td>
<td></td>
<td>– Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 30 days; AND</td>
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<td></td>
<td></td>
<td>– Patient does not have any of the following:</td>
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<td></td>
<td></td>
<td>• Obesity</td>
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<td>• Obstructive Sleep Apnea</td>
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<td>• Severe Lung Disease; AND</td>
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<td>– Prescriber is aware of contraindication in patients younger than 12 years of age due to serious risks, including slowed or difficult breathing and death, and agrees to accept risks</td>
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<tr>
<td></td>
<td></td>
<td>• Patients ≥ 18 years of age: See carisoprodol prior authorization criteria</td>
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</tr>
<tr>
<td>cyclobenzaprine ER</td>
<td>NP</td>
<td>See Amrix ^® prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Soma*</td>
<td>NP</td>
<td>See carisoprodol prior authorization criteria</td>
<td>4/day</td>
<td></td>
</tr>
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<tr>
<td>Typical Antipsychotics</td>
<td></td>
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</tbody>
</table>

**CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):**

Antipsychotics prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if **ONE** of the following is met:

- Prescriber has completed the State’s training program on the appropriate use of psychotropic medications for individuals with I/DD:
  - Training available at: [https://cme.mc.vanderbilt.edu/content/appropriate-use-antipsychotic-medications-people-idd-helping-individuals-get-best-behavioral](https://cme.mc.vanderbilt.edu/content/appropriate-use-antipsychotic-medications-people-idd-helping-individuals-get-best-behavioral)
  - Note: 1.5 hours of free continuing medical education units are available upon completion of the 90-minute training. Completion of training is required only once, regardless of the number of patients with I/DD. Training can be completed in 10–15-minute intervals in any order and dispersed per preferences of the reviewer; **AND**
  - Provide signature, module #, and date course was completed; **OR**
- Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; (a Primary Care Provider Checklist of Behavioral/Emotional Concerns is available at: [http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf](http://vkc.mc.vanderbilt.edu/etoolkit/wp-content/uploads/BehEmotionalConcernsPCP.pdf)); **AND**
  - Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; **AND**
  - Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers. Example available at: [http://vkc.mc.vanderbilt.edu/etoolkit/wpcontent/uploads/CrisisManagementPlan.pdf](http://vkc.mc.vanderbilt.edu/etoolkit/wpcontent/uploads/CrisisManagementPlan.pdf)); **OR**
- Short-term therapy has been prescribed and meets the following:
  - Behavioral symptoms significant enough to place the person at potential risk or needing higher level of care or loss of community placement; **AND**
  - Efficacy and potential side effects to be monitored; **AND**
  - Need for requested medication will be evaluated once other non-pharmacological interventions have been tried; **OR**
- Short-term therapy has been prescribed, and meets the following:
  - Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; **AND**
  - Efficacy and potential side effects to be monitored; **AND**
  - Need for requested medication will be evaluated once other non-pharmacological interventions have been tried.

**Note the following:**

- Duration of short-term therapy is 90 days for Antipsychotics
- Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.
- The I/DD Worksheet can be found at: [https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf](https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_IDD_Worksheet.pdf)

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>chlorpromazine</td>
<td>P</td>
<td></td>
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<tr>
<td>fluphenazine</td>
<td>P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>haloperidol</td>
<td>P</td>
<td></td>
<td></td>
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<tr>
<td>loxapine</td>
<td>P</td>
<td></td>
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</tr>
<tr>
<td>perphenazine</td>
<td>P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pimozide</td>
<td>P</td>
<td></td>
<td>General PA Form</td>
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<tr>
<td>thioridazine</td>
<td>P</td>
<td></td>
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<tr>
<td>thiothixene</td>
<td>P</td>
<td></td>
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</tr>
<tr>
<td>trifluoperazine</td>
<td>P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>molindone</td>
<td>NP</td>
<td></td>
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</tr>
<tr>
<td>Orap®</td>
<td>NP</td>
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</tr>
</tbody>
</table>

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<tbody>
<tr>
<td></td>
<td></td>
<td><em>Topical Anesthetics</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>lidocaine (excluding lotion)</td>
<td>P</td>
<td></td>
<td>1 tube/Rx: 5% ointment: 35.44g &amp; 35g 3% cream: 28.35g</td>
<td></td>
</tr>
<tr>
<td>lidocaine/hydrocortisone</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>lidocaine/prilocaine</td>
<td>P</td>
<td></td>
<td>30 grams/Rx</td>
<td></td>
</tr>
<tr>
<td>EMLA®</td>
<td>NP</td>
<td></td>
<td>30g/Rx</td>
<td></td>
</tr>
<tr>
<td>lidocaine patches</td>
<td>NP</td>
<td>Will be approved for patients with a diagnosis of neuropathic pain who have had a failure of, contraindication to, or intolerance of:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• One tricyclic antidepressant AND one anticonvulsant; OR</td>
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<td></td>
<td></td>
<td>• Two anticonvulsants</td>
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<tr>
<td>Lidoderm*</td>
<td>NP</td>
<td>Will be approved for patients with a diagnosis of neuropathic pain who have had a failure of, contraindication to, or intolerance of:</td>
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<tr>
<td></td>
<td></td>
<td>• One tricyclic antidepressant AND one anticonvulsant; OR</td>
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<tr>
<td></td>
<td></td>
<td>• Two anticonvulsants</td>
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<tr>
<td>LidoPure®</td>
<td>NP</td>
<td>Will be approved for patients with a diagnosis of post-herpetic neuralgia who have failed gabapentin AND had a failure, contraindication, or intolerance to ONE of the following:</td>
<td>3/day</td>
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<tr>
<td></td>
<td></td>
<td>• A tricyclic antidepressant</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>• An anticonvulsant (other than gabapentin)</td>
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<tr>
<td>Piaglis®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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</tr>
<tr>
<td>Pramosone® 2.5%–1% lotion</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Zilacaine®</td>
<td>NP</td>
<td>Will be approved for patients with a diagnosis of post-herpetic neuralgia who have failed gabapentin AND had a failure, contraindication, or intolerance to ONE of the following:</td>
<td>3/day</td>
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<tr>
<td></td>
<td></td>
<td>• A tricyclic antidepressant</td>
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<tr>
<td></td>
<td></td>
<td>• An anticonvulsant (other than gabapentin)</td>
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<td></td>
<td></td>
<td><em>Topical Antibiotic Agents for Skin and Soft Tissue Infections</em></td>
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<tr>
<td>mupirocin ointment</td>
<td>P</td>
<td></td>
<td>44g/Rx</td>
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<tr>
<td>Bactroban® cream</td>
<td>NP</td>
<td></td>
<td>30g/Rx</td>
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</tr>
<tr>
<td>Bactroban® ointment</td>
<td>NP</td>
<td></td>
<td>44g/Rx</td>
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<tr>
<td>Centany®</td>
<td>NP</td>
<td></td>
<td>44g/Rx</td>
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</tr>
</tbody>
</table>

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## DERMATOLOGICS

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<table>
<thead>
<tr>
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<th>Prior Authorization Criteria</th>
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</thead>
<tbody>
<tr>
<td><strong>Topical Antineoplastics</strong></td>
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</tr>
<tr>
<td>Carac®</td>
<td>P</td>
<td>Will be approved for the following criteria:</td>
<td>1 package/Rx</td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of actinic keratosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>diclofenac 3% gel</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Panretin®</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
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</tr>
<tr>
<td>Targretin®</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
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</tr>
<tr>
<td>Efudex®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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<tr>
<td>Picato®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
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<tr>
<td>Solaraze*</td>
<td>NP</td>
<td>Will be approved for the following criteria:</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of actinic keratosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tolak®</td>
<td>NP</td>
<td>Will be approved for the following criteria:</td>
<td>1 package/Rx</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Trial and failure of TWO preferred fluorouracil products with the same indication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valchlor®</td>
<td>NP</td>
<td>Will be approved for patients meeting <strong>ALL</strong> of the following criteria:</td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of stage IA or IB mycosis fungoides; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Patient has received skin directed therapy</td>
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<tr>
<td>Zyclara®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td><strong>Topical Antibiotics for Acne</strong></td>
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<tr>
<td>Azelex®</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>benzoyl peroxide</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td>(2.5%, 5%, 10% excluding cleanser, gel, microspheres, and towelettes)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>clindamycin phosphate</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>(excluding foam, lotion, &amp; 75 mL bottle of gel)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>erythromycin (excluding swab &amp; gels)</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
</tbody>
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<tbody>
<tr>
<td><strong>Topical Antibiotics for Acne (continued)</strong></td>
<td></td>
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</tr>
<tr>
<td>Aczone®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>benzoyl peroxide (cleanser, gel, microspheres, towelettes, and all strengths not listed as preferred)</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>benzoyl peroxide kits and other dermatological kits</td>
<td>NP</td>
<td>Approval will be granted upon documentation of ALL of the following:</td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>clindamycin phosphate foam, lotion, and gel (75 mL bottle)</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>clindamycin/benzoyl peroxide gel</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>erythromycin swab &amp; gel</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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</tr>
<tr>
<td>sodium sulfacetamide/sulfur</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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</tr>
<tr>
<td>sulfacetamide suspension</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>All branded single agent and combination products of: benzoyl peroxide, clindamycin, erythromycin, and sodium sulfacetamide</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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<tr>
<td><strong>Topical Antibiotics for Rosacea</strong></td>
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<tr>
<td>Finacea® 15% gel</td>
<td>P</td>
<td></td>
<td>50g/Rx</td>
<td></td>
</tr>
<tr>
<td>metronidazole 0.75% cream, lotion, and gel</td>
<td>P</td>
<td></td>
<td>60g/Rx</td>
<td></td>
</tr>
<tr>
<td>metronidazole 1% gel</td>
<td>P</td>
<td></td>
<td>60g/Rx</td>
<td></td>
</tr>
<tr>
<td>Finacea® 15% foam</td>
<td>NP</td>
<td></td>
<td>50g/Rx</td>
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</thead>
<tbody>
<tr>
<td><strong>Topical Antibiotics for Rosacea (continued)</strong></td>
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</tbody>
</table>
| Finacea® Plus gel NP      |     | Approval will be granted upon documentation of ALL of the following:  
  - Trial and failure of THREE preferred agents  
  - Trial and failure of the individual components of the kit                                                                                                                   |             |          |
| MetroCream® NP            | 60g/Rx | Will be approved if the following is met:  
  - Patient age < 21 years of age; **AND**  
  - Patient has a diagnosis rosacea or erythema; **AND**  
  - Unless contraindicated, have tried and failed at least 2 of the following: brimonidine (Mirvaso), ivermectin (Soolantra) tetracycline, minocycline, doxycycline, erythromycin, clindamycin, benzoyl peroxide; **AND**  
  - Trial/failure of 2 preferred topical agents for rosacea                                                                                                                     | 30g/30 days |          |
| MetroGel® 1% NP           | 60g/Rx |                                                                                                                                                                                                                              |             |          |
| MetroLotion® NP           | 60g/Rx |                                                                                                                                                                                                                              |             |          |
| Mirvaso® NP               | 30g/Rx |                                                                                                                                                                                                                              |             |          |
| Noritate® 1% cream NP     | 60g/Rx |                                                                                                                                                                                                                              |             |          |
| Rhofade® NP               | 30g/30 days | Will be approved if the following is met:  
  - Positive diagnostic microbiological or histological test (including KOH preparation, periodic acid Schiff (PAS) stain, or lab culture)  
  - Underlying disease (i.e., diabetes, peripheral vascular disease, poor circulation, immunocompromised recipients, etc.)  
  - Recipient has tried and failed or has an intolerance or contra-indication to terbinafine                                                                                |             |          |
| Rosadan® Kit NP           | 1/Rx |                                                                                                                                                                                                                              |             |          |
| Soolantra® NP             | 30g/30 days |                                                                                                                                                                                                                              |             |          |
| **Topical Antifungals**                                                                                                                                                          |             |          |
| ciclopirox P              | 1 package/Rx | For onychomycosis will be authorized if **ALL** of the following are true:  
  - Positive diagnostic microbiological or histological test (including KOH preparation, periodic acid Schiff (PAS) stain, or lab culture)  
  - Underlying disease (i.e., diabetes, peripheral vascular disease, poor circulation, immunocompromised recipients, etc.)  
  - Recipient has tried and failed or has an intolerance or contra-indication to terbinafine                                                                                |             |          |
| ciclopirox solution 8% P  |         |                                                                                                                                                                                                                              |             |          |
| clotrimazole 1% cream & soln P | 1 package/Rx |                                                                                                                                                                                                                              |             |          |
| ketoconazole (shampoo and cream) P | 1 package/Rx |                                                                                                                                                                                                                              |             |          |
| nystatin powder P         | 120g/Rx |                                                                                                                                                                                                                              |             |          |
| Bensal HP® NP             | 1 package/Rx |                                                                                                                                                                                                                              |             |          |

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<tr>
<td><strong>Topical Antifungals (continued)</strong></td>
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<tr>
<td><strong>Ciclodan Kit</strong></td>
<td>NP</td>
<td>Approval will be granted upon documentation of ALL of the following:</td>
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<tr>
<td></td>
<td></td>
<td>- Trial and failure of TWO preferred agents</td>
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<td></td>
<td></td>
<td>- Trial and failure of the individual components of the kit</td>
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<tr>
<td></td>
<td></td>
<td>1 package/Rx</td>
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<tr>
<td><strong>Ciclopiroxi nail kit</strong></td>
<td>NP</td>
<td>For onychomycosis will be authorized if ALL of the following are true:</td>
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<tr>
<td></td>
<td></td>
<td>- Positive diagnostic microbiological or histological test (including KOH preparation, periodic acid Schiff (PAS) stain, or lab culture)</td>
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<tr>
<td></td>
<td></td>
<td>- Underlying disease (i.e. diabetes, peripheral vascular disease, poor circulation, immunocompromised recipients, etc.)</td>
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<td></td>
<td></td>
<td>- Recipient has tried and failed or has an intolerance or contraindication to terbinafine</td>
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<td></td>
<td></td>
<td>- Recipient has tried and failed the preferred topical ciclopirox 8% solution</td>
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<td></td>
<td></td>
<td>1 package/Rx</td>
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<tr>
<td><strong>Clotrimazole 1% cream &amp; soln (Rx)</strong></td>
<td>NP</td>
<td>Approval will be granted upon documentation of ALL of the following:</td>
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<tr>
<td></td>
<td></td>
<td>- Trial and failure of TWO preferred agents</td>
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<tr>
<td></td>
<td></td>
<td>- Trial and failure of the individual components of the kit</td>
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<td></td>
<td></td>
<td>1 package/Rx</td>
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<td></td>
<td></td>
<td>See ciclopirox nail kit prior authorization criteria</td>
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<tr>
<td><strong>Clotrimazole/betamethasone</strong></td>
<td>NP</td>
<td>1 package/Rx</td>
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<tr>
<td><strong>CNL 8® Nail Kit</strong></td>
<td>NP</td>
<td>See ciclopirox nail kit prior authorization criteria</td>
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<tr>
<td><strong>Econazole</strong></td>
<td>NP</td>
<td>1 package/Rx</td>
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<tr>
<td><strong>Ertaczo®</strong></td>
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<td>1 package/Rx</td>
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<td></td>
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<tr>
<td><strong>Exelderm®</strong></td>
<td>NP</td>
<td>1 package/Rx</td>
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<tr>
<td><strong>Extina®</strong></td>
<td>NP</td>
<td>1 package/Rx</td>
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<tr>
<td><strong>Jublia®</strong></td>
<td>NP</td>
<td>See ciclopirox nail kit prior authorization criteria.</td>
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<tr>
<td><strong>Ketocon Kit</strong></td>
<td>NP</td>
<td>Approval will be granted upon documentation of ALL of the following:</td>
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<tr>
<td></td>
<td></td>
<td>- Trial and failure of TWO preferred agents</td>
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<tr>
<td></td>
<td></td>
<td>- Trial and failure of the individual components of the kit</td>
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<tr>
<td></td>
<td></td>
<td>1 package/Rx</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ketodan Kit</strong></td>
<td>NP</td>
<td>See Ketocon Kit prior authorization criteria</td>
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<tr>
<td><strong>Luliconazole</strong></td>
<td>NP</td>
<td>Approval will be granted upon documentation of ALL of the following:</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>- Diagnosis of an FDA-approved indication; AND</td>
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<tr>
<td></td>
<td></td>
<td>- Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>1 package/Rx</td>
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<tr>
<td><strong>Loprox®</strong></td>
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<td>1 package/Rx</td>
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<tr>
<td><strong>Luzu®</strong></td>
<td>NP</td>
<td>See luliconazole prior authorization criteria</td>
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<tr>
<td></td>
<td></td>
<td>1 package/Rx</td>
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</table>

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DERMATOLOGICS

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<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topical Antifungals (continued)</td>
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<tr>
<td>miconazole/zinc/petrolatum</td>
<td>NP</td>
<td>See Vusion® prior authorization criteria</td>
<td>1 package/Rx</td>
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<tr>
<td>Naftin®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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<td>naftifine gel</td>
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<td>1 package/Rx</td>
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<td>nystatin/triamcinolone</td>
<td>NP</td>
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<td>1 package/Rx</td>
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<tr>
<td>oxiconazole</td>
<td>NP</td>
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<td>1 package/Rx</td>
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<td>Oxistat®</td>
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<td>Pedipirox-4 Nail¹</td>
<td>NP</td>
<td>See ciclopirox nail kit prior authorization criteria</td>
<td>1 package/Rx</td>
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<tr>
<td>Penlac®</td>
<td>NP</td>
<td>See ciclopirox nail kit prior authorization criteria</td>
<td>1 package/Rx</td>
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</tr>
<tr>
<td>Vusion®</td>
<td>NP</td>
<td>Approval will be granted for patients meeting ALL of the following:</td>
<td>1 package/Rx</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Recipient must have a diagnosis of complicated diaper dermatitis.</td>
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<tr>
<td></td>
<td></td>
<td>• Recipient must be four weeks of age or older.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Recipient must have tried and failed treatment with either a topical antifungal agent or topical antifungal combination agent.</td>
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<tr>
<td>Topical Antipsoriatics</td>
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</tr>
<tr>
<td>calcipotriene cream</td>
<td>P</td>
<td>See calcipotriene scalp soln prior authorization criteria</td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>calcipotriene scalp soln</td>
<td>P</td>
<td>Will be approved if recipient has had failure of, intolerance to, or contraindication to at least one topical steroid.</td>
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<tr>
<td>tazarotene 1% cream</td>
<td>P</td>
<td>See Tazorac® prior authorization criteria</td>
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<tr>
<td>Tazorac® 0.5% gel and cream</td>
<td>P</td>
<td>Will be approved for the following:</td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For a diagnosis of psoriasis if the recipient has had a failure of, intolerance to, or contraindication to, at least one topical steroid.</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For a diagnosis of keratosis follicularis or actinic keratosis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For a diagnosis of acne in patients less than 21 years of age.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vectical®</td>
<td>P</td>
<td>See calcipotriene scalp soln prior authorization criteria</td>
<td></td>
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<tr>
<td>calcipotriene ointment</td>
<td>NP</td>
<td>See calcipotriene scalp soln prior authorization criteria</td>
<td>1 package/Rx</td>
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<tr>
<td>calcitriol ointment</td>
<td>NP</td>
<td>See calcipotriene scalp soln prior authorization criteria</td>
<td>1 package/Rx</td>
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<tr>
<td>calcipotriene/betamethasone</td>
<td>NP</td>
<td>See calcipotriene scalp soln prior authorization criteria</td>
<td>1 package/Rx</td>
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<tr>
<td>Dovonex®</td>
<td>NP</td>
<td>See calcipotriene scalp soln prior authorization criteria</td>
<td>1 package/Rx</td>
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<tr>
<td>Dovonex® Scalp soln</td>
<td>NP</td>
<td>See calcipotriene scalp soln prior authorization criteria</td>
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</tr>
<tr>
<td>Enstilar®</td>
<td>NP</td>
<td>See calcipotriene scalp soln prior authorization criteria</td>
<td>1 package/Rx</td>
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<tr>
<td>Sorilux®</td>
<td>NP</td>
<td>See calcipotriene scalp soln prior authorization criteria</td>
<td>1 package/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Taclonex®</td>
<td>NP</td>
<td>See calcipotriene scalp soln prior authorization criteria</td>
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</tr>
<tr>
<td>Tazarac® 1% cream</td>
<td>NP</td>
<td>Will be approved for the following:</td>
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<tr>
<td></td>
<td></td>
<td>• For a diagnosis of psoriasis if the recipient has had a failure of, intolerance to, or contraindication to, at least one topical steroid.</td>
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<tr>
<td></td>
<td></td>
<td>• For a diagnosis of keratosis follicularis or actinic keratosis.</td>
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<tr>
<td></td>
<td></td>
<td>• For a diagnosis of acne in patients less than 21 years of age.</td>
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</tr>
<tr>
<td><strong>Antipsoratics, Oral</strong></td>
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<tr>
<td>methoxsalen capsules</td>
<td>NP</td>
<td>Will be approved for patients who meet the following criteria:</td>
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<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of psoriasis; AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trial/failure, contraindication, or intolerance of TWO preferred topical antipsorotics.</td>
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<tr>
<td>Oxsoralen-Ultra® capsules</td>
<td>NP</td>
<td>Will be approved for patients who meet the following criteria:</td>
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<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of psoriasis; AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trial/failure, contraindication, or intolerance of TWO preferred topical antipsorotics.</td>
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<tr>
<td><strong>Antiseborrheic Agents</strong></td>
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<tr>
<td>selenium sulfide 2.5% lotion</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Ovace®</td>
<td>NP</td>
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<td>1 package/Rx</td>
<td>Form</td>
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<tr>
<td>Ovace® Plus</td>
<td>NP</td>
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<td>1 package/Rx</td>
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<tr>
<td><strong>Topical Antivirals</strong></td>
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<tr>
<td>acyclovir 5% ointment</td>
<td>P</td>
<td></td>
<td>1 tube/Rx</td>
<td></td>
</tr>
<tr>
<td>Denavir® cream</td>
<td>P</td>
<td></td>
<td>1 tube/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td>acyclovir cream</td>
<td>NP</td>
<td></td>
<td>1 tube/Rx</td>
<td></td>
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<tr>
<td>Xerese®</td>
<td>NP</td>
<td>Trial and failure of the individual components of the kit.</td>
<td>1 tube/Rx</td>
<td>Form</td>
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<tr>
<td>Zovirax® cream</td>
<td>NP</td>
<td></td>
<td>1 tube/Rx</td>
<td></td>
</tr>
<tr>
<td>Zovirax® ointment</td>
<td>P</td>
<td></td>
<td>1 tube/Rx</td>
<td></td>
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</tbody>
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</thead>
<tbody>
<tr>
<td><strong>Topical Antipruritics/Antihistamines</strong></td>
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<tr>
<td>doxepin cream</td>
<td>NP</td>
<td>Approval will be granted for individuals meeting the following criteria:</td>
<td>45g/90 days</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recipient must have moderate pruritus due to various forms of eczematous dermatitis, including atopic dermatitis and lichen simplex chronicus</td>
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<tr>
<td></td>
<td></td>
<td>• Recipient must have an intolerance, contraindication to, or inadequate response to BOTH of the following:</td>
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<tr>
<td></td>
<td></td>
<td>– A topical corticosteroid</td>
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<tr>
<td></td>
<td></td>
<td>– An oral antihistamine (first or second generation) or a topical antihistaminic agent (i.e., diphenhydramine topical cream)</td>
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<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> 5% cream may be used in combination with a topical or oral corticosteroid in order to relieve pruritus in order to reduce corticosteroid course of therapy. 5% cream should not be used for longer than eight days. Longer usage has been shown to result in higher systemic levels and increase the likelihood of contact sensitization.</td>
<td></td>
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</tr>
<tr>
<td>Prudoxin®</td>
<td>NP</td>
<td>See doxepin cream prior authorization criteria</td>
<td>45g/90 days</td>
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</tr>
<tr>
<td>Zonalon®</td>
<td>NP</td>
<td>See doxepin cream prior authorization criteria</td>
<td>45g/90 days</td>
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<tr>
<td><strong>Topical Agents for Burns</strong></td>
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<tr>
<td>silver sulfadiazine</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td>General PA Form</td>
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<tr>
<td>SSD®</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Silvadene®</td>
<td>NP</td>
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<td>1 package/Rx</td>
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<tr>
<td>Sulfamylon®</td>
<td>NP</td>
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<td>1 package/Rx</td>
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<tr>
<td><strong>Topical Steroids: Least Potent</strong></td>
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<tr>
<td>hydrocortisone 1% cream and ointment (Rx &amp; OTC)</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td>hydrocortisone 2.5% cream, lotion, and ointment</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td>General PA Form</td>
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<tr>
<td>Ala-Scalp® 2% lotion</td>
<td>NP</td>
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<td>1 package/Rx</td>
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<tr>
<td>MiCort® HC 2.5% cream</td>
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<td>1 package/Rx</td>
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### Dermatologics

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<tbody>
<tr>
<td><strong>Topical Steroids: Mild</strong></td>
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<tr>
<td>betamethasone valerate 0.1% lotion</td>
<td>P</td>
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<td>1 package/Rx</td>
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<tr>
<td>Desonate® 0.05% gel</td>
<td>NP</td>
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<td>1 package/Rx</td>
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<tr>
<td>desonide 0.05% cream and ointment</td>
<td>NP</td>
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<td>1 package/Rx</td>
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<tr>
<td>fluocinolone acetonide 0.01% cream, oil and solution</td>
<td>NP</td>
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<td>1 package/Rx</td>
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<tr>
<td>Synalar® 0.01% solution</td>
<td>NP</td>
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<tr>
<td><strong>Topical Steroids: Lower Mid-Strength</strong></td>
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<tr>
<td>betamethasone dipropionate 0.05% lotion</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
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</tr>
<tr>
<td>betamethasone valerate 0.1% cream</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
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<tr>
<td>clocortolone 0.1% cream and pump</td>
<td>NP</td>
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<td>1 package/Rx</td>
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<tr>
<td>Cutivate® 0.05% cream and lotion</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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<tr>
<td>Derma-Top® 0.1% cream and ointment</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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</tr>
<tr>
<td>desonide 0.05% lotion</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>hydrocortisone butyrate 0.1% cream, lotion, ointment, and solution</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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<tr>
<td>hydrocortisone valerate 0.2% cream</td>
<td>NP</td>
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<td>1 package/Rx</td>
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<tr>
<td>Locoid Lipocream®</td>
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<td>60 g/Rx</td>
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<tr>
<td>Pandel® 0.1% cream</td>
<td>NP</td>
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<td>1 package/Rx</td>
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<tr>
<td>prednicarbate 0.1% cream and ointment</td>
<td>NP</td>
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<td>1 package/Rx</td>
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<tr>
<td><strong>Topical Steroids: Mid-Strength</strong></td>
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<tr>
<td>triamcinolone acetonide 0.1% cream</td>
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<td>1 package/Rx</td>
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<tr>
<td>Elocon 0.1% cream and lotion</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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<tr>
<td>flurandrenolide 0.5% ointment</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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</tr>
<tr>
<td>hydrocortisone valerate 0.2% ointment</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
</tbody>
</table>

| **Topical Steroids: Upper Mid-Strength** |     |                              |             |         |
| betamethasone valerate 0.1% ointment | P   |                              | 1 package/Rx|         |
| fluticasone propionate 0.005% ointment | P |                              | 1 package/Rx|         |
| triamcinolone acetonide 0.025% cream, lotion and ointment | P |                              | 1 package/Rx|         |
| triamcinolone acetonide 0.1% lotion and ointment | P |                              | 1 package/Rx|         |
| triamcinolone acetonide 0.5% cream and ointment | P |                              | 1 package/Rx|         |
| amcinonide 0.1% cream and lotion     | NP  |                              | 1 package/Rx|         |
| betamethasone dipropionate 0.05% cream | NP |                              | 1 package/Rx|         |
| betamethasone dipropionate 0.05% ointment | NP |                              | 1 package/Rx|         |
| desoximetasone 0.05% gel and ointment | NP |                              | 1 package/Rx|         |
| desoximetasone 0.25% cream, ointment, spray | NP |                              | 1 package/Rx|         |

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<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Topical Steroids: Upper Mid-Strength (continued)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>diflorasone diacetate 0.05% cream and ointment</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Elocon® 0.1% ointment</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>fluocinonide 0.05% cream, gel, and ointment</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Halog® 0.1% ointment and cream</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td><strong>Topical Steroids: Potent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>betamethasone dipropionate, augmented 0.05% cream</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Apexicon E® 0.05% cream</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>betamethasone dipropionate, augmented 0.05% lotion</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>betamethasone dipropionate 0.05% ointment</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>desoximetasone 0.05% gel and ointment</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>desoximetasone 0.25% cream, ointment, spray</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>diflorasone diacetate 0.05% cream and ointment</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Elocon® 0.1% ointment</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>fluocinonide 0.05% cream, gel, and ointment</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Halog® 0.1% ointment and cream</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
</tbody>
</table>

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**DERMATOLOGICS**

*Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.*

<table>
<thead>
<tr>
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<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Topical Steroids: Super Potent</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>clobetasol propionate 0.05% cream, gel, ointment and solution</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>clobetasol propionate emollient base 0.05% cream</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Ultravate® 0.05% lotion</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
</tbody>
</table>
| Bryhali® lotion                                  | NP  | Diagnosis of an FDA-approved indication; **AND**
Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the individual components | 200g/28 days|         |
| betamethasone dipropionate, augmented 0.05% gel, and ointment | NP  |                              | 1 package/Rx|         |
| clobetasol propionate 0.05% foam, lotion, shampoo, and spray | NP  |                              | 1 package/Rx|         |
| clobetasol propionate emollient base 0.05% foam | NP  |                              | 1 package/Rx|         |
| Clodan® Kit                                      | NP  | See Bryhali® prior authorization criteria | 1 package/Rx|         |
| fluocinonide 0.1% cream                          | NP  |                              | 1 package/Rx|         |
| halobetasol propionate 0.05% cream, foam, and ointment | NP  |                              | 1 package/Rx|         |
| Lexette®                                        | NP  | See Bryhali® prior authorization criteria | 100g/Rx|         |
| Temovate® 0.05% ointment                        | NP  |                              | 90g/Rx      |         |

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<tbody>
<tr>
<td>Emollients</td>
<td></td>
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</tr>
<tr>
<td>ammonium lactate</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td>General PA</td>
</tr>
<tr>
<td>Enzyme Preps and Wound Healing</td>
<td></td>
<td>Will be approved only for patients with a diagnosis of lower extremity diabetic ulcers.</td>
<td>3 tubes/month</td>
<td>General PA</td>
</tr>
<tr>
<td>Santyl®</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td>General PA</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Genital Warts</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Imiquimod</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Condylox®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td>General PA</td>
</tr>
<tr>
<td>Veregen®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td>General PA</td>
</tr>
<tr>
<td>Zyclara®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Keratolytic Agents</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
| all generic urea products | P | • Documented diagnosis of hyperkeratotic condition (e.g., lesions, necrotic tissue, cracks and/or fissures); AND
  • Requires debridement due to local infection, necrotic tissue, fibrinous or purulent debris, or eschar | 1 package/Rx| General PA|
| all generic salicylic acid products | NP |                                                                                               | 1 package/Rx|           |
| all brand urea products | NP |                                                                                               | 1 package/Rx|           |
| all brand salicylic acid products | NP |                                                                                               | 1 package/Rx|           |

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**DERMATOLOGICS**

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<tbody>
<tr>
<td><strong>PDE-4 Inhibitors, Topical</strong></td>
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</tbody>
</table>
| Eucrisa® NP  |     | Will be approved if all of the following are met:  
  • Patient is ≥ 2 years of age; **AND**  
  • Diagnosis of atopic dermatitis; **AND**  
  • Trial and failure of 2 Topical Corticosteroids and 1 Topical Calcineurin Inhibitor (e.g., pimecrolimus or tacrolimus); **OR**  
  • Trial and failure of either class (Topical Corticosteroids or Topical Calcineurin Inhibitors) **AND** where therapy is not preferred with the other class:  
    − Conditions that preclude the use of steroids:  
      • Treatment of sensitive areas (face, anogenital, skin folds)  
      • Steroid Induced Atrophy  
      • Long-term uninterrupted use  
    − Conditions that preclude the use of Topical Calcineurin Inhibitors:  
      • Severely impaired skin barrier (Netherton Syndrome)  
      • Risk/Presence of new primary malignancy (e.g., skin cancer, lymphoma, or other lymphoproliferative disorders).  

