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 <u>Medicaid Approved Drug List (ADL)</u> 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 <u>Medicaid Approved Drug List</u> (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.

Priority Health

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 Prime Therapeutics:

https://mi.primetherapeutics.com/

DRUG	CRITERIA
acitretin	Approved Diagnosis:
Attruby	Approved Diagnosis: Wild-type ATTR-CM Hereditary 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 OR clinical evidence of heart failure AND 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 AND Will not be used concurrently with Amvuttra, Onpattro, Wainua, Vyndaqel, or Vyndamax 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 Attruby in combination with Vyndaqel, Vyndamax, Amvuttra, Wainua or Onpatro. Therapy may be discontinued if patient is noncompliant with medical or pathamacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug 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 daysContinuation 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:
 - o 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:
 - o 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
 - o patient has congenital heart disease (CHD); OR
 - o 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
 - o 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

- 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)
 - o Initial authorization: up to 8 months
 - o Continuation authorization: N/A
- Diagnosis of Microscopic (lymphocytic and collagenous) colitis
 - o Initial authorization: up to 3 months
 - o 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 monthsContinuation 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:
 - o iPTH iPTH level must be > 300 (biPTH >160) to initiate therapy
 - o calcium calcium must be > 8.4 to initiate therapy
 - renal function
 - o 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:
 - o history of seizures
 - o 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
 - o myasthenia gravis
 - o demyelinating peripheral neuropathies (such as Guillain-Barre syndrome)
 - o Alzheimer's disease
 - o Lambert Eaton myasthenic syndrome

- 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 pretreatment baseline.



desmopressin

Approved Diagnosis:

• Diabetes Insipidus

Approval Timeframe:

Initial authorization: 1 yearContinuation 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:
 - o Appetite stimulation in AIDS patients: 3 months
 - Chemotherapy-induced nausea and vomiting: duration of chemotherapy treatment
- Continuation authorization:
 - o 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
 - o Dexamethasone
 - o Promethazine
 - Prochlorperazine
- Treatment plan must be included with request

- Documentation showing the patient has experienced a positive response to therapy must be submitted
 - o 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
 - o Azathioprine
 - o 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 monthsContinuation authorization: N/A

<u>Prescriber Specialty Requirement:</u> 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

<u>Prescriber Specialty Requirement:</u> 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:
 - o Age 6-11 years: 2 tubes (20gm) is covered every 30 days
 - o 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 timespan of data, then sexual maturity rating (Tanner Staging) and measurement of sex hormones may be submitted with only 6 months of growth data.
 - o 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 there 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:
 - o Visually prominent acne consisting of many comedones, inflamed papules, or pustules
 - o 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

- 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 monthsContinuation 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
 - o 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
- Symptomatic chronic heart failure

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:

Chronic Kidney Disease (CKD) with Type 2 Diabetes

- 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

Symptomatic Chronic Heart Failure

- Have a diagnosis of chronic heart failure (NYHA Class II-IV); AND
- Patient is at least 18 years of age; AND
- Must be prescribed by, or in consultation with (notes must be submitted), a cardiologist; AND
- Patient has been using at least 2 of the following HF medications at goal doses for HF treatment or maximally tolerated dosing:
 - o ACE inhibitor, ARB, or Entresto
 - o Beta blocker (e.g., Bisoprolol, carvedilol, or sustained release metoprolol)
 - o Spironolactone
 - o Oral diuretic (e.g., furosemide); AND
- Documented LVEF of ≥40% assessed within the previous 12 months; AND
- At baseline, members meet all the following:
 - o Estimated glomerular filtration rate (eGFR) ≥ 25ml/min/1.73m2; **AND**
 - Serum potassium level <5.0mEq/L

- Documentation showing both of the following:
 - o 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
 - o 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:
 - o Gabapentin
 - o tricyclic antidepressant
 - nerve block
 - o trigger point injection
 - o SNRIs
 - o 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:
 - o intralesional corticosteroid therapy; OR
 - o prescription topical corticosteroid therapy (e.g., betamethasone dipropionate); OR
 - o 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.

- 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

 $\bullet \qquad \hbox{Baseline hemoglobin level between 5.5 g/dL and } 10.5 g/dL$

- 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:
 - o Reduction in severe allergic reactions
 - o Reduction in epinephrine use
 - $\circ \qquad \text{Reduction in physician/clinic visits due to peanut allergy (physician office/ER visits/hospitalizations)}$
 - 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
 - o 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)
 - o 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
 - o infectious disease specialist
 - o 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
 - o Latent infection due to mycobacterium tuberculosis
 - o 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 yearContinuation authorization: 1 year

Prescriber Specialty Requirement:

- Must be prescribed by a doctor with one of the following specialties
 - Pulmonologist
 - o Infectious Disease Specialist

Age Limitation: Patient must be age 5 years or older

Initial Criteria

• Documentation confirming diagnosis must be submitted

- · 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:
 - o toxoplasmosis: 6 weeks
 - o pneumocystis: 3 months
- Continuation authorization:
 - toxoplasmosis: 6 monthspneumocystis: 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
- · Living independently
- Baseline ALS functional rating scale (ALSFRS-R);
 - o 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

- Documentation that the patient has experienced a positive clinical response compared to baseline (e.g., slowing
 of disease progression)
- 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
 - o 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
 - o 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
 - o 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 <u>BOTH</u> of the following categories:
 - Tricyclic Antidepressants (TCA) OR Selective Serotonin Reuptake Inhibitors (SSRIs) or Serotoninnorepinephrine 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:
 - o 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;
 - o adherence to the prescribed medication regimen
 - o 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
 - o 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.

