# Expedited Authorization Codes and Criteria Table

## What is new in this version of the expedited authorization list?

Effective for dates of service on and after June 8, 2024, the Health Care Authority (HCA) will implement the following changes:

| Product | Code | Criteria |
|---|---|---|
| **90-day supply required** | 090 | Removed |
| **Adderall®/XR** *(amphetamine salt combo)* | 075 | Removed |
| *amphetamine salt combo/XR* | 075 | Removed |
| **Alpha-agonists** | 076 | Removed |
| **Anoro Ellipta®** *(umeclidinium-vilanterol)* | 150 | Removed |
| **Arcapta™ Neohaler™** *(indacaterol)* | 150 | Removed |
| **Second Generation Antipsychotics (Atypical Antipsychotics) (Generics First)** | 402 | Removed |
| | 403 | Removed |
| | 405 | Removed |
| barbiturates | 180 | Removed |
| **Brovana®** *(arformoterol)* | 150 | Removed |
| *bupropion SR/XL* | 014 | Removed |
| **Concerta®** *(methylphenidate HCl)* | 075 | Removed |
| **Daytrana®** *(methylphenidate HCl)* transdermal patch | 075 | Removed |
| **Dexedrine SA®** *(d-amphetamine)* | 075 | Removed |
| *Dexmethylphenidate /SA* | 075 | Removed |
| **Diclegis®** *(doxylamine-pyridoxine)* | 129 | Removed |
| **Dulera®** *(mometasone furoate-formoterol fumarate)* | 151 | Removed |

| | | |
|---|---|---|
| **Focalin®/XR** *(dexmethylphenidate)* | 075 | Removed |
| **Incruse Ellipta®** *(umeclidinium bromide)* | 150 | Removed |
| **Intron A®** *(interferon alpha-2b recombinant)* | 030 | Removed |
| | 031 | Removed |
| | 032 | Removed |
| | 033 | Removed |
| | 107 | Removed |
| | 109 | Removed |
| | 135 | Removed |
| **Metadate ®/ER** *(methylphenidate HCl)* | 075 | Removed |
| *methylphenidate /LA/SR/OSM* | 075 | Removed |
| **Methylin®** /XR/chewable/ solution | 075 | Removed |
| **Nephro-vite®, Nephro-Vite® Rx, and Nephron® FA** | 096 | Removed |
| **Perforomist®** *(formoterol fumarate)* | 150 | Removed |
| **Pulmozyme®** *(dornase alpha)* | 053 | Removed |
| **Rectiv® (nitroglycerin)** | 081 | Removed |
| **Rena-Vite® Rena-Vite RX®** *(folic acid-vit B comp W-C)* | 096 | Removed |
| **Riomet®** *(metformin) oral solution* | 086 | Removed |
| **Ritalin®/LA** *(methylphenidate HCl)* | 075 | Removed |
| **Savella®** *(milnacipran HCl)* | 066 | Removed |
| **Seebri Neohaler®** *(glycopyrrolate)* | 150 | Removed |
| **Serevent® Diskus®** *(salmeterol)* | 150 | Removed |
| **Stiolto®** *(tiotropium bromide-olodaterol)* | 150 | Removed |
| **Striverdi®** *(olodaterol)* | 150 | Removed |
| **Tudorza® Pressair®** *(aclidinum bromide)* | 150 | Removed |

| | | |
|---|---|---|
| **Utibron Neohaler®** *(indacaterol-glycopyrrolate)* | 150 | Removed |
| **Vancomycin oral** | 069 | Removed |
| **Vyvanse®** *(lisdexamfetamine dimesylate)* | 075 | Removed |
| **Wellbutrin SR® and XL®** *(bupropion HCl)* | 014 | Removed |

# What is expedited authorization (EA)?

**(WAC 182-530-3200(4))**

The expedited authorization process is designed to eliminate the need to request authorization from HCA. The intent is to establish authorization criteria and associate these criteria with specific codes, enabling providers to create an "EA" number when appropriate.

## How is an EA number created?

To bill HCA for drugs that meet the expedited authorization criteria on the following pages, the pharmacist must create an 11-digit EA number. The first 8 digits of the EA number must be 85000000. The last 3 digits must be the code number of the diagnosis/condition that meets the EA criteria.

> **Example:** The 11-digit EA number for Accutane (for the treatment of "severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy") would be **85000000002** (85000000 = first eight digits, 002 = diagnosis/condition code).

**Reminder:** EA numbers are only for drugs listed in this table. EA numbers are not valid for any of the following:

- Other drugs requiring authorization through the Prescription Drug Program
- Waiving the State Maximum Allowable Cost (SMAC) or Automated Maximum Allowable Cost (AMAC) price.
- Authorizing the third or fifth fill in the month.

**Note:** Use of an EA number does not exempt claims from edits, such as per-calendar-month prescription limits or early refills.

**EA guidelines:**

**Diagnoses** - Diagnostic information may be obtained from the prescriber, client, client's caregiver, or family member to meet the conditions for EA. Drug claims submitted without an

appropriate diagnosis/condition code for the dispensed drug are denied.

