Highmark Clinical Management Programs

Prior Authorization Program: Prior authorization is necessary for coverage for certain medications. In these cases, clinical criteria, based on plan coverage conditions approved by the Pharmacy and Therapeutics Committee, must be met or other information must be provided before coverage is considered. Your doctor must submit documentation of the rationale for the use of the medication prior to dispensing. Drugs that typically require prior authorization and their uses are listed below.

To request a drug that requires prior authorization, your doctor should complete the medication request form and fax to 412-544-7546. Your physician may also call 1-800-600-2227 if a form is not available and one will be faxed to his or her office.

Please note, some drugs included under this program may be covered, excluded, or require prior authorization depending on the product and/or group specific requirements.

Prior Authorization	
Brand Name Drug/Drug Category	**Drug Use§**
Actiq / Fentora/ Onsolis	Cancer pain management (up to 120 units/month)
Adcirca	Pulmonary Arterial Hypertension
Afinitor	Advanced renal cell cancer
Amitiza	Chronic idiopathic constipation; Constipation predominant Irritable Bowel Syndrome
Androgens / Anabolic Steroids	Hormone deficiency
Arcalyst	Cryopyrin-Associated Periodic Syndromes
Chenodal	Gallstones
Cimzia	Crohn's Disease, Rheumatoid arthritis
Contraceptives (oral/injectable)*	Non-contraceptive use
Enbrel	Rheumatoid arthritis/psoriatic arthritis, ankylosing spondylitis, juvenile rheumatoid arthritis, psoriasis
Kineret	Rheumatoid arthritis
Fertility Medications*	Infertility
Forteo	Osteoporosis
Gleevec	Cancer treatment for chronic mylogenous leukemia (CML)
Growth Hormones	Hormone deficiency
Humira	Rheumatoid arthritis/psoriatic arthritis, ankylosing spondylitis, juvenile rheumatoid arthritis, psoriasis and Crohn's Disease
Ilaris	Cryopyrin-Associated Periodic Syndromes
Inteferons	Cancer treatment; liver disease
Iressa	Refractory non-small cell lung cancer
Letairis	Pulmonary Arterial Hypertension
Mecasermin/IGF-1	Primary insulin-like growth factor-1 deficiency or growth hormone gene deletion
Mozobil	Hematopoietic stem cell mobilization for collection and subsequent autologous transplantation
Nexavar	Kidney cancer and refractory liver cancer
Provigil/Nuvigil	Narcolepsy; obstructive sleep apnea
Revatio	Pulmonary arterial hypertension
Revlimid	Myelodysplastic Syndrome with deletion 5q chromosomal abnormality, Multiple myeloma
Savella	Fibromyalgia
Simponi	Rheumatoid arthritis/psoriatic arthritis, ankylosing spondylitis
Smoking cessation medications*	Smoking cessation
Sprycel	Cancer treatment for advanced CML; treatment of refractory Philadelphia chromosome positive ALL
Stelara	Psoriasis

Prior Authorization	
Brand Name Drug/Drug Category	Drug Use
Sutent	Cancer treatment for renal cell cancer and gastrointestinal stromal tumors (GIST)
Tarceva	Refractory non-small cell lung cancer or pancreatic cancer
Tasigna	Chronic-phase or accelerated-phase Philadelphia chromosome positive (Ph+) CML
Thalidomide	Multiple myeloma
Thrombopoiesis Stimulating Agents (Nplate; Promacta)	Chronic immune (idiopathic) thrombocytopenia purpura
Tracleer	Pulmonary arterial hypertension
Tykerb	Breast cancer treatment
Votrient	Advanced renal cell carcinoma (RCC)
Wellbutrin*	Depression
Xenazine	Chorea associated with Huntington's disease
Xyrem	Narcolepsy
Zolinza	Cutaneous T-cell lymphoma

*In some cases, individual group benefits may require prior authorization for smoking cessation, contraceptives, and/or fertility.
§See specific Highmark prior authorization policy for detailed approval criteria.

Quantity Level Limit Program: The following table contains a list of medications and the corresponding quantity level limits (number of units per prescription) that will be applied when members receive these medications through their prescription drug benefit. The edits do not limit the number of refills. Please note that each medication has both retail and mail-order quantity level limits. Quantity level limits are applied for a variety of reasons: (1) to prevent the stockpiling of medication; (2) to promote adherence to an appropriate course of therapy for reasons of efficacy and safety; and (3) to prevent medication misuse or abuse. Please take these limits into consideration when prescribing the medications listed in the following table.

