Georgia Medicaid Traditional Drug Criteria
Effective 10/1/2022

Drug Name	Criteria	Approval Duration
ACETAMIN-CODEIN 300-30 MG/12.5	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
ACETAMINOP-CODEINE 120-12 MG/5	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
ACETAMINOPHEN-COD #2 TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
ACETAMINOPHEN-COD #3 TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
ACETAMINOPHEN-COD #4 TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
ACETYLCYSTEINE 10% VIAL	•Approve if Fax States for Use in Acetaminophen Overdose OR •As Mucolytic for Diagnoses Such As Chronic Emphysema, Chronic Asthmatic Bronchitis, Emphysema With Bronchitis, Pneumonia, Bronchitis, Pulmonary Complications Of Cystic Fibrosis	Acetaminophen Overdose = 30 Days Mucolytic = 3 Months
ACETYLCYSTEINE 20% VIAL	•Approve if Fax States for Use in Acetaminophen Overdose OR •As Mucolytic for Diagnoses Such As Chronic Emphysema, Chronic Asthmatic Bronchitis, Emphysema With Bronchitis, Pneumonia, Bronchitis, Pulmonary Complications Of Cystic Fibrosis	Acetaminophen Overdose = 30 Days Mucolytic = 3 Months
ACITRETIN 10 MG CAPSULE	•Diagnosis of One of The Following: •Hyperkeratotic Dermatitis of The Palms •Lichen Planus •Palmoplantar Pustulosis •Prophylaxis of Skin Cancer in High-Risk Kidney Transplant Recipients •Psoriasis Classified as Severe •Squamous Cell Carcinoma •Subcorneal Pustular Dermatosis (SPD; Sneddon-Wilkinson disease) •Quantity Limit 30 Capsules/26 Days	1 Year
ACITRETIN 17.5 MG CAPSULE	•Diagnosis of One of The Following: •Hyperkeratotic Dermatitis of The Palms •Lichen Planus •Palmoplantar Pustulosis •Prophylaxis of Skin Cancer in High-Risk Kidney Transplant Recipients •Psoriasis Classified as Severe •Squamous Cell Carcinoma •Subcorneal Pustular Dermatosis (SPD; Sneddon-Wilkinson disease) •Quantity Limit 30 Capsules/26 Days	1 Year
ACITRETIN 25 MG CAPSULE	•Diagnosis of One of The Following: •Hyperkeratotic Dermatitis of The Palms •Lichen Planus •Palmoplantar Pustulosis •Prophylaxis of Skin Cancer in High-Risk Kidney Transplant Recipients •Psoriasis Classified as Severe •Squamous Cell Carcinoma •Subcorneal Pustular Dermatosis (SPD; Sneddon-Wilkinson disease) •Quantity Limit 30 Capsules/26 Days	1 Year
ACTIMMUNE 100 MCG/0.5 ML VIAL	Diagnosis of Chronic Granulomatous Disease or Malignant Osteoporosis	3 Months for Initial Authorizations 1 Year for Re-Authorizations

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Drug Name	Criteria	Approval Duration
ACTOPLUS MET XR 15-1,000 MG TB	•60 Day Trial of: Metformin IR or Metformin ER (Glucophage or Glucophage ER) - [Not Required if: HbA1C Greater Than 7.5% OR •Allergy, Intolerance, or Side Effect to Metformin •OR Renal/Kidney Disease/Elevated Creatine (CR)] •Note: This Medication Will Pay With an Electronic Step if There Are 30 Days of Metformin Use in The Last 120 Days	1 Year
ACTOPLUS MET XR 30-1,000 MG TB	•60 Day Trial of: Metformin IR or Metformin ER (Glucophage or Glucophage ER) - [Not Required if: HbA1C Greater Than 7.5% OR •Allergy, Intolerance, or Side Effect to Metformin •OR Renal/Kidney Disease/Elevated Creatine (CR)] •Note: This Medication Will Pay With an Electronic Step if There Are 30 Days of Metformin Use in The Last 120 Days	1 Year
ACUVAIL 0.45% OPHTH SOLUTION	•Clinical Reason Supported by Chart Notes why (after a One Time Trial Of) the below cannot be used: •Ketorolac (Acular) 0.5% Eye Drops	30 Days
ACYCLOVIR 5% CREAM	•Diagnosis of Cold Sores/Oral Herpes Simplex/ HSV-Type 1/Herpes Labialis •3 Day Trial of: Docosanol (FDA Approved for Ages 12 & Older) [Will Still Accept Denavir as a Trial] •Clinical Reason Supported by Chart Notes Why (After a 30-Day Trial of) The Below Cannot be Used: •Acyclovir 5% Ointment •Quantity Limit 1 Tube (5 grams)/30 Days	30 Days
ACYCLOVIR 5% OINTMENT	• Diagnosis of Acute Outbreak Of Genital Herpes Simplex/HSV-Type 2 OR • Diagnosis of Cold Sores/Oral Herpes Simplex/HSV-Type 1/Herpes Labialis • 3 Day Trial of: Docosanol (FDA Approved Age 12 And Up) [Will Still Accept Denavir As A Trial]	30 days
ADAPALENE 0.1% CREAM	•Clinical Reason Supported by Chart Notes Why (After a Trial of) The Below Cannot be Used: •Differin OTC •Quantity Limit 45 Grams (1 Tube) / 26 Days	1 Year
ADAPALENE 0.1% GEL	•Clinical Reason Supported by Chart Notes Why (After a Trial of) The Below Cannot be Used: •Differin OTC •Quantity Limit 45 Grams (1 Tube) / 26 Days	1 Year
ADAPALENE 0.1% LOTION	• Clinical reason supported by chart notes why, after a trial, Differin OTC cannot be used	1 Year
ADAPALENE 0.1% SOLUTION	•Clinical Reason Supported by Chart Notes Why (After a Trial of) The Below Cannot be Used: •Differin OTC •Quantity Limit 45 Grams (1 Tube) / 26 Days	1 Year
ADAPALENE 0.3% GEL	•Clinical Reason Supported by Chart Notes Why (After a Trial of) The Below Cannot be Used: •Differin OTC •Quantity Limit 45 Grams (1 Tube) / 26 Days	1 Year
ADAPALENE 0.3% GEL PUMP	•Clinical Reason Supported by Chart Notes Why (After a Trial of) The Below Cannot be Used: •Differin OTC •Quantity Limit 45 Grams (1 Tube) / 26 Days	1 Year
ADAPALENE-BNZYL PEROX 0.1-2.5%	•Clinical Reason Supported by Chart Notes Why (After a Trial of) The Below Cannot be Used: •Benzoyl peroxide gel 2.5% and Differin OTC •Quantity Limit 45 Grams/26 Days	1 Year
ADASUVE 10 MG INHALATION POWDR	•Clinical Reason Supported by Chart Notes Why (After a 90-day Trial of) The Below Cannot be Used: •Aripiprazole (Abilify) Tablets	1 Year
ADEFOVIR DIPIVOXIL 10 MG TAB	Age 12 years and older	1 Year
ADEFOVIR DIPIVOXIL 10 MG TAB	**Age 12 years and older. **Diagnosis of chronic hepatitis B. **Prescribed by infectious disease specialist, gastroenterologist, hepatologist or transplant physician	1 Year
AEMCOLO DR 194 MG TABLET	•Diagnosis of Traveler's Diarrhea •A One-Time Trial in The Last 30 Days of: ciprofloxacin, azithromycin, or Rifaximin •Quantity Limit 12 Tablets/30 Days	30 Days
AFLURIA 2018-2019 SYRINGE	•Under Age of 19: Use The Vaccines for Children (VFC) Program •Age of 19 and Over: If Billing to The Medical Benefit, No PA is Required OR •If Billing to The Pharmacy Benefit, No PA is Required. However, Pharmacy MUST Bill Using The Broader Vaccine Network (BVN)	N/A
AFLURIA 2018-2019 VIAL	•Under Age of 19: Use The Vaccines for Children (VFC) Program •Age of 19 and Over: If Billing to The Medical Benefit, No PA is Required OR •If Billing to The Pharmacy Benefit, No PA is Required. However, Pharmacy MUST Bill Using The Broader Vaccine Network (BVN)	N/A

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AFLURIA QUAD 2018-2019 SYRINGE	•Under Age of 19: Use The Vaccines for Children (VFC) Program •Age of 19 and Over: If Billing to The Medical Benefit, No PA is Required OR •If Billing to The Pharmacy Benefit, No PA is Required. However, Pharmacy MUST Bill Using The Broader Vaccine Network (BVN)	N/A
AFLURIA QUAD 2018-2019 VIAL	•Under Age of 19: Use The Vaccines for Children (VFC) Program •Age of 19 and Over: If Billing to The Medical Benefit, No PA is Required OR •If Billing to The Pharmacy Benefit, No PA is Required. However, Pharmacy MUST Bill Using The Broader Vaccine Network (BVN)	N/A
AGONEAZE 2.5%-2.5% CREAM DRESS	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 Year
ALBENDAZOLE 200 MG TABLET	• Diagnosis of Hydatid Disease OR Neurocysticercosis OR • Diagnosis of Enterobius vermicularis (pinworm) AND a 30 Day Trial of: any formulary pyrantel pamoate product	90 days
ALENDRONATE SOD 70 MG/75 ML	•Clinical Reason Supported by Chart Notes Why (After a Trial of) The Below Cannot be Used: •alendronate (Fosamax) tablet	1 Year
ALOGLIPTIN 12.5 MG TABLET	• 30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 Year
ALOGLIPTIN 25 MG TABLET	• 30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 Year
ALOGLIPTIN 6.25 MG TABLET	• 30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 Year
ALOGLIPTIN-METFORMIN 12.5-1000	• 30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 Year
ALOGLIPTIN-METFORMIN 12.5-500	• 30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 Year
ALOGLIPTIN-PIOGLIT 12.5-15 MG	• 30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 Year
ALOGLIPTIN-PIOGLIT 12.5-30 MG	• 30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 Year
ALOGLIPTIN-PIOGLIT 12.5-45 MG	• 30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 Year
ALOGLIPTIN-PIOGLIT 25-15 MG TB	• 30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 Year
ALOGLIPTIN-PIOGLIT 25-30 MG TB	• 30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 Year
ALOGLIPTIN-PIOGLIT 25-45 MG TB	• 30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 Year
ALOMIDE 0.1% EYE DROPS	• Age 2 Years Or Older • 30 Day Trial of each: cromolyn ophthalmic drops, ketotifen ophthalmic drops	6 months
ALOSETRON HCL 0.5 MG TABLET	• Diagnosis of Severe-Diarrhea OR IBS (Irritable Bowel Syndrome) • 7 Day Trial of: Atropine-Diphenoxylate (Lomotil) Or Dicyclomine (Bentyl)	1 Year
ALOSETRON HCL 1 MG TABLET	• Diagnosis of Severe-Diarrhea OR IBS (Irritable Bowel Syndrome) • 7 Day Trial of: Atropine-Diphenoxylate (Lomotil) Or Dicyclomine (Bentyl)	1 Year
ALPHAGAN P 0.1% DROPS	•Clinical Reason Supported by Chart Notes Why (After a 30-Day Trial of) The Below Cannot be Used: •Brimonidine 0.2% Eye Drops	1 year
ALREX 0.2% EYE DROPS	7-Day Trial Each of Two Preferred Alternatives: dexamethasone 0.1% Ophthalmic Solution, prednisolone acetate (Pred Forte, Omnipred) 1%, or prednisolone sodium phosphate 1%	3 Months
ALTABAX 1% OINTMENT	•One Time Trial of: mupirocin ointment •Quantity Limit 15 Grams (1 Tube) / 26 Days	30 Days
ALUNBRIG 90 MG TABLET	•Pharmacy Benefit •Diagnosis of Non-Small Cell Lung Cancer •Previous Trial of and Progression or Intolerance While on crizotinib	6 Months
ALVESCO 160 MCG INHALER	•Age = 12 Years and Older •Diagnosis of Asthma •30 Day Trial of: Flovent or Arnuity (Does Not Need to be Within the Last 120 Days) •Note: 1 Inhaler Contains 60 Doses	1 year

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Drug Name	Criteria	Approval Duration
ALVESCO 80 MCG INHALER	•Age = 12 Years and Older •Diagnosis of Asthma •30 Day Trial of: Flovent or Arnuity (Does Not Need to be Within the Last 120 Days) •Note: 1 Inhaler Contains 60 Doses	1 year
AMCINONIDE 0.1% CREAM	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of two of the following for 7 days each: Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05%	1 year
AMELUZ 10% GEL	•Medical Benefit ONLY •Diagnosis of Actinic Keratosis, Mild-to-Moderate Severity on the Face and Scalp with Multiple Lesions (per Chart Notes) •Trial of 5-FU 5% cream Used Daily or BID for 2-3 weeks for Face/Scalp Lesions or 0.5% cream Daily for 4 Weeks (Facial Lesions), imiquimod 5% Twice Weekly for 30 Days, or Picato (ingenol mebutate) 0.015% Gel Daily for 3 Days OR •A Contraindication to All 3	3 Months
AMIODARONE HCL 100 MG TABLET	Trial of amiodarone 200 mg or 400 mg Tablet	1 year
AMLODIPINE-ATORVAST 10-10 MG	•Clinical Reason Supported by Chart Notes Why (After a 90-day Trial of) The Below Cannot be Used: •amlodipine AND atorvastatin (Lipitor) used at the same time	1 year
AMLODIPINE-ATORVAST 10-20 MG	•Clinical Reason Supported by Chart Notes Why (After a 90-day Trial of) The Below Cannot be Used: •amlodipine AND atorvastatin (Lipitor) used at the same time	1 year
AMLODIPINE-ATORVAST 10-40 MG	•Clinical Reason Supported by Chart Notes Why (After a 90-day Trial of) The Below Cannot be Used: •amlodipine AND atorvastatin (Lipitor) used at the same time	1 year
AMLODIPINE-ATORVAST 10-80 MG	•Clinical Reason Supported by Chart Notes Why (After a 90-day Trial of) The Below Cannot be Used: •amlodipine AND atorvastatin (Lipitor) used at the same time	1 year
AMLODIPINE-ATORVAST 2.5-10 MG	•Clinical Reason Supported by Chart Notes Why (After a 90-day Trial of) The Below Cannot be Used: •amlodipine AND atorvastatin (Lipitor) used at the same time	1 year
AMLODIPINE-ATORVAST 2.5-20 MG	•Clinical Reason Supported by Chart Notes Why (After a 90-day Trial of) The Below Cannot be Used: •amlodipine AND atorvastatin (Lipitor) used at the same time	1 year
AMLODIPINE-ATORVAST 2.5-40 MG	•Clinical Reason Supported by Chart Notes Why (After a 90-day Trial of) The Below Cannot be Used: •amlodipine AND atorvastatin (Lipitor) used at the same time	1 year
AMLODIPINE-ATORVAST 5-10 MG	•Clinical Reason Supported by Chart Notes Why (After a 90-day Trial of) The Below Cannot be Used: •amlodipine AND atorvastatin (Lipitor) used at the same time	1 year
AMLODIPINE-ATORVAST 5-20 MG	•Clinical Reason Supported by Chart Notes Why (After a 90-day Trial of) The Below Cannot be Used: •amlodipine AND atorvastatin (Lipitor) used at the same time	1 year
AMLODIPINE-ATORVAST 5-40 MG	•Clinical Reason Supported by Chart Notes Why (After a 90-day Trial of) The Below Cannot be Used: •amlodipine AND atorvastatin (Lipitor) used at the same time	1 year
AMLODIPINE-ATORVAST 5-80 MG	•Clinical Reason Supported by Chart Notes Why (After a 90-day Trial of) The Below Cannot be Used: •amlodipine AND atorvastatin (Lipitor) used at the same time	1 year
AMNESTEEM 10 MG CAPSULE	•Diagnosis of Non-Hodgkin’s Lymphoma Or Prophylaxis Of Non-Melanoma Skin Cancers OR •Diagnosis of Acne •Trials of 90 Days Total of the Below (at least 1 topical AND at least 1 oral totaling 90 Days) Either at the Same Time, Separately, or Overlapping: •Topicals: Benzoyl Peroxide 5% Or 10%; Benzoyl Peroxide 4% Or 8% Liquid (Panoxyl), Erythromycin/Benzoyl (Benzamycin), Sulfacetamide (Klaron), Clindamycin Topical (Cleocin T), Erythromycin Topical, Tretinoin Cream or Gel or Adapalene 0.1% Gel or Cream [or Previously Approved for and Currently Using: Tazorac, Benzamycin, Acanya, Akne-Mycin, or Tretinoin Microsphere] AND •Orals: Minocycline, Doxycycline, Tetracycline, or Erythromycin •Quantity Limit 60 Capsules/26 Days	1 year

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AMNESTEEM 20 MG CAPSULE	•Diagnosis of Non-Hodgkin's Lymphoma Or Prophylaxis Of Non-Melanoma Skin Cancers OR •Diagnosis of Acne •Trials of 90 Days Total of the Below (at least 1 topical AND at least 1 oral totaling 90 Days) Either at the Same Time, Separately, or Overlapping: •Topicals: Benzoyl Peroxide 5% Or 10%; Benzoyl Peroxide 4% Or 8% Liquid (Panoxyl), Erythromycin/Benzoyl (Benzamycin), Sulfacetamide (Klaron), Clindamycin Topical (Cleocin T), Erythromycin Topical, Tretinoin Cream or Gel or Adapalene 0.1% Gel or Cream [or Previously Approved for and Currently Using: Tazorac, Benzamycin, Acanya, Akne-Mycin, or Tretinoin Microsphere] AND •Orals: Minocycline, Doxycycline, Tetracycline, or Erythromycin •Quantity Limit 60 Capsules/26 Days	1 year
AMNESTEEM 40 MG CAPSULE	•Diagnosis of Non-Hodgkin's Lymphoma Or Prophylaxis Of Non-Melanoma Skin Cancers OR •Diagnosis of Acne •Trials of 90 Days Total of the Below (at least 1 topical AND at least 1 oral totaling 90 Days) Either at the Same Time, Separately, or Overlapping: •Topicals: Benzoyl Peroxide 5% Or 10%; Benzoyl Peroxide 4% Or 8% Liquid (Panoxyl), Erythromycin/Benzoyl (Benzamycin), Sulfacetamide (Klaron), Clindamycin Topical (Cleocin T), Erythromycin Topical, Tretinoin Cream or Gel or Adapalene 0.1% Gel or Cream [or Previously Approved for and Currently Using: Tazorac, Benzamycin, Acanya, Akne-Mycin, or Tretinoin Microsphere] AND •Orals: Minocycline, Doxycycline, Tetracycline, or Erythromycin •Quantity Limit 60 Capsules/26 Days	1 year
ANADROL-50 TABLET	Diagnosis of Anemia	1 year
ANDRODERM 2 MG/24HR PATCH	•Diagnosis of Hypogonadism •Total Testosterone Lab Value = ≤ 300ng/dL Before Treatment (for New Starts Only) OR a Total Testosterone Lab Value Within the Normal Range During Treatment (for Continuation of Care) •Clinical Reason Supported by Chart Notes Why (After a 90-day Trial of) The Below Cannot be Used: •Testosterone TD (Fortesta) or Testosterone (Androgel, Testim, Vogelxo) 1% (50 mg/5G) Gel Packet (Both Still Require a PA Also)	1 year
ANDRODERM 4 MG/24HR PATCH	•Diagnosis of Hypogonadism •Total Testosterone Lab Value = ≤ 300ng/dL Before Treatment (for New Starts Only) OR a Total Testosterone Lab Value Within the Normal Range During Treatment (for Continuation of Care) •Clinical Reason Supported by Chart Notes Why (After a 90-day Trial of) The Below Cannot be Used: •Testosterone TD (Fortesta) or Testosterone (Androgel, Testim, Vogelxo) 1% (50 mg/5G) Gel Packet (Both Still Require a PA Also)	1 year
ANGELIQ 0.25 MG-0.5 MG TABLET	Trial of: norethindrone acetate-ethinyl (Femhrt) or Prempro	1 year
ANGELIQ 0.5 MG-1 MG TABLET	Trial of: norethindrone acetate-ethinyl (Femhrt) or Prempro	1 year
ANODYNE LPT 2.5-2.5% CRM-DRESS	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 year
ANUCORT-HC 25 MG SUPPOSITORY	Clinical Reason why (After a 90-Day Trial of) the Below Cannot be Used: hydrocortisone rectal cream	1 year
APEXICON E 0.05% CREAM	•Clinical Reason Supported by Chart Notes Why The Below Cannot be Used: •30-Day Trial of diflorasone 0.05% cream AND •30 Day Trial of diflorasone 0.05% ointment	1 year
APLENZIN ER 174 MG TABLET	• Clinical reason supported by chart notes why after a 90 day trial, bupropion XL (WELLBUTRIN XL) 150MG or 300MG tablet cannot be used	1 year
APLENZIN ER 348 MG TABLET	• Clinical reason supported by chart notes why after a 90 day trial, bupropion XL (WELLBUTRIN XL) 150MG or 300MG tablet cannot be used	1 year
APLENZIN ER 522 MG TABLET	• Clinical reason supported by chart notes why after a 90 day trial, bupropion XL (WELLBUTRIN XL) 150MG or 300MG tablet cannot be used	1 year
APOKYN 30 MG/3 ML CARTRIDGE	•Diagnosis of Parkinson's Disease with Acute Intermittent "Off" Episodes •Continues to Experience Motor Fluctuations Despite Use of carbidopa/levodopa, Including Attempts to Adjust Dose and Formulation •Has Also Tried an Adjunct Agent (e.g., amantadine, entacapone, selegiline, pramipexole, ropinirole, etc.) for at Least 30 Days Yet Remains Uncontrolled •Reauthorization Requirement: Must Have Documentation of reduced Frequency of Off-Episodes from Baseline	3 Months for Initial Authorizations 1 Year for Re-Authorizations
APRACLONIDINE HCL 0.5% DROPS	• Trial of brimonidine ophthalmic 0.2%	1 year

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Drug Name	Criteria	Approval Duration
APREPITANT 125 MG CAPSULE	• Age 12 years or older • Diagnosis of prevention of nausea/vomiting associated with moderate to high emetogenic chemotherapy • Used in combination with other antiemetics (example: a 5-HT3 receptor antagonist and corticosteroid for adults and one or oth in members under 18) OR • Diagnosis of Prevention of post-operative nausea/vomiting • Previous trial/failure with at least one of the following: promethazine, ondansetron, prochlorperazine, scopolamine transdermal patch, metoclopramide	For emetogenic chemotherapy: 6 months For Post-Operative nausea/vomitting: 30 days
APREPITANT 125-80-80 MG PACK	•Age 12 years or Older •Diagnosis of Prevention of Nausea/Vomiting Associated with Moderate to High Emetogenic Chemotherapy •Trial of aprepitant Oral Capsules or Documented Inability to Swallow Capsule Formulation, Used in Combination with Other Antiemetics (Example: A 5-HT3 Receptor Antagonist and Corticosteroid for Adults and One or Other in Members Under 18) •Dose Limit = Capsules/11 Days	6 Months
APREPITANT 40 MG CAPSULE	• Age 12 years or older • Diagnosis of prevention of nausea/vomiting associated with moderate to high emetogenic chemotherapy • Used in combination with other antiemetics (example: a 5-HT3 receptor antagonist and corticosteroid for adults and one or oth in members under 18) OR • Diagnosis of Prevention of post-operative nausea/vomiting • Previous trial/failure with at least one of the following: promethazine, ondansetron, prochlorperazine, scopolamine transdermal patch, metoclopramide	For emetogenic chemotherapy: 6 months For Post-Operative nausea/vomitting: 30 days
APREPITANT 80 MG CAPSULE	• Age 12 years or older • Diagnosis of prevention of nausea/vomiting associated with moderate to high emetogenic chemotherapy • Used in combination with other antiemetics (example: a 5-HT3 receptor antagonist and corticosteroid for adults and one or oth in members under 18) OR • Diagnosis of Prevention of post-operative nausea/vomiting • Previous trial/failure with at least one of the following: promethazine, ondansetron, prochlorperazine, scopolamine transdermal patch, metoclopramide	For emetogenic chemotherapy: 6 months For Post-Operative nausea/vomitting: 30 days
APRIZIO PAK	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 year
APRIZIO PAK II 2.5%-2.5% CRM	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 year
ARMODAFINIL 150 MG TABLET	• Diagnosis of Narcolepsy, Cataplexy Max dose = 250 mg daily OR • Diagnosis of Obstructive sleep apnea • Documentation of CPAP or mandibular advancement device (if patient cannot use CPAP) Max dose = 150 mg daily OR • Diagnosis of Shift Work disorder	1 year
ARMODAFINIL 200 MG TABLET	• Diagnosis of Narcolepsy, Cataplexy Max dose = 250 mg daily OR • Diagnosis of Obstructive sleep apnea • Documentation of CPAP or mandibular advancement device (if patient cannot use CPAP) Max dose = 150 mg daily OR • Diagnosis of Shift Work disorder	1 year

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Drug Name	Criteria	Approval Duration
ARMODAFINIL 250 MG TABLET	• Diagnosis of Narcolepsy, Cataplexy Max dose = 250 mg daily OR • Diagnosis of Obstructive sleep apnea • Documentation of CPAP or mandibular advancement device (if patient cannot use CPAP) Max dose = 150 mg daily OR • Diagnosis of Shift Work disorder	1 year
ARMODAFINIL 50 MG TABLET	• Diagnosis of Narcolepsy, Cataplexy Max dose = 250 mg daily OR • Diagnosis of Obstructive sleep apnea • Documentation of CPAP or mandibular advancement device (if patient cannot use CPAP) Max dose = 150 mg daily OR • Diagnosis of Shift Work disorder	1 year
ASMANEX HFA 100 MCG INHALER	•Diagnosis of Asthma •30-Day Trial of Arnuity or Flovent •Quantity Limit 1 Inhaler (13g)/month •Note: 1 Inhaler Contains 120 Doses	1 year
ASMANEX HFA 200 MCG INHALER	•Diagnosis of Asthma •30-Day Trial of Arnuity or Flovent •Quantity Limit 1 Inhaler (13g)/month •Note: 1 Inhaler Contains 120 Doses	1 year
ASMANEX TWISTHALER 110 MCG #30	•Diagnosis ofAsthma •30-Day Trial of Arnuity or Flovent •Quantity Limit 1 Inhaler/30 Days •For 110 mcg Strength, 1 Inhaler Contains 30 Doses	1 year
ASMANEX TWISTHALER 220 MCG #14	•Diagnosis ofAsthma •30-Day Trial of Arnuity or Flovent •Quantity Limit 1 Inhaler/30 Days •For 220 mcg Strength, 1 Inhaler Contains 60 Doses	1 year
ASMANEX TWISTHALER 220 MCG #30	•Diagnosis ofAsthma •30-Day Trial of Arnuity or Flovent •Quantity Limit 1 Inhaler/30 Days •For 220 mcg Strength, 1 Inhaler Contains 60 Doses	1 year
ASMANEX TWISTHALER 220 MCG #60	•Diagnosis ofAsthma •30-Day Trial of Arnuity or Flovent •Quantity Limit 1 Inhaler/30 Days •For 220 mcg Strength, 1 Inhaler Contains 60 Doses	1 year
ASMANEX TWISTHALR 220 MCG #120	•Diagnosis ofAsthma •30-Day Trial of Arnuity or Flovent •Quantity Limit 1 Inhaler/30 Days •For 220 mcg Strength, 1 Inhaler Contains 60 Doses	1 year
ASPIRIN-DIPYRIDAM ER 25-200 MG	• Diagnosis of Transient Ischemia ff the Brain or Complete Ischemic Stroke due to Thrombosis • A 30 day Trial of dipyridamole with OTC aspirin used at the same time	1 year
AUGMENTIN 125-31.25 MG/5 ML	•Do Not Override for Gold Card Providers •Clinical Reason Why After a 7-Day Trial of One of the Below Cannot be Used: •Amoxicillin-clavulanate suspension 200-28.5/5 or amoxicillin-clavulanate suspension 250-62.5/5	As Requested, up to a 14-Days Supply
AVANDIA 2 MG TABLET	•30 Day Trial of: Metformin IR or Metformin ER (Glucophage or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect to Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)] AND •60-Day Trial of: pioglitazone (Actos)	1 year
AVANDIA 4 MG TABLET	•30 Day Trial of: Metformin IR or Metformin ER (Glucophage or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect to Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)] AND •60-Day Trial of: pioglitazone (Actos)	1 year
AVAR 9.5%-5% FOAM	•Clinical Reason Supported by Chart Notes Why (After a 90-Day Trial of) the Below Cannot be Used: •Sulfacetamide Sodium W/ Sulfur (Avar-E LS) 10-2% Cream	1 year

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Drug Name	Criteria	Approval Duration
AVAR 9.5-5% CLEANSING PADS	90 Day Trial of: Avar-E LS 10-2% cream, Sulfacetamide Sodium w/ Sulfur Suspension 10-5%, Sulfacetamide Sodium w/ Sulfur lotion 10-5%, Or Sulfacetamide Sodium w/ Sulfur emulsion, Avar cleanser, Rosanil, Prascion 10-5%	1 year
AVAR LS 10-2% CLEANSING PADS	• Clinical Reason Supported by Chart Notes Why (After a 90-Day Trial of) the Below Cannot be Used: • Sulfacetamide Sodium W/ Sulfur (Avar-E LS) 10-2% Cream	1 year
AVAR-E GREEN EMOLLIENT CREAM	• Clinical Reason Supported By Chart Notes Why (After A Trial of) The Below Cannot Be Used: • SULFACETAMIDE SODIUM W/ SULFUR SUSPENSION 10-5%, SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%, OR SULFACETAMIDE SODIUM W/ SULFUR EMULSION, AVAR CLEANSER , ROSANIL, PRASCION 10-5% [Dose: 57 Grams (1 Tube) / 26 Days]	1 year
AVAR-E LS CREAM	• Clinical Reason Supported By Chart Notes Why (After A Trial of) The Below Cannot Be Used: • SULFACETAMIDE SODIUM W/ SULFUR SUSPENSION 10-5%, SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%, OR SULFACETAMIDE SODIUM W/ SULFUR EMULSION, AVAR CLEANSER , ROSANIL, PRASCION 10-5% [Dose: 57 Grams (1 Tube) / 26 Days]	1 year
AVASTIN 100 MG/4 ML VIAL	For ophthalmic diagnoses: • Age 18 years or older • Prescribed by or under the guidance of an ophthalmologist • No concurrent ocular or periocular infection • Eye condition appropriate as indicated by 1 or more of the following: - Diabetic macular edema - Macular edema following retinal vein occlusion - Neovascular age-related macular degeneration All other diagnoses must be submitted through the Eviti portal	1 year
AVASTIN 400 MG/16 ML VIAL	For ophthalmic diagnoses: • Age 18 years or older • Prescribed by or under the guidance of an ophthalmologist • No concurrent ocular or periocular infection • Eye condition appropriate as indicated by 1 or more of the following: - Diabetic macular edema - Macular edema following retinal vein occlusion - Neovascular age-related macular degeneration All other diagnoses must be submitted through the Eviti portal	1 year
AVC 15% CREAM	One Time Trial of: fluconazole Oral Tablet or miconazole Vaginal Suppositories	30 Days
AVITA 0.025% CREAM	• If Age Below 12 Or Over 26, Diagnosis Below Is Required: • Diagnosis of Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), OR Rosacea	1 year
AVITA 0.025% GEL	• If Age Below 12 Or Over 26, Diagnosis Below Is Required: • Diagnosis of Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), OR Rosacea	1 year
AZASITE 1% EYE DROPS	• One time Trial of: ciprofloxacin or ofloxacin opthalmic	30 days
AZATHIOPRINE 100 MG TABLET	Requires trial of generic azathioprine	1 year
AZATHIOPRINE 75 MG TABLET	Requires trial of generic azathioprine	1 year
AZELAIC ACID 15% GEL	• 30 Day Trial of: metronidazole Topical • Quantity Limit 50 Grams/26 Day	1 year
AZELASTIN-FLUTIC 137-50MCG SPR	• Diagnosis of seasonal allergic rhinitis • Clinical reason why azelastine and fluticasone cannot used at the same time	1 year
AZELEX 20% CREAM	• Trial of: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or Differin OTC • Quantity Limit 30 Grams (1 Tube)/26 Days	1 year
BACLOFEN 5 MG/5 ML SOLUTION	• Diagnosis of spasticity resulting from multiple sclerosis or spinal cord injury • Inability to swallow generic baclofen tablets or Fleqsuvy (Fleqsuvy also requires auth.)	1 year
BAQSIMI 3 MG SPRAY TWO PACK	Any claim for insulin (ex. admelog, insulin lispro (humalog), novolog, fiasp, apidra, Basaglar, Lantus, Humulin N/R, Novolog Mix, etc) in the last 120 days	1 year
BARACLUDE 0.05 MG/ML SOLUTION	• Diagnosis of chronic hepatitis B • Prescribed by infectious disease specialist, gastroenterologist, hepatologist or transplant physician	1 year
BASAGLAR 100 UNIT/ML KWIKPEN	*30 day trial of insulin glargine-yfgn	1 year
BAXDELA 450 MG TABLET	Diagnosis of Acute Bacterial Skin and Skin Structure Infection (ABSSSI) or Community-Acquired Bacterial Pneumonia (CABP)*Trial and failure of (or documented resistance to) a preferred fluoroquinolone (ciprofloxacin, levofloxacin, moxifloxacin (requires step))	As requested, up to 14 days

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Drug Name	Criteria	Approval Duration
BELBUCA 150 MCG FILM	For Initial Authorization: •30-Day Trial Each of Two of the Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, Or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program (PDMP) - PMP AWARXE (GA) •If Cumulative MED is > 80 MED/Day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (Or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPH. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes)	Up to 90 Days for Initial Authorization Up to 6 Months for Re-Authorization
BELBUCA 300 MCG FILM	For Initial Authorization: •30-Day Trial Each of Two of the Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, Or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program (PDMP) - PMP AWARXE (GA) •If Cumulative MED is > 80 MED/Day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (Or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPH. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes)	Up to 90 Days for Initial Authorization Up to 6 Months for Re-Authorization

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Drug Name	Criteria	Approval Duration
BELBUCA 450 MCG FILM	For Initial Authorization: •30-Day Trial Each of Two of the Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, Or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program (PDMP) - PMP AWARXE (GA) •If Cumulative MED is > 80 MED/Day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (Or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPH. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes)	Up to 90 Days for Initial Authorization Up to 6 Months for Re-Authorization
BELBUCA 600 MCG FILM	For Initial Authorization: •30-Day Trial Each of Two of the Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, Or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program (PDMP) - PMP AWARXE (GA) •If Cumulative MED is > 80 MED/Day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (Or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPH. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes)	Up to 90 Days for Initial Authorization Up to 6 Months for Re-Authorization

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Drug Name	Criteria	Approval Duration
BELBUCA 75 MCG FILM	For Initial Authorization: •30-Day Trial Each of Two of the Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, Or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program (PDMP) - PMP AWARXE (GA) •If Cumulative MED is > 80 MED/Day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (Or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPH. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes)	Up to 90 Days for Initial Authorization Up to 6 Months for Re-Authorization
BELBUCA 750 MCG FILM	For Initial Authorization: •30-Day Trial Each of Two of the Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, Or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program (PDMP) - PMP AWARXE (GA) •If Cumulative MED is > 80 MED/Day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (Or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPH. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes)	Up to 90 Days for Initial Authorization Up to 6 Months for Re-Authorization

Drug Name	Criteria	Approval Duration
BELBUCA 900 MCG FILM	For Initial Authorization: •30-Day Trial Each of Two of the Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, Or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program (PDMP) - PMP AWARXE (GA) •If Cumulative MED is > 80 MED/Day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (Or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPH. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes)	Up to 90 Days for Initial Authorization Up to 6 Months for Re-Authorization
BENZEFOAM 5.3% EMOLLIENT FOAM	Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Benzoyl Peroxide 2.5% Wash or Gel (Panoxyl), Benzoyl Peroxide 4% Cleanser (Panoxyl), Benzoyl Peroxide 5% Gel (Panoxyl), Benzoyl Peroxide 5% Lotion, Benzoyl Peroxide 3%, 6%, 9% Cleanser (Triz), Benzoyl Peroxide 10% Wash (Desquam-X/Panoxyl), Benzoyl Peroxide 10% Gel (Panoxyl), Benzoyl Peroxide 10% Lotion or Benzoyl Peroxide-Erythromycin (Benzamycin) 5-3% Gel •Quantity Limit 100 Grams (1 Tube) / 26 Days	1 year
BENZEFOAM ULTRA 9.8% FOAM	Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Benzoyl Peroxide 2.5% Wash or Gel (Panoxyl), Benzoyl Peroxide 4% Cleanser (Panoxyl), Benzoyl Peroxide 5% Gel (Panoxyl), Benzoyl Peroxide 5% Lotion, Benzoyl Peroxide 3%, 6%, 9% Cleanser (Triz), Benzoyl Peroxide 10% Wash (Desquam-X/Panoxyl), Benzoyl Peroxide 10% Gel (Panoxyl), Benzoyl Peroxide 10% Lotion or Benzoyl Peroxide-Erythromycin (Benzamycin) 5-3% Gel •Quantity Limit 100 Grams (1 Tube) / 26 Days	1 year
BESER 0.05% KIT	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of two of the following for 7 days each: Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone) • Clinical reason why Beser lotion cannot be used	1 year
BESER 0.05% LOTION	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of two of the following for 7 days each: Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone)	1 year

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BETAMETHASONE DP 0.05% OINT	14 days trial in the last 120 days of one of the following: betamethasone dipropionate augmented crm 0.05% (DIPROLENE AF), betamethasone dipropionate augmented lotion 0.05% (DIPROLENE), betamethasone dipropionate crm, lotion 0.05%, desoximetasone crm 0.25% (TOPICORT), fluocinonide soln 0.05%, triamcinolone acetonide crm, oint 0.5% OR Diagnosis of Atopic Dermatitis (Extrinsic [allergic], Intrinsic [non-allergic] eczema) or Psoriasis OR Prescriber specialty Dermatology or Rheumatology	1 year
BETAMETHASONE DP AUG 0.05% GEL	Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Betamethasone DP 0.05% Cream, Lotion or Ointment •Quantity Limit 50 Grams/26 Days	1 year
BETAMETHASONE VALER 0.12% FOAM	Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Betamethasone Valerate 0.1% Cream, Lotion, or Ointment •Quantity Limit 100 mL (1 Bottle)/26 Days	1 year
BETIMOL 0.5% EYE DROPS	Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Timolol (Timoptic) 0.25% Eye Drops or Timolol (Timoptic) 0.5% Eye Drops	1 year
BETOPTIC S 0.25% EYE DROPS	Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Betaxolol 0.5% Eye Drop	1 year
BEXAROTENE 75 MG CAPSULE	•Diagnosis of Cutaneous T-Cell Lymphoma •Must Use the Preferred Specialty Pharmacy Accredo •If Claim Is Over $75,000, Send to RPh For Clinical Review	For Initial Authorizations: •Input Two Separate PAs •PA #1 For the First 25 Days (Add A 15 Day Supply Max) •PA #2 For Days 26 To End of Year Auth (Add A 30 Day Supply Max) For Re-Authorizations: •1 Year (Add A 30 Day Supply Max)
BIDIL 20 MG-37.5 MG TABLET	Clinical Reason Supported by Chart Notes Why (After A 90-Day Trial Of) The Below Cannot Be Used: •Hydralazine And Isosorbide used at the same time	1 year
BIMATOPROST 0.03% EYE DROPS	30 day Trial of Latanoprost 0.005% eye drops	1 year
BINOSTO 70 MG EFFERVESCENT TAB	•If Fax States Allergy, Side Effects or Intolerance To: Alendronate (Fosamax) OR •Trials Of: Alendronate	1 year
BREXAFEMME 150 MG TABLET	• Member is an adult female or post-menarchal pediatric female • Diagnosis of acute vulvovaginal candidiasis (vaginal yeast infection) • Trial and failure of oral fluconazole • Quantity limit: 1 blister pack of 4 tablets (max 3 courses per year)	7 days
BREZTRI AEROSPHERE INHALER	•Diagnosis of COPD •Member Has Tried A 30-Day Trial of One of The Following Preferred Products and Still Experience COPD Exacerbations: •Combination Product LABA + ICS (i.e., Dulera, Salmeterol/Fluticasone); or LABA (i.e., Serevent Diskus, Striverdi) + ICS (i.e., Flovent, Arnuity) used at the same time; OR •Combination Product LABA + LAMA (i.e., Stiolto Respimat); or LABA (i.e., Serevent Diskus, Striverdi) + LAMA (i.e., Spiriva Respimat) •THEN •A 30-Day Trial of Trelegy Ellipta (May Skip Combination Product Trial If Member Is Already on Trelegy) •QL: 1 Canister/30 Days (Max 10.7 Grams Or 120 Inhalations)	1 year
BRILINTA 60 MG TABLET	• Member has a diagnosis of Coronary Artery Disease (CAD) and is at high-risk for getting a myocardial infarction (MI) or stroke (examples of risk factors are diabetes, hypertension, dyslipidemia, obesity, smoking, CKD, etc.) OR • Member has had acute ischemic stroke or high-risk transient ischemic attack (TIA) and is at risk for subsequent stroke; OR • Member has a diagnosis of Acute Coronary Syndrome (ACS) or a history of myocardial infarction (MI) and meets one of the following: • Documented allergy, side effects or intolerance to: Clopidogrel (Plavix) OR • 30 Day Trial of: clopidogrel (Plavix)	1 year

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BRILINTA 90 MG TABLET	• Member has a diagnosis of Coronary Artery Disease (CAD) and is at high-risk for getting a myocardial infarction (MI) or stroke (examples of risk factors are diabetes, hypertension, dyslipidemia, obesity, smoking, CKD, etc.) OR • Member has had acute ischemic stroke or high-risk transient ischemic attack (TIA) and is at risk for subsequent stroke; OR • Member has a diagnosis of Acute Coronary Syndrome (ACS) or a history of myocardial infarction (MI) and meets one of the following: • Documented allergy, side effects or intolerance to: Clopidogrel (Plavix) OR • 30 Day Trial of: clopidogrel (Plavix)	1 year
BRIMONIDINE TARTRATE 0.15% DRP	Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Brimonidine 0.2% Eye Drop	1 year
BRIMONIDINE-TIMOLOL 0.2%-0.5%	•Clinical Reason Supported By Chart Notes Why (After A Trial Of) The Below Cannot Be Used: • BRIMONIDINE 0.2% EYE DROP	1 year
BRIVIACT 10 MG TABLET	• Diagnosis of seizures • 1 month of age or older • Trial and failure of at least 1 preferred anticonvulsant	1 year
BRIVIACT 10 MG/ML ORAL SOLN	• Diagnosis of seizures • 1 month of age or older • Trial and failure of at least 1 preferred anticonvulsant	1 year
BRIVIACT 100 MG TABLET	• Diagnosis of seizures • 1 month of age or older • Trial and failure of at least 1 preferred anticonvulsant	1 year
BRIVIACT 25 MG TABLET	• Diagnosis of seizures • 1 month of age or older • Trial and failure of at least 1 preferred anticonvulsant	1 year
BRIVIACT 50 MG TABLET	• Diagnosis of seizures • 1 month of age or older • Trial and failure of at least 1 preferred anticonvulsant	1 year
BRIVIACT 50 MG/5 ML VIAL	• Diagnosis of seizures • 1 month of age or older • Trial and failure of at least 1 preferred anticonvulsant	1 year
BRIVIACT 75 MG TABLET	• Diagnosis of seizures • 1 month of age or older • Trial and failure of at least 1 preferred anticonvulsant	1 year
BROMFENAC SODIUM 0.09% EYE DRP	30-Day Trial of: Diclofenac (Voltaren) 0.1% Eye Drops	30 Days
BUDESONIDE ER 9 MG TABLET	30-Day Trial Of: Apriso ER, Mesalamine (Asacol HD), Delzicol, or Balsalazide (Colazal)	1 year
BUPRENORPHINE 10 MCG/HR PATCH	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
BUPRENORPHINE 15 MCG/HR PATCH	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
BUPRENORPHINE 20 MCG/HR PATCH	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
BUPRENORPHINE 5 MCG/HR PATCH	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
BUPRENORPHINE 7.5 MCG/HR PATCH	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
BUPRENORPHINE-NALOX 2-0.5MG TB	Age > 15 years	1 year
BUPRENORPHINE-NALOX 8-2 MG TAB	Age > 15 years	1 year

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Drug Name	Criteria	Approval Duration
BUTALB-ACETAMIN-CAF-COD 50-325	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
BUTALB-ACETAMIN-CAFF 50-300-40	•90-Day Trial of Butalbital-Acetaminophen-Caffeine Tablet 50-325-40 mg •Dose Limit: 48 Capsules/26 Days	1 year
BUTALBITAL-ACETAMINOPHN 50-300	•Clinical Reason Why (After a 90-Day Trial Each) TWO of The Following Cannot be Used: Butalbital/Acetaminophen/Caffeine, Butalbital/Aspirin/Caffeine, Butalbital-Acetaminophen 50-325 (Also Requires PA)	3 Months
BUTALBITAL-ACETAMINOPHN 50-300	•Clinical Reason Why (After a 90-Day Trial Each) TWO of The Following Cannot be Used: Butalbital/Acetaminophen/Caffeine, Butalbital/Aspirin/Caffeine, Butalbital-Acetaminophen 50-325 (Also Requires PA)	3 Months
BYDUREON 2 MG PEN INJECT	• Adults: Trial and failure of Rybelsus or Trulicity (requires trial and failure of metformin) • Age 10 to less than 18: Trial and failure of metformin	1 year
BYDUREON BCISE 2 MG AUTOINJECT	• Adults: Trial and failure of Rybelsus or Trulicity (requires trial and failure of metformin) • Age 10 to less than 18: Trial and failure of metformin	1 year
BYVALSON 5 MG-80 MG TABLET	•Diagnosis of Hypertension •30 Day Trial of One of Each (Group) used at the same time: Valsartan, Irbesartan, Losartan, Or Candesartan AND •Carvedilol, Nadolol, Atenolol, Metoprolol, Propranolol, Sotalol or Bisoprolol	1 year
CAFFEINE CIT 60 MG/3 ML ORAL	Coded To Pay for Members Age < 18 If Request Is for Member Age > 18, Setup/Send to RPh With Diagnosis and Dose Requested	6 Months
CALCIPOTRIENE-BETAMETH DP OINT	•Trial of: Calcipotriene (Dovonex) •Quantity Limit 60 Grams (1 Tube)/26 Days	1 year
CALCITRIOL 3 MCG/G OINTMENT	Trial of calcipotriene (Dovonex)	1 year
CAMBIA 50 MG POWDER PACKET	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial of) The Below Cannot Be Used: •Diclofenac Potassium (Cataflam) Tablet and Diclofenac Sodium (Voltaren) Tablet	1 year
CARBAGLU 200 MG TAB FOR SUSP	Diagnosis of Hyperammonemia	1 year
CARBIDOPA 25 MG TABLET	Trial of: Carbidopa/Levodopa (Sinemet)	1 year
CARBIDOPA-LEVO 10-100 MG ODT	•An Inability to Swallow OR •Trial Of: Carbidopa/Levodopa Non-ODT	1 year
CARBIDOPA-LEVO 25-100 MG ODT	•An Inability to Swallow OR •Trial Of: Carbidopa/Levodopa Non-ODT	1 year
CARBIDOPA-LEVO 25-250 MG ODT	•An Inability to Swallow OR •Trial Of: Carbidopa/Levodopa Non-ODT	1 year
CARBINOXAMINE 4 MG/5 ML LIQUID	Trial of: Chlorpheniramine OR Diphenhydramine	1 year
CARBINOXAMINE MALEATE 4 MG TAB	Trial of: Chlorpheniramine OR Diphenhydramine	1 year
CARBINOXAMINE MALEATE 6 MG TAB	Trial of chlorpheniramine or diphenhydramine	1 year
CARDURA XL 4 MG TABLET	Set Up and Send •Clinical Reason Supported by Chart Notes or Provider Call (After Trial Listed Below) why the Below Cannot be Used: •90-Day Trial of Non-XL Doxazosin	1 year

