Blue Cross Complete
Pharmacy Prior Authorization Guidelines

Medications that require prior authorization are identified as requiring prior authorization on the ***Blue Cross Complete Preferred Drug List***. Prior authorization helps ensure that safe, high-quality, cost-effective drug therapy is prescribed prior to the use of more expensive agents that may not have proven value over current formulary medications. The criteria for approval are based on current medical information and are approved by the Blue Cross Complete Pharmacy and Therapeutics Committee. If a drug requires prior authorization, either certain clinical criteria must be met, including previous treatment with one or more formulary agents, or other information must be provided, before coverage is approved.

The *Blue Cross Complete Preferred Drug List* is an abbreviated list and does not include all covered drugs. Drugs not included may be nonformulary and not covered. Requests for nonformulary drugs will only be considered when the following criteria have been met:

- The member has tried and failed to respond to an adequate trial of the available formulary agents from the same drug class, or the available formulary agents would pose an unnecessary risk to the member.
- The prescriber and Blue Cross Complete agree that it is medically necessary.
- The drug is not excluded from coverage by the State of Michigan's Medicaid program. (For details, refer to the list of drug exclusions in the "Blue Cross Complete pharmacy services" section of the *Blue Cross Complete Provider Manual*.)
- The drug is not part of the 100% Medicaid Health Plan Carve-Out, which is payable by the State of Michigan and not by Blue Cross Complete.

Authorization requests that do not include documentation of medical necessity or failure of formulary alternatives, as applicable, will be denied.

Brand-name drugs that are available as generics but that physicians prescribe or members request to be dispensed as written (DAW) are also nonformulary and are not covered. DAW requests may be considered for coverage if a serious event or a quality issue occurred while trying the covered generic version. The request must be determined to be medically necessary by the physician and approved by Blue Cross Complete. The physician must submit a completed *MedWatch* form to the FDA to document serious adverse events or a quality issue with the covered generic. A copy must also be included with the *Blue Cross Complete Medication Prior Authorization Request* form located at **MiBlueCrossComplete.com/providers**. Information regarding the FDA MedWatch program and the MedWatch online forms are available at **FDA MedWatch Program**.

Drug Class	Drugs Requiring Prior Authorization	Preferred Drug Alternatives	Criteria (Requires intolerance or treatment failure with a preferred drug unless otherwise noted.)
Anti-infectives			
Cephalosporins	Cedax®, Suprax®	Generic cephalosporins such as Keflex® (g), Omnicef® (g), Vantin® (g)	
Macrolides	Erythromycin base Filmtab®, Ketek®, PCE®, Zmax®	Biaxin XL® (g), erythromycin (g), Zithromax® (g)	
Quinolones	Avelox®, Factive®, Noroxin®	Cipro® XR (g), Floxin® (g), Levaquin® (g)	

Drug Class	Drugs Requiring Prior Authorization	Preferred Drug Alternatives	Criteria (Requires intolerance or treatment failure with a preferred drug unless otherwise noted.)
Antineoplastics and immunosuppressants			
Miscellaneous antineoplastic agents	Afinitor®, Bosulif®, Erivedge™, Hycamtin®, Jakafi®, Revlimid®, Stivarga®, Synribo®, Temodar®, Thalomid®, Xtandi®, Zytiga®		Requires FDA-approved indication
Cardiovascular			
Angiotensin receptor blockers	Atacand®, Atacand HCT®, Avapro® (g), Avalide® (g), Azor®, Benicar®, Benicar HCT®, Diovan® (g), Diovan HCT®, Exforge®, Micardis®, Micardis® HCT, Teveten® (g), Teveten® HCT	Cozaar® (g), Hyzaar® (g)	Requires intolerance with an ACE inhibitor and a preferred ARB
Cholesterol-lowering	Advicor®, Altoprev®, Crestor®, Lescol® XL, Simcor®, Vytorin®	Lipitor® (g), Mevacor® (g), Zocor® (g)	Altoprev, Crestor, Lescol XL, Vytorin: require intolerance or treatment failure with a high-dose generic statin (≥40 mg) Advicor, Simcor: require at least 3 months of successful treatment with the individual agents used concomitantly
	Pravachol® (g)	Lipitor® (g), Zocor®	
Miscellaneous	Tekturna®, Tekturna HCT®		Requires documentation that the member has experienced failure of or intolerance to or treatment failure with ALL of the following drug classes: diuretics, beta blockers, ACE inhibitors and ARBs
Central nervous system			
Migraine	Amerge® (g), Axert®, Frova®, Relpax®, Zomig ZMT®	Imitrex® (g)	
Muscle relaxants	Skelaxin® (g)	Robaxin® (g)	
Narcotics	Actiq® (g), Fentora®	Generic short-acting narcotics such as morphine sulfate IR (g), Roxanol™ (g), Tylenol® #3 (g), Vicodin ES® (g)	Requires a cancer diagnosis for coverage, tolerance to high doses of narcotics, and current use of long-acting narcotic. Approved for breakthrough pain management only

