Priority Health Choice, Medicaid PA Criteria

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

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

What is a prior authorization?

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

How to know when a medication requires prior authorization

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

How to use this criteria document

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

Not all medications are covered by this plan

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

Priority Health

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

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

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

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

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

Corlanor	**Approved Diagnosis:** • Heart Failure **Approval Timeframe:** • Initial authorization: 12 months • Continuation authorization: 12 months **Prescriber Specialty Requirement:** none **Age Limitation:** none **Initial Criteria:** • Diagnosis of stable symptomatic chronic heart failure (NYHA class II, III or IV); **AND** • Left ejection fraction ≤35%; **AND** • The patient is in sinus rhythm; **AND** • Patient has a resting heart rate >70 beats per minute; **AND** • One of the following: ○ Patient is on maximum tolerated doses of beta-blockers (e.g., carvedilol, metoprolol succinate, bisoprolol); **OR** ○ Patient has a contraindication to or intolerance to beta-blocker therapy; **OR** For pediatric patients ages 6 months and older: • Diagnosis of stable symptomatic heart failure due to dilated cardiomyopathy (DCM); **AND** • Patient is in sinus rhythm; **AND** • Patient has an elevated heart rate for age **Continuation Criteria:** • Attestation that the patient has experienced positive clinical response to therapy
dalfampridine	**Approved Diagnosis:** • For treatment to improve walking in patients with Multiple Sclerosis (MS) **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 12 months **Prescriber Specialty Requirement:** none **Age Limitation:** Patient must be between ages 18 to 70 years old. **Initial Criteria:** • Must be receiving immunomodulatory therapy (unless immunomodulatory therapy is not indicated for patient's MS type) • Must have significant and continuous walking impairment that impairs ability to complete normal daily activities (such as meal preparation, household chores, etc.) attributable to ambulation or functional status despite optimal treatment for MS • Must have creatinine clearance greater than 50 mL/minute • Must have one of the following: ○ Baseline timed 25-foot walk test (T25FW) is completed within 8-45 seconds, *OR* ○ Expanded Disability Status Scale (EDSS) score that is greater than or equal to 4.5 but less than 7 • Patient must not have: ○ history of seizures ○ require the use of a wheelchair (bilateral assistance is acceptable, such as a brace, cane, or crutch, as long as the patient can walk 20 meters without resting) ○ a spinal cord injury ○ myasthenia gravis ○ demyelinating peripheral neuropathies (such as Guillain-Barre syndrome) ○ Alzheimer's disease ○ Lambert Eaton myasthenic syndrome **Continuation Criteria:** • Patient must currently meet all the initial therapy criteria listed above • Must maintain an 85% adherence rate to therapy, which will be verified based on Priority Health's medication fill history for the patient. • The patient's functional impairment must resolve as a result of increased speed of ambulation resulting in the member being able to complete instrumental activities (meal preparation, household chores, etc.) • Requires at least a 20% improvement in timed walking speed as documented by the T25FW test from pre-treatment baseline.

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

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

Exservan	**Approved Diagnosis:** • Amyotrophic Lateral Sclerosis (ALS) **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** Prescribed by or in consultation with a neurologist **Age Limitation:** Patient must be age 18 years or older **Initial Criteria** • Documentation that the patient cannot swallow tablets **Continuation Criteria** • Documentation showing the patient has experienced clinical benefit from therapy
Eysuvis	**Approved Diagnosis:** • Dry Eye Disease (DED) **Approval Timeframe:** • Initial authorization: 2 weeks • Continuation authorization: 2 weeks **Prescriber Specialty Requirement:** • Must be prescribed by an ophthalmologist **Age Limitation:** Patient must be age 18 years or older **Initial Criteria:** • Patient currently has a dry eye flare up; **AND** • Patient does NOT have viral diseases of the cornea and conjunctiva (e.g., epithelial herpes simplex keratitis [dendritic keratitis], vaccinia, and varicella), mycobacterial infection of the eye, or fungal diseases of ocular structures; **AND** • Patient has had a trial and failure of an ocular lubricant (e.g., artificial tears), including preservative-free formulation; **AND** • Patient has had a trial and failure of a generic ophthalmic steroid; **AND** • Prescriber attestation that causative factors cannot be mitigated **Continuation Criteria:** • Patient continues to meet initial criteria; **AND** • Patient has had an examination under magnification (e.g., slit lamp) and evaluation of the intraocular pressure (IOP); **AND** • Absence of unacceptable toxicity from the drug (e.g., infection, delayed healing, corneal or scleral thinning, increased IOP, cataracts); **AND** • Patient is NOT a candidate for long-term treatment or alternative therapies (e.g., punctal occlusion, ophthalmic immunomodulators); **AND** • Attestation of improved that signs and symptoms of DED has improved, but continued treatment is needed

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

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

Ingrezza	**Approved Diagnosis:** • Tardive Dyskinesia secondary to use of a dopamine antagonist • Chorea associated with Huntington's **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with, a neurologist or psychiatrist **Age Limitation:** 18 years or older **Initial Criteria:** • Documentation confirming diagnosis of chorea associated with Huntington's disease; **OR** • Documentation confirming diagnosis of Tardive Dyskinesia secondary to use of a dopamine antagonist (i.e., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.); **AND** • For tardive dyskinesia, attestation that a baseline AIMS test has been completed **Continuation Criteria:** • Attestation of patient's improvement in symptoms associated with their condition; **AND** • For tardive dyskinesia, attestation that a follow-up AIMS test has been completed **AND t**here has been a positive response to therapy
isotretinoin Amnesteem Claravis Isotretinoin Myorisan Zenatane	**Approved Diagnosis:** • For treatment of severe recalcitrant nodular 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:** • Current chart notes detailing the diagnosis, including laboratory tests as appropriate for diagnosis, must be submitted with request; **AND** • Documentation of trial, and subsequent clinical failure or intolerance, with at least 2 oral antibiotics (2 different strengths of the same drug will not be accepted). Patient must have taken antibiotics consistently for a total combined duration of at least 6 consecutive months; **AND** • Documentation of trial, and subsequent clinical failure or intolerance, with at least one topical retinoid product. Patient must have used consistently for at least 6 consecutive months. **Continuation Criteria:** • Documentation showing the patient has experienced improvement or maintained stable clinical status. • Continuation of therapy requests will be reviewed for coverage after that patient has been off therapy for a period of 2 months or more, and if warranted by persistent or recurring severe nodular 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.

Kerendia	**Approved Diagnosis:** • Chronic Kidney Disease (CKD) with Type 2 Diabetes **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** none **Age Limitation:** Patient must be age 18 years or older **Initial Criteria:** • Documentation showing member is currently receiving a maximally tolerated dosage of an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) OR has a contraindication to ACE inhibitor or ARB therapy; **AND** • Member is not taking any strong CYP3A4 inhibitors; **AND** • At baseline, member meets all of the following: ○ Estimated glomerular filtration rate (eGFR) >25ml/min/1.73m2; **AND** ○ Urine albumin-to-creatinine ratio >30mg/g; **AND** ○ Serum potassium level <5.0mEq/L **Continuation Criteria:** • Documentation showing both of the following: ○ Member has eGFR >25ml/min/1.73m2; **AND** ○ Member serum potassium level <5.0mEq/L
Lidocaine 5% patch	**Approved Diagnosis:** • Post-Herpetic Neuralgia (PHN) • Diabetic Neuropathic Pain • Peripheral polyneuropathy • SUD related concerns **Approval Timeframe:** • Initial authorization: ○ PHN: up to 90 days ○ Neuropathic pain: initially 2 months ○ Pain with SUD related concerns: up to 6 months • Continuation authorization: up to 12 months **Prescriber Specialty Requirement:** none **Age Limitation:** none **Initial Criteria:** • Documentation confirming diagnosis; **AND** Diabetic Neuropathic Pain • Must have documented trial and failure, or contraindication to, with TWO of the following: ○ Gabapentin ○ tricyclic antidepressant ○ nerve block ○ trigger point injection ○ SNRIs ○ TENS unit Peripheral Polyneuropathy • Patient must have history of substance use disorder (SUD) or SUD related concerns • Patient's peripheral polyneuropathy must not be due to post-herpetic neuralgia, diabetes, or cancer **Continuation Criteria:** • Requires documentation of positive response to the use of the patch

Livtencity	**Approved Diagnosis:** • Active Cytomegalovirus (CMV) infection/disease **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: N/A **Prescriber Specialty Requirement:** none **Age Limitation:** patient must be age 12 years or older **Initial Criteria:** • Patient is at least 12 years of age *and* weighs at least 35 kg; **AND** • Patient is a recipient of a hematopoietic stem cell or solid organ transplant; **AND** • Documentation showing Active Cytomegalovirus (CMV) infection/disease; **AND** • Patient is refractory to treatment (with or without genotypic resistance) with one of the following: ○ ganciclovir ○ valganciclovir ○ cidofovir ○ foscarnet
Octreotide	**Approved Diagnosis:** To treat: • Acromegaly • Symptoms associated with metastatic vasoactive intestinal peptide tumors • Side effects of chemotherapy/radiation • HIV/AIDS-associated diarrhea • Symptoms of metastatic carcinoid tumors • Symptoms associated with carcinoid tumors **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 1 year **Prescriber Specialty Requirement:** none **Age Limitation:** none **Initial Criteria:** • Documentation must be submitted confirming the patient's diagnosis. **Continuation Criteria:** • Documentation showing the patient has experienced improvement or maintained stable clinical status. • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
Oxbryta	**Approved Diagnosis:** • Sickle-cell disease **Approval Timeframe:** • Initial authorization: 12 months • Continuation authorization: 12 months **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation, with a hematologist or other specialist with expertise in the diagnosis and management of sickle cell disease **Age Limitation:** • Oxbryta 500mg tablet: patient must be age 12 years or older • Oxbryta 300mg tablets and tablet for suspension: patient must be age 4 years or older **Initial Criteria** • Baseline hemoglobin level between 5.5 g/dL and 10.5g/dL **Continuation Criteria** • Patient must show an increase in hemoglobin level from initial baseline; **OR** • Provider attests to other positive clinical response

Oxervate	**Approved Diagnosis:** • Neurotrophic keratitis **Approval Timeframe:** • Initial authorization: 56 days per affected eye • Continuation authorization: N/A **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation, with an ophthalmologist **Age Limitation:** Patient must be age 2 years or older **Initial Criteria** • Attestation that the patient or caregiver has been counseled on proper administration technique • Documentation that the member has a diagnosis of stage 2 (recurrent/persistent epithelial defect) or stage 3 (corneal ulcer) neurotrophic keratitis in affected eye(s) • Documentation that the member has tried and failed at least two conventional non-surgical treatments (e.g. preservative-free artificial tears, lubricant eye ointment, topical antibiotic eye drops, therapeutic contact lenses)
Palforzia	**Approved Diagnosis:** • Peanut Allergy **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** • Must be prescribed by an ○ Allergy specialist ○ Immunology specialist **Age Limitation:** Patient must be age 4 years to 17 years of age • Patients who start therapy prior to 18 years of age may continue therapy **Initial Criteria** • Documented clinical history of allergy to peanuts or peanut-containing foods • A confirmed peanut diagnosis based on one of the following: ○ Peanut skin prick test >8mm ○ Serum IgE to peanut ≥14 kUA/L ○ A reaction that required epinephrine or ED visit • Used in conjunction with a peanut-avoidant diet • Patient has been prescribed and/or has a refill history of epinephrine auto-injector • Prescriber, health care setting, pharmacy, patient must meet manufacturer's REMS requirements **Continuation Criteria** • Positive response to treatment as documented by at least ONE (1) of the following compared to pre-treatment: ○ Reduction in severe allergic reactions ○ Reduction in epinephrine use ○ Reduction in physician/clinic visits due to peanut allergy (physician office/ER visits/hospitalizations) ○ Improvement in quality of life or productivity **Additional Information** • Palforzia is not indicated for patients with the following ○ History of severe or life-threatening episode of anaphylaxis or anaphylactic shock within 60 days ○ Uncontrolled asthma ○ History of eosinophilic esophagitis (EoE); other eosinophilic gastrointestinal disease; chronic, recurrent, or severe gastroesophageal reflux disease (GERD); symptoms of dysphagia or recurrent gastrointestinal symptoms of undiagnosed etiology ○ History of a mast cell disorder, including mastocytosis, urticarial pigmentosa, and hereditary or idiopathic angioedema ○ History of cardiovascular disease, including uncontrolled or inadequately controlled hypertension