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CARISOPRODOL 250 MG TABLET	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Carisoprodol 350 mg Tablet (1/2 Tab)	1 year
CARISOPRODOL-ASPIRIN-CODEIN TB	•30-Day Trial of: Carisoprodol 350 mg Tablet •Note: There is a 7-Day Limit for All Short-Acting Opioids and No More Than 2 Fills in 45 Days. Above This, PA is Required. If PA is Approved for > 7 Days, okay to Add Matching Day Supply up to 30 Days	1 year
CAROSPIR 25 MG/5 ML SUSPENSION	•Diagnosis of Heart Failure (Max Dose 20 mg Daily), Hypertension (Max Dose 75 mg Daily), or Edema Associated with Cirrhosis (Max Dose 75 mg Daily) •Documented Inability to Swallow Tablets or Pediatric (Age < 12)	1 year
CARVEDILOL ER 10 MG CAPSULE	•Set Up and Send •Clinical Reason Supported by Chart Notes or Provider Call (After Trial Listed Below) why the Below Cannot be Used: •30-Day Trial of Carvedilol	1 year
CARVEDILOL ER 20 MG CAPSULE	•Set Up and Send •Clinical Reason Supported by Chart Notes or Provider Call (After Trial Listed Below) why the Below Cannot be Used: •30-Day Trial of Carvedilol	1 year
CARVEDILOL ER 40 MG CAPSULE	•Set Up and Send •Clinical Reason Supported by Chart Notes or Provider Call (After Trial Listed Below) why the Below Cannot be Used: •30-Day Trial of Carvedilol	1 year
CARVEDILOL ER 80 MG CAPSULE	•Set Up and Send •Clinical Reason Supported by Chart Notes or Provider Call (After Trial Listed Below) why the Below Cannot be Used: •30-Day Trial of Carvedilol	1 year
CEFACLOR 250 MG/5 ML SUSP	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Cefaclor 250 mg and 500 mg Capsule or Cephalexin 125 mg/5 mL Suspension	30 Days
CEFACLOR 375 MG/5 ML SUSPEN	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Cefaclor 250 mg and 500 mg Capsule or Cephalexin 125 mg/5 mL Suspension	30 Days
CEFIXIME 100 MG/5 ML SUSP	•Diagnosis of Gonorrhea and/or Chlamydia OR •Diagnosis of Anything Else •One Time Trial of: Cephalexin, Cefuroxime, Cefprozil, Cefdinir, Cefaclor or Cefadroxil	30 Days
CEFIXIME 200 MG/5 ML SUSP	•Diagnosis of Gonorrhea and/or Chlamydia OR •Diagnosis of Anything Else •One Time Trial of: Cephalexin, Cefuroxime, Cefprozil, Cefdinir, Cefaclor or Cefadroxil	30 Days
CEFPODOXIME 100 MG TABLET	One Time Trial of: Cephalexin, Cefuroxime, Cefprozil, Cefdinir, Cefaclor or Cefadroxil	30 Days
CEFPODOXIME 100 MG/5 ML SUSP	One Time Trial of: Cephalexin, Cefuroxime, Cefprozil, Cefdinir, Cefaclor or Cefadroxil	30 Days
CEFPODOXIME 200 MG TABLET	One Time Trial of: Cephalexin, Cefuroxime, Cefprozil, Cefdinir, Cefaclor or Cefadroxil	30 Days
CEFPODOXIME 50 MG/5 ML SUSP	One Time Trial of: Cephalexin, Cefuroxime, Cefprozil, Cefdinir, Cefaclor or Cefadroxil	30 Days
CELECOXIB 100 MG CAPSULE	• Member must have ONE of the following: - Age 60 years and older - Diagnosis of gastrointestinal bleed, gastroesophageal reflux disease, peptic ulcer disease, gastrointestinal perforation, Crohn's disease, or familial adenomatous polyposis (FAP) in the past 2 years - Chemotherapy in the past 30 days - Anticoagulant or antiplatelet therapy in the past 30 days (Warfarin, Xarelto, Eliquis, etc) - 30 day Trial of two of the following: Meloxicam, diclofenac, sulindac, ketorolac (only requires 5 day trial) - 2 years of age or older with a diagnosis of juvenile rheumatoid arthritis (JRA)	1 year
CELECOXIB 200 MG CAPSULE	• Member must have ONE of the following: - Age 60 years and older - Diagnosis of gastrointestinal bleed, gastroesophageal reflux disease, peptic ulcer disease, gastrointestinal perforation, Crohn's disease, or familial adenomatous polyposis (FAP) in the past 2 years - Chemotherapy in the past 30 days - Anticoagulant or antiplatelet therapy in the past 30 days (Warfarin, Xarelto, Eliquis, etc) - 30 day Trial of two of the following: Meloxicam, diclofenac, sulindac, ketorolac (only requires 5 day trial) - 2 years of age or older with a diagnosis of juvenile rheumatoid arthritis (JRA)	1 year

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CELECOXIB 400 MG CAPSULE	• Member must have ONE of the following: - Age 60 years and older - Diagnosis of gastrointestinal bleed, gastroesophageal reflux disease, peptic ulcer disease, gastrointestinal perforation, Crohn's disease, or familial adenomatous polyposis (FAP) in the past 2 years - Chemotherapy in the past 30 days - Anticoagulant or antiplatelet therapy in the past 30 days (Warfarin, Xarelto, Eliquis, etc) - 30 day Trial of two of the following: Meloxicam, diclofenac, sulindac, ketorolac (only requires 5 day trial) - 2 years of age or older with a diagnosis of juvenile rheumatoid arthritis (JRA)	1 year
CELECOXIB 50 MG CAPSULE	• Member must have ONE of the following: - Age 60 years and older - Diagnosis of gastrointestinal bleed, gastroesophageal reflux disease, peptic ulcer disease, gastrointestinal perforation, Crohn's disease, or familial adenomatous polyposis (FAP) in the past 2 years - Chemotherapy in the past 30 days - Anticoagulant or antiplatelet therapy in the past 30 days (Warfarin, Xarelto, Eliquis, etc) - 30 day Trial of two of the following: Meloxicam, diclofenac, sulindac, ketorolac (only requires 5 day trial) - 2 years of age or older with a diagnosis of juvenile rheumatoid arthritis (JRA)	1 year
CEPHALEXIN 750 MG CAPSULE	One Time Trial of: Cephalexin 500 mg Capsule	30 Days
CESAMET 1 MG CAPSULE	•One Time Trial of: Ondansetron, Meclizine, Promethazine, Prochlorperazine, Granisetron •Dose Limit: 20/30 Days	6 Months
CEVIMELINE HCL 30 MG CAPSULE	30 day Trial of Pilocarpine Tablet Or OTC Saliva Substitute (i.e., Salivasure, Salese (Numoisyn) Lozenges, Aquoral Aerosol Solution, Or Caphosol, Numoisyn, Biotene, Mouthkote, Moi-Stir Solution)	1 year
CHEMET 100 MG CAPSULE	• Age <18 • Diagnosis of lead poisoning • Blood lead levels >45 mcg/dL	1 year
CHLOROQUINE PH 250 MG TABLET	•Diagnosis of COVID-19 Infection (Not for Prophylaxis): Max 14 Day Supply (Adults & Children) OR •Diagnosis of Malaria Chemoprophylaxis or Malaria Treatment (Adults & Children) OR •Diagnosis of Extraintestinal Amebiasis (Age 18 and Older) Dose Limits: •Malaria Chemoprophylaxis: 500 mg Weekly X 6 Weeks (Adults & Children) •Malaria Treatment: Max 1 g on day 1, 500 mg 6-, 24- and 48- Hours After First Dose (Adults & Children) •Extraintestinal amebiasis: 1 Gram Daily X 2 Days, 500 mg Daily X 2-3 Weeks	Per RPh If Meets Above Approve for: •Malaria Chemoprophylaxis = 6 Weeks •Malaria Treatment = 1 Week •Extraintestinal Amebiasis = 3 Weeks
CHLOROQUINE PH 500 MG TABLET	•Diagnosis of COVID-19 Infection (Not for Prophylaxis): Max 14 Day Supply (Adults & Children) OR •Diagnosis of Malaria Chemoprophylaxis or Malaria Treatment (Adults & Children) OR •Diagnosis of Extraintestinal Amebiasis (Age 18 and Older) Dose Limits: •Malaria Chemoprophylaxis: 500 mg Weekly X 6 Weeks (Adults & Children) •Malaria Treatment: Max 1 g on day 1, 500 mg 6-, 24- and 48- Hours After First Dose (Adults & Children) •Extraintestinal amebiasis: 1 Gram Daily X 2 Days, 500 mg Daily X 2-3 Weeks	Per RPh If Meets Above Approve for: •Malaria Chemoprophylaxis = 6 Weeks •Malaria Treatment = 1 Week •Extraintestinal Amebiasis = 3 Weeks
CHLORPROMAZINE 100 MG/ML CONC	• Clinical reason why oral tablets cannot be used	1 year
CHLORPROMAZINE 30 MG/ML CONC	• Clinical reason why oral tablets cannot be used	1 year
CHLORZOXAZONE 250 MG TABLET	Clinical Reason Why (After a 90-Day Trial) the Below Cannot be Used: •Chlorzoxazone 500 mg	3 Months
CHLORZOXAZONE 750 MG TABLET	Clinical Reason Why (After a 90-Day Trial) the Below Cannot be Used: •Chlorzoxazone 500 mg	3 Months
CICLODAN 8% KIT	• Diagnosis of mild to moderate onchomycosis • Trial and failure an oral therapy (e.g. fluconazole, terbinafine)	1 year
CICLOPIROX 8% TREATMENT KIT	Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Ciclopirox (Penlac, Ciclodan) 8% Solution AND vitamin E used at the same time •Quantity Limit 1 kit/26 Days	30 Days
CILOXAN 0.3% OINTMENT	Clinical Reason Supported by Chart Notes why (after a One Time Trial Of) the Below Cannot Be Used: •Ciprofloxacin Solution	30 Days
CINACALCET HCL 30 MG TABLET	• One of the following diagnoses: primary hyperparathyroidism in members for whom parathyroidectomy is appropriate but not possible, secondary hyperparathyroidism in members with CKD on dialysis, or parathyroid carcinoma	1 year

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CINACALCET HCL 60 MG TABLET	• One of the following diagnoses: primary hyperparathyroidism in members for whom parathyroidectomy is appropriate but not possible, secondary hyperparathyroidism in members with CKD on dialysis, or parathyroid carcinoma	1 year
CINACALCET HCL 90 MG TABLET	• One of the following diagnoses: primary hyperparathyroidism in members for whom parathyroidectomy is appropriate but not possible, secondary hyperparathyroidism in members with CKD on dialysis, or parathyroid carcinoma	1 year
CIPROFLOX-DEXAMETH OTIC SUSP	• Member has ear tubes OR A one-time Trial of the followings: Ciprofloxacin 0.3% opthalmic solution or Ciprofloxacin 0.2% otic solution AND Dexamethasone 0.1% ophthalmic solution used at the same time (please note that the opthalmic (eye) drops can be used in the ears)	7 days
CLARINEX 0.5 MG/ML (2.5 MG/5)	•If Patient Is Under 2 Years Old OR Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Desloratadine Reditabs or Tablets	1 year
CLARINEX-D 12 HR 2.5-120 MG TB	Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Desloratadine (Clarinex) And Pseudoephedrine used at the same time	1 year
CLENPIQ SOLUTION	Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •PEF-3350, Gavilyte-G (Golytely)	30 Days
CLIND PH-BENZOYL PEROX 1.2-5%	Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Benzoyl Peroxide 5% Gel (Panoxyl) With Clindamycin, Clindamax (Cleocin T) 1% Lotion, Clindamycin Swab (Cleocin T) 1% Pledgets, Clindamycin Phosphate 1% Solution used at the same time •Quantity Limit 45 Grams (1 Tube)/26 Days	1 year
CLINDAMYCIN PHOSPHATE 1% FOAM	Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Benzoyl Peroxide 5% Gel (Panoxyl) With Clindamycin, Clindamax (Cleocin T) 1% Lotion, Clindamycin Swab (Cleocin T) 1% Pledgets, Clindamycin Phosphate 1% Solution used at the same time	1 year
CLINDAMYCIN-BENZOYL PEROX 1-5%	Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Benzoyl Peroxide 5% Gel (Panoxyl) With Clindamycin, Clindamax (Cleocin T) 1% Lotion, Clindamycin Swab (Cleocin T) 1% Pledgets, Clindamycin Phosphate 1% Solution used at the same time •Dose Limit: 1 Tube Per Fill	1 year
CLINDAMYCIN-BNZ PEROX 1-5% PMP	Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Benzoyl Peroxide 5% Gel (Panoxyl) With Clindamycin, Clindamax (Cleocin T) 1% Lotion, Clindamycin Swab (Cleocin T) 1% Pledgets, Clindamycin Phosphate 1% Solution used at the same time •Dose Limit: 1 Tube Per Fill	1 year
CLINDA-TRETINOIN 1.2%-0.025%	Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Clindamycin Pledgets or Clindamycin Topical Solution and Tretinoin Gel or Cream •[Quantity Limit 60 Grams (1 Tube)/26 Days]	1 year
CLINPRO 5000 1.1% TOOTHPASTE	Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •ACT AntiCavity Fluoride Rinse, ACT Restoring Fluoride Rinse, ACT Total Care Rinse, Denta 5000 Plus 1.1% Cream, Phos-Flur 0.02% Rinse, Or SF 5000 Plus 1.1% Cream	1 year
CLOBAZAM 10 MG TABLET	• Diagnosis of Seizure or Epilepsy • 30 day Trial of one of the following: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), valproic acid (Depakene) or Zonisamide	1 year
CLOBAZAM 2.5 MG/ML SUSPENSION	• Diagnosis of Seizure or Epilepsy • 30 day Trial of one of the following: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), valproic acid (Depakene) or Zonisamide	1 year
CLOBAZAM 20 MG TABLET	• Diagnosis of Seizure or Epilepsy • 30 day Trial of one of the following: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), valproic acid (Depakene) or Zonisamide	1 year

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CLOBETASOL 0.05% CREAM	• 14 days trial in the last 120 days of one of the following: betamethasone dipropionate augmented crm 0.05% (DIPROLENE AF) betamethasone dipropionate augmented lotion 0.05% (DIPROLENE) betamethasone dipropionate crm, lotion 0.05% desoximetasone crm 0.25% (TOPICORT) fluocinonide soln 0.05% triamcinolone acetonide crm, oint 0.5% OR • Diagnosis of Atopic Dermatitis (Extrinsic [allergic], Intrinsic [non-allergic] eczema) or Psoriasis or Lichen sclerosus OR • Prescriber specialty Dermatology or Rheumatology	3 months
CLOBETASOL 0.05% GEL	• 14 days trial in the last 120 days of one of the following: betamethasone dipropionate augmented crm 0.05% (DIPROLENE AF) betamethasone dipropionate augmented lotion 0.05% (DIPROLENE) betamethasone dipropionate crm, lotion 0.05% desoximetasone crm 0.25% (TOPICORT) fluocinonide soln 0.05% triamcinolone acetonide crm, oint 0.5% OR • Diagnosis of Atopic Dermatitis (Extrinsic [allergic], Intrinsic [non-allergic] eczema) or Psoriasis OR • Prescriber specialty Dermatology or Rheumatology	1 year
CLOBETASOL 0.05% SHAMPOO	• 14 days trial in the last 120 days of one of the following: betamethasone dipropionate augmented crm 0.05% (DIPROLENE AF) betamethasone dipropionate augmented lotion 0.05% (DIPROLENE) betamethasone dipropionate crm, lotion 0.05% desoximetasone crm 0.25% (TOPICORT) fluocinonide soln 0.05% triamcinolone acetonide crm, oint 0.5% OR • Diagnosis of Atopic Dermatitis (Extrinsic [allergic], Intrinsic [non-allergic] eczema) or Psoriasis or Lichen sclerosus OR • Prescriber specialty Dermatology or Rheumatology	3 months
CLOBETASOL 0.05% SOLUTION	• 14 days trial in the last 120 days of one of the following: betamethasone dipropionate augmented crm 0.05% (DIPROLENE AF) betamethasone dipropionate augmented lotion 0.05% (DIPROLENE) betamethasone dipropionate crm, lotion 0.05% desoximetasone crm 0.25% (TOPICORT) fluocinonide soln 0.05% triamcinolone acetonide crm, oint 0.5% OR • Diagnosis of Atopic Dermatitis (Extrinsic [allergic], Intrinsic [non-allergic] eczema) or Psoriasis OR • Prescriber specialty Dermatology or Rheumatology	1 year
CLOBETASOL 0.05% TOPICAL LOTN	Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: • Clobetasol (Temovate) 0.05% Cream, Clobetasol (Temovate) 0.05% Gel, Clobetasol (Temovate) 0.05% Ointment or Clobetasol, Cormax Scalp (Temovate) 0.05% Solution • [Quantity Limit 118 mL (1 Tube)/26 Days]	1 year
CLOBETASOL EMULSION 0.05% FOAM	Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: • Clobetasol (Temovate) 0.05% Cream, Clobetasol (Temovate) 0.05% Gel, Clobetasol (Temovate) 0.05% Ointment or Clobetasol, Cormax Scalp (Temovate) 0.05% Solution • [Quantity Limit 100 Grams (1 Tube/26 Days]	1 year

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CLOBETASOL PROP 0.05% FOAM	Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Clobetasol (Temovate) 0.05% Cream, Clobetasol (Temovate) 0.05% Gel, Clobetasol (Temovate) 0.05% Ointment or Clobetasol, Cormax Scalp (Temovate) 0.05% Solution •[Quantity Limit 100 Grams (1 Tube)/26 Days]	1 year
CLOBETASOL PROP 0.05% SPRAY	Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Clobetasol, Cormax Scalp (Temovate) 0.05% Solution •[Quantity Limit 125 mL (1 Bottle)/26 Days]	1 year
CLOBETAVIX KIT	Clinical reason supported by chart notes why (after a Trial of) one of the following cannot be used: clobetasol, cormax scalp (Temovate) 0.05% solution	1 year
CLOCORTOLONE 0.1% CREAM PUMP	•Diagnosis of Atopic Dermatitis (Eczema) •Trial Of: 2 Different Agents For 7 Days Each: •Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone DP 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone) •[Quantity Limit 45 Grams (1 Tube)/26 Days]	1 year
CLODAN 0.05% KIT	Clinical reason supported by chart notes why (after a Trial of) one of the following cannot be used: clobetasol, cormax scalp (Temovate) 0.05% solution	1 year
CLODAN 0.05% SHAMPOO	Clinical reason supported by chart notes why (after a Trial of) one of the following cannot be used: clobetasol, cormax scalp (Temovate) 0.05% solution	1 year
CLOTRIMAZOLE 1% SOLUTION	Clinical Reason Why, After A 90 Day Trial, Clotrimazole Cream Cannot Be Used	1 year
CLOTRIMAZOLE-BETAMETHASONE LOT	•Clinical Reason Supported by Chart Notes Why (After A-90 Day Trial Of) The Below Cannot Be Used: Clotrimazole/Betamethasone 1%-0.05% Cream •[Quantity Limit 30 mL Per Month]	Per RPh
COLCHICINE 0.6 MG CAPSULE	•Diagnosis of Gout or Pericarditis •Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Colchicine (Colcrys) 0.6 mg Tablet	1 year
COLESEVELAM 625 MG TABLET	• Diagnosis of Hyperlipidemia • 30 Day Trial of: Simvastatin Or Atorvastatin • 30 day trial (or allergy, adverse effect, side effect, or intolerance to) of Cholestyramine Or Colestipol OR • Diagnosis of Liver Disease • 30 day trial (or allergy, adverse effect, side effect, or intolerance to) of Cholestyramine OR • Diagnosis of Diabetes • 30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 year
COLESEVELAM HCL 3.75 G PACKET	• Diagnosis of Hyperlipidemia • 30 Day Trial of: Simvastatin Or Atorvastatin • 30 day trial (or allergy, adverse effect, side effect, or intolerance to) of Cholestyramine Or Colestipol OR • Diagnosis of Liver Disease • 30 day trial (or allergy, adverse effect, side effect, or intolerance to) of Cholestyramine OR • Diagnosis of Diabetes • 30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 year
COLESTIPOL HCL GRANULES	•Set Up and Send •Clinical Reason Supported by Chart Notes or Provider Call (After Trial Listed Below) Why the Below Cannot Be Used: •30 Day Trial of Colestipol Tablets	1 year
COLESTIPOL HCL GRANULES PACKET	•Set Up and Send •Clinical Reason Supported by Chart Notes or Provider Call (After Trial Listed Below) Why the Below Cannot Be Used: •30 Day Trial of Colestipol Tablets	1 year

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COLY-MYCIN S OTIC SUSP DROP	One Time Trial of: Neomycin/Hydrocortisone/Polymyxin OTIC	30 Days
COMBIGAN 0.2%-0.5% EYE DROPS	• Age 2 years or older • Diagnosis of glaucoma or ocular hypertension • Clinical reason why (after a 90 day trial) member is unable to take individual active ingredients of combination product at the same time: Brimonidine 0.2% and Timolol 0.5%	1 year
CORDRAN 4 MCG/SQ CM TAPE LARGE	•Diagnosis of Atopic Dermatitis (Eczema) •Trial Of: 2 Different Agents For 7 Days Each: •Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone DP 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone) •[Quantity Limit 1 (Box)/26 Days]	1 year
CORLANOR 5 MG/5 ML ORAL SOLN	•Diagnosis of Worsening Heart Failure with Left Ventricular Ejection Fraction Of 35% Or Less •Sinus Rhythm with Resting Heart Rate At Least 70 Beats Per Minute •Currently Taking or Are Unable to Take A Beta-Blocker (I.E. Carvedilol, Labetalol, Metoprolol, Atenolol, Nadolol, Propranolol, Sotalol, Or Bisoprolol)	1 year
CORTISPORIN OINTMENT	•One Time Trial Of: OTC Triple Antibiotic Ointment (Neosporin) And Hydrocortisone used at the same time •[Quantity Limit 15 Grams (1 Tube)/26 Days]	30 Days
CRESEMBA 186 MG CAPSULE	•Diagnosis of Aspergillosis OR Mucormycosis •7 Day Trial of: Itraconazole	1 year
CROMOLYN 100 MG/5 ML ORAL CONC	Diagnosis of mastocytosis AND a Trial of: diphenhydramine (Benadryl).	1 year
CUVPOSA 1 MG/5 ML SOLUTION	• Diagnosis fo Drooling With Neurological Conditions Associated With Problem Drooling (Cerebral Palsy) Or Frey Syndrome • Age 3-16 years • Clinical reason supported by chart notes why, after a Trial of, glycopyrrolate tablets cannot be used	1 year
CYCLOBENZAPRINE 7.5 MG TABLET	Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Cyclobenzaprine Tablet 5 mg and 10 mg	1 year
CYCLOMYDRIL EYE DROPS	Trial Of: 1% Atropine Eye Drops/2.5% Phenylephrine Eye Drops used at the same time	1 year
CYCLOSERINE 250 MG CAPSULE	Trial of: Rifampin	1 year
CYCLOTENS REFILL PAK	• Diagnosis of muscle spasms • Member is receiving physical therapy • A 90-day trial and failure of cyclobenzaprine alone	1 year
CYSTADANE 1 GRAM/SCOOP POWDER	Diagnosis of Homocystinuria	3 Months
DALIRESP 250 MCG TABLET	•Diagnosis of Severe COPD with Chronic Bronchitis and History of Exacerbations (or Request States to Reduce Risk of Exacerbations) •With •30 Day Trial Each of Two of The Following Four Groups: •Breo/Dulera/Advair/Fluticasone-Salmeterol (Airduo) OR •Arnuity/Flovent/Pulmicort OR •Spiriva Respimat (Respimat is Preferred) OR •Montelukast (Singulair)/Theophylline •[Quantity Limit 1 Tablet/Day]	1 year
DALIRESP 500 MCG TABLET	•Diagnosis of Severe COPD with Chronic Bronchitis and History of Exacerbations (or Request States to Reduce Risk of Exacerbations) •With •30 Day Trial Each of Two of The Following Four Groups: •Breo/Dulera/Advair/Fluticasone-Salmeterol (Airduo) OR •Arnuity/Flovent/Pulmicort OR •Spiriva Respimat (Respimat is Preferred) OR •Montelukast (Singulair)/Theophylline •[Quantity Limit 1 Tablet/Day]	1 year
DAPSONE 5% GEL	•30-Day Trial in The Last Year Of 2 Different Agents: •Differin OTC, Benzoyl Peroxide 5% Or 10%, Benzoyl Peroxide 4% Or 8% Liquid (Panoxyl), Clindamycin Topical (Cleocin T), Erythromycin Topical, Erythromycin/Benzoyl (Benzamycin), Sulfacetamide (Klaron), Or Tretinoin Cream or Gel •[Quantity Limit 60 Grams (1 Tube)/26 Days]	3 Months for Initial Authorizations 1 Year for Re-Authorizations

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DAPSONE 7.5% GEL PUMP	•Clinical Reason Supported by Chart Notes Why (After 30 Day Trial Of 2 Different Agents) The Below Cannot Be Used: •Trial Of: Differin OTC, Benzoyl Peroxide 5% Or 10%, Benzoyl Peroxide 4% Or 8% Liquid (Panoxyl), Clindamycin Topical (Cleocin T), Erythromycin Topical, Erythromycin/Benzoyl (Benzamycin), Sulfacetamide (Klaron), Or Tretinoin Cream Or Gel	3 Months for Initial Authorizations 1 Year for Re-Authorizations
DARIFENACIN ER 15 MG TABLET	30 day Trial of at least one of the following: Oxybutynin, Oxybutynin XL, Tolterodine, Tolterodine ER, Trospium, Or Trospium XR	1 year
DARIFENACIN ER 7.5 MG TABLET	30 day Trial of at least one of the following: Oxybutynin, Oxybutynin XL, Tolterodine, Tolterodine ER, Trospium, Or Trospium XR	1 year
DARTISLA ODT 1.7 MG TABLET	•Member is 18 years of age or older •Member has a diagnosis of peptic ulcer disease •Previous 30-day trial and failure of at least one of the following: glycopyrrolate 2 mg tablets, formulary PPI or formulary H2RA •Quantity Limit: 120 tablets per 30 days •Approve for 1 year; Reapprove for one year if improvement in signs and symptoms of disease	1 year
DAYVIGO 10 MG TABLET	Must have a 7-day trial within the last 120 days of Zolpidem Or Zaleplon	1 year
DAYVIGO 5 MG TABLET	Must have a 7-day trial within the last 120 days of Zolpidem Or Zaleplon	1 year
DEFERASIROX 125 MG TB FOR SUSP	• Diagnosis of Chronic Iron Overload Due To Blood Transfusions and age of 2 Years and Older OR • Diagnosis of Chronic Iron Overload with Non-Transfusion-Dependent Thalassemia (NTDT) Syndromes and Age 10 Years and Older • Liver Iron (Fe) Concentration (LIC) Of At Least 5 mg Fe per Gram of Dry Weight (Fe/g dw) • Serum Ferritin Greater Than 300 mcg/L • Serum Creatinine Less Than 2 Times The Age-Appropriate Upper Limit Of Normal (ULN) • Creatinine Clearance (CICr) Less Than 40 mL/min • Does Not Have A Diagnosis of MDS with a Platelet Count >50 x 109/L	1 year
DEFERASIROX 180 MG GRANULE PKT	Set Up and Send to RPh •Diagnosis of Chronic Iron Overload Due to Blood Transfusions •Age= 2 Years and Older OR •Diagnosis of Chronic Iron Overload with Non-Transfusion-Dependent Thalassemia (NTDT) Syndromes •Age= 10 Years and Older •Liver Iron (Fe) Concentration (LIC) of at Least 5 mg Fe per Gram of Dry Weight (Fe/g dw) •Serum Ferritin Greater Than 300 mcg/L •Serum Creatinine Less Than 2 Times The Age-Appropriate Upper Limit Of Normal (ULN) OR Creatinine Clearance (CICr) Less Than 40 mL/min •Does Not Have a Diagnosis of MDS •Platelet Count >50 x 109/L For Re-Authorizations •Set Up and Send to RPh •Previously Approved On (Date) For (Length of Time) •Claims/RD = •Diagnosis of	1 year
DEFERASIROX 180 MG TABLET	• Diagnosis of Chronic Iron Overload Due To Blood Transfusions • Age 2 Years And Older OR • Diagnosis of Chronic Iron Overload With Non-Transfusion-Dependent Thalassemia (NTDT) Syndromes • Age 10 Years And Older • Liver Iron (Fe) Concentration (LIC) Of At Least 5 mg Fe Per Gram Of Dry Weight (Fe/g dw) • Serum Ferritin Greater Than 300 mcg/L • Serum Creatinine Less Than 2 Times The Age-Appropriate Upper Limit Of Normal (ULN) OR Creatinine Clearance (CICr) Less Than 40 mL/min • Member does not have a diagnosis of MDS • Platelet count >50 x 109/L	1 year

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DEFERASIROX 250 MG TB FOR SUSP	• Diagnosis of Chronic Iron Overload Due To Blood Transfusions and age of 2 Years and Older OR • Diagnosis of Chronic Iron Overload with Non-Transfusion-Dependent Thalassemia (NTDT) Syndromes and Age 10 Years and Older • Liver Iron (Fe) Concentration (LIC) Of At Least 5 mg Fe per Gram of Dry Weight (Fe/g dw) • Serum Ferritin Greater Than 300 mcg/L • Serum Creatinine Less Than 2 Times The Age-Appropriate Upper Limit Of Normal (ULN) • Creatinine Clearance (CICr) Less Than 40 mL/min • Does Not Have A Diagnosis of MDS with a Platelet Count >50 x 109/L	1 year
DEFERASIROX 360 MG GRANULE PKT	Set Up and Send to RPh •Diagnosis of Chronic Iron Overload Due to Blood Transfusions •Age= 2 Years and Older OR •Diagnosis of Chronic Iron Overload with Non-Transfusion-Dependent Thalassemia (NTDT) Syndromes •Age= 10 Years and Older •Liver Iron (Fe) Concentration (LIC) of at Least 5 mg Fe per Gram of Dry Weight (Fe/g dw) •Serum Ferritin Greater Than 300 mcg/L •Serum Creatinine Less Than 2 Times The Age-Appropriate Upper Limit Of Normal (ULN) OR Creatinine Clearance (CICr) Less Than 40 mL/min •Does Not Have a Diagnosis of MDS •Platelet Count >50 x 109/L For Re-Authorizations •Set Up and Send to RPh •Previously Approved On (Date) For (Length of Time) •Claims/RD = •Diagnosis of	1 year
DEFERASIROX 360 MG TABLET	• Diagnosis of Chronic Iron Overload Due To Blood Transfusions • Age 2 Years And Older OR • Diagnosis of Chronic Iron Overload With Non-Transfusion-Dependent Thalassemia (NTDT) Syndromes • Age 10 Years And Older • Liver Iron (Fe) Concentration (LIC) Of At Least 5 mg Fe Per Gram Of Dry Weight (Fe/g dw) • Serum Ferritin Greater Than 300 mcg/L • Serum Creatinine Less Than 2 Times The Age-Appropriate Upper Limit Of Normal (ULN) OR Creatinine Clearance (CICr) Less Than 40 mL/min • Member does not have a diagnosis of MDS • Platelet count >50 x 109/L	1 year
DEFERASIROX 500 MG TB FOR SUSP	• Diagnosis of Chronic Iron Overload Due To Blood Transfusions and age of 2 Years and Older • OR• • Diagnosis of Chronic Iron Overload with Non-Transfusion-Dependent Thalassemia (NTDT) Syndromes and Age 10 Years and Older. • Liver Iron (Fe) Concentration (LIC) Of At Least 5 mg Fe per Gram of Dry Weight (Fe/g dw). • Serum Ferritin Greater Than 300 mcg/L • Serum Creatinine Less Than 2 Times The Age-Appropriate Upper Limit Of Normal (ULN) OR • Creatinine Clearance (CICr) Less Than 40 mL/min. • Does Not Have A Diagnosis of MDS with a Platelet Count >50 x 109/L.	1 year
DEFERASIROX 90 MG GRANULE PKT	Set Up and Send to RPh •Diagnosis of Chronic Iron Overload Due to Blood Transfusions •Age= 2 Years and Older OR •Diagnosis of Chronic Iron Overload with Non-Transfusion-Dependent Thalassemia (NTDT) Syndromes •Age= 10 Years and Older •Liver Iron (Fe) Concentration (LIC) of at Least 5 mg Fe per Gram of Dry Weight (Fe/g dw) •Serum Ferritin Greater Than 300 mcg/L •Serum Creatinine Less Than 2 Times The Age-Appropriate Upper Limit Of Normal (ULN) OR Creatinine Clearance (CICr) Less Than 40 mL/min •Does Not Have a Diagnosis of MDS •Platelet Count >50 x 109/L For Re-Authorizations •Set Up and Send to RPh •Previously Approved On (Date) For (Length of Time) •Claims/RD = •Diagnosis of	1 year

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DEFERASIROX 90 MG TABLET	• Diagnosis of Chronic Iron Overload Due To Blood Transfusions • Age 2 Years And Older OR • Diagnosis of Chronic Iron Overload With Non-Transfusion-Dependent Thalassemia (NTDT) Syndromes • Age 10 Years And Older • Liver Iron (Fe) Concentration (LIC) Of At Least 5 mg Fe Per Gram Of Dry Weight (Fe/g dw) • Serum Ferritin Greater Than 300 mcg/L • Serum Creatinine Less Than 2 Times The Age-Appropriate Upper Limit Of Normal (ULN) OR Creatinine Clearance (CICr) Less Than 40 mL/min • Member does not have a diagnosis of MDS • Platelet count >50 x 109/L	1 year
DEFERIPRONE 500 MG TABLET	*Dx= Chronic Iron Overload	1 year
DEMECLOCYCLINE 150 MG TABLET	One time Trial of minocycline or doxycycline	30 days
DEMECLOCYCLINE 300 MG TABLET	One time Trial of minocycline or doxycycline	30 days
DENAVIR 1% CREAM	• Diagnosis of Cold Sores • 3 day Trial of: Docosanol	30 days
DERMACINRX EMPRICAINE KIT	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 year
DERMASORB TA 0.1% COMPLETE KIT	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Agents used at the same time Triamcinolone 0.1% And an Emollient Lotion or Ointment (Cerave; Cetaphil; Aveeno; Lubriderm (Eucerin))	1 year
DESCOVY 120-15 MG TABLET	•Diagnosis of HIV-1 Infection OR •Diagnosis of Pre-Exposure Prophylaxis (PrEP) AND •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Truvada	1 year
DESCOVY 200-25 MG TABLET	Diagnosis= HIV-1 infection	1 year
DESLORATADINE 5 MG TABLET	• A 30-day trial and failure of OTC antihistamine: cetirizine, loratadine, fexofenadine (Note: OTC antihistamine requires formulary exception review for coverage.)	1 year
DESONIDE 0.05% LOTION	Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Desonide (Desowen) 0.05% Cream or Ointment •Quantity Limit 118 mL (1 Bottle)/26 Days	1 year
DESOXIMETASONE 0.05% CREAM	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of two of the following for 7 days each: Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone)	1 year
DESOXIMETASONE 0.05% GEL	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of two of the following for 7 days each: Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone)	1 year
DESOXIMETASONE 0.05% OINTMENT	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of two of the following for 7 days each: Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone)	1 year
DESOXIMETASONE 0.25% CREAM	• A 30-day trial and failure of OTC antihistamine: cetirizine, loratadine, fexofenadine (Note: OTC antihistamine requires formulary exception review for coverage.)	1 year

Drug Name	Criteria	Approval Duration
DESOXIMETASONE 0.25% OINTMENT	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of two of the following for 7 days each: Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone)	1 year
DESOXIMETASONE 0.25% SPRAY	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of two of the following for 7 days each: Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone)	1 year
DESVENLAFAXINE ER 100 MG TAB	30 day trials of two of the three following groups (one must be within the last year): • Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) • Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); • Bupropion XL Or SR (Wellbutrin SR Or XL)	1 year
DESVENLAFAXINE ER 50 MG TAB	30 day trials of two of the three following groups (one must be within the last year): • Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) • Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); • Bupropion XL Or SR (Wellbutrin SR Or XL)	1 year
DESVENLAFAXINE SUCCNT ER 100MG	• 30 day trial each of 2 of the 3 following groups with one trial occuring in the last year -Group-1: Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) -Group-2: Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); -Group-3: Bupropion XL Or SR (Wellbutrin SR Or XL)	1 year
DESVENLAFAXINE SUCCNT ER 25 MG	• 30 day trial each of 2 of the 3 following groups with one trial occuring in the last year -Group-1: Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) -Group-2: Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); -Group-3: Bupropion XL Or SR (Wellbutrin SR Or XL)	1 year
DESVENLAFAXINE SUCCNT ER 50 MG	• 30 day trial each of 2 of the 3 following groups with one trial occuring in the last year -Group-1: Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) -Group-2: Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); -Group-3: Bupropion XL Or SR (Wellbutrin SR Or XL)	1 year
DEXCOM G6 RECEIVER	•Member is 2 years of age or older •Member has a diagnosis Diabetes (type 1 or type 2) •Currently utilizing 3 or more injections of insulin per day (must have claims in last 120 days)	1 year
DEXCOM G6 SENSOR	•Member is 2 years of age or older •Member has a diagnosis Diabetes (type 1 or type 2) •Currently utilizing 3 or more injections of insulin per day (must have claims in last 120 days)	1 year
DEXCOM G6 TRANSMITTER	•Member is 2 years of age or older •Member has a diagnosis Diabetes (type 1 or type 2) •Currently utilizing 3 or more injections of insulin per day (must have claims in last 120 days)	1 year
DEXLANSOPRAZOLE DR 30 MG CAP	Trial & failure of at least 30 days of one of the following: esomeprazole, lansoprazole, omeprazole, or pantoprazole	1 year
DEXLANSOPRAZOLE DR 60 MG CAP	Trial & failure of at least 30 days of one of the following: esomeprazole, lansoprazole, omeprazole, or pantoprazole	1 year

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Drug Name	Criteria	Approval Duration
DEXTENZA 0.4 MG INSERT	•Minimum age 18 years •Diagnosis of ocular inflammation and pain following ophthalmic surgery OR ocular itching associated with allergic conjunctivitis •For post-cataract surgery: Trial and failure of ALL of the following: ophthalmic corticosteroids and nonsteroidal anti-inflammatory drugs (NSAIDs) •For allergic conjunctivitis: Trial and failure of ALL of the following: antihistamines, mast cell stabilizers, and topical corticosteroids •Quantity: 1 insert per eye per 30 days •Do not renew for post-surgical indication.	30 Days
DEXTENZA 0.4 MG INSERT	•Minimum age 18 years •Diagnosis of ocular inflammation and pain following ophthalmic surgery OR ocular itching associated with allergic conjunctivitis •For post-cataract surgery: Trial and failure of ALL of the following: ophthalmic corticosteroids and nonsteroidal anti-inflammatory drugs (NSAIDs) •For allergic conjunctivitis: Trial and failure of ALL of the following: antihistamines, mast cell stabilizers, and topical corticosteroids •Quantity: 1 insert per eye per 30 days •Do not renew for post-surgical indication.	30 Days
DEXYCU 9% VIAL	•Minimum age 18 years •Diagnosis of postoperative ophthalmic inflammation •Trial and failure of ophthalmic corticosteroids AND nonsteroidal anti-inflammatory drugs (NSAIDs) •Quantity: 1 vial per eye per 30 days • Not eligible for reauthorization	30 Days
DHIVY 25-100 MG TABLET	•Diagnosis of ONE of the following: -Parkinson's disease -Postencephalitic Parkinsonism -Symptomatic Parkinsonism •Age ≥ 18 years old •Previous trial and failure of generic carbidopa-levodopa, unless contraindicated or clinically significant adverse effects are experienced •Quantity Limit 240 tablets per 30 days •Renew if positive clinical response	1 Year
DIAZOXIDE 50 MG/ML ORAL SUSP	Diagnosis of Hypoglycemia due to Extenuating Circumstances	1 year
DICLOFENAC 1.5% TOPICAL SOLN	Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Voltaren Gel •Quantity Limit 150 ml (1 Bottle)/26 Days	1 year
DICLOFENAC EPOLAMINE 1.3% PTCH	•Diagnosis of Low Back Pain or Generalized Pain •30-Day trial within the last Year of the ANY of the following: •NSAIDS (Naproxen, Ibuprofen, Flurbiprofen, Nabumetone, Diclofenac, Etodolac, Indomethacin, Ketoprofen, Meloxicam, Oxaprozin, Sulindac or Piroxicam) or Voltaren 1% Gel OR •Diagnosis of Osteoarthritis •30-Day Trial Within the Last Year of ANY of the Following: •NSAIDS (Celecoxib (Celebrex), Naproxen, Ibuprofen, Flurbiprofen, Nabumetone, Diclofenac, Etodolac, Indomethacin, Ketoprofen, Meloxicam, Oxaprozin, Sulindac or Piroxicam) AND •Set Up and Send to RPh •Clinical Reason Why the Requested Patch Is Required When the Topical Voltaren Gel Has Failed After a 30-Day Trial Within the Last Year of Topical Voltaren Gel •Quantity Limit 60 Patches/ 26 Days	1 year
DICLOFENAC SODIUM 3% GEL	Diagnosis of Actinic Keratosis	90 Days
DICLOZOR KIT	• Diagnosis of osteoarthritis in the hand, wrist, elbow, foot, ankle, or knee • Clinical reason why, after a 30 day trial, diclofenac 1% gel cannot be used	1 year
DIFLORASONE 0.05% CREAM	• 14 days trial in the last 120 days of one of the following: betamethasone dipropionate augmented crm 0.05% (DIPROLENE AF, betamethasone dipropionate augmented lotion 0.05% (DIPROLENE) , betamethasone dipropionate crm, lotion 0.05% , desoximetasone crm 0.25% (TOPICORT), fluocinonide soln 0.05% triamcinolone acetonide crm, oint 0.5% OR • Diagnosis of Atopic Dermatitis (Extrinsic [allergic], Intrinsic [non-allergic] eczema) or Psoriasis OR • Prescriber specialty Dermatology or Rheumatology	1 year

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DIFLORASONE 0.05% OINTMENT	• 14 days trial in the last 120 days of one of the following: betamethasone dipropionate augmented crm 0.05% (DIPROLENE AF, betamethasone dipropionate augmented lotion 0.05% (DIPROLENE) , betamethasone dipropionate crm, lotion 0.05% , desoximetasone crm 0.25% (TOPICORT), fluocinonide soln 0.05% triamcinolone acetonide crm, oint 0.5% OR • Diagnosis of Atopic Dermatitis (Extrinsic [allergic], Intrinsic [non-allergic] eczema) or Psoriasis OR • Prescriber specialty Dermatology or Rheumatology	3 months
DIFLUPREDNATE 0.05% EYE DROP	One Time Trial Of: Dexamethasone 0.1% Ophthalmic Solution, Prednisolone Acetate (Pred Forte, Omnipred) 1%, Or Prednisolone Sodium Phosphate 1%	30 Days
DIHYDROERGOTAMINE 4 MG/ML SPRY	Clinical reason supported by chart notes why (after a 30 day trial each) two of the following cannot be used: Dihydroergotamine injection, ergotamine/caffeine, almotriptan, naratriptan, rizatriptan, sumatriptan	1 year
DILATRATE-SR 40 MG CAPSULE	•Set Up and Send •Clinical Reason Supported by Chart Notes or Provider Call (After Trial Listed Below) Why the Below Cannot Be Used: •90 Day Trial of Isosorbide Dinitrate	1 year
DIPENTUM 250 MG CAPSULE	Clinical reason supported by chart notes why, after a trial, sulfasalazine cannot be used	1 year
DIVIGEL 0.25 MG GEL PACKET	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Estradiol Tablets, Estradiol Patches (Climara) or Alora	1 year
DIVIGEL 0.5 MG GEL PACKET	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Estradiol Tablets, Estradiol Patches (Climara) or Alora	1 year
DIVIGEL 1 MG GEL PACKET	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Estradiol Tablets, Estradiol Patches (Climara) or Alora	1 year
DONNATAL ELIXIR	30-Day Trial of: Phenobarbital 20 mg/5 mL Elixir and Hyoscyamine, Hyosyne 125 mcg/5 mL Elixir used at the same time	1 year
DORZOLAMIDE-TIMOLOL 2%-0.5%	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Dorzolamide HCL/Timolol Maleate (Cosopt)	1 year
DOTTI 0.025 MG PATCH	•Clinical Reason Why After A 30 Day Trial the Following Cannot Be Used: Estradiol (Climara) Patch or Alora Patch •Note: This Is A Twice Weekly Patch	1 year
DOTTI 0.0375 MG PATCH	•Clinical Reason Why After A 30 Day Trial the Following Cannot Be Used: Estradiol (Climara) Patch or Alora Patch •Note: This Is A Twice Weekly Patch	1 year
DOTTI 0.05 MG PATCH	•Clinical Reason Why After A 30 Day Trial the Following Cannot Be Used: Estradiol (Climara) Patch or Alora Patch •Note: This Is A Twice Weekly Patch	1 year
DOTTI 0.075 MG PATCH	•Clinical Reason Why After A 30 Day Trial the Following Cannot Be Used: Estradiol (Climara) Patch or Alora Patch •Note: This Is A Twice Weekly Patch	1 year
DOTTI 0.1 MG PATCH	•Clinical Reason Why After A 30 Day Trial the Following Cannot Be Used: Estradiol (Climara) Patch or Alora Patch •Note: This Is A Twice Weekly Patch	1 year
DOXEPIN 5% CREAM	30 day Trial of: OTC topical antihistamine (diphenhydramine HCl 2%, Anti-Itch (Benadryl) 1% cream, or anti-itch (Benadryl) 2% cream)	30 days
DOXEPIN HCL 3 MG TABLET	• Diagnosis of insomnia characterized by difficulty with sleep maintenance (staying asleep after falling asleep)	1 year
DOXEPIN HCL 6 MG TABLET	• Diagnosis of insomnia characterized by difficulty with sleep maintenance (staying asleep after falling asleep)	1 year
DOXERCALCIFEROL 0.5 MCG CAP	7 day Trial of Paricalcitriol (Zemplar) in the last 30 days	1 year
DOXERCALCIFEROL 1 MCG CAPSULE	7 day Trial of Paricalcitriol (Zemplar) in the last 30 days	1 year
DOXERCALCIFEROL 2.5 MCG CAP	7-Day Trial of Paricalcitriol (Zemplar) In the Last 30 Days (Zemplar Requires 7 Day Trial of Calcitriol)	1 year
DOXYCYCLINE HYC DR 100 MG TAB	•Diagnosis of Acne or Rosacea •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) the Following Cannot be Used: Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet OR •Diagnosis of Anything Other Than Acne or Rosacea •Clinical Reason Supported by Chart Notes Why (After A 7 Day Trial Of) the Following Cannot be Used: Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet	1 Year for Acne or Rosacea 30 Days for Anything Other Than Acne or Rosacea

