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MEDICAL NECESSITY CRITERIA

DRUG CLASS	MEDICAL NECESSITY CRITERIA (NON COVERED DRUGS)
ALLERGIC REACTION/ (ANAPHYLAXIS) TREATMENT	ADRENACLICK
NASAL STEROIDS	BECONASE AQ, OMNARIS, QNASL, RHINOCORT AQUA, VERAMYST, ZETONNA, DYMISTA
OPHTHALMICS	LASTACAFT
ANTIVIRALS	VALTREX
BETA AGONISTS, SHORT ACTING	PROVENTIL HFA, VENTOLIN HFA, XOPENEX HFA
STEROID INHALANTS, BETA AGONIST COMBINATIONS, ANTICHOLINERGICS	AEROSPAN, ALVESCO, TUDORZA PRESSAIR
ASTHMA/COPD	SYMBICORT
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS (ADHD)	ADDERALL XR
FIBRATES	TRICOR
STATINS	ALTOPREV, LESCOL XL, LIPITOR, LIVALO
HMG CO-A REDUCTASE INHIBITOR COMBINATIONS	ADVICOR, LIPTRUZET
TOPICAL CORTICOSTEROIDS	APEXICON E, OLUX-E
DIABETES - BIGUANIDES	FORTAMET, GLUMETZA, RIOMET
DIABETES - DPP-4 INHIBITORS & COMBINATIONS	KAZANO, KOMBIGLYZE XR, NESINA, ONGLYZA, OSENI
DIABETES – INJECTABLE INCRETIN MIMETICS	BYETTA
DIABETES - INSULINS	APIDRA, HUMALOG, HUMALOG MIX 50/50, HUMALOG MIX 75/25, HUMULIN 70/30, HUMULIN N, HUMULIN R

DIABETES - THIAZOLIDINEDIONES	**ACTOS**
DIABETES – SODIUM-GLUCOSE CO-TRANSPORTER-2 (SGLT2) INHIBITORS	**FARXIGA**
DIABETES SUPPLIES	**BREEZE 2 STRIPS AND KITS, OTHER TEST STRIPS**
PROTON PUMP INHIBITORS	**PREVACID** **PROTONIX**
PROSTAGLANDIN ANALOGS	**LUMIGAN**
PLATELET AGGREGATION INHIBITORS	**PLAVIX**
ANGIOTENSIN II RECEPTOR ANTAGONIST AND COMBINATIONS	**ATACAND, ATACAND HCT, DIOVAN HCT, EDARBI, EDARBYCLOR, TEVETEN, TEVETEN HCT**
CALCIUM CHANNEL BLOCKERS	**NORVASC**
IBD/ULCERATIVE COLITIS	**ASACOL HD, DELZICOL**
MUSCULOSKELETAL AGENTS	**AMRIX**
OPIOID DEPENDENCE AGENTS	**SUBOXONE FILM**
URINARY ANTISPASMODICS	**DETROL LA, OXYTROL, TOVIAZ**
ORAL CORTICOSTEROIDS	**RAYOS**
NSAID/COMBINATIONS	**ARTHROTEC, DUEXIS, FLECTOR, NAPRELAN, PENNSAID, VIMOVO**
BPH AGENTS AND COMBINATIONS	**JALYN**
HYPNOTICS, NON-BENZODIAZEPINES	**INTERMEZZO, LUNESTA, ROZEREM**

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ANDROGENS	**ANDROGEL, NATESTO, TESTIM, TESTOSTERONE GEL, VOGELXO**
IMMUNOSUPPRESSANTS	**HECORIA**

Status: CVS Caremark Criteria
Type: Medical Necessity Criteria ***Ref # 717-A***

CRITERIA FOR APPROVAL

1. Is the requested drug being used for an FDA-Approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? Yes No

2. Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives below? Yes No
(If yes, documentation is required for approval)

(For internal use only, will not be printed on fax forms - Requirement: 3 in a class with 3 or more alternatives, 2 in a class with 2 alternatives, or 1 in a class with only 1 alternative).

Formulary alternatives are: PA ADMIN TO ENTER DRUG SPECIFIC ALTERNATIVES AND NUMBER OF ALTERNATIVES REQUIRED

Drug Name_____ Trial Year_____ Reason for Failure_____

Drug Name_____ Trial Year_____ Reason for Failure_____

Drug Name_____ Trial Year_____ Reason for Failure_____

[If yes, then no further questions.]

3. Does the patient have a documented clinical reason such as expected adverse reaction or contraindication that prevents them from trying the formulary alternatives listed below? Yes No
(If yes, documentation is required for approval)

Formulary alternatives are: PA ADMIN TO ENTER DRUG SPECIFIC ALTERNATIVES

Reason(s) the patient cannot try the formulary alternatives:
_____

Guidelines for Approval			
Duration of Approval		**12 Months**	
Set 1		**Set 2**	
Yes to question(s)	**No to question(s)**	**Yes to question(s)**	**No to question(s)**
1	None	1	2
2		3	

Internal Use Only – Mapping Instructions

	Yes	No
1.	Go to 2	Deny
2.	Approve, 12 months	Go to 3
3.	Approve, 12 months	Deny

RATIONALE

The intent of the criteria is to ensure that patients follow selection elements noted in labeling and/or practice guidelines in order to decrease the potential for inappropriate utilization. The intent of this Formulary Medical Necessity program is to confirm the appropriate coverage of the target drugs for patients. These criteria apply to all medications subject to formulary medical necessity not otherwise managed through drug specific criteria.

This policy is intended to ensure that medications subject to formulary medical necessity are utilized in accordance with FDA indications and uses found in the compendia of current literature including American Hospital Formulary Service Drug Information (AHFS), Micromedex, or current accepted guidelines.

If the prescriber provides evidence of trial and failure of 3 formulary alternatives (generics and/or formulary brands) in a class with 3 or more alternatives available, the request will be approved. If the prescriber provides evidence of trial and failure of 2 formulary alternatives (generics and/or formulary brands) in a class with 2 alternatives available, the request will be approved. If the prescriber provides evidence of trial and failure of 1 formulary alternative (generic and/or formulary brands) in a class where only one alternative exists, the request will be approved.

If the prescriber provides evidence of a clinical reason such as expected adverse reaction or contraindication that prevents the patient from trying the formulary alternatives, the request will be approved.

REFERENCES

N/A

Written by:	UM Development
Date Written:	11/2011
Revised:	(CS) 12/2011, 02/2012, (JK) 04/2012 (added weblink), (JK) 09/2012 (target drug updates) (CS) 10/2012 target drug updates, (NB) 07/2013, (NB) 10/2013 (removed Contour strips), (TM) 02/2014, (NB) 07/2014 (added Suboxone Film, changed name to combine 717-A and 708-A)
Reviewed:	Medical Affairs (WF) 11/2011, 12/2011, 02/2012, 05/2012; (DNC) 09/2012, KP (10/2012), (LS) 08/2013, (DC) 02/2014 External Review: 11/2012, 08/2013, 06/2014