Samaritan Health Plans

Prior Authorization Criteria

Large Group Commercial Plans

PLEASE READ: This document contains information about the criteria for coverage for this plan.

Updated on 11/1/2026. For more recent information or other questions, please contact Pharmacy Services at 541-768-7864 or toll free 866-203-0360 (TTY 800-735-2900) or visit **samhealthplans.org**. Pharmacy Services is available Monday through Friday, from 8 a.m. to 5 p.m.

Abatacept (ORENCIA)

Products Affected	
• **ORENCIA**	• **ORENCIA CLICKJECT**

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Adult Rheumatoid Arthritis (RA)**
	• Diagnosis of moderately to severely active rheumatoid arthritis
	• Trial and failure, contraindication, or intolerance to ONE nonbiologic disease-modifying antirheumatic drug (DMARD) (e.g., methotrexate [Rheumatrex/Trexall], Arava [leflunomide], Azulfidine [sulfasalazine])
	• Trial and failure, contraindication, or intolerance to TWO of the following, or attestation demonstrating a trial may be inappropriate:
	  ○ Cimzia (certolizumab pegol)
	  ○ Humira (adalimumab)
	  ○ Rinvoq (upadacitinib)
	  ○ Simponi (golimumab)
	  ○ Xeljanz/XR (tofacitinib/ER).
	
	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
	• Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis
	• Trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses:
	  ○ Methotrexate
	  ○ Leflunomide
	• Trial and failure, contraindication, or intolerance to two of the following, or attestation demonstrating a trial may be inappropriate:
	  ○ Enbrel (etanercept)
	  ○ Humira (adalimumab)
	  ○ Xeljanz (tofacitinib)
	
	Psoriatic Arthritis (PsA)

Criteria Details	

	• Diagnosis of active psoriatic arthritis with one of the following:
	  ○ Actively inflamed joints
	  ○ Dactylitis
	  ○ Enthesitis
	  ○ Axial disease
	  ○ Active skin and/or nail involvement
	• Trial and failure, contraindication, or intolerance to **TWO** of the following:
	  ○ Cimzia (certolizumab pegol)
	  ○ Humira (adalimumab)
	  ○ Simponi (golimumab)
	  ○ Ustekinumab
	  ○ Tremfya (guselkumab)
	  ○ Skyrizi (risankizumab-rzaa)
	  ○ Rinvoq (upadacitinib)
	  ○ Xeljanz/XR (tofacitinib/ER).
	
	Prophylaxis for Acute Graft versus Host Disease (aGVHD)
	• Used for prophylaxis of acute graft versus host disease (aGVHD)
	• Patient will receive hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor
	• Recommended antiviral prophylactic treatment for Epstein-Barr Virus (EBV) reactivation (e.g., acyclovir) will be administered prior to Orencia
	• Continued for six months after HSCT
	• Used in combination with both of the following:
	  ○ calcineurin inhibitor (e.g., cyclosporine, tacrolimus)
	  ○ methotrexate

Age Restrictions	**aGVHD:** 2 years of age or older
Prescriber Restrictions	**RA, PJIA:** Prescribed by or in consultation with a rheumatologist **PsA:** Prescribed by or in consultation with a dermatologist or rheumatologist
Coverage Duration	**RA, PJIA, PsA: Initial**: 6 months. **Renewal**: 12 months **aGVHD: Initial:** 2 months. **Renewal**: N/A
Renewal Criteria	Documented positive clinical response to therapy **RA, PJIA:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the total active (swollen and tender) joint count from baseline, or improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline.

Criteria Details	
	PsA: Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline, or reduction in the body surface area (BSA) involvement from baseline.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Acitretin (SORIATANE)

Products Affected

- ACITRETIN

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Diagnosed with severe psoriasis** • Patient is unresponsive to at least 2 conventional therapies (topical corticosteroids, vitamin D analogs, Tazorac, topical tacrolimus, Elidel, phototherapy).
Age Restrictions	Females of childbearing age **AND** able to bear children must comply with ALL the following: • 2 negative urine or serum pregnancy tests prior to therapy • commit to using 2 effective forms of birth control starting 1 month prior to acitretin treatment monthly pregnancy tests during therapy
Prescriber Restrictions	Prescribed by a dermatologist.
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.
Renewal Criteria	**Renewal Criteria**: Documentation of continued effectiveness. **Renewal Criteria** for females able to bear children: Documentation of required pregnancy monitoring **AND** continued effectiveness.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Adalimumab (HUMIRA) & Biosimilars

Products Affected

- CYLTEZO INJ (Auto-Injector & Prefilled syringe)
- HYRIMOZ (Auto-Injector & Prefilled syringe)
- HUMIRA PEDIA INJ CROHNS
- HUMIRA PEN INJ 80/0.8ML
- HUMIRA PEN KIT CD/UC/HS
- HUMIRA PEN KIT PED UC
- HUMIRA PEN KIT CD/UC/HS
- HUMIRA INJ 40/0.4ML
- HUMIRA PEN INJ 40/0.4ML
- HUMIRA INJ 20/0.2ML
- HUMIRA INJ 10/0.1ML
- HUMIRA PEN KIT PS/UV
- HUMIRA PEDIA INJ CROHNS
- HUMIRA KIT 40MG/0.8
- HUMIRA PEN INJ 40MG/0.8
- HUMIRA PEN INJ CD/UC/HS
- HUMIRA PEN INJ PS/UV

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Rheumatoid arthritis (RA)**
	• Diagnosis of moderately to severely active RA **AND** trial and failure, contraindication, or intolerance to one non-biologic disease-modifying antirheumatic drug (DMARD) [e.g., methotrexate (Rheumatrex/Trexall), Arava (leflunomide), Azulfidine (sulfasalazine)].
	
	Polyarticular Juvenile idiopathic arthritis (PJIA)
	• Diagnosis of moderate to severely active polyarticular JIA
	• Trial and failure, contraindication, or intolerance to one of the following non-biologic disease-modifying antirheumatic drugs (DMARDs)
	  ○ Arava (leflunomide)
	  ○ Methotrexate (Rheumatrex/Trexall).
	
	Psoriatic arthritis (PsA)
	• Diagnosis of active PsA with one of the following
	  ○ actively inflamed joints
	  ○ dactylitis
	  ○ enthesitis
	  ○ axial disease
	  ○ active skin and/or nail involvement.

Criteria Details	

	Ankylosing spondylitis (AS)
	• Diagnosis of active ankylosing spondylitis
	• Trial and failure, contraindication, or intolerance to two NSAIDs (e.g., diclofenac, ibuprofen, indomethacin, meloxicam, naproxen)
	
	Crohn's disease (CD)
	• Diagnosis of moderately to severely active Crohn's disease
	• One of the following:
	  ○ frequent diarrhea and abdominal pain,
	  ○ at least 10% weight loss
	  ○ complications such as obstruction, fever, abdominal mass
	  ○ abnormal lab values (e.g. C-reactive protein)
	  ○ CD Activity Index greater than 220
	• Trial and failure, contraindication, or intolerance to one of the following conventional therapies
	  ○ 6-mercaptopurine
	  ○ Azathioprine
	  ○ corticosteroids (e.g., prednisone, methylprednisolone)
	  ○ methotrexate
	
	Ulcerative Colitis (UC)
	• Diagnosis of moderately to severely active ulcerative colitis
	• One of the following
	  ○ Greater than 6 stools per day
	  ○ frequent blood in the stools
	  ○ frequent urgency
	  ○ presence of ulcers
	  ○ abnormal lab values (e.g. hemoglobin, ESR, CRP)
	  ○ dependent on, or refractory to, corticosteroids
	• Trial and failure, contraindication, or intolerance to one of the following conventional therapies
	  ○ 6-mercaptopurine
	  ○ aminosalicylate [e.g., mesalamine sulfasalazine, azathioprine, Corticosteroids (e.g., prednisone, methylprednisolone).
	
	Plaque Psoriasis (PP): Diagnosis of moderate to severe chronic plaque psoriasis with one of the following: 1) greater than or equal to 3% body surface area involvement, 2) severe scalp psoriasis, 3) palmoplantar, facial, or genital involvement. **AND** a minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following

Criteria Details	
	topical therapies: corticosteroids, vitamin D analogs, tazarotene, calcineurin inhibitors, anthralin, coal tar. **Hidradenitis Suppurativa (HS):** Diagnosis of moderate to severe hidradenitis suppurativa (i.e., Hurley Stage II or III) **Uveitis (UV):** Diagnosis of non-infectious uveitis **AND** uveitis is classified as one of the following: intermediate, posterior or panuveitis.
Age Restrictions	
Prescriber Restrictions	**RA, PJIA, AS:** Prescribed by or in consultation with a rheumatologist **PsA:** Prescribed by or in consultation with one of the following: Dermatologist or Rheumatologist. **CD, UC:** Prescribed by or in consultation with a gastroenterologist **PsO, HS:** Prescribed by or in consultation with a dermatologist **UV:** Prescribed by or in consultation with one of the following: ophthalmologist or rheumatologist
Coverage Duration	**RA, PJIA, PsA, PsO, AS, CD, HS, UV Initial**: 6 months; **Renewal:** 12 months **UC: Initial:** 12 weeks; **Renewal:** 12 months
Renewal Criteria	**RA, PJIA:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the total active (swollen and tender) joint count from baseline, or improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline. **PsA:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline, or reduction in the body surface area (BSA) involvement from baseline. **AS:** Documentation of positive clinical response to therapy as evidenced by improvement from baseline for least one of the following: disease activity (e.g., pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (e.g., lumbar spine motion, chest expansion), or total active (swollen and tender) joint count. **CD:** Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts,

Criteria Details	
	erythrocyte sedimentation rate, C-reactive protein level]) from baseline, or reversal of high fecal output state. **UC:** One of the following: For patients who initiated Humira therapy within the past 12 weeks: Documentation of clinical remission or significant clinical benefit by eight weeks (Day 57) of therapy OR For patients who have been maintained on Humira therapy for longer than 12 weeks: Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, or reversal of high fecal output state. **PsO:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, or improvement in symptoms (e.g., pruritus, inflammation) from baseline. **HS, UV:** Documentation of positive clinical response to therapy.
Effective Date	09/01/2023
P&T Approval Date	07/11/2023
P&T Revision Date	

Alpelisib (VIJOICE)

Products Affected

- Vijoice TAB

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Confirmed diagnosis of PROS **AND** has at least one severe clinical manifestation of PROS **AND** has a PIK3CA mutation that is confirmed by genetic testing
Age Restrictions	At least 2 years of age
Prescriber Restrictions	Prescribed by or in consultation with a provider who specializes in treatment of genetic disorders
Coverage Duration	**Initial:** 24 weeks. **Renewal:** 6 months.
Renewal Criteria	Documentation of a reduction in volume from baseline in at least one lesion **AND** an improvement in at least one symptom of PROS from baseline
Effective Date	10/01/2022
P&T Approval Date	09/13/2022
P&T Revision Date	

Apremilast (OTEZLA)

Products Affected

- Otezla
- Otezla XR

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Plaque Psoriasis (PsO):**
	• Diagnosis of plaque psoriasis
	• Trial and failure of a minimum duration of a 30-day trial, contraindication, or intolerance to one of the following topical therapies:
	  ○ Corticosteroids (e.g. betamethasone, clobetasol)
	  ○ Vitamin D analogs (e.g. calcitriol, calcipotriene)
	  ○ Tazarotene
	  ○ Calcineurin inhibitors (e.g. tacrolimus, pimecrolimus)
	
	Psoriatic Arthritis (PsA):
	• Diagnosis of active psoriatic arthritis with one of the following:
	  ○ Actively inflamed joints
	  ○ Dactylitis
	  ○ Enthesitis
	  ○ Axial disease
	  ○ Active skin and/or nail involvement
	
	Oral Ulcers Associated with Behçet's Disease:
	• Diagnosis of Behçet's Disease
	• Patient has active oral ulcers

Age Restrictions	Age 6 or older
Prescriber Restrictions	**Plaque psoriasis:** Prescribed by or in consultation with a dermatologist. **Psoriatic arthritis**: Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	**Initial:** 6 months. **Renewal:** 12 months.
Renewal Criteria	**Plaque Psoriasis (PsO)**: • Documentation of positive clinical response to therapy as evidenced by one of the following:

Criteria Details	
	○ Reduction the body surface area (BSA) involvement from baseline ○ Improvement in symptoms (e.g., pruritus, inflammation) from baseline **Psoriatic Arthritis (PsA):** • Documentation of positive clinical response to therapy as evidenced by one of the following: ○ Reduction in body surface area (BSA) from baseline ○ Reduction in the total active (swollen and tender) joint count from baseline ○ Improvement in symptoms (e.g., pain, stiffness, pruritus, inflammation) from baseline **Behçet's Disease**: • Documentation of positive clinical response to therapy (e.g., reduction in pain from oral ulcers or reduction in number of oral ulcers).
Effective Date	03/01/2026
P&T Approval Date	01/11/2022
P&T Revision Date	10/18/2023, 10/18/2023, 06/19/2024, 09/18/2024, 06/18/2025, 09/17/2025, 11/20/2025

Bedaquiline (SIRTURO)

Products Affected

- Sirturo tablets

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Pulmonary tuberculosis** • Evidence of active pulmonary tuberculosis caused by mycobacterium tuberculosis that is resistant to at least rifampin and isoniazid. • The member weighs at least 15kg. • Sirturo is prescribed as part of a guideline recommended multi-drug treatment regimen.
Exclusion Criteria	Medication is being received through a county clinic with a state funded TB program.
Age Restrictions	5 years of age or older
Prescriber Restrictions	Prescribed by Infectious Disease
Coverage Duration	**Pulmonary tuberculosis:** 24 weeks
Renewal Criteria	N/A
Effective Date	05/01/2025
P&T Approval Date	03/11/2025
P&T Revision Date	03/11/2025

Bempedoic acid (NEXLETOL)

Products Affected

- NEXLETOL TABLETS
- NEXLIZET TABLETS

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Established clinical ASCVD:**
	• Documentation of very high risk ASCVD as evidenced by either:
	  ○ History of multiple major ASCVD events **OR**
	  ○ One major ASCVD event AND multiple high-risk conditions.
	• Documentation of a current LDL greater than or equal to 55 mg/dl.
	• Documentation that:
	  ○ Patient is receiving maximally tolerated statin therapy (atorvastatin 40-80mg, rosuvastatin 20-40mg) or has a documented clinical intolerance to statins **AND**
	  ○ Is receiving ezetimibe or has a documented intolerance to ezetimibe.
	
	Primary or familial hyperlipidemia:
	• Documentation of an untreated (i.e., prior to lipid lowering therapy) LDL greater than 190 mg/dL.
	• Documentation of current LDL greater than 100 mg/dL.
	• Documentation that:
	  ○ Patient is receiving maximally tolerated statin therapy (atorvastatin 40-80mg, rosuvastatin 20-40mg) or has a documented clinical intolerance to statins **AND**
	  ○ Is receiving ezetimibe or has a documented intolerance to ezetimibe.

Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.
Coverage Duration	**Initial**: 6 months. **Renewal**: 12 months

Criteria Details	
Renewal Criteria	Documented positive clinical response to therapy (significant decrease in lipid levels).
Effective Date	11/1/2026
P&T Approval Date	9/10/2024
P&T Revision Date	9/8/2026, 9/10/2024

Belumosudil (REZUROCK)

Products Affected

- REZUROCK

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Diagnosed with chronic graft-versus-host disease (cGVHD) **AND** who have tried and failed of at least two prior lines of systemic therapy for cGVHD **AND** not currently taking Imbruvica (ibrutinib)
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by oncologist or transplant specialist
Coverage Duration	**Initial**: 3 months. **Renewal**: 6 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	04/01/2022
P&T Approval Date	03/08/2022
P&T Revision Date	03/08/2022

Brexipiprazole (REXULTI)

Products Affected

- REXULTI

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Major Depressive Disorder (MDD):** A diagnosis of MDD **AND** prior treatment failure (at least 3 weeks) of or contraindication to 3 prior antidepressants **AND** one antipsychotic FDA approved as adjunct treatment for MDD **AND** to be used concurrently with an antidepressant. **Schizophrenia:** A diagnosis of schizophrenia **AND** prior treatment failure with a minimum of 2 antipsychotics **AND** Vraylar.
Age Restrictions	**Schizophrenia:** Aged 13 or older **Major Depressive Disorder (MDD):** Aged 18 or older
Prescriber Restrictions	
Coverage Duration	**Initial:** 3 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of treatment success **AND** continued need for Rexulti.
Effective Date	
P&T Approval Date	
P&T Revision Date	

BUTRANS, BUPRENORPHINE PATCH, BELBUCA

Products Affected

- BELBUCA
- BUPRENORPHINE PATCH

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Cancer or End-of-Life Care: Patient is being treated for cancer related pain or pain associated with end-of-life:** Documented trial and failure of, scheduled short-acting opioid therapy **AND** documented trial and failure or contraindication to long-acting morphine sulfate therapy. Documented trial/failure of, or reason why fentanyl is not appropriate. **Other Chronic Pain:** Documented above the line diagnosis, FDA indicated, or guideline supported condition. Documented severe chronic pain (greater than 3mo) that is severe enough to require around the clock analgesic therapy **AND** documented trial and failure or contraindication to short-acting opioid therapy **AND** documented trial and failure of, or contraindication to long-acting morphine sulfate therapy **AND** documented trial and failure of, or reason why fentanyl is not appropriate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial cancer/end of life:** 12 months. **Initial non-cancer/end of life**: 6 months. **Renewal:** 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Cenegermin (Oxervate)

Products Affected

- Oxervate Ophthalmic

Prior Authorization Criteria

Criteria Details	
Required Medical Information	• Confirmed diagnosis of stage 2 or 3 neurotrophic keratitis • Trial and failure of at least one ocular lubricant used for at least 2 weeks
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist
Coverage Duration	**Initial:** 8 weeks. **Renewal:** N/A, no renewal allowed
Effective Date	11/01/2025
P&T Approval Date	09/09/2025
P&T Revision Date	09/09/2025

Certolizumab Pegol (CIMZIA)

Products Affected

- Cimzia

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Crohn's Disease (CD):** Diagnosis of moderately to severely active Crohn's disease with one of the following: 1) frequent diarrhea and abdominal pain, 2) at least 10% weight loss, 3) complications such as obstruction, fever, abdominal mass, 4) abnormal lab values (e.g. C-reactive protein), CD Activity Index greater than 220. **AND** trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: 6-mercaptopurine, Azathioprine, Corticosteroids (e.g., prednisone, methylprednisolone), Methotrexate. **Rheumatoid Arthritis (RA):** Diagnosis of moderately to severely active RA **AND** trial and failure, contraindication or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. **Psoriatic Arthritis (PsA):** Diagnosis of active psoriatic arthritis with one of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, active skin and/or nail involvement. **Ankylosing Spondylitis (AS):** Diagnosis of active ankylosing spondylitis **AND** minimum duration of one month trial and failure, contraindication, or intolerance to two different nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen) at maximally tolerated doses. **Plaque Psoriasis (PsO):** Diagnosis of moderate to severe plaque psoriasis with one of the following: 1) greater than or equal to 3% body surface area involvement, 2) severe scalp psoriasis, 3) palmoplantar, facial, or genital involvement **AND** a minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids, vitamin D analogs, tazarotene, calcineurin inhibitors, anthralin, coal tar.