<table>
<thead>
<tr>
<th></th>
<th>1 tube/month</th>
<th>General PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pediculosides/Scabicides</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natroba™ P</td>
<td>2 bottles/Rx</td>
<td></td>
</tr>
<tr>
<td>permethrin P</td>
<td>2 tubes/Rx</td>
<td></td>
</tr>
<tr>
<td>Crotan® NP</td>
<td>1 bottle/Rx</td>
<td></td>
</tr>
<tr>
<td>Permethrin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Elimite® NP                                            | 454g bottle:  
  1 bottle/Rx  
  Other sizes: 120 g/Rx | General PA Form |
| Eurax® NP                                               | 2/Rx         |                 |
| Lindane NP                                             | 1 bottle/Rx  |                 |
| Lindane NP                                             |              |                 |
| Malathion NP                                           | 2 bottles/Rx |                 |
| Ovide® NP                                               | 2 bottles/Rx |                 |
| Sklice® NP                                              | 1 tube/Rx    |                 |
| Spinosad NP                                             | 2 bottles/Rx |                 |
| Ulesfia® NP                                             | 2 bottles/Rx |                 |

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### Dermatologics

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Retinoids, Oral</strong></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
| Absorica*   | NP   | • Approval requires BOTH the patient and physician have registered with the iPledge program. (Registration with the program helps to ensure appropriate counseling has been provided to the patient and proper procedures have been followed with regards to the risks of use in women of child-bearing age. Information regarding the iPledge program is available at [https://www.ipledgeprogram.com](https://www.ipledgeprogram.com) or by calling 1-866-495-0654)  
• Will not be covered for the diagnosis of acne or rosacea for recipients ≥ 21 years of age. The following diagnoses will be considered for coverage for patients ≥ 21 years of age on a case by case basis: chronic myelogenous leukemia, head or neck cancer, ichthyosis, keratosis follicularis, neuroblastoma, or pityriasis rubra pilaris. | 10mg (3/day); 17.5, 22.5, 25mg (2/day) | General PA Form                          |
| acitretin   | NP   | Will not be covered for the diagnosis of acne or rosacea for recipients > 21 years of age. Will be approved only for patients meeting ALL of the following:  
• Recipient has a diagnosis of severe psoriasis (covering at least 10-20% of the body surface area).  
• Recipient has tried and failed, or had an intolerance or contraindication to ALL of the following:  
  – Topical corticosteroids  
  – Topical antipsoriatics (i.e., Dovonex®, Tazorac®, Taclonex®)  
  – Phototherapy (i.e., UVB, PUVA), if available to the patient within their geographic area.  
• Recipient must NOT have impaired liver or kidney function, or abnormally elevated lipid levels.  
• Recipient must NOT be receiving concomitant methotrexate (due to risk of hepatitis) or tetracyclines (due to risk of increased intracranial pressure).  
**If the recipient is female:**  
• Must have had TWO negative urine or serum pregnancy tests (one performed during the first 5 days of the menstrual period immediately preceding the beginning of Soriatane® therapy).  
• Must have committed to use TWO effective forms of contraception simultaneously, unless absolute abstinence is chosen, or the patient has undergone a hysterectomy or bilateral tubal ligation or is clearly postmenopausal. The two selected forms of contraception must be initiated at least one month prior to starting acitretin and continued for three years after discontinuing the drug.  
• Must have read and signed a Patient Agreement/Informed Consent for Female Patients form. | 10mg (3/day); 17.5, 22.5, 25mg (2/day) | General PA Form                          |

Amnesteem®   | NP   | See Absorica® prior authorization criteria                                                                                                                                                                                                                                                                                                                   |              |                          |
| Claravis®   | NP   | See Absorica® prior authorization criteria                                                                                                                                                                                                                                                                                                                   |              |                          |
| Myorisan®   | NP   | See Absorica® prior authorization criteria                                                                                                                                                                                                                                                                                                                   |              |                          |
| Soriatane®  | NP   | See acitretin prior authorization criteria                                                                                                                                                                                                                                                                                                                   | 10mg (3/day); 17.5, 22.5, 25mg (2/day) |                          |
| Sotret®     | NP   | See Absorica® prior authorization criteria                                                                                                                                                                                                                                                                                                                   |              |                          |
| Zenatane®   | NP   | See Absorica® prior authorization criteria                                                                                                                                                                                                                                                                                                                   |              |                          |

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### Dermatologies

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<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retinoids, Topical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Differin</td>
<td>P</td>
<td>See tretinoin prior authorization criteria</td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Tazarotene 0.1% cream</td>
<td>P</td>
<td>See Tazorac® prior authorization criteria (Topical Antipsoriatics section).</td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Tazorac® 0.5% gel and cream</td>
<td>P</td>
<td>See Tazorac® prior authorization criteria (Topical Antipsoriatics section).</td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Tretinoin</td>
<td>P</td>
<td>For a diagnosis of acne, keratosis follicularis, verruca plana, or actinic keratosis:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Patients &lt; 21 years old will be approved.</td>
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<tr>
<td></td>
<td></td>
<td>• Patients &gt; 21 years old will be approved as follows:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>– For keratosis follicularis - approved for 12 months.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>– For verruca plana - approved for 2 months.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>– For actinic keratosis for the prevention of future lesions – approved for 12 months. Will not be covered for a diagnosis of acne.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adapalene</td>
<td>NP</td>
<td>See tretinoin prior authorization criteria</td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Adapalene/benzoyl peroxide</td>
<td>NP</td>
<td>See tretinoin prior authorization criteria</td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Altreno®</td>
<td>NP</td>
<td>● Patients less than 21 years of age:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Diagnosis of acne vulgaris in children; AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents</td>
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<tr>
<td></td>
<td></td>
<td>● Will not be covered for adults.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atralin®</td>
<td>NP</td>
<td>See tretinoin prior authorization criteria</td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Clindamycin/tretinoin</td>
<td>NP</td>
<td>See tretinoin prior authorization criteria</td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Epiduo®</td>
<td>NP</td>
<td>See adapalene/benzoyl peroxide prior authorization criteria</td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Epiduo® Forte</td>
<td>NP</td>
<td>See adapalene/benzoyl peroxide prior authorization criteria</td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Fabior®</td>
<td>NP</td>
<td>See Tazorac® prior authorization criteria (Topical Antipsoriatics section)</td>
<td>1 package/Rx</td>
<td></td>
</tr>
</tbody>
</table>
## DERMATOLOGICS

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</tr>
</thead>
</table>
| Retinoids, Topical (continued) |     | • Recipients < 21 years old will be approved if patient meets the following criteria:  
  - Diagnosis of acne, keratosis follicularis, verruca plana, or actinic keratosis:  
    • Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents  
  • Recipients ≥ 21 years old will be approved as follows:  
    - For keratosis follicularis - Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents (Approval duration 12 months)  
      • For verruca plana - Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents (Approval duration 2 months)  
      • For actinic keratosis for the prevention of future lesions: Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents (Approval duration 12 months)  
    - Will not be covered for a diagnosis of acne |             |        |
| Retin A Micro   | NP  | See tretinoin prior authorization criteria                                                                                                                                                                                                   | 1 package/Rx|         |
| Retin A®        | NP  | See tretinoin prior authorization criteria                                                                                                                                                                                                   | 1 package/Rx|         |
| Tazorac® 1% cream | NP  | See Tazorac® prior authorization criteria (Topical Antipsoriatics section)                                                                                                                                                                         |             |         |
| tretinoin gel   | NP  | See tretinoin prior authorization criteria                                                                                                                                                                                                   |             |         |
| tretinoin microsphere gel | NP  | See tretinoin prior authorization criteria                                                                                                                                                                                                   |             |         |
| Veltin™         | NP  | See tretinoin prior authorization criteria                                                                                                                                                                                                   |             |         |
| Ziana®          | NP  | See tretinoin prior authorization criteria                                                                                                                                                                                                   |             |         |

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### DIABETIC SUPPLIES (OTC)

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<tr>
<td><strong>Abbott Products</strong></td>
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</tr>
<tr>
<td>FreeStyle Meters: Lite, Freedom Lite, InsuLinx, and Precision Xtra</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freestyle Test Strips: Lite, InsuLinx, &amp; Precision Xtra</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All other Abbott diabetic supplies</td>
<td>P</td>
<td></td>
<td>Diabetic Supply</td>
<td></td>
</tr>
<tr>
<td><strong>AgaMatrix Products</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Various</td>
<td>NP</td>
<td>See prior authorization criteria for Breeze-2 Meter (Bayer Products)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bayer Products</strong></td>
<td></td>
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</tbody>
</table>
| Bayer Meters: Breeze-2 & Contour | NP | Non-preferred meters will be approved for patients meeting ONE of the following criteria:  
  - Patient is using an insulin pump that does not adequately communicate with a preferred meter.  
  - Patient requires a special meter due to visual impairment | Meters:  
  - 1/365 days;  
  - Test Strips:  
    - Age < 6: 306/30 days  
    - Age > 6: 204/30 days | Diabetic Supply |
| Bayer Test Strips | NP | | Diabetic Supply | |
| All other Bayer diabetic supplies | NP | Will be approved for individuals who meet prior authorization criteria and receive a prior authorization for a Bayer diabetes meter. | Diabetic Supply | |
| **Home Diagnostics Products** | | | | |
| Various | NP | See prior authorization criteria for Breeze-2 Meter (Bayer Products). | Meters:  
  - 1/365 days;  
  - Test Strips:  
    - Age < 6: 306/30 days  
    - Age > 6: 204/30 days | Diabetic Supply | |

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<tr>
<td><strong>Johnson and Johnson Products</strong></td>
<td></td>
<td><strong>Meters:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OneTouch Meters: UltraMini, Ping, Ultra-2, UltraLink, UltraSmart</td>
<td>NP</td>
<td>See prior authorization criteria for Breeze-2 Meter (Bayer Products)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Johnson &amp; Johnson Test Strips</strong></td>
<td>NP</td>
<td>Will be approved for individuals who meet prior authorization criteria and receive a prior authorization for a OneTouch diabetes meter.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All other OneTouch diabetic supplies</td>
<td>NP</td>
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</tbody>
</table>

| **LifeScan Products**                     |     | **Meters:**                                                                                  |             |          |
| Various                                   | NP  | See prior authorization criteria for Breeze-2 Meter (Bayer Products)                         |             |          |

| **Roche Products**                        |     | **Meters:**                                                                                  |             |          |
| Accu-Chek Meters: Aviva & Compact Plus    | NP  | See prior authorization criteria for Breeze-2 Meter (Bayer Products)                         |             |          |
| Roche Test Strips                         | NP  |                                                                                              |             |          |
| All other Roche diabetic supplies         | NP  | Will be approved for individuals who meet prior authorization criteria and receive a prior authorization for an Accu-Chek diabetes meter. |             |          |

| **All Manufacturers**                     |     |                                                                                              |             |          |
| Ketone Testing Strips                    |     | 50 /30 days                                                                                  | General PA Form |        |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### ENDOCRINE/METABOLIC AGENTS

**Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.**

<table>
<thead>
<tr>
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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adrenocorticotropic Hormone</strong></td>
<td></td>
<td>Corticotropin will be approved only for recipients who meet <strong>ONE</strong> of the following criteria:</td>
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<tr>
<td>H.P. Acthar Gel</td>
<td>NP</td>
<td>• Appropriate FDA-approved diagnosis (e.g., diuresis in nephrotic syndrome, treatment of SLE or polymyositis, or acute MS exacerbation) for use AND has a contraindication or intolerance to oral and injectable glucocorticoids; OR</td>
<td>1/day</td>
<td>General PA Form</td>
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<td></td>
<td></td>
<td>• Diagnosis of infantile spasms</td>
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<tr>
<td><strong>Agents for Gout</strong></td>
<td></td>
<td>Will be approved for patients meeting the following criteria:</td>
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</tr>
<tr>
<td>colchicine capsules</td>
<td>P</td>
<td>• For initiation of colchicine for acute gout attack:</td>
<td></td>
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</tr>
<tr>
<td>(generic for Mitigare®)</td>
<td></td>
<td>- At the time of current, acute attack, must have trial and failure of at least 14 days of NSAID therapy (initiated in combination with urate lowering therapy of allopurinol, febuxostat or probenecid); OR</td>
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<td></td>
<td></td>
<td>- Must have a history of GI bleeding or comorbidities that would not allow trial of NSAIDs to be initiated in combination with urate lowering therapy; OR</td>
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<td></td>
<td></td>
<td>- Polyanarticular attack or attack affecting multiple large joints such that combination therapy with urate lowering therapy is required</td>
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<td></td>
<td></td>
<td>• For continuation of colchicine prophylaxis for gout:</td>
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<tr>
<td></td>
<td></td>
<td>- Current history of urate lowering therapy with compliance in the past three months; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>- Patient is currently experiencing gout symptoms; <strong>OR</strong></td>
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<td></td>
<td></td>
<td>- Patient has elevated urate level (≥ 6) in the past three months.</td>
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<tr>
<td>colchicine tablet</td>
<td>P</td>
<td>Will be approved for patients meeting the following criteria:</td>
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<td>General PA Form</td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of Familial Mediterranean Fever; <strong>OR</strong></td>
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<td></td>
<td>• Diagnosis of acute pericarditis, <strong>AND</strong> must be taken concurrently with NSAID (unless contraindicated); <strong>OR</strong></td>
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<td></td>
<td>• For initiation of colchicine for acute gout attack:</td>
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<td>- At the time of current, acute attack, must have trial and failure of at least 14 days of NSAID therapy (initiated in combination with urate lowering therapy of allopurinol, febuxostat or probenecid); OR</td>
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<td>- Patient is currently experiencing gout symptoms; <strong>OR</strong></td>
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<td></td>
<td>- Patient has elevated urate level (≥ 6) in the past three months.</td>
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<tr>
<td>Colcrys®</td>
<td>NP</td>
<td>See colchicine tablet prior authorization criteria</td>
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</tbody>
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</table>
| **Duzallo®** | NP | Will be approved if ALL the following is met:  
  - Patient has a diagnosis of hyperuricemia associated with gout; **AND**
  - The patient’s estimated Creatinine clearance rate (eCLcr) (measured within the past six months) has been submitted; **AND**
  - The patient’s current serum uric acid level (measured within the past six months) has been submitted; **AND**
  - At least one of the following is true:
    - The member has taken a minimum of 300 mg of allopurinol daily (eCLcr above 60 mL/min) for at least three consecutive months and has not achieved target serum uric acid levels.
    - The member has taken a minimum of 200 mg of allopurinol daily (eCLcr 45–60 mL/min) for at least three consecutive months and has not achieved target serum uric acid levels.
  - The member does NOT have any of the following contraindications to Duzallo®:
    - eCLcr below 45 mL/min
    - Kidney transplant recipient
    - Dialysis treatment
    - TLS (tumor lysis syndrome)
    - LNS (Lesch-Nyhan syndrome) | 1/day | General PA Form |

| **Febuxostat** | NP | See Uloric® prior authorization criteria | | |

| **Mitigare®** | NP | Will be approved for patients meeting the following criteria:  
  - For initiation of colchicine for acute gout attack:  
    - Must have trial and failure of at least 14 days of NSAID therapy (initiated in combination with urate lowering therapy of allopurinol, febuxostat or probenecid), **OR**
    - Must have a history of GI bleeding or comorbidities that would not allow trial of NSAIDs, **OR**
    - Polynarthritis attack or attack affecting multiple large joints such that combination therapy is required  
  - For continuation of colchicine prophylaxis for gout:  
    - Current history of urate lowering therapy with compliance in the past three months; **AND**
    - Patient is currently experiencing gout symptoms; **OR**
    - Patient has elevated urate level (≥ 6) in the past three months.
    - Additionally, approval requires trial and failure of preferred colchicine product | | |

| **Uloric®** | NP | Uloric® will be approved for patients with trial and failure, contraindication, or intolerance to allopurinol. | | |

| **Zurampic** | NP | Will be approved for patients meeting the following criteria:  
  - Used as an adjunct therapy in combination with a xanthine oxidase inhibitor (i.e., allopurinol or febuxostat) for the treatment of hyperuricemia associated with gout in patients unable to achieve target serum uric acid levels after at least a 3-month trial of a xanthine oxidase inhibitor.  
  **NOTE:** Zurampic® should be used in combination with a xanthine oxidase inhibitor, as acute renal failure has occurred and is more common when the agent is given alone. | 1/day | |

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### ENDOCRINE/METABOLIC AGENTS

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<td><strong>Anabolic Steroids</strong></td>
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<tr>
<td>Anadrol-50®</td>
<td>NP</td>
<td>- Will be approved for patients meeting <strong>ALL</strong> of the following criteria:</td>
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<td></td>
<td></td>
<td>- Recipient must have a diagnosis of <strong>ONE</strong> of the following:</td>
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<td>- Anemias caused by deficient red blood cell production</td>
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<td>- Acquired or congenital aplastic anemia</td>
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<td>- Myelofibrosis</td>
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<td>- Hypoplastic anemias</td>
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<td>- Recipient must not have severe hepatic dysfunction.</td>
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<td>- Recipient must not have prostate or breast cancer.</td>
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<td><strong>Note:</strong> Will not be approved for enhancing athletic performance.</td>
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<tr>
<td>Oxandrin®</td>
<td>NP</td>
<td>- Will be approved for patients meeting <strong>ALL</strong> of the following criteria:</td>
<td></td>
<td>General PA Form</td>
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<tr>
<td></td>
<td></td>
<td>- Recipient is using the drug for <strong>ANY</strong> of the following indications:</td>
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<td></td>
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<td>- To promote weight gain after weight loss following extensive surgery, chronic infection (including HIV/AIDS wasting), or severe trauma including extensive burns</td>
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<td></td>
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<td>- To offset protein catabolism associated with prolonged administration of corticosteroids</td>
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<td>- To relieve bone pain associated with osteoporosis</td>
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<td></td>
<td>- Recipient does not have hypercalcemia.</td>
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<tr>
<td></td>
<td></td>
<td>- Recipient does not have prostate or breast cancer.</td>
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<td></td>
<td></td>
<td><strong>Note:</strong> Will not be approved for enhancing athletic performance.</td>
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<tr>
<td>oxandrolone</td>
<td>NP</td>
<td>- See Oxandrin® prior authorization criteria</td>
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### ENDOCRINE/METABOLIC AGENTS

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<tr>
<td>Androgens</td>
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</tbody>
</table>
| Androgel® (1% packets, 1.62% packets, and 1% pump) | P | Will be approved for patients meeting **ALL** of the following criteria: **Initial Requests:**  
- Patient age 21 years of age or less **AND** Diagnoses of Micropenis, Congenital or Acquired Anorchia, Kallmann Syndrome, Klinefelter Syndrome **OR** Hypogonadotropic hypogonadism/central hypogonadism due to one of the following etiologies:  
  - Congenital midline brain defects: Septo-optic Dysplasia, Holoprosencephaly, Hypopituitarism  
  - CNS tumors and treatment including irradiation, surgery and chemotherapy  
  - Significantly delayed puberty  
  - Approval requires:  
    - Baseline Luteinizing Hormone  
    - Baseline testosterone level  
- Patient age 21 years of age or less: diagnosis not specified above:  
  - Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone  
    - Baseline hematocrit ≤ 50%  
    - Baseline Luteinizing Hormone  
- Patient age 22 years of age and older:  
  - Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone  
    - Baseline hematocrit ≤ 50%  
    - Baseline Luteinizing Hormone  
    - PSA level < 3 ng/mL  
- Requests for diagnosis of gender dysphoria will be referred to the state on a case-by-case basis for determination **Renewal Requests (labs not required for renewals for patients 21 years of age and less):**  
  - Documentation of low or normal fasting testosterone level from previous 12 months  
  - Hematocrit ≤ 50%  
  - PSA level <3 ng/mL | 1 package/Rx | General PA Form |
| Depo-Testosterone® 200 mg/mL (1 mL vials) | P | See Androgel® prior authorization criteria | 4 mL/30 days |         |

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<tbody>
<tr>
<td>Androderm*</td>
<td>NP</td>
<td>Will be approved for patients meeting <strong>ALL</strong> of the following criteria:</td>
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<td><strong>Initial Requests:</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Patient age 21 years of age or less AND Diagnoses of Micropenis, Congenital or Acquired Anorchia, Kallmann Syndrome, Klinefelter Syndrome OR Hypogonadotrophic hypogonadism/central hypogonadism due to one of the following etiologies:</td>
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<td>– Congenital midline brain defects: Septo-optic Dysplasia, Holoprosencephaly, Hypopituitarism</td>
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<td></td>
<td>– CNS tumors and treatment including irradiation, surgery and chemotherapy</td>
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<td>• Approval requires:</td>
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<td></td>
<td></td>
<td>– Baseline Luteinizing Hormone</td>
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<td>– Baseline testosterone level</td>
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<td></td>
<td></td>
<td>– Intolerance or contraindication to an inactive ingredient in ALL preferred topical testosterone that is not in the requested product</td>
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<td></td>
<td>• Patient age 21 years of age or less: diagnosis not specified above:</td>
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<td></td>
<td></td>
<td>– Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone</td>
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<td></td>
<td></td>
<td>– Baseline hematocrit ≤ 50%</td>
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<td>– Baseline Luteinizing Hormone</td>
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<td></td>
<td>– PSA level &lt; 3 ng/mL</td>
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<td></td>
<td>– Intolerance or contraindication to an inactive ingredient in ALL preferred topical testosterone that is not in the requested product</td>
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<td></td>
<td>• Requests for diagnosis of gender dysphoria will be referred to the state on a case-by-case basis for determination</td>
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<td></td>
<td></td>
<td><strong>Renewal Requests (labs not required for renewals for patients 21 years of age and less):</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Documentation of low or normal fasting testosterone level from previous 12 months</td>
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<tr>
<td></td>
<td></td>
<td>• Hematocrit ≤ 50%</td>
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<td></td>
<td>• PSA level &lt; 3 ng/mL</td>
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<tr>
<td>Androgens (continued)</td>
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</tbody>
</table>

**Androgens**

Will be approved for patients meeting the following criteria:

**Initial Requests:**
- Treatment of advancing, inoperable metastatic mammary cancer in women who are 1 to 5 years post-menopausal
- OR
- Patient age 21 years of age or less AND Diagnoses of Micropenis, Congenital or Acquired Anorchia, Kallmann Syndrome, Klinefelter Syndrome OR Hypogonadotrophic hypogonadism/central hypogonadism due to one of the following etiologies:
  - Congenital midline brain defects: Septo-optic Dysplasia, Holoprosencephaly, Hypopituitarism
  - CNS tumors and treatment including irradiation, surgery and chemotherapy
  - Significantly delayed puberty
  - Approval requires:
    - Baseline Luteinizing Hormone
    - Baseline testosterone level
    - Intolerance or contraindication to at least ONE preferred testosterone product
- Patient age 21 years of age or less: diagnosis not specified above:
  - Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone
  - Baseline hematocrit ≤ 50%
  - Baseline Luteinizing Hormone
  - Intolerance or contraindication to at least ONE preferred testosterone product
- Patient age 22 years of age and older:
  - Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone
  - Baseline hematocrit ≤ 50%
  - Baseline Luteinizing Hormone
  - PSA level < 3 ng/mL
  - Intolerance or contraindication to at least ONE preferred testosterone product
- Requests for diagnosis of gender dysphoria will be referred to the state on a case-by-case basis for determination

**Renewal Requests (labs not required for renewals for patients 21 years of age and less):**
- Documentation of low or normal fasting testosterone level from previous 12 months
- Hematocrit ≤ 50%
- PSA level < 3 ng/mL

**Androxy®**

NP

See Android® prior authorization criteria

**Axiron®**

NP

See Androderm® prior authorization criteria

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<td>Androgens (continued)</td>
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<td>Will be approved for patients meeting the following criteria:</td>
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<tr>
<td>Delatestryl®</td>
<td>NP</td>
<td><strong>Initial Requests:</strong></td>
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<tr>
<td></td>
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<td>• Patient age 21 years of age or less AND Diagnoses of Micropenis, Congenital or Acquired Anorchia, Kallmann Syndrome, Klinefelter Syndrome OR Hypogonadotrophic hypogonadism/central hypogonadism due to one of the following etiologies:</td>
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<td>− CNS tumors and treatment including irradiation, surgery and chemotherapy</td>
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<td>− Approval requires:</td>
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<tr>
<td></td>
<td></td>
<td>• Baseline Luteinizing Hormone</td>
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<tr>
<td>Depo-Testosterone® (excluding 200 mg/mL 1 mL vial)</td>
<td>NP</td>
<td><strong>Renewal Requests (labs not required for renewals for patients 21 years of age and less):</strong></td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
<td>− Hematocrit ≤ 50%</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>− PSA level &lt; 3 ng/mL</td>
<td>4 mL/30 days</td>
<td></td>
</tr>
<tr>
<td>Fortesta®</td>
<td>NP</td>
<td><strong>Prior Authorization Criteria</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>See Delatestryl® prior authorization criteria</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methitest®</td>
<td>NP</td>
<td><strong>Prior Authorization Criteria</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>See Androderm® prior authorization criteria</strong></td>
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<td><strong>Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.</strong></td>
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</tbody>
</table>
## ENDOCRINE/METABOLIC AGENTS

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>methyltestosterone</td>
<td>NP</td>
<td>See Android* prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natesto* nasal gel</td>
<td>NP</td>
<td>See Androderm* prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Striant*</td>
<td>NP</td>
<td>See Androderm* prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testim*</td>
<td>NP</td>
<td>See Androderm* prior authorization criteria</td>
<td>1 package/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td>testosterone cypionate</td>
<td>NP</td>
<td>See Delatestryl* prior authorization criteria</td>
<td>4 mL/30 days</td>
<td></td>
</tr>
<tr>
<td>testosterone enanthate</td>
<td>NP</td>
<td>See Delatestryl* prior authorization criteria</td>
<td>4 mL/30 days</td>
<td></td>
</tr>
<tr>
<td>testosterone gel (generic Androgel*, Fortesta*, Testim*, &amp; Vogelxo*)</td>
<td>NP</td>
<td>See Androderm* prior authorization criteria</td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>testosterone solution (generic Axiron*)</td>
<td>NP</td>
<td>See Androderm* prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testred*</td>
<td>NP</td>
<td>See Androderm* prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vogelxo*</td>
<td>NP</td>
<td>See Androderm* prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Xyosted*</td>
<td>NP</td>
<td>See Delatestryl* prior authorization criteria</td>
<td>2 mL/30 days</td>
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### Antidiuretic/Vasopressor Agents

<table>
<thead>
<tr>
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<th>PA Form</th>
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</thead>
</table>
| Nocdurna* | NP | Will be approved for patients meeting ALL of the following criteria:  
- Have a diagnosis of nocturnal polyuria (voiding ≥ 2 times per night); AND  
- Patient ≥ 50 years of age; AND  
- Does not have a diagnosis of central diabetes insipidus or obstructive uropathy; AND  
- Does not have a diagnosis of hemophilia A or von Willebrand disease; AND  
- Patient is not pregnant; AND  
- Patient has tried behavioral measures  
Will not be approved for patients with any of the following contraindications:  
- Hyponatremia  
- Polydipsia  
- Primary nocturnal enuresis  
- Current condition that causes fluid or electrolyte imbalance, including uncontrolled diabetes mellitus  
- Syndrome of inappropriate antidiuretic hormone secretion (SIADH)  
- Concomitant use of loop diuretics or systemic or inhaled glucocorticoids  
- eGFR < 50 mL/min/1.73m²  
- NYHA Class II-IV CHF  
- Uncontrolled hypertension | 1/day | General PA Form |
| Noctiva* | NP | See Nocdurna* prior authorization criteria | 1 bottle/30 days |         |
| Stimate* | NP | Will be approved for patients with diagnosis of von Willebrand Disease or Hemophilia A |             |         |

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## ENDOCRINE/METABOLIC AGENTS

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<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bone: Bisphosphonate</strong></td>
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</tr>
<tr>
<td>alendronate</td>
<td>P</td>
<td></td>
<td>5, 10, 40mg: 1/day</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>35, 70mg: 4/28 days</td>
<td></td>
</tr>
<tr>
<td>alendronate solution</td>
<td>P</td>
<td></td>
<td>10 mL/day</td>
<td></td>
</tr>
<tr>
<td>ibandronate</td>
<td>P</td>
<td></td>
<td>1/28 days</td>
<td></td>
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<tr>
<td>Actonel*</td>
<td>NP</td>
<td></td>
<td>5, 30mg: 1/day</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>35mg: 4/28 days</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>150mg: 1/28 days</td>
<td></td>
</tr>
<tr>
<td>Atelvia*</td>
<td>NP</td>
<td></td>
<td>4/28 days</td>
<td></td>
</tr>
<tr>
<td>Binosto®</td>
<td>NP</td>
<td></td>
<td>4/28 days</td>
<td></td>
</tr>
<tr>
<td>Boniva®</td>
<td>NP</td>
<td></td>
<td>1/28 days</td>
<td></td>
</tr>
<tr>
<td>etidronate</td>
<td>NP</td>
<td></td>
<td>1/day: 200mg; 4/day: 400mg</td>
<td></td>
</tr>
<tr>
<td>etidronate</td>
<td>NP</td>
<td></td>
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<tr>
<td>Fosamaz*</td>
<td>NP</td>
<td></td>
<td>see alendronate</td>
<td></td>
</tr>
<tr>
<td>Fosamax Plus D®</td>
<td>NP</td>
<td></td>
<td>4/28 days</td>
<td></td>
</tr>
<tr>
<td>risedronate</td>
<td>NP</td>
<td></td>
<td>150mg: 1/28 days</td>
<td></td>
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<tr>
<td>Skelid*</td>
<td>NP</td>
<td></td>
<td>2/day</td>
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<tr>
<td><strong>Bone: Calcitonin</strong></td>
<td></td>
<td>Will be approved for patients meeting ALL of the following criteria:</td>
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<tr>
<td>calcitonin nasal spray</td>
<td>P</td>
<td>• Diagnosis of osteoporosis in postmenopausal women greater than five years postmenopause, AND</td>
<td>3.7mL/30 days</td>
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<tr>
<td></td>
<td></td>
<td>- Trial and failure, contraindication or intolerance to BOTH bisphosphonates AND raloxifene.</td>
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<tr>
<td>Fortical®</td>
<td>NP</td>
<td>Fortical® will be approved for patients meeting ALL of the following criteria:</td>
<td>3.7mL/30 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of osteoporosis in postmenopausal women greater than five years postmenopause; AND</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Trial and failure, contraindication or intolerance to BOTH bisphosphonates AND raloxifene; AND</td>
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<tr>
<td></td>
<td></td>
<td>- Trial and failure, contraindication or intolerance to preferred agents.</td>
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</tr>
</tbody>
</table>

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ENDOCRINE/METABOLIC AGENTS

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<tr>
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</thead>
<tbody>
<tr>
<td><strong>Bone: Calcitonin (continued)</strong></td>
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</tbody>
</table>
| Miacalcin* injection              | NP  | Will be approved for patients meeting the following criteria:  
  - Diagnosis of Paget’s disease of the bone; **AND**  
  - Treatment of hypercalcemia; **OR**  
  - Diagnosis of osteoporosis in postmenopausal women greater than five years postmenopause; **AND**  
  - Trial and failure, contraindication or intolerance to both bisphosphonates **AND** raloxifene; **AND**  
  - Trial and failure, contraindication or intolerance to preferred agents                                                                                       | 1mL/day     | General PA Form                                                         |
| Miacalcin* nasal spray            | NP  | See Fortical* prior authorization criteria                                                                                                               | 3.7mL/30 days |                                                                         |
| **Bone: Parathyroid Hormone**     |     |                                                                                                                                                                                                                                                                                        |             |                                                                         |
| Forteo*                           | NP  | Will be approved for individuals at high risk for fracture, with a T-score below -2.5 SD, who:  
  - Have experienced an insufficient response or intolerance to an adequate trial of a bisphosphonate, or have a contraindication to bisphosphonate use, plus a history of osteoporotic fracture; **AND**  
  - Have been screened and found not to have pre-existing hyperparathyroidism; **AND**  
  - Total lifetime length of therapy with PTH analogs has not exceeded 2 years                                                                                     | 1 pen/28 days |                                                                         |
| Natpara*                          | NP  | Will be approved for patients meeting the following:  
  - Diagnosis of hypoparathyroidism; **AND**  
  - Persistent hypocalcemia not adequately controlled with maximally tolerated doses of vitamin D and calcium; **AND**  
  - Documentation patient is concomitantly taking Vitamin D with calcium supplements.                                                                          | 2 cartridges/28 days | General PA Form                                                         |
| Tymlos*                           | NP  | Will be approved for patients meeting the following criteria:  
  **Initiation:**  
  - Patient has diagnosis of post-menopausal osteoporosis; **AND**  
  - Confirmation patient is receiving calcium and vitamin D supplementation if dietary intake is inadequate; **AND**  
  - Documented Hip bone densitometry (femoral neck or total hip) or lumbar spine T-score -2.5 (standard deviations) or below; **AND**  
  - Patient is at a high risk for fractures; **AND**  
  - Patient is not at increased risk for osteosarcoma (e.g., Paget’s disease of bone, bone metastases or skeletal malignancies, etc.); **AND**  
  - Patient has not received therapy with parathyroid hormone analogs (e.g., teriparatide) in excess of 24 months in total; **AND**  
  - Documented treatment failure, contraindication, or ineffective response to a minimum (12) month trial on previous therapy with oral bisphosphonates (e.g., alendronate, risedronate, ibandronate)  
  **Renewal:**  
  - Disease response (absence of fractures); **AND**  
  - Absence of unacceptable toxicity from the drug (e.g., osteosarcoma, orthostatic hypotension, hypercalcemia, hypercalcuria and urolithiasis, etc.); **AND**  
  - Total lifetime length of therapy with PTH analogs has not exceeded 2 years                                                                                     | 1/30 days   |                                                                         |

