

Prior Authorization

FOR PRESCRIPTION DRUGS

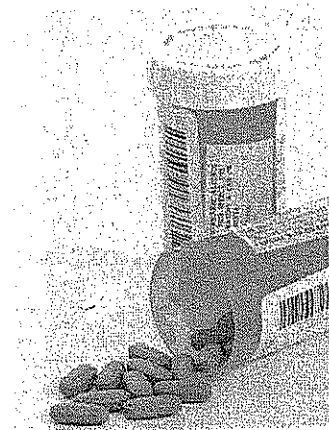
Certain prescription medications require prior authorization before benefits are available. Prior authorization helps to ensure a drug is medically necessary and part of a specific treatment plan.

How to Receive Prior Authorization

The prescribing physician should notify Wellmark in advance about a medical condition that requires the use of any drug appearing on the prior authorization list. If Wellmark authorizes the drug, the prescription can be filled at any participating pharmacy. For most drugs, the authorization is valid for one year.

Your physician can make a prior authorization request by calling the Wellmark Clinical Call Center. Only your physician can handle the prior authorization request. This is not something you can do on behalf of your physician.

If you need to fill the prescription before receiving prior authorization, you will need to pay the regular retail price up front and submit a paper claim. If the prior authorization is approved, Wellmark reimburses you for the maximum allowable fee, which is the amount Wellmark would have reimbursed a network pharmacy for the prescription. Without prior authorization for specified drugs, you are responsible for paying the entire billed charge.



Receiving prior authorization in advance prevents delays at the pharmacy.

Prior Authorization List

Updated 02/16/11

Your coverage manual has specific information about your plan's prior authorization requirements. Visit www.wellmark.com for the most current prior authorization list.

The following drugs require prior authorization. This is general information and is not intended to provide a complete listing of approval or denial criteria:

MEDICATION NAME	DESCRIPTION
Accolate (Asthma)	Step therapy. For treatment of allergic rhinitis, members greater than 18 years of age must try a nasal steroid and a non-sedating antihistamine.
Aciphex (Gastrointestinal)	Step therapy. Member must first try/ fail 2 generic Proton Pump Inhibitors.
Actemra (Rheumatoid Arthritis)	Prior approval recommended. Refer to Wellmark Medical Policy.
Actiq (Pain)	Prior Authorization. For the treatment of cancer-related pain.
Adcirca (Pulmonary Hypertension)	Prior authorization. For the treatment of Pulmonary Arterial Hypertension.
Alsuma (Migraine)	Prior authorization required. Must provide medical justification that sumatriptan oral, nasal, and injectable forms cannot be used.

MEDICATION NAME	DESCRIPTION
Ambien CR (Sleep Aid)	Wellmark Step Therapy requires patients to try Ambien IR, Sonata, or generics zolpidem or zaleplon prior to moving to another sedative hypnotic. Ambien IR, Sonata, and generics zolpidem and zaleplon do not require step therapy.
Amitiza (Gastrointestinal)	Prior authorization. For the treatment of chronic constipation or irritable bowel syndrome (IBS) in women 18 years of age or older who have tried or unable to tolerate other laxatives.
Antara (Cholesterol)	Step Therapy. Member must first try generic fenofibrate, micronized fenofibrate, or gemfibrozil first.
Atroin (Acne)	Prior authorization. If over the age of 35, approval will not be given for treatment of cosmetic conditions, e.g., sunspots or wrinkles.
Avastin (Cancer)	Prior approval recommended. Refer to Wellmark Medical Policy.