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

Pyrimethamine	**Approved Diagnosis:** • Treatment of toxoplasmosis • Secondary prevention of toxoplasmosis in patients with HIV • Prevention of pneumocystis pneumonia (PCP) in patients with HIV **Approval Timeframe:** • Initial authorization: ○ toxoplasmosis: 6 weeks ○ pneumocystis: 3 months • Continuation authorization: ○ toxoplasmosis: 6 months ○ pneumocystis: 3 months **Prescriber Specialty Requirement:** none **Age Limitation:** none **Initial Criteria:** • Documentation confirming patient's diagnosis must be submitted **Continuation Criteria:** For continuation when used for toxoplasmosis prophylaxis, patient must have met ONE of the following requirements: • Patient remains symptomatic • Patient is not receiving antiretroviral therapy • Patient has a detectable HIV viral load • Patient has maintained a CD4 count > 200 cells/microliter for less than six months For continuation when used for pneumocystis prophylaxis, patient must have met ONE of the following requirements: • CD4 count <200 cells/microliter • Oropharyngeal candidiasis • CD4 count percentage <14 • CD4 cell count between 200 and 250 cells/microliter IF frequent monitoring (eg, every three months) of CD4 cell counts is not possible

Radicava ORS	**Approved Diagnosis:** • "definite" or "probable" amyotrophic lateral sclerosis (ALS) **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 6 months **Prescriber Specialty Requirement:** Prescribed by or in consultation with a neurologist **Age Limitation:** Patient must be age 20-75 years **Initial Criteria** • Clinical documentation confirming diagnosis of "definite" or "probable" amyotrophic lateral sclerosis (ALS) as defined by the revised El Escorial World Federation of Neurology/Arlie House criteria • Disease duration of ≤ 2 years (provide date of diagnosis) • Living independently • Score of ≥ 2 on each individual item of the revised ALS functional rating scale (ALSFRS-R) ○ Completed copy of ALSFRS-R must be included with request • Forced vital capacity (FVC) ≥ 80% • Must be used in combination with riluzole unless there is documentation of intolerance or contraindication to riluzole **Continuation Criteria** • FCV of greater than or equal to 30%, does not require tracheostomy/artificial ventilation, and is not on continuous Bilevel Positive Airway Pressure (BiPAP) • Ambulatory (able to walk with or without assistance) • Able to self-feed • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

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

Relyvrio	**Approved Diagnosis:** • Amyotrophic Lateral Sclerosis (ALS) **Approval Timeframe:** • Initial authorization: 12 months • Continuation authorization: 12 months **Prescriber Specialty Requirement:** • Prescribed by, or in consultation with, a neurologist **Age Limitation:** Patient must be ≥ 18 years old **Initial Criteria** • Documentation confirming diagnosis of ALS as determined by revised El Escorial criteria; **AND** • Initiation of drug is within 18 months of symptom onset; **AND** • Slow vital capacity (SVC) exceeding 60% of the predicted; **AND** • Patient is currently taking, or has previously failed, treatment with riluzole **Continuation Criteria** • Prescriber attests of positive clinical response • Request is for an FDA approved dose
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** • Patient must be under observed therapy

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

Type 2 Narcolepsy

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

Continuation Criteria

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

Additional Information

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

Stimate	**Approved Diagnosis:** • Hemophilia A • von Willebrands Disease – Type I **Approval Timeframe:** • Initial authorization: 1 year • Continuation authorization: 1 year **Prescriber Specialty Requirement:** none **Age Limitation:** none **Initial Criteria** • Documentation confirming diagnosis must be submitted **Continuation Criteria** • Documentation showing the patient has experienced symptomatic improvement or maintained stable clinical status. • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

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

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

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 12 years or older **Initial Criteria:** • Documentation confirming diagnosis of Chronic Hepatitis B infection with compensated liver disease; **AND** • Documented trial, clinical failure, or contraindication to Entecavir; **AND** • Trial of tenofovir disoproxil fumarate unless one of the following conditions are met: ○ History of osteoporosis or osteopenia ○ Renal impairment defined by creatinine clearance (CrCl) < 50 mL/min or history of chronic renal disease ○ Trial of tenofovir disoproxil fumarate is inappropriate.; **OR** • Persistent viremia or breakthrough infection while taking lamivudine or adefovir **(NOTE: lamivudine and adefovir are no longer recommended in current guidelines)**; **AND** • Attestation confirming no HIV risk or negative HIV status **Continuation Criteria:** • Documentation confirming patient has had positive clinical response; **AND** • Confirmation of continued monitoring according to available guidelines (i.e. HBV DNA, ALT, etc.); **AND** • CrCl remains ≥ 15 mL/min • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
Verquvo	**Approved Diagnosis:** • Symptomatic chronic heart failure **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 12 months **Prescriber Specialty Requirement:** Must be prescribed by, or in consultation with (notes must be submitted), a cardiologist **Age Limitation:** Must be age 18 years or older **Initial Criteria:** • Documentation that member has chronic heart failure, New York Heart Association [NYHA] Class II-IV who has had a decompensation while on standard therapy for heart failure • Documentation of a left ventricular ejection fraction (LVEF) of less than 45% • Documentation that member is currently taking or has a contraindication to **ALL** of the following: ○ ACE inhibitor, ARB, or Entresto ○ Beta blocker ○ Oral diuretic (not applicable if member had IV diuretics in previous 3 months) • History of hospitalization for heart failure in the previous 6 months or required outpatient IV diuretics for heart failure in the previous 3 months. • Prescriber attestation that member is not or will not be using Verquvo concomitantly with other soluble guanylate cyclase (sGC) stimulators (e.g. riociguat) or PDE-5 inhibitors (e.g. sildenafil, tadalafil, vardenafil and avanafil). • **For female patients of childbearing potential:** ○ Documentation of a negative pregnancy test in the previous 30 days and provider attestation that member has been counseled on the risks and advised to use contraception throughout treatment with and one month following Verquvo administration. **Continuation Criteria:** • Documentation that member has had no intolerable adverse effects from treatment • Documentation that member is responding positively to treatment demonstrated by improvement or slowing of decline in signs and symptoms of heart failure.

Vtama	**Approved Diagnosis:** • Plaque psoriasis **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 1 year **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with, a dermatologist **Age Limitation:** Patient must be age 18 years or older **Initial Criteria** • Documentation confirming treatment of an FDA approved indication for topical tapinarof; **AND** • Documented trial, failure, or intolerance to at least one high potency **or** very high potency topical steroid; **AND** • Documented trial, failure, or intolerance to topical calcipotriene, calcitriol, tazarotene, or combination products containing prior stated ingredients; **OR** • Clinical documentation as to why therapies listed above are not appropriate; **AND** • Prescribed volume is appropriate for treating the estimated body surface area affected; **OR** • Prescriber attests that the volume is necessary for up to a 34-day supply per fill **Continuation Criteria** • Attestation that topical tapinarof has contributed to a positive response or patient is stable on therapy. • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
Vyndamax **Vyndaqel**	**Approved Diagnosis:** • Wild-type ATTR-CM • Hereditary ATTR-CM **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 1 year **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with (notes must be submitted), a cardiologist **Age Limitation:** Patient must be age 18 years or older **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** ○ Diagnosis by radionuclide imaging requires all the following to be met: ▪ Grade 2 or 3 cardiac uptake on radionuclide imaging ▪ Echocardiogram (ECHO) or cardiac magnetic resonance (CMR) imaging demonstrating cardiac involvement (i.e., increased left ventricular wall thickness) ▪ Absence of monoclonal protein identified in serum and urine immunofixation (IFE) and serum free light chain (sFLC) assay; **AND** • Medical history of heart failure that includes one of the following ○ at least one prior hospitalization of heart failure ○ clinical evidence of heart failure • Must not currently have, or have history of: ○ New York Heart Association (NYHA) Class 4 heart failure ○ Primary (light-chain) amyloidosis ○ Prior liver or heart transplant or an implanted cardiac device • Will not be used concurrently with Amvuttra, Onpattro or Tegsedi **Continuation Criteria** • Documentation that the patient has experienced a positive clinical response to Vyndaqel/Vyndamax compared to baseline (i.e. reduced cardiovascular-related hospitalizations, improved function, improved quality of life); **AND** • Patient is not receiving tafamidis (Vyndaqel, Vyndamax) in combination with Amvuttra, Tegsedi or Onpattro. • Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

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

Type 2 Narcolepsy

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

Idiopathic Hypersomnia

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

Continuation Criteria

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

Additional Information

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

Zoryve	**Approved Diagnosis:** • Plaque psoriasis **Approval Timeframe:** • Initial authorization: 6 months • Continuation authorization: 1 year **Prescriber Specialty Requirement:** • Must be prescribed by, or in consultation with, a dermatologist **Age Limitation:** Must be age 6 years or older **Initial Criteria** • Documentation confirming treatment of an FDA approved indication for topical Roflumilast; **AND** • Documented trial, failure, or intolerance to at least one high potency **or** very high potency topical steroid; **AND** • Documented trial, failure, or intolerance to topical calcipotriene, calcitriol, tazarotene, or combination products containing prior stated ingredients; **OR** • Clinical documentation as to why therapies listed above are not appropriate; **AND** • Prescribed volume is appropriate for treating the estimated body surface area affected; **OR** • Prescriber attests that the volume is necessary for up to a 34-day supply per fill **Continuation Criteria** • Attestation that topical 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 / moexipril HCT Monopril® / Monopril HCT® perindopril Prinivil® Qbrelis® quinapril / quinapril HCT trandolapril Vasotec® / Vaseretic® Zestril® / Zestoretic® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Patient is clinically stable and switching would cause a deterioration in condition; **OR** • Therapeutic failure on one preferred medication **See additional medication-specific criteria below:** EPANED® (*enalapril solution*) • PDL criteria may be bypassed if patient is unable to swallow tablets. QBRELIS® • PDL criteria may be bypassed if patient is unable to swallow tablets. **Duration of Approval:** 1 year
Alpha Adrenergic Agents	**Preferred Agents:** *No Prior Authorization required* Catapres TTS® clonidine clonidine ER clonidine transdermal guanfacine methyldopa **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* methyldopa / HCTZ **Non-Preferred Agent PA Criteria:** ▪ Allergy to the preferred medications; **OR** ▪ Contraindication or drug to drug interaction with the preferred medications; **OR** ▪ History of unacceptable side effects; **OR** ▪ Therapeutic failure on one preferred medication **Duration of Approval**: 1 year

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

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

Angiotensin Receptor Antagonists	**Preferred Agents:** *No Prior Authorization required* Losartan/ losartan-HCTZ olmesartan/ olmesartan- HCT valsartan/valsartan-HCTZ **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Atacand® / Atacand HCTZ® Avapro®/ Avalide® Benicar®/ Benicar HCTZ® candesartan/ candesartan HCTZ Cozaar® Diovan®/ Diovan HCTZ® Edarbi® Edarbyclor® eprosartan Hyzaar® irbesartan/ irbesartan HCTZ Micardis® / Micardis HCTZ® telmisartan/ telmisartan HCTZ **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Patient is clinically stable, and switching would cause a deterioration in condition • Therapeutic failure on one preferred medication **Duration of Approval**: 1 year
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.* Lonhala Magnair nebulizer solution tiotropium (DPI) Tudorza Pressair® (DPI) Yupelri® nebulizer solution **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • The patient's condition is clinically stable such that switching medications would cause deterioration in the condition; **OR** • Therapeutic failure after a two-week trial with one preferred medication **Duration of Approval**: 1 year
Anticoagulants	**Preferred Agents:** *No Prior Authorization required* Eliquis® enoxaparin Jantoven® Pradaxa® warfarin Xarelto®/ Xarelto® Dose Pack **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Arixtra® Coumadin® dabigatran etexilate Fondaparinux Fragmin® syringes and vials Lovenox® Pradaxa Oral Pellets® Savaysa® **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 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* Emend® (80mg) granisetron ondansetron **Non-Preferred Agents:** *Prior Authorization Required. Criteria below* Akynzeo® Aprepitant Emend Pack® Sancuso® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with 48-hour trial with one preferred medication **See additional medication-specific criteria below:** AKYNZEO • May only be approved for highly emetogenic regimens or regimens including anthracyclines and cyclophosphamide that are not considered highly emetogenic, **AND** • Therapeutic failure on a preferred 5-HT3 receptor antagonist (granisetron, ondansetron) and a preferred substance P receptor agonist (Emend) **Duration of Approval**: 1 year