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<tbody>
<tr>
<td><strong>Bone: SERMs</strong></td>
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<tr>
<td>raloxifene</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Evista*</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td>Form</td>
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<tr>
<td><strong>Contraceptives, Non-Oral</strong></td>
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<tr>
<td>DEPO-PROVERA CONTRACEPTIVE*</td>
<td>P</td>
<td></td>
<td>1 vial/ 90 days</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Depo SubQ Provera*</td>
<td>P</td>
<td></td>
<td>1 vial/ 90 days</td>
<td>General PA Form</td>
</tr>
<tr>
<td>medroxyprogesterone acetate injection</td>
<td>P</td>
<td></td>
<td>1 vial/ 90 days</td>
<td></td>
</tr>
<tr>
<td>NuvaRing*</td>
<td>P</td>
<td></td>
<td>1/28 days</td>
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<tr>
<td>Xulane*</td>
<td>P</td>
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<td></td>
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<tr>
<td><strong>Contraceptives, Oral</strong></td>
<td></td>
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<tr>
<td>Various</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Various</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td>Form</td>
</tr>
<tr>
<td><strong>Diabetes: Alpha-Glucosidase Inhibitors</strong></td>
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<tr>
<td>acarbose</td>
<td>P</td>
<td>• Will be approved for patients who have met the following criteria:</td>
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<tr>
<td>Glyset*</td>
<td>P</td>
<td>• Will be approved for patients who have met the following criteria:</td>
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<tr>
<td>miglitol</td>
<td>NP</td>
<td>• Will be approved for patients who have met the following criteria:</td>
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<tr>
<td>Precose*</td>
<td>NP</td>
<td>• Will be approved for patients who have met the following criteria:</td>
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<tr>
<td><strong>Diabetes: Amylin Analogs</strong></td>
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<tr>
<td>Symlin*</td>
<td>NP</td>
<td>Symlin* will be approved for patients meeting ALL of the following criteria:</td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of Type 1 or 2 diabetes</td>
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<td></td>
<td></td>
<td>• On insulin therapy</td>
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<tr>
<td></td>
<td></td>
<td>• Failure to achieve adequate glycemic control (HbA1c ≤ 6.5%)</td>
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<td></td>
<td></td>
<td>Patients meeting any of the following will NOT be approved:</td>
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<tr>
<td></td>
<td></td>
<td>• Recurrent, severe hypoglycemia requiring assistance during the past 6 months</td>
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<tr>
<td></td>
<td></td>
<td>• Confirmed diagnosis of gastroparesis</td>
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<td></td>
<td></td>
<td>• Requiring the use of drugs that stimulate gastrointestinal motility</td>
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</tbody>
</table>

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**ENDOCRINE/METABOLIC AGENTS**

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</thead>
</table>
| Humalog® KwikPen® | P | • Prior authorization not required for children (< 21 years of age)  
• Will be approved for adults (≥ 21 years old) meeting ONE of the following criteria:  
  – Recipient or caregiver has poor eyesight such that dosing errors may occur  
  – Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., Parkinson’s Disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis) | | |
| Humalog® Mix 50/50® KwikPen® | P | See Humalog® KwikPen prior authorization criteria | | |
| Humalog® Mix 75/25® KwikPen® | P | See Humalog® KwikPen prior authorization criteria | | |
| Admelog® SoloStar® | NP | Will be approved for patients meeting the following criteria:  
• Recipient or caregiver has poor eyesight such that dosing errors may occur and WILL BE ASSISTED BY A NON-VISUALLY IMPAIRED PERSON and/or caregiver; OR  
• Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., Parkinson’s Disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis); AND  
• Recipient has contraindication to preferred insulin lispro product that is not also observed with the requested agent. | | General PA Form |
| Afrezza® | NP | Will be approved for patients who meet the following criteria:  
• Patient does not have a history of smoking in the past 6 months; AND  
• Patient does not have a history of chronic lung disease (e.g., asthma, COPD); AND  
• Patient has a diagnosis of Diabetes Mellitus type 2; OR  
• Patient has a diagnosis of Diabetes Mellitus type 1; AND  
  – Concurrently taking a long-acting insulin  
• Recipient or caregiver has poor eyesight such that dosing errors may occur; OR  
• Recipient or caregiver has problems with manual dexterity which may result in dosing errors (i.e., Parkinson’s Disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis) | 3/day: 4-unit cartridges; 9/day: 8-unit cartridges | |
| Fiasp® | NP | Approval requires trial and failure, contraindication or intolerance of TWO preferred agents and Novolog® | | |
| Fiasp® FlexTouch® | NP | • Patient < 21 years of age approval requires trial and failure, contraindication or intolerance of 2 preferred agents and Novolog; OR  
• For patients ≥ 21 years old approval requires trial and failure, contraindication or intolerance of 2 preferred agents and Novolog; AND ONE of the following criteria:  
  – Recipient or caregiver has poor eyesight such that dosing errors may occur  
  – Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., Parkinson’s Disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis) | | |
| Humalog® Jr Kwik Pen® | NP | Approval will be granted upon documentation of ALL of the following:  
• Documentation the patient requires half unit (0.5) dosing or adjustments that cannot be achieved with Humalog® Kwik Pen® | | |

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<tbody>
<tr>
<td><strong>Diabetes: Rapid-Acting Insulins</strong>&lt;br&gt;(continued)</td>
<td></td>
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</tr>
<tr>
<td>Humalog® U-200 KwikPen®</td>
<td>NP</td>
<td>Approval will be granted upon documentation of <strong>ALL</strong> of the following:</td>
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<tr>
<td></td>
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<td>– Diagnosis of an FDA-approved indication; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>– Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents</td>
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</tr>
<tr>
<td>Novolog® FlexPen®</td>
<td>NP</td>
<td>• For patient &lt; 21 years of age approval requires trial and failure, contraindication or intolerance of 2 preferred agents&lt;br&gt;• For patients ≥ 21 years old approval requires trial and failure, contraindication or intolerance of 2 preferred agents, PLUS meeting <strong>ONE</strong> of the following criteria:&lt;br&gt;– Recipient or caregiver has poor eyesight such that dosing errors may occur&lt;br&gt;– Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., Parkinson’s Disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis)</td>
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<tr>
<td><strong>Diabetes: Short-Acting Insulins</strong></td>
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<td></td>
</tr>
<tr>
<td>Humulin® 70/30® KwikPen®</td>
<td>P</td>
<td>See Humalog® KwikPen prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humulin® R® U-500 KwikPen®</td>
<td>NP</td>
<td>• Prior authorization not required for children (&lt; 21 years of age)&lt;br&gt;• Will be approved for adults (≥ 21 years old) meeting <strong>ONE</strong> of the following criteria:&lt;br&gt;– Recipient or caregiver has poor eyesight such that dosing errors may occur&lt;br&gt;– Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., Parkinson’s Disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis)</td>
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</tr>
<tr>
<td><strong>Diabetes: Intermediate-Acting Insulins</strong></td>
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</tr>
<tr>
<td>Humulin® N® KwikPen®</td>
<td>P</td>
<td>See Humalog® KwikPen prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Novolog® Mix 70/30® FlexPen®</td>
<td>NP</td>
<td>See Novolog® FlexPen® prior authorization criteria</td>
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</tr>
<tr>
<td><strong>Diabetes: Long-Acting Insulins</strong></td>
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<tr>
<td>Basaglar® KwikPen®</td>
<td>NP</td>
<td>Will be approved for patients meeting following criteria:&lt;br&gt;– Recipient or caregiver has poor eyesight such that dosing errors may occur; <strong>OR</strong>&lt;br&gt;– Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., Parkinson’s Disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis); <strong>AND</strong>&lt;br&gt;– Recipient has contraindication to preferred insulin glargine pen that is not also observed with the requested agent.</td>
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</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
## ENDOCRINE/METABOLIC AGENTS

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes: Long-Acting Insulins (continued)</strong></td>
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<tr>
<td><strong>Toujeo® Max® Solostar®</strong></td>
<td>NP</td>
<td>Will be approved for patients meeting the following criteria:</td>
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<td></td>
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<td>• Recipient requires more than 80 units of insulin per injection; <strong>OR</strong></td>
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<td></td>
<td></td>
<td>• Recipient or caregiver has poor eyesight such that dosing errors may occur; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>− Recipient has a contraindication to Lantus Solostar that is not observed with the requested agent; <strong>OR</strong></td>
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<td></td>
<td></td>
<td>• Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., Parkinson’s Disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis); <strong>AND</strong></td>
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<td></td>
<td></td>
<td>− Recipient has a contraindication to Lantus® Solostar that is not also observed with the requested agent.</td>
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<tr>
<td><strong>Note:</strong> Max dose in one injection for Toujeo® Max® Solostar is 160 units</td>
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<tr>
<td><strong>Toujeo® Solostar®</strong></td>
<td>NP</td>
<td>Will be approved for patients meeting the following criteria:</td>
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<tr>
<td></td>
<td></td>
<td>• Recipient or caregiver has poor eyesight such that dosing errors may occur; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., Parkinson’s Disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Recipient has a contraindication to Lantus Solostar that is not also observed with the requested agent.</td>
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<tr>
<td><strong>Note:</strong> Max dose in one injection for BOTH Toujeo® Solostar and Lantus® Solostar is 80 units.</td>
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<tr>
<td><strong>Tresiba® FlexTouch®</strong></td>
<td>NP</td>
<td>Approval requires trial and failure, contraindication or intolerance of 2 preferred, long-acting insulin agents</td>
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<tr>
<td><strong>Tresiba® vial</strong></td>
<td>NP</td>
<td>Will be approved if the following are met:</td>
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<tr>
<td></td>
<td></td>
<td>• Approval requires trial and failure, contraindication or intolerance of 2 preferred, long-acting insulin agents; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the Tresiba® FlexTouch®</td>
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<tr>
<td><strong>Diabetes: Incretin Mimetics &amp; Combinations</strong></td>
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<tr>
<td><strong>Byetta®</strong></td>
<td>P</td>
<td>Will be approved for recipients who meet <strong>ALL</strong> the following criteria:</td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of type 2 diabetes; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>− Hemoglobin A1c &gt; 6.5% - ≤ 7.4% (for initial approval only); <strong>AND</strong></td>
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<td></td>
<td></td>
<td>− Trial and failure of metformin monotherapy (unless contraindicated); <strong>OR</strong></td>
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<td></td>
<td></td>
<td>− Hemoglobin A1c ≥ 7.5%; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>− Must be concomitantly receiving metformin, sulfonylurea, TZD, DPP-4 inhibitor, SGLT-2 inhibitor, or long-acting insulin</td>
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<td>Incretin mimetics will NOT be covered for the following:</td>
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<td></td>
<td></td>
<td>• Diagnosis of Type 1 diabetes</td>
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<td></td>
<td>• Treatment of diabetic ketoacidosis</td>
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<td></td>
<td></td>
<td>• Use for weight loss</td>
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<td></td>
<td></td>
<td>• Diagnosis of end-stage renal disease or CrCl ≤ 30 mL/min (Byetta® only)</td>
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<td></td>
<td></td>
<td>• Personal or immediate family history of medullary thyroid carcinoma or multiple endocrine neoplasia type 2 (MEN2)</td>
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<tr>
<td><strong>Smcg (1.2mL per 30 days); 10mcg (2.4mL per 30 days)</strong></td>
<td>Incretin Mimetic PA Form</td>
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</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
## ENDOCRINE/METABOLIC AGENTS

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

### Prior Authorization Criteria

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bydureon® Pen and vials</strong></td>
<td>P</td>
<td>Will be approved for recipients who meet <strong>ALL</strong> the following criteria:</td>
<td>4mL/28 days</td>
<td>Incretin Mimetic PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of type 2 diabetes; <strong>AND</strong></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>• Hemoglobin A1c &gt; 6.5% - ≤ 7.4% (for initial approval only); <strong>AND</strong></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>• Trial and failure of metformin monotherapy (unless contraindicated); <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Hemoglobin A1c ≥ 7.5%; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Must be concomitantly receiving metformin, sulfonylurea, TZD, DPP-4 inhibitor, SGLT-2 inhibitor, or basal insulin; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Patient must not be receiving prandial insulin</td>
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<td>Incretin mimetics will <strong>NOT</strong> be covered for the following:</td>
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<td></td>
<td></td>
<td>• Diagnosis of Type I diabetes</td>
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<td>• Treatment of diabetic ketoacidosis</td>
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<td></td>
<td>• Use for weight loss</td>
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<td></td>
<td></td>
<td>• Personal or immediate family history of medullary thyroid carcinoma or multiple endocrine neoplasia type 2 (MEN2)</td>
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<tr>
<td><strong>Victoza®</strong></td>
<td>P</td>
<td>See Byetta® prior authorization criteria</td>
<td>9mL/30 days</td>
<td></td>
</tr>
<tr>
<td><strong>Adlyxin®</strong></td>
<td>NP</td>
<td>Will be approved for patients who meet <strong>ALL</strong> of the following criteria:</td>
<td>6 mL (2 pens)/28 days</td>
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<td></td>
<td></td>
<td>• Diagnosis of type 2 diabetes; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Hemoglobin A1c &gt; 6.5% - ≤ 7.4% (for initial approval only); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Trial and failure of metformin monotherapy (unless contraindicated); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Trial and failure, contraindication or intolerance to BOTH preferred incretin mimetics (Byetta® or Bydureon® AND Victoza®); <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Hemoglobin A1c ≥ 7.5%; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>• Must be concomitantly receiving metformin, sulfonylurea, TZD, DPP-4 inhibitor, SGLT-2 inhibitor; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Trial and failure, or contraindication or intolerance to BOTH preferred incretin mimetics (Byetta® or Bydureon® AND Victoza®)</td>
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</tbody>
</table>

Incretin Mimetics & Combinations will **NOT** be covered for the following:

- Diagnosis of Type I diabetes
- Treatment of diabetic ketoacidosis
- Use for weight loss
- Personal or immediate family history of medullary thyroid carcinoma or multiple endocrine neoplasia type 2 (MEN2)

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
**Diabetes: Incretin Mimetics & Combinations (continued)**

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bydureon® BCise®</td>
<td>NP</td>
<td>Will be approved for recipients who meet ALL the following criteria:</td>
<td>3.4 mL/28 days</td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of type 2 diabetes; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Hemoglobin A1c &gt; 6.5%-≤ 7.4% (for initial approval only); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Trial and failure of metformin monotherapy (unless contraindicated); <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Hemoglobin A1c ≥ 7.5%; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Must be concomitantly receiving metformin, sulfonylurea, TZD, DPP-4 inhibitor, or SGLT-2 inhibitor; <strong>AND</strong></td>
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<td></td>
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<td>• Clinically valid reason as to why a preferred exenatide pen injector cannot be used; <strong>AND</strong></td>
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<td>Incretin mimetics will NOT be covered for the following:</td>
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<td></td>
<td></td>
<td>• Diagnosis of Type I diabetes</td>
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<td>• Treatment of diabetic ketoacidosis</td>
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<td>• Use for weight loss</td>
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<td></td>
<td>• Personal or immediate family history of medullary thyroid carcinoma or multiple endocrine neoplasia type 2 (MEN2)</td>
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<tr>
<td>Ozempic®</td>
<td>NP</td>
<td>Will be approved for recipients who meet ALL the following criteria:</td>
<td>0.25mg/0.5mg</td>
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<td></td>
<td></td>
<td>• Diagnosis of type 2 diabetes; <strong>AND</strong></td>
<td>1 pen/28 days; 1mg: 2 pens/28 days</td>
<td>Incretin Mimetic PA Form</td>
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<td>• Hemoglobin A1c &gt; 6.5% - ≤ 7.4% (for initial approval only); <strong>AND</strong></td>
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<td></td>
<td>• Trial and failure of metformin monotherapy (unless contraindicated); <strong>AND</strong></td>
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<td></td>
<td>• Trial and failure, or contraindication or intolerance to BOTH preferred incretin mimetics; <strong>OR</strong></td>
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<td></td>
<td></td>
<td>• Hemoglobin A1c ≥ 7.5%; <strong>AND</strong></td>
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<td></td>
<td>• Must be concomitantly receiving metformin, sulfonylurea, TZD, DPP-4 inhibitor, or SGLT-2 inhibitor; <strong>AND</strong></td>
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<td></td>
<td>• Trial and failure, or contraindication or intolerance to BOTH preferred incretin mimetics (Byetta® or Bydureon® <strong>AND</strong> Victoza®)</td>
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<td>Incretin mimetics will NOT be covered for the following:</td>
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<td>• Diagnosis of Type I diabetes</td>
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<td>• Treatment of diabetic ketoacidosis</td>
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<td></td>
<td>• Personal or immediate family history of medullary thyroid carcinoma or multiple endocrine neoplasia type 2 (MEN2)</td>
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</table>
### ENDOCRINE/METABOLIC AGENTS

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes: Incretin Mimetics &amp; Combinations (continued)</strong></td>
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<tr>
<td>Soliqua®</td>
<td>NP</td>
<td>Will be approved for patients who meet <strong>ALL</strong> of the following criteria:</td>
<td>5 pens/30 days</td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of type 2 diabetes; <strong>AND</strong></td>
<td></td>
<td>Incretin Mimetic PA Form</td>
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<tr>
<td></td>
<td></td>
<td>• Trial and failure of metformin (unless contraindicated); <strong>AND</strong></td>
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<td></td>
<td>• Trial/failure of 2 preferred GLP-1 receptor agonists [documented per TennCare paid claims]; <strong>AND</strong></td>
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<td>• Patient is currently taking; but inadequately controlled on a long acting basal insulin (e.g., insulin glargine, degludec, detemir) [documented per TennCare paid claims]; <strong>AND</strong></td>
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<td>Incretin Mimetics &amp; Combinations will NOT be covered for the following:</td>
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<td>• Diagnosis of Type I diabetes</td>
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<td>• Treatment of diabetic ketoacidosis</td>
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<td>• Use for weight loss</td>
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<td></td>
<td>• Personal or immediate family history of medullary thyroid carcinoma or multiple endocrine neoplasia type 2 (MEN2)</td>
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<tr>
<td>Tanzeum®</td>
<td>NP</td>
<td>Will be approved for patients who meet <strong>ALL</strong> of the following criteria:</td>
<td>4 mL/28 days</td>
<td>Incretin Mimetic PA Form</td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of type 2 diabetes; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>– Hemoglobin A1c &gt; 6.5% - ≤ 7.4% (for initial approval only); <strong>AND</strong></td>
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<td></td>
<td>– Trial and failure of metformin monotherapy (unless contraindicated); <strong>AND</strong></td>
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<td></td>
<td>– Trial and failure, contraindication or intolerance to BOTH preferred incretin mimetics; <strong>OR</strong></td>
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<td></td>
<td></td>
<td>– Hemoglobin A1c ≥ 7.5%; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>– Must be concomitantly receiving metformin, sulfonylurea, TZD, DPP-4 inhibitor, SGLT-2 inhibitor, or long acting insulin; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>– Trial and failure, or contraindication or intolerance to BOTH preferred incretin mimetics (Byetta® or Bydureon® AND Victoza®)</td>
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<td>Incretin mimetics will NOT be covered for the following:</td>
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<td></td>
<td></td>
<td>• Diagnosis of Type I diabetes</td>
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<td></td>
<td>• Personal or immediate family history of medullary thyroid carcinoma or multiple endocrine neoplasia type 2 (MEN2)</td>
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</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
**Diabetes: Incretin Mimetics & Combinations (continued)**

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
</table>
| Trulicity®   | NP  | Will be approved for recipients who meet **ALL** the following criteria:                                                                                          • Diagnosis of type 2 diabetes; **AND**  
  – Hemoglobin A1c > 6.5% - ≤ 7.4% (for initial approval only); **AND**  
  – Trial and failure of metformin monotherapy (unless contraindicated); **AND**  
  – Trial and failure, or contraindication or intolerance to BOTH preferred incretin mimetics; **OR**  
  – Hemoglobin A1c ≥ 7.5%; **AND**  
  – Must be concomitantly receiving metformin, sulfonylurea, TZD, DPP-4 inhibitor, or SGLT-2 inhibitor; **AND**  
  – Trial and failure, or contraindication or intolerance to BOTH preferred incretin mimetics (Byetta® or Bydureon® AND Victoza®)  
  Incretin mimetics will NOT be covered for the following:                                                                 • Diagnosis of Type 1 diabetes  
  • Treatment of diabetic ketoacidosis  
  • Use for weight loss  
  • Personal or immediate family history of medullary thyroid carcinoma or multiple endocrine neoplasia type 2 (MEN2)                                                                                                                                                                                                                                                                                                                                  | 2 mL/28 days | **Incretin Mimetic PA Form** |
| Xultophy®    | NP  | See Soliqua® prior authorization criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 5 pens/30 days |                          |

**Diabetes: Biguanides**

<table>
<thead>
<tr>
<th>Medication</th>
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</tr>
</thead>
</table>
| metformin    | P   | 500 mg: 4/day  
  850 mg & 1000 mg: 2/day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |             |                          |
| metformin ER | P   | 500 mg: 1/day  
  1000 mg: 2/day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |             | **General PA Form**      |
| Fortamet     | NP  | 500 mg: 3/day  
  1000 mg: 2/day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |             |                          |
| Glucophage®  | NP  | 500 mg: 4/day  
  850 mg & 1000 mg: 2/day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |             | **General PA Form**      |
| Glucophage XR® | NP  | 500 mg: 4/day  
  750 mg: 2/day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |             |                          |
| Glumetza®    | NP  | 500 mg: 1/day  
  1000 mg: 2/day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |             |                          |
| metformin ER osmotic | NP | 500 mg: 3/day  
  1000 mg: 2/day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |             |                          |
| Riomet®      | NP  |  • No PA required for 11 years old and younger.  
  • All others: Will be approved for patients unable to swallow tablets.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 20 mL/day    |                          |

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# ENDOCRINE/METABOLIC AGENTS

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes: DPP-4 Inhibitors and Combos</strong></td>
<td></td>
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</tr>
<tr>
<td>Janumet*</td>
<td>P</td>
<td>Will be approved for recipients who meet the following criteria:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of type 2 diabetes; <strong>AND</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>– Hemoglobin A1c &gt; 6.5 – ≤ 7.4%, <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trial and failure of metformin monotherapy; <strong>OR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Hemoglobin A1c ≥ 7.5%</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>Janumet XR*</td>
<td>P</td>
<td>Will be approved for recipients who meet the following criteria:</td>
<td>50/500mg,</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• See Janumet* prior authorization criteria</td>
<td>100/1000mg:</td>
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<tr>
<td></td>
<td></td>
<td>1/day</td>
<td></td>
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</tr>
<tr>
<td>Januvia*</td>
<td>P</td>
<td>Will be approved for recipients who meet the following criteria:</td>
<td>1/day</td>
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<td></td>
<td></td>
<td>• See Janumet* prior authorization criteria</td>
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<tr>
<td></td>
<td></td>
<td>• See Janumet* prior authorization criteria</td>
<td></td>
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</tr>
<tr>
<td>Kombiglyze® XR</td>
<td>P</td>
<td>Will be approved for recipients who meet the following criteria:</td>
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<td></td>
<td></td>
<td>• See Janumet* prior authorization criteria</td>
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</tr>
<tr>
<td>Onglyza*</td>
<td>P</td>
<td>Will be approved for recipients who meet the following criteria:</td>
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<tr>
<td></td>
<td></td>
<td>• See Januvia* prior authorization criteria</td>
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</tr>
<tr>
<td>alogliptin</td>
<td>NP</td>
<td>Will be approved for recipients who meet the following criteria:</td>
<td>1/day</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of type 2 diabetes; <strong>AND</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>– Hemoglobin A1c &gt; 6.5 – ≤ 7.4%, <strong>AND</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Trial and failure, contraindication or intolerance to metformin; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Trial and failure, contraindication or intolerance to the preferred single entity DPP-4 inhibitors; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>– Hemoglobin A1c ≥ 7.5%; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Patient is receiving metformin, sulfonylurea, TZD, incretin mimetic or SGLT2-inhibitor concomitantly</td>
<td></td>
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</tr>
<tr>
<td>alogliptin/metformin</td>
<td>NP</td>
<td>Will be approved for recipients who meet the following criteria:</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of type 2 diabetes; <strong>AND</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>– Hemoglobin A1c &gt; 6.5 – ≤ 7.4%, <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Trial and failure of metformin monotherapy; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Trial and failure, contraindication or intolerance to the preferred DPP-4/metformin combination products; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>– Hemoglobin A1c ≥ 7.5%; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Trial and failure, contraindication or intolerance to the preferred DPP-4/metformin combination products</td>
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</tr>
</tbody>
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### ENDOCRINE/METABOLIC AGENTS

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</table>
| alogliptin/pioglitazone     | NP   | Will be approved for recipients who meet the following criteria:  
- Diagnosis of type 2 diabetes; **AND**  
  - Hemoglobin A1c ≥ 7.5; **AND**  
  - Trial and failure of metformin AND either a GLP-1, DPP-4 inhibitor, SGLT-2 inhibitor or TZD (unless, recipient has an adverse reaction, intolerance or contraindication to metformin); **AND**  
- Trial and failure, contraindication or intolerance to the preferred single entity DPP-4 inhibitors | 1/day       |         |
| Jentadueto®                 | NP   | See alogliptin/metformin prior authorization criteria                                                                ------------------------------------------------------------------------------------------------------------------------| 2/day       |         |
| Jentadueto® XR              | NP   | See alogliptin/metformin prior authorization criteria                                                                                                                                                                                                                                                   | 2.5/1000mg: 2/day; 5/1000mg: 1/day |         |
| Kazano®                     | NP   | See alogliptin/metformin prior authorization criteria                                                                ------------------------------------------------------------------------------------------------------------------------| 2/day       |         |
| Nesina®                     | NP   | See alogliptin prior authorization criteria                                                                --------------------------------------------------------------------------------------------------------------------------------                                                      | 1/day       |         |
| Oseni®                      | NP   | See alogliptin/pioglitazone prior authorization criteria                                                                                                                                                                                                                                              | 1/day       |         |
| Qtern®                      | NP   | Will be approved if ALL of the following are true:  
- Diagnosis of Diabetes Type II; **AND**  
- Patient’s HbA1c level is greater than 6.5 (for initial approval); **AND**  
- Patient has tried and failed metformin or a metformin containing product (unless, recipient has an adverse reaction, intolerance or contraindication to metformin); **AND**  
- Trial and failure, contraindication, or intolerance to preferred agent; **AND**  
- Patient has tried and failed at least ONE agent from any 2 of the following classes:  
  - DPP4 Inhibitor  
  - Incretin Mimetic  
  - TZD | 1/day       |         |
| Tradjenta®                  | NP   | See alogliptin prior authorization criteria                                                                                                                                                                                                                                                   | 1/day       |         |

#### GLP-2 Analogs

<table>
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<th>PA Form</th>
</tr>
</thead>
</table>
| Gattex®    | NP  | Will be approved for patients that meet ALL of the following criteria:  
- Diagnosis of short bowel syndrome, **AND**  
- Dependent on parenteral nutrition for at least 12 months; **AND**  
- Receiving parenteral nutrition at least 3 times weekly  
Renewal Criteria:  
Will be approved for patients that meet the following criteria:  
- Patient is continually receiving parenteral nutrition while taking the requested agent. | General PA Form |

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ENDOCRINE/METABOLIC AGENTS

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</tr>
<tr>
<td>nateglinide</td>
<td>P</td>
<td>Will be approved for patients who have met the following criteria:</td>
<td>3/day</td>
<td></td>
</tr>
<tr>
<td>• Trial and failure, contraindication or intolerance of metformin monotherapy</td>
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</tr>
<tr>
<td>repaglinide</td>
<td>P</td>
<td>See nateglinide prior authorization criteria</td>
<td>4/day (0.5 &amp; 1mg) / 8/day (2mg)</td>
<td></td>
</tr>
<tr>
<td>Prandin*</td>
<td>NP</td>
<td>Will be approved for patients who have met the following criteria:</td>
<td>4/day (0.5 &amp; 1mg) / 8/day (2mg)</td>
<td>General PA Form</td>
</tr>
<tr>
<td>• Trial and failure of metformin monotherapy; <strong>AND</strong></td>
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<tr>
<td>• Trial and failure of TWO preferred agents</td>
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<tr>
<td>Prandimet*</td>
<td>NP</td>
<td>See Prandin* prior authorization criteria</td>
<td>5/day</td>
<td></td>
</tr>
<tr>
<td>repaglinide/metformin</td>
<td>NP</td>
<td>See Prandin* prior authorization criteria</td>
<td>5/day</td>
<td></td>
</tr>
<tr>
<td>Starlix*</td>
<td>NP</td>
<td>See Prandin* prior authorization criteria</td>
<td>3/day</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes: SGLT2 Inhibitors and Combinations</strong></td>
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<tr>
<td>Jardiance*</td>
<td>P</td>
<td>Will be approved if ALL of the following are true:</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>• Diagnosis of Diabetes Type II; <strong>AND</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Patient’s HbA1c level is greater than 6.5 (for initial approval); <strong>AND</strong></td>
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</tr>
<tr>
<td>- Patient has tried and failed metformin or a metformin containing product (unless, recipient has an adverse reaction, intolerance or contraindication to metformin); <strong>AND</strong></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>- Patient has tried and failed at least ONE agent from any 2 of the following classes:</td>
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<td></td>
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<tr>
<td>- DPP4 Inhibitor</td>
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<tr>
<td>- Incretin Mimetic</td>
<td></td>
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<tr>
<td>- TZD</td>
<td></td>
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<tr>
<td>• Diagnosis of Diabetes Type II, AND Coronary Vascular Disease:</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>- Hemoglobin A1c &gt; 6.5 – ≤ 7.4%; <strong>AND</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Trial and failure, contraindication or intolerance to metformin (or alpha-glucosidase inhibitor, sulfonylurea or TZD) if recipient has adverse reaction, intolerance or contraindication to metformin); <strong>OR</strong></td>
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<td></td>
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<tr>
<td>- Hemoglobin A1c ≥ 7.5%; <strong>AND</strong></td>
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<tr>
<td>- Patient is receiving metformin, sulfonylurea, or a TZD, incretin mimetic or DPP-4 inhibitor concomitantly</td>
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<td><strong>Diabetes: SGLT2 Inhibitors and Combinations (continued)</strong></td>
<td></td>
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</tr>
<tr>
<td>Farxiga®</td>
<td>NP</td>
<td>Will be approved if ALL of the following are true:</td>
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<tr>
<td></td>
<td></td>
<td>- Diagnosis of Diabetes Type II; <strong>AND</strong></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>- Patient’s HbA1c level is greater than 6.5 (for initial approval); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Patient has tried and failed metformin or a metformin containing product (unless, recipient has an adverse reaction, intolerance or contraindication to metformin); <strong>AND</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Trial and failure, contraindication, or intolerance to preferred agent; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Patient has tried and failed at least ONE agent from any 2 of the following classes:</td>
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<tr>
<td></td>
<td></td>
<td>- DPP4 Inhibitor</td>
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<tr>
<td></td>
<td></td>
<td>- Incretin Mimetic</td>
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<td></td>
<td></td>
<td>- TZD</td>
<td></td>
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<tr>
<td>Glyxambi®</td>
<td>NP</td>
<td>Will be approved if ALL of the following are true:</td>
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<tr>
<td></td>
<td></td>
<td>- Diagnosis of Diabetes Type II; <strong>AND</strong></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>- Patient’s HbA1c level is greater than 6.5 (for initial approval); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Patient has tried and failed metformin or a metformin containing product; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Trial and failure, contraindication, or intolerance to preferred agent; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Patient has tried and failed at least ONE agent from any 2 of the following classes:</td>
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<tr>
<td></td>
<td></td>
<td>- DPP4 Inhibitor</td>
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<tr>
<td></td>
<td></td>
<td>- Incretin Mimetic</td>
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<tr>
<td></td>
<td></td>
<td>- TZD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invokamet®</td>
<td>NP</td>
<td>Will be approved if ALL of the following are true:</td>
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<tr>
<td></td>
<td></td>
<td>- Diagnosis of Diabetes Type II; <strong>AND</strong></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>- Patient’s HbA1c level is greater than 6.5 (for initial approval); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Patient has tried and failed metformin or a metformin containing product; <strong>AND</strong></td>
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<td></td>
<td></td>
<td>- Trial and failure, contraindication, or intolerance to preferred agent; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Patient has tried and failed at least ONE agent from any 2 of the following classes:</td>
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<tr>
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<td></td>
<td>- DPP4 Inhibitor</td>
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<td></td>
<td>- Incretin Mimetic</td>
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<td></td>
<td></td>
<td>- TZD</td>
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</tr>
<tr>
<td>Invokamet XR®</td>
<td>NP</td>
<td>Will be approved if the following are met (Initial PA duration: 1 year):</td>
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<tr>
<td></td>
<td></td>
<td>- Patient has a diagnosis of Diabetes Type II; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Patient has tried or failed metformin monotherapy; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Patient has been treated or not adequately controlled on a regimen containing both ertugliflozin (Steglatro) and metformin; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Patient’s estimated glomerular filtration rate (eGFR) is not &lt; 30 mL/min/1.73 m2, end-stage renal disease (ESRD), or be on dialysis; <strong>AND</strong></td>
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<td></td>
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<td></td>
<td></td>
<td>- Patient does not have metabolic acidosis</td>
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<td><strong>Renewal (PA duration 1 year)</strong></td>
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<td></td>
<td></td>
<td>- Patient has met the above criteria; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Medical documentation of clinical benefit (e.g., improvement or stabilization in HbA1c) has been submitted; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Patient has absence of unacceptable toxicity from the drug</td>
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</tbody>
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<td></td>
<td></td>
</tr>
<tr>
<td>Steglatro®</td>
<td>NP</td>
<td>See Farxiga® prior authorization criteria</td>
<td>2/day (5mg); 1/day (15mg)</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Steglujan®</td>
<td>NP</td>
<td>Will be approved if the following are met (Initial PA duration: 1 year): • Patient has a diagnosis of Diabetes Type II; AND • Patient has tried or failed metformin monotherapy; AND • Patient has tried or failed at least 2 preferred products from 2 separate drug classes indicated for T2DM; AND • Patient’s estimated glomerular filtration rate (eGFR) is not &lt; 30 mL/min/1.73 m2, end-stage renal disease (ESRD), or be on dialysis; AND • Patient does not have metabolic acidosis <strong>Renewal (PA duration 1 year)</strong> • Patient has met the above criteria; AND • Medical documentation of clinical benefit (e.g., improvement or stabilization in HbA1c) has been submitted; AND Patient has absence of unacceptable toxicity from the drug</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Synjardy®</td>
<td>NP</td>
<td>See Invokamet® prior authorization criteria</td>
<td>2/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Synjardy XR®</td>
<td>NP</td>
<td>See Invokamet® prior authorization criteria • Additionally, must have clinically valid reason as to why patient cannot use Synjardy®</td>
<td>1/day (25/1000mg); 2/day (all other strengths)</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Xigduo® XR</td>
<td>NP</td>
<td>See Invokamet® prior authorization criteria</td>
<td>1/day (5/500mg, 10/500mg, 10/1,000mg); 2/day (5/1,000mg)</td>
<td>General PA Form</td>
</tr>
</tbody>
</table>