**Unlisted Diagnoses** - If the drug is prescribed for a diagnosis/condition, or age that does not appear on the EA list, additional justification is required. The pharmacist must request authorization by either one of the following:

- ✓ Phone 1-800-562-3022
- ✓ Fax 1-866-668-1214

**Documentation** - Dispensing pharmacists must write both of the following on the original prescription:

- ✓ The full name of the person who provided the diagnostic information.
- ✓ The diagnosis/condition and/or the criteria code from the attached table.

| Drug | Code | Criteria |
|---|---|---|
| **Aciphex®** *(rabeprazole)* | 079 | Diagnosis of *H. pylori* with ulcer present. Limited to 28 units for 14 days for initial fill. |
| **Second Generation Antipsychotics (Atypical Antipsychotics) (Generics First)** **Abilify®** *(aripiprazole)* *aripiprazole* *clozapine* **Clozaril®** *(clozapine)* **Fanapt®** *(iloperidone)* **Geodon®** *(ziprasidone HCl)* **Invega™** *(paliperidone)* **Latuda®** *(lurasidone HCl)* *olanzapine* *quetiapine* **Risperdal®** *(risperidone)M-tab* *risperidone* **Saphris®** *(asenapine)* **Seroquel®** *(quetiapine) /XR* | 400 | Continuation of therapy. |
| | 401 | Patient is not a new start. |
| | 404 | Pharmacy has chart note on file documenting patient's refusal of a generic atypical antipsychotic, or their request for a specific atypical antipsychotic. |
| | 406 | Patient in Crisis. |

| Drug | Code | Criteria |
|---|---|---|
| *Ziprasidone*<br>**Zyprexa®**<br>*(olanzapine)*<br>**Zydis®** | | |
| **Blood Glucose Test Strips** | 263 | Gestational Diabetes (any quantity necessary up to two months post-delivery) |
| | 264 | Insulin-dependent diabetic (age 21 and older, up to 100 strips and 100 lancets per month) |
| | 265 | Insulin-dependent diabetic (age 20 and younger, up to 300 strips and 300 lancets per month) |
| | 266 | Patient had diabetes prior to pregnancy (any quantity necessary up to two months post-delivery) |
| *buprenorphine* | 077 | buprenorphine monotherapy for pregnant clients. Limited to 32 mg per day, 28 days at a time for up to 12 months. |
| *buprenorphine* | 078 | buprenorphine monotherapy for non-pregnant clients while prior authorization is initiated. Limited to 32mg per day, 7 days at a time for up to 14 days every 6 months. |
| **contraceptives (oral, transdermal, and intra-vaginal)** | 131 | Used as a contraceptive, dispense 1 year |
| | 132 | Used as a contraceptive, dispensed less than a twelve month supply due to ONE of the following:<br>• The prescriber is unwilling to change dispensed quantity to twelve-month supply<br>• The patient does not want twelve-month supply<br>• The pharmacy does not have adequate stock |
| | 133 | Used for other diagnosis, not related to contraception up to a 90-day supply |
| **Dexilant®**<br>*(dexlansoprazole)* | 079 | Diagnosis of *H. pylori* with ulcer present. Limited to 28 units for 14 days for initial fill. |
| *esomeprazole magnesium* | 079 | Diagnosis of *H. pylori* with ulcer present. Limited to 28 units for 14 days for initial fill. |
| *esomeprazole strontium* | 079 | Diagnosis of *H. pylori* with ulcer present. Limited to 28 units for 14 days for initial fill. |
| **Gonadotropin-releasing Hormone (GnRH) Agonists**<br><br>**Eligard** *(leuprolide)*<br>**Fensolvi** *(leuprolide)*<br>**Lupron Depot/Depot-Ped** | 103 | GnRH therapy for puberty suppression in adolescents diagnosed with gender dysphoria **AND** a pediatric endocrinologist or other clinician experienced in pubertal assessment has determined hormone treatment to be appropriate.<br><br>This code will not override prior authorization for brands with generic equivalents or non-preferred products unless client has met tried and failed criteria. |

