Point-of-Sale Edits

Point-of-Sale (POS) edits are safety limitations that are automatically verified through computer programming at the time that a prescription claim is submitted at the pharmacy. These edits can be applied to *any* medication, whether or not it is listed in the Preferred Drug List / Non-Preferred Drug List (PDL/NPDL). The first section of this document is organized to follow the order of the therapeutic classes in the PDL/NPDL and explains the POS edits for those medications. The second section of this document found HERE explains the POS edits for medications that are *not* on the PDL/NPDL.

For additional information, please contact the appropriate plan at the phone number found on page 25 of this document (Click HERE to go to page 25).

POS Abbreviations in This Document

AL – Age Limit
BH – Behavioral Health Clinical Authorization for Children Younger than 6 Years of Age
BY – Diagnosis Codes Bypass Some Requirements
CL – Additional Clinical Information is Required
CU – Concurrent Use with Other Medication Is Restricted
DD – Drug-Drug Interaction
DS – Maximum Days' Supply Allowed
DT – Duration of Therapy Limit
DX – Diagnosis Code Requirement
ER – Early Refill
MD – Maximum Dose Limit
PR – Enrollment in a Physician-Supervised Program Required
PU – Prior Use of Other Medication is Required
QL – Quantity Limit
RX – Specific Prescription Requirement
TD – Therapeutic Duplication
UN – Drug Use Not Warranted
X – Prescriber Must Have 'X' DEA Number
YQ – Yearly Quantity Limit

Therapeutic Class	POS Edits
Acne Agents, Topical	**AL** – All agents are limited to use in recipients who are younger than 21 years of age when used for acne.
	BY – Pharmacy claims submitted with a diagnosis code for psoriasis (L40*) will bypass the age restriction for tazarotene cream or tazarotene gel. ** Any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code*
	CL – Additional clinical information (acne severity) is required for all topical acne agents.
ADD/ADHD – Stimulants and Related Agents	**AL** – Armodafinil and modafinil are limited to use in recipients who are at least 17 years of age.
	BH – Additional behavioral-health related clinical information (trial of behavioral therapy, etc.) is required for all agents when requested for recipients who are younger than 6 years of age.
	CU – Armodafinil and modafinil are monitored at the pharmacy POS for concurrent use with sedative hypnotics.
	DX – Pharmacy claims for all agents must be submitted with an appropriate diagnosis code found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources. - Because some agents used for ADHD are also commonly used for hypertension/heart conditions (*clonidine immediate-release tablet, clonidine patch, guanfacine immediate-release tablet*), these agents *do not require a diagnosis at the pharmacy POS if the recipient is 21 years of age or older.*
	TD – These agents are monitored at the pharmacy POS for duplication of therapy. - Armodafinil and modafinil with each other. - Armodafinil and modafinil with any other stimulant or related agent. - Short-acting ADHD agents with other short-acting ADHD agents. - Long-acting ADHD agents with other long-acting ADHD agents. - ADHD agents written by **TWO** different prescribers.
Allergy – Antihistamines, Minimally Sedating	**TD** – These agents are monitored at the pharmacy POS for duplication of therapy with each other and with other sedating antihistamines.
Allergy – Rhinitis Agents, Nasal	No additional POS edits apply.
Alzheimer's Agents	No additional POS edits apply.
Androgenic Agents	No additional POS edits apply.

<table>
<tr><th>Therapeutic Class</th><th>POS Edits</th></tr>
<tr><td rowspan="8">Antipsychotic Agents – Antipsychotic Oral Agents</td><td>AL – Pimavanserin (Nuplazid®) is limited to use in recipients who are at least 18 years old.</td></tr>
<tr><td>BH – Additional behavioral-health related clinical information (trial of behavioral therapy, etc.) is required for all agents EXCEPT pimavanserin (Nuplazid®) when requested for recipients who are younger than 6 years of age.</td></tr>
<tr><td>CL – Additional clinical information is required for pimavanserin (Nuplazid®).</td></tr>
<tr><td>DX – Pharmacy claims for all agents must be submitted with an appropriate diagnosis code found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources.</td></tr>
<tr><td>MD – Some agents have a maximum daily dose as listed in the chart below.</td></tr>
<tr><td>
<table>
<tr><th rowspan="2">Generic – Brand Example</th><th colspan="7">Age (Years)</th></tr>
<tr><th>Younger than 5</th><th>5</th><th>6-9</th><th>10-12</th><th>13-15</th><th>16-17</th><th>18 and older</th></tr>
<tr><td>Aripiprazole – Abilify®</td><td>5mg</td><td>20mg</td><td>20mg</td><td>20mg</td><td>30mg</td><td>30mg</td><td>30mg</td></tr>
<tr><td>Aripiprazole – Abilify® MyCite®</td><td>0mg</td><td>0mg</td><td>0mg</td><td>0mg</td><td>0mg</td><td>0mg</td><td>30mg</td></tr>
<tr><td>Asenapine – Saphris®</td><td>0mg</td><td>0mg</td><td>0mg</td><td>20mg</td><td>20mg</td><td>20mg</td><td>20mg</td></tr>
<tr><td>Brexpiprazole – Rexulti®</td><td>0mg</td><td>0mg</td><td>0mg</td><td>0mg</td><td>0mg</td><td>4mg</td><td>4mg</td></tr>
<tr><td>Cariprazine – Vraylar®;</td><td>0mg</td><td>0mg</td><td>0mg</td><td>0mg</td><td>0mg</td><td rowspan="2">4.5mg</td><td rowspan="2">6mg</td></tr>
<tr><td>Vraylar® Therapy Pack</td><td>0mg</td><td>0mg</td><td>0mg</td><td>0mg</td><td>0mg</td></tr>
<tr><td>Clozapine – Clozaril®, FazaClo®, Versacloz®</td><td>0mg</td><td>0mg</td><td>0mg</td><td>0mg</td><td>0mg</td><td>0mg</td><td>900mg</td></tr>
<tr><td>Iloperidone – Fanapt®</td><td>0mg</td><td>0mg</td><td>0mg</td><td>0mg</td><td>0mg</td><td>16mg</td><td>24mg</td></tr>
<tr><td>Lurasidone – Latuda®</td><td>0mg</td><td>0mg</td><td>0mg</td><td>80mg</td><td>80mg</td><td>80mg</td><td>160mg</td></tr>
<tr><td>Olanzapine – Zyprexa®</td><td>10mg</td><td>20mg</td><td>20mg</td><td>20mg</td><td>30mg</td><td>30mg</td><td>40mg</td></tr>
<tr><td>Olanzapine/Fluoxetine – Symbyax®</td><td>0mg</td><td>0mg</td><td>0mg</td><td>12mg/50mg</td><td>12mg/50mg</td><td>12mg/50mg</td><td>18mg/75mg</td></tr>
<tr><td>Paliperidone – Invega®</td><td>3mg</td><td>6mg</td><td>6mg</td><td>6mg</td><td>9mg</td><td>9mg</td><td>12mg</td></tr>
<tr><td>Quetiapine – Seroquel®</td><td>100mg</td><td>600mg</td><td>600mg</td><td>600mg</td><td>1000mg</td><td>1000mg</td><td>1200mg</td></tr>
<tr><td>Risperidone – Risperdal®</td><td>3mg</td><td>6mg</td><td>6mg</td><td>6mg</td><td>8mg</td><td>8mg</td><td>16mg</td></tr>
<tr><td>Ziprasidone – Geodon®</td><td>30mg</td><td>60mg</td><td>60mg</td><td>60mg</td><td>120mg</td><td>120mg</td><td>200mg</td></tr>
</table>
</td></tr>
<tr><td>
QL – Selected agents have quantity limits as listed in the chart to the right.
<table>
<tr><th colspan="2">Quantity Limits for Selected Antipsychotic Oral Agents</th></tr>
<tr><th>Medication</th><th>Quantity Limit</th></tr>
<tr><td>Nuplazid™ 17mg</td><td>60 tablets every 30 days</td></tr>
<tr><td>Nuplazid™ 34 mg</td><td>30 capsules every 30 days</td></tr>
<tr><td>Vraylar® Therapy Pack</td><td>Limited to 1 pack per 18-month period</td></tr>
</table>
</td></tr>
<tr><td>TD – These agents are monitored at the pharmacy POS for duplication of therapy with each other (oral with oral).</td></tr>
</table>