Antifungals – Oral	**Preferred Agents:** *No Prior Authorization required* clotrimazole troches fluconazole griseofulvin oral suspension ketoconazole nystatin oral susp, tablets terbinafine **Non-Preferred Agents:** *Prior Authorization Required. Criteria below* Ancobon Brexafemme® Cresemba® Diflucan® flucytosine griseofulvin tablet/microsize tablets/ultramicrosize tablets itraconazole Noxafil®, Noxafil DR®, Noxafil PowderMix Suspension Oravig® posaconazole Sporanox® Tolsura® Vfend® Vivjoa® voriconazole **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Trial and failure with one month with one preferred medication: **OR** • Serious illness resulting immunocompromised status **See additional medication-specific criteria below:** BREXAFEMME® • Diagnosis of vulvovaginal candidiasis; **OR** • Patient has diagnosis of recurrent vulvovaginal candidiasis with ≥3 episodes of vulvovaginal candidiasis (VVC) in a 12-month period; **AND** • Attestation that the provider has confirmed a negative pregnancy test or that the patient is not of childbearing potential • Quantity Limit: Treatment – 4 tablets, Maintenance – 24 tablets • Length of approval: Treatment – one time, Maintenance – 6 months VFEND® (VORICONAZOLE) • Aspergillosis – no trial/failure required SPORANOX® (ITRACONAZOLE) • Onychomycosis with previous failure on or contraindication to terbinafine: length of approval - toenails 12 weeks; fingernails - 6 weeks. • Below diagnoses without previous trial: ○ Aspergillosis ○ Blastomycosis ○ Febrile neutropenia ○ Histoplasmosis CRESEMBA® • Diagnosis of aspergillosis; **AND** • Patient is 18 years or older; **AND** • Trial on voriconazole/Vfend or amphotericin B - approve without trials if intolerant to prerequisite meds or renal dysfunction. VIVJOA® • Patient has diagnosis of recurrent vulvovaginal candidiasis with ≥3 episodes of vulvovaginal candidiasis (VVC) in a 12-month period; **AND** • Patient is a biological female who is postmenopausal or has another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy); **AND** • Patient has tried and failed or has a contraindication or intolerance to maintenance antifungal therapy with oral fluconazole. • Quantity limit: 18 tablets per treatment course • Length of approval: one time **Duration of Approval**: For the duration of the prescription up to 6 months, unless otherwise noted in Medication-Specific Information

Antifungals – Topical	**Preferred Agents:** *No Prior Authorization required unless noted* ciclopirox 8% soln (generic Ciclodan®) ciclopirox 0.77% cream (generic for Loprox® and Ciclodan®) clotrimazole OTC cream, solution clotrimazole Rx cream clotrimazole/betamethasone cream ketoconazole miconazole nitrate nystatin nystatin/triamcinolone cream, ointment tolnaftate cream, powder **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* butenafine Ciclodan® ciclopirox suspension (generic for Loprox®) ciclopirox gel, shampoo, kit clotrimazole / betamethasone lotion econazole nitrate Ertaczo® Extina® Jublia® Kerydin® ketoconazole foam Ketodan® Loprox® Lotrimin AF® luliconazole Luzu® Mentax® miconazole/zinc oxide/petrolatum Mycozyl AC® Naftin® naftifine 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:** JUBLIA® (EFINACONAZOLE) • Diagnosis of toenail onychomycosis; **AND** • Patient age 6 years or older; **AND** • Trial and failure on ciclopirox or allergy to ciclopirox KERYDIN® (TAVABOROLE) -applies to brand and generic • Diagnosis of toenail onychomycosis; **AND** • Patient must be 6 years or older; **AND** • Documented trial and failure on ciclopirox or allergy to ciclopirox **Duration of Approval:** up to 6 months

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

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

Antimigraine Agents, Preventive Treatment	**Preferred Agents for Migraine Prevention:** *Prior Authorization required* Aimovig® Emgality® Nurtec ODT® **Clinical PA Criteria for Migraine Prevention:** • For initial requests: ○ Patient has a diagnosis of migraine with or without aura; **AND** ○ Patient is ≥ 18 years of age; **AND** ○ Patient has ≥ four migraine days per month for at least three months; **AND** ○ Patient has tried and failed ≥ one-month trial of any two of the following oral medications: • Antidepressants (e.g., amitriptyline, venlafaxine) • Beta blockers (e.g., propranolol, metoprolol, timolol, atenolol) • Anti-epileptics (e.g., valproate, topiramate) • Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan); **OR** ○ Diagnosis of cluster headaches (Emgality only) • For Renewal requests: ○ Patient demonstrated significant decrease in the number, frequency, and/or intensity of headaches **Non-Preferred Agents for Migraine Prevention:** *Prior Authorization Criteria below* Ajovy® Qulipta® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after a one-month trial of one preferred medication • Must meet Clinical PA Criteria for Migraine Prevention above **Duration of Approval**: Initial: 6 months Continuation: 12 months
Antimigraine Agents, Acute Treatment – Triptans	**Preferred Agents:** *No Prior Authorization required* Imitrex® nasal spray rizatriptan tab and ODT sumatriptan tablets, injection **Non-Preferred Agents:** *Prior Authorization required* almotriptan eletriptan Frova® frovatriptan Imitrex® naratriptan Maxalt®/ Maxalt MLT® Relpax® sumatriptan-naproxen sumatriptan nasal spray 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 Saxenda (liraglutide) Wegovy (semaglutide) Xenical (orlistat) **Preferred Agent PA Criteria:** **Initial Criteria:** • Patient age ≥18 years must have an initial body mass index (BMI) ≥ 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 risk factors: o hypertension, coronary artery disease, diabetes, dyslipidemia, or sleep apnea; **OR** • Patient age ≥12 years to <18 years must have an initial BMI per CDC growth charts at the 95th percentile or greater for age and sex (obesity); **OR** • Patient age ≥12 years to <18 years with BMI in the 85th-94th percentile (overweight) per CDC growth charts and has at least one of the following weight-related coexisting conditions: o diabetes, sleep apnea, hypertension, or dyslipidemia; **AND** • Patient age ≥12 years (Wegovy, Xenical/orlistat, Saxenda); **OR** • Patient age ≥18 years (benzphetamine, diethylpropion, phentermine, phendimetrazine); **AND** • For patients with an eating disorder, prescriber attests that treatment has been optimized and confirms the safety and appropriateness of this anti-obesity treatments; **AND** • Prescriber attests that metabolic or other reason(s) for obesity/symptoms have been ruled out or diagnosed and treated (e.g., thyroid dysfunction, diabetes, sleep apnea, etc.); **AND** • Prescriber attests to patient's absence of any contraindications to use of the requested product, including pregnancy, lactation, a personal or family history of medullary thyroid cancer or multiple endocrine neoplasia type II; **AND** • Prescriber attests medication therapy is part of a total treatment plan including diet and exercise/activity as appropriate for the patient's ability; **AND** • Prescriber attests that patient has been informed weight may return with cessation of medication unless healthy lifestyle diet and activity changes, as appropriate for the patient's ability, are permanently adopted. **MDHHS recommends that prescribers consider the benefits of a diabetes prevention program for their patients.** **Renewal Criteria:** • For adults age ≥18 years, prescriber provides clinical documentation showing that the patient has maintained a weight loss of ≥ 5% from baseline weight at initiation of therapy • For patients age ≥12 years to <18 years , prescriber provides clinical documentation showing that the patient has maintained or improved BMI percentile per CDC growth charts from baseline weight at initiation of therapy. **Duration of Approval**: 6 months for both initial *and* renewal requests

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

AntiParkinson's Agents – Other	**Preferred Agents:** *No Prior Authorization required* amantadine capsule, syrup benztropine tablet (*Carve Out) carbidopa tablet / levodopa ER carbidopa/levodopa IR tablets rasagiline trihexyphenidyl tablet (*Carve Out) **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* amantadine tablet Azilect® carbidopa carbidopa tablet / levodopa ODT carbidopa/levodopa/entacapone tablet Comtan® Dhivy® Duopa® entacapone Gocovri® Inbrija® Lodosyn® Nourianz® Ongentys® Osmolex ER® Rytary® selegiline capsule, tablet Sinemet® Stalevo® Tasmar® tolcapone trihexyphenidyl elixir (*Carve Out) Xadago® Zelapar® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure of one month with one preferred medication **See additional medication-specific criteria below:** 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 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 tablet valacyclovir tablet **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Sitavig® tablet Valtrex® caplet Zovirax® suspension **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Trial and failure on ten days of two preferred medications **Duration of Approval**: up to 6 months
Antivirals – Influenza	**Preferred Agents:** *No Prior Authorization required* oseltamivir Relenza® rimantadine Xofluza® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Flumadine® Tamiflu® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a five-day trial with two preferred medications **Duration of Approval**: up to 6 months
Antivirals – Topical	**Preferred Agents:** *No Prior Authorization required* Acyclovir ointment Denavir® Zovirax® cream **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* acyclovir cream penciclovir (generic for Denavir) Xerese® 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) Utibron Neohaler® (DPI) **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 • The patient's condition is clinically stable such that switching medications would cause deterioration in the condition • Therapeutic failure after a two-week trial with one preferred medication **Duration of Approval**: 1 year
Beta Adrenergic and Corticosteroid Inhaler Combinations	**Preferred Agents:** *No Prior Authorization required* Advair Diskus® (DPI) Advair HFA® (MDI) Dulera® (MDI) fluticasone/salmeterol (generic for Advair Diskus) fluticasone/salmeterol (generic for Advair HFA) Symbicort® (MDI) Wixela® (DPI) (generic for Advair Diskus) **Non-Preferred Agents:** *Prior Authorization Criteria below* AirDuo Digihaler AirDuo Respiclick® (DPI) Breo Ellipta® (DPI) budesonide/formoterol (generic for Symbicort) fluticasone-vilanterol (generic for Breo Ellipta) fluticasone/salmeterol (generic for AirDuo) **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after a two-week trial with one preferred medication **Duration of Approval**: 1 year
Beta Adrenergic / Anticholinergic / Corticosteroid Inhaler Combinations	**Preferred Agents:** *No Prior Authorization required* Trelegy Ellipta **Non-Preferred Agents:** *Prior Authorization Criteria below* Breztri Aerosphere **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medication; **OR** • Contraindication or drug to drug interaction with the preferred medication; **OR** • History of unacceptable side effects; **OR** • The patient's condition is clinically stable such that switching medications would cause deterioration in the condition; **OR** • Therapeutic failure after a two-week trial with the preferred medication **Duration of Approval**: 1 year

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

Beta Blockers	**Preferred Agents:** *No Prior Authorization required* atenolol atenolol / chlorthalidone bisoprolol fumarate HCT Bystolic® carvedilol Coreg CR® labetalol metoprolol / metoprolol XL metoprolol succinate metoprolol tartrate propranolol propranolol LA Sorine sotalol / sotalol AF **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* acebutolol Betapace® / Betapace AF® Betaxolol bisoprolol fumarate carvedilol ER Coreg® Corgard® Hemangeol oral solution® Inderal LA®/ Inderal XL® Innopran XL® Kapspargo® Lopressor® metoprolol HCT nadolol nebivolol pindolol propranolol HCT Sotylize® Tenormin®/ Tenoretic® timolol maleate Toprol XL® Ziac® **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
Bile Salts	**Preferred Agents:** *No Prior Authorization required* ursodiol capsules (generic for Actigall) ursodiol tablets **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Reltone® Urso®/Urso Forte® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure on a one-month trial of one preferred medication **Duration of Approval**: 1 year

