GEORGIA MEDICAID FEE-FOR-SERVICE
TOPICAL ANTINEOPLASTIC AND GENITAL WARTS THERAPY PA
SUMMARY

Preferred	Non-Preferred
Bexarotene gel Carac (fluorouracil 0.5% cream) Condylox (podofilox 0.5% gel) Efudex (fluorouracil 5% cream) Fluorouracil 2%, 5% solution generic Imiquimod 5% cream generic Valchlor (mechlorethamine gel)*	Diclofenac 3% gel generic Podofilox 0.5% solution generic Veregen (sinecatechins ointment) Zyclara (imiquimod 2.5%, 3.75% cream)

*preferred but requires PA

LENGTH OF AUTHORIZATION: Varies

PA CRITERIA:

Valchlor

- Approvable for members with a diagnosis of Stage IA or IB mycosis fungoides-type cutaneous T-cell lymphoma who have tried and failed other skin-directed therapy.

Diclofenac 3% Gel Generic

- Approvable for members with a diagnosis of actinic keratosis (AK) who have experienced ineffectiveness, allergies, contraindications, drug-to-drug interactions or intolerable side effects to the preferred products, fluorouracil (Carac, Efudex) and imiquimod 5% (Aldara).

Podofilox 0.5% Solution Generic

- For members with a diagnosis of external genital and perianal warts (EGW, condyloma acuminata), prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Condylox Gel (podofilox 0.5%), is not appropriate for the member.

Veregen

- Approvable for immunocompetent members 18 years or older with a diagnosis of external genital and perianal warts (EGW, condyloma acuminata) who have experienced ineffectiveness, allergies, contraindications, drug-to-drug interactions or intolerable side effects to podofilox (Condylox) and imiquimod 5% (Aldara).

Zyclara

- Approvable for members with a diagnosis of actinic keratosis when being used to treat a large area of skin or prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic imiquimod 5%, is not appropriate for the member.

- For members 12 years of age or older with a diagnosis of external genital and perianal warts (EGW, condyloma acuminata), prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic imiquimod 5%, is not appropriate for the member.

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.