<table>
<tr><th>Therapeutic Class</th><th>POS Edits</th></tr>
<tr><td rowspan="5">Antipsychotic Agents – Antipsychotic Injectable Agents</td><td>BH – Additional behavioral-health related clinical information (trial of behavioral therapy, etc.) is required for all agents when requested for recipients who are younger than 6 years of age.</td></tr>
<tr><td>DX – Pharmacy claims for all agents must be submitted with an appropriate diagnosis code found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources.</td></tr>
<tr><td>
MD – Some agents have a maximum daily dose as listed in the chart to the right.
<table>
<tr><th>Generic – Brand Example</th><th>Maximum Dose for 18 Years of Age and Older</th></tr>
<tr><td>Aripiprazole – Aristada®</td><td>1064mg</td></tr>
<tr><td>Paliperidone – Invega Trinza®</td><td>819mg</td></tr>
<tr><td>Risperidone – Perseris™</td><td>120mg</td></tr>
</table>
</td></tr>
<tr><td>
PU – These agents require evidence in pharmacy claims indicating established tolerance with previous use of an oral or injectable form.
<table>
<tr><th>Generic (Brand Example)</th><th>Claim for At Least a 14-Day Supply of Oral in Previous 30-Day Period</th><th>Number of Injectable Claims in Previous Period of Time</th></tr>
<tr><td>Aripiprazole (Abilify Maintena®)</td><td rowspan="3">Aripiprazole</td><td rowspan="3">ONE claim for ANY aripiprazole injectable product in the previous 365 days</td></tr>
<tr><td>Aripiprazole (Aristada®)</td></tr>
<tr><td>Aripiprazole (Aristada Initio®)</td></tr>
<tr><td>Olanzapine (Zyprexa Relprevv®)</td><td>Olanzapine</td><td>ONE claim for Zyprexa Relprevv® in the previous 365 days</td></tr>
<tr><td>Paliperidone (Invega Sustenna®)</td><td>Paliperidone or Risperidone</td><td>ONE claim for any risperidone injectable product OR Invega Sustenna® in the previous 365 days</td></tr>
<tr><td>Paliperidone (Invega Trinza®)</td><td>N/A</td><td>FOUR claims for Invega Sustenna® in the previous 120-day period OR ONE claim for Invega Trinza® in the previous 365 days</td></tr>
<tr><td>Risperidone (Risperdal Consta®)</td><td>Risperidone</td><td>ONE claim for Risperdal Consta® in previous 365 days</td></tr>
<tr><td>Risperidone (Perseris™)</td><td>Risperidone</td><td>ONE claim for Risperdal Consta® OR Perseris® in the previous 365 days</td></tr>
</table>
</td></tr>
<tr><td>
QL – Some agents have quantity limits as listed in the chart to the right.
<table>
<tr><th>Medication</th><th>Quantity Limit</th></tr>
<tr><td>Abilify Maintena®</td><td>1 unit every 28 days</td></tr>
<tr><td>Aristada® 441mg; 662mg; 882mg syringe</td><td>1 unit every 28 days</td></tr>
<tr><td>Aristada® 1064mg syringe</td><td>1 unit every 56 days</td></tr>
<tr><td>Aristada® Initio™ 675mg syringe</td><td>Limited to 1 unit per 18-month period</td></tr>
<tr><td>Invega Sustenna®</td><td>1 unit every 28 days</td></tr>
<tr><td>Invega Trinza®</td><td>1 unit per rolling 90 days</td></tr>
<tr><td>Perseris™</td><td>1 unit every 28 days</td></tr>
<tr><td>Risperdal Consta®</td><td>2 units every 28 days</td></tr>
<tr><td>Zyprexa Relprevv® 210mg & 300mg</td><td>2 units every 28 days</td></tr>
<tr><td>Zyprexa Relprevv® 405mg</td><td>1 unit every 28 days</td></tr>
</table>
</td></tr>
<tr><td>TD – These agents are monitored at the pharmacy POS for duplication of therapy with each other (injectable with injectable).</td></tr>
</table>

<table>
<tr><th>Therapeutic Class</th><th>POS Edits</th></tr>
<tr><td>Antivirals, Oral</td><td>No additional POS edits apply.</td></tr>
<tr><td rowspan="6">Anxiolytics</td><td>AL – Alprazolam XR and alprazolam ODT are limited to use in recipients who are at least 18 years of age.</td></tr>
<tr><td>BH – Additional behavioral-health related clinical information (trial of behavioral therapy, etc.) is required for all agents, EXCEPT meprobamate, when requested for recipients who are younger than 6 years of age.</td></tr>
<tr><td>BY – Pharmacy claims for selected anxiolytics, when submitted with a seizure-related diagnosis code will bypass the behavioral-health clinical authorization requirement, the restriction on concurrent use with opioids, and quantity limits (see Anxiolytic Quantity Limits with Bypass Diagnosis Codes chart below).</td></tr>
<tr><td>CU – Benzodiazepines are monitored at POS for concurrent use with opioids and buprenorphine-containing products.
- Concurrent pharmacy claims for benzodiazepines and buprenorphine will deny.
- Incoming benzodiazepine pharmacy claims will deny when the recipient has an active prescription (a prescription in which the days' supply has not expired) for an opioid.</td></tr>
<tr><td>DX – Pharmacy claims for alprazolam ER and alprazolam ODT require an appropriate diagnosis code found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources.</td></tr>
<tr><td>
QL – Solid oral dosage forms have quantity limits. A diagnosis code bypass is available for some agents as listed in the charts to the right.
<table>
<tr><th colspan="3">Anxiolytic Quantity Limits with Bypass Diagnosis Codes</th></tr>
<tr><th>Generic (Brand Example)</th><th colspan="2">Quantity Limit</th></tr>
<tr><td>Clonazepam (Klonopin®)</td><td colspan="2">90 units in 30 days</td></tr>
<tr><td>Clorazepate (Tranxene T-Tab®)</td><td colspan="2">90 units in 30 days</td></tr>
<tr><td>Diazepam (Valium®)</td><td colspan="2">90 units in 30 days</td></tr>
<tr><td>Lorazepam (Ativan®) Injectable</td><td colspan="2">No Quantity Limit Applicable</td></tr>
<tr><td rowspan="3">Seizure-Related Diagnosis Codes Will Bypass Behavioral Health Clinical Authorization Requirement or Concurrent Use with Opioids or Applicable Quantity Limits</td><td>Epilepsy, Seizures</td><td>G40.*</td></tr>
<tr><td>Convulsions in Newborn</td><td>P90</td></tr>
<tr><td>Other Convulsions</td><td>R56.*</td></tr>
<tr><td colspan="3">* Any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM code</td></tr>
<tr><th colspan="3">Anxiolytic Quantity Limits without Bypass Diagnosis Codes</th></tr>
<tr><th>Generic (Brand Example)</th><th colspan="2">Quantity Limit</th></tr>
<tr><td>Alprazolam ER (Xanax XR®)</td><td colspan="2">30 units in 30 days</td></tr>
<tr><td>Alprazolam (Xanax®)</td><td colspan="2">90 units in 30 days</td></tr>
<tr><td>Chlordiazepoxide (Librium®)</td><td colspan="2">90 units in 30 days</td></tr>
<tr><td>Lorazepam (Ativan®)</td><td colspan="2">90 units in 30 days</td></tr>
<tr><td>Oxazepam</td><td colspan="2">90 units in 30 days</td></tr>
</table>
</td></tr>
<tr><td>TD – These agents are monitored at the pharmacy POS for duplication of therapy with each other and with oxybate (Xyrem®).</td></tr>
</table>

Therapeutic Class	POS Edits	
Asthma/COPD – Bronchodilator, Anticholinergics (COPD) – Inhalation	No additional POS edits apply.	
Asthma/COPD – Bronchodilator, Anticholinergics (COPD) – Oral	**CL** – Additional clinical information (test results, history of COPD exacerbations, etc.) is required for roflumilast (Daliresp®).	
Asthma/COPD – Bronchodilator, Beta-Adrenergic Inhalation Agents	No additional POS edits apply on all **EXCEPT** albuterol MDI and levalbuterol MDI (short-acting beta agonist inhalers).	
	BY – Pharmacy claims for short-acting beta agonist inhalers will bypass the yearly quantity limit when submitted with an appropriate diagnosis code found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources.	
	YQ – A maximum of six (6) short-acting beta agonist inhalers per calendar year will be allowed without prescriber consultation.	
	TD – These agents are monitored at the pharmacy POS for duplication of therapy with each other.	
Asthma/COPD – Bronchodilator, Beta-Adrenergic - Oral Agents	No additional POS edits apply.	
Asthma/COPD – Glucocorticoids, Inhalation	No additional POS edits apply.	
Asthma/COPD – Leukotriene Modifiers	No additional POS edits apply.	
Colony Stimulating Factors	**CL** – Additional clinical information (diagnosis, etc.) is required for colony stimulating factors.	
Cystic Fibrosis, Oral	**Ivacaftor (Kalydeco®)**	**CL** – Additional clinical information (gene mutation, etc.) is required for ivacaftor (Kalydeco®).
	Lumacaftor/ Ivacaftor (Orkambi®)	**CL** – Additional clinical information (gene mutation, etc.) is required for lumacaftor/ivacaftor (Orkambi®).
	Tezacaftor (Symdeko®)	**CL** – Additional clinical information (gene mutation, etc.) is required for tezacaftor (Symdeko®).
Depression – Antidepressants, Other	**BH** – Additional behavioral-health related clinical information (trial of behavioral therapy, etc.) is required for all agents when requested for recipients who are younger than 6 years of age.	