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MEDICATION NAME	DESCRIPTION
Avita (Acne)	Prior authorization. If over the age of 35, approval will not be given for treatment of cosmetic conditions; e.g., sunspots or wrinkles.
Avonex (Multiple Sclerosis)	Prior authorization. For the treatment of patients with relapsing forms of multiple sclerosis.
Avert (Migraine)	Step Therapy. Member must first try sumatriptan (Imitrex) or naratriptan (Amerge).
Banzel (Seizures)	Prior authorization. For the treatment of Lennox-Gastaut Syndrome.
Betaseron (Multiple Sclerosis)	Prior authorization. For the treatment of patients with relapsing forms of multiple sclerosis.
Botox (Cervical Dystonia)	Prior approval recommended. Refer to Wellmark Medical Policy.
Bupropion SR (Antidepressant)	If using for smoking cessation, refer to your Benefits Certificate, Coverage Manual or Policy.
Bupropion XL (Antidepressant)	If using for smoking cessation, refer to your Benefits Certificate, Coverage Manual or Policy.
Byetta (Diabetes)	For the treatment of Type 2 Diabetes when other drugs to treat diabetes have been tried and/or have failed.
CNLS NAIL KIT (Antifungal)	Prior authorization. Physician must provide documentation that oral alternatives are not appropriate.
Celebrex (Anti-inflammatory)	Prior authorization required if under age 60. Documentation must demonstrate failure of traditional NSAID and PPI therapy in the last 12 months. Quantity limits apply.
Cervarix (Vaccine)	Prior authorization. For use in females 10 through 25. If the series is started prior to age 25 but the member turns 26 before the series is completed a prior authorization is required.
Cialis (Erectile Dysfunction)	Prior authorization. Member must have a diagnosis of erectile dysfunction unrelated to either psychological disorders or medication side effect.
Genza (Cough's)	Prior approval recommended. Refer to Wellmark Medical Policy.
Copaxone (Multiple Sclerosis)	Prior authorization. For the treatment of patients with relapsing forms of multiple sclerosis.
Dymbalta (Antidepressant)	Step Therapy. Member must first try generic SSRI/SNRI first.
Daytrana (ADHD)	Prior authorization. Physician must provide documentation of medical necessity, e.g., inability to swallow oral medications.
Deviant (Gastrointestinal)	Step therapy. Member must first try/all 2 generic Proton Pump Inhibitors.
Differin (Acne)	Prior authorization. If over the age of 35, approval will not be given for treatment of cosmetic conditions; e.g., sunspots or wrinkles.
Dysport (Cervical Dystonia)	Prior approval recommended. Refer to Wellmark Medical Policy.
Edluar (Sleep Aid)	Wellmark Step Therapy requires patients to try Ambien IR, Sonata, or generics zolpidem or zaleplon prior to moving to another sedative hypnotic. Ambien IR, Sonata, and generics zolpidem and zaleplon do not require step therapy.
Embeda (Pain)	Prior authorization. Member must be unable to take traditional morphine products and be at risk of narcotic overdose.
Enbrel (Arthritis/Psoriasis)	Prior authorization. Treatment with Enbrel is indicated for the following when conventional DMARD therapy has been unsuccessful: Ankylosing spondylitis, moderate to severely active polyarticular juvenile idiopathic arthritis, adult chronic moderate to severe plaque psoriasis, active psoriatic arthritis and moderate to severely active rheumatoid arthritis.
Epiduo (Acne)	Prior authorization. If over the age of 35, approval will not be given for treatment of cosmetic conditions; e.g., sunspots or wrinkles.
Erbix (Cancer)	Prior approval recommended. Refer to Wellmark Medical Policy.
Extavia (Multiple Sclerosis)	Prior authorization. For the treatment of patients with relapsing forms of multiple sclerosis.
Fenoglide (Cholesterol)	Step Therapy. Member must first try generic fenofibrate, micronized fenofibrate, or gemfibrozil first.
Fentora (Pain)	Prior Authorization. For the treatment of cancer-related pain.
Frova (Migraine)	Step Therapy. Member must first try sumatriptan (Imitrex) or naratriptan (Amerge).
Gardasil (Vaccine)	Prior authorization. For use in females & males age 9 through 26. If the series is started prior to age 26 but the member turns 27 before the series is completed a prior authorization is required.