Biologic Immunomodulators AGENTS TO TREAT NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS	**Preferred Agents:** *No Prior Authorization required* Cosentyx® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Cimzia®, Cimzia Kit® Rinvoq ER® 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. RINVOQ ER® (UPADACITINIB) • Diagnosis of non-radiographic axial spondyloarthritis; **AND** • Patient must be 18 years or older TALTZ® (IXEKIZUMAB) • Patient must be 18 years or older; **AND** • Diagnosis of non-radiographic axial spondyloarthritis (nr-axSpA); **AND** • Must be prescribed by a rheumatologist or dermatologist or asthma/allergy specialist **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information

Biologic Immunomodulators AGENTS TO TREAT ANKYLOSING SPONDYLITIS	**Preferred Agents:** *No Prior Authorization required* Cosentyx® Enbrel® Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Amjevita® Cimzia®, Cimzia Kit® Rinvoq ER® Simponi®, Simponi Aria® Taltz® Xeljanz®, Xeljanz 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:** AMJEVITA® (ADALIMUMAB-ATTO) • Patient is 18 years of age or older; **AND** • Diagnosis of ankylosing spondylitis RINVOQ ER® (UPADACITINIB) • Diagnosis of ankylosing spondylitis; **AND** • Patient must be 18 years or older TALTZ® (*IXEKIZUMAB*) • Patient must be 6 years of age or older with a diagnosis of moderate to severe plaque psoriasis; **OR** • Patient must be 18 years or older with a diagnosis of psoriatic arthritis or active ankylosing spondylitis; **AND** • Must be prescribed by a rheumatologist or dermatologist or asthma/allergy specialist XELJANZ® (*TOFACITINIB*) • Diagnosis of rheumatoid arthritis (RA) or psoriatic arthritis (PsA), or polyarticular juvenile idiopathic arthritis (pJIA) or ankylosing spondylitis (AS); **AND** ○ Failure or inadequate response to methotrexate; **AND** ○ Must be prescribed by or in consultation with a rheumatologist or dermatologist; **OR** • Diagnosis of ulcerative colitis; **AND** ○ Prescribed by or in consultation with a gastroenterologist • Xeljanz Solution is only approved for Polyarticular Course Juvenile Idiopathic Arthritis (pJIA) **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information

Biologic Immunomodulators AGENTS TO TREAT CROHN'S DISEASE	**Preferred Agents:** *No Prior Authorization required* Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Amjevita® Cimzia®, Cimzia Kit® Entyvio® Rinvoq ER® Skyrizi® Stelara® **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:** AMJEVITA® (ADALIMUMAB-ATTO) • Patient is 6 years of age or older; **AND** • Diagnosis of moderate to severe Crohn's disease ENTYVIO® (*VEDOLIZUMAB*) • Diagnosis of Crohn's disease; **OR** • 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 (Asacol®HD, Pentasa®, Lialda®, Apriso®, Delzicol®), olsalazine (Dipentum®), balsalazide (Colazal®, sulfasalazine (Azulfidine®)] ○ Oral steroid ○ Thiopurine [i.e., azathioprine (Imuran®), mercaptopurine (Purinethol®)] ○ TNF (tumor necrosis factor) blocker [i.e., infliximab (Remicade®, etanercept (Enbrel®)] ○ **Length of authorization**: Initial approval = 14 weeks; continuation = 1 year RINVOQ ER® (UPADACITINIB) • Diagnosis of moderately to severely active Crohn's disease; **AND** • Patient must be 18 years or older SKYRIZI® (*RISANKIZUMAB*) • Diagnosis of Crohn's Disease; **AND** • Prescribed by, or in consultation with, a gastroenterologist or rheumatologist **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information

Biologic Immunomodulators AGENTS TO TREAT HIDRADENITIS SUPPURATIVA	**Preferred Agents:** *No Prior Authorization required* Csentyx® Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Amjevita® **See additional medication-specific criteria below:** AMJEVITA® (ADALIMUMAB-ATT0) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe hidradenitis suppurativa **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information
Biologic Immunomodulators AGENTS TO TREAT JUVENILE IDIOPATHIC ARTHRITIS	**Preferred Agents:** *No Prior Authorization required* Enbrel® Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Actemra® SC Amjevita® Orencia® SC Simponi ARIA® Xeljanz®, Xeljanz® 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 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:** AMJEVITA® (ADALIMUMAB-ATT0) • Patient is 2 years of age or older; **AND** • Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis XELJANZ® (*TOFACITINIB*) • Diagnosis of rheumatoid arthritis (RA) or psoriatic arthritis (PsA), or polyarticular juvenile idiopathic arthritis (pJIA) or ankylosing spondylitis (AS); **AND** ○ Failure or inadequate response to methotrexate; **AND** ○ Must be prescribed by or in consultation with a rheumatologist or dermatologist; **OR** • Diagnosis of ulcerative colitis; **AND** ○ Prescribed by or in consultation with a gastroenterologist • Xeljanz Solution is only approved for Polyarticular Course Juvenile Idiopathic Arthritis (pJIA) **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information

Biologic Immunomodulators AGENTS TO TREAT PLAQUE PSORIASIS	**Preferred Agents:** *No Prior Authorization required* Cosentyx® Enbrel® Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Amjevita® Cimzia®, Cimzia Kit® Ilumya® Otezla® Siliq® Skyrizi® Sotyktu® Stelara® Taltz® Tremfya® **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:** AMJEVITA® (ADALIMUMAB-ATTO) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe plaque psoriasis ILUMYA® (*TILDRAKIZUMAB*) • Diagnosis of moderate to severe plaque psoriasis; **AND** • Patient must be 18 years or older OTEZLA® (*APREMILAST*) • Diagnosis of psoriatic arthritis with 3 or more swollen and tender joints; **OR** • Diagnosis of plaque psoriasis; **OR** • Diagnosis of oral ulcers associated with Behcet's Disease; **AND** • Must be prescribed by or in consultation with a rheumatologist or dermatologist SILIQ® (*BRODALUMAB*) • Diagnosis of plaque psoriasis; **AND** • Patient must be 18 years or older SKYRIZI® (*RISANKIZUMAB*) • Diagnosis of moderate to severe plaque psoriasis; **OR** • Diagnosis of active psoriatic arthritis**: 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 TALTZ® (*IXEKIZUMAB*) • Patient must be 6 years of age or older with a diagnosis of moderate to severe plaque psoriasis; OR • Patient must be 18 years or older with a diagnosis of psoriatic arthritis or active ankylosing spondylitis; AND • Must be prescribed by a rheumatologist or dermatologist or asthma/allergy specialist TREMFYA® (*GUSELKUMAB)* • Diagnosis of moderate to severe plaque psoriasis; **OR** • Diagnosis of psoriatic arthritis; **AND** • Patient must be 18 years or older **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information

Biologic Immunomodulators AGENTS TO TREAT PSORIATIC ARTHRITIS	**Preferred Agents:** *No Prior Authorization required* Cosentyx® Enbrel® Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below* Amjevita® Cimzia®, Cimzia Kit® Orencia® SC Otezla® Rinvoq ER® Simponi®, Simponi Aria® Skyrizi® Stelara® Taltz® Tremfya® Xeljanz®, Xeljanz 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:** AMJEVITA® (ADALIMUMAB-ATTO) • Patient is 18 years of age or older; **AND** • Diagnosis of psoriatic arthritis OTEZLA® (*APREMILAST*) • Diagnosis of psoriatic arthritis with 3 or more swollen and tender joints; **OR** • Diagnosis of plaque psoriasis; **OR** • Diagnosis of oral ulcers associated with Behcet's Disease; **AND** • Must be prescribed by or in consultation with a rheumatologist or dermatologist RINVOQ ER® (*UPADACITINIB*) • Diagnosis of psoriatic arthritis; **AND** • Patient must be 18 years or older SKYRIZI® (*RISANKIZUMAB*) • Diagnosis of moderate to severe plaque psoriasis; **OR** • Diagnosis of active psoriatic arthritis: **AND** • Prescribed by or in consultation with a dermatologist or rheumatologist TALTZ® (*IXEKIZUMAB*) • Patient must be 6 years of age or older with a diagnosis of moderate to severe plaque psoriasis; OR • Patient must be 18 years or older with a diagnosis of psoriatic arthritis or active ankylosing spondylitis; AND • Must be prescribed by a rheumatologist or dermatologist or asthma/allergy specialist TREMFYA® (*GUSELKUMAB)* • Diagnosis of moderate to severe plaque psoriasis; OR • Diagnosis of psoriatic arthritis; AND • Patient must be 18 years or older XELJANZ® (*TOFACITINIB*) • Diagnosis of rheumatoid arthritis (RA) or psoriatic arthritis (PsA), or polyarticular juvenile idiopathic arthritis (pJIA) or ankylosing spondylitis (AS); **AND** ○ Failure or inadequate response to methotrexate; **AND** ○ Must be prescribed by or in consultation with a rheumatologist or dermatologist; **OR** • Diagnosis of ulcerative colitis; **AND** ○ Prescribed by or in consultation with a gastroenterologist • Xeljanz Solution is only approved for Polyarticular Course Juvenile Idiopathic Arthritis (pJIA) **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information

Biologic Immunomodulators AGENTS TO TREAT RHEUMATOID ARTHRITIS	**Preferred Agents:** *No Prior Authorization required* Enbrel® Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Actemra® SC Amjevita® Cimzia®, Cimzia Kit® Kevzara® Kineret® (*Carve Out) Olumiant® Orencia® SC Rinvoq ER® Xeljanz®, Xeljanz XR® Simponi®, Simponi Aria® **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:** AMJEVITA® (ADALIMUMAB-ATTO) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe rheumatoid arthritis KEVZARA® (*SARILUMAB*) (PDL CRITERIA DO NOT APPLY FOR POLYMYALGIA RHEUMATICA) • Diagnosis of Polymyalgia Rheumatica (PMR); **OR** • Diagnosis of moderately to severely active rheumatoid arthritis (RA); **AND** • Patient must be 18 years or older OLUMIANT® (BARICITINIB) (PDL CRITERIA DO NOT APPLY FOR ALOPECIA AREATA) • Diagnosis of severe alopecia areata; **AND** • Patient must be 18 years or older RINVOQ ER® (*UPADACITINIB*) • Diagnosis of moderate to severe rheumatoid arthritis; **AND** • Patient must be 18 years or older XELJANZ® (*TOFACITINIB*) • Diagnosis of rheumatoid arthritis (RA) or psoriatic arthritis (PsA), or polyarticular juvenile idiopathic arthritis (pJIA) or ankylosing spondylitis (AS); **AND** ○ Failure or inadequate response to methotrexate; **AND** ○ Must be prescribed by or in consultation with a rheumatologist or dermatologist; **OR** • Diagnosis of ulcerative colitis; **AND** ○ Prescribed by or in consultation with a gastroenterologist • Xeljanz Solution is only approved for Polyarticular Course Juvenile Idiopathic Arthritis (pJIA) **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information

Biologic Immunomodulators AGENTS TO TREAT ULCERATIVE COLITIS	**Preferred Agents:** *No Prior Authorization required* Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Amjevita® Entyvio® Rinvoq ER® Simponi® Stelara® Xeljanz®, Xeljanz 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:** AMJEVITA® (ADALIMUMAB-ATT0) • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe ulcerative colitis ENTYVIO® (VEDOLIZUMAB) • Diagnosis of Crohn's disease; **OR** • 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: o Aminosalicylate [i.e., mesalamine (Asacol®HD, Pentasa®, Lialda®, Apriso®, Delzicol®), olsalazine (Dipentum®), balsalazide (Colazal®, sulfasalazine (Azulfidine®)] o Oral steroid o Thiopurine [i.e., azathioprine (Imuran®), mercaptopurine (Purinethol®)] o TNF (tumor necrosis factor) blocker [i.e., infliximab (Remicade®, etanercept (Enbrel®)] • Length of authorization: Initial approval = 14 weeks; renewal = 1 year RINVOQ ER® (UPADACITINIB) • Diagnosis of moderately to severely active ulcerative colitis; **AND** • Patient must be 18 years or older XELJANZ® (TOFACITINIB) • Diagnosis of rheumatoid arthritis (RA) or psoriatic arthritis (PsA), or polyarticular juvenile idiopathic arthritis (pJIA) or ankylosing spondylitis (AS); **AND** o Failure or inadequate response to methotrexate; **AND** o Must be prescribed by or in consultation with a rheumatologist or dermatologist; **OR** • Diagnosis of ulcerative colitis; **AND** o Prescribed by or in consultation with a gastroenterologist • Xeljanz Solution is only approved for Polyarticular Course Juvenile Idiopathic Arthritis (pJIA) **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information