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Drug Name	Criteria	Approval Duration
DOXYCYCLINE HYC DR 150 MG TAB	•Diagnosis of Acne or Rosacea •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) the Following Cannot be Used: Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet OR •Diagnosis of Anything Other Than Acne or Rosacea •Clinical Reason Supported by Chart Notes Why (After A 7 Day Trial Of) the Following Cannot be Used: Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet	1 Year for Acne or Rosacea 30 Days for Anything Other Than Acne or Rosacea
DOXYCYCLINE HYC DR 200 MG TAB	•Diagnosis of Acne or Rosacea •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) the Following Cannot be Used: Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet OR •Diagnosis of Anything Other Than Acne or Rosacea •Clinical Reason Supported by Chart Notes Why (After A 7 Day Trial Of) the Following Cannot be Used: Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet	1 Year for Acne or Rosacea 30 Days for Anything Other Than Acne or Rosacea
DOXYCYCLINE HYC DR 50 MG TAB	•Diagnosis of Acne or Rosacea •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) the Following Cannot be Used: Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet OR •Diagnosis of Anything Other Than Acne or Rosacea •Clinical Reason Supported by Chart Notes Why (After A 7 Day Trial Of) the Following Cannot be Used: Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet	1 Year for Acne or Rosacea 30 Days for Anything Other Than Acne or Rosacea
DOXYCYCLINE HYC DR 75 MG TAB	•Diagnosis of Acne or Rosacea •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) the Following Cannot be Used: Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet OR •Diagnosis of Anything Other Than Acne or Rosacea •Clinical Reason Supported by Chart Notes Why (After A 7 Day Trial Of) the Following Cannot be Used: Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet	1 Year for Acne or Rosacea 30 Days for Anything Other Than Acne or Rosacea
DOXYCYCLINE HYC DR 80 MG TAB	•Diagnosis of Acne or Rosacea •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) the Following Cannot be Used: Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet OR •Diagnosis of Anything Other Than Acne or Rosacea •Clinical Reason Supported by Chart Notes Why (After A 7 Day Trial Of) the Following Cannot be Used: Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet	1 Year for Acne or Rosacea 30 Days for Anything Other Than Acne or Rosacea
DOXYCYCLINE IR-DR 40 MG CAP	•Diagnosis of Acne or Rosacea •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) the Following Cannot be Used: Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet OR •Diagnosis of Anything Other Than Acne or Rosacea •Clinical Reason Supported by Chart Notes Why (After A 7 Day Trial Of) the Following Cannot be Used: Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet	1 Year for Acne or Rosacea 30 Days for Anything Other Than Acne or Rosacea

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DOXYCYCLINE MONO 150 MG CAP	• Diagnosis of Acne or Rosacea • Clinical Reason Supported By Chart Notes Why (After A 90 Day Trial of) the following cannot be used: Doxycycline Monohydrate 50mg Or 100mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg Or 100 mg Capsule, Doxycyline Hyclate 20 mg Or 100 mg Tablet OR For all other diagnoses: Clinical Reason Supported By Chart Notes Why (After A 7 Day Trial of) the following cannot be used: Doxycycline Monohydrate 50mg Or 100mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg Or 100 mg Capsule, Doxycyline Hyclate 20 mg Or 100 mg Tablet	For diagnosis of acne or rosacea: 1 year For all other diagnoses: 30 days
DOXYCYCLINE MONO 75 MG CAPSULE	•Diagnosis of Acne or Rosacea •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) the Following Cannot be Used: Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet OR •Diagnosis of Anything Other Than Acne or Rosacea •Clinical Reason Supported by Chart Notes Why (After A 7 Day Trial Of) the Following Cannot be Used: Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet	1 Year for Acne or Rosacea 30 Days for Anything Other Than Acne or Rosacea
DOXYLAMINE-PYRIDOXINE 10-10 MG	Clinical reason supported by chart notes why (after a 14 day Trial of) the following cannot be used: OTC Doxylamine (Unisom) and pyridoxine (vitamin B6) used at the same time	6 months
DRONABINOL 10 MG CAPSULE	• Diagnosis of Appetite stimulation in AIDS patients or Cancer chemotherapy-induced nausea and vomiting	1 year
DRONABINOL 2.5 MG CAPSULE	• Diagnosis of Appetite stimulation in AIDS patients or Cancer chemotherapy-induced nausea and vomiting	1 year
DRONABINOL 5 MG CAPSULE	• Diagnosis of Appetite stimulation in AIDS patients or Cancer chemotherapy-induced nausea and vomiting	1 year
DROSP-EE-LEVOMEF 3-0.02-0.451	• Clinical Reason Supported By Chart Notes Why (After A Trial of) The Below Cannot Be Used:: • Gianvi, Loryna, or Vestura with Folic Acid used at the same time	1 year
DULERA 100 MCG-5 MCG INHALER	• Diagnosis of asthma or COPD requiring maintenance inhaler therapy • Trial of fluticasone-salmeterol inhaler or documentation that an HFA inhaler is required over a DPI	1 year
DULERA 200 MCG-5 MCG INHALER	• Diagnosis of asthma or COPD requiring maintenance inhaler therapy • Trial of fluticasone-salmeterol inhaler or documentation that an HFA inhaler is required over a DPI	1 year
DULERA 50 MCG-5 MCG INHALER	• Diagnosis of asthma or COPD requiring maintenance inhaler therapy • Trial of fluticasone-salmeterol inhaler or documentation that an HFA inhaler is required over a DPI	1 year
DULOXETINE HCL DR 40 MG CAP	• 30 day trial and failure of a preferred strength of duloxetine (20mg, 30mg, 60mg)	1 year
DUOBRII 0.01%-0.045% LOTION	• Diagnosis of Plaque Psoriasis • Clinical reason why, after a 90 day trial each, two of the following cannot be used: Calcipotriene (Dovonex), Tazarotene (Tazorac) (also requires PA), Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone)	1 year
DURLAZA ER 162.5 MG CAPSULE	•Clinical Reason Why (After A Trial of) the Below Cannot be Used: •Aspirin 81 mg	1 year
DUTASTERIDE 0.5 MG CAPSULE	• 90-day Trial of: doxazosin, terazosin, tamsulosin or prazosin	1 year
DUTASTERIDE-TAMSULOSIN 0.5-0.4	Clinical reason supported by chart notes why (after a 90 day Trial of) the following cannot be used: Tamsulosin AND Dutasteride (Avodart) used at the same time	1 year
DYANAVEL XR 2.5 MG/ML SUSP	•Documented diagnosis of ADHD •Minimum age 6 years •Trial and failure of at least 2 preferred CNS stimulant products •Duration: 1 year; renew if positive clinical response and no signs of abuse/misuse	1 year

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ECONAZOLE NITRATE 1% CREAM	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) One of the Following Topical or Oral Agents Cannot Be Used: Clotrimazole, Ketoconazole, Miconazole, Terbinafine or Tolnaftate •Quantity Limit 85 Grams (1 Tube)/26 Days	1 Month
EFFER-K 10 MEQ TABLET EFF	•Clinical Reason Supported by Chart Notes Why (After A Trial of) the Below Cannot be Used: •Formulary Potassium Supplement	1 year
EFFER-K 20 MEQ TABLET EFF	•Clinical Reason Supported by Chart Notes Why (After A Trial of) the Below Cannot be Used: •Formulary Potassium Supplement	1 year
EGRIFTA 1 MG VIAL	•Diagnosis of HIV/AIDS in the Past 2 Years AND •Member is 18 Years of Age or Older AND •Prescriber Must Confirm Member is Not Pregnant	1 year
ELESTRIN 0.06% GEL	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial of) the Below Cannot be Used: •Estradiol Tablets, Estradiol Patches (Climara) or Alora	1 year
ELETRIPTAN HBR 20 MG TABLET	•Age 6-17 Years Old: A One Time Trial of Sumatriptan Tablets, Injection, or Nasal Spray or Rizatriptan •Age 18 and Older: A One Time Trial of At Least 2 of The Following 4 Drugs: Sumatriptan Tablets, Injection, or Nasal Spray, Naratriptan, Rizatriptan or Almotriptan (Axert)	1 year
ELETRIPTAN HBR 40 MG TABLET	•Age 6-17 Years Old: A One Time Trial of Sumatriptan Tablets, Injection, or Nasal Spray or Rizatriptan •Age 18 and Older: A One Time Trial of At Least 2 of The Following 4 Drugs: Sumatriptan Tablets, Injection, or Nasal Spray, Naratriptan, Rizatriptan or Almotriptan (Axert)	1 year
ELIGARD 22.5 MG SYRINGE KIT	Diagnosis of Advanced Prostate Cancer	1 year
ELIQUIS 2.5 MG TABLET	• One of the following diagnoses: 1) atrial fibrillation or flutter, 2) deep vein thrombosis (DVT) in a patient undergoing knee or hip replacement surgery, 3) treatment of DVT or pulmonary embolism (PE), or 4) to reduce the risk of recurrence of DVT or PE	1 year
ELIQUIS 5 MG TABLET	• One of the following diagnoses: 1) atrial fibrillation or flutter, 2) deep vein thrombosis (DVT) in a patient undergoing knee or hip replacement surgery, 3) treatment of DVT or pulmonary embolism (PE), or 4) to reduce the risk of recurrence of DVT or PE	1 year
ELIQUIS DVT-PE TREAT START 5MG	• One of the following diagnoses: 1) atrial fibrillation or flutter, 2) deep vein thrombosis (DVT) in a patient undergoing knee or hip replacement surgery, 3) treatment of DVT or pulmonary embolism (PE), or 4) to reduce the risk of recurrence of DVT or PE	1 year
ELYXYB 120 MG/4.8 ML SOLUTION	• Member is age 18 years or older • Has completed a 30 day trial with at least two preferred oral NSAIDs • A clinical reason why the oral solution is needed • Quantity Limit: 120mg (4.8 mL) per day	1 year
EMADINE 0.05% EYE DROPS	•If Fax States Patient Is Pregnant OR •Age 3 Years or Older •15-Day Trial of OTC Ketotifen (Refresh/Zyrtec Eye Drops/Wal-Zyr/Alaway/Claritin Eye Drops/RiteAid or CVS Eye Itch EYE DROPS (Zaditor) AND •15-Day Trial of Azelastine (Optivar)	3 Months

Georgia Medicaid Traditional Drug Criteria
Effective 10/1/2022

Drug Name	Criteria	Approval Duration
EMBEDA ER 100-4 MG CAPSULE	For Initial Authorization: •30-Day Trial Each of Two of the Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, Or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program (PDMP) - PMP AWARXE (GA) •If Cumulative MED is > 80 MED/Day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (Or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPH. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes)	Up to 90 Days for Initial Authorization Up to 6 Months for Re-Authorization
EMBEDA ER 20-0.8 MG CAPSULE	For Initial Authorization: •30-Day Trial Each of Two of the Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, Or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program (PDMP) - PMP AWARXE (GA) •If Cumulative MED is > 80 MED/Day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (Or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPH. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes)	Up to 90 Days for Initial Authorization Up to 6 Months for Re-Authorization

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Drug Name	Criteria	Approval Duration
EMBEDA ER 30-1.2 MG CAPSULE	For Initial Authorization: •30-Day Trial Each of Two of the Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, Or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program (PDMP) - PMP AWARXE (GA) •If Cumulative MED is > 80 MED/Day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (Or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPH. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes)	Up to 90 Days for Initial Authorization Up to 6 Months for Re-Authorization
EMBEDA ER 50-2 MG CAPSULE	For Initial Authorization: •30-Day Trial Each of Two of the Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, Or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program (PDMP) - PMP AWARXE (GA) •If Cumulative MED is > 80 MED/Day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (Or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPH. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes)	Up to 90 Days for Initial Authorization Up to 6 Months for Re-Authorization

Georgia Medicaid Traditional Drug Criteria
Effective 10/1/2022

Drug Name	Criteria	Approval Duration
EMBEDA ER 60-2.4 MG CAPSULE	For Initial Authorization: •30-Day Trial Each of Two of the Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, Or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program (PDMP) - PMP AWARXE (GA) •If Cumulative MED is > 80 MED/Day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (Or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPH. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes)	Up to 90 Days for Initial Authorization Up to 6 Months for Re-Authorization
EMBEDA ER 80-3.2 MG CAPSULE	For Initial Authorization: •30-Day Trial Each of Two of the Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, Or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program (PDMP) - PMP AWARXE (GA) •If Cumulative MED is > 80 MED/Day, Prescriber Must Be Pain Management Specialist OR A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (Or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPH. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes)	Up to 90 Days for Initial Authorization Up to 6 Months for Re-Authorization
EMPRICAINE-II 2.5%-2.5% CRM KT	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 year

Georgia Medicaid Traditional Drug Criteria
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Drug Name	Criteria	Approval Duration
EMSAM 12 MG/24 HOURS PATCH	• A claim for Emsam in the last 30 days OR • If Previously Approved By CareSource AND Currently Using: Trintellix (Formerly Known As Brintellix), Pristiq, Venlafaxine ER Tablets, Viibryd, Desvenlafaxine ER, Khedezla, Fetzima, Or Fluvoxamine ER (Luvox) OR • 30 Day Trials Each Of 2 Of The 3 Following Preferred Formulary Groups (One Of Which Must Have Occurred Within The Last Year) -Group-1: Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) -Group-2: Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); -Group-3: Bupropion XL Or SR (Wellbutrin SR Or XL)	1 year
EMSAM 6 MG/24 HOURS PATCH	• A claim for Emsam in the last 30 days OR • If Previously Approved By CareSource AND Currently Using: Trintellix (Formerly Known As Brintellix), Pristiq, Venlafaxine ER Tablets, Viibryd, Desvenlafaxine ER, Khedezla, Fetzima, Or Fluvoxamine ER (Luvox) OR • 30 Day Trials Each Of 2 Of The 3 Following Preferred Formulary Groups (One Of Which Must Have Occurred Within The Last Year) -Group-1: Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) -Group-2: Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); -Group-3: Bupropion XL Or SR (Wellbutrin SR Or XL)	1 year
EMSAM 9 MG/24 HOURS PATCH	• A claim for Emsam in the last 30 days OR • If Previously Approved By CareSource AND Currently Using: Trintellix (Formerly Known As Brintellix), Pristiq, Venlafaxine ER Tablets, Viibryd, Desvenlafaxine ER, Khedezla, Fetzima, Or Fluvoxamine ER (Luvox) OR • 30 Day Trials Each Of 2 Of The 3 Following Preferred Formulary Groups (One Of Which Must Have Occurred Within The Last Year) -Group-1: Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) -Group-2: Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); -Group-3: Bupropion XL Or SR (Wellbutrin SR Or XL)	1 year
EMVERM 100 MG TABLET CHEW	•30-Day Trial of: Pin-X, Pamix 144 mg/mL (50 mg/mL) OTC Or Pinworm Tab Medicine 180 mg OTC •Quantity Limit 6 Tablets/21 Days	1 Month
ENALAPRIL 1 MG/ML ORAL SOLN	• Age < 12 years OR • Age 12 years and older • Clinical reasonupported by chart notes why (after a 90 day Trial of) enalapril tablets cannot be used	1 year
ENDARI 5 GRAM POWDER PACKET	*5 years of age or older;*Dx= sickle cell disease;*=2 painful crises within 12 months; *Stable on hydroxyurea for at least 3 months OR contraindication to hydroxyurea or failure/intolerance of hydroxyurea (ex. No reduction in pain crisis, intolerable side effects)	1 year

Georgia Medicaid Traditional Drug Criteria
Effective 10/1/2022

Drug Name	Criteria	Approval Duration
ENDOCET 10-325 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
ENDOCET 2.5-325 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

Drug Name	Criteria	Approval Duration
ENDOCET 5-325 TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
ENDOCET 7.5-325 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
ENTECAVIR 0.5 MG TABLET	• Diagnosis of chronic hepatitis B • Prescribed by infectious disease specialist, gastroenterologist, hepatologist or transplant physician	1 year
ENTECAVIR 1 MG TABLET	• Diagnosis of chronic hepatitis B • Prescribed by infectious disease specialist, gastroenterologist, hepatologist or transplant physician	1 year
ENTRESTO 24 MG-26 MG TABLET	•Diagnosis: Member has NYHA class II-IV heart failure •Quantity Limit 60 tablets per 30 days •Renew x 1 year if positive clinical response	1 Year
ENTRESTO 49 MG-51 MG TABLET	•Diagnosis: Member has NYHA class II-IV heart failure •Quantity Limit 60 tablets per 30 days •Renew x 1 year if positive clinical response	1 Year

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Drug Name	Criteria	Approval Duration
ENTRESTO 97 MG-103 MG TABLET	•Diagnosis: Member has NYHA class II-IV heart failure •Quantity Limit 60 tablets per 30 days •Renew x 1 year if positive clinical response	1 Year
EPINASTINE HCL 0.05% EYE DROPS	•Approve If Previously Approved for Alocril, Alrex, Bepreve, Or Pazeo OR •Age 2 Years or Older •15-Day Trial of: OTC Ketotifen (Alaway/Claritin Eye Drops/Refresh/RiteAid or CVS Eye Itch Eye Drops (Zaditor)/Wal-Zyr/ Zyrtec Eye Drops) AND •15-Day Trial of: Azelastine (Optivar)	3 Months
EPIVIR HBV 25 MG/5 ML SOLN	• Diagnosis of chronic hepatitis B • Prescribed by infectious disease specialist, gastroenterologist, hepatologist or transplant physician	1 year
EPRONTIA 25 MG/ML SOLUTION	•Member has a diagnosis of one of the following: oPartial-onset seizures oPrimary generalized tonic-clonic seizures oSeizures associated with Lennox-Gastaut syndrome oMigraines OR •Diagnosis of Seizures oMember is at least 2 years old oTrial of one of the following: Fycompa, Felbatol or topiramate sprinkle capsules OR •Diagnosis of Migraines oMember is at least 12 years old oTrial of at least one preferred CGRP •Initial Approval Duration oSeizures: 1 year, Max dose of 16mL per day oMigraines: 1 Year, Max dose of 4mL per day	1 year
ERGOLOID MESYLATES 1 MG TAB	• Diagnosis of idiopathic decline in mental capacity • Provider attests that the benefits outweigh the risks of use in members aged >65	1 year
ERTACZO 2% CREAM	• Diagnosis of Tinea pedis • 30 Day Trial of: Ketoconazole Cream, Clotrimazole Cream, Or Miconazole Cream [Dose: 60 Grams (1 Tube) / 26 days]	60 days
ERYTHROMYCIN-BENZOYL GEL	•Clinical Reason Supported by Chart Notes Why (After A 90-Day Trial of) The Below Cannot be Used: Erythromycin 2% Gel and Benzoyl Peroxide 5% Gel Used Together or Separately •Quantity Limit 46.6 Grams (1 Jar)/26 Days	1 year
ESOMEP-EZS KIT	• 90 day trial of both a tablet and capsule proton pump inhibitor (pantoprazole tablet, omeprazole capsule, lansoprazole capsule, esomeprazole capsule) • Clinical reason why a compounded solution cannot be used	1 year
ESOMEPRAZOLE DR 10 MG PACKET	• Trial and failure of esomeprazole capsules; OR • Documented inability to swallow capsules	1 year
ESOMEPRAZOLE DR 20 MG PACKET	• Trial and failure of esomeprazole capsules; OR • Documented inability to swallow capsules	1 year
ESOMEPRAZOLE DR 40 MG PACKET	• Trial and failure of esomeprazole capsules; OR • Documented inability to swallow capsules	1 year
ESOMEPRAZOLE MAG DR 40 MG CAP	•Do Not Approve Even if Previously Approved •Clinical Reason Why OTC Nexium Cannot be Used After a 90-Day Trial of OTC Formulation •Quantity Limit 1 Capsule/Day	6 Months for GERD 1 Year for Barrett's, Zollinger and Continuous Therapy With Concurrent Medication
ESZOPICLONE 1 MG TABLET	• Diagnosis of insomnia characterized by difficulty with either sleep onset or sleep maintenance	1 year
ESZOPICLONE 2 MG TABLET	• Diagnosis of insomnia characterized by difficulty with either sleep onset or sleep maintenance	1 year
ESZOPICLONE 3 MG TABLET	• Diagnosis of insomnia characterized by difficulty with either sleep onset or sleep maintenance	1 year
ETIDRONATE DISODIUM 200 MG TAB	•If fax States Allergy, Side Effects, or Intolerance to: Alendronate (Fosamax) OR •Trials of: Alendronate	1 year

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Drug Name	Criteria	Approval Duration
EUCRISA 2% OINTMENT	Initial Authorization: • Diagnosis of atopic dermatitis • Age 3 months or older • One of the following must be met: A) For use on non-sensitive areas: 30 day Trial of an intermediate or high potency topical steroid AND a 30 day Trial of either Protopic OR Elidel (generic tacrolimus or pimecrolimus). NOTE: Age less than 2 years does not have to try Protopic or Elidel. B) For use on sensitive areas: 30 day Trial of Protopic OR Elidel (generic tacrolimus or pimecrolimus). NOTE: If patient is less than 2 years of age, ok to approve without trial. Reauthorization: • Positive clinical response as evidenced by documentation of symptom improvement.	For initial authorization: 3 months For reauthoriazation: 1 year
EURAX 10% CREAM	• Diagnosis of Scabies • 7 Day Trial of: Permethrin (Elimate) 5% Cream OR • Diagnosis of Atopic Dermatitis (Eczema) • Trial of: 2 Different Agents For 7 Days Each• Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone)	30 days
EVZIO 2 MG AUTO-INJECTOR	Excluded Benefit	N/A
EZETIMIBE-SIMVASTATIN 10-10 MG	• Clinical reason supported by chart notes or provider call (after trial listed below) why the below cannot be used: • 30 Day Trial of: Simvastatin AND Zetia used at the same time • Include Paid Claims For: Atorvastatin (Lipitor), Fenofibrate (Lofibra Or Tricor), And Simvastatin (Zocor)	1 year
EZETIMIBE-SIMVASTATIN 10-20 MG	• Clinical reason supported by chart notes or provider call (after trial listed below) why the below cannot be used: • 30 Day Trial of: Simvastatin AND Zetia used at the same time • Include Paid Claims For: Atorvastatin (Lipitor), Fenofibrate (Lofibra Or Tricor), And Simvastatin (Zocor)	1 year
EZETIMIBE-SIMVASTATIN 10-40 MG	• Clinical reason supported by chart notes or provider call (after trial listed below) why the below cannot be used: • 30 Day Trial of: Simvastatin AND Zetia used at the same time • Include Paid Claims For: Atorvastatin (Lipitor), Fenofibrate (Lofibra Or Tricor), And Simvastatin (Zocor)	1 year
EZETIMIBE-SIMVASTATIN 10-80 MG	• Clinical reason supported by chart notes or provider call (after trial listed below) why the below cannot be used: • 30 Day Trial of: Simvastatin AND Zetia used at the same time • Include Paid Claims For: Atorvastatin (Lipitor), Fenofibrate (Lofibra Or Tricor), And Simvastatin (Zocor)	1 year
FAMOTIDINE 40 MG/5 ML SUSP	*No PA Required if age < 12 years For age 12 years and older: *7 day trial of famotidine tablets OR *Fax states in ability to swallow pills	1 year
FAMOTIDINE 40 MG/5 ML SUSP	Age < 12 years	1 year
FANAPT 1 MG TABLET	• Diagnosis of Bipolar Disorder (Or Mood Disorder ONLY For Ages Under 15), Schizophrenia or Autism • 60 Day Trial of: Aripiprazole (Abilify)	1 year
FANAPT 10 MG TABLET	• Diagnosis of Bipolar Disorder (Or Mood Disorder ONLY For Ages Under 15), Schizophrenia or Autism • 60 Day Trial of: Aripiprazole (Abilify)	1 year
FANAPT 12 MG TABLET	• Diagnosis of Bipolar Disorder (Or Mood Disorder ONLY For Ages Under 15), Schizophrenia or Autism • 60 Day Trial of: Aripiprazole (Abilify)	1 year
FANAPT 2 MG TABLET	• Diagnosis of Bipolar Disorder (Or Mood Disorder ONLY For Ages Under 15), Schizophrenia or Autism • 60 Day Trial of: Aripiprazole (Abilify)	1 year
FANAPT 4 MG TABLET	• Diagnosis of Bipolar Disorder (Or Mood Disorder ONLY For Ages Under 15), Schizophrenia or Autism • 60 Day Trial of: Aripiprazole (Abilify)	1 year
FANAPT 6 MG TABLET	• Diagnosis of Bipolar Disorder (Or Mood Disorder ONLY For Ages Under 15), Schizophrenia or Autism • 60 Day Trial of: Aripiprazole (Abilify)	1 year

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FANAPT 8 MG TABLET	• Diagnosis of Bipolar Disorder (Or Mood Disorder ONLY For Ages Under 15), Schizophrenia or Autism • 60 Day Trial of: Aripiprazole (Abilify)	1 year
FAYOSIM TABLET	Trial of: Any Formulary Birth Control	1 year
FEBUXOSTAT 40 MG TABLET	• 30 Day Trial of: Allopurinol [Not Required If: Allergy, Intolerance, Or Side Effect To Allopurinol]	1 year
FEBUXOSTAT 80 MG TABLET	• 30 Day Trial of: Allopurinol [Not Required If: Allergy, Intolerance, Or Side Effect To Allopurinol]	1 year
FENOFIBRATE 30 MG CAPSULE	Trial & failure of at least 30 days of one of the following preferred fenofibrate products: fenofibrate 48mg tablets, 54mg tablets, 67mg capsules, 134mg capsules, 145mg tablets, 160mg tablets, 200mg capsules	1 year
FENOFIBRATE 90 MG CAPSULE	Trial & failure of at least 30 days of one of the following preferred fenofibrate products: fenofibrate 48mg tablets, 54mg tablets, 67mg capsules, 134mg capsules, 145mg tablets, 160mg tablets, 200mg capsules	1 year
FENOPROFEN 600 MG TABLET	• Diagnosis of osteoarthritis, rheumatoid arthritis, or mild to moderate pain AND a 14 day Trial of a non-steroidal anti-inflammatory agent (ibuprofen, meloxicam, indomethacin, etodolac, naproxen, etc.)	3 months
FENTANYL 100 MCG/HR PATCH	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
FENTANYL 12 MCG/HR PATCH	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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FENTANYL 25 MCG/HR PATCH	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
FENTANYL 50 MCG/HR PATCH	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
FENTANYL 75 MCG/HR PATCH	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
FIASP 100 UNIT/ML FLEXTOUCH	• Clinical reason why (after a 90 day trial) insulin lispro cannot be used [Dose: 1 ml per day] • Greater quantity may be approved if directions on PA form match quantity requested Note: 1 box (15ml) = 1500 units	1 year
FIASP 100 UNIT/ML VIAL	• Clinical reason why (after a 90 day trial) insulin lispro cannot be used [Dose: 1 ml per day] • Greater quantity may be approved if directions on PA form match quantity requested Note: 1 box (15ml) = 1500 units	1 year
FIRVANQ 25 MG/ML SOLUTION	Diagnosis of Clostridium Difficile	10 Days
FIRVANQ 50 MG/ML SOLUTION	Diagnosis of Clostridium Difficile	10 days
FLECTOR 1.3% PATCH	•Diagnosis of Low Back Pain or Generalized Pain •30-Day Trial Within the Last Year of ANY of the Following: •NSAIDS (Naproxen, Ibuprofen, Flurbiprofen, Nabumetone, Diclofenac, Etodolac, Indomethacin, Ketoprofen, Meloxicam, Oxaprozin, Sulindac or Piroxicam) or Voltaren 1% Gel OR •Diagnosis of Osteoarthritis •30-Day Trial Within the Last Year of ANY of the Following: •NSAIDS (Celecoxib (Celebrex), Naproxen, Ibuprofen, Flurbiprofen, Nabumetone, Diclofenac, Etodolac, Indomethacin, Ketoprofen, Meloxicam, Oxaprozin, Sulindac or Piroxicam) AND •Set Up and Send to RPh •Clinical Reason Why the Requested Patch is Required when the TOPICAL VOLTAREN GEL has Failed •After a 30-Day Trial Within the Last Year of TOPICAL VOLTAREN GEL •Quantity Limit 60 Patches/26 Days	1 year
FLEQSUVY 25 MG/5 ML SUSPENSION	•Diagnosis of spasticity resulting from multiple sclerosis or spinal cord injury •Inability to swallow generic baclofen tablets or Fleqsuvy (Fleqsuvy also requires auth.)	1 year
FLEQSUVY 25 MG/5 ML SUSPENSION	•Diagnosis of spasticity resulting from multiple sclerosis or spinal cord injury •Inability to swallow generic baclofen tablets or Fleqsuvy (Fleqsuvy also requires auth.)	1 year
FLUAD 2018-2019 SYRINGE	•Under the Age of 19: Use the Vaccines for Children (VFC) Program •Age Of 19 and Over: If Billing to the Medical Benefit, No PA Is Required OR •If Billing to The Pharmacy Benefit, No PA Is Required. However, Pharmacy MUST Bill Using the Broader Vaccine Network (BVN)	N/A

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FLUARIX QUAD 2018-2019 SYRINGE	•Under the Age of 19: Use the Vaccines for Children (VFC) Program •Age Of 19 and Over: If Billing to the Medical Benefit, No PA Is Required OR •If Billing to The Pharmacy Benefit, No PA Is Required. However, Pharmacy MUST Bill Using the Broader Vaccine Network (BVN)	N/A
FLUBLOK QUAD 2018-2019 SYRINGE	•Under the Age of 19: Use the Vaccines for Children (VFC) Program •Age Of 19 and Over: If Billing to the Medical Benefit, No PA Is Required OR •If Billing to The Pharmacy Benefit, No PA Is Required. However, Pharmacy MUST Bill Using the Broader Vaccine Network (BVN)	N/A
FLUCELVAX QUAD 2018-2019 SYR	•Under the Age of 19: Use the Vaccines for Children (VFC) Program •Age Of 19 and Over: If Billing to the Medical Benefit, No PA Is Required OR •If Billing to The Pharmacy Benefit, No PA Is Required. However, Pharmacy MUST Bill Using the Broader Vaccine Network (BVN)	N/A
FLUCELVAX QUAD 2018-2019 VIAL	•Under the Age of 19: Use the Vaccines for Children (VFC) Program •Age Of 19 and Over: If Billing to the Medical Benefit, No PA Is Required OR •If Billing to The Pharmacy Benefit, No PA Is Required. However, Pharmacy MUST Bill Using the Broader Vaccine Network (BVN)	N/A
FLUCYTOSINE 250 MG CAPSULE	•Diagnosis of Cryptococcus Meningitis •One Time Trial of: Fluconazole OR •Diagnosis of Candida; UTI, Septicemia, and Pulmonary •One Time Trial of: Fluconazole or Ketoconazole	30 Days
FLUCYTOSINE 500 MG CAPSULE	•Diagnosis of Cryptococcus Meningitis •One Time Trial of: Fluconazole OR •Diagnosis of Candida; UTI, Septicemia, and Pulmonary •One Time Trial of: Fluconazole or Ketoconazole	30 Days
FLULAVAL QUAD 2018-2019 VIAL	•Under the Age of 19: Use the Vaccines for Children (VFC) Program •Age Of 19 and Over: If Billing to the Medical Benefit, No PA Is Required OR •If Billing to The Pharmacy Benefit, No PA Is Required. However, Pharmacy MUST Bill Using the Broader Vaccine Network (BVN)	N/A
FLUMIST QUAD NASAL 2018-19 VAC	•Clinical Reason Supported by Chart Notes Why the Below Cannot Be Used: •Afluria Quad, Fluad, Fluad Quad, Fluarix Quad, Flublok Quad, Flucelvax Quad, Flulaval Quad, Fluzone HD, Fluzone Quad •VFC Rules Still Apply: •Under Age of 19: Use The Vaccines For Children (VFC) Program •Age Of 19 And Over: Pharmacy Must Bill Using The Broader Vaccine Network (BVN)	10 Days
FLUMIST QUAD NASAL 2019-20 VAC	•Clinical Reason Supported by Chart Notes Why the Below Cannot Be Used: •Afluria Quad, Fluad, Fluad Quad, Fluarix Quad, Flublok Quad, Flucelvax Quad, Flulaval Quad, Fluzone HD, Fluzone Quad •VFC Rules Still Apply: •Under Age of 19: Use The Vaccines For Children (VFC) Program •Age Of 19 And Over: Pharmacy Must Bill Using The Broader Vaccine Network (BVN)	12 Days
FLUMIST QUAD NASAL 2020-21 VAC	•Clinical Reason Supported by Chart Notes Why the Below Cannot Be Used: •Afluria Quad, Fluad, Fluad Quad, Fluarix Quad, Flublok Quad, Flucelvax Quad, Flulaval Quad, Fluzone HD, Fluzone Quad •VFC Rules Still Apply: •Under Age of 19: Use The Vaccines For Children (VFC) Program •Age Of 19 And Over: Pharmacy Must Bill Using The Broader Vaccine Network (BVN)	14 Days
FLUNISOLIDE 0.025% SPRAY	• 30 day trial and failure of fluticasone nasal spray	1 year
FLUOCINOLONE OIL 0.01% EAR DRP	Diagnosis of Chronic Eczematous External Otitis (Chronic Itchiness and Inflammation of the Ear Canal)	3 Months
FLUOCINONIDE 0.05% CREAM	• 14 days trial in the last 120 days of one of the following: betamethasone dipropionate augmented crm 0.05% (DIPROLENE AF) betamethasone dipropionate augmented lotion 0.05% (DIPROLENE) betamethasone dipropionate crm, lotion 0.05% desoximetasone crm 0.25% (TOPICORT) fluocinonide soln 0.05% triamcinolone acetonide crm, oint 0.5% OR • Diagnosis of Atopic Dermatitis (Extrinsic [allergic], Intrinsic [non-allergic] eczema) or Psoriasis OR • Prescriber specialty Dermatology or Rheumatology	1 year

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Drug Name	Criteria	Approval Duration
FLUOCINONIDE 0.05% GEL	• 14 days trial in the last 120 days of one of the following: betamethasone dipropionate augmented crm 0.05% (DIPROLENE AF) betamethasone dipropionate augmented lotion 0.05% (DIPROLENE) betamethasone dipropionate crm, lotion 0.05% desoximetasone crm 0.25% (TOPICORT) fluocinonide soln 0.05% triamcinolone acetonide crm, oint 0.5% OR • Diagnosis of Atopic Dermatitis (Extrinsic [allergic], Intrinsic [non-allergic] eczema) or Psoriasis OR • Prescriber specialty Dermatology or Rheumatology	1 year
FLUOCINONIDE 0.05% OINTMENT	• 14 days trial in the last 120 days of one of the following: betamethasone dipropionate augmented crm 0.05% (DIPROLENE AF) betamethasone dipropionate augmented lotion 0.05% (DIPROLENE) betamethasone dipropionate crm, lotion 0.05% desoximetasone crm 0.25% (TOPICORT) fluocinonide soln 0.05% triamcinolone acetonide crm, oint 0.5% OR • Diagnosis of Atopic Dermatitis (Extrinsic [allergic], Intrinsic [non-allergic] eczema) or Psoriasis OR • Prescriber specialty Dermatology or Rheumatology	1 year
FLUOXETINE HCL 10 MG TABLET	Clinical reason supported by chart notes why (after a Trial of) fluoxetine capsules cannot be used	1 year
FLUOXETINE HCL 20 MG TABLET	Clinical reason supported by chart notes why (after a Trial of) fluoxetine capsules cannot be used	1 year
FLUOXETINE HCL 60 MG TABLET	Clinical reason supported by chart notes why (after a Trial of) the below cannot be used: fluoxetine (10mg, 20mg, 40mg, or 20 mg/5 ml soln)	1 year
FLURANDRENOLIDE 0.05% CREAM	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of: 2 Different Agents For 30 Days Each• Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05%	1 year
FLURANDRENOLIDE 0.05% LOTION	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of: 2 Different Agents For 30 Days Each• Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05%	1 year
FLUTICASONE PROP 0.05% LOTION	Clinical reason supported by chart notes why (after a 90 day Trial of) the following cannot be used: Fluticasone Propionate (Cutivate) 0.05% cream or Fluticasone Propionate (Cutivate) 0.005% ointment OR For use on scalp: • Age 2-11 years: Trial of betamethasone DP 0.05% lotion, betamethasone valerate 0.1% lotion • Age 12-17 years: Trial of bethamethasone DP 0.05% lotion, betamethasone valerate 0.1% lotion, Mometasone (Elocon) 0.1% lotion • Age 18 and older: Trial of betamethasone DP 0.05% lotion, betamethasone valerate 0.1% lotion, Mometasone (Elocon) 0.1% Lotion, fluocinolone 0.01% Topical solution	1 year
FLUVASTATIN ER 80 MG TABLET	30 Day Trial Within The Last Year Of: Simvastatin (Zocor) Or Atorvastatin (Lipitor)	1 year
FLUVASTATIN SODIUM 20 MG CAP	30 Day Trial Within The Last Year Of: Simvastatin (Zocor) Or Atorvastatin (Lipitor)	1 year
FLUVASTATIN SODIUM 40 MG CAP	30 Day Trial Within The Last Year Of: Simvastatin (Zocor) Or Atorvastatin (Lipitor)	1 year

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FLUVOXAMINE ER 100 MG CAPSULE	30 day trials of two of the three following groups (one must be within the last year): • Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) • Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); • Bupropion XL Or SR (Wellbutrin SR Or XL)	1 year
FLUVOXAMINE ER 150 MG CAPSULE	30 day trials of two of the three following groups (one must be within the last year): • Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) • Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); • Bupropion XL Or SR (Wellbutrin SR Or XL)	1 year
FLUZONE HIGH-DOSE 2018-19 SYR	•Under the Age of 19: Use the Vaccines for Children (VFC) Program •Age Of 19 and Over: If Billing to the Medical Benefit, No PA Is Required OR •If Billing to The Pharmacy Benefit, No PA Is Required. However, Pharmacy MUST Bill Using the Broader Vaccine Network (BVN)	N/A
FLUZONE QUAD 2018-2019 SYRINGE	•Under the Age of 19: Use the Vaccines for Children (VFC) Program •Age Of 19 and Over: If Billing to the Medical Benefit, No PA Is Required OR •If Billing to The Pharmacy Benefit, No PA Is Required. However, Pharmacy MUST Bill Using the Broader Vaccine Network (BVN)	N/A
FLUZONE QUAD 2018-2019 VIAL	•Under the Age of 19: Use the Vaccines for Children (VFC) Program •Age Of 19 and Over: If Billing to the Medical Benefit, No PA Is Required OR •If Billing to The Pharmacy Benefit, No PA Is Required. However, Pharmacy MUST Bill Using the Broader Vaccine Network (BVN)	N/A
FLUZONE QUAD PEDI 2018-19 SYR	•Under the Age of 19: Use the Vaccines for Children (VFC) Program •Age Of 19 and Over: If Billing to the Medical Benefit, No PA Is Required OR •If Billing to The Pharmacy Benefit, No PA Is Required. However, Pharmacy MUST Bill Using the Broader Vaccine Network (BVN)	N/A
FREESTYLE LIBRE 10 DAY READER	•Member is 18 years of age or older •Member has a diagnosis Diabetes (type 1 or type 2) •Currently utilizing 3 or more injections of insulin per day (must have claims in last 120 days)	1 year
FREESTYLE LIBRE 10 DAY SENSOR	•Member is 18 years of age or older •Member has a diagnosis Diabetes (type 1 or type 2) •Currently utilizing 3 or more injections of insulin per day (must have claims in last 120 days)	1 year
FREESTYLE LIBRE 14 DAY READER	•Member is 18 years of age or older •Member has a diagnosis Diabetes (type 1 or type 2) •Currently utilizing 3 or more injections of insulin per day (must have claims in last 120 days)	1 year
FREESTYLE LIBRE 14 DAY SENSOR	•Member is 18 years of age or older •Member has a diagnosis Diabetes (type 1 or type 2) •Currently utilizing 3 or more injections of insulin per day (must have claims in last 120 days)	1 year
FREESTYLE LIBRE 2 READER	•Member is 4 years of age or older •Member has a diagnosis Diabetes (type 1 or type 2) •Currently utilizing 3 or more injections of insulin per day (must have claims in last 120 days)	1 year
FREESTYLE LIBRE 2 SENSOR	•Member is 4 years of age or older •Member has a diagnosis Diabetes (type 1 or type 2) •Currently utilizing 3 or more injections of insulin per day (must have claims in last 120 days)	1 year
FREESTYLE LIBRE 3 SENSOR	•Member is 4 years of age or older •Member has a diagnosis Diabetes (type 1 or type 2) •Currently utilizing 3 or more injections of insulin per day (must have claims in last 120 days)	1 year
FROVATRIPTAN SUCC 2.5 MG TAB	•Age 6-17 Years Old: A One Time Trial of Sumatriptan Tablets, Injection, or Nasal Spray or Rizatriptan •Age 18 And Older: A One Time Trial of At Least 2 Of The Following 4 Drugs: Sumatriptan Tablets, Injection, or Nasal Spray, Naratriptan, Rizatriptan or Almotriptan (Axert)	1 year

Drug Name	Criteria	Approval Duration
FYCOMPA 0.5 MG/ML ORAL SUSP	• Previously Approved For And Currently Using Aptiom, Banzel, Lyrica, Onfi, Potiga Or Vimpat OR • Trial of 30 Days Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
FYCOMPA 10 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Lyrica, Onfi, Potiga Or Vimpat OR • Trial of 30 Days Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
FYCOMPA 12 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Lyrica, Onfi, Potiga Or Vimpat OR • Trial of 30 Days Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
FYCOMPA 2 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Lyrica, Onfi, Potiga Or Vimpat OR • Trial of 30 Days Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
FYCOMPA 4 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Lyrica, Onfi, Potiga Or Vimpat OR • Trial of 30 Days Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
FYCOMPA 6 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Lyrica, Onfi, Potiga Or Vimpat OR • Trial of 30 Days Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
FYCOMPA 8 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Lyrica, Onfi, Potiga Or Vimpat OR • Trial of 30 Days Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
GATIFLOXACIN 0.5% EYE DROPS	•Diagnosis of Cataract Surgery or Corneal Ulcer/Keratitis OR •Diagnosis of Conjunctivitis •One Time Trial of: Ciprofloxacin or Ofloxacin Ophthalmic	30 Days
GATIFLOXACIN 0.5%-DEXAMET 0.1%	•Diagnosis of Cataract Surgery or Corneal Ulcer/Keratitis OR •Diagnosis of Conjunctivitis •One Time Trial of: Ciprofloxacin or Ofloxacin Ophthalmic	30 Days
GELNIQUE 10% GEL PUMP	A 90-Day Trial of Oxybutynin, Oxybutynin XL or Oxybutynin Syrup	1 year
GELNIQUE 10% GEL SACHET	A 90-Day Trial of Oxybutynin, Oxybutynin XL or Oxybutynin Syrup	1 year
GLATIRAMER 20 MG/ML SYRINGE	• Age 18 years of age or older • Diagnosis of relapsing remitting multiple sclerosis	1 year
GLYCINE 1.5% IRRIGATION	Trial of: Normal Saline	1 year
GLYCOPYRROLATE 1 MG/5 ML SOLN	Age < 12 or documented inability to swallow tablets	1 year

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Drug Name	Criteria	Approval Duration
GRASTEK 2,800 BAU SL TABLET	•Member is 5 to 65 years of age •Prescribed by or in consultation with an allergist or immunologist •Diagnosis of grass pollen-induced allergic rhinitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens •Trial and failure of conventional pharmacotherapy (i.e., antihistamines, nasal steroids) •Does NOT have evidence of severe, unstable, or uncontrolled asthma	1 year
GRASTEK 2,800 BAU SL TABLET	•Member is 5 to 65 years of age •Prescribed by or in consultation with an allergist or immunologist •Diagnosis of grass pollen-induced allergic rhinitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens •Trial and failure of conventional pharmacotherapy (i.e., antihistamines, nasal steroids) •Does NOT have evidence of severe, unstable, or uncontrolled asthma	1 year
GUANIDINE HCL 125 MG TABLET	Diagnosis of Myasthenic Syndrome of Eaton-Lambert	1 year
GYNAZOLE 1 2% CREAM	One time Trial of one of the following: miconazole nitrate vaginal suppositories, clotrimazole vaginal cream 1% or 2%, terconazole 0.4% or 0.8%, or tioconazole (Vagistat-1, Monistat-1) 6.5% ointment	30 days
HALCINONIDE 0.1% CREAM	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of two of the following for 7 days each: Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone)	1 year
HALOBETASOL PROP 0.05% CREAM	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of: 2 Different Agents For 7 Days Each• Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone)	1 year
HALOBETASOL PROP 0.05% FOAM	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of: 2 Different Agents For 7 Days Each• Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone)	1 year
HALOG 0.1% OINTMENT	•Diagnosis of Atopic Dermatitis (Eczema) •Trial Of: 2 Different Agents For 30 Days Each •Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone) •Quantity Limit 60 Grams (1 Tube)/26 Days	1 year
HELIDAC THERAPY PACK	Approve for 30 Days Due To Tetracycline Backorder	30 Days
HUMALOG 100 UNIT/ML CARTRIDGE	*Clinical reason why (after a 90 day trial) insulin lispro cannot be used	1 year
HUMALOG 200 UNIT/ML KWIKPEN	*Clinical reason why (after a 90 day trial of) insulin lispro cannot be used	1 year
HUMALOG JR 100 UNIT/ML KWIKPEN	*Clinical reason why (after a 90 day trial of) insulin lispro cannot be used OR *Member requires half-unit dosing	1 year
HUMALOG MIX 50-50 KWIKPEN	*Clinical reason why (after a 90 day trial of) insulin lispro cannot be used OR *Clinical reason why this formulation is medically necessary when single-ingredient insulins are available	1 year
HUMALOG MIX 75-25 KWIKPEN	*Clinical reason why (after a 90 day trial of) insulin lispro cannot be used OR *Clinical reason why this formulation is medically necessary when single-ingredient insulins are available	1 year