Criteria Details	
	Non-radiographic Axial Spondyloarthritis (nr-axSpA): Diagnosis of active non-radiographic axial spondyloarthritis **AND** patient has objective signs of inflammation (e.g., C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints.) **AND** minimum duration of one month trial and failure, contraindication, or intolerance to two different NSAIDs (e.g., ibuprofen, naproxen) at maximally tolerated doses
Age Restrictions	
Prescriber Restrictions	**CD:** Prescribed by or in consultation with a gastroenterologist **RA, AS, nr-axSpA:** Prescribed by or in consultation with a rheumatologist **PsA:** Prescribed by or in consultation with one of the following: Dermatologist or Rheumatologist **PsO:** Prescribed by or in consultation with a dermatologist
Coverage Duration	**CD: Initial:** 16 weeks; **Renewal:** 12months **RA, PsA, AS, PsO, nr-axSpA: Initial:** 6 months; **Renewal**: 12 months
Renewal Criteria	**CD:** Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, or reversal of high fecal output state. **RA:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the total active (swollen and tender) joint count from baseline, or improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline. **PsA:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline, or reduction in the body surface area (BSA) involvement from baseline. **AS, nr-axSpA:** Documentation of positive clinical response to therapy as evidenced by improvement from baseline for least one of the following: disease activity (e.g., pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial

Criteria Details	
	status (e.g., lumbar spine motion, chest expansion), or total active (swollen and tender) joint count. **PsO:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, or improvement in symptoms (e.g., pruritus, inflammation) from baseline.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Clobazam (ONFI)

Products Affected

- Clobazam **10mg Tablets**
- Clobazam **20mg Tablets**
- Clobazam **2.5mg/mL suspension**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Lennox-Gastaut Syndrome** • Confirmed diagnosis. **Refractory Seizures** • Documentation showing appropriate trial of 2 or more tolerated anticonvulsant therapies.
Age Restrictions	**Solution only** One of the following: • Pediatric member age 10 or under • Documentation inability of the member to use the preferred tablet formulation
Prescriber Restrictions	Neurologist
Coverage Duration	**Initial**: 12 months. **Renewal**: Lifetime.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	5/1/2025
P&T Approval Date	7/11/2023
P&T Revision Date	3/11/2025, 3/12/2024, 7/11/2023

Compounds (standard criteria for all compounded medications)

Products Affected

- All compounded medications

Prior Authorization Criteria

Criteria Details	
Required Medical Information	• Each active ingredient in the compounded drug is FDA-approved or national compendia* supported for the condition being treated. • The requested amounts are supported by national compendia* or two peer-reviewed literature for the condition being treated in the requested route of delivery. • If any prescription ingredients require prior authorization and/or step therapy, all drug-specific criteria must be also met. • The patient has tried and failed therapy or had an intolerance to two FDA-approved commercially-available prescription therapeutic alternatives, one of which is the same route of administration as the requested compound, unless one of the following criteria are met: ○ Patient has a contraindication to commercially available products ○ Only one or no other therapeutic alternatives are commercially available ○ Prepared strength(s) is/are not commercially available or currently in short supply ○ Prepared in a different dosage form for a patient who is unable to take the commercially available formulation (mixing or reconstituting commercially available products based on the manufacturer's instructions or the product's approved labeling does NOT meet this criteria). ○ Patient has an allergy or sensitivity to inactive ingredients (e.g. dyes, preservatives, sugars, etc.) that are found in commercially available products.

Criteria Details	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 6 months. **Renewal**: 12 months.
Renewal Criteria	
Effective Date	
P&T Approval Date	
P&T Revision Date	

Continuous Glucose Monitor (CGM)

Products Affected

- **DEXCOM G6 & G7 SYSTEMS**
- **FREESTYLE LIBRE SYSTEMS**

Prior Authorization Criteria

Criteria Details	

Required Medical Information	Patient has documented diagnosis of type 1 or type 2 diabetes mellitus.
	Patient must have ALL of the following:
	• Intensive insulin regimen (3 or more insulin injections per day, or use of continuous subcutaneous insulin infusion pump).
	• Patient consistently monitors blood glucose 3 or more times per day.
	• Patient is motivated and knowledgeable about use of continuous glucose monitoring, is adherent to diabetic treatment plan, and participates in ongoing education and support.
	• Patient must have 1 OR more of the following:
	  ○ Dawn phenomenon, known or suspected, Hypoglycemic unawareness (i.e., patient does not have symptoms with hypoglycemia).
	  ○ Nocturnal hypoglycemia, known or suspected.
	  ○ Postprandial hyperglycemia, known or suspected.
	  ○ Significant change to diabetes treatment regimen (e.g., initiation of insulin, change from multiple-dose insulin to insulin pump therapy).
	Unexplained hyperglycemia.

Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 12 months. **Renewal:** 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	01/01/2024
P&T Approval Date	11/14/2023

Criteria Details	
P&T Revision Date	11/14/2023

Colony-Stimulating Factors

Products Affected

- **NIVESTYM**
- **ZARIXIO**
- **NUESASTA/NEULASTA ONPRO**
- **UDENYCA/UDENYCA ONPRO**

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Bone Marrow/Stem Cell Transplant**:
	• One of the following:
	  ○ Patient has non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant (BMT) **OR**
	  ○ Used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis **OR**
	  ○ Patient has had a peripheral stem cell transplant (PSCT) and has received myeloablative chemotherapy.
	
	Acute Myeloid Leukemia (AML) Induction or Consolidation Therapy:
	• Diagnosis of acute myeloid leukemia (AML).
	• Patient has completed induction or consolidation chemotherapy.
	
	Febrile Neutropenia Prophylaxis:
	• Patient will be receiving prophylaxis for febrile neutropenia (FN) due to one of the following:
	  ○ Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer.
	  ○ Patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown.
	  ○ Patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN.
	  ○ Patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN **AND** has one or more risk factors associated with chemotherapy induced infection, FN, or neutropenia.
	  ○ Patient is receiving myelosuppressive anticancer drugs associated with neutropenia **AND** has a history of FN or dose-

Criteria Details	
	limiting event during a previous course of chemotherapy (secondary prophylaxis). **Treatment of High-Risk Febrile Neutropenia:** • Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. • Diagnosis of febrile neutropenia (FN). • Patient is at high risk for infection-associated complications. **Severe Chronic Neutropenia (SCN):** • For patients with severe chronic neutropenia (SCN) (i.e., congenital, cyclic, and idiopathic neutropenias with chronic absolute neutrophil count [ANC] less than or equal to 500 cells/mm^3) **Acute Radiation Syndrome (ARS):** • Patient was/will be acutely exposed to myelosuppressive doses of radiation cells/mm^3). **Human Immunodeficiency Virus (HIV) Related Neutropenia:** • Patient is infected with HIV virus. • ANC less than or equal to 1,000 (cells/mm3).
Age Restrictions	
Prescriber Restrictions	**HIV Related Neutropenia –** Hematologist, Oncologist, or Infectious Disease Specialist **All Other Diagnosis -** Hematologist or Oncologist
Coverage Duration	**Bone Marrow/Stem Cell Transplant**: 3 months or duration of therapy. **AML Induction/Consolidation Therapy:** 3 months or duration of therapy. **Febrile Neutropenia (FN) Prophylaxis**: 3 months or duration of therapy. **Treatment of High-Risk FN:** 3 months or duration of therapy. **Severe Chronic Neutropenia (SCN):** 12 months. **Acute Radiation Syndrome (ARS):** 1 month
Renewal Criteria	
Effective Date	09/01/2024
P&T Approval Date	07/09/2024

Cyclosporine ophthalmic emulsion (RESTASIS)

Products Affected

- RESTASIS
- RESTASIS MULTIDOSE

Prior Authorization Criteria

Criteria Details	
Required Medical Information	The patient has a diagnosis of lack of tear production due to ocular inflammation associated with keratoconjunctivitis sicca **AND ONE** of the following: The patient is not currently using a topical ophthalmic anti-inflammatory drug or punctal plug **OR** the patients current use of topical ophthalmic anti-inflammatory drug or punctal plug will be discontinued before starting the requested agent **AND** the patient has previously tried or is currently using aqueous enhancements (e.g. artificial tears, gels, ointments) **OR** the patient has a documented intolerance, contraindication, or hypersensitivity to aqueous enhancements **AND** the patient is not currently using Xiidra OR the patients current use of Xiidra will be discontinued before starting Restasis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial:** 12 months. **Renewal:** 12 months
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Deutetrabenazine (AUSTEDO)

Products Affected

- Austedo 6mg TAB
- Austedo 9mg TAB
- Austedo 12mg TAB

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Chorea associated with Huntington's Disease:** Documentation of the degree of chorea present and the impact on functional ability and/or quality of life as a baseline **AND** documentation of mental status, specifically depression and suicidality. **Tardive Dyskinesia:** Clinical documentation of tardive dyskinesia including 1) At least one month of past or current exposure to a dopamine receptor blocker, 2) Dyskinetic or dystonic involuntary movements, 3) Exclusion of other causes of abnormal movements **AND** clear documentation that tardive dyskinesia causes functional impairment **AND** documentation of the degree of tardive dyskinesia with the AIMS scale as a baseline **AND** one of the following: tried and failed an 8-week trial of at least 2 other agents within the same therapeutic category at a clinically effective and maximally tolerated dose for the patient's primary neuropsychiatric diagnosis **OR** evidence the medications precipitating tardive dyskinesia are medically necessary **AND** trial and failure or contraindication to clonazepam and amantadine.
Age Restrictions	Age 18 and older
Prescriber Restrictions	**Huntington's Disease**: neurologist **Tardive Dyskinesia:** neurologist or psychiatrist
Coverage Duration	**Initial**: 3 months. **Renewal**: 12 months.
Renewal Criteria	**Huntington's Chorea:** clinical response such as improvement in chorea, ability to perform ADLs, reduction in falls, or increase in quality of life. **AND** documentation of continued monitoring of mental status specifically for depression and suicidality.

Criteria Details	
	Tardive Dyskinesia: Follow-up AIMS assessment showing improvement from Baseline **AND** documented improvement in functioning such as ability to perform ADLs, reduction in falls and increase in quality of life.
Effective Date	07/01/2023
P&T Approval Date	05/09/2023
P&T Revision Date	

Dimethyl Fumarate (TECFIDERA)

Products Affected

- DIMETHYL FUMARATE
- DIMETHYL FUMARATE STARTER PACK

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Multiple sclerosis:** Patient is diagnosed with relapsing forms of multiple sclerosis.
Age Restrictions	
Prescriber Restrictions	Prescribed by a neurologist.
Coverage Duration	**Initial:** 6 months. **Renewal:** 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	03/01/2023
P&T Approval Date	01/10/2023
P&T Revision Date	

Direct-Acting Antivirals (use in Hepatitis C)

Products Affected

- LEDIPASVIR-SOFOSBUVIR
- **MAVYRET**
- SOFOSBUVIR-VELPATASVIR

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Treatment of Hepatitis C:** • Expected survival from non-HCV-associated morbidities more than 1 year. • Must have all pretreatment testing completed: including genotype, HBV, HIV, and cirrhosis status. • Care must be provided by or in consultation with a specialist (hepatologist, gastroenterologist, or infectious disease specialist). • Attestation that the patient and provider will comply with case management to promote the best possible outcome for the patient and adhere to monitoring requirements required by the Oregon Health Authority, including measuring and reporting of a posttreatment viral load OR attestation from the patient and provider that they have opted out of OHA case management. Case management includes assessment of treatment barriers and offer of patient support to mitigate potential barriers to regimen adherence as well as facilitation of SVR12 evaluation to assess treatment success. • Documentation if the patient has a GT 1a infection or GT 3 infection and the patient had a baseline NS5a resistance test that documents a resistant variant to Elbasvir/grazoprevir or Daclatasvir + sofosbuvir. Note: Baseline NS5A resistance testing is required. • Documentation of the prescribed regimen includes a NS3/4a protease inhibitor (glecaprevir, simeprevir, paritaprevir, voxilaprevir). • Documentation if the patient has moderate-severe hepatic impairment (Child-Pugh B or Child-Pugh C). Documentation if the prescribed regimen for the retreatment after failure of a DAA due to noncompliance or loss of follow-up and the prescribed

Criteria Details	
	drug regimen is a recommended regimen based on the patient's genotype, age, treatment status (retreatment or treatment naive) and cirrhosis status.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist
Coverage Duration	**Initial:** 2-4 months.
Renewal Criteria	
Effective Date	12/01/2022
P&T Approval Date	11/08/2022
P&T Revision Date	

Disposable Insulin Pump (OMNIPOD)

Products Affected

- OMNIPOD 5
- OMNIPOD DASH

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Insulin dependent diabetes mellitus – pediatric (under age 18)**
	• Documentation of Type 1 Diabetes Mellitus or Diabetes with C-reactive protein levels indicating insulin dependence.
	• On intensive insulin therapy (>3 daily insulin injections) requiring frequent self-adjustments for at least 6 months prior to initiation of the insulin pump.
	• Documentation self-testing of blood glucose at least 4 times per day during the previous 2 months
	• Evidence of completion of a comprehensive diabetes education program in the last 12 months (member or caregiver/parent).
	
	Insulin dependent diabetes mellitus – adult
	• All of the above pediatric requirements AND
	• Documentation of 1 of the following:
	  ○ HbA1c >7%
	  ○ History of recurring hypoglycemia
	  ○ Wide fluctuations in blood glucose before mealtime
	  ○ Dawn phenomenon with fasting blood sugars frequently exceeding 200mg/dL
	  ○ History of severe glycemic excursions
	• Inability to use a traditional (non-disposable) insulin pump.

Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 6 months **Renewal**: 12 months
Renewal Criteria	Documentation of positive clinical response to therapy and in-person visit with provider within the last 6 months.

Criteria Details	
Effective Date	03/01/2024
P&T Approval Date	01/09/2024
P&T Revision Date	

Dornase alfa (PULMOZYME)

Products Affected

- PULMOZYME

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Cystic Fibrosis (CF):** Diagnosis of CF.
Age Restrictions	
Prescriber Restrictions	Prescribed by pulmonologist
Coverage Duration	**Initial**: 12 months. **Renewal**: 12months.
Renewal Criteria	CF, Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).
Effective Date	
P&T Approval Date	
P&T Revision Date	

Dronabinol (MARINOL)

Products Affected

- DRONABINOL

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Nausea and Vomiting Associated with Cancer Chemotherapy (CINV):** Failure, contraindication, or intolerance to one 5HT-3 receptor antagonist (e.g., Anzemet [dolasetron], Kytril [granisetron], or Zofran [ondansetron]). Failure, contraindication, or intolerance to one of the following: Compazine (prochlorperazine), Decadron (dexamethasone), Haldol (haloperidol), Zyprexa (olanzapine). **AIDS anorexia:** Diagnosis of anorexia with weight loss in patients with AIDS. Patient is on antiretroviral therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Dupilumab (DUPIXENT)

Products Affected

- **DUPIXENT**

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Moderate to Severe Asthma:**
	• Documentation of inadequate control of asthma symptoms with one of the following:
	  ○ inhaled corticosteroids and long acting beta2 agonist **OR**
	  ○ inhaled corticosteroids and long-acting muscarinic antagonist.
	
	Atopic Dermatitis:
	• Diagnosed with severe atopic dermatitis defined as having functional impairment as indicated by Dermatology Life Quality Index (DLQI) ≥ 11 or Children's Dermatology Life Quality Index (CDLQI) ≥ 13 (or severe score on another validated tool)
	• One or more of the following:
	  ○ At least 10% of body surface area involvement
	  ○ Hand, foot, or mucous membrane involvement
	• Documented contraindication or failed trial to ALL of the following:
	  ○ Moderate-high potency corticosteroid (e.g., clobetasol, fluocinonide, fluticasone)
	  ○ Topical calcineurin inhibitor (e.g. tacrolimus)
	  ○ Oral immunomodulator therapy (e.g. cyclosporine, methotrexate, azathioprine, mycophenolate mofetil) **OR** the member is oral corticosteroid dependent.
	
	Eosinophilic Esophagitis:
	• Confirmed diagnosis of EoE
	• Weight ≥ 15 kg
	• Two or more episodes of dysphagia per week
	• Inadequate response to an 8-week trial, intolerance, or contraindication to high-dose PPI therapy
	• **I**nadequate response to and 8-to-12-week trial, intolerance, or contraindication to swallowed inhaled respiratory corticosteroid therapy.

Criteria Details

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP):
• Diagnosis of CRSwNP, including objective evidence of the presence of bilateral nasal polyps
• Will not be used in combination with other biologics for eosinophilic indications.
• Trial and failure to adequately reduce symptoms with:
  ○ At least 2 months of saline nasal irrigations and inhaled nasal corticosteroids used at doses appropriate for nasal polyp treatment.
  ○ Systemic corticosteroid treatment for nasal polyps at least once within the last 2 years or prior nasal polyp removal surgery.
• Inhaled nasal corticosteroids will be used concomitantly with dupilumab (unless not tolerated or contraindicated).
 	
Prurigo Nodularis (PN):
• Diagnosis of PN verified by a dermatologist and the patient has had the diagnosis for at least 3 months.
• Severe or very severe itch (WI-NRS score ≥7) reported within the past week.
• At least 20 PN lesions in total on both legs and/or both arms and/or trunk.
• Trial and failure (inadequate efficacy after 4 week trial, intolerable side effects) or contraindication to recommended first line agents for the treatment of PN including:
  ○ High potency topical steroids
  ○ Phototherapy
  ○ At least one systemic agent (immunosuppressant, gabapentinoid, or antidepressant).
 	
Chronic Obstructive Pulmonary Disease (COPD):
• Diagnosis of COPD confirmed by post-bronchodilator FEV1/FVC < 0.7 on spirometry.
• Blood eosinophil count (BEC) ≥300 cells/μL within the past 3 months.
• Chronic bronchitis, defined as a chronic productive cough for ≥ 3 months in the past year, in the absence of other known causes of chronic cough.
• ≥ 2 moderate COPD exacerbation (defined as requiring treatment with either systemic corticosteroids and/or antibiotics) or ≥ 1 severe COPD exacerbation (defined as requiring hospitalization or observation for over 24 hours in emergency department of urgent care) within the past year despite the adherent use of inhaled LABA +

Criteria Details	
	LAMA+ ICS triple therapy [or LABA + LAMA dual therapy if ICS are contraindicated].
Age Restrictions	**Moderate to Severe Asthma:** 6 years and older **Atopic Dermatitis:** 6 months and older **Eosinophilic Esophagitis:** 1 year and older **CRSwNP:** 12 years and older **Prurigo Nodularis:** 18 years and older **COPD:** 18 years and older
Prescriber Restrictions	**Atopic dermatitis**: Prescribed by a Dermatologist **Eosinophilic Esophagitis**: Prescribed by Gastroenterologist or Immunologist **CRSwNP**: Prescribed by ENT or Immunologist **Prurigo Nodularis**: Prescribed by Dermatologist **Asthma/COPD:** Pulmonologist
Coverage Duration	**Initial:** 6 months. **Renewal:** 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	03/01/2025
P&T Approval Date	11/08/2022
P&T Revision Date	01/14/2025

Elagolix (ORLISSA)

Products Affected

- **ORILISSA TAB 150MG**
- **ORILISSA TAB 200MG**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Diagnosis of moderate to severe pain associated with endometriosis **AND** trial and failure, contraindication, or intolerance to a 3-month trial of prescription strength NSAIDs **AND** trial and failure, contraindication, or intolerance to two 3-month trials of hormonal therapies (eg combined oral contraceptives, progestins, or levonorgestrel IUD, etc.). **Additional info required for 200 mg tablet twice daily:** documentation of coexisting dyspareunia
Age Restrictions	At least 18 years old but not yet through menopause
Prescriber Restrictions	Prescribed by obstetrician or gynecologist
Coverage Duration	**200MG dose**: **Initial:** 6 months; **Renewal:** No **Renewal**s allowed **150MG dose: Initial:** 6 months; **Renewal:** 18months
Renewal Criteria	**150MG ONLY** Documentation of positive clinical response to therapy **AND** total therapy durations is less than 24 months.
Effective Date	03/01/2023
P&T Approval Date	01/10/2023
P&T Revision Date	

Elefibranor (IQIRVO)

Products Affected

- **IQIRVO TABLETS**

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Primary biliary cholangitis:**
	• Diagnosis of primary biliary cholangitis (PBC) confirmed by two of the following:
	  ○ Biochemical evidence of cholestasis based on ALP elevation
	  ○ Presence of AMA or other PBC-specific autoantibodies
	  ○ Histology confirmation after biopsy
	• Trial and failure of 12 months of ursodiol.
	• No current decompensated cirrhosis.

Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist or hepatologist.
Coverage Duration	**Initial:** 6 months; **Renewal:** 12 months
Renewal Criteria	Documented positive clinical response to therapy.
Effective Date	11/1/2024
P&T Approval Date	9/10/2024
P&T Revision Date	9/10/2024

Eltrombopag (Promacta)

Products Affected

- **Eltrombopag tablets**

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Immune Thrombocytopenia (ITP):**
	• Diagnosis of one of the following:
	  ○ Persistent ITP
	  ○ Chronic ITP
	  ○ Relapsed/refractory ITP
	• Baseline platelet count is less than 30,000/mcL.
	• One of the following:
	  ○ Patient has had a prior splenectomy
	  ○ Trial and failure of corticosteroids (e.g., prednisone, methylprednisolone) or immunoglobulins
	
	Aplastic Anemia (severe first-line):
	• Diagnosis of refractory severe aplastic anemia
	• One of the following:
	  ○ Used for first-line treatment (i.e., patient has not received prior immunosuppressive therapy with any equine antithymocyte globulin plus cyclosporine, alemtuzumab, or high dose cyclophosphamide)
	  ○ Patient meets at least 2 of the following:
	  ▪ Absolute neutrophil count < 500/mcL
	  ▪ Platelet count < 20,000/mcL
	  ▪ Absolute reticulocyte count < 60,000/mcL
	  ○ Used in combination with standard immunosuppressive therapy (e.g., Atgam [antithymocyte globulin equine] and cyclosporine)
	  •
	
	Aplastic Anemia (severe refractory):
	• Diagnosis of refractory severe aplastic anemia

Criteria Details	

	• Trial and failure, contraindication, or intolerance to immunosuppressive therapy with antithymocyte globulin (ATG) and cyclosporine
	• Patient has thrombocytopenia defined as platelet count less than 30,000/mcL
	
	Chronic Hepatitis C-Associated Thrombocytopenia:
	• Diagnosis of chronic hepatitis C-associated thrombocytopenia
	• One of the following:
	  ○ Planning to initiate and maintain interferon-based treatment
	  ○ Currently receiving interferon-based treatment

Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	**Immune Thrombocytopenia (ITP): Initial:** 12 months; **Renewal:** 12 months **Aplastic Anemia (severe first-line): Initial:** 6 months; **Renewal:** 12 months **Aplastic Anemia (severe refractory): Initial:** 16 weeks; **Renewal:** 12 months **Chronic Hepatitis C-Associated Thrombocytopenia: Initial:** 3 months; **Renewal:** 12 months
Renewal Criteria	Documented positive clinical response to therapy as evidenced by an increase in platelet count.
Effective Date	1/1/2026
P&T Approval Date	11/11/2025
P&T Revision Date	11/11/2025

Elexacaftor-tezacaftor-ivacaftor (TRIKAFTA)

Products Affected

- TRIKAFTA

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Cystic Fibrosis**
	• Presence of at least one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA):
	  ○ F508del mutation
	  ○ A mutation in the CFTR gene that is responsive based on clinical, in vitro, or extrapolated data.
	• Not to be used in combination with other CFTR modulator treatments

Age Restrictions	6 years of age and older
Prescriber Restrictions	Pulmonologist or Specialist affiliated with a CF care center.
Coverage Duration	**Initial**: 6 months **Renewal**: 12 months
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	05/01/2025
P&T Approval Date	03/11/2025
P&T Revision Date	05/01/2021, 09/01/2021, 03/11/2025
References	• Alyftrek [package insert]. Boston, MA: Vertx Pharmaceuticals Inc.; 2025.

Endothelin Receptor Antagonists

Products Affected

- Ambrisentan tablets
- Bosentan Tablets

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**<u>Pulmonary Arterial Hypertension</u>** • Clinically documented diagnosis of Pulmonary Arterial Hypertension (WHO group 1 pulmonary hypertension)
Age Restrictions	• Ambrisentan: 18 years of age and over • Bosentan: 3 years and up
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	**Initial:** 6 months. **Renewal:** 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	9/1/2025
P&T Approval Date	7/13/2021
P&T Revision Date	7/8/2025, 7/13/2021

Erythropoietic Agents

Products Affected

- **PROCRIT**
- **ARANESP**
- **RETACRIT**

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Anemia due to Chronic Kidney Disease (CKD)**:
	• Diagnosis of chronic kidney disease.
	• Verification of adequate iron stores.
	• Verification of anemia with hematocrit less than 30% or hemoglobin less than 10g/dL within 30 days of request **AND**
	  ○ Patient is on dialysis. **OR**
	  ○ Patient is not on dialysis but the rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion **AND** reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal.
	
	Anemia in HIV Patients:
	• Verification of adequate iron stores.
	• Verification of anemia with hematocrit less than 36% or hemoglobin less than 12g/dL within 30 days of request.
	• Serum erythropoietin less than or equal to 500mU/mL.
	• Patient is receiving zidovudine therapy or diagnosed with HIV.
	
	Anemia due to Chemotherapy:
	• Verification that other causes of anemia have been ruled out.
	• Verification of adequate iron stores.
	• Verification of anemia with hematocrit less than 30% or hemoglobin less than 10g/dL within 2 weeks of request.
	• Verification that the cancer is a non-myeloid malignancy.
	• Patient is receiving chemotherapy.
	
	Preoperative for reduction of allogeneic blood transfusion:
	• Patient is scheduled to undergo elective, non-cardiac, non-vascular surgery.
	• Hemoglobin is greater than 10 to less than or equal to 13.

Criteria Details	
	• Patient is at high risk for perioperative transfusions. • Patient is unwilling or unable to donate autologous blood pre-operatively. • Verification of adequate iron stores. **Anemia in Myelodysplastic Syndrome (MDS):** • Diagnosis of MDS. • Serum erythropoietin less than or equal to 500mU/mL **OR** diagnosis of transfusion dependent MDS. Verification of adequate iron stores.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Anemia in HIV or CKD** **Initial:** 6 months. **Renewal:** 12 months. **Anemia due to chemotherapy** **Initial:** 3 months. **Renewal:** 3 months. **Anemia in MDS** **Initial:** 3 months. **Renewal:** 12 months. **Preop Initial:** 1 month.

Renewal Criteria	**Anemia due to CKD:**
	• One of the following:
	  ○ Patient is on dialysis and most recent or average Hct over 3 months is 33% or less (Hgb 11g/dL or less)
	  ○ Patient is not on dialysis and most recent or average Hct over 3 months is 30% or less (Hgb 10g/dL or less)
	  ○ Request is for a pediatric member and most recent or average Hct over 3 months is 36% or less (Hgb 12g/dL or less)
	• Decrease in the need for blood transfusion **OR** Hemoglobin increased greater than or equal to 1d/dL from pre-treatment level
	• Verification of adequate iron stores
	
	Anemia in HIV Patients:
	• Most recent or average Hct over 3 months is 36% or less (Hgb 12g/dL or less).
	• Decrease in the need for blood transfusion **OR** Hemoglobin increased greater than or equal to 1d/dL from pre-treatment level.

Criteria Details	
	Anemia due to chemotherapy: • Most recent or average Hct over 3 months is 30% or less (Hgb 10g/dL or less). • Decrease in the need for blood transfusion **OR** Hemoglobin increased greater than or equal to 1d/dL from pre-treatment level. • Patient is receiving chemotherapy. **Anemia in MDS Patients:** • Most recent or average Hct over 3 months is 36% or less (Hgb 12g/dL or less). Decrease in the need for blood transfusion **OR** Hemoglobin increased greater than or equal to 1.5d/dL from pre-treatment level.
Effective Date	9/1/2024
P&T Approval Date	7/9/2024
P&T Revision Date	7/9/2024

Erenumbab (AIMOVIG)

Products Affected

- **AIMOVIG** 70MG/ML
- **AIMOVIG** 140MG/ML

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Diagnosis of episodic migraines:** Patient has 4 to 14 migraine days per month, but no more than 14 headache days per month **OR** **Diagnosis of chronic migraines**: Patient has greater than or equal to 15 headache days per month, of which at least 8 must be migraine days for at least 3 months **AND** medication overuse headache has been considered and potentially offending medication(s) have been discontinued **AND** **Two of the following:** History of failure or contraindication (after at least a two month trial) or intolerance to Elavil (amitriptyline) or Effexor (venlafaxine) **OR** history of failure or contraindications (after at least a two month trial) or intolerance to Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate) **OR** history of failure or contraindication (after at least a two month trial) or intolerance to one of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol **OR** history of failure or contraindication (after at least a two month trial) or intolerance to Atacand (candesartan) **AND** medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, pain specialist, or headache specialist.
Coverage Duration	**Initial**: 6 months. **Renewal:** 12 months.
Renewal Criteria	Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity **AND** use of acute migraine medications [e.g., nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen), triptans (e.g., eletriptan, rizatriptan,

Criteria Details	
	sumatriptan)] has decreased since the start of CGRP therapy **AND** medication will not be used in combination with another CGRP inhibitor for preventive treatment of migraines. * **AND For Chronic Migraine only:** Patient continues to be monitored for medication overuse headache
Effective Date	12/01/2022
P&T Approval Date	11/08/2022
P&T Revision Date	12/01/2022, 01/11/2022

Etrasimod arginine (VELSIPITY)

Products Affected

- **VELSIPITY TAB**

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Ulcerative Colitis (UC):**
	• Documentation of moderate-to-severe ulcerative colitis
	• The member is transitioning to the requested treatment from a different biologic product previously approved by the plan OR documented failure of at least 1 of the following:
	  ○ Mesalamine, sulfasalazine OR
	  ○ Mercaptopurine, azathioprine, OR
	  ○ Corticosteroids (prednisone, methylprednisolone)
	• Trial and failure of both infliximab and adalimumab

Age Restrictions	Must be at least 18 years of age
Prescriber Restrictions	Prescribed by or in collaboration with a Gastroenterologist
Coverage Duration	**Initial**: 6 months. **Renewal:** 12 months.
Renewal Criteria	Evidence of a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission.
Effective Date	03/01/2024
P&T Approval Date	01/09/2024
P&T Revision Date	

Etanercept (ENBREL)

Products Affected

- **ENBREL**
- **ENBREL SURECLICK**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**ALL:** must have a negative tuberculin test (TB) **AS:** Patient has a documented diagnosis of ankylosing spondylitis. Clinical documentation showing an inadequate response, intolerance, or contraindication to one or more non-steroidal anti-inflammatory drugs NSAIDs (trial at maximum dose for at least 2-3 weeks before considering them as failures) or analgesic agents if NSAIDs do not completely control the pain, or sulfasalazine (if peripheral joint involvement is present). **CD:** Clinical documentation showing an inadequate response, intolerance, or contraindication to budesonide, mesalamine, or corticosteroids, or non-biologic DMARDs (i.e., azathioprine, methotrexate, mercaptopurine. JIA: Clinical documentation showing inadequate response, intolerance, or contraindication to one or more NSAID **AND** one or more non-biologic DMARD (i.e., methotrexate, sulfasalazine). **PP:** Patient has documented diagnosis of moderate to severe plaque psoriasis for at least 6 months with at least one of the following: Incapacitation due to plaque location (e.g., head and neck, palms, soles, or genitalia) **OR** Involvement of at least 10 percent of body surface area (BSA) **OR** Psoriasis Area and Severity Index (PASI) score of 12 or greater, **AND** patient is free of any clinically important active infections **AND** clinical documentation of inadequate or non-candidate to a 3-month minimum trial of at least 1 systemic agent (e.g., immunosuppressive, retinoic acid derivatives, and/or methotrexate, **AND** did not respond or non-candidate to a 3-month minimum trial of phototherapy.
Age Restrictions	

Criteria Details	
Prescriber Restrictions	
Coverage Duration	**Initial:** 12 months. **Renewal:** 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	02/01/2022
P&T Approval Date	01/11/2022
P&T Revision Date	

Fezolinetant (VEOZAH)

Products Affected

- VEOZAH **TAB 45MG**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Vasomotor Symptoms (VMS):** • Diagnosis of moderate-to-severe VMS due to menopause • Documented contraindication, intolerance, or inadequate response to at least 2 hormonal therapies AND Documented contraindication, intolerance, or inadequate response to two nonhormonal therapies (e.g., one SNRI and one SSRI).
Age Restrictions	
Prescriber Restrictions	Gynecologist
Coverage Duration	**Initial**: 3 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of at least 50% reduction in VMS from baseline.
Effective Date	09/01/2023
P&T Approval Date	7/11/2023
P&T Revision Date	

Filgrastim (NEUPOGEN)

Products Affected

- NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Bone marrow/stem cell transplant (BMSCT):** Prescribed for non-myeloid malignancies & undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant **OR** for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis **OR** for peripheral stem cell transplant patients who have received myeloablative chemotherapy. **Acute myeloid leukemia (AML):** Patients diagnosed with AML following induction or consolidation chemotherapy. **Primary prophylaxis of chemotherapy-induced febrile neutropenia (CFN):** Patients receiving chemotherapy associated with greater than 20% incidence of febrile neutropenia **OR** selected chemotherapy regimen associated with 10-20% incidence of febrile neutropenia **AND** one or more risk factors associated with chemotherapy-induced infection, febrile neutropenia, or neutropenia. **Secondary prophylaxis of febrile neutropenia:** Patient has a history of febrile neutropenia with previous chemotherapy **AND** is receiving myelosuppressive chemotherapy associated with neutropenia (ANC less than 500 cells/mm^3). **Neutropenia associated with dose dense chemotherapy (NDDC):** Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer **OR** patient is receiving a dose-dense chemotherapy regimen **AND** the incidence of febrile neutropenia is unknown. **Severe chronic neutropenia (SCN):** Diagnosed with congenital, cyclic, **AND** idiopathic neutropenia with chronic ANC less than or equal to 500 cells/mm^3.

Criteria Details	
	Febrile Neutropenia (FN): Patient receiving myelosuppressive chemotherapy associated with neutropenia (ANC less than or equal to 500 cells/mm^3) **AND** is at high risk for infection-associated complications. **Acute radiation syndrome (ARS):** Patient is/was acutely exposed to myelosuppressive doses of radiation.
Age Restrictions	Prescribed by hematologist or oncologist.
Prescriber Restrictions	**Initial**: 12 months. **Renewal**: 12 months.
Coverage Duration	Documentation of positive clinical response to therapy.
Renewal Criteria	Prescribed by hematologist or oncologist.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Fingolimod (GILENYA)

Products Affected

- **GILENYA**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	**Initial:** 6 months. **Renewal:** 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Flutamide (EULEXIN)

Products Affected

- FLUTAMIDE

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Metastatic prostate cancer:** Diagnosed with locally confined Stage B2 to C **AND** Stage D2 metastatic prostate cancer. Prescribed for combination use with a LHRH agonist **AND** documentation of current liver function.
Age Restrictions	
Prescriber Restrictions	Prescribed by an oncologist.
Coverage Duration	**Initial**: 6 months. **Renewal**: 6 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Fremanezumab-vfrm (AJOVY)

Products Affected

- **AJOVY**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Diagnosis of episodic migraines:** Patient has 4 to 14 migraine days per month, but no more than 14 headache days per month **OR** **Diagnosis of chronic migraines**: Patient has greater than or equal to 15 headache days per month, of which at least 8 must be migraine days for at least 3 months **AND** medication overuse headache has been considered and potentially offending medication(s) have been discontinued **AND** **Two of the following:** History of failure or contraindication (after at least a two month trial) or intolerance to Elavil (amitriptyline) or Effexor (venlafaxine) **OR** history of failure or contraindications (after at least a two month trial) or intolerance to Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate) **OR** history of failure or contraindication (after at least a two month trial) or intolerance to one of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol **OR** history of failure or contraindication (after at least a two month trial) or intolerance to Atacand (candesartan) **AND** medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, pain specialist, or headache specialist.
Coverage Duration	**Initial**: 6 months. **Renewal:** 12 months.
Renewal Criteria	Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity **AND** use of acute migraine medications [e.g., nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen), triptans (e.g., eletriptan, rizatriptan, sumatriptan)] has decreased since the start of CGRP therapy **AND**

Criteria Details	
	medication will not be used in combination with another CGRP inhibitor for preventive treatment of migraines. * **AND For Chronic Migraine only:** Patient continues to be monitored for medication overuse headache
Effective Date	
P&T Approval Date	
P&T Revision Date	

Galcanezumab-gnlm (EMGALITY)

Products Affected

- **Emgality 100mg/mL**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Diagnosis of episodic cluster headache **AND** patient has experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least 3 months **AND** medication will not be used in combination with another CGRP inhibitor.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, pain specialist, or headache specialist.
Coverage Duration	**Initial**: 3 months **Renewal**: 12 months
Renewal Criteria	Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity **AND** Medication will not be used in combination with another CGRP inhibitor.
Effective Date	
P&T Approval Date	
P&T Revision Date	

General Oncology

Products Affected

- Abemaciclib (Verzenio)
- Abiraterone
- Acalabrutinib (Calquence)
- Adagrasib (Krazati)
- Alectinib (Alecensa)
- Alpelisib (Piqray)
- Ascinimib (Scemblix)
- Asparaginase Erwinia (Rylaze)
- Avutometinib/Defactinib (Avmapki/Fazynja Pak)
- Belzutifan (Welireg)
- Bicalutamide
- Binimetinib (Mektovi)
- Bosutinib (Bosulif)
- Brigatinib (Alunbrig)
- Busulfan (Myleran)
- Cabozantinib (Cabometyx)
- Capivasertib (Truqap)
- Capmatinib (Tabrecta)
- Ceritinib (Zykadia)
- Chlorambucil (Leukeran)
- Crizotinib (Xalkori)
- Dabrafenib (Tafinlar)
- Darolutamide (Nubeqa)
- Dasatinib
- Dordaviprone (Modeyso)
- Elacestrant (Orserdu)
- Encorafenib (Braftovi)
- Entrectinib (Rozlytrek)
- Erlotinib
- Estramustine (Emcyt)
- Etoposide
- Everolimus
- Flutamide (Eulexin)
- Fruquintinib (Fruzaqla)
- Futibatinib (Lytgobi)
- Gefitinib
- Ibrutinib (Imbruvica)
- Inavolisib (Itovebi)
- Infigratinib (Truseltiq)
- Ivosidenib (Tibsovo)
- Lazertinib (Lazcluze)
- Lenvatinib (Lenvima)
- Lomustine (Gleostine)
- Lorlatinib (Lobrena)
- Melphalan
- Mesna
- Midostaurin (Rydapt)
- Mitotane
- Mobocertinib (Exkivity)
- Nilotinib (Tasigna)
- Nilutamide (Nilandron)
- Niraparib/Abiraterone (Akeega)
- Nirogacestat (Ogsiveo)
- Olaparib (Lynparza)
- Olutasidenib (Rezlidhia)
- Osimertinib (Tagrisso)
- Pacritinib (Vonjo)
- Palbociclib (Ibrance)
- Pazopanib
- Pemigatinib (Pemazyre)
- Pexidartinib (Turalio)
- Pirtobrutinib (Jaypirca)
- Ponatinib (Iclusig)
- Procarbazine
- Quizartinib (Vanflyta)
- Repotrectinib (Augtyro)
- Relacorilant (Lifyorli)
- Ribociclib (Kisqali)
- Selpercatinib (Retevmo)
- Sonrotoclax (Beqalzi)
- Sorafenib
- Sotorasib (Lumakras)
- Sunitinib

- Talazoparib (Talzenna)
- Taletrectinib (Ibtrozi)
- Temozolomide
- Tepotinib (Tepmetko)
- Thioguanine (Tabloid)
- Tivozanib (Fotivda)
- Topotecan (Hycamtin)
- Toremifene (Fareston)
- Tovorafenib (Ojemda)
- Trametinib (Mekinist)
- Trifluridine/Tipiracil (Lonsurf)
- Tucatinib (Tukysa)
- Umbralisib (Ukoniq)
- Vepdegestrant (Veppanu)
- Vimseltinib (Romvimza)
- Vorasidinib (Voranigo)
- Vorinostat (Zolinza)
- Zanubrutinib (Brukinsa)
- Zidesamtinib (Jideytro)
- Zongertinib (Hernexeos)

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Medication is being used for an FDA approved age **AND** medication is being used for FDA approved indication **OR** Medication is being used according to National Comprehensive Cancer Network (NCCN) guidelines
Age Restrictions	
Prescriber Restrictions	Prescribed by oncologist
Coverage Duration	**Initial:** 3 months. **Renewal:** up to 6 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	11/1/2026
P&T Approval Date	10/01/2022
P&T Revision Date	09/08/2026, 5/12/2026, 11/11/2025, 7/8/2025, 5/13/2025, 3/11/2025, 5/14/2024, 03/01/2024, 01/09/2024, 11/1/2023, 09/01/2023, 7/11/2023, 05/09/2023, 03/14/2023, 01/10/2023, 10/01/2022

Glatiramer (GLATOPA)

Products Affected

- **GLATIRAMER INJ 20MG/ML**
- **GLATIRAMER INJ 40MG/ML**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis
Age Restrictions	
Prescriber Restrictions	Prescribed by Neurologist
Coverage Duration	**Initial:** 12 months. **Renewal:** up to 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy
Effective Date	03/01/2023
P&T Approval Date	01/10/2023
P&T Revision Date	

Glucagon-Like Peptide-1 (GLP1s) Receptor Agonist

Products Affected

- **BYDUREON BCISE**
- **BYETTA 10 MCG PEN**
- **BYETTA 5MCG PEN**
- **MOUNJARO**
- **OZEMPIC**
- **RYBELSUS**
- **TRULICITY**
- **VICTOZA**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	• Patient must have clinically diagnosed Type 2 Diabetes • Patient has had trial of, or contraindication to maximally tolerated dose of metformin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial:** 12 months, **Renewal**: 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	03/01/2024
P&T Approval Date	
P&T Revision Date	

Golimumab (SIMPONI)

