Clinical Criteria, Step Therapy, and Quantity Limits for TennCare Preferred Drug List (PDL)

July 1, 2025

Note: All agents must be prescribed by a provider with a Tennessee Medicaid Provider ID.

ANALGESICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Agents for Dependency				
Lucemyra®	P	**Initial Criteria:** • Must be ≥ 18 years of age; **AND** • Patient is not pregnant or breast feeding; **AND** • Attestation that if patient is at risk for QT interval prolongation (congestive heart failure, bradyarrhythmia, hepatic impairment, renal impairment, or taking other medicinal products that lead to QT prolongation), baseline electrocardiogram (ECG) has been performed; **AND** • Patient has tried and failed, had a contraindication to, or experienced an adverse reaction/intolerance to clonidine; **AND** • Prescriber to provide verbal attestation of a comprehensive treatment plan between provider and patient; **AND** • In the case of opioid use disorder (OUD), provide verbal attestation that patient: ○ Has a referral to **OR** active involvement in substance abuse counseling; **OR** ○ Is unable to have counseling **AND** provides verbal attestation that patient has been offered medication-assisted treatment (MAT) as part of a comprehensive treatment plan; **AND** • Provide verbal attestation that patient is NOT prescribed concurrent opioid medication without explanation (verified by state opioid database, if available); **AND** • Provide verbal attestation that the patient is capable of and instructed how to self-monitor for hypotension, orthostasis, bradycardia, and associated symptoms; **AND** • Provide verbal attestation that the patient has been provided with a tapering schedule and instructions on when to contact their healthcare provider for further guidance. **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • If the renewal is a continuation of the initial approval because additional therapy is needed, approve up to 7 additional days (for a total of 14 days of treatment, including days of treatment received as inpatient, if any)	16/day	General PA Form
Vivitrol® injection	P		1 vial per 28 days	
lofexidine	NP	See Lucemyra® prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance to preferred Lucemyra®	16/day	

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Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Buprenorphine and Buprenorphine/Naloxone				
Buprenorphine Enhanced Supportive Medication-Assisted Recovery and Treatment (BESMART) Network Provider only:				
buprenorphine/ naloxone tablets	P		8/2 mg: 3/day; 2/0.5 mg: 3/day ^	Buprenorphine Products PA Form
buprenorphine/ naloxone film	P		12/3 mg: 2/day; 8/2 mg: 3/day; 4/1 mg: 2/day; 2/0.5 mg: 3/day ^	
buprenorphine	NP	**Criteria:** • Diagnosis of opiate addiction; **AND** • Prescriber is enrolled and in good standing in the BESMART program; **AND** • Buprenorphine will not be approved for treatment of depression or pain; **AND** • ONE of the following: ○ Patients is actively pregnant (must provide estimated due date) ○ Patient is actively breastfeeding (must provide delivery date) ○ Request is for a two-day induction for patients transitioning off of Methadone ○ Patient is unable to take naloxone containing products due to a contraindication, drug to drug interaction, or history of toxic side effects that caused immediate or long-term damage (DOCUMENTATION REQUIRED). **Note**: Mild rash, itching, and GI intolerance are not accepted as intolerance to naloxone. **PA Approval durations**: – Pregnancy: 3 months past due date; – Breastfeeding: 6 months (maximum 4 approvals); – Contraindication to Naloxone: Initial Authorization 6-months, Reauthorization 12 months **Note**: The PA for buprenorphine monotherapy sublingual tablets in pregnant or breastfeeding patients diagnosed with opioid use disorder can be bypassed using Professional Pharmacy Service (PPS) Codes.	8 mg: 3/day; 2 mg: 3/day ^	
Suboxone® film	NP	**Criteria:** (6-month duration for initial request; 12-month duration for reauthorization) • Diagnosis of opiate addiction; **AND** • Prescriber is enrolled and in good standing in the BESMART program; **AND** • Buprenorphine will not be approved for treatment of depression or pain; **AND** • Patient has a documented allergy to inactive ingredient in preferred product that is not in requested product (DOCUMENTATION REQUIRED)	12/3 mg: 2/day; 8/2 mg: 3/day; 4/1 mg: 2/day; 2/0.5 mg: 3/day^	
Zubsolv®	NP	See Suboxone film prior authorization criteria	11.4/2.9 mg: 1/day 8.6/2.1 mg: 2/day; 5.7/1.4 mg: 3/day; 2.9/0.71 mg: 2/day; 1.4/0.36 mg: 3/day; 0.7/0.18 mg: 3/day	

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Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
***** For children, larger quantities may be approved as medically necessary.* ***^*** *Requests for 4/day will only be approved if dose is being titrated or patient's condition is too unstable to attempt to change to a higher strength.* ***Note**: Nurse Practitioner (NP) , Physician Assistant (PA) and other mid-level prescribers in the BESMART network are limited to MDD 16mg/day per TN state law.*				
All other TennCare Providers:				
buprenorphine/ naloxone tablets	P	**Criteria:** (6-month duration for initial request; 12-month duration for reauthorization) • Diagnosis of opiate addiction; **AND** • Prescriber is NOT a nurse practitioner or physician assistant; **AND** • Physician attests they have reviewed the Tennessee Controlled Substances Database for this patient on the date of the prior authorization request to ensure that concomitant narcotic or benzodiazepine use is not occurring. Additional Information: • Buprenorphine will not be approved for treatment of depression or pain. • Buprenorphine will not be approved for recipients whose medication history indicates use of concomitant narcotics or benzodiazepines without a clinically valid reason and drug tapering plan. • Quantity limit is as a single daily dose. Twice daily dosing may be approved as clinically necessary. • Physicians will be asked to provide an anticipated treatment plan for the patient (including anticipated dosing for induction & maintenance phases, anticipated frequency of office visits, & anticipated plan for psychosocial counseling). • The "Here to Help" program as an exclusive provider of counseling will not be accepted. • Prior Authorizations will be assigned to the prescribing physician. • Requests for buprenorphine from a different physician will require a new prior authorization request and documentation that the previous prescribing physician has communicated transfer of care.	8/2 mg: 2/day for 6 months then 1/day*; 2/0.5 mg: 3/day* ^	Buprenorphine Products PA Form
buprenorphine	NP	**Criteria:** See buprenorphine/naloxone tab prior authorization criteria; **AND** • ONE of the following: ○ Patients is actively pregnant (must provide estimated due date) ○ Patient is actively breastfeeding (must provide delivery date) ○ Request is for a two-day induction for patients transitioning off of Methadone ○ Patient is unable to take naloxone containing products due to a contraindication, drug to drug interaction, or history of toxic side effects that caused immediate or long-term damage (DOCUMENTATION REQUIRED). **Note**: Mild rash, itching, and GI intolerance are not accepted as intolerance to naloxone. **PA Approval Durations**: – Pregnancy: 3 months past due date; – Breastfeeding: 6 months (maximum 4 approvals); – Contraindication to Naloxone: Initial Authorization 6-months, Reauthorization 12 months	8 mg: 2/day for 6 months then 1/day*; 2 mg: 3/day* ^	
buprenorphine/ naloxone film	NP	See buprenorphine/naloxone tab prior authorization criteria; **AND** • Patient has a documented allergy to inactive ingredient in preferred product that is not in requested product (DOCUMENTATION REQUIRED)	12/3mg & 8/2 mg: 2/day for 6 months then 1/day*; 4/1 mg: 2/day 2/0.5 mg: 3/day* ^	
Suboxone® film	NP	See buprenorphine/naloxone tab prior authorization criteria; **AND** • Patient has a documented allergy to inactive ingredient in preferred product that is not in requested product (DOCUMENTATION REQUIRED)		

ANALGESICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Zubsolv®	NP	See buprenorphine/naloxone tab prior authorization criteria • Patient has a documented allergy to inactive ingredient in preferred product that is not in requested product (DOCUMENTATION REQUIRED)	11.4/2.9 & 8.6/2.1 mg: 1.day; 5.7/1.4mg :2/day for 6 months then 1/day*; 2.9/0.71 mg: 2/day; 1.4/0.36 mg: 3/day; 0.7/0.18 mg:3/day*	
***** For children, larger quantities may be approved as medically necessary. **^** *Requests for 4/day will only be approved if dose is being titrated or patient's condition is too unstable to attempt to change to a higher strength*				
Transmucosal Fentanyl Products				
fentanyl lozenge	NP	• Medication is ordered for the treatment of breakthrough cancer pain • Recipient must be receiving around-the-clock scheduled long-acting opioids • Recipient must be tolerant to opioids, defined as one of the following: ○ ≥ 60 mg oral morphine per day for at least one week without adequate pain relief ○ ≥ 25 mcg/hr transdermal fentanyl for at least one week without adequate pain relief ○ ≥ 30 mg oral oxycodone/day for at least one week without adequate pain relief ○ ≥ 8 mg oral hydromorphone/day for at least one week without adequate pain relief ○ ≥ 25 mg oral oxymorphone/day for at least one week without adequate pain relief ○ Equianalgesic dose of another opioid for at least one week without adequate pain relief • Trial and failure, contraindication, intolerance, or drug-to-drug interaction with at least 2 immediate release opioid products **Note**: Prescription should be written by or in consultation with an oncologist or pain management specialist unless patient is enrolled in or eligible for hospice care.	4/day	General PA Form
Fentora®	NP	See fentanyl lozenge prior authorization criteria	4/day	
Subsys®	NP	See fentanyl lozenge prior authorization criteria	4/day	
Naloxone Products				
Kloxxado®	P		2 sprayers/30 days	General PA Form
naloxone injection	P		2 injections/30 days	
naloxone nasal spray (Rx & OTC)	P		2 sprayers/30 days	
Narcan®	P		2 sprayers/30 days	
Opvee®	P		2 sprayers/30 days	

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Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Narcotic Agonist/Antagonists				
nalbuphine	P	• Trial and failure of at least 2 short acting narcotics; **OR** • Documented contraindication, or intolerance to short acting narcotics; **AND** • Unable to swallow, OR Unable to absorb medications through the GI tract.	10 mg/mL: 4 mL/day 20 mg/mL: 8 mL/day	General PA Form
butorphanol nasal spray	NP	• Documented inability to swallow or absorb PO narcotics, **OR** • For the treatment of migraines; **AND** ○ Recipient MUST be receiving prophylactic therapy for migraines, **AND** ○ Trial and failure, intolerance, or contraindication to at least **ONE** agent in EACH of the following categories: • 5-HT1 receptor antagonist (triptans) • Anti-migraine combinations • NSAIDs	2.5 mL/30 days	
pentazocine/ naloxone	NP	• Contraindication, or intolerance to ALL short acting narcotics • Prescriber has checked the Tennessee Controlled Substance Database for this patient within the last 30 days	12/day	

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Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Narcotics, Long-Acting **Approval of non-preferred agents in the Long-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.** ***** Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit:** Acute Use Opioid Criteria *******				
fentanyl patch 12, 25, 50, 75, & 100 mcg	P	See morphine ER tablets prior authorization criteria	10 patches/30 days; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day	

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Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Narcotics, Long-Acting **Approval of non-preferred agents in the Long-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.** ***** Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit:** Acute Use Opioid Criteria *******				

morphine ER tablets	P	• Management of severe pain with need for around-the-clock analgesia for an extended period; **AND**
		• Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; **AND**
		• Pain agreement required. Please refer to the Opioid and Controlled Substance Agreement; **AND**
		• Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider; **AND**
		• Requests for strengths ≥ 90mg: (Please refer to the TennCare MME Conversion Chart)
		  ○ Recipient must be opioid tolerant (as demonstrated by at least a week or longer history of morphine ≥ 60 mg/day, oral oxycodone ≥ 30 mg/day, oral hydromorphone ≥ 8 mg/day, or an equianalgesic dose of another opioid); **AND**
		• If request is for a female of child-bearing age (14-44 years), patient is not pregnant; **AND**
		  ○ Using contraception; **OR**
		  ○ Has an intrauterine device (IUD) or implant; **OR**
		  ○ Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND**
		• The provider attests to investigating ALL of the following before submitting a PA:
		  ○ History of substance abuse
		  ○ Frequent requests for early refills
		  ○ Reported frequent instances of lost tablets
		  ○ Requests for odd quantities which requires fractional dosing
		  ○ Requests for short-term or prn usage
		  ○ Medication history indicates concurrent use of other extended-release opioids
		Note: Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age on the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary.
			1/day;
			
			*^Max Total:
			Non-Chronic: 60 MME/day;
			Chronic: 200 MME/day
				Acute Opioid PA Form
				
				Chronic Opioid PA Form
				
				Exceptions Opioid PA Form

tramadol ER	P	See morphine ER prior authorization criteria	1/day; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day	

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Belbuca®	NP	• Management of severe pain with need for around-the-clock analgesia for an extended period; **AND**
		• Prescriber has checked the Tennessee Controlled Substance Database for this patient within the last 7 days; **AND**
		• Patients who have not been titrated down to no more than 30 mg morphine (or morphine equivalents) per day will NOT be approved; **AND**
		• Pain agreement required. Please refer to the Opioid and Controlled Substance Agreement; **AND**
		• Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider; **AND**
		• If request is for a female of child-bearing age (14-44 years), patient is not pregnant; **AND**
		  ○ Using contraception; **OR**
		  ○ Has an intrauterine device (IUD) or implant; **OR**
		  ○ Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND**
		• The prescriber attests to investigating all of following before submitting a PA:
		  ○ History of substance abuse
		  ○ Frequent requests for early refills
		  ○ Reported frequent instances of lost tablets
		  ○ Requests for odd quantities which requires fractional dosing
		  ○ Requests for short-term or prn usage
		  ○ Medication history indicates concurrent use of other extended-release opioids; **AND**
		• Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated
		Note: Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age on the risks of becoming pregnant while receiving opioids, including risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary.
			2/day;
			*^Max Total:
			Non-Chronic: 60 MME/day;
			Chronic: 200 MME/day
				Acute Opioid PA Form
				Chronic Opioid PA Form
				Exceptions Opioid PA Form

buprenorphine patch	NP	See Belbuca® prior authorization criteria Additionally, Butrans® 7.5, 10, 15, and 20 mcg/hr will be approved for opioid-experienced patients only.	4 patches/28 days; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day	
Butrans®	NP	See Belbuca® prior authorization criteria Additionally, Butrans® 7.5, 10, 15, and 20 mcg/hr will be approved for opioid-experienced patients only.	4 patches/28 days; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day	

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Narcotics, Long-Acting **Approval of non-preferred agents in the Long-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.** ***** Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit: Acute Use Opioid Criteria *****				

ConZip®	NP	• Management of severe pain with need for around-the-clock analgesia for an extended period; **AND**
		• Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; **AND**
		• Pain agreement required. Please refer to the Opioid and Controlled Substance Agreement; **AND**
		• Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider; **AND**
		• If request is for a female of child-bearing age (14-44 years), patient is not pregnant; **AND**
		  ○ Using contraception; **OR**
		  ○ Has an intrauterine device (IUD) or implant; **OR**
		  ○ Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND**
		• The prescriber attests to investigating ALL of the following before submitting a PA:
		  ○ History of substance abuse
		  ○ Frequent requests for early refills
		  ○ Reported frequent instances of lost tablets
		  ○ Requests for odd quantities which requires fractional dosing
		  ○ Requests for short-term or prn usage
		  ○ Medication history indicates concurrent use of other extended-release opioids; **AND**
		• If patient is 12 to 18 years of age: (For patients less than 12 years of age, approval will not be granted)
		  ○ Patient does not have any of the following:
		  – Obesity (BMI ≥ 30)
		  – Obstructive Sleep Apnea
		  – Severe Lung Disease (acute or severe asthma, COPD, Cystic Fibrosis, hypoxemia, hypercapnia, pneumonia, pulmonary hypertension, etc.)
		  – Recent adenectomy/tonsillectomy; **AND**
		  ○ Trial and failure or contraindication to acetaminophen; **AND**
		  ○ Trial and failure or contraindication to ALL NSAIDs; **AND**
		• Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated
		Note: Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age on the risks of becoming pregnant while receiving opioids, including risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary.
			1/day;
			
			*^Max Total:
			Non-Chronic: 60 MME/day;
			Chronic: 200 MME/day
				Acute Opioid PA Form
				
				Chronic Opioid PA Form
				
				Exceptions Opioid PA Form

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fentanyl patch 37.5, 62.5, & 87.5 mcg	NP	See hydromorphone ER prior authorization criteria	10 patches/30 days; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day	

hydrocodone ER	NP	• The prescriber has checked the Tennessee Controlled Substance Database for this patient within the last 7 days; **AND**
		• Pain agreement required. Please refer to the Opioid and Controlled Substance Agreement; **AND**
		• Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider
		• If request is for a female of child-bearing age (14-44 years), patient is not pregnant; **AND**
		  ○ Using contraception; **OR**
		  ○ Has an intrauterine device (IUD) or implant; **OR**
		  ○ Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND**
		• Approval of non-preferred agents requires: Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.
		• The following should be investigated before a PA is granted:
		  ○ History of substance abuse
		  ○ Frequent requests for early refills
		  ○ Reported frequent instances of lost tablets
		  ○ Requests for odd quantities which requires fractional dosing
		  ○ Requests for short-term or prn usage
		  ○ Medication history indicates concurrent use of other extended-release opioids
		• Requests for strengths ≥ 90mg: (Please refer to the TennCare MME Conversion Chart)
		  ○ Recipient must be opioid tolerant (as demonstrated by at least a week or longer history of morphine ≥ 60 mg/day, oral oxycodone ≥ 30 mg/day, oral hydromorphone ≥ 8 mg/day, or an equianalgesic dose of another opioid)
			Tabs: 1/day;
			Caps: 2/day;
			
			*^Max Total:
			Non-Chronic: 60 MME/day;
			Chronic: 200 MME/day
				Acute Opioid PA Form
				
				Chronic Opioid PA Form
				
				Exceptions Opioid PA Form

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hydromorphone ER	NP	• Management of severe pain with need for around-the-clock analgesia for an extended period; **AND**
		• Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; **AND**
		• Pain agreement required. Please refer to the Opioid and Controlled Substance Agreement; **AND**
		• Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider; **AND**
		• Requests for strengths ≥ 90mg: (Please refer to the TennCare MME Conversion Chart)
		  ○ Recipient must be opioid tolerant (as demonstrated by at least a week or longer history of morphine ≥ 60 mg/day, oral oxycodone ≥ 30 mg/day, oral hydromorphone ≥ 8 mg/day, or an equianalgesic dose of another opioid); **AND**
		• If request is for a female of child-bearing age (14-44 years), patient is not pregnant; **AND**
		  ○ Using contraception; **OR**
		  ○ Has an intrauterine device (IUD) or implant; **OR**
		  ○ Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND**
		• The provider attests to investigating ALL of the following before submitting a PA:
		  ○ History of substance abuse
		  ○ Frequent requests for early refills
		  ○ Reported frequent instances of lost tablets
		  ○ Requests for odd quantities which requires fractional dosing
		  ○ Requests for short-term or prn usage
		  ○ Medication history indicates concurrent use of other extended-release opioids; **AND**
		• Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated
		Note: Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age on the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary.
			Tablet: 1/day;
			
			*^Max Total:
			Non-Chronic: 60 MME/day;
			Chronic: 200 MME/day
				Acute Opioid PA Form
				
				Chronic Opioid PA Form
				
				Exceptions Opioid PA Form

Hysingla® ER	NP	See hydromorphone ER prior authorization criteria	1/day; *^Max Total: Non-Chronic: 60MME/day; Chronic: 200 MME/day	

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methadone	NP	• One of the following:
		  ○ Diagnosis of Metastatic Neoplasia
		  ○ Infants up to 1 year of age who are discharged from hospital on a methadone taper will be approved for up to 30 days
		  ○ Management of severe pain with need for around-the-clock analgesia for an extended period AND patient has contraindication to all other long-acting opioids; **AND**
		• Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; **AND**
		• Pain agreement required. Please refer to the Opioid and Controlled Substance Agreement; **AND**
		• Concomitant use of benzodiazepines & opioids will only be approved under the care of, or referral to, a mental health provider; **AND**
		• Requests for strengths ≥ 90mg: (Please refer to the TennCare MME Conversion Chart)
		  ○ Recipient must be opioid tolerant (as demonstrated by at least a week or longer history of morphine ≥ 60 mg/day, oral oxycodone ≥ 30 mg/day, oral hydromorphone ≥ 8 mg/day, or an equianalgesic dose of another opioid); **AND**
		• If request is for a female of child-bearing age (14-44 years), patient is not pregnant; **AND**
		  ○ Using contraception; **OR**
		  ○ Has an intrauterine device (IUD) or implant; **OR**
		  ○ Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND**
		• The following should be investigated before a PA is granted:
		  ○ History of substance abuse
		  ○ Frequent requests for early refills
		  ○ Reported frequent instances of lost tablets
		  ○ Requests for odd quantities which requires fractional dosing
		  ○ Requests for short-term or prn usage
		  ○ Medication history indicates concurrent use of other extended-release opioids; **AND**
		Note: TennCare does not cover any form of methadone for the treatment of opioid addiction.
		Note: Use of opioid analgesics during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age on the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary.
			5 mg: 8/day;
			10 mg: 4/day;
			5 mg/5 mL: 40mL/day; 10 mg/5 mL: 20 mL/day;
			10 mg/mL: 4 mL/day;
			
			*^Max Total:
			Non-Chronic:
			60 MME/day;
			Chronic: 200 MME/day
				Acute Opioid PA Form
				
				Chronic Opioid PA Form
				
				Exceptions Opioid PA Form

Methadose®	NP	See methadone prior authorization criteria	See methadone	
morphine ER capsules	NP	See hydromorphone ER prior authorization criteria	Beads Caps: 1/day; Caps: 2/day *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	

ANALGESICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Narcotics, Long-Acting **Approval of non-preferred agents in the Long-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.** ***** Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit: Acute Use Opioid Criteria *****				
MS Contin®	NP	See hydromorphone ER prior authorization criteria	15, 30, 60 mg: 3/day; 100 mg: 2/day; 200 mg: 1/day; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day	Acute Opioid PA Form Chronic Opioid PA Form Exceptions Opioid PA Form
oxycodone ER	NP	See hydromorphone ER prior authorization criteria	2/day; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day	
Oxycontin®	NP	See hydromorphone ER prior authorization criteria		
Oxymorphone ER	NP	See hydromorphone ER prior authorization criteria **Note**: Due to cross-reactivity with morphine, oxymorphone SR will not be approved for patients with immune-mediated morphine allergy.		

***^Morphine Milligram Equivalent (MME) Criteria:**

- Indication or diagnosis is Cancer pain or Hospice
  - ***Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days (document date); AND***
  - Document prescriber's specialty; **AND**
  - Patient has a written treatment plan with established objectives; **AND**
  - ***Patient has a signed Pain Management Agreement; AND***
  - If request is for a female of child-bearing age (14-44 years), patient is not pregnant**; AND**
    - Using contraception (e.g., barrier, oral contraceptive, rhythm method); **OR**
    - Has an intrauterine device (IUD) or implant; **OR**
    - Has history of hysterectomy, tubal ligation, or endometrial ablation

ANALGESICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Narcotics, Short-Acting **Approval of non-preferred agents in the Short-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.** ***** Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit:** Acute Use Opioid Criteria *******				
codeine/APAP	P	• Patient is ≥ 12 years of age and < 18 years of age; **AND** • Trial and failure of acetaminophen; **AND** • Contraindication to ALL NSAIDs; **AND** • Patient does not have any of the following: ○ Obesity ○ Obstructive Sleep Apnea ○ Severe Lung Disease (acute or severe asthma, COPD, Cystic Fibrosis, hypoxemia, hypercapnia, pneumonia, etc.) ○ Recent adenectomy/tonsillectomy	12/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	Acute Opioid PA Form Chronic Opioid PA Form Exceptions Opioid PA Form
Endocet®	P		2.5/325 mg tab: 12/day; All other tabs: 8/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	
hydrocodone/ APAP 325 mg	P		5/325 mg tab: 12/day; 7.5/325 & 10/325 mg tabs: 8/day; soln: 120 mL/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	
hydrocodone/ ibuprofen	P		5/200 mg tab: 12/day; 7.5/200 mg tab: 8/day; 10/200 mg tab: 6/day; *^Max Total: Non-Chronic:60 MME/day; Chronic: 200 MME/day	
hydromorphone tabs	P		2 mg: 7/day; 4 mg: 3/day; 8 mg: 1/day; *^Max Total: Non-Chronic:60 MME/day Chronic: 200 MME/day	
morphine IR tabs	P		6/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	

ANALGESICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Narcotics, Short-Acting **Approval of non-preferred agents in the Short-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.** ***** Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit:** Acute Use Opioid Criteria *******				

morphine solution	P	• Prescriber has checked the Tennessee Controlled Substance Database for this patient within the last 7 days (document date); OR request is for a hospice patient, HIV/AIDS patient, active cancer patient, OR long-term care facility resident (document name of facility); **AND**
		• Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider; **AND**
		• Pain agreement required. Please refer to the Opioid and Controlled Substance Agreement; **AND**
		• If patient is females and of child-bearing age (14-44 years), patient is not pregnant; **AND**
		  ○ One of the following:
		  – Using contraception
		  – Has an intrauterine device (IUD) or implant
		  – Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND**
		• Recipient must be opioid tolerant (as demonstrated by ≥1 week history of morphine ≥ 60 mg/day, oral oxycodone ≥ 30 mg/day, oral hydromorphone ≥ 8 mg/day, or an equianalgesic dose of another opioid)
			*^Max Total:
			Non-Chronic: 60 MME/day
			Chronic: 200 MME/day
				Acute Opioid PA Form

oxycodone/ APAP 325mg	P		2.5/325 mg tab: 12/day; All other tabs: 8/day; soln: 40 mL/day *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	Chronic Opioid PA Form
oxycodone concentrate	P	See morphine solution prior authorization criteria	*^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	Exceptions Opioid PA Form
oxycodone tabs	P		5 & 10 mg: 8/day; 15, 20, & 30 mg: 4/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	
oxycodone soln	P		*^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	

ANALGESICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Narcotics, Short-Acting **Approval of non-preferred agents in the Short-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.** ***** Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit:** Acute Use Opioid Criteria *******				

tramadol	P	• Patient is ≥ 12 years of age and < 18 years of age; **AND**
		• Patient does not have any of the following:
		  ○ Obesity (BMI ≥ 30)
		  ○ Obstructive Sleep Apnea
		  ○ Severe Lung Disease (acute or severe asthma, COPD, Cystic Fibrosis, hypoxemia, hypercapnia, pneumonia, etc.)
		  ○ Recent adenectomy/tonsillectomy; **AND**
		• Trial and failure or contraindication to acetaminophen; **AND**
		• Trial and failure or contraindication to ALL NSAIDs
		Note: Patients 18 years and older will only be subject to the quantity limit and opioid criteria
			8 tabs/day;
			80 mL/day
			*^Max Total:
			Non-Chronic: 60 MME/day
			Chronic: 200 MME/day
				Acute Opioid PA Form
				
				Chronic Opioid PA Form
				
				Exceptions Opioid PA Form

tramadol/APAP	P	See tramadol prior authorization criteria	12/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	
Apadaz®	NP		6.12/325 mg tab: 8/day; 8.16/325 mg tab: 6/day; 4.08/325 mg tab: 12/day Max: 4 g APAP/day	
benzhydrocodone/ APAP	NP		See Apadaz®	

butalbital/APAP/ caffeine/codeine	NP	• Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long- term damage (NOTE: this does not include GI intolerance) with ALL preferred short-acting narcotic agents; **AND**
		• One of the following:
		  ○ Patients ≥ 18 years of age
		  ○ Patient is ≥ 12 years of age and < 18 years of age; **AND**
		  – Trial and failure of acetaminophen; **AND**
		  – Contraindication to ALL NSAIDs; **AND**
		  – Patient does not have any of the following:
		  • Obesity
		  • Obstructive Sleep Apnea
		  • Severe Lung Disease (acute or severe asthma, COPD, Cystic Fibrosis, hypoxemia, hypercapnia, pneumonia, etc.)
		  • Recent adenectomy/tonsillectomy
			Butalbital-containing products: 20/30 days**
			Max: 4 g APAP/day	

butalbital/ASA/ caffeine/codeine	NP	See butalbital/APAP/caffeine/codeine prior authorization criteria	Butalbital-containing products: 20/30 days**	

ANALGESICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Narcotics, Short-Acting **Approval of non-preferred agents in the Short-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.** ***** Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit:** Acute Use Opioid Criteria *******				
codeine	NP	See butalbital/APAP/caffeine/codeine prior authorization criteria	15 mg & 30 mg: 12/day; 60 mg: 6/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	Acute Opioid PA Form Chronic Opioid PA Form Exceptions Opioid PA Form
dihydrocodeine/ APAP/caffeine	NP	See butalbital/APAP/caffeine/codeine prior authorization criteria	8 tabs/day; Max: 4 g APAP/day	

Dilaudid®	NP	• Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents; **AND**
		• Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days; **AND**
		• Pain agreement required. Please refer to the Opioid and Controlled Substance Agreement; **AND**
		• Concomitant use of benzodiazepines and opioids will only be approved under the care of, or referral to, a mental health provider.
		• If request is for a female of child-bearing age (14-44 years), patient is not pregnant; **AND**
		  ○ Using contraception; **OR**
		  ○ Has an intrauterine device (IUD) or implant; **OR**
		  ○ Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND**
		• Has history of hysterectomy, tubal ligation, or endometrial ablation
		Note: Use of opioids during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary.
			2 mg: 7/day;
			4 mg: 3/day;
			8 mg: 1/day;
			*^Max Total:
			Non-Chronic: 60 MME/day
			Chronic: 200 MME/day	

Fioricet® with codeine	NP	See butalbital/APAP/caffeine/codeine prior authorization criteria	Butalbital-containing products: 20/30 days** Max: 4 g APAP/day	
hydrocodone/ APAP 300 mg	NP	See Dilaudid® prior authorization criteria	5/300 mg tab: 12/day; 10/300 mg tab: 6/day; Soln: 89 mL/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	
hydromorphone liquid	NP	See Dilaudid® prior authorization criteria	15 mL/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	
hydromorphone suppositories	NP	See Dilaudid® prior authorization criteria	5/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	

ANALGESICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Narcotics, Short-Acting **Approval of non-preferred agents in the Short-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.** ***** Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit: Acute Use Opioid Criteria *****				
levorphanol	NP	See Dilaudid® prior authorization criteria	6/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	Acute Opioid PA Form Chronic Opioid PA Form Exceptions Opioid PA Form
Lortab®	NP	See Dilaudid® prior authorization criteria	5/325 mg tabs: 8/day; All other tabs: 8/day; soln: 89 mL/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	
meperidine	NP	See Dilaudid® prior authorization criteria	tabs: 12/day; soln: 60 mL/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	
morphine suppositories	NP	See Dilaudid® prior authorization criteria	5 mg: 12/day; All others: 6/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	
Nalocet®	NP	See Dilaudid® prior authorization criteria	12/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	
Oxaydo®	NP	See Dilaudid® prior authorization criteria	8/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	
oxycodone/ APAP 300 mg	NP	See Dilaudid® prior authorization criteria	2.5/325 mg tab: 12/day; All other tabs: 8/day; soln: 40 mL/day *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	

ANALGESICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Narcotics, Short-Acting **Approval of non-preferred agents in the Short-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.** ***** Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit:** Acute Use Opioid Criteria *******				
oxycodone caps	NP	See Dilaudid® prior authorization criteria	8/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	Acute Opioid PA Form Chronic Opioid PA Form Exceptions Opioid PA Form
oxymorphone	NP	See Dilaudid® prior authorization criteria	4/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	
Percocet®	NP	See Dilaudid® prior authorization criteria	2.5/325 mg: 12/day; All others: 8/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	
Prolate®	NP	See Dilaudid® prior authorization criteria	tabs: 8/day; soln: 40 mL/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200	
Qdolo®	NP		*^Max Total: Non-Chronic: 60 MME/day Chronic: 200	
Roxicodone®	NP	See Dilaudid® prior authorization criteria	4/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	
Roxybond®	NP	See Dilaudid® prior authorization criteria	4/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	

ANALGESICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Narcotics, Short-Acting **Approval of non-preferred agents in the Short-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.** ***** Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit:** Acute Use Opioid Criteria *******				

Seglentis®	NP	• Patient is > 12 years of age and < 18 years of age; **AND**
		  ○ Patient does not have any of the following:
		  – Obesity (BMI ≥ 30)
		  – Obstructive Sleep Apnea
		  – Severe Lung Disease (acute or severe asthma, COPD, Cystic Fibrosis, hypoxemia, hypercapnia, pneumonia, pulmonary hypertension, etc.)
		  – Recent adenectomy/tonsillectomy; **AND**
		  ○ Trial and failure or contraindication to acetaminophen; **AND**
		  ○ Trial and failure or contraindication to ALL NSAIDs**; AND**
		  ○ Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents; **AND**
		• Patient is ≥ 18 years of age:
		  ○ If request is for a female of child-bearing age (14-44 years), patient is not pregnant; **AND**
		  – Using contraception; **OR**
		  – Has an intrauterine device (IUD) or implant; **OR**
		  – Has history of hysterectomy, tubal ligation, or endometrial ablation; **AND**
		  ○ Contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents; **AND**
		Note: Use of opioids during pregnancy has been associated with Neonatal Opioid Withdrawal Syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome. Providers should offer access to contraceptive services when necessary.
			12/day;
			*^Max Total:
			Non-Chronic: 60 MME/day
			Chronic: 200 MME/day
				Acute Opioid PA Form
				Chronic Opioid PA Form
				Exceptions Opioid PA Form

Ultracet®	NP	See Seglentis® prior authorization criteria	12/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	

ANALGESICS

Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.

Medication	PDL	Prior Authorization Criteria	Qty. Limits	PA Form
Narcotics, Short-Acting				

Approval of non-preferred agents in the Short-Acting Narcotics class requires contraindication, drug to drug interaction, or history of toxic side effects that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents, unless otherwise indicated.

***** Edits on agents in the Short-Acting and Long-Acting Narcotics classes of the PDL impact all first-time (acute) and non-chronic opioid users. For details, visit: Acute Use Opioid Criteria *****

****Quantity Limit Override Criteria for Butalbital-Containing Products:***

Requests for butalbital-containing products for quantities greater than 20 per 30 days will be approved for patients meeting the following criteria:

- Trial and failure of at least 2 prophylactic headache treatments: a tricyclic antidepressant (unless contraindicated) PLUS at least one of the following: divalproex sodium, sodium valproate, topiramate, frovatriptan or beta-blocker

***^Morphine Milligram Equivalent (MME) Criteria:**

- Indication or diagnosis is Cancer pain or Hospice
  - ***Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 7 days (document date); AND***
  - Document prescriber's specialty; **AND**
  - Patient has a written treatment plan with established objectives; **AND**
  - ***Patient has a signed Pain Management Agreement; AND***
  - Female of child-bearing age (14-44 years):
    - Is not pregnant; **AND**
    - Using contraception; **OR**
    - Has an intrauterine device (IUD) or implant; **OR**
    - Has history of hysterectomy, tubal ligation or endometrial ablation

ANALGESICS

Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.

Medication	PDL	Prior Authorization Criteria	Qty. Limits	PA Form
NSAIDs				
celecoxib	P		2/day	General PA Form
diclofenac 1% gel	P		10 g/day	
ketorolac tabs	P		20/60 days	
Pennsaid	P	• Diagnosis of osteoarthritis pain of the knee		
Voltaren® gel	P		10 g/day	
Celebrex®	NP		2/day	
diclofenac caps, packet, and solution	NP	• Clinically valid reason why the preferred NSAIDs cannot be used		
diclofenac patch	NP	• Clinically valid reason why the preferred NSAIDs cannot be used	2 patches/day	
diclofenac potassium 25 mg tabs		• Clinically valid reason why the preferred diclofenac products cannot be used		

ANALGESICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Elyxb®	NP	• Diagnosis of migraine; **AND** • Patient is unable to swallow solid dosage forms	120 mg/day	
Lofena®	NP	• Clinically valid reason why the preferred diclofenac products cannot be used		
ketorolac spray	NP	Trial and failure, contraindication, or intolerance of oral ketorolac; **OR** Patient is unable to swallow solid dosage forms	5 bottles/60 days	
Flector®	NP	Clinically valid reason why the preferred NSAIDs cannot be used	2 patches/day	
meloxicam caps	NP	• Clinically valid reason why the preferred meloxicam tablets cannot be used	1/day	
Sprix®	NP	• Trial and failure, contraindication, or intolerance of oral ketorolac; **OR** • Patient is unable to swallow solid dosage forms	5 bottles/60 days	General PA Form
Toradol®	NP		20/60 days	
NSAID/Anti-Ulcer Agents				
diclofenac/ misoprostol	P	• Patient is ≥ 60 years old; **OR** • Patients < 60 years old and is at high risk for GI side effects as indicated by ANY of the following: ○ History of peptic ulcer disease/GI bleed/NSAID gastropathy ○ GERD (gastroesophageal reflux disease) due to conventional NSAIDS ○ Patient on anticoagulants ○ Patient on chronic corticosteroids ○ History of platelet dysfunction or coagulopathy, including use of clopidogrel or aspirin ○ Patient on methotrexate	50 mg/200 mcg: 4/day; 75 mg/200 mcg: 2/day	General PA Form
Ibuprofen/ famotidine	P	• Patient is at high risk for GI side effects as indicated by ANY of the following: History of peptic ulcer disease/GI bleed/NSAID gastropathy GERD (gastroesophageal reflux disease) due to conventional NSAIDS Patient on anticoagulants Patient on chronic corticosteroids History of platelet dysfunction or coagulopathy, including use of clopidogrel or aspirin Patient on methotrexate	3/day	
Vimovo®	P	• See Duexis® prior authorization criteria	2/day	
Arthrotec®	NP		50 mg/200 mcg: 4/day; 75 mg/200 mcg: 2/day	
Duexis®	NP		3/day	
naproxen/ esomeprazole	NP		2/day	

ANALGESICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Non-Opioid Analgesics				
Journavx®	P	**Journavx is available without prior authorization for up to 30 tablets per 180 days. Requests exceeding this quantity limit will require prior authorization.** **Criteria: (approval duration-14-days)** • Patient is 18 years of age or older; **AND** • Diagnosis of moderate to severe acute pain; **AND** • Medication will not be used for longer than 14 days for any one acute pain occurrence; **AND** • Prescriber attests that pain cannot be controlled with conventional pharmacological therapies such as acetaminophen, NSAIDS, and local anesthetics; **AND** • Patient does not have severe hepatic impairment (Child Pugh Class-C); **AND** • Medication will not be used in combination with opioid products (e.g. oxycodone, hydrocodone); **AND** • Medication will not be used in combination with strong CYP3A inhibitors; **AND** • For female patients with reproductive potential, prescriber attest to BOTH of the following: ○ Patient is not pregnant prior to initiation of therapy • Patients taking concomitant hormonal contraceptives containing progestins other than levonorgestrel and norethindrone have been advised to use alternative contraceptives during Journavx treatment and for 28 days after discontinuation of therapy	30 /180 days	General PA Form
Salicylates				
salsalate	P		500 mg: 6/day; 750 mg: 4/day	General PA Form
diflunisal	NP		3/day	

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antibiotics: Agents for Diarrhea				
vancomycin soln	P	• Patient is unable to swallow sold dosage forms; **OR** • Patient is < 12 years of age	2,000 mg/day	
Aemcolo®	NP	• Patient is being treated for traveler's diarrhea; **AND** • Trial and failure, contraindication, intolerance, drug-drug interaction or resistance to a fluoroquinolone or azithromycin	12 tabs/Rx; max 24 tabs/year	
Firvanq®	NP	• Trial and failure, contraindication, or intolerance to generic vancomycin solution	2,000 mg/day	
Vancocin®	NP	• Trial and failure, contraindication, or intolerance to vancomycin capsules		
Antibiotics: Aminoglycosides, Oral				

Arikayce®	NP	**Initial Criteria:**
		• Patient is ≥ 18 years of age; **AND**
		• Diagnosis of Mycobacterium avium complex (MAC) lung disease as determined by the following:
		  ○ Chest radiography or high-resolution computed tomography (HRCT) scan; **AND**
		  ○ At least two positive sputum cultures; **AND**
		  ○ Other conditions such as tuberculosis and lung malignancy have been ruled out; **AND**
		• Patient has failed a multi-drug regimen with a macrolide (clarithromycin or azithromycin), rifampin, and ethambutol. (Failure is defined as continual positive sputum cultures for MAC while adhering to a multi-drug treatment regimen for a minimum duration of 6-months); **AND**
		• Prescribed in conjunction with a multi-drug antimycobacterial regimen
		Renewal Criteria:
		• Patient has demonstrated response to therapy defined as having three consecutive monthly negative sputum cultures by month six of treatment; **AND**
		• Patient has not experienced toxicity to amikacin treatment (e.g., ototoxicity, renal toxicity, neuromuscular blockade)
			8.4 mL/day	General PA Form

Antibiotics: Anti-Tuberculosis, Oral				
Sirturo®	NP	**Criteria: (9-month approval duration)** • Patient is ≥ 5 years of age and weighs ≥ 15 kg; **AND** • Patient has a diagnosis of pulmonary multi drug-resistant tuberculosis (MDR-TB); **AND** • Sirturo is prescribed as part of a combination regimen with at least 3 other drugs to which the patient's MDR-TB isolate has been shown to be susceptible; **AND** Sirturo is prescribed by, or in consultation with, an infectious disease specialist		
Antibiotics: Cephalosporins Third Generation				
cefpodoxime suspension	NP	• Patient less than 12 years of age and treatment is for genitourinary infection; **OR** • Patient is unable to swallow solid dosage forms		General PA Form
Antibiotics: Lincosamides, Oral				
clindamycin pediatric solution	P	• Patient less than 12 years of age; **OR** • Patient is unable to swallow solid dosage forms		General PA Form
Cleocin® Pediatric granules	NP	• Patient is unable to swallow solid dosage forms		

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antibiotics: Macrolides				
azithromycin packet	P		2 g/Rx	General PA Form
azithromycin suspension	P			
azithromycin tablets	P		250, 500 mg: 12/Rx 600 mg: 8/month	
clarithromycin ER/XL	NP		2/day	
Dificid® tablets & suspension	NP	• Diagnosis of *Clostridium difficile (C. diff)* associated diarrhea **Note**: Individuals started on Dificid® therapy in the hospital will be approved for this agent following hospital discharge to allow for completion of the course of therapy.	Tabs: 2/day Susp: 1 bottle/Rx	
Zithromax® packet	NP		2 g/Rx	
Zithromax® susp	NP			
Zithromax® tablet	NP		250, 500 mg: 12/Rx 600 mg: 8/month	
Antibiotics: Nitrofurans, Oral				
nitrofurantoin suspension	P	• Patient is unable to swallow solid dosage forms **Note**: PA not required for patients less than 12 years of age.		General PA Form
Antibiotics: Oxazolidinones				
linezolid tablets	P	• Treatment is for ONE of the following: ○ Vancomycin Resistant Enterococcus faecalis infections ○ Healthcare-associated Methicillin-Resistant Staph Aureus (MRSA) infections or community-acquired MRSA with polyresistance ○ Community-acquired pneumonia (CAP) caused by S. pneumoniae or S. aureus (MSSA) ○ Nosocomial pneumonia caused by S. pneumoniae or S. aureus (including MSSA and MRSA) ○ Complicated skin and skin structure infections (SSSI) caused by S. aureus (MSSA and MRSA), S. pyogenes, or S. agalactiae. ○ Uncomplicated SSTI caused by S. aureus (MSSA only) or S. pyogenes ○ Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy)	2/day	General PA Form
linezolid suspension	P	• One of the following: ○ Patient is less than 12 years of age ○ Patient is unable to swallow oral dosage forms ○ Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy)		
Sivextro®	NP	• Diagnosis of acute bacterial skin and skin structure infection; **AND** ○ Patient must be resistant to or have a contraindication, or intolerance, to all other treatment options; **OR** • Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy)	1/day	
Zyvox® suspension	NP		60 mL/day	
Zyvox® tablets	NP		2/day	

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antibiotics: Quinolones, Oral				

Baxdela®	NP	• Patient age ≥ 18 years of age; **AND**
		• ONE of the following:
		  ○ Diagnosis of acute bacterial skin and skin structure infection (ABSSSI); **AND**
		  – Trial and failure to, contraindication, or resistance to ONE preferred standard of care agents for ABSSSI (e.g., linezolid, clindamycin, doxycycline, SMX-TMP, vancomycin, cephalosporin, a preferred fluoroquinolone)
		  ○ Diagnosis of community-acquired bacterial pneumonia (CABP); **AND**
		  – Trial and failure to, contraindication, or resistance to TWO preferred standard of care agents for CABP (e.g., macrolide, doxycycline, a preferred fluoroquinolone, beta-lactam, linezolid)
		  ○ Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy)
			2/day;
			Max 14-day supply
				General PA Form

Cipro® suspension	NP	• Patient is unable to swallow solid dosage forms		
ciprofloxacin suspension	NP	• Patient is unable to swallow solid dosage forms		
Levofloxacin solution	NP	• Patient is unable to swallow solid dosage forms		
moxifloxacin	NP	• Trial and failure, contraindication, or intolerance to 2 preferred agents; **OR** • Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy)		
Antibiotics: Tetracyclines				
doxycycline hyclate caps	P		50 mg: 3/day; All others: 2/day	General PA Form
doxycycline hyclate tabs 50, 100 mg			50 mg: 3/day; All others: 2/day	
doxycycline monohydrate caps 50, 100 mg	P		50 mg: 3/day; All others: 2/day	
demeclocycline	NP	• Trial and failure of 2 preferred agents; **OR** • Treatment is for syndrome of inappropriate antidiuretic hormone secretion (SAIDH)		
Doryx®	NP		50 mg: 3/day; All others: 2/day	
doxycycline DR	NP		50 mg: 3/day; All others: 2/day	
doxycycline hyclate tabs 20, 75, 150 mg	NP	• Agent is used as an adjunct to scaling and root planting to promote attachment level gain and to reduce pocket depth for adult periodontitis	2/day	
doxycycline monohydrate caps 75, 150 mg	NP		2/day	
doxycycline suspension	NP	• Patient is unable to swallow solid dosage forms		

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
minocycline ER	NP	• Patient is ≤ 21 years old; **AND** • Diagnosis of non-nodular moderate to severe acne vulgaris with inflammatory lesions; **AND** • Patient requires long-term therapy with an oral tetracycline; **AND** • Trial and failure, contraindication, or intolerance of TWO of the following topical agents: ○ Metronidazole (Metrogel®) ○ Azelaic acid (Azelex®, Finacea®) ○ Erythromycin (A/T/S® solution, gel) ○ Clindamycin (Cleocin T®) ○ Topical keratolytic agents (such as benzoyl peroxide, salicylic acid preparations); **AND** • Clinically valid reason why the preferred minocycline capsules cannot be used	1/day	General PA Form
Minolira® ER	NP	See minocycline ER prior authorization criteria	1/day	
Nuzyra®	NP	**Criteria: (approval duration: 14 days)** • Patient is ≥ 18 years of age; **AND** • One of the following: ○ Community-acquired bacterial pneumonia (CABP); **AND** – Trial and failure to, contraindication, or resistance to TWO preferred standard of care agents for CABP (e.g., macrolide, doxycycline, a preferred fluoroquinolone, beta-lactam, linezolid) ○ Diagnosis of acute bacterial skin and skin structure infections (ABSSSI); **AND** – Trial and failure to, contraindication, or resistance to ONE preferred standard of care agents for ABSSSI (e.g., linezolid, clindamycin, doxycycline, SMX-TMP, vancomycin, cephalosporin, a preferred fluoroquinolone) ○ Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy)	3/day; Max 14-day supply	
Oracea®	NP	• Diagnosis of inflammatory lesions (papules and pustules) of rosacea; **AND** • Patient is < 21 years of age; **AND** • Patient requires long-term therapy (greater than 3 months) with an oral antibiotic; **AND** • Trial and failure, contraindication, or intolerance to ONE of the following topical agents: ○ Metronidazole (e.g., MetroGel®, MetroCream®) ○ Azelaic Acid (e.g., Azelex®, Finacea®) ○ Erythromycin gel or solution	2/day	
Solodyn®	NP	See minocycline ER prior authorization criteria	1/day	
Targadox®	NP		3/day	General PA Form
Vibramycin®	NP		50 mg: 3/day; All others: 2/day	
Ximino®	NP	See minocycline ER prior authorization criteria	1/day	
Antibiotics: UTI Agents, Miscellaneous				
fosfomycin	NP	• Trial and failure, contraindication, intolerance, or resistance to at least 2 of the following agents: ○ Sulfamethoxazole/trimethoprim ○ Quinolones ○ Nitrofurantoin	1 packet (3 g) per course of therapy	General PA Form

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antibiotics, Vaginal				
Cleocin® cream	P		40 g/Rx	General PA Form
metronidazole 0.75% vaginal gel	P		70 g/Rx	
Nuvessa®	P		5 g/Rx	
Vandazole®	P		70 g/Rx	
clindamycin phos 2% cream	NP		40 g/Rx	
Clindesse® vaginal cream	NP		5 g/Rx	
Antifungals, Oral				
fluconazole suspension	P	• Patient is unable to swallow solid dosage forms; **OR** Patients ≤ 20 years of age		
fluconazole tablets	P		150 mg: 4/28 days	
Sporanox® capsules	P		4/day	
Sporanox® solution	P	• Patient is unable to swallow sold dosage forms	40 mL/day	
terbinafine tablets	P		84/year	
Ancobon®	NP	• Diagnosis of systemic candidiasis or cryptococcosis; **OR** • Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy)		
Brexafemme®	NP	• Diagnosis of vulvovaginal candidiasis; **AND** • One of the following: ○ Patient is ≥ 18 years of age ○ Patient is a post-menarchal female; **AND** • Patient is not pregnant; **AND** • Trial and failure, contraindication, or intolerance to 1 preferred oral agent (fluconazole tablets) OR 1 preferred topical agent (miconazole-3 kit or terconazole)	4 tabs/Rx	
Cresemba® oral	NP	• Patient is ≥ 6 years of age; **AND** ○ Diagnosis of one of the following: – Invasive aspergillosis; **AND** • Trial and failure, contraindication, or intolerance to voriconazole OR posaconazole – Invasive mucormycosis; **AND** ○ A fungal culture and relevant laboratory study (including histopathology) has been obtained to isolate and identify the causative organism(s); **OR** • Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy)		
Diflucan® susp	NP	• Patient is unable to swallow solid dosage forms		
Diflucan® tablets	NP		150 mg: 4/28 days	

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
flucytosine	NP	• Diagnosis of systemic candidiasis or cryptococcosis; **OR** • Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy)		
itraconazole caps	NP	• Trial and failure of preferred Sporanox® capsules	4/day	
itraconazole soln	NP	• Patient is unable to swallow solid dosage forms; **AND** • Trial and failure of preferred Sporanox® solution	40 mL/day	
ketoconazole	NP	• Trial and failure, contraindication, or intolerance to TWO preferred agents; **OR** • Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy)		
Noxafil®	NP	• ONE of the following: ○ As indicated for the prophylaxis of invasive *aspergillus* and/or *candida* in patients who are at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with Graft versus Host Disease (GVHD), recipients with hematologic malignancies (leukemia, lymphoma, myelodysplastic syndromes) with prolonged neutropenia from chemotherapy, or recipients with AIDS. ○ Treatment of Fusariosis disease ○ Treatment of Zygomycetes disease ○ Treatment of other fungal infections or molds that are refractory or resistant to, or in patient who have a contraindication, or intolerance to itraconazole or voriconazole ○ Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy)		
Oravig®	NP	• Patient is 18 years of age or older; **AND** • Patient has a diagnosis of oropharyngeal candidiasis; **AND** • Patient has a contraindication, allergic reaction, or drug-drug interaction to clotrimazole troche and nystatin	1/day	
posaconazole	NP	See Noxafil® prior authorization criteria		
Tolsura®	NP	• Diagnosed of ONE of the following: ○ Aspergillosis (pulmonary and extrapulmonary) ○ Blastomycosis (pulmonary and extrapulmonary) ○ Histoplasmosis (including chronic cavitary pulmonary disease, disseminated, or nonmeningeal); **AND** • Clinically valid reason why the patient cannot use the other itraconazole capsules or solution	4/day	General PA Form
Vfend®	NP	• Treatment is for ONE of the following: ○ Candidemia (in non-neutropenic patients) ○ Esophageal candidiasis ○ Invasive aspergillosis ○ Serious fungal infections caused by *S. apiospermum* and *Fusarium* species including *F. solani* ○ Part of standard anti-fungal regimen in febrile neutropenic patients ○ Other fungal infections that are refractory or resistant to other oral triazole agents (i.e., fluconazole, ketoconazole); **OR** • Patient is continuing therapy from an inpatient hospital stay (to facilitate completion of therapy)	18/84 days	
Vivjoa®	NP	• Diagnosis of recurrent vulvovaginal candidiasis (RVCC); **AND** • Provider attests patient is NOT of reproductive potential; **AND** • The member has experienced ≥ 3 episodes of VVC in less than one year; **AND** • Failure of a maintenance course of oral fluconazole defined as 100-mg, 150-mg, or 200-mg taken weekly for 6-months		
voriconazole	NP	See Vfend prior authorization criteria		

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antifungals, Vaginal				
Gynazole-1	P		5 gm/day	
miconazole-3 kit	P		1 box/Rx	
miconazole-3 vaginal supp	P		1 box/Rx	
terconazole	P		1 box/Rx	
Anti-Infectives: Anthelmintics				
albendazole	P	• Treatment of neurocysticercosis caused by *Taenia solium*; **AND** ○ Prescribed by, or in consultation with, an Infectious Disease specialist; **OR** • Treatment of cystic hydatid disease caused by *Echinococcus granulosus*; **OR** • Treatment of hookworm		General PA Form
ivermectin tablets	P		20/90 days	
Emverm®	NP	• Treatment of *Enterobius vermicularis* (pinworm) in single or mixed infections; **AND** ○ Recipient has tried and failed, has an intolerance, OR contraindication to pyrantel pamoate; **OR** • Treatment of *Ancylostoma duodenale* (common hookworm) or *Necator americanus* (American hookworm); **AND** ○ Recipient has tried and failed, has an intolerance, OR contraindication to albendazole; **OR** • Treatment of *Trichuris trichiura* (whipworm) or *Ascaris lumbricoides* (common roundworm); **AND** ○ Recipient has tried and failed, has an intolerance, OR contraindication to ivermectin **Length of authorization**: Will be based on FDA indication		
Stromectol®	NP		20/90 days	
Anti-Infectives: Antiprotozoals, Oral				
atovaquone	P	• Treatment is for Pneumocystis pneumonia (PCP) prevention or treatment; **AND** ○ Trial and failure, contraindication, intolerance to sulfamethoxazole/trimethoprim; **OR** • Diagnosis of Toxoplasmosis gondii encephalitis; **AND** ○ Trial and failure, contraindication, intolerance to sulfamethoxazole/trimethoprim; **OR** Diagnosis of Babesiosis		
benznidazole	NP	Diagnosis of American trypanosomiasis (Chagas disease) caused by Trypanosoma cruzi	12.5 mg: 6/day 100 mg: 4/day	
Lampit®	NP	• Diagnosis of American trypanosomiasis (Chagas disease) caused by Trypanosoma cruzi		
Likmez®		• Patient is unable to swallow solid dosage forms; **OR** • Patients less than 12 years of age		General PA Form
Mepron®	NP	See atovaquone prior authorization criteria: **AND** • Trial and failure, contraindication, intolerance, or drug-drug interaction to sulfamethoxazole/trimethoprim		

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

nitazoxanide tablets	NP	• Patient is > 12 years of age or older; **AND**
		• One of the following:
		  ○ Treatment of diarrhea caused by *Cryptosporidium parvum* (Note: Will not be approved for the treatment of diarrhea caused by C. parvum in HIV-infected or immunodeficient patients); **OR**
		  ○ Treatment of diarrhea caused by *Giardia lamblia*; **AND**
		  – Patient has failed and failed, or has a contraindication, intolerance, or adverse drug reaction to tinidazole and metronidazole
			6/day	General PA Form

pyrimethamine	NP	Treatment of toxoplasmosis when used in combination with a sulfonamide		
Solosec®	NP	• Patient is 12 years of age or older; **AND** • One of the following: • Diagnosis of bacterial vaginosis; **AND** • Trial and failure, contraindication, or intolerance to one of the following: • Cleocin® vaginal cream • Cleocin® vaginal suppository • clindamycin capsules • metronidazole tablets • metronidazole vaginal gel • Diagnosis of trichomoniasis caused by *Trichomonas vaginalis* (*T. vaginalis*); **AND** • Trial and failure, contraindication, or intolerance to preferred metronidazole tablets	1 pack/month	General PA Form
sulfadiazine	NP	• Treatment of *Toxoplasma gondii* encephalitis in combination with pyrimethamine; **OR** • Rheumatic fever prophylaxis in patients who have a contraindication or intolerance to penicillin		
Antivirals: COVID Treatment				
Lagevrio®	P	• Patient is ≥ 18 years of age and older	40/5 days	General PA Form
Paxlovid®	P	• Patient is > 12 years of age and older	30/5 days	
Antivirals: Cytomegalovirus Agents				
Livtencity®	NP	• Patient is ≥ 12 years of age and weighs ≥ 35kg; **AND** • Diagnosis of post-transplant cytomegalovirus (CMV) infection; **AND** • Infection is refractory to prior treatment with at least one of the following: ○ Ganciclovir, valganciclovir, cidofovir or foscarnet	4/day	General PA Form

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Prevymis®	NP	• Patient is > 18 years of age and older; **AND**
		• One of the following:
		  ○ Patient is scheduled or has received an allogeneic hematopoietic stem cell transplant (HSCT) and ONE of the following:
		  – Patient is seropositive for CMV; **OR**
		  – Treatment is for prophylaxis against CMV disease; **OR**
		  ○ Patient is a kidney transplant recipient and **BOTH** of the following:
		  – Patient is 12 years of age and older and weighs at least 40 kg; **AND**
		  – Patient is high risk of CMV Disease (e.g., Donor CMV seropositive/Recipient CMV seronegative [D+/R-]); **AND**
		• Must be prescribed by, or in consultation with, an oncology, hematology, infectious disease, or transplant specialist; **AND**
		• Patient is NOT receiving concurrent therapy with pimozide, ergot alkaloids, or cyclosporine in conjunction with either pitavastatin or simvastatin
		Note: When co-administered with cyclosporine the recommended dose of Prevymis is 240 mg daily.
			1/day	General PA Form

Antivirals: Hepatitis B				
entecavir	P		1/day	General PA Form
lamivudine-HBV	P		1/day	
tenofovir	P		1/day	
adefovir	NP		1/day	
Baraclude® solution	NP	• Diagnosis of chronic hepatitis B virus infection with evidence of active viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease; **AND** • Patient is unable to swallow tablets; **AND** • Prescriber will monitor hepatic function closely for at least several months in patients who discontinue therapy **Note**: Prior authorization is not required for patients 2 through 11 years of age	20 ml/day	
Baraclude® tablets	NP		1/day	

Vemlidy®	NP	• Patient is 6 years of age and older; **AND**
		• Diagnosis of Chronic Hepatitis B virus (HBV) infection in adults with compensated liver disease; **AND**
		• Inadequate treatment response (detectable HBV DNA level after 24 weeks of therapy), virologic breakthrough, resistance, intolerance, or contraindication to entecavir; **AND**
		• Patient has ONE of the following:
		  ○ History of osteoporosis or osteopenia
		  ○ Renal impairment defined by CrCL <50 mL/min
		  ○ Clinically valid reason as to why the preferred tenofovir disoproxil fumarate (TDF) cannot be used; **AND**
		• Patient is not using Vemlidy® as monotherapy if (HIV)-1 positive (must have additional antiviral therapy if HIV-1 positive for coverage of both disease states); **AND**
		• Prescriber will monitor hepatic function closely at repeated intervals for at least several months in patients who discontinue therapy
			1/day	

Viread® powder	NP	• Patient has had a trial and failure, contraindication, or intolerance to 2 preferred agents; **OR** • Patient is 6 years of age or younger and being treated for post-exposure prophylaxis (PEP)		
Viread® tablets	NP		1/day	

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antivirals: Hepatitis C Antivirals				
Epclusa® tablet	P	• One of the following: ○ **Diagnosis of Chronic Hepatitis C, Genotype 1, 2, 4, 5, and 6** – Treatment naïve patients with OR without compensated cirrhosis (Child-Pugh A) (Total duration – 12 weeks); **OR** ○ **Diagnosis of Chronic Hepatitis C, Genotype 3** – Treatment naïve patient without cirrhosis (Total Duration-12 weeks) – Treatment naïve patient with compensated cirrhosis (Child-Pugh A) without baseline NS5A RAS Y93H (Total duration – 12 weeks); – Treatment naïve patient with compensated cirrhosis (Child-Pugh A) with baseline NS5A RAS Y93H AND given in combination with ribavirin (Total duration – 12 weeks); ○ **Diagnosis of Chronic Hepatitis C, Genotype 1, 2, 3, 4, 5, and 6** – Patients with decompensated cirrhosis (Child-Pugh B or C) AND given in combination with ribavirin (Total duration – 12 weeks); **OR** – Patients with decompensated cirrhosis (Child-Pugh B or C) who are ribavirin ineligible (Total duration – 24 weeks); **AND** • If patient has a history of HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease, or Gastroenterology); **AND** • Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, requires escalation and documentation of ALL the following: ○ Requested HCV treatment regimen is recommended by the AASLD/IDSA guidelines for treatment-experienced patients (HCV Guidance - Treatment Experienced) ○ Current quantitative HCV RNA levels ○ Quantitative HCV RNA level measured 12 weeks after completion of previous treatment ○ Previous treatment history ○ Genotype testing from current and previous infections; **AND** • Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C **Note:** Patients previously treated with one of the following are considered treatment-naïve: sofosbuvir+ daclatasvir, peginterferon alfa + ribavirin, paritaprevir/ritonavir/ombitasvir/dasabuvir, and telaprevir or boceprevir + pegylated interferon, ribavirin	1/day	Epclusa PA Form

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Harvoni® tablet	P	• One of the following: ○ **Diagnosis of Chronic Hepatitis C, genotype 1** – Patients without cirrhosis: • Treatment naïve patients with documentation of pre-treatment HCV RNA < 6 million IU/mL (Total duration – 8 weeks) • Treatment naïve patients with documentation of pre-treatment HCV RNA > 6 million IU/mL (Total duration – 12 weeks) • Liver or kidney transplant patient (Total duration – 12 weeks); **OR** – Patients with compensated cirrhosis (Child-Pugh A): • Treatment naïve patients (Total duration – 12 weeks) • Liver or kidney transplant patient (Total duration – 12 weeks); **OR** – Patients with decompensated cirrhosis (Child-Pugh B or C): • Given in combination with ribavirin (Total duration – 12 weeks) • If ribavirin ineligible, may take as monotherapy (Total duration – 24 weeks); **OR** ○ **Diagnosis of Chronic Hepatitis C, genotype 4, 5, 6** – Treatment naïve patients with OR without compensated cirrhosis (Child-Pugh A) (Total Duration- 12 weeks) – Liver or kidney transplant patient with or without compensated cirrhosis (Child-Pugh A) (Total duration – 12 weeks) – Patients with decompensated cirrhosis (Child-Pugh B or C) • Given in combination with ribavirin (Total duration – 12 weeks) • If ribavirin ineligible, may take as monotherapy (Total duration – 24 weeks); **AND** • If patient has a history of HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology); AND • Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, requires escalation and documentation of ALL the following: ○ Requested HCV treatment regimen is recommended by the AASLD/IDSA guidelines for treatment-experienced patients (HCV Guidance - Treatment Experienced) ○ Current quantitative HCV RNA levels ○ Quantitative HCV RNA level measured 12 weeks after completion of previous treatment ○ Previous treatment history ○ Genotype testing from current and previous infections; AND ○ Patient has been screened for Hepatitis B prior to treatment with a direct-acting antiviral agent for Chronic Hepatitis C **Note:** Patients previously treated with one the following are considered treatment-naïve: sofosbuvir+ daclatasvir, peginterferon alfa + ribavirin, paritaprevir/ritonavir/ombitasvir/dasabuvir, and telaprevir or boceprevir + pegylated interferon, ribavirin	1/day	Harvoni PA Form
ledipasvir/sofosbuvir	P	See Harvoni® tablet prior authorization criteria	1/day	Harvoni PA Form

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Mavyret®	P	**Diagnosis of Chronic Hepatitis C, all genotypes**
		• Patients with or without cirrhosis:
		  ○ Treatment naïve patients (Total authorization 8 weeks); **OR**
		  ○ Liver or kidney transplant recipients (Total duration – 12 weeks); **OR**
		• If patient has a history of HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology); **AND**
		• Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, requires escalation and documentation of ALL the following:
		  ○ Requested HCV treatment regimen is recommended by the AASLD/IDSA guidelines for treatment-experienced patients (HCV Guidance - Treatment Experienced)
		  ○ Current quantitative HCV RNA levels
		  ○ Quantitative HCV RNA level measured 12 weeks after completion of previous treatment
		  ○ Previous treatment history
		  ○ Genotype testing from current and previous infections; **AND**
		• Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C
		Note: Patients previously treated with one the following are considered treatment-naïve: sofosbuvir+ daclatasvir, peginterferon alfa + ribavirin, paritaprevir/ritonavir/ombitasvir/dasabuvir, and telaprevir or boceprevir + pegylated interferon, ribavirin
			3/day	Mavyret PA Form

Mavyret® pellet	P	See Mavyret® prior authorization criteria; **AND** Patient is unable to swallow tablets	5/day	
sofosbuvir/ velpatasvir	P	See Epclusa® tablet prior authorization criteria	1/day	Epclusa PA Form
Epclusa® pellet	NP	See Epclusa® tablet prior authorization criteria; **AND** Patient is unable to swallow tablets	150 mg: 1/day 200 mg: 2/day	
Harvoni® pellet	NP	See Harvoni® tablet prior authorization criteria; **AND** Patient is unable to swallow tablets	1 pak/28 days	Harvoni PA Form

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Sovaldi® tablets	NP	• One of the following: ○ **Diagnosis of Chronic Hepatitis C, genotype 1 or 4** (Total duration – 12 weeks) – Used in combination with ribavirin and peginterferon alfa; **OR** – Patient must have a contraindication or drug-drug interaction with two preferred agents; **OR** – Patients must be treatment naïve to all HCV therapy (including therapies with pegylated interferon or ribavirin); **OR** – If patient has a documented contraindication to interferon; may use in combination with ribavirin alone (Total duration – 24 weeks); **AND** ○ **Diagnosis of Chronic Hepatitis C, genotype 2** (Total duration – 12 weeks): – Treatment-naïve and treatment-experienced with or without cirrhosis (Child-Pugh A); **AND** – Requires contraindication or drug-drug interaction with two preferred agents; **AND** – Used in combination with ribavirin ○ **Diagnosis of Chronic Hepatitis C, genotype 3** (Total duration – 24 weeks): – Treatment-naïve and treatment-experienced without cirrhosis or with compensated cirrhosis (Child-Pugh A); **AND** – Requires contraindication or drug-drug interaction with Mavyret and Epclusa; **AND** – Used in combination with ribavirin • If patient has a history of HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease, or Gastroenterology); **AND** • Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, requires escalation and documentation of ALL the following: ○ Requested HCV treatment regimen is recommended by the AASLD/IDSA guidelines for treatment-experienced patients (HCV Guidance - Treatment Experienced) ○ Current quantitative HCV RNA levels ○ Quantitative HCV RNA level measured 12 weeks after completion of previous treatment ○ Previous treatment history ○ Genotype testing from current and previous infections; **AND** • Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C; **AND** • If request is for diagnosis of Hepatocellular Carcinoma awaiting liver transplant (Length of authorization: 48 wks), must be used in combination with ribavirin; **AND** ○ Must meet ALL Milan criteria, defined as: – The presence of a tumor 5 cm or less in diameter in subjects with single hepatocellular carcinoma – No more than three tumor nodules, each 3 cm or less in diameter, in subjects with multiple tumors – No extrahepatic manifestations of the cancer and no evidence of vascular invasion of the tumor; **AND** • If request is for Sovaldi pellet, patient must be unable to swallow tablets.	1/day	Sovaldi PA Form
Sovaldi® pellet	NP	See Sovaldi® tablet prior authorization criteria; **AND** • Patient is unable to swallow tablets	1 pack/28 days	

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Vosevi®	NP	• **Diagnosis of chronic Hepatitis C, genotype 1–6**
		  ○ Sofosbuvir- based treatment failures, with or without compensated cirrhosis (Total duration – 12 weeks); **OR**
		  ○ Glecaprevir/Pibrentasvir treatment failure with or without compensated cirrhosis (Total duration – 12 weeks); **OR**
		  ○ Multiple Direct-Acting Antiviral (DAA) treatment failures in combination with weight-based ribavirin (Total duration- 24 weeks); **AND**
		• If patient has a history of HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology); **AND**
		• Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, requires escalation and documentation of all the following:
		  ○ Requested HCV treatment regimen is recommended by the AASLD/IDSA guidelines for treatment-experienced patients (HCV Guidance - Treatment Experienced)
		  ○ Current quantitative HCV RNA levels
		  ○ Quantitative HCV RNA level measured 12 weeks after completion of previous treatment
		  ○ Previous treatment history
		  ○ Genotype testing from current and previous infections; **AND**
		• Patient does not have, nor has ever had, decompensated cirrhosis [Child-Pugh score greater than 6 (class B or C)]; **AND**
		• Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C
			1/day	Vosevi PA Form

