Priority Health Choice, Medicaid PA Criteria

This document contains information regarding Priority Health Medicaid pharmacy prior authorizations.

Prior authorization criteria for medications covered on Priority Health Choice Medicaid, Medicaid CSHCS, and Healthy MI plans is listed below. The criteria listed in this document is approved by the Michigan Department of Health and Human Services (MDHHS), via the Medicaid Common Formulary.

What is a prior authorization?

When a medication requires prior authorization, it means that certain criteria must be met before the medication can be covered.

How to know when a medication requires prior authorization

The best way to know when a medication requires prior authorization is to use the Medicaid Approved Drug List (ADL) tool. If a drug is listed as non-formulary, or not at all, prescribers can use the Medicaid Pharmacy Authorization form to request a formulary exception.

How to use this criteria document

This criteria document is meant to be used alongside the Medicaid Approved Drug List (also known as the drug formulary) and the Medicaid Pharmacy Prior Authorization form. For approval of a brand-name drug where a generic is available, the patient must meet dispense as written (DAW) criteria.

Not all medications are covered by this plan

The certificate of coverage (COC) for this plan includes a list of medications excluded from coverage by Medicaid. Carve Out medications are excluded from coverage under this Priority Health Medicaid plan but may be covered by the Fee For Service Medicaid plan. For more information on Fee For Service Medicaid coverage and authorizations, providers and beneficiaries should contact MagellanRx: https://michigan.magellanrx.com/

Priority Health

DRUG	CRITERIA
acitretin	**Approved Diagnosis:** • Moderate to severe psoriasis **Approval Timeframe:** • Initial authorization: 12 months • Continuation authorization: 12 months **Prescriber Specialty Requirement:** none **Age Limitation:** none **Initial Criteria:** • Must have completed, at minimum, a 90-day trial of methotrexate resulting in clinical failure • Must have minimum 90-day trial of high dose topical steroid (example: augmented betamethasone, clobetasol) **Continuation Criteria:** • Documentation showing the patient has experienced symptomatic improvement or maintained stable clinical status. • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy.
Austedo	**Approved Diagnosis:** • Chorea associated with Huntington's disease • Tardive Dyskinesia secondary to use of a dopamine antagonist **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with, a neurologist or psychiatrist **Age Limitation:** 18 years or older **Initial Criteria:** • Documentation confirming diagnosis of Chorea associated with Huntington's disease or Tardive Dyskinesia secondary to use of a dopamine antagonist (i.e., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.); **AND** • For tardive dyskinesia, attestation that a baseline AIMS test has been completed **Continuation Criteria:** • Attestation of patient's improvement in symptoms associated with their condition; **AND** • For tardive dyskinesia, attestation that a follow-up AIMS test has been completed **AND** there has been a positive response to therapy
benznidazole	**Approved Diagnosis:** • Chagas disease (American trypanosomiasis) due to Trypanosoma cruzi **Approval Timeframe:** • Initial authorization: 60 days • Continuation authorization: N/A **Prescriber Specialty Requirement:** none **Age Limitation:** none **Initial Criteria:** • Must have a confirmed diagnosis of Chagas disease (American trypanosomiasis) due to Trypanosoma cruzi

Beyfortus	**Approved Diagnosis:** • Prevention of RSV lower respiratory tract disease in: ○ Neonates and infants born during or entering their first RSV season ○ Children up to 24 months of age who remain vulnerable to severe RSV disease through their second RSV season **Approval Timeframe:** • For planned cardiac surgery with cardiopulmonary bypass: ○ 2 doses, to include 1 dose before surgery and 1 dose after surgery • All other requests: ○ 1 dose **Prescriber Specialty Requirement:** none **Age Limitation:** Patient must be age 24 months or younger **Initial Criteria:** • Mother did not receive vaccination against RSV in the 2nd or 3rd trimester; **AND** • Patient is < 8 months of age and born during (or entering) their first respiratory syncytial virus (RSV) season and has not received a previous dose of Beyfortus; **OR** • Patient is up to 24 months of age entering their second RSV season and is at increased risk of severe RSV disease such as but not limited to: ○ patient has chronic lung disease (CLD) and they required medical support during the 6-month period before the start of the second RSV season; **OR** ○ patient has congenital heart disease (CHD); **OR** ○ patient is immunocompromised; **OR** ○ patient has neuromuscular disorder; **OR** ○ patient has cystic fibrosis with manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable) or weight for length < 10th percentile; **OR** ○ patient is Alaska Native; **OR** ○ patient is American Indian; **AND** • Patient has not received 5 doses of palivizumab (Synagis®) for the current RSV season
Bronchitol	**Approved Diagnosis:** • Cystic fibrosis **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: up to 1 year **Prescriber Specialty Requirement:** • Must be prescribed by a Pulmonologist **Age Limitation:** 18 years or older **Initial Criteria:** • Documentation confirming diagnosis of cystic fibrosis; **AND** • Attestation that the Bronchitol Tolerance Test (BTT) has been performed to confirm the patient is suitable for Bronchitol therapy; **AND** • Documentation of trial and failure of hypertonic saline; **AND** • Documentation that Bronchitol will be used as add-on maintenance therapy to improve pulmonary function **Continuation Criteria:** • Attestation that the member has had positive response to treatment; **AND** • Patient did not experience event of hemoptysis (coughing up blood)

budesonide EC 3mg	**Approved Diagnosis:** • Crohn's disease (mild to moderate) • Microscopic (lymphocytic and collagenous) colitis **Approval Timeframe:** • Diagnosis of Crohn's disease (mild to moderate) ○ Initial authorization: up to 8 months ○ Continuation authorization: N/A • Diagnosis of Microscopic (lymphocytic and collagenous) colitis ○ Initial authorization: up to 3 months ○ Continuation authorization: N/A **Prescriber Specialty Requirement:** • Must be prescribed by, or in collaboration with, a gastroenterologist **Age Limitation:** none **Initial Criteria:** Crohn's disease (mild to moderate) • Must have active Crohn's disease; **AND** • Must have an intolerance to, or history of, unacceptable side effects to prednisone (or other systemic steroids) Microscopic (lymphocytic and collagenous) colitis • Documentation confirming diagnosis via endoscopic evaluation and biopsy of the colonic mucosa; **AND** • Must have active microscopic colitis (≥3 stools or ≥1 watery stool per day); **OR** • Must have diarrhea that persists despite the use of antidiarrheals **Additional Information:** • Budesonide EC 3mg caps are covered for a total of 570 capsules per year; up to 16 weeks at 9mg once daily, up to 3 months at 6mg once daily, and up to 1 month at 3mg once daily.
Calcitriol ointment	**Approved Diagnosis:** • Diagnosis of psoriasis **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 1 year **Prescriber Specialty Requirement:** none **Age Limitation:** 2 years and older **Initial Criteria:** • Prescribed to treat an FDA approved indication for Topical Vitamin D analogs; **AND** • Documented trial, failure, or intolerance of at least one high potency or very high potency topical steroid; **OR** • Documented trial, failure, or intolerance of one low or medium potency topical steroid and justification for avoidance of a higher potency topical steroid; **OR** • Topical steroid avoidance due to pediatric age **Quantity Limit:** Appropriate amount to cover affected area for up to 34 days based on provider estimate or body surface area (BSA) estimate. • Age 7 years and older: max recommended is 200 grams/week • Age 2-6 years: max recommended is 100 grams/week • **Prescriber must provide clinical justification for exceeding safe limit** **Continuation Criteria:** • Prescriber attests to positive clinical response or stable disease **Additional Information:** • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred within 6 months of therapy initiation.

Camzyos	**Approved Diagnosis:** • Diagnosis of symptomatic New York Heart Association (NYHA) class II or III obstructive hypertrophic cardiomyopathy (HCM) **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 1 year **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with, a cardiologist **Age Limitation:** ≥ 18 years or older **Initial Criteria:** • Documentation confirming diagnosis must be submitted; **AND** • Member has a left ventricular ejection fraction (LVEF) of ≥ 55%; **AND** • Prescriber attests that the member will not be prescribed disopyramide, ranolazine, or combination therapy of beta blocker and calcium channel blocker, while the member is receiving Camzyos; **AND** • For females of childbearing potential, a pregnancy test is performed and is negative before starting therapy; **AND** • Attestation provided of patient, provider, and pharmacy enrollment in Camzyos Risk Evaluation and Mitigation Strategy (REMS) Program **Continuation Criteria:** • Prescriber attests to positive clinical response or stable disease; **AND** • Prescriber attests that the member will not be prescribed disopyramide, ranolazine, or combination therapy of beta blocker and calcium channel blocker, while the member is receiving Camzyos; **AND** • Prescriber attests that the member is not pregnant; **AND** • LVEF is ≥ 50% **Additional Information:** • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

cinacalcet	**Approved Diagnosis:** • Treatment of severe hypercalcemia in adult patients with primary hyperparathyroidism for who parathyroidectomy would be indicated on the bases of serum calcium levels, but who are unable to undergo parathyroidectomy • Treatment of secondary hyperparathyroidism in adult patients with chronic kidney disease (CKD) on dialysis • Treatment of hypercalcemia in adult patients with parathyroid carcinoma **Approval Timeframe:** • Initial authorization: 3 months • Continuation authorization: 6 months **Prescriber Specialty Requirement:** • Must be prescribed by a nephrologist, endocrinologist, or an oncologist by parathyroid carcinoma **Age Limitation:** 18 years or older **Initial Criteria:** • Documentation confirming diagnosis must be submitted Treatment of secondary hyperparathyroidism in adult patients with chronic kidney disease (CKD) on dialysis • Must submit current labs for all the following: ○ iPTH - iPTH level must be > 300 (biPTH >160) to initiate therapy ○ calcium - calcium must be > 8.4 to initiate therapy ○ renal function ○ serum phosphorous calcium • Must have a documented 3-month trial with subsequent clinical failure, or intolerance to both of the following: ○ an approved formulary phosphate binder ○ calcitriol or Vitamin D analogs Treatment of parathyroid carcinoma (PC): • Confirmation that the patient has hypercalcemia as defined by baseline serum calcium (Ca) > 10mg/dL (corrected for albumin) Treatment of primary hyperparathyroidism: • Confirmation the patient is eligible for, but unable to undergo parathyroidectomy • Severe hypercalcemia as defined by baseline (pre-treatment) serum calcium (Ca) >12 mg/dL (corrected for albumin) **Continuation Criteria:** • Documentation showing absence of unacceptable toxicity from the drug (e.g. hypocalcemia, seizures, hypotension, worsening heart failure, arrhythmia, adynamic bone disease); **AND** Treatment of secondary hyperparathyroidism in adult patients with chronic kidney disease (CKD) on dialysis • Adequate documentation of disease response as indicated by improvement of intact parathyroid hormone (iPTH) levels from baseline; **AND** • Current intact parathyroid hormone (iPTH) >150 pg/ml; **AND** • Current serum calcium (Ca) >7.5 mg/dL Treatment of parathyroid carcinoma (PC) • Adequate documentation of disease response as indicated by improvement of serum calcium (Ca) from baseline; **AND** • Current serum calcium (Ca) > 8.4 mg/dL Treatment of primary hyperparathyroidism • Adequate documentation of disease response as indicated by improvement of serum calcium (Ca) from baseline; **AND** • Current serum calcium (Ca) > 8.4 mg/dL **Additional Information:** • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

dalfampridine	**Approved Diagnosis:** • For treatment to improve walking in patients with Multiple Sclerosis (MS) **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 12 months **Prescriber Specialty Requirement:** none **Age Limitation:** Patient must be between ages 18 to 70 years old. **Initial Criteria:** • Must be receiving immunomodulatory therapy (unless immunomodulatory therapy is not indicated for patient's MS type) • Must have significant and continuous walking impairment that impairs ability to complete normal daily activities (such as meal preparation, household chores, etc.) attributable to ambulation or functional status despite optimal treatment for MS • Must have creatinine clearance greater than 50 mL/minute • Must have one of the following: ○ Baseline timed 25-foot walk test (T25FW) is completed within 8-45 seconds, *OR* ○ Expanded Disability Status Scale (EDSS) score that is greater than or equal to 4.5 but less than 7 • Patient must not have: ○ history of seizures ○ require the use of a wheelchair (bilateral assistance is acceptable, such as a brace, cane, or crutch, as long as the patient can walk 20 meters without resting) ○ a spinal cord injury ○ myasthenia gravis ○ demyelinating peripheral neuropathies (such as Guillain-Barre syndrome) ○ Alzheimer's disease ○ Lambert Eaton myasthenic syndrome **Continuation Criteria:** • Patient must currently meet all the initial therapy criteria listed above • Must maintain an 85% adherence rate to therapy, which will be verified based on Priority Health's medication fill history for the patient. • The patient's functional impairment must resolve as a result of increased speed of ambulation resulting in the member being able to complete instrumental activities (meal preparation, household chores, etc.) • Requires at least a 20% improvement in timed walking speed as documented by the T25FW test from pre-treatment baseline.

desmopressin	**Approved Diagnosis:** • Diabetes Insipidus **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** none **Age Limitation:** none **Initial Criteria:** • Must have a confirmed diagnosis of diabetes insipidus • Must have a documented inadequate response, or clinical contraindication, to a minimum 3-month trial of a maximum tolerated dose of desmopressin tablets. **Continuation Criteria:** • Documentation showing the patient has experienced improvement or maintained stable clinical status. • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
dronabinol	**Approved Diagnosis:** • Appetite stimulation in AIDS patients • Chemotherapy-induced nausea and vomiting **Approval Timeframe:** • Initial authorization: ○ Appetite stimulation in AIDS patients: 3 months ○ Chemotherapy-induced nausea and vomiting: duration of chemotherapy treatment • Continuation authorization: ○ Appetite stimulation in AIDS patients: 12 months ○ Chemotherapy-induced nausea and vomiting: to be determined by clinical reviewer based on treatment plan **Prescriber Specialty Requirement:** none **Age Limitation:** none **Initial Criteria:** Appetite stimulation in AIDS patients • Must have AIDS with anorexia associated with weight loss • Must have documented trial and failure, intolerance, or contraindication to megestrol Chemotherapy-induced nausea and vomiting • Patient must be currently receiving chemotherapy • Must have documented trial and failure, intolerance, or contraindication to an emetic regimen consistent with NCCN guidelines, including: ○ Ondansetron ○ Granisetron ○ Dexamethasone ○ Promethazine ○ Prochlorperazine • Treatment plan must be included with request **Continuation Criteria:** • Documentation showing the patient has experienced a positive response to therapy must be submitted ○ Appetite stimulation in AIDS patients: patients weight must have stabilized ○ Chemotherapy-induced nausea and vomiting: decreased episodes of nausea and vomiting • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Enspryng	**Approved Diagnosis:** • Neuromyelitis optica spectrum disorder **Approval Timeframe:** • Initial authorization: 12 months • Continuation authorization: 12 months **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with, a neurologist or other provider who specializes in the treatment of NMOSD **Age Limitation:** Patient must be age 18 years or older **Initial Criteria:** • Member has a diagnosis of anti-aquaporin-4 (AQP4) antibody positive NMOSD; **AND** • Clinical evidence of at least 1 documented relapse (including first attack) in last 12 months; **AND** • Prescriber attests that the member has been assessed for the following baseline values prior to first dose: ○ Hepatitis B virus ○ Tuberculosis ○ Liver transaminase levels ○ Neutrophil Count; **AND** • Prescriber attests that the member has or will avoid vaccinations within recommended time frames prior to initiation of Enspryng (see below); **AND** • Documented trial and failure or medical contraindication to one of the following: ○ Rituximab ○ Azathioprine ○ Mycophenolate mofetil **Continuation Criteria:** • Documentation that the prescriber has evaluated the member and recommends continuation of therapy (clinical benefit); **AND** • Request is for an FDA approved/medically accepted dose **Additional Information:** • Prescriber attests that member has not received (or will not receive) live or attenuated-live virus vaccines within 4 weeks prior to initiation of Enspryng and non-live vaccines at least 2 weeks prior to initiation of therapy

Eohilia	**Approved Diagnosis:** • Eosinophilic esophagitis **Approval Timeframe:** • Initial authorization: 3 months • Continuation authorization: N/A **Prescriber Specialty Requirement:** Prescribed by or in consultation with a gastroenterologist or an allergist **Age Limitation:** Patient must be age 11 years or older **Initial Criteria** • The patient has at least 15 eosinophils/high-power field (hpf) in the esophagus as confirmed by a biopsy; **AND** • Patient did not respond clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor
Exservan	**Approved Diagnosis:** • Amyotrophic Lateral Sclerosis (ALS) **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** Prescribed by or in consultation with a neurologist **Age Limitation:** Patient must be age 18 years or older **Initial Criteria** • Documentation that the patient cannot swallow tablets **Continuation Criteria** • Documentation showing the patient has experienced clinical benefit from therapy

Hyftor	**Approved Diagnosis:** • facial angiofibroma associated with tuberous sclerosis **Approval Timeframe:** • Initial authorization: 3 months • Continuation authorization: 1 year **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with, either a dermatologist or neurologist **Age Limitation:** Must be at least 6 years old **Initial Criteria:** • Documentation must be submitted confirming diagnosis of facial angiofibroma associated with tuberous sclerosis **Continuation Criteria:** • Prescriber attests to positive symptom improvement based on size and redness of facial angiofibroma **Additional Information** • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy. • Quantity Limit: ○ Age 6-11 years: 2 tubes (20gm) is covered every 30 days ○ Age 12 years and older: 3 tubes (30gm) is covered every 30 days

Increlex	**Approved Diagnosis:** • Severe primary IGF-1 deficiency: ○ Mutation in the GH-receptor ○ Mutation in the post-GHR signaling pathway ○ IGF-1 gene defects • Growth hormone gene deletion and have developed neutralizing antibodies to growth hormone **Approval Timeframe:** • Initial authorization: 12 months • Continuation authorization: 12 months **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation (consultation notes must be submitted) with a pediatric endocrinologist **Age Limitation:** Must be at least age 2 years, but not older than age 17 years **Initial Criteria:** Documentation must be provided for each of the following: • Current height measurement at less than the 3rd percentile for age and sex • IGF-1 level greater than or equal to 3 standard deviations below normal (based on lab reference range for age and sex) • Epiphyses must be confirmed as open for members age 10 and older (submit radiograph report). • Parental height (height of each parent, if available, or explanation of why not available – such as child adopted, or one parent no longer involved and is unavailable for measurement) • Clinically determined growth failure as defined by abnormally low growth rate velocity ○ Prescriber must submit the member's height and weight measurements: • These measurements must be logged in a table and plotted on standard CDC growth chart. • Height and weight measurements must cover at least a one-year timespan. **Exception: If a member is in puberty, bone age may be advancing secondary to sex hormone production. If previous growth data cannot be found to provide the "one-year" or longer time-span of data, then sexual maturity rating (Tanner Staging) and measurement of sex hormones may be submitted with only 6 months of growth data.* ○ Abnormal growth velocity is defined by the following: • A history of lower than normal growth velocity, as shown by growth charts spanning at least 6 months of time, **and** • Height: Baseline height must be < the 3rd percentile or > 2 standard deviations [SD] below the mean for gender and age, a measure of the degree of short stature. Primary IGFD • Normal or elevated growth hormone levels (stimulation testing is not required when levels are normal to high) Growth hormone gene deletion • Documentation of prior treatment with growth hormone (typically 3-6 month trial) and subsequent antibody development **Continuation Criteria:** • Epiphyses are open; **AND** • Rate of growth with Increlex is greater than pretreatment rate of growth **Additional Information** • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy. • Member must not be receiving concurrent growth hormone therapy **or** pharmacologic doses of corticosteroids.

Ingrezza	**Approved Diagnosis:** • Tardive Dyskinesia secondary to use of a dopamine antagonist • Chorea associated with Huntington's **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with, a neurologist or psychiatrist **Age Limitation:** 18 years or older **Initial Criteria:** • Documentation confirming diagnosis of chorea associated with Huntington's disease; **OR** • Documentation confirming diagnosis of Tardive Dyskinesia secondary to use of a dopamine antagonist (i.e., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.); **AND** • For tardive dyskinesia, attestation that a baseline AIMS test has been completed **Continuation Criteria:** • Attestation of patient's improvement in symptoms associated with their condition; **AND** • For tardive dyskinesia, attestation that a follow-up AIMS test has been completed **AND t**here has been a positive response to therapy
isotretinoin Amnesteem Claravis Isotretinoin Zenatane	**Approved Diagnosis:** • For treatment of moderate or severe acne **Approval Timeframe:** • Initial authorization: 5 months • Continuation authorization: will be determined by clinical reviewer **Prescriber Specialty Requirement:** • Must be prescribed by a dermatologist **Age Limitation:** Patient must be age 12 years or older **Initial Criteria:** • For diagnosis of severe acne, documentation must be submitted showing that the patient has severe acne as demonstrated by one or more of the following: ○ Visually prominent acne consisting of many comedones, inflamed papules, or pustules ○ Presence of large, inflamed papules or nodules (lesions >5 mm in diameter) ○ Associated scarring; **OR** • For diagnosis of moderate acne, the patient must have: ○ Documentation of trial, and subsequent clinical failure or intolerance, with one oral antibiotic taken consistently for a duration of at least 3 consecutive months; **AND** ○ Documentation of trial, and subsequent clinical failure or intolerance, with at least one topical retinoid product consistently for a duration of at least 3 consecutive months; **AND** ○ Documentation of trial, and subsequent clinical failure or intolerance, with benzoyl peroxide consistently for a duration of at least 3 consecutive months **Continuation Criteria:** • Documentation showing the patient has experienced improvement or maintained stable clinical status. • Continuation of therapy requests will be reviewed for coverage after that patient has been off therapy for a period of 2 months or more, and if warranted by persistent or recurring moderate to severe acne. • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Ivabradine	**Approved Diagnosis:** • Heart Failure **Approval Timeframe:** • Initial authorization: 12 months • Continuation authorization: 12 months **Prescriber Specialty Requirement:** none **Age Limitation:** none **Initial Criteria:** • Diagnosis of stable symptomatic chronic heart failure (NYHA class II, III or IV); **AND** • Left ejection fraction ≤35%; **AND** • The patient is in sinus rhythm; **AND** • Patient has a resting heart rate >70 beats per minute; **AND** • One of the following: ○ Patient is on maximum tolerated doses of beta-blockers (e.g., carvedilol, metoprolol succinate, bisoprolol); **OR** ○ Patient has a contraindication to or intolerance to beta-blocker therapy; **OR** For pediatric patients ages 6 months and older: • Diagnosis of stable symptomatic heart failure due to dilated cardiomyopathy (DCM); **AND** • Patient is in sinus rhythm; **AND** • Patient has an elevated heart rate for age **Continuation Criteria:** • Attestation that the patient has experienced positive clinical response to therapy
Kerendia	**Approved Diagnosis:** • Chronic Kidney Disease (CKD) with Type 2 Diabetes **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** none **Age Limitation:** Patient must be age 18 years or older **Initial Criteria:** • Documentation showing member is currently receiving a maximally tolerated dosage of an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) OR has a contraindication to ACE inhibitor or ARB therapy; **AND** • Member is not taking any strong CYP3A4 inhibitors; **AND** • At baseline, member meets all of the following: ○ Estimated glomerular filtration rate (eGFR) ≥ 25ml/min/1.73m2; **AND** ○ Urine albumin-to-creatinine ratio >30mg/g; **AND** ○ Serum potassium level <5.0mEq/L **Continuation Criteria:** • Documentation showing both of the following: ○ Member has eGFR ≥ 25ml/min/1.73m2; **AND** ○ Member serum potassium level <5.0mEq/L

L-Glutamine	**Approved Diagnosis:** • Sickle Cell Disease **Approval Timeframe:** • Initial authorization: 12 months • Continuation authorization: 12 months **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with, a hematologist or other specialist with expertise in the diagnosis and management of sickle cell disease **Age Limitation:** Patient must be age 5 years or older **Initial Criteria:** • Documentation confirming diagnosis must be submitted; **AND** • Documentation of an inadequate response to a maximally tolerated dose of hydroxyurea OR justification must be provided regarding intolerance, contraindication, or patient/family refusal to the use of hydroxyurea; **AND** • Request must be for an FDA approved dose/frequency **Continuation Criteria:** • Provider attestation that member is tolerating current therapy; **AND** • Patient must continue on an FDA approved dose
Lidocaine 5% patch	**Approved Diagnosis:** • Post-Herpetic Neuralgia (PHN) • Diabetic Neuropathic Pain • Peripheral polyneuropathy • SUD related concerns **Approval Timeframe:** • Initial authorization: ○ PHN: up to 90 days ○ Neuropathic pain: initially 2 months ○ Pain with SUD related concerns: up to 6 months • Continuation authorization: up to 12 months **Prescriber Specialty Requirement:** none **Age Limitation:** none **Initial Criteria:** • Documentation confirming diagnosis; **AND** Diabetic Neuropathic Pain • Must have documented trial and failure, or contraindication to, with TWO of the following: ○ Gabapentin ○ tricyclic antidepressant ○ nerve block ○ trigger point injection ○ SNRIs ○ TENS unit Peripheral Polyneuropathy • Patient must have history of substance use disorder (SUD) or SUD related concerns • Patient's peripheral polyneuropathy must not be due to post-herpetic neuralgia, diabetes, or cancer **Continuation Criteria:** • Requires documentation of positive response to the use of the patch

Litfulo	**Approved Diagnosis:** • Severe alopecia areata **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: up to 1 year **Prescriber Specialty Requirement:** Prescribed by or in consultation with a dermatologist **Age Limitation:** patient must be age 12 years or older **Initial Criteria:** • Documentation must be submitted confirming the patient's diagnosis; **AND** • Severity of Alopecia Tool (SALT) score of ≥50 (range: 0 to 100, with 0 representing no scalp hair loss and 100 complete scalp hair loss); **AND** • Current AA episode lasting at least 6 months without spontaneous regrowth; **AND** • Documentation of inadequate response to a 3-month trial of at least one of the following: ○ intralesional corticosteroid therapy; **OR** ○ prescription topical corticosteroid therapy (e.g., betamethasone dipropionate); **OR** ○ systemic immunomodulator therapy (e.g., corticosteroids, methotrexate, cyclosporine) **Continuation Criteria:** • Provider documentation of clinical improvement in hair regrowth as indicated by improvement in post-treatment SALT score; **AND** • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy. **Additional Information** • Not covered for patients with a diffuse hair loss pattern or other forms of alopecia such as androgenetic alopecia (Hamilton-Norwood classification system grade IV or greater) or chemotherapy-induced hair loss • Cannot be used in combination with other JAK inhibitors, biologic immunomodulators, cyclosporine, or other potent immunosuppressants (e.g., methotrexate, azathioprine)
Octreotide	**Approved Diagnosis:** To treat: • Acromegaly • Symptoms associated with metastatic vasoactive intestinal peptide tumors • Side effects of chemotherapy/radiation • HIV/AIDS-associated diarrhea • Symptoms of metastatic carcinoid tumors • Symptoms associated with carcinoid tumors **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 1 year **Prescriber Specialty Requirement:** none **Age Limitation:** none **Initial Criteria:** • Documentation must be submitted confirming the patient's diagnosis. **Continuation Criteria:** • Documentation showing the patient has experienced improvement or maintained stable clinical status. • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Ohtuvayre	**Approved Diagnosis:** • moderate to severe chronic obstructive pulmonary disease (COPD) **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: for up to 12 months **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with, a pulmonologist **Age Limitation:** patient must be age 18 years or older **Initial Criteria** • Documentation must be submitted confirming diagnosis; **AND** • Documentation of spirometry demonstrating FEV1/FVC ratio <0.7; **AND** • Documentation of post-bronchodilator FEV1 ≥30% and ≤ 80% of predicted normal; **AND** • Documentation of modified Medical Research Council (mMRC) dyspnea score of ≥ 2 **OR** COPD Assessment Test (CAT) score of ≥ 10; **AND** • Patient had inadequate response after a 3-month trial of either a LAMA/LABA dual-maintenance therapy **OR** LAMA/LABA/ICS triple-maintenance therapy; **AND** • Patient will continue LAMA/LABA dual therapy **OR** LAMA/LABA/ICS triple therapy in combination with Ohtuvayre unless not tolerated or contraindicated; **AND** • Member does not have a diagnosis of asthma; **AND** • Prescriber attests Ohtuvayre will not be used in combination with roflumilast **Continuation Criteria** • Documentation showing member demonstrated a decrease in symptoms and/or COPD exacerbations vs baseline; **AND** • Member will continue use of dual or triple therapy that includes (LABA/LAMA) in conjunction with Ohtuvayre; **AND** • Prescriber attests Ohtuvayre will not be used in combination with roflumilast
Oxbryta	**Approved Diagnosis:** • Sickle-cell disease **Approval Timeframe:** • Initial authorization: 12 months • Continuation authorization: 12 months **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation, with a hematologist or other specialist with expertise in the diagnosis and management of sickle cell disease **Age Limitation:** • Oxbryta 500mg tablet: patient must be age 12 years or older • Oxbryta 300mg tablets and tablet for suspension: patient must be age 4 years or older **Initial Criteria** • Baseline hemoglobin level between 5.5 g/dL and 10.5g/dL **Continuation Criteria** • Patient must show an increase in hemoglobin level from initial baseline; **OR** • Provider attests to other positive clinical response