### Diabetes: Sulfonylureas and Combos

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>glimepiride</td>
<td>P</td>
<td>Will be approved for patients who have met the following criteria: • Trial and failure, or contraindication or intolerance to, metformin monotherapy</td>
<td>2/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>glipizide</td>
<td>P</td>
<td>See glimepiride prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>glipizide ER/XL</td>
<td>P</td>
<td>See glimepiride prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>glyburide</td>
<td>P</td>
<td>See glimepiride prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>glyburide micronized</td>
<td>P</td>
<td>See glimepiride prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amaryl®</td>
<td>NP</td>
<td>Will be approved for patients who have met the following criteria: • Trial and failure, or contraindication or intolerance to, metformin monotherapy; AND • Trial and failure, contraindication or intolerance of TWO preferred agents</td>
<td>2/day</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### ENDOCRINE/METABOLIC AGENTS

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Diabetes: Sulfonylureas and Combos (continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>chlorpropamide</td>
<td>NP</td>
<td>See Amaryl® prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabeta®</td>
<td>NP</td>
<td>See Amaryl® prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucotrol®</td>
<td>NP</td>
<td>See Amaryl® prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucotrol XL®</td>
<td>NP</td>
<td>See Amaryl® prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glynase PresTab®</td>
<td>NP</td>
<td>See Amaryl® prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>tolazamide</td>
<td>NP</td>
<td>See Amaryl® prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>tolbutamide</td>
<td>NP</td>
<td>See Amaryl® prior authorization criteria</td>
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<tr>
<td></td>
<td></td>
<td><strong>Diabetes: TZDs and Combos</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pioglitazone</td>
<td>P</td>
<td>Will be approved for monotherapy or combination therapy in patients who have had a failure, contraindication, drug to drug interaction, or intolerance to an adequate trial of metformin.</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>pioglitazone/metformin</td>
<td>P</td>
<td>See pioglitazone prior authorization criteria</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>Actos®</td>
<td>NP</td>
<td>Will be approved for monotherapy or combination therapy in patients who have had a failure, contraindication, drug to drug interaction, or intolerance to an adequate trial of metformin.</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>ACTOplus Met®</td>
<td>NP</td>
<td>See Actos® prior authorization criteria</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>ACTOplus Met® XR</td>
<td>NP</td>
<td>Will be approved for monotherapy or combination therapy in patients with:</td>
<td>1/day</td>
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<td></td>
<td></td>
<td>• Failure of an adequate trial of metformin; AND</td>
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<td></td>
<td></td>
<td>• Trial and failure of Actoplus Met*</td>
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<tr>
<td>Avandamer®</td>
<td>NP</td>
<td>See Actos® prior authorization criteria</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>Avandaryl®</td>
<td>NP</td>
<td>See Actos® prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Avandia®</td>
<td>NP</td>
<td>See Actos® prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Duetact®</td>
<td>NP</td>
<td>See Actos® prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>pioglitazone/glimepiride</td>
<td>NP</td>
<td>See Actos® prior authorization criteria</td>
<td>1/day</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>Disease Modifying Anti-Rheumatic Drugs (DMARDs)</strong></td>
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<tr>
<td>sulfasalazine</td>
<td>P</td>
<td></td>
<td>8/day</td>
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</tr>
<tr>
<td>sulfasalazine EC</td>
<td>P</td>
<td></td>
<td>8/day</td>
<td></td>
</tr>
<tr>
<td>Azulfidine®</td>
<td>NP</td>
<td></td>
<td>8/day</td>
<td></td>
</tr>
<tr>
<td>Azulfidine EN®</td>
<td>NP</td>
<td></td>
<td>8/day</td>
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</tr>
</tbody>
</table>

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### ENDOCRINE/METABOLIC AGENTS

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
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</tr>
</thead>
</table>
| Otrexup*   | NP  | Will be approved for patients meeting following criteria:  
- Diagnosis of Rheumatoid Arthritis (RA):  
  - Trial/failure of TWO preferred DMARD agents; AND  
  - Must have an allergy or contraindication to benzoyl alcohol or other preservative contained in injectable methotrexate that is not in requested agent; OR  
  - Patient is experiencing dexterity issues without assistance to a caregiver who can administer the requested agent  
- Diagnosis of polyarticular Juvenile Idiopathic Arthritis (pJIA):  
  - Trial/failure of TWO preferred NSAIDs and/or corticosteroids; AND  
  - Must have an allergy or contraindication to benzoyl alcohol or other preservative contained in injectable methotrexate that is not in requested agent; OR  
  - Patient is experiencing dexterity issues without assistance to a caregiver who can administer the requested agent  
- Diagnosis of psoriasis:  
  - Trial/failure of TWO preferred topical treatments approved for that indication; AND  
  - Must have an allergy or contraindication to benzoyl alcohol or other preservative contained in injectable methotrexate that is not in requested agent. | 4 syringes/28 days | General PA Form |
| Rasuvo*    | NP  | See Otrexup* prior authorization criteria | 4 injections/28 days | |
| Xatmep*    | NP  | Approval requires:  
- Age ≤ 12 years; AND  
  - Dosing that will not allow the use of preferred methotrexate tablets; OR  
  - Patient unable to swallow methotrexate tablets | | |

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### ENDOCRINE/METABOLIC AGENTS

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Anti-Rheumatic: Kinase Inhibitors</strong></td>
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</tr>
</tbody>
</table>
| Olumiant®        | NP  | Will be approved, if ALL the following have been met:  
• Patient has a diagnosis of Rheumatoid Arthritis; **AND**  
• Patient must have tried and failed or been intolerant to at least methotrexate (unless there is a documented absolute contraindication such as alcohol abuse, cirrhosis, chronic liver disease) **AND** TWO preferred immunomodulators (e.g., Enbrel, Humira); **AND**  
• Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab and abatacept), OR potent immunosuppressants (i.e., azathioprine, or cyclosporine). | 1/day      |         |
| Xeljanz®         | NP  | Will be approved, if ALL the following have been met:  
• Diagnosis of Rheumatoid or Psoriatic Arthritis  
  − Patient must have tried and failed or been intolerant to at least methotrexate (unless there is a documented absolute contraindication such as alcohol abuse, cirrhosis, chronic liver disease) AND TWO preferred immunomodulators.  
  − Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab and abatacept), OR potent immunosuppressants (i.e., azathioprine, or cyclosporine).  
• Diagnosis of Ulcerative Colitis  
  − Tired and failed a corticosteroid **OR** an immunosuppressive agent; **AND**  
  − Tired and failed, or have contraindication or intolerance to, preferred immunomodulator approved for use in Ulcerative Colitis; **AND**  
  − Patient is not currently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab and abatacept), OR potent immunosuppressants (i.e., azathioprine, or cyclosporine).                                                                 | 2/day      | General PA Form |
| Xeljanz® XR      | NP  | Will be approved, if ALL the following have been met:  
• Diagnosis of Rheumatoid or Psoriatic Arthritis  
  − Patient must have tried and failed or been intolerant to at least methotrexate (unless there is a documented absolute contraindication such as alcohol abuse, cirrhosis, chronic liver disease) AND TWO preferred immunomodulators.  
  − Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab and abatacept), OR potent immunosuppressants (i.e., azathioprine, or cyclosporine).  
  − Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the immediate release product. | 1/day      |         |

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### ENDOCRINE/METABOLIC AGENTS

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Estrogen / Progestin, Transdermal</strong></td>
<td></td>
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</tr>
<tr>
<td>CombiPatch®</td>
<td>P</td>
<td></td>
<td>8/28 days</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Climara Pro®</td>
<td>NP</td>
<td></td>
<td>4/28 days</td>
<td>Form</td>
</tr>
<tr>
<td><strong>Estrogens, Transdermal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alora*</td>
<td>P</td>
<td></td>
<td>8/28 days</td>
<td></td>
</tr>
<tr>
<td>estradiol transdermal biweekly patch</td>
<td>P</td>
<td></td>
<td>8/28 days</td>
<td></td>
</tr>
<tr>
<td>estradiol transdermal weekly patch</td>
<td>P</td>
<td></td>
<td>4/28 days</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Climara*</td>
<td>NP</td>
<td></td>
<td>4/28 days</td>
<td>Form</td>
</tr>
<tr>
<td>Menostar*</td>
<td>NP</td>
<td></td>
<td>4/28 days</td>
<td></td>
</tr>
<tr>
<td>Minivelle*</td>
<td>NP</td>
<td></td>
<td>8/28 days</td>
<td></td>
</tr>
<tr>
<td>Vivelle-Dot®</td>
<td>NP</td>
<td></td>
<td>8/28 days</td>
<td></td>
</tr>
<tr>
<td><strong>Estrogens, Vaginal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premarin® Vaginal Cream</td>
<td>P</td>
<td></td>
<td>2 grams/day</td>
<td>General PA Form</td>
</tr>
</tbody>
</table>

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### ENDOCRINE/METABOLIC AGENTS

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</tr>
</thead>
<tbody>
<tr>
<td>Glucocorticoids, Oral</td>
<td></td>
<td>Will be approved for an initial request for 6 months for patients meeting ALL of the following criteria:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient must have documentation of a confirmed diagnosis of Duchenne muscular dystrophy (DMD); <strong>AND</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Age ≥ 2 years; <strong>AND</strong></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>- Patient retains meaningful voluntary motor function (e.g., patient is able to speak, manipulate objects using upper extremities, ambulate, etc.); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient should be receiving physical therapy; <strong>AND</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Patient has experienced at least ONE of the following unacceptable adverse reactions directly attributable to previous therapy with prednisone:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emflaza®</td>
<td>NP</td>
<td>- Patient has experienced significant weight gain (e.g., crossing 2 percentile lines and/or reaching 98th percentile for age and sex); <strong>OR</strong></td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td>Orapred ODT®</td>
<td>NP</td>
<td>- Patient has manifested significant behavioral changes negatively impacting function at school, home, day care, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>prednisolone ODT</td>
<td>NP</td>
<td>Requests for continuation after the initial PA will be approved for patients meeting the following criteria:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient retains meaningful voluntary motor function (e.g., patient is able to speak, manipulate objects using upper extremities, ambulate, etc.); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient continues to receive physical therapy; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Patient has received benefit from therapy, which may include ONE or more of the following:</td>
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<tr>
<td></td>
<td></td>
<td>- Stability or slowing of decline in motor function</td>
<td></td>
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<td></td>
<td></td>
<td>- Stability or slowing of decline in respiratory function</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Stability or slowing of decline in sequelae related to diminished strength of stabilizing musculature (e.g., scoliosis, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Quality of Life</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**ENDOCRINE/METABOLIC AGENTS**

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<tr>
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<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Growth Hormone Agents</td>
<td></td>
<td>Will be approved for patients meeting the following criteria:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>1. Daily dose within approved dosage range for somatropin for requested indication per clinical compendium; AND</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>2. Daily dose based on weight of the enrollee, supported by submitted growth charts; AND</td>
<td></td>
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</tr>
<tr>
<td>Genotropin®</td>
<td></td>
<td>3. Approval will be based on dosage form resulting in least wastage of product</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>For patients &lt; 21 years old</strong>, will be approved if ANY of the following criteria are met:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Patient has a diagnosis of short stature associated with Turner’s Syndrome or Noonan Syndrome or mutations of the Short Stature Homeobox (SHOX) gene</td>
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<td></td>
<td></td>
<td>- Patient has a diagnosis of Prader-Willi Syndrome</td>
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<td>- Patient has evidence of hypothalamic-pituitary disease or structural lesions/trauma to the pituitary, including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation and meets any of the following:</td>
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<tr>
<td></td>
<td></td>
<td>- Failed a GH stimulation test (peak GH level &lt;10ng/mL)</td>
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<td>- Documented low IGF-1 level (below normal for patient’s age)</td>
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<td></td>
<td>- Has deficiencies in 3 or more pituitary axes</td>
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<td></td>
<td></td>
<td>- Patient has chronic renal insufficiency (CrCl &lt; 30mL/min/1.73m2)</td>
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<tr>
<td></td>
<td></td>
<td>- Patient is a newborn infant and has evidence of hypoglycemia AND either a low GH level (&lt;20 ng/mL) or a low for age IGF-1/IGF Binding Protein #3 level</td>
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<tr>
<td></td>
<td></td>
<td>- Patient has failed two GH stimulation tests (defined as peak GH level &lt; 10 ng/mL) OR has failed one GH stimulation test and has a documented low IGF-1 level based on age normal values.</td>
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<tr>
<td></td>
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<td>- Continuation of GH therapy will be approved only if height velocity is within range of normal for patient’s age or bone age.</td>
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<td></td>
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<td>- Therapy will not be approved once epiphyseal fusion occurs.</td>
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<td></td>
<td></td>
<td>- Diagnosis of Small for Gestational Age (SGA) or Intrauterine Growth Retardation (IGR), &gt; 2 years old, and has a height at least 2 standard deviations below the population mean for age</td>
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<td></td>
<td></td>
<td>- Patient has a diagnosis of AIDS wasting/cachexia</td>
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<td></td>
<td></td>
<td>- Short bowel syndrome and receiving specialized nutrition support. <strong>Note</strong>: GH therapy will NOT be approved for idiopathic short stature.</td>
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<td></td>
<td></td>
<td><strong>Patients ≥ 21 years old</strong>, will be approved for ANY of the following:</td>
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<tr>
<td></td>
<td></td>
<td>- Patient has evidence of hypothalamic-pituitary disease or structural lesions/trauma to the pituitary, including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation (can be diagnosed either in childhood or adulthood) AND meets any one of the following:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Failed at least one GH stimulation test</td>
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<td></td>
<td></td>
<td>- Has at least one documented low IGF-1 level</td>
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<td></td>
<td></td>
<td>- Has deficiencies in 3 or more pituitary axes</td>
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<td></td>
<td><strong>Note</strong>: For recipients diagnosed in childhood with hypothalamic-pituitary disease or structural lesions/trauma to the pituitary who have a past history of GH use, no retesting is necessary.</td>
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<td></td>
<td></td>
<td>- Failure of two GH stimulation tests (peak GH level &lt; 5 ng/mL) or failure of one GH stimulation test and documented low IGF-1.</td>
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<td></td>
<td></td>
<td>- Therapy will NOT be approved once epiphyseal fusion occurs.</td>
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<td></td>
<td></td>
<td>- Patient has a diagnosis of AIDS wasting/cachexia</td>
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<td></td>
<td></td>
<td>- Short bowel syndrome and receiving specialized nutrition support.</td>
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</tbody>
</table>

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**ENDOCRINE/METABOLIC AGENTS**

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<tr>
<td></td>
<td></td>
<td><strong>Growth Hormone Agents (continued)</strong></td>
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<tr>
<td>Humatrope*</td>
<td>NP</td>
<td>See Genotropin* prior authorization criteria</td>
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<tr>
<td>Norditropin*</td>
<td>NP</td>
<td>See Genotropin* prior authorization criteria</td>
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<tr>
<td>Nutropin*</td>
<td>NP</td>
<td>See Genotropin* prior authorization criteria</td>
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<tr>
<td>Nutropin AQ*</td>
<td>NP</td>
<td>See Genotropin* prior authorization criteria</td>
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<tr>
<td>Omnitrope*</td>
<td>NP</td>
<td>See Genotropin* prior authorization criteria</td>
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<tr>
<td>Saizen*</td>
<td>NP</td>
<td>See Genotropin* prior authorization criteria</td>
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<tr>
<td>Serostim*</td>
<td>NP</td>
<td>See Genotropin* prior authorization criteria</td>
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<tr>
<td>Tev-Tropin*</td>
<td>NP</td>
<td>See Genotropin* prior authorization criteria</td>
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<tr>
<td>Zomacton*</td>
<td>NP</td>
<td>See Genotropin* prior authorization criteria</td>
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<tr>
<td>Zorbive*</td>
<td>NP</td>
<td>See Genotropin* prior authorization criteria</td>
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</tbody>
</table>

**Hematopoietic Agents**

Epogen* | P | Will be approved if the patient meets the following criteria: |
|         |    | - Lab values obtained within 30 days of the date of administration; **AND** |
|         |    | - Adequate iron stores as demonstrated by serum ferritin ≥ 100 ng/mL (mcg/L) and transferrin saturation (TSAT) ≥ 20%; **AND** |
|         |    | - Hemoglobin (Hb) < 10 g/dL and/or hematocrit (Hct) < 30% (unless otherwise specified); **AND** |
|         |    | - The patient has 1 of the following diagnoses: |
|         |    |   - Anemia secondary to chemotherapy; **AND** |
|         |    |     - Patient is at least 5 years of age; **AND** |
|         |    |     - Patient is receiving concurrent myelosuppressive chemotherapy; **AND** |
|         |    |     - Upon initiation, there is at least 2 additional months of planned chemotherapy; **AND** Patient’s chemotherapy is not intended to cure their disease (i.e., palliative treatment); **OR** |
|         |    |   - Anemia secondary to zidovudine treated, HIV-infected patient; **AND** |
|         |    |     - Zidovudine dose is ≤ 4,200 mg/week; **AND** Endogenous serum erythropoietin (EPO) levels ≤ 500 mUnits/ml; **OR** |
|         |    |   - Anemia secondary to hepatitis C virus (HCV) treatment in patients receiving both ribavirin and interferon-alfa therapy; **OR** |
|         |    |   - Anemia secondary to myelodysplastic syndrome (MDS); **AND** |
|         |    |     - Treatment of lower risk disease associated with symptomatic anemia; **AND** |
|         |    |     - Endogenous serum erythropoietin (EPO) level ≤ 500 mUnits/mL; **OR** |
|         |    |   - Anemia secondary to myeloproliferative neoplasms (MPN) – Myelofibrosis; **AND** |
|         |    |     - Endogenous serum EPO ≤ 500 mUnits/mL; **OR** |
|         |    |   - Anemia secondary to multiple myeloma; **OR** |
|         |    |   - Anemia of prematurity, in combination with iron supplementation; **OR** |

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**ENDOCRINE/METABOLIC AGENTS**

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<tbody>
<tr>
<td>Hematopoietic Agents (continued)</td>
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</tbody>
</table>
| Epogen® (continued) | P | - Anemia secondary to rheumatoid arthritis; OR
- Anemia secondary to chronic kidney disease (CKD); AND
  - Patient is at least 1 month of age; AND
  - Hemoglobin (Hb) ≤ 12.9 g/dL; OR
- Reduction of allogeneic blood transfusions in elective noncardiac, nonvascular surgery; AND
  - Hb > 10 g/dL to ≤ 13 g/dL and/or Hct is 30% to 39%; AND
  - Patient is NOT willing to donate autologous blood pre-operatively; AND
- Other causes of anemia (e.g., hemolysis, bleeding, vitamin deficiency, etc.) have been ruled out; AND
- The patient does NOT have any of the following:
  - Uncontrolled hypertension, OR
  - Pure red cell aplasia (PRCA) that begins after treatment with an ESA, OR
  - Serious allergic reaction to an ESA

**Renewal Criteria**

- Last dose < 60 days ago; AND
- Lab values obtained within 30 days of the date of administration; AND
- Adequate iron stores as demonstrated by serum ferritin ≥ 100 ng/mL (mcg/L) and transferrin saturation (TSAT) ≥ 20% measured within the previous 3 months; AND
- The following criteria are met, depending on diagnosis:
  - Anemia secondary to chronic kidney disease:
    - Pediatric patients: Hb < 12 g/dL and/or Hct < 36%
    - Adults: Hb < 11 g/dL and/or Hct < 33%
  - Anemia secondary to chemotherapy treatment:
    - Hb < 10 g/dL and/or Hct < 30%; AND
    - Patient is receiving concurrent myelosuppressive chemotherapy
  - Anemia secondary to zidovudine treated, HIV-infected patients:
    - Hb < 12 g/dL and/or Hct < 36%; AND
    - Patient is receiving zidovudine administered at ≤ 4200 mg/week; AND
    - Endogenous serum EPO ≤ 500 mUnits/mL;
  - Anemia secondary to myelodysplastic syndrome (MDS):
    - Hb < 12 g/dL and/or Hct < 36%
  - Anemia secondary to myeloproliferative neoplasms:
    - Hb < 10 g/dL and/or Hct < 30%
  - Anemia secondary to Hepatitis C treatment:
    - Hb < 11 g/dL and/or Hct < 33%; AND
    - Patient must be receiving interferon AND ribavirin
  - All other indications:
    - Hb < 11 g/dL and/or Hct < 33%

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### ENDOCRINE/METABOLIC AGENTS

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<tr>
<td><strong>Hematopoietic Agents (continued)</strong></td>
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<tr>
<td>Procrit*</td>
<td>P</td>
<td>See Epogen® prior authorization criteria</td>
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<tr>
<td>Retacrit*</td>
<td>P</td>
<td>See Epogen® prior authorization criteria</td>
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<tr>
<td>Aranesp*</td>
<td>NP</td>
<td>See Epogen® prior authorization criteria</td>
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<tr>
<td><strong>Hormones: LHRH</strong></td>
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<tr>
<td>Leuprolide</td>
<td>P</td>
<td>Leuprolide will be approved for patients meeting ONE of the following criteria:</td>
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<td></td>
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<td>• Diagnosis of prostate cancer in male patient</td>
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<td></td>
<td></td>
<td>• Diagnosis of central precocious puberty in children (onset of secondary sexual development before 8 [girls] or 9 years of age [boys])</td>
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<td><strong>Hyperparathyroid Agents</strong></td>
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<tr>
<td>Sensipar*</td>
<td>P</td>
<td>Approval requires</td>
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<td></td>
<td></td>
<td>• Secondary Hyperparathyroidism due to Chronic Kidney Disease (CKD), AND patient must be on dialysis; OR</td>
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<td></td>
<td></td>
<td>• Parathyroid Carcinoma resulting in hypercalcemia; OR</td>
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<td></td>
<td></td>
<td>• Severe Hypercalcemia in patients with primary HPT who are unable to undergo parathyroidectomy.</td>
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<tr>
<td>Cinacalcet</td>
<td>NP</td>
<td>Approval requires</td>
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<tr>
<td></td>
<td></td>
<td>• Secondary Hyperparathyroidism due to Chronic Kidney Disease (CKD), AND patient must be on dialysis; OR</td>
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<tr>
<td></td>
<td></td>
<td>• Parathyroid Carcinoma resulting in hypercalcemia; OR</td>
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<tr>
<td></td>
<td></td>
<td>• Severe Hypercalcemia in patients with primary HPT who are unable to undergo parathyroidectomy.</td>
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</tr>
<tr>
<td>Doxercalciferol capsules</td>
<td>NP</td>
<td>Will be approved if the following is met:</td>
<td>0.5mcg, 2.5 mcg: 1/day; 1 mcg: 3/day</td>
<td>General PA Form</td>
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<tr>
<td></td>
<td></td>
<td>• Recipients experiencing (or with a history of) hypercalcemia and/or hyperphosphatemia with calcitriol use; AND</td>
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<td></td>
<td></td>
<td>• Trial and failure, contraindications, or intolerance to Sensipar®</td>
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<tr>
<td>Paricalcitol capsules</td>
<td>NP</td>
<td>See doxercalciferol capsules prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Rayaldee*</td>
<td>NP</td>
<td>Will be approved if ALL of the following are true:</td>
<td>2/day</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Secondary Hyperparathyroidism due to Stage 3 or Stage 4 Chronic Kidney Disease (CKD); AND</td>
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<td></td>
<td></td>
<td>• Serum total 25-hydroxyvitamin D levels less than 30 ng/mL; AND</td>
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<td></td>
<td></td>
<td>• Trial and failure of calcitriol or vitamin D</td>
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<tr>
<td>Zemplar* capsules</td>
<td>NP</td>
<td>See doxercalciferol capsules prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
</tbody>
</table>

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## ENDOCRINE/METABOLIC AGENTS

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<tbody>
<tr>
<td><strong>Insulin-Like Growth Factor-1 Hormones</strong></td>
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<tr>
<td>Increlex®</td>
<td>P</td>
<td>Will be approved for patients &lt;21 years old, who do not have closed epiphyses, with a diagnosis of:</td>
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<tr>
<td></td>
<td></td>
<td>• Growth failure due to severe primary IGF-1 deficiency defined by the following (documentation must be provided):</td>
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<td></td>
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<td>• Height standard deviation score ≤ -3</td>
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<tr>
<td></td>
<td></td>
<td>• Basal IGF-1 standard deviation score ≤ -3</td>
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<td>• Normal or elevated growth hormone; OR</td>
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<td></td>
<td>• Growth hormone gene deletion in a patient who has developed neutralizing antibodies to growth hormone (GH); AND</td>
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<td></td>
<td></td>
<td>• Secondary causes of IGF-1 deficiency have been ruled out (e.g. hypothyroidism, malnutrition, hepatic disease, GHD, chronic corticosteroid treatment)</td>
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<td></td>
<td></td>
<td><strong>Note:</strong> Will not be approved for patients with active or secondary neoplasms, secondary forms of IGF-1 deficiency, weight loss management, nor as a substitute for growth hormone.</td>
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<tr>
<td><strong>Progestins, Oral</strong></td>
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<tr>
<td>megestrol acetate suspension 40mg/mL</td>
<td>P</td>
<td>Will be approved for patients with a diagnosis of endometriosis</td>
<td>20mL/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>norethindrone acetate</td>
<td>P</td>
<td>Will be approved for patients with a diagnosis of endometriosis</td>
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<tr>
<td>Aygestin®</td>
<td>NP</td>
<td>Will be approved for patients with a diagnosis of endometriosis</td>
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<td>General PA Form</td>
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<tr>
<td>Megace® ES</td>
<td>NP</td>
<td>Will be approved for individuals meeting the following criteria:</td>
<td>5mL/day</td>
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<tr>
<td></td>
<td></td>
<td>• Inability to swallow the 10mL (400mg) or 20mL (800mg) dose of the regular-strength suspension</td>
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<tr>
<td>Megace®</td>
<td>NP</td>
<td></td>
<td>20mL/day</td>
<td></td>
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<tr>
<td>megestrol acetate suspension 625mg/5mL</td>
<td>NP</td>
<td>See Megace® ES prior authorization criteria</td>
<td>5mL/day</td>
<td></td>
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<tr>
<td><strong>Progesterone Receptor Antagonists</strong></td>
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<tr>
<td>Korlym®</td>
<td>NP</td>
<td>Will be approved for patients meeting ALL the following criteria:</td>
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<td>General PA Form</td>
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<td></td>
<td></td>
<td>• Diagnosis of Cushing’s Syndrome</td>
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<td>• Type 2 diabetes mellitus or glucose intolerance</td>
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<td></td>
<td></td>
<td>• Have failed surgical treatment OR are not candidate for surgery</td>
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<td></td>
<td></td>
<td>• Will NOT be approved for use during pregnancy</td>
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### ENDOCRINE/METABOLIC AGENTS

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<tr>
<td><strong>SERM/Estrogen Combinations</strong></td>
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</tbody>
</table>
| Duavee*            | NP  | Will be approved for patients meeting the following criteria:  
• Patient has an intact uterus with a diagnosis of moderate to severe vasomotor symptoms associated with menopause; **OR**  
• Patient has an intact uterus with a diagnosis of post-menopausal osteoporosis; **AND**  
• Patient has an allergy to preferred SERM agent(s)                                                                                                                                                                                                                                                                                                                                                                           | 1/day       | General PA Form     |
| **Somatostatic Agents**                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |             |                     |
| octreotide         | P   | Will be approved for patient who meet ONE of the following:  
• Diagnosis of acromegaly; **OR**  
• Severe diarrhea/flushing episodes associated with metastatic carcinoid tumors; **OR**  
• Profuse watery diarrhea associated with VIP-secreting tumors                                                                                                                                                                                                                                                                                                                                                                    |             |                     |
| Sandostatin*       | NP  | See prior authorization criteria for octreotide                                                                                                                                                                                                                                                                                                                                                                                                                                           |             |                     |
| Signifor*          | NP  | Will be approved for patients who meet ALL of the following criteria:  
• Diagnosis of Cushing’s Disease or Cushing’s Syndrome; **AND**  
• Patient has failed surgery (i.e., pituitary, adrenal gland, pancreas tumor removal); **OR** patient is not a candidate for surgery                                                                                                                                                                                                                                                                          | 2 ampules/day | General PA Form     |
| Xermelo*           | NP  | Will be approved for patients who meet ALL of the following criteria:  
• Patient has a carcinoid/neuroendocrine tumor and has been diagnosed with carcinoid syndrome; **AND**  
• Patient has been receiving therapy with the FDA-approved maximum (or highest tolerated) dose of a somatostatin analog therapy (e.g., octreotide I/R or LAR, lanreotide depot) for at least 3 months; **AND**  
• Patient will continue to receive somatostatin analog therapy  
• Patient has tried and received an inadequate response to antidiarrheals (e.g., loperamide); **AND**  
• Patient has at least 4 bowel movements per day                                                                                                                                                                                                                                                                                                                                                                           | 3/day       |                     |

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**GASTROINTESTINAL**

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<tr>
<td><strong>5-ASA Derivatives, Oral</strong></td>
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<tr>
<td>Apriso®</td>
<td>P</td>
<td></td>
<td>4/day</td>
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<tr>
<td>Asacol®</td>
<td>P</td>
<td></td>
<td>6/day</td>
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<tr>
<td>Delzicol®</td>
<td>P</td>
<td></td>
<td>6/day</td>
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<tr>
<td>sulfasalazine</td>
<td>P</td>
<td></td>
<td>8/day</td>
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<tr>
<td>sulfasalazine EC</td>
<td>P</td>
<td></td>
<td>8/day</td>
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<tr>
<td>Sulfazine®</td>
<td>P</td>
<td></td>
<td>8/day</td>
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<tr>
<td>Sulfazine® EC</td>
<td>P</td>
<td></td>
<td>8/day</td>
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<tr>
<td>Asacol® HD</td>
<td>NP</td>
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<td>Azulfidine®</td>
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<td>balsalazide</td>
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<td>Colazal®</td>
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<td>General PA Form</td>
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<td>Dipentum®</td>
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<td>Giazo®</td>
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<td>Lialda®</td>
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<td>Mesalamine DR</td>
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<tr>
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<tr>
<td>Pentasa®</td>
<td>NP</td>
<td></td>
<td></td>
<td>General PA Form</td>
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</table>

**Agents for Irritable Bowel Syndrome (IBS)**

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amitiza®</td>
<td>P</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>Linzess®</td>
<td>P</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Lotronex®</td>
<td>P</td>
<td>2/day</td>
<td></td>
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</tbody>
</table>

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</thead>
<tbody>
<tr>
<td><strong>Agents for Irritable Bowel Syndrome (IBS) (continued)</strong></td>
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</tbody>
</table>
| alosetron          | NP           | Will be approved for female patients age ≥18 years upon documentation of the following:  
- Prescriber enrollment in the Alosetron REMS Program. *(For more information visit: [www.AlosetronREMS.com](http://www.AlosetronREMS.com) or call 1-844-267-8675)*  
- Diagnosis of severe, diarrhea-predominant, irritable bowel syndrome (IBS)  
- Chronic IBS symptoms lasting 6 months or more  
- Ruled out anatomic or biochemical abnormalities of the GI tract  
- Allergy or intolerance to inactive ingredient in Lotronex®  | 2/day       | General PA Form                                                  |
| Viberzi®           | NP           | Will be approved for patients age ≥18 years upon documentation of ALL of the following:  
- Diagnosis of severe, diarrhea-predominant, irritable bowel syndrome (IBS)  
- Chronic IBS symptoms lasting 6 months or more  
- Ruled out anatomic or biochemical abnormalities of the GI tract  
- Patient has NO history of the following: alcohol abuse/addiction or drink more than 3 alcoholic drinks per day, pancreatitis or structural diseases of the pancreas, severe hepatic impairment (Child Pugh Class-C), severe constipation, biliary duct (gallbladder) obstruction or Sphincter of Oddi disease/dysfunction.  
- Trial and failure, intolerance or contraindication to Lotronex®  | 2/day       | General PA Form                                                  |
| **Agents for Chronic Constipation**                                             |                                                          |                                                                                                                                                                                                                                                                                                                                                          |             |                       |
| Amitiza®           | P            | Approval for Linzess® will be granted upon documentation of:  
- Diagnosis of idiopathic chronic constipation; **OR**  
- Constipation predominate irritable bowel syndrome (IBS) in patients ages 6 and older; **AND**  
- Trial and failure, contraindication or intolerance to Amitiza®  | 2/day       | General PA Form                                                  |
| Linzess®           | NP           | Note: Use of linaclotide should be avoided in patients 6–17 years of age.  
- Diagnosis of idiopathic chronic constipation; **OR**  
- Constipation predominate irritable bowel syndrome (IBS) in patients ages 6 and older; **AND**  
- Trial and failure, contraindication or intolerance to Amitiza®  | 1/day       | General PA Form                                                  |
| Movantik®          | NP           | Will be approved for patients meeting the following:  
- Diagnosis of opioid-induced constipation in chronic non-cancer pain; **AND**  
- Documentation of paid claims by TennCare for opioids for at least 150 out of 180 days; **AND**  
- Trial and failure or contraindication or intolerance to Amitiza®  | 1/day       |                       |

