Prior Authorization Criteria Document for Presbyterian Turquoise Care

General Information and Definitions:

- Inclusion of a drug on this list does not mean that it will be covered.
- Prior Authorization (PA) - You or your doctor must get permission or an OK from Presbyterian Turquoise Care before you fill your drug. If you don't get permission, Presbyterian Turquoise Care may not pay for the drug. You or your doctor can ask for permission by fax, phone, email or regular mail.
- Step Therapy (ST) – You must first try certain drugs to treat a health problem before a different drug will be covered for the same health problem. For example, if Drug A and Drug B both treat your health problem, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the plan may then cover Drug B.

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Prior Authorization Criteria

Adalimumab

Products Affected

- Adalimumab-adbm (2 Pen) Auto-Injector Kit 40 MG/0.4ML Subcutaneous
- Adalimumab-adbm (2 Pen) Auto-Injector Kit 40 MG/0.8ML Subcutaneous
- Adalimumab-adbm (2 Syringe) Prefilled Syringe Kit 10 MG/0.2ML Subcutaneous
- Adalimumab-adbm (2 Syringe) Prefilled Syringe Kit 20 MG/0.4ML Subcutaneous
- Adalimumab-adbm (2 Syringe) Prefilled Syringe Kit 40 MG/0.4ML Subcutaneous
- Adalimumab-adbm (2 Syringe) Prefilled Syringe Kit 40 MG/0.8ML Subcutaneous
- Hadlima PushTouch Solution Auto-Injector 40 MG/0.4ML Subcutaneous
- Hadlima PushTouch Solution Auto-Injector 40 MG/0.8ML Subcutaneous
- Hadlima Solution Prefilled Syringe 40 MG/0.4ML Subcutaneous
- Hadlima Solution Prefilled Syringe 40 MG/0.8ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded. Diagnosis of Hidradenitis Suppurative requires Prior Authorizaion criteria to be met.
Exclusion Criteria	
Required Medical Information	HS: Hurley Stage III or refractory Hurley Stage II HS and a trial of an antibiotic (topical 1% clindamycin, doxycycline) or hormonal therapy (finasteride). *Safety edit applicable to all diagnoses: Current PPD (tuberculosis) negative skin test or negative QuantiFERON-TB Gold test before the initiation of therapy.
Age Restrictions	
Prescriber	

PA Criteria	Criteria Details
Restrictions	
Coverage Duration	Up to 1 year
Other Criteria	Use of Presbyterian Specialty Pharmacy is required.

Adbry

Products Affected

- Adbry Solution Auto-Injector 300 MG/2ML Subcutaneous
- Adbry Solution Prefilled Syringe 150 MG/ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	1. moderate-to-severe atopic dermatitis in adults and pediatric patients 12 years of age and older
Exclusion Criteria	
Required Medical Information	All of the following must be met: 1) Moderate to severe atopic dermatitis as measured by Eczema Area and Severity Index (EASI) score greater than or equal to 16 and/or Investigator Global Assessment (IGA) score greater than or equal to 3 PLUS at least 10% body surface area (BSA) involvement, AND 2) age 12 and up, AND 3) inadequate control with topical therapy OR topical therapy is not appropriate. For Adults: up to two (2)of the 300 mg autoinjectors or prefilled syringes for loading and one (1) 300 mg autoinjector or prefilled syringes every other week for maintenance. For pediatrics: up to two (2) of the 150 mg autoinjectors or prefilled syringes for loading and one (1) 150 mg autoinjector or prefilled syringes every other week for maintenance.
Age Restrictions	12 years
Prescriber Restrictions	
Coverage Duration	Initial 6 months, continuation 12 months

PA Criteria	Criteria Details
Other Criteria	Reauthorization: an IGA score of 0 or 1, or at least a 75% reduction in EASI from baseline

Ajovy

Products Affected

- Ajovy Solution Auto-Injector 225 MG/1.5ML Subcutaneous
- Ajovy Solution Prefilled Syringe 225 MG/1.5ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	1) prevention of chronic or episodic migraines in adults, 2) prevention of episodic migraines in pediatrics ages 6-17 years.
Exclusion Criteria	
Required Medical Information	1) Prevention of migraines in adults, all of the following must be met: a) a diagnosis of chronic or episodic migraine chronic migraine as defined by International Headache Society (IHS) International Classification of Headache Disorders (ICHD)-3 beta guidelines, AND b) a 3-month trial of at least two prophylactic medications from at least two (2) of the following categories: i. Anticonvulsants (e.g. divalproex, valproate, topiramate) ii. Beta-blockers (e.g. metoprolol, propranolol, timolol) iii. Antidepressants (e.g. amitriptyline, venlafaxine) iv. Candesartan, AND c) member has been evaluated for and does not have medication overuse headache. 2) Prevention of episodic migraines in children, all of the following must be met: a) child must be between ages 6-17 years, AND b) must weight 45 kg or more, AND c) a 3-month trial of at least two prophylactic medications from at least two (2) of the following: i. amitriptyline, ii. topiramate, iii. propranolol, AND d) member has been evaluated for and does not have medication overuse headache.
Age Restrictions	6
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or headache specialist.

PA Criteria	Criteria Details
Coverage Duration	Initial: 3 months. Continuation: Up to 12 months
Other Criteria	Reauthorization: 1) positive response to Ajovy.

Albenza (albendazole)

Products Affected

- Albendazole Tablet 200 MG Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Documentation showing that all formulary alternatives have been trialed for the requested diagnosis AND the dose is within the recommended dosing for the diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	N/A
Other Criteria	

Ambien CR (zolpidem)(Cent Care)

Products Affected

- Zolpidem Tartrate ER Tablet Extended Release 12.5 MG Oral
- Zolpidem Tartrate ER Tablet Extended Release 6.25 MG Oral

PA Criteria	Criteria Details
Covered Uses	Insomnia
Exclusion Criteria	N/A
Required Medical Information	Patient must have a documented treatment failure of all of the following: Zolpidem oral tablets, A formulary benzodiazepine used for the treatment of insomnia AND Trazodone
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Quantity Limit: 30 tablets per 30 days

Amicar Solution (aminocaproic acid)

Products Affected

- Aminocaproic Acid Solution 0.25 GM/ML
  Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Documents must show patient is unable to swallow tablets and are not currently taking other oral non-dissolving tablets or capsules
Age Restrictions	Maximum: 12 years of age
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	

AndroGel 1% (testosterone topical gel)(Cent Care)

Products Affected

- Testosterone GEL 12.5 MG/ACT (1%) TRANSDERMAL
- Testosterone Gel 20.25 MG/1.25GM (1.62%) Transdermal
- Testosterone Gel 20.25 MG/ACT (1.62%) Transdermal
- Testosterone Gel 25 MG/2.5GM (1%) Transdermal
- Testosterone GEL 50 MG/5GM (1%) TRANSDERMAL

PA Criteria	Criteria Details
Covered Uses	1. Primary hypogonadism in men (congenital or acquired). 2. Hypogonadotropic hypogonadism (congenital or acquired). 3. As a continuous therapy for gender dysphoria/gender identity disorder
Exclusion Criteria	Exclusions: 1. Due to a lack of controlled evaluations in women and the potential for virilizing effects, testosterone products will not be approved for use in women who do not meet criterion for gender dysphoria/gender identity disorder. 2. Testosterone replacement will not be covered for the treatment of sexual dysfunction.
Required Medical Information	1. Primary hypogonadism in men (congenital or acquired). Testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchidectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals AND Lab results required are two low TOTAL testosterone levels (drawn on separate days) and one lab with an elevated LH and FSH. 2. Hypogonadotropic hypogonadism (congenital or acquired). Idiopathic gonadotropin or LHRH deficiency or pituitary hypothalamic injury from tumors, trauma, or radiation AND Lab results required are two low TOTAL testosterone levels (drawn on separate days) and one lab with a low or low-normal LH and FSH (If your patient has low LH and FSH levels, please follow-up on these low levels or consider a referral to an endocrinology provider). 3. As a continuous therapy for gender dysphoria/gender identity disorder when all of the following are met: a. The patient's insurance benefit includes coverage for the treatment of gender dysphoria/gender identity disorder. b. The

PA Criteria	Criteria Details
	patient meets DSM 5 criteria for diagnosis of Persistent Gender Dysphoria documented by a qualified licensed mental health professional experienced in the field, i. If significant medical or mental health concerns are present, there must be documentation that they are well controlled. c. One of the following: i. Member has lived as their chosen or reassigned gender full-time for 12 months or more, ii. Treatment plan documents that the patient will live as their reassigned gender full-time for a minimum of 12 months while concurrently receiving continuous hormone therapy, iii. Patient has completed gender transition and requires continued hormone therapy to maintain physical characteristics more congruent with their gender identity.
Age Restrictions	18 years or greater
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	2.5gm packets: 75gm (30 packets) for 30 days (1 packet per day), 5gm packets: 300gm (60 packets) for 30 days (2 packets per day), Pump: 300gm for 30 days (8 actuations per day).

AndroGel 1.62% (testosterone topical gel)(COMM, EXC)

Products Affected

- Testosterone Gel 40.5 MG/2.5GM (1.62%) Transdermal

PA Criteria	Criteria Details
Covered Uses	1. Primary hypogonadism in men (congenital or acquired). 2. Hypogonadotropic hypogonadism (congenital or acquired). 3. As a continuous therapy for gender dysphoria/gender identity disorder
Exclusion Criteria	Exclusions: 1. Due to a lack of controlled evaluations in women and the potential for virilizing effects, testosterone products will not be approved for use in women who do not meet criterion for gender dysphoria/gender identity disorder. 2. Testosterone replacement will not be covered for the treatment of sexual dysfunction.
Required Medical Information	1. Primary hypogonadism in men (congenital or acquired). Testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchidectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals AND Lab results required are two low TOTAL testosterone levels (drawn on separate days) and one lab with an elevated LH and FSH. 2. Hypogonadotropic hypogonadism (congenital or acquired). Idiopathic gonadotropin or LHRH deficiency or pituitary hypothalamic injury from tumors, trauma, or radiation AND Lab results required are two low TOTAL testosterone levels (drawn on separate days) and one lab with a low or low-normal LH and FSH (If your patient has low LH and FSH levels, please follow-up on these low levels or consider a referral to an endocrinology provider). 3. As a continuous therapy for gender dysphoria (16 years of age and up)- Specific criteria apply. Refer to the Gender Dysphoria Treatment Criteria located on phs.org.

PA Criteria	Criteria Details
Age Restrictions	18 years or greater
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Quantity Limits: Pump = 150gm for 30 days (4 actuations per day).

Anzemet (dolasetron) Tablets(Cent Care)

Products Affected

- Anzemet Tablet 50 MG Oral

PA Criteria	Criteria Details
Covered Uses	1. Nausea and vomiting associated with moderately emetogenic cancer chemotherapy
Exclusion Criteria	N/A
Required Medical Information	Patient has a documented treatment failure with antiemetic regimens that include generic ondansetron or generic granisetron. Treatment failure is defined as an allergy, intolerable side effects, significant drug-drug interactions, or lack of complete response.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Quantity Limit: 3 tablets per 30 days

Aranesp (darbepoetin alfa)(Cent Care)

Products Affected

- Aranesp (Albumin Free) SOLUTION 100 MCG/ML INJECTION
- Aranesp (Albumin Free) SOLUTION 25 MCG/ML INJECTION
- Aranesp (Albumin Free) SOLUTION 40 MCG/ML INJECTION
- Aranesp (Albumin Free) SOLUTION 60 MCG/ML INJECTION

PA Criteria	Criteria Details
Covered Uses	1. Treatment of anemia associated with chronic renal failure, including patients on dialysis and patients not on dialysis, 2. For the treatment of anemia in patients with nonmyeloid malignancies where anemia is due to the effect of concomitantly administered chemotherapy, 3. Anemia due to HCV Treatment
Exclusion Criteria	The use of Aranesp is considered experimental, investigational, and unproven for any indication not listed above, including but not limited to the following: a. Aplastic anemia, b. B-12 and folate deficiency anemias, c. Iron deficiency anemia, d. Post-hemorrhagic anemia
Required Medical Information	1. Treatment of anemia associated with chronic renal failure, including patients on dialysis and patients not on dialysis. a. The maximum dose for the first 4 weeks of treatment is 9 mcg/kg. b. Hemoglobin must be <11g/dl. 2. For the treatment of anemia in patients with nonmyeloid malignancies where anemia is due to the effect of concomitantly administered chemotherapy. a. The maximum dose for the first 4 weeks of treatment is 9 mcg/kg. b. Hemoglobin must be <11g/dl. 3. Anemia due to HCV Treatment: a. Recent (within 2-3 weeks) hemoglobin <10g/dl AND b. Persists for at least 2 weeks after ribavirin dose reduction (may be reduced in 200mg incremental reductions or one-time reduction to 600mg/day) OR Patient is receiving peginterferon/ribavirin alone with documented evidence that the patient is post-liver transplantation or HIV/HCV co-infected.
Age Restrictions	N/A

PA Criteria	Criteria Details
Prescriber Restrictions	N/A
Coverage Duration	Up to 6 months
Other Criteria	Code: J0881. 1mcg (0.001mg) = 1 billable unit

Aricept ODT (donepezil orally disintegrating) Criteria

Products Affected

- Donepezil HCl TABLET DISPERSIBLE 10 MG ORAL
- Donepezil HCl TABLET DISPERSIBLE 5 MG ORAL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Documentation that the patient is unable to take or swallow oral medication, should not be on other tablets or capsules
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Quantity Limit: 30 tablets per 30 days.

Arixtra (fondaparinux)(Cent Care)

Products Affected

- Fondaparinux Sodium SOLUTION 10 MG/0.8ML Subcutaneous
- Fondaparinux Sodium Solution 2.5 MG/0.5ML Subcutaneous
- Fondaparinux Sodium SOLUTION 5 MG/0.4ML Subcutaneous
- Fondaparinux Sodium Solution 7.5 MG/0.6ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	1. Patient will be undergoing total knee replacement, total hip replacement, hip fracture repair, pulmonary embolism treatment or deep venous thrombosis treatment, 2. The patient has an allergy or HIT with documented antiplatelet antibody to unfractionated heparin (UFH).
Exclusion Criteria	Contraindications: 1. Patients with creatinine clearance < 30 ml/min, 2. Patient with weight <50 kg (deep vein thrombosis prophylaxis) Evidence of active bleeding, 3. Bacterial endocarditis, 4. Thrombocytopenia with a positive test for antiplatelet antibody to fondaparinux, 5. Hypersensitivity to fondaparinux, 6. Epidural/spinal anesthesia
Required Medical Information	Chart notes documenting: 1. Patient will be undergoing total knee replacement, total hip replacement, hip fracture repair, pulmonary embolism treatment or deep venous thrombosis treatment AND The patient has an allergy or Heparin Induced Thrombocytopenia (HIT) with documented antiplatelet antibody to low molecular weight heparin (LMWH), OR 2. The patient has an allergy or HIT with documented antiplatelet antibody to unfractionated heparin (UFH).
Age Restrictions	N/A
Prescriber Restrictions	N/A

PA Criteria	Criteria Details
Coverage Duration	1 time
Other Criteria	Fondaparinux 2.5 mg SQ daily, initiated 6 hours postoperatively for thromboprophylaxis. Fondaparinux weight adjusted dosing for thromboembolism treatment; 5.0 mg, 7.5 mg, 10 mg for body weights of

Arnuity

Products Affected

- Arnuity Ellipta Aerosol Powder Breath Activated 100 MCG/ACT Inhalation
- Arnuity Ellipta Aerosol Powder Breath Activated 200 MCG/ACT Inhalation
- Arnuity Ellipta Aerosol Powder Breath Activated 50 MCG/ACT Inhalation

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	

Asmanex

Products Affected

- Asmanex (120 Metered Doses) Aerosol Powder Breath Activated 220 MCG/ACT Inhalation
- Asmanex (14 Metered Doses) Aerosol Powder Breath Activated 220 MCG/ACT Inhalation
- Asmanex (30 Metered Doses) Aerosol Powder Breath Activated 110 MCG/ACT Inhalation
- Asmanex (30 Metered Doses) Aerosol Powder Breath Activated 220 MCG/ACT Inhalation
- Asmanex (60 Metered Doses) Aerosol Powder Breath Activated 220 MCG/ACT Inhalation
- Asmanex HFA Aerosol 100 MCG/ACT Inhalation
- Asmanex HFA Aerosol 200 MCG/ACT Inhalation
- Asmanex HFA Aerosol 50 MCG/ACT Inhalation

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year

PA Criteria	Criteria Details
Other Criteria	

Astagraf XL (tacrolimus extended release)

Products Affected

- Tacrolimus ER Capsule Extended Release 24 Hour 0.5 MG Oral
- Tacrolimus ER Capsule Extended Release 24 Hour 1 MG Oral
- Tacrolimus ER Capsule Extended Release 24 Hour 5 MG Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Patient has tried and failed tacrolimus immediate release capsules despite good adherence (tacrolimus levels must be submitted showing poor control) and pharmacy claims show regular fills
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Up to 1 Year
Other Criteria	Quantity Limits: 0.5 MG - 30 capsules per 30 days; 1 MG - 120 capsules per 30 days; 5 MG - 90 capsules per 30 days.

Austedo (deutetrabenazine)(COMM, EXC, CentCare)

Products Affected

- Austedo TABLET 12 MG Oral
- Austedo TABLET 6 MG Oral
- Austedo TABLET 9 MG Oral
- Austedo XR Patient Titration Tablet Extended Release Therapy Pack 12 & 18 & 24 & 30 MG Oral
- Austedo XR Tablet Extended Release 24 Hour 12 MG Oral
- Austedo XR Tablet Extended Release 24 Hour 18 MG Oral
- Austedo XR Tablet Extended Release 24 Hour 24 MG Oral
- Austedo XR Tablet Extended Release 24 Hour 30 MG Oral
- Austedo XR Tablet Extended Release 24 Hour 36 MG Oral

PA Criteria	Criteria Details
Covered Uses	Tardive Dyskinesia. Disease specific criteria must be met.
Exclusion Criteria	N/A
Required Medical Information	Tardive Dyskinesia i. The patient has documented diagnosis of tardive dyskinesia. ii. At least 60 days of stable (drug and dose) exposure to a first generation antipsychotic, second generation antipsychotic, or certain dopamine receptor-blocking drugs used in the treatment of nausea and gastroparesis (e.g., prochlorperazine, promethazine, metoclopramide). iii. Documentation of a baseline Abnormal Involuntary Movement Scale (AIMS) must be provided.
Age Restrictions	Approved for use in adults only.
Prescriber Restrictions	The medication is prescribed by or in consultation with a neurologist or psychiatrist.
Coverage Duration	Initial Approval: 6 months. Renewal One Year

PA Criteria	Criteria Details
Other Criteria	Continuation of Therapy: Tardive Dyskinesia: Documented improvement in AIMS compared to baseline. Specialty Pharmacy Required. Quantity Limits:- 6mg and 9mg - 90 tablets for 30 days- 12mg - 120 tablets for 30 days.

Baraclude (entecavir)

Products Affected

- Entecavir Tablet 0.5 MG Oral
- Entecavir TABLET 1 MG Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Drug will not be approved if: 1) Immune-tolerant chronic hepatitis B(CHB), 2)Inactive chronic hepatitis B, 3)Children 2 to 18 years old with persistently normal ALT, regardless of HBV DNA levels 4) There is insufficient evidence to support the use of entecavir in pregnant women
Required Medical Information	1) Immune-active CHB AND one of the following: a) ALT more than 2 times upper limit of normal, b) significant histological disease (significant inflammation or fibrosis on biopsy)and HBV DNA greater than 2000IU/mL if HBeAG negative or greater than 20000IU/mL if HBeAG positive c) cirrhosis and HBV DNA greater than 2000IU/mL d)high risk factors (more than 40years old, family history of liver cancer, previous treatment or extra-hepatic symptoms), 2)Immune-tolerant CHB and more than 40 years old, HBV DNA at least 1,000,000IU/mL 3)compensated cirrhosis 4)HBs-AG positive and decompensated cirrhosis 5)2 to 18 years old with elevated ALT and HBV DNA greater than 1,000,000IU/mL
Age Restrictions	at least 2 years old
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	Continuation: 1) HBeAg-positive adults without cirrhosis who seroconvert to anti-HBe(continue for at least 12 months of persistently normal ALT and undetectable serum HBV DNA levels) 2) HBeAg or HBsAG positive with cirrhosis 3) HBeAg-negative immune-active CHB Quantity Limit: 30 tablets per 30 days.

Belsomra (suvorexant) (COMM, EXC, Cent Care)

Products Affected

- Belsomra TABLET 10 MG ORAL
- Belsomra TABLET 15 MG ORAL
- Belsomra TABLET 20 MG ORAL
- Belsomra TABLET 5 MG ORAL

PA Criteria	Criteria Details
Covered Uses	Insomnia. The patient must have a documented treatment failure of all of the following: a. Zolpidem oral tablets. b. A formulary benzodiazepine. c. Trazodone.
Exclusion Criteria	N/A
Required Medical Information	Chart notes documenting medical indication, planned course of therapy and previous therapies attempted (if applicable) including dose, duration, and result(s) are required.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Up to one year.
Other Criteria	Quantity Limit: 30 tablets for 30 days.