Oxervate	**Approved Diagnosis:** • Neurotrophic keratitis **Approval Timeframe:** • Initial authorization: 56 days per affected eye • Continuation authorization: N/A **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation, with an ophthalmologist **Age Limitation:** Patient must be age 2 years or older **Initial Criteria** • Attestation that the patient or caregiver has been counseled on proper administration technique • Documentation that the member has a diagnosis of stage 2 (recurrent/persistent epithelial defect) or stage 3 (corneal ulcer) neurotrophic keratitis in affected eye(s) • Documentation that the member has tried and failed at least two conventional non-surgical treatments (e.g. preservative-free artificial tears, lubricant eye ointment, topical antibiotic eye drops, therapeutic contact lenses)
Palforzia	**Approved Diagnosis:** • Peanut Allergy **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** • Must be prescribed by an ○ Allergy specialist ○ Immunology specialist **Age Limitation:** Patient must be age 1 to 17 years of age • Patients who start therapy prior to 18 years of age may continue therapy **Initial Criteria** • Documented clinical history of allergy to peanuts or peanut-containing foods • A confirmed peanut diagnosis based on one of the following: ○ Peanut skin prick test >8mm ○ Serum IgE to peanut ≥14 kUA/L ○ A reaction that required epinephrine or ED visit • Used in conjunction with a peanut-avoidant diet • Patient has been prescribed and/or has a refill history of epinephrine auto-injector • Prescriber, health care setting, pharmacy, patient must meet manufacturer's REMS requirements **Continuation Criteria** • Positive response to treatment as documented by at least ONE (1) of the following compared to pre-treatment: ○ Reduction in severe allergic reactions ○ Reduction in epinephrine use ○ Reduction in physician/clinic visits due to peanut allergy (physician office/ER visits/hospitalizations) ○ Improvement in quality of life or productivity **Additional Information** • Palforzia is not indicated for patients with the following ○ History of severe or life-threatening episode of anaphylaxis or anaphylactic shock within 60 days ○ Uncontrolled asthma ○ History of eosinophilic esophagitis (EoE); other eosinophilic gastrointestinal disease; chronic, recurrent, or severe gastroesophageal reflux disease (GERD); symptoms of dysphagia or recurrent gastrointestinal symptoms of undiagnosed etiology ○ History of a mast cell disorder, including mastocytosis, urticarial pigmentosa, and hereditary or idiopathic angioedema ○ History of cardiovascular disease, including uncontrolled or inadequately controlled hypertension

Pretomanid	**Approved Diagnosis:** • Tuberculosis that is: ○ Pulmonary extensively drug resistant (XDR) ○ Treatment intolerant or nonresponsive multidrug-resistant (MDR) **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: if needed, 1 month intervals **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with (notes must be submitted), an ○ infectious disease specialist ○ pulmonologist **Age Limitation:** Patient must be age 5 years or older **Initial Criteria** • Patient is concomitantly taking bedaquiline and linezolid (with a medical necessity PA approval as needed) ○ Bedaquiline ○ Enter approval for ▪ Weeks 1 to 2: 400mg once daily ▪ Weeks 3 to 24: 200mg 3 times weekly • Baseline complete blood counts and electrocardiogram should be obtained **Continuation Criteria** • Documentation Requirements: Ongoing labs and ECG should be documented. • Patient must continue to meet the above criteria; **AND** • Patient has demonstrated clinical improvement in response to treatment; **AND** • Patient has not developed any contraindications or other exclusions to its continued use. **Additional Information** • Pretomanid is not indicated for patients with the following ○ Drug-sensitive (DS) tuberculosis ○ Latent infection due to mycobacterium tuberculosis ○ Extra-pulmonary infection due to M. tuberculosis ○ MDR-TB that is not treatment-intolerant or nonresponsive to standard therapy
Pulmozyme	**Approved Diagnosis:** • Cystic Fibrosis **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** • Must be prescribed by a doctor with one of the following specialties ○ Pulmonologist ○ Infectious Disease Specialist **Age Limitation:** Patient must be age 5 years or older **Initial Criteria** • Documentation confirming diagnosis must be submitted **Continuation Criteria** • Must provide documentation showing stabilization of disease • Must provide documentation supporting decreased incidence of respiratory infections

Pyrimethamine	**Approved Diagnosis:** • Treatment of toxoplasmosis • Secondary prevention of toxoplasmosis in patients with HIV • Prevention of pneumocystis pneumonia (PCP) in patients with HIV **Approval Timeframe:** • Initial authorization: ○ toxoplasmosis: 6 weeks ○ pneumocystis: 3 months • Continuation authorization: ○ toxoplasmosis: 6 months ○ pneumocystis: 3 months **Prescriber Specialty Requirement:** none **Age Limitation:** none **Initial Criteria:** • Documentation confirming patient's diagnosis must be submitted **Continuation Criteria:** For continuation when used for toxoplasmosis prophylaxis, patient must have met ONE of the following requirements: • Patient remains symptomatic • Patient is not receiving antiretroviral therapy • Patient has a detectable HIV viral load • Patient has maintained a CD4 count > 200 cells/microliter for less than six months For continuation when used for pneumocystis prophylaxis, patient must have met ONE of the following requirements: • CD4 count <200 cells/microliter • Oropharyngeal candidiasis • CD4 count percentage <14 • CD4 cell count between 200 and 250 cells/microliter IF frequent monitoring (eg, every three months) of CD4 cell counts is not possible
Radicava ORS	**Approved Diagnosis:** • "definite" or "probable" amyotrophic lateral sclerosis (ALS) **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 6 months **Prescriber Specialty Requirement:** Prescribed by or in consultation with a neurologist **Age Limitation:** Patient must be age 20-75 years **Initial Criteria** • Clinical documentation confirming diagnosis of "definite" or "probable" amyotrophic lateral sclerosis (ALS) as defined by the revised El Escorial World Federation of Neurology/Arlie House criteria • Disease duration of ≤ 2 years (provide date of diagnosis) • Living independently • Score of ≥ 2 on each individual item of the revised ALS functional rating scale (ALSFRS-R) ○ Completed copy of ALSFRS-R must be included with request • Forced vital capacity (FVC) ≥ 80% • Must be used in combination with riluzole unless there is documentation of intolerance or contraindication to riluzole **Continuation Criteria** • FCV of greater than or equal to 30%, does not require tracheostomy/artificial ventilation, and is not on continuous Bilevel Positive Airway Pressure (BiPAP) • Ambulatory (able to walk with or without assistance) • Able to self-feed • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

ranolazine ER	**Approved Diagnosis:** • Chronic Stable Angina **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** none **Age Limitation:** Patient must be age 18 years or older **Initial Criteria** ranolazine ER (generic for RANEXA®) • Documentation confirming diagnosis must be submitted **AND** • Must have documented trials of at least 1 anti-anginal agent from ALL 3 of the following drug classes; ○ Beta blocker: acebutolol, atenolol, carvedilol, metoprolol, nadolol, or propranolol ○ Calcium channel blocker (CCB): amlodipine, felodipine, or nifedipine ○ Long acting (LA) nitrate: isosorbide dinitrate, isosorbide mononitrate, nitroglycerin patch **AND** • Documentation that ranolazine will be used in addition (add-on) to another anti-anginal medication or patient has contraindication to beta-blockers, calcium channel blockers, and long-acting nitrates. **AND** • Must not have creatinine clearance less than 60 ml/min **AND** • Must not be combined with a strong inhibitor or inducer of CYP3A (i.e. ketoconazole, itraconazole, ritonavir, rifampin, phenytoin, carbamazepine, etc). Aspruzyo Sprinkle® (ranolazine) • Documentation confirming diagnosis must be submitted **AND** • Must have documented trials of at least 1 anti-anginal agent from ALL 3 of the following drug classes; ○ Beta blocker: acebutolol, atenolol, carvedilol, metoprolol, nadolol, or propranolol ○ Calcium channel blocker (CCB): amlodipine, felodipine, or nifedipine ○ Long acting (LA) nitrate: isosorbide dinitrate, isosorbide mononitrate, nitroglycerin patch **AND** • Documentation that ranolazine will be used in addition (add-on) to another anti-anginal medication or patient has contraindication to beta-blockers, calcium channel blockers, and long-acting nitrates. **AND** • Must not have creatinine clearance less than 60 ml/min **AND** • Must not be combined with a strong inhibitor or inducer of CYP3A (i.e. ketoconazole, itraconazole, ritonavir, rifampin, phenytoin, carbamazepine, etc).**AND** • Contraindication to ranolazine (Ranexa) ER tablets due to swallowing difficulties **OR** • Administration via nasogastric (NG) or gastric tube **Continuation Criteria** • See initial criteria
Sirturo	**Approved Diagnosis:** • Multi-drug resistant tuberculosis (MDR-TB) **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: N/A **Prescriber Specialty Requirement:** none **Age Limitation:** none **Initial Criteria** • Documentation confirming diagnosis • Patient must be under observed therapy

sodium oxybate solution	**Approved Diagnosis:** • Type 1 Narcolepsy (cataplexy in narcolepsy) • Type 2 Narcolepsy [narcolepsy without cataplexy; excessive daytime sleepiness (EDS) in narcolepsy] **Approval Timeframe:** • Initial authorization: 3 months • Continuation authorization: up to 6 months **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with (notes must be submitted), a board-certified; ○ Sleep medicine specialist ○ Neurologist ○ Pulmonologist ○ Psychiatrist **Age Limitation:** Patient must be age 7 years or older **Initial Criteria** • Documentation confirming diagnosis; **AND** • Documentation of current weight. Patient must weigh at least 21kg; **AND** • Have excessive daytime sleepiness daily for at least 3 months (AASM ICSD-3 Criteria), **AND** • Provide documentation of nocturnal polysomnography (PSG) confirmation [to rule out other conditions and confirm adequate sleep before first Multiple Sleep Latency Test (MSLT)] • Provide documentation of a positive Multiple Sleep Latency Test (MSLT) including: ○ Mean Sleep latency ≤ 8 minutes, **AND** ○ 2 or more sleep onset rapid eye movement (REM) periods < 15 minutes • EXCEPTION to positive MSLT test for Type 1 Narcolepsy (cataplexy in narcolepsy): Hypocretin-1 ≤ 110 pg/mL (or < 1/3 of mean normal control values) may be alternative to MSLT sleep study • Member is not currently on a sedative hypnotic agent (examples include but are not limited to: Lunesta (eszopiclone), Ambien (zolpidem), Sonata (zaleplon), Restoril (temazepam), Halcion (triazolam), or Belsomra (suvorexant)) • Member is not currently on other prescription or non-prescription sedatives, including but not limited to excessive alcohol or marijuana use. • Metabolic and psychiatric causes have been evaluated and ruled out; if present, attestation that treatment has been optimized. • Provider attests that patient is enrolled in the sodium oxybate/Xywav/Xyrem REMS program. Type 1 Narcolepsy • Member has cataplexy defined as more than one episode of generally brief (less than 2 minutes) usually bilaterally symmetrical, sudden loss of muscle tone with retained consciousness • Member did not achieve treatment goals or experienced inadequate clinical response after an adherent trial at maximum therapeutic dose, persistent intolerable adverse effects, or contraindication to at least ONE medication from BOTH of the following categories: ○ Tricyclic Antidepressants (TCA) OR Selective Serotonin Reuptake Inhibitors (SSRIs) or Serotonin-norepinephrine Reuptake Inhibitor (SNRI): ▪ TCA: imipramine, nortriptyline, protriptyline, clomipramine, etc ▪ SSRI/SNRI: fluoxetine, venlafaxine, atomoxetine, etc ○ Non-amphetamine stimulant OR Amphetamine-based stimulant or a methylphenidate-based stimulant: Non-amphetamine stimulant: modafanil (Provigil) or armodafanil (Nuvigil); ▪ Non-amphetamine stimulant: modafanil (Provigil) or armodafanil (Nuvigil) ▪ Amphetamine-based products: amphetamine/dextroamphetamine mixed salts; amphetamine/dextroamphetamine mixed salts extended-release; dextroamphetamine extended-release ▪ Methylphenidate-based products: methylphenidate, methylphenidate extended-release, dexmethylphenidate *Continued >*

Type 2 Narcolepsy

- Other conditions that cause EDS have been ruled out or treated, including (but not limited to): shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, effects of sedating medications, idiopathic hypersomnolence, insufficient sleep at night (sleep deprivation), obstructive sleep apnea, central sleep apnea, periodic limb movement disorder (including restless legs syndrome), depression, Circadian rhythm disorders (including delayed sleep phase syndrome), and sedating medications.
- Member did not achieve treatment goals or experienced inadequate clinical response after a documented adherent trial at maximum therapeutic dose, persistent intolerable adverse effects or contraindication to at least ONE medication from ALL of the following categories:
    - Non-amphetamine stimulant: modafanil (Provigil), armodafanil (Nuvigil)
    - Amphetamine-based stimulant: amphetamine/dextroamphetamine mixed salts; amphetamine/dextroamphetamine mixed salts extended-release; dextroamphetamine extended-release
    - Methylphenidate based stimulants: o methylphenidate, methylphenidate extended-release dexmethylphenidate
    - Dopamine and norepinephrine reuptake inhibitor (DNRI): Sunosi (solriamfetol)
    - Histamine-3 (H3) receptor antagonist/inverse agonist: Wakix (pitolisant)

Continuation Criteria

- Consultation notes must be submitted for initial request and for continuation of treatment requests at least ONCE annually
- Patient must be adherent to therapy at least 85% of the time, including;
    - adherence to the prescribed medication regimen
    - tolerance to therapy
    - no severe adverse reactions or drug toxicity
- Documentation of efficacy and positive response to therapy as evidenced by response of decreasing cataplexy events and improvement in score for appropriate test (e.g. Epworth Sleepiness Scale, Clinical Global Impression of Change, etc.) for EDS [ALL APPLICABLE]
    - Decrease or reduction in the frequency of cataplexy events/attacks associated with therapy for Type 1 Narcolepsy
    - Decrease or reduction in symptoms of excessive daytime sleepiness associated with therapy
    - For excessive daytime sleepiness (EDS): Improvement in the Epworth Sleepiness Scale (ESS), Clinical Global Impression of Change or Maintenance of Wakefulness Test (MWT) for Type 1 and 2 Narcolepsy
- Patient must have a documented attempt to decrease dose or step down to alternative drugs

Additional Information

- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
- Must not be administered with alcohol or CNS depressant anxiolytics, sedatives, hypnotics, or other sedative CNS depressant drugs
- Patient must not have uncontrolled hypertension

Synagis	**Approved Diagnosis:** • Prematurity • Chronic Lung Disease • Heart Disease • Neuromuscular Disease, congenital airway anomaly, or pulmonary abnormality • Immunocompromised **Approval Timeframe:** • Initial authorization: maximum of 5 doses per RSV season (typically October 1 to May 1, this must be confirmed on an annual basis) • Continuation authorization: will be determined by clinical reviewer **Prescriber Specialty Requirement:** none **Age Limitation:** Patient must be age 24 months or younger **Initial Criteria: For patients age 0 to 12 months:** • Children who have not had a dose of Beyfortus™ (nirsevimab) in the current RSV season**; AND** • Mother did not receive vaccination against RSV in the 2nd or 3rd trimester; **AND** Prematurity • Documentation confirming that patient was born at 28 weeks, 6 days gestation or earlier during their first RSV season Chronic Lung Disease • Documentation confirming that patient was born at 31 weeks, 6 days gestation or earlier • Documentation confirming that patient required more than 21% oxygen for at least 28 days after birth • NICU discharge summary must be included Heart Disease • Documentation confirming that patient has hemodynamically significant cyanotic Congenital Heart Disease • Documentation confirming that patient has acyanotic Congenital Heart Disease and is receiving medication for CHF • NICU discharge summary must be included Neuromuscular Disease / Congenital Airway Anomaly / Pulmonary Abnormality • Documentation confirming that disease impairs patient's ability to clear secretions from the lower airways • Please note, routine use in cystic fibrosis and Down Syndrome is not recommended Immunocompromised • Documentation confirming that patient will be profoundly immunocompromised because of chemotherapy or other conditions during the RSV season. **Initial Criteria: For patients age 12 to 24 months:** • Children who have not had a dose of Beyfortis™ (nirsevimab) in the current RSV season; **AND** Chronic Lung Disease • Documentation confirming that patient was born at 31 weeks, 6 days gestation or earlier • Documentation confirming that patient required 28+ days of supplemental oxygen after birth • Documentation that the patient continues to require medical support (supplemental oxygen, chronic corticosteroids, or diuretic therapy) within 6 months of the start of their second RSV season Immunocompromised • Documentation confirming that patient will be profoundly immunocompromised because of chemotherapy or other conditions during the RSV season. **Continuation Criteria: all ages** • Considered in a case-by-case basis. If any infant or young child receiving monthly Synagis prophylaxis experiences a breakthrough RSV hospitalization, monthly prophylaxis should be discontinued because of the extremely low likelihood of a second RSV hospitalization in the same season (<0.5%) **Additional Information** • The recommended dose of Synagis is 15mg/kg body weight administered intramuscularly. • This medication may be approved under either the pharmacy benefit *or* the medical benefit (not both)

Tazarotene cream and gel	**Approved Diagnosis:** • psoriasis • acne vulgaris **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: up to 1 year **Prescriber Specialty Requirement:** none **Age Limitation:** • Treatment of acne vulgaris: ○ Must be age ≥12 years • Treatment of psoriasis: ○ Cream: must be age ≥18 years ○ Gel: must be age ≥12 years **Initial Criteria** • Prescribed to treat an FDA approved indication for Tazarotene; **AND** • For the treatment of **psoriasis:** ○ Documented trial, failure, or intolerance to at least one high potency or very high potency topical steroid; **OR** ○ Documented trial, failure, or intolerance of one low or medium potency topical steroid **and** justification for avoidance of a higher potency topical steroid; **OR** ○ Topical steroid avoidance due to pediatric age**; AND** ○ Documented trial, failure or intolerance to a topical vitamin D analogue (i.e. calcipotriene or calcitriol) or a clinical reason why both cannot be used • For the treatment of **acne vulgaris:** ○ Documented trial, failure or intolerance to one of the following: ▪ Topical adapalene ▪ Topical tretinoin **Continuation Criteria** • Attestation that tazarotene has contributed to a positive response or patient is stable on therapy • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
Tiglutik	**Approved Diagnosis:** • Amyotrophic Lateral Sclerosis (ALS) **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** Prescribed by or in consultation with a neurologist **Age Limitation:** Patient must be age 18 years or older **Initial Criteria** • Documentation that the patient cannot swallow tablets **Continuation Criteria** • Documentation showing the patient has experienced clinical benefit from therapy

tolvaptan	**Approved Diagnosis:** • Autosomal dominant polycystic kidney disease (ADPKD) **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** Nephrologist **Age Limitation:** Patient must be age 18 years or older **Initial Criteria:** • Supporting documentation must be submitted confirming patient has a diagnosis of autosomal dominant polycystic kidney disease (ADPKD) confirmed via imaging; **AND** • Attestation of baseline ALT, AST, and bilirubin tests within normal limits; **AND** • Patient must have an estimated glomerular filtration rate (eGFR) of ≥ 25mL/min/1.73m2; **AND** • Patient's disease must be is rapidly progressing or likely to rapidly progress as evidenced by: ○ Total kidney volume (TKV) of at least 750mL,; **OR** ○ Rapid loss of eGFR of at least 2.5mL/min/1.73m2 per year **Continuation Criteria:** • Attestation that baseline ALT, AST, and bilirubin tests continue to be within normal limits
Tryvio	**Approved Diagnosis:** • Resistant Hypertension despite concurrent use of 3 or more antihypertensive drug classes **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with, a specialist with experience in the treatment of RH such as a cardiologist, nephrologist or endocrinologist **Age Limitation:** Must be age 18 years or older **Initial Criteria:** • Clinical documentation demonstrating failure to reach blood pressure goal despite concurrent use of 3 or more antihypertensive drug classes; **AND** • Clinical documentation demonstrating failure to reach blood pressure goal despite addition of a mineralocorticoid receptor antagonist (i.e., spironolactone OR eplerenone) to the current 3 drug regimen; **OR** • Contraindication (i.e. hyperkalemia, renal impairment, etc.) or drug to drug interaction (i.e. CYP3A4 Inhibitors, potassium-sparing diuretics, etc.) preventing the use of both spironolactone and eplerenone; **AND** • For patients who can become pregnant, the prescriber attests: ○ patient is not pregnant or lactating ○ patient has been counseled on the risk of major birth defects AND to use acceptable methods of contraception before treatment with TRYVIO, during treatment with TRYVIO, and for one month after ○ treatment discontinuation; **AND** • Prescriber is enrolled in TRYVIO REMS program **Continuation Criteria:** • For patients who can become pregnant, prescriber attests patient is not pregnant or lactating • Clinical documentation demonstrates blood pressure improvement compared to baseline • Prescriber attests that patient has not experienced unacceptable adverse effects from TRYVIO therapy (i.e. hepatotoxicity, clinically significant anemia, clinically significant edema)

Vemlidy	**Approved Diagnosis:** • Chronic Hepatitis B **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 12 months **Prescriber Specialty Requirement:** none **Age Limitation:** Must be age 6 years or older **Initial Criteria:** • Documentation confirming diagnosis of Chronic Hepatitis B infection with compensated liver disease; **AND** • Documented trial, clinical failure, or contraindication to Entecavir; **AND** • Trial of tenofovir disoproxil fumarate unless one of the following conditions are met: ○ History of osteoporosis or osteopenia ○ Renal impairment defined by creatinine clearance (CrCl) < 50 mL/min or history of chronic renal disease ○ Trial of tenofovir disoproxil fumarate is inappropriate.; **OR** • Persistent viremia or breakthrough infection while taking lamivudine or adefovir **(NOTE: lamivudine and adefovir are no longer recommended in current guidelines)**; **AND** • Attestation confirming no HIV risk or negative HIV status **Continuation Criteria:** • Documentation confirming patient has had positive clinical response; **AND** • Confirmation of continued monitoring according to available guidelines (i.e. HBV DNA, ALT, etc.); **AND** • CrCl remains ≥ 15 mL/min • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
Verquvo	**Approved Diagnosis:** • Symptomatic chronic heart failure **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 12 months **Prescriber Specialty Requirement:** Must be prescribed by, or in consultation with (notes must be submitted), a cardiologist **Age Limitation:** Must be age 18 years or older **Initial Criteria:** • Documentation that member has chronic heart failure, New York Heart Association [NYHA] Class II-IV who has had a decompensation while on standard therapy for heart failure • Documentation of a left ventricular ejection fraction (LVEF) of less than 45% • Documentation that member is currently taking or has a contraindication to **ALL** of the following: ○ ACE inhibitor, ARB, or Entresto ○ Beta blocker ○ Oral diuretic (not applicable if member had IV diuretics in previous 3 months) • History of hospitalization for heart failure in the previous 6 months or required outpatient IV diuretics for heart failure in the previous 3 months. • Prescriber attestation that member is not or will not be using Verquvo concomitantly with other soluble guanylate cyclase (sGC) stimulators (e.g. riociguat) or PDE-5 inhibitors (e.g. sildenafil, tadalafil, vardenafil and avanafil). • **For female patients of childbearing potential:** ○ Documentation of a negative pregnancy test in the previous 30 days and provider attestation that member has been counseled on the risks and advised to use contraception throughout treatment with and one month following Verquvo administration. **Continuation Criteria:** • Documentation that member has had no intolerable adverse effects from treatment • Documentation that member is responding positively to treatment demonstrated by improvement or slowing of decline in signs and symptoms of heart failure.