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### GASTROINTESTINAL

**Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.**

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<tr>
<td><strong>Agents for Chronic Constipation (continued)</strong></td>
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</tbody>
</table>
| Symproic® | NP | Will only be approved for the following:  
- Patient is diagnosed with Opioid Induced Constipation related to chronic non-cancer pain; **AND**  
- Patient is currently on opioids (discontinue if patient not on opioids); **AND**  
- Documentation of paid claims by TennCare for opioids at least 150 days within past 180 days; **AND**  
- Trial and failure, contraindication, or intolerance to Amitiza®; **AND**  
- Trial and failure, contraindication or intolerance of naloxegol [e.g., Movantik®] (as confirmed by paid claims by TennCare); **AND**  
- Patient does not have the following conditions:  
  - Known or suspected gastrointestinal obstruction; **OR**  
  - Hypersensitivity to naldemedine tosylate; **OR**  
  - Pregnancy; **OR**  
  - Severe hepatic impairment (Child-Pugh Class C)  
  **Note:** Safety and efficacy has not been established in patients < 18 years of age | 1/day | General PA Form |
| Trulance® | NP | Will be approved if the following is met:  
- Age ≥ 6 years  
- Patient has diagnosis of chronic idiopathic constipation (CIC); **AND**  
- Trial and failure of, or contraindication or intolerance to, BOTH Amitiza® and Linzess®  
  **Note:** Safety and efficacy has not been established in patients < 18 years of age; and is contraindicated in patients less than 6 years of age. | 1/day | |
| ondansetron tablets and ODT | P | May be approved for recipients meeting ONE of the following:  
- Receiving highly or moderately emetogenic chemotherapy; **OR**  
- Receiving radiation therapy; **OR**  
- Treated for post-operative nausea and vomiting (PONV)  
  **Note:** Generic ondansetron is unrestricted in patients less than 6 years old. Additionally, quantities of 10 per 30 days are unrestricted. | 10/30 days | General PA Form |
| Anzemet® | NP | May be approved for recipients meeting ONE of the following:  
- Receiving highly or moderately emetogenic chemotherapy; **OR**  
- Receiving radiation therapy; **OR**  
- Treated for post-operative nausea and vomiting (PONV)  
- Additionally, patient has tried and failed, or has contraindication or intolerance to preferred 5HT3 antagonist | 1/30 days | General PA Form |
| granisetron | NP | See Anzemet® prior authorization criteria | 2/30 days | |
| Kytril® | NP | See Anzemet® prior authorization criteria | 2/30 days | |

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### Gastrointestinal

**Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.**

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<tr>
<td><strong>Anti-Emetics: 5-HT3 Receptor Antagonists (continued)</strong></td>
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</tbody>
</table>
| ondansetron oral solution   | NP  | • See ondansetron prior authorization criteria  
  • Additionally, ondansetron solution will be approved only for patient meeting the following criteria:  
  – Dose not achievable with ODT tab  
  – Allergy or intolerance to inactive ingredient in ODT tab (i.e., dye, filler, excipient, etc)  
  Note: For patients less than 6 years old, quantities of 20mL per 30 days are unrestricted.                                                                |             |                       |
| Sancuso®                    | NP  | See Anzemet® prior authorization criteria                                                                                                                                  | 1/30 days  |                       |
| Zofran®                     | NP  | See Anzemet® prior authorization criteria                                                                                                                                  | 12/30 days | General PA Form       |
| Zofran® ODT                 | NP  | See Anzemet® prior authorization criteria                                                                                                                                  | 12/30 days |                       |
| Zofran Solution*            | NP  | • See ondansetron prior authorization criteria  
  • Additionally, ondansetron solution will be approved only for patient meeting the following criteria:  
  – Dose not achievable with ODT tab  
  – Allergy or intolerance to inactive ingredient in ODT tab (i.e., dye, filler, excipient, etc)                                                                 |             |                       |
| Zuplenz®                    | NP  | See Zofran® solution prior authorization criteria                                                                                                                            | 12/30 days |                       |
| **Anti-Emetics: Anticholinergics**                                                                                                                                          |             |                       |
| promethazine                | P   | • Prior authorization will not be required for patients 2 years of age or older.  
  • For patients less than 2 years of age, prior authorization will be approved if ALL of the following criteria are met:  
  – Prescriber documents medical necessity  
  – Prescriber is aware of contraindication and agrees to accept risk  
  Will be approved if patient meets ANY of the following criteria:  
  – Recipient has tried and failed, or is intolerant to at least one of the following agents: meclizine, promethazine, dimenhydrinate, diphenhydramine or metoclopramide  
  – Unable to take oral medications  
  – Will be in an area/situation for an extended period of time where taking short acting agents would not be feasible |             | Promethazine PA Form  |
| Transderm-Scōp™            | P   | Will be approved if recipient meets ANY of the following criteria:  
  – Recipient has tried and failed, or is intolerant to at least one of the following agents: meclizine, promethazine, dimenhydrinate, diphenhydramine or metoclopramide  
  – Unable to take oral medications  
  – Will be in an area/situation for an extended period of time where taking short acting agents would not be feasible | 4 patches/30 days | General PA Form       |
| Phenergan®                  | NP  | • Use of two preferred agents, unless patient has a contraindication or allergy, AND  
  • Clinical reason as to why patient cannot use generic equivalent; AND  
  • For patients less than 2 years of age, prior authorization will be approved if ALL of the following criteria are met:  
  – Prescriber documents medical necessity  
  – Prescriber is aware of contraindication and agrees to accept risk  
  Will be approved if recipient meets ANY of the following criteria:  
  – Recipient has tried and failed, or is intolerant to at least one of the following agents: meclizine, promethazine, dimenhydrinate, diphenhydramine or metoclopramide  
  – Unable to take oral medications  
  – Will be in an area/situation for an extended period of time where taking short acting agents would not be feasible |             | Promethazine PA Form  |
| scopolamine patches         | NP  | • See Transderm-Scōp™ prior authorization criteria                                                                                                                                                                                   | 4 patches/30 days | General PA Form       |

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## GASTROINTESTINAL

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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<tr>
<td><strong>Anti-Emetics: Delta-9-THC Derivatives</strong></td>
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<tr>
<td>Cesamet®</td>
<td>NP</td>
<td>Will only be approved for recipients who meet the following:</td>
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<td></td>
<td>• For treatment of severe nausea/vomiting associated with cancer chemotherapy:</td>
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<tr>
<td></td>
<td></td>
<td>- Recipient must have failure, intolerance, medical reason, or contraindication that prohibits taking Emend + 5HT3 receptor antagonist + corticosteroid.</td>
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<tr>
<td>dronabinol</td>
<td>NP</td>
<td>Will only be approved for recipients who meet ONE of the following:</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For treatment of severe nausea/vomiting associated with cancer chemotherapy for patients actively being treated for cancer:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Recipient must have failure, intolerance, medical reason, or contraindication that prohibits taking Emend + 5HT3 receptor antagonist + corticosteroid.</td>
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<td></td>
<td></td>
<td>• For treatment of AIDS-related wasting:</td>
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<td></td>
<td></td>
<td>- Recipient must have tried and failed, or have intolerance or contraindication to, megestrol acetate oral suspension (Megace®).</td>
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<tr>
<td>Marinol®</td>
<td>NP</td>
<td>See dronabinol prior authorization criteria</td>
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<td></td>
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<tr>
<td>Syndros®</td>
<td>NP</td>
<td>See dronabinol prior authorization criteria</td>
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<td></td>
<td></td>
<td>• Additionally, requires dosing that will not allow the use of dronabinol capsules to be opened and contents emptied on food or drink.</td>
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<tr>
<td><strong>Anti-Emetics: NK-1 Receptor Antagonists</strong></td>
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<tr>
<td>aprepitant</td>
<td></td>
<td>Will only be approved for recipients who meet ONE of the following:</td>
<td>80mg (2/ course of treatment, up to a 1-month supply); 40mg, 125mg, &amp; Tri pack (1/course of treatment, up to a 1-month supply)</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Receiving a highly emetogenic chemotherapy regimen or the combination of an anthracycline (doxorubicin or epirubicin) and cyclophosphamide; OR</td>
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<tr>
<td></td>
<td></td>
<td>• Receiving a moderately emetogenic chemotherapy regimen and has failed other previous antiemetic regimens; OR</td>
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<td></td>
<td></td>
<td>• Treatment for PONV with trial and failure or contraindication to a 5HT3-receptor antagonist; OR</td>
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<td></td>
<td>• Refractory nausea that would require hospitalization</td>
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<td><strong>Note:</strong> Will be approved for 3 days/treatment course up to 1 month’s supply. If chemotherapy is more frequent than weekly, may approve a quantity sufficient for THREE days beyond the chemotherapy duration. Chronic continuous administration is not recommended.</td>
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<tr>
<td>Akynzeo®</td>
<td>NP</td>
<td>Will be approved for patients who meet the following criteria:</td>
<td>1/course of treatment (up to 1-month supply)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Receiving a highly emetogenic chemotherapy regimen or the combination of an anthracycline (doxorubicin or epirubicin) and cyclophosphamide; AND</td>
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<tr>
<td></td>
<td></td>
<td>• Receiving a moderately emetogenic chemotherapy regimen and has failed other previous antiemetic regimens; AND</td>
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<td></td>
<td>- Trial and failure, contraindication, adverse event or drug-drug interaction to Emend®; OR</td>
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<tr>
<td></td>
<td></td>
<td>- Trial and failure, contraindication, adverse event or drug-drug interaction to Emend®</td>
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<tr>
<td>Antiemetics: NK-1 Receptor Antagonists (continued)</td>
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</tr>
<tr>
<td>Emend*</td>
<td>NP</td>
<td>See aprepitant prior authorization criteria</td>
<td>80mg (2/course of treatment, up to a 1-month supply); 40mg, 125mg, &amp; Tri pack (1/course of treatment, up to a 1-month supply)</td>
<td>General PA Form</td>
</tr>
</tbody>
</table>
| Varubi*    | NP  | Will be approved for patients who meet the following criteria:  
- Receiving a highly emetogenic chemotherapy regimen or the combination of an anthracycline (doxorubicin or epirubicin) and cyclophosphamide; **AND**  
- Trial and failure, contraindication, adverse event or drug-drug interaction to Emend*; **OR**  
- Receiving a moderately emetogenic chemotherapy regimen and has failed other previous antiemetic regimens; **AND**  
- Trial and failure, contraindication, adverse event or drug-drug interaction to Emend* | 2/course of treatment (up to 1-month supply) |                       |
| Diclegis*  | P   | Will be approved for pregnancy-induced nausea or vomiting | 4/day |                       |
| Bonjesta*  | NP  | Will be approved if the following is met:  
- Patient has a diagnosis of pregnancy-induced nausea or vomiting; **AND**  
- Patient has failed documented conservative measures (e.g., dietary changes, trigger avoidance, etc); **AND**  
- Patient has clinically valid reason as to why the preferred agent (Diclegis) cannot be used. | 2/day | General PA Form       |
| doxylamine succinate/vitamin B6 | NP | See Diclegis* prior authorization criteria | 4/day |                       |
| Cuvposa*   | NP  | Approval for Cuvposa* will be granted for patients unable to swallow tablets. **Note:** No prior authorization required for patients less than 8 years of age. | | General PA Form       |
| budesonide capsules | P | Will be approved for individuals with a diagnosis of mild to moderate Crohn’s disease involving the ileum or the ascending colon. | |                       |
| budesonide DR tablets | NP | Will be approved for individuals with a diagnosis of mild to moderate ulcerative colitis. | 1/day | General PA Form       |
| Entocort EC* | NP | Will be approved for individuals with a diagnosis of mild to moderate Crohn’s disease involving the ileum or the ascending colon. | |                       |
| Uceris* foam | NP | Will be approved for individuals with a diagnosis of mild to moderate ulcerative colitis. | 66.8g/day |                       |
| Uceris* tablet | NP | Will be approved for individuals with a diagnosis of mild to moderate ulcerative colitis. | 1/day |                       |

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### GASTROINTESTINAL

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<tr>
<td><strong>H. pylori Combo Products</strong></td>
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</tbody>
</table>
| I. P. lansoprazole/amoxiclarithromycin | P   | Will be approved if the following conditions are met:  
- Documentation of recent positive *H. pylori* test (NOTE: For recurrent infection, antibody testing is not considered sufficient testing)                                    |                                  |                     |
| *Pylera*                         | P   | Will be approved if the following conditions are met:  
- Documentation of recent positive *H. pylori* test; **AND**  
- Trial and failure, contraindication or intolerance to BOTH preferred combination agents                                                                                     | 1 box per Rx (up to 2 courses of therapy per year) | General PA Form     |
| *Omeclamox-Pak*                  | NP  | Will be approved if the following conditions are met:  
- Documentation of recent positive *H. pylori* test; **AND**  
- Trial and failure, contraindication or intolerance to BOTH preferred combination agents                                                                                     |                                  |                     |
| *Prevpac*                        | NP  | See *Omeclamox-Pak* prior authorization criteria                                                                                                                                                                                  |                                  |                     |
| Gallstone Solubilizing Agents/Bile Acid Salts | |                                                                                                                                                                                                                                |                                  |                     |
| ursodiol                         | P   |                                                                                                                                                                                                                                | 250mg (3/day); 300mg: 3/day 500mg (2/day) |                     |
| *Actigall*                       | NP  | Will be approved if the following criteria is met:  
- Patient has a diagnosis of Bile Acid Synthesis Disorders due to Single Enzyme Defects (SED); **OR** will be used as adjunctive treatment of manifestations or complications of Peroxisomal Disorders (PDs) **AND**  
- Prescribed by a hepatologist or gastroenterologist                                                                                                                  | 3/day                            | General PA Form     |
| *Cholbam*                        | NP  | Will be approved if the following criteria is met:  
- Patient has a diagnosis of primary biliary cholangitis (PBC) **AND**  
- Prescribed by a hepatologist or gastroenterologist **AND**  
- Will be taken in combination with ursodeoxycholic acid (e.g., *ursodiol*) **OR**                                                                                      | 1/day                            | General PA Form     |
| *Ocaliva*                        | NP  | Will be approved if the following criteria is met:  
- Patient has a diagnosis of primary biliary cholangitis (PBC) **AND**  
- Prescribed by a hepatologist or gastroenterologist **AND**  
- Will be taken in combination with ursodeoxycholic acid (e.g., *ursodiol*) **OR**  
- **Submitted Lab Documentation indicates the patient had an inadequate response (no reduction in ALP or total bilirubin after 1-year trial) to ursodeoxycholic acid (e.g., *ursodiol*) **OR**  
- **Patient has a contraindication or intolerance to ursodeoxycholic acid**                                                                                          |                                  |                     |
| *Urso*                           | NP  | Will be approved if the following criteria is met:  
- Patient has a diagnosis of primary biliary cholangitis (PBC) **AND**  
- Prescribed by a hepatologist or gastroenterologist **AND**  
- Will be taken in combination with ursodeoxycholic acid (e.g., *ursodiol*) **OR**  
- **Submitted Lab Documentation indicates the patient had an inadequate response (no reduction in ALP or total bilirubin after 1-year trial) to ursodeoxycholic acid (e.g., *ursodiol*) **OR**  
- **Patient has a contraindication or intolerance to ursodeoxycholic acid**                                                                                          | 3/day                            |                     |
| *Urso Forte*                     | NP  | Will be approved if the following criteria is met:  
- Patient has a diagnosis of primary biliary cholangitis (PBC) **AND**  
- Prescribed by a hepatologist or gastroenterologist **AND**  
- Will be taken in combination with ursodeoxycholic acid (e.g., *ursodiol*) **OR**  
- **Submitted Lab Documentation indicates the patient had an inadequate response (no reduction in ALP or total bilirubin after 1-year trial) to ursodeoxycholic acid (e.g., *ursodiol*) **OR**  
- **Patient has a contraindication or intolerance to ursodeoxycholic acid**                                                                                          | 3/day                            |                     |

### Anti-Diarrheal

<table>
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<tr>
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</table>
| *Fulyzaq*  | NP  | *Fulyzaq* will be approved for recipients meeting ALL of the following criteria:  
- Patient has non-infectious diarrhea of at least 1-month duration; **AND**  
- Diagnosis of HIV or AIDS; **AND**  
- Currently receiving anti-retroviral therapy                                                                                                                                                                                                 | 3/day       | General PA Form               |

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<td><strong>Motility Agents</strong></td>
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<tr>
<td>metoclopramide</td>
<td>P</td>
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<td></td>
</tr>
<tr>
<td>metoclopramide ODT</td>
<td>NP</td>
<td>Will be approved for patients who are:</td>
<td>12-week duration limit</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unable to swallow, <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Unable to absorb medications through the GI tract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metozolv™ ODT</td>
<td>NP</td>
<td>See metoclopramide ODT prior authorization criteria</td>
<td></td>
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<tr>
<td>Reglan® ODT</td>
<td>NP</td>
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<tr>
<td><strong>Mucosal Protectants</strong></td>
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<td></td>
</tr>
<tr>
<td>sucralfate suspension</td>
<td>NP</td>
<td>Approval for sucralfate suspension will be granted if patient:</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Has a trial and failure or intolerance to sucralfate tablets, <strong>OR</strong></td>
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<td></td>
<td></td>
<td>• Has documented difficulty swallowing/dysphagia</td>
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<td>Note: Prior authorization is not required for patients 12 years of age and under.</td>
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<tr>
<td><strong>Proton Pump Inhibitors</strong></td>
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<tr>
<td>pantoprazole</td>
<td>P</td>
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<tr>
<td>Protonix® suspension</td>
<td>P</td>
<td></td>
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<tr>
<td>omeprazole</td>
<td>P</td>
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<tr>
<td>Aciphex®</td>
<td>NP</td>
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<tr>
<td>Aciphex® sprinkles</td>
<td>NP</td>
<td>Patient must be unable to swallow whole tablets; <strong>AND</strong></td>
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<td>PPi PA Form</td>
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<td></td>
<td></td>
<td>• Trial, failure, contraindication or intolerance to Protonix® suspension</td>
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<tr>
<td>Dexilant®</td>
<td>NP</td>
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<tr>
<td>esomeprazole</td>
<td>NP</td>
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<tr>
<td>lansoprazole</td>
<td>NP</td>
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<tr>
<td>lansoprazole ODT</td>
<td>NP</td>
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<tr>
<td>Nexium®</td>
<td>NP</td>
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<tr>
<td>omeprazole/sodium bicarbonate</td>
<td>NP</td>
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<tr>
<td>Prevacid®</td>
<td>NP</td>
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<tr>
<td>Prevacid Solutab®</td>
<td>NP</td>
<td>Patient must be unable to swallow; <strong>OR</strong></td>
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<td></td>
<td></td>
<td>• Patient must be unable to absorb medications through the GI tract; <strong>OR</strong></td>
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<td></td>
<td></td>
<td>• Patient must be unable to swallow solid oral dosage forms; <strong>AND</strong> trial, failure, contraindication or intolerance to Prevacid® suspension</td>
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</tbody>
</table>

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## Gastrointestinal

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prilosec®</td>
<td>NP</td>
<td></td>
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<tr>
<td>Protonix®</td>
<td>NP</td>
<td></td>
<td></td>
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<tr>
<td>rabeprazole</td>
<td>NP</td>
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<tr>
<td>Zegerid®</td>
<td></td>
<td><strong>Twice-daily dosing</strong> for PPIs will be approved for any of the following:</td>
<td>1/day (see note below regarding approvals for twice daily dosing)</td>
<td>PPI PA Form</td>
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<tr>
<td></td>
<td></td>
<td>- Treatment of H. Pylori (Duration up to 1 month); <strong>OR</strong></td>
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<td></td>
<td></td>
<td>- Treatment of GI Bleed/Hemorrhagic Gastritis (Duration up to 1 year); <strong>OR</strong></td>
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<td></td>
<td>- Patient has a diagnosis of Barrett’s Esophagus with documentation of uncontrolled reflux symptoms or esophagitis (following a trial of once daily PPI therapy); <strong>OR</strong></td>
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<td></td>
<td>- Uncontrolled symptoms following a 30-day trial of once daily PPI therapy (Duration up to 6 months); renewals will require member to attempt step down to once daily PPI therapy, if patient fails step down to once daily dosing will not be asked to step down again</td>
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</table>

### Saliva Stimulating Agents

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>pilocarpine</td>
<td>P</td>
<td>Approval will be granted upon documentation of diagnosis of Sjögren’s syndrome OR radiation-induced xerostomia.</td>
<td>3/day</td>
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<tr>
<td>cevimeline</td>
<td>NP</td>
<td>See pilocarpine prior authorization criteria</td>
<td>3/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Evocac®</td>
<td>NP</td>
<td>See pilocarpine prior authorization criteria</td>
<td>3/day</td>
<td></td>
</tr>
<tr>
<td>Salagen®</td>
<td>NP</td>
<td>See pilocarpine prior authorization criteria</td>
<td>3/day</td>
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</tr>
</tbody>
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<tr>
<td><strong>Anti-inflammatory: PDE-4 Inhibitors</strong></td>
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</tbody>
</table>
| Otezla* | NP | Will be approved for patients who meet the following criteria:  
• Diagnosis of active psoriatic arthritis  
  – Failed an adequate trial of methotrexate (unless contraindicated); **AND**  
  – Contraindication, drug-drug interaction, or adverse reaction to ALL preferred immunomodulator agents with same indication (e.g., Enbrel®, Humira®, Cosentyx®).  
• Diagnosis of moderate to severe plaque psoriasis  
  – Will be approved for patients with treatment failure with topical treatments from at least 2 of the following: corticosteroids, calcipotriene, coal tar, tazarotene (Note: treatment failure with 2 topical corticosteroids does NOT meet the requirement) **AND** at least ONE oral treatment (Soriatane®, methotrexate, cyclosporine) unless contraindicated; **AND**  
  – Contraindication, drug-drug interaction, or adverse reaction to ALL preferred immunomodulator agents with same indication (e.g., Enbrel®, Humira®, Cosentyx®). | 30mg: 2/day Starter Pack: 1/Rx | General PA Form |
| **Anti-inflammatory: Systemic IL-4 Antagonists** |
| Dupixent* | NP | Will be approved for patients meeting following criteria:  
**Diagnosis of Atopic Dermatitis**  
**Initiation:**  
• Be ≥ 12 years of age; **AND**  
• Have a diagnosis of moderate to severe atopic dermatitis with ≥ 1 of the following:  
  – Involvement of at least 10% of body surface area (BSA); OR  
  – Scoring Atopic Dermatitis (SCORAD) score of 20 or more; OR  
  – Investigator’s Global Assessment (IGA) with a score ≥ 3; OR  
  – Eczema Area and Severity Index (EASI) score of ≥ 16; OR  
  – Incapacitation due to AD lesion location (e.g., head and neck, palms, soles, or genitalia); **AND**  
• Have a prior trial and failure (documented by claims) or contraindication to 1 topical corticosteroids of medium to high potency (e.g., mometasone, fluocinolone) AND 1 topical calcineurin inhibitor; **AND**  
• Not have responded adequately (or have contraindication) to a 3-month minimum trial of at least 1 immunosuppressive systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.); **AND**  
• Not have responded adequately (or is not a candidate) to a 3-month minimum trial of phototherapy (e.g., psoralens with UVA light [PUVA], UVB, etc) provided patient has access to photo treatment within range of TennCare provided transportation area; **AND**  
• Is not pregnant; **AND**  
• Patient will not receive live vaccines during treatment  
**Renewal Criteria:**  
Patient must:  
• Continue to meet above criteria; **AND**  
• Documented response compared to baseline as measured by measures used to qualify moderate to severe AD at baseline (e.g., pruritus, BSA involvement, EASI, IGA, SCORAD). | 2 syringes/28 days | General PA Form |

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### IMMUNOLOGICS

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</table>
| **Dupixent**<sup>™</sup> (continued) | NP  | Renewal Criteria (continued): Diagnosis of Eosinophilic or Corticosteroid-Dependent Asthma:  
- Patient age >= 12 years; **AND**  
- Prior Authorization must be obtained by either a pulmonologist or an allergy/asthma specialist; **AND**  
- Must have diagnosis of step 5 or higher (moderate to severe persistent) asthma; **AND**  
- Inadequately controlled asthma despite treatment with high dose inhaled or oral corticosteroid daily for at least 3 consecutive months; **AND**  
- A long-acting beta agonist (unless there is a documented intolerance or contraindication) daily for at least 3 consecutive months; **AND**  
- Documentation of at least 2 or more asthma exacerbations (as evidenced by an asthma related ER visit/Hospital admission or a course of oral systemic corticosteroids) in the last 6 months; **AND**  
- Patient is not pregnant; **AND**  
- Patient will not receive live vaccines during treatment; **AND**  
- No current, routine use of tobacco related products. Length of Authorization: 6 months; subsequent renewals will be granted upon verification of marked clinical improvement demonstrated by a reduction in, or nadir of, asthma related exacerbations. | 2 syringes/28 days | General PA Form |
| **Cosentyx**<sup>™</sup> | P   | Will be approved for patients who meet the following criteria:  
- Diagnosis of chronic, moderate to severe Plaque Psoriasis; **AND**  
  - Treatment failure with topical treatments from at least 2 of the following: corticosteroids, calcipotriene, coal tar, tazarotene (Note: treatment failure with 2 topical corticosteroids does NOT meet the requirement) **AND** at least one oral treatment (Soriatane®, methotrexate, cyclosporine), unless contraindicated. **Length of authorization**: Initial PA of 6 months, and yearly thereafter if medication is well tolerated. For continuation of therapy after the initial PA, a 50% reduction of total Psoriasis Area Severity Index (PASI) score must be achieved  
- Diagnosis of Ankylosing Spondylitis; **AND**  
  - Failed an adequate trial of TWO NSAIDs (unless contraindicated)  
- Diagnosis of Psoriatic Arthritis: Failed an adequate trial of methotrexate (unless contraindicated) | 300 mg dose: 2 pens/28 days; 150 mg dose: 1 pen/28 days | General PA Form |

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### Immunomodulators (continued)

<table>
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<tr>
<th>Medication</th>
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</thead>
</table>
| **Enbrel** | P   | • Diagnosis of Ankylosing Spondylitis:  
  – Will be approved for patients who have failed an adequate trial of TWO NSAIDs (unless contraindicated).  
  • Diagnosis of Juvenile Rheumatoid Arthritis (JRA) or Juvenile Idiopathic Arthritis:  
  – Will be approved for patients who have tried and failed (or have an intolerance or contraindication to) methotrexate.  
  • Diagnosis of chronic, moderate to severe Plaque Psoriasis:  
  – Treatment failure with topical treatments from at least 2 of the following: corticosteroids, calcipotriene, coal tar, tazarotene (Note: treatment failure with 2 topical corticosteroids does NOT meet the requirement) **AND** at least one oral treatment (Soriatane®, methotrexate, cyclosporine), unless contraindicated.  
  Length of authorization: Initial PA of 6 months, and yearly thereafter if medication is well tolerated. For continuation of therapy after the initial PA, a 50% reduction of total Psoriasis Area Severity Index (PASI) score must be achieved.  
  Diagnosis of Psoriatic Arthritis:  
  – Will be approved for patients who have failed an adequate trial of methotrexate (unless contraindicated).  
  • Diagnosis of Rheumatoid Arthritis:  
  – Will be approved for patients that have failed or been intolerant to at least methotrexate (unless there is a documented absolute contraindication such as alcohol abuse, cirrhosis, chronic liver disease) **AND** one other DMARD. For recipients who have a contraindication to methotrexate, only one DMARD must be tried and failed. | 25mg: 8 doses per 28 days; 50mg: 4 doses per 28 days | General PA Form |
| **Enbrel Mini Cartridge** | P   | See Enbrel prior authorization criteria | 50mg: 4 doses per 28 days | |
| **Humira** | P   | • Diagnosis of Ankylosing Spondylitis, Juvenile Rheumatoid Arthritis (JRA), Juvenile Idiopathic Arthritis, Plaque Psoriasis, Psoriatic Arthritis, or Rheumatoid Arthritis:  
  – See Enbrel prior authorization criteria  
  • Diagnosis of Crohn’s Disease or Ulcerative Colitis:  
  – Tried and failed a corticosteroid **OR** an immunosuppressive agent.  
  • Diagnosis of moderate to severe Hidradenitis Suppurativa (HS)  
  • Diagnosis of non-infectious intermediate, posterior or panuveitis:  
  • Diagnosis must be by or in consultation with an ophthalmologist | 2 syringes/28 days; Psoriasis Starter Pack: 1 kit/28 days; Crohn’s Starter Pack: 1 kit/28 days | |

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### IMMUNOLOGICS

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<tr>
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<tbody>
<tr>
<td>Actemra® and Actemra ACTPen®</td>
<td>NP</td>
<td><strong>Immunomodulators (continued)</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of Rheumatoid Arthritis:</td>
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<tr>
<td></td>
<td></td>
<td>– See Enbrel® prior authorization criteria; <strong>AND</strong></td>
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<td></td>
<td>– Requires trial and failure (or contraindication or intolerance to) to Enbrel® <strong>AND</strong> Humira prior to receiving approval.</td>
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<td>• Diagnosis of active polyarticular or active systemic Juvenile Idiopathic Arthritis:</td>
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<td>– Will be approved for patients who have tried and failed (or have an intolerance or contraindication to) methotrexate; <strong>AND</strong></td>
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<td></td>
<td>– Requires trial and failure (or contraindication or intolerance to) to Enbrel® <strong>AND</strong> Humira prior to receiving approval.</td>
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<td>• Diagnosis of Giant Cell Arteritis:</td>
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<td>– Requires trial and failure of high-dose glucocorticoid for a minimum 2-week duration, OR occurrence of GCA relapse while patient on prednisone doses greater than 20 mg/day, OR member has contraindication or intolerance to corticosteroids</td>
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<tr>
<td>Cimzia®</td>
<td>NP</td>
<td><strong>Immunomodulators (continued)</strong></td>
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<td></td>
<td>• Diagnosis of Ankylosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis:</td>
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<td></td>
<td></td>
<td>– See Enbrel® prior authorization criteria; <strong>AND</strong></td>
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<td></td>
<td>– Requires trial and failure (or contraindication or intolerance to) TWO preferred immunomodulators with same indication prior to receiving approval.</td>
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<td>• Diagnosis of Crohn’s Disease:</td>
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<td></td>
<td>– Tried and failed a corticosteroid OR an immunosuppressive agent; <strong>AND</strong></td>
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<td></td>
<td>– Requires trial and failure (or contraindication or intolerance to) to Humira® prior to receiving approval.</td>
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<td>• Diagnosis of Plaque Psoriasis:</td>
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<td></td>
<td>– See Enbrel® prior authorization criteria for Plaque Psoriasis; <strong>AND</strong></td>
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<td></td>
<td>– Requires trial and failure (or contraindication or intolerance to) TWO preferred immunomodulators with same indication prior to receiving approval.</td>
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<td><strong>Length of Authorization:</strong> Initial PA of 6 months and yearly thereafter if medication is well tolerated. For continuation of therapy after the initial PA, a 50% reduction of total Psoriasis Area Severity Index (PASI) score must be achieved.</td>
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<td>• Diagnosis of active non-radiographic axial spondyloarthritis:</td>
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<td>– Will be approved for patients who have failed an adequate trial of TWO NSAIDs (unless contraindicated).</td>
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</thead>
</table>
| **Kevzara® Pen and syringes NP** |     | Will be approved for patients meeting ALL of the following criteria:  
  • Diagnosis of Rheumatoid Arthritis (Initial Approval 6 months):  
    - Patient must have failed or been intolerant to at least methotrexate (unless there is a documented absolute contraindication such as alcohol abuse, cirrhosis, chronic liver disease) AND one other DMARD. For recipients who have a contraindication to methotrexate, only one DMARD must be tried and failed; **AND**  
    - Requires trial and failure (or contraindication or intolerance to) to at least TWO preferred immunomodulators with the same indication prior to receiving approval; **AND**  
    - Patient has been evaluated and screened for the presence of latent TB infection prior to initiating treatment; **AND**  
    - Patient will not receive live vaccines during therapy or for 30 days prior to initiation of therapy  
  **Kevzara will NOT be approved if patient meets ANY of the following:**  
  • Active infection, including clinically important localized infections  
  • Untreated latent tuberculosis (TB)  
  • Absolute neutrophil count (ANC) < 2,000/mm3  
  • Platelet count < 150,000/mm3  
  • AST or ALT > 1.5 times the upper limit of normal (ULN)  
  • Concurrent use of a TNFα inhibitor or other biologic DMARD  
  **Renewal Criteria (6 months):**  
  Coverage can be renewed based upon the following criteria:  
  • Patient continues to meet initial approval criteria; **AND**  
  • Absence of unacceptable toxicity from the drug (defined as: serious infection, severe hypersensitivity reaction, gastrointestinal perforation, neutropenia, thrombocytopenia, hepatotoxicity, etc.); **AND**  
  • Ongoing monitoring for TB; **AND**  
  • Disease response as indicated by improvement in signs compared to baseline (e.g., decrease in number of tender and swollen joint counts)  
  | 2 pens or syringes/30 days | *General PA Form* |
| **Kineret® NP** |     |   
  • Diagnosis of Rheumatoid Arthritis:  
    - See Enbrel® prior authorization criteria; **AND**  
    - Requires trial and failure (or contraindication or intolerance to) Enbrel® AND Humira® prior to receiving approval.  
  • Diagnosis of Neonatal-Onset Multisystem Inflammatory Disease (NOMID):  
    - Requires trial or failure (or contraindication or intolerance to) both Arcalyst® AND Ilaris®  
  | 0.67 mL (1 syringe)/day |   |

