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

April 1, 2024

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 Opioid Use Disorder				
Vivitrol® injection	P		1 vial per 28 days	

Lucemyra®	NP	**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)
		• **Note**: Safety and efficacy has not been established in patients < 18 years of age
			16/day	General PA Form

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

Please use Google Chrome, Microsoft Edge, or Firefox as your browser to access the files on the TennCare site.

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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**
Buprenorphine and Buprenorphine/Naloxone				
Buprenorphine Enhanced Supportive Medication-Assisted Recovery and Treatment (BESMART) Network Provider only:				
buprenorphine/ naloxone tablets	P	No PA required for up to max daily dose (MDD) of 16 mg of preferred products buprenorphine/naloxone tabs and films. Criteria for requests for patients 21 years of age and older for >16 mg to ≤24 mg ** • Diagnosis of opiate addiction; **AND** • Prescriber is enrolled and in good standing in the BESMART program; **AND** • Prescriber provides clinical rationale for the requested dosage with one of the following reasons: ○ Pregnant patients confirmed by provider attestation. ○ Postpartum patients for a period of 12 months from delivery date as shown by medical records or insurance claim. ○ Recent IV drug users confirmed by prescriber attestation and a positive urine drug screen ○ Current users receiving greater than 50 mg of methadone for OUD treatment transitioning to buprenorphine agonist therapy demonstrated by paid claims data from the enrollee's health insurer, provider attestation, or medical records. ○ Newly eligible TennCare enrollees who are current users of 16 mg to 24 mg per day of buprenorphine demonstrated by paid claims data from the enrollee's previous health insurer PA duration- Opioid Addiction: Initial Authorization – 6-months; Total max duration up to 12 months; Pregnancy: through duration of pregnancy; Postpartum: 12 months post-delivery **Applies to adult enrollees only. Children have access to 24 mg of buprenorphine daily across both networks; criterion applies.	8/2 mg: 2/day; 2/0.5 mg: 3/day ^	Buprenorphine Products PA Form
buprenorphine/ naloxone film	P	See buprenorphine/naloxone tab prior authorization criteria	12/3 mg: 1/day; 8/2 mg: 2/day; 4/1 mg: 2/day; 2/0.5 mg: 3/day ^	
buprenorphine	NP	See buprenorphine/naloxone tab prior authorization criteria • Additionally, must be unable to take buprenorphine/naloxone as indicated by ONE of the following: ○ Patients who are actively pregnant or breastfeeding ○ 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 (Note: This does not include GI intolerance – FAX DOCUMENTATION REQUIRED) PA duration- Pregnancy: Duration of Pregnancy; Breastfeeding Patients: 6-months; Contraindication to Naloxone: Initial Authorization 6-months, Reauthorization 12 months	8 mg: 2/day; 2 mg: 3/day ^	
Suboxone® film	NP	See buprenorphine/naloxone tab prior authorization criteria • Additionally, a documented allergy to inactive ingredient in preferred product that is not in requested product	12/3 mg: 1/day; 8/2 mg: 2/day; 4/1 mg: 2/day; 2/0.5 mg: 3/day^	
Zubsolv®	NP	See buprenorphine/naloxone tab prior authorization criteria • Additionally, a documented allergy to inactive ingredient in preferred product that is not in requested product	11.4/2.9 mg & 8.6/2.1 mg: 1/day; 5.7/1.4 mg: 2/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**
All other TennCare Providers:				
buprenorphine/ naloxone tablets	P	• 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 x 6-months then 1/day*; 2/0.5 mg: 3/day* ^	Buprenorphine Products PA Form
buprenorphine	NP	See buprenorphine/naloxone tab prior authorization criteria • Additionally, must be unable to take buprenorphine/naloxone as indicated by ONE of the following: ○ Patients who are pregnant (Note: Buprenorphine without naloxone will not be approved for patients who are breastfeeding) ○ 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 (Note: This does not include GI intolerance, nausea, vomiting, headaches – FAX DOCUMENTATION REQUIRED)	8 mg: 2/day x 6-months then 1/day*; 2 mg: 3/day* ^	
buprenorphine/ naloxone film	NP	See buprenorphine/naloxone tab prior authorization criteria • Additionally, a documented allergy to inactive ingredient in preferred product that is not in requested product	8/2 mg: 2/day x 6-months then 1/day*; 2/0.5 mg: 3/day* ^	
Suboxone® film	NP	See buprenorphine/naloxone tab prior authorization criteria • Additionally, a documented allergy to inactive ingredient in preferred product that is not in requested product	12/3 mg: 1/day x 6-months* 8/2 mg: 2/day x 6-months, then 1/day*; 4/1 mg: 2/day 2/0.5 mg: 3/day* ^	
Zubsolv®	NP	See buprenorphine/naloxone tab prior authorization criteria • Additionally, a documented allergy to inactive ingredient in preferred product that is not in requested product	11.4/2.9 mg & 8.6/2.1 mg: 1/day x 6-months*; 5.7/1.4 mg: 2/day x 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***				

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

Nucynta® ER	P	See morphine ER tablets prior authorization criteria	2/day; *^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 *****				

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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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 *****				

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

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	

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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 *******				

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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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 *****				

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	

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**
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	2/day; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day	
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.	2/day; *^Max Total: Non-Chronic:60 MME/day; Chronic:200 MME/day	
tramadol ER	NP	See ConZip® prior authorization criteria	1/day; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day	
Xtampza ER®	NP	See hydromorphone ER prior authorization criteria	2/day; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day	
Zohydro ER®	NP	See hydromorphone ER prior authorization criteria	2/day; *^Max Total: Non-Chronic: 60 MME/day; Chronic: 200 MME/day	

***^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

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**
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	

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**
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	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 Exceptions Opioid PA Form
oxycodone concentrate	P	See morphine solution prior authorization criteria	*^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	
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	

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**
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
				Acute Opioid PA Form
				Chronic Opioid PA Form
				Exceptions Opioid PA Form

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

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**
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	Acute Opioid PA Form

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**
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	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	
Nucynta®	NP	See Dilaudid® prior authorization criteria	6/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 caps	NP	See Dilaudid® prior authorization criteria	8/day; *^Max Total: Non-Chronic: 60 MME/day Chronic: 200 MME/day	

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**
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 *******				
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	Acute Opioid PA Form Chronic Opioid PA Form Exceptions Opioid PA Form
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	

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**
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	

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**
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**
Narcotics: 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 two 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
fentanyl lozenge	NP	See fentanyl lozenge prior authorization criteria	4/day	

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**
Fentora®	NP	See fentanyl lozenge prior authorization criteria	4/day	
Subsys®	NP	See fentanyl lozenge prior authorization criteria	4/day	
Non-Steroidal Anti-Inflammatory Drugs (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	
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 capsules	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	
Zorvolex®	NP	• Clinically valid reason why the preferred NSAIDs cannot be used		
NSAID/Anti-Ulcer Agents				
Arthrotec®	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

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**
Duexis®	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	
diclofenac/ misoprostol	NP		50 mg/200 mcg: 4/day; 75 mg/200 mcg: 2/day	
famotidine/ ibuprofen	NP		3/day	
naproxen/ esomeprazole	NP		2/day	
Salicylates				
salsalate	P		500 mg: 6/day; 750 mg: 4/day	General PA Form
diflunisal	NP		3/day	

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

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

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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: 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		
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

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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: 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	
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	
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)		

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

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: 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		

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	

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

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**

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

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	

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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, Oral				
fluconazole suspension	P	• Patient is unable to swallow solid dosage forms; **OR** • Patients ≤ 20 years of age		General PA Form
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	
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)		General PA Form

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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**
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	
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, itraconazole); **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		
Antifungals, Vaginal				
Gynazole-1	P		5 gm/day	
miconazole-3 kit	P		1 box/Rx	
miconazole-3 vaginal supp	P		1 box/Rx	

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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**
terconazole	P		1 box/Rx	
Anti-Infectives: Anthelmintics, Oral				
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: Antiprotozoal Agents, Miscellaneous				
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		General PA Form
benznidazole	NP	• Diagnosis of American trypanosomiasis (Chagas disease) caused by Trypanosoma cruzi	12.5 mg: 6/day 100 mg: 4/day	General PA Form
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		
nitazoxanide tablets	NP	• Patient is > 12 years of age or older • 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) ○ 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		

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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**
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

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 meets ONE of the following:
		  – Patient is seropositive for CMV
		  – Treatment is for prophylaxis against CMV disease
		  ○ Patient is a kidney transplant recipient; **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 any of the following:
		  ○ Pimozide
		  ○ Ergot alkaloids
		  ○ 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

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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 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 > 12 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 tenofovir alafenamide (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	

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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, 3 (without baseline NS5A RAS Y93H), 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 with baseline NS5A RAS Y93H** – Treatment naïve patients with compensated cirrhosis (Child-Pugh A) AND given in combination with ribavirin (Total duration – 12 weeks); **OR** ○ **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 HIV, 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

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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 HIV, 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

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

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 HIV, 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

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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 HIV, 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	

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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 HIV, 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 HIV, 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

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

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	

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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* ~~therapy (ART)~~; **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	See prior authorization criteria for Selzentry® tablets	150 mg: 2/day; 300 mg: 4/day	
Selzentry® 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.	75 ,150 mg: 2/day; 25, 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

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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	
Emtriva®	P		caps: 1/day; soln: 24 mL/day	
lamivudine	P		100 & 300 mg: 1/day; 150 mg: 2/day; soln: 30 mL/day	

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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**
stavudine	P		caps: 2/day; soln: 80 mL/day	
zidovudine	P		100 mg: 6/day; 300 mg: 2/day; syrup: 60 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	
Combivir®	P		2/day	
Complera®	P		1/day	
Delstrigo®	P		1/day	
Descovy®	P		1/day	

Dovato®	P	**Initial Criteria:**
		• Patient has a diagnosis of HIV; **AND**
		• Patient has no known resistance to the individual components (lamivudine/dolutegravir); **AND**
		• Patient meets ONE of the following:
		  ○ Patient is ARV treatment-naïve
		  ○ Patient is virologically suppressed (HIV-1 RNA < 50 copies/mL) on a current ART regimen for ≥ 6 months
		Renewal Criteria:
		• Patient demonstrates documented efficacy (e.g., reduced viral load/improved CD4, remain virologically suppressed);
			1/day	

emtricitabine/ tenofovir	P		1/day	
efavirenz/emtricita-bine/tenofovir	P		1/day	
Genvoya®	P		1/day	
lamivudine/ zidovudine	P		2/day	General PA Form
Odefsey®	P		1/day	
Stribild®	P		1/day	

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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**

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 dosing frequency
		Renewal Criteria:
		• Patient demonstrates documented efficacy (e.g., reduced viral load/improved CD4, remaining virologically suppressed)
			1/day	

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				
Norvir® solution	P		15 mL/day	General PA Form
ritonavir tablet	P			

Norvir® pack	NP	• One of the following:
		  ○ Patient has a diagnosis of HIV-1; **AND**
		  – Patient will be taking in combination with other antiretroviral agents; **AND**
		  – Patient is ≤ 18 years of age; **OR**
		  ○ Clinically valid reason why the preferred ritonavir (e.g., Norvir) oral solution cannot be used, including patients with polyurethane feeding tubes.
		Note: Norvir oral powder should only be used for dosing increments of 100 mg; prescribed dosing 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 to **OR** has experienced an adverse reaction to ritonavir; **AND** • Patient is not pregnant; **AND** • Patient does not have renal impairment	1/day	

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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 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	
Lexiva®	P		700 mg: 4/day; susp: 56 mL/day	
lopinavir/ritonavir	P		soln: 6 mL/day tabs: 1/day	
Prezcobix®	P		1/day	
Prezista® susp	P		800 mg: 1/day; All other strengths: 2/day; susp: 12 mL/day	
Reyataz® powder	P		5/day	General PA Form
Viracept®	P		tabs: 4/day	
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	

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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**
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 ≥ 12 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	

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

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**
Alpha/Beta Blockers				
carvedilol	P		2/day	General PA Form
carvedilol ER	NP		1/day	
Coreg®	NP		2/day	
Coreg CR®	NP		1/day	
ACE Inhibitors (ACEI)				
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	

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

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**
ACEI/Diuretic				
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	
Angiotensin II Receptor Antagonists (ARB)				
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	

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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**
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	
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®	P	• Diagnosis of chronic heart failure (NYHA Class II-IV)	2/day	General PA Form
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)		

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Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**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		General 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®	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	
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

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Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Xarelto® suspension	NP	• Patient is unable to swallow solid dosage forms		
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	

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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	

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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	General PA Form
Aspruzyo Sprinkle®	NP	See ranolazine ER prior authorization criteria; **AND** • Patient is unable to swallow solid dosage form	2/day	

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

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Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Corlanor®	NP	• 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
Ranexa®		See ranolazine ER prior authorization criteria; **AND** • Clinically valid reason as to why the patient cannot take generic ranolazine ER	2/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	

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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 New York Heart Association (NYHA) Class II or Class III 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		

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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
Diuretics: Thiazide and Related Diuretics				
Diuril®	NP	• Patient is unable to swallow solid dosage forms		General PA Form
Hemostatics, Oral				
Lysteda®	P	• See tranexamic acid prior authorization criteria	30 /28 days	General PA Form

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.		

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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 >18 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

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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

Nexletol®	NP	**Initial Criteria (6-month duration):**
		• Age ≥ 18 years; **AND**
		• Diagnosis of ONE of the following:
		  ○ 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 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

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Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**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		
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				
Antara®	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)		General PA Form
fenofibrate caps	NP	See Antara prior authorization criteria		
fenofibrate tabs 40, 54, & 120 mg	NP	See Antara prior authorization criteria		
fenofibric acid	NP	See Antara prior authorization criteria		
Fenoglide®	NP	See Antara prior authorization criteria		
Fibricor®	NP	See Antara prior authorization criteria		
Lipofen®	NP	See Antara prior authorization criteria		
Lofibra®	NP	See Antara prior authorization criteria		
TriCor®	NP	See Antara prior authorization criteria		
Trilipix®	NP	See Antara prior authorization criteria		

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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		
Niaspan®	NP	See niacin ER prior authorization criteria		
Lipotropics: Omega-3 Fatty Acids				
Lovaza®	P	**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)	4/day	General PA Form
omega-3 acid ethyl esters	P	See Lovaza® prior authorization criteria	4/day	
Vascepa®	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)	0.5 g: 2/day 1 g: 4/day	
icosapent ethyl	NP	**Initial Criteria:** • Diagnosis of Severe Hypertriglyceridemia (TG level is above 500 mg/dl); **AND** • Clinically valid reason why preferred Vascepa® cannot be used **Renewal Criteria:** • Documentation of positive clinical response (e.g., reduction in TG from baseline)	0.5 g: 2/day 1 g: 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	

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

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

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**
prasugrel	P	• 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		

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	

Zontivity®	NP	• Patient has a history of myocardial infarction (MI) or established peripheral arterial disease (PAD); **AND** • Patients must not have a history of stroke, transient ischemic attack (TIA), intracranial hemorrhage (ICH), active pathological bleeding, or peptic ulcer due to the risk of bleeding; **AND** • Concomitant therapy with clopidogrel, unless patient has a contraindication to clopidogrel, in which case patient must have concomitant therapy with aspirin	1/day	General PA Form

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

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**
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	
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

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

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**
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
Orenitram®	NP	See Opsumit® prior authorization criteria	3/day	General PA Form
Revatio® tab	NP	See Adcirca® prior authorization criteria	3/day	
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	General PA Form
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	General PA Form
Tracleer® tabs	NP	See Adcirca® prior authorization criteria	2/day	General PA Form
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	
Pulmonary Fibrosis				
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	
pirfenidone capsules	NP	See Esbriet prior authorization criteria	9/day: 267 mg	

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

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**
Thrombopoietin Agonists				

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®	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	

Promacta® suspension	NP	See Promacta® prior authorization criteria • Patient is unable to swallow solid dosage forms	4 packets/day	

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

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

Vasodilator/Nitrate Combos				
BiDil®	NP	• Clinically valid reason why the generic equivalent cannot be used		General PA Form
Vasopressors				
droxidopa	NP	See Northera® prior authorization criteria	100 & 200 mg: 3/day 300 mg: 6/day	General PA Form
Northera®	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	

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

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	
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	• Patient is less than 12 years of age; **OR** • Inability 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; **AND**
		  – Inability to open capsule and empty contents in food or drink
			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® 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	
Neurontin® solution	NP	See gabapentin solution prior authorization criteria	72 mL/day	
Neurontin® tablets	NP		600 mg: 6/day; 800 mg: 4.5/day	

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

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 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				
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	
Mirapex®	NP		3/day	
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	
Razadyne® ER	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	

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

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	
Namenda®	NP	• Diagnosis of moderate to severe Alzheimer's disease	See memantine	
Namenda XR®	NP	• Diagnosis of moderate to severe Alzheimer's disease; **AND** • Documented intolerance or contraindication to an inactive ingredient that is present in the regular-release product, but NOT in the XR product	1/day	
Namzaric®	NP	• Diagnosis of moderate to severe dementia associated with Alzheimer's disease • Concomitantly taking donepezil and memantine (immediate release or extended release) [≥10mg/day on both agents] • Clinical reason why recipient is unable to take the components individually	1/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

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

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-Parkinson Agents: Adenosine Receptor Antagonist				

Nourianz®	NP	• Diagnosis of Parkinson's disease; **AND**
		  ○ Patient is experiencing an "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**
		• Patient does not meet the following:
		  ○ Severe hepatic impairment (Child-Pugh C)
		  ○ Presence of hallucinations/psychotic behavior
		  ○ Presence of impulse control/compulsive behaviors
		  ○ Concomitantly using drugs that are strong CYP3A4 inducers
		  ○ Patient is pregnant; **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**
		• Patient has had trial and failure, intolerance, or contraindication to ONE preferred agent in TWO different classes for Parkinson's disease such as:
		  ○ Dopamine agonists (e.g., pramipexole, ropinirole)
		  ○ Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
		  ○ Monoamine oxidase (MAO) B inhibitors (e.g., selegiline)
			1/day	General PA Form

Anti-Parkinson Agents: Dopamine Precursor/Decarboxylase Inhibitor				
Dhivy®	NP	• Clinically valid reason as to why all the preferred carbidopa/levodopa agents cannot be used		General PA Form
Inbrija®	NP	• Patient has a diagnosis of Parkinson's disease; **AND** • Experiencing "off" episodes; **AND** • Will be concurrently receiving carbidopa/levodopa therapy; **AND** • Patient is not currently taking a nonselective monoamine oxidase (MAO) inhibitor or has not recently (within two weeks) taken a nonselective MAO inhibitor; **AND** • Patient does not have asthma, COPD, or other chronic lung disease	60 blisters/month	

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

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-Parkinson Agents: COMT Inhibitors and Combos				

Ongentys®	NP	• Patient must be 18 years of age or older; **AND**
		• Patient has a diagnosis of Parkinson's disease; **AND**
		  ○ Patient is experiencing "off" episode; **AND**
		• Patient is currently being treated and has received treatment with a carbidopa/levodopa agent for at least 1 year with clinical improvement; **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; **AND**
		  ○ 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 monoamine oxidase inhibitors (MAOIs)
		  ○ Patient has a history of pheochromocytoma, paraganglioma, or other catecholamine secreting neoplasms
		  ○ Patient has end-stage renal disease (ESRD) (CrCl <15 mL/min)
		  ○ Patient is pregnant
			1/day	General PA Form

Anti-Parkinson 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®		
Gocovri®	NP	• Patient has a diagnosis of dyskinesia associated with Parkinson's disease; **OR** • 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); **AND** • Patient will NOT receive live vaccines during treatment (inactivated vaccines may be utilized)	68.5 mg: 1/day; 137 mg: 2/day	

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

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**
Kynmobi®	NP	See Apokyn® prior authorization criteria	5/day	
Mirapex®	NP		3/day	
Mirapex® ER	NP		1/day	
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		

Osmolex® ER tabs and tablet pack	NP	**Initial Criteria:**
		• One of the following:
		  ○ Diagnosis of Parkinson's disease; **AND**
		  – Trial and failure, contraindication, or intolerance to 2 preferred agents for Parkinson's disease treatment
		  ○ Treatment of drug-induced extrapyramidal reactions; **AND**
		  – Trial and failure, contraindication, or intolerance to 2 preferred agents for restless leg syndrome; **OR**
		• Patient does not have end-stage renal disease (creatinine clearance below 15 mL/min/1.73 m2); **AND**
		• Patient will NOT receive live vaccines during treatment (inactivated vaccines may be utilized); **AND**
		• Patient has had an adequate trial of or is intolerant to amantadine IR (capsules)
		Renewal Criteria:
		• Patient meets initial criteria; **AND**
		• Documented treatment efficacy as defined by control of Parkinson's disease symptoms OR decreased extrapyramidal effects; **AND**
		• Patient has not experienced any treatment-restricting adverse effects (e.g., falling asleep while engaged in activities of daily living, compulsive behaviors, suicidal ideation, or exacerbation of psychosis)
			193 mg & 258 mg: 1/day;
			129 mg: 2/day;
			Pack: 1/30 days	

pramipexole ER	NP		1/day	
Anti-Parkinson Agents: MAOI-Bs				

Xadago®	NP	• Patient has Parkinson's disease; **AND**
		• Patient is receiving concomitant therapy with carbidopa/levodopa; **AND**
		• Patient is experiencing "off episodes" with monotherapy using carbidopa/levodopa; **AND**
		• Patient does not have severe hepatic impairment (Child-Pugh Score > 9); **AND**
		• Patient is not taking any of the following:
		  ○ dextromethorphan
		  ○ other MAO-I inhibitors or other drugs that are potent inhibitors of monoamine oxidase (e.g., linezolid)
		  ○ other serotonergic drugs (e.g., SNRIs, SSRIs, TCAs, St. John's wort, cyclobenzaprine)
		  ○ opioid drugs (e.g., meperidine, methadone, propoxyphene, tramadol)
		  ○ sympathomimetic medications (e.g., methylphenidate, amphetamine); **AND**
		• Trial and failure, contraindication, or intolerance to preferred MAO-B inhibitor
			1/day	

Zelapar®	NP	• Inability to swallow solid dosage forms; **OR** • Adverse reaction to selegiline due to secondary active metabolites, l-amphetamine and l-methamphetamine		

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

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:*
• *Prescriber has completed the State's training program on the appropriate use of psychotropic medications for individuals with I/DD:*
  ○ *Existing Gold Card prescribers should provide signature, module #, and date course was completed; **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 has been prescribed and the following is meet: (duration of short-term therapy is 90 days)*
  ○ *One of the following:*
  – *Behavioral symptoms 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 tablets	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

buspirone	P		30 mg: 2/day; All other strengths: 3/day	General PA Form

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

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	

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

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 ER	NP	See alprazolam tablets prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance to immediate release alprazolam; **AND** • Trial and failure, contraindication, or intolerance of TWO preferred agents	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	

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

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**
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
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

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

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**
Banzel® tablet	P	• Diagnosis of Lennox-Gastaut Syndrome; **AND** • Used as adjunct therapy with at least one other anticonvulsant; **AND** • Trial and failure, contraindication, or intolerance to clobazam		
clobazam tablets	P	• Diagnosis of Lennox-Gastaut Syndrome; **AND** • Used as adjunct therapy with at least one other anticonvulsant		

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

Diastat®	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	
diazepam rectal gel	P	See Diastat prior authorization criteria	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 TWO of the following within the past 12 months (documented by claims): clobazam, levetiracetam, valproate, lamotrigine, topiramate, rufinamide, felbamate, stiripentol, fenfluramine, lacosamide and perampanel; **AND**
		• Epidiolex will be used as adjunct therapy with ONE of the following (documented by claims): clobazam, levetiracetam, valproate, lamotrigine, topiramate, rufinamide, felbamate, stiripentol, fenfluramine, lacosamide, perampanel
		Renewal Criteria
		• Epidiolex will be used as adjunct therapy with ONE of the flowing (documented by claims): clobazam, levetiracetam, valproate, lamotrigine, topiramate, rufinamide, felbamate, stiripentol, fenfluramine, lacosamide, perampanel
				General PA Form

gabapentin capsules	P		100 mg: 6/day 300 mg: 12/day 400 mg: 9/day Max daily gabapentin dose: 3600 mg	

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

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**
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

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	

pregabalin capsules	P	• Diagnosis of neuropathic pain; **OR** • Diagnosis of postherpetic neuralgia; **OR** • Diagnosis of fibromyalgia; **OR** • Diagnosis of seizure disorder		
pregabalin solution	P	• Patient is less than 12 years of age; **OR** • Inability to swallow solid oral dosage forms		
phenobarbital	P	• Will be approved for use ONLY in patients with diagnosis of seizure disorders.		
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		

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

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**

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	

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 6 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 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)
			5 boxes/30 days	General PA Form

zonisamide	P		25 mg (4/day); 50 mg (2/day); 100 mg (6/day)	

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

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**
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® suspension	NP	• Used as adjunctive therapy for Lennox-Gastaut Syndrome when used in combination with at least one other anticonvulsant; **AND** • Trial and failure, contraindication, or intolerance to clobazam; **AND** • Patient must be unable to swallow tablets		
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 dosage 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	

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

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**
Diacomit®	NP	**Initial Criteria:** • Patient must be ≥ 2 years of age; **AND** • Patient must also be taking clobazam concomitantly; **AND** • Patient has been diagnosed with Dravet syndrome (DS) by a pediatric neurologist or pediatric epileptologist; if there are no specialists in the area, prescriber may verbally attest to no specialists in the area; **AND** • Prescriber to provide verbal attestation that baseline serum hematologic testing has been completed; **AND** • Prescriber to provide verbal attestation that patient has refractory epilepsy (patient has failed to become seizure free with adequate trials of two antiepileptic drugs [AED]); **AND** • Prescriber to provide verbal attestation Diacomit will be used in adjunct to ≥ 1 antiepileptic drug, including clobazam; **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** • Prescriber to provide verbal attestation every six months that hematologic testing has been completed; **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, etc.).	250 mg (1/day); 500 mg (6/day)	General PA Form

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

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**
Anticonvulsants *(continued)*				
Elepsia® XR	NP	• Patient has a diagnosis or history of partial-onset seizures; **AND** • Will be used as adjunctive therapy for partial onset seizures when used in combination with at least ONE other anticonvulsant; **AND** • Patient must be 12 years of age or older; **AND** • Prescriber must provide a clinically valid reason as to why the preferred agent (levetiracetam ER) cannot be used (NOTE: Patient convenience is NOT an approvable reason); **AND** • Patient has tried and remains uncontrolled on single-drug therapy of at least one antiepileptic; **AND** • Provider has received a baseline lab assessment of renal function; **AND** • Patient does not have a history of hypersensitivity to levetiracetam; **AND** • Female patients should be advised to use effective contraception	1000 mg: 3/day; 1500 mg: 2/day	General PA Form

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	

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.		

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**
Fintepla®	NP	**Initial Criteria:** • Patient must be ≥ 2 years of age; **AND** • Patient has been diagnosed with Dravet syndrome (DS) or Lennox-Gastaut syndrome (LGS) by a pediatric neurologist or pediatric epileptologist; if there are no specialists in the area, prescriber may verbally attest to no specialists in the area; **AND** • Prescriber attests patient has not received MAOI therapy within 14 days and will not receive during Fintepla therapy; **AND** • Prescriber to provide verbal attestation that baseline echocardiogram has been completed; AND monitored every 6-months during treatment, and 3 to 6-months after final dose of Fintepla; **AND** • Patient must have an eGFR > *15 ml/min/1.73 m²*; **AND** • Patient has had a trial and failure, contraindication, or intolerance of 2 preferred anticonvulsant agents **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Prescriber to provide verbal attestation every six months that lab monitoring (echocardiogram, CMP, etc.) has been completed; **AND** • Patient has no treatment-limiting adverse effects (e.g., serotonin syndrome, abnormal AST/ALT, CrCl, abnormal echocardiogram); **AND** • Prescriber to provide verbal attestation of Fintepla effectiveness (e.g., reduced seizure frequency, etc.)	1 bottle/30 days	General PA Form
Fycompa®	NP	• Diagnosis of partial onset seizures with or without secondarily generalized seizures in patients with epilepsy ≥ 4 years of age; **AND** ○ Trial and failure, contraindication, or intolerance to TWO preferred agents, one of which must be lacosamide **OR** • Diagnosis of primary generalized tonic-clonic (PGTC) seizures in patients with epilepsy ≥ 12 years of age; **AND** ○ Used as adjunctive therapy in combination with at least ONE other anticonvulsant; **AND** ○ Trial and failure, contraindication, or intolerance to TWO preferred agents	2, 4, 8, 10, & 12 mg: 1/day; 6 mg: 2/day	
gabapentin solution	NP	• Inability to swallow solid oral dosage forms, **AND** • Patient and caregiver are unable to open capsule and empty contents in food or drink **Note:** Prior authorization criteria is waived for recipients 12 years of age and under	72 mL/day Max total daily gabapentin dose: 3600 mg	
gabapentin tablets	NP	• Documented allergy or contraindication to an inactive ingredient in the capsules that is NOT present in the tablets	100 & 600 mg: 6/day; 800 mg: 4.5/day; All other strengths: 3/day Max total 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; **OR** • Unable to absorb medications through the GI tract		General PA Form
Lamictal® XR	NP	• Patient must have a trial/failure of a regular-release lamotrigine product and 1 other preferred agent		

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

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**
lamotrigine ER	NP	• Patient must have a trial/failure of a regular-release lamotrigine product and 1 other preferred agent		
lamotrigine ODT	NP	• Unable to swallow; **OR** • Unable to absorb medications through the GI tract		General PA Form
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
Qudexy® XR	NP	See topiramate ER prior authorization criteria	200 mg: 2/day All other strengths: 1/day	General PA Form
rufinamide tablet	NP	See Banzel tablet prior authorization criteria		
rufinamide suspension	NP	See Banzel suspension prior authorization criteria		
Sabril®	NP	• Treatment is for one of the following: ○ Adjunctive therapy for patients with refractory complex partial seizures who have responded inadequately to several alternative treatments; **AND** – Patient has tried and failed at least TWO preferred anticonvulsants ○ Monotherapy for patients with infantile spasms; **AND** • Provider attests to vision assessment at baseline, every 3 months while on therapy, and approximately 3-6-months after discontinuation of therapy **Note:** This drug is subject to REMS requirements to ensure the benefits of treatment outweigh the risks of vision loss		
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	
Sympazan®	NP	• Patient has a diagnosis of Lennox-Gastaut syndrome (LGS); **AND**	2/day	

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

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**
		• 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)		
topiramate ER	NP	• Adjunctive therapy for patients with partial-onset seizures, 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; **OR** • Initial monotherapy in patients with partial-onset or primary generalized tonic-clonic seizures; **OR** • Migraine Prophylaxis in patients ≥ 12 years of age; **AND** ○ Patient must have a trial/failure of an Trokendi XR and 1 other preferred agent	200 mg: 2/day All other strengths: 1/day	
vigabatrin	NP	See Sabril® prior authorization criteria		
Vigadrone®	NP	See Sabril® prior authorization criteria		
Vimpat®	NP	See lacosamide prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance to lacosamide		
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 TWO 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 capsule formulation	30 mL/day	

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

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, etc) **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	2/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, etc). **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	Will only be approved for the treatment of chorea associated with Huntington's disease.		