MEDICATION NAME	DESCRIPTION
Genotropin (Growth Hormone)	Prior authorization. Treatment with growth hormone is indicated for the following: pediatric growth hormone deficiency, growth failure in children small for gestational age (SGA) or with intrauterine growth retardation, Turner Syndrome, Prader-Willi Syndrome, adult growth hormone deficiency syndrome and idiopathic short stature (non-growth hormone deficient).
Heceptin (Cancer)	Prior approval recommended. Refer to Wellmark Medical Policy.
Humatrope (Growth Hormone)	Prior authorization. Treatment with growth hormone is indicated for the following: pediatric growth hormone deficiency, growth failure in children small for gestational age (SGA) or with intrauterine growth retardation, Turner Syndrome, adult growth hormone deficiency syndrome, idiopathic short stature (non-growth hormone deficient), short stature due to homeobox (SHOX) gene deficiency.
Humira (Arthritis/Psoriasis)	Prior authorization. Treatment with Humira is indicated for the following when conventional DMARD therapy has been unsuccessful: Ankylosing spondylitis, juvenile idiopathic arthritis, adult chronic severe plaque psoriasis, active psoriatic arthritis, moderate to severely active adult rheumatoid arthritis and moderate to severely active adult Crohn's disease.
Immunoglobulin	Prior approval recommended. Refer to Wellmark Medical Policy.
Increlex (Growth Factor)	Prior authorization. Treatment with growth hormone is indicated for the following: growth failure in children with severe primary insulin-like growth factor 1 deficiency (IGF-1 deficiency) or primary IGF1 or growth failure in children with GH gene deletions who have developed neutralizing antibodies to GH.
Interferon (Hepatitis C)	Prior authorization. Indicated for patients with chronic Hepatitis C. The prescribing physician is a gastroenterologist, hepatologist or infectious disease specialist and patients must be considered naive to treatment (previously untreated) with pegylated interferon.
Intuniv (ADHD)	Prior authorization. Member must try two stimulants and immediate release guanfacine first.
Itraconazole (Antifungal)	Prior authorization. Approval will not be given for treatment of cosmetic conditions; e.g., uncomplicated nail fungus.
Kapvay (ADHD)	Prior authorization. The use of Kapvay is considered not medically necessary because clonidine is available in tablet and transdermal patch formulations which are more cost effective.
Kineret (Arthritis)	Prior authorization. For treatment of rheumatoid arthritis after failure with at least one systemic agent.
Kuvan (Phenylketonuria)	Prior authorization. For treatment of phenylketonuria (PKU) with elevated phenylalanine levels (hyperphenylalaninemia).
Lamisil Granules (Antifungal)	Prior authorization. Approval will not be given for treatment of cosmetic conditions; e.g., uncomplicated nail fungus.
Levitra (Erectile Dysfunction)	Prior authorization. Member must have a diagnosis of erectile dysfunction unrelated to either psychological disorders or medication side effect.
Lexapro (Antidepressant)	Step Therapy. Member must first try generic SSRI/SNRI first.
Lipofen (Cholesterol)	Step Therapy. Member must first try generic fenofibrate, micronized fenofibrate, or gemfibrozil first.
Lofibra Caps (Cholesterol)	Step Therapy. Member must first try generic fenofibrate, micronized fenofibrate, or gemfibrozil first.
Lofibra Tab (Cholesterol)	Step Therapy. Member must first try generic fenofibrate, micronized fenofibrate, or gemfibrozil first.
Lopid (Cholesterol)	Step Therapy. Member must first try generic fenofibrate, micronized fenofibrate, or gemfibrozil first.
Lunesta (Sleep Aid)	Wellmark Step Therapy requires patients to try Ambien IR, Sonata, or generics zolpidem or zaleplon prior to moving to another sedative hypnotic. Ambien IR, Sonata, and generics zolpidem and zaleplon do not require step therapy.
Luvax CR (Antidepressant)	Step Therapy. Member must first try generic SSRI/SNRI first.
Maxalt (Migraine)	Step Therapy. Member must first try sumatriptan (Imitrex) or naratriptan (Amerge).
Mirapex ER (Parkinson's Disease)	Prior authorization. Member must have a diagnosis of Parkinson's Disease.
Myobloc (Cervical Dystonia)	Prior approval recommended. Refer to Wellmark Medical Policy.
Nexium (Gastrointestinal)	Step therapy. Member must first try/all 2 generic Proton Pump Inhibitors.