Botox (onabotulinumtoxinA)(COMM, EXC, Cent Care)

Products Affected

- Botox SOLUTION RECONSTITUTED 100 UNIT INJECTION
- Botox SOLUTION RECONSTITUTED 200 UNIT INJECTION

PA Criteria	Criteria Details
Covered Uses	1. Blepharospasm (doses of 100 units or less), 2. Cervical Dystonia (doses of 300 units or less), 3. Cerebral Palsy (doses of 400 units or less), 4. Facial Nerve Disorder/Hemi-facial Spasm (doses of 100 units or less), 5. Severe Palmar Hyperhidrosis (doses of 100 units or less) 6. Severe Primary Axillary Hyperhidrosis (doses of 100 units or less) 7. Laryngeal Dystonia (doses of 100 units or less) 8. Limb Dystonia (doses of 100 units or less) 9. Chronic Migraine Prophylaxis (total dose of 155 units or less) 10. Spasmodic Torticollis (doses of 300 units or less) 11. Spasticity resulting from an acquired or congenital brain disorder (doses of 400 units or less) 12. Strabismus (doses of 100 units or less) 13. Urinary incontinence treatment due to detrusor overactivity (doses of 200 units or less) associated with a neurologic condition (e.g. spinal cord injury, MS) 14. Overactive bladder (OAB) (doses of 100 units or less) with symptoms of urinary incontinence, urgency and frequency in adults who have had an inadequate response to or are intolerant of an anticholinergic medication. 15. Upper and lower limb spasticity for individuals over the age of 2 years. (maximum total doses: Adult: up to 400 units, pediatric upper limb spasticity: 200 units, pediatric lower limb spasticity: 300 units).
Exclusion Criteria	For migraine prophylaxis: Botox will not be approved if calcitonin gene-related peptide receptors (CGRP) has been used in the last 4 (four) months
Required Medical Information	Chart notes documenting medical indication, planned course of therapy and previous therapies attempted (if applicable) including dose, duration, and result(s) are required. Documentation requirements for specific diagnoses are as follows: 1. Severe Palmar Hyperhidrosis (doses of 100 units or less) that meets

PA Criteria	Criteria Details
	following criteria: Documented trials and failures of drying agents such as topical aluminum chloride (DrySol, Xerac AC, and Hypercare) 2. Severe Primary Axillary Hyperhidrosis (doses of 100 units or less) that meets the following criteria: Documented trials and failures of anticholinergics and drying agents such as topical aluminum chloride (DrySol, Xerac AC, and Hypercare) 3. Chronic Migraine Prophylaxis (total dose of 155 units or less) that meets the following criteria: a. 15 days per month or more with headache lasting 4 hours a day or longer, b. Documented trials and failures of at least 2(two) prophylactic therapies for at least 60(sixty) days each, c. Must be prescribed by, or in consultation with a neurologist. 4. Urinary incontinence treatment due to detrusor overactivity (doses of 200 units or less) associated with a neurologic condition (e.g. spinal cord injury, MS) a. Age greater than or equal to 18 years: who have had an inadequate response to or are intolerant of two anticholinergic medications used for urinary incontinence such as oxybutynin and tolterodine. b. Age less than 18 years: (check package for minimum age): who have had an inadequate response to or are intolerant of one anticholinergic medications used for urinary incontinence such as oxybutynin 5. Overactive bladder (OAB) (doses of 100 units or less) with symptoms of urinary incontinence, urgency and frequency in adults who have had an inadequate response to or are intolerant of an anticholinergic medication.
Age Restrictions	N/A
Prescriber Restrictions	Botox must be prescribed by, or in consultation with a neurologist.
Coverage Duration	One year.
Other Criteria	Code: J0585. 1 unit = 1 billable unit.

Cellcept (mycophenolate mofetil) Suspension

Products Affected

- Mycophenolate Mofetil Suspension Reconstituted 200 MG/ML Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	The patient must be 12 years of age or younger OR the patient must be unable to take or swallow tablets and are not currently taking other oral non-dissolving tablets or capsules
Age Restrictions	Maximum: 12 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

Codeine and Tramadol Medications in Children

Products Affected

- Acetaminophen-Codeine Solution 120-12 MG/5ML Oral
- Acetaminophen-Codeine Solution 300-30 MG/12.5ML Oral
- Acetaminophen-Codeine Tablet 300-15 MG Oral
- Acetaminophen-Codeine Tablet 300-30 MG Oral
- Acetaminophen-Codeine TABLET 300-60 MG ORAL
- Butalbital-APAP-Caff-Cod CAPSULE 50-325-40-30 MG ORAL
- Butalbital-ASA-Caff-Codeine Capsule 50-325-40-30 MG Oral
- Codeine Sulfate TABLET 30 MG ORAL
- Codeine Sulfate TABLET 60 MG ORAL
- TraMADol HCl TABLET 50 MG ORAL

PA Criteria	Criteria Details
Covered Uses	(1) Patient must be greater than 12 years of age. Codeine and tramadol containing medications will not be covered for any indication in patients under 12 years of age. (2) For patients aged 12 to 18 years documentation must be provided confirming that patient does not have any of the following medical conditions: obesity, obstructive sleep apnea, severe lung disease. (3) Tramadol will not be covered for the treatment of postoperative pain management of tonsillectomy and/or adenoidectomy.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Not covered for patients under 12 years of age. Prior authorization required for patients 12 to 18 years of age.
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	Up to 3 months.
Other Criteria	Quantity Limits: 300-15 MG - 13 tablets per day; 300-30 MG - 13 tablets per day; 300-60 MG - 13 tablets per day; 50-325-40-30 MG - 180 capsules per 30 days; 50-325-40-30 MG - 6 capsules per day; 30 MG - 180 tablets per 30 days; 60 MG - 180 tablets per 30 days; 50 MG - 240 tablets per 30 days.

Combipatch

Products Affected

- CombiPatch Patch Twice Weekly 0.05-0.14 MG/DAY Transdermal
- CombiPatch Patch Twice Weekly 0.05-0.25 MG/DAY Transdermal

PA Criteria	Criteria Details
Covered Uses	1. Treatment of moderate to severe vasomotor symptoms due to menopause, 2. Treatment of moderate to severe symptoms of vulvar and vaginal atrophy due to menopause, 3. Treatment of hypoestrogenism due to hypogonadism, castration, or primary ovarian failure.
Exclusion Criteria	
Required Medical Information	1) Severe vasomotor symptoms due to menopause: diagnosis of severe vasomotor symptoms. 2) hypoestrogenism due to hypogonadism, castration, or primary ovarian failure: diagnosis of hypoestrogenism due to hypogonadism, castration, or primary ovarian failure. 3) Severe symptoms of vulvar and vaginal atrophy due to menopause, all of the following must be met: a) If diagnosis is solely for the treatment of symptoms of vulvar and vaginal atrophy, a topical vaginal product must be tried.
Age Restrictions	18
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	

Continuous Glucose Monitors (CGM) and Supplies

Products Affected

- Dexcom G6 Receiver Device
- Dexcom G6 Sensor
- Dexcom G6 Transmitter
- Dexcom G7 15 Day Sensor
- Dexcom G7 Receiver Device
- Dexcom G7 Sensor
- Guardian 4 Glucose Sensor
- Guardian 4 Transmitter
- Guardian Link 3 Transmitter
- Guardian Sensor (3)
- Guardian Sensor 3
- Minimed Instinct Gluc Sensor

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus type 1 OR 2
Exclusion Criteria	Patient is pregnant (Freestyle 14 Day and Dexcom 6 only) or critically ill.
Required Medical Information	1) The beneficiary is insulin-treated with multiple (three or more) daily injections of insulin or on a compatible insulin pump. 2) Patient has inadequate glycemic control (A1c 7% or higher) despite intensive diabetes management including multiple adjustments in self-monitoring and insulin administration, OR, patient has a history of inadequate glycemic control (despite compliance) of recurrent (2 or more events within a 30-day period), severe hypoglycemic events (e.g., BG less than 70 mg/dL) despite appropriate modifications in insulin therapy and member compliance. 3) All patients must be capable of using devices safely (either by themselves or with a caregiver. 4) Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person visit with the beneficiary to evaluate their diabetes control and determined that criteria (1,2, and 3) above are met 5) Patient is not concurrently using Diabetic Test Strips for routine blood glucose monitoring. Member will be allowed a sufficient quantity for the purposes of calibration and/or other scenarios described at the end of this policy. Preferred Products: 1) Freestyle Libre 2) For Freestyle 14 Day, must be 18 years of age or older.3) For Freestlye Libre 2 and Freestyle Libre 3, must be 4 years of age and older. 4) DexCom will only be covered for : a. Pediatric patients aged 2 to 4. b.Patients established on a compatible insulin pump.

PA Criteria	Criteria Details
	c. Trial and failure of a Freestyle Libre product, or have a documented medical or other reason why Freestyle Libre products cannot be used. 5) Guardian 3: a. Patient has been established on a Medtronic insulin pump.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) Year
Other Criteria	1. Treating practitioner must submit documentation that an in-person visit with the beneficiary has occurred every six months or more frequently to assess adherence to their CGM regimen and diabetes treatment plan. 2. Patient is stable on current CGM regimen as evidenced by an HgbA1c less than 7% or no episodes of severe hypoglycemic events. 3. For continuation purposes, a retrial of a Freestyle Libre product is not required. Quantity Limits: Dexcom G6 Receiver Device - 1 receiver per 365 days; Dexcom G6 Sensor - 3 sensors per 30 days; Dexcom G6 Transmitter - 1 transmitter per 90 days; Dexcom G7 15 Day Sensor - 2 sensors per 30 days; Dexcom G7 Receiver Device - 1 receiver per 365 days; Dexcom G7 Sensor - 3 sensors per 30 days; Guardian 4 Glucose Sensor - 5 sensors per 30 days; Guardian 4 Transmitter - 1 transmitter per 365 days; Guardian Link 3 Transmitter - 1 transmitter per 365 days; Guardian Sensor (3) - 5 sensors per 30 days; Guardian Sensor 3 - 5 sensors per 30 days; Minimed Instinct Gluc Sensor - 2 sensors per 30 days.

Crinone (progesterone gel) (Cent Care)

Products Affected

- Crinone Gel 8 % Vaginal

PA Criteria	Criteria Details
Covered Uses	To reduce the risk of spontaneous preterm birth in pregnant women with a short cervix (less than or equal to 20mm before 24 weeks) on ultrasound examination in the current pregnancy and no history of preterm birth.
Exclusion Criteria	N/A
Required Medical Information	Chart notes documenting a cervical length of less than or equal to 20mm prior to 24 weeks and no history of preterm birth.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through 36 weeks gestation.
Other Criteria	

Crysvita (burosumab-twza) Criteria

Products Affected

- Crysvita Solution 10 MG/ML Subcutaneous
- Crysvita Solution 20 MG/ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded. 1)Familial x-linked hypophosphatemic vitamin D refractory rickets 2)diagnosis of FGF23-related hypophosphatemia in tumor-induced osteomalacia (TIO) Associated with phosphaturic mesenchymal tumors that cannot be curatively resected or localized
Exclusion Criteria	
Required Medical Information	(1) Diagnosis of XLH confirmed by one of the following:- Genetic testing OR Elevated FGF23 level greater than 30 pg/mL (2) Documented baseline serum phosphorus level that is below the normal range for age. (3) Patient has a reduced tubular resorption of phosphate corrected for glomerular filtration rate (TmP/GFR). (4) Presence of clinical signs and symptoms of the disease (e.g. rickets, growth retardation, musculoskeletal pain, bone fractures). (5) Patient is not receiving oral phosphate or active vitamin D analogs. (6) Patient does not have severe renal impairment (eGFR less than 30 mL/min/1.73 m2) (7) Requested dose is recommended per the U.S. FDA approved labeling.
Age Restrictions	For XLH at least 6 months of age, for tumor induced osteomalacia at least 2 years of age
Prescriber Restrictions	Prescribed by, or in consultation with, a specialist experienced in the treatment of metabolic bone disorders (i.e., endocrinologist or nephrologist).
Coverage Duration	Initial Length of Approval: 6 months, Renewal Length of Approval: 1 year

PA Criteria	Criteria Details
Other Criteria	Continuation of Therapy Criteria: (1) Patient has experienced normalization of serum phosphate while on therapy. (2) Patient has experienced a positive clinical response to Crysvita evidenced by increased serum phosphorus levels, a reduction in serum total alkaline phosphatase activity, improvement in symptoms (e.g., increased height velocity, reduction of generalized bone pain) and/or improvement in radiographic imaging of Rickets/osteomalacia. (3) Requested dose is recommended per the U.S. FDA approved labeling. Quantity limits: Pediatric patients: up to 3 vials of 30mg per two(2) weeks, Adults: Up to 3 vials of 30mg per 4 weeks

Daliresp (roflumilast)(Cent Care)

Products Affected

- Roflumilast Tablet 500 MCG Oral

PA Criteria	Criteria Details
Covered Uses	1) To reduce the risk of COPD exacerbations in patients with severe COPD associated with chronic bronchitis and a history of exacerbations.
Exclusion Criteria	N/A
Required Medical Information	All of the following must be met: a) Patient must be 18 years of age or older, AND b) Patient must have a diagnosis of severe COPD (defined by the GOLD guidelines as FEV1 less than 50% predicted) with chronic bronchitis (GOLD Group E), AND c) and documentation of at least 1 exacerbations in the last year, AND d) Patient must be receiving two standard treatments for severe COPD (i.e. long-acting B-agonist, long-acting anticholinergic, and short-acting anticholinergic). If blood eosinophils are 100 cells/µL or more, the patient also be receiving an inhaled steroid.
Age Restrictions	18 years or greater
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Quantity Limit: 30 tablets per 30 days

Dantrolene

Products Affected

- Dantrolene Sodium CAPSULE 100 MG ORAL
- Dantrolene Sodium CAPSULE 50 MG ORAL
- Dantrolene Sodium Capsule 25 MG Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Chart notes with liver function tests. If no observable benefit is derived from the administration of dantrolene sodium after a total of 45 days, therapy should be discontinued. The lowest possible effective dose for the individual patient should be prescribed.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	

Dayvigo (lemborexant)

Products Affected

- DayVigo Tablet 10 MG Oral
- DayVigo Tablet 5 MG Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Patient must have a documented treatment failure of all the following: Zolpidem oral tablets, A formulary benzodiazepine used for the treatment of insomnia AND Trazodone
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Quantity Limit: 30 tablets per 30 days.

Delatestryl (testosterone enanthate injection)(Cent Care)

Products Affected

- Testosterone Enanthate SOLUTION 200 MG/ML Intramuscular

PA Criteria	Criteria Details
Covered Uses	1. Primary hypogonadism in men (congenital or acquired). 2. Hypogonadotropic hypogonadism (congenital or acquired). 3. As a continuous therapy for gender dysphoria/gender identity disorder
Exclusion Criteria	Exclusions: 1. Due to a lack of controlled evaluations in women and the potential for virilizing effects, testosterone products will not be approved for use in women who do not meet criterion for gender dysphoria/gender identity disorder. 2. Testosterone replacement will not be covered for the treatment of sexual dysfunction.
Required Medical Information	1. Primary hypogonadism in men (congenital or acquired). Testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchidectomy, Klinefelter?s syndrome, chemotherapy, or toxic damage from alcohol or heavy metals AND Lab results required are two low TOTAL testosterone levels (drawn on separate days) and one lab with an elevated LH and FSH. 2. Hypogonadotropic hypogonadism (congenital or acquired). Idiopathic gonadotropin or LHRH deficiency or pituitary hypothalamic injury from tumors, trauma, or radiation AND Lab results required are two low TOTAL testosterone levels (drawn on separate days) and one lab with a low or low-normal LH and FSH (If your patient has low LH and FSH levels, please follow-up on these low levels or consider a referral to an endocrinology provider). 3. As a continuous therapy for gender dysphoria/gender identity disorder when all of the following are met: a. The patient?s insurance benefit includes coverage for the treatment of gender dysphoria/gender identity disorder. b. The patient meets DSM 5 criteria for diagnosis of Persistent Gender

PA Criteria	Criteria Details
	Dysphoria documented by a qualified licensed mental health professional experienced in the field, i. If significant medical or mental health concerns are present, there must be documentation that they are well controlled. c. One of the following: i. Member has lived as their chosen or reassigned gender full-time for 12 months or more, ii. Treatment plan documents that the patient will live as their reassigned gender full-time for a minimum of 12 months while concurrently receiving continuous hormone therapy, iii. Patient has completed gender transition and requires continued hormone therapy to maintain physical characteristics more congruent with their gender identity.
Age Restrictions	18 years or greater
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	100mg Code: J3120. 100mg = 1 billable unit, 200mg Code: J3130. 200mg = 1 billable unit

Depen (penicillamine)

Products Affected

- penicillAMINE Tablet 250 MG Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	The appropriate disease specific criteria below must be met:(1) Member has a documented diagnosis of Wilson's Disease(2) Member has a documented diagnosis of cystinuria and ALL of the following are met: (a) Member has tried and failed conservative therapy including: high fluid intake, sodium and protein restriction, urinary alkalinization. (b) The member must have had an adequate trial and failure of (3 months or more)or contraindication or intolerance to use of tiopronin (Thiola).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Wilson's Disease: 1 year, Cystinuria: 6 months
Other Criteria	Cystinuria continuation of therapy criteria: Documentation of benefit must be submitted (i.e. decrease in stone formation). Quantity Limit: 240 tablets per 30 days.

Depo-Testosterone (testosterone cypionate injection)(Cent Care)

Products Affected

- Depo-Testosterone SOLUTION 100 MG/ML Intramuscular
- Testosterone Cypionate Solution 100 MG/ML Intramuscular
- Testosterone Cypionate SOLUTION 200 MG/ML Intramuscular

PA Criteria	Criteria Details
Covered Uses	1. Primary hypogonadism in men (congenital or acquired). 2. Hypogonadotropic hypogonadism (congenital or acquired). 3. As a continuous therapy for gender dysphoria/gender identity disorder
Exclusion Criteria	Exclusions: 1. Due to a lack of controlled evaluations in women and the potential for virilizing effects, testosterone products will not be approved for use in women who do not meet criterion for gender dysphoria/gender identity disorder. 2. Testosterone replacement will not be covered for the treatment of sexual dysfunction.
Required Medical Information	1. Primary hypogonadism in men (congenital or acquired). Testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchidectomy, Klinefelter?s syndrome, chemotherapy, or toxic damage from alcohol or heavy metals AND Lab results required are two low TOTAL testosterone levels (drawn on separate days) and one lab with an elevated LH and FSH. 2. Hypogonadotropic hypogonadism (congenital or acquired). Idiopathic gonadotropin or LHRH deficiency or pituitary hypothalamic injury from tumors, trauma, or radiation AND Lab results required are two low TOTAL testosterone levels (drawn on separate days) and one lab with a low or low-normal LH and FSH (If your patient has low LH and FSH levels, please follow-up on these low levels or consider a referral to an endocrinology provider). 3. As a continuous therapy for gender dysphoria/gender identity disorder when all of the following are met: a. The patient?s insurance benefit includes coverage for the treatment of gender dysphoria/gender identity disorder. b. The

PA Criteria	Criteria Details
	patient meets DSM 5 criteria for diagnosis of Persistent Gender Dysphoria documented by a qualified licensed mental health professional experienced in the field, i. If significant medical or mental health concerns are present, there must be documentation that they are well controlled. c. One of the following: i. Member has lived as their chosen or reassigned gender full-time for 12 months or more, ii. Treatment plan documents that the patient will live as their reassigned gender full-time for a minimum of 12 months while concurrently receiving continuous hormone therapy, iii. Patient has completed gender transition and requires continued hormone therapy to maintain physical characteristics more congruent with their gender identity.
Age Restrictions	18 years or greater
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	100mg Code: J1070. 100mg = 1 billable unit, 200mg Code: J1080. 200mg = 1 billable unit

Dificid (fidaxomicin)(Cent Care)

Products Affected

- Dificid Suspension Reconstituted 40 MG/ML Oral

PA Criteria	Criteria Details
Covered Uses	Treatment of Clostridium difficile-associated diarrhea (CDAD)
Exclusion Criteria	N/A
Required Medical Information	A diagnosis of Clostridium difficile-associated diarrhea AND A documented trial and failure of oral vancomycin in a tapered and/or pulsed regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 time
Other Criteria	Quantity Limit: 136mL for 30 days.

Dolophine (methadone tablets)(Cent Care)

Products Affected

- Methadone HCl Tablet 10 MG Oral
- Methadone HCl Tablet 5 MG Oral

PA Criteria	Criteria Details
Covered Uses	Treatment of Pain
Exclusion Criteria	Methadone is excluded from coverage for use in drug treatment programs
Required Medical Information	Chart notes documenting medical indication
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Quantity Limit: 180 tablets for 30 days.