<u>Initial Criteria:</u> 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:
 - o Must be age ≥12 years
- · Treatment of psoriasis:
 - o Cream: must be age ≥18 years
 - o 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:
 - o 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)

<u>Approval Timeframe:</u>

- Initial authorization: 1 year
- Continuation authorization: 1 year

<u>Prescriber Specialty Requirement:</u> 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:
 - o Total kidney volume (TKV) of at least 750mL,; OR
 - o 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:
 - o 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

- 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:
 - o 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:
 - o 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. riociquat) 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.

- 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
- Atopic dermatitis

<u>Approval Timeframe:</u>

- Initial authorization: 6 months
- Continuation authorization: 1 year

Prescriber Specialty Requirement:

Must be prescribed by, or in consultation with, a dermatologist

Age Limitation:

- For plaque psoriasis, patient must be age 18 years or older
- For atopic dermatitis, patient must be age 2 years or older

Initial Criteria

Plaque Psoriasis:

- Documentation confirming treatment of plaque psoriasis; 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
- For quantities greater than 60 grams per 30 days, prescriber must attest that the volume of drug is necessary for adequate treatment of the patient

Atopic Dermatitis:

- Prescribed to treat atopic dermatitis; AND
- Documented trial, failure, or intolerance to at least one topical steroid; OR
- Clinical documentation as to why topical steroid therapy is not appropriate; AND
- For quantities greater than 60 grams per 30 days, prescriber must attest that the volume of drug is necessary for adequate treatment of the patient

- 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
 - o at least one prior hospitalization of heart failure
 - o 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

- 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;
 - o 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 <u>BOTH</u> of the following categories:
 - Tricyclic Antidepressants (TCA) OR Selective Serotonin Reuptake Inhibitors (SSRIs) or Serotoninnorepinephrine 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:
 - o 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)
 - o 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
 - o 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;
 - o 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
 - o 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).

- 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, Zoryve Foam)
- 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:
 - o Must be age 9 years or older for Seborrheic Dermatitis
 - Must be 12 years or older for Plaque Psoriasis

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

- 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 Zestril® / Zestoretic® Non-Preferred Agent PA Criteria: Allergy to the preferred medications; OR Contraindication or drug to drug interaction with the preferred medications; 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. OBRELIS® PDL criteria may be bypassed if patient is unable to swallow tablets.
Alpha Adrenergic Agents	Preferred Agents: No Prior Authorization required



Alzheimer's Dementia

Preferred Agents: No Prior Authorization required

donepezil tabs, ODT Exelon® patch

galantamine immediate release memantine immediate release rivastigmine capsules

<u>Non-Preferred Agents:</u> Prior Authorization Required. Criteria below.

Adlarity®

donepezil 23 mg®

galantamine ER caps, solution

memantine ER
Namenda®
Namenda XR®
Namzaric®
rivastigmine patch

Zunveyl

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



Androgenic Agents (topical)

<u>Preferred Agents:</u> 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:
 - o Severe renal or cardiac diseases
 - o Benign prostatic hyperplasia with obstruction
 - Prostate cancer
 - o 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:
 - o Severe renal or cardiac diseases
 - Benign prostatic hyperplasia with obstruction
 - Prostate cancer
 - o Undiagnosed genital bleeding
 - o Breast cancer
 - Pregnancy



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 Diovan® / Diovan HCTZ® Edarbi®

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

<u>Preferred Agents:</u> 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



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



Anticoagulants

Preferred Agents: No Prior Authorization required

dabigatran etexilate

Eliquis®

enoxaparin Jantoven®

Jantoven

warfarin

Xarelto®/ Xarelto® Dose Pack

Non-Preferred Agents: Prior Authorization Required. Criteria below.

Arixtra®

Fondaparinux

Fragmin® syringes and vials

Lovenox®

Pradaxa®

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:

AKYNZEC

- 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)



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

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; OR
- Diagnosis of mucormycosis; AND
- Patient is 6 years or older; AND
- Patient weight is >16 kg; 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
 - o 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
<u>Duration of Approval</u> : For the duration of the prescription up to 6 months, unless otherwise noted in Medication-Specific Information

Antifungals – Topical

<u>Preferred Agents:</u> 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

econazole nitrate 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

Ertaczo®

Extina®

ketoconazole foam

Ketodan®

Loprox®

Lotrimin AF®

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

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

<u>Preferred Agents:</u> 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

 $\underline{\textbf{Preferred Agents}} \hbox{:} \ \ \textit{No Prior Authorization required}$

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



Antihyperuricemic Agents

Preferred Agents: No Prior Authorization required

allopurinol tablet

colchicine tablets (generic for Colcrys)

febuxostat tablet

probenecid/colchicine tablet

probenecid tablet

Non-Preferred Agents: Prior Authorization Required. Criteria below.

Colchicine capsules (generic for Mitigare)

Colcrys (colchicine) 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



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
 - o 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

<u>Preferred Agents:</u> 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

Symbravo® 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

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 (Iiraglutide) or Zepbound) concurrently with a DPP4 inhibitor; AND
- Patient age ≥12 years (phentermine/topiramate, Wegovy, Xenical, Saxenda(liraglutide)); OR
- Patient age ≥ 17 years (phentermine); AND
- Patient age ≥12 years to <18 years must have an initial BMI per <u>CDC growth charts</u> 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:
 - o 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:
 - o 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.

Non-Preferred Agents: Prior Authorization Required.

liraglutide

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; AND
- Must also meet the preferred agent PA criteria listed above

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 <u>CDC growth charts</u> from baseline weight at initiation of therapy.