Therapeutic Class	POS Edits
Depression – Selective Serotonin Reuptake Inhibitors (SSRIs)	**BH** – Additional behavioral-health related clinical information (trial of behavioral therapy, etc.) is required for all agents when requested for recipients who are younger than 6 years of age.
	DX – Pharmacy claims for paroxetine (Brisdelle®) must be submitted with an appropriate diagnosis code for moderate-to-severe vasomotor symptoms associated with menopause (E28.310, E89.41, N95.1).
	TD – These agents are monitored at the pharmacy POS for duplication of therapy with each other.
Dermatology – Antibiotics, Topical	No additional POS edits apply.
Dermatology – Antifungals, Topical	No additional POS edits apply.
Dermatology – Antiparasitic Agents, Topical	No additional POS edits apply.
Dermatology – Antipsoriatics, Oral	No additional POS edits apply.
Dermatology – Antipsoriatics, Topical	No additional POS edits apply.
Dermatology - Antiviral Agents, Topical	No additional POS edits apply.
Dermatology – Atopic Dermatitis Immunomodulators	No additional POS edits apply on all **EXCEPT** dupilumab (Dupixent®).
	CL – Additional clinical information (appropriate dose and frequency, severity of diagnosis, etc.) is required for dupilumab (Dupixent®).
Dermatology – Emollients	No additional POS edits apply.
Dermatology – Immunomodulators, Topical	No additional POS edits apply on all **EXCEPT** imiquimod.
	DX – Pharmacy claims for imiquimod must be submitted with an appropriate diagnosis code found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources.
Dermatology – Steroids, Topical – Low Potency	No additional POS edits apply.
Dermatology – Steroids, Topical – Medium Potency	No additional POS edits apply.

<table>
<tr><th>Therapeutic Class</th><th colspan="3">POS Edits</th></tr>
<tr><td>Dermatology – Steroids, Topical – High Potency</td><td colspan="3">No additional POS edits apply.</td></tr>
<tr><td>Dermatology – Steroids, Topical – Very High Potency</td><td colspan="3">No additional POS edits apply.</td></tr>
<tr><td>Diabetes – Alpha-Glucosidase Inhibitors</td><td colspan="3">No additional POS edits apply.</td></tr>
<tr><td rowspan="20">Diabetes – Hypoglycemics – Incretin Mimetics/Enhancers</td><td rowspan="17">MD – Some agents are limited to a maximum dose as listed in the chart to the right.</td><td>Generic (Brand Example)</td><td>Maximum Dose</td></tr>
<tr><td>Alogliptin (Nesina®, Generic)</td><td>25mg/day</td></tr>
<tr><td>Alogliptin/Metformin (Kazano®, Generic)</td><td>25mg/2000mg per day</td></tr>
<tr><td>Alogliptin/Pioglitazone (Oseni®, Generic)</td><td>25mg/45mg per day</td></tr>
<tr><td>Dulaglutide (Trulicity®)</td><td>1.5mg/week</td></tr>
<tr><td>Exenatide (Bydureon®, Bydureon® BCise™)</td><td>2mg/week</td></tr>
<tr><td>Exenatide (Byetta®)</td><td>20mcg/day</td></tr>
<tr><td>Linagliptin (Tradjenta®)</td><td>5mg/day</td></tr>
<tr><td>Linagliptin/Metformin (Jentadueto®, Jentadueto XR®)</td><td>5mg/2000mg per day</td></tr>
<tr><td>Liraglutide (Victoza®)</td><td>1.8mg/day</td></tr>
<tr><td>Lixisenatide (Adlyxin®, Adlyxin® Starter Kit)</td><td>20mcg/day</td></tr>
<tr><td rowspan="2">Pramlintide (Symlin®)</td><td>Type 1 diabetes: 60mcg SQ immediately prior to each major meal</td></tr>
<tr><td>Type 2 diabetes: 120mcg SQ immediately prior to each major meal</td></tr>
<tr><td>Saxagliptin (Onglyza®)</td><td>5mg/day</td></tr>
<tr><td>Saxagliptin/Metformin ER (Kombiglyze XR®)</td><td>5mg/2000mg per day</td></tr>
<tr><td>Semaglutide (Ozempic®)</td><td>1mg/week</td></tr>
<tr><td>Sitagliptin (Januvia®)</td><td>100mg/day</td></tr>
<tr><td>Sitagliptin/Metformin (Janumet®, Janumet XR®)</td><td>100mg/2000mg per day</td></tr>
<tr><td colspan="3">PU – The pharmacy POS system verifies that there has been at least a 90-day supply of metformin in the previous 180-day period OR that there has been at least a 60-day supply of any incretin mimetic/enhancer in the previous 90-day period.</td></tr>
<tr><td colspan="3">TD – GLP-1 receptor agonists are monitored at the pharmacy POS for duplication of therapy with DPP-4 inhibitors. Conversely, DPP-4 inhibitors are monitored at the pharmacy POS for duplication of therapy with GLP-1 receptor agonists.</td></tr>
</table>

Therapeutic Class	POS Edits
Diabetes – Hypoglycemics – Insulins & Related Agents	No additional POS edits apply.
Diabetes – Hypoglycemics – Meglitinides	No additional POS edits apply.
Diabetes – Hypoglycemics – Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	**PU** – The pharmacy POS system verifies that there has been at least a 90-day supply of metformin in the previous 180-day period **OR** that there has been at least a 60-day supply of any SGLT2 in the previous 90-day period.
Diabetes – Hypoglycemics – Sulfonylureas	**TD** – These agents are monitored at the pharmacy POS for duplication of therapy with each other.
Diabetes – Hypoglycemics – Thiazolidinediones (TZDs)	No additional POS edits apply.
Diabetes - Metformins	No additional POS edits apply.
Digestive Disorders – Antiemetic/ Antivertigo Agents	No additional POS edits apply on all **EXCEPT** prochlorperazine.
	BH – Additional behavioral-health related clinical information (trial of behavioral therapy, etc.) is required for all agents when requested for recipients who are younger than 6 years of age.
	BY – Prochlorperazine pharmacy claims that are submitted with a diagnosis code for severe nausea or vomiting (G43.A0, K91.0, R11.*) will bypass the Behavioral Health Clinical Authorization requirement for children younger than 6 years of age. ** Any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code*
	DX – Pharmacy claims for prochlorperazine must be submitted with an appropriate diagnosis code found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources.
Digestive Disorders – Bile Acid Salts	No additional POS edits apply.

Therapeutic Class	POS Edits
Digestive Disorders – Histamine II Receptor Blockers	**BY** – Pharmacy claims submitted with an appropriate diagnosis code will bypass the 180-day per rolling 365-days duration of therapy limit. A list of bypass diagnosis codes is found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources.
	DT – These agents are limited to a maximum 180-day duration of therapy in a rolling 365-day period.
Digestive Disorders – Pancreatic Enzymes	No additional POS edits apply.
Digestive Disorders – Proton Pump Inhibitors	**BY** – Pharmacy claims submitted with an appropriate diagnosis code will bypass the 180-day per rolling 365-days duration of therapy limit. A list of bypass diagnosis codes is found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources.
	DT – These agents are limited to a maximum 180-day duration of therapy in a rolling 365-day period.
	TD – These agents are monitored at the pharmacy POS for duplication of therapy with each other.
Digestive Disorders – Ulcerative Colitis Agents	No additional POS edits apply.
Epinephrine, Self-Injected	**QL** – These agents are limited to a quantity of 8 syringes (4 boxes of 2 syringes) per rolling 365-days.
GI Motility, Chronic	No additional POS edits apply.
Glucocorticoids, Oral	**CL -** Additional clinical information (provider specialty, etc.) is required for Emflaza®.
Gout Agents - Antihyperuricemics	No additional POS edits apply.
Growth Deficiency – Growth Hormones	**CL** – Additional clinical information (provider specialty, etc.) is required for these agents.
	DX – Pharmacy claims for all agents must be submitted with an appropriate diagnosis code found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources.

