MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

April 26, 2018

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1200 – Prescribed Drugs are being proposed based on recommendations approved at the October 19, 2017 Drug Use Review (DUR) Board meeting. The DUR Board recommended revised prior authorization criteria for Xolair® (omalizumab) for pediatric patients. The DUR board recommended the new prior authorization criteria for Austedo® (deutetrabenazine), Brineura® (cerliponase alfa), Ingrezza® (Valbenazine), Emflaza® (deflazacort), and Xadago® (safinamide). The DUR Board also recommended new prior authorization criteria for Codeine and Tramadol for pediatric patients.

These changes are effective May 7, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 31550 PRESCRIBED DRUGS	MTL PRESCRIBED DRUGS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A Section P	**Xolair® (omalizumab)**	Revised Xolair® previously reviewed date to "October 19, 2017."
Appendix A P.1.a.2.a	**Xolair® (omalizumab)**	Revised prior authorization criteria to read "The recipient must be six years of age or older…" and deleted the 12.
Appendix A Section OOO	**Austedo® (deutetrabenazine)**	Added new drug Austedo® (deutetrabenazine) and criteria. Added Therapeutic Class Austedo ® (deutetrabenazine). Added Last Reviewed by the DUR Board: October 19, 2017. Added standard disclaimer that Austedo® (deutetrabenazine) is subject to prior authorization and quantity limitations. Added Coverage and Limitations which

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		must be met and documented. Added the recipient must have a diagnosis of chorea associated with Huntington's disease, must be 18 years of age or older, and prescribed by or in consultation with a neurologist. Added prior authorization will not be approved for recipients who are suicidal or have untreated/inadequately treated depression, or hepatic impairment, or are currently utilizing monoamine oxidase inhibitors (MAOIs), reserpine or tetrabenazine. Added Recertification Request Guidelines; authorization for continued use shall be reviewed at least every 12 months when the following criteria are met: documentation of positive clinical response to Austedo® therapy. Added Recertification will not be approved for recipients who are suicidal or have untreated/inadequately treated depression, or hepatic impairment, or are currently utilizing monoamine oxidase inhibitors (MAOIs), reserpine or tetrabenazine. Added Prior Authorization Guidelines, initial request will be for 12 months.
Appendix A Section PPP	**Brineura® (cerliponase alfa)**	Added new drug, Brineura® (cerliponase alfa) and criteria. Added Therapeutic Class, Brineura® (cerliponase alfa). Added Last Reviewed by the DUR Board: October 19, 2017. Added standard disclaimer that Brineura® (cerliponase alfa) is subject to prior authorization and quantity limitations. Added Coverage and Limitations which must be met and documented. Added the recipient must have a diagnosis of symptomatic late infantile neuronal ceroid lipofuscinosis type 2 (CLN2) also known as tripeptidyl peptidase 1 (TPP1) deficiency, and the diagnosis must be confirmed by TPP1 enzyme detected by a dried blood spot test and CLN2 genotype analysis, and the recipient must be three years of age or older, and prescribed by or in consultation with a neurologist with expertise in the diagnosis of CLN2, and the drug must be administered by, or under the direction of, a physician knowledgeable in intraventricular administration, and the recipient must not have acute intraventricular access-related complications (e.g., leakage, device failure or device-related infections), and the recipient must not have ventriculoperitoneal shunt. Added Recertification Request Guidelines; authorization for continued use shall be reviewed at least every 12 months when all of the following criteria are met: recipient must not have acute intraventricular access-related complications (e.g., leakage, device failure or device-related infections), and the recipient must not have ventriculoperitoneal shunt and documentation of a positive

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		clinical response from Brineura® therapy (e.g., improvement in walking or crawling, or no evidence of disease progression). Added Prior Authorization Guidelines, initial request will be for four months.
Appendix A Section QQQ	**Ingrezza® (valbenazine)**	Added new drug Ingrezza® (valbenazine) and criteria. Added Therapeutic Class, Ingrezza® (valbenazine). Added Last Reviewed by the DUR Board: October 19, 2017. Added standard disclaimer that Ingrezza® (valbenazine) is subject to prior authorization and quantity limitations. Added Coverage and Limitations which must be met and documented. Added the recipient must have a diagnosis of tardive dyskinesia (TD) confirmed by the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM) and the following: at least 60 days of stable (drug, dose) neuroleptic medication exposure (either typical or first generation antipsychotic agents (such as, chlorpromazine, haloperidol or fluphenazine), atypical or second-generation antipsychotic agents (such as, clozapine, risperidone, olanzapine, quetiapine or aripiprazole), or certain dopamine receptor-blocking drugs used in treatment of nausea and gastroparesis (such as, prochlorperazine, promethazine or metoclopramide)), and the presence of involuntary athetoid or choreiform movements lasting at least 30 days. Added the recipient must be 18 years of age or older, and must be prescribed by or in consultation with a neurologist or psychiatrist, and the recipient must have persistent symptoms of TD despite a trial of dose reduction, tapering or discontinuation of the offending medication, or the recipient must not be a candidate for a trial of dose reduction, tapering or discontinuation of the offending medication. Added Recertification Request Guidelines; authorization for continued use shall be reviewed at least every 12 months when the following criteria are met: documentation of positive clinical response to Ingrezza® therapy. Added Prior Authorization Guidelines initial request will be for three months.
Appendix A Section RRR	**Emflaza® (deflazacort)**	Added Last Reviewed by the DUR Board: October 19, 2017. Added standard disclaimer that Emflaza® (deflazacort) is subject to prior authorization and quantity limitations. Added Coverage and Limitations which must be met and documented. Added the recipient must have a diagnosis of Duchenne muscular dystrophy (DMD), and the recipient must be five years of age or older, and must have received

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		genetic testing for a mutation of the dystrophin gene, and one of the following; there must be documentation of a confirmed mutation of the dystrophin gene, or muscle biopsy confirming an absence of dystrophin protein, and the medication must be prescribed by or in consultation with a neurologist who has experience treating children, and has had at least a three month trial and failure of prednisone (prednisolone or equivalent dose) or a documented intolerance to prednisone (prednisolone or equivalent dose) given at a dose of 0.75 mg/kg/day or 10 mg/kg/weekend, and the recipient must not be a candidate for a trial of dose reduction, tapering or discontinuation of the offending medication, and the dose will not exceed 0.9 milligrams per kilogram of body weight once daily. Added Recertification Request Guidelines; authorization for continued use shall be reviewed at least every 12 months when the following criteria are met: documentation of positive clinical response to Emflaza® therapy (e.g., improvement or preservation of muscle strength) and the dose will not exceed 0.9 milligrams per kilogram of body weight once daily. Added Prior Authorization Guidelines, initial request will be for 12 months.
Appendix A Section SSS	**Xadago (safinamide)**	Added standard disclaimer that Xadago® (safinamide) is subject to prior authorization and quantity limitations. Added Coverage and Limitations which must be met and documented. Added the recipient must have a diagnosis of Parkinson's disease, and the recipient must be five years of age or older, and documented continued Levodopa and/or other dopaminergic treatments, and recipient reports greater than 1.5 hours per day of "off" episodes. Off episodes refer to the "end-of-dose wearing off" and unpredictable "on/off" episodes. Added the recipient must not also be taking any of the following drugs: other monoamine oxidase inhibitors (MAOIs), or other drugs that are potent inhibitors of MAOIs (e.g., linezolid), opioid drugs (e.g., tramadol, meperidine and related derivatives), selective norepinephrine reuptake inhibitors (SNRIs), tri- or tetra-cyclic or triazolopyridine antidepressants (TCAs), cyclobenzaprine, methylphenidate, amphetamine and their derivatives, St. John's wort, or dextromethorphan. The recipient must not have severe hepatic impairment (e.g., Child-Pugh C). Added Recertification Request Guidelines; authorization for continued use shall be reviewed at least every 12 months when the following criteria are met: documentation of

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		positive clinical response to Xadago® therapy and documented continued Levodopa and/or other dopaminergic treatments. Added Prior Authorization Guidelines, initial request will be for three months.
Appendix A Section TTT	**Codeine and Tramadol**	Added new drugs, codeine, codeine with acetaminophen and tramadol, tramadol with acetaminophen, and criteria. Added Therapeutic Class Opioid Analgesic. Added Last Reviewed by the DUR Board: October 19, 2017. Added standard disclaimer that codeine, codeine with acetaminophen and tramadol, tramadol with acetaminophen are subject to prior authorization and quantity limitations. Added Coverage and Limitations which must be met and documented. Added all the following criteria must be met for codeine, codeine with acetaminophen: the recipient must be 12 years of age or older, and the lowest effective dose for the shortest period of time is being requested, and the recipient must not be obese (BMI > 30 kg/m²), have obstructive sleep apnea, or severe lung disease, and the recipient is not being prescribed the drug for post-surgical pain following a tonsillectomy and/or adenoidectomy. Added all the following criteria must be met for tramadol, tramadol with acetaminophen: the recipient must be 12 years of age or older, and the lowest effective dose for the shortest period of time is being requested, and the recipient must not be obese (BMI > 30 kg/m²), have obstructive sleep apnea, or severe lung disease, and the recipient is not being prescribed the drug for post-surgical pain following a tonsillectomy and/or adenoidectomy. Added the prescribed dose does not exceed 200mg/day and does not exceed a five-day supply. Tramadol Extended Release (ER) will not be approved for children under 18 years of age and will reject at point of sale. Added Prior Authorization Guidelines, requests for codeine, codeine with acetaminophen, and tramadol, tramadol with acetaminophen will be for one month. Prior authorization approval will be given for the lowest effective dose for the shortest period of time requested.
Appendix B	**CATAMARAN AD HOC REPORTING SYSTEM**	Corrected title to OptumRx AD HOC REPORTING SYSTEM.

P. Monoclonal Antibody Agents

Therapeutic Class: Respiratory Monoclonal Antibody Agents
Last Reviewed by the DUR Board: July 28, 2016
Xolair previously reviewed: ~~July 24, 2014 and April 23, 2015~~October 19, 2017

Xolair® (Omalizumab) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

a. Xolair® (Omalizumab)

1. The recipient will not use the requested antiasthmatic monoclonal antibody in combination with other antiasthmatic monoclonal antibodies.

2. All of the following criteria must be met and documented for a diagnosis of moderate to severe persistent asthma:

a. The recipient must be ~~12~~ six years of age or older; and

b. The recipient must have a history of a positive skin test or Radioallergosorbent (RAST) test to a perennial aeroallergen; and

c. The prescriber must be either a pulmonologist or allergist/ immunologist; and

d. The recipient must have had an inadequate response, adverse reaction or contraindication to inhaled, oral corticosteroids; and

e. The recipient must have had an inadequate response, adverse reaction or contraindication to an oral second generation antihistamine; and

f. The recipient must have had an inadequate response, adverse reaction or contraindication to a leukotriene receptor antagonist; and

g. The recipient must have had a pretreatment serum total Immunoglobulin E (IgE) level between 30 IU/mL and 700 IU/mL; and

h. The recipient's current weight must be recorded; and

i. The requested dose is appropriate for the recipient’s pre-treatment serum IgE and body weight (see Table 1).

3. All the following criteria must be met and documented for diagnosis of chronic idiopathic urticaria (CIU); and

   a. The recipient is 12 years of age or older; and

   b. The recipient must have had an inadequate response, adverse reaction or contraindication to two different oral second generation antihistamines; and

   c. The recipient must have had an inadequate response, adverse reaction or contraindication to an oral second generation antihistamine in combination with a leukotriene receptor antagonist; and

   d. The prescriber must be either an allergist/immunologist, dermatologist or a rheumatologist or there is documentation in the recipient's medical record that a consultation was done by an allergist/immunologist, dermatologist or a rheumatologist regarding the diagnosis and treatment recommendations; and

   e. The requested dose is:

      1. Initial therapy: 150 mg every four weeks or 300 mg every four weeks and clinical rationale for starting therapy at 300 mg every four weeks has been provided.

      2. Continuation of therapy: 150 mg or 300 mg every four weeks.

b. Nucala® (mepolizumab), Cinqair® (reslizumab)

   1. All the following criteria must be met and documented:

      a. The recipient will not use the requested antiasthmatic monoclonal antibody in combination with other antiasthmatic monoclonal antibodies; and

      b. The recipient must have a diagnosis of severe eosinophilic-phenotype asthma; and

      c. The recipient must be an appropriate age:

         1. Mepolizumab: 12 years of age or older

         2. Reslizumab: 18 years of age or older

d. And, the prescriber must be either a pulmonologist or allergist/ immunologist; and

e. The recipient must be uncontrolled on current therapy including high dose corticosteroid and/or on a secondary asthma inhaler; and

f. There is documentation of the recipient's vaccination status; and

g. The requested dose is appropriate:

1. Mepolizumab: 100 mg subcutaneously every four weeks.

2. Reslizumab: 3 mg/kg via intravenous infusion of 20 to 50 minutes every four weeks.

2. Prior Authorization Guidelines

a. Prior Authorization approval will be for 12 months.

b. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

Table 1: Dosing for Xolair® (omalizumab)*

Pre-treatment Serum IgE (IU/mL)	Body Weight (kg)			
	30-60	**>60-70**	**>70-90**	**>90-150**
≥30-100	150 mg	150 mg	150 mg	300 mg
>100-200	300 mg	300 mg	300 mg	225 mg
>200-300	300 mg	225 mg	225 mg	300 mg
>300-400	225 mg	225 mg	300 mg	
>400-500	300 mg	300 mg	375 mg	
>500-600	300 mg	375 mg		
>600-700	375 mg	**DO NOT DOSE**		
Every 2 Weeks Dosing				
Every 4 Weeks Dosing				

OOO. Austedo® (deutetrabenazine)

Therapeutic Class: Austedo® (deutetrabenazine)
Last Reviewed by the DUR Board: October 19, 2017

Austedo® (deutetrabenazine) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if all the following criteria are met and documented:

a. Initial request:

1. The recipient must have a diagnosis of chorea associated with Huntington's disease; and

2. The recipient must be 18 years of age or older; and

3. The medication is prescribed by or in consultation with a neurologist; and

4. Prior authorization will not be approved for recipients who are suicidal or have untreated/inadequately treated depression, or hepatic impairment, or are currently utilizing monoamine oxidase inhibitors (MAOIs), reserpine or tetrabenazine.

b. Recertification request (the recipient must meet all of the following criteria):

1. Authorization for continued use shall be reviewed at least every 12 months when the following criteria are met:

a. Documentation of positive clinical response to Austedo® therapy.

2. Recertification will not be approved for recipients who are suicidal or have untreated/inadequately treated depression, or hepatic impairment, or are currently utilizing monoamine oxidase inhibitors (MAOIs), reserpine or tetrabenazine.

c. Prior Authorization Guidelines

1. Initial prior authorization approval will be for 12 months.

2. Prior authorization forms are available at:
http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

PPP. Brineura® (cerliponase alfa)

Therapeutic Class: Brineura® (cerliponase alfa)
Last Reviewed by the DUR Board: October 19, 2017

Brineura® (cerliponase alfa) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if all the following criteria are met and documented:

a. Initial request:

1. The recipient must have a diagnosis of symptomatic late infantile neuronal ceroid lipofuscinosis Type 2 (CLN2) also known as tripeptidyl peptidase 1 (TPP1) deficiency; and

2. The diagnosis must be confirmed by TPP1 enzyme detected by a dried blood spot test and CLN2 genotype analysis; and

3. The recipient must be three years of age or older; and

4. The drug must be prescribed by or in consultation with a neurologist with expertise in the diagnosis of CLN2; and

5. The drug must be administered by, or under the direction of, a physician knowledgeable in intraventricular administration; and

6. The recipient must not have acute intraventricular access-related complications (e.g., leakage, device failure or device-related infections); and

7. The recipient must not have ventriculoperitoneal shunt.

b. Recertification request (the recipient must meet all of the following criteria):

1. Authorization for continued use shall be reviewed at least every 12 months when the following criteria are met:

a. The recipient must not have acute intraventricular access-related complications (e.g., leakage, device failure or device-related infections); and

b. The recipient must not have ventriculoperitoneal shunt; and

c. Documentation of positive clinical response to Brineura®, (e.g., improvement in walking or crawling, or no evidence of disease progression).

c. Prior Authorization Guidelines

1. Initial prior authorization approval will be for four months.

2. Prior authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

QQQ. Ingrezza® (valbenazine)

Therapeutic Class: Ingrezza® (valbenazine)
Last Reviewed by the DUR Board: October 19, 2017

Ingrezza® (valbenazine) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if all the following criteria are met and documented:

a. Initial request:

1. The recipient must have a diagnosis of tardive dyskinesia (TD) confirmed by the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM), and the following:

a. At least 60 days of stable (drug, dose) neuroleptic medication exposure (either typical or first generation antipsychotic agents (such as, chlorpromazine, haloperidol or fluphenazine), atypical or second-generation antipsychotic agents (such as, clozapine, risperidone, olanzapine, quetiapine or aripiprazole, or certain dopamine receptor-blocking drugs used in treatment of nausea and gastroparesis (such as, prochlorperazine, promethazine or metoclopramide)); and

b. The presence of involuntary athetoid or choreiform movements lasting at least 30 days.

2. The recipient must be 18 years of age or older; and

3. The drug must be prescribed by or in consultation with a neurologist or psychiatrist; and

4. The recipient must have persistent symptoms of TD despite a trial of dose reduction, tapering or discontinuation of the offending medication; or

5. The recipient must not be a candidate for a trial of dose reduction, tapering or discontinuation of the offending medication.

b. Recertification request (the recipient must meet all of the following criteria):

1. Authorization for continued use shall be reviewed at least every 12 months when the following criteria are met:

a. Documentation of positive clinical response to Ingrezza® therapy.

c. Prior Authorization Guidelines

1. Initial prior authorization approval will be for three months.

2. Prior authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

RRR. Emflaza® (deflazacort)

Therapeutic Class: Emflaza® (deflazacort)
Last Reviewed by the DUR Board: October 19, 2017

Emflaza® (deflazacort) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if all the following criteria are met and documented:

a. Initial request:

1. The recipient must have a diagnosis of Duchenne muscular dystrophy (DMD); and

2. The recipient must be five years of age or older; and

3. The recipient must have received genetic testing for a mutation of the dystrophin gene, and one of the following;

a. Documentation of a confirmed mutation of the dystrophin gene; or

b. Muscle biopsy confirming an absence of dystrophin protein; and

4. The medication must be prescribed by or in consultation with a neurologist who has experience treating children; and

5. The recipient has had at least a three month trial and failure of prednisone (prednisolone or equivalent dose) or a documented intolerance to prednisone (prednisolone or equivalent dose) given at a dose of 0.75 mg/kg/day or 10 mg/kg/weekend; and

6. The recipient must not be a candidate for a trial of dose reduction, tapering or discontinuation of the offending medication; and

7. The dose will not exceed 0.9 milligrams per kilogram of body weight once daily.

b. Recertification request (the recipient must meet all of the following criteria):

1. Authorization for continued use shall be reviewed at least every 12 months when the following criteria are met:

a. Documentation of positive clinical response to Emflaza® therapy (e.g., improvement or preservation of muscle strength); and

b. The dose will not exceed 0.9 milligrams per kilogram of body weight once daily.

c. Prior Authorization Guidelines

1. Initial prior authorization approval will be for 12 months.

2. Prior authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

SSS. Xadago® (safinamide)

Therapeutic Class: Xadago® (safinamide)
Last Reviewed by the DUR Board: October 19, 2017

Xadago® (safinamide) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if all the following criteria are met and documented:

a. Initial request:

1. The recipient must have a diagnosis of Parkinson's disease; and

2. The recipient must be five years of age or older; and

3. Documented continued Levodopa and/or other dopaminergic treatments; and

4. Recipient reports greater than 1.5 hours per day of "off" episodes ("off" episodes refer to "end-of-dose wearing off" and unpredictable "on/off" episodes); and

5. Recipient must not also be taking any of the following drugs: other MAOIs inhibitors, or other drugs that are potent inhibitors of MAOI (e.g., linezolid), opioid drugs (e.g., tramadol, meperidine and related derivatives), selective norepinephrine reuptake inhibitors (SNRIs), tri- or tetra-cyclic or triazolopyridine antidepressants (TCAs), cyclobenzaprine, methylphenidate, amphetamine and their derivatives, St. John's wort or dextromethorphan; and

6. The recipient must not have severe hepatic impairment (e.g., Child-Pugh C).

b. Recertification request (the recipient must meet all of the following criteria):

2. Authorization for continued use shall be reviewed at least every 12 months when the following criteria are met:

a. Documentation of positive clinical response to Xadago® therapy; and

b. Documented continued Levodopa and/or other dopaminergic

treatments.

c. Prior Authorization Guidelines

3. Initial prior authorization approval will be for three months.

4. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

TTT. Codeine and Tramadol for Children

Therapeutic Class: Opioid Analgesic
Last Reviewed by the DUR Board: October 19, 2017

Codeine, codeine with acetaminophen and tramadol, tramadol with acetaminophen are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

a. Codeine, codeine with acetaminophen

1. All of the following criteria must be met:

a. The recipient must be 12 years of age or older; and

b. The lowest effective dose for the shortest period of time is being requested; and

c. The recipient must not be obese (BMI > 30 kg/m^2), have obstructive sleep apnea, or severe lung disease; and

d. The recipient is not being prescribed the drug for post-surgical pain following a tonsillectomy and/or adenoidectomy.

b. Tramadol, tramadol with acetaminophen

a. All of the following criteria must be met:

a. The recipient must be 12 years of age or older; and

b. The lowest effective dose for the shortest period of time is being requested; and

c. The recipient must not be obese (BMI > 30 kg/m^2), have obstructive sleep apnea, or severe lung disease; and

d. The recipient is not being prescribed the drug for post-surgical pain following a tonsillectomy and/or adenoidectomy; and

e. The prescribed dose does not exceed 200mg/day and does not exceed a five day supply.

b. Tramadol Extended Release (ER) will not be approved for children under

18 years of age and will reject at point of sale.

c. Prior Authorization Guidelines

a. Codeine, codeine with acetaminophen

1. Prior authorization approval will be given for the lowest effective dose for the shortest period of time requested.

a. Prior authorization will be given for a one month time period.

b. Prior authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

b. Tramadol, tramadol with acetaminophen

1. Prior authorization approval will be given for the lowest effective dose for the shortest period of time requested.

2. Prior authorization will be given for a one month time period.

3. Prior authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

~~CATAMARAN~~ OptumRx AD HOC REPORTING SYSTEM
STANDARD THERAPEUTIC CLASSES

Standard Therapeutic	
Class	Description
00	MEDICAL SUPPLIES
01	ANTI-ULCER PREPS/GASTROINTESTI
02	EMETICS
03	ANTIDIARRHEALS
04	ANTISPASMODIC-ANTICHOLINERGICS
05	BILE THERAPY
06	LAXATIVES
07	ATARACTICS-TRANQUILIZERS
08	MUSCLE RELAXANTS
09	ANTIPARKINSON
10	CNS STIMULANTS
11	PSYCHOSTIMULANTS-ANTIDEPRESSAN
12	AMPHETAMINE PREPARATIONS
13	ALL OTHER ANTIOBESITY PREPS
14	ANTIHISTAMINES
15	BRONCHIAL DILATORS
16	COUGH PREPARATIONS/EXPECTORANT
17	COLD AND COUGH PREPARATIONS
18	ADRENERGICS
19	TOPICAL NASAL AND OTIC PREPARA
20	OPHTHALMIC PREPARATIONS
21	TETRACYCLINES
22	PENICILLINS
23	STREPTOMYCINS
24	SULFONAMIDES
25	ERYTHROMYCINS
26	CEPHALOSPORINS
27	OTHER ANTIBIOTICS
28	URINARY ANTIBACTERIALS
29	CHLORAMPHENICOL
30	ANTINEOPLASTICS
31	ANTIPARASITICS
32	ANTIMALARIALS
33	ANTIVIRALS
34	TB PREPARATIONS
35	TRIMETHOPRIM
36	CONTRACEPTIVES, NON-SYSTEMIC
37	VAGINAL CLEANSERS
38	GENERAL ANTIBACTERIALS AND ANT
39	DIAGNOSTICS