**Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments**

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| Criteria 1 | NP – Azasite, Bacitracin, Besivance, Blephamide, Gatifloxacin, Levofloxacin, Moxifloxacin (Generic of Moxeza), Neomycin/Polymyxin/Hydrocortisone, Pred-G, Sulfacetamide Sodium Ophth Oint 10%, Tobradex ST (BvG), Zylet |

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| **Criteria Title** | Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments | | |
| **Criteria Subtitle** | Non-Preferred Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| AZASITE | 062828 | GCNSeqNo |
| BACITRACIN | 007990 | GCNSeqNo |
| BESIVANCE | 065230 | GCNSeqNo |
| BLEPHAMIDE | 007911 | GCNSeqNo |
| GATIFLOXACIN | 066373 | GCNSeqNo |
| LEVOFLOXACIN | 046793 | GCNSeqNo |
| MOXIFLOXACIN (GEN of MOXEZA) | 067217 | GCNSeqNo |
| NEOMYCIN/POLYMYXIN/HYDROCORTISONE | 007964 | GCNSeqNo |
| PRED-G | 013728 | GCNSeqNo |
| SULFACETAMIDE SODIUM OPTH OINT 10% | 007979 | GCNSeqNo |
| TOBRADEX ST | 066617 | GCNSeqNo |
| ZYLET | 058620 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0996 |  | Select and Free Text | Does the patient have an infection that is caused by an organism resistant to **ALL** preferred antibiotics?    If yes, please provide documentation of the diagnosis and any culture and sensitivity reports. | Y | 1003 |
| N | 0997 |
| 2 | 0997 |  | Select | Is the patient completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility?  Please note: only the remaining course will be authorized. | Y | 1003 |
| N | 0998 |
| 3 | 0998 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0999 |
| N | 1235 |
| 4 | 0999 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 3 days with at least two preferred drugs?  If yes, please submit the medication trials and dates. | Y | 1001 |
| N | 1000 |
| 5 | 1000 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1001 |
| N | 1236 |
| 6 | 1001 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1002 |
| N | 1003 |
| 7 | 1002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1003 |
| N | 1235 |
| 8 | 1003 |  | Select | Is the request for any of the following agents: Brand Tobradex ST or generic tobramycin 0.3% and dexamethasone 0.05%? | Y | 1004 |
| N | END (Pending Manual Review) |
| 9 | 1004 |  | Select | Which product is being requested? | Generic tobramycin 0.3% and dexamethasone 0.05% | 1005 |
| Brand Tobradex ST | END (Pending Manual Review) |
| Other | 1235 |
| 10 | 1005 |  | Select and Free Text | Has the brand medication been attempted and failed or is the brand medication contraindicated? If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 11 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 12 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 30 days

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| **Last Approved** | 6/2/2023 |
| **Other** |  |