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

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:*
• *Prescriber has completed the State's training program on the appropriate use of psychotropic medications for individuals with I/DD:*
  ○ *Existing Gold Card prescribers should provide signature, module #, and date course was completed; **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 has been prescribed and the following is meet: (Duration of short-term therapy is 90 days)*
  ○ *One of the following:*
  – *Behavioral symptoms 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	

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

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:*
• *Prescriber has completed the State's training program on the appropriate use of psychotropic medications for individuals with I/DD:*
  ○ *Existing Gold Card prescribers should provide signature, module #, and date course was completed; **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 has been prescribed and the following is meet: (Duration of short-term therapy is 90 days)*
  ○ *One of the following:*
  – *Behavioral symptoms 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		

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

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**
Remeron®	NP			General PA Form
Remeron SolTab®	NP	• Patient is unable to swallow solid dosage forms		
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)		
Wellbutrin® IR & SR	NP			
Wellbutrin XL®	NP		1/day	
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:*
• *Prescriber has completed the State's training program on the appropriate use of psychotropic medications for individuals with I/DD:*
  ○ *Existing Gold Card prescribers should provide signature, module #, and date course was completed; **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 has been prescribed and the following is meet: (Duration of short-term therapy is 90 days)*
  ○ *One of the following:*
  – *Behavioral symptoms 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*				

duloxetine 20, 30, & 60 mg	P		2/day	SNRI PA Form
Effexor XR®	P		1/day	
Pristiq®	P		1/day	
venlafaxine IR tabs	P		2/day	
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	
desvenlafaxine ER	NP		1/day	

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

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**
Fetzima®	NP		Titration Pack: 1/day (56 tabs/ lifetime)	SNRI PA Form
venlafaxine 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:*
• *Prescriber has completed the State's training program on the appropriate use of psychotropic medications for individuals with I/DD:*
  ○ *Existing Gold Card prescribers should provide signature, module #, and date course was completed; **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 has been prescribed and the following is meet: (Duration of short-term therapy is 90 days)*
  ○ *One of the following:*
  – *Behavioral symptoms 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	
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	
Viibryd	P		1/day	
Celexa®	NP		10, 20 mg: 1.5/day 40 mg: 1/day	

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

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**
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 • Adequate trial and failure of TWO agents at an appropriate dose (defined as: 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	
vilazodone	NP		1/day	
Zoloft®	NP		25, 50 mg: 1.5/day; 100 mg: 2/day	

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

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:*
• *Prescriber has completed the State's training program on the appropriate use of psychotropic medications for individuals with I/DD:*
  ○ *Existing Gold Card prescribers should provide signature, module #, and date course was completed; **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 has been prescribed and the following is meet:*
  ○ *One of the following:*
  – *Behavioral symptoms 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			

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

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				

amphetamine salt ER combination	P	• Agent must not be prescribed by a pain clinic
		• Patient **does not** meet any of the following:
		  ○ Concurrently taking a benzodiazepine, barbiturate, sedative hypnotic, opioid (including buprenorphine), MAOI (monoamine oxidase inhibitor) agent, or meprobamate/carisoprodol.
		  ○ No active alcohol or substance abuse for last 3 years, if patient ≥ 21 years of age
		  ○ Glaucoma
		  ○ Hyperthyroidism
		  ○ Symptomatic arteriosclerosis, cardiac disease and/or cardiac abnormalities
		• Patient has a 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 in at least 2 major settings (school, work, social settings, and/or home) or creates significant difficulties in at least 2 major settings (school, work, social settings, and/or home); **OR**
		• Patient has a diagnosis of Narcolepsy supported with documentation of polysomnography; **OR**
		• Diagnosis of Organic Brain Disorder; **OR**
		• 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 aged 20 years of age and younger 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
				Schedule II Stimulant 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	
amphetamine (5 & 10mg)	P	See amphetamine salt ER combination prior authorization criteria	See Evekeo®	
Aptensio XR®	P	See amphetamine salt ER combination prior authorization criteria	1/day	

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

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**
Concerta®	P	See amphetamine salt ER combination prior authorization criteria	18, 27, 54 mg: 1/day; 36 mg: 2/day	
Daytrana®	P	See amphetamine salt ER combination prior authorization criteria	1/day	
dexmethylphenidate	P	See amphetamine salt ER combination prior authorization criteria	1/day	Schedule II Stimulant PA Form
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	
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		
methylphenidate solution (generic for Methylin®)	P	See amphetamine salt ER combination prior authorization criteria		
methylphenidate ER tablets (10 and 20 mg)	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	

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

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 **does not** meet any of the following:
		  ○ Concurrently taking a benzodiazepine, barbiturate, sedative hypnotic, opioid (including buprenorphine), MAOI (monoamine oxidase inhibitor) agent, or meprobamate/carisoprodol.
		  ○ No active alcohol or substance abuse for last 3 years, if patient ≥ 21 years of age
		  ○ Glaucoma
		  ○ Hyperthyroidism
		  ○ Symptomatic arteriosclerosis, cardiac disease and/or cardiac abnormalities
		• Patient has a 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 in at least 2 major settings (school, work, social settings, and/or home) or creates significant difficulties in at least 2 major settings (school, work, social settings, and/or home); **OR**
		• Patient has a diagnosis of Narcolepsy supported with documentation of polysomnography; **OR**
		• Diagnosis of Organic Brain Disorder; **OR**
		• 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
		• Additionally, non-preferred agents require trial and failure, contraindication, or intolerance of 2 preferred agents unless otherwise indicated.
		Note: For preferred products, patients aged 20 years of age and younger will be subject to the initial criteria if they exceed 80 mg/day of total amphetamine. For non-preferred products, patients aged 20 years of age and younger will only be required to meet the trial/failure criteria if request is for less than 80mg/day of total amphetamine.
			See amphetamine salt IR combo	Schedule II Stimulant 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	
Adhansia XR®	NP	See Adderall® prior authorization criteria	1/day	
Adzenys ER® solution	NP	See Adderall® prior authorization criteria Patient must have clinical reason as to why the preferred generic methylphenidate solution cannot be used.	10mL/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	
Azstarys®	NP	See Adderall® prior authorization criteria	1/day	

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

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**
Cotempla XR® ODT	NP	See Adderall® prior authorization criteria	1/day	Schedule II Stimulant 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	
Dexedrine Spansule®	NP	See Adderall® prior authorization criteria	4/day Max total amphetamine dose (Age ≥ 21): 60 mg/day	
Dyanavel XR®	NP	See Adderall® prior authorization criteria	8 mL/day Max total amphetamine dose (Age ≥ 21): 60 mg/day	
Evekeo® tab & ODT	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		
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	
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	

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

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 ER 24hr capsules (generic for Aptensio® XR, Ritalin® LA)	NP	See Adderall® prior authorization criteria	1/day	Schedule II Stimulant PA Form
methylphenidate ER OSM tablets (generic for Concerta® & Relexxii®)	NP	See Adderall® prior authorization criteria	See Concerta®	
methylphenidate XR ODT (generic for Cotempla® XR ODT)	NP	See Adderall® prior authorization criteria	1/day	
Mydayis ER®	NP	See Adderall® prior authorization criteria	1/day	
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	
Antihyperkinesis: Non-Stimulants				
atomoxetine	P		60 mg, 80 mg, 100 mg: 1/day All other strengths: 2/day	General PA Form
guanfacine ER	P		1/day	

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

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**

Qelbree®	P	• Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD); **AND**
		• Patient is 6 years of age or older; **AND**
		• Prescriber attests to assessing patient's baseline blood pressure and heart rate prior to therapy, following increases in dosage, and periodically while on therapy; **AND**
		• Prescriber attests that patient will be screened for bipolar disorder and risk factors for developing a manic episode prior to initiating therapy; **AND**
		• Patient must not meet any of the following
		  ○ Concomitant use of monoamine oxidase inhibitors (MAOIs)
		  ○ Concomitant use of sensitive CYP1A2 substrates or CYP1A2 substrates with a narrow therapeutic range
		  ○ Hepatic Impairment
		  ○ Pregnancy; **AND**
		• Patient has had a 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

clonidine 12hr ER	NP	• Trial and failure, contraindication, or intolerance of 2 preferred non-stimulant antihyperkinesis agents; **AND** • Trial and failure of immediate release product **OR** allergy to inactive ingredient in immediate release product that is not in requested product	4/day	
Intuniv®	NP	See clonidine ER prior authorization criteria	1/day	
Strattera®	NP		60, 80, 100 mg: 1/day All others: 2/day	
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	

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

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**

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	

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	

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

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**

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

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

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

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**

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

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	

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

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**
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 injection and nasal spray	NP	• Trial and failure, or contraindication, to TWO preferred products in ANY of the following categories: ○ Triptans ○ RX NSAIDS ○ Migraine combination products • Trial and failure of ONE preferred agent	8 mL/30 days	
Ergomar®	NP	See dihydroergotamine injection prior authorization criteria	20 tabs/30 days	
Migergot®	NP		15/30 days	
Trudhesa®	NP	See dihydroergotamine injection prior authorization criteria	1 package/30 days	
Antimigraine: Barbiturate Combination Agents				
__Quantity Limit Override Criteria for Butalbital-Containing Products__: 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	
butalbital/ASA/ caffeine	NP	• Allergy or intolerance to APAP	20/30 days**	
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	
Zomig® nasal spray	P		6/30 days	
Frova®	NP		9/30 days	

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

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**
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	
Migranow Kit®	NP	• Patient has a contraindication, allergic reaction, or serious adverse event to ALL preferred Selective 5-HT1 Agonists; **AND** • Provider must provide documentation as to why the requested drug for the requested indication is the only appropriate choice versus the preferred agents	1 kit/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	
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 kit	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 nasal	NP		6/30 days	
sumatriptan/ naproxen	NP		9/30 days	
Tosymra®	NP		12/30 days	General PA Form
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	
Zomig® tablets	NP		6/30 days	

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

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:*
• *Prescriber has completed the State's training program on the appropriate use of psychotropic medications for individuals with I/DD:*
  ○ *Existing Gold Card prescribers should provide signature, module #, and date course was completed; **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 has been prescribed and the following is meet:*
  ○ *One of the following:*
  – *Behavioral symptoms 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	

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

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:*
• *Prescriber has completed the State's training program on the appropriate use of psychotropic medications for individuals with I/DD:*
  ○ *Existing Gold Card prescribers should provide signature, module #, and date course was completed; **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 has been prescribed and the following is meet:*
  ○ *One of the following:*
  – *Behavioral symptoms 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	
clozapine	P		1/day	
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	

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

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 Sustenna®	P	• Patient is ≥ 18 years of age; **AND** • Patient has documented tolerance to the oral active ingredient	1 syringe/28 days	Atypical Antipsychotic PA form
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	
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	

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

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**
quetiapine	P		4/day	Atypical Antipsychotic PA form
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	
Saphris®	P	See lurasidone prior authorization criteria	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 tabs	P		2/day	
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

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

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 MyCite®	NP	See lurasidone prior authorization criteria; **AND** • Clinically valid reason why none of the other forms of aripiprazole cannot be used	1/day	
asenapine	NP	See lurasidone prior authorization criteria; **AND** • Clinically valid reason why the preferred Saphris® cannot be used	2/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	
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 must attest that patient does not meet any of the following:
		  ○ Patient is using opioids or has used a short-acting opioid in the last 7 days or a long-acting opioid in the last 14 days
		  ○ Patient is undergoing acute opioid withdrawal
		• Clinically valid reason why preferred olanzapine formulations cannot be used
			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	
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	Atypical Antipsychotic PA form
Risperdal®	NP	See Abilify® tablets prior authorization criteria	2/day	

Risperdal Consta®	NP	• Patient is ≥ 18 years of age; **AND**
		• 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	

Rykindo®	NP	See Risperdal Consta® prior authorization criteria	2 injections/28 days	

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

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**
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	
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

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

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:*
• *Prescriber has completed the State's training program on the appropriate use of psychotropic medications for individuals with I/DD:*
  ○ *Existing Gold Card prescribers should provide signature, module #, and date course was completed; **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 has been prescribed and the following is meet: (duration of short-term therapy is 90 days)*
  ○ *One of the following:*
  – *Behavioral symptoms 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*	
Rozerem®	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	• Patient must 18 years of age or older • Diagnosis of insomnia characterized by difficulties with sleep onset and/or sleep maintenance • Medical documentation that rules out other insomnia related disorders (e.g., movement, breathing, psychiatric disorders and medication) • Documented trial (at least 3 weeks) of non-pharmacological therapies (e.g., stimulus control, sleep restriction, sleep hygiene measures and relaxation therapy) • Patient should not have any of the following diagnoses: Narcolepsy, COPD, or moderate to severe OSA • Will not be given to patients with severe hepatic impairment, and baseline liver enzymes documentation required • Trial and failure, contraindication, or intolerance of 2 preferred agents • Patient should avoid concomitantly taking strong or moderate CYP3A inhibitors and strong or moderate CYP3A inducers • 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*	

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

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**
doxepin (generic for Silenor)	NP	See Silenor prior authorization criteria	14/30 days*	
Edluar®	NP	Approved only for patients with difficulty swallowing/absorption	14/30 days*	
estazolam	NP	See flurazepam prior authorization criteria	14/30 days*	Anti-anxiety 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 **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
		Note: Caution is warranted if patient is concurrently taking CYP3A4 inhibitors [e.g., fluvoxamine, itraconazole, ketoconazole] as patient is at increased risk of toxicity.
			14/30 days*	

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 **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
		Note: Caution is warranted if patient is concurrently taking CYP3A4 inhibitors [e.g., fluvoxamine, itraconazole, ketoconazole] as patient is at increased risk of toxicity.
			14/30 days*	

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

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**

Hetlioz® capsule	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*	

Intermezzo®	NP		14/30 days*	
Lunesta®	NP		14/30 days*	
ramelteon	NP		14/30 days*	
quazepam	NP	See flurazepam prior authorization criteria	14/30 days*	
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** • 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** • Patient should not have any of the following diagnoses: Narcolepsy, COPD, or moderate to severe OSA; **AND** • Will not be given to patients with severe hepatic impairment, and baseline liver enzymes documentation required; **AND** • Trial and failure, contraindication, or intolerance of 2 preferred agents; **AND** • Patient should avoid concomitantly taking strong or moderate CYP3A inhibitors and strong or moderate CYP3A inducers; **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
Silenor®	NP	• Documented trial/failure (defined as ≥ 1 week) at an appropriate dose of the doxepin 10mg/mL concentrated solution	14/30 days*	
tasimelteon	NP	See Hetlioz prior authorization criteria; **AND** • Clinically valid reason why Hetlioz® cannot be used	5 mL per day 158 mL/60 days*	
temazepam (excludes 7.5 & 22.5 mg)	NP	See flurazepam prior authorization criteria	14/30 days*	Anti-anxiety Form

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

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**

temazepam (7.5 & 22.5 mg)	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 **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**
		• Trial and failure of temazepam 15 mg and/or 30 mg strength,
		Note: Caution is warranted if patient is concurrently taking CYP3A4 inhibitors [e.g., fluvoxamine, itraconazole, ketoconazole] as patient is at increased risk of toxicity
			14/30 days*	

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*	
Zolpimist®	NP		7.7 mL/60 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** • 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	4/day	

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

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**

carisoprodol/ ASA/codeine	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**
		• 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 does not have any of the following:
		  ○ Obesity
		  ○ Obstructive Sleep Apnea
		  ○ Severe lung disease (acute or severe asthma, COPD, cystic fibrosis, pneumonia, pulmonary hypertension, etc.)
		  ○ Recent adenectomy/tonsillectomy; **AND**
		• Prescriber is aware of risks, including slowed or difficult breathing and death with concurrent opioid use, and agrees to accept risks; **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	

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

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:*
• *Prescriber has completed the State's training program on the appropriate use of psychotropic medications for individuals with I/DD:*
  ○ *Existing Gold Card prescribers should provide signature, module #, and date course was completed; **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 has been prescribed and meets the following:*
  ○ *One of the following:*
  – *Behavioral symptoms 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*				

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			

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

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 Anesthetics				
lidocaine (excluding lotion and solution)	P		1 tube/Rx	General PA Form
lidocaine patch 5%	P	• Diagnosis of post-herpetic neuralgia	2/day	
lidocaine/prilocaine	P		30 g/Rx	
ZTLido®	P	• Diagnosis of Postherpetic neuralgia	2/day	
lidocaine/ hydrocortisone	NP	• Diagnosis of FDA-approved indication; **AND** • Clinically valid reason why the preferred topical anesthetics cannot be used	1 package/Rx	
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		
LidoPure®	NP	• Diagnosis of FDA-approved indication; **AND** • Clinically valid reason why the preferred topical anesthetics cannot be used	3/day	
Pliaglis®	NP		1 package/Rx	
Pramosone® 2.5-1% lotion	NP		1 package/Rx	
Prizotral®	NP	See LidoPure® prior authorization criteria	1 box/30 days	
Zilacaine®	NP	See LidoPure® prior authorization criteria	3/day	
Topical Antibiotic Agents for Skin and Soft Tissue Infections				
mupirocin ointment	P		44 g/Rx	General PA Form
Centany®	NP		44 g/Rx	
Xepi®	NP		1 tube/Rx	
Topical Antineoplastics				
Carac®	P		1 package/Rx	General PA Form
diclofenac 3% gel	P	• Diagnosis of actinic keratosis	1 package/Rx	
Imiquimod	P		1 package/Rx	
Targretin®	P		1 package/Rx	
Aldara®	NP	• Diagnosis of actinic keratosis; **OR** • Diagnosis of basal cell carcinoma	1 package/Rx	
bexarotene	NP		1 package/Rx	
Efudex®	NP		1 package/Rx	

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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	
Klisyri®	NP	• Diagnosis of actinic keratosis of the face or scalp; **AND** • Patient is 18 years of age or older; **AND** • One of the following: ○ Trial and failure, contraindication, or intolerance to 2 preferred topical antineoplastic agents for actinic keratosis ○ Clinically valid reason as to why the preferred topical antineoplastic agents for actinic keratosis cannot be used	5 single dose packets per month	
Panretin®	NP		1 package/Rx	
Valchlor®	NP	• Diagnosis of stage IA or IB mycosis fungoides; **AND** • Patient has received skin directed therapy	1 package/Rx	
Zyclara®	NP	See Aldara® prior authorization criteria	1 package/Rx	
Topical Antibiotics for Acne				
Azelex®	P		1 package/Rx	General PA Form
benzoyl peroxide 2.5%, 5%, 10% (excluding cleanser, gel, microspheres, and towelettes)	P		1 package/Rx	
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	General PA Form
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** • Prescriber provides peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the preferred agents; **AND** • Valid clinical rationale for 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**	1 package/28 days	

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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**

		• Trial and failure, contraindication, or intolerance to ALL the following:
		  ○ Two preferred topical antibiotic agents for Acne
		  ○ Preferred 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		

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	
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** • 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 package/Rx	
dermatological kits	NP	• Trial and failure of THREE preferred agents; **AND** • Trial and failure of the individual components of the kit	1 package/Rx	
clindamycin (excluding preferred products)	NP		1 package/Rx	
erythromycin/benzol peroxide	NP		1 package/Rx	
erythromycin swab & gel	NP		1 package/Rx	
sulfacetamide suspension	NP		1 package/Rx	
All branded single agent and combination products of benzoyl peroxide, clindamycin, erythromycin, and sodium sulfacetamide	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 **Note**: Will not be covered for adults	1 tube/30 days	

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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 Agents for Rosacea				
Finacea®	P		50 g/Rx	General PA Form
metronidazole cream, lotion, and gel	P		60 g/Rx	
Rosadan®	P		45 g/Rx	
brimonidine gel	NP		30 g/Rx	
Epsolay®	NP		30 g/30 days	
ivermectin cream	NP		45 g/Rx	
Finacea® Plus gel	NP	• Trial and failure of THREE preferred agents; **AND** • Trial and failure of the individual components of the kit		
MetroCream®	NP		60 g/Rx	General PA Form
MetroGel®	NP		60 g/Rx	
MetroLotion®	NP		60 g/Rx	
Noritate® cream	NP		60 g/Rx	
Rhofade®	NP	• Patient age < 21 years of age; **AND** • Patient has a diagnosis rosacea or erythema; **AND** • Trial and failure, or contraindication, of at least 2 of the following: brimonidine (Mirvaso), ivermectin (Soolantra) tetracycline, minocycline, doxycycline, erythromycin, clindamycin, benzoyl peroxide; **AND** • Trial and failure of 2 preferred topical agents for rosacea	30 g/30 days	
Rosadan® Kit	NP		1/Rx	
Soolantra®	NP		30 g/30 days	
Zilxi®	NP	• Diagnosis of inflammatory lesions of rosacea; **AND** • Patient must be 18 to 20 years of age; **AND** • Trial and failure, intolerance, contraindication to ALL Preferred topical 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 topical agents	30 g/28 days	
Topical Antifungals				
ciclopirox cream	P		1 package/Rx	General PA Form
ciclopirox solution 8%	P	• Diagnosis of mild to moderate onychomycosis of fingernails and toenails without lunula involvement, due to Trichophyton rubrum; **AND** • Prescriber attests that patient is immunocompetent; **AND** • Trial and failure, contraindication, or intolerance to terbinafine; **AND** • If request is for ciclopirox nail kit, prescriber provides a clinically valid reason for why the preferred topical ciclopirox 8% solution cannot be used		
clotrimazole 1% cream & soln (OTC)	P		1 package/Rx	
clotrimazole 1% cream (Rx)	P		1 package/Rx	
clotrimazole/ betamethasone	P		1 package/Rx	

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

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/ triamcinolone	P		1 package/Rx	
ketoconazole (shampoo and cream)	P		1 package/Rx	
nystatin powder	P		120 g/Rx	
Ciclodan®	NP		1 package/Rx	
ciclopirox gel and suspension	NP		1 package/Rx	
ciclopirox nail kit	NP	See ciclopirox solution 8% prior authorization criteria		
clotrimazole 1% solution (Rx)	NP		1 package/Rx	
econazole	NP		1 package/Rx	
Ertaczo®	NP		1 package/Rx	
Exelderm®	NP		1 package/Rx	
Extina®	NP		1 package/Rx	
Jublia®	NP	• Diagnosis of mild to moderate onychomycosis of fingernails and toenails without lunula involvement, due to Trichophyton rubrum; **AND** • Trial and failure, contraindication, or intolerance to terbinafine; **AND** • Trial and failure, contraindication, or intolerance to the preferred topical ciclopirox 8% solution; **AND** • If request is for Kerydin®, patient has a documented allergy to an inactive ingredient in generic tavaborole solution	1 package/Rx	
Kerydin®	NP	See Jublia® prior authorization criteria		
Ketodan Kit	NP	• Trial and failure of TWO preferred agents; **AND** • Trial and failure of the individual components of the kit	1 package/Rx	
luliconazole	NP		1 package/Rx	
Loprox®	NP		1 package/Rx	
Luzu®	NP		1 package/Rx	
miconazole/zinc/ petrolatum	NP	See Vusion® prior authorization criteria	1 package/Rx	General PA Form
Naftin®	NP		1 package/Rx	
naftifine gel	NP		1 package/Rx	
oxiconazole	NP		1 package/Rx	
Oxistat®	NP		1 package/Rx	
Vusion®	NP	• Diagnosis of complicated diaper dermatitis; **AND** • Recipient must be four weeks of age or older; **AND** • Trial and failure of either a topical antifungal agent or a topical antifungal combination agent	1 package/Rx	

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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 Antipsoriatics				
calcipotriene cream	P	• Trial and failure, contraindication, or intolerance to at least one topical steroid	1 package/Rx	General PA Form
calcipotriene scalp soln	P	See calcipotriene cream prior authorization criteria		
Sorilux®	P	See calcipotriene cream prior authorization criteria	1 package/Rx	
Taclonex®	P	See calcipotriene cream prior authorization criteria		
tazarotene 1% cream	P	• One of the following: ○ Diagnosis of psoriasis; **AND** – Trial and failure, contraindication, or intolerance to at least one topical steroid; **OR** ○ Diagnosis of acne in patients less than 21 years of age		
Tazorac® gel	P	See tazarotene 0.1% cream prior authorization criteria	1 package/Rx	
Vectical®	P	See calcipotriene cream prior authorization criteria		
calcipotriene ointment and foam	NP	See calcipotriene cream prior authorization criteria	1 package/Rx	
calcitriol ointment	NP	See calcipotriene cream prior authorization criteria	1 package/Rx	
calcipotriene/ betamethasone	NP	See calcipotriene cream prior authorization criteria	1 package/Rx	
Dovonex®	NP	See calcipotriene cream prior authorization criteria		
Duobrii®	NP	**Initial Criteria:** • Patient has a diagnosis of plaque psoriasis; **AND** • Trial and failure, contraindication, or intolerance to at least one topical steroid; **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 individual components taken concomitantly. **Renewal Criteria:** • Patient continues to meet the initial criteria; **AND** • Provider continues to monitor for adverse effects throughout the duration of treatment; **AND** • Documented clinical improvement in response to treatment	200 mg/30 days	
Enstilar®	NP	See calcipotriene cream prior authorization criteria	1 package/Rx	General PA Form
Tazorac® 0.1% cream	NP	See tazarotene 1% cream prior authorization criteria		
Vtama®	NP	**Initial Criteria:** • Diagnosis of plaque psoriasis; **AND** • Prescribed by, or in consultation with, a dermatologist; **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 **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	

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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®	NP	**Initial Criteria:** • Diagnosis of plaque psoriasis; **AND** • Patient is 6 years of age or older; **AND** • Trial and failure, contraindication, or intolerance to 2 preferred topical antipsoriatic agents; **AND** • Patient does not have moderate to severe liver impairment (Child-Pugh B or C) **Renewal Criteria:** • Patient continues to be monitored for liver impairment; **AND** • Documented clinical improvement in response to treatment; **AND** • Patient does not have any treatment limiting adverse effects		
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 **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)		

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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**
Atopic Dermatitis, Topical				
Elidel®	P		1 package/Rx	
tacrolimus ointment	P		1 package/Rx	
Eucrisa®	NP	• Patient is ≥ 2 years; **AND** ○ Diagnosis of atopic dermatitis; **AND** ○ One of the following: – Trial and failure of 2 topical corticosteroids AND 1 topical calcineurin Inhibitor (e.g., Elidel or tacrolimus ointment) – Trial and failure of either a topical corticosteroid OR a topical calcineurin inhibitor AND conditions preclude use of both classes: • Conditions that preclude the use of steroids: ○ Treatment of sensitive areas (face, anogenital, skin folds) ○ Steroid Induced Atrophy ○ Long-term uninterrupted use • Conditions that preclude the use of topical calcineurin inhibitors: ○ Severely impaired skin barrier (Netherton Syndrome) ○ Risk/presence of new primary malignancy (e.g., skin cancer, lymphoma, or other lymphoproliferative disorders); **OR** • Patient is <2 years and greater than 3 months of age; **AND** ○ Diagnosis of atopic dermatitis; **AND** ○ Trial and failure of 2 topical corticosteroids unless patient has one of the following conditions that would preclude the use of steroids: – Treatment of sensitive areas (face, anogenital, skin folds) – Steroid Induced Atrophy – Long-term uninterrupted use	1 tube/month	General PA Form

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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**

Opzelura®	NP	**Initial Criteria (2 month duration):**
		• One of the following:
		  ○ Diagnosis of mild to moderate atopic dermatitis that is not adequately controlled with topical prescription therapies or when those therapies are not advisable; **AND**
		  – Patient has an Investigator's Global Assessment (IGA) score of 2 (mild) to 3 (moderate); **OR**
		  ○ Diagnosis of Nonsegmental Vitiligo; **AND**
		• Patient is 12 years of age or older; **AND**
		• Patient is not immunocompromised; **AND**
		• Patient is not breastfeeding; **AND**
		• Trial and failure of a preferred topical steroid UNLESS patient one of the following conditions that precludes use:
		  ○ Treatment of sensitive areas (face, anogenital, skin folds)
		  ○ Steroid Induced Atrophy
		  ○ Long-term uninterrupted use; **AND**
		• Trial and failure of a preferred topical calcineurin inhibitor (e.g., Elidel or tacrolimus ointment) UNLESS patient has one of the following conditions that precludes use:
		  ○ Severely impaired skin barrier (Netherton Syndrome)
		  ○ Risk/Presence of new primary malignancy (e.g., skin cancer, lymphoma, or other lymphoproliferative disorders); **AND**
		• Patient is not using concomitantly with any of the following:
		  ○ Therapeutic biologics (e.g., Dupixent, Humira, etc.)
		  ○ Other Janus kinase (JAK) inhibitors (e.g., Xeljanz, Rinvoq, etc.)
		  ○ Potent immunosuppressants (e.g., azathioprine, cyclosporine, etc.); **AND**
		• Provider shall:
		  ○ Monitor CBC as clinically indicated to address thrombocytopenia, anemia, and neutropenia
		  ○ Counsel and monitor for serious infections while patient is taking this drug
		Renewal Criteria (6-month duration):
		• 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** • Patient must have history of a therapeutic failure on a corticosteroid, but requirement is waived if treatment is for face or groin; **AND** • Trial and failure of 1 preferred agent (e.g., Elidel® or tacrolimus ointment)	1 package/Rx	
Protopic®	NP	See pimecrolimus prior authorization criteria; **AND** • For Protopic® 0.1% the patient must be ≥ 16 years of age	1 package/Rx	
Antiseborrheic Agents				
selenium sulfide 2.5% lotion	P		1 package/Rx	General PA Form
Topical Antivirals				
acyclovir 5% oint	P		1 tube/Rx	General PA Form
penciclovir cream	P		1 tube/Rx	
acyclovir cream	NP		1 tube/Rx	

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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**
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	
Topical Antipruritics/Antihistamines				
doxepin cream	NP	• Recipient must have moderate pruritus due to various forms of eczematous dermatitis, including atopic dermatitis and lichen simplex chronicus; **AND** • Recipient must have an intolerance, contraindication to, or inadequate response to **BOTH** of the following: ○ A topical corticosteroid ○ An oral antihistamine (first or second generation) or a topical antihistaminic agent **Note:** Doxepin 5% cream may be used in combination with a topical or oral corticosteroid in order to relieve pruritus in order to reduce corticosteroid course of therapy. Doxepin 5% cream should not be used for longer than eight days. Longer usage has been shown to result in higher systemic levels and increase the likelihood of contact sensitization.	45 g/90 days	General PA Form
Prudoxin®	NP	See doxepin cream prior authorization criteria	45 g/90 days	
Zonalon®	NP	See doxepin cream prior authorization criteria	45 g/90 days	
Topical Agents for Burns				
silver sulfadiazine	P		1 package/Rx	
SSD®	P		1 package/Rx	
mafenide	NP		1 package/Rx	General PA Form
Silvadene®	NP		1 package/Rx	
Sulfamylon®	NP		1 package/Rx	
Topical Steroids: Least Potent				
hydrocortisone 0.5% cream and ointment (Rx & OTC)	P		1 package/Rx	
hydrocortisone 1% cream, lotion, gel, and ointment (Rx & OTC)	P		1 package/Rx	General PA Form
hydrocortisone 2.5% cream, lotion, and ointment	P		1 package/Rx	

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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				
betamethasone 0.1% lotion	P		1 package/Rx	General PA Form
desonide 0.05% cream	P		1 package/Rx	
fluocinolone 0.01% cream, oil, solution	P		1 package/Rx	
Locoid Lipocream®	P		1 package/Rx	
desonide 0.05% ointment	NP		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	General PA Form
betamethasone valerate 0.1% cream	P		1 package/Rx	
clocortolone 0.1% cream and pump	NP		1 package/Rx	
desonide 0.05% lotion	NP		1 package/Rx	
hydrocortisone 0.1% cream, lotion, ointment, solution	NP		1 package/Rx	
hydrocortisone valerate 0.2% cream	NP		1 package/Rx	
Pandel® 0.1% cream	NP		1 package/Rx	
prednicarbate 0.1% cream and ointment	NP		1 package/Rx	
Topical Steroids: Mid-Strength				
triamcinolone acetonide 0.1% cream	P		1 package/Rx	General PA Form
Elocon® 0.1% cream and lotion	NP		1 package/Rx	
flurandrenolide 0.5% ointment	NP		1 package/Rx	

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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**
hydrocortisone valerate 0.2% ointment	NP		1 package/Rx	
Topical Steroids: Upper Mid-Strength				
betamethasone valerate 0.1% ointment	P		1 package/Rx	General PA Form
fluticasone propionate 0.005% ointment	P		1 package/Rx	
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 dipropionate 0.05% ointment	NP		1 package/Rx	
desoximetasone 0.05% gel and ointment	NP		1 package/Rx	
desoximetasone 0.25% cream, ointment, spray	NP		1 package/Rx	
Topical Steroids: Upper Mid-Strength *(continued)*				
diflorasone diacetate 0.05% cream and ointment	NP		1 package/Rx	General PA Form

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

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**
Elocon® 0.1% ointment	NP		1 package/Rx	
fluocinonide 0.05% cream, gel, and ointment	NP		1 package/Rx	
Topical Steroids: Potent				
betamethasone dipropionate, augmented 0.05% cream	P		1 package/Rx	General PA Form
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 ointment	NP		1 package/Rx	
desoximetasone 0.25% cream, ointment, spray	NP		1 package/Rx	
diflorasone diacetate 0.05% cream and ointment	NP		1 package/Rx	
Elocon® 0.1% 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	

