

UCare Prior Authorization Criteria for Minnesota Health Care Programs

Note: 1) The criteria listed are the minimum to approve coverage for purposes of utilization management. In all cases it is expected that drugs will be used in conformity with FDA guidance regarding dosage, contraindications, warnings and clinical monitoring even though these are not included in the criteria. 2) "Treatment Failure" means that an accepted treatment has been tried for a reasonable time and has either not been tolerated or has not produced a satisfactory clinical response.

DRUGS	PRIOR AUTHORIZATION CRITERIA
Actiq (fentanyl)	<p>Approve 12 months of therapy with Actiq if the following criteria have been met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of cancer or other terminal pain; AND 2. The patient is opioid tolerant (has been on morphine 60mg/day, fentanyl patch 25mcg/hr, oxycodone 30mg/day, hydromorphone 8mg/day or an equianalgesic dose of another opioid for a week or longer).
Amphetamines (dextroamphetamine, dextroamphetamine mixed salts, methamphetamine)	<p>Approve 12 months of therapy with generic amphetamine if the following criteria have been met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of attention deficit disorder (ADD) or attention deficit disorder with hyperactivity (ADHSD); OR 2. The patient has a diagnosis of narcolepsy, OR 3. The patient has a diagnosis of major depressive disorder.
Aranesp (darbopoeitin alfa)	<p>Approve 12 months of therapy with Aranesp if the following criteria have been met:</p> <ol style="list-style-type: none"> 1. The patient has anemia associated with CRF and the patient Hb is $\leq 11.0\text{g/dL}$ OR the patient has previously been on darbopoetin alfa or epoetin alfa and the Hb is $\leq 12.0\text{g/dL}$. <p>Approve 4 months of therapy with Aranesp if the following criteria have been met:</p> <ol style="list-style-type: none"> 1. The patient has anemia associate with concomitant chemotherapy and the patient's Hb is $\leq 10.0\text{g/dL}$ OR the Hb is $\leq 12.0\text{g/dL}$ and the physician anticipates a Hb decrease or the patient has co-morbidities that require higher Hb levels. <p>Approve 6 months of therapy with Aranesp if the following criteria have been met:</p> <ol style="list-style-type: none"> 1. The patient has anemia associate with myelodysplastic syndrome (MDS) and the patient Hb is $\leq 12.0\text{g/dL}$; OR 2. The patient has New York Heart Association functional class III heart failure and the Hb is $\leq 10.0\text{g/dL}$ AND the underlying causes of anemia have been evalutated AND whose anemia persists despite transfusions OR have contraindications to transfusions (e.g.; fluid overload). An additional 6 months of Aranesp may be allowed if the Hb remains $\leq 12.0\text{g/dL}$.

Avonex or Rebif (interferon beta-1a)	Approve 12 months of therapy with Avonex or Rebif if the following criteria have been met: <ol style="list-style-type: none"> 1. The patient has a diagnosis of relapsing-remitting multiple sclerosis; OR 2. The patient has a diagnosis of secondary progressive multiple sclerosis and is currently taking Avonex or Rebif.
Betaseron (interferon beta-1b)	Approve 12 months of therapy with Betaseron if the following criteria have been met: <ol style="list-style-type: none"> 1. The patient has a diagnosis of relapsing-remitting multiple sclerosis; OR 2. The patient has a diagnosis of secondary progressive multiple sclerosis and is currently taking Betaseron.
Byetta (exenatide)	Approve 12 months of therapy with Byetta if the following criteria have been met: <ol style="list-style-type: none"> 1. The patient has a diagnosis of Type 2 diabetes mellitus; AND 2. The patient has received treatment with metformin (alone or in combination with a sulfonylurea or thiazolidinedione) and failed to achieve adequate glycemic control; OR 3. The patient has received treatment with a sulfonylurea (alone or in combination with metformin) and failed to achieve adequate glycemic control; OR 4. The patient has received treatment with a thiazolidinedione (alone or in combination with metformin) and failed to achieve adequate glycemic control; OR 5. All three of the above classes of medications (metformin, sulfonylurea, thiazolidinedione) are contraindicated for this patient (e.g., due to drug interactions or because the patient was unable to tolerate treatment).
Celebrex (celecoxib)	Approve 12 months of therapy with Celebrex if the following criteria have been met: <ol style="list-style-type: none"> 1. The patient is at least 18 years of age; AND 2. The patient has a diagnosis of familial adenomatous polyposis (FAP); OR 3. The patient has a diagnosis of osteoarthritis, rheumatoid arthritis, ankylosing spondylitis, primary dysmenorrhea, or acute pain and at least one of the following: <ol style="list-style-type: none"> a) The patient has a coagulation disorder due to platelet dysfunction; OR b) The patient has a history of peptic ulcer disease or GI bleeding; OR c) The patient has failed or is unable to tolerate at least 2 prescription strength NSAIDs in the last 6 months.
Copaxone (glatiramer)	Approve 12 months of therapy with Copaxone if the following criteria have been met: <ol style="list-style-type: none"> 1. The patient has a diagnosis of relapsing-remitting multiple sclerosis; OR 2. The patient has a diagnosis of secondary progressive multiple sclerosis.

