

NYS Medicaid Program Clinical Criteria Form for Prescribers

Clinical Criteria (Please complete for applicable drugs/drug classes)

Antibiotics - Topical:

Is this medication being used for the eradication of nasal colonization with methicillin resistant *Staphylococcus aureus* (MRSA) in a patient greater than 12 years of age?

Yes No

Anticonvulsants – Second Generation:

For Lyrica® (pregabalin) only: Is Lyrica prescribed for the treatment of Diabetic Peripheral Neuropathy (DPN)?

Yes No

If Yes, has the patient experienced a treatment failure or adverse reaction to a tricyclic antidepressant or gabapentin?

Yes No

Antidiabetic Agents:

For all antidiabetic agents, except metformin, insulins, or GLP-1 Agonists (Byetta®, Bydureon®, Victoza®):

Does the patient have a contraindication to or an experience of a treatment failure with metformin with or without insulin?

Yes No

For Byetta®, Bydureon®, and Victoza® only:

Has the patient experienced a treatment failure with metformin plus another oral antidiabetic agent?

Yes No

Antipsychotics – Second Generation:

Clinical editing will allow patients currently stabilized on a non-preferred Atypical Antipsychotic agent to continue to receive that agent without prior authorization.

For Invega® (paliperidone) only:

Has the patient experienced a treatment failure or adverse reaction to risperidone?

Yes No

For Seroquel® (quetiapine) only:

Is the patient younger than 10 years of age?

Yes No

If Yes, what is the clinical justification for using quetiapine in a patient less than 10 years of age?

Is the dosage prescribed less than 100mg/day?

Yes No

If YES, what is the clinical rationale for prescribing < 100mg/day?

Antihistamines - Second Generation Oral:

Patient is under 24 months of age.

Yes No

For billing questions, call 1-800-343-9000.

For clinical concerns or Preferred Drug Program questions, visit www.nyhealth.gov and <http://newyork.fhsc.com> or call 1-877-309-9493.

Note: Processing May Be Delayed if Information Submitted is Illegible or Incomplete.

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Clinical Criteria (Please complete for applicable drugs/drug classes)
Central Nervous System (CNS) Stimulants:
Patient-specific considerations for drug selection include treatment of excessive sleepiness associated with shift work sleep disorder or as an adjunct to standard treatment for obstructive sleep apnea. <input type="checkbox"/> Yes <input type="checkbox"/> No
Under CDRP, appropriate diagnosis is required for CNS Stimulants for enrollees 18 and older, regardless of preferred status. Please indicate the diagnosis in the space provided.
Corticosteroids - Inhaled:
Patient-specific considerations for drug selection include concerns related to pregnancy. <input type="checkbox"/> Yes <input type="checkbox"/> No
Growth Hormones - For enrollees under 21 years (For enrollees 21 and older, please refer to CDRP):
Are you using the nonpreferred product for an FDA approved indication that is not listed for a preferred agent? <input type="checkbox"/> Yes <input type="checkbox"/> No
Appropriate diagnosis is required for all Growth Hormones, regardless of age or preferred status. Please indicate the diagnosis in the space provided.
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) - Prescription:
Patients who meet one of the following criteria will not require prior authorization for Celebrex®: <ul style="list-style-type: none"> • Over the age of 65 years • Concurrent use of an anticoagulant agent • History of GI Bleed/Ulcer or Peptic Ulcer Disease
Restasis® (cyclosporine ophthalmic):
What diagnosis is the Restasis® being prescribed for?
Has the patient experienced a treatment failure or adverse reaction to artificial tear/gel/ointment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Serotonin Receptor Agonists (Triptans):
Is the patient receiving migraine prophylaxis or has the patient failed prophylaxis therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has the patient been evaluated for medication overuse headache? <input type="checkbox"/> Yes <input type="checkbox"/> No
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs):
Is the SNRI prescribed for treatment of Chronic Musculoskeletal Pain or Fibromyalgia? <input type="checkbox"/> Yes <input type="checkbox"/> No
If No, has the patient experienced a treatment failure or adverse reaction to a Selective Serotonin Reuptake Inhibitor? <input type="checkbox"/> Yes <input type="checkbox"/> No

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Clinical Criteria (Please complete for applicable drugs/drug classes)**For Cymbalta® (duloxetine) only: Is Cymbalta prescribed for the treatment of Diabetic Peripheral Neuropathy (DPN)?** Yes No**If Yes, has the patient experienced a treatment failure or adverse reaction to a tricyclic antidepressant or gabapentin?** Yes No**Singulair® (montelukast):**

DIAGNOSIS:

 Asthma Reactive Airway Disease Other:**Has the patient experienced a treatment failure or adverse reaction with an intranasal corticosteroid or an oral antihistamine?** Yes No**Tramadol extended-release (Conzip®, Ryzolt®, Ultram® ER):****Has your patient experienced a treatment failure or adverse reaction to immediate-release tramadol?** Yes No**Note:** Processing May Be Delayed if Information Submitted is Illegible or Incomplete.