<table>
<tr><th>Therapeutic Class</th><th colspan="3">POS Edits</th></tr>
<tr><td>H. Pylori Treatment</td><td colspan="3">No additional POS edits apply.</td></tr>
<tr><td rowspan="13">Heart Disease, Hyperlipidemia - Anticoagulants</td><td colspan="3">BY – Pharmacy claims for injectable dalteparin, enoxaparin and fondaparinux that are submitted with a diagnosis code for cancer (C00.*-C96.*) or pregnancy (O00.*-O9A.*) will bypass the maximum duration of therapy edit.
* Any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code</td></tr>
<tr><td colspan="3">DT – Pharmacy claims for injectable dalteparin, enoxaparin and fondaparinux are limited to a maximum 35 days duration of therapy.</td></tr>
<tr><td rowspan="11">QL – Quantity limits apply to both preferred and non-preferred agents.</td><td colspan="2">Quantity Limits for Anticoagulants</td></tr>
<tr><td>Generic (Brand Example)</td><td>Quantity Limit</td></tr>
<tr><td>Apixaban (Eliquis®)</td><td>2 tablets/day
(Initial 4 tablets/day for 7 days when treating DVT/PE)</td></tr>
<tr><td>Dabigatran Etexilate Mesylate (Pradaxa®)</td><td>2 capsules/day</td></tr>
<tr><td>Dalteparin Sodium (Fragmin®)</td><td>2 syringes or vials/day</td></tr>
<tr><td>Edoxaban Tosylate (Savaysa®)</td><td>1 tablet/day</td></tr>
<tr><td>Enoxaparin Sodium (Lovenox®)</td><td>2 syringes or vials/day</td></tr>
<tr><td>Fondaparinux Sodium (Arixtra®)</td><td>1 syringe/day</td></tr>
<tr><td>Rivaroxaban (Xarelto®) 2.5mg</td><td>2 tablets/day</td></tr>
<tr><td>Rivaroxaban (Xarelto®) 10mg, 15mg & 20mg</td><td>1 tablet/day</td></tr>
<tr><td>Rivaroxaban (Xarelto®) Starter Pack</td><td>1 pack (51 tablets)/365 days</td></tr>
<tr><td>Warfarin (Coumadin®)</td><td>None</td></tr>
<tr><td>Heart Disease, Hyperlipidemia – Anticoagulants – Platelet Aggregation Inhibitors</td><td colspan="3">No additional POS edits apply.</td></tr>
<tr><td>Heart Disease, Hyperlipidemia – Hypertension – ACE Inhibitors & Direct Renin Inhibitors</td><td colspan="3">TD – These agents are monitored at the pharmacy POS for duplication of therapy with each other (ACE inhibitors with other ACE inhibitors; angiotensin receptor blockers with other angiotensin receptor blockers).</td></tr>
</table>

Therapeutic Class	POS Edits
Heart Disease, Hyperlipidemia – Hypertension – Angiotensin Modulators/Calcium Channel Blockers Combinations	**PU** – Amlodipine/valsartan/HCTZ and amlodipine/olmesartan/HCTZ are monitored at POS to verify claims for previous use of **TWO** drug therapies from **TWO** of the following classes: calcium channel blockers, angiotensin receptor blockers, and/or diuretics.
	TD – These agents are monitored at the pharmacy POS for duplication of therapy with each other (ACE inhibitors with other ACE inhibitors; angiotensin receptor blockers with other angiotensin receptor blockers; beta blockers with other beta blockers; calcium channel blockers with other calcium channel blockers).
Heart Disease, Hyperlipidemia – Hypertension – Beta Blocker Agents	**TD** – These agents are monitored at the pharmacy POS for duplication of therapy with each other (beta blockers with other beta blockers).
Heart Disease, Hyperlipidemia – Hypertension – Calcium Channel Blockers	**TD** – These agents are monitored at the pharmacy POS for duplication of therapy with each other (calcium channel blockers with other calcium channel blockers).
Heart Disease, Hyperlipidemia – Lipotropics, Other	No additional POS edits apply on all **EXCEPT** alirocumab (Praluent®), evolocumab (Repatha®) and lomitapide (Juxtapid®).
	CL – Additional clinical information (test results, prescriber specialty, etc.) is required for alirocumab (Praluent®), evolocumab (Repatha®) and lomitapide (Juxtapid®).
Heart Disease, Hyperlipidemia – Statins & Statin Combination Agents	No additional POS edits apply on all **EXCEPT** amlodipine/atorvastatin
	TD – Amlodipine/atorvastatin is monitored at the pharmacy POS for duplication of therapy with other calcium channel blockers. -
Heart Disease, Hyperlipidemia – Pulmonary Arterial Hypertension (PAH)	**DD** – Pharmacy claims for sildenafil (Revatio®) and tadalafil (Adcirca®) are monitored at the pharmacy POS for a drug-drug interaction with nitrates. - Incoming prescriptions for sildenafil (Revatio®) or tadalafil (Adcirca®) will deny when the recipient has an active prescription (a prescription in which the days' supply has not expired) for a nitrate. - Incoming prescriptions for a nitrate will deny when the recipient has an active prescription (a prescription in which the days' supply has not expired) for sildenafil (Revatio®) or tadalafil (Adcirca®)
	DX – Pharmacy claims for all agents must be submitted with an appropriate diagnosis code found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources.

Therapeutic Class	POS Edits
Heart Disease, Hyperlipidemia - Sympatholytics	No additional POS edits apply on all **EXCEPT** Clonidine and Guanfacine.
	BH – Additional behavioral-health related clinical information (trial of behavioral therapy, etc.) is required for clonidine (oral and transdermal) and guanfacine (oral) when used in recipients who are younger than 6 years old.
	BY – Pharmacy claims for clonidine (oral and transdermal) and guanfacine (oral) for recipients who are younger than 6 years old that are submitted with a hypertension/congenital heart disease-related diagnosis code will bypass the behavioral health clinical authorization requirement.
	DX – Pharmacy claims for clonidine (oral and transdermal) and guanfacine (oral) for recipients who are younger than 21 years old must be submitted with an appropriate diagnosis code found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources.
Heart Disease, Hyperlipidemia – Vasodilators, Coronary	No additional POS edits apply.
Hematologic Agents, Hematopoietic Agents – Erythropoietins	No additional POS edits apply.
Hemodialysis – Phosphate Binders	No additional POS edits apply.
Hemophilia Treatment	No additional POS edits apply.
Immunosuppressives, Oral	No additional POS edits apply.
Infectious Disorders – Antibiotics – Cephalosporin and Related Antibiotics	No additional POS edits apply.
Infectious Disorders – Antibiotics – Fluoroquinolones	No additional POS edits apply.

Therapeutic Class	POS Edits
Infectious Disorders – Antibiotics – Gastrointestinal Antibiotics	No additional POS edits apply.
Infectious Disorders – Antibiotics – Inhaled Antibiotics	**DX** – Pharmacy claims must be submitted with an appropriate diagnosis code found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources.
Infectious Disorders – Antibiotics – Lincosamides	No additional POS edits apply.
Infectious Disorders – Antibiotics – Macrolides - Ketolides	No additional POS edits apply.
Infectious Disorders – Antibiotics – Nitrofuran Derivatives	No additional POS edits apply.
Infectious Disorders – Antibiotics – Oxazolidinones	**CL** – Additional clinical information (diagnosis, pathogen, etc.) is required for these agents.
Infectious Disorders – Antibiotics – Streptogramins	No additional POS edits apply.
Infectious Disorders – Antibiotics – Tetracyclines	No additional POS edits apply.
Infectious Disorders – Antibiotics – Vaginal	No additional POS edits apply.
Infectious Disorders – Antibiotics – Antifungals, Oral	No additional POS edits apply.

Therapeutic Class	POS Edits		
Infectious Disorders – Hepatitis C Agents – Direct Acting Antiviral Agents	**AL** – These agents are limited to use in recipients who are within agent-specific age ranges. *[a]Override available if younger than minimum age but weighs at least 45kg.* *[b]Recipients 3-17 years of age must have genotype 2 or 3 without cirrhosis or with compensated cirrhosis*	**Treatment~~Minimum Age~~**	**Minimum Age**
		Daclatasvir (Daklinza®)	≥ 18 years
		Elbasvir/Grazoprevir (Zepatier®)	≥ 18 years
		Glecaprevir/Pibrentasvir (Mavyret®)	≥ 12 years[a]
		Ledipasvir/Sofosbuvir (Harvoni®; Authorized Generic)	≥ 3 years
		Ombitasvir/Paritaprevir/Ritonavir - Dasabuvir (Viekira PAK®)	≥ 18 years
		Sofosbuvir (Sovaldi®)	≥ 3 years[b]
		Sofosbuvir/Velpatasvir (Epclusa®; Authorized Generic)	≥ 18 years
		Sofosbuvir/Velpatasvir/Voxilaprevir (Vosevi®)	≥ 18 years
	CL – Additional clinical information (diagnosis, genotype, signed patient treatment agreement, etc.) is required for **all non-preferred** agents.		
	DT – These agents are limited to a maximum duration of therapy as listed in the table to the right. Maximum duration for some agents is based on clinical information*. **~~Duration ranges depend upon agent- and patient-specific factors.~~ *Refer to individual prescribing information.* ~~*Any duration of therapy greater than the minimum duration listed in this chart must be clinically justified based on the prescribing information and rationale* ***must be stated on the request.***~~	**Treatment~~Maximum Duration of Therapy*~~**	**Duration of Therapy***
		Daclatasvir (Daklinza®) + Sofosbuvir (Sovaldi®)	12 weeks
		Elbasvir/Grazoprevir (Zepatier®)	12 – 16 weeks
		Glecaprevir/Pibrentasvir (Mavyret®)	8 – 16 weeks
		Ledipasvir/Sofosbuvir (Harvoni®; Authorized Generic)	12 – 24 weeks
		Ombitasvir/Paritaprevir/Ritonavir - Dasabuvir (Viekira PAK®)	12 – 24 weeks
		Sofosbuvir (Sovaldi®)	12 – 48 weeks
		Sofosbuvir/Velpatasvir (Epclusa®; Authorized Generic)	12 weeks
		Sofosbuvir/Velpatasvir/Voxilaprevir (Vosevi®)	12 weeks
	DX – Pharmacy claims must be submitted with an appropriate diagnosis code for Chronic Hepatitis C (B18.2).		
	QL – These agents are limited to a maximum quantity limit **per rolling 28 days** as listed in the table to the right. **AG – Authorized Generic*	**Treatment~~Maximum Quantity Limit Per Rolling 28 Days~~**	**Quantity per Rolling 28 days**
		Daclatasvir (Daklinza®) tablet	28
		Elbasvir/Grazoprevir (Zepatier®) tablet	28
		Glecaprevir/Pibrentasvir (Mavyret®) tablet	84
		Ledipasvir/Sofosbuvir (Harvoni®) 90mg/400mg tablet	28
		Ledipasvir/Sofosbuvir (Harvoni®) 45mg/200mg tablet	56
		Ledipasvir/Sofosbuvir (Harvoni®) 45mg/200mg packet	56
		Ledipasvir/Sofosbuvir (Harvoni®) 33.75mg/150mg packet	28
		Ledipasvir/Sofosbuvir (AG* for Harvoni®) 90mg/400mg tablet	28
		Ombitasvir/Paritaprevir/Ritonavir - Dasabuvir (Viekira PAK®) tablet	112
		Sofosbuvir (Sovaldi®) 400mg tablet	28
		Sofosbuvir (Sovaldi®) 200mg tablet	56
		Sofosbuvir (Sovaldi®) 200mg packet	56