Products Affected

- SIMPONI INJ **50/0.5ML**
- SIMPONI INJ **100MG/ML**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Rheumatoid Arthritis (RA):** Diagnosis of moderately to severely active RA AND trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine **AND** patient is receiving concurrent therapy with methotrexate **OR** has a contraindication or intolerance to methotrexate. **Psoriatic Arthritis (PsA):** Diagnosis of active PsA with one of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, active skin and/or nail involvement. **Ankylosing Spondylitis (AS):** Diagnosis of active ankylosing spondylitis **AND** minimum duration of one month trial and failure, contraindication, or intolerance to two NSAIDs (e.g., diclofenac, ibuprofen, indomethacin, meloxicam, naproxen). **Polyarticular Juvenile Idiopathic Arthritis (PJIA):** Diagnosis of moderate to severely active PJIA AND trial and failure, contraindication, or intolerance to one of the following non-biologic disease-modifying antirheumatic drugs (DMARDs): leflunomide, methotrexate. **Ulcerative Colitis (UC):** Diagnosis of moderately to severely active ulcerative colitis with one of the following: 1) Greater than 6 stools per day, 2) frequent blood in the stools, 3) frequent urgency, 4) presence of ulcers, 5) abnormal lab values (e.g. hemoglobin, ESR, CRP), 6) dependent on, or refractory to, corticosteroids. AND trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, aminosalicylate [e.g., mesalamine sulfasalazine, azathioprine, Corticosteroids (e.g., prednisone, methylprednisolone).
Age Restrictions	

Criteria Details	
Prescriber Restrictions	**RA, AS, PJIA:** Prescribed by or in consultation with a rheumatologist **PsA:** Prescribed by or in consultation with one of the following: Dermatologist or Rheumatologist **UC:** Prescribed by or in consultation with a gastroenterologist
Coverage Duration	**RA, PsA, AS, PJIA: Initial:** 6 months; **Renewal:** 12 months **UC: Initial:** 10 weeks; **Renewal**: 12 months
Renewal Criteria	**RA, PJIA:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the total active (swollen and tender) joint count from baseline, or improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline. **PsA:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline, or reduction in the body surface area (BSA) involvement from baseline. **AS:** Documentation of positive clinical response to therapy as evidenced by improvement from baseline for least one of the following: disease activity (e.g., pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (e.g., lumbar spine motion, chest expansion), or total active (swollen and tender) joint count. **UC:** Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, or reversal of high fecal output state.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Grass Pollen Allergen Extract – Timothy Grass (GRASTEK)

Products Affected

- **GRASTEK**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Grass pollen-induced allergic rhinitis.
Age Restrictions	
Prescriber Restrictions	Prescribed by Allergy and Immunology specialist.
Coverage Duration	**Initial**: 3 months. **Renewal**: 3 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Gonadotropin-Releasing Hormone Agonists

Products Affected

- Lupron Depot
- Eligard
- Lupron
- Leuprorelin

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Endometriosis**
	• Diagnosis of endometriosis
	• One of the following:
	  ○ History of inadequate pain control response following a trial of at least 6 months, or history of intolerance or contraindication to one of the following:
	  ▪ Danazol
	  ▪ Combination (estrogen/progestin) oral contraceptive
	  ▪ Progestins
	  ○ Patient has had surgical ablation to prevent recurrence
	
	Uterine Leiomyomata (Fibroids) - For the reduction of the size of fibroids [off-label]
	• For use prior to surgery to reduce the size of fibroids to facilitate a surgical procedure (e.g., myomectomy, hysterectomy)
	
	Uterine Leiomyomata (Fibroids) – Anemia
	• For the treatment of anemia
	• Anemia is caused by uterine leiomyomata (fibroids)
	• Patient has tried and had an inadequate response to at least 1 month of monotherapy with iron
	• Used in combination with iron therapy
	• For use prior to surgery
	
	Central Precocious Puberty (CPP)
	• Diagnosis of central precocious puberty (idiopathic or neurogenic)
	• Early onset of secondary sexual characteristics in one of the following:
	  ○ Females less than 8 years of age
	  ○ Males less than 9 years of age

Criteria Details	

	• Advanced bone age of at least one year compared with chronological age
	• One of the following:
	  ○ Both of the following:
	  ▪ Patient has undergone gonadotropin-releasing hormone agonist (GnRHa) testing
	  ▪ Peak luteinizing hormone (LH) level above pre-pubertal range
	  ○ Patient has a random LH level in the pubertal range
	• One of the following:
	  ○ Patient had one of the following diagnostic evaluations to rule out tumors, when suspected:
	  ▪ Diagnostic imaging of the brain (MRI or CT scan) (in patients with symptoms suggestive of a brain tumor or in those 6 years of age or younger)
	  ▪ Pelvic/testicular/adrenal ultrasound (if steroid levels suggest suspicion)
	  ▪ Adrenal steroids to rule out congenital adrenal hyperplasia (when pubarche precedes thelarche or gonadarche)
	• Patient has no suspected tumors
	
	Prostate Cancer
	• Diagnosis of advanced or metastatic prostate cancer
	• Trial and failure, contraindication, or intolerance to any brand Lupron formulation
	
	Gender Dysphoria/Gender Incongruence (off-label)
	• Using gonadotropin for suppression of puberty
	• Diagnosis of gender dysphoria/gender incongruence

Age Restrictions	
Prescriber Restrictions	**Central Precocious Puberty (CPP): Pediatric endocrinologist**
Coverage Duration	**Endometriosis: Initial**: 6 months; **Renewal:** 6 months **Uterine Leiomyomata (Fibroids): Initial**: 4 months; **Renewal:** 3 months **Uterine Leiomyomata (Fibroids) – Anemia Initial**: 3 months **Central Precocious Puberty (CPP): Initial**: 12 months; **Renewal:** 12 months **Prostate Cancer: Initial**: 12 months; **Renewal:** 12 months **Gender Dysphoria/Gender Incongruence: Initial**: 12 months; **Renewal:** 12 months
Renewal Criteria	**Endometriosis**

Criteria Details	

	• Recurrence of symptoms following a trial of at least 6 months with leuprolide acetate
	• Used in combination with one of the following:
	  ○ Norethindrone 5 mg daily
	  ○ Other "add-back" sex-hormones (e.g., estrogen, medroxyprogesterone)
	  ○ Other bone-sparing agents (e.g., bisphosphonates)
	
	Central Precocious Puberty (CPP)
	• LH levels have been suppressed to pre-pubertal levels
	• Prescribed by or in consultation with a pediatric endocrinologist
	
	Prostate Cancer
	• Diagnosis of advanced or metastatic prostate cancer

Effective Date	8/1/2024
P&T Approval Date	5/13/2024
P&T Revision Date	

Guselkumab (TREMFYA)

Products Affected

- Tremfya Auto-Injector
- Tremfya IV Solution
- Tremfya Prefilled Syringe

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**<u>Plaque Psoriasis</u>**
	• Diagnosis of moderate to severe plaque psoriasis
	• One of the following:
	  ○ Greater than or equal to 3% body surface area involvement
	  ○ Severe scalp psoriasis
	  ○ Palmoplantar (i.e., palms, soles), facial, or genital involvement
	• Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies:
	  ○ Corticosteroids (e.g., betamethasone, clobetasol)
	  ○ Vitamin d analogs (e.g., calcitriol, calcipotriene)
	  ○ Tazarotene
	  ○ Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
	  ○ Anthralin
	  ○ Coal tar
	
	<u>Psoriatic Arthritis</u>
	• Diagnosis of active psoriatic arthritis
	• One of the following:
	  ○ Actively inflamed joints
	  ○ Dactylitis
	  ○ Enthesitis
	  ○ Axial disease
	  ○ Active skin and/or nail involvement
	
	<u>Crohn's Disease</u>
	• Diagnosis of moderately to severely active Crohn's Disease
	• One of the following:
	  ○ Documentation of one of the following:
	  ▪ Frequent Diarrhea and abdominal pain
	  ▪ At least 10% weight loss

Criteria Details	
	▪ Complications such as obstruction, fever, abdominal mass ▪ Abnormal lab values (e.g. C-reactive protein) ▪ CD Activity Index (CDAI) greater than 220 **<u>Ulcerative Colitis</u>** • Diagnosis of moderately to severely active ulcerative colitis • One of the following: ○ Documentation of one of the following: ▪ Greater than 6 stools per day ▪ Frequent blood in the stools ▪ Frequent urgency ▪ Presence of ulcers ▪ Abnormal lab values (e.g., hemoglobin, erythrocyte sedimentation rate, C-reactive protein) ▪ Dependent on, or refractory to, corticosteroids
Age Restrictions	
Prescriber Restrictions	• **Plaque Psoriasis:** Dermatologist • **Psoriatic Arthritis:** Dermatologist Rheumatologist • **Crohn's Disease and Ulcerative Colitis:** Gastroenterologist
Coverage Duration	• **Plaque Psoriasis and Psoriatic Arthritis:** ○ Initial: 6 months ○ Renewal: 12 months • **Crohn's Disease and Ulcerative Colitis:** ○ Initial IV: 3 months ○ Initial SC: 6 months ○ Renewal SC: 12 months
Renewal Criteria	• **Plaque Psoriasis** – Documentation of positive clinical response to therapy as evidenced by one of the following: ○ Reduction the body surface area (BSA) involvement from baseline ○ Improvement in symptoms (e.g., pruritus, inflammation) from baseline • **Psoriatic Arthritis** – Documentation of positive clinical response to therapy as evidenced by one of the following: ○ Reduction in the total active (swollen and tender) joint count from baseline

Criteria Details	
	○ Improvement in symptoms (e.g., pain, stiffness, pruritus, inflammation) from baseline ○ Reduction in the body surface area (BSA) involvement from baseline • **Crohn's Disease, Ulcerative Colitis** – Documentation of positive clinical response to therapy as evidenced by at least one of the following: ○ Improvement in intestinal inflammation (e.g. mucosal healing, improvement in lab values) from baseline ○ Reversal of high fecal output state
Effective Date	9/1/2025
P&T Approval Date	10/28/2022
P&T Revision Date	7/8/2025, 5/8/2023, 10/28/2022

Imiquimod (ZYCLARA)

Products Affected

- IMIQUIMOD CREAM 3.75% EXTERNAL

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Actinic keratosis:** Diagnosed with clinically typical (nonhyperkeratotic, nonhypertrophic, visible or palpable) actinic keratosis on the face or scalp **AND** the patient is immunocompetent. Ge**nital and perianal warts:** Diagnosed with external genital **AND** perianal warts (condyloma acuminata).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 6 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Inclisiran (LEQVIO)

Products Affected

- **LEQVIO SOLUTION**

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Established clinical ASCVD:**
	• Documentation of very high risk ASCVD as evidenced by either:
	  ○ History of multiple major ASCVD events **OR**
	  ○ One major ASCVD event AND multiple high-risk conditions.
	• Documentation of a current LDL greater than or equal to 55 mg/dl.
	• Documentation that:
	  ○ Patient is receiving maximally tolerated statin therapy (atorvastatin 40-80mg, rosuvastatin 20-40mg) or has a documented clinical intolerance to statins **AND**
	  ○ Is receiving ezetimibe or has a documented intolerance to ezetimibe.
	• Documentation of failure of PCSK9 inhibitor (Repatha or Praluent).
	
	Primary or familial hyperlipidemia:
	• Documentation of an untreated (i.e., prior to lipid lowering therapy) LDL greater than 190 mg/dL.
	• Documentation of current LDL greater than 100 mg/dL.
	• Documentation that:
	  ○ Patient is receiving maximally tolerated statin therapy (atorvastatin 40-80mg, rosuvastatin 20-40mg) or has a documented clinical intolerance to statins **AND**
	  ○ Is receiving ezetimibe or has a documented intolerance to ezetimibe.
	• Documentation of failure of PCSK9 inhibitor (Repatha or Praluent).

Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.

Criteria Details	
Coverage Duration	**Initial:** 6 months; **Renewal:** 12 months
Renewal Criteria	Documented positive clinical response to therapy (significant decrease in lipid levels).
Effective Date	11/1/2024
P&T Approval Date	9/10/2024
P&T Revision Date	9/10/2024

Insulin Degludec (TRESIBA)

Products Affected

- **TRESIBA FLEXTOUCH U-100 & U-200**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**U-100 & *U-200:** Must have tried and failed formulary long-acting insulin analogues **OR** have documented intolerance or contraindication to formulary long-acting insulin analogues **AND** have significant barriers to sardized administration requiring flexibility in dose timing. ***(U-200)** Patient must require greater than 160 units of insulin per dose **AND** have difficulty with multiple daily injections.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial:** 12 months. **Renewal:** 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	5/1/2024
P&T Approval Date	3/12/2024
P&T Revision Date	3/12/2024

Interferon Alfa-2b (INTRON A)

Products Affected

- **INTRON A**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Chronic hepatitis B:** Diagnosed with chronic hepatitis B infection **AND** patient is without decompensated liver disease. **Chronic hepatitis C:** Diagnosed with chronic hepatitis C infection **AND** patient is without decompensated liver disease **AND** patient has not previously been treated with interferon **AND** is prescribed for use with ribavirin **OR** patient has intolerance or contraindication to ribavirin. **Metastatic renal cell carcinoma (RCC):** Diagnosed with metastatic RCC **AND** prescribed in combination with Avastin (bevacizumab). **AIDS-related Kaposi sarcoma (KS):** Diagnosed with AIDS-related KS. **Condylomata acuminata (CA)**: Diagnosed with CA involving external surfaces of the genital & perianal areas. **Follicular lymphoma (FL):** Diagnosed with clinically aggressive follicular non-Hodgkin lymphoma. Prescribed in conjunction with anthracycline-containing combination chemotherapy. **Hairy cell leukemia (HCL)**: Diagnosed with HCL. Melanoma: Diagnosed with malignant melanoma. Prescribed as adjuvant to surgical treatment who are free of disease but at high risk for systemic recurrence **AND** must be administered within 56 days of surgery.
Age Restrictions	Patient must be 18 years or older.
Prescriber Restrictions	Prescribed by a specialist.
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.

Criteria Details	
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Interferon beta-1a (AVONEX)

Products Affected

- AVONEX PEN
- AVONEX PREFILLED
- AVONEX PREFILLED

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Diagnosis of a relapsing form of Multiple Sclerosis **AND** trial and failure, contraindication, or intolerance to all of the following: dimethyl furmate, fingolimod, glatiramer acetate/glatopa.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	**Initial:** 12 months. **Renewal:** 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	03/01/2023
P&T Approval Date	01/10/2023
P&T Revision Date	

Interferon beta-1a (REBIF)

Products Affected

- REBIF **INJ 22/0.5ML**
- REBIF **INJ 44/0.5 ML**
- REBIF REBIDO **INJ 22/0.5ML**
- REBIF REBIDO **INJ 44/0.5ML**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis **AND** trial and failure, contraindication, or intolerance to all of the following: dimethyl furmate, fingolimod, glatiramer acetate/glatopa, avonex.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	**Initial:** 12 months. **Renewal:** 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	03/01/2023
P&T Approval Date	01/10/2023
P&T Revision Date	

Interferon beta-1b (EXTAVIA)

Products Affected

- EXTAVIA **INJ 0.3MG**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis **AND** trial and failure, contraindication, or intolerance to all of the following: dimethyl furmate, fingolimod, glatiramer acetate/glatopa.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	**Initial:** 12 months. **Renewal:** 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	03/01/2023
P&T Approval Date	01/10/2023
P&T Revision Date	

Interferon Gamma-1b (ACTIMMUNE)

Products Affected

- ACTIMMUNE

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Chronic granulomatous disease:** Diagnosed with chronic granulomatous disease with need to reduce the frequency **AND** severity of serious infections. Patient is on an antibacterial/antifungal prophylaxis regime **AND** documentation of the patient's body surface area (BSA) & prescribed dose. **Malignant osteopetrosis:** Diagnosed with severe malignant osteopetrosis, documentation of the patient's body surface area (BSA) & prescribed dose.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Ivacaftor (KALYDECO)

Products Affected

- KALYDECO

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Diagnosis of Cystic Fibrosis with documentation showing at least one CFTR gene mutation that has shown to be responsive to Kalydeco
Age Restrictions	6 months of age and older
Prescriber Restrictions	Prescribed by pulmonologist
Coverage Duration	**Initial**: 3 months **Renewal**: 6 months
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Ivermectin (STROMECTOL)

Products Affected

- **IVERMECTIN**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Treatment of FDA approved diagnosis including Strongyloidiasis, Onchocerciasis, Infestation by Phthirus pubis, Scabies, Enterobiasis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial:** 6 months, **Renewal**s: reinfection 6 months
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Ixekizumab (TALTZ)

Products Affected

- TALTZ

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Plaque Psoriasis (PsO):** Diagnosis of moderate to severe chronic plaque psoriasis with one of the following: 1) greater than or equal to 3% body surface area involvement, 2) severe scalp psoriasis, 3) palmoplantar, facial, or genital involvement **AND** a minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids, vitamin D analogs, tazarotene, calcineurin inhibitors, anthralin, coal tar **AND** trial and failure, contraindication, or intolerance to ONE of the following: Cimzia, Humira, Skyrizi, Ustekinumab, or Tremya. **Psoriatic Arthritis (PsA):** Diagnosis of active psoriatic arthritis with one of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, active skin and/or nail involvement **AND** trial and failure, contraindication, or intolerance to ONE of the following: Cimzia, Enbrel, Humira, Simponi, Ustekinumab, Tremfya, Skyrizi, Rinvoq, or Xeljanz **Ankylosing Spondylitis (AS):** Diagnosis of active ankylosing spondylitis **AND** minimum duration of one month trial and failure, contraindication, or intolerance to **TWO** non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., diclofenac, ibuprofen, indomethacin, meloxicam, naproxen) **AND** trial and failure, contraindication, or intolerance to ONE of the following: Cimzia, Enbrel, Humira, Simponi, Rinvoq, Xeljanz. **Non-radiographic Axial Spondyloarthritis (nr-axSpA):** Diagnosis of active non-radiographic axial spondyloarthritis **AND** patient has objective signs of inflammation (e.g., C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints.) **AND** minimum duration of one month trial and failure, contraindication, or intolerance to **TWO** non-steroidal anti-inflammatory drugs (NSAIDs) (e.g.,

Criteria Details	
	diclofenac, ibuprofen, meloxicam, naproxen) **AND** trial and failure, contraindication, or intolerance to Cimzia.
Age Restrictions	
Prescriber Restrictions	**Plaque Psoriasis (PP):** Prescribed by or in consultation with a dermatologist **Psoriatic Arthritis (PsA):** Prescribed by or in consultation with a dermatologist or rheumatologist **Ankylosing Spondylitis (AS):** Prescribed by or in consultation with a rheumatologist **Non-radiographic Axial Spondyloarthritis:** Prescribed by or in consultation with a rheumatologist
Coverage Duration	**Initial**: 12 months; **Renewal:** 12 months
Renewal Criteria	**PsO:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, or improvement in symptoms (e.g., pruritus, inflammation) from baseline. **PsA:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline, or reduction in the body surface area (BSA) involvement from baseline. **AS, nr-axSpA:** Documentation of positive clinical response to therapy as evidenced by improvement from baseline for least one of the following: disease activity (e.g., pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (e.g., lumbar spine motion, chest expansion), or total active (swollen and tender) joint count.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Lacosamide (VIMPAT)

Products Affected

- Lacosamide **TAB 50MG, 100MG, 150MG, 200MG**
- Lacosamide **Solution 10MG/ML**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Focal Seizures** • Documentation confirming epilepsy or seizure disorder • **Solution only:** Member under age 10 or unable to use tablets **Primary Generalized Tonic-Clonic Seizures** • Documentation confirming epilepsy or seizure disorder • **Solution only:** Member under age 10 or unable to use tablets
Age Restrictions	**Solution only** One of the following: • Pediatric member age 10 or under • Documentation inability of the member to use the preferred tablet formulation
Prescriber Restrictions	Neurologist
Coverage Duration	**Initial**: 12 months. **Renewal**: Lifetime.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	5/1/2025
P&T Approval Date	7/11/2023
P&T Revision Date	3/11/2025, 3/12/2024, 7/11/2023

Lanthanum Carbonate (FOSRENOL)

Products Affected

- Lanthanum carbonate 500MG
- Lanthanum carbonate 750MG
- Lanthanum carbonate 1000MG

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Diagnosis of hyperphosphatemia in chronic kidney disease **AND** trial and failure, contraindication, or intolerance (at least 6 weeks) to both maximally tolerated calcium acetate and sevelamer carbonate
Age Restrictions	6 years or older
Prescriber Restrictions	Nephrologist
Coverage Duration	**Initial**: 6 months **Renewal**: 12 months
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	07/01/2023
P&T Approval Date	05/09/2023
P&T Revision Date	

Lasmiditan (REYVOW)

Products Affected

- **REYVOW 100MG TAB**
- **REYVOW 50MG TAB**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Medication intended for use for acute use for the treatment of migraine headaches **AND** documentation patient is on preventative therapy **AND** trial and failure (defined as trial period of 6 weeks per agent) or contraindication to at least 3 generic oral formulary triptans use at up to the maximally indicated dosing and in combination with NSAID therapy (naproxen) **OR** trial and failure to intolerance to NSAID treatment alone if triptans contraindicated **OR** contraindication to all triptans and NSAIDs
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Prescribed by neurologist or headache specialist
Coverage Duration	**Initial**: 3 months **Renewal**: 6 months
Renewal Criteria	Documented positive clinical response to therapy
Effective Date	07/01/2023
P&T Approval Date	05/09/2023
P&T Revision Date	

Lebrikizumab (EBGLYSS)

Products Affected

- **Ebglyss autoinjector**
- **Ebglyss prefilled syringe**

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Atopic dermatitis:**
	• Diagnosed with severe atopic dermatitis defined as having functional impairment as indicated by Dermatology Life Quality Index (DLQI) ≥ 11 or Children's Dermatology Life Quality Index (CDLQI) ≥ 13 (or severe score on another validated tool)
	• One or more of the following:
	  ○ At least 10% of body surface area involvement
	  ○ Hand, foot, or mucous membrane involvement
	• Documented contraindication or failed trial to ALL of the following:
	  ○ Moderate-high potency corticosteroid (e.g., clobetasol, fluocinonide, fluticasone)
	  ○ Topical calcineurin inhibitor (e.g. tacrolimus)
	  ○ Oral immunomodulator therapy (e.g. cyclosporine, methotrexate, azathioprine, mycophenolate mofetil) **OR** the member is oral corticosteroid dependent.

Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist.
Coverage Duration	**Initial**: 6 months **Renewal**: 12 months
Renewal Criteria	Documentation of positive clinical response to therapy
Effective Date	1/1/2025
P&T Approval Date	11/12/2024
P&T Revision Date	11/12/2024

Lenacapavir (Sunlenca)

Products Affected

- Sunlenca Therapy Pack
- Sunlenca Subcutaneous

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**<u>Multi-Drug-Resistant HIV</u>** • Diagnosis of MDR HIV-1 infection with resistance to at least two drugs in each of at least three of the following classes: NRTIs, NNRTIs, PIs, and INSTIs • Will be used in combination with an optimized baseline regimen (OBR) • Current ARV regimen has been stable for at least 2 months • HIV-1 RNA is ≥400 copies/mL
Prescriber Restrictions	HIV Specialist
Coverage Duration	**Initial**: 6 months. **Renewal**: 12 months.
Renewal Criteria	• Continues to be used in combination with an optimized background regimen (OBR) • Provider states that patient continues to receive clinical benefit from the treatment
Effective Date	4/1/2023
P&T Approval Date	3/14/2023
P&T Revision Date	3/14/2023

Lenacapavir (Yeztugo)

Products Affected

- Yeztugo inj.
- Yeztugo Tablets

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**<u>Pre-Exposure Prophylaxis (PrEP)</u>**
	• Confirmation the drug is being used for PrEP (a different product is used for treatment)
	• Submission of medical records documenting both of the following U.S. Food and Drug (FDA)-approved tests prior to use of Yeztugo:
	  ○ Negative HIV-1 antigen/antibody test
	  ○ Negative HIV-1 RNA assay
	• Trial and failure, contraindication, or intolerance to generic emtricitabine-tenofovir disoproxil fumarate 200/300mg.

Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.

Renewal Criteria	• Provider attests that patient is adherent to the testing appointments and scheduled injections of Yeztugo
	• Submission of medical records documenting both of the following U.S. Food and Drug (FDA)-approved tests prior to use of Yeztugo:
	  ○ Negative HIV-1 antigen/antibody test
	  ○ Negative HIV-1 RNA assay

Effective Date	11/1/2025
P&T Approval Date	9/9/2025
P&T Revision Date	9/9/2025

Lidocaine Topical Anesthetic (LIDODERM)

Products Affected

- LIDOCAINE **EXTERNAL PATCH 5%**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Diagnosis of post-herpetic neuralgia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 3 months. **Renewal**: 3 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Lifitegrast (XIIDRA)

Products Affected

- XIIDRA

Prior Authorization Criteria

Criteria Details	
Required Medical Information	The patient has a diagnosis of lack of tear production due to ocular inflammation associated with keratoconjunctivitis sicca **AND ONE** of the following: • The patient is not currently using a topical ophthalmic anti-inflammatory drug or punctal plug **OR** • The patients current use of topical ophthalmic anti-inflammatory drug or punctal plug will be discontinued before starting the requested agent **AND** The patient has previously tried or is currently using aqueous enhancements (e.g. artificial tears, gels, ointments) **OR** • The patient has a documented intolerance, contraindication, or hypersensitivity to aqueous enhancements. The patient is not currently using Restasis **OR** the patients current use of Restasis will be discontinued before starting Xiidra.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 12 months **Renewal:** 12 months
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Linezolid (ZYVOX)

Products Affected

- LINEZOLID
- LINEZOLID IN SODIUM CHLORIDE

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Clinically documented infection that is susceptible to linezolid if the patient has a severe allergy to beta lactamase inhibitors or any antibiotic that the organism is susceptible **OR** clinically documented infection that is susceptible to linezolid if the patient has failed treatment with antibiotics that the organism is susceptible **OR** clinically documented Vancomycin-Resistant Enterococcus faecium infection **OR** clinically documented MRSA **AND** has failed or is intolerant to Vancomycin if the organism is susceptible to Vancomycin.
Age Restrictions	**Solution only** One of the following: • Pediatric member age 10 or under • Documentation inability of the member to use the preferred tablet formulation
Prescriber Restrictions	Prescribed by or in consultation with an Infectious Disease specialist.
Coverage Duration	**Initial**: length of treatment. **Renewal**: length of treatment.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	5/1/2024
P&T Approval Date	3/12/2024
P&T Revision Date	3/12/2024

Lisdexamfetamine (VYVANSE)

Products Affected

- Lisdexamfetamine

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**ADHD:** Prior trial (30-day trial) of an extended-release amphetamine product (amphetamine salts ER, dextroamphetamine ER, etc.) and an extended-release methylphenidate product (dexmethylphenidate ER, methylphenidate ER). **BED:** Clinical documentation confirming binge eating disorder diagnosis per DSM-5 criteria **AND** trial and failure of at least two therapeutic alternatives including SSRIs, topiramate, and/or methylphenidate.
Age Restrictions	**BED:** 18 years of age or older
Prescriber Restrictions	
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	03/01/2025
P&T Approval Date	01/14/2025
P&T Revision Date	01/14/2025

Long Acting Opiates AND Dolophine

Products Affected

- FENTANYL PATCH 72 HOUR 100 MCG/HR TRANSDERMAL
- FENTANYL PATCH 72 HOUR 12 MCG/HR TRANSDERMAL
- FENTANYL PATCH 72 HOUR 25 MCG/HR TRANSDERMAL
- FENTANYL PATCH 72 HOUR 37.5 MCG/HR TRANSDERMAL
- FENTANYL PATCH 72 HOUR 50 MCG/HR TRANSDERMAL
- FENTANYL PATCH 72 HOUR 62.5 MCG/HR TRANSDERMAL
- FENTANYL PATCH 72 HOUR 75 MCG/HR TRANSDERMAL
- FENTANYL PATCH 72 HOUR 87.5 MCG/HR TRANSDERMAL
- HYDROCODONE BITARTRATE ER
- HYDROMORPHONE HCL ER
- METHADONE HCL
- MORPHINE SULFATE ER BEADS CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL
- MORPHINE SULFATE ER BEADS CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL
- MORPHINE SULFATE ER BEADS CAPSULE EXTENDED RELEASE 24 HOUR 45 MG ORAL
- MORPHINE SULFATE ER BEADS CAPSULE EXTENDED RELEASE 24 HOUR 60 MG ORAL
- MORPHINE SULFATE ER BEADS CAPSULE EXTENDED RELEASE 24 HOUR 75 MG ORAL
- MORPHINE SULFATE ER BEADS CAPSULE EXTENDED RELEASE 24 HOUR 90 MG ORAL
- MORPHINE SULFATE ER ORAL CAPSULE EXTENDED RELEASE 24 HOUR
- MORPHINE SULFATE ER ORAL TABLET EXTENDED RELEASE
- **NUCYNTA ER**
- OXYCODONE HCL ER
- **OXYCONTIN**
- OXYMORPHONE HCL ER

XTAMPZA ER

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Cancer, end of life, or palliative care:** No coverage restrictions. **Non-cancer/end of life care:** Documented use of current and/or recent usage of short-acting opioids for at least 15 days prior to long-acting opioids. • **For opioid naive (14 or fewer days filled in previous 120 days):** 7-day maximum quantity limit, equal to or less than 50 MED [morphine equivalents per day].

Criteria Details	
	• **For opioid experienced (greater than or equal to 15 days filled in previous 120 days):** equal to or less than 90 MED [morphine equivalents per day]. Restricted to 2 fills in a 60-day period for both naive **AND** experienced.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Lotilaner (XDEMVY)

Products Affected

- Xdemvy 0.25% Ophthalmic solution

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Diagnosis:** Demodex Blepharitis • Documentation of at least mild erythema of the upper eyelid margin • Presence of mites upon examination of eyelashes by light microscopy or presence of collarettes on slit lamp examination
Age Restrictions	18 years of age or older
Prescriber Restrictions	Optometrist or Ophthalmologist
Coverage Duration	**Initial**: 6 weeks. **Renewal**: No renewals allowed
Renewal Criteria	
Effective Date	5/1/2024
P&T Approval Date	3/12/2024
P&T Revision Date	3/12/2024

Lumacaftor/ivacaftor (ORKAMBI)

Products Affected

- ORKAMBI ORAL PACKET
- ORKAMBI ORAL TABLET
- ORKAMBI ORAL TABLET

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Clinical documentation of cystic fibrosis diagnosis with homozygous F508del mutation.
Age Restrictions	2 years of age and older
Prescriber Restrictions	Prescribed by pulmonologist
Coverage Duration	**Initial**: 3 months **Renewal**: 6 months
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Methylphenidate solution/chewable

Products Affected

- METHYLPHENIDATE HCL ORAL SOLUTION
- METHYLPHENIDATE HCL ORAL TABLET CHEWABLE

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Documentation that the patient has difficulty swallowing pills and/or has tried and failed methylphenidate tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Mirabegron (Myrbetriq)

Products Affected

- Mirabegron ER tablets

Covered Uses	• All Food and Drug Administration (FDA)-approved indications not otherwise excluded by plan design
	  ○ Overactive Bladder with symptoms of urge urinary incontinence, urgency, and urinary frequency
	  ○ Neurogenic detrusor overactivity in pediatric members

Required Medical Information and Criteria	**<u>Overactive Bladder with symptoms of urge urinary incontinence, urgency, and urinary frequency</u>**
	• Documented trial and failure, intolerance, or contraindication to at least 3 of the following:
	  ○ Oxybutynin IR or ER
	  ○ Fesoterodine
	  ○ Solifenacin
	  ○ Tolterodine IR or ER
	  ○ Trospium IR or ER (requires step therapy through oxybutynin)
	
	<u>Neurogenic Detrusor Overactivity in pediatric members</u>
	• Is there documented trial and failure, intolerance, or contraindication to both of the following:
	  ○ Oxybutynin IR or ER
	  ○ Solifenacin

Renewal Criteria	• Documentation of positive clinical response to therapy
Age Restriction	• 3 years of age and older
Prescriber Restriction	• N/A
Coverage Duration	• **All Diagnoses:**

	○ Initial: 12 months ○ Renewal: 12 months

Effective Date:	7/1/2025
P&T Approval Date:	5/13/2025
P&T Revision Date:	5/13/2025

References

- Cameron AP, Chung DE, Dielubanza EJ, et al. The AUA/SUFU guideline on the diagnosis and treatment of idiopathic overactive bladder. J Urol. Published online April 23, 2024.
- Myrbetriq [package insert]. Northbrook, IL: Astellas.; 2021.

Mirikizumab-mrkz (OMVOH)

Products Affected

- Omvoh

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**All diagnoses**: • Initial testing for latent TB and treatment, if necessary, before starting treatment. • No current active infection at initiation of therapy. • Risks and benefits documented in cases of chronic or recurrent infection. • Will NOT be used in combination with another biologic or Otezla **Ulcerative Colitis (UC):** • Documentation of moderate-to-severe ulcerative colitis • The member is transitioning to the requested treatment from a different biologic product previously approved by the plan OR documented failure of at least 1 of the following: • Mesalamine, sulfasalazine OR • Mercaptopurine, azathioprine, OR • Corticosteroids (prednisone, methylprednisolone) • Trial and failure of both infliximab and adalimumab
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultations with a Gastroenterologist.
Coverage Duration	**Initial**: 6 months. **Renewal**: 12 months.
Renewal Criteria	Evidence of a significant response such as a decrease in bloody stools per day or elimination of signs of toxicity.
Effective Date	7/1/2024
P&T Approval Date	5/14/2024

Criteria Details	
P&T Revision Date	

Mitapivat (PYRUKYND)

Products Affected

- PYRUKYND

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Diagnosis of PKD with at least two mutations within the PKLR gene, including a missense mutation **AND** confirmation of current hemoglobin is ≤ 10mg/dL **AND** patient is not homozygous for the R479H mutation **AND** does not have two non-missense variants in the PKLR gene, without the presence of another missense variant **AND** patient has had at least 6 RBC transfusions within the previous year for hemolytic anemia due to PKD **AND** prescriber confirmed concomitant use of daily folic acid **AND** confirmation that the patient does not have moderate or severe hepatic dysfunction.
Age Restrictions	At least 18 years of age
Prescriber Restrictions	Prescribed by or in consultations with a hematologist
Coverage Duration	**Initial**: 3 months. **Renewal**: 6 months.
Renewal Criteria	Clinical documentation showing an increase in Hb at least 1.5 mg/dL over baseline and/or a reduction in frequency of transfusions.
Effective Date	08/01/2022
P&T Approval Date	07/12/2022
P&T Revision Date	

Mobocertinib (EXKIVITY)

Products Affected

- Exkivity

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Treatment supported for the diagnosis in NCCN guidelines **AND** treatment being used according to FDA indication **AND** prior trial and failure of contraindication to Rybrevant (amivantamab).
Age Restrictions	18 and older
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	**Initial:** 6 months. **Renewal:** 12 months.
Renewal Criteria	Clinical documentation showing continued adherence and toleration with lack of disease progression
Effective Date	02/01/2022
P&T Approval Date	01/11/2022
P&T Revision Date	

Naltrexone (VIVITROL)

Products Affected

- VIVITROL INJ.

Prior Authorization Criteria

Criteria Details	
Required Medical Information	The medication will be sent directly to the administering provider and will not be dispensed directly to the member
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 12 months **Renewal**: 12 months
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	5/1/2024
P&T Approval Date	3/12/2024
P&T Revision Date	3/12/2024

Omalizumab (XOLAIR)

Products Affected

- XOLAIR AUTO-INJECTOR
- XOLAIR PREFILLED SYRINGE

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Severe Asthma:**
	• Confirmed diagnosis of moderate to severe persistent asthma.
	• Positive skin test or RAST to a perennial aeroallergen.
	• Baseline IgE serum level within FDA label.
	• Documentation of steps taken to avoid, within reason, environmental allergens and other triggers environmental allergens and other triggers.
	• Documented trial and failure, with claims history of adherence to**:**
	  ○ High dose inhaled corticosteroid with a long-acting beta agonist (e.g., Advair),
	  ○ Long acting anti-muscarinic (e.g., Spiriva)**,**
	  ○ Leukotriene Inhibitor (e.g., Singulair).
	• Documented trial and failure of, or contraindication to allergen immunotherapy.
	
	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP):
	• Confirmed diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP).
	• Documentation of recurrent nasal polyps after prior sinus surgery.
	• Documented risk of another sinus surgery, or a statement why sinus surgery is not medically appropriate.
	• Documented trial and failure, with claims history of adherence to**:**
	  ○ At least 2 intranasal corticosteroids (e.g., fluticasone, mometasone),
	  ○ Sinuva.
	• Documentation that Xolair is intended as adjunct therapy with nasal corticosteroids.
	
	Chronic Idiopathic Urticaria- refractory (CIU):
	• Documentation of chronic spontaneous or idiopathic urticaria**.**

Criteria Details	

	• Documented trial and failure of at least 6 weeks of maximally tolerated doses of all the following:
	  ○ 1st generation antihistamine – (e.g., doxepin, hydroxyzine)
	  ○ 2nd generation antihistamine – (e.g., cetirizine, levocetirizine, fexofenadine, loratadine, desloratadine)
	  ○ Histamine Type-2 Receptor Antagonists (e.g., famotidine, cimetidine)
	  ○ Leukotriene inhibitor (e.g., montelukast, zafirlukast)
	
	IgE-Mediated Food Allergy:
	• Diagnosis of IgE Mediated Food Allergy as evidenced by one of the following:
	  ○ Positive skin prick test (defined as greater than or equal to 4 mm wheal greater than saline control) to food,
	  ○ Positive food specific IgE (greater than or equal to 6 kUA/L),
	  ○ Positive oral food challenge, defined as experiencing dose-limiting symptoms at a single dose of less than or equal to 300 mg of food protein.
	• Clinical history of IgE mediated food allergy.
	• Used in conjunction with food allergen avoidance.
	• Both of the following:
	  ○ Baseline (pre-Xolair treatment) serum total IgE level is greater than or equal to 30 IU/mL and less than or equal to 1850 IU/mL,
	  ○ Dosing is according to serum total IgE levels and body weight.
	• Xolair will not be used concomitantly with Palforzia.
	• Attestation that the member is co-prescribed epinephrine or has epinephrine at home.

Age Restrictions	**Asthma:** 6 years of age and older **CIU:** 12 years of age and older **CRSwNP:** 18 years of age and older **IgE Mediated Food Allergy:** 1 year of age and older
Prescriber Restrictions	**Asthma:** Prescribed by or in consultation with a pulmonologist or immunologist. **CIU:** Prescribed by or in consultation with an immunologist. **CRSwNP**: Prescribed by or in consultation with an allergist or ENT. **IgE Mediated Food Allergy:** Prescribed by or in consultation with an allergist or immunologist.
Coverage Duration	**Asthma - Initial:** 6 months. **Renewal**: 12 months. **CRSwNP - Initial:** 6 months. **Renewal**: 12 months. **CIU - Initial**: 4 months. **Renewal**: 6 months. **IgE Mediated Food Allergy - Initial:** 6 months. **Renewal**: 12 months.

Criteria Details	
Renewal Criteria	**IgE Mediated Food Allergy:** • Patient demonstrates positive clinical response to therapy (e.g., reduction of type 1 allergic reactions, including anaphylaxis, following accidental exposure to one or more foods). • Used in conjunction with food allergen avoidance. • Dosing will continue to be based on body weight and pretreatment IgE serum levels. **All Other Diagnoses:** Documentation of clinically significant improvement in symptoms.
Effective Date	9/1/2024
P&T Approval Date	7/9/2024
P&T Revision Date	7/9/2024

Paliperidone (INVEGA HAFYERA)

Products Affected

- **INVEGA HAFYERA**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Clinical documentation of a diagnosis of schizophrenia **AND** trial and failure (defined by at least 6 months of treatment) of Invega Trinza **OR** Invega Sustenna **AND** clinical need or concern for adherence which could be improved upon with twice yearly dosing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Pancrelipase (CREON) (PANCREAZE)

Products Affected

- PANCREAZE
- CREON

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Confirmed diagnosis of cystic fibrosis **OR** history of pancreatectomy **OR** diagnosis of exocrine pancreatic cancer **OR** diagnosis of chronic pancreatitis confirmed by imaging **OR** confirmed diagnosis of pancreatic insufficiency confirmed with one of the following methods: • Steatorrhea with fecal fat determination **OR** • Measurement of fecal elastase **OR** Secretin or CCK pancreatic function testing **OR** Two of the following CFTR mutations (G542X, W1282X, R553X, 621+1G>T, 1717-1G>A, 3120+1G>A , R1162X, 3659delC, 1898+1G>A, 2184delA, 711+1G>T, F508del, I507del, G551D, N1303K, R560T).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months
Renewal Criteria	Documentation of positive clinical response to therapy
Effective Date	
P&T Approval Date	
P&T Revision Date	

PCSK9 inhibitors

Products Affected

- Praluent
- Repatha

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Established clinical atherosclerotic cardiovascular disease (ASCVD):**
	• Confirmed diagnosis of atherosclerotic cardiovascular disease (ASCVD).
	• Documentation of a current LDL greater than or equal to 55 mg/dl.
	• Documentation that:
	  ○ Patient is receiving maximally tolerated statin therapy (atorvastatin 40-80mg, rosuvastatin 20-40mg) or has a documented clinical intolerance to statins **AND**
	  ○ Is receiving ezetimibe or has a documented intolerance to ezetimibe.
	
	Primary or familial hyperlipidemia:
	• Documentation of an untreated (i.e., prior to lipid lowering therapy) LDL greater than 190 mg/dL.
	• Documentation of current LDL greater than 100 mg/dL.
	• Documentation that:
	  ○ Patient is receiving maximally tolerated statin therapy (atorvastatin 40-80mg, rosuvastatin 20-40mg) or has a documented clinical intolerance to statins **AND**
	  ○ Is receiving ezetimibe or has a documented intolerance to ezetimibe.

Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.
Coverage Duration	**Initial**: 6 months. **Renewal**: 12 months.
Renewal Criteria	Documented positive clinical response to therapy (significant decrease in lipid levels).

Criteria Details	
Effective Date	11/1/2026
P&T Approval Date	1/11/2022
P&T Revision Date	09/08/2026, 09/10/2024, 01/11/2022

Peanut Powder (PALFORZIA)

Products Affected

- **PALFORZIA (12 MG DAILY DOSE)**
- **PALFORZIA (120 MG DAILY DOSE)**
- **PALFORZIA (160 MG DAILY DOSE)**
- **PALFORZIA (20 MG DAILY DOSE)**
- **PALFORZIA (200 MG DAILY DOSE)**
- **PALFORZIA (240 MG DAILY DOSE)**
- **PALFORZIA (3 MG DAILY DOSE)**
- **PALFORZIA (300 MG MAINTENANCE)**
- **PALFORZIA (300 MG TITRATION)**
- **PALFORZIA (40 MG DAILY DOSE)**
- **PALFORZIA (6 MG DAILY DOSE)**
- **PALFORZIA (80 MG DAILY DOSE)**

PALFORZIA INITIAL ESCALATION

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Confirmed positive skin test or peanut-specific serum IgE greater than 0.35 kUA/L Concurrent prescription with injectable epinephrine medical justification supports necessity for oral immunotherapy despite peanut avoidance.
Age Restrictions	Patient must be between 4 and 17 at therapy initiation
Prescriber Restrictions	Prescribed by allergist or immunologist enrolled in Palforzia REMS program
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.
Renewal Criteria	Currently receiving medication byway of previously approved SHP authorization or documents showing **Initial** approval criteria was/has been met. For patients who required use of injectable epinephrine while on Palforzia, must have medical justification that supports continued need for Palforzia. If greater than 18 years old, must have medical justification that supports continued need for oral immunotherapy despite peanut avoidance and documentation that Initial dose escalation happened between age 4 and 17.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Pegfilgrastim (NEULASTA)

Products Affected

- **NEULASTA**
- **NEULASTA ONPRO**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Primary prophylaxis of chemotherapy-induced febrile neutropenia (CFN):** Patients receiving chemotherapy associated with greater than 20% incidence of febrile neutropenia **OR** selected chemotherapy regimen associated with 10-20% incidence of febrile neutropenia **AND** one or more risk factors associated with chemotherapy-induced infection, febrile neutropenia, or neutropenia. **Secondary prophylaxis of febrile neutropenia:** Patient has a history of febrile neutropenia with previous chemotherapy **AND** is receiving myelosuppressive chemotherapy associated with neutropenia (ANC less than 500 cells/mm^3). **Neutropenia associated with dose dense chemotherapy (NDDC):** Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer OR patient is receiving a dose-dense chemotherapy regimen **AND** the incidence of febrile neutropenia is unknown. **Febrile Neutropenia (FN):** Patient receiving myelosuppressive chemotherapy associated with neutropenia (ANC less than or equal to 500 cells/mm^3) **AND** is at high risk for infection-associated complications. Acute radiation syndrome **(ARS):** Patient is/was acutely exposed to myelosuppressive doses of radiation.
Age Restrictions	
Prescriber Restrictions	Prescribed by hematologist or oncologist.
Coverage Duration	**Initial** CFN, Secondary prophylaxis FN, NDDC:3 months or treatment duration.

Criteria Details	
	Initial FN, ARS:1 month.
Renewal Criteria	**Renewal Criteria** for CFN, Secondary prophylaxis FN, **AND** NDDC documentation of therapy continuation: 3-month additional approval. **Renewal Criteria** for FN **AND** ARS documentation of therapy continuation: 1-month additional approval.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Phosphodiesterase Type 5 (PDE5) inhibitors

Products Affected

- Sildenafil 20mg tablet
- Tadalafil 20mg tablet
- Sildenafil oral solution

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**<u>Pulmonary Arterial Hypertension</u>** • Clinically documented diagnosis of Pulmonary Arterial Hypertension (WHO group 1 pulmonary hypertension)
Age Restrictions	**Solution only** One of the following: • Pediatric member age 10 or under Documentation inability of the member to use the preferred tablet formulation
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	9/1/2025
P&T Approval Date	7/13/2021
P&T Revision Date	7/8/2025, 3/12/2024, 7/13/2021

Pitolisant (WAKIX)

Products Affected

- **WAKIX 4.45MG TAB**
- **WAKIX 17.8NG TAB**

Prior Authorization Criteria

Criteria Details	

Required Medical Information	• Confirmation of diagnosis of narcolepsy based on polysomnography AND a multiple sleep latency test.
	• Documentation that CYP2D6 testing has been done, and the dosing will be adjusted if the patient is a poor metabolizer.
	• For Excessive Daytime Sleepiness (EDS) the following is required:
	  ○ Documentation of fatigue severity using a validated measure (e.g. Epworth score, Brief Fatigue Inventory, or other validated measure
	  ○ Trial and failure or contraindication to ALL the following:
	  ▪ Modafinil (at least 200mg dose) AND armodafinil
	  ▪ Mixed amphetamine salts, methylphenidate or dexmethylphenidate, AND dextroamphetamine
	  ▪ Sunosi (solriamfetol)
	  ▪ A sodium oxybate product
	• For Cataplexy the following is required:
	  ○ Diagnosis of Cataplexy confirmed by a specialist.
	  ○ Trial and failure or contraindication to ALL the following:
	  ▪ SSRI antidepressant (e.g. fluoxetine)
	  ▪ SNRI antidepressant (e.g. venlafaxine and duloxetine)
	  ▪ Tricyclic antidepressant (e.g. clomipramine)
	  ▪ Sodium oxybate product titrated to maximally tolerated dose.

Age Restrictions	18 years of age and older
Exclusions	• Severe renal or hepatic impairment • Pregnant or actively trying to conceive
Prescriber Restrictions	Prescribed by Sleep Specialist or Neurologist
Coverage Duration	**Initial**: 3 months. **Renewal**: 6 months
Renewal Criteria	Documentation of positive clinical response to therapy.

Criteria Details	
Effective Date	03/01/2025
P&T Approval Date	01/14/2025
P&T Revision Date	01/14/2025

Plozasiran (Redemplo)

Products Affected

- **Redemplo Prefilled Syringe 25mg/0.5mL**

Prior Authorization Criteria

Criteria Details	

Required Medical Information	• Diagnosis of familial chylomicronemia syndrome (FCS) (type 1 hyperlipoproteinemia.
	• One of the following:
	  ○ Disease is confirmed by the presence of biallelic pathogenic variants in FCS-causing genes (i.e., LPL, GPIHBP1, APOA5, APOC2, or LMF1) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) or
	  ○ A North American FCS (NAFCS) Score of greater than or equal to 45 or
	  ○ A Moulin score greater than 10.
	• Both of the following:
	  ○ One of the following:
	  ▪ Patient has tried or will receive treatment with standard of care triglyceride lowering therapy (i.e., prescription omega-3 fatty acid [e.g. Lovaza, Vascepa] and a fibrate [e.g., fenofibrate, gemfibrozil) or
	  ▪ Patient has an intolerance to standard of care triglyceride lowering therapy (i.e., prescription omega-3 fatty acid [e.g. Lovaza, Vascepa] and a fibrate [e.g., fenofibrate, gemfibrozil)
	  ○ Baseline fasting triglyceride levels are greater than or equal to 880 mg/dL prior to treatment with requested drug
	• Requested drug will be used as adjunct to a low-fat diet.
	• Requested drug will not be used in combination with Tryngolza (olezarsen)

Prescriber Restrictions	Prescribed by a Cardiologist, Endocrinologist, Gastroenterologist, or Lipid specialist (lipidologist)
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months
Renewal Criteria	• Patient demonstrates positive clinical response to therapy (e.g., reduction in triglyceride levels from baseline) and

Criteria Details	
	• Requested drug will not be used in combination with Tryngolza (olezarsen)
Effective Date	05/01/2026
P&T Approval Date	03/10/2026
P&T Revision Date	03/10/2026

Pramlintide Acetate (SYMLIN)

Products Affected

- SYMLINPEN 60
- SYMLINPEN 120

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Coverage is provided for the use of pramlintide as an adjunct treatment in type 1 and type 2 diabetic patients 18 or older who use mealtime insulin therapy **AND** who meet all of the following criteria: • Are currently on mealtime insulin. • Have an HbA1c less than or equal to 9%. • Are monitoring blood glucose levels regularly **AND** reliably (3 or more times per day). • Are capable of monitoring blood glucose levels pre- **AND** post-meals **AND** at bedtime. • Have failed to achieve adequate control of blood glucose levels despite individualized management of their insulin therapy. Are receiving ongoing care under the guidance of a health care provider skilled in use of insulin **AND** supported by the services of a diabetes educator.
Age Restrictions	Patient must be 18 years or older.
Prescriber Restrictions	
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Pretomanid

Products Affected

- PRETOMANID TAB

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**<u>Pulmonary tuberculosis</u>** • Evidence of extensively drug-resistant active pulmonary tuberculosis (XDR-TB) caused by mycobacterium tuberculosis. ○ XDR-TB is defined as TB that is resistant to rifampicin and isoniazid, at least one fluoroquinolone (levofloxacin or moxifloxacin) and a second-line injectable (amikacin, capreomycin, and kanamycin) OR Isoniazid, rifampin a fluoroquinolone AND bedaquiline or linezolid. • Pretomanid is prescribed as part of a guideline recommended multi-drug treatment regimen.
Age Restrictions	Patient must be 14 years or older.
Exclusion Criteria	• Use outside of recognized treatment guidelines. • Medication is being received through a county clinic with a state funded TB program.
Prescriber Restrictions	Infectious Disease
Coverage Duration	**Pulmonary tuberculosis:** 24 weeks
Renewal Criteria	N/A
Effective Date	05/01/2025
P&T Approval Date	03/11/2025
P&T Revision Date	03/11/2025

Priftin (rifapentine)

Products Affected

- Priftin

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Latent tuberculosis:** • Used in combination with isoniazid **Active tuberculosis:** • Priftin will be used as part of multi-drug regimen
Age Restrictions	• Age ≥ 2 years old with latent TB • Age ≥ 12 years old with active TB
Exclusion Criteria	• The drug will NOT be received from a county clinic with a state funded TB program.
Prescriber Restrictions	• **Latent TB:** Not limited by specialty • **Active TB:** Infectious disease specialist required for multidrug resistant cases only
Coverage Duration	**Latent TB**: 3 months. **Active TB**: 6 months.
Renewal Criteria	N/A
Effective Date	5/1/2025
P&T Approval Date	3/12/2024
P&T Revision Date	3/11/2025, 3/12/2024

Ranolazine (RANEXA)

Products Affected

- RANOLAZINE ER

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Diagnosis of chronic angina not controlled with other antianginal therapy. May be used with beta-blockers, nitrates, calcium channel blockers, anti-platelet therapy, lipid-lowering therapy, ACE inhibitors, and angiotensin receptor blockers.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Resmetirom (REZDIFFRA)

Products Affected

- Rezdiffra 60MG/80MG/100MG TAB

Prior Authorization Criteria

Criteria Details	

Required Medical Information	• Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH)
	• Patient does not have cirrhosis (e.g. decompensated cirrhosis)
	• Submission of medical records (e.g. chart notes) showing diagnosis has been confirmed by one of the following:
	  ○ FibroScan-aspartate aminotransferase (FAST)
	  ○ MRI-aspartate aminotransferase (MAST)
	  ○ Liver biopsy
	• Submission of medical records (e.g. chart notes) showing disease is fibrosis stage F2 or F3 as confirmed by one of the following:
	  ○ FibroScan
	  ○ Fibrosis-4 index (FIB-4)
	  ○ Magnetic resonance Elastography (MRE)
	• Presence of greater than or equal to 3 metabolic risk factors (e.g., Type 2 diabetes, hypertension, obesity)
	• Submission of medical records (e.g. chart notes) confirming drug is used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community based program)
	• Medication will not be used in combination with Wegovy (semaglutide) for the treatment of MASH
	• Trial and inadequate response, contraindication, or intolerance to Wegovy(semaglutide)

Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by Gastroenterologist; Hepatologist; Endocrinologist

Criteria Details	
Coverage Duration	**Initial**: 6 months. **Renewal**: 12 months
Renewal Criteria	Patient demonstrates positive response to therapy (e.g., MASH resolution, fibrosis stage improvement, etc.) AND Submission of medical records (e.g., chart notes) confirming drug will continue to be used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program)
Effective Date	4/1/2026
P&T Approval Date	5/14/2024
P&T Revision Date	2/19/2026

Ribavirin (VIRAZOLE)

Products Affected

- RIBAVIRIN INHALATION

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Respiratory Syncytial Virus (RSV) Infection:** Chart notes / written medical summary documenting diagnosis of RSV.
Age Restrictions	
Prescriber Restrictions	Request is initiated by an infectious disease specialist.
Coverage Duration	**Initial**: 3 months.
Renewal Criteria	
Effective Date	
P&T Approval Date	
P&T Revision Date	

Rifaximin (XIFAXAN)

Products Affected

- XIFAXAN

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**IBS-D:** Diagnosis of IBS with diarrhea **Hepatic Encephalopathy:** must have one of the following: used as add-on therapy to lactulose **AND** unable to achieve an optimal clinical response with lactulose monotherapy **OR** a history of contraindication or intolerance to lactulose.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**IBS-D Initial**: 14 Days. **Renewal**: 30 Days. **HE Initial**: 12 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Rimegepant (NURTEC)

Products Affected

- NURTEC ODT

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Acute treatment:** Diagnosis of migraine with or without aura **AND** will be used for the acute treatment of migraine **AND** patient has fewer than 15 headache days per month **AND** trial and failure or intolerance to 3 generic triptans or contraindications to all triptans and NSAID combined treatment **OR** trial and failure or intolerance to NSAID treatment alone if triptans contraindicated **OR** contraindication to all triptans and NSAIDs **AND** medication will not be used in combination with another CGRP inhibitor **AND** if patient has 4 or more headache days per month, then patient must currently be treated with amitriptyline, venlafaxine, divalproex, topiramate, candesartan or a beta-blocker or have a contraindication or intolerance to all of these medications. **Prophylaxis treatment**: Diagnosis of episodic migraines **AND** patient has 4 to 18 migraine days per month but no more than 18 headache days per month **AND** trial and failure of at least 2 months intolerance or contraindication of two of the following sets: 1) amitriptyline or venlafaxine; 2) divalproex or topiramate; 3) one of the following beta blocker: atenolol, propranolol, nadolol, timolol, or metoprolol; 4) candesartan **AND** not used in combination with another CGRP inhibitor.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, pain specialist, or headache specialist
Coverage Duration	**Acute Initial**: 3 months; **Renewal**: 12 months **Prophylaxis Initial**: 6 months; **Renewal** 12 months
Renewal Criteria	Documentation of positive clinical response to therapy
Effective Date	

Criteria Details	
P&T Approval Date	
P&T Revision Date	

Risankizumab (SKYRIZI)

Products Affected

- SKYRIZI

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Plaque Psoriasis (PsO):** Diagnosis of moderate to severe chronic plaque psoriasis with one of the following: 1) greater than or equal to 3% body surface area involvement, 2) severe scalp psoriasis, 3) palmoplantar, facial, or genital involvement **AND** a minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies: corticosteroids, vitamin D analogs, tazarotene, calcineurin inhibitors, anthralin, coal tar. **Psoriatic Arthritis (PsA):** Diagnosis of active PsA with one of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, active skin and/or nail involvement. **Crohn's disease (CD):** Diagnosis of moderately to severely active Crohn's disease with one of the following: 1) frequent diarrhea and abdominal pain, 2) at least 10% weight loss, 3) complications such as obstruction, fever, abdominal mass, 4) abnormal lab values (e.g. C-reactive protein), CD Activity Index greater than 220 **AND** trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroids (e.g., prednisone, methylprednisolone), methotrexate.*induction dose is IV, maintenance is subcutaneous. **Ulcerative Colitis (UC):** Diagnosis of moderately to severely active ulcerative colitis with one of the following: 1) greater than 6 stools per day, 2) frequent blood in the stools, 3) frequent urgency, 4) presence of ulcers, 5) abnormal lab values (e.g., hemoglobin, erythrocyte sedimentation rate, C-reactive protein), 6) dependent on, or refractory to, corticosteroids. **AND** trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroids (e.g., prednisone, methylprednisolone), aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine). *induction dose is IV, maintenance is subcutaneous.

Criteria Details	
Age Restrictions	
Prescriber Restrictions	**PsA:** Prescribed by or in consultation with one of the following: Dermatologist or Rheumatologist. **CD/UC:** Prescribed by or in consultation with a gastroenterologist **PsO:** Prescribed by or in consultation with a dermatologist
Coverage Duration	**Initial**: 6 months. **Renewal**: 12 months
Renewal Criteria	**PsO**: Documentation of positive clinical response to therapy as evidenced by ONE of the following: Reduction in the body surface area (BSA) involvement from baseline **OR** improvement in symptoms (e.g., pruritus, inflammation) from baseline. **PsA:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline, or reduction in the body surface area (BSA) involvement from baseline. **CD/UC:** Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, or reversal of high fecal output state.
Effective Date	10/1/2024
P&T Approval Date	
P&T Revision Date	7/9/2024

Risdiplam (EVRYSDI)

Products Affected

- EVRYSDI **SOL 0.75MG/ML**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Spinal Muscular Atrophy (SMA):** • Confirmed (via genetic testing) diagnosis of 5q-autosomal recessive SMA (type 1, 2 or 3) • Patient is not dependent on invasive ventilation or tracheostomy OR use of non-invasive ventilation beyond uses for sleeping • Is not receiving concomitant chronic SMN modifying therapy such as Spinraza Patient has not previously received gene replacement therapy for the treatment of SMA (e.g. Zolgensma)
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist with expertise in the treatment of SMA
Coverage Duration	**Initial**: 12 months. **Renewal**: up to 12 months.
Renewal Criteria	Documentation of clinical improvement from baseline in motor functionality confirmed by standard exams (e.g. BSID-III, CHOP INTEND, HINE-2, RULM test)
Effective Date	09/01/2023
P&T Approval Date	7/11/2023
P&T Revision Date	

Roflumilast (DALLIRESP)

Products Affected

- DALIRESP

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Diagnosis of moderate to severe COPD **AND** patient has chronic bronchitis **AND** patient has tried **AND** failed or has an intolerance or contraindication to two previous COPD therapies (Advair HFA, Advair Diskus, Breo Ellipta, Combivent Respimat, Anoro Ellipta, Dulera, Symbicort).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Sacubitril/Valsartan (ENTRESTO)

Products Affected

- ENTRESO

Prior Authorization Criteria

Criteria Details	
Required Medical Information	The patient has a diagnosis of New York Heart Association class II to IV heart failure **AND** patient is receiving concomitant therapy with one of the following beta blockers: carvedilol, bisoprolol, sustained-released metoprolol, unless unable to tolerate or contraindicated **AND** patient will discontinue use of any concomitant ***ACE inhibitor or ARB before initiating therapy. ***ACE inhibitors must be discontinued at least 36 hours prior to ENTRESTO.**
Age Restrictions	
Prescriber Restrictions	Cardiologist or in consultation with a cardiologist
Coverage Duration	**Initial**: 12 months **Renewal**: 12 months
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Seladelpar (LIVDELZI)

Products Affected

- Livdelzi Capsules

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Primary biliary cholangitis:**
	• Diagnosis of primary biliary cholangitis (PBC) confirmed by two of the following:
	  ○ Biochemical evidence of cholestasis based on ALP elevation
	  ○ Presence of AMA or other PBC-specific autoantibodies
	  ○ Histology confirmation after biopsy
	• Documentation of at least 12 months of inadequate response to ursodiol
	• No current decompensated cirrhosis

Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist or gastroenterologist
Coverage Duration	**Initial**: 6 months. **Renewal**: up to 12 months.
Renewal Criteria	Documented adherence to medication regimen and clinical benefit
Effective Date	01/01/2025
P&T Approval Date	11/12/2024
P&T Revision Date	11/12/2024

Semaglutide (WEGOVY)

Products Affected

- Wegovy

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Reduction of Major Adverse Cardiovascular Events**
	• Treatment is being requested to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke).
	• Age is 18 or older.
	• Wegovy is being used as adjunct to lifestyle modification (e.g. dietary or caloric restriction, exercise, behavioral support, community-based program)
	• Patient has established cardiovascular disease as evidenced by one of the following: prior MI, prior stroke, peripheral aterial disease (e.g. intermittent claudication with ankle-brachial index <0.85, peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease)
	• BMI greater than or equal to 27 kg/m2
	• Wegovy is not being used in combination with any other GLP-1 receptor agonist or tirzepatide containing product
	
