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

Interim Criteria for Agents Awaiting PAC Review

February 1, 2026

Abbreviations:

B	Budgetary Reduction edit for utilization control	Caps	Capsules
I/DD	Intellectual and Developmental Disabilities (I/DD)	Conc	Concentrate
NP	Non-Preferred Agent	Cr	Cream
P	Preferred Agent	Oint	Ointment
PA	Prior Authorization	Soln	Solution
PAC	Pharmacy Advisory Committee	Susp	Suspension
PDL	Preferred Drug List	Tabs	Tablets
QL	Quantity Limit		

Faxed PA submissions require the use of the **General PA Form,** unless a drug/class specific form is noted under the Prior Authorization Criteria or drug class header.

Interim Criteria for Agents Awaiting PAC Review Approval of NP agents requires trial and failure, contraindication or intolerance of 2 preferred agents, unless otherwise indicated.		
Medication	**Prior Authorization Criteria**	**Quantity Limit**
Hernexeos®	**Initial Criteria:** • Diagnosis of unresectable or metastatic non-squamous non-small cell lung cancer (NCSLC); **AND** • Patient is positive for HER2 (ERBB2) tyrosine kinase domain activating mutations; **AND** • Patient is 18 years of age or older; **AND** • Patient has documented disease progression on at least one prior systemic therapy (e.g., platinum and Carboplatin based chemotherapy); **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., hepatotoxicity, left ventricular dysfunction, interstitial lung disease/pneumonitis)	
Ibtrozi®	**Initial Criteria:** • Diagnosis of locally advanced or metastatic non-small cell lung cancer; **AND** • ROS1-positive mutation present; **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, interstitial lung disease, QTc interval prolongation, etc.)	3 capsules/day

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Brinsupri®	**Initial Criteria:**
	• Diagnosis of non-cystic fibrosis bronchiectasis (NCFB); **AND**
	• Diagnosis has been confirmed by a documented computed tomography (CT) scan; **AND**
	• Prescribed by, or in consultation with, a pulmonologist or infectious disease specialist; **AND**
	• One of the following:
	  ○ Patient is 12 to 17 years of age with at least one documented pulmonary exacerbation in the past 12 months requiring systemic antibiotic therapy; **OR**
	  ○ Patient is 18 years of age or older with at least two documented pulmonary exacerbations in the past 12 months requiring systemic antibiotic therapy;
	Renewal Criteria:
	• Patient demonstrates positive clinical response to therapy (e.g., stabilization or reduction in number of pulmonary exacerbations, reduced cough or sputum)
		1 tablet/day

Wayrilz®	**Initial Criteria:**
	• Patient is ≥ 18 years old; **AND**
	• Patient has a diagnosis of chronic OR persistent immune thrombocytopenia; **AND**
	• Trial and failure (platelet count ≥ 50 x 109/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**
	• Females must use effective contraception due to embryo-fetal toxicity; **AND**
	• Prescribed by, or in consultation with, a hematologist; **AND**
	• Patient has received a baseline and will receive ongoing routine monitoring that includes:
	  ○ Neutropenia (measure ANC monthly)
	  ○ Hepatotoxicity (measure LFTs monthly)
	Renewal Criteria:
	• Patient has laboratory values documenting platelet response to therapy (platelet count ≥ 50 x 109/L); **AND**
	• Patient has not experienced severe adverse effect as a result of Wayrilz® therapy
		2/day

Bluejepa®	• Diagnosis of uncomplicated urinary tract infection (uUTI); **AND**
	• Patient is 12 years of age or older and weighs at least 40 kg; **AND**
	• Infection has been confirmed to have been caused by one of the following:
	  ○ *Escherichia coli*
	  ○ *Klebsiella pneumoniae*
	  ○ *Citrobacter freundii complex*
	  ○ *Staphylococcus saprophyticus*
	  ○ *Enterococcus faecalis*; **AND**
	• Trial and failure, contraindication, intolerance, or resistance to at least 2 of the following agents:
	  ○ Sulfamethoxazole/trimethoprim
	  ○ Quinolones
	  ○ Nitrofurantoin; **AND**
	• Prescribed by, or in consultation with, an infectious disease specialist
		20 tabs/30 days

Modeyso®	**Initial Criteria:** • Diagnosis of diffuse midline glioma; **AND** • Patient is positive for H3 K27M mutation; **AND** • Patient has progressed on at least one prior therapy (e.g., radiation therapy) • 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., QT prolongation, Torsades de pointes, polymorphic ventricular tachycardia, confusional state)	20 caps/28 days

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Medication	Prior Authorization Criteria	Quantity Limit

Harliku®	**Initial Criteria:**
	• Diagnosis of alkaptonuria (AKU); **AND**
	• Used for the reduction of urine homogentisic acid; **AND**
	• Disease is confirmed by ONE of the following:
	  ○ Presence of a mutation in the homogentisate 1,2-dioxygenase (HGD) gene as detected by an FDA-approved test
	  ○ Presence of elevated homogentisic acid (HGA) levels in urine greater than 0.4 g/24h; **AND**
	• Prescribed by or in consultation with a specialist (i.e., someone experienced with treatment of inborn errors of metabolism, rheumatologist)
	Renewal Criteria:
	• Patient demonstrates positive clinical response to therapy (e.g., reduced levels of urinary HGA)
		1 tab/day