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Drug Name	Criteria	Approval Duration
HYDROCODONE ER 10 MG CAPSULE	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
HYDROCODONE ER 15 MG CAPSULE	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
HYDROCODONE ER 20 MG CAPSULE	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
HYDROCODONE ER 30 MG CAPSULE	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
HYDROCODONE ER 40 MG CAPSULE	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
HYDROCODONE ER 50 MG CAPSULE	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
HYDROCODONE-ACETAMIN 10-300 MG	For Initial Authorizations: •Clinical Reason After A 30 Day Trial/Failure That the Following Cannot Continue Hydrocodone-Acetaminophen Containing 325 mg Acetaminophen (Trial Per Pharmacy Claims or Doctor Notes with Trial Dates Listed) OR •If Diagnosis Is One of The Following, Approve X 1 Year: A) Active Cancer Treatment or Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia. If Diagnosis Is One of The Following, Approve X 6 Months: A) Severe Burns, B) Traumatic Crushing of Tissue, C) Amputation, D) Major Orthopedic Surgery OR •If Diagnosis Is Moderate to Severe Pain (List Diagnosis Code), AND •Member on Opioids < 90 Days in the Past 120 Days (Naïve Utilizer): •Dose is < 50 MED (Hydrocodone 5 mg = 12 Tabs/Day, 7.5 mg = 8 Tabs/Day, 10 mg = 6 Tabs/Day) •Member Has Experienced an Inadequate Response, Intolerance or Contraindication To At Least 2 Preferred Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, and Antidepressants) •Prescriber Attests to Discussing Benefits/Risks of Opioids with Member •Prescriber Attests to Checking State PDMP •Approve as Requested up to 90 days, up to 50 MED ((Hydrocodone 5 mg = 12 Tabs/Day, 7.5 mg = 8 Tabs/Day, 10 mg = 6 Tabs/Day) •Member on Opioids > 90 Days in the Past 120 Days (Chronic Utilizer): •Dose is < 50 MED (Hydrocodone 5 mg = 12 Tabs/Day, 7.5 mg = 8 Tabs/Day, 10 mg = 6 Tabs/Day) •Prescriber Attests to Discussing Benefits/Risks of Opioids with Member •Prescriber Attests to Checking State PDMP Duration of therapy: •Less Than 90 Days = Approve X 90 Days up to 50 MED (Hydrocodone 5 mg = 12 Tabs/Day, 7.5 mg = 8 Tabs/Day, 10 mg = 6 Tabs/Day) If More Than 90 Days: •If Dose is > 80 MED, Prescriber is Pain Management, Pain Management Consulted, or Pain Management Unavailable and Rationale for Higher Dose	Per Criteria
HYDROCODONE-ACETAMIN 10-325 MG	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
HYDROCODONE-ACETAMIN 5-325 MG	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
HYDROCODONE-ACETAMIN 7.5-325	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
HYDROCODONE-ACETAMN 7.5-325/15	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
HYDROCODONE-CHLORPHEN ER SUSP	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
HYDROCODONE-HOMATROPINE SOLN	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
HYDROCODONE-IBUPROFEN 10-200	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
HYDROCODONE-IBUPROFEN 5-200 MG	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
HYDROCODONE-IBUPROFEN 7.5-200	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
HYDROCORTISONE BUTYR 0.1% OINT	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of two of the following for 7 days each: Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone)	1 year

Drug Name	Criteria	Approval Duration
HYDROCORTISONE BUTYR 0.1% SOLN	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of two of the following for 7 days each: Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone)	1 year
HYDROMORPHONE 1 MG/ML SOLUTION	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
HYDROMORPHONE 2 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
HYDROMORPHONE 4 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
HYDROMORPHONE 5 MG/5 ML SOLN	**Initial Authorization: *Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery *OR* *Diagnosis is moderate to severe pain (with diagnosis code) AND *Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants), Prescriber attests to discussing the benefits/risks of opioids with member, Prescriber attests to checking state PDMP *OR* *Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED, prescriber attests to discussing the benefits/risks of opioids with member, prescriber attests to checking state PDMP, duration of therapy is <90 days *Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED, prescriber attests to discussing the benefits/risks of opioids with member, prescriber attests to checking state PDMP. *If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose. *Prescriber attests to patient specific treatment plan. *Prescriber attests to assessing for addiction risk or mental health concerns. *If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk. **REAUTHORIZATION *Meets all initial criteria *AND* *Prescriber attests to or submits documentation supporting benefit of continued therapy outweighs risks to patient safety.	1 year

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Drug Name	Criteria	Approval Duration
HYDROMORPHONE 8 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
HYDROMORPHONE HCL ER 12 MG TAB	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
HYDROMORPHONE HCL ER 16 MG TAB	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
HYDROMORPHONE HCL ER 32 MG TAB	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
HYDROMORPHONE HCL ER 8 MG TAB	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
HYPER-SAL 7% VIAL	90 Day Trial Of: Sodium Chloride 7% Nebulizing Solution	1 year
IBSRELA 50 MG TABLET	•Diagnosis of Irritable Bowel Syndrome with Constipation •Clinical Reason Why After a 90-day Trial of Trulance (Requires PA) Cannot be Used	1 year
IBUDONE 5-200 MG TABLET	For Initial Authorizations: •Clinical reason after a 30-day trial/failure that the following cannot continue hydrocodone-ibuprofen 7.5 mg-200 mg (trial per pharmacy claims or doctor notes with trial dates listed) OR •If diagnosis is one of the following, approve for 1 year: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia. If diagnosis is one of the following, approve x 6 months: A) severe burns, B) traumatic crushing of tissue, C) amputation, D) major orthopedic surgery OR •If diagnosis is moderate to severe pain (list diagnosis code), AND •Member on opioids < 90 days in the past 120 days (naïve utilizer): •Dose is < 50 MED (Hydrocodone 5 mg = 12 tabs/day, 10 mg = 6 tabs/day) •Member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) •Prescriber attests to discussing benefits/risks of opioids with member •Prescriber attests to checking state PDMP •Approve as requested up to 90 days, up to 50 MED (Hydrocodone 5 mg = 12 tabs/day, 10 mg = 6 tabs/day) •Member on opioids > 90 days in the past 120 days (chronic utilizer): •Dose is < 50 MED (Hydrocodone 5 mg = 12 tabs/day, 7.5 mg = 8 tabs/day, 10 mg = 6 tabs/day) •Prescriber attests to discussing benefits/risks of opioids with member •Prescriber attests to checking state PDMP •Duration of therapy: •Less than 90 days = approve x 90 days up to 50 MED (Hydrocodone 5 mg = 12 tabs/day, 10 mg = 6 tabs/day) •If more than 90 days: •If dose is > 80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose •Prescriber attests to patient specific treatment plan	Per Criteria
IBUPAK KIT	• Clinical reason why (after a 90 day trial each) ibuprofen tablets or suspension alone cannot be used	1 year
IMIQUIMOD 5% CREAM PACKET	•Diagnosis of actinic keratosis Approval duration: 16 weeks OR • Diagnosis of external genital warts Approval duration: 16 weeks OR • Diagnosis of superficial basal cell carcinoma Approval duration: 6 weeks	6 weeks

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Drug Name	Criteria	Approval Duration
INSULIN ASPART 100 UNIT/ML CRT	•Clinical Reason why (after a 90-day Trial) insulin lispro Cannot Be Used •Quantity Limit 1 mL/Day •Note: 1 Vial = 1,000 Units	1 year
INSULIN ASPART 100 UNIT/ML PEN	•Clinical Reason why (After a 90-Day Trial) insulin lispro Cannot be Used •Quantity Limit 1 mL/Day •Tech May Approve Quantity Greater Than 1 mL/Day if SIG (Directions) on PA Form Match Quantity Requested •Note: 1 Box (15 mL) = 1,500 Units	1 year
INSULIN ASPART PRO MIX70-30 PN	*Clinical reason why (after a 90 day trial of) insulin lispro cannot be used OR *Clinical reason why this formulation is medically necessary when single-ingredient insulins are available	1 year
INSULIN GLARGINE 100 UNIT/ML	*30 day trial of insulin glargine-yfgn	1 year
INTRAROSA 6.5 MG VAG INSERT	Excluded Benefit	N/A
INVEGA HAFYERA 1,092 MG/3.5 ML	• At least 18 years of age • Diagnosis of schizophrenia • Member has been on Invega Sustenna for at least 4 months OR Invega Trinza for 3 months • Quantity limit: 1 prefilled syringe per 6 months • Approve x 1 year; renew if clinically stable	1 year
INVEGA HAFYERA 1,560 MG/5 ML	• At least 18 years of age • Diagnosis of schizophrenia • Member has been on Invega Sustenna for at least 4 months OR Invega Trinza for 3 months • Quantity limit: 1 prefilled syringe per 6 months • Approve x 1 year; renew if clinically stable	1 year
INVOKANA 100 MG TABLET	Clinical Reason why (After a 90-Day Trial) Steglatro Cannot be Used	1 year
INVOKANA 300 MG TABLET	Clinical Reason why (After a 90-Day Trial) Steglatro Cannot be Used	1 year
IOPIDINE 1% EYE DROPS	• Trial of brimonidine ophthalmic 0.2%	1 year
ISOTRETINOIN 10 MG CAPSULE	•Diagnosis of Non-Hodgkin's Lymphoma or Prophylaxis of Non-Melanoma Skin Cancers OR •Diagnosis of Acne •Trials Of 90 Days Total of the Below (at least 1 topical AND at least 1 oral totaling 90 days) Either at The Same Time, Separately, Or Overlapping: •Topicals: Benzoyl Peroxide 5% Or 10%; Benzoyl Peroxide 4% Or 8% Liquid (Panoxyl), Erythromycin/Benzoyl (Benzamycin), Sulfacetamide (Klaron), Clindamycin Topical (Cleocin T), Erythromycin Topical, Tretinoin Cream or Gel or Adapalene 0.1% Gel Or Cream [Or Previously Approved For And Currently Using: Tazorac, Benzamycin, Acanya, Akne-Mycin, Or Tretinoin Microsphere] AND •Orals: Minocycline, Doxycycline, Tetracycline, or Erythromycin •Quantity Limit 60 Capsules/26 Days	1 year
ISOTRETINOIN 20 MG CAPSULE	•Diagnosis of Non-Hodgkin's Lymphoma or Prophylaxis of Non-Melanoma Skin Cancers OR •Diagnosis of Acne •Trials Of 90 Days Total of the Below (at least 1 topical AND at least 1 oral totaling 90 days) Either at The Same Time, Separately, Or Overlapping: •Topicals: Benzoyl Peroxide 5% Or 10%; Benzoyl Peroxide 4% Or 8% Liquid (Panoxyl), Erythromycin/Benzoyl (Benzamycin), Sulfacetamide (Klaron), Clindamycin Topical (Cleocin T), Erythromycin Topical, Tretinoin Cream or Gel or Adapalene 0.1% Gel Or Cream [Or Previously Approved For And Currently Using: Tazorac, Benzamycin, Acanya, Akne-Mycin, Or Tretinoin Microsphere] AND •Orals: Minocycline, Doxycycline, Tetracycline, or Erythromycin •Quantity Limit 60 Capsules/26 Days	1 year

Drug Name	Criteria	Approval Duration
ISOTRETINOIN 30 MG CAPSULE	•Diagnosis of Non-Hodgkin's Lymphoma or Prophylaxis of Non-Melanoma Skin Cancers OR •Diagnosis of Acne •Trials Of 90 Days Total of the Below (at least 1 topical AND at least 1 oral totaling 90 days) Either at The Same Time, Separately, Or Overlapping: •Topicals: Benzoyl Peroxide 5% Or 10%; Benzoyl Peroxide 4% Or 8% Liquid (Panoxyl), Erythromycin/Benzoyl (Benzamycin), Sulfacetamide (Klaron), Clindamycin Topical (Cleocin T), Erythromycin Topical, Tretinoin Cream or Gel or Adapalene 0.1% Gel Or Cream [Or Previously Approved For And Currently Using: Tazorac, Benzamycin, Acanya, Akne-Mycin, Or Tretinoin Microsphere] AND •Orals: Minocycline, Doxycycline, Tetracycline, or Erythromycin •Quantity Limit 60 Capsules/26 Days	1 year
ISOTRETINOIN 40 MG CAPSULE	•Diagnosis of Non-Hodgkin's Lymphoma or Prophylaxis of Non-Melanoma Skin Cancers OR •Diagnosis of Acne •Trials Of 90 Days Total of the Below (at least 1 topical AND at least 1 oral totaling 90 days) Either at The Same Time, Separately, Or Overlapping: •Topicals: Benzoyl Peroxide 5% Or 10%; Benzoyl Peroxide 4% Or 8% Liquid (Panoxyl), Erythromycin/Benzoyl (Benzamycin), Sulfacetamide (Klaron), Clindamycin Topical (Cleocin T), Erythromycin Topical, Tretinoin Cream or Gel or Adapalene 0.1% Gel Or Cream [Or Previously Approved For And Currently Using: Tazorac, Benzamycin, Acanya, Akne-Mycin, Or Tretinoin Microsphere] AND •Orals: Minocycline, Doxycycline, Tetracycline, or Erythromycin •Quantity Limit 60 Capsules/26 Days	1 year
ISOXSUPRINE 10 MG TABLET	Diagnosis of Cerebrovascular Insufficiency (Stroke or TIA (Transient Ischemic Attack) or Peripheral Vascular Disease (Arteriosclerosis Obliterans, Thromboangitis Obliteranse (Buerger Disease), or Raynaud Disease)	1 year
ISRADIPINE 2.5 MG CAPSULE	90 day Trial of: Amlodipine, Felodipine or Nifedipine	1 year
ISRADIPINE 5 MG CAPSULE	90 day Trial of: Amlodipine, Felodipine or Nifedipine	1 year
ITRACONAZOLE 10 MG/ML SOLUTION	One Time Trial of: Fluconazole Oral Solution	3 Months
IVERMECTIN 0.5% LOTION	•Diagnosis of Head Lice (for age 6 months and older) •One Time Trial within the last 30 day per age group below: •Age 6 Months up to 2 Years old: Lice Treatment Liquid 1%, Permethrin (Rid Foam), Spinosad (Natroba), Benzyl Alcohol Lotion (Ulesfia) •Age 2 Years - 3 Years: Lice Treatment Liquid 1%, Permethrin (Rid Foam), Pyrethrins-Piperonyl Butoxide, Pronto Plus (Rid Liquid), Lice-Aid (Tegrin-LT), Lice Killing Shampoo (Pronto), Stop Lice Kit (Rid Complete Kit), Benzyl Alcohol Lotion (Ulesfia), Or Spinosad (Natroba) •Age 4 Years To 5 Years Old: Lice Treatment Liquid 1%, Permethrin (Rid Foam), Pyrethrins-Piperonyl Butoxide, Pronto Plus (Rid Liquid), Lice-Aid (Tegrin-Lt), Lice Killing Shampoo (Pronto), Stop Lice Kit (Rid Complete Kit), Benzyl Alcohol Lotion (Ulesfia) Or Spinosad (Natroba) •Age 6 Years and Older: Lice Treatment Liquid 1%, Permethrin (Rid Foam), Pyrethrins-Piperonyl Butoxide, Pronto Plus (Rid Liquid), Lice-Aid (Tegrin-Lt), Lice Killing Shampoo (Pronto), Stop Lice Kit (Rid Complete Kit), Spinosad (Natroba), Benzyl Alcohol Lotion (Ulesfia) Or Malathion (Ovide) •Quantity Limit 117 mL (1 box)/26 Days	30 Days
IVERMECTIN 1% CREAM	•Diagnosis of Rosacea with Inflammatory Lesions in Adults (18+) •Trial and Failure of the Following for at Least 3 Months: Oral Minocycline OR Doxycycline, AND Topical Metronidazole •Quantity Limit 30 Grams (1 Tube)/26 days	3 Months for Initial Authorizations 12 Months for Re-Authorizations
JANUMET 50-1,000 MG TABLET	•30 Day Trial Of: Metformin IR or Metformin ER (Glucophage or Glucophage ER) - [Not Required If: HBA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect to Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)] THEN •60 Day Trial Of: Jentadueto Tablets (Which Also Requires A PA)	1 year
JANUMET 50-500 MG TABLET	•30 Day Trial Of: Metformin IR or Metformin ER (Glucophage or Glucophage ER) - [Not Required If: HBA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect to Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)] THEN •60 Day Trial Of: Jentadueto Tablets (Which Also Requires A PA)	1 year
JANUMET XR 100-1,000 MG TABLET	•30 Day Trial Of: Metformin IR or Metformin ER (Glucophage or Glucophage ER) - [Not Required If: HBA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect to Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)] THEN •60 Day Trial Of: Jentadueto Tablets (Which Also Requires A PA)	1 year

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JANUMET XR 50-1,000 MG TABLET	•30 Day Trial Of: Metformin IR or Metformin ER (Glucophage or Glucophage ER) - [Not Required If: HBA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect to Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)] THEN •60 Day Trial Of: Jentadueto Tablets (Which Also Requires A PA)	1 year
JANUMET XR 50-500 MG TABLET	•30 Day Trial Of: Metformin IR or Metformin ER (Glucophage or Glucophage ER) - [Not Required If: HBA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect to Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)] THEN •60 Day Trial Of: Jentadueto Tablets (Which Also Requires A PA)	1 year
JANUVIA 100 MG TABLET	•30 Day Trial Of: Metformin IR or Metformin ER (Glucophage or Glucophage ER) - [Not Required If: HBA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect to Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)] THEN •60 Day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), Alogliptin-Pioglitazone (Oseni), or Tradjenta Tablets (Which Also Requires A PA)	1 year
JANUVIA 25 MG TABLET	•30 Day Trial Of: Metformin IR or Metformin ER (Glucophage or Glucophage ER) - [Not Required If: HBA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect to Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)] THEN •60 Day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), Alogliptin-Pioglitazone (Oseni), or Tradjenta Tablets (Which Also Requires A PA)	1 year
JANUVIA 50 MG TABLET	•30 Day Trial Of: Metformin IR or Metformin ER (Glucophage or Glucophage ER) - [Not Required If: HBA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect to Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)] THEN •60 Day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), Alogliptin-Pioglitazone (Oseni), or Tradjenta Tablets (Which Also Requires A PA)	1 year
JARDIANCE 10 MG TABLET	•Criteria for heart failure (10 mg tablet only) •Diagnosis of NYHA class II, III, or IV heart failure •Member has an ejection fraction > 40% or member has a previous trial and failure with either an ARNi, ACEi or ARB •Quantity Limit 30 tablets per 30 days •Renew x 1 year if positive clinical response •Criteria for diabetes •30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)] •Quantity Limit 30 tablets per 30 days •Renew x 1 year if positive clinical response	1 Year
JARDIANCE 25 MG TABLET	•Criteria for heart failure (10 mg tablet only) •Diagnosis of NYHA class II, III, or IV heart failure •Member has an ejection fraction > 40% or member has a previous trial and failure with either an ARNi, ACEi or ARB •Quantity Limit 30 tablets per 30 days •Renew x 1 year if positive clinical response •Criteria for diabetes •30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)] •Quantity Limit 30 tablets per 30 days •Renew x 1 year if positive clinical response	1 Year
JATENZO 158 MG CAPSULE	•Male at least 18 years of age •Member has a documented diagnosis of hypogonadism associated with a structural or genetic etiology, and Jatenzo is NOT being prescribed for age-related low testosterone •Documentation of below normal serum testosterone labs (less than 300 ng/dL) from at least 2 separate readings (on different mornings) •Member has signs/symptoms of testosterone deficiency •Trial and failure of at least 2 preferred alternative testosterone products •QL: 120 capsules per 30 days •Renew x 12 mo if lab results show testosterone levels are within range per the assay reference level	6 Months

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JATENZO 198 MG CAPSULE	•Male at least 18 years of age •Member has a documented diagnosis of hypogonadism associated with a structural or genetic etiology, and Jatenzo is NOT being prescribed for age-related low testosterone •Documentation of below normal serum testosterone labs (less than 300 ng/dL) from at least 2 separate readings (on different mornings) •Member has signs/symptoms of testosterone deficiency •Trial and failure of at least 2 preferred alternative testosterone products •QL: 120 capsules per 30 days •Renew x 12 mo if lab results show testosterone levels are within range per the assay reference level	6 Months
JATENZO 237 MG CAPSULE	•Male at least 18 years of age •Member has a documented diagnosis of hypogonadism associated with a structural or genetic etiology, and Jatenzo is NOT being prescribed for age-related low testosterone •Documentation of below normal serum testosterone labs (less than 300 ng/dL) from at least 2 separate readings (on different mornings) •Member has signs/symptoms of testosterone deficiency •Trial and failure of at least 2 preferred alternative testosterone products •QL: 120 capsules per 30 days •Renew x 12 mo if lab results show testosterone levels are within range per the assay reference level	6 Months
JENTADUETO 2.5 MG-1000 MG TAB	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)	1 year
JENTADUETO 2.5 MG-500 MG TAB	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)	1 year
JENTADUETO 2.5 MG-850 MG TAB	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)	1 year
JENTADUETO XR 2.5 MG-1,000 MG	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)	1 year
JENTADUETO XR 5 MG-1,000 MG TB	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)	1 year
JUBLIA 10% TOPICAL SOLUTION	•90 Day Trial of: Ciclopirox (Penlac, Ciclodan) 8% Solution Within All Claims History AND •30 Day Trial of: Oral Terbinafine or Oral Itraconazole •Quantity Limit 4 mL (1 bottle)/26 Days	60 Days
KADIAN ER 200 MG CAPSULE	•Do Not CC Even If Previously Approved by CareSource •Member is 18 Years or Older •Diagnosis of Cancer Related Pain, Sickle Cell Disease, Terminally Ill, or Hospice OR •Set Up and Send to RPh •Member is 18 Years or Older •Diagnosis of Chronic Non-Cancer Related Pain •Prescribed by Pain Management Specialist •Documented Inadequate Response to Immediate Release Opioid Therapy (Examples = Hydrocodone/Acetaminophen, Oxycodone/Acetaminophen, Oxycodone, etc.) with Use of IR Opioid in Last 30 Days Supported by Pharmacy Claims •No Claims for Buprenorphine-Naloxone, Buprenorphine, Naloxone, or Naltrexone in the Past 12 Months •Information on How Strength/Dose/Frequency of Immediate Release Opioid Will Change •Quantity Limit 30 Capsules/27 Days	3 Months for Pain/Pain Management, Burns, Terminally Ill, Hospice 6 Months for Cancer Related Pain, Sickle Cell Anemia
KATERZIA 1 MG/ML SUSPENSION	• No PA if under 12 years of age; all others must have documented medical necessity for why they cannot use generic amlodipine tablets.	1 Year
KERENDIA 10 MG TABLET	• At least 18 years of age • Diagnoses of type 2 diabetes AND chronic kidney disease (CKD) • eGFR must be at least 25 • Serum potassium must be less than 5 mEq/L • Concurrent use of an ACEi or ARB • Trial and failure of an SGLT2 inhibitor (Invokana or Farxiga) • Quantity: 30 tablets per 30 days • Duration: 1 year; renew if positive clinical response	1 year
KERENDIA 20 MG TABLET	• At least 18 years of age • Diagnoses of type 2 diabetes AND chronic kidney disease (CKD) • eGFR must be at least 25 • Serum potassium must be less than 5 mEq/L • Concurrent use of an ACEi or ARB • Trial and failure of an SGLT2 inhibitor (Invokana or Farxiga) • Quantity: 30 tablets per 30 days • Duration: 1 year; renew if positive clinical response	1 year

Drug Name	Criteria	Approval Duration
KETOCONAZOLE 2% FOAM	• 30-Day Trial of: Ketoconazole (Nizoral) 2% Shampoo or Ketoconazole (Kuric) 2% Cream • Quantity Limit 100 Grams (1 Bottle)/26 Days	30 Days
KETOPROFEN ER 200 MG CAPSULE	• 30 day trial and failure of IR ketoprofen	1 year
KIMYRSA 1,200 MG VIAL	• Patient must be ≥ 18 years of age. • Diagnosis of an acute bacterial skin/skin structure infection (ABSSSI) likely due to a gram-positive organism • Previous trial and failure of vancomycin • Recent culture and sensitivity (C&S) results • Quantity Limit 1 vial per 1 day • No reauthorization as this is a one-time dose	7 Days
K-PHOS ORIGINAL TABLET	• Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: • Formulary Potassium Supplement	1 year
LACOSAMIDE 100 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
LACOSAMIDE 100 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
LACOSAMIDE 100 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
LACOSAMIDE 100 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
LACOSAMIDE 150 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year

Drug Name	Criteria	Approval Duration
LACOSAMIDE 150 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
LACOSAMIDE 200 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
LACOSAMIDE 200 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
LACOSAMIDE 200 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
LACOSAMIDE 200 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
LACOSAMIDE 50 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
LACOSAMIDE 50 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year

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LACOSAMIDE 50 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
LACOSAMIDE 50 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
LAMIVUDINE 100 MG TABLET	**Diagnosis of chronic hepatitis B. **Prescribed by infectious disease specialist, gastroenterologist, hepatologist or transplant physician	1 year
LANOXIN 187.5 MCG TABLET	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Digoxin, Digitek (Lanoxin) 125 mcg Tablet or Digoxin, Digitek (Lanoxin) 250 mcg Tablet	1 year
LANSOPRAZOLE DR 30 MG CAPSULE	•Do Not Approve Even If Previously Approved •Clinical Reason Why OTC Lansoprazole/Prevacid Cannot be Used After a 90-Day Trial of OTC Formulation •Quantity Limit 2 Capsules/Day	6 Months for GERD 1 Year for Barrett's, Zollinger and Continuous Therapy with Concurrent Medication
LANSOPRAZOLE ODT 15 MG TABLET	•May Approve If Diagnosis of Autism or Asperger's OR •May Approve If Member Has A G Or J Tube And Is Unable To Use Other Agents OR •After A 30 Day Trial of The Below Cannot Be Used: •Lansoprazole Capsules (Which Can Be Opened and Sprinkled On 1 Tablespoon of Applesauce or Emptied Into 60 mL Of Apple, Orange, Or Tomato Juice) OR First Lansoprazole 3 mg/mL Suspension	1 year
LANSOPRAZOLE ODT 30 MG TABLET	•May Approve If Diagnosis of Autism or Asperger's OR •May Approve If Member Has A G Or J Tube And Is Unable To Use Other Agents OR •After A 30 Day Trial of The Below Cannot Be Used: •Lansoprazole Capsules (Which Can Be Opened and Sprinkled On 1 Tablespoon of Applesauce or Emptied Into 60 mL Of Apple, Orange, Or Tomato Juice) OR First Lansoprazole 3 mg/mL Suspension	1 year
LANTUS 100 UNIT/ML VIAL	•Must Have 30-Day Trial of Insulin Glargine-Yfgn •Dose Up To 40 mL/30 Days	1 year
LASTACAFT 0.25% EYE DROPS	Member is pregnant OR Age 2-3 years old OR • 15 day Trial of OTC Ketotifen (Refresh/Zyrtec Eye Drops/Wal-Zyr/Alaway/Claritin Eye Drops/RiteAid or CVS Eye Itch EYE DROPS (Zaditor) AND • 15 day Trial of azelastine (Optivar)	3 months
LATUDA 120 MG TABLET	• Diagnosis of Bipolar Depression OR • Diagnosis of Schizophrenia • 30 day trial of at least two of the following: Aripiprazole (Abilify), Risperidone (Risperdal), Clozapine (Clozaril), Olanzapine (Zyprexa), Quetiapine IR or ER (Seroquel or XR) Or Ziprasidone (Geodon) Schizophrenia	1 year

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LATUDA 20 MG TABLET	• Diagnosis of Bipolar Depression OR • Diagnosis of Schizophrenia • 30 day trial of at least two of the following: Aripiprazole (Abilify), Risperidone (Risperdal), Clozapine (Clozaril), Olanzapine (Zyprexa), Quetiapine IR or ER (Seroquel or XR) Or Ziprasidone (Geodon) Schizophrenia	1 year
LATUDA 40 MG TABLET	• Diagnosis of Bipolar Depression OR • Diagnosis of Schizophrenia • 30 day trial of at least two of the following: Aripiprazole (Abilify), Risperidone (Risperdal), Clozapine (Clozaril), Olanzapine (Zyprexa), Quetiapine IR or ER (Seroquel or XR) Or Ziprasidone (Geodon) Schizophrenia	1 year
LATUDA 60 MG TABLET	• Diagnosis of Bipolar Depression OR • Diagnosis of Schizophrenia • 30 day trial of at least two of the following: Aripiprazole (Abilify), Risperidone (Risperdal), Clozapine (Clozaril), Olanzapine (Zyprexa), Quetiapine IR or ER (Seroquel or XR) Or Ziprasidone (Geodon) Schizophrenia	1 year
LATUDA 80 MG TABLET	• Diagnosis of Bipolar Depression OR • Diagnosis of Schizophrenia • 30 day trial of at least two of the following: Aripiprazole (Abilify), Risperidone (Risperdal), Clozapine (Clozaril), Olanzapine (Zyprexa), Quetiapine IR or ER (Seroquel or XR) Or Ziprasidone (Geodon) Schizophrenia	1 year
LETROZOLE 2.5 MG TABLET	Diagnosis of Breast Cancer	1 year
LEVALBUTEROL 0.31 MG/3 ML SOL	•If Fax States Intolerance or Side Effect to Albuterol (Examples: Tachycardia, Jitteriness, Shaking, Increased Heart Rate, Agitation, etc.) OR •30-Day Trial of Albuterol Inhalation Solution •Quantity Limit 0.31 mg = 1,080 mL/Month	1 year
LEVALBUTEROL 0.63 MG/3 ML SOL	•If Fax States Intolerance or Side Effect to Albuterol (Examples: Tachycardia, Jitteriness, Shaking, Increased Heart Rate, Agitation, etc.) OR •30-Day Trial of Albuterol Inhalation Solution •Quantity Limit 0.63 mg = 540 mL/Month	1 year
LEVALBUTEROL 1.25 MG/3 ML SOL	•If Fax States Intolerance or Side Effect to Albuterol (Examples: Tachycardia, Jitteriness, Shaking, Increased Heart Rate, Agitation, etc.) OR •30-Day Trial of Albuterol Inhalation Solution •Quantity Limit 1.25 mg = 270 mL/Month	1 year
LEVALBUTEROL CONC 1.25 MG/0.5	•If Fax States Intolerance or Side Effect to Albuterol (Examples: Tachycardia, Jitteriness, Shaking, Increased Heart Rate, Agitation, etc.) OR •30-Day Trial of Albuterol Inhalation Solution •Quantity Limit 90 mL (6 Boxes)/30 Days	1 year
LEVOFLOXACIN 0.5% EYE DROPS	One Time Trial of: Ciprofloxacin or Ofloxacin Ophthalmic	30 Days

Drug Name	Criteria	Approval Duration
LEVORPHANOL 2 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
LEVORPHANOL 3 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
LEVULAN KERASTICK	Diagnosis of For the treatment of Non-Hyperkeratotic Actinic Keratoses of the Face or Scalp	1 year
LIDOCAINE 5% OINTMENT	•30 Day Trial of: Lidocaine 2% Gel, Lidocaine 3% Cream, or Lidocaine 4% Cream •Quantity Limit 50 Grams (1 Tube/26 Days]	1 year
LIDOCAINE 5% PATCH	•30-Day Trial of Lidocaine 4% Patch •Quantity Limit 1 Patch/Day	1 year
LIDOCAINE HCL 4% SOLUTION	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •If Being Administered Orally: Lidocaine Viscous 2% •If Being Administered Nasally: Approve •If Being Administered Topically: Lidocaine 3% Cream or Lidocaine 4% Cream •Quantity Limit 50 mL/26 Days]	30 Days

Drug Name	Criteria	Approval Duration
LIDOCAINE-HC 3-0.5% CREAM	• Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: • Lidocaine 3% Cream AND Hydrocortisone 0.5% Cream used at the same time at the Same Time	30 Days
LIDOCAINE-HC 3-0.5% CREAM KIT	• Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: • Lidocaine 3% Cream AND Hydrocortisone 0.5% Cream used at the same time at the Same Time	30 Days
LIDOCAINE-HC 3-2.5% GEL KIT	• Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: • Lidocaine 3% Cream with Hydrocortisone, Proctosol-HC, Proctozone, Proctocream, Proctocare (Anusol-HC) 2.5% Cream used at the same time	30 Days
LIDOCAINE-TETRACAINE 7%-7% CRM	30-Day Trial of: Lidocaine-Prilocaine Cream 2.5-2.5%	30 Days
LIDOPRIL XR 2.5-2.5% CRM-DRESS	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 year
LIDO-PRILO CAINE PACK	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 year
LINEZOLID 100 MG/5 ML SUSP	Diagnosis of Vancomycin IV-Resistant Enterococcus (VRE) or Pneumonia; Skin And Skin Structure Infections	30 Days
LINEZOLID 600 MG TABLET	Diagnosis of Vancomycin IV-Resistant Enterococcus (VRE) or Diagnosis of Pneumonia, Skin And Skin Structure Infections (Including but not limited to MRSA)	30 days
LIVIXIL PAK 2.5-2.5% CRM-DRESS	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 year
LO LOESTRIN FE 1-10 TABLET	• Trial of: Any Formulary Birth Control	1 year
LOKELMA 10 GRAM POWDER PACKET	• Diagnosis of Hyperkalemia • Prescribed by or in Consultation with a Nephrologist or Cardiologist • Prior Attempt of any ONE of the Following Approaches to Reduce the Modifiable Risks for Hyperkalemia: • Dose Reduction of Renin-Angiotensin-Aldosterone System (RAAS) Inhibitors (e.g., Lisinopril, Enalapril, Valsartan, Losartan, Spironolactone) • Prior Treatment with Loop or Thiazide Diuretics (e.g., Furosemide, Bumetanide, Torsemide, Hydrochlorothiazide, Chlorthalidone) • Previous trial and failure, intolerance or contraindication to oral sodium polystyrene sulfonate	As Requested, Up to 1 Year
LOKELMA 10 GRAM POWDER PACKET	• Diagnosis of Hyperkalemia • Prescribed by or in Consultation with a Nephrologist or Cardiologist • Prior Attempt of any ONE of the Following Approaches to Reduce the Modifiable Risks for Hyperkalemia: Dose Reduction of renin-Angiotensin-Aldosterone System (RAAS) Inhibitors (ex. Lisinopril, Enalapril, Valsartan, Losartan, Spironolactone) OR Prior Treatment with Loop or Thiaizide Diuretics (ex. Furosemide, Bumetanide, Torsemide, Hydrochlorothiazide, Chlorthalidone) • Previous trial and failure, intolerance or contraindication to oral sodium polystyrene sulfonate	1 year
LOKELMA 10 GRAM POWDER PACKET	• Diagnosis of Hyperkalemia • Prescribed by or in Consultation with a Nephrologist or Cardiologist • Prior Attempt of any ONE of the Following Approaches to Reduce the Modifiable Risks for Hyperkalemia: Dose Reduction of renin-Angiotensin-Aldosterone System (RAAS) Inhibitors (ex. Lisinopril, Enalapril, Valsartan, Losartan, Spironolactone) OR Prior Treatment with Loop or Thiaizide Diuretics (ex. Furosemide, Bumetanide, Torsemide, Hydrochlorothiazide, Chlorthalidone) • Previous trial and failure, intolerance or contraindication to oral sodium polystyrene sulfonate	1 year
LOKELMA 10 GRAM POWDER PACKET	• Diagnosis of Hyperkalemia • Prescribed by or in Consultation with a Nephrologist or Cardiologist • Prior Attempt of any ONE of the Following Approaches to Reduce the Modifiable Risks for Hyperkalemia: Dose Reduction of renin-Angiotensin-Aldosterone System (RAAS) Inhibitors (ex. Lisinopril, Enalapril, Valsartan, Losartan, Spironolactone) OR Prior Treatment with Loop or Thiaizide Diuretics (ex. Furosemide, Bumetanide, Torsemide, Hydrochlorothiazide, Chlorthalidone) • Previous trial and failure, intolerance or contraindication to oral sodium polystyrene sulfonate	1 year

Drug Name	Criteria	Approval Duration
LOKELMA 5 GRAM POWDER PACKET	•Diagnosis of Hyperkalemia •Prescribed by or in Consultation with a Nephrologist or Cardiologist •Prior Attempt of any ONE of the Following Approaches to Reduce the Modifiable Risks for Hyperkalemia: •Dose Reduction of Renin-Angiotensin-Aldosterone System (RAAS) Inhibitors (e.g., Lisinopril, Enalapril, Valsartan, Losartan, Spironolactone) •Prior Treatment with Loop or Thiazide Diuretics (e.g., Furosemide, Bumetanide, Torsemide, Hydrochlorothiazide, Chlorthalidone) •Previous trial and failure, intolerance or contraindication to oral sodium polystyrene sulfonate	As Requested, Up to 1 Year
LOKELMA 5 GRAM POWDER PACKET	•Diagnosis of Hyperkalemia •Prescribed by or in Consultation with a Nephrologist or Cardiologist •Prior Attempt of any ONE of the Following Approaches to Reduce the Modifiable Risks for Hyperkalemia: Dose Reduction of renin-Angiotensin-Aldosterone System (RAAS) Inhibitors (ex. Lisinopril, Enalapril, Valsartan, Losartan, Spironolactone) OR Prior Treatment with Loop or Thiaizide Diuretics (ex. Furosemide, Bumetanide, Torsemide, Hydrochlorothiazide, Chlorthalidone) •Previous trial and failure, intolerance or contraindication to oral sodium polystyrene sulfonate	1 year
LOKELMA 5 GRAM POWDER PACKET	•Diagnosis of Hyperkalemia •Prescribed by or in Consultation with a Nephrologist or Cardiologist •Prior Attempt of any ONE of the Following Approaches to Reduce the Modifiable Risks for Hyperkalemia: Dose Reduction of renin-Angiotensin-Aldosterone System (RAAS) Inhibitors (ex. Lisinopril, Enalapril, Valsartan, Losartan, Spironolactone) OR Prior Treatment with Loop or Thiaizide Diuretics (ex. Furosemide, Bumetanide, Torsemide, Hydrochlorothiazide, Chlorthalidone) •Previous trial and failure, intolerance or contraindication to oral sodium polystyrene sulfonate	1 year
LOKELMA 5 GRAM POWDER PACKET	•Diagnosis of Hyperkalemia •Prescribed by or in Consultation with a Nephrologist or Cardiologist •Prior Attempt of any ONE of the Following Approaches to Reduce the Modifiable Risks for Hyperkalemia: Dose Reduction of renin-Angiotensin-Aldosterone System (RAAS) Inhibitors (ex. Lisinopril, Enalapril, Valsartan, Losartan, Spironolactone) OR Prior Treatment with Loop or Thiaizide Diuretics (ex. Furosemide, Bumetanide, Torsemide, Hydrochlorothiazide, Chlorthalidone) •Previous trial and failure, intolerance or contraindication to oral sodium polystyrene sulfonate	1 year
LORCET 5-325 MG TABLET	**Initial Authorization: *Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery *OR* *Diagnosis is moderate to severe pain (with diagnosis code) AND *Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants), Prescriber attests to discussing the benefits/risks of opioids with member, Prescriber attests to checking state PDMP *OR* *Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED, prescriber attests to discussing the benefits/risks of opioids with member, prescriber attests to checking state PDMP, duration of therapy is <90 days *Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED, prescriber attests to discussing the benefits/risks of opioids with member, prescriber attests to checking state PDMP. *If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose. *Prescriber attests to patient specific treatment plan. *Prescriber attests to assessing for addiction risk or mental health concerns. *If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk. **REAUTHORIZATION *Meets all initial criteria *AND* *Prescriber attests to or submits documentation supporting benefit of continued therapy outweighs risks to patient safety.	As requested, up to 6 months

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Drug Name	Criteria	Approval Duration
LORCET HD 10-325 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
LORCET PLUS 7.5-325 MG TABLET	**Initial Authorization: *Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery *OR* *Diagnosis is moderate to severe pain (with diagnosis code) AND *Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants), Prescriber attests to discussing the benefits/risks of opioids with member, Prescriber attests to checking state PDMP *OR* *Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED, prescriber attests to discussing the benefits/risks of opioids with member, prescriber attests to checking state PDMP, duration of therapy is <90 days *Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED, prescriber attests to discussing the benefits/risks of opioids with member, prescriber attests to checking state PDMP. *If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose. *Prescriber attests to patient specific treatment plan. *Prescriber attests to assessing for addiction risk or mental health concerns. *If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk. **REAUTHORIZATION *Meets all initial criteria *AND* *Prescriber attests to or submits documentation supporting benefit of continued therapy outweighs risks to patient safety.	As requested, up to 6 months
LOREEV XR 1 MG CAPSULE	•Minimum age 18 years •Documented diagnosis of anxiety disorder •Currently receiving stable, evenly divided, three times daily dosing with lorazepam tablets; lorazepam tablets will be stopped when Loreex XR is initiated. •Duration: 4 months; renew x 6 months if positive clinical response and benefit outweighs risks for continuation.	Intitial Authorization: 4 months Reauthorization: 6 months
LOREEV XR 1.5 MG CAPSULE	•Minimum age 18 years •Documented diagnosis of anxiety disorder •Currently receiving stable, evenly divided, three times daily dosing with lorazepam tablets; lorazepam tablets will be stopped when Loreex XR is initiated. •Duration: 4 months; renew x 6 months if positive clinical response and benefit outweighs risks for continuation.	Intitial Authorization: 4 months Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
LOREEV XR 2 MG CAPSULE	•Minimum age 18 years •Documented diagnosis of anxiety disorder •Currently receiving stable, evenly divided, three times daily dosing with lorazepam tablets; lorazepam tablets will be stopped when Loreex XR is initiated. •Duration: 4 months; renew x 6 months if positive clinical response and benefit outweighs risks for continuation.	Intitial Authorization: 4 months Reauthorization: 6 months
LOREEV XR 3 MG CAPSULE	•Minimum age 18 years •Documented diagnosis of anxiety disorder •Currently receiving stable, evenly divided, three times daily dosing with lorazepam tablets; lorazepam tablets will be stopped when Loreex XR is initiated. •Duration: 4 months; renew x 6 months if positive clinical response and benefit outweighs risks for continuation.	Intitial Authorization: 4 months Reauthorization: 6 months
LUBIPROSTONE 24 MCG CAPSULE	• 7 day trial within the last 60 days of one of the following: Methylcellulose (Citrucel), Psyllium (Metamucil), Polyethylene glycol (Miralax), Bisacodyl (Dulcolax), Senna (Senokot), Docusate (Colace), Lactulose, or Sorbitol QL = 60/26 days	1 year
LUBIPROSTONE 8 MCG CAPSULE	• 7 day trial within the last 60 days of one of the following: Methylcellulose (Citrucel), Psyllium (Metamucil), Polyethylene glycol (Miralax), Bisacodyl (Dulcolax), Senna (Senokot), Docusate (Colace), Lactulose, or Sorbitol QL = 60/26 days	1 year
LULICONAZOLE 1% CREAM	30 day Trial of ketoconazole clotrimazole, Lamisil gel, or terbinafine cream	30 days
LUMIGAN 0.01% EYE DROPS	30 day Trial of: Latanoprost 0.005% Eye Drops	1 year
LUPANETA PK 11.25-5 MG 3MO KIT	•Diagnosis of Endometriosis (One 6 Month Authorization Only) •30-Day Trial of Both: NSAIDs AND Contraceptives	6 Months
LUPANETA PK 3.75-5 MG 1MO KIT	•Diagnosis of Endometriosis (One 6 Month Authorization Only) •30-Day Trial of Both: NSAIDs AND Contraceptives	6 Months
LYBALVI 10-10 MG TABLET	• At least 18 years of age • Diagnosis of schizophrenia or bipolar I disorder • Trial and failure of olanzapine due to weight gain after 4 weeks but with some level of demonstrated efficacy; OR trial and failure of at least 2 preferred second-generation oral antipsychotics with failure due to weight gain • Member does NOT have dementia-related psychosis • Member is NOT using ANY opioids or undergoing acute opioid withdrawal. (Initiation of Lybalvi must be delayed at least 7 days after the last use of short-acting opioids and 14 days after long-acting opioids). • Quantity limit: 30 tablets per 30 days • Approve x 1 year; renew if clinically stable	1 year
LYBALVI 15-10 MG TABLET	• At least 18 years of age • Diagnosis of schizophrenia or bipolar I disorder • Trial and failure of olanzapine due to weight gain after 4 weeks but with some level of demonstrated efficacy; OR trial and failure of at least 2 preferred second-generation oral antipsychotics with failure due to weight gain • Member does NOT have dementia-related psychosis • Member is NOT using ANY opioids or undergoing acute opioid withdrawal. (Initiation of Lybalvi must be delayed at least 7 days after the last use of short-acting opioids and 14 days after long-acting opioids). • Quantity limit: 30 tablets per 30 days • Approve x 1 year; renew if clinically stable	1 year
LYBALVI 20-10 MG TABLET	• At least 18 years of age • Diagnosis of schizophrenia or bipolar I disorder • Trial and failure of olanzapine due to weight gain after 4 weeks but with some level of demonstrated efficacy; OR trial and failure of at least 2 preferred second-generation oral antipsychotics with failure due to weight gain • Member does NOT have dementia-related psychosis • Member is NOT using ANY opioids or undergoing acute opioid withdrawal. (Initiation of Lybalvi must be delayed at least 7 days after the last use of short-acting opioids and 14 days after long-acting opioids). • Quantity limit: 30 tablets per 30 days • Approve x 1 year; renew if clinically stable	1 year

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Drug Name	Criteria	Approval Duration
LYBALVI 5-10 MG TABLET	• At least 18 years of age • Diagnosis of schizophrenia or bipolar I disorder • Trial and failure of olanzapine due to weight gain after 4 weeks but with some level of demonstrated efficacy; OR trial and failure of at least 2 preferred second-generation oral antipsychotics with failure due to weight gain • Member does NOT have dementia-related psychosis • Member is NOT using ANY opioids or undergoing acute opioid withdrawal. (Initiation of Lybalvi must be delayed at least 7 days after the last use of short-acting opioids and 14 days after long-acting opioids). • Quantity limit: 30 tablets per 30 days • Approve x 1 year; renew if clinically stable	1 year
LYLLANA 0.025 MG PATCH	•Clinical Reason Why After a 30-Day Trial of the Following Cannot be Used: Estradiol (Climara) Patch or Alora Patch •Quantity Limit 8 Patches/Month	1 year
LYLLANA 0.0375 MG PATCH	•Clinical Reason Why After a 30-Day Trial of the Following Cannot be Used: Estradiol (Climara) Patch or Alora Patch •Quantity Limit 8 Patches/Month	1 year
LYLLANA 0.05 MG PATCH	•Clinical Reason Why After a 30-Day Trial of the Following Cannot be Used: Estradiol (Climara) Patch or Alora Patch •Quantity Limit 8 Patches/Month	1 year
LYLLANA 0.075 MG PATCH	•Clinical Reason Why After a 30-Day Trial of the Following Cannot be Used: Estradiol (Climara) Patch or Alora Patch •Quantity Limit 8 Patches/Month	1 year
LYLLANA 0.1 MG PATCH	•Clinical Reason Why After a 30-Day Trial of the Following Cannot be Used: Estradiol (Climara) Patch or Alora Patch •Quantity Limit 8 Patches/Month	1 year
LYUMJEV 100 UNIT/ML KWIKPEN	• Clinical Reason Supported By Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: insulin lispro • QL 1 mL/day (regardless of strength).	1 year
LYUMJEV 200 UNIT/ML KWIKPEN	• Clinical Reason Supported By Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: insulin lispro • QL 1 mL/day (regardless of strength).	1 year
LYVISPAH 10 MG GRANULE PACKET	•Diagnosis of spasticity resulting from multiple sclerosis or spinal cord injury •Inability to swallow generic baclofen tablets	1 year
LYVISPAH 20 MG GRANULE PACKET	•Diagnosis of spasticity resulting from multiple sclerosis or spinal cord injury •Inability to swallow generic baclofen tablets	1 year
LYVISPAH 5 MG GRANULE PACKET	•Diagnosis of spasticity resulting from multiple sclerosis or spinal cord injury •Inability to swallow generic baclofen tablets	1 year
MEFENAMIC ACID 250 MG CAPSULE	•Currently on Warfarin (Supported by Claims) OR Aspirin (Supported by Claims or Chart Notes) OR •30-Day Trial of: Celecoxib (Celebrex), Naproxen, Ibuprofen, Flurbiprofen, Nabumetone, Diclofenac, Etodolac, Indomethacin, Ketoprofen, Meloxicam, Oxaprozin, Sulindac or Piroxicam	1 year
MEGESTROL 625 MG/5 ML SUSP	•Diagnosis of Anorexia, Cachexia, or an Unexplained, Significant Weight Loss AND •Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Megestrol Acetate (Megace) 40 mg/mL Suspension	1 year
MELODETTA 24 FE CHEWABLE TAB	•Trial Of: Any Formulary Birth Control •Not Required If: Member Has the Inability to Swallow	1 year
MELOXICAM 10 MG CAPSULE	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Meloxicam Suspension OR Tablet	1 year
MELOXICAM 5 MG CAPSULE	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Meloxicam Suspension OR Tablet	1 year
MENTAX 1% CREAM	30 day Trial of clotrimazole, ketoconazole, or miconazole AND Trial of Lotrimin ultra (butenafine hcl)	30 days