Duration of Approval: 6 months for both initial and renewal requests



AntiParkinson's Agents – Dopamine Agonists

<u>Preferred Agents:</u> No Prior Authorization required

pramipexole ropinirole

Non-Preferred Agents: Prior Authorization Required. Criteria below.

bromocriptine Neupro® Onapgo® 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

See additional medication-specific criteria below:

ONAPAGO (APOMORPHINE) CARTRIDGE

- Patient is ≥ 18 years of age; 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 3 hours of "off" time per day despite optimized carbidopa/levodopa therapy



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)

Preferred Agent PA Criteria:

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®

Nourianz®

 $\hbox{Ongentys} \\ {}^{\textstyle \otimes}$

Rytary®

selegiline capsule, tablet

Sinemet®

tolcapone

trihexyphenidyl elixir (*Carve Out)

Vyalev®

Xadago®

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

Non-Preferred Agents: Prior Authorization Required. Criteria below.

Flumadine® Tamiflu® Xofluza®

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)

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



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) 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



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 HFA (except Prasco) albuterol sulfate nebulizer solution

Ventolin HFA® (MDI) Xopenex HFA® (MDI)

Non-Preferred Agents: Prior Authorization Required. Criteria below.

Airsupra®

albuterol HFA (manufactured by Prasco)

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



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

 $\underline{\textbf{Non-Preferred Agents}} : \textit{ Prior Authorization Required. Criteria below}.$

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



Biologic Immunomodulators

AGENTS TO TREAT ANKYLOSING SPONDYLITIS Preferred Agents: No Prior Authorization required

adalimumab-adbm (unbranded Cyltezo)

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-fkjp (unbranded Hulio)

adalimumab-ryvk (unbranded Simlandi)

Amjevita®

Cimzia®, Cimzia Kit®

Cyltezo®

Hadlima®

Hulio®

Hyrimoz®

Idacio®

 $Rinvoq \\ {\tt \$}$

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-ATTO)

- 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

Continued >



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® (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 **GIANT CELL ARTERITIS** (GCA)

Non-Preferred Agents: Prior Authorization Required

Actemra Rinvoq

Tyenne

Non-Preferred Agent PA Criteria:

ACTEMRA® (TOCILIZUMAB)

- Patient is 18 years of age or older; AND
- Diagnosis of giant cell arteritis

RINVOQ® (UPADACITINIB)

- Patient is 18 years or older; AND
- Diagnosis of giant cell arteritis

TYENNE® (TOCILIZUMAB-AAZG)

- Patient is 18 years or older; AND
- Diagnosis of giant cell arteritis



Biologic Immunomodulators

AGENTS TO TREAT CROHN'S DISEASE

Preferred Agents: No prior authorization except select Preferred biosimilars for Stelara - see criteria below

adalimumab-adbm (unbranded Cyltezo)

Humira®

Pyzchiva®

Steqeyma®

Non-Preferred Agents: Prior Authorization Required. Criteria below.

Abrilada®

adalimumab-aacf (unbranded Idacio)

adalimumab-aaty (unbranded Yuflyma)

adalimumab-adaz (unbranded Hyrimoz)

adalimumab-fkjp (unbranded Hulio)

adalimumab-ryvk (unbranded Simlandi) Amjevita®

Cimzia®, Cimzia Kit®

Cvltezo®

Entyvio®

Hadlima®

Hulio®

Hyrimoz®

Idacio® Omvoh®

Otulfi®

Rinvog®

Simlandi® Selarsdi®

Skvrizi®

Stelara®

Tremfya®

ustekinumab-aekn (unbranded Selarsdi)

ustekinumab-ttwe (unbranded Pyzchiva)

Yesintek®

Yuflyma®

Yusimry®

Zymfentra® pen/syringe

Preferred Agent PA Criteria:

PYZCHIVA® (USTEKINUMAB-TTWE)

- Diagnosis of Crohn's disease; AND
- Trial/failure of preferred Tumor Necrosis Factor (TNF) Blocker; AND
- Quantity limit
 - 520mg for initial dose 0
 - 90mg every 8 weeks

STEQEYMA (USTEKINUMAB-STBA)

- Diagnosis of Crohn's disease; AND
- Trial/failure of preferred Tumor Necrosis Factor (TNF) Blocker; AND
- Quantity limit
 - 520mg for initial dose
 - 0 90mg every 8 weeks

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-ATTO)

- 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®, Delzicol®), olsalazine (Dipentum®), balsalazide (sulfasalazine (Azulfidine®)]
 - o Oral steroid
 - o 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

<u>OMVOH</u>

- 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

OTULFI (USTEKINUMAB-AAUZ)

- Diagnosis of Crohn's disease AND
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- · Quantity limit:
 - o 520mg for initial dose
 - o 90mg every 8 weeks

RINVOQ® (UPADACITINIB)

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

SELARSDI® (USTEKINUMAB-AEKN)

- Diagnosis of Crohn's disease; AND
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- Quantity limit
 - 520mg for initial dose
 - o 90mg every 8 weeks

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
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- Quantity limit:
 - o 520 mg for initial dose
 - o 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

USTEKINUMAB-TTWE (UNBRANDED PYZCHIVA®)

- Diagnosis of Crohn's disease; AND
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- Quantity limit:
 - o 520mg for initial dose
 - o 90mg every 8 weeks

YESINTEK (USTEKINUMAB-STBA)

- Diagnosis of Crohn's disease; AND
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- · Quantity Limit:
 - o 520 mg for initial dose
 - o 90 mg every 8 weeks

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

<u>Duration of Approval:</u> 1 year, unless otherwise noted in Medication-Specific Information



Biologic Immunomodulators

AGENTS TO TREAT **HIDRADENITIS SUPPURATIVA**

Preferred Agents: No Prior Authorization required adalimumab-adbm (unbranded Cyltezo)

> Cosentyx® Humira®

Non-Preferred Agents: Prior Authorization Required. Criteria below.

