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

<table>
<thead>
<tr>
<th>Preferred</th>
<th>Non-Preferred</th>
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</thead>
<tbody>
<tr>
<td>Condylox (podofilox gel)</td>
<td>Carac (fluorouracil 0.5%)</td>
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<tr>
<td>Fluorouracil 0.5%, 2%, 5% generic</td>
<td>Diclofenac 3% gel generic</td>
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<tr>
<td>Imiquimod 5% generic</td>
<td>Picato (ingenol mebutate)</td>
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<tr>
<td>Podofilox 0.5% solution generic</td>
<td>Veregen (sinecatechins)</td>
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<tr>
<td>Tolak (fluorouracil 4%)</td>
<td>Zyclara (imiquimod 2.5%, 3.75%)</td>
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LENGTH OF AUTHORIZATION: Varies

PA CRITERIA:

**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, Tolak) and imiquimod 5% (Aldara).

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

**AND**
- If applicable, the skin must be healed from any previous drug or surgical treatment.

**Veregen**
- Approvable for immunocompetent members 18 years or older for the treatment 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 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 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.

Revised 12/19/2017
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.