Benign Prostatic Hypertrophy (BPH) Quantity Limit Program Summary

Quantity limits apply to Medicaid.

POLICY REVIEW CYCLE

Effective Date	Date of Origin
10/1/2023	9/1/2016

FDA APPROVED INDICATIONS AND DOSAGE

Agent(s)	FDA Indication(s)	Notes	Ref#

See package insert for FDA prescribing information: https://dailymed.nlm.nih.gov/dailymed/index.cfm

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
	Terazosin HCl Cap 1 MG (Base Equivalent)	1 ; 1 MG	30	Capsule	30	DAYS			
	Terazosin HCl Cap 10 MG (Base Equivalent)	10 MG	60	Capsules	30	DAYS			
	Terazosin HCl Cap 2 MG (Base Equivalent)	2 MG	30	Capsules	30	DAYS			
	Terazosin HCl Cap 5 MG (Base Equivalent)	5 MG	30	Capsules	30	DAYS			
Avodart	Dutasteride Cap 0.5 MG	0.5 MG	30	Tablets	30	DAYS			
Cardura	Doxazosin Mesylate Tab 1 MG	1 MG	30	Tablets	30	DAYS			
Cardura	Doxazosin Mesylate Tab 2 MG	2 MG	30	Tablets	30	DAYS			
Cardura	Doxazosin Mesylate Tab 4 MG	4 MG	30	Tablets	30	DAYS			
Cardura	Doxazosin Mesylate Tab 8 MG	8 MG	60	Tablets	30	DAYS			
Cardura xl	doxazosin mesylate tab er	4 MG ; 8 MG	30	Tablets	30	DAYS			
Entadfi	Finasteride-Tadalafil Cap	5-5 MG	30	Capsules	30	DAYS			
Flomax	Tamsulosin HCl Cap 0.4 MG	0.4 MG	60	Capsules	30	DAYS			

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Jalyn	Dutasteride-Tamsulosin HCl Cap 0.5-0.4 MG	0.5-0.4 MG	30	Capsules	30	DAYS			
Proscar	Finasteride Tab 5 MG	5 MG	30	Tablets	30	DAYS			
Rapaflo	silodosin cap	4 MG ; 8 MG	30	Capsules	30	DAYS			
Uroxatral	Alfuzosin HCl Tab ER 24HR 10 MG	10 MG	30	Tablets	30	DAYS			

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
	Terazosin HCl Cap 1 MG (Base Equivalent)	1 ; 1 MG	Medicaid
	Terazosin HCl Cap 10 MG (Base Equivalent)	10 MG	Medicaid
	Terazosin HCl Cap 2 MG (Base Equivalent)	2 MG	Medicaid
	Terazosin HCl Cap 5 MG (Base Equivalent)	5 MG	Medicaid
Avodart	Dutasteride Cap 0.5 MG	0.5 MG	Medicaid
Cardura	Doxazosin Mesylate Tab 1 MG	1 MG	Medicaid
Cardura	Doxazosin Mesylate Tab 2 MG	2 MG	Medicaid
Cardura	Doxazosin Mesylate Tab 4 MG	4 MG	Medicaid
Cardura	Doxazosin Mesylate Tab 8 MG	8 MG	Medicaid
Cardura xl	doxazosin mesylate tab er	4 MG ; 8 MG	Medicaid
Entadfi	Finasteride-Tadalafil Cap	5-5 MG	Medicaid
Flomax	Tamsulosin HCl Cap 0.4 MG	0.4 MG	Medicaid
Jalyn	Dutasteride-Tamsulosin HCl Cap 0.5-0.4 MG	0.5-0.4 MG	Medicaid
Proscar	Finasteride Tab 5 MG	5 MG	Medicaid
Rapaflo	silodosin cap	4 MG ; 8 MG	Medicaid
Uroxatral	Alfuzosin HCl Tab ER 24HR 10 MG	10 MG	Medicaid

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
QL Standalone	**Quantity limit for the Target Agent(s)** will be approved when ONE of the following is met: 1. The requested quantity (dose) does NOT exceed the program quantity limit **OR** 2. The requested quantity (dose) is greater than the program quantity limit AND ONE of the following: A. BOTH of the following: 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication **AND** 2. Information has been provided to support therapy with a higher dose for the requested indication **OR** B. BOTH of the following: 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication **AND** 2. Information has been provided to support why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit **OR** C. BOTH of the following:

Module	Clinical Criteria for Approval
	1. The requested quantity (dose) is greater than the maximum FDA labeled dose for the requested indication **AND** 2. Information has been provided to support therapy with a higher dose for the requested indication **Length of Approval**: up to 12 months