Abrilada®

adalimumab-aacf (unbranded Idacio) adalimumab-aaty (unbranded Yuflyma) adalimumab-adaz (unbranded Hyrimoz) 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-ATTO)

- 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

<u>Duration of Approval:</u> 1 year, unless otherwise noted in Medication-Specific Information

Biologic Immunomodulators

AGENTS TO TREAT JUVENILE IDIOPATHIC ARTHRITIS Preferred Agents: No Prior Authorization required

adalimumab-adbm (unbranded Cyltezo)

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-fkjp (unbranded Hulio) adalimumab-ryvk (unbranded Simlandi)

Amjevita®

Cimzia®, Cimzia Kit®

Cyltezo®

Hadlima®

Hulio®

Hyrimoz®

Idacio®

Kevzara®

Orencia® SC Rinvog®

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-ATTO)

- 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

<u>Duration of Approval:</u> 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® 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® (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

<u>Duration of Approval:</u> 1 year, unless otherwise noted in Medication-Specific Information



Biologic Immunomodulators

AGENTS TO TREAT PLAQUE PSORIASIS

Preferred Agents: No prior authorization except select Preferred biosimilars for Stelara – see criteria below

adalimumab-adbm (unbranded Cyltezo)

Cosentyx®

Enbrel®

Humira®

Pyzchiva®

Steqeyma®

Preferred Agent PA Criteria:

PYZCHIVA® (USTEKINUMAB-TTWE)

- Diagnosis of plaque psoriasis; AND
- Trial/failure of preferred Tumor Necrosis Factor (TNF) Blocker; AND
- · Quantity limit
 - $_{\odot}$ 90 mg every 12 weeks with initial dose Week 0 and 4

STEQEYMA (USTEKINUMAB-STBA)

- Diagnosis of plaque psoriasis; AND
- Trial/failure of preferred Tumor Necrosis Factor (TNF) Blocker; AND
- Quantity limit:
 - o 90 mg every 12 weeks with initial dose Week 0 and 4

Non-Preferred Agents: Prior Authorization Required. Criteria below.

Abrilada® **Otulfi®** adalimumab-aacf (unbranded Idacio) Selarsdi® Simlandi® adalimumab-aaty (unbranded Yuflyma) adalimumab-adaz (unbranded Hyrimoz) Skvrizi® adalimumab-fkjp (unbranded Hulio) Sotyktu® Stelara® adalimumab-ryvk (unbranded Simlandi) Amjevita® Taltz® Bimzelx® Tremfya®

Cimzia®, Cimzia Kit® ustekinumab-aekn (unbranded Selarsdi)
Cyltezo® ustekinumab-ttwe (unbranded Pyzchiva)

Hadlima®Yesintek®Hulio®Yuflyma®Hyrimoz®Yusimry®

Idacio® Ilumva®

Otezla®/Otezla XR®

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 plague 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®/OTEZLA XR (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; AND
- For Otezla must weigh at least 20 kg OR
- For Otezla XR must weigh at least 50 kg

OTULFI (USTEKINUMAB-AAUZ)

- Diagnosis of plaque psoriasis; AND
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- Quantity limit:
 - o 90 mg every 12 weeks with initial dose Week 0 and 4

SELARSDI® (USTEKINUMAB-AEKN)

- Diagnosis of plaque psoriasis; AND
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- Quantity limit:
 - 90 mg every 12 weeks with initial dose Week 0 and 4

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
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- Quantity limit:
 - o 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)

USTEKINUMAB-TTWE (UNBRANDED PYZCHIVA®)

- Diagnosis of plaque psoriasis; AND
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- Quantity limit:
 - o 90mg every 12 weeks with initial dose Week 0 and 4

YESINTEK (USTEKINUMAB-STBA)

- Diagnosis of psoriasis; AND
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- Quantity limit:
 - o 90 mg every 12 weeks with initial dose Week 0 and 4

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

<u>Duration of Approval:</u> 1 year, unless otherwise noted in Medication-Specific Information



Biologic Immunomodulators

AGENTS TO TREAT
PSORIATIC ARTHRITIS

<u>Preferred Agents:</u> No Prior Authorization required except select Preferred biosimilars for Stelara – see criteria below

adalimumab-adbm (unbranded Cyltezo)

Cosentyx® Enbrel® Humira® Pyzchiva®

Steqeyma®

Preferred Agent PA Criteria:

PYZCHIVA® (USTEKINUMAB-TTWE)

- Diagnosis of psoriatic arthritis; AND
- Trial/failure of preferred Tumor Necrosis Factor (TNF) Blocker; AND
- · Quantity limit
 - o 90 mg every 12 weeks with initial dose Week 0 and 4

STEQEYMA (USTEKINUMAB-STBA)

- Diagnosis of psoriatic arthritis; AND
- Trial/failure of preferred Tumor Necrosis Factor (TNF) Blocker; AND
- Quantity limit:
 - o 90 mg every 12 weeks with initial dose Week 0 and 4

Non-Preferred Agents: Prior Authorization Required. Criteria below

Abrilada® Otulfi® adalimumab-aacf (unbranded Idacio) Selarsdi® adalimumab-aaty (unbranded Yuflyma) adalimumab-adaz (unbranded Rinvoq LQ® Hyrimoz) Simlandi®

adalimumab-fkjp (unbranded Hulio) Simponi®, Simponi Aria®

adalimumab-ryvk (unbranded Simlandi) Skyrizi®
Amjevita® Stelara®
Bimzelx® Taltz®
Cimzia®, Cimzia Kit® Tremfya®

Cyltezo® ustekinumab-aekn (unbranded Selarsdi)
Hadlima® ustekinumab-ttwe (unbranded Pyzchiva)