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Drug Name	Criteria	Approval Duration
MEPERIDINE 100 MG TABLET	For Initial Authorizations: •If Diagnosis Is One of The Following, Approve X 6 Months: A) Active Cancer Treatment or Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Severe Burns, F) Traumatic Crushing of Tissue, G) Amputation, H) Major Orthopedic Surgery OR If Diagnosis is Moderate to Severe Pain (List Diagnosis Code), AND Member on Opioids < 90 Days in the Past 120 Days (Naïve Utilizer): If Member is on a Benzo Within the Last 30 Days, Member Must be Naive for Both Benzo and Opioid (< 90/120 Days of Each) AND Days' Supply of Benzo and Opioid is < 7 Days for Each Product (If Member Exceeds this Limit, Please Review Benzo-Opioid Criteria Tab; if Member Meets Criteria, Continue to Next Bullet Point) Dose is < 50 MED Member Has Experienced an Inadequate Response, Intolerance, or Contraindication to at Least 2 Preferred Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, and Antidepressants) Prescriber Attests to Discussing Benefits/Risks of Opioids with Member Prescriber Attests to Checking State PDMP Approve as Requested up to 90 Days, up to Quantity Limit or 50 MED (Whichever is Lower) Member on Opioids > 90 Days in the Past 120 Days (Chronic Utilizer): Dose is < 50 MED Prescriber Attests to Discussing Benefits/Risks of Opioids with Member Prescriber Attests to Checking State PDMP Duration of Therapy: • Less Than 90 Days = Approve X 90 Days up to Quantity Limit or 50 MED (Whichever is Lower) • If More Than 90 Days: If Dose is > 80 MED, Prescriber is Pain Management, Pain Management Consulted, or Pain Management Unavailable and Rationale for Higher Dose Prescriber Attests to Patient Specific Treatment Plan	Per Criteria
MEPERIDINE 50 MG TABLET	For Initial Authorizations: •If Diagnosis Is One of The Following, Approve X 6 Months: A) Active Cancer Treatment or Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Severe Burns, F) Traumatic Crushing of Tissue, G) Amputation, H) Major Orthopedic Surgery OR If Diagnosis is Moderate to Severe Pain (List Diagnosis Code), AND Member on Opioids < 90 Days in the Past 120 Days (Naïve Utilizer): If Member is on a Benzo Within the Last 30 Days, Member Must be Naive for Both Benzo and Opioid (< 90/120 Days of Each) AND Days' Supply of Benzo and Opioid is < 7 Days for Each Product (If Member Exceeds this Limit, Please Review Benzo-Opioid Criteria Tab; if Member Meets Criteria, Continue to Next Bullet Point) Dose is < 50 MED Member Has Experienced an Inadequate Response, Intolerance, or Contraindication to at Least 2 Preferred Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, and Antidepressants) Prescriber Attests to Discussing Benefits/Risks of Opioids with Member Prescriber Attests to Checking State PDMP Approve as Requested up to 90 Days, up to Quantity Limit or 50 MED (Whichever is Lower) Member on Opioids > 90 Days in the Past 120 Days (Chronic Utilizer): Dose is < 50 MED Prescriber Attests to Discussing Benefits/Risks of Opioids with Member Prescriber Attests to Checking State PDMP Duration of Therapy: • Less Than 90 Days = Approve X 90 Days up to Quantity Limit or 50 MED (Whichever is Lower) • If More Than 90 Days: If Dose is > 80 MED, Prescriber is Pain Management, Pain Management Consulted, or Pain Management Unavailable and Rationale for Higher Dose Prescriber Attests to Patient Specific Treatment Plan	Per Criteria
MESALAMINE 4 GM/60 ML KIT	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Mesalamine (Rowasa) 4 GM/60 mL Enema	1 year
METAXALONE 400 MG TABLET	•7-Day Trial Within the Last 90 Days Of: Cyclobenzaprine, Baclofen, Methocarbomal, Or Tizanidine (Carisoprodol- Accepted Trial Not Preferred Agent) •Note: This Medication Will Pay with Electronic Step If There Is 7 Days of Cyclobenzaprine, Baclofen, Methocarbomal, Tizanidine or Carisoprodol Use in The Last 120 Days	1 year

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Drug Name	Criteria	Approval Duration
METAXALONE 800 MG TABLET	•7-Day Trial Within the Last 90 Days Of: Cyclobenzaprine, Baclofen, Methocarbomal, Or Tizanidine (Carisoprodol- Accepted Trial Not Preferred Agent) •Note: This Medication Will Pay with Electronic Step If There Is 7 Days of Cyclobenzaprine, Baclofen, Methocarbomal, Tizanidine or Carisoprodol Use in The Last 120 Days	1 year
METFORMIN HCL 500 MG/5 ML SOLN	• 30 day Trial of: metformin ER (Glucophage ER) AND • Clinical Reason Supported By Chart Notes Why The Liquid Is Required	1 year
METHADONE 10 MG/5 ML SOLUTION	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
METHADONE 10 MG/ML ORAL CONC	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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METHADONE 5 MG/5 ML SOLUTION	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
METHADONE HCL 10 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
METHADONE HCL 5 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
METHADONE INTENSOL 10 MG/ML	INITIAL AUTHORIZATION:*Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR*Diagnosis is moderate to severe chronic pain (INCLUDE DIAGNOSIS CODE) AND*Member's previous treatment plan included short-acting opioid for at least the last 60 days*Prescriber attests to checking prescription drug monitoring program*If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose*Prescriber attests to a patient specific treatment plan*If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine useREAUTHORIZATION*Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes). Documentation may be requested per RPH.*One of the following diagnoses, approve as requested up to 6 months: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation)*Diagnosis is moderate to severe chronic pain (please list specific diagnosis code in notes) with ALL of the following:*Member meets all initial criteria*If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	As requested, up to 6 months
METHERGINE 0.2 MG TABLET	• Clinical reason why, after a 30 day trial, methylergonovine tablets cannot be used	1 year
METHYLPHENIDATE ER 72 MG TAB	• 30 day trial of methylphenidate capsules or preferred strength of methylphenidate ER tablets (18mg, 27mg, 36mg, 54mg)	1 year
METHYLTESTOSTERONE 10 MG CAP	• Diagnosis of hypogonadism • Total Testosterone lab value = ≤ 300ng/dL before treatment (for new starts only) • Clinical reason supported by chart notes why (after a 90 day Trial of) the following cannot be used: Testosterone TD (Fortesta) or Testosterone (Androgel, Testim, Vogelxo) 1% (50 mg/5G) Gel Packet	1 year
METOPROLOL ER-HCTZ 100-12.5 MG	•Clinical Reason Why (After A 90 Day Trial Each) Two of The Following Groups Be Used: •Metoprolol/HCTZ 50 mg-25 mg, 100 mg-25 mg, 100 mg-50 mg OR •Metoprolol and Hydrochlorothiazide used at the same time	3 Months
METOPROLOL ER-HCTZ 25-12.5 MG	•Clinical Reason Why (After A 90 Day Trial Each) Two of The Following Groups Be Used: •Metoprolol/HCTZ 50 mg-25 mg, 100 mg-25 mg, 100 mg-50 mg OR •Metoprolol and Hydrochlorothiazide used at the same time	3 Months

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METOPROLOL ER-HCTZ 50-12.5 MG	•Clinical Reason Why (After A 90 Day Trial Each) Two of The Following Groups Be Used: •Metoprolol/HCTZ 50 mg-25 mg, 100 mg-25 mg, 100 mg-50 mg OR •Metoprolol and Hydrochlorothiazide used at the same time	3 Months
METOPROLOL TARTRATE 37.5 MG TB	30 Day Trial of: Metoprolol Tartrate 25 mg, 50 mg, or 100 mg Tablet	1 year
METOPROLOL TARTRATE 37.5 MG TB	30 Day Trial of: Metoprolol Tartrate 25 mg, 50 mg, or 100 mg Tablet	1 year
METOPROLOL TARTRATE 37.5 MG TB	30 Day Trial of: Metoprolol Tartrate 25 mg, 50 mg, or 100 mg Tablet	1 year
METOPROLOL TARTRATE 75 MG TAB	30 Day Trial of: Metoprolol Tartrate 25 mg, 50 mg, or 100 mg Tablet	1 year
METOPROLOL TARTRATE 75 MG TAB	30 Day Trial of: Metoprolol Tartrate 25 mg, 50 mg, or 100 mg Tablet	1 year
METRONIDAZOLE TOP 1% GEL PUMP	•Clinical Reason Supported by Chart Notes Why (After A One Time Trial Of) The Below Cannot Be Used: •Metronidazole 0.75% Topical Lotion, Cream, or Gel •Quantity Limit 60 Grams (1 Tube)/26 Days	1 year
METRONIDAZOLE TOPICAL 1% GEL	•Clinical Reason Supported by Chart Notes Why (After A One Time Trial Of) The Below Cannot Be Used: •Metronidazole 0.75% Topical Lotion, Cream, or Gel •Quantity Limit 60 Grams (1 Tube)/26 Days	1 year
METYROSINE 250 MG CAPSULE	• Diagnosis of Pheochromocytoma	1 year
MEXILETINE 150 MG CAPSULE	Diagnosis of Ventricular Arrhythmias	1 year
MEXILETINE 200 MG CAPSULE	Diagnosis of Ventricular Arrhythmias	1 year
MEXILETINE 250 MG CAPSULE	Diagnosis of Ventricular Arrhythmias	1 year
MIBELAS 24 FE CHEWABLE TABLET	•Trial Of: Any Formulary Birth Control •Not Required If: Member Has the Inability to Swallow	1 year
MIDAZOLAM 10 MG/2 ML SYRINGE	•No PA Required If ≤18 Years Old •If >18 Years Old: •Bill to Medical Benefit Unless •Being Used with Atomizer for Seizures (If States This Then Okay To Approve Through Pharmacy)	1 year
MIDAZOLAM 2 MG/2 ML ISECURE	•No PA Required If ≤18 Years Old •If >18 Years Old: •Bill to Medical Benefit Unless •Being Used with Atomizer for Seizures (If States This Then Okay To Approve Through Pharmacy)	1 year
MIDAZOLAM 5 MG/ML ISECURE SYR	•No PA Required If ≤18 Years Old •If >18 Years Old: •Bill to Medical Benefit Unless •Being Used with Atomizer for Seizures (If States This Then Okay To Approve Through Pharmacy)	1 year
MIDAZOLAM HCL 1 MG/ML VIAL	•No PA Required If ≤18 Years Old •If >18 Years Old: •Bill to Medical Benefit Unless •Being Used with Atomizer for Seizures (If States This Then Okay To Approve Through Pharmacy)	1 year
MIDAZOLAM HCL 1 MG/ML VIAL	•No PA Required If ≤18 Years Old •If >18 Years Old: •Bill to Medical Benefit Unless •Being Used with Atomizer for Seizures (If States This Then Okay To Approve Through Pharmacy)	1 year
MIDAZOLAM HCL 10 MG/10 ML VIAL	•No PA Required If ≤18 Years Old •If >18 Years Old: •Bill to Medical Benefit Unless •Being Used with Atomizer for Seizures (If States This Then Okay To Approve Through Pharmacy)	1 year
MIDAZOLAM HCL 10 MG/2 ML VIAL	•No PA Required If ≤18 Years Old •If >18 Years Old: •Bill to Medical Benefit Unless •Being Used with Atomizer for Seizures (If States This Then Okay To Approve Through Pharmacy)	1 year
MIDAZOLAM HCL 10 MG/2 ML VIAL	•No PA Required If ≤18 Years Old •If >18 Years Old: •Bill to Medical Benefit Unless •Being Used with Atomizer for Seizures (If States This Then Okay To Approve Through Pharmacy)	1 year
MIGLITOL 100 MG TABLET	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 year
MIGLITOL 25 MG TABLET	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 year

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MIGLITOL 50 MG TABLET	*30 Day Trial Of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 year
MILLIPRED 5 MG TABLET	One Time Trial of: Prednisone Tablet	30 Days
MINOCYCLINE ER 135 MG TABLET	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Minocycline	3 Months
MINOCYCLINE ER 45 MG TABLET	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Minocycline	3 Months
MINOCYCLINE ER 90 MG TABLET	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Minocycline	3 Months
MIRVASO 0.33% GEL	•Diagnosis Of Moderate to Severe Persistent Facial Erythema of Rosacea in Adults (18+) •Will Not Be Used in Combination with Rhofade •Re-Authorization Requirement: Chart Notes Showing Symptom Improvements •Quantity Limit 30 Grams/26 Days	3 Months for Initial Authorizations 12 Months for Re-Authorizations
MODAFINIL 100 MG TABLET	• Diagnosis of Narcolepsy, Cataplexy OR • Diagnosis of Obstructive sleep apnea • Documentation of CPAP or mandibular advancement device (if patient cannot use CPAP) OR • Diagnosis of Shift Work disorder Max dose = 200 mg daily	1 year
MODAFINIL 200 MG TABLET	• Diagnosis of Narcolepsy, Cataplexy OR • Diagnosis of Obstructive sleep apnea • Documentation of CPAP or mandibular advancement device (if patient cannot use CPAP) OR • Diagnosis of Shift Work disorder Max dose = 200 mg daily	1 year
MODERNA COVID(6M-5Y) VACC(EUA)	Age 6 months - 5 years old	
MODERNA COVID(6M-5Y) VACC(EUA)	Age 6 months - 5 years old	
MOLNUPIRAVIR 200 MG CAP (EUA)	Age ≥ 18 years	1 year
MOMETASONE FUROATE 50 MCG SPRY	• Diagnosis of Nasal Polyps OR Ages 2-3: 7 Day Trial Within The Last 90 Days Of: Nasacort OTC Allergy 24HR Spray OR Ages 4-5: 7 Day Trial Within The Last 90 Days Of: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Or Nasacort OTC Allergy 24HR Spray OR Ages 6 And Older: 7 Day Trial Within The Last 90 Days Of 2 Of The Following Drugs: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Flunisolide, Or Nasacort OTC Allergy 24HR Spray [Note: This Medication Will Pay With An Electronic Step If There Are 7 Days Of 2 Of The Following Drugs: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Flunisolide, Or Nasacort OTC Allergy 24HR Spray Use In The Last 120 Days] [Note: 1 Bottle Contains 120 Sprays]	1 year
MORGIDOX 1X100 MG KIT	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Doxycycline Monohydrate 50 mg or 100 mg Capsule, Doxycycline Monohydrate 75 mg Tablet, Doxycycline Hyclate 50 mg or 100 mg Capsule, Doxycyline Hyclate 20 mg or 100 mg Tablet with a Formulary Cleanser	30 Days

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MORPHABOND ER 100 MG TABLET	For Initial Authorizations: •30-Day Trial Each of Two of The Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program PMP Awarxe •If Cumulative Med Is > 80 Med/Day, Prescriber Must Be Pain Management Specialist or A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes) •Member Meets All Initial Criteria	Initial Authorization Up to 90 Days Up to 6 Months for Re-Authorization
MORPHABOND ER 15 MG TABLET	For Initial Authorizations: •30-Day Trial Each of Two of The Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program PMP Awarxe •If Cumulative Med Is > 80 Med/Day, Prescriber Must Be Pain Management Specialist or A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes) •Member Meets All Initial Criteria	Initial Authorization Up to 90 Days Up to 6 Months for Re-Authorization

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MORPHABOND ER 30 MG TABLET	For Initial Authorizations: •30-Day Trial Each of Two of The Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program PMP Awarxe •If Cumulative Med Is > 80 Med/Day, Prescriber Must Be Pain Management Specialist or A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes) •Member Meets All Initial Criteria	Initial Authorization Up to 90 Days Up to 6 Months for Re-Authorization
MORPHABOND ER 60 MG TABLET	For Initial Authorizations: •30-Day Trial Each of Two of The Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program PMP Awarxe •If Cumulative Med Is > 80 Med/Day, Prescriber Must Be Pain Management Specialist or A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes) •Member Meets All Initial Criteria	Initial Authorization Up to 90 Days Up to 6 Months for Re-Authorization

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Drug Name	Criteria	Approval Duration
MORPHINE SULF 10 MG SUPPOS	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
MORPHINE SULF 10 MG/5 ML SOLN	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
MORPHINE SULF 100 MG/5 ML CONC	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
MORPHINE SULF 20 MG SUPPOS	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

Drug Name	Criteria	Approval Duration
MORPHINE SULF 20 MG/5 ML SOLN	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
MORPHINE SULF 30 MG SUPPOS	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
MORPHINE SULF 5 MG SUPPOS	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
MORPHINE SULF ER 100 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
MORPHINE SULF ER 15 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
MORPHINE SULF ER 200 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
MORPHINE SULF ER 30 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
MORPHINE SULF ER 60 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
MORPHINE SULFATE ER 10 MG CAP	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
MORPHINE SULFATE ER 100 MG CAP	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
MORPHINE SULFATE ER 20 MG CAP	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
MORPHINE SULFATE ER 30 MG CAP	For Initial Authorizations: •30-Day Trial Each of Two of The Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program PMP Awarxe •If Cumulative Med Is > 80 Med/Day, Prescriber Must Be Pain Management Specialist or A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes) •Member Meets All Initial Criteria	Initial Authorization Up to 90 Days Up to 6 Months for Re-Authorization

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Drug Name	Criteria	Approval Duration
MORPHINE SULFATE ER 40 MG CAP	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
MORPHINE SULFATE ER 50 MG CAP	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
MORPHINE SULFATE ER 60 MG CAP	For Initial Authorizations: •30-Day Trial Each of Two of The Following: Fentanyl Transdermal Patch, Morphine Sulfate ER, or Oxymorphone ER (Non-Abuse Deterrent) •If Member Has One of The Following Diagnoses, Approve for Up To 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing Of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid For At Least The Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program PMP Awarxe •If Cumulative Med Is > 80 Med/Day, Prescriber Must Be Pain Management Specialist or A Pain Management Prescriber Unavailable to Patient and There Is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, Etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use For Re-Authorization: •Chart Notes (or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis Is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes) •Member Meets All Initial Criteria	Initial Authorization Up to 90 Days Up to 6 Months for Re-Authorization
MORPHINE SULFATE ER 80 MG CAP	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
MORPHINE SULFATE IR 15 MG TAB	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
MORPHINE SULFATE IR 30 MG TAB	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
MOVANTIK 12.5 MG TABLET	Currently taking Linzess, Amitiza or Movantik for at least the last 30 days OR 7 day Trial of Lactulose, Constulose, Enulose, Generlac, Kristalose, Smooth Lax, Polyethylene Glycol, Peg 3350, ClearLax, GentleLax, or PureLax (MiraLax) Powder in the last 30 days	1 year
MOVANTIK 25 MG TABLET	Currently taking Linzess, Amitiza or Movantik for at least the last 30 days OR 7 day Trial of Lactulose, Constulose, Enulose, Generlac, Kristalose, Smooth Lax, Polyethylene Glycol, Peg 3350, ClearLax, GentleLax, or PureLax (MiraLax) Powder in the last 30 days	1 year

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Drug Name	Criteria	Approval Duration
MOXIFLOXACIN 0.5% EYE DROPS	•Diagnosis of Cataract Surgery or Corneal Ulcer/Keratitis OR •Diagnosis of Conjunctivitis •One Time Trial Of: Ciprofloxacin or Ofloxacin Ophthalmic	30 Days
MOXIFLOXACIN HCL 400 MG TABLET	One Time Trial Of: Ciprofloxacin or Levofloxacin	30 Days
MUGARD ORAL WOUND RINSE	Diagnosis of Treating Sores and Ulcers in The Mouth Caused by Various Conditions (e.g., Radiation, Chemotherapy, Canker Sores, Surgery, Poorly Fitting Dentures)	1 year
MULTAQ 400 MG TABLET	Trial of: Flecainide, Propafenone, Sotalol, or Digoxin	1 year
MUPIROCIN 2% CREAM	•30 Day Trial of Mupirocin Ointment •Quantity Limit 15 Grams (1 Tube)/26 Days	30 Days
MYRBETRIQ ER 25 MG TABLET	30 Day Trial of at least one of the following: Oxybutynin, Oxybutynin XL, Tolterodine, Tolterodine ER, Trospium, Or Trospium XR	1 year
MYRBETRIQ ER 50 MG TABLET	30 Day Trial of at least one of the following: Oxybutynin, Oxybutynin XL, Tolterodine, Tolterodine ER, Trospium, Or Trospium XR	1 year
MYRBETRIQ ER 8 MG/ML SUSP	30 Day Trial of at least one of the following: Oxybutynin, Oxybutynin XL, Tolterodine, Tolterodine ER, Trospium, Or Trospium XR	1 year
MYTESI 125 MG DR TABLET	• Member Must Have A Diagnosis Of HIV Or AIDS And Be Receiving Antiretroviral Therapy • Documentation Of A 14 Day Trial of Loperamide Or Diphenoxylate-Atropine With Documentation In Chart Notes Of Clinical Failure • Must Have Documentation In Chart Notes Of Negative Results From Stool Cultures, C. Difficile Toxin Assay And Parasites Or Ova Examination To Rule Out Infectious-Diarrhea	1 year
NAFTIFINE HCL 1% CREAM	30 day Trial of ketoconazole, clotrimazole, Lamisil gel, terbinafine cream	60 days
NAFTIFINE HCL 1% GEL	30 day Trial of ketoconazole, clotrimazole, Lamisil gel, terbinafine cream	60 days
NAFTIFINE HCL 2% CREAM	30 day Trial of ketoconazole, clotrimazole, Lamisil gel, terbinafine cream	60 days
NAFTIN 2% GEL	•30 Day Trial of: Ketoconazole, Clotrimazole, Lamisil Gel, Terbinafine Cream •Quantity Limit 60 Grams (2%)/26 Days	60 Days
NAPROXEN 125 MG/5 ML SUSPEN	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: Naproxen Tablets (For Adults) or Ibuprofen Liquid or Chewable Tablets (For Children and/or Members Unable to Swallow) •Quantity Limit 120 mL/26 Days	1 year
NAPROXEN SOD CR 375 MG TABLET	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Naproxen DR (EC-Naprosyn) 375 mg Tablet or Naproxen DR (EC-Naprosyn) 500 mg Tablet	1 year
NAPROXEN SOD ER 500 MG TABLET	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Naproxen DR (EC-Naprosyn) 375 mg Tablet or Naproxen DR (EC-Naprosyn) 500 mg Tablet	1 year
NAPROXEN-ESOMEPRAZ DR 375-20MG	• Clinical Reason Supported By Chart Notes Why (After A 30 Day Trial of (Within All Pharmacy Claims)) The Below Cannot Be Used: • Omeprazole, Lansoprazole, Pantoprazole, OTC Nexium 20 mg. Or Esomeprazole (Nexium) 20 mg Or 40 mg AND Naproxen used at the same time	1 year
NAPROXEN-ESOMEPRAZ DR 500-20MG	• Clinical Reason Supported By Chart Notes Why (After A 30 Day Trial of (Within All Pharmacy Claims)) The Below Cannot Be Used: • Omeprazole, Lansoprazole, Pantoprazole, OTC Nexium 20 mg. Or Esomeprazole (Nexium) 20 mg Or 40 mg AND Naproxen used at the same time	1 year
NATAZIA 28 TABLET	Trial of: Any Formulary Birth Control	1 year
NATESTO NASAL 5.5 MG/0.122 GM	•Total Testosterone Lab Value = ≤ 300ng/dl Before Treatment (For New Starts Only) •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Testosterone TD (Fortesta) or Testosterone (Androgel, Testim, Vogelxo) 1% (50 mg/5 g) Gel Packet (Both Still Require a PA Also)	1 year
NATPARA 100 MCG DOSE CARTRIDGE	•Diagnosis of Hypocalcemia with Hypoparathyroidism (Low PTH Levels) •30 Day Trial Of: Calcium and Vitamin D used at the same time	1 year
NATPARA 25 MCG DOSE CARTRIDGE	•Diagnosis of Hypocalcemia with Hypoparathyroidism (Low PTH Levels) •30 Day Trial Of: Calcium and Vitamin D used at the same time	1 year
NATPARA 50 MCG DOSE CARTRIDGE	•Diagnosis of Hypocalcemia with Hypoparathyroidism (Low PTH Levels) •30 Day Trial Of: Calcium and Vitamin D used at the same time	1 year
NATPARA 75 MCG DOSE CARTRIDGE	•Diagnosis of Hypocalcemia with Hypoparathyroidism (Low PTH Levels) •30 Day Trial Of: Calcium and Vitamin D used at the same time	1 year
NATURE-THROID 113.75 MG TABLET	90 Day Trial of: Armour Thyroid Tablet	1 year
NATURE-THROID 130 MG TABLET	90 Day Trial of: Armour Thyroid Tablet	1 year
NATURE-THROID 146.25 MG TABLET	90 Day Trial of: Armour Thyroid Tablet	1 year
NATURE-THROID 16.25 MG TABLET	90 Day Trial of: Armour Thyroid Tablet	1 year
NATURE-THROID 162.5 MG TABLET	90 Day Trial of: Armour Thyroid Tablet	1 year
NATURE-THROID 195 MG TABLET	90 Day Trial of: Armour Thyroid Tablet	1 year
NATURE-THROID 260 MG TABLET	90 Day Trial of: Armour Thyroid Tablet	1 year

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NATURE-THROID 32.5 MG TABLET	90 Day Trial of: Armour Thyroid Tablet	1 year
NATURE-THROID 325 MG TABLET	90 Day Trial of: Armour Thyroid Tablet	1 year
NATURE-THROID 48.75 MG TABLET	90 Day Trial of: Armour Thyroid Tablet	1 year
NATURE-THROID 65 MG TABLET	90 Day Trial of: Armour Thyroid Tablet	1 year
NATURE-THROID 81.25 MG TABLET	90 Day Trial of: Armour Thyroid Tablet	1 year
NATURE-THROID 97.5 MG TABLET	90 Day Trial of: Armour Thyroid Tablet	1 year
NAYZILAM 5 MG NASAL SPRAY	• Diagnosis of intermittent episodes of frequent seizures • Age 12 years and older • Trial and failure of midazolam solution plus atomizer, or clinical rationale why this cannot be used	1 year
NEBIVOLOL 10 MG TABLET	A 90 Day Trial Within the Last Year of Carvedilol, Labetalol, Metoprolol, Atenolol, Nadolol, Propranolol, Sotalol, or Bisoprolol	1 year
NEBIVOLOL 2.5 MG TABLET	A 90 Day Trial Within the Last Year of Carvedilol, Labetalol, Metoprolol, Atenolol, Nadolol, Propranolol, Sotalol, or Bisoprolol	1 year
NEBIVOLOL 20 MG TABLET	A 90 Day Trial Within the Last Year of Carvedilol, Labetalol, Metoprolol, Atenolol, Nadolol, Propranolol, Sotalol, or Bisoprolol	1 year
NEBIVOLOL 5 MG TABLET	A 90 Day Trial Within the Last Year of Carvedilol, Labetalol, Metoprolol, Atenolol, Nadolol, Propranolol, Sotalol, or Bisoprolol	1 year
NERLYNX 40 MG TABLET	•Age 18 Years and Older •Diagnosis of Early State Her2-Overexpressed/Amplified Breast Cancer	6 Months
NEUPRO 2 MG/24 HR PATCH	• Diagnosis of Restless Leg Syndrome (RLS) (30 day trial) or Parkinson's (90 day trial) • Trial of: ropinirole or pramipexole	1 year
NIACIN ER 1,000 MG TABLET	•90 Day Trial of Simvastatin or Atorvastatin AND •Clinical Reason Supported by Chart Notes or Provider Call (After Trial Listed Below) Why the Below Cannot be Used: •90 Day Trial of OTC Niacin	1 year
NIACIN ER 500 MG TABLET	•90 Day Trial of Simvastatin or Atorvastatin AND •Clinical Reason Supported by Chart Notes or Provider Call (After Trial Listed Below) Why the Below Cannot be Used: •90 Day Trial of OTC Niacin	1 year
NIACIN ER 750 MG TABLET	•90 Day Trial of Simvastatin or Atorvastatin AND •Clinical Reason Supported by Chart Notes or Provider Call (After Trial Listed Below) Why the Below Cannot be Used: •90 Day Trial of OTC Niacin	1 year
NICOTROL CARTRIDGE INHALER	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Nicotine Gum, Lozenges, or Patches •Quantity Limit 168 Cartridges/Month	6 Months
NICOTROL NS 10 MG/ML SPRAY	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Nicotine Gum, Lozenges, or Patches •Quantity Limit 40 mL/Month	6 Months
NIMODIPINE 30 MG CAPSULE	Diagnosis of Subarachnoid Hemorrhage (SAH)	1 year
NISOLDIPINE ER 17 MG TABLET	•90-Day Trial of: Amlodipine, Felodipine or Nifedipine •Quantity Limit 1 Tablet/Day	1 year
NISOLDIPINE ER 34 MG TABLET	•90-Day Trial of: Amlodipine, Felodipine or Nifedipine •Quantity Limit 1 Tablet/Day	1 year
NISOLDIPINE ER 8.5 MG TABLET	•90-Day Trial of: Amlodipine, Felodipine or Nifedipine •Quantity Limit 1 Tablet/Day	1 year
NITAZOXANIDE 500 MG TABLET	Diagnosis of Diarrhea Caused by Giarda Lamblia OR Cryptosporidium Parvum	30 Days
NORLIQVA 1 MG/ML SOLUTION	• No PA if under 12 years of age; all others must have documented medical necessity for why they cannot use generic amlodipine tablets.	1 Year

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Drug Name	Criteria	Approval Duration
NUCYNTA 100 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
NUCYNTA 50 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
NUCYNTA 75 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
NUCYNTA ER 100 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
NUCYNTA ER 150 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
NUCYNTA ER 200 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
NUCYNTA ER 250 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
NUCYNTA ER 50 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
NURTEC ODT 75 MG TABLET	•Criteria for prevention of episodic migraine: •At least 18 years of age •Member has a documented diagnosis of episodic migraine, defined as between 4 and 14 headache days per month, with some causing disability •Member has tried and failed at least 2 prophylactic medications, for at least 8 weeks each, from different therapeutic classes: beta blocker, antidepressant, anticonvulsant •QL: 16 tabs/30 days •Renew x 12 months if: Reduction in monthly headache days or Improvement in migraine-related disability •Criteria for acute migraine: •At least 18 years of age •Diagnosis of acute migraine headache, with or without aura •Must have a 30-day trial each of ALL of the following: One NSAID drug (e.g., Ibuprofen, naproxen, etc.); AND Two triptan drugs (e.g., sumatriptan, rizatriptan, naratriptan or almotriptan) •If member is not able to take triptan drugs due to contraindication or adverse events, then a 30-day trial of 2 NSAIDs are required •Cannot be used together with Ubrelvy •QL: 8 tabs/28 days •Renew x 12 months if positive clinical response	6 Months
NUZYRA 150 MG TABLET	•Diagnosis of Community Acquired Pneumonia (CAP) •Clinical Reason Why Any of The Below Cannot Be Used: •Azithromycin, Doxycycline, Levofloxacin, Linezolid (Also Requires PA) or a Beta Lactam Antibiotic (High-Dose Amoxicillin, Amoxicillin/Clavulanate [Augmentin]) AND a Macrolide (Azithromycin) •OR •Documented Resistance to All Formulary Antibiotics •OR •Diagnosis of Acute Bacterial Skin and Skin Structure Infections (ABSSSI) •Clinical reason Why Any of The Below Cannot Be Used: •Sulfamethoxazole/Trimethoprim ± Rifampin, Doxycycline, Fluoroquinolone (ex. Levofloxacin), Linezolid, Cephalexin, Clindamycin, Penicillin •OR •Documented Resistance to All Formulary Antibiotics •Quantity Limit 29 Tablets/14 Days	Up to 14 Days
NYMALIZE 60 MG/20 ML SOLUTION	•Diagnosis of Subarachnoid Hemorrhage (SAH) •AND •Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Nimodipine (Nimotop) 30 mg Capsule	1 year
NYMALIZE 60 MG/20 ML SOLUTION	•Diagnosis of Subarachnoid Hemorrhage (SAH) •AND •Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Nimodipine (Nimotop) 30 mg Capsule	1 year
NYSTATIN-TRIAMCINOLONE CREAM	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Nystatin and Triamcinolone used at the same time •Quantity Limit 60 Grams Per Month	1 year
NYSTATIN-TRIAMCINOLONE OINTM	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Nystatin and Triamcinolone used at the same time •Quantity Limit 60 Grams Per Month	1 year
OBREDON 2.5-200 MG/5 ML SOLN	One Time Trial of: Guaifenesin-Codeine 200-10 mg/5 mL Liquid	30 Days
ODACTRA 12 SQ-HDM SL TABLET	•Member is 18 to 65 years of age •Prescribed by or in consultation with an allergist or immunologist •Diagnosis of house dust mite (HDM)-induced allergic rhinitis confirmed by in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites, or skin testing to licensed house dust mite allergen extracts •Trial and failure of conventional pharmacotherapy (i.e., antihistamines, nasal steroids) •Does NOT have evidence of severe, unstable, or uncontrolled asthma	1 year
ODACTRA 12 SQ-HDM SL TABLET	•Member is 18 to 65 years of age •Prescribed by or in consultation with an allergist or immunologist •Diagnosis of house dust mite (HDM)-induced allergic rhinitis confirmed by in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites, or skin testing to licensed house dust mite allergen extracts •Trial and failure of conventional pharmacotherapy (i.e., antihistamines, nasal steroids) •Does NOT have evidence of severe, unstable, or uncontrolled asthma	1 year

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Drug Name	Criteria	Approval Duration
ODACTRA 12 SQ-HDM SL TABLET	•Member is 18 to 65 years of age •Prescribed by or in consultation with an allergist or immunologist •Diagnosis of house dust mite (HDM)-induced allergic rhinitis confirmed by in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites, or skin testing to licensed house dust mite allergen extracts •Trial and failure of conventional pharmacotherapy (i.e., antihistamines, nasal steroids) •Does NOT have evidence of severe, unstable, or uncontrolled asthma	1 year
OLANZAPINE-FLUOXETINE 12-25 MG	• Clinical reason supported by chart notes why (after a Trial of) the below cannot be used • fluoxetine (Prozac) with olanzapine(Zyprexa) used at the same time	1 year
OLANZAPINE-FLUOXETINE 12-50 MG	• Clinical reason supported by chart notes why (after a Trial of) the below cannot be used • fluoxetine (Prozac) with olanzapine(Zyprexa) used at the same time	1 year
OLANZAPINE-FLUOXETINE 6-25 MG	• Clinical reason supported by chart notes why (after a Trial of) the below cannot be used • fluoxetine (Prozac) with olanzapine(Zyprexa) used at the same time	1 year
OLANZAPINE-FLUOXETINE 6-50 MG	• Clinical reason supported by chart notes why (after a Trial of) the below cannot be used • fluoxetine (Prozac) with olanzapine(Zyprexa) used at the same time	1 year
OLOPATADINE 665 MCG NASAL SPRY	•30 Day Trial of: Azelastine (Astelin) •OR •If Fax States Allergy, Intolerance, or Side Effects to: Azelastine (Astelin) •Note: 1 Bottle Contains 240 Sprays	1 year
OLOPATADINE HCL 0.1% EYE DROPS	•Member is Age 3 or Older •15 Day Trial of OTC Ketotifen (Refresh/Zyrtec Eye Drops/Wal-Zyr/Alaway/Claritin Eye Drops/RiteAid or CVS Eye Itch Eye Drops (Zaditor) •AND •15 Day Trial of Azelastine (Optivar)	1 year
OLOPATADINE HCL 0.2% EYE DROP	•15-Day Trial of OTC Ketotifen (Refresh/Zyrtec Eye Drops/Wal-Zyr/Alaway/Claritin Eye Drops/RiteAid or CVS Eye Itch EYE DROPS (Zaditor) •AND •15-Day Trial of Azelastine (Optivar) •OR •If Child is Age 2-3 Years Old	1 year
OMECLAMOX-PAK COMBO PACK	•Clinical reason supported by chart notes why (after a 90 day trial of) the below cannot be used •Previous trial and failure, intolerance or contraindication to generic Prevpac	30 Days
OMECLAMOX-PAK DAILY CARD	•Clinical reason supported by chart notes why (after a 90 day trial of) the below cannot be used •Previous trial and failure, intolerance or contraindication to generic Prevpac	30 Days
OMEPRAZOLE-BICARB 20-1,100 CAP	•Do Not CC Even If Previously Approved by CareSource •30 Day Trial of Zegerid OTC 20-1,100 mg Capsules AND A Clinical Reason Why the RX Version Is Needed When the OTC Version Has Failed	1 year
OMEPRAZOLE-BICARB 20-1,680 PKT	• 30 Day Trial of: Omeprazole Capsules Or First-Omeprazole 2 mg/mL Suspension AND Lansoprazole Capsule Or First-Lansoprazole 3 mg/mL Suspension AND • Clinical Reason Why The Packet Is Needed	1 year
OMEPRAZOLE-BICARB 40-1,100 CAP	•Do Not CC Even If Previously Approved by CareSource •30 Day Trial of Zegerid OTC 20-1,100 mg Capsules WITH Omeprazole (Prilosec) 20 mg Capsules used at the same time AND A Clinical Reason Why the RX Version Is Needed When the OTC Version Has Failed	1 year
OMEPRAZOLE-BICARB 40-1,680 PKT	• 30 Day Trial of: Omeprazole Capsules Or First-Omeprazole 2 mg/mL Suspension AND Lansoprazole Capsule Or First-Lansoprazole 3 mg/mL Suspension AND • Clinical Reason Why The Packet Is Needed	1 year

Drug Name	Criteria	Approval Duration
OMNIPOD 5 G6 PODS (GEN 5) 5PK	INITIATION: Age 6 or older Diagnosis of Type 1 Diabetes Mellitus. AND Maintenance therapy for at least six months involving at least THREE injections of insulin per day AND Glucose self-testing at least THREE times per day on average during the past month. AND High risk for preventable complications of diabetes. AND Individual (or caregiver) is capable of managing the pump AND The member has ONE of the following symptoms or conditions: Glycated hemoglobin level (HbA1c) greater than 7%. OR A history of recurring hypoglycemia. OR A history of severe glycemic excursions. OR Criteria for Type 2: Must meet all of the following Age 6 or older Diagnosis of Type 2 Diabetes Mellitus. AND Prescribed by or in consultation with an endocrinologist AND Maintenance therapy for at least six months involving at least THREE injections of insulin per day and DAILY documented adjustments of insulin dosage. AND Glucose self-testing at least THREE times per day on average during the past month. AND Individual (or caregiver) is capable of managing the pump AND The member has 4/5 has the following symptoms or conditions: Documented glycated hemoglobin level (HbA1c) greater than 7% within the past month. AND Documented history of recurring hypoglycemia. AND Documented fluctuations in blood glucose before mealtime. Documented early morning increase in fasting blood sugar (exceeds 200 mg/dl). AND Documented severe glycemic excursions. Initial Limits: 1 controller device every 4 years	1 year
ONGLYZA 2.5 MG TABLET	•30 Day Trial of: Metformin IR or Metformin ER (Glucophage or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect to Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)] THEN •60-Day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), Alogliptin-Pioglitazone (Oseni), Or Tradjenta (Which Also Requires a PA)	1 year
ONGLYZA 5 MG TABLET	•30 Day Trial of: Metformin IR or Metformin ER (Glucophage or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect to Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)] THEN •60-Day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), Alogliptin-Pioglitazone (Oseni), Or Tradjenta (Which Also Requires a PA)	1 year
ONMEL 200 MG TABLET	•Diagnosis of Onychomycosis (Toe Fungus) •Trial of: Itraconazole (Sporanox) Capsule	60 Days
ONZETRA XSAIL 11 MG/NOSEPIECE	•Age 18 and Older •A One Time Trial of at Least 2 of the Following 3 Drugs: Sumatriptan Tablets, Injection or Nasal Spray, Naratriptan, Almotriptan, or Rizatriptan	1 year
OPIUM TINCTURE 10 MG/ML	•Diagnosis of Severe-Diarrhea OR IBS (Irritable Bowel Syndrome) •7 Day Trial of: Atropine-Diphenoxylate (Lomotil) or Dicyclomine (Bentyl)	1 year
OPZELURA 1.5% CREAM	• 12 years of age or older • Diagnosis of mild-moderate atopic dermatitis with 3% to 20% body surface area (BSA) affected • Member is NOT immunocompromised • Trial and failure of at least 2 of the following other topical prescription therapies with inadequate control after at least 3 weeks: Topical corticosteroid (moderate to very high potency), topical calcineurin inhibitor (Elidel, Protoptic), and/or Eucrisa • Will NOT be used in combination with other JAK inhibitors, biologics, or potent immunosuppressants such as azathioprine or cyclosporine • Quantity limit: 60 grams (1 tube) per 28 days • Duration: 3 months; renew x 1 year if chart notes document meaningful reduction in itch and skin inflammation	1 year
ORACIT ORAL SOLUTION	30-day Trial of: Cytra-2, Sodium Citrate/Citric Acid (Shohl's Modified) 334 mg-500 mg Oral Solution	1 year
ORALAIR 300 IR SUBLINGUAL TAB	•Member is 5 to 65 years of age •Prescribed by or in consultation with an allergist or immunologist •Diagnosis of grass pollen-induced allergic rhinitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the following five grass species: Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass •Trial and failure of conventional pharmacotherapy (i.e., antihistamines, nasal steroids) •Does NOT have evidence of severe, unstable, or uncontrolled asthma	1 year

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ORAVIG 50 MG BUCCAL TABLET	30-Day Trial of: Oral Nystatin Tablet or Suspension	30 Days
ORPHENAD-ASA-CAFF 50-770-60 MG	Trial Of Cyclobenzaprine, Baclofen, Methocarbomal or Tizanidine (Carisoprodol-Accepted Trial Not Preferred Agent)	1 year
OSMOLEX ER 193 MG TABLET	•Diagnosis of Parkinson's Disease or Treatment of Drug-Induced Extrapyramidal Reactions •Clinical Reason why (After A 90 Day Trial Of) Amantadine IR Cannot Be Used (Do Not Approve Soley for Convenience)	1 year
OSMOLEX ER 258 MG TABLET	•Diagnosis of Parkinson's Disease or Treatment of Drug-Induced Extrapyramidal Reactions •Clinical Reason why (After A 90 Day Trial Of) Amantadine IR Cannot Be Used (Do Not Approve Soley for Convenience)	1 year
OTOVEL 0.3%-0.025% EAR DROPS	•Diagnosis of Otitis Media with Tympanostomy Tubes •Prescriber Specialty = ENT (Ear, Nose, Throat) •Trial and Failure of One of the Following: Ofloxacin	7 Days
OTREXUP 10 MG/0.4 ML AUTO-INJ	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Methotrexate Injection	1 year
OTREXUP 12.5 MG/0.4 ML AUTOINJ	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Methotrexate Injection	1 year
OTREXUP 15 MG/0.4 ML AUTO-INJ	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Methotrexate Injection	1 year
OTREXUP 17.5 MG/0.4 ML AUTOINJ	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Methotrexate Injection	1 year
OTREXUP 20 MG/0.4 ML AUTO-INJ	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Methotrexate Injection	1 year
OTREXUP 22.5 MG/0.4 ML AUTOINJ	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Methotrexate Injection	1 year
OTREXUP 25 MG/0.4 ML AUTO-INJ	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Methotrexate Injection	1 year
OVACE PLUS 9.8% LOTION	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Sulfacetamide Sodium (Klarion) 10% Lotion	1 year
OXANDROLONE 10 MG TABLET	•Diagnosis of Bone Pain with Osteoporosis •OR •Diagnosis of Protein Catabolism •OR •Diagnosis of Need for Weight Gain •Trial of: Megesterol	1 Year for Bone Pain with Osteoporosis 6 Months for Protein Catabolism 3 Months for Need for Weight Gain
OXANDROLONE 2.5 MG TABLET	•Diagnosis of Bone Pain with Osteoporosis •OR •Diagnosis of Protein Catabolism •OR •Diagnosis of Need for Weight Gain •Trial of: Megesterol	1 Year for Bone Pain with Osteoporosis 6 Months for Protein Catabolism 3 Months for Need for Weight Gain
OXICONAZOLE NITRATE 1% CREAM	• Diagnosis of Tinea Pedis, Tinea Cruris, Tinea Corporis, Or Tinea (Pityriasis) Versicolor • 30 day Trial of Ketoconazole Cream, Clotrimazole Cream, Or Miconazole Cream	3 months
OXISTAT 1% LOTION	•Diagnosis of Tinea Pedis, Tinea Cruris, Tinea Corporis, or Tinea (Pityriasis) Versicolor •30-Day Trial of: Ketoconazole Cream, Clotrimazole Cream, or Miconazole Cream	3 Months
OXTELLAR XR 150 MG TABLET	• Clinical Reason Supported By Chart Notes Why (After A 30 Day Trial of) The Below Cannot Be Used: • Oxcarbazepine (Trileptal)	1 year
OXTELLAR XR 300 MG TABLET	• Clinical Reason Supported By Chart Notes Why (After A 30 Day Trial of) The Below Cannot Be Used: • Oxcarbazepine (Trileptal)	1 year
OXTELLAR XR 600 MG TABLET	• Clinical Reason Supported By Chart Notes Why (After A 30 Day Trial of) The Below Cannot Be Used: • Oxcarbazepine (Trileptal)	1 year

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Drug Name	Criteria	Approval Duration
OXYCODON-ACETAMINOPHEN 7.5-300	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
OXYCODONE HCL 10 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
OXYCODONE HCL 100 MG/5 ML CONC	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
OXYCODONE HCL 15 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