Drug Class	Drugs Requiring Prior Authorization	Preferred Drug Alternatives	Criteria (Requires intolerance or treatment failure with a preferred drug unless otherwise noted.)
Central nervous system (continued)			
Narcotics (continued)	Avinza®, Kadian®, OxyContin®	Generic long acting narcotics such as Fentanyl (g), MS Contin® (g), methadone (g), Oramorph (g)	Requires intolerance or treatment failure with one long-acting formulary agent, such as methadone, MS Contin (g), Oramorph (g) and Fentanyl patch (g)
NSAIDs	Celebrex®, Naprelan®	Generic NSAIDs such as Lodine® (g), Motrin® (g), Naprosyn® (g), Relafen® (g), Voltaren® (g)	Requires age ≥60 or concomitant use of oral steroids or risk of GI bleed (history of PUD, previous GI bleed, alcoholism)
Dermatology			
Topical steroids	Cloderm®, Cordran®, Halog®, Locoid Lipocream®, Pandel®	Generic topical steroids such as betamethasone, fluocinolone, triamcinolone Luxiq®, Olux E®	Topical steroids
Endocrinology			
Diabetic drugs	Actos®, Avandia®, Avandaryl®, Glumetza®, Prandin®, Starlix® (g)	Generic metformin and sulfonylureas	Requires intolerance or treatment failure with metformin and a sulfonylurea
	Glyset®	Precose® (g)	
	Byetta®, Victoza®, Januvia®	Generic metformin, generic sulfonylureas, and insulin	Requires intolerance or treatment failure with the following: insulin, metformin, sulfonylurea
	Invokana®, Invokamet®	Generic metformin	Requires members must try three months of metformin first.
	Janumet®, Janumet® XR, Actoplus Met® (g), Avandamet®	Generic metformin, generic sulfonylureas, and insulin	Requires member try at least three months of combination therapy with the individual agents that are in the combination product
	Symlin®	Generic metformin, generic sulfonylureas, and insulin	Requires failure to meet desired glucose control with insulin and concurrent treatment with insulin
Other	Korlym™	Ketoconazole or Metyrapone®	Approved for patients 18 years of age or older. Requires indication of hyperglycemia in patients with Cushing's syndrome who have diabetes mellitus type 2 or glucose intolerance and who are not candidates for surgery or radiotherapy OR where surgery or radiotherapy has failed.

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Gastrointestinal			
Proton pump inhibitors	Aciphex® (g), Nexium OTC®, Prevacid Solutab® (g), Zegerid® (g)	Prilosec (g), Prilosec OTC (g), Protonix (g), Prevacid OTC (g)	Requires intolerance or treatment failure with omeprazole and Protonix (g)
Lifestyle modification			
Smoking cessation drugs		Over-the-counter nicotine replacement therapy (e.g., generic lozenges, patches, gum), Chantix® and Zyban® (g)	
Weight loss drugs	Xenical®		Requires BMI >35 or >30 if comorbidities and member age is between 18 and 65 years. Coverage limited to 3 months. Additional coverage requires documented weight loss of 10 pounds. Lifetime maximum benefit is limited to 6 months.
Multiple sclerosis			
	Gilenya™		Requires FDA-labeled indication, h/o chicken pox, Varicella Zoster vaccine, or antibodies confirmed via serology; baseline ophthalmologic exam, baseline CBC, liver transaminase, bilirubin levels, baseline ECG where appropriate
	Aubagio®		FDA-labeled Indication
Obstetrics and gynecology			
Oral contraceptives	Amethia® Lo, Beyaz®, Camrese Lo®, Generess® FE, Gianvi®, Loryna™, Loestrin®, Loestrin® 24 FE, Minastrin 24 FE, Ortho Tri-Cyclen Lo®, Ovcon® 50, Vestora®, Zenchant™ FE, Zeosa™	Generic oral contraceptives such as Loestrin® FE (g), Seasonale® (g), Yasmin® (g)	Requires intolerance or treatment failure with two preferred drugs
Estrogens	Alora®, Estrogel®, Estring®, Menest®, Menostar®, Ogen® (g), Premarin®, Syntest®, Vivelle-Dot®	Estrace® (g)	