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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: 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	
Bryhali® lotion	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 individual components	200 g/28 days	
betamethasone dipropionate, augmented 0.05% gel, and ointment	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	
Clodan® Kit	NP	See Bryhali® prior authorization criteria	1 package/Rx	
fluocinonide 0.1% cream	NP		1 package/Rx	
halobetasol propionate 0.05% cream, foam, and ointment	NP		1 package/Rx	
Lexette®	NP	See Bryhali® prior authorization criteria	100 g/Rx	
Temovate® 0.05% ointment	NP		90 g/Rx	
Ultravate® 0.05% lotion	NP		1 package/Rx	

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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	P		1 package/Rx	General PA Form
Genital Warts				
imiquimod	P		1 package/Rx	General PA Form
Condylox®	P		1 package/Rx	
Aldara®	NP		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; **AND** • Patient has tried/failed permethrin (unless patient has a contraindication)	1 bottle/Rx	
Eurax®	NP	See Crotan® prior authorization criteria	2/Rx	
ivermectin lotion	NP		1 tube/Rx	
lindane	NP	• Not approved for infants or individuals with seizure disorders • Patients must have tried and failed or be unable to tolerate all other approved therapies as listed below: ○ For use in lice infestation: permethrin, malathion, ivermectin, spinosad, and benzyl alcohol ○ For use in scabies: permethrin	1 bottle/Rx	
malathion	NP		2 bottles/Rx	
Ovide®	NP		2 bottles/Rx	
Sklice®	NP		1 tube/Rx	
spinosad	NP		2 bottles/Rx	
Topical Anticholinergic				

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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**
Qbrexza®	NP	**Initial Criteria:** • Patient is ≥ 9 years of age; but less than 21 years of age; **AND** • Documented diagnosis of primary axillary hyperhidrosis; **AND** • Hyperhidrosis Disease Severity Scale (HDSS) grade of 3 or 4; **AND** • Clinical documentation that diagnosis negatively impacts activities of daily living; **AND** • Patient does not have a medical condition exacerbated by anticholinergic effects (e.g., glaucoma, paralytic ileus, cardiovascular status in acute hemorrhage, severe ulcerative colitis, myasthenia gravis, Sjögren's syndrome); **AND** • Patient will not concomitantly take additional anticholinergic medications; **AND** • Provider has ruled out all other causes of secondary hyperhidrosis. **Renewal Criteria:** • Patient is ≥ 9 years of age; but less than 21 years of age; **AND** • Provider reports at least 1-point reduction in sweating severity using the Hyperhidrosis Disease • Severity Scale (HDSS); **AND** • Patient has no documented dysregulation of temperature control; **AND** • Patient will not concomitantly take additional anticholinergic medications; **AND** • Patient does not have any new medical condition exacerbated by anticholinergic effects (e.g., glaucoma, paralytic ileus, cardiovascular status in acute hemorrhage, severe ulcerative colitis, myasthenia gravis, Sjögren's syndrome)	1/day	General PA Form
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** • Patient is 20 years of age or younger and has a diagnosis of severe recalcitrant nodular acne **Note:** Will not be covered for the diagnosis of 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		
Myorisan®	NP	See Absorica® prior authorization criteria		
isotretinoin	NP	See Absorica® prior authorization criteria		
Zenatane®	NP	See Absorica® prior authorization criteria		
Retinoids, Topical				
adapalene	P	See tretinoin prior authorization criteria	1 package/Rx	General PA Form
Avita®	P	See tretinoin prior authorization criteria	1 package/Rx	
tazarotene 0.1% cream	P	See Tazorac® prior authorization criteria (Topical Antipsoriatics section)	1 package/Rx	
Tazorac® 0.5% gel and cream	P	See Tazorac® prior authorization criteria (Topical Antipsoriatics section)	1 package/Rx	

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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**
tretinoin cream	P	• One of the following: ○ Patient is < 21 years old; **AND** – Diagnosis of acne, keratosis follicularis, verruca plana, or actinic keratosis ○ 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	
Aklief®	NP	• Patients less than 21 years of age: ○ Diagnosis of acne vulgaris in children 9 years and older; **AND** ○ Trial and failure, contraindication, or intolerance of 2 preferred agents • 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 **Note**: Will not be covered for patients 21 years of age and older	1 package/Rx	
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** • 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/28 days	
clindamycin/tretinoin	NP	See tretinoin prior authorization criteria	1 package/Rx	
Epiduo Forte®	NP	See adapalene/benzoyl peroxide prior authorization criteria	1 package/Rx	
Fabior®	NP	See Tazorac® prior authorization criteria (Topical Antipsoriatics section)	1 package/Rx	
Retin A Micro®	NP	See tretinoin prior authorization criteria	1 package/Rx	
Retin A®	NP	See tretinoin prior authorization criteria	1 package/Rx	
Tazorac® 0.1% cream	NP	See Tazorac® prior authorization criteria (Topical Antipsoriatics section)		
tretinoin gel	NP	See tretinoin prior authorization criteria	1 package/Rx	
Ziana®	NP	See tretinoin prior authorization criteria		

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)				

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

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**
Abbott Products				
FreeStyle Meters: Lite, Freedom Lite, InsuLinx, and Precision Xtra	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, & Precision Xtra	P			
All other Abbott diabetic supplies	P			
AgaMatrix Products				
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			

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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**
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			
All Manufacturers				
Ketone Testing Strips			50 /30 days	General PA Form
Continuous Glucose Monitors and Supplies				
Dexcom				
G6 Sensor; G6 Transmitter; G7 Sensor/ Transmitter; Receivers: Dexcom G7, Dexcom G6	P	**Initial Criteria:** • Patient has Diagnosis of Type 1 Diabetes Mellitus OR Diagnosis of Type 2 Diabetes Mellitus; **AND** • Patient meets at least one of the following: ○ Documented HbA1C ≥7% measured within 6-months of PA request (e.g., submission of chart notes or lab data) ○ Documented frequent hypoglycemia or nocturnal hypoglycemia episodes with blood glucose < 50 mg/dL ○ Documented history of hypoglycemic unawareness ○ Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL ○ History of emergency room visit or hospitalization related to ketoacidosis or hypoglycemia; **OR** ○ Diagnosis of Gestational Diabetes Mellitus with suboptimal glycemic control that is likely to cause risk or harm to the mother/fetus; **AND** • Prescribed by or in consultation with an endocrinologist or healthcare practitioner with experience in diabetes management; **AND** • Patient requires frequent use of insulin (≥ 3 times per day) or is currently on an insulin pump **Renewal Criteria:** • Patient has been seen and evaluated by an endocrinologist or healthcare practitioner with experience in diabetes management at least once on an annual basis; **AND** • Documented evidence of improvement or compliance with current CGM treatment plan based on submitted medical documentation or log data of device (e.g. decreased A1C, decreased hypoglycemia episodes, decreased percentage of time below therapeutic range (TBR), increased percentage of time in therapeutic range (TTR))	G6 Sensor: 3/30 days; G6 Transmitter: 1/90 days; G7 Sensor/ Transmitter 3/ 30 days; Receivers: 1/365 days	Diabetic Supply PA Form

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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**
Senseonics and Ascensia Diabetes Care				
Eversense Mis Sensor	NP	• See Dexcom prior authorization criteria; **AND** • Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom	1/90 days	Diabetic Supply PA Form
Eversense E3 Sensor	NP	• See Dexcom prior authorization criteria; **AND** • Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom	2/365 days	
Transmitters: Eversense, 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	1/365 days	
Abbot				
Readers: Freestyle, Freestyle Libre 2	NP	• See Dexcom prior authorization criteria; **AND** • Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom	1/365 days	Diabetic Supply PA Form
Freestyle Kit Sensor	NP	• See Dexcom prior authorization criteria; **AND** • Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom	2/18 days	
Medtronic				
Guardian Repl Ped, Guardian Charger, Guardian Tst Plug	NP	• See Dexcom prior authorization criteria; **AND** • Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom	1/365 days	Diabetic Supply PA Form
Guardian Connect Continuous Glucose Monitor	NP	• See Dexcom prior authorization criteria; **AND** • Prescriber must submit clinical documentation (e.g., medical records) why the patient cannot use CGM Dexcom	1/365 days	

Guardian Link 3 Transmitter kit; Guardian 4 transmitter; Guardian 4 sensor; Guardian 3 Sensor	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
			Transmitters: 1/365 days
			
			Sensors: 5/30 days	

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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® and Omnipod Dash®	P	**Criteria (6-month duration):**
		• If the request is for Omnipod 5:
		  ○ Diagnosis of Type 1 Diabetes Mellitus; **AND**
		• If the request is for Omnipod DASH:
		  ○ Diagnosis of Type 1 Diabetes Mellitus; **OR**
		  ○ Diagnosis of Type 2 Diabetes Mellitus; **AND**
		  – Has HgA1c of greater than 7% with 2 consecutive HbA1c within 9 months, *OR* not meeting individual goal for A1c or time in range (if on a CGMS) with 2 consecutive HbA1c within 9 months; **AND**
		  – Is currently on multi-regimen diabetes treatment including at least a GLP-1 or SGLT-2 agent; **AND**
		• Prescribed by or in consultation with an endocrinologist or diabetologist; **AND**
		• Prescriber must provide a clinically valid reason as to why the Omnipod insulin management system is the only insulin pump that can be utilized by the patient; **AND**
		• Patient or caregiver has completed a physician-directed comprehensive diabetes management program which included a visit with a dietician; **AND**
		• Patient has met one of the following insulin administration methods within the last 6-months:
		  ○ If patient has used insulin pump within the last 6-months, clinically valid reason why current insulin pump is no longer appropriate; **OR**
		  ○ Administration of at least three daily insulin injections with frequent self- adjustments of insulin dose and exhibits one or more of the following criteria while on a regimen of multiple daily injections of insulin:
		  – Glycosylated hemoglobin level (HbA1c) >7%
		  – History of reoccurring hypoglycemia
		  – Wide fluctuations in blood glucose before mealtime
		  – Dawn phenomenon with fasting blood glucose frequently exceeding 200 mg/dL
		  – History of severe glycemic excursions; **AND**
		• Documented monitored blood glucose self-testing ≥ 4 times a day or regular use of calibrated CGMS during 2 months prior to initiation of insulin pump; **AND**
		• Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting the member's insulin administration methods and blood glucose monitoring methods.
		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

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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**

Omnipod Go®	P	**Criteria (6-month duration):**
		• Patient is ≥ 18 years of age; **AND**
		• Patient has Diagnosis of Type 2 diabetes and meets ALL of the following:
		  ○ Has HbA1C ≥ 7%
		  ○ Patient is currently on multi-regimen diabetes treatment including at least a GLP-1 or SGLT-2 agent; **AND**
		• Is not using more than 40 units of basal insulin per day; **AND**
		• Prescriber by or in consultation with an endocrinologist or diabetologist; **AND**
		• Prescriber must provide a clinically valid reason as to why the Omnipod GO insulin management system is needed for the patient versus standard insulin injections; **AND**
		• Patient or caregiver has completed a physician-directed comprehensive diabetes management program
		Renewal Criteria:
		• Patient is ≥ 18 years of age; **AND**
		• Patient has Diagnosis of Type 2 diabetes; **AND**
		• Is not using more than 40 units of basal insulin per day; **AND**
		• Documentation of a positive clinical response (e.g. decrease HbA1C from baseline)
			Pods: 10/30 days;
			Device: 1/year
				General PA Form

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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**

Cequr Simplicity®	P	**Criteria (6-month duration):**
		• One of the following:
		  ○ Diagnosis of Type 1 Diabetes Mellitus
		  ○ Diagnosis of Type 2 Diabetes Mellitus; **AND**
		  – Has HgA1c of greater than 7% with 2 consecutive HbA1c within 9 months, *OR* not meeting individual goal for A1c or time in range (if on a CGMS) with 2 consecutive HbA1c within 9 months; **AND**
		  – Is currently on multi-regimen diabetes treatment including at least a GLP-1 or SGLT-2 agent; **AND**
		• Patient is ≥ 21 years old; **AND**
		• Prescribed by or in consultation with an endocrinologist or diabetologist; **AND**
		• Prescriber must provide a clinically valid reason as to why the Simplicity® insulin management system is the only insulin pump that can be utilized by the patient; **AND**
		• Patient or caregiver has completed a physician-directed comprehensive diabetes management program which included a visit with a dietician; **AND**
		• Patient has met one of the following insulin administration methods within the last 6-months:
		  ○ If patient has used insulin pump within the last 6-months, clinically valid reason why current insulin pump is no longer appropriate; **OR**
		  ○ Administration of at least three daily insulin injections with frequent self- adjustments of insulin dose and exhibits one or more of the following criteria while on a regimen of multiple daily injections of insulin:
		  – Glycosylated hemoglobin level (HbA1c) >7%
		  – History of reoccurring hypoglycemia
		  – Wide fluctuations in blood glucose before mealtime
		  – Dawn phenomenon with fasting blood glucose frequently exceeding 200 mg/dL
		  – History of severe glycemic excursions; **AND**
		• Documented monitored blood glucose self-testing ≥ 4 times a day or regular use of calibrated CGMS during 2 months prior to initiation of insulin pump; **AND**
		• Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting the member's insulin administration methods and blood glucose monitoring methods.
		Renewal Criteria:
		Documentation of a positive clinical response (e.g. decrease HbA1C from baseline, decrease hypoglycemia episodes, decrease fasting and mealtime blood glucose levels)
			10 patches/30 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 products	P	Refer to OTC List for covered NDCs		General PA Form

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

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**
Adrenocorticotropic Hormone				
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 Gout				

colchicine tablet	P	• Diagnosis of Familial Mediterranean Fever; **OR**
		• Diagnosis of acute pericarditis, **AND** must be taken concurrently with NSAID (unless contraindicated); **OR**
		• For initiation of colchicine for acute gout attack; **OR**
		• For continuation of colchicine prophylaxis for gout:
		  ○ Current history of urate lowering therapy with compliance in the past three months; **AND**
		  ○ One of the following:
		  – Patient is currently experiencing gout symptoms; **OR**
		  – Urate level ≥ 6 mg/dL in the past three months
				General PA Form

allopurinol 200 mg tabs	NP			
colchicine capsules	NP	See colchicine tablet prior authorization criteria; **AND** • Trial and failure of the preferred colchicine product		
Colcrys®	NP	See colchicine tablet prior authorization criteria; **AND** • Trial and failure of the preferred colchicine product		

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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**

Gloperba®	NP	**Initial Criteria (3 months):**
		• Diagnosis or history of gout flares; **AND**
		• Patient is 18 years of age or older; **AND**
		• Patient has had a trial and failure of colchicine tablets; **OR**
		  ○ Patient is unable to swallow or has difficulty swallowing colchicine tablets/capsules; **AND**
		• Females of reproductive potential and males with female partners of reproductive potential should be advised to use effective contraception; **AND**
		• Patient does not meet the following:
		  ○ Presence of an active gout flare
		  ○ Renal or hepatic impairment
		  ○ In combination with CYP3A4 and P-gp inhibitors; **AND**
		• Prescriber attests that the following will be monitored:
		  ○ CBC, ALTs, ASTs, Scr
		  ○ Serum uric acid levels
		  ○ Neuromuscular toxicity (creatine phosphokinase (CPK), SGOT, SGPT, and LDH)
		Renewal Criteria (3 months):
		• Patient continues to meet the initial criteria; **AND**
		• Patient has not experienced any treatment-restricting adverse effects (e.g., colchicine toxicity, neuromuscular toxicity, blood dyscrasias, liver and renal toxicity)
			300 ml/28 days	

Mitigare®	NP	See colchicine tablet prior authorization criteria; **AND** • Trial and failure of the preferred colchicine product		
Uloric®	NP	• Trial and failure, contraindication, or intolerance to allopurinol; **AND** • Clinically valid reason as to why the preferred febuxostat cannot be used		
Androgens				

Androderm®	P	**Initial Criteria:**
		• Patient age 21 years of age or less AND Diagnoses of Micropenis, Congenital or Acquired Anorchia, Kallmann Syndrome, Klinefelter Syndrome OR Hypogonadotrophic hypogonadism/central hypogonadism due to one of the following etiologies:
		  ○ Congenital midline brain defects: Septo-optic Dysplasia, Holoprosencephaly, Hypopituitarism
		  ○ CNS tumors and treatment including irradiation, surgery, and chemotherapy
		  ○ Significantly delayed puberty
		  ○ Approval requires:
		  – Baseline Luteinizing Hormone
		  – Baseline testosterone level [faxed labs required]
		• Patient age 21 years of age or less: diagnosis not specified above:
		  ○ Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone [faxed labs required] and requires:
		  – Baseline hematocrit ≤ 50%
		  – Baseline Luteinizing Hormone
		• Patient age 22 years of age and older:
				General PA Form

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

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**
		○ Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone [faxed labs required] and requires: – Baseline hematocrit ≤ 50% – Baseline Luteinizing Hormone – PSA level < 3 ng/mL • Requests for diagnosis of gender dysphoria will be reviewed on a case-by-case basis for determination **Renewal Requests:** • Documentation of low or normal fasting testosterone level from previous 12 months [faxed labs required] • Hematocrit ≤ 50% • PSA level <3 ng/mL [not required for <21]		
AndroGel® pump	P	See Androderm® prior authorization criteria	1 package/Rx	
testosterone gel	P	See Androderm® prior authorization criteria	1 package/Rx	
testosterone cypionate	P	See Androderm® prior authorization criteria	4 mL/30 days	
AndroGel® 1% and 1.62% packets	NP	**Initial Criteria:** • Patient age 21 years of age or less AND Diagnoses of Micropenis, Congenital or Acquired Anorchia, Kallmann Syndrome, Klinefelter Syndrome OR Hypogonadotrophic hypogonadism/central hypogonadism due to one of the following etiologies: ○ Congenital midline brain defects: Septo-optic Dysplasia, Holoprosencephaly, Hypopituitarism ○ CNS tumors and treatment including irradiation, surgery, and chemotherapy ○ Significantly delayed puberty ○ Approval requires: – Baseline Luteinizing Hormone – Baseline testosterone level [faxed labs required] ○ Intolerance or contraindication to an inactive ingredient in ALL preferred topical testosterone that is not in the requested product • Patient age 21 years of age or less: diagnosis not specified above: ○ Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone [faxed labs required] and requires: ○ Baseline hematocrit ≤ 50% ○ Baseline Luteinizing Hormone ○ Intolerance or contraindication to an inactive ingredient in ALL preferred topical testosterone that is not in the requested product • Patient age 22 years of age and older: ○ Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone [faxed labs required] and requires: ○ Baseline hematocrit ≤ 50% ○ Baseline Luteinizing Hormone ○ PSA level < 3 ng/mL ○ Intolerance or contraindication to an inactive ingredient in ALL preferred topical testosterone that is not in the requested product	1 package/Rx	General PA Form

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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**
		• Requests for diagnosis of gender dysphoria will be reviewed on a case-by-case basis for determination **Renewal Requests:** • Documentation of low or normal fasting testosterone level from previous 12 months [faxed labs required] • Hematocrit ≤ 50% • PSA level < 3 ng/mL [not required for <21]		
Depo-Testosterone®	NP	See AndroGel® 1% and 1.62% packets prior authorization criteria	4 mL/30 days	
Fortesta®	NP	See AndroGel® 1% and 1.62% packets prior authorization criteria		General PA Form
Jatenzo®	NP	See AndroGel® 1% and 1.62% packets prior authorization criteria	2/day	
Methitest®	NP	**Initial Criteria:** • Patient age 21 years of age or less AND Diagnoses of Micropenis, Congenital or Acquired Anorchia, Kallmann Syndrome, Klinefelter Syndrome OR Hypogonadotrophic hypogonadism/central hypogonadism due to one of the following etiologies: ○ Congenital midline brain defects: Septo-optic Dysplasia, Holoprosencephaly, Hypopituitarism ○ CNS tumors and treatment including irradiation, surgery and chemotherapy ○ Significantly delayed puberty ○ Approval requires: – Baseline Luteinizing Hormone – Baseline testosterone level [faxed labs required] • Intolerance or contraindication to at least ONE preferred testosterone product • Patient age 21 years of age or less: diagnosis not specified above: ○ Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone [faxed labs required] and requires: – Baseline hematocrit ≤ 50% – Baseline Luteinizing Hormone – Intolerance or contraindication to at least ONE preferred testosterone product • Patient age 22 years of age and older: ○ Diagnosis of hypogonadism as confirmed by 2 baseline fasting testosterone levels drawn in the AM on separate dates demonstrating low testosterone [faxed labs required]and requires: ○ Baseline hematocrit ≤ 50% ○ Baseline Luteinizing Hormone ○ PSA level < 3 ng/mL ○ Intolerance or contraindication to at least ONE preferred testosterone product • Requests for diagnosis of gender dysphoria will be reviewed on a case-by-case basis for determination **Renewal Requests:** • Documentation of low or normal fasting testosterone level from previous 12 months [faxed labs required] • Hematocrit ≤ 50% • PSA level < 3 ng/mL [not required for <21]		
methyltestosterone	NP	See Methitest® prior authorization criteria		
Natesto® nasal gel	NP	See AndroGel® 1% and 1.62% packets prior authorization criteria		

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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**
Testim®	NP	See AndroGel® 1% and 1.62% packets prior authorization criteria	1 package/Rx	
testosterone enanthate injection	NP	See AndroGel® 1% and 1.62% packets prior authorization criteria; **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	4 mL/30 days	
Tlando®	NP	See AndroGel® 1% and 1.62% packets prior authorization criteria	2/day	
Vogelxo®	NP	See AndroGel® 1% and 1.62% packets prior authorization criteria		
Xyosted®	NP	See testosterone enanthate injection prior authorization criteria	2 mL/30 days	
Antidiuretic/Vasopressor Agents				
Nocdurna®	NP	• Diagnosis of nocturnal polyuria (voiding ≥ 2 times per night); **AND** • Patient ≥ 50 years of age; **AND** • Does not have a diagnosis of central diabetes insipidus or obstructive uropathy; **AND** • Does not have a diagnosis of hemophilia A or von Willebrand disease; **AND** • Patient Is not pregnant; **AND** • Patient has tried behavioral measures Will **not** be approved for patients with any of the following contraindications: • Hyponatremia • Polydipsia • Primary nocturnal enuresis • Current condition that causes fluid or electrolyte imbalance, including uncontrolled diabetes mellitus • Syndrome of inappropriate antidiuretic hormone secretion (SIADH) • Concomitant use of loop diuretics or systemic of inhaled glucocorticoids • eGFR < 50 mL/min/1.73 m^2 • NYHA Class II-IV CHF • Uncontrolled hypertension	1/day	General PA Form
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.		General PA Form
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.		
Bone: Bisphosphonate				
alendronate	P		5, 10, 40 mg: 1/day 35, 70 mg: 4/28 days	General PA Form

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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**
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	
Binosto®	NP		4/28 days	
Fosamax®	NP		see alendronate	
Fosamax Plus D®	NP		4/28 days	
risedronate	NP		150 mg: 1/28 days	
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 preferred agents	1 mL/day	
Fortical®	NP	• 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 preferred agents.	3.7 mL/30 days	
Miacalcin® injection	NP	See calcintonin injection prior authorization criteria	1 mL/day	
Miacalcin® nasal spray	NP	See Fortical® prior authorization criteria	3.7 mL/30 days	
Bone: Parathyroid Hormone				
Forteo®	NP	• Patient has a high risk for fracture with a T-score below -2.5 SD; **AND** • Have experienced an insufficient response or intolerance to an adequate trial of a bisphosphonate, or have a contraindication to bisphosphonate use, plus a history of osteoporotic fracture; **AND** • Have been screened and found not to have pre-existing hyperparathyroidism; **AND** • Have been screened for risk factors for the development of calciphylaxis or worsening of previously stable cutaneous calcification including underlying autoimmune disease, kidney failure, and concomitant warfarin or systemic corticosteroid use; **AND**	1 pen/28 days	General PA Form

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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**
		• Total lifetime length of therapy with PTH analogs has not exceeded 2 years (exception: prescriber documents continued or returned risk of fracture after 2 years of therapy)		
Natpara®	NP	• Diagnosis of hypoparathyroidism; **AND** • Persistent hypocalcemia not adequately controlled with maximally tolerated doses of vitamin D and calcium; **AND** • Documentation patient is concomitantly taking Vitamin D with calcium supplements.	2 cartridges/28 days	
teriparatide	NP	See Forteo prior authorization criteria	1 pen/28 days	General PA Form

Tymlos®	NP	**Initiation Criteria:**
		• Patient has one of the following diagnoses:
		  ○ Post-menopausal osteoporosis at high risk for fracture;
		  ○ Osteoporosis in men at high risk for fracture; **AND**
		• Confirmation patient is receiving calcium and vitamin D supplementation if dietary intake is inadequate; **AND**
		• Documented Hip bone densitometry (femoral neck or total hip) or lumbar spine T-score -2.5 (standard deviations) or below; **AND**
		• Patient is not at increased risk for osteosarcoma (e.g., Paget's disease of bone, bone metastases or skeletal malignancies, etc.); **AND**
		• Patient has not received therapy with parathyroid hormone analogs (e.g., teriparatide) in excess of 24 months in total; **AND**
		• Documented treatment failure, contraindication, or ineffective response to a minimum (12) month trial on previous therapy with oral bisphosphonates (e.g., alendronate, risedronate, ibandronate)
		Renewal Criteria:
		• Disease response (absence of fractures); **AND**
		• Absence of unacceptable toxicity from the drug (e.g., osteosarcoma, orthostatic hypotension, hypercalcemia, hypercalcuria and urolithiasis, etc.); **AND**
		• Total lifetime length of therapy with PTH analogs has not exceeded 2 years
			1/30 days	General PA Form

Bone: SERMs				
raloxifene	P		1/day	General PA Form
Evista®	NP		1/day	

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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**
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	
Haloette®	NP		1/28 days	
Phexxi®	NP	• Patient has tried and failed or had a contraindication to two preferred non-oral contraceptives; **AND** • Provider attests the patient will be monitored for cystitis and pyelonephritis	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	
Diabetes: Alpha-Glucosidase Inhibitors				
acarbose	P	• Trial and failure, contraindication, or intolerance to metformin monotherapy		General PA Form
miglitol	NP	• Trial and failure, contraindication, or intolerance to metformin monotherapy; **AND** • Trial and failure, contraindication, or intolerance of TWO preferred agents		
Precose®	NP	See miglitol prior authorization criteria		

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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**
Diabetes: Amylin Analogs				
SymlinPen®	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: Rapid-Acting Insulins				
Apidra® SoloStar®	P	• Prior authorization not required for patients < 21 years of age; **OR** • Patient is 21 years of age or older; **AND** ○ Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., 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		General PA Form
Humalog® KwikPen®	P	See Apidra® Solostar® prior authorization criteria		General PA Form
Humalog® Jr Kwik Pen®	P	• Prior authorization not required for patients < 21 years of age; **OR** • Patient is 21 years of age or older; AND ○ Patient requires half unit (0.5) dosing or adjustments that cannot be achieved with Humalog® Kwik Pen®		
insulin lispro KwikPen	P	See Apidra® Solostar® prior authorization criteria		General PA Form
insulin lispro Jr Kwikpen	P	See Humalog® Jr KwikPen prior authorization criteria		
Admelog® SoloStar®	NP	• Patient < 21 years of age; **AND** ○ Trial and failure or intolerance of TWO preferred rapid acting insulin agents; **OR** • Patients ≥ 21 years old; **AND** ○ Trial and failure or intolerance of 2 preferred rapid acting insulin agents; **AND** ○ Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., 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		General PA Form

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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**

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**
		• 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

Fiasp® FlexTouch®	NP	See Admelog® SoloStar® prior authorization criteria		General PA Form
Humalog® U-200 KwikPen®	NP	See Admelog® SoloStar® prior authorization criteria; **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® 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		General PA Form
Lyumjev® Kwikpen®	NP	See Admelog® SoloStar® prior authorization criteria; **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		
Novolog® FlexPen®	NP	See Admelog® SoloStar® prior authorization criteria		
Diabetes: Intermediate-Acting Insulins				
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
Diabetes: Mixed Insulins				

Humalog Mix 50/50® KwikPen®	P	• Prior authorization not required for patients < 21 years of age; **OR**
		• Patient is 21 years of age or older; **AND**
		  ○ Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., 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
				General PA Form

Humalog Mix 75/25® KwikPen®	P	See Humalog® Mix 50/50® KwikPen prior authorization criteria		General PA Form
Humulin 70/30® KwikPen®	P	See Humalog® Mix 50/50® KwikPen prior authorization criteria		
insulin aspart mix 70/30 FlexPen	P	See Humalog® Mix 50/50® KwikPen prior authorization criteria		

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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 lispro mix 75/25 KwikPen®	NP	• Patient < 21 years of age; **AND**
		  ○ Trial and failure or intolerance of TWO preferred rapid acting insulin agents; **OR**
		• Patients ≥ 21 years old; **AND**
		  ○ Trial and failure or intolerance of 2 preferred rapid acting insulin agents; **AND**
		  ○ Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., 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
				General PA Form

Novolog Mix 70/30® FlexPen®	NP	See insulin lispro mix 75/25 KwikPen® prior authorization criteria		
Diabetes: Long-Acting Insulins				

Basaglar KwikPen®	NP	• Patients < 21 years of age approval requires a contraindication to the preferred insulin glargine pen that is not observed with the requested agent; **OR**
		• For patients ≥ 21 years old approval requires a contraindication to the preferred insulin glargine pen that is not observed with the requested agent; **AND**
		  ○ Recipient or caregiver has problems with manual dexterity which may result in dosing errors (e.g., 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
				General PA Form

insulin degludec FlexTouch	NP	See Toujeo Solostar® prior authorization criteria		General PA Form
Rezvoglar®	NP	See prior authorization criteria for Basaglar KwikPen®		
Semglee®	NP	See prior authorization criteria for Basaglar KwikPen®		
Tresiba FlexTouch®	NP	See Toujeo Solostar® prior authorization criteria		

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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**
Diabetes: GLP-1 Receptor Agonists				

Byetta®	P	**Initial Criteria:**
		• Diagnosis of type 2 diabetes; **AND**
		• Submission of lab test for one of the following:
		  ○ HbA1C level*
		  ○ Oral glucose tolerance test
		  ○ Random plasma glucose ≥ 200 mg/dL with classic symptoms of hyperglycemia or hyperglycemic crisis; **AND**
		• One of the following:
		  ○ Patient has or is at high-risk of atherosclerotic cardiovascular disease (ASCVD), chronic kidney disease (CKD), or heart failure (HF)
		  ○ Trial and failure, contraindication, or intolerance TWO of the following;
		  – Metformin or metformin containing product
		  – SGLT2 or combination product
		  – TZD
		  – Sulfonylurea
		  – Insulin; **AND**
		• Patient must not be receiving prandial insulin if on Byetta
		• GLP-1 Receptor Agonists will NOT be covered for the following:
		  ○ Diagnosis of Type I diabetes
		  ○ Treatment of diabetic ketoacidosis
		  ○ Use for weight loss
		  ○ Diagnosis of end-stage renal disease or CrCl ≤ 30 mL/min (Byetta® only)
		  ○ 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 one of the following:
		  ○ Reduction of HbA1c from baseline
		  ○ Achievement or maintenance of therapeutic HbA1c goal
		  ○ Improvement in fasting blood glucose levels
		  ○ Patient is at increased risk of ASCVD, CKD, or HF
		Note*: HbA1c level can be from early stages in patient treatment. If original HbA1c is unknown, or current HbA1c is controlled due to another current diabetic regimen, please include current regimen and current HbA1c.
			5 mcg:
			1.2 mL/ 30 days
			
			10 mcg: 2.4 mL/30 days
				GLP-1 Agonist PA Form

Ozempic®	P	See Byetta prior authorization criteria	1 pen/28 days	
Victoza®	P	See Byetta prior authorization criteria	9 mL/30 days	

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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**