Dupixent (dupilumab)

Products Affected

- Dupixent Solution Auto-Injector 200 MG/1.14ML Subcutaneous
- Dupixent Solution Auto-Injector 300 MG/2ML Subcutaneous
- Dupixent Solution Prefilled Syringe 200 MG/1.14ML Subcutaneous
- Dupixent Solution Prefilled Syringe 300 MG/2ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded. 1. Atopic Dermatitis (AD) 2. Asthma 3. Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) 4. Eosinophilic Esophagitis (EoE) 5. Chronic Obstructive Pulmonary Disease (COPD). 6. Spontaneous Urticaria (CSU).
Exclusion Criteria	
Required Medical Information	1. AD: a. diagnosis of moderate to severe AD, b. 6 months of age and older, c. trial and failure, contraindication, or intolerance to eachg: i. medium to high potency topical steroid (e.g., mometasone, fluocinolone, fluocinonide), ii. topical calcineurin inhibitor, d. Investigator Global Assessment score of 3 or greater, e. Eczema Area and Severity Index score of 16 or greater, f. minimum BSA involvement of greater than or equal to 10%. 2. Asthma: a. moderate to severe defined as pre-bronchodilator FEV1 less than or equal to 80%, b. 6 years of age and older, c. Meets one of the following: i. Daily dependence on oral corticosteroids in addition to the regular use of an inhaled corticosteroid plus an additional controller and history of one or more asthma exacerbations in the past 12 months that required treatment with systemic corticosteroids, or emergency visit or hospitalization for treatment. ii. Blood eosinophils of 150 cells/mcL or more. 3. CRSwNP: a. 12 years of age and older, b. to be used as add-on maintenance treatment for individuals with i. nasal polyps detected by direct examination, endoscopy, or sinus CT scan and ii. significant rhinosinusitis such as nasal obstruction rhinorrhea, or reduction or loss of smell as documented by the prescriber, c. Bilateral Nasal Polyp Score (NPS) of at least 5, and NPS of at least

PA Criteria	Criteria Details
	2 in each nostril, d. documented inadequate response to nasal corticosteroids, e. patient has received treatment with systemic corticosteroids within the past 2 years (or has a contraindication) or has had prior surgery for nasal polyps. 4. EoE: a. 1 year of age or older. b. trial/failure of a proton pump inhibitor or topical corticoid steroid, greater than or equal to 15 intraepithelial eosinophils per high-power field.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an allergist, immunologist, dermatologist, pulmonologist, orolaryngologist, gastroenterologist.
Coverage Duration	Up to one (1) year
Other Criteria	5. COPD: 1. FEV1/FVC less than 0.7 and post bronchodilator FEV1 of 30% to 70%. 2. Eosinophilic phenotype with blood count 300 or more. 3. Two moderate or one severe exacerbations within the past 12 months. 4. Failure of triple therapy (LABA+LAMA+ICS). 5. Will be used as add-on therapy to triple therapy (or double therapy if ICS contraindicated). 6. CSU: 1. 12 year or older 2. Trial and failure (unless intolerance) of two antihistamines, a leukotriene antagonist.3. Member has not received prior anti-IgE treatment. For renewal: AD: Documentation of positive clinical response and will not be used in combination with another biologic medication. Asthma: Documented clinical response demonstrated by reduction in frequency of exacerbations, decreased utilization of rescue medications, increase in FEV1 from pretreatment baseline, reduction in oral corticosteroid 5. COPD: 1. FEV1/FVC less than 0.7 and post bronchodilator FEV1 of 30% to 70%. 2. Eosinophilic phenotype with blood count 300 or more. 3. Two moderate or one severe exacerbations within the past 12 months. 4. Failure of triple therapy (LABA+LAMA+ICS). 5. Will be used as add-on therapy

PA Criteria	Criteria Details
	to triple therapy (or double therapy if ICS contraindicated). 6. CSU: 1. 12 year or older 2. Trial and failure (unless intolerance) of two antihistamines, a leukotriene antagonist.3. Member has not received prior anti-IgE treatment. For renewal: AD: Documentation of positive clinical response and will not be used in combination with another biologic medication. Asthma: Documented clinical response demonstrated by reduction in frequency of exacerbations, decreased utilization of rescue medications, increase in FEV1 from pretreatment baseline, reduction in oral corticosteroid

Dysport (abobotulinumtoxin A) (COMM/EXCH/Cent Care)

Products Affected

- Dysport Solution Reconstituted 300 UNIT Intramuscular
- Dysport SOLUTION RECONSTITUTED 500 UNIT Intramuscular

PA Criteria	Criteria Details
Covered Uses	1. Cervical Dystonia. 2. Upper limb spasticity in the following muscle groups:: biceps brachii, brachialis, brachioradialis, flexor carpi radialis or ulnaris, flexor digitorum profundus or superficialis, pronator teres in accordance with approved dosages listed in prescribing information for each muscle group. 3. Lower limb spasticity in the following muscle groups: flexor digitorum longus, flexor halucis longus, gastrocnemius medial head or gastrocnemius lateral head, soleus, tibialis posterior in accordance with approved dosages listed in prescribing information for each muscle group. 4. Pediatric lower limb spasticity (ages 2 and older) in accordance with approved dosage listed in the prescribing information.
Exclusion Criteria	The use of Dysport for improving the appearance of glabellar lines will not be approved as this is a cosmetic use and a benefit exclusion.
Required Medical Information	Chart notes documenting medical indication, planned course of therapy and previous therapies attempted (if applicable) including dose, duration, and result(s) are required.
Age Restrictions	N/A
Prescriber Restrictions	N/A

PA Criteria	Criteria Details
Coverage Duration	Up to one year.
Other Criteria	Code: J05865 units = 1 billable unit

Ebglyss

Products Affected

- Ebglyss Solution Auto-Injector 250 MG/2ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	1. moderate-to-severe atopic dermatitis in adults and pediatric patients 12 years of age and older
Exclusion Criteria	
Required Medical Information	All of the following must be met: 1) Moderate to severe atopic dermatitis as measured by Eczema Area and Severity Index (EASI) score ?16 and/or Investigator Global Assessment (IGA) score ?3 PLUS at least 10% body surface area (BSA) involvement, AND 2) age 12 and up and weighing at least 40 kg, AND 3) inadequate control with topical therapy OR topical therapy is not appropriate.
Age Restrictions	12
Prescriber Restrictions	Must be prescribed by or in consultation with an allergist, immunologist, dermatologist.
Coverage Duration	Initial 6 months, continuation 12 months
Other Criteria	Reauthorization: an IGA score of 0 or 1, or at least a 75% reduction in EASI from baseline

Edecrin (ethacryinic acid)/ COMM/EXC/Cent Care

Products Affected

- Ethacrynic Acid TABLET 25 MG ORAL

PA Criteria	Criteria Details
Covered Uses	The patient must have a documented sulfa allergy OR the patient must have failed a 30-day trial of bumetanide, furosemide, or toresemide.
Exclusion Criteria	N/A
Required Medical Information	Documentation of contraindications to formulary alternatives and/or previous therapeutic trials.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Up to one year.
Other Criteria	N/A

Elmiron (pentosan)(Cent Care)

Products Affected

- Elmiron CAPSULE 100 MG ORAL

PA Criteria	Criteria Details
Covered Uses	Treatment of interstitial cystitis pain
Exclusion Criteria	N/A
Required Medical Information	1. Must have documented diagnosis of interstitial cystitis AND 2. Documentation of a minimum 30-day trial and failure of or intolerance to amitriptyline.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Continuation of Therapy: Documentation of improvement in pain. Quantity Limit: 90 tablets per 30 days.

Emend (aprepitant) Capsules(Cent Care)

Products Affected

- Aprepitant CAPSULE 125 MG Oral
- Aprepitant CAPSULE 40 MG Oral
- Aprepitant Capsule 80 MG Oral
- Aprepitant Capsule Therapy Pack 80 & 125 MG Oral

PA Criteria	Criteria Details
Covered Uses	Prevention of chemotherapy induced nausea and vomiting (CINV)
Exclusion Criteria	N/A
Required Medical Information	1. The patient must be receiving Emend in combination with a 5-HT3 antagonist and dexamethasone. 2. Must meet one of the following: a) The patient is being treated with a cancer chemotherapy regimen which has high emetogenic potential. b) The patient is being treated with a cancer chemotherapy regimen which includes an anthracycline and cyclophosphamide in combination. c) The patient is receiving a cancer chemotherapy regimen which has moderate emetogenic potential and has failed antiemetic therapy with a 5-HT3 antagonist in combination with dexamethasone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Quantity Limit: 40mg - 1 capsule for a prescription fill, 80mg - 3 capsules for a prescription fill, 125mg - 1 capsule for a prescription fill, 80/125mg pack - 1 package (contains 3 capsules) for a prescription fill.

Emend Oral Suspension (aprepitant) Comm/HIX/CC

Products Affected

- Emend Suspension Reconstituted 125 MG/5ML Oral

PA Criteria	Criteria Details
Covered Uses	Prevention of chemotherapy induced nausea and vomiting (CINV)
Exclusion Criteria	N/A
Required Medical Information	1. The patient must be 12 years of age or younger or the patient must be unable to take or swallow Emend capsules. 2. The patient must be receiving Emend in combination with a 5-HT3 antagonist and dexamethasone. 3. Must meet one of the following: a). The patient is being treated with a cancer chemotherapy regimen which has high emetogenic potential. b)The patient is being treated with a cancer chemotherapy regimen which includes an anthracycline and cyclophosphamide in combination. c) The patient is receiving a cancer chemotherapy regimen which has moderate emetogenic potential and has failed antiemetic therapy with a 5-HT3 antagonist in combination with dexamethasone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Six (6) months.
Other Criteria	Quantity Limit: Six (6) kits for 28 days.

Emgality

Products Affected

- Emgality Solution Auto-Injector 120 MG/ML Subcutaneous
- Emgality Solution Prefilled Syringe 120 MG/ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	1) episodic or chronic migraine prevention, 2) episodic cluster headaches
Exclusion Criteria	
Required Medical Information	1. Chronic Migraine or Episodic Migraine Headache Prophylaxis, all of the following must be met: a) a diagnosis of chronic or episodic migraine chronic migraine as defined by International Headache Society (IHS) International Classification of Headache Disorders (ICHD)-3 beta guidelines, AND b) a 3-month trial of at least two prophylactic medications from at least two (2) of the following categories: i. Anticonvulsants (e.g. divalproex, valproate, topiramate) ii. Beta-blockers (e.g. metoprolol, propranolol, timolol) iii. Antidepressants (e.g. amitriptyline, venlafaxine) iv. Candesartan, AND c) member has been evaluated for and does not have medication overuse headache, AND d) up to 2 ml for loading and 1 ml for maintenance will be covered. 2. Episodic Cluster headaches, all of the following must be met: a) a diagnosis of cluster headaches as defined by International Headache Society (IHS) International Classification of Headache Disorders (ICHD)-3 beta guidelines, AND b) a 3-month trial of at least two prophylactic medications from at least two (2) of the following: i. verapamil, ii. oral steroids, iii. lithium, iv. topiramate, v. nerve blocks, AND c) member has been evaluated for and does not have medication overuse, AND 4) up to 3 ml for a loading dose then 1 ml monthly until end of cluster period will be covered.
Age Restrictions	18

PA Criteria	Criteria Details
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or headache specialist.
Coverage Duration	Initial: 3 months. Continuation: Up to 12 months
Other Criteria	Reauthorization: 1) positive response to Emgality.

Epiduo (adapalene/benzoyl peroxide)

Products Affected

- Epiduo Forte GEL 0.3-2.5 % EXTERNAL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	To be use as a topical treatment of acne vulgaris in adults and pediatric patients 12 years of age and older in which first line monotherapy is not indicated in this setting.
Age Restrictions	12 years of age and older.
Prescriber Restrictions	
Coverage Duration	Three (3) years
Other Criteria	Quantity limit of 45 grams per 30 days

Eucrisa (crisaborole)

Products Affected

- Eucrisa Ointment 2 % External

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded. Atopic Dermatitis
Exclusion Criteria	
Required Medical Information	Documents must show 1) Diagnosis of moderate to severe atopic dermatitis, defined as an ISGA score of at least 3. 2) Failure of at least one low potency topical corticosteroid AND 3) failure of at least one medium or high potency topical corticosteroid AND 4) failure of at least one topical immunomodulatory therapy such as pimecrolimus or tacrolimus
Age Restrictions	minimum 3 months
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Continuation criteria: Documents showing a decrease in severity by at least 2 (two) point from baseline Quantity Limit: 60 grams per 30 days.

Euflexxa (sodium hyaluronate 1%)(Cent Care)

Products Affected

- Euflexxa Solution Prefilled Syringe 20 MG/2ML Intra-Articular

PA Criteria	Criteria Details
Covered Uses	Osteoarthritis (OA) of the knee
Exclusion Criteria	Not covered for OA of joints other than knee joints
Required Medical Information	Indications for initial approval (all must be met). Chart notes documenting: 1. Clinical diagnosis of osteoarthritis of the knee supported by radiographic evidence of osteophytes in the knee joint, sclerosis in bone adjacent to the knee or joint space narrowing OR Documented symptomatic arthritis of the knee according to the American College of Rheumatology clinical and laboratory criteria which requires knee pain and at least five (5) of the following: a. Age older than 50 years, b. Bony enlargement on exam, c. Bony tenderness on exam, d. Crepitus on exam on exam, d. No palpable warmth on exam, e. Morning stiffness that improves within 30 minutes of activity, f. Erythrocyte sedimentation rate less than 40mm/hour, g. Rheumatoid factor less than 1:40, h. Synovial fluid analysis: clear viscous, white blood cell count less than 2,000 microliters (2.00 x 109/L), 2. The pain cannot be attributed to other forms of joint disease (e.g. acute knee injuries, rheumatoid arthritis, patella-femoral syndrome, chondromalacia of the knee), 3. The pain interferes with functional activities. 4. Documented lack of sufficient improvement in pain or function following a three month trial of at least two of the following: a. Non-pharmacological interventions (e.g. exercise, weight loss, physical therapy), b. Non-narcotic analgesics (e.g. acetaminophen, topical capsaicin, tramadol), c. Non-steroidal anti-inflammatory drugs (NSAIDs), d. Intra-articular corticosteroids, 5. Bilateral injections may be allowed if both knees meet the criteria for coverage.

PA Criteria	Criteria Details
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One series of 3 injections.
Other Criteria	Criteria for Continuation of Therapy (all of the following must be met): 1. Documentation of a significant reduction in pain and improvement in function as a result of the previous injections must be provided. 2. Pain has recurred. 3. At least 6 months have passed since the prior series of injections. Quantity Limit: One series of injections. Preferred Specialty Pharmacy Dispensing Required. Code: J7323. 1 injection = billable unit

Evenity (romosozumab-aqqg)

Products Affected

- Evenity Solution Prefilled Syringe 105 MG/1.17ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded. For the treatment of osteoporosis in postmenopausal women at high risk for fracture, defined as a history of osteoporotic fracture, or multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy.
Exclusion Criteria	
Required Medical Information	1. Bone Mineral Density (BMD) T-score -3.5 or less based on BMD measurements from lumbar spine, femoral neck, total hip, and/or one-third radius (wrist) -OR- 2.Bone mineral density (BMD) T-score between -2.5 and -3.5 in the lumbar spine, femoral neck, total hip, and/or one-third radius (wrist) -AND- a. History of one of the following: i. Vertebral compression fracture ii. Fracture of the hip iii. Fracture of the distal radius iv. Fracture of the pelvis v. Fracture of the proximal humerus -OR- 3. BMD T-score between -1.0 and -2.5 and one of the following FRAX 10-year fracture probabilities: i. Major osteoporotic fracture at 20% or more ii. Hip fracture at 3% or more -OR- 4. History of failure, contraindication, or intolerance to an intravenous bisphosphonate AND Jubbonti or Wyost.
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	One year maximum per lifetime.
Other Criteria	Limitations of Use: Limit duration of use to 12 monthly doses. If osteoporosis therapy remains warranted, continued therapy with an anti-resorptive agent should be considered

Exelon (rivastigmine) Patch

Products Affected

- Rivastigmine Tartrate Capsule 1.5 MG Oral
- Rivastigmine Tartrate Capsule 3 MG Oral
- Rivastigmine Tartrate CAPSULE 4.5 MG ORAL
- Rivastigmine Tartrate CAPSULE 6 MG ORAL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Documented trial and failure of formulary preferred cholinesterase inhibitors, donepezil and galantamine
Age Restrictions	At least 18 years of age
Prescriber Restrictions	
Coverage Duration	up to one (1) year
Other Criteria	Quantity Limit: 30 patches per 30 days.

Eysuvis

Products Affected

- Eysuvis Suspension 0.25 % Ophthalmic

PA Criteria	Criteria Details
Covered Uses	1. short-term (up to two weeks) treatment of the signs and symptoms of dry eye disease
Exclusion Criteria	
Required Medical Information	1. short-term (up to two weeks) treatment of the signs and symptoms of dry eye disease, all must be met: a) 18 years of age or older, AND b) treatment is planned for 2 weeks or less, AND 3) diagnosis of dry eye disease based on a validated tool (e.g. slit lamp test, Schirmer?s test, Tear break up time (TBUT), etc.)
Age Restrictions	
Prescriber Restrictions	The medication is prescribed by or in consultation with an ophthalmologist, optometrists, or other relevant eye specialist.
Coverage Duration	14 days
Other Criteria	

Fasenra

Products Affected

- Fasenra Pen Solution Auto-Injector 30 MG/ML Subcutaneous
- Fasenra Solution Prefilled Syringe 10 MG/0.5ML Subcutaneous
- Fasenra Solution Prefilled Syringe 30 MG/ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded. 1) severe asthma and asthma with an eosinophilic phenotype ages 6 and up, 2) Eosinophilic Granulomatosis with Polyangiitis, 3) Hypereosinophilic Syndrome ages 12 and up.
Exclusion Criteria	
Required Medical Information	1) Asthma: age 6 years or older AND 2) currently receiving (and will continue to receive) standard therapy with a medium to high-dose ICS + a LABA for at least 3-6 months (with documented compliance, example 500 mcg/day fluticasone) AND 3) a)diagnosis of severe asthma evidenced by an FEV1 below 80% for adults or 90% for pediatric patients despite treatment PLUS b) 2 or more exacerbations in the past year requiring oral steroids OR dependance on oral daily steroids, AND 4) eosinophilic phenotype (elevated above standard reference range for the lab), AND 5) will not be used in combination with other biologic therapy.
Age Restrictions	
Prescriber Restrictions	Prescriber restrictions: Pulmonologist, hematologist, allergist/immunologist, rheumatologist
Coverage Duration	Up to one (1) year

PA Criteria	Criteria Details
Other Criteria	Reauthorization: remains on standard inhaled maintenance therapy AND positive response to Fasenra.

Firvanq (vancomycin)

Products Affected

- Firvanq SOLUTION RECONSTITUTED 25 MG/ML Oral
- Firvanq SOLUTION RECONSTITUTED 50 MG/ML Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Orally administered vancomycin hydrochloride capsule is not effective for other types of infections and will not be approved for systemic infections. AND member documentation member cannot swallow tablets or capsules.
Required Medical Information	Documentation member cannot swallow tablets or capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Three (3) months
Other Criteria	

Forteo (teriparatide)(Cent Care)

Products Affected

- Teriparatide Solution Pen-Injector 560 MCG/2.24ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	1. Treatment of Postmenopausal Women with Osteoporosis at High Risk for Fracture, 2. Increase of Bone Mass in Men with Primary or Hypogonadal Osteoporosis at High Risk for Fracture 3. Treatment of Men and Women with Glucocorticoid-Induced Osteoporosis at High Risk for Fracture
Exclusion Criteria	N/A
Required Medical Information	Bone Mineral Density (BMD) T-score -3.0 or less based on BMD measurements from lumbar spine, femoral neck, total hip, and/or one-third radius (wrist) -OR- 2. Bone mineral density (BMD) T-score between -2.5 and -3.0 in the lumbar spine, femoral neck, total hip, and/or one-third radius (wrist) -AND- a. History of one of the following: i. Vertebral compression fracture ii. Fracture of the hip iii. Fracture of the distal radius iv. Fracture of the pelvis v. Fracture of the proximal humerus -OR- 3. BMD T-score between -1.0 and -2.5 and one of the following FRAX 10-year fracture probabilities: i. Major osteoporotic fracture at 20% or more ii. Hip fracture at 3% or more -OR- 4. History of failure, contraindication, or intolerance to an intravenous bisphosphonate AND Jubbonti or Wyost. Length of Approval: 1 year. Please note parathyroid hormone (PTH) analogs should not be used for more than 2 years. Cumulative use of PTH analogs for greater than 2 years will not be approved.
Age Restrictions	N/A
Prescriber	N/A

PA Criteria	Criteria Details
Restrictions	
Coverage Duration	1 year
Other Criteria	Preferred Specialty Pharmacy Dispensing Required.

Gel-One (cross-linked hyaluronate) Comm/HIX/CC

Products Affected

- Durolane Prefilled Syringe 60 MG/3ML
  Intra-articular

PA Criteria	Criteria Details
Covered Uses	Osteoarthritis (OA) of the knee
Exclusion Criteria	Not covered for OA of joints other than knee joints.
Required Medical Information	Indications for initial approval (all must be met). Chart notes documenting: 1. Clinical diagnosis of osteoarthritis of the knee supported by radiographic evidence of osteophytes in the knee joint, sclerosis in bone adjacent to the knee or joint space narrowing OR Documented symptomatic arthritis of the knee according to the American College of Rheumatology clinical and laboratory criteria which requires knee pain and at least five (5) of the following: a. Age older than 50 years, b. Bony enlargement on exam, c. Bony tenderness on exam, d. Crepitus on exam on exam, d. No palpable warmth on exam, e. Morning stiffness that improves within 30 minutes of activity, f. Erythrocyte sedimentation rate less than 40mm/hour, g. Rheumatoid factor less than 1:40, h. Synovial fluid analysis: clear viscous, white blood cell count less than 2,000 microliters (2.00 x 109/L), 2. The pain cannot be attributed to other forms of joint disease (e.g. acute knee injuries, rheumatoid arthritis, patella-femoral syndrome, chondromalacia of the knee), 3. The pain interferes with functional activities. 4. Documented lack of sufficient improvement in pain or function following a three month trial of at least two of the following: a. Non-pharmacological interventions (e.g. exercise, weight loss, physical therapy), b. Non-narcotic analgesics (e.g. acetaminophen, topical capsaicin, tramadol), c. Non-steroidal anti-inflammatory drugs (NSAIDs), d. Intra-articular corticosteroids, 5. Bilateral injections may be allowed if both knees meet the criteria for coverage.