Zepatier®	NP	• One of the following:
		  ○ **Diagnosis of Chronic Hepatitis C, genotype 1*a* without NS5A polymorphism, genotype 1b, genotype 4** (Total duration – 12 weeks);
		  – Patient must have a contraindication or drug-drug interaction with two preferred agents
		  ○ **Diagnosis of Chronic Hepatitis C, genotype 1a WITH NS5A polymorphism** (Total duration – 16 weeks);
		  – Patient must have a contraindication or drug-drug interaction with two preferred agents; **OR**
		  ○ **Diagnosis of Chronic Hepatitis C, genotype 4** (Total duration – 16 weeks)
		  – Patient failed prior treatment with peginterferon alfa + ribavirin; **AND**
		  – Patient must have a contraindication or drug-drug interaction with two preferred agents; **AND**
		• If patient has a history of HBV co-infection, prior history with direct acting hepatitis C antivirals, or decompensated cirrhosis, authorization is being requested by or in consultation with a physician specialist with experience in the treatment of hepatitis C infection (e.g., Hepatology, Infectious Disease or Gastroenterology); **AND**
		• Patients requiring retreatment of HCV or 2nd course of therapy with Hepatitis C Direct Acting Antiviral, approval requires:
		  ○ Requested HCV treatment regimen is recommended by the AASLD/IDSA guidelines for treatment-experienced patients (HCV Guidance - Treatment Experienced)
		  ○ Current quantitative HCV RNA levels
		  ○ Quantitative HCV RNA level measured 12 weeks after completion of previous treatment
		  ○ Previous treatment history
		  ○ Genotype testing from current and future infections; **AND**
		• Patient does not have decompensated cirrhosis (defined as a Child-Pugh score > 6 [class B or C]); **AND**
		• Patient has been screened for Hepatitis B prior to treatment with any direct-acting antiviral agent for Chronic Hepatitis C
			1/day	Zepatier PA Form

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antivirals: Hepatitis C Pegylated Interferons				

Pegasys® syringes	P	Diagnosis of ONE of the following:
		• Chronic Hepatitis C and one of the following:
		  ○ Adult Patients: In combination therapy with other hepatitis C virus drugs for adults with compensated liver disease. Pegasys monotherapy is indicated only if patient has contraindication or significant intolerance to other Hepatitis C drugs
		  ○ Pediatric Patients: In combination with ribavirin for pediatric patients 5 years of age and older with compensated liver disease
		• Chronic Hepatitis B and one of the following:
		• Adult Patients: Treatment of adults with HBeAg-positive and HBeAg-negative chronic hepatitis B (CHB) infection who have compensated liver disease and evidence of viral replication and liver inflammation; **OR**
		• Pediatric Patients: Treatment of non-cirrhotic pediatric patients 3 years of age and older with HBeAg-positive CHB and evidence of viral replication and elevations in serum alanine aminotransferase (ALT)
		Note: Prior authorization will be required after 24 weeks of therapy
			4/24 days	General PA Form

Pegasys® vials	P	See prior authorization criteria for Pegasys® syringes	4/24 days	
Antivirals: Herpes Agents, Oral				
famciclovir	P		125 mg: 20/30 days; 250 mg: 60/30 days; 500 mg: 3/day & 21/Rx	General PA Form
valacyclovir	P		500 mg: 60/30 days 1000 mg: 30/Rx	
Sitavig® buccal tabs	NP		2/Rx	
Valtrex®	NP		See valacyclovir	
Antivirals: HIV Attachment Inhibitors				
Rukobia®	NP	**Initial Criteria:** • Diagnosis of treatment-experienced multidrug-resistant HIV-1 infection; **AND** • HIV-1 RNA levels ≥ 200 copies/mL; **AND** • Prescriber attests that the patient lacks sufficient treatment options due to resistance, intolerability, contraindication, or other safety concerns to construct a fully suppressive antiretroviral regimen; **AND** • Will not be used with strong cytochrome P450 (CYP)3A inducers • Prescribed by, or in consultation with or by an infectious disease specialist **Renewal Criteria:** • Patient demonstrates documented efficacy (e.g., reduced viral load/improved CD4, remain virologically suppressed)	2/day	

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antivirals: HIV Capsid Inhibitors				
Sunlenca®	P	• Diagnosis of treatment-experienced multidrug-resistant HIV-1 infection; **AND** • HIV-1 RNA levels ≥ 200 copies/mL; **AND** • Prescriber attests that the patient lacks sufficient treatment options due to resistance, intolerability, contraindication, or other safety concerns to construct a fully suppressive antiretroviral regimen; **AND** • Agent will be used in combination with *an optimized* antiretroviral *regimen;* **AND** • Prescriber attests the patient has received or will receive the subcutaneous dose; **AND** • Prescribed by, or in consultation with or by an infectious disease specialist	1 pack/year	General PA Form
Antivirals: HIV CCR5 Antagonists				
maraviroc tablets	P	• Diagnosis of CCR5-tropic HIV-1 via a co-receptor tropism; **AND** • Verification that agent will be administered in combination with other antiretroviral agents	150 mg: 2/day; 300 mg: 4/day	
Selzentry® tablets	NP	• Diagnosis of CCR5-tropic HIV-1 via a co-receptor tropism; **AND** • Verification that agent will be administered in combination with other antiretroviral agents; **AND** • Trial and failure, contraindication, or intolerance to maraviroc tablets	150 mg: 2/day; 300 mg: 4/day	
Selzentry® solution	NP	• Diagnosis of CCR5-tropic HIV-1 via a co-receptor tropism; **AND** • Verification that agent will be administered in combination with other antiretroviral agents; **AND** • Patient is 11 years of age or younger OR patient is unable to swallow tablets		
Antivirals: HIV Fusion Inhibitors				
Fuzeon®	P	**Initial Criteria:** • Diagnosis of treatment-experienced multidrug-resistant HIV-1 infection; **AND** • HIV-1 RNA levels > 200 copies/mL; **AND** • Prescriber attests that the patient lacks sufficient treatment options due to resistance, intolerability, contraindication, or other safety concerns to construct a fully suppressive antiretroviral regimen; **AND** • Agent will be used in combination with an optimized antiretroviral regimen therapy (ART); **AND** • Prescribed by, or in consultation with or by an infectious disease specialist **Renewal Criteria:** • Patient demonstrates documented efficacy (e.g., reduced viral load/improved CD4, remain virologically suppressed)	1 kit/30 days (2 vials/day)	General PA Form

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antivirals: HIV Integrase Inhibitors				
Isentress®	P		tabs: 2/day; chews: 6/day; granules: 2 packs/day	General PA Form
Tivicay®	P		2/day	
Tivicay PD®	P	• Patient is ≤ 6 years of age; **OR** • Patient is unable to swallow solid dosage forms; **OR** • Clinically valid reason why the patient cannot use Tivicay tablets	3 bottles/30 days	
Isentress® HD	NP	• Verification that agent will be administered in combination with other antiretroviral agents; **AND** • Clinically valid reason why the patient cannot use the preferred agents	2/day	
Juluca®	NP	• Patient has a diagnosis of HIV; **AND** • Patient does not have any prior history of treatment failure to other HIV agents **OR** known resistance to the individual components (dolutegravir/rilpivirine); **AND** • Patient is virologically suppressed (HIV-1 RNA < 50 copies/mL) on a current ART regimen for ≥ 6-months	1/day	
Antivirals: HIV NNRTIs				
efavirenz	P		50 mg: 7/day; 200 mg: 2/day; 600 mg: 1/day	General PA Form
Intelence®	P	• Patient is treatment-experienced; **AND** • Patient will concomitantly take at least two additional antiretroviral agents; **AND** Patient has documented non-nucleoside reverse transcriptase inhibitor (NNRTI) resistance	2/day	
nevirapine	P		200 mg 2/day; Susp: 40 mL/day	
Pifeltro®	P		1/day	
etravirine	NP	See Intelence prior authorization criteria	2/day	
nevirapine ER	NP		1/day	
Antivirals: HIV NRTIs				
abacavir	P		tabs: 2/day soln: 30mL/day	General PA Form
emtricitabine	P		1/day	
lamivudine	P		100 & 300 mg: 1/day; 150 mg: 2/day; soln: 30 mL/day	
stavudine	P		caps: 2/day; soln: 80 mL/day	

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
zidovudine	P		100 mg: 6/day; 300 mg: 2/day; syrup: 60 mL/day	
Emtriva®	NP		caps: 1/day; soln: 24 mL/day	
Epivir®	NP		150 mg: 2/day; 300 mg: 1/day; soln: 30 mL/day	
Retrovir®	NP		100 mg: 6/day; syrup: 60 mL/day	
Ziagen®	NP		tabs: 2/day; soln: 30 mL/day	
Antivirals: HIV NRTI Combos				
abacavir/ lamivudine	P		1/day	
Biktarvy®	P		1/day	
Complera®	P		1/day	
Delstrigo®	P		1/day	
Descovy®	P		1/day	
Dovato®	P		1/day	
emtricitabine/ tenofovir	P		1/day	
efavirenz/emtricita-bine/tenofovir	P		1/day	
Genvoya®	P		1/day	
lamivudine/ zidovudine	P		2/day	
Odefsey®	P		1/day	
Stribild®	P		1/day	

Symtuza®	P	**Initial Criteria:**
		• Patient has a diagnosis of HIV-1; **AND**
		• Patient has no known substitutions associated with resistance to darunavir or tenofovir; **AND**
		• One of the following:
		  ○ Patient is ARV treatment-naïve; **OR**
		  ○ Patient is ARV treatment-experienced and meets the following requirements:
		  – Virologically suppressed (HIV-1 RNA < 50 copies/mL) on a stable ARV regimen for ≥ 6-months; **OR**
		  – Patient is switching medication due to adverse effects or documented compliance issues due to pill burden or dose frequency
		Renewal Criteria:
		• Patient demonstrates documented efficacy (e.g., reduced viral load/improved CD4, remaining virologically suppressed)
			1/day	General PA Form

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Triumeq®	P		1/day	
Trizivir®	P		2/day	
Cimduo®	NP		1/day	
efavirenz/lamivudine/tenofovir	NP		1/day	
Epzicom®	NP		1/day	
Symfi®	NP		1/day	
Symfi® Lo®	NP		1/day	
Triumeq PD®	NP		6/day	
Truvada®	NP		1/day	
Antivirals: HIV Pharmacokinetic Enhancers				
ritonavir tablet	P			

Norvir® pack	NP	• Patient has a diagnosis of HIV-1; **AND**
		• The requested will be used in combination with other antiretroviral agents; **AND**
		• One of the following:
		  ○ Patient is ≤ 18 years of age; **OR**
		  ○ Clinically valid reason why the preferred ritonavir tablets cannot be used
		Note: Norvir oral powder is dosed in increments of 100 mg; prescription should not be written for <100 mg increments
			12/day	

Norvir® tablet	NP		12/day	
Tybost®	NP	• Verification that agent will be administered in combination with Prezista® (darunavir) **OR** atazanavir; **AND** • Patient has a contraindication or intolerance to ritonavir; **AND** • Patient is not pregnant; **AND** • Patient does not have renal impairment	1/day	
Antivirals: HIV Protease Inhibitors				
atazanavir caps	P		See Reyataz®	
darunavir	NP		800 mg: 1/day; All other strengths: 2/day; susp: 12 mL/day	
Evotaz®	P		1/day	
fosamprenavir	P		4/day	
lopinavir/ritonavir	P		soln: 6 mL/day tabs: 1/day	
Prezcobix®	P		1/day	
Prezista® suspension	P		12 mL/day	
Reyataz® powder	P		5/day	General PA Form
Viracept®	P		tabs: 4/day	

ANTI-INFECTIVES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Aptivus®	P	• Confirmation that patient has had previous exposure to at least one PI indicated for first line therapy.	caps: 4/day; soln: 10 mL/day	
Kaletra®	NP		soln: 15 mL/day tabs: 6/day	
Prezista® tabs	NP		800 mg: 1/day; All other strengths: 2/day	
Reyataz® caps	NP		300 mg: 1/day; 150, 200 mg: 2/day	
Antivirals: Influenza				
oseltamivir capsules and suspension	P		caps: 20/180 days; susp: 300 mL/180 days	Influenza Antiviral PA Form
Relenza®	P		40/180 days	
Tamiflu® capsules and suspension	NP		See oseltamivir	
Xofluza®	NP	• Agent is being used for treatment of influenza OR post-exposure prophylaxis of influenza; **AND** • Treatment is being used for ONE of the following: ○ Acute uncomplicated influenza in patients ≥ 5 years of age who have been symptomatic for no more than 48 hours and who are otherwise healthy ○ Acute uncomplicated influenza in patients ≥ 5 years of age who are at high risk of developing influenza-related complications ○ Post-exposure prophylaxis of influenza in patients > 5 years of age; **AND** • One of the following: ○ Contraindication to both Relenza® and Tamiflu® that is not associated with requested agent ○ Area surveillance data that indicates an oseltamivir resistant strain ○ Recurrent documented influenza in the same flu season that was previously treated with a preferred agent	2/Rx	

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
ACE Inhibitors (AEIs)				
ramipril	P		2/day	General PA Form
Altace®	NP		2/day	
captopril	NP	• Trial and failure, contraindication, or intolerance of TWO preferred agents **Note**: PA is not required for members 18 years of age and younger		
Epaned®	NP	• Patient is unable to swallow solid dosage forms **Note**: PA is not required for members 8 years of age and younger		
enalapril suspension	NP	See Epaned® prior authorization criteria **Note**: PA is not required for members 8 years of age and younger		
moexipril	NP		7.5 mg: 1/day; 15 mg: 2/day	
perindopril	NP		2 mg, 4 mg: 1/day; 8 mg: 2/day	
Qbrelis® solution	NP	• Patient is unable to swallow solid dosage forms **Note**: PA is not required for members 7 years of age and younger		
trandolapril	NP		1/day	
ACEIs + Calcium Channel Blockers				
benazepril/ amlodipine	P		5/40 mg: 2/day; All others: 1/day	General PA Form
Lotrel®	NP	• Patient is unable to take the two components separately	5/40 mg: 2/day; All others: 1/day	
Prestalia®	NP	• Patient is unable to take the two components separately	1/day	
trandolapril/ verapamil	NP	• Patient is unable to take the two components separately	1/day	
ACEIs + Diuretics				
benazepril/HCTZ	NP	• Patient is unable to take the two components separately		General PA Form
Alpha-Beta Blockers				
carvedilol	P		2/day	General PA Form
carvedilol ER	NP		1/day	
Coreg®	NP		2/day	
Coreg CR®	NP		1/day	

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Angiotensin II Receptor Antagonists (ARBs)				
irbesartan	P		1/day	General PA Form
losartan	P		25 mg, 100 mg: 1/day; 50 mg: 2/day	
olmesartan	P		1/day	
valsartan	P		1/day	
Atacand®	NP		1/day	
Avapro®	NP		1/day	
Benicar®	NP		1/day	
candesartan	NP		4 & 32 mg: 1/day; 8 mg & 16 mg: 2/day	
Cozaar®	NP		25 mg, 100 mg: 1/day; 50 mg: 2/day	
Diovan®	NP		1/day	
Edarbi™	NP		1/day	
Micardis®	NP		1/day	
telmisartan	NP		1/day	
valsartan solution	NP	• Patient is unable to swallow solid dosage forms	80 mL/day	
ARB + Calcium Channel Blocker				
valsartan/ amlodipine	P		1/day	General PA Form
valsartan/ amlodipine/HCTZ	P	• Patient is unable to take the components separately	1/day	
Azor®	NP		1/day	
Exforge®	NP		1/day	
Exforge HCT®	NP	• Patient is unable to take the components separately	1/day	
olmesartan/ amlodipine	NP		1/day	
olmesartan/ amlodipine/HCTZ	NP	• Patient is unable to take the components separately	20/5/12.5 mg: 2/day; All others: 1/day	
telmisartan/ amlodipine	NP		1/day	

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Tribenzor®	NP	• Patient is unable to take the components separately	20/5/12.5 mg: 2/day; All others: 1/day	
ARB + Diuretic				
irbesartan/HCTZ	P		1/day	General PA Form
losartan/HCTZ	P		1/day	
olmesartan/HCTZ	P		1/day	
valsartan/HCTZ	P		1/day	
Atacand HCT®	NP		1/day	
Avalide®	NP		1/day	
Benicar HCT®	NP		1/day	
candesartan/HCTZ	NP		1/day	
Diovan HCT®	NP		1/day	
Edarbyclor®	NP		1/day	
Hyzaar®	NP		1/day	
Micardis HCT®	NP		1/day	
telmisartan/HCTZ	NP		1/day	
ARB + Neprilysin Inhibitor				
Entresto® tablets	P	• Diagnosis of chronic heart failure (NYHA Class II-IV)	2/day	General PA Form
Entresto® sprinkles	NP	• Diagnosis of chronic heart failure (NYHA Class II-IV); **AND** • Clinically valid reason why Entresto tablets cannot be used	8/day	
Antianginals: Nitrates				
Rectiv®	P	• Diagnosis of history of anal fissure; **AND** • Patient is a candidate for surgery		General PA Form
GoNitro® powder	NP	• Clinically valid reason why the preferred agents cannot be used; **OR** • Patient is unable to swallow solid dosage forms or sublingual formulations (e.g., spray, tablet)		General PA Form
nitroglycerin spray	NP	• Trial and failure, contraindication, or intolerance of TWO preferred agents; **OR** • Clinically valid reason why the preferred agent cannot be used		

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antiarrhythmics, Oral				
dofetilide	P		2/day	General PA Form
Multaq®	NP	• Not on concurrent Class I or III anti-arrhythmic agent; **AND** • Not hospitalized for exacerbation of heart failure in past 30 days; **AND** • Patient does not have NYHA class IIIb or IV heart failure; **AND** • Trial and failure, contraindication, or intolerance of TWO of the following preferred antiarrhythmic agents: (Note: Requirement is waived if patient has structural heart disease) ○ amiodarone ○ flecainide ○ propafenone ○ sotalol		
Sotylize®	NP	• Patient is unable to swallow tablets and capsules **Note**: PA is not required for patients 8 years of age and younger		
Tikosyn®	NP		2/day	
Anticoagulants, Injectable				
enoxaparin	P		2 injections/day	General PA Form
fondaparinux	P		1 injection/day	
Arixtra®	NP		1 injection/day	
Lovenox®	NP		2 syringes/day	
Anticoagulants, Oral				
Eliquis®	P		2/day	General PA Form
Pradaxa® caps	P		2/day	
Xarelto®	P		2.5 & 15 mg: 2/day 10 & 20 mg: 1/day;	
dabigatran	NP	• Clinically valid reason why the preferred Pradaxa cannot be used	2/day	
Pradaxa® packs	NP	• Patient is unable to swallow sold dosage forms; **OR** • Clinically valid reason why the patient cannot use Pradaxa oral pellets	2/day	
Savaysa®	NP	• One of the following: ○ Diagnosis of non-valvular atrial fibrillation; **AND** – Documentation that CrCl NOT ≥ 95 mL/min as calculated by Cockcroft-Gault equation ○ Diagnosis of deep vein thrombosis or pulmonary embolism; **AND** • Trial and failure, intolerance, or contraindication to Xarelto® and Pradaxa®	1/day	General PA Form
Xarelto® suspension	NP	• Patient is unable to swallow solid dosage forms		

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antihypertensives, Miscellaneous				
clonidine weekly patch	P		0.1, 0.2 mg: 4/28 days; 0.3 mg: pt ≤21: 4/28 days pt >21: 8/28 days	General PA Form
clonidine 24hr ER	NP		1/day	
minoxidil	NP	• Diagnosis of severe hypertension (symptomatic or associated with target organ damage only); **AND** • Trial and failure, contraindication, or intolerance to TWO of the following: ○ ACEI or ARBs ○ Beta-blocker ○ Calcium channel blockers ○ Methyldopa ○ Clonidine; **AND** • Patient is concomitantly taking a diuretic (e.g., hydrochlorothiazide, chlorthalidone, furosemide, etc.); **AND** • Patient does not have diagnosis of pheochromocytoma (minoxidil may stimulate secretions of catecholamines from the tumor) **Note**: Minoxidil will not be approved for alopecia		
Vecamyl®	NP	• Diagnosis of Essential Hypertension or Malignant Hypertension, **AND** • Trial and failure, contraindication, or intolerance to **ALL** the following: ○ ACE inhibitor-or-ARB ○ Beta blocker ○ Calcium Channel Blocker ○ Clonidine ○ Hydralazine; **AND** • Patient is concomitantly taking a diuretic (e.g., hydrochlorothiazide, chlorthalidone, furosemide)	10/day	

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Beta Blockers				
metoprolol succinate ER	P		1/day	General PA Form
Hemangeol®	NP	• Diagnosis of Infantile Hemangioma; **AND** • Clinically valid reason why the preferred propranolol solution cannot be used		
InnoPran XL®	NP		80 mg: 2/day; 120 mg: 1/day	
Kapspargo Sprinkle®	NP	• Diagnosis of ONE of the following: ○ Heart Failure or LVEF ≤ 40% ○ Hypertension ○ Angina Pectoris; **AND** • Patient is unable to swallow tablets and capsules	1/day	
Toprol XL®	NP	• Diagnosis of one of the following: ○ Heart Failure or LVEF ≤ 40% ○ Paroxysmal Atrial Fibrillation	1/day	
Calcium Channel Blockers (DHP)				
amlodipine	P		2.5 & 5 mg (1.5/day); 10 mg (1/day)	General PA Form
nifedipine ER/SA/XL	P		1/day	
Norliqva®	P	• Diagnosis of one of the following: ○ Hypertension ○ Chronic stable angina or treatment ○ Vasospastic Angina (Prinzmetal's or Variant Angina) ○ Confirmed or suspected vasospastic angina ○ Angiographically documented Coronary Artery Disease in patients without heart failure and an ejection fraction ≥ 40%; **AND** • One of the following: ○ Patient is unable to swallow solid dosage forms; **OR** ○ Clinically valid reason why nimodipine capsules cannot be used	10 mL/day	
isradipine	NP		2.5 mg (2/day); 5 mg (4/day)	
Katerzia®	NP	See Norliqva prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance to Norliqva®	10 mL/day	General PA Form
nimodipine	NP	• Diagnosis of subarachnoid hemorrhage (SAH)		
nisoldipine	NP		1/day	
Norvasc®	NP		See amlodipine	

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Nymalize®	NP	• Diagnosis of Subarachnoid Hemorrhage; **AND**
		• One of the following:
		  ○ Patient is unable to swallow solid dosage forms
		  ○ Clinically valid reason why nimodipine capsules cannot be used
			120 mL/day	

Procardia® XL	NP		1/day	
Sular®	NP		1/day	
Calcium Channel Blockers (Non-DHP)				
verapamil ER/SR	P		1/day	General PA Form
Cardizem LA®	NP		1/day	
diltiazem ER caps	NP		1/day	
Cardiac Agents, Miscellaneous				
ranolazine ER	P		2/day	

ivabradine	P	• Diagnosis of Congestive Heart Failure (NYHA class II to IV) and documentation of the following:
		  ○ Left ventricular ejection fraction ≤ 35%; **AND**
		  ○ In sinus rhythm with resting heart rate ≥ 70 beats per minute; **AND**
		  ○ One of the following:
		  – Currently taking a maximum tolerated dose of a beta-blocker and still experiencing heart failure symptoms; **OR**
		  – Patient has a contraindication, adverse reaction, or drug-drug interaction to a beta-blocker; **OR**
		• Diagnosis of Congestive Heart Failure (NYHA class II to IV) due to dilated cardiomyopathy (DCM); **AND**
		  ○ Left ventricular ejection fraction ≤ 45%; **AND**
		  ○ Patient is in sinus rhythm with elevated heart rate; **AND**
		• Will **NOT** be approved for patients with any of the following:
		  ○ Concomitant use of potent CYP3A inhibitors or inducers
		  ○ Acute decompensated heart failure
		  ○ Clinically significant hypotension or bradycardia
		  ○ Sick sinus syndrome, sinoatrial block, or 3rd degree AV block, unless a functioning demand pacemaker is present
		  ○ Severe hepatic impairment
		  ○ Pacemaker dependence (heart rate maintained exclusively by the pacemaker)
			2/day	General PA Form

Aspruzyo Sprinkle®	NP	• Diagnosis of chronic angina; **AND**
		• Failure to achieve an adequate response, or intolerance to, at least ONE agent from TWO of the following classes:
		  ○ Beta-blocker (e.g., atenolol, bisoprolol, metoprolol, propranolol)
		  ○ Long-acting nitrate (e.g., nitroglycerin, isosorbide dinitrate, isosorbide mononitrate)
		  ○ Non-DHP calcium channel blocker (e.g., diltiazem, verapamil); **AND**
		• Patient is unable to swallow solid dosage form
			2/day	

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Camzyos®	NP	**Initial Criteria:** • Diagnosis of obstructive hypertrophic cardiomyopathy (HCM); **AND** • Left ventricular hypertrophy (LVH) confirmed by cardiac imaging (i.e., echocardiography, cardiac MRI); **AND** • Heart failure is classified New York Heart Association (NYHA) class II or III Patient has New York Heart Association (NYHA) Class II or III symptoms (e.g., shortness of breath, chest pain); **AND** • Patient has left ventricular outflow tract (LVOT) peak gradient > 50 mmHg at rest or with provocation; **AND** • Patient has a left ventricular ejection fraction > 55% (for initiation of therapy); **AND** • Prescribed by or in consultation with a cardiologist; **AND** • Trial and failure, contraindication, or intolerance to TWO of the following at a maximally tolerated dose: ○ Non-vasodilating beta blocker (e.g., bisoprolol, propranolol) ○ Calcium channel blocker (e.g., verapamil, diltiazem) ○ Disopyramide **Renewal Criteria:** • Documentation of positive clinical response to therapy (e.g., NHYA class remains stable or improves improved symptom relief, improvement of LVOT gradient); **AND** • Patient has a left ventricular ejection fraction > 50%; **AND** • Prescribed by, or in consultation with, a cardiologist	1/day	General PA Form
Corlanor®	NP	See ivabradine prior authorization criteria; **AND** • Clinically valid reason why ivabradine cannot be used	2/day	General PA Form
Ranexa®	NP	• Diagnosis of chronic angina; **AND** • Failure to achieve an adequate response, or intolerance to, at least ONE agent from TWO of the following classes: ○ Beta-blocker (e.g., atenolol, bisoprolol, metoprolol, propranolol) ○ Long-acting nitrate (e.g., nitroglycerin, isosorbide dinitrate, isosorbide mononitrate) ○ Non-DHP calcium channel blocker (e.g., diltiazem, verapamil); **AND** • Clinically valid reason why the patient cannot use generic ranolazine ER	2/day	General PA Form

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Tryvio®	NP	**Initial Criteria: (6-month duration)** • Diagnosis of resistant hypertension; **AND** • Patient is 18 years of age or older; **AND** • Submission of medical records (e.g. chart notes) documenting patient has not achieved target blood pressure (e.g. systolic <130/80) following concurrent maximumly tolerated treatment with at least THREE of the following antihypertensive classes unless contraindicated or intolerance: ○ ACE inhibitors or Angiotensin II receptor blockers (ARBs) ○ Beta blockers ○ Calcium channel blockers ○ Mineralocorticoid Receptor Antagonists ○ Thiazide diuretics; **AND** • Tryvio will be used in combination with at least one other hypertensive drug **Renewal Criteria** • Submission of medical records (e.g. chart notes) documenting a positive clinical response to therapy (e.g. decrease of systolic blood pressure from baseline); **AND** • Patient is receiving concomitant therapy with other hypertensive drugs (documented by claims or medical records)	1/day	General PA Form
Verquvo®	NP	• Diagnosis of symptomatic chronic heart failure (NYHA class II-IV) with reduced ejection fraction (≤45%); **AND** • Prescribed by, or in consultation with, a cardiologist (initial approval only); **AND** • Patient has had a heart failure hospitalization in the last 6-months **OR** has received outpatient IV diuretics for heart failure in the last 3 months; **AND** • Patient is 18 years of age or older; **AND** • Patient is currently being treated with an ACEI, ARB, or Entresto; **AND** • Patient is currently being treated with a beta blocker; **AND** • Patient is not pregnant or breastfeeding; **AND** • Female patients of reproductive potential will be counseled to use effective contraception during treatment with therapy and for at least one month after the last dose; **AND** • Patient does not meet any of the following: ○ Concomitant use with another soluble guanylate cyclase (sGC) stimulator (e.g., Adempas) ○ Concomitant use with a PDE-5 inhibitor (e.g., tadalafil, sildenafil)	1/day	General PA Form
Direct Renin Inhibitors				
aliskiren	NP	Patient has a diagnosis of hypertension; **AND** Trial and failure, contraindication, or intolerance to an agent from at least TWO of the following drug classes: ACEI/ARB Calcium channel blocker Thiazide diuretic	1/day	General PA Form
Tekturna®	NP	See aliskiren prior authorization criteria	1/day	

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Tekturna HCT®	NP	• Trial and failure, contraindication, or intolerance to an agent from at least TWO of the following drug classes: • ACEI/ARB • Calcium channel blocker • Thiazide diuretic • Patient is unable to take the individual components	1/day	
Diuretics: Carbonic Anhydrase				
dichlorphenamide	NP	See Keveyis criteria**; AND** • Trial and failure of Keveyis®	2/day	

Keveyis®	NP	**Initial Criteria: (2-month duration)**
		• Diagnosis of Primary Hypokalemic/Hyperkalemic Periodic Paralysis, and related variants; **AND**
		• Patient does not have any of the following:
		  ○ Hepatic insufficiency
		  ○ Severe pulmonary disease
		  ○ Hypersensitivity to dichlorphenamide or other sulfonamides
		• Avoid concomitant use with high dose aspirin
		Renewal Criteria:
		• Clinical documentation that patient has exhibited a reduction in symptoms or attacks; **AND**
		• Patient's serum potassium and bicarbonate levels are being monitored
			2/day	General PA Form

Diuretics: Loop				
Furoscix®	NP	• Diagnosis of chronic heart failure; **AND** • Patient has signs and symptoms of congestive heart failure due to fluid overload; **AND** • The patient is currently receiving maximal oral diuretic therapy; **AND** • Prescriber attests that additional oral diuretic therapy would be ineffective; **AND** • Prescribed by, or in verbal consultation with, a cardiologist; **AND** • Prescriber has demonstrated appropriate administration use of the On-Body Infusor®	4 devices/month	
Diuretics: Potassium Sparing				

CaroSpir®	NP	• One of the following:
		  ○ Diagnosis of hypertension
		  ○ Diagnosis of heart failure
		  ○ Diagnosis of edema associated with hepatic cirrhosis; **AND**
		• Patient is unable to swallow solid dosage forms
		Note: PA not required for patients < 6 years of age
			15 mL/day	General PA Form

eplerenone	NP	• One of the following:
		  ○ Patient has a diagnosis of hypertension
		  ○ Patient has a diagnosis of congestive heart failure
		  ○ Patient has a diagnosis of Duchenne muscular dystrophy (DMD); **AND**
		• Trial and failure, contraindication, or intolerance of spironolactone
				General PA Form

Inspra®	NP	See eplerenone prior authorization criteria		

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Kerendia®	NP	• Patient is ≥ 18 years of age; **AND** • Diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D); **AND** • Currently taking the maximum tolerated dose of an ACE inhibitor or ARB, unless contraindicated or intolerant; **AND** • Currently taking an antidiabetic agent (e.g., insulin, metformin, GLP-1 receptor agonist, SGLT2 inhibitor)	1/day	General PA Form

spironolactone susp	NP	• One of the following:
		  ○ Diagnosis of hypertension
		  ○ Diagnosis of heart failure
		  ○ Diagnosis of edema associated with hepatic cirrhosis; **AND**
		• Patient is unable to swallow solid dosage forms; **AND**
		• Trial and failure of Carospir®		

Diuretics: Thiazide and Related				
Diuril®	NP	• Patient is unable to swallow solid dosage forms		General PA Form
Hemostatics, Oral				

tranexamic acid	P	• Diagnosis of acute uterine or cyclic heavy menstrual bleeding; **AND**
		  ○ Trial and failure, contraindication, or intolerance to ALL the following:
		  – Two other forms of hormone therapy (oral, vaginal, topical, or injectable estrogen and/or progesterone)
		  – Levonorgestrel-releasing IUD; **OR**
		• All other diagnoses require trial and failure, intolerance, or contraindication to aminocaproic acid.		

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Lipotropics: Antihyperlipidemic Agents				

Praluent®	P	**Cardiovascular disease (CVD) Prevention**
		Initial Criteria (6-month duration):
		• Treatment is for the prevention of cardiovascular disease; **AND**
		• Patient age ≥ 18 years; **AND**
		• Patient has history of ONE of the following:
		  ○ MI, unstable angina, or symptomatic peripheral artery disease
		  ○ Stroke
		  ○ Primary Hyperlipidemia (including heterozygous familial hypercholesterolemia (HeFH))
		  ○ Baseline LDL-C ≥ 190; **AND**
		• Documented current LDL-C value (within 3 months); **AND**
		• Patient specific target LDL-C value is provided; **AND**
		• One of the following:
		  ○ Failure to reach patient specific LDL target despite a ≥ 3-month trial (supported by claims history or clinical documentation) of concurrent therapy with BOTH the following, unless contraindicated or intolerance:
		  – High-intensity statin (atorvastatin/rosuvastatin)
		  – Ezetimibe; **OR**
		  ○ Patient requires > 25% additional LDL-C lowering to meet LDL target after a > 3-month trial (supported by claims history or clinical documentation) of therapy with a high-intensity statin, unless contraindicated or intolerance; **AND**
		• Agent will be used in combination with other lipid lowering therapies, unless documented intolerance
		Renewal Criteria:
		• Documentation of positive clinical response to therapy (e.g., LDL reduction from baseline, patient has meet LDL-C target)
		Heterozygous familial hypercholesterolemia (HeFH) or homozygous familial hypercholesterolemia (HoFH)
		Initial Criteria (6-month duration):
		• Diagnosis of HeFH or HoFH confirmed by one of the following:
		  ○ Presence of a mutation in LDL receptor, ApoB, PCSK9 gene
		  ○ Clinical criteria using either the Simon Broome or WHO/Dutch Lipid Network criteria; **AND**
		• Patient age is appropriate according to package labeling (i.e., Praluent is indicated for age >8 years, Repatha is indicated for age >10 years); **AND**
		• One of the following:
		  ○ Failure to reach patient specific LDL target despite a ≥ 3-month trial (supported by claims history or clinical documentation) of concurrent therapy with BOTH the following, unless contraindicated or intolerance:
		  – High-intensity statin (atorvastatin/rosuvastatin)
		  – Ezetimibe; **OR**
		  ○ Patient requires > 25% additional LDL-C lowering to meet LDL target after a > 3-month trial (supported by claims history or clinical documentation) of therapy with a high-intensity statin, unless contraindicated or intolerance; **AND**
		• Agent will be used in combination with other lipid lowering therapies, unless documented intolerance
		Renewal Criteria:
		• Documentation of positive clinical response to therapy (e.g., LDL reduction from baseline, patient has meet LDL-C target)
			2 pens /28 days	PCSK9 Inhibitors PA Form

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Repatha®	P	• See Praluent® prior authorization criteria	Repatha: 2/28 days Repatha Pushtronex: 1/28 days	PCSK9 Inhibitors PA Form

Juxtapid®	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by one of the following:
		  ○ Presence of a mutation in LDL receptor, ApoB, PCSK9 gene
		  ○ Clinical criteria using either the Simon Broome or WHO/Dutch Lipid Network criteria; **AND**
		• Patient age is appropriate according to package labeling (i.e., Praluent is indicated for age >18 years, Repatha is indicated for age >10 years; **AND**
		• Documented current LDL-C value (within 3 months); **AND**
		• Patient specific target LDL-C value is provided; **AND**
		• Failure to reach patient specific LDL target despite a ≥ 3-month trial (supported by claims history or clinical documentation) of concurrent therapy with BOTH the following, unless contraindicated or intolerance:
		  ○ High-intensity statin (atorvastatin/rosuvastatin)
		  ○ Ezetimibe; **AND**
		• Trial and failure, contraindication, or intolerance to Repatha; **AND**
		• Agent will be used in combination with other lipid lowering therapies, unless documented intolerance; **AND**
		• If female, documentation patient is not currently pregnant; **AND**
		• Patient is not concomitantly taking strong or moderate inhibitors of cytochrome P450 (CYP) 3A4
		Renewal Criteria:
		• Documentation of positive clinical response to therapy (e.g., LDL reduction from baseline, patient has meet LDL-C target)
			5 mg, 10mg: 1/day
			20mg: 3/day
				General PA Form

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Nexletol®	NP	**Primary Prevention of Cardiovascular Disease**
		Initial Criteria (6-month duration):
		• Age ≥ 18 years; **AND**
		• Agent is being use for primary prevention of cardiovascular disease; **AND**
		• Documented current LDL-C value (within 3 months); **AND**
		• Patient specific target LDL-C value is provided; **AND**
		• Failure to reach patient specific LDL target despite a > 3-month trial (supported by claims history or clinical documentation) of concurrent therapy with BOTH the following, unless contraindicated or intolerance:
		  ○ High-intensity statin (atorvastatin/rosuvastatin)
		  ○ Ezetimibe
		Renewal criteria:
		• Documentation of positive clinical response to therapy (e.g., LDL reduction from baseline, patient has meet LDL-C target)
		
		All Other Indications
		Initial Criteria (6-month duration):
		• Age ≥ 18 years; **AND**
		• Diagnosis of ONE of the following:
		  ○ Primary hyperlipidemia
		  ○ Atherosclerotic cardiovascular disease (ASCVD)
		  ○ Heterozygous familial hypercholesterolemia (HeFH)) confirmed by one of the following:
		  – Presence of a mutation in LDLR, ApoB, PCSK9 or ARH adaptor protein (LDLRAP1) gene
		  – Clinical criteria is met using either the Simon Broome or WHO/Dutch Lipid Network criteria; **AND**
		• Documented current LDL-C value (within 3 months); **AND**
		• Patient specific target LDL-C value is provided; **AND**
		• Failure to reach patient specific LDL target despite a ≥ 3-month trial (supported by claims history or clinical documentation) of concurrent therapy with BOTH the following, unless contraindicated or intolerance:
		  ○ High-intensity statin (atorvastatin/rosuvastatin)
		  ○ Ezetimibe; **AND**
		• Trial and failure, contraindication, or intolerance to Repatha; **AND**
		• Agent will be used in combination with other lipid lowering therapies, unless documented intolerance
		Renewal criteria:
		• Documentation of positive clinical response to therapy (e.g., LDL reduction from baseline, patient has meet LDL-C target)
			1/day	General PA Form

Nexlizet®	NP	• See Nexeltol® prior authorization criteria	1/day	General PA Form
Lipotropics: Bile Acid Sequestrant				
colesevelam packets	NP	• Patient is unable to swallow solid dosage forms		General PA Form
Welchol® packets	NP	• Patient is unable to swallow solid dosage forms		

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Lipotropics: Cholesterol Absorption Inhibitors				

Zetia®	NP	• One of the following:
		  • Patient is currently taking a high-intensity statin and has experienced less than anticipated therapeutic response
		  • Patient is unable to tolerate lower doses of high-intensity therapy
		  • Use in combination with a bile acid sequestrant, fibrate, or niacin will be approved.
		  • For requests as monotherapy, recipients must have been intolerant to, or have a contraindication to, a statin
			1/day	General PA Form

Lipotropics: Combination Agents				
ezetimibe/ simvastatin	NP	• For patients that require ≤45% LDL reduction: 4-week trial and failure of both atorvastatin and simvastatin; **OR** • For patients that require >45% LDL reduction: 4-week trial and failure of atorvastatin	1/day	General PA Form

Roszet®	NP	• One of the following:
		  ○ For patients that require ≤45% LDL reduction: 4-week trial and failure of both atorvastatin and rosuvastatin
		  ○ For patients that require >45% LDL reduction: 4-week trial and failure of atorvastatin; **AND**
		• Clinically valid reason as to why the patient is unable to take components individually
			1/day	

Vytorin®	NP	See ezetimibe/simvastatin prior authorization criteria	1/day	
Lipotropics: Fibric Acid Derivatives				
fenofibrate caps	NP	• Patient will take fenofibrate concomitantly with a sulfonylurea, thiazolidinedione, repaglinide, or a statin; **OR** • Clinically valid reason why a preferred agent cannot be used (e.g., gemfibrozil, fenofibrate tabs 48, 145, & 160 mg)		
fenofibrate tabs 40, 54, & 120 mg	NP	See fenofibrate caps prior authorization criteria		
fenofibric acid	NP	See fenofibrate caps prior authorization criteria		
Fenoglide®	NP	See fenofibrate caps prior authorization criteria		
Fibricor®	NP	See fenofibrate caps prior authorization criteria		
Lipofen®	NP	See fenofibrate caps prior authorization criteria		
Lofibra®	NP	See fenofibrate caps prior authorization criteria		
TriCor®	NP	See fenofibrate caps prior authorization criteria		

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Lipotropics: Niacin Derivatives				

niacin ER	P	One of the following:
		• Triglycerides > 500 mg/dL; **AND**
		  ○ Trial and failure. contraindication, or intolerance to BOTH gemfibrozil and fenofibrate; **OR**
		• Diagnosis of hyperlipidemia; **AND**
		  ○ Use in combination with a statin will be approved if the dose of the statin tried is considered sufficient to achieve ≥35% LDL reduction; **OR**
		  ○ For requests as monotherapy, recipients must have been intolerant to, or have a contraindication to a statin
				General PA Form

Niacor®	NP	See niacin ER prior authorization criteria		
Lipotropics: Omega-3 Fatty Acids				
omega-3 acid ethyl esters	P	**Initial Criteria:** • Diagnosis of Severe Hypertriglyceridemia (TG level is above 500 mg/dl) **Renewal Criteria:** • Documentation of positive clinical response (e.g., reduction in TG from baseline)	4/day	General PA Form
icosapent ethyl	NP	**Initial Criteria:** • Diagnosis of Severe Hypertriglyceridemia (TG level is above 500 mg/dl); **OR** • Patient is on maximally tolerated statin AND has triglyceride levels ≥ 135 **Renewal Criteria:** • Documentation of positive clinical response (e.g., reduction in TG from baseline)	0.5 g: 2/day 1 g: 4/day	
Lovaza®	NP	**Initial Criteria:** • Diagnosis of Severe Hypertriglyceridemia (TG level is above 500 mg/dl); **AND** • Trial and failure, contraindication, or intolerance to preferred omega-3 acid ethyl esters **Renewal Criteria:** • Documentation of positive clinical response (e.g., reduction in TG from baseline)	4/day	
Lipotropics: Low and Moderate Intensity Statins				
atorvastatin	P		1/day	General PA Form
lovastatin	P		1/day	
pravastatin	P		1/day	
simvastatin 5, 10, 20, & 40 mg	P		1/day	General PA Form
Altoprev®	NP		1/day	
Atorvaliq®	NP	• Patient is unable to swallow solid dosage forms	80 mg/day	
Ezallor Sprinkles®	NP	• Patient is unable to swallow solid dosage forms	1/day	
Flolipid®	NP	• Patient is 10 to 17 years of age; **AND** • Patient is unable to swallow solid dosage forms	40 mg/day	
fluvastatin	NP		1/day	
fluvastatin ER	NP		1/day	

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Lescol XL®	NP		1/day	
Livalo®	NP		1/day	
pitavastatin	NP		1/day	
Zocor®	NP		1/day	
Zypitamag®	NP		1/day	
Lipotropics: High Intensity Statins				
atorvastatin	P		1/day	High Potency Statin PA Form
rosuvastatin	P		1/day	
simvastatin 80 mg	P	• Patient has previously received simvastatin 80 mg for 12 months or longer with no evidence of myopathy	1/day	
Crestor®	NP		1/day	
Ezallor Sprinkles®	NP	• Patient is unable to swallow solid dosage forms	1/day	
Lipitor®	NP		1/day	
Lipotropics: Statin + Calcium Channel Blocker				
amlodipine/ atorvastatin	NP	• Patient is unable to take the 2 components separately	1/day	General PA Form
Caduet®	NP	• Patient is unable to take the 2 components separately	1/day	
Pheochromocytoma Agents				
Demser®	NP	• Documentation of pheochromocytoma diagnosis; **AND** • Trial and failure of an alpha and beta blocker		General PA Form
dibenzyline	NP	• Diagnosis of pheochromocytoma diagnosis	4/day	
metyrosine	NP	See Demser prior authorization criteria		
phenoxybenzamine	NP	See dibenzyline prior authorization criteria	4/day	
Platelet Inhibitors				
Brilinta®	P	• History of Myocardial Infarction (MI); **OR** • ACS initial event (USA, NSTEMI or STEMI) or recurrence within previous 12 months; **OR** • Patient has diagnosis of coronary artery disease (CAD) and is at high risk for myocardial infarction (MI) or stroke, **OR** • Acute ischemic stroke or transient ischemic attack (TIA) risk reduction **Note**: Will NOT be approved if patient is receiving aspirin doses > 100mg/day (includes Rx & OTC aspirin containing products)		General PA Form
prasugrel	P	• Patients has unstable angina, NSTEMI, or STEMI; **AND** • PCI will be performed, or PCI is planned; **AND** • Age < 75 years; **AND** • Weight ≥ 60 kg; **AND** • No history of stroke or TIA		

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Cablivi®	NP	**Criteria: (2-month duration)**
		• Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP); **AND**
		• Used in combination with both of the following:
		  ○ Plasma exchange until at least 2 days after normalization of the platelet count
		  ○ Immunosuppressive therapy (e.g., corticosteroids); **AND**
		• Date Cablivi IV was initiated/administered by a healthcare provider; **AND**
		• Total treatment duration will be limited to 58 days beyond the last therapeutic plasma exchange; **AND**
		• The patient has not experienced more than two recurrences of aTTP while on Cablivi
		Note: If started as an inpatient hospital regimen and this is continuation of therapy, Cablivi® will be approved		

Durlaza®	NP	• Trial and failure, contraindication, or intolerance to 2 preferred platelet inhibitors with the same indication; **AND** • Clinically valid reason why OTC aspirin cannot be used	1/day	
Effient®	NP	• Patients has unstable angina, NSTEMI, or STEMI; **AND** • PCI has been performed, or PCI is planned; **AND** • Age < 75 years; **AND** • Weight ≥ 60 kg; **AND** • No history of stroke or TIA; **AND** • Trial and failure of prasugrel		

Yosprala®	NP	• Diagnosis of one of the following:
		  ○ Ischemic stroke,
		  ○ Transient ischemia of the brain,
		  ○ Previous myocardial infarction,
		  ○ Unstable angina pectoris,
		  ○ Chronic stable angina pectoris; **OR**
		• Patient has had **ONE** of the following:
		  ○ Coronary Artery Bypass Graft (CABG)
		  ○ Percutaneous Transluminal Coronary Angioplasty (PTCA); **AND**
		• Patient meets **ALL** the following:
		  ○ Patient is considered a high-risk candidate for aspirin-associated gastric ulcers due to **ONE** of the following:
		  – Age ≥ 55, OR
		  – Documented history of gastric ulcers; **AND**
		  ○ Patient had an inadequate treatment response, or intolerance to use of aspirin and omeprazole separately
			1/day	

Pulmonary Arterial Hypertension (PAH) Agents				
Alyq®	P	• Diagnosis of Pulmonary arterial hypertension (PAH)/ elevated pulmonary vascular resistance or primary pulmonary hypertension (PPH); **OR** • Diagnosis of Congenital heart disease with elevated pulmonary vascular resistance	2/day	General PA Form
ambrisentan	P	See Alyq® prior authorization criteria	1/day	
bosentan	P	See Alyq® prior authorization criteria	2/day	
sildenafil	P	See Alyq® prior authorization criteria	3/day	

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
tadalafil	P	See Alyq® prior authorization criteria	2/day	
Tyvaso®	P	• Diagnosis of pulmonary arterial hypertension (PAH)/ elevated pulmonary vascular resistance or primary pulmonary hypertension (PPH); **OR** • Diagnosis of pulmonary hypertension associated with interstitial lung disease (PH-ILD; WHO Group 3) to improve exercise ability; **OR** • Diagnosis of congenital heart disease with elevated pulmonary vascular resistance	2.9 mL/day	
Ventavis®	P	See Alyq® prior authorization criteria	3 mL/day	
Adcirca®	NP	• Diagnosis of one of the following: ○ Pulmonary arterial hypertension (PAH)/elevated pulmonary vascular resistance or primary pulmonary hypertension ○ Congenital heart disease with elevated pulmonary vascular resistance; **AND** • Clinically valid reason why the preferred generic cannot be used	2/day	General PA Form
Adempas®	NP	• One of the following: ○ Diagnosis of pulmonary arterial hypertension (PAH)/ elevated pulmonary vascular resistance or primary pulmonary hypertension (PPH); **AND** – Trial of ONE preferred agent with persistent signs or symptoms ○ Diagnosis of congenital heart disease with elevated pulmonary vascular resistance; **AND** – Trial of ONE preferred agent with persistent signs or symptoms ○ Diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) with one of the following: – Patient has disease that is inoperable; **OR** – Patient has residual post-pulmonary endarterectomy hypertension **Note**: Use of Adempas® is contraindicated in patients also taking PDE-5 inhibitors	3/day	General PA Form
Letairis®	NP	See Adcirca® prior authorization criteria	1/day	General PA Form
Liqrev®	NP	• Diagnosis of one of the following: ○ Pulmonary arterial hypertension (PAH)/ elevated pulmonary vascular resistance or primary pulmonary hypertension ○ Congenital heart disease with elevated pulmonary vascular resistance; **AND** • One of the following: ○ Patient is unable to swallow tablets ○ Patient is < 6 years of age ○ Clinically valid reason why a preferred tablet formulation cannot be used	240mg/day	General PA Form
Opsumit®	NP	• Diagnosis of one of the following: ○ Pulmonary arterial hypertension (PAH)/ elevated pulmonary vascular resistance or primary pulmonary hypertension ○ Congenital heart disease with elevated pulmonary vascular resistance; **AND** • Trial of one preferred agent with persistent signs or symptoms	1/day	General PA Form
Opsynvi®	NP	• Diagnosis of Pulmonary arterial hypertension (PAH)/ elevated pulmonary vascular resistance or primary pulmonary hypertension; **AND** • Clinically valid reason as to why the patient is unable to take components of Opsynvi individually	1/day	
Orenitram®	NP	See Opsumit® prior authorization criteria	3/day	
Revatio® tab	NP	See Adcirca® prior authorization criteria	3/day	

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Revatio® suspension	NP	See Liqrev® prior authorization criteria	6 ml/day; Max day supply=60	
sildenafil suspension	NP	See Liqrev® prior authorization criteria	6 ml/day; Max day supply=60	
Tadliq®	NP	See Liqrev® prior authorization criteria	10mL/day	
Tracleer® soluble tabs	NP	• Diagnosis of one of the following: ○ Pulmonary arterial hypertension (PAH)/ elevated pulmonary vascular resistance or primary pulmonary hypertension (PPH) ○ Diagnosis of congenital heart disease with elevated pulmonary vascular resistance; **AND** • Patient is unable to swallow solid dosage forms	2.9 mL/day	
Tracleer® tabs	NP	See Adcirca® prior authorization criteria	2/day	
Tyvaso DPI®	NP	• Diagnosis of one of the following: ○ Pulmonary arterial hypertension (PAH)/elevated pulmonary vascular resistance or primary pulmonary hypertension ○ Pulmonary hypertension associated with interstitial lung disease; **AND** • Clinically valid reason why the preferred Tyvaso inhalation solution cannot be used	Single cartridges: 4/day; Combo cartridges: 8/day; Kits: 2/year	
Uptravi®	NP	See Opsumit® prior authorization criteria	Tabs: 2 /day; Pack: 1 /Rx	
Winrevair®	NP	• Patient is 18 years of age or older; **AND** • Diagnosis of Pulmonary arterial hypertension (PAH)/ elevated pulmonary vascular resistance or primary pulmonary hypertension; **AND** • Patient is Functional Class II or III; **AND** • Trial and failure of 1 agent with persistent signs and symptoms from TWO different classes for PAH such as: ○ Endothelin receptor antagonist (e.g. ambrisentan, bosentan) ○ Phosphodiesterade-5 inhibitors (e.g. sildenafil, tadalafil) ○ Prostacyclin analogue or receptor agonist (e.g., treprostinil, epoprostenol, Uptravi, Ventavis); **AND** • Winrevair will be used in combination with other PAH therapies	1 kit/21 days	
Pulmonary Fibrosis Agents				
Ofev®	P	• Diagnosis of one of the following: ○ Idiopathic pulmonary fibrosis ○ Interstitial Lung Disease Associated with Systemic Sclerosis- associated interstitial lung disease (SSc-ILD) ○ Chronic Fibrosing Interstitial Lunch Diseases (ILDs) with a progressive phenotype (at least 10% of the lungs show presence of fibrotic ILD); **AND** • Prescribed by, or in consultation with, a pulmonologist (initial approval only)	2/day	General PA Form
pirfenidone tablets	P	• Patient has a diagnosis of idiopathic pulmonary fibrosis; **AND** • Prescribed by, or in consultation with, a pulmonologist (initial approval only)	534, 801 mg: 3/day; 267 mg: 9/day	
Esbriet®	NP	• Patient has a diagnosis of idiopathic pulmonary fibrosis; **AND** • Prescribed by, or in consultation with, a pulmonologist (initial approval only); **AND** • Clinically valid reason as to why the preferred pirfenidone cannot be used	3/day: 801 mg: 3/day 9/day: 267 mg	

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
pirfenidone capsules	NP	See Esbriet prior authorization criteria	9/day: 267 mg	
Thrombopoietin Agonists, Orals				
Promacta® tabs	NP	• Diagnosis of persistent or chronic thrombocytopenia purpura (ITP) in patients ≥1 year of age; **AND** ○ Documentation of failure or insufficient response to adequate treatment with corticosteroids AND immunoglobulins, OR ITP related splenectomy; **AND** ○ Documentation that patient's thrombocytopenia and clinical condition puts the patient at increased risk of bleeding; **OR** • Diagnosis of thrombocytopenia in patient with chronic hepatitis C; **AND** ○ Patient receiving (or planning to initiate) interferon-based anti-viral therapy; **OR** • Diagnosis of severe aplastic anemia in patients 2 years of age or older; **AND** ○ Patient will use in combination with standard immunosuppressive therapy for first-line treatment; **OR** • Diagnosis of severe aplastic anemia; **AND** • Patient has tried and failed or has intolerance to immunosuppressive therapy	1/day	
Doptelet®	NP	• Patient is ≥ 18 years old; **AND** • Patient must have a diagnosis of thrombocytopenia and meet one of the following: ○ Chronic liver disease AND scheduled to undergo a medical procedure; **AND** – Patient is scheduled to take the requested agent 10 to 13 days prior to the procedure, with the procedure occurring 5 to 8 days following the last dose of Doptelet®; **OR** – Prescribed dose is according to baseline platelet count (10 tabs per 5 days ≥ 40 x 10^9/L or 15 tabs per 5 days for platelets < 40 x 10^9/L) – **PA Duration: single course of treatment per scheduled procedure, QL=15 per treatment** ○ Chronic Immune Thrombocytopenia (ITP); **AND** – Patient has had an insufficient response to a previous treatment; **AND** – Patient has a platelet count of < 50 x 109/L – **PA Duration: 1 year, QL= 2/day**	See criteria	General PA Form
Mulpleta®	NP	**Criteria**: (PA duration – single course of treatment per scheduled procedure): • Patient is ≥ 18 years old; **AND** • Patient has a diagnosis of Chronic Liver Disease (CLD); **AND** • Patient does NOT have Child-Pugh class C liver disease, absence of hepatopetal blood flow, a prothrombotic condition other than CLD nor a history of splenectomy, partial splenic embolization, or thrombosis; **AND** • Patient has a platelet count of < 50 x 10^9/L; **AND** • Patient has an upcoming invasive procedure scheduled; **AND** • Patient is scheduled to take the requested agent 8 to 14 days prior to the procedure, with the procedure occurring 2 to 8 days following the last dose of Mulpleta®; **AND** • Patient is NOT scheduled for a thoracotomy, laparotomy, open-heart surgery, craniotomy, or organ resection.	7 tabs/Rx	
Promacta® suspension	NP	See Promacta® prior authorization criteria • Patient is unable to swallow solid dosage forms	4 packets/day	

CARDIOVASCULAR *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Tavalisse®	NP	**Initial Criteria:**
		• Patient has a diagnosis of chronic immune thrombocytopenia; **AND**
		• Trial and failure (platelet count ≥ 50 x 10^9/L not achieved) of ONE of the following:
		  ○ Corticosteroids
		  ○ Thrombopoietin receptor antagonists (e.g., Promacta)
		  ○ Splenectomy
		  ○ Azathioprine (Azasan, Imuran), cyclosporine (Neoral, Sandimmune), cyclophosphamide (Cytoxan), mycophenolate mofetil (CellCept), danazol, or rituximab (Rituxan); **AND**
		• Patient is not on concomitant therapy with a strong CYP3A4 inducer; **AND**
		• Patient has received a baseline and will receive ongoing routine monitoring that includes:
		  ○ Neutropenia (measure ANC monthly)
		  ○ Hepatotoxicity (measure LFTs monthly)
		  ○ Hypertension (measure blood pressure every 2 weeks until stable dose established, then monthly)
		Renewal Criteria:
		• Patient has laboratory values documenting platelet response to therapy (platelet count ≥ 50 x 10^9/L; **AND**
		• Patient has not experienced severe adverse effect as a result of fostamatinib therapy
			2/day	General PA Form

Vasopressors				
droxidopa	NP	• Diagnosis of symptomatic neurogenic orthostatic hypotension secondary to primary autonomic failure, dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy; **AND** • Trial and failure, contraindication, or intolerance to midodrine OR fludrocortisone	100 & 200 mg: 3/day 300 mg: 6/day	General PA Form
Northera®	NP	See droxidopa prior authorization criteria	100 & 200 mg: 3/day 300 mg: 6/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Agents for Neuropathic Pain and Fibromyalgia **Note: The maximum daily dose limit for gabapentin, including all formulations and Brand products, is 3,600 mg.**				
duloxetine 20,30, & 60 mg	P		2/day	SNRI PA Form
gabapentin capsules	P		100 mg: 6/day; 300 mg: 12/day; 400 mg: 9/day	General PA Form
Horizant®	P	• Diagnosis of post-herpetic neuralgia; **OR** • Diagnosis of Restless Leg Syndrome	1/day Max daily gabapentin dose: 3600 mg	
lidocaine 5% patch	P	• Diagnosis of post-herpetic neuralgia	2/day	
pregabalin capsules	P	• Diagnosis of neuropathic pain; **OR** • Diagnosis of postherpetic neuralgia; **OR** • Diagnosis of fibromyalgia; **OR** • Diagnosis of seizure disorder		
pregabalin solution	P	See pregabalin capsules prior authorization criteria: **AND** • Patient is less than 12 years of age; **OR** • Patient is unable to swallow solid oral dosage forms		
Cymbalta®	NP		2/day	SNRI PA Form
duloxetine 40 mg	NP	• Clinically valid reason as to why the preferred duloxetine strengths (20 mg, 30 mg, 60 mg) cannot be used	2/day	

gabapentin solution	NP	• One of the following:
		  ○ Patient is less than 12 years of age; **OR**
		  ○ Inability to swallow solid oral dosage forms
			72 mL/day	General PA Form

gabapentin tablets	NP	• Documented allergy or contraindication to an inactive ingredient in the capsules that is NOT present in the tablets	600 mg: 6/day; 800 mg: 4.5/day	
Gralise®	NP	• Clinically valid reason why the preferred gabapentin agents cannot be used	3/day	
Lyrica® capsules		See pregabalin capsules prior authorization criteria; **AND** • Trial and failure of preferred pregabalin capsules		
Lyrica® solution		See pregabalin solution prior authorization criteria; **AND** • Trial and failure of preferred pregabalin solution		
Lyrica® CR	NP	• Diagnosis of postherpetic neuralgia OR neuropathic pain associated with-diabetic peripheral neuropathy; **AND** • Trial and failure, contraindication, or intolerance to a tricyclic antidepressant OR gabapentin; **AND** • Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus immediate-release pregabalin	82.5 mg & 165 mg: 1/day 330 mg: 2/day	
Neurontin® capsules	NP		100 mg: 6/day; 300 mg: 12/day; 400 mg: 9/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Neurontin® solution	NP	See gabapentin solution prior authorization criteria	72 mL/day	
Neurontin® tablets	NP		600 mg: 6/day; 800 mg: 4.5/day	
pregabalin CR	NP	See Lyrica® CR prior authorization criteria	82.5 mg & 165 mg: 1/day 330 mg: 2/day	General PA Form
Savella®	NP	• Patient has a diagnosis of fibromyalgia accompanied by fatigue; **AND** • Patient is 18 years of age or older; **AND** • Patient MUST have tried and failed, or have contraindication, or intolerance to duloxetine	2/day	
Agents for Restless Leg Syndrome (RLS)				
pramipexole	P		3/day	General PA Form
Horizant®	P	• Diagnosis of Restless Leg Syndrome; **OR** • Diagnosis of post-herpetic neuralgia	1/day Max daily gabapentin dose: 3600 mg	
Neupro®	NP	• Diagnosis of Parkinson's Disease or Restless Leg Syndrome, **AND** • Trial and failure, contraindication, or intolerance to Horizant, pramipexole, and ropinirole, **OR** • Inability to swallow		
Alzheimer's: Cholinesterase Inhibitors				
donepezil (excluding 23 mg)	P		1/day	General PA Form
donepezil ODT	P	• Patient is unable to swallow; **OR** • Unable to absorb medications through the GI tract	1/day	
Exelon®	P		1/day	
Adlarity®	NP		4 patch/month	
Aricept®	NP		1/day	
Aricept® 23 mg	NP	• Patient has been established (at least 3 months) on therapy with Aricept 10mg daily	1/day	
Aricept® ODT	NP	• Patient is unable to swallow; **OR** • Unable to absorb medications through the GI tract	1/day	
donepezil 23 mg	NP	• Patient has been established (at least 3 months) on therapy with donepezil 10mg daily	1/day	
galantamine ER	NP		1/day	
rivastigmine patch	NP		1/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Alzheimer's: NMDA Receptor Agent				
memantine tablets	P		5, 10 mg: 2/day; Titration Pack: 1/Rx	General PA Form
memantine ER	NP	• Diagnosis of moderate to severe Alzheimer's disease	1/day	
memantine solution	NP	• Diagnosis of moderate to severe Alzheimer's disease	10mL/day	
Namzaric®	NP	• Diagnosis of moderate to severe dementia associated with Alzheimer's disease; **AND** • Concomitantly taking donepezil and memantine (immediate release or extended release) [≥10mg/day on both agents]; **AND** • Clinical reason why recipient is unable to take the components individually	1/day	
Zunvey®	NP		2/day	
Analeptics				
caffeine citrate soln	NP	**Criteria (2-month duration)** • Diagnosis of apnea in premature infants (born between 28 and <33 weeks gestational age); **AND** • Patient is continuing therapy from an inpatient hospital stay (to facilitate transition to outpatient for completion of therapy); **AND** • Infant does not have renal impairment, hepatic impairment, or cardiovascular disease; **AND** • Prescriber must attest that they are aware of the risks of fatal necrotizing enterocolitis in premature infants and will monitor patient for efficacy and to avoid serious toxicity; **AND** • Prescribed by, or in consultation with a board-certified neonatologist		General PA Form
Antiparkinson Agents: Adenosine Antagonists				

Nourianz®	NP	**Initial Criteria: (6-month duration)**
		• Diagnosis of Parkinson's disease; **AND**
		  ○ Patient is experiencing "off" episode; **AND**
		• Patient is 18 years of age or older; **AND**
		• Patient is currently being treated with a stable dosage of levodopa/carbidopa; **AND**
		• Prescriber advises women of childbearing potential to use contraception during treatment; **AND**
		• Prescriber agrees to monitor the following:
		  ○ Patients with moderate hepatic impairment (Child-Pugh B) for adverse reactions
		  ○ Exacerbation of pre-existing dyskinesia
		  ○ Presence of hallucinations/psychotic behavior
		  ○ Presence of impulse control/compulsive behaviors; **AND**
		• Trial and failure, intolerance, or contraindication to ONE agent in TWO different antiparkinson classes (e.g., Dopamine Agents, Decarboxylase Inhibitors, COMT Inhibitors, MAO-B inhibitors, NMDA Antagonists)
		Renewal Criteria:
		• Patient is currently being treated with levodopa/carbidopa; **AND**
		• Patient has a positive clinical response to therapy (e.g., reduction in number or total daily hours of "off" episodes, increase "on" time without troublesome dyskinesia)
			1/day	General PA Form

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antiparkinson Agents: COMT Inhibitors				
Ongentys®	NP	**Initial Criteria: (6-month duration)** • Diagnosis of Parkinson's disease; **AND** • Patient is experiencing "off" episodes; **AND** • Patient is currently being treated with a stable dose of carbidopa/levodopa; **AND** • Trial and failure, intolerance, or contraindication to ONE agent in TWO different antiparkinson classes (e.g., dopamine agents, decarboxylase inhibitors, COMT inhibitors, MAO-B inhibitors, NMDA antagonists); **AND** • Will not be taken concomitantly with a non-selective monoamine oxidase inhibitor (MAOI); **AND** • Patient does not have a history of pheochromocytoma, paraganglioma, or other catecholamine secreting neoplasms **Renewal Criteria:** • Patient is currently being treated with levodopa/carbidopa; **AND** • Patient has a positive clinical response to therapy (e.g., reduction in number or total daily hours of "off" episodes, increase "on" time without troublesome dyskinesia)	1/day	General PA Form
Antiparkinson Agents: Dopamine Agents				
pramipexole	P		3/day	

Apokyn®	NP	• Patient has a diagnosis of Parkinson's disease; **AND**
		• Patient is experiencing acute, intermittent treatment of "off" episodes; **AND**
		• Must be 18 years of age or older; **AND**
		• Patient is currently being treated with a carbidopa/levodopa agent; **AND**
		• Patient has had a trial and failure, contraindication, or intolerance of TWO of the following preferred adjunct drugs prescribed in combination with levodopa/carbidopa, each from different classes:
		  ○ MAO-B inhibitor: selegiline
		  ○ COMT inhibitor: entacapone, carbidopa/levodopa/entacapone, Stalevo
		  ○ Dopamine agonist: pramipexole, ropinirole; **AND**
		• Patient must not meet any of the following:
		  ○ Patient is on concomitant 5HT3 antagonist
		  ○ Patient is pregnant
		  ○ Patient has a sensitivity to sulfites
				General PA Form

apomorphine injection	NP	See prior authorization criteria for Apokyn®		
Neupro®	NP	• Diagnosis of Parkinson's Disease OR Restless Leg Syndrome, **AND** ○ Trial and failure, contraindication, or intolerance to BOTH pramipexole AND ropinirole, **OR** • Inability to swallow		
pramipexole ER	NP		1/day	
Antiparkinson Agents: Levodopa Combinations				
Dhivy®	NP	Clinically valid reason as to why all the preferred carbidopa/levodopa agents cannot be used		
Inbrija®		**Initial Criteria: (6-month duration)**	60 blisters/month	General PA

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
	NP	• Diagnosis of Parkinson's disease; **AND** • Experiencing "off" episodes; **AND** • Patient is currently being treated with a stable dose of carbidopa/levodopa; **AND** • Trial and failure, intolerance, or contraindication to ONE agent in TWO different antiparkinson classes (e.g., dopamine agents, decarboxylase inhibitors, COMT inhibitors, MAO-B inhibitors, NMDA antagonists); **AND** • Will not be taken concomitantly with a non-selective monoamine oxidase inhibitor (MAOI); **AND** • Patient does not have asthma, COPD, or other chronic lung disease **Renewal Criteria:** • Patient is currently being treated with levodopa/carbidopa; **AND** • Patient has a positive clinical response to therapy (e.g., reduction in number or total daily hours of "off" episodes, increase "on" time without troublesome dyskinesia)		Form
Antiparkinson Agents: MAOI-Bs				
Xadago®	NP		1/day	General PA Form
Zelapar®	NP	• Inability to swallow solid dosage forms; **OR** • Clinically valid reason why the preferred selegiline formulation cannot be used		
Antiparkinson Agents: NMDA Antagonists				

Gocovri®	NP	**Initial Criteria:**
		• One of the following:
		  ○ Patient has a diagnosis of dyskinesia associated with Parkinson's disease
		  ○ Patient is experiencing "off" episodes; **AND**
		• Patient must be on concomitant levodopa-based therapy; **AND**
		• Patient has tried/failed an adequate trial of or is intolerant to amantadine immediate release; **AND**
		• Patient does not have end-stage renal disease (creatinine clearance < 15 mL/min/1.73 m_2)
		Renewal Criteria:
		• Patient is currently being treated with levodopa/carbidopa; **AND**
		Patient has a positive clinical response to therapy (e.g., reduction in number or total daily hours of "off" episodes, increase "on" time without troublesome dyskinesia)
			68.5 mg: 1/day;
			137 mg: 2/day	

Osmolex® ER tabs	NP	**Initial Criteria:**
		• One of the following:
		  ○ Diagnosis of Parkinson's disease
		  ○ Treatment of drug-induced extrapyramidal reactions; **AND**
		• Patient does not have end-stage renal disease (creatinine clearance below 15 mL/min/1.73 m2); **AND**
		• Patient has had an adequate trial of or is intolerant to amantadine IR (capsules)
		Renewal Criteria:
		• Documentation of decreased Parkinson's disease symptoms OR decreased extrapyramidal effects
			193 mg & 258 mg: 1/day;
			129 mg: 2/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENT'S WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):
*Anti-anxiety agents prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if **ONE** of the following is met:*
• *Prescribed bay a Gold Card prescriber; **OR***
• *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; **AND***
  ○ *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; **AND***
  ○ *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers*
• *Short-term therapy (less than 90 days) has been prescribed; **AND***
  ○ *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement; **OR***
  – *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; **AND***
  ○ *Efficacy and potential side effects to be monitored; **AND***
  ○ *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried*
***Note the following**:*
• *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.*
• *The I/DD Worksheet can be found at: I/DD Prior Authorization Form*				