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<tr>
<td><strong>Immunomodulators (continued)</strong></td>
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</tbody>
</table>
| Orencia® | NP | • Diagnosis of Rheumatoid Arthritis:  
  – See Enbrel® prior authorization criteria; AND  
  – Requires trial and failure (or contraindication or intolerance to) Enbrel® AND Humira® prior to receiving approval.  
• Diagnosis of Polyarticular Juvenile Idiopathic Arthritis  
  – Will be approved for patients who have tried and failed (or have an intolerance or contraindication to) methotrexate monotherapy; AND  
  – Requires trial and failure (or contraindication or intolerance to) Enbrel® AND Humira® prior to receiving approval  
• Diagnosis of Psoriatic Arthritis:  
  – Will be approved for patients who have failed an adequate trial of methotrexate (unless contraindicated); AND  
  – Requires trial and failure (or contraindication or intolerance to) to at least TWO preferred immunomodulators with the same indication prior to receiving approval | 4 mL/28 days | |
| Siliq® | NP | Will be approved for patients meeting ALL of the following criteria:  
• Patient has a diagnosis of moderate to severe plaque psoriasis; AND  
• Patient has failed an adequate trial of at least TWO topical treatments (corticosteroids, calcipotriene, coal tar, tazarotene); AND  
• Patient has tried/failed at least ONE oral treatment (Soriatane®, methotrexate, cyclosporine) unless contraindicated; AND  
• Patient has a contraindication, drug-drug interaction, or adverse reaction to ALL preferred immunomodulator agents with same indication (e.g., Enbrel®, Humira®); AND  
• Patient has been evaluated and screened for the presence of latent tuberculosis (TB) infection prior to initiating treatment; AND  
  – Patient will not receive live vaccines during therapy; AND  
  – Patient does not have a history of Crohn’s disease; AND  
  – Prescriber and patient have met the requirements of the Siliq REMS program  
• **Length of authorization:** Initial PA of 4 months, and yearly thereafter if medication is well tolerated. For continuation of therapy after the initial PA, a 50% reduction of total Psoriasis Area Severity Index (PASI) score must be achieved. | 2 syringes/28 days | General PA Form |
| Simponi® | NP | • Diagnosis of Ankylosing Spondylitis, Psoriatic Arthritis, or Rheumatoid Arthritis:  
  – See Enbrel® prior authorization criteria; AND  
  – Requires trial and failure (or contraindication or intolerance to) TWO preferred immunomodulators with same indication prior to receiving approval.  
• Diagnosis of Ulcerative Colitis:  
  – See Humira® prior authorization criteria; AND  
  – Recipients will have to try and fail (or have an intolerance or contraindication to) Humira® prior to receiving approval. | 0.5 mL/28 days | |

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<th>PA Form</th>
</tr>
</thead>
</table>
| **Stelara**      | NP  | - Diagnosis of Plaque Psoriasis:  
  - See Enbrel® prior authorization criteria for Plaque Psoriasis; **AND**  
  - Requires trial and failure (or contraindication or intolerance to) TWO preferred immunomodulators with same indication prior to receiving approval.  
- Diagnosis of Psoriatic Arthritis:  
  - See Enbrel® prior authorization criteria for Psoriatic Arthritis; **AND**  
  - Requires trial and failure (or contraindication or intolerance to) TWO preferred immunomodulators with the same indication.  
- Diagnosis of Crohn’s disease:  
  - Tried and failed a corticosteroid **OR** an immunosuppressive agent; **AND**  
  - Requires trial and failure (or contraindication or intolerance to) to Humira® prior to receiving approval. | 6 mL/56 days (applies to syringes only) | **General PA Form** |
| **Taltz**        | NP  | - Diagnosis of chronic, moderate to severe Plaque Psoriasis; **AND**  
  - Treatment failure with at least TWO topical treatments (corticosteroids, calcipotriene, coal tar, tazarotene) and at least ONE oral treatment (Soriatane®, methotrexate, cyclosporine), unless contraindicated; **AND**  
  - Requires trial and failure (or contraindication or intolerance to) TWO preferred immunomodulators with same indication prior to receiving approval.  
**Length of Authorization:** Initial PA of 6 months, and yearly thereafter if medication is well tolerated. For continuation of therapy after the initial PA, a 50% reduction of total Psoriasis Area Severity Index (PASI) score must be achieved.  
- Diagnosis of Psoriatic Arthritis:  
  - Will be approved for patients who have failed an adequate trial of methotrexate (unless contraindicated); **AND**  
  - Requires trial and failure (or contraindication or intolerance to) TWO preferred immunomodulators with the same indication.  
- Diagnosis of active Ankylosing Spondylitis:  
  - Will be approved for patients who have failed an adequate trial of TWO NSAIDs (unless contraindicated); **AND**  
  - Requires trial and failure (or contraindication or intolerance to) TWO preferred immunomodulators with same indication prior to receiving approval. | 4 mL/28 days | **General PA Form** |
| **Tremfya**      | NP  |  
  - See Tremfya® pre-filled syringe prior authorization criteria  
  - Additionally, provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the Tremfya prefilled syringe | 1/56 days | **General PA Form** |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### IMMUNOLOGICS

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
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</thead>
<tbody>
<tr>
<td><strong>Immunomodulators (continued)</strong></td>
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</tbody>
</table>
| Tremfya® pre-filled syringe NP | • Diagnosis of Plaque Psoriasis (Initial Approval: 6 months)  
  – Age 18 years or older; **AND**  
  – Patient has been evaluated for the presence of latent TB infection prior to initiating treatment; **AND**  
  – Patient does not have a clinically important active infection; **AND**  
  – Patient will not receive live vaccines during therapy or for 30 days prior to initiation of therapy; **AND**  
  – Patient has moderate-to-severe plaque psoriasis for at least 6 months with at least 1 of the following:  
  – Involvement of at least 10% of body surface area (BSA); **OR**  
  – Psoriasis Area and Severity Index (PASI) score of 12 or greater; **OR**  
  – Incapacitation due to plaque location (e.g., head and neck, palms, soles, or genitalia); **AND**  
  – Patient did not respond adequately (or is not a candidate) to a 3-month minimum trial of topical agents (e.g., anthralin, coal tar preparations, corticosteroids, emollients, immunosuppressives, keratolytics, retinoic acid derivatives, and/or vitamin D analogues); **AND**  
  – Patient did not respond adequately (or is not a candidate) to a 3-month minimum trial of at least 1 systemic agent (e.g., immunosuppressives, retinoic acid derivatives, and/or methotrexate); **AND**  
  – Patient did not respond adequately (or is not a candidate) to a 3-month minimum trial of phototherapy (e.g., Psoralens with UVA light [PUVA] or UVB with coal tar or dithranol); **AND**  
  – Patient has a contraindication, drug-drug interaction, or adverse reaction to ALL preferred immunomodulator agents with the same indication (e.g., Enbrel, Humira) | 1/56 days | General PA Form |

Initial Prior Authorization duration: 6 months

**Renewal Criteria (6 months):**

Coverage may be renewed based upon the following criteria:

- Patient continues to meet criteria above; **AND**
- Absence of unacceptable toxicity from the drug (examples of unacceptable toxicity include clinically important infections, severe injection site reactions, etc.); **AND**
- Ongoing monitoring for TB

For Plaque Psoriasis
- Disease response as indicated by improvement in signs and symptoms compared to baseline such as redness, thickness, scaliness, and/or the amount of surface area involvement.

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### IMMUNOLOGICS

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<tbody>
<tr>
<td><strong>Immunomodulators, Topical</strong></td>
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</tr>
<tr>
<td>Elidel®</td>
<td>P</td>
<td>• Patient must have a diagnosis of atopic dermatitis.</td>
<td>1 package/Rx</td>
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<tr>
<td></td>
<td></td>
<td>• Patient must have history of a therapeutic failure on a corticosteroid, but requirement is waived if treatment is for face or groin.</td>
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</tr>
<tr>
<td>pimecrolimus</td>
<td>NP</td>
<td>See Elidel® prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protopic®</td>
<td>NP</td>
<td>See Elidel® prior authorization criteria</td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>tacrolimus ointment</td>
<td>NP</td>
<td>See Protopic® prior authorization criteria</td>
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</table>

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>Immunosuppressants</strong></td>
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<tr>
<td>Astagraf XL®</td>
<td>NP</td>
<td>Will be approved if the following criteria is met:</td>
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<tr>
<td></td>
<td></td>
<td>• Allergy to an agent contained within the preferred medications; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Contraindication to or drug-to-drug interaction with agent contained in a preferred medication; <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>• History of unacceptable/toxic side effects to an agent contained in the preferred medications <strong>AND</strong> If there has been a therapeutic failure of at least one preferred medication(s) within the same class</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Azasan®</td>
<td>NP</td>
<td>Non-Preferred agents will be approved if the following criteria is met:</td>
<td>3/day</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• All transplant recipients will be allowed a prior authorization for any drug.</td>
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<td><strong>Note</strong>: The PA requirement may be overridden at POS via an ICD-9 code override.</td>
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<tr>
<td></td>
<td></td>
<td>• New recipients requiring immunosuppressants for autoimmune diseases (i.e., rheumatoid arthritis, plaque psoriasis) will be required to have tried and failed at least one preferred medication(s) within the same class.</td>
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</tr>
<tr>
<td>CellCept®</td>
<td>NP</td>
<td>See Azasan® prior authorization criteria</td>
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<td></td>
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<tr>
<td>Envarsus® XR</td>
<td>NP</td>
<td>See Astagraf XL® prior authorization criteria</td>
<td></td>
<td></td>
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<tr>
<td>Hecoria®</td>
<td>NP</td>
<td>See Azasan® prior authorization criteria</td>
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<td></td>
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<tr>
<td>Imuran®</td>
<td>NP</td>
<td>See Azasan® prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mycophenolic acid</td>
<td>NP</td>
<td>See Azasan® prior authorization criteria</td>
<td></td>
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<tr>
<td>Myfortic®</td>
<td>NP</td>
<td>See Azasan® prior authorization criteria</td>
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<tr>
<td>Neoral®</td>
<td>NP</td>
<td>See Azasan® prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prograf® capsules</td>
<td>NP</td>
<td>See Azasan® prior authorization criteria</td>
<td></td>
<td></td>
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<tr>
<td>Prograf® granules for suspension</td>
<td>NP</td>
<td>See Azasan® prior authorization criteria</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Additionally, patient must be unable to swallow tablets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapamune®</td>
<td>NP</td>
<td>See Azasan® prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sandimmune®</td>
<td>NP</td>
<td>See Azasan® prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sirolimus</td>
<td>NP</td>
<td>See Azasan® prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zortress®</td>
<td>NP</td>
<td>See Azasan® prior authorization criteria</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### IMMUNOLOGICS

**Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.**

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<tr>
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<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multiple Sclerosis Agents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avonex&lt;sup&gt;a&lt;/sup&gt;</td>
<td>P</td>
<td></td>
<td>4/28 days</td>
</tr>
<tr>
<td>Avonex&lt;sup&gt;a&lt;/sup&gt; Admin Pack</td>
<td>P</td>
<td></td>
<td>4/28 days</td>
</tr>
<tr>
<td>Betaseron&lt;sup&gt;b&lt;/sup&gt;</td>
<td>P</td>
<td></td>
<td>14/28 days</td>
</tr>
<tr>
<td>Copaxone&lt;sup&gt;c&lt;/sup&gt; 20 mg/mL</td>
<td>P</td>
<td></td>
<td>1 mL/day</td>
</tr>
<tr>
<td>Rebif&lt;sup&gt;d&lt;/sup&gt;</td>
<td>P</td>
<td></td>
<td>6 mL/28 days</td>
</tr>
<tr>
<td>Copaxone&lt;sup&gt;c&lt;/sup&gt; 40 mg/mL</td>
<td>NP</td>
<td>See glatiramer 40 mg/mL prior authorization criteria</td>
<td>12 mL/30 days</td>
</tr>
<tr>
<td>Extavia&lt;sup&gt;e&lt;/sup&gt;</td>
<td>NP</td>
<td></td>
<td>15/30 days</td>
</tr>
<tr>
<td>glatiramer 20 mg/mL</td>
<td>NP</td>
<td>Will be approved if recipient meets ALL of the following:</td>
<td>1/30 days</td>
</tr>
<tr>
<td>glatiramer 40 mg/mL</td>
<td>NP</td>
<td>Will be approved if recipient meets ALL of the following:</td>
<td>12 mL/30 days</td>
</tr>
<tr>
<td>Glatopa&lt;sup&gt;f&lt;/sup&gt;</td>
<td>NP</td>
<td>Will be approved for patients who meet the following criteria:</td>
<td>1/30 days</td>
</tr>
<tr>
<td>Plegridy&lt;sup&gt;g&lt;/sup&gt;</td>
<td>NP</td>
<td>Will be approved for patients who meet the following criteria:</td>
<td>2 pens/28 days</td>
</tr>
<tr>
<td>Zinbryta&lt;sup&gt;h&lt;/sup&gt;</td>
<td>NP</td>
<td>Will be approved for patients who meet the following criteria:</td>
<td>1/month</td>
</tr>
</tbody>
</table>

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**IMMUNOLOGICS**

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</tr>
</thead>
<tbody>
<tr>
<td>dalfampridine ER</td>
<td>P</td>
<td></td>
<td>2/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Ampyra*</td>
<td>NP</td>
<td></td>
<td>2/day</td>
<td>Form</td>
</tr>
</tbody>
</table>

**MS Agents: Potassium Channel Blockers**

<table>
<thead>
<tr>
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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>dalfampridine ER</td>
<td>P</td>
<td>Will be approved for recipients with a diagnosis of relapsing, remitting Multiple Sclerosis (RRMS) who meet ONE of the following criteria:</td>
<td>2/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Ampyra*</td>
<td>NP</td>
<td></td>
<td>2/day</td>
<td>Form</td>
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</tbody>
</table>

**MS Agents: Oral Disease Modifying Agents**

<table>
<thead>
<tr>
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<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aubagio*</td>
<td>P</td>
<td>Will be approved for recipients with a diagnosis of relapsing, remitting Multiple Sclerosis (RRMS) who meet ONE of the following criteria:</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Gilenya*</td>
<td>P</td>
<td>See Aubagio* prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tecfidera*</td>
<td>NP</td>
<td>Will be approved for recipients with a diagnosis of relapsing, remitting Multiple Sclerosis (RRMS) who meet ONE of the following criteria AND have tried or failed or have a contraindication or intolerance to Gilenya* AND Aubagio*:</td>
<td>2/day</td>
<td></td>
</tr>
</tbody>
</table>

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### MISCELLANEOUS

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<tbody>
<tr>
<td><strong>Gaucher’s Disease Agents</strong></td>
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<tr>
<td>Cerdelga™</td>
<td>NP</td>
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<td>2/day</td>
<td>General PA Form</td>
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</table>

#### Hereditary Angioedema (HAE) Agents

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Firazyr™</td>
<td>P</td>
<td>Will be approved for recipients who meet the following criteria:</td>
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<tr>
<td></td>
<td></td>
<td>• Diagnosis of Hereditary Angioedema (HAE)</td>
<td></td>
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<tr>
<td>Kalbitor™</td>
<td>P</td>
<td>Will be approved for recipients who meet the following criteria:</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Hereditary Angioedema (HAE)</td>
<td></td>
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</tr>
<tr>
<td>Takhzyro™</td>
<td>NP</td>
<td>• Must be prescribed by, or in consultation with, a specialist in: allergy, immunology, hematology, pulmonology, or medical genetics; <strong>AND</strong></td>
<td>2 injections (4mL)/28 days</td>
<td>General PA Form</td>
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<tr>
<td></td>
<td></td>
<td>• Patient must be ≥12 years of age; <strong>AND</strong></td>
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<td></td>
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<td>• Patient has clinical presentations consistent with 1 of the following HAE subtypes:</td>
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<tr>
<td></td>
<td></td>
<td>- Type I:</td>
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<tr>
<td></td>
<td></td>
<td>• Low C1 inhibitor (C1-INH) antigenic level (C1-INH antigenic level below the lower limit of normal as defined by the laboratory performing the test); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Patient has a family history of HAE; <strong>OR</strong></td>
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<td>• Patient has a normal C1q level; <strong>OR</strong></td>
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<td>- Type II:</td>
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<tr>
<td></td>
<td></td>
<td>• Normal to elevated C1-INH antigenic level; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test); <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Patient has a history of 1 of the following criteria for long-term HAE prophylaxis:</td>
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<tr>
<td></td>
<td></td>
<td>- History of 2 or more severe HAE attacks per month (e.g., airway swelling, debilitating cutaneous or gastrointestinal episodes); <strong>OR</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Patient is disabled more than 5 days per month by HAE; <strong>OR</strong></td>
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<td></td>
<td></td>
<td>- History of recurrent laryngeal attacks caused by HAE; <strong>AND</strong></td>
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<td></td>
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<td>• Treatment of patient with “on-demand” therapy (e.g., Kalbitor, Firazyr, Ruconest, or Berinert) did not provide satisfactory control or access to “on-demand therapy” is limited; <strong>AND</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Patient has tried and failed, is intolerant to, or has a contraindication to attenuated (17 alpha-alkylated) androgens (e.g., danazol) for HAE prophylaxis; <strong>AND</strong></td>
<td></td>
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</tbody>
</table>

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Effective Date: December 2, 2019
### MISCELLANEOUS

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</table>
| Hereditary Angioedema (HAE) Agents (continued) | NP  |  - Takhzuro will not be used in combination with C1 inhibitor prophylaxis (e.g., Cinryze or Haegarda); AND  
  - Patient is avoiding the following possible triggers for HAE attacks:  
    - Helicobacter pylori infections (confirmed by lab test); AND  
    - Estrogen-containing oral contraceptive agents OR hormone replacement therapy; AND  
    - Antihypertensive agents containing angiotensin-converting enzyme (ACE) inhibitors.  
**Renewal Criteria**  
- Patient continues to meet initial criteria; AND  
- Improvement in severity and duration of attacks have been achieved and sustained; AND  
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: severe hypersensitivity reactions, thromboembolic events, etc.  
- Patients who have demonstrated improvement/stabilization of disease and are well-controlled (e.g., attack free) for > 6 months may consider a trial of every 4-week dosing. | 2 injections (4mL)/28 days | General PA Form |
| Orfadin® suspension      | NP  | Will be approved for patients who meet ALL of the following criteria:  
- Diagnosis of hereditary tyrosinemia type 1; AND  
- Agent is prescribed by a physician specializing in the condition being treated; AND  
- Patient has a clinically valid reason as to why the capsule formulation cannot be utilized | General PA Form |
| Oral Iron Chelators      | NP  | Exjade® will be approved for recipients who meet ONE of the following criteria:  
- Diagnosis of chronic iron overload due to blood transfusions in patients two years of age and older; AND  
  - Serum ferritin > 1,000 mcg/L; OR  
  - Liver iron concentration is > 3.2 Fe/g dw L;  
- Diagnosis of non-transfusion-dependent thalassemia (NTDT) in patients aged 10 and older; AND  
  - Serum ferritin > 1,000 mcg/L; OR  
  - Liver iron concentration is > 3.2 Fe/g dw L  
**Note**: Exjade® will not be approved for recipients with creatinine clearance less than 40 mL/min or for recipients with platelet count less than 50x109/L.  
**Note**: It is recommended that if the serum ferritin is consistently <500mcg/L therapy should be stopped; however, this may be up to the prescriber’s discretion in his/her experience of treating patients with iron-overload. | General PA Form |

**Note**: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### MISCELLANEOUS

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
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<tbody>
<tr>
<td>Oral Iron Chelators (continued)</td>
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**Ferriprox®**

NP

- Ferriprox® will be approved for recipients who meet ALL of the following criteria:
  - Diagnosis of transfusional iron overload due to thalassemia syndromes; **AND**
    - Serum ferritin > 1000mcg/L; **OR**
    - Liver iron concentration > 3.2 Fe/g dw L; **AND**
    - Clinically valid reason as to why patient cannot use Exjade® **Note:** It is recommended that if the serum ferritin is consistently < 500mcg/L therapy should be stopped; however, this may be up to the prescriber’s discretion in his/her experience of treating patients with iron-overload

**Jadenu®**

NP

- Will be approved for patients meeting following criteria:
  - Diagnosis of chronic iron overload due to blood transfusions in patients two years of age and older, **AND**
    - Serum ferritin > 1,000 mcg/L; **OR**
    - Liver iron concentration > 3.2 Fe/g dw L; **AND**
    - Clinically valid reason as to why patient cannot use Exjade®; **OR**
  - Diagnosis of non-transfusion-dependent thalassemia (NTDT) in patients aged 10 and older, **AND**
    - Serum ferritin > 1,000 mcg/L; **OR**
    - Liver iron concentration > 3.2 Fe/g dw L;
    - Clinically valid reason as to why patient cannot use Exjade®

Will **not** be approved for recipients with creatinine clearance < 40 mL/min or for recipients with platelet count < 50x10⁹/L.

**Note:** It is recommended that if the serum ferritin is consistently < 500mcg/L, therapy should be stopped; however, this may be up to the prescriber’s discretion in his/her experience of treating patients with iron-overload.

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**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
**ONCOLOGY**

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</thead>
</table>
| **Braftovi®** | P | Will be approved if the following is met:  
- Patient has a diagnosis of unresectable or metastatic melanoma with BRAF V600E or V600K mutation, as confirmed by an FDA-approved test (e.g., ThxID™ BRAF V600/K); **AND**  
- Prescribed by or in consultation with an oncologist; **AND**  
- Patient must be ≥ 18 years of age; **AND**  
- Prescribed in combination with binimetinib (e.g., Mektovi®).  
**Renewal Criteria:**  
Will be approved if patient meets the following:  
- Patient continues to meet initial criteria; **AND**  
- No unacceptable disease progression or unacceptable toxicity | 50mg: 5/day; 75mg: 6/day | General PA Form |
| **Eligard®** | P | Will be approved for patients meeting the following criteria:  
- Diagnosis of prostate cancer in male patient | 2/day | |
| **Jakafi®** | P | Will be approved if the following is met:  
- Patient has a diagnosis of advanced or metastatic breast cancer that is hormone receptor (HR)-positive; **AND**  
- Human epidermal growth factor receptor 2 (HER2)-negative; **AND**  
- Is being used in combination with an aromatase inhibitor; **AND**  
- Female patient is postmenopausal as defined by 1 of the following:  
  - Prior bilateral oophorectomy  
  - Age > 60 years  
  - Age < 60 years and amenorrhea for ≥ 12 months (in the absence of chemotherapy, tamoxifen, toremifene or ovarian suppression) and FSH and estradiol levels in the postmenopausal range  
**Renewal Criteria:**  
- Patient continues to meet initial review criteria; **AND**  
- Tumor response with stabilization of disease OR decrease in size of tumor or tumor spread; **AND**  
- Absence of unacceptable toxicity from the drug at current dosage level | 63 tabs/28 days | |
| **Kisqali®/Femara®** | P | Will be approved if the following is met:  
- Patient has a diagnosis of advanced or metastatic breast cancer that is hormone receptor (HR)-positive; **AND**  
- Human epidermal growth factor receptor 2 (HER2)-negative; **AND**  
**Renewal Criteria:**  
- Patient continues to meet initial review criteria; **AND**  
- Tumor response with stabilization of disease OR decrease in size of tumor or tumor spread; **AND**  
- Absence of unacceptable toxicity from the drug at current dosage level | 200mg pack: (49 tabs/28 days); 400mg pack: (70 tabs/28 days); 600mg pack: (91 tabs/28 days) | |

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<tr>
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<tr>
<td>Oncology (continued)</td>
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<tr>
<td>Leuprolide</td>
<td>P</td>
<td>Leuprolide will be approved for patients meeting ONE of the following criteria:</td>
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<td></td>
<td></td>
<td>• Diagnosis of prostate cancer in male patient</td>
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<td></td>
<td></td>
<td>• Diagnosis of central precocious puberty in children (onset of secondary sexual development before 8 [girls] or 9 years of age [boys])</td>
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<tr>
<td>Lonsurf®</td>
<td>P</td>
<td></td>
<td>8/day</td>
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<tr>
<td>Lynparza®</td>
<td>P</td>
<td></td>
<td>16/day</td>
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<tr>
<td>Mektovi®</td>
<td>P</td>
<td>Will be approved if the following is met (Initial PA duration: 6 months):</td>
<td>6/day</td>
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<td>• Patient has a diagnosis of unresectable or metastatic melanoma with BRAF V600E or V600K mutation, as confirmed by an FDA-approved test (e.g., ThxID™ Braf V600/K); AND</td>
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<td>• Prescribed by or in consultation with an oncologist; AND</td>
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<td>• Patient must be ≥ 18 years of age; AND</td>
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<td>• Prescribed in combination with encorafenib (e.g. Braftovi™)</td>
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<td><strong>Renewal Criteria: (PA duration: 1 year)</strong></td>
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<td>Will be approved if patient meets the following:</td>
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<td>• Patient continues to meet initial criteria; AND</td>
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<td>• No unacceptable disease progression or unacceptable toxicity.</td>
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<tr>
<td>Rubraca®</td>
<td>P</td>
<td>Will be approved if the following is met (PA duration: 6 months):</td>
<td>4/day</td>
<td>General PA Form</td>
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<td>• Patient is ≥ 18 years of age; AND</td>
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<td></td>
<td>• Patient has a diagnosis of HER2-negative locally advanced or metastatic breast cancer; AND</td>
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<td>• Patient has a BRCA-positive mutated germline confirmed by an FDA-approved test (e.g., BRACAnalysis CDx); AND</td>
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<td>• Provider will monitor complete blood counts at baseline and monthly thereafter;</td>
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<td>• Patient must have received treatment with an anthracycline and/or a taxane (unless contraindicated) as adjuvant, and/or metastatic treatment; OR</td>
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<td>• Patient received prior platinum-based chemotherapy, patient did not experience disease progression nor relapsed within 6 months of receiving neoadjuvant or adjuvant platinum therapy; AND</td>
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<td>• Patient does not meet any of the following:</td>
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<td>– Patient does not have untreated CNS metastases (patient has completed definitive local therapy and may have stable CNS lesions on repeat brain imaging);</td>
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<td>– Patient will not use requested agent in combination with any other PARP inhibitors.</td>
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<td>– Patient has not received prior therapy with a PARP-inhibitor (e.g., Lynparza);</td>
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<td><strong>Renewal Criteria: (6 months)</strong></td>
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<td>• Patient continues to meet initial criteria; AND</td>
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<td>• Tumor response has been demonstrated with either stabilization of disease or decrease in size of tumor or tumor spread; AND</td>
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<td>• Absence of unacceptable toxicity from; AND</td>
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<td></td>
<td>• Patient has not developed myelodysplastic syndrome (MDS)/acute myeloid leukemia (AML).</td>
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</tbody>
</table>

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## ONCOLOGY
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</table>
| **Venclexta**     | P   | Will be approved if the following is met (PA duration: 6 months):  
• Patient is ≥ 18 years of age; AND  
• Requested agent will be prescribed by, or in consultation with, an oncologist; AND  
• Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as confirmed by an FDA-approved test (e.g., cobas® EGFR Mutation Test v2); AND  
• Patient has not received prior therapies to treat metastatic disease; OR recurrent disease with a minimum of 12 months disease-free following completion of systemic therapy.  
**Renewal Criteria:**  
• Initial criteria has been met and clinical documentation indicates patient is responding positively to therapy.                                                                                                                                                                                                                                                                                                                                                   | 1/day       | General PA Form                              |
| **Vizimpro**      | P   | Will be approved if the following is met (PA duration: 6 months):  
• Patient is ≥ 18 years of age; AND  
• Requested agent will be prescribed by, or in consultation with, an oncologist; AND  
• Patient has a diagnosis of NSCLC with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as confirmed by an FDA-approved test (e.g., cobas® EGFR Mutation Test v2); AND  
• Patient has not received prior therapies to treat metastatic disease; OR recurrent disease with a minimum of 12 months disease-free following completion of systemic therapy.  
**Renewal Criteria:**  
• Initial criteria has been met and clinical documentation indicates patient is responding positively to therapy.                                                                                                                                                                                                                                                                                                                                                   | 1/day       |                                              |
| **Zejula**        | P   | Will be approved for patients who are unable to swallow tablets                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 3/day       |                                              |
| **Afinitor Disperz** | NP  | Will be approved if the following is met (Initial Request 6 months):  
• Patient has a diagnosis of advanced mantle cell lymphoma; AND  
• Patient will be using acalabrutinib as monotherapy; AND  
• Patient has received at least 1 prior therapy for mantle cell lymphoma; AND has NOT received any prior treatment with a BTK inhibitor (e.g., ibrutinib).  
**Renewal Criteria (PA duration 6 months):**  
Patient must:  
• Continue to meet the above criteria; AND  
• Patient has documented efficacy with stabilization of disease or decrease in size of tumor or tumor spread; AND  
• Patient has absence of unacceptable adverse effects (e.g., anemia, thrombocytopenia, headache, neutropenia, diarrhea, fatigue, myalgia, and bruising).                                                                                                                                                                                                                                                                                                 | 1/day       |                                              |
| **Calquence**     | NP  | Will be approved if the following is met (PA duration: 6 months):  
• Patient is ≥ 18 years of age; AND  
• Requested agent will be prescribed by, or in consultation with, an oncologist; AND  
• Patient has a diagnosis of advanced mantle cell lymphoma; AND  
• Patient will be using acalabrutinib as monotherapy; AND  
• Patient has received at least 1 prior therapy for mantle cell lymphoma; AND has NOT received any prior treatment with a BTK inhibitor (e.g., ibrutinib).  
**Renewal Criteria (PA duration 6 months):**  
Patient must:  
• Continue to meet the above criteria; AND  
• Patient has documented efficacy with stabilization of disease or decrease in size of tumor or tumor spread; AND  
• Patient has absence of unacceptable adverse effects (e.g., anemia, thrombocytopenia, headache, neutropenia, diarrhea, fatigue, myalgia, and bruising).                                                                                                                                                                                                                                                                                                 | 1/day       |                                              |

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## Oncology (continued)

### Copiktra® NP

**Initial Criteria:**
- Patient is at least 18 years old; AND
- Patient does not have an active infection, including clinically important localized infections; AND
- Patient has not received previous therapy with a small-molecule inhibitor (phosphatidylinositol-3 kinase inhibitor [PI3-K]) therapy (e.g., Zydelig); AND
- Patient has not received previous therapy with a Bruton’s tyrosine kinase (BTK) inhibitor (e.g., Imbruvica and Calquence) AND
- Patient does not have CNS lymphoma or leukemia; AND
- Patient has chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL); AND
- Patient has relapsed or refractory disease; AND
- Used as a single agent; AND
- Patient has received ≥ 2 prior therapies, which included treatment with ofatumumab (Arzerra); AND
- Patient is not eligible for purine analog therapy (e.g., fludarabine, cytarabine); AND
- Patient must not have undergone prior autologous hematopoietic stem cell transplant (HSCT) within 180 days of the first dose OR prior allogeneic transplant; AND
- Patient does not have Richter’s transformation or prolymphocytic leukemia; OR
- Patient has follicular lymphoma; AND
- Used as a single agent; AND
- Patient has a diagnosis of low-grade follicular lymphoma (i.e., excludes large cell, grade 3b disease); AND
- Patient must not have undergone prior allogeneic hematopoietic stem cell transplant (HSCT); AND
- Used as subsequent therapy for relapsed or refractory disease, after ≥ 2 prior therapies including both rituximab and chemotherapy (i.e., alkylator or purge analog) OR radioimmunotherapy.

**Renewal Criteria:**
- Patient continues to meet criteria identified in initial criteria; AND
- Disease response as defined by lack of disease progression, improvement in tumor size and/or improvement in patient symptoms; AND
- Absence of unacceptable toxicity from the drug (e.g., active/severe infections, hematologic toxicity [neutropenia], severe diarrhea or colitis, hepatotoxicity, pneumonitis, severe cutaneous reactions [Stevens-Johnson syndrome and toxic epidermal necrolysis], anaphylaxis).