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MEDICATION NAME	DESCRIPTION
Norditropin (Growth Hormone)	Prior authorization. Treatment with growth hormone is indicated for the following: pediatric growth hormone deficiency, growth failure in children small for gestational age (SGA) or with intrauterine growth retardation, Turner Syndrome, adult growth hormone deficiency syndrome and Noonan Syndrome.
Noxafil (Antifungal)	Prior authorization. Approval required to ensure drug is being used for an approved indication and duration of therapy.
Nutropin (Growth Hormone)	Prior authorization. Treatment with growth hormone is indicated for the following: pediatric growth hormone deficiency, growth failure secondary to chronic renal failure/insufficiency in children who have not received a renal transplant, Turner Syndrome, adult growth hormone deficiency syndrome and idiopathic short stature (non-growth hormone deficient).
Nutropin AQ (Growth Hormone)	Prior authorization. Treatment with growth hormone is indicated for the following: pediatric growth hormone deficiency, growth failure secondary to chronic renal failure/insufficiency in children who have not received a renal transplant, Turner Syndrome, adult growth hormone deficiency syndrome and idiopathic short stature (non-growth hormone deficient).
Ruvigil (Narcolepsy)	Prior authorization. Physician must provide documentation of medical necessity, e.g. excessive sleepiness related to narcolepsy, sleep apnea with CPAP, Multiple Sclerosis or Parkinson's Disease.
Olepto (Depression)	Prior authorization. For the treatment of Major Depressive Disorder after failure of immediate-release trazodone and inability to take medications multiple times per day.
Orimotrope (Growth Hormone)	Prior authorization. Treatment with growth hormone is indicated for the following: pediatric growth hormone deficiency and adult growth hormone deficiency syndrome.
Onsolis (Pain)	Prior Authorization. For the treatment of cancer-related pain.
Oral Contraceptives	Requires prior authorization if your plan does not cover this benefit.
Drencia (Rheumatoid Arthritis)	Prior approval recommended. Refer to Wellmark Medical Policy.
Peg-Intron (Hepatitis C)	Prior authorization. Indicated for patients with chronic Hepatitis C. The prescribing physician is a gastroenterologist, hepatologist or infectious disease specialist and patients must be considered naive to treatment (previously untreated) with pegylated interferon.
Pegasis (Hepatitis C)	Prior authorization. Indicated for patients with chronic Hepatitis C. The prescribing physician is a gastroenterologist, hepatologist or infectious disease specialist and patients must be considered naive to treatment (previously untreated) with pegylated interferon.
Pegasis Kit (Hepatitis C)	Prior authorization. Indicated for patients with chronic Hepatitis C. The prescribing physician is a gastroenterologist, hepatologist or infectious disease specialist and patients must be considered naive to treatment (previously untreated) with pegylated interferon.
Penlac (Antifungal)	Prior authorization. Physician must provide documentation that oral alternatives are not appropriate.
Pexeva (Antidepressant)	Step Therapy. Member must try generic SSRI/SNRI first.
Pradaxa (Anticoagulant)	Step Therapy. Member must have a contraindication to or a trial of warfarin first.
Prisbiq (Antidepressant)	Step Therapy. Member must try generic and preferred SSRI/SNRI first.
Promacta (ITP)	Prior authorization. For the treatment of idiopathic thrombocytopenic purpura (ITP) who have failed treatment with steroids, immunoglobulins, or removal of the spleen.
Provigil (Narcolepsy)	Prior authorization. Physician must provide documentation of medical necessity, e.g. excessive sleepiness related to narcolepsy, sleep apnea with CPAP, Multiple Sclerosis or Parkinson's Disease.
Rebif Syringe 22MCG/0.5ML (Multiple Sclerosis)	Prior authorization. For the treatment of patients with relapsing forms of multiple sclerosis.
Rebif Syringe 44MCG/0.5ML (Multiple Sclerosis)	Prior authorization. For the treatment of patients with relapsing forms of multiple sclerosis.
Rebif Titration Pack (Multiple Sclerosis)	Prior authorization. For the treatment of patients with relapsing forms of multiple sclerosis.
Relpax (Migraine)	Step Therapy. Member must first try sumatriptan (Imitrex) or naratriptan (Amerge).
Remicade (Arthritis/Psoriasis)	Prior approval recommended. Refer to Wellmark Medical Policy.
Requip XL (Parkinson's Disease)	Prior authorization. Member must have a diagnosis of Parkinson's Disease.
Retin-A (Acne)	Prior authorization. If over the age of 35, approval will not be given for treatment of cosmetic conditions, e.g., sunspots or wrinkles.