Therapeutic Class	POS Edits		
		Sofosbuvir (Sovaldi®) 150mg packet	28
		Sofosbuvir/Velpatasvir (Epclusa®; AG*) tablet	28
		Sofosbuvir/Velpatasvir/Voxilaprevir (Vosevi®) tablet	28
	TD – These agents are monitored at the pharmacy POS for duplication of therapy with each other.		
Infectious Disorders – Hepatitis C Agents – Not Direct Acting Antiviral Agents	**DX** – Pharmacy claims must be submitted with an appropriate diagnosis code found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources.		
Multiple Sclerosis - Multiple Sclerosis Agents - Immunomodulatory Agents	**CL** – Additional clinical information (prescriber specialty, response to therapy, etc.) is required for these agents.		
Oncology Oral – Breast	No additional POS edits apply.		
Oncology Oral – Hematologic	No additional POS edits apply on all **EXCEPT** pomalidomide.		
	DX – Pharmacy claims for pomalidomide must be submitted with an appropriate diagnosis code found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources.		
Oncology Oral – Lung	No additional POS edits apply.		
Oncology Oral – Other	No additional POS edits apply.		
Oncology Oral – Prostate	No additional POS edits apply.		
Oncology Oral - Renal Cell	No additional POS edits apply.		
Oncology Oral – Skin	No additional POS edits apply.		
Ophthalmic Disorders Allergic Conjunctivitis	No additional POS edits apply.		
Ophthalmic Disorders Antibiotics	No additional POS edits apply.		
Ophthalmic Disorders Antibiotic-Steroid Combinations	No additional POS edits apply.		
Ophthalmic Disorders Anti-Inflammatories	No additional POS edits apply.		

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<table>
<tr><th>Therapeutic Class</th><th colspan="3">POS Edits</th></tr>
<tr><td>Ophthalmic Disorders Anti-Inflammatory/ Immunomodulators</td><td colspan="3">No additional POS edits apply.</td></tr>
<tr><td>Ophthalmic Disorders Glaucoma Agents - Intraocular Pressure (IOP) Reducers</td><td colspan="3">No additional POS edits apply.</td></tr>
<tr><td rowspan="9">Opiate Dependence Agents</td><td rowspan="6">AL – The agents listed in the table to the right are limited to use in recipients who meet specific age requirements.</td><td colspan="2">Minimum Age Requirements</td></tr>
<tr><td>Generic (Brand Example)</td><td>Minimum Age</td></tr>
<tr><td>Buprenorphine (Probuphine®)</td><td>16 years</td></tr>
<tr><td>Buprenorphine (Sublocade®)</td><td>18 years</td></tr>
<tr><td>Buprenorphine SL</td><td>16 years</td></tr>
<tr><td>Buprenorphine/Naloxone (Bunavail®, Suboxone®, Zubsolv®)</td><td>16 years</td></tr>
<tr><td>Naltrexone (Vivitrol®)</td><td>18 years</td></tr>
<tr><td colspan="3">CU – Concurrent opioid analgesic, benzodiazepine and/or any buprenorphine-containing agent prescriptions will deny.</td></tr>
<tr><td colspan="3">DD – Pharmacy claims for naltrexone extended-release injectable suspension (Vivitrol®) will deny for drug-drug interaction when the recipient has an active prescription (a prescription in which the days' supply has not expired) for an opioid.</td></tr>
<tr><td colspan="3">DX – Pharmacy claims for some agents must be submitted with an appropriate diagnosis code.
- Pharmacy claims for all buprenorphine opiate dependence agents (single-ingredient and combination) must be submitted with a diagnosis code for opioid dependence (F11.2*).
- Naltrexone extended-release injectable suspension (Vivitrol®) must be submitted with either a diagnosis code for opioid dependence (F11.2*) or alcohol dependence (F10.2*).
* Any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code</td></tr>
<tr><td colspan="3">MD – Buprenorphine agents (single-ingredient and combination) are limited to a maximum daily dose of 24mg per day of buprenorphine or buprenorphine equivalent. Refer to specific product prescribing information for buprenorphine equivalence charts.</td></tr>
<tr><td rowspan="7">QL – Some agents have quantity limits as listed in the chart to the right.</td><td colspan="2">Quantity Limits</td></tr>
<tr><td>Generic (Brand Example)</td><td>Quantity Limit</td></tr>
<tr><td>Buprenorphine Implant Kit (Probuphine®)</td><td>2 kits/720 days</td></tr>
<tr><td>Buprenorphine Extended-Release Injection (Sublocade®)</td><td>1 unit/30 days</td></tr>
<tr><td>Buprenorphine SL Tablet 2mg</td><td>2 units/day</td></tr>
<tr><td>Buprenorphine SL Tablet 8mg</td><td>3 units/day</td></tr>
<tr><td>Buprenorphine/Naloxone 2.1mg/0.3mg (Bunavail®)</td><td>1 unit/day</td></tr>
<tr><td>Buprenorphine/Naloxone 4.2mg/0.7mg (Bunavail®)</td><td>3 units/day</td></tr>
</table>

Therapeutic Class	POS Edits		
(continued on next page)		Buprenorphine/Naloxone 6.3mg/1mg (Bunavail®)	2 units/day
		Buprenorphine/Naloxone 2mg/0.5mg SL Tab (Suboxone®)	2 units/day
		Buprenorphine/Naloxone 2mg/0.5mg SL Film (Suboxone®)	1 unit/day
Opiate Dependence Agents		Buprenorphine/Naloxone 4mg/1mg SL Film (Suboxone®)	1 unit/day
		Buprenorphine/Naloxone 8mg/2mg SL Film/Tab (Suboxone®)	3 units/day
		Buprenorphine/Naloxone 12mg/3mg SL Film (Suboxone®)	2 units/day
		Buprenorphine/Naloxone SL Tablet 0.7mg/0.18mg (Zubsolv®)	1 unit/day
		Buprenorphine/Naloxone SL Tablet 1.4mg/0.36mg (Zubsolv®)	1 unit/day
		Buprenorphine/Naloxone SL Tablet 2.9mg/0.71mg (Zubsolv®)	1 unit/day
		Buprenorphine/Naloxone SL Tablet 5.7mg/1.4mg (Zubsolv®)	3 units/day
		Buprenorphine/Naloxone SL Tablet 8.6mg/2.1mg (Zubsolv®)	2 units/day
		Buprenorphine/Naloxone SL Tablet 11.4mg/2.9mg (Zubsolv®)	1 unit/day
		Naltrexone Extended-Release Injectable Suspension (Vivitrol®)	1 unit/28 days
		Naloxone Nasal Spray (Narcan®)	2 units/90 days
		Naloxone Injectable Solution/Cartridge 0.4mg/ml	2 units/90 days
		Naloxone Injectable Solution Syringe 1mg/ml	2 units/90 days
		Naloxone Injectable Solution (5ml, 10ml, 20ml) 1mg/ml	1 unit/90 days
		Naloxone Injectable Solution (10ml) 0.4mg/ml	1 unit/90 days
	TD – These agents are monitored at the pharmacy POS for duplication of therapy with each other, with opioid analgesics, and with benzodiazepines. - Incoming prescriptions for buprenorphine or buprenorphine/naloxone agents will deny when the recipient has an active prescription (a prescription in which the days' supply has not expired) for any buprenorphine or buprenorphine/naloxone agent. Concurrent opioid analgesic and/or benzodiazepine prescriptions will deny for recipients with an active buprenorphine or buprenorphine/naloxone prescription (a prescription in which the days' supply has not expired).		
	X – Prescribers of buprenorphine must meet enrollment and certification requirements.		
Osteoporosis - Bone Resorption Suppression Agents	No additional POS edits apply.		
Otic Agents Antibiotics	No additional POS edits apply.		
Otic Agents	No additional POS edits apply.		