PA Criteria	Criteria Details
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	See Other Criteria section for coverage duration details.
Other Criteria	Criteria for Continuation of Therapy (all of the following must be met): 1. Documentation of a significant reduction in pain and improvement in function as a result of the previous injections must be provided. 2. Pain has recurred. 3. At least 6 months have passed since the last injection. Quantity Limit: One dose to knee. Preferred Specialty Pharmacy Dispensing required. Code: J7326. 30mg (one dose) = billable unit.

Gender Affirming Medical Treatment (GNRH Analogs and Cross-Sex Hormones)

Products Affected

- Lupron Depot-Ped (1-Month) KIT 11.25 MG Intramuscular
- Lupron Depot-Ped (1-Month) KIT 15 MG Intramuscular
- Lupron Depot-Ped (1-Month) KIT 7.5 MG Intramuscular
- Lupron Depot-Ped (3-Month) Kit 11.25 MG Intramuscular
- Lupron Depot-Ped (3-Month) Kit 30 MG Intramuscular

PA Criteria	Criteria Details
Covered Uses	1. Treatment with GNRH Analogs (e.g., Lupron, Lupron Depot) as an initial or continuous therapy for gender affirming treatment in children and adolescents (less than 18 years of age). All of the following must be met: a. The patient's benefit includes coverage of gender affirming therapy. b. For initiation, one letter of assessment from a healthcare professional who has competencies in the assessment of transgender and gender diverse people is required. The letter shall address all of the following: i. Member has the capacity to make a fully informed decision and to consent to treatment. ii. Medical provider attests that the adolescent has been informed of the potential irreversible effect and side effects of treatment, including potential loss of fertility and options to preserve fertility. iii. Mental health and physical conditions that could negatively impact the outcome of gender affirming intervention have been assessed, with risks and benefits discussed. iv. If medical or mental health concerns are present, they are reasonably well controlled. v. Adolescent has given informed consent and the parents, caretakers, or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process. c. The drug must be initiated by a pediatric endocrinologist or a medical provider experienced in child or adolescent gender affirming treatment. d. The treating provider has confirmed that puberty has started in the adolescent (at least Tanner stage 2). 2. Masculinizing or feminizing gender affirming treatment as initial or continuous therapy in children and adolescents (less than 18 years of age). All of the following must

PA Criteria	Criteria Details
	be met: a. The patient's benefit includes coverage of gender affirming therapy. b. Member is at least 16 years of age (with medical director review, exceptions may be considered on a case by case basis). c. For initiation of gender affirming hormonal treatment, one letter of assessment from a healthcare professional who has competencies in the assessment of transgender and gender diverse people is required. The letter shall address all of the following: i. Member has the capacity to make a fully informed decision and to consent for treatment. ii. Medical provider attests that the adolescent has been informed of the potential irreversible effects and side effects, including the potential loss of fertility and options to preserve fertility). iii. All mental health and physical conditions that could negatively impact the outcome of gender affirming intervention have been assessed, with risks and benefits discussed. iv. If medical or mental health concerns are present, they must be reasonably well controlled. v. The adolescent has given informed consent and the parents, caretakers, or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process. d. Gender marker is not necessary for initial approval and refills for continuation.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	Up to 12 months
Other Criteria	Masculinizing or Feminizing Gender Affirming Hormone Treatment for Initial or Continuous Therapy in Adults (18 years of age and older). All of the following must apply: a. The patient's insurance benefit includes coverage of gender affirming therapy. b. For initiation, one letter from a healthcare professional who has competencies in the assessment of transgender and gender diverse people is required. The letter shall address all of the following: i. Medical provider attests that the member has been informed of the potential irreversible effects and side effects of treatment, including potential loss of fertility and options to preserve fertility. ii.All mental health and physical conditions that could negatively impact the outcome of gender affirming intervention have been assessed, with risks and benefits discussed. iii. If medical or mental health concerns are present, they must be reasonably well controlled. c. Gender marker (male, female, or other) is not necessary for initial approval and refills for continuation of therapy. -OR- d. Patient has completed gender transition and requires continued hormone treatment for gender affirming maintenance. e. Exclusions: i. Due to a lack of controlled evaluations in females and the potential for virilizing effects, testosterone products will not be approved for use in females requesting virilizing medications for purposes other than transgender related affirmation therapy. ii.Testosterone replacement will not be covered for the treatment of sexual dysfunction.

Genotropin

Products Affected

- Genotropin Cartridge 12 MG Subcutaneous
- Genotropin Cartridge 5 MG Subcutaneous
- Genotropin MiniQuick Prefilled Syringe 0.2 MG Subcutaneous
- Genotropin MiniQuick Prefilled Syringe 0.4 MG Subcutaneous
- Genotropin MiniQuick Prefilled Syringe 0.6 MG Subcutaneous
- Genotropin MiniQuick Prefilled Syringe 0.8 MG Subcutaneous
- Genotropin MiniQuick Prefilled Syringe 1 MG Subcutaneous
- Genotropin MiniQuick Prefilled Syringe 1.2 MG Subcutaneous
- Genotropin MiniQuick Prefilled Syringe 1.4 MG Subcutaneous
- Genotropin MiniQuick Prefilled Syringe 1.6 MG Subcutaneous
- Genotropin MiniQuick Prefilled Syringe 1.8 MG Subcutaneous
- Genotropin MiniQuick Prefilled Syringe 2 MG Subcutaneous

PA Criteria	Criteria Details
Covered Uses	1) Adult patients with endogenous GH deficiency (adult or childhood onset), (list under DX validation), 2) pediatric patients who have growth failure due to an inadequate secretion of endogenous growth hormone (list under DX validation), 3) growth failure due to Prader-Willi syndrome (list under DX validation), 4) pediatric patients born small for gestational age (SGA) who fail to manifest catch-up growth by age 2 years (list under PA), 5) growth failure associated with Turner syndrome (list under DX validation)
Exclusion Criteria	1) Idiopathic Short Stature (ISS)
Required Medical Information	1) pediatric patients born small for gestational age (SGA) who fail to manifest catch-up growth by age 2 years, all of the following must be met: a) Documented birth weight of less than 2,500 g at a gestational age of more than 37 weeks OR a birth weight or length below the 3rd percentile for gestational age. b) Documented lack of sufficient catch-up growth by age 2 and height less than 2 SD for chronological age.

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	Reauthorization: 1) Epiphyses must not be closed, AND 2) First year of therapy: HV must double the pretreatment rate, OR After first year of therapy: HV must be 2.5 cm/yr or more.

Granulocyte-Colony Stimulating Factors

Products Affected

- Fulphila Solution Prefilled Syringe 6 MG/0.6ML Subcutaneous
- Udenyca Onbody Solution Prefilled Syringe 6 MG/0.6ML Subcutaneous
- Udenyca Solution Auto-Injector 6 MG/0.6ML Subcutaneous
- Udenyca Solution Prefilled Syringe 6 MG/0.6ML Subcutaneous
- Zarxio Solution Prefilled Syringe 300 MCG/0.5ML Injection
- Zarxio Solution Prefilled Syringe 480 MCG/0.8ML Injection
- Ziextenzo Solution Prefilled Syringe 6 MG/0.6ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	1. Cancer patients receiving myelosuppressive therapy. 2. Patients with acute myeloid leukemia receiving induction or consolidation chemotherapy. 3. Cancer patients receiving bone marrow transplant. 4. Patients undergoing peripheral blood progenitor cell collection and therapy. 5. Patients with severe chronic neutropenia (cyclic or idiopathic) that meets the following criteria: Documentation that the patient is symptomatic with at least three clinically significant infections treated with antibiotics or one life-threatening infection treated with IV antibiotic therapy during the previous 12 months. AND one of the following: a. Documented diagnosis of severe chronic neutropenia (idiopathic) with an ANC of less than 500/mm3 on three separate occasions over the previous 6 months. OR b. Documented diagnosis of severe chronic neutropenia (cyclic) with five consecutive days per cycle with an ANC less than 500/mm3 for each of 3 regularly spaced cycles over a 6-month period. 6. Patients with severe chronic neutropenia (congenital) that have a documented diagnosis of congenital neutropenia.
Exclusion Criteria	
Required Medical Information	Chart notes documenting medical indication, planned course of therapy and previous therapies attempted (if applicable) including dose, duration, and result(s) are required. Compendial Uses: Non-FDA approved uses are considered to be "medically-accepted

PA Criteria	Criteria Details
	indications" based on the drug information sources that CMS has recognized to be authoritative compendia will be considered for approval for treatment if the diagnosis, dosing, frequency, and length of therapy are supported by, and are consistent with published medical literature. Continuation of treatment or retreatment for a compendial use will only be approved if medically necessary, if clinical improvement has been demonstrated, and if supported by published medical literature.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Up to 1 Year
Other Criteria	Exceptions: Other medical conditions or exceptions to the above conditions of coverage will be considered through the Prior Authorization process. Clinical, peer-reviewed, published evidence will be required for any diagnosis not otherwise listed. Preferred Specialty Pharmacy Dispensing Required.

Hemophilia

Products Affected

- Afstyla KIT 1000 UNIT Intravenous
- Afstyla KIT 1500 UNIT Intravenous
- Afstyla KIT 2000 UNIT Intravenous
- Afstyla KIT 250 UNIT Intravenous
- Afstyla KIT 2500 UNIT Intravenous
- Afstyla KIT 3000 UNIT Intravenous
- Afstyla KIT 500 UNIT Intravenous
- BeneFIX KIT 1000 UNIT Intravenous
- BeneFIX KIT 2000 UNIT Intravenous
- BeneFIX KIT 250 UNIT Intravenous
- BeneFIX KIT 3000 UNIT Intravenous
- BeneFIX KIT 500 UNIT Intravenous
- Corifact KIT 1000-1600 UNIT Intravenous
- Humate-P Solution Reconstituted 1000-2400 UNIT Intravenous
- Humate-P SOLUTION RECONSTITUTED 250-600 UNIT Intravenous
- Humate-P Solution Reconstituted 500-1200 UNIT Intravenous
- Kogenate FS KIT 1000 UNIT Intravenous
- Kogenate FS KIT 2000 UNIT Intravenous
- Kogenate FS KIT 250 UNIT Intravenous
- Kogenate FS KIT 3000 UNIT Intravenous
- Kogenate FS KIT 500 UNIT Intravenous
- Novoeight SOLUTION RECONSTITUTED 1000 UNIT Intravenous
- Novoeight SOLUTION RECONSTITUTED 1500 UNIT Intravenous
- Novoeight SOLUTION RECONSTITUTED 2000 UNIT Intravenous
- Novoeight SOLUTION RECONSTITUTED 250 UNIT Intravenous
- Novoeight SOLUTION RECONSTITUTED 3000 UNIT Intravenous
- Novoeight SOLUTION RECONSTITUTED 500 UNIT Intravenous
- NovoSeven RT Solution Reconstituted 1 MG Intravenous
- NovoSeven RT SOLUTION RECONSTITUTED 2 MG Intravenous
- NovoSeven RT SOLUTION RECONSTITUTED 5 MG Intravenous
- NovoSeven RT SOLUTION RECONSTITUTED 8 MG Intravenous
- Nuwiq KIT 1000 UNIT Intravenous
- Nuwiq Kit 1500 UNIT Intravenous
- Nuwiq KIT 2000 UNIT Intravenous
- Nuwiq KIT 250 UNIT Intravenous
- Nuwiq KIT 2500 UNIT Intravenous
- Nuwiq KIT 3000 UNIT Intravenous
- Nuwiq KIT 4000 UNIT Intravenous
- Nuwiq KIT 500 UNIT Intravenous
- Nuwiq SOLUTION RECONSTITUTED 1000 UNIT Intravenous
- Nuwiq SOLUTION RECONSTITUTED 2000 UNIT Intravenous
- Nuwiq SOLUTION RECONSTITUTED 250 UNIT Intravenous
- Nuwiq SOLUTION RECONSTITUTED 2500 UNIT Intravenous
- Nuwiq SOLUTION RECONSTITUTED 3000 UNIT Intravenous

- Nuwiq SOLUTION RECONSTITUTED 4000 UNIT Intravenous
- Nuwiq SOLUTION RECONSTITUTED 500 UNIT Intravenous
- Rixubis SOLUTION RECONSTITUTED 2000 UNIT Intravenous
- Rixubis SOLUTION RECONSTITUTED 250 UNIT Intravenous
- Xyntha KIT 1000 UNIT Intravenous
- Xyntha KIT 2000 UNIT Intravenous
- Xyntha KIT 250 UNIT Intravenous
- Xyntha KIT 500 UNIT Intravenous
- Xyntha Solofuse KIT 1000 UNIT Intravenous
- Xyntha Solofuse KIT 2000 UNIT Intravenous
- Xyntha Solofuse KIT 250 UNIT Intravenous
- Xyntha Solofuse KIT 3000 UNIT Intravenous
- Xyntha Solofuse KIT 500 UNIT Intravenous

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	1. Documentation of member diagnosis, requested factor product, requested dose (including member weight), and frequency. 2. Documentation of treatment plan, which should include the plan for the type of bleed and the need for prophylaxis. 3. Prescriber is requesting a factor product that is in accordance with the product's FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines for the member's diagnosis and dosing being prescribed. 4. Prescriber attests to counseling member and/or caregiver that a treatment log be maintained, and a copy will be submitted for renewal purposes. 5. History of bleeding episodes, including any requiring hospitalization.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hematologist.

PA Criteria	Criteria Details
Coverage Duration	6 months
Other Criteria	Renewal: 1. Documentation of positive clinical response. 2. Prescriber attests to no evidence of intolerable adverse effects or unacceptable toxicity from the factor agent and development of neutralizing antibodies. 3. Submission of treatment log, including any bleeding episodes that required hospitalization. 4. Any increase in dose must be supported by an acceptable clinical rationale (i.e., weight gain, half-life study results, increase in breakthrough bleeding when patient is fully adherent to therapy, etc.).

Hepatitis C Treatment Criteria(Cent Care)

Products Affected

- Ribavirin TABLET 200 MG ORAL

PA Criteria	Criteria Details
Covered Uses	Treatment of Chronic Hepatitis C Infection. Note: Preferred formulary medications must be utilized before consideration of non-formulary agents and all medications are subject to formulary quantity limits and approved dosages.
Exclusion Criteria	N/A
Required Medical Information	1. Patient must be diagnosed with Chronic Hepatitis C Infections including laboratory documentation of genotype and subtype. 2. Patient must currently have detectable HCV RNA levels 3. Child - Pugh Score 4. Chart notes documenting presence or absence of ascites and encephalopathy. 5. Additional required lab results (within the past 3 months): a. Aspartate transaminase (AST, including upper and lower limit), b. Alanine Transaminase (ALT), c. Platelet Count, d. Bilirubin, e. Albumin, f. INR within 6 months of request (only patients with cirrhosis) g. Absolute Neutrophil Count (ANC), h. Hemoglobin (Hgb), Serum Creatinine (SCr).
Age Restrictions	3 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	Length of approval will be dependent on multiple factors and must be recommended in either the medic
Other Criteria	1. Treatment history: If treatment experienced, provide regimen received including duration of therapy. If regimen was not completed, include reason for discontinuation. The response to

PA Criteria	Criteria Details
	therapy: 1) Responder: i. Relapse, ii Reinfection, 2) Non-responder: i Null responder (HCV RNA levels declined less than 2 log10 IU/ml by week 12), ii Partial responders (greater than 2 log10 IU/ml response whose virus remained detectable by week 24), 2. Hepatitis A and B screening including HBsAg, anti-HBs, anti-HBc, HAV Ab3 (labs required). Hep B tests drawn within the past 3 months not required unless patient is at current risk. Specialty pharmacy required.

Humulin u-500 (insulin human regular)

Products Affected

- HumuLIN R U-500 KwikPen Solution
  Pen-injector 500 UNIT/ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Documentation showing that the patient has had adequate trials of preferred insulin products AND that the patient is using a total of more than 200 units of insulin units per day from basal and bolus insulins
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Up to One (1) year
Other Criteria	

Hylenex (hyaluronidase Human)

Products Affected

- Hylenex SOLUTION 150 UNIT/ML INJECTION

PA Criteria	Criteria Details
Covered Uses	Dispersion/absorption enhancement of injected drugs (extravasation management)
Exclusion Criteria	
Required Medical Information	Documents must show that this drug is being used as part of a chemotherapy regimen to treat extravasation of appropriate agents
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Up to six (6) months
Other Criteria	

Ingrezza

Products Affected

- Ingrezza Capsule 40 MG Oral
- Ingrezza Capsule 60 MG Oral
- Ingrezza CAPSULE 80 MG Oral
- Ingrezza Capsule Sprinkle 40 MG Oral
- Ingrezza Capsule Sprinkle 60 MG Oral
- Ingrezza Capsule Sprinkle 80 MG Oral
- Ingrezza Capsule Therapy Pack 40 & 80 MG Oral

PA Criteria	Criteria Details
Covered Uses	1. tardive dyskinesia 2. chorea associated with Huntington?s disease
Exclusion Criteria	
Required Medical Information	Tardive Dyskinesia i. The patient has documented diagnosis of tardive dyskinesia. ii. At least 60 days of stable (drug and dose) exposure to a first generation antipsychotic, second generation antipsychotic, or certain dopamine receptor-blocking drugs used in the treatment of nausea and gastroparesis (e.g., prochlorperazine, promethazine, metoclopramide). iii. Documentation of a baseline Abnormal Involuntary Movement Scale (AIMS) must be provided.
Age Restrictions	18
Prescriber Restrictions	The medication is prescribed by or in consultation with a neurologist or psychiatrist.
Coverage Duration	Initial Approval: 6 months. Renewal One Year
Other Criteria	Continuation of Therapy: Tardive Dyskinesia: Documented improvement in AIMS compared to baseline.

IVIG (Immune Globulin (human), IV)(COMM, EXC)

Products Affected

- Flebogamma DIF SOLUTION 10 GM/200ML Intravenous
- Flebogamma DIF SOLUTION 20 GM/400ML Intravenous
- Flebogamma DIF SOLUTION 5 GM/100ML Intravenous
- Gammagard ERC Solution 10 GM/100ML Injection
- Gammagard ERC Solution 5 GM/50ML Injection
- Gammagard S/D Less IgA SOLUTION RECONSTITUTED 10 GM Intravenous
- Gammagard S/D Less IgA SOLUTION RECONSTITUTED 5 GM Intravenous
- Gammagard Solution 2.5 GM/25ML Injection
- Gammagard Solution 20 GM/200ML Injection
- Gammagard SOLUTION 30 GM/300ML INJECTION
- Gamunex-C SOLUTION 1 GM/10ML INJECTION
- Gamunex-C SOLUTION 10 GM/100ML INJECTION
- Gamunex-C SOLUTION 2.5 GM/25ML INJECTION
- Gamunex-C SOLUTION 20 GM/200ML INJECTION
- Gamunex-C SOLUTION 40 GM/400ML INJECTION
- Gamunex-C SOLUTION 5 GM/50ML INJECTION

PA Criteria	Criteria Details
Covered Uses	Use for the following indications will be considered for approval for treatment with IVIG when supported by current treatment guidelines, and standard interventions, treatments, and/or therapy have failed or are contraindicated. Dosing, frequency, and length of therapy must be supported by, and consistent with published medical literature. Diagnosis of one of the following: a. Children with acquired immunodeficiency syndrome (AIDS) b. bone marrow and organ transplant recipients (except corneal) who are at risk for cytomegalovirus (CMV) and pneumonia due to immunosuppressant agents, c. post bone marrow transplant, d. adults with human immunodeficiency virus (HIV) who are immunosuppressed in association with AIDS or AIDS-related complex (ARC) e. infection, prevention in: HIV-infected patients, patients with primary defective antibody synthesis, hypogammaglobulinemia and/or recurrent bacterial infections, with B-cell chronic lymphocytic leukemia, f. Kawasaki syndrome, g. Primary immunodeficiencies including congenital

PA Criteria	Criteria Details
	agammaglobulinemia, hypogammaglobulinemia, common variable immunodeficiency, X-linked immunodeficiency, severe combined immunodeficiency, Wiskott-Aldrich syndrome, h. idiopathic or immune thrombocytopenia purpura (ITP).
Exclusion Criteria	The use of intravenous and/or subcutaneous immunoglobulin is considered experimental, investigational, and unproven for any indication not listed above, including but not limited to the following: acquired Factor VIII inhibition, acquired von Willebrand's Syndrome, acute lymphoblastic leukemia, acute renal failure, adrenoleukodystrophy, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig disease), antiphospholipid ab syndrome, aplastic anemia, asthma and inflammatory chest disease, Behcet's Syndrome, burns, chronic (primary or secondary) progressive multiple sclerosis, chronic fatigue syndrome, congenital heart block, cystic fibrosis, demyelinating optic neuritis, diabetes mellitus, Diamond-Blackfan anemia, endotoxemia, epilepsy, euthyroid ophthalmopathy, Factor VIII inhibitors, acquired, hemolytic transfusion reaction (except post-transfusion purpura), Hemolytic Uremic syndrome, Hemophagocytic syndrome, inclusion-body myositis, membranous nephropathy, motor neuron syndromes, multiple myeloma (except multiple myeloma with stable plateau phase disease who are at high risk of recurrent infections - see Off-Label Indications above), myelopathy, HTLV-1 associated, neonatal hemolytic disease, nephrotic syndrome, non-immune thrombocytopenia, paraproteinemic neuropathy, post-infectious sequelae, progressive lumbosacral plexopathy, recent-onset dilated cardiomyopathy, recurrent otitis media, recurrent, spontaneous fetal loss with previous pregnancies, refractory rheumatoid arthritis, adult and juvenile, thrombotic thrombocytopenic purpura, uveitis. EXCEPTIONS: Exceptions to these conditions of coverage are considered through the Prior Authorization process. Clinical, peer reviewed, published evidence will be required for any diagnosis not otherwise listed.
Required Medical	Chart notes documenting medical indication, planned course of therapy and previous therapies attempted (if applicable) including dose, duration, and result(s) are required.