Biologic Immunomodulators AGENTS TO TREAT UVEITIS	**Preferred Agents:** *No Prior Authorization required* Humira® **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Amjevita® **See additional medication-specific criteria below:** AMJEVITA® (ADALIMUMAB-ATT0) • Patient is 18 years of age or older; **AND** • Diagnosis of non-infectious intermediate, posterior, or panuveitis **Duration of Approval:** 1 year, unless otherwise noted in Medication-Specific Information
BPH Agents – 5-Alpha Reductase (5AR) Inhibitors	**Preferred Agents:** *No Prior Authorization required* Dutasteride capsule finasteride 5mg tablet (generic for Proscar®) **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Avodart® softgel dutasteride/tamsulosin capsule Entadfi® Jalyn® capsule Proscar® 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 a one-month trial with one preferred medication **See additional medication-specific criteria below:** ENTADFI® (FINASTERIDE/TADALAFIL) • Prescriber attests that Entadfi is not being used for erectile dysfunction (ED) • Length of approval: 26 weeks per lifetime **Duration of Approval**: 1 year (unless specified in drug specific criteria)
BPH Agents – Alpha Blockers	**Preferred Agents:** *No Prior Authorization required* Alfuzosin tablet Doxazosin tablet Prazosin capsule Tamsulosin capsule Terazosin capsule **Non-Preferred Agents:** *Prior Authorization Required. Criteria below.* Cardura® tablet Cardura XR® tablet Flomax® capsule Minipress® capsule Rapaflo® capsule Silodosin (generic for Rapaflo) capsule **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Therapeutic failure with a one-month trial with one preferred medication **Duration of Approval**: 1 year, unless otherwise noted in drug-specific criteria

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

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

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

Direct Renin Inhibitors	**Preferred Agents:** *No Prior Authorization required* N/A **Non-Preferred Agents:** *Prior Authorization Criteria below* aliskiren Tekturna® / Tekturna HCT® **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
Electrolyte Depleters	**Preferred Agents:** *Clinical Prior Authorization below* calcium acetate capsules and tablets sevelamer carbonate tablets (generic for Renvela) **Clinical PA Criteria:** • Diagnosis of chronic kidney disease **Non-Preferred Agents:** *Prior Authorization Criteria below* Auryxia® Fosrenol® / Fosrenol® powder pak lanthanum Renagel® Renvela powder pkts and tablets sevelamer carbonate powder pkts (generic for Renvela) sevelamer tablets (generic for Renagel) Velphoro® **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. **Duration of Approval**: 1 year
Epinephrine Injectable	**Preferred Agents:** *No Prior Authorization required* Epi Pen®, Epi Pen Jr® **Non-Preferred Agents:** *Prior Authorization required* Auvi-Q® epinephrine (generic for Adrenaclick®) epinephrine (generic for Epi Pen®) Symjepi® **Non-Preferred Agent PA Criteria:** • Therapeutic failure with preferred medication **Duration of Approval**: 1 year

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

GI Motility, Chronic CHRONIC IDIOPATHIC CONSTIPATION (CIC)	**Preferred Agents:** *No Prior Authorization required* Amitiza® capsule Linzess® capsule **Non-Preferred Agents:** *Prior Authorization required* lubiprostone capsule (generic Amitiza®) Motegrity® tablet Trulance® 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** **See additional medication-specific criteria below:** MOTEGRITY® (*PRUCALOPRIDE*) • Diagnosis of chronic idiopathic constipation (CIC); **AND** • Prescribed by or in consultation with a gastroenterologist; **AND** • Therapeutic failure after one-month trial of one preferred agent for CIC TRULANCE® (*PLECANATIDE*) • Diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); **AND** • Therapeutic failure after one-month trial of one preferred agent for CIC or IBS-C **Duration of Approval**: Up to 1 year
GI Motility, Chronic IRRITABLE BOWEL SYNDROME WITH CONSTIPATION (IBS-C)	**Preferred Agents:** *No Prior Authorization required* Amitiza® capsule Linzess® capsule **Non-Preferred Agents:** *Prior Authorization required* Ibsrela® lubiprostone capsule (generic Amitiza®) Trulance® 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** **See additional medication-specific criteria below:** 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 • Quantity Limit = 2 tablets/day TRULANCE® (*PLECANATIDE*) • Diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C); **AND** • Therapeutic failure after one-month trial of one preferred agent for IBS-C **Duration of Approval**: Up to 1 year

GI Motility, Chronic IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D)	**Preferred Agents:** *No Prior Authorization Required* diphenoxylate/atropine (generic Lomotil®) loperamide (generic Imodium®) **Non-Preferred Agents:** *Prior Authorization required* alosetron tablet Lotronex® tablet Viberzi® 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 after one-month trial of diphenoxylate/atropine or loperamide **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* Amitiza® capsule **Non-Preferred Agents:** *Prior Authorization required* lubiprostone capsule (generic Amitiza®) Movantik® Relistor® syringe, vial Symproic® 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** **See additional medication-specific criteria below:** RELISTOR® (*METHYLNALTREXONE*) • Diagnosis of opioid induced constipation (OIC); **AND** • Therapeutic failure after one-month trial of one preferred agent for OIC SYMPROIC® (*NALDEMEDINE TOSYLATE*) • Diagnosis of opioid induced constipation (OIC); **AND** • Therapeutic failure after one-month trial of one preferred agent for OIC **Duration of Approval**: Up to 1 year

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

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

Growth Hormones	**Preferred Agents:** *Prior Authorization required* Genotropin® Norditropin® Norditropin Flexpro® **Non-Preferred Agents:** *Prior Authorization required* Humatrope® Nutropin AQ® Omnitrope® Serostim® Skytrofa® Zomacton® **PA Criteria (preferred and non-preferred):** • Requests must be submitted by an endocrinologist or nephrologist. • Panhypopituitarism – Cachexia, pituitary; Necrosis of pituitary (postpartum); Pituitary insufficiency NOS; Sheehan's syndrome; Simmond's disease. • Pituitary dwarfism – Isolated deficiency of (human) growth hormone [HGH]; Lorain-Levi dwarfism). • Endocrine disorders – Other specified endocrine disorders: Pineal gland dysfunction; Progeria; Werner's syndrome. • Indeterminate sex and pseudohermaphroditism – Gynandrism; Hermaphroditism; Ovotestis; Pseudohermaphroditism (male, female); Pure gonadal dysgenesis • Gonadal dysgenesis – Turner's Syndrome (female only); XO syndrome; Ovarian dysgenesis • Noonan Syndrome – Norditropin® is the only medication with this indication • Prader-Willi Syndrome. **Genotropin®**, Norditropin FlexPro, and Omnitrope® are the only medications with this indication • Idiopathic Short Stature - individual medical record and necessity review will be required. • **CKD – stage 1, 2 or 3** (CRI): **Nutropin®** is the only medication with this indication • **CKD – stage 4 or 5** (CRF or ESRD) • **SHOX: Humatrope®** is the only medication with this indication • For non-preferred medications: Must have an allergy to inactive ingredients in the preferred medications REQUIRED TESTING INFORMATION: • **Growth hormone stimulation testing:** o Pituitary dwarfism: the patient must have failed ***two*** kinds of growth hormone stimulation tests for the diagnosis. Testing is required for pediatric, adolescent, and adult patients. For adolescent patients whose epiphyseal growth plates are closed and for adult patients, testing must be done after growth hormone therapy has been suspended for at least 3 months. o Requester should document the kinds of stimulation tests performed, the result (lab value), reference range and date. • **Bone age x-rays (required regardless of diagnosis; x-ray does not have to be performed within a specific time frame):** o Pediatric patients - bone x-ray report is required ***unless*** the prescriber is a (pediatric) endocrinologist o Adolescent patients (13 to 19 years of age)– bone x-ray report is required UNLESS the prescriber is a (pediatric) endocrinologist; the requester must also note whether or not the epiphyseal growth plates have closed. o Adult patients – bone x-ray report is **NOT** required. 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. **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 **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 the preferred agent **Duration of Approval**: 1 year
Hematopoietic Agents	**Preferred Agents:** *Clinical Prior Authorization below* Aranesp® Epogen® Retacrit® **Non-Preferred Agents:** *Prior Authorization Criteria below* Procrit® **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 **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 with one preferred medication • See additional medication/diagnoses-specific criteria above **Duration of Approval**: For the duration of the prescription up to 6 months, unless otherwise noted in Medication/Diagnoses-Specific Information

Immunomodulators

AGENTS TO TREAT ASTHMA

Preferred Agents: *Prior Authorization required*

Dupixent®
Fasenra® pen
Xolair® Syringe

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**
  - Patient must be 12 years of age or older

XOLAIR® (*OMALIZUMAB*)

- **Moderate to severe asthma; AND**
  - 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**
  - 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**
  - Patient must be 6 years of age or older

TEZSPIRE (*TEZEPELUMAB-EKKO*) PRE-FILLED PENS

- **Patient must have severe asthma; AND**
  - 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

Duration of Approval: 1 year

Immunomodulators

AGENTS TO TREAT ATOPIC DERMATITIS

Preferred Agents: *Prior Authorization required*

Adbry®
Dupixent®
Elidel®
Eucrisa®

Clinical PA Criteria For Atopic Dermatitis Indications For Each Agent

- Diagnosis of atopic dermatitis
  - Dupixent®: moderate to severe for ages ≥ 6 months
  - Elidel®: mild to moderate for ages > 2 years
  - Eucrisa®: mild to moderate for ages ≥ 3 months
  - Adbry®: moderate to severe for ages ≥ 12 years

See additional medication-specific criteria below:

Non-Preferred Agents: *Prior Authorization required*

Cibinqo
Opzelura®
pimecrolimus (generic for Elidel)
Protopic®
Rinvoq ER®
Tacrolimus

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:
  - **pimecrolimus** – mild to moderate for ages ≥ 2 years (PDL Brand Preferred Over Generic, must use Elidel® cream)
  - **Tacrolimus/Protopic®** 0.03%: moderate to severe for ages ≥ 2 years
  - **Tacrolimus/Protopic®** 0.1%: moderate to severe for ages ≥ 16 years
  - **Rinvoq ER®** moderate to severe for ages ≥ 12 years

See additional medication-specific criteria below:

ADBRY® (TRALOKINUMAB-LDRM)

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

CIBINQO® (ABROCITINIB)

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

DUPIXENT® (*DUPILUMAB*)

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

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

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

Duration of Approval: 6 months for **FDA approved diagnosis** noted above, unless otherwise noted in Medication/Diagnosis-Specific Criteria

Immunomodulators AGENTS TO TREAT CHRONIC IDIOPATHIC URTICARIA	**Preferred Agents:** *Prior Authorization required* Xolair® Syringe **Clinical PA Criteria for Chronic Idiopathic Urticaria Indications:** XOLAIR® (OMALIZUMAB) • **Diagnosis of 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 **Duration of Approval**: 1 year
Immunomodulators AGENTS TO TREAT CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP)	**Preferred Agents:** *Prior Authorization required* Dupixent® Xolair® Syringe **Clinical PA Criteria for chronic rhinosinusitis with nasal polyposis (CRSwNP) Indications:** DUPIXENT® (*DUPILUMAB*) • **Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP); AND** ○ Patient ≥ 18 years old; **AND** ○ Patient has inadequate response after 3 consistent months use of intranasal steroids or oral corticosteroids; **AND** ○ Patient is concurrently treated with intranasal corticosteroids 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** ○ Patient is concurrently treated with intranasal corticosteroids **Non-Preferred Agents:** *Prior Authorization required* Nucala® syringe, auto-injector **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medication; **OR** • Contraindication or drug to drug interaction with the preferred medication; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after a one-month trial with the preferred medication **See additional medication-specific criteria below:** NUCALA (MEPOLIZUMAB) • **Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP); AND** ○ Patient ≥ 18 years old; **AND** ○ Patient has inadequate response after 3 consistent months use of intranasal steroids or oral corticosteroids; **AND** ○ Patient is concurrently treated with intranasal corticosteroids **Duration of Approval**: 1 year