Voquezna	**Approved Diagnosis:** • Erosive esophagitis • Non-erosive gastroesophageal reflux disease (GERD) **Approval Timeframe:** • Initial authorization: 8 months • Continuation authorization: 6 months **Prescriber Specialty Requirement:** none **Age Limitation:** Patient must be age 18 years or older **Initial Criteria** • Documentation confirming diagnosis of erosive esophagitis; **OR** • Diagnosis of non-erosive gastroesophageal reflux disease (GERD); **AND** • Clinical documentation must be provided that demonstrates patient had a therapeutic failure after one-month trial with one preferred proton pump inhibitor (PPI) **Continuation Criteria** • Clinical documentation must be submitted that demonstrates patient has had significant improvement in signs and symptoms of erosive esophagitis or non-erosive gastroesophageal reflux disease (GERD) • Provider attests that continuation beyond the FDA-approved duration of therapy is medically necessary • Provider attests risks vs. benefits of continuation have been weighed and discussed with the patient (i.e. Risks of C. difficile-associated infection, fractures, fundic gland polyps, hypomagnesemia, tubulointerstitial nephritis, vitamin B12 deficiency, etc.)
Vtama	**Approved Diagnosis:** • Plaque psoriasis **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 1 year **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with, a dermatologist **Age Limitation:** Patient must be age 18 years or older **Initial Criteria** • Documentation confirming treatment of an FDA approved indication for topical tapinarof; **AND** • Documented trial, failure, or intolerance to at least one high potency **or** very high potency topical steroid; **AND** • Documented trial, failure, or intolerance to topical calcipotriene, calcitriol, tazarotene, or combination products containing prior stated ingredients; **OR** • Clinical documentation as to why therapies listed above are not appropriate; **AND** • Prescribed volume is appropriate for treating the estimated body surface area affected; **OR** • Prescriber attests that the volume is necessary for up to a 34-day supply per fill **Continuation Criteria** • Attestation that topical tapinarof has contributed to a positive response or patient is stable on therapy. • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Vyndamax **Vyndaqel**	**Approved Diagnosis:** • Wild-type ATTR-CM • Hereditary ATTR-CM **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with (notes must be submitted), a cardiologist **Age Limitation:** none **Initial Criteria** • Documentation confirming diagnosis ○ ATTR-CM must be confirmed by genetic testing, tissue biopsy, or radionuclide imaging (99mTcPYP, 99mTc- DPD, or 99mTc-HMDP scan); **AND** • Medical history of heart failure that includes one of the following ○ at least one prior hospitalization of heart failure ○ clinical evidence of heart failure • Must not currently have, or have history of: ○ New York Heart Association (NYHA) Class 4 heart failure ○ Primary (light-chain) amyloidosis ○ Prior liver or heart transplant or an implanted cardiac device • Will not be used concurrently with Amvuttra, Onpattro, Wainua or Attruby **Continuation Criteria** • Documentation that the patient has experienced a positive clinical response to Vyndaqel/Vyndamax compared to baseline (i.e. reduced cardiovascular-related hospitalizations, improved function, improved quality of life); **AND** • Patient is not receiving tafamidis (Vyndaqel, Vyndamax) in combination with Amvuttra, Attruby, Wainua or Onpattro. • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Xywav	**Approved Diagnosis:** • Type 1 Narcolepsy (cataplexy in narcolepsy) • Type 2 Narcolepsy [narcolepsy without cataplexy; excessive daytime sleepiness (EDS) in narcolepsy] • Idiopathic Hypersomnia **Approval Timeframe:** • Initial authorization: 3 months • Continuation authorization: up to 6 months **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with (notes must be submitted), a board-certified; ○ Sleep medicine specialist ○ Neurologist ○ Pulmonologist ○ Psychiatrist **Age Limitation:** Patient must be • Narcolepsy (Type 1 & 2): Patient must be age 7 years or older; **OR** • Idiopathic Hypersomnia: Patient must be age 18 years or older **Initial Criteria** • Rationale for lower sodium needed for approval of Xywav except when the indication is for idiopathic hypersomnia in adults • Documentation confirming diagnosis; **AND** • Documentation of current weight. Patient must weigh at least 21kg; **AND** • Have excessive daytime sleepiness daily for at least 3 months (AASM ICSD-3 Criteria), **AND** • Provide documentation of nocturnal polysomnography (PSG) confirmation [to rule out other conditions and confirm adequate sleep before first Multiple Sleep Latency Test (MSLT)] • Provide documentation of a positive Multiple Sleep Latency Test (MSLT) including: ○ Mean Sleep latency ≤ 8 minutes, **AND** ○ 2 or more sleep onset rapid eye movement (REM) periods < 15 minutes EXCEPTION to positive MSLT test for: ○ Type 1 Narcolepsy (cataplexy in narcolepsy): Hypocretin-1 ≤ 110 pg/mL (or < 1/3 of mean normal control values) may be alternative to MSLT sleep study ○ Idiopathic Hypersomnia: the number of sleep-onset rapid eye movement sleep periods (SOREMPs) is less than two • Member is not currently on a sedative hypnotic agent (examples include but are not limited to: Lunesta (eszopiclone), Ambien (zolpidem), Sonata (zaleplon), Restoril (temazepam), Halcion (triazolam), or Belsomra (suvorexant)) • Member is not currently on other prescription or non-prescription sedatives, including but not limited to excessive alcohol or marijuana use. • Metabolic and psychiatric causes have been evaluated and ruled out; if present, attestation that treatment has been optimized. • Provider attests that patient is enrolled in the Xywav/Xyrem REMS program. Type 1 Narcolepsy • Member has cataplexy defined as more than one episode of generally brief (less than 2 minutes) usually bilaterally symmetrical, sudden loss of muscle tone with retained consciousness • Member did not achieve treatment goals or experienced inadequate clinical response after an adherent trial at maximum therapeutic dose, persistent intolerable adverse effects, or contraindication to at least ONE medication from BOTH of the following categories: ○ Tricyclic Antidepressants (TCA) OR Selective Serotonin Reuptake Inhibitors (SSRIs) or Serotonin-norepinephrine Reuptake Inhibitor (SNRI): ▪ TCA: imipramine, nortriptyline, protriptyline, clomipramine, etc ▪ SSRI/SNRI: fluoxetine, venlafaxine, atomoxetine, etc ○ Non-amphetamine stimulant OR Amphetamine-based stimulant or a methylphenidate-based stimulant: Non-amphetamine stimulant: modafanil (Provigil) or armodafanil (Nuvigil); ▪ Non-amphetamine stimulant: modafanil (Provigil) or armodafanil (Nuvigil) ▪ Amphetamine-based products: amphetamine/dextroamphetamine mixed salts; amphetamine/dextroamphetamine mixed salts extended-release; dextroamphetamine extended-release ▪ Methylphenidate-based products: methylphenidate, methylphenidate extended-release, dexmethylphenidate *Continued >*

Type 2 Narcolepsy

- Other conditions that cause EDS have been ruled out or treated, including (but not limited to): shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, effects of sedating medications, idiopathic hypersomnolence, insufficient sleep at night (sleep deprivation), obstructive sleep apnea, central sleep apnea, periodic limb movement disorder (including restless legs syndrome), depression, Circadian rhythm disorders (including delayed sleep phase syndrome), and sedating medications.
- Member did not achieve treatment goals or experienced inadequate clinical response after a documented adherent trial at maximum therapeutic dose, persistent intolerable adverse effects or contraindication to at least ONE medication from ALL of the following categories:
    - Non-amphetamine stimulant: modafanil (Provigil), armodafanil (Nuvigil)
    - Amphetamine-based stimulant: amphetamine/dextroamphetamine mixed salts; amphetamine/dextroamphetamine mixed salts extended-release; dextroamphetamine extended-release
    - Methylphenidate based stimulants: o methylphenidate, methylphenidate extended-release dexmethylphenidate
    - Dopamine and norepinephrine reuptake inhibitor (DNRI): Sunosi (solriamfetol)
    - Histamine-3 (H3) receptor antagonist/inverse agonist: Wakix (pitolisant)

Idiopathic Hypersomnia

- Documentation confirming diagnosis; **AND**
- Prescribed by or in consultation with a neurologist or sleep medicine specialist; **AND**
- Must rule out all the following diagnoses:
    - Narcolepsy of cataplexy
    - Narcolepsy of EDS
    - Insufficient sleep syndrome

Continuation Criteria

- Consultation notes must be submitted for initial request and for continuation of treatment requests at least ONCE annually
- Patient must be adherent to therapy at least 85% of the time, including;
    - adherence to the prescribed medication regimen
    - tolerance to therapy
    - no severe adverse reactions or drug toxicity
- Documentation of efficacy and positive response to therapy as evidenced by response of decreasing cataplexy events and improvement in score for appropriate test (e.g. Epworth Sleepiness Scale, Clinical Global Impression of Change, etc.) for EDS [ALL APPLICABLE]
    - Decrease or reduction in the frequency of cataplexy events/attacks associated with therapy for Type 1 Narcolepsy
    - Decrease or reduction in symptoms of excessive daytime sleepiness associated with therapy
    - For excessive daytime sleepiness (EDS): Improvement in the Epworth Sleepiness Scale (ESS), Clinical Global Impression of Change or Maintenance of Wakefulness Test (MWT) for Type 1 and 2 Narcolepsy
- Patient must have a documented attempt to decrease dose or step down to alternative drugs

Additional Information

- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
- Must not be administered with alcohol or CNS depressant anxiolytics, sedatives, hypnotics, or other sedative CNS depressant drugs
- Patient must not have uncontrolled hypertension

Yorvipath	**Approved Diagnosis:** • Hypoparathyroidism **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 12 months **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with, an endocrinologist **Age Limitation:** Must be age 18 years or older **Initial Criteria** • Provider attests that the patient is currently receiving conventional therapy, including: active vitamin D (calcitriol) and elemental calcium, and that patient's disease cannot be adequately controlled on conventional therapy alone. • Documentation must be submitted for current labs (within 60 days of request) for the following: ○ Albumin-corrected serum calcium (must be > 7.8mg/dL to start therapy) ○ Serum vitamin D level (must be greater than or equal to 20 ng/mL to start therapy) • Medication is prescribed at an FDA approved dose (maximum dose of 30mcg once daily). **Continuation Criteria** • Documentation must be submitted of a recent albumin-corrected serum calcium in the lower-half of the normal reference range or just below the normal reference range (~8–9 mg/dL) **AND** • Patient no longer requires active vitamin D or therapeutic doses of elemental calcium greater than 600 mg per day; **OR** • Patient has had a significant reduction in required dosages of active vitamin D or therapeutic doses of elemental calcium and is still actively titrating doses of Yorvipath **AND** • Medication is prescribed at an FDA approved dose

Zoryve	**Approved Diagnosis:** • Plaque Psoriasis (Zoryve 0.3% Cream) • Mild to moderate atopic dermatitis (Zoryve 0.15% Cream) • Seborrheic Dermatitis (Zoryve Foam) **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 1 year **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with, a dermatologist **Age Limitation:** • Zoryve Cream: Must be age 6 years or older • Zoryve Foam: Must be age 9 years or older **Initial Criteria** • Documentation confirming treatment of an FDA approved indication for topical Roflumilast; **AND** • Prescribed volume is appropriate for treating the estimated body surface area affected or prescriber attests that the volume is necessary for up to a 34-day supply per fill; **AND** Plaque Psoriasis • Documented trial, failure, or intolerance to at least one high potency **or** very high potency topical steroid; **AND** • Documented trial, failure, or intolerance to topical calcipotriene, calcitriol, tazarotene, or combination products containing prior stated ingredients; **OR** • Clinical documentation as to why therapies listed above are not appropriate Seborrheic Dermatitis • Documented trial, failure, or intolerance to at least one topical steroid; **AND** • Documented trial, failure, or intolerance to at least one topical antifungal; **OR** • Clinical documentation as to why prerequisite therapies listed above are not appropriate. Mild to Moderate Atopic Dermatitis • Documented trial, failure, or intolerance to at least one topical steroid; **OR** • Clinical documentation as to why prerequisite therapies listed above are not appropriate **Continuation Criteria** • Attestation that topical roflumilast has contributed to a positive response or patient is stable on therapy. • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

PDL DRUG CLASS	CRITERIA
ACE Inhibitors	**Preferred Agents:** *No Prior Authorization required* Benazepril/ benazepril-HCT enalapril/ enalapril-HCT lisinopril/ lisinopril HCT ramipril **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Accupril® Accuretic® Altace® captopril/ captopril HCT Epaned® enalapril solution (generic Epaned) fosinopril/ fosinopril HCT Lotensin®/ Lotensin HCT® moexipril Monopril® / Monopril HCT® perindopril Qbrelis® quinapril / quinapril HCT trandolapril Vasotec® / Vaseretic® Zestril® / Zestoretic® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Patient is clinically stable and switching would cause a deterioration in condition; **OR** • Therapeutic failure on one preferred medication **See additional medication-specific criteria below:** EPANED® (*enalapril solution*) • PDL criteria may be bypassed if patient is unable to swallow tablets. QBRELIS® • PDL criteria may be bypassed if patient is unable to swallow tablets. **Duration of Approval:** 1 year
Alpha Adrenergic Agents	**Preferred Agents:** *No Prior Authorization required* clonidine clonidine ER clonidine transdermal guanfacine methyldopa Nexiclon XR® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* methyldopa / HCTZ **Non-Preferred Agent PA Criteria:** ▪ Allergy to the preferred medications; **OR** ▪ Contraindication or drug to drug interaction with the preferred medications; **OR** ▪ History of unacceptable side effects; **OR** ▪ Therapeutic failure on one preferred medication **Duration of Approval**: 1 year

Alzheimer's Dementia	**Preferred Agents:** *No Prior Authorization required* donepezil tabs, ODT Exelon® patch galantamine immediate release memantine immediate release rivastigmine capsules **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Adlarity® Aricept® donepezil 23 mg® galantamine ER caps, solution memantine ER Namenda® Namenda XR® Namzaric® rivastigmine patch **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with one-month trial of one preferred medication **Duration of Approval**: 1 year

Androgenic Agents (topical)	**Preferred Agents:** *Prior Authorization Required. Criteria below.* testosterone gel 1.62% pump (generic for Androgel) **Preferred Agent PA Criteria:** • Serum testosterone levels <300 ng/dL • For requests submitted for gender dysphoria INITIAL REQUEST ○ Patient has had an initial evaluation completed by a health care provider experienced in gender dysphoria that specializes in treatment and evaluation of gender disorders (including health history, physical exam, desired treatment goals and relevant lab testing); **AND** ○ Persistent well documented gender dysphoria; **AND** ○ Patient has the ability to make a fully informed decision and consent of treatment; **AND** ○ Prior consent for treatment including potential adverse health effects, expected benefits/effects including future body image changes and potential effects on fertility; **AND** ○ No significant medical or mental health concerns and, if so, they been addressed and been deemed to not be a contraindication to therapy RENEWAL REQUEST ○ Patient has had ongoing follow-up and monitoring following standard guidelines including addressing mental health concerns. For example, Version 7 WPATH Standards of Care or 2017 Clinical Practice Guideline, Endocrine Society: https://doi.org/10.1210/jc.2017-01658 • Contraindications: ○ Severe renal or cardiac diseases ○ Benign prostatic hyperplasia with obstruction ○ Prostate cancer ○ Undiagnosed genital bleeding ○ Breast cancer ○ Pregnancy **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Androgel® packet and gel pump Fortesta® Natesto Testim® testosterone Vogelxo® **Non-Preferred Agent PA Criteria:** • Trial and failure with one preferred medication is required • Decreased testosterone levels • Contraindications: ○ Severe renal or cardiac diseases ○ Benign prostatic hyperplasia with obstruction ○ Prostate cancer ○ Undiagnosed genital bleeding ○ Breast cancer ○ Pregnancy **Duration of Approval**: 1 year

Angiotensin Receptor Antagonists	**Preferred Agents:** *No Prior Authorization required* Losartan/ losartan-HCTZ olmesartan/ olmesartan- HCT valsartan/valsartan-HCTZ **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Atacand® / Atacand HCTZ® Avapro®/ Avalide® Benicar®/ Benicar HCTZ® candesartan/ candesartan HCTZ Cozaar® Diovan®/ Diovan HCTZ® Edarbi® Edarbyclor® eprosartan Hyzaar® irbesartan/ irbesartan HCTZ Micardis® / Micardis HCTZ® telmisartan/ telmisartan HCTZ **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Patient is clinically stable, and switching would cause a deterioration in condition • Therapeutic failure on one preferred medication **Duration of Approval**: 1 year
Angiotensin II - Receptor Neprilsyin Inhibitors	**Preferred Agents:** *Clinical Prior Authorization below* Entresto® ENTRESTO® (SACUBITRIL-VALSARTAN) TABLETS • Quantity Limit: 60 tablets per 30 days **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Entresto® Sprinkles sacubitril-valsartan **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure on one preferred medication **See additional medication-specific criteria below:** ENTRESTO® (SACUBITRIL-VALSARTAN) SPRINKLES • Allow PDL bypass if patient is unable to swallow tablets • Quantity Limit: 60 capsules per 30 days **Duration of Approval**: 1 year

Antibiotics – Inhaled	**Preferred Agents:** *No Prior Authorization required* Bethkis® ampule Cayston® inhalation solution Kitabis® pak Tobi-Podhaler® tobramycin solution (Generic for Tobi inhalation solution) **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* TOBI inhalation solution tobramycin pak (eneric for Kitabis Pak) tobramycin 300mg/4mL ampule (generic Bethkis) **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Trial and failure with one month with one preferred medication **Duration of Approval**: 1 year
Anticholinergic Agents – Long Acting	**Preferred Agents:** *No Prior Authorization required* Incruse Ellipta® (DPI) Spiriva® Handihaler (DPI) Spiriva Respimat® (ISI) **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* tiotropium (DPI) Tudorza Pressair® (DPI) Yupelri® nebulizer solution **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • The patient's condition is clinically stable such that switching medications would cause deterioration in the condition; **OR** • Therapeutic failure after a two-week trial with one preferred medication **Duration of Approval**: 1 year

Anticoagulants	**Preferred Agents:** *No Prior Authorization required* Eliquis® enoxaparin Jantoven® Pradaxa® warfarin Xarelto®/ Xarelto® Dose Pack **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Arixtra® dabigatran etexilate Fondaparinux Fragmin® syringes and vials Lovenox® Pradaxa Oral Pellets® rivaroxaban Savaysa® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure on one preferred medication **See additional medication-specific criteria below:** PRADAXA ORAL PELLETS® (DAGABITRAN) • Patient must be 11 years old or younger • When used for VTE treatment, attestation that parenteral anticoagulation has been used for at least 5 days **Duration of Approval**: up to 6 months
Antiemetics	**Preferred Agents:** *No Prior Authorization required* aprepitant 40mg, 80mg, 125mg capsules granisetron ondansetron 4mg, 8mg tablets, solution ondansetron ODT 4mg, 8mg **Non-Preferred Agents:** *Prior Authorization Required. Criteria below* Akynzeo® aprepitant 125-80-80mg pack Emend® 80mg capsules Emend Pack® ondansetron ODT 16mg Sancuso® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with 48-hour trial with one preferred medication **See additional medication-specific criteria below:** AKYNZEO • May only be approved for highly emetogenic regimens or regimens including anthracyclines and cyclophosphamide that are not considered highly emetogenic, **AND** • Therapeutic failure on a preferred 5-HT3 receptor antagonist (granisetron, ondansetron) and a preferred substance P receptor agonist (Emend) **Duration of Approval**: 1 year

Antifungals – Oral	**Preferred Agents:** *No Prior Authorization required* clotrimazole troches fluconazole griseofulvin oral suspension ketoconazole nystatin oral susp, tablets terbinafine **Non-Preferred Agents:** *Prior Authorization Required. Criteria below* Ancobon Brexafemme® Cresemba® Diflucan® flucytosine griseofulvin tablet/microsize tablets/ultramicrosize tablets itraconazole Noxafil®, Noxafil DR®, Noxafil PowderMix Suspension Oravig® posaconazole Sporanox® Tolsura® Vfend® Vivjoa® voriconazole **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Trial and failure with one month with one preferred medication: **OR** • Serious illness resulting immunocompromised status **See additional medication-specific criteria below:** BREXAFEMME® • Diagnosis of vulvovaginal candidiasis; **OR** • Patient has diagnosis of recurrent vulvovaginal candidiasis with ≥3 episodes of vulvovaginal candidiasis (VVC) in a 12-month period; **AND** • Attestation that the provider has confirmed a negative pregnancy test or that the patient is not of childbearing potential • Quantity Limit: Treatment – 4 tablets, Maintenance – 24 tablets • Length of approval: Treatment – one time, Maintenance – 6 months CRESEMBA® • Diagnosis of aspergillosis; **AND** • Patient is 18 years or older; **AND** • Trial on voriconazole/Vfend or amphotericin B - approve without trials if intolerant to prerequisite meds or renal dysfunction. NOXAFIL® (POSACONAZOLE) 300 MG SUSPENSION PACKETS) • Maximum patient age = 17 years SPORANOX® (ITRACONAZOLE) • Onychomycosis with previous failure on or contraindication to terbinafine: length of approval - toenails 12 weeks; fingernails - 6 weeks. • Below diagnoses without previous trial: ○ Aspergillosis ○ Blastomycosis ○ Febrile neutropenia ○ Histoplasmosis VFEND® (VORICONAZOLE) • Aspergillosis – no trial/failure required *Continued >*

	VIVJOA® • Patient has diagnosis of recurrent vulvovaginal candidiasis with ≥3 episodes of vulvovaginal candidiasis (VVC) in a 12-month period; **AND** • Patient is a biological female who is postmenopausal or has another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy); **AND** • Patient has tried and failed or has a contraindication or intolerance to maintenance antifungal therapy with oral fluconazole. • Quantity limit: 18 tablets per treatment course • Length of approval: one time **Duration of Approval**: For the duration of the prescription up to 6 months, unless otherwise noted in Medication-Specific Information

Antifungals – Topical	**Preferred Agents:** *No Prior Authorization required unless noted* ciclopirox 8% soln (generic Ciclodan®) ciclopirox 0.77% cream (generic for Loprox® and Ciclodan®) clotrimazole OTC cream, solution clotrimazole Rx cream clotrimazole/betamethasone cream ketoconazole miconazole nitrate nystatin nystatin/triamcinolone cream, ointment tolnaftate cream, powder **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* butenafine Ciclodan® ciclopirox suspension (generic for Loprox®) ciclopirox gel, shampoo, kit clotrimazole / betamethasone lotion clotrimazole Rx solution econazole nitrate Ertaczo® Extina® Jublia® ketoconazole foam Ketodan® Loprox® Lotrimin AF® luliconazole Luzu® miconazole/zinc oxide/petrolatum Micotrin AC® Mycozyl AC® Naftin® Naftifine oxiconazole Oxistat® tavaborole Vusion® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Trial and failure with two weeks with two preferred medications; **OR** • Organism resistant to the preferred medications **See additional medication-specific criteria below:** CICLOPIROX SHAMPOO • Bypass trial and failure of two preferred medications and instead allow a trial and failure of two weeks with one preferred shampoo medication JUBLIA® (EFINACONAZOLE) • Diagnosis of toenail onychomycosis; **AND** • Patient age 6 years or older; **AND** • Trial and failure on ciclopirox or allergy to ciclopirox TAVABOROLE • Diagnosis of toenail onychomycosis; **AND** • Patient must be 6 years or older; **AND** • Documented trial and failure on ciclopirox or allergy to ciclopirox VUSION® (MICONAZOLE NITRATE/ZINC OXIDE/PETROLATUM) • Maximum patient age = 16 years **Duration of Approval:** up to 6 months

Antihistamines – 2nd Generation	**Preferred Agents:** *No Prior Authorization required* cetirizine tablets cetirizine 1mg/ml solution fexofenadine tablets levocetirizine tablets loratadine/ loratadine ODT **Non-Preferred Agents:** *Prior Authorization Required. Criteria below* cetirizine chewable tabs, soft gels cetirizine 5mg/5ml solution cups Clarinex® desloratadine levocetirizine solution **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Trial and failure on one preferred second-generation antihistamine or clinical rationale why they cannot be tried **Duration of Approval**: 1 year
Antihypertensive Combinations: ACEI	**Preferred Agents:** *No Prior Authorization required* amlodipine / benazepril capsule **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Lotrel® capsule trandolapril / verapamil tablet **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with one-month trial of one preferred medication **Duration of Approval**: 1 year
Antihypertensive Combinations: ARB	**Preferred Agents:** *No Prior Authorization required* amlodipine/olmesartan amlodipine/valsartan amlodipine/valsartan/HCTZ **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Azor® amlodipine/olmesartan/HCTZ Exforge® / Exforge HCT® telmisartan/amlodipine Tribenzor® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Therapeutic failure with one-month trial of one preferred medication **Duration of Approval**: 1 year

Antihyperuricemic Agents	**Preferred Agents:** *No Prior Authorization required* allopurinol tablet colchicine tablets (generic for Colcrys) probenecid/colchicine tablet probenecid tablet **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Colchicine capsules (generic for Mitigare) Colcrys (colchicine) tablet febuxostat tablet Mitigare® (colchicine capsules) Uloric (febuxostat) tablet Zyloprim (allopurinol) tablet Gloperba (colchicine) Oral Solution **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after one-month trial of one preferred agent **See additional medication-specific criteria below:** COLCRYS® (COLCHICINE) TABLETS • PDL criteria may be bypassed for diagnosis of treatment of an acute gout flare or Familial Mediterranean Fever prophylaxis. GLOPERBA® (COLCHICINE) ORAL SOLUTION • Patient has difficulty swallowing tablets or has an enteral tube feeding **Duration of Approval**: 1 year
Antimigraine Agents, Acute Treatment – Other	**Preferred Agents for Acute Migraines:** *Prior Authorization required* Nurtec ODT® **Preferred Agent PA Criteria for Acute Migraines:** • Patient has a diagnosis of migraine with or without aura; **AND** • Patient is ≥18 years of age; **AND** • Patient must have tried and failed, or have contraindication to one preferred triptan medication • NURTEC ODT® (RIMEGEPANT) – Quantity Limit: 54 tablets per 90 days **Non-Preferred Agents for Acute Migraines:** *Prior Authorization required* Elyxyb® Reyvow® Ubrelvy® Zavzpret® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after a one-month trial of the preferred medication; **AND** • Patient has a diagnosis of migraine with or without aura **AND** • Patient is ≥18 years of age **AND** • Patient must have tried and failed, or have contraindication to one preferred triptan medication • ELYXYB® (CELECOXIB) - Quantity Limit: 14 doses per 30 days • REYVOW® (LASMIDITAN) – Quantity Limit: 8 tablets per 30 day • UBRELVY® (UBROGEPANT) – Quantity Limit: 16 tablets per 30 days **Duration of Approval:** 1 year

Antimigraine Agents, Preventive Treatment	**Preferred Agents for Migraine Prevention:** *Prior Authorization required* Aimovig® Ajovy® Emgality® Nurtec ODT® **Clinical PA Criteria for Migraine Prevention:** • For initial requests: ○ Patient has a diagnosis of migraine with or without aura; **AND** ○ Patient is ≥ 18 years of age; **AND** ○ Patient has ≥ four migraine days per month for at least three months; **AND** ○ Patient has tried and failed ≥ one-month trial of any two of the following oral medications: • Antidepressants (e.g., amitriptyline, venlafaxine) • Beta blockers (e.g., propranolol, metoprolol, timolol, atenolol) • Anti-epileptics (e.g., valproate, topiramate) • Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan); **OR** ○ Diagnosis of cluster headaches (Emgality only) • For Renewal requests: ○ Patient demonstrated significant decrease in the number, frequency, and/or intensity of headaches **Non-Preferred Agents for Migraine Prevention:** *Prior Authorization Criteria below* Qulipta® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after a one-month trial of one preferred medication • Must meet Clinical PA Criteria for Migraine Prevention above **Duration of Approval**: Initial: 6 months Continuation: 12 months
Antimigraine Agents, Acute Treatment – Triptans	**Preferred Agents:** *No Prior Authorization required* rizatriptan tab and ODT sumatriptan tablets, injection, nasal spray **Non-Preferred Agents:** *Prior Authorization required* almotriptan eletriptan Frova® frovatriptan Imitrex® naratriptan Maxalt®/ Maxalt MLT® Relpax® sumatriptan-naproxen Tosymra® Zembrace Symtouch® zolmitriptan, zolmitriptan ODT zolmitriptan nasal spray Zomig® nasal spray Zomig® tablet **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with treatment with use of **two** of the preferred agents **Duration of Approval**: 6 months

Anti-Obesity Agents	**Preferred Agents:** *Prior Authorization required* Adipex-P (phentermine) benzphetamine diethylpropion Lomaira (phentermine) Orlistat phendimetrazine phentermine phentermine/topiramate (only available as generic) Saxenda (liraglutide) Wegovy (semaglutide) Xenical (orlistat) Zepbound® **Preferred Agent PA Criteria:** **Initial Criteria:** • Prescriber attests that the patient will not use more than one weight loss medication in this drug class concurrently; **AND** • Prescriber attests that the patient will not use an anti-obesity GLP-1 agonist (Wegovy, Saxenda or Zepbound) concurrently with a DPP4 inhibitor; **AND** • Patient age ≥12 years (phentermine/topiramate, Wegovy, Xenical, Saxenda); **OR** • Patient age ≥ 17 years (phentermine); **AND** • Patient age ≥12 years to <18 years must have an initial BMI per CDC growth charts at the 95th percentile or greater for age and sex (obesity); **OR** • Patient age ≥12 years to <18 years with BMI in the 85th - 94th percentile (overweight) per CDC growth charts and has at least one of the following weight-related coexisting conditions: ○ diabetes, sleep apnea, hypertension, or dyslipidemia; **OR** • Patient age ≥18 years (benzphetamine, diethylpropion, phendimetrazine, Zepbound®**); AND** • Patient age ≥18 years must have an initial body mass index [BMI] ≥ than 30 kg/m2; **OR** • Patient age ≥18 must have an initial body mass index [BMI] ≥ than 27 kg/m2 but < 30 kg/m2 and at least one of the following: ○ hypertension, coronary artery disease, diabetes, dyslipidemia, or sleep apnea; **OR** ○ This medication is being prescribed for cardiovascular risk reduction in members with prior myocardial infarction, prior stroke, or peripheral arterial disease (Wegovy); **AND** • For patients with an eating disorder, prescriber attests that treatment has been optimized and confirms the safety and appropriateness of this anti-obesity treatments; **AND** • Prescriber attests that metabolic or other reason(s) for obesity/symptoms have been ruled out or diagnosed and treated (e.g., thyroid dysfunction, diabetes, sleep apnea, etc.); **AND** • Prescriber attests to patient's absence of any contraindications to use of the requested product, including pregnancy, lactation, a personal or family history of medullary thyroid cancer or multiple endocrine neoplasia type II; **AND** • Prescriber attests medication therapy is part of a total treatment plan including diet and exercise/activity as appropriate for the patient's ability; **AND** • Prescriber attests that patient has been informed weight may return with cessation of medication unless healthy lifestyle diet and activity changes, as appropriate for the patient's ability, are permanently adopted. **MDHHS recommends that prescribers consider the benefits of a diabetes prevention program for their patients.** **Renewal Criteria:** • For adults age ≥18 years, prescriber provides clinical documentation showing that the patient has maintained a weight loss of ≥ 5% from baseline weight at initiation of therapy • For patients age ≥12 years to <18 years , prescriber provides clinical documentation showing that the patient has maintained or improved BMI percentile per CDC growth charts from baseline weight at initiation of therapy. **Duration of Approval**: 6 months for both initial *and* renewal requests

AntiParkinson's Agents – Dopamine Agonists	**Preferred Agents:** *No Prior Authorization required* pramipexole ropinirole **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* bromocriptine Neupro® pramiprexole ER ropinirole ER **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure of one month with one preferred medication; **OR** • Patients using bromocriptine for indications other than Parkinson's do not need to meet non-preferred agent criteria **Duration of Approval**: 1 year