Anti-Anxiety and Anti-Panic Agents				

alprazolam tabs	P	• Diagnosis of one of the following:
		  ○ Anxiety disorder
		  ○ Panic disorder with or without agoraphobia; **AND**
		• Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., cognitive behavioral therapy, worry exposure, applied relaxation, muscle relaxation, short-term psychodynamic psychotherapy, mindfulness-based therapy); **AND**
		• Trial and failure, contraindication, or intolerance to therapy with TWO of the following:
		  ○ SSRI (minimum trial duration of 4 weeks)
		  ○ SNRI (minimum trial duration of 4 weeks)
		  ○ Buspirone; **AND**
		• Due to increased risk of toxicity, patient should not be pregnant **OR** concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates; **AND**
		• Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse; **AND**
		• Prescriber has checked the Tennessee Controlled Substance Monitoring Database (CSMD) on the date of the request for concomitant controlled substance use
			3/day	Anti-anxiety PA Form

alprazolam ER tabs	P	See alprazolam tablets prior authorization criteria	2/day	
buspirone	P		30 mg: 2/day; All other strengths: 3/day	General PA Form

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

chlordiazepoxide	P	• Diagnosis of acute alcohol withdrawal syndrome; **OR**
		• Diagnosis of anxiety disorder; **AND**
		  ○ Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., cognitive behavioral therapy, worry exposure, applied relaxation, muscle relaxation, mindfulness-based therapy); **AND**
		  ○ Trial and failure, contraindication, or intolerance to therapy with TWO of the following:
		  – SSRI (minimum trial duration of 4 weeks)
		  – SNRI (minimum trial duration of 4 weeks)
		  – Buspirone; **AND**
		• Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse; **AND**
		• Due to increased risk of toxicity, patient should not be pregnant **OR** concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates; **AND**
		• Prescriber has checked the Tennessee Controlled Substance Monitoring Database (CSMD) on the date of the request for concomitant controlled substance use
			4/day	Anti-anxiety PA Form

clonazepam	P	• Diagnosis of seizure disorder; **OR**
		• Diagnosis of panic disorder; **AND**
		  ○ Trial and failure, contraindication, or intolerance to therapy with TWO of the following:
		  – SSRI (minimum trial duration of 4 weeks)
		  – SNRI (minimum trial duration of 4 weeks)
		  – Buspirone; **AND**
		• Due to increased risk of toxicity, patient should not be pregnant OR concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates; **AND**
		• Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse
		• Prescriber has checked the Tennessee Controlled Substance Monitoring Database (CSMD) on the date of the request for concomitant controlled substance use
			3/day	

clorazepate	P	• Diagnosis of acute alcohol withdrawal syndrome; **OR**
		• Diagnosis of seizure disorder; **AND**
		  ○ Must be used in conjunction with another anticonvulsant; **OR**
		• Diagnosis of anxiety disorder; **AND**
		  ○ Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., cognitive behavioral therapy, worry exposure, applied relaxation, muscle relaxation, mindfulness-based therapy); **AND**
		  ○ Trial and failure, contraindication, or intolerance to therapy with TWO of the following:
		  – SSRI (minimum trial duration of 4 weeks)
		  – SNRI (minimum trial duration of 4 weeks)
		  – Buspirone; **AND**
		• Due to increased risk of toxicity, patient should not be pregnant **OR** concurrently taking CNS stimulants, opiates, carisoprodol/meprobamate, or barbiturates; **AND**
		• Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse (does not apply to diagnosis of acute alcohol withdrawal syndrome); **AND**
		• Prescriber has checked the Tennessee Controlled Substance Monitoring Database (CSMD) on the date of the request for concomitant controlled substance use
			3/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Anti-anxiety Agents *(continued)*				

diazepam tablets, solution, concentrate	P	• Diagnosis of acute alcohol withdrawal syndrome; **OR**
		• Diagnosis of seizure disorder; **AND**
		  ○ Must be used in conjunction with another anticonvulsant; **OR**
		• Diagnosis of muscle spasms; **AND**
		  ○ Patient has tried and failed at least TWO preferred skeletal muscle relaxants; **OR**
		• Diagnosis of anxiety disorder; **AND**
		  ○ Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., cognitive behavioral therapy, worry exposure, applied relaxation, muscle relaxation, mindfulness-based therapy); **AND**
		  ○ Trial and failure, contraindication, or intolerance to therapy with TWO of the following:
		  – SSRI (minimum trial duration of 4 weeks)
		  – SNRI (minimum trial duration of 4 weeks)
		  – Buspirone; **AND**
		• Due to increased risk of toxicity, patient should not be pregnant **OR** concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates; **AND**
		• Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse (does not apply to diagnosis of acute alcohol withdrawal syndrome); **AND**
		• Prescriber has checked the Tennessee Controlled Substance Monitoring Database (CSMD) on the date of the request for concomitant controlled substance use
			tabs: 4/day
			soln: 10 mL/day
			concentrate: 2 mL/day
				Anti-anxiety PA Form

lorazepam tablets and concentrate	P	• Patient is < 1 year of age and completing taper following inpatient hospital use for Neonatal Withdrawal symptoms; **OR**
		• Diagnosis of anxiety disorder; **AND**
		  ○ Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., cognitive behavioral therapy, worry exposure, applied relaxation, muscle relaxation, mindfulness-based therapy); **AND**
		  ○ Trial and failure, contraindication, or intolerance to therapy with TWO of the following:
		  – SSRI (minimum trial duration of 4 weeks)
		  – SNRI (minimum trial duration of 4 weeks)
		  – Buspirone; **AND**
		• Due to increased risk of toxicity, patient should not be pregnant **OR** concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates; **AND**
		• Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse; **AND**
		• Prescriber has checked the Tennessee Controlled Substance Monitoring Database (CSMD) on the date of the request for concomitant controlled substance use
			tabs: 3/day
			concentrate: 3 mL/day	

Xanax®	P	See alprazolam tablets prior authorization criteria	3/day	
Xanax® XR	P	See alprazolam tablets prior authorization criteria	2/day	
alprazolam ODT	NP	See alprazolam prior authorization criteria; **AND** • Patient is unable to swallow solid dosage forms or unable to absorb medications through the GI tract; **AND** • Trial and failure, contraindication, or intolerance to the BOTH preferred concentrate solutions	3/day	
alprazolam concentrate	NP	See alprazolam prior authorization criteria; **AND** • Patient is unable to swallow solid dosage forms or unable to absorb medications through the GI tract; **AND** • Patient must have a trial and failure, contraindication, or intolerance to the BOTH preferred concentrate solutions	6 mL/day	Anti-anxiety PA Form

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Ativan®	NP	See lorazepam prior authorization criteria; **AND** • Clinically valid reason as to why the preferred lorazepam tablets or concentrate cannot be used	3/day	
Loreev XR®	NP	See lorazepam prior authorization criteria; **AND** • Clinically valid reason as to why the preferred lorazepam tablets or concentrate cannot be used	1/day	
meprobamate	NP	See alprazolam prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance of TWO preferred agents		
oxazepam	NP	See chlordiazepoxide prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance of TWO preferred agents	4/day	

Valium®	NP	• Diagnosis of acute alcohol withdrawal syndrome; **OR**
		• Diagnosis of seizure disorder; **AND**
		  ○ Must be used in conjunction with another anticonvulsant; **AND**
		  ○ Trial and failure of the following preferred agents:
		  – Clorazepate
		  – Diazepam
		• Diagnosis of muscle spasms; **AND**
		  ○ Trial and failed TWO preferred skeletal muscle relaxants; **OR**
		• Diagnosis of acute alcohol withdrawal syndrome; **OR**
		• Diagnosis of anxiety disorder; **AND**
		  ○ Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., cognitive behavioral therapy, worry exposure, applied relaxation, muscle relaxation, mindfulness-based therapy); **AND**
		  ○ Trial and failure, contraindication, or intolerance to therapy with TWO of the following:
		  – SSRI (minimum trial duration of 4 weeks)
		  – SNRI (minimum trial duration of 4 weeks)
		  – Buspirone; **AND**
		• Due to increased risk of toxicity, patient should not be pregnant OR concurrently taking CNS stimulants, opiates, carisoprodol/meprobamate, or barbiturates; **AND**
		• Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse (does not apply to diagnosis of acute alcohol withdrawal syndrome); **AND**
		• Prescriber has checked the Tennessee Controlled Substance Monitoring Database (CSMD) on the date of the request for the concomitant controlled substance use; **AND**
		• Trial and failure of 2 preferred agents
			3/day	

Anticonvulsants				
Aptiom®	P	• Use as monotherapy for partial onset seizures and trial and failure with ONE preferred anticonvulsant with the same indication; **OR** • Use as adjunctive therapy for partial onset seizures when used in combination with at least ONE other anticonvulsant.		General PA Form
clobazam tablets	P	• Diagnosis of Lennox-Gastaut Syndrome; **AND** • Used as adjunct therapy with at least one other anticonvulsant		

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

clonazepam	P	• Diagnosis of seizure disorder; **OR**
		• Diagnosis of panic disorder; **AND**
		  ○ Trial and failure, contraindication, or intolerance to therapy with TWO of the following:
		  – SSRI (minimum trial duration of 4 weeks)
		  – SNRI (minimum trial duration of 4 weeks)
		  – Buspirone; **AND**
		• Due to increased risk of toxicity, patient should not be pregnant OR concurrently taking CNS stimulants, opiates, carisoprodol, meprobamate, or barbiturates; **AND**
		• Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse; **AND**
		• Prescriber has checked the Tennessee Controlled Substance Database on the date of the request for concomitant controlled substance use
			3/day	Anti-anxiety PA Form

diazepam rectal gel	P	• Prior Authorization will not be required for patients less than 21 years of age. • Will be approved for patients 21 years of age and older with a Diagnosis of Seizure Disorder or Epilepsy.	2 packs/30 days	

Epidiolex®	P	**Initial Criteria:**
		• Diagnosis of one of the following:
		  ○ Dravet Syndrome (DS)
		  ○ Lennox-Gastaut Syndrome (LGS)
		  ○ Tuberous sclerosis complex (TSC)
		  ○ Treatment-Refractory Epilepsy; **AND**
		• Trial of 2 anticonvulsants within the past 12 months (documented by claims); **AND**
		• Epidiolex will be used as adjunct therapy with ≥ 1 anticonvulsant (documented by claims)
		Renewal Criteria
		• Epidiolex will be used as adjunct therapy with ≥ 1 anticonvulsant (documented by claims)		

gabapentin capsules	P		100 mg: 6/day 300 mg: 12/day 400 mg: 9/day Max daily gabapentin dose: 3600 mg	
gabapentin solution	P	• Inability to swallow solid oral dosage forms, **AND** ○ Patient and caregiver are unable to open capsule and empty contents in food or drink; **OR** • Patient is < 12 years of age	72 mL/day Max daily gabapentin dose: 3600 mg	
lacosamide tablets	P	• Use as monotherapy for partial onset seizures requires trial and failure with at least ONE other preferred anticonvulsant for the same indication; **OR** • Use as adjunctive therapy for partial onset seizures when used in combination with at least ONE other anticonvulsant; **OR** • Used as adjunctive therapy in the treatment of primary generalized tonic-clonic (PGTC) seizures in patients 4 years of age and older		General PA Form

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Libervant®	P	**Initial Criteria (6-month duration):**
		• Diagnosis of intermittent, stereotypic episodes of frequent seizure activity (e.g., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern; **AND**
		• Patient is 2 to 5 years of age; **AND**
		• Prescribed by, or in consultation with, a neurologist; **AND**
		• Patient is on a stable antiepileptic regimen; **AND**
		• Prescriber has counseled patient on the following:
		  ○ Risks if combined with opioids or benzodiazepines
		  ○ Identification of a seizure cluster
		  ○ Proper administration
		  ○ When to seek emergency medical treatment; **AND**
		• Patient is not using moderate or strong CYP2C19 and CYP 3A4 inhibitors or, if unavoidable, prescriber will monitor toxicity risk during concomitant use; **AND**
		• Patient does not have acute narrow-angle glaucoma
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• Patient does not have treatment-limiting adverse effects (e.g., treatment-limiting central nervous system depression or cognitive impairment, worsened glaucoma, respiratory depression, suicidal ideation, clinically significant changes in blood pressure or heart rate); **AND**
		• Prescriber to provide verbal attestation of diazepam effectiveness (e.g., decreased typical length of repetitive seizures)
			10 doses/ 30 days	General PA Form

Nayzilam®	P	**Initial Criteria (6-month duration):**
		• Patient has diagnosis of intermittent, stereotypic episodes of frequent seizure activity (e.g., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern; **AND**
		• Patient is 12 years of age or older; **AND**
		• Prescribed by, or in consultation with, a neurologist; **AND**
		• Patient is on a stable antiepileptic regimen; **AND**
		• Prescriber has counseled patient on the following:
		  ○ Risks if combined with opioids
		  ○ Identification of a seizure cluster
		  ○ Proper administration
		  ○ When to seek emergency medical treatment; **AND**
		• Patient is not using moderate or strong CYP 3A4 inhibitors or, if unavoidable, prescriber will monitor toxicity risk during concomitant use; **AND**
		• Due to increased risk of toxicity, patient should not be pregnant OR concurrently taking CNS stimulants, CNS depressants, carisoprodol, meprobamate, or barbiturates; **AND**
		• Patient does not have acute narrow-angle glaucoma
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• Patient does not have treatment-limiting adverse effects (e.g., treatment-limiting central nervous system depression or cognitive impairment, worsened glaucoma, respiratory depression, suicidal ideation, clinically significant changes in blood pressure or heart rate); **AND**
		• Prescriber to provide verbal attestation of midazolam effectiveness (e.g., decreased typical length of repetitive seizures)
			10 doses/
			30 days
				General PA Form

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
pregabalin capsules	P	• Diagnosis of neuropathic pain; **OR** • Diagnosis of postherpetic neuralgia; **OR** • Diagnosis of fibromyalgia; **OR** • Diagnosis of seizure disorder		General PA Form

pregabalin solution	P	• One of the following:
		  ○ Diagnosis of neuropathic pain
		  ○ Diagnosis of postherpetic neuralgia
		  ○ Diagnosis of fibromyalgia
		  ○ Diagnosis of seizure disorder; **AND**
		• Patient is less than 12 years of age; **OR**
		  ○ Patient is unable to swallow solid oral dosage forms
				General PA Form

phenobarbital	P	• Will be approved for use ONLY in patients with diagnosis of seizure disorders.		General PA Form
phenobarbital elixir	P	• Will be approved for use ONLY in patients with diagnosis of seizure disorders. **Note**: PA is not required for patients less than 2 years of age		
rufinamide tablets	P	• Diagnosis of Lennox-Gastaut Syndrome; **AND** • Used as adjunct therapy with at least one other anticonvulsant		
rufinamide susp	P	• Diagnosis of Lennox-Gastaut Syndrome; **AND** • Used as adjunct therapy with at least one other anticonvulsant; **AND** • Unable to swallow solid dosage forms		

Trokendi XR	P	• Adjunctive therapy for patients with partial-onset seizures or primary generalized tonic-clonic seizures; OR seizures associated with Lennox-Gastaut syndrome; **AND**
		  ○ Will be used approved in combination with at least one other anticonvulsant; **AND**
		  ○ Trial and failure of preferred immediate release product and one additional preferred agent; **OR**
		• Initial monotherapy in patients with partial-onset or primary generalized tonic-clonic seizures; **AND**
		  ○ Trial and failure of preferred immediate release product and one additional preferred agent; **OR**
		• Migraine Prophylaxis in patients ≥ 12 years of age
			25, 50, & 100 mg: 1/day;
			200 mg: 2/day
				General PA Form

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Valtoco®	P	**Initial Criteria (6-month duration):**
		• Patient has diagnosis of intermittent, stereotypic episodes of frequent seizure activity (e.g., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern; **AND**
		• Patient is 2 years of age or older; **AND**
		• Prescribed by, or in consultation with, a neurologist; **AND**
		• Patient is on a stable antiepileptic regimen; **AND**
		• Prescriber has counseled patient on the following:
		  ○ Risks if combined with opioids
		  ○ Identification of a seizure cluster
		  ○ Proper administration
		  ○ When to seek emergency medical treatment; **AND**
		• Patient is not using CYP 2C19 and CYP 3A4 inhibitors or, if unavoidable, prescriber will monitor toxicity risk during concomitant use; **AND**
		• Due to increased risk of toxicity, patient should not be pregnant OR concurrently taking CNS stimulants, CNS depressants, carisoprodol, meprobamate, or barbiturates; **AND**
		• Patient does not have acute narrow-angle glaucoma
		Renewal Criteria (1 year duration):
		• Patient continues to meet initial criteria; **AND**
		• Patient does not have treatment-limiting adverse effects (e.g., treatment-limiting CNS depression or cognitive impairment, worsened glaucoma, respiratory depression, suicidal ideation, clinically significant changes in blood pressure); **AND**
		• Prescriber to provide verbal attestation of diazepam effectiveness (e.g., decreased typical length of repetitive seizures)
			5 boxes/30 days	

zonisamide	P		25 mg (4/day); 50 mg (2/day); 100 mg (6/day)	
Ztalmy®	P	**Initial Criteria:** • Patient is 2 years of age and older; **AND** • Diagnosis of seizure disorder associated with cyclin-dependent kinase-like 5 deficiency disorder; **AND** • Prescriber has confirmed that patient is not pregnant (if applicable) and counseled patient on risks of pregnancy while taking Ztalmy; **AND** • Prescriber has confirmed member does not have hepatic disease and will monitor hepatic function (dose reductions may be required in impaired hepatic function) **Renewal Criteria:** • Prescriber has confirmed that patient is not pregnant (if applicable); **AND** • Prescriber has confirmed member does not have hepatic disease and will monitor hepatic function (dose reductions may be required in impaired hepatic function)	36 mL/day	General PA Form
Banzel® tablets	NP	• Diagnosis of Lennox-Gastaut Syndrome; AND • Used as adjunct therapy with at least one other anticonvulsant		
Banzel® suspension	NP	• Diagnosis of Lennox-Gastaut Syndrome; **AND** • Used as adjunct therapy with at least one other anticonvulsant; **AND** • Unable to swallow solid dosage forms		

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Briviact® solution	NP	See Briviact® tablets prior authorization criteria • Additionally, patient must be unable to swallow tablets	20 mL/day	
Briviact® tablets	NP	• Patient is ≥ 1 month of age; **AND** • Have diagnosis of partial-onset seizures; **AND** • Have tried and failed at least 1 other medication indicated for partial-onset seizures **NOTE**: A dose reduction is required for all stages of hepatic impairment (Child-Pugh A, B, and C) and use is not recommended in end- stage renal disease patients.	2/day	
clobazam suspension	NP	• Must meet clobazam tablets prior authorization criteria; **AND** • Patient must be unable to swallow tablets		
clonazepam ODT	NP	• Must meet clonazepam prior authorization criteria; **AND** • Patient must be unable to swallow, OR unable to absorb medications through the GI tract.	3/day	
Diacomit®	NP	**Initial Criteria:** • Patient is ≥ 6 months of age; **AND** • Patient must also be taking clobazam concomitantly; **AND** • Diagnosis of Dravet syndrome (DS); **AND** • Prescribed by neurologist or epileptologist; **AND** • Prescriber attests that baseline serum hematologic testing has been completed; **AND** • Prescriber attests the patient has refractory epilepsy (failed to become seizure free after trials of 2 antiepileptic drugs); **AND** • If the oral powder for suspension is prescribed, the patient does not have phenylketonuria (PKU). **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Patient has no treatment-limiting adverse effects (e.g., thrombocytopenia, neutropenia, new onset or worsened depression; suicidal thoughts, worsened seizure control); **AND** • Prescriber to provide verbal attestation of Diacomit effectiveness (e.g., reduced seizure frequency and/or duration)	250 mg (1/day); 500 mg (6/day)	General PA Form
Elepsia® XR	NP	• Patient has a diagnosis or history of partial-onset seizures, juvenile myoclonic epilepsy, or primary generalized tonic-clonic seizure; **AND** • Will be used as adjunctive therapy with another anticonvulsant; **AND** • Patient must be 12 years of age or older; **AND** • Clinically valid reason why the preferred levetiracetam ER cannot be used	1000 mg: 3/day; 1500 mg: 2/day	

Eprontia® solution	NP	• One of the following:
		  ○ Will be used as initial monotherapy for the treatment of partial-onset or primary generalized tonic-clonic seizures in patients 2 years of age and older
		  ○ Will be used as adjunctive therapy for the treatment of partial-onset seizures, primary generalized tonic-clonic seizures, and seizures associated with Lennox-Gastaut syndrome in patients 2 years of age and older
		  ○ Will be used as preventive treatment of migraine in patients 12 years and older; **AND**
		• Patient is unable to swallow tablets
			16 ml/day	General PA Form

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Felbatol® and felbamate	NP	**Initial Criteria:**
		• Used as adjunctive therapy for the treatment of partial and generalized seizures associated with Lennox-Gastaut Syndrome in children 2-14 years of age with a contraindication to, or trial and failure of, **TWO** of the following:
		  ○ Valproic acid/divalproex sodium
		  ○ Lamotrigine
		  ○ Topiramate
		• Used as monotherapy and adjunctive therapy for the treatment of partial seizures with or without generalization in adults > 14 years of age with a contraindication to, or trial and failure of, **THREE** of the following:
		  ○ Carbamazepine
		  ○ Oxcarbazepine
		  ○ Phenytoin
		  ○ Gabapentin
		  ○ Lamotrigine
		  ○ Topiramate
		  ○ Valproic acid/divalproex sodium
		Note: Will not be approved if there is a history of blood dyscrasia or liver disease unless the prescriber can make a compelling clinical case demonstrating that the benefits of the drug outweigh the risks.		

Fintepla®	NP	**Initial Criteria:** • Patient must be ≥ 2 years of age; **AND** • Diagnosis of Dravet syndrome (DS) or Lennox-Gastaut syndrome (LGS); **AND** • Prescribed by a neurologist or epileptologist; **AND** • Patient has not received MAOI therapy within 14 days and will not receive during Fintepla therapy; **AND** • Prescriber attestation that baseline echocardiogram has been completed and will be monitored throughout treatment and 3 – 6 months after the final dose; **AND** • Inadequate response to trials of 2 preferred anticonvulsant agents **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Patient has no treatment-limiting adverse effects (e.g., serotonin syndrome, abnormal AST/ALT, CrCl, abnormal echocardiogram); **AND** • Patient is responding to therapy (e.g., reduced seizure frequency and/or duration)	1 bottle/30 days	General PA Form

Fycompa®	NP	• Diagnosis of partial onset seizures with or without secondarily generalized seizures; **AND**
		  ○ Patient is ≥ 4 years of age; **AND**
		  ○ Trial and failure, contraindication, or intolerance to 2 preferred agents, one of which must be lacosamide **OR**
		• Will be used as adjunctive therapy for the treatment of primary generalized tonic-clonic (PGTC) seizures; **AND**
		  ○ Patient is ≥ 12 years of age; **AND**
		  ○ Trial and failure, contraindication, or intolerance to TWO preferred agents
			2, 4, 8, 10, & 12 mg: 1/day;
			6 mg: 2/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
gabapentin tablets	NP	• Clinically valid reason why the preferred gabapentin capsules cannot be used	100 & 600 mg: 6/day; 800 mg: 4.5/day; All other strengths: 3/day Max daily gabapentin dose: 3600 mg	
Klonopin®	NP	See clonazepam prior authorization criteria; **AND** • Trial and failure of clonazepam	3/day	Anti-anxiety PA Form
Lamictal® ODT	NP	• Unable to swallow solid dosage forms		General PA Form
Lamictal® XR	NP	• Trial and failure of a regular-release lamotrigine product and 1 other preferred agent		
lamotrigine ER	NP	• Trial and failure of a regular-release lamotrigine product and 1 other preferred agent		
lamotrigine ODT	NP	• Unable to swallow solid dosage forms		General PA Form
Lyrica® capsules	NP	See pregabalin capsules prior authorization criteria; **AND** • Trial and failure of preferred pregabalin capsules		
Lyrica® solution	NP	See pregabalin solution prior authorization criteria; **AND** • Trial and failure of preferred pregabalin solution		
Lyrica® CR	NP	• Diagnosis of postherpetic neuralgia OR neuropathic pain associated with-diabetic peripheral neuropathy; **AND** • Trial and failure, contraindication, or intolerance to a tricyclic antidepressant OR gabapentin; **AND** • Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus immediate-release pregabalin	82.5 mg & 165 mg: 1/day 330 mg: 2/day	
Motpoly ®XR	NP	• One of the following: ○ Initial monotherapy for partial onset seizures ○ Adjunctive therapy for partial onset seizures and will be used in combination with at least one other anticonvulsant; **AND** • Trial and failure of preferred immediate release product and one additional preferred agent		
Neurontin® solution	NP	See gabapentin solution prior authorization criteria. **Note:** Prior authorization criteria is waived for recipients 12 years of age and under	72 mL/day Max total daily gabapentin dose: 3600mg	
Onfi®	NP	See clobazam tablets prior authorization criteria		Anti-anxiety PA Form

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Qudexy® XR	NP	• Will be used as monotherapy or adjunctive therapy in patients with focal (partial) onset or primary generalized tonic-clonic seizures; **OR** • Will be used as adjunctive therapy in patients with seizures associated with Lennox-Gastaut syndrome; **OR** • Migraine Prophylaxis in patients ≥ 12 years of age; **AND** ○ Trial and failure of an Trokendi XR and 1 other preferred agent	200 mg: 2/day All other strengths: 1/day	General PA Form
rufinamide tablet	NP	• Diagnosis of Lennox-Gastaut Syndrome; **AND** • Used as adjunct therapy with at least one other anticonvulsant		General PA Form
Sabril®	NP	• Adjunctive therapy for patients with refractory complex partial seizures who have responded inadequately to several alternative treatments; **AND** ○ Patient has tried and failed 2 preferred anticonvulsants; **OR** • Monotherapy for patients with infantile spasms **Note:** This drug is subject to REMS requirements to ensure the benefits of treatment outweigh the risks of vision loss		General PA Form
Spritam®	NP	• Patient is unable to swallow solid oral dosage form; **AND** • Provider must have a clinically valid reason as to why the generic levetiracetam solution cannot be used	250, 500, & 1000 mg: 2/day; 750 mg: 4/day	General PA Form
Sympazan®	NP	• Patient has a diagnosis of Lennox-Gastaut syndrome (LGS); **AND** • Requested drug will be used as adjunctive therapy in combination with at least one other anticonvulsant; **AND** • Provider must have a clinically valid reason as to why both clobazam tablets and suspension cannot be used. (NOTE: Patient convenience is NOT an approvable reason)	2/day	General PA Form
topiramate ER	NP	• Will be used as monotherapy or adjunctive therapy in patients with focal (partial) onset or primary generalized tonic-clonic seizures; **OR** • Will be used as adjunctive therapy in patients with seizures associated with Lennox-Gastaut syndrome; **OR** • Migraine Prophylaxis in patients ≥ 12 years of age; **AND** ○ Trial and failure of an Trokendi XR and 1 other preferred agent	200 mg: 2/day All other strengths: 1/day	General PA Form
vigabatrin	NP	See Sabril® prior authorization criteria		General PA Form
Vigafyde®		• Treatment is for monotherapy for patients with infantile spasms; **AND** • Clinically valid reason why vigabatrin 50 mg/mL powder oral solution cannot be used **Note**: This drug is subject to REMS requirements to ensure the benefits of treatment outweigh the risks of vision loss		
Vigadrone®	NP	See Sabril® prior authorization criteria		General PA Form
Vimpat®	NP	See lacosamide prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance to lacosamide		

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Xcopri®	NP	**Initial criteria:** • Diagnosis of partial-onset seizures; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Must be 18 years of age and older; **AND** • Trial and failure, contraindication, or intolerance to 2 preferred anticonvulsants indicated for partial-onset seizures; **AND** • Patient does not have Familial Short QT syndrome **Renewal criteria:** • Patient must demonstrate disease improvement and stabilization as a result of the medication; **AND** • Patient is absent of unacceptable toxicity from the drug; **AND** • Patient's QT interval is being monitored	2/day	General PA Form
Zonisade®	NP	• Diagnosis of partial-onset seizures; **AND** • Zonisade will be used as adjunctive therapy; **AND** • Patient must be unable to swallow solid dosage forms	30 mL/day	General PA Form

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Movement Disorders				
Austedo®	P	**Diagnosis of tardive dyskinesia:** • Patient age ≥ 18 years; **AND** • Documentation that AIMS test has been completed (e.g., score or copy of AIMS assessment); **AND** • Prescribed by, or in consultation with, a neurologist or psychiatrist (or other mental health provider), provided patient has reasonable access; **AND** • Documentation or claims history of current or former chronic patient use of a dopamine antagonist (e.g., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine) **Diagnosis of chorea related to Huntington's Disease:** • Physician is experienced in the treatment of Huntington's Disease or is in a Center of Excellence for Huntington's Disease; **AND** • Patient does not have a history of untreated or inadequately treated depression or suicidal ideation due to a boxed warning that it increases the risk of depression and suicidal thoughts and behavior **Patients meeting any of the following criteria will NOT be approved:** • Concurrent therapy with tetrabenazine, reserpine, or MAOIs • Hepatic impairment • Hypersensitivity to the active ingredient • Pregnancy	4/day	General PA Form
Austedo XR®	P	See Austedo prior authorization criteria	1/day	
Ingrezza®	P	**Diagnosis of tardive dyskinesia:** • Patient age ≥ 18 years; **AND** • Documentation that AIMS test has been completed (e.g., score or copy of AIMS assessment); **AND** • Prescribed by, or in consultation with, a neurologist or psychiatrist (or other mental health provider), provided patient has reasonable access; **AND** • Documentation or claims history of current or former chronic patient use of a dopamine antagonist (e.g., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine) **Diagnosis of chorea related to Huntington's Disease:** • Physician is experienced in the treatment of Huntington's Disease or is in a Center of Excellence for Huntington's Disease; **AND** • Patient does not have a history of untreated or inadequately treated depression or suicidal ideation due to a boxed warning that it increases the risk of depression and suicidal thoughts and behavior **Patients meeting any of the following criteria will NOT be approved:** ○ Concurrent use of MAOIs or strong CYP3A4 inducers ○ Hypersensitivity to the active ingredient ○ Pregnancy	40 mg: 2/day 60, 80 mg: 1/day	
tetrabenazine	P	Will only be approved for the treatment of chorea associated with Huntington's disease.		
Xenazine®	P	• Diagnosis of chorea associated with Huntington's disease; **AND** • Clinically valid reason why preferred generic tetrabenazine cannot be used		

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antidepressants: MAOIs				

CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENT'S WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):
*Antidepressants prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if **ONE** of the following is met:*
• *Prescribed by a Gold Card prescriber; **OR***
• *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; **AND***
  ○ *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; **AND***
  ○ *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers; **OR***
• *Short-term therapy (less than 90 days) has been prescribed; **AND***
  ○ *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement; **OR***
  – *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; **AND***
  ○ *Efficacy and potential side effects to be monitored; **AND***
  ○ *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried*
***Note the following**:*
• *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.*
• *The I/DD Worksheet can be found at: I/DD Prior Authorization Form*				

phenelzine	P	• Diagnosis of major depression; **AND**
		• Trial and failure of THREE antidepressant agents from TWO different following drug classes:
		  ○ SSRIs
		  ○ SNRIs
		  ○ New generation antidepressants
			6 tabs/day	General PA Form

Emsam®	NP	See Marplan® prior authorization criteria; **AND** • Patient must be 13 years of age or older	1/day	

Marplan®	NP	• Diagnosis of major depression; **AND**
		• Trial and failure of THREE antidepressant agents from TWO different following drug classes:
		  ○ SSRIs
		  ○ SNRIs
		  ○ New generation antidepressants; **AND**
		• Trial and failure, contraindication, or intolerance to preferred phenelzine
			6 tabs/day	

Nardil®	NP	See Marplan® prior authorization criteria	6 tabs/day	
Parnate®	NP	See Marplan® prior authorization criteria	6 tabs/day	
tranylcypromine	NP	See Marplan® prior authorization criteria	6 tabs/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antidepressants: New Generation				

CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENT'S WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):
*Antidepressants prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if **ONE** of the following is met:*
• *Prescribed by a Gold Card prescriber; **OR***
• *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; **AND***
  ○ *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; **AND***
  ○ *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers*
• *Short-term therapy (less than 90 days) has been prescribed; **AND***
  ○ *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement; **OR***
  – *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; **AND***
  ○ *Efficacy and potential side effects to be monitored; **AND***
  ○ *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried*
***Note the following**:*
• *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.*
• *The I/DD Worksheet can be found at: I/DD Prior Authorization Form*				

Aplenzin®	P			General PA Form
bupropion IR/SR	P			
bupropion XL	P		1/day	
mirtazapine	P			
mirtazapine ODT	P	• Patient is unable to swallow solid dosage forms		
trazodone (excluding 300mg)	P			

Auvelity®	NP	• Diagnosis of Major Depressive Disorder (MDD); **AND**
		• Patient is 18 years of age or older; **AND**
		• Trial and failure, or contraindication, intolerance to 2 preferred antidepressants; **AND**
		• Patient does not have ANY of the following:
		  ○ Seizure disorder
		  ○ Current or prior diagnosis of bulimia or anorexia nervosa
		  ○ Undergoing abrupt discontinuation of alcohol, benzodiazepines, barbiturates, or antiepileptic drugs; **AND**
		• Prescriber attests patient has not received MAOI therapy within 14 days and will not receive during therapy		

Forfivo XL®	NP	• Trial and failure, contraindication, or intolerance of 2 preferred agents; **AND** • Patient must currently be on a bupropion product titrated to a dose of 300 mg per day		
nefazodone	NP	• Diagnosis of major depression; **AND** • Trial and failure, contraindication, or intolerance of 2 preferred agents; **AND** • Patient does not have hepatic impairment		
Remeron®	NP			General PA
Remeron SolTab®	NP	• Patient is unable to swallow solid dosage forms		

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
trazodone 300mg	NP	• Trial and failure, contraindication, or intolerance of 2 preferred agents; **AND** • Clinically valid reason why the preferred lower strength tablets cannot be used (i.e., trazodone 50mg, 100mg, 150mg)		Form
Wellbutrin® IR & SR	NP			
Wellbutrin XL®	NP		1/day	
Zurzuvae®	NP	**Criteria: (3 month-duration)** • Patient is 18 years of age or older; **AND** • Diagnosis of postpartum depression (PPD); **AND** • Patient's symptoms began in the third trimester or within 4 weeks of delivery; **AND** • Prescriber attests that the PPD requires rapid improvement and resolution of symptoms; **AND** • Prescribed by, or in consultation with, a psychiatrist, psychologist, or an obstetrician-gynecologist; **AND** • Prescriber attests to ALL of the following: ○ Patient has been advised not to drive or operate machinery until at least 12 hours after administration due central nervous system (CNS) depressant effects such as somnolence and confusion ○ Females of reproductive potential have been advised to use effective contraception during treatment and for 1 week after the final dose due to potential risk to fetus and to notify healthcare provider if they become pregnant during treatment ○ Lactating women have been counseled on risk versus benefits of breastfeeding while on treatment	1 treatment course/year	General PA Form
Antidepressants: SNRIs				
CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENT'S WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD): *Antidepressants prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if **ONE** of the following is met:* • *Prescribed by a Gold Card prescriber; **OR*** • *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; **AND*** ○ *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; **AND*** ○ *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers; **OR*** • *Short-term therapy (less than 90 days) has been prescribed; **AND*** ○ *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement; **OR*** – *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; **AND*** ○ *Efficacy and potential side effects to be monitored; **AND*** ○ *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried* ***Note the following**:* • *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.* • *The I/DD Worksheet can be found at: I/DD Prior Authorization Form*			
desvenlafaxine ER	P		1/day	
duloxetine 20, 30, & 60 mg	P		2/day	SNRI PA Form
Effexor XR®	P		1/day	
venlafaxine IR tabs	P		2/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
venlafaxine ER caps	P		37.5, 75 mg: 1/day 150 mg: 2/day **Note**: for 225 & 375 mg doses: use 150 mg & 75 mg caps	
Cymbalta®	NP		2/day	
duloxetine 40 mg	NP	• Clinically valid reason why the preferred duloxetine capsules (20, 30, or 60 mg) cannot be used	2/day	
Fetzima®	NP		Titration Pack: 1/day (56 tabs/ lifetime)	SNRI PA Form
Pristiq®	NP		1/day	
venlafaxine besylate ER tabs	NP	• Clinically valid reason why preferred venlafaxine agents cannot be used (Effexor XR, venlafaxine ER caps, venlafaxine IR tabs)	1/day	
venlafaxine ER tabs	NP		1/day	
Antidepressants: SSRI				

CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):
*Antidepressants prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if **ONE** of the following is met:*
• *Prescribed by a Gold Card prescriber; **OR***
• *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; **AND***
  ○ *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; **AND***
  ○ *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers; **OR***
• *Short-term therapy (less than 90 days) has been prescribed; **AND***
  ○ *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement; **OR***
  – *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; **AND***
  ○ *Efficacy and potential side effects to be monitored; **AND***
  ○ *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried*
***Note the following**:*
• *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.*
• *The I/DD Worksheet can be found at: I/DD Prior Authorization Form*				

citalopram	P		10, 20 mg: 1.5/day 40 mg: 1/day	General PA Form
escitalopram	P		1.5/day	
escitalopram solution	P			
fluoxetine capsules	P		3/day	
fluoxetine solution	P			
fluvoxamine	P		3/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
paroxetine tablets	P		10, 20 mg: 1/day; 30, 40 mg: 2/day	
sertraline	P		25, 50 mg: 1.5/day; 100 mg: 2/day	
vilazodone	P		1/day	
Celexa®	NP		10, 20 mg: 1.5/day 40 mg: 1/day	
fluoxetine DR caps	NP	• Stabilized at a dose of 20 mg/day of fluoxetine for > one month; **AND** • Documented reason why the patient is unable to continue fluoxetine 20 mg daily	4/28 days	General PA Form
fluoxetine tablets	NP		20 mg: 3/day; 60 mg: 1/day	
fluvoxamine ER	NP		100 mg: 3/day; 150 mg: 2/day	
Lexapro®	NP		1.5/day	
paroxetine 7.5 mg	NP	• Diagnosis of hot flashes associated with menopause; **AND** • Trial and failure, contraindication, or intolerance to estrogen therapy; **AND** • An allergy or intolerance to an inactive ingredient in paroxetine		
paroxetine CR	NP		12.5, 25 mg: 1/day; 37.5 mg: 2/day	
Paxil® tablets	NP		10, 20 mg: 1/day; 30, 40 mg: 2/day	
Paxil® CR	NP		See paroxetine CR	
Paxil® solution	NP			
Prozac®	NP		3/day	
sertraline capsules	NP		1/day	
Trintellix®	NP	• Diagnosis of Major Depression Disorder; **AND** • Adequate trial and failure of TWO agents at an appropriate dose (3 weeks at the maximum tolerated dose within the recommended therapeutic range) within the following drug classes: SSRI, SNRI, or New Generation Antidepressants	1/day	
Viibryd	NP		1/day	
Zoloft®	NP		25, 50 mg: 1.5/day; 100 mg: 2/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antidepressants: Tricyclics				

CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):
*Antidepressants prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if **ONE** of the following is met:*
• *Prescribed by a Gold Card prescriber; **OR***
• *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; **AND***
  ○ *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; **AND***
  ○ *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers; **OR***
• *Short-term therapy (less than 90 days) has been prescribed; **AND***
  ○ *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement; **OR***
  – *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; **AND***
  ○ *Efficacy and potential side effects to be monitored; **AND***
  ○ *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried*
***Note the following**:*
• *Duration of short-term therapy is 90 days for antidepressants*
• *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.*
• *The I/DD Worksheet can be found at: I/DD Prior Authorization Form*				

amitriptyline	P			General PA Form
doxepin caps	P			
imipramine tabs	P			
nortriptyline	P			
amoxapine	NP			
Anafranil®	NP	See prior authorization criteria for clomipramine		
clomipramine	NP	• Diagnosis of obsessive-compulsive disorder; **AND** • Trial and failure of at least 2 unique SSRIs		
desipramine	NP			
imipramine caps	NP			
Norpramin®	NP			
nortriptyline solution	NP	• Patient is unable to swallow nortriptyline capsules		
Pamelor®	NP			
protriptyline	NP			

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antihyperkinesis: Stimulants				
Adderall® XR	P	See amphetamine salt ER combination prior authorization criteria	5, 10, 15 mg: 1/day 25 & 30mg: 2/day 20mg: 3/day Max total amphetamine dose (Age ≥ 21): 60mg/day	Anti-hyperkinesis: Stimulants PA Form
amphetamine salt ER combination	P	• Agent must not be prescribed by a pain clinic • Patient will not concurrently take a benzodiazepine, barbiturate, sedative hypnotic, opioid (including buprenorphine), MAOI (monoamine oxidase inhibitor) agent, or meprobamate/carisoprodol; **AND** • Patient has NOT had active alcohol or substance abuse for last 3 years, if patient ≥ 21 years of age; **AND** • One of the following: ○ Diagnosis of Attention Deficit Disorder and/or Hyperactivity Disorder (ADD/ADHD); **AND** – Documentation that the symptoms affect the patient's ability to function in daily life tasks or creates significant difficulties in at least 2 major settings (school, work, social settings, and/or home) ○ Diagnosis of Narcolepsy supported with documentation of polysomnography or multiple sleep latency test (MSLT) ○ Diagnosis of neurocognitive disorder (also known as organic brain disorder) ○ Diagnosis of treatment resistant Major Depressive Disorder; **AND** – Adequate trial and failure of 3 agents at an appropriate dose (defined as: 3 weeks at the maximum tolerated dose within the recommended therapeutic range) from at least 3 distinct drug classes: • SSRI • SNRI • New Generation Antidepressants • TCAs **Note**: Patients ≤ 20 years of age will be subject to the initial criteria if they exceed 80 mg/day of total amphetamine.	5, 10, 15 mg: 1/day 25 & 30 mg: 2/day 20 mg: 3/day Max total amphetamine dose (Age ≥ 21): 60 mg/day	Anti-hyperkinesis: Stimulants PA Form
amphetamine salt IR combo	P	See amphetamine salt ER combination prior authorization criteria	5, 7.5, 10, & 12.5 mg: 4/day 15 & 30 mg: 2/day 20 mg: 3/day Max total amphetamine dose (Age ≥ 21): 60 mg/day	Anti-hyperkinesis: Stimulants PA Form
amphetamine sulfate	P	See amphetamine salt ER combination prior authorization criteria	5 mg tab & ODT: 3/day 10 mg tab & ODT: 6/day 15 mg ODT: 4/day 20 mg ODT: 6/day Max total amphetamine dose (Age ≥ 21): 60 mg/day	Anti-hyperkinesis: Stimulants PA Form

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Aptensio XR®	P	See amphetamine salt ER combination prior authorization criteria	1/day	
Concerta®	P	See amphetamine salt ER combination prior authorization criteria	18, 27, 54 mg: 1/day; 36 mg: 2/day	Anti-hyperkinesis: Stimulants PA Form
Daytrana®	P	See amphetamine salt ER combination prior authorization criteria	1/day	
dexmethylphenidate	P	See amphetamine salt ER combination prior authorization criteria	1/day	
dexmethylphenidate XR	P	See amphetamine salt ER combination prior authorization criteria	1/day	
dextroamphetamine tablets	P	See amphetamine salt ER combination prior authorization criteria	20 mg: 3/day 30 mg: 2/day All others: 4/day Max total amphetamine dose (Age ≥ 21): 60mg/day	Anti-hyperkinesis: Stimulants PA Form
Focalin XR®	P	See amphetamine salt ER combination prior authorization criteria	1/day	
methylphenidate (generic for Ritalin®)	P	See amphetamine salt ER combination prior authorization criteria	1/day	
methylphenidate solution	P	See amphetamine salt ER combination prior authorization criteria		Anti-hyperkinesis: Stimulants PA Form
methylphenidate ER tablets	P	See amphetamine salt ER combination prior authorization criteria	See Metadate ER®	
ProCentra®	P	See amphetamine salt ER combination prior authorization criteria	20 mL/day Max (Age ≥ 21): 60mg/day	
Vyvanse® capsules and chewables	P	See amphetamine salt ER combination prior authorization criteria	1/day; Max total amphetamine dose (Age ≥ 21): 60mg/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Adderall®	NP	• Agent must not be prescribed by a pain clinic
		• Patient will not concurrently take a benzodiazepine, barbiturate, sedative hypnotic, opioid (including buprenorphine), MAOI (monoamine oxidase inhibitor) agent, or meprobamate/carisoprodol; **AND**
		• Patient has NOT had active alcohol or substance abuse for last 3 years, if patient ≥ 21 years of age; **AND**
		• One of the following:
		  ○ Diagnosis of Attention Deficit Disorder and/or Hyperactivity Disorder (ADD/ADHD); **AND**
		  – Documentation that the symptoms affect the patient's ability to function in daily life tasks or creates significant difficulties in at least 2 major settings (school, work, social settings, and/or home)
		  ○ Diagnosis of Narcolepsy supported with documentation of polysomnography or multiple sleep latency test (MSLT)
		  ○ Diagnosis of neurocognitive disorder (also known as organic brain disorder)
		  ○ Diagnosis of treatment resistant Major Depressive Disorder; **AND**
		  – Adequate trial and failure of 3 agents at an appropriate dose (defined as: 3 weeks at the maximum tolerated dose within the recommended therapeutic range) from at least 3 distinct drug classes:
		  • SSRI
		  • SNRI
		  • New Generation Antidepressants
		  • TCAs; **AND**
		• Trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated
			See amphetamine salt IR combo	Anti-hyperkinesis: Stimulants PA Form

Adderall® XR	NP	See Adderall® prior authorization criteria	5, 10, 15 mg: 1/day 25 & 30mg: 2/day 20mg: 3/day Max total amphetamine dose (Age ≥ 21): 60mg/day	
Adzenys XR® ODT	NP	See Adderall® prior authorization criteria	1/day	
amphetamine ER suspension	NP	See Adderall® prior authorization criteria • Patient must have clinical reason as to why the preferred generic methylphenidate solution cannot be used.	10mL/day	Anti-hyperkinesis: Stimulants PA Form
Azstarys®	NP	See Adderall® prior authorization criteria	1/day	
Cotempla XR® ODT	NP	See Adderall® prior authorization criteria	1/day	Anti-hyperkinesis: Stimulants PA Form
Desoxyn®	NP	See Adderall® prior authorization criteria	4/day Max total amphetamine dose (Age ≥ 21): 60 mg/day	
dextroamphetamine solution	NP	See Adderall® prior authorization criteria	20 mL/day Max total amphetamine dose (Age ≥ 21): 60 mg/day	Anti-hyperkinesis: Stimulants PA

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Dexedrine®	NP	See Adderall® prior authorization criteria	4/day Max total amphetamine dose (Age ≥ 21): 60 mg/day	Form
Dyanavel XR®	NP	See Adderall® prior authorization criteria	8 mL/day Max total amphetamine dose (Age ≥ 21): 60 mg/day	Anti-hyperkinesis: Stimulants PA Form
Evekeo® tab	NP	See Adderall® prior authorization criteria	5 mg tab & ODT: 3/day 10 mg tab & ODT: 6/day 15 mg ODT: 4/day 20 mg ODT: 6/day Max total amphetamine dose (Age ≥ 21): 60 mg/day	
Focalin®	NP	See Adderall® prior authorization criteria		Anti-hyperkinesis: Stimulants PA Form
Jornay PM®	NP	See Adderall® prior authorization criteria	1/day	
lisdexamfetamine caps and chewables	NP	See Adderall® prior authorization criteria	1/day; Max total amphetamine dose (Age ≥ 21): 60mg/day	
methamphetamine	NP	See Adderall® prior authorization criteria	4/day Max total amphetamine dose (Age ≥ 21): 60 mg/day	Anti-hyperkinesis: Stimulants PA Form
Methylin® solution	NP	See Adderall® prior authorization criteria		
methylphenidate chewables	NP	See Adderall® prior authorization criteria		
methylphenidate patch	NP	See Adderall® prior authorization criteria	1/day	Anti-hyperkinesis: Stimulants PA Form
methylphenidate ER 24hr capsules (generic for Aptensio XR, Ritalin LA)	NP	See Adderall® prior authorization criteria	1/day	
methylphenidate ER OSM tablets (generic for Concerta® & Relexxii®)	NP	See Adderall® prior authorization criteria	See Concerta®	Anti-hyperkinesis: Stimulants PA

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
methylphenidate XR ODT (generic for Cotempla® XR ODT)	NP	See Adderall® prior authorization criteria	1/day	Form
Mydayis ER®	NP	See Adderall® prior authorization criteria	1/day	Anti-hyperkinesis: Stimulants PA Form
Quillichew ER®	NP	See Adderall® prior authorization criteria	1/day	
Quillivant XR®	NP	See Adderall® prior authorization criteria	12 mL/day	
Relexxii® ER	NP	See Adderall® prior authorization criteria	1/day	
Ritalin®	NP	See Adderall® prior authorization criteria	1/day	
Ritalin® LA	NP	See Adderall® prior authorization criteria	1/day	
Zenzedi®	NP	See Adderall® prior authorization criteria	20 mg: 3/day 30 mg: 2/day All others: 4/day Max total amphetamine dose (Age ≥ 21): 60mg/day	Anti-hyperkinesis: Stimulants PA Form
Antihyperkinesis: Non-Stimulants				
atomoxetine	P		60 mg, 80 mg, 100 mg: 1/day All other strengths: 2/day	General PA Form
clonidine 12hr ER	P		4/day	
guanfacine ER	P		1/day	
Qelbree®	P	• Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD); **AND** • Patient is 6 years of age or older; **AND** • Patient's blood pressure and heart rate will be assessed prior to therapy and monitored throughout therapy; **AND** • Patient will not concomitantly use monoamine oxidase inhibitors (MAOIs); **AND** • Patient will not concomitantly use CYP1A2 substrates or CYP1A2 substrates with a narrow therapeutic range; **AND** • Patient is not pregnant; **AND** • Trial and failure, contraindication, or intolerance to 2 preferred antihyperkinesis stimulant and/or non-stimulant agents	100 mg: 2/day 150 mg: 2/day 200 mg: 3/day	General PA Form
Intuniv®	NP	• Clinically valid reason why preferred guanfacine ER cannot be used	1/day	

Onyda XR®	NP	• Diagnosis of attention deficit hyperactivity disorder (ADHD); **AND**
		• Patient is 6 years of age or older; **AND**
		• One of the following:
		  ○ Trial &failure, contraindication, or intolerance of 2 preferred non-stimulant antihyperkinesis agents; **OR**
		  ○ Patient is unable to swallow solid dosage forms
			4mL/day	

Strattera®	NP		60, 80, 100 mg: 1/day All others: 2/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Agents for Narcolepsy				

modafinil	P	• Diagnosis of ADD/ADHD; **AND**
		  ○ Contraindication, adverse reaction, or drug-drug interaction to **ALL** preferred antihyperkinesis agents; **OR**
		• Daytime sleepiness/hypersomnolence occurring for at least 3 months; **AND**
		  ○ Diagnosis is associated with ONE of the following:
		  – Idiopathic hypersomnia
		  – Diagnosis of Narcolepsy
		  – Obstructive sleep apnea/hypopnea syndrome supported by a documented sleep study, **AND**
		  • Trial and failure (minimum duration 3 months with documented compliance) of Continuous Positive Airway Pressure (CPAP) or BiPAP device, unless contraindications
		  – Diagnosis of Shift Work Sleep Disorder; **AND**
		  • Statement of patient's work schedule showing a minimum of 6 hours work between 10 pm and 8 am; **AND**
		  ○ Hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out
			2/day	Narcolepsy Agents PA Form

Provigil®	P	See modafinil prior authorization criteria	2/day	

Xyrem®	P	• Enrolled in the Xyrem Program (1-866-997-3688); **AND**
		• One of the following:
		  ○ Diagnosis of cataplexy associated with narcolepsy
		  ○ Diagnosis of excessive daytime sleepiness/hypersomnolence associated with narcolepsy occurring ≥ 3 months; **AND**
		  – Trial and failure, intolerance, or contraindication to modafinil; **AND**
		• Hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out
			9 grams/day	Narcolepsy Agents PA Form

armodafinil	NP	• Daytime sleepiness/hypersomnolence occurring for at least 3 months; **AND**
		• Diagnosis is associated with ONE of the following:
		  ○ Diagnosis of Narcolepsy
		  ○ Obstructive sleep apnea/hypopnea syndrome supported by a documented sleep study, **AND**
		  – Trial and failure (minimum duration 3 months with documented compliance) of Continuous Positive Airway Pressure (CPAP) or BiPAP device, unless contraindications
		  ○ Diagnosis of Shift Work Sleep Disorder; **AND**
		  – Statement of patient's work schedule showing a minimum of 6 hours work between 10 pm and 8 am; **AND**
		• Hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out; **AND**
		• Trial and failure, contraindication, or intolerance to modafinil
			50mg: 2/day
			150mg, 200mg, 250mg: 1/day	

Nuvigil®	NP	See armodafinil prior authorization criteria	50mg: 2/day 150mg, 200mg, 250mg: 1/day	
sodium oxybate	NP	See Xyrem® prior authorization criteria; **AND** • Trial and failure of Xyrem®	9 grams/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Sunosi®	NP	• Daytime sleepiness/hypersomnolence occurring for at least 3 months; **AND**
		• Diagnosis is associated with ONE of the following:
		  ○ Diagnosis of Narcolepsy
		  ○ Obstructive sleep apnea/hypopnea syndrome supported by a documented sleep study, **AND**
		  – Trial and failure (minimum duration 3 months with documented compliance) of Continuous Positive Airway Pressure (CPAP) or BiPAP device, unless contraindications; **AND**
		• Hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out; **AND**
		• Trial and failure, contraindication, or intolerance to modafinil
			1/day	

Wakix®	NP	• Daytime sleepiness/hypersomnolence occurring for at least 3 months; **AND**
		• ONE of the following:
		  ○ Diagnosis of cataplexy associated with narcolepsy; **AND**
		  – Trial and failure, contraindication, or intolerance to Xyrem
		  ○ Diagnosis of excessive daytime sleepiness (EDS) associated with Narcolepsy; **AND**
		  – Trial and failure, contraindication, or intolerance to modafinil; **AND**
		• Hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out
			2/day	

Xywav®	NP	• Enrolled in the Xywav Program (1-866-997-3688); **AND**
		• One of the following:
		  ○ Diagnosis of cataplexy associated with narcolepsy; **AND**
		  – Clinically valid reason is given why the patient requires Xywav over Xyrem
		  ○ Diagnosis of excessive daytime sleepiness/hypersomnolence associated with narcolepsy occurring ≥ 3 months; **AND**
		  – Trial and failure, intolerance, or contraindication to modafinil; AND
		  – Clinically valid reason is given why the patient requires Xywav over Xyrem
		  ○ Diagnosis of idiopathic hypersomnia (IH) in patients ≥ 18 years of age; **AN**D
		  – Trial and failure, intolerance, or contraindication to modafinil; **AND**
		• Hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out
			18 mL per day	Narcolepsy Agents PA Form

Antimigraine Preparations: CGRP Antagonists				

Aimovig®	P	**Initial Criteria:**
		• Patient has a diagnosis of migraine with or without aura; **AND**
		• Patient has ≥ 4 migraine days per month; **AND**
		• Patient is utilizing prophylactic interventions (e.g., behavioral therapy, physical therapy, life-style modifications); **AND**
		• Trial (duration ≥ 8weeks) and failure of TWO of the following oral medication classes, unless contraindicated:
		  ○ Antidepressants (i.e., amitriptyline, venlafaxine)
		  ○ Beta blockers (i.e., propranolol, metoprolol, timolol, atenolol)
		  ○ Antiepileptics (i.e., valproate, topiramate)
		Renewal Criteria:
		• Patient has experienced positive response to therapy (e.g., decrease in the number, frequency, and/or intensity of headaches, improved function, decreased reliance on acute treatments for migraine headaches); **AND**
		• Patient has absence of unacceptable toxicity (e.g., intolerable injection site pain or constipation)
			1 syringe/30 days	General PA Form

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Emgality® syringe & pen	P	**Initial Criteria:**
		• Diagnosis of episodic cluster headache; **OR**
		• Diagnosis of migraine with or without aura; **AND**
		  ○ Patient has ≥ 4 migraine days per month; **AND**
		  ○ Patient is utilizing prophylactic interventions (e.g., behavioral therapy, physical therapy, life-style modifications); **AND**
		  ○ Trial (duration ≥ 8weeks) and failure of TWO of the following oral medication classes, unless contraindicated:
		  – Antidepressants (i.e., amitriptyline, venlafaxine)
		  – Beta blockers (i.e., propranolol, metoprolol, timolol, atenolol)
		  – Antiepileptics (i.e., valproate, topiramate); OR
		Renewal Criteria:
		• Patient has experienced positive response to therapy (e.g., decrease in the number, frequency, and/or intensity of headaches, improved function, decreased reliance on acute treatments for migraine headaches); **AND**
		• Patient has absence of unacceptable toxicity (e.g., intolerable injection site pain or constipation)
			1 syringe/month (120 mg for migraine and 300 mg for cluster headache)	General PA Form

Nurtec ODT®	P	**Initial Criteria:**
		• Diagnosis of migraine with or without aura; **AND**
		• One of one of the following:
		  ○ Acute treatment of migraine, **AND**
		  – Medication will not be used in combination with another acute CGRP inhibitor; **AND**
		  – Trial and failure or intolerance to TWO triptans (e.g., eletriptan, rizatriptan, sumatriptan) OR contraindication to all triptans
		  ○ Preventative treatment of migraine; **AND**
		  – Patient has ≥ 4 migraine days per month; **AND**
		  – Patient is utilizing prophylactic interventions (e.g., behavioral therapy, physical therapy, life-style modifications); **AND**
		  – Trial (duration ≥ 8weeks) and failure of TWO of the following oral medication classes, unless contraindicated:
		  • Antidepressants (i.e., amitriptyline, venlafaxine)
		  • Beta blockers (i.e., propranolol, metoprolol, timolol, atenolol)
		  • Antiepileptics (i.e., valproate, topiramate); **AND**
		Renewal Criteria:
		• Patient has experienced positive response to therapy (e.g., decrease in the number, frequency, and/or intensity of headaches, improved function, decreased reliance on acute treatments for migraine headaches)
			Acute treatment: 1 dose pack (8 tablets)/30 days
			
			Prophylaxis: 2 dose packs (16 tablets)/30 days
				General PA Form

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Qulipta®	P	**Initial Criteria:**
		• Patient has a diagnosis of migraine with or without aura; **AND**
		• Patient has ≥ 4 migraine days per month; **AND**
		• Patient is utilizing prophylactic interventions (e.g., behavioral therapy, physical therapy, lifestyle modifications); **AND**
		• Trial (duration ≥ 8weeks) and failure of TWO of the following oral medication classes, unless contraindicated:
		  ○ Antidepressants (i.e., amitriptyline, venlafaxine)
		  ○ Beta blockers (i.e., propranolol, metoprolol, timolol, atenolol)
		  ○ Antiepileptics (i.e., valproate, topiramate); **AND**
		Renewal Criteria:
		• Patient has experienced positive response to therapy (e.g., decrease in the number, frequency, and/or intensity of headaches, improved function, decreased reliance on acute treatments for migraine headaches)
			1/day	

Ubrelvy®	P	**Initial Criteria:** • Diagnosis of migraine with or without aura and will be used for the acute treatment of migraine, **AND** • Trial and failure or intolerance to TWO triptans (e.g., eletriptan, rizatriptan, sumatriptan) OR contraindication to all triptan; **AND** • Medication will not be used in combination with another acute CGRP inhibitor **Renewal Criteria:** • Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea)	1 box (10 tablets) / 30 days	
Ajovy® autoinjector and prefilled syringe	NP	See Aimovig prior authorization criteria; **AND** • Trial and failure of Aimovig and Emgality	3 injections/90 days	
Zavzpret®		**Initial Criteria:** • Diagnosis of migraine with or without aura and will be used for the acute treatment of migraine, **AND** • Trial and failure or intolerance to Nurtec ODT and Ubrelvy; **AND** • Medication will not be used in combination with another acute CGRP inhibitor **Renewal Criteria:** • Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea)	60 mg/30 days (6 devices)	General PA Form
Antimigraine: Ergotamine Derivatives				
Migranal®	P		8 mL/30 days	General PA Form
dihydroergotamine nasal spray	P		8 mL/30 days	
dihydroergotamine injection	NP		8 mL/30 days	
Migergot®	NP		15/30 days	
Trudhesa®	NP	See dihydroergotamine injection prior authorization criteria	1 package/30 days	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antimigraine: Barbiturate Combination Agents				
<u>Quantity Limit Override Criteria for Butalbital-Containing Products</u>: Butalbital-containing products have a quantity limit of 20 caps per 30 days. Requests for quantities greater than 20/30 will be approved if the following criteria is met: • Trial and failure of a tricyclic antidepressant (unless contraindicated); **AND** • Trial and failure of divalproex sodium, sodium valproate, topiramate, frovatriptan, or a beta-blocker				
butalbital/APAP	P		20/30 days** APAP: 4 g/day	General PA Form
butalbital/APAP/ caffeine	P		20/30 days** APAP: 4 g/day	
Allzital®	NP		20/30 days** APAP: 4 g/day	
butalbital/ASA/ caffeine	NP	• Allergy or intolerance to APAP	20/30 days**	
Fioricet®	NP		20/30 days** APAP: 4 g/day	
Esgic®	NP		20/30 days** APAP: 4 g/day	
Antimigraine: Selective 5-HT1 Agonists				
eletriptan	P		6/30 days	General PA Form
rizatriptan	P		12/30 days	
rizatriptan ODT	P		12/30 days	
sumatriptan tabs	P		9/30 days	
sumatriptan vials	P		8 vials/30 days	
zolmitriptan nasal spray	P		6/30 days	
Frova®	NP		9/30 days	
frovatriptan	NP		9/30 days	
Imitrex Injectable®	NP		8 vials/30 days	General PA Form
Imitrex Kit®	NP	• Clinically valid reason why the injectable vials cannot be used (**NOTE:** Patient convenience is NOT an approvable reason)	4/30 days	
Imitrex Nasal®	NP		6/30 days	
Imitrex® tablets	NP		9/30 days	
Maxalt®	NP		12/30 days	
Maxalt MLT®	NP		12/30 days	
naratriptan	NP		9/30 days	
Onzetra Xsail®	NP	• Patient has an allergy to an inactive ingredient found in the preferred sumatriptan containing agents; **AND** • Patient has a contraindication, allergic reaction, or drug-drug interaction to preferred rizatriptan containing agents; **AND** • Clinically valid reason why the patient requires a nasal powder (**NOTE:** Patient convenience is NOT an approval reason)	16/30 days	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Relpax®	NP		6/30 days	
Reyvow®	NP	**Initial Criteria (3-month duration):** • Agent is being used for acute treatment of migraine with or without aura; **AND** • Patient is 18 years of age or older; **AND** • Trial and failure, contraindication, or intolerance to TWO triptans (e.g., eletriptan, rizatriptan, sumatriptan); **AND** **Renewal Criteria:** • Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea)	4/30 days	
sumatriptan autoinjector	NP	• Clinically valid reason as to why the patient cannot use the injectable vials. (**Note:** Patient convenience is NOT an approvable reason)	4/30 days	
sumatriptan cartridge		• Clinically valid reason as to why the patient cannot use the injectable vials. (**Note:** Patient convenience is NOT an approvable reason)		
sumatriptan nasal	NP		6/30 days	
sumatriptan/ naproxen	NP		9/30 days	
Tosymra®	NP		12/30 days	
Treximet®	NP		9/30 days	
zolmitriptan nasal spray and tablets	NP		6/30 days	
Zembrace Symtouch®	NP	• Patient has an allergy to an inactive ingredient found in the preferred sumatriptan containing agents; **AND** • Patient has a contraindication, allergic reaction, or drug-drug interaction to preferred rizatriptan containing agents; **AND** • Clinically valid reason why the patient requires an autoinjector device (**NOTE:** Patient convenience is NOT an approval reason)	2 mL/30 days	General PA Form
Zomig® nasal spray	NP	•	6/30 days	
Zomig® tablets	NP		6/30 days	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Atypical Antipsychotic/SSRI Combos				
CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD): *Antipsychotics prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if **ONE** of the following is met:* • *Prescribed by a Gold Card prescriber; **OR*** • *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; **AND*** ○ *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; **AND*** ○ *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers; **OR*** • *Short-term therapy (less than 90 days) has been prescribed; **AND*** ○ *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement; **OR*** – *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; **AND*** ○ *Efficacy and potential side effects to be monitored; **AND*** ○ *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried* ***Note the following**:* • *Duration of short-term therapy is 90 days for antipsychotics* • *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.* • *The I/DD Worksheet can be found at: I/DD Prior Authorization Form*				
fluoxetine/ olanzapine	NP	• For diagnosis of depressive episodes associated with bipolar disorder; **AND** ○ Refractory to treatment with components taken separately • For diagnosis of major depressive disorder: ○ Must have undergone an adequate trial of at least **ONE** agent in THREE of the following classes of antidepressants (unless contraindicated or intolerant to): – Selective serotonin reuptake inhibitors (SSRIs) – Serotonin-norepinephrine reuptake inhibitors (SNRIs) – New generation antidepressants (including bupropion, mirtazapine, etc.); **AND** ○ Refractory to treatment with components taken separately	1/day	Atypical Antipsychotic PA form
Symbyax®	NP	See fluoxetine/olanzapine prior authorization criteria	1/day	

CENTRAL NERVOUS SYSTEM

Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.

