



**GEORGIA MEDICAID FEE-FOR-SERVICE
BENIGN PROSTATIC HYPERTROPHY (BPH) AGENTS PA SUMMARY**

Preferred	Non-Preferred
Alfuzosin generic Doxazosin generic Finasteride generic Tamsulosin generic Terazosin generic	Avodart (dutasteride) Cardura XL (doxazosin extended-release) Cialis 2.5 mg, 5 mg (tadalafil) Dutasteride generic Dutasteride/tamsulosin generic Jalyn (dutasteride/tamsulosin) Rapaflo (silodosin)

LENGTH OF AUTHORIZATION: 1 Year

NOTE:

- ❖ Only Cialis 2.5 mg and 5 mg strengths are covered with prior authorization. Cialis 10 mg and 20 mg strengths are not covered.
- ❖ If generic Dutasteride is approved, the PA will be issued for brand Avodart. If generic Dutasteride/tamsulosin is approved, the PA will be issued for brand Jalyn.

PA CRITERIA:

Avodart and Dutasteride Generic

- ❖ Approvable for members with benign prostatic hyperplasia (BPH) who have experienced ineffectiveness, allergies, contraindications, drug-to-drug interactions or intolerable side effects to the preferred product finasteride.
- ❖ In addition for generic dutasteride, the prescriber must submit a written letter of medical necessity stating the reasons brand Avodart is not appropriate for the member.

Cardura XL

- ❖ Prescriber must submit a written letter of medical necessity stating the reason(s) the preferred products, doxazosin AND either alfuzosin, tamsulosin or terazosin, are not appropriate for the member.

Cialis 2.5 mg and 5 mg

- ❖ Approvable for members with BPH who do not have a current or past history (within past 5 years) of erectile dysfunction (ED)

AND

- ❖ Member must have tried and failed to receive therapeutic benefit from an alpha blocker (alfuzosin, doxazosin, silodosin, tamsulosin, terazosin) given in combination with a 5-alpha reductase inhibitor (finasteride or dutasteride)

OR

- ❖ Member must have experienced allergies, contraindications, drug-drug interactions or a history of intolerable side effects to all of the following



agents: doxazosin, tamsulosin, terazosin, finasteride and dutasteride (Avodart).

- ❖ Approvable for members with pulmonary artery hypertension (PAH) who are younger than 18 years of age and who are under the care or referral of a cardiologist or pulmonologist.

Jalyn and Dutasteride/Tamsulosin Generic

- ❖ Prescribers must submit a written letter of medical necessity stating the reasons the two separate prescriptions, Avodart (requires PA) and generic tamsulosin, are not appropriate for the member.
- ❖ In addition for generic dutasteride/tamsulosin, prescriber must also state the reasons brand Jalyn is not appropriate for the member.

Rapaflo

- ❖ Approvable for members with BPH who have experienced ineffectiveness, allergies, contraindications, drug-to-drug interactions, or a history of intolerable side effects to at least two of the following preferred products: alfuzosin, doxazosin, tamsulosin and terazosin.

EXCEPTIONS:

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- ❖ For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

PA and APPEAL PROCESS:

- ❖ For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.