Drug Name	Criteria	Approval Duration
OXYCODONE HCL 20 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
OXYCODONE HCL 30 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
OXYCODONE HCL 5 MG CAPSULE	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
OXYCODONE HCL 5 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
OXYCODONE HCL 5 MG/5 ML SOLN	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
OXYCODONE HCL ER 10 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
OXYCODONE HCL ER 15 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
OXYCODONE HCL ER 20 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
OXYCODONE HCL ER 30 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
OXYCODONE HCL ER 40 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
OXYCODONE HCL ER 60 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
OXYCODONE HCL ER 80 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
OXYCODONE-ACETAMINOPH 10-300/5	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
OXYCODONE-ACETAMINOPHEN 10-325	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
OXYCODONE-ACETAMINOPHEN 5-325	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
OXYCODONE-ACETAMINOPHN 2.5-300	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
OXYCODONE-ACETAMINOPHN 2.5-325	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
OXYCODONE-ACETAMINOPHN 7.5-325	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
OXYCODONE-ASPIRIN 4.8355-325	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization: •For Initial Authorizations •Clinical Reason After A 30-Day Trial/Failure That the Following Cannot Continue Oxycodone IR or Oxycodone-Acetaminophen (Trial Per Pharmacy Claims or Doctor Notes with Trial Dates Listed) •OR •If Diagnosis Is One of The Following, Approve X 1 Year: A) Active Cancer Treatment or Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia. If Diagnosis Is One of The Following, Approve X 6 Months: A) Severe Burns, B) Traumatic Crushing of Tissue, C) Amputation, D) Major Orthopedic Surgery •OR •If Diagnosis is Moderate to Severe Pain (List Diagnosis Code), AND •Member on Opioids < 90 Days in the Past 120 Days (Naïve Utilizer): •Dose is < 50 MED (8 Tabs/Day) •Member has Experienced an Inadequate Response, Intolerance or Contraindication To At Least 2 Preferred Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, and Antidepressants) •Prescriber Attests to Discussing Benefits/Risks of Opioids with Member •Prescriber Attests to Checking State PDMP •Approve as Requested up to 7 Days for Fill up to 4 Tabs/Day •Member on Opioids > 90 Days in the Past 120 Days (Chronic Utilizer): •Dose is < 50 MED (8 Tabs/Day) •Prescriber Attests to Discussing Benefits/Risks of Opioids with Member •Prescriber Attests to Checking State PDMP •Duration of Therapy: •Less than 90 Days = Approve as Requested up to 7 Days for Fill up to 4 Tabs/Day •If more than 90 Days: •If Dose is > 80 MED, Prescriber is Pain Management, Pain Management Consulted, or Pain Management Unavailable and Rationale for Higher Dose •Prescriber Attests to Patient Specific Treatment Plan •Prescriber Attests to Assessing for Addiction Risk or Mental Health Concerns •If Patient Is Also Treated with A Benzodiazepine, Prescriber Attests That Benefit of Using Both Together Outweighs Risk	Up to 6 months
OXYCODONE-IBUPROFEN 5-400 TAB		Per Criteria

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Drug Name	Criteria	Approval Duration
OXYMORPHONE HCL 10 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
OXYMORPHONE HCL 5 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months

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Drug Name	Criteria	Approval Duration
OXYMORPHONE HCL ER 10 MG TAB	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
OXYMORPHONE HCL ER 15 MG TAB	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
OXYMORPHONE HCL ER 20 MG TAB	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
OXYMORPHONE HCL ER 30 MG TAB	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
OXYMORPHONE HCL ER 40 MG TAB	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
OXYMORPHONE HCL ER 5 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

Drug Name	Criteria	Approval Duration
OXYMORPHONE HCL ER 7.5 MG TAB	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
OXYTROL 3.9 MG/24HR PATCH	•Gender Male: •Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Oxybutynin or Oxybutynin ER •Gender Female: •Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Oxytrol for Women OTC 3.9 mg/24HR Patch	1 year
OZEMPIC 0.25-0.5 MG/DOSE PEN	*60 day trial of Trulicity or Rybelsus (which requires a 30 day trial of metformin or metformin ER)	1 year
OZEMPIC 1 MG/DOSE (2 MG/1.5ML)	*60 day trial of Trulicity or Rybelsus (which requires a 30 day trial of metformin or metformin ER)	1 year
OZEMPIC 1 MG/DOSE (4 MG/3 ML)	60-Day Trial of Trulicity or Rybelsus (Which Requires a 30-Day Trial of Metformin or Metformin ER)	1 year
OZEMPIC 2 MG/DOSE (8 MG/3 ML)	60-Day Trial of Trulicity or Rybelsus (Which Requires a 30-Day Trial of Metformin or Metformin ER)	1 year
OZOBAX 5 MG/5 ML SOLUTION	•Diagnosis of spasticity resulting from multiple sclerosis or spinal cord injury •Inability to swallow generic baclofen tablets or Fleqsuvy (Fleqsuvy also requires auth.)	1 year
PACNEX HP 7% CLEANSING PADS	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Benzoyl Peroxide 2.5% Wash or Gel (Panoxyl), Benzoyl Peroxide 4% Cleanser (Panoxyl), Benzoyl Peroxide 5% Gel (Panoxyl), Benzoyl Peroxide 5% Lotion, Benzoyl Peroxide 3%, 6%, 9% Cleanser (Triz), Benzoyl Peroxide 10% Wash (Desquam-X/Panoxyl), Benzoyl Peroxide 10% Gel (Panoxyl), Benzoyl Peroxide 10% Lotion or Benzoyl Peroxide-Erythromycin (Benzamycin) 5-3% Gel	1 year
PAIN EASE MIST SPRAY	Diagnosis of Controlling Pain Associated with Injections, and Certain Other Procedures (Dialysis)	10 Days
PANCREAZE DR 10,500 UNIT CAP	•If Authorization is From Rainbow Babies and Children's •OR •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Viokace, Ultresa or Creon	1 year
PANCREAZE DR 16,800 UNIT CAP	•If Authorization is From Rainbow Babies and Children's •OR •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Viokace, Ultresa or Creon	1 year
PANCREAZE DR 21,000 UNIT CAP	•If Authorization is From Rainbow Babies and Children's •OR •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Viokace, Ultresa or Creon	1 year

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Drug Name	Criteria	Approval Duration
PANCREAZE DR 4,200 UNIT CAP	•If Authorization is From Rainbow Babies and Children's •OR •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Viokace, Ultresa or Creon	1 year
PANRETIN 0.1% GEL	Diagnosis of Kaposi Sarcoma (KS) Cutaneous Lesions	6 Months
PAREGORIC LIQUID	One Time Trial of: Imodium or Loperamide	3 Months
PARICALCITOL 1 MCG CAPSULE	7 Day Trial of Calcitriol in the Last 30 Days	1 year
PARICALCITOL 2 MCG CAPSULE	7 Day Trial of Calcitriol in the Last 30 Days	1 year
PARICALCITOL 4 MCG CAPSULE	7 Day Trial of Calcitriol in the Last 30 Days	1 year
PAROMOMYCIN 250 MG CAPSULE	•Diagnosis of Intestinal Amebiasis •OR •Diagnosis of Hepatic Coma/Encephalopathy AND a Clinical Reason Lactulose, Neomycin, or Metronidazole Cannot be Used	3 Months
PAROXETINE ER 12.5 MG TABLET	• Clinical reason supported by chart notes why (after a Trial of) the below cannot be used • non-CR paroxetine [Dose: 1 Tablet/day]	1 year
PAROXETINE ER 25 MG TABLET	• Clinical reason supported by chart notes why (after a Trial of) the below cannot be used • non-CR paroxetine [Dose: 1 Tablet/day]	1 year
PAROXETINE ER 37.5 MG TABLET	• Clinical reason supported by chart notes why (after a Trial of) the below cannot be used • non-CR paroxetine [Dose: 1 Tablet/day]	1 year
PAROXETINE MESYLATE 7.5 MG CAP	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Paroxetine IR	1 year
PASER GRANULES 4 GM PACKET	Trial of rifampin	1 year
PAXLOVID CO-PACK (EUA)	Age > 12 years	1 year
PAZEO 0.7% EYE DROPS	•Approve If Previously Approved for Alocril, Alrex, Bepreve, Or Epinastine (Elestat) •OR •15 Day Trial Of: OTC Ketotifen (Alaway/Claritin Eye Drops/Refresh/RiteAid or CVS Eye Itch Eye Drops (Zaditor)/Wal-Zyr/ Zyrtec Eye Drops) •AND •15 Day Trial of: Azelastine (Optivar) •OR •If Child Is Age 2-3 Years Old	1 year
PEG3350 100-7.5-2.691-1.01-5.9	•Clinical Reason Why, After A 90 Day Trial the Following Cannot Be Used: •PEG 3350 Powder	1 year
PENICILLAMINE 250 MG CAPSULE, TABLET	• Diagnosis of Wilson disease or cystinuria	1 year
PERTZYE DR 16,000 UNIT CAPSULE	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Viokace, Ultresa or Creon	1 year
PERTZYE DR 8,000 UNIT CAPSULE	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Viokace, Ultresa or Creon	1 year
PHENOXYBENZAMINE HCL 10 MG CAP	Diagnosis of Pheochromocytoma	1 year
PHOSPHOLINE IODIDE 0.125%	• Clinical reason why (after a 90 day trial each) two of the following cannot be used: Latanoprost, brimonidine, dorzolamide, dorzolamide/timolol, levobunolol, metipranolol, timolol, betaxolol, brimonidine, brimonidine/timolol, pilocarpine	1 year
PICATO 0.015% GEL	•Diagnosis of Actinic Keratoses •Trial of: Fluorouracil (Efudex) 5% Cream	1 year
PICATO 0.05% GEL	•Diagnosis of Actinic Keratoses •Trial of: Fluorouracil (Efudex) 5% Cream	1 year
PIMECROLIMUS 1% CREAM	• Diagnosis of Alopecia is excluded OR • Diagnosis of Atopic Dermatitis Or Eczema • 7 Day Trial of: Tacrolimus (Protopic) 0.1% Or 0.03% Ointment	1 year
PIOGLITAZONE-GLIMEPIRIDE 30-2	• 30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)] [Note: This Medication Will Pay With An Electronic Step If There Are 30 Days Of Metformin Use In The Last 120 Days]	1 year

Drug Name	Criteria	Approval Duration
PIOGLITAZONE-GLIMEPIRIDE 30-4	• 30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)] [Note: This Medication Will Pay With An Electronic Step If There Are 30 Days Of Metformin Use In The Last 120 Days]	1 year
PLEXION 9.8-4.8% CLEANSER	90 Day Trial of: Avar-E LS 10-2% Cream, Sulfacetamide Sodium with Sulfur Suspension 10-5%, Sulfacetamide Sodium with Sulfur Lotion 10-5%, or Sulfacetamide Sodium with Sulfur Emulsion, Avar Cleanser, Rosanil, Prascion 10-5%	1 year
PLIAGLIS 7%-7% CREAM	30 Day Trial of: Lidocaine-Prilocaine Cream 2.5-2.5%	30 Days
POSACONAZOLE DR 100 MG TABLET	One Time Trial of: Fluconazole	30 Days
POTASSIUM CL 25 MEQ TAB EFF	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Formulary Potassium Supplement	1 year
PRADAXA 110 MG CAPSULE	• Adults: Trial and failure of Xarelto or Eliquis • Pediatrics: No previous trial required	1 year
PRADAXA 150 MG CAPSULE	• Adults: Trial and failure of Xarelto or Eliquis • Pediatrics: No previous trial required	1 year
PRADAXA 75 MG CAPSULE	• Adults: Trial and failure of Xarelto or Eliquis • Pediatrics: No previous trial required	1 year
PRAMIPEXOLE ER 0.375 MG TABLET	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Non-ER Pramipexole	1 year
PRAMIPEXOLE ER 0.75 MG TABLET	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Non-ER Pramipexole	1 year
PRAMIPEXOLE ER 1.5 MG TABLET	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Non-ER Pramipexole	1 year
PRAMIPEXOLE ER 2.25 MG TABLET	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Non-ER Pramipexole	1 year
PRAMIPEXOLE ER 3 MG TABLET	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Non-ER Pramipexole	1 year
PRAMIPEXOLE ER 4.5 MG TABLET	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Non-ER Pramipexole	1 year
PRAMOSONE 1%-1% CREAM	30 Day Trial of: Hydrocortisone 2.5% (Lotion, Cream or Ointment) and Pramoxine HCL 1% (Lotion or Cream) used at the same time at The Same Time	1 year
PRAMOSONE 2.5%-1% CREAM	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Hydrocortisone 2.5% Cream and Pramoxine HCL 1% Cream used at the same time at The Same Time	1 year
PRAMOSONE 2.5%-1% LOTION	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Hydrocortisone 2.5% Lotion and Pramoxine HCL 1% Lotion used at the same time at The Same Time	1 year
PRAMOSONE E 2.5%-1% CREAM	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Hydrocortisone 2.5% Cream and Pramoxine HCL 1% Cream used at the same time at The Same Time	1 year
PRED-G S.O.P. EYE OINTMENT	Trial and failure of prednisone and gentamicin used separately OR documented reason why the two cannot be used at the same time	1 year
PREDNISOLONE 10 MG/5 ML SOLN	30 Day Trial of Prednisolone Solution 5 mg/5 mL or 15 mg/5 mL	1 year
PREDNISOLONE 20 MG/5 ML SOLN	30 Day Trial of Prednisolone Solution 5 mg/5 mL or 15 mg/5 mL	1 year

Drug Name	Criteria	Approval Duration
PREGABALIN 100 MG CAPSULE	Diagnosis of partial onset seizures OR Diagnosis of neuropathic pain associated with diabetic peripheral neuropathy and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day Trial of and inadequate response or intolerance to one of the following: a)SNRI antidepressant (ex. duloxetine or venlafaxine), b)Tricyclic antidepressant (amitriptyline, nortriptyline, clomipramine, desipramine), c)Gabapentin, OR Diagnosis of post herpetic neuralgia and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day trial and inadequate response or intolerance to one of the following medications: a)Gabapentin, b)Lidocaine patch (Lidoderm), c)Tricyclic antidepressant (amitriptyline, desipramine, nortriptyline) OR Diagnosis of Neuropathic pain due to spinal cord injury Previously approved for pregabalin (Lyrica) in the past year and PA recently expired OR Diagnosis of central neuropathic pain cause by primary lesion or dysfunction of the central nervous system (spinal cord or brain) and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day trial and inadequate response or intolerance to one of the following:a)Gabapentin, b)Tricyclic antidepressant (amitriptyline, desipramine, nortriptyline) OR	1 year
PREGABALIN 150 MG CAPSULE	Diagnosis of partial onset seizures OR Diagnosis of neuropathic pain associated with diabetic peripheral neuropathy and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day Trial of and inadequate response or intolerance to one of the following: a)SNRI antidepressant (ex. duloxetine or venlafaxine), b)Tricyclic antidepressant (amitriptyline, nortriptyline, clomipramine, desipramine), c)Gabapentin, OR Diagnosis of post herpetic neuralgia and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day trial and inadequate response or intolerance to one of the following medications: a)Gabapentin, b)Lidocaine patch (Lidoderm), c)Tricyclic antidepressant (amitriptyline, desipramine, nortriptyline) OR Diagnosis of Neuropathic pain due to spinal cord injury Previously approved for pregabalin (Lyrica) in the past year and PA recently expired OR Diagnosis of central neuropathic pain cause by primary lesion or dysfunction of the central nervous system (spinal cord or brain) and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day trial and inadequate response or intolerance to one of the following:a)Gabapentin, b)Tricyclic antidepressant (amitriptyline, desipramine, nortriptyline) OR	1 year
PREGABALIN 20 MG/ML SOLUTION	**Criteria for Fibromyalgia, Neuropathy, Neuralgia or Sciatica AND a 30 day trial and failure with TWO of the following medications: Gabapentin At Accepted Daily Doses of 1200mg To 2400mg, Amitriptyline, Or Duloxetine Capsule *OR* **Criteria for Seizure Or Epilepsy AND a 30 day trial of 2 of The Following medications: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year

Drug Name	Criteria	Approval Duration
PREGABALIN 200 MG CAPSULE	Diagnosis of partial onset seizures OR Diagnosis of neuropathic pain associated with diabetic peripheral neuropathy and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day Trial of and inadequate response or intolerance to one of the following: a)SNRI antidepressant (ex. duloxetine or venlafaxine), b)Tricyclic antidepressant (amitriptyline, nortriptyline, clomipramine, desipramine), c)Gabapentin, OR Diagnosis of post herpetic neuralgia and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day trial and inadequate response or intolerance to one of the following medications: a)Gabapentin, b)Lidocaine patch (Lidoderm), c)Tricyclic antidepressant (amitriptyline, desipramine, nortriptyline) OR Diagnosis of Neuropathic pain due to spinal cord injury Previously approved for pregabalin (Lyrica) in the past year and PA recently expired OR Diagnosis of central neuropathic pain cause by primary lesion or dysfunction of the central nervous system (spinal cord or brain) and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day trial and inadequate response or intolerance to one of the following:a)Gabapentin, b)Tricyclic antidepressant (amitriptyline, desipramine, nortriptyline) OR	1 year
PREGABALIN 225 MG CAPSULE	Diagnosis of partial onset seizures OR Diagnosis of neuropathic pain associated with diabetic peripheral neuropathy and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day Trial of and inadequate response or intolerance to one of the following: a)SNRI antidepressant (ex. duloxetine or venlafaxine), b)Tricyclic antidepressant (amitriptyline, nortriptyline, clomipramine, desipramine), c)Gabapentin, OR Diagnosis of post herpetic neuralgia and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day trial and inadequate response or intolerance to one of the following medications: a)Gabapentin, b)Lidocaine patch (Lidoderm), c)Tricyclic antidepressant (amitriptyline, desipramine, nortriptyline) OR Diagnosis of Neuropathic pain due to spinal cord injury Previously approved for pregabalin (Lyrica) in the past year and PA recently expired OR Diagnosis of central neuropathic pain cause by primary lesion or dysfunction of the central nervous system (spinal cord or brain) and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day trial and inadequate response or intolerance to one of the following:a)Gabapentin, b)Tricyclic antidepressant (amitriptyline, desipramine, nortriptyline) OR	1 year

Drug Name	Criteria	Approval Duration
PREGABALIN 25 MG CAPSULE	Diagnosis of partial onset seizures OR Diagnosis of neuropathic pain associated with diabetic peripheral neuropathy and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day Trial of and inadequate response or intolerance to one of the following: a)SNRI antidepressant (ex. duloxetine or venlafaxine), b)Tricyclic antidepressant (amitriptyline, nortriptyline, clomipramine, desipramine), c)Gabapentin, OR Diagnosis of post herpetic neuralgia and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day trial and inadequate response or intolerance to one of the following medications: a)Gabapentin, b)Lidocaine patch (Lidoderm), c)Tricyclic antidepressant (amitriptyline, desipramine, nortriptyline) OR Diagnosis of Neuropathic pain due to spinal cord injury Previously approved for pregabalin (Lyrica) in the past year and PA recently expired OR Diagnosis of central neuropathic pain cause by primary lesion or dysfunction of the central nervous system (spinal cord or brain) and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day trial and inadequate response or intolerance to one of the following:a)Gabapentin, b)Tricyclic antidepressant (amitriptyline, desipramine, nortriptyline) OR	1 year
PREGABALIN 300 MG CAPSULE	Diagnosis of partial onset seizures OR Diagnosis of neuropathic pain associated with diabetic peripheral neuropathy and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day Trial of and inadequate response or intolerance to one of the following: a)SNRI antidepressant (ex. duloxetine or venlafaxine), b)Tricyclic antidepressant (amitriptyline, nortriptyline, clomipramine, desipramine), c)Gabapentin, OR Diagnosis of post herpetic neuralgia and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day trial and inadequate response or intolerance to one of the following medications: a)Gabapentin, b)Lidocaine patch (Lidoderm), c)Tricyclic antidepressant (amitriptyline, desipramine, nortriptyline) OR Diagnosis of Neuropathic pain due to spinal cord injury Previously approved for pregabalin (Lyrica) in the past year and PA recently expired OR Diagnosis of central neuropathic pain cause by primary lesion or dysfunction of the central nervous system (spinal cord or brain) and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day trial and inadequate response or intolerance to one of the following:a)Gabapentin, b)Tricyclic antidepressant (amitriptyline, desipramine, nortriptyline) OR	1 year

Drug Name	Criteria	Approval Duration
PREGABALIN 50 MG CAPSULE	Diagnosis of partial onset seizures OR Diagnosis of neuropathic pain associated with diabetic peripheral neuropathy and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day Trial of and inadequate response or intolerance to one of the following: a)SNRI antidepressant (ex. duloxetine or venlafaxine), b)Tricyclic antidepressant (amitriptyline, nortriptyline, clomipramine, desipramine), c)Gabapentin, OR Diagnosis of post herpetic neuralgia and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day trial and inadequate response or intolerance to one of the following medications: a)Gabapentin, b)Lidocaine patch (Lidoderm), c)Tricyclic antidepressant (amitriptyline, desipramine, nortriptyline) OR Diagnosis of Neuropathic pain due to spinal cord injury Previously approved for pregabalin (Lyrica) in the past year and PA recently expired OR Diagnosis of central neuropathic pain cause by primary lesion or dysfunction of the central nervous system (spinal cord or brain) and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day trial and inadequate response or intolerance to one of the following:a)Gabapentin, b)Tricyclic antidepressant (amitriptyline, desipramine, nortriptyline) OR	1 year
PREGABALIN 75 MG CAPSULE	Diagnosis of partial onset seizures OR Diagnosis of neuropathic pain associated with diabetic peripheral neuropathy and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day Trial of and inadequate response or intolerance to one of the following: a)SNRI antidepressant (ex. duloxetine or venlafaxine), b)Tricyclic antidepressant (amitriptyline, nortriptyline, clomipramine, desipramine), c)Gabapentin, OR Diagnosis of post herpetic neuralgia and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day trial and inadequate response or intolerance to one of the following medications: a)Gabapentin, b)Lidocaine patch (Lidoderm), c)Tricyclic antidepressant (amitriptyline, desipramine, nortriptyline) OR Diagnosis of Neuropathic pain due to spinal cord injury Previously approved for pregabalin (Lyrica) in the past year and PA recently expired OR Diagnosis of central neuropathic pain cause by primary lesion or dysfunction of the central nervous system (spinal cord or brain) and one of the following: 1. Previously approved for pregabalin (Lyrica) in the past year and PA recently expired 2. 30 day trial and inadequate response or intolerance to one of the following:a)Gabapentin, b)Tricyclic antidepressant (amitriptyline, desipramine, nortriptyline) OR	1 year
PREPOPIK POWDER PACKET	One Time Trial Within the Last 30 Days of: Gavilyte-H or Peg-Prep Kit	30 Days
PRESTALIA 14 MG-10 MG TABLET	•Diagnosis of Hypertension •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial) of the Below Cannot Be Used: Amlodipine and Perindopril used at the same time OR Amlodipine/Benazepril	1 year
PRESTALIA 3.5 MG-2.5 MG TABLET	•Diagnosis of Hypertension •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial) of the Below Cannot Be Used: Amlodipine and Perindopril used at the same time OR Amlodipine/Benazepril	1 year
PRESTALIA 7 MG-5 MG TABLET	•Diagnosis of Hypertension •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial) of the Below Cannot Be Used: Amlodipine and Perindopril used at the same time OR Amlodipine/Benazepril	1 year

Georgia Medicaid Traditional Drug Criteria
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Drug Name	Criteria	Approval Duration
PRETOMANID 200 MG TABLET	• Prescribed by infectious disease or pulmonology specialist • Diagnosis of adults with pulmonary extensively drug resistant (XDR) or treatment-intolerant or nonresponsive multidrug-resistant (MDR) tuberculosis (TB) • Must be prescribed in combination with bedaquiline and linezolid	26 weeks
PREVACID 24HR DR 15 MG CAPSULE	• Clinical reason why OTC lansoprazole/Prevacid cannot be used after a 90 day Trial of OTC formulation	6 Months for GERD Add a D 365 750 1 Year for Barrett's, Zollinger and Continuous therapy w/concurrent med Add a D 365 750
PREVYMIS 240 MG TABLET	•Diagnosis of Prevention of Cytomegalovirus (CMV) Infection AND •Hematopoetic Stem Cell Transplant (HSCT) Within the Last 28 Days •Note: IV Solution is Medical Benefit Only	3 Months
PREVYMIS 480 MG TABLET	•Diagnosis of Prevention of Cytomegalovirus (CMV) Infection AND •Hematopoetic Stem Cell Transplant (HSCT) Within the Last 28 Days •Note: IV Solution is Medical Benefit Only	3 Months
PRILOLID 2.5-2.5% CRM-DRESS	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 year
PRILOVIX 2.5%-2.5% CREAM DRESS	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 year
PRILOVIX LITE 2.5%-2.5% CREAM	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 year
PRILOVIX LITE PLUS 2.5%-2.5%	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 year
PRILOVIX ULTRALITE 2.5%-2.5%	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 year
PRILOVIX ULTRLT PLUS 2.5%-2.5%	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 year
PRIZOPAK II 2.5%-2.5% CRM KIT	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 year
PROBENECID-COLCHICINE TABLET	• Diagnosis of chronic gouty arthritis with frequent, recurrent acute attacks of gout noted on request or in chart notes	1 year
PROPARACAINE 0.5% EYE DROPS	One Time Trial of: Tetracaine	30 Days
PURIXAN 20 MG/ML ORAL SUSP	•Setup and Send to RPh for Approval Duration •Diagnosis of Acute Lymphoblastic Leukemia •Must Use the Preferred Specialty Pharmacy Accredo	Up to 12 Months
PYRIMETHAMINE 25 MG TABLET	• Trial of hydroxychloroquine not required due to current drug shortage Diagnosis of prophylaxis of PCP AND/OR prophylaxis of Toxoplasmosis • Diagnosis of HIV • Dapsone and Leucovorin OR Atovaquone and Leucovorin in claims history Reauthorization: • Dapsone and Leucovorin OR Atovaquone and Leucovorin in claims history Diagnosis of treatment of Toxoplasmosis encephalitis • Diagnosis of HIV • One Time Trial Within The Last 30 Days Of: A Sulfonamide (i.e.: SMZ/TMP, Sulfasalazine) In Recent Claims Hx OR documented sulfa allergy • Clindamycin and Leucovorin OR Atovaquone and Leucovorin in claims history Reauthorization: • Clindamycin and Leucovorin OR Atovaquone and Leucovorin in claims history • Diagnosis of Acute Malaria • Trial of TWO anti-malarial agents from this list taken at separate times: Quinine, Malarone, Mefloquine, Primaquine, Hydroxychloroquine or Chloroquine (also requires a PA) in the past 120 days Reauthorization: • Chart notes state that member is still having signs and symptoms of acute malaria. • Diagnosis of Chemoprophylaxis Of Malaria Due To Susceptible Strains of Plasmodia • Trial of TWO anti-malarial agents from this list taken at separate times: Quinine, Malarone, Coartem, Mefloquine, Primaquine, Hydroxychloroquine or Chloroquine (also requires a PA) in the past 120 days	Up to 6 months

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Drug Name	Criteria	Approval Duration
QELBREE ER 100 MG CAPSULE	•Documented diagnosis of ADHD •Trial and failure of at least 2 preferred ADHD drugs, one of which must be atomoxetine unless the member has a documented inability to swallow capsules •QL 90 capsules per 30 days (60/30 for peds) •Renew if positive clinical response	1 Year
QELBREE ER 150 MG CAPSULE	•Documented diagnosis of ADHD •Trial and failure of at least 2 preferred ADHD drugs, one of which must be atomoxetine unless the member has a documented inability to swallow capsules •QL 90 capsules per 30 days (60/30 for peds) •Renew if positive clinical response	1 Year
QELBREE ER 200 MG CAPSULE	•Documented diagnosis of ADHD •Trial and failure of at least 2 preferred ADHD drugs, one of which must be atomoxetine unless the member has a documented inability to swallow capsules •QL 90 capsules per 30 days (60/30 for peds) •Renew if positive clinical response	1 Year
QNASL 80 MCG NASAL SPRAY	•Ages 2-3: 30 Day Trial of Nasacort OTC Allergy 24HR Spray •OR •Ages 4-5: 30 Day Trial of Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, or Nasacort OTC Allergy 24HR Spray •OR •Ages 6 And Older: 30 Day Trial Of 2 Of the Following 4 Drugs: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Flunisolide, or Nasacort OTC Allergy 24HR Spray •Note: 1 Bottle Contains 120 Sprays	1 year
QNASL CHILDREN'S 40 MCG SPRAY	•Ages 2-3: 30 Day Trial of Nasacort OTC Allergy 24HR Spray •OR •Ages 4-5: 30 Day Trial of Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, or Nasacort OTC Allergy 24HR Spray •OR •Ages 6 And Older: 30 Day Trial Of 2 Of the Following 4 Drugs: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Flunisolide, or Nasacort OTC Allergy 24HR Spray •Note: 1 Bottle Contains 120 Sprays	1 year
QUINIDINE SULFATE 200 MG TAB	Diagnosis of Fax Must State for Life-Threatening Arrhythmia (Atrial Fibrillation, Atrial Flutter, Suppression of Ventricular Arrhythmias)	1 year
QUINIDINE SULFATE 300 MG TAB	Diagnosis of Fax Must State for Life-Threatening Arrhythmia (Atrial Fibrillation, Atrial Flutter, Suppression of Ventricular Arrhythmias)	1 year
QULIPTA 10 MG TABLET	•At least 18 years of age •Member has a documented diagnosis of episodic migraine, defined as between 4 and 14 headache days per month, with some causing disability •Member has tried and failed at least 2 prophylactic medications, for at least 8 weeks each, from different therapeutic classes: beta blocker, antidepressant, anticonvulsant •QL: 30/30 •Renew x 12 months if: Reduction in monthly headache days or Improvement in migraine-related disability	6 Months
QULIPTA 30 MG TABLET	•At least 18 years of age •Member has a documented diagnosis of episodic migraine, defined as between 4 and 14 headache days per month, with some causing disability •Member has tried and failed at least 2 prophylactic medications, for at least 8 weeks each, from different therapeutic classes: beta blocker, antidepressant, anticonvulsant •QL: 30/30 •Renew x 12 months if: Reduction in monthly headache days or Improvement in migraine-related disability	6 Months
QULIPTA 60 MG TABLET	•At least 18 years of age •Member has a documented diagnosis of episodic migraine, defined as between 4 and 14 headache days per month, with some causing disability •Member has tried and failed at least 2 prophylactic medications, for at least 8 weeks each, from different therapeutic classes: beta blocker, antidepressant, anticonvulsant •QL: 30/30 •Renew x 12 months if: Reduction in monthly headache days or Improvement in migraine-related disability	6 Months

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Drug Name	Criteria	Approval Duration
QUTENZA 8% KIT (4 PATCH)	•Diagnosis of Postherpetic Neuralgia OR Neuropathic Pain Associated with Diabetic Peripheral Neuropathy of the Feet •Trial And Failure Of At Least 3 Of the Following for No Less Than 30 Days Each: Gabapentin at Max Tolerated Dose, Pregabalin at Max Tolerated Dose, Lidocaine 5% Patch, OTC Capsaicin •Re-Authorization Requires: Improved Pain Level with Treatment but has Symptom Recurrence •Quantity Limit: 4 Patches/90 Days •Note: This is a Medical Benefit Drug (J7336)	For Initial Authorizations = 3 Months For Re-Authorizations = 12 Months
QUVIVIQ 25 MG TABLET	•Must have a 7-day trial within the last 120 days of Zolpidem or Zaleplon •Limit 30 tablets per 30 days •Renew if positive clinical response and no signs of abuse/dependence	1 year
QUVIVIQ 50 MG TABLET	•Must have a 7-day trial within the last 120 days of Zolpidem or Zaleplon •Limit 30 tablets per 30 days •Renew if positive clinical response and no signs of abuse/dependence	1 year
QVAR REDIHALER 40 MCG	• Age < 12 years OR • Diagnosis of Asthma • 30 day Trial of Arnuity or Flovent	1 year
QVAR REDIHALER 80 MCG	• Age < 12 years OR • Diagnosis of Asthma • 30 day Trial of Arnuity or Flovent	1 year
RABAVERT RABIES VACCINE VIAL	•Under the Age of 19: Use the Vaccines for Children (VFC) Program •Age Of 19 and Over: If Billing to the Medical Benefit, No PA Is Required OR •If Billing to The Pharmacy Benefit, No PA Is Required. However, Pharmacy MUST Bill Using the Broader Vaccine Network (BVN)	N/A
RABEPRAZOLE SOD DR 20 MG TAB	30 day trials each of 2 of the following : Nexium 24HR (OTC) (BID dosing), Pantoprazole 40 mg, Lansoprazole 15 mg (OTC) (BID dosing), Omeprazole 40 mg (Or 20mg BID)	1 year
RAGWITEK SUBLINGUAL TABLET	•Member Has a Diagnosis of Short Ragweed Pollen-Induced Allergic Rhinitis •Chart Notes Must Confirm the Diagnosis with Documentation of Positive Skin Test Or In Vitro Testing for Pollen-Specific IgE Antibodies for Short Ragweed Pollen •Ragwitek is Prescribed by or in Consultation with an Allergist or Immunologist •Member Has Had a Trial and Failure of Conventional Pharmacotherapy (i.e., Antihistamine, Nasal Steroid) •Member Does NOT Have Evidence of Severe, Uncontrolled Asthma •Member is Between 5 and 65 Years of Age	1 year
RASAGILINE MESYLATE 0.5 MG TAB	Trial of: Bromocriptine, Amantadine, Carbidopa/Levodopa, Pramipexole, Ropinirole, or Selegiline	1 year
RASAGILINE MESYLATE 1 MG TAB	Trial of: Bromocriptine, Amantadine, Carbidopa/Levodopa, Pramipexole, Ropinirole, or Selegiline	1 year
RASUVO 10 MG/0.2 ML AUTOINJ	•Diagnosis of RA, pJIA or Psoriasis •Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Methotrexate Injection	1 year
RASUVO 12.5 MG/0.25 ML AUTOINJ	•Diagnosis of RA, pJIA or Psoriasis •Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Methotrexate Injection	1 year
RASUVO 15 MG/0.3 ML AUTOINJ	•Diagnosis of RA, pJIA or Psoriasis •Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Methotrexate Injection	1 year
RASUVO 17.5 MG/0.35 ML AUTOINJ	•Diagnosis of RA, pJIA or Psoriasis •Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Methotrexate Injection	1 year
RASUVO 20 MG/0.4 ML AUTOINJ	•Diagnosis of RA, pJIA or Psoriasis •Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Methotrexate Injection	1 year
RASUVO 22.5 MG/0.45 ML AUTOINJ	•Diagnosis of RA, pJIA or Psoriasis •Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Methotrexate Injection	1 year

Drug Name	Criteria	Approval Duration
RASUVO 25 MG/0.5 ML AUTOINJ	•Diagnosis of RA, pJIA or Psoriasis •Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Methotrexate Injection	1 year
RASUVO 30 MG/0.6 ML AUTOINJ	•Diagnosis of RA, pJIA or Psoriasis •Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Methotrexate Injection	1 year
RASUVO 7.5 MG/0.15 ML AUTOINJ	•Diagnosis of RA, pJIA or Psoriasis •Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Methotrexate Injection	1 year
RAYALDEE ER 30 MCG CAPSULE	•For Initial Authorizations: •Member is Diagnosed with Secondary Hyperparathyroidism with Stage 3 or 4 Kidney Disease. •Member is 18 Years or Older •Member Meets ALL the Following Lab Value Criteria: •Total Serum 25-Hydroxyvitamin D Level Less Than 30ng/mL •Serum Corrected Calcium Less Than 9.8 mg/mL •Member Had At Least A 30-Day Trial (Each) Of At Least 2 Of the Following Alternative Vitamin D Analogs: •Calcitriol (Rocaltrol) •Doxercalciferol (Hectorol) •Paricalcitol (Zemplar) •For Re-Authorizations: •Member is Diagnosed with Secondary Hyperparathyroidism with Stage 3 or 4 Kidney Disease •Clinical Documentation Showing a biological Response as Indicated by all of the Following: •Total Serum 25-Hydroxyvitamin D Level Increased from Baseline (Initial Authorization) But Less Than 100ng/mL •Quantity Limit 60 Capsules/30 Days	6 Months for Initial Authorizations 12 Months for Re-Authorizations
RECTIV 0.4% OINTMENT	• Diagnosis of anal fissures	3 months
RELEXXII ER 72 MG TABLET	• Diagnosis of ADHD, AND • 30 day trial <u>each</u> of: generic methylphenidate capsules or preferred strength of methylphenidate ER tablets (18mg, 27mg, 36mg, or 54mg) AND generic methylphenidate ER 72 mg	1 year
RELION NOVOLOG MIX 70-30 VIAL	*Clinical reason why (after a 90 day trial of) insulin lispro cannot be used OR *Clinical reason why this formulation is medically necessary when single-ingredient insulins are available	1 year
RESTASIS 0.05% EYE EMULSION	• Clinical Reason Supported By Chart Notes Why (After A 90 Day Trial of) The Below Cannot Be Used: Xiidra	1 year
RESTASIS MULTIDOSE 0.05% EYE	• Clinical Reason Supported By Chart Notes Why (After A 90 Day Trial of) The Below Cannot Be Used: Xiidra	1 year
Rexulti	• Diagnosis of Major Depressive Disorder • Concurrent Therapy With Formulary Anti-Depressants (i.e., Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline, Venlafaxine Tablet, Venlafaxine ER Capsule, Duloxetine Or Bupropion AND •60 Day Trial Of: Aripiprazole (Abilify) OR • Diagnosis of Schizophrenia • 60 Day Trial Of: Aripiprazole (Abilify)	1 year
REXULTI 0.25 MG TABLET	• Diagnosis of Major Depressive Disorder • Concurrent Therapy With Formulary Anti-Depressants (i.e., Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline, Venlafaxine Tablet, Venlafaxine ER Capsule, Duloxetine Or Bupropion AND •60 Day Trial Of: Aripiprazole (Abilify) OR • Diagnosis of Schizophrenia • 60 Day Trial Of: Aripiprazole (Abilify)	1 year

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REXULTI 0.5 MG TABLET	• Diagnosis of Major Depressive Disorder • Concurrent Therapy With Formulary Anti-Depressants (i.e., Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline, Venlafaxine Tablet, Venlafaxine ER Capsule, Duloxetine Or Bupropion AND •60 Day Trial Of: Aripiprazole (Abilify) OR • Diagnosis of Schizophrenia • 60 Day Trial Of: Aripiprazole (Abilify)	1 year
REXULTI 1 MG TABLET	• Diagnosis of Major Depressive Disorder • Concurrent Therapy With Formulary Anti-Depressants (i.e., Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline, Venlafaxine Tablet, Venlafaxine ER Capsule, Duloxetine Or Bupropion AND •60 Day Trial Of: Aripiprazole (Abilify) OR • Diagnosis of Schizophrenia • 60 Day Trial Of: Aripiprazole (Abilify)	1 year
REXULTI 2 MG TABLET	• Diagnosis of Major Depressive Disorder • Concurrent Therapy With Formulary Anti-Depressants (i.e., Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline, Venlafaxine Tablet, Venlafaxine ER Capsule, Duloxetine Or Bupropion AND •60 Day Trial Of: Aripiprazole (Abilify) OR • Diagnosis of Schizophrenia • 60 Day Trial Of: Aripiprazole (Abilify)	1 year
REXULTI 3 MG TABLET	• Diagnosis of Major Depressive Disorder • Concurrent Therapy With Formulary Anti-Depressants (i.e., Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline, Venlafaxine Tablet, Venlafaxine ER Capsule, Duloxetine Or Bupropion AND •60 Day Trial Of: Aripiprazole (Abilify) OR • Diagnosis of Schizophrenia • 60 Day Trial Of: Aripiprazole (Abilify)	1 year
REXULTI 4 MG TABLET	• Diagnosis of Major Depressive Disorder • Concurrent Therapy With Formulary Anti-Depressants (i.e., Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline, Venlafaxine Tablet, Venlafaxine ER Capsule, Duloxetine Or Bupropion AND •60 Day Trial Of: Aripiprazole (Abilify) OR • Diagnosis of Schizophrenia • 60 Day Trial Of: Aripiprazole (Abilify)	1 year
RHOFADE 1% CREAM	•Diagnosis of Moderate to Severe Persistent Facial Erythema of Rosacea in Adults (18+) •Will Not be Used in Combination with Mirvaso •Re-Authorization Requirement: Chart Notes Showing Symptom Improvements •Quantity Limit 30 Grams (1 Tube)/26 Days	3 Months for Initial Authorizations 12 Months for Re-Authorizations
RIFATER TABLET	Trial of: Agents used at the same time (Rifampin/Isoniazid/Pyrazinamide)	1 year
RILUZOLE 50 MG TABLET	Diagnosis of Amyotrophic Lateral Sclerosis	1 year
RISEDRONATE SOD DR 35 MG TAB	•If Fax States Allergy, Side Effects or Intolerance To: Alendronate (Fosamax) •OR •Trials of: Alendronate	1 year
ROCKLATAN 0.02%-0.005% EYE DRP	• Clinical reason why (after a 90 day trial each) two of the following cannot be used: Latanoprost, brimonidine, dorzolamide, dorzolamide/timolol, levobunolol, metipranolol, timolol, betaxolol, brimonidine, brimonidine/timolol, pilocarpine	1 year

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ROPINIROLE HCL ER 12 MG TABLET	•Diagnosis of Parkinson's Disease AND •Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Immediate Release Ropinirole	1 year
ROPINIROLE HCL ER 2 MG TABLET	• Diagnosis of Parkinson's Disease AND • Clinical Reason Supported By Chart Notes Why (After A 30 Day Trial of) The Below Cannot Be Used: • Immediate Release Ropinirole	1 year
ROPINIROLE HCL ER 4 MG TABLET	• Diagnosis of Parkinson's Disease AND • Clinical Reason Supported By Chart Notes Why (After A 30 Day Trial of) The Below Cannot Be Used: • Immediate Release Ropinirole	1 year
ROPINIROLE HCL ER 6 MG TABLET	•Diagnosis of Parkinson's Disease AND •Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Immediate Release Ropinirole	1 year
ROPINIROLE HCL ER 8 MG TABLET	• Diagnosis of Parkinson's Disease AND • Clinical Reason Supported By Chart Notes Why (After A 30 Day Trial of) The Below Cannot Be Used: • Immediate Release Ropinirole	1 year
ROSADAN 0.75% CREAM KIT	• 90 day trial of metronidazole 0.75% cream • Clinical reason why metronidazole 0.75% cream cannot be used	1 year
ROSADAN 0.75% GEL KIT	• 90 day trial of metronidazole 0.75% cream • Clinical reason why metronidazole 0.75% cream cannot be used	1 year
ROSULA 10%-5% CLOTHS	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Avar-E LS 10-2% Cream, Sulfacetamide Sodium with Sulfur Suspension 10-5%, Sulfacetamide Sodium with Sulfur Lotion 10-5%, or Sulfacetamide Sodium with Sulfur Emulsion, Avar Cleanser, Rosanil, Prascion 10-5%	1 year
ROSUVASTATIN CALCIUM 10 MG TAB	30 Day Trial of One of The Following: Atorvastatin, Pravastatin, Lovastatin, Simvastatin	1 year
ROSUVASTATIN CALCIUM 20 MG TAB	30 Day Trial of One of The Following: Atorvastatin, Pravastatin, Lovastatin, Simvastatin	1 year
ROSUVASTATIN CALCIUM 40 MG TAB	30 Day Trial of One of The Following: Atorvastatin, Pravastatin, Lovastatin, Simvastatin	1 year
ROSUVASTATIN CALCIUM 5 MG TAB	30 Day Trial of One of The Following: Atorvastatin, Pravastatin, Lovastatin, Simvastatin	1 year
RUFINAMIDE 40 MG/ML SUSPENSION	•Diagnosis of Seizure or Epilepsy •Trial Of 30 Days Of 1 Of the Following: •Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) or Zonisamide AND •Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Banzel Tablet (Which also requires a PA)	1 year
RYBELSUS 14 MG TABLET	30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 year
RYBELSUS 3 MG TABLET	30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 year
RYBELSUS 7 MG TABLET	30 Day Trial of: Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) - [Not Required If: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)]	1 year
RYDAPT 25 MG CAPSULE	•Pharmacy Benefit •Diagnosis of Acute Myeloid Lukemia That is FLT3 Mutation-Positive and Used in Combination with Cytarabine and Daunorubicin Induction and Cytarabine Consolidation •OR •Diagnosis of Aggressive Systemic Mastocytosis (ASM), Systematic Mastocytosis with Associated Hematological Neoplasm (SM-AHN), or Mast Cell Leukemia	6 Months
SALICYLIC ACID 27.5% LIQUID	•Clinical Reason Supported by Chart Notes why (After a One Time Trial Of) the Below Cannot be Used: •Salicylic Acid 17% Gel or Salicylic Acid 17% •Quantity Limit 10 mL (1 Tube)/26 Days]	30 Days
SALICYLIC ACID 6% FOAM	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •OTC Salicylic Acid 6% Cream, Gel, or Lotion	1 year

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SALIVAMAX POWDER PACKET	30 Day Trial of: Pilocarpine Tablet or OTC Saliva Substitute (i.e., Salivasure, Salese (Numoisyn) Lozenges, Aquoral Aerosol Solution, or Caphosol, Numoisyn, Biotene, Mouthkote, Moi-Stir Solution)	1 year
SALSALATE 500 MG TABLET	Diagnosis of Rheumatoid Arthritis or Osteoarthritis	3 Months
SALSALATE 750 MG TABLET	Diagnosis of Rheumatoid Arthritis or Osteoarthritis	3 Months
SAMSCA 15 MG TABLET	Diagnosis of Hypervolemic and Euvolemic Hyponatremia	30 days
SAVAYSA 30 MG TABLET	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Eliquis Tablet, Fondaparinux (Arixtra) Syringe, or Xarelto Tablet	1 year
SAVAYSA 60 MG TABLET	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Eliquis Tablet, Fondaparinux (Arixtra) Syringe, or Xarelto Tablet	1 year
SAVELLA 100 MG TABLET	• Diagnosis of: Fibromyalgia • 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule	1 year
SAVELLA 12.5 MG TABLET	• Diagnosis of: Fibromyalgia • 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule	1 year
SAVELLA 25 MG TABLET	• Diagnosis of: Fibromyalgia • 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule	1 year
SAVELLA 50 MG TABLET	• Diagnosis of: Fibromyalgia • 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule	1 year
SCOPOLAMINE 1 MG/3 DAY PATCH	•Diagnosis of Prevention of Nausea/Vomiting Associated with Motion Sickness or From Anesthesia and Surgery •Age 18 and Older •Trial of Meclizine Tablets •OR •May Approve if Patient has Cancer Diagnosis •Okay to Approve Brand due to long Term Back Order of Generic Products •Quantity Limit Up To 10/30 Days	For Anesthesia/Surgery: 1 Month For Motion Sickness: 3 Months For Cancer: 1 Year
SECUADO 3.8 MG/24 HR PATCH	• Diagnosis of schizophrenia • Clinical reason why oral alternatives cannot be used. Preferred alternatives include: aripiprazole, quetiapine, risperidone, ziprasidone	1 year
SECUADO 5.7 MG/24 HR PATCH	• Diagnosis of schizophrenia • Clinical reason why oral alternatives cannot be used. Preferred alternatives include: aripiprazole, quetiapine, risperidone, ziprasidone	1 year
SECUADO 7.6 MG/24 HR PATCH	• Diagnosis of schizophrenia • Clinical reason why oral alternatives cannot be used. Preferred alternatives include: aripiprazole, quetiapine, risperidone, ziprasidone	1 year
SEEBRI NEOHALER 15.6 MCG INHAL	•Diagnosis of COPD •30 Day Trial of: Spiriva Respimat or Tudorza •Quantity Limit 60 Capsules/Month	1 year
SEGLUROMET 2.5-1;000 MG TABLET	• 30 day Trial of Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) OR • One of the following: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)	1 year
SEGLUROMET 2.5-500 MG TABLET	• 30 day Trial of Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) OR • One of the following: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)	1 year
SEGLUROMET 7.5-1;000 MG TABLET	• 30 day Trial of Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) OR • One of the following: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)	1 year
SEGLUROMET 7.5-500 MG TABLET	• 30 day Trial of Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) OR • One of the following: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)	1 year
SELENIUM SULFIDE 2.25% SHAMPOO	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Selenium Sulfide (Selsun) 2.5% Lotion/Shampoo •Quantity Limit 180 mL (1 Bottle)/26 Days	1 year
SELENIUM SULFIDE 2.5% LOTION	• Diagnosis of: Tinea versicolor; OR • Diagnosis of: Seborrheic dermatitis of the scalp for which OTC selenium sulfide products have not been effective (Note: OTC products require formulary exception authorization for coverage)	1 year