<table>
<tr><th>Therapeutic Class</th><th>POS Edits</th></tr>
<tr><td>Anti-Infectives and Anesthetics</td><td></td></tr>
<tr><td>Pain Management Antimigraine Agents – CGRP Antagonists</td><td>CL – Additional clinical information (prescriber specialty, migraine history, etc.) is required for all CGRP agents.</td></tr>
<tr><td>Pain Management Antimigraine Agents - Ergotamine</td><td>No additional POS edits apply.</td></tr>
<tr><td>Pain Management Antimigraine Agents - Triptans</td><td>DX – Pharmacy claims for all agents for recipients who are younger than 18 years of age must be submitted with an appropriate diagnosis code for migraines – G43.0*, G43.1* or G43.7*
* Any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code

QL –Quantity limits are listed in the table to the right.
<table>
<tr><th colspan="2">Quantity Limits for Oral Triptans and Onzetra®</th></tr>
<tr><th>Generic (Brand Example)</th><th>Quantity Limit per Rolling 30 days</th></tr>
<tr><td>Almotriptan (Axert®)</td><td>12</td></tr>
<tr><td>Eletriptan (Relpax®)</td><td>6</td></tr>
<tr><td>Frovatriptan (Frova®)</td><td>9</td></tr>
<tr><td>Naratriptan (Amerge®)</td><td>9</td></tr>
<tr><td>Rizatriptan Tablet (Maxalt®, Maxalt MLT®)</td><td>12</td></tr>
<tr><td>Sumatriptan/Naproxen (Treximet®)</td><td>9</td></tr>
<tr><td>Sumatriptan (Imitrex®)</td><td>9</td></tr>
<tr><td>Zolmitriptan (Zomig®, Zomig ZMT®)</td><td>6</td></tr>
<tr><td>Sumatriptan Nasal Powder (Onzetra® Xsail®)</td><td>1 kit</td></tr>
</table></td></tr>
<tr><td>Pain Management Cytokine and CAM Antagonists</td><td>CL – Additional clinical information (diagnosis, maximum dose, etc.) is required for all Cytokines and CAM Antagonists.</td></tr>
</table>

Therapeutic Class	POS Edits
Pain Management Narcotic Analgesics - Short-Acting	**AL** – Some agents are limited to use in recipients who are within agent-specific age ranges. - Codeine single-ingredient products are limited to use in recipients who are at least 18 years of age. Codeine combination products are limited to use in recipients who are at least 12 years of age. - Fentanyl nasal solution (Lazanda®) and fentanyl sublingual spray (Subsys®) are limited to use in recipients who are at least 18 years old. - Tramadol and tramadol/acetaminophen are limited to use in recipients who are at least 17 years old.
	BY – Bypass diagnosis codes can be found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources. - With the exception of fentanyl buccal and sublingual agents (e.g., Abstral®, Fentora®), pharmacy claims submitted with a diagnosis code for cancer, palliative end-of-life care, second or third degree burns or corrosions, or sickle cell crisis, will bypass the quantity limits. - Pharmacy claims for any short-acting narcotic analgesic, when submitted with a diagnosis code for cancer, palliative end-of-life care, second or third degree burns or corrosions, or sickle cell crisis, will bypass the maximum morphine milligram equivalent (MME) limit. - Pharmacy claims for any short-acting narcotic analgesic, when submitted with a diagnosis code for cancer or palliative end-of-life care, will bypass the restriction on concurrent use of opioids with benzodiazepines.
	CU – Concurrent use of opioid analgesics and benzodiazepines is monitored at the pharmacy POS. - Pharmacy claims for an opioid analgesic will deny when the recipient has an active prescription (a prescription in which the days' supply has not expired) for a benzodiazepine.
	DX - Pharmacy claims for all Schedule II opioid prescriptions must be submitted with a valid diagnosis code. - Pharmacy claims for fentanyl buccal and sublingual agents (e.g., Abstral®, Fentora®) must be submitted with a cancer-related diagnosis code (C00.*-C96.*). ** Any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code*

	MD – Pharmacy claims for some agents are limited to a maximum daily dose.
	- Tapentadol is limited to a maximum daily dose of 700mg per day.
	- Tramadol immediate-release is limited to a maximum daily dose based on age:
	  o 400mg/day for recipients who are younger than 76 years of age;
	  o 300mg/day for recipients who are older than 75 years of age.
	- Tramadol/acetaminophen is limited to a maximum daily dose of 8 tablets per day.

(continued on next page)

<table>
<tr><th>Therapeutic Class</th><th colspan="4">POS Edits</th></tr>
<tr><td rowspan="3">Pain Management Narcotic Analgesics - Short-Acting</td><td colspan="4">MME – The cumulative daily morphine milligram equivalent (MME) for all active opioid prescriptions will be limited to a maximum of 90 MME per day.</td></tr>
<tr><td rowspan="19">QL – Quantity limits for short-acting narcotic analgesics are based upon the recipient’s recent history of opioid use.</td><td colspan="2">No Opioid Claim in Previous 90-days</td><td colspan="2">Opioid Claim in Previous 90-days</td></tr>
<tr><td>Generic</td><td>7-day Quantity Limit</td><td>Generic</td><td>30-day Quantity Limit</td></tr>
<tr><td>Codeine/Acetaminophen</td><td>28 units</td><td>Codeine/Acetaminophen</td><td>Not Addressed</td></tr>
<tr><td>Benzhydrocodone/Acetaminophen</td><td>28 units</td><td>Benzhydrocodone/Acetaminophen</td><td>45 units</td></tr>
<tr><td>Fentanyl Buccal/Sublingual</td><td>Not Addressed</td><td>Fentanyl Buccal/Sublingual</td><td>120 units</td></tr>
<tr><td>Hydrocodone/Acetaminophen</td><td>28 units</td><td>Hydrocodone/Acetaminophen</td><td>45 units</td></tr>
<tr><td>Hydrocodone/Ibuprofen</td><td>28 units</td><td>Hydrocodone/Ibuprofen</td><td>30 units</td></tr>
<tr><td>Hydromorphone</td><td>28 units</td><td>Hydromorphone</td><td>45 units</td></tr>
<tr><td>Meperidine</td><td>28 units</td><td>Meperidine</td><td>45 units</td></tr>
<tr><td>Morphine</td><td>28 units</td><td>Morphine</td><td>45 units</td></tr>
<tr><td>Oxycodone</td><td>28 units</td><td>Oxycodone</td><td rowspan="3">45 units total</td></tr>
<tr><td>Oxycodone/Acetaminophen</td><td>28 units</td><td>Oxycodone/Acetaminophen</td></tr>
<tr><td>Oxycodone/Aspirin</td><td>28 units</td><td>Oxycodone/Aspirin</td></tr>
<tr><td>Oxycodone/Ibuprofen</td><td>14 units</td><td>Oxycodone/Ibuprofen</td><td>28 units</td></tr>
<tr><td>Oxymorphone</td><td>28 units</td><td>Oxymorphone</td><td>45 units</td></tr>
<tr><td>Tapentadol</td><td>28 units</td><td>Tapentadol</td><td>45 units</td></tr>
<tr><td>Tramadol</td><td>28 units</td><td>Tramadol</td><td>45 units</td></tr>
<tr><td>Tramadol/Acetaminophen</td><td>28 units</td><td>Tramadol/Acetaminophen</td><td>40 units</td></tr>
<tr><td colspan="4">TD – These agents are monitored at the pharmacy POS for duplication of therapy with each other and with buprenorphine-containing agents.
- These agents are monitored at the pharmacy POS for duplication of therapy with each other (short-acting narcotics with other short-acting narcotics).
- Pharmacy claims for an opioid analgesic for recipients with an active prescription (a prescription in which the days’ supply has not expired) for buprenorphine-containing agents will deny.</td></tr>
</table>

Therapeutic Class	POS Edits
Pain Management Narcotic Analgesics - Long-Acting	**AL** – Tramadol and tramadol/acetaminophen are limited to use in recipients who are at least 17 years of age.
	BY – Bypass diagnosis codes can be found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources. - Pharmacy claims submitted with a diagnosis code for cancer, palliative end-of-life care, second or third degree burns or corrosions, or sickle cell crisis will bypass the quantity limits and the maximum morphine milligram equivalent (MME) limits. - Pharmacy claims submitted with a diagnosis code for cancer or palliative end-of-life care will bypass the previous use requirement (see **PU** below) and the restriction on concurrent use of opioids with benzodiazepines.
	CU – Concurrent use of opioid analgesics and benzodiazepines is monitored at the pharmacy POS. - Pharmacy claims for an opioid analgesic will deny when the recipient has an active prescription (a prescription in which the days' supply has not expired) for a benzodiazepine. - Pharmacy claims for an opioid analgesic will deny when the recipient has an active prescription (a prescription in which the days' supply has not expired) for a benzodiazepine. .
	DX - Pharmacy claims for all Schedule II opioid prescriptions must be submitted with a valid diagnosis code. - Pharmacy claims for buprenorphine transdermal patch (Butrans®) must be submitted with a valid diagnosis code. Claims submitted for buprenorphine transdermal patch (Butrans®) without a diagnosis code or with a diagnosis code related to the management of addictive disorders or substance abuse (F11.2*) will deny. ** Any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code*
	MD – Pharmacy claims for some agents are limited to a maximum daily dose. - Buprenorphine buccal film (Belbuca®) is limited to a maximum daily dose of 1800mcg/24hr. - Buprenorphine transdermal (Butrans®) is limited to a maximum daily dose of 480mcg/24hr (20mcg/hr). Each patch is intended to be worn for seven days. - Morphine sulfate ER (Avinza®) is limited to a maximum daily dose of 1600mg/day. - Tapentadol is limited to a maximum daily dose of 700mg per day. - Tramadol sustained-release is limited to a maximum daily dose of 300mg/day.
	MME –For each recipient, the cumulative daily morphine milligram equivalent (MME) for all active opioid prescriptions will be limited to a maximum of 90 MME per day.
(continued on next page)	**PU** – The pharmacy POS system verifies that there has been at least one short-acting or long-acting opioid claim within the previous 90-day period before a long-acting opioid claim will process at POS.

