Other Clinical Criteria for Prescribers  
New York State Medicaid Fee-For-Service Program

To request prior authorization via fax, please complete the standardized fax form. A faxed request takes up to 24 hours. Specific clinical criteria are associated with certain drug classes and immediately follow this form. *If your fax includes the standardized fax form, only the Member Name, ID, DOB, and Clinical Criteria need to be completed and faxed as an attachment to process your request.* Please note that certain Clinical Drug Review Program (CDRP) drugs, step therapy as well as drugs that have exceeded frequency/quantity/duration limits set by the Drug Utilization Review Board.

| Enrollee Information | |
| --- | --- |
| enrollee Name: | |
| enrollee Id number (2 letters, 5 numbers, 1 letter): | enrollee date of birth: |

| Prescriber Information | | |
| --- | --- | --- |
| prescriber Name: | | |
| Contact person: | | |
| 10-digit Npi number: | office Phone Number:  (     )      - | office Fax number:  (     )     - |

| Diagnosis and Medical Information | | | | | |
| --- | --- | --- | --- | --- | --- |
| Diagnosis: | | | | | |
| Drug Name: | | Strength: | | Route of Administration: | |
| New Prescription:  Yes  No | Frequency: | Quantity: | Days’ Supply: | | Refills: |

| Rationale for Request of Prior Authorization (Form Cannot be Processed without Required Explanation): | | |
| --- | --- | --- |
| Patient has experienced a treatment failure with a preferred drug. | | Yes  No |
| Patient has experienced an adverse drug reaction with a preferred drug. | | Yes  No |
| There is a documented history of successful therapeutic control with a nonpreferred drug and transition to a preferred drug is medically contraindicated. | | Yes  No |
|  | Other (Please specify the clinical reason the patient is unable to use a preferred agent in the same drug class. If necessary, fax additional pages): | |
|  |  | |

I attest that this is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by New York Medicaid.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Prescriber’s signature |  | date |

| 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 |
| 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.  Yes  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.  Yes  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?  Yes  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®:   * 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?  Yes  No |
| Serotonin Receptor Agonists (Triptans): |
| Is the patient receiving migraine prophylaxis or has the patient failed prophylaxis therapy?  Yes  No |
| Has the patient been evaluated for medication overuse headache?  Yes  No |
| Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs): |
| Is the SNRI prescribed for treatment of Chronic Musculoskeletal Pain or Fibromyalgia?  Yes  No  If No, has the patient experienced a treatment failure or adverse reaction to a Selective Serotonin Reuptake Inhibitor?  Yes  No |
| *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 |

I attest that this is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by New York Medicaid.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Prescriber’s signature |  | date |