PA Criteria	Criteria Details
Information	
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Up to 1 year
Other Criteria	IVIG may be considered medically necessary when standard interventions/therapy has failed, become intolerable, or are contraindicated for any of the following off-label indications: 1. Acute inflammatory demyelinating polyneuropathy in patients with one or more of the following: rapid deterioration with acute symptoms for less than 2 weeks, rapidly deteriorating ability to ambulate, unable to ambulate for 10 meters, or deteriorating PFTs. 2. Autoimmune hemolytic anemia not responsive to corticosteroids. 3. Autoimmune neutropenia not responsive to other modalities. 4. Chronic inflammatory demyelinating polyneuropathy used alone or following therapeutic plasma exchange to prolong its effect. 5. Hyperimmunoglobulin E syndrome. 6. Infection prophylaxis and/or treatment adjunct in high-risk, preterm, low-birth-weight neonates. 7. Refractory inflammatory myopathies for corticosteroid-resistant patients. 8. Lambert-Eaton myasthenic syndrome not controlled by anticholinesterases and diaminopyridine. 9. Malignancies of various types, especially leukemic illnesses that are vulnerable to recurrent infections due to an immunosuppressed system, including multiple myeloma with stable plateau phase disease and a high risk of recurrent infections. 10. Multifocal motor neuropathy in patients with anti-GM1 antibodies and conduction who are not responsive to conventional therapy (i.e. corticosteroids or immunosuppressants). 11. Multiple Sclerosis (severe

PA Criteria	Criteria Details
	manifestations of RRMS only) when patient is not responsive to other therapy. 12. Myasthenia gravis with one of the following: acute severe decompensation not responsive to other treatments, myasthenia crisis in patients with contraindications to plasma exchange, or chronic debilitating disease not responsive to cholinesterase inhibitors, steroids, or azathioprine. 13. Severe neonatal alloimune thrombocytopenia not responsive to other interventions. 14. Severe post transfusion purpura. 15. Pure red cell aplasia with documented parovirus B19 infection and with severe, refractory anemia. 16. Prior to solid organ transplant for treatment of patients at high risk of anti-body mediated rejection, including highly sensitized patients, and those receiving an ABO incompatible organ. 17. Treatment of antibody mediated rejections following a solid organ transplant. 18. Stiff Person Syndrom when anti-GAD antibody is present and other therapy has failed (i.e., benzodiazepines, baclofen, phenytoin, clonidine, tizanidine). 19. Systemic Lupus Erythromatosus in patients with severe active illness not responsive to other interventions. 20. Toxic Shock Syndrome or Toxic Necrotizing Fasciitis due to streptococcal or staphylococcal organisms and one of the following: infection is refractory to several hours of aggressive therapy OR an undrainable focus is present OR the patient has persistent oliguria with pulmonary edema. 21. Vasculitis Syndrome in patients with severe active illnesses not responsive to other interventions.

Liquid drugs

Products Affected

- Enalapril Maleate Solution 1 MG/ML Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	The patient is unable to take or swallow oral medications and should be on other oral tablets or capsules
Age Restrictions	Criteria applies to patients greater than 12 years of age
Prescriber Restrictions	
Coverage Duration	up to one (1) year
Other Criteria	

LOKELMA (sodium zirconium cyclosilicate)

Products Affected

- Lokelma Packet 10 GM Oral
- Lokelma Packet 5 GM Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded
Exclusion Criteria	
Required Medical Information	Documents showing the following is required- 1.) Baseline potassium 5.1 to less than 6.5mmol/liter at two screenings 2.) Patient is adhering to a low-potassium diet 3.) Medications known to cause hyperkalemia has been discontinued or reduced to the lowest effective dose.
Age Restrictions	at least 18 years old
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Quantity Limits: 10 GM - 30 packets per 30 days; 5 GM - 90 packets per 30 days.

Lovenox (enoxaparin) Quantity

Products Affected

- Enoxaparin Sodium Solution 300 MG/3ML Injection
- Enoxaparin Sodium Solution Prefilled Syringe 100 MG/ML Injection
- Enoxaparin Sodium Solution Prefilled Syringe 120 MG/0.8ML Injection
- Enoxaparin Sodium Solution Prefilled Syringe 150 MG/ML Injection
- Enoxaparin Sodium Solution Prefilled Syringe 30 MG/0.3ML Injection
- Enoxaparin Sodium Solution Prefilled Syringe 40 MG/0.4ML Injection
- Enoxaparin Sodium Solution Prefilled Syringe 60 MG/0.6ML Injection
- Enoxaparin Sodium Solution Prefilled Syringe 80 MG/0.8ML Injection

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded. Prior authorization only applies to quantities exceeding 30 syringes in a 90 day period
Exclusion Criteria	
Required Medical Information	Indications for Approval:One of the following must be met:1. The patient has an active cancer diagnosis.2. The patient is currently pregnant and has a condition associated with a high risk of developing thrombosis (e.g., personal or family history of venous thromboembolism, current deep vein thromboembolism or pulmonary embolism, factor V Leiden mutation, mechanical prosthetic heart valve, atrial fibrillation, antiphospholipid antibody syndrome). Pregnancy must be confirmed by positive lab results or imaging.3. Other indications medical records must be submitted documenting a medical reason for avoiding the use of formulary agents and the requested duration of therapy must be supported in by the medical compendia.
Age Restrictions	N/A
Prescriber	

PA Criteria	Criteria Details
Restrictions	
Coverage Duration	See below
Other Criteria	Active Cancer diagnosis: 6 months, Pregnancy: Up to 6 weeks after delivery Date, other indications: up to 6 months Quantity Limits: 300 MG/3ML - 6 mL per day; 100 MG/ML - 2 syringes per day; 150 MG/ML - 2 syringes per day; 30 MG/0.3ML - 2 syringes per day; 40 MG/0.4ML - 2 syringes per day; 60 MG/0.6ML - 2 syringes per day; 80 MG/0.8ML - 2 syringes per day.

Megace ES (megestrol)(Cent Care)

Products Affected

- Megestrol Acetate SUSPENSION 625 MG/5ML ORAL

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	N/A
Required Medical Information	Chart notes documenting medical indication, planned course of therapy and previous therapies attempted (if applicable) including dose, duration, and result(s) are required.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

Migraine

Products Affected

- Aimovig Solution Auto-Injector 140 MG/ML Subcutaneous
- Aimovig Solution Auto-Injector 70 MG/ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	1. Chronic Migraine 2. Episodic Migraine
Exclusion Criteria	
Required Medical Information	1. Chronic Migraine: a. 15 or more migraine-like or tension-type headache days per month, and has experienced for more than 3 months. b. 3 month trial of at least two prophylactic medications from at least two of the following categories: i. Anticonvulsants (e.g. divalproex, valproate, topiramate) ii. Beta-blockers (e.g. metoprolol, propranolol, timolol) iii. Antidepressants (e.g. amitriptyline, venlafaxine) iv. Candesartan. c. Member has been evaluated for and does not have medication overuse headache. d. The patient has a documented trial and failure of two Botox (onabotulinumtoxinA) injections (minimum 6 months of treatment). 2. Episodic Migraine: a. The patient has 4 to 14 migraine days per month. b. The patient has been evaluated for and does not have medication overuse headache. c. 3 month trial of at least two prophylactic medications from at least two of the following categories: i. Anticonvulsants (e.g. divalproex, valproate, topiramate) ii. Beta-blockers (e.g. metoprolol, propranolol, timolol) iii. Antidepressants (e.g. amitriptyline, venlafaxine). iv. Candesartan. d. An oral CGRP for preventive treatment MAY be considered after documentation has been provided that the member has failed a three month treatment of Aimovig.
Age Restrictions	18 years of age or older.

PA Criteria	Criteria Details
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or headache specialist.
Coverage Duration	Initial: 3 months. Continuation: Up to 12 months
Other Criteria	Continuation Criteria (all must met): (1) Documentation that member has experienced a reduction of 2 or more migraine days per month, (2) Member has not received a Botox injection while on Aimovig and will not be initiating Botox for headache prophylaxis while using Aimovig. Quantity Limit: 1 auto-injector per 28 days.

Mounjaro (tirzepatide)

Products Affected

- Mounjaro Solution Auto-Injector 10 MG/0.5ML Subcutaneous
- Mounjaro Solution Auto-Injector 12.5 MG/0.5ML Subcutaneous
- Mounjaro Solution Auto-Injector 15 MG/0.5ML Subcutaneous
- Mounjaro Solution Auto-Injector 2.5 MG/0.5ML Subcutaneous
- Mounjaro Solution Auto-Injector 5 MG/0.5ML Subcutaneous
- Mounjaro Solution Auto-Injector 7.5 MG/0.5ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded. To be used an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus (T2DM).
Exclusion Criteria	
Required Medical Information	Indications for approval (all must be met):1. Diagnosis of type 2 diabetes mellitus (T2DM). 2. The member has tried and failed a 90-day course of two of the following drug classes: biguanide, sodium-glucose cotransporter 2 (SGLT2) inhibitor (e.g., Steglatro, Farxiga), a dipeptidyl peptidase-4 (DPP-4) inhibitor (e.g., Januvia), a sulfonylurea or thiazolidinedione unless contraindicated or not tolerated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Quantity Limit: 4 auto-injectors per 28 days.

Mulpleta (lusutrombopag)

Products Affected

- Mulpleta Tablet 3 MG Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Low risk procedures such as paracentesis, routine endoscopy, or central line placement
Required Medical Information	Documents must show that 1) procedure date is within 8(eight) to 14 (fourteen) days from request date 2)Baseline platelets are less than 50x10^9/L 3) the procedure carries and intermediate to high risk of bleeding (i.e. spinal surgery, cardiac surgery, large polypectomy, liver biopsy)
Age Restrictions	at least 18 years old
Prescriber Restrictions	gastroenterologist, hematologist, or hepatologist
Coverage Duration	7 days (one course only)
Other Criteria	Quantity Limit: 7 tablets per 7 days.

Multaq (dronedarone)(Cent Care)

Products Affected

- Multaq TABLET 400 MG ORAL

PA Criteria	Criteria Details
Covered Uses	Patient has one of the following indications: 1. Atrial Fibrillation, 2. Paroxysmal Atrial Fibrillation, 3. Atrial Flutter AND Must meet all of the following criteria: a. Must not have NYHA Class IV heart failure or NYHA Class II-III heart failure with a recent decompensation. b. A documented trial and failure of: i. Two generic antiarrhythmics such as flecainide, sotalol, or propafenone. OR ii. Amiodarone with unacceptable side effects.
Exclusion Criteria	N/A
Required Medical Information	Chart notes documenting medical indication, planned course of therapy and previous therapies attempted (if applicable) including dose, duration, and result(s) are required.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Quantity Limit: 60 tablets for 30 days.

Myrbetriq (mirabegron)

Products Affected

- Myrbetriq Tablet Extended Release 24 Hour 25 MG Oral
- Myrbetriq Tablet Extended Release 24 Hour 50 MG Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	The member is at increased risk for CNS adverse effects due to comorbid conditions, advanced age, or other medications.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Quantity Limit: 1 tablet per day.

Norditropin

Products Affected

- Norditropin FlexPro Solution Pen-Injector 10 MG/1.5ML Subcutaneous
- Norditropin FlexPro Solution Pen-Injector 15 MG/1.5ML Subcutaneous
- Norditropin FlexPro Solution Pen-Injector 30 MG/3ML Subcutaneous
- Norditropin FlexPro Solution Pen-Injector 5 MG/1.5ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	1) short stature born small for gestational age (SGA) with no catch-up growth by age 2 to 4 years (list under PA), 2) growth failure due to Prader-Willi Syndrome, Turner Syndrome, or Noonan Syndrome (list under DX validation), 3) Replacement of endogenous growth hormone in adults with growth hormone deficiency (list under DX validation), 4) pediatric patients who have growth failure due to an inadequate secretion of endogenous growth hormone (list under DX validation)
Exclusion Criteria	1) Idiopathic Short Stature (ISS)
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year

PA Criteria	Criteria Details
Other Criteria	Reauthorization: 1) Epiphyses must not be closed, AND 2) First year of therapy: HV must double the pretreatment rate, OR After first year of therapy: HV must be 2.5 cm/yr or more.

Nuedexta (dextroamphetamine/quinidine) (COMM, EXC, Cent Care)

Products Affected

- Nuedexta Capsule 20-10 MG Oral

PA Criteria	Criteria Details
Covered Uses	Documented diagnosis for the treatment of pseudobulbar affect secondary to a neurological disease or injury (e.g. Multiple Sclerosis, Parkinsons, stroke, traumatic brain injury).
Exclusion Criteria	N/A
Required Medical Information	Medical records including the following: Indications for Approval (all of the following must be met): 1. Documented diagnosis for the treatment of pseudobulbar affect secondary to a neurological disease or injury (e.g. Multiple Sclerosis, Parkinsons, stroke, traumatic brain injury). 2. Must be prescribed by or in consultation with a neurologist. 3. Member must have a documented baseline score greater than or equal to 13 on the Center for Neurologic Study - Lability Scale (CNS-LS). 4. Documents showing the number of daily episodes must be submitted. Continuation of Treatment Criteria (all of the following must be met): 1. Documentation showing the CNS-LS score has decreased and the decrease is maintained. 2. Documented decrease in the number of daily episodes.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist.
Coverage Duration	Initial Approval - one month. Continuation of therapy - 6 months.

PA Criteria	Criteria Details
Other Criteria	Quantity Limit: 60 tablets for 30 days.

Nurtec

Products Affected

- Nurtec Tablet Dispersible 75 MG Oral

PA Criteria	Criteria Details
Covered Uses	1) Acute treatment of migraine. 2) prevention of chronic or episodic migraines in adults
Exclusion Criteria	
Required Medical Information	1) Acute treatment of migraines, all of the following must be met: a) member has tried a 30-day trial of at least two (2) of the following drugs: almotriptan (Axert®), eletriptan (Relpax®), frovatriptan (Frova®), naratriptan (Amerge®), rizatriptan (Maxalt®/Maxalt-MLT®), sumatriptan (Imitrex®), zolmitriptan (Zomig®), AND b) member has less than 4 migraine days per month OR member has more than 4 migraine days per month and is on a preventive therapy. 2) Prevention of migraines in adults, all of the following must be met: a) a diagnosis of episodic migraine chronic migraine as defined by International Headache Society (IHS) International Classification of Headache Disorders (ICHD)-3 beta guidelines, AND b) a 3-month trial of at least two prophylactic medications from at least two (2) of the following categories: i. Anticonvulsants (e.g. divalproex, valproate, topiramate) ii. Beta-blockers (e.g. metoprolol, propranolol, timolol) iii. Antidepressants (e.g. amitriptyline, venlafaxine) iv. Candesartan, AND c) member has been evaluated for and does not have medication overuse headache.
Age Restrictions	18 years old minimum
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or headache specialist.

PA Criteria	Criteria Details
Coverage Duration	Initial Approval: 6 months. Renewal One Year
Other Criteria	

Nutritional Supplementation(Cent Care)

Products Affected

- Advera Liquid Oral
- Arginaid Extra Liquid Oral
- Balanced Nutritional Shake Pls Liquid Oral
- Benecalorie Liquid Oral
- Boost Breeze 2-Flavor Pack Liquid Oral
- Boost Breeze Liquid Oral
- Boost Glucose Control Liquid Oral
- Boost Glucose Ctrl Max Protein Liquid Oral
- Boost High Protein Liquid Oral
- Boost Kid Essentials 1.0 Cal Liquid Oral
- Boost Kid Essentials 1.5 Cal Liquid Oral
- Boost Kid Essentials 1.5/Fiber Liquid Oral
- Boost Liquid Oral
- Boost Max Protein Liquid Oral
- Boost Original Liquid Oral
- Boost Plus Liquid Oral
- Boost Very High Calorie Liquid Oral
- Boost VHC Liquid Oral
- Boost Women Liquid Oral
- Carnation Breakfast Essentials Liquid Oral
- Compleat Liquid Enteral
- Compleat Liquid Oral
- Compleat Org Blend 1.2-Chicken Liquid Oral
- Compleat Org Blend 1.2-Plant Liquid Oral
- Compleat Organic Blends Liquid Oral
- Compleat Ped OrgBlend 1.2-Chic Liquid Oral
- Compleat Ped OrgBlend 1.2-Plnt Liquid Oral
- Compleat Pedi Peptide 1.5 Liquid Enteral
- Compleat Pedi Peptide 1.5 Liquid Oral
- Compleat Pedi Standard 1.0 Liquid Enteral
- Compleat Pedi Standard 1.0 Liquid Oral
- Compleat Pedi Standard 1.4 Liquid Enteral
- Compleat Pedi Standard 1.4 Liquid Oral
- Compleat Pediatric Liquid Oral
- Compleat Pediatric Org Blends Liquid Oral
- Compleat Peptide 1.5 Liquid Enteral
- Compleat Peptide 1.5 Liquid Oral
- Compleat Standard 1.4 Liquid Enteral
- Compleat Standard 1.4 Liquid Oral
- Diabetisource AC Liquid Enteral
- Diabetisource AC Liquid Oral
- Enlive Liquid Oral
- Ensure Active Heart Health Liquid Oral
- Ensure Active High Protein Liquid Oral
- Ensure Active Light Liquid Oral
- Ensure Active Liquid Oral
- Ensure Bone Health Revigor Liquid Oral
- Ensure Clear Liquid Oral
- Ensure Clinical St Revigor Liquid Oral
- Ensure Compact Liquid Oral
- Ensure Complete Liquid Oral
- Ensure Complete Shake Liquid Oral
- Ensure Enlive Liquid Oral
- Ensure Healthy Mom Liquid Oral
- Ensure High Calcium Liquid Oral
- Ensure High Protein Liquid Oral
- Ensure Immune Health Liquid Oral
- Ensure Liquid Oral
- Ensure Max Protein Liquid Oral
- Ensure Max Protein with Caffei Liquid Oral

- Ensure Muscle Health Revigor Liquid Oral
- Ensure Nutra Shake Hi-Cal Liquid Oral
- Ensure Nutrition Shake Liquid Oral
- Ensure Orig Therapeutic Nutri Liquid Oral
- Ensure Original Liquid Oral
- Ensure Original/Fiber Liquid Oral
- Ensure Plant-Based Protein Liquid Oral
- Ensure Plus High Protein Liquid Oral
- Ensure Plus HN Liquid Oral
- Ensure Plus Liquid Oral
- Ensure Plus with Fiber Liquid Oral
- Ensure Pre-Surgery Liquid Oral
- Ensure Surgery Liquid Oral
- Ensure Surgical Nutrition Liquid Oral
- Ensure/Fiber Liquid Oral
- EO28 Splash Liquid Oral
- Equate Liquid Oral
- Equate Plus Liquid Oral
- Fibersource HN Liquid Enteral
- Fibersource HN Liquid Oral
- Glucerna 1.0 Cal Liquid Oral
- Glucerna 1.0 Cal/CarbSteady Liquid Oral
- Glucerna 1.0 Cal/Fiber Liquid Oral
- Glucerna 1.2 Cal Liquid Enteral
- Glucerna 1.2 Cal Liquid Oral
- Glucerna 1.5 Cal Liquid Enteral
- Glucerna 1.5 Cal Liquid Oral
- GLUCERNA 1.5 Cal/Carbsteady Liquid Oral
- Glucerna Advance Shake Liquid Oral
- Glucerna Carbsteady Liquid Oral
- Glucerna Hunger Smart Shake Liquid Oral
- Glucerna Liquid Enteral
- Glucerna Liquid Oral
- Glucerna OS Liquid Oral
- Glucerna Select Liquid Oral
- Glucerna Shake Liquid Oral
- Glucerna Snack Shake Liquid Oral
- Glucerna Weight Loss Shake Liquid Oral
- HCU Lophlex LQ Liquid Oral
- Hi-Cal Liquid Oral
- Impact Advanced Recovery Liquid Oral
- Impact Liquid Enteral
- Impact Liquid Oral
- Impact Peptide 1.5 Liquid Enteral
- Innovacin Liquid Oral
- Introlite Liquid Enteral
- Isosource 1.5 Cal Liquid Enteral
- Isosource 1.5 Cal Liquid Oral
- Isosource HN Liquid Enteral
- Isosource HN Liquid Oral
- Jevity 1 Cal Liquid Enteral
- Jevity 1 Cal Liquid Oral
- Jevity 1 Cal/Fiber Liquid Enteral
- Jevity 1 Cal/Fiber Liquid Oral
- Jevity 1.2 Cal Liquid Enteral
- Jevity 1.2 Cal Liquid Oral
- Jevity 1.2 Cal/Fiber Liquid Enteral
- Jevity 1.5 Cal/Fiber Liquid Enteral
- Jevity 1.5 Cal/Fiber Liquid Oral
- KetoCal 2.5:1 LQ Multi Fiber Liquid Oral
- KetoCal 4:1 Liquid Oral
- KetoCal 4:1 LQ Multi Fiber Liquid Oral
- KetoCal 4:1 LQ Multi-Fiber Liquid Oral
- Lophlex LQ 20 Liquid Oral
- MSUD Lophlex LQ Liquid Oral
- Neocate Splash Junior Liquid Oral
- Nepro Liquid Enteral
- Nepro Liquid Oral
- Nepro/CarbSteady Liquid Enteral
- Nepro/CarbSteady Liquid Oral
- NovaSource Renal Liquid Enteral
- NovaSource Renal Liquid Oral
- Nutren Junior Liquid Enteral
- Nutren Junior/Fiber Liquid Enteral
- Nutrifocus Liquid Oral
- Nutritional Supplement Liquid Oral
- Nutritional Supplement Plus Liquid Oral
- Optimental Liquid Enteral

