University System of Georgia
Prior Authorization, Step Therapy and Quantity Limit List
(Updated 1/1/2016)

Prior Authorization (PA)

Your doctor will need to obtain a prior authorization for the drugs listed below, before your prescription drug plan administered by CVS/caremark® will cover them. The prior authorization process ensures that you are receiving the appropriate drugs for the treatment of specific conditions and in quantities approved by the U.S. Food and Drug Administration (FDA).

For prior authorization review, your **doctor** should call CVS/caremark toll-free at **1-800-294-5979 before** you go to the pharmacy. The prior authorization line is for your doctor's use only.

Drug Class	Products Requiring Prior Authorization (PA)
Acne	Differin (adapalene) – *PA required only in adults age 30 and older*
	Tazorac/Fabior (tazarotene)
	Topical Retinoids (Atralin, Avita, Retin-A, Retin-A Micro, Tretin-X, tretinoin, Veltin, Ziana) – *PA required only in adults age 30 and older*
ADHD/Narcolepsy	Amphetamine products (Adderall, Adderall XR, Desoxyn, Dexedrine, Dynavel XR, Evekeo, LiQuadd/ProCentra, Vyvanse) – *PA required only in adults age 22 and older*
	Methylphenidate products (Aptensio XR, Concerta, Daytrana, Focalin Products, Metadate Products, Methylin Products, Quillivant XR, Ritalin Products) – *PA required only in adults age 22 and older*
	Strattera (atomoxetine) – *PA required only in adults age 22 and older*
Anabolic Steroids	Anadrol-50, Oxandrin
Antifungals, Topical	Ciclopirox Products (Penlac)
Compounded Medications*	Select medications (check with the pharmacy) *A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available.
Narcolepsy – Other	Provigil (modafinil), Nuvigil (armodafinil), Xyrem (sodium oxybate)
Pain	Oral-Intranasal Fentanyl (Abstral, Actiq, Fentora, Lazanda, Subsys)
Testosterone Products, Topical & Buccal	AndroGel, Androderm, Axiron, Fortesta, Striant, Testim, Testosterone Cream, Testosterone Ointment, Testosterone Powder

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Advanced Control Specialty Formulary™ and Specialty Guideline Management

The Advanced Control Specialty Formulary encourages utilization of clinically appropriate and lowest net cost medications within select specialty categories. Generics should be considered the first line of prescribing. If there is no generic available, there may be more than one brand-name medicine to treat a condition. We may contact your doctor after receiving your prescription to request consideration of a preferred product or generic equivalent. This may result in your doctor prescribing, when medically appropriate, a different product in place of your original prescription. For specific information about your prescription benefit coverage, please visit **www.caremark.com** or contact a CVS/caremark Customer Care representative toll-free at **1-877-362-3922**.

In addition, your doctor will need to obtain a prior authorization for specialty drugs, before they will be covered by your prescription benefit plan. The prior authorization process ensures that you are receiving the appropriate drugs for the treatment of specific conditions.

For a full list of specialty drugs, please refer to **www.CVSspecialty.com**. For specialty drug prior authorization review, your **doctor** should call CVS/specialty™ toll-free at **1-866-814-5506 before** you go to the pharmacy. The prior authorization line is for your doctor's use only.

Step Therapy

Before your prescription drug plan will cover one of the drugs listed below, you will need to try one of the covered options available for that drug. Please consult with your doctor about what covered medications are right for you. Your **doctor** should call CVS/caremark toll-free at **1-800-294-5979** to request prior authorization. The prior authorization line is for your doctor's use only.

Drug Class	Products Requiring Step Therapy
Brand Minocycline Extended-Release (Acne)	Solodyn, Ximino
COX-2 Inhibitors (Pain)	Celebrex (celecoxib)
Immunosuppressants, Topical (eczema, psoriasis)	Elidel (pimecrolimus), Protopic (tacrolimus)

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Quantity Limits

The drugs listed on the following pages have limits based on U.S. Food and Drug Administration (FDA)-approved prescribing information, approved medical guidelines and/or the average utilization quantity for the drugs.

The limits listed below affect only the amount of medication that the prescription benefit plan pays for, not whether you can get a greater quantity. The final decision about the amount of medication you receive remains between you and your doctor.