DDAVP or Minitran (desmopressin)	<p>Approve 12 months of therapy with generic desmopressin if the following criteria have been met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of central cranial diabetes insipidus; OR 2. The patient has a diagnosis of primary nocturnal enuresis; AND 3. The patient is at least six years of age; AND 4. The patient has tried and failed the use of an enuresis alarm or other nonpharmacologic therapy. <p>Note – only the tablet form will be approved for members <18 years of age.</p>
Enbrel (etanercept)	<p>Approve 12 months of therapy with Enbrel if the following criteria are met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of one of the following: juvenile rheumatoid arthritis (JRA), rheumatoid arthritis (RA), psoriatic arthritis, ankylosing spondylitis (AS) or plaque psoriasis; AND 2. The patient is at least 18 years of age for any diagnosis other than juvenile arthritis; AND 3. For a patient with arthritis, the patient has tried and failed at least one of the following: leflunomide (Arava), hydroxychloroquine (Plaquenil), methotrexate, sulfasalazine (Azulfidine), d-penicillamine (Cuprimine), or azathioprine (Imuran) OR the patient is currently taking methotrexate; OR 4. For a patient with a diagnosis of plaque psoriasis, the patient has tried at least one antipsoriatic therapy (e.g., topical steroids, PUVA).
Epogen or Procrit (epoetin alfa)	<p>Approve 12 months of therapy with Epogen/Procrit if the following criteria have been met:</p> <ol style="list-style-type: none"> 1. The patient has anemia associated with CRF and the patient Hb is $\leq 11.0\text{g/dL}$ OR the patient has previously been on darbopoetin alfa or epoetin alfa and the Hb is $\leq 12.0\text{g/dL}$; OR 2. The patient has anemia associated with HIV treatment if the Hb is $< 10.0\text{g/dL}$ OR endogenous erythropoietin levels are < 5000 for therapy initiation; OR 3. The patient has anemia associated with ribavirin therapy for Hepatitis C; AND if the Hb $\leq 10.0\text{g/dL}$. <p>Approve 4 months of therapy with Aranesp if the following criteria have been met:</p> <ol style="list-style-type: none"> 1. The patient has anemia associate with concomitant chemotherapy and the patient Hb is $\leq 10.0\text{g/dL}$ OR the Hb is $\leq 12.0\text{g/dL}$ and the physician anticipates a Hb decrease or the patient has co-morbidities that require higher Hb levels. <p>Approve 6 months of therapy with Aranesp if the following criteria have been met:</p> <ol style="list-style-type: none"> 1. The patient has anemia associate with myoplastic syndrome (MDS) and the patient Hb is $\leq 12.0\text{g/dL}$; OR 2. The patient has New York Heart Association functional class III heart failure and Hb is $\leq 10.0\text{g/dL}$ and the underlying causes of anemia have been evalutated and whose anemia persists despite transfusions or have contraindications to transfusions (e.g.; fluid overload). An additional 6 months