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SELZENTRY 150 MG TABLET	•Diagnosis of CCR5-TropicHIV-1 Infection AND •CCR5-Tropic Virus Verified by Trophile or Other Validated Assay for Determining HIV Tropism •Quantity Limit 60/26 Days	1 year
SELZENTRY 20 MG/ML ORAL SOLN	•Diagnosis of CCR5-TropicHIV-1 Infection AND •CCR5-Tropic Virus Verified by Trophile or Other Validated Assay for Determining HIV Tropism •Quantity Limit 1,840 mL/26 Days	1 year
SELZENTRY 300 MG TABLET	•Diagnosis of CCR5-TropicHIV-1 Infection AND •CCR5-Tropic Virus Verified by Trophile or Other Validated Assay for Determining HIV Tropism •Quantity Limit 120/26 Days	1 year
SEMGLEE (YFGN) 100 UNIT/ML PEN	*30 day trial of insulin glargine-yfgn	1 year
SEMGLEE (YFGN) 100 UNIT/ML VL	*30 day trial of insulin glargine-yfgn	1 year
SEMGLEE 100 UNIT/ML PEN	*30 day trial of insulin glargine-yfgn	1 year
SERNIVO 0.05% SPRAY	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Betamethasone Valerate 0.1% Cream, Lotion, or Ointment	1 year
SEROSTIM 6 MG VIAL	•Set And Send to RPh for Review •Follow Serostim Policy on Website •For Initial Authorizations: •Special Population = Yes/No •Diagnosis of Growth Hormone Deficiency (GHD) [For Other Diagnoses Follow Policy] •Prescriber Specialty = •Clinical Info Required: •Most Recent Chart Note (Give Date of Note) •Growth Charts (Give Date of Chart Note) •Growth Hormone Stimulation Test Provided (Y or N) •Bone Age SD Differential = •For Re-Authorizations: •Special Population = Yes/No •Diagnosis of Growth Hormone Deficiency (GHD) [For Other Diagnoses Follow Policy] •Prescriber Specialty = •Clinical Info Required: •Most Recent Chart Note (Give Date of Note) •Growth Charts (Give Date of Chart Note) •Growth Velocity = •Quantity Limit 30 mL/22 Days	6 Months for Initial Authorizations 1 Year for Re-Authorizations
SEVELAMER 0.8 GM POWDER PACKET	•Approve If Fax States Elevated Calcium, High Calcium, Hypercalcemia, etc. •OR •Approve If Fax States Member Is Unable to Swallow •OR •30 Day Trial Of: Calcium Acetate (PhosLo)	1 year
SEVELAMER 2.4 GM POWDER PACKET	•Approve If Fax States Elevated Calcium, High Calcium, Hypercalcemia, etc. •OR •Approve If Fax States Member Is Unable to Swallow •OR •30 Day Trial Of: Calcium Acetate (PhosLo)	1 year
SEVELAMER CARBONATE 800 MG TAB	• Diagnosis of Elevated Calcium, High Calcium, Hypercalcemia, etc OR • Member Is Unable To Swallow OR • 30 Day Trial of: Calcium Acetate (PhosLo)	1 year
SEVELAMER HCL 400 MG TABLET	• Diagnosis of Elevated Calcium, High Calcium, Hypercalcemia, etc OR • Member Is Unable To Swallow OR • 30 Day Trial of: Calcium Acetate (PhosLo)	1 year
SEVELAMER HCL 800 MG TABLET	•Approve If MD States CA-PHos Product Levels Are Elevated •OR •Diagnosis of Reduction or Control of Serum Phosphorous in Patients with CKD on Dialysis AND •30 Day Trial of Calcium Acetate (PhosLo)	1 year

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SF 1.1% GEL	Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: ACT AntiCavity Fluoride Rinse, ACT Restoring Fluoride Rinse, ACT Total Care Rinse, Denta 5000 Plus 1.1% Cream, Phos-Flur 0.02% Rinse, or SF 5000 Plus 1.1% Cream	1 year
SIKLOS 1,000 MG TABLET	•Member is 2 years of age or older •Diagnosis of sickle cell anemia or sickle cell disease •Experiences recurrent moderate to severe pain crises •Documented trial and failure of generic hydroxyurea or overt inability to swallow capsules	1 year
SIKLOS 100 MG TABLET	•Member is 2 years of age or older •Diagnosis of sickle cell anemia or sickle cell disease •Experiences recurrent moderate to severe pain crises •Documented trial and failure of generic hydroxyurea or overt inability to swallow capsules	1 year
SIKLOS 100 MG TABLET	•Member is 2 years of age or older •Diagnosis of sickle cell anemia or sickle cell disease •Experiences recurrent moderate to severe pain crises •Documented trial and failure of generic hydroxyurea or overt inability to swallow capsules	1 year
SILA III 0.1% KIT	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of two of the following for 7 days each: Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone) • Trial of triamcinolone 0.1% (following trials mentioned above) AND clinical reason why the kit is required	1 year
SILDENAFIL 20 MG TABLET	• Age < 18 years old • Diagnosis of Pulmonary Arterial Hypertension • Prescribed by or in consultation with a cardiologist, pulmonologist, or rheumatologist • Clinical reason why (after a 90 day trial) tablets cannot be used or documented inability to swallow tablets OR • 18 years or older • WHO Group 1 with NYHA Functional class II or III symptoms • PAP pressures not adequately controlled using an oral vasodilator (e.g. calcium channel blocker) at maximal doses or the patient was not vasodilator sensitive as determined by an epoprostenol, adenosine, or inhaled nitric oxide challenge	1 year
SILODOSIN 4 MG CAPSULE	90-Day Trial of Doxazosin, Terazosin, Tamsulosin, or Prazosin	1 year
SILODOSIN 8 MG CAPSULE	90-Day Trial of Doxazosin, Terazosin, Tamsulosin, or Prazosin	1 year
SIMBRINZA 1%-0.2% EYE DROPS	30-Day Trial of Brimonidine 0.2% Eye Drop with Dorzolamide (Trusopt) 2% Eye Drops	1 year
SITAVIG 50 MG BUCCAL TABLET	•Clinical Reason Supported by Chart Notes why (after a One Time Trial Of) the Below Cannot be Used: •Acyclovir (Zovirax) 200 mg Capsule, Acyclovir (Zovirax) 400 mg Tablet, or Acyclovir (Zovirax) 800 mg Tablet	1 year
SIVEXTRO 200 MG TABLET	3 Day Trial of: Vancomycin IV or IV/Oral Linezolid (Zyvox)	30 Days
SKYADERM-LP 2.5-2.5% CRM-DRESS	• Clinical reason why, after a 30 day trial each, the following canot be used: lidocaine 3% cream, lidocaine-prilocaine cream	1 year
SOAANZ 20 MG TABLET	•Diagnosis of Heart Failure or Renal Disease •Documentation of Current Swelling in the Lower Limbs or Abdomen •Previous Trial and Failure (i.e., Swelling) with a Preferred Loop Diuretic •Dosing/Quantity Limit: 200 mg per day (20 mg Tablets= 2 per day, 60 mg Tablets= 3 per day)	1 year
SOD SULFACE-SULFUR 9-4.5% KIT	90 Day Trial Of: Avar-E LS 10-2% Cream, Sulfacetamide Sodium with Sulfur Suspension 10-5%, Sulfacetamide Sodium with Sulfur Lotion 10-5%, or Sulfacetamide Sodium with Sulfur Emulsion, Avar Cleanser, Rosanil, Prascion 10-5%	1 year
SOD SULFACETAMIDE 10% SHAMPOO	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Sulfacetamide Sodium (Klarion) 10% Lotion •Quantity Limit 237 mL (1 Bottle)/26 Days	1 year
SOD SULFACET-SULFUR 10-4% PAD	*Trial Of: Avar-E Ls 10-2% Cream, Sulfacetamide Sodium W/ Sulfur Suspension 10-5%, Sulfacetamide Sodium W/ Sulfur Lotion 10-5%, Or Sulfacetamide Sodium W/ Sulfur Emulsion, Avar Cleanser , Rosanil, Prascion 10-5%	1 year

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SOD SULFAC-SULFUR 9.8-4.8% CRM	90 Day Trial of: Avar-E LS 10-2% Cream, Sulfacetamide Sodium with Sulfur Suspension 10-5%, Sulfacetamide Sodium with Sulfur Lotion 10-5%, or Sulfacetamide Sodium with Sulfur Emulsion, Avar Cleanser, Rosanil, Prascion 10-5%	1 year
SODIUM CHLORIDE 0.9% IRRIG	Diagnosis of Needed for Irrigation	3 Months
SODIUM FLUORIDE 1.1% GEL	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •ACT AntiCavity Fluoride Rinse, ACT Restoring Fluoride Rinse, ACT Total Care Rinse, Denta 5000 Plus 1.1% Cream, Phos-Flur 0.02% Rinse, or SF 5000 Plus 1.1% Cream	1 year
SODIUM FLUORIDE 5000 PPM PASTE	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •ACT AntiCavity Fluoride Rinse, ACT Restoring Fluoride Rinse, ACT Total Care Rinse, Denta 5000 Plus 1.1% Cream, Phos-Flur 0.02% Rinse, or SF 5000 Plus 1.1% Cream	1 year
SODIUM SULFACETAMIDE 10% WASH	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Sulfacetamide Sodium (Klarion) 10% Lotion •Quantity Limit 340 Grams (1 Tube)/26 Days	1 year
SODIUM SULFACETAMIDE 10% WASH	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Sulfacetamide Sodium (Klarion) 10% Lotion •Quantity Limit 340 Grams (1 Tube)/26 Days	1 year
SOLIFENACIN 10 MG TABLET	•Approve If Member Was Previously Approved for Myrbetriq ER •30 Day Trial of at Least One of the Following: Oxybutynin, Oxybutynin XL, Tolterodine, Tolterodine ER, Trospium, or Trospium XR (Tolterodine, Tolterodine ER, Trospium, Trospium SR Also Require PA)	1 year
SOLIFENACIN 5 MG TABLET	•Approve If Member Was Previously Approved for Myrbetriq ER •30 Day Trial of at Least One of the Following: Oxybutynin, Oxybutynin XL, Tolterodine, Tolterodine ER, Trospium, or Trospium XR (Tolterodine, Tolterodine ER, Trospium, Trospium SR Also Require PA)	1 year
SOLIQUA 100 UNIT-33 MCG/ML PEN	• 30 day Trial of Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) OR • One of the following: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)	1 year
SOLOSEC 2 GM GRANULE PACKET	• Diagnosis of bacterial vaginosis AND trial and failure of metronidazole or clindamycin; OR • Diagnosis of trichomoniasis AND trial and failure of metronidazole tablets or tinidazole	7 days
SORBITOL 3.3% UROLOGIC SOLN	Diagnosis of Urologic Irrigation	3 Months
SORILUX 0.005% FOAM	Trial of calcipotriene (Dovonex)	1 year
SOTYLIZE 5 MG/ML ORAL SOLUTION	90 Day Trial of: Sotalol (Betapace) Tablet	1 year
SPINOSAD 0.9% TOPICAL SUSP	• Diagnosis of head lice • One time trial and failure of Malathion, OTC permethrin, or OTC pyrethrins in the last 60 days	7 days
SPIRIVA 18 MCG CP-HANDIHALER	•Diagnosis of COPD (Emphysema, Chronic Bronchitis) AND •Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Spiriva Respimat •Quantity Limit 30 Capsules/Month	1 year
SPRITAM 1,000 MG TABLET	•For Age 4 Years and Older: •Weight > 20 kg •Diagnosis of Partial Onset Seizures •Trial of and Inadequate Response or Intolerance to 1 Preferred Product (e.g., Levetiracetam, Lamotrigine, Gabapentin, Felbamate, Topiramate, Oxcarbazepine) •For Ages 12 Years and Older: •Diagnosis of Juvenile Myoclonic Epilepsy •Trial of and Inadequate Response or Intolerance to 1 Preferred Product (e.g., Levetiracetam, Lamotrigine, Gabapentin, Felbamate, Topiramate, Oxcarbazepine) •For Ages 6 Years and Older: •Weight > 20 kg •Diagnosis of Primary Generlized Tonic-Clonic Seizures AND Idiopathic Generalized Epilepsy •Trial of and Inadequate Response or Intolerance to 1 Preferred Product (e.g., Levetiracetam, Lamotrigine, Gabapentin, Felbamate, Topiramate, Oxcarbazepine)	1 year

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SPRITAM 250 MG TABLET	•For Age 4 Years and Older: •Weight > 20 kg •Diagnosis of Partial Onset Seizures •Trial of and Inadequate Response or Intolerance to 1 Preferred Product (e.g., Levetiracetam, Lamotrigine, Gabapentin, Felbamate, Topiramate, Oxcarbazepine) •For Ages 12 Years and Older: •Diagnosis of Juvenile Myoclonic Epilepsy •Trial of and Inadequate Response or Intolerance to 1 Preferred Product (e.g., Levetiracetam, Lamotrigine, Gabapentin, Felbamate, Topiramate, Oxcarbazepine) •For Ages 6 Years and Older: •Weight > 20 kg •Diagnosis of Primary Generlized Tonic-Clonic Seizures AND Idiopathic Generalized Epilepsy •Trial of and Inadequate Response or Intolerance to 1 Preferred Product (e.g., Levetiracetam, Lamotrigine, Gabapentin, Felbamate, Topiramate, Oxcarbazepine)	1 year
SPRITAM 500 MG TABLET	•For Age 4 Years and Older: •Weight > 20 kg •Diagnosis of Partial Onset Seizures •Trial of and Inadequate Response or Intolerance to 1 Preferred Product (e.g., Levetiracetam, Lamotrigine, Gabapentin, Felbamate, Topiramate, Oxcarbazepine) •For Ages 12 Years and Older: •Diagnosis of Juvenile Myoclonic Epilepsy •Trial of and Inadequate Response or Intolerance to 1 Preferred Product (e.g., Levetiracetam, Lamotrigine, Gabapentin, Felbamate, Topiramate, Oxcarbazepine) •For Ages 6 Years and Older: •Weight > 20 kg •Diagnosis of Primary Generlized Tonic-Clonic Seizures AND Idiopathic Generalized Epilepsy •Trial of and Inadequate Response or Intolerance to 1 Preferred Product (e.g., Levetiracetam, Lamotrigine, Gabapentin, Felbamate, Topiramate, Oxcarbazepine)	1 year
SPRITAM 750 MG TABLET	•For Age 4 Years and Older: •Weight > 20 kg •Diagnosis of Partial Onset Seizures •Trial of and Inadequate Response or Intolerance to 1 Preferred Product (e.g., Levetiracetam, Lamotrigine, Gabapentin, Felbamate, Topiramate, Oxcarbazepine) •For Ages 12 Years and Older: •Diagnosis of Juvenile Myoclonic Epilepsy •Trial of and Inadequate Response or Intolerance to 1 Preferred Product (e.g., Levetiracetam, Lamotrigine, Gabapentin, Felbamate, Topiramate, Oxcarbazepine) •For Ages 6 Years and Older: •Weight > 20 kg •Diagnosis of Primary Generlized Tonic-Clonic Seizures AND Idiopathic Generalized Epilepsy •Trial of and Inadequate Response or Intolerance to 1 Preferred Product (e.g., Levetiracetam, Lamotrigine, Gabapentin, Felbamate, Topiramate, Oxcarbazepine)	1 year
SPRIX 15.75 MG NASAL SPRAY	•Diagnosis of Moderate to Severe Pain •Clinical Reason Supported by Chart Notes Why (After A Trial Of) Two Oral NSAIDs (Meloxicam, Naproxen, Ibuprofen, Diclofenac, Ketorolac, Celecoxib, etc.) Cannot be Used •OR •Patient Is Unable to Swallow, Has Dysphagia, Esophagitis, Mucositis, or Uncontrollable Nausea/Vomiting (Must Be Documented in Chart Notes) •AND •Total Duration of Use of Ketorlac Alone or Sequentially with Other Formulations of Ketorolac Must Not Exceed 5 Days (If Claims of Ketorlac Will Exceed 5 Days, Setup and Send to RPh •Quantity Limit 2 Units/Day	5 Days
SSS 10-5 FOAM	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Sulfacetamide Sodium with Sulfur Suspension 10-5%, Sulfacetamide Sodium with Sulfur Lotion 10-5%, or Sulfacetamide Sodium with Sulfur Emulsion, Avar Cleanser, Rosanil, Prascion 10-5%	1 year

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STEGLATRO 15 MG TABLET	• 30 day Trial of Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) OR • One of the following: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)	1 year
STEGLATRO 5 MG TABLET	• 30 day Trial of Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) OR • One of the following: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)	1 year
STEGLUJAN 15-100 MG TABLET	•90-Day Trial of Steglatro or Segluromet AND •90-day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)	1 year
STEGLUJAN 5-100 MG TABLET	•90-Day Trial of Steglatro or Segluromet AND •90-day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)	1 year
STERILE WATER FOR IRRIGATION	Diagnosis of Need for Irrigation	3 Months
STRIANT 30 MG MUCOADHESIVE	•Diagnosis of Hypogonadism •Total Testosterone Lab Value = ≤ 300ng/dL Before Treatment (For New Starts Only) •Clinical Reason Supported by Chart Notes Why (After a 90-Day Trial of) the Below Cannot be Used: •Testosterone TD (Fortesta) or Testosterone (Androgel, Testim, Vogelxo) 1% (50 mg/5G) Gel Packet (Both Still Require a PA Also)	1 year
SUCRAID 8,500 UNITS/ML SOLN	Diagnosis of Sucrase Deficiency	1 year
SULCONAZOLE NITRATE 1% CREAM	Diagnosis of Tinea infection (Tinea corporis/tinea cruris, tinea pedis, Tinea versicolor)	1 month
SULCONAZOLE NITRATE 1% SOLN	Diagnosis of Tinea infection (Tinea corporis/tinea cruris, tinea pedis, Tinea versicolor)	1 month
SULFACETAMIDE-SULFUR 8-4% SUSP	*Trial Of: Avar-E Ls 10-2% Cream, Sulfacetamide Sodium W/ Sulfur Suspension 10-5%, Sulfacetamide Sodium W/ Sulfur Lotion 10-5%, Or Sulfacetamide Sodium W/ Sulfur Emulsion, Avar Cleanser , Rosanil, Prascion 10-5%	1 year
SULFACETAMIDE-SULFUR 9-4% CLSR	Required Trial of One of the Following: Avar-E LS 10-2% Cream, Sulfacetamide Sodium W/ Sulfur Suspension 10-5%, Sulfacetamide Sodium W/ Sulfur Lotion 10-5%, or Sulfacetamide Sodium W/ Sulfur Emulsion, Avar Cleanser, or Rosanil, Prascion 10-5%	1 year
SULFACLEANSE 8-4 SUSPENSION	• Trial of: Avar-E Ls 10-2% Cream, Sulfacetamide Sodium W/ Sulfur Suspension 10-5%, Sulfacetamide Sodium W/ Sulfur Lotion 10-5%, Or Sulfacetamide Sodium W/ Sulfur Emulsion, Avar Cleanser , Rosanil, Prascion 10-5%	1 year
SULFAMYLON 8.5% CREAM	Trial of: Silver Sulfdiazine	3 Months
SUMATRIPTAN-NAPROXEN 85-500 MG	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Naproxen and Sumatriptan used at the same time	1 year
SUMAVEL DOSEPRO 6 MG/0.5 ML	•A Trial of Sumatriptan Tablets, Injection, AND Nasal Spray AND •Clinical Reason Supported by Chart Notes or Provider Call Why the Needle Free Injectable is Required	1 year
SUNOSI 150 MG TABLET	•Diagnosis of narcolepsy •Age ≥ 18 years •90 day trial of both of the following: Armodafinil (Nuvigil), Modafinil (Provigil) OR •Diagnosis of Obstructive Sleep Apnea (OSA) •Age ≥ 18 years •Residual sleepiness despite use of continuous positive airway pressure (CPAP) for at least one month •90 day trial of both of the following: Armodafinil (Nuvigil), Modafinil (Provigil)	1 year
SUNOSI 75 MG TABLET	•Diagnosis of narcolepsy •Age ≥ 18 years •90 day trial of both of the following: Armodafinil (Nuvigil), Modafinil (Provigil) OR •Diagnosis of Obstructive Sleep Apnea (OSA) •Age ≥ 18 years •Residual sleepiness despite use of continuous positive airway pressure (CPAP) for at least one month •90 day trial of both of the following: Armodafinil (Nuvigil), Modafinil (Provigil)	1 year

Drug Name	Criteria	Approval Duration
SYLATRON 200 MCG KIT	Diagnosis of Melanoma	1 year
SYLATRON 300 MCG KIT	Diagnosis of Melanoma	1 year
SYLATRON 600 MCG KIT	Diagnosis of Melanoma	1 year
SYMJEPI 0.15 MG/0.3 ML SYRINGE	•Clinical Reason Why Epi-Pen (Brand) or Epinephrine 0.15 mg/0.15 mL Cannot be Used After a 90-Day Trial •Quantity Limit 4 Pens (2 Packs)/365 Days	Per RPh If Approving for 2 Boxes; Approve for 1 Year
SYMJEPI 0.3 MG/0.3 ML SYRINGE	•Clinical Reason Why Epi-Pen (Brand) or Epinephrine 0.15 mg/0.15 mL Cannot be Used After a 90-Day Trial •Quantity Limit 4 Pens (2 Packs)/365 Days	Per RPh If Approving for 2 Boxes; Approve for 1 Year
SYMLINPEN 120 PEN INJECTOR	60 day Trial of Humalog, Novolog, or Apidra	1 year
SYMLINPEN 60 PEN INJECTOR	60 day Trial of Humalog, Novolog, or Apidra	1 year
SYMPROIC 0.2 MG TABLET	• 30 day trial each and clinical reason both of the below cannot be used: Amitiza (also requires PA), Movantik (also requires PA)	1 year
SYNALAR TS 0.01% KIT	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Fluocinolone Acetonide 0.01% Solution & OTC Cleanser	1 year
SYNAREL 2 MG/ML NASAL SPRAY	Diagnosis of Endometriosis	1 year
SYNDROS 5 MG/ML SOLUTION	•Diagnosis of Anorexia Associated with Weight Loss in Patients with AIDS •OR •Diagnosis of Cancer Chemotherapy-Induced Nausea and Vomiting in Patients who have Failed Conventional Antiemetic Treatments (Examples: Metoclopramide, Promethazine, Prochlorperazine, Meclizine, Oral 5-HT3 Receptor Antagonists) •AND •30-Day Trial of Dronabinol •Quantity Limit 240 mL/25 Days	6 Months
SYNERA PATCH	Diagnosis of Local Dermal Analgesia on Intact Skin Before Superficial Venous Access and Superficial Dermatologic Procedures	1 year
SYNJARDY 12.5-1,000 MG TABLET	•30-Day Trial of: Metformin IR or ER •THEN •60 Day Trial of: Segluromet	1 year
SYNJARDY 12.5-500 MG TABLET	•30-Day Trial of: Metformin IR or ER •THEN •60 Day Trial of: Segluromet	1 year
SYNJARDY 5-1,000 MG TABLET	•30-Day Trial of: Metformin IR or ER •THEN •60 Day Trial of: Segluromet	1 year
SYNJARDY 5-500 MG TABLET	•30-Day Trial of: Metformin IR or ER •THEN •60 Day Trial of: Segluromet	1 year
SYNJARDY XR 10-1,000 MG TABLET	•30-Day Trial of: Metformin IR or ER •THEN •60 Day Trial of: Segluromet	1 year
SYNJARDY XR 12.5-1,000 MG TAB	•30-Day Trial of: Metformin IR or ER •THEN •60 Day Trial of: Segluromet	1 year
SYNJARDY XR 25-1,000 MG TABLET	•30-Day Trial of: Metformin IR or ER •THEN •60 Day Trial of: Segluromet	1 year
SYNJARDY XR 5-1,000 MG TABLET	•30-Day Trial of: Metformin IR or ER •THEN •60 Day Trial of: Segluromet	1 year
TADALAFIL 20 MG TABLET	Patient must be 18 years or older WHO Group 1 with NYHA Functional class II or III symptoms PAP pressures not adequately controlled using an oral vasodilator (e.g. calcium channel blocker) at maximal doses or the patient was not vasodilator sensitive as determined by an epoprostenol, adenosine, or inhaled nitric oxide challenge	1 year
TADALAFIL 5 MG TABLET	Diagnosis of Erectile Dysfunction is excluded OR • Diagnosis of Benign Prostatic Hypertrophy (BPH) • 30-day trial and failure or clinically significant adverse effects with one of the following doxazosin, terazosin, tamsulosin, or prazosin AND • 90-day trial and failure or clinically significant adverse effects with finasterirde	1 year
TALICIA DR 10-250-12.5 MG CAP	*Tried and failed or unable to try generic Prevpac *Dx= Helicobacter pylori gastrointestinal tract infection	14 days
TASIGNA 150 MG CAPSULE	Diagnosis of Chronic Myelogenous Leukemia	1 year
TASIGNA 200 MG CAPSULE	Diagnosis of Chronic Myelogenous Leukemia	1 year

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TAVABOROLE 5% TOPICAL SOLUTION	•90-Day Trial of: Ciclopirox (Penlac, Ciclodan) 8% Solution Within All Claims History AND •30-Day Trial of: Oral Terbinafine or Oral Itraconazole •Quantity Limit 10 mL (1 Bottle)/26 Days	60 Days
TAZAROTENE 0.1% CREAM	•Diagnosis of Psoriasis •Trial of: Calcipotriene (Dovonex) •OR •Diagnosis of Acne •Trial of: Tretinoin Cream or Gel or Differin OTC •Quantity Limit 30 Grams (1 Tube)/26 Days	1 year
TAZORAC 0.05% CREAM	•Diagnosis of Psoriasis •Trial of: Calcipotriene (Dovonex) •OR •Diagnosis of Acne •Trial of: Tretinoin Cream or Gel or Differin OTC •Quantity Limit 30 Grams (1 Tube)/26 Days	1 year
TAZORAC 0.05% GEL	•Diagnosis of Psoriasis •Trial of: Calcipotriene (Dovonex) •OR •Diagnosis of Acne •Trial of: Tretinoin Cream or Gel or Differin OTC •Quantity Limit 30 Grams (1 Tube)/26 Days	1 year
TAZORAC 0.1% GEL	•Diagnosis of Psoriasis •Trial of: Calcipotriene (Dovonex) •OR •Diagnosis of Acne •Trial of: Tretinoin Cream or Gel or Differin OTC •Quantity Limit 30 Grams (1 Tube)/26 Days	1 year
TESTOPEL 75 MG PELLETS	•Diagnosis of Hypogonadism •Total Testosterone Lab Value = ≤ 300ng/dL Before Treatment (for New Starts Only) •Clinical Reason Supported by Chart Notes why (After a 90-Day Trial of) the Below Cannot be Used: •Testosterone TD (Fortesta) or Testosterone (Androgel, Testim, Vogelxo) 1% (50 mg/5G) Gel Packet (Both Still Require a PA Also)	1 year
TESTOSTERON CYP 1,000 MG/10 ML	•Diagnosis of Hypogonadism •Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment (For New Starts Only) •OR •Diagnosis of Gender Dysphoria (Must be 18 Years or Older)	1 year
TESTOSTERON CYP 2,000 MG/10 ML	Diagnosis of Hypogonadism Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment For Gender Dysphoria, see CareSource Policy	1 year
TESTOSTERON ENAN 1,000 MG/5 ML	Diagnosis of Hypogonadism Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment OR Diagnosis of delayed puberty (male) For Gender Dysphoria, see CareSource Policy	1 year
TESTOSTERONE 1% (25MG/2.5G) PK	• Hypogonadism • Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment (For New Starts Only) OR • See "Gender Affirming Therapy Policy" if applicable	1 year
TESTOSTERONE 1% (50 MG/5 G) PK	• Hypogonadism • Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment (For New Starts Only) OR • See "Gender Affirming Therapy Policy" if applicable	1 year
TESTOSTERONE 1.62% (2.5 G) PKT	•Diagnosis of Hypogonadism •Total Testosterone Lab Value = ≤ 300ng/dL Before Treatment (For New Starts Only) OR a Total Testosterone lab Value Within the Normal Range During Treatment (for Continuation of Care) •Clinical Reason Supported by Chart Notes why (After a 90-Day Trial of) the Below Cannot be Used: •Testosterone TD (Fortesta) or Testosterone (Androgel, Testim, Vogelxo) 1% (50 mg/5G) Gel Packet (Both Still Require A PA Also)	1 year
TESTOSTERONE 1.62% GEL PUMP	Diagnosis of Hypogonadism Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment For Gender Dysphoria, see CareSource Policy	1 year

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TESTOSTERONE 1.62%(1.25 G) PKT	Diagnosis of Hypogonadism Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment For Gender Dysphoria, see CareSource Policy	1 year
TESTOSTERONE 10 MG GEL PUMP	•If Previously Approved for and Currently Using: Testim, Striant, Androxy, Methitest, Android (Testred), Androgel or Androderm •OR •Diagnosis of Hypogonadism •Total Testosterone lab Value = ≤ 300ng/dL Before Treatment (for New Starts Only) •Quantity Limit 60 Grams/30 Days	1 year
TESTOSTERONE 50 MG/5 GRAM GEL	• Diagnosis of Hypogonadism • Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment (For New Starts Only)	1 year
TESTOSTERONE 50 MG/5 GRAM PKT	•Diagnosis of Hypogonadism •Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment (For New Starts Only) •Quantity Limit 100 G/30 Days	1 year
TESTOSTERONE CYP 100 MG/ML	Diagnosis of Hypogonadism Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment For Gender Dysphoria, see CareSource Policy	1 year
TESTOSTERONE CYP 200 MG/ML	•Diagnosis of Hypogonadism •Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment (For New Starts Only) •OR •Diagnosis of Gender Dysphoria (Must be 18 years or Older)	1 year
TESTOSTERONE ENAN 200 MG/ML	•Diagnosis of Hypogonadism •Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment (For New Starts Only) •Dose = 50 to 400 mg Every 2 to 4 Weeks (FDA-Approved Dose Range)] •OR •Diagnosis of Breast Cancer (Female) •Dose = 200 to 400 mg Every 2 to 4 Weeks] •OR •Diagnosis of Delayed Puberty (Male) •OR •Diagnosis of Gender Dysphoria (Must be 18 Years and Above) •Dose = 50 to 200 mg Every 2 to 4 Weeks for a Limited Duration (Example: 4-6 Months)	Hypogonadism = 1 Year Breast Cancer (Female) = 1 Year Delayed Puberty (Male) = 6 Months Gender Dysphoria = 1 Year
TETRABENAZINE 12.5 MG TABLET	Diagnosis of Chorea Associated with Huntington's Disease	1 year
TETRABENAZINE 25 MG TABLET	Diagnosis of Chorea Associated with Huntington's Disease	1 year
THALOMID 100 MG CAPSULE	Diagnosis of Multiple myeloma or Erythema nodosum leprosum	3 Months for the Initial Authorization, 1 Year for Re-Authorization
THALOMID 150 MG CAPSULE	Diagnosis of Multiple myeloma or Erythema nodosum leprosum	3 Months for the Initial Authorization, 1 Year for Re-Authorization
THALOMID 200 MG CAPSULE	Diagnosis of Multiple myeloma or Erythema nodosum leprosum	3 Months for the Initial Authorization, 1 Year for Re-Authorization
THALOMID 50 MG CAPSULE	Diagnosis of Multiple myeloma or Erythema nodosum leprosum	3 Months for the Initial Authorization, 1 Year for Re-Authorization
TIBSOVO 250 MG TABLET	•Diagnosis of Relapsed or Refractory Acute Myeloid Leukemia (AML) with Susceptible IDH1 Mutation •OR •Diagnosis of Newly Diagnosed AML •Age 75 Years or Older OR Have Comorbidities That Preclude Use of Intensive Induction Chemotherapy	6 Months
TIMOLOL MALEATE 0.5% EYE DROP	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Timolol (Timoptic) 0.5% Eye Drops or Timolol (Timoptic-XE) 0.5% Gel Eye Solution	1 year
TINIDAZOLE 250 MG TABLET	•Diagnosis of Trichomoniasis, Bacterial Vaginosis, Giardiasis, or Amebiasis •Trial and Failure of Metronidazole	30 Days
TINIDAZOLE 500 MG TABLET	•Diagnosis of Trichomoniasis, Bacterial Vaginosis, Giardiasis, or Amebiasis •Trial and Failure of Metronidazole	30 Days
TIVICAY 50 MG TABLET	• Diagnosis of HIV-1 infection • Authorization is requested as part of an appropriate combination regimen (e.g. in combination with Epzicom or rilpivirine) • Clinical reason why a single tablet regimen (e.g. Triumeq or Juluca) should not be used	1 year

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TIVORBEX 20 MG CAPSULE	Trial of: Indomethacin 25 mg or 50 mg Capsule	1 year
TIVORBEX 40 MG CAPSULE	Trial of: Indomethacin 25 mg or 50 mg Capsule	1 year
TIZANIDINE HCL 2 MG CAPSULE	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Tizanidine Tablet	1 year
TIZANIDINE HCL 4 MG CAPSULE	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Tizanidine Tablet	1 year
TIZANIDINE HCL 6 MG CAPSULE	•Clinical Reason Supported by Chart Notes Why (After A Trial Of) The Below Cannot Be Used: •Tizanidine Tablet	1 year
TLANDO 112.5 MG CAPSULE	•Male at least 18 years of age •Member has a documented diagnosis of hypogonadism associated with a structural or genetic etiology, and Tlando is NOT being prescribed for age-related low testosterone •Documentation of below normal serum testosterone labs (less than 300 ng/dL) from at least 2 separate readings (on different mornings) •Member has signs/symptoms of testosterone deficiency •Trial and failure of at least 2 preferred alternative testosterone products •QL: 120 capsules per 30 days •Renew x 12 mo if lab results show testosterone levels are within range (300 – 1080 ng/dL per prescribing information)	6 Months
TOBRAMYCIN 1,200 MG/30 ML VIAL	*Age < 18 years and *Diagnosis of Non-Cystic Fibrosis	1 year
TOBRAMYCIN 80 MG/2 ML VIAL	• Age < 18 years • Diagnosis of Non-Cystic Fibrosis	1 year
TOLCAPONE 100 MG TABLET	Trial of: Entacapsuleone (Comtan) Tablet	1 year
TOLTERODINE TART ER 2 MG CAP	• 30 day Trial of at least one of the following: oxybutynin, oxybutynin ER, tolterodine (also requires PA)	1 year
TOLTERODINE TART ER 4 MG CAP	• 30 day Trial of at least one of the following: oxybutynin, oxybutynin ER, tolterodine (also requires PA)	1 year
TOLVAPTAN 15 MG TABLET	Diagnosis of Hypervolemic and Euvolemic Hyponatremia	30 Days
TOLVAPTAN 30 MG TABLET	Diagnosis of Hypervolemic and Euvolemic Hyponatremia	30 days
TOSYMRA 10 MG NASAL SPRAY	•Age 18 and Older •Clinical Reason Why (After A One Time Trial Each) Two of The Following Cannot Be Used: •Sumatriptan Tablets, Injection or Nasal Spray, Naratriptan, Almotriptan, or Rizatriptan	1 year
TOUJEO MAX SOLOSTR 300 UNIT/ML	•Clinical Reason Supported by Chart Notes Why the Below Cannot Be Used: •30-Day Trial of Insulin Glargine-Yfgn	1 year
TOUJEO SOLOSTAR 300 UNIT/ML	•Clinical Reason Supported by Chart Notes Why the Below Cannot Be Used: •30-Day Trial of Insulin Glargine-Yfgn •Quantity Limit 1 mL/Day	1 year
TRADJENTA 5 MG TABLET	30-Day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)	1 year
TRAMADOL ER 100 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
TRAMADOL ER 200 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
TRAMADOL ER 300 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
TRAMADOL HCL 50 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
TRAMADOL HCL ER 100 MG CAPSULE	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
TRAMADOL HCL ER 100 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
TRAMADOL HCL ER 150 MG CAPSULE	•For Initial Authorizations: •30-Day Trial That the Following Cannot Continue: Tramadol ER Tablets (Ultram ER) •If Member has one of the Following Diagnoses, Approve for up to 90 Days Maximum: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes): •Member's Previous Treatment Plan Included Short-Acting Opioid for at Least the Last 60 Days •Prescriber Attests to Checking Prescription Drug Monitoring Program (PDMP) - PMP AWARXE •If Cumulative MED is > 80 MED/Day, Prescriber Must be Pain Management Specialist OR a Pain Management Prescriber Unavailable to Patient and There is Rationale for Higher Dose •Prescriber Attests to Attest to A Patient Specific Treatment Plan (e.g., Assessment of Pain and Function Scores, A Baseline Urine Drug Test, Plans for Random Urine Drug Screens, An Opioid Contract, etc.) •If Member Is Being Treated Concurrently with Benzodiazepine, Prescriber Attests That the Benefit Outweighs the Risk of Benzodiazepine Use •For Re-Authorizations: •Chart Notes (or PA Request) State the Benefit of Continued Therapy Outweighing Risks to Patient Safety (Examples: Continued Adherence, Pain/Function Sores, Improvement in Function and/or Quality of Life, Random Urine Drug Screens, No Serious Adverse Outcomes). Documentation May Be Requested Per RPh. •If Member Has One of The Following Diagnoses, Approve as Requested Up To 6 Months: A) Active Cancer Treatment of Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia, E) Catastrophic Injury (Severe Burns, Traumatic Crushing of Tissue, Amputation) •If Diagnosis is Moderate to Severe Chronic Pain (Please List Specific Diagnosis Code in Notes)	Up to 90 Days for Initial Authorizations Up to 6 Months for Re-Authorizations

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Drug Name	Criteria	Approval Duration
TRAMADOL HCL ER 200 MG CAPSULE	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
TRAMADOL HCL ER 200 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
TRAMADOL HCL ER 300 MG CAPSULE	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
TRAMADOL HCL ER 300 MG TABLET	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
TRAMADOL-ACETAMINOPHN 37.5-325	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment or cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) severe burns, F) traumatic crushing of tissue, G) amputation, H) major orthopedic surgery OR Diagnosis is moderate to severe pain (with diagnosis code) Member is on opioids <60 days in the past 365 days (naive utilizers), dose is <50 MED, member has experienced an inadequate response, intolerance or contraindication to at least 2 preferred non-opioid treatment options (NSAIDs, acetaminophen, anticonvulsants, and antidepressants) Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP OR Member is on opioids >60 days in the past 365 days (chronic utilizer), dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP, duration of therapy is <90 days Member is on opioids >60 days in the past 365 days (chronic utilizer) Dose is <50 MED Prescriber attests to discussing the benefits/risks of opioids with member Prescriber attests to checking state PDMP If dose is >80 MED, prescriber is pain management, pain management consulted, or pain management unavailable and rationale for higher dose Prescriber attests to patient specific treatment plan Prescriber attests to assessing for addiction risk or mental health concerns If patient is also treated with a benzodiazepine, prescriber attests that benefit of using both together outweighs risk Reauthorization:	Up to 6 months
TRANDOLAPR-VERAPAM ER 1-240 MG	•Clinical Reason Supported by Chart Notes Why (After a 90-Day Trial of) the Below Cannot be Used: •Trandolapril and Verapamil used at the same time	1 year
TRANDOLAPR-VERAPAM ER 2-180 MG	•Clinical Reason Supported by Chart Notes Why (After a 90-Day Trial of) the Below Cannot be Used: •Trandolapril and Verapamil used at the same time	1 year
TRANDOLAPR-VERAPAM ER 2-240 MG	•Clinical Reason Supported by Chart Notes Why (After a 90-Day Trial of) the Below Cannot be Used: •Trandolapril and Verapamil used at the same time	1 year
TRANDOLAPR-VERAPAM ER 4-240 MG	•Clinical Reason Supported by Chart Notes Why (After a 90-Day Trial of) the Below Cannot be Used: •Trandolapril and Verapamil used at the same time	1 year
TRANEXAMIC ACID 650 MG TABLET	•Diagnosis of Uterine Fibroids •OR •Diagnosis of Cyclic Heavy Menstrual Bleeding, DUB (Dysfunctional Uterine Bleeding), Menorrhagia, Excessive Bleeding, or Dysmenorrhea •And Trials Per Age Groups Below: •Age Over 50 Years of Age •No Trials Needed •Age 40-50 Years of Age •30-Day Trial of: Medroxyprogesterone (Provera) or Medroxyprogesterone Shot •Age Under 40 Years of Age •30-Day Trial of: Formulary Oral Contraceptives, Nuvaring, Medroxyprogesterone (Provera) or Medroxyprogesterone Shot	1 year
TRAVOPROST 0.004% EYE DROP	• 30 day Trial of: Latanoprost 0.005% EYE DROPS	1 year
TRELEGY ELLIPTA 100-62.5-25	• Diagnosis of COPD • Member has tried a 30-day Trial of one of the following preferred products and still experience COPD exacerbations: • Combination product LABA + ICS (i.e., Dulera, Salmeterol/Fluticasone); OR LABA (i.e., Serevent diskus, Striverdi) + ICS (i.e., Flovent, Arnuity) used at the same time; OR • Combination product LABA + LAMA (i.e., Stiolto respimat); OR LABA (i.e., Serevent diskus, Striverdi) + LAMA (i.e., Spiriva respimat). OR • Diagnosis of Asthma • Member has tried a 30-day Trial of one of the following preferred products and still experience asthma exacerbations: • Combination product LABA + ICS (i.e., Dulera, Salmeterol/Fluticasone); OR LABA (i.e., Serevent diskus, Striverdi) + ICS (i.e., Flovent, Arnuity) used at the same time.	1 year

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Drug Name	Criteria	Approval Duration
TRELEGY ELLIPTA 200-62.5-25	• Diagnosis of COPD • Member has tried a 30-day Trial of one of the following preferred products and still experience COPD exacerbations: • Combination product LABA + ICS (i.e., Dulera, Salmeterol/Fluticasone); OR LABA (i.e., Serevent diskus, Striverdi) + ICS (i.e., Flovent, Arnuity) used at the same time; OR • Combination product LABA + LAMA (i.e., Stiolto respimat); OR LABA (i.e., Serevent diskus, Striverdi) + LAMA (i.e., Spiriva respimat). • Diagnosis of Asthma • Member has tried a 30-day Trial of one of the following preferred products and still experience asthma exacerbations: • Combination product LABA + ICS (i.e., Dulera, Salmeterol/Fluticasone); OR LABA (i.e., Serevent diskus, Striverdi) + ICS (i.e., Flovent, Arnuity) used at the same time.	1 year
TREPROSTINIL 100 MG/20 ML VIAL	•Medical Benefit Only •For Initial Authorizations: •Diagnosis of •Prescriber Specialty = •Requirements That Have Been Met = •Requirements That Have Not Been Met = •For Re-Authorizations: •Previously Approved On (Date) For (Length of Time) •Date Of Last Fill = •Diagnosis of •Prescriber Specialty =	1 year
TREPROSTINIL 20 MG/20 ML VIAL	•Medical Benefit Only •For Initial Authorizations: •Diagnosis of •Prescriber Specialty = •Requirements That Have Been Met = •Requirements That Have Not Been Met = •For Re-Authorizations: •Previously Approved On (Date) For (Length of Time) •Date Of Last Fill = •Diagnosis of •Prescriber Specialty =	1 year
TREPROSTINIL 200 MG/20 ML VIAL	•Medical Benefit Only •For Initial Authorizations: •Diagnosis of •Prescriber Specialty = •Requirements That Have Been Met = •Requirements That Have Not Been Met = •For Re-Authorizations: •Previously Approved On (Date) For (Length of Time) •Date Of Last Fill = •Diagnosis of •Prescriber Specialty =	1 year
TREPROSTINIL 50 MG/20 ML VIAL	•Medical Benefit Only •For Initial Authorizations: •Diagnosis of •Prescriber Specialty = •Requirements That Have Been Met = •Requirements That Have Not Been Met = •For Re-Authorizations: •Previously Approved On (Date) For (Length of Time) •Date Of Last Fill = •Diagnosis of •Prescriber Specialty =	1 year
TRESIBA 100 UNIT/ML VIAL	*30 day trial of insulin glargine-yfgn	1 year
TRESIBA FLEXTOUCH 100 UNIT/ML	*30 day trial of insulin glargine-yfgn	1 year
TRESIBA FLEXTOUCH 200 UNIT/ML	*30 day trial of insulin glargine-yfgn	1 year
TRETINOIN 0.01% GEL	• Diagnosis of Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), Or Rosacea • Clinical Reason Supported By Chart Notes Why (After A 30 day trial in the last year) The Below Cannot Be Used: Tretinoin (Retin-A) 0.05% Cream	1 year