AntiParkinson's Agents – Other	**Preferred Agents:** *No Prior Authorization required (except rasagiline)* amantadine capsule, syrup benztropine tablet (*Carve Out) carbidopa tablet / levodopa ER carbidopa/levodopa IR tablets entacapone rasagiline trihexyphenidyl tablet (*Carve Out) RASAGILINE (AZILECT®) • Patient is ≥ 18 years of age **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* amantadine tablet Azilect® carbidopa carbidopa tablet / levodopa ODT carbidopa/levodopa/entacapone Tablet Crexont® Dhivy® Duopa® Gocovri® Inbrija® Lodosyn® Nourianz® Ongentys® Rytary® selegiline capsule, tablet Sinemet® Tasmar® tolcapone trihexyphenidyl elixir (*Carve Out) Vyalev® Xadago® Zelapar® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure of one month with one preferred medication **See additional medication-specific criteria below:** AZILECT® (RASAGILINE) • Patient is ≥ 18 years of age CREXONT® (CARBIDOPA/LEVODOPA) • Patient is 18 years or older; **AND** • Prescribed by or in consultation with a neurologist GOCOVRI® (AMANTADINE EXTENDED-RELEASE) • Diagnosis of dyskinesia associated with Parkinson's disease; **OR** • Experiencing Off-episodes of Parkinson's disease; **AND** • The patient is receiving concomitant levodopa-based therapy; **AND** • Patient has failure, contraindication, or intolerance to immediate-release amantadine INBRIJA® (LEVODOPA INHALATION) • Prescribed by or in consultation with a neurologist; **AND** • Medication will be used concomitantly with levodopa/carbidopa ONGENTYS® (OPICAPONE) • Patient has a diagnosis of Parkinson's Disease; **AND** • Patient is experiencing 'off' time on levodopa/carbidopa therapy; **AND** • Medication will be used concomitantly with levodopa/carbidopa and will not be used as monotherapy RYTARY® (CARBIDOPA/LEVODOPA) • Patient is 18 years of age or older; **AND** • Prescribed by or in consultation with a neurologist

	VYALEV® (FOSLEVODOPA AND FOSCARBIDOPA) • Patient is 18 years of age or older; **AND** • Diagnosis of Parkinson's disease that is levodopa-responsive; **AND** • Prescribed by or in consultation with a neurologist; **AND** • Prescriber attests that the patient is experiencing persistent motor fluctuations with a minimum of 2.5 hours of "off" time per day despite optimized carbidopa/levodopa therapy XADAGO® (SAFINAMIDE) • Patient must be 18 years or older; **AND** • Patient is experiencing 'off' time on levodopa/carbidopa therapy; **AND** • Medication will be used concomitantly with levodopa/carbidopa and will not be used as monotherapy. **Duration of Approval:** up to 1 year
Antivirals – Herpes	**Preferred Agents:** *No Prior Authorization required* acyclovir tablets, capsules, suspension famciclovir valacyclovir **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Valtrex® Zovirax® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Trial and failure on ten days of two preferred medications **Duration of Approval**: up to 6 months
Antivirals – Influenza	**Preferred Agents:** *No Prior Authorization required* oseltamivir Relenza® rimantadine Xofluza® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Flumadine® Tamiflu® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a five-day trial with two preferred medications **Duration of Approval**: up to 6 months

Antivirals – Topical	**Preferred Agents:** *No Prior Authorization required* acyclovir cream acyclovir ointment Denavir® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* penciclovir (generic for Denavir) Xerese® Zovirax® cream Zovirax® ointment **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with one preferred medication **Duration of Approval**: 1 year
Beta Adrenergic and Anticholinergic Combinations	**Preferred Agents:** *No Prior Authorization required* Anoro Ellipta® (DPI) Bevespi Aerosphere® (MDI) Combivent RESPIMAT® (ISI) ipratropium/albuterol nebulizer solution Stiolto Respimat® (ISI) **Non-Preferred Agents:** *Prior Authorization Criteria below* Duaklir Pressair® (DPI) umeclidinium/vilanterol (DPI) **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • The patient's condition is clinically stable such that switching medications would cause deterioration in the condition; **OR** • Therapeutic failure after a two-week trial with one preferred medication **Duration of Approval**: 1 year

Beta Adrenergic and Corticosteroid Inhaler Combinations	**Preferred Agents:** *No Prior Authorization required* Advair Diskus® (DPI) Advair HFA® (MDI) Dulera® (MDI) Symbicort® (MDI) **Non-Preferred Agents:** *Prior Authorization Criteria below* AirDuo Digihaler AirDuo Respiclick® (DPI) Airsupra® Breo Ellipta® (DPI) Breyna® budesonide/formoterol (generic for Symbicort) fluticasone-vilanterol (generic for Breo Ellipta) fluticasone/salmeterol (generic for Advair Diskus) fluticasone/salmeterol (generic for Advair HFA) fluticasone/salmeterol (generic for AirDuo) Wixela® (DPI) (generic for Advair Diskus) **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after a two-week trial with one preferred medication **Maximum Age Limits:** • **Breo Ellipta (fluticasone/vilanterol) 50-25 mcg –** 11 years • **Dulera (mometasone/formoterol) 50 mcg/5mcg –** 11 years **Duration of Approval**: 1 year
Beta Adrenergic / Anticholinergic / Corticosteroid Inhaler Combinations	**Preferred Agents:** *No Prior Authorization required* Trelegy Ellipta **Non-Preferred Agents:** *Prior Authorization Criteria below* Breztri Aerosphere **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medication; **OR** • Contraindication or drug to drug interaction with the preferred medication; **OR** • History of unacceptable side effects; **OR** • The patient's condition is clinically stable such that switching medications would cause deterioration in the condition; **OR** • Therapeutic failure after a two-week trial with the preferred medication **Duration of Approval**: 1 year

Beta Adrenergics – Long Acting	**Preferred Agents:** *No Prior Authorization required* Serevent® (DPI) **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* arformoterol tartrate nebulizer solution Brovana® nebulizer solution formoterol nebulizer solution Perforomist® nebulizer solution Striverdi Respimat® (ISI) **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after a two-week trial with one preferred medication **See additional medication-specific criteria below:** BROVANA® (ARFORMOTEROL) NEBULIZER SOLUTION • Bypass PDL criteria if patient requires long-acting beta-adrenergic medication and cannot use a dry powder inhaler PERFOROMIST® (FORMOTEROL) NEBULIZER SOLUTION • Bypass PDL criteria if patient requires long-acting beta-adrenergic medication and cannot use a dry powder inhaler STRIVERDI RESPIMAT® (OLODATEROL) INHALER • Diagnosis of COPD (must not be used for asthma or acute exacerbations) inhaler **Duration of Approval**: 1 year
Beta Adrenergics – Short Acting	**Preferred Agents:** *No Prior Authorization required* albuterol sulfate nebulizer solution Ventolin HFA® (MDI) Xopenex HFA® (MDI) **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* albuterol HFA (MDI) levalbuterol HFA (MDI) levalbuterol nebulizer solution ProAir Digihaler® (DPI) ProAir Respiclick® (DPI) **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after a two-week trial with one preferred medication **Duration of Approval**: 1 year

Beta Blockers	**Preferred Agents:** *No Prior Authorization required* atenolol atenolol / chlorthalidone bisoprolol fumarate bisoprolol fumarate HCT carvedilol Hemangeol oral solution® labetalol metoprolol / metoprolol XL metoprolol succinate metoprolol tartrate nadolol nebivolol propranolol propranolol LA sotalol / sotalol AF **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* acebutolol Betapace® / Betapace AF® Betaxolol Bystolic® carvedilol ER Inderal LA®/ Inderal XL® Innopran XL® Kapspargo® Lopressor® metoprolol HCT pindolol propranolol HCT Sotylize® Tenormin®/ Tenoretic® timolol maleate Toprol XL® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Patient is clinically stable, and switching would cause a deterioration in condition; **OR** • Therapeutic failure with one-month trial of one preferred medication **See additional medication-specific criteria below:** HEMANGEOL (PROPRANOLOL) • Maximum age of 1 year **Duration of Approval:** 1 year
Bile Salts	**Preferred Agents:** *No Prior Authorization required* ursodiol capsules (generic for Actigall) ursodiol tablets **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Reltone® Urso Forte® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure on a one-month trial of one preferred medication **Duration of Approval**: 1 year

Biologic Immunomodulators AGENTS TO TREAT ANKYLOSING SPONDYLITIS	**Preferred Agents:** *No Prior Authorization required* Cosentyx® Enbrel® Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Abrilada® Bimzelx® adalimumab-aacf (unbranded Idacio) adalimumab-aaty (unbranded Yuflyma) adalimumab-adaz (unbranded Hyrimoz) adalimumab-adbm (unbranded Cyltezo) adalimumab-fkjp (unbranded Hulio) adalimumab-ryvk (unbranded Simlandi) Amjevita® Cimzia®, Cimzia Kit® Cyltezo® Hadlima® Hulio® Hyrimoz® Idacio® Rinvoq® Rinvoq LQ® Simlandi® Simponi®, Simponi Aria® Taltz® Xeljanz®, Xeljanz XR® Yuflyma® Yusimry® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • The patient's condition is clinically stable at this time, so that switching medications would cause deterioration in their condition; **OR** • Therapeutic failure with one preferred medication in the same subclass • Bypass PDL criteria of failure with a preferred agent in cases when the non-preferred product has a unique FDA approved indication. **See additional medication-specific criteria below:** ABRILADA® (ADALIMUMAB-AFZB) • Patient is 18 years of age or older; **AND** • Diagnosis of ankylosing spondylitis AMJEVITA® (ADALIMUMAB-ATT0) • Patient is 18 years of age or older; **AND** • Diagnosis of ankylosing spondylitis BIMZELX® (BIMEKIZUMAB-BKZX) • Diagnosis of active ankylosing spondylitis (AS); **AND** • Patient must be 18 years or older CYLTEZO® (ADALIMIMAB-ADBM) • Patient is 18 years of age or older; **AND** • Diagnosis of ankylosing spondylitis HADLIMA® (ADALIMUMAB-BWWD) • Patient is 18 years of age or older; **AND** • Diagnosis of ankylosing spondylitis HULIO® (ADALIMUMAB-FKJP) • Patient is 18 years of age or older; **AND** • Diagnosis of ankylosing spondylitis

	HYRIMOZ® (ADALIMUMAB-ADAZ) • Patient is 18 years of age or older; **AND** • Diagnosis of ankylosing spondylitis IDACIO® (ADALIMUMAB-AACF) • Patient is 18 years of age or older; **AND** • Diagnosis of ankylosing spondylitis RINVOQ® / RINVOQ LQ® (UPADACITINIB) • Patient must be 18 years or older; **AND** • Diagnosis of ankylosing spondylitis SIMLANDI® (ADALIMUMAB-RYVK) • Patient must be 18 years or older; **AND** • Diagnosis of ankylosing spondylitis TALTZ® (*IXEKIZUMAB*) • Patient must be 18 years or older; **AND** • Diagnosis of active ankylosing spondylitis; **AND** • Must be prescribed by a rheumatologist or dermatologist or asthma/allergy specialist XELJANZ® / XELJANZ XR® (*TOFACITINIB*) TABLETS • Patient is 18 years of age or older; **AND** • Diagnosis of ankylosing spondylitis (AS); **AND** • Must be prescribed by or in consultation with a rheumatologist or dermatologist • Note: Xeljanz Solution is only approved for pJIA YUFLYMA® (ADALIMUMAB-AATY) • Patient is 18 years of age or older; **AND** • Diagnosis of ankylosing spondylitis YUSIMRY® (ADALIMUMAB-AQVH) • Patient is 18 years of age or older; **AND** • Diagnosis of ankylosing spondylitis **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information
Biologic Immunomodulators AGENTS TO TREAT CROHN'S DISEASE	**Preferred Agents:** *No Prior Authorization required* Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Abrilada® adalimumab-aacf (unbranded Idacio) adalimumab-aaty (unbranded Yuflyma) adalimumab-adaz (unbranded Hyrimoz) adalimumab-adbm (unbranded Cyltezo) adalimumab-fkjp (unbranded Hulio) adalimumab-ryvk (unbranded Simlandi) Amjevita® Cimzia®, Cimzia Kit® Cyltezo® Entyvio® Hadlima® Hulio® Hyrimoz® Idacio® Omvoh® Rinvoq® Rinvoq LQ® Simlandi® Skyrizi® Stelara® Tremfya® Yuflyma® Yusimry® Zymfentra® pen/syringe

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications: **OR**
- Contraindication or drug to drug interaction with the preferred medications; **OR**
- History of unacceptable side effects; **OR**
- The patient's condition is clinically stable at this time, so that switching medications would cause deterioration in their condition; **OR**
- Therapeutic failure with one preferred medication in the same subclass
- Bypass PDL criteria of failure with a preferred agent in cases when the non-preferred product has a unique FDA approved indication.

See additional medication-specific criteria below:

ABRILADA® (ADALIMUMAB-AFZB)

- Patient is 6 years of age or older; **AND**
- Diagnosis of moderate to severe Crohn's disease

AMJEVITA® (ADALIMUMAB-ATT0)

- Patient is 6 years of age or older; **AND**
- Diagnosis of moderate to severe Crohn's disease

CYLTEZO® (ADALIMIMAB-ADBM)

- Patient is 6 years of age or older; **AND**
- Diagnosis of moderate to severe Crohn's disease

ENTYVIO® (*VEDOLIZUMAB*)

- Diagnosis of Crohn's disease; **AND**
- Patient must be 18 years or older; **AND**
- Trial and failure on one medication from **each** of the following classes:
    - Aminosalicylate [i.e., mesalamine, Pentasa®, Lialda®, Apriso®, Delzicol®), olsalazine (Dipentum®), balsalazide (Colazal®, sulfasalazine (Azulfidine®)]
    - Oral steroid
    - Thiopurine [i.e., azathioprine (Imuran®), mercaptopurine (Purinethol®)]
    - TNF (tumor necrosis factor) blocker [i.e., infliximab (Remicade®, adalimumab (Humira®)]
    - **Length of authorization**: Initial approval = 14 weeks; continuation = 1 year

HADLIMA® (ADALIMUMAB-BWWD)

- Patient is 6 years of age or older; **AND**
- Diagnosis of moderate to severe Crohn's disease

HULIO® (ADALIMUMAB-FKJP)

- Patient is 6 years of age or older; **AND**
- Diagnosis of moderate to severe Crohn's disease

HYRIMOZ® (ADALIMUMAB-ADAZ)

- Patient is 6 years of age or older; **AND**
- Diagnosis of moderate to severe Crohn's disease

IDACIO® (ADALIMUMAB-AACF)

- Patient is 6 years of age or older; **AND**
- Diagnosis of moderate to severe Crohn's disease

OMVOH

- Diagnosis of moderately to severely active Crohn's disease; **AND**
- Patient must be 18 years or older; **AND**
- Prescribed by or in consultation with a gastroenterologist

RINVOQ® / RINVOQ LQ® (UPADACITINIB)

- Patient must be 18 years or older; **AND**
- Diagnosis of moderately to severely active Crohn's disease

SIMLANDI® (ADALIMUMAB-RYVK)

- Patient must be 6 years or older; **AND**
- Diagnosis of moderate to severe Crohn's disease

	SKYRIZI® (*RISANKIZUMAB*) • Patient is 18 years of age or older; **AND** • Diagnosis of Crohn's disease; **AND** • Must be prescribed by or in consultation with a gastroenterologist or rheumatologist STELARA® (USTEKINUMAB) • Diagnosis of Crohn's disease; **AND** • Quantity limit: ○ 520 mg for initial dose ○ 90 mg every 8 weeks TREMFYA® (GUSELKUMAB) • Diagnosis of moderately to severely active Crohn's disease (CD); **AND** • Patient must be 18 years or older YUFLYMA® (ADALIMUMAB-AATY) • Patient is 6 years of age or older; **AND** • Diagnosis of moderate to severe Crohn's disease YUSIMRY® (ADALIMUMAB-AQVH) • Patient is 6 years of age or older; **AND** • Diagnosis of moderate to severe Crohn's disease ZYMFENTRA® (INFLIXIMAB-DYYB) • Patient is 18 years of age or older; **AND** • Diagnosis is moderate to severe Crohn's disease; **AND** • Prescriber attests that the patient has completed an intravenous induction regimen with an infliximab product; **AND** • Prescribed by or in consultation with a gastroenterologist **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information
Biologic Immunomodulators AGENTS TO TREAT HIDRADENITIS SUPPURATIVA	**Preferred Agents:** *No Prior Authorization required* Cosentyx® Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Abrilada® adalimumab-aacf (unbranded Idacio) adalimumab-aaty (unbranded Yuflyma) adalimumab-adaz (unbranded Hyrimoz) adalimumab-adbm (unbranded Cyltezo) adalimumab-fkjp (unbranded Hulio) adalimumab-ryvk (unbranded Simlandi) Amjevita® Bimzelx® Cyltezo® Hadlima® Hulio® Hyrimoz® Idacio® Simlandi® Yuflyma® Yusimry® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications: **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • The patient's condition is clinically stable at this time, so that switching medications would cause deterioration in their condition; **OR** • Therapeutic failure with one preferred medication in the same subclass • Bypass PDL criteria of failure with a preferred agent in cases when the non-preferred product has a unique FDA approved indication. **See additional medication-specific criteria below:**

ABRILADA® (ADALIMUMAB-AFZB)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe hidradenitis suppurativa

AMJEVITA® (ADALIMUMAB-ATT0)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe hidradenitis suppurativa

BIMZELX® (BIMEKIZUMAB-BKZX)
- Diagnosis of moderate-to-severe hidradenitis suppurativa (HS); **AND**
- Patient must be 18 years or older

CYLTEZO® ADALIMIMAB-ADBM)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe hidradenitis suppurativa

HADLIMA® (ADALIMUMAB-BWWD)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe hidradenitis suppurativa

HULIO® (ADALIMUMAB-FKJP)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe hidradenitis suppurativa

HYRIMOZ® (ADALIMUMAB-ADAZ)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe hidradenitis suppurativa

IDACIO® (ADALIMUMAB-AACF)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe hidradenitis suppurativa

SIMLANDI® (ADALIMUMAB-RYVK)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe hidradenitis suppurativa

YUFLYMA® (ADALIMUMAB-AATY)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe hidradenitis suppurativa

YUSIMRY® (ADALIMUMAB-AQVH)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe hidradenitis suppurativa

Duration of Approval: 1 year, unless otherwise noted in Medication-Specific Information

Biologic Immunomodulators AGENTS TO TREAT JUVENILE IDIOPATHIC ARTHRITIS	**Preferred Agents:** *No Prior Authorization required* Enbrel® Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Abrilada® Actemra® SC adalimumab-aacf (unbranded Idacio) adalimumab-aaty (unbranded Yuflyma) adalimumab-adaz (unbranded Hyrimoz) adalimumab-adbm (unbranded Cyltezo) adalimumab-fkjp (unbranded Hulio) adalimumab-ryvk (unbranded Simlandi) Amjevita® Cimzia®, Cimzia Kit® Cyltezo® Hadlima® Hulio® Hyrimoz® Idacio® Kevzara® Orencia® SC Rinvoq® Rinvoq LQ® Simlandi® Simponi ARIA® Tyenne® Xeljanz®, Xeljanz® Solution Yuflyma® Yusimry® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • The patient's condition is clinically stable at this time, so that switching medications would cause deterioration in their condition; **OR** • Therapeutic failure with one preferred medication in the same subclass • Bypass PDL criteria of failure with a preferred agent in cases when the non-preferred product has a unique FDA approved indication. **See additional medication-specific criteria below:** ABRILADA® (ADALIMUMAB-AFZB) • Patient is 2 years of age or older; **AND** • Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis ACTEMRA® (TOCILIZUMAB) • Patient is 2 years of age or older; **AND** • Diagnosis of active polyarticular juvenile idiopathic arthritis; **OR** • Diagnosis of active systemic juvenile idiopathic arthritis AMJEVITA® (ADALIMUMAB-ATT0) • Patient is 2 years of age or older; **AND** • Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis CYLTEZO® (ADALIMIMAB-ADBM) • Patient is 2 years of age or older; **AND** • Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis HADLIMA® (ADALIMUMAB-BWWD) • Patient is 2 years of age or older; **AND** • Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis HULIO® (ADALIMUMAB-FKJP) • Patient is 2 years of age or older; **AND** • Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis

	HYRIMOZ® (ADALIMUMAB-ADAZ) • Patient is 2 years of age or older; **AND** • Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis IDACIO® (ADALIMUMAB-AACF) • Patient is 2 years of age or older; **AND** • Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis KEVZARA® (SARILUMAB) - PDL CRITERIA DO NOT APPLY FOR POLYMYALGIA RHEUMATICA • Patient must be 18 years or older; **AND** • Diagnosis of Polymyalgia Rheumatica (PMR); **OR** • Diagnosis of moderately to severely active rheumatoid arthritis (RA); OR • Patient weight is 63 kg or greater; **AND** • Diagnosis of polyarticular juvenile idiopathic arthritis RINVOQ® / RINVOQ LQ® (UPADACITINIB) • Patient must be 2 years or older; **AND** • Diagnosis of polyarticular juvenile idiopathic arthritis SIMLANDI® (ADALIMUMAB-RYVK) • Patient must be 2 years or older; **AND** • Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis TYENNE® (TOCILIZUMAB-AAZG) • Patient is 2 years of older; **AND** • Diagnosis of active polyarticular juvenile idiopathic arthritis; **OR** • Diagnosis of active systemic juvenile idiopathic arthritis XELJANZ® TABLETS / XELJANZ® SOLUTION (*TOFACITINIB*) • Patient is 2 years of age or older; **AND** • Diagnosis of polyarticular juvenile idiopathic arthritis (pJIA) (Note: Xeljanz solution is only approved for Pjia) YUFLYMA® (ADALIMUMAB-AATY) • Patient is 2 years of age or older; **AND** • Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis YUSIMRY® (ADALIMUMAB-AQVH) • Patient is 2 years of age or older; **AND** • Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information
Biologic Immunomodulators AGENTS TO TREAT NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS	**Preferred Agents:** *No Prior Authorization required* Cosentyx® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Bimzelx® Cimzia®, Cimzia Kit® Rinvoq® Rinvoq LQ® Taltz® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • The patient's condition is clinically stable at this time, so that switching medications would cause deterioration in their condition; **OR** • Therapeutic failure with one preferred medication in the same subclass • Bypass PDL criteria of failure with a preferred agent in cases when the non-preferred product has a unique FDA approved indication.

	BIMZELX® (BIMEKIZUMAB-BKZX) • Diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; **AND** • Patient must be 18 years or older RINVOQ® / RINVOQ LQ® (UPADACITINIB) • Patient must be 18 years or older; **AND** • Diagnosis of non-radiographic axial spondyloarthritis TALTZ® (IXEKIZUMAB) • Patient must be 18 years or older; **AND** • Diagnosis of non-radiographic axial spondyloarthritis (nr-axSpA); **AND** • Must be prescribed by a rheumatologist or dermatologist or asthma/allergy specialist **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information
Biologic Immunomodulators AGENTS TO TREAT PLAQUE PSORIASIS	**Preferred Agents:** *No Prior Authorization required* Cosentyx® Enbrel® Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Abrilada® adalimumab-aacf (unbranded Idacio) adalimumab-aaty (unbranded Yuflyma) adalimumab-adaz (unbranded Hyrimoz) adalimumab-adbm (unbranded Cyltezo) adalimumab-fkjp (unbranded Hulio) adalimumab-ryvk (unbranded Simlandi) Amjevita® Bimzelx® Cimzia®, Cimzia Kit® Cyltezo® Hadlima® Hulio® Hyrimoz® Idacio® Ilumya® Otezla® Siliq® Simlandi® Skyrizi® Sotyktu® Stelara® Taltz® Tremfya® Yuflyma® Yusimry® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • The patient's condition is clinically stable at this time, so that switching medications would cause deterioration in their condition; **OR** • Therapeutic failure with one preferred medication in the same subclass • Bypass PDL criteria of failure with a preferred agent in cases when the non-preferred product has a unique FDA approved indication. **See additional medication-specific criteria below:** ABRILADA® (ADALIMUMAB-AFZB) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe plaque psoriasis AMJEVITA® (ADALIMUMAB-ATTO) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe plaque psoriasis

BIMZELX® (BIMEKIZUMAB-BKZX)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe plaque psoriasis

CYLTEZO® (ADALIMIMAB-ADBM)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe plaque psoriasis

HADLIMA® (ADALIMUMAB-BWWD)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe plaque psoriasis

HULIO® (ADALIMUMAB-FKJP)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe plaque psoriasis

HYRIMOZ® (ADALIMUMAB-ADAZ)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe plaque psoriasis

IDACIO® (ADALIMUMAB-AACF)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe plaque psoriasis

ILUMYA® (*TILDRAKIZUMAB*)
- Patient must be 18 years or older; **AND**
- Diagnosis of moderate to severe plaque psoriasis

OTEZLA® (*APREMILAST*)
- Patient must be 6 years or older; **AND**
- Diagnosis of plaque psoriasis; **OR**
- Patient must be 18 years or older; **AND**
- Diagnosis of oral ulcers associated with Behcet's Disease; **AND**
- Must be prescribed by or in consultation with a rheumatologist or dermatologist

SILIQ® (*BRODALUMAB*)
- Patient must be 18 years or older; **AND**
- Diagnosis of plaque psoriasis

SIMLANDI® (ADALIMUMAB-RYVK)
- Patient must be 18 years or older; **AND**
- Diagnosis of moderate to severe plaque psoriasis

SKYRIZI® (*RISANKIZUMAB*)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe plaque psoriasis; **AND**
- Prescribed by or in consultation with a dermatologist or rheumatologist

SOTYKTU® (DEUCRAVACITINIB)
- Patient must be 18 years or older; **AND**
- Diagnosis of moderate to severe plaque psoriasis**; AND**
- Must be prescribed by, or in consultation with, a dermatologist; **AND**
- Quantity Limit: 1 per day

STELARA® (USTEKINUMAB)
- Diagnosis of psoriasis; **AND**
- Quantity limit:
    - 90 mg every 12 weeks with initial dose Week 0 and 4

TALTZ® (*IXEKIZUMAB*)
- Patient must be 6 years of age or older with a diagnosis of moderate to severe plaque psoriasis; **AND**
- Must be prescribed by a rheumatologist or dermatologist or asthma/allergy specialist

	TREMFYA® (*GUSELKUMAB)* • Patient must be 18 years or older**; AND** • Diagnosis of moderate to severe plaque psoriasis (PSO) YUFLYMA® (ADALIMUMAB-AATY) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe plaque psoriasis YUSIMRY® (ADALIMUMAB-AQVH) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe plaque psoriasis **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information
Biologic Immunomodulators AGENTS TO TREAT PSORIATIC ARTHRITIS	**Preferred Agents:** *No Prior Authorization required* Cosentyx® Enbrel® Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below* Abrilada® adalimumab-aacf (unbranded Idacio) adalimumab-aaty (unbranded Yuflyma) adalimumab-adaz (unbranded Hyrimoz) adalimumab-adbm (unbranded Cyltezo) adalimumab-fkjp (unbranded Hulio) adalimumab-ryvk (unbranded Simlandi) Amjevita® Bimzelx® Cimzia®, Cimzia Kit® Cyltezo® Hadlima® Hulio® Hyrimoz® Idacio® Orencia® SC Otezla® Rinvoq® Rinvoq LQ® Simlandi® Simponi®, Simponi Aria® Skyrizi® Stelara® Taltz® Tremfya® Xeljanz®, Xeljanz XR® Yuflyma® Yusimry **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • The patient's condition is clinically stable at this time, so that switching medications would cause deterioration in their condition; **OR** • Therapeutic failure with one preferred medication in the same subclass • Bypass PDL criteria of failure with a preferred agent in cases when the non-preferred product has a unique FDA approved indication. **See additional medication-specific criteria below:** ABRILADA® (ADALIMUMAB-AFZB) • Patient is 18 years of age or older; **AND** • Diagnosis of psoriatic arthritis AMJEVITA® (ADALIMUMAB-ATT0) • Patient is 18 years of age or older; **AND** • Diagnosis of psoriatic arthritis BIMZELX® (BIMEKIZUMAB-BKZX) • Diagnosis of active psoriatic arthritis (PsA); **AND** • Patient must be 18 years or older CYLTEZO® (ADALIMIMAB-ADBM) • Patient is 18 years of age or older; **AND** • Diagnosis of psoriatic arthritis