- Optimental Liquid Oral
- Osmolite 1 Cal Liquid Enteral
- Osmolite 1 Cal Liquid Oral
- Osmolite 1.2 Cal Liquid Enteral
- Osmolite 1.2 Cal Liquid Oral
- Osmolite 1.5 Cal Liquid Enteral
- Osmolite 1.5 Cal Liquid Oral
- Osmolite HN Liquid Oral
- Osmolite Liquid Oral
- Oxepa 1.5 Liquid Oral
- Oxepa Liquid Oral
- PediaSure 1.0 Cal Liquid Oral
- PediaSure 1.0 Cal/Fiber Liquid Oral
- PediaSure 1.5 Cal Liquid Oral
- PediaSure 1.5 Cal/Fiber Liquid Oral
- PediaSure Grow & Gain Liquid Oral
- PediaSure Grow & Gain Organic Liquid Oral
- PediaSure Grow & Gain/Fiber Liquid Oral
- PediaSure Harvest 1.0 Cal Liquid Oral
- PediaSure Liquid Oral
- PediaSure NutriPals Liquid Oral
- PediaSure Pediatric Liquid Oral
- PediaSure Peptide 1.0 Cal Liquid Oral
- PediaSure Peptide 1.5 Cal Liquid Oral
- PediaSure Reduced Calorie Liquid Oral
- PediaSure Shake/Fiber Liquid Oral
- PediaSure SideKicks Clear Liquid Oral
- PediaSure SideKicks Liquid Oral
- PediaSure SideKicks Shake Liquid Oral
- PediaSure/Fiber Liquid Oral
- Peptamen 1.5 Cal/Prebio1 Liquid Enteral
- Peptamen 1.5 Cal/Prebio1 Liquid Oral
- Peptamen Intense VHP Liquid Enteral
- Peptamen Intense VHP Liquid Oral
- Peptamen Junior HP Liquid Oral
- Peptamen Junior PHGG 1.2 Liquid Oral
- Perative 1.3 Cal Liquid Oral
- Perative Liquid Oral
- PhenylAde GMP Ready Liquid Oral
- Pivot 1.5 Cal Liquid Enteral
- Pivot 1.5 Cal Liquid Oral
- PKU Lophlex LQ 20 Liquid Oral
- ProMod Liquid Oral
- Promote 1.0 Liquid Oral
- Promote 1.0 with Fiber Liquid Oral
- Promote Liquid Enteral
- Promote Liquid Oral
- Promote/Fiber Liquid Enteral
- Promote/Fiber Liquid Oral
- ProSource No Carb Liquid Oral
- ProSource Protein Liquid Oral
- ProSure Liquid Oral
- Protality Liquid Oral
- Pulmocare 1.5 Liquid Oral
- Pulmocare Liquid Enteral
- Pulmocare Liquid Oral
- Re/Neph Liquid Oral
- Re/Neph LP/HC Liquid Oral
- Re/Neph Reduced Sugar Liquid Oral
- Real Food Blends Liquid Enteral
- Resource 2.0 Liquid Oral
- SM Nutri-Drink + Liquid Oral
- SM Nutri-Drink Liquid Oral
- Suplena 1.8/CarbSteady Liquid Oral
- Suplena Liquid Oral
- Suplena/Carb Steady Liquid Oral
- TwoCal HN 2.0 Liquid Oral
- TwoCal HN Liquid Enteral
- TwoCal HN Liquid Oral
- TYR Lophlex LQ Liquid Oral
- Vital 1.0 Cal Liquid Enteral
- Vital 1.0 Cal Liquid Oral
- Vital 1.5 Cal Liquid Enteral
- Vital 1.5 Cal Liquid Oral
- Vital AF 1.2 Cal Adv Formula Liquid Oral
- Vital AF 1.2 Cal Liquid Enteral
- Vital AF 1.2 Cal Liquid Oral
- Vital High Protein Liquid Oral

- Vital HP 1.0 Cal Liquid Enteral
- Vital HP 1.0 Cal Liquid Oral
- Vital Jr Liquid Oral
- Vital Peptide 1.5 Cal Liquid Oral
- Vivonex RTF Liquid Enteral
- Vivonex RTF Liquid Oral

PA Criteria	Criteria Details
Covered Uses	1. For patients who must be tube fed oral nutritional supplements and products, requests should be submitted directly to Presbyterian Health Plan?s enteral nutrition provider. 2. Oral nutritional support: a. On the basis of a specific medical indication for a patient who has a defined need for which nutritional support is considered therapeutic, and for which regular food, blenderized food, or commercially available retail consumer nutritional supplements would not meet his or her medical needs. A current dietary or nutritional consult will be required for evaluation. b. When medically necessary due to inborn errors of metabolism. A current dietary or nutritional consult will be required for evaluation. c. When medically necessary to correct or ameliorate physical illnesses or conditions in a patient under 21 years of age. A current dietary or nutritional consult will be required for evaluation. Examples of medical necessity: i. Diagnosis or clinical condition that relates to the need for restoration of a pathological loss of tissue and attempts at regular food intake have failed to increase the protein and caloric absorption. ii. Conditions related to swallowing disorders, malabsorption syndromes, and/or chronic conditions with persistent weight loss, or debilitated skin integrity contribution or poor healing of tissues, i.e. decubitus ulcers, etc.
Exclusion Criteria	Exclusions: 1. Coverage does not include commercially available food alternatives, such as low or sodium-free foods, low or fat-free foods, low or cholesterol-free foods, low or sugar-free foods, low or high calorie foods for weight loss or weight gain, or alternative foods due to food allergies or intolerance. 2. Enteral nutrition for non-tube fed patients or patients who DO NOT have inborn errors of metabolism or other medical conditions under the age of 5 years is not a covered benefit. Patients under 5 years old should be referred to Women, Infants, and Children (WIC) Food and Nutrition Services.

PA Criteria	Criteria Details
Required Medical Information	Chart notes documenting medical indication and planned course of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	up to 1 year
Other Criteria	N/A

Nuvessa (metronidazole)

Products Affected

- Nuvessa GEL 1.3 % Vaginal

PA Criteria	Criteria Details
Covered Uses	Bacterial Vaginosis
Exclusion Criteria	
Required Medical Information	Must meet all: 1. Diagnosis of bacterial vaginosis. 2. 12 years of age and older. 3.Member must use metronidazole 0.75% vaginal gel, unless contraindicated orclinically significant adverse effects are experienced, or documentation supports necessity of metronidazole 1.3% vaginal gel. 4. Dose does not exceed one applicator as a single dose.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two (2) months
Other Criteria	

Ofev (nintedanib)

Products Affected

- Nintedanib Esylate Capsule 100 MG Oral
- Nintedanib Esylate Capsule 150 MG Oral

PA Criteria	Criteria Details
Covered Uses	Interstitial pulmonary fibrosis (IPF) or Interstitial lung disease (ILD)
Exclusion Criteria	Will not be approved in combination with Esbriet (pirfenidone)
Required Medical Information	(1)Patient has a baseline FVC at least 50%, (2)For IPF: diagnosis is confirmed by one of the following: a)Finding on high-resolution computed tomography indicates usual interstitial pneumonia (UIP) b)A surgical lung biopsy demonstrates UIP c)Exclusions from other known causes of interstitial lung disease must be documented (i.e. occupational or environmental exposure, drug toxicity, or connective tissue disease)(3)For ILD with a progressive phenotype: a) greater than 10% fibrotic features on computed tomography, b)presented with clinical signs of progression, c)FVC at least 45% predicted, d)DLCO 30-79% of predicted, e)Progression on standard management,(4) The patient is a nonsmoker or has been abstinent from smoking for at least 6 weeks
Age Restrictions	at least forty (40) years of age
Prescriber Restrictions	Prescribed by or in consultation with a Pulmonologist
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	Continuation Criteria 1. Predicted FVC has not declined by 10% or more OR more than 200mL decrease 2. Patient continues to be smoke free Quantity Limit: 60 capsules per 30 days.

Omnipod Dash

Products Affected

- Omnipod 5 Libre Intro Kit
- Omnipod 5 Libre Pods
- Omnipod DASH Intro (Gen 4) Kit
- Omnipod DASH PDM (Gen 4) Kit
- Omnipod DASH Pods (Gen 4)

PA Criteria	Criteria Details
Covered Uses	Diabetes Mellitus Type 1 or 2
Exclusion Criteria	
Required Medical Information	1.The patient is currently using Blood Glucose Monitor (BGM) AND is testing four or more times per day or using a Continuous Glucose Monitor (CGM) on a regular basis.2. The beneficiary is insulin-treated with three or more injections of insulin daily3. The beneficiary's insulin treatment regimen requires frequent adjustment by the beneficiary based on BGM or CGM testing results.4. Within six (6) months prior to ordering the insulin pump, the treating practitioner has an in-person visit or tele-visit with the beneficiary to evaluate their diabetes control and determined that criteria (1-4) above are met
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	1 year for pods
Other Criteria	Continuation of Therapy Criteria:1. Treating practitioner must submit documentation that an in-person visit or tele-visit with the beneficiary has occurred every six months or more frequently2. Beneficiary is responding positively to therapyQuantity limit: 10

PA Criteria	Criteria Details
	pods per monthFor requests exceeding this quantity, documents and clinical rationale must be provided

Ongentys (opicapone)

Products Affected

- Ongentys Capsule 50 MG Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Acute, intermittent treatment of hypomobility, off episodes (end-of-dose wearing off and unpredictable on/off episodes) associated with advanced Parkinsons disease
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Specialty Pharmacy required Quantity Limit: 30 capsules per 30 days.

ORIAHNN (elagolix/estradiol/norethindrone)

Products Affected

- Oriahnn Capsule Therapy Pack 300-1-0.5 & 300 MG Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	1) Documented heavy menstrual bleeding due to uterine fibroids, 2) Trial and therapeutic failure of any two of the following drugs: a.hormonal contraceptives (oral or intrauterine), b. GnRH analogs, c. tranexamic acid
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 months, CONTINUATION: 1 year up to a total of 24 months of treatment
Other Criteria	CONTINUATION CRITERIA: Documented benefit from treatment AND patient has not been treated for more than 24 months with Oriahnn Quantity Limit: 60 capsules per 30 days.

Orilissa (elagolix)

Products Affected

- Orilissa Tablet 150 MG Oral
- Orilissa Tablet 200 MG Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Pregnancy, Osteoporosis, Severe hepatic impairment,Concomitant use of strong organic anion transporting polypeptide (OATP) 1B1 inhibitors (e.g., cyclosporine and gemfibrozil)
Required Medical Information	Documents showing trial and failure of at least two of the following:a. Nonsteroidal anti-inflammatory medicationb. Hormonal contraceptivec. GnRH agonist
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 3 months, Continuation: 150mg: 1 Year, 200mg: 3 months
Other Criteria	Continuation of therapy Criteria:1. Documentation that patient has decrease in endometriosis related pain.2. Documented decrease in analgesic medications used.*NOTE*A maximum of 24 months of therapy with Orilissa 150 mg will be authorized and a maximum of 6 months of therapy with Orilissa 200 mg will be authorized. Quantity Limits: 150 MG - 30 tablets per 30 days; 200 MG - 60 tablets per 30 days.

PCSK9 Inhibitors

Products Affected

- Repatha Solution Prefilled Syringe 140 MG/ML Subcutaneous
- Repatha SureClick Solution Auto-Injector 140 MG/ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded. 1. Atherosclerotic Cardiovascular Disease (ASCVD) as confirmed by one of the following: a. Acute coronary syndromes. b. History of myocardial infarction. c. Stable or unstable angina. d. Coronary or other arterial revascularization. e. Stroke. f. Transient ischemic attack. g. Peripheral arterial disease presumed to be of atherosclerotic origin. h. In adults at increased risk for these events.2. Heterozygous familial hypercholesterolemia (HeFH) as confirmed by Dutch Lipid Clinic diagnostic criteria score greater than or equal to 9 (i.e. definite FH).3. Homozygous Familial Hypercholesterolemia (HoFH): a. Genetic analysis (note that evolocumab is not covered for members with two LDL receptor negative alleles), or b. An untreated LDL level over 500mg/dl, and the presence of xanthomas before the age of 10, or evidence of heterozygous familial hypercholesterolemia in both parents. 4. To reduce the risk of major adverse cardiovascular (CV) events (CV death, myocardial infarction [MI], stroke, unstable angina requiring hospitalization, or coronary vascularization) in adults at increased risk for these events.
Exclusion Criteria	Will not be approved when used in combination with another proprotein convertase subtilsin/kexin type 9 (PCSK9) inhibitor.
Required Medical Information	Treating provider attests to ONE of the following: a. Patient has been receiving at least 8 consecutive weeks of at least one high-intensity statin. b. Patient is unable to tolerate* moderate- and high-intensity statins. c. Has a labeled contraindication to all statins or d. Has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times the upper limit of normal (ULN). 2. LDL-C equal to or greater than 70mg/dl, or less than 50% LDL-C reduction from baseline while

PA Criteria	Criteria Details
	on maximally tolerated lipid lowering regimen. 3. Medication is used as adjunct to a low-fat diet and exercise.
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with one of the following: a. Cardiologist b. Endocrinologist c. Lipid specialist
Coverage Duration	Initial approval: 6 months. Continuation: 1 year
Other Criteria	Trial and failure of the preferred formulary drug (Repatha) is required before consideration of non-formulary drugs in this class. All drugs are subject to formulary quantity limits and approved dosages. *Statin Intolerance for the purpose of this criteria is defined as intolerable and persistent (i.e. more than 2 weeks) symptoms: 1) Myalgia (muscle symptoms without CK elevations), or 2) Myositis (muscle symptoms with CK elevations greater than 10 times upper limit of normal [ULN])Table 1.HIGH-INTENSITY statin atorvastatin 40-80 mg, Crestor (rosuvastatin) 20-40 mg MODERATE-INTENSITY statin atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin greater than 20 mg, pravastatin more than 40 mg, lovastatin 40 mg, fluvastatin XL 80 mg, fluvastatin 40 mg twice daily, or pitavastatin greater than 2 mg LOW-INTENSITY statin simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, pitavastatin 1 mg Quantity limit: 1. Diagnosis of HeFH or patients with primary hyperlipidemia with established clinical atherosclerotic CVD is two injections monthly. 2. Diagnosis of HoFH is three injections monthly.

Perforomist (formoterol)

Products Affected

- Formoterol Fumarate Nebulization Solution 20 MCG/2ML Inhalation

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded. All FDA approved indications
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Three (3) years
Other Criteria	

Posaconazole

Products Affected

- Posaconazole Tablet Delayed Release 100 MG Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	13 years of age and older
Prescriber Restrictions	
Coverage Duration	Three (3) months
Other Criteria	

Praluent

Products Affected

- Praluent Solution Auto-Injector 150 MG/ML Subcutaneous
- Praluent Solution Auto-Injector 75 MG/ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	1) To reduce the risk of major adverse cardiovascular (CV) events (coronary heart disease death, myocardial infarction, stroke, or unstable angina requiring hospitalization) in adults at increased risk for these events, 2) As an adjunct to diet and exercise to reduce low- density lipoprotein cholesterol (LDL-C) in adults with hypercholesterolemia or homozygous familial hypercholesterolemia (HoFH), and 3) Pediatric patients with heterozygous familial hypercholesterolemia (HeFH).
Exclusion Criteria	
Required Medical Information	1) To reduce the risk of CV events, all of the following must be met: a) estalished cardiovascular disease as confirmed by one of the following: i. Acute coronary syndrome, ii. History of myocardial infarction, iii. Stable or unstable angina, iv. Coronary or other arterial revascularization, v. Stroke, vi. Transient ischemic attack, vii. Peripheral arterial disease presumed to be of atherosclerotic origin, AND b) trial of failure of, or intolerance to both of the follwing for at least twelve (12) weeks: i. at least one high intensity statin drug (or maximally tolerated intensity), ii. a statin drug in combination with ezetimibe. 2) As an adjunct to diet and exercise hypercholesterolemia or homozygous familial hypercholesterolemia (HoFH) in adults, all of the following must be met: a) baseline labs showing elevated LDL, AND b) trial of failure of, or intolerance to both of the follwing for at least twelve (12) weeks: i. at least one high intensity statin drug, (or maximally tolerated intensity), ii. a statin drug in combination with ezetimibe, AND c) on a low-fat diet. 3) Pediatric patients with heterozygous familial hypercholesterolemia (HeFH), all of the following must be met: a) 8-17 years of age, AND b) on a low-fat diet, AND c) trial of failure of, or intolerance to both of the follwing for at least

PA Criteria	Criteria Details
	twelve (12) weeks: i. at least one high intensity statin drug, (or maximally tolerated intensity), ii. a statin drug in combination with ezetimibe.
Age Restrictions	8
Prescriber Restrictions	Must be prescribed by, or in consultation with one of the following: a. Cardiologist b. Endocrinologist c. Lipid specialist
Coverage Duration	Initial approval: 6 months. Continuation: 1 year
Other Criteria	Reauthorization: 1) documentation showing adequate LDL response (including dose escalation if appropriate).

Prevacid SoluTabs (lansoprazole orally disintegrating tablet)(Cent Care)

Products Affected

- Lansoprazole Tablet Delayed Release Dispersible 15 MG Oral (Rx)
- Lansoprazole Tablet Delayed Release Dispersible 30 MG Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications AND 1. Patients with a feeding tube. OR 2. Patients under one year of age.
Exclusion Criteria	N/A
Required Medical Information	Chart notes documenting medical indication, planned course of therapy and previous therapies attempted (if applicable) including dose, duration, and result(s) are required.
Age Restrictions	Maximum: 1 year of age
Prescriber Restrictions	N/A
Coverage Duration	up to 1 year
Other Criteria	N/A Quantity Limit: 60 tablets per 30 days.

Proton Pump Inhibitors (PPI) Packets

Products Affected

- NexIUM PACKET 10 MG ORAL
- NexIUM PACKET 2.5 MG ORAL
- NexIUM PACKET 20 MG ORAL
- NexIUM PACKET 40 MG ORAL
- NexIUM PACKET 5 MG ORAL
- Protonix PACKET 40 MG ORAL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded. All FDA-approved indications AND 1. Patients with a feeding tube. 2. Patients under one year of age (Nexium) or at least five year of age (Nexium).
Exclusion Criteria	
Required Medical Information	Chart notes documenting medical indication, planned course of therapy and previous therapies attempted (if applicable) including dose, duration, and result(s) are required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Three (3) years
Other Criteria	

pulmicort

Products Affected

- Pulmicort Flexhaler Aerosol Powder Breath Activated 180 MCG/ACT Inhalation
- Pulmicort Flexhaler Aerosol Powder Breath Activated 90 MCG/ACT Inhalation

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	

Qulipta

Products Affected

- Qulipta Tablet 10 MG Oral
- Qulipta Tablet 30 MG Oral
- Qulipta Tablet 60 MG Oral

PA Criteria	Criteria Details
Covered Uses	1) prevention of chronic or episodic migraines in adults
Exclusion Criteria	
Required Medical Information	1) Prevention of migraines in adults, all of the following must be met: a) a diagnosis of chronic or episodic migraine chronic migraine as defined by International Headache Society (IHS) International Classification of Headache Disorders (ICHD)-3 beta guidelines, AND b) a 3-month trial of at least two prophylactic medications from at least two (2) of the following categories: i. Anticonvulsants (e.g. divalproex, valproate, topiramate) ii. Beta-blockers (e.g. metoprolol, propranolol, timolol) iii. Antidepressants (e.g. amitriptyline, venlafaxine) iv. Candesartan, AND c) member has been evaluated for and does not have medication overuse headache.
Age Restrictions	18
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or headache specialist.
Coverage Duration	Initial: 3 months. Continuation: Up to 12 months
Other Criteria	Reauthorization: 1) positive response to Qulipta

Retacrit (epoetin alpha-epbx) Criteria

Products Affected

- Retacrit Solution 10000 UNIT/ML Injection
- Retacrit Solution 2000 UNIT/ML Injection
- Retacrit Solution 20000 UNIT/ML Injection
- Retacrit Solution 3000 UNIT/ML Injection
- Retacrit Solution 4000 UNIT/ML Injection
- Retacrit Solution 40000 UNIT/ML Injection

PA Criteria	Criteria Details
Covered Uses	Treatment of anemia associated with chronic renal failure, including patients on dialysis and patients not on dialysis. a. The maximum dose for the first 4 weeks of treatment is 9 mcg/kg. b. Hemoglobin must be less than 11g/dl. 2. For the treatment of anemia in patients with nonmyeloid malignancies where anemia is due to the effect of concomitantly administered chemotherapy. a. The maximum dose for the first 4 weeks of treatment is 9 mcg/kg. b. Hemoglobin must be less than 11g/dl. 3. Anemia due to HCV Treatment: a. Recent (within 2-3 weeks) hemoglobin less than 10g/dl AND b. Persists for at least 2 weeks after ribavirin dose reduction (may be reduced in 200mg incremental reductions or one-time reduction to 600mg/day) OR Patient is receiving peginterferon/ribavirin alone with documented evidence that the patient is post-liver transplantation or HIV/HCV co-infected.
Exclusion Criteria	The use of Procrit is considered experimental, investigational, and unproven for any indication not listed above, including but not limited to the following: a. Aplastic anemia, b. B-12 and folate deficiency anemias, c. Iron deficiency anemia, d. Post-hemorrhagic anemia Exceptions: Exceptions to the above conditions of coverage are considered through the Medical Exception process. Clinical, peer-reviewed, published evidence will be required for any diagnosis not otherwise listed.
Required Medical Information	Chart notes documenting medical indication, planned course of therapy and previous therapies attempted (if applicable) including dose, duration, and result(s) are required.