	<p>of Aranesp may be allowed if the Hb remains \leq 12.0g/dL.</p> <p>Approve 1 month of therapy with Epogen/procrit if the following criteria have been met:</p> <ol style="list-style-type: none"> 1. The patient is undergoing major surgery utilizing hemodilution intraoperatively. <p>Approve 21 days of therapy with Epogen/Procrit if the following criteria have been met:</p> <ol style="list-style-type: none"> 1. The patient is scheduled to undergo elective, noncardiac, nonvascular surgery to reduce the need for allogenic blood transfusions secondary to significant anticipate blood loss; AND the Hb \leq 13.0g/dL
Humira (adalimumab)	<p>Approve 12 months of therapy with Humira if the following criteria are met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of one of the following: juvenile rheumatoid arthritis (JRA), rheumatoid arthritis (RA), psoriatic arthritis, ankylosing spondylitis (AS), plaque psoriasis, or Crohn's disease; AND 2. The patient is at least 18 years of age for any diagnosis other than juvenile arthritis; AND 3. For a patient with arthritis, the patient has tried and failed at least one of the following: leflunomide (Arava), hydroxychloroquine (Plaquenil), methotrexate, sulfasalazine (Azulfidine), d-penicillamine (Cuprimine), or azathioprine (Imuran); OR 4. For a patient with a diagnosis of plaque psoriasis, the patient has tried at least one antipsoriatic therapy (e.g., topical steroids, PUVA); OR 5. For patient's with Crohn's disease, the patient has had an inadequate response to conventional therapy OR a loss of response to or inability to tolerate infliximab (Remicade).
Kineret (anakinra)	<p>Approve 12 months of therapy with Kineret if the following criteria are met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of rheumatoid arthritis; AND 2. The patient is at least 18 years of age; AND 3. The patient has tried and failed at least one of the following: leflunomiide (Arava), hydroxychloroquine (Plaquenil), methotrexate, sulfasalazine (Azulfidine), d-penicillamine (Cuprimine), or azathioprine (Imuran).
Provigil (modafinil)	<p>Approve 12 months of therapy with Provigil if the following criteria are met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of excessive daytime sleepiness due to narcolepsy; OR 2. The patient has a diagnosis of obstructive sleep apnea/hypopnea syndrome; OR 3. The patient has a shift work sleep disorder; OR 4. The patient has severe fatigue associated with multiple sclerosis.

Stimate (desmopressin nasal solution)	Approve 12 months of therapy with Stimate if the following criteria are met: <ol style="list-style-type: none"> 1. The patient has a diagnosis of Hemophilia A with Factor VIII coagulant activity level of > 5%; OR 2. The patient has a diagnosis of mild to moderate Type I Von Willebrand's disease and Factor VIII coagulant activity level > 5% with no evidence of an abnormal molecular form of Factor VIII antigen.
Tretinoins	Approve 12 months of therapy with tretinoin if the following criteria are met: <ol style="list-style-type: none"> 1. The patient has a diagnosis of acne vulgaris OR acne rosacea OR actinic keratosis. <p>Note – PA not required if patient < 26 years of age.</p>
Xenical (orlistat)	Approve 12 months of therapy with tretinoin if the following criteria are met: <ol style="list-style-type: none"> 1. The patient is at least 12 years of age; AND 2. The patient has a diagnosis of Diabetes Mellitus; OR 3. The patient has a diagnosis of hyperlipidemia.
Xolair (omalizumab)	Approve 12 months of therapy with Xolair for patients who meet the following criteria: <ol style="list-style-type: none"> 1. The patient is at least 12 years of age; AND 2. The patient has a diagnosis of moderate to severe persistent asthma; AND 3. The patient has had a positive skin test or <i>in vitro</i> reactivity to a perennial aeroallergen; AND 4. The patient has been inadequately controlled with inhaled corticosteroids; AND 5. The patient's baseline IgE serum level is between 30 and 700 IU/mL.
Zyvox (linezolid)	Approve a one time course of therapy with Zyvox if the following criteria are met: <ol style="list-style-type: none"> 1. Therapy was initiated in an institutional setting and additional drug is required to complete therapy; OR 2. Culture and sensitivity testing demonstrate that the bacteria are susceptible to Zyvox AND <ol style="list-style-type: none"> a) The patient experienced a failure on alternative antimicrobial therapy OR b) The patient has an intolerance, allergy or contraindication to alternative antimicrobial therapies.