	HADLIMA® (ADALIMUMAB-BWWD) • Patient is 18 years of age or older; **AND** • Diagnosis of psoriatic arthritis HULIO® (ADALIMUMAB-FKJP) • Patient is 18 years of age or older; **AND** • Diagnosis of psoriatic arthritis HYRIMOZ® (ADALIMUMAB-ADAZ) • Patient is 18 years of age or older; **AND** • Diagnosis of psoriatic arthritis IDACIO® (ADALIMUMAB-AACF) • Patient is 18 years of age or older; **AND** • Diagnosis of psoriatic arthritis OTEZLA® (*APREMILAST*) • Patient is 18 years of age or older; **AND** • Diagnosis of psoriatic arthritis with 3 or more swollen and tender joints; **OR** • Diagnosis of oral ulcers associated with Behcet's Disease; **AND** • Must be prescribed by or in consultation with a rheumatologist or dermatologist RINVOQ® / RINVOQ LQ® (*UPADACITINIB*) • Patient must be 2 years or older; **AND** • Diagnosis of psoriatic arthritis SIMLANDI® (ADALIMUMAB-RYVK) • Patient is 18 years of age or older; **AND** • Diagnosis of psoriatic arthritis SKYRIZI® (*RISANKIZUMAB*) • Patient is 18 years of age or older; **AND** • Diagnosis of active psoriatic arthritis: **AND** • Prescribed by or in consultation with a dermatologist or rheumatologist STELARA® (USTEKINUMAB) • Diagnosis of psoriatic arthritis; **AND** • Quantity limit: ○ 90 mg every 12 weeks with initial dose Week 0 and 4 TALTZ® (*IXEKIZUMAB*) • Patient must be 18 years or older; **AND** • Diagnosis of psoriatic arthritis; **AND** • Must be prescribed by a rheumatologist or dermatologist or asthma/allergy specialist TREMFYA® (*GUSELKUMAB)* • Patient must be 18 years or older; **AND** • Diagnosis of psoriatic arthritis (PsA) XELJANZ® / XELJANZ XR® (*TOFACITINIB*) TABLETS • Patient is 18 years of age or older**; AND** • Diagnosis of psoriatic arthritis (PsA); **AND** • Must be prescribed by or in consultation with a rheumatologist or dermatologist • Note: Xeljanz Solution is only approved for pJIA YUFLYMA® (ADALIMUMAB-AATY) • Patient must be 18 years or older; **AND** • Diagnosis of psoriatic arthritis

	YUSIMRY® (ADALIMUMAB-AQVH) • Patient must be 18 years or older; **AND** • Diagnosis of psoriatic arthritis **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information
Biologic Immunomodulators AGENTS TO TREAT RHEUMATOID ARTHRITIS	**Preferred Agents:** *No Prior Authorization required* Enbrel® Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Abrilada® Actemra® SC adalimumab-aacf (unbranded Idacio) adalimumab-aaty (unbranded Yuflyma) adalimumab-adaz (unbranded Hyrimoz) adalimumab-adbm (unbranded Cyltezo) adalimumab-fkjp (unbranded Hulio) adalimumab-ryvk (unbranded Simlandi) Amjevita® Cimzia®, Cimzia Kit® Cyltezo® Hadlima® Hulio® Hyrimoz® Idacio® Kevzara® Kineret® (*Carve Out) Olumiant® Orencia® SC Rinvoq® Rinvoq LQ® Simlandi® Simponi®, Simponi Aria® Tyenne® Xeljanz®, Xeljanz XR® Yuflyma® Yusimry® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • The patient's condition is clinically stable at this time, so that switching medications would cause deterioration in their condition; **OR** • Therapeutic failure with one preferred medication in the same subclass • Bypass PDL criteria of failure with a preferred agent in cases when the non-preferred product has a unique FDA approved indication. **See additional medication-specific criteria below:** ABRILADA® (ADALIMUMAB-AFZB) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe rheumatoid arthritis ACTEMRA® (TOCILIZUMAB) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe rheumatoid arthritis; **OR** • Diagnosis of giant cell arteritis; **OR** • Diagnosis of systemic sclerosis-associated interstitial lung disease AMJEVITA® (ADALIMUMAB-ATTO) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe rheumatoid arthritis

	CYLTEZO® (ADALIMIMAB-ADBM) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe rheumatoid arthritis HADLIMA® (ADALIMUMAB-BWWD) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe rheumatoid arthritis HULIO® (ADALIMUMAB-FKJP) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe rheumatoid arthritis HYRIMOZ® (ADALIMUMAB-ADAZ) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe rheumatoid arthritis IDACIO® (ADALIMUMAB-AACF) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severely active rheumatoid arthritis KEVZARA® (*SARILUMAB*) **-** PDL CRITERIA DO NOT APPLY FOR POLYMYALGIA RHEUMATICA • Patient must be 18 years or older; **AND** • Diagnosis of Polymyalgia Rheumatica (PMR); **OR** • Diagnosis of moderately to severely active rheumatoid arthritis (RA); **OR** • Patient weight is 63 kg or greater; **AND** • Diagnosis of polyarticular juvenile idiopathic arthritis OLUMIANT® (BARICITINIB) (PDL CRITERIA DO NOT APPLY FOR ALOPECIA AREATA) • Diagnosis of moderate to severe rheumatoid arthritis**; OR** • Diagnosis of severe alopecia areata; **AND** • Patient must be 18 years or older RINVOQ® / RINVOQ LQ® (*UPADACITINIB*) • Patient must be 18 years or older; **AND** • Diagnosis of moderate to severe rheumatoid arthritis SIMLANDI® (ADALIMUMAB-RYVK) • Patient must be 18 years or older; **AND** • Diagnosis of moderate to severe rheumatoid arthritis TYENNE® (TOCILIZUMAB-AAZG) • Patient is 18 years or older; **AND** • Diagnosis of moderate to severe rheumatoid arthritis; **OR** • Diagnosis of giant cell arteritis XELJANZ® / XELJANZ XR® (*TOFACITINIB*) TABLETS • Patient is 18 years of age or older; **AND** • Diagnosis of rheumatoid arthritis (RA); **AND** • Must be prescribed by or in consultation with a rheumatologist or dermatologist • Note: Xeljanz Solution is only approved for pJIA YUFLYMA® (ADALIMUMAB-AATY) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe rheumatoid arthritis YUSIMRY® (ADALIMUMAB-AQVH) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe rheumatoid arthritis **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information

Biologic Immunomodulators AGENTS TO TREAT ULCERATIVE COLITIS	**Preferred Agents:** *No Prior Authorization required* Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Abrilada® adalimumab-aacf (unbranded Idacio) adalimumab-aaty (unbranded Yuflyma) adalimumab-adaz (unbranded Hyrimoz) adalimumab-adbm (unbranded Cyltezo) adalimumab-fkjp (unbranded Hulio) adalimumab-ryvk (unbranded Simlandi) Amjevita® Cyltezo® Entyvio® Hadlima® Hulio® Hyrimoz® Idacio® Omvoh® Rinvoq® Rinvoq LQ® Simlandi® Simponi® Skyrizi® Stelara® Tremfya® Velsipity® Xeljanz®, Xeljanz XR® Yuflyma® Yusimry® Zeposia® Zymfentra® pen/syringe **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications: **OR** • History of unacceptable side effects; **OR** • The patient's condition is clinically stable at this time, so that switching medications would cause deterioration in their condition; **OR** • Therapeutic failure with one preferred medication in the same subclass • Bypass PDL criteria of failure with a preferred agent in cases when the non-preferred product has a unique FDA approved indication. **See additional medication-specific criteria below:** ABRILADA® (ADALIMUMAB-AFZB) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe ulcerative colitis AMJEVITA® (ADALIMUMAB-ATT0) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe ulcerative colitis CYLTEZO® (ADALIMIMAB-ADBM) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe ulcerative colitis ENTYVIO® (VEDOLIZUMAB) • Diagnosis of ulcerative colitis; **AND** • Patient must be 18 years or older; **AND** • Trial and failure on one medication from each of the following classes: ○ Aminosalicylate [i.e., mesalamine (Pentasa®, Lialda®, Apriso®, Delzicol®), olsalazine (Dipentum®), balsalazide (Colazal®, sulfasalazine (Azulfidine®)] ○ Oral steroid ○ Thiopurine [i.e., azathioprine (Imuran®), mercaptopurine (Purinethol®)] ○ TNF (tumor necrosis factor) blocker [i.e., infliximab (Remicade®, adalimumab (Humira®)] • Length of authorization: Initial approval = 14 weeks; renewal = 1 year

HADLIMA® (ADALIMUMAB-BWWD)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe ulcerative colitis

HULIO® (ADALIMUMAB-FKJP)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe ulcerative colitis

HYRIMOZ® (ADALIMUMAB-ADAZ)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe ulcerative colitis

IDACIO® (ADALIMUMAB-AACF)
- Patient is 18 years of age or older; **AND**
- Diagnosis of moderate to severe ulcerative colitis

OMVOH
- Diagnosis of moderately to severely active ulcerative colitis (UC); **AND**
- Patient must be 18 years or older; **AND**
- Prescribed by or in consultation with a gastroenterologist

RINVOQ® / RINVOQ LQ® (UPADACITINIB)
- Patient must be 18 years or older; **AND**
- Diagnosis of moderately to severely active ulcerative colitis

SIMLANDI® (ADALIMUMAB-RYVK)
- Patient must be 18 years or older; **AND**
- Diagnosis of moderate to severe ulcerative colitis

SKYRIZI® (RISANKIZUMAB)
- Patient is 18 years of age or older; **AND**
- Diagnosis of ulcerative colitis; **AND**
- Prescribed by or in consultation with a gastroenterologist or rheumatologist

STELARA® (USTEKINUMAB)
- Diagnosis of ulcerative colitis; **AND**
- Quantity limit:
    - 520 mg for initial dose
    - 90 mg every 8 weeks

TREMFYA® (GUSELKUMAB)
- Diagnosis of moderately to severely active ulcerative colitis (UC); **AND**
- Patient must be 18 years or older

VELSIPITY® (ETRASIMOD ARGININE)
- Diagnosis of moderately to severely active ulcerative colitis (UC); **AND**
- Patient must be 18 years or older; **AND**
- Prescribed by or in consultation with a gastroenterologist; **AND**
- Patient has obtained a baseline electrocardiogram (ECG); **AND**
- Patient does NOT have an active infection, including clinically important localized infections; **AND**
- Patient has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy; **AND**
- For patients with a history of uveitis and/or diabetes ONLY: A baseline ophthalmic evaluation of the fundus, including the macula, has been performed before starting treatment; **AND**
- Prescriber attests that a CBC with lymphocyte count, ALT, AST, and total bilirubin have been obtained for the patient in the past 6 months.

XELJANZ® / XELJANZ XR® (TOFACITINIB) TABLETS
- Patient is 18 years of age or older; **AND**
- Diagnosis of ulcerative colitis; **AND**
- Prescribed by or in consultation with a gastroenterologist
- Note: Xeljanz solution is only approved for pJIA

	YUFLYMA® (ADALIMUMAB-AATY) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe ulcerative colitis YUSIMRY® (ADALIMUMAB-AQVH) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe ulcerative colitis ZEPOSIA® (OZANIMOD) • Patient is 18 years of age or older; **AND** • Diagnosis of moderately to severely active ulcerative colitis (UC); **AND** • Prescribed by or in consultation with a gastroenterologist; **AND** • Patient has obtained a baseline electrocardiogram (ECG); **AND** • Patient does NOT have an active infection, including clinically important localized infections; **AND** • Patient has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy; **AND** • For patients with a history of uveitis and/or diabetes ONLY: A baseline ophthalmic evaluation of the fundus, including the macula, has been performed before starting treatment; **AND** • Prescriber attests that a CBC with lymphocyte count, ALT, AST, and total bilirubin have been obtained for the patient in the past 6 months ZYMFENTRA® (INFLIXIMAB-DYYB) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe ulcerative colitis; **AND** • Prescriber attests that the patient has completed an intravenous induction regimen with an infliximab product; **AND** • Prescribed by or in consultation with a gastroenterologist **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information
Biologic Immunomodulators AGENTS TO TREAT UVEITIS	**Preferred Agents:** *No Prior Authorization required* Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Abrilada® adalimumab-aacf (unbranded Idacio) adalimumab-aaty (unbranded Yuflyma) adalimumab-adaz (unbranded Hyrimoz) adalimumab-adbm (unbranded Cyltezo) adalimumab-fkjp (unbranded Hulio) adalimumab-ryvk (unbranded Simlandi) Amjevita® Cyltezo® Hadlima® Hulio® Hyrimoz® Idacio® Simlandi® Yuflyma® Yusimry® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications: **OR** • History of unacceptable side effects; **OR** • The patient's condition is clinically stable at this time, so that switching medications would cause deterioration in their condition; **OR** • Therapeutic failure with one preferred medication in the same subclass • Bypass PDL criteria of failure with a preferred agent in cases when the non-preferred product has a unique FDA approved indication. **See additional medication-specific criteria below:**

	ABRILADA® (ADALIMUMAB-AFZB) • Patient is 18 years of age or older; **AND** • Diagnosis of non-infectious intermediate, posterior, or panuveitis AMJEVITA® (ADALIMUMAB-ATT0) • Patient is 18 years of age or older; **AND** • Diagnosis of non-infectious intermediate, posterior, or panuveitis CYLTEZO® (ADALIMIMAB-ADBM) • Patient is 18 years of age or older: **AND** • Diagnosis of non-infectious intermediate, posterior, or panuveitis HADLIMA® (ADALIMUMAB-BWWD) • Patient is 18 years of age or older: **AND** • Diagnosis of non-infectious intermediate, posterior, or panuveitis HULIO® (ADALIMUMAB-FKJP) • Patient is 18 years of age or older: **AND** • Diagnosis of non-infectious intermediate, posterior, or panuveitis HYRIMOZ® (ADALIMUMAB-ADAZ) • Patient is 18 years of age or older: **AND** • Diagnosis of non-infectious intermediate, posterior, or panuveitis IDACIO® (ADALIMUMAB-AACF) • Patient is 18 years of age or older: **AND** • Diagnosis of non-infectious intermediate, posterior, or panuveitis SIMLANDI® (ADALIMUMAB-RYVK) • Patient is 18 years of age or older: **AND** • Diagnosis of non-infectious intermediate, posterior, or panuveitis YUFLYMA® (ADALIMUMAB-AATY) • Patient is 18 years of age or older; **AND** • Diagnosis of non-infectious intermediate, posterior, or panuveitis YUSIMRY® (ADALIMUMAB-AQVH) • Patient is 18 years of age or older: **AND** • Diagnosis of non-infectious intermediate, posterior, or panuveitis **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information

BPH Agents – 5-Alpha Reductase (5AR) Inhibitors	**Preferred Agents:** *No Prior Authorization required* dutasteride finasteride 5mg (generic for Proscar®) **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Avodart® dutasteride/tamsulosin Proscar® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with one preferred medication **Duration of Approval**: 1 year (unless specified in drug specific criteria)
BPH Agents – Alpha Blockers	**Preferred Agents:** *No Prior Authorization required* Alfuzosin tablet Doxazosin tablet Prazosin capsule Tamsulosin capsule Terazosin capsule **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Cardura® tablet Cardura XR® tablet Flomax® capsule Minipress® capsule Rapaflo® capsule Silodosin (generic for Rapaflo) capsule **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Therapeutic failure with a one-month trial with one preferred medication **Duration of Approval**: 1 year, unless otherwise noted in drug-specific criteria

Calcium Channel Blockers - Dihydropyridine	**Preferred Agents:** *Clinical Prior Authorization below* amlodipine besylate nifedipine/nifedipine SA Norliqva® NORLIQVA® SUSPENSION (AMLODIPINE) • Patient age of 6 years or greater • Allow if patient has swallowing difficulties **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* felodipine ER isradipine Katerzia® levamlodipine nicardipine nisoldipine Norvasc® Procardia XL® Sular® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Patient is clinically stable, and switching would cause a deterioration in condition; **OR** • Therapeutic failure with one-month trial of one preferred medication **See additional medication-specific criteria below:** KATERZIA® SUSPENSION (AMLODIPINE) • Patient age of 6 years or greater • Allow if patient has swallowing difficulties (PDL criteria does not apply) **Duration of Approval:** 1 year
Calcium Channel Blockers – Non-Dihydropyridine	**Preferred Agents:** *No Prior Authorization required* Diltiazem tablet / diltiazem XR / diltiazem ER capsule Taztia XT® capsule verapamil / verapamil ER tablet **Non-Preferred Agents:** *Prior Authorization Criteria below* Cardizem® tablet / Cardizem LA® tablet / Cardizem CD® capsule diltiazem LA tablet Matzim LA® tablet Tiadylt ER® capsule Tiazac® capsule verapamil ER capsules Verelan PM® pellet capsules verapamil cap 24-hr pellet capsules **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Patient is clinically stable, and switching would cause a deterioration in condition; **OR** • Therapeutic failure with one-month trial of one preferred medication **Duration of Approval**: 1 year

Cephalosporins - 1st Generation	**Preferred Agents:** *No Prior Authorization required* cefadroxil capsules cefadroxil suspension cephalexin **Non-Preferred Agents:** *Prior Authorization Criteria below* cefadroxil tablets **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Infection caused by an organism resistant to the preferred cephalosporins • Therapeutic failure (duration = 3 days) with any two preferred cephalosporins medications **Duration of Approval**: Date of service
Cephalosporins - 2nd Generation	**Preferred Agents:** *No Prior Authorization required* Cefuroxime cefprozil tablet cefprozil suspension **Non-Preferred Agents:** *Prior Authorization Criteria below* Cefaclor cefaclor ER **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Infection caused by an organism resistant to the preferred cephalosporins • Therapeutic failure (duration = 3 days) with any two preferred cephalosporins medications **Duration of Approval**: Date of service
Cephalosporins – 3rd Generation	**Preferred Agents:** *No Prior Authorization required* cefdinir capsules, suspension cefixime capsules **Non-Preferred Agents:** *Prior Authorization Criteria below* cefixime suspension cefpodoxime tablets cefpodoxime suspension **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Infection caused by an organism resistant to the preferred cephalosporins; **OR** • Therapeutic failure (duration = 3 days) with any two preferred cephalosporins medications **Duration of Approval**: Date of service

Colony Stimulating Factors	**Preferred Agents:** *No Prior Authorization required* Neupogen® Nyvepria® **Non-Preferred Agents:** *Prior Authorization Criteria below* Fulphila® Fylnetra® Granix® Leukine® Neulasta® syringe; Neulasta® Onpro Kit Nivestym® Releuko® Stimufend® Udenyca® Zarxio® Ziextenzo® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with one preferred medication **Duration of Approval**: 1 year
Combination Benzoyl Peroxide and Clindamycin	**Preferred Agents:** *No Prior Authorization required* clindamycin / benzoyl peroxide **Non-Preferred Agents:** *Prior Authorization Criteria below* Acanya® gel and pump Cabtreo® clindamycin / benzoyl peroxide (generic Onexton®) Neuac 1.25% kit® Onexton® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with one preferred medication **Duration of Approval**: 1 year
Combination Nasal Sprays	**Preferred Agents:** **Non-Preferred Agents:** *Prior Authorization Criteria below* azelastine/fluticasone spray Dymista® Ryaltris® **Non-Preferred Agent PA Criteria:** • 1 month trial and failure of one preferred nasal antihistamine; **AND** • 1 month trial and failure of one preferred nasal corticosteroid **Duration of Approval**: 1 year

Direct Renin Inhibitors	**Preferred Agents:** *No Prior Authorization required* N/A **Non-Preferred Agents:** *Prior Authorization Criteria below* aliskiren Tekturna® **Non-Preferred Agent PA Criteria:** • Trial/failure on an ACE inhibitor or an ARB; **OR** • Clinical rationale why neither is appropriate. **Duration of Approval**: 1 year
Epinephrine self-administered	**Preferred Agents:** *No Prior Authorization required* epinephrine (generic for Adrenaclick® by Amneal) epinephrine (generic for Epi Pen®/EpiPen Jr® by Teva) epinephrine (generic for Epi Pen®/EpiPen Jr® by Mylan) Epi Pen®, Epi Pen Jr® **Non-Preferred Agents:** *Prior Authorization required* Auvi-Q® Neffy® **Non-Preferred Agent PA Criteria:** • Therapeutic failure or contraindication to use of a preferred medication **See additional medication-specific criteria below:** NEFFY® (EPINEPHRINE) • Patient weighs at least 30kg **Duration of Approval**: 1 year

Gastrointestinal Antibiotics	**Preferred Agents:** *No Prior Authorization required* Dificid® metronidazole 250mg and 500mg tablets neomycin tablets tinidazole vancomycin capsules vancomycin solution **Non-Preferred Agents:** *Prior Authorization required* Aemcolo® Firvanq® Flagyl® tablets and capsules Likmez® metronidazole capsules metronidazole 125mg tablets nitazoxanide tablets Vancocin® Xifaxan® 200mg Xifaxan® 550mg **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure of one month with one preferred medication **See additional medication-specific criteria below:** AEMCOLO® (*RIFAMYCIN*) • Travelers' diarrhea caused by noninvasive strains of E. coli and age ≥18 years of age (PDL criteria do not apply); **AND** • The patient has had an inadequate response, intolerance or contraindication to azithromycin or a fluoroquinolone • Quantity Limit: 12 tablets • Length of authorization: 3 days DIDICID® (FIDAXOMICIN) 40 MG/ML ORAL SUSPENSION • Maximum patient age = 17 years LIKMEZ® (METRONIDAZOLE) • PDL criteria may be bypassed if patient is less than 12 years of age OR unable to swallow tablets • Quantity Limit: 400 mL per 10 days • Length of approval: Duration of the prescription NITAZOXANIDE (ALINIA®) – PDL CRITERIA DO NOT APPLY • Tablets: ○ For treatment of diarrhea caused by Cryptosporidium parvum or Giardia lamblia **AND** ○ The patient has had a trial on metronidazole or a clinical reason why it cannot be tried ○ Length of authorization = 1 month ○ Quantity limit = 6 tablets per rolling 30 days XIFAXAN® (PDL criteria do not apply) • 200 mg tabs: ○ Travelers' diarrhea caused by noninvasive strains of *E. coli* and age ≥ 12 years of age ○ The patient has had an inadequate response, intolerance, or contraindication to azithromycin or a fluoroquinolone. • 550 mg tabs: ○ Reduction in risk of overt hepatic encephalopathy recurrence in patients ≥ 18 years of age (PDL criteria do not apply) ○ Diagnosis of irritable bowel syndrome with diarrhea (IBS-D) in patients ≥18 years of age (PDL criteria do not apply) **Duration of Approval**: 1 year, unless otherwise noted in drug-specific criteria

GI Motility, Chronic CHRONIC IDIOPATHIC CONSTIPATION (CIC)	**Preferred Agents:** *No Prior Authorization required* Linzess® lubiprostone **Non-Preferred Agents:** *Prior Authorization required* Amitiza® Motegrity® prucalopride Trulance® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with one preferred medication within the same subclass **See additional medication-specific criteria below:** AMITIZA® (LUBIPROSTONE) • Patient is ≥ 18 years of age; **AND** • Quantity limit of 2 capsules per day LINZESS® (LINACLOTIDE) • Patient is ≥ 6 years of age; **AND** • Quantity limit of 1 capsule per day MOTEGRITY® (*PRUCALOPRIDE*) • Diagnosis of chronic idiopathic constipation (CIC); **AND** • Prescribed by or in consultation with a gastroenterologist; **AND** • Therapeutic failure after one-month trial of one preferred agent for CIC TRULANCE® (*PLECANATIDE*) • Diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); **AND** • Therapeutic failure after one-month trial of one preferred agent for CIC or IBS-C **Duration of Approval**: Up to 1 year

GI Motility, Chronic IRRITABLE BOWEL SYNDROME WITH CONSTIPATION (IBS-C)	**Preferred Agents:** *No Prior Authorization required* Linzess® lubiprostone **Non-Preferred Agents:** *Prior Authorization required* Amitiza® Ibsrela® Trulance® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with one preferred medication within the same subclass **See additional medication-specific criteria below:** AMITIZA® (LUBIPROSTONE) • Patient is ≥ 18 years of age; **AND** • Quantity limit of 2 capsules per day LINZESS® (LINACLOTIDE) • Patient is ≥ 6 years of age • Quantity limit of 1 capsule per day IBSRELA® (TENAPANOR) • Diagnosis of irritable bowel syndrome with constipations (IBS-C): **AND** • Patient is ≥ 18 years of age **AND** • Therapeutic failure after one-month trial of one preferred agent of IBS-C TRULANCE® (*PLECANATIDE*) • Diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); **AND** • Therapeutic failure after one-month trial of one preferred agent for IBS-C **Duration of Approval**: Up to 1 year

GI Motility, Chronic IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D)	**Preferred Agents:** *No Prior Authorization Required* diphenoxylate/atropine (generic Lomotil®) loperamide (generic Imodium®) **Non-Preferred Agents:** *Prior Authorization required* alosetron Lotronex® Viberzi® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with one preferred medication within the same subclass **See additional medication-specific criteria below:** LOTRONEX® (*ALOSETRON*) • Diagnosis of irritable bowel syndrome with diarrhea (IBS-D); **AND** • Therapeutic failure after one-month trial of diphenoxylate/atropine or loperamide; **AND** • Member is female VIBERZI® (*ELUXADOLINE*) • Diagnosis of irritable bowel syndrome with diarrhea (IBS-D); **AND** • Therapeutic failure after one-month trial of diphenoxylate/atropine or loperamide **Duration of Approval**: Up to 1 year
GI Motility, Chronic OPIOID-INDUCED CONSTIPATION (OIC)	**Preferred Agents:** *No Prior Authorization required* lubiprostone **Non-Preferred Agents:** *Prior Authorization required* Amitiza® Movantik® Relistor® Symproic® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with one preferred medication within the same subclass **See additional medication-specific criteria below:** AMITIZA® (LUBIPROSTONE) • Patient is ≥ 18 years of age • Quantity limit of 2 capsules per day RELISTOR® (*METHYLNALTREXONE*) • Diagnosis of opioid induced constipation (OIC); **AND** • Therapeutic failure after one-month trial of one preferred agent for OIC SYMPROIC® (*NALDEMEDINE TOSYLATE*) • Diagnosis of opioid induced constipation (OIC); **AND** • Therapeutic failure after one-month trial of one preferred agent for OIC **Duration of Approval**: Up to 1 year

Glaucoma ALPHA-2 ADRENERGICS	**Preferred Agents:** *No Prior Authorization required* Apraclonidine brimonidine tartrate 0.2% **Non-Preferred Agents:** *Prior Authorization required* Alphagan P® brimonidine tartrate 0.1% brimonidine tartrate 0.15% Iopidine® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with one preferred medication within the same subclass **Duration of Approval**: 1 year
Glaucoma BETA BLOCKERS	**Preferred Agents:** *No Prior Authorization required* Betoptic S® Carteolol timolol maleate (generic for Timoptic®) **Non-Preferred Agents:** *Prior Authorization required* Betaxolol Betimol® Istalol® Levobunolol timolol (generic for Betimol®) timolol maleate (generic for Istalol®) timolol maleate (generic for Timoptic® Ocudose) Timoptic®/Timoptic Ocudose® Timoptic XE® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with one preferred medication within the same subclass **Duration of Approval**: 1 year
Glaucoma CARBONIC ANHYDRASE INHIBITORS	**Preferred Agents:** *No Prior Authorization required* brinzolamide dorzolamide dorzolamide / timolol (generic Cosopt®) Simbrinza® **Non-Preferred Agents:** *Prior Authorization required* Azopt® Cosopt®/ Cosopt PF® dorzolamide / timolol PF (generic for Cosopt PF®) **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with one preferred medication within the same subclass **Duration of Approval**: 1 year

Glaucoma COMBINATION ALPHA-2 ADRENERGIC-BETA BLOCKER	**Preferred Agents:** *No Prior Authorization required* Combigan® **Non-Preferred Agents:** *Prior Authorization required* brimonidine-timolol **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with one preferred medication within the same subclass **Duration of Approval**: 1 year
Glaucoma PROSTAGLANDIN ANALOGUES	**Preferred Agents:** *No Prior Authorization required* latanoprost **Non-Preferred Agents:** *Prior Authorization required* bimatoprost (generic for Lumigan) Iyuzeh® Lumigan® tafluprost (generic for Zioptan®) Travatan Z® travoprost (generic for Travatan®) Vyzulta® Xalatan® Xelpros® Zioptan® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with one preferred medication within the same subclass **Duration of Approval**: 1 year
Glucagon Agents	**Preferred Agents:** *No Prior Authorization required* Baqsimi® Gvoke Pen® Zegalogue® **Non-Preferred Agents:** *Prior Authorization required* Glucagon Emergency Kit (Amphastar and Fresenius) Gvoke® Syringe, Kit, Vial **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • History of trial and failure with one preferred medication **Duration of Approval**: 1 year