Bydureon BCise®	NP	**Initial Criteria:**
		• Diagnosis of type 2 diabetes; **AND**
		• Submission of lab test for one of the following:
		  ○ HbA1C level*
		  ○ Oral glucose tolerance test
		  ○ Random plasma glucose ≥ 200 mg/dL with classic symptoms of hyperglycemia or hyperglycemic crisis; **AND**
		• One of the following:
		  ○ Patient has or is at high-risk of atherosclerotic cardiovascular disease (ASCVD), chronic kidney disease (CKD), or heart failure (HF)
		  ○ Trial and failure, contraindication, or intolerance TWO of the following;
		  – Metformin or metformin containing product
		  – SGLT2 or combination product
		  – TZD
		  – Sulfonylurea
		  – Insulin; **AND**
		• Trial and failure, contraindication, or intolerance to BOTH of the following:
		  ○ Byetta OR Victoza; **AND**
		  ○ Ozempic
		• GLP-1 Receptor Agonists will NOT be covered for the following:
		  ○ Diagnosis of Type I diabetes
		  ○ Treatment of diabetic ketoacidosis
		  ○ Use for weight loss
		  ○ 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 one of the following:
		  ○ Reduction of HbA1c from baseline
		  ○ Achievement or maintenance of therapeutic HbA1c goal
		  ○ Improvement in fasting blood glucose levels
		  ○ Patient is at increased risk of ASCVD, CKD, or HF
		Note*: HbA1c level can be from early stages in patient treatment. If original HbA1c is unknown, or current HbA1c is controlled due to another current diabetic regimen, please include current regimen and current HbA1c.
			3.4 mL/28 days	GLP-1 Agonist PA Form

Rybelsus®	NP	See Bydureon BCise® prior authorization criteria	1/day	
Soliqua®	NP	See Bydureon BCise® prior authorization criteria **AND** • Patient is currently taking, but inadequately controlled on, a long-acting insulin (e.g., insulin glargine, degludec, detemir) documented per TennCare paid claims	5 pens/30 days	
Trulicity®	NP	See Bydureon BCise® prior authorization criteria	2 mL/28 days	GLP-1 Agonist PA Form
Mounjaro®		See Bydureon BCise® prior authorization criteria	2 mL/28 days	
Xultophy®	NP	See Bydureon BCise® prior authorization criteria **AND** • Patient is currently taking, but inadequately controlled on, a long-acting insulin (e.g., insulin glargine, degludec, detemir) documented per TennCare paid claims	5 pens/30 days	

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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**
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	
Glumetza®	NP		500 mg: 1/day 1000 mg: 2/day	
metformin ER osmotic	NP		500 mg: 3/day 1000 mg: 2/day	General PA Form
metformin solution	NP	• See Riomet prior authorization criteria	20 mL/day	
Riomet®	NP	• No PA required for 11 years old and younger. • All others: Will be approved for patients unable to swallow tablets	20 mL/day	
Diabetes: DPP-4 Inhibitors and Combos				
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	DPP-4 PA Form
Jentadueto® XR	P		2.5/1000 mg: 2/day; 5/1000 mg: 1/day	
Kombiglyze® XR	P		2/day	
Onglyza®	P		1/day	
Tradjenta®	P		1/day	
alogliptin	NP	• Diagnosis of type 2 diabetes; **AND** • Patient's HbA1c level is greater than 6.5 (for **initial** approval); **AND** • Trial and failure, contraindication, or intolerance to TWO preferred single entity DPP-4 inhibitors (Januvia, Onglyza, Tradjenta)	1/day	DPP-4 PA Form
alogliptin/metformin	NP	• Diagnosis of type 2 diabetes; **AND** • Patient's HbA1c level is greater than 6.5 (for **initial** approval); **AND** • Trial and failure, contraindication, or intolerance to TWO preferred DPP-4/metformin combination products (Janumet, Janumet XR, Jentadueto, Jentadueto XR, Kombiglyze XR)	2/day	

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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**
alogliptin/pioglitazone	NP	See alogliptin/metformin prior authorization criteria	1/day	
Kazano®	NP	See alogliptin/metformin prior authorization criteria	2/day	DPP-4 PA Form
Nesina®	NP	See alogliptin prior authorization criteria	1/day	
Oseni®	NP	See alogliptin/pioglitazone prior authorization criteria	1/day	
Diabetes: Meglitinides and Combos				
nateglinide	P	• Trial and failure, contraindication, or intolerance of metformin monotherapy	3/day	General PA Form
repaglinide	P	• Trial and failure, contraindication, or intolerance of metformin monotherapy	0.5, 1 mg: 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	
Jardiance®	P		1/day	
Synjardy®	P		2/day	
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	• Requested medication is being used to reduce the risk of cardiovascular death, hospitalization for heart failure, and urgent heat failure visit in adults with one of the following:
		  ○ Heart Failure
		  ○ Type 2 diabetes mellitus, chronic kidney disease, and other cardiovascular risk factors; **AND**
		• Trial and failure or intolerance to Farxiga TWO preferred agents
			1/day	

Invokamet XR®	NP	• Diagnosis of Type 2 Diabetes; **AND** • Trial and failure or intolerance to TWO preferred single-entity SGLT2 agents (Farxiga, Invokana, Jardiance); **AND** • Clinically valid reason as to why patient cannot use Invokamet®	2/day	General PA Form
Qtern®	NP	• Trial and failure or intolerance to separate components (Farxiga and Onglyza)	1/day	
Steglatro®	NP	• Diagnosis of Type 2 Diabetes; **AND**	2/day (5 mg);	

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

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**
		• Trial and failure or intolerance to TWO preferred single-entity SGLT2 agents (Farxiga, Invokana, Jardiance)	1/day (15 mg)	
Segluromet®	NP	• Diagnosis of Type 2 Diabetes; **AND** • Trial and failure or intolerance to TWO preferred single-entity SGLT2 agents (Farxiga, Invokana, Jardiance); **AND** • Clinically valid reason as to why the patient cannot use a preferred single-entity SGLT2 agent and metformin as separate agents; **AND** • Patient does not have metabolic acidosis	2/day	
Steglujan®	NP	• Diagnosis of Type 2 Diabetes; **AND** • Trial and failure or intolerance to TWO preferred single-entity SGLT2 agents (Farxiga, Invokana, Jardiance); **AND** • Patient does not have metabolic acidosis	1/day	
Synjardy XR®	NP	• Diagnosis of Type 2 Diabetes; **AND** • Trial and failure or intolerance to TWO preferred single-entity SGLT2 agents (Farxiga, Invokana, Jardiance); **AND** • Clinically valid reason as to why patient cannot use Synjardy	1/day (25/1000 mg); 2/day (all other strengths)	
Trijardy XR®	NP	• Diagnosis of Type 2 Diabetes; **AND** • Trial and failure or intolerance to TWO preferred single-entity SGLT2 agents (Farxiga, Invokana, Jardiance); **AND** • 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: Sulfonylureas and Combos				
glimepiride	P		2/day	General PA Form
Amaryl®	NP	• Trial and failure, or contraindication, or intolerance to, metformin monotherapy; **AND** • Trial and failure, contraindication, or intolerance of TWO preferred agents	2/day	
Glucotrol XL®	NP	See Amaryl® prior authorization criteria		
Glynase PresTab®	NP	See Amaryl® prior authorization criteria		
Diabetes: TZDs and Combos				
pioglitazone	P	• Trial and failure, contraindication, or intolerance to metformin or a metformin containing product	1/day	TZD and Combos PA Form
pioglitazone/ metformin	P	• Trial and failure, contraindication, or intolerance to metformin or a metformin containing product	2/day	
Actos®	NP	• Trial and failure, contraindication, or intolerance to metformin or a metformin containing product; **AND** • Patient must have an allergy or intolerance to an inactive ingredient in the generic equivalent	1/day	
ACTOplus Met®	NP	See Actos® prior authorization criteria	2/day	
Duetact®	NP	• Trial and failure, contraindication, or intolerance to metformin or a metformin containing product; **AND** • Trial and failure, contraindication, or intolerance to pioglitazone; **AND** • Clinically valid reason why the patient cannot use pioglitazone and glimepiride as separate agents	1/day	
pioglitazone/ glimepiride	NP	See Duetact® prior authorization criteria	1/day	

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

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**
Diabetes: Glucagon Agents				
Baqsimi®	P		2/Rx	General PA Form
Gvoke Hypopen®	P		2/Rx	
Gvoke® syringe	P		2/Rx	
Zegalogue®	NP		2/Rx	
Disease Modifying Anti-Rheumatic Drugs (DMARDs)				
sulfasalazine	P		8/day	General PA Form
sulfasalazine EC	P		8/day	
Azulfidine®	NP		8/day	
Azulfidine EN®	NP		8/day	
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 injections/28 days	
Reditrex®	NP	See Otrexup® prior authorization criteria	4 injections/28 days	
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 tablets		

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

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**
Anti-Rheumatic: Kinase Inhibitors				

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, 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
		  ○ Risk of malignancy has been considered and it has been determined that Jak Kinase inhibitor therapy is appropriate; **AND**
		• One of the following:
		  ○ Diagnosis of moderately to severely active Rheumatoid Arthritis (RA), active Polyarticular Course Juvenile Idiopathic Arthritis (pcJIA), or active Psoriatic Arthritis (PsA); **AND**
		  – Trial and failure or intolerance to methotrexate (unless there is a documented absolute contraindication such as alcohol abuse, cirrhosis, chronic liver disease); **AND**
		  – Trial and failure or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel)
		  ○ 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 or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel)
		Renewal Criteria:
		• Patient continues to meet initial approval criteria; **AND**
		• 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, etc.)
			2/day	General PA Form

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

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**

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 Kinase inhibitor therapy is appropriate; **AND**
		• One of the following:
		  ○ Diagnosis of moderately to severely active rheumatoid arthritis OR active psoriatic arthritis; **AND**
		  – Trial and failure or intolerance to methotrexate (unless there is a documented absolute contraindication such as alcohol abuse, cirrhosis, chronic liver disease); **AND**
		  – Trial and failure or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel)
		  ○ 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 Ankylosing spondylitis; **AND**
		  – Trial and failure or intolerance to a TNF-inhibitor (e.g. Humira)
		  ○ Diagnosis of moderately to severely active Crohn's Disease; **AND**
		  – Trial and failure or intolerance to a TNF-inhibitor (e.g., Humira); **OR**
		  ○ Diagnosis of moderate to severe Atopic Dermatitis; **AND**
		  – Trial and failure (documented by claims) or contraindication to 1 topical corticosteroid of medium-to-high potency (e.g., mometasone, fluocinolone); **AND**
		  – Trial and failure, contraindication, or intolerance to a topical calcineurin inhibitor
		  ○ Diagnosis of active ankylosing spondylitis; **AND**
		  – Trial and failure 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 or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel)
		Renewal Criteria:
		• Patient continues to meet initial approval criteria; **AND**
		• 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, etc.)
			1/day	General PA Form

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

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**

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 the risks of heart-related events (heart attack, stroke, blood clots, etc.) or cardiovascular risk factors
		  ○ Risk of malignancy has been considered and it has been determined that Jak Kinase inhibitor therapy is appropriate; **AND**
		• One of the following:
		  ○ Diagnosis of moderately to severely active Rheumatoid Arthritis; **AND**
		  – Trial and failure or intolerance to methotrexate (unless there is a documented absolute contraindication such as alcohol abuse, cirrhosis, chronic liver disease); **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 least 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:
		• For a diagnosis of Rheumatoid Arthritis, patient continues to meet initial approval criteria; **AND**
		• 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, etc.)
		Note: Will not be covered for COVID-19 treatment in post hospitalized patients
			1/day	General PA Form

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

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**

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 the risks of heart-related events (heart attack, stroke, blood clots, etc.) or cardiovascular risk factors
		  ○ Risk of malignancy has been considered and it has been determined that Jak Kinase inhibitor therapy is appropriate; **AND**
		• Diagnosis of active Polyarticular Course Juvenile Idiopathic Arthritis (pcJIA); **AND**
		• Trial and failure or intolerance to methotrexate (unless there is a documented absolute contraindication such as alcohol abuse, cirrhosis, chronic liver disease); **AND**
		• Trial and failure or intolerance to a TNF-inhibitor (e.g. Humira, Enbrel); **AND**
		• Trial and failure, contraindication, or intolerance to ONE preferred agent; **AND**
		Renewal Criteria
		• Patient continues to meet initial approval criteria; **AND**
		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, etc.)
			10 mL/day	

Xeljanz® XR 11 mg	NP	• See Xeljanz® tablet prior authorization criteria; **AND**
		  ○ Trial and failure, contraindication, or intolerance to ONE preferred agent; **AND**
		  ○ Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the immediate release product
			1/day	General PA Form

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 the risks of heart-related events (heart attack, stroke, blood clots, etc.) or cardiovascular risk factors
		  ○ Risk of malignancy has been considered and it has been determined that Jak Kinase inhibitor therapy is appropriate; **AND**
		• Diagnosis of moderately to severely active Ulcerative Colitis (UC); **AND**
		• Trial and failure, contraindication, or intolerance to Humira; **AND**
		• Trial and failure, contraindication, or intolerance to ONE preferred agent; **AND**
		• Provider must provide peer-reviewed medical literature documenting why the requested drug for the requested indication is the only appropriate choice versus the immediate release product
		Renewal Criteria:
		• Patient continues to meet initial approval criteria; **AND**
		• 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, etc.)
			1/day	

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

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**
Estrogen / Progestin Combos, 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	
Estrogens, Transdermal				
estradiol biweekly patch	P		8/28 days	General PA Form
estradiol weekly patch	P		4/28 days	
Alora®	NP		8/28 days	
Climara®	NP		4/28 days	
Divigel®	NP		1/day	
Elestrin®	NP		1/28 days	
estradiol gel	NP		1/day	
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

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

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**
Glucocorticoids, Oral				

Alkindi Sprinkles®	NP	• Diagnosis of adrenocortical insufficiency; **AND**
		• Patient is 18 years of age or younger; **AND**
		• Patient does not have ANY of the following:
		  ○ Hypersensitivity to hydrocortisone
		  ○ Untreated fungal and bacterial infections; **AND**
		• Clinically valid reason as to why the preferred prednisolone solution cannot be used
			0.5 mg: 3/day
			1 mg: 3/day
			2 mg: 3/day
			5 mg: 4/day	

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 must NOT have any of the following:
		  ○ Systemic fungal or bacterial infection
		  ○ Glaucoma
		  ○ Herpes Simplex Keratitis
		  ○ Ocular infection
		  ○ Tympanic membrane perforation
		  ○ Prior hypersensitivity with dexamethasone
		  ○ Strong CYP3A4 inhibitors or inducers
		  ○ Pregnant or breastfeeding; **AND**
		• Female patients should use effective contraception during treatment and for at least 1 week after treatment; **AND**
		• Trial and failure, contraindication, or intolerance to two preferred dexamethasone products; **AND**
		• Clinically valid reason why the preferred agents cannot be used
			2/day	General PA Form

Orapred ODT®	NP	• Unable to swallow, **OR** • Unable to absorb medications through the GI tract		
prednisolone ODT	NP	See Orapred ODT® prior authorization criteria		
Rayos®	NP	• Trial and failure, contraindication, or intolerance to TWO preferred products (trial must include predinisone); **AND** • Clinically valid reason why the preferred agents cannot be used	1 mg: 3/day 2 mg: 2/day 5 mg: 12/day	

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

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**
GnRH Antagonist				

Myfembree®	P	**Initial Criteria:**
		• Patient age is ≥ 18 years; **AND**
		• Diagnosis of one of the following:
		  ○ Heavy menstrual bleeding associated with uterine leiomyomas/fibroids
		  ○ Moderate to severe pain associated with endometriosis; **AND**
		• Patient must be premenopausal; **AND**
		• Patient has tried and failed 2 medications in the following drug classes:
		  ○ Hormonal contraceptives (including oral or transdermal formulations, vaginal ring, or intrauterine device)
		  ○ NSAIDs
		  ○ Hemostatics (e.g., tranexamic acid)
		  ○ Oral progesterone; **AND**
		• Prescribed by, or in consultation with, an obstetrics/gynecology or reproductive specialist; **AND**
		• Patient will use effective non-hormonal contraception during treatment and 1 week after stopping therapy; **AND**
		• Total treatment duration should not exceed 24 months due to risk of continued bone loss
		Renewal Criteria (only for 150 mg strength):
		• Patient has positive response to therapy (e.g., reduction in pain and discomfort from baseline, sustained reduction in menstrual blood loss per cycle); **AND**
		• Patient will use effective non-hormonal contraception during treatment and 1 week after stopping therapy; **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	

Orilissa®	P	**Initial Criteria:**
		• Patient age is ≥ 18 years; **AND**
		• Patient has confirmed diagnosis of endometriosis; **AND**
		• Patient has tried and failed 2 medications in the following drug classes:
		  ○ Hormonal contraceptives (including oral or transdermal formulations, vaginal ring, or intrauterine device)
		  ○ NSAIDs
		  ○ Hemostatics (e.g., tranexamic acid)
		  ○ Oral progesterone; **AND**
		• Prescribed by, or in consultation with, an obstetrics/gynecology or reproductive specialist; **AND**
		• Pregnancy is excluded prior to initiating treatment**; AND**
		• Total treatment duration should not exceed 24 months due to risk of continued bone loss
		Renewal Criteria (only for 150 mg strength):
		• Patient continues to meet the initial criteria; **AND**
		• Patient is considered to have clinically meaningful response to treatment
			1/day: 150 mg;
			2/day: 200 mg
				General PA Form

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

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				

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

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**
Genotropin®	P	**Will be approved for patients meeting the following 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 **For patients < 21 years old**, **will be approved if ANY of the following criteria are met:** • Diagnosis of short stature associated with Turner's Syndrome or Noonan Syndrome or mutations of the Short Stature Homeobox (SHOX) gene • Diagnosis of Prader-Willi Syndrome • Patient has evidence of hypothalamic-pituitary disease or structural lesions/trauma to the pituitary, including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation and meets any of the following: ○ Failed a GH stimulation test (peak GH level <10ng/mL) ○ Documented low IGF-1 level (below normal for patient's age) ○ Has deficiencies in 3 or more pituitary axes • Patient has chronic renal insufficiency (CrCl < 30 mL/min/1.73 m^2) • 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/IGF Binding Protein #3 level • Patient has failed two GH stimulation tests (defined as peak GH level < 10 ng/mL) OR has failed one GH stimulation test and has a documented low IGF-1 level based on age normal values ○ Continuation of therapy will be approved only if height velocity is within normal range for patient's age or bone age ○ Therapy will not be approved once epiphyseal fusion occurs • Diagnosis of Small for Gestational Age (SGA) or Intrauterine Growth Retardation (IGR), > 2 years old, and has a height at least 2 standard deviations below the population mean for age **Note**: GH therapy will NOT be approved for idiopathic short stature **Patients ≥ 21 years old, will be approved for ANY of the following:** • Patient has evidence of hypothalamic-pituitary disease or structural lesions/trauma to the pituitary, including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation (can be diagnosed in childhood or adulthood); **AND** ○ One of the following: – Failed at least one GH stimulation test – Has at least one documented low IGF-1 level – Has deficiencies in 3 or more pituitary axes – Note: For recipients diagnosed in childhood with hypothalamic-pituitary disease or structural lesions/trauma to the pituitary who have a past history of GH use, no retesting is necessary; **OR** • Failure of 2 GH stimulation tests (peak GH level < 5 ng/mL) or failure of one GH stimulation test and documented low IGF-1 **Renewal Criteria:** • For diagnosis of Growth Hormone deficiency, Small for Gestational Age (SGA,) or Intrauterine Growth Retardation (IGR): ○ Agent is prescribed by, or in consultation with, an endocrinologist; **AND** ○ Patient has open epiphyses (therapy will NOT be approved once epiphyseal fusion occurs)**; AND** ○ Documentation of positive clinical response to therapy (e.g., increased IGF-1 levels, improvement in linear growth or body composition) • For all other diagnoses: Patient continues to meet initial criteria		Growth Hormone PA Form

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

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**
Egrifta®	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		
Humatrope®	NP	See Genotropin® prior authorization criteria		
Norditropin®	NP	See Genotropin® prior authorization criteria		
Nutropin AQ®	NP	See Genotropin® prior authorization criteria		
Ngenla®	NP	**Initial Criteria:** • Patient is at least 3 years of age and less than 18 years of age; **AND** • Patient weighs at least 11.5kg; **AND** • Diagnosis of growth failure due to inadequate secretion of endogenous growth hormone (GH); **AND** • Agent is prescribed by, or in consultation with, an endocrinologist; **AND** • Documentation that diagnosis of growth hormone deficiency has been confirmed by two evidence-based diagnostics (e.g., imaging, measurement of insulin-like growth factor 1 (IGF-1) levels, growth hormone stimulation test); **AND** • Prescriber attests that a baseline fundoscopic eye examination to exclude preexisting papilledema; **AND** • Patient provides a clinically valid reason why preferred Genotropin injection cannot be used **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Patient has open epiphyses; **AND** • Prescriber attests that patient has an annualized height velocity of > 2.5 cm/year		
Omnitrope®	NP	See Genotropin® prior authorization criteria		
Saizen®	NP	See Genotropin® prior authorization criteria		

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

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**

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)		

Skytrofa®	NP	**Initial Criteria:** • Patient is at least 1 year of age and less than 18 years of age; **AND** • Patient weighs at least 11.5kg; **AND** • Diagnosis of growth failure due to inadequate secretion of endogenous growth hormone (GH); **AND** • Agent is prescribed by, or in consultation with, an endocrinologist; **AND** • Documentation that diagnosis of growth hormone deficiency has been confirmed by two evidence-based diagnostics (e.g., imaging, measurement of insulin-like growth factor 1 (IGF-1) levels, growth hormone stimulation test); **AND** • Prescriber attests that a baseline fundoscopic eye examination to exclude preexisting papilledema; **AND** • Patient provides a clinically valid reason why preferred Genotropin injection cannot be used **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Patient has open epiphyses; **AND** • Prescriber attests that patient has an annualized height velocity of > 2.5 cm/year		

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

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	**Initial Criteria:**
		• Agent is prescribed by, or in consultation with, an endocrinologist; **AND**
		• Daily dose based on weight of the enrollee, supported by submitted growth charts; **AND**
		• Clinically valid reason as to why the patient cannot take the preferred product Genotropin; **AND**
		• **For patients < 21 years old, will be approved if ANY of the following criteria are met:**
		  ○ Patient has evidence of hypothalamic-pituitary disease or structural lesions/trauma to the pituitary, including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation and meets any of the following:
		  – Failed a GH stimulation test (peak GH level <10ng/mL)
		  – Documented low IGF-1 level (below normal for patient's age)
		  – Has deficiencies in 3 or more pituitary axes
		  ○ Patient has failed two GH stimulation tests (defined as peak GH level < 10 ng/mL) OR has failed one GH stimulation test and has a documented low IGF-1 level based on age normal values
		  – Continuation of therapy will be approved only if height velocity is within normal range for patient's age or bone age
		  – Therapy will not be approved once epiphyseal fusion occurs
		  ○ **Note**: GH therapy will NOT be approved for idiopathic short stature
		• **Patients ≥ 21 years old, will be approved for ANY of the following:**
		  ○ Patient has evidence of hypothalamic-pituitary disease or structural lesions/trauma to the pituitary, including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation (can be diagnosed either in childhood or adulthood) AND meets any one of the following:
		  – Failed at least one GH stimulation test
		  – Has at least one documented low IGF-1 level
		  – Has deficiencies in 3 or more pituitary axes
		  – Note: For recipients diagnosed in childhood with hypothalamic-pituitary disease or structural lesions/trauma to the pituitary who have a past history of GH use, no retesting is necessary
		  ○ Failure of two GH stimulation tests (peak GH level < 5 ng/mL) or failure of one GH stimulation test and documented low IGF-1
		  – Therapy will NOT be approved once epiphyseal fusion occurs
		Renewal Criteria:
		• For diagnosis of Growth Hormone deficiency:
		  ○ Agent is prescribed by, or in consultation with, an endocrinologist; **AND**
		  ○ Patient has open epiphyses (therapy will NOT be approved once epiphyseal fusion occurs)**; AND**
		  ○ Documentation of positive clinical response to therapy (e.g., increased IGF-1 levels, improvement in linear growth or body composition)
		• For all other diagnoses: Patient continues to meet initial criteria		

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

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**
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		Growth Hormone PA Form
Zorbtive®	NP	• Diagnosis of Short Bowel Syndrome; **AND** • Patient is currently receiving specialized nutritional support (e.g., intravenous parenteral nutrition, fluid, and micronutrient supplements); **AND** • Patient has not previously received 4 weeks of treatment with Zorbtive **Note:** Treatment with Zorbtive will not be authorized beyond 4 weeks. Administration for more than 4 weeks has not been adequately studied.		
Hematopoietic Agents				
Retacrit®	P	See Epogen® prior authorization criteria		
Aranesp®	NP	See Epogen® prior authorization criteria		

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

Epogen®	NP	**Initial Criteria:** • Lab values obtained within 30 days of the date of administration; **AND** • Adequate iron stores demonstrated by serum ferritin ≥ 100 ng/mL (mcg/L) and transferrin saturation (TSAT) ≥ 20%; **AND** • Hemoglobin (Hb) < 10 g/dL and/or hematocrit (Hct) < 30% (unless otherwise specified); **AND** • One of the following: ○ Anemia secondary to 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 – Patient's chemotherapy is not intended to cure their disease (i.e., palliative treatment) ○ Anemia secondary to zidovudine treated, HIV-infected patient; **AND** – Zidovudine dose is ≤ 4,200 mg/week; AND Endogenous serum erythropoietin (EPO) levels ≤ 500 mUnits/mL; **OR** ○ Anemia secondary to hepatitis C virus (HCV) treatment in patients receiving ribavirin and interferon-alfa therapy; **OR** ○ Anemia secondary to myelodysplastic syndrome (MDS); **AND** – Treatment of lower risk disease associated with symptomatic anemia; **AND** – Endogenous serum erythropoietin (EPO) level ≤ 500 mUnits/mL; **OR** ○ Anemia secondary to myeloproliferative neoplasms (MPN) – Myelofibrosis; **AND** – Endogenous serum EPO ≤ 500 mUnits/mL; **OR** ○ Anemia secondary to multiple myeloma; **OR** ○ Anemia of prematurity, in combination with iron supplementation; **OR** ○ Anemia secondary to rheumatoid arthritis; **OR** ○ Anemia secondary to chronic kidney disease (CKD); **AND** – Hemoglobin (Hb) ≤ 12.9 g/dL; **OR** ○ Reduction of allogeneic blood transfusions in elective noncardiac, nonvascular surgery; **AND** – Hb > 10 g/dL to ≤ 13 g/dL and/or Hct is 30% to 39%; **AND** – Patient is NOT willing to donate autologous blood pre-operatively; **AND** • Other causes of anemia (e.g., hemolysis, bleeding, vitamin deficiency, etc.) have been ruled out **Renewal Criteria** • Last dose < 60 days ago; **AND** • Lab values obtained within 30 days of the date of administration; **AND** • Adequate iron stores as demonstrated by serum ferritin ≥ 100 ng/mL (mcg/L) and transferrin saturation (TSAT) ≥ 20% measured within the previous 3 months; **AND** • The following criteria are met, depending on diagnosis: ○ Anemia secondary to chronic kidney disease and Hb < 12 g/dL and/or Hct < 36% for children OR Hb < 11 g/dL and/or Hct < 33% for adults ○ Anemia secondary to chemotherapy treatment and Hb <10 g/dL and/or Hct < 30%; **AND** – Patient is receiving concurrent myelosuppressive chemotherapy ○ Anemia secondary to zidovudine treated, HIV-infected patients and Hb < 12 g/dL and/or Hct < 36%; **AND** – Patient is receiving zidovudine administered at ≤ 4200 mg/week; **AND** – Endogenous serum EPO ≤ 500 mUnits/mL; ○ Anemia secondary to myelodysplastic syndrome (MDS) and Hb <12 g/dL and/or Hct <36% ○ Anemia secondary to myeloproliferative neoplasms and Hb <10 g/dL and/or Hct <30% ○ Anemia secondary to myelodysplastic syndrome (MDS) and Hb <12 g/dL and/or Hct <36% ○ Anemia secondary to myeloproliferative neoplasms and Hb <10 g/dL and/or Hct <30% ○ Anemia secondary to Hepatitis C treatment and Hb < 11 g/dL and/or Hct < 33%; **AND** – Patient must be receiving interferon AND ribavirin ○ All other indications: Hb < 11 g/dL and/or Hct < 33%		General PA Form

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

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**

Jesduvroq®	NP	**Initial Criteria: (6-month duration)**
		• Diagnosis of anemia due to CKD; **AND**
		• Patient has been receiving dialysis for ≥ 4 months; **AND**
		• Recent documentation (within 30 days or request) of ALL the following:
		  ○ Hemoglobin level <10 g/dL
		  ○ Serum ferritin ≥ 100 ng/mL (mcg/L)
		  ○ Transferrin saturation (TSAT) ≥ 20%; **AND**
		• Trial and failure, contraindication, or intolerance to erythropoiesis-stimulating agents (ESAs); **AND**
		• Prescriber attests to ALL of the following:
		  ○ Will not use in combination with ESAs
		  ○ Will not use in combination with strong CYP2C8 inhibitor such as gemfibrozil
		  ○ Patient does not have uncontrolled hypertension
		Renewal Criteria:
		• Patient is receiving dialysis for anemia due to CKD; **AND**
		• Submitted documentation demonstrating an increase hemoglobin from baseline; **AND**
		• Recent documentation (within 30 days or request) of ALL the following:
		  ○ Serum ferritin ≥ 100 ng/mL (mcg/L)
		  ○ Transferrin saturation (TSAT) ≥ 20%; **AND**
		• Prescriber attests to ALL of the following:
		  ○ Will not use in combination with ESAs
		  ○ Will not use in combination with strong CYP2C8 inhibitor such as gemfibrozil
		  ○ Patient does not have uncontrolled hypertension
			1mg, 2mg, 4mg: 1/day
			6mg: 2/day
			8mg:3/day
				General PA Form

Procrit®	NP	See Epogen® prior authorization criteria		
Hormones: LHRH/GNRH Agonists				
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])		General PA Form
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])		
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	

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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**
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	
Neurokinin 3 (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 40 mg/mL	P		20 mL/day	General PA Form
norethindrone acetate	P	• Diagnosis of endometriosis		
Aygestin®	NP	• Diagnosis of endometriosis		
megestrol suspension 625 mg/5 mL	NP	• Inability to swallow the 10 mL (400 mg) or 20 mL (800 mg) dose of the regular-strength suspension	5 mL/day	
SERM/Estrogen Combinations				
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
Vasopressor Receptor 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; **AND** • Patient does not have a known hypersensitivity to tolvaptan; **AND** • Patient does not have any of the following: ○ History of symptoms of significant liver impairment or injury (not including uncomplicated polycystic liver disease)		General PA Form

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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**
		○ Uncorrected abnormal blood sodium concentration ○ Inability to sense or respond to thirst ○ Hypovolemia ○ Uncorrected urinary outflow obstruction ○ Anuria; **AND** • Patient does not concurrently use a strong CYP 3A inhibitors; **AND** • A baseline alanine aminotransferase (ALT), aspartate aminotransferase (AST), and bilirubin have been performed and are within normal range (results must be within 3 months of request). Labs must also be repeated 2 weeks and 4 weeks after initiation, and then continued monthly for the first 18 months and every 3 months thereafter. **Renewal Criteria (6-month duration):** • Patients must continue to meet the initial criteria; **AND** • Patient's most recent ALT, AST, and bilirubin are within normal range (results must be within 3 months of request)		
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		

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

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	NP		4/day	
mesalamine ER (generic Apriso®)	NP		4/day	
mesalamine DR (generic Delzicol®)	NP		6/day	
mesalamine HD (generic Asacol HD®)	NP		6/day	
Pentasa®	NP		250 mg (16/day); 500 mg (8/day)	
Agents for Irritable Bowel Syndrome (IBS)				
Amitiza®	P		2/day	General PA Form
Linzess®	P		1/day	
Lotronex®	P	• Patient is female and ≥ 18 years of age; **AND** • Prescriber is enrolled in the Alosetron REMS Program; **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 hypercoaguable state ○ Crohn's disease or ulcerative colitis ○ Diverticulitis ○ Severe hepatic impairment	2/day	

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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**
alosetron	NP	See Lotronex prior authorization criteria; **AND** • Allergy or intolerance to inactive ingredient in Lotronex®	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 meet the following:
		  ○ Patients with known or suspected mechanical gastrointestinal obstruction
		  ○ Presence of severe diarrhea; **AND**
		• History of failure, contraindication, or intolerance to BOTH Amitiza® 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**
		• Member is responding positively to therapy
			2/day	

lubiprostone	NP		2/day	

Viberzi®	NP	• Patient is ≥ 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 has NO 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
			2/day	