Orlynvah®	• Diagnosis of uncomplicated urinary tract infection (uUTI); **AND**
	• Patient is 18 years of age or older; **AND**
	• Infection has been confirmed to have been caused by one of the following:
	  ○ Escherichia coli
	  ○ Klebsiella pneumoniae
	  ○ Proteus mirabilis; **AND**
	• Trial and failure, contraindication, intolerance, or resistance to at least 2 of the following agents:
	  ○ Sulfamethoxazole/trimethoprim
	  ○ Quinolones
	  ○ Nitrofurantoin; **AND**
	• Prescribed by, or in consultation with, an infectious disease specialist
	NOTE: Reserve use for infections caused by drug-resistant pathogens with limited treatment options.
		10 tabs/course of therapy

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Medication	Prior Authorization Criteria	Quantity Limit

Wegovy® tablets	**CV Risk Reduction due to prior MI, prior stroke, or PAD**
	Initial Criteria (1yr duration)
	• Treatment is being requested to reduce the risk of major adverse cardiovascular events; **AND**
	• Patient must be 18 years of age or older meet labeled age minimum; **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 complementary nutritional and lifestyle changes (e.g. dietary modification, increased physical activity as medically able, structured behavioral intervention, comprehensive weight management); **AND**
	• Will not be used concomitantly with DPP-4 inhibitors; **AND**
	• Will not be co-administered with another GLP-1 receptor agonists; AND
	• Submission of medical records (i.e. chart notes) providing a clinically valid reason why patient can't use Wegovy injectable (NOTE: Patient convenience, mild injection site reactions, or needle phobia is NOT an approvable reason. Patient must have contraindication to the excipients in the injectable Wegovy product.)
	
	Renewal Criteria (1 year duration)
	• 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**
	• One of the following:
	  ○ Patient is currently on the 25mg once daily maintenance dose; **OR**
	  ○ Submission of medical records (i.e. chart notes) demonstrating a positive clinical response (e.g. decrease in body weight, blood pressure, heart rate, etc.) with no adverse effects (e.g. nausea, diarrhea, constipation, hypoglycemia, acute pancreatitis/gallbladder disease, etc.) at a lower maintenance dose; **AND**
	• Prescriber attests patient is participating in complementary nutritional and lifestyle changes (e.g. dietary modification, increased physical activity as medically able, structured behavioral intervention, comprehensive weight management); **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)
	Note: Patients not meeting the above renewal criteria may be approved for up to one month to allow for titration off medication.
	
	Continued below.
		1 tablet/day

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Medication	Prior Authorization Criteria	Quantity Limit

Wegovy® tablets	**Weight Management**
	Initial Criteria: (1-year duration)
	• Patient must be 18yrs of age or older; **AND**
	• Treatment is for the management of obesity; **AND**
	• One of the following:
	  – Submission of medical records (e.g. chart notes) documenting a body mass index (BMI) ≥ 30 kg/m2; **OR**
	  – Submission of medical records (e.g. chart notes) documenting a BMI of greater than 27 kg/m2 with a weight related comorbidity (e.g. hypertension, dyslipidemia, diabetes, coronary heart disease, MASH/NASH, obstructive sleep apnea); **AND**
	• Trial and failure, or contraindication, or intolerance to 2 preferred GLP-1 agonist weight management agents (e.g., appetite and absorption agents, neurobehavioral appetite modulators) and ; **AND**
	• Prescriber attests patient is participating in complementary nutritional and lifestyle changes (e.g., dietary modification, increased physical activity as medically able, structured behavioral intervention, comprehensive weight management program); **AND**
	• Medication will not be used in combination with other medications FDA approved for obesity/weight loss; **AND**
	• Will not be co-administered with another GLP-1 receptor agonist; **AND**
	• Patient does not have personal or immediate family history of medullary thyroid carcinoma or multiple endocrine neoplasia type 2 (MEN2); **AND**
	• Trial and failure of 2 preferred GLP-1 agonist weight management agents; **AND**
	• Submission of medical records (i.e. chart notes) providing a clinically valid reason why patient can't use Wegovy injectable (NOTE: Patient convenience, mild injection site reactions, or needle phobia is NOT an approvable reason. Patient must have contraindication to the excipients in the injectable Wegovy product.)
	
	Renewal Criteria:
	• Patient has continued participating in complementary nutritional and lifestyle changes (e.g., dietary modification, increased physical activity as medically able, structured behavioral intervention, comprehensive weight management program); **AND**
	• One of the following:
	  ○ Patient is currently on the 25mg once daily maintenance dose; **OR**
	  ○ Submission of medical records (i.e., chart notes) demonstrating a positive clinical response (e.g., decrease in body weight, blood pressure, heart rate, etc.) with no adverse effects (e.g., nausea, diarrhea, constipation, hypoglycemia, acute pancreatitis/gallbladder disease, etc.) at a lower maintenance dose; **AND**
	• Medication will not be used in combination with other medications for obesity/weight loss; **AND**
	• Submission of medical records (e.g., chart notes) documenting a weight loss of ≥ 5% of baseline body weight
	Note: Patients not meeting the above renewal criteria may be approved for up to one month to allow for titration off medication.
		1 tablet/day