Growth Hormones	**Preferred Agents:** *Prior Authorization required* Genotropin® Norditropin® Norditropin Flexpro® **Clinical PA Criteria (preferred and non-preferred):** • Requests must be submitted by an endocrinologist or nephrologist. • Panhypopituitarism – Cachexia, pituitary; Necrosis of pituitary (postpartum); Pituitary insufficiency NOS; Sheehan's syndrome; Simmond's disease. • Pituitary dwarfism – Isolated deficiency of (human) growth hormone [HGH]; Lorain-Levi dwarfism). • Endocrine disorders – Other specified endocrine disorders: Pineal gland dysfunction; Progeria; Werner's syndrome. • Indeterminate sex and pseudo hermaphroditism – Gynandrism; Hermaphroditism; Ovotestis; Pseudo hermaphroditism (male, female); Pure gonadal dysgenesis • Gonadal dysgenesis – Turner's Syndrome (female only); XO syndrome; Ovarian dysgenesis • Noonan Syndrome – Norditropin® is the only medication with this indication • Prader-Willi Syndrome. **Genotropin®**, Norditropin FlexPro, and Omnitrope® are the only medications with this indication • Idiopathic Short Stature – individual medical record and necessity review will be required. • **CKD – stage 1, 2 or 3** (CRI): **Nutropin®** is the only medication with this indication • **CKD – stage 4 or 5** (CRF or ESRD) • **SHOX: Humatrope®** is the only medication with this indication • For non-preferred medications: Must have an allergy to inactive ingredients in the preferred medications REQUIRED TESTING INFORMATION: • **Growth hormone stimulation testing:** o Pituitary dwarfism: the patient must have failed ***two*** kinds of growth hormone stimulation tests for the diagnosis. Testing is required for pediatric, adolescent, and adult patients. For adolescent patients whose epiphyseal growth plates are closed and for adult patients, testing must be done after growth hormone therapy has been suspended for at least 3 months. o Requester should document the kinds of stimulation tests performed, the result (lab value), reference range and date. • **Bone age x-rays (required regardless of diagnosis; x-ray does not have to be performed within a specific time frame):** o Pediatric patients – bone x-ray report is required unless the prescriber is a (pediatric) endocrinologist o Adolescent patients (13 to 19 years of age)– bone x-ray report is required UNLESS the prescriber is a (pediatric) endocrinologist; the requester must also note whether or not the epiphyseal growth plates have closed o Adult patients – bone x-ray report is NOT required • **Papilledema:** o Provider is aware of the risk of intracranial hypertension and the role of fundoscopic examination to assess and monitor for papilledema. • For Idiopathic Short Stature, individual medical record and necessity review will be required. o Requests that do not meet clinical criteria will require further review and must include the patient's diagnosis including ICD-10, if available. Growth charts should be provided, if available, at time of review (ensure that the correct chart is being submitted based on the patient's age – i.e., 0–3 vs 2–20) in addition to documentation of small for gestational age at birth, if appropriate *Continued>*

Growth Hormones	**Non-Preferred Agents:** *Prior Authorization criteria below* Humatrope® Ngenla® Nutropin AQ® Omnitrope® Serostim® Sogroya® Skytrofa® Zomacton® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with one preferred medication; **OR** • The patient's condition is clinically stable such that switching medications would cause deterioration in the condition **See additional medication-specific criteria below:** NGENLA® (SOMATROGON-GHLA) • Maximum patient age = 16 years SOGROYA® (SOMAPACITANB-BECO) • Quantity Limit: 8 mgs per week SKYTROFA® (LONAPEGSOMATROPIN-TCGD) • Maximum patient age = 16 years **Duration of Approval**: 1 year
H. pylori Treatment	**Preferred Agents:** *No Prior Authorization required* Pylera® **Non-Preferred Agents:** *Prior Authorization Criteria below* bismuth/metronidazole/tetracycline lansoprazole/amoxicillin/clarithromycin Omeclamox-PAK® Talicia Voquezna Dual Pak® Voquezna Triple Pak® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after one course (e.g., 10-14 days) trial of the preferred agent **Duration of Approval**: 1 year

Hematopoietic Agents	**Preferred Agents:** *Clinical Prior Authorization below* Aranesp® Epogen® Retacrit® **Non-Preferred Agents:** *Prior Authorization Criteria below* Jesduvroq® Procrit® Vafseo **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after one-month trial with one preferred medication • See additional medication/diagnoses-specific criteria below **Clinical PA Criteria:** CHRONIC KIDNEY DISEASE STAGE 3, STAGE 4 [CRF - CHRONIC RENAL FAILURE] AND STAGE 5 [ESRD END STAGE RENAL DISEASE] (EPOGEN®, PROCRIT®, RETACRIT® AND ARANESP®): • Hemoglobin level < 10 g/dL before treatment with **Epogen®, Procrit®, Retacrit®, Aranesp®** or transfusions • **RENEWAL:** CURRENT hemoglobin level < 12 g/Dl KIDNEY TRANSPLANT PATIENTS - TRANSPLANTED KIDNEY IS NOTED AS NOT YET FUNCTIONING TO ANTICIPATED POTENTIAL (EPOGEN®, PROCRIT®, RETACRIT® AND ARANESP®): • < 1-year post transplant • CURRENT hemoglobin level < 12 g/dL • Length of Authorization: 6 months CHEMOTHERAPY OR RADIATION THERAPY CONFIRMED AS CURRENT (EPOGEN®, PROCRIT®, RETACRIT® AND ARANESP® ONLY): • Hemoglobin level < 10 g/dL before beginning treatment with **Epogen®, Procrit®, Retacrit®, Aranesp®** or transfusions • **RENEWAL:** CURRENT hemoglobin level < 12 g/dL ANEMIA IN AIDS PATIENTS: (EPOGEN®, PROCRIT®, RETACRIT® ONLY) • Hemoglobin level < 10 g/dL ANEMIC PATIENTS SCHEDULED TO UNDERGO NON-CARDIAC, NON-VASCULAR SURGERY TO DECREASE NEED FOR TRANSFUSIONS: (EPOGEN®, PROCRIT®, RETACRIT® ONLY) • Clinical rationale why alternative approaches such as donating own blood prior or transfusion is not an option. • CURRENT hemoglobin level < 10 g/dL MYELODYSPLASIA AND MYELODYSPLASTIC SYNDROME (EPOGEN®, PROCRIT®, RETACRIT® ONLY): • CURRENT hemoglobin level < 10 g/dL HEPATITIS C WITH CURRENT INTERFERON TREATMENT (EPOGEN®, PROCRIT®, RETACRIT® ONLY): • Beginning hemoglobin level < 10 g/dL • **RENEWAL:** CURRENT hemoglobin level < 12 g/dL JESDUVROQ® (DAPRODUSTAT) **Initial** • Patient is ≥18 years of age; **AND** • Diagnosis of anemia due to chronic kidney disease (CKD); **AND** • Patient has been receiving dialysis for ≥ 4 months; **AND** • Prescribed by or in consultation with a nephrologist or hematologist**; AND** • Recent documentation (within 30 days of request) of **ALL** the following: ○ Patient is currently receiving an erythropoiesis-stimulating agent AND transitioning to Jesduvroq; **AND** ○ Patient has a hemoglobin level ≤ 12.0 g/dL; **OR** ○ Patient is NOT currently receiving an erythropoiesis-stimulating agent; **AND** ○ Patient has a baseline (prior to initiation of Jesduvroq) hemoglobin level < 11 g/dL; **AND** ○ Serum ferritin > 100 ng/mL (mcg/L); **AND** ○ Transferrin saturation (TSAT) >20% • Length of approval: 6 months **Renewal** • Patient must continue to meet the above criteria; **AND** • Patient has experienced an increase in Hb from baseline; **AND** • Hemoglobin is < 12 g/dL • Length of approval: 1 year

	VAFSEO® (VADADUSTAT) **Initial** • Patient is 18 years of age or older; **AND** • Diagnosis of anemia due to chronic kidney disease (CKD); **AND** • Patient has been receiving dialysis for ≥3 months; **AND** • Prescribed by or in consultation with a nephrologist or hematologist; **AND** • Recent documentation (within 30 days of request) of **ALL** the following: ○ Patient is currently receiving an erythropoiesis-stimulating agent AND transitioning to Vafseo; **AND** ○ Patient has a hemoglobin level ≤ 12.0 g/dL; **OR** ○ Patient is NOT currently receiving an erythropoiesis-stimulating agent; **AND** ○ Patient has a baseline (prior to initiation of Vafseo) hemoglobin level < 11 g/dL; **AND** ○ Serum ferritin > 100 ng/mL (mcg/L); **AND** ○ Transferrin saturation (TSAT) >20% • Length of approval: 6 months **Renewal** • Patient must continue to meet the above criteria; **AND** • Patient has experienced an increase in Hb from baseline; **AND** • Hemoglobin is < 12 g/dL • Length of approval: 1 year **Duration of Approval**: For the duration of the prescription up to 6 months, unless otherwise noted in Medication/Diagnoses-Specific Information

Immunomodulators AGENTS TO TREAT ASTHMA	**Preferred Agents:** *Prior Authorization required* Dupixent® Fasenra® pen Xolair® syringe, autoinjectors **Clinical PA Criteria for Asthma Indications:** • Patient's asthma symptoms have not been adequately controlled by at least three months of an asthma treatment regimen that must include an inhaled corticosteroid; **AND** • Prescribed by or in consultation with an allergist, immunologist, or pulmonologist **See additional medication-specific criteria below:** DUPIXENT® (*DUPILUMAB*) **NOTE:** (1) A 56-day supply will be allowed for patients requiring dosing once every 28 days (every 4 weeks) (2) The pre filled PEN is for use in adult and pediatric patients aged 2 years and older, (3) The pre-filled SYRINGE is for use in adult and pediatric patients aged 6 months and older. • **Patient must have moderate to severe asthma diagnosed as ONE of the following types:** o Asthma with eosinophilic phenotype with eosinophil count ≥ 150 cells/mcL; **OR** o Oral corticosteroid dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months; **AND** o Patient must be 6 years of age or older FASENRA® (*BENRALIZUMAB*): • **Patient must have severe asthma; AND** o Eosinophil blood count of ≥ 150 cells/µL within last 6 weeks or ≥ 300 cells/µL within the last 12 months; **AND** o Patient must be 6 years of age or older XOLAIR® (*OMALIZUMAB*) • **Moderate to severe persistent asthma; AND** o Patient is 6 years of age or older; **AND** o Patient has a positive skin test or in vitro testing (RAST, etc.) for allergen specific IgE antibodies for one or more seasonal aeroallergens; **AND** o Baseline IgE level is ≥ 30 IU/ml **Non-Preferred Agents:** *Prior Authorization required* Nucala® Syringe, Autoinjector Tezspire® pen **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after a one-month trial of one preferred medication **See additional medication-specific criteria below:** NUCALA (*MEPOLIZUMAB*) • **Patient must have severe asthma; AND** o Eosinophil blood count of ≥ 150 cells/µL within last 6 weeks or ≥ 300 cells/µL within the last 12 months; **AND** o Patient must be 6 years of age or older; **AND** o For Nucala 40mg/0.4 ml, patient age must be ≤ 11 years of age TEZSPIRE (*TEZEPELUMAB-EKKO*) PRE-FILLED PENS • **Patient must have severe asthma; AND** o Patient is 12 years of age or older; **AND** o Patient has been trained to self-administer this product; **AND** o Member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Tezspire; **AND** o Bypass PDL criteria if patient does not meet specific criteria for Preferred agents (e.g. eosinophil blood count and/or IgE blood level requirements) **Duration of Approval**: 1 year

Immunomodulators

AGENTS TO TREAT ATOPIC DERMATITIS

Preferred Agents: *Prior Authorization required*

Adbry®
Dupixent®
Elidel®
Eucrisa®
pimecrolimus (generic for Elidel)
tacrolimus

Clinical PA Criteria For Atopic Dermatitis Indications For Each Agent

- Diagnosis of atopic dermatitis
  - Dupixent®: moderate to severe for ages ≥ 6 months
  - Elidel®: mild to moderate for ages > 2 years
  - pimecrolimus – mild to moderate for ages > 2 years
  - Eucrisa®: mild to moderate for ages ≥ 3 months
  - Adbry®: moderate to severe for ages ≥ 12 years
  - Tacrolimus 0.03%: moderate to severe for ages ≥ 2 years
  - Tacrolimus 0.1%: moderate to severe for ages ≥ 16 years

See additional medication-specific criteria below:

Non-Preferred Agents: *Prior Authorization required*

Cibinqo
Ebglyss®
Nemluvio®
Opzelura®
Rinvoq®

Non-Preferred Agent PA Criteria:

- Diagnosis of atopic dermatitis; **AND**
- Allergy to the preferred medication(s); **OR**
- Contraindication or drug to drug interaction with the preferred medications; **OR**
- History of unacceptable side effects; **OR**
- Therapeutic failure with one-month trial of one preferred medication
- Additional disease severity and age limits:
  - **Rinvoq**® moderate to severe for ages ≥ 12 years

See additional medication-specific criteria below:

ADBRY® (TRALOKINUMAB-LDRM)

- **Diagnosis of moderate to severe atopic dermatitis; AND**
  - Patient age ≥ 12 years old; **AND**
  - **Adbry 150mg;**
    - Quantity limit: 4 syringes per 28 days (with special allowance for initial dose)
  - **Adbry 300mg;**
    - Quantity limit: 2 Autoinjectors per 28 days (with special allowance for initial dose)

CIBINQO® (ABROCITINIB)

- **Diagnosis of moderate to severe atopic dermatitis; AND**
  - Patient age ≥ 12 years old

DUPIXENT® (*DUPILUMAB*)

NOTE: (1) A 56-day supply will be allowed for patients requiring dosing once every 28 days (every 4 weeks) **(2)** The pre-filled PEN is for use in adult and pediatric patients aged 2 years and older, **(3)** The pre-filled SYRINGE is for use in adult and pediatric patients aged 6 months and older.

- **Diagnosis of moderate to severe atopic dermatitis; AND**
  - Patient ≥ 6 months old

EBGLYSS® (LEBRIKIZUMAB-LBKZ)

- Diagnosis of moderate to severe atopic dermatitis; **AND**
- Patient is 12 years of age or older; **AND**
- Patient weighs at least 40 kg (88 lbs)
- Quantity Limit: 1 pen (2mL) per 28-day days (special allowance for initial and subsequent induction fills)
- Length of approval: 6 months

	NEMLUVIO (NEMOLIZUMAB-ILTO) • Diagnosis of moderate to severe atopic dermatitis; **AND** • Patient is 12 years of age or older • Quantity Limit: 1 pen (30mg) per 28 days (special allowance of 2 pens for loading dose • Length of approval: 6 months **Renewal** • Documentation submitted demonstrating a positive response to therapy. • Prescriber attests the patient has achieved clear or almost clear skin, and in accordance with the product label, the patient will be transitioned to a dosage of 1 pen (30 mg) every 8 weeks. NOTE: renewal PA will limit dosage accordingly; **OR** • Prescriber attests the patient has not achieved clear or almost clear skin yet but has had a positive response to therapy. Prescriber is requesting continuation of dosage of 1 pen (30 mg) every 4 weeks. OPZELURA® (*RUXOLITINIB PHOSPHATE*) • **Diagnosis of mild to moderate atopic dermatitis; AND** o Patient has atopic dermatitis estimated to affect ≤ 20% of the body surface area; **AND** o Patient age ≥12 years old **Duration of Approval**: 6 months for **FDA approved diagnosis** noted above, unless otherwise noted in Medication/Diagnosis-Specific Criteria
Immunomodulators AGENTS TO TREAT CHRONIC IDIOPATHIC URTICARIA / CHRONIC SPONTANEOUS URTICARIA	**Preferred Agents:** *Prior Authorization required* Dupixent® Xolair® syringe, autoinjectors **Clinical PA Criteria below:** DUPIXENT® (DUPILUMAB): • **Diagnosis of Chronic Spontaneous Urticaria (CSU) / Chronic Idiopathic Urticaria; AND** o Patient is 12 years of age or older; **AND** o Prescribed by or in consultation with an allergist, immunologist, or dermatologist; **AND** o Patient has had urticaria for at least 6 weeks with symptoms present despite an adherent trial of at least 2 weeks duration of an H1-antihistamine XOLAIR® (OMALIZUMAB) • **Diagnosis of Chronic Idiopathic Urticaria / Chronic Spontaneous Urticaria (CSU); AND** o Patient is 12 years of age or older; **AND** o Prescribed by or in consultation with an allergist, immunologist, or dermatologist; **AND** o Patient has had urticaria for at least 6 weeks with symptoms present despite an adherent trial of at least 2 weeks duration of an H1-antihistamine **Duration of Approval**: 1 year
Immunomodulators AGENTS TO TREAT CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)	**Preferred Agents:** *Prior Authorization required* Dupixent® **Clinical PA Criteria for Chronic Obstructive Pulmonary Disease (COPD) Indications:** DUPIXENT® (*DUPILUMAB*) • **Diagnosis of inadequately controlled chronic obstructive pulmonary disease (COPD); AND** o Patient has an eosinophilic count ≥300 cells/mcL; **AND** o Patient ≥ 18 years old; **AND** o Patient is concurrently treated with triple therapy with inhaled corticosteroid [ICS], long-acting beta-2 agonist [LABA], and long-acting muscarinic antagonist [LAMA]; **OR** o Patient is concurrently treated with a LABA and LAMA if ICS therapy is contraindicated. **Duration of Approval**: 1 year

Immunomodulators AGENTS TO TREAT CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP)	**Preferred Agents:** *Prior Authorization required* Dupixent® Xolair® syringe, autoinjectors **Clinical PA Criteria for chronic rhinosinusitis with nasal polyposis (CRSwNP) Indications:** DUPIXENT® (*DUPILUMAB*) • **Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP); AND** ○ Patient ≥ 12 years old; **AND** ○ Patient has inadequate response after 3 consistent months use of intranasal steroids or oral corticosteroids; **AND** ○ Patient is concurrently treated with intranasal corticosteroids XOLAIR® (OMALIZUMAB) • **Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP); AND** ○ Patient ≥ 18 years old; **AND** ○ Prescribed by or in consultation with an allergist, immunologist or otolaryngologist; **AND** ○ Patient has not been adequately controlled by at least three months of treatment with an intranasal steroids or oral corticosteroids; **AND** ○ Baseline IgE level is ≥ 30 IU/ml; **AND** ○ Patient is concurrently treated with intranasal corticosteroids **Non-Preferred Agents:** *Prior Authorization required* Nucala® syringe, auto-injector **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medication; **OR** • Contraindication or drug to drug interaction with the preferred medication; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after a one-month trial with the preferred medication **See additional medication-specific criteria below:** NUCALA (MEPOLIZUMAB) • **Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP); AND** ○ Patient ≥ 18 years old; **AND** ○ Patient has inadequate response after 3 consistent months use of intranasal steroids or oral corticosteroids; **AND** ○ Patient is concurrently treated with intranasal corticosteroids **Duration of Approval**: 1 year
Immunomodulators AGENTS TO TREAT EOSINOPHILIC ESOPHAGITIS (EOE)	**Preferred Agents:** Clinical *Prior Authorization below* Dupixent® **Clinical PA Criteria for eosinophilic esophagitis (EOE) Indications:** DUPIXENT® (*DUPILUMAB*) • **Diagnosis of eosinophilic esophagitis (EoE); AND** ○ Patient ≥ 1 years old; **AND** ○ Patient weighs ≥ 15 kg; **AND** ○ Prescribed by or consultation with an allergist or gastroenterologist; **AND** ○ Patient did not respond clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor **Duration of Approval**: 1 year

Immunomodulators AGENTS TO TREAT EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA)	**Preferred Agents:** Clinical *Prior Authorization below* Fasenra® **Clinical PA Criteria for Eosinophilic Granulomatosis with Polyangiitis (EGPA):** FASENRA® (BENRALIZUMAB) • Diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA); **AND** • Patient is 18 years of age or older **Non-Preferred Agents:** *Prior Authorization required* Nucala® syringe, auto-injector **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medication; **OR** • Contraindication or drug to drug interaction with the preferred medication; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after a one-month trial with the preferred medication **See additional medication-specific criteria below:** NUCALA (MEPOLIZUMAB) • **Diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA); AND** ○ Patient is 18 years of age or older **Duration of Approval**: 1 year
Immunomodulators AGENTS TO TREAT HYPEREOSINOPHILIC SYNDROME (HES)	**Non-Preferred Agents:** *Prior Authorization required* Nucala® syringe, auto-injector **Non-Preferred Agent PA Criteria:** NUCALA (MEPOLIZUMAB) • **Diagnosis of hypereosinophilic syndrome (HES); AND** ○ Patient is 12 years of age or older **Duration of Approval**: 1 year
Immunomodulators AGENTS TO TREAT IGE-MEDIATED FOOD ALLERGY	**Preferred Agents:** Clinical *Prior Authorization below* Xolair **Clinical PA Criteria for IgE-Mediated Food Allergy** XOLAIR® (OMALIZUMAB) • **Diagnosis of IgE-mediated food allergy; AND** ○ Patient is 1 year of age or older; **AND** ○ Prescribed by or in consultation with an allergist or immunologist; **AND** ○ Patient will follow food allergen avoidance in conjunction with Xolair; **AND** ○ Baseline IgE level is ≥ 30 IU/ml **Duration of Approval**: 1 year

Immunomodulators AGENTS TO TREAT NONSEGMENTAL VITILIGO	**Non-Preferred Agents:** *Prior Authorization required* Opzelura® **Non-Preferred Agent PA Criteria:** OPZELURA® (RUXOLITINIB PHOSPHATE) • **Diagnosis of nonsegmental vitiligo; AND** ○ Patient has vitiligo involvement estimated to affect ≤ 10% of the body surface area; **AND** ○ Patient is ≥12 years old; **AND** ○ Prescribed by or in consultation with a dermatologist **Duration of Approval**: 1 year
Immunomodulators AGENTS TO TREAT PRURIGO NODULARIS (PN)	**Preferred Agents:** Clinical *Prior Authorization below* Dupixent® **Clinical PA Criteria for prurigo nodularis (PN) indications:** DUPIXENT® (*DUPILUMAB*) • **Diagnosis of prurigo nodularis (PN); AND** ○ Patient ≥18 years old; **AND** ○ Prescribed by or in consultation with a dermatologist, allergist, or immunologist **Non-Preferred Agents: Prior Authorization Criteria below** Nemluvio® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medication; **OR** • Contraindication or drug to drug interaction with one preferred medication; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after a one-month trial with the preferred medication **See additional medication-specific criteria below:** NEMLUVIO® (NEMOLIZUMAB-ILTO): • Diagnosis for prurigo nodularis; **AND** • Patient is 18 years of age or older; **AND** • Prescribed by or in consultation with a dermatologist, allergist or immunologist • Quantity Limit: 1 pen (30mg) per 28 days (special allowance of 2 pens for loading dose and patients weighing ≥90 kg) **Duration of Approval**: 1 year

Incretin Mimetics	**Preferred Agents:** *Clinical Prior Authorization below* Byetta® Ozempic® Trulicity® Victoza® **Clinical Preferred Agent PA Criteria:** • Patient has a diagnosis of type 2 diabetes: **AND** • Discontinuation of other GLP-1 agonists; **AND** • Discontinuation of DPP4 Inhibitors **Non-Preferred Agents:** *Prior Authorization required* Bydureon Bcise® exenatide liraglutide Mounjaro® Rybelsus® Soliqua® Xultophy® **Non-Preferred Agent PA Criteria:** • Diagnosis of type 2 diabetes; **AND** • Discontinuation of other GLP-1 agonists; **AND** • Discontinuation of DPP4 Inhibitors; **AND** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Trial and failure with one preferred medication within same subgroup **See additional medication-specific criteria below:** SOLIQUA® (INSULIN GLARGINE/LIXISENATIDE) • One-month trial and failure with one of the preferred medications in each subgroup of the components (basal insulin and GLP-1 agonist) XULTOPHY® *(INSULIN DEGLUDEC/LIRAGLUTIDE)* • One-month trial and failure with one of the preferred medications in each subgroup of the components (basal insulin and GLP-1 agonist) **Duration of Approval**: Up to 1 year

Inhaled Glucocorticoids	**Preferred Agents:** *No Prior Authorization required* Alvesco® (MDI) Arnuity Ellipta® (DPI) Asmanex® Twisthaler (DPI) budesonide 0.25 and 0.5mg nebulizer solution budesonide 1mg nebulizer solution (generic for Pulmicort Respules) fluticasone propionate HFA (generic for Flovent HFA) Pulmicort Flexihaler® (DPI) QVAR Redihaler® (MDI) **Non-Preferred Agents:** *Prior Authorization Criteria below* Armonair Digihaler Asmanex HFA® (DPI) fluticasone prop diskus (Generic Flovent Diskus) Pulmicort® 1mg Respules nebulizer solution Pulmicort® 0.25mg and 0.5mg Respules **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a two-week trial with one preferred medication • For children less than 13 years of age or a patient with a significant disability: inability to use the inhaler on preferred medications, or non-compliance because of taste, dry mouth **See additional medication-specific criteria below:** ASMANEX® HFA (mometasone) • Requests submitted referencing exception due to compatibility with spacer/chamber will require trial only on Flovent® HFA ASMANEX® TWISTHALER 110MCG (mometasone) ONLY – AGE LIMIT • Requests submitted to exceed the age limit of 11 years may be approved if a lower dose is needed and the dose requested does not exceed 1 inhaler per 30 days **Maximum Age Limits:** • **Arnuity Ellipta (fluticasone) 50 mcg) –** 11 years • **Asmanex (mometasone) HFA 50 mcg –** 12 years • **Pulmicort 0.25 mg/2 ml Respules (budesonide)** – 8 years • **Pulmicort 0.5 mg/2 ml Respules (budesonide)** – 8 years • **Pulmicort 1 mg/2 ml Respules (budesonide)** – 8 years **Duration of Approval**: 1 year

Insulins, Mixes	**Preferred Agents:** *No Prior Authorization required* Humalog® 50/50 kwikpens Humalog® 75/25 pens, vials Humulin® 70/30 Kwikpens, vials insulin aspart 70/30 pens, vials (generic for Novolog®) **Non-Preferred Agents:** *Prior Authorization required* Insulin lispro 75/25 pens Novolin® 70/30 pens, vials Novolog® 70/30 pens, vials **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Patient is clinically stable, and switching would cause a deterioration in condition; **OR** • Therapeutic failure with one preferred medication within same subgroup **Duration of Approval**: 1 year
Insulins, Basal	**Preferred Agents:** *No Prior Authorization required* Lantus® pens, vials Levemir® pens, vials **Non-Preferred Agents:** *Prior Authorization required* Basaglar® kwikpens, tempo pens insulin degludec pens, vials (generic Tresiba) insulin glargine solostar/max solostar U300 pens (generic for Toujeo) insulin glargine-YFGN pens, vials (biosimilar for Semglee®) Rezvoglar® Semglee® (YFGN) pens, vials Toujeo Solostar®/Max Solostar® pens Tresiba® pens, vials **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Patient is clinically stable, and switching would cause a deterioration in condition; **OR** • Therapeutic failure with one preferred medication within same subgroup **See additional medication-specific criteria below:** TOUJEO SOLOSTAR®/MAX SOLOSTAR® AND insulin glargine solostar/max solostar U300 pens • Trial and failure on both preferred medications in this class **Duration of Approval**: 1 year

Insulins, Rapid Acting	**Preferred Agents:** *No Prior Authorization required* Apidra® pens, vials Humalog® U-100 cartridges, kwikpens, tempo pens, vials insulin aspart pens, vials (generic for Novolog®) insulin lispro U-100 kwikpens, vials (gen for Humalog) Novolog® cartridges **Non-Preferred Agents:** *Prior Authorization required* Admelog® vials; Admelog Solostar® pens Afrezza® inhalation cartridges Fiasp® pens, vials, pumpcart Humalog® U-200 kwikpens insulin aspart cartridges (generic for Novolog®) Lyumjev® kwikpens, tempo pens Novolog® pens, vials **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Patient is clinically stable, and switching would cause a deterioration in condition; **OR** • Therapeutic failure with one preferred medication within same subgroup **Duration of Approval**: 1 year
Insulins, Traditional	**Preferred Agents:** *No Prior Authorization required* Humulin® R U-500 pens, vials Humulin® N vials Humulin® R vials Novolin® N vials Novolin® R vials **Non-Preferred Agents:** *Prior Authorization required* Humulin® N Kwikpens **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Patient is clinically stable, and switching would cause a deterioration in condition; **OR** • Therapeutic failure with one preferred medication within same subgroup **Duration of Approval**: 1 year