### Prior Authorization Criteria

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<td>2/day</td>
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## ONCOLOGY

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<tr>
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<tr>
<td>Daurismo®</td>
<td>NP</td>
<td>Initial Approval Criteria (PA duration: 6 months)</td>
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<td></td>
<td></td>
<td>• Patient has newly-diagnosed acute myeloid leukemia (AML); AND</td>
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<td>• Patient ≥ 55 years old AND has severe cardiac disease (LVEF &lt; 45% or have a cumulative anthracycline dose equivalent to ≥ 400-550mg/m2 of doxorubicin or ≥ 125 mg/m2 of idarubicin) OR has a serum creatinine &gt; 1.3 mg/dL OR have a baseline Eastern Cooperative Oncology Group (ECOG) performance status of 2; OR</td>
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<td>General PA Form</td>
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<tr>
<td></td>
<td></td>
<td>• Patient has newly-diagnosed acute myeloid leukemia (AML); AND</td>
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<td>• Women of child-bearing potential have a negative pregnancy test; AND</td>
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<td>• Patient has a baseline QTc interval of ≤ 470 ms and does not have a history of long QT syndrome; AND</td>
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<td>• Patient does not have severe renal impairment (e.g., eGFR &lt; 30 mL/min) or moderate-severe hepatic impairment (total bilirubin &gt; 3 x ULN and any AST); AND</td>
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<td>• Patient does not have a diagnosis of AML M3 Promyelocytic Leukemia (APL) or a t(9:22) cytogenetic translocation; AND</td>
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<td>• Patient does not have known active, uncontrolled central nervous system (CNS) leukemia; AND</td>
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<td>• Gladasdegib will be used in conjunction with subcutaneous cytarabine; AND</td>
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<td>• Patient ≥ 75 years of age.</td>
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<td><strong>Renewal Criteria (PA duration: 6 months)</strong></td>
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<td>• Patient continues to meet above criteria; AND</td>
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<td>• Patient demonstrates disease stabilization or improvement as evidenced by a complete response (CR) (e.g., morphologic, cytogenetic or molecular complete response), complete hematologic response, or a partial response by CBC, bone marrow cytogenetic analysis, QPCR, or FISH; AND</td>
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<td>• Patient is absent of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: QTc-interval prolongation (e.g., interval ≥ 500 ms and/or interval prolongation with signs and symptoms of severe arrhythmia) etc.</td>
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| Erleada® | NP | Will be approved if the following is met: | 4/day | |
| | | • Patient has NON-metastatic castration-resistant disease (nmCRPC); AND | | |
| | | • Patient will receive a gonadotropin-releasing hormone (GnRH)-analog (e.g., leuprolide, goserelin, triptorelin) or has had a bilateral orchiectomy | | |
| | | **Renewal Criteria** | | |
| | | • Patient continues to meet the above criteria; AND | | |
| | | • Tumor response with stabilization of disease or decrease in size of tumor or tumor spread; AND | | |
| | | • Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include seizures, excessive falls and/or fractures and any other Grade 3 or above side effects that are intolerable to patient, etc. | | |

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### Oncology

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<tr>
<td><strong>Lorbrena</strong></td>
<td>NP</td>
<td>Will be approved if the following is met:</td>
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<tr>
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<td></td>
<td>- Patient has a diagnosis of Metastatic non-small cell lung cancer (NSCLC)</td>
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<td>- Patient is 18 years of age or older; <strong>AND</strong></td>
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<td>- Patient meets the following:</td>
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<td>- Anaplastic lymphoma kinase (ALK)-positive; <strong>AND</strong></td>
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<td>- Patient has disease progression on ONE of the following:</td>
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<td>- Crizotinib (Xalkori) and at least one other ALK inhibitor for metastatic disease; <strong>OR</strong></td>
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<td>- Alectinib (Alecensa) as the first ALK inhibitor therapy for metastatic disease; <strong>OR</strong></td>
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<td>- Ceritinib (Zykadia) as the first ALK inhibitor therapy for metastatic disease.</td>
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<td>- Prescriber attests they will monitor <strong>ALL</strong> the following:</td>
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<td>- ECG</td>
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<td>- Serum cholesterol and triglycerides; <strong>AND</strong></td>
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<td>- Prescriber will consult with female patient of reproductive potential to use effective non-hormonal contraception during therapy and for 6 months after the last dose; Or will consult with male patients with a partner of reproductive potential to use effective contraception during therapy and for 3 months after the last dose</td>
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<td><strong>Renewal Requests:</strong></td>
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<td>Will be approved if the following is met:</td>
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<td></td>
<td>- Patient has a diagnosis of Metastatic non-small cell lung cancer (NSCLC)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Patient is 18 years of age or older; <strong>AND</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Prescriber attests they will monitor ALL the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- ECG</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Serum cholesterol and triglycerides; <strong>AND</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Prescriber will consult with female patient of reproductive potential to use effective non-hormonal contraception during therapy and for 6 months after the last dose; Or will consult with male patients with a partner of reproductive potential to use effective contraception during therapy and for 3 months after the last dose.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Purixan</strong></td>
<td>NP</td>
<td>• No prior authorization required for patient 11 years of age and under</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patients aged 12 years and older will be approved for patients unable to swallow tablets</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tibsovo</strong></td>
<td>NP</td>
<td>Will be approved if the following is met (Initial PA duration: 6 months):</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient must be ≥ 18 years of age; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient is diagnosed with relapsed or refractory (defined as &lt; 12 months after initial therapy) Acute Myeloid Leukemia; <strong>OR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Patient is not a candidate for intensive remission induction therapy; <strong>AND</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Patient has an isocitrate dehydrogenase-1 (IDH1) mutation, as detected by an FDA-approved test (e.g., RealTime™ IDH1 Assay); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Medication will be used as a single agent.</td>
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<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>ONCOLOGY</strong></td>
<td></td>
<td>Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Oncology (continued)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Vitrakvi** | NP | Will be approved if the following is met:  
  - Patient has a solid tumor (e.g., soft tissue sarcoma, salivary gland, infantile fibrosarcoma, thyroid, lung, or gastrointestinal stromal tumors); AND  
  - The tumor has a positive NTRK gene fusion status, without a known acquired resistance mutation, as determined by laboratory testing (e.g., next generation sequencing [NGS] or fluorescence in situ hybridization [FISH]); AND  
  - Patient’s tumor is metastatic or surgical resection is likely to result in severe morbidity; AND  
  - Patient has no satisfactory alternative treatments or has progressed following treatment. | 25mg: 3/day; 100mg: 2/day; 20 mg/mL: 10 mL/day | |
| | | **Renewal Criteria** | | |
| | | - Patient continues to meet above criteria; AND  
  - Patient has tumor response with stabilization of disease or decrease in size of tumor or tumor spread; AND  
  - Patient does not have unacceptable toxicity such as severe neurotoxicity, hepatotoxicity; (adverse effects resolve following dose recommendations/no permanent discontinuation required). | | |
| **Xospata** | NP | Initial Approval Criteria:  
  - Patient must be ≥ 18 years of age; AND  
  - Patient has a diagnosis of acute myeloid leukemia (AML) that is refractory OR relapsed to first-line AML therapy; AND  
  - AML is positive for FLT3 mutation as detected by an FDA-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay); AND  
  - Electrocardiogram (ECG) confirmed QTcF ≤ 500 msec; AND  
  - Serum potassium and magnesium are within normal limits; AND  
  - Females of child-bearing potential had a negative pregnancy test within 7 days before starting gilteritinib; AND  
  - Female and male patients of reproductive potential have been advised to use effective contraception during treatment and for at least 6 and 4 months, respectively, after the last dose. | 3/day | General PA Form |
| | | **Renewal Criteria:** | | |
| | | - Patient continues to meet above criteria; AND  
  - Patient has disease stabilization or improvement as evidenced by a complete response (CR) (e.g., morphologic, cytogenetic or molecular complete response), complete hematologic response, or a partial response by CBC, bone marrow cytogenic analysis, quantitative PCR, or fluorescence in situ hybridization (FISH); AND  
  - Patient does not have unacceptable toxicity (adverse effects resolve following a dose reduction, no permanent discontinuation required). | | |
| **Yonsa** | NP | Will be approved if the following is met:  
  - Patient has metastatic castration-resistant disease (mCRPC); AND  
  - Patient will receive a gonadotropin-releasing hormone (GnRH)-analog (e.g., leuprolide, goserelin, triptorelin) or has had a bilateral orchiectomy; AND  
  - Will be taken in combination with methylprednisolone | | |
| | | **Renewal Criteria** | | |
| | | - Patient continues to meet the above criteria; AND  
  - Tumor response with stabilization of disease or decrease in size of tumor or tumor spread | | |

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**OPHTHALMICS**

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</tr>
</thead>
<tbody>
<tr>
<td>apraclonidine</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>brimonidine tartrate 0.2%</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Alphagan P®</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>brimonidine tartrate 0.15%</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>lopidine*</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
</tbody>
</table>

**Ophthalmic Alpha-2 Agonists**

<table>
<thead>
<tr>
<th>Medication</th>
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<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>apraclonidine</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>brimonidine tartrate 0.2%</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Alphagan P®</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>brimonidine tartrate 0.15%</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>lopidine*</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
</tbody>
</table>

**Ophthalmic Antibiotics**

<table>
<thead>
<tr>
<th>Medication</th>
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</tr>
</thead>
<tbody>
<tr>
<td>ciprofloxacin</td>
<td>P</td>
<td></td>
<td>10 mL/Rx</td>
<td></td>
</tr>
<tr>
<td>erythromycin</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Gentak®</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>gentamicin</td>
<td>P</td>
<td></td>
<td>15 mL/Rx</td>
<td></td>
</tr>
<tr>
<td>Moxeza®</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>neomycin/bac/poly B</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>neomycin/poly B/gramicidin</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>polymyxin B/TMP</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>sulfacetamide sodium drops</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>tobramycin</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Tobrex® ointment</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>AzaSite®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Besivance®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Bleph-10®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Ciloxan®</td>
<td>NP</td>
<td></td>
<td>10 mL/Rx</td>
<td></td>
</tr>
</tbody>
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</thead>
<tbody>
<tr>
<td><strong>Ophthalmic Antibiotics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>gatifloxacin 0.5% solution</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>levofloxacin 0.5% solution</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>moxifloxacin</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>sulfacetamide ointment</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Tobrex* solution</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td><strong>Ophthalmic Antibiotic/Steroid Combos</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>neomycin/BAC/poly B/HC</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>sulfacetamide/prednisolone</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Pred-G*</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>TobraDex* suspension</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Blephamide*</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Maxitrol*</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>neomycin/poly B/HC</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>TobraDex* ointment</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>TobraDex* ST suspension</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>tobramycin/dexamethasone suspension</td>
<td>NP</td>
<td>Will be approved if the recipient has a contraindication or intolerance to any two of the preferred ophthalmic antibiotic/steroid combination products, OR if there are concerns over a potential increase in intra-ocular pressure (IOP) with other steroids (i.e., glaucoma, recipient is pre- or post-cataract surgery and a known steroid-responder).</td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Zylet*</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
</tbody>
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<tbody>
<tr>
<td><strong>Ophthalmic Antifungals</strong></td>
<td></td>
<td>General PA Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natacyn®</td>
<td>NP</td>
<td>Will be approved for patients meeting the following criteria:</td>
<td>1 package/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of ophthalmic fungal infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ophthalmic Antivirals</strong></td>
<td></td>
<td>General PA Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>trifluridine</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Zirgan®</td>
<td>NP</td>
<td>Prior authorization required for beneficiaries ages 5 and older</td>
<td></td>
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</tr>
<tr>
<td><strong>Ophthalmic Antihistamines</strong></td>
<td></td>
<td>General PA Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bepreve®</td>
<td>P</td>
<td></td>
<td>10mL/Rx</td>
<td></td>
</tr>
<tr>
<td>Ketotifen OTC</td>
<td>P</td>
<td></td>
<td>10mL/Rx</td>
<td></td>
</tr>
<tr>
<td>olopatadine</td>
<td>P</td>
<td></td>
<td>5mL/Rx</td>
<td></td>
</tr>
<tr>
<td>Pazeo®</td>
<td>P</td>
<td></td>
<td>2.5mL/Rx</td>
<td></td>
</tr>
<tr>
<td>azelastine</td>
<td>NP</td>
<td></td>
<td>6mL/Rx</td>
<td></td>
</tr>
<tr>
<td>Elestat®</td>
<td>NP</td>
<td></td>
<td>5mL/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Emadine®</td>
<td>NP</td>
<td></td>
<td>5mL/Rx</td>
<td></td>
</tr>
<tr>
<td>epinastine</td>
<td>NP</td>
<td></td>
<td>5mL/Rx</td>
<td></td>
</tr>
<tr>
<td>Lastacaft®</td>
<td>NP</td>
<td></td>
<td>3mL/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Pataday®</td>
<td>NP</td>
<td></td>
<td>2.5mL/Rx</td>
<td></td>
</tr>
<tr>
<td>Patanol®</td>
<td>NP</td>
<td></td>
<td>5mL/Rx</td>
<td></td>
</tr>
<tr>
<td>Zaditor®</td>
<td>NP</td>
<td></td>
<td>10mL/Rx</td>
<td></td>
</tr>
<tr>
<td><strong>Ophthalmic Beta Blockers</strong></td>
<td></td>
<td>General PA Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>carteolol</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>timolol maleate</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Betaxolol</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Betoptic-S®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Istatol®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td>levobunolol</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>metipranolol</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>timolol gel solution</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Timoptic®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Timoptic Ocudose®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
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<tr>
<td><strong>Ophthalmic Carbonic Anhydrase Inhibitors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Azopt®</td>
<td>P</td>
<td></td>
<td>15 mL/30 days</td>
<td></td>
</tr>
<tr>
<td>dorzolamide</td>
<td></td>
<td></td>
<td>10 mL/30 days</td>
<td></td>
</tr>
<tr>
<td>dorzolamide/timolol</td>
<td>P</td>
<td></td>
<td>10 mL/30 days</td>
<td></td>
</tr>
<tr>
<td>Cosopt®</td>
<td>NP</td>
<td></td>
<td>10 mL/30 days</td>
<td></td>
</tr>
<tr>
<td>Cosopt PF®</td>
<td>NP</td>
<td></td>
<td>2 vials/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Trusopt®</td>
<td>NP</td>
<td></td>
<td>10 mL/30 days</td>
<td></td>
</tr>
</tbody>
</table>

| **Ophthalmic Decongestants** |     |                               |             |         |
| phenylephrine               | P   |                               | 1 package/Rx | General PA Form |

| **Glaucoma Combinations**   |     |                               |             |         |
| Combigan®                   | P   | Combigan® will be approved if the following criteria is met: | 1 package/Rx | General PA Form |
|                             |     | • Patient is on simultaneous therapy with brimonidine and timolol for at least 60 days  
|                             |     | • Patient demonstrates non-compliance with 2 products individually. |             |         |
| Simbrinza®                  | P   | Simbrinza® will be approved if the following criteria is met: | 1 package/Rx | General PA Form |
|                             |     | • Patient is on simultaneous therapy with brimonidine and Azopt® for at least 60 days |             |         |

| **Glaucoma Direct Acting, Miotics** |     |                               |             | General PA Form |
| Isopto® Carpine             | NP  |                               | 1 package/Rx |         |
| phospholine iodide          | NP  |                               | 1 package/Rx |         |

| **Glaucoma, Miscellaneous** |     |                               |             | General PA Form |
| Rhopressa®                  | NP  | Will be approved if the following is met: | 5 mL/30 days |         |
|                             |     | • Patient has a diagnosis of ocular hypertension or open-angle glaucoma; **AND**  
|                             |     | • Patient has tried/failed or is intolerant to BOTH a prostaglandin inhibitor AND beta-adrenergic antagonist; **AND**  
|                             |     | • Patient has not had previous glaucoma intraocular surgery or glaucoma laser procedure in the affected eye; **OR**  
|                             |     | • Patient has not had ocular surgery or laser treatment within 3 months prior to initiation; **AND**  
|                             |     | • Patient does not currently have: Ocular infection, ocular inflammation, blepharitis, conjunctivitis, or ocular disease. |             |         |
|                             |     | **Renewal Criteria:** |             |         |
|                             |     | • Patient must continue to meet above criteria; **AND**  
|                             |     | • Medical documentation that requested medication has demonstrated efficacy (e.g., reduction in IOP). |             |         |

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### OPHTHALMICS

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<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ophthalmic Immunomodulators</strong></td>
<td></td>
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</tr>
<tr>
<td>Restasis®</td>
<td>P</td>
<td>Will be approved for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Treatment of moderate to severe keratoconjunctivitis sicca (KCS) in patients who have failed at least <strong>ONE</strong> of the following therapies:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Artificial tear drops or ointments administered at least 4x/day</td>
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<tr>
<td></td>
<td></td>
<td>- Punctal plugs</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Treatment of dry eyes in recipients with Sjögren’s disease</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Recipients using the agent status post corneal transplant</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Treatment of severe atopic keratoconjunctivitis who have tried and failed at least <strong>TWO</strong> ophthalmic steroids or have contraindication or intolerance to ophthalmic steroids.</td>
<td>60 vials/30 days</td>
<td></td>
</tr>
<tr>
<td>Restasis® multidose</td>
<td>P</td>
<td>See Restasis® prior authorization criteria</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td>Cequa®</td>
<td>NP</td>
<td>See Xiidra® prior authorization criteria</td>
<td>1 package/Rx</td>
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</tr>
<tr>
<td>XIIDRA®</td>
<td>NP</td>
<td>Will be approved for patients meeting <strong>ALL</strong> of the following:</td>
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<tr>
<td></td>
<td></td>
<td>• Treatment of moderate to severe keratoconjunctivitis sicca (KCS) in patients who have failed:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Artificial tear drops or ointments administered at least 4x/day, OR punctal plugs; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>- Trial and failure or contraindication to Restasis® (minimum trial duration of 12 weeks as confirmed by TennCare paid claims)</td>
<td>2/day</td>
<td></td>
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<tr>
<td><strong>Ophthalmic Mast Cell Stabilizers</strong></td>
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<tr>
<td>Cromolyn sodium</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Alocril®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td></td>
</tr>
<tr>
<td>Alomide®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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</tr>
<tr>
<td><strong>Ophthalmic Lubricants and Artificial Tears</strong></td>
<td></td>
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</tr>
<tr>
<td>Lacrisert®</td>
<td>NP</td>
<td>Will be approved for patient’s meeting <strong>ALL</strong> of the following:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Patient has diagnosis of Dry Eye Syndrome, Keratoconjunctivitis Sicca, or acute Keratoconjunctivitis; <strong>AND</strong></td>
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<tr>
<td></td>
<td></td>
<td>• Patient has experienced a therapeutic failure with RESTASIS in the previous 60 days</td>
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</tr>
</tbody>
</table>

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**OPHTHALMICS**

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<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>diclofenac P</td>
<td>See flurbiprofen prior authorization criteria</td>
<td>1 package/Rx</td>
<td>Ophthalmic NSAIDs PA Form</td>
<td></td>
</tr>
<tr>
<td>flurbiprofen P</td>
<td>Will be approved if ANY of the following are true: • Recipient has a contraindication, intolerance or adverse reaction to an ophthalmic steroid (i.e., prednisolone). Acceptable reasons for not using an ophthalmic steroid (not inclusive): – Potential increase in intraocular pressure (IOP) with ophthalmic steroids that would place the patient at risk (i.e., glaucoma, pre/post-cataract surgery) – Concerns that the steroid would impair wound healing – Concerns that the steroid may cause/induce infection due to immunosuppression. • Use of the agent is for pain pre/post-ocular surgery • Concomitant use of an ophthalmic steroid and an ophthalmic NSAID is needed to control inflammation</td>
<td>1 package/Rx</td>
<td>Ophthalmic NSAIDs PA Form</td>
<td></td>
</tr>
<tr>
<td>ketorolac P</td>
<td>See flurbiprofen prior authorization criteria</td>
<td>1 package/Rx</td>
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<td></td>
</tr>
<tr>
<td>Acular® LS® NP</td>
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<tr>
<td>Acuvail® NP</td>
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<tr>
<td>Bromday® NP</td>
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<tr>
<td>Bromite® NP</td>
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<tr>
<td>bromfenac NP</td>
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<tr>
<td>Ilevro* NP</td>
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<tr>
<td>Nevanac® NP</td>
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<tr>
<td>Ocufen® NP</td>
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<tr>
<td>Prolensa® NP</td>
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<tr>
<td>Voltaren® NP</td>
<td></td>
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<tr>
<td>Ophthalmic Prostaglandin Agonists</td>
<td></td>
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</tr>
<tr>
<td>latanoprost P</td>
<td>5 mL/ Rx</td>
<td>General PA Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lumigan® 0.01% P</td>
<td>5 mL/ Rx</td>
<td>General PA Form</td>
<td></td>
<td></td>
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<tr>
<td>bimatoprost 0.03% NP</td>
<td>5 mL/ Rx</td>
<td>General PA Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travatan® Z NP</td>
<td>5 mL/ Rx</td>
<td>General PA Form</td>
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</tr>
</tbody>
</table>

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<tbody>
<tr>
<td><strong>Ophthalmic Prostaglandin Agonists (continued)</strong></td>
<td></td>
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</tr>
</tbody>
</table>
| Vyzulta<sup>®</sup>  | NP  | Will be approved if the following is met:   
- Patient has a diagnosis of open-angle glaucoma or ocular hypertension; **AND**  
- Patient does not have any hypersensitivity to latanoprostene bunod or its derivatives (e.g., latanoprost); **AND**  
- Patient has had an adequate trial and failure of at least 2 preferred prostaglandin analogues (e.g., bimatoprost [Lumigan], latanoprost [Xalatan])  
**Renewal Criteria:**  
Patient must:   
- Continue to meet the above criteria; **AND**  
- Patient has documented efficacy as defined by decrease in, or sustained lowering of, intraocular pressure; **AND**  
- Patient has not experienced any treatment-restricting adverse effects (e.g., significant conjunctival hyperemia, eye irritation, eye pain, and instillation site pain). | 5 mL/Rx     | General PA Form |
| Xalatan<sup>®</sup>  | NP  | Initial PA Criteria:  
Will be approved if the following is met:  
- Patient has a diagnosis of open-angle glaucoma or ocular hypertension; **AND**  
- Patient does not have any hypersensitivity to latanoprost; **AND**  
- Patient has an allergy or contraindication to benzalkonium chloride (BAK)  
**Renewal Criteria:**  
Patient must:   
- Continue to meet the above criteria; **AND**  
- Patient has documented efficacy as defined by decrease in, or sustained lowering of, intraocular pressure; **AND**  
- Patient has not experienced any treatment-restricting adverse effects (e.g., significant conjunctival hyperemia, eye irritation, eye pain, and instillation site pain). | 5 mL/Rx     |             |
| Xelpros<sup>®</sup>  | NP  |                                                                                                                                                                                                                                |             |             |
| **Ophthalmic Steroids**                                          |     |                                                                                                                                                                                                                                |             |             |
| Alrex<sup>®</sup>    | P   |                                                                                                                                                                                                                                | 1 package/Rx |             |
| Durezol<sup>®</sup> | P   |                                                                                                                                                                                                                                | 1 package/Rx |             |
| fluorometholone     | P   |                                                                                                                                                                                                                                | 1 package/Rx |             |
| FML<sup>®</sup> ointment | P   |                                                                                                                                                                                                                                | 1 package/Rx | General PA Form |
| Lotemax<sup>®</sup> drops | P   |                                                                                                                                                                                                                                | 1 package/Rx |             |
| Pred Mild<sup>®</sup> | P   |                                                                                                                                                                                                                                | 1 package/Rx |             |
| prednisolone acetate | P   |                                                                                                                                                                                                                                | 1 package/Rx |             |
| dexamethasone       | NP  |                                                                                                                                                                                                                                | 1 package/Rx |             |

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<tbody>
<tr>
<td><strong>Ophthalmic Steroids (continued)</strong></td>
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<tr>
<td>Flarex®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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<tr>
<td>FML Forte®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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<tr>
<td>FML Liquifilm®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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</tr>
<tr>
<td>Lotemax® gel and ointment</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td>loteprednol</td>
<td>NP</td>
<td></td>
<td>15 ml/Rx</td>
<td></td>
</tr>
<tr>
<td>Maxidex®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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<tr>
<td>prednisolone sodium phosphate</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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<tr>
<td>Pred Forte®</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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<tr>
<td><strong>Miscellaneous Ophthalmics</strong></td>
<td></td>
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<tr>
<td>Cystaran®</td>
<td>NP</td>
<td>Will be approved for patients with a diagnosis of cystinosis.</td>
<td>1 package/Rx</td>
<td>General PA Form</td>
</tr>
</tbody>
</table>

# OTICS

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<tbody>
<tr>
<td><strong>Otic Quinolones</strong></td>
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<tr>
<td>Ciprodex®</td>
<td>P</td>
<td></td>
<td>7.5mL/Rx</td>
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<tr>
<td>ciprofloxacin otic</td>
<td>P</td>
<td></td>
<td>14mL/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Cipro® HC</td>
<td>NP</td>
<td></td>
<td>10mL/Rx</td>
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<tr>
<td>ofloxacin otic</td>
<td>NP</td>
<td></td>
<td>10mL/Rx</td>
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</tr>
<tr>
<td><strong>Otic Steroid/Antibiotic Combinations</strong></td>
<td></td>
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<tr>
<td>HC/neomycin/poly mycin B</td>
<td>P</td>
<td></td>
<td>1 package/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Coly-Mycin® S</td>
<td>NP</td>
<td></td>
<td>1 package/Rx</td>
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<tr>
<td><strong>Miscellaneous Otics</strong></td>
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<tr>
<td>acetic acid/HC</td>
<td>P</td>
<td></td>
<td>10mL/Rx</td>
<td>General PA Form</td>
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<tr>
<td>DermOtic® oil</td>
<td>NP</td>
<td></td>
<td>20mL/Rx</td>
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</tbody>
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<tbody>
<tr>
<td><strong>Alpha Blockers for BPH</strong></td>
<td></td>
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</tr>
<tr>
<td>alfuzosin</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>tamsulosin</td>
<td>P</td>
<td></td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>Cardura XL</td>
<td>NP</td>
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<tr>
<td>Flomax®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
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</tr>
<tr>
<td>Uroxatral®</td>
<td>NP</td>
<td></td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td><strong>Androgen Hormone Inhibitors</strong></td>
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</tr>
<tr>
<td>dutasteride</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>finasteride</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Avodart®</td>
<td>NP</td>
<td></td>
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<tr>
<td>Proscar®</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td><strong>Combination Agents for BPH</strong></td>
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</tr>
<tr>
<td>dutasteride/tamsulosin</td>
<td>NP</td>
<td>Will be approved if the following criteria is met:</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has a diagnosis of benign prostatic hyperplasia (BPH) with an enlarged prostate; AND</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Patient has a contraindication or adverse event to finasteride; AND</td>
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<tr>
<td></td>
<td></td>
<td>• Patient is unable to use the individual components</td>
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<tr>
<td>Jalyn®</td>
<td>NP</td>
<td>See dutasteride/tamsulosin prior authorization criteria</td>
<td>1/day</td>
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</tr>
<tr>
<td><strong>Phosphorus Depleters</strong></td>
<td></td>
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</tr>
<tr>
<td>Renvela® tablets</td>
<td>P</td>
<td>Will be approved for patients who meet the following criteria:</td>
<td>9/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trial and failure of preferred phosphorus depleter (unless patient has a contraindication, allergy, or intolerable side effect); AND</td>
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<tr>
<td></td>
<td></td>
<td>• Contraindication to sevelamer powder for suspension; AND</td>
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<td></td>
<td></td>
<td>• Unable to swallow tablets</td>
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<tr>
<td>Fosrenol® powder pack</td>
<td>NP</td>
<td>Will be approved for patients who meet the following criteria:</td>
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<tr>
<td></td>
<td></td>
<td>• Trial and failure of preferred phosphorus depleter (unless patient has a contraindication, allergy, or intolerable side effect); AND</td>
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<tr>
<td></td>
<td></td>
<td>• Contraindication to sevelamer powder for suspension; AND</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Unable to swallow tablets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renvela® powder for suspension</td>
<td>NP</td>
<td>Will be approved for patients who are:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Unable to swallow tablets</td>
<td>0.8g powder packets: 6/day; 2.4g powder packets: 5/day</td>
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<td></td>
</tr>
<tr>
<td>sevelamer powder packets</td>
<td>NP</td>
<td>Will be approved for patients who are:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unable to swallow tablets</td>
<td>0.8g powder packets: 6/day; 2.4g powder packets: 5/day</td>
<td></td>
</tr>
<tr>
<td>sevelamer carbonate tablets</td>
<td>NP</td>
<td></td>
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<tbody>
<tr>
<td><strong>Phosphorus Depleters (continued)</strong></td>
<td></td>
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</tbody>
</table>
| Velphoro® NP  | NP  | Will be approved for patients who meet the following criteria:  
  - Trial/failure of **TWO** phosphorus depletors (unless patient has a contraindication, allergy, or intolerable side effect);  
  - Contraindication to sevelamer powder for suspension; **AND**  
  - Unable to swallow tablets                                                                                                                                                                                                                                                                               |             | General PA Form |
| **Urinary Acidifying Agents**                                                                                                                                                                                                                                                                                                                                             |             |         |
| Renacidin® NP | NP  | Will be approved only for patients with a diagnosis of apatite and/or struvite calculi who:  
  - Have received antibiotic therapy, **AND**  
  - Are not candidates for surgery or have residual calculi following surgery                                                                                                                                                                                                                               |             | General PA Form |
| Toviaz* P     |     |                                                                                                                                                                                                                                                                                                                                                          | 1/day       |         |
| VESIcare* P   |     |                                                                                                                                                                                                                                                                                                                                                          | 1/day       |         |
| darifenacin NP | NP  |                                                                                                                                                                                                                                                                                                                                                          | 1/day       |         |
| Detrol* NP    |     |                                                                                                                                                                                                                                                                                                                                                          | 2/day       |         |
| Detrol LA* NP | NP  |                                                                                                                                                                                                                                                                                                                                                          | 1/day       |         |
| Ditropan XL* NP | NP   | 5mg (1/day); 10, 15mg (2/day)                                                                                                                                                                                                                                                                                                                              |             |         |
| Enablex* NP   |     |                                                                                                                                                                                                                                                                                                                                                          | 1/day       |         |
| flavoxate NP  |     |                                                                                                                                                                                                                                                                                                                                                          | 2 fills per 60 days | General PA Form |
| Gelnique™ NP  |     | 3%: 3.1 gm/day  
10%: 1 sachet/day                                                                                                                                                                                                                                                                                                                                  |             |         |
| Myrbetriq* NP |     |                                                                                                                                                                                                                                                                                                                                                          | 1/day       |         |
| oxybutynin ER NP |     | See Ditropan XL                                                                                                                                                                                                                                                                                                                                    |             |         |
| Oxytrol* NP   |     | 8 patches/26 days                                                                                                                                                                                                                                                                                                                                       |             |         |
| solifenacin NP |     |                                                                                                                                                                                                                                                                                                                                                          | 1/day       |         |
| tolterodine NP |     |                                                                                                                                                                                                                                                                                                                                                          | 2/day       |         |
| tolterodine ER NP |     | 1/day                                                                                                                                                                                                                                                                                                                                                 |             |         |
| trospium NP   |     | 2/day                                                                                                                                                                                                                                                                                                                                                   |             |         |
| trospium XR NP |     | 1/day                                                                                                                                                                                                                                                                                                                                                   |             |         |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
## RESPIRATORY

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anaphylaxis Therapy Agents</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>epinephrine</td>
<td>P</td>
<td></td>
<td>2/Rx</td>
<td></td>
</tr>
<tr>
<td>epinephrine auto injector</td>
<td>P</td>
<td></td>
<td>2/Rx</td>
<td></td>
</tr>
<tr>
<td>Symjepi*</td>
<td>P</td>
<td></td>
<td>2/Rx</td>
<td></td>
</tr>
<tr>
<td>EpiPen*</td>
<td>NP</td>
<td></td>
<td>2/Rx</td>
<td>Form</td>
</tr>
<tr>
<td>EpiPen-Jr*</td>
<td>NP</td>
<td></td>
<td>2/Rx</td>
<td></td>
</tr>
<tr>
<td><strong>Anticholinergics, Inhaled</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>albuterol/ipratropium</td>
<td>P</td>
<td>Will be approved if patient meets ALL the following:</td>
<td>18 mL/day</td>
<td></td>
</tr>
<tr>
<td>Atrovent® HFA*</td>
<td>P</td>
<td>• A diagnosis of COPD; <strong>AND</strong></td>
<td>2 inhalers/30 days</td>
<td></td>
</tr>
<tr>
<td>Bevespi® Aerosphere*</td>
<td>P</td>
<td>• Trial and failure, contraindication or adverse reaction to TWO preferred inhaled anticholinergics, which must include a long-acting product (Spiriva*)</td>
<td>1 inhaler/month</td>
<td></td>
</tr>
<tr>
<td>ipratropium solution</td>
<td>P</td>
<td>Will be approved if patient has a diagnosis of COPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiriva*</td>
<td>P</td>
<td>Will be approved if patient meets ALL the following:</td>
<td>10 mL/day</td>
<td></td>
</tr>
<tr>
<td>Anoro® Ellipta*</td>
<td>NP</td>
<td>• A diagnosis of COPD; <strong>AND</strong></td>
<td>2 blisters/day</td>
<td></td>
</tr>
<tr>
<td>Combivent® Respimat®</td>
<td>NP</td>
<td>• Trial and failure, contraindication or adverse reaction to TWO preferred inhaled anticholinergics, which must include a long-acting product (Spiriva*); <strong>OR</strong></td>
<td>2 inhalers/30 days</td>
<td>Form</td>
</tr>
<tr>
<td>Incruse® Ellipta®</td>
<td>NP</td>
<td>• Failure to achieve adequate response on concomitant therapy with individual components.</td>
<td>1 blister/day</td>
<td></td>
</tr>
<tr>
<td>Lonhala® Magnair®</td>
<td>NP</td>
<td>Will be approved if ALL of the following are met:</td>
<td>2 mL/day</td>
<td></td>
</tr>
<tr>
<td>Seebri® Neohaler®</td>
<td>NP</td>
<td>• Diagnosis of COPD; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiriva® Respimat®</td>
<td>NP</td>
<td>• Trial and failure, contraindication or adverse reaction to TWO preferred inhaled anticholinergics, which must include a long-acting product (Spiriva*); <strong>OR</strong></td>
<td>1 inhaler/30 days</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.