Quantity Level Limits			
Drug Brand Name®	Drug Use	Retail Limit	Mail Order Limit
Actonel 35 mg	Osteoporosis	4 tablets	12 tablets
Actonel w/calcium	Osteoporosis	28 tablets	84 tablets
Actonel 75 mg tablets	Osteoporosis	2 tablets	6 tablets
Actonel 150 mg tablets	Osteoporosis	1 tablets	3 tablets
Amitiza	Chronic idiopathic constipation; IBS-C	60 capsules	180 capsules
Androgel pump (non-formulary)	testosterone replacement	4 pumps (2 packages)	12 pumps (6 packages)
Alora (non-formulary)	estrogen replacement	1 box (8 patches)	3 boxes (24 patches)
Boniva (non-formulary)	Osteoporosis	1 tablet	3 tablets
Byetta (non-formulary)	type II diabetes	1 pen	3 pens
Caverject[1]	impotency	6 injections	18 injections
Cialis[1] (non-formulary)	impotency	6 tablets	18 tablets
Climara (formulary) and Climara Pro (non-formulary)	estrogen replacement	1 box (4 patches)	3 boxes (12 patches)
Clomid / Serophene (clomiphene)[2]	ovulatory stimulant	Females only	Females only
Combipatch	estrogen replacement	8 patches	24 patches
Cordran Tape	anti-inflammatory	2 tapes	6 tapes
Diastat Rectal Gel	seizures	2 prefilled applicators	2 prefilled applicators
Edex[1] (non-formulary)	impotency	6 injections	18 injections
Elestrin™ 144 gm	estrogen replacement	1 metered pump	3 metered pumps
Emend (non-formulary)	anti-emetic	3 capsules	3 capsules
Emend 40mg (non-formulary)	anti-emetic	1 capsule	1 capsule
Esclim (non-formulary)	estrogen replacement	1 box (8 patches)	3 boxes (24 patches)
Estraderm	estrogen replacement	1 box (8 patches)	3 boxes (24 patches)
Estrasorb (non-formulary)	estrogen replacement	1 carton (56 pouches)	3 cartons (168 pouches)
Estrogel 93 gm (non-formulary)	estrogen replacement	1 metered-pump	2 metered-pumps
Estrogel 50 gm (non-formulary)	Estrogen replacement	1 metered-pump	3 metered-pumps

Quantity Level Limits			
Drug Brand Name®	**Drug Use**	**Retail Limit**	**Mail Order Limit**
Estring	estrogen replacement	1 ring	1 ring
EvaMist	estrogen replacement	1 metered-pump	3 metered-pumps
Evoclin	acne	1-100g or 2-50g containers	3-100g or 6-50g containers
Femring (non-formulary)	estrogen replacement	1 ring	1 ring
Forteo (prior auth required)	osteoporosis	1 multi-dose pen	3 multi-does pens
Fortical	Osteoporosis	1 bottle	3 bottles
Fosamax and Fosamax plus D, 35 mg and 70 mg	osteoporosis	4 tablets	12 tablets
Fosamax Oral Solution	osteoporosis	4 bottles (300 mL)	12 bottles (900 mL)
Gelnique (non-formulary)	overactive bladder	30 sachets	90 sachets
GlucaGen HypoKit	hypoglycemia	1 kit	1 kit
Glucagon Emergency Kit	Hypoglycemia	1 kit	1 kit
Levitra[1] (non-formulary)	impotency	6 tablets	18 tablets
LoSeasonique[6]	contraception	1 pack	1 pack
Lotronex[3]	irritable bowel-diarrhea (females >18)	60 tablets	180 tablets
Menostar (non-formulary)	estrogen replacement	1 box (4 patches)	3 boxes (12 patches)
Miacalcin Nasal Spray	osteoporosis	1 bottles	3 bottles
Muse[1]	impotency	6 suppositories	18 suppositories
Nascobal Gel	vitamin b-12 deficiency	1 bottle	2 bottles
Nuvaring	contraception	1 ring	3 rings
OrthoEvra	contraception	3 patches	9 patches
Oxytrol	overactive bladder	8 patches	24 patches
Plan B[4]	emergency contraceptive	1 kit per Rx	1 kit per Rx
Prozac (90 mg only) (non-formulary)	anti-depressant	4 tablets	12 tablets
Relenza[5]	flu	1 Diskhaler and Five Rotadisks	1 Diskhaler and Five Rotadisks
Sancuso	Granisetron transdermal system	3 patches	3 patches
Seasonale (non-formulary)[6]	contraception	1 pack	1 pack
Seasonique[6]	contraception	1 pack	1 pack
Stadol Nasal Spray (non-formulary)	acute pain management	1 inhaler	3 inhalers
Tamiflu[7]	flu	Ten 75mg capsules (5 days supply)	Ten 75mg capsules (5 days supply)
Toradol (non-formulary)	acute pain management	20 tablets	20 tablets
Twinject	Serious allergic reactions	2 devices	2 devices
Viagra[1]	impotency	6 tablets	18 tablets
Victoza	type II diabetes	3 pens	9 pens
Vivelle	estrogen replacement	1 box (8 patches)	3 boxes (24 patches)
Xifaxan 200 mg	travellers diarrhea	9 (200mg) tablets	9 (200mg) tablets
ZolpiMist (non-formulary)	Zolpidem tartrate oral spray	1 inhaler	1 inhalers