		Generic (Brand Example)	Quantity Limit

<table>
<tr><th>Therapeutic Class</th><th colspan="3">POS Edits</th></tr>
<tr><td rowspan="13">Pain Management Narcotic Analgesics - Long-Acting</td><td rowspan="12">QL – Quantity limits for long-acting narcotic analgesics are based on a 30-day supply.</td><td>Fentanyl Patch (Duragesic®) 12mcg/hr, 25mcg/hr, 37.5mcg/hr, 50mcg/hr</td><td>10 units</td></tr>
<tr><td>Fentanyl Patch (Duragesic®) 62.5mcg/hr, 75mcg/hr, 87.5mcg/hr, 100mcg/hr</td><td>20 units</td></tr>
<tr><td>Hydromorphone (Exalgo®)</td><td>30 units</td></tr>
<tr><td>Hydrocodone (Zohydro ER®)</td><td>60 units</td></tr>
<tr><td>Hydrocodone (Hysingla ER®)</td><td>30 units</td></tr>
<tr><td>Morphine (Avinza®)</td><td>30 units</td></tr>
<tr><td>Morphine (Kadian®)</td><td>30 units</td></tr>
<tr><td>Morphine (MS Contin®)</td><td>60 units</td></tr>
<tr><td>Morphine/Naltrexone (Embeda®)</td><td>60 units</td></tr>
<tr><td>Oxycodone (Oxycontin®)</td><td>60 units</td></tr>
<tr><td>Oxycodone (Xtampza ER®)</td><td>60 units</td></tr>
<tr><td>Oxymorphone (Opana ER®)</td><td>60 units</td></tr>
<tr><td>Tapentadol (Nucynta ER®)</td><td>60 units</td></tr>
<tr><td>Tramadol ER (Conzip®)</td><td>30 units</td></tr>
<tr><td colspan="3">TD – These agents are monitored at the pharmacy POS for duplication of therapy with each other and with buprenorphine-containing agents.
- These agents are monitored at the pharmacy POS for duplication of therapy with each other (long-acting narcotics with other long-acting narcotics).
- Pharmacy claims for an opioid analgesic for recipients with an active prescription (a prescription in which the days' supply has not expired) for buprenorphine-containing agents will deny.</td></tr>
<tr><td rowspan="3">Pain Management Neuropathic Pain</td><td colspan="3">No additional POS edits apply on all EXCEPT duloxetine and lidocaine patch.</td></tr>
<tr><td colspan="3">BH – Additional behavioral-health related clinical information (trial of behavioral therapy, etc.) is required for duloxetine when requested for recipients who are younger than 6 years of age.</td></tr>
<tr><td colspan="3">QL – Pharmacy claims for lidocaine patches are limited to 30 patches every rolling 30 days. Override is available through an authorization process when the recipient has a diagnosis of post-herpetic neuralgia.</td></tr>
<tr><td>Pain Management Non-Steroidal Anti-</td><td colspan="3">DS – Pharmacy claims for oral ketorolac are limited to a maximum five day supply.</td></tr>
</table>

Therapeutic Class	POS Edits
Inflammatory Drugs (NSAIDS) –	**DX** –Pharmacy claims for new prescriptions for celecoxib will deny for "Drug Use Not Warranted" if the claim is not submitted with a valid diagnosis code and rationale for use of celecoxib rather than a non-selective NSAID (See **UN** below).
	QL – Pharmacy claims for oral ketorolac are limited to a maximum quantity of 20 tablets.
	TD – These agents are monitored at the pharmacy POS for duplication of therapy with each other.
	UN – Pharmacy claims for celecoxib will deny for "Drug Use Not Warranted" if the claim is not submitted with a valid diagnosis code and rationale for use of celecoxib rather than a non-selective NSAID (e.g., history of GI bleed). Pharmacy claims submitted with a diagnosis code but without a rationale for celecoxib use will process without an override when one of the following conditions is verified in pharmacy claims: - Recipient has a current prescription for an H2 receptor antagonist; **OR** - Recipient has a current prescription for a Proton Pump Inhibitor; **OR** - Recipient has a current prescription for warfarin; **OR** - Recipient has current prescriptions indicating chronic use of oral steroids; **OR** - Recipient is sixty years old or older.
Pain Management Skeletal Muscle Relaxants	No additional POS edits apply on all **EXCEPT** carisoprodol-containing products.
	QL – Carisoprodol-containing products have a quantity limit of 90 tablets per rolling 90 days. The quantity limit applies to all strengths and combinations of carisoprodol.
PARKINSON'S – Antiparkinson Agents – Anticholinergic and Other	No additional POS edits apply.
PEDIATRIC MULTIVITAMINS	No additional POS edits apply.
PITUITARY SUPPRESSIVE AGENTS	**DX** – Pharmacy claims for all agents must be submitted with an appropriate diagnosis code found at THIS LINK in the ICD-10-CM Diagnosis Code Policy Chart under Pharmacy Resources.

<table>
<tr><th>Therapeutic Class</th><th>POS Edits</th></tr>
<tr><td>PROGESTATIONAL AGENTS</td><td>DX – Pharmacy claims for hydroxyprogesterone caproate that is indicated for pre-term labor (Makena®, its generic and authorized generic) and progesterone, micronized, vaginal (Crinone®) require an appropriate diagnosis code at POS.
- Hydroxyprogesterone caproate that is indicated for pre-term labor (Makena®, its generic and authorized generic) requires a diagnosis code for pregnancy with a history of pre-term labor (O09.21*).
- Progesterone, micronized, vaginal (Crinone®) requires a diagnosis code for secondary amenorrhea (N91.1).
* Any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code</td></tr>
<tr><td>PROSTATE - Benign Prostatic Hyperplasia Treatment (BPH)</td><td>No additional POS edits apply.</td></tr>
<tr><td rowspan="4">SEDATIVE/ HYPNOTICS</td><td>BH – Additional behavioral-health related clinical information (trial of behavioral therapy, etc.) is required for doxepin when requested for recipients who are younger than 6 years of age.</td></tr>
<tr><td>CL – Additional clinical information (prescriber specialty, severity of diagnosis, etc.) is required for tasimelteon.</td></tr>
<tr><td>
MD – Sedative/hypnotics have a maximum daily dose as listed in the chart to the right.
<table>
<tr><th colspan="2">Maximum Daily Dose for Selected Sedative/Hypnotics</th></tr>
<tr><th>Generic Name (Brand Example)</th><th>Maximum Dose Per Day</th></tr>
<tr><td>Doxepin (Silenor®)</td><td>6 mg/day</td></tr>
<tr><td>Estazolam (ProSom®)</td><td>2 mg/day</td></tr>
<tr><td>Eszopiclone (Lunesta®)</td><td>3 mg/day</td></tr>
<tr><td>Flurazepam (Dalmane®)</td><td>30 mg/day</td></tr>
<tr><td>Quazepam (Doral®)</td><td>15 mg/day</td></tr>
<tr><td>Ramelteon (Rozerem®)</td><td>8 mg/day</td></tr>
<tr><td>Suvorexant (BELSOMRA®)</td><td>20mg/day</td></tr>
<tr><td>Tasimelteon (Hetlioz®)</td><td>20mg/day</td></tr>
<tr><td>Temazepam (Restoril®)</td><td>30 mg/day</td></tr>
<tr><td>Triazolam (Halcion®)</td><td>0.5 mg/day</td></tr>
<tr><td>Zaleplon (Sonata®)</td><td>20 mg/day</td></tr>
<tr><td>Zolpidem IR tablet (Ambien®)</td><td>10 mg/day</td></tr>
<tr><td>Zolpidem SL tablet (Edluar®)</td><td>10 mg/day</td></tr>
<tr><td>Zolpidem Oral Spray (ZolpiMist®)</td><td>10 mg (2sprays)/day</td></tr>
<tr><td>Zolpidem ER Tablet (Ambien CR®)</td><td>12.5 mg/day</td></tr>
<tr><td>Zolpidem SL Tablet (Intermezzo®)</td><td>1.75mg/day (female)</td></tr>
<tr><td>Zolpidem SL Tablet (Intermezzo®)</td><td>3.5 mg/day (male)</td></tr>
</table>
</td></tr>
<tr><td>TD – These agents are monitored at the pharmacy POS for duplication of therapy with other sedative/hypnotic agents.</td></tr>
<tr><td>SINUS NODE INHIBITORS</td><td>CL – Additional clinical information (prescriber specialty, diagnosis, etc.) is required for ivabradine.</td></tr>
</table>