Medication	PDL	Prior Authorization Criteria	Qty. Limits	PA Form
Atypical Antipsychotics				

CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):
*Antipsychotics prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if **ONE** of the following is met:*
• *Prescribed by a Gold Card prescriber; **OR***
• *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; **AND***
  ○ *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; **AND***
  ○ *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers*
• *Short-term therapy (less than 90 days) has been prescribed; **AND***
  ○ *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement; **OR***
  – *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; **AND***
  ○ *Efficacy and potential side effects to be monitored; **AND***
  ○ *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried*
***Note the following**:*
• *Duration of short-term therapy is 90 days for antipsychotics*
• *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.*
• *The I/DD Worksheet can be found at: I/DD Prior Authorization Form*				

***Note**: A list of ICD-10 to allow PA bypass for preferred atypical antipsychotics that require PA can be found at Appropriate Diagnosis for PA Bypass List*				
Abilify Asimtufii®	P	• Patient is > 18 years of age; **AND** • Patient has documented tolerance to the oral active ingredient	1 injection/60 days	Atypical Antipsychotic PA form
Abilify Maintena®	P	• Patient is ≥ 18 years of age; **AND** • Patient has documented tolerance to the oral active ingredient	1/30 days	
aripiprazole ODT	P		1/day	
aripiprazole solution	P		10 mL/day	
aripiprazole tablets	P		1/day	
Aristada®	P	• Patient is ≥ 18 years of age; **AND** • Patient has documented tolerance to the oral active ingredient	1064 mg: 1/60 days; All other strengths: 1/30 days	
Aristada® Initio	P	• Patient is ≥ 18 years of age; **AND** • Patient has documented tolerance to the oral active ingredient	2.4 mL/60 days	
asenapine	NP	See lurasidone prior authorization criteria	2/day	
clozapine	P		1/day	
Erzofri®	P	• Patient is ≥ 18 years of age; **AND** • Patient has documented tolerance to the oral active ingredient	1 injection/28 days	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Invega Hafyera®	P	• Patient is ≥ 18 years of age; **AND** • TennCare prescription claims history must indicate patient has been on Invega Sustenna® for 4 months OR Invega Trinza for at least one three-month cycle	1 syringe/168 days	Atypical Antipsychotic PA form
Invega Sustenna®	P	• Patient is ≥ 18 years of age; **AND** • Patient has documented tolerance to the oral active ingredient	1 syringe/28 days	
Invega Trinza®	P	• Patient is ≥ 18 years of age; **AND** • TennCare prescription claims history must indicate patient has been on Invega Sustenna® for 4 months	1 syringe/76 days	

lurasidone	P	• Diagnosis of ONE of the following:
		  ○ Agitation in dementia
		  ○ Bipolar and manic disorders
		  ○ Bipolar depression, bipolar maintenance, bipolar mania-acute, bipolar mixed states
		  ○ Brief psychotic disorder
		  ○ Delusional disorder
		  ○ Depression with psychotic symptoms
		  ○ Drug-induced psychotic disorder with hallucinations
		  ○ Impulse control disorders, including Oppositional Defiant Disorder and Intermittent Explosive Disorder
		  ○ Organic psychotic condition
		  ○ Psychosis secondary to a medical condition, psychotic depression, psychotic disorders
		  ○ Schizoaffective disorder, schizoid/schizotypal personality disorder, schizophrenia, schizophrenic disorders
		  ○ Substance-induced psychotic disorder, substance-induced withdrawal psychotic disorder
		  ○ Severe refractory OCD or PTSD
		  ○ Tourette's/Severe tic disorder; **OR**
		• Diagnosis of major depressive disorder (MDD)**; AND**
		  ○ Atypical agents will be approved only as adjunctive treatment for MDD; **AND**
		  ○ Adequate trial(4 - 6 weeks) of ONE agent from any of the following classes (unless contraindication or intolerance):
		  – SSRIs
		  – SNRIs
		  – TCAs
		  – New generation antidepressants (including bupropion, mirtazapine, etc.); **OR**
		• For patients without one of the above diagnoses:
		  ○ May be approved if the physician can provide documented clinical evidence supporting the use of the requested medication for the requested indication
			1/day	Atypical Antipsychotic PA form

olanzapine tablets	P		1/day	Atypical Antipsychotic PA form
olanzapine IM injection	P	See lurasidone prior authorization criteria	1/day	
olanzapine ODT	P	See lurasidone prior authorization criteria; **AND** • Patient is unable to swallow solid dosage forms or absorb medications through the GI tract; **OR** • Non-response due to noncompliance	1/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
paliperidone ER	P		6 mg: 2/day; All other strengths: 1/day	
Perseris®	P	• Patient is ≥ 18 years of age; **AND** • Patient has documented tolerance to oral risperidone	1 injection/month	Atypical Antipsychotic PA form
quetiapine	P		4/day	
quetiapine ER	P	See lurasidone prior authorization criteria	2/day	
risperidone ODT	P	See olanzapine ODT prior authorization criteria	2/day	
risperidone solution	P	See lurasidone prior authorization criteria		Atypical Antipsychotic PA form
risperidone tabs	P		2/day	
Uzedy	P	• Patient is ≥ 18 years of age; **AND** • Documented tolerance to the oral active ingredient	50, 75, 100, & 125 mg: 1 injection/30 days 150, 200, & 250 mg: 1 injection/60 days	
Vraylar®	P	See lurasidone prior authorization criteria	1/day	
ziprasidone injection	P	See lurasidone prior authorization criteria	2/day	
ziprasidone caps	P		2/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Abilify® tablets	NP	• Approval of non-preferred atypical antipsychotics requires trial and failure of ONE preferred agent; **AND** • Diagnosis of ONE of the following: ○ Agitation in dementia ○ Bipolar and manic disorders ○ Bipolar depression, bipolar maintenance, bipolar mania-acute, bipolar mixed states ○ Brief psychotic disorder ○ Delusional disorder ○ Depression with psychotic symptoms ○ Drug-induced psychotic disorder with hallucinations ○ Impulse control disorders, including Oppositional Defiant Disorder and Intermittent Explosive Disorder ○ Organic psychotic condition ○ Psychosis secondary to a medical condition, psychotic depression, psychotic disorders ○ Schizoaffective disorder, schizoid/schizotypal personality disorder, schizophrenia, schizophrenic disorders ○ Substance-induced psychotic disorder, substance-induced withdrawal psychotic disorder ○ Severe refractory OCD or PTSD ○ Tourette's/Severe tic disorder; **OR** • Diagnosis of major depressive disorder (MDD)**; AND** ○ Atypical agents will be approved only as adjunctive treatment for MDD; **AND** ○ Adequate trial(4 - 6 weeks) of ONE agent from any of the following classes (unless contraindication or intolerance): – SSRIs – SNRIs – TCAs – New generation antidepressants (including bupropion, mirtazapine, etc.); **OR** • For patients without one of the above diagnoses: ○ May be approved if the physician can provide documented clinical evidence supporting the use of the requested medication for the requested indication	1/day	Atypical Antipsychotic PA form
Abilify MyCite®	NP	See lurasidone prior authorization criteria; **AND** • Clinically valid reason why none of the other forms of aripiprazole cannot be used	1/day	
Caplyta®	NP	See Abilify® tablets prior authorization criteria	1/day	
clozapine ODT	NP	See Abilify® tablets prior authorization criteria; **AND** • Patient is unable to swallow solid dosage forms or absorb medications through the GI tract; **OR** • Non-response due to noncompliance	12.5 & 25 mg: 2/day; 100mg: 9/day; 150mg: 6/day; 200mg: 4/day	
Clozaril®	NP	See Abilify® tablets prior authorization criteria	1/day	
Cobenfy®		• Patient is 18 years of age or older; **AND** • Diagnosis of schizophrenia; **AND** • Approval of non-preferred atypical antipsychotics requires trial and failure of ONE preferred agent; **AND** • Prescriber attests patient does NOT have any of the following: ○ Urinary retention ○ Moderate (Child-Pugh Class B) or severe (Child-Pugh Class C) hepatic impairment ○ Gastric retention ○ Untreated narrow-angle glaucoma	2/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Fanapt®	NP	See Abilify® tablets prior authorization criteria	2/day	Atypical Antipsychotic PA form
Geodon®	NP	See Abilify® tablets prior authorization criteria	2/day	
Invega®	NP	See Abilify® tablets prior authorization criteria	6 mg: 2/day; All others: 1/day	
Latuda®	NP	See Abilify® tablets prior authorization criteria		
Lybalvi®	NP	• Patient is ≥18 years of age; **AND** • One of the following: ○ Diagnosis of schizophrenia ○ Diagnosis of Bipolar I disorder and will be used for the acute treatment of manic or mixed episodes ○ Diagnosis of Bipolar I disorder and will be used as maintenance monotherapy treatment • Prescriber attests to **ALL** of the following: ○ Patient is NOT using opioids; nor has used a short-acting opioid in the last 7 days; nor used a long-acting opioid in the last 14 days ○ Patient is NOT undergoing acute opioid withdrawal; **AND** • Approval of non-preferred atypical antipsychotics requires trial and failure of ONE preferred agent; **AND** • Submission of medical records (e.g. chart notes) documenting ONE of the following: ○ Patient has a BMI of 30 kg/m2 or greater; **OR** ○ Patient has a BMI of 27 kg/m2 or greater with a weight-related comorbidity (e.g., dyslipidemia, hypertension, type 2 diabetes, sleep apnea) ; **OR** ○ Patient has a documented history of weight gain of greater than or equal to 10% of their baseline weight after trial and failure of a preferred atypical antipsychotic; **OR** ○ Patient is stable on Lybalvi (minimum trial duration 4 weeks) and the request is for continuation of therapy	1/day	Atypical Antipsychotic PA form
Nuplazid®	NP	• Hallucinations and/or delusions associated with Parkinson's disease psychosis; **AND** • Must be ≥18 years of age; **AND** • Trial of dose adjustment or withdrawal of anti-Parkinson medications (anticholinergics, amantadine, dopamine agonists, COMT inhibitors, selegiline) prior to treatment with Nuplazid® • Trial and failure of ONE preferred agent **Note:** Coverage will not be approved for psychosis not related to Parkinson's disease	2/day	
Opipza®	NP	See lurasidone prior authorization criteria; AND • Clinically valid reason why none of the other forms of aripiprazole (e.g. aripiprazole ODT) cannot be used	2mg, 5mg: 1/day; 10mg: 3/day	Atypical Antipsychotic PA form
Rexulti®	NP	See Abilify® tablets prior authorization criteria **Note**: Rexulti used for the diagnosis of agitation in dementia does NOT require trial and failure of ONE preferred agent	1/day	
Risperdal®	NP	See Abilify® tablets prior authorization criteria	2/day	
Risperdal Consta®	NP	• Patient is ≥ 18 years of age; **ANDa** • Documented tolerance to the oral active ingredient; **AND** • One of the following: ○ Diagnosis of Bipolar Disorder ○ Clinically valid reason why the patient cannot use the preferred long-acting injectables	2 vials/28 days	Atypical Antipsychotic PA form
risperidone ER injection	NP	See Risperdal Consta® prior authorization criteria	2 vials/28 days	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Rykindo®	NP	See Risperdal Consta® prior authorization criteria	2 injections/28 days	
Saphris®	NP	See Abilify® tablets prior authorization criteria	2/day	
Secuado®	NP	See Abilify® tablets prior authorization criteria; **AND** • Patient is unable to swallow solid dosage forms or absorb medications through the GI tract; **OR** • Non-response due to noncompliance	1/day	Atypical Antipsychotic PA form
Seroquel®	NP	See Abilify® tablets prior authorization criteria	4/day	
Seroquel® XR	NP	See Abilify® tablets prior authorization criteria	2/day	
Versacloz®	NP	See Abilify® tablets prior authorization criteria; **AND** • Allergy or intolerance to inactive ingredient in clozapine ODT tab (i.e., dye, filler, excipient, etc); **OR** • Dose not achievable with ODT tab		
Zyprexa® IM injection	NP	• Patient is ≥ 18 years of age; **AND** • Patient has documented tolerance to the oral active ingredient; **AND** • Trial and failure of ONE preferred atypical antipsychotic	1/day	Atypical Antipsychotic PA form
Zyprexa® tablets	NP	See Abilify® tablets prior authorization criteria	1/day	
Zyprexa Relprevv®	NP	• Patient is ≥ 18 years of age; **AND** • Documented tolerance to the oral active ingredient; **AND** • Clinically valid reason why the patient cannot use the preferred long-acting injectables	210mg, 300mg: 1 injection/2 weeks; 450mg: 1 injection/month	
Zyprexa Zydis®	NP	See Abilify® tablets prior authorization criteria; **AND** • Patient is unable to swallow solid dosage forms or absorb medications through the GI tract; **OR** • Non-response due to noncompliance	1/day	
Miscellaneous CNS Agents				
Nuedexta®	NP	• Diagnosis of Pseudobulbar Affect (PBA); **AND** • The following patient circumstances have been excluded: ○ Heart failure or high grade (second/third degree) atrioventricular block (AV) without an implanted pacemaker ○ Patient receiving drugs that prolong QT interval and are metabolized by CYP2D6 system ○ Prolonged QT interval (including congenital long QT syndrome) or a history of torsades de pointes ○ Concomitantly taking monoamine oxidase inhibitors (MAOIs) or have used a MAOI in the past 14 days	2/day	General PA Form
Mood Stabilizers				
Lamictal® ODT	NP	• Unable to swallow; **OR** • Unable to absorb medications through the GI tract		General PA Form

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Sedative Hypnotics				

CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD):
*Sedative hypnotics prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if **ONE** of the following is met:*
• *Prescribed by a Gold Card prescriber; **OR***
• *Mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; **AND***
  ○ *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; **AND***
  ○ *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers*
• *Short-term therapy (less than 90 days) has been prescribed; **AND***
  ○ *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement; **OR***
  – *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; **AND***
  ○ *Efficacy and potential side effects to be monitored; **AND***
  ○ *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried*
***Note the following**:*
• *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.*
• *The I/DD Worksheet can be found at: I/DD Prior Authorization Form*				

doxepin concentrate 10mg/mL	P			General PA Form
eszopiclone	P		14/30 days*	
ramelteon	P		14/30 days*	
zaleplon	P		14/30 days*	
zolpidem	P		14/30 days*	
Ambien®	NP		14/30 days*	
Ambien CR®	NP		14/30 days*	
Belsomra®	NP		14/30 days*	
Dayvigo®	NP	• Diagnosis of insomnia characterized by difficulties with sleep onset and/or sleep maintenance; **AND** • Patient is 18 years of age or older; **AND** • Narcolepsy and other insomnia related disorders have been ruled out (e.g., movement, breathing, psychiatric disorders, medications); **AND** • Trial (at least 3 weeks) of non-pharmacological therapies (e.g., stimulus control, sleep restriction, sleep hygiene measures and relaxation therapy); **AND** • Trial and failure, contraindication, or intolerance of 2 preferred agents; **AND** • Patients who are pregnant should be registered in the Dayvigo® pregnancy registry	14/30 days*	
Doral®	NP	See Halcion® prior authorization criteria	14/30 days*	
doxepin soln	NP	• Documented trial/failure (defined as ≥ 1 week) at an appropriate dose of the doxepin 10mg/mL concentrated solution	14/30 days*	
Edluar®	NP	• Patient is unable to swallow solid dosage forms	14/30 days*	
estazolam	NP	See flurazepam prior authorization criteria	14/30 days*	Anti-anxiety

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
flurazepam	NP	• Diagnosis of Insomnia; **AND** • Medical documentation that rules out other insomnia related disorders (e.g., movement, breathing, psychiatric disorders and medication); **AND** • Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., stimulus control, sleep restriction, sleep hygiene measures and relaxation therapy); **AND** • Use of 2 preferred agents, unless patient has a contraindication or allergy; **AND** • Due to increased risk of toxicity, patient should not be pregnant; **AND** • Will not be taken concurrently with CNS stimulants, opiates, carisoprodol, meprobamate or barbiturates; **AND** • Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse	14/30 days*	Form
Halcion®	NP	• Diagnosis of Insomnia; **AND** • Medical documentation that rules out other insomnia related disorders (e.g., movement, breathing, psychiatric disorders & medication/substance use); **AND** • Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., stimulus control, sleep restriction, sleep hygiene measures & relaxation therapy); **AND** • Use of 2 preferred agents, unless patient has a contraindication or allergy; **AND** • Clinical reason as to why patient cannot use generic equivalent; **AND** • Due to increased risk of toxicity, patient should not be pregnant; **AND** • Will not be taken concurrently with CNS stimulants, opiates, carisoprodol, meprobamate or barbiturates; **AND** • Due to increased risk of dependency, patient does not have a history of alcohol **OR** drug dependence/abuse	14/30 days*	

Hetlioz® capsules	NP	• Treatment of non-24-hour sleep wake disorder (non-24 or N24) in members who are unable to distinguish between light and darkness in both eyes; **OR**
		• Treatment of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) in patients 16 years of age and older; **AND**
		• Trial and failure or contraindication to melatonin; **AND**
		• Patient will not take any of the following:
		  ○ Strong CYP1A2 inhibitors (e.g., fluvoxamine)
		  ○ Strong CYP3A4 inducers (e.g., rifampin)
			30/60 days*	General PA Form

Hetlioz® suspension	NP	• Treatment of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS); **AND**
		• Patient is at least 3 years of age but not greater than 15 years of age; **AND**
		• Trial and failure or contraindication to melatonin; **AND**
		• Patient is unable to swallow/absorb medications through the GI tract; **AND**
		• Patient will not take any of the following:
		  ○ Strong CYP1A2 inhibitors (e.g., fluvoxamine)
		  ○ Strong CYP3A4 inducers (e.g., rifampin)
			5 mL per day
			158 mL/60 days*	

Lunesta®	NP		14/30 days*	
Rozerem®	NP		14/30 days*	
quazepam	NP	See flurazepam prior authorization criteria	14/30 days*	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Quviviq®	NP	• Patient must 18 years of age or older; **AND** • Diagnosis of insomnia characterized by difficulties with sleep onset and/or sleep maintenance; **AND** • Narcolepsy and other insomnia related disorders have been ruled out (e.g., movement, breathing, psychiatric disorders, medications); **AND** • Trial (at least 3 weeks) of non-pharmacological therapies (e.g., stimulus control, sleep restriction, sleep hygiene measures and relaxation therapy); **AND** • Trial and failure, contraindication, or intolerance of 2 preferred agents; **AND** • Patient should not have any of the following diagnoses: Narcolepsy, COPD, or moderate to severe OSA; **AND** • Concurrently not taking CNS stimulants, opiates, carisoprodol, meprobamate or barbiturates; **AND** • Due to increased risk of dependency, patient does not have a history of alcohol or drug dependence/abuse; **AND** • Patients who are pregnant should be registered in the Quviviq® pregnancy registry	14/30 days*	
Restoril®	NP	See Halcion® prior authorization criteria	14/30 days*	Anti-anxiety Form
Rozerem®	NP		14/30 days*	
tasimelteon capsules		See Hetlioz capsules prior authorization criteria; **AND** Clinically valid reason why Hetlioz® cannot be used	30/60 days*	
tasimelteon suspension	NP	See Hetlioz suspension prior authorization criteria; **AND** • Clinically valid reason why Hetlioz® cannot be used	5 mL per day 158 mL/60 days*	
temazepam	NP	See flurazepam prior authorization criteria	14/30 days*	Anti-anxiety Form
triazolam	NP	See flurazepam prior authorization criteria	14/30 days*	
zolpidem ER	NP		14/30 days*	General PA Form
zolpidem tartrate SL	NP		14/30 days*	
**** For children, larger quantities may be approved as medically necessary.***				
Skeletal Muscle Relaxants				
Amrix ®	NP	• Diagnosis of an FDA-approved indication; **AND** • Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred cyclobenzaprine	1/day	General PA Form
baclofen solution	NP	• Diagnosis of spasticity with flexor spasms and concomitant pain, clonus, and/or muscular rigidity (e.g., multiple sclerosis, spinal cord injury, other spinal cord disease); **AND** • Documented inability to swallow baclofen tablets	16 mL/day	
baclofen suspension	NP	• Diagnosis of spasticity with flexor spasms and concomitant pain, clonus, and/or muscular rigidity (e.g., multiple sclerosis, spinal cord injury, other spinal cord disease); **AND** • Documented inability to swallow baclofen tablets; **AND** • Trial and failure of baclofen solution	16 mL/day	
carisoprodol	NP	• Patient is 16 years of age or older; **AND** • Contraindication, drug to drug interaction, or history of toxic side effects that will cause immediate or long-term damage with ALL preferred skeletal muscle relaxants; **AND**	4/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
		• Patient does not have a history of, or received treatment for, drug dependency or drug abuse; **AND** • Prescriber must have checked the Tennessee Controlled Substance Database for this patient within the last 30 days; **AND** • Patient is not concurrently utilizing any other opioid therapy		
cyclobenzaprine ER	NP	See Amrix® prior authorization criteria	1/day	
Fleqsuvy®	NP	See baclofen suspension prior authorization criteria	16 mL/day	
Lyvispah®	NP	See baclofen suspension prior authorization criteria	4 packets/day	
Norgesic Forte®	NP	• Diagnosis of an FDA-approved indication**; AND** • Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents		
Soma®	NP	See carisoprodol prior authorization criteria	4/day	

CENTRAL NERVOUS SYSTEM *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Typical Antipsychotics				
CLASS PRIOR AUTHORIZATION CRITERIA FOR PATIENTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD): *Antipsychotics prescribed for disorders related to Intellectual and Developmental Disabilities will be approved if **ONE** of the following is met:* • *Prescribed by a Gold Card prescriber; **OR*** • *There has been a mental health assessment applicable to behavioral symptoms for which the medication is being prescribed; **AND*** ○ *Underlying physical condition such as pain, discomfort, and environmental issues have been evaluated, treated, and behavioral symptoms persist; **AND*** ○ *Non-pharmacological interventions have been tried and behavioral symptoms persist (e.g., behavior plan, crisis intervention, and stabilization strategies or training) and training and support have been provided to family or other caregivers; **OR*** • *Short-term therapy (less than 90 days) has been prescribed; **AND*** ○ *Behavioral symptoms are significant enough to place the person at potential risk or needing higher level of care or loss of community placement; **OR*** – *Continuation of existing therapy to address serious and ongoing behavioral symptoms while other prior authorization criteria are met; **AND*** ○ *Efficacy and potential side effects to be monitored; **AND*** ○ *Need for requested medication will be evaluated once other non-pharmacological interventions have been tried* ***Note the following**:* • *Drug specific step therapy, NP criteria and Brand Medically Necessary Criteria will still apply to this patient population.* • *The I/DD Worksheet can be found at: I/DD Prior Authorization Form*				
chlorpromazine	P			General PA Form
fluphenazine	P			
haloperidol	P			
loxapine	P			
perphenazine	P			
pimozide	P			
thioridazine	P			
thiothixene	P			
trifluoperazine	P			
molindone	NP			
Orap®	NP			

DERMATOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Acne Agents, Topical (Covered for recipients < 21 years old only)				
benzoyl peroxide 2.5%, 5%, 10% (excluding cleanser, gel, microspheres, and towelettes)	P		1 package/Rx	General PA Form
clindamycin phosphate (excluding foam, lotion, & 75 mL bottle of gel)	P		1 package/Rx	
clindamycin/benzoyl peroxide gel	P		1 package/Rx	
erythromycin (excluding swab & gels)	P		1 package/Rx	
sodium sulfacetamide/ sulfur	P		1 package/Rx	
Aczone®	NP	• Patient is at least 12 years of age and less than 21 years of age; **AND** • Patient has a diagnosis of acne vulgaris; **AND** • Clinically valid reason why generic dapsone gel cannot be used	1 package/Rx	

Amzeeq®	NP	• Diagnosis of non-nodular moderate to severe acne vulgaris; **AND**
		• Patient is at least 9 years of age and less than 21 years of age; **AND**
		• Trial and failure, contraindication, or intolerance to ALL the following:
		  ○ 2 preferred agents
		  ○ minocycline capsules; **AND**
		• Prescriber must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents
			1 package/28 days	

benzoyl peroxide (excluding preferred products)	NP		1 package/Rx	
Cabtreo®	NP	• Patient is at least 12 years of age and less than 21 years of age; **AND** • Patient has a diagnosis of acne vulgaris; **AND** • Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents	1 package/Rx	
clindamycin (excluding preferred products)	NP		1 package/Rx	
dapsone gel	NP	• Patient is at least 12 years of age and less than 21 years of age; **AND** • Patient has a diagnosis of acne vulgaris; **AND** • Clinically valid reason why the preferred agents cannot be used	1 package/Rx	

DERMATOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
dermatological kits	NP	• Trial and failure of 3 preferred agents; **AND** • Trial and failure of the individual components of the kit	1 package/Rx	General PA Form
erythromycin/benzol peroxide	NP		1 package/Rx	
erythromycin swab & gel	NP		1 package/Rx	
sulfacetamide suspension	NP		1 package/Rx	
Winlevi®	NP	• Diagnosis of acne vulgaris; **AND** • Patient is at least 12 years of age and less than 21 years of age; **AND** • Trial and failure, contraindication, or intolerance of 2 preferred agents; **AND** • Prescriber provides peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents	1 tube/30 days	
All branded single agent and combination products of benzoyl peroxide, clindamycin, erythromycin, and sodium sulfacetamide	NP		1 package/Rx	
Agents for Burns, Topical				
silver sulfadiazine	P		1 package/Rx	General PA Form
SSD®	P		1 package/Rx	
mafenide	NP		1 package/Rx	
Silvadene®	NP		1 package/Rx	
Sulfamylon®	NP		1 package/Rx	
Agents for Rosacea, Topical (Covered for recipients < 21 years old only)				
Finacea® foam	P		50 g/Rx	General PA Form
metronidazole cream, lotion, and gel	P		60 g/Rx	
brimonidine gel	NP		30 g/Rx	
ivermectin cream	NP		45 g/Rx	
Mirvaso®	NP		30 g/Rx	

DERMATOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Noritate® cream	NP		60 g/Rx	
Rhofade®	NP	• Patient age < 21 years of age; **AND** • Patient has a diagnosis of persistent facial erythema associated with rosacea; **AND** • Trial and failure, or contraindication, of 2 of the following: brimonidine, ivermectin, tetracycline, minocycline, doxycycline, erythromycin, clindamycin, benzoyl peroxide; **AND** • Trial and failure of 2 preferred topical agents for rosacea	30 g/30 days	
Anesthetics, Topical				
lidocaine (excluding lotion, solution, kits)	P		1 tube/Rx	General PA Form
lidocaine patch 5%	P	• Diagnosis of post-herpetic neuralgia	3/day	
lidocaine/prilocaine	P		30 g/Rx	
ZTLido®	P	• Diagnosis of Postherpetic neuralgia	3/day	
lidocaine kits	NP	• Diagnosis of FDA-approved indication; **AND** • Clinically valid reason why the preferred topical anesthetics cannot be used; **AND** • For combination kits, trial and failure of individual agents		
lidocaine/ hydrocortisone	NP	• Diagnosis of FDA-approved indication; **AND** • Clinically valid reason why the preferred topical anesthetics cannot be used	1 package/Rx	
Pliaglis®	NP		1 package/Rx	
Pramosone® 2.5-1% lotion	NP		1 package/Rx	
Antibiotics, Topical				
mupirocin ointment	P		44 g/Rx	General PA Form
mupirocin cream	NP		30 g/Rx	
Antifungal Agents, Topical				
ciclopirox cream	P		1 package/Rx	General PA Form
ciclopirox solution 8%	P			
clotrimazole 1% cream & soln (OTC)	P		1 package/Rx	
clotrimazole 1% cream (Rx)	P		1 package/Rx	
clotrimazole/ betamethasone	P		1 package/Rx	
ketoconazole (cream and shampoo)	P		1 package/Rx	
nystatin/ triamcinolone	P		1 package/Rx	

DERMATOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
nystatin powder	P		120 g/Rx	
Vusion®	P		1 package/Rx	
ciclopirox gel and suspension	NP		1 package/Rx	
ciclopirox nail kit	NP	• Clinically valid reason for why the preferred topical ciclopirox 8% solution cannot be used		
clotrimazole 1% solution (Rx)	NP		1 package/Rx	
econazole	NP		1 package/Rx	
Ertaczo®	NP		1 package/Rx	
Jublia®	NP	• Diagnosis of mild to moderate onychomycosis of the toenails; **AND** • Trial and failure, contraindication, or intolerance to the preferred topical ciclopirox 8% solution	1 package/Rx	
Klayesta®	NP		1 package/Rx	
luliconazole	NP		1 package/Rx	
Luzu®	NP		1 package/Rx	
miconazole/zinc/ petrolatum	NP	• Clinically valid reason for why the preferred Vusion cannot be used	1 package/Rx	
naftifine gel	NP		1 package/Rx	
Nyamyc®	NP		1 package/Rx	
oxiconazole	NP		1 package/Rx	
Oxistat®	NP		1 package/Rx	
tavaborole soln	NP	See Jublia® prior authorization criteria	1 package/Rx	
Antineoplastics, Topical				
diclofenac 3% gel	P	• Diagnosis of actinic keratosis	1 package/Rx	
fluorouracil 5% cream	P		1 package/Rx	
imiquimod	P		1 package/Rx	
Targretin®	P		1 package/Rx	
bexarotene	NP		1 package/Rx	
Efudex®	NP		1 package/Rx	
fluorouracil 0.5% cream	NP		1 package/Rx	

DERMATOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Hyftor®	NP	**Initial Criteria (4-month duration):** • Diagnosis of facial angiofibroma associated with tuberous sclerosis complex; **AND** • Patient is 6 years of age or older; **AND** • Prescribed by or in consultation with a dermatologist or neurologist; **AND** • Patient is not a candidate for laser therapy or surgical treatments **Renewal Criteria:** • Documentation of positive clinical response to therapy (e.g., improvement in size or redness of facial angiofibroma)	30 g/month	General PA Form
Valchlor®	NP	• Diagnosis of stage IA or IB mycosis fungoides-type cutaneous T-cell lymphoma; **AND** • Patient has received skin directed therapy	1 package/Rx	
Zyclara®	NP	• Diagnosis of actinic keratosis; **OR** • Diagnosis of basal cell carcinoma	1 package/Rx	
Antipruritics/Antihistamines, Topical				
doxepin cream	NP	• Patient has moderate pruritus due to various forms of eczematous dermatitis, including atopic dermatitis and lichen simplex chronicus; **AND** • Inadequate response, intolerance, or contraindication to BOTH of the following: ○ A topical corticosteroid ○ An oral antihistamine (first or second generation) or a topical antihistaminic agent	45g/90 days	General PA Form
Prudoxin®	NP	See doxepin cream prior authorization criteria	45g/90 days	
Zonalon®	NP	See doxepin cream prior authorization criteria	45g/90 days	
Antipsoriatics, Oral				
acitretin	NP	• Patient has a diagnosis of severe psoriasis; **AND** • Minimum duration of a 4-week trial and failure, contraindication, or intolerance to at least two of the following: ○ Corticosteroids (e.g., betamethasone, clobetasol) ○ Vitamin D analogs (e.g., calcitriol, calcipotriene) ○ Tazarotene ○ Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus) • Prescriber attests to each of the following: ○ Patient does-NOT have impaired liver or kidney function, or abnormally elevated lipid levels ○ Patient will NOT be receiving concomitant methotrexate (due to risk of hepatitis) or tetracyclines (due to risk of increased intracranial pressure) ○ If applicable, appropriate laboratory assessments and counseling have been conducted regarding risks associated with pregnancy **Note:** Will not be covered for the diagnosis of acne or rosacea for recipients ≥ 21 years of age.	10 mg (3/day); 17.5, 22.5, & 25 mg (2/day)	General PA Form
methoxsalen	NP	• Diagnosis of severe, recalcitrant, disabling psoriasis supported by biopsy; **AND** • Minimum duration of a 4-week trial and failure, contraindication, or intolerance to at least two of the following: ○ Corticosteroids (e.g., betamethasone, clobetasol) ○ Vitamin D analogs (e.g., calcitriol, calcipotriene) ○ Tazarotene ○ Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)		

DERMATOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antipsoriatics, Topical				
calcipotriene cream	P	• Trial and failure, contraindication, or intolerance to ≥ 1 topical steroid	1 package/Rx	General PA Form
calcipotriene foam		• Trial and failure, contraindication, or intolerance to ≥ 1 topical steroid	1 package/Rx	
calcipotriene scalp soln	P	• Trial and failure, contraindication, or intolerance to ≥ 1 topical steroid		
Sorilux®	P	• Trial and failure, contraindication, or intolerance to ≥ 1 topical steroid	1 package/Rx	
Taclonex®	P	• Trial and failure, contraindication, or intolerance to ≥ 1 topical steroid		
tazarotene 0.1% cream	P	• Diagnosis of psoriasis; **OR** • Diagnosis of acne in patients less than 21 years of age	1 package/Rx	
calcipotriene ointment	NP	• Trial and failure, contraindication, or intolerance to ≥ 1 topical steroid; **AND** • Trial and failure, contraindication, or intolerance to a preferred topical antipsoriatic agent	1 package/Rx	
calcitriol ointment	NP	See calcipotriene foam prior authorization criteria	1 package/Rx	
calcipotriene/ betamethasone	NP	See calcipotriene ointment prior authorization criteria	1 package/Rx	
Calcitrene® ointment		See calcipotriene ointment prior authorization criteria	1 package/Rx	
Duobrii®	NP	• Patient has a diagnosis of plaque psoriasis; **AND** • Trial and failure, contraindication, or intolerance to at least one topical steroid; **AND** • Clinically valid reason why the preferred individual components cannot be taken separately	200 mg/30 days	
Enstilar®	NP	See calcipotriene ointment prior authorization criteria	1 package/Rx	
Sorilux®	NP	See calcipotriene ointment prior authorization criteria	1 package/Rx	

tazarotene 1% gel	NP	• Diagnosis of psoriasis AND Both of the following:
		  ○ Trial and failure, contraindication, or intolerance to at least one topical steroid;
		  ○ Trial and failure, contraindication, or intolerance to a preferred topical antipsoriatic agent**; OR**
		• Diagnosis of acne in patients less than 21 years of age; **AND**
		  ○ Trial and failure, contraindication, or intolerance to TWO preferred topical retinoids
			1 package/Rx	

Vtama®	NP	**Initial Criteria:**
		• Diagnosis of plaque psoriasis; **AND**
		  ○ Minimum duration of a 4-week trial and failure, contraindication, or intolerance to at least two of the following:
		  – Corticosteroids (e.g., betamethasone, clobetasol)
		  – Vitamin D analogs (e.g., calcitriol, calcipotriene)
		  – Tazarotene
		  – Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus; **OR**
		• Diagnosis of atopic dermatitis and Both of the following:
		  ○ Trial and failure, contraindication, or intolerance to a topical corticosteroid AND a topical calcineurin inhibitor; **AND**
		• Prescribed by, or in consultation with, a dermatologist
		Renewal Criteria:
		• Documentation of positive clinical response to therapy as evidenced by one of the following:
		  ○ Reduction in the body surface area (BSA) involvement from baseline
		  ○ Improvement in symptoms (e.g., pruritus, inflammation) from baseline
			60 grams/28 days	

DERMATOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Zoryve® 0.3% cream	NP	**Initial Criteria:** • Diagnosis of mild to plaque psoriasis; **AND** • Patient is 6 years of age or older; AND • Patient does not have moderate to severe liver impairment (Child-Pugh B or C); **AND** • Request is for Zoryve 0.3% cream; **AND** • Trial and failure, contraindication, or intolerance to TWO preferred topical antipsoriatic agents **Renewal Criteria:** • Patient continues to be monitored for liver impairment; **AND** • Documented clinical improvement in response to treatment (e.g. reduction in itch, rash, inflammation)	60 grams/28 days	General PA Form
Antiseborrheic Agents				
selenium sulfide 2.5% lotion	P		1 package/Rx	General PA Form

Zoryve® 0.3% topical foam	NP	**Initial Criteria: (3-month duration)**
		• Diagnosis of seborrheic dermatitis; **AND**
		• Patient is 9 years of age or older; **AND**
		• Patient does not have moderate to severe liver impairment (Child-Pugh B or C); **AND**
		• Trial and failure, contraindication, or intolerance to BOTH of the following agents:
		  ○ Topical antifungals (ketoconazole, ciclopirox, miconazole, clotrimazole)
		  ○ Topical corticosteroids
		Renewal Criteria:
		• Patient continues to be monitored for liver impairment; **AND**
		• Documented clinical improvement in response to treatment (e.g., decreased erythema, scaling, inflammation); **AND**
		• Patient does not have any treatment limiting adverse effects
			1 can (60 gr)/30 days	

Antivirals, Topical				
acyclovir 5% ointment	P		1 tube/Rx	General PA Form
penciclovir cream	P		1 tube/Rx	
acyclovir cream	NP		1 tube/Rx	General PA Form
Denavir® cream	NP		1 tube/Rx	
Xerese®	NP	• Patient must be 6 years of age and older; **AND** • Diagnosis of recurrent herpes labialis; **AND** • Trial and failure of the individual components of the kit	1 tube/Rx	
Zovirax® cream	NP		1 tube/Rx	
Zovirax® ointment	NP		1 tube/Rx	
Atopic Dermatitis, Topical				
Elidel®	P		1 package/Rx	
tacrolimus ointment	P		1 package/Rx	

DERMATOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Eucrisa®	NP	• Diagnosis of atopic dermatitis; **AND**
		• One of the following:
		  ○ Patient is ≥ 2 years and meets BOTH of the following; **AND**
		  – Trial and failure, contraindication, or intolerance to BOTH of the following:
		  • A topical corticosteroid; **AND**
		  • A topical calcineurin Inhibitor (e.g., Elidel or tacrolimus ointment)**; OR**
		  ○ Patient is <2 years and greater than 3 months of age; **AND**
		  – Trial and failure, contraindication, or intolerance to ONE topical corticosteroid
			1 tube/month	General PA Form

Opzelura®	NP	**Initial Criteria:**
		• One of the following:
		  ○ Diagnosis of mild to moderate atopic dermatitis (3-month approval duration)and BOTH of the following:
		  – Patient is not immunocompromised; **AND**
		  – Opzelura will only be used for short-term and/or non-continuous chronic treatment; ***OR***
		  ○ Diagnosis of Nonsegmental Vitiligo (12-month approval duration); **AND**
		• Patient is 12 years of age or older; **AND**
		• Patient is not breastfeeding; **AND**
		• Trial and failure, contraindication, or intolerance to a topical corticosteroid; **AND**
		• Trial and failure, contraindication, or intolerance to a topical calcineurin inhibitor; **AND**
		• Prescriber attests to each of the following:
		  ○ Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab, abatacept) OR potent immunosuppressants (i.e., azathioprine, cyclosporine); **AND**
		  ○ Benefits of using this agent outweigh the heart-related or cardiovascular risk factors; **AND**
		  ○ Risk of malignancy has been considered and it has been determined that Jak Kinase inhibitor therapy is appropriate
		Renewal Criteria:
		• Positive response to therapy [e.g., reduction in symptoms (itch, rash, etc.), re-pigmentation, etc.]
			240 g/month	Topical Immuno-modulators PA Form

pimecrolimus	NP	• Patient must have a diagnosis of atopic dermatitis; **AND** • Trial and failure of 1 preferred agent (e.g., Elidel® or tacrolimus ointment)	1 package/Rx	
Zoryve® 0.15% cream	NP	**Initial Criteria:** • Diagnosis of mild to moderate atopic dermatitis; **AND** • Patient is 6 years of age or older; **AND** • Patient does not have moderate to severe liver impairment (Child-Pugh B or C); **AND** • Request is for Zoryve 0.15% cream; **AND** • Trial and failure, contraindication, or intolerance to ONE topical corticosteroid; **AND** • Trial and failure, contraindication, or intolerance to ONE topical calcineurin inhibitor **Renewal Criteria:** • Patient continues to be monitored for liver impairment; **AND** • Documented clinical improvement in response to treatment (e.g. reduction in itch, rash, inflammation)	60 gram/28 days	

DERMATOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Emollients				
ammonium lactate (Rx & OTC)	P		1 package/Rx	General PA Form
Genital Warts				
imiquimod	P		1 package/Rx	General PA Form
Condylox®	P		1 package/Rx	
Imiquimod pump	NP		1 package/Rx	
Veregen®	NP		1 package/Rx	
Zyclara®	NP		1 package/Rx	
Keratolytic Agents				
generic urea products	P		1 package/Rx	General PA Form
generic salicylic acid products	P		1 package/Rx	
brand urea products	NP		1 package/Rx	
brand salicylic acid products	NP		1 package/Rx	
Pediculocides/Scabicides				
Natroba®	P		2 bottles/Rx	General PA Form
permethrin	P		2 tubes/Rx	
VanaLice®	P		1 bottle/Rx	
Crotan®	NP	• Patient is being treated for scabies or pruritis; **AND** • Patient has tried/failed permethrin (unless patient has a contraindication)	1 bottle/Rx	
ivermectin lotion	NP		1 tube/Rx	
malathion	NP		2 bottles/Rx	
Ovide®	NP		2 bottles/Rx	
Sklice®	NP		1 tube/Rx	
spinosad	NP		2 bottles/Rx	
Retinoids, Oral				
Absorica® & Absorica LD®	NP	• Diagnosis of chronic myelogenous leukemia, head or neck cancer, ichthyosis, keratosis follicularis, neuroblastoma, or pityriasis rubra pilaris will be reviewed on a case-by-case basis; **OR** • Diagnosis of severe recalcitrant nodular acne **AND** ○ Patient is < 21 years of age (will not be covered for acne or rosacea for recipients ≥ 21 years of age) **Note:** Active registration and compliance with the iPLEDGE program is required by prescriber, patient, and pharmacy.		General PA Form
Accutane®	NP	See Absorica® prior authorization criteria		
Amnesteem®	NP	See Absorica® prior authorization criteria		
Claravis®	NP	See Absorica® prior authorization criteria		
isotretinoin	NP	See Absorica® prior authorization criteria		
Zenatane®	NP	See Absorica® prior authorization criteria		

DERMATOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Retinoids, Topical				
adapalene	P	See tretinoin prior authorization criteria	1 package/Rx	General PA Form
tazarotene 0.1% cream	P	See Tazorac® prior authorization criteria (Topical Antipsoriatics section)	1 package/Rx	

tretinoin cream	P	• Patient is < 21 years old; **AND**
		  ○ Diagnosis of acne, keratosis follicularis, verruca plana, or actinic keratosis; **OR**
		• Patient is ≥ 21 years old: **AND**
		  ○ Diagnosis of keratosis follicularis (1 year approval duration); **OR**
		  ○ Diagnosis of verruca plana (2-month approval duration); **OR**
		  ○ Diagnosis of actinic keratosis for the prevention of future lesions (1 year approval duration)
		Note: Will not be covered for patients > 21 years old with a diagnosis of acne
			1 package/Rx	

adapalene/benzoyl peroxide	NP	See tretinoin prior authorization criteria In addition, non-preferred criteria and trial and failure of individual components is required.	1 package/Rx	General PA Form
Altreno®	NP	See Aklief® prior authorization criteria	1 package/Rx	
Atralin®	NP	See tretinoin prior authorization criteria	1 package/Rx	
Arazlo®	NP	• Patient is 9 years of age or older and less than 21 years of age; **AND** • Diagnosis of acne; **AND** • Patient is not pregnant; **AND** • Trial and failure, contraindication, or intolerance to 2 preferred agents; **AND** • Clinically valid reason why the requested drug is the only appropriate choice versus the preferred agents	1 package/28 days	
clindamycin/tretinoin	NP	See tretinoin prior authorization criteria	1 package/Rx	
Fabior®	NP	See Tazorac® prior authorization criteria (Topical Antipsoriatics section)	1 package/Rx	
Retin A®	NP	See tretinoin prior authorization criteria	1 package/Rx	
Retin A Micro®	NP	See tretinoin prior authorization criteria	1 package/Rx	
tretinoin gel	NP	See tretinoin prior authorization criteria	1 package/Rx	
Ziana®	NP	See tretinoin prior authorization criteria		
Topical Steroids: Least Potent				
hydrocortisone 0.5% cream and ointment (Rx & OTC)	P		1 package/Rx	General PA Form
hydrocortisone 1% cream, lotion, gel, and ointment (Rx & OTC)	P		1 package/Rx	
hydrocortisone 2.5% cream, lotion, and ointment	P		1 package/Rx	

DERMATOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Topical Steroids: Mild				
desonide 0.05% cream& ointment	P		1 package/Rx	
fluocinolone 0.01% cream, oil, solution	P		1 package/Rx	
Synalar® 0.01% solution	NP		1 package/Rx	
Topical Steroids: Lower Mid-Strength				
betamethasone dipropionate 0.05% lotion	P		1 package/Rx	
betamethasone valerate 0.1% cream	P		1 package/Rx	
Locoid Lipocream	P		1 package/Rx	
clocortolone 0.1% cream and pump	NP		1 package/Rx	
desonide 0.05% lotion	NP		1 package/Rx	General PA Form
hydrocortisone butyrate 0.1% cream, lotion, ointment, solution	NP		1 package/Rx	
hydrocortisone valerate 0.2% cream	NP		1 package/Rx	
Locoid® lotion	NP		1 package/Rx	
Pandel® 0.1% cream	NP		1 package/Rx	
Topical Steroids: Mid-Strength				
triamcinolone acetonide 0.1% cream	P		1 package/Rx	General PA Form
hydrocortisone valerate 0.2% ointment	NP		1 package/Rx	
Topical Steroids: Upper Mid-Strength				
betamethasone valerate 0.1% cream and ointment	P		1 package/Rx	General PA Form
fluticasone propionate 0.005% ointment	P		1 package/Rx	

DERMATOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
triamcinolone acetonide 0.025% cream, lotion and ointment	P		1 package/Rx	
triamcinolone acetonide 0.05% ointment	P		1 package/Rx	
triamcinolone acetonide 0.1% lotion and ointment	P		1 package/Rx	
triamcinolone acetonide 0.5% cream and ointment	P		1 package/Rx	
amcinonide 0.1% cream and lotion	NP		1 package/Rx	
betamethasone dipropionate 0.05% cream	NP		1 package/Rx	
betamethasone valerate 0.12% foam	NP		1 package/Rx	
desoximetasone 0.05% cream	NP		1 package/Rx	
fluocinonide 0.05% emulsified base cream	NP		1 package/Rx	
Topical Steroids: Potent				
betamethasone dipropionate, augmented 0.05% cream	P		1 package/Rx	
ApexiCon E® 0.05% cream	NP		1 package/Rx	
betamethasone dipropionate, augmented 0.05% lotion	NP		1 package/Rx	
betamethasone dipropionate 0.05% ointment	NP		1 package/Rx	
desoximetasone 0.05% gel and	NP		1 package/Rx	General PA

DERMATOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
ointment				Form
desoximetasone 0.25% cream, ointment, spray	NP		1 package/Rx	
diflorasone diacetate 0.05% cream and ointment	NP		1 package/Rx	
fluocinonide 0.05% cream, gel, and ointment	NP		1 package/Rx	
Halog® 0.1% ointment and cream	NP		1 package/Rx	
Halog® solution	NP		120 mL per 30 days	
Topical Steroids: Super Potent				
clobetasol propionate 0.05% cream, gel, ointment, lotion, and solution	P		1 package/Rx	General PA Form
clobetasol propionate emollient base 0.05% cream	P		1 package/Rx	
fluocinonide 0.1% cream	P		1 package/Rx	
Bryhali® lotion	NP	• Diagnosis of an FDA-approved indication; **AND** • Clinically valid reason why the preferred individual components cannot be taken concomitantly	200 g/28 days	
betamethasone dipropionate, augmented 0.05% gel and ointment	NP		1 package/Rx	
clobetasol 0.025% cream	NP		1 package/Rx	
clobetasol propionate 0.05% foam, shampoo, and spray	NP		1 package/Rx	
clobetasol propionate emollient base 0.05% foam	NP		1 package/Rx	
halobetasol propionate 0.05%	NP		1 package/Rx	

DERMATOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
cream, foam, and ointment				
Lexette®	NP	See Bryhali® prior authorization criteria	100 g/Rx	
Ultravate® 0.05% lotion	NP		1 package/Rx	
Wound Care, Topical				

Filsuvez®	NP	**Initial Criteria: (6-month duration)**
		• One of the following:
		  ○ Diagnosis of Dystrophic Epidermolysis bullosa (EB);
		  ○ Diagnosis of Junctional Epidermolysis bullosa (EB); **AND**
		• Prescriber attests the target wound(s) meet ALL of the following:
		  ○ Wound is clean in appearance and does not appear to be infected
		  ○ Wound is 10 cm^2 to 50 cm^2; **AND**
		• Patient will continue standard treatments for EB such as appropriate wound management and avoiding skin trauma; **AND**
		• Prescribed by or in consultation with a dermatologist or wound management
		Renewal Criteria:
		• Patient has a clinical response to therapy (e.g., decreased wound size, decreased frequency of wound dressing changes, reduction in pain)
		Note: New wounds untreated with Filsuvez or recurrent reopened wounds are subject to initial criteria. Unhealed wounds > 6 months should rule out squamous cell and basal cell carcinoma.
			15 tubes/per 30 days	General PA Form

DIABETIC SUPPLIES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Blood Glucose Meters and Test Strips (OTC)				
Abbott Products				
FreeStyle Meters: Lite, Freedom Lite, InsuLinx	P		**Meters:** 1/730 days **Test Strips:** Age ≤ 5: 306/30 days Age > 6: 204/30 days	Diabetic Supply PA Form
Freestyle Test Strips: Lite, InsuLinx	P			
All other Abbott diabetic supplies	P			
AgaMatrix Products				

DIABETIC SUPPLIES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Various	NP	See prior authorization criteria for Breeze-2 Meter (Bayer Products)	**Meters:** 1/365 days **Test Strips:** Age ≤ 5: 306/30 days Age > 6: 204/30 day	Diabetic Supply PA Form
Bayer Products				
Bayer Meters: Breeze-2 & Contour	NP	• Non-preferred meters will be approved for patients meeting **ONE** of the following criteria: ○ Patient is using an insulin pump that does not adequately communicate with a preferred meter. ○ Patient requires a special meter due to visual impairment	**Meters:** 1/365 days; **Test Strips:** Age ≤ 5: 306/30 days Age > 6: 204/30 days	Diabetic Supply PA Form
Bayer Test Strips	NP	• Will be approved for individuals who meet prior authorization criteria and receive a prior authorization for a Bayer diabetes meter.		
All other Bayer diabetic supplies	NP			
Home Diagnostics Products				
Various	NP	See prior authorization criteria for Breeze-2 Meter (Bayer Products)	See Bayer Products	Diabetic Supply PA Form
Johnson and Johnson Products				
OneTouch Meters: UltraMini, Ping, Ultra-2, UltraLink, UltraSmart	NP	See prior authorization criteria for Breeze-2 Meter (Bayer Products)	**Meters:** 1/365 days; **Test Strips:** Age ≤ 5: 306/30 days Age > 6; 204/30 days	Diabetic Supply PA Form
Johnson & Johnson Test Strips	NP	Will be approved for individuals who meet prior authorization criteria and receive a prior authorization for a OneTouch diabetes meter.		
All other OneTouch diabetic supplies	NP			
LifeScan Products				
Various	NP	See prior authorization criteria for Breeze-2 Meter (Bayer Products)	**Meters:** 1/365 days; **Test Strips:** Age ≤ 5: 306/36 days Age > 6: 204/30 days	Diabetic Supply PA Form
Roche Products				
Accu-Chek Meters: Aviva & Compact Plus	NP	See prior authorization criteria for Breeze-2 Meter (Bayer Products)	**Meters:** 1/365 days; **Test Strips:** Age ≤ 5: 306/36 days Age > 6: 204/30 days	Diabetic Supply PA Form
Roche Test Strips	NP	Will be approved for individuals who meet prior authorization criteria and receive a prior authorization for an Accu-Chek diabetes meter.		
All other Roche diabetic supplies	NP			

DIABETIC SUPPLIES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
All Manufacturers				
Ketone Testing Strips			50 /30 days	General PA Form
Continuous Glucose Monitors and Supplies				
Dexcom				

Dexcom G6;
Dexcom G7
	P	**Initial Criteria:**
		• One of the following:
		  ○ Patient is pregnant and has Type 1 Diabetes Mellitus (DM), Type 2 DM, or Gestational Diabetes**; OR**
		  ○ Patient has a diagnosis of Type 1 DM Or Type 2 DM; **AND**
		  – Patient is on insulin therapy or an insulin pump; **OR**
		  – Patient is currently on glucose lowering therapy other than insulin therapy (e.g., SGLT2, metformin, SU, TZD, DPP-4) and meets ONE of the following:
		  • History problematic hypoglycemia (e.g., frequent/severe or nocturnal hypoglycemia, hypoglycemia unawareness)
		  • Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL
		  • History of emergency room visit or hospitalization related to ketoacidosis or hypoglycemia
		  • Prescriber must submit medical records (e.g., chart notes) providing clinical rationale why the patient cannot use or continue to use traditional blood glucose monitoring devices (e.g. fingerstick); (Note: Patient convenience is NOT an approvable reason); **AND**
		• Prescriber attests to BOTH the following:
		  ○ Patient or caregiver will receive diabetes self-management education; **AND**
		  ○ Patient or caregiver has received sufficient training using the requested CGM
		Renewal Criteria:
		• Patient has received benefit from therapy which may include ONE or more of the following:
		  ○ Decreased A1C from baseline
		  ○ Decreased hypoglycemia episodes
		  ○ Decreased percentage of time below therapeutic range (TBR)
		  ○ Increased percentage of time in therapeutic range (TTR)
			G6
			Sensor: 3/30 days
			Transmitter: 1/90 days
			Receiver: 1/year
			
			G7
			Sensor/Transmitter: 3/month
			Receiver: 1/year
				Diabetic Supply PA Form

Senseonics and Ascensia Diabetes Care				
Eversense Mis	NP	• See Dexcom prior authorization criteria; **AND** • Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom	Sensor: 1/90 days Transmitter: 1/90 days	Diabetic Supply PA Form
Eversense E3	NP	• See Dexcom prior authorization criteria; **AND** • Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom	Sensor: 2/year Transmitter: 1/year	
Eversense E365	NP	• See Dexcom prior authorization criteria; **AND** • Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom	Sensor: 1/year Transmitter: 1/year	

DIABETIC SUPPLIES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Abbot				
Freestyle; Freestyle Libre 2 Freestyle Libre 3	NP	• See Dexcom prior authorization criteria; **AND** • Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom	Readers: 1/year Sensors:2/28 days	Diabetic Supply PA Form
Freestyle Libre Plus (2 and 3)		• See Dexcom prior authorization criteria; **AND** • Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom	2 kits/30 days	
Medtronic				

Guardian 3;
Guardian 4
	NP	• One of the following:
		  ○ Patient is a currently using MiniMed insulin pump; **OR**
		  ○ See Dexcom prior authorization criteria; **AND**
		• Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom
			Transmitter: 1/year
			Sensors: 5/30 days	

Guardian Connect	NP	• See Dexcom prior authorization criteria; **AND** • Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom	1 transmitter/year	
Guardian CGM supplies	NP	• See Dexcom prior authorization criteria; **AND** • Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom	Charger: 1/year Test plug: 1/year	Diabetic Supply PA Form

DIABETIC SUPPLIES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Insulin Management Systems				
Omnipod 5® Omnipod Dash®	P	**Initial Criteria: (6-month duration)** • Diagnosis of type 1 or type 2 diabetes mellitus; **AND** • Prescribed by, or in consultation with, an endocrinologist or diabetologist; **AND** • Submission of medical records(e.g., chart notes) documenting ONE of the following: ○ Patient is < 21 years of age and requires intensive insulin therapy and blood glucose monitoring (e.g.,3 or more injections, 3 or more blood glucose readings per day or utilizes a CGM) ○ Patient is ≥ 21 years of age and has difficulty maintaining stable blood glucose levels (hyperglycemia or hypoglycemia) or individual A1C/Time in Range (TIR) goals despite intensive insulin therapy and blood glucose monitoring (3 or more injections, 3 or more blood glucose readings per day, or utilizes a CGM) ○ Patient has physical impairments resulting in difficulty with self-injection of insulin (e.g., retinopathy, neuropathy) ○ Prescriber has provided clinical rationale for the use of disposable insulin delivery devices vs traditional insulin pump; **AND** • Prescriber attests that the patient or caregiver will receive diabetes self-management education; **AND** • Prescriber attests that the patient or caregiver has received sufficient training using the requested CGM **Renewal Criteria:** • Documentation of a positive clinical response (e.g. decrease HbA1C from baseline, decrease hypoglycemia episodes, decrease fasting and mealtime blood glucose levels)	Pods: 10/30 days; Device: 1/year	General PA Form
Cequr Simplicity®	P	**Initial Criteria: (6-month duration)** • Diagnosis of type 1 or type 2 diabetes mellitus; **AND** • Patient is ≥ 21 years old; **AND** • Prescribed by, or in consultation with, an endocrinologist or diabetologist; **AND** • Submission of medical records(e.g., chart notes) documenting ONE of the following: ○ Patient has difficulty maintaining stable blood glucose levels (hyperglycemia or hypoglycemia) or individual A1C/Time in Range (TIR) goals despite intensive insulin therapy and blood glucose monitoring (3 or more injections, 3 or more blood glucose readings per day, or utilizes a CGM) ○ Patient has physical impairments resulting in difficulty with self-injection of insulin (e.g., retinopathy, neuropathy) ○ Prescriber has provided clinical rationale for the use of disposable insulin delivery devices vs traditional insulin pump; **AND** • Prescriber attests that the patient or caregiver will receive diabetes self-management education; **AND** • Prescriber attests that the patient or caregiver has received sufficient training using the requested CGM **Renewal Criteria:** • Documentation of a positive clinical response (e.g. decrease HbA1C from baseline, decrease hypoglycemia episodes, decrease fasting and mealtime blood glucose levels)	3-day patch: 10 /30 days 4-day patch: 8 /32 days	General PA Form
InPen®	NP	• Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use the preferred products		General PA Form
V-Go® products	NP	• Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use the preferred products	30 patches/30 days	
Insulin Syringes and Pen Needles (OTC)				
BD/Embecta products	P	Refer to OTC List for covered NDCs		General PA Form

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Adrenocorticotropins				
Acthar® gel	NP	• Appropriate FDA-approved diagnosis (e.g., diuresis in nephrotic syndrome, treatment of SLE or polymyositis, or acute MS exacerbation) for use AND has a contraindication, or intolerance to oral and injectable glucocorticoids; **OR** • Diagnosis of infantile spasms	1/day	General PA Form
Cortrophin® gel	NP	See Acthar® gel prior authorization criteria; **AND** • Clinically valid reason why Acthar® gel cannot be used	1/day	
Agents for Dyspareunia				
Intrarosa®	NP	• Female younger than 21 years of age; **AND** • Cessation of menses due to menopause; **AND** • Painful intercourse **Note:** This product is excluded from coverage in patients 21 years of age and older. Not a Covered Benefit.		
Osphena®	NP	See Intrarosa® prior authorization criteria **Note:** This product is excluded from coverage in patients 21 years of age and older. Not a Covered Benefit.		
Agents for Gout				
colchicine capsules	NP	• Clinically valid reason why the preferred colchicine product cannot be used		
Gloperba®	NP	**Criteria: (3 months)** • Clinically valid reason why colchicine tablets or capsules cannot be used; **OR** • Patient is unable to swallow sold dosage forms	300 ml/28 days	
Mitigare®	NP	• Clinically valid reason why the preferred colchicine product cannot be used		
Uloric®	NP	• Clinically valid reason as to why the preferred febuxostat cannot be used		
Androgens				
AndroGel® pump	P	**Initial Criteria:** • Diagnosis of primary or hypogonadotropic hypogonadism; **AND** • Documentation of at least 2 morning (before 10am) total testosterone baseline levels done on separate days within the past 6 months that are considered low per laboratory testing **Renewal Requests:** • Documentation of low or normal fasting testosterone level from previous 12 months **Note**: Requests for diagnosis of gender dysphoria will be reviewed on a case-by-case basis for determination	1 package/Rx	General PA Form
testosterone gel (excluding 2%)	P	See AndroGel® pump prior authorization criteria	1 package/Rx	
testosterone cypionate	P	See AndroGel® pump prior authorization criteria	4 mL/30 days	

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
testosterone enanthate injection	P	**Initial Criteria:** • Diagnosis of primary or hypogonadotropic hypogonadism; **AND** ○ Documentation of at least 2 morning (before 10am) total testosterone baseline levels done on separate days within the past 6 months that are considered low per laboratory testing; **OR** • Diagnosis of delayed puberty; **OR** • Palliative treatment of androgen-responsive, advanced, inoperable, metastatic breast cancer in women who are 1-5 years postmenopausal and in premenopausal women who have benefited from oophorectomy **Renewal Requests:** • Documentation of low or normal fasting testosterone level from previous 12 months **Note**: Requests for diagnosis of gender dysphoria will be reviewed on a case-by-case basis for determination	4 mL/30 days	General PA Form
testosterone transdermal solution	P	See AndroGel® pump prior authorization criteria	1 package/Rx	General PA Form
AndroGel® packets	NP	**Initial Criteria:** • Diagnosis of primary or hypogonadotropic hypogonadism; **AND** • Documentation of at least 2 morning (before 10am) total testosterone baseline levels done on separate days within the past 6 months that are considered low per laboratory testing; **AND** • Trial and failure of TWO preferred drugs **Renewal Requests:** • Documentation of low or normal fasting testosterone level from previous 12 months **Note**: Requests for diagnosis of gender dysphoria will be reviewed on a case-by-case basis for determination	1 package/Rx	General PA Form
Depo-Testosterone®	NP	See AndroGel® packets prior authorization criteria	4 mL/30 days	
Jatenzo®	NP	See AndroGel® packets prior authorization criteria	2/day	

Methitest®	NP	**Initial Criteria:**
		• Diagnosis of primary or hypogonadotropic hypogonadism; **AND**
		  ○ Documentation of at least 2 morning (before 10am) total testosterone baseline levels done on separate days within the past 6 months that are considered low per laboratory testing; **OR**
		• Diagnosis of delayed puberty; **AND**
		  ○ Clinically valid reason why preferred testosterone enanthate IM injection cannot be used; **OR**
		• Palliative treatment of androgen-responsive, advanced, inoperable, metastatic breast cancer in women who are 1-5 years postmenopausal and in premenopausal women who have benefited from oophorectomy
		Renewal Requests:
		• Documentation of low or normal fasting testosterone level from previous 12 months
		Note: Requests for diagnosis of gender dysphoria will be reviewed on a case-by-case basis for determination		

methyltestosterone	NP	See Methitest® prior authorization criteria		
Natesto® nasal gel	NP	See AndroGel® packets prior authorization criteria		
Testim®	NP	See AndroGel® packets prior authorization criteria	1 package/Rx	
Testosterone 2% gel	NP	See AndroGel® packets prior authorization criteria	1 package/Rx	

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Tlando®	NP	See AndroGel® packets prior authorization criteria	2/day	
Undecatrex®		See AndroGel® packets prior authorization criteria	4/day	
Vogelxo®	NP	See AndroGel® packets prior authorization criteria		
Xyosted®	NP	See AndroGel® pump prior authorization criteria	2 mL/30 days	
Bone: Bisphosphonate				
alendronate	P		5, 10, 40 mg: 1/day 35, 70 mg: 4/28 days	
alendronate solution	P		10 mL/day	
Atelvia®	P		4/28 days	
ibandronate	P		1/28 days	
Actonel®	NP		5, 30 mg: 1/day 35 mg: 4/28 days 150 mg: 1/28 days	General PA Form
Binosto®	NP		4/28 days	
Fosamax®	NP		see alendronate	
Fosamax Plus D®	NP		4/28 days	
risedronate	NP		5, 30 mg: 1/day 35 mg: 4/28 days 150 mg: 1/28 days	

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Bone: Calcitonin				
calcitonin nasal spray	P	• Diagnosis of osteoporosis in postmenopausal women greater than five years post menopause, **AND** • Trial and failure, contraindication, or intolerance to **BOTH** bisphosphonates **AND** raloxifene.	3.7 mL/30 days	General PA Form

calcitonin injection	NP	• Diagnosis of Paget's disease of the bone; **AND**
		  ○ Trial and failure, contraindication, or intolerance to bisphosphonates; **OR**
		• Treatment of hypercalcemia; **OR**
		• Diagnosis of osteoporosis in postmenopausal women greater than five years post-menopause; **AND**
		  ○ Trial and failure, contraindication, or intolerance to **BOTH** bisphosphonates **AND** raloxifene; **AND**
		  ○ Trial and failure, contraindication, or intolerance to the preferred agent
			1 mL/day	

Miacalcin® injection	NP	See calcitonin injection prior authorization criteria	1 mL/day	
Bone: Parathyroid Hormone				

Forteo®	P	**Initial Criteria:**
		• Diagnosis of ONE of the following:
		  ○ Postmenopausal osteoporosis and patient is female; **OR**
		  ○ Osteoporosis and patient is male; **OR**
		  ○ Glucocorticoid-induced osteoporosis; **AND**
		  – History of prednisone or its equivalent at a dose ≥ 5 mg/day; **AND**
		• Patient meets ONE of the following:
		  ○ Has a high risk for fracture (e.g., T-score of ≤ -3.0 even in the absence of fractures, T-score of -2.5 or below plus a fragility fracture, severe or multiple fractures, very high fracture probability by FRAX [e.g., major osteoporosis fracture > 30%, hip fracture > 4.5%]); **OR**
		  ○ Unable to tolerate bisphosphonates or has a relative contraindications to oral bisphosphonates (achalasia, scleroderma esophagus, esophageal strictures); **OR**
		  ○ Had an adequate trial of other osteoporosis therapies and had an insufficient response (fracture and/or loss of bone mineral density in spite of adherence to therapy); **AND**
		• Total lifetime length of therapy with PTH analogs has not exceeded 2 years
		Renewal Criteria:
		• The prescriber attests that the patient remains at, or has returned to, having a high risk for fracture despite 24 months of cumulative use of parathyroid hormone analogs; **AND**
		• The prescriber attests that the risk versus benefit of use greater than 24 months of cumulative use of parathyroid hormone analogs has been reviewed with the patient
			1 pen/28 days	General PA Form

teriparatide	NP	See Forteo prior authorization criteria; **AND** • Clinically valid reason why preferred Forteo® cannot be used	1 pen/28 days	General PA Form

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Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Tymlos®	NP	**Initial Criteria:**
		• Diagnosis of ONE of the following:
		  ○ Postmenopausal osteoporosis and patient is female
		  ○ Osteoporosis and patient is male; **AND**
		• Patient meets ONE of the following:
		  ○ Has a high risk for fracture (e.g., T-score of ≤ -3.0 even in the absence of fractures, T-score of -2.5 or below plus a fragility fracture, severe or multiple fractures, very high fracture probability by FRAX [e.g., major osteoporosis fracture > 30%, hip fracture > 4.5%]); **OR**
		  ○ Unable to tolerate bisphosphonates or has a relative contraindications to oral bisphosphonates (achalasia, scleroderma esophagus, esophageal strictures); **OR**
		  ○ Had an adequate trial of other osteoporosis therapies and had an insufficient response (fracture and/or loss of bone mineral density in spite of adherence to therapy); **AND**
		• Total lifetime length of therapy with PTH analogs has not exceeded 2 years
		Renewal Criteria:
		• The prescriber attests that the patient remains at, or has returned to, having a high risk for fracture despite 24 months of cumulative use of parathyroid hormone analogs; **AND**
		• The prescriber attests that the risk versus benefit of use greater than 24 months of cumulative use of parathyroid hormone analogs has been reviewed with the patient
			1/28 days	General PA Form

Bone: SERMs				
raloxifene	P		1/day	General PA Form
Evista®	NP		1/day	
Contraceptives, Non-Oral				
Depo IM Provera ®	P		1 vial/ 90 days	General PA Form
Depo SubQ Provera®	P		1 vial/ 90 days	
medroxyprogesterone acetate injection	P		1 vial/ 90 days	
Nuvaring®	P		1/28 days	
Xulane®	P		3/28 days	
Annovera®	NP	• Patient has tried and failed or had a contraindication to two preferred non-oral contraceptives; **AND** • Clinically valid reason as to why preferred Nuvaring cannot be used	1/year	
Eluryng®	NP		1/28 days	
Etonogestrel-ethinyl estradiol vaginal ring	NP		1/28 days	General PA Form
Haloette®	NP		1/28 days	

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Phexxi®	NP	• One of the following: ○ Patient has tried and failed or had a contraindication to two preferred non-oral contraceptives; **OR** ○ Patient has a contraindication or has experienced a clinically significant adverse event to hormonal agents; **AND** • Provider attests that patient has been counseled regarding the higher rate of pregnancy prevention with the use of other contraception methods (e.g., injection, oral contraception, transdermal patch, vaginal ring) compared to Phexxi	12/month	
Twirla ®	NP	• Trial and failure, or contraindication/intolerance of two preferred non-oral contraceptives **AND** • Avoid concomitant use of hepatitis C drug combinations containing ombitasvir/paritaprevir/ritonavir, with or without dasabuvir	3/28 days	
Zafemy®	NP		3/28 days	
Contraceptives, Oral				
Various	P		1/day	General PA Form
Emergency contraceptives	P		1/21 days	
Various	NP		1/day	
Corticosteroids, Oral				
Alkindi Sprinkles®	NP	• Diagnosis of adrenocortical insufficiency; **AND** • Patient is 18 years of age or younger	0.5 mg, 1 mg, 2 mg: 3/day 5 mg: 4/day	General PA Form
Eohilia®	NP	**Criteria: (3-month duration)** • Patient is 11 years of age or older; **AND** • Diagnosis of Eosinophilic esophagitis (EoE); **AND** • Prescribed by, or in consultation with, a gastroenterologist, allergist, or immunologist; **AND** • Prescriber attest patient meets both of the following: ○ Esophageal biopsy consists of ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) following treatment course of a proton pump inhibitor; **AND** ○ Patient has symptoms of esophageal dysfunction (e.g., feeding difficulties, vomiting, pain, dysphagia); **AND** • Trial and failure, or contraindication, to swallowed inhaled corticosteroids such as budesonide or fluticasone	180 packs / 365 days	General PA Form
Hemady®	NP	• Patient must be 18 years of age or older; **AND** • Patient must have a diagnosis of Multiple Myeloma; **AND** • Must be used in combination with other anti-myeloma agents; **AND** • Patient does not have systemic fungal infection	2/day	General PA Form
prednisolone ODT	NP	• Unable to swallow, **OR** • Unable to absorb medications through the GI tract		General PA

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Rayos®	NP		1 mg: 3/day 2 mg: 2/day 5 mg: 12/day	Form
Diabetes: Alpha-Glucosidase Inhibitors				
miglitol	NP	• Trial and failure, contraindication, or intolerance of the preferred		
Diabetes: Amylin Analogs				
Symlin Pen®	NP	• Diagnosis of Type 1 or 2 diabetes; **AND** • On insulin therapy; **AND** • Failure to achieve adequate glycemic control (HbA1c ≤ 6.5%); **AND** • Patients meeting any of the following will NOT be approved: ○ Recurrent, severe hypoglycemia requiring assistance during the past 6-months ○ Confirmed diagnosis of gastroparesis ○ Requiring the use of drugs that stimulate gastrointestinal motility		General PA Form
Diabetes: Biguanides				
metformin	P		500 mg: 4/day 850 & 1000 mg: 2/day	General PA Form
metformin ER	P		500 mg: 1/day 1000 mg: 2/day	
metformin ER osmotic	P		500 mg: 1/day 1000 mg: 2/day	
metformin ER modified release	NP		500 mg: 1/day 1000 mg: 2/day	
metformin solution	NP	• Patient is ≤ 11 years of age; **OR** • Patient is unable to swallow sold dosage forms	20 mL/day	
Riomet®	NP	See prior authorization criteria for metformin solution	20 mL/day	
Diabetes: DPP-4 Inhibitors and Combinations				
Janumet®	P		2/day	DPP-4 PA Form
Janumet XR®	P		50/500 mg, 100/1000 mg: 1/day; 50/1000 mg: 2/day	
Januvia®	P		1/day	
Jentadueto®	P		2/day	

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Jentadueto® XR	P		2.5/1000 mg: 2/day; 5/1000 mg: 1/day	DPP-4 PA Form
saxagliptin	P		1/day	
Tradjenta®	P		1/day	
alogliptin	NP		1/day	
alogliptin/metformin	NP		2/day	DPP-4 PA Form
alogliptin/ pioglitazone	NP	• Clinically valid reason why a DPP-4 inhibitor and pioglitazone cannot be taken separately	1/day	
saxagliptin/ metformin	NP		2/day	
sitagliptin	NP		1/day	DPP-4 PA Form
sitagliptin/metformin	NP	• Clinically valid reason why Janumet or Janumet XR cannot be used	2/day	
Zituvimet®	NP	• Clinically valid reason why Janumet or Janumet XR cannot be used	50/500 mg, 100/1000 mg: 1/day; 50/1000 mg: 2/day	DPP-4 PA Form
Zituvimet XR®	NP	• Clinically valid reason why Janumet or Janumet XR cannot be used	2/day	
Zituvio®	NP	• Clinically valid reason why Januvia® cannot be used	1/day	
Diabetes: Glucagon Agents				
Baqsimi®	P		2/Rx	General PA Form
Gvoke	P		2/Rx	
Zegalogue®	NP		2/Rx	
Diabetes: Meglitinides				
nateglinide	P		3/day	General PA Form
repaglinide	P		0.5mg, 1mg: 4/day 2 mg: 8 day	
Diabetes: SGLT2 Inhibitors and Combinations				
Farxiga®	P		1/day	General PA Form
Glyxambi®	P		1/day	
Invokana®	P		1/day	
Invokamet®	P		2/day	