Hulio® Xeljanz®, Xeljanz XR®

Hyrimoz® Yesintek® Idacio® Yuflyma® Orencia® SC Yusimry

Otezla/Otezla XR®

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-ATTO)

- 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®/OTEZLA XR (APREMILAST)

- Patient is 6 years of age or older; AND
- · Diagnosis of active psoriatic arthritis; 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; AND
- For Otezla must weigh at least 20 kg OR
- For Otezla XR must weigh at least 50 kg

OTULFI (USTEKINUMAB-AAUZ)

- Diagnosis of psoriatic arthritis; AND
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- Quantity limit:
 - o 90 mg every 12 weeks with initial dose Week 0 and 4

RINVOQ® / RINVOQ LQ® (UPADACITINIB)

- Patient must be 2 years or older; AND
- · Diagnosis of psoriatic arthritis

SELARSDI® (USTEKINUMAB-AEKN)

- Diagnosis of psoriatic arthritis; AND
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- Quantity limit:
 - o 90 mg every 12 weeks with initial dose Week 0 and 4

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
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- Quantity limit:
 - o 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)

USTEKINUMAB-TTWE (UNBRANDED PYZCHIVA®)

- Diagnosis of psoriatic arthritis; AND
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- Quantity limit:
 - o 90mg every 12 weeks with initial dose Week 0 and 4

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

YESINTEK (USTEKINUMAB-STBA)

- Diagnosis of psoriatic arthritis; AND
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- Quantity limit:
 - o 90 mg every 12 weeks with initial dose Week 0 and 4

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

<u>Preferred Agents:</u> No Prior Authorization required

adalimumab-adbm (unbranded Cyltezo)

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-fkjp (unbranded Hulio)

adalimumab-ryvk (unbranded Simlandi)

Amjevita®

Cimzia®, Cimzia Kit®

Cyltezo®

Hadlima®

Hulio®

Hyrimoz® Idacio®

Kevzara®

Kineret® (*Carve Out)

Olumiant®

Orencia® SC

Rinvoq®

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 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® (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

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

<u>Preferred Agents:</u> No prior authorization except select Preferred biosimilars for Stelara – see criteria below

adalimumab-adbm (unbranded Cyltezo)

Humira®

Pyzchiva®

Steqeyma®

Preferred Agent PA Criteria:

PYZCHIVA® (USTEKINUMAB-TTWE)

- Diagnosis of ulcerative colitis; AND
- Trial/failure of preferred Tumor Necrosis Factor (TNF) Blocker; AND
- Quantity limit
 - $\circ \hspace{0.5cm} \textbf{520mg for initial dose} \\$
 - o 90mg every 8 weeks

STEQEYMA (USTEKINUMAB-STBA)

- Diagnosis of ulcerative colitis; AND
- Trial/failure of preferred Tumor Necrosis Factor (TNF) Blocker; AND
- Quantity limit
 - o 520mg for initial dose
 - o 90mg every 8 weeks

Non-Preferred Agents: Prior Authorization Required. Criteria below.

Abrilada®

adalimumab-aacf (unbranded Idacio)

adalimumab-aaty (unbranded Yuflyma)

adalimumab-adaz (unbranded Hyrimoz)

adalimumab-fkjp (unbranded Hulio)

adalimumab-ryvk (unbranded Simlandi) Amjevita®

Cyltezo®

Entyvio®

Hadlima®

Hadiima® Hulio®

Hyrimoz®

Idacio®

 $\mathsf{Omvoh} \mathbb{B}$

Rinvoq® Selarsdi®

Simlandi®

Simponi®



Skyrizi®

Stelara®

Tremfya®

ustekinumab-aekn (unbranded Selarsdi)

ustekinumab-ttwe (unbranded Pyzchiva)

Velsipity®

Xeljanz®, Xeljanz XR®

Yesintek®

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-ATTO)

- · 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®, Delzicol®), olsalazine (Dipentum®), balsalazide (sulfasalazine (Azulfidine®)]
 - o Oral steroid
 - o Thiopurine [i.e., azathioprine (Imuran®), mercaptopurine (Purinethol®)]
 - o 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

OTULFI (USTEKINUMAB-AAUZ)

- Diagnosis of ulcerative colitis; AND
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- · Quantity limit:
 - o 520mg for initial dose
 - o 90mg every 8 weeks

RINVOQ® (UPADACITINIB)

- Patient must be 18 years or older; AND
- Diagnosis of moderately to severely active ulcerative colitis

SELARSDI® (USTEKINUMAB-AEKN)

- Diagnosis of ulcerative colitis; AND
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- Quantity limit:
 - o 520mg for initial dose
 - o 90mg every 8 weeks

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
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- Quantity limit:
 - o 520 mg for initial dose
 - o 90 mg every 8 weeks

TREMFYA® (GUSELKUMAB)

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

USTEKINUMAB-TTWE (UNBRANDED PYZCHIVA®)

- Diagnosis of ulcerative colitis; AND
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- Quantity limit:
 - o 520mg for initial dose
 - o 90mg every 8 weeks

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

YESINTEK (USTEKINUMAB-STBA)

- Diagnosis of ulcerative colitis; AND
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara; AND
- · Quantity limit:
 - o 520 mg for initial dose
 - o 90 mg every 8 weeks

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

<u>Preferred Agents:</u> No Prior Authorization required adalimumab-adbm (unbranded Cyltezo)

Humira®

Non-Preferred Agents: Prior Authorization Required. Criteria below.