Xifaxan®	NP	Agent is being used for one of the following:
		• **Rifaximin 200 mg strength tablets:**
		  ○ Treatment of traveler's diarrhea (uncomplicated by fever and/or blood in stool) PLUS trial and failure, contraindication, intolerance, drug-drug interaction or resistance to a fluoroquinolone or azithromycin; **OR**
		• **Rifaximin 550 mg strength tablets:**
		  ○ Documented use for reduction in risk of overt hepatic encephalopathy recurrence for patients who do not adequately respond to lactulose; **OR**
		  ○ Treatment of diarrhea-predominant IBS PLUS trial and failure, contraindication, or intolerance to ALL preferred antidiarrheals (refer to Gastrointestinal, Antidiarrheals class); **AND**
		• Patient is not pregnant
			3/day	

Agents for Chronic Constipation				
Amitiza®	P		2/day	General PA Form
Linzess®	P		1/day	
lubiprostone	NP		2/day	

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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, toxic megacolon/megarectum); **AND** • Trial and failure of, or contraindication, or intolerance to, BOTH Amitiza® and Linzess®	1/day	
Movantik®	NP	• Diagnosis of opioid-induced constipation in an adult patient with chronic non-cancer pain, including patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation; **AND** • Patient does not have severe hepatic impairment (Child-Pugh Class C); **AND** • Documentation of paid claims by TennCare for at least one month of opioid therapy within the past 90 days; **AND** • Prescriber attests that Movantik® will be discontinued when opioid treatment is discontinued; **AND** • Prescriber attests that laxative therapy will be discontinued prior to the initiation of therapy; **AND** • Trial and failure or contraindication, or intolerance to Amitiza®	1/day	

Relistor® injectable	NP	• Diagnosis of opioid-induced constipation in an adult patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation:
		  ○ Documentation of paid claims by TennCare for at least one month of opioid therapy within the past 90 days; **AND**
		  ○ Trial and failure of PEG, lactulose, and Amitiza (as confirmed by paid claims by TennCare); **OR**
		• Diagnosis of opioid-induced constipation in an adult patient with advanced illness or pain caused by active cancer who requires opioid dosage escalation for palliative care:
		  ○ Must be receiving hospice; **AND**
		  ○ Trial and failure of PEG, lactulose, and Amitiza (as confirmed by paid claims by TennCare)
				General PA Form

Relistor® tablets	NP	• Diagnosis of opioid-induced constipation in an adult patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation; **AND** • Documentation of paid claims by TennCare for at least one month of opioid therapy within the past 90 days; **AND** • Trial and failure of PEG, lactulose, and Amitiza (as confirmed by paid claims by TennCare)	3/day	General PA Form

Symproic®	NP	• Diagnosis of opioid-induced constipation in an adult patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation; **AND**
		• Documentation of paid claims by TennCare for at least one month of opioid therapy within the past 90 days; **AND**
		• Prescriber attests that Symproic will be discontinued when opioid treatment is discontinued; **AND**
		• Trial and failure, contraindication, or intolerance to Amitiza®; **AND**
		• Patient does NOT have any of the following conditions:
		  ○ Known or suspected gastrointestinal obstruction
		  ○ Hypersensitivity to naldemedine tosylate
		  ○ Pregnancy
		  ○ Severe hepatic impairment (Child-Pugh Class C)
			1/day	General PA Form

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

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**
Trulance®	NP	• Age ≥ 18 years; **AND** • Patient has diagnosis of chronic idiopathic constipation (CIC); **OR** • Patient has a diagnosis of 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, BOTH Amitiza® and Linzess®	1/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		
Anti-Emetics: 5-HT3 Receptor Antagonists				
ondansetron tablets and ODT	P	**Note**: 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)	10/30 days	General PA Form
granisetron	NP	• ONE of the following: ○ Receiving highly or moderately emetogenic chemotherapy ○ Receiving radiation therapy ○ Nausea or vomiting associated with pregnancy; **AND** – Trial and failure, or contraindication to TWO conventional antiemetics (i.e., metoclopramide, prochlorperazine, dexamethasone, Diclegis) ○ Treated for post-operative nausea and vomiting (PONV); **AND** Patient has tried and failed, or has contraindication, or intolerance to preferred 5HT3 antagonist	Tabs: 60/30 days Inj: 2 mL/30 days	
ondansetron oral solution	NP	• The requested dose is not achievable with ondansetron ODT; **OR** • Allergy or intolerance to inactive ingredient in ODT tab (e.g., dye, filler, excipient) **Note**: PA is not required for patients < 6 years of age	350 mL/30 days	
Sancuso®	NP	See granisetron prior authorization criteria	1/30 days	
Anti-Emetics: 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

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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**
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 50 mg 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
Anti-Emetics: 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** • Requires dose that will not allow the use of dronabinol capsules to be opened and contents emptied on food or drink		
Antiemetics: NK-1 Receptor Antagonists				
aprepitant	NP	• ONE of the following: ○ Receiving a highly emetogenic chemotherapy regimen or the combination of an anthracycline (doxorubicin or epirubicin) and cyclophosphamide ○ Receiving a moderately emetogenic chemotherapy regimen and has failed two other antiemetic regimens; ○ Treatment for PONV with trial and failure or contraindication to a 5HT3-receptor antagonist ○ Refractory nausea that would require hospitalization **Note**: Will be approved for 3 days/treatment course up to 1 month's supply. If chemotherapy is more frequent than weekly, may approve a quantity sufficient for **THREE** days beyond the chemotherapy duration. Chronic continuous administration is not recommended.	80 mg (2/course of treatment, up to a 1-month supply); 40 mg, 125 mg, & Tri pack (1/course of treatment, up to a 1-month supply)	General PA Form

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

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**
Akynzeo®	NP	• ONE of the following: ○ Receiving a highly emetogenic chemotherapy regimen or the combination of an anthracycline (doxorubicin or epirubicin) and cyclophosphamide ○ Receiving a moderately emetogenic chemotherapy regimen and has failed other previous antiemetic regimens; **AND** • Trial and failure, contraindication, or intolerance to Emend®	1/course of treatment (up to 1-month supply)	
Emend®	NP	See aprepitant prior authorization criteria	80 mg (2/course of treatment, up to a 1-month supply); 40 mg, 125 mg, & Tri pack (1/course of treatment, up to a 1-month supply)	
Varubi®	NP	See Akynzeo® prior authorization criteria	2/course of treatment (up to 1-month supply)	
Antiemetics: Miscellaneous Agents				
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, etc); **AND** • Clinically valid reason as to why preferred Diclegis® cannot be used	2/day	
doxylamine succinate/vitamin B6	NP	• Clinically valid reason as to why preferred Diclegis® cannot be used	4/day	
Antispasmodics/Anticholinergics				
glycopyrrolate solution	P	• Patients unable to swallow tablets **Note:** No prior authorization required for patients < 8 years of age.		General PA Form
Cuvposa®	NP	• Patients unable to swallow tablets **Note**: No prior authorization required for patients < 8 years of age.		
Miscellaneous Agents for Inflammatory Bowel Disease				
budesonide DR caps	P	• Diagnosis of mild to moderate Crohn's disease involving the ileum or the ascending colon		General PA Form
Uceris® tablet	P	• Diagnosis of mild to moderate ulcerative colitis	1/day	
budesonide ER tabs	NP	• Diagnosis of mild to moderate ulcerative colitis	1/day	
Entocort EC®	NP	• Diagnosis of mild to moderate Crohn's disease involving the ileum or the ascending colon		
Ortikos ER®	NP	• Diagnosis of mild to moderate Crohn's disease involving the ileum or the ascending colon; **AND** • Clinically valid reason as to why budesonide capsules and Entocort cannot be used	1/day	

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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**
Uceris® foam	NP	• Diagnosis of mild to moderate ulcerative colitis	66.8 g/day	
H. pylori Combo Products				
Pylera®	P	• Documentation of recent positive *H. pylori* test (NOTE: For recurrent infection, antibody testing is not considered sufficient testing)	1 box/Rx (up to 2 courses of therapy per year)	General PA Form
Omeclamox®	NP	• Documentation of recent positive *H. pylori* test; **AND** • Trial and failure, contraindication, or intolerance to preferred combination agent		
lansoprazole/amox/ clarithromycin	NP	• Documentation of recent positive *H. pylori* test (NOTE: For recurrent infection, antibody testing is not considered sufficient testing); **AND** • Trial and failure, contraindication, or intolerance to preferred combination agent		
Talicia®	NP	• Documentation of recent positive H. pylori test; **AND** • Provider must provide a clinically valid reason as to why the preferred combination product (Pylera) cannot be used		
Voquezna Dual Pak®	NP	• Documentation of recent positive H. pylori test; **AND** • Trial and failure, contraindication, or intolerance to preferred combination agent	1 box/Rx (up to 2 courses of therapy per year	General PA Form
Voquezna Triple Pak®	NP	• Documentation of recent positive H. pylori test; **AND** • Trial and failure, contraindication, or intolerance to preferred combination agent	1 box/Rx (up to 2 courses of therapy per 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/Bile Acid Salts				
ursodiol	P		200, 250, 300, & 400 mg: 3/day; 500 mg: 2/day:	General PA Form

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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**
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		

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

Reltone®	NP		3/day	
Urso Forte®	NP		2/day	
Laxatives				
Sutab®	NP		24 tablets per colonoscopy	
Motility Agents				
metoclopramide	P		12-week duration limit	
metoclopramide solution	P		12-week duration limit	

Gimoti®	NP	• Patient must have acute and recurrent diabetic gastroparesis; **AND**
		• Patient is 18 years of age or older; **AND**
		• Patient does not have any of the following:
		  ○ Moderate or severe hepatic impairment (Child-Pugh B or C)
		  ○ Moderate or severe renal impairment (creatinine clearance less than 60 mL/minute)
		  ○ Concurrent use of strong CYP2D6 inhibitors
		  ○ History of tardive dyskinesia (TD) or dystonic reaction to metoclopramide
		  ○ Pheochromocytoma, catecholamine-releasing paragangliomas
		  ○ Epilepsy
		  ○ Hypersensitivity to metoclopramide
		  ○ Depression and suicidal ideation
		  ○ Gastrointestinal hemorrhage, mechanical obstruction, or perforation; **AND**
		• Prescriber must provide a clinically valid reason (e.g., unable to swallow, allergy to inactive ingredients, etc.) as to why oral metoclopramide (including solution) cannot be used
			1 sprayer per Rx	General PA Form

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	

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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**
Mucosal Protectants				
Carafate® suspension	NP	• Has a trial and failure or intolerance to sucralfate tablets, **OR** • Has documented difficulty swallowing/dysphagia **Note:** Prior authorization is not required for patients 13 years of age and under.		General PA Form
sucralfate suspension	NP	See Carafate suspension prior authorization criteria **Note:** Prior authorization is not required for patients 13 years of age and under.		
Proton Pump Inhibitors				
Dexilant®	P		1/day	
Nexium® Granules	P	• Patient must be unable to swallow whole tablets	*See below for 2/day quantity limit criteria	
pantoprazole	P			
Protonix® suspension	P			
omeprazole	P			
Omeprazole ODT	P			
Aciphex®	NP			
Aciphex® sprinkles	NP	• Patient must be unable to swallow whole tablets; **AND** • Trial, failure, contraindication, or intolerance to Protonix® suspension		
dexlansoprazole	NP			
esomeprazole	NP			
esomeprazole suspension packets	NP	• Patient must be unable to swallow whole tablets; **AND** • Trial, failure, contraindication, or intolerance to Protonix® suspension and Nexium granules		

First-Lansoprazole®	NP	• Patient is unable to swallow oral dosage forms in the last 30 days; **OR**
		• Patient is unable to absorb medications through the GI tract (G-tube); **OR**
		• Both of the following:
		  ○ Patient is unable to swallow solid oral dosage forms in the past 30 days; **AND**
		  ○ Trial, failure, contraindication, or intolerance to Protonix suspension packets (age over 5 and at least 40kg)
		Note: No PA required for members 5 years of age and younger.		

Konvomep®	NP	• Patient is unable to swallow oral dosage forms in the last 30 days; **OR**
		• Patient is unable to absorb medications through the GI tract (G-tube); **OR**
		• Both of the following:
		  ○ Patient is unable to swallow solid oral dosage forms in the past 30 days; **AND**
		  ○ Trial, failure, contraindication, or intolerance to Protonix suspension packets (age over 5 and at least 40kg)
		Note: No PA required for members less than 6 years old		

lansoprazole	NP			
lansoprazole ODT	NP			
Nexium®	NP			

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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**
omeprazole/sodium bicarbonate	NP			
pantoprazole suspension	NP	• Clinically valid reason why the preferred Protonix® suspension cannot be used		
Prevacid®	NP			
Prevacid Solutab®	NP	• Patient must be unable to swallow; **OR** • Patient must be unable to absorb medications through the GI tract; **OR** • Patient must be unable to swallow solid oral dosage forms; **AND** trial, failure, contraindication, or intolerance to Protonix® suspension		
Prilosec®	NP			
Protonix® tablets	NP			
rabeprazole	NP			
Zegerid®	NP			
		Twice-daily dosing for PPIs will be approved for the any of the following: • Treatment of H. Pylori (duration up to 1 month); **OR** • Treatment of GI Bleed/Hemorrhagic Gastritis (duration up to 1 year); **OR** • Patient has a diagnosis of Barrett's Esophagus with documentation of uncontrolled reflux symptoms or esophagitis (following a trial of once daily PPI therapy); **OR** • Uncontrolled symptoms following a 30-day trial of once daily PPI therapy (Duration up to 6-months); renewals will require member to attempt step down to once daily PPI therapy, if patient fails step down to once daily dosing will not be asked to step down again		
Saliva Stimulating Agents				
pilocarpine	P	• Documentation of diagnosis of Sjögren's syndrome OR radiation-induced xerostomia.	3/day	General PA Form
cevimeline	NP	See pilocarpine prior authorization criteria	3/day	
Evoxac®	NP	See pilocarpine prior authorization criteria	3/day	
Salagen®	NP	See pilocarpine prior authorization criteria	3/day	

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

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

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

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

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

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**

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**
		• One of the following:
		  ○ Patient is 4 to 17 years of age AND Patient is in the initial dose escalation phase; **OR**
		  ○ Patient is 4 years of age and older AND Patient is in the up-dosing or maintenance phase of therapy; **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

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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.
				General PA Form

Anti-Inflammatory: Immunoglobulins				

Adbry®	P	**Initial Criteria (6-monthduration):**
		• 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., pruritus, BSA involvement, EASI, IGA, SCORAD)
			Initial month:
			6 syringes/28 days
			
			Maintenance:
			4 syringes/28 days
				General PA Form

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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	**Eosinophilic or Corticosteroid-Dependent Asthma Diagnosis**
		Initial Criteria (6-monthduration):
		• Patient is ≥ 6 years old; **AND**
		• One of the following:
		  ○ Patient is currently dependent on oral corticosteroids for the treatment of asthma; **OR**
		  ○ Dupixent will be used to treat eosinophilic asthma as defined by one of the following:
		  – Baseline (pre-treatment) peripheral blood eosinophil level > 150 cells per microliter
		  – Peripheral blood eosinophil levels > 300 cells/microliter within the past 12 months; **AND**
		  • Asthma is inadequately controlled as shown by one of the following:
		  ○ One or more asthma exacerbations requiring systemic corticosteroids within the past 12 months
		  ○ Any prior intubation for an asthma exacerbation
		  ○ Prior asthma-related hospitalization within the past 12 months; **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)
		  – One additional asthma controller medication [e.g., long-acting beta-2 agonist LABA, leukotriene receptor antagonist, theophylline]; **OR**
		  ○ One maximally dosed combination inhaled corticosteroid (ICS)/ LABA) product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol]); **AND**
		• Dupixent 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 in forced expiratory volume in 1 second [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 corticosteroid (ICS)/ LABA) product
		Diagnosis of Prurigo Nodularis (PN)
		Initial Criteria:
		• Patient age ≥ 18 years; **AND**
		• Both of the following:
		  ○ WI-NRS ≥ 7 on a scale of 0 to 10
		  ○ Patient has 20 or more nodular lesions (IGA PN-S ≥ 3); **AND**
		• Inadequate response, intolerance, or contraindication to a topical Steroid OR topical calcineurin inhibitor; **AND**
		• Prescribed by, or in consultation with, a pulmonologist, allergist, or immunologist
		Renewal Criteria:
		Documentation of positive clinical response (e.g., improved WI-NRS or IGA PN-S score)
			2 syringes/28 days	General PA Form

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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	**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., pruritus, BSA involvement, EASI, IGA, SCORAD)
		Chronic rhinosinusitis with nasal polyposis (CRSwNP) Diagnosis
		Initial Criteria (6-month duration):
		• Patient is ≥ 18 years of age; **AND**
		• One of the following:
		  ○ Presence of bilateral nasal polyps
		  ○ Patient has previously required surgical removal of bilateral nasal polyps; **AND**
		• Documentation of inadequate response, intolerance, or contraindication to BOTH of the following:
		  ○ Nasal corticosteroid spray
		  ○ Oral corticosteroid; **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
		Eosinophilic Esophagitis (EoE) Diagnosis
		Initial Criteria (6-month duration):
		• Patient weighs at least 15 kg; **AND**
		• Provider attests that patient meets both of the following:
		  ○ ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) following treatment course of a proton pump inhibitor
		  ○ Symptoms of dysphagia as measured by the Dysphagia Symptom Questionnaire (DSQ); **AND**
		• Trial and failure, or contraindication, to swallowed inhaled corticosteroids such as budesonide or fluticasone; **AND**
		• Prescribed by, or in consultation with, a gastroenterologist, allergist, or immunologist
		Renewal Criteria:
		• Provider attests patient's clinical improvement is demonstrated by reduction in esophageal intraepithelial eosinophil count or symptoms of dysphagia
			2 syringes/28 days	General PA Form

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

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	**Initial Criteria (6-month duration):**
		• Diagnosis of severe asthma; **AND**
		• Patient is ≥ 12 years old; **AND**
		• One of the following:
		  ○ Patient is currently dependent on oral corticosteroids for the treatment of asthma; **OR**
		  ○ Fasenra will be used to treat eosinophilic asthma as defined by one of the following:
		  – Baseline (pre-treatment) peripheral blood eosinophil level > 150 cells per microliter
		  – Peripheral blood eosinophil levels > 300 cells/microliter within the past 12 months; **AND**
		  • Asthma is inadequately controlled as shown by one of the following:
		  ○ One or more asthma exacerbations requiring systemic corticosteroids within the past 12 months
		  ○ Any prior intubation for an asthma exacerbation
		  ○ Prior asthma-related hospitalization within the past 12 months; **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., long-acting beta-2 agonist LABA, leukotriene receptor antagonist, theophylline]; **OR**
		  ○ One maximally dosed combination inhaled corticosteroid (ICS)/ LABA) product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol]); **AND**
		• Fasenra 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 in forced expiratory volume in 1 second [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 corticosteroid (ICS)/ LABA) product
			Initial (first 3 doses): 1/30 days
			
			Maintenance: 1/56 days
				General PA Form

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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	**Severe Asthma Diagnosis**
		Initial Criteria (6-month duration):
		• Patient is ≥ 6 years old; **AND**
		• One of the following:
		  ○ Patient is currently dependent on oral corticosteroids for the treatment of asthma; **OR**
		  ○ Nucala will be used to treat eosinophilic asthma as defined by one of the following:
		  – Baseline (pre-treatment) peripheral blood eosinophil level > 150 cells per microliter
		  – Peripheral blood eosinophil levels > 300 cells/microliter within the past 12 months; **AND**
		  • Asthma is inadequately controlled as shown by one of the following:
		  ○ One or more asthma exacerbations requiring systemic corticosteroids within the past 12 months
		  ○ Any prior intubation for an asthma exacerbation
		  ○ Prior asthma-related hospitalization within the past 12 months; 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., long-acting beta-2 agonist LABA, leukotriene receptor antagonist, theophylline]; **OR**
		  ○ One maximally dosed combination inhaled corticosteroid (ICS)/ LABA) product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol]); **AND**
		• Nucala 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 in forced expiratory volume in 1 second [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 corticosteroid (ICS)/ LABA) product
		Eosinophilic granulomatosis with polyangiitis (EGPA) Diagnosis
		Initial Criteria (6-month duration):
		• Trial and failure, or contraindication, to treatment with azathioprine, cyclophosphamide, or methotrexate; **AND**
		• Patient's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy); **AND**
		• Patient is currently receiving corticosteroid therapy (e.g., prednisolone, prednisone); **AND**
		• Prescribed by, or in consultation with, a pulmonologist, rheumatologist, allergist, or immunologist
		Renewal Criteria:
		• Documentation of positive clinical response to therapy (e.g., increase in remission time)
			3 pens or syringes / 28 days	General PA Form

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

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) Diagnosis**
		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**
		• Prescribed by, or in consultation with a pulmonologist, rheumatologist, allergist, or immunologist; **AND**
		• Patient has tried and failed Gleevec (imatinib)
		Renewal Criteria:
		• Documentation of positive clinical response to therapy
		Chronic rhinosinusitis with nasal polyps (CRSwNP) Diagnosis
		Initial Criteria (6-month duration):
		• Patient is ≥ 18 years of age; **AND**
		• One of the following:
		  ○ Presence of bilateral nasal polyps
		  ○ Patient has previously required surgical removal of bilateral nasal polyps; **AND**
		• Documentation of inadequate response, intolerance, or contraindication to BOTH of the following:
		  ○ Nasal corticosteroid spray
		  ○ Oral corticosteroid; **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

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

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	**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:
		  ○ One or more asthma exacerbations requiring systemic corticosteroids within the past 12 months
		  ○ Any prior intubation for an asthma exacerbation
		  ○ Prior asthma-related hospitalization within the past 12 months; **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., long-acting beta-2 agonist LABA, leukotriene receptor antagonist, theophylline]; **OR**
		  ○ One maximally dosed combination inhaled corticosteroid (ICS)/ LABA) product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol]); **AND**
		• Tezspire 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 in forced expiratory volume in 1 second [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 corticosteroid (ICS)/ LABA) product
			4 pens or syringes /28 days	General PA Form

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

Xolair®	P	**Moderate to Severe Allergic Asthma or Nonallergic Eosinophilic Asthma Diagnosis**
		Initial Criteria (6-month duration):
		• Patient is ≥ 6 years old; **AND**
		• Dose requested is consistent with corresponding weight and IgE level per manufacturer's dosing chart; **AND**
		• One of the following:
		  ○ Xolair will be used to treat eosinophilic asthma as defined by one of the following:
		  – Baseline (pre-treatment) peripheral blood eosinophil level > 150 cells per microliter
		  – Peripheral blood eosinophil levels > 300 cells/microliter within the past 12 months
		  ○ Xolair will be used to treat persistent allergic asthma
		  ○ Patient is currently dependent on oral corticosteroids for the treatment of asthma; **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:
		  ○ One or more asthma exacerbations requiring systemic corticosteroids within the past 12 months
		  ○ Any prior intubation for an asthma exacerbation
		  ○ Prior asthma-related hospitalization within the past 12 months; **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., long-acting beta-2 agonist LABA, leukotriene receptor antagonist, theophylline]; **OR**
		  ○ One maximally dosed combination inhaled corticosteroid (ICS)/ LABA) product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol]); **AND**
		• Xolair 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 in forced expiratory volume in 1 second [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 corticosteroid (ICS)/ LABA) product
		Chronic Idiopathic Urticaria (CIU) Diagnosis
		Initial Criteria (6-month duration):
		• Patient is ≥ 12 years of age; **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, loratadine)
		  – 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

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

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)
		Nasal polyps Diagnosis
		Initial Criteria (6-monthduration):
		• Patient is ≥ 18 years of age; **AND**
		• Patient has chronic rhinosinusitis; **AND**
		• One of the following:
		  ○ Presence of bilateral nasal polyps
		  ○ Patient has previously required surgical removal of bilateral nasal polyps; **AND**
		• Documentation of inadequate response, intolerance, or contraindication to BOTH of the following:
		  ○ Nasal corticosteroid spray
		  ○ Oral corticosteroid; **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		

Cibinqo®	NP	**Initial criteria (6-monthduration):**
		• 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 Dupixent or Adbry
		Renewal Criteria:
		• Documented positive response to therapy (e.g., pruritus, BSA involvement, EASI, IGA, SCORAD)
			1/day	General PA Form

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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				

Enbrel®,
Enbrel Mini Cartridge®,
Enbrel Sureclick®
	P	**Initial Criteria (6-monthduration):**
		• Diagnosis of Ankylosing Spondylitis
		• Diagnosis of Juvenile Rheumatoid Arthritis (JRA), Juvenile Idiopathic Arthritis, or Active Juvenile Psoriatic Arthritis (JPsA):
		  ○ Trial and failure, contraindication, or intolerance to methotrexate
		• Diagnosis of chronic, moderate to severe Plaque Psoriasis:
		  ○ 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
		• Diagnosis of MILD Psoriatic Arthritis
		  ○ Trial and failure, contraindication, or intolerance to methotrexate
		• Diagnosis of moderate to severe Psoriatic Arthritis
		• Diagnosis of Rheumatoid Arthritis:
		  ○ Trial and failure, contraindication, or intolerance to methotrexate; **AND**
		  ○ If methotrexate is contraindicated, trial and failure of another oral DMARD is required
		Renewal Criteria:
		• Patient continues to meet initial approval criteria; **AND**
		• 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, etc.)
			25 mg dose:
			8 syringes/28 days
			
			50 mg dose:
			4 syringes/28 days
				General PA Form

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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**

Humira®,
Hadlima® 40 mg/0.4 mL
	P	**Initial Criteria (6-monthduration):**
		• Diagnosis of Ankylosing Spondylitis
		• Diagnosis of Juvenile Rheumatoid Arthritis (JRA) or Juvenile Idiopathic Arthritis
		• Diagnosis of chronic, moderate to severe Plaque Psoriasis:
		  ○ 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
		• Diagnosis of MILD Psoriatic Arthritis:
		  ○ Trial and failure, contraindication, or intolerance to methotrexate
		• Diagnosis of moderate to severe Psoriatic Arthritis
		• Diagnosis of Rheumatoid Arthritis:
		  ○ Trial and failure, contraindication, or intolerance to methotrexate; **AND**
		  ○ If methotrexate is contraindicated, trial and failure of another oral DMARD is required
		• Diagnosis of MILD Ulcerative Colitis:
		  ○ Trial and failure of a corticosteroid OR an immunosuppressive agent
		• Diagnosis of moderate to severe Ulcerative Colitis
		• Diagnosis of Chron's disease and ONE off the following:
		  ○ Previous trial and failure of infliximab in the past 365 days
		  ○ Diagnosis of Crohn's disease classified as moderate, severe, or fistulizing
		  ○ >90 days of drug therapy with one of the following: azathioprine, mercaptopurine, mesalamine, methotrexate, or systemic glucocorticoid
		• Diagnosis of moderate to severe Hidradenitis Suppurativa (HS)
		  ○ >90 days of drug therapy with one of the following: oral or topical antibiotic therapy, oral retinoid therapy, dapsone, or acitretin
		• Diagnosis of non-infectious intermediate, posterior or panuveitis:
		  ○ Diagnosis of Uveitis must be by, or in consultation with, an ophthalmologist
		  ○ >90 days of drug therapy with one of the following: oral/injectable steroid therapy, methotrexate, mycophenolate, azathioprine, cyclosporine, tacrolimus, cyclophosphamide
		Renewal Criteria:
		• Patient continues to meet initial approval criteria; AND
		• 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, <UC disease activity index, reduction in inflammatory bumps/abscesses, decreases in flares, etc.)
			2 syringes/28 days
			
			Starter Packs:
			1 kit/28 days
			
			Hidradenitis Suppurativa (HS) diagnosis only:
			4 syringes/28 days	

Kineret®	P	**Initial Criteria (6-monthduration):**
		• Diagnosis of Rheumatoid Arthritis:
		  ○ Trial and failure, contraindication, or intolerance to methotrexate; **AND**
		  ○ If methotrexate is contraindicated, trial and failure of another oral DMARD is required
		• Diagnosis of Neonatal-Onset Multisystem Inflammatory Disease (NOMID)
		• Diagnosis of Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
		Renewal Criteria:
		• Patient continues to meet initial approval criteria; **AND**
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of tender and swollen joint counts, etc.)
			1 syringe/ day	General PA Form

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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**

Orencia®	P	**Initial Criteria (6-monthduration):**
		• Diagnosis of Rheumatoid Arthritis:
		  ○ Trial and failure, contraindication, or intolerance to methotrexate; **AND**
		  ○ If methotrexate is contraindicated, trial and failure of another oral DMARD is required
		• Diagnosis of Polyarticular Juvenile Idiopathic Arthritis
		  ○ Trial and failure, contraindication, or intolerance to methotrexate
		• Diagnosis of MILD Psoriatic Arthritis:
		  ○ Trial and failure, contraindication, or intolerance to methotrexate
		• Diagnosis of moderate to severe Psoriatic Arthritis
		• Prophylaxis of acute graft versus host disease:
		  ○ In combination with a calcineurin inhibitor and methotrexate; **AND**
		  ○ In patients undergoing hematopoietic stem cell transplantation from a matched or 1 allele-mismatched unrelated-donor
		Renewal Criteria:
		• Patient continues to meet initial approval criteria; **AND**
		• 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, etc.)
			4 mL/28 days	General PA Form

Otezla®	P	**Initial Criteria (6-monthduration):**
		• Diagnosis of Plaque Psoriasis:
		  ○ 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
		• Diagnosis of MILD Psoriatic Arthritis:
		  ○ Trial and failure, contraindication, or intolerance to methotrexate
		• Diagnosis of moderate to severe Psoriatic Arthritis
		• Diagnosis of oral lesions associated with Behçet's Disease
		  ○ Patient has active oral ulcers; **AND**
		  ○ Trial and failure, contraindication, or intolerance to colchicine; **AND**
		  ○ Trial and failure, contraindication, or intolerance to a corticosteroid, methotrexate, or azathioprine
		Renewal Criteria:
		• Patient continues to meet initial approval criteria; **AND**
		• 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, etc.)
			30 mg: 2/day
			Starter Pack: 1/Rx
				General PA Form

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

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-monthduration):**
		• Diagnosis of chronic, moderate to severe Plaque Psoriasis; **AND**
		  ○ Patient is 6 years of age or older; **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
		• Diagnosis of MILD Psoriatic Arthritis:
		  ○ Trial and failure, contraindication, or intolerance to methotrexate
		• Diagnosis of moderate to severe Psoriatic Arthritis
		• Diagnosis of Axial spondyloarthrisis (axSpA), Active Ankylosing Spondylitis (AS), or Active non-radiographic axial spondyloarthritis (nr-axSpA)
		Renewal Criteria:
		• Patient continues to meet initial approval criteria; **AND**
		• 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, etc.)
			1 syringe/28 days	General PA Form

Abrilada®	NP	**Initial Criteria (6-monthduration):**
		• Diagnosis of one of the following:
		  – Ankylosing Spondylitis
		  – Psoriatic Arthritis:
		  – Rheumatoid Arthritis
		  – Juvenile Idiopathic Arthritis (JIA)
		  – Plaque Psoriasis; **AND**
		  ○ Trial and failure, contraindication, or intolerance to TWO preferred immunomodulators with same indication; **OR**
		• Diagnosis of Crohn's Disease; **AND**
		  ○ Trial and failure, contraindication, or intolerance to Humira/Hadlima 40 mg/0.4 mL, Entyvio, or infliximab; **OR**
		• Diagnosis of moderate to severe Hidradenitis Suppurativa (HS); **AND**
		  ○ Trial and failure, contraindication, or intolerance of Humira/Hadlima 40 mg/0.4 mL; **OR**
		• Diagnosis of Ulcerative Colitis:
		  ○ Trial and failure to two of the following (or have an intolerance or contraindication to all agents):
		  – Humira or Hadlima 40 mg/0.4 mL
		  – Entyvio
		  – Infliximab
		  – Xeljanz
		  – Rinvoq
		Renewal Criteria:
		• Patient continues to meet initial approval criteria; **AND**
		• 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, endoscopic remission etc.)
			2 injectors/28 days	General PA Form

adalimumab	NP	See Abrilada® prior authorization criteria	2 injectors/28 days	

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

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**

Actemra®,
Actemra ACTPen®
	NP	**Initial Criteria (6-monthduration):**
		• Diagnosis of Rheumatoid Arthritis:
		  ○ Trial and failure, contraindication, or intolerance to methotrexate; **AND**
		  ○ Trial and failure, contraindication, or intolerance to Enbrel or Humira/Hadlima 40 mg/0.4 mL
		• Diagnosis of active Polyarticular Juvenile Idiopathic Arthritis
		  ○ Trial and failure, contraindication, or intolerance to methotrexate
		  ○ Trial and failure, contraindication, or intolerance to Enbrel or Humira/Hadlima 40 mg/0.4 mL
		• Diagnosis of active Systemic Juvenile Idiopathic Arthritis
		• Diagnosis of Giant Cell Arteritis:
		  ○ Trial and failure of > 90 days of drug therapy with systemic glucocorticoids, azathioprine, or methotrexate; **OR**
		  ○ Occurrence of GCA relapse while patient on prednisone doses greater than 20 mg/day, **OR**
		  ○ Contraindication or intolerance to all the above agents
		• Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD):
		  ○ 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:
		• Patient continues to meet initial approval criteria; **AND**
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of tender and swollen joint counts, etc.)
			3.6 mL/28 days	General PA Form