MEDICATION NAME	DESCRIPTION
Revatio (Pulmonary Hypertension)	Prior authorization. For the treatment of Pulmonary Arterial Hypertension.
Rituxan (Cancer)	Prior approval recommended. Refer to Wellmark Medical Policy.
Rozeren (Sleep Aid)	Wellmark Step Therapy requires patients to try Ambien IR, Sonata, or generics zolpidem or zaleplon prior to moving to another sedative hypnotic. Ambien IR, Sonata, and generics zolpidem and zaleplon do not require step therapy.
Saizen (Growth Hormone)	Prior authorization. Treatment with growth hormone is indicated for the following: pediatric growth hormone deficiency and adult growth hormone deficiency syndrome.
Serostim (Growth Hormone)	Prior authorization. Treatment with growth hormone is indicated for the following: HIV-associated wasting or cachexia.
Simponi (Arthritis)	Prior authorization. Treatment with Simponi is indicated for the following when conventional DMARD therapy has been unsuccessful: Moderately to severely active rheumatoid arthritis, active psoriatic arthritis, active ankylosing spondylitis.
Singular (Asthma)	Step therapy. For treatment of allergic rhinitis, members greater than 18 years of age must try a nasal steroid and a non-sedating antihistamine.
Sporanox Capsules (Antifungal)	Prior authorization. Approval will not be given for treatment of cosmetic conditions, e.g., uncomplicated nail fungus.
Sporanox Solution (Antifungal)	Prior authorization. Approval will not be given for treatment of cosmetic conditions, e.g., uncomplicated nail fungus.
Stelara (Psoriasis)	Prior approval recommended. Refer to Wellmark Medical Policy.
Sumavel Dosepro (Migraine)	Prior authorization required. Must provide medical justification that sumatriptan oral, nasal, and injectable forms cannot be used.
Synagra (Infection)	Prior approval recommended. Refer to Wellmark Medical Policy.
Tasigna (Leukemia)	Prior authorization. For treatment of Philadelphia chromosome positive chronic phase chronic myeloid leukemia and chronic myeloid leukemia (CML) in members who are resistant or intolerant to treatment with Gleevec.
Tev-Tropin (Growth Hormone)	Prior authorization. Treatment with growth hormone is indicated for the following: pediatric growth hormone deficiency.
Tretin-X (Acne)	Prior authorization. If over the age of 35, approval will not be given for treatment of cosmetic conditions, e.g., sunspots or wrinkles.
Trexmet (Migraine)	Prior authorization. Member must be unable to use sumatriptan and naproxen separately.
Ticor (Cholesterol)	Step Therapy. Member must first try generic fenofibrate, micronized fenofibrate, or gemfibrozil first.
Triglide (Cholesterol)	Step Therapy. Member must first try generic fenofibrate, micronized fenofibrate, or gemfibrozil first.
Triplic (Cholesterol)	Step Therapy. Member must first try generic fenofibrate, micronized fenofibrate, or gemfibrozil first.
Tykerb (Cancer)	Prior authorization. For treatment of HER2+ breast cancer after other treatment options have failed.
Tysabri (Multiple Sclerosis)	Prior approval recommended. Refer to Wellmark Medical Policy.
Tyvaso (Pulmonary Hypertension)	Prior authorization. For the treatment of Pulmonary Arterial Hypertension.
Uloric (Gout)	Prior authorization. Member must first fail or be unable to tolerate treatment with allopurinol (generic Zyloprim). For the treatment of Gout.
Vecibix (Cancer)	Prior approval recommended. Refer to Wellmark Medical Policy.
Ventavis (Pulmonary Hypertension)	Prior authorization. For the treatment of Pulmonary Arterial Hypertension.
Viagra (Erectile Dysfunction)	Prior authorization. Member must have a diagnosis of erectile dysfunction unrelated to either psychological disorders or medication side effect.
Victoza (Diabetes)	For the treatment of Type 2 Diabetes when other drugs to treat diabetes have been tried and/or have failed.
Wellbutrin SR (Antidepressant)	If using for smoking cessation, refer to your Benefits Certificate, Coverage Manual or Policy.
Wellbutrin XL (Antidepressant)	If using for smoking cessation, refer to your Benefits Certificate, Coverage Manual or Policy.
Xenazine (Huntington's Disease)	Prior authorization. For the treatment of Huntington's Disease.
Xecomin (Cervical Dystonia)	Prior approval recommended. Refer to Wellmark Medical Policy.
Xolair (Asthma)	Prior approval recommended. Refer to Wellmark Medical Policy.