	Metabolic Dysfunction-Associated Steatohepatitis (MASH)
	• Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH)
	• Patient does not have cirrhosis (e.g., decompensated cirrhosis)
	• Diagnosis of fibrosis stage F2 or F3 as confirmed by one of the following:
	  ○ Enhanced liver fibrosis (ELF) test
	  ○ Liver stiffness measurement (LSM) by vibration-controlled transient elastography (VCTE) (e.g., FibroScan)
	  ○ FibroScan aspartate aminotransferase (FAST)
	  ○ MRI aspartate aminotransferase (MAST)
	  ○ Magnetic Resonance Elastography combined with fibrosis-4 index (MEFIB)
	  ○ Liver biopsy within the past 12 months
	• Member is age 18 or older

Criteria Details	
	• Used in as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program) • Wegovy is not being used in combination with any other GLP-1 receptor agonist or tirzepatide containing product • Wegovy is not being used in combination with resmetirom
Exclusions	• Weight loss is excluded from coverage
Prescriber Restrictions	**Reduction of Major Adverse Cardiovascular Events** Prescribed by or in consultation with a cardiologist **Metabolic Dysfunction-Associated Steatohepatitis (MASH)** Prescribed by or in consultation with a Gastroenterologist, Hepatologist, or Endocrinologist
Coverage Duration	**Initial**: 6 months. **Renewal**: 12 months.
Renewal Criteria	**Reduction of Major Adverse Cardiovascular Events** • Member is currently on a maintenance dose of 1.7mg or 2.4mg • Documentation of continuation of lifestyle modification program with reduced calorie diet and regular physical activity alongside continuous Wegovy use (80% adherence) • Wegovy is not being used in combination with any other GLP-1 receptor agonist or tirzepatide containing product **Metabolic Dysfunction-Associated Steatohepatitis (MASH)** • Patient demonstrates positive response to therapy (e.g., improvement in liver function tests (LFTs), fibrosis stage improvement, improvement from baseline on MASH-specific imaging [VCTE >/= 25%, MRE >/= 20%, etc.], etc.) • Patient has not progressed to cirrhosis • Documentation of continuation of lifestyle modification program with reduced calorie diet and regular physical activity alongside continuous Wegovy use (80% adherence) • Wegovy is not being used in combination with any other GLP-1 receptor agonist or tirzepatide containing product • Wegovy is not being used in combination with resmetirom
Effective Date	1/1/2026
P&T Approval Date	5/14/2024
P&T Revision Date	11/11/2025, 5/14/2024

Sodium Oxybate

Products Affected

- Sodium Oxybate 500mg/mL

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**<u>Cataplexy and Narcolepsy</u>**
	• Confirmation of diagnosis of narcolepsy and cataplexy based on BOTH:
	  ○ Polysomnography
	  ○ A multiple sleep latency test with cataplexy
	• Trial and failure or contraindication to ALL the following
	  ○ SSRI antidepressant (e.g. fluoxetine)
	  ○ SNRI antidepressant (e.g. venlafaxine or duloxetine)
	  ○ Tricyclic antidepressant (e.g. clomipramine)
	
	<u>Excessive Somnolence due to Narcolepsy</u>
	• Confirmation of diagnosis of narcolepsy based on BOTH:
	  ○ Polysomnography
	  ○ A multiple sleep latency test
	• Baseline documentation of fatigue severity using a validated measure (e.g. Epworth score, Brief Fatigue Inventory, or other validated tool).
	• Trial and failure or contraindication to ALL the following:
	  ○ Modafinil (maximum recommended/tolerated dose)
	  ○ At least 2 stimulant medications (amphetamine, methylphenidate, dextroamphetamine, etc.)
	  ○ Sunosi (maximum recommended/tolerated dose)

Age Restrictions	Age ≥7 years old and weight ≥20kg
Prescriber Restrictions	Sleep specialist, Neurologist, Pulmonologist
Coverage Duration	**Initial**: 3 months. **Renewal**: 12 months.

Criteria Details	
Renewal Criteria	• Request for a continued maintenance dose within FDA approved limits based on indication. • Documented clinical efficacy and tolerability to therapy compared to baseline (for Epworth Sleepiness scale—improvement of at least 3 points is considered clinically significant).
Effective Date	11/1/2025
P&T Approval Date	9/9/2025
P&T Revision Date	9/9/2025

Solriamfetol (Sunosi)

Products Affected

- Sunosi Tablets

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**<u>Excessive somnolence secondary to narcolepsy</u>**
	• Confirmed diagnosis of narcolepsy based on BOTH
	  ○ Polysomnography
	  ○ A multiple sleep latency test
	• Baseline documentation of fatigue severity using a validated measure (e.g. Epworth score, Brief Fatigue Inventory, or other validated tool).
	• Documentation of recent cardiovascular risk assessment (including blood pressure) with a physician attestation that benefits of therapy outweigh the risk.
	• Trial and failure, adverse reaction, or contraindication to the following:
	  ○ Modafinil titrated to maximum recommended/tolerated dose
	  ○ Methylphenidate titrated to maximum recommended/tolerated dose
	  ○ Dextroamphetamine titrated to maximum recommended/tolerated dose
	
	<u>Excessive somnolence secondary to Obstructive Sleep Apnea</u>
	• The medication is intended for the treatment of residual excessive daytime sleepiness in Obstructive Sleep Apnea in a patient treated with CPAP (AHI <5/hour cannot be achieved)
	  ○ CPAP use has been optimized
	  ○ Compliance using device
	• Baseline documentation of fatigue severity using a validated measure (e.g. Epworth score, Brief Fatigue Inventory, or other validated tool).
	• Documentation of recent cardiovascular risk assessment (including blood pressure) with a physician attestation that benefits of therapy outweigh the risk.

Criteria Details	

	• Trial and failure, adverse reaction, or contraindication to preferred formulary options
	  ○ Modafinil titrated to maximum recommended/tolerated dose
	  ○ Methylphenidate titrated to maximum recommended/tolerated dose

Age Restrictions	Age 18 and older
Prescriber Restrictions	Sleep specialist, Neurologist, Pulmonologist
Coverage Duration	**Initial**: 6 months. **Renewal**: 12 months.
Renewal Criteria	**<u>Excessive somnolence secondary to narcolepsy</u>** • Documentation of blood pressure evaluation in the last 3 months. • Documentation of clinical benefit and tolerability to therapy compared to baseline (must use same clinical measure used to diagnose EDS or fatigue at baseline [Epworth Sleepiness Scale—improvement of at least 3 points is considered clinically significant]). **<u>Excessive somnolence secondary to Obstructive Sleep Apnea</u>** • Documentation of blood pressure evaluation in the last 3 months. • Documentation of adherence to primary OSA treatment (e.g. CPAP). • Documentation of clinical benefit and tolerability to therapy compared to baseline (must use same clinical measure used to diagnose EDS or fatigue at baseline [Epworth Sleepiness Scale—improvement of at least 3 points is considered clinically significant]).
Effective Date	11/1/2025
P&T Approval Date	9/9/2025
P&T Revision Date	9/9/2025

Somatropins

Products Affected

- **GENOTROPIN**
- **GENOTROPIN MINIQUICK**
- **HUMATROPE**
- **NORDITROPIN FLEXPRO**
- **NUTROPIN AQ NUSPIN 10**
- **NUTROPIN AQ NUSPIN 20**
- **NUTROPIN AQ NUSPIN 5**
- **OMNITROPE**
- **SAIZEN**
- **SAIZENPREP**
- **SEROSTIM**
- **ZORBTIVE**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**For children:** Growth hormone deficiency in individuals less than 16 years of age or radiographic evidence of non-closure of epiphyseal plates. Appropriate medical work up: Assessment **AND** evaluation must indicate absolute growth less than 4.5 cm per year without growth hormone. Subnormal growth, greater than or equal to 2 standard deviations below the mean for age. **For adults:** Biochemical diagnosis of adult growth hormone deficiency by means of a subnormal response to a standard growth hormone stimulation test (peak growth hormone Less than or equal to 5 mcg/L). Confirmatory testing may not be required in patients with congenital/genetic growth hormone deficiency or multiple pituitary hormone deficiencies due to organic diseases. **Adult-onset:** Patients who have adult growth hormone deficiency whether alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy, or trauma. Turners Syndrome in females is an approved indication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.

Criteria Details	
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Sotatercept (WINREVAIR)

Products Affected

- WINREVAIR INJECTION

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Pulmonary Arterial Hypertension (PAH):**
	• Diagnosis of symptomatic PAH (WHO Group 1 PH) confirmed by right heart catheterization.
	• WHO functional class II or III symptoms.
	• On a stable dose of both
	  ○ Endothelin-1 receptor antagonists (ERA) **and**
	  ○ Phosphodiesterase type 5 inhibitors **or** guanylate cyclase stimulant
	• Current PAH background therapies (ERA, PDE5i, etc.) will be continued unless not tolerated.
	• Baseline platelet count >500,000

Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	**Initial**: 6 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	11/1/2024
P&T Approval Date	9/10/2024
P&T Revision Date	9/10/2024

Sparsentan (FILSPARI)

Products Affected

- FILSPARI **TAB 200MG**
- FILSPARI **TAB 400MG**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Primary immunoglobulin A nephropathy:** • Urine protein-to-creatine ratio (UPCR) ≥ 1.5 and eGFR ≥ 30 mL/min?1.73 m2 • Biopsy-verified primary IgA nephropathy • No history of kidney transplant and not currently receiving dialysis Member has failed to achieve a reduction in proteinuria to under 1 gram/day while receiving maximally tolerated doses of an ACE inhibitor or ARB for at least 12 weeks
Age Restrictions	18 or older
Prescriber Restrictions	Nephrologist
Coverage Duration	**Initial**: 6 months. **Renewal**: 12 months.
Renewal Criteria	Improved or stable kidney function compared to baseline **OR** reduction in proteinuria
Effective Date	09/01/2023
P&T Approval Date	7/11/2023
P&T Revision Date	

Suzetrigine (Journavx)

Products Affected

- Journavx tablets

Covered Uses	• All Food and Drug Administration (FDA)-approved indications not otherwise excluded by plan design ○ Acute, moderate to severe pain

Required Medical Information and Criteria	**<u>Acute moderate to severe pain</u>**
	• Clinical documentation of post-operative use following one of the following:
	  ○ Abdominoplasty
	  ○ Bunionectomy
	• Documentation of one of the following:
	  ○ Diagnosis of opioid use disorder
	  ○ Prescriber has a specific concern for opioid abuse.

Renewal Criteria	• Not eligible for renewal, patients will need to meet initial criteria with new surgery to be eligible for a new prescription.
Exclusion Criteria	• Use for more than 14 days. • Any use outside of acute post-procedural pain.
Age Restriction	• Age 18 or older.

Coverage Duration	• **Acute moderate to severe pain:**
	  ○ Initial: 14 days
	  ○ Renewal: N/A

Effective Date:	7/1/2025
P&T Approval Date:	5/13/2025

P&T Revision Date:	5/13/2025

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Tacrolimus (PROTOPIC)

Products Affected

- TACROLIMUS EXTERNAL

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Atopic Dermatitis:** Clinically diagnosed moderate-to-severe atopic dermatitis (10 percent BSA, hand, foot or mucous membrane involvement, or functional impairment) **AND** trial and failure of topical steroids or reason why they would not be medically appropriate. **Psoriasis:** diagnosis of moderate to severe Psoriasis (10 percent BSA, hand, foot or mucous membrane involvement, or functional impairment) **AND** trial and failure or contraindication to a high potency topical corticosteroid.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Tazarotene (AVAGE) (TAZORAC)

Products Affected

- TAZAROTENE 0.1% CREAM

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Psoriasis**: diagnosis of moderate to severe Psoriasis (10% BSA, hand, foot or mucous membrane involvement **AND** functional impairment) **AND** trial and failure of high potency topical corticosteroids or medical reason why they would be inappropriate **Other FDA approved indications (i.e., severe acne):** trial and failure/contraindication to two formulary alternatives used to treat the approved indication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Terbinafine Hydrochloride (LAMISIL)

Products Affected

- TERBINAFINE HCL

Prior Authorization Criteria

Criteria Details	
Required Medical Information	For the treatment of onychomycosis of the toenail or fingernail due to dermatophytes (tinea unguium) **AND** patient is experiencing pain which limits normal activity (i.e., unable to wear shoes, difficulty walking, etc.) **OR** patient has diabetes **OR** patient has peripheral vascular diseas, **OR** patient is immunocompromised.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	**Initial**: 3 months. **Renewal**: 3 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Tezacaftor/ivacaftor (SYMDEKO)

Products Affected

- SYMDEKO

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Clinical documentation of cystic fibrosis diagnosis with homozygous F508del mutation.
Age Restrictions	6 years of age and older
Prescriber Restrictions	Prescribed by a pulmonologist
Coverage Duration	**Initial**: 3 months **Renewal**: 6 months
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	
P&T Approval Date	
P&T Revision Date	

Ticagrelor

Products Affected

- Ticagrelor tablets

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**<u>Acute Coronary Syndrome</u>**
	• Member has:
	  ○ Either non-ST-elevation acute coronary syndrome (NSTE-ACS) or ST-elevation myocardial infarction (STEMI) AND
	  ○ Has had percutaneous coronary intervention (PCI) AND
	  ○ Has a contraindication to prasugrel
	OR
	• Member has NSTE-ACS and is treated with medical therapy alone (has not had PCI)
	
	<u>Minor Ischemic Stroke</u>
	• Member has had a minor non-cardioembolic ischemic stroke (NIHSS score ≤5) in the immediate past
	• Did not receive IV alteplase
	• Has a reason that clopidogrel can't be used

Age Restrictions	18 years of age and older
Prescriber Restrictions	• **Acute Coronary Syndrome:** Cardiologist • **Minor Ischemic Stroke:** Cardiologist, Neurologist

Coverage Duration	• **Acute Coronary Syndrome:**
	  ○ Initial: 12 months
	  ○ Renewal: 12 months
	
	• **Minor Ischemic Stroke:**
	  ○ Initial: 1 month
	  ○ Renewal: N/A

Renewal Criteria	• **Acute Coronary Syndrome:** Documentation of positive clinical response to therapy and continued need for treatment

Criteria Details	
	• **Minor ischemic stroke:** Renewal not appropriate
Effective Date	9/1/2025
P&T Approval Date	7/11/2023
P&T Revision Date	7/8/2025, 7/11/2023

Tobramycin Solution

Products Affected

- **Tobramycin nebulization solution**

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Use must be for cystic fibrosis or any FDA-approved or compendia supported indication.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist, pulmonologist, or cystic fibrosis specialist
Coverage Duration	**Cystic Fibrosis:** Lifetime **Other diagnoses: Initial**: 3 months; **Renewal**: 12 months
Renewal Criteria	Confirmed diagnosis with clinical evidence supporting chronic use
Effective Date	01/01/2025
P&T Approval Date	11/12/2024
P&T Revision Date	11/12/2024

Tocilizumab

Products Affected

- ACTEMRA INJ PF syringe
- TYENNE INJ PF syringe
- TYENNE INJ AUTO-Inj
- TYENNE IV
- ACTEMRA INJ ACTPEN

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Rheumatoid Arthritis (RA):** Diagnosis of moderately to severely active rheumatoid arthritis **AND** trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine **AND** trial and failure, contraindication, or intolerance to **TWO** of the following, or attestation demonstrating a trial may be inappropriate: Cimzia (certolizumab pegol), Enbrel (etanercept), Humira (adalimumab), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz/XR (tofacitinib/ER). **Systemic Juvenile Idiopathic Arthritis (SJIA):** Diagnosis of active systemic juvenile idiopathic arthritis **AND** trial and failure, contraindication, or intolerance to **ONE** of the following: Non-steroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen, naproxen), Systemic glucocorticoid (e.g., prednisone), methotrexate. **Polyarticular Juvenile Idiopathic Arthritis (PJIA):** Diagnosis of active polyarticular juvenile idiopathic arthritis **AND** trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, **AND** trial and failure, contraindication, or intolerance to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel (etanercept), Humira (adalimumab), Xeljanz (tofacitinib). **Giant Cell Arteritis (GCA):** Diagnosis of giant cell arteritis **AND** trial and failure, contraindication, or intolerance to a glucocorticoid. **Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD):** Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) as documented by the following: exclusion of other known causes of

Criteria Details	
	interstitial lung disease (ILD) (e.g., domestic and occupational environmental exposures, connective tissue disease, drug toxicity) **AND** one of the following: In patients not subjected to surgical lung biopsy, the presence of idiopathic interstitial pneumonia (e.g., fibrotic nonspecific interstitial pneumonia [NSIP], usual interstitial pneumonia [UIP] **AND** centrilobular fibrosis) pattern on high-resolution computed tomography (HRCT) revealing SSc-ILD or probable SSc-ILD OR In patients subjected to a lung biopsy, both HRCT **AND** surgical lung biopsy pattern revealing SSc-ILD or probable SSc-ILD. **Cytokine Release Syndrome (CRS) Risk due to CAR T-Cell Therapy:** Patient will receive or is receiving chimeric antigen receptor (CAR) T-cell immunotherapy (i.e., Kymriah [tisagenlecleucel], Yescarta [axicabtagene ciloleucel])
Age Restrictions	
Prescriber Restrictions	**RA, SJIA, PJIA, GCA:** Prescribed by or in consultation with a rheumatologist. **SSc-ILD:** Prescribed by or in consultation with a pulmonologist or rheumatologist. **CRS:** Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	**RA, SJIA, PJIA, GCA, SSc-ILD: Initial:** 6 months; **Renewal**: 12 months **Cytokine Release Syndrome (CRS) Risk due to CAR T-Cell Therapy: Initial:** 2 months.
Renewal Criteria	**RA, PJIA:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the total active (swollen **AND** tender) joint count from baseline, or improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline. **SJIA:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the total active (swollen **AND** tender) joint count from baseline, or improvement in clinical features or symptoms (e.g., pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline. **GCA, SSc-ILD:** Documentation of positive clinical response to therapy.
Effective Date	09/01/2024
P&T Approval Date	07/11/2023
P&T Revision Date	7/9/2024

Tofacitinib (XELJANZ)

Products Affected

- XELJANZ
- XELJANZ XR

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Rheumatoid Arthritis (RA):** Diagnosis of moderately to severely active rheumatoid arthritis **AND** trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine **AND** patient has had an inadequate response or intolerance to one or more TNF inhibitors (e.g., Cimzia, Humira, Simponi) **AND** patient will not be taking Xeljanz in combination with a potent immunosuppressant (e.g azathioprine or cyclosporine). **Psoriatic Arthritis (PsA):** Diagnosis of active psoriatic arthritis with one of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, active skin and/or nail involvement **AND** trial and failure, contraindication, or intolerance to one or more TNF inhibitors (e.g. Cimzia, Enbrel, Humira, Simponi) **AND** patient is will not be taking Xeljanz in combination with a potent immunosuppressant (e.g azathioprine or cyclosporine). **Ankylosing Spondylitis (AS):** Diagnosis of active ankylosing spondylitis **AND** minimum duration of one month trial and failure, contraindication, or intolerance to **TWO** non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., diclofenac, ibuprofen, indomethacin, meloxicam, naproxen) AND Trial and failure, contraindication, or intolerance to one or more TNF inhibitors (e.g. Cimzia, Enbrel, Humira, Simponi) **AND** patient will not be taking Xeljanz in combination with a potent immunosuppressant (e.g azathioprine or cyclosporine). **Ulcerative Colitis (UC):** Diagnosis of moderately to severely active ulcerative colitis with one of the following: 1) Greater than 6 stools per day, 2) frequent blood in the stools, 3) frequent urgency, 4) presence of ulcers, 5) abnormal lab values (e.g. hemoglobin, ESR, CRP), 6) dependent on, or refractory to, corticosteroids. AND trial and failure, contraindication, or intolerance to one of the following conventional

Criteria Details	
	therapies: 6-mercaptopurine, aminosalicylate [e.g., mesalamine sulfasalazine, azathioprine, Corticosteroids (e.g., prednisone, methylprednisolone) **AND** trial and failure, contraindication, or intolerance to one or more TNF inhibitors (e.g. Humira, Simponi) **AND** patient will not be taking Xeljanz in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine). **Polyarticular Juvenile Idiopathic Arthritis (PJIA):** Diagnosis of active polyarticular course juvenile idiopathic arthritis **AND** trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide **AND** trial and failure, contraindication, or intolerance to one or more TNF inhibitors (e.g. Enbrel, Humira) **AND** patient will not be taking Xeljanz in combination with a potent immunosuppressant (e.g azathioprine or cyclosporine).
Age Restrictions	**Solution only** One of the following: • Pediatric member age 10 or under • Documentation inability of the member to use the preferred tablet formulation
Prescriber Restrictions	**RA, AS, PJIA:** Prescribed by or in consultation with a rheumatologist **PsA:** Prescribed by or in consultation with a dermatologist or rheumatologist **UC:** Prescribed by or in consultation with a gastroenterologist
Coverage Duration	**RA, PsA, AS, PJIA: Initial**: 6 months. **Renewal** 12 months **Ulcerative Colitis (UC): Initial**: 4 months. **Renewal** 12 months
Renewal Criteria	**RA, PJIA:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the total active (swollen and tender) joint count from baseline, or improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline **AND** will not be used in combination with biologic DMARDs or potent immunosuppressants (e.g., azathioprine or cyclosporine). **PsA:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline, or reduction in the body surface area (BSA) involvement from baseline **AND** will not be used in combination with biologic DMARDs or potent immunosuppressants (e.g., azathioprine or cyclosporine).