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

Arcalyst®	NP	• Patient has diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS), and Muckle-Wells Syndrome (MWS); **OR**
		• Patient has 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**
		• Patient has diagnosis of recurrent pericarditis (RP) and meets all of the following:
		• Trial and failure, contraindication, or intolerance to ONE of the following:
		  ○ Colchicine
		  ○ Corticosteroids
		  ○ NSAIDS
			8 vials/month	General PA Form

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

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**
Bimzelx®	NP	**Initial Criteria** • Diagnosis of chronic, moderate to severe Plaque Psoriasis; **AND** • Patient has a contraindication, drug-drug interaction, or adverse reaction to ALL preferred immunomodulator agents with same indication; **AND** • Patient has been evaluated and screened for the presence of latent tuberculosis (TB) infection prior to initiating treatment; **AND** • Patient will not receive live vaccines during therapy; **Renewal Criteria** • Patient continues to meet initial approval criteria; **AND** • Disease response to therapy and tolerability compared to baseline (e.g., a 50% reduction of total Psoriasis Area Severity Index (PASI) score, etc.)	2 injections/ 56 days	General PA Form

Cimzia®	NP	**Initial Criteria (6-monthduration):**
		• One of the following:
		  ○ Diagnosis of one of the following:
		  – Ankylosing Spondylitis
		  – Psoriatic Arthritis:
		  – Rheumatoid Arthritis
		  – Plaque Psoriasis; **AND**
		  ○ Trial and failure, contraindication, or intolerance to TWO preferred immunomodulators with same indication, **OR**
		• Diagnosis of Crohn's Disease; **AND**
		  ○ Trial and failure, contraindication, or intolerance to Humira/Hadlima 40 mg/0.4 mL, Entyvio, or infliximab
		Renewal Criteria:
		• Patient continues to meet initial approval criteria; **AND**
		• 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, endoscopic remission etc.)
			2 kits/28 days
			(4 syringes)
				General PA Form

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

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**

Cosentyx®	NP	**Initial Criteria (6-monthduration):**
		• Diagnosis of chronic, moderate to severe Plaque Psoriasis in patients 6 years of age and older; **AND**
		  ○ Trial and failure, contraindication, or intolerance to TWO preferred immunomodulators with same indication
		• Diagnosis of Ankylosing Spondylitis in adults; **AND**
		  ○ Trial and failure, contraindication, or intolerance to TWO preferred immunomodulators with same indication
		• Diagnosis of Psoriatic Arthritis in patients 2 years of age and older; **AND**
		  ○ Trial and failure, contraindication, or intolerance to TWO preferred immunomodulators with same indication
		• Diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; **AND**
		  ○ Trial and failure, contraindication, or intolerance of Taltz
		• Diagnosis of Active Enthesitis-related arthritis in patients 4 years of age and older; **AND**
		  ○ Failed an adequate trial of TWO NSAIDs (unless contraindicated); **AND**
		• Diagnosis of moderate to severe Hidradenitis Suppurativa (HS); **AND**
		  ○ Trial and failure, contraindication, or intolerance of Humira/Hadlima 40 mg/0.4 mL
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• 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, reduction in inflammatory bumps/abscesses, decreases in flares, etc.)
			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

Cyltezo®	NP	See Abrilada® prior authorization criteria	2 injectors/28 days	
Entyvio®	NP	**Initial Criteria: (4-month duration)** • Diagnosis of moderate to severe ulcerative colitis (UC); **AND** • Trial and failure, contraindication, or intolerance 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:** • Diagnosis of moderate to severe ulcerative colitis; **AND** • 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) **Note**: Entyvio should be discontinued in patients who do not show evidence of therapeutic benefit by week 14. Entyvio SC formulation is not FDA approved for Crohn's Disease and will not be approved for that diagnosis.		General PA Form
Hadlima (low concentration)®	NP	See Abrilada® prior authorization criteria	2 injectors/28 days	
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	

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

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**

Kevzara®	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of Rheumatoid Arthritis:
		  ○ Trial and failure, contraindication, or intolerance to 2 preferred immunomodulators with same indication: **AND**
		  ○ Patient has been evaluated and screened for the presence of latent TB infection prior to initiating treatment and continues to be screened during therapy; **OR**
		• Diagnosis of Polymyalgia Rheumatic; AND
		  ○ Trial and failure, contraindication, or intolerance to systemic corticosteroids; **AND**
		  ○ Patient will not receive live vaccines during therapy or for 30 days prior to initiation of therapy.
		• Will NOT be approved if patient meets ANY of the following:
		  ○ Active infection, including clinically important localized infections
		  ○ Absolute neutrophil count (ANC) < 2,000/mm3
		  ○ Platelet count < 150,000/mm3
		  ○ AST or ALT > 1.5 times the upper limit of normal (ULN)
		Renewal Criteria (6-month duration):
		• Patient continues to meet initial approval criteria; **AND**
		• Disease response to therapy and tolerability compared to baseline (e.g., decrease in number of tender and swollen joint counts)
			2 pens or syringes /30 days	General 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):
		  ○ Humira or Hadlima 40 mg/0.4 mL
		  ○ Entyvio
		  ○ Infliximab
		  ○ Xeljanz
		  ○ Rinvoq
		Renewal Criteria:
		• Patient continues to meet the initial criteria; **AND**
		• Disease response to therapy and tolerability compared to baseline (e.g. endoscopic remission etc.)
			2 auto-injectors/28 days	General PA Form

Siliq®	NP	**Initial Criteria (6-month duration):** • Patient has a diagnosis of moderate to severe plaque psoriasis; **AND** • Patient has a contraindication, drug-drug interaction, or adverse reaction to ALL preferred immunomodulator agents with same indication; **AND** • Patient has been evaluated and screened for the presence of latent tuberculosis (TB) infection prior to initiating treatment; **AND** • Patient will not receive live vaccines during therapy; **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:** • Patient continues to meet initial approval criteria; **AND** • Disease response to therapy and tolerability compared to baseline (e.g., a 50% reduction of total Psoriasis Area Severity Index (PASI) score, etc.)	2 syringes/28 days	General PA Form

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

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, Psoriatic Arthritis, or Rheumatoid Arthritis:
		  ○ Trial and failure, contraindication, or intolerance to 2 preferred immunomodulators with same indication
		• Diagnosis of Ulcerative Colitis:
		  ○ Trial and failure to two of the following (or have an intolerance or contraindication to all agents):
		  – Humira or Hadlima 40 mg/0.4 mL
		  – Entyvio
		  – Infliximab
		  – Xeljanz
		  – Rinvoq
		Renewal Criteria:
		• Patient continues to meet initial approval criteria; **AND**
		• 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, endoscopic remission etc.)
			1 syringe /28 days	

Skyrizi®	NP	**Initial Criteria (6-month duration):**
		• Age 18 years or older; **AND**
		• Patient has been evaluated for the presence of latent TB infection prior to initiating treatment and continues to monitor during treatment; **AND**
		• Patient does not have a clinically important active infection; **AND**
		• Patient will not receive live vaccines during therapy or for 30 days prior to initiation of therapy; **AND**
		• ONE of the following:
		  ○ Diagnosis of moderate-to-severe plaque psoriasis (PsO); **AND**
		  – One of the following:
		  • Involvement of at least 10% of body surface area (BSA)
		  • Psoriasis area and severity index (PASI) score of 12 or greater
		  • Incapacitation due to plaque location (e.g., head and neck, palms, soles, or genitalia); **AND**
		  – Patient did not respond adequately (or is not a candidate) to a 3-month minimum trial of phototherapy (e.g., Psoralens with UVA light [PUVA] or UVB with coal tar or dithranol); **AND**
		  – Trial and failure, contraindication, or intolerance to 2 preferred immunomodulators with same indication
		  ○ Diagnosis of active psoriatic arthritis (PsA) for at least 6-months; **AND**
		  – ≥ 5 tender joints and ≥ 5 swollen joints, active plaque psoriasis or psoriatic nail disease at baseline; **AND**
		  – Trial and failure, contraindication, or intolerance to 2 preferred immunomodulators with same indication
		  ○ Diagnosis of moderately to severely active Crohn's disease (CD); **AND**
		  – Patient has a Crohn's disease activity index (CDAI) of 220 to 450; **AND**
		  – Simple endoscopic score for Crohn's disease (SES-CD) ≥6 (or ≥4 for isolated ileal disease); **AND**
		  – Trial and failure, contraindication, or intolerance to 2 preferred immunomodulators with same indication
		Renewal Criteria:
		• Patient continues to meet the initial criteria; **AND**
		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, endoscopic remission etc.)
			Cartridge: 1 per 8 weeks
			
			Auto-injector, pre-filled syringe, and pre-filled syringe kit: 2 per 84 days	

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

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

Stelara®	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of Plaque Psoriasis:
		  ○ Trial and failure, contraindication, or intolerance to 2 preferred immunomodulators with same indication
		• Diagnosis of Psoriatic Arthritis**:**
		  ○ Trial and failure, contraindication, or intolerance to 2 preferred immunomodulators with same indication
		• Diagnosis of Crohn's disease or Ulcerative Colitis:
		  ○ Trial and failure to two of the following (or have an intolerance or contraindication to all agents):
		  – Humira or Hadlima 40 mg/0.4 mL
		  – Entyvio
		  – Infliximab
		  – Xeljanz
		  – Rinvoq
		Renewal Criteria:
		• Patient continues to meet the initial criteria; **AND**
		• 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, endoscopic remission etc.)
			Plaque Psoriasis, Psoriatic Arthritis: 1 pen/84 days
			
			Crohn's Disease and Ulcerative Colitis: 1 pen/56 days
				General PA Form

Tremfya® autoinjector	NP	• Patient must meet ALL Tremfya prefilled-syringe criteria **AND** • Provider must provide clinical rationale as to why the autoinjector is required over the prefilled syringe	1 autoinjector (1 mL) / 56 days	

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

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® pre-filled syringe	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of Plaque Psoriasis:
		  ○ Age 18 years or older; **AND**
		  ○ Patient has been evaluated for the presence of latent TB infection prior to initiating treatment and will be monitored throughout treatment; **AND**
		  ○ Patient does not have a clinically important active infection; **AND**
		  ○ Patient will not receive live vaccines during therapy or for 30 days prior to initiation of therapy; **AND**
		  ○ Patient has moderate-to-severe plaque psoriasis for at least 6-months with at least 1 of the following:
		  – Involvement of at least 10% of body surface area (BSA); **OR**
		  – Psoriasis Area and Severity Index (PASI) score of 12 or greater; **OR**
		  – Incapacitation due to plaque location (e.g., head and neck, palms, soles, or genitalia); **AND**
		  ○ Patient did not respond adequately (or is unable to access) to a 3-month minimum trial of phototherapy (e.g., Psoralens with UVA light [PUVA] or UVB with coal tar or dithranol); **AND**
		  ○ Trial and failure to ALL preferred immunomodulator agents with the same indication
		• Diagnosis of Psoriatic Arthritis:
		  ○ Trial and failure, contraindication, or intolerance to 2 preferred immunomodulators with same indication
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• 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, etc.)
			1 syringe (1 mL) / 56 days	General PA Form

Velsipity®	NP	**Initial Criteria (3-month duration)**
		• Patient is ≥ 18 years old; **AND**
		• 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):
		  ○ Humira
		  ○ Entyvio
		  ○ Infliximab
		  ○ Xeljanz
		  ○ Rinvoq
		• 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
		  ○ 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
		• Patient continues to meet initial criteria; **AND**
		• Disease response to therapy and tolerability compared to baseline (e.g., endoscopic remission, decreased stool frequency, decreased rectal bleeding)
			1/day	General PA Form

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

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

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				
Rapamune ®	P	• Patient is a transplant recipient; **OR** • Patient has a diagnosis of lymphangioleiomyomatosis		General PA Form
Zortress®	P	• 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. • New recipients requiring immunosuppressants for autoimmune diseases (i.e., rheumatoid arthritis, plaque psoriasis) will be required to have tried and failed at least one preferred medication(s) within the same class.		
Astagraf XL®	NP	• See Zortress® prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance to ONE preferred agent		
Azasan®	NP	See Zortress® prior authorization criteria		

Benlysta®	NP	**Initial Criteria (6-month duration):**
		• One of the following:
		  ○ Patient is ≥ 5 years of age AND has a diagnosis of active systemic lupus erythematosus (SLE)
		  ○ Patient is ≥ 18 years of age AND has a diagnosis of active lupus nephritis; **AND**
		• Prescribed by a specialist (e.g., rheumatologist); **AND**
		• Condition is unresponsive to standard treatment regimen corticosteroids and other immunosuppressive agents; **AND**
		• Must be used in combination with standard treatment regimens (e.g., corticosteroids, mycophenolate, azathioprine, hydroxychloroquine); **AND**
		• Will NOT be approved for the following:
		  ○ Severe active lupus nephritis (proteinuria > 6 g/24 hr or serum creatinine > 2.5 mg/dL)
		  ○ Severe active central nervous system lupus
		Renewal Criteria:
		• Patient meets the Initial Criteria; **AND**
		• ONE of the following:
		  ○ Patient's daily required dose of oral corticosteroids has decreased since the previous authorization
		  ○ Patient has documented improvement in functional impairment
		  ○ Patient has experienced a decrease in the number exacerbations since initiating belimumab
			4 syringes/28 days	

CellCept® tablets and capsules	NP	See Zortress® prior authorization criteria		
Envarsus® XR	NP	• See Zortress® prior authorization criteria; **AND** • Trial and failure, contraindication, or intolerance to ONE preferred agent	3/day	
everolimus dispersible tabs	NP	• Patient is unable to swallow solid dosage forms		
Imuran®	NP	See Zortress® prior authorization criteria		

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

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 (6-month duration):**
		• Patient must be 18 years of age or older; **AND**
		• Patient must have a diagnosis of systemic lupus erythematosus; **AND**
		• Patient has active lupus nephritis with one of the following:
		  ○ Class III or IV with a urine protein to creatinine (UPCR) ratio of ≥1.5 mg/mg
		  ○ Class V with a UPCR of ≥2 mg/mg; **AND**
		• Must take in combination with mycophenolate mofetil and corticosteroids; **AND**
		• Patient tried and failed mycophenolate mofetil and corticosteroid treatment alone prior to adding on Lupkynis; **AND**
		• Will NOT take in combination with cyclophosphamide; **AND**
		• Must be prescribed by, or in consultation with, a rheumatologist or nephrologist; **AND**
		• Patient must avoid grapefruit or grapefruit juice during therapy; **AND**
		• Patient must have a baseline estimated glomerular filtration rate (eGFR) of > 45 mL/min/1.73 m2; **AND**
		• Prescriber must assess eGFR every two weeks for the first month, and every four weeks thereafter; **AND**
		• Prescriber must attain blood pressure (BP) at baseline, and assess every 2 weeks for the first month after initial dosage, and as clinically indicated thereafter; **AND**
		• Patient must not meet any of the following:
		  ○ Concomitantly taking strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin)
		  ○ Concomitantly taking strong and moderate CYP3A4 inducers
		  ○ Patient is pregnant
		Renewal Criteria (6-month duration):
		• Patient continues to meet initial criteria; **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 (decreased eGFR, increased blood pressure or hypertensive crisis)
			6/day	

mycophenolic acid	NP	See Zortress® prior authorization criteria		
Myfortic®	NP	See Zortress® prior authorization criteria		
Neoral®	NP	See Zortress® prior authorization criteria		
Prograf® capsules	NP	See Zortress® prior authorization criteria		
Prograf® granules for suspension	NP	• See Zortress® prior authorization criteria; **AND** • Patient must be unable to swallow tablets		

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

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**
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	
Sandimmune® oral solution	NP	See Zortress® prior authorization criteria		
sirolimus tablets and solution	NP	See Rapamune® prior authorization criteria; **AND** • Clinically reason why brand Rapamune solution or tablets cannot be used		
Multiple Sclerosis Agents, Injectable				
Avonex®	P		4/28 days	General PA Form
Avonex Pack®	P		4/28 days	
Copaxone® 20 mg/mL	P		1 mL/day	
Betaseron®	NP		14/28 days	
Copaxone® 40 mg/mL	NP	• Patient is ≥ 18 years old; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Diagnosis of FDA-approved indication, **AND** • Provider must provide peer-reviewed medical literature documenting why the drug for the requested indication(s) is the only appropriate choice versus the preferred agents	12 mL/30 days	
Extavia®	NP	• Patient is ≥ 18 years old; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Patient has tried and failed preferred Betaseron®	15/30 days	
glatiramer 20 mg/mL	NP		1/day	
glatiramer 40 mg/mL	NP	See Copaxone® 40 mg/mL prior authorization criteria	12 mL/30 days	
Glatopa®	NP		1/day	

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

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 (3 month duration):**
		• Patient must be 18 years of age or older; **AND**
		• Prescribed by, or in consultation with, a neurologist; **AND**
		• Patient has relapsing forms of multiple sclerosis (MS) to include one of the following:
		  ○ Relapsing, remitting Multiple Sclerosis (RRMS)
		  ○ Clinically Isolated syndrome
		  ○ Active secondary progressive disease(SPMS); **AND**
		• Prescriber attests that initial dose was administered under the guidance of a healthcare professional; **AND**
		• Trial and failure, contraindication, or intolerance to 2 preferred agents for MS treatment (not required for SPMS); **AND**
		• Patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment; **AND**
		• Patient does not have an active infection, including clinically important localized infections; **AND**
		• Patient will not receive live or live-attenuated vaccines during treatment; **AND**
		• Patient will not use any other agents for treatment of relapsing forms of MS and/or secondary progressive disease
		• For patients of reproductive potential, the following has been addressed:
		  ○ Provider has counseled patient 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 for 10 days after the last dose; **AND**
		  ○ Provider has confirmed (via pregnancy test) that the patient is not pregnant prior to receiving treatment
		Renewal Criteria (6-month duration):
		• Patient continues to meet initial criteria
		• Patient must demonstrate disease improvement or response to therapy (e.g., manifestations of MS disease activity include, but are not limited to, an increase in annualized relapse rate [ARR], development of new/worsening T2 hyperintensities or enhancing lesions on brain/spinal MRI, and progression of sustained impairment as evidenced by expanded disability status scale [EDSS], timed 25-foot walk [T25-FW)], 9-hole peg test [9-HPT]
			Initiation: 3 pens the 1st month
			
			Maintenance: 1 pen/month	

Plegridy®	NP	• Patient is ≥ 18 years old; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Diagnosis of multiple sclerosis; **AND** • Trial/failure of ALL preferred agents in PDL class “Multiple Sclerosis Agents, Injectable”	2 pens/28 days	
Rebif®	NP		6 mL /28 days	

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

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**
Multiple Sclerosis (MS) Agents, Oral				
dalfampridine ER	P		2/day	
dimethyl fumarate	P	See teriflunomide prior authorization criteria	2/day	
fingolimod	P	See teriflunomide prior authorization criteria	1/day	
teriflunomide	P	**Initial Criteria:** • Patient is ≥ 18 years old; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Diagnosis of relapsing, remitting Multiple Sclerosis (RRMS); **AND** • Trial and failure of interferon ß or glatiramer; **OR** ○ Contraindication, drug-drug interaction, or intolerance to **BOTH** interferon ß and glatiramer **Renewal Criteria:** • Continuous monitoring of response to therapy will be performed (manifestations of MS disease activity, which may include, but are not limited to, an increase in annualized relapse rate [ARR], development of new/worsening T2 hyperintensities or enhancing lesions on brain/spinal MRI, and progression of sustained impairment as evidenced by expanded disability status scale [EDSS], timed 25-foot walk [T25-FW], 9-hole peg test [9-HPT])		
Ampyra®	NP	• Clinically valid reason why preferred dalfampridine cannot be used	2/day	
Aubagio®	NP	**Initial Criteria:** • Patient is ≥ 18 years old; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Diagnosis of relapsing, remitting Multiple Sclerosis (RRMS); **AND** • Trial and failure of interferon ß or glatiramer; **OR** ○ Contraindication, drug-drug interaction, or intolerance to **BOTH** interferon ß and glatiramer; **AND** • Clinically valid reason why preferred teriflunomide cannot be used **Renewal Criteria:** • Continuous monitoring of response to therapy will be performed (manifestations of MS disease activity, which may include, but are not limited to, an increase in annualized relapse rate [ARR], development of new/worsening T2 hyperintensities or enhancing lesions on brain/spinal MRI, and progression of sustained impairment as evidenced by expanded disability status scale [EDSS], timed 25-foot walk [T25-FW], 9-hole peg test [9-HPT])		General PA Form

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

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**

Bafiertam®	NP	**Initial Criteria:**
		• Patient is ≥ 18 years old; **AND**
		• Prescribed by, or in consultation with, a neurologist; **AND**
		• Diagnosis of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease; **AND**
		• Trial and failure, contraindication, or intolerance of Aubagio® or fingolimod; **AND**
		• Trial and failure, contraindication, or intolerance of dimethyl fumarate; **AND**
		• Trial and failure of interferon ß or glatiramer; **OR**
		  ○ Contraindication, drug-drug interaction, or intolerance to **BOTH** interferon ß and glatiramer; **AND**
		• Patient will not use any other agents for disease modifying treatment of MS; **AND**
		• For female patients of reproductive potential, the following has been addressed:
		  ○ Patient is not pregnant and does not plant to become pregnant while utilizing therapy; AND
		  ○ Patient is not breastfeeding or plans to breastfeed while on therapy
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• Documentation of positive clinical response to therapy (e.g., improvement in radiologic disease activity, clinical relapses, disease progression)
			4/day	

Gilenya®	NP	• Patient is ≥ 18 years old; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Diagnosis of relapsing, remitting Multiple Sclerosis (RRMS); **AND** • Trial and failure, contraindication, or intolerance of Aubagio® or fingolimod; **AND** • Trial and failure, contraindication, or intolerance of dimethyl fumarate; **AND** • Trial and failure of interferon ß or glatiramer; **OR** ○ Contraindication, drug-drug interaction, or intolerance to BOTH interferon ß and glatiramer	1/day	General PA Form

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

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**

Mavenclad®	NP	**Initial Criteria:**
		• Patient is ≥ 18 years old; **AND**
		• Prescribed by, or in consultation with, a neurologist; **AND**
		• One of the following:
		  ○ Diagnosis of a relapsing form of multiple sclerosis (e.g., relapsing-remitting disease [RRMS]) and patient has had ≥ 1 relapse in the previous 12 months
		  ○ Active secondary progressive disease [SPMS] with relapses
		• Trial and failure, contraindication, or intolerance to Aubagio®, dimethyl fumarate, OR fingolimod® (not required for SPMS); **AND**
		• Patient will not use any other agents for treatment of relapsing forms of MS and/or secondary progressive disease; **AND**
		• Patient should be screened for the presence of tuberculosis according to local guidelines; **AND**
		• Patient has been evaluated and screened for the presence of hepatitis B and hepatitis C virus (HBV/HCV) prior to initiating treatment; **AND**
		• Patient has been tested for antibodies to the varicella zoster virus (VZV) or has received immunization for VZV four to six weeks prior to beginning therapy; **AND**
		• Patient has a baseline MRI within 3 months prior to initiating the first treatment course; **AND**
		• For patients of reproductive potential:
		  ○ Provider has counseled patient to use contraception during treatment and for 6-months after the last dose; **AND**
		  ○ Lactating women will be counseled to discontinue breast feeding during treatment and for 10 days after the last dose; **AND**
		  ○ Provider has confirmed (via pregnancy test) that the patient is not pregnant prior to receiving treatment
		• Patient does NOT meet any of the following:
		  ○ Patient has a current diagnosis of malignancy
		  ○ Patient has human immunodeficiency virus (HIV) infection
		  ○ Requested agent will be used in combination with antineoplastics, immunosuppressives, or immunomodulators
		  ○ Patient has an active infection (including clinically important localized infections)
		  ○ Patient's lymphocyte count is less than 800 cells/mL
		Renewal Criteria:
		• At least 43 weeks (approx. 10 months) has/will have elapsed since the end of the first treatment course; **AND**
		• Patient is receiving ongoing monitoring for presence of TB or other active infections; **AND**
		• Continuous monitoring of response to therapy will be performed (manifestations of MS disease activity include, but are not limited to, an increase in annualized relapse rate [ARR], development of new/worsening T2 hyperintensities or enhancing lesions on brain/spinal MRI, and progression of sustained impairment as evidenced by expanded disability status scale [EDSS], timed 25-foot walk [T25-FW], 9-hole peg test [9-HPT])
			40 tabs/2 years	General PA Form

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

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 ≥ 18 years old; **AND**
		• Prescribed by, or in consultation with, a neurologist; AND
		• One of the following:
		  ○ Diagnosis of a relapsing form of multiple sclerosis (e or clinically isolated syndrome (CIS)
		  ○ Active secondary progressive disease [SPMS]
		• Patient CYP2C9 variant status has been tested to determine genotyping (required for dosing); **AND**
		• Patient has obtained a baseline electrocardiogram (ECG); **AND**
		• Patient has been tested for varicella zoster virus (VZV) antibodies **OR** has received immunization for VZV 4 wks prior to therapy; **AND**
		• Patient has had a baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment; **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
		  ○ Prolonged QTc interval at baseline (> 500 msec)
		  ○ History of Mobitz Type II second- or third-degree atrioventricular block or sick sinus syndrome (unless treated with a functioning pacemaker)
		  ○ CYP2C9*3/*3 genotype
		  ○ Active infection (including clinically important localized infections); **AND**
		• Patient will not be initiating therapy after previous treatment with alemtuzumab (Lemtrada); **AND**
		• Patient will not use any other agents for disease modifying treatment of MS; **AND**
		• For female patients of reproductive potential, the following has been addressed:
		  ○ Provider has counseled patient to use effective contraception during treatment with therapy and for at least 10 days a fter the last dose; **AND**
		  ○ Lactating patient has been counseled on the risks versus benefits of breastfeeding while on treatment
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• Patient has had an ophthalmic re-evaluation if changes in vision have been experienced; **AND**
		• There is documented continuous monitoring of response to therapy (e.g., manifestations of MS disease activity include, but are not limited to, an increase in annualized relapse rate [ARR], development of new/worsening T2 hyperintensities or enhancing lesions on brain/spinal MRI, and progression of sustained impairment as evidenced by expanded disability status scale [EDSS], timed 25-foot walk [T25-FW)], 9-hole peg test [9-HPT]
			Starter pack:
			1 pack/Rx;
			0.25 mg:
			4 tabs/day;
			2 mg: 1 tab/day
				General PA Form

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

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**
Ponvory®	NP	**Initial Criteria:** • Patient ≥ 18 years old; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Patient has a diagnosis of a relapsing form of multiple sclerosis (MS); **AND** • Patient has diagnosis of clinically isolated syndrome, or active secondary progressive disease; **AND** • Trial and failure, contraindication, or intolerance to Aubagio®, dimethyl fumarate, OR fingolimod (not required for SPMS); **AND** • Patient has had a baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment; **AND** • Patient must NOT meet 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 ○ Prolonged QTc interval at baseline (> 500 msec) ○ Presence of Mobitz type II second-degree, third degree atrioventricular (AV) block, sick sinus syndrome unless the patient has a functioning pacemaker ○ Severe untreated sleep apnea ○ Active infection (including clinically important localized infections); **AND** • For female patients of reproductive potential, all the following has been addressed: ○ Provider has counseled patient to use effective contraception during treatment and for 10 days after last dose ○ Lactating patients have been counseled on the risks versus benefits of breastfeeding while on treatment **Renewal Criteria:** • Patient continues to meet initial criteria; **AND** • Patient has had an ophthalmic re-evaluation if changes in vision have been experienced; **AND** • There is documented continuous monitoring of response to therapy (e.g., manifestations of MS disease activity include, but are not limited to, an increase in annualized relapse rate [ARR], development of new/worsening T2 hyperintensities or enhancing lesions on brain/spinal MRI, and progression of sustained impairment as evidenced by expanded disability status scale [EDSS], timed 25-foot walk [T25-FW)], 9-hole peg test [9-HPT]	1/day	
Tascenso ODT®	NP	• Patient is ≥ 10 years old; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Diagnosis of relapsing, remitting Multiple Sclerosis (RRMS); **AND** • Trial and failure, contraindication, or intolerance of fingolimod; **AND** • Trial and failure, contraindication, or intolerance of Aubagio® or dimethyl fumarate; **AND** • Trial and failure of interferon ß or glatiramer; **OR** ○ Contraindication, drug-drug interaction, or intolerance to BOTH interferon ß and glatiramer	1/day	
Tecfidera®	NP	• Patient is ≥ 18 years old; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Diagnosis of relapsing, remitting Multiple Sclerosis (RRMS); **AND** • Trial and failure, contraindication, or intolerance to Aubagio® or fingolimod; **AND** • Trial and failure of dimethyl fumarate and generic fingolimod; **AND** • Trial and failure of interferon ß or glatiramer; **OR** ○ Contraindication, drug-drug interaction, or intolerance to BOTH interferon ß and glatiramer	2/day	

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

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**
Vumerity®	NP	• Patient is ≥ 18 years old; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Diagnosis of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease; **AND** • Trial and failure, contraindication, or intolerance of dimethyl fumarate; **AND** • Trial and failure of interferon ß or glatiramer; **OR** ○ Contraindication, drug-drug interaction, or intolerance to BOTH interferon ß and glatiramer	4/day	

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

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 old; 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 2 of the following: Aubagio®, dimethyl fumarate, fingolimod; **OR**
		  ○ Diagnosis of moderately to severely active ulcerative colitis (UC) in adults; **AND**
		  – Trial and failure, contraindication, or intolerance to ONE immunomodulator agent with an ulcerative colitis indication (adalimumab, infliximab, golimumab, tofacitinib, upadacitinib, ustekinumab, vedolizumab); **AND**
		• Patient has been tested for antibodies to the varicella zoster virus (VZV) OR has received immunization for VZV 4 weeks prior to beginning therapy; **AND**
		• If patient has a history of uveitis or macular edema OR patient experiences vision changes during therapy, prescriber attests to obtain an ophthalmic evaluation of the fundus, including the macula; **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)
		  ○ Active infection (including clinically important localized infections); **AND**
		• Zeposia will NOT be used in combination with the any of the following:
		  ○ Dextromethorphan-containing products
		  ○ Monoamine Oxidase Inhibitors (MAOIs)
		  ○ Adrenergic and Serotonergic agents
		  ○ Tyramine; **AND**
		• For female patients of reproductive potential, all the following has been addressed:
		  ○ Patient has been counseled to use effective contraception during treatment and for 3 months after the last dose
		  ○ Lactating patients have been counseled on the risks versus benefits of breastfeeding while on treatment
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• Patient has had an ophthalmic re-evaluation if changes in vision have been experienced; **AND**
		• There is documented continuous monitoring of response to therapy (e.g., manifestations of MS disease activity include, but are not limited to, an increase in annualized relapse rate [ARR]; development of new/worsening T2 hyperintensities or enhancing lesions on brain/spinal MRI; and progression of sustained impairment as evidenced by expanded disability status scale [EDSS], timed 25-foot walk [T25-FW)], 9-hole peg test [9-HPT])
			1/day	General PA Form