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Jardiance®	P		1/day	
Synjardy®	P		2/day	
Synjardy XR®	P		1/day (25/1000 mg); 2/day (all other strengths)	
Xigduo® XR	P		1/day	
dapagliflozin	NP	• Clinically valid reason why the preferred Farxiga® cannot be used	1/day	
dapagliflozin/ metformin ER	NP	• Clinically valid reason why the preferred Xigduo XR ® cannot be used	1/day	
Inpefa®	NP	• Trial and failure of TWO preferred combination SGLT2/metformin ER agents (Synjardy XR, Xigduo XR)	1/day	
Invokamet XR®	NP	• Trial and failure or intolerance of TWO preferred combination SGLT2/metformin ER agents (Synjardy XR, Xigduo XR)	2/day	General PA Form
Qtern®	NP	• Trial and failure of separate components (Farxiga and Onglyza)	1/day	
Steglatro®	NP	• Trial and failure or intolerance to TWO preferred single-entity SGLT2 agents (Farxiga, Invokana, Jardiance)	2/day (5 mg); 1/day (15 mg)	
Segluromet®	NP	• Trial and failure of TWO preferred combination SGLT2/metformin immediate release agents (Invokamet, Synjardy)	2/day	
Steglujan®	NP	• Clinically valid reason why a preferred single-entity SGLT2 agent and DPP-4 inhibitor cannot be used as separate agents	1/day	
Trijardy XR®	NP	• Clinically valid reason as to why patient cannot use the patient cannot use Glyxambi and metformin ER as separate agents	10/5/1000 mg, 2.5/5/1000 mg: 1/day; 5/2.5/1000 mg, 12.5/2.5/1000 mg: 2/day	
Diabetes: Thiazolidinediones (TZDs) and Combinations				
pioglitazone	P		1/day	TZD and Combos PA Form
pioglitazone/ metformin	P		3/day	
Actos®	NP		1/day	
ActoPlus Met®	NP		2/day	
Duetact®	NP	• Clinically valid reason why the patient cannot use pioglitazone and glimepiride as separate agents	1/day	
pioglitazone/ glimepiride	NP	• Clinically valid reason why the patient cannot use pioglitazone and glimepiride as separate agents	1/day	

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Estrogens, Transdermal				
estradiol biweekly patch	P		8/28 days	General PA Form
estradiol weekly patch	P		4/28 days	
Dotti®	P		4/28 days	
Lyllana®	P		4/28 days	
Alora®	NP		8/28 days	General PA Form
Climara®	NP		4/28 days	
Divigel®	NP		1/day	
Elestrin®	NP		1/28 days	
estradiol gel	NP		1/day	General PA Form
Menostar®	NP		4/28 days	
Minivelle®	NP		8/28 days	
Vivelle-Dot®	NP		8/28 days	
Estrogens, Vaginal				
Premarin® cream	P		2 grams/day	General PA Form
Estrace®	NP		42.5 g/Rx	
estradiol cream	NP		42.5 g/Rx	
Estrogen/Progestin, Oral				
Premphase®	P		1/day	General PA Form
Prempro®	P		1/day	
Estrogen/Progestin, Transdermal				
CombiPatch®	P		8/28 days	General PA Form
Climara Pro®	NP		4/28 days	
Estrogen/SERM				
Duavee®	NP	• Patient has an intact uterus with a diagnosis of moderate to severe vasomotor symptoms associated with menopause; **OR** • Patient has an intact uterus with a diagnosis of post-menopausal osteoporosis	1/day	General PA Form

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
GLP-1 Agonists				

Ozempic®	P	**Diabetes Type 2**
		Initial Criteria:
		• Submission of medical records (e.g. chart notes) confirming diagnosis of type 2 diabetes as evidenced by ONE of the following laboratory values:
		  ○ A1C greater than or equal to 6.5%*
		  ○ Fasting plasma glucose (FPG) greater than or equal to 126 mg/dL
		  ○ 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test
		  ○ Random plasma glucose greater than or equal to 200 mg/dL in patient with classic symptoms of hyperglycemia or hyperglycemic crisis; **AND**
		• Will not be used concomitantly with DPP-4 inhibitors; **AND**
		• Will not be co-administered with another GLP-1 receptor agonists; **AND**
		• Patients does not have personal or immediate family history of medullary thyroid carcinoma or multiple endocrine neoplasia type 2 (MEN2)
		Renewal Criteria:
		• Submission of recent medical records (e.g., chart notes and/or labs) documenting a positive clinical response to therapy (e.g. reduction in HbA1C, HbA1C goal achieved, improvement in fast blood glucose levels, improvement in ASCVD); **AND**
		• Will not be used concomitantly with DPP-4 inhibitors; **AND**
		• Will not be co-administered with another GLP-1 receptor agonists; **AND**
		* **Note**: A1C level can be from early stages in treatment. If original HbA1c is unknown, or current HbA1c is controlled due to another current diabetic regimen, please include current regimen and current A1C.
		Noncirrhotic nonalcoholic steatohepatitis (NASH) or Metabolic dysfunction associated steatohepatitis (MASH)
		Initial Criteria:
		• Diagnosis of NASH or MASH; **AND**
		• Submission of medical records (e.g. chart notes) confirming disease is fibrosis stage F2 or F3 as confirmed by ONE of the following:
		  ○ FibroScan
		  ○ Fibrosis-4 index (FIB-4)
		  ○ Magnetic Resonance Elastography (MRE)
		  ○ Liver Biopsy; **AND**
		• Prescriber attests patient is participating in a supervised comprehensive weight management program that encourages behavioral modification, reduced calorie diet, and increased physical activity; **AND**
		• Prescribed by or in consultation with a gastroenterologist or hepatologist; **AND**
		• Will not be used concomitantly with DPP-4 inhibitors; **AND**
		• Will not be co-administered with another GLP-1 receptor agonists; **AND**
		• Patients does not have personal or immediate family history of medullary thyroid carcinoma or multiple endocrine neoplasia type 2 (MEN2)
		Renewal Criteria:
		• Submission of recent medical records (e.g., chart notes and/or labs) documenting a positive clinical response to therapy (e.g. NASH/MASH disease symptoms)
			5 mcg:
			1.2 mL/ 30 days
			
			10 mcg: 2.4 mL/30 days
				GLP-1 Agonist PA Form

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Victoza®	P	See Ozempic® prior authorization criteria		
Rybelsus®	NP	See Ozempic® prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance to 2 preferred agents	1/day	GLP-1 Agonist PA Form
Soliqua®	NP	See Ozempic® prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance to 2 preferred agents; **AND** • Patient is currently taking, but inadequately controlled on, a long-acting insulin documented per TennCare paid claims	5 pens/30 days	
Trulicity®	NP	See Ozempic® prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance to 2 preferred d agents	2 mL/28 days	
Mounjaro®	NP	See Ozempic® prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance to 2 preferred agents	2 mL/28 days	

Wegovy®	NP	**CV Risk Reduction due to prior MI, prior stroke, or PAD**
		Initial Criteria
		• Treatment is being requested to reduce the risk of major adverse cardiovascular events; **AND**
		• Patient is 18 years of age or older; **AND**
		• Submitted medical documentation (e.g. chart notes) of initial BMI ≥ 27 kg/m^2; **AND**
		• Submitted medical documentation (e.g. chart notes) of ONE of the following:
		  ○ Prior myocardial infarction
		  ○ Prior stroke (ischemic and hemorrhagic stroke)
		  ○ Symptomatic peripheral arterial disease as evidenced by intermittent claudication with ankle–brachial index < 0.85, peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease; **AND**
		• Patient is on optimized guideline-directed therapy including beta-blockers, RAS inhibitors, and lipid lowering agents to ensure reduced cardiovascular risk unless contraindicated (supported by medical documentation or claims history); **AND**
		• Prescriber attests patient is participating in a supervised comprehensive weight management program that encourages behavioral modification, reduced calorie diet, and increased physical activity; **AND**
		• Will not be used concomitantly with DPP-4 inhibitors; **AND**
		• Will not be co-administered with another GLP-1 receptor agonists
		Renewal Criteria
		• Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g., patient has not had a major cardiovascular event within the past 12 months, decreased body weight or waist circumference from baseline, decrease blood pressure, total cholesterol, LDL, or triglyceride levels from baseline); **AND**
		• Patient is participating in a supervised comprehensive weight management program that encourages behavioral modification, reduced calorie diet, and increased physical activity; AND
		• Will not be used concomitantly with DPP-4 inhibitors; **AND**
		• Will not being co-administered with another GLP-1 receptor agonists (e.g. Byetta, Ozempic, Victoza); **AND**
		• Patient is on optimized guideline-directed therapy including beta-blockers, RAS inhibitors, and lipid lowering agents to ensure reduced cardiovascular risk unless contraindicated (supported by medical documentation or claims history)
			4 injectors/28 days	GLP-1 Agonist PA Form

Xultophy®	NP	See Ozempic® prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance to 2 preferred agents; **AND** • Patient is currently taking, but inadequately controlled on, a long-acting insulin documented per TennCare paid claims	5 pens/30 days	

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Zepbound®	NP	**Obstructive Sleep Apnea**
		Initial Criteria: (6 months)
		• Patient is 18 years of age or older; **AND**
		• Diagnosis of moderate to severe Obstructive Sleep Apnea (OSA); **AND**
		• Hypersomnolence secondary to another sleep disorder, neurologic disorder, medical condition, or by medicine or substance use has been ruled out; **AND**
		• Submission of medical records (e.g. chart notes) documenting BOTH of the following:
		  ○ Initial BMI ≥ 30 kg/m^2; **AND**
		  ○ ≥ 15 respiratory events per hour of sleep confirmed by sleep study; **AND**
		• Patient is participating in a supervised comprehensive weight management program that encourages behavioral modification, reduced calorie diet, and increased physical activity; **AND**
		• Trial and failure (minimum duration 3 months with documented compliance) of Continuous Positive Airway Pressure (CPAP) or BiPAP device, unless contraindicated; **AND**
		• Will not be used concomitantly with DPP-4 inhibitors; **AND**
		• Will not being co-administered with another GLP-1 receptor agonists; **AND**
		• Patients does not have personal or immediate family history of medullary thyroid carcinoma or multiple endocrine neoplasia type 2 (MEN2)
		Renewal Criteria:
		• Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g., decrease number of apneas and hypopneas during sleep from baseline); **AND**
		• Patient is participating in a supervised comprehensive weight management program that encourages behavioral modification, reduced calorie diet, and increased physical activity; **AND**
		• Will not be used concomitantly with DPP-4 inhibitors; **AND**
		• Will not being co-administered with another GLP-1 receptor agonists
			4 injectors/28 days	GLP-1 Agonist PA Form

GnRH Agonists / LHRH Analogs				
leuprolide	P	• Diagnosis of prostate cancer in male patient; **OR** • Diagnosis of central precocious puberty in children (onset of secondary sexual development before 8 [girls] or 9 years of age [boys])		
Fensolvi®	NP	See leuprolide prior authorization criteria		
Lupron Ped-Depot®	NP	• Diagnosis of central precocious puberty in children (onset of secondary sexual development before 8 years of age [girls] or 9 years of age [boys])		

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Growth Hormone Agents				
Genotropin®	P	**NOTE**: **Growth hormone therapy will NOT be approved for idiopathic short stature (ISS)** **Criteria:** • Agent is prescribed by, or in consultation with, an endocrinologist; **AND** • Daily dose within approved dosage range for somatotropin for requested indication per clinical compendium; **AND** • Daily dose based on weight of the enrollee, supported by submitted growth charts; **AND** • Approval will be based on dosage form resulting in least wastage of product • ONE of the following: ○ Diagnosis of growth hormone (GH) deficiency in a child or adolescent confirmed by ONE of the following: – Lab results of TWO GH stimulation tests are both below the age adjusted normal range (< 10 mcg/mL); **OR** – Lab results to ONE GH stimulation test are the age adjusted below normal range (< 10 mcg/mL) and IGF-1 or IGFBP-3 levels are below the age and gender adjusted normal range; **OR** ○ Diagnosis of adult growth hormone deficiency; **AND** – Patient had a diagnosis of childhood-onset GHD; **AND** – Lab results to ONE GH stimulation test are below the age adjusted normal range; **OR** ○ Diagnosis of GH deficiency due to hypothalamic-pituitary disease or a known structural, genetic, or traumatic cause (e.g., pituitary tumor, pituitary surgical damage, head trauma, cranial irradiation) and ONE of the following: – Lab results to ONE GH stimulation test are below the age adjusted normal range – IGF-1 levels are below the age adjusted normal range normal for patient's age – The patient has deficiencies in 3 or more pituitary axes; **OR** ○ Patient is a newborn infant and has evidence of hypoglycemia AND either a low GH level (<20 ng/mL) or a low for age IGF-1/IGFBP-3 level; **OR** ○ Diagnosis of Small for Gestational Age (SGA) or fetal growth restriction (FGR) and patient is > 2 years old with a height at least 2 standard deviations below the population mean for age; **OR** ○ Diagnosis of short stature associated with Turner Syndrome or Noonan Syndrome; **OR** ○ Diagnosis of short stature associated with short stature homeobox (SHOX) gene deficiency; **OR** ○ Diagnosis of Prader-Willi Syndrome; **OR** ○ Patient has chronic kidney disease (CKD)		Growth Hormone PA Form
Egrifta SV®	NP	• Recipient must be at least 18 years of age, but less than 21 years old; **AND** • Diagnosis of Acquired Immunodeficiency Syndrome (AIDs) or Human Immunodeficiency Virus (HIV); **AND** • Prescribed by, or in consultation with, an endocrinologist or provider with expertise in HIV; **AND** • Waist circumference greater than or equal to 95 cm for males, or greater than or equal to 94 cm for females; **AND** • Waist to hip ratio greater than or equal to 0.94 for males, or greater than or equal to 0.88 for females **Note**: For recipients ≥ 21 years of age, these agents are a non-covered benefit		Growth Hormone PA Form
Humatrope®	NP	See Genotropin® prior authorization criteria		Growth Hormone PA Form
Norditropin®	NP	See Genotropin® prior authorization criteria		
Nutropin AQ®	NP	See Genotropin® prior authorization criteria		

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Ngenla®	NP	**Initial Criteria:**
		• Patient meets the minimum age requirement per label and is less than 18 years of age; **AND**
		• Patient weighs at least 11.5kg; **AND**
		• Agent is prescribed by, or in consultation with, an endocrinologist; **AND**
		• Diagnosis of growth failure due to growth hormone deficiency has been confirmed by ONE of the following:
		  ○ Lab results of TWO GH stimulation tests are both below the age adjusted normal range (< 10 mcg/mL); **OR**
		  ○ Lab results to ONE GH stimulation test are the age adjusted below normal range (< 10 mcg/mL) and IGF-1 or IGFBP-3 levels are below the age and gender adjusted normal range; **OR**
		• Epiphyses has not closed; **AND**
		• Clinically valid reason why preferred Genotropin cannot be used
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• Prescriber attests that patient has had a height increase of at least 2.5 cm/year over the previous year
				Growth Hormone PA Form

Omnitrope®	NP	See Genotropin® prior authorization criteria		

Serostim®	NP	**Initial Criteria:**
		• Diagnosis of HIV-associated wasting syndrome or cachexia; **AND**
		• One of the following:
		  ○ Unintentional weight loss of >10% over the last 12 months
		  ○ Unintentional weight loss of > 7.5% over the last 6-months
		  ○ Loss of 5% body cell mass (BCM) within 6-months
		  ○ Body mass index (BMI) < 20 kg/m2; AND
		  ○ Body cell mass (BCM) below 40% total body weight in males or 35% total body weight in females; **AND**
		• Nutritional evaluation since onset of wasting first occurred; **AND**
		• Patient has not had weight loss due to other underlying treatable conditions (e.g., depression, mycobacterium avium complex, chronic infectious diarrhea, malignancy); AND
		• Anti-retroviral therapy has been optimized to decrease the viral load and will be continued throughout the course of treatment; **AND**
		• Trial and failure of megestrol
		Renewal Criteria:
		• Evidence of positive response to therapy (i.e., > 2% increase in body weight and/or BCM); **AND**
		• A target goal has not been achieved (i.e., weight, BCM, BMI)
				Growth Hormone PA Form

Skytrofa®	NP	See Ngenla® prior authorization criteria		

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Sogroya®	NP	• Clinically valid reason as to why the patient cannot take the preferred Genotropin; **AND**
		• Daily dose based on weight of the enrollee, supported by submitted growth charts; **AND**
		• Prescribed by, or in consultation with, an endocrinologist; **AND**
		• One of the following:
		  ○ Diagnosis of growth failure due to growth hormone (GH) deficiency confirmed by ONE of the following:
		  – Lab results of 2 GH stimulation tests are below the age adjusted normal range (< 10 mcg/mL); **OR**
		  – Lab results to ONE GH stimulation test are below the age adjusted norma (< 10 mcg/mL) and IGF-1 or IGFBP-3 levels are below the age and gender adjusted normal range; **OR**
		  ○ Diagnosis of adult growth hormone deficiency; **AND**
		  – Submission of clinical records supporting a diagnosis of childhood-onset GHD; **AND**
		  – Lab results to ONE GH stimulation test are below the age adjusted normal range; **OR**
		  ○ Diagnosis of hormone deficiency due to hypothalamic-pituitary disease or structural damage (e.g., pituitary tumor, pituitary surgical damage, cranial irradiation, head trauma, subarachnoid hemorrhage) and ONE of the following:
		  – Lab results of ONE GH stimulation test are both below the age adjusted normal range
		  – Growth hormone levels of a GH stimulation test are below the age adjusted normal range
		  – IGF-1 level is below the age adjusted normal range
		  – The patient has deficiencies in 3 or more pituitary axes		

Voxzogo®	NP	**Initial Criteria:** • Diagnosis of achondroplasia; **AND** • Prescribed by, or in consultation with, an endocrinologist; **AND** • Patient has open epiphyses; **AND** • Patient will not have limb-lengthening surgery during treatment with Voxzogo®; **AND** • Provider attests that patient/caregiver has been properly trained on preparation and administration of Voxzogo **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Provider attests that patient has an annualized growth velocity ≥ 1.5 cm/year		General PA Form
Zomacton®	NP	See Genotropin® prior authorization criteria		

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Hematopoietic Agents				
Retacrit®	P	• Documentation that the patient has been assessed for iron deficiency and has adequate iron stores (defined as TSAT ≥ 20% or serum ferritin ≥ 100 mcg/L within the prior 3 months) or is receiving iron therapy before starting erythropoiesis stimulating agent; **AND** • Other causes of anemia (e.g., hemolysis, bleeding, vitamin deficiency) have been ruled out; **AND** • One of the following: • Anemia secondary to myelosuppressive chemotherapy; **AND** ○ Patient is at least 5 years of age and receiving concurrent myelosuppressive chemotherapy; **AND** ○ Upon initiation, there is at least 2 additional months of planned chemotherapy; **AND** ○ Hemoglobin ≤ 10 g/dL; **OR** • Anemia secondary to zidovudine treatment in HIV-infected patient; **AND** ○ Zidovudine dose is ≤ 4,200 mg/week; **AND** ○ *S*erum erythropoietin (EPO) levels ≤ 500 mU/mL; **AND** ○ ONE of the following: – For initial therapy, hemoglobin ≤ 10 g/dL; **OR** – For continuation of therapy, hemoglobin ≤ 12 g/dL; **OR** • Anemia secondary to hepatitis C virus (HCV) in patients receiving ribavirin and interferon-alfa therapy; **AND** ○ For initial therapy, hemoglobin ≤ 10 g/dL; **OR** ○ For continuation of therapy, hemoglobin ≤ 12 g/dL; **OR** • Anemia secondary to myelodysplastic syndrome (MDS), myeloproliferative neoplasms (MPN) – Myelofibrosis, or multiple myeloma; **AND** ○ *S*erum erythropoietin (EPO) levels ≤ 500 mU/mL; **AND** ○ ONE of the following: – For initial therapy, hemoglobin ≤ 10 g/dL; **OR** – For continuation of therapy, hemoglobin ≤ 12 g/dL; **OR** • Anemia of prematurity, in combination with iron supplementation; **OR** • Anemia secondary to rheumatoid arthritis; **OR** • Anemia secondary to chronic kidney disease (CKD); **AND** ○ For initial therapy, hemoglobin ≤ 10 g/dL; **OR** ○ For continuation of therapy, hemoglobin ≤ 12 g/dL; **OR** • Reduction of allogeneic blood transfusions in elective noncardiac, nonvascular surgery; **AND** ○ Patient is NOT willing to donate autologous blood pre-operatively ○ Hemoglobin is > 10 g/dL and ≤ 13 g/dL		General PA Form
Aranesp®	NP	See Retacrit ® prior authorization criteria		General PA Form
Epogen®	NP	See Retacrit ® prior authorization criteria		

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Mircera®	NP	• Documentation that the patient has been assessed for iron deficiency and has adequate iron stores (defined as TSAT > 20% or serum ferritin ≥ 100mcg/L within the prior 3 months) or is receiving iron therapy before starting erythropoiesis stimulating agent; **AND** • Other causes of anemia (e.g., hemolysis, bleeding, vitamin deficiency, etc.) have been ruled out; **AND** • Diagnosis of anemia secondary to chronic kidney disease (CKD) and ONE of the following: ○ Patient is 18 years of age or older; **AND** – For initial therapy, hemoglobin is < 10 g/dL; **OR** – For continuation of therapy, hemoglobin ≤ 12 g/dL; **OR** ○ Patient is between 3 months and 17 years of age; **AND** – Patient's hemoglobin stabilized following administration of another erythropoietin stimulating agent (ESA)		General PA Form
Procrit®	NP	See Retacrit ® prior authorization criteria		
Vafseo®	NP	• Documentation that the patient has been assessed for iron deficiency and has adequate iron stores (defined as TSAT > 20% or serum ferritin ≥ 100mcg/L within the prior 3 months) or is receiving iron therapy before starting erythropoiesis stimulating agent; **AND** • Diagnosis of anemia due to chronic kidney disease (CKD); **AND** • Patient has been receiving dialysis for ≥ 3 months; **AND** • Hemoglobin level <10 g/dL • Clinically valid reason why erythropoiesis stimulating agents (ESAs) cannot be used	100mg, 450mg: 1/day 300mg: 2/day	General PA Form
Hyperparathyroid Agents				
cinacalcet	P	• Secondary Hyperparathyroidism due to Chronic Kidney Disease (CKD), AND patient must be on dialysis; **OR** • Parathyroid Carcinoma resulting in hypercalcemia; **OR** • Severe Hypercalcemia in patients with primary HPT who are unable to undergo parathyroidectomy		General PA Form
doxercalciferol capsules	NP	• Recipients experiencing (or with a history of) hypercalcemia and/or hyperphosphatemia with calcitriol use; **AND** • Trial and failure, contraindication, or intolerance to cinacalcet	0.5, 2.5 mcg: 1/day; 1 mcg: 3/day	
paricalcitol capsules	NP	See doxercalciferol capsules prior authorization criteria	1/day	
Rayaldee®	NP	• Secondary Hyperparathyroidism due to Stage 3 or Stage 4 Chronic Kidney Disease (CKD); **AND** • Serum total 25-hydroxyvitamin D levels less than 30 ng/mL; **AND** • Trial and failure, contraindication, or intolerance of cinacalcet	2/day	
Sensipar®	NP	See cinacalcet prior authorization criteria; **AND** • Clinically valid reason why the preferred cinacalcet agent cannot be used		
Zemplar® capsules	NP	See doxercalciferol capsules prior authorization criteria	1/day	

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Insulin, Rapid-Acting				
Afrezza®	NP	• Patient is not a current smoker and does not have a history of smoking in the past 6-months; **AND** • Prescriber attests that baseline spirometry has been performed prior to therapy and will be performed after 6-months of therapy, and every year thereafter; **AND** • Patient does not have a history of chronic lung disease (e.g., asthma, COPD); **AND** • Patient has ONE of the following diagnoses: ○ Type 2 Diabetes ○ Type 1 Diabetes while concurrently taking a long-acting insulin; **AND** • One of the following: ○ Recipient or caregiver has problems with manual dexterity which may result in dosing errors (i.e., Parkinson's Disease, rheumatoid arthritis in the finger/hand joints, multiple sclerosis, lupus, osteoarthritis, stroke); **OR** Recipient or caregiver has poor eyesight such that dosing errors may occur	Cartridges: 4-unit: 3/day 8-unit: 6/day 12-unit:6/day Combo package: 1 box/month	General PA Form
Humalog U-200 KwikPen®	NP	Patient requires > 100 insulin units/day		General PA Form
Humalog TempoPen®		Clinically valid reason why a preferred insulin pen (e.g. KwikPen, FlexPen) cannot be used		
Lyumjev® KwikPen and vial	NP	• Trial and failure or intolerance of 2 preferred, rapid-acting insulin agents; **AND** Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents		
Lyumjev TempoPen®	NP	Clinically valid reason why a preferred insulin pen (e.g. KwikPen, FlexPen) cannot be used		
Insulin, Intermediate-Acting				
Humulin N KwikPen®	P	Prescriber must provide valid clinical rationale as to why patient is unable to utilize preferred Novolin N FlexPen®		General PA Form
Insulin, Long-Acting				
Basaglar KwikPen®	NP	Contraindication or intolerance to a preferred insulin glargine pen that is not expected with the requested agent		General PA Form
Basaglar Tempo Pen®	NP	Clinically valid reason why a preferred insulin pen cannot be used (e.g. Solostar)		
insulin degludec FlexTouch	NP			
Rezvoglar®	NP	Contraindication or intolerance to a preferred insulin glargine pen that is not expected with the requested agent		General PA Form
Semglee®	NP	Contraindication or intolerance to a preferred insulin glargine pen that is not expected with the requested agent		
Tresiba FlexTouch®	NP			

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
NK3 Antagonists				
Veozah®	NP	• Diagnosis of moderate to severe vasomotor symptoms due to menopause; **AND** • Trial and failure, contraindication, or intolerance to TWO of the following: ○ Gabapentin ○ Menopausal hormone therapy (e.g., estrogen monotherapy or estrogen + progesterone) ○ Oxybutynin ○ SSRI (e.g., paroxetine, escitalopram, citalopram) ○ SNRI (e.g., venlafaxine and desvenlafaxine)	1/day	General PA Form
Progestins, Oral				
megestrol suspension	P		40mg: 20 mL/day 625 mg: 5 mL/day	General PA Form
norethindrone acetate	P	Diagnosis of endometriosis		
Uterine Disorder GnRH Modulators				
Myfembree®	P	**Initial Criteria:** • Patient age is ≥ 18 years; **AND** • One of the following: ○ Diagnosis of heavy menstrual bleeding associated with uterine leiomyomas/fibroids; **AND** – Trial and failure of one of the following: • Estrogen/progestin contraceptive (including tablets, vaginal ring, or patch) • Progestin-only contraceptive (including tablets, IM injection, IUD); **OR** ○ Diagnosis of moderate to severe pain associated with endometriosis; **AND** – Trial and failure, or contraindication, to an analgesic (e.g., ibuprofen, meloxicam, naproxen); **OR** – Trial and failure of one of the following: • Estrogen/progestin contraceptive (including tablets, vaginal ring, or patch) • Progestin-only contraceptive (including tablets, IM injection, IUD); **AND** • Patient must be premenopausal; **AND** • Prescribed by, or in consultation with, an OB/GYN or reproductive specialist; **AND** • Total treatment duration should not exceed 24 months due to risk of continued bone loss **Renewal Criteria:** • Patient has positive response to therapy (e.g., reduction in pain and discomfort from baseline, sustained reduction in menstrual blood loss per cycle); **AND** Total treatment duration should not exceed 24 months	1/day	General PA Form
Oriahnn®	P	See Myfembree® prior authorization criteria	1 box/28 days	

ENDOCRINE/METABOLIC AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Orilissa®	P	**Initial Criteria:**
		• Patient age is ≥ 18 years; **AND**
		• Diagnosis of moderate to severe pain associated with endometriosis; **AND**
		  ○ Trial and failure, or contraindication, to an analgesic (e.g., ibuprofen, meloxicam, naproxen); **OR**
		  ○ Trial and failure of one of the following:
		  – Estrogen/progestin contraceptive (including tablets, vaginal ring, or patch)
		  – Progestin-only contraceptive (including tablets, IM injection, IUD); **AND**
		• Patient must be premenopausal; **AND**
		• Prescribed by, or in consultation with, an OB/GYN or reproductive specialist; **AND**
		• Total treatment duration should not exceed 24 months due to risk of continued bone loss
		Renewal Criteria (only for 150 mg strength):
		• Positive response to therapy (e.g., reduction in pain and discomfort from baseline); **AND**
		Total treatment duration should not exceed 24 months
			1/day: 150 mg;
			2/day: 200 mg
				General PA Form

Vasopressor Antagonists				
Jynarque®	NP	**Initial Criteria (6-month duration):** • Patient has a diagnosis of autosomal dominant polycystic kidney disease (ADPKD); **AND** • Patient is 18 years of age or older; **AND** • Prescribed by, or in consultation with, a nephrologist; **AND** • Prescriber and patient are enrolled in the Jynarque REMS program		General PA Form
Jynarque Pak®	NP	See Jynarque® prior authorization criteria		
Samsca®	NP	• Diagnosis of hyponatremia; **AND** • Medication was initiated in a hospital setting		
tolvaptan	NP	See Samsca® prior authorization criteria		

GASTROINTESTINAL *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
5-ASA Derivatives, Oral				
Apriso®	P		4/day	General PA Form
Delzicol®	P		6/day	
sulfasalazine	P		8/day	
sulfasalazine EC	P		8/day	
Azulfidine®	NP		8/day	
Azulfidine® EN	NP		8/day	
balsalazide	NP		9/day	
Colazal®	NP		9/day	
Dipentum®	NP		4/day	
Lialda®	NP		4/day	
mesalamine DR caps	NP		6/day	
mesalamine DR tabs	NP		800 mg: 6/day 1.2 gm: 4/day	
mesalamine ER 24 Hour caps	NP		4/day	
mesalamine ER caps			500 mg: 8/day	
Pentasa®	NP		250 mg: 16/day; 500 mg: 8/day	
Agents for Chronic Constipation				
Linzess®	P		1/day	General PA Form
lubiprostone	P		2/day	

Movantik®	P	• Age ≥ 18 years; **AND**
		• One of the following:
		  ○ Diagnosis of opioid-induced constipation with chronic non-cancer pain
		  ○ Diagnosis of opioid-induced constipation with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation; **AND**
		• Submission of medical records (e.g., chart notes, control substance monitoring data base) or confirmed pharmacy claims documenting at ≥1 of opioid therapy within the past 90 days; **AND**
		• Prescriber attests that Movantik® will be discontinued when opioid treatment is discontinued
			1/day	General PA Form

Amitiza®	NP		2/day	

GASTROINTESTINAL *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Motegrity®	NP	• Age ≥ 18 years; **AND** • Patient has diagnosis of chronic idiopathic constipation (CIC); **AND** • Patient does not have intestinal perforation or obstruction due to structural or functional disorder of the gut wall, obstructive ileus, or severe inflammatory conditions of the intestinal tract (e.g., Crohn's disease, ulcerative colitis); **AND** • Trial and failure of, or contraindication, or intolerance to lubiprostone AND Linzess®	1/day	General PA Form
prucalopride	NP	See Motegrity® prior authorization criteria; **AND** • Clinically valid why Motegrity® cannot be used		

Relistor® injectable	NP	• Age ≥ 18 years; **AND**
		• One of the following:
		  ○ Diagnosis of opioid-induced constipation with chronic non-cancer pain
		  ○ Diagnosis of opioid-induced constipation with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation
		  ○ Diagnosis of opioid-induced constipation with advanced illness or pain caused by active cancer who requires opioid dosage escalation for palliative care; **AND**
		• Submission of medical records (e.g., chart notes, control substance monitoring data base) or confirmed pharmacy claims documenting at >1 of opioid therapy within the past 90 days; **AND**
		• Prescriber attests that Relistor® will be discontinued when opioid treatment is discontinued
				General PA Form

Relistor® tablets	NP	• Age ≥ 18 years; **AND**
		• One of the following:
		  ○ Diagnosis of opioid-induced constipation with chronic non-cancer pain
		  ○ Diagnosis of opioid-induced constipation with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation; **AND**
		• Submission of medical records (e.g., chart notes, control substance monitoring data base) or confirmed pharmacy claims documenting at ≥1 of opioid therapy within the past 90 days; **AND**
		• Prescriber attests that the requested drug will be discontinued when opioid treatment is discontinued
		• Trial and failure of, or contraindication, or intolerance to Movantik®
			3/day	General PA Form

Symproic®	NP	See Relistor® tablets prior authorization criteria; **AND** Patient does not have known or suspected gastrointestinal obstruction	1/day	

Trulance®	NP	• Age ≥ 18 years; **AND**
		• Diagnosis of one of the following:
		  ○ Chronic idiopathic constipation (CIC)
		  ○ Irritable bowel syndrome with constipation (IBS-C); **AND**
		Patient does not have a known or suspected mechanical gastrointestinal obstruction; **AND**
		Trial and failure of, or contraindication, or intolerance to, lubiprostone OR Linzess®
			1/day	General PA Form

GASTROINTESTINAL *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Agents for Irritable Bowel Syndrome (IBS)				

alosetron	P	**Initial Criteria:**
		• Patient is female and ≥ 18 years of age; **AND**
		• Diagnosis of severe, diarrhea-predominant, irritable bowel syndrome (IBS); **AND**
		• Chronic IBS symptoms lasting 6-months or more; **AND**
		• Provider has ruled out anatomic or biochemical abnormalities of the GI tract; **AND**
		• Patient is not concomitantly using fluvoxamine; **AND**
		• Patient does not have a history of the following conditions:
		  ○ Chronic or severe constipation or sequalae from constipation
		  ○ Intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions
		  ○ Ischemic colitis, impaired intestinal circulation, thrombophlebitis, or hypercoagulable state
		  ○ Crohn's disease or ulcerative colitis
		  ○ Diverticulitis
		  ○ Severe hepatic impairment
		Renewal Criteria:
		• Patient continues to meet the initial criteria; **AND**
		• Patient has not experienced any treatment-restricting adverse effects (e.g., severe constipation); **AND**
		• Positive response to therapy (e.g., decrease stool frequency, frequent bowel urgency, and abdominal pain)
			2/day	General PA Form

Linzess®	P		1/day	
lubiprostone	P		2/day	
Amitiza®	NP		2/day	
Ibsrela®	NP	**Initial Criteria:** • Patient is ≥ 18 years of age; **AND** • Diagnosis of irritable bowel syndrome with constipation (IBS-C); **AND** • Patient does not have known or suspected mechanical gastrointestinal obstruction; **AND** • Trial and failure, contraindication, or intolerance to lubiprostone AND Linzess® **Renewal Criteria:** • Patient continues to meet the initial criteria; **AND** • Patient has not experienced any treatment-restricting adverse effects (e.g., severe diarrhea); **AND** • Positive response to therapy (e.g., decrease stool frequency, frequent bowel urgency, and abdominal pain)	2/day	
Lotronex®	NP	• Clinically valid reason why the preferred generic alosetron cannot be used	2/day	

GASTROINTESTINAL *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Viberzi®	NP	**Initial Criteria:**
		• Patient is ≥ 18 years of age; **AND**
		• Diagnosis of severe, diarrhea-predominant, irritable bowel syndrome (IBS); **AND**
		• Patient does not have history of the following:
		  ○ alcohol abuse/addiction or drink more than 3 alcoholic drinks per day
		  ○ pancreatitis or structural diseases of the pancreas
		  ○ severe hepatic impairment (Child Pugh Class-C)
		  ○ severe constipation
		  ○ absence of gallbladder
		  ○ biliary duct (gallbladder) obstruction or Sphincter of Oddi disease/dysfunction
		Renewal Criteria:
		• Patient continues to meet the initial criteria; **AND**
		• Patient has not experienced any treatment-restricting adverse effects (e.g., severe diarrhea); **AND**
		• Positive response to therapy (e.g., decrease stool frequency, frequent bowel urgency, and abdominal pain)
			2/day	

Xifaxan®	NP	• One of the following:
		  ○ Treatment of uncomplicated traveler's diarrhea (1-month approval duration); **AND**
		  – Request is for Rifaximin 200 mg tablets; **AND**
		  – Trial and failure, contraindication, intolerance, or resistance to a fluoroquinolone or azithromycin
		  ○ Treatment of diarrhea-predominant IBS (3-month approval duration)
		  ○ Documented use for reduction in risk of overt hepatic encephalopathy (12-month approval duration)
			3/day	

Antidiarrheals				
Mytesi®	NP	• Patient has non-infectious diarrhea of at least one month duration; **AND** • Patient has a diagnosis of HIV or AIDS; **AND** • Patiently is currently receiving anti-retroviral therapy		
Antiemetics: 5-HT3 Receptor Antagonists				
ondansetron tablets and ODT	P	**Note**: Prior authorization is not required for quantities up to 30 tablets per 90 days. For requests that exceed the quantity limit, one of the following must be met: • Receiving highly or moderately emetogenic chemotherapy • Receiving radiation therapy • Treatment is for post-operative nausea and vomiting (PONV) • Nausea or vomiting associated with pregnancy and trial and failure of TWO conventional antiemetics (i.e., metoclopramide, prochlorperazine, dexamethasone, Diclegis)	30/90 days	General PA Form

Anzemet®		• ONE of the following:
		  ○ Receiving highly or moderately emetogenic chemotherapy
		  ○ Receiving radiation therapy
		  ○ Treated for post-operative nausea and vomiting (PONV); **AND**
		• Trial and failure, contraindication, or intolerance to a preferred 5HT3 antagonist
			2/30	

granisetron	NP	See Anzemet® prior authorization criteria	Tabs: 60/30 days Inj: 2 mL/30 days	

GASTROINTESTINAL *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
ondansetron solution	NP	• Patient < 6 years of age; **OR** • The requested dose is not achievable with ondansetron ODT; **OR** • Allergy or intolerance to inactive ingredient in ODT tab (e.g., dye, filler, excipient)		
Sancuso®	NP	See Anzemet® prior authorization criteria	1/30 days	
Antiemetics: Anticholinergics				
promethazine	P	• Patients < 2 years of age; **AND** • Prescriber documents medical necessity; **AND** • Prescriber is aware of contraindication and agrees to accept risk **Note**: Prior authorization is not required for patients 2 years of age or older		Promethazine PA Form
Transderm-Scop®	P	• One of the following: ○ Recipient has tried and failed, or is intolerant to TWO of the following agents: meclizine, promethazine, dimenhydrinate, diphenhydramine or metoclopramide ○ Unable to take oral medications ○ Therapy is needed for an extended period of time where taking short acting agents would not be feasible ○ Has a tracheotomy or is ventilator dependent	10 patches/30 days	General PA Form
Phenergan®	NP	• One of the following: ○ Patient is ≥ 2 years of age, **AND** – Clinical reason as to why patient cannot use generic equivalent ○ Patients < 2 years of age; **AND** – Prescriber documents medical necessity; **AND** – Prescriber is aware of contraindication and agrees to accept risk; **AND** – Clinical reason as to why patient cannot use generic equivalent		Promethazine PA Form
promethazine suppositories	NP	See promethazine prior authorization criteria **Note**: Prior authorization is not required for patients 2 years of age or older		
scopolamine patches	NP	See Transderm-Scop® prior authorization criteria; **AND** • Clinically valid reason as to why preferred Transderm-Scop® cannot be used	10 patches/30 days	General PA Form
Antiemetics: Delta-9-THC Derivatives				
dronabinol	NP	• Request is for the treatment of severe nausea/vomiting associated with cancer chemotherapy for patients actively being treated for cancer; **AND** ○ Trial and failure, intolerance, intolerance, medical reason, or contraindication that prohibits taking Emend + 5HT3 receptor antagonist + corticosteroid; **OR** • Request is for the treatment of AIDS-related wasting**; AND** ○ Trial and failure, intolerance, or contraindication to megestrol acetate oral suspension		
Marinol®	NP	See dronabinol prior authorization criteria		
Syndros®	NP	See dronabinol prior authorization criteria; **AND** • Unable to swallow solid dosage forms		

GASTROINTESTINAL *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antiemetics: NK-1 Antagonists				
aprepitant	P	• Receiving a highly emetogenic chemotherapy regimen; **OR** • Receiving a moderately emetogenic chemotherapy regimen and has failed two other antiemetic regimens; **OR** • Treatment for PONV with trial and failure or contraindication to a 5HT3-receptor antagonist; **OR** • Refractory nausea that would require hospitalization	40 mg: 1/30 days 80 mg: 4/30 days 125 mg: 2/30 days	General PA Form
Akynzeo®	NP	• ONE of the following: ○ Receiving a highly emetogenic chemotherapy regimen ○ Receiving a moderately emetogenic chemotherapy regimen and has failed other previous antiemetic regimens; **AND** • Trial and failure, contraindication, or intolerance to aprepitant	2/30 days	
Emend®	NP	See aprepitant prior authorization criteria; **AND** • Clinically valid reason preferred aprepitant cannot be used	80 mg: 4/30 days Tri-Pack: 2 packs/30 days	
Antiemetics: Miscellaneous				
Diclegis®	P		4/day	General PA Form
Bonjesta®	NP	• Patient has a diagnosis of pregnancy-induced nausea or vomiting; **AND** • Patient has failed documented conservative measures (e.g., dietary changes, trigger avoidance); **AND** • Clinically valid reason as to why preferred Diclegis® cannot be used	2/day	
doxylamine/ pyridoxine	NP	• Clinically valid reason as to why preferred Diclegis® cannot be used	4/day	
Antispasmodics/Anticholinergics				
glycopyrrolate solution	P	• Patients unable to swallow tablets; **OR** • Patient is < 8 years of age		General PA Form
Cuvposa®	NP	• Patients unable to swallow tablets; **OR** • Patient is < 8 years of age		
Combination Products for *H. pylori*				
Pylera®	P	• Documentation of recent positive *H. pylori* test	1 box/Rx; 2 courses of therapy/year)	General PA Form
Talicia®	P	• Documentation of recent positive *H. pylori* test		
bismuth subcitrate/ metronidazole/ tetracycline	NP	• Documentation of recent positive *H. pylori* test; **AND** • Trial and failure, contraindication, or intolerance to a preferred combination agent	1 box/Rx; 2 courses of therapy/year)	
lansoprazole/amox/ clarithromycin	NP	• Documentation of recent positive *H. pylori* test; **AND** • Trial and failure, contraindication, or intolerance to a preferred combination agent		
Omeclamox-Pak®	NP	• Documentation of recent positive *H. pylori* test; **AND** • Trial and failure, contraindication, or intolerance to a preferred combination agent		

GASTROINTESTINAL *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Voquezna Dual Pak®	NP	• Documentation of recent positive H. pylori test; **AND** • Trial and failure, contraindication, or intolerance to a preferred combination agent	1 box/Rx; 2 courses of therapy/year)	General PA Form
Voquezna Triple Pak®	NP	• Documentation of recent positive H. pylori test; **AND** • Trial and failure, contraindication, or intolerance to a preferred combination agent	1 box/Rx; 2 courses of therapy/year)	General PA Form
Fecal Microbiota				

Vowst®	NP	**Criteria: (2-month duration)**
		• Patient is ≥ 18 years old; **AND**
		• Treatment is to prevent the recurrence of Clostridioides difficile infection (CDI); **AND**
		• Patient has had three or more episodes of CDI within the past year; **AND**
		• Submission of medical records (e.g. chart notes, lab test) of a positive C. difficile stool test with toxin A/B results within the previous 30 days; **AND**
		• Patient has completed a full treatment course with ONE of the following antibiotic therapies 2 to 4 days prior to initiating Vowst:
		  ○ Fidaxomicin
		  ○ Vancomycin; **AND**
		• Prescriber by or in consultation with an infectious disease specialist or gastroenterologist; **AND**
		• The agent will not to be used in combination with other products for prevention of CDI, such as Zinplava or Rebyota
			12 caps/year	General PA Form

Gallstone Solubilizing Agents				
ursodiol	P		200, 250, 300, & 400 mg: 3/day; 500 mg: 2/day:	General PA Form
Cholbam®	NP	• Diagnosis of Bile Acid Synthesis Disorders due to Single Enzyme Defects (SED); **OR** ○ Agent will be used as adjunctive treatment for manifestations of Peroxisomal Disorders (PDs); **AND** • Prescribed by a hepatologist or gastroenterologist		

Iqirvo®	NP	• Patient has a diagnosis of primary biliary cholangitis (PBC) **AND**
		• Prescribed by a hepatologist or gastroenterologist **AND**
		• ONE of the following:
		  ○ Both of the following:
		  – Will be taken in combination with ursodiol; **AND**
		  – Submitted lab documentation indicates the patient had an inadequate response (no reduction in ALP or total bilirubin after 1-year trial) to ursodiol; **OR**
		  ○ Patient has a contraindication, or intolerance to ursodiol
			1/day	

Livdelzi®	NP	See Iqirvo® prior authorization criteria		

GASTROINTESTINAL *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Ocaliva®	NP	See Iqirvo® prior authorization criteria	1/day	
Reltone®	NP		3/day	
Urso Forte®	NP		2/day	
Hepatotrophics				
Rezdiffra®	NP	**Initial Criteria** • Patient is 18 years of age or older; **AND** • Diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) or metabolic dysfunction associated steatohepatitis (MASH); **AND** • Submission of medical records (e.g. chart notes) confirming disease is fibrosis stage F2 or F3 as confirmed by ONE of the following: ○ FibroScan ○ Fibrosis-4 index (FIB-4) ○ Magnetic Resonance Elastography (MRE) ○ Liver Biopsy; **AND** • Prescriber attests patient is participating in a supervised comprehensive weight management program that encourages behavioral modification, reduced calorie diet, and increased physical activity; **AND** • Patient does not have decompensated cirrhosis (Child-Pugh Class B or C); **AND** • Prescribed by or in consultation with a gastroenterologist or hepatologist **Renewal Criteria** • Prescriber attest patient is participating in a supervised comprehensive weight management program that encourages behavioral modification, reduced calorie diet, and increased physical activity; **AND** • Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g. NASH resolution, fibrosis stage improvements)	1/day	General PA Form
Inflammatory Bowel Disease, Miscellaneous Agents				
budesonide foam	P		66.8 g/day	General PA Form
Uceris® tablet	P		1/day	
hydrocortisone AC suppository	P		12/30 days	
budesonide ER tabs	NP	• Trial and failure of preferred Uceris tablets	1/day	
Uceris® foam	NP		66.8 g/day	
Laxatives				
Sutab®	NP		24 tabs per colonoscopy	General PA Form

GASTROINTESTINAL *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Motility Agents				
metoclopramide	P		12-week duration limit	General PA Form
metoclopramide solution	P		12-week duration limit	
Gimoti®	NP	• Patient must have acute and recurrent diabetic gastroparesis; **AND** • Patient is ≥ 18 years of age; **AND** • Patient does not have a history of tardive dyskinesia (TD) or dystonic reaction to metoclopramide; **AND** • Clinically valid reason why metoclopramide tablets or solution cannot be used	1 bottle per Rx	
metoclopramide ODT	NP	• Unable to swallow, **OR** • Unable to absorb medications through the GI tract	12-week duration limit	
Reglan®	NP		12-week duration limit	
Mucosal Protectants				
Carafate® suspension	NP	• Patient is < 13 years of age; **OR** • Trial and failure, or intolerance to, sucralfate tablets, **OR** • Has documented difficulty swallowing/dysphagia		General PA Form
sucralfate suspension	NP	See Carafate suspension prior authorization criteria		

GASTROINTESTINAL *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Proton Pump Inhibitors				
The quantity limit for proton pump inhibitors is 1 per day. If request is for twice daily dosing, one of the following must be met: • Treatment of H. Pylori (1-month duration) • Treatment of GI Bleed/Hemorrhagic Gastritis (12-motnh duration) • Patient has a diagnosis of Barrett's Esophagus with documentation of uncontrolled reflux symptoms or esophagitis (following a trial of once daily PPI therapy) • Uncontrolled symptoms following a 30-day trial of once daily PPI therapy (1-month duration); renewals will require member to attempt step down to once daily PPI therapy. If patient fails step down to once daily dosing, they will not be asked to step down again				
Dexilant®	P		1/day	General PA Form
esomeprazole	P		1/day	
lansoprazole	P		1/day	
Nexium® pack	P	• Unable to swallow solid dosage forms	1/day	
omeprazole	P		1/day	
omeprazole ODT	P		1/day	General PA Form
omeprazole/sodium bicarbonate	P		1/day	
pantoprazole	P		1/day	
Protonix® packs	P		1/day	
dexlansoprazole	NP		1/day	
esomeprazole packs	NP	• Unable to sallow solid dosage forms; **AND** • Trial, failure, contraindication, or intolerance to Protonix® suspension and Nexium granules	1/day	General PA Form
First-Lansoprazole®	NP	• Unable to sallow solid dosage forms; **AND** ○ Trial, failure, contraindication, or intolerance to Protonix suspension packets; **OR** • Patient is < 6 years of age	1/day	
Konvomep®	NP	See First-Lansoprazole® prior authorization criteria	1/day	General PA Form
lansoprazole ODT	NP		1/day	
Nexium®	NP		1/day	
pantoprazole pack	NP	• Clinically valid reason why the preferred Protonix® suspension cannot be used	1/day	
Prevacid®	NP		1/day	General PA Form
Prevacid SoluTab®	NP	• Unable to swallow solid oral dosage forms; **AND** • Trial, failure, contraindication, or intolerance to Protonix® suspension	1/day	

GASTROINTESTINAL *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Voquezna®	NP	• Patient is 18 years of age or older; **AND**
		• One of the following diagnoses:
		  ○ Active treatment of erosive esophagitis **(2-month approval duration); OR**
		  ○ Maintenance treatment of healed erosive esophagitis **(6-month approval duration); AND**
		  – Request is for Voquezna 10 mg tablets; **OR**
		  ○ Non-erosive gastroesophageal reflux disease (GERD) **(1-month approval duration); AND**
		  – Request is for Voquezna 10 mg tablets; **AND**
		• Trial and failure, contraindication, or intolerance to TWO preferred proton pump inhibitors
			1/day; **AND**
			10 mg: 180 days/ year
			20 mg: 60 days/ year	

Prilosec®	NP		1/day	
Protonix® tablets	NP		1/day	
rabeprazole	NP		1/day	General PA Form
Zegerid®	NP		1/day	

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Allergen Specific Immunotherapy				

Grastek®	NP	• Diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis; **AND**
		• Documentation initial dose was administered in the physician office or medical facility; **AND**
		• Must be prescribed by an allergy/immunology specialist; **AND**
		• Patient's diagnosis is confirmed with documentation of **ONE** of the following:
		  ○ A positive skin test to **ONE** of the pollen extracts contained in the requested agent
		  ○ Pollen specific IgE antibodies to **ONE** of the pollen extracts contained in the requested agent; **AND**
		• Trial and failure, contraindication, or intolerance to **ONE** agent from **TWO** of the following classes:
		  ○ Oral antihistamine
		  ○ Intranasal antihistamine
		  ○ Intranasal corticosteroid
		  ○ Leukotriene receptor antagonist; **AND**
		• Documented trial/failure or drug-drug interaction of subcutaneous allergen immunotherapy (SCIT, or allergy shots) [Note: Failure defined as lack of efficacy, allergic reaction, documented intolerable side effects; agent will not be approved for needle phobia]; **AND**
		• Patient has been prescribed and trained to administer epinephrine in case of severe allergic reaction; **AND**
		• Oral Anti-allergens will NOT be approved if patient meets ANY of the following:
		  ○ Patient experienced a severe reaction post initial dose administered in the physician's office
		  ○ Patient has concomitant allergen immunotherapy
		  ○ Patient has a history of severe, unstable, or uncontrolled asthma
		  ○ Patient has a history of eosinophilic esophagitis; **AND**
		• Treatment is requested within 12 weeks prior to season of allergen being treated (Grass season: April-September)
		Note: Prior authorizations may be processed for Grastek® between January 1 and March 31; with PA requests being accepted 2 weeks prior to this period. Requests received after March 31 will not be processed.
			1/day	General PA Form

Odactra®	NP	• Diagnosis of house dust mite (HDM) induced allergic rhinitis with or without conjunctivitis; **AND**
		• Patient's diagnosis confirmed with documentation of ONE of the following:
		  ○ Confirmed in vitro IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus HDMs
		  ○ Confirmed skin testing to licensed HDM allergen extracts; **AND**
		• Prescribed by or in consultation with an allergy/immunology specialist; **AND**
		• Documentation initial dose was administered in the physician office or medical facility; **AND**
		• Trial and failure, contraindication, or intolerance to ONE agent from TWO of the following classes:
		  ○ Oral antihistamine
		  ○ Intranasal antihistamine
		  ○ Intranasal corticosteroid
		  ○ Leukotriene receptor antagonist; **AND**
		• Patient has been prescribed and trained to administer epinephrine in case of severe allergic reaction; **AND**
		• Oral Anti-allergens will NOT be approved if patient meets ANY of the following:
		  ○ Patient experienced a severe reaction post initial dose administered in the physician's office
		  ○ Patient has concomitant allergen immunotherapy
		  ○ Patient has a history of severe, unstable, or uncontrolled asthma
		  ○ Patient has a history of eosinophilic esophagitis
			1/day	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Oralair®	NP	• Diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis; **AND**
		• Documentation initial dose was administered in the physician office or medical facility; **AND**
		• Must be prescribed by an allergy/immunology specialist; **AND**
		• Patient's diagnosis is confirmed with documentation of **ONE** of the following:
		  ○ A positive skin test to **ONE** of the pollen extracts contained in the requested agent
		  ○ Pollen specific IgE antibodies to **ONE** of the pollen extracts contained in the requested agent; **AND**
		• Trial and failure, contraindication, or intolerance to **ONE** agent from **TWO** of the following classes:
		  ○ Oral antihistamine
		  ○ Intranasal antihistamine
		  ○ Intranasal corticosteroid
		  ○ Leukotriene receptor antagonist; **AND**
		• Documented trial/failure or drug-drug interaction of subcutaneous allergen immunotherapy (SCIT, or allergy shots) [Note: Failure defined as lack of efficacy, allergic reaction, documented intolerable side effects; agent will not be approved for needle phobia]; **AND**
		• Patient has been prescribed and trained to administer epinephrine in case of severe allergic reaction; **AND**
		• Oral Anti-allergens will NOT be approved if patient meets ANY of the following:
		  ○ Patient experienced a severe reaction post initial dose administered in the physician's office
		  ○ Patient has concomitant allergen immunotherapy
		  ○ Patient has a history of severe, unstable, or uncontrolled asthma
		  ○ Patient has a history of eosinophilic esophagitis; **AND**
		• Treatment is requested within 4 months prior to season of allergen being treated (Grass season: April-September)
		Note: Prior authorizations may be processed for Oralair® between December 1 and March 31; with PA requests being accepted 2 weeks prior to this period. Requests received after March 31 will not be processed.
			tabs: 1/day;
			Dose Pak: total max limit 100 mg IR/300 mg IR
				General PA Form

Palforzia®	NP	**Initial Criteria:**
		• Diagnosis of peanut allergy confirmed by one of the following:
		  ○ Serum peanut-specific immunoglobulin E (IgE) of greater than or equal to 0.35 kUA/L
		  ○ Mean wheal diameter greater than or equal to 3 mm compared to control on skin prick testing for peanut; **AND**
		• Initial doses for each up-dose will be administered and monitored at the prescriber's office and distributed by the specialty pharmacy; **AND**
		• Prescribed by, or in consultation with, an allergist or immunologist that is enrolled in Palforzia REMS Program; **AND**
		• Provider must prescribe injectable epinephrine, instruct, and train patients on its appropriate use; **AND**
		• Must be used in conjunction with a peanut-avoidant diet; **AND**
		• Patient must not have ANY of the following:
		  ○ Severe, persistent, or uncontrolled Asthma
		  ○ History of eosinophilic esophagitis or other eosinophilic gastrointestinal disease
		  ○ History of severe or life-threatening episode(s) of anaphylaxis or anaphylactic shock within the past 2 months
		Renewal Criteria:
		• Documentation (medical records, chart notes, etc.) of tolerance to therapy during the initial dose escalation and up-dosing phases; **AND**
		• Documentation of positive clinical response to Palforzia therapy; **AND**
		• Patient continues to use in conjunction with a peanut-avoidant diet; **AND**
		• Prescribed by, or in consultation with, an allergist or immunologist that is enrolled in the Palforzia REMS Program
				General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Ragwitek®	NP	• Diagnosis of grass pollen-induced allergic rhinitis with or without conjunctivitis; **AND**
		• Documentation initial dose was administered in the physician office or medical facility; **AND**
		• Must be prescribed by an allergy/immunology specialist; **AND**
		• Patient's diagnosis is confirmed with documentation of **ONE** of the following:
		  ○ A positive skin test to **ONE** of the pollen extracts contained in the requested agent
		  ○ Pollen specific IgE antibodies to **ONE** of the pollen extracts contained in the requested agent; **AND**
		• Trial and failure, contraindication, or intolerance to **ONE** agent from **TWO** of the following classes:
		  ○ Oral antihistamine
		  ○ Intranasal antihistamine
		  ○ Intranasal corticosteroid
		  ○ Leukotriene receptor antagonist; **AND**
		• Documented trial/failure or drug-drug interaction of subcutaneous allergen immunotherapy (SCIT, or allergy shots) [Note: Failure defined as lack of efficacy, allergic reaction, documented intolerable side effects; agent will not be approved for needle phobia] ; **AND**
		• Patient has been prescribed and trained to administer epinephrine in case of severe allergic reaction; **AND**
		• Oral Anti-allergens will NOT be approved if patient meets ANY of the following:
		  ○ Patient experienced a severe reaction post initial dose administered in the physician's office
		  ○ Patient has concomitant allergen immunotherapy
		  ○ Patient has a history of severe, unstable, or uncontrolled asthma
		  ○ Patient has a history of eosinophilic esophagitis; **AND**
		• Treatment is requested within 12 wks prior to season of allergen being treated (Ragweed season: August-December)
		Note: Prior authorizations may be processed for Ragwitek® between May 1st thru July 31st; with PA requests being accepted 2 weeks prior to this period. Requests received after July 31st will not be processed.
			1/day	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Anti-Rheumatic: Kinase Inhibitors				

Rinvoq®	P	**Initial Criteria (6-month duration):**
		• Prescriber attests to each of the following:
		  ○ Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab, abatacept) OR potent immunosuppressants (i.e., azathioprine, cyclosporine); **AND**
		  ○ Benefits of using this agent outweigh the risks of heart-related events (heart attack, stroke, blood clots, etc.) or cardiovascular risk factors; **AND**
		  ○ Risk of malignancy has been considered and it has been determined that Jak inhibitor therapy is appropriate; **AND**
		• One of the following:
		  ○ Diagnosis of moderately to severely active rheumatoid arthritis (RA) or active polyarticular juvenile idiopathic arthritis (pJIA); **AND**
		  – Trial and failure, contraindication, or intolerance to leflunomide, methotrexate, OR sulfasalazine; **AND**
		  – Trial and failure, contraindication, or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel); **OR**
		  ○ Diagnosis of active psoriatic arthritis (PSA); **AND**
		  – Trial and failure, contraindication, or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel); **OR**
		  ○ Diagnosis of moderately to severely active Ulcerative Colitis (UC); **AND**
		  – Trial and failure, contraindication, or intolerance to TNF-inhibitor (e.g. Humira, Enbrel)
		  ○ Diagnosis of moderately to severely active Crohn's Disease; **AND**
		  – Trial and failure, contraindication, or intolerance to a TNF-inhibitor (e.g., Humira); **OR**
		  ○ Diagnosis of moderate to severe Atopic Dermatitis; **AND**
		  – Trial and failure, contraindication, or intolerance to 1 topical corticosteroid of medium-to-high potency; **AND**
		  – Trial and failure, contraindication, or intolerance to a topical calcineurin inhibitor; **OR**
		  ○ Diagnosis of active ankylosing spondylitis; **AND**
		  – Trial and failure, contraindication, or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel); **AND**
		  ○ Diagnosis of active non-radiographic axial spondylarthritis (nr-axSpA) with objective signs of inflammation; **AND**
		  – Trial and failure, contraindication, or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel)
		Renewal Criteria:
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, lower UC disease activity index)
			1/day	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Rinvoq LQ®	P	**Initial Criteria (6-month duration):**
		• Prescriber attests to each of the following:
		  ○ Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab) OR potent immunosuppressants (i.e., azathioprine, cyclosporine); **AND**
		  ○ Benefits of using this agent outweigh heart-related events or cardiovascular risk factors; **AND**
		  ○ Risk of malignancy has been considered, and it has been determined that Jak inhibitor therapy is appropriate; **AND**
		• One of the following:
		  ○ Diagnosis of active Polyarticular Juvenile Idiopathic Arthritis (pJIA); **AND**
		  – Trial and failure, contraindication, or intolerance to leflunomide, methotrexate, OR sulfasalazine; **OR**
		  ○ Diagnosis of active psoriatic arthritis (PSA); **AND**
		  – Trial and failure, contraindication, or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel); **AND**
		• One of the following:
		  ○ Patient weighs <30 kg
		  ○ Patient is unable to swallow solid dosage forms
		Renewal criteria:
		• One of the following:
		  ○ Patient weighs <30 kg
		  ○ Patient is unable to swallow oral dosage forms; **AND**
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts)
			30 mL/day	

Xeljanz® tablet	P	**Initial Criteria (6-month duration):**
		• Prescriber attests to each of the following:
		  ○ Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab) OR potent immunosuppressants (i.e., azathioprine, cyclosporine); **AND**
		  ○ Benefits of using this agent outweigh heart-related events or cardiovascular risk factors; **AND**
		  ○ Risk of malignancy has been considered and it has been determined that Jak inhibitor therapy is appropriate; **AND**
		• One of the following:
		  ○ Diagnosis of moderately to severely active Rheumatoid Arthritis (RA), or active Polyarticular Course Juvenile Idiopathic Arthritis (pcJIA); **AND**
		  – Trial and failure, contraindication, or intolerance to leflunomide, methotrexate, OR sulfasalazine; **AND**
		  – Trial and failure or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel)
		  ○ Diagnosis of active Psoriatic Arthritis (PsA); **AND**
		  – Trial and failure, contraindication, or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel); **OR**
		  ○ Diagnosis of moderately to severely active Ulcerative Colitis (UC); **AND**
		  – Trial and failure, contraindication, or intolerance to Humira
		  ○ Diagnosis of Ankylosing spondylitis; **AND**
		  – Trial and failure, contraindication, or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel)
		Renewal Criteria:
		Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of tender and swollen joint counts, lower UC disease activity index)
			2/day	

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Olumiant®	NP	**Initial Criteria (6-month duration):**
		• Prescriber attests to each of the following:
		  ○ Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab, abatacept) OR potent immunosuppressants (i.e., azathioprine, cyclosporine); **AND**
		  ○ Benefits of using this agent outweigh heart-related events or cardiovascular risk factors
		  ○ Risk of malignancy has been considered and it has been determined that Jak inhibitor therapy is appropriate; **AND**
		• One of the following:
		  ○ Diagnosis of moderately to severely active Rheumatoid Arthritis; **AND**
		  – Trial and failure, contraindication, or intolerance to leflunomide, methotrexate, OR sulfasalazine; **AND**
		  – Trial and failure, contraindication, or intolerance a preferred TNF-inhibitors (e.g., Enbrel, Humira); **AND**
		  – Trial and failure, contraindication, or intolerance to ONE preferred agent; **OR**
		  ○ Diagnosis of Severe alopecia areata; **AND**
		  – Patient is at ≥ 18 years old but less than 21 years old (indication is not a covered benefit in patients ≥ 21 years old); **AND**
		  – Recipient has ≥ 50% scalp hair loss; **AND**
		  – Prescriber attest patient does not have other underlying causes of hair loss (e.g. male pattern hair loss (androgenic alopecia), female pattern hair loss, telogen effluvium, traction alopecia, and tinea capitis); **AND**
		  – Recipient must be evaluated every 4 months by a physician and submit chart documentation indicating patient has had improved hair growth/decreased hair loss
		Renewal Criteria:
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of tender and swollen joint counts, lower UC disease activity index, Alopecia areata: improvement in extent and density of scalp hair loss)
		Note: Will not be covered for COVID-19 treatment in post hospitalized patients
			1/day	General PA Form

Xeljanz® solution	NP	**Initial Criteria:**
		• Prescriber attests to each of the following:
		  ○ Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab, abatacept) OR potent immunosuppressants (i.e., azathioprine, cyclosporine); **AND**
		  ○ Benefits of using this agent outweigh heart-related events or cardiovascular risk factors; AND
		  ○ Risk of malignancy has been considered and it has been determined that Jak inhibitor therapy is appropriate; **AND**
		• Diagnosis of active Polyarticular Juvenile Idiopathic Arthritis (pcJIA); **AND**
		• Trial and failure, contraindication, or intolerance to leflunomide, methotrexate, OR sulfasalazine; **AND**
		• Trial and failure or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel); **AND**
		• One of the following:
		  ○ Patient weighs <40 kg
		  ○ Patient is unable to swallow oral dosage forms
		Renewal Criteria
		• One of the following:
		  ○ Patient weighs <40 kg
		  ○ Patient is unable to swallow oral dosage forms
		Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of tender and swollen joint counts, lower UC disease activity index)
			10 mL/day	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Xeljanz® XR 11 mg	NP	• See Xeljanz® tablet prior authorization criteria; **AND** Clinically valid reason why the preferred Xeljanz immediate release product cannot be used	1/day	

Xeljanz® XR 22 mg	NP	**Initial Criteria (6-month duration):**
		• Prescriber attests to each of the following:
		  ○ Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab, abatacept) OR potent immunosuppressants (i.e., azathioprine, cyclosporine); **AND**
		  ○ Benefits of using this agent outweigh heart-related events or cardiovascular risk factors; AND
		  ○ Risk of malignancy has been considered and it has been determined that Jak inhibitor therapy is appropriate; **AND**
		• Diagnosis of moderately to severely active Ulcerative Colitis (UC); **AND**
		• Trial and failure, contraindication, or intolerance a preferred adalimumab product; **AND**
		• Clinically valid reason why the preferred Xeljanz immediate release product cannot be used
		Renewal Criteria:
		Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of tender and swollen joint counts, lower UC disease activity index)
			1/day	General PA Form

Disease Modifying Anti-Rheumatic Drugs (DMARDs)				
sulfasalazine	P		8/day	General PA Form
sulfasalazine EC	P		8/day	
Azulfidine®	NP		8/day	General PA Form
Azulfidine EN®	NP			
Jylamvo®	NP	• Dosing that will not allow the use of preferred methotrexate tablets; **OR** • Patient unable to swallow methotrexate tablets	4 syringes/28 days	

Otrexup®	NP	• Diagnosis of Rheumatoid Arthritis (RA) or polyarticular Juvenile Idiopathic Arthritis (pJIA); **AND**
		  ○ Trial/failure of TWO preferred DMARD agents; **AND**
		  ○ Must have an allergy or contraindication to benzoyl alcohol or other preservative contained in injectable methotrexate that is not in requested agent; **OR**
		  ○ Patient is experiencing dexterity issues without assistance to a caregiver who can administer the requested agent; **OR**
		• Diagnosis of psoriasis:
		  ○ Trial and failure of TWO topical antipsoriatic agents; **AND**
		  ○ Clinically valid reason why oral methotrexate cannot be used; **AND**
		  ○ One of the following:
		  – Patient has an allergy or contraindication to benzoyl alcohol or other preservative in injectable methotrexate that is not in requested agent
		  – Patient is experiencing dexterity issues without assistance to a caregiver who can administer the requested agent
			4 syringes/28 days	General PA Form

Rasuvo®	NP	See Otrexup® prior authorization criteria	4 syringes/28 days	General PA Form

Xatmep®	NP	• Age ≤ 12 years; **AND**
		• One of the following:
		  ○ Dosing that will not allow the use of preferred methotrexate tablets
		  ○ Patient unable to swallow methotrexate tablet		

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Immunomodulators: TNF Inhibitors				

Enbrel®;
Enbrel Mini Cartridge®;
Enbrel Sureclick®
	P	**Initial Criteria (6-month duration):**
		• Diagnosis of Ankylosing Spondylitis; **OR**
		• Diagnosis of chronic, moderate to severe Plaque Psoriasis; **AND**
		  ○ Trial and failure of ONE topical treatment of a corticosteroid, calcipotriene, OR tazarotene; **AND**
		  ○ Trial and failure, or contraindication, of ONE oral treatment with acitretin, methotrexate, OR cyclosporine; **OR**
		• Diagnosis of active Psoriatic Arthritis (PsA); **OR**
		• Diagnosis of active Juvenile Psoriatic arthritis (JPsA); **OR**
		• Diagnosis of Rheumatoid Arthritis (RA) or Polyarticular Juvenile Idiopathic Arthritis (pJIA); **AND**
		  ○ Trial and failure, contraindication, or intolerance to methotrexate, leflunomide, OR sulfasalazine
		Renewal Criteria:
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of tender and swollen joint counts, a 50% reduction of total Psoriasis Area Severity Index (PASI) score)
			25 mg dose:
			8 syringes/28 days
			
			50 mg dose:
			4 syringes/28 days
				General PA Form

Humira®;
Hadlima®;
Simlandi®
	P	**Initial Criteria (6-month duration):**
		• Diagnosis of Ankylosing Spondylitis (AS); **OR**
		• Diagnosis of chronic, moderate to severe Plaque Psoriasis and both the following:
		  ○ Trial and failure of ONE topical treatment of a corticosteroid, calcipotriene, OR tazarotene; **AND**
		  ○ Trial and failure, or contraindication, of ONE oral treatment with acitretin, methotrexate, OR cyclosporine; **OR**
		• Diagnosis of Generalized pustular psoriasis (GPP) confirmed by ONE of the following:
		  ○ Presence of sterile, macroscopically visible pustules on non-acral skin and pustulation is NOT restricted to psoriatic plaques (i.e. occurs outside of psoriatic plaques)
		  ○ Skin biopsy confirming presence of Kogoj's spongiform pustules
		  ○ Genetic confirmation of IL36RN, CARD14, or AP1S3 mutation; **OR**
		• Diagnosis of active Psoriatic Arthritis (PsA); **OR**
		• Diagnosis of active Juvenile Psoriatic arthritis (JPsA); **OR**
		• Diagnosis of Rheumatoid Arthritis (RA) or Polyarticular Juvenile Idiopathic Arthritis (pJIA); **AND**
		  ○ Trial and failure, contraindication, or intolerance to methotrexate, leflunomide, OR sulfasalazine; **OR**
		• Diagnosis of moderate*ly* to severely active Ulcerative Colitis (UC); **OR**
		• Diagnosis of moderately to severely active Crohn's Disease (CD) and ONE of the following:
		  ○ Previous trial and failure of infliximab in the past 365 days
		  ○ Crohn's disease is classified as moderate, severe, or fistulizing
		  ○ ≥ 90 days of drug therapy with one of the following: azathioprine, mercaptopurine, mesalamine, methotrexate, or systemic glucocorticoid; **OR**
		• Diagnosis of moderate to severe Hidradenitis Suppurativa (HS); **OR**
		• Diagnosis of non-infectious intermediate, posterior or panuveitis (UV); **AND**
		  ○ Diagnosis of Uveitis must be by, or in consultation with, an ophthalmologist; **AND**
		  ○ ≥ 90 days of drug therapy with one of the following: oral/injectable steroid therapy, methotrexate, mycophenolate, azathioprine, cyclosporine, tacrolimus, cyclophosphamide
		Renewal Criteria:
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score, <UC disease activity index, reduction in inflammatory bumps/abscesses, decreases in flares)
			2 syringes/28 days
			