Immunomodulators AGENTS TO TREAT EOSINOPHILIC ESOPHAGITIS (EOE)	**Preferred Agents:** Clinical *Prior Authorization below* Dupixent® **Clinical PA Criteria for eosinophilic esophagitis (EOE) Indications:** DUPIXENT® (*DUPILUMAB*) • **Diagnosis of eosinophilic esophagitis (EoE); AND** ○ Patient ≥12 years old; **AND** ○ Patient weighs ≥ 40 kg; **AND** ○ Prescribed by or consultation with an allergist or gastroenterologist; **AND** ○ Patient did not respond clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor **Duration of Approval**: 1 year
Immunomodulators AGENTS TO TREAT EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA)	**Non-Preferred Agents:** *Prior Authorization required* Nucala® syringe, auto-injector **Non-Preferred Agent PA Criteria:** NUCALA (MEPOLIZUMAB) • **Diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA); AND** ○ Patient is 18 years of age or older **Duration of Approval**: 1 year
Immunomodulators AGENTS TO TREAT HYPEREOSINOPHILIC SYNDROME (HES)	**Non-Preferred Agents:** *Prior Authorization required* Nucala® syringe, auto-injector **Non-Preferred Agent PA Criteria:** NUCALA (MEPOLIZUMAB) • **Diagnosis of hypereosinophilic syndrome (HES); AND** ○ Patient is 12 years of age or older **Duration of Approval**: 1 year
Immunomodulators AGENTS TO TREATS NONSEGMENTAL VITILIGO	**Non-Preferred Agents:** *Prior Authorization required* Opzelura® **Non-Preferred Agent PA Criteria:** OPZELURA® (RUXOLITINIB PHOSPHATE) • **Diagnosis of nonsegmental vitiligo; AND** ○ Patient has vitiligo involvement estimated to affect ≤ 10% of the body surface area; **AND** ○ Patient is ≥12 years old; **AND** ○ Prescribed by or in consultation with a dermatologist **Duration of Approval**: 1 year
Immunomodulators AGENTS TO TREAT PRURIGO NODULARIS (PN)	**Preferred Agents:** Clinical *Prior Authorization below* Dupixent® **Clinical PA Criteria for prurigo nodularis (PN) indications:** DUPIXENT® (*DUPILUMAB*) • **Diagnosis of prurigo nodularis (PN); AND** ○ Patient ≥18 years old; **AND** ○ Prescribed by or in consultation with a dermatologist, allergist, or immunologist **Duration of Approval**: 1 year

Incretin Mimetics	**Preferred Agents:** *No Prior Authorization required* Byetta® Trulicity® Victoza® **Non-Preferred Agents:** *Prior Authorization required* Bydureon Bcise® Mounjaro® Ozempic® Rybelsus® Soliqua® Xultophy® **Non-Preferred Agent PA Criteria:** • Diagnosis of type 2 diabetes; **AND** • Discontinuation of other 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** • Trial and failure with one preferred medication within same subgroup **See additional medication-specific criteria below:** SOLIQUA® (INSULIN GLARGINE/LIXISENATIDE) • One-month trial and failure with one of the preferred medications in each subgroup of the components (basal insulin and GLP-1 agonist) XULTOPHY® *(INSULIN DEGLUDEC/LIRAGLUTIDE)* • One-month trial and failure with one of the preferred medications in each subgroup of the components (basal insulin and GLP-1 agonist) **Duration of Approval**: Up to 1 year

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

Insulins, Mixes	**Preferred Agents:** *No Prior Authorization required* Humalog® 50/50 pens, vials Humalog® 75/25 pens, vials Humulin® 70/30 Kwikpens, vials insulin aspart 70/30 pens, vials **Non-Preferred Agents:** *Prior Authorization required* Insulin lispro 75/25 pens Novolin® 70/30 pens, vials Novolog® 70/30 pens, vials **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Therapeutic failure with one preferred medication within same subgroup **Duration of Approval**: 1 year
Insulins, Basal	**Preferred Agents:** *No Prior Authorization required* Lantus® pens, vials Levemir® pens, vials **Non-Preferred Agents:** *Prior Authorization required* Basaglar® kwikpens, tempo pens insulin degludec pens, vials (generic Tresiba) insulin Glargine Solostar U100 pens, vials (biosimilar for Lantus®) insulin Glargine-YFGN pens, vials (biosimilar for Semglee®) Rezvoglar® Semglee® pens, vials Toujeo Solostar® pens Tresiba® pens, vials **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 within same subgroup **See additional medication-specific criteria below:** TOUJEO SOLOSTAR® *(INSULIN GLARGINE)* • Trial and failure on both preferred medications in this class **Duration of Approval**: 1 year

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

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

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

Lipotropics: Others	**Preferred Agents:** *No Prior Authorization required* ezetimibe **Non-Preferred Agents:** *Prior Authorization required* Icosapent Ethyl Lovaza® Nexletol Nexlizet® omega-3 acid ethyl esters capsule (generic for Lovaza) Vascepa® 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:** LOVAZA® (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 VASCEPA® (ICOSAPENT ETHYL) – PDL CRITERIA DO NOT APPLY • Adjunct to diet to reduce severe triglyceride (TG) levels in adult patients with severe (≥ 500 mg/dL) hypertriglyceridemia**; OR** • Adjunct to maximally tolerated statin therapy in adult patients with elevated triglyceride (TG) levels (≥ 150 mg/dL) and one of the following: ○ Established cardiovascular disease; **OR** ○ Diabetes mellitus and 2 or more additional risk factors for cardiovascular disease (i.e., men >55 years and women >65 years, cigarette smoker or stopped smoking within the past 3 months, hypertension (pretreatment blood pressure >140mmHg systolic or >90mmHg diastolic) **Duration of Approval**: 1 year

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

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

Multiple Sclerosis Agents	**Preferred Agents:** *No Prior Authorization required* Avonex® Betaseron® vial / Betaseron® Kit Copaxone 20 mg dimethyl fumarate (generic for Tecfidera) Gilenya® **Non-Preferred Agents:** *Prior Authorization required* Aubagio® Bafiertam™ Copaxone® 40 mg Extavia® fingolimod (generic for Gilenya) glatiramer 20 mg/ml and 40 mg/ml Glatopa® Kesimpta® Mavenclad® Mayzent® Plegridy® Ponvory® Rebif® / Rebif Rebidose® Tascenso ODT® Tecfidera® teriflunomide 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 one preferred medication **See additional medication-specific criteria below:** BAFIERTAM™ (MONOMETHYL FUMARATE) • Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS); **AND** • Prescribed by or in consultation with a neurologist; **AND** • Attestation that Bafiertam will be used as single agent monotherapy • Quantity limit: 120 per 30 days • Initial length of authorization: 6 months • **Renewal Criteria:** ○ Attestation of tolerance to maintenance dose ○ Attestation of a CBC, including lymphocyte count, serum aminotransferase, ALP, and total bilirubin levels ○ Length of Authorization: 1 year KESIMPTA® (OFATUMUMAB) • Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS); **AND** • Prescribed by or in consultation with a neurologist; **AND** • Attestation that Kesimpta will be used as single agent monotherapy • Attestation that the first injection will be monitored by a healthcare professional • 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 on two preferred medications *Continued >*

Multiple Sclerosis Agents	MAYZENT® (SIPONIMOD) • Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS); **AND** • Prescribed by or in consultation with a neurologist; **AND** • Patient CYP2C9 variant status has been tested to determine genotyping (required for dosing); **AND** • Patient has obtained a baseline electrocardiogram (ECG); **AND** • Patient has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy; **AND** • For patients with a history of uveitis and/or diabetes ONLY: A baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment; **AND** • Therapeutic failure on two preferred medications PLEGRIDY® (PEGINTERFERON BETA-1A) • Therapeutic failure on 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 on two preferred medications TASCENSO ODT® (FINGOLIMOD) • Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS); **AND** • Patient age ≥10 years; **AND** • Prescribed by or in consultation with a neurologist; **AND** • Patient is unable to use 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 on two preferred medications ZEPOSIA® (OZANIMOD) • Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS); **AND** • Prescribed by or in consultation with a neurologist; **OR** • Diagnosis of moderately or severely active ulcerative colitis (UC); **AND** • Prescribed by or in consultation with a gastroenterologist; **AND** • Patient has obtained a baseline electrocardiogram (ECG); **AND** • Patient does NOT have an active infection, including clinically important localized infections; **AND** • Patient has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy; **AND** • For patients with a history of uveitis and/or diabetes ONLY: A baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment; **AND** • Prescriber attests that a CBC with lymphocyte count, ALT, AST, and total bilirubin have been obtained for the patient in the past 6 months; **AND** • For MS, therapeutic failure on two preferred MS medications. • For diagnosis of ulcerative colitis (UC), may bypass PDL criteria **Duration of Approval**: 1 year

Narcotics – Long Acting	**Preferred Agents:** *Clinical Prior Authorization for codeine and tramadol containing products only* morphine sulfate ER tablet 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® buprenorphine film 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® Nucynta ER® Oxycontin® oxycodone ER oxymorphone ER tramadol ER capsules Xtampza ER® **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 XTAMPZA ER® • Diagnosis of severe chronic pain requiring around the clock opioid analgesia; **AND** • Patient ≥ 18 years old; **AND** • Alternative treatment options have been ineffective, not tolerated or inadequate for controlling pain **Duration of Approval**: 6 months for Zohydro® ER; 1 year for all other medications **Chronic Opioid Management with High Morphine Milligram Equivalents (MME)** **Note:** Total daily MME of >90 MME/day requires review using the criteria below. This limit applies to *all* opioids (i.e. short acting, long, acting, transdermal including PDL preferred and non-preferred drugs) **Initial High MME Exceptions:** If any are "True", no further information is required and member meets the requirements for this section. If all are "False" then proceed to the remaining requirements under *Additional High MME Criteria*. • Does the patient have documented "current" cancer-related pain? • Does the patient have pain related to sickle cell disease? • Is the patient in hospice or palliative care? • Patient resides in a long-term care or other facility that is exempt from reporting to or checking the State Prescription Drug Monitoring Program (i.e. MAPS) (NOTE: upon discharge from long-term care member must meet the additional high MME Criteria below). *Continued >*

	Additional High MME Criteria: • **Prescribers must attest to *all* the following:** ○ Risk assessment has been performed ○ Pain Medication Agreement with informed consent has been reviewed with, completed and signed by the patient ○ MAPS/NarxCare report has been reviewed by prescriber in last 30 days. (Please do not submit the MAPS report.) Concurrently prescribed drugs have been reviewed and that based on prescriber's assessment the drugs and doses are safe for the member. ○ Concurrently prescribed drugs have been reconciled and reviewed for safety ○ The following non-opioid pain interventions have been recommended and/or utilized: ▪ Non-opioid medications ▪ Adjuvant therapies such as physical therapy (PT), occupational therapy (OT), behavioral therapies, or weight loss ○ A toxicology screen (urine or blood) from a commercial lab has been performed at appropriate intervals. Results from toxicology screen showed expected results. ○ Patient has been counseled on obtaining and the appropriate utilization of a Narcan (naloxone) kit. ○ If applicable, the patient has been counselled on the potential increased risk of adverse effects when opioids are taken concomitantly with opioid potentiators (e.g. benzodiazepines/sedative hypnotics, stimulants, gabapentinoids, muscle relaxers). • **Additional Documentation:** ○ Current documentation provided outlining pain related history and physical(s) including clinical justification supporting need for exceeding high MME ○ Recent non-opioid medications utilized for pain management or rationale these cannot be used ○ Documentation includes list of all current opioid medications (long and short-acting) and when the regimen was initiated. ○ Duration of current opioid therapy and current daily Morphine Milligram Equivalent ▪ Opioid Oral MME conversion factor table can be found under the following resources: • CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR • https://www.hhs.gov/guidance/document/opioid-oral-morphine-milligram-equivalent-mme-conversion-factors-0 ○ 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

Narcotics – Short and Intermediate Acting	**SHORT ACTING NARCOTIC 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)* Actiq® Apadaz® benzhydrocodone/acetaminophen 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 Nucynta® oxycodone capsule oxycodone tablets (20mg, 30mg) oxycodone oral concentrated solution oxycodone oral syringe oxymorphone pentazocine/naloxone Percocet® 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 (ACTIQ®, 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 narcotics must be maximally optimized. • No concomitant use of other inducers of cytochrome P450 • No concomitant use of other inhibitors of cytochrome P450 *Continued >*