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

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® **Note**: It is recommended that if the serum ferritin is consistently < 500mcg/L therapy should be stopped; however, this may be up to the prescriber's discretion and experience of treating patients with iron-overload		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

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

ONCOLOGY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Oncology				
anastrozole	P	• For male patients, diagnosis of breast cancer • For female patients, no PA required		
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; **AND** – Prescribed in combination with Erbitux ○ 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
Eligard®	P	• Diagnosis of prostate cancer in male patient		General PA Form
Jakafi®	P		2/day	
Kisqali®	P	**Initial Criteria:** • Patient has a diagnosis of advanced or metastatic breast cancer that is hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative; **AND** • Prescribed by, or in consultation with, an oncologist; **AND** • Will be utilized in combination with ONE of the following: ○ An aromatase inhibitor as initial endocrine-based therapy ○ Fulvestrant as initial endocrine-based therapy or following disease progression on endocrine therapy in postmenopausal women or in men; **AND** • Female patient is postmenopausal as defined by ONE of the following: ○ Prior bilateral oophorectomy ○ Age > 60 years ○ Age < 60 years and amenorrhea for ≥ 12 months (in the absence of chemotherapy, tamoxifen, toremifene or ovarian suppression) and FSH and estradiol levels in the postmenopausal range **Renewal Criteria:** • Patient continues to meet initial review 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 at current dosage level	63 tabs/28 days	General PA Form

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

ONCOLOGY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Kisqali®/Femara®	P	**Initial Criteria:** • Patient has a diagnosis of advanced or metastatic breast cancer that is hormone receptor (HR)-positive; **AND** • Human epidermal growth factor receptor 2 (HER2)-negative **Renewal Criteria:** • Patient continues to meet initial review 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 at current dosage level	200mg pack: 49 tabs/28 days; 400 mg pack: 70 tabs/28 days; 600 mg pack: 91 tabs/28 days	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
Lonsurf®	P		8/day	General PA Form
Lynparza®	P		4/day	
Mektovi®	P	**Initial Criteria (6-month duration):** • 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
Rubraca®	P		4/day	

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

ONCOLOGY *Approval of NP 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

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

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

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

Vizimpro®	P	**Initial Criteria (6-month duration):**
		• Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as confirmed by an FDA-approved test (e.g., cobas® EGFR Mutation Test v2); **AND**
		• Requested agent will be prescribed by, or in consultation with, an oncologist; **AND**
		• Patient does not have brain metastases; **AND**
		• If applicable, prescriber attests that patient has been advised to use effective contraception during treatment with and for at least 17 days after the final dose; **AND**
		• Prescriber attests that the patient will not use the agent with ANY of the following:
		  ○ Proton pump inhibitors
		  ○ CYP2D6 substrates
		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)
			1/day	General PA Form

Zejula®	P		3/day	General PA Form
Afinitor Disperz®	NP	• Patient is unable to swallow solid dosage forms		

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:
		  ○ Patient will receive a gonadotropin-releasing hormone (GnRH)-analog (e.g., leuprolide, goserelin, triptorelin)
		  ○ 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

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

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

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**
		• Prescriber attests to monitoring for intracranial hemorrhage and CNS adverse reactions; **AND**
		• Female patients of reproductive potential and male patients undergoing treatment with female partners of reproductive age should use effective contraception during treatment and for 6 weeks the final dose
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• No unacceptable disease progression or unacceptable toxicity
			1/day	General PA Form

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

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

ONCOLOGY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**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)
		  ○ EGFR <30ml/min
		  ○ History or presence of active serious or untreated autoimmune disease; **AND**
		• Patient is not an immunosuppressed transplant recipient; **AND**
		• Prescriber attests to the following:
		  ○ Patient will be advised to have eye examinations before and during treatment
		  ○ Serum triglycerides will be monitored before treatment and intermittently during treatment
		  ○ Liver enzymes, hepatic function, and serum creatinine will be monitored at baseline and during treatment
		  ○ Blood counts will be obtained at baseline and will be monitored every 2 weeks during duration titration, and at least every 3-6-months during maintenance treatment; **AND**
		• For women of childbearing age, provider has confirmed (via pregnancy test) 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

Brukinsa®	NP	**Initial Criteria:**
		• Diagnosis of one of the following:
		  ○ Mantle cell lymphoma (MCL) and have received at least one prior therapy (e.g., rituximab-based regimens, CHOP-based regimens, etc.)
		  ○ Waldenström's macroglobulinemia
		  ○ Relapsed or refractory marginal zone lymphoma (MZL) and have received at least one anti-CD20-based regimen; **AND**
		• Brukinsa will be used as monotherapy; **AND**
		• Provider attests to monitor for signs and symptoms of any level of bleeding events such as intracranial and gastrointestinal hemorrhage, hematuria, hemothorax, purpura, and petechiae; **AND**
		• Provider attests to monitor for opportunistic infections, cytopenias, second primary malignancies, and cardiac arrhythmias; **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 the initial criteria; **AND**
		• Absence of unacceptable toxicity from Brukinsa (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
			4/day	General PA Form

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

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

Calquence®	NP	**Initial Criteria (6-month duration):**
		• One of the following:
		  ○ Patient has a diagnosis of advanced mantle cell lymphoma; **AND**
		  – Patient will be using acalabrutinib as monotherapy; **AND**
		  – Patient has received at least 1 prior therapy for mantle cell lymphoma; **AND** has NOT received any prior treatment with a BTK inhibitor (e.g., ibrutinib)
		  ○ Patient has a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL); **AND**
		  – Patient will be using acalabrutinib as monotherapy OR in combination with obinutuzumab (e.g., Gazyva)
		  ○ Patient has relapsed or refractory disease; **AND**
		  – Patient does not have ibrutinib (e.g., Imbruvica) refractory disease with BTK C481S mutations; **AND**
		  – Patient has not had prior therapy with a BCL-2 inhibitor (e.g., Venclexta), BTK inhibitor (e.g., ibrutinib, or a P13K inhibitor (e.g., idelalisib)
		• Provider attests to monitor for signs and symptoms of any level of bleeding events; **AND**
		• Provider attests to monitor for opportunistic infections, cytopenias, second primary malignancies, and cardiac arrhythmias; **AND**
		• Patient must not be pregnant or breastfeeding; **AND**
		• Females of reproductive potential should be advised to use effective contraception during treatment and for 1 week after the final dose
		Renewal Criteria (6-month duration):
		• Patient continues to meet the initial criteria; **AND**
		• Patient has documented efficacy with stabilization of disease or decrease in size of tumor or tumor spread; **AND**
		• Patient has absence of unacceptable adverse effects (e.g., anemia, thrombocytopenia, headache, neutropenia, diarrhea, fatigue, myalgia, and bruising)
			2/day	General PA Form

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

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

Copiktra®	NP	**Initial Criteria:**
		• Diagnosis of ONE of the following:
		  ○ Relapsed or refractory chronic lymphocytic leukemia (CLL)
		  ○ Small lymphocytic lymphoma (SLL)
		• Patient has not received therapy with ANY of the following:
		  ○ Phosphoinositide 3-kinase (PI3K) inhibitors (e.g., Zydelig)
		  ○ Bruton's tyrosine kinase (BTK) inhibitor (e.g., Imbruvica and Calquence); **AND**
		• Used as a single agent; **AND**
		• Patient has received at least 2 prior therapies which included treatment with ofatumumab (Arzerra); **AND**
		• Patient must not have undergone prior autologous hematopoietic stem cell transplant (HSCT) within 180 days of the first dose **OR** prior allogeneic transplant; **AND**
		• Patient does not have an active infection, including clinically important localized infections; **AND**
		• Patient must not be pregnant or breastfeeding; **AND**
		• Prescriber attests to counsel and/or monitor regarding the following:
		  ○ Signs and symptoms of infection
		  ○ Diarrhea and colitis
		  ○ Cutaneous reactions
		  ○ Pneumonitis
		  ○ Hepatotoxicity
		  ○ Neutropenia
		  ○ Female patients of reproductive potential should use effective contraception during treatment and for at least 1 month after treatment
		  ○ Males undergoing treatment with female partners of reproductive age should use effective contraception during treatment and 1 month after treatment due to male mediated teratogenicity
		Renewal Criteria:
		• Patient continues to meet criteria identified in initial criteria; **AND**
		• Disease response as defined by lack of disease progression, improvement in tumor size and/or improvement in patient symptoms; **AND**
		• Absence of unacceptable toxicity from the drug (e.g., active/severe infections, hematologic toxicity [neutropenia], severe diarrhea or colitis, hepatotoxicity, pneumonitis, severe cutaneous reactions [Stevens-Johnson syndrome and toxic epidermal necrolysis], anaphylaxis)
			2/day	General PA Form

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

ONCOLOGY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Oncology *(continued)*				
Daurismo®	NP	**Initial Approval Criteria (6-month duration):** • Patient has newly diagnosed acute myeloid leukemia (AML); **AND** • 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** • Patient has a baseline QTc interval of ≤ 470 ms and does not have a history of long QT syndrome; **AND** • Patient does not have severe renal impairment (e.g., eGFR < 30 mL/min) or moderate-severe hepatic impairment (total bilirubin > 3 x ULN and any AST); **AND** • Daurismo® will be used in conjunction with low-dose subcutaneous cytarabine; **AND** • Daurismo® will not be used concomitantly with strong CYP3A4 inhibitors **Renewal Criteria (6-month duration):** • Patient continues to meet initial criteria; **AND** • Patient demonstrates disease stabilization or improvement as evidenced by a complete response (CR) (e.g., morphologic, cytogenetic or molecular complete response), complete hematologic response, or a partial response by CBC, bone marrow cytogenetic analysis, QPCR, or FISH; **AND** • Patient is absent of unacceptable toxicity of QTc-interval prolongation (e.g., interval ≥ 500 ms and/or interval prolongation with signs and symptoms of severe arrhythmia)	25 mg: 84/28 days; 100 mg: 28/28 days	General 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: ○ Patient will receive a gonadotropin-releasing hormone (GnRH)-analog (e.g., leuprolide, goserelin, triptorelin) ○ Patient has had a bilateral orchiectomy **Renewal Criteria (6-month duration)**: • 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
everolimus tablets for suspension	NP	• Patient is unable to swallow solid dosage forms		General PA Form

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

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

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

ONCOLOGY *Approval of NP 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:**
		• ONE of the following:
		  ○ Diagnosis of metastatic RET fusion-positive non-small cell lung cancer (NSCLC) that is detected by an FDA approved test
		  ○ Diagnosis of 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; **AND**
		• Prescriber attests to ALL the following:
		  ○ Patient has had baseline liver enzymes prior to initiating therapy, and prescriber attests to monitor every 2 weeks for 3 months then monthly thereafter
		  ○ Patient has had baseline blood pressure prior to initiating therapy, and prescriber attests to monitor 1 week after initiating treatment, and every month thereafter
		  ○ In the presence of any hemorrhagic event, prescriber attests to get baseline CBC and every 2 weeks for 3 months then monthly thereafter
		  ○ If patient is scheduled for elective surgery, dose will be withheld for at least 5 days prior, and at least 2 weeks following major surgery and until adequate wound healing
		  ○ Patient must not be pregnant or breastfeeding
		  ○ Females of reproductive potential have been advised to use effective non-hormonal contraception due to embryo-fetal toxicity during treatment and for 2 weeks after the final dose
		• Prescriber attests that the agent will not be administered with ANY of the following:
		  ○ Strong CYP3A inhibitors or inducers
		  ○ Combined P-gp and Strong CYP3A inhibitors
		  ○ Severe or life-threatening interstitial lung disease (Grade 3 or 4)
		  ○ Life-threatening uncontrolled hypertension (Grade 4)
		  ○ Severe or life-threatening hepatotoxicity (Grade 3 or 4)
		  ○ Severe or life-threatening hemorrhage
		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

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

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

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

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 10^9/L; **AND** • Provider attests patient is not currently taking ruxolitinib; OR ruxolitinib will be discontinued prior to initiation of the requested agent; **AND** • Provider attests patient is not thiamine deficient (vitamin B1) and will monitor thiamine level during treatment **Renewal Criteria:** • Patient's platelet count > 50 x 109 /L; **AND** • Patient has experienced a decrease in symptoms; **AND** • Absence of unacceptable toxicity; **AND** • Prescriber agrees to continue monitoring thiamine (vitamin B1) levels	4/day	General PA Form
Imbruvica® suspension	NP	• Patient is unable to swallow capsules		General PA Form

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

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

Jaypirca®	NP	**Initial Criteria:**
		• One of the following:
		  ○ Diagnosis of one mantle cell lymphoma (MCL); **AND**
		  – Patient has received TWO prior therapies including a BTK inhibitor (e.g., Ibrutinib, acalabrutinib, zanubrutinib)
		  ○ 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; **AND**
		• Provider attests to monitor for signs and symptoms of any level of bleeding events such as intracranial and gastrointestinal hemorrhage, hematuria, hemothorax, purpura, and petechiae; **AND**
		• Provider attests to monitor for opportunistic infections, cytopenias, second primary malignancies, and cardiac arrhythmias; **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 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

Koselugo®	NP	**Initial Criteria:** • Diagnosis of neurofibromatosis type 1 (NF1) with symptomatic, inoperable plexiform neurofibromas (PN); **AND** • Patient must not be pregnant or breastfeeding; **AND** • Females of reproductive potential and males with female partners of reproductive potential should be advised to use effective contraception; **AND** • Patient has had baseline liver function tests (ALT/AST); **AND** • Patient should have a normal baseline ejection fraction of 55% to 70%; **AND** • Patient has had a baseline ophthalmic examination; **AND** • Patient has had baseline serum Creatine Phosphokinase (CPK); **AND** • Patient will not concomitantly take strong or Moderate CYP3A4 Inhibitors or fluconazole; strong and moderate CYP3A4 inducers; Vitamin E supplements; Vitamin K antagonists; or antiplatelet agents **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 (RPED), severe diarrhea, rash, increased bleeding, Myalgia)	10 mg: 10/day 25 mg: 4/day	General PA Form

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

ONCOLOGY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Krazati®	NP	• 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** • 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, etc.); **AND** • Prescriber attests that patient is not pregnant or breastfeeding during treatment with Krazati 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
Lorbrena®	NP	• Diagnosis of Metastatic non-small cell lung cancer (NSCLC) and is Anaplastic lymphoma kinase (ALK)-positive; **AND** • Prescribed by, or in consultation with, an oncologist; **AND** • Prescriber attests they will monitor all the following: ○ ECG ○ Serum cholesterol and triglycerides; **AND** • Prescriber will consult with female patient of reproductive potential to use effective non-hormonal contraception during therapy and for 6-months after the last dose; **OR** will consult with male patients with a partner of reproductive potential to use effective contraception during therapy and for 3 months after the last dose	3/day: 25 mg; 1/day: 100 mg	General PA Form
Lumakras®	NP	• 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** • 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, etc.); **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: Monitor 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: Monitor for new or worsening pulmonary symptoms; **AND** • Prescriber attests that Patient will not take Lumakras with: ○ Acid-reducing agents (e.g., proton pump inhibitors, H_2 receptor antagonists, antacids, etc.) ○ Strong CYP3A4 inducers (e.g., rifampin, carbamazepine, etc.)		General PA Form

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

ONCOLOGY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**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
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
Mekinist solution®	NP	• Patient is <8 years old; **OR** • Patient is unable to swallow solid dosage forms		General PA Form
Nubeqa®	NP	**Initial Criteria (6-month duration):** • ONE of the following: ○ Patient has non-metastatic castration-resistant prostate cancer (nmCRPC); **AND** – Patient will receive a gonadotropin-releasing hormone (GnRH) analog (e.g., leuprolide, goserelin, triptorelin); **OR** – Patient has had a bilateral orchiectomy ○ Diagnosis of metastatic hormone-sensitive prostate cancer (mHSPC); **AND** – Nubeqa will be used in combination with docetaxel **Renewal Criteria (6-month duration):** • 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

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

ONCOLOGY *Approval of NP 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

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**
		• Prescriber will obtain baseline CBC and monitor every other week for the first 2 cycles and prior to the start of each cycle thereafter; **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**
		• Patient does not have Myelodysplastic syndrome (MDS); **AND**
		• Patient has had a hematopoietic stem cell transplant
		Renewal Criteria:
		• Patient must continue to meet the initial criteria; **AND**
		• Patient has documented efficacy with stabilization of disease; **AND**
		• Patient has absence of unacceptable adverse effects (e.g., myelosuppression, renal impairment, hepatic impairment)
			1/day	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

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

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

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

ONCOLOGY *Approval of NP 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 not received chemotherapy for advanced breast cancer; **AND** • Patient has not previously been treated with fulvestrant; **AND** • Patient has not been treated with another PI3K inhibitor or mTOR (mammalian target of rapamycin) inhibitor; **AND** • Patient has a PIK3CA-mutation as detected by the therascreen PIK3CA RGQ PCR kit, an FDA-approved companion diagnostic; **AND** • Alpelisib Is being given in combination with fulvestrant; **AND** • Patient does not have ANY of the following: ○ Inflammatory breast cancer ○ Type 1 Diabetes or Uncontrolled Type 2 Diabetes (fasting plasma glucose level >140 mg/dL or glycosylated hemoglobin level of > 6.4%) ○ Uncontrolled central nervous system metastases ○ Pneumonitis **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 (adverse effects resolve following outlined dosing recommendations and no permanent discontinuation of the medication is required according to labeling)	200 mg: 1/day, 250 & 300 mg: 2/day	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
Qinlock®	NP	• 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); **AND** • Patient does not have ANY of the following: ○ Uncontrolled hypertension ○ Grade 3 or 4 left ventricular systolic dysfunction; **AND** • Provider attests to ALL the following: ○ Patient will be evaluated for suspicious skin lesions throughout treatment ○ Qinlock for at least 1 week prior to elective surgeries and to not administer for 2 weeks following major surgery ○ Patient must not be pregnant or breastfeeding ○ Females of reproductive potential and males with female partners of reproductive potential should be advised to use effective contraception during treatment and for 1 week after the final dose ○ Patient will not concomitantly take strong CYP3A4 inducers	3/day	General PA Form

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

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

Retevmo®	NP	**Initial Criteria (3 month duration):**
		• 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; **AND**
		• Prescriber attests to ALL the following:
		  ○ Patient has had baseline liver enzymes prior to initiating therapy, and prescriber attests to monitor every 2 weeks for 3 months
		  ○ Patient has had baseline blood pressure prior to initiating therapy, and prescriber attests to monitor 1 week after initiating treatment, and every month thereafter
		  ○ For patients at significant risk of developing QTc prolongation, patient has had baseline EKG and electrolytes prior to initiating therapy, and prescriber attests to monitor patients periodically during treatment, and monitor patients more frequently who are at risk for QT prolongation (concomitantly administered with strong and moderate CYP3A inhibitors or drugs known to prolong QTc interval)
		  ○ Patient has had baseline TSH levels prior to initiating therapy, and prescriber attests to monitor patients periodically during treatment
		  ○ If patient is scheduled for elective surgery, dose will be withheld for at least 7 days prior, and at least 2 weeks following major surgery and until adequate wound healing
		  ○ Patient must not be pregnant or breastfeeding
		  ○ Females of reproductive potential will be advised to use effective contraception due to embyro-fetal toxicity; **AND**
		• Avoid coadministration with ALL the following:
		  ○ Strong and Moderate CYP3A Inducers
		  ○ CYP2C8 and CYP3A Substrates
		Renewal Criteria (6-month duration):
		• Initial criteria continues to be met and patient is responding positively to therapy; **AND**
		• Patient does not have unacceptable toxicity (e.g., severe or life-threatening hemorrhaging) or side effects (e.g., patient has stable blood pressure, stable QTc interval, and has not experienced an increase in liver enzymes)
			80mg: 4/day
			40mg: 6/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 demonstrates disease stabilization or improvement as evidenced by complete remission, complete remission with partial hematologic recovery, or reduction in red blood cell (RBC) and/or platelet transfusions from baseline; **AND** • Patient does not have unacceptable toxicity (hepatoxicity, differentiation syndrome)	2/day	General PA Form

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

ONCOLOGY *Approval of NP 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 [e.g., cognitive impairment, mood disorders, dizziness, sleep disturbances], 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	

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

Scemblix®	NP	• Patient has ONE of the following:
		  ○ 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**
		• Patient will receive ongoing routine monitoring of ALL the following:
		  ○ Complete blood counts
		  ○ Serum lipase and amylase
		  ○ Blood pressure; **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
				General PA Form

Synribo®	NP	**Initial Criteria (6-monthduration):**
		• Diagnosis of chronic myeloid leukemia (CML); **AND**
		• Patient has chronic or accelerated/advanced phase disease; **AND**
		• Patient has a history of resistance and/or intolerance to 2 or more tyrosine kinase inhibitors (TKI); **AND**
		• Prescribed by or in consultation with a specialist (e.g. oncologist, hematologist); **AND**
		• Prescriber attests to the following:
		  ○ Patients of reproductive potential will be counseled to use effective contraception during treatment with therapy and at least 6-months after final dose
		  ○ Male patients undergoing treatment with female partners of reproductive age should use effective contraception during treatment and at least 3 months after final dose
		  ○ If home administration, patient or caregiver has been trained on proper handling, storage conditions, administration, disposal, and clean-up of accidental spillage
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• Patient has positive clinical response to therapy; **AND**
		• Patient has not experienced any treatment-restricting adverse effects
				General PA Form

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ONCOLOGY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Tabrecta®	NP	**Initial Criteria (3-month duration):** • 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** • Patient has baseline ALT, AST, and bilirubin measured and within normal limits; **AND** • Patient does not have severe hepatic impairment (Child Pugh C); **AND** • Patient does not have a history of interstitial lung disease; **AND** • Prescriber attests that patient has been advised to limit direct ultraviolet exposure; **AND** • Patient must not be pregnant or breastfeeding; **AND** • If applicable, female patients of reproductive potential, or males undergoing treatment with female partners of reproductive age, should use effective contraception during treatment and for at least 1 week after treatment; **AND** • Patient will not concomitantly take with strong and moderate CYP3A inducers **Renewal Criteria (6-month duration):** • 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
Tafinlar solution®	NP	• Patient is <8 years old; **OR** • Patient is unable to swallow solid dosage forms		General PA Form

Tazverik®	NP	**Initial Criteria (3 month duration):**
		• 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 at least 2 prior systemic therapies OR patient has not had satisfactory alternative treatment option; **AND**
		• Prescribed by, or in consultation with, an oncologist; **AND**
		• Prescriber attests to ALL the following:
		  ○ Prescriber will obtain baseline CBC required prior to initiating therapy
		  ○ Patient is not pregnant
		  ○ Females and males undergoing treatment with female partners of reproductive age should use effective contraception during treatment and for at least 1 week after treatment
		  ○ Patient will not concomitantly take the requested agent with strong or 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
			2/day	General PA Form

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

Tepmetko®	NP	**Initial Criteria:**
		• Diagnosis of metastatic non-small cell lung cancer (NSCLC) harboring mesenchymal-epithelial transition (*MET*) exon 14 skipping alterations; **AND**
		• Patient must have ALL the following:
		  ○ Epidermal growth factor receptor (EGFR) wild-type and anaplastic lymphoma kinase (ALK) negative status
		  ○ At least one measurable lesion as defined by Response Evaluation Criteria in Solid Tumors (RECIST) version 1.1
		  ○ Eastern Cooperative Oncology Group (ECOG) Performance Status of 0 to 1; **AND**
		• Prescribed by, or in consultation with, an oncologist; **AND**
		• Patient has had baseline liver enzymes prior to initiating therapy, and prescriber attests to monitor every 2 weeks for first 3 months of treatment and then once a month or as clinically indicated; **AND**
		• Females of reproductive potential and males with female partners of reproductive potential should be advised to use effective contraception during and for 1 week after treatment; **AND**
		• Patient must not meet any of the following:
		  ○ Suspected/confirmation of interstitial lung disease
		  ○ Pregnant
		  ○ Breastfeeding (avoid during treatment and for at least 1 week after the last dose)
		  ○ Symptomatic CNS metastases
		  ○ Clinically significant uncontrolled cardiac disease
		  ○ Received treatment with any MET or hepatocyte growth factor (HGF) inhibitor; **AND**
		• Patient must avoid concomitant use with any of the following:
		  ○ Strong CYP3A inducers
		  ○ P-gp substrates
		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

Tibsovo®	NP	**Criteria (6-month duration):**
		• Diagnosis of ONE of the following:
		  ○ Newly diagnosed acute myeloid leukemia (AML); **AND**
		  – Patient is ≥75 years of age OR has comorbidities that precludе use of intensive induction chemotherapy; **AND**
		  • Patient will take Tibsovo as monotherapy: **OR**
		  • Patient will take Tibsovo in combination with azacitidine
		  ○ Relapsed or refractory (defined as < 12 months after initial therapy) acute myeloid leukemia (AML) or myelodysplastic syndromes (MDS) : **AND**
		  – Patient will take Tibsovo as monotherapy
		  ○ Locally advanced or metastatic cholangiocarcinoma; **AND**
		  – Previously treated with at least one gemcitabine- or 5-FU-containing regimen; **AND**
		• Patient has an isocitrate dehydrogenase-1 (IDH1) mutation, as detected by an FDA-approved test (e.g., RealTime™ IDH1 Assay); **AND**
		• Prescriber attests that the patient will receive ongoing routine monitoring for the following:
		  ○ QTc Interval Prolongation: Monitor electrocardiogram and electrolytes
		  ○ Guillain-Barre Syndrome: Monitor signs and symptoms of new motor and/or sensory findings
			2/day	General PA Form

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Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**PA Form**
Tukysa®	NP	**Initial Criteria:** • Prescribed by, or in consultation with, an oncologist; **AND** • Patient has advanced unresectable or metastatic HER2-positive breast cancer; **AND** • Patient has received at least one or more prior anti-HER2 based regimen; **AND** • Must be used in combination with trastuzumab and capecitabine; **AND** • Patient has baseline ALT, AST, and bilirubin measured and within normal limits; **AND** • Patient continues to receive ALT/AST and bilirubin monitoring every 3 weeks during treatment; **AND** • Patient will not concomitantly take Tukysa with strong CYP3A inducers or moderate CYP2C8 inhibitors; **AND** • Patient must not be pregnant and should use effective contraception during treatment and for at least 1 week after treatment; **AND** • Males undergoing treatment with female partners of reproductive age should use effective contraception during treatment and 1 week after treatment due to male mediated teratogenicity **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
Turalio®	NP	• Must be Prescribed by, or in consultation with, a hematologist/oncologist; **AND** • Diagnosis of symptomatic tenosynovial giant cell tumor (TGCT) and both of the following: ○ Patient has severe morbidity or functional limitations (e.g., worst stiffness numeric rating scale [NRS] of 4 or greater); **AND** ○ Patient is not a candidate for surgical resection associated with potential worsening, functional limitation, or severe morbidity; **AND** • Prescriber will monitor for hepatotoxicity; **AND** • Female patients are not pregnant or breastfeeding; **AND** • Prescriber will advise females of reproductive potential to use effective non-hormonal contraception during treatment and for at least 1 month after the last dose; **AND** • Prescriber will advise males with female partners of reproductive potential to use effective contraception during treatment and for at least 1 week after the last dose	4/day	General PA Form
Vanflyta®	NP	**Initial Criteria:** • Patient has newly diagnosis 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 demonstrates disease stabilization or improvement as evidenced by a complete response (CR) (e.g., morphologic, cytogenetic, or molecular complete response), complete hematologic response, or a partial response by CBC, bone marrow cytogenic analysis, quantitative PCR, or fluorescence in situ hybridization (FISH)	2/day	General PA Form

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

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

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

ONCOLOGY *Approval of NP 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	• Diagnosis of Von Hippel-Lindau (VHL) disease who 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**
		• Provider attests to monitor oxygen saturation and monitor for anemia before initiation of and periodically throughout treatment; **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 due to embryo-fetal toxicity during treatment and for 1 week after the last dose
			3/day	General PA Form

Xalkori® sprinkles		• Patient is unable to swallow oral dosage forms		
Xospata®	NP	**Initial Criteria:** • Patient has a diagnosis of acute myeloid leukemia (AML) that is refractory **OR** relapsed to first-line AML therapy; **AND** • AML is positive for FLT3 mutation as detected by an FDA-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay); **AND** • Electrocardiogram (ECG) confirmed QTcF ≤ 500 msec; **AND** • Serum potassium and magnesium are within normal limits; **AND** • Females of child-bearing potential had a negative pregnancy test within 7 days before starting gilteritinib; **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 has disease stabilization or improvement as evidenced by a complete response (CR) (e.g., morphologic, cytogenetic or molecular complete response), complete hematologic response, or a partial response by CBC, bone marrow cytogenic analysis, quantitative PCR, or fluorescence *in situ* hybridization (FISH); **AND** • Patient does not have unacceptable toxicity (adverse effects resolve following a dose reduction, no permanent discontinuation required)	3/day	General PA Form

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

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

Xpovio®	NP	**Initial Criteria (3 month duration):**
		• Patient must meet one of the following:
		  ○ Diagnosis of multiple myeloma; **AND**
		  – Patient has received at least one prior therapy; **AND**
		  ○ Diagnosis of multiple myeloma; **AND**
		  – Patient has relapsed or refractory disease; **AND**
		  – Patient has received at least four prior therapies; **AND**
		  – Disease has been refractory to ALL of the following:
		  • Two proteasome inhibitors
		  • Two immunomodulatory agents
		  • One anti-CD38 monoclonal antibody; **AND**
		  – Agent is used in combination with dexamethasone
		  ○ 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
		  ○ Diagnosis of multiple myeloma; **AND**
		  – Agent is used in combination with bortezomib and dexamethasone; **AND**
		  – Patient has received at least one prior therapy
		• Requested agent will be prescribed by, or in consultation with, an oncologist
		• Prescriber attests to the following:
		  ○ Baseline CBC and CMP will be obtained to monitor for platelet counts, neutrophil counts, and serum sodium levels; **AND**
		• Patient does not have an active infection, including clinically important localized infections; **AND**
		  ○ If applicable, female patients and male patients with female partners of reproductive age have been advised to use effective contraception during treatment and for at least 1 week after treatment
		Renewal Criteria (6-month duration):
		• Patient continues to meet initial criteria; **AND**
		• Prescriber attests to ALL the following:
		  ○ Patient has experienced lack of disease progression, and/or improvement in symptoms
		  ○ Patient has absence of unacceptable toxicity from the drug (e.g., thrombocytopenia, neutropenia, gastrointestinal toxicity, hyponatremia, neurological toxicity)
			4 packs/month	General PA Form

Xtandi® tablets	NP	• Diagnosis of ONE of the following:
		  ○ Castration-resistant prostate cancer
		  ○ Metastatic castration-sensitive prostate cancer
		  ○ Non-metastatic castration-sensitive prostate cancer with biochemical recurrence at high risk for metastasis; **AND**
		• Documented allergy or contraindication to an inactive ingredient in the capsules that is NOT in the tablets
				General PA Form

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

ONCOLOGY *Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated.*				
Medication	**PDL**	**Prior Authorization Criteria**	**Qty. Limits**	**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:
		  ○ Patient will receive a gonadotropin-releasing hormone (GnRH)-analog (e.g., leuprolide, goserelin, triptorelin)
		  ○ Patient has a bilateral orchiectomy; **AND**
		• Male patients with female partners of reproductive potential have been advised to use effective contraception during treatment and for 3 weeks after the final dose, if applicable
		Renewal Criteria (6-month duration):
		• Patient continues to meet the initial criteria; **AND**
		• Tumor response with stabilization of disease or decrease in size of tumor or tumor spread
				General PA Form

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

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	
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	
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	
Meibo®	NP	See Cequa® prior authorization criteria	3 bottles/30 days	
Restasis® Multidose	NP	See cyclosporine emulsion 0.05% prior authorization criteria	1 bottle/30 days	
Tyrvaya®	NP	See Cequa® prior authorization criteria		
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 0.15%	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 (2X Day)	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	
Vigamox	P		1 package/Rx	
AzaSite®	NP		1 package/Rx	
Besivance®	NP		1 package/Rx	