Therapeutic Class	POS Edits
SMOKING CESSATION PRODUCTS	No additional POS edits apply on all **EXCEPT** nicotine gum, nicotine patch and nicotine nasal spray.
	PR – Prescribers must certify, in their own handwriting, that the recipient is enrolled in a physician-supervised behavioral program in order for nicotine transdermal patches, nicotine polacrilex gum, and nicotine spray to be covered.
	RX – Nicotine transdermal patches, nicotine polacrilex gum, and nicotine spray are covered only with a handwritten prescription signed by the prescribing provider. There are no provisions for refills. The prescriber will need to rewrite a prescription each time.
UROLOGY INCONTINENCE – Bladder Relaxant Preparations	No additional POS edits apply.
UTERINE DISORDER TREATMENT	**CL** – Additional clinical information (prescriber specialty, diagnosis, etc.) is required for elagolix.

Pharmacy Prior Authorization Phone Numbers for MCOs and FFS
Aetna Better Health of Louisiana **1-855-242-0802**
AmeriHealth Caritas Louisiana **1-800-684-5502**
Fee-for-Service (FFS) Louisiana Legacy Medicaid **1-866-730-4357**
Healthy Blue **1-844-521-6942**
Louisiana Healthcare Connections **1-888-929-3790**
UnitedHealthcare **1-800-310-6826**

ADDITIONAL AGENTS THAT HAVE POINT-OF-SALE (POS) REQUIREMENT(S)					
Click Here for Behavioral Health Agents Listed Below for Children Younger Than Six (BH)				Click Here for Agents Listed Below with POS Requirements	
Acetaminophen	**POS**	Exjade®, Jadenu® (Deferasirox)	**POS**	Palynziq® (Pegvaliase-pqpz)	**CL**
Acthar® (Corticotropin)	**CL**	EXONDYS 51® (Eteplirsen)	**CL, DX**	Pamidronate Disodium	**CL**
Actimmune® (Interferon Gamma-1b)	**POS**	Fabrazyme® (Agalsidase beta)	**POS**	Proleukin® (Aldesleukin)	**POS**
Alferon N® (Interferon Alfa-N3)	**POS**	Fasenra® (Benralizumab)	**CL**	Protriptyline	**BH, TD**
Amitriptyline	**BH, TD**	Flolan® (Epoprostenol Sodium)	**POS**	Pulmozyme® (Dornase Alfa)	**POS**
Amitriptyline/Chlordiazepoxide	**BH**	Fycompa® (Perampanel)	**POS**	Ravicti® (Glycerol Phenylbutyrate)	**CL**
Amoxapine	**BH, TD**	Gattex® (Teduglutide)	**CL**	Reclast® (Zoledronic acid)	**CL, QL**
Amyotrophic Lateral Sclerosis – Radicava®, Rilutek®, Tiglutik™	**POS**	Hereditary Angioedema – Berinert®, Cinryze®, Firazyr®, Haegarda®, Kalbitor®, Ruconest®, Takhzyro™	**CL**	Remodulin® (Treprostinil Sodium) INJECTION	**POS**
Aspirin	**POS**	HIV Agents	**POS**	Rinvoq™ (Upadacitinib)	**CL**
Austedo® (Deutetrabenazine)	**CL**	Imipramine	**BH, TD**	Rybelsus® (Semaglutide)	**POS**
Beyaz® (Drospirenone/Ethinyl Estradiol/ Levomefolate Calcium)	**POS**	Increlex® (Mecasermin)	**CL**	Samsca® (Tolvaptan)	**CL, POS**
Botox® (OnabotulinumtoxinA)	**DX, QL**	Ingrezza® (Valbenazine)	**CL**	Santyl® (Collagenase)	**QL**
Buphenyl® (Sodium Phenylbutyrate)	**CL**	Intron-A® (Interferon Alfa-2B Recombinant)	**POS**	Skyrizi® (Risankizumab-rzaa)	**CL**
Cablivi® (Caplacizumab-yhdp)	**CL**	Isotretinoin	**POS**	Soliris® (Eculizumab)	**POS**
Carafate® (Sucralfate)	**POS**	Jynarque® (Tolvaptan)	**CL**	Spinraza® (Nusinersen) SPINRAZA® FORM	**CL, DX**
Carbaglu® (Carglumic Acid)	**CL**	Kuvan® (Sapropterin Dihydrochloride)	**CL**	Spravato® (Esketamine)	**CL**
Chlordiazepoxide/Clidinium	**BH**	Lithium	**BH**	Sunosi™ (Solriamfetol)	**POS**
Chlorpromazine Injectable	**BH**	Lokelma® (Sodium Zirconium Cyclosilicate)	**CL**	Sylatron® (Peginterferon alfa-2b)	**POS**
Cialis® (Tadalafil) 2.5mg, 5mg	**POS**	Lorazepam Injectable	**BY**	Synagis® (Palivizumab) Criteria & Request Form	**AL, CL, DT, QL**
Cinqair® (Reslizumab)	**CL**	Lumizyme® (Alglucosidase alfa)	**POS**	Tegsedi™ (Inotersen)	**POS**

Clomipramine	**BH, TD**	Maprotiline	**BH**	Tosymra® (Sumatriptan)	**POS**
Clonazepam Tablet	**BH, BY, QL**	Mavenclad® (Cladribine)	**CL**	Trikafta™ (Elexacaftor/Ivacaftor/Tezacaftor)	**CL**
Cuprimine®, Depen® (Penicillamine)	**CL, POS**	Mayzent® (Siponimod)	**CL**	Trimipramine	**BH, TD**
Daraprim® (Pyrimethamine)	**CL**	Methadone	**CL, DX, QL**	Veletri® (Epoprostenol)	**POS**
Desipramine	**BH, TD**	Mosquito Repellant to Decrease Zika Virus Exposure Risk. FFS Notice MCO Notice	**AL, DX, QL**	Veltassa® (Patiromer)	**CL**
Doral® (Quazepam)	**MD**	Myobloc® (RimabotulinumtoxinB)	**DX**	Vyndamax™, Vyndaqel® (Tafamidis)	**CL, QL**
Doxepin (10mg-150mg)	**BH, TD**	Mytesi® (Crofelemer)	**CL**	Vyondys 53® (Golodirsen)	**CL**
Dysport® (AbobotulinumtoxinA)	**DX**	Nexplanon® (Etonogestrel)	**POS**	Wakix® (Pitolisant)	**POS**
Egrifta®, Egrifta SV™ (Tesamorelin)	**POS**	Nortriptyline	**BH, TD**	Xenazine® (Tetrabenazine)	**CL**
Endari® (L-Glutamine)	**CL**	Nucala® (Mepolizumab)	**CL**	Xenical® (Orlistat)	**DX, QL**
Enzyme Replacement Therapy for Mucopolysaccharidosis – Aldurazyme™, Elaprase™, Mepsevii™, Naglazyme™, Vimizim™	**CL**	Nuedexta® (Dextromethorphan/Quinidine)	**CL, QL**	Xeomin® (IncobotulinumtoxinA)	**DX, QL**
Epidiolex® (Cannabidiol)	**CL**	Onpattro® (Patisiran)	**POS**	Xolair® (Omalizumab)	**CL**
Equetro® (Carbamazepine)	**BH, BY**	Oralair® (Mixed Grass Allergen Extract)	**POS**	Xyrem® (Sodium Oxybate)	**CL, TD**
				Zolgensma® (Onasemnogene Abeparvovec-xioi)	**CL**
				Zulresso™ (Brexanolone)	**CL**

Revision	Date
Document Developed	January 2020
Included Urology and Uterine Disorder therapeutic class POS edits	February 2020
Added clinical criteria and/or POS edit information for Acthar®, Aldurazyme™, Cablivi®, Elaprase™, Egrifta®/Egrifta SV™, Epidiolex®, Gattex®, Mayzent®, Mepsevii™, Naglazyme™, Nuedexta®, Onpattro®, Pamidronate Disodium, Radicava®, Reclast®, Rilutek®, Rinvoq™, Rybelsus®, Sunosi®, Tegsedi™, Tiglutik™, Vyndamax™, Vyndaqel®, Vimizim™, Wakix™; updated criteria for Myobloc®, Nucala®, and Spinraza®; added Spinraza® Request Form	March 2020
Moved methadone to POS document	March 2020
Added clinical criteria and/or POS edit information for Buphenyl®, Carbaglu®, Cuprimine®, Depen®, Emflaza®, Jynarque®, Mytesi®, Ravicti®, Samsca®, Trikafta™, Vyondys 53® and Zulresso™	May 2020