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 (QDOLO®) 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: 14 days for Apadaz®; 1 year for all other medications

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

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

Additional High MME Criteria:

- **Prescribers must attest to *all* the following:**
  - Risk assessment has been performed
  - Pain Medication Agreement with informed consent has been reviewed with, completed and signed by the patient
  - MAPS/NarxCare report has been reviewed by prescriber in last 30 days. (Please do not submit the MAPS report.) Concurrently prescribed drugs have been reviewed and that based on prescriber's assessment the drugs and doses are safe for the member.
  - Concurrently prescribed drugs have been reconciled and reviewed for safety
  - The following Non-opioid pain interventions have been recommended and/or utilized:
    - Non-opioid medications
    - Adjuvant therapies such as physical therapy (PT), occupational therapy (OT), behavioral therapies, or weight loss
  - A toxicology screen (urine or blood) from a commercial lab has been performed at appropriate intervals. Results from toxicology screen showed expected results.
  - Patient has been counseled on obtaining and the appropriate utilization of a Narcan (naloxone) kit.
  - If applicable, the patient has been counselled on the potential increased risk of adverse effects when opioids are taken concomitantly with opioid potentiators (e.g. benzodiazepines/sedative hypnotics, stimulants, gabapentinoids, muscle relaxers).
- **Additional Documentation:**
  - Current documentation provided outlining pain related history and physical(s) including clinical justification supporting need for exceeding high MME
  - Recent non-opioid medications utilized for pain management or rationale these cannot be used
  - Documentation includes list of all current opioid medications (long and short-acting) and when the regimen was initiated.
  - Duration of current opioid therapy and current daily Morphine Milligram Equivalent
    - Opioid Oral MME conversion factor table can be found under the following resources:
      - CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR
      - https://www.hhs.gov/guidance/document/opioid-oral-morphine-milligram-equivalent-mme-conversion-factors-0
  - 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

Narcotics – Transdermal	**Preferred Agents:** *No Prior Authorization required (see MME criteria below)* Butrans® patches fentanyl patches 12, 25, 50, 75, and 100 mcg only (generic only) **Non-Preferred Agents:** *Prior Authorization required (see MME criteria below)* buprenorphine patches (generic Butrans®) fentanyl generic patches 37.5 mcg, 62.5 mcg and 87.5 mcg only **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medication • History of unacceptable side effects • Therapeutic failure of one week with the preferred medication **Duration of Approval**: 1 year **Chronic Opioid Management with High Morphine Milligram Equivalents (MME)** **Note:** Total daily MME of >90 MME/day requires review using the criteria below. This limit applies to *all* opioids (i.e. short acting, long, acting, transdermal including PDL preferred and non-preferred drugs) **Initial High MME Exceptions:** If any are "True", no further information is required and member meets the requirements for this section. If all are "False" then proceed to the remaining requirements under *Additional High MME Criteria*. • Does the patient have documented "current" cancer-related pain? • Does the patient have pain related to sickle cell disease? • Is the patient in hospice or palliative care? • Patient resides in a long-term care or other facility that is exempt from reporting to or checking the State Prescription Drug Monitoring Program (i.e. MAPS) (NOTE: upon discharge from long-term care member must meet the additional high MME Criteria below). **Additional High MME Criteria:** • **Prescribers must attest to *all* the following:** ○ Risk assessment has been performed ○ Pain Medication Agreement with informed consent has been reviewed with, completed and signed by the patient ○ MAPS/NarxCare report has been reviewed by prescriber in last 30 days. (Please do not submit the MAPS report.) Concurrently prescribed drugs have been reviewed and that based on prescriber's assessment the drugs and doses are safe for the member. ○ Concurrently prescribed drugs have been reconciled and reviewed for safety ○ The following Non-opioid pain interventions have been recommended and/or utilized: ▪ Non-opioid medications ▪ Adjuvant therapies such as physical therapy (PT), occupational therapy (OT), behavioral therapies, or weight loss ○ A toxicology screen (urine or blood) from a commercial lab has been performed at appropriate intervals. Results from toxicology screen showed expected results. ○ Patient has been counseled on obtaining and the appropriate utilization of a Narcan (naloxone) kit. ○ If applicable, the patient has been counselled on the potential increased risk of adverse effects when opioids are taken concomitantly with opioid potentiators (e.g. benzodiazepines/sedative hypnotics, stimulants, gabapentinoids, muscle relaxers). • **Additional Documentation:** ○ Current documentation provided outlining pain related history and physical(s) including clinical justification supporting need for exceeding high MME ○ Recent non-opioid medications utilized for pain management or rationale these cannot be used ○ Documentation includes list of all current opioid medications (long and short-acting) and when the regimen was initiated. ○ Duration of current opioid therapy and current daily Morphine Milligram Equivalent ▪ Opioid Oral MME conversion factor table can be found under the following resources: • CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR • https://www.hhs.gov/guidance/document/opioid-oral-morphine-milligram-equivalent-mme-conversion-factors-0 ○ 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

Nasal Antihistamines	**Preferred Agents:** *No Prior Authorization required* azelastine **Non-Preferred Agents:** *Prior Authorization required* olopatadine spray Patanase Nasal® **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 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 nasal polyps • Therapeutic failure with a three-month trial with a preferred medication **Duration of Approval**: 1 year

Neuropathic Pain	**Preferred Agents:** *No Prior Authorization required* Cymbalta® capsule (*Carve Out) Drizalma Sprinkles® capsule (*Carve Out) duloxetine (generic for Cymbalta) capsule (*Carve Out) duloxetine (generic for Irenka) capsule (*Carve Out) gabapentin capsule, tablet, solution (*Carve Out) Lyrica®, Lyrica CR® capsule (*Carve Out) Neurontin® capsule, tablet, solution (*Carve Out) Pregabalin capsule, solution (*Carve Out) Savella® tablet **Non-Preferred Agents:** *Prior Authorization required* Gralise® tablet Horizant® tablet **Non-Preferred Agent PA Criteria:** GRALISE® (GABAPENTIN) • Diagnosis of postherpetic neuralgia, neuropathy, diabetic neuropathy or chronic pain. • Therapeutic failure with one-month trial of one preferred medication • Dosage limit = 1800 mg/day HORIZANT® (GABAPENTIN ENACARBIL) • Diagnosis of restless leg syndrome; AND • Therapeutic failure on a one-month trial of pramipexole (Mirapex®), ropinirole (Requip®) or levodopa/carbidopa (Sinemet®): **OR** • Diagnosis of postherpetic neuralgia (PHN) • Therapeutic failure with one-month trial of one preferred medication • Dosage limit = 1200 mg/day **Duration of Approval**: 1 year unless otherwise specified
NON-STEROIDAL ANTI-INFLAMMATORY – COX II INHIBITORS	**Preferred Agents:** *No Prior Authorization required (see ADL for step therapy requirements)* celecoxib **Non-Preferred Agents:** *Prior Authorization Criteria below* Celebrex® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Therapeutic failure of one month each with two preferred NSAIDS **See additional medication-specific criteria below:** CELEBREX® (CELECOXIB) • Therapeutic failure of one month each with two preferred NSAIDS (unless clinically contraindicated), including generic celecoxib **Duration of Approval**: For the duration of the prescription up to 1 year

NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS)	**Preferred Agents:** *No Prior Authorization required* diclofenac sodium diclofenac topical gel 1% (generic Voltaren Gel®) diclofenac topical gel 1% (OTC) diclofenac topical solution 1.5% ibuprofen indomethacin ketorolac tablets meloxicam tablets (generic for Mobic) nabumetone naproxen OTC naproxen (generic for Naprosyn®) sulindac **Non-Preferred Agents:** *Prior Authorization required* Arthrotec® Daypro® diclofenac sodium ER diclofenac epolamine 1.3% patch diclofenac-misoprostol diclofenac potassium diclofenac 2% pump (generic Pennsaid®) diflunisal dual action pain (OTC -ibuprofen/apap) Duexis® EC-naproxen etodolac / etodolac ER Feldene® fenoprofen Flector Patch® flurbiprofen ibuprofen-famotidine indomethacin ext release ketoprofen ext release ketoprofen immediate release ketorolac nasal spray (generic for Sprix) Licart Patch® Lofena® meclofenamate sodium mefenamic acid meloxicam capsule Mobic® Nalfon® Naprelan CR® naproxen (generic for Anaprox) naproxen delayed release naproxen/esomeprazole (generic for Vimovo) naproxen suspension oxaprozin Pennsaid® piroxicam Relafen DS® tolmetin sodium Vimovo® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure of one month each with two preferred medications **See additional medication-specific criteria below:** *Continued >*

	LICART® (DICLOFENAC EPOLAMINE PATCHES) • Length of authorization: 2 months SPRIX® (KETOROLAC TROMETHAMINE) • Contraindication to oral dosage forms (i.e., inability to swallow) • Length of authorization: 30 days VIMOVO® (NAPROXEN/ESOMEPRAZOLE) AND DUEXIS®(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 Zaditor® **Non-Preferred Agents:** *Prior Authorization required* Alrex® bepotastine Bepreve® epinastine Lastacaft® Pataday® Pataday® Once daily Patanol® Pazeo® Zerviate® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Therapeutic failure with a one-month trial with one preferred medication **Duration of Approval**: 1 year

Ophthalmic Anti-Inflammatory/Immunomodulator	**Preferred Agents:** *No Prior Authorization required* Restasis® Xiidra® **Non-Preferred Agents:** *Prior Authorization required* Cequa® cyclosporine (generic Restasis®) Eysuvis® Tyrvaya® Verkazia® **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 **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 VERKAZIA® (CYCLOSPORINE): (PDL criteria do not apply) • Patient is ≥4 years of age; **AND** • Diagnosis of moderate to severe vernal keratoconjunctivitis; **AND** • Trial and failure, contraindication, or intolerance to one of the following: o Topical ophthalmic "dual-action" mast cell stabilizer and antihistamine (e.g., olopatadine, azelastine) **OR** o Topical ophthalmic mast cell stabilizers (e.g., cromolyn); **AND** • Prescribed by or in consultation with an ophthalmologist or optometrist **Duration of Approval**: 1 year (Except Eysuvis – 2 weeks)
Ophthalmic Fluoroquinolones	**Preferred Agents:** *No Prior Authorization required* ciprofloxacin ofloxacin Vigamox® **Non-Preferred Agents:** *Prior Authorization Criteria below* Besivance® Ciloxan® gatifloxacin moxifloxacin (generic for Moxeza®) moxifloxacin (generic for Vigamox®) eye drops Ocuflox® Zymaxid® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with one preferred medication **Duration of Approval**: 1 year

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

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

Oral Hypoglycemics – Combinations	**Preferred Agents:** *No Prior Authorization required* glyburide / metformin Invokamet® Janumet®/Janumet XR® Jentadueto® Synjardy® Xigduo® **Non-Preferred Agents:** *Prior Authorization required* Actoplus Met® alogliptin/metformin alogliptin/pioglitazone Duetact® glipizide / metformin Glyxambi® Invokamet XR® Jentadueto XR® Kazano® Kombiglyze XR® Oseni® pioglitazone/glimepride pioglitazone/metformin Qtern® saxagliptin/metformin ER Segluromet® Steglujan® Synjardy XR® Trijardy 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** • 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:** *No Prior Authorization required* Januvia® Tradjenta® **Non-Preferred Agents:** *Prior Authorization required* alogliptin Nesina® Onglyza® saxagliptin **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 – SGLT2 Inhibitors	**Preferred Agents:** No *Prior Authorization required* Farxiga® tablets Invokana® tablets Jardiance® tablets **Non-Preferred Agents:** *Prior Authorization required* Steglatro® 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 • Therapeutic failure with a one-month trial with two preferred medications within the same class **Duration of Approval**: 1 year
Oral Hypoglycemics – Thiazolidinediones	**Preferred Agents:** *No Prior Authorization required* pioglitazone **Non-Preferred Agents:** *Prior Authorization required* Actos® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial with a preferred medication **Duration of Approval**: 1 year
OSTEOPOROSIS AGENTS: BISPHOSPHONATES	**Preferred Agents:** *No Prior Authorization required* alendronate sodium **Non-Preferred Agents:** *Prior Authorization Criteria below* Actonel® alendronate sodium oral solution Atelvia® Boniva® Fosamax® Fosamax Plus D® Ibandronate risedronate (Actonel) risedronate (Atelvia) **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Trial and failure with six months with one preferred medication • Unique FDA approved indication not included in preferred medications **Duration of Approval**: 1 year