Note: Some of the quantity limits have a prior authorization available if you exceed the drug's limit. Those drugs with a prior authorization available are noted in chart on the following pages. If your doctor has determined that a greater amount is appropriate, your **doctor** should call CVS/caremark toll-free at **1-800-294-5979** to request prior authorization for a larger quantity. The prior authorization line is for your doctor's use only.

Quantity Limits	Quantity Per 1-Month Supply	Quantity Per 3-Month Supply	Prior Authorization Available (To Exceed Quantity Limit)
Anti-Migraine *(quantities accumulate across the class*)			
Alsuma Injection (sumatriptan)	12 units (6 mL)	36 units (18 mL)	Yes
Amerge (naratriptan)	12 tablets	36 tablets	Yes
Axert (almotriptan)	12 tablets	36 tablets	Yes
Frova (frovatriptan)	18 tablets	54 tablets	Yes
Imitrex (sumatriptan) 4 mg Injection Syringes	18 units (9 mL)	54 units (27 mL)	Yes
Imitrex (sumatriptan) 6 mg Injection Syringes	12 units (6 mL)	36 units (19 mL)	Yes
Imitrex (sumatriptan) 6 mg Injection Vials	12 units (6 mL)	40 units (20 mL)	Yes
Imitrex (sumatriptan) 5 mg nasal spray (NS)	24 nasal units	72 nasal units	Yes
Imitrex (sumatriptan) 20 mg nasal spray (NS)	12 nasal units	36 nasal units	Yes
Imitrex (sumatriptan) oral	12 tablets	36 tablets	Yes
Maxalt, Maxalt MLT (rizatriptan)	18 tablets	54 tablets	Yes
Migranal (dihydroergotamine nasal spray)	8 nasal units	24 nasal units	No
Relpax (eletriptan)	12 tablets	36 tablets	Yes
Sumavel DosePro 4 mg (sumatriptan)	18 DosePro units	54 DosePro units	Yes
Sumavel DosePro 6 mg (sumatriptan	12 DosePro units	36 DosePro units	Yes

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Quantity Limits	Quantity Per 1-Month Supply	Quantity Per 3-Month Supply	Prior Authorization Available (To Exceed Quantity Limit)
Treximet 85/500 mg (sumatriptan/ naproxen sodium)	9 tablets	36 tablets	Yes
Treximet 10/60 mg (sumatriptan/ naproxen sodium)	9 tablets	18 tablets	Yes
Zomig nasal spray (zolmitriptan)	12 nasal units	36 nasal units	Yes
Zomig/Zomig ZMT (zolmitriptan)	12 tablets	36 tablets	Yes
Erectile Dysfunction *(quantities accumulate across the class)*			
Caverject, Edex, Muse, Cialis (5 mg, 10 mg, 20 mg), Levitra, Staxyn, Stendra, Viagra	6 units	18 units	No, except Cialis 5 mg
Cialis 2.5 mg	30 units	90 units	No
Influenza			
Relenza Caps (zanamivir inhalation)	40 capsules per 90 days		Yes
Tamiflu 30 mg Caps (oseltamivir)	28 capsules per 90 days		Yes
Tamiflu 45 mg, 75 mg Caps (oseltamivir)	14 capsules per 90 days		Yes
Tamiflu 30 mg/5 mL Oral Liquid (oseltamivir)	180 mL per 90 days		Yes
Pain			
butorphanol (Stadol NS)	2 bottles	6 bottles	Yes
ketoroloc tabs (Toradol)	20 tablets	20 tablets	No
ketorolac nasal spray (Sprix)	5 bottles	5 bottles	No
Opana ER (oxymorphone hydrochloride extended-release tablets) – 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg	120 tablets	360 tablets	Yes
Opana ER (oxymorphone hydrochloride extended-release tablets) – 30 mg, 40 mg	60 tablets	180 tablets	Yes
Oxycontin (oxycodone hydrochloride controlled-release tablets) – 10 mg, 15 mg, 20 mg, 30 mg, 40 mg	120 tablets	360 tablets	Yes
Oxycontin (oxycodone hydrochloride controlled-release tablets) – 60 mg, 80 mg	60 tablets	180 tablets	Yes