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 6 months
Other Criteria	Quantity Limits:-2000 U/mL, 3000 U/mL, 4000 U/mL, 10000 U/mL: 12 vials (12 mL) per 28 days.-40000 U/mL: 4 vials (4 mL) per 28 days.Length of Approval: Up to 6 months.Code: J0885 (non-ESRD use). 1000 units = 1 billable unit Code: J0886 (ESRD on dialysis). 1000 units = 1 billable unit

Scopolamine

Products Affected

- Scopolamine Patch 72 Hour 1 MG/3DAYS Transdermal

PA Criteria	Criteria Details
Covered Uses	1) nausea and vomiting associated with motion sickness, 2) post-operative nausea and vomiting (PONV) associated with recovery from anesthesia and/or opiate analgesia and surgery.
Exclusion Criteria	
Required Medical Information	1) Diagnosis of a covered use.
Age Restrictions	18
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	

Sensipar (cinacalcet)(Cent Care)

Products Affected

- Cinacalcet HCl Tablet 30 MG Oral
- Cinacalcet HCl Tablet 60 MG Oral
- Cinacalcet HCl Tablet 90 MG Oral

PA Criteria	Criteria Details
Covered Uses	1. The patient has a diagnosis of secondary hyperparathyroidism with chronic kidney disease on chronic dialysis and all of the following: a. Intact parathyroid hormone (iPTH) greater than 300 pg/ml b. Serum calcium level greater than 8.4 mg/dl (corrected for serum albumin) c.The patient has continued hyperparathyroidism despite management with standard therapy (i.e. dietary phosphate restriction, phosphate binders, and vitamin D) 2. The patient has a diagnosis of hypercalcemia with Parathyroid Carcinoma and all of the following: a. Serum calcium level greater than 12.5 mg/dl (corrected for serum albumin) b. Medication is being given to the patient to control hypercalcemia prior to surgical intervention in a patient who is not a surgical candidate or recurrence despite surgical intervention 3. Severe hypercalcemia (serum calcium level greater than 12.5 mg/dl corrected for serum albumin) in patients with primary hyperparathyroidism who are unable to undergo parathyroidectomy.
Exclusion Criteria	N/A
Required Medical Information	Chart notes documenting medical indication, planned course of therapy and previous therapies attempted (if applicable) including dose, duration, and result(s) are required.
Age Restrictions	N/A
Prescriber Restrictions	N/A

PA Criteria	Criteria Details
Coverage Duration	1 year
Other Criteria	N/A

Spiriva Handihaler

Products Affected

- Spiriva Respimat Aerosol Solution 1.25 MCG/ACT Inhalation
- Spiriva Respimat Aerosol Solution 2.5 MCG/ACT Inhalation

PA Criteria	Criteria Details
Covered Uses	1. maintenance treatment of bronchospasm associated with chronic obstructive pulmonary disease (COPD), 2. reduce exacerbations in COPD patients.
Exclusion Criteria	
Required Medical Information	All of the following must be met: a) clinical diagnosis of COPD evidenced by FEV1/FVC less than 0.7, AND b) at least 18 years of age.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	Reauthorization: documentation showing Spiriva Handihaler is working for you.

Striverdi (olodaterol)

Products Affected

- Striverdi Respimat Aerosol Solution 2.5 MCG/ACT Inhalation

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	In patients with more symptoms (eg, Group B), will be used in combination with long-acting muscarinic antagonist. In addition, a short-acting bronchodilator is used for intermittent symptom relief. Not used for acute exacerbations. If symptoms are less severe, may be used as monotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Three (3) years
Other Criteria	

Tadalafil BPH

Products Affected

- Tadalafil Tablet 2.5 MG Oral
- Tadalafil Tablet 5 MG Oral

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded.
Exclusion Criteria	Tadalafil is excluded from coverage for the treatment of Erectile Dysfunction.
Required Medical Information	Diagnosis of benign prostatic hyperplasia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	

Testopel Pellets (testosterone pellets)(Cent Care)

Products Affected

- Testopel PELLET 75 MG IMPLANT

PA Criteria	Criteria Details
Covered Uses	1. Primary hypogonadism in men (congenital or acquired). 2. Hypogonadotropic hypogonadism (congenital or acquired). 3. As a continuous therapy for gender dysphoria/gender identity disorder
Exclusion Criteria	Exclusions: 1. Due to a lack of controlled evaluations in women and the potential for virilizing effects, testosterone products will not be approved for use in women who do not meet criterion for gender dysphoria/gender identity disorder. 2. Testosterone replacement will not be covered for the treatment of sexual dysfunction.
Required Medical Information	1. Primary hypogonadism in men (congenital or acquired). Testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchidectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals AND Lab results required are two low TOTAL testosterone levels (drawn on separate days) and one lab with an elevated LH and FSH. 2. Hypogonadotropic hypogonadism (congenital or acquired). Idiopathic gonadotropin or LHRH deficiency or pituitary hypothalamic injury from tumors, trauma, or radiation AND Lab results required are two low TOTAL testosterone levels (drawn on separate days) and one lab with a low or low-normal LH and FSH (If your patient has low LH and FSH levels, please follow-up on these low levels or consider a referral to an endocrinology provider). 3. As a continuous therapy for gender dysphoria/gender identity disorder when all of the following are met: a. The patient?s insurance benefit includes coverage for the treatment of gender dysphoria/gender identity disorder. b. The patient meets DSM 5 criteria for diagnosis of Persistent Gender Dysphoria documented by a qualified licensed mental health professional experienced in the field, i. If significant medical or mental health concerns are present, there must be documentation that they are well controlled. c. One of the following: i. Member

PA Criteria	Criteria Details
	has lived as their chosen or reassigned gender full-time for 12 months or more, ii. Treatment plan documents that the patient will live as their reassigned gender full-time for a minimum of 12 months while concurrently receiving continuous hormone therapy, iii. Patient has completed gender transition and requires continued hormone therapy to maintain physical characteristics more congruent with their gender identity.
Age Restrictions	18 years or greater
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Must have a documented trial and failure of testosterone gel 1% (generic for Androgel 1%). Quantity Limit: 6 pellets for 3 months.

Tezspire

Products Affected

- Tezspire Solution Auto-Injector 210 MG/1.91ML Subcutaneous
- Tezspire Solution Prefilled Syringe 210 MG/1.91ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	1) add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma, and 2) add-on maintenance treatment of adult and pediatric patients aged 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyps.
Exclusion Criteria	
Required Medical Information	ASTHMA: All of the following must be met: a) at least 12 years of age, AND b) Patient must have severe asthma (FEV1 below 80% predicted normal for adults or below 90% for adults), AND c) Patient must have been on regular treatment with medium or high-dose inhaled corticosteroids (ICS) and at least one additional asthma controller, AND d) must be used in combination with existing asthma therapy (monotherapy will not be authorized as this agent is only FDA-approved as an add-on maintenance treatment). NASAL POLYPS: All of the following must be met: a) at least 12 years of age, AND b) Patient has been unable to obtain symptom relief from at least 4-weeks of intranasal corticosteroid, AND c) Patient will receive Tezspire as add-on therapy in combination with another maintenance treatment for the same indication, AND d) Patient is not receiving Tezspire in combination with any of the following for treatment of the same indication: i) Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab) Fasenra (benralizumab), Nucala (mepolizumab)], ii. Anti-IgE-therapy [e.g., Xolair (omalizumab)], iii. Anti-interleukin-4 therapy [e.g., Dupixent (dupilumab)].
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	Must be prescribed by or in consultation with an allergist, immunologist, pulmonologist, orolaryngologist.
Coverage Duration	Up to one (1) year
Other Criteria	Reauthorization criteria: Asthma: Documented clinical response demonstrated by reduction in frequency of exacerbations, decreased utilization of rescue medications, increase in FEV1 from pretreatment baseline,or reduction in oral corticosteroid. Nasal Polyps: Reduction from baseline in nasal polyp score or improvement in symptoms (improvement in taste/small or reduction in nasal congestion).

Trulicity (dulaglatide)

Products Affected

- Trulicity Solution Auto-Injector 0.75 MG/0.5ML Subcutaneous
- Trulicity Solution Auto-Injector 1.5 MG/0.5ML Subcutaneous
- Trulicity Solution Auto-Injector 3 MG/0.5ML Subcutaneous
- Trulicity Solution Auto-Injector 4.5 MG/0.5ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded. To be used as an adjunct to diet and exercise to improve glycemic control in adults and pediatric patients 10 years of age and older with type 2 diabetes mellitus.
Exclusion Criteria	
Required Medical Information	Indications for approval (all must be met):1. Diagnosis of type 2 diabetes mellitus (T2DM).2. Uncontrolled T2DM as evidenced by an HgbA1c of 7% or greater than has been measured within the past 90 days.3. Within the past 180 days: a. The member has been on a maximized therapeutic dose of metformin (e.g., 2000 mg daily) for at least 90 days, AND b. The member has tried and failed a 90-day course of either a sodium-glucose cotransporter 2 (SGLT2) inhibitor (e.g., Farxiga, Steglatro) or a dipeptidyl peptidase-4 (DPP-4) inhibitor (e.g., alogliptin). 4. Documented trial of Mounjaro or submission of clinical describing inability to use Mounjaro.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Renewal: Up to 12 months

PA Criteria	Criteria Details
Other Criteria	Continuation criteria:1. HgbA1c must decrease by 0.5% or more if initial HgbA1c is less than or equal to 8%.2. HgbA1c must decrease by 1% or more if initial HgbA1c is greater than 8%. Quantity Limit: 4 auto-injectors per 28 days.

Tymlos (abaloparatide) Criteria

Products Affected

- Tymlos Solution Pen-injector 3120 MCG/1.56ML Subcutaneous

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded. 1. Treatment of postmenopausal women with osteoporosis at high risk for fracture or patients who have failed or are intolerant to others available osteoporosis therapy. 2. Treatment to increase bone density in men with osteoporosis at high risk for fracture or patients who have failed or are intolerant to other available osteoporosis therapy.
Exclusion Criteria	
Required Medical Information	1. Bone Mineral Density (BMD) T-score -3.5 or less based on BMD measurements from lumbar spine, femoral neck, total hip, and/or one-third radius (wrist) -OR- 2.Bone mineral density (BMD) T-score between -2.5 and -3.5 in the lumbar spine, femoral neck, total hip, and/or one-third radius (wrist) -AND- a. History of one of the following: i. Vertebral compression fracture ii. Fracture of the hip iii. Fracture of the distal radius iv. Fracture of the pelvis v. Fracture of the proximal humerus -OR- 3. BMD T-score between -1.0 and -2.5 and one of the following FRAX 10-year fracture probabilities: i. Major osteoporotic fracture at 20% or more ii. Hip fracture at 3% or more -OR- 4. History of failure, contraindication, or intolerance to an intravenous bisphosphonate AND Jubbonti or Wyost.
Age Restrictions	
Prescriber	

PA Criteria	Criteria Details
Restrictions	
Coverage Duration	1 year, no more than 2 years cumulative treatment with PTH analogs
Other Criteria	Please note parathyroid hormone (PTH) analogs should not be used for more than 2 years. Cumulative use of PTH analogs for greater than 2 years will not be approved. Specialty pharmacy required.

Ubrelvy

Products Affected

- Ubrelvy Tablet 100 MG Oral
- Ubrelvy Tablet 50 MG Oral

PA Criteria	Criteria Details
Covered Uses	1) Acute treatment of migraine
Exclusion Criteria	
Required Medical Information	1) Acute treatment of migraines, all of the following must be met: a) member has tried a 30-day trial of at least two (2) of the following drugs: almotriptan (Axert?), eletriptan (Relpax?), frovatriptan (Frova?), naratriptan (Amerge?), rizatriptan (Maxalt?/Maxalt-MLT?), sumatriptan (Imitrex?), zolmitriptan (Zomig?), AND b) member has less than 4 migraine days per month OR member has more than 4 migraine days per month and is on a preventive therapy.
Age Restrictions	18
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or headache specialist.
Coverage Duration	Initial: 3 months. Continuation: Up to 12 months
Other Criteria	Reauthorization: 1) positive response to Ubrelvy.

Vabysmo (faricimab-svoa)

Products Affected

- Vabysmo Solution 6 MG/0.05ML Intravitreal
- Vabysmo Solution Prefilled Syringe 6 MG/0.05ML Intravitreal

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	The member has had prior therapy with bevacizumab or Pavlu, and provider attests that the member has not demonstrated a positive clinical response (e.g., improvement or maintenance in best corrected visual acuity or visual field, or a reduction in the rate of vision decline, or a reduction in the risk of more severe vision loss).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist.
Coverage Duration	Initial: 3 months. Continuation: Up to 6 months
Other Criteria	Continuation criteria: positive clinical response to therapy, such as improvement or maintenance in best corrected visual acuity or visual field, or a reduction in the rate of vision decline, or a reduction in the risk of more severe vision loss.

Valcyte (valganciclovir)

Products Affected

- ValGANciclovir HCl SOLUTION RECONSTITUTED 50 MG/ML ORAL
- valGANciclovir HCl Tablet 450 MG Oral

PA Criteria	Criteria Details
Covered Uses	1.Treatment of cytomegalovirus (CMV) retinitis in adult patients with acquired immunodeficiency syndrome (AIDS). 2. Prevention of CMV disease in adult patients at high-risk with kidney, heart, and kidney-pancreas transplants. 3. Prevention of CMV disease in pediatric patients at high risk with kidney or heart transplants. 4. Prevention and treatment of CMV disease in patients with a liver transplant.
Exclusion Criteria	
Required Medical Information	Chart notes documenting medical indication, planned course of therapy and previous therapies attempted (if applicable) including dose, duration, and result(s) are required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Up to 6 months
Other Criteria	Quantity Limits: 50 MG/ML - 900 mL per 30 days; 450 MG - 60 tablets per 30 days.

Vancocin (vancomycin) Oral Capsules

Products Affected

- Vancomycin HCl Capsule 125 MG Oral
- Vancomycin HCl Capsule 250 MG Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Orally administered vancomycin hydrochloride capsule is not effective for other types of infections and will not be approved for systemic infections.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Three (3) months
Other Criteria	

Varizig (Varicella-Zoster Immune Glob (Human) IM Inj 125 Unit/1.2ML)

Products Affected

- VariZIG Solution 125 UNIT/1.2ML
  Intramuscular

PA Criteria	Criteria Details
Covered Uses	Indications for Approval: 1. Immunocompromised patients without evidence of immunity. 2. Newborn infants whose mothers have signs and symptoms of varicella around the time of delivery (i.e. 5 days before to 2 days after). 3. Hospitalized premature infants born at equal to or greater than 28 weeks gestation whose mothers do not have evidence of immunity to varicella. 4. Hospitalized premature infants born at less than 28 weeks gestation or who weigh greater than 1,000 grams at birth, regardless of their mothers evidence of immunity to varicella. 5. Pregnant women without evidence of immunity.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	N/A

PA Criteria	Criteria Details
Other Criteria	Varizig should be administered as soon as possible within 10 days of varicella-zoster virus exposure.

VELTASSA (patiromer)

Products Affected

- Veltassa Packet 1 GM Oral
- Veltassa PACKET 16.8 GM ORAL
- Veltassa PACKET 25.2 GM ORAL
- Veltassa Packet 8.4 GM Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Documents showing the following is required- 1. Baseline potassium 5.1 to less than 6.5mmol/liter at two screenings2. Patient is adhering to a low-potassium diet3. Medications known to cause hyperkalemia has been discontinued or reduced to the lowest effective dose4. Adequate trial of diuretics (loop or thiazides) or there are medical reasons for avoiding them. Adequate trial is defined as at least 4 weeks of a stable doseb. Loop diuretics are recommended if GFR is less than 40 ml/min/1.73m2
Age Restrictions	at least 12 years old
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Quantity Limit: 30 packets per 30 days.

Veozah (fezolinetant)

Products Affected

- Veozah Tablet 45 MG Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	1. Cirrhosis. 2. Severe renal impairment or end-stage renal disease. 3. Concomitant use with CYP1A2 inhibitors.
Required Medical Information	All of the following must be met: 1. Diagnosis of moderate (sensation of heat with sweating) to severe (sensation of heat with sweating, causing cessation of activity) vasomotor symptoms due to menopause. 2. Member doe not have cirrhosis. 3. Baseline liver function tests (LFTs) performed prior to therapy, followed by 3 months, 6 months, and 9 months after initiating therapy. 4. Member does not have sever renal impairment of end-state renal disease. 5. Trial and failure, unless contraindicated (e.g., history of estrogen-dependent cancers) or not tolerated to at least one drug from each: a. hormonal therapy, such as estradiol, Premarin, Prempro), AND b. non-hormonal therapy, such as selective serotonin reuptake inhibitors (SSRIs), selective serotonin and norepinephrine reuptake inhibitors (SNRIs), clonidine, gabapentin.
Age Restrictions	At least 18 years of age
Prescriber Restrictions	
Coverage Duration	Initial: 6 months. Initial renewal: 6 months. Subsequent renewals: up to 1 year.
Other Criteria	Continuation criteria: 1. Documentation of positive clinical response (decrease in frequency and severity of vasomotor

PA Criteria	Criteria Details
	symptoms from baseline). 2. Follow-up LFTs at 3 months, 6 months, and 9 months after initiation of therapy. Quantity Limit: 2 tablets per day.

Vfend (voriconazole)

Products Affected

- Vfend IV SOLUTION RECONSTITUTED 200 MG Intravenous
- Voriconazole Solution Reconstituted 200 MG Intravenous
- Voriconazole TABLET 200 MG ORAL
- Voriconazole Tablet 50 MG Oral

PA Criteria	Criteria Details
Covered Uses	The patient has a documented diagnosis of one of the following: 1. Invasive aspergillosis. 2. Candida Krusei. 3. An organism known to be resistant to high dose fluconazole and susceptible to voriconazole.
Exclusion Criteria	N/A
Required Medical Information	Documentation must include a culture report or susceptibility report if applicable.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	
Other Criteria	Continuation of Therapy Criteria: To ensure that therapeutic blood levels have been reached, voriconazole trough levels must be provided with each subsequent request for continuation of therapy. Quantity Limit: 60 tablets per 30 days.

Vosevi (sofosbuvir-velpatasvir-voxilaprevir)

Products Affected

- Vosevi TABLET 400-100-100 MG Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	1. Patient is 18 years of age and older. 2. Patient meets ONE of the following (i or ii): i. Patient does not have cirrhosis - OR ii. Patient had a prior null response, prior partial response, or relapse after prior treatment with an HCV direct-acting antiviral regimen containing an NS5A inhibitor. prescribed by or in consultation with a gastroenterologist,hepatologist, infectious diseases physician, or a liver transplant physician.add specialty mandate
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.
Coverage Duration	Three (3) months
Other Criteria	

Xenazine (tetrabenazine)(COMM, EXC, CentCare)

Products Affected

- Tetrabenazine Tablet 12.5 MG Oral
- Tetrabenazine Tablet 25 MG Oral

PA Criteria	Criteria Details
Covered Uses	1. Chorea associated with Huntington disease: 2. Tardive Dyskinesia. Disease specific criteria must be met. 3. Tics associated with Tourette syndrome.
Exclusion Criteria	N/A
Required Medical Information	Documentation of the following: 1. PATIENT does not have untreated or inadequately treated depression. 2. PATIENT is not actively suicidal. 3. PATIENT does not have hepatic impairment. 4. PATIENT is not taking a monoamine oxidase inhibitor or reserpine. 5. APPROPRIATE disease specific criteria must also be met: A) CHORIA ASSOCIATED WITH HUNTINGTON DISEASE- i) Patient must be ambulatory. ii) The baseline total maximal chorea score from the UHDRS must be provided. iii) Patient must have a documented trial and failure, or intolerance to, or a medical reason for avoiding the use of amantadine or riluzole. B) TARDIVE DYSKINESIA - i) Prescribed by a neurologist or psychiatrist, ii) Trial and failure of one of the following: amantadine, anticholinergic medication, or a benzodiazepine, iii) Documentation of tardive dyskinesia and baseline Abnormal Involuntary Movement Scale (AIMS) must be provided. C) TICS ASSOCIATED WITH TOURETTE SYNDROME - i) Documentation showing the tics are interfering with social interactions, school or job performance, activities of daily living or are causing discomfort, pain, or injury. ii) Inadequate response to or a medical reason for avoiding the use of the following modalities: For tics due to Tourette syndrome, risperidone or fluphenazine. For tics due to Tourette syndrome with concurrent ADHD, clonidine or guanfacine.