MEDICATION NAME	DESCRIPTION
Kyzal (Antihistamine)	Step therapy. Member must have seasonal allergies AND try Zyrtec, Zyrtec OTC or Zyrtec-D AND also try Allegra (fexofenadine) or Allegra-D.
Zafirlukast (Asthma)	Step therapy. For treatment of allergic rhinitis, members greater than 18 years of age must try a nasal steroid and a non-sedating antihistamine.
Ziana (Acne)	Prior authorization. If over the age of 35, approval will not be given for treatment of cosmetic conditions, e.g., sunspots or wrinkles.
Zolpimist (Sleep Aid)	Wellmark Step Therapy requires patients to try Ambien IR, Sonata, or generics zolpidem or zaleplon prior to moving to another sedative hypnotic. Ambien IR, Sonata, and generics zolpidem and zaleplon do not require step therapy.
Zorng (Migraine)	Step Therapy. Member must first try sumatriptan (Imitrex) or naratriptan (Amerge).
Zorbtive (Growth Hormone)	Prior authorization. Treatment with growth hormone is indicated for the following: short bowel syndrome.
Zyclara (Actinic Keratosis)	Prior authorization. Member must have tried alternative therapies prior to approval.
Zylo (Asthma)	Step therapy. For treatment of allergic rhinitis, members greater than 18 years of age must try a nasal steroid and a non-sedating antihistamine.
Zylo CR (Asthma)	Step therapy. For treatment of allergic rhinitis, members greater than 18 years of age must try a nasal steroid and a non-sedating antihistamine.

Step therapy requires trying other therapeutically equivalent drug options first. When the pharmacist files the claim, the computer system searches the prescription claim history to determine if a therapeutically equivalent option has been tried. If a claim is found, the prescription is approved. If a claim is not found, the pharmacist will be asked to contact the physician. The physician can either prescribe a therapeutically equivalent option or contact the Wellmark Clinical Call Center for a prior authorization.

See Quantity Limits for more information.

Certain medications require prior authorization to ensure that a drug is medically necessary and part of a specific treatment plan.

The prescribing physician should contact Wellmark's Clinical Call Center at 1-800-600-8055 to request approval for drugs requiring prior authorization; obtaining the approval in advance will help to prevent delays at the pharmacy.

After the drug is approved, the prescription can be filled at any pharmacy that contracts with Catalyst Rx.

The approval is valid for one year for most drugs.

Your benefits certificate, coverage manual, or policy has specific information about your plan's prior authorization requirements.

Visit www.wellmark.com for the most current prior authorization listing and quantity limits. Additional drugs may be added to this list throughout the year.