Abrilada®

adalimumab-aacf (unbranded Idacio) adalimumab-aaty (unbranded Yuflyma)

adalimumab-adaz (unbranded Hyrimoz)

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

<u>Duration of Approval:</u> 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

<u>Preferred Agents:</u> 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

Tezruly (terazosin) 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 with a one-month trial with one preferred medication

See additional medication-specific criteria below:

TEZRULY (TERAZOSIN) ORAL SOLUTION

- Patient is ≥ 18 years of age; AND
- Patient is unable to swallow a solid oral dosage form of generic terazosin

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

<u>Preferred Agents:</u> 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

diltiazem LA tablet Matzim LA® tablet Tiadylt ER® 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



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

Fulphila® Fylnetra® Neupogen®

Non-Preferred Agents: Prior Authorization Criteria below

Granix®

Leukine®

Neulasta® syringe; Neulasta® Onpro Kit

Nivestym® Nyvepria® 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

<u>Preferred Agents:</u> No Prior Authorization required

clindamycin / benzoyl peroxide

Non-Preferred Agents: Prior Authorization Criteria below

Acanya® gel and pump

clindamycin / benzoyl peroxide (generic Onexton®)

Neuac 1.25% 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
- 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



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 selfadministered

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



Gastrointestinal Antibiotics

Preferred Agents: No Prior Authorization required

Dificid tablets®

metronidazole 250mg and 500mg tablets

neomycin tablets

tinidazole

vancomycin capsules vancomycin solution

Non-Preferred Agents: Prior Authorization required

Aemcolo®

Dificid Suspension®

Firvanq®

fidaxomicin

Flagyl® tablets and capsules

Likmez®

metronidazole capsules

nitazoxanide tablets

Vancocin®

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 per claim
- 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:
 - o For treatment of diarrhea caused by Cryptosporidium parvum or Giardia lamblia AND
 - \circ $\,$ $\,$ 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

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

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

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®

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



GI Motility, Chronic

IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D) <u>Preferred Agents:</u> 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® 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

SYMPROIC® (NALDEMEDINE TOSYLATE)

- Diagnosis of opioid induced constipation (OIC); AND
- Therapeutic failure after one-month trial of one preferred agent for OIC



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%

lopidine®

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



Glaucoma

COMBINATION ALPHA-2 ADRENERGIC-BETA BLOCKER <u>Preferred Agents:</u> 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)

lyuzeh® 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

<u>Preferred Agents:</u> No Prior Authorization required

Baqsimi® Zegalogue®

Non-Preferred Agents: Prior Authorization required

Glucagon Emergency Kit (Amphastar and Fresenius)

Gvoke® Syringe, Kit, Vial, 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
- History of trial and failure with one preferred medication



Growth Hormones

<u>Preferred Agents:</u> Prior Authorization required

Genotropin® Norditropin® Norditropin Flexpro®

Clinical PA Criteria (preferred and non-preferred):

- Reguests must be submitted by an endocrinologist or nephrologist.
- Panhypopituitarism/Hypopituitarism Cachexia, pituitary; Necrosis of pituitary (postpartum); Pituitary insufficiency NOS; Sheehan's syndrome; Simmond's disease, and Growth Hormone Deficiency
- 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:

- 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.
- 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
 - 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
 - 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



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

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



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
 - o 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
 - o 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
 - o Patient is NOT currently receiving an erythropoiesis-stimulating agent; AND
 - o 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

<u>Duration of Approval</u>: For the duration of the prescription up to 6 months, unless otherwise noted in Medication/Diagnoses-Specific Information



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:
 - Asthma with eosinophilic phenotype with eosinophil count ≥ 150 cells/mcL; **OR**
 - Oral corticosteroid dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months; AND
 - Patient must be 6 years of age or older

FASENRA® (BENRALIZUMAB):

- Patient must have severe asthma; AND
 - 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
 - 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
 - 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
 - Patient has been trained to self-administer this product; AND
 - Member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Tezspire; AND
 - Bypass PDL criteria if patient does not meet specific criteria for Preferred agents (e.g. eosinophil blood count and/or IgE blood level requirements)



AGENTS TO TREAT ATOPIC DERMATITIS

Preferred Agents: Prior Authorization required

Adbry® Dupixent® Eucrisa®

pimecrolimus (generic for Elidel)

tacrolimus

Clinical PA Criteria For Atopic Dermatitis Indications For Each Agent

- Diagnosis of atopic dermatitis
 - o Dupixent®: moderate to severe for ages ≥ 6 months
 - o pimecrolimus mild to moderate for ages > 2 years
 - o Eucrisa®: mild to moderate for ages ≥ 3 months
 - o Adbry®: moderate to severe for ages ≥ 12 years
 - o Tacrolimus 0.03%: moderate to severe for ages ≥ 2 years
 - o 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
 - o 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
 - o 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
 - o 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
- Patient has atopic dermatitis estimated to affect ≤ 20% of the body surface area; AND
- Patient age ≥12 years old

<u>Duration of Approval</u>: 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
- Patient is 12 years of age or older; AND
- Prescribed by or in consultation with an allergist, immunologist, or dermatologist; AND
- 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
- Patient is 12 years of age or older; AND
- Prescribed by or in consultation with an allergist, immunologist, or dermatologist; AND
- 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®

Preferred Agent PA Criteria:

DUPIXENT® (DUPILUMAB)

- Diagnosis of inadequately controlled chronic obstructive pulmonary disease (COPD); AND
- Patient has had an eosinophilic count ≥300 cells/mcL; AND
- Patient ≥ 18 years old; AND
- Patient is concurrently treated with triple therapy with inhaled corticosteroid [ICS], long-acting beta-2 agonist [LABA], and long-acting muscarinic antagonist [LAMA]; OR
- Patient is concurrently treated with a LABA and LAMA if ICS therapy is contraindicated.