| Drug | Code | Criteria |
|---|---|---|
| *(leuprolide)*<br>**Supprelin LA** *(histrelin)*<br>**Triptodur** *(triptorelin)*<br>**Vantas** *(histrelin)*<br>**Zoladex** *(goserlin)* | | |
| **<u>Gonadotropin-releasing Hormone (GnRH) Agonists</u>**<br><br>**Eligard** *(leuprolide)*<br>**Fensolvi** *(leuprolide)*<br>**Lupron Depot/Depot-Ped** *(leuprolide)*<br>**Supprelin LA** *(histrelin)*<br>**Triptodur** *(triptorelin)*<br>**Vantas** *(histrelin)*<br>**Zoladex** *(goserlin)* | 104 | For clients 18 years of age and older:<br>• GnRH therapy for the treatment of gender dysphoria.<br><br>For clients 17 years of age and under:<br>• GnRH therapy for the treatment of gender dysphoria; AND<br>• A pediatric endocrinologist or other clinician experienced in pubertal assessment has determined hormone treatment to be appropriate.<br><br>This code will not override prior authorization for brands with generic equivalents or non-preferred products unless client has met tried and failed criteria. |
| **Lancets** | 263 | Gestational Diabetes (up to two months post delivery) |
| | 264 | Insulin-dependent diabetic (age 21 and older) |
| | 265 | Insulin-dependent diabetic (age 20 and younger) |
| | 266 | Patient had diabetes prior to pregnancy |
| *lansoprazole* | 079 | Diagnosis of *H. pylori* with ulcer present. Limited to 28 units for 14 days for initial fill. |
| **Methadone products** | 540 | Client is in active cancer treatment, hospice care, palliative care, or other end-of-life care. This code will override the 18 or 42 doses, and the chronic use (42 days in a 90-day period) limit, but NOT the 120 MME limit. |
| **Nexium®**<br>**Nexium® granules** *(esomeprazole)* | 079 | Diagnosis of *H. pylori* with ulcer present. Limited to 28 units for 14 days for initial fill. |
| *omeprazole OTC/RX* | 079 | Diagnosis of *H. pylori* with ulcer present. Limited to 28 units for 14 days for initial fill. |
| *omeprazole-sodium bicarbonate* | 079 | Diagnosis of *H. pylori* with ulcer present. Limited to 28 units for 14 days for initial fill. |

| Drug | Code | Criteria |
|---|---|---|
| **Opioid products (excludes injectable/IV) containing:**<br>benzhydrocodone<br>buprenorphine (pain indications only)<br>butorphanol<br>codeine<br>dihydrocodeine<br>fentanyl<br>hydrocodone<br>hydromorphone<br>levorphanol<br>meperidine<br>morphine<br>oxycodone<br>oxymorphone<br>pentazocine<br>tapentadol<br>tramadol | 540 | Client is in active cancer treatment, hospice care, palliative care, or other end-of-life care. This code will override the 18 or 42 doses, and the chronic use (42 days in a 90 day period) limit, but NOT the 120 MME limit. |
| | 541 | Prescriber has indicated "EXEMPT" on the prescription. This code will override the 18 or 42 doses, but NOT the chronic use (42 days in a 90 day period) limit or the 120 MME limit. |
| *oxandrolone* | | Before any code is allowed, there must be an absence of all of the following:<br>a) Hypercalcemia;<br>b) Nephrosis;<br>c) Carcinoma of the breast;<br>d) Carcinoma of the prostate; and<br>Pregnancy. |
| | 110 | Treatment of unintentional weight loss in patients who have had extensive surgery, severe trauma, chronic infections (such as AIDS wasting), or who fail to maintain or gain weight for no conclusive pathophysiological cause. |
| | 111 | To compensate for the protein catabolism due to long-term corticosteroid use. |
| | 112 | Treatment of bone pain due to osteoporosis. |
| *pantoprazole sodium* | 079 | Diagnosis of *H. pylori* with ulcer present. Limited to 28 units for 14 days for initial fill. |
| **Prevacid®** *(lansoprazole)* | 079 | Diagnosis of *H. pylori* with ulcer present. Limited to 28 units for 14 days for initial fill. |
| **Prevacid® SoluTab™** *(lansoprazole)* | 079 | Diagnosis of *H. pylori* with ulcer present. Limited to 28 units for 14 days for initial fill. |

| Drug | Code | Criteria |
|---|---|---|
| **Prilosec OTC®**<br>**Prilosec® Rx**<br>*(omeprazole)* | 079 | Diagnosis of *H. pylori* with ulcer present. Limited to 28 units for 14 days for initial fill. |
| **Protonix®**<br>*(pantoprazole)* | 079 | Diagnosis of *H. pylori* with ulcer present. Limited to 28 units for 14 days for initial fill. |
| **Protonix® Pak**<br>*(pantoprazole)* | 079 | Diagnosis of *H. pylori* with ulcer present. Limited to 28 units for 14 days for initial fill. |
| *rabeprazole sodium* | 079 | Diagnosis of *H. pylori* with ulcer present. Limited to 28 units for 14 days for initial fill. |
| **SymlinPen®**<br>*(pramlintide acetate)* | 267 | Diagnosis of type 1 diabetes. |
| **Testosterone therapy**<br><br>**Aveed** *(testosterone undecanoate)*<br>**AndroDerm** *(testosterone transdermal patch)*<br>**testosterone cypionate IM**<br>**testosterone transdermal gel 1.62%**<br>**Xyosted** *(testosterone enanthate)* | 102 | For clients 18 years of age and older:<br>• Testosterone therapy for the treatment of gender dysphoria.<br><br>For clients 17 years of age and under:<br>• Testosterone therapy for the treatment of gender dysphoria; AND<br>• A pediatric endocrinologist or other clinician<br>• experienced in pubertal assessment has determined hormone treatment to be appropriate.<br><br>This code will not override prior authorization for brands with generic equivalents or non-preferred products unless client has met tried and failed criteria. |
| **Zegerid®**<br>*(omeprazole-sodium bicarbonate)* | 079 | Diagnosis of *H. pylori* with ulcer present. Limited to 28 units for 14 days for initial fill. |