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Quantity Limits	Quantity Per 1-Month Supply	Quantity Per 3-Month Supply	Prior Authorization Available (To Exceed Quantity Limit)
Respiratory – SHORT-ACTING Beta 2 Agonist/Combinations			
Albuterol inhalation solution (AccuNeb) 0.63 mg/3 mL and 1.25 mg/3 mL	120 - 125 vials (360 - 375 mL), varies by package size	360 - 375 vials (1,180 -1,125 mL), varies by package size	No
Albuterol inhalation solution 0.083%	125 vials (375 mL)	375 vials (1125 mL)	No
Albuterol inhalation solution 0.5%	3 (20 mL) containers or 120 vials	9 (20 mL) containers or 360 vials	No
ProAir HFA inhaler (albuterol)	2 containers, varies by package size	6 containers, varies by package size	No
ProAir RespiClick (albuterol)	2 containers	6 containers	No
Ventolin HFA inhaler (albuterol) – 8 gram container (60 inhalations/container)	6 containers (48 gm)	18 containers (144 gm)	No
Ventolin HFA inhaler (albuterol) – 18 gram container (200 inhalations/container)	2 containers (36 gm)	6 containers (108 gm)	No
Xopenex HFA inhaler (levalbuterol) – 15 gram container (200 inhalations/ container)	2 containers (30 gm)	6 containers (90 gm)	No
Xopenex inhalation solution 0.31 mg/3 mL, 0.63 mg/3mL, 1.25 mg/3mL (levalbuterol)	96 - 100 vials (288 - 300 mL), varies by package size	288 - 300 vials (864 - 900 mL), varies by package size	No
Xopenex inhalation soln conc 1.25 mg/ 0.5 mL (levalbuterol)	90 vials (90 ea)	270 vials (270 ea)	No
Respiratory – LONG-ACTING Beta 2 Agonist/Combinations			
Advair Diskus (fluticasone/salmeterol)	1 container (60 ea)	3 containers (180 ea)	No
Advair HFA (fluticasone/salmeterol)	1 container (12 g)	3 containers (36 g)	No
Anoro Ellipta (umeclidinium/vilanterol)	1 container (60 ea)	3 containers (180 ea)	No
Arcapta Neohaler (indacaterol)	1 container (30 ea)	3 containers (90 ea)	No
Breo Ellipta (fluticasone furoate/vilanterol)	1 container (60 ea)	3 containers (180 ea)	No
Brovana inhalation solution (aformeterol tartrate)	60 vials (120 mL)	180 vials (360 mL)	No
Dulera Inhalation Aerosol 100 mcg/5 mcg and 200 mcg/5 mcg (mometasone/ formoterol)	1 container (13 gm)	3 containers (39 gm)	No

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Quantity Limits	Quantity Per 1-Month Supply	Quantity Per 3-Month Supply	Prior Authorization Available (To Exceed Quantity Limit)
Foradil Aerolizer (formoterol)	1 container (60ea)	3 containers (180 ea)	No
Perforomist inhalation solution (formoterol)	60 vials (120 mL)	180 vials (360 mL)	No
Serevent Diskus (salmeterol)	1 container (60 ea)	3 containers (180 ea)	No
Stiolto Respimat (tiotropium bromide/ olodaterol)	1 container (4 gm)	3 containers (12 gm)	No
Striverdi Respimat (olodaterol)	1 container (4 gm)	3 containers (12 gm)	No
Symbicort inhalation aerosol (budesonide/ formoterol)	1 container (11 gm)	3 containers (31 gm)	No
Utibron Neohaler (indacaterol/ glycopyrrolate	1 package (60 capsules)	3 packages (180 capsules)	No
Respiratory – Mast Cell Stabilizers and Anticholinergics			
Atrovent HFA Inhaler (ipratropium bromide)	2 containers (26 gm)	6 containers (78 gm)	No
Combivent Respimat Inhaler (ipratropium/albuterol)	2 containers (8 gm)	6 containers (24 gm)	No
Cromolyn Inhalation Solution (cromolyn)	120 units (240 mL)	360 units (720 mL)	No
DuoNeb Inhalation Solution (ipratropium/albuterol)	180 vials (540 mL)	540 vials(1620 mL)	No
Incruse Ellipta (umeclidinium) Inhaler	1 package (30 blisters)	3 packages (90 blisters)	No
Ipratropium Inhalation Solution (ipratropium bromide)	125 units (313 mL)	375 units (939 mL)	No
Seebri Neohaler (glycopyrrolate)	1 package (60 capsules)	3 packages (180 capsules)	No
Spiriva Handihaler (tiotropium)	30 units + 1 Handihaler device	90 units + 1 Handihaler device	No
Spiriva Respimat (tiotropium)	1 cartridge	3 cartridges	No
Tudorza Pressair Inhaler (aclidinium bromide)	1 - 2 containers (varies by package size)	3 - 6 containers (varies by package size)	No
Respiratory – Inhaled Corticosteroids			
Aerospan (flunisolide)	2 containers	6 containers	No
Alvesco inhalation (ciclesoide) 80 mcg	3 containers	9 containers	No