---

Effective Date: December 2, 2019

Clinical Criteria, Step Therapy, and Quantity Limits for TennCare Preferred Drug List (PDL)
### RESPIRATORY

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anticholinergics, Inhaled (continued)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Stiolo® Respinat®  | NP  | Will be approved if patient meets ALL the following:  
• A diagnosis of COPD  
• Trial and failure, contraindication or adverse reaction to TWO preferred inhaled anticholinergics, which must include a long-acting product (Spiriva®)  
**Note:** Patients with a contraindication or adverse reaction to Spiriva® will not be approved.                                                                                      | 1 inhaler/30 days |         |
| Trelegy® Ellipta®  | NP  | Will be approved for the following:  
• Diagnosis of chronic obstructive pulmonary disease (COPD); **AND**  
• Trial and failure (as defined by continued symptoms, including exacerbations) of adequate treatment with 2 dual combination therapies (e.g., inhaled corticosteroid + long-acting beta-agonist or long-acting beta-agonist + long-acting antimuscarinic); **AND**  
• Patient does not have known hypersensitivity to milk proteins, fluticasone,umeclidinium, vilanterol, or other known excipients.  
**Renewal Criteria:**  
• Documentation of continued efficacy via prescriber’s expert opinion on patient evaluation; **AND**  
• Patient has not experienced any intolerable adverse effects (e.g., hypersensitivity, bronchospasm, worsening of intraocular pressure, increased severe infections). | 2 blisters/day | General PA Form |
| Tudorza®          | NP  | Will be approved if the following is met **(Initial PA duration: 1 year)**:  
• Patient must be ≥ 18 years of age; **AND**  
• Patient has a diagnosis of COPD; **AND**  
• Patients is a candidate for long-acting anticholinergic treatment based on severity (e.g., GOLD class B-D); **AND**  
• Patient is unable to master proper inhaler technique, as attested by prescriber; **AND**  
• Patient is not prescribed other inhaled long-acting anticholinergic agents.  
**Renewal Criteria (PA duration: 1 year)**  
• Patient continues to meet above criteria; **AND**  
• Patient symptoms are clinically improving, as documented by provider; **AND**  
• Patient demonstrates continued compliance, based on fill history (not using PRN); **AND**  
• Prescriber documents that nebulized therapy continues to be required.                                                                                                                        | 3 mL/day     |         |
| Utibron Neohaler® | NP  | See Anoro Ellipta® prior authorization criteria                                                                                                                                                                              | 1 inhaler/30 days |         |
| Yupelri®          | NP  | Will be approved if the following is met **(Initial PA duration: 1 year)**:  
• Patient must be ≥ 18 years of age; **AND**  
• Patient has a diagnosis of COPD; **AND**  
• Patients is a candidate for long-acting anticholinergic treatment based on severity (e.g., GOLD class B-D); **AND**  
• Patient is unable to master proper inhaler technique, as attested by prescriber; **AND**  
• Patient is not prescribed other inhaled long-acting anticholinergic agents.                                                                                                                        | 2 boxes/30 days | General PA Form |
| ipratropium 0.3%  | P   |                                                                                                                                                                                                                           | 2 boxes/30 days |         |
| ipratropium 0.6%  | P   |                                                                                                                                                                                                                           | 3 boxes/30 days |         |

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Antiallergens, Oral</td>
<td>NP</td>
<td><strong>ALL of the following MUST be met for approval of an oral Anti-Allergen:</strong>&lt;br&gt; - Diagnosis of allergic rhinitis with or without conjunctivitis&lt;br&gt; - Documentation initial dose was administered in the physician office or medical facility&lt;br&gt; - Must be prescribed by an allergy/immunology specialist&lt;br&gt; - Patients diagnosis is confirmed with documentation of <strong>ONE</strong> of the following:&lt;br&gt;   - A positive skin test to <strong>ONE</strong> of the pollen extracts contained in the requested agent; <strong>OR</strong>&lt;br&gt;   - Pollen specific IgE antibodies to <strong>ONE</strong> of the pollen extracts contained in the requested agent&lt;br&gt; - Trial/failure, contraindication, or drug-drug interaction to at least <strong>ONE</strong> agent from <strong>TWO</strong> of the following classes:&lt;br&gt;   - Oral antihistamine&lt;br&gt;   - Intranasal antihistamine&lt;br&gt;   - Intranasal corticosteroid&lt;br&gt;   - Leukotriene receptor antagonist&lt;br&gt; - Documented trial/failure or drug-drug interaction of subcutaneous allergen immunotherapy (SCIT, or allergy shots)&lt;br&gt;   [Note: Failure defined as: lack of efficacy, allergic reaction, documented intolerable side effects; agent will not be approved for needle phobia]&lt;br&gt; - Patient has been prescribed and trained to administer epinephrine in case of severe allergic reaction; <strong>AND</strong>&lt;br&gt; - Treatment is requested at least 12 weeks prior to season of allergen being treated&lt;br&gt;&lt;br&gt;Note: <strong>PA's (prior authorizations) may be processed for Grastek® between the dates of January 1st thru March 31st of the current year of use; with PA requests being accepted 2 weeks prior to this period. Requests received after March 31st will not be processed. PA's may be processed for Ragwitek® between the dates of May 1st thru July 31st of the current year of use; with PA requests being accepted 2 weeks prior to this period. Requests received after July 31st will not be processed.</strong>&lt;br&gt; Oral Anti-allergens will <strong>NOT</strong> be approved if patient meets ANY of the following:&lt;br&gt; - Patient experienced a severe reaction post initial dose administered in the physician’s office&lt;br&gt; - Request is during the active season of allergen (Ragweed season: August-November; Grass season: April-September)&lt;br&gt; - Patient has concomitant allergen immunotherapy&lt;br&gt; - Patient has a history of severe, unstable, or uncontrolled asthma&lt;br&gt; - Patient has a history of eosinophilic esophagitis&lt;br&gt;&lt;br&gt;Note: Grastek is recommended for patients ≥ 5 years of age</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
</tbody>
</table>
**RESPIRATORY**

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Antiallergens, Oral (continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oralair™</td>
<td>NP</td>
<td>ALL of the following MUST be met for approval of an oral Anti-Allergen:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of allergic rhinitis with or without conjunctivitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Documentation initial dose was administered in the physician office or medical facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Must be prescribed by an allergy/immunology specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patients diagnosis is confirmed with documentation of ONE of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A positive skin test to ONE of the pollen extracts contained in the requested agent; OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pollen specific IgE antibodies to ONE of the pollen extracts contained in the requested agent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trial/failure, contraindication, or drug-drug interaction to at least ONE agent from TWO of the following classes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Oral antihistamine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Intranasal antihistamine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Intranasal corticosteroid</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Leukotriene receptor antagonist</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Documented trial/failure or drug-drug interaction of subcutaneous allergen immunotherapy (SCIT, or allergy shots)</td>
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<tr>
<td></td>
<td></td>
<td>[Note: Failure defined as: lack of efficacy, allergic reaction, documented intolerable side effects; agent will not be approved for needle phobia]</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has been prescribed and trained to administer epinephrine in case of severe allergic reaction; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Treatment is requested at least 4 weeks prior to season of allergen being treated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> PA(s) (prior authorizations) may be processed for Oralair between the dates of December 1st thru March 31st of the current year of use; with PA requests being accepted 2 weeks prior to this period. Requests received after March 31st will not be processed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oral Anti-allergens will NOT be approved if patient meets ANY of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient experienced a severe reaction post initial dose administered in the physician’s office</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Request is during the active season of allergen (Ragweed season: August-November; Grass season: April-September)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has concomitant allergen immunotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has a history of severe, unstable, or uncontrolled asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has a history of eosinophilic esophagitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>NOTE:</strong> Oralair™ is recommended for patients ≥ 5 years of age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ragwitek™</td>
<td>NP</td>
<td>See prior authorization criteria for Grastek™</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>NOTE:</strong> Ragwitek™ is recommended only for patients ≥ 18 years of age</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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## RESPIRATORY

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

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<tr>
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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antihistamines, Nasal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>azelastine</td>
<td>P</td>
<td></td>
<td>2 bottles/30 days</td>
<td></td>
</tr>
<tr>
<td>olopatadine drops</td>
<td>P</td>
<td></td>
<td>1 bottle/30 days</td>
<td></td>
</tr>
<tr>
<td>Astepro*</td>
<td>NP</td>
<td>Will be approved for the following:</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trial and failure of TWO preferred intranasal corticosteroids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dymista*</td>
<td>NP</td>
<td>Recipient must be unable to take the two components individually.</td>
<td>1 bottle/30 days</td>
<td></td>
</tr>
<tr>
<td>Patanase*</td>
<td>NP</td>
<td></td>
<td>1 bottle/30 days</td>
<td></td>
</tr>
<tr>
<td><strong>Antihistamines, Oral Non-Sedating</strong> (Covered for recipients &lt; 21 years old only)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cetirizine</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>cetirizine chewable</td>
<td>P</td>
<td>Will be approved for patients who have clinically valid reason not to use liquid formulation</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>cetirizine/PSE</td>
<td>P</td>
<td></td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>levocetirizine tablets</td>
<td>P</td>
<td></td>
<td>1 tab/day</td>
<td></td>
</tr>
<tr>
<td>loratadine</td>
<td>P</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>loratadine RDT</td>
<td>P</td>
<td>Will be approved for patients who are:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unable to swallow, OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unable to absorb medications through the GI tract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>loratadine/PSE</td>
<td>P</td>
<td></td>
<td>12 Hour (2/day);</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>24 Hour (1/day)</td>
<td></td>
</tr>
<tr>
<td>Allegra*</td>
<td>NP</td>
<td></td>
<td>60mg (2/day);</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>180mg (1/day)</td>
<td></td>
</tr>
<tr>
<td>Allegra D*</td>
<td>NP</td>
<td></td>
<td>12 Hour (2/day);</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>24 Hour (1/day)</td>
<td></td>
</tr>
<tr>
<td>Allegra* ODT</td>
<td>NP</td>
<td>See loratadine RDT prior authorization criteria</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>Clarinex D*</td>
<td>NP</td>
<td></td>
<td>12 Hour (2/day);</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>24 Hour (1/day)</td>
<td></td>
</tr>
<tr>
<td>Clarinex* RediTabs*</td>
<td>NP</td>
<td>See loratadine RDT prior authorization criteria</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Clarinex* tabs</td>
<td>NP</td>
<td></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Clarinex* syrup</td>
<td>NP</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Clinical Criteria, Step Therapy, and Quantity Limits for TennCare Preferred Drug List (PDL)**
**RESPIRATORY**

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<tbody>
<tr>
<td><strong>Antihistamines, Oral Non-Sedating (Covered for recipients &lt; 21 years old only) (continued)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claritin D*</td>
<td>NP</td>
<td></td>
<td>12 Hour (2/day); 24 Hour (1/day)</td>
</tr>
<tr>
<td>Claritin* chewable</td>
<td>NP</td>
<td>Will be approved for patients who have clinically valid reason not to use liquid formulation</td>
<td>1/day</td>
</tr>
<tr>
<td>Claritin* tabs</td>
<td>NP</td>
<td></td>
<td>1/day</td>
</tr>
<tr>
<td>Claritin RediTabs*</td>
<td>NP</td>
<td>See loratadine RDT prior authorization criteria</td>
<td>1/day</td>
</tr>
<tr>
<td>desloratadine</td>
<td>NP</td>
<td></td>
<td>1/day</td>
</tr>
<tr>
<td>desloratadine ODT</td>
<td>NP</td>
<td>See loratadine RDT prior authorization criteria</td>
<td>1/day</td>
</tr>
<tr>
<td>fexofenadine</td>
<td>NP</td>
<td></td>
<td>60mg (2/day); 180mg (1/day)</td>
</tr>
<tr>
<td>fexofenadine/PSE</td>
<td>NP</td>
<td></td>
<td>12 Hour (2/day); 24 Hour (1/day)</td>
</tr>
<tr>
<td>levocetirizine solution</td>
<td>NP</td>
<td></td>
<td>10mL/day</td>
</tr>
<tr>
<td>Semprex*D</td>
<td>NP</td>
<td></td>
<td>4/day</td>
</tr>
<tr>
<td>Xyzal*</td>
<td>NP</td>
<td></td>
<td>1 tab or 10mL/day</td>
</tr>
<tr>
<td>Zyrtec* chewable</td>
<td>NP</td>
<td>Will be approved for patients who have clinically valid reason not to use liquid formulation</td>
<td>1/day</td>
</tr>
<tr>
<td>Zyrtec* tabs</td>
<td>NP</td>
<td></td>
<td>1/day</td>
</tr>
<tr>
<td>Zyrtec* ODT</td>
<td>NP</td>
<td>See loratadine RDT prior authorization criteria</td>
<td>1/day</td>
</tr>
<tr>
<td>Zyrtec D*</td>
<td>NP</td>
<td></td>
<td>1/day</td>
</tr>
</tbody>
</table>

**Beta Agonists: Combination Products**

<table>
<thead>
<tr>
<th>Medication</th>
<th>P</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dulera*</td>
<td>P</td>
<td>Will only be approved for the treatment of asthma or the treatment of other reversible airway disease(s) where optimal doses of inhaled steroids are being used and breakthrough symptoms require frequent use of inhaled short-acting bronchodilators.</td>
<td>1 inhaler/30 days</td>
</tr>
<tr>
<td>fluticasone/salmeterol</td>
<td>P</td>
<td>See AirDuo Resplicick* prior authorization criteria</td>
<td>1 inhaler/30 days</td>
</tr>
<tr>
<td>Symbicort*</td>
<td>P</td>
<td>See Advair Diskus* prior authorization criteria</td>
<td>1 inhaler/30 days</td>
</tr>
<tr>
<td>Wixela*</td>
<td>P</td>
<td>See Advair Diskus* prior authorization criteria</td>
<td>2 blisters/day</td>
</tr>
</tbody>
</table>

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
# RESPIRATORY

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beta Agonists: Combination Products (continued)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Advair Diskus*        | NP  | Will be approved if ONE of the following is met:
- For the treatment of asthma or the treatment of other reversible airway disease(s) where optimal doses of inhaled steroids are being used and breakthrough symptoms require frequent use of inhaled short-acting bronchodilators
- For the treatment of COPD where optimal doses of a long-acting beta agonist are being used and symptoms are still uncontrolled. | 2 blisters/day |                                              |
| Advair HFA*           | NP  | Will only be approved for the following:
- For the treatment of asthma or other reversible airway disease(s) where optimal doses of inhaled steroids are being used and breakthrough symptoms require frequent use of inhaled short-acting bronchodilators
- Will not be approved for the treatment of chronic obstructive pulmonary disease (COPD). | 1 inhaler/30 days | **Beta Agonist Combos**                      |
| AirDuo Respiclick*    | NP  | Will be approved for patients meeting the following:
- For the treatment of asthma or the treatment of other reversible airway disease(s) where optimal doses of inhaled steroids are being used and breakthrough symptoms require frequent use of inhaled short-acting bronchodilators;
- AND
- Trial and failure, contraindication or intolerance of TWO preferred agents | 1 inhaler/30 days |                                              |
| Breo Ellipta*         | NP  | See Advair Diskus' prior authorization criteria                                                                                                                                                                               | 2/day       |                                              |
| fluticasone/salmeterol| NP  | See AirDuo Respiclick* prior authorization criteria                                                                                                                                                                           | 1 inhaler/30 days |                                              |
| **Beta Agonists: Long Acting** |     |                                                                                                                                                                                                                                |             |                                              |
| Serevent Diskus*      | P   | • PA not required for individuals currently receiving both an inhaled corticosteroid and a short-acting beta-agonist (based on a 90-day systematic claims review).
• Approved if ONE of the following criteria is met:
  - A diagnosis of asthma (step 3 or higher, or moderate persistent to severe-persistent) and currently treated with an inhaled steroid and an inhaled short-acting beta-agonist
  **Note:** a short-acting beta-agonist should still be provided for acute symptom relief.
| 2 blisters/day | **General PA Form** |
| Arcapta™ Neohaler™   | NP  |                                                                                                                                                                                                                                | 1/day       |                                              |
| Striverdi® Respimat   | NP  |                                                                                                                                                                                                                                | 1/day       |                                              |
| **Beta Agonists: Nebulizer** |     |                                                                                                                                                                                                                                | 3 bottles of 20mL; 125 nebs/month | **General PA Form** |
| albuterol nebulizer solution | P    |                                                                                                                                                                                                                                |             |                                              |
| AccuNeb*              | NP  |                                                                                                                                                                                                                                | 125 nebs/month |                                              |

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# RESPIRATORY

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</thead>
<tbody>
<tr>
<td><strong>Beta Agonists: Nebulizer (continued)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Brovana*               | NP  | Will be approved if the following criteria are met:  
- Diagnosis of COPD; **AND**  
- Trial and failure, intolerance to, salmeterol DPI or formoterol DPI; **OR**  
- Difficulty using a dry powder inhaler (DPI).                                                                                                                                                                                               | 60 nebs/month   | PA Form |
| levalbuterol           | NP  | Authorized for patients with side effects to albuterol                                                                                                                                                                                          | 96 nebs/month   |         |
| Perforomist*           | NP  | Will be approved if the following criteria are met:  
- Diagnosis of asthma (step 3 or higher, or moderate persistent to severe-persistent) **AND** currently treated with an inhaled steroid and an inhaled short-acting beta-agonist; **OR**  
- Diagnosis of exercise-induced bronchospasm **WITH** trial and failure of a short-acting beta-agonist. ([Note: A short-acting beta-agonist should still be provided for acute symptom relief]; **OR**  
- Diagnosis of COPD; **AND**  
  - Trial and failure, intolerance to, salmeterol DPI or formoterol DPI; **OR**  
  - Difficulty using a dry powder inhaler (DPI).                                                                                                                                                                                                 | 60 nebs/month   | PA Form |
| Xopenex® nebulizer solution | NP | See levalbuterol prior authorization criteria                                                                                                                                                                                               | 96 nebs/month   |         |
| **Beta Agonists: Short-Acting MDI**                                                                                                                                                                                                                                                                  |
| albuterol HFA          | P   |                                                                                                                                                                                                                                             | 2 inhalers/ month |         |
| Proventil® HFA         | NP  |                                                                                                                                                                                                                                             | 2 inhalers/ month |         |
| levalbuterol HFA       | NP  | Authorized for patients with side effects from albuterol                                                                                                                                                                                     | 2 canisters (30g/month) |         |
| Maxair Autohaler*      | NP  |                                                                                                                                                                                                                                             | 1 inhaler/ month | General PA Form |
| ProAir® HFA            | NP  | See albuterol HFA prior authorization criteria                                                                                                                                                                                               | 2 inhalers/ month |         |
| ProAir Respliclick®    | NP  | See albuterol HFA prior authorization criteria                                                                                                                                                                                               | 2 inhalers/ month |         |
| Ventolin® HFA          | NP  | See albuterol HFA prior authorization criteria                                                                                                                                                                                               | 2 inhalers/ month |         |
| Xopenex® HFA           | NP  | See levalbuterol HFA prior authorization criteria                                                                                                                                                                                               | 2 canisters (30g/month) |         |

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## RESPIRATORY

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
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<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cystic Fibrosis Agents</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bethkis</strong></td>
<td>P</td>
<td>Will be approved if the patient has a diagnosis of Cystic Fibrosis</td>
<td>224mL/56 days</td>
<td></td>
</tr>
<tr>
<td><strong>Kitabis</strong></td>
<td>P</td>
<td>Will be approved if the patient has a diagnosis of Cystic Fibrosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pulmozyme</strong></td>
<td>P</td>
<td>Will be approved if the patient has a diagnosis of Cystic Fibrosis</td>
<td>5mL/day</td>
<td></td>
</tr>
<tr>
<td>tobramycin vial (excluding 1.2g vials)</td>
<td>P</td>
<td>Claims exceeding $200 will only be approved for diagnoses of Cystic Fibrosis or Pseudomonas Infection.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cayston</strong></td>
<td>NP</td>
<td>Will be approved if all the following have been met:</td>
<td>84mL/56 days</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Cystic Fibrosis; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trial and failure, contraindication, intolerance or resistance to preferred inhaled tobramycin product.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOBI® Podhaler and inhalation solution</strong></td>
<td>NP</td>
<td>Will be approved if all of the following have been met:</td>
<td>Podhaler: 224 caps/56 days; Solution: 280mL/56 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Cystic Fibrosis, <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>tobramycin nebulizer</td>
<td>NP</td>
<td>Will be approved if all of the following have been met:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of Cystic Fibrosis, <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trial and failure, intolerance or resistance to preferred inhaled tobramycin product</td>
<td></td>
<td></td>
</tr>
<tr>
<td>tobramycin solution 300mg/5mL</td>
<td>NP</td>
<td>See Tobi® Podhaler prior authorization criteria</td>
<td>280mL/56 days</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Cystic Fibrosis Agents: CFTR Potentiators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Kalydeco</strong></td>
<td>NP</td>
<td>Will be approved if ALL of the following have been met:</td>
<td>2/day</td>
<td>CFTR Potentiators PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Must be prescribed by a provider at a CF Center of Excellence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Age ≥ 6 months old</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lab documentation confirming patient has one mutation in the CFTR gene that is responsive to ivacaftor</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has received baseline liver function tests (ALT and AST)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has received baseline FEV1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Baseline ophthalmic examinations for patients 6 months to 18 years of age</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• NOTE: will NOT be approved for homozygous F508del mutation in the CFTR gene</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Duration of Initial PA approval: 6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal of prior authorization will be approved for patients meeting the following criteria:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improvement in at least one of the following compared to baseline:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Stable or improved FEV1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Decreased pulmonary exacerbations compared to pretreatment baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Improvement in BMI</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Duration of Renewal PA approval: 12 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### RESPIRATORY

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<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cystic Fibrosis Agents: CFTR Potentiators (continued)</strong></td>
<td></td>
<td></td>
<td></td>
<td>CFTR Potentiators Form</td>
</tr>
</tbody>
</table>
| Orkambi*         | NP  | Will be approved if ALL of the following have been met:  
• Must be prescribed by a provider at a CF Center of Excellence  
• Age ≥ 2 years old  
• Lab documentation confirming patient has homozygous F508del mutation in the CFTR gene  
• Baseline serum transaminases < 3x ULN and bilirubin < 2x ULN  
• Baseline ophthalmic examinations for patients 2 to 18 years of age  
• Duration of Initial PA approval: 6 months  
Renewal of prior authorization will be approved for patients meeting the following criteria:  
• Improvement in at least one of the following compared to baseline:  
  - Stable or improved FEV1; OR  
  - Decreased pulmonary exacerbations compared to pretreatment baseline; OR  
  - Improved BMI compared to pretreatment baseline  
• Renewal of prior authorizations will NOT be approved in the following situations:  
  - Patients with an ALT or AST greater than 5 times ULN when not associated with elevated bilirubin.  
  - Patients with an ALT or AST greater than 3 times ULN when associated with bilirubin elevations greater than 2 times ULN  
Duration of Renewal PA approvals: 12 months | 4/day       |         |
| Symdeko*         | NP  | Will be approved if the following is met: (Initial PA Duration: 6 months)  
• Must be prescribed by a provider at a CF Center of Excellence; AND  
• Age ≥ 6 years old  
• Lab documentation confirming patient is homozygous for the F508del mutation in the CFTR gene; OR  
  Have a baseline predicted FEV1 (renewal will require reported measurement within previous 30 days); AND  
• Patient does not have a known hypersensitivity to tezacaftor or ivacaftor  
Renewal Criteria: (PA duration 6 months)  
Will be approved for patients meeting the following criteria:  
• Patient has disease response as indicated by at least 1 or more of the following:  
  - Decreased pulmonary exacerbations compared to pretreatment baseline  
  - Improvement or stabilization of lung function compared to baseline  
  - Decrease in decline of lung function; OR improvement in quality of life, weight gain, OR growth; AND  
• Patient has not received a lung transplant; AND  
• Patient does not have evidence of toxicity from the drug (e.g., elevated transaminases [ALT or AST], cataracts). | 2/day       |         |

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### Respiratory

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<table>
<thead>
<tr>
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<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>montelukast tabs and chewables</td>
<td>P</td>
<td><strong>Leukotriene Receptor Antagonists</strong></td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td>Accolate*</td>
<td>NP</td>
<td>• Recipients less than 3 years of age: no prior authorization required.</td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>montelukast granules</td>
<td>NP</td>
<td>• Recipients 12 years and younger:</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Will be approved ONLY for patients who have clinically valid reason not to use chewable tablets</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recipients &gt; 12 years old:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of asthma or exercise-induced bronchoconstriction (EIB) documented with concomitant use of at least one other asthma medication; OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For treatment of seasonal allergic rhinitis OR chronic idiopathic urticaria, patient must have failed trial of an intranasal corticosteroid OR a non-sedating antihistamine; AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Will be approved ONLY for patients who have clinically valid reason not to use chewable tablets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Singulair* tabs and chewables</td>
<td>NP</td>
<td>• Recipients 12 years and younger: subject to PDL criteria ONLY</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Singulair* granules</td>
<td>NP</td>
<td>• Recipients 12 years and younger:</td>
<td>1/day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Will be approved ONLY for patients who have clinically valid reason not to use chewable tablets</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recipients &gt; 12 years old:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosis of asthma or exercise-induced bronchoconstriction (EIB) documented with concomitant use of at least one other asthma medication; OR</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>• For treatment of seasonal allergic rhinitis OR chronic idiopathic urticaria, patient must have failed trial of an intranasal corticosteroid OR a non-sedating antihistamine; AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Will be approved ONLY for patients who have clinically valid reason not to use chewable tablets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>zafirlukast</td>
<td>NP</td>
<td></td>
<td>2/day</td>
<td></td>
</tr>
<tr>
<td>zileuton CR</td>
<td>NP</td>
<td></td>
<td>4/day</td>
<td></td>
</tr>
<tr>
<td>Zyflo*</td>
<td>NP</td>
<td></td>
<td>4/day</td>
<td></td>
</tr>
<tr>
<td>Zyflo CR *</td>
<td>NP</td>
<td></td>
<td>4/day</td>
<td></td>
</tr>
</tbody>
</table>

### Mast Cell Stabilizers

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>cromolyn</td>
<td>P</td>
<td></td>
<td>120 vials/month</td>
<td>General PA Form</td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td><strong>Miscellaneous: OTC Products</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peak Flow Meters</td>
<td></td>
<td></td>
<td>4 per 365 days</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Spacers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Phosphodiesterase 4 Inhibitor**

<table>
<thead>
<tr>
<th>Daliresp*</th>
<th>NP</th>
<th>Daliresp* will be approved for recipients meeting the following criteria:</th>
<th></th>
<th>General PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Diagnosis of COPD associated with chronic bronchitis, <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient is currently receiving standard of care COPD treatments, unless contraindicated (short acting β agonists OR short acting anticholinergics <strong>PLUS</strong> long acting β agonists OR long acting anticholinergics), <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient has a history of continued COPD exacerbations on their current COPD treatment regimen.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Non-Narcotic Antitussives**

<table>
<thead>
<tr>
<th>benzonatate</th>
<th>P</th>
<th>No PA required for recipients &gt; 11 years old.</th>
<th>3/day</th>
<th>General PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Will be approved for children ≤ 10 if the prescriber verifies:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Patient has no trouble swallowing capsules whole, <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>− Physician is aware that, if chewed, benzonatate may cause numbness of the mouth, tongue, throat, and esophagus, increasing the risk of choking.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tessalon*</td>
<td>NP</td>
<td>See benzonatate prior authorization criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tessalon Perles*</td>
<td>NP</td>
<td>See benzonatate prior authorization criteria</td>
<td>3/day</td>
<td></td>
</tr>
<tr>
<td>Zonatuss*</td>
<td>NP</td>
<td>See benzonatate prior authorization criteria</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Steroids: Intranasal**

| budesonide nasal (OTC)       | P   | 2 per 30 days                                                                                 |             | General PA Form |
| fluticasone propionate       | P   | 1 per 30 days                                                                                 |             |                 |
| Nasacort* (OTC)              | P   | 2 per 30 days                                                                                 |             |                 |
| Beconase AQ*                 | NP  | 2 per 30 days                                                                                 |             |                 |
| budesonide nasal (Rx only)   | P   | 2 per 30 days                                                                                 |             |                 |
| Flonase*                     | NP  | 1 per 30 days                                                                                 |             |                 |

Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.

### RESPIRATORY

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>mometasone furoate NP</td>
<td></td>
<td>1 per 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasacort AQ*</td>
<td>NP</td>
<td>1 per 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasonex®</td>
<td>NP</td>
<td>1 per 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Omnaris®</td>
<td>NP</td>
<td>1 per 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qnasl®</td>
<td>NP</td>
<td>1 per 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rhinocort Aqua*</td>
<td>NP</td>
<td>2 per 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>triamcinolone acetonide</td>
<td>NP</td>
<td>1 per 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veramyst®</td>
<td>NP</td>
<td>1 per 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Xhance*</td>
<td>NP</td>
<td>Will be approved if the following is met:</td>
<td>2 per 30 days</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has been diagnosed with nasal polyps; AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has a trial/failure, contraindication, or intolerance to at least 2 preferred nasal corticosteroid agents; AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has a clinically valid reason as to why preferred fluticasone propionate products cannot be used</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zetonna®</td>
<td>NP</td>
<td>1 per 30 days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Steroids: Orally Inhaled

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asmanex Twalphaler®</td>
<td>P</td>
<td>1/30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flovent HFA*</td>
<td>P</td>
<td>2/30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aerospan®</td>
<td>NP</td>
<td>2/30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alvesco®</td>
<td>NP</td>
<td>2/30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arnuity Ellipta®</td>
<td>NP</td>
<td>1 blister/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asmanex HFA®</td>
<td>NP</td>
<td>1/30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>budesonide respules</td>
<td>NP</td>
<td>PA not required for beneficiaries ages 6 and under.</td>
<td>0.25 and 0.5mg/2mL (2 vials/day); 1mg/2mL (1 vial/day)</td>
<td></td>
</tr>
</tbody>
</table>
### RESPIRATORY

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Steroids: Orally Inhaled (continued)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flovent Diskus*</td>
<td>NP</td>
<td></td>
<td>50mcg (2 blisters/day); 100mcg (4 blisters/day) 250mcg (8 blisters/day)</td>
<td>General PA Form</td>
</tr>
<tr>
<td>Pulmicort Flexhaler*</td>
<td>NP</td>
<td></td>
<td>2/30 days</td>
<td></td>
</tr>
<tr>
<td>Pulmicort Respules*</td>
<td>NP</td>
<td></td>
<td>See budesonide respules</td>
<td></td>
</tr>
<tr>
<td>QVAR Redihaler*</td>
<td>NP</td>
<td></td>
<td>2/30 days</td>
<td></td>
</tr>
</tbody>
</table>

### SMOKING CESSATION AGENTS

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Smoking Cessation Agents</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>bupropion sustained release</td>
<td>P</td>
<td></td>
<td>2/day; Adults: 24 weeks/yr*</td>
<td></td>
</tr>
<tr>
<td>Chantix*</td>
<td>P</td>
<td></td>
<td>Adults: 24 weeks/yr*</td>
<td>General PA Form</td>
</tr>
<tr>
<td>nicotine polacrilex gum</td>
<td>P</td>
<td></td>
<td>Adults: 24 weeks/yr*</td>
<td>General PA Form</td>
</tr>
<tr>
<td>nicotine polacrilex lozenge</td>
<td>P</td>
<td></td>
<td>Adults: 24 weeks/yr*</td>
<td>General PA Form</td>
</tr>
<tr>
<td>nicotine transdermal patch</td>
<td>P</td>
<td></td>
<td>Adults: 24 weeks/yr*</td>
<td></td>
</tr>
<tr>
<td>Nicotrol® inhaler</td>
<td>NP</td>
<td></td>
<td>Adults: 24 weeks/yr*</td>
<td></td>
</tr>
<tr>
<td>Nicotrol® nasal spray</td>
<td>NP</td>
<td></td>
<td>Adults: 24 weeks/yr*</td>
<td></td>
</tr>
<tr>
<td>Zyban*</td>
<td>NP</td>
<td></td>
<td>2/day; Adults: 24 weeks/yr*</td>
<td></td>
</tr>
</tbody>
</table>

* For children, larger quantities may be approved as medically necessary.

**Note:** All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.
### VITAMINS/ELECTROLYTES

Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.

<table>
<thead>
<tr>
<th>Medication</th>
<th>PDL</th>
<th>Prior Authorization Criteria</th>
<th>Qty. Limits</th>
<th>PA Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cystine Depleting Agent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procysbi®</td>
<td>NP</td>
<td>Will be approved for a diagnosis of cystinosis</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td><strong>Folic Acid Preparations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l-methylfolate (OTC)</td>
<td>NP</td>
<td>Will be approved if the following are met:</td>
<td></td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has documented methylenetetrahydrofolate reductase (MTHFR) mutation / deficiency; AND</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Age &lt; 21 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Potassium Depletors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lokelma®</td>
<td>NP</td>
<td>Initial Request</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Will be approved if the following is met:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient must be ≥ 18 years of age; <strong>AND</strong></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has a diagnosis of chronic hyperkalemia; <strong>AND</strong></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has tried/failed a preferred potassium depleter agent.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal Request</td>
<td>1/day</td>
<td>General PA Form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Will be approved if the following is met:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient meets initial criteria; <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has not experienced treatment-limiting adverse effects (e.g., edema); <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient has documented efficacy [e.g., decreasing serum potassium levels or levels within normal limits [3.5 to 5 mEq/L]].</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veltassa®</td>
<td>NP</td>
<td></td>
<td>1 packet/day</td>
<td></td>
</tr>
<tr>
<td><strong>Vitamin K Products</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mephyton®</td>
<td>P</td>
<td></td>
<td>5/Rx</td>
<td>General PA Form</td>
</tr>
<tr>
<td><strong>Zinc Supplements</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Galzin* (zinc acetate)</td>
<td>NP</td>
<td>Will be approved for a diagnosis of Wilson’s disease and intolerance to zinc sulfate.</td>
<td></td>
<td>General PA Form</td>
</tr>
</tbody>
</table>

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