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

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**
Ciloxan®	NP		10 mL/Rx	
gentamicin	NP		15 mL/Rx	
gatifloxacin 0.5% soln	NP		1 package/Rx	
levofloxacin 0.5% soln	NP		1 package/Rx	
moxifloxacin (3X Day)	NP		1 package/Rx	
sulfacetamide oint	NP		1 package/Rx	
Tobrex®	NP		1 package/Rx	
Ophthalmic Antibiotic/Steroid Combos				
neomycin/BAC/poly B/HC	P		1 package/Rx	
sulfacetamide/ prednisolone	P		1 package/Rx	
Pred-G®	P		1 package/Rx	
tobramycin/ dexamethasone	P		1 package/Rx	
Blephamide®	NP		1 package/Rx	General PA Form
Maxitrol®	NP		1 package/Rx	
neomycin/poly B/HC	NP		1 package/Rx	
TobraDex®	NP		1 package/Rx	
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	

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

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 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 Form
Alomide®	NP			
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	
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	
brinzolamide	NP		15 mL/30 days	

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

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**
Cosopt®	NP		10 mL/30 days	
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	
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
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	
bromfenac	NP		1 package/Rx	
Ilevro®	NP		1 package/Rx	

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

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**
Nevanac®	NP		1 package/Rx	
Prolensa®	NP		1 package/Rx	
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	
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	
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	
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	General PA Form
FML Forte®	NP		1 package/Rx	
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	
loteprednol suspension	NP		15 ml/Rx	
Maxidex®	NP		1 package/Rx	

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

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**
prednisolone sodium phosphate	NP		1 package/Rx	
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** • Patient weighs at least 45 kg; **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**	2/day	General PA Form

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

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**

		• Documentation of other 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)		

Amyotrophic Lateral Sclerosis (ALS)				

Exservan®	NP	**Initial Criteria:**
		• Diagnosis of Amyotrophic Lateral Sclerosis (ALS); **AND**
		• Patient is unable to swallow tablets; **AND**
		• Prescriber attests that baseline serum aminotransferases will be taken prior to therapy and during therapy; **AND**
		• Patient must not meet any of the following:
		  ○ Pregnancy
		  ○ Baseline elevations of serum aminotransferases greater than 5 times upper limit of normal
		Renewal criteria:
		• Prescriber attests that patient has demonstrated positive response to therapy; **AND**
		• Patient has not developed treatment limiting adverse effects (hepatic injury, neutropenia, interstitial lung disease)
			2/day	General PA Form

Radicava ORS®	NP	**Initial Criteria (6-month duration):** • Submission of medical records (e.g., chart notes, previous medical history, diagnostic testing including imaging, nerve conduction studies, laboratory values) to support a diagnosis of "definite" or "probable" amyotrophic lateral sclerosis (ALS) per the revised EL Escorial diagnostic criteria; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Patient has scores of 2 or greater in all items of the ALS Functional Rating Scale-Revised (ALSFRS-R) criteria at the start of treatment; **AND** • Patient has a percent (%) 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
Relyvio®	NP	**Initial Criteria (6-month duration):** • Diagnosis of amyotrophic lateral sclerosis (ALS); **AND** • Patient has slow vital capacity (SVC) greater than 60% of predicted at start of treatment; **AND** • Prescribed by, or in consultation with, a neurologist; **AND** • Prescriber attests that patient does not have any of the following: ○ Pregnancy	56 packets/month	General PA Form

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

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**
		○ Tracheostomy or permanent assisted ventilation ○ Concomitant use with bile acid sequestering agents (e.g. cholestyramine, colestipol, colesevelam) ○ Concomitant use of aluminum-based antacids (e.g. Maalox, Mylanta) ○ Enterohepatic Circulation Disorders, Pancreatic Disorders, or Intestinal Disorders **Renewal Criteria:** • Prescriber attests that patient has demonstrated positive response to therapy; **AND** • Patient has not developed treatment limiting adverse effects (e.g. diarrhea, abdominal pain)		
Tiglutik/Teglutik®	NP	See Exservan® prior authorization criteria	20 mL/day	
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]); **AND** • Prescribed by, or in consultation with, a rheumatologist, nephrologist, pulmonologist, or a provider with expertise in vascular medicine; **AND** • Agent will be used as adjunctive therapy with standard therapy (e.g., cyclophosphamide, azathioprine, mycophenolate, rituximab) including glucocorticoids (e.g., methylprednisolone, prednisone); **AND** • Patient does not meet any of the following: ○ Concomitant use of strong CYP3A4 inducers ○ Active, serious infection including localized infections ○ Has active, untreated and/or uncontrolled chronic liver disease (e.g., chronic active hepatitis B, untreated hepatitis C, uncontrolled autoimmune hepatitis) and cirrhosis **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

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

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)				

Emflaza®	P	**Initial Criteria:**
		• Documentation of a confirmed diagnosis of Duchenne muscular dystrophy (DMD); **AND**
		• Age ≥ 2 years; **AND**
		• Patient retains meaningful voluntary motor function (e.g., patient can speak, manipulate objects using upper extremities, ambulate, etc.); **AND**
		• Patient has experienced at least ONE of the following unacceptable adverse reactions directly attributable to previous therapy with prednisone:
		  ○ Patient has experienced significant weight gain (e.g., crossing 2 percentile lines and/or reaching 98th percentile for age and sex)
		  ○ Patient has manifested significant behavioral changes negatively impacting function at school, home, day care, etc.;
		Renewal Criteria:
		• Patient retains meaningful voluntary motor function (e.g., patient can speak, manipulate objects using upper extremities, ambulate, etc.); **AND**
		• Patient has received benefit from therapy, which may include ONE or more of the following:
		  ○ Stability or slowing of decline in motor function or respiratory function
		  ○ Stability or slowing of decline in diminished strength of stabilizing musculature (e.g., scoliosis)
		  ○ Quality of Life
				General PA Form

deflazacort	NP	See Emflaza prior authorization criteria; **AND** • Clinically valid reason why preferred Emflaza cannot be used		

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

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**
Fabry Disease				

Galafold®	NP	**Initial Criteria (6-month duration):**
		• Prescribed by, or in consultation with, clinical genetics professional with knowledge in management of Fabry disease; **AND**
		• 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) determined by, or in consult with, clinical genetics professional as causing Fabry disease (pathogenic); **AND**
		• Baseline echocardiogram, estimate glomerular filtration rate (eGFR), 24-hour urine protein, urine GL-3 and/or GL-3 inclusions, and alpha-galactosidase (α-Gal, male patients only) must be performed prior to initiation; **AND**
		• Patient has not undergone, or scheduled to undergo, kidney transplantation or currently on dialysis; **AND**
		• Will NOT be used in combination with agalsidase beta
		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; **AND**
		• Absence of unacceptable toxicity (e.g., kidney infections); **AND**
		• Absence of progression into renal impairment or end-stage renal disease (e.g., eGFR < 30 mL/min/1.73 m^2)
			14/28 days	General PA Form

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

Fibrodysplasia ossificans progressive (FOP)				

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

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**
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
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
Gaucher Disease				
Cerdelga®	NP		2/day	General PA Form
Glucagon-Like Peptide-2 (GLP-2) Analog				
Gattex®	NP	**Initial Criteria:** • Diagnosis of short bowel syndrome, **AND** • Dependent on parenteral nutrition for at least 12 months; **AND** • Receiving parenteral nutrition at least 3 times weekly **Renewal Criteria:** • Patient is continually receiving parenteral nutrition while taking the requested agent		General PA Form

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

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**
Hereditary Angioedema (HAE) Agents				
icatibant	P	• Prescribed by, or in consultation with, a specialist in allergy, immunology, hematology, pulmonology, or genetics; **AND** • Patient must be ≥18 years of age **AND** • Patient has clinical presentations consistent with 1 of the following HAE subtypes: ○ Type I: – Low C1 inhibitor (C1-INH) antigenic level (C1-INH antigenic level below the lower limit of normal as defined by the laboratory performing the test); **AND** – Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); AND – Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test); **AND** – Patient has a family history of HAE; **OR** – Patient has a normal C1q level; **OR** ○ Type II: – Normal to elevated C1-INH antigenic level; **AND** – Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); **AND** – Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test; **AND** • Will be using to treat acute HAE attacks **AND** • Patient is avoiding the following possible triggers for HAE attacks: ○ Helicobacter pylori infections (confirmed by lab test); **AND** ○ Estrogen-containing oral contraceptive agents OR hormone replacement therapy; **AND** ○ Antihypertensive agents containing angiotensin-converting enzyme (ACE) inhibitors		General PA Form
Kalbitor®	P	See icatibant prior authorization criteria		
Firazyr®	NP	See icatibant prior authorization criteria; **AND** • Patient has tried and failed, contraindication, or intolerance to two preferred agents (icatibant and Kalbitor)		

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

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**
Hereditary Angioedema (HAE) Agents (*continued*)				

Haegarda®	NP	**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**
		• Patient has clinical presentations consistent with 1 of the following HAE subtypes:
		  ○ Type I:
		  – Low C1 inhibitor (C1-INH) antigenic level (C1-INH antigenic level below the lower limit of normal as defined by the laboratory performing the test); **AND**
		  – Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); AND
		  – Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test); **AND**
		  – Patient has a family history of HAE; **OR**
		  – Patient has a normal C1q level; **OR**
		  ○ Type II:
		  – Normal to elevated C1-INH antigenic level; **AND**
		  – Low C4 level (C4 below the lower limit of normal as defined by the laboratory performing the test); **AND**
		  – Low C1-INH functional level (C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test; **AND**
		• Patient has a history of ONE of the following criteria for long-term HAE prophylaxis:
		  ○ ≥2 severe HAE attacks per month (e.g., airway swelling, debilitating cutaneous, gastrointestinal episodes)
		  ○ Patient is disabled more than 5 days per month by HAE
		  ○ History of recurrent laryngeal attacks caused by HAE; **AND**
		• Will not be used in combination with other routine prophylaxis HAE agents (e.g., Haegarda, Takhzyro, Orladeyo); **AND**
		• Patient is avoiding the following possible triggers for HAE attacks:
		  ○ Helicobacter pylori infections (confirmed by lab test)
		  ○ Estrogen-containing oral contraceptive agents OR hormone replacement therapy
		  ○ Antihypertensive agents containing angiotensin-converting enzyme (ACE) inhibitors
		Renewal Criteria:
		• Patient continues to meet initial criteria; **AND**
		• 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); **AND**
		• Patients who have demonstrated improvement/stabilization of disease and are well-controlled (e.g., attack free) for > 6-months may consider a trial of every 4-week dosing
			2 injections/28 days	General PA Form

Orladeyo®	NP	See Haegarda® prior authorization criteria	1/day	General PA Form
Takhzyro®	NP	See Haegarda® prior authorization criteria	2 injections /28 days	

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

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**
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	
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

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

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

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

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**
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, ursodeoxycholic acid); **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	• 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, ursodeoxycholic acid); **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

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)				
Filspari®	NP	**Initial Criteria (6-month duration):** • Patient has diagnosis of biopsy proven Primary IgA nephropathy; **AND** • Patient is at risk of rapid disease progression (e.g., urine protein-to-creatine ratio (UPCR) ≥ 1.5 g/g or proteinuria >0.75 to 1 g/day despite ≥ 90 days of optimized supportive care); **AND** • Filspari will be used to reduce proteinuria; **AND** • Patient has tried and failed max tolerated doses of a preferred angiotensin II receptor blocker or ACE inhibitor minimum duration of 90 days; **OR** ○ Patient is currently experiencing rapid disease progression; **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** • Prescriber and patient have met the requirements of Filspari REMS Program **Renewal Criteria:** • Patient has positive clinical response to Filspari therapy (e.g., reduction of proteinuria from baseline, decreased UPCR)	1/day	General PA Form

Tarpeyo®	NP	• Patient is 18 years of age or older; **AND**
		• Patient has a diagnosis of immunoglobulin A nephropathy (IgAN), as proven by biopsy with proteinuria and is at risk for rapid disease progression; **AND**
		• Patient has proteinuria, defined as either > 1 g/day or urine protein-to-creatinine-ratio (UPCR) > 0.8 g/g; **AND**
		• Patient has an eGFR > 35 mL/min/1.73 m^2; **AND**
		• Patient is concomitantly using an ACE inhibitor or ARB at a maximally tolerated dose; **AND**
		• Prescriber attests agent will not be prescribed to patients with any of the following:
		  ○ Active or quiescent tuberculosis infection
		  ○ Untreated fungal, bacterial, systemic viral or parasitic infection
		  ○ Ocular herpes simplex
		  ○ Concomitant use of potent CYP3A4 inhibitors
		  ○ Severe hepatic impairment (Child-Pugh Class C)
		  ○ Other glomerulopathies, nephrotic syndrome, or previous treatment with systemic immunosuppressants
			4/day	General PA Form

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

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**
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**
		• 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:
		• Height increase of at least 2 cm/year over the previous year of treatment as documented by both:
		  ○ Previous height and date obtained
		  ○ Current height and date obtained; **AND**
		  ○ Patient is not treated with concurrent growth hormone therapy
				General 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 channel 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	8/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**
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

Neuromyelitis Optica Spectrum Disorder (NMOSD)				

Enspryng®	NP	**Initial Criteria (6-month duration):**
		• Diagnosis of neuromyelitis optica spectrum disorder (NMOSD); **AND**
		• Patient is 18 years old of age or older; **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**
		• Patient will not receive live or live-attenuated vaccines during treatment; **AND**
		• Baseline monitoring for liver enzymes and neutrophil counts; **AND**
		• Patient has tried and failed, had a contraindication, or intolerance to TWO of the following:
		  ○ Mycophenolate mofetil
		  ○ Rituximab
		  ○ Azathioprine
		  ○ Corticosteroid
		Renewal criteria:
		• Patient continues to meet initial criteria; **AND**
		• Patient has demonstrated positive response to therapy
			Loading Dose:
			1/14 days for 6 weeks
			
			Maintenance:
			1/28 days
				General PA Form

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

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 peripheral blood flow cytometry diagnostic testing showing the absence or deficiency of glycosylphosphatidylinositol-anchored proteins on at least 2 cell lineages; **AND**
		• Prescribed by, or in consultation with, one of the following:
		  ○ Hematologist
		  ○ Oncologist; **AND**
		• Member meets ONE of the following criteria:
		  ○ Thrombotic event(s) attributable to PNH (e.g., arterial/venous thrombosis, hepatic vein thrombosis) or major adverse vascular events from thromboembolism
		  ○ Symptoms of PNH that inhibit the patient's quality of life (e.g., anemia, extreme fatigue, difficulty swallowing, recurrent abdominal pain, smooth muscle dystonia, thromboses, chronic kidney disease, organ damage secondary to chronic hemolysis)
		  ○ Pregnant and potential benefit outweighs potential fetal risk; **AND**
		• One of the following:
		  ○ Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of PNH (e.g., Soliris, Ultomiris)
		  ○ Patient is currently receiving Soliris which will be discontinued after an initial 4 week overlap period with Empaveli
		  ○ Patient is currently receiving Ultomiris which will be stopped and Empaveli will be initiated no more than 4 weeks after the last dose; **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., improvement in size or redness of facial angiofibroma)
		• Prescribed by, or in consultation with, one of the following:
		  ○ Hematologist
		  ○ Oncologist; **AND**
		• Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of PNH (e.g., Soliris, Ultomiris)
		• 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

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

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	• Patient has diagnosis of Phenylketonuria (PKU); **AND** • Prescribed by, or in consultation with, a physician who specializes in the treatment of inherited metabolic disorders; **AND** • Patient is currently following a PKU diet and will continue to follow PKU diet during treatment; **AND** • Patient has blood phenylalanine (Phe) concentrations > 600 µmol/L on existing management; **AND** • Patient will receive first dose of Palynziq® in prescribing MD's office; **AND** • 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** • Patient must be on a phenylalanine restricted diet; **AND** • Phenylalanine (Phe) levels cannot be maintained within recommended range with dietary intervention alone; **AND** • Documentation of baseline Phe level > 600 µmol/L prior to treatment		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		General 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

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

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**
Sickle Cell Disease				
Endari®	NP	**Initial Criteria:** • Diagnosis of sickle cell disease; **AND** • Member has received > 3 months of hydroxyurea therapy or has 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, which may include one or more of the following: ○ Decrease in number of days in crisis ○ Decrease in number of days in hospital ○ Decrease in the occurrence of Acute Chest Syndrome	6 packets/day	General PA Form
Oxbryta® tablets	NP	**Initial Criteria:** • Diagnosis of sickle cell disease; **AND** • Member has received > 3 months of hydroxyurea therapy or has intolerance to hydroxyurea **Renewal Criteria:** • Documentation of positive clinical response to therapy, which may include one or more of the following: ○ Increase in hemoglobin level of greater than or equal to 1 g/dL from baseline ○ Decreased annualized incidence rate of vaso-occlusive crises [VOCs]) ○ Decrease in transfusion dependency ○ Decrease in number of days in hospital ○ Decrease in number of days in crisis	3 tabs/day	General PA Form
Oxbryta® suspension	NP	See Oxbryta prior authorization criteria; **AND** • Patient is unable to swallow tablets		General PA Form
Siklos®	NP	**Initial Criteria:** • Patient has a diagnosis of sickle cell anemia with recurrent moderate to severe painful crisis; **AND** • At least 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 **Renewal Criteria:** • Documentation of positive clinical response to therapy, which may include one or more of the following: ○ Decreased in number of vaso-occlusive crises ○ Decrease in transfusion dependency ○ Decrease in number of days in crisis ○ Decrease in number of days in hospital ○ Decrease in the occurrence of Acute Chest Syndrome		General PA Form

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

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**
Somatostatins and Related Agents				
Korlym®	P	• Diagnosis of Cushing's Syndrome; **AND** • Type 2 diabetes mellitus or glucose intolerance; **AND** • Have failed surgical treatment **OR** are not candidate for surgery; **AND** • Will NOT be approved for use during pregnancy		General PA Form
octreotide	P	• Diagnosis of acromegaly; **OR** • Severe diarrhea/flushing episodes associated with metastatic carcinoid tumors; **OR** • Profuse watery diarrhea associated with VIP-secreting tumors		
Isturisa®	NP	**Initial Criteria (6-month duration):** • Patient has Cushing's disease and pituitary surgery is not an option or has not been curative; **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** • 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	4/day	General 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 prior to initiating therapy, and prescriber attests to monitor regularly thereafter; **AND** • Patient has had a baseline 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)		General PA Form
Sandostatin®	NP	See prior authorization criteria for octreotide		

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

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**
Signifor®	NP	• Diagnosis of Cushing's Disease or Cushing's Syndrome; **AND** • Surgery is not an option or has not been curative; **AND** • Prescribed by, or in consultation with, an endocrinologist		General PA Form
Xermelo®	NP	• Patient has a carcinoid/neuroendocrine tumor and has been diagnosed with carcinoid syndrome; **AND** • Patient has been receiving therapy with the FDA-approved maximum (or highest tolerated) dose of a somatostatin analog therapy (e.g., octreotide I/R or LAR, lanreotide depot) for at least 3 months; **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	3/day	General PA Form
Spinal Muscular Atrophy (SMA)				

Evrysdi®	NP	**Initial Criteria:**
		• Diagnosis of Spinal Muscular Atrophy (SMA); **AND**
		• Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis and treatment of SMA; **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 at least one motor test score over a period of 6-months); **AND**
		• Will not be used with drugs that are substrates of multidrug and toxin extrusion (MATE) transporters; **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**
		• Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis and treatment of SMA; **AND**
		• Patient has clinically significant improvement in SMA associated signs and symptoms (progression, stabilization, or decreased decline in motor function)
			3 bottles/28 days	General PA Form

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

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**
Transthyretin Amyloidosis Agents				

Tegsedi®	NP	**Initial Criteria:**
		• 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**
		• Presence of clinical signs and symptoms of the disease (peripheral or autonomic neuropathy, motor disability); **AND**
		• Patient is not receiving the requested agent in combination with either of the following:
		  ○ Oligonucleotide agents (e.g., Onpattro)
		  ○ Tafamidis (e.g., Vyndaqel, Vyndamax)
		Renewal Criteria:
		• Patient has previously received treatment with the requested agent (e.g., confirmed by paid pharmacy claims or submitted medical documentation); **AND**
		• Prescribed by or in consultation with a neurologist, cardiologist, or specialist with knowledge of ATTRv; **AND**
		• Patient has demonstrated a benefit from therapy (e.g., improved neurologic impairment, motor function, slowing of disease progression, quality of life assessment); **AND**
		• Patient is not receiving Tegsedi in combination with ANY of the following:
		  ○ Oligonucleotide agents (e.g., Onpattro)
		  ○ Tafamidis (e.g., Vyndaqel, Vyndamax)
			248 mg/week	General PA Form

Vyndamax®	NP	• Patient is 18 years of age or older; **AND**
		• Must be prescribed in consultation with a cardiologist; **AND**
		• Patient has a 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 has clinical symptoms of cardiomyopathy and heart failure (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema, etc.); **AND**
		• Patient is currently taking a diuretic; **AND**
		• Patient does not meet any of the following:
		  ○ 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
		  ○ Previous treatment with tafamidis
		  ○ Renal or hepatic impairment
			1/day	

Vyndaqel®	NP	See prior authorization criteria for Vyndamax	4/day	
Wainua®	NP	See Tegsedi prior authorization criteria	1 injector/28 days	

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

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**
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		
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	• Diagnosis of Wilson's disease confirmed by a genetic mutation of the ATP7B gene; **OR** • Diagnosis of Wilson's disease confirmed by TWO of the following: ○ Presence of hepatic abnormality (e.g., acute liver failure, cirrhosis, fatty liver) ○ Presence of neurological symptoms (e.g., dystonia, hypertonia, rigidity with tremors, muscle spasms dysphasia, polyneuropathy) ○ Presence of Kayser-Fleischer rings ○ Serum ceruloplasmin level less than 20 mg/dL ○ Basal urinary copper excretion greater than 40 mcg/24 hours or the testing laboratory's upper limit of normal ○ Hepatic parenchymal copper content greater than 50 mcg/g dry weight; **AND** ○ History of intolerance, failure, or contraindication to penicillamine	8/day	
trientine	NP	See Syprine® prior authorization criteria	8/day	

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

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	
Uroxatral®	NP		1/day	
Androgen Hormone Inhibitors				
dutasteride	P		1/day	General PA Form
finasteride	P		1/day	
Avodart®	NP		1/day	
Proscar®	NP		1/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	
Cystine Depleting Agent				
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

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

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**
Phosphorus Depletors				
sevelamer carbonate tablets	P		9/day	General PA Form
Renvela® packs	P	• Patient is unable to swallow solid dosage forms	0.8 g packets: 6/day 2.4 g packets: 5/day	
Renvela® tablets	NP		9/day	
Fosrenol® powder 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		
sevelamer carbonate packs	NP	• Patient is unable to swallow solid dosage forms	0.8 g packets: 6/day 2.4 g packets: 5/day	
Velphoro®	NP	See Fosrenol® prior authorization criteria		
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 Acidifying Agents				
Renacidin®	NP	• Diagnosis of apatite and/or struvite calculi; **AND** • Patient has received antibiotic therapy, **AND** • Patient is not a candidate for surgery or has residual calculi following surgery		General PA Form
Urinary Tract Antispasmodics				
oxybutynin ER	P		5 mg: 1/day; 10, 15 mg: 2/day	General PA Form
solifenacin	P		1/day	
Toviaz®	P		1/day	
darifenacin	NP		1/day	
Detrol®	NP		2/day	
Detrol LA®	NP		1/day	
Ditropan XL®	NP		5 mg: 1/day; 10, 15 mg: 2/day	
Enablex®	NP		1/day	
fesoterodine	NP		1/day	
flavoxate	NP		2 fills per 60 days	
Gelnique™	NP		3%: 3.1 gm/day 10%: 1 sachet/day	

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

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**
Gemtesa®	NP	• Patient is 18 years of age or older: **AND** • Patient has diagnosis of overactive bladder (OAB); **AND** • Provider must have a clinically valid reason as to why the preferred agents cannot be used	1/day	
Myrbetriq®	NP		1/day	
Oxytrol®	NP		8 patches/26 days	
tolterodine	NP		2/day	
tolterodine ER	NP		1/day	
trospium	NP		2/day	
trospium XR	NP		1/day	
VESIcare®	NP		Tab: 1/day Susp: 10 mL/day	

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

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	P		2/Rx	General PA Form
epinephrine auto injector	P		2/Rx	
Auvi-Q	NP		2/Rx	
EpiPen®	NP		2/Rx	
EpiPen-Jr®	NP		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)	

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

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	General PA Form
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	General PA Form
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	General PA Form
Cystic Fibrosis Agents				
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		General PA Form
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	

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

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	See Bethkis® prior authorization criteria	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: CFTR Potentiators				

Kalydeco®	NP	**Initial Criteria (6-month duration):**
		• Must be prescribed by a provider at a CF Center of Excellence; **AND**
		• Lab documentation confirming patient has one mutation in the CFTR gene that is responsive to Kalydeco®; **AND**
		• Patient has received baseline liver function tests (ALT and AST); **AND**
		• If member is > 6 years old, baseline predicted FEV1; **AND**
		• Patient receives baseline ophthalmic examination
		Note: will NOT be approved for homozygous F508del mutation in the CFTR gene
		Renewal Criteria:
		• Prescriber attests patient is continuing to receive periodic follow-up ophthalmic examinations; **AND**
		• Patient does not have evidence of toxicity from the drug (e.g., elevated transaminases [ALT or AST], cataracts); **AND**
		• Improvement in at least one of the following compared to baseline:
		  ○ Decreased pulmonary exacerbations compared to pretreatment baseline
		  ○ Improvement or stabilization of lung function compared to baseline
		  ○ Decrease in decline of lung function (as evidenced per new FEV1 in the past 30 days)
		  ○ Improvement in quality of life, weight gain, or growth
			2/day	CFTR Potentiators PA Form

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

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):**
		• Must be prescribed by a provider at a CF Center of Excellence; **AND**
		• Age ≥ 1 years old; **AND**
		• Lab documentation confirming patient has homozygous F508del mutation in the CFTR gene; **AND**
		• Patient has received baseline liver function tests (ALT and AST); **AND**
		• Patient receives baseline ophthalmic examination; **AND**
		• If member is > 6 years old, baseline predicted FEV1
		Renewal Criteria:
		• Patient continues to receive periodic follow-up ophthalmic examinations; **AND**
		• Patient does not have evidence of toxicity from the drug (e.g., elevated transaminases [ALT or AST], cataracts); **AND**
		• Improvement in at least one of the following compared to baseline:
		  ○ Decreased pulmonary exacerbations compared to pretreatment baseline
		  ○ Improvement or stabilization of lung function compared to baseline
		  ○ Decrease in decline of lung function (as evidenced per new FEV1 in the past 30 days)
		  ○ Improvement in quality of life, weight gain, or growth
			4/day	CFTR Potentiators PA Form

Symdeko®	NP	**Initial Criteria (6-month duration):**
		• Must be prescribed by a provider at a CF Center of Excellence; **AND**
		• Age ≥ 6 years old; **AND**
		• Lab documentation confirming patient is homozygous for the F508del mutation in the CFTR gene; **OR** who have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor based on in vitro data; **AND**
		• Patient has received baseline liver function tests (ALT and AST)*;* **AND**
		• Patient receives baseline ophthalmic examination; **AND**
		• Have a baseline predicted FEV1 (renewal will require reported measurement within previous 30 days); **AND**
		Renewal Criteria:
		• Patient continues to receive periodic follow-up ophthalmic examinations; **AND**
		• Patient does not have evidence of toxicity from the drug (e.g., elevated transaminases [ALT or AST], cataracts); **AND**
		• One of the following:
		  ○ Patient has not received a lung transplant; **AND**
		  – Patient has disease response as indicated by at least one of the following:
		  • Decreased pulmonary exacerbations compared to pretreatment baseline
		  • Improvement or stabilization of lung function compared to baseline
		  • Decrease in decline of lung function (as evidenced per new FEV1 in the past 30 days)
		  • Improvement in quality of life, weight gain, or growth; **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	CFTR Potentiators PA Form

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

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**
Trikafta®	NP	**Initial Criteria (6-month duration):** • Must be prescribed by a provider at a CF Center of Excellence; **AND** • Patient is ≥ 2 years of age; **AND** • Faxed lab documentation confirming patient has at least one copy of the F508del mutation in the CFTR gene **OR** a mutation in the CFTR gene that is responsive based on in vitro data; **AND** • Baseline ALT, AST, and bilirubin have been assessed prior to beginning therapy; **AND** • Patient receives baseline ophthalmic examinations; **AND** • If member is > 6 years old, baseline predicted FEV1 (renewal requires reported measurement within previous 30 days) **Renewal Criteria:** • Patient continues to receive periodic follow-up ophthalmic examinations; **AND** • Patient does not have evidence of toxicity from the drug (e.g., elevated transaminases [ALT or AST], cataracts); **AND** • One of the following: ○ Patient has not received a lung transplant; **AND** – Patient has disease response as indicated by at least one of the following: • Decreased pulmonary exacerbations compared to pretreatment baseline • Improvement or stabilization of lung function compared to baseline • Decrease in decline of lung function (as evidenced per new FEV1 in the past 30 days) • Improvement in quality of life, weight gain, or growth; **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	CFTR Potentiators 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	

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

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**

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	
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	
Lonhala Magnair®	NP	See Duaklir Pressair prior authorization criteria	2 mL/day	

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

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**
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	
Inhaled: Beta Agonists-Corticosteroid Combination Products				
Advair HFA®	P		1 inhaler/month	Beta Agonist Combos
Dulera®	P		2 inhalers/month	
fluticasone/ salmeterol Diskus	P		1 inhaler/month	
Symbicort®	P		2 inhalers/month	
Advair Diskus®	NP	• Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** • Clinically valid reason why the patient cannot use the preferred fluticasone/salmeterol Diskus	2 blisters/day	
AirDuo Digihaler®	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	
AirDuo RespiClick®	NP	See AirDuo Digihaler® prior authorization criteria	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	

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

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**
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 HFA	NP	• Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** • Clinically valid reason why the patient cannot use the preferred Advair HFA®	1 inhaler/month	
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 fluticasone/salmeterol 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	
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	
ProAir® Digihaler	NP	• Trial and failure, contraindication, or intolerance of TWO preferred agents; **AND** • A clinically valid reason as to why ALL preferred agents cannot be used	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	
Xopenex®	NP	• Patients has experienced intolerable side effects to albuterol (e.g., tachycardia, etc.)	96 nebs/month	

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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: 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
ArmonAir Digihaler®	P	See Alvesco® prior authorization criteria	1/30 days	
Arnuity Ellipta®	P		1 blister/day	General PA Form
Asmanex HFA®	P		1/30 days	
Asmanex Twisthaler®	P		1/30 days	
budesonide suspension	P	• Diagnosis of asthma; **AND** • Patient is between 12 months and 8 years of age; **Note**: PA not required for patients < 8 years of age. Budesonide suspension is not FDA approved for patients ≥ 8 years of age.	0.25, 0.5 mg: 2 vials/day; 1 mg: 1 vial/day	
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 between 12 months and 8 years of age	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	
Beconase AQ®	NP		2/30 days	
budesonide nasal (Rx only)	P		2/30 days	General PA Form
Flonase®	NP		1/30 days	
flunisolide	NP		2/30 days	

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

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**
mometasone furoate	NP		1/30 days	
Nasacort AQ®	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 been diagnosed with chronic rhinosinusitis with nasal polyps (CRSwNP); **AND** • 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	
Zetonna®	NP		1/30 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	
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	

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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**
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 Inhibitor				
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	General 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	

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

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				
Denovo®	P	• Patient has documented methylenetetrahydrofolate reductase (MTHFR) mutation/deficiency		General PA Form
Cerefolin®	NP	See Denovo® prior authorization criteria		
Deplin®	NP	See Denovo® prior authorization criteria		
Elfolate ®	NP	See Denovo® prior authorization criteria		
L-methylfolate	NP	See Denovo® prior authorization criteria		

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

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**
Potassium Depletors				
Lokelma®	NP	**Initial Criteria:** • Patient must be ≥ 18 years of age; **AND** • Patient has a diagnosis of chronic hyperkalemia; **AND** • Patient has tried/failed a preferred potassium depletor agent. **Renewal Criteria:** • Patient meets initial criteria; **AND** • Patient has not experienced treatment-limiting adverse effects (e.g., edema); **AND** • Patient has documented efficacy [e.g., decreasing serum potassium levels or levels within normal limits [3.5 to 5 mEq/L])	1/day	General PA Form
Veltassa®	NP		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	

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