			Starter Packs:
			1 kit/28 days
			
			Hidradenitis Suppurativa (HS) diagnosis only:
			4 syringes/28 days
				General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Abrilada®	NP	**Initial Criteria (6-month duration):** • Diagnosis of one of the following: – Ankylosing Spondylitis (AS) – Active Psoriatic Arthritis (PsA) – Rheumatoid Arthritis (RA) – Polyarticular Juvenile Idiopathic Arthritis (pJIA) – Plaque Psoriasis (PsO) – Moderately to severely active Crohn's Disease (CD) – Hidradenitis Suppurativa (HS) – Moderately to severely active Ulcerative Colitis (UC) – Non-infectious intermediate, posterior or panuveitis (UV); **AND** • Clinically valid reason why ALL the preferred adalimumab products cannot be used **Renewal Criteria:** • Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score, endoscopic remission)	2 injectors/28 days	General PA Form
adalimumab	NP	See Abrilada® prior authorization criteria	2 injectors/28 days	General PA Form
Amjevita®	NP	See Abrilada® prior authorization criteria	2 injectors/28 days	
Cimzia®	NP	**Initial Criteria (6-month duration):** • One of the following: ○ Diagnosis of one of the following: – Ankylosing spondylitis (AS) – Axial spondyloarthritis, nonradiographic (nr-axSpA) – Active psoriatic arthritis (PsA) – Rheumatoid arthritis (RA) – Plaque psoriasis (PsO); – Polyarticular Juvenile Idiopathic Arthritis (pJIA); **AND** ○ Trial and failure, contraindication, or intolerance to TWO preferred immunomodulators with same indication; **OR** • Diagnosis of moderately to severely active Crohn's disease; **AND** ○ Trial and failure, contraindication, or intolerance to a preferred adalimumab product Entyvio, or infliximab **Renewal Criteria:** • Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score, endoscopic remission)	2 kits/28 days (4 syringes)	General PA Form
Cyltezo®	NP	See Abrilada® prior authorization criteria	2 injectors/28 days	General PA Form
Hulio®	NP	See Abrilada® prior authorization criteria	2 injectors/28 days	
Hyrimoz®	NP	See Abrilada® prior authorization criteria	2 injectors/28 days	
Idacio®	NP	See Abrilada® prior authorization criteria	2 injectors/28 days	

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Simponi®	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of Ankylosing Spondylitis, active Psoriatic Arthritis (PsA), or Rheumatoid Arthritis (RA):
		  ○ Trial and failure, contraindication, or intolerance to 2 preferred immunomodulators with same indication; **OR**
		• Diagnosis of moderately to severely active Ulcerative Colitis (UC):
		  ○ Trial and failure to two of the following (or have an intolerance or contraindication to all agents):
		  – A preferred adalimumab product
		  – Entyvio
		  – Infliximab
		  – A preferred JAK inhibitor (e.g. Xeljanz and Rinvoq)
		Renewal Criteria:
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score, endoscopic remission)
			1 syringe /28 days	General PA Form

Yuflyma®	NP	See Abrilada® prior authorization criteria	2 injectors/28 days	General PA Form
Yusimry®	NP	See Abrilada® prior authorization criteria	2 injectors/28 days	

Zymfentra®	NP	**Initial Criteria**
		• Patient is 18 years of age or older; **AND**
		• Diagnosis of ONE of the following:
		  ○ Moderately to severely active Crohn's disease
		  ○ Moderately to severely active Ulcerative Colitis; **AND**
		• Prescriber attests that patient has received three IV doses of infliximab prior to transitioning to subcutaneous therapy; **AND**
		• Submission of medical records demonstrating a positive clinical response following a treatment minimum of 10 weeks of infliximab IV
		Renewal Criteria
		• Diagnosis of ONE of the following:
		  ○ Moderately to severely active Crohn's disease
		  ○ Moderately to severely active Ulcerative Colitis; **AND**
		• Disease response to therapy and tolerability compared to baseline (e.g., decreased UC disease activity index, endoscopic remission, decreased number of soft stools, decreased abdominal pain)
			2/28 days	General PA Form

Immunomodulators: Interleukin Inhibitors				
Kineret®	P	**Initial Criteria (6-month duration):** • Diagnosis of Rheumatoid Arthritis; AND ○ Trial and failure, contraindication, or intolerance to methotrexate, leflunomide, OR sulfasalazine; **OR** • Diagnosis of Neonatal-Onset Multisystem Inflammatory Disease (NOMID) • Diagnosis of Deficiency of Interleukin-1 Receptor Antagonist (DIRA) **Renewal Criteria:** • Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts)	1 syringe/day	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Taltz®	P	**Initial Criteria (6-month duration):**
		• Diagnosis of chronic, moderate to severe Plaque Psoriasis; **AND**
		  ○ Trial and failure to ONE topical treatment of a corticosteroid, calcipotriene, OR tazarotene; **AND**
		  ○ Trial and failure, or contraindication, to ONE oral treatment with acitretin, methotrexate, OR cyclosporine; **OR**
		• Diagnosis of active Psoriatic Arthritis (PsA); **OR**
		• Diagnosis of Axial spondyloarthritis (axSpA), Active Ankylosing Spondylitis (AS), or Active non-radiographic axial spondyloarthritis (nr-axSpA)
		Renewal Criteria:
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score)
			1 syringe/28 days	General PA Form

Tyenne®	P	**Initial Criteria: (6-month duration)**
		• Diagnosis of Rheumatoid Arthritis; **AND**
		  ○ Trial and failure, contraindication, or intolerance to methotrexate, leflunomide, OR sulfasalazine; **OR**
		• Diagnosis of active Systemic Juvenile Idiopathic Arthritis (SJIA); **OR**
		• Diagnosis of Giant Cell Arteritis (GCA) and ONE of the following:
		  ○ Trial and failure of > 90 days of therapy with systemic glucocorticoids, azathioprine, or methotrexate unless contraindicated or intolerance; **OR**
		  ○ Occurrence of GCA relapse while patient on prednisone doses greater than 20 mg/day, **OR**
		  ○ Patient will be utilizing systemic glucocorticoids with tocilizumab
		Renewal Criteria:
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease number of tender/swollen joint course)
			4 injections (3.6mL)/ 28 days	General PA Form

Actemra®, Actemra ACTPen®	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of Rheumatoid Arthritis or active Polyarticular Juvenile Idiopathic Arthritis (pJIA); **AND**
		  ○ Trial and failure, contraindication, or intolerance to methotrexate, leflunomide, OR sulfasalazine; **AND**
		  ○ Clinically valid reason why the preferred product Tyenne cannot be used; **OR**
		• Diagnosis of active Systemic Juvenile Idiopathic Arthritis; **AND**
		  ○ Clinically valid reason why the preferred product Tyenne cannot be used; **OR**
		• Diagnosis of Giant Cell Arteritis (CGA); **AND**
		  ○ One of the following:
		  – Trial and failure of > 90 days of drug therapy with systemic glucocorticoids, azathioprine, or methotrexate
		  – Occurrence of GCA relapse while patient on prednisone doses greater than 20 mg/day
		  – Patient will be utilizing systemic glucocorticoid with tocilizumab; **AND**
		  ○ Clinically valid reason why the preferred product Tyenne cannot be used
		• Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD); **AND**
		  ○ Patient is 18 years of age or older; **AND**
		  ○ Patient's onset of disease was 5 years ago or less; **AND**
		  ○ Patient has active disease with elevated inflammatory markers or platelets
		Renewal Criteria:
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts)
			3.6 mL/28 days	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Arcalyst®	NP	• Diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS), and Muckle-Wells Syndrome (MWS); **OR**
		• Diagnosis of Deficiency of Interleukin-1 Receptor Antagonist (DIRA); **AND**
		  ○ Patient has tried and failed or have contraindication or intolerance to preferred agent Kineret; **OR**
		• Diagnosis of recurrent pericarditis (RP) and meets all of the following; **AND**
		• Trial and failure, contraindication, or intolerance to ONE of the following:
		  ○ Colchicine
		  ○ Corticosteroids
		  ○ NSAIDS
			8 vials/month	General PA Form

Bimzelx®	NP	**Initial Criteria:**
		• Diagnosis of moderate to severe Plaque Psoriasis (PsO), Active Psoriatic Arthritis (PsA), or Ankylosing Spondylitis (AS); **AND**
		  ○ Trial and failure, contraindication, or intolerance to TWO preferred immunomodulators with the same indication; **OR**
		• Diagnosis of Non-Radiographic Axial Spondyloarthritis (nr-axSpA); **AND**
		  ○ Trial and failure, contraindication, or intolerance to Taltz; **OR**
		• Diagnosis of moderate to severe Hidradenitis Suppurativa (HS); **AND**
		  ○ Trial and failure, contraindication, or intolerance of a preferred adalimumab product
		Renewal Criteria:
		• Disease response to therapy and tolerability compared to baseline (e.g., reduction of total PASI score, reduction in inflammatory bumps/abscesses)
			1 injections/28 days	General PA Form

Cosentyx®	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of chronic, moderate to severe Plaque Psoriasis(PsO), Ankylosing Spondylitis (AS), active Psoriatic Arthritis (PsA); **AND**
		  ○ Trial and failure, contraindication, or intolerance to TWO preferred immunomodulators with same indication; **OR**
		• Diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; **AND**
		  ○ Trial and failure, contraindication, or intolerance of Taltz; **OR**
		• Diagnosis of Active Enthesitis-related arthritis (ERA); **AND**
		  ○ Failed an adequate trial of ONE NSAID (unless contraindicated); **AND**
		• Diagnosis of moderate to severe Hidradenitis Suppurativa (HS); **AND**
		  ○ Trial and failure, contraindication, or intolerance of a preferred adalimumab product
		Renewal Criteria:
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of tender and swollen joint counts, a 50% reduction of total PASI score, reduction in inflammatory bumps/abscesses, decreases in flares)
			300 mg dose:
			2 pens/28 days;
			
			150 mg dose:
			1 pen /28 days
			
			Hidradenitis Suppurativa (HS) diagnosis only-
			300 mg dose:
			4 syringes/28 days
				General PA Form

Kevzara®	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of Rheumatoid Arthritis (RA) or active Polyarticular Juvenile Idiopathic Arthritis (pJIA); **AND**
		  ○ Trial and failure, contraindication, or intolerance to 2 preferred immunomodulators with same indication: **OR**
		• Diagnosis of Polymyalgia Rheumatic (PR); **AND**
		  ○ Trial and failure, contraindication, or intolerance to systemic corticosteroids; **AND**
		Renewal Criteria (6-month duration):
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts)
			2 pens or syringes /30 days	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Omvoh® Auto-injector	NP	**Initial Criteria: (6-month duration)**
		• Diagnosis of Ulcerative Colitis; **AND**
		  ○ Trial and failure to two of the following (or have an intolerance or contraindication to all agents):
		  – A preferred adalimumab product
		  – Entyvio
		  – Infliximab
		  – A preferred JAK inhibitor (e.g. Xeljanz or Rinvoq); OR
		• Diagnosis of moderately to severely active Crohn's disease (CD); **AND**
		  ○ Trial and failure, contraindication, or intolerance to a preferred adalimumab product, Entyvio, or infliximab; **AND**
		  ○ Prescriber attests that patient has received three IV doses of Omvoh prior to transitioning to subcutaneous therapy
		Renewal Criteria:
		• Disease response to therapy and tolerability compared to baseline (e.g., endoscopic remission)
			2 auto-injectors/28 days	General PA Form

Otulfi®	NP	See prior authorization criteria for Stelara®	See Stelara®	General PA Form
Pyzchiva®	NP	See prior authorization criteria for Stelara®	See Stelara®	
Selarsdi®	NP	See prior authorization criteria for Stelara®	See Stelara®	
Siliq®	NP	**Initial Criteria (6-month duration):** • Diagnosis of moderate to severe plaque psoriasis (PsO); **AND** • Patient has a contraindication, drug-drug interaction, or adverse reaction to TWO preferred immunomodulator agents with same indication; **AND** • Patient does not have a history of Crohn's disease; **AND** • Prescriber and patient have met the requirements of the Siliq REMS program **Renewal Criteria:** • Disease response to therapy and tolerability compared to baseline (e.g., a 50% reduction of total PASI score)	2 syringes/28 days	General PA Form

Skyrizi®	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of Plaque Psoriasis (PsO) or active psoriatic arthritis (PsA); **AND**
		  ○ Trial and failure to ALL preferred immunomodulator agents with the same indication; **OR**
		• Diagnosis of moderately to severely active Crohn's disease (CD); **AND**
		  ○ Trial and failure, contraindication, or intolerance to a preferred adalimumab product, Entyvio, or infliximab; **OR**
		• Diagnosis of moderately to severely active Ulcerative Colitis (UC); **AND**
		  ○ Trial and failure to two of the following (or have an intolerance or contraindication to all agents):
		  ○ A preferred adalimumab product
		  ○ Entyvio
		  ○ Infliximab
		  ○ A preferred JAK inhibitor (e.g. Xeljanz or Rinvoq)
		Renewal Criteria:
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score)
			Cartridge: 1 per 8 weeks
			
			Auto-injector, pre-filled syringe, and pre-filled syringe kit: 2 per 84 days
				General PA Form

Steqeyma®	NP	See prior authorization criteria for Stelara®	See Stelara®	

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Spevigo®	NP	**Initial Criteria:**
		• Diagnosis of Generalized pustular psoriasis (GPP) confirmed by ONE of the following:
		  ○ Presence of sterile, macroscopically visible pustules on non-acral skin and pustulation is NOT restricted to psoriatic plaques (i.e. occurs outside of psoriatic plaques)
		  ○ Skin biopsy confirming presence of Kogoj's spongiform pustules;
		  ○ Genetic confirmation of IL36RN, CARD14, or AP1S3 mutation; **AND**
		• Patient is 12 years of age and older and weights at least 40 kg; **AND**
		• Prescriber attest to ALL of the following:
		  ○ Treatment is NOT for an active GPP flare
		  ○ Patient has been evaluated and screened for the presence of latent TB infection prior to initiating treatment
		  ○ Patient will not receive live vaccines during therapy and 16 weeks after treatment; **AND**
		• Trial and failure to BOTH of the following (or have an intolerance or contraindication to all agents):
		  ○ A TNF inhibitor (e.g. adalimumab, infliximab, and etanercept)
		  ○ Taltz; **AND**
		• Prescribed by, or in consultation with, a dermatologist
		Renewal Criteria:
		• Submission of medical records (e.g. chart notes) documenting disease response to therapy and tolerability compared to baseline (e.g., decreased number of GPP flares)
		Note: The Spevigo subcutaneous formulation is not FDA approved for the treatment of GPP flare and will not be approved for that diagnosis. A SQ loading dose is not required following treatment of a GPP flare with IV Spevigo
			2/28 days	General PA Form

Stelara® prefilled syringe and 45 mg/0.5 mL vial	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of Plaque Psoriasis (PsO) or active Psoriatic Arthritis (PsA); **AND**
		  ○ Trial and failure, contraindication, or intolerance to 2 preferred immunomodulators with same indication; **OR**
		• Diagnosis of moderately to severely active Crohn's disease (CD); **AND**
		  ○ Trial and failure, contraindication, or intolerance to a preferred adalimumab product, Entyvio, or infliximab; **OR**
		• Diagnosis of moderately to severely active Ulcerative Colitis (UC); **AND**
		  ○ Trial and failure to two of the following (or have an intolerance or contraindication to all agents):
		  – A preferred adalimumab product
		  – Entyvio
		  – Infliximab
		  – A preferred JAK inhibitor (e.g. Xeljanz or Rinvoq)
		Renewal Criteria:
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score)
			Plaque Psoriasis, Psoriatic Arthritis:
			1 injection/84 days
			
			Crohn's Disease and Ulcerative Colitis:
			1 injection/56 days
				General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Tremfya®	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of Plaque Psoriasis (PsO) or active psoriatic arthritis (PsA); **AND**
		  ○ Trial and failure to ALL preferred immunomodulator agents with the same indication; **OR**
		• Diagnosis of moderately to severely active Ulcerative Colitis (UC); **AND**
		  ○ Trial and failure to two of the following (or have an intolerance or contraindication to all agents):
		  – A preferred adalimumab product
		  – Entyvio
		  – Infliximab
		  – A preferred JAK inhibitor (e.g. Xeljanz or Rinvoq)
		Renewal Criteria:
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score)
			1 syringe (1 mL) / 56 days
			1 autoinjector/ 56 days
				General PA Form

ustekinumab	NP	See prior authorization criteria for Stelara®	See Stelara®	
Yesintek®	NP	See prior authorization criteria for Stelara®	See Stelara®	
Immunomodulators: Miscellaneous				
Orencia®	P	**Initial Criteria (6-month duration):** • Diagnosis of Rheumatoid Arthritis (RA) or Polyarticular Juvenile Idiopathic Arthritis (pJIA); **AND** ○ Trial and failure, contraindication, or intolerance to leflunomide, methotrexate, or sulfasalazine; **OR** • Diagnosis of active Psoriatic Arthritis PsA) **Renewal Criteria:** • Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score)	4 mL/28 days	General PA Form

Otezla®	P	**Initial Criteria (6-month duration):**
		• Diagnosis of Plaque Psoriasis (PsO); **AND**
		  ○ Trial and failure to a topical treatment of a corticosteroid, calcipotriene, OR tazarotene; **AND**
		  ○ Trial and failure, or contraindication, to oral treatment with Soriatane®, methotrexate, cyclosporine; **OR**
		• Diagnosis of active severe Psoriatic Arthritis (PsA); **OR**
		• Diagnosis of oral lesions associated with Behçet's Disease; **AND**
		  ○ Patient has active oral ulcers; **AND**
		  ○ Trial and failure, contraindication, or intolerance to colchicine
		Renewal Criteria:
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of swollen joint counts, a 50% reduction of total PASI score)
			30 mg: 2/day
			Starter Pack: 1/Rx
				General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Entyvio®	NP	**Initial Criteria: (4-month duration)**
		• One of the following:
		  ○ Diagnosis of moderate to severe Crohn's disease
		  ○ Diagnosis of moderate to severe ulcerative colitis (UC); **AND**
		• Trial and failure, contraindication, or intolerance of a TNF- inhibitor (e.g., Humira, Infliximab) supported by paid claims or chart notes; **AND**
		• Prescriber attests that patient has or will receive ≥ 2 intravenous doses of Entyvio prior to transitioning to subcutaneous therapy
		Renewal Criteria:
		• Patient is established on Entyvio therapy for ≥ 14 weeks (supported by paid claims or chart notes); **AND**
		• Documentation of positive disease response to therapy and tolerability compared to baseline (e.g., decreased UC disease activity index, endoscopic remission, decreased stool frequency)
				General PA Form

Sotyktu®	NP	**Initial Criteria (6-month duration):** • Diagnosis of moderate to severe Plaque Psoriasis (PsO); **AND** • Trial and failure, contraindication, or intolerance to 2 preferred immunomodulators with same indication **Renewal Criteria:** • Disease response to therapy and tolerability compared to baseline (e.g., a 50% reduction of total PASI score)	1/day	General PA Form

Velsipity®	NP	**Initial Criteria (3-month duration)**
		• Diagnosis of moderately to severely active ulcerative colitis (UC); **AND**
		• Patient is ≥ 18 years old; **AND**
		• Trial and failure to two of the following (or have an intolerance or contraindication to all agents):
		  ○ A preferred adalimumab product
		  ○ Entyvio
		  ○ Infliximab
		  ○ A preferred JAK inhibitor (e.g. Xeljanz or Rinvoq); **AND**
		• Patient does not have a recent (within the previous 6 months) myocardial infarction, unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure with hospitalization, or Class III/IV heart failure; **AND**
		• Patient does not have a history or presence of Mobitz Type II second-degree, or third-degree atrioventricular block, sick sinus syndrome, or sino-atrial block (unless treated with a functioning pacemaker)
		Renewal Criteria
		• Disease response to therapy and tolerability compared to baseline (e.g., endoscopic remission, decreased stool frequency, decreased rectal bleeding)
			1/day	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Immunosuppressants				
Astagraf XL®	NP	• Trial and failure, contraindication, or intolerance to ONE preferred agent **Note**: The PA requirement may be overridden at POS via an ICD-10 code override.		General PA Form
Azasan®	NP	• Diagnosis of rheumatoid arthritis; **AND** ○ Trial and failure of ONE preferred agent with the same indication (e.g., azathioprine); **OR** • All transplant recipients will be allowed a prior authorization for any drug **Note**: The PA requirement may be overridden at POS via an ICD-10 code override.		General PA Form
CellCept® tablets	NP	All transplant recipients will be allowed a prior authorization for any drug. **Note**: The PA requirement may be overridden at POS via an ICD-10 code override.		General PA Form
CellCept® capsules	NP	See CellCept® tablets prior authorization criteria		General PA Form
Envarsus® XR	NP	• Trial and failure, contraindication, or intolerance to ONE preferred agent **Note**: The PA requirement may be overridden at POS via an ICD-10 code override.		
Imuran®	NP	See Azasan® prior authorization criteria		General PA Form
Myfortic®	NP	See CellCept® tablets prior authorization criteria		
Neoral®	NP	• Diagnosis of rheumatoid arthritis or plaque psoriasis; **AND** ○ Trial and failure of ONE preferred agent with the same indication (e.g., cyclosporine, GENGRAF); **OR** • All transplant recipients will be allowed a prior authorization for any drug **Note**: The PA requirement may be overridden at POS via an ICD-10 code override.		General PA Form
Prograf® capsules	NP	See CellCept® tablets prior authorization criteria		General PA Form
Prograf® packets	NP	• Trial and failure, contraindication, or intolerance to ONE preferred agent **Note**: The PA requirement may be overridden at POS via an ICD-10 code override.		
Sandimmune® caps	NP	See CellCept® tablets prior authorization criteria		General PA Form
Zortress®	NP	See CellCept® tablets prior authorization criteria		
Lupus and Lupus Nephritis Agents				

Benlysta®	NP	**Initial Criteria: (6-month duration)**
		• Patient is ≥ 5 years of age; **AND**
		• Diagnosis of one of the following:
		  ○ Active systemic lupus erythematosus (SLE); **OR**
		  ○ Active lupus nephritis; **AND**
		  – Diagnosis has been confirmed by biopsy or biopsy is contraindicated in the patient; **AND**
		• Prescribed by, or consultation with, a rheumatologist or nephrologist; **AND**
		• Must be used in combination with standard treatment regimens (e.g., corticosteroids, mycophenolate, azathioprine); **AND**
		• Patient does not have severe active central nervous system lupus
		Renewal Criteria:
		• Patient meets the initial criteria; **AND**
		• Positive clinical response to therapy (e.g., reduction in corticosteroid dose, reduction in flares, improvement in organ dysfunction)
			4 syringes/28 days	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Lupkynis®	NP	**Initial Criteria:** • Patient is ≥ 18 years of age; **AND** • Diagnosis of active lupus nephritis; **AND** • Diagnosis has been confirmed by biopsy or biopsy is contraindicated in the patient; **AND** • Must take in combination with mycophenolate mofetil and corticosteroids; **AND** • Will NOT take in combination with cyclophosphamide or Benlysta; **AND** • Prescribed by, or in consultation with, a rheumatologist or nephrologist; **AND** • Will not be used concomitantly with strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin); **AND** • Patient is not pregnant **Renewal Criteria:** • Must take in combination with mycophenolate mofetil and corticosteroids; **AND** • Will NOT take in combination with cyclophosphamide or Benlysta; **AND** • Prescribed by, or in consultation with, a rheumatologist or nephrologist; **AND** • Patient has experienced a positive response to therapy (evidence of long-term preservation of kidney function, prevention of disease flares, prevention of organ damage); **AND** • Patient has not experienced treatment-limiting adverse effects (eGFR decline, blood pressure increase, hypertensive crisis)	6/day	General PA Form
Multiple Sclerosis Agents, Injectable				
Avonex®	P		4/28 days	General PA Form
Avonex Pack®	P		4/28 days	
Copaxone®	P		20mg: 1 mL/day 40mg: 12 mL/30 days	
Betaseron®	NP		14/28 days	
glatiramer	NP		20mg: 1 mL/day 40mg: 12 mL/30 days	General PA Form
Glatopa®	NP		1/day	

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Kesimpta®	NP	**Initial Criteria:**
		• Patient is ≥ 18 years of age; **AND**
		• Prescribed by, or in consultation with, a neurologist; **AND**
		• Patient has a relapsing form of multiple sclerosis (i.e. clinically Isolated syndrome, relapsing-remitting Multiple Sclerosis [RRMS], active secondary progressive disease [SPMS]); **AND**
		• Prescriber attests that initial dose was administered under the guidance of a healthcare professional; **AND**
		• Patient meets ONE of the following:
		  ○ Patient has active secondary progressive disease (SPMS); **OR**
		  ○ Trial and failure, contraindication, or intolerance to one disease modifying therapy for MS; **OR**
		  ○ Submission of medical records (e.g., chart notes) documenting clinical features of highly active MS such as high radiological burden of disease, high relapse frequency, severe relapse(s) requiring corticosteroids and/or hospitalization, severe physical or cognitive impairment; **AND**
		• Patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment; **AND**
		• For patients of reproductive potential, the following has been addressed:
		  ○ Patient has been counseled to use effective contraception during treatment and for 6-months after the last dose; **AND**
		  ○ Lactating women will be counseled to discontinue breast feeding during treatment; **AND**
		  ○ Provider has confirmed (via pregnancy test) that the patient is not pregnant prior to receiving treatment
		Renewal Criteria:
		• Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression)
			Initiation: 3 pens the 1st month
			
			Maintenance: 1 pen/month
				General PA Form

Plegridy®	NP	• Patient is ≥ 18 years old; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Diagnosis of relapsing forms of Multiple Sclerosis which include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease; **AND** • Trial and failure, contraindication, or intolerance of 2 preferred injectable MS agents	2 pens/28 days	General PA Form
Rebif®	NP		6 mL /28 days	
Multiple Sclerosis (MS) Agents, Oral				
dalfampridine ER	P		2/day	
dimethyl fumarate	P	**Initial Criteria:** • Patient must be the labeled age minimum; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Patient has a relapsing form of multiple sclerosis (i.e., clinically isolated syndrome, relapsing-remitting disease, active secondary progressive disease) **Renewal Criteria:** • Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression)	2/day	General PA Form
fingolimod	P	See dimethyl fumarate prior authorization criteria	1/day	
teriflunomide	P	See dimethyl fumarate prior authorization criteria		

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Ampyra®	NP	• Clinically valid reason why preferred dalfampridine cannot be used	2/day	General PA Form
Aubagio®	NP	See dimethyl fumarate prior authorization criteria; **AND** • Clinically valid reason why preferred dalfampridine cannot be used		
Bafiertam®	NP	**Initial Criteria:** • Patient is ≥ 18 years old; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Patient has a relapsing form of multiple sclerosis (i.e. clinically Isolated syndrome, relapsing-remitting disease, active secondary progressive disease); **AND** • Trial and failure, contraindication, or intolerance of teriflunomide or fingolimod; **AND** • Trial and failure, contraindication, or intolerance of dimethyl fumarate; **AND** **Renewal Criteria:** • Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression)	4/day	General PA Form
Gilenya®	NP	**Initial Criteria:** • Patient is ≥ 10 years of age; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Diagnosis of a relapsing form of multiple sclerosis (i.e., clinically isolated syndrome, relapsing-remitting disease, active secondary progressive disease); **AND** • Clinically valid reason why preferred fingolimod cannot be used **Renewal Criteria:** • Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression)	1/day	General PA Form

Mavenclad®	NP	**Initial Criteria:**
		• Patient is ≥ 18 years of age; **AND**
		• Prescribed by, or in consultation with, a neurologist; **AND**
		• ONE of the following:
		  ○ Diagnosis of relapsing-remitting multiple sclerosis [RRMS]; **AND**
		  – Trial and failure, contraindication, or intolerance to teriflunomide, dimethyl fumarate, or fingolimod; **OR**
		  ○ Diagnosis of active secondary progressive disease [SPMS]; **AND**
		• For patients of reproductive potential:
		  ○ Provider has counseled patient to use contraception during treatment and for 6-months after the last dose
		  ○ Lactating women will be counseled to discontinue breast feeding during treatment
		  ○ Provider has confirmed (via pregnancy test) that the patient is not pregnant prior to receiving treatment; **AND**
		• Prescriber attests to ALL of the following:
		  ○ Patient does not have a currently malignancy
		  ○ Patient does not have serious active chronic infections such as HIV, tuberculosis, and active hepatitis
		  ○ Patient has been screened for the presence of tuberculosis
		Renewal Criteria:
		• At least 43 weeks (approx. 10 months) has/will have elapsed since the end of the first treatment course; **AND**
		• Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression)
			40 tabs/2 years	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Mayzent®	NP	**Initial Criteria:**
		• Patient is ≥ 18 years of age; **AND**
		• Prescribed by, or in consultation with, a neurologist; **AND**
		• Patient has a relapsing form of multiple sclerosis (i.e. clinically Isolated syndrome, relapsing-remitting disease, active secondary progressive disease); **AND**
		• Patient does NOT have any of the following:
		  ○ Recent (within 6-months) myocardial infarction, unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure with hospitalization, or Class III/IV heart failure; **OR**
		  ○ Prolonged QTc interval at baseline (> 500 msec); **OR**
		  ○ History of Mobitz Type II second- or third-degree atrioventricular block or sick sinus syndrome (unless treated with a functioning pacemaker) ; **OR**
		  ○ CYP2C9*3/*3 genotype; **OR**
		  ○ Active infection (including clinically important localized infections); **AND**
		• Patient will not be initiating therapy after previous treatment with alemtuzumab (Lemtrada); **AND**
		• For female patients of reproductive potential, the following has been addressed:
		  ○ Provider has counseled patient to use effective contraception during treatment with therapy
		  ○ Lactating patient has been counseled on the risks versus benefits of breastfeeding while on treatment
		Renewal Criteria:
		• Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression)
			Starter pack:
			1 pack/Rx;
			0.25 mg:
			4 tabs/day;
			2 mg: 1 tab/day
				General PA Form

Ponvory®	NP	**Initial Criteria:**
		• Patient ≥ 18 years old; **AND**
		• Prescribed by, or in consultation with, a neurologist; **AND**
		• ONE of the following:
		  ○ Diagnosis of relapsing-remitting multiple sclerosis [RRMS]; **AND**
		  – Trial and failure, contraindication, or intolerance to teriflunomide, dimethyl fumarate, or fingolimod; **OR**
		  ○ Diagnosis of active secondary progressive disease [SPMS]; **AND**
		• Patient must NOT meet any of the following:
		  ○ Recent (within 6-months) myocardial infarction, unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure with hospitalization, or Class III/IV heart failure; **OR**
		  ○ Presence of Mobitz type II second-degree, third degree atrioventricular (AV) block, sick sinus syndrome unless the patient has a functioning pacemaker; **AND**
		• For female patients of reproductive potential, all the following has been addressed:
		  ○ Provider has counseled patient to use effective contraception during treatment
		  ○ Lactating patients have been counseled on the risks versus benefits of breastfeeding while on treatment
		Renewal Criteria:
		• Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression)
			1/day	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Tascenso ODT®	NP	**Initial Criteria:** • Patient is ≥ 10 years of age; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Patient has a relapsing form of multiple sclerosis (i.e. clinically Isolated syndrome, relapsing-remitting disease, active secondary progressive disease); **AND** • Patient is unable to swallow sold dosage forms **Renewal Criteria:** • Patient is unable to swallow sold dosage forms; **AND** • Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression)	1/day	General PA Form
Tecfidera®	NP	**Initial Criteria:** • Patient is ≥ 18 years of age; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Patient has a relapsing form of multiple sclerosis (i.e. clinically Isolated syndrome, relapsing-remitting disease, active secondary progressive disease); **AND** • Clinically valid reason why preferred dimethyl fumarate cannot be used **Renewal Criteria:** • Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression)	2/day	General PA Form
Vumerity®	NP	**Initial Criteria:** • Patient is ≥ 18 years of age; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Patient has a relapsing form of multiple sclerosis (i.e. clinically Isolated syndrome, relapsing-remitting disease, active secondary progressive disease); **AND** • Trial and failure, contraindication, or intolerance of teriflunomide or fingolimod; **AND** • Trial and failure, contraindication, or intolerance of dimethyl fumarate **Renewal Criteria:** • Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression)	4/day	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Zeposia®	NP	**Initial Criteria:**
		• Patient is ≥ 18 years of age; **AND**
		• ONE of the following:
		  ○ Diagnosis of relapsing forms of multiple sclerosis, including clinical isolated syndrome, relapsing-remitting disease, and active secondary progressive disease: **AND**
		  – Prescribed by, or in consultation with, a neurologist; **AND**
		  – Trial and failure, contraindication, or intolerance to teriflunomide, dimethyl fumarate, OR fingolimod (not required for SPMS); **OR**
		  ○ Diagnosis of moderately to severely active ulcerative colitis (UC) in adults; **AND**
		  – Trial and failure to two of the following (or have an intolerance or contraindication to all agents):
		  • A preferred adalimumab product
		  • Entyvio
		  • Infliximab
		  • A preferred JAK inhibitor (e.g. Xeljanz and Rinvoq); **AND**
		• Patient does NOT have any of the following:
		  ○ Recent (within the previous 6-months) myocardial infarction, unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure with hospitalization, or Class III/IV heart failure
		  ○ Severe untreated sleep apnea
		  ○ History or presence of Mobitz Type II second-degree, or third-degree atrioventricular block, sick sinus syndrome, or sino-atrial block (unless treated with a functioning pacemaker)
		  ○ Concomitantly taking a monoamine oxidase (MAO) inhibitor; **AND**
		• For female patients of reproductive potential, all the following has been addressed:
		  ○ Patient has been counseled to use effective contraception during treatment
		  ○ Lactating patients have been counseled on the risks versus benefits of breastfeeding while on treatment
		Renewal Criteria:
		• Documentation of positive clinical response to therapy (e.g., improvement or stabilization in radiologic disease activity, clinical relapses, disease progression, endoscopic remission)
			1/day	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Respiratory and Allergy Biologics				

Adbry®	P	**Initial Criteria (6-month duration):**
		• Patient is ≥ 12 years of age; **AND**
		• Diagnosis of moderate to severe atopic dermatitis with ≥ 1 of the following:
		  ○ Involvement of at least 10% of body surface area (BSA)
		  ○ Scoring Atopic Dermatitis (SCORAD) score of 20 or more
		  ○ Investigator's Global Assessment (IGA) with a score ≥ 3
		  ○ Eczema Area and Severity Index (EASI) score of ≥ 16
		  ○ Incapacitation due to AD lesion location (e.g., head and neck, palms, soles, or genitalia); **AND**
		• Trial and failure (documented by claims) or contraindication to both of the following:
		  ○ A topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone)
		  ○ A topical calcineurin inhibitor; **AND**
		• Prescribed by, or in consultation with, a dermatologist, allergist, or immunologist
		Renewal Criteria:
		• Documented positive response to therapy (e.g., improved pruritus, BSA involvement, EASI, IGA, or SCORAD)
			Initial month:
			6 syringes
			
			Maintenance:
			4 syringes/28 days
				General PA Form

Ebglyss®	P	See Adbry prior authorization criteria	Initial 6 months: 4 pens Maintenance: 1 pens/28 days	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Dupixent®	P	**Asthma**
		Initial Criteria (6-month duration):
		• Diagnosis of moderate to severe asthma; **AND**
		• Patient is ≥ 6 years old; **AND**
		• One of the following:
		  ○ Asthma is an eosinophilic phenotype as defined by a baseline (pre- treatment) peripheral blood eosinophil level ≥ 150 cells/µL or peripheral blood eosinophil levels > 300 cells/mcL; **OR**
		  ○ Patient is currently dependent on oral corticosteroids for the treatment of asthma; **AND**
		• Asthma is inadequately controlled as shown by one of the following:
		  ○ Two more exacerbations requiring systemic corticosteroids within the past 12 months; **OR**
		  ○ Asthma-related emergency treatment (e.g., hospitalization, intensive care unit stay, or mechanical ventilation in the past 12 months; **OR**
		  ○ Patient is currently dependent on oral corticosteroids for the treatment of asthma; **AND**
		• Patient is currently being treated with ONE of the following, unless there is a contraindication:
		  ○ Combination therapy including BOTH of the following:
		  – One medium or high dose inhaled corticosteroid (ICS); **AND**
		  – One additional asthma controller medication [e.g., LABA, leukotriene antagonist, theophylline]; **OR**
		  ○ One maximally dosed combination inhaled ICS/ LABA or ICS/LAMA/LABA product; **AND**
		• Will be used as adjunct therapy along with above asthma treatment; **AND**
		• Prescribed by, or in consultation with, a pulmonologist, allergist, or immunologist
		Renewal Criteria:
		• Documentation of a positive clinical response (e.g., reduction in exacerbations, improvement of FEV1, decreased use of rescue medications); **AND**
		• Patient is being treated with ONE of the following, unless there is a contraindication:
		  ○ Combination therapy including both a high-dose ICS and an additional asthma controller medication
		  ○ One maximally dosed combination inhaled ICS/ LABA or ICS/LAMA/LABA product
		
		Atopic Dermatitis Diagnosis
		Initial Criteria (6-month duration):
		• Patient is ≥ 6-months of age; **AND**
		• Diagnosis of moderate to severe atopic dermatitis with ≥ 1 of the following:
		  ○ Involvement of at least 10% of body surface area (BSA)
		  ○ Scoring Atopic Dermatitis (SCORAD) score of 20 or more
		  ○ Investigator's Global Assessment (IGA) with a score ≥ 3
		  ○ Eczema Area and Severity Index (EASI) score of ≥ 16
		  ○ Incapacitation due to AD lesion location (e.g., head and neck, palms, soles, or genitalia); **AND**
		• Trial and failure (documented by claims) or contraindication to both of the following:
		  ○ A topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone)
		  ○ A topical calcineurin inhibitor; **AND**
		• Prescribed by, or in consultation with, a dermatologist, allergist, or immunologist
		Renewal Criteria:
		• Documented positive response to therapy (e.g., improved pruritus, BSA involvement, EASI, IGA, or SCORAD)
			2 syringes/28 days	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Dupixent®
(continued)
	P	**Chronic Idiopathic Urticaria (CIU)**
		Initial Criteria (6-month duration):
		• Patient is ≥ 12 years of age; **AND**
		• Diagnosis of chronic spontaneous idiopathic urticaria (CSU) or chronic idiopathic urticaria (CIU); **AND**
		• Patient remains symptomatic despite a 2-week trial to BOTH the following taken in combination:
		  ○ A second generation H1-antihistamine (e.g., cetirizine, fexofenadine, levocetirizine, loratadine); **AND**
		  ○ One of the following:
		  – Different second generation H1-antihistamine (e.g., cetirizine, fexofenadine, levocetirizine)
		  – First generation H1-antihistamine (e.g., diphenhydramine, chlorpheniramine, hydroxyzine)
		  – H2-receptor antihistamine (e.g., famotidine, cimetidine, ranitidine)
		  – Leukotriene modifier (e.g., montelukast); **AND**
		• Prescribed by, or in consultation with, an allergist, dermatologist, or immunologist
		Renewal Criteria:
		• Documentation of positive clinical response to therapy (e.g., reduction in exacerbations, itch severity, hives)
		
		Chronic rhinosinusitis with nasal polyposis (CRSwNP)
		Initial Criteria (6-month duration):
		• Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) confirmed by ONE of the following:
		  ○ Presence of bilateral nasal polyps
		  ○ Patient has previously required surgical removal of bilateral nasal polyps; **AND**
		• Patient is ≥ 12 years of age; **AND**
		• One of the following:
		  ○ Patient has required prior sinus surgery; **OR**
		  ○ Patient has required systemic corticosteroids for CRSwNP
		  ○ Symptoms persist after trial of TWO of the following classes of agents:
		  – Nasal saline irrigations
		  – Intranasal corticosteroids
		  – Antileukotriene agents; **AND**
		• Must be used in combination with intranasal corticosteroid, unless contraindication or intolerance; **AND**
		• Prescribed by, or in consultation with, an allergist, immunologist, otolaryngologist, or pulmonologist
		Renewal Criteria:
		• Documentation of positive clinical response to therapy; **AND**
		• Will continue to use in combination with intranasal corticosteroids
			2 syringes/28 days	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Dupixent®
(continued)
		Chronic Obstructive Pulmonary Disease (COPD)
		Initial Criteria (6-month duration):
		• Diagnosis of COPD; **AND**
		• Patient is ≥ 18 years of age; **AND**
		• Eosinophilic phenotype confirmed by peripheral blood eosinophil levels > 300 cells/mcL; **AND**
		• COPD is inadequately controlled as shown by one of the following:
		  ○ Two or more exacerbations requiring systemic corticosteroids and/or antibiotics within the past 12 months; **OR**
		  ○ COPD-related emergency treatment (e.g., hospitalization in the past 12 months, mechanical ventilation); **AND**
		• Patient is currently receiving standard of care COPD treatment, unless contraindicated (i.e., ICS/LAMA/LABA); **AND**
		• Post-bronchodilator FEV1/FVC ratio <0.7 and FEV1 ≤ 79%; **AND**
		• Medication will be used as maintenance add-on therapy
		Renewal Criteria
		• Positive clinical response to treatment (e.g., improved FEV1 from baseline, reduction in COPD exacerbations); **AND**
		• Patient is currently receiving standard of care COPD treatment, unless contraindicated (i.e., ICS/LAMA/LABA); **AND**
		Medication will be used as maintenance add-on therapy
		
		Eosinophilic Esophagitis (EoE)
		Initial Criteria (6-month duration):
		• Diagnosis of eosinophilic esophagitis (EOE) as confirmed by an esophageal biopsy demonstrating ≥ 15 intraepithelial eosinophils per high power field (documentation required); **AND**
		• Patient is ≥ 1 years of age and weighs at least 15 kg; **AND**
		• Patient is experiencing symptoms related to esophageal dysfunction (e.g., dysphagia, food impaction, chest pain that may not respond to antacids, gastroesophageal reflux disease-like symptoms); **AND**
		• Symptoms are inadequately controlled after a trial of ONE of the following:
		  ○ Proton pump inhibitor (e.g., pantoprazole, omeprazole); **OR**
		  ○ Topical esophageal corticosteroids (e.g., budesonide, fluticasone); **AND**
		• Prescribed by, or in consultation with, a gastroenterologist, allergist, or immunologist
		Renewal Criteria:
		• Documentation of positive clinical response to therapy (e.g., reduction of eosinophil count, improvement of symptoms)
		
		Prurigo Nodularis (PN)
		Initial Criteria:
		• Diagnosis of Prurigo Nodularis (PN); **AND**
		• Patient age ≥ 18 years; **AND**
		• Patient has 20 or more nodular lesions (IGA PN-S ≥ 3); **AND**
		• Inadequate response, intolerance, or contraindication to a topical steroid; **AND**
		• Prescribed by, or in consultation with, a dermatologist, allergist, or immunologist
		Renewal Criteria:
		• Documentation of positive clinical response (e.g., improved symptoms or IGA PN-S)
			2 syringes/28 days	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Fasenra®	P	**Asthma**
		Initial Criteria (6-month duration):
		• Diagnosis of moderate to severe asthma; **AND**
		• Patient is ≥ 6 years old; **AND**
		• One of the following:
		  ○ Asthma is an eosinophilic phenotype as defined by a baseline (pre- treatment) peripheral blood eosinophil level ≥ 150 cells/µL or peripheral blood eosinophil levels > 300 cells/mcL; **OR**
		  ○ Patient is currently dependent on oral corticosteroids for the treatment of asthma; **AND**
		• Asthma is inadequately controlled as shown by one of the following:
		  ○ Two more exacerbations requiring systemic corticosteroids within the past 12 months; **OR**
		  ○ Asthma-related emergency treatment (e.g., hospitalization, intensive care unit stay, or mechanical ventilation); **OR**
		  ○ Patient is currently dependent on oral corticosteroids for the treatment of asthma; **AND**
		• Patient is currently being treated with ONE of the following, unless there is a contraindication:
		  ○ Combination therapy including both of the following:
		  – One high dose inhaled corticosteroid (ICS)
		  – One additional asthma controller medication [e.g., LABA, leukotriene receptor antagonist, theophylline]; **OR**
		  ○ One maximally dosed combination ICS/ LABA or ICS/LAMA/LABA product; **AND**
		• Will be used as adjunct therapy along with above asthma treatment; **AND**
		• Prescribed by, or in consultation with, a pulmonologist, allergist, or immunologist
		Renewal Criteria:
		• Documentation of a positive clinical response (e.g., reduction in exacerbations, improvement of FEV1, decreased use of rescue medications); **AND**
		• Patient is being treated with ONE of the following, unless there is a contraindication:
		  ○ Combination therapy including both a high-dose ICS and an additional asthma controller medication
		  ○ One maximally dosed combination ICS/ LABA or ICS/LAMA/LABA product
		
		Eosinophilic granulomatosis with polyangiitis (EGPA)
		Initial Criteria (6-month duration):
		• Diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA); **AND**
		• Patient is ≥ 18 years of age; **AND**
		• Patient is currently taking standard therapy [i.e., systemic glucocorticoids (e.g., prednisolone, prednisone) with or without immunosuppressive therapy (e.g., cyclophosphamide, rituximab)]; **AND**
		• One of the following:
		  ○ Patient has relapsing disease (defined as a relapse requiring additional or dose escalation of corticosteroids or immunosuppressant, or hospitalization); **OR**
		  ○ Refractory disease as defined as failure to attain remission within the prior 6 months following induction treatment with standard therapy regimens; **AND**
		• Patient's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy); **AND**
		• Prescribed by, or in consultation with, a pulmonologist, rheumatologist, allergist, or immunologist
		Renewal Criteria:
		• Documentation of positive clinical response to therapy (e.g., reduced frequency or severity of relapses, reduction or discontinuation of corticosteroids or immunosuppressants)
			Initial (first 3 doses): 1/30 days
			
			Maintenance: 1/56 days
				General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Nemluvio®	P	**Atopic Dermatitis Diagnosis**
		Initial Criteria (6-month duration):
		• Patient is ≥ 12 years of age; **AND**
		• Diagnosis of moderate to severe atopic dermatitis with ≥ 1 of the following:
		  ○ Involvement of at least 10% of body surface area (BSA)
		  ○ Scoring Atopic Dermatitis (SCORAD) score of 20 or more
		  ○ Investigator's Global Assessment (IGA) with a score ≥ 3
		  ○ Eczema Area and Severity Index (EASI) score of ≥ 16
		  ○ Incapacitation due to AD lesion location (e.g., head and neck, palms, soles, or genitalia); **AND**
		• Trial and failure (documented by claims) or contraindication to both of the following:
		  ○ A topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone)
		  ○ A topical calcineurin inhibitor; **AND**
		• Prescribed by, or in consultation with, a dermatologist, allergist, or immunologist
		Renewal Criteria:
		• Documented positive response to therapy (e.g., improved pruritus, BSA involvement, EASI, IGA, or SCORAD)
		
		Prurigo Nodularis (PN)
		Initial Criteria:
		• Diagnosis of Prurigo Nodularis (PN); **AND**
		• Patient age ≥ 18 years; **AND**
		• Patient has 20 or more nodular lesions (IGA PN-S ≥ 3); **AND**
		• Inadequate response, intolerance, or contraindication to a topical steroid; **AND**
		• Prescribed by, or in consultation with, a dermatologist, allergist, or immunologist; **AND**
		• Trial and failure, contraindication, or intolerance to Dupixent
		Renewal Criteria:
		• Documentation of positive clinical response (e.g., improved symptoms or IGA PN-S)
			2 injections/28 days	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Nucala®	P	**Asthma**
		Initial Criteria (6-month duration):
		• Diagnosis of moderate to severe asthma; **AND**
		• Patient is ≥ 6 years old; **AND**
		• One of the following:
		  ○ Asthma is an eosinophilic phenotype as defined by a baseline (pre- treatment) peripheral blood eosinophil level ≥ 150 cells/µL or peripheral blood eosinophil levels > 300 cells/mcL; **OR**
		  ○ Patient is currently dependent on oral corticosteroids for the treatment of asthma; **AND**
		• Asthma is inadequately controlled as shown by one of the following:
		  ○ Two more exacerbations requiring systemic corticosteroids within the past 12 months
		  ○ Asthma-related emergency treatment (e.g., hospitalization, intensive care unit stay, or mechanical ventilation)
		  ○ Patient is currently dependent on oral corticosteroids for the treatment of asthma; **AND**
		• Patient is currently being treated with ONE of the following, unless there is a contraindication:
		  ○ Combination therapy including both of the following:
		  – One high dose inhaled corticosteroid (ICS)
		  – One additional asthma controller medication [e.g., LABA, leukotriene receptor antagonist, theophylline]; **OR**
		  ○ One maximally dosed combination ICS/ LABA or ICS/LAMA/LABA product; **AND**
		• Will be used as adjunct therapy along with above asthma treatment; **AND**
		• Prescribed by, or in consultation with, a pulmonologist, allergist, or immunologist
		Renewal Criteria:
		• Documentation of a positive clinical response (e.g., reduction in exacerbations, improvement of FEV1, decreased use of rescue medications); **AND**
		• Patient is being treated with ONE of the following, unless there is a contraindication:
		  ○ Combination therapy including both a high-dose ICS and an additional asthma controller medication
		  ○ One maximally dosed combination ICS/ LABA or ICS/LAMA/LABA product
		Eosinophilic granulomatosis with polyangiitis (EGPA)
		Initial Criteria (6-month duration):
		• Diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA); **AND**
		• Patient is ≥ 18 years of age; **AND**
		• Patient is currently taking standard therapy [i.e., systemic glucocorticoids (e.g., prednisolone, prednisone) with or without immunosuppressive therapy (e.g., cyclophosphamide, rituximab)]; **AND**
		• One of the following:
		  ○ Patient has relapsing disease (defined as a relapse requiring additional or dose escalation of corticosteroids or immunosuppressant, or hospitalization); **OR**
		  ○ Refractory disease as defined as failure to attain remission within the prior 6 months following induction treatment with standard therapy regimens; **AND**
		• Patient's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy); **AND**
		• Prescribed by, or in consultation with, a pulmonologist, rheumatologist, allergist, or immunologist
		Renewal Criteria:
		• Documentation of positive clinical response to therapy (e.g., reduced frequency or severity of relapses, reduction or discontinuation of corticosteroids or immunosuppressants)
			3 pens or syringes / 28 days	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Nucala®
(continued)
	P	**Hypereosinophilic syndrome (HES)**
		Initial Criteria (6-month duration):
		• Patient is ≥ 12 years of age; **AND**
		• Patient has had HES for > 6-months without an identifiable non-hematologic secondary cause (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy, etc.); **AND**
		• Patient does not have FIP1L1-PDGFRα kinase-positive HES; **AND**
		• Baseline (pre-Nucala treatment) blood eosinophil level ≥1000 cells/µL (documentation required); **AND**
		• Patient is currently receiving a stable dose of background HES therapy (e.g., oral corticosteroid, immunosuppressor, or cytotoxic therapy); **AND**
		• Prescribed by, or in consultation with a pulmonologist, rheumatologist, allergist, or immunologist; **AND**
		Renewal Criteria:
		• Documentation of positive clinical response to therapy
		
		Chronic rhinosinusitis with nasal polyps (CRSwNP) Diagnosis
		Initial Criteria (6-month duration):
		• Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) confirmed by ONE of the following:
		  ○ Presence of bilateral nasal polyps
		  ○ Patient has previously required surgical removal of bilateral nasal polyps; **AND**
		• Patient is ≥ 18 years of age; **AND**
		• One of the following:
		  ○ Patient has required prior sinus surgery; **OR**
		  ○ Patient has required systemic corticosteroids for CRSwNP; **OR**
		  ○ Symptoms persist after trial of TWO of the following classes of agents:
		  – Nasal saline irrigations
		  – Intranasal corticosteroids
		  – Antileukotriene agents; **AND**
		• Must be used in combination with intranasal corticosteroid, unless contraindication or intolerance; **AND**
		• Prescribed by, or in consultation with, an allergist, immunologist, otolaryngologist, or pulmonologist
		Renewal Criteria:
		• Documentation of positive clinical response to therapy; **AND**
		• Will continue to use in combination with intranasal corticosteroids
			3 pens or syringes /28 days	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Tezspire®	P	**Asthma**
		Initial Criteria (6-month duration):
		• Diagnosis of severe asthma; **AND**
		• Patient is ≥ 12 years old; **AND**
		• Patient has inadequately controlled asthma as shown by one of the following:
		  ○ Two more exacerbations requiring systemic corticosteroids within the past 12 months; **OR**
		  ○ Asthma-related emergency treatment (e.g., hospitalization, intensive care unit stay, or mechanical ventilation); **OR**
		  ○ Patient is currently dependent on oral corticosteroids for the treatment of asthma; **AND**
		• Patient is currently being treated with ONE of the following, unless there is a contraindication:
		  ○ Combination therapy including both of the following:
		  – One medium or high dose inhaled corticosteroid (ICS); **AND**
		  – One additional asthma controller medication [e.g., LABA, leukotriene antagonist, theophylline]; **OR**
		  ○ One maximally dosed combination inhaled ICS/ LABA or ICS/LAMA/LABA product; **AND**
		• Will be used as adjunct therapy along with above asthma treatment; **AND**
		• Prescribed by, or in consultation with, a pulmonologist, allergist, or immunologist
		Renewal Criteria:
		• Documentation of a positive clinical response (e.g., reduction in exacerbations, improvement of FEV1, decreased use of rescue medications); **AND**
		• Patient is being treated with ONE of the following, unless there is a contraindication:
		  ○ Combination therapy including both a high-dose ICS and an additional asthma controller medication
		  ○ One maximally dosed combination ICS/ LABA or ICS/LAMA/LABA product
			4 pens or syringes /28 days	General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Xolair®	P	**Asthma**
		Initial Criteria (6-month duration):
		• Diagnosis of moderate to severe persistent; **AND**
		• Patient is ≥ 6 years old; **AND**
		• Dose requested is consistent with corresponding weight and IgE level per manufacturer's dosing chart; **AND**
		• Baseline (pre-treatment) serum total IgE level greater than or equal to 30 IU/mL and less than or equal to 1300 IU/mL; **AND**
		• Positive skin test or in vitro reactivity to a perennial aeroallergen; **AND**
		• Patient has inadequately controlled asthma as shown by one of the following:
		  ○ Two more exacerbations requiring systemic corticosteroids within the past 12 months; **OR**
		  ○ Asthma-related emergency treatment (e.g., hospitalization, intensive care unit stay, or mechanical ventilation; **OR**
		• Patient is currently dependent on oral corticosteroids for the treatment of asthma; **AND**
		• Patient is currently being treated with ONE of the following, unless there is a contraindication:
		  ○ Combination therapy including both of the following:
		  – One medium or high dose inhaled corticosteroid (ICS); **AND**
		  – One additional asthma controller medication [e.g., LABA, leukotriene antagonist, theophylline]; **OR**
		  ○ One maximally dosed combination inhaled ICS/ LABA or ICS/LAMA/LABA product; **AND**
		• Will be used as adjunct therapy along with above asthma treatment; **AND**
		• Prescribed by, or in consultation with, a pulmonologist, allergist, or immunologist
		Renewal Criteria:
		• Documentation of a positive clinical response (e.g., reduction in exacerbations, improvement of FEV1, decreased use of rescue medications); **AND**
		• Patient is being treated with ONE of the following, unless there is a contraindication:
		  ○ Combination therapy including both a high-dose ICS and an additional asthma controller medication
		One maximally dosed combination ICS/ LABA or ICS/LAMA/LABA product
		
		Chronic Idiopathic Urticaria (CIU)
		Initial Criteria (6-month duration):
		• Patient is ≥ 12 years of age; **AND**
		• Diagnosis of chronic spontaneous idiopathic urticaria (CSU) or chronic idiopathic urticaria (CIU); **AND**
		• Patient remains symptomatic despite a 2-week trial to BOTH the following taken in combination:
		  ○ A second generation H1-antihistamine (e.g., cetirizine, fexofenadine, levocetirizine, loratadine); **AND**
		  ○ One of the following:
		  – Different second generation H1-antihistamine (e.g., cetirizine, fexofenadine, levocetirizine)
		  – First generation H1-antihistamine (e.g., diphenhydramine, chlorpheniramine, hydroxyzine)
		  – H2-receptor antihistamine (e.g., famotidine, cimetidine, ranitidine)
		  – Leukotriene modifier (e.g., montelukast); **AND**
		• Prescribed by, or in consultation with, an allergist, dermatologist, or immunologist
		Renewal Criteria:
		• Documentation of positive clinical response to therapy (e.g., reduction in exacerbations, itch severity, hives)
				General PA Form

IMMUNOLOGICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Xolair®
(continued)
		IgE-mediated food allergy
		• Diagnosis of IgE-mediated food allergy confirmed by BOTH of the following:
		  ○ History of type I allergic reactions; **AND**
		  ○ Food specific skin prick testing (SPT) or IgE antibody in vitro testing; **AND**
		• Xolair is to be used in combination with food allergen avoidance; **AND**
		• Dose requested is consistent with corresponding weight and IgE level per manufacturer's dosing chart; **AND**
		• Prescribed by, or in consultation with allergist or immunologist
		Chronic rhinosinusitis with nasal polyps (CRSwNP)Initial Criteria (6-month duration):
		• Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) confirmed by ONE of the following:
		  ○ Presence of bilateral nasal polyps
		  ○ Patient has previously required surgical removal of bilateral nasal polyps; **AND**
		• Patient is ≥ 18 years of age; **AND**
		• One of the following:
		  ○ Patient has required prior sinus surgery; **OR**
		  ○ Patient has required systemic corticosteroids for CRSwNP; **OR**
		  ○ Symptoms persist after trial of TWO of the following classes of agents:
		  – Nasal saline irrigations
		  – Intranasal corticosteroids
		  – Antileukotriene agents; **AND**
		• Must be used in combination with intranasal corticosteroid, unless contraindication or intolerance; **AND**
		• Prescribed by, or in consultation with, an allergist, immunologist, otolaryngologist, or pulmonologist
		Renewal Criteria:
		• Documentation of positive clinical response to therapy; **AND**
		• Will continue to use in combination with intranasal corticosteroids
				General PA Form

Cibinqo®	NP	**Initial criteria (6-month duration):**
		• Patient is ≥ 12 years of age; **AND**
		• Diagnosis of moderate to severe atopic dermatitis with ≥ 1 of the following:
		  ○ Involvement of at least 10% of body surface area (BSA)
		  ○ Scoring Atopic Dermatitis (SCORAD) score of 20 or more
		  ○ Investigator's Global Assessment (IGA) with a score ≥ 3
		  ○ Eczema Area and Severity Index (EASI) score of ≥ 16
		  ○ Incapacitation due to AD lesion location (e.g., head and neck, palms, soles, or genitalia); **AND**
		• Trial and failure (documented by claims) or contraindication to both of the following:
		  ○ A topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone)
		  ○ A topical calcineurin inhibitor; **AND**
		• Prescribed by, or in consultation with, a dermatologist, allergist, or immunologist
		• Trial and failure, contraindication, or intolerance of a preferred agent indicated for atopic dermatitis (e.g., Adbry, Dupixent, Ebglyss, Nemluvio)
		Renewal Criteria:
		• Documented positive response to therapy (e.g., improved pruritus, BSA involvement, EASI, IGA, or SCORAD)
			1/day	General PA Form

MISCELLANEOUS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Oral Iron Chelators				
deferiprone	NP	• Patient has a diagnosis of ONE of the following: ○ Transfusional iron overload due to thalassemia syndromes regardless of prior chelation exposure ○ Transfusional iron overload in patients with sickle cell disease or other anemias; AND • Patient is 8 years of age and up (tablets); OR 3 years of age and up (solution); AND • ONE of the following: ○ Serum ferritin > 1,000 mcg/L ○ Liver iron concentration is > 3.2 Fe/g dw L; **AND** • Clinically valid reason as to why patient cannot use Exjade®		General PA Form
deferasirox	NP	See Exjade® prior authorization criteria; **AND** • Clinically valid reason as to why patient cannot use Exjade®		General PA Form
Exjade®	NP	• Patient has a diagnosis of ONE of the following: ○ Chronic iron overload due to blood transfusions in patients 2 years of age and older ○ Non-transfusion-dependent thalassemia (NTDT) in patients aged 10 and older; **AND** ONE of the following: ○ Serum ferritin > 1,000 mcg/L; OR ○ Liver iron concentration is > 3.2 Fe/g dw L If platelet count is less than 50x109/L., creatinine clearance is greater than 40 mL/min		General PA Form
Ferriprox®	NP	See deferiprone prior authorization criteria		General PA Form
Ferriprox Twice-A-Day®	NP	See deferiprone prior authorization criteria		
Jadenu®	NP	See Exjade® prior authorization criteria; **AND** • Clinically valid reason as to why patient cannot use Exjade®		General PA Form
Oral Iron Supplements				
Accrufer®	NP	• Patient has iron deficiency; **AND** • Patient is 18 years of age or older; **AND** • Patient must NOT meet any of the following: ○ Hemochromatosis and other iron overload syndromes ○ Receiving repeated blood transfusions or intravenous iron supplementation ○ Irritable bowel disease (IBD) flare ○ Concomitant use of dimercaprol	2/day	General PA Form
Saliva Stimulating Agents				
pilocarpine	P		3/day	General PA Form
cevimeline	NP	Trial and failure, contraindication, or intolerance of pilocarpine	3/day	
Evoxac®	NP	Trial and failure, contraindication, or intolerance of pilocarpine	3/day	

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Acute Myeloid Leukemia (AML) Agents				
Venclexta®	P		Ramp-Up Phase Dosing: Dispense 7-day supply of 10mg tabs (for 20mg dose); followed by 7-day supply of 50mg tabs	General PA Form

Daurismo®	NP	**Initial Approval Criteria (6-month duration):**
		• ONE of the following:
		  ○ Patient ≥ 75 years of age
		  ○ Patient has comorbidities that preclude the use of intensive induction chemotherapy (i.e., Severe Cardiac Disease, Baseline serum creatinine > 1.3 mg/dL, or Baseline Eastern Cooperative Oncology Group (ECOG) performance status of 2); **AND**
		• Women of child-bearing potential must have a negative pregnancy test; **AND**
		• Female patients of reproductive potential and males undergoing treatment with female partners of reproductive should use effective contraception during treatment and for at least 30 days after treatment; **AND**
		• Daurismo® will be used in conjunction with low-dose subcutaneous cytarabine; **AND**
		Renewal Criteria (6-month duration):
		Patient continues to meet initial criteria; **AND**
		Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., QTc- interval prolongation)
			25 mg: 84/28 days; 100 mg: 28/28 days	General PA Form

Onureg®	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of acute myeloid leukemia; **AND**
		• Patient has achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy and are not able to complete intensive curative therapy; **AND**
		• Female patients of child-bearing potential have a negative pregnancy test and have been advised that:
		  ○ Female patients should use effective contraception during treatment and for at least 6-months after treatment
		  ○ Males undergoing treatment with female partners of reproductive age should use effective contraception during treatment and for at least 3 months after treatment due to male mediated teratogenicity; **AND**
		Renewal Criteria:
		Patient must continue to meet the initial criteria; **AND**
		Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., myelosuppression, renal impairment, hepatic impairment)
			1/day	General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Vanflyta®	NP	**Initial Criteria:** • Patient has newly diagnosed acute myeloid leukemia (AML); **AND** • AML is FLT3 internal tandem duplication (ITD)-positive as detected by an FDA-approved test; **AND** • Vanflyta will be used in combination with cytarabine and anthracycline induction and high dose cytarabine consolidation therapy followed by maintenance monotherapy therapy; **AND** • Vanflyta will not be used as maintenance monotherapy following allogeneic hematopoietic stem cell transplantation (HSCT); **AND** • Patient and prescriber are enrolled in the Vanflyta REMS program **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., hypokalemia, hypomagnesemia, long QT syndrome)	2/day	General PA Form
Xospata®	NP	**Initial Criteria:** Patient has a diagnosis of acute myeloid leukemia (AML); **AND** AML is positive for FLT3 mutation as detected by an FDA-approved; **AND** Females of child-bearing potential had a negative pregnancy test within 7 days before starting Xospata®; **AND** Female and male patients of reproductive potential have been advised to use effective contraception during treatment and for at least 6 and 4 months, respectively, after the last dose **Renewal Criteria:** Patient continues to meet initial criteria; **AND** Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., QT prolongation)	3/day	General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antimetabolites				

Inqovi®	NP	**Initial Criteria: (3-month duration)**
		• Diagnosis of myelodysplastic syndromes (MDS), patients previously treated and untreated, de novo and secondary MDS with the following French American-British subtypes:
		  ○ Refractory anemia
		  ○ Refractory anemia with ringed sideroblasts
		  ○ Refractory anemia with excess blasts
		  ○ Chronic myelomonocytic leukemia [CMML])
		  ○ Intermediate-1, intermediate-2, and high-risk international prognostic IPSS groups; **AND**
		• Patient has tried and failed or is not a candidate for Allogenic stem cell transplantation**; AND**
		• Prescriber will obtain baseline CBC, creatinine clearance (CrCl), and liver enzymes prior to therapy and prior to each cycle; **AND**
		• Patient must not be pregnant or breastfeeding; **AND**
		• Female patients should use effective contraception during treatment and for at least 6-months after treatment; **AND**
		• Males undergoing treatment with female partners of reproductive age should use effective contraception during treatment and 3 months after treatment due to male mediated teratogenicity; **AND**
		• Will not be used concomitantly with drugs metabolized by cytidine deaminase enzyme (i.e., gemcitabine, capecitabine, cytarabine, azacytidine)
		Renewal Criteria: (3-month duration)
		Continues to meet initial criteria; **AND**
		Patient has positive disease response, defined as disease stabilization; **AND**
		Prescriber attests to delay next cycle and reduce dose if patient experiences elevated liver enzymes or renal impairment OR if patient's absolute neutrophil count (ANC) is less than 1,000 cells/microL and platelet count is less than 50,000 cell/microL
			5 per 28-day cycle	General PA Form

Purixan®	NP	• Diagnosis of acute lymphocytic leukemia (ALL); **AND**
		• ONE of the following:
		  ○ For patients ≤ 11 years of age, no prior authorization required
		  ○ For patients > 11 years of age, Purixan will be approved for patients unable to swallow tablets
				General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Colorectal Cancer Agents, Miscellaneous				
Lonsurf®	P		8/day	General PA Form
Fruzaqla®	NP	**Initial Criteria:** • Diagnosis of metastatic colorectal cancer; **AND** • Patient has tried and failed, contraindication, or intolerance to ALL of the following chemotherapy-based regimens: ○ Fluoropyrimidine, ○ Oxaliplatin ○ Irinotecan ○ Anti- vascular endothelial growth factor (VEGF) therapy (e.g., bevacizumab); **AND** • If RAS wild-type, patient has tried and failed, contraindication, or intolerance to anti-epidermal growth factor receptor (EGFR) therapy (e.g., cetuximab, panitumumab); **AND** • Prescribed by or in consultation with an oncologist **Renewal Criteria:** Patient continues to meet initial criteria; **AND** Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND** Patient does not have unacceptable toxicity (e.g., hypertension, hemorrhagic events)	5 mg: 21/28 days 1 mg: 84/28 days	General PA Form
EGFR Inhibitors				
Lazcluze®	NP	**Initial Criteria** • Diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC); **AND** • Disease is positive for epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations as detected by an FDA-approved test; **AND** • Lazcluze will be used in combination with Rybrevant; **AND** • Prescribed by, or in consultation with, an oncologist **Renewal Criteria** • Patient continues to meet the initial criteria; **AND** • Patient does not have unacceptable toxicity (e.g., interstitial lung disease, keratitis, venous thromboembolic events)	80mg: 2/day 240mg: /day	General PA Form
Vizimpro®	NP	• Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC); **AND** • Disease is positive for EGFR mutations as confirmed by FDA approved Test (e.g. cobas® EGFR Mutation Test v2); **AND** • Requested agent will be prescribed by, or in consultation with, an oncologist	1/day	General PA Form
Enzyme Inhibitors: ALK				
Lorbrena®	P		3/day: 25 mg; 1/day: 100 mg	General PA Form
Xalkori sprinkles®	NP	Patient is unable to swallow oral dosage forms		

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Enzyme Inhibitors: BCR-ABL Kinase				

Danziten®	NP	**Initial Criteria**
		• Diagnosis of ONE of the following:
		  ○ Adult patient with newly diagnosed Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase; **OR**
		  ○ Adult patient with chronic phase and accelerated phase Ph+ CML; **AND**
		  – Patient must be resistant to or have contraindication or intolerant to imatinib; **AND**
		• Prescribed by, or in consultation with, an oncologist;
		Renewal Criteria
		• Patient continues to meet initial criteria; **AND**
		• Patient does not show evidence of progressive disease or unacceptable toxicity (e.g. QT prolongation)
			4/day	General PA Form

dasatinib	NP	• Clinically valid reason why preferred Sprycel cannot be used		General PA Form
Imkeldi®	NP	• Patient is <8 years old; **OR** • Patient is unable to swallow oral dosage forms	10mL/day	
Scemblix®	NP	• Patient has ONE of the following: Newly diagnosed Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase; **OR** Philadelphia chromosome-positive CML in chronic phase (Ph+ CML-CP) previously treated with two or more tyrosine kinase inhibitors (TKIs); **OR** Ph+ CML-CP with the T315I mutation; **AND** Prescribed by, or in consultation with, an oncologist; **AND** Females of reproductive potential will use effective contraception during treatment and for 1 week after receiving the last dose of Scemblix; **AND** Patient will not breastfeed during treatment with Scemblix and for 1 week after the last dose		
Enzyme Inhibitors: BRAF Kinase & MEK				