PA Criteria	Criteria Details
Age Restrictions	Approved for use in adults only.
Prescriber Restrictions	Must be prescribed by a neurologist or in consultation with a neurologist.
Coverage Duration	Initial approval: 6 months. Renewal: One year.
Other Criteria	Continuation of Therapy: 1. For all indications, documentation of continued monitoring for depression, suicidal ideation and hepatic impairment. 2. Huntington Disease chorea - documentation of improvement in the total maximal chorea score from the UHDRS compared to baseline. 3. Tardive Dyskinesia: Documented improvement in AIMS compared to baseline. 4. Tics due to Tourette syndrome: Documented reduction in frequency and intensity of tics.

Xeomin (incobotulinumtoxinA)

Products Affected

- Xeomin SOLUTION RECONSTITUTED 100 UNIT Intramuscular
- Xeomin SOLUTION RECONSTITUTED 200 UNIT Intramuscular
- Xeomin SOLUTION RECONSTITUTED 50 UNIT Intramuscular

PA Criteria	Criteria Details
Covered Uses	1. Upper limb spasticity in adult and pediatric patients 2 ot 17 years of age (excluding spasticity caused by cerebral palsy in pediatric patients). 2. Cervical dystonia in adults. 3. Blepharospasm in adults.
Exclusion Criteria	
Required Medical Information	1. Upper Limb Spasticity. a. Diagnosis of upper limb spasticity in adults and pediatric patients 2 to 17 years of age (excluding spasticity caused by cerebral palsy in pediatric patients). b.Prescribed by or in consultation with a neurologist. c.For adult patients, dose will not exceed 400 units, divided among affected muscles. d. For pediatric patients, dose will dose will not exceed 8 units/kg (maximum 200 units) per single upper limb or 16 units/kg in both upper limbs, divided among affected muscles 2. Cervical dystonia. a. Diagnosis of cervical dystonia. b. Member is 18 years of age or older. c. Member is experiencing involuntary contractions of the neck and shoulder muscles (e.g., splenius capitis, sternocleidomastoid, levator scapulae, scalene, trapezius, semispinalis capitis) resulting in abnormal postures or movements of the neck, shoulders, or head. d. Contractions are causing pain and functional impairment. e. Dose does not exceed more than 120 units per treatment session. 3. Blepharospasm. a. Diagnosis of blepharospasm. b. Prescribed by or in consultation with a neurologist or ophthalmologist. c. Member is 18 years of age or older. d. Member is experiencing significant disability in daily functional activities due to interference with vision. e. Dose does not exceed 25 units per eye per treatment session.

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One (1) year
Other Criteria	

Xifaxan (rifaximin)

Products Affected

- Xifaxan TABLET 200 MG ORAL
- Xifaxan TABLET 550 MG ORAL

PA Criteria	Criteria Details
Covered Uses	1. Traveler's diarrhea (200mg strength only) 2. Hepatic encephalopathy (200mg and 550mg strengths) 3. Irritable Bowel Syndrome, Diarrhea Predominant (IBS-D) 4. Small Intestine Bacterial Overgrowth (SIBO)
Exclusion Criteria	N/A
Required Medical Information	1. Traveler's diarrhea (200mg strength only) - Patient must meet all of the following criteria: Documented diagnosis of traveler's diarrhea due to a noninvasive strain of E.Coli. Documented treatment failure with an oral antibiotic such as azithromycin or ciprofloxacin. 2. Hepatic encephalopathy (200mg and 550mg strengths) - Patient must meet all of the following criteria: Documented diagnosis of hepatic encephalopathy. Documented treatment failure or documented intolerance or contraindication to lactulose. 3. Irritable Bowel Syndrome, Diarrhea Predominant (IBS-D) - Patient must meet all of the following criteria: Documented diagnosis of Irritable Bowel Syndrome with diarrhea as the predominant symptom.Documented trial and failure of dietary modification (e.g. low FODMAP diet, lactose avoidance, gluten avoidance). Documented trial and failure of at least two of the following: antidiarrheals (i.e. loperamide), antispasmodics, or tricyclic antidepressants. 4. Small Bacterial Overgrowth (SIBO) - Patient must meet all of the following criteria:?Documentation of a positive lactulose/glucose breath test must be submitted and one of the following are met:a.An absolute increase in hydrogen by at least 20 ppm above baseline within 90 minutes.b.A methane level by at least 10 ppm?The patient must have a documented trial and failure of one other antibiotic treatment (e.g., amoxicillin/clavulanate, metronidazole plus cephalexin, metronidazole plus sulfamethoxazole/trimethoprim double strength).

PA Criteria	Criteria Details
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Traveler's Diarrhea: 1 time. Hepatic Encephalopathy: 1 year. IBS-D: 1 time. SIBO: 1 time
Other Criteria	Quantity Limits: For traveler's diarrhea - 9 tablets (200mg) for 3 days for any one 30-day period. For hepatic encephalopathy - 200mg tablets(up to 180 tablets for 30 days), 550mg tablets - 60 tablets for 30 days. For IBS-D - 42 tablets (550mg) for 14 days for any one 30-day period. Patients who experience a recurrent of symptoms can be retreated up to two times with the same dosage regimen. SIBO - 42 tablets (550 mg) for 14 days

Xolair (omalizumab)(Cent Care)

Products Affected

- Xolair Solution Auto-Injector 150 MG/ML Subcutaneous
- Xolair Solution Auto-Injector 300 MG/2ML Subcutaneous
- Xolair Solution Auto-Injector 75 MG/0.5ML Subcutaneous
- Xolair Solution Prefilled Syringe 150 MG/ML Subcutaneous
- Xolair Solution Prefilled Syringe 300 MG/2ML Subcutaneous
- Xolair Solution Prefilled Syringe 75 MG/0.5ML Subcutaneous
- Xolair Solution Reconstituted 150 MG Subcutaneous

PA Criteria	Criteria Details
Covered Uses	1. Treatement of Treatment of Moderate to severe persistent asthma. 2. Treatment of Chronic Idiopathic Urticaria. 3. Chronic Rhinosinusitis with Nasal Polyps. 4. IgE-Mediated Food Allergy. Treatment of Chronic Idiopathic Urticaria: All of the following must be met: 1. The patient must have a documented diagnosis of chronic idiopathic urticaria. 2. Must be prescribed by Allergist/Immunologist. 3. Documentation of all the following is required: a. Minimum 30 day trial of scheduled, high dose non-sedating anti-histamines in combination with montelukast. b. Minimum of one short course of corticosteroids. c. Minimum 30 day trial of immunosuppressant, immunomodulatory or anti-inflammatory agent (i.e. cyclosporine, mycophenolate, tacrolimus, dapsone, hydroxychloroquine, sulfasalazine or methotrexate).Continuation of treatment for Chronic Idiopathic Urticaria: Documentation of ALL the following is required: 1. Reduction in exacerbation frequency. 2. Reduction in exacerbation intensity. 3. Decrease in oral corticosteroid use. Treatment of Moderate to severe persistent asthma: All of the following must be met: 1. The requesting physician is an allergist or pulmonologist. 2. The patient age is 6 years or greater. 3. The patient has a documented IgE level greater than 30 IU/ml. 4. The diagnosis of allergic asthma is supported by clinical and lab findings such as positive skin tests, symptom patterns, etc. 5. The patient has a documented failure on a minimum 6-month trial of inhaled steroid and long-acting beta-2 agonist combination therapy at maximum doses. 6. There is sufficient evidence of persistent symptoms

PA Criteria	Criteria Details
	requiring frequent rescue therapy, practitioner visits despite inhaled corticosteroids, or emergency room visits.
Exclusion Criteria	N/A
Required Medical Information	1. Treatement of Treatment of Moderate to severe persistent asthma, all of the following must be met: a) The requesting physician is an allergist or pulmonologist, AND b) The patient age is 6 years or greater, AND c) The patient has a documented IgE level greater than 30 IU/ml, and d) The diagnosis of allergic asthma is supported by clinical and lab findings such as positive skin tests, symptom patterns, etc, AND e) The patient has a documented failure (demonstrated by poor symptom control or 2 or more exacerbations per year) on a minimum 3 to 6-month trial of a medium to high dose inhaled steroid and another asthma controller combination therapy at maximum doses with good adherence and management of contributory factors. Reauthorization: documentation of positive response (based on spirometry or measureable symptom control such as Asthma Control Questionnaire or Asthma Control Test). 2. Treatment of Chronic Idiopathic Urticaria: All of the following must be met: a) The patient must have a documented diagnosis of chronic idiopathic urticaria, AND b) the patient must be at least 12 years of age, AND c) Must be prescribed by Allergist/Immunologist, AND d) Failure of a minimum 30-day trial of an antihistamine drug targeting the H1 receptor. Failure is measured using a validated rating scale (e.g . Urticaria Activity Score over 7 Days (UAS7), UCT (Urticaria Control Test, etc). Reauthorization: a) Reduction in exacerbation frequency (change in itch severity score or other validated rating scale). 3. Chronic Rhinosinusitis with Nasal Polyps, all must be met: a) 18 years of age and older, AND b) documented inadequate response to nasal corticosteroids, AND c) will be used as add-on to nasal steroid maintenance treatment, AND d) patient must have all of the following: i. nasal polyps detected by direct examination, endoscopy, or sinus CT scan and ii. significant rhinosinusitis such as nasal obstruction rhinorrhea, or reduction or loss of smell as documented by the prescriber

PA Criteria	Criteria Details
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CIU: 3 months initially. Asthma: 3 months initially. Subsequent approvals: up to 6 months.
Other Criteria	Required Med Info Continued: iii. Bilateral Nasal Polyp Score (NPS) of at least 5, and NPS of at least 2 in each nostril, AND e) Must be prescribed by or in consultation with an allergist, immunologist, orolaryngologist, AND f) will not be used in combination with another biologic that treats your condition. Reauthorization, all must be met: a) continued use of a nasal steroid, AND b) continues to not be used with another biologic that treats your condition, AND c) a documented positive response. 4. IgE-Mediated Food Allergy, all must be met: a) Patient must be at least 1 year of age, AND b) it must be prescribed by an allergist or immunologist, AND c) must have one of the following: i. A positive skin prick test with a red circle of greater than or equal to 4 mm greater than the control prick, ii. Food-specific IgE level (test used to measure how severe your allergy is) greater than or equal to 6 kUA/L, iii. Positive oral food challenge test, AND d) will be used in combination with food allergen avoidance, AND e) Patient has a history of a severe allergic reaction to the food such as hives, swelling, wheezing, low blood pressure, or stomach upset requiring treatment with Epinephrine, and f) will be co-prescribed. Reauthorization: 1) Xolair will be used in combination with food avoidance. *Dosing for Chronic Idiopathic Urticaria: 150 mg or 300 mg by subcutaneous route every 4 weeks Dosing: Dosing of Xolair is considered medically necessary according to the FDA-approved labeling of Xolair (see Xolair prescribing information) Code: J2357. 5mg = 1 billable unit.

Xyrem (sodium oxybate)(Cent Care)

Products Affected

- Sodium Oxybate Solution 500 MG/ML
  Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Exclusions: 1. Xyrem will not be approved if patient is being treated with sedative hypnotics or other CNS depressants. 2. Patients with succinic semialdehyde dehydrogenase deficiency. 3. Patients with a history of drug abuse.
Required Medical Information	1.A documented diagnosis of cataplexy in narcolepsy requiring treatment. All of the following are required: a. b. The patient has a documented trial and failure of, or intolerance to a tricyclic antidepressant or formulary selective serotonin receptor inhibitor (SSRI). 2. Excessive daytime sleepiness (EDS) in narcolepsy. All of the following are required: a. The patient has a documented trial and failure of, or intolerance to an adequate trial of a preferred formulary cerebral stimulant (methylphenidate or dextroamphetamine) AND armodafinil or modafinil AND Sunosi (solriamfetol) AND Wakix (pitolisant)
Age Restrictions	at least 7 years old
Prescriber Restrictions	Prescribed by a neurologist or sleep specialist
Coverage Duration	1 year
Other Criteria	For all indications: prescriber must participate in the Xyrem Success Program Quantity Limit: 540 mL per 30 days.

Zortress (everolimus)(Cent Care)

Products Affected

- Everolimus Tablet 0.25 MG Oral
- Everolimus Tablet 0.5 MG Oral
- Everolimus Tablet 0.75 MG Oral
- Everolimus Tablet 1 MG Oral

PA Criteria	Criteria Details
Covered Uses	Criteria is dependent upon diagnosis: 1. Kidney transplant: a. Zortress is being administered in combination with basiliximab induction and concurrently with reduced doses of cyclosporine and corticosteroids. 2. Liver Transplant: a. Zortress is being administered no earlier than 30 days post-transplant with low dose tacrolimus and corticosteroids.
Exclusion Criteria	N/A
Required Medical Information	Chart notes documenting medical indication, planned course of therapy and previous therapies attempted (if applicable) including dose, duration, and result(s) are required.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

Zyvox (linezolid)(Cent Care)

Products Affected

- Linezolid in Sodium Chloride Solution 600-0.9 MG/300ML-% Intravenous
- Linezolid SOLUTION 600 MG/300ML Intravenous
- Linezolid Suspension Reconstituted 100 MG/5ML Oral
- Linezolid Tablet 600 MG Oral

PA Criteria	Criteria Details
Covered Uses	1. An infectious disease specialist consult, chart notes and culture and sensitivities must be received with the request. AND 2. The patient must have failed other antibacterials that the culture shows sensitivities to or the patient has a contraindication to the other antibacterials.
Exclusion Criteria	N/A
Required Medical Information	Chart notes documenting medical indication, planned course of therapy and previous therapies attempted (if applicable) including dose, duration, and result(s) are required.
Age Restrictions	N/A
Prescriber Restrictions	Infectious Disease Consultation must be documented.
Coverage Duration	1 time
Other Criteria	N/A

Step Therapy Criteria

Amitiza (lubiprostone)

Products Affected

- Lubiprostone Capsule 24 MCG Oral
- Lubiprostone Capsule 8 MCG Oral

Details

Criteria	There must be a claim history of an osmotic laxative (PEG-3350 or lactulose) within the past 120 days

Boniva (ibandronate) tablets

Products Affected

- Ibandronate Sodium Tablet 150 MG Oral

Details

Criteria	A documented trial and failure of alendronate.

Detrol/Detrol LA (tolterodine/tolterodine ER)

Products Affected

- Detrol LA Capsule Extended Release 24 Hour 2 MG Oral
- Detrol LA Capsule Extended Release 24 Hour 4 MG Oral
- Tolterodine Tartrate ER Capsule Extended Release 24 Hour 2 MG Oral
- Tolterodine Tartrate ER Capsule Extended Release 24 Hour 4 MG Oral
- Tolterodine Tartrate Tablet 1 MG Oral
- Tolterodine Tartrate Tablet 2 MG Oral

Details

Criteria	The patient must have a 30-day prescription fill of generic oxybutynin, oxybutynin XL, or oxybutynin transdermal (Oxytrol for Women) within the past 545 days.

Diastat (diazepam gel)

Products Affected

- diazePAM Gel 10 MG Rectal
- diazePAM Gel 2.5 MG Rectal
- diazePAM Gel 20 MG Rectal

Details

Criteria	Step therapy is required for patients 18 years of age and older. The patient must have a claim history within the past 120 days of a 30-day fill of an anti- epileptic agent.

DPP-4 Inhibitors, Preferred (Kazano, Nesina)

Products Affected

- Alogliptin-metFORMIN HCl Tablet 12.5-1000 MG Oral
- Alogliptin-metFORMIN HCl Tablet 12.5-500 MG Oral
- Segluromet Tablet 2.5-1000 MG Oral
- Segluromet Tablet 2.5-500 MG Oral
- Segluromet Tablet 7.5-1000 MG Oral
- Segluromet Tablet 7.5-500 MG Oral

Details

Criteria	The patient must have a 90-day prescription fill of metformin within the past 545 days.

Finacea (azelaic acid 15%) Gel, Foam

Products Affected

- Finacea Foam 15 % External

Details

Criteria	The patient must have a 30-day prescription fill of metronidazole topical within the past 120 days.

Freestyle (Continuous Glucose Monitor)

Products Affected

- FreeStyle Libre 14 Day Reader Device
- FreeStyle Libre 14 Day Sensor
- FreeStyle Libre 2 Plus Sensor
- FreeStyle Libre 2 Reader Device
- FreeStyle Libre 2 Sensor
- FreeStyle Libre 3 Plus Sensor
- FreeStyle Libre 3 Reader Device
- FreeStyle Libre 3 Sensor
- FreeStyle Libre Reader Device

Details

Criteria	The patient must have a claim history of a 30-day supply of insulin in the past 120 days for new starts and continuations.

ICS/LABA combos (AirDuo, Dulera, Symbicort)

Products Affected

- Dulera Aerosol 100-5 MCG/ACT Inhalation
- Dulera Aerosol 200-5 MCG/ACT Inhalation
- Dulera Aerosol 50-5 MCG/ACT Inhalation

Details

Criteria	The patient must have a prescription claim history of an orally inhaled corticosteroid or orally inhaled anticholinergic within the past 150 days OR FEV1 of less than 50%.

Kytril (granisetron) tablets

Products Affected

- Granisetron HCl Tablet 1 MG Oral

Details

Criteria	The patient must have a prescription claim history of at least a 5-day trial of generic ondansetron oral tablets within the past 120 days.

LEVETIRACETAM EXTENDED RELEASE TABLETS

Products Affected

- levETIRAcetam ER Tablet Extended Release 24 Hour 500 MG Oral
- levETIRAcetam ER Tablet Extended Release 24 Hour 750 MG Oral

Details

Criteria	Pharmacy claim of levetiracetam immediate release in the last 180 days

Memantine ER

Products Affected

- Memantine HCl ER Capsule Extended Release 24 Hour 14 MG Oral
- Memantine HCl ER Capsule Extended Release 24 Hour 21 MG Oral
- Memantine HCl ER Capsule Extended Release 24 Hour 28 MG Oral
- Memantine HCl ER Capsule Extended Release 24 Hour 7 MG Oral

Details

Criteria	The patient must have a claim history of donepezil or Namenda immediate release tablets within the past 545 days.

Nayzilam/Valtoco

Products Affected

- Nayzilam Solution 5 MG/0.1ML Nasal
- Valtoco 10 MG Dose Liquid 10 MG/0.1ML Nasal
- Valtoco 15 MG Dose Liquid Therapy Pack 2 x 7.5 MG/0.1ML Nasal
- Valtoco 20 MG Dose Liquid Therapy Pack 2 x 10 MG/0.1ML Nasal
- Valtoco 5 MG Dose Liquid 5 MG/0.1ML Nasal

Details

Criteria	You must have had history of any formulary anti-convulsant in the past 180 days.

Onfi (clobazam)

Products Affected

- cloBAZam Suspension 2.5 MG/ML Oral
- cloBAZam Tablet 10 MG Oral
- cloBAZam Tablet 20 MG Oral

Details

Criteria	You must have tried and failed at least two (2) formulary anti-convulsants in the past 180 days.

Oseni (alogliptin and pioglitazone

Products Affected

- Alogliptin-Pioglitazone Tablet 12.5-30 MG Oral
- Alogliptin-Pioglitazone Tablet 25-15 MG Oral
- Alogliptin-Pioglitazone Tablet 25-30 MG Oral
- Alogliptin-Pioglitazone Tablet 25-45 MG Oral

Details

Criteria	The patient must have a 90-day prescription fill of metformin or alogliptin within the past 545 days.

Prevacid (lansoprazole capsule)

Products Affected

- Lansoprazole Capsule Delayed Release 30 MG Oral
- Prevacid Capsule Delayed Release 30 MG Oral

Details

Criteria	The patient must have a claim history within the past 545 days of a 30-day trial of omeprazole and pantoprazole.

Ranexa

Products Affected

- Ranolazine ER Tablet Extended Release 12 Hour 1000 MG Oral
- Ranolazine ER Tablet Extended Release 12 Hour 500 MG Oral

Details

Criteria	The member must have a claim history within the past 120 days of all of the following agents: a) Beta Blocker b) Calcium Channel Blocker c) Nitrate

Sporanox (itraconazole)

Products Affected

- Itraconazole Capsule 100 MG Oral
- Sporanox CAPSULE 100 MG ORAL

Details

Criteria	The patient must have a claim history of terbinafine tablets or fluconazole tablets within the past 90 days.

Steglatro (ertugliflozin)

Products Affected

- Steglatro Tablet 5 MG Oral

Details

Criteria	The member must have had a 90-day trial of metformin or a metformin-containing product within the past 120 days.

Stiolto Respimat (tiotropium/olodaterol)

Products Affected

- Stiolto Respimat Aerosol Solution 2.5-2.5 MCG/ACT Inhalation

Details

Criteria	The patient must have a 30- day prescription fill of a formulary long-acting anticholinergic or a long-acting beta agonist (LABA) product within the past 180 days. the patient is diagnosed with COPD and in GOLD group B or worse. Group B defined a CAAT equal to or greater than 10 or mMRC grade equal to or greater than 2.

Tresiba (insulin degludec)

Products Affected

- Insulin Degludec FlexTouch Solution Pen-Injector 100 UNIT/ML Subcutaneous
- Insulin Degludec FlexTouch Solution Pen-Injector 200 UNIT/ML Subcutaneous
- Insulin Degludec Solution 100 UNIT/ML Subcutaneous
- Tresiba FlexTouch Solution Pen-Injector 100 UNIT/ML Subcutaneous
- Tresiba FlexTouch Solution Pen-Injector 200 UNIT/ML Subcutaneous
- Tresiba Solution 100 UNIT/ML Subcutaneou

Details

Criteria	The patient must have a prescription claim history of a preferred insulin glargine product within the past 545 days.