Non-Preferred Agents: Prior Authorization Required Nucala

Non-Preferred Agent PA Criteria:

NUCALA® (MEPOLIZUMAB)

- Diagnosis of inadequately controlled chronic obstructive pulmonary disease (COPD); AND
- Patient has had an eosinophilic count ≥300 cells/mcL; AND
- Patient ≥ 18 years old; AND
- Patient is concurrently treated with triple therapy with inhaled corticosteroid [ICS], long-acting beta-2 agonist [LABA], and long-acting muscarinic antagonist [LAMA]; OR
- Patient is concurrently treated with a LABA and LAMA if ICS therapy is contraindicated.



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
 - o 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
 - o 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
 - o Patient ≥ 18 years old; **AND**
 - Patient has inadequate response after 3 consistent months use of intranasal steroids or oral corticosteroids; AND
 - $\circ \qquad \hbox{Patient is concurrently treated with intranasal corticosteroids}$

Duration of Approval: 1 year

Immunomodulators

AGENTS TO TREAT EOSINOPHILIC ESOPHAGITIS (EOE) $\underline{\textbf{Preferred Agents:}} \ \ \textbf{Clinical Prior Authorization below}$

Dupixent®

Clinical PA Criteria for eosinophilic esophagitis (EOE) Indications:

DUPIXENT® (DUPILUMAB)

- Diagnosis of eosinophilic esophagitis (EoE); AND
 - o Patient ≥ 1 years old; **AND**
 - o 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



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
 - Bypass PDL criteria of a failure with a preferred agent when the non-preferred product has a unique FDA approved indication.

Duration of Approval: 1 year

Immunomodulators

<u>Preferred Agents:</u> Clinical Prior Authorization below

Xolair

AGENTS TO TREAT IGE-MEDIATED FOOD ALLERGY

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
 - o Prescribed by or in consultation with an allergist or immunologist; AND
 - o Patient will follow food allergen avoidance in conjunction with Xolair; AND
 - o Baseline IgE level is ≥ 30 IU/ml



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
 - o Patient has vitiligo involvement estimated to affect ≤ 10% of the body surface area; AND
 - o Patient is ≥12 years old; **AND**
 - o Prescribed by or in consultation with a dermatologist
 - Bypass PDL criteria of a failure with a preferred agent when the non-preferred product has a unique FDA approved indication.

Duration of Approval: 1 year

Immunomodulators

AGENTS TO TREAT PRURIGO NODULARIS (PN) <u>Preferred Agents:</u> Clinical Prior Authorization below

Dupixent®

Clinical PA Criteria for prurigo nodularis (PN) indications:

DUPIXENT® (DUPILUMAB)

- Diagnosis of prurigo nodularis (PN); AND
 - o Patient ≥18 years old; AND
 - $\circ \qquad \hbox{Prescribed by or in consultation with a dermatologist, allergist, or immunologist}$

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)



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)



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) fluticasone ellipta (Generic Arnuity Ellipta) 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® 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

Duration of Approval: 1 year

Insulins, Mixes

<u>Preferred Agents:</u> No Prior Authorization required

Humalog® 50/50 kwikpens Humalog® 75/25 vials Humulin® 70/30 Kwikpens, vials

insulin aspart 70/30 pens, vials (generic for Novolog®)

Insulin lispro mix 75/25 kwikpens

Non-Preferred Agents: Prior Authorization required

Humalog® 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



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

Duration of Approval: 1 year

Insulins, Rapid Acting

Preferred Agents: No Prior Authorization required

Humalog® U-100 cartridges, kwikpens, tempo pens, vials insulin aspart cartridges, pens, vials (generic for Novolog®) insulin lispro U-100 kwikpens, vials (gen for Humalog)

Non-Preferred Agents: Prior Authorization required

Admelog® vials; Admelog Solostar® pens

Afrezza® inhalation cartridges

Apidra® pens, vialsFiasp® pens, vials, pumpcart

Humalog® U-200 kwikpens Lyumjev® kwikpens, tempo pens Novolog® cartridges, 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 pens, vials Humulin® R vials

Non-Preferred Agents: Prior Authorization required

Novolin® N vials Novolin® R 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



Preferred Agents: No Prior Authorization required Insulin Proglycem Suppressants 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 Preferred Agents: See Age Criteria for chew tablets below Leukotriene montelukast tablets, 4mg chew tabs, 5mg chew tabs **Inhibitors Preferred Agent PA Criteria:** MONTELUKAST (SINGULAIR®) clinical rationale why the (swallow) tablet dosage form inappropriate for the following age limits: o 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 **Preferred Agents:** No Prior Authorization required **Lipotropics: Fibric** fenofibrate, nanocrystallized (generic for Tricor®) **Acid Derivatives** 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®)

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



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

 $\underline{\textbf{Preferred Agents:}} \ \ \textit{No Prior Authorization required}$

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



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

7 atio

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:
 - o 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)



Lipotropics: PCSK9 Inhibitors

Preferred Agents: Prior Authorization required

Praluent® Repatha®

Clinical PA Criteria:

REPATHA® (EVOLOCUMAB) AND PRALUENT® (ALIROCUMAB)

Initial Criteria:

- Must have diagnosis of
 - o atherosclerotic cardiovascular disease (ASCVD); or
 - o homozygous familialhypercholesterolemia (HoFH); or
 - o 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)
 - o ASCVD: LDL-C is < 70 mg/dL
 - o 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®

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



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; 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 macrolide medications; OR
- Therapeutic failure (duration = 3 days) with two preferred medications

<u>Duration of Approval</u>: 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), relapsingremitting 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:
 - o Attestation of tolerance to maintenance dose
 - o 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), relapsingremitting 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

Continued >



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), relapsingremitting 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), relapsingremitting 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