Braftovi®	P	**Initial Criteria:**
		Prescribed by, or in consultation with, an oncologist; **AND**
		• One of the following:
		  ○ Diagnosis of unresectable or metastatic melanoma; **AND**
		  – Patient is positive for BRAF V600E or V600K mutation as confirmed by an FDA-approved test; **AND**
		  – Prescribed in combination with Mektovi®
		  ○ Diagnosis of metastatic colorectal cancer (CRC); **AND**
		  – Cancer is positive for BRAF V600E mutation as confirmed by an FDA-approved test after prior therapy
		  ○ Diagnosis of metastatic non-small cell lung cancer (NSCLC);
		  – Cancer is positive for BRAF V600E mutation, as detected by an FDA-approved test; **AND**
		  – Prescribed in combination with Mektovi®
		Renewal Criteria:
		Patient continues to meet initial criteria; **AND**
		No unacceptable disease progression or unacceptable toxicity
			6/day	General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Mektovi®	P	**Initial Criteria:**
		• Prescribed by, or in consultation with, an oncologist; **AND**
		• Prescribed in combination with Braftovi®; **AND**
		• One of the following:
		  ○ Diagnosis of unresectable or metastatic melanoma; **AND**
		  – Patient is positive for BRAF V600E or V600K mutation as confirmed by an FDA-approved test; **AND**
		  ○ Diagnosis of metastatic non-small cell lung cancer (NSCLC);
		  – Cancer is positive for BRAF V600E mutation as detected by an FDA-approved test; **AND**
		Renewal Criteria:
		Patient continues to meet initial criteria; **AND**
		No unacceptable disease progression or unacceptable toxicity
			6/day	General PA Form

Gomekli®	NP	**Initial Criteria:**
		• Diagnosis of neurofibromatosis type 1 (NF1); **AND**
		• Patient has plexiform neurofibromas that are BOTH of the following:
		  ○ Not amenable to complete resection
		  ○ Causing significant morbidity (e.g., disfigurement, motor dysfunction, pain, airway dysfunction, visual impairment); **AND**
		• Prescribed by, or in consultation with, an oncologist or neurologist; **AND**
		• If the request is for the tablets for oral suspension, patient is unable to swallow solid dosage forms
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• Prescriber attests that patient has experienced improvement in disease severity and/or symptoms; **AND**
		• Patient does not have unacceptable toxicity (e.g., retinal pigment epithelial detachment, ventricular dysfunction, rash)
			1mg cap: 6/day
			2 mg cap: 4/day
			1 mg susp tab: 8/day	

Koselugo®	NP	**Initial Criteria:** • Diagnosis of neurofibromatosis type 1 (NF1); **AND** • Patient has symptomatic, inoperable plexiform neurofibromas (PN); **AND** • Prescribed by, or in consultation with, an oncologist or neurologist **Renewal Criteria:** Patient continues to meet initial criteria; **AND** Prescriber attests that patient has experienced improvement in disease severity and/or symptoms; **AND** Patient does not have unacceptable toxicity (e.g., retinal pigment epithelial detachment, severe diarrhea, rash, increased bleeding, myalgia)	10 mg: 10/day 25 mg: 4/day	General PA Form
Mekinist® solution	NP	• Patient is <8 years old; **OR** • Patient is unable to swallow solid dosage forms		General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Ojemda®	NP	**Initial Criteria:** • Diagnosis of relapsed or refractory pediatric low-grade glioma (PLGG); **AND** • Patient has BRAF fusion or rearrangement or BRAF V600 mutation; **AND** • Prescribed by, or in consultation with, an oncologist **Renewal Criteria:** • Patient demonstrates disease stabilization or clinical response to therapy (e.g., stabilized or decrease tumor size, decreased pain, improved vision, increased quality of life)	24/28 days	General PA Form
Tafinlar® solution	NP	• Patient is <8 years old; **OR** • Patient is unable to swallow solid dosage forms		
Enzyme Inhibitors: BTK				
Brukinsa®	P		4/day	General PA Form
Calquence®	P		2/day	
Imbruvica® suspension	NP	• Patient is unable to swallow capsules		

Jaypirca®	NP	**Initial Criteria:**
		• Diagnosis of mantle cell lymphoma (MCL); **AND**
		  ○ Patient has received TWO prior therapies including a BTK inhibitor (e.g., Ibrutinib, acalabrutinib, zanubrutinib); **AND**
		  ○ Jaypirca® will be used as monotherapy; **OR**
		• Diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL); **AND**
		  ○ Patient has received TWO prior therapies including a BTK inhibitor (e.g., Ibrutinib, acalabrutinib, zanubrutinib) and a BCL-2 inhibitor (e.g., Venclexta); **AND**
		  ○ Jaypirca® will be used as monotherapy
		Renewal Criteria:
		• Patient continues to meet the initial criteria; **AND**
		• Absence of unacceptable toxicity from Jaypirca (e.g., hemorrhage, severe infections, myelosuppression (neutropenia, thrombocytopenia, anemia), atrial fibrillation/flutter, second primary malignancies); **AND**
		• Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread
			50 mg: 1/day
			100 mg: 2/day
				General PA Form

Enzyme Inhibitors: CDK				
Kisqali®	P		63 tabs/28 days	General PA Form
Kisqali/Femara®	P		200mg pack: 49 tabs/28 days; 400 mg pack: 70 tabs/28 days; 600 mg pack: 91 tabs/28 days	

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Enzyme Inhibitors: FGFR				
Balversa®	NP	**Initial Criteria:** • Patient has a diagnosis of locally advanced or metastatic urothelial carcinoma; **AND** • Patient has a susceptible FGFR3 or FGFR2 genetic alteration as confirmed by an FDA-approved diagnostic; **AND** • Patient has progressed during or following ≥ 1 prior line of platinum-containing chemotherapy, including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy; **AND** • Prescribed by, or in consultation with, an oncologist; **AND** • Provider attests to ALL the following: ○ Patient has received a baseline ophthalmological examination (e.g., assessment of visual acuity, slit lamp examination, fundoscopy, and optical coherence tomography) ○ Patient has had a baseline serum phosphate level measurement and it is within normal limits ○ Patient phosphate intake is restricted to < 800 mg per day ○ Patient will not concomitantly take the requested agent with a strong CYP2C9 or CYP3A4 inhibitors (e.g., fluconazole, itraconazole) or with strong CYP2C9 or CYP3A4 inducers (e.g., rifampicin) or, if therapy is unavoidable, prescriber attestation that the patient will be monitored for adverse reactions **Renewal Criteria:** Patient continues to meet initial criteria; **AND** • Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND** • Patient does not have unacceptable toxicity (e.g., central serous retinopathy/retinal pigment epithelial detachment (CSR/RPED), severe hyperphosphatemia)	3 mg (3/day); 4 mg (2/day); 5 mg (1/day)	General PA Form
Lytgobi®	NP	**Initial Criteria (6-month duration):** • Patient has diagnosis of unresectable, locally advanced, or metastatic intrahepatic cholangiocarcinoma; **AND** • Patient has fibroblast growth factor receptor 2 (FGFR2) gene fusions or other rearrangements as detected by • FDA approved test; **AND** • The patient has progressed on at least one systemic therapy; **AND** • The prescriber attest to ALL of the following: ○ Patient will have an ophthalmological examination including optical coherence tomography (OCT) ○ performed prior to initiation of therapy, every 2 months for the first 6-months of treatment and every 3 ○ months thereafter, and urgently at any time for visual symptoms ○ Prescriber will obtain baseline phosphate levels and monitor for hyperphosphatemia throughout treatment ○ Patient is not pregnant ○ Female patients of reproductive potential and males with female partners of reproductive age have been advised to use effective contraception during treatment and for at least 1 week after the last dose ○ Patient is not concomitantly taking strong dual P-gp and CYP3A Inducers (e.g. rifampin) **Renewal Criteria:** • Positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND** • Patient does not have unacceptable toxicity (e.g., retinal pigment epithelial detachment, severe hyperphosphatemia)	12 mg: 84/month 16 mg: 112/month 20 mg: 140/month	General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Pemazyre®	NP	**Initial Criteria:**
		• One of the following:
		  ○ Diagnosis of previously treated unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test
		  ○ Diagnosis of relapsed or refractory myeloid/lymphoid neoplasms (MLNs) with FGFR1 rearrangement; **AND**
		• Prescriber attests to ALL the following:
		  ○ Patient will have an ophthalmological examination including optical coherence tomography (OCT) performed prior to initiation of therapy, every 2 months for the first 6-months of treatment and every 3 months thereafter, and urgently at any time for visual symptoms
		  ○ Prescriber will obtain baseline phosphate levels and monitoring for hyperphosphatemia
		  ○ Females and males with female partners will be advised to use effective contraception during treatment and for 1 week after the final dose due to embryo-fetal toxicity
		  ○ Patient is not concomitantly taking strong and moderate CYP3A Inducers
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND**
		• Patient does not have unacceptable toxicity (e.g., retinal pigment epithelial detachment, severe hyperphosphatemia)
			14 tablets/ 21 days	General PA Form

Enzyme Inhibitors: HER2 Targeted Therapies				

Tukysa®	NP	**Initial Criteria:**
		• ONE of the following:
		  ○ Diagnosis of advanced unresectable or metastatic HER2-positive breast cancer and both of the following:
		  – Patient has received at least one or more prior anti-HER2 based regimen;
		  – Must be used in combination with trastuzumab and capecitabine; **OR**
		  ○ Diagnosis of RAS wild-type, HER2-positive unresectable or metastatic colorectal cancer; **AND**
		  – Must be used in combination with trastuzumab; **AND**
		• Prescribed by, or in consultation with, an oncologist; **AND**
		• Prescriber attests to ALL of the following:
		  ○ Patient has baseline ALT, AST, and bilirubin measured and within normal limits
		  ○ Patient continues to receive ALT/AST and bilirubin monitoring every 3 weeks during treatment
		Renewal Criteria:
		Patient continues to meet initial criteria; **AND**
		Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND**
		Patient does not have unacceptable toxicity (e.g., diarrhea, hepatotoxicity)
			50 mg: 10/day
			150 mg: 4/day
				General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Enzyme Inhibitors: Isocitrate Dehydrogenase (IDH)				
Tibsovo®	P		2/day	General PA Form
Rezlidhia®	NP	**Initial Criteria (6-month duration):** • Patient has diagnosis of relapsed or refractory acute myeloid leukemia (AML); AND • Patient has an isocitrate dehydrogenase-1 (IDH1) mutation, as detected by an FDA-approved test **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., hepatoxicity, differentiation syndrome)	2/day	General PA Form
Rezlidhia®	NP	**Initial Criteria:** • Diagnosis of grade 2 astrocytoma or oligodendroglioma; **AND** • Tumor has susceptible isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation; **AND** • Patient has had prior surgery including biopsy, sub-total resection, or gross total resection; **AND** • Prescribed by, or in consultation with, an oncologist **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., hepatoxicity)	40mg: 1/day 10mg: 2/day	General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Enzyme Inhibitors: KRAS				
Krazati®	NP	• ONE of the following: ○ Diagnosis of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC) as confirmed by an FDA-approved test; **AND** – Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitors [anti- PD-1, PD-L1 immunotherapy], platinum-based chemotherapy); **AND** – Patient has at least one measurable lesion as defined by Response Evaluation Criteria in Solid Tumors (RECIST v1.1); **OR** ○ Diagnosis of KRAS G12C-mutated locally advanced or metastatic colorectal cancer (CRC) as confirmed by an FDA-approved test; **AND** – Patient has tried and failed, contraindication, or intolerance to ALL the following chemotherapy-based regimens: • Fluoropyrimidine • Oxaliplatin • Irinotecan; **AND** – Krazati will be used in combination with cetuximab; **AND** Prescribed by, or in consultation with, an oncologist; **AND** Prescriber attests that patient is not pregnant or breastfeeding during treatment and for 1 week after the final dose; **AND** Prescriber attests that patient will be monitored for the following: Hepatotoxicity: Monitor liver function tests ((ALT, AST, and total bilirubin) prior to the start of Krazati, every 3 weeks for the first 3 months of treatment then once monthly as clinically indicated Interstitial Lung Disease (ILD)/Pneumonitis: Monitor for new or worsening pulmonary symptoms; **AND** Prescriber attests that Patient will not take Krazati with: Acid-reducing agents (e.g., proton pump inhibitors, H_2 receptor antagonists, antacids, etc.) • Strong CYP3A4 inducers (e.g., rifampin, carbamazepine, etc.)	6/day	General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Lumakras®	NP	ONE of the following: Diagnosis of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC) as confirmed by an FDA-approved test for detection of KRAS G12C; **AND** Patient has at least one measurable lesion as defined by Response Evaluation Criteria in Solid Tumors (RECIST v1.1); **AND** Diagnosis of KRAS G12C-mutated locally advanced or metastatic colorectal cancer (CRC) as confirmed by an FDA-approved test; **AND** Trial and failure, contraindication, or intolerance to ALL the following chemotherapy-based regimens: Fluoropyrimidine Oxaliplatin Irinotecan; AND Agent will be used in combination with panitumumab; **AND** Prescribed by, or in consultation with, an oncologist; **AND** Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitors [anti- PD-1, PD-L1 immunotherapy], platinum-based chemotherapy); **AND** Prescriber attests that patient is not pregnant or breastfeeding during treatment with Lumakras and for 1 week after the final dose; **AND** Prescriber attests that Patient will be monitored for the following: Hepatotoxicity: Liver function tests ((ALT, AST, and total bilirubin) prior to the start of Lumakras, every 3 weeks for the first 3 months of treatment then once monthly as clinically indicated Interstitial Lung Disease (ILD)/Pneumonitis: New or worsening pulmonary symptoms; **AND** Prescriber attests that the patient will not take Lumakras with: Acid-reducing agents (e.g., proton pump inhibitors, H_2 receptor antagonists, antacids.) Strong CYP3A4 inducers (e.g., rifampin, carbamazepine)		General PA Form
Enzyme Inhibitors: Menin				
Revuforj®	NP	**Initial Criteria (6-month duration)** • Diagnosis of relapsed or refractory acute leukemia (e.g. acute myeloid leukemia (AML), Acute lymphoblastic leukemia (ALL), or Mixed phenotype acute leukemia (MPAL)); **AND** • Disease is positive for lysine methyltransferase 2A gene (KMT2A) translocation; **AND** • Prescribed by, or in consultation with, an oncologist or hematologist **Renewal Criteria** • Patient continues to meet initial criteria; **AND** • Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., differentiation syndrome, QTc-interval prolongation)		General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Enzyme Inhibitors: MET				
Tabrecta®	P	**Initial Criteria:** Patient must have metastatic non-small cell lung cancer (NSCLC); **AND** Prescribed by, or in consultation with, an oncologist; **AND** Patient must have a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping in tumor specimens as confirmed by an FDA-approved test; **AND** **Renewal Criteria:** Patient continues to meet the initial criteria; **AND** Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND** • Patient does not have unacceptable toxicity (e.g., interstitial lung disease, liver enzymes outside of normal limits)	4/day	General PA Form
Tepmetko®	NP	**Initial Criteria:** • Diagnosis of metastatic non-small cell lung cancer (NSCLC); **AND** • Disease is harboring mesenchymal-epithelial transition (MET) exon 14 skipping alterations; **AND** • Prescribed by, or in consultation with, an oncologist **Renewal Criteria:** • Patient continues to meet the initial criteria; **AND** • Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND** • Patient does not have unacceptable toxicity (e.g. interstitial lung disease, liver enzymes outside of normal limits)	2/day	General PA Form
Enzyme Inhibitors: MTOR				
Afinitor Disperz®	NP	• Patient is unable to swallow solid dosage forms		General PA Form
everolimus soluble tabs	NP	• Patient is unable to swallow solid dosage forms		
Enzyme Inhibitors: PARP Inhibitors				
Lynparza®	P		4/day	General PA Form
Rubraca®	P		4/day	

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Talzenna®	P	**Initial Criteria (6-month duration):**
		• One of the following:
		  ○ Diagnosis of HER2-negative locally advanced or metastatic breast cancer; **AND**
		  – Patient has a BRCA-positive mutated germline confirmed by an FDA-approved test (e.g., BRACAnalysis CDx); **AND**
		  – Patient must have received treatment with an anthracycline and/or a taxane (unless contraindicated) as neoadjuvant, adjuvant, and/or metastatic treatment; **AND**
		  – If patient received prior platinum-based chemotherapy, disease progression nor relapse were experienced within 6-months of receiving neoadjuvant or adjuvant platinum therapy; **OR**
		  ○ Diagnosis of metastatic castration-resistant prostate cancer; **AND**
		  – Patient has homologous recombination repair (HRR) gene mutation; **AND**
		  – Patient must use in combination with Xtandi; **AND**
		  – Patient has had a bilateral orchiectomy OR will receive a gonadotropin-releasing hormone (GnRH)-analog (e.g., leuprolide, goserelin, triptorelin) ; **AND**
		• Provider will monitor complete blood counts at baseline and monthly thereafter; **AND**
		• Patient does not have untreated CNS metastases (patient has completed definitive local therapy and may have stable CNS lesions on repeat brain imaging); **AND**
		• Patient will not use requested agent in combination with any other PARP inhibitors; **AND**
		• Patient has not received prior therapy with a PARP-inhibitor (e.g., Lynparza)
		Renewal Criteria (6-month duration):
		• Patient continues to meet initial criteria; **AND**
		• Tumor response has been demonstrated with either stabilization of disease or decrease in size of tumor or tumor spread; **AND**
		• Absence of unacceptable toxicity from; **AND**
		• Patient has not developed myelodysplastic syndrome (MDS)/acute myeloid leukemia (AML)
			1/day	General PA Form

Zejula®	P		3/day	General PA Form
Enzyme Inhibitors: RET				

Retevmo®	P	**Initial Criteria:**
		• Patient must have ONE of the following diagnoses:
		  ○ Locally advanced or metastatic *RET* fusion-positive non-small cell lung cancer (NSCLC)
		  ○ Advanced or metastatic *RET*-mutant medullary thyroid cancer (MTC) who require systemic therapy
		  ○ Advanced or metastatic *RET* fusion-positive thyroid cancer who require systemic therapy and who are radioactive iodine-refractory
		  ○ Locally advanced or metastatic solid tumors with a RET gene fusion that have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options; **AND**
		• Prescribed by, or in consultation with, an oncologist
		Renewal Criteria:
		• Patient continues to meet the initial criteria; **AND**
		• Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND**
		• Patient does not have unacceptable toxicity (e.g., severe or life-threatening hemorrhaging, uncontrolled blood pressure, interstitial lung disease, elevated liver enzymes, QT interval prolongation)
			80mg: 4/day
			40mg: 6/day
				General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Gavreto®	NP	**Initial Criteria:**
		• Diagnosis of ONE of the following:
		  ○ Metastatic RET fusion-positive non-small cell lung cancer (NSCLC) that is detected by an FDA approved test
		  ○ Advanced or metastatic RET fusion-positive thyroid cancer who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate); **AND**
		• Requested agent will be prescribed by, or in consultation with, an oncologist
		Renewal Criteria:
		• Patient continues to meet the initial criteria; **AND**
		• Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND**
		• Patient does not have unacceptable toxicity (e.g., interstitial lung disease, elevated liver enzymes, severe or life-threatening hemorrhaging, uncontrolled blood pressure)
			4/day	General PA Form

Enzyme Inhibitors: Tropomyosin Receptor Kinase (TRK)				

Augtyro®	NP	**Initial Criteria: (6-month duration)**
		• Patient has diagnosis of ONE of the following:
		  ○ Diagnosis of locally advanced or metastatic Non-Small Cell Lung Cancer (NSCLC); **AND**
		  – Tumor is ROS1 rearrangement positive; **OR** ~~**AND**~~
		  ○ NTRK Gene Fusion-Positive Solid Tumor and BOTH of the following:
		  – Disease is locally advanced or metastatic or where surgical resection is likely to result in severe morbidity
		  – Disease has progressed following treatment or there is no satisfactory alternative treatment; **OR**
		  ○ Diagnosis of secretory breast cancer or mammary analogue secretory cancer; **AND**
		• Tumor is ROS1 rearrangement positive; **AND**
		• Prescribed by, or in consultation with, an oncologist; **AND**
		• For patients with reproductive potential, prescriber attest to all of the following:
		  ○ Patient is not pregnant prior to initiation of therapy
		  ○ Female patients have been advised to use effective contraception during treatment and for 2 months after the final dose
		  ○ Female patients have been advised to not breastfeed during treatment and 10 days after the final dose
		  ○ Male patients with female partners of reproductive potential have been advised to use effective contraception during treatment and for 4 months after the final dose
		Renewal Criteria:
		• Patient must continue to meet the initial criteria; **AND**
		• Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND**
		• Patient does not have unacceptable toxicity (e.g., hepatotoxicity, central nervous system effects, hyperuricemia, skeletal fractures, creatine phosphokinase elevation, interstitial lung disease/pneumonitis)
			8/day	General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Rozlytrek® capsules	NP	**Initial Criteria (6-month duration):** Patient meets ONE of the following disease specific criteria: Diagnosis of recurrent, advanced, or metastatic Non-Small Cell Lung Cancer (NSCLC); **AND** Disease is ROS1 positive as detected by an FDA-approved test NTRK Gene Fusion-Positive Solid Tumor; **AND** Presence of a neurotrophic tyrosine receptor kinase (NTRK) gene fusion as detected by an FDA-approved test, without a known acquired resistance mutation; **AND** Disease is metastatic or where surgical resection is likely to result in severe morbidity; **AND** Disease has progressed following treatment or there is no satisfactory alternative treatment; **AND** Prescribed by, or in consultation with, an oncologist; **AND** Patient does not have a history of prolonged QTc interval (e.g., QTc interval > 450 milliseconds); **AND** Patient will not use therapy in combination with drugs which prolong QT-interval; **AND** Patient will not use therapy with other NTRK-inhibitor therapy or ROS1-directed therapy; **AND** Patient does not have signs and symptoms of hyperuricemia as evidenced by a baseline serum; **AND** Patient will avoid concomitant use with moderate or strong CYP3A inducers or inhibitors; **AND** Provider attests to perform ALL the following: Assess left ventricular ejection fraction (LVEF) prior to initiation of Rozlytrek in patients with symptoms or known risk factors for CHF Monitor liver tests, including ALT and AST, every 2 weeks during the first month of the patient's treatment, then monthly thereafter, and as clinically indicated Assess serum uric acid levels prior to initiation and periodically during treatment with Rozlytrek Assess QT interval and electrolytes at baseline and periodically during treatment patients who have or who are at risk for QTc interval prolongation Advise females of reproductive potential of the potential risk to a fetus and use of effective contraception during treatment and for 5 weeks following the final dose Advise males with female partners of reproductive potential to use effective contraception during treatment and for 3 months after the final dose **Renewal Criteria (6-month duration):** Patient must continue to meet the initial criteria; **AND** Documented disease response with treatment, as defined by stabilization of disease or decrease in size of tumor or tumor spread; **AND** There is absence of unacceptable toxicity from the drug (e.g., congestive heart failure, hepatotoxicity, central nervous system effects, hyperuricemia, QT-interval prolongation, visual disturbances)	100 mg: 5/day; 200 mg: 3/day	General PA Form
Rozlytrek® pack	NP	See Rozlytrek capsules prior authorization criteria; **AND** • Clinically valid reason why Rozlytrek capsules cannot be used	600mg/day	General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Vitrakvi®	NP	**Initial Criteria:**
		• Patient has a solid tumor (e.g., soft tissue sarcoma, salivary gland, infantile fibrosarcoma, thyroid, lung, or gastrointestinal stromal tumors); **AND**
		• Prescribed by, or in consultation with, an oncologist; **AND**
		• Patient meets ALL the following:
		  ○ Presence of a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation
		  ○ Disease is metastatic or surgical resection is likely to result in severe morbidity
		  ○ Disease has progressed following treatment or there is no satisfactory alternative treatment; **AND**
		• Provider attests to ALL the following:
		  ○ Monitor liver tests including ALT and AST every 2 weeks during the first month of treatment, then monthly thereafter and as clinically indicated
		  ○ Advise females with reproductive potential and males with female partners of reproductive potential to use effective contraception during treatment and for 1 week after the final dose
		Renewal Criteria:
		Patient continues to meet initial criteria; **AND**
		Patient has tumor response with stabilization of disease or decrease in size of tumor or tumor spread; **AND**
		Patient does not have unacceptable toxicity such as severe neurotoxicity, hepatotoxicity; (adverse effects resolve following dose recommendations/no permanent discontinuation required)
			25 mg: 3/day;
			100 mg: 2/day;
			20 mg/mL:
			10 mL/day
				General PA Form

Hormonal Agents: Aromatase Inhibitors				
anastrozole	P	• For male patients, diagnosis of breast cancer • For female patients, no PA required		General PA Form
Hormonal Agents: Anti-Androgens Second Generation				

Akeega®	NP	**Initial Criteria (6-month duration)**
		• Diagnosis of metastatic castration-resistant prostate cancer (mCRPC); **AND**
		• Patient has a deleterious or suspected deleterious BRCA-mutated (BRCAm) germline confirmed by an FDA approved test; **AND**
		• Will be taken in combination with prednisone; **AND**
		• ONE of the following:
		  ○ Medication will used in combination with androgen deprivation therapy (ADT) (e.g., leuprolide, goserelin, triptorelin, degarelix, relugolix)
		  ○ Patient has had a bilateral orchiectomy
		Renewal Criteria
		• Patient continues to meet the initial criteria; **AND**
		• Tumor response with stabilization of disease or decrease in size of tumor or tumor spread; **AND**
		• Absence of unacceptable toxicity from the drug (e.g., hepatotoxicity, fractures, hypertension)
			2/day	General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Erleada®	NP	**Initial Criteria (6-month duration):**
		• Patient has diagnosis of ONE of the following:
		  ○ Non-metastatic castration-resistant disease prostate cancer (nmCRPC)
		  ○ Metastatic castration-sensitive disease prostate cancer (mCSPC); **AND**
		• ONE of the following:
		  ○ Medication will used in combination with androgen deprivation therapy (ADT) (e.g., leuprolide, goserelin, triptorelin, degarelix, relugolix)
		  ○ Patient has had a bilateral orchiectomy
		Renewal Criteria:
		Patient continues to meet the initial criteria; **AND**
		Tumor response with stabilization of disease or decrease in size of tumor or tumor spread; **AND**
		• Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include seizures, excessive falls and/or fractures and any other Grade 3 or above side effects that are intolerable to patient, etc.
			4/day	General PA Form

Nubeqa®	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of ONE of the following:
		  ○ Non-metastatic castration-resistant prostate cancer (nmCRPC); **AND**
		  ○ Metastatic hormone-sensitive prostate cancer (mHSPC); **AND**
		• ONE of the following:
		  ○ Medication will used in combination with androgen deprivation therapy (ADT) (e.g., leuprolide, goserelin, triptorelin, degarelix, relugolix); **OR**
		  ○ Patient has had a bilateral orchiectomy
		Renewal Criteria:
		• Patient continues to meet the initial criteria; **AND**
		• Tumor response with stabilization of disease or decrease in size of tumor or tumor spread; **AND**
		• Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include elevated hepatic enzymes, hyperbilirubinemia, neutropenia, or any other Grade 3 or above side effects that are intolerable to patient, etc.
			4/day	General PA Form

Xtandi® tablets	NP	• Documented allergy or contraindication to an inactive ingredient in the capsules that is NOT in the tablets		General PA Form

Yonsa®	NP	**Initial Criteria (6-month duration):**
		• Patient has metastatic castration-resistant prostate cancer (mCRPC); **AND**
		• Will be taken in combination with methylprednisolone; **AND**
		• ONE of the following:
		  ○ Medication will used in combination with androgen deprivation therapy (ADT) (e.g., leuprolide, goserelin, triptorelin, degarelix, relugolix)
		  ○ Patient has a bilateral orchiectomy; **AND**
		Renewal Criteria:
		• Patient continues to meet the initial criteria; **AND**
		• Tumor response with stabilization of disease or decrease in size of tumor or tumor spread
		• Absence of unacceptable toxicity from the drug (e.g., elevated hepatic enzymes, hypokalemia, fluid retention, hypertension)
				General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Hormonal Agents: GnRH Agonists & LNRH Analogs				
Eligard®	P	• Diagnosis of prostate cancer in male patient		General PA Form
leuprolide	P	• Leuprolide will be approved for patients meeting **ONE** of the following criteria: ○ Diagnosis of prostate cancer in male patient ○ Diagnosis of central precocious puberty in children (onset of secondary sexual development before 8 [girls] or 9 years of age [boys])		General PA Form
Lupron Depot®	NP	• Will be approved for self-administering patients with ONE of the following: ○ Diagnosis of prostate cancer in male patient ○ Diagnosis of endometriosis in female patient ○ Diagnosis of uterine leiomyomas in female patient ○ Diagnosis of recurrent ovarian carcinoma		General PA Form
Orgovyx®	NP	• Diagnosis of advanced prostate cancer in male patient; **AND** • Male patients with female partners of reproductive potential have been advised to use effective contraception during treatment and for two weeks after the last dose; **AND** • Patient will not take requested medication with ANY of the following: ○ P-GP Inhibitors ○ Strong CYP3A Inducers ○ cisapride ○ pimozide ○ thioridazine	30/month (32 tablets for initial month of therapy)	General PA Form
Hormonal Agents: SERM/SERD				
Orserdu®	NP	**Initial Criteria (6-month duration):** • Patient has hormone receptor-positive, HER2-negative advanced breast; **AND** • Patient has received at least one endocrine based regimen; **AND** • Patient has ESR1 mutation detected by FDA-approved test; **AND** • If female, patient is postmenopausal; **AND** • Orserdu will be used as monotherapy; **AND** • Prescribed by, or in consultation with, an oncologist; **AND** • Patient must not be pregnant or breastfeeding; **AND** • Females of reproductive potential and males undergoing treatment with female partners of reproductive age should be advised to use effective contraception during treatment and for 1 week after the final dose **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Patient has positive disease response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND** • Patient does not have unacceptable toxicity (e.g., dyslipidemia, musculoskeletal pain)	345 mg: 1/day 86 mg: 3/day	General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Multikinase Inhibitors: Renal and Thyroid Cancers				

Fotivda®	NP	**Initial Criteria (6-month duration):**
		• Patient has diagnosis of relapsed or refractory advanced renal cell carcinoma (RCC); **AND**
		• Patient has had two or more prior systemic therapies [two kinase inhibitors (KIs), a KI plus an immune checkpoint inhibitor, or a KI plus other systemic agents]; **AND**
		• Prescriber attests to ALL the following:
		  ○ Patient's blood pressure will be assessed prior to and during therapy
		  ○ Patient will be closely monitored due to increased risk of Arterial and venous Thromboembolic Events, Hemorrhagic Events, Proteinuria, and Thyroid Dysfunction
		  ○ Fotivda will be withheld for at least 24 days before elective surgery and will not administer for at least 2 weeks following major surgery and adequate wound healing
		  ○ Patient's baseline liver function tests will be assessed
		  ○ Female and male patients of reproductive potential have been advised to use effective contraception during treatment and for one month after the last dose
		  ○ Agent will not be co-administered with strong CYP3A inducers
		  ○ Patient does not have a history of allergic reactions to tartrazine (only applies to requests for Fotivda 0.89 mg)
		  ○ Female patients are not pregnant or breastfeeding; **AND**
		• Will not use in patients with any of the following:
		  ○ Strong CYP3A inducers
		  ○ History of allergic reactions to tartrazine
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• Prescriber attests to positive response to therapy indicated by tumor response with stabilization of disease OR decrease in size of tumor or tumor spread; **AND**
		• Patient has absence of unacceptable toxicity from the drug (e.g., uncontrolled hypertension, onset of cardiac failure, arterial and venous Thromboembolic Events, hemorrhagic events, proteinuria, thyroid dysfunction, onset of Reversible Posterior Leukoencephalopathy Syndrome (RPLS), or increased LFT's)
			21/28 days	General PA Form

Multiple Myeloma Agents				
lenalidomide	NP	• Clinically valid reason why Revlimid cannot be used		General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Xpovio®	NP	**Initial Criteria (6-month duration):**
		• One of the following:
		  ○ Diagnosis of multiple myeloma; **AND**
		  – Patient has received at least one prior therapy
		  ○ Diagnosis of diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from follicular lymphoma; **AND**
		  – Patient has relapsed or refractory disease; **AND**
		  – Patient has received at least 2 lines of systemic therapy; **AND**
		• Prescribed by, or in consultation with, an oncologist
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• Prescriber attests that the patient has experienced lack of disease progression, and/or improvement in symptoms; **AND**
		• Patient has absence of unacceptable toxicity from the drug (e.g., thrombocytopenia, neutropenia, gastrointestinal toxicity, hyponatremia, neurological toxicity)
			4 packs/month	General PA Form

Myelofibrosis				
Jakafi®	P		2/day	General PA Form

Besremi®	NP	• Diagnosis of polycythemia vera; **AND**
		• Prescribed by, or in consultation with, an oncologist or hematologist; **AND**
		• Patient does not have ANY of the following:
		  ○ Severe, acute, or unstable cardiovascular disease
		  ○ Existence of, or history of severe psychiatric disorders, particularly severe depression, suicidal ideation, or suicide attempt
		  ○ Hypersensitivity to interferon or to any component of BESREMI
		  ○ Hepatic impairment (Child-Pugh B or C)
		  ○ History or presence of active serious or untreated autoimmune disease; **AND**
		• Patient is not an immunosuppressed transplant recipient; **AND**
		• For women of childbearing age, provider has confirmed that the patient is not pregnant prior to receiving treatment; **AND**
		• Patients of reproductive potential will be counseled to use effective contraception during treatment and for at least 8 weeks after the final dose
				General PA Form

Inrebic®	NP	**Initial Criteria:** • Patient has a diagnosis of primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis; **AND** • Patient is considered intermediate-2 risk or high-risk; **AND** • Patient's platelet count ≥ 50 x 109/L; **AND** • Provider attests patient is not thiamine deficient (vitamin B1) and will monitor thiamine level during treatment **Renewal Criteria:** Patient has positive clinical response to therapy (e.g., reduction in symptoms, decreased spleen size); AND Absence of unacceptable toxicity (e.g., encephalopathy, anemia, thrombocytopenia, hepatoxicity, major adverse cardiovascular events, thrombosis, and malignancies); **AND** • Prescriber agrees to continue monitoring thiamine (vitamin B1) levels	4/day	General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Ojjaara®	NP	**Initial Criteria:** • Patient has a diagnosis of primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis; **AND** • Patient is considered intermediate-1, intermediate-2, or high-risk; **AND** • Patient is anemic (e.g., hemoglobin (Hb) < 10 g/dL and/or hematocrit (Hct) < 30%) **Renewal Criteria:** • Patient has positive clinical response to therapy (e.g., reduction in symptoms, decreased spleen size, decreased number of transfusion); **AND** • Absence of unacceptable toxicity (e.g., thrombocytopenia, neutropenia, hepatotoxicity, major adverse cardiovascular events, thrombosis, and malignancies)	1/day	General PA Form
Vonjo®	NP	**Initial Criteria** • Patient has a diagnosis of primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis; **AND** • Patient is considered intermediate risk or high-risk; **AND** • Platelet count is below 50 x 10^9/L **Renewal Criteria:** • Patient has positive clinical response to therapy (e.g., reduction in symptoms, decreased spleen size, decreased number of transfusions); **AND** • Absence of unacceptable toxicity (e.g., thrombocytopenia, major adverse cardiovascular events, thrombosis, malignancies)	4/day	General PA Form
PI3K Inhibitors				
Itovebi®	NP	**Initial Criteria** • Patient has hormone receptor-positive, HER2-negative locally advanced or metastatic breast cancer; **AND** • Patient has a PIK3CA mutation as detected by an FDA-approved test; **AND** • Patient has experienced disease recurrence on or after completing adjuvant endocrine therapy; **AND** • Agent is being given in combination with Ibrance and fulvestrant; **AND** • Agent is prescribed by, or in consultation with, an oncologist **Renewal criteria** • Patient continues to meet initial criteria; **AND** • Patient has clinical response defined as disease stabilization or decrease in size or spread of tumor; **AND** • Patient does not have unacceptable toxicity (e.g., hyperglycemia, diarrhea, stomatitis)	3mg: 2/day 9mg: 1/day	General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Piqray®	NP	**Initial Criteria:** • Patient has hormone receptor-positive, HER2-negative advanced breast cancer; **AND** • Agent is prescribed by, or in consultation with, an oncologist; **AND** • Patient has experienced disease progression on after an endocrine based regimen for advanced disease OR has relapsed disease within 12 months after completion of adjuvant endocrine therapy; **AND** • Patient has a PIK3CA-mutation as detected by an FDA-approved test; **AND** • Piqray® will be given in combination with fulvestrant; **AND** **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Patient has tumor response with stabilization of disease or decrease in the size of tumor or tumor spread; **AND** • Patient does not have unacceptable toxicity such as severe cutaneous reaction or pneumonitis		General PA Form
Truqap®	NP	**Initial Criteria** • Patient has hormone receptor-positive, HER2-negative locally advanced or metastatic breast cancer; **AND** • Patient has one or more PIK3CA/AKT1/PTEN-alterations as detected by an FDA-approved test; **AND** • Patient has experienced disease progression on after an endocrine based regimen for advanced disease OR has relapsed disease within 12 months after completion of adjuvant endocrine therapy; **AND** • Agent is being given in combination with fulvestrant; **AND** • Agent is prescribed by, or in consultation with, an oncologist **Renewal criteria** Patient continues to meet initial criteria; **AND** Patient has clinical response defined as disease stabilization or decrease in size of tumor or tumor spread; **AND** Patient does not have unacceptable toxicity (e.g., hyperglycemia, diarrhea, cutaneous adverse reactions)	64/28 days	General PA Form
Rare/Miscellaneous Oncology Conditions				
Ayvakit®	NP	**Initial Criteria:** • Diagnosis of ONE of the following: ○ Unresectable or metastatic gastrointestinal stromal tumors (GIST) with platelet-derived growth factor-alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations ○ Indolent systemic mastocytosis (ISM) ○ Advanced systemic mastocytosis (AdvSM) Note: Includes aggressive systemic mastocytosis (ASM), systemic mastocytosis with an associated hematological neoplasm (SM-AHN), and mast cell leukemia (MCL); **AND** • Prescribed by, or in consultation with, an oncologist; **AND** **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., intracranial hemorrhage, cognitive dysfunction)	1/day	General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Iwilfin®	NP	**Initial Criteria:** • Diagnosis of high-risk neuroblastoma (HRNB); **AND** • Patient had a partial response to prior multiagent, multimodality therapy; **AND** • Patient has received anti-GD2 immunotherapy (e.g., dinutuximab); **AND** • Prescribed by, or in consultation with, an oncologist **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Patient does not show evidence of progressive disease or unacceptable toxicity (e.g., hepatotoxicity, hearing loss)		General PA Form
Ogsiveo®	NP	**Initial Criteria:** • Diagnosis of progressing desmoid tumor (also known as aggressive fibromatosis); **AND** • Prescriber has reviewed and evaluated appropriate treatment options and attests that the patient requires systemic therapy; **AND** • Prescribed by, or in consultation with, an oncology, hematology, or gastroenterology specialist **Renewal Criteria:** • Patient demonstrates disease stabilization or clinical response to therapy (e.g., decrease tumor size, decreased pain, improved physical function, increased quality of life)	6/day	General PA Form
Qinlock®	NP	**Initial Criteria:** • Diagnosis of unresectable, locally advanced, or metastatic gastrointestinal stromal tumor (GIST); **AND** • Prescribed by, or in consultation with, an oncologist; **AND** • Patient has been previously treated with at least THREE kinase systemic therapies (e.g., imatinib, avapritinib, sunitinib, regorafenib) **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Patient does not show evidence of progressive disease and unacceptable toxicity (e.g., uncontrolled hypertension, cardiac dysfunction)	3/day	General PA Form
Rezurock®	NP	**Initial Criteria (6-month duration):** • Patient has diagnosis of Chronic Graft-Versus-Host Disease; **AND** • Patient is 12 years of age or older; **AND** • Patient has a history of allogenic hematopoietic cell transplant (HCT); **AND** • Agent is prescribed by, or in consultation with, an oncologist, hematologist, or bone marrow transplant specialist; **AND** • Patient has had a previous failure of at least one systemic corticosteroid therapy (i.e., methylprednisolone, prednisone, etc.); **AND** • Patient has had a previous failure of at least one non-steroidal systemic immunosuppressant therapy (e.g., abatacept, alemtuzumab, calcineurin inhibitor, etanercept, hydroxychloroquine, ibrutinib, imatinib, interleukin-2, low-dose methotrexate, mTOR inhibitor, mycophenolate mofetil, pentostatin, rituximab, ruxolitinib, etc.); **AND** • Prescriber attests, if applicable, that patient will be advised that effective contraception should be used during treatment and for at least one week after last dose **Renewal Criteria:** • Patient continues to meet the initial criteria; **AND** Patient is responding positively to treatment	1/day	General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Romvimza®	NP	**Initial Criteria** • Diagnosis of symptomatic tenosynovial giant cell tumor (TGCT); **AND** • Patient has severe morbidity or functional limitations (e.g., worst stiffness numeric rating scale [NRS] of > 4); **AND** • Patient is not a candidate for surgical resection associated with potential worsening, functional limitation, or severe morbidity; **AND** • Prescribed by, or in consultation with, a hematologist or oncologist **Renewal Criteria** • Patient continues to meet initial criteria; **AND** • Patient does not show evidence of progressive disease and unacceptable toxicity (e.g., hepatotoxicity)		

Tazverik®	NP	**Initial Criteria:**
		• Diagnosis of ONE of the following:
		  ○ Metastatic or locally advanced epithelioid sarcoma; **AND**
		  – Patient not eligible for complete resection
		  ○ Relapsed or refractory follicular lymphoma; **AND**
		  – Tumor is positive for an EZH2 mutation as detected by an FDA approved test; **AND**
		  – Patient has received ≥ 2 prior systemic therapies OR has not had satisfactory alternative treatment option; **AND**
		• Prescribed by, or in consultation with, an oncologist; **AND**
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• Patient does not show evidence of progressive disease and unacceptable toxicity (e.g. secondary malignancy)
			8/day	General PA Form

Turalio®	NP	**Initial Criteria:** • Diagnosis of symptomatic tenosynovial giant cell tumor (TGCT); **AND** • Patient has severe morbidity or functional limitations (e.g., worst stiffness numeric rating scale [NRS] of ≥ 4); **AND** • Patient is not a candidate for surgical resection associated with potential worsening, functional limitation, or severe morbidity; **AND** • Prescribed by, or in consultation with, a hematologist or oncologist; **AND** • Prescriber is enrolled in the Turalio REMS Program **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Patient does not show evidence of progressive disease and unacceptable toxicity (e.g., hepatotoxicity)	4/day	General PA Form

ONCOLOGY AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Welireg®	NP	**Initial Criteria:**
		• ONE of the following:
		  ○ Diagnosis of Von Hippel-Lindau (VHL) disease and require therapy for ONE of the following VHL-associated cancers, not requiring immediate surgery:
		  – Renal cell carcinoma (RCC)
		  – Central nervous system (CNS) hemangioblastomas
		  – Pancreatic neuroendocrine tumors (pNET); **AND**
		  ○ Diagnosis of advanced renal cell carcinoma (RCC) and patient has tried and failed, contraindication, or intolerance to ALL of the following:
		  – Programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor (e.g., nivolumab, avelumab, pembrolizumab)
		  – Vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI) (e.g., Cabometyx, Inlyta, Lenvima, Nexavar, Sutent); **AND**
		• Prescribed by, or in consultation with, a hematologist or oncologist; **AND**
		• Patient is not pregnant or breastfeeding; **AND**
		• Females of reproductive potential and males with female partners of reproductive potential should be advised to use effective non-hormonal contraception during treatment and for 1 week after the last dose
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• Patient does not show evidence of progressive disease and unacceptable toxicity (e.g., anemia, hypoxia)
			3/day	General PA Form

OPHTHALMICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Dry Eye Disease Agents				
Lacrisert	P		60 inserts/30 days	General PA Form
Restasis®	P	• Treatment of vernal keratoconjunctivitis (VKC) (i.e., severe atopic keratoconjunctivitis); **OR** • Diagnosis of dry eye disease [i.e., dry eye syndrome, keratoconjunctivitis sicca (KCS)]	60 vials/30 days	
Xiidra®	P	• Diagnosis of dry eye disease [i.e., dry eye syndrome, keratoconjunctivitis sicca (KCS)]; **AND** • Trial and failure or contraindication to Restasis® (trial duration ≥ 12 weeks confirmed by paid claims)	2 vials/day	
Cequa®	NP	• Diagnosis of dry eye disease [i.e., dry eye syndrome, keratoconjunctivitis sicca (KCS)]; **AND** • Trial and failure, or contraindication, to both the following: ○ Restasis® (trial duration > 12 weeks confirmed by paid claims) ○ Xiidra® (trial duration > 12 weeks confirmed by paid claims)	2 vials/day	General PA Form
cyclosporine emulsion 0.05%	NP	• One of the following: ○ Treatment of vernal keratoconjunctivitis (VKC) (i.e., severe atopic keratoconjunctivitis) ○ Diagnosis of dry eye disease [i.e., dry eye syndrome, keratoconjunctivitis sicca (KCS)]; **AND** • Clinically valid reason why the preferred Restasis® cannot be used	60 vials/30 days	General PA Form
Miebo®	NP	See Cequa® prior authorization criteria	3 bottles/30 days	General PA Form
Restasis Multidose®		See cyclosporine emulsion 0.05% prior authorization criteria	1 bottle/30 days	
Tyrvaya®	NP	See Cequa® prior authorization criteria		General PA Form
Vevye®	NP	See Cequa® prior authorization criteria	3 bottles/30 days	
Ophthalmic Alpha-2 Agonists				
apraclonidine	P		1 package/Rx	General PA Form
brimonidine 0.2%	P		1 package/Rx	
Alphagan P®	P		1 package/Rx	
brimonidine 0.1%, 0.15%	NP		1 package/Rx	
Iopidine®	NP		1 package/Rx	
Ophthalmic Antibiotics				
ciprofloxacin	P		10 mL/Rx	General PA Form
erythromycin	P		1 package/Rx	
moxifloxacin	P		1 package/Rx	
neomycin/bac/poly B	P		1 package/Rx	
neomycin/poly B/gramicidin	P		1 package/Rx	
polymyxin B/TMP	P		1 package/Rx	
sulfacetamide soln	P		1 package/Rx	
tobramycin	P		1 package/Rx	
AzaSite®	NP		1 package/Rx	

OPHTHALMICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Besivance®	NP		1 package/Rx	General PA Form
Ciloxan®	NP		10 mL/Rx	
gentamicin	NP		15 mL/Rx	
gatifloxacin 0.5% soln	NP		1 package/Rx	General PA Form
levofloxacin 0.5% soln	NP		1 package/Rx	
moxifloxacin (3X Day)	NP		1 package/Rx	
sulfacetamide oint	NP		1 package/Rx	General PA Form
Tobrex®	NP		1 package/Rx	
Ophthalmic Antibiotic/Steroid Combos				
neomycin/BAC/poly B/HC	P		1 package/Rx	General PA Form
sulfacetamide/ prednisolone	P		1 package/Rx	
tobramycin/ dexamethasone	P		1 package/Rx	General PA Form
Maxitrol®	NP		1 package/Rx	
neomycin/poly B/HC	NP		1 package/Rx	
TobraDex®	NP		1 package/Rx	General PA Form
TobraDex ST®	NP		1 package/Rx	
Zylet®	NP	• Trial and failure, contraindication, or intolerance of TWO preferred agents; **OR** • There is concern over a potential increase in intra-ocular pressure (IOP) with other steroids (i.e., glaucoma, recipient is pre- or post-cataract surgery and a known steroid-responder)	1 package/Rx	
Ophthalmic Antifungals				
Natacyn®	NP	• Diagnosis of ophthalmic fungal infection	1 package/Rx	General PA Form
Ophthalmic Antivirals				
trifluridine	P		1 package/Rx	General PA Form
Zirgan®	P		1 package/Rx	
Ophthalmic Anti-Allergics				
azelastine	P		6 mL/Rx	General PA Form
Bepreve®	P		10 mL/Rx	
cromolyn sodium	P		1 package/Rx	
ketotifen	P		10 mL/Rx	
olopatadine	P		5 mL/Rx	
Alocril®	NP		1 package/Rx	General PA

OPHTHALMICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Alomide®	NP			Form
epinastine	NP		5 mL/Rx	
Lastacaft®	NP		3 mL/Rx	
Pataday®	NP		5 mL/Rx	
Verkazia®	NP	**Initial Criteria (6-month duration):** • Diagnosis of moderate to severe vernal keratoconjunctivitis; **AND** • Trial and failure, contraindication, or intolerance of one agent in ALL the following categories: ○ Ophthalmic antihistamines (e.g., azelastine, olopatadine) ○ Ophthalmic mast cell stabilizers (e.g., cromolyn sodium) ○ Ophthalmic corticosteroids (e.g., dexamethasone, prednisolone, fluorometholone) **Renewal Criteria:** • Patient demonstrates positive clinical response to therapy as evidenced by an improvement in clinical signs and symptoms (e.g., itching, photophobia, papillary hypertrophy, mucus discharge, conjunctival hyperaemia)	120/30 days	General PA Form
Zerviate®	NP	• Clinically valid reason as to why patient cannot use a preferred ophthalmic antihistamine product	30 vials/Rx	
Ophthalmic Beta Blockers				
carteolol	P		1 package/Rx	General PA Form
timolol maleate	P		1 package/Rx	
Betaxolol	NP		1 package/Rx	
Betoptic-S®	NP		1 package/Rx	
Istalol®	NP		1 package/Rx	General PA Form
levobunolol	NP		1 package/Rx	
timolol gel solution	NP		1 package/Rx	
Timoptic Ocudose®	NP		1 package/Rx	
Ophthalmic Carbonic Anhydrase Inhibitors				
Azopt®	P		15 mL/30 days	General PA Form
dorzolamide	P		10 mL/30 days	
dorzolamide/timolol	P		10 mL/30 days	General PA Form
brinzolamide	NP		15 mL/30 days	
Cosopt®	NP		10 mL/30 days	General PA Form
Cosopt PF®	NP		2 vials/day	
Ophthalmic Kinase Inhibitors				
Rhopressa®	P	Patient has a diagnosis of ocular hypertension or open-angle glaucoma; **AND** • Patient has tried/failed or is intolerant to BOTH a prostaglandin inhibitor AND beta-adrenergic antagonist	5 ml/30 days	General PA Form
Rocklatan®	P	See Rhopressa® prior authorization criteria	5 ml/Rx	

OPHTHALMICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Glaucoma Combinations				
Combigan®	P	• Patient is on simultaneous therapy with brimonidine and timolol for at least 60 days; **AND** • Patient demonstrates non-compliance with 2 products individually.	1 package/Rx	General PA Form
Simbrinza®	P	• Patient is on simultaneous therapy with brimonidine and Azopt® for at least 60 days	1 package/Rx	
brimonidine/timolol	NP	• Patient is on simultaneous therapy with brimonidine and timolol for at least 60 days; **AND** • Trial and failure, contraindication, or intolerance of Combigan.	1 package/Rx	
Miotics				
phospholine iodide	NP		1 package/Rx	General PA Form
Vuity®	NP	• Diagnosis of presbyopia; **AND** • Patient is 18 years of age or older; **AND** • Patient is not a candidate for surgery or surgery was non-curative; **AND** • Clinically valid reason as to why the preferred pilocarpine cannot be used	2.5 mL/30 days	
Miscellaneous Ophthalmics				
Cystaran®	NP	• Diagnosis of cystinosis	1 package/Rx	General PA Form
Cystadrops®	NP	Patient is being treated for Corneal cystine crystal deposits with cystinosis; **AND** • Prescriber must provide a clinically valid reason as to why Cystaran cannot be used	1 package/Rx	
Oxervate®	NP	• Patient must be ≥ 2 years of age; **AND** • Patient must have a diagnosis of moderate to severe (stage 2 or stage 3) neurotrophic keratitis (NK); **AND** • Prescribed by, or in consultation with, an ophthalmologist; **AND** • Prescriber attests that patient or caregiver has been counseled on proper administration technique	2 ml/day (lifetime therapy QL=112 ml for 8 weeks of therapy)	General PA Form
Xdemvy®	NP	**Criteria: (2-month duration)** • Diagnosis of Demodex blepharitis; **AND** • Patient has collarettes, cylindrical deposits at the base of eyelashes, confirmed by slit lamp examination; **AND** • Prescribed by or in consultation with an ophthalmologist or optometrist	1 bottle (10 ml)/ 50 days	General PA Form
Ophthalmic NSAIDs ***Approval of NP agents requires trial and failure, contraindication, or intolerance of ONE preferred agent***				
diclofenac	P		1 package/Rx	Ophthalmic NSAIDs PA Form
flurbiprofen	P		1 package/Rx	
ketorolac	P		1 package/Rx	
Acular LS®	NP		1 package/Rx	
Acuvail®	NP		1 package/Rx	
BromSite®	NP		1 package/Rx	Ophthalmic NSAIDs PA Form
bromfenac	NP		1 package/Rx	
Ilevro®	NP		1 package/Rx	
Nevanac®	NP		1 package/Rx	
Prolensa®	NP		1 package/Rx	

OPHTHALMICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Ophthalmic Prostaglandin Agonists				
latanoprost	P		5 mL/Rx	General PA Form
Lumigan®	P		5 mL/Rx	
Travatan Z®	P		5 mL/Rx	
Zioptan®	P		1 container/day	General PA Form
bimatoprost	NP		5 mL/ Rx	
tafluprost	NP		1 container/day	
travoprost	NP	• Clinically valid reason why preferred Travatan Z® cannot be used	5 mL/ Rx	
Iyuzeh®	NP	• Clinically valid reason why preferred Travatan Z® cannot be used	1 container/day	General PA Form
Vyzulta®	NP		5 mL/ Rx	
Xalatan®	NP		5 mL/ Rx	
Xelpros®	NP		5 mL/ Rx	
Ophthalmic Steroids				
Alrex®	P		1 package/Rx	General PA Form
difluprednate	P		1 package/Rx	
fluorometholone	P		1 package/Rx	
Lotemax® suspension	P		1 package/Rx	
Pred Mild®	P		1 package/Rx	
prednisolone acetate	P		1 package/Rx	General PA Form
dexamethasone	NP		1 package/Rx	
Durezol®	NP		1 package/Rx	
Eysuvis®	NP	Patient is being treated for symptoms of Dry Eye disease; **AND** Patient has had a trial and failure of Restasis; **AND** Patient has had a trial and failure of a preferred loteprednol product (e.g., Alrex, Lotemax suspension)	1 package/Rx	
Flarex®	NP		1 package/Rx	
FML Forte®	NP		1 package/Rx	General PA Form
FML Liquifilm®	NP		1 package/Rx	
Lotemax SM® gel	NP		1 package/Rx	
Lotemax ointment	NP		1 package/Rx	
loteprednol gel	NP		1 package/Rx	General PA Form
loteprednol suspension	NP		15 ml/Rx	
Maxidex®	NP		1 package/Rx	
prednisolone sodium phosphate	NP		1 package/Rx	

OPHTHALMICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Pred Forte®	NP		1 package/Rx	
Ophthalmic Vasoconstrictors				
phenylephrine	P			General PA Form

OTICS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Otic Quinolones				
ciprofloxacin otic	P		14 mL/Rx	General PA Form
ofloxacin otic	P		10 mL/Rx	
Otic Steroid/Antibiotic Combinations				
HC/neomycin/ polymyxin B	P		1 package/Rx	General PA Form
ciprofloxacin-dexamethasone	P		7.5 mL/Rx	
Cipro® HC	NP		10 mL/Rx	
Miscellaneous Otics				
acetic acid/HC	P		10 mL/Rx	General PA Form
DermOtic®	P		20 mL/Rx	

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Activated PI3K Delta Syndrome (APDS)				
Joenja®	NP	**Initial Criteria (6-month duration):** • Patient is ≥ 12 years of age and weighs ≥ 45kg; **AND** • Diagnosis of activated phosphoinositide 3-kinase delta syndrome (APDS); **AND** • Diagnosis has been confirmed by the presence of an APDS-associated genetic variant in either PIK3CD or PIK3R1; **AND** • Documentation of clinical findings and manifestations consistent with APDS (e.g., recurrent respiratory tract infections and viral infections, lymphadenopathy, hepatosplenomegaly, autoimmune cytopenia); **AND** • Prescribed by, or in consultation with, hematologist, allergist, or immunologist; **AND** • For patients with reproductive potential, the prescriber attests to all of the following: ○ Patient is not pregnant prior to initiation of therapy ○ Patient has been counseled on potential risk during pregnancy ○ Patient has been advised to use effective contraception during treatment and for 1 week after the last dose ○ Patient has been advised to not breastfeed during treatment and for 1 week after the last dose **Renewal Criteria:** • Disease response to therapy and tolerability compared to baseline (e.g., decreased lymph node size, increased functional B cell counts, decreased infections/hospitalizations, and decreased utilization of immunoglobulin replacement therapy)	2/day	General PA Form
Amyotrophic Lateral Sclerosis (ALS)				
Radicava ORS®	NP	**Initial Criteria (6-month duration):** • Submission of medical records (e.g., chart notes, diagnostic tests, nerve conduction studies, lab values) to support a diagnosis of "definite" or "probable" ALS per the revised EL Escorial diagnostic criteria; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Patient has scores ≥ 2 in all items of the ALS Functional Rating Scale-Revised (ALSFRS-R) criteria at the start of treatment; **AND** • Patient has a forced vital capacity (%FVC) greater than or equal to 80% at the start of treatment • Patient must not be pregnant **Renewal Criteria (6-month duration):** • Prescribed by, or in consultation with, a neurologist; **AND** • Documentation of positive clinical response to therapy (e.g., slowing in the decline of functional abilities); **AND** • Patient is not dependent on invasive ventilation or tracheostomy		General PA Form
Teglutik®	NP	• Diagnosis of Amyotrophic Lateral Sclerosis (ALS); **AND** • Patient is unable to swallow tablets; **AND**	20 mL/day	

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Antineutrophil Cytoplasmic Autoantibody (ANCA)				
Tavneos®	NP	**Initial criteria (6-month duration):** • Diagnosis of severe active anti-neutrophil cytoplasmic autoantibody ANCA-associated vasculitis (granulomatosis with polyangiitis [GPA] or microscopic polyangiitis [MPA]) confirmed by ONE of the following: o ANCA test positive for proteinase 3 (PR3) antigen o ANCA test positive for myeloperoxidase (MPO) antigen o Tissue biopsy; **AND** • Prescribed by, or in consultation with, a rheumatologist, nephrologist, pulmonologist, or a provider with expertise in vascular medicine; **AND** • Will be used as adjunctive therapy with standard therapy (e.g., cyclophosphamide, azathioprine, mycophenolate, rituximab); **AND** • Patient is concurrently on glucocorticoids or has an intolerance or contraindication to glucocorticoids **Renewal Criteria:** • Patient continues to meet initial approval criteria; **AND** • Disease response to therapy and tolerability compared to baseline	6 caps/day	General PA Form
CHAPLE Disease				
Veopoz®	NP	**Initial Criteria:** • Diagnosis of CD55-deficient protein-losing enteropathy (CHAPLE disease); **AND** • Patient has documentation of genetic testing confirming biallelic CD55 loss-of-function mutation; **AND** • Prescriber attests to ALL of the following: o Patient has received *or will receive* Veopoz IV loading dose; o Patient has completed or updated meningococcal vaccination at least 2 weeks prior to administering the first dose of Veopoz unless the risk of delaying therapy outweighs the risk; **AND** • Prescribed by or in consultation with a clinical specialist knowledgeable in appropriate disease management (e.g., geneticist, gastroenterologist, hematologist) **Renewal Criteria:** • Patient has positive clinical response to therapy (e.g., normalization of serum albumin, decreased abdominal pain, diarrhea, facial edema, and peripheral edema)	8 vials/28 days	General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Duchenne Muscular Dystrophy (DMD)				
Duvyzat®	NP	**Initial Criteria:** • Documentation of a confirmed diagnosis of Duchenne muscular dystrophy (DMD); **AND** • Age ≥ 6 years; **AND** • Patient retains meaningful voluntary motor function (e.g., patient can speak, manipulate objects using upper extremities, ambulate); **AND** • Will be used in combination with a stable dose of corticosteroids (e.g. prednisone, Emflaza, Agamree); **AND** • Prescribed by, or in consultation, with a neuromuscular specialist or medical geneticist **Renewal Criteria:** • Patient retains meaningful voluntary motor function (e.g., patient can speak, manipulate objects using upper extremities, ambulate); **AND** • Will be used in combination with a stable dose of corticosteroids (e.g. prednisone, Emflaza, Agamree); **AND** • Patient has received benefit from therapy [e.g., stability or slowing in the decline of symptoms (motor function, respiratory function, musculature strength), quality of life]	12 mL/day	General PA Form

Emflaza®	P	**Initial Criteria:**
		• Documentation of a confirmed diagnosis of Duchenne muscular dystrophy (DMD); **AND**
		• Age ≥ 2 years; **AND**
		• Patient has experienced ≥ ONE of the following adverse reactions directly attributable to therapy with prednisone:
		  ○ Significant weight gain (e.g., crossing 2 percentile lines and/or reaching 98th percentile for age and sex)
		  ○ Significant behavioral changes negatively impacting function at school, home, day care, etc.
		Renewal Criteria:
		• Patient has received benefit from therapy [e.g., stability or slowing in the decline of symptoms (motor function, respiratory function, musculature strength), quality of life]
				General PA Form

Agamree®	NP	See Emflaza prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance to Emflaza	3 bottles (300mL)/ month	
deflazacort	NP	See Emflaza prior authorization criteria; **AND** Clinically valid reason why preferred Emflaza cannot be used		
Fatty Acid Oxidation Disorder (FAOD)				

Dojolvi®	NP	**Initial Criteria:**
		• Diagnosis of long-chain fatty acid oxidation disorders (LC-FAOD) as confirmed by two of the following:
		  ○ Acylcarnitine profile
		  ○ Molecular/genetic test
		  ○ Fibroblast test; AND
		• Patient does not have pancreatic insufficiency; **AND**
		• Prescribed by, or in consultation with, a clinical specialist knowledgeable in appropriate disease-related dietary management (e.g., geneticist, cardiologist, gastroenterologist, etc.); **AND**
		• For patients receiving another medium-chain triglyceride product, discontinue prior to the first dose of Dojolvi®
		Renewal Criteria:
		• Evidence of positive clinical response from baseline (e.g., reduction in signs/symptoms such as hypoglycemia, hepatopathy, skeletal myopathy, rhabdomyolysis, cardiomyopathy, etc.)
				General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Familial Chylomicronemia Syndrome (FCS)				
Tryngolza®	NP	**Initial Criteria (6-month duration):** • Patient is 18 years of age or older; **AND** • Diagnosis of Familial Chylomicronemia Syndrome (FCS) confirmed by ONE of the following: ○ Genetic variants in the FCS-causing genes (e.g. GPIHBP1, APOA5I, APOC2I and LMF1) ○ A North American FCS (NAFCS) Score of greater than or equal to 45 ○ Fasting triglyceride levels > 880 mg/dL with lack of response to triglyceride lowering therapy (e.g. statins, fibrates, omega-3 fatty acids); **AND** • Prescriber attests patient will follow a low fat diet (≤ 20 g/day) while on Tryngolza; **AND** • Prescribed by, or in consultation with, a cardiologist, endocrinologist, gastroenterologist, or lipidologist **Renewal Criteria** • Documentation of positive clinical response to therapy (e.g., triglyceride reduction from baseline, decreased incidence of acute pancreatitis)	1/28 days	General PA Form
Congenital Adrenal Hyperplasia (CAH)				
Crenessity®	NP	**Initial criteria** • Patient is 4 years of age and older; **AND** • Diagnosis of classic congenital adrenal hyperplasia (CAH); **AND** • Patient is currently receiving glucocorticoid replacement therapy for adrenal insufficiency; **AND** • Crenessity will be used as adjunctive treatment with glucocorticoid replacement to control androgens; **AND** • Prescribed by, or in consultation with, an endocrinologist **Renewal criteria** • Crenessity will be used as adjunctive treatment with glucocorticoid replacement to control androgens; **AND** • Positive response to therapy (e.g., improvement or stabilization in steroid regimen or androgen levels)	50 mg=2/day 100 mg=4 day solution= 4 mL/day	General PA Form
Fibrodysplasia ossificans progressive (FOP)				
Sohonos®	NP	• Diagnosis of fibrodysplasia ossificans progressive (FOP); **AND** • One of the following: ○ Female aged ≥ 8 years of age ○ Male aged ≥ 10 years of age; **AND** • Diagnosis of FOP confirmed by one of the following: ○ Mutation in the ALK2/ACVR1 gene ○ Classic FOP clinical features such as malformation of big toe and progressive heterotopic endochondral ossification in ribbons, sheets, and plates ○ Radiographic bone scans detecting heterotopic ossification (HO); **AND** • Prescriber attests to all of the following: ○ Patient is not pregnant ○ Female patients of reproductive potential will be counseled to use effective contraception during treatment with therapy and for at least 1 month after last dose ○ For pediatric patients, premature epiphyseal closure has not occurred		General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Friedreich's Ataxia				
Skyclarys®	NP	**Initial Criteria** • Patient is ≥ 16 years old; **AND** • Patient has diagnosis of Friedreich's ataxia (FA); **AND** • Patient has documentation of genetic testing confirming frataxin (FXN) gene mutation; **AND** • Prescribed by, or in consultation with, a neurologist, geneticist, or cardiologist **Renewal Criteria** • Patient has disease stabilization or clinical response to therapy	3/day	General PA Form
Glucagon-Like Peptide-2 (GLP-2) Analog				
Gattex®	NP	**Initial Criteria:** • Diagnosis of short bowel syndrome, **AND** • Patient is dependent on parenteral nutrition and/or fluids/electrolytes; **AND** • Submission of medical records (e.g. chart notes) documenting that patient has been unable to significantly reduce PN/IV support **Renewal Criteria:** • Submission of medical records (e.g. chart notes) demonstrating a positive response to therapy (e.g. decreased frequency or volume of parenteral nutrition and/or fluids/electrolytes from baseline)		General PA Form
Hereditary Angioedema (HAE) Agents				
Sajazir®	P	• Prescribed by, or in consultation with, a specialist in allergy, immunology, hematology, pulmonology, or genetics; **AND** • Patient is ≥ 18 years of age; **AND** • Submission of medical records (e.g. chart notes and labs) documenting a diagnosis consistent with 1 of the following HAE subtypes: ○ Type I: – Low C1 inhibitor (C1-INH) antigenic level (below the limit of normal defined by the lab performing the test); **AND** – Low C1-INH functional level (below the limit of normal defined by the lab performing the test); **OR** ○ Type II: – Normal to elevated C1-INH antigenic level; **AND** – Low C1-INH functional level (below the limit of normal defined by the lab performing the test); **OR** ○ Type III: – Normal C1-INH antigenic level; **AND** – One of the following: • Confirmed presence of a FXII, angiopoietin-1, plasminogen, KNG1, MYOF, or HS3ST6 gene mutation; **OR** • Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema; **AND** • Medication will be using to treat acute HAE attacks; **AND** • Medication will not be used in combination with other approved treatments for acute HAE attacks; **AND** • Prescriber attests patient is avoiding all possible triggers for HAE attacks	6 injections/28 days	General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Takhzyro®	P	**Initial Criteria:** • Prescribed by, or in consultation with, a specialist in allergy, immunology, hematology, pulmonology, or genetics; **AND** • Patient must be ≥ the labeled age minimum (Haegarda ≥6 years; Orladeyo ≥12 years; Takhzyro ≥2 years); **AND** • Submission of medical records (e.g. chart notes and labs) documenting a diagnosis consistent with 1 of the following HAE subtypes: ○ Type I: – Low C1 inhibitor (C1-INH) antigenic level (below the limit of normal defined by the lab performing the test); **AND** – Low C1-INH functional level (below the limit of normal defined by the lab performing the test); **OR** ○ Type II: – Normal to elevated C1-INH antigenic level; **AND** – Low C1-INH functional level (below the limit of normal defined by the lab performing the test); **AND** ○ Type III: – Normal C1-INH antigenic level; **AND** – One of the following: • Confirmed presence of a FXII, angiopoietin-1, plasminogen, KNG1, MYOF, or HS3ST6 gene mutation; **OR** • Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema; **AND** • Will not be used in combination with other routine prophylaxis HAE agents (e.g., Haegarda, Takhzyro, Orladeyo); **AND** • Prescriber attests patient is avoiding all possible triggers for HAE attacks **Renewal Criteria:** • Improvement in severity and duration of attacks have been achieved and sustained; **AND** • Absence of unacceptable toxicity from the drug (e.g., severe hypersensitivity reactions, thromboembolic events)	2 injections /28 days	General PA Form
Firazyr®	NP	See Sajazir® prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance to 2 preferred agents	6 injections/28 days	General PA Form
Haegarda®	NP	See Takhzyro® prior authorization criteria	2 injections/28 days	
icatibant	NP	See Sajazir® prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance to 2 preferred agents	6 injections/28 days	
Orladeyo®	NP	See Takhzyro® prior authorization criteria	1/day	
Homocystinuria Agents				
Cystadane®	P	• Diagnosis of moderate to severe hyperhomocysteinemia • Genetic test confirming ONE of the following: ○ cystathionine beta-synthase (CBS) deficiency ○ 5,10-methylenetetrahydrofolate reductase (MTHRF) deficiency ○ cobalamin cofactor metabolism (cbl) defect; AND ; **AND** • Prescribed by, or in consultation with, a physician who specializes in the treatment of inherited metabolic disorders; **AND** • Patient had an inadequate response or is unable to be managed by diet and vitamin supplementation with folic acid, vitamin B12, and vitamin B6	6 g/day	General PA Form
betaine anhydrous powder	NP	See Cystadane® prior authorization criteria; **AND** • Clinically valid reason why preferred Cystadane® cannot be used	6 g/day	