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Drug Name	Criteria	Approval Duration
TRETINOIN 0.025% CREAM	For age > 12 years or over 26 years, diagnosis of one of the following: Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), or Rosacea	1 year
TRETINOIN 0.025% GEL	For age > 12 years or over 26 years, diagnosis of one of the following: Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), or Rosacea	1 year
TRETINOIN 0.05% CREAM	For age > 12 years or over 26 years, diagnosis of one of the following: Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), or Rosacea	1 year
TRETINOIN 0.05% GEL	• Diagnosis of Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), Or Rosacea AND • Clinical reason supported by chart notes Why (After A 30-day trial in the last year) of the below cannot be used: • Tretinoin (Retin-A) 0.05% Cream	1 year
TRETINOIN 0.1% CREAM	For age > 12 years or over 26 years, diagnosis of one of the following: Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), or Rosacea	1 year
TRETINOIN GEL MICRO 0.04% PUMP	•Diagnosis of Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), or Rosacea AND •Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Tretinoin (Retin-A) Gel or Cream •Quantity Limit 45 Grams (1 Tube)/26 Days]	1 year
TRETINOIN GEL MICRO 0.04% TUBE	•Diagnosis of Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), or Rosacea AND •Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Tretinoin (Retin-A) Gel or Cream •Quantity Limit 45 Grams (1 Tube)/26 Days]	1 year
TRETINOIN GEL MICRO 0.1% PUMP	•Diagnosis of Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), or Rosacea AND •Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Tretinoin (Retin-A) Gel or Cream •Quantity Limit 45 Grams (1 Tube)/26 Days]	1 year
TRETINOIN GEL MICRO 0.1% TUBE	•Diagnosis of Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), or Rosacea AND •Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Tretinoin (Retin-A) Gel or Cream •Quantity Limit 45 Grams (1 Tube)/26 Days]	1 year
TRETIN-X 0.075% CREAM	• If Age Below 12 Or Over 26, Diagnosis Below Is Required: • Diagnosis of Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), OR Rosacea	1 year
TRIAMCINOLONE 0.05% OINTMENT	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of two of the following for 7 days each: Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone)	1 year
TRIAMCINOLONE 0.147 MG/G SPRAY	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Topical Triamcinolone Ointment/Cream/Lotion •Quantity Limit 63 mL (1 Bottle)/26 Days]	1 year
TRIANEX 0.05% OINTMENT	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used: •Trial of: Triamcinolone 0.5% Ointment or Triamcinolone 0.1% Ointment	3 Months
TRIDERM 0.5% CREAM	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of two of the following for 7 days each: Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone)	1 year
TRIENTINE HCL 250 MG CAPSULE	•Diagnosis of Wilson's Disease •Trial of: Cuprimine 250 mg Capsule	1 year

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Drug Name	Criteria	Approval Duration
TRIESENCE 40 MG/ML VIAL	• Prescribed by or in consultation with an ophthalmologist • Diagnosis of one of the following: - Sympathetic ophthalmia - Temporal arteritis - Uveitis - Ocular inflammatory conditions unresponsive to topical corticosteroids • Quantity: 1 injection per eye per 28 days	1 year
Trintellix	• 30 Day Trial Each Of 2 Of The 3 Following Preferred Formulary Groups (One Of Which Must Have Occurred Within The Last Year) -Group-1: Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) -Group-2: Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); -Group-3: Bupropion XL Or SR (Wellbutrin SR Or XL)	1 year
TRINTELLIX 10 MG TABLET	• 30 Day Trial Each Of 2 Of The 3 Following Preferred Formulary Groups (One Of Which Must Have Occurred Within The Last Year) -Group-1: Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) -Group-2: Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); -Group-3: Bupropion XL Or SR (Wellbutrin SR Or XL)	1 year
TRINTELLIX 20 MG TABLET	• 30 Day Trial Each Of 2 Of The 3 Following Preferred Formulary Groups (One Of Which Must Have Occurred Within The Last Year) -Group-1: Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) -Group-2: Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); -Group-3: Bupropion XL Or SR (Wellbutrin SR Or XL)	1 year
TRINTELLIX 5 MG TABLET	• 30 Day Trial Each Of 2 Of The 3 Following Preferred Formulary Groups (One Of Which Must Have Occurred Within The Last Year) -Group-1: Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) -Group-2: Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); -Group-3: Bupropion XL Or SR (Wellbutrin SR Or XL)	1 year
TRITOCIN 0.05% OINTMENT	• Diagnosis of Atopic Dermatitis (Eczema) • Trial of two of the following for 7 days each: Fluticasone Propionate (Cutivate) 0.05% Cream, Prednicarbate (Dermatop) 0.1% Cream, Betamethasone Dp 0.05%, Betamethasone Valerate 0.1%,Hydrocortisone 0.1%, Hydrocortisone 2.5%, Prednicarbate (Dermatop) 0.1% Ointment, Fluocinonide 0.05%, Fluocinonide-E 0.05%, Clobetasol (Temovate) 0.05%, Clobetasol-E (Temovate E) 0.05%, Fluocinolone 0.01%, Triamcinolone 0.025%, Triamcinolone 0.1%, Triamcinolone 0.5%, Fluticasone Propionate (Cutivate) 0.005% Ointment, Diflorasone 0.05% (Accepted Trials But Not Recommended: Mometasone And Alclometasone)	1 year
TRIUMEQ 600-50-300 MG TABLET	Genetic test to confirm negative for HLA-B*5701 allele	1 year
TROSPIUM CHLORIDE 20 MG TABLET	30-Day Trial of Oxybutynin or Oxybutynin ER	1 year
TROSPIUM CHLORIDE ER 60 MG CAP	30-Day Trial of at Least One of the Following: Oxybutynin, Oxybutynin ER, or Trospium (Also Requires PA)	1 year
TRUDHESA NASAL SPRAY	• Prescribed by or in consultation with a neurologist or headache specialist • Patient is at least 18 years of age • Member has a diagnosis of migraine with or without aura • Must have a 30-day trial each of ALL of the following: One NSAID drug (e.g. Ibuprofen, naproxen, etc.); AND Two triptan drugs (e.g. sumatriptan, rizatriptan, naratriptan or almotriptan); • If member is not able to take triptan drugs due to contraindication or adverse events, then a 30-day trial of 2 NSAIDs are required; • Documentation a cardiac exam has been completed; • Quantity: 0.725 mg (4mg/mL single dose vials); 12 mL/28 days	1 year
TRULANCE 3 MG TABLET	• Age 18 or older • Diagnosis of Chronic idiopathic constipation or Irritable bowel sydnrome with constipation (IBS-C) • 90 day trial of lubiprostone (Amitiza)	1 year
TRULICITY 0.75 MG/0.5 ML PEN	• 30 day Trial of Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) OR • One of the following: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)	1 year

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TRULICITY 1.5 MG/0.5 ML PEN	• 30 day Trial of Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) OR • One of the following: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)	1 year
TRULICITY 3 MG/0.5 ML PEN	• 30 day Trial of Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) OR • One of the following: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)	1 year
TRULICITY 4.5 MG/0.5 ML PEN	• 30 day Trial of Metformin IR Or Metformin ER (Glucophage Or Glucophage ER) OR • One of the following: HbA1C Greater Than 7.5% OR Allergy, Intolerance, or Side Effect To Metformin OR Renal/Kidney Disease/Elevated Creatine (CR)	1 year
TUDORZA PRESSAIR 400 MCG INHAL	•Diagnosis of COPD (Emphysema, Chronic Bronchitis) •30-Day Trial of: Spiriva Respimat •Quantity Limit 1 Inhaler/Month	1 year
TUSSICAPS 10 MG-8 MG CAPSULE	One Time Trial of: Benzonatate Capsule	30 Days
TUSSICAPS 5 MG-4 MG CAPSULE	One Time Trial of: Benzonatate Capsule	30 Days
TWIRLA 120-30 MCG/DAY PATCH	•Trial of Xulane Patch •Quantity Limit: 1 Carton (3 Patches) per 4 Weeks	1 year
TWYNEO 0.1%-3% CREAM	•At least 9 years of age with a documented diagnosis of acne •Trial and failure of at least 3 preferred topical acne medications, including tretinoin plus benzoyl peroxide used concurrently •Renew if positive clinical response	1 Year
TYRVAYA 0.03 MG NASAL SPRAY	•Minimum age 18 years •Diagnosis of postoperative ophthalmic inflammation •Trial and failure of ophthalmic corticosteroids AND nonsteroidal anti-inflammatory drugs (NSAIDs) •Quantity: 1 vial per eye per 30 days • Not eligible for reauthorization	30 Days
TYRVAYA 0.03 MG NASAL SPRAY	•Minimum age 18 years •Diagnosis of postoperative ophthalmic inflammation •Trial and failure of ophthalmic corticosteroids AND nonsteroidal anti-inflammatory drugs (NSAIDs) •Quantity: 1 vial per eye per 30 days • Not eligible for reauthorization	30 Days
UBRELVY 100 MG TABLET	Age 18 or older; Diagnosis of acute migraine headache, with or without aura; Must have a 30-day trial each of ALL of the following: One NSAID drug (e.g. Ibuprofen, naproxen, etc.); AND Two triptan drugs (e.g. sumatriptan, rizatriptan, naratriptan or almotriptan); If member is not able to take triptan drugs due to contraindication or adverse events, then a 30-day trial of 2 NSAIDs are required Cannot be used together with Nurtec ODT; o Reauth: Chart notes must be provided showing benefit from use of medication.	1 year
UBRELVY 50 MG TABLET	Age 18 or older; Diagnosis of acute migraine headache, with or without aura; Must have a 30-day trial each of ALL of the following: One NSAID drug (e.g. Ibuprofen, naproxen, etc.); AND Two triptan drugs (e.g. sumatriptan, rizatriptan, naratriptan or almotriptan); If member is not able to take triptan drugs due to contraindication or adverse events, then a 30-day trial of 2 NSAIDs are required Cannot be used together with Nurtec ODT; o Reauth: Chart notes must be provided showing benefit from use of medication.	1 year
UCERIS 2 MG RECTAL FOAM	•Clinical Reason Supported by Chart Notes Why (After A 56 Day Trial) The Below Cannot Be Used: •Budesonide EC (Entocort EC) 3 mg Capsule	1 year

Drug Name	Criteria	Approval Duration
ULESFIA 5% LOTION	• Diagnosis of Head Lice (for age 6 months and older) • One Time Trial within the last 30 day per age group below: • Age 6 Months up to 2 Years old: LICE TREATMENT LIQUID 1%, permethrin (Rid Foam), spinosad (Natroba), benzyl alcohol lotion (Ulesfia) Age 2 Years - 3 Years: LICE TREATMENT LIQUID 1%, permethrin (RID FOAM), PYRETHRINS-PIPERONYL BUTOXIDE, PRONTO PLUS (RID LIQUID), LICE-AID (TEGRIN-LT), LICE KILLING SHAMPOO (PRONTO), STOP LICE KIT (RID COMPLETE KIT), benzyl alcohol lotion (Ulesfia), or spinosad (Natroba) • Age 4 Years to 5 Years old: LICE TREATMENT LIQUID 1%, permethrin (RID FOAM), PYRETHRINS-PIPERONYL BUTOXIDE, PRONTO PLUS (RID LIQUID), LICE-AID (TEGRIN-LT), LICE KILLING SHAMPOO (PRONTO), STOP LICE KIT (RID COMPLETE KIT), benzyl alcohol lotion (Ulesfia) or spinosad (Natroba) • Age 6 Years and older: LICE TREATMENT LIQUID 1%, permethrin (RID FOAM), PYRETHRINS-PIPERONYL BUTOXIDE, PRONTO PLUS (RID LIQUID), LICE-AID (TEGRIN-LT), LICE KILLING SHAMPOO (PRONTO), STOP LICE KIT (RID COMPLETE KIT), spinosad (Natroba), benzyl alcohol lotion (Ulesfia) or malathion (Ovide) [Dose: 227 Grams (1 box) / 26 Days]	30 days
UREA 47% CREAM	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Urea Lo 40% Cream or Cerovel, X-Viate, Urea-C40, or Urea 40% Lotion •Quantity Limit 142 Grams (1 Tube)/26 Days	1 year
URIBEL CAPSULE	30-Day Trial of: Urelle Tablet, Urogesic-Blue or Utrona-C	30 Days
UTIBRON NEOHALER 27.5-15.6 MCG	•Diagnosis of COPD AND •30-Day Trial of Stiolto Respimat Mist Inhaler •Quantity Limit 60 Capsules/Month]	1 year
VALTOCO 10 MG NASAL SPRAY	• Diagnosis of seizure •6 years or older • Trial and failure of midazolam solution plus atomizer or clinical rationale why this cannot be used	1 year
VALTOCO 15 MG NASAL SPRAY	• Diagnosis of seizure •6 years or older • Trial and failure of midazolam solution plus atomizer or clinical rationale why this cannot be used	1 year
VALTOCO 20 MG NASAL SPRAY	• Diagnosis of seizure •6 years or older • Trial and failure of midazolam solution plus atomizer or clinical rationale why this cannot be used	1 year
VALTOCO 5 MG NASAL SPRAY	• Diagnosis of seizure •6 years or older • Trial and failure of midazolam solution plus atomizer or clinical rationale why this cannot be used	1 year
VANATOL LQ ORAL SOLUTION	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Butalbital-Acetaminophen-Caffeine 50-325-40 mg Capsule or Tablet •Quantity Limit Up To 720 mL/30 Days	1 year
VANCOMYCIN 250 MG/5 ML SOLN	Diagnosis of Clostridium Difficile	10 days
VANCOMYCIN HCL 125 MG CAPSULE	• Diagnosis of Clostridium Difficile • Clinical reason why After a 10-Day Trial of Firvanq cannot be used	10 Days
VANCOMYCIN HCL 250 MG CAPSULE	• Diagnosis of Clostridium Difficile • Clinical reason why After a 10-Day Trial of Firvanq cannot be used	10 Days
VELPHORO 500 MG CHEWABLE TAB	• Elevated Calcium, High Calcium, Hypercalcemia, etc OR Fluid Restriction Or Has Difficulty Swallowing Pills OR • 30 Day Trial of: Calcium Acetate (PhosLo) [Not Required If: Member Has The Inability To Swallow]	1 year
VELTASSA 16.8 GM POWDER PACKET	•Diagnosis of Hyperkalemia •Prescribed by or in Consultation with a Nephrologist or Cardiologist •Prior Attempt of any ONE of the Following Approaches to Reduce the Modifiable Risks for Hyperkalemia: Dose Reduction of renin-Angiotensin-Aldosterone System (RAAS) Inhibitors (ex. Lisinopril, Enalapril, Valsartan, Losartan, Spironolactone) OR Prior Treatment with Loop or Thiaizide Diuretics (ex. Furosemide, Bumetanide, Torsemide, Hydrochlorothiazide, Chlorthalidone) •Previous trial and failure, intolerance or contraindication to oral sodium polystyrene sulfonate	1 year

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VELTASSA 25.2 GM POWDER PACKET	•Diagnosis of Hyperkalemia •Prescribed by or in Consultation with a Nephrologist or Cardiologist •Prior Attempt of any ONE of the Following Approaches to Reduce the Modifiable Risks for Hyperkalemia: Dose Reduction of renin-Angiotensin-Aldosterone System (RAAS) Inhibitors (ex. Lisinopril, Enalapril, Valsartan, Losartan, Spironolactone) OR Prior Treatment with Loop or Thiaizide Diuretics (ex. Furosemide, Bumetanide, Torsemide, Hydrochlorothiazide, Chlorthalidone) •Previous trial and failure, intolerance or contraindication to oral sodium polystyrene sulfonate	1 year
VELTASSA 8.4 GM POWDER PACKET	•Diagnosis of Hyperkalemia •Prescribed by or in Consultation with a Nephrologist or Cardiologist •Prior Attempt of any ONE of the Following Approaches to Reduce the Modifiable Risks for Hyperkalemia: Dose Reduction of renin-Angiotensin-Aldosterone System (RAAS) Inhibitors (ex. Lisinopril, Enalapril, Valsartan, Losartan, Spironolactone) OR Prior Treatment with Loop or Thiaizide Diuretics (ex. Furosemide, Bumetanide, Torsemide, Hydrochlorothiazide, Chlorthalidone) •Previous trial and failure, intolerance or contraindication to oral sodium polystyrene sulfonate	1 year
VENCLEXTA 10 MG TABLET	•Diagnosis of Chronic Lymphocytic Leukemia (CLL) •Member Is Positive for the 17p Chromosome Deletion •Member Has Received At Least One Prior Therapy For CLL •OR •Diagnosis of Acute Myeloid Leukemia (AML) •Used in Combination with Azacitidine, Decitabine, or Cytarabine •Age 75 Years or Older OR Unable to receive intensive induction Chemotherapy	1 year
VENCLEXTA 100 MG TABLET	•Diagnosis of Chronic Lymphocytic Leukemia (CLL) •Member Is Positive for the 17p Chromosome Deletion •Member Has Received At Least One Prior Therapy For CLL •OR •Diagnosis of Acute Myeloid Leukemia (AML) •Used in Combination with Azacitidine, Decitabine, or Cytarabine •Age 75 Years or Older OR Unable to receive intensive induction Chemotherapy	1 year
VENCLEXTA 50 MG TABLET	•Diagnosis of Chronic Lymphocytic Leukemia (CLL) •Member Is Positive for the 17p Chromosome Deletion •Member Has Received At Least One Prior Therapy For CLL •OR •Diagnosis of Acute Myeloid Leukemia (AML) •Used in Combination with Azacitidine, Decitabine, or Cytarabine •Age 75 Years or Older OR Unable to receive intensive induction Chemotherapy	1 year
VENELEX OINTMENT	7-Day Trial of: Cerave, Cetaphil, Aveeno, Lubriderm (Eucerin), TheraPlex, Velvachol, NutraDerm, Ammonium Lactate, LacLotion, AmLactin, Geri-Hydrolac, AL-12 (LacHydrin, Lac-Hydrin Twelve) Lotion	1 year
VENNGEL ONE 1% KIT	• Diagnosis of osteoarthritis in the hand, wrist, elbow, foot, ankle, or knee • Clinical reason why, after a 30 day trial, diclofenac 1% gel cannot be used	1 year
VERIPRED 20 20 MG/5 ML SOLN	One Time Trial of: Prednisolone 15 mg/5 mL Solution	30 Days
VERKAZIA 0.1% EYE EMULSION	•Member is Age 4 Years or Older •Diagnosis of Moderate to Severe Vernal Keratoconjunctivitis (VKC) •Trial and Failure to One Agent from TWO of the Following Different Medication Classes: •Generic Ophthalmic Antihistamines (e.g., Olopatadine) •Generic Ophthalmic Mast Cell Stabilizers (e.g., Cromolyn Sodium) •Generic Ophthalmic Corticosteroids (e.g., Dexamethasone, Prednisolone, Fluorometholone) •Quantity: 1 Package per 22 Days for Each Package Size (30,60,120 Vials)	30 Days
VERQUVO 2.5 MG TABLET	•Age 18 or Older •Diagnosis of Chronic Heart Failure (NYHA class II-IV) with Ejection Fraction Less Than 45% •Previous Heart Failure Hospitalization in the Last 6 Months OR Received Outpatient IV Diuretic Treatment for Heart Failure Within the Last 3 Months •Member has been on or Previously Been Treated with ACEi, ARB, or Entresto AND a Beta-Blocker, Unless Contraindicated •Re-Authorization Criteria: •Chart Notes Show Clinical Benefit from Use of Medication •Quantity Limit: 30 Tablets per 30 Days	1 year

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Drug Name	Criteria	Approval Duration
VERQUVO 5 MG TABLET	•Age 18 or Older •Diagnosis of Chronic Heart Failure (NYHA class II-IV) with Ejection Fraction Less Than 45% •Previous Heart Failure Hospitalization in the Last 6 Months OR Received Outpatient IV Diuretic Treatment for Heart Failure Within the Last 3 Months •Member has been on or Previously Been Treated with ACEi, ARB, or Entresto AND a Beta-Blocker, Unless Contraindicated •Re-Authorization Criteria: •Chart Notes Show Clinical Benefit from Use of Medication •Quantity Limit: 30 Tablets per 30 Days	1 year
VIBRAMYCIN 50 MG/5 ML SYRUP	•Clinical Reason Supported by Chart Notes why (after a One Time Trial Of) the Below Cannot be Used: •Doxycycline (Vibramycin) 25 mg/5 mL Suspension	30 Days
VICODIN 5-300 MG TABLET	•For Initial Authorizations: •Clinical Reason After a 30-Day Trial/Failure That the Following Cannot Continue Hydrocodone-Acetaminophen Containing 325 mg Acetaminophen (Trial Per Pharmacy Claims or Doctor Notes with Trial Dates Listed) •OR •If diagnosis is One of The Following, Approve X 1 Year: A) Active Cancer Treatment or Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia. If Diagnosis Is One of The Following, Approve X 6 Months: A) Severe Burns, B) Traumatic Crushing of Tissue, C) Amputation, D) Major Orthopedic Surgery •OR •If diagnosis is Moderate to Severe Pain (List Diagnosis Code), AND •Member on Opioids < 90 Days in The Past 120 Days (Naïve Utilizer): •Dose is < 50 MED (Hydrocodone 5 mg = 12 Tabs/Day, 7.5 mg = 8 Tabs/Day, 10 mg = 6 Tabs/Day) •Member has Experienced an Inadequate Response, Intolerance or Contraindication To At Least 2 Preferred Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) •Prescriber Attests to Discussing Benefits/Risks of Opioids with Member •Prescriber Attests to Checking State PDMP •Approve as Requested up to 90 Days, up to 50 MED ((Hydrocodone 5 mg = 12 Tabs/Day, 7.5 mg = 8 Tabs/Day, 10 mg = 6 Tabs/Day) •Member on Opioids > 90 Days in the Past 120 Days (Chronic Utilizer): •Dose is < 50 MED (Hydrocodone 5 mg = 12 Tabs/Day, 7.5 mg = 8 Tabs/Day, 10 mg = 6 Tabs/Day) •Prescriber Attests to Discussing Benefits/Risks of Opioids with Member •Prescriber Attests to Checking State PDMP •Duration of Therapy: •Less than 90 Days = Approve X 90 Days up to 50 MED (Hydrocodone 5 mg = 12 Tabs/Day, 7.5 mg = 8 Tabs/Day, 10 mg = 6 Tabs/Day) •If more than 90 Days: •If Dose is > 80 MED, Prescriber is Pain Management, Pain Management Consulted, or Pain Management Unavailable and Rationale for Higher Dose	Per Criteria
VICODIN HP 10-300 MG TABLET	•For Initial Authorizations: •Clinical Reason After a 30-Day Trial/Failure That the Following Cannot Continue Hydrocodone-Acetaminophen Containing 325 mg Acetaminophen (Trial Per Pharmacy Claims or Doctor Notes with Trial Dates Listed) •OR •If diagnosis is One of The Following, Approve X 1 Year: A) Active Cancer Treatment or Cancer Related Pain, B) Palliative Care, C) End-Of-Life or Hospice Care, D) Sickle Cell Anemia. If Diagnosis Is One of The Following, Approve X 6 Months: A) Severe Burns, B) Traumatic Crushing of Tissue, C) Amputation, D) Major Orthopedic Surgery •OR •If diagnosis is Moderate to Severe Pain (List Diagnosis Code), AND •Member on Opioids < 90 Days in The Past 120 Days (Naïve Utilizer): •Dose is < 50 MED (Hydrocodone 5 mg = 12 Tabs/Day, 7.5 mg = 8 Tabs/Day, 10 mg = 6 Tabs/Day) •Member has Experienced an Inadequate Response, Intolerance or Contraindication To At Least 2 Preferred Non-Opioid Treatment Options (NSAIDs, Acetaminophen, Anticonvulsants, And Antidepressants) •Prescriber Attests to Discussing Benefits/Risks of Opioids with Member •Prescriber Attests to Checking State PDMP •Approve as Requested up to 90 Days, up to 50 MED ((Hydrocodone 5 mg = 12 Tabs/Day, 7.5 mg = 8 Tabs/Day, 10 mg = 6 Tabs/Day) •Member on Opioids > 90 Days in the Past 120 Days (Chronic Utilizer): •Dose is < 50 MED (Hydrocodone 5 mg = 12 Tabs/Day, 7.5 mg = 8 Tabs/Day, 10 mg = 6 Tabs/Day) •Prescriber Attests to Discussing Benefits/Risks of Opioids with Member •Prescriber Attests to Checking State PDMP •Duration of Therapy: •Less than 90 Days = Approve X 90 Days up to 50 MED (Hydrocodone 5 mg = 12 Tabs/Day, 7.5 mg = 8 Tabs/Day, 10 mg = 6 Tabs/Day) •If more than 90 Days: •If Dose is > 80 MED, Prescriber is Pain Management, Pain Management Consulted, or Pain Management Unavailable and Rationale for Higher Dose	Per Criteria

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VILAZODONE (VIIBRYD) 10 MG, 20 MG, 40 MG TABLET	• At least 18 years of age • Diagnosis of major depressive disorder • 90 day trial and failure of at least two preferred generic antidepressants (e.g. escitalopram, fluoxetine, sertraline, duloxetine, venlafaxine, etc.)	1 year
VILAZODONE HCL 10 MG TABLET	• At least 18 years of age • Diagnosis of major depressive disorder • 90 day trial and failure of at least two preferred generic antidepressants (e.g. escitalopram, fluoxetine, sertraline, duloxetine, venlafaxine, etc.)	1 year
VILAZODONE HCL 20 MG TABLET	• At least 18 years of age • Diagnosis of major depressive disorder • 90 day trial and failure of at least two preferred generic antidepressants (e.g. escitalopram, fluoxetine, sertraline, duloxetine, venlafaxine, etc.)	1 year
VILAZODONE HCL 40 MG TABLET	• At least 18 years of age • Diagnosis of major depressive disorder • 90 day trial and failure of at least two preferred generic antidepressants (e.g. escitalopram, fluoxetine, sertraline, duloxetine, venlafaxine, etc.)	1 year
VIMPAT 10 MG/ML SOLUTION	•Previously Approved for And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga •OR •Age = 17 Years and Older •Diagnosis of Seizure or Epilepsy •30-Day Trial of 1 of the Following: •Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) or Zonisamide	1 year
VIMPAT 100 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
VIMPAT 150 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
VIMPAT 200 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
VIMPAT 50 MG TABLET	• Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga OR • Age 17 years and older • Diagnosis of Seizure or Epilepsy • 30 Day Trial of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide	1 year
VISTOGARD 10 GRAM PACKET	Diagnosis of 5-FU/Capecitabine Toxicity	1 year
VIVOTIF EC CAPSULE	Diagnosis of For Immunization of Adults and Children Older Than 6 Years Against Disease Caused by Salmonella Typhi	30 Days

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VORICONAZOLE 200 MG TABLET	• Diagnosis of Post Transplant Aspergillosis Prophylaxis or Fungal Meningitis OR • Diagnosis of Candidemia and Other Candida Infections; Esophageal Candidiasis; Invasive Aspergillosis • One-Time Trial of fluconazole or itraconazole	1 Year for Post Transplant Aspergillosis Prophylaxis or Fungal Meningitis 30 Days for Candidemia and Other Candida Infections; Esophageal Candidiasis; Invasive Aspergillosis
VORICONAZOLE 40 MG/ML SUSP	• One-Time Trial of fluconazole or itraconazole	30 Days
VORICONAZOLE 50 MG TABLET	• Diagnosis of Post Transplant Aspergillosis Prophylaxis or Fungal Meningitis OR • Diagnosis of Candidemia and Other Candida Infections; Esophageal Candidiasis; Invasive Aspergillosis • One-Time Trial of fluconazole or itraconazole	1 Year for Post Transplant Aspergillosis Prophylaxis or Fungal Meningitis 30 Days for Candidemia and Other Candida Infections; Esophageal Candidiasis; Invasive Aspergillosis
VRAYLAR 1.5 MG CAPSULE	• Diagnosis of Bipolar I Disorder OR Schizophrenia • 30 day Trial of aripiprazole (Abilify)	1 year
VRAYLAR 3 MG CAPSULE	• Diagnosis of Bipolar I Disorder OR Schizophrenia • 30 day Trial of aripiprazole (Abilify)	1 year
VRAYLAR 4.5 MG CAPSULE	• Diagnosis of Bipolar I Disorder OR Schizophrenia • 30 day Trial of aripiprazole (Abilify)	1 year
VRAYLAR 6 MG CAPSULE	• Diagnosis of Bipolar I Disorder OR Schizophrenia • 30 day Trial of aripiprazole (Abilify)	1 year
VUITY 1.25% EYE DROP	•At least 18 years of age •Diagnosis of presbyopia •Prescribed by an ophthalmologist •Not using with any other pilocarpine ophthalmic formulations •Documented medical inability to wear corrective lenses •Quantity Limit: 1 bottle per 28 days •Approve for 1 year; renew if positive clinical response and no serious side effects	1 year
VUSION OINTMENT	•Diagnosis of Diaper Rash •Quantity Limit 50 Grams (1 Tube)/26 Days	3 Months
VYLEESI 1.75 MG/0.3 ML AUTOINJ	Sexual Dysfunction: Set up and Send to the RPH	N/A
WESTHROID 130 MG TABLET	30-Day Trial of: Armour Thyroid Tablet	1 year
WESTHROID 195 MG TABLET	30-Day Trial of: Armour Thyroid Tablet	1 year
WESTHROID 32.5 MG TABLET	30-Day Trial of: Armour Thyroid Tablet	1 year
WESTHROID 65 MG TABLET	30-Day Trial of: Armour Thyroid Tablet	1 year
WESTHROID 97.5 MG TABLET	30-Day Trial of: Armour Thyroid Tablet	1 year
WINLEVI 1% CREAM	•Documented Diagnosis of Acne •12 Years of Age or Older •Trial and Failure of at Least 2 Preferred Prescription Strength Topical Acne Medications •Quantity: 1 Tube (60 Grams) Per 30 Days	3 Months; Renew if Positive Clinical Response (i.e., Reduced Number of Lesions From Baseline)
WP THYROID 81.25 MG TABLET	30-Day Trial Of: Armour Thyroid Tablet	1 year
XARELTO 10 MG TABLET	• One of the following diagnoses: 1) atrial fibrillation or flutter, 2) deep vein thrombosis (DVT) in a patient undergoing knee or hip replacement surgery, 3) treatment of DVT or pulmonary embolism (PE), or 4) to reduce the risk of recurrence of DVT or PE OR Diagnosis of DVT or PE (includes patients at risk of recurrence of DVT and/or PE) •For members < 6 months of age oAt least 37 weeks of gestation at birth oHave had at least 10 days of oral feeding oWeigh ≥2.6 kg at the time of dosing OR Diagnosis of Thromboprophylaxis in pediatric patient with congenital heart disease •Must be at least 2 years of age and less than 18 years of age •Documentation of previous Fontan procedure	1 year

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XARELTO 15 MG TABLET	• One of the following diagnoses: 1) atrial fibrillation or flutter, 2) deep vein thrombosis (DVT) in a patient undergoing knee or hip replacement surgery, 3) treatment of DVT or pulmonary embolism (PE), or 4) to reduce the risk of recurrence of DVT or PE OR Diagnosis of DVT or PE (includes patients at risk of recurrence of DVT and/or PE) •For members < 6 months of age oAt least 37 weeks of gestation at birth oHave had at least 10 days of oral feeding oWeigh ≥2.6 kg at the time of dosing OR Diagnosis of Thromboprophylaxis in pediatric patient with congenital heart disease •Must be at least 2 years of age and less than 18 years of age •Documentation of previous Fontan procedure	1 year
XARELTO 2.5 MG TABLET	• Requires concomitant use with aspirin	1 year
XARELTO 20 MG TABLET	• One of the following diagnoses: 1) atrial fibrillation or flutter, 2) deep vein thrombosis (DVT) in a patient undergoing knee or hip replacement surgery, 3) treatment of DVT or pulmonary embolism (PE), or 4) to reduce the risk of recurrence of DVT or PE OR Diagnosis of DVT or PE (includes patients at risk of recurrence of DVT and/or PE) •For members < 6 months of age oAt least 37 weeks of gestation at birth oHave had at least 10 days of oral feeding oWeigh ≥2.6 kg at the time of dosing OR Diagnosis of Thromboprophylaxis in pediatric patient with congenital heart disease •Must be at least 2 years of age and less than 18 years of age •Documentation of previous Fontan procedure	1 year
XARELTO DVT-PE TREAT START 30D	• One of the following diagnoses: 1) atrial fibrillation or flutter, 2) deep vein thrombosis (DVT) in a patient undergoing knee or hip replacement surgery, 3) treatment of DVT or pulmonary embolism (PE), or 4) to reduce the risk of recurrence of DVT or PE OR Diagnosis of DVT or PE (includes patients at risk of recurrence of DVT and/or PE) •For members < 6 months of age oAt least 37 weeks of gestation at birth oHave had at least 10 days of oral feeding oWeigh ≥2.6 kg at the time of dosing OR Diagnosis of Thromboprophylaxis in pediatric patient with congenital heart disease •Must be at least 2 years of age and less than 18 years of age •Documentation of previous Fontan procedure	1 year
XATMEP 2.5 MG/ML ORAL SOLUTION	•Diagnosis of Acute Lymphoblastic Leukemia (ALL) or Polyarticular Juvenile Idiopathic Arthritis (PJIA). •Age < 18 Years •Clinical Reason Supported by Chart Notes Why (After A 90-Day Trial Of) The Following Agents Cannot Be Used: Methotrexate Injections or Methotrexate Tablets	1 year
XEPI 1% CREAM	• Diagnosis of Impetigo • Clinical reason why (After a 5-Day trial) of the Following cannot be used: mupirocin Cream	5 Days

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Drug Name	Criteria	Approval Duration
XIAFLEX 0.9 MG VIAL	•For Initial Authorizations: •Diagnosis of Adult Patients with Dupuytren Contracture of Palmar Fascia with a Palpable Cord •Must Use the Preferred Specialty Pharmacy Accredo •Set Up and Send to RPh •Diagnosis of Peyronie's Disease •Curvature Must Be Greater Than 15% And Pain Involved •Must Use the Preferred Specialty Pharmacy Accredo •For Re-Authorizations: •Previously Approved On (Date) For (Length of Time) •Diagnosis of Adult Patients with Dupuytren Contracture of Palmar Fascia with a Palpable Cord OR Peyronie's Disease •Must use the Preferred Specialty Pharmacy Accredo	1 Year for Adult Patients with Dupuytren Contracture of Palmar Fascia with A Palpable Cord 6 Months for Peyronie's Disease
XIFAXAN 200 MG TABLET	• Diagnosis of Traveler's Diarrhea • A one-time trial in the Last 30 Days of: ciprofloxacin or metronidazole tablets	10 days
XIFAXAN 550 MG TABLET	• Diagnosis of Hepatic Encephalopathy • History of a 15-Day trial and Failure in the Last 90 Days or a Contraindication to lactulose OR • Diagnosis of Irritable Bowel Syndrome-Diarrhea (IBS-D) • A 30-Day trial in the Last 90 Days and Inadequate Response or Intolerance to Medications in TWO of the Following Categories or has a Contraindication to all of the Following Medications: loperamide OR antispasmodics (hyoscyamine, dicyclomine) OR tricyclic antidepressants (amitriptyline, desipramine, doxepin) OR • Diagnosis of Inflammatory Bowel Disease (Crohn's, Ulcerative Colitis, Diverticulitis) • History of a One Time trial and Failure Within the last 90 Days, Contraindication, or Intolerance to BOTH of the Following: ciprofloxacin or metronidazole Tablets OR • Diagnosis of SIBO (Small Intestine Bacterial Overgrowth) • A one-time trial in the Last 30 Days of: amoxicillin-clavulanic acid, clindamycin, metronidazole Tablets OR tetracycline	1 Year 14 Days For Re-Auths, There Must Be A Time Lapse Of At Least 10 Weeks Since Completion Of Last Course Of Xifaxan. Approval duration: 14 Days. Maximum of 3 courses in last 12 months. 6 Months For Initial Auths For Re-Auths, Documentation Of Positive Clinical Response To Xifaxan Therapy Must Be Provided. Approval duration: 12 months 14 Days
XIIDRA 5% EYE DROPS	• Diagnosis of Dry Eye Disease • 30 day Trial of at least TWO agents from different groups of the following supported by pharmacy claims and/or specific trial date listed on request with directions to use QID routinely for at least 30 days: Cellulose based artificial tears: Refresh Tears, Refresh Plus, Refresh Optive, Refresh Celluvisc, Refresh Liquigel, Systane Lubricant Eye Gel, Genteal Mild, Genteal Moderate, Genteal Gel (Severe), GenTeal Tears, Bion Tears, Visine Tears, TheraTears, Retaine Povidone based: Soothe Long Lasting Hydration, Soothe Hydration, Polyethylne glycol based artificial tears: Blink Tears, Systane, Systane Balance, Systane Ultra, Systane Gel, Systane Sport, Soothe Preservative Free Lubricant, Advanced Eye relief Dry Eye Rejuvenation, Oasis Tears, Oasis tears Plus PVA (polyvinyl alcohol)-based artificial tears: Murine, Refresh Classic, Tears Again, HypoTears Oil-based tears: Soothe XP, Refresh PM, Refresh Lacrilube, Systane Nighttime, Geneteal ointment, Soothe Night Time Ointment, Retain PM OR • If member has paid claims for Restasis, Freshkote, or Lacrisert	1 year
XOFLUZA 20 MG TAB (40 MG DOSE)	• Age 12 years or older • Diagnosis of influenza symptomatic for less than 48 hours OR seeking prophylaxis following direct contact with an individual diagnosed with influenza • Statement of medical necessity why oseltamivir cannot be used • Quantity limit: 4 tablets/yr or 4 bottles/yr (2 courses per year)	7 Days
XOFLUZA 40 MG TAB (80 MG DOSE)	• Age 12 years or older • Diagnosis of influenza symptomatic for less than 48 hours OR seeking prophylaxis following direct contact with an individual diagnosed with influenza • Statement of medical necessity why oseltamivir cannot be used • Quantity limit: 4 tablets/yr or 4 bottles/yr (2 courses per year)	7 Days

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Drug Name	Criteria	Approval Duration
XTAMPZA ER 13.5 MG CAPSULE	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
XTAMPZA ER 18 MG CAPSULE	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
XTAMPZA ER 27 MG CAPSULE	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
XTAMPZA ER 36 MG CAPSULE	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months

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Drug Name	Criteria	Approval Duration
XTAMPZA ER 9 MG CAPSULE	Initial Authorization: Diagnosis is one of the following: A) active cancer treatment of cancer related pain, B) palliative care, C) end-of-life or hospice care, D) sickle cell anemia, E) catastrophic injury (severe burns, traumatic crushing of tissue, amputation) OR Diagnosis is moderate to severe chronic pain (with diagnosis code) Member's previous treatment plan included short-acting opioid for at least the last 60 days Prescriber attests to checking prescription drug monitoring program If cumulative MED is >80 MED per day prescriber must be pain management specialist OR a pain management prescriber is unavailable to the patient and there is rationale for the higher dose Prescriber attests to a patient specific treatment plan If member is being treated concurrently with benzodiazepine, prescriber attests that the benefit outweighs the risk of benzodiazpine use Reauthorization: Chart notes or PA request state the benefit of continued therapy outweighing risks to patient safety (examples: continued adherence, pain/function sores, improvement in function and/or quality of life, random urine drug screens, no serious adverse outcomes) Documentation may be requested per pharmacist review Member meets all initial criteria If member has been on opioid therapy for >/= 90 days prescriber attests to the patient being reassessed for addiction risk or mental health concerns including referral to an addiction medicine specialist.	Intial Authorization: 90 days Reauthorization: 6 months
XULTOPHY 100 UNIT-3.6MG/ML PEN	Clinical reason supported by chart notes why (after a 30 day Trial of) the below cannot be used: Long acting insulin and a GLP 1 agonist	1 year
XURIDEN GRANULE PACKET	Diagnosis of Hereditary Orotic Aciduria	1 year
XYOSTED 100 MG/0.5 ML AUTO-INJ	•Diagnosis of Hypogonadism •Total Testosterone Lab Value = ≤ 300ng/dL Before Treatment (For New Starts Only) •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used •Trial of: Testosterone TD (Fortesta) or Testosterone (Androgel, Testim, Vogelxo) 1% (50 mg/5G) Gel Packet (Both Still Require A PA Also)	1 year
XYOSTED 50 MG/0.5 ML AUTO-INJ	•Diagnosis of Hypogonadism •Total Testosterone Lab Value = ≤ 300ng/dL Before Treatment (For New Starts Only) •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used •Trial of: Testosterone TD (Fortesta) or Testosterone (Androgel, Testim, Vogelxo) 1% (50 mg/5G) Gel Packet (Both Still Require A PA Also)	1 year
XYOSTED 75 MG/0.5 ML AUTO-INJ	•Diagnosis of Hypogonadism •Total Testosterone Lab Value = ≤ 300ng/dL Before Treatment (For New Starts Only) •Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) The Below Cannot Be Used •Trial of: Testosterone TD (Fortesta) or Testosterone (Androgel, Testim, Vogelxo) 1% (50 mg/5G) Gel Packet (Both Still Require A PA Also)	1 year
YOSPRALA DR 81-40 MG TABLET	•Diagnosis of Secondary Prevention of Cardiovascular and Cerebrovascular Events (History of Ischemic Stroke, Transient Ischemia of The Brain, History of Myocardial Infarction, Unstable Angina Pectoris, Chronic Stable Angina Pectoris, History of Coronary Artery Bypass Graft (CABG), or Percutaneous Transluminal Coronary Angioplasty) AND •Has A Documented History Of A Gastric Ulcer While On Chronic Aspirin Therapy •OR •High Risk of Developing Gastric Ulcer in Patient Age 55 Or Older (Must Be Described In Chart Notes) AND •90-Day Trial of all of the Following: •Aspirin in Combination with Misoprostol (Or Contraindication to Misoprostol) •Aspirin in Combination with ALL Formulary PPI's •For Re-Authorizations: •Member Must Have Met Initial Criteria and Did Not Experience a Gastric Ulcer While on Yosprala Therapy. •Quantity Limit 30 Tablets/26 Days	6 Months
YUPELRI 175 MCG/3 ML SOLUTION	•Clinical Reason Supported by Chart Notes Why (After A 90 Day Trial Of) Spriva Respimat Cannot be Used •Quantity Limit 30 Vials/Month	1 year

Drug Name	Criteria	Approval Duration
ZAFIRLUKAST 10 MG TABLET	• 30 Day Trial of: Montelukast (Singulair)	1 year
ZAFIRLUKAST 20 MG TABLET	• 30 Day Trial of: Montelukast (Singulair)	1 year
ZELNORM 6 MG TABLET	•Irritable Bowel Syndrome with Constipation •Clinical Reason Why After A 90 Day Trial Trulance (Requires PA) Cannot Be Used	1 year
ZEMBRACE SYMTOUCH 3 MG/0.5 ML	•Age = Between 18 And 65 Years Old •Diagnosis of Migraine Headaches •Member Has Tried and Failed At Least One of The Preferred Medications (Naratriptan, Rizatriptan, Zolmitriptan, Almotriptan or Sumatriptan) •Member Does Not Have ANY Of the Following Contraindications to Treatment: •History of Coronary Artery Disease or Coronary Spasm •Wolff-Parkinson-White Syndrome •History of Stroke, Transient Ischemic Attack, or Hemiplegic, or Basilar Migraine •Peripheral Vascular Disease •Ischemic Bowel Disease •Uncontrolled Hypertension	1 year
ZENPEP DR 10,000 UNIT CAPSULE	*Clinical reason supported by chart notes why (after a 90 day trial of) the below cannot be used *VIOKACE, ULTRESA or CREON	1 year
ZENPEP DR 15,000 UNIT CAPSULE	*Clinical reason supported by chart notes why (after a 90 day trial of) the below cannot be used *VIOKACE, ULTRESA or CREON	1 year
ZENPEP DR 20,000 UNIT CAPSULE	*Clinical reason supported by chart notes why (after a 90 day trial of) the below cannot be used *VIOKACE, ULTRESA or CREON	1 year
ZENPEP DR 25,000 UNIT CAPSULE	*Clinical reason supported by chart notes why (after a 90 day trial of) the below cannot be used *VIOKACE, ULTRESA or CREON	1 year
ZENPEP DR 3,000 UNIT CAPSULE	*Clinical reason supported by chart notes why (after a 90 day trial of) the below cannot be used *VIOKACE, ULTRESA or CREON	1 year
ZENPEP DR 40,000 UNIT CAPSULE	*Clinical reason supported by chart notes why (after a 90 day trial of) the below cannot be used *VIOKACE, ULTRESA or CREON	1 year
ZENPEP DR 5,000 UNIT CAPSULE	*Clinical reason supported by chart notes why (after a 90 day trial of) the below cannot be used *VIOKACE, ULTRESA or CREON	1 year
ZERVIATE 0.24% EYE DROP	• Diagnosis of allergic conjunctivitis • A 30 day trial and failure of a preferred ophthalamic antihistamine: azelastine, epinastine, olopatadine	1 year
ZETONNA 37 MCG NASAL SPRAY	Ages 2-3: 30 day Trial of Nasacort OTC Allergy 24HR Spray OR Ages 4-5: 30 day Trial of Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Or Nasacort OTC Allergy 24HR Spray OR Ages 6 and older: 30 day trial 2 of following: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Flunisolide, Or Nasacort OTC Allergy 24HR Spray	1 year
ZILEUTON ER 600 MG TABLET	• 30 Day Trial of: Montelukast (Singulair) [Not Required If: Allergy, Intolerance, Or Side Effect To Montelukast (Singulair)]	1 year
ZILRETTA 32 MG VIAL	• At least 18 years of age • Painful osteoarthritis of the knee confirmed by radiographic evidence • Trial and failure of ALL of the following for at least 3 months: - Non-pharm treatment such as exercise, weight loss, physical therapy, bracing - Simple analgesics such as acetaminophen or NSAIDs (oral or topical) - Immediate release intra-articular corticosteroid injection • The knee requested to be treated has not been previously injected with Zilretta • Limit: 1 injection per knee per lifetime	30 days
ZIOPTAN 0.0015% EYE DROPS	• 30 Day Trial of: Latanoprost 0.005% Eye Drops	1 year
ZONTIVITY 2.08 MG TABLET	•If Fax States Patient Was Started on This Medication in The Hospital •OR •Any Claims for the Requested Medication (Any Strength or Dose) •OR •30-Day Trial of: Clopidogrel (Plavix) •Not Required If: Allergy, Intolerance, or Side Effect to Clopidogrel (Plavix)	1 year
ZORVOLEX 18 MG CAPSULE	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Diclofenac Potassium (Cataflam) Tablet and Diclofenac Sodium (Voltaren) Tablet	1 year
ZORVOLEX 35 MG CAPSULE	•Clinical Reason Supported by Chart Notes Why (After A 30 Day Trial Of) The Below Cannot Be Used: •Diclofenac Potassium (Cataflam) Tablet and Diclofenac Sodium (Voltaren) Tablet	1 year

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Drug Name	Criteria	Approval Duration
ZTLIDO 1.8% TOPICAL SYSTEM	•Clinical Reason Why (After A 90 Day Trial Each) Two of The Following Cannot Be Used: •Lidocaine 5% Patch, Lidocaine 4% OTC Patch	6 Months
Z-TUSS AC 2 MG-9 MG/5 ML LIQ	•One Time Trial Per Age Groups Below: •Ages 2-6: Off-Label Can Recommend Dextromethorphan •Ages 6-12: Dextromethorphan •Ages 12 & Over: Dextromethorphan or Benzonatate Capsule	30 Days
ZYLET EYE DROPS	•Use Before Surgery •OR •Diagnosis of Bacterial Infection of The Eye •One Time Trial of: Tobra-Dex or Neomycin/Polymyxin/Dexamethasone Ophthalmic	30 Days