Nasal Antihistamines

<u>Preferred Agents:</u> 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



NON-STEROIDAL ANTI-**INFLAMMATORY -COX II INHIBITORS**

<u>Preferred Agents:</u> 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® Lofena®

diclofenac sodium ER meclofenamate sodium diclofenac epolamine 1.3% patch mefenamic acid diclofenac-misoprostol meloxicam capsule diclofenac potassium Nalfon®

diclofenac 2% pump (generic Pennsaid®) Naprelan CR®

diflunisal Naprosyn Suspension® Dolobid® naproxen (generic for Anaprox) dual action pain (OTC -ibuprofen/apap) naproxen delayed release

naproxen/esomeprazole (generic for Vimovo) EC-naproxen

etodolac / etodolac ER naproxen suspension

Feldene® oxaprozin fenoprofen Pennsaid® flurbiprofen piroxicam ibuprofen-famotidine Relafen DS® indomethacin ext release, oral susp Tolectin® tolmetin sodium ketoprofen ext release

ketoprofen immediate release 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



Ophthalmic Anti-Inflammatory/Immu nomodulator

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:
 - Topical ophthalmic "dual-action" mast cell stabilizer and antihistamine (e.g., olopatadine, azelastine)
 OR
 - 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 Fluoroguinolones

<u>Preferred Agents:</u> No Prior Authorization required

ciprofloxacin

moxifloxacin (generic for Vigamox®)

ofloxacin

Non-Preferred Agents: Prior Authorization Criteria below

Besivance® Ciloxan® 0.3% Oint. 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



Ophthalmic Macrolides

<u>Preferred Agents:</u> 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



Opioids - Long Acting

<u>Preferred Agents:</u> 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 <u>Additional High MME Criteria</u>.

- 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. If patient is currently pregnant, must provide the name and location of the OB/GYN following this high-risk 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 <u>Additional High MME Criteria</u>.

- 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.
- 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
- 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.
- o 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
- o 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: <u>CDC Clinical Practice</u>
 <u>Guideline for Prescribing Opioids for Pain United States, 2022 | MMWR</u>
- 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 <u>Additional High MME Criteria</u>.

- 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
- 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
- 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
- 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
- o 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: <u>CDC Clinical Practice Guideline for Prescribing</u> <u>Opioids for Pain — United States, 2022 | MMWR</u>
- 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 - AlphaGlucosidase 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

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



Oral Hypoglycemics - Combinations

Preferred Agents: No Prior Authorization required (except for agents containing DPP-4 indicated with *)

glyburide / metformin *Janumet®/*Janumet XR® *Jentadueto®/*Jentadueto XR® Synjardy® / Synjardy XR® Xigduo XR®

Clinical PA Criteria for Preferred Agents That Contain a DPP-4 Inhibitor (indicated by leading *):

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®

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

Tradjenta® Januvia®

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 one preferred medication within the same class



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

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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: BISPHOSPHONATE S

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



OSTEOPOROSIS AGENTS: OTHER

Preferred Agents: No Prior Authorization required (except for Forteo)

Calcitonin nasal spray

Forteo®

Non-Preferred Agents: Prior Authorization Criteria below

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)

- 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)

<u>Duration of Approval</u>: 1 year (Forteo and Tymlos – maximum 2 years per lifetime)

OSTEOPOROSIS AGENTS: SERMs

<u>Preferred Agents:</u> 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



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

<u>Duration of Approval</u>: 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

<u>Preferred Agents:</u> 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

XPH0ZAH®

- Trial of two preferred medications
- Patient is currently receiving dialysis



PHOSPODIESTERAS E-4 (PDE-4) INHIBITORS

<u>Preferred Agents:</u> 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.



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

<u>Preferred Agents:</u> 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

<u>Preferred Agents:</u> 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

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



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) bosentan susp. (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



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; OR
- Contraindication or drug to drug interaction with the preferred medications; OR
- · History of unacceptable side effects; OR
- Infection is caused by an organism that is resistant to the NO PA REQUIRED quinolone medications; OR
- Trial/failure (duration = 3 days) of any two preferred quinolone medications; OR
- Antibiotic therapy initiated in hospital

See additional medication-specific criteria below:

MOXIFLOXACIN

- PDL criteria and quantity limit do not apply when used for the treatment of active drug-susceptible pulmonary tuberculosis for patients ≥12 years of age.
- Length of approval = 17 weeks when used for the treatment of active drug-susceptible pulmonary tuberculosis

<u>Duration of Approval</u>: Date of service; if needed, longer lengths may be approved for transplant recipients



Skeletal Muscle Relaxants

<u>Preferred Agents:</u> 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



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

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

<u>Duration of Approval</u>: For the duration of the prescription up to 6 months

Topical Steroids - Very High Potency

<u>Preferred Agents:</u> 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

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

<u>Duration of Approval</u>: For the duration of the prescription up to 6 months



Ulcerative Colitis - Oral

<u>Preferred Agents:</u> No Prior Authorization required

mesalamine (generic for Lialda)

Pentasa®

sulfasalazine/ sulfasalazine DR

Non-Preferred Agents: Prior Authorization required

Azulfidine DR®

Balsalazide

budesonide ER (generic Uceris)

Delzicol® Dipentum® Giazo®

Lialda® mesalamine (generic for Apriso) mesalamine (generic for Asacol) mesalamine (generic for Delzicol) Mesalamine (generic for Pentasa®)

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

<u>Preferred Agents:</u> No Prior Authorization required

fesoterodine ER

 $Myrbetriq {\small \$} \ oxybutynin \ / \ oxybutynin \ ER$

solifenacin

tolterodine/ tolterodine ER

trospium

Non-Preferred Agents: Prior Authorization required

darifenacin ER
Ditropan XL®
flavoxate HCL
Gemtesa®
mirabegron ER
Oxytrol®
Toviaz®
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



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