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Ophthalmology			
Anti-infectives	Vigamox®	Ciloxan® (g), Ocuflox® (g) Quixin® (g)	
Beta blockers	Betimol®, Betoptic S®	Betagan® (g), timolol (g)	
Glaucoma	Isopto® Carbachol, Miostat®, Phospholine Iodide®, Travatan®	Alphagan® (g), Alphagan® P(g), Azopt®, Cosopt® (g), Iopidine®, Isopto® Carpine (g), Lumigan®, Trusopt® (g), Xalatan® (g)	
Respiratory			
Inhaled beta-agonists	Short-acting beta-agonist: Xopenex HFA®	Ventolin® HFA	
	Long-acting beta-agonists: Foradil®	Serevent®	
Inhaled corticosteroids	Alvesco®, Asmanex®	Asmanex®, Flovent® HFA, Pulmicort®, Pulmicort Respules® (g), QVAR®	
Intranasal steroids	Beconase AQ®, Nasacort OTC®, Nasonex®, Omnaris®, Rhinocort Aqua®, Veramyst®, QNASL®	Flonase® (g), Nasacort (g)	
Miscellaneous	Zyflo®, Zyflo CR®	Singulair®	
	Daliresp®		Requires: • Prescriber is a pulmonologist • Diagnosis of chronic bronchitis FEV1 (forced expiratory volume at 1 second) is less than or equal to 70% of predicted • Concurrent use with a long acting broncodilator such as a beta agonist or an anticholinergic • Patient has experienced at least one COPD (chronic obstructive pulmonary disease) exacerbation within the past 12 months.
	Singulair® Granules		Requires: • Patient is 2 years of age or older • Documentation of inability to use chewable tablets

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Rheumatology / musculoskeletal			
Gout	Uloric®	Zyloprim® (g)	
Osteoporosis	Boniva®	Actonel®, Fosamax® (g)	
	Fortical	Miacalcin® (g)	
	Symlin®	Generic metformin, generic sulfonylureas, and insulin	Requires failure to meet desired glucose control with insulin and concurrent treatment with insulin
Urology			
Benign prostatic hypertrophy	Avodart®, Cardura® XL	Cardura® (g), Proscar® (g), Hytrin® (g), Flomax® (g) Uroxatral® (g)	
Incontinence	Detrol® LA, Enablex®, Oxytrol®, Myrbetriq®, Vesicare®	Ditropan XL® (g), Detrol® (g), Sanctura XR®, Sanctura®	
Miscellaneous			
Miscellaneous	Firazyr®		FDA-labeled indications
	Flolan®		Pulmonary artery hypertension with New York Heart Association Functional Class III or IV and World Health Organization Group I, unresponsive to conventional treatment
	Kalydeco™		Covered for patients with cystic fibrosis AND at least one G551D mutation in the CFTR gene
	Nuedexta®		Requires diagnosis of pseudobulbar affect (PBA) in patients with an underlying neurologic condition [e.g., multiple sclerosis (MS), stroke, amyotrophic lateral sclerosis (ALS)] and who experience episodes on a daily basis
	Adcirca®, Letairis®, Revatio®, Tracleer®, Flolan®, Tyvaso®, Ventavis®, Opsumit®, Remodulin®		Pulmonary artery hypertension with New York Heart Association Functional Class III or IV and World Health Organization Group I, unresponsive to conventional treatment
	Xenazine®		Requires FDA-approved indication