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Hutchinson-Gilford Progeria Syndrome				

Zokinvy®	NP	**Initial Criteria (6-month duration):**
		• Patient has a diagnosis of Hutchinson-Gilford Progeria Syndrome; **OR**
		• Patient has processing deficient Progeroid Laminopathies with either:
		  ○ Heterozygous LMNA mutation with progerin-like protein accumulation
		  ○ Homozygous or compound heterozygous ZMPSTE24 mutations; **AND**
		• Patient must be 12 months of age or older; **AND**
		• Patient must have a body surface area (BSA) of 0.39 m2 and above; **AND**
		• Females must use effective contraception due to embryo-fetal toxicity; **AND**
		• Patient must not meet any of the following:
		  ○ Other Progeroid Syndromes or processing proficient Progeroid Laminopathies
		  ○ Concomitant use of strong or moderate CYP3A inhibitors or inducers
		  ○ Concomitant use of midazolam
		  ○ Concomitant use of lovastatin, simvastatin, and atorvastatin
		  ○ Patient is pregnant
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• Patient has experienced a positive response to therapy, as documented by provider; **AND**
		• Patient has not experienced treatment-limiting adverse effects (e.g., laboratory Abnormalities: changes in electrolytes, complete blood counts, and liver enzymes, decrease in renal function, retinal toxicity)
				General PA Form

Hyperoxaluria Agents				

Rivfloza®	NP	**Initial Criteria: (6-month duration)**
		• Patient is 2 years of age or older; **AND**
		• Diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by ONE of the following:
		  ○ Genetic testing demonstrating mutation in the alanine-glyoxylate aminotransferase (AGXT) gene
		  ○ Liver biopsy demonstrating absent or reduced alanine-glyoxylate aminotransferase (AGT) activity; **AND**
		• Patient has ONE of the following*:*
		  ○ Elevated urinary oxalate excretion
		  ○ Elevated plasma oxalate levels
		  ○ Urinary oxalate creatinine ratio above the age-specific upper limit of normal
		• Patient has relatively preserved kidney function (e.g., eGFR ≥ 30 mL/min/1.73 m^2); **AND**
		• Prescribed by, or in consultation with, a hematologist, nephrologist, urologist, or geneticist
		Renewal Criteria:
		Patient has positive clinical response to therapy (e.g., decreased urinary oxalate excretion or plasma concentration, decreased number or size of kidney stones, improved kidney function)
			1/28 days	General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Hypophosphatasia (HPP) Agents				
Strensiq®	NP	**Initial Criteria (6-month duration):** • Diagnosis of perinatal, infantile, or juvenile-onset hypophosphatasia (HPP); **AND** • Onset of clinical signs and symptoms of HPP prior to age 19 years (e.g., rickets, skeletal deformities, fractures, respiratory compromise, vitamin B6 dependent seizure, craniosynostosis, dental abnormalities, severe osteopenia); **AND** • Clinical diagnosis of HPP evidenced by one of the following: ○ Serum alkaline phosphatase (ALP) below age-adjusted normal range ○ Genetic confirmation of ALPL mutation; ○ Elevated plasma pyridoxal 5'-phosphate (PLP) levels; **AND** • Prescribed by, or in consultation with, a physician who specializes in the treatment of inherited metabolic disorders **Note**: 80 mg/0.8 mL vial will not be approved for pediatric patients weighing < 40 kg **Renewal Criteria**: • Documentation of positive clinical response to therapy (e.g., healing of the skeletal manifestations, improved respiratory, motor function, and linear growth); **AND** • Prescribed by, or in consultation with, a physician who specializes in the treatment of inherited metabolic disorders		General PA Form
IBAT (Ileal Bile Acid Transporter) Inhibitors				
Bylvay®	NP	• One of the following: ○ Diagnosis of progressive familial intrahepatic cholestasis (PFIC); **AND** – Patient does not have ABCB11 variant resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3) ○ Diagnosis of Alagille syndrome (ALGS) confirmed by presence of the JAG1 or Notch2 gene mutation; **AND** • Prescribed by, or in consultation with, hepatologist or gastroenterologist; **AND** • Patient is experiencing moderate to severe pruritus confirmed by ONE of the following: ○ Total serum bile acid > 3x the upper limit of normal ○ Conjugated bilirubin > 1 mg/dL. ○ Fat soluble vitamin deficiency otherwise unexplainable. ○ GGT > 3x the upper limit of normal ○ Intractable pruritus explainable only by liver disease; **AND** • Trial and failure to at TWO other conventional treatments for the symptomatic relief of pruritus (e.g., bile acid-binding agents, naltrexone, phenobarbital, rifampin, ursodiol); **AND** • Provider attests to monitor the following: ○ Liver-function tests at baseline and during treatment ○ Fat-soluble vitamin (FSV) levels at baseline and during treatment		General PA Form
Livmarli®	NP	See Bylvay® prior authorization criteria		

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
IgA Nephropathy (IgAN)				

Fabhalta®	NP	**Initial Criteria (6-month duration)**
		• One of the following:
		  ○ Diagnosis of primary IgA immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy; **AND**
		  – Patient is at risk of rapid disease progression (e.g., proteinuria > 0.5 g/day or UPCR > 0.8 g/g); **AND**
		  – Inadequate response to a stable max tolerated doses of an ARB or an ACE inhibitor; **AND**
		  – Patient has an eGFR > 20 mL/min/1.73 m2; **OR**
		  ○ Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by flow cytometry; **AND**
		  – Patient has symptoms attributed to PNH (e.g., anemia, extreme fatigue, difficulty swallowing, recurrent abdominal pain, smooth muscle dystonia, thrombosis, CKD, organ damage secondary to chronic hemolysis); **AND**
		  ○ Diagnosis of complement 3 glomerulopathy (C3G) confirmed by kidney biopsy; **AND**
		  – Medication is being used to reduce proteinuria (e.g., proteinuria > 0.5 g/day or UPCR > 0.8 g/g); **AND**
		  – Inadequate response to a stable max tolerated doses of an ARB or an ACE inhibitor; **AND**
		  – Patient has an eGFR > 30 mL/min/1.73 m2; **AND**
		• Prescribed by, or in consultation with, a hematologist, nephrologist, or oncologist; **AND**
		• Prescriber is enrolled in the Fabhalta REMS Program; **AND**
		• One of the following:
		  ○ Will not be used concurrently with another complement inhibitor; **OR**
		  ○ Patient is currently receiving another complement inhibitor (e.g., Empaveli, Soliris, Ultomiris) which will be discontinued and Fabhalta will be initiated in accordance with the FDA approved labeling
		Renewal Criteria:
		• Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH); **AND**
		• Prescribed by, or in consultation with, a hematologist or oncologist; **AND**
		• Patient is not receiving Empaveli in combination with another complement inhibitor
			2/day	

Filspari®	NP	**Initial Criteria: (6-month duration)** • Patient is 18 years of age or older; **AND** • Diagnosis of primary IgA immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy; **AND** • Patient is at risk of rapid disease progression (e.g., proteinuria > 0.5 g/day or UPCR > 0.8 g/g); **AND** • Patient has an eGFR > 30 mL/min/1.73 m2; **AND** • Inadequate response to a stable max tolerated doses of an ARB or an ACE inhibitor; **AND** • Use of renin-angiotensin-aldosterone system (RAAS) inhibitors (e.g., ACE inhibitors, ARBs), endothelin receptor antagonists (e.g., Letairis, Opsumit, Tracleer), and aliskiren will be discontinued prior to initiating treatment; **AND** • Prescribed by, or in consultation with, a nephrologist **Renewal Criteria:** • Patient has positive clinical response to Filspari therapy (e.g., reduction of proteinuria from baseline, decreased UPCR)	1/day	General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Tarpeyo®	NP	• Patient is 18 years of age or older; **AND** • Diagnosis of primary IgA immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy; **AND** • Patient is at risk of rapid disease progression (e.g., proteinuria > 0.5 g/day or UPCR > 0.8 g/g); **AND** • Patient has an eGFR > 30 mL/min/1.73 m2; **AND** • Inadequate response to a stable max tolerated doses of an ARB or an ACE inhibitor, unless contraindicated; **AND** • Prescribed by, or in consultation with, a nephrologist	4/day	General PA Form
Vanrafia®		See Filspari® prior authorization criteria	1/day	
IGF-1 Deficiency				

Increlex®	P	**Initial Criteria:**
		• Patient is < 21 years old; **AND**
		• Epiphyses is open (therapy will not be approved once epiphyseal fusion occurs); **AND**
		• One of the following:
		  ○ Diagnosis of growth failure due to severe primary IGF-1 deficiency defined by the following (documentation required):
		  – Height standard deviation score ≤ -3
		  – Basal IGF-1 standard deviation score ≤ -3
		  – Normal or elevated growth hormone
		  ○ Diagnosis of growth hormone (GH) gene deletion in a patient who has developed neutralizing antibodies to GH; **AND**
		  – Secondary causes of IGF-1 deficiency have been ruled out (e.g., hypothyroidism, malnutrition, hepatic disease, GHD, chronic corticosteroid treatment); **AND**
		• Secondary causes of IGF-1 deficiency have been ruled out (e.g., hypothyroidism, malnutrition, hepatic disease, GHD, chronic corticosteroid treatment); **AND**
		• Patient will not be treated with concurrent growth hormone therapy
		Note: Will not be approved for patients with active or secondary neoplasms, secondary forms of IGF-1 deficiency, weight loss management, nor as a substitute for growth hormone.
		Renewal Criteria:
		• Patient is < 21 years old; **AND**
		• Prescriber attests patient has had a height increase of ≥ 2 cm/year over the previous year of treatment; **AND**
		• Epiphyses is open; **AND**
		• Patient is not treated with concurrent growth hormone therapy
				General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Lambert-Eaton Myasthenic Syndrome (LEMS)				
Firdapse®	NP	**Initial Criteria:** • Diagnosis of Lambert-Eaton Myasthenic Syndrome (LEMS) confirmed by a positive anti-P/Q type voltage-gated calcium ch annel antibody test; **AND** • Patient is ≥ 6 years old; **AND** • Patient does not have a history of seizures; **AND** • Patient does not have a hypersensitivity to amifampridine or another aminopyridine (such as dalfampridine [Ampyra®]) **Renewal Criteria:** • Patient has not experienced any treatment-restricting adverse effects; **AND** • Patient must demonstrate disease improvement, stabilization, and/or slowing in the rate of decline due to the medication	10/day	General PA Form
Leptin Deficiency				

Myalept®	NP	**Initial Criteria:**
		• Diagnosis of congenital or acquired lipodystrophy**; AND**
		• Leptin deficiency confirmed by laboratory testing; **AND**
		• Patient has one of the following complications of lipodystrophy:
		  ○ Diabetes mellitus
		  ○ Hypertriglyceridemia
		  ○ Hepatic steatosis
		  ○ Polycystic ovarian syndrome
		  ○ Acanthosis nigricans; **AND**
		• Requested agent will be used as adjunct to dietary management of lipodystrophy; **AND**
		• Documented baseline HbA1C, fasting glucose, triglycerides, and liver enzymes provided; **AND**
		• Patient does NOT have HIV-related or partial lipodystrophy or metabolic disease without concurrent evidence of generalized lipodystrophy; **AND**
		• Prescriber is enrolled in the Myalept REMS program
		Renewal Criteria:
		• Documented positive clinical response to therapy (e.g., improved glycemic control, decrease in triglycerides)
				General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Lysosomal Storage Disease				

Aqneursa®	NP	**Initial Criteria**
		• Patient weighs at least 15 kg; **AND**
		• Diagnosis of Niemann-Pick disease type C confirmed by one of the following:
		  ○ Genetically confirmed mutations in both alleles of NPC1 or NPC2; **OR**
		  ○ Mutation in only one allele of NPC1 or NPC2 plus either positive filipin staining or elevated cholestane triol/oxysterols (>2 x upper limit of normal); **AND**
		• Patient has at least one neurological symptom of the disease (e.g., hearing loss, vertical supranuclear gaze palsy, ataxia, dementia, dystonia, seizures, dysarthria, or dysphagia); **AND**
		• Prescribed by, or in consultation with, a neurologist, a medical geneticist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
		Renewal Criteria
		• Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g., improvement or stabilization in neurological symptoms of disease)
				General PA Form

Cerdelga®	NP		2/day	

Galafold®	NP	**Initial Criteria (6-month duration):**
		• Patient is ≥ 18 years old; **AND**
		• Documented diagnosis of Fabry disease with biochemical/genetic confirmation by 1 of the following:
		  ○ Males only: α-galactosidase A (α-Gal A) activity in plasma, isolated leukocytes, and/or cultured cells
		  ○ Plasma or urinary globotriaosylceramide(Gb3/GL-3) or globotriaosylsphingosine (lyso-Gb3)
		  ○ Detection of pathogenic mutations in the GALA/GLA gene by molecular genetic testing; **AND**
		• Patient has an amenable GLA mutation (as defined in the migalastat labeling or determined by a clinical genetics professional); **AND**
		• Will NOT be used in combination with agalsidase beta or Elfabrio (pegunigalsidase alfa); **AND**
		• Prescribed by, or in consultation with, clinical genetics professional with knowledge in management of Fabry disease
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• Prescriber attests to patient compliance with therapy; **AND**
		• Disease response to treatment as defined by a reduction in urine GL-3 and/or GL-3 inclusions compared to pre-treatment baseline or there has been improvement in clinical symptoms (e.g. stabilization of kidney function, slow or prevention of organ function decline); **AND**
		• Absence of unacceptable toxicity (e.g., kidney infections); **AND**
			14/28 days	General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Miplyffa®	NP	**Initial Criteria:**
		• Patient is 2 years of age or older; **AND**
		• Diagnosis of Niemann-Pick disease type C confirmed by ONE of the following:
		  ○ Genetically confirmed mutations in both alleles of NPC1 or NPC2; **OR**
		  ○ Mutation in only one allele of NPC1 or NPC2 plus either positive filipin staining or elevated cholestane triol/oxysterols (>2 x upper limit of normal); **AND**
		• Patient has at least one neurological symptom of the disease (e.g., hearing loss, vertical supranuclear gaze palsy, ataxia, dementia, dystonia, seizures, dysarthria, dysphagia); **AND**
		• Miplyffa will be used in combination with miglustat; **AND**
		• Prescribed by, or in consultation with, a neurologist, a medical geneticist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
		Renewal Criteria:
		• Patient continued to meet initial criteria; **AND**
		• Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g., improvement or stabilization in neurological symptoms of disease)
				General PA Form

Opfolda®	NP	• Patient is ≥ 18 years old and weighs at least 40 kg; **AND**
		• Diagnosis of late-onset Pompe disease confirmed by ONE of the following:
		  ○ Documentation demonstrating deficiency of acid alpha-glucosidase (GAA) enzyme activity
		  ○ Molecular genetic test demonstrating pathogenic variants in GAA; **AND**
		• Prescriber attest patient did not have clinical improvement on enzyme replacement therapy (e.g., Lumizyme, Nexviazyme, Elfabrio); **AND**
		• Must be used in combination with Pombiliti (cipaglucosidase alfa); **AND**
		Prescribed by, or in consultation with, a neurologist, a medical geneticist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
			8/28 days	General PA Form

Procysbi®	NP	**Initial Criteria (6-month duration):** • Diagnosis of nephropathic cystinosis; **AND** • Patient is ≥ 1 year old; **AND** • Trial and failure, contraindication, or intolerance to Cystagon®; **AND** • WBC cystine levels or plasma cysteamine concentration will be monitored **Renewal Criteria:** • Documentation of positive clinical response to therapy; **AND** WBC cystine levels or plasma cysteamine concentration will be monitored		General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Neuromyelitis Optica Spectrum Disorder (NMOSD)				

Enspryng®	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of neuromyelitis optica spectrum disorder (NMOSD); **AND**
		• Patient ≥ 12 years old of age; **AND**
		• Patient is anti-aquaporin-4 (AQP4) antibody positive; **AND**
		• Patient has been screened, and does not have any of the following:
		  ○ Active Hepatitis B infection
		  ○ Active or untreated latent tuberculosis
		  ○ Active infection; **AND**
		• Prescribed by or in consultation with a neurologist or ophthalmologist
		Renewal criteria:
		• Patient has demonstrated positive response to therapy
			Loading Dose:
			3 syringes/28 days
			Maintenance:
			1/28 days
				General PA Form

Myasthenia Gravis				

Zilbrysq®	NP	**Initial Criteria: (6- month duration)**
		• Diagnosis of generalized myasthenia gravis (gMG); **AND**
		• Documented positive serology for acetylcholine receptor (AChR) autoantibodies; **AND**
		• Patient has a baseline MG-Activities of Daily Living (MG-ADL) total score of ≥6; **AND**
		• Patient has tried and failed, or has contraindication, or intolerance to TWO of the following:
		  ○ Corticosteroids
		  ○ Azathioprine
		  ○ Cyclosporine
		  ○ mycophenolate mofetil
		  ○ methotrexate
		  ○ tacrolimus; **AND**
		• Prescribed by, or in consultation with, a neurologist or neuromuscular specialist; **AND**
		• Prescriber is enrolled in the Zilbrysq REMS Program; **AND**
		• Patient has not failed a previous course of Zilbrysq, Ultomiris, or Soliris therapy; **AND**
		• Patient is not receiving Zilbrysq in combination with another complement inhibitor (e.g., Soliris, Ultomiris)
		Renewal Criteria:
		• Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g., reduction in MG-ADL score or improvement in talking, chewing, swallowing, breathing, double vision, eyelid drop, movement)
			1/day	General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Paroxysmal Nocturnal Hemoglobinuria (PNH)				

Empaveli®	NP	**Initial Criteria:**
		• Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by flow cytometry; **AND**
		• Prescribed by, or in consultation with, a hematologist or oncologist; **AND**
		• Patient has symptoms attributed to PNH (e.g., anemia, extreme fatigue, difficulty swallowing, recurrent abdominal pain, smooth muscle dystonia, thrombosis, CKD, organ damage secondary to chronic hemolysis); **AND**
		• One of the following:
		  ○ Will not be used concurrently combination with another complement inhibitor (e.g., Soliris, Ultomiris)
		  ○ Patient is currently receiving another complement inhibitor (e.g., Empaveli, Soliris, Ultomiris) which will be discontinued and Fabhalta will be initiated in accordance with the FDA approved labeling; **AND**
		• One of the following:
		  ○ The requested quantity does not exceed 1,080 mg twice weekly
		  ○ The requested quantity is for 1,080 mg every 3 days and lactate dehydrogenase (LDH) is >2 the upper limit of the normal range (LDH level documentation is required)
		Renewal Criteria:
		• Documentation of positive clinical response to therapy (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH); **AND**
		• Prescribed by, or in consultation with, a hematologist or oncologist; **AND**
		• Patient is not receiving Empaveli in combination with another complement inhibitor; **AND**
		• One of the following:
		  ○ The requested quantity does not exceed 1,080 mg twice weekly
		  ○ The requested quantity is for 1,080 mg every 3 days and lactate dehydrogenase (LDH) is >2 the upper limit of the normal range (LDH level documentation is required)
			200 mL/30 days	General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Fabhalta®	NP	**Initial Criteria: (6-month duration)**
		• One of the following:
		  ○ Diagnosis of primary IgA immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy; **AND**
		  – Patient is at risk of rapid disease progression (e.g., proteinuria > 0.5 g/day or UPCR > 0.8 g/g); **AND**
		  – Inadequate response to a stable max tolerated doses of an ARB or an ACE inhibitor; **AND**
		  – Patient has an eGFR > 20 mL/min/1.73 m2; **OR**
		  ○ Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by flow cytometry; **AND**
		  – Patient has symptoms attributed to PNH (e.g., anemia, extreme fatigue, difficulty swallowing, recurrent abdominal pain, smooth muscle dystonia, thrombosis, CKD, organ damage secondary to chronic hemolysis); **AND**
		• Prescribed by, or in consultation with, a hematologist, nephrologist, or oncologist; **AND**
		• Prescriber is enrolled in the Fabhalta REMS Program; **AND**
		• One of the following:
		  ○ Will not be used concurrently with another complement inhibitor; **OR**
		  ○ Patient is currently receiving another complement inhibitor (e.g., Empaveli, Soliris, Ultomiris) which will be discontinued and Fabhalta will be initiated in accordance with the FDA approved labeling
		Renewal Criteria:
		• Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH); **AND**
		• Prescribed by, or in consultation with, a hematologist or oncologist; **AND**
		• Patient is not receiving Empaveli in combination with another complement inhibitor
			2/day	General PA Form

Voydeya®	NP	**Initial Criteria: (6-month duration)** • Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by flow cytometry; **AND** • Patient has symptoms attributed to PNH (e.g., anemia, extreme fatigue, difficulty swallowing, recurrent abdominal pain, smooth muscle dystonia, thrombosis, CKD, organ damage secondary to chronic hemolysis); **AND** • Patient is experiencing extravascular hemolysis (EVH) while on complement C5 inhibitor Ultomiris or Soliris; **AND** • Prescriber attests Voydeya will be used in combination with Ultomiris or Soliris; **AND** • Prescriber is enrolled in the Voydeya REMS Program; **AND** • Prescribed by, or in consultation with, a hematologist or oncologist **Renewal Criteria:** • Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g. hemoglobin stabilization, decreased number of blood transfusions, improvement in signs and symptoms of the disease); **AND** • Prescribed by, or in consultation with, a hematologist or oncologist; **AND** • Patient will continue to use Voydeya in combination with Ultomiris or Soliris	6/day	General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Phenylketonuria (PKU)				

Palynziq®	P	• Diagnosis of Phenylketonuria (PKU); **AND**
		• Prescribed by, or in consultation with, a physician who specializes in the treatment of inherited metabolic disorders; **AND**
		• Patient will receive first dose of Palynziq® in prescribing MD's office; **AND**
		• Patient meets ONE of the following:
		  ○ Patient has blood phenylalanine (Phe) concentrations > 600 µmol/L; **OR**
		  ○ Prescriber attests patient cannot maintain a healthy diet with Phe restriction; **OR**
		  ○ Patient has neurocognitive deficits; **OR**
		  ○ Trial and failure, contraindication, or intolerance of sapropterin
				General PA Form

sapropterin	P	• Patient has diagnosis of Phenylketonuria (PKU); **AND** • Prescribed by, or in consultation with, a metabolic specialist; **AND** • Prescriber attests that Phenylalanine (Phe) levels cannot be maintained within recommended range (120-360 umol/L) with dietary intervention alone; **AND** • Medication will be used in conjunction with a phenylalanine restricted diet		General PA Form
Javygtor®	NP	See sapropterin prior authorization criteria; **AND** • Clinically valid reason why the preferred sapropterin agents cannot be used		General PA Form
Kuvan®	NP	See sapropterin prior authorization criteria; **AND** • Clinically valid reason why the preferred sapropterin agents cannot be used		
PIK3CA-Related Overgrowth Spectrum (PROS)				

Vijoice®	NP	**Initial Criteria (6-month duration)**:
		• Diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS); **AND**
		• Patient has a mutation of the PIK3CA gene; **AND**
		• Patient is 2 years of age or older; **AND**
		• Patient has severe manifestations of PROS and requires systemic therapy; **AND**
		• Vijoice will NOT be used for an oncology diagnosis; **AND**
		• Prescriber attests to monitor, and potentially discontinue Vijoice treatment, if patient shows any of the following:
		  ○ Signs or symptoms of severe cutaneous adverse reactions (SCARs)
		  ○ New or worsening respiratory symptoms or is suspected to have developed pneumonitis
		  ○ Severe diarrhea
		  ○ Severe hyperglycemia
		  ○ Severe hypersensitivity; **AND**
		• Female and male patients of reproductive potential have been advised to use effective contraception during treatment and for one week after the last dose
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		Prescriber attests patient has had ≥ 20% reduction from baseline in the measurable target lesion volume confirmed by at least one subsequent imaging assessment
				General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Pyruvate Kinase (PK) Deficiency				

Pyrukynd®	NP	**Initial Criteria (6-month duration):**
		• Patient has diagnosis of hemolytic anemia with pyruvate kinase (PK) deficiency; **AND**
		• Patient has at least 2 variant alleles in the PK liver and red blood cell gene of which at least 1 was a missense variant; **AND**
		• Hemoglobin is <10 g/dL; **AND**
		• One of the following:
		  ○ Patient has symptomatic anemia
		  ○ Patient is transfusion dependent; **AND**
		• Prescribed by or in consultation with a hematologist
		Renewal Criteria:
		• Documentation of positive clinical response to therapy as evidenced by one of the following:
		  ○ Hemoglobin increase ≥ 1.5 g/dL from baseline
		  ○ Reduction in the number of red blood cell units transfused from baseline
			2 tabs/day	General PA Form

Rett Syndrome				
Daybue®	NP	**Initial Criteria**: • Patient is > 2 years old; AND • Diagnosis of Rett Syndrome; AND • Prescribed by, or in consultation with, a neurologist, clinical geneticist, or developmental pediatrician **Renewal Criteria**: • Documentation of positive clinical response to Daybue® (e.g. improvement or stabilization in purposeful hand skills, spoken language, repetitive hand movements, and gait abnormalities)	120 mL/day	General PA Form
Sickle Cell Disease				

Endari®	NP	**Initial Criteria:**
		• Diagnosis of sickle cell disease; **AND**
		• Patient meets ONE of the following:
		  ○ Endari will be used in combination with hydroxyurea; **OR**
		  ○ Trial and failure, contraindications, or intolerance to hydroxyurea; **AND**
		• Dosed according to weight-based dosing found in package insert:
		  ○ < 30 kg, up to 2 packets per day
		  ○ 30-65 kg, up to 4 packets per day
		  ○ 65 kg, up to 6 packets per day
		Renewal Criteria:
		• Documentation of positive clinical response to therapy (e.g., decrease in number of days in crisis, number of days in hospital, occurrence of Acute Chest Syndrome)
			6 packs/day	General PA Form

L-glutamine pack	NP	See Endari prior authorization criteria; **AND** • Trial and failure, contraindications, or intolerance to Endari®	6 packs/day	General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Siklos®	NP	• Patient has a diagnosis of sickle cell anemia with recurrent moderate to severe painful crisis; **AND**
		• ONE of the following:
		  ○ Documentation of need for dosing that will not allow the use of a preferred hydroxyurea agent
		  ○ Patient unable to swallow hydroxyurea capsules
				General PA Form

Xromi®	NP	• Diagnosis of sickle cell anemia with recurrent moderate to severe painful crises; **AND**
		• One of the following:
		  ○ Documentation of need for dosing that will not allow the use of a preferred hydroxyurea agent; **OR**
		  ○ Patient is unable to swallow solid oral dosage forms of hydroxyurea
				General PA Form

Somatostatins and Related Agents				
Korlym®	P	• Diagnosis of Cushing's Syndrome; **AND** • Patient has type 2 diabetes mellitus or glucose intolerance; **AND** • Patient has failed surgical treatment **OR** is not candidate for surgery; **AND** • Will NOT be approved for use during pregnancy		General PA Form
octreotide	P	• Diagnosis of acromegaly; **OR** • Treatment is for severe diarrhea/flushing episodes associated with metastatic carcinoid tumors; **OR** • Treatment is for profuse watery diarrhea associated with VIP-secreting tumors		
Isturisa®	NP	**Initial Criteria (6-month duration):** • Diagnosis of Cushing's disease; **AND** • Patient has failed surgical treatment **OR** is not candidate for surgery; **AND** • Trial and failure (trial duration ≥ 90 days) or intolerance to oral ketoconazole; **AND** • Patient is 18 years of age or older; **AND** • Prescribed by, or in consultation with, an endocrinologist **Renewal Criteria:** • Documentation of positive clinical response to therapy (e.g., normalization or reduction of urinary free cortisol, improvement in signs or symptoms of the disease)	1 mg: 4/day 5 mg: 2/day 10 mg: 6/day	General PA Form
Mifepristone 300 mg tablet	NP	See Korlym prior authorization criteria; **AND** Clinically valid reason why the preferred Korlym® cannot be used		
Mycapssa®	NP	• Diagnosis of acromegaly; **AND** • Patient has previously taken, responded to, and tolerated treatment with octreotide or lanreotide; **AND** • Clinically valid reason why the patient is unable to be maintained on current octreotide or lanreotide therapy	4/day	General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Recorlev®	NP	**Initial Criteria:** • Diagnosis of Cushing's Syndrome; **AND** • Patient is being treated for endogenous hypercortisolemia (e.g., pituitary adenoma, ectopic tumor, adrenal • adenoma); **AND** • Surgery is not an option or has not been curative; **AND** • Trial and failure (trial duration > 90 days) or intolerance to oral ketoconazole; **AN**D • Patient is 18 years of age or older; **AND** • Prescribed by or in consultation with an endocrinologist; AND • Patient has had baseline liver enzymes and an electrocardiogram prior to initiating therapy, and prescriber attests to monitor regularly thereafter; **AND** • Patient does not have hypokalemia and hypomagnesemia, or has been corrected prior to therapy **Renewal Criteria:** • Documentation of positive clinical response to therapy (e.g., normalization or reduction of urinary free cortisol, improvement in signs or symptoms of the disease)	8/day	General PA Form
Sandostatin®	NP	See prior authorization criteria for octreotide; **AND** • Clinically valid reason why preferred octreotide cannot be used		General PA Form
Signifor®	NP	• Diagnosis of Cushing's Disease; **AND** • Surgery is not an option or has not been curative; **AND** • Prescribed by, or in consultation with, an endocrinologist	2 injections/day	
Somavert®	NP	• Diagnosis of acromegaly; **AND** • Tral and failure, intolerance, or contraindication to octreotide		
Xermelo®	NP	**Initial Criteria:** • Patient has a carcinoid/neuroendocrine tumor and has been diagnosed with carcinoid syndrome; **AND** • Patient has had an inadequate treatment response to at least a 3-month trial of SSA (somatostatin analog) therapy at the highest tolerated dose; **AND** • Patient will continue to receive somatostatin analog therapy; **AND** • Patient has tried and received an inadequate response to antidiarrheals (e.g., loperamide); **AND** • Patient has at least 4 bowel movements per day **Renewal Criteria:** • Documentation of positive clinical response to therapy (e.g., decrease in number of bowel movements per day)	3/day	General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Spinal Muscular Atrophy (SMA)				

Evrysdi®	NP	**Initial Criteria:**
		• Diagnosis of Spinal Muscular Atrophy (SMA); **AND**
		• Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation or deletion of genes in chromosome 5q confirming in one of the following:
		  ○ Homozygous gene deletion or mutation of SMN1 gene; **OR**
		  ○ Compound heterozygous mutation of SMN1 gene; **AND**
		• Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis and treatment of SMA; **AND**
		• Patient will not receive concomitant survival motor neuron (SMN) modifying therapy (e.g., Spinraza); **AND**
		• One of the following:
		  ○ Patient has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma); **OR**
		  ○ Both of the following:
		  – Patient has previously received gene therapy for the treatment of SMA (e.g., Zolgensma); **AND**
		  – Provider attests that there has been an inadequate response to gene therapy (e.g., sustained decrease in ≥ 1 motor test score over a period of 6-months); **AND**
		• Advise female patients of reproductive potential to use effective contraception during treatment and for at least 1 month after the last dose
		Renewal criteria
		• Patient continues to meet initial criteria; **AND**
		• Patient has clinically significant improvement in SMA associated signs and symptoms (progression, stabilization, or decreased decline in motor function)
			Tabs: 1/day
			Soln:3 bottles/ 28 days
				General PA Form

Transthyretin Amyloidosis Agents				

Attruby®	NP	**Initial Criteria**
		• Patient is 18 years of age or older; **AND**
		• Prescribed by or in consultation with a cardiologist; **AND**
		• Diagnosis of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) with cardiomyopathy; **AND**
		• Patient has New York Heart Association Class I, II or III heart failure; **AND**
		• Patient does not meet have any of the following:
		  ○ Impaired renal function (glomerular filtration rate < 15 mL/min/1.73 m2)
		  ○ History of heart transplantation
		  ○ New York Heart Association Class IV; **AND**
		• Patient will not use in combination with another medication indicated for the management cardiomyopathy or neuropathy of transthyretin-mediated amyloidosis (e.g., Amvuttra, Onpattro, Vyndaqel, Vyndamax)
		Renewal Criteria
		• Patient meets initial criteria; **AND**
		• Patient has demonstrated a positive benefit from therapy (e.g., improved clinical symptoms of heart failure)
			4/day	General PA Form

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Vyndamax®	NP	**Initial Criteria:**
		• Patient is 18 years of age or older; **AND**
		• Must be prescribed in consultation with a cardiologist; **AND**
		• Diagnosis of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) with cardiomyopathy; **AND**
		• Patient has New York Heart Association Class I, II or III heart failure; **AND**
		• Patient does not have any of the following:
		  ○ Impaired renal function (glomerular filtration rate < 25 mL/min/1.73 m2)
		  ○ History of liver or heart transplantation
		  ○ Implanted left ventricular assist device (LVAD) [pacemaker or cardiac defibrillator allowed]
		  ○ Patient is pregnant or breastfeeding
		  ○ New York Heart Association Class IV; **AND**
		• Patient will not use in combination with another medication indicated for the management cardiomyopathy or neuropathy of transthyretin-mediated amyloidosis (e.g., Amvuttra, Onpattro, Attruby)
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• Patient has demonstrated a positive benefit from therapy (e.g., improved clinical symptoms of heart failure)
			1/day	General PA Form

Vyndaqel®	NP	See prior authorization criteria for Vyndamax	4/day	

Wainua®	NP	**Initial Criteria:**
		• Patient is 18 years of age or older; **AND**
		• Diagnosis of hereditary transthyretin-mediated amyloidosis (ATTRv amyloidosis) with polyneuropathy; **AND**
		• Documentation that patient has a transthyretin (TTR) mutation (e.g., V30M); **AND**
		• Prescribed by, or in consultation with, a neurologist, cardiologist, or specialist with knowledge of ATTRv; **AND**
		• Documentation of ONE of the following:
		  ○ Patient has a baseline polyneuropathy disability (PND) score ≤ IIIb
		  ○ Patient has a baseline familial amyloidotic polyneuropathy (FAP) stage of 1 or 2
		  ○ Patient has a baseline neuropathy impairment score (NIS) between 10 and 130; **AND**
		• Patient has not had a liver transplant; **AND**
		• Will not be used in combination with another medication indicated for the management cardiomyopathy or neuropathy of transthyretin-mediated amyloidosis (e.g., Amvuttra, Onpattro, Attruby, Vyndaqel, Vyndamax)
		Renewal Criteria:
		• Patient has demonstrated a benefit from therapy (e.g., improved neurologic impairment, motor function, slowing of disease progression, quality of life assessment); **AND**
		• Will not be used in combination with another medication indicated for the management cardiomyopathy or neuropathy of transthyretin-mediated amyloidosis (e.g., Amvuttra, Onpattro, Attruby, Vyndaqel, Vyndamax)
			1 injector/28 days	General PA Form

Tyrosinemia Type 1				
Orfadin® suspension	NP	• Diagnosis of hereditary tyrosinemia type 1; **AND** • Agent is prescribed by a physician specializing in the condition being treated; **AND** • Patient has a clinically valid reason as to why the Orfadin® capsules cannot be utilized		General PA Form
nitisinone capsule	NP	See Orfadin® suspension prior authorization criteria		

RARE CONDITIONS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Nityr® tablet	NP	See Orfadin® suspension prior authorization criteria		
Urea Cycle Disorders				
Carbaglu®	P	• Diagnosis of urea cycle disorders		General PA Form
Pheburane®	P	• Diagnosis of urea cycle disorders		
carglumic acid	NP	• Diagnosis of urea cycle disorders; **AND** • Trial and failure, contraindication, or intolerance of Carbaglu®		
Olpruva®	NP	• Diagnosis of urea cycle disorders; **AND** • Trial and failure, contraindication, or intolerance of Pheburane®		
Ravicti®	NP	See Olpruva® prior authorization criteria		
sodium phenylbutyrate	NP	• Diagnosis of urea cycle disorders; **AND** • Trial and failure, contraindication, or intolerance of Buphenyl®		
Wilson Disease				
Galzin®	NP	• Diagnosis of Wilson's disease; **AND** • Intolerance to zinc sulfate		General PA Form
Syprine®	NP		8/day	
trientine	NP		250mg: 8/day 500mg: 4/day	
WHIM Syndrome				
Xolremdi®	NP		4/day	General PA Form

RENAL AND GENITOURINARY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Alpha Blockers for BPH				
alfuzosin	P		1/day	General PA Form
tamsulosin	P		2/day	
Cardura XL	NP		1/day	
Flomax®	NP		2/day	

RENAL AND GENITOURINARY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Androgen Hormone Inhibitors				
dutasteride	P		1/day	General PA Form
finasteride	P		1/day	
Avodart®	NP		1/day	
Proscar®	NP		1/day	
Tezruly®	NP	• Patient is unable to swallow solid dosage forms	20mL/day	
Agents for BPH				
Cialis®	NP	• Diagnosis of Benign Prostatic Hypertrophy; **AND** • Patient is NOT concurrently receiving nitrates or guanylate cyclase stimulators; **AND** • Trial and failure, contraindication, or intolerance to at least ONE agent from each of the following classes: ○ Alpha blockers for BPH ○ Androgen Hormone Inhibitors		General PA Form
dutasteride/ tamsulosin	NP	Patient has a diagnosis of benign prostatic hyperplasia (BPH) with an enlarged prostate; **AND** Patient has a contraindication or adverse event to finasteride; **AND** Patient is unable to use the individual components	1/day	
Entadfi®	NP	**Criteria (6-month duration):** • Diagnosis of Benign Prostatic Hyperplasia (BPH) with an enlarged prostate; **AND** • Total length of therapy has not exceeded 26 weeks; **AND** • Trial and failure, contraindication, or intolerance to combination therapy with alpha blocker and androgen • hormone inhibitor; **AND** • Clinically valid reason why the individual components of Entadfi® cannot be used (finasteride and tadalafil); **AND** • Patient is NOT concurrently receiving nitrates or guanylate cyclase stimulators	1/day; 182/year	
Jalyn®	NP	See dutasteride/tamsulosin prior authorization criteria	1/day	
Phosphorus Depletors				
sevelamer carbonate tablets	P		9/day	
Renvela® packs	P	Patient is unable to swallow solid dosage forms	0.8 g packets: 6/day 2.4 g packets: 5/day	
Auryxia®	NP	• Diagnosis of hyperphosphatemia in chronic kidney disease on dialysis; **AND** ○ Trial and failure, contraindication, or intolerance to TWO preferred agents; **OR** • Diagnosis of iron deficiency anemia in chronic kidney disease NOT on dialysis; **AND** Trial and failure, contraindication, or intolerance to TWO oral iron products (e.g., ferrous sulfate, ferrous gluconate)		General PA Form
Fosrenol® packs	NP	• Trial and failure, contraindication, or intolerance of TWO preferred phosphorus depletors; **AND** • Contraindication to sevelamer powder for suspension; **AND** • Patient is unable to swallow solid dosage forms		General PA Form
Renvela® tablets	NP		9/day	
sevelamer carbonate packs	NP	Patient is unable to swallow solid dosage forms	0.8 g packets: 6/day 2.4 g packets: 5/day	
Xphozah®	NP	• Patient is 18 years of age or older; **AND**	2/day	General PA

RENAL AND GENITOURINARY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
		• Diagnosis of chronic kidney disease (CKD); **AND** • Patient is currently on dialysis; **AND** • Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** • Agent will be used as adjunctive therapy to reduce serum phosphorus; **AND** • Patient does not have known or suspected mechanical gastrointestinal obstruction		Form
Kidney Stone Agents				
Thiola EC®	NP	• Patient has tried/failed an adequate trial of or is intolerant to two preferred agents; **AND** • Clinically valid reason why preferred Thiola cannot be used		General PA Form
Urinary Tract Antispasmodics				
fesoterodine	P		1/day	General PA Form
Myrbetriq® tabs	P		1/day	
oxybutynin ER tabs	P		5 mg: 1/day; 10, 15 mg: 2/day	General PA Form
Oxytrol®	P		8 patches/28 days	
solifenacin	P		1/day	
tolterodine ER caps	P		1/day	
tolterodine tabs	P		2/day	General PA Form
darifenacin	NP		1/day	
Detrol®	NP		2/day	
Detrol LA®	NP		1/day	
flavoxate	NP		2 fills/ 60 days	
Gelnique®	NP		1 pack (1 gr)/day	
Gemtesa®	NP	Patient is 18 years of age or older: **AND** Diagnosis of overactive bladder (OAB); **AND** Trial and failure of one preferred anticholinergic agent (e.g., fesoterodine, oxybutynin, solifenacin, tolterodine); **AND** Trial and failure, or contraindication, or intolerance to Myrbetriq	1/day	General PA Form
mirabegron tabs	NP	• Clinically valid reason why preferred Myrbetriq® cannot be used	1/day	
Myrbetriq® susp	NP	• Clinically valid reason why Myrbetriq tablets cannot be used; **OR** • Diagnosis of neurogenic detrusor overactivity (NDO); **AND** • Trial and failure, contraindication, or intolerance to oxybutynin solution		General PA Form
Toviaz®	NP		1/day	
trospium	NP		2/day	General PA Form
trospium XR	NP		1/day	
VESIcare® susp	NP	• Diagnosis of neurogenic detrusor overactivity (NDO); **AND** • Trial and failure, contraindication, or intolerance to oxybutynin solution	10 mL/day	General PA Form
VESIcare® tabs	NP		1/day	

RESPIRATORY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Anaphylaxis Therapy Agents				
epinephrine auto injector	P		2/Rx	General PA Form
Auvi-Q	NP		2/Rx	
EpiPen®	NP		2/Rx	
EpiPen-Jr®	NP		2/Rx	
Neffy®	NP	• Clinically valid reason why the preferred epinephrine auto-injector cannot be used	2/Rx	
Anticholinergics, Nasal				
ipratropium 0.3%	P		2 boxes/30days	General PA Form
ipratropium 0.6%	P		3 boxes/30days	
Antihistamines, Nasal				
Azelastine	P		2 bottles/30 days	General PA Form
Dymista®	P		1 bottle/30 days	
olopatadine	P		1 bottle/30 days	
azelastine/ fluticasone	NP	• Trial and failure of preferred Dymista®	1 bottle/30 days	
Ryaltris®	NP	• Diagnosis of Seasonal Allergic Rhinitis; **AND** • Patient is 12 years of age or older; **AND** • Trial and failure, contraindication, or intolerance to Dymista; **AND** • Clinically valid reason as to why the patient is unable to take components of Ryaltris individually (**Note:** Patient convenience is not an approvable reason)	1 bottle/30 days	General PA Form
Antihistamines: Non-Sedating, Oral (Covered for recipients < 21 years old only)				
cetirizine	P		1/day	General PA Form
cetirizine chewable	P	• Clinically valid reason why the liquid formulation cannot be used	1/day	
cetirizine/PSE	P		2/day	
levocetirizine tablets	P		1/day	
loratadine tablets	P		1/day	
loratadine syrup	P		10 mL/day	
loratadine chewable	P		1/day	
loratadine RDT	P	• Patient is unable to swallow solid dosage forms	1/day	
loratadine/PSE	P		12 Hour: 2/day; 24 Hour (1/day)	
Allegra®	NP		60mg: 2/day); 180mg (1/day)	
Allegra D®	NP		12 Hour: 2/day; 24 Hour: 1/day	
Allegra® ODT	NP	• Patient is unable to swallow solid dosage forms	2/day	
Clarinex D®	NP		12 Hour (2/day); 24 Hour (1/day)	

RESPIRATORY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Clarinex RediTabs®	NP	• Patient is unable to swallow solid dosage forms	1/day	
Clarinex® tabs	NP		1/day	
Clarinex® syrup	NP		10mg/day	
Claritin D®	NP		12 Hour: 2/day; 24 Hour: 1/day	
Claritin® chewable	NP	• Clinically valid reason why the liquid formulation cannot be used	1/day	
Claritin® tabs	NP		1/day	
Claritin RediTabs®	NP	• Patient is unable to swallow solid dosage forms	1/day	
desloratadine	NP		1/day	
desloratadine ODT	NP	• Patient is unable to swallow solid dosage forms	1/day	
fexofenadine	NP		60 mg: 2/day); 180 mg (1/day)	
fexofenadine/PSE	NP		12 Hour: 2/day; 24 Hour: 1/day	
levocetirizine solution	NP		10 mL/day	
Semprex®-D	NP		4/day	
Xyzal®	NP		5 mg/day	
Zyrtec® chewable	NP	• Clinically valid reason why the liquid formulation cannot be used	1/day	
Zyrtec® tabs	NP		1/day	
Zyrtec® ODT	NP	• Patient is unable to swallow solid dosage forms	1/day	
Zyrtec D®	NP		1/day	
Antitussives, Non-Narcotic				
benzonatate	P	• Patient is ≥ 10 years of age; **OR** • Patient is < 10 years of age and prescriber is aware that, if chewed, benzonatate may cause numbness of the mouth, tongue, throat, and esophagus, increasing the risk of choking	3/day	
Cystic Fibrosis Agents, Inhaled/Injectable				
Bethkis®	P	• Diagnosis of Cystic Fibrosis or *Pseudomonas* infection	224 mL/56 days	
Kitabis Pak®	P	• Diagnosis of Cystic Fibrosis or *Pseudomonas* infection	280 mL/56 days	
Pulmozyme®	P	• Diagnosis of Cystic Fibrosis or *Pseudomonas* infection	5 mL/day	
tobramycin solution 300 mg/5 mL	P	• Diagnosis of Cystic Fibrosis or *Pseudomonas* infection	280 mL/56 days	
tobramycin vial (excluding 1.2 g vials)	P	• Claims exceeding $200 will only be approved for diagnoses of Cystic Fibrosis or *Pseudomonas* infection		
Bronchitol	NP	• Diagnosis of Cystic Fibrosis; **AND** • Patient must not have an episode of hemoptysis (>60 mL) in the last 3 months; **AND** • Must be 18 years of age or older; **AND** • Patient must have baseline FEV1 >40% to <90%; **AND**	20/day	

RESPIRATORY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
		• Patient has passed the Bronchitol Tolerance Test; **AND** • Must be used concomitantly with a short-acting bronchodilator; **AND** • Prescriber attests that the patient has been instructed to administer the agent 5-15 minutes after a short-acting bronchodilator		
Cayston®	NP	• Diagnosis of Cystic Fibrosis or Pseudomonas Infection; **AND** • Trial and failure, contraindication, intolerance, or resistance to preferred inhaled tobramycin product	84 mL/56 days	General PA Form
tobramycin solution 300 mg/4 mL (generic for Bethkis)	NP	• Diagnosis of Cystic Fibrosis or *Pseudomonas* infection; **AND** • Clinically valid reason why preferred Bethkis® cannot be used	224 mL/56 days	
TOBI® Podhaler and inhalation solution	NP	• Diagnosis of Cystic Fibrosis or Pseudomonas Infection; **AND** • Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents	Podhaler: 224 caps/56 days; Solution: 280 mL/56 days	
Cystic Fibrosis Agents, Oral				

Alyftrek®	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of cystic fibrosis (CF); **AND**
		• Must be prescribed by, or in consultation with, a provider at a CF Center of Excellence or pulmonologist; **AND**
		• Age ≥ 6 years old; **AND**
		• Lab documentation confirming ONE of the following:
		  ○ Patient has at least one copy of the F508del mutation in the CFTR gene
		  ○ Patient has a mutation in the CFTR gene that is responsive based on in vitro data; **AND**
		• For patients 6- 12 years of age, prescriber attests to obtain ophthalmic examination before and during treatment
		Renewal Criteria:
		• Disease response to therapy and tolerability compared to baseline (e.g., decreased pulmonary exacerbations, improvement, or stabilization of lung function)
			4-20-50 mg: 3/day
			10-50-125 mg: 2/day
				General PA Form

Kalydeco®	NP	**Initial Criteria (6-month duration):** • Diagnosis of cystic fibrosis (CF); **AND** • Must be prescribed by, or in consultation with, a provider at a CF Center of Excellence or pulmonologist; **AND** • Lab documentation confirming patient has one mutation in the CFTR gene that is responsive to Kalydeco®; **AND** • For patients 2- 12 years of age, prescriber attests to obtain ophthalmic examination before and during treatment **Renewal Criteria:** • Disease response to therapy and tolerability compared to baseline (e.g., decreased pulmonary exacerbations, improvement, or stabilization of lung function) **Note**: will NOT be approved for homozygous F508del mutation in the CFTR gene	2/day	General PA Form

RESPIRATORY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Orkambi®	NP	**Initial Criteria (6-month duration):** • Diagnosis of cystic fibrosis (CF); **AND** • Must be prescribed by, or in consultation with, a provider at a CF Center of Excellence or pulmonologist; **AND** • Age ≥ 1 years old; **AND** • Lab documentation confirming patient has homozygous F508del mutation in the CFTR gene • For patients 2- 12 years of age, prescriber attests to obtain ophthalmic examination before and during treatment **Renewal Criteria:** Disease response to therapy and tolerability compared to baseline (e.g., decreased pulmonary exacerbations, improvement, or stabilization of lung function)	Tablets: 4/day Granules: 2/day	General PA Form

Symdeko®	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of cystic fibrosis (CF); **AND**
		• Must be prescribed by, or in consultation with, a provider at a CF Center of Excellence or pulmonologist; **AND**
		• Age ≥ 6 years old; **AND**
		• Lab documentation confirming ONE of the following:
		  ○ Patient is homozygous for the F508del mutation in the CFTR gene
		  ○ Patient has ≥1 mutation in the CFTR gene that is responsive based on in vitro data; **AND**
		• For patients 2- 12 years of age, prescriber attests to obtain ophthalmic examination before and during treatment
		Renewal Criteria:
		• Patient had not received a lung transplant; **AND**
		  ○ Disease response to therapy and tolerability compared to baseline (e.g., decreased pulmonary exacerbations, improvement or stabilization of lung function); **OR**
		• Patient has received a lung transplant; **AND**
		Prescriber attests that the patient continues to experience nonpulmonary CF related symptoms (e.g., sinus, gastrointestinal, diabetes, pancreatic)
			2/day	General PA Form

Trikafta®	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of cystic fibrosis (CF); **AND**
		• Must be prescribed by, or in consultation with, a provider at a CF Center of Excellence or pulmonologist; **AND**
		• Patient is ≥ 2 years of age; **AND**
		• Lab documentation confirming ONE of the following:
		  ○ Patient is homozygous for the F508del mutation in the CFTR gene
		  ○ Patient has ≥1 mutation in the CFTR gene that is responsive based on in vitro data; **AND**
		• For patients 2- 12 years of age, prescriber attests to obtain ophthalmic examination before and during treatment
		Renewal Criteria:
		• Patient had not received a lung transplant; **AND**
		  ○ Disease response to therapy and tolerability compared to baseline (e.g., decreased pulmonary exacerbations, improvement or stabilization of lung function); **OR**
		• Patient has received a lung transplant; **AND**
		Prescriber attests that the patient continues to experience nonpulmonary CF related symptoms (e.g., sinus, gastrointestinal, diabetes, pancreatic)
			3/day	General PA Form

RESPIRATORY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Inhaled: Anticholinergics and Anticholinergic Combinations				
Anoro Ellipta®	P		2 blisters/day	General PA Form
albuterol/ ipratropium	P		18 mL/day	
Atrovent HFA®	P		2 inhalers/month	
ipratropium solution	P		10 mL/day	
Spiriva HandiHaler ®	P		1 capsule/day	

Spiriva Respimat®	P	• Diagnosis of Asthma; **AND**
		  ○ Patient age ≥ 6 years; **AND**
		  ○ Diagnosis of step 4 or higher asthma; **AND**
		  ○ Optimal doses of inhaled steroids and long-acting beta-agonists are being used and breakthrough symptoms require frequent use of inhaled short-acting bronchodilators; **OR**
		• Diagnosis of Chronic Obstructive Pulmonary Disorder (COPD); **AND**
		  ○ Must be used as maintenance therapy only; **AND**
		  ○ Trial and failure, contraindication, or intolerance to Spiriva HandiHaler®
			1 inhaler/month	

Trelegy Ellipta®	P	**Initial Criteria:**
		• Diagnosis of chronic obstructive pulmonary disease (COPD); **AND**
		  ○ Trial and failure (as defined by continued symptoms, including exacerbations) of adequate treatment with a long-acting beta-agonist + long-acting antimuscarinic; **AND**
		  ○ Must be used as maintenance therapy only; **OR**
		• A diagnosis of asthma in patients 12 years of age or older; **AND**
		  ○ Trial and failure (as defined by continued symptoms, including exacerbations) of adequate treatment with 2 dual combination inhaled corticosteroid + long-acting beta-agonist therapies; **AND**
		  ○ Must be used as maintenance therapy only; **AND**
		  ○ Patient does not have known hypersensitivity to milk proteins
		Renewal Criteria:
		• Documentation of continued efficacy via prescriber's medical opinion on patient evaluation; **AND**
		• Patient has not experienced any intolerable adverse effects (e.g., hypersensitivity, bronchospasm, worsening of intraocular pressure, increased severe infections)
			2 blisters/day	General PA Form

Bevespi Aerosphere®	NP	Diagnosis of Chronic Obstructive Pulmonary Disorder (COPD)**; AND** Must be used as maintenance therapy only; **AND** Trial and failure, contraindication, or intolerance to TWO preferred inhaled anticholinergic/anticholinergic combination agents	1 inhaler/ month	

RESPIRATORY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Breztri Aerosphere®	NP	**Initial Criteria:** • Diagnosis of chronic obstructive pulmonary disease (COPD); **AND** • Must be used as maintenance therapy only; **AND** • Trial and failure (as defined by continued symptoms, including exacerbations) of adequate treatment with a long-acting beta-agonist + long-acting antimuscarinic; **AND** • Trial and failure, contraindication, or intolerance to the preferred product Trelegy Ellipta **Renewal Criteria:** Documentation of continued efficacy via prescriber's medical opinion on patient evaluation; **AND** Patient has not experienced any intolerable adverse effects (e.g., hypersensitivity, bronchospasm, worsening of intraocular pressure, increased severe infections)	1 inhaler/month	
Combivent Respimat®	NP	Diagnosis of Chronic Obstructive Pulmonary Disorder (COPD); **AND** Trial and failure, contraindication, or intolerance to TWO preferred inhaled anticholinergic/anticholinergic combination agents	2 inhalers/month	General PA Form
Duaklir Pressair®	NP	Diagnosis of Chronic Obstructive Pulmonary Disorder (COPD); **AND** Must be used as maintenance therapy only; **AND** Trial and failure, contraindication, or intolerance to TWO preferred inhaled anticholinergic/anticholinergic combination agents	1 inhaler/month	
Incruse Ellipta®	NP	Diagnosis of Chronic Obstructive Pulmonary Disorder (COPD); **AND** Must be used as maintenance therapy only; **AND** Trial and failure, contraindication, or intolerance to TWO preferred inhaled anticholinergic/anticholinergic combination agents Patient must not have severe hypersensitivity to milk proteins	1 blister/day	
Stiolto Respimat®	NP	See Duaklir Pressair prior authorization criteria	1 inhaler/month	
tiotropium inhalation capsules	NP	• Clinically valid reason why the patient cannot use the preferred brand Spiriva HandiHaler	1 capsule/day	General PA Form
Tudorza®	NP	See Incruse Ellipta® prior authorization criteria	1 inhaler/month	
Yupelri®	NP	**Initial Criteria:** • Patient must be ≥ 18 years of age; **AND** • Diagnosis of Chronic Obstructive Pulmonary Disorder (COPD); **AND** • Trial and failure, contraindication, or intolerance to TWO preferred inhaled anticholinergic/anticholinergic combination agents; **AND** • Must be used as maintenance therapy only**; AND** • Patient is unable to master proper inhaler technique, as attested by prescriber; **AND** • Patient is not prescribed other inhaled long-acting anticholinergic agents. **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Patient symptoms are clinically improving, as documented by provider; **AND** • Patient demonstrates continued compliance, based on fill history (not using PRN); **AND** • Prescriber documents that nebulized therapy continues to be required.	3 mL/day	

RESPIRATORY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Inhaled: Beta Agonists-Corticosteroid Combination Products				
Advair HFA®	P		1 inhaler/month	Beta Agonist Combos
Advair Diskus®	P		2 blisters/day	
Dulera®	P		2 inhalers/month	
fluticasone/ salmeterol aerosol	P		1 inhaler/month	
Symbicort®	P		2 inhalers/month	
AirDuo RespiClick®	NP	• Agent will be used for the treatment of asthma in patients 12 years of age or older; **AND** • Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** • Patient must not have severe hypersensitivity to milk proteins	1 inhaler/month	
Airsupra®	NP	• Agent will be used for the treatment of asthma in patients 18 years of age and older; **AND** • Trial and failure, contraindication, or intolerance to preferred agents Symbicort and Dulera	2 inhalers/month	
Breo Ellipta®	NP	• Agent will be used for the treatment of asthma in patients 18 years of age or older; **OR** • Agent will be used for the treatment of COPD where optimal doses of a long-acting beta agonist and/or long-acting muscarinic antagonists are being used and symptoms are still uncontrolled (100/25 mcg strength only); **AND** • Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** • Patient must not have severe hypersensitivity to milk proteins	2/day	
Breyna®	NP	• Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** • Clinically valid reason why the patient cannot use the preferred brand Symbicort®	2 inhalers/month	
budesonide/ formoterol	NP	• Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** • Clinically valid reason why the patient cannot use the preferred brand Symbicort®	2 inhalers/month	
fluticasone/ salmeterol powder	NP	• Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** • Clinically valid reason why the patient cannot use the preferred Advair HFA® or Advair Diskus® cannot be used.	55, 113, 232, -14mcg: 1 inhaler/month 100, 250, 500 -50mcg: 2 blisters/day	
fluticasone/ vilanterol	NP	See Breo Ellipta® prior authorization criteria; **AND** • Clinically valid reason why the patient cannot use the brand Breo Ellipta®	2/day	
Wixela®	NP	• Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** • Clinically valid reason why the patient cannot use the preferred Advair HFA® or Advair Diskus®	2 blisters/day	
Inhaled: Beta Agonists, Long Acting				
Serevent Diskus®	P		2 blisters/day	General PA Form
Striverdi Respimat®	NP	• Diagnosis of COPD; **AND** • Trial and failure, contraindication, or intolerance of the preferred agent (Serevent Diskus)	1/day	
Inhaled: Beta Agonists, Short Acting				
albuterol HFA	P		2 inhalers/month	
Proventil® HFA	P		2 inhalers/month	

RESPIRATORY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Ventolin® HFA	P		2 inhalers/month	
Xopenex® HFA	P	• Patients has experienced intolerable side effects to albuterol (e.g., tachycardia, etc.)	2 canisters/month	
levalbuterol HFA	NP	• Patients has experienced intolerable side effects to albuterol (e.g., tachycardia, etc.); **AND** • Clinically valid rationale for why patient cannot use brand Xopenex HFA®	2 canisters /month	
ProAir RespiClick®	NP		2 inhalers/month	
Inhaled: Nebulizers, Beta Agonists				
albuterol nebulizer solution	P		125 nebs/month (3 bottles/month	General PA Form
arformoterol	P		60 nebs/month	
Brovana®	NP	• Diagnosis of COPD; **AND** • Difficulty using a dry powder inhaler (DPI); **AND** • Trial and failure, contraindication, or intolerance of the preferred agent (arformoterol nebulizer)	60 nebs/month (120 mL/month)	
formoterol	NP	See Brovana® prior authorization criteria	60 nebs/month	
levalbuterol	NP	• Patients has experienced intolerable side effects to albuterol (e.g., tachycardia)	96 nebs/month	
Perforomist®	NP	See Brovana® prior authorization criteria	60 nebs/month	
Inhaled: Nebulizers, Mast Cell Stabilizers				
cromolyn solution	P	• Diagnosis of asthma	120 vials/month	General PA Form
Inhaled: Steroids				
Alvesco®	P	• Diagnosis of asthma; **AND** • Patient is 12 years of age or older	2/30 days	General PA Form
Arnuity Ellipta®	P		1 blister/day	General PA Form
Asmanex HFA®	P		1/30 days	
Asmanex Twisthaler®	P		1/30 days	
budesonide suspension	P	• ONE of the following: ○ Diagnosis of asthma; **AND** – Patient is < 8 years old; **OR** ○ Diagnosis of Eosinophilic esophagitis (EoE); **AND** – Prescribed by, or in consultation with, a gastroenterologist, allergist, or immunologist; **AND** – Prescriber attest to both of the following: • Esophageal biopsy consists of ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) following treatment course of a proton pump inhibitor; **AND** • Patient is experiencing symptoms of esophageal dysfunction (e.g., feeding difficulties, vomiting, dysphagia) **Note**: PA not required for patients ≤ 8 years of age	0.25, 0.5 mg: 2 vials/day; 1 mg: 1 vial/day	

RESPIRATORY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Flovent Diskus®	P		50 mcg: 2/day; 100 mcg: 4/day; 250 mcg: 8/day	
Flovent HFA®	P		2/30 days	
fluticasone HFA	P		2/30 days	
Pulmicort Flexhaler®	P	• Diagnosis of asthma; **AND** • Patient is 6 years of age or older	2/30 days	
Pulmicort Respules®	P	• Diagnosis of asthma; **AND** • Patient is ≤ 8 years old	0.25, 0.5 mg: 2 vials/day; 1 mg: 1 vial/day	
QVAR RediHaler®	P		2/30 days	
Intranasal: Steroids				
budesonide nasal (OTC)	P		2/30 days	General PA Form
fluticasone propionate	P		1/30 days	
Nasacort® (OTC)	P		2/30 days	
budesonide nasal (Rx only)	P		2/30 days	General PA Form
flunisolide	NP		2/30 days	
mometasone furoate	NP		1/30 days	
Nasonex®	NP		1/30 days	
Omnaris®	NP		1/30 days	
Qnasl®	NP		1/30 days	
triamcinolone acetonide	NP		1/30 days	
Xhance®	NP	• Patient has a trial/failure, contraindication, or intolerance to at least 2 preferred nasal corticosteroid agents; **AND** • Patient has a clinically valid reason as to why preferred fluticasone propionate products cannot be used	2/30 days	
Leukotriene Modifiers				
montelukast tabs and chewables	P		1/day	General PA Form
Accolate®	NP	• Trial and failure, contraindication, or intolerance of a preferred agent (montelukast tablets or chewables); **AND** • Patient is 5 years of age or older and has a diagnosis of asthma	2/day	

RESPIRATORY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

montelukast granules	NP	• One of the following:
		  ○ Diagnosis of asthma in patients 12 months of age or older; **OR**
		  ○ Diagnosis of exercise-induced bronchoconstriction (EIB) documented with concomitant use of at least one other asthma medication in patients 6 years of age or older; **OR**
		  ○ For treatment of seasonal allergic rhinitis in patients 2 years of age or older OR perennial allergic rhinitis in patients 6-months of age or older, patient must have failed trial of an intranasal corticosteroid OR a non-sedating antihistamine; **AND**
		• Will be approved ONLY for patients who have clinically valid reason not to use chewable tablets
		Note: For patients less than 3 years of age, no prior authorization is required
			1/day	

Singulair® tabs and chewables	NP	• One of the following:
		  ○ Diagnosis of asthma in patients 12 months of age or older; **OR**
		  ○ Diagnosis of exercise-induced bronchoconstriction (EIB) documented with concomitant use of at least one other asthma medication in patients 6 years of age or older; **OR**
		  ○ For treatment of seasonal allergic rhinitis in patients 2 years of age or older OR perennial allergic rhinitis in patients 6-months of age or older, patient must have failed trial of an intranasal corticosteroid OR a non-sedating antihistamine; **AND**
		• Trial and failure, contraindication, or intolerance of a preferred agent (montelukast tablets or chewables)
			1/day	

Singulair® granules	NP	See montelukast granules prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance of a preferred agent (montelukast tablets or chewables)	1/day	
zafirlukast	NP	See Accolate® prior authorization criteria	2/day	
zileuton CR	NP	• Trial and failure, contraindication, or intolerance of a preferred agent (montelukast tablets or chewables); **AND** • Patient is 12 years of age or older and has a diagnosis of asthma	4/day	
Zyflo®	NP	See zileuton CR prior authorization criteria	4/day	
Miscellaneous: OTC Products				
Peak Flow Meters			4 per 365 days	General PA Form
Spacers			4 per 365 days	
Phosphodiesterase 4 (PDE-4) Inhibitors				
roflumilast	P	**Initial Criteria (6-month duration):** • Diagnosis of COPD associated with chronic bronchitis, **AND** • Patient has forced expiratory volume in 1 second [FEV1] < 50%; **AND** • Patient is currently receiving standard of care COPD treatments, unless contraindicated (short acting β agonists OR short acting anticholinergics PLUS long acting β agonists OR long-acting anticholinergics), **AND** • Patient has a history of continued COPD exacerbations on their current COPD treatment regimen **Renewal Criteria** • Positive clinical response to treatment (e.g., improvement in FEV1 from baseline, reduction in COPD exacerbations); **AND** • Patient is currently receiving standard of care COPD treatments, unless contraindicated (short acting β agonists OR short acting anticholinergics PLUS long acting β agonists OR long-acting anticholinergics)	250 mcg: 28/year 500 mcg: 1/day	

RESPIRATORY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Daliresp®	NP	See roflumilast prior authorization criteria; **AND** • Clinically valid reason why the patient cannot use the preferred generic roflumilast	250 mcg: 28/year 500 mcg: 1/day	

Ohtuvayre®	NP	• Patient is ≥ 18 years of age; **AND**
		• Diagnosis of Chronic Obstructive Pulmonary Disorder (COPD); **AND**
		• Submission of medical records (e.g. chart notes) that patient meets ALL the following:
		  ○ Bronchodilator FEV1/FVC ratio of <0.7
		  ○ FEV1 % predicted of ≤ 79%
		  ○ Modified medical research council (mMRC) dyspnea scale score of ≥ 2; **AND**
		• Trial and failure (as defined by continued symptoms, including exacerbations) of adequate treatment concomitantly with ONE of the following:
		  ○ A long-acting beta-agonist (LABA) + long-acting antimuscarinic (LAMA) + inhaled corticosteroid; **OR**
		  ○ A long-acting beta-agonist (LABA) and long-acting antimuscarinic (LAMA); **AND**
		• Medication must be used as maintenance therapy only
			2 ampules/day	

SMOKING CESSATION AGENTS *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Smoking Cessation Agents				
apo-varenicline	P		2/day; 24 weeks/yr*	
bupropion sustained release	P		2/day; 24 weeks/yr*	General PA Form
Chantix®	P		2/day; 24 weeks/yr*	
nicotine polacrilex gum	P		24 weeks/yr*	
nicotine polacrilex lozenge	P		24 weeks/yr*	
nicotine transdermal patch	P		24 weeks/yr*	
Varenicline	P		2/day; 24 weeks/yr*	
Nicotrol® inhaler	NP		24 weeks/yr*	
Nicotrol® nasal spray	NP		24 weeks/yr*	
Zyban®	NP		2/day; 24 weeks/yr*	
**** For children, larger quantities may be approved as medically necessary.***				

VITAMINS/ELECTROLYTES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Folic Acid Preparations				
L-methylfolate	NP	• Patient has documented methylenetetrahydrofolate reductase (MTHFR) mutation/deficiency		
Potassium Depletors				

Lokelma®	NP	**Initial Criteria:**
		• Patient must be ≥ 18 years of age; **AND**
		• Patient has a diagnosis of chronic hyperkalemia; **AND**
		• One of the following:
		  ○ Trial and failure, contraindication, or intolerance to a loop or thiazide diuretic; **OR**
		  ○ Trial and failure, contraindication, or intolerance to a preferred potassium deplete agent
		Renewal Criteria:
		• Patient has a positive clinical response to therapy [e.g., decreased serum potassium levels, levels within normal limits)
			1/day	General PA Form

VITAMINS/ELECTROLYTES *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**

Veltassa®	NP	**Initial Criteria:**
		• Patient must be ≥ 12 years of age; **AND**
		• Patient has a diagnosis of chronic hyperkalemia; **AND**
		• One of the following:
		  ○ Trial and failure, contraindication, or intolerance to a loop or thiazide diuretic; **OR**
		  ○ Trial and failure, contraindication, or intolerance to a preferred potassium deplete agent
		Renewal Criteria:
		• Patient has a positive clinical response to therapy [e.g., decreased serum potassium levels, levels within normal limits)
			1 packet/day	

Vitamin B Products				
cyanocobalamin injection	P	• Diagnosis of Pernicious Anemia; **AND** • Product is being administered by the patient, patient's caregiver, or in a long-term care facility **NOTE:** If the medication is being administered in the prescriber's office **OR** by a Home Health Nurse, coverage must be obtained through the patient's MCO.		General PA Form

cyanocobalamin nasal spray	P	• Diagnosis of one of the following:
		  ○ Pernicious Anemia
		  ○ B12 deficiency; **AND**
		  – Provider must submit lab documentation confirming deficiency		

hydroxocobalamin injection	P	See cyanocobalamin injection prior authorization criteria		

cyanocobalamin, OTC	P	Will be approved for patients who meet the following criteria:
		• Diagnosis of Pernicious Anemia
		  ○ Patient must be **UNDER** 21 years old (not a covered benefit for adults)
		• Diagnosis of B12 deficiency
		  ○ Patient must be **UNDER** 21 years old (not a covered benefit for adults)
		  ○ Provider must submit lab documentation confirming deficiency		

Nascobal® nasal spray	NP			
Vitamin K Products				
phytonadione	P		5/Rx	