1. Drugs used to treat impotency are sold as a separate benefit from the Quantity Level Limit program. These drugs are either covered at the limits listed above or are excluded, depending on the particular group benefit.
2. Clomid®, Serophene® and the generic for both, clomiphene, may be excluded if the group excludes fertility coverage.
3. Lotronex® is covered for females ages 18 and over when used to treat irritable bowel syndrome.
4. Plan B® is not covered for ≥18 years of age; covered < 18 years
5. Coverage for Relenza® is limited to a five day supply of 1 diskhaler and five rotadisks per copayment in patients 7 years or older. Additional treatment courses (1 diskhaler and five rotadisks) will require an additional copayment.
6. Coverage for LoSeasonique® Seasonale® and Seasonique™ is limited to 1 Extended-Cycle Tablet Dispenser per 91 days. The Extended-Cycle Tablet Dispenser contains 3 blister packs containing a total of 91 tablets. Two packs contain 28 tablets each and the third pack contains 31 tablets.
7. Coverage for Tamiflu™ is limited to a five day supply of ten (10) 75mg capsules per copayment in patients 13 years or older. Additional treatment courses (ten 75mg capsules) will require an additional copayment.

MRxC Programs: The managed prescription drug coverage (MRxC) program consists of online edits that encourage the safe and effective use of targeted medications. Many of the criteria are automated in order to reduce the administrative burden on physicians and to reduce member disruption. All MRxC programs include a mechanism by which a patient's specific pattern of drug use is identified at the point of sale, and if the automated criteria are met, the claim will process automatically with no further authorization required. If the automated criteria are not met, the dispensing pharmacist will be prompted to have providers contact Highmark's Medical and Pharmacy affairs department for standard prior authorization processing.

Managed Prescription Drug Coverage (MRxC)	
Brand Name Drug/Drug Category	**Drug Use***
Cox-II Inhibitors	Pain in patients with independent risk factors for NSAID induced gastropathy or documented failure/intolerance to NSAIDS.
Proton Pump Inhibitors	*Dose limit.* High dose override available for gastroesophageal reflux disease, peptic ulcer disease, NSAID ulcer prophylaxis, and hypersecretory conditions.
Migraine Therapy	*Dose limit*. High dose override available upon documentation of migraine prophylaxis therapy.
Oral Antifungals	*Dose limit.* High dose override available for uses other than treatment of onychomycosis
Pain Management	*Dose limit.* High dose override available upon documentation that the additional quantity is necessary to provide adequate analgesia or for cancer diagnosis.
Leukotriene Receptor Antagonists	Asthma, allergic rhinitis, chronic urticaria, or eosinophilic esophagitis.
Subutex and Suboxone	*Dose limit.* Override available upon documentation of pregnancy (Subutex) or as long at total daily dose is not greater than 24 mg (Subutex and Suboxone).
Non-Stimulant Medications for ADHD	ADHD after trial of a stimulant, documented contraindication to a stimulant, or history of drug abuse/diversion.
Lyrica	Neuropathic pain associated with diabetic peripheral neuropathy (DPN) and postherpetic neuralgia (PHN); idiopathic neuropathy; seizure disorder; or fibromyalgia.
Erectile Dysfunction Therapy	Dose limit.
Cymbalta	Major depressive disorder, generalized anxiety disorder, fibromyalgia, neuropathic pain, and diabetic peripheral neuropathy (DPN).
Pristiq	Major depressive disorder
Atypical Antipsychotics	Schizophrenia, bipolar mania, autism spectrum disorder, and as adjunctive treatment of major depressive disorder.
Uloric	Treatment of gout following an adequate trial of allopurinol or other accepted gout treatment.
Lidoderm Patch	Post-herpetic neuralgia (PHN).
Kuvan	In combination with a Phe-restricted diet for treatment of phenylketonuria (PKU).
H.P. Acthar Gel	Various endocrine, neurological, rheumatic, collagen, dermatologic, allergic, ophthalmic, respiratory, hematologic, neoplastic, edematous, gastrointestinal conditions where corticosteroids are either ineffective or untolerated.
Ampyra	To improve walking ability in patients with MS, who have an Expanded Disability Status Score (EDSS) of greater than or equal to 4.5 but less than 7.
Xifaxan 550mg	To reduce the risk of overt hepatic encephalopathy recurrence.

*See specific Highmark Managed Prescription Drug Coverage (MRxC) policy for detailed approval criteria.