OSTEOPOROSIS AGENTS: OTHER	**Preferred Agents:** *No Prior Authorization required* Calcitonin nasal spray **Non-Preferred Agents:** *Prior Authorization Criteria below* Forteo® teriparatide Tymlos® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Trial and failure with six months with one preferred medication • Unique FDA approved indication not included in preferred medications **See additional medication-specific criteria below:** FORTEO® (TERIPARATIDE) – PDL CRITERIA DOES NOT APPLY • Treatment of osteoporosis in postmenopausal women who are at high risk for fractures • Increase of bone mass in men with primary or hypogonadal osteoporosis who are at high risk for fractures • Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture 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 **Duration of Approval**: 1 year
OSTEOPOROSIS AGENTS: SERMs	**Preferred Agents:** *No Prior Authorization required* raloxifene **Non-Preferred Agents:** *Prior Authorization Criteria below* Evista® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Trial and failure with six months with one preferred medication • Unique FDA approved indication not included in preferred medications **Duration of Approval**: 1 year
Otic Quinolones	**Preferred Agents:** *No Prior Authorization required* Ciprodex® ciprofloxacin-dexamethasone (generic for Ciprodex®) ofloxacin otic **Non-Preferred Agents:** *Prior Authorization Criteria below* ciprofloxacin otic Cipro HC® ciprofloxacin-fluocinolone (generic for Otovel®) **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure (duration = 3 days) with one preferred medication **Duration of Approval**: 1 year for all medications

Oxazolidinones	**Preferred Agents:** *No Prior Authorization required* Linezolid tablets **Non-Preferred Agents:** *Prior Authorization Criteria below* Linezolid suspension Sivextro® Zyvox® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medication • Contraindication or drug to drug interaction with the preferred medication • History of unacceptable side effects **See additional medication-specific criteria below:** SIVEXTRO® (TEDIZOLID PHOSPHATE) For diagnosis of non-purulent cellulitis • Trial, failure or intolerance to first line beta lactam therapy; **AND** • Trial, failure or intolerance to at least two of the following agents: clindamycin, sulfamethoxazole/trimethoprim (SMZ/TMP), tetracycline (minocycline or doxycycline); **OR** • Culture and sensitivity results demonstrate resistance to first line agents; **OR** • Contraindication or intolerance to all other treatment options For diagnosis of purulent cellulitis, abscess, or wound infection: • Trial, failure or intolerance to at least two of the following agents: clindamycin, sulfamethoxazole/trimethoprim (smz/tmp), tetracycline (minocycline or doxycycline); **OR** • Culture and sensitivity results demonstrate resistance to first line agents; **OR** • Contraindication or intolerance to all other treatment options **Duration of Approval**: 2 months
Pancreatic Enzymes	**Preferred Agents:** *Prior Authorization required* Creon® Zenpep® **Clinical PA Criteria:** • Cystic fibrosis or chronic pancreatic insufficiency. **Non-Preferred Agents:** *Prior Authorization required* Pertzye® Viokace® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after one-month trial of one preferred agent **See additional medication-specific criteria below:** PERTYZE®, VIOKACE® • Must meet both PDL (trial on preferred medication) and clinical criteria **Duration of Approval**: 1 year

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

Progestational Agents	**Preferred Agents:** medroxyprogesterone (oral) progesterone (oral) norethindrone (oral) **Non-Preferred Agents:** *Prior Authorization required* Aygestin® (oral) Crinone® (vaginal) progesterone (intramuscular) Prometrium® (oral) Provera® (oral) **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Therapeutic failure with a one-month trial of a preferred medication for the indication **See additional medication-specific criteria below:** CRINONE® (*PROGESTERONE VAGINAL*) • Excluded for diagnosis of fertility **Duration of Approval**: 1 year, unless otherwise noted
Progestins for Cachexia	**Preferred Agents:** *No Prior Authorization required* megestrol oral suspension (generic Megace®) **Non-Preferred Agents:** *Prior Authorization required* megestrol oral suspension (generic Megace ES®) **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Therapeutic failure after one-month trial of one preferred agent **Duration of Approval**: 1 year

Proton Pump Inhibitors	**Preferred Agents:** *No Prior Authorization required* Nexium® susp pkts omeprazole (Rx) capsules pantoprazole tablets Protonix® tablets, suspension **Non-Preferred Agents:** *Prior Authorization required* Aciphex® tabs 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 Rabeprazole tabs Zegerid® caps, susp pkts **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure after one-month trial with one preferred medication **Duration of Approval**: 1 year

Pulmonary Arterial Hypertension (PAH) Agents	**Preferred Agents:** *Prior Authorization required* Adempas® Alyq® ambrisentan (generic for Letairis) Opsumit® sildenafil suspension (generic for Revatio®) sildenafil tablets (generic for Revatio®) tadalafil (generic for Adcirca) Tracleer® tablets Tyvaso® Uptravi® Ventavis® **Preferred Agent PA Criteria:** • Diagnosis of pulmonary hypertension • Must be prescribed by, or in consultation with, a cardiologist or pulmonologist **Non-Preferred Agents:** *Prior Authorization Criteria below* Adcirca® bosentan tablets (generic for Tracleer) Letairis® Orenitram ER® Orenitram Titration Kit Revatio® suspension Revatio® tablets Tadliq® Tracleer® suspension Tyvaso DPI® **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:** TADLIQ® (TADALAFIL) • Patient is 18 years of age or older **Duration of Approval**: 1 year
Quinolones	**Preferred Agents:** *No Prior Authorization required* Cipro® suspension ciprofloxacin tablets, suspension levofloxacin **Non-Preferred Agents:** *Prior Authorization required* Avelox® Baxdela® Cipro® tablets moxifloxacin ofloxacin **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Infection is caused by an organism that is resistant to the NO PA REQUIRED quinolone medications • Trial/failure (duration = 3 days) of any two preferred quinolone medications • Antibiotic therapy initiated in hospital **Duration of Approval**: Date of service; if needed, longer lengths may be approved for transplant recipients

Skeletal Muscle Relaxants	**Preferred Agents:** *No Prior Authorization required* ***(except baclofen solution)*** baclofen tablets baclofen oral solution (Ozobax) cyclobenzaprine methocarbamol orphenadrine citrate tizanidine tablets BACLOFEN ORAL SOLUTION (*OZOBAX*) • allow if the patient has difficulty swallowing **Non-Preferred Agents:** *Prior Authorization Criteria below* Amrix® baclofen suspension (generic Fleqsuvy) chlorzoxazone cyclobenzaprine ER Dantrium® dantrolene sodium Fexmid® Fleqsuvy® Lorzone® Lyvispah® metaxalone Norgesic Forte® orphenadrine-aspirin-caffeine 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 **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications • Contraindication or drug to drug interaction with the preferred medications • History of unacceptable side effects • Therapeutic failure after one month with one preferred medication **See additional medication-specific criteria below:** XEPI® CREAM (OZENOXACIN) • Quantity limit = 2 tubes per month • Length of authorization – 1 month **Duration of Approval:** 1 year

Topical Steroids – Low Potency	**Preferred Agents:** *No Prior Authorization required* hydrocortisone acetate cream hydrocortisone acetate ointment hydrocortisone/aloe hydrocortisone cream hydrocortisone lotion hydrocortisone ointment **Non-Preferred Agents:** *Prior Authorization required* alclometasone dipropionate ointment and cream Aqua Glycolic HC® Derma-smooth – FS ® Desonide® ointment, cream, lotion fluocinolone 0.01% oil 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 • For **low potency** medications, trial and failure of 14 days with **one** of preferred medication (hydrocortisone) • For **immunocompromised patients**, trial and failure of 14 days with **one** preferred topical steroid **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 Cloderm® Cutivate® cream and lotion fluocinolone acetonide cream, solution flurandrenolide cream, lotion, ointment fluticasone propionate lotion hydrocortisone butyrate cream, lotion, ointment, solution hydrocortisone valerate cream and ointment Locoid® cream, lotion, solution Locoid Lipocream® Luxiq® 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 • For **medium potency** medications, trial and failure of 14 days with **both** of the preferred medications (at least one formulation of each fluticasone *and* mometasone) • For **immunocompromised patients**, trial and failure of 14 days with **one** preferred topical steroid **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 triamcinolone acetonide cream, lotion, ointment **Non-Preferred Agents:** *Prior Authorization required* betamethasone dipropionate augmented cream, gel, lotion, ointment desoximetasone cream, ointment, gel, and spray diflorasone diacetate cream and ointment Diprolene® ointment fluocinonide cream, ointment and gel fluocinonide emollient and solution halcinonide Halog® cream, ointment, solution Kenalog® aerosol Topicort® cream, ointment, gel, and spray triamcinolone spray Vanos® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects • For **high potency** medications, trial and failure of 14 days with **both** of the preferred medications (at least one formulation of each betamethasone *and* triamcinolone) • For **immunocompromised patients**, trial and failure of 14 days with **one** preferred topical steroid **Duration of Approval**: For the duration of the prescription up to 6 months

Topical Steroids – Very High Potency	**Preferred Agents:** *No Prior Authorization required* clobetasol propionate solution clobetasol propionate cream clobetasol propionate ointment halobetasol propionate cream halobetasol propionate ointment **Non-Preferred Agents:** *Prior Authorization Criteria below* ApexiCon® E Cream Bryhali® clobetasol emollient and lotion clobetasol propionate foam, gel, spray and shampoo Clobex® spray and shampoo Clodan® shampoo and kit halobetasol propionate (generic for Lexette®) Impeklo® Lexette® Olux® Olux-E® Temovate® ointment 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 • For **very high potency** medications, trial and failure of 14 days with **one** of the preferred medications (at least one formulation of clobetasol *or* halobetasol) • For **immunocompromised patients**, trial and failure of 14 days with **one** preferred topical steroid **Duration of Approval**: For the duration of the prescription up to 6 months
Ulcerative Colitis – Oral	**Preferred Agents:** *No Prior Authorization required* Apriso® Lialda® sulfasalazine/ sulfasalazine DR **Non-Preferred Agents:** *Prior Authorization required* Asacol HD® Azulfidine DR® Balsalazide budesonide ER (generic Uceris) Colazal® Delzicol® Dipentum® Giazo® mesalamine (generic for Apriso) mesalamine (generic for Delzicol) mesalamine (generic for Lialda) Mesalamine (generic for Pentasa®) Pentasa® Uceris® **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 with one preferred medication **Duration of Approval**: 1 year

Urinary Tract Antispasmodics	**Preferred Agents:** *No Prior Authorization required* oxybutynin / oxybutynin ER solifenacin Toviaz® **Non-Preferred Agents:** *Prior Authorization required* darifenacin ER Detrol®/ Detrol LA® Ditropan XL® fesoterodine fumarate flavoxate HCL Gelnique® Gemtesa® Myrbetriq® Oxytrol® tolterodine/ tolterodine ER trospium/ trospium ER Vesicare® Vesicare LS Suspension® **Non-Preferred Agent PA Criteria:** • Allergy to the preferred medications; **OR** • Contraindication or drug to drug interaction with the preferred medications; **OR** • History of unacceptable side effects; **OR** • Therapeutic failure with a one-month trial of one preferred medication **See additional medication-specific criteria below:** GELNIQUE • Clinical rationale why preferred agents inappropriate: inability to swallow, etc. **Duration of Approval**: 1 year

Uterine Disorder Treatments	**Preferred Agents:** *Clinical Prior Authorization Below* Myfembree® Oriahnn® Orilissa ® MYFEMBREE® (RELUGOLIX/NORETHINDRONE) • Patient ≥ 18 years old; **AND** • Patient is premenopausal**; AND** • Confirmed diagnosis of: • Uterine leiomyomas (fibroids) with heavy menstrual bleeding; **AND** o 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** o 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: o Non-steroidal anti-inflammatory drugs (NSAIDs); **AND** o 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 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