Criteria Details	
	AS: Documentation of positive clinical response to therapy as evidenced by improvement from baseline for least one of the following: disease activity (e.g., pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (e.g., lumbar spine motion, chest expansion), or total active (swollen and tender) joint count. AND will not be used in combination with biologic DMARDs or potent immunosuppressants (e.g., azathioprine or cyclosporine). **UC:** Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, or reversal of high fecal output state **AND** will not be used in combination with biologic DMARDs or potent immunosuppressants (e.g., azathioprine or cyclosporine).
Effective Date	5/1/2024
P&T Approval Date	3/12/2024
P&T Revision Date	07/11/2023, 01/11/2022

Tranexamic Acid

Products Affected

- Tranexamic Acid 650MG TAB

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Hemophilia Diagnosis**
	• Intending to use for hemorrhage prophylaxis for tooth extraction(s)
	
	Abnormal Uterine Bleeding
	• Currently using or documented trial and failure or contradiction to ALL the following treatments:
	  ○ Cobombined Oral Contraceptive therapy
	  ○ Profestin therapy (oral or LM) or Levonogrestrel IUD
	• NSAID therapy

Age Restrictions	
Prescriber Restrictions	Prescribed by Hematologist, Hemophilia specialist, Dentist, Gynecologist
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months.
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	7/1/2024
P&T Approval Date	5/14/2024
P&T Revision Date	

Prostacyclin Agonists

Products Affected

- Orenitram tablets
- Remodulin
- Treprostinil
- Tyvaso

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**<u>Pulmonary Arterial Hypertension</u>**
	• Clinically documented diagnosis of Pulmonary Arterial Hypertension (WHO group 1 pulmonary hypertension)
	• Clinical documentation of WHO functional class III or IV
	• Evidence of an unfavorable response or intolerance to all of the following:
	  ○ Phosphodiesterase Type 5 inhibitor (sildenafil, tadalafil)
	  ○ Endothelin Receptor Antagonist (ambrisentan, bosentan)
	  ○ Combination therapy with a Phosphodiesterase Type 5 inhibitor + Endothelin Receptor Antagonist (ambrisentan + tadalafil)
	• The requested medication will be an add on to an already established first line agent or agents (sildenafil, tadalafil, ambrisentan, bosentan)

Age Restrictions	Age 16 or older
Prescriber Restrictions	• **Pulmonary Arterial Hypertension:** Cardiologist or Pulmonologist

Coverage Duration	• **Pulmonary Arterial Hypertension:**
	  ○ Initial: 6 months
	  ○ Renewal: 12 months

Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	9/1/2025
P&T Approval Date	7/13/2021
P&T Revision Date	7/8/2025, 7/13/2021

Ubrogepant (UBRELVY)

Products Affected

- UBRELVY

Prior Authorization Criteria

Criteria Details	
Required Medical Information	Diagnosis of migraine with or without aura **AND** will be used for the acute treatment of migraine **AND** patient has fewer than 15 headache days per month **AND** trial and failure or intolerance to 3 generic triptans and NSAID (ibuprofen, naproxen, diclofenac) combined treatment **OR** trial and failure or intolerance to NSAID treatment alone if triptans contraindicated **OR** contraindication to all triptans and NSAIDs **AND** medication will not be used in combination with another CGRP inhibitor **AND** if patient has 4 or more headache days per month, then patient must currently be treated with amitriptyline, venlafaxine, divalproex, topiramate, candesartan or a beta-blocker or have a contraindication or intolerance to all of these medications.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with one of the following specialists: Neurologist, pain specialist, headache specialist
Coverage Duration	**Initial:** 3 months **Renewal**: 12 months
Renewal Criteria	Documentation of positive clinical response to therapy and will not be used for preventative treatment of migraine.
Effective Date	08/01/2023
P&T Approval Date	05/09/2023
P&T Revision Date	

Upadacitinib (RINVOQ)

Products Affected

- RINVOQ TABLETS
- RINVOQ LQ SOLUTION

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Rheumatoid Arthritis (RA):**
	• Diagnosis of moderately to severely active rheumatoid arthritis
	• Trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses:
	  ○ methotrexate,
	  ○ leflunomide,
	  ○ sulfasalazine
	• Trial and failure, contraindication, or intolerance to one or more TNF inhibitors (e.g. adalimumab, certolizumab pegol, etanercept, golimumab)
	• Not used in combination with other Janus kinase (JAK) inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine).
	
	Psoriatic Arthritis (PsA):
	• Diagnosis of active psoriatic arthritis with one of the following:
	  ○ Actively inflamed joints
	  ○ Dactylitis
	  ○ Enthesitis
	  ○ Axial disease
	  ○ Active skin and/or nail involvement
	• Trial and failure, contraindication, or intolerance to one or more TNF inhibitors (e.g. adalimumab, certolizumab pegol, etanercept, golimumab)
	• Not used in combination with other Janus kinase (JAK) inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine).
	
	Ankylosing spondylitis (AS):
	• Diagnosis of active ankylosing spondylitis

Criteria Details	

	• Minimum duration of one month trial and failure, contraindication, or intolerance to two different nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., diclofenac, ibuprofen, indomethacin, meloxicam, naproxen).
	• Trial and failure, contraindication, or intolerance to one or more TNF inhibitors (e.g. adalimumab, certolizumab pegol, etanercept, golimumab)
	• Not used in combination with other Janus kinase (JAK) inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine).
	
	Atopic Dermatitis (AD):
	• Diagnosis of moderate to severe atopic dermatitis
	• One of the following:
	  ○ Involvement of at least 10% body surface area (BSA),
	  ○ SCORing Atopic Dermatitis (SCORAD) index value of at least 25
	• A minimum duration of a 30-day trial and failure, contraindication, or intolerance to at least one of the following:
	  ○ Medium or higher potency topical corticosteroid,
	  ○ Pimecrolimus cream,
	  ○ Tacrolimus ointment, or
	  ○ Eucrisa (crisaborole) ointment
	• A minimum duration of 12-week trial and failure, contraindication, or intolerance of at least one systemic drug for the treatment of AD (e.g. Dupixent)
	• Not used in combination with other Janus kinase (JAK) inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine).
	
	Crohn's disease (CD):
	• Diagnosis of moderately to severely active Crohn's disease with one of the following:
	  ○ Frequent diarrhea and abdominal pain,
	  ○ At least 10% weight loss,
	  ○ Complications such as obstruction, fever, abdominal mass,
	  ○ Abnormal lab values (e.g. C-reactive protein), CD Activity Index greater than 220
	• One of the following:

Criteria Details	
	○ Trial and failure, contraindication, or intolerance to one or more TNF inhibitors (e.g. adalimumab, certolizumab pegol) ○ If treatment is inadvisable with a TNF inhibitor (i.e., contraindication), patient has had a trial of a systemic therapy approved for CD (e.g., guselkumab, mirikizumab-mrkz, risankizumab-rzaa, ustekinumab) • Not used in combination with other Janus kinase (JAK) inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine). **Ulcerative colitis (CD):** • Diagnosis of moderately to severely active ulcerative colitis with one of the following: ○ Greater than 6 stools per day ○ Frequent blood in the stools ○ Frequent urgency ○ Presence of ulcers ○ Abnormal lab values (e.g., hemoglobin, ESR, CRP) ○ Dependent on, or refractory to, corticosteroids • One of the following: ○ Trial and failure, contraindication, or intolerance to one or more TNF inhibitors (e.g. adalimumab, golimumab) ○ If treatment is inadvisable with a TNF inhibitor (i.e., contraindication), patient has had a trial of a systemic therapy approved for UC (e.g., guselkumab, mirikizumab-mrkz, risankizumab-rzaa, ustekinumab) • Not used in combination with other Janus kinase (JAK) inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine). **Polyarticular juvenile idiopathic arthritis (PJIA):** • Diagnosis of active polyarticular juvenile idiopathic arthritis • Trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: ○ methotrexate, ○ leflunomide, • Trial and failure, contraindication, or intolerance to one or more TNF inhibitors (e.g. adalimumab, etanercept) • Not used in combination with other Janus kinase (JAK) inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine).

Criteria Details	
Age Restrictions	**AD**: Age 12 or older
Prescriber Restrictions	**RA, AS, PJIA:** Prescribed by or in consultation with a rheumatologist **PsA:** Prescribed by or in consultation with one of the following: Dermatologist or Rheumatologist. **AD:** Prescribed by or in consultation with one of the following: Dermatologist or Allergist/Immunologist. **CD/UC:** Prescribed by or in consultation with a gastroenterologist
Coverage Duration	**Initial**: 6 months. **Renewal**: 12 months
Renewal Criteria	**RA/PJIA:** Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in total active joint count, improvement in symptoms (e.g., improvement in number of swollen/tender joints, pain, or stiffness). **AND** Rinvoq will not be used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine). **PsA:** Documentation of positive clinical response to therapy as evidenced by one of the following: Reduction in BSA from baseline, reduction in total active joint count, improvement in symptoms(e.g., improvement in number of swollen/tender joints, pain, or stiffness) **AND** Rinvoq will not be used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine). **AS:** Documentation of positive clinical response to therapy as evidenced by improvement from baseline for least one of the following: disease activity (e.g., pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (e.g., lumbar spine motion, chest expansion), or total active (swollen and tender) joint count **AND** Rinvoq will not be used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine). **AD:** Documentation of a positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, or reduction in SCORing Atopic Dermatitis (SCORAD) index value from baseline **AND** Rinvoq will not be used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine).

Criteria Details	
	UC: Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, or reversal of high fecal output state **AND** Rinvoq will not be used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine). **CD:** Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, or reversal of high fecal output state **AND** Rinvoq will not be used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine).
Effective Date	1/1/2026
P&T Approval Date	10/16/2019
P&T Revision Date	09/16/2020 ; 08/19/2021 ; 03/16/2022 ; 04/20/2022 ; 06/15/2022 ; 08/18/2022 ; 10/19/2022 ; 12/14/2022 ; 07/19/2023 ; 07/19/2023 ; 06/19/2024 ; 02/20/2025 ; 04/16/2025 ; 06/18/2025 ; 11/20/2025 ; 11/20/2025

Ustekinumab

Products Affected

- Selarsdi
- Steqeyma
- Yesintek

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**<u>All diagnoses</u>**
	• Initial testing for latent TB and treatment, if necessary, before starting treatment.
	• No current active infection at initiation of therapy.
	• Risks and benefits documented in cases of chronic or recurrent infection.
	• Will NOT be used in combination with another biologic or Otezla
	
	<u>Crohn's Disease (CD)</u>
	• Documentation of moderate-to-severe Crohn's Disease
	• One of the following:
	  ○ The member is transitioning to the requested treatment from a different biologic product previously approved by the plan OR
	  ○ Documented trial and failure of at least 1 of the following: 6-mercaptopurine, azathioprine, corticosteroid, methotrexate
	• Trial and failure of both infliximab and adalimumab
	
	<u>Plaque Psoriasis (PP)</u>
	• Documentation of severe plaque psoriasis, defined as having functional impairment as indicated by Dermatology Life Quality Index (DLQI) = 11 or Children's Dermatology Life Quality Index (CDLQI) = 13 (or severe score on other validated tool) AND one or more of the following:
	  ○ At least 10% of body surface area involved
	  ○ Hand, foot, face, or mucous membrane involvement
	• The member is transitioning to the requested treatment from a different biologic product previously approved by the plan OR documented failure of all the following:
	  ○ High-potency topical corticosteroids (augmented betamethasone, clobetasol, etc.)

Criteria Details	
	○ At least one other topical agent (calcipotriene, tazarotene, anthralin, tar, etc.) ○ PUVA or UVB Phototherapy ○ Methotrexate ○ At least 1 other second line systemic agent such as cyclosporine or acitretin • Trial and failure of both infliximab and adalimumab **<u>Psoriatic Arthritis (PsA)</u>** • Documentation of psoriatic arthritis based on at least 3 out of 5 of the following: ○ Psoriasis (1 point for personal or family history, 2 points for current) ○ Psoriatic nail dystrophy ○ Negative test result for RF ○ Dactylitis (current of history) ○ Radiological evidence of juxta-articular new bone formation • The member is transitioning to the requested treatment from a different biologic product previously approved by the plan OR documented failure of conventional therapy with both of the following: ○ NSAIDs for 3 months at maximum recommended or tolerated anti-inflammatory dose unless contraindicated, AND ○ Methotrexate or other DMARD such as leflunomide, sulfasalazine, or cyclosporine • Trial and failure of both infliximab and adalimumab **<u>Ulcerative Colitis (UC)</u>** • Documentation of moderate-to-severe ulcerative colitis • The member is transitioning to the requested treatment from a different biologic product previously approved by the plan OR documented failure of at least 1 of the following: ○ Mesalamine, sulfasalazine OR ○ Mercaptopurine, azathioprine, OR ○ Corticosteroids (prednisone, methylprednisolone) • Trial and failure of both infliximab and adalimumab
Age Restrictions	**PsO/PsA**: 6 and older
Exclusion Criteria	• Not to be used in combination with other biologics for the same indication.

Criteria Details	
Prescriber Restrictions	• **Crohn's Disease and Ulcerative Colitis:** Gastroenterologist. • **Plaque Psoriasis:** Dermatologist. • **Psoriatic Arthritis:** Dermatologist or Rheumatologist.
Coverage Duration	**Initial**: 6 months. **Renewal**: 12 months.
Renewal Criteria	• **CD:** Evidence of a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission. • **PP:** Evidence of positive clinical response to therapy as evidenced by ONE of the following: reduction of body surface area (BSA) involvement from baseline, improvement in symptoms (e.g. pruritus, inflammation) from baseline, or evidence of functional improvement. • **PsA:** Evidence of a 20% or greater improvement in tender joint count and swollen joint count. • **UC:** Evidence of a significant response such as a decrease in bloody stools per day or elimination of signs of toxicity.
Effective Date	05/01/2025
P&T Approval Date	03/11/2025
P&T Revision Date	3/11/2025, 7/11/2023, 1/11/2022
References	• Selarsdi [package insert]. Parsippany, NJ: Teva Pharmaceuticals; 2025. • Yesintek [package insert]. Cambridge, MA: Biocon Biologics; 2024. • Steqeyma [package insert]. Jersey City, NJ: Celltrion USA Inc.; 2024.

Vedolizumab (ENTYVIO)

Products Affected

- **ENTYVIO**

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Crohn's Disease**
	• Documentation of moderately to severely active Crohn's disease
	• One of the following:
	  ○ Frequently diarrhea and abdominal pain
	  ○ At least 10% weight loss
	  ○ Complications such as obstruction, fever abdominal mass
	  ○ Abnormal lab values (e.g., C-reactive protein [CRP])
	• Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:
	  ○ 6-mercaptopurine
	  ○ azathioprine
	  ○ corticosteroids (e.g., prednisone)
	  ○ methotrexate
	• One of the following:
	  ○ Trial and failure, contraindication, or intolerance to TWO of the following:
	  ▪ Cimzia (certolizumab pegol)
	  ▪ Humira (adalimumab), Amjevita, Cyltezo, Hyrimoz, or Brand Adalimumab-adaz
	  ▪ Ustekinumab
	  ▪ Skyrizi (risankizumab-rzaa)
	  ○ For continuation of prior Entyvio therapy, defined as no more than a 45-day gap in therapy
	
	Ulcerative Colitis
	• Diagnosis of moderately to severely active ulcerative colitis
	• One of the following:
	  ○ Greater than 6 stools per day
	  ○ Frequent blood in the stools
	  ○ Frequent urgency
	  ○ Presence of ulcers

Criteria Details	
	○ Abnormal lab values (e.g., hemoglobin, ESR, CRP) ○ Dependent on, or refractory to, corticosteroids • Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies : ○ 6-mercaptopurine ○ Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine) ○ Azathioprine ○ Corticosteroids (e.g., prednisone) • One of the following: ○ Trial and failure, contraindication, or intolerance to TWO of the following, or attestation demonstrating a trial may be inappropriate*: ▪ Humira (adalimumab), Amjevita, Cyltezo, Hyrimoz, or Brand Adalimumab-adaz ▪ Simponi (golimumab) ▪ Ustekinumab ▪ Rinvoq (upadacitinib) ▪ Xeljanz/XR (tofacitinib/ER) ○ For continuation of prior Entyvio therapy, defined as no more than a 45-day gap in therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by or in collaboration with a Gastroenterologist
Coverage Duration	**Initial**: 14 weeks. **Renewal:** 12 months.
Renewal Criteria	**Crohn's Disease:** Documentation of positive clinical response to therapy as evidenced by at least one of the following: • Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline • Reversal of high fecal output state **Ulcerative Colitis:** Documentation of positive clinical response to therapy as evidenced by at least one of the following: • Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline • Reversal of high fecal output state
Effective Date	5/1/2024

Criteria Details	
P&T Approval Date	3/12/2024
P&T Revision Date	

Vonoprazan (VOQUEZNA)

Products Affected

- VOQUEZNA 10MG
- VOQUEZNA 20MG

Prior Authorization Criteria

Criteria Details	

Required Medical Information	**Erosive esophagitis-**
	• Imaging confirmed LA Classification Grade C/D erosive esophagitis AND
	• Documented contraindication, intolerance, or inadequate response to 2 or more PPIs (i.e., lansoprazole, omeprazole, esomeprazole, etc.) at maximum tolerated twice-daily dosing for at least 8 weeks each.
	
	H. Pylori Infection –
	• Confirmed H. pylori positive infection AND
	• Documented contraindication, intolerance, or inadequate response to:
	  ○ Standard first-line therapies for H.pylori infection
	  ▪ Bismuth quadruple therapy
	  ▪ Rifabutin triple therapy (rifabutin, amoxicillin, omeprazole)
	• Co-prescribed in combination with antibiotics.
	
	Non-Erosive Esophagitis-
	• Documented contraindication, intolerance, or inadequate response to 2 or more PPIs (i.e., lansoprazole, omeprazole, esomeprazole, etc.) at maximum tolerated twice-daily dosing for at least 8 weeks each.

Age Restrictions	Must be at least 18 years of age
Prescriber Restrictions	• **Erosive or Non-Erosive Esophagitis:** Gastroenterologist
Coverage Duration	**Initial healing of erosive esophagitis**: 2 months **Maintenance of healing of erosive esophagitis:** 6 months **H. Pylori eradication:** 14 days **Non-Erosive Esophagitis:** 4 weeks

Criteria Details	
Renewal Criteria	Renewals past the above timelines are not allowed
Effective Date	09/01/2026
P&T Approval Date	01/09/2024
P&T Revision Date	07/14/2026, 01/09/2024

Xanomeline and trospium (COBENFY)

Products Affected

- COBENFY CAPS

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Schizophrenia:** • Confirmed diagnosis of schizophrenia. • Used as monotherapy (not used in combination with 1st or 2nd generation antipsychotic therapy). • Documentation of prior therapy, intolerance, or contraindication to 2 generic antipsychotics indicated for the treatment of schizophrenia (risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, paliperidone, asenapine, or lurasidone).
Age Restrictions	18 years of age and older
Prescriber Restrictions	Psychiatry
Coverage Duration	**Initial**: 12 months. **Renewal**: 12 months
Renewal Criteria	Documentation of positive clinical response to therapy.
Effective Date	03/01/2025
P&T Approval Date	01/14/2025
P&T Revision Date	01/14/2025

Zuranolone (ZURZUVAE)

Products Affected

- ZURZUVAE

Prior Authorization Criteria

Criteria Details	
Required Medical Information	**Postpartum Depression** • Physician attestation of moderate to severe postpartum depression (PPD) diagnosis and submission of validated screening tool result(s) (e.g. EPDS, PHQ-9) that will be used to monitor a patient's response to Zurzuvae therapy • Physician attestation that patient has not had a major depressive episode prior to third trimester of pregnancy and no later than the first 4 weeks following delivery • Patient has tried/failed generic SSRI or SNIR for PPD
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by psychiatrist or OB/GYN
Coverage Duration	**Initial**: 3 months. **Renewal**: N/A
Renewal Criteria	
Effective Date	7/1/2024
P&T Approval Date	5/14/2024
P&T Revision Date	