Insulin Suppressants	**Preferred Agents:** *No Prior Authorization required* Proglycem **Non-Preferred Agents:** *Prior Authorization required* diazoxide (generic for Proglycem) **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with one preferred medication within same subgroup **Duration of Approval**: 1 year
Leukotriene Inhibitors	**Preferred Agents:** *See Age Criteria for chew tablets below* montelukast tablets, 4mg chew tabs, 5mg chew tabs **Preferred Agent PA Criteria:** MONTELUKAST (SINGULAIR®) • clinical rationale why the (swallow) tablet dosage form inappropriate for the following age limits: ○ 4mg chew tabs – prior authorization (PA) required for patients > 5 ○ 5mg chew tabs – PA required for patients > 14 ○ Granules – PA required for patients > 5. Requests for granules for patients <5 may bypass PDL criteria if the patient is unable to chew or swallow a tablet. **Non-Preferred Agents:** *Prior Authorization required* Accolate® montelukast granules Singulair® tablets, 4mg chew tabs, 5mg chew tabs, granules zafirlukast Zileuton ER® Zyflo® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Trial and failure with one month with one preferred medication **Duration of Approval**: 1 year
Lipotropics: Fibric Acid Derivatives	**Preferred Agents:** *No Prior Authorization required* fenofibrate, nanocrystallized (generic for Tricor®) fenofibric acid capsules (generic for Lofibra® caps) fenofibrate tablets (generic for Lofibra® tablets) gemfibrozil **Non-Preferred Agents:** *Prior Authorization required* Antara® fenofibrate, micronized capsules (generic for Antara®) fenofibrate, nanocrystallized (generic for Triglide®) fenofibric acid (generic for Fibricor®) fenofibric acid (generic for Trilipix®) Fenoglide® Fibricor® Lopid® Lipofen® Tricor® Trilipix® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Patient is clinically stable, and switching would cause a deterioration in condition; **OR** • Therapeutic failure with one-month trial of one preferred medication **Duration of Approval**: 1 year

Lipotropics: Niacin Derivatives	**Preferred Agents:** *No Prior Authorization required* niacin tablets (OTC) niacin ER tablets (OTC) niacin ER capsules (OTC) Slo-Niacin tablets (OTC) **Non-Preferred Agents:** *Prior Authorization required* niacin ER (generic for Niaspan) **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Patient is clinically stable, and switching would cause a deterioration in condition; **OR** • Therapeutic failure with one-month trial of one preferred medication **Duration of Approval**: 1 year
Lipotropics: Non-Statins - Bile Acid Sequestrants	**Preferred Agents:** *No Prior Authorization required* cholestyramine/ cholestyramine light colestipol tablets Prevalite powder, packets **Non-Preferred Agents:** *Prior Authorization Criteria below* Colestid® tablet colestipol granules colesevelam tablet, packet Questran®/ Questran Light® Welchol® powder and tablets **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Patient is clinically stable, and switching would cause a deterioration in condition • Therapeutic failure with one-month trial of one preferred medication **Duration of Approval**: 1 year

Lipotropics: Others	**Preferred Agents:** *No Prior Authorization required* ezetimibe **Non-Preferred Agents:** *Prior Authorization required* Icosapent Ethyl Nexletol Nexlizet® omega-3 acid ethyl esters capsule Zetia® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Patient is clinically stable, and switching would cause a deterioration in condition; **OR** • Therapeutic failure with one-month trial of one preferred medication **See additional medication-specific criteria below:** OMEGA-3 ACID ETHYL ESTERS – PDL CRITERIA DO NOT APPLY • Adjunct to diet to reduce severe triglyceride (TG) levels (hypertriglyceridemia) in adult patients. • Triglyceride levels ≥ 500 mg/Dl NEXLETOL® (*BEMPEDOIC ACID*) – PDL CRITERIA DO NOT APPLY • Patient is ≥ 18 years of age; **AND** • Established atherosclerotic cardiovascular disease (ASCVD); **OR** • Heterozygous familial hypercholesterolemia; **AND** • Failure to achieve target LDL-C on maximally-tolerated doses of statins; **AND** • Therapy will used in conjunction with maximally-tolerated doses of a statin NEXLIZET® (BEMPEDOIC ACID/EZETIMIBE) – PDL CRITERIA DO NOT APPLY • Patient is ≥ 18 years of age; **AND** • Established atherosclerotic cardiovascular disease (ASCVD); **OR** • Heterozygous familial hypercholesterolemia; **AND** • Failure to achieve target LDL-C on maximally-tolerated doses of statins; **AND** • Therapy will be used in conjunction with maximally-tolerated doses of a statin ICOSAPENT ETHYL – PDL CRITERIA DO NOT APPLY • Adjunct to diet to reduce severe triglyceride (TG) levels in adult patients with severe (≥ 500 mg/dL) hypertriglyceridemia**; OR** • Adjunct to maximally tolerated statin therapy in adult patients with elevated triglyceride (TG) levels (≥ 150 mg/dL) and one of the following: ○ Established cardiovascular disease; **OR** ○ Diabetes mellitus and 2 or more additional risk factors for cardiovascular disease (i.e., men >55 years and women >65 years, cigarette smoker or stopped smoking within the past 3 months, hypertension (pretreatment blood pressure >140mmHg systolic or >90mmHg diastolic) **Duration of Approval**: 1 year

Lipotropics: PCSK9 Inhibitors	**Preferred Agents:** *Prior Authorization required* Praluent® Repatha® **Clinical PA Criteria:** REPATHA® (*EVOLOCUMAB*) AND PRALUENT® (*ALIROCUMAB*) **Initial Criteria:** • Must have diagnosis of ○ atherosclerotic cardiovascular disease (ASCVD); *or* ○ homozygous familialhypercholesterolemia (HoFH); *or* ○ heterozygous familial hypercholesterolemia (HeFH) • Treatment failure with the highest available dose or maximally tolerated dose of high intensity statin (atorvastatin or rosuvastatin) for at least 8 weeks • If intolerant to statins, this must be supported by submitted chart notes/labs • Patient has failed to reach target LDL-C levels (document lab values) ○ ASCVD: LDL-C is < 70 mg/dL ○ HeFH or HoFH: LDL-C is < 100 mg/dL **Renewal Criteria:** • Lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating medication **Duration of Approval**: 1 year
Lipotropics: Statins	**Preferred Agents:** *No Prior Authorization required* Atorvastatin ezetimibe/simvastatin lovastatin pravastatin rosuvastatin simvastatin **Non-Preferred Agents:** *Prior Authorization required* amlodipine / atorvastatin Altoprev® Atorvaliq® Caduet® Crestor® Ezallor® Sprinkle fluvastatin capsule / fluvastatin ER Lescol XL® Lipitor® Livalo® pitavastatin Vytorin® Zocor® Zypitamag® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Patient is clinically stable, and switching would cause a deterioration in condition; **OR** • Therapeutic failure with one-month trial of one preferred medication **See additional medication-specific criteria below:** ATORVALIQ® (ATORVASTATIN) • Patient cannot swallow whole tablets • Quantity Limit: 20 ml per day EZALLOR® SPRINKLE (ROSUVASTATIN) • Patient cannot swallow whole tablets **Duration of Approval:** 1 year

Macrolides	**Preferred Agents:** *No Prior Authorization required* Azithromycin Clarithromycin erythromycin ethylsuccinate tablets erythromycin ethylsuccinate 200mg suspension Erythrocin® **Non-Preferred Agents:** *Prior Authorization required* clarithromycin ER E.E.S.® tablet, suspension EryPed® Ery-Tab® Erythromycin base erythromycin ethylsuccinate 400mg suspension Zithromax® tablets, suspension **Non-Preferred Agent PA Criteria** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Infection caused by an organism resistant to the preferred macrolide medications • Therapeutic failure (duration = 3 days) with two preferred medications **Duration of Approval**: Date of service

Multiple Sclerosis Agents

Preferred Agents: *No Prior Authorization required*

Avonex®
Betaseron® vial / Betaseron® Kit
Copaxone 20 mg
dimethyl fumarate (generic for Tecfidera)
fingolimod (generic for Gilenya)
Kesimpta®
teriflunomide (generic for Aubagio)

Non-Preferred Agents: *Prior Authorization required*

Aubagio®
Bafiertam™
Copaxone® 40 mg
Gilenya®
glatiramer 20 mg/ml and 40 mg/ml
Glatopa®
Mavenclad®
Mayzent®
Plegridy®
Ponvory®
Rebif® / Rebif Rebidose®
Tascenso ODT®
Tecfidera®
Vumerity
Zeposia®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications; **OR**
- Contraindication or drug to drug interaction with the preferred medications; **OR**
- History of unacceptable side effects; **OR**
- Therapeutic failure of one month with two preferred medications

See additional medication-specific criteria below:

BAFIERTAM™ (MONOMETHYL FUMARATE)

- Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS); **AND**
- Prescribed by or in consultation with a neurologist; **AND**
- Attestation that Bafiertam will be used as single agent monotherapy
- Quantity limit: 120 per 30 days
- Initial length of authorization: 6 months
- **Renewal Criteria:**
  - Attestation of tolerance to maintenance dose
  - Attestation of a CBC, including lymphocyte count, serum aminotransferase, ALP, and total bilirubin levels
  - Length of Authorization: 1 year

MAVENCLAD® (CLADRIBINE)

- Diagnosis of relapsing forms of multiple sclerosis (MS) to include relapsing-remitting disease and active secondary progressive disease; **AND**
- Prescribed by or in consultation with a neurologist
- Therapeutic failure of one-month trial of at least two preferred medications

MAYZENT® (SIPONIMOD)

- Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS); **AND**
- Prescribed by or in consultation with a neurologist; **AND**
- Patient CYP2C9 variant status has been tested to determine genotyping (required for dosing); **AND**
- Patient has obtained a baseline electrocardiogram (ECG); **AND**
- Patient has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy; **AND**
- For patients with a history of uveitis and/or diabetes ONLY: A baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment; **AND**
- Therapeutic failure of one-month trial of at least two preferred medications

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Multiple Sclerosis Agents	PLEGRIDY® (PEGINTERFERON BETA-1A) • Therapeutic failure of one-month trial of at least two preferred medications required. PONVORY® (PONESIMOD) • Patient age between 18 years and 55 years; **AND** • Patient has a diagnosis of a relapsing form of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) or active secondary progressive disease (SPMS); **AND** • Prescribed by or in consultation with a neurologist; **AND** • Patient has obtained a baseline electrocardiogram (ECG); **AND** • Prescriber attestation that first-dose monitoring, as clinically indicated, will occur; **AND** • Patient does NOT have an active infection, including clinically important localized infections; **AND** • Patient has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy; **AND** • For patients with a history of uveitis and/or diabetes ONLY: baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment; **AND** • Prescriber attestation that ponesimod will NOT be used in combination with anti-neoplastic, immunosuppressive, or immune-modulating therapies, or, if therapy is unavoidable, the patient will be monitored closely for adverse reactions and/or dose modifications; **AND** • Therapeutic failure of one-month trial of at least two preferred medications TASCENSO ODT® (FINGOLIMOD) • Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS); **AND** • Patient age ≥10 years; **AND** • Prescribed by or in consultation with a neurologist; **AND** • Patient is unable to use generic fingolimod capsules or brand Gilenya capsules due to swallowing difficulties • Length of approval: 1 year VUMERITY® (DIROXIMEL FUMARATE) • Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS); **AND** • Prescribed by or in consultation with a neurologist; **AND** • Therapeutic failure of one-month trial of at least two preferred medications ZEPOSIA® (OZANIMOD) • Patient is 18 Years of age or older; **AND** • Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS); **AND** • Prescribed by or in consultation with a neurologist; **OR** • Diagnosis of moderately or severely active ulcerative colitis (UC); **AND** • Prescribed by or in consultation with a gastroenterologist; **AND** • Patient has obtained a baseline electrocardiogram (ECG); **AND** • Patient does NOT have an active infection, including clinically important localized infections; **AND** • Patient has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy; **AND** • For patients with a history of uveitis and/or diabetes ONLY: A baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment; **AND** • Prescriber attests that a CBC with lymphocyte count, ALT, AST, and total bilirubin have been obtained for the patient in the past 6 months; **AND** • For MS, therapeutic failure of one-month trial of at least two preferred MS medications. • For diagnosis of ulcerative colitis (UC), may bypass PDL criteria **Duration of Approval**: 1 year

Nasal Antihistamines	**Preferred Agents:** *No Prior Authorization required* azelastine **Non-Preferred Agents:** *Prior Authorization required* olopatadine spray **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Trial and failure on one preferred medication **Duration of Approval**: 1 year
Nasal Corticosteroids	**Preferred Agents:** *No Prior Authorization required* fluticasone (Rx) **Non-Preferred Agents:** *Prior Authorization Criteria below* Beconase AQ® budesonide flunisolide fluticasone (OTC) mometasone spray (RX) mometasone 24hr (OTC) Nasonex 24hr (OTC) Omnaris® Qnasl® triamcinolone Xhance® Zetonna® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications**; OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with a preferred medication **See additional medication-specific criteria below:** XHANCE® (FLUTICASONE) • Diagnosis of chronic rhinosinusitis with or without nasal polyps in adults • Therapeutic failure with a three-month trial with a preferred medication **Duration of Approval**: 1 year

NON-STEROIDAL ANTI-INFLAMMATORY – COX II INHIBITORS	**Preferred Agents:** *No Prior Authorization required (see ADL for step therapy requirements)* celecoxib **Non-Preferred Agents:** *Prior Authorization Criteria below* Celebrex® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Therapeutic failure of one month each with two preferred NSAIDS **See additional medication-specific criteria below:** CELEBREX® (CELECOXIB) • Therapeutic failure of one month each with two preferred NSAIDS (unless clinically contraindicated), including generic celecoxib **Duration of Approval**: For the duration of the prescription up to 1 year

NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS)

Preferred Agents: *No Prior Authorization required*

diclofenac sodium
diclofenac topical gel 1% (generic Voltaren Gel®)
diclofenac topical gel 1% (OTC)
diclofenac topical solution 1.5%
ibuprofen
indomethacin
ketorolac tablets
meloxicam tablets (generic for Mobic)
nabumetone
naproxen OTC
naproxen (generic for Naprosyn®)
sulindac

Non-Preferred Agents: *Prior Authorization required*

Arthrotec®
Daypro®
diclofenac sodium ER
diclofenac epolamine 1.3% patch
diclofenac-misoprostol
diclofenac potassium
diclofenac 2% pump (generic Pennsaid®)
diflunisal
Dolobid®
dual action pain (OTC -ibuprofen/apap)
EC-naproxen
etodolac / etodolac ER
Feldene®
fenoprofen
flurbiprofen
ibuprofen-famotidine
indomethacin ext release, oral susp
ketoprofen ext release
ketoprofen immediate release
Lofena®
meclofenamate sodium
mefenamic acid
meloxicam capsule
Nalfon®
Naprelan CR®
Naprosyn Suspension®
naproxen (generic for Anaprox)
naproxen delayed release
naproxen/esomeprazole (generic for Vimovo)
naproxen suspension
oxaprozin
Pennsaid®
piroxicam
Relafen DS®
Tolectin®
tolmetin sodium
Vimovo®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications; **OR**
- Contraindication or drug to drug interaction with the preferred medications; **OR**
- History of unacceptable side effects; **OR**
- Therapeutic failure of one month each with two preferred medications

See additional medication-specific criteria below:

VIMOVO® (NAPROXEN/ESOMEPRAZOLE) AND IBUPROFEN/FAMOTIDINE

- History of or active GI bleed/ulcer OR
- Risk for bleed/ulcer –
- Therapeutic failure with one preferred medication

Duration of Approval: For the duration of the prescription up to 1 year, unless otherwise noted in Medication-Specific Information

OPHTHALMIC ANTIHISTAMINES	**Preferred Agents:** *No Prior Authorization required* azelastine ketotifen fumarate (OTC Only) olopatadine (OTC only) **Non-Preferred Agents:** *Prior Authorization required* alcaftadine Alrex® bepotastine Bepreve® epinastine Lastacaft® loteprednol (generic for Alrex) olopatadine RX Pataday® Pataday® Once daily Zaditor® Zerviate® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with one preferred medication **Duration of Approval**: 1 year

Ophthalmic Anti-Inflammatory/Immunomodulator	**Preferred Agents:** *No Prior Authorization required* Restasis® single-use vials Xiidra® **Non-Preferred Agents:** *Prior Authorization required* Cequa® cyclosporine (generic Restasis®) Eysuvis® Miebo® Restasis® multidose vials Tyrvaya® Verkazia® Vevye® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a six-week trial with one preferred medication; **AND** **See additional medication-specific criteria below:** EYSUVIS® (LOTEPREDNOL) • For renewal: Patient has had an examination under magnification (e.g., slit lamp) and evaluation of the intraocular pressure (IOP) • Renewal Length of approval: 2 weeks MIEBO® (PERFLUOROHEXYLOCTANE/PF) • Patient is 18 years of age or older; **AND** • Quantity Limit: 3.0 mls per 30 days VERKAZIA® (CYCLOSPORINE): (PDL criteria do not apply) • Patient is ≥4 years of age; **AND** • Diagnosis of moderate to severe vernal keratoconjunctivitis; **AND** • Trial and failure, contraindication, or intolerance to one of the following: o Topical ophthalmic "dual-action" mast cell stabilizer and antihistamine (e.g., olopatadine, azelastine) **OR** o Topical ophthalmic mast cell stabilizers (e.g., cromolyn); **AND** • Prescribed by or in consultation with an ophthalmologist or optometrist VEVYE® (CYCLOSPORINE) • Patient is 18 years of age or older; **AND** • Quantity Limit: 2 ml per 30 days **Duration of Approval**: 1 year (Except Eysuvis – 2 weeks)
Ophthalmic Fluoroquinolones	**Preferred Agents:** *No Prior Authorization required* ciprofloxacin moxifloxacin (generic for Vigamox®) ofloxacin **Non-Preferred Agents:** *Prior Authorization Criteria below* Besivance® Gatifloxacin levofloxacin moxifloxacin (generic for Moxeza®) Ocuflox® Vigamox® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with one preferred medication **Duration of Approval**: 1 year

Ophthalmic Macrolides	**Preferred Agents:** *No Prior Authorization required* erythromycin 0.5% eye ointment **Non-Preferred Agents:** *Prior Authorization required* Azasite® eye drops **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Therapeutic failure with one preferred medication **Duration of Approval**: 1 year
OPHTHALMIC MAST CELL STABILIZERS	**Preferred Agents:** *No Prior Authorization required* cromolyn sodium **Non-Preferred Agents:** *Prior Authorization Criteria below* Alomide® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with one preferred medication **Duration of Approval**: 1 year
OPHTHALMIC NSAIDS	**Preferred Agents:** *No Prior Authorization required* diclofenac flurbiprofen ketorolac **Non-Preferred Agents:** *Prior Authorization required* Acular® Acular LS® Acuvail® bromfenac (generic for Bromsite®) bromfenac sodium (generic for Prolensa®) Bromsite® Ilevro® Ketorolac LS Nevanac® Prolensa® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Medical necessity of lower strength dosages for post-operative pain relief; **OR** • Therapeutic failure with a trial with one preferred medication **Duration of Approval**: 1 year

Opioids – Long Acting	**Preferred Agents:** *Clinical Prior Authorization for codeine and tramadol containing products only* morphine sulfate ER tablet Oxycontin® tramadol ER tablet **Preferred Agent PA Criteria:** • ≥ 12 years of age (for codeine and tramadol containing products only) **Non-Preferred Agents:** *Prior Authorization required (see MME criteria below)* Belbuca® Conzip ER® Diskets hydrocodone ER capsules (generic Zohydro ER®) hydrocodone ER tablets (generic Hysingla ER®) hydromorphone ER® Hysingla ER® Methadone Methadose tablet dispersible, oral concentrate morphine sulfate ER caps (generic Avinza®) morphine sulfate ER caps (generic Kadian®) MS Contin® oxycodone ER oxymorphone ER tramadol ER capsules **Non-Preferred Agent PA Criteria:** • ≥ 12 years of age (for codeine and tramadol containing products only); **AND** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure of one week with one preferred medication **See additional medication-specific criteria below:** BELBUCA® • Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia; **AND** • Patient ≥ 18 years old **Duration of Approval**: 6 months for Zohydro® ER; 1 year for all other medications **Chronic Opioid Management with High Morphine Milligram Equivalents (MME)** **Note:** Total daily MME of >90 MME/day requires review using the criteria below. This limit applies to *all* opioids (i.e. short acting, long, acting, transdermal including PDL preferred and non-preferred drugs) **Initial High MME Exceptions:** If any are "True", no further information is required and member meets the requirements for this section. If all are "False" then proceed to the remaining requirements under *Additional High MME Criteria*. • Does the patient have documented "current" cancer-related pain? • Does the patient have pain related to sickle cell disease? • Is the patient in hospice or palliative care? • Patient resides in a long-term care or other facility that is exempt from reporting to or checking the State Prescription Drug Monitoring Program (i.e. MAPS) (NOTE: upon discharge from long-term care member must meet the additional high MME Criteria below). **Additional High MME Criteria:** • **Prescribers must attest to *all* the following:** o Risk assessment has been performed o Pain Medication Agreement with informed consent has been reviewed with, completed and signed by the patient o MAPS/NarxCare report has been reviewed by prescriber in last 30 days. (Please do not submit the MAPS report.) Concurrently prescribed drugs have been reviewed and that based on prescriber's assessment the drugs and doses are safe for the member. o Concurrently prescribed drugs have been reconciled and reviewed for safety o The following non-opioid pain interventions have been recommended and/or utilized: ▪ Non-opioid medications ▪ Adjuvant therapies such as physical therapy (PT), occupational therapy (OT), behavioral therapies, or weight loss o A toxicology screen (urine or blood) from a commercial lab has been performed at appropriate intervals. Results from toxicology screen showed expected results. o Patient has been counseled on obtaining and the appropriate utilization of a Narcan (naloxone) kit.

	○ If applicable, the patient has been counselled on the potential increased risk of adverse effects when opioids are taken concomitantly with opioid potentiators (e.g. benzodiazepines/sedative hypnotics, stimulants, gabapentinoids, muscle relaxers). • **Additional Documentation:** ○ Current documentation provided outlining pain related history and physical(s) including clinical justification supporting need for exceeding high MME ○ Recent non-opioid medications utilized for pain management or rationale these cannot be used ○ Documentation includes list of all current opioid medications (long and short-acting) and when the regimen was initiated. ○ If patient is currently pregnant, must provide the name and location of the OB/GYN following this high-risk pregnancy ○ Duration of current opioid therapy and current daily Morphine Milligram Equivalent ○ There are numerous apps that can be used to calculate the daily MME. Additional information on Calculating Total Daily Dose of Opioids is available at: ▪ CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR **Criteria for Continuation of Therapy:** • The patient must continue to meet high MME criteria and provide all required documentation • Documentation of taper plan or rationale why taper is not appropriate is required

Opioids - Short and Intermediate Acting	**SHORT ACTING OPIOID 7-DAY LIMIT** Claims submitted for short acting narcotics for more than a 7-day supply for opioid naïve patients (i.e., those with no claim for an opioid medication within the past 180 days) will deny for prior authorization. This applies to all short and intermediate acting narcotics. **Preferred Agents:** *Clinical Prior Authorization for codeine and tramadol containing products only* codeine codeine/APAP Endocet hydrocodone/APAP hydromorphone oral tablets morphine sulfate tablets, solution, suppository oxycodone tabs (5mg, 10mg, 15mg) oxycodone oral solution oxycodone/APAP tramadol-acetaminophen tramadol **Preferred Agent PA Criteria:** • ≥ 12 years of age (for codeine and tramadol containing products only) **Non-Preferred Agents:** *Prior Authorization required (see MME criteria below)* butorphanol codeine / APAP/caffeine /butalbital codeine / ASA /caffeine /butalbital Dilaudid® all forms fentanyl citrate buccal Fentora® Fioricet w/ Codeine® hydrocodone/ ibuprofen hydromorphone suppository levorphanol meperidine tablets, solution Nalocet® oxycodone capsule oxycodone tablets (20mg, 30mg) oxycodone oral concentrated solution oxymorphone pentazocine/naloxone Percocet® Prolate® Roxicodone® RoxyBond® Seglentis® tramadol oral solution (generic Qdolo solution) **Non-Preferred Agent PA Criteria:** • ≥ 12 years of age (for codeine and tramadol containing products only); **AND** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure of one week each with two preferred medications **See additional medication-specific criteria below:** FENTANYL – ORAL (FENTORA®) • Management of breakthrough cancer pain in patients established on immediate release and long-acting opioid therapy. • Requests for controlled substances must be under the name and ID of the prescribing physician. • ≥ 18 years of age • Medication must be prescribed by a physician who is experienced in the use of Schedule II opioids • Current dosage regimen of the long acting and regularly prescribed immediate release opioids must be maximally optimized. • No concomitant use of other inducers of cytochrome P450 • No concomitant use of other inhibitors of cytochrome P450 ROXYBOND® (OXYCODONE) TABLETS • PDL criteria may be bypassed to allow coverage if an abuse deterrent formulation is needed

SEGLENTIS (CELECOXIB/TRAMADOL)

- Patient age is 12 years and older; **AND**
- Prescriber attests that Seglentis will not be used for postoperative management in children younger than 18 years of age following tonsillectomy and/or adenoidectomy; **AND**
- Quantity Limit = 120 tablets per 30 days

TRAMADOL ORAL SOLUTION

- Patient age is 12 years and older; **AND**
- Allow if patient has difficulty swallowing tablets
- Quantity limit = 80 mL per day (400mg/day)

Duration of Approval: 1 year

Chronic Opioid Management with High Morphine Milligram Equivalents (MME)
Note: Total daily MME of >90 MME/day requires review using the criteria below. This limit applies to *all* opioids (i.e. short acting, long, acting, transdermal including PDL preferred and non-preferred drugs)
Initial High MME Exceptions: If any are "True", no further information is required and member meets the requirements for this section. If all are "False" then proceed to the remaining requirements under *Additional High MME Criteria*.

- Does the patient have documented "current" cancer-related pain?
- Does the patient have pain related to sickle cell disease?
- Is the patient in hospice or palliative care?
- Patient resides in a long-term care or other facility that is exempt from reporting to or checking the State Prescription Drug Monitoring Program (i.e. MAPS) (NOTE: upon discharge from long-term care member must meet the additional high MME Criteria below).

