

**Simply Healthcare Plans Medicaid 2012  
Prior Authorization Requirements**

<b>Prior Authorization Drug Name/Category</b>	<b>Covered with PA</b>	<b>Covered without PA</b>	<b>Not Covered</b>
Xeloda (capecitabine)	X		
Pulmozyme (dornase alfa inhalation solution)	X		
Lovenox (enoxaparin)	X		
Xolair (omalizumab)	X		
Procrit (epoetin alfa)	X		
Neupogen (filgrastim)	X		
Copaxone (glatiramer)	X		
Infergen (interferon alfacon-1)	X		
Avonex (interferon beta-1a)	X		
Betaseron (interferon beta-1b)	X		
Dexferrum, Infed (inron dextran inj)	X		
Lupron Depot, Lupron Depot Ped (leuprolide acetate)	X		
Peg-Intron (peginterferon alfa-2b)	X		
Rebetol (ribaririn-Ribasphere)	X		
Depo Testosterone Injection (testosterone cypionate inj)	X		
Synagis	X		
Intron A	X		
Botox	X		
Androgel	X		
Hepsera	X		
Pegasys	X		
Copegus	X		
Pentam Injection	X		
Vancocin	X		
Ketek	X		
E.S.P Suspension	X		
Vidaza	X		
Zoladex	X		
Etoposide	X		
Ifosfamide	X		
Androxy Tab	X		
Android Cap	X		
Androderm Dis	X		
Provigil	X		
Methadone	X		
Oxycodone	X		
Nalbuphine Injection	X		
Fragmin Injection	X		
Heparin Sod Injection	X		
Innohep Injection	X		
Serostim	X		
Enbrel Injection	X		

Gold Sodium Thiomalate Injection	X		
Humira	X		
Kineret	X		
Tobi Neb	X		
Ceftriaxone Injection	X		
Symlyn	X		
Ondansetron	X		
Itraconazole Cap	X		
Fuzeon	X		
Selzentry Tab	X		
Seroquel 25mg, 50mg &100mg	X		
Singulair	X		
Tracleer	X		
All Injectibles (except for insulins, cyanocobalamin injection, medroxypr ac injection, depo-estradiol injection, dihydroergot injection, doxycycl hyc injection, ampicillin injection, bicillin c-r injection, oxacillin injection, penicillin gk injection, )	X		

### **Additional Prior Authorization Requirements**

#### **Simvastatin**

- First fill for new members will process. All remaining fills will require a PA for Simvastatin 80mg dose. The FDA strongly advises against the high dose for risk of myopathy, characterized by muscle weakness and/or pain.

#### **HIV/AIDS Drugs**

- Require a PA for anyone older than 1 year. One-month overrides are permitted to allow time for the verification form to be submitted to Medicaid.

#### **CIII and CIV Drugs**

- Maximum of four prescriptions per 30 days. PA required for fifth prescription per month.

#### **CII Drugs**

- Pain Management patients may receive up to 4 CII prescriptions per month. PA required for fifth prescription per month.
- Oncology and sickle cell patients may receive up to 6 CII prescriptions per month. PA required for seventh prescription per month.

#### **Antipsychotics**

- PA required for children up to age 6
- Require a PA for children ages 6-12 when the dose exceeds high dose limits listed in the chart below.

**Simply Healthcare Plans Medicaid 2012  
Step Therapy Requirements**

<b>Step Therapy</b>	<b>Criteria</b>	<b>Apply Step Therapy Criteria?</b>
<b>Antibiotics</b>	Must have tried and failed Amoxicillin, Ampicillin, Generic Augmentin, Cefpodoxime, Cephalexin, Ciprofloxacin, Clindamycin, Dicloxacillin, Doxycycline, Dynapen susp, Erythromycin, Penicillin, SMZ-TMP, Sumycin or Tetracycline within last 30 days prior to utilizing Avelox, Ceclor, Ceftin, Cefzil, Duricef, Noroxin, or Omnicef	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Antidiabetics</b>	Must have tried and failed Metformin prior to utilizing Actos, Actoplus Met, Avandia, Avandaryl, Avandamet, Duetact, Januvia, or Janumet	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Angiotensin II Receptor Block</b>	Must have tried and failed an ACE Inhibitor prior to utilizing Benicar, Benicar HCT, Micardis or Micardis HCT	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>HMG-CoA Reductase Inhibitors</b>	Must have tried and failed Simvastatin prior to utilizing Crestor or Vytorin	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Antiasthmatic</b>	Must have tried and failed a Formulary Antiasthmatic prior to using Advair or Symbicort	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Urinary Antispasmodics</b>	Must have tried and failed Oxybutynin prior to utilizing Detrol, Detrol LA or Ditropan XL	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Antihistamines</b>	Must have tried and failed Loratadine syrup prior to utilizing Cetrizine syrup or Fexofenadine suspension	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Bronchodilators</b>	Must have tried and failed Albuterol prior to utilizing Spiriva	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Pediculicides</b>	Must have tried and failed Elimite, Lice B Gone, RID or nix prior to utilizing Ovide (malathion)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Singular</b>	Must have tried and failed Advair, Serevent, Albuterol, Asmanex 120 Aer 220mcg, Combivent, Atrovent, Atrovent HFA, Ipratropium, Pulmicort Inhaler, Pulmicort suspension, Flovent Disk or Flovent HFA prior to utilizing Singular tabs or chewables	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Nasal Steroids</b>	Must have tried and failed fluticasone or flunisolide prior to utilizing Beconase AQ, Nasacort AQ or Rhinocort Sus Aqua	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No