GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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

Preferred	Non-Preferred
Alfuzosin generic Doxazosin generic Dutasteride generic Finasteride generic Tamsulosin generic Terazosin generic	Cardura XL (doxazosin extended-release) Cialis 2.5 mg, 5 mg (tadalafil) Dutasteride/tamsulosin generic Entadfi (finasteride/tadalafil) 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.

PA CRITERIA:

Cardura XL

- Prescriber must submit a written letter of medical necessity stating the reasons 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 benign prostatic hyperplasia (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: alfuzosin, doxazosin, silodosin, tamsulosin, terazosin, finasteride and dutasteride.
- 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.

Dutasteride/Tamsulosin Generic

- Prescriber must submit a written letter of medical necessity stating the reasons the two separate preferred products, generic dutasteride and generic tamsulosin, are not appropriate for the member.

Entadfi

- Prescriber must submit a written letter of medical necessity stating the reasons the two separate products, generic finasteride 5 mg and brand Cialis 5 mg, are not appropriate for the member and the member must meet the criteria for brand Cialis 5 mg.

Rapaflo

- Approvable for members with BPH who have experienced inadequate response, allergies, contraindications, drug-to-drug interactions or 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.