Additional High MME Criteria:

- **Prescribers must attest to *all* the following:**
  - Risk assessment has been performed
  - Pain Medication Agreement with informed consent has been reviewed with, completed and signed by the patient
  - MAPS/NarxCare report has been reviewed by prescriber in last 30 days. (Please do not submit the MAPS report.) Concurrently prescribed drugs have been reviewed and that based on prescriber's assessment the drugs and doses are safe for the member.
  - Concurrently prescribed drugs have been reconciled and reviewed for safety
  - The following Non-opioid pain interventions have been recommended and/or utilized:
    - Non-opioid medications
    - Adjuvant therapies such as physical therapy (PT), occupational therapy (OT), behavioral therapies, or weight loss
  - A toxicology screen (urine or blood) from a commercial lab has been performed at appropriate intervals. Results from toxicology screen showed expected results.
  - Patient has been counseled on obtaining and the appropriate utilization of a Narcan (naloxone) kit.
  - If applicable, the patient has been counselled on the potential increased risk of adverse effects when opioids are taken concomitantly with opioid potentiators (e.g. benzodiazepines/sedative hypnotics, stimulants, gabapentinoids, muscle relaxers).
- **Additional Documentation:**
  - Current documentation provided outlining pain related history and physical(s) including clinical justification supporting need for exceeding high MME
  - Recent non-opioid medications utilized for pain management or rationale these cannot be used
  - Documentation includes list of all current opioid medications (long and short-acting) and when the regimen was initiated.
  - Duration of current opioid therapy and current daily Morphine Milligram Equivalent
    - There are numerous apps that can be used to calculate the daily MME. Additional information on Calculating Total Daily Dose of Opioids is available at: CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR
  - If patient is currently pregnant, must provide the name and location of the OB/GYN following this high-risk pregnancy

Criteria for Continuation of Therapy:

- The patient must continue to meet high MME criteria and provide all required documentation
- Documentation of taper plan or rationale why taper is not appropriate is required

Opioids – Transdermal	**Preferred Agents:** *No Prior Authorization required (see MME criteria below)* Butrans® patches fentanyl patches 12, 25, 50, 75, and 100 mcg only (generic only) **Non-Preferred Agents:** *Prior Authorization required (see MME criteria below)* buprenorphine patches (generic Butrans®) fentanyl generic patches 37.5 mcg, 62.5 mcg and 87.5 mcg only **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medication • History of unacceptable side effects • Therapeutic failure of one week with the preferred medication **Duration of Approval**: 1 year **Chronic Opioid Management with High Morphine Milligram Equivalents (MME)** **Note:** Total daily MME of >90 MME/day requires review using the criteria below. This limit applies to *all* opioids (i.e. short acting, long, acting, transdermal including PDL preferred and non-preferred drugs) **Initial High MME Exceptions:** If any are "True", no further information is required and member meets the requirements for this section. If all are "False" then proceed to the remaining requirements under *Additional High MME Criteria*. • Does the patient have documented "current" cancer-related pain? • Does the patient have pain related to sickle cell disease? • Is the patient in hospice or palliative care? • Patient resides in a long-term care or other facility that is exempt from reporting to or checking the State Prescription Drug Monitoring Program (i.e. MAPS) (NOTE: upon discharge from long-term care member must meet the additional high MME Criteria below). **Additional High MME Criteria:** • **Prescribers must attest to *all* the following:** ○ Risk assessment has been performed ○ Pain Medication Agreement with informed consent has been reviewed with, completed and signed by the patient ○ MAPS/NarxCare report has been reviewed by prescriber in last 30 days. (Please do not submit the MAPS report.) Concurrently prescribed drugs have been reviewed and that based on prescriber's assessment the drugs and doses are safe for the member. ○ Concurrently prescribed drugs have been reconciled and reviewed for safety ○ The following Non-opioid pain interventions have been recommended and/or utilized: ▪ Non-opioid medications ▪ Adjuvant therapies such as physical therapy (PT), occupational therapy (OT), behavioral therapies, or weight loss ○ A toxicology screen (urine or blood) from a commercial lab has been performed at appropriate intervals. Results from toxicology screen showed expected results. ○ Patient has been counseled on obtaining and the appropriate utilization of a Narcan (naloxone) kit. ○ If applicable, the patient has been counselled on the potential increased risk of adverse effects when opioids are taken concomitantly with opioid potentiators (e.g. benzodiazepines/sedative hypnotics, stimulants, gabapentinoids, muscle relaxers). • **Additional Documentation:** ○ Current documentation provided outlining pain related history and physical(s) including clinical justification supporting need for exceeding high MME ○ Recent non-opioid medications utilized for pain management or rationale these cannot be used ○ Documentation includes list of all current opioid medications (long and short-acting) and when the regimen was initiated. ○ Duration of current opioid therapy and current daily Morphine Milligram Equivalent ○ There are numerous apps that can be used to calculate the daily MME. Additional information on Calculating Total Daily Dose of Opioids is available at: CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR ○ If patient is currently pregnant, must provide the name and location of the OB/GYN following this high-risk pregnancy **Criteria for Continuation of Therapy:** • The patient must continue to meet high MME criteria and provide all required documentation • Documentation of taper plan or rationale why taper is not appropriate is required

Oral Hypoglycemics – 2nd Generation Sulfonylureas	**Preferred Agents:** *No Prior Authorization required* glimepiride glipizide / glipizide ER glyburide glyburide micronized **Non-Preferred Agents:** *Prior Authorization required* Glucotrol XL® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with two preferred medications within the same class **Duration of Approval**: 1 year
Oral Hypoglycemics – Alpha-Glucosidase Inhibitors	**Preferred Agents:** *No Prior Authorization required* acarbose miglitol **Non-Preferred Agents:** *Prior Authorization required* Precose® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with two preferred medications within the same class **Duration of Approval**: 1 year
Oral Hypoglycemics – Biguanides	**Preferred Agents:** *No Prior Authorization required* metformin metformin XR (generic Glucophage XR®) **Non-Preferred Agents:** *Prior Authorization required* Glumetza® metformin 625mg, 750mg tablets metformin ER osmotic (generic for Fortamet) metformin ER (generic for Glumetza) metformin solution (generic for Riomet immediate release) Riomet® Riomet ER® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with a preferred medication **Duration of Approval**: 1 year

Oral Hypoglycemics – Combinations	**Preferred Agents:** *Clinical Prior Authorization below* glyburide / metformin Janumet®/Janumet XR® Jentadueto® Synjardy® / Synjardy XR® Xigduo XR® **Clinical PA Criteria for Preferred Agents That Contain a DPP-4 Inhibitor:** • Discontinuation of GLP-1 agonists **Non-Preferred Agents:** *Prior Authorization required* Actoplus Met® alogliptin/metformin alogliptin/pioglitazone dapagliflozin/metformin ER Duetact® glipizide / metformin Glyxambi® Invokamet® / Invokamet XR® Jentadueto XR® Kazano® Oseni® pioglitazone/glimepiride pioglitazone/metformin Qtern® saxagliptin/metformin ER sitagliptin/metformin sitagliptin/metformin ER Segluromet® Steglujan® Trijardy XR Zituvimet®/ Zituvimet XR® **Non-Preferred Agent PA Criteria:** • Discontinuation of GLP-1 agonists (Only applies to products that contain a DPP-4 inhibitor); **AND** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with two preferred medications within the same class **Duration of Approval**: 1 year
Oral Hypoglycemics – DPP4 Inhibitors	**Preferred Agents:** *Clinical Prior Authorization below* Januvia® Tradjenta® **Clinical Preferred Agent PA Criteria** • Discontinuation of GLP-1 agonists **Non-Preferred Agents:** *Prior Authorization required* alogliptin Nesina® saxagliptin sitagliptin (generic for Zituvio®) Zituvio® **Non-Preferred Agent PA Criteria:** • Discontinuation of GLP-1 agonists; **AND** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with two preferred medications within the same class **Duration of Approval**: 1 year

Oral Hypoglycemics – SGLT2 Inhibitors	**Preferred Agents:** No *Prior Authorization required* Farxiga® Jardiance® **Non-Preferred Agents:** *Prior Authorization required* dapagliflozin Inpefa® Invokana® Steglatro® **Non-preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with two preferred medications within the same class **Duration of Approval**: 1 year
Oral Hypoglycemics – Thiazolidinediones	**Preferred Agents:** *No Prior Authorization required* pioglitazone **Non-Preferred Agents:** *Prior Authorization required* Actos® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with a preferred medication **Duration of Approval**: 1 year
OSTEOPOROSIS AGENTS: BISPHOSPHONATES	**Preferred Agents:** *No Prior Authorization required* alendronate sodium **Non-Preferred Agents:** *Prior Authorization Criteria below* Actonel® alendronate sodium oral solution Atelvia® Binosto® Boniva® Fosamax® Fosamax Plus D® Ibandronate risedronate (Actonel) risedronate (Atelvia) **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Trial and failure with six months with one preferred medication • Unique FDA approved indication not included in preferred medications **Duration of Approval**: 1 year

OSTEOPOROSIS AGENTS: OTHER	**Preferred Agents:** *No Prior Authorization required* Calcitonin nasal spray **Non-Preferred Agents:** *Prior Authorization Criteria below* Forteo® teriparatide Tymlos® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Trial and failure with six months with one preferred medication • Unique FDA approved indication not included in preferred medications **See additional medication-specific criteria below:** FORTEO® (TERIPARATIDE) – PDL CRITERIA DOES NOT APPLY • Treatment of osteoporosis in postmenopausal women who are at high risk for fractures • Increase of bone mass in men with primary or hypogonadal osteoporosis who are at high risk for fractures • Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture • Length of authorization: maximum cumulative duration of 2 years per lifetime, unless clinical documentation is provided showing patient remains at or has returned to having a high risk for fracture TYMLOS® (ABALOPARATIDE) – PDL CRITERIA DOES NOT APPLY • Treatment of osteoporosis in postmenopausal women who are at high risk for fractures; **OR** • Treatment of osteoporosis in men who are at high risk for fractures • Length of authorization: maximum cumulative duration of 2 years per lifetime (includes any prior use of Forteo) **Duration of Approval**: 1 year (Forteo and Tymlos – maximum 2 years per lifetime)
OSTEOPOROSIS AGENTS: SERMs	**Preferred Agents:** *No Prior Authorization required* raloxifene **Non-Preferred Agents:** *Prior Authorization Criteria below* Evista® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Trial and failure with six months with one preferred medication • Unique FDA approved indication not included in preferred medications **Duration of Approval**: 1 year

Otic Antibiotics	**Preferred Agents:** *No Prior Authorization required* ciprofloxacin-dexamethasone (generic for Ciprodex®) neomycin-polymyxin-HC ear soln/susp ofloxacin otic **Non-Preferred Agents:** *Prior Authorization Criteria below* ciprofloxacin otic ciprofloxacin-fluocinolone (generic for Otovel®) Cipro HC® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure (duration = 3 days) with one preferred medication **Duration of Approval**: 1 year for all medications
Oxazolidinones	**Preferred Agents:** *No Prior Authorization required* Linezolid tablets **Non-Preferred Agents:** *Prior Authorization Criteria below* Linezolid suspension Sivextro® Zyvox® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medication • Contraindication or drug to drug interaction with the preferred medication • History of unacceptable side effects **See additional medication-specific criteria below:** SIVEXTRO® (TEDIZOLID PHOSPHATE) For diagnosis of non-purulent cellulitis • Trial, failure or intolerance to first line beta lactam therapy; **AND** • Trial, failure or intolerance to at least two of the following agents: clindamycin, sulfamethoxazole/trimethoprim (SMZ/TMP), tetracycline (minocycline or doxycycline); **OR** • Culture and sensitivity results demonstrate resistance to first line agents; **OR** • Contraindication or intolerance to all other treatment options For diagnosis of purulent cellulitis, abscess, or wound infection: • Trial, failure or intolerance to at least two of the following agents: clindamycin, sulfamethoxazole/trimethoprim (smz/tmp), tetracycline (minocycline or doxycycline); **OR** • Culture and sensitivity results demonstrate resistance to first line agents; **OR** • Contraindication or intolerance to all other treatment options **Duration of Approval**: 2 months

Pancreatic Enzymes	**Preferred Agents:** *Prior Authorization required* Creon® Zenpep® **Clinical PA Criteria:** • Cystic fibrosis or chronic pancreatic insufficiency. **Non-Preferred Agents:** *Prior Authorization required* Pertzye® Viokace® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after one-month trial of one preferred agent **See additional medication-specific criteria below:** PERTYZE®, VIOKACE® • Must meet both PDL (trial on preferred medication) and clinical criteria **Duration of Approval**: 1 year
Phosphate Depleters	**Preferred Agents:** *Clinical Prior Authorization below* calcium acetate capsules and tablets sevelamer carbonate tablets (generic for Renvela) **Clinical PA Criteria:** • Diagnosis of chronic kidney disease **Non-Preferred Agents:** *Prior Authorization Criteria below* Auryxia® ferric citrate Fosrenol® / Fosrenol® powder pak lanthanum Renvela powder pkts and tablets sevelamer carbonate powder pkts (generic for Renvela) sevelamer tablets (generic for Renagel) Velphoro® Xphozah® **Non-Preferred Agent PA Criteria:** • Diagnosis of chronic kidney disease; **AND** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with one month with one preferred medication **See additional medication-specific criteria below:** VELPHORO® • Trial on **two** preferred medications XPHOZAH® • Trial of two preferred medications • Patient is currently receiving dialysis **Duration of Approval**: 1 year

PHOSPODIESTERASE-4 (PDE-4) INHIBITORS	**Preferred Agents:** *Clinical Prior Authorization below* roflumilast (generic Daliresp®) **Preferred Agent PA Criteria:** ROFLUMILAST • Severe COPD associated with chronic bronchitis and a history of exacerbations; **AND** • Trial/failure on at least one first-line or second-line agent; **AND** • Adjunctive therapy (roflumilast must be used in conjunction with first-line or second-line agent) **Non-Preferred Agents:** *Prior Authorization required* Daliresp® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with one preferred medication **See additional medication-specific criteria below:** DALIRESP® *(roflumilast)* • Severe COPD associated with chronic bronchitis and a history of exacerbations; **AND** • Trial/failure on at least one first-line or second-line agent; **AND** • Adjunctive therapy (Daliresp® must be used in conjunction with first-line or second-line agent) **Duration of Approval**: 1 year
PLATELET AGGREGATION INHIBITORS	**Preferred Agents:** *No Prior Authorization required* Brilinta® clopidogrel prasugrel **Non-Preferred Agents:** *Prior Authorization required* aspirin/dipyridamole dipyridamole Effient® Plavix® ticagrelor **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with one-month trial of one preferred medication **See additional medication-specific criteria below:** EFFIENT® • Due to a black box warning related to increase in risk of bleeds in patients > 75 • PDL criteria must be met and the MD will need to document medical necessity or clinical rationale for consideration. **Duration of Approval**: 1 year

Potassium Binders	**Preferred Agents:** *No Prior Authorization required* Lokelma® powder packets sodium polystyrene sulfonate oral powder SPS Suspension kionex suspension **Non-Preferred Agents:** *Prior Authorization required* Veltassa® oral powder packets **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects**: OR** • Therapeutic failure with a one-month trial of one preferred medication **Duration of Approval**: 1 year
Progestational Agents	**Preferred Agents:** medroxyprogesterone (oral) progesterone (oral) norethindrone (oral) **Non-Preferred Agents:** *Prior Authorization required* Crinone® (vaginal) progesterone (intramuscular) Prometrium® (oral) Provera® (oral) **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects**: OR** • Therapeutic failure with a one-month trial of a preferred medication for the indication **See additional medication-specific criteria below:** CRINONE® (*PROGESTERONE VAGINAL)* • Excluded for diagnosis of fertility **Duration of Approval**: 1 year, unless otherwise noted

Progestins for Cachexia	**Preferred Agents:** *No Prior Authorization required* megestrol oral suspension (generic Megace®) **Non-Preferred Agents:** *Prior Authorization required* megestrol oral suspension (generic Megace ES®) **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Therapeutic failure after one-month trial of one preferred agent **Duration of Approval**: 1 year
Proton Pump Inhibitors	**Preferred Agents:** *No Prior Authorization required* Nexium® susp pkts omeprazole (Rx) capsules pantoprazole tablets Protonix® suspension **Non-Preferred Agents:** *Prior Authorization required* Dexilant® caps dexlansoprazole (generic for Dexilant) esomeprazole magnesium capsules, susp pkts esomeprazole magnesium OTC caps, tabs Konvomep® lansoprazole caps, ODT lansoprazole OTC caps Nexium® capsules omeprazole OTC caps, tabs, ODT omeprazole/sodium bicarbonate caps, susp pkts pantoprazole suspension Prevacid caps, solutabs Prilosec® susp Protonix® tablets Rabeprazole tabs Zegerid® caps, susp pkts **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after one-month trial with one preferred medication **Duration of Approval**: 1 year

Pulmonary Arterial Hypertension (PAH) Agents	**Preferred Agents:** *Prior Authorization required* Adempas® Alyq® ambrisentan (generic for Letairis) Opsumit® sildenafil suspension (generic for Revatio®) sildenafil tablets (generic for Revatio®) tadalafil (generic for Adcirca) Tracleer® tablets Tyvaso® Uptravi® Ventavis® **Preferred Agent PA Criteria:** • Diagnosis of pulmonary hypertension • Must be prescribed by, or in consultation with, a cardiologist or pulmonologist **Non-Preferred Agents:** *Prior Authorization Criteria below* Adcirca® bosentan tablets (generic for Tracleer) Letairis® Liqrev® Opsynvi® Orenitram ER® Orenitram Titration Kit Revatio® suspension Revatio® tablets Tadliq® Tracleer® suspension Tyvaso DPI® Winrevair **Non-Preferred Agent PA Criteria:** • Diagnosis of pulmonary hypertension; **AND** • Must be prescribed by, or in consultation with, a cardiologist or pulmonologist; **AND** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with one-month trial of one preferred medication **See additional medication-specific criteria below:** OPSYNVI® *(MACITENTAN/TADALAFIL)* • Patient is ≥ 18 years of age • Quantity limit: 1 per day TADLIQ® (TADALAFIL) • Patient is 18 years of age or older WINREVAIR® (SOTATERCEPT-CSRK) • Diagnosis of PAH WHO group 1, functional class II or III; **AND** • Documented trial and failure of, or contraindication to, at least 2 months of combination therapy including one PDE-5 inhibitor AND one ERA; **AND** • Winrevair is being used as add on therapy to standard care; **AND** • Platelet count of > 50,000/mm3 (> (>50x109/L), acceptable hemoglobin levels, and other labs in accordance with the product label; **AND** • Counseling has occurred regarding the need for effective contraception due to risk of embryo-fetal toxicity, and the risk of impaired fertility with use of this medication **Duration of Approval**: 1 year

Quinolones	**Preferred Agents:** *No Prior Authorization required* Cipro® suspension ciprofloxacin tablets, suspension levofloxacin **Non-Preferred Agents:** *Prior Authorization required* Avelox® Baxdela® Cipro® tablets moxifloxacin ofloxacin **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Infection is caused by an organism that is resistant to the NO PA REQUIRED quinolone medications • Trial/failure (duration = 3 days) of any two preferred quinolone medications • Antibiotic therapy initiated in hospital **Duration of Approval**: Date of service; if needed, longer lengths may be approved for transplant recipients
Skeletal Muscle Relaxants	**Preferred Agents:** *No Prior Authorization required* ***(except baclofen solution)*** baclofen tablets baclofen oral solution (Ozobax) cyclobenzaprine methocarbamol orphenadrine citrate tizanidine tablets BACLOFEN ORAL SOLUTION (*OZOBAX*) • allow if the patient has difficulty swallowing **Non-Preferred Agents:** *Prior Authorization Criteria below* Amrix® baclofen suspension (generic Fleqsuvy) chlorzoxazone cyclobenzaprine ER Dantrium® dantrolene sodium Fexmid® Fleqsuvy® Lorzone® Lyvispah® metaxalone Norgesic Forte® orphenadrine-aspirin-caffeine Tanlor® tizanidine capsules Zanaflex® capsules and tablets **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with two preferred medications • Non-preferred criteria does not apply to dantrolene sodium if diagnosis is cerebral palsy **See additional medication-specific criteria below:** FLEQSUVY ORAL SOLUTION (BACLOFEN) (PDL criteria do not apply) • Trial and failure with preferred oral solution LYVISPAH GRANULE PACKETS (BACLOFEN) (PDL criteria do not apply) • Trial and failure with preferred oral solution **Duration of Approval**: 1 year

Topical Antibiotics	**Preferred Agents:** *No Prior Authorization required* mupirocin ointment **Non-Preferred Agents:** *Prior Authorization required* Centany® mupirocin cream Xepi® Cream **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Therapeutic failure after one month with one preferred medication **See additional medication-specific criteria below:** XEPI® CREAM (OZENOXACIN) • Quantity limit = 2 tubes per month • Length of authorization – 1 month **Duration of Approval:** 1 year
Topical Steroids – Low Potency	**Preferred Agents:** *No Prior Authorization required* hydrocortisone acetate cream hydrocortisone acetate ointment hydrocortisone/aloe hydrocortisone cream hydrocortisone lotion hydrocortisone ointment **Non-Preferred Agents:** *Prior Authorization required* alclometasone dipropionate ointment and cream Capex® Shampoo Derma-smooth – FS ® Desonide® ointment, cream, lotion fluocinolone 0.01% oil hydrocortisone solution Proctocort® Texacort ® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects • Trial and failure of 14 days with **one** of preferred medications (hydrocortisone) **Duration of Approval**: For the duration of the prescription up to 6 months

Topical Steroids – Medium Potency	**Preferred Agents:** *No Prior Authorization required* fluticasone propionate cream fluticasone propionate ointment mometasone furoate ointment mometasone furoate cream mometasone furoate solution **Non-Preferred Agents:** *Prior Authorization required* Beser kit Beser lotion betamethasone valerate foam clocortolone cream Cutivate® cream and lotion fluocinolone acetonide cream, solution flurandrenolide lotion, ointment fluticasone propionate lotion hydrocortisone butyrate cream, lotion, ointment, solution hydrocortisone valerate cream and ointment Locoid® lotion Locoid Lipocream® Pandel® prednicarbate cream and ointment Synalar® solution, cream and ointment Synalar TS® kit **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects **OR** • Trial and failure of 14 days with **one** of the preferred medications **Duration of Approval**: For the duration of the prescription up to 6 months
Topical Steroids – High Potency	**Preferred Agents:** *No Prior Authorization required* betamethasone dipropionate cream, lotion, ointment betamethasone valerate cream, lotion, ointment fluocinonide cream, ointment, gel and solution triamcinolone acetonide cream, lotion, ointment **Non-Preferred Agents:** *Prior Authorization required* amcinonide cream betamethasone dipropionate augmented cream, gel, lotion, ointment clobetasol 0.025% cream desoximetasone cream, ointment, gel, and spray diflorasone diacetate cream and ointment Diprolene® ointment fluocinonide emollient halcinonide Halog® cream, ointment, solution Kenalog® aerosol Topicort® cream, ointment, gel, and spray triamcinolone spray Vanos® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects **OR** • Trial and failure of 14 days with **one** of the preferred medications **Duration of Approval**: For the duration of the prescription up to 6 months

Topical Steroids – Very High Potency	**Preferred Agents:** *No Prior Authorization required* clobetasol propionate solution clobetasol propionate 0.05% cream clobetasol propionate ointment halobetasol propionate cream halobetasol propionate ointment **Non-Preferred Agents:** *Prior Authorization Criteria below* ApexiCon® E Cream Bryhali® clobetasol emollient and lotion clobetasol propionate foam, gel, spray and shampoo Clobex® spray and shampoo Clodan® shampoo and kit halobetasol propionate (generic for Lexette®) Olux® Tovet Kit Tovet Emollient Ultravate® lotion **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects • Trial and failure of 14 days with **one** of the preferred medications **Duration of Approval**: For the duration of the prescription up to 6 months
Ulcerative Colitis – Oral	**Preferred Agents:** *No Prior Authorization required* Apriso® mesalamine (generic for Lialda) Pentasa® sulfasalazine/ sulfasalazine DR **Non-Preferred Agents:** *Prior Authorization required* Azulfidine DR® Balsalazide budesonide ER (generic Uceris) Colazal® Delzicol® Dipentum® Giazo® Lialda® mesalamine (generic for Apriso) mesalamine (generic for Asacol) mesalamine (generic for Delzicol) Mesalamine (generic for Pentasa®) Uceris® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after one-month trial with one preferred medication **Duration of Approval**: 1 year

Urinary Tract Antispasmodics	**Preferred Agents:** *No Prior Authorization required* fesoterodine ER oxybutynin / oxybutynin ER solifenacin **Non-Preferred Agents:** *Prior Authorization required* darifenacin ER Detrol®/ Detrol LA® Ditropan XL® flavoxate HCL Gemtesa® mirabegron ER Myrbetriq® Oxytrol® tolterodine/ tolterodine ER Toviaz® trospium/ trospium ER Vesicare® Vesicare LS Suspension® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial of one preferred medication **Duration of Approval**: 1 year

Uterine Disorder Treatments	**Preferred Agents:** *Clinical Prior Authorization Below* Myfembree® Oriahnn® Orilissa ® MYFEMBREE® (RELUGOLIX/NORETHINDRONE) • Patient ≥ 18 years old; **AND** • Patient is premenopausal**; AND** • Confirmed diagnosis of: • Uterine leiomyomas (fibroids) with heavy menstrual bleeding; **AND** ○ Failure on an adequate trial of hormonal contraceptives (including oral or transdermal formulations, vaginal ring or intrauterine device); **OR** • Moderate to severe pain associated with endometriosis; **AND** ○ Failure on an adequate trial of the following therapies: ▪ Non-steroidal anti-inflammatory drugs (NSAIDS); **AND** ▪ Hormonal contraceptives (including oral or transdermal formulations, vaginal ring or intrauterine device); **AND** • Prescribed by or in consultation with an obstetrics/gynecology or reproductive specialist; **AND** • Pregnancy is excluded prior to treatment; **AND** • Patient will use effective non-hormonal contraception during treatment with requested medication and one week after stopping therapy; **AND** • Patient does not have osteoporosis; **AND** • Patient does not have severe hepatic impairment (Child Pugh C); **AND** • Patient has not completed a previous course of hormonal treatment that could contribute to bone loss; **AND** • Quantity limit: 28 tablets per 28 days ORIAHNN® (ELAGOLIX/ESTRADIOL/NORETHINDRONE) • Patient ≥ 18 years old; **AND** • Patient is premenopausal; **AND** • Confirmed diagnosis of uterine leiomyomas (fibroids) with heavy menstrual bleeding; **AND** • Failure on an adequate trial of hormonal contraceptives (including oral or transdermal formulations, vaginal ring or intrauterine device); **AND** • Prescribed by or in consultation with an obstetrics/gynecology or reproductive specialist; **AND** • Pregnancy is excluded prior to treatment; **AND** • Patient will use effective non-hormonal contraception during treatment with requested medication and one week after stopping therapy; **AND** • Patient does not have osteoporosis; **AND** • Patient does not have severe hepatic impairment (Child Pugh C); **AND** • Patient has not completed a previous course of hormonal treatment that could contribute to bone loss; **AND** • Quantity limit: 56 tablets per 28 days ORILISSA® (ELAGOLIX) 150MG • Patient ≥ 18 years old; **AND** • Confirmed diagnosis of endometriosis; **AND** • Failure on an adequate trial of the following therapies: ○ Non-steroidal anti-inflammatory drugs (NSAIDs); **AND** ○ Hormonal contraceptives (including oral or transdermal formulations, vaginal ring or intrauterine device); **AND** • Prescribed by or in consultation with an obstetrics/gynecology or reproductive specialist; **AND** • Pregnancy is excluded prior to treatment; **AND** • Patient will use effective non-hormonal contraception during treatment with requested medication and one week after stopping therapy; **AND** • Patient does not have osteoporosis; **AND** • Patient does not have severe hepatic impairment (Child Pugh C); **AND** • Patient has not completed a previous course of hormonal treatment that could contribute to bone loss; **AND** • Quantity limit: 28 tablets per 28 days *Continued >*

	ORILISSA® (ELAGOLIX) 200MG • Patient ≥ 18 years old; **AND** • Confirmed diagnosis of endometriosis with dyspareunia; **AND** • Failure on an adequate trial of the following therapies: ○ Non-steroidal anti-inflammatory drugs (NSAIDs); **AND** ○ Hormonal contraceptives (including oral or transdermal formulations, vaginal ring or intrauterine device); **AND** • Prescribed by or in consultation with an obstetrics/gynecology or reproductive specialist; **AND** • Pregnancy is excluded prior to treatment; **AND** • Patient will use effective non-hormonal contraception during treatment with requested medication and one week after stopping therapy; **AND** • Patient does not have osteoporosis; **AND** • Patient does not have severe hepatic impairment (Child Pugh C); **AND** • Patient has not completed a previous course of hormonal treatment that could contribute to bone loss; **AND** • Treatment duration of Orilissa 200mg twice daily has not exceeded a total of 6 months; **AND** • Quantity limit: 56 tablets per 28 **Duration of Approval**: • Oriahnn, Orilissa 150mg and Myfembree = 1 year (maximum total duration of 24 months) • Orilissa 200mg = 6 months (maximum duration)
Vaginal Antibiotics	**Preferred Agents:** *No Prior Authorization required* Cleocin (clindamycin) Ovules clindamycin (generic for Cleocin) 2% cream Clindesse (clindamycin) 2% Cream metronidazole (generic for Metro-Gel and Vandazole) 0.75% gel Nuvessa (metronidazole) 1.3% Gel **Non-Preferred Agents:** *Prior Authorization required* Cleocin (clindamycin) 2% Cream Metronidazole 1.3% Gel Vandazole (metronidazole) 0.75% Gel Xaciato (clindamycin) 2% Gel **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with one preferred medication **See additional medication-specific criteria below:** XACIATO® (CLINDAMYCIN) • Patient is 12 years of age or older **Duration of Approval**: 6 months