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Quantity Limits	Quantity Per 1-Month Supply	Quantity Per 3-Month Supply	Prior Authorization Available (To Exceed Quantity Limit)
Alvesco inhalation (ciclesonide) 160 mcg	2 containers	6 containers	No
Arnuity Ellipta (fluticasone furoate)	1 package	3 packages	No
Asmanex 110 mcg (mometasone furoate)	2 containers	6 containers	No
Asmanex 30 Aer 220 mcg (mometasone furoate)	4 containers	12 containers	No
Asmanex 60 Aer 220 mcg (mometasone furoate)	2 packages	6 packages	No
Asmanex 120 Aer 220 mcg (mometasone furoate)	1 package	3 packages	No
Asmanex HFA 100 mcg, 200 mcg (mometasone furoate)	1 package	3 packages	No
Flovent Diskus 50 mcg/inhalation (fluticasone)	3 packages	9 packages	No
Flovent Diskus 100 mcg/inhalation (fluticasone)	4 packages	12 packages	No
Flovent Diskus 250 mcg/inhalation (fluticasone)	4 packages	12 packages	No
Flovent HFA 44 mcg/inhalation (fluticasone)	2 containers	6 containers	No
Flovent HFA 110 mcg/inhalation (fluticasone)	2 containers	6 containers	No
Flovent HFA 220 mcg/inhalation (fluticasone)	2 containers	6 containers	No
Pulmicort Flexhaler 180 mcg/inhalation (budesonide)	2 containers	6 containers	No
Pulmicort Flexhaler 90 mcg/inhalation (budesonide)	3 containers	9 containers	No
Pulmicort Respules 0.25 mg per respule (budesonide)	90 respules	270 respules	No
Pulmicort Respules 0.5 mg per respule (budesonide)	60 respules	180 respules	No
Pulmicort Respules 1 mg per respule (budesonide)	30 respules	90 respules	No
Qvar Inhaler 40 mcg (beclomethasone)	2 containers	6 containers	No
Qvar Inhaler 80 mcg (beclomethasone)	2 containers	6 containers	No
Allergy – Intranasal Steroids/Antihistamines			
Astelin (azelastine)	2 containers	6 containers	No
Astepro (azelastine)	2 containers	6 containers	No

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Quantity Limits	Quantity Per 1-Month Supply	Quantity Per 3-Month Supply	Prior Authorization Available (To Exceed Quantity Limit)
Beconase AQ (beclomethasone)	2 containers	6 containers	No
Dymista (azelastine/fluticasone)	1 container	3 containers	No
Flonase (fluticasone)	1 container	3 containers	No
Flunisolide (flunisolide)	3 containers	9 containers	No
Nasacort AQ (triamcinolone)	1 container	3 containers	No
Nasonex (mometasone)	2 containers	6 containers	No
Omnaris (ciclesonide)	1 container	3 containers	No
Patanase (olopatadine)	1 container	3 containers	No
Qnasl (beclomethasone)	1 container	3 containers	No
Rhinocort Aqua (budesonide)	2 containers	6 containers	No
Veramyst (fluticasone furoate)	1 container	3 containers	No
Zetonna (ciclesonide)	1 container	3 containers	No

Log in to **www.caremark.com** to check coverage and copay‡ information for a specific medicine. For additional information, contact a CVS/caremark Customer Care Representative toll-free at **1-877-362-3922**.

‡Copay, copayment or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.