Florida Healthy Kids

Pharmacy Prior Authorization
Non-Formulary and Prior Authorization Guidelines

Scroll down to see PA Criteria by drug class, or Ctrl+F to search document by drug name

PA Guideline	Requirements	Duration of Approval if Requirements Are Met
Medications requiring Prior Authorization	Requests for Medications requiring Prior Authorization (PA) will be reviewed based on the PA Guidelines/Criteria for that medication. Scroll down to view the PA Guidelines for specific medications. Medications that do not have a specific Prior Authorization guideline will follow the Non-Formulary Medication Guideline. Additional information may be required on a case-by-case basis to allow for adequate review.	**As documented in individual guideline**
Medications requiring Step Therapy	Medications that require Step Therapy (ST) require trial and failure of formulary agents prior to their authorization. If the prerequisite medications have been filled within the specified time frame, the prescription will automatically process at the pharmacy. Prior Authorization will be required for prescriptions that do not process automatically at the pharmacy.	**Initial Approval:** Indefinite
Intravenous and Injectable Iron Agents	https://ahca.myflorida.com/content/download/6366/file/Injectable_and_Intravenous_Iron_Agents_Criteria.pdf	

Ranolazine
(Ranexa)[i]
	For members who meet all of the following criteria:
	• Age is 18 years or older
	• Diagnosis is for chronic angina
	• There was inadequate trial and failure with one formulary agent from each of the following three drug classes:
	  ○ Beta blockers
	  ○ Calcium channel blockers
	  ○ Long-acting nitrates
		Initial Approval:
		1 year
		
		Renewal Approval:
		1 year
		
		Quantity Level Limit:
		2 tablets/day

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	• Or there was a documented contraindication, or intolerance to the following three drug classes:
	  ○ Beta blockers
	  ○ Calcium channel blockers
	  ○ Long-acting nitrates	

Rectiv	**Rectiv may be authorized when the following criteria are met:** • Member has a diagnosis of pain associated with anal fissures.	**Initial Approval:** 6 months **Renewal Approval:** 1 year
Xolair[ii]	**May be authorized when all of the following are met:** • Member six years of age and older • Diagnosis of moderate to severe persistent asthma • Prescribed by, or after consultation with a pulmonologist or allergist/immunologist • Positive skin test or in vitro reactivity to a perennial allergen (for example: dust mite, animal dander, cockroach, etc.) • Documentation to support Immunoglobulin E (IgE) is between 30 and 1300 International unit (IU)/millimeter(ml) • Member has been compliant with medium to high dose inhaled corticosteroids (ICS) + a long-acting beta agonist (LABA) for at least three months or other controller medications (for example: LTRA (Leukotriene	**Initial Approval:** **Asthma:** 6 months **Chronic urticaria:** 3 months **Renewal Approval:** **Asthma:** 1 year ***Requires***

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	Receptor Antagonists) or theophylline) if intolerant to a long-acting beta agonist (LABA)
	• Asthma symptoms are poorly controlled on one of the above regimens as defined by any of the following:
	  ○ Daily use of rescue medications (short-acting inhaled beta-2 agonists)
	  ○ Nighttime symptoms occurring more than once a week
	  ○ At least two exacerbations in the last 12 months requiring additional medical treatment (systemic corticosteroids, emergency department visits, or hospitalization)
	• Member will not receive in combination with Interleukin-5 (IL-5) antagonists (Nucala, Fasenra, or Cinqair) or Dupixent
	May be authorized when all of the following criteria are met:
	• Member is 12 years of age and older
	• Diagnosis of chronic urticaria
	• Prescribed by an allergist/immunologist or dermatologist
	• Currently receiving H1 antihistamine therapy
	• Failure of a 4-week, compliant trial of a high dose, second generation antihistamine (cetirizine, loratadine, fexofenadine)
	AND
	• Failure of a 4-week, compliant trial of at least THREE of the following combinations:
	  ○ H1 antihistamine + Leukotriene inhibitor (montelukast or zafirlukast)
	  ○ H1 antihistamine + H2 antihistamine (ranitidine or cimetidine)
		Demonstration of clinical improvement (for example: decreased use of rescue medications or systemic corticosteroids, reduction in number of emergency department visits or hospitalizations) and compliance with asthma controller medications
		
		Chronic urticaria:
		6 months
		
		Requires
		Demonstration of adequate symptom control (for example: decreased itching)
		
		<u>Dosing Restriction:</u>
		• **Asthma:** Per manufacturer, do not exceed 375mg every 2 weeks
		Urticaria: Initial dose of 150mg per 4 weeks. Dose may be increased to 300mg per 4 weeks if necessary.

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	○ H1 antihistamine + Doxepin ○ First generation + second generation antihistamine ***Note: Off-label use for Allergic Rhinitis or food allergy is not covered*** **Xolair is not indicated for the relief of acute bronchospasm or status asthmaticus **	

[i] **